

business insurance

update

Bermuda insurers underwrite \$6.2 billion in gross premiums

HAMILTON, Bermuda—The 1982 financial returns of 757 Bermuda-based insurers show they underwrote \$6.2 billion in gross premiums and \$4.3 billion in net premiums against capital and surplus of \$7.6 billion and total assets of \$13.6 billion.

About another 200 insurers have yet to file financial returns.

The aggregate figures released by the Bermuda government last week
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Reporting weekly for corporate risk, employee benefit and financial executives/\$1.25 a copy; \$45 a year

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Physicians faced with ballooning malpractice rates

By STEVE TARAVELLA

Physicians and surgeons nationwide are being hit this year with medical malpractice insurance rate increases of 20% to 30%, with no relief in sight in the near future, either.

The increasing severity and frequency of medical malpractice claims are forcing malpractice insurers to raise rates in all parts of the country—not just the traditionally high-risk areas like California, New York and Florida.

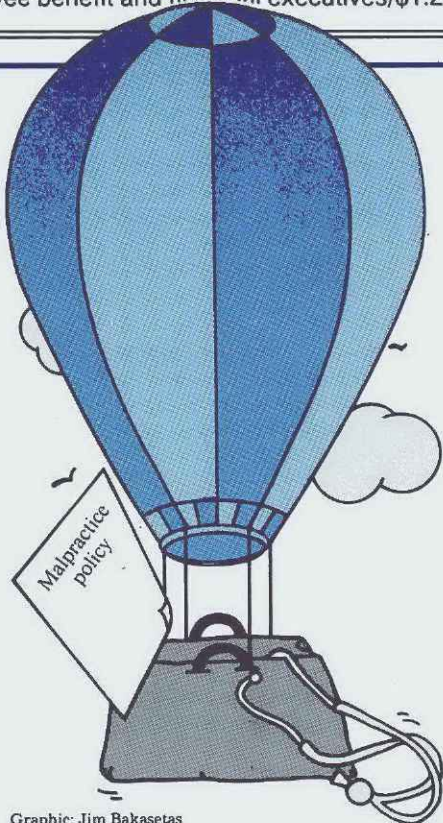
"The concern here is the same one as everywhere," says a leading Texas malpractice insurer. "That's the growing severity of losses and claims, especially in OB-GYNs."

Along with obstetricians and gynecologists, neurosurgeons also are among the doctors hit hardest by the rate increases.

And, in a few cases, the current increases reflect only a smidgen of what insurers said they need to cover losses. One insurer in New York requested a 180% rate increase, but the state Insurance Department cut it back to 30%.

The rate increases come at a time when more hospitals are requiring doctors to carry certain limits of medical malpractice coverage before receiving staff privileges.

"We get a steady application rate from bare doctors, many applying because they're required to," observes Dr. Joseph D. Sabella, president of The Doctors' Co. in Santa Monica, Calif., the second-largest physician-owned insurer in the na-



Graphic: Jim Bakasetas

tion. The company covers about 9,000 California physicians and surgeons.

Dr. Sabella says many of these physicians are good, competent doctors who just never thought they would be the object of a lawsuit and, therefore, never bothered to buy insurance.

Generally, hospitals now require minimum liability coverage of \$200,000 per occurrence and \$600,000 aggregate. Most physicians and surgeons carry coverage of at least \$1 million per occurrence and \$3 million aggregate.

There is rarely a deductible on physi-

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Hyatt says M&M acted negligently

By DOUGLAS McLEOD

KANSAS CITY, Mo.—Hyatt Corp. is charging its broker, Marsh & McLennan Inc., with negligence as the insurance coverage dispute following the 1981 tragedy at the Kansas City Hyatt Regency Hotel again escalates.

Attorneys connected with the case expect a new volley of claims and counterclaims among the parties to the skywalk litigation after two new actions were filed earlier this month in state court.

Hyatt amended previously filed court papers to charge M&M with negligence in arranging the hotel chain's liability insurance.

The Hyatt amendment also makes a claim against liability insurers for Hallmark Cards Inc., whose Crown Center Redevelopment Corp. subsidiary owned the hotel building.

Hyatt demands that Commercial Union Insurance Co. and others on the Hallmark line indemnify Hyatt, the operator of the hotel, for legal expenses in defending and settling damage claims.

Meanwhile, Northbrook Excess & Surplus Insurance Co., Hyatt's first excess liability insurer, has filed a claim against CU and American Insurance Co., charging that delay by the Hallmark insurers in paying damage claims forced Northbrook to pay the limits of its policy earlier than it should have, resulting in a loss of investment income.

Lawyers involved in the skywalk litigation say that Hyatt and Hallmark insurers will file more claims against one another as they prepare to litigate the question of which insurers are responsible for paying legal costs and when they should have paid.

Consideration of the insurance questions by a Jackson County Circuit Court is expected to begin as soon as the last remaining damage claims from victims are settled, possibly as early as Dec. 1, lawyers say.

Two skywalks suspended above the lobby of the Kansas City Hyatt collapsed while loaded with hotel guests on July 17, 1981, killing 114 and injuring at least 200.

So far, about \$60 million in injury and death claims have been paid, including \$24.9 million in federal and state class-action settlements and an estimated \$35 million paid before the class settlements were certified.

In addition, state court juries have awarded another \$24 million in compensatory damages to four individual claimants, and several other individual cases are pending. However, attorneys involved with the cases say these judgments may still be appealed.

The latest jury award—and the largest—came last Wednesday, when a Jackson County Circuit Court jury awarded \$15 million to 36-year-old Sally Ann Firestone. Ms. Firestone, who suffered a broken neck and spinal cord damage in the accident, was left a quadriplegic and was considered the most seriously injured survivor.

While insurers for Hyatt, Hallmark and companies involved in the construction of the hotel have paid victims' claims, they have quarreled since the accident over which should have paid first and how much.

Hyatt carried \$201 million in liability coverage through 23 insurers, including \$1 million in primary coverage written by Occidental Fire & Casualty Co. of North Carolina; \$25
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Employers support unisex ruling despite costs

By LORRIE GAWLA

Benefit managers support the Supreme Court's ruling that women and men must be paid equal pension benefits for equal contributions, but they don't want Congress to take this unisex notion any further.

Sixty-three percent of the benefit managers responding to a recent *Business Insurance* Employee Benefit Board survey said they agree with the Supreme Court decision in *Norris vs. Arizona Governing Committee* (BI, July 11), but almost the same number—56%—are opposed to legislation pending in Congress that would eliminate sex as a rating factor for all lines of insurance.

While benefit managers may support the *Norris* decision, the survey showed that some employers will pay as much as \$25,000 in administrative costs to overhaul their pension plans to conform with the ruling. And, 40% of the survey respondents have hired or will

hire consultants or actuaries to help them amend their pension plans.

Despite this added expense for some employers, the survey also showed that few employees were complaining about unequal benefits.

The *Business Insurance* Employee Benefit Board is composed of benefit managers from large and small corporations, institutions and government entities who have volunteered to answer periodic surveys from BI.

Of all the questions asked on the survey, benefit managers were most opinionated about the unisex insurance legislation, S. 372 and H.R. 100, pending in the Senate and House.

Under this legislation, sponsored by Sen. Robert Packwood, R-Ore., and Rep. John Dingell, D-Mich., the cost of life, medical, disability, automobile and all other forms of

insurance would have to be calculated without any consideration of the sex of the policyholder.

Currently, women often pay less for life insurance because statistics show they live longer, less for auto insurance because they have fewer accidents and more for medical and disability insurance because they are sick more frequently than men.

Many benefit managers oppose the proposal simply because they believe sex is a valid factor in setting insurance rates.

"Unisex legislation is not realistic," says the director of employee benefits for a transportation services firm with 20,000 employees. "Insurance companies have set rates based on their data and experience. To do otherwise is arbitrary."

"When a legitimate, provable difference

exists, it should be able to be used to determine rates," wrote a benefits manager from a telecommunications firm.

"In reality, women live longer than men. Rates should be based on reality," says the manager of personnel administration for a manufacturer with 628 employees.

Other benefit managers are opposed to unisex rating because they think it will cost employers more while actually reducing employees' benefits.

"While on the surface unisex rating seems the equal way to go, in fact, sound actuarial evaluations would show a contrary result," says the benefit manager for a health care provider with 2,750 employees. The cost of implementing unisex rating "would be horrendous," he added.

"Effectively, more employees would be negatively impacted than would be positively helped and the administrative and legal costs

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employee benefit board

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Bank details how it recovered from disaster
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Hospital risk managers hold annual conference
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update

Bermuda releases financial data

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are the first confirmation of estimates of the size of the Bermuda marketplace (BI, April 25). In comparison, the U.S. property/casualty insurance market in 1982 had net written premiums of \$104.2 billion against capital and surplus of \$60.8 billion and total assets of \$251.2 billion. The most recent financial reports from Lloyd's of London show that its 437 syndicates at year-end 1980 had \$4.5 billion in net premiums (BI, Sept. 5).

Robert Baker, chairman of the Insurance Advisory Committee in Bermuda, noted Bermuda insurers' net premiums are only one-half of their capital and surplus "and the ratio of 2-1 is considered conservative. So obviously there is a lot of unused capacity here that is just waiting for the market to turn—biding its time."

Mr. Baker estimates that of the \$6.2 billion in gross premiums reported for 1982 about \$5.2 billion was written by captive insurance companies for their parent companies and unrelated risks. Insurers and reinsurers in Bermuda writing only unrelated risks underwrote about \$1 billion in gross premiums in 1982.

Holiday Inns covered for hotel

NEW YORK—A federal judge has ruled that Holiday Inns Inc. is covered under an all-risk policy for losses arising out of fighting in Lebanon during 1975 and 1976.

U.S. District Judge Charles S. Haight Jr. said in his Sept. 19 decision that the losses in Lebanon were due to a series of "civil commotions" that are covered under the policy. He rejected the argument of defendant Aetna Insurance Co. that the losses stemmed from a "civil war" and, therefore, were excluded under the policy.

Holiday Inns, based in Memphis, Tenn., is seeking \$11 million from Aetna for damages to a 400-room hotel in Beirut. Judge Haight did not rule on how much money Aetna should pay.

The all-risk policy was written through AFIA Worldwide Insurance in the name of Aetna, a unit of CIGNA Corp. Holiday Inns reportedly paid extra under its all-risk policy for coverage for claims arising out of "riot, strike and civil commotion."

In a statement released by AFIA, Vp Bowdre P. Mays said that AFIA's lawyers are reviewing the decision and expect to appeal.

Attorneys press for dismissal

NEW YORK—Attorneys for asbestos disease victims are again pressing to have Manville Corp.'s reorganization petition dismissed.

The attorneys asked last week that the U.S. District Court in Manhattan take the Manville case from U.S. Bankruptcy Court and dismiss Manville's petition. A hearing is set for Oct. 18.

Last year, plaintiffs' attorneys filed a motion to dismiss the petition with the bankruptcy court, alleging it was filed in bad faith.

Meanwhile, five Manville directors met last week with other creditor groups to work out a consensual reorganization plan. Attorneys for asbestos claimants did not participate.

Bill on KAL claims introduced

WASHINGTON—Rep. Don Bonker, D-Wash., has introduced legislation, H.R. 3918, that would direct the secretary of state to begin negotiations with the Soviet Union on claims filed by families of victims on the Korean Air Lines jetliner downed by the Soviets.

Under the legislation, claims would first have to be validated by the U.S. Foreign Claims Settlement Commission, part of the Justice Department, before U.S.-Soviet negotiations would begin.

MGIC to halt some underwriting

NEW YORK—MGIC Indemnity Corp. has announced an agreement with Chicago-based CNA Insurance Cos. under which CNA will acquire the majority of its casualty insurance business.

Under the agreement, effective Oct. 1, CNA will reinsure 100% of MGIC Indemnity's professional liability business, which accounts for \$25 million in annual premiums. It includes directors and officers liability, trust errors and omissions, mortgage interest, IRA/Keogh plan errors and omissions, pension trust liability and non-profit organization professional liability insurance policies.

MGIC Indemnity will continue to accept application and information requests for these coverages during a six-month transition period, according to MGIC President Jack Schreihofer. The MGIC policies now in force will take a maximum of three years to run off and renewals will be made on CNA policies, he added.

Mr. Schreihofer said that the professional liability business, which still produces a profit, no longer fits into the long-range plans of parent MGIC Investment Corp., which is owned by Baldwin-United Corp. Baldwin announced recently it would sell MGIC Investment.

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'Pre-impact' damage suits permitted for DC-10 crash

By DOUGLAS McLEOD

CHICAGO—Families of Illinois residents killed in the 1979 crash of an American Airlines DC-10 jetliner may sue for "pre-impact pain and suffering" under a new ruling by two federal judges.

The two judges reversed their own previous order barring such damage claims, relying on a recent Illinois Supreme Court decision that revised the state law concerning awards for psychological suffering.

Lawyers representing the families are divided over whether the ruling will significantly increase damage awards, though, and an attorney for McDonnell-Douglas Corp., which manufactured the airliner, insists the ruling will have "zero effect."

The American DC-10 crashed on May 25, 1979, moments after taking off from Chicago's O'Hare International Airport, killing all 273 passengers on board.

All but about 70 of the approximately 275 damage claims that resulted have been resolved, with payments so far totaling more than \$90 million, lawyers say. About 24 cases are still pending in Chicago.

Under an agreement among American, McDonnell-Douglas and their insurers, American is paying 75% of the passenger claims and the aircraft manufacturer is paying 25% (BI, May 4, 1981).

U.S. District Court Judges Hubert L. Will and Edwin A. Robson had earlier ruled out any damage awards for the psychological suffering of the crash victims.

In reversing themselves, the judges relied on a state Supreme Court ruling of last June that allowed a bystander in a fatal accident to collect damages for psychological suffering even though he wasn't physically injured himself.

The federal judges' ruling means that lawyers in the DC-10 case need only prove by circumstantial evidence that the crash victims showed some physical symptom

of stress—such as sweating—to collect damages for pre-impact pain and suffering, according to Robert J. Glenn, a plaintiffs' attorney. Mr. Glenn's firm, Motherway & Glenn, represents 20 of the remaining Chicago plaintiffs as co-counsel with Chicago attorney Philip Corboy.

Mr. Glenn said he put off bringing the cases to trial while waiting for the Supreme Court decision.

He speculated that awards under the new ruling could range anywhere from \$10,000 to \$500,000 per plaintiff.

A U.S. District Court jury in Manhattan awarded the family of one crash victim \$10,000 in pre-impact pain-and-suffering damages and \$7 million in compensatory damages.

Mr. Glenn said that a Texas jury recently awarded \$500,000 in such damages for each of five persons killed when a small plane broke up at 11,000 feet and crashed.

"It's hard to tell what juries will do with pain and suffering for such a short duration," said Kevin M. Forde, a Chicago attorney acting as liaison counsel for the plaintiffs' lawyers.

Mr. Forde said juries would be more likely to concentrate on compensatory awards.

Norman J. Barry, whose Chicago firm of Rothschild, Barry & Myers represents McDonnell-Douglas, doesn't expect any awards under the new ruling at all.

The federal judges "misinterpreted" the state Supreme Court decision, Mr. Barry said. Even so, he added, American and McDonnell-Douglas will have to wait until a complaint is filed seeking damages for pre-impact suffering before they can appeal the ruling.

None of the approximately 40 Illinois plaintiffs whose claims have already been resolved will be able to refile new claims under the ruling. Those plaintiffs have already signed releases barring further lawsuits or have had their cases dismissed.

Lloyd's brokers, rock star covered for risky weekend

By STACY SHAPIRO

LONDON—What do two Lloyd's of London brokers and a popular British rock star have in common?

Well, they're all a bit flighty.

The trio—two aviation consultants at Lloyd's broker Stewart Wrightson P.L.C. and rock singer Leo Sayer—were scheduled over the weekend to stage some high-flying aviation stunts to be televised by the British Broadcasting Corp.

But before any of the daredevils took off, the BBC and the pilots themselves made sure the safety precautions were taken and that adequate life and liability insurance had been purchased.

The first stunt, set to occur last Saturday, featured Stewart Wrightson aviation consultant Tim Ridgeway, who was attempting to put himself in the "Guinness Book of World Records" by shattering the record for travel between London's Marble Arch and the Arc de Triomphe in Paris.

If all went well, Mr. Ridgeway was to have broken the 24-year-old record of 40 minutes, 44 seconds by:

- Hopping onto a motorcycle at the Marble Arch and zooming to White City Stadium in London.
- Flying an Alan Mann Agusta 109 helicopter from the stadium to London's Biggin Hill airport.
- Piloting a privately owned Hawker Hunter jet aircraft, which he would fly across the English Channel to Paris.

• Jumping into an Aerospatial Dauphin helicopter after landing at Le Bourget Field outside Paris and flying to the Bois de Boulogne in Paris.

• And, finally, driving another motorcycle to the Arc de Triomphe.

Mr. Ridgeway was to have been met by British television cameras and a representative of the "Guinness Book of World Records" upon his speedy arrival at the Paris monument.

Following Mr. Ridgeway's stunt, David Boyce, the other Stewart Wrightson aviation consultant, was to race against Mr. Sayer, the rock star, between London and Paris. Mr. Boyce was to have begun his journey in Paris, while Mr. Sayer would reverse Mr. Boyce's route and begin in London.

"I will beat him—no problem," Mr. Boyce bragged to *Business Insurance* last week.

Mr. Boyce—along with another Lloyd's broker, David Springbett, chairman of Pearson Webb Springbett—already holds the record time from London to New York. The duo was clocked at three hours, 59 minutes, 44 seconds on the westward leg of the stunt, and three hours, 40 minutes, 40 seconds on the eastward flight.

"I have always been an enthusiast for things like this," Mr. Boyce remarked.

Mr. Boyce was to use much the same equipment as Mr. Ridgeway did during his attempt on the record. Mr. Sayer, however, was to pilot a Falcon jet aircraft owned by former world road-racing champion

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Panel again delays tort reform vote

WASHINGTON—The Senate Commerce Committee is again delaying consideration of a bill that would establish a federal product liability law.

A committee vote on the legislation, proposed by Sen. Robert Kasten, R-Wis., was scrubbed last week after Sen. Slade Gorton, R-Wash., was prepared to introduce about a dozen amendments to the bill.

While some of those amendments involved only technical changes, others are far-reaching and are opposed by Sen. Kasten.

For example, one amendment would restore the doctrine of "collateral estoppel," which Sen. Kasten wants to delete from current product liability laws. The collateral estoppel doctrine allows a fact to be established in a case by showing that a previous court accepted the fact. That saves a party in a lawsuit the cost of re-litigating an issue.

The Justice Department earlier opposed eliminating the collateral estoppel doctrine because it wasn't aware "that a problem existed in this area for which a federal solution was appropriate."

The delay in voting on the measure, S. 44, gives Sens. Kasten and Gorton a chance to try to work out their differences so that Sen. Gorton will support the bill.

Sen. Gorton's support is considered vital to the bill's chances of gaining committee and Senate approval because other moderate Senate Republicans may follow his lead. Mr. Gorton previously served as attorney general in Washington state.

A new vote on the bill is not expected until sometime next month. The bill was earlier delayed until the Reagan administration agreed to support it.

Study says regulators can't cope with boom in financial services

By DOUGLAS McLEOD

NEW YORK—Financial services conglomerates are growing so quickly that they've outstripped the ability of state regulators to keep watch over them, a new study concludes.

In a period of "overnight takeovers" and the blurring of lines among the insurance, banking and securities industries, state insurance departments may not be able to protect the public against insolvencies unless they have better equipment and more manpower, says the study prepared by a task force of the Conference of Insurance Legislators.

"In the fast mix and match of their companies and products, America's financial leaders are doing some imaginative things with other people's money," the report begins.

"Many of their efforts are very worthwhile. But others are proving a little too inventive, aggressive and perhaps even reckless, and have raised serious questions as to the ability of regulators to keep watch."

The report, entitled "Risk...Reality...Reason...In Financial Services Deregulation," was prepared by the COIL Task Force on Multi-Purpose Financial Products and Regulatory Initiative. It was presented to the annual meeting of the Society of Chartered Property and Casualty Underwriters earlier this month by New York state Sen. John R. Dunne, the task force's chairman.

"Like it or not, there are some real dangers with the deregulation of financial services," Sen. Dunne said. "In this day of quick takeovers and instantaneous fund transfers, a company holding millions of dollars in policyholders' funds can go broke in no time, and it could take insurance regulators months to learn about it."

One needn't look too far for an example of the problem, the report notes. "The hard times that have befallen the Baldwin-United Corp. provide a current and ongoing case in point."

Cincinnati-based Baldwin-United, fighting to avoid insolvency, this month announced its intention to sell its largest subsidiary, MGIC Investment Corp., to help pay off the thousands of holders of single-premium

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Twin Cities' employers compare hospital costs

By CAROL CAIN

MINNEAPOLIS—Twin Cities' employers are poring over a recently published hospital price comparison to see if they can use the information to revise their benefit packages or evaluate preferred provider organizations.

The report is so new that most benefit managers haven't had a chance to decide how the information can be used, though many are predicting it will increase hospital competition and help reduce cost increases.

But, employers and insurers already point out the report notes that hospital charges in the Twin Cities can vary by as much as 100%.

This information could foster a price sensitivity that wasn't present before, explains Fred Sattler, director of health care management for Northwestern National Life Insurance Co. in Minneapolis.

Heralded as unprecedented, the report contains average prices—both for specific hospitals and the entire group—for 101 "case mix groups" based on 25 diagnoses.

"A case mix group defines a medically meaningful and understandable hospital product or service provided to patients with similar medical conditions," notes Allan N. Johnson, vp of the Council of Community Hospitals in Minneapolis, the group that developed and coordinated the report.

For example, normal childbirths were divided into two groups: procedures with no complications and those that included sterilization or dilation and curettage. The first category had an average charge of \$1,009, a low charge of \$656 and a high charge of \$1,311. The average charge for the latter category was \$1,716, with a low of \$1,349 and a high of \$2,274.

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Anatomy of a disaster

Minneapolis bank's disaster plan allowed it. . .

By JIM DAVIS

BALTIMORE—Foresight and thoroughness are key elements for businesses developing catastrophe recovery plans, say officials at Norwest Corp. in Minneapolis.

"If you have a plan that outlines how you'll react to a disaster, you'll be able to operate with some logic, you won't be groping," said Virgil M. Dissmeyer, executive vp and corporate operations officer for Norwest Information Services Inc., the data processing arm of Norwest Corp. "You'll have organized confusion instead of chaos."

When it comes to recovering from disasters, Mr. Dissmeyer and his fellow workers have solid experience.

Last Thanksgiving Day, Nov. 25, 1982, a five-alarm fire destroyed the 17-story building that was the headquarters for Norwest Corp., including its Northwestern National Bank of Minneapolis unit, which changed its name this year to Norwest Bank Minneapolis N.A.

Although the blaze, believed to be the largest office fire ever in the United States, destroyed most of Norwest's records and equipment in the building,

the company was still able to restore most operations within a week, working from eight different locations.

Norwest officials explained the bank's catastrophe recovery plan that provided direction for this comeback at a seminar entitled "Anatomy of a Disaster" in Baltimore earlier this month. The seminar was co-sponsored by the Bank Administration Institute of Rolling Meadows, Ill., a non-profit bank industry research group.

Fortuitously, the bank's disaster recovery plan, developed during the first six months of 1982, was finalized just before the fire, Mr. Dissmeyer said. Previously, individual bank departments had separate recovery plans, but they weren't coordinated.

Development of the overall corporate disaster plan was directed by Project Analyst Yvonne A. Carlton.

"You've got to set a deadline for when the plan will be completed," she said. "Otherwise, planning will go on and on, and it will never get done. Then meet those deadlines, or at least tell your supervisors well in advance that there will be some slippage. Otherwise, the plan won't have any credibility."

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. . . to quickly rebound from total destruction

By JIM DAVIS

BALTIMORE—At 4:30 p.m. last Thanksgiving, a five-alarm fire began that would destroy most of the 17-story Northwestern National Bank building in downtown Minneapolis.

By 6:30 p.m., as firefighters battled to control the blaze, the bank had already issued a press release—the first of many—to employees and customers.

The release told customers that bank operations would be restored as quickly as possible and it advised employees not to report to work the next day unless they were contacted by their supervisors.

This quick dissemination of information to both employees and customers is a crucial part of the bank's disaster recovery plan, which company offi-

cial explained at a seminar entitled "Anatomy of a Disaster," held Sept. 12 and 13 in Baltimore.

The seminar was sponsored by the bank and the Bank Administration Institute of Rolling Meadows, Ill., a non-profit industry research group.

The bank, which has since changed its name to Norwest Bank Minneapolis N.A., is a subsidiary of Norwest Corp. The destroyed bank building was corporate headquarters.

"Identify what needs to be done and delegate responsibility," said John C. Nelson, senior vp of the bank's consumer banking group. "If employees are clear on their direction, there's nothing they won't do. The key is to tell them what their mission is and give them the responsibility to do it."

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Photos: Wide World and Norwest Bank

Norwest Corp. was able to open a new consumer banking facility in leased space shortly after a Thanksgiving Day fire destroyed its headquarters in downtown Minneapolis.

UNR blames bankruptcy on insurer 'conspiracy'

By STEPHEN TARNOFF

CHICAGO—UNR Industries Inc. says a massive "conspiracy of silence" by the insurance industry to fix prices, boycott and intimidate policyholders and deny coverage in asbestos-related cases forced it into bankruptcy.

Insurers began this conspiracy, the asbestos defendant claims, to avoid paying defense and indemnification costs in connection with more than 20,000 asbestos cases and other potentially large cumulative trauma suits.

A UNR lawsuit containing these allegations, filed earlier this month in U.S. Bankruptcy Court in Chicago, is apparently the first asbestos coverage suit to accuse insurers of violating federal antitrust laws.

The suit charges that the insurance industry misrepresented the interpretation of policies, sought to disrupt and eliminate the market for liability policies and sought to preserve the insurers' competitive position in

the industry.

The 54-page complaint says UNR's primary and excess insurers, various other insurers and reinsurers as well as industry trade organizations participated in the conspiracy.

As a result, UNR has had to pay \$23 million in awards, settlements and defense costs in asbestos litigation, the suit says, with insurers paying only \$7 million.

UNR's expenditure forced it to file for bankruptcy under Chapter 11 of the Federal Bankruptcy Act in August 1982, it says.

UNR is seeking from the defendants named in the suit more than \$100 million in damages, which can be tripled under federal antitrust laws.

Among those named in the suit are UNR's primary insurers, including Continental Insurance Co.; Bituminous Casualty Corp.; Zurich Insurance Co.; American Mutual Liability Insurance Co.; National Surety Corp.; and Fireman's Fund Insurance Cos., which

was not a primary insurer but was alleged to control National Surety.

UNR excess insurers named in the action include The Home Insurance Co.; Commercial Union Insurance Co. as the successor company of Employers Liability Assurance Corp.; Falcon Insurance Co. as successor to The Employer's Surplus Lines Corp.; Northbrook Excess & Surplus Insurance Co.; First State Insurance Co.; and Continental Casualty Co., a unit of CNA Financial Corp.

In addition, the Insurance Services Office, a ratemaking and policy-writing organization funded by the insurance industry, and Underwriters Adjusting Co., a claims-handling subsidiary of Continental Insurance, are named.

According to attorney Daniel H. Williams of the Los Angeles firm of Paul, Hastings, Janofsky & Walker, which represents UNR, the suit details a "classic example of when insurance companies get together and withhold benefits."

The insurers conspired to deprive policyholders of coverage in order to "cut a better deal for the insurance industry," he said, adding that the impact of the conspiracy forced UNR into bankruptcy.

"It (the suit) is the first time any manufacturer has made allegations under federal antitrust law," Mr. Williams notes.

Representatives of the insurance companies named in the suit, however, say UNR's claims are false and that prior court decisions, as well as UNR's own actions, illustrate that there was no conspiracy.

"That's not the case," Peter C. John, an attorney for the Chicago firm of Phelan, Pope & John, says of the conspiracy charges, adding that they are "tortured and concocted. They are outrageous charges and claims."

"The facts are never what they appear, especially in claims as exaggerated and concocted as these are," Mr. John says.

Although UNR's suit takes a different ap-
Continued on next page

UNR blames bankruptcy on 'conspiracy'

Continued from previous page
proach from the coverage suits filed by other asbestos defendants, some of the same arguments are used in the newest claim.

For instance, the complaint questions the validity of the exposure and manifestation theories of liability coverage for long-latent injuries.

Some insurers, advocating the exposure theory, contend that insurers on the risk when an asbestos disease victim inhaled asbestos fibers are liable for defense and indemnification costs.

Others, those that support the manifestation theory, say only those on the risk when an asbestos disease is actually diagnosed must pay.

On the other hand, virtually all asbestos defendants argue that all

insurers, from the time of exposure through manifestation, should be liable.

Another point at issue in the UNR complaint is the validity of an interim funding arrangement, known as the Houston agreement, which UNR's primary insurers set up in the mid-1970s to pay asbestos claims.

Under the arrangement, Zurich and Bituminous each agreed to pay 25% of UNR's defense and indemnification costs, Continental agreed to pay 15% and UNR 35%. The agreement also specified that claims were to be paid according to the exposure theory.

But, in its suit, UNR contends that both the exposure and manifestation interpretations espoused by insurers and the funding arrangements are the results of the

insurers' conspiracy to deprive UNR and other insureds of coverage.

"We don't admit that the dispute over manifestation and exposure is a genuine dispute," Mr. Williams says. "It isn't a legitimate basis for insurers' argument."

UNR argues that drafters of the standard liability insurance policies rejected the manifestation theory, that they anticipated UNR and other insureds' broad interpretation of coverage and that the insurance industry was aware of this.

Moreover, the suit contends that the insurers knew they could not seek contributions from insureds for defense and indemnification costs, even though that's what the Houston agreement called for.

It also contends that insurers had a duty to defend all suits and that

under pre-1966 policies, the duty to defend continues even after exhaustion of policy limits.

Under UNR's standard-form liability policies, dating back to the 1930s, the liability of its insurers is "co-extensive with the liability of UNR," the suit says. "Thus, just as UNR is held jointly and severally liable in the asbestos cases for all injury so long as at least some injury is attributable to UNR, likewise each insurance carrier is jointly and severally liable to UNR so long as at least some injury takes place during the insurance carrier's policy period."

"These provisions mean that UNR's insurance carriers owe UNR a full defense and indemnification of the asbestos cases."

Despite their awareness of the extent of their liability, however,

Zurich, Bituminous, Continental and its Underwriters Adjusting Co. subsidiary—and subsequently the industry as a whole—have refused to fully defend and indemnify UNR and other asbestos defendants, the suit says.

"UNR's insurance carriers were afraid of the vast liability represented by the asbestos cases, and they were afraid that they could also be held liable under standard-form insurance policies issued to other manufacturers involved in other cumulative injury cases," the complaint says.

To avoid such liability, UNR's primary insurers entered the conspiracy, the suit says.

The purpose of the conspiracy includes imposing "fraudulent coverage interpretations" on insureds that effectively permit insurers to retroactively raise the price of past insurance coverage by drastically reducing benefits, the suit says. It also permits insurers to save themselves billions of dollars by eliminating their obligations to policyholders, the suit adds.

In addition, according to the lawsuit, the conspiracy serves to:

- Make an example of asbestos manufacturers so that other companies will forego claims against the conspirators in cumulative injury cases.

- Force UNR into bankruptcy so it will eventually liquidate and be unable to sue the insurers for coverage.

- Disrupt and eliminate the market for liability policies so the insurance industry can market new claims-made or manifestation-theory policies, which provide greatly reduced coverage at a greatly increased price.

- Preserve and maintain the relative competitive positions of insurance companies within the insurance industry.

To carry out the conspiracy, the suit alleges, Zurich and Bituminous—later joined by Continental and UAC—agreed not to honor their defense and indemnification obligations, misrepresented the true meaning of the policies, forced UNR to accept less than what it was entitled to, fixed prices and would not sell the company any more insurance.

The defendants' actions deprived UNR of insurance benefits, forced it to spend millions of dollars to defend and settle claims its insurers were responsible for and, ultimately, forced the company into bankruptcy because of the cash drain and its inability to obtain credit from lenders, the suit adds.

Beginning in about 1977, the scope of the conspiracy was substantially enlarged and the number of participants grew dramatically, the suit adds.

The conspiracy grew when the Insurance Services Office, other insurers and industry associations like the American Insurance Assn. and the Alliance of American Insurers joined the plot, the complaint adds.

The conspiracy even extended to reinsurers, which refused to make payments due on reinsurance treaties and extend or enter into new treaties unless direct insurers, including UNR's, participated in the conspiracy, the complaint adds.

Thus, insurers agreed and carried out their plans not to honor their policies and to "boycott, coerce and intimidate" policyholders into giving up benefits. They also refused to provide defense and indemnity payments, agreed to fix prices retroactively and sought to impose the "claims-made" form on insureds, the suit charges.

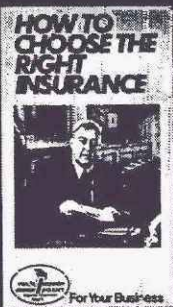
UNR was told that it would not receive any money from insurers unless it contributed to its own de-

Continued on page 6

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Insurers challenging UNR's attorneys

CHICAGO—In addition to the suit filed by UNR Industries Inc. against its insurers over coverage for asbestos claims, a battle is raging between two of the insurers and the law firm representing UNR.

Commercial Union Insurance Co. and Continental Insurance Co. are challenging the right of Paul, Hastings, Janofsky & Walker, a Los Angeles law firm, to represent UNR.

The firm, one of the more aggressive involved in the asbestos coverage litigation, also represents asbestos defendants GAF Corp. and Nicolet Inc, which have filed bad-faith actions against their insurers in California.

CU and Continental charge that the law firm should be disqualified from representing UNR because it represents the insurers in labor relations and employment discrimination matters.

Both claim the firm neglected to obtain the "informed consent" of the insurers, which is required when a law firm is to represent a client that is pitted against one of the firm's existing clients.

"The Janofsky firm breached Rule 5-105 of the American Bar Assn. Code of Professional Responsi-

bility when it failed to obtain Commercial Union's informed consent to the adverse representation," says CU's motion to disqualify the firm.

This "informed consent" includes disclosure of all relevant facts of actual and potential conflicts of loyalty arising out of the adverse representation and must be given to a person authorized to give consent on behalf of the client, the CU motion says.

CU argues that although the law firm contacted CU, it never disclosed the scope and extent of litigation it intended to pursue on behalf of UNR. Moreover, the CU official it did contact did not have the power to consent to the firm's representation.

Continental makes similar arguments and also says the law firm violated the Federal Bankruptcy Act by failing to disclose completely its representation of GAF and Nicolet in asbestos litigation.

"We contend that we certainly did get informed consent," said Ronald M. Oster, an attorney with the Janofsky firm. He accused the insurers of attempting to withdraw consent previously given, adding that the firm has offered to withdraw its representation of both insurers.

UNR claims conspiracy

Continued from page 4
fense and settlement of asbestos cases and that it would not receive coverage for non-asbestos claims, the suit says.

Insurers also threatened UNR and other asbestos manufacturers that they would be subjected to "prolonged, expensive and uncertain" litigation unless they accepted the insurers' demands.

"The insurance carriers have carried out the purposes of their conspiracy, maintained their 'conspiracy of silence' and massive litigation has ensued throughout the United States pursuant to the goals of the conspiracy," the lawsuit says.

"Further, a climate of uncertainty and fear has spread among large commercial risks. The new claims-made policy has been drafted and circulated for comment

by ISO, and the conspirators are seeking to have the policy implemented and to revoke the previously issued coverage."

Speaking for UNR's primary insurers, Zurich, Bituminous and Continental, Mr. John denied that there ever was a conspiracy.

The "crux of the whole matter" is the question of what coverage and defense obligations are owed to insureds, he says, and courts have differed in decisions as to what those coverage obligations are.

Mr. John stated that court decisions favoring the exposure theory support the insurers' arguments and the basis for the Houston agreement.

INA vs. 48 Insulations, the first coverage interpretation ruling that favored prorating coverage and defense costs, "totally agreed with" the Houston agreement, Mr. John said.

In addition, he denied that insurers had conspired to decide on one coverage theory, adding that he was aware of only one memorandum upon which UNR bases its allegations.

That document, which contained minutes of a meeting among the insurers, indicates there was a discussion of possible coverage interpretations courts might read into the policy but there was no agreement on a course of action insurers should take, Mr. John said. Nor have insurers taken a unanimous position since then, he adds.

Moreover, Mr. John says it was not UNR's insurers but UNR itself that pushed for continuation of the Houston agreement, and that they were a "willing participant," with experienced in-house and outside counsel advising them.

"It went on for six or seven years with a great deal of cooperation between insurers and insureds," he says.

Only after the decision in Keene Corp. vs. INA was handed down in 1981, which greatly broadened coverage for policyholders, did UNR suddenly change its mind about what coverage theory it supported.

"The only party that has changed its position throughout the entire process is (UNR)," Mr. John added.

"My question is, who is setting up whom?"

An attorney for a UNR excess insurer, Commercial Union Insurance Co., called the lawsuit a "con-trivance."

Anthony P. Katauskas, with the Chicago firm of Jacobs, Williams & Montgomery, Ltd., said that the allegations are not really designed to come to a resolution of UNR's insurance disputes but are an effort to "capture the public's eye to the detriment of insurers."

Mr. Katauskas said that the contentions, especially with respect to CU, are not valid, and that CU has never even been asked to defend or indemnify any claim filed against UNR.

Specifically, UNR's suit alleges the defendants violated the Sherman Antitrust Act and the McCarran-Ferguson Act.

In addition, it charges all or some of the insurers with breach of fiduciary duties, bad faith, breach of contract, fraud, intentional interference with contract, violating state unfair claims practices and abuse of process.

It also seeks the rescission of UNR's agreements with Zurich, Bituminous, Continental and UAC that reduced or eliminated UNR's past insurance coverage, and to recover withheld sums.

The suit also seeks a declaration by the court that coverage for defense and indemnification be provided on the broadened basis, not under exposure or manifestation. ■

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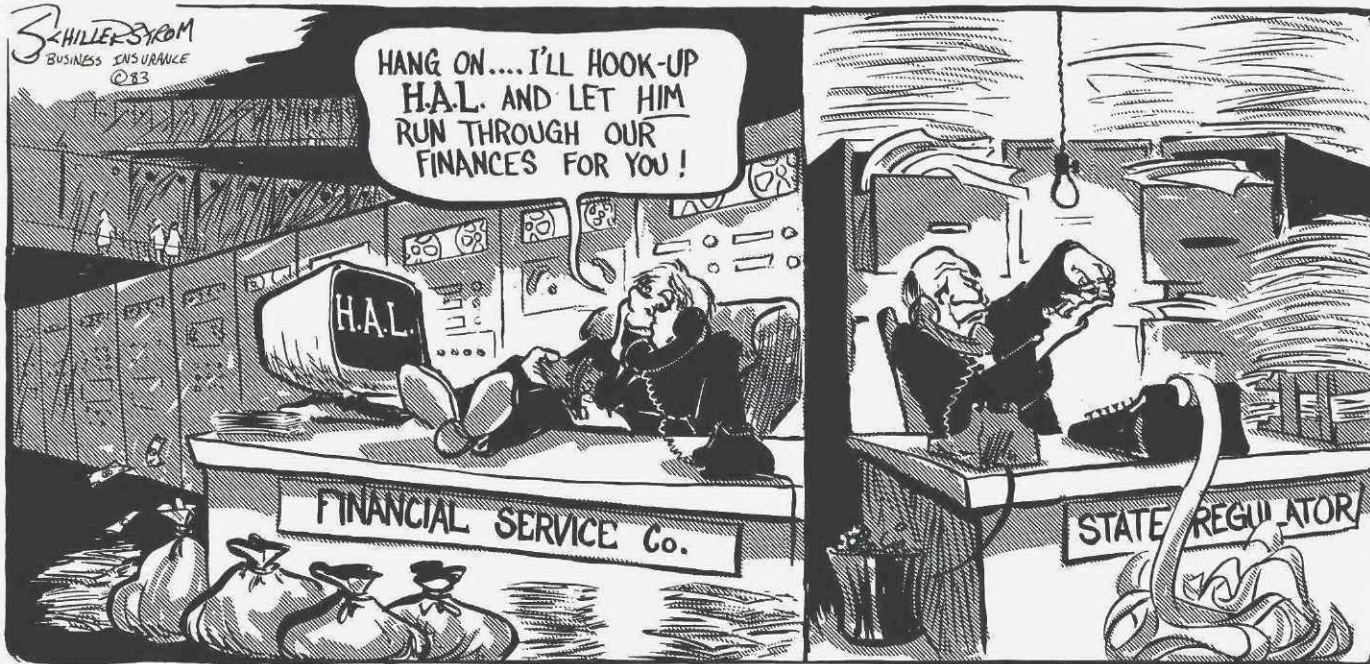
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opinions



It'll take teamwork for an upset

DAVID VS. Goliath; Landon vs. Roosevelt; North-western vs. Ohio State—all great mismatches.

Now, according to a recently released report by the Conference of Insurance Legislators (see story, page 3), another valiant struggle can be added to this list: state insurance regulators vs. ever-expanding financial services conglomerates.

Insurance departments, the study explains, don't have the money, machinery or the manpower to keep up with the abrupt shifts in the financial services marketplace, especially now that the roles among insurers, banks and securities brokerages are blurred.

It's true: States often are unable to detect cases of fraud or insolvency until it's too late. Too often they are only stepping in to try and represent the public after a company fails instead of uncovering improprieties before they endanger the public.

A good example of this problem, according to the COIL report, is the much-publicized case of Baldwin-United Corp. The Arkansas Insurance Department, which regulates several Baldwin-owned life insurers that issued several billion dollars in single-premium deferred annuities, "by its own admission came perilously close to breaking down" under the strain of the investigation, the report notes.

Arkansas and other state regulators have placed the Baldwin SPDA insurers in rehabilitation, but the thousands of people holding the annuities have no guarantee that they will receive what they were promised.

There is simply no way that underfunded, under-

staffed and underautomated state insurance regulators can adequately supervise huge financial services conglomerates, which have the money to attract the most canny executives and buy the most modern computers and which are rapidly bursting the traditional barriers separating different financial services.

To expect financially strapped states to spend more money on insurance regulation—a low-priority item when there are budgets to balance and roads to repair—is probably a pipe dream. But there are things states can do to bolster their regulatory efforts.

For instance, COIL suggests that the National Assn. of Insurance Commissioners, funded by the states, buy a mainframe computer, to which states could link smaller minicomputers. By spreading the cost of automation across 50 states, the price won't be nearly as high as if each state tried to do the job on its own.

Also, state insurance regulators should strive to work with both state and federal banking and securities supervisors. States jealously guard their independence from the feds, but to shun needed expertise is to invite disaster that could ultimately cost states their regulatory authority. For example, some observers say the SPDAs issued by Baldwin are much more like a securities product than an insurance policy. Maybe if securities examiners also had been looking at the companies, Baldwin's excesses could have been curbed.

Cooperation is the key when you're an underdog. By banding together, maybe the insurance regulators can repeat David's upset victory.

letters

Risk management is more than a finance subset

To the editor: A comment on the ideas Professors Doherty and Gahin expressed at the American Risk & Insurance Assn. conference (BI, Aug. 29). Years ago, I, too, thought risk management was just a subset of finance. But I have learned more since. Risk management is not just concerned with how to pay for losses. It is just as much, or even more concerned with keeping losses from happening in the first place. And there is a great deal more room for future improvement (cost-saving and revenue-producing) in loss con-

trol than in loss financing.

Keeping people's fingers out of machinery designing, producing safe products, getting employees to exercise more care in incurring medical expenses—these are management problems, people management problems, a subset of finance.

In the United Kingdom and other places, risk management is generally thought of as being, first, loss control. In the military in the United States, this also is true. But most risk and insurance man-

agers and risk and insurance professors are still too firmly captured by their finance and insurance backgrounds to have recognized and expanded into the more important side of dealing with risk planning—organizing, leading and controlling so as to cut the losses, not just finding the cheapest ways to pay for it all.

Professor Gahin is, however, right about the impropriety of putting a wall between "pure" and "speculative" risks.

Bob A. Hedges

Professor of Insurance and Risk
Temple University
School of Business Administration
Philadelphia

Naming additional insureds

To the editor: From the standpoint of municipalities, being named as an additional insured (BI, Aug. 29) is accompanied by one concern.

By adding your client as an additional insured to a vendor's policy, you are diminishing the coverage of that vendor because now the vendor's insurer has two

"insureds" to protect and defend instead of one. My caution is to be certain the vendor has sufficient coverage to defend your client as well.

Edward A. Crosby
President
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P.C.W. Underwriting gets a new name

By STACY SHAPIRO

LONDON—P.C.W. Underwriting Agencies Ltd., the Lloyd's of London underwriting agency that is the target of investigations by Lloyd's, the British Department of Trade and the City of London Fraud Squad, is changing its name.

Minet Holdings P.L.C., the agency's parent company, changed the agency's name to Richard Beckett Underwriting Agencies Ltd. Mr. Beckett is the new underwriter for the syndicates managed by P.C.W.

The investigations are probing alleged improper reinsurance transactions to benefit several former P.C.W. and Minet officials, including former Minet Chairman John Wallrock (*BI*, Nov. 29, 1982).

Minet's current chairman and

london line

chief executive, Ray Pettitt, says that despite the investigations and the name change, the security of the underwriting agency is stronger than ever.

"Since the end of last year, we have been taking extremely positive steps to strengthen P.C.W. Underwriting Agencies Ltd.

"This change of name is the logical sequence," he said.

Lloyd's will probably finish its investigation of P.C.W.'s reinsurance arrangements soon, Lloyd's has said.

Explosives labeling

All explosives in Britain will be

labeled and classified under new regulations that take effect Nov. 1, says Britain's Health and Safety Commission.

The new regulations will introduce a single system of classification and labeling for both commercial and military explosives. The system is recommended by the United Nations.

The regulations on the classification and labeling of explosives also follow the requirements of a European Economic Community directive dealing with packaging dangerous goods.

Currently, there are several different systems of explosives classifications used in Britain. Explosives

manufacturers will be given five years to switch from these systems to the newly developed, unified labeling system.

"With one unified system for all explosives, procedures should be simplified for manufacturers, transport operators, emergencies services and so on," the commission says.

"Safety standards should also be improved because the regulations require more information to be displayed on labels."

According to the new regulations, any explosive product will have to be classified by the Health and Safety Executive, a quasi-government safety authority that oversees the Health and Safety Commission.

Military explosives will be classified by the secretary of state for de-

fense.

There will also be strict controls concerning when explosives can be removed from their packaging.

The U.N. symbol for explosive material—a bursting bomb in an orange diamond—must be on all explosive products. A U.N. designation also will be on the package to denote what category of explosives it is. Aids to safety and security also must be listed on the product and/or its packaging.

In addition, fireworks will have to conform to these labeling requirements.

Inspection procedures

The British Health and Safety Executive has published a leaflet describing the methods its inspectors use to inspect industrial sites for health and safety violations.

The leaflet gives valuable insight to British manufacturers on how inspectors carry out their inspections.

"During a visit an inspector discusses what needs to be done with all interested parties, such as managers, safety representatives and employees," the leaflet says.

"An inspector considers various factors—for example, the seriousness of the risk, the nature of any breach of the law, methods available for remedying the situation and general standards in the organization, including its policy and organizational arrangements for securing health and safety."

To obtain a leaflet or for more information, contact the Health and Safety Executive, 25 Chapel St., London NW 1 4DT, England; 01-262-3277.

Howden exodus

Eight key employees at Alexander Howden Insurance Brokers Ltd., the British retail brokerage unit of Alexander & Alexander Services Inc., have jumped ship.

The group, who all worked at Howden's Lloyd's and London Market Reinsurance Division, which places excess-of-loss reinsurance treaties, will begin work next month at Lloyd's of London broker Alwen Hough Johnson Ltd. That brokerage was founded by former Howden employees 10 years ago.

Leading the exodus was Paul Moir, chief executive officer of the reinsurance division. Among the others who tendered their resignation were Managing Director Edward Duffin and Directors Michael Mills, Alistair Couch, David Moss and Christopher Hayles.

Sources in the market speculate that Mr. Moir and his team decided to leave Howden amid rumors that A&A would be acquired by broker Sedgwick Group P.L.C., which has the largest reinsurance division in London (*BI*, July 18).

The talks between Sedgwick and A&A now appear to have ended, but it was too late for Mr. Moir to change his plans.

Mr. Moir would not confirm if the acquisition rumors prompted his resignation.

"I was given an opportunity which I had looked to go to," he said. "I had worked for Howden for so many years and I was not treated badly by A&A or the Howden group. I am very sad to leave, but there are so many reasons that go into a decision like this. I can't name them all."

Mr. Moir says he has not taken any of Howden's accounts with him. "We have no business at all from anywhere; we are starting from scratch," he said.

A.L. Abrahams, a Howden employee for 29 years, has been picked to replace Mr. Moir as the chief executive officer of the reinsurance division.



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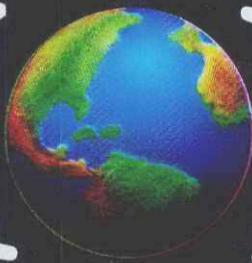
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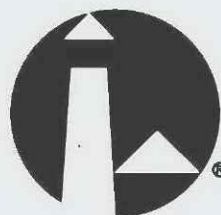
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BI 9/26/83

Fitt named president of Employers Re

Michael G. Fitt has been named president and chief executive officer of Employers Reinsurance Corp. in Overland Park, Kan. He will also continue in his post as chairman of ERC.

Mr. Fitt succeeds **Clyde F. DeWitt**, who will retire in March 1984. Mr. DeWitt has assumed the post of vice chairman.

In addition, ERC promoted **Delmar L. Burton** to executive vp for marketing, claims and administrative services. **James M. Estes** was named executive vp and will supervise treaty underwriting



Mr. Fitt

comings & goings: industry

operations. And, **G. William Gunnison**, who was also named executive vp, will direct individual-lines underwriting activities at the company. All three men had been senior vps.

Other reinsurer changes:

Francis D. Ruyak elected senior vp of Constitution Reinsurance Corp. in New York. He will continue to manage the company's treaty underwriting department. Mr. Ruyak was previously



Mr. Gunnison

vp-treaty underwriting at Constitution Re.

Michael J. Quinones appointed vp-underwriting for Mentor Holding Corp. in New Orleans. Mr. Quinones had been an underwriting officer of the Mentor companies in Bermuda and an officer and director of the group's London-based operations.

George J. McGarry joined Thomas A. Greene & Co. in San Francisco as a vp in the treaty department. He previously was manager of property operations and worked in the treaty department of North Star Reinsurance Co. Thomas A. Greene & Co. is a reinsurance intermediary owned by

Alexander & Alexander Services Inc.

Insurers

Michael O'Reilly elected senior vp of Federal Insurance Co., a subsidiary of The Chubb Corp., in Short Hills, N.J. Mr. O'Reilly will continue in his present post as vp of Chubb Corp.

Thomas A. Ruden appointed senior vp-claims division and general counsel of Empire Mutual/Allcity Group in New York. He will oversee all claims department activities and corporate legal matters. Mr. Ruden had been an executive vp of Ideal Mutual Insurance Co.

Excess/surplus

Terry Younghanz elected vp-

underwriting at Athena Assurance Co. in St. Paul, Minn. Mr. Younghanz formerly was large-accounts Midwest regional manager for the company.

Athena, a surplus and specialty risk insurance company, is a subsidiary of Atwater-McMillian Inc., which is part of St. Paul Fire & Marine Insurance Co.

Roy A. Haebich appointed resident vp of Markel Service Inc., a specialty general agency, in Richmond, Va. Mr. Haebich is responsible for all production and marketing activities in most Eastern and Midwestern states. Mr. Haebich previously was vp of Integon Insurance Corp.

Frank A. Powers named president of American National General Agencies Inc. in Los Angeles. He succeeds **Stanley M. Brummel** who retired. Mr. Powers was previously executive vp of finance and administration for ANGA. ANGA is a wholly owned subsidiary of Bayly, Martin & Fay International Inc.

Agents/brokers

Harlan J. Campbell joined Emett & Chandler Cos. Inc. in Los Angeles as vp. He had been with Marsh & McLennan Cos. Inc.

Benjamin F. Round appointed vp and regional manager of Jardine Ter Bush & Powell Inc. in Schenectady, N.Y. Mr. Round heads the Syracuse and Hoosick Falls, N.Y., operations and will continue managing the Schenectady property/casualty division. He has been with the brokerage since 1972.

Peter L. Scardello Jr. has been elected executive vp of Oliver/Pilcher Insurance in Phoenix, Ariz. He had been vp-finance at the agency, which he joined in 1975.



Mr. Scardello

Scott E. Robinson and **Stephen C. Felker** have been elected senior vice presidents of Lawton-Byrne-Bruner Insurance Agency in St. Louis.

Alfred D. Haynes III transferred to the Stamford, Conn., office of Johnson & Higgins, where he will be vp and manager of the casualty department. He had been in the casualty department of the New York office.

M. Susan Hackley named vp-claims of the New York office of Fred S. James & Co. Inc.

Other suppliers

A.H. Knautz promoted to executive vp at Equifax Services Inc. in Atlanta. He was most recently a vp of Equifax's General Management Systems marketing. Mr. Knautz has been with Equifax Services since 1957.

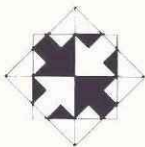
Keith Kinghorn appointed regional benefits director for Fred S. James & Co. Inc. Mr. Kinghorn will be based James' Atlanta office. He was most recently with Peat Marwick Mitchell & Co.

Darrell Baird named vp at Captive & Self Insurance Services Inc. in San Bruno, Calif. He will be responsible for the sale of offshore programs. Mr. Baird previously was with Argonaut Insurance Co. as commercial group insurance manager.

Ward R.H. Ching joined Risk Management Inc. in Los Angeles, a subsidiary of Emett & Chandler Cos. Inc., as vp-research and strategic planning services. Mr. Ching had been with Marsh & McLennan Cos. Inc.



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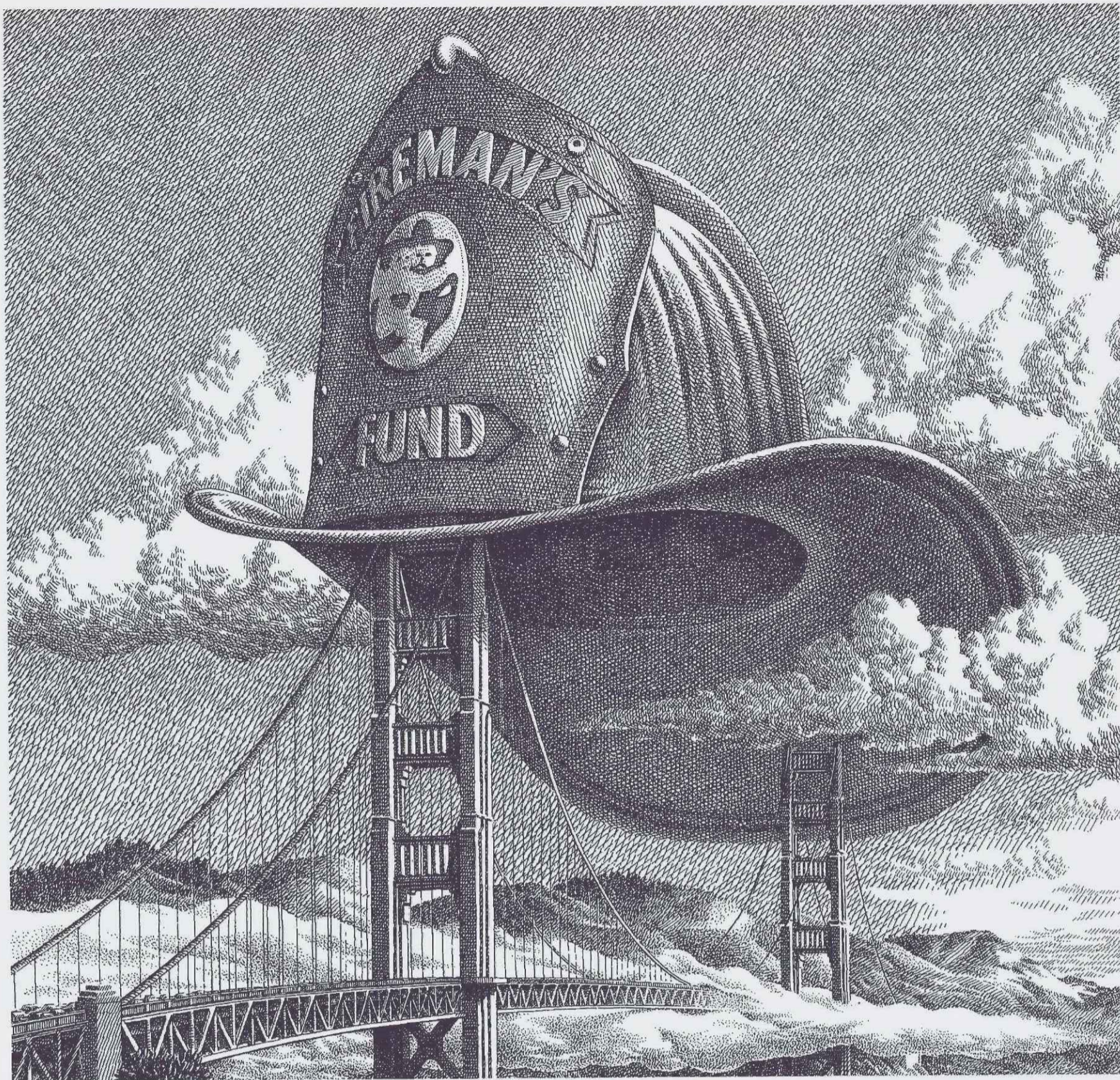
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comings & goings: buyers

Kemper selects Gerrit Starke for human resources post

Gerrit Starke, 47, has been promoted to director of human resources, a new position at Kemper Group in Long Grove, Ill. Mr. Starke will oversee employee benefits, as well as other personnel areas, for the insurance and financial services company. He joined Kemper in 1959 as an underwriter in Syracuse, N.Y. Subsequently, he moved to Kemper's Long Grove home office, serving most recently as director of corporate personnel. Mr. Starke received a business degree in The Netherlands, where he was born. He also received the Associate in Risk Management and Associate in Management designa-

tions, as well as the Certificate in General Insurance. Mr. Starke reports to Chief Insurance Officer Rudolph F. Landolt.

Leslie Linhart, 35, is director of risk management for Canada Post Corp. in Montreal. It is a new position. She will handle risk management for property/casualty programs, loss prevention and self-insurance at the company. Prior to joining the company, Ms. Linhart held risk management positions at Daon Develop Corp. in Vancouver, British Columbia, and Via Rail Canada Inc. in Montreal. She is a deputy member of the Risk & Insurance Management Society. Ms. Linhart reports to Vp and Treasurer Dereck Millar.

Betty C. Brawner, 27, is an insurance analyst for Anheuser-Busch Cos. Inc. in St. Louis. In this new position, Ms. Brawner will have responsibilities for the risk management and property/casualty insurance programs for the company. She is a recent graduate of Memphis State University in Memphis, Tenn., where she received a bachelor of business administration degree in insurance and a master of business administration degree in finance. She was selected outstanding insurance student in 1982 by the Memphis Chapter of the Society of Chartered Property & Casualty Underwriters. Ms. Brawner reports to John W. Robson, director of corporate risk management and insurance.

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Multiemployer law draws legislators' attention

By JERRY GEISEL

WASHINGTON—Congressional interest in multiemployer pension plan problems is on the rise.

Sen. Don Nickles, R-Okla., plans to introduce legislation to overhaul the Multiemployer Amendments Act, the 1980 law that gives multiemployer pension plans the power to seek enormous payments from withdrawing employers to pay for unfunded vested benefits.

Under the act, withdrawing from multiemployer plans can be very expensive. Some companies that went out of business and withdrew from multiemployer plans have been hit with withdrawal liability claims that are more than double their net worth (BI, Sept. 19).

The Nickles legislation is expected to contain several features to reduce the impact of withdrawal liability. They include:

- Eliminating withdrawal liability for employers that are forced to leave multiemployer plans because of events beyond their control, like a natural disaster, loss of contract or death of partners.

- Requiring all plans to give an employer an individual statement, informing a company what it would owe the plan if it withdrew. Currently, employers often don't know the amount of their withdrawal liability until they actually leave a plan.

- Requiring more uniformity in the interest rate assumptions used by multiemployer plans. An interest rate assumption is an estimate of the rate of return of pension plan assets. If a plan uses a low interest rate assumption, that assumption can increase the amount of an employer's withdrawal liability.

Sen. Nickles, who chairs the Senate Labor subcommittee, isn't the only senator interested in easing employers' multiemployer pension plan withdrawal liability problems.

Sens. John Danforth, R-Mo., and John Chafee, R-R.I., already have introduced legislation that would overturn a retroactive provision that allows plans to collect withdrawal liability payments from employers that left the plans between April 29, 1980, the law's effective date, and Sept. 26, 1980, the date President Carter signed the legislation.

Under the Danforth-Chafee bill, S. 1573, the effective date of the withdrawal liability provision would be pushed back to Sept. 26, 1980.

As a result, several dozen firms that left multiemployer plans during that five-month period would not have to pay tens of millions of

OSHA panel to meet

WASHINGTON—The National Advisory Committee on Occupational Safety and Health will meet in the nation's capital this week to discuss occupational health policy.

The meetings will begin at 9:45 a.m. Tuesday and Wednesday in Room N-3437 at the Frances Perkins Department of Labor Building, 200 Constitution Ave., N.W., Washington, D.C. 20210.

The committee will discuss the recent activities of the Occupational Health and Safety Administration and the National Institute for Occupational Safety and Health.

The advisory committee was established to advise the secretary of labor and the secretary of health and human services on the administration of the Occupational Safety and Health Act of 1970. That law created OSHA.

The 10-member committee includes representatives from safety and health research, management, labor and the public. ■

washington

dollars in withdrawal liability claims.

Some employers contend that they were unaware that Congress was about to pass legislation imposing withdrawal liability at the time they left the plans.

Recently, a federal appellate court in Richmond, Va., ruled that the retroactive provision in the multiemployer law is constitu-

tional. Another federal appellate court had earlier ruled the law unconstitutional.

The conflict increases the chances the Supreme Court will ultimately resolve the issue.

Railroad safety

The National Transportation Safety Board says railroad signal

systems should be upgraded so they will all automatically flash stop signals to trains whenever a part of the system malfunctions or is disconnected.

The safety board says that such fail-safe signaling should first be installed on tracks used for passenger trains and hazardous materials, and then on other tracks as major signal or track repairs are made.

Pension administrator

Alan Lebowitz, the Labor De-

partment's assistant administrator for the Office of Fiduciary Standards, has been appointed acting U.S. pension administrator.

Mr. Lebowitz replaces Jeffrey Clayton, who left the Labor Department this month to join a Salt Lake City law firm.

Benefit cap opposed

Placing a cap on the amount of tax-free group health insurance employers provide would do little
Continued on facing page



Continued from facing page to dampen the fires of health care inflation, a research group says.

A tax cap "probably would have little effect on health care inflation as long as Medicare and Medicaid spending continues to rise," according to the Employee Benefit Research Institute, a Washington-based benefits think tank.

EBRI Research Associate Deborah J. Chollet notes that much of the growth in demand for health services has come from the public sector.

For example, Medicare and Medicaid now account for 35.5% of expenditures for hospital care, up from 26.3% in 1965.

By contrast, during the same

time period, private health insurance's share of the nation's hospital care expenditures dropped to 33.2% from 41.8%.

EBRI notes that Medicare and Medicaid have supported much of the inflation in hospital care. Between 1976 and 1980 Medicare spending rose at an annual rate of 14%, while Medicaid spending rose an average of 18%. During the same period, hospital expenditures covered by private health insurance rose by an annual average of only 11.9%.

The Reagan administration is the strongest proponent of limiting tax-free health insurance. It is backing legislation, S. 640, which would make employer contributions that

exceed \$2,100 a year for family coverage and \$840 for individual coverage taxable income.

Mine violations

The federal Mine Safety and Health Administration has hired American Bureau of Collections Inc. of Buffalo, N.Y., to assist the agency in collecting fines.

The fines are charged to mine operators that have been slapped with penalties for violating mandatory federal mine safety and health rules.

Benefits taxation

Legislation, S. 1817, that would

set permanent rules on the taxation of employee benefits—like employer-provided parking spaces—that aren't covered by the tax code may be attached to a tax bill.

The legislation, introduced by Sens. Steve Symms, R-Idaho; Daniel Moynihan, D-N.Y.; and Spark Matsunaga, D-Hawaii, proposes new rules for taxing non-statutory benefits (BI, Aug. 15).

The measure, which essentially would protect the tax-free status of benefits that employers now provide, could become part of a tax bill that may be introduced in Congress next month, said Anne Canfield, an aide to Sen. Symms.

A current moratorium that prevents the Treasury Department

from issuing new rules on the tax status of non-statutory benefits expires Dec. 31.

Erlenborn to exit

Congress's leading pension expert is leaving government for private industry.

Rep. John Erlenborn, R-Ill., says he will not seek re-election when his term expires next year.

"I have been part of government as a state and federal legislator for 27 years," he said. "Now I seek a new kind of challenge in the world of free enterprise."

Rep. Erlenborn, 56, sponsored several major pieces of pension legislation since coming to Washington in 1965. For example, he introduced several bills that would have set reporting requirements for state and local pension programs. He also backed legislation that would have reduced employers' pension reporting requirements under the Employee Retirement Income Security Act.

Rep. Erlenborn co-sponsored legislation Congress enacted last year to close the loopholes that allowed self-funded multiple employer health care trusts to operate in a regulatory vacuum (BI, Dec. 27, 1982).

More recently, Rep. Erlenborn was working on legislation that would shore up the financial base of the Pension Benefit Guaranty Corp. by making it more difficult for employers to dump their underfunded pension plans.

Rep. Erlenborn, who represents Illinois' 13th District in the western Chicago suburbs, said he has not yet received job offers from the private sector. ■

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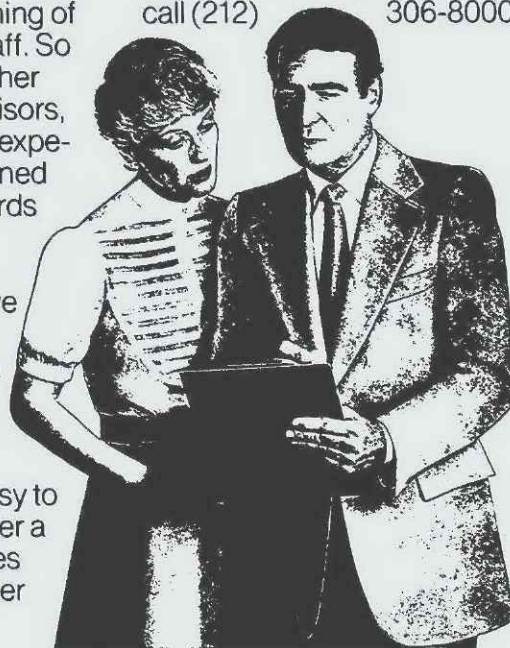
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Canadian life insurer opens U.S. subsidiary

Toronto-based Confederation Life Insurance Co., a mutual company, has formed a new U.S. stock insurance subsidiary.

Confederation Life Insurance & Annuity Co., which the parent company plans to have licensed nationwide, will provide life insurance, accident and health insurance, annuities and pension plans.

Based at Confederation's U.S. headquarters in Atlanta, the stock subsidiary is headed by Chairman Patrick Burns and President Peter Lloyd.

California PPO

Blue Cross of California says it has reached agreements with 42 hospitals statewide to participate in its preferred provider organization, known as the Prudent Buyer Plan.

markets

Blue Cross says groups can expect to save 10% to 15% on health care premiums by participating in the PPO plan, which should be available statewide by Jan. 1, 1984. The 42 hospitals were chosen from among 144 that submitted proposals to Blue Cross.

Meanwhile, Blue Cross & Blue Shield of Kansas City has decided to form a PPO program and is in the process of soliciting participation from Kansas City physicians, hospitals and ambulatory surgical facilities.

Joint venture

Travelers Corp. announced that

it is forming a joint venture with Guinness Peat Group P.L.C., a British investment banking firm, to provide foreign investors with real estate opportunities in the U.S.

The new company, London & Hartford Corp., will invest in office buildings, shopping centers and other commercial properties to be developed by Prospect Co., a Travelers subsidiary.

London & Hartford's offices are located in Hartford, Conn., but other offices are planned for New York and London.

New intermediary

A new company, Ashford Reinsur-

ance Intermediaries Corp., has been formed as a subsidiary of New York-based Ashford Holding Corp. In addition to acting as a reinsurance intermediary, the new firm will operate as an associate broker on the New York Insurance Exchange.

Henry J. O'Shea will serve as president and Donald B. Sharp as vp of ARIIC, which is located at 160 Water St., New York, N.Y. 10038; 2-2-558-6048.

Benefits firm formed

New York Claim Administrators, a new benefit plan designer and administrator, has been formed to specialize in self-insured benefit administration for groups of 100 or more workers.

The new firm headed by presi-

dent Ronald K. Zoeller, is located at 2525 One Marine Midland Center, Buffalo, N.Y. 14203; 716-856-6590.

Transport specialist

Lloyd's of London broker Hogg Robinson Group P.L.C. has acquired a major interest in broker F.S. Betts & Co. Ltd. Hogg Robinson will merge its existing transport division, H.L. Thomson Ltd., with Betts to form Hogg Robinson Thomson Betts Ltd., a company specializing in insurance requirements for the transport industry.

The chairman of the new brokerage subsidiary is Robert Jensen, an executive director of Hogg Robinson & Gardner Mountain (Marine) Ltd.

Acquisitions

F.B. Beattie & Co. Inc., a Seattle-based insurance brokerage specializing in surplus lines, has been acquired by General America Corp., a subsidiary of SAFECO Corp. The firm's management and operations will remain unchanged.

Tucker, Johnston & Smelzer Inc., a Pittsburgh-based agency, has acquired the Pittsburgh agency operations of James S. Kemper Agency Inc. Kemper operations have been moved to TJ&S present offices and Kemper's office head, Gary L. Aldinger, has been named a vp of TJ&S.

Symons Financial Holdings Ltd., a Toronto-based property/casualty insurance holding company, has acquired all the outstanding stock of International Underwriting Managers Ltd. and its subsidiary, Pafco Insurance Co. Ltd.

Lloyd's of London broker C.E. Heath P.L.C. has purchased W. Adams (Insurance Brokers) Ltd., a brokerage based in Hertford, England.

New offices

CIGNA Corp. has moved its Pacific Area headquarters from Honolulu to Tokyo to place the company's management closer to the "dynamic business center of the Asian Pacific," the company said. The new headquarters office is located at Akasaka Twin Towers, 18th Floor, 17-22 Akasaka, 2-Chome, Minato-ku, Tokyo, 107 Japan. The telephone number is 81-3-584-2261.

Fred S. James & Co. Inc. has opened two new offices to manage captive insurance companies. Fred S. James & Co. of Vermont Inc. will serve Vermont-domiciled captives and is located at 595 Dorset St., The Willows, Burlington, Vt. 05401; 802-658-0188. Dr. Harry Shuford, a James vp, will manage the Vermont office. James (Cayman) Ltd., which is not yet established in its own offices, will manage captives domiciled in the Cayman Islands. Warren D. Sproule, executive vp and managing director of James (Bermuda) Ltd., will serve as interim manager of the new operation.

Three Crum & Forster organizations have moved their administrative offices to new quarters in New Jersey. C&F Underwriters Group, U.S. Insurance Group and Crum & Forster Personal Insurance have moved to new offices at 211 Mount Airy Road, Basking Ridge, N.J., 07920; 201-953-3000.

William M. Mercer Inc. has moved its New Jersey office to new quarters at 95 Madison Ave., Morristown, N.J. 07960; 201-538-5400.

The Wetzel Co. Inc., a Houston-based excess/surplus lines brokerage, has opened a new office at Suite 300, Norwood Tower, 114 W. Seventh at Colorado, Austin, Texas 78701; 512-480-8231.



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South Dakota appoints new insurance director

PIERRE, S.D.—Susan L. Walker is the new director of the Division of Insurance of the South Dakota Department of Commerce. She had been serving as acting director since April, when former director Henry J. Lussem left.

Before her appointment, Ms. Walker was deputy director of the securities division of the Department of Commerce, where she had worked for three years. Before that, she was a clerk with the South Dakota Supreme Court.

Ms. Walker has a law degree from the University of South Dakota.

Among the programs Ms. Walker

is exploring in her new position is the implementation of a continuing education program for insurance agents.

Mr. Lussem, who was director of the division for three years, told *Business Insurance* that he was fired by Gov. William Janklow, who had appointed him.

According to Mr. Lussem, he was fired after commenting in a television interview on the state's new law that allows state-chartered banks to enter the insurance business as underwriters and brokers (*BI*, Feb. 28, March 7).

Mr. Lussem said he believed the new law would not bring as many new jobs to the state as the governor had predicted. The governor's office would not comment on Mr. Lussem's leaving.

Mr. Lussem has returned to his job as an insurance agent.

Arizona comp rates

PHOENIX, Ariz.—An average 9.9% reduction in the state's workers compensation insurance rates will take effect Oct. 1.

The reduction is the fourth consecutive decrease in the base workers compensation rate level since 1980, according to Arizona Insurance Director J. Michael Low.

Work comp rates in Arizona were reduced an average of 10.7% in 1982, 17.2% in 1981 and 15.5% in 1980.

"The reductions result from favorable loss experience and more accurate reserving practices on the part of the State Fund and the private insurers," Mr. Low said.

The base rate in Arizona is currently at 56% of the 1979 rate level, Mr. Low said.

"When one takes into account the substantial deviations that many carriers have filed with the department, current rates are as low as 38% of what was charged back in 1979," he noted.

The rate reductions, coupled with downward deviations encouraged by the Arizona Department of Insurance, have resulted in savings to employers, Mr. Low said. This should help make the state an attractive site for new business, he added.

Comp hearing set

SACRAMENTO, Calif.—An Oct. 11 hearing is set on a proposed average 2.4% rate decrease in workers compensation insurance rates.

California rates were increased an average 15.1% this year.

The Workers' Compensation Insurance Rating Bureau, the rating authority in California, had expected an average 7% decrease for next year based on loss experience. But increased benefits mandated by the Legislature, which will go into effect Jan. 1, will result in a 5.2% increase in rates. That cost increase will counteract the decrease earned through loss experience, said Robert Meyer, vp and actuary for the WCIRB.

Work comp benefit levels also were increased at the beginning of this year, forcing workers compensation rates up an average of 15.1% in 1983, even though the WCIRB filed for a 6% decrease. In 1982 rates were increased an average of 0.2% and in 1981 they were decreased an average of 3.5%, Mr. Meyer said.

No one is speculating on whether Insurance Commissioner Bruce Bunner, who was appointed in March, will approve the rates filed for the 416 employer classifications in California.

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Disaster planning pays off for bank in Minneapolis

Continued from page 3

While the disaster plan is being developed, Ms. Carlton said, it's most important that ideas be solicited from the people who manage the operations for which the plan is being designed.

"Don't come in as an outside expert," she said. "If you give them (operations managers) the benefit of being experts in their areas, you won't get into shouting matches. If the managers make a bad decision, they're the ones who will have to live with them."

The Norwest disaster plan includes a general section followed by instructions specific to individual departments.

The general section outlines sites near the bank in downtown Minneapolis where employees should gather after a disaster if it happens while they are at work. Because last year's fire took place on Thanksgiving, no one was working in the building.

The plan also specifies a location, several blocks away from the bank, that will serve as a control center for directing recovery operations. The plan names the people who will have supervisory responsibility at the center, along with their backups.

"We hadn't planned for backups, and we found out how important that step is," said Calvin Wilson, Norwest Bank's assistant vp of security. "When we tried to contact people (when the fire occurred), we found a lot of them were away for Thanksgiving."

To expedite contacting employees, no person has to call more than five other people, said John Nugent, Norwest Information Services' vp of security and administration.

A disaster plan must pay particular attention to the establishment of internal and external communications during the disaster, Norwest officials agree.

"If you don't supply good, accurate, up-to-date information, then people will start to develop rumors—bad information—on their own," said Adaire C. Peterson, Norwest Bank's Administration Services Department assistant vp.

A communications center and departmental spokespersons should be designated, she said, to eliminate the chance of conflicting information going to employees who are not on the scene and to outsiders.

Another lesson the bank learned from the fire was that "We should have been a lot more aware of our outside environment," said John W. Greenman, executive vp of Norwest Properties Inc. "There's a tendency to just look at protecting your own building, but that's not enough."

He noted that the Norwest fire started in a vacant department store next door to the bank.

Besides possibly preventing a disaster, keeping track of the local real estate market will keep you current on what buildings are available to be leased if needed after a disaster, Mr. Greenman said.

If a business is already in leased space, he said, its officers should know the terms under which the lease could be broken in the event of a catastrophe that doesn't completely destroy the facility.

A disaster plan will operate more smoothly, Mr. Dissmeyer said, if company officials discuss its details with the local fire and police departments, as well as outside vendors who might be called on to provide replacement equipment.

Similarly, copies of the disaster plan should be kept at several locations, to ease access and minimize the chance that all will be destroyed.

Before the Norwest fire, Mr. Wilson said, some 40 copies of its disaster plan had been distributed.

As a result of the fire, Norwest officials also learned the importance of building blueprints, which could help firefighters and company officials move around the structure, said Mr. Dissmeyer.

A set of these blueprints should be kept offsite, he said.

In deciding what operations are most important to maintain after a disaster, company officials have to be selective, Ms. Carlton said.

"Don't write contingency plans for 'like to' activities," she said. "Just try to save your meat and potatoes, the ones you can't afford to lose."

For Norwest, this meant the data processing department, whose work affects almost all bank operations from automatic teller machines to international banking. Among the equipment destroyed in last year's blaze were 153 computer terminals and two data processors.

In addition to providing services for the 88 Norwest Corp. banks, Norwest Information Services also supplies service to nearly 600 other banks.

As a result, Mr. Nugent said, failure of the Norwest system could cripple not only the Norwest banking system, but possibly banking systems throughout the area, which include the Ninth Federal Reserve District and parts of the Seventh and Tenth districts.

"Losing our data-processing system is a risk we can't afford to assume," Mr. Nugent said.

To emphasize the importance of this operation, he cited a University of Minnesota study estimating that essential banking functions would cease two days after a data center failure.

For these reasons, Mr. Nugent said, "we decided the only way we could survive is by putting in alternative facilities."

Norwest operates two data processing centers, several miles apart, that equally share the workload. If one were to fail, the other could assume most of its duties.

In addition, all important records are put on microfilm and sent off-site daily for storage in case the originals are damaged or destroyed.

Last year's fire also underscored the importance of maintaining written records, Mr. Nugent said. After the fire, the bank's disaster plan was rewritten to advise employees to clear papers from desktops when they finish work, to reduce the possibility of water damage.

Similarly, Mr. Nugent observed that work written with felt-tip pens and pencils will probably be illegible after exposure to water or heat.

Papers that were damaged by water during the bank blaze were frozen, Ms. Carlton said, to retard the growth of mold, especially in bundled papers. They were then dried.

Sponges for the drying-out operation cost some \$24,000, said Richard H. Klovstad, Norwest Corp.'s

risk management vp.

Finally, Mr. Dissmeyer emphasized the importance of continually updating a corporate disaster recovery plan.

Norwest's security department reviews its overall plan once every year—most recently in January of this year—and department heads must review their department's plans when they assume responsibility and whenever a significant change in operations is made.

Elements of the plan that can be tested should be, Mr. Dissmeyer said. These dry runs, which include such procedures as evacuation drills, help assure that the plan is economically acceptable and technically feasible. ■

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Quick reaction cuts bank's losses after fire

Continued from page 3

After relocation plans were begun, Norwest managers started calling employees Thanksgiving night to tell them where they should go to report to work the next day. By the middle of the next week, most of the bank's operations

had been restored.

Activities were relocated in eight different sites in downtown Minneapolis. Three of the workplaces conveniently were in buildings connected by the city's famed sky-way system of glass-enclosed walkways.

Norwest officials said that recent construction of new office buildings had created a glut of office space in Minneapolis at the time of the fire, which made the bank's relocation task much easier than it might have been in another city. Owners of unoccupied space started

contacting bank officials the night of the fire.

During the day after the fire, the bank leased more than 300,000 square feet of office space. Norwest had occupied 400,000 square feet of the bank building's 550,000 square feet of office space.

However, some employees were not called back to work until the middle of January, although they received their regular salary in the interim.

During this time, employees continued to be kept informed of their status and the bank's condition. This contact encouraged them to believe the situation was under control, said Adaire C. Peterson, Norwest Bank's assistant vp of administrative services.

A special hot line was set up that employees could call for answers to questions they had. And a message from bank President W. James Armstrong was included in the first paycheck employees received after the fire, assuring them that their positions would not be eliminated.

As important as providing employees with complete information, Ms. Peterson said, is having something for all of them to do.

Some of the people who did not return to their regular jobs immediately were given other responsibilities, she said, such as directing bank customers to new locations that had been established for different operations and answering the telephones that were installed to answer questions about the fire.

"These concrete tasks did more than just give people something to do," Ms. Peterson said. "They provided social support, an opportunity for people to talk with others and share experiences."

To encourage this interaction, she said, the bank supplied free food and drink, as well as a place for employees to congregate.

Companies that have been hit by disaster also should make a special effort to keep the public aware of their status, Norwest officials said.

Because the company made an effort to provide the media with complete information, local newspapers and radio stations were extremely cooperative in helping the bank to disseminate instructions to employees, such as those contained in the initial press release.

The bank also ran advertisements to assure customers their accounts were safe and the bank would continue operating.

But recovering from the disaster required more than good public relations, Norwest officials emphasized.

Immediate action also had to be taken to begin cleaning up the smoldering bank building, they said.

One "simple, obvious step" was to board up windows in the burned-out building, lock doors and install a steel fence around the building, said Calvin Wilson, the bank's assistant vp of security. This work started the day after the fire.

"Everyone wanted to get into the building right away, to see which of their possessions were left," he said. "We had to provide them with a safe opportunity to do that, while maintaining our records that were in the building and hadn't been destroyed."

To limit access into the building and maintain security, special passes were printed that were required for entry into the building beginning the day after the fire.

"You can't be too stringent in allowing access," said Virgil M. Dissmeyer, executive vp and corporate operations officer for Norwest Information Services Inc., the data processing arm of Norwest.

People who wanted to enter the bank building had to receive specific approval from Mr. Dissmeyer or another specially designated security official.

Security guards from contract services were hired to check the passes, with help from bank employees. In addition, off-duty

Continued on page 26

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Bank restored vital operations quickly

Continued from page 24

armed Minneapolis policemen were stationed on the street around the building to discourage intruders from entering the building.

It took two weeks to remove all the records that hadn't been destroyed by the fire, Mr. Wilson said.

Meanwhile, efforts were being made to restore vital banking functions in other locations.

Perhaps the most important services to get back in operation from a public relations standpoint, Norwest officials said, were those involving consumer banking.

"It's only 10% of the bank's business," said Mr. Nelson, "but its appearance is vitally important to our public image."

For this reason, he said, customers were assured their accounts were safe through press releases,

fliers, advertisements and personal contacts.

Management also decided the department had to be returned to virtually normal operation by the Monday following Thanksgiving.

"Customers would be willing to put up with difficulty, at least for a while," Mr. Nelson said. "But they wanted to be able to use the bank."

The 350 consumer banking employees were contacted the night of the fire and directed where to report the next day. Temporary space in nearby buildings was located over the weekend and furniture was ordered Friday night and delivered Sunday.

"You wouldn't believe how cooperative local stores were in helping us," Mr. Dissmeyer said. "By the end of the weekend, we must have cleared out just about all the furni-

ture for sale or lease in Minneapolis."

Had the fire taken place during the depths of winter, with several feet of snow on the ground, moving this furniture, as well as many other recovery activities, would have been far more difficult, Norwest officials point out.

Because there was a chance of severe water and smoke damage, the safety-deposit vaults underneath the bank building, which housed some 15,000 safety-deposit boxes, were not opened until the Thursday after the fire, Mr. Nelson said.

The vault opening was videotaped, he said, "to show there was no cover-up." Virtually none of the items stored in the boxes were damaged or destroyed, officials said.

An important factor for businesses that own buildings that have

been hit by disasters, officials noted, is the maintenance of good relationships with tenants.

By the end of the weekend after the fire, each of the bank building's eight tenants, which occupied about 150,000 of the building's 550,000 square feet of space, had located space, they said.

Norwest officials say the burned-out building will be demolished, at a cost of \$1.2 to \$1.3 million although no date has been set. A new building on the site should be complete by 1987, they add.

In the meantime, the bank will continue to operate in temporary facilities in downtown Minneapolis. Placement of operations in these locations is in its final stages.

Because the city's downtown area is geographically compact, operations will not be severely hin-

dered during this period, Norwest officials said.

Although the bank's losses may exceed \$100 million, Norwest officials say they have been able to learn from the experience.

In fact, records of the recovery process have been documented and will be saved to serve as an information source in the event of future catastrophes.

One of the most important lessons the fire taught supervisors was to resist the urge to overmanage, Mr. Nelson said.

"We had lots of participative delegation," Mr. Dissmeyer said, "stripped away a lot of red tape and, almost without exception, saw people handle responsibility they had never had before."

"Now, we'd like to retain the corporate culture that developed." ■

Special committee worked with insurer

BALTIMORE—Good documentation and record keeping are essential for businesses seeking payments from insurers for disaster losses, said Richard H. Klovstad, Norwest Corp.'s risk management vp.

"The better you prepare your claim, the better your chances of collecting. And your skills in negotiating have a direct relationship to the amount of your award."

Norwest's insurance, a blanket replacement value property insurance policy with an extra-expense endorsement, is provided by St. Paul Fire & Marine Insurance Co.

Norwest does not carry business interruption insurance, Mr. Klovstad said, "because we're a service organization and can't afford to stay closed."

The company's claims, which have been estimated at about \$80 million, have been settled in principal, he said.

To guarantee reimbursement for its claims, Norwest established a claims management control task force immediately after last year's Thanksgiving Day fire to identify the total loss and claims that would be filed with St. Paul.

The task force was made up of people from Norwest's insurance, accounting, legal, building and data processing departments, as well as an outside consultant. It met weekly to suggest decisions it thought management should make.

The purpose behind the task force was to let it worry about the insurance claims process so other employees responsible for the bank operations could worry about getting the business functioning again, Mr. Klovstad said.

One of the first items of business for the task force was to spearhead an inventory of items recovered from the building to determine what had been lost.

All of the proof-of-loss records generated were kept in a locked document room. The names of all persons entering and leaving the room were recorded. A card catalog of claims records was developed.

Eventually, the amount of documentation became so great that a messenger service had to be employed to move the records, Mr. Klovstad said.

Items that would be replaced in the event of a disaster should be insured for their replacement cost, Mr. Klovstad advised. If an item would not be replaced, it should only be insured to its current cash value, he said.

"However, insurance is not a substitute for the control of risk," he said. "A company that carries insurance should take whatever steps to react to a disaster that a company without insurance would take." ■

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HMO rates rise more slowly than traditional plans' rates

ROCKVILLE, Md.—Health maintenance organizations have been more successful than commercial insurers in holding the line on health care costs, according to a new survey.

Between 1980 and 1982, the average monthly premium for individual coverage charged by traditional health insurance plans rose to \$57.86 from \$39.48, a 46.6% increase, while the premium for individual coverage charged by HMOs climbed to \$57.37 from \$44.40, a 29.2% increase.

Similarly, the average family premium charged by indemnity plans increased 42.6%, rising to \$152.75 per month from \$107.12, while family coverage charged by HMOs rose a more moderate 34.4% to \$153.76.

If current trends continue, HMO premiums will be lower than traditional health indemnity plan premiums in the next one to three years, according to the survey conducted by the federal Office of Health Maintenance Organizations in Rockville, Md.

To learn about HMO trends, the OHMO in conjunction with Hay Associates, a Philadelphia-based employee benefit consulting firm, surveyed 235 major employers, most of which have offered HMO coverage for at least three years.

The survey report, "Employer Attitudes Toward Health Maintenance Organizations," reveals how HMOs have grown as an alternative to conventional health insurance plans. Between 1978 and 1982, the percentage of employees enrolled in HMOs at the surveyed companies climbed to 23% from 14%. By contrast, indemnity plans' shares of the health care market dropped to 77% from 86%.

Employers on the West Coast reported the highest percentage of employees enrolled in HMOs: 33%. Employers in the North Central states had the second highest HMO penetration rate, 28%, followed by 18% among employers in the South and 14% for employers in the Northeast.

Large employers, those with more than 5,000 employees, had the highest percentage of employees enrolled in HMOs, 25%, compared to 20% for employers with 1,000 to 4,999 workers and 21% for employers with fewer than 1,000 employees.

Metropolitan areas that have the highest percentage of employees enrolled in HMOs include: San Francisco/Oakland, 33%; Minneapolis/St. Paul, 26%; Los Angeles, 25%; and Portland, Ore., 23%.

According to the survey, the biggest HMO growth is expected in cities where HMOs have been offered only recently. Those cities include Atlanta; Austin, Texas; Buffalo, N.Y.; Columbus, Ohio; Dallas; Houston; Kansas City, Mo.; Memphis, Tenn.; and Oklahoma City.

Although HMO membership has increased to 12 million people from 3 million since 1970, the survey found that the HMO concept still turns off many employees.

The most important factor that discourages employees from joining HMOs was the "reluctance to break ties with family physicians." In addition, employers reported that workers complained that HMOs were inconveniently located.

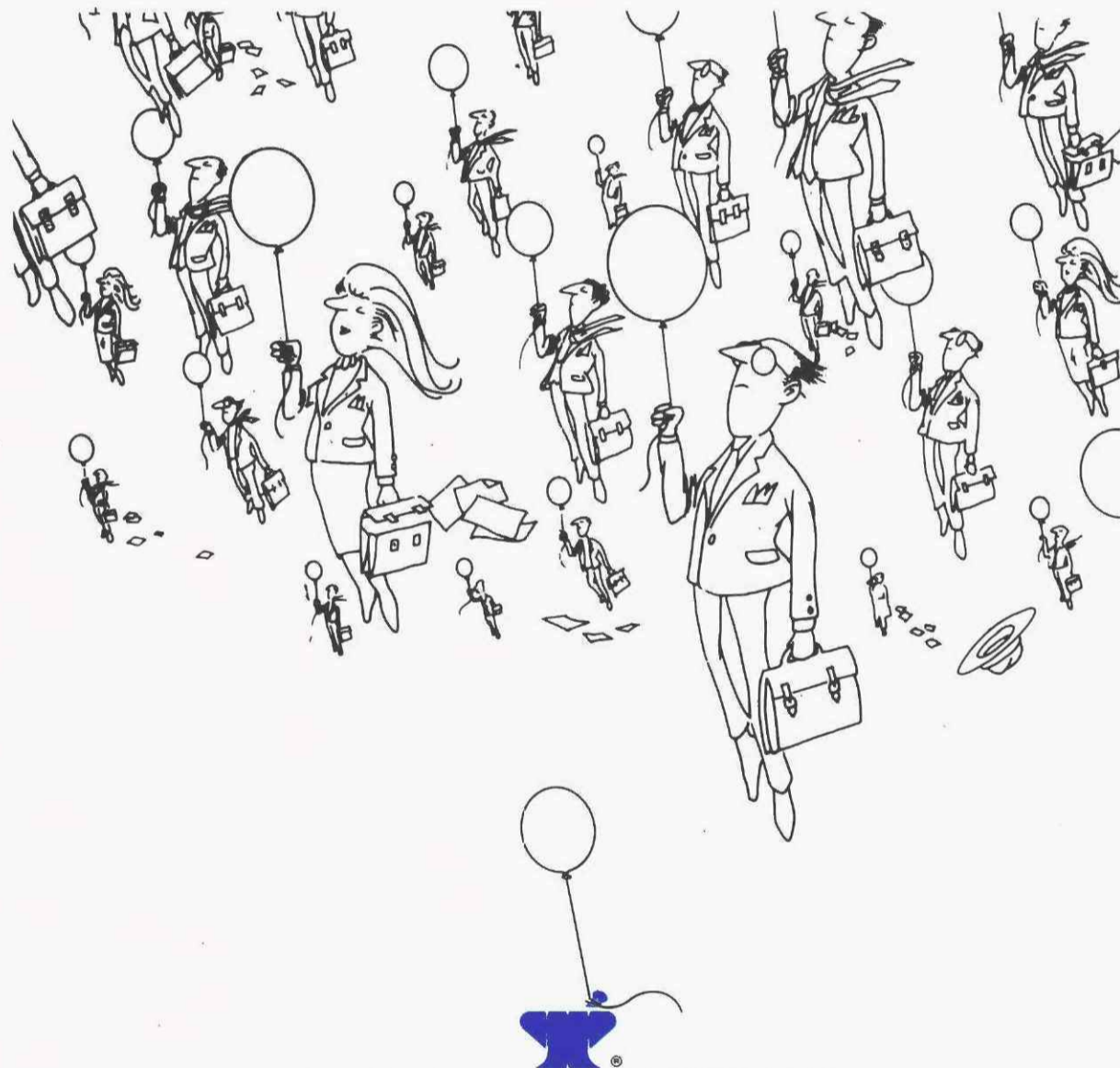
On the other hand, 86% of employers said employees were attracted to HMOs because the plans had no or minimal coinsurance requirements and deductibles.

While conventional health insurance plans nearly always impose higher deductibles than HMOs, they also are more likely to offer more than just standard medical and hospital benefits.

For example, 77% of the indemnity plans offered by surveyed employers provided dental care, compared with 59% of HMOs. Some 98% of the indemnity plans offered prescription drug benefits, compared with 78% of the HMOs.

On the other hand, just 17% of indemnity plans provided vision care benefits, compared with 93% of the HMOs. In addition, 95% of the HMOs offered hearing services, while that benefit was offered by only 7% of the indemnity plans.

Large employers were most interested in sponsoring HMOs. Some 33% of employers with more than 5,000 employees said they would consider sponsoring a new HMO, compared with 21% of employers with between 1,000 and 4,999 employees and 10% of employers with less than 1,000 employees.



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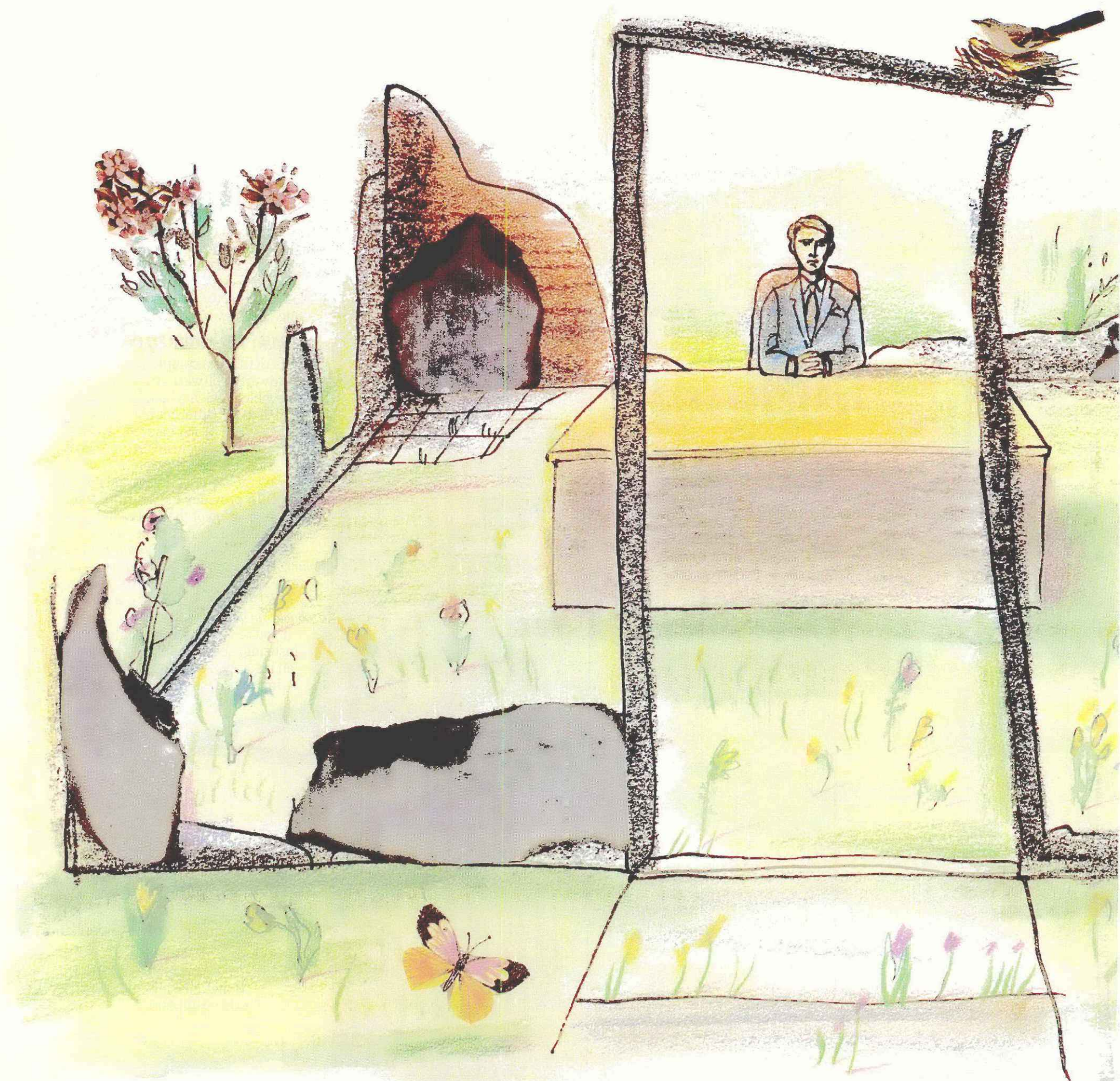
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There isn't an insurance company anywhere that couldn't cite examples showing how good their claims service is. You know the type of examples we mean. The true test, however, is to ask a corporation or its insurance broker—the people who really live with the service—how they feel their insurance company performs.

So we would like to invite you to speak with our insureds or with your broker. Ask them the tough questions: find out how they really feel about AFIA's claim service. They'll tell you.

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An actuary's analysis of the security of a self-insured

Continued from previous page

let alone true unreported and reopened claims. Hence, when average factors are used to estimate IBNR, there could be an incentive to intentionally understate claim amounts. For this reason, it is vital to collect sufficient information to ascertain an adequate case reserve level for each self-insurer on an individual basis.

A few more points should be noted. In estimating loss liabilities, a forecast of the future is being made. Hence, there cannot be one right answer or one best procedure to use. A number of techniques are available to project these liabilities. The key is to have the data necessary to utilize the various reserving models and to assess the relative strengths and weaknesses of each for a particular company.

Once the cost of prior claims has been analyzed, a projection of the cost of the future self-insurance program can be made. This will let both the regulator and the company know the likely cost of continuing the program and assist in deciding if self-insurance is the best option to pursue.

Several adjustments must be made to past claims to bring them up to the level of claim costs expected in the coming year.

First, realize that benefits are directly related to the state statute governing workers compensation. The consistent pattern of states for many years has been to increase legislated indemnity payments to claimants. Also, the allowances in medical fee schedules used by various states have increased over time, upping costs.

The net effect has been that from 1971 to 1981, nationwide benefit levels have increased by 57.2%. This translates into an annual rate of increase of 4.6%.

In addition to the increased benefit levels, costs may rise due to increased claim frequency and benefit utilization. These two factors also have generally been going up in recent years. It is not uncommon for states to have claim costs increase at 3% to 5% a year because of these factors.

Finally, recognize that the exposure to workers compensation claims has probably changed over time. The exposure is related to both the weekly wage of employees (since this determines the benefit level) and the number of employees covered. Nationwide wage levels have been increasing at 7% to 9% per year.

Combining these factors, we find that workers comp costs per employee have been increasing, on average, about 17.5% per year.

This rapid increase in claims costs also has an impact on the adequacy of reserve levels. At an average annual rate of 17.5%, claim costs will double in about four years. If this rapid increase in claims costs is not incorporated in establishing individual claims reserves, they can become significantly understated in a short period.

From a regulator's point of view, if only the expected losses of the self-insurer were funded, the actual losses would exceed the amount available to pay claims nearly 50% of the time. In order to have a greater assurance that the reserve will be sufficient to pay all claims as they become due, an additional amount above the expected losses needs to be set aside. This extra portion is referred to as a contingency loading, safety loading or surplus.

The amount of contingency loading relative to expected losses depends upon three main factors: the amount of losses expected, the type of loss distribution involved and the program of excess insurance in place.

The larger the expected number of claims, the less relative variation there will be about the average value. Hence, a smaller percentage contingency loading is necessary. This is a result of probability theory, known as the law of large numbers: The more observations made, the closer the actual result should be proportionately to the expected result.

For example, if the expected number of claims is 10, the probability that the actual number of claims will exceed the expected number by at least 20% (12 or more claims) is 30%. However, when the expected number of claims is 50, the corresponding probability is only 9%. For 50 expected claims, a 30%

Graphic: Jim Bakasetas

probability is attained at 54 claims. Hence, a 20% contingency loading with 10 expected claims provides essentially the same safety level as an 8% contingency loading with 50 expected claims.

The loss distribution is important because some types of claims are inherently more variable than others. For example, major permanent partial claims have an expected variation of approximately 75% of the average claim cost. For medical malpractice claims, the expected variation can be four times the average claim cost. Claims that have less expected variation require a smaller contingency loading.

Excess insurance influences contingency loading because it affects claim cost and claim variation differently. Although excess insurance will reduce both, the claim variation reduction is usually much greater and, hence, a smaller relative loading is possible.

Another factor to consider in setting the contingency loading is a minimum funding requirement. This, in turn, can be related to the maximum benefit on a single claim. At current benefit levels, a lifetime benefit to a 20-year-old claimant could easily cost \$500,000. Although such an event may be unlikely, one might occur and should be considered when setting a security deposit.

The contingency loading also plays an important role for the self-insurer. In addition to giving a single-point estimate for the expected cost of workers compensation claims in a given year, the analysis of the contingency loading allows a range of results to be given.

For example, in addition to stating that the expected claim is \$1 million, a 90% confidence interval of \$800,000 to \$1 million might be given. With the extra information, the self-insurer can better assess whether the cost savings of self-insuring is worth the added risk.

Levels of self-insurance retention and excess coverage are closely tied to the contingency loading and the factors that affect it. In addition, the excess coverage level is dependent upon the self-insurer's net worth and its attitude toward risk.

The greater the company's wealth, the more risk it can reasonably retain, and the greater the self-insurance retention can be. The more adverse a company is to risk, the smaller the self-insurance retention and the larger the excess limits will be. A very risk-adverse company would probably choose to purchase commercial insurance coverage and not retain any of the workers compensation risk. Models exist to incorporate a company's viewpoint in the process to decide which excess coverage levels should be obtained.

The payment patterns of self-insurance costs will normally be determined as part of the reserving process if sufficient data is available. This payment pattern has two main purposes.

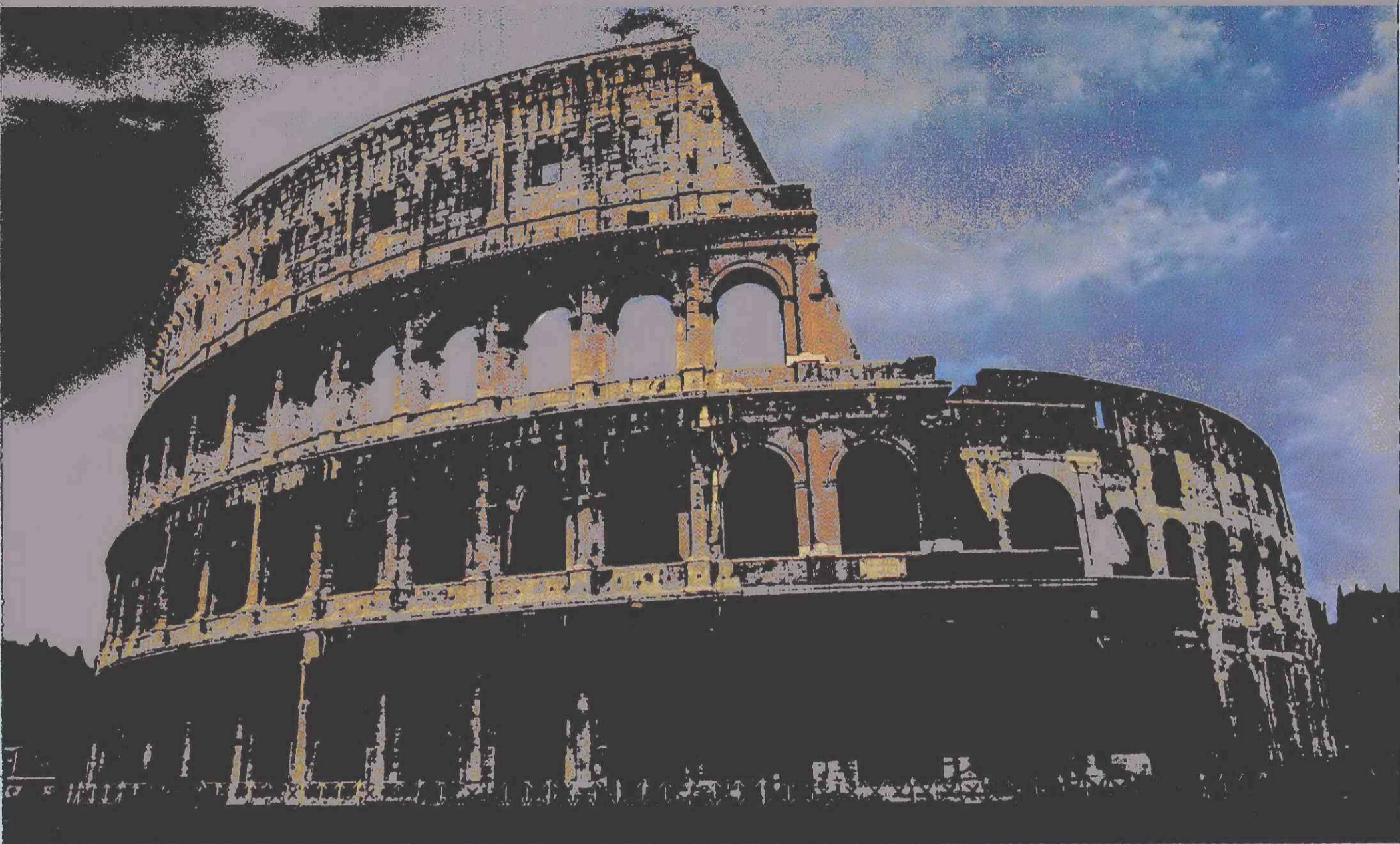
First, it allows the company and regulator to examine the projected outgo in various periods to insure that sufficient funds will be available to pay benefits as they come due.

Second, if a formal self-insurance fund is established, the payment pattern is used to determine the amount of investment income to offset those payments. This arises because the actual benefit payments will not be made until some time in the future. Therefore, only the present value of these future disbursements needs to be funded currently. The payment pattern also can be used as a guide to what maturity schedule the investments should follow. This will allow sufficient funds to be available to pay claims without having to liquidate investments prematurely.

The overall purpose of an actuarial study is to allow both the self-insurer and regulator to obtain an accurate picture of the cost and risk involved in self-insuring workers compensation. With this information, a more informed decision can be made as to whether or not self-insurance is the best course of action. ■

Allen I. Schwartz is a senior actuary at Woodward & Looney Inc. in New York.

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In fact, even if a roof doesn't fall in, architects and engineers can still be involved in a suit.

After a crime in a suburban mall, for example, an architectural firm was actually sued for designing a shopping center that was "conducive to kidnapping."

And if that seems absurd, consider this: an engineer was called in as a consultant on a problem limited to the roof at the Hyatt Hotel in Kansas City. He was later sued for failing to notice structural weakness in the skywalk that collapsed there.

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If you're interested in this subject and would like more information, please write to Insurance Company of North America at 1600 Arch Street, Dept. RC, Philadelphia, Pennsylvania 19101.

Or if you're an architect or engineer and would like to discuss your specific situation, please call your agent or broker.

After all, you never know when something might go boom.



Fall's the time to hit the books and stock your reference shelf

By Claudette Dampier

THESE recent publications can be additions to or the beginning of your risk management reference library.

"International Handbook"
Carolyn McDonald Wood, editor
City Financial Insurance
Publications Ltd.
20/24 Ropemaker St.,
London EC2Y 9AS
175 pages, \$45 loose-leaf ring binder;
\$27 for annual update service

Listing more than 100 countries, this handbook is a round-the-world tour of insurance laws and regulations. You can find details on obscure places like Vanuatu (an island northeast of Australia) and Mauritania (in northwestern Africa) here.

Within each national listing is a multitude of categories like licensing and supervision, reserves, insurance contracts, insurance with non-resident insurers, obligatory insurance, obligatory reinsurance cessions, premium taxes, federal supervisory authority, state or provincial authority, insurer associations, chambers of commerce and legal associations, law firms and loss adjusters—almost more than you'd want to

books & ideas

know about insurance anywhere.

Naturally, not all those subjects apply to all countries, or, in some cases, the material couldn't be found. For instance, looking at the entries, it appears the editor had an easier time gathering details on Australian, rather than Angolan, insurance regulations.

European Economic Community directives and a list of international organizations pertaining to insurance and finance, as well as a bibliography are included.

This loose-leaf edition was created to allow update service subscribers to easily add the inserts as they are published.

"1983 Commercial Lines
Valuation Guide"
E.H. Boeckh Co.
615 E. Michigan St., Milwaukee,
Wis. 53202
339 pages, \$38.50 paperback

If you're in charge of property/casualty insurance for a conglomerate, a regional fast-food chain or even a three-store group of mom-and-pop groceries, the

"Commercial Lines Valuation Guide" is your book.

This guide contains "cost information and methods for determining the value of commercial, industrial and institutional buildings." All the details are laid out in a plain, straightforward manner.

The book also adds that the materials and construction costs are pegged to the prices of one region. But it supplies basic instructions for the reader to figure replacement costs for your specific building and location.

After 28 pages of instructions, the heart of the matter arrives—the valuation tables for a garden variety of buildings—more than 75 of them. A glossary and index complete the book.

This valuation guide won't win any awards for compelling reading. But, it has the facts risk and insurance managers need to make building calculations.

"Oilfield Manual"
By Jack R. Robertson, revised by Fred
Berger and Larry Caspers
Insurance Planning Inc.
P.O. Box 488, Hays, Kan. 67601
101 pages, \$49.50 paper ring binder

This is definitely a nuts-and-bolts reference guide to oilfield operations and procedures.

The manual is composed of outlines on various operations and procedures. The outlines cover topics from specialty tool operations to the installation or recovery of casings to instrument logging to oil reclaiming.

Within each specific outline, there are checklists on applicable workers compensation codes, tools and equipment used in oilfields, commonly found hazards and oil field terminology.

One-tenth of the manual is devoted to an oil well and rig glossary. A two-page description of oil property forms is included.

Fairly standard "beauty shots" of oil wells and rigs and equipment accompany the text. The only diagram, an oil rig, was accompanied by identifying terms written, instead of printed or typed, which made it difficult to read.

The Perspective section, which is a forum for readers' opinions, is compiled and edited by Assistant Copy Editor Claudette Dampier. She can be reached at 312-649-5282.

Reinsurer bound when insurer follows policy

FOLLOW-THE-fortune clauses bind a reinsurer only when the reinsured settles a claim covered by an underlying policy, not when the reinsured makes payments outside the scope of that policy, a federal appellate court ruled.

During the 1970s, American Insurance Co. insured Dow Chemical Co. for all damages that Dow became legally obliged to pay.

In 1974, North American Co. for Property & Casualty Insurance reinsured part of AIC's risk and assumed a layer of liability between \$250,000 and \$500,000 per damage award.

In 1977 a Minnesota jury verdict was entered against Dow for \$147,000 for compensatory damages and \$750,000 for punitive damages caused by a fire in a building insulated with Styrofoam, a Dow product. While the award was on appeal, AIC settled a number of Styrofoam cases, including this case, for \$1.2 million. Of that settlement, \$500,000 was allocated to the Minnesota case.

AIC then requested North American to honor its reinsurance policy and reimburse AIC for \$250,000 of the Minnesota award. North American refused. AIC sued but lost in court.

On appeal, North American claimed that the Minnesota jury had awarded punitive damages against Dow for deliberate corporate misbehavior and, consequently, most of AIC's Minnesota settlement had compensated Dow for damages excluded by the wording of the insurance and reinsurance policies.

legal briefs

Since the compensation damage award was less than \$250,000, North American claimed it had no duty to reimburse AIC. The appellate court agreed that it was clear that the settlement here was primarily designed to compensate Dow for a punitive award that was excluded from the reinsurance policy.

Therefore, the court said it would be unfair to North American to hold it liable for damages beyond the scope of the policy form. *American Insurance Co. vs. North American Co. for Property & Casualty Insurance*, 2nd U.S. Court of Appeals, Dec. 30, 1982 (BI/05/0.-\$5).

Altering death benefits

The Supreme Court of Wisconsin ruled that an injured employee can compromise his or her dependents' death benefit claims.

In 1971 Francis Pigeon entered into a general compromise agreement with his employer and its insurer with regard to his claim for benefits. His claim arose from disability from emphysema and silicosis caused by industrial exposure to silica dust. While there was disagreement as to whether cigarette smoking was the primary cause, a compromise agreement was agreed to entitling Mr. Pigeon to a partial permanent disability of 50% of the body as a whole. The settlement was to be paid in installments.

Mr. Pigeon died in 1977. The insurer

paid his widow the balance due under the compromise agreement. She then filed for death benefits. The Industrial Commission denied benefits but was reversed by a trial court. The Court of Appeals, however, restored the commission's decision barring benefits.

The Supreme Court affirmed. Wisconsin law, according to the court, allows an employee to enter into a compromise of all liability for the injury that is binding upon his or her dependents.

"The words 'all liability' include not only the injured employee's claim for disability benefits," the court said, "but also his or her dependent's claim for death benefits." The court emphasized that compromise furthers the purpose of the workers compensation law by enabling an injured employee to negotiate a settlement and bypass the costs and uncertainty of litigation. *Pigeon vs. Department of Industry*, Supreme Court of Wisconsin, Nov. 30, 1982 (BI/02/0.-\$5).

Compensable injuries

A husband's claim for the loss of services and consortium of his wife was barred by law where the wife was injured in the scope of her employment by a fellow employee, according to an Ohio appellate court ruling.

Judy Maynard and Jackie Henderson

were fellow employees. Ms. Maynard received injuries in an automobile accident caused by the alleged negligence of Ms. Henderson. Ms. Maynard filed for and received benefits on a workers compensation claim for her injuries.

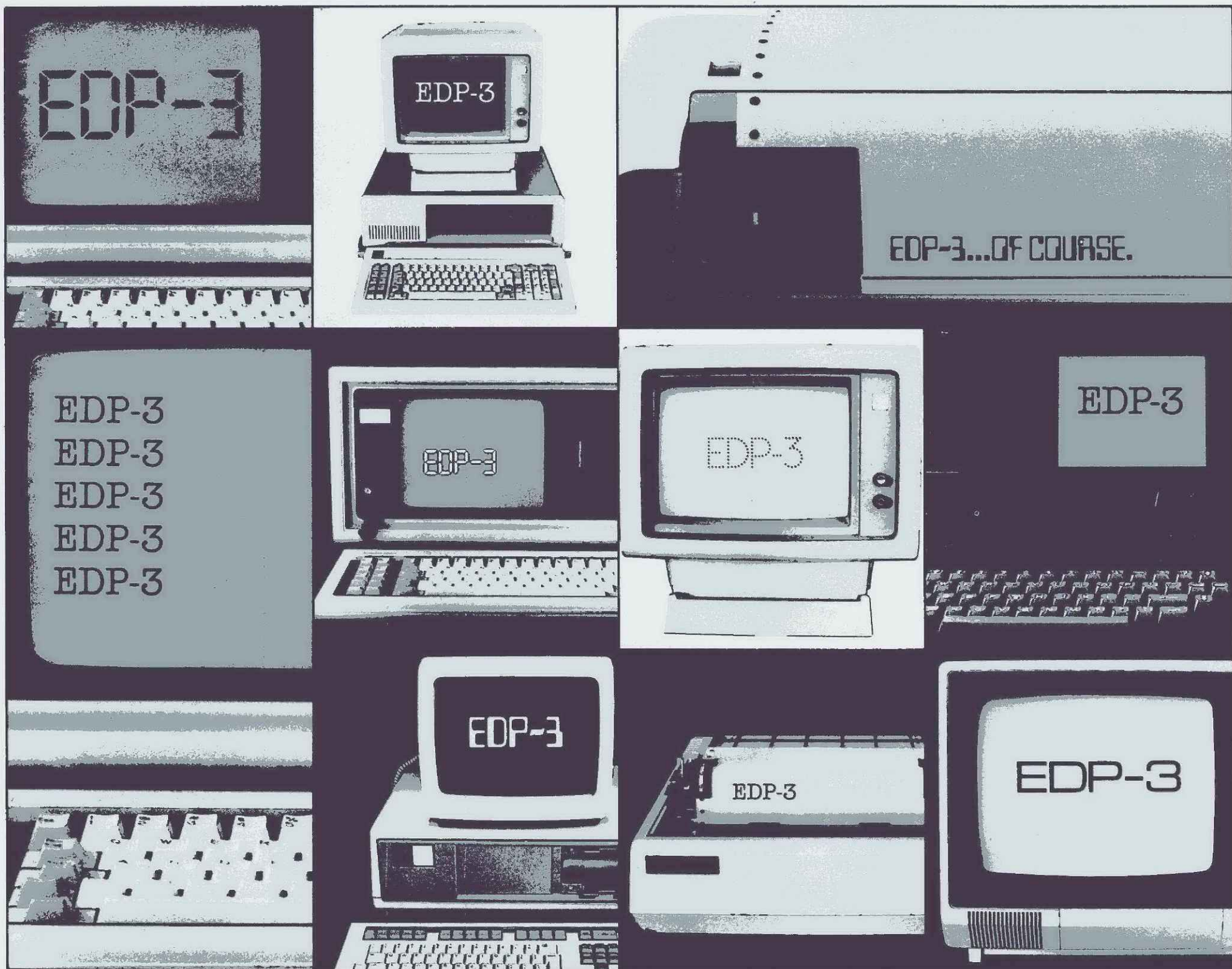
Ms. Maynard and her husband, Harry, filed a suit against Ms. Henderson for damages. Mr. Maynard's claim was for loss of services and consortium derived from his wife's injury. The trial court dismissed the suit.

At issue on appeal was whether the workers compensation law, which bars actions against a fellow employee, was applicable to Mr. Maynard's claim against Ms. Henderson. She argued that the only condition in the law for her immunity from suit was that such injury, occupational disease or death of the employee be compensable, not that a derivative claim of a third party be compensable.

According to the court, the only injury that must be compensable to provide immunity against any damage claims was the bodily injury to the employee. The court affirmed the lower court decision. *Maynard vs. Henderson*, Court of Appeals of Ohio, March 9, 1982 (BI/04/0.-\$5).

These abstracts were prepared by Cases Unlimited Inc. A copy of an entire decision may be obtained by sending a check for \$5 made out to Cases Unlimited to Business Insurance, 740 N. Rush St., Chicago, Ill. 60611. List the number for each opinion.

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Fifth annual ASHRM conference

Hospital risk managers stress fundamentals

By SALLIE J. DRURY

BOSTON—Hospital risk management is no longer the paper-shuffling job of the past.

That's the message that was delivered to those attending a session on the fundamentals of hospital risk management that kicked off the fifth annual conference of the American Society for Hospital Risk Management, held Aug. 29 to Sept. 1 in Boston.

The ASHRM presents the fundamentals session annually at its conference to provide the many new hospital risk managers—entering the field from a variety of backgrounds—with the basics of dealing with a hospital's particular risks.

Jane J. Reynolds, director of risk management for the Greenville (S.C.) Hospital System, was one of four panel members sharing "not just the fundamentals for beginners, but extra tidbits for everyone" on hospital risk management.

"The first thing is that we can't tell you how you are going to set up your risk management program," Ms. Reynolds said. "There's no one way to do it."

"And, there is such a broad scope of responsibilities that all of your positions will be different," said panelist Carol Y. Niedt, loss prevention consultant with the Health Care Insurance Exchange, a non-profit insurance company owned by New Jersey hospitals, based in



'Credibility is a major issue. I get asked, 'How much money have you saved us?' Everyone wants hard data to justify the risk management department,' Ms. Reynolds says.

Princeton, N.J.

Although panelists said hospital risk managers wear many hats, they share common goals, like preventing losses, and common needs, like increasing their credibility.

"Credibility is a major issue," Ms. Reynolds said. "I get asked, 'How much money have you saved us?'"

Everyone wants hard data to justify the risk management department.

"Plus, risk managers are concerned that they want to make themselves indispensable.

"To start to do that," she continued, "you have to work on communicating to different people—not just to the financial officers, but

to the board of trustees, who now realize they are responsible for everything that happens in the hospital—what your program is all about. But of course, you first need to have a viable program going."

A viable program begins with targeting problem areas. Panelists named medical, custodial and business departments as those problem areas.

"Everyone remembers that the medical staff poses a risk because of malpractice liability," Ms. Niedt said. "And you'll remember the risk of housekeeping services because you've heard stories about losing wallets or false teeth, falling out of bed or slipping on a wet floor.

"But the business office is an often-neglected system," she said. "In some ways it's the most important system. It is the place for patient complaints.

"The first thing that takes a patient to an attorney is anger. The last thing you want in your business office is someone pushing for payment of treatment that shouldn't have happened (such as hospital-caused injury).

"If treatment is required for an iatrogenic injury, the best thing to do is make sure those charges never get entered into the billing computer rather than telling the patient, after the bill comes, that the hospital is going to eat thus and such charges," she continued.

"Otherwise, the patient, who has been informed that an error in administering the original treatment requires additional treatment, gets a huge bill after he comes home from work one day. That's after 5 p.m., so he can't get hold of the hospital business office until the next day, and he's angry.

"Meanwhile, he goes to a neighbor, who tells him he ought to sue. By the time he finally gets through to the hospital, he might have his attorney calling you."

The use of patient representatives also can keep anger over any error in treatment at a low level.

A patient representative would notify the patient that, say, an error had been made in medication. He or she would keep lines of communication open between the hospital and the patient.

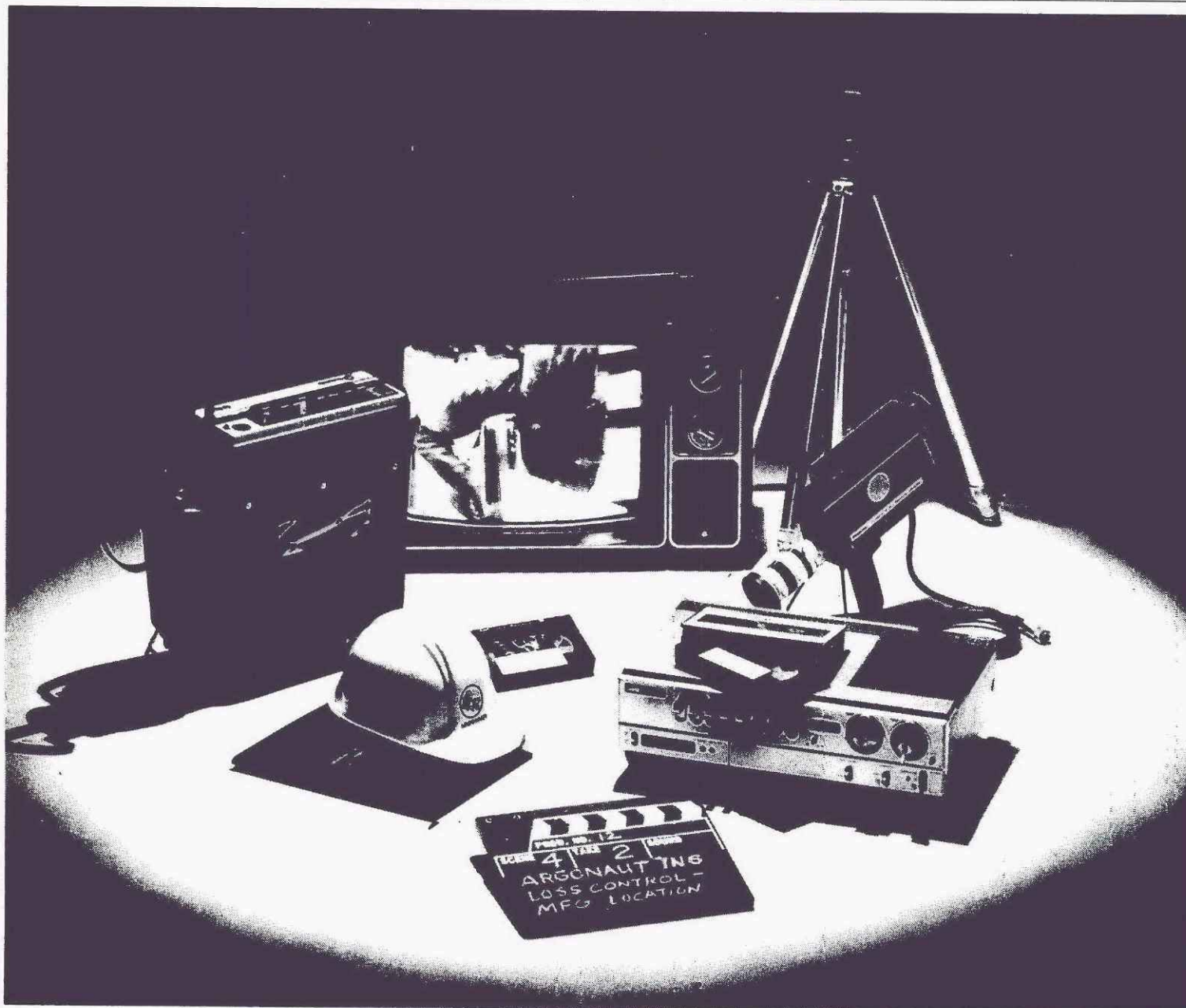
"If a patient is given a chance to have his questions answered, and in a timely fashion, and if he is assured that the hospital is concerned and is taking responsibility, nine times out of 10 he won't be angry," Ms. Niedt said.

If the patient relations department is doing its job properly, she said, it is looking out for the patient's rights and following up on complaints. "They help form that bridge. They fulfill a human need.

"Patients often don't bother the hospital staff for questions," she continued. "With a patient representative we can say, 'Here at last is a person for you to contact with your questions.'"

Ms. Niedt also stressed that the risk manager needs to get feedback from the patient relations department to make

Continued on page 39



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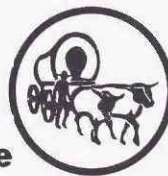
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Effective patient relations can help cut claims

Continued from page 38
sure problems are handled quickly or help head them off.

While the patient relations department provides a means of communication between hospital and patient, the risk manager also is concerned with communication between himself and the hospital staff, the panelists said.

"Rounds, or personal visits to other departments, are crucial," Ms. Niedt said. "Meet the department heads. Visit the areas. Let these people know you are a non-threatening person."

Risk managers also should have an open-door policy, she stressed. "It makes it difficult to manage your time that way, since anyone can come in and interrupt a project at any time, but in the end you'll be glad you have the communication."

However, she added that the open-door policy requires two-way feedback, that risk managers must follow up when problems are brought to them. "You have a responsibility to get back to those people that come in, tell them their comments have been useful and tell them how the incident turned out," Ms. Niedt said.

Communications may also take the form of an incident report. This is a written, objective record by a witness of any occurrence involving a patient, visitor or employee that could result in a claim.

"You have some flexibility on what you want to have on your incidence reports," said Peggy Martin, director of quality assurance/risk management for Children's Hospital Medical Center in Boston. "But you must give your people guidelines on how and when to fill them out."



Ms. Niedt

Ms. Niedt agreed and stressed that everyone in the hospital is qualified to complete an incident report.

"If someone falls out of bed and they're discovered by housekeeping, that's who should fill out the report," she said. "Don't make the housekeeping person tell his supervisor who tells the head nurse who fills out the report. That's third-hand information."

"Just because they aren't degreed or clinical people doesn't mean they can't record their first-hand observations of the incident," she said.

"And the risk manager must be privy to all this incident report information," Ms. Martin added.

Although incident reports can provide the risk manager with valuable information to both head off potential claims and target new risk areas, they may also expose the hospital to more risks, depending on what state the hospital is in.

"Find out if incident reports are discoverable in your state," Ms. Niedt said. "If so, you have no protection from litigation."

"You need to be very careful in your design of the reports and what they include. Don't ask, 'What could have been done to prevent this problem?' because that's conjecture. If incident reports can be called into court, that kind of question will mean just getting out your checkbook and moving on to the next incident."

Ms. Reynolds reminded those attending the conference that most incidents have only the slimmest chances of resulting in lawsuits, although they are helpful in other ways.

"You get them on everything

and 99% of them will be consulted, dealt with and shelved," she said. "Those 99% never see the attorney's office."

Similar to incident reports is the medical log, written information maintained by various departments but not submitted to the risk management office.

"The log has saved many a defendant's neck," Ms. Niedt said. "It's very problem-oriented, and you're the one who needs to know what the problems are."

"If there has been an equipment failure, if the lab has taken forever to get results back, if assistance is offered a patient and the assistance is refused, it will be in the log. And the log will be very important if the patient sues for negligence," Ms. Martin said.

If there is a lawsuit or claim filed,

the risk manager may or may not be involved in the legal process. If he or she is not, the risk manager should know who handles claims, who screens the incident reports and the insurers. The risk manager should also be involved in the discovery process when information on the case is exchanged among the parties involved.

Other tips on handling claims were provided by Ms. Reynolds:

- Make medical management the immediate response. "In any claims situation, you do as much as you can *medically* first," she said. "Record the information, handle the problem and then find out why it happened to prevent a recurrence."

- Preserve evidence. "If a salesman comes for faulty equipment,

never give it up. Tell him to test another piece of equipment from the same lot number, but save your evidence."

- Document all incidents.
- Notify physicians of all unusual circumstances.

- Start an investigation as soon as possible.

- Control the repercussions of the particular incident by communicating formally with the staff involved.

- Evaluate costs.
- Develop a communications system for billing if charges are to be retained by the hospital.

- Know who is influential at the insurance company and in the attorney's office.

- Know the statute of limitations in your state.

"Finally, the sooner you decide

to defend or settle, the better," Ms. Reynolds said.

"And if you aren't the person who buys insurance for your hospital, get on the committee that buys it, even if it's advisory status," she said.

"You are the one with all the data on losses."

And know how cases that go to court turn out, she said. "They will affect your premium."

"You need to combine the experience of all of your professions in risk management," said Sharyn Colegrove, coordinator of risk management at South Bay Hospital in Redondo Beach, Calif. "Even in the hospital, especially in the hospital, you have to follow the basic risk management steps: identification, elimination, reduction, assumption and transfer." ■

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Hospital risk management growing rapidly

By SALLIE J. DRURY

BOSTON—They come from the legal department. They come from the quality assurance area. They come from the nursing field. Some even come from insurance backgrounds.

"More and more people are being handed the title 'risk manager' in hospitals," says Jane J. Reynolds, director of risk management for the Greenville (S.C.) Hospital System and president-elect for 1985 of the American Society for Hospital Risk Management.

These new risk managers gathered with the seasoned professionals for the fifth annual conference of the American Society for Hospital Risk Management of the American Hospital Assn., held Aug. 29 to Sept. 1 in Boston.

"We were very pleased with the turnout. The meetings are what really set us up for success, so we put a lot of time into planning them," says William Ryan.



"We're just beginning to define the term 'risk management,'" Ms. Reynolds said. "At that, the definition needs to be flexible."

David Meyers, ASHRM director and senior staff specialist at the AHA in Chicago, estimates that the number of hospital risk managers has increased by 25% to 30% in the last two years.

In 1980, about half of the hospitals in the country had risk man-

agers, he estimated.

Unlike the commercial risk manager, who often has emerged from a background of purchasing insurance, the hospital risk manager is only just now gaining financial responsibilities.

"The purchase of insurance had been left to a financial executive," Ms. Reynolds said. "But increasingly, hospital risk managers have been given the insurance responsi-

bilities.

"Now that we have these responsibilities, we want to have more control over the financial aspects of risk than just calling a broker and asking for a policy," Ms. Reynolds continued.

"We have a tendency to be suspicious when someone says 'Here is what I'm selling and here are your needs.' We want to be able to say 'Here are my needs and here is what I want to buy.'"

These new responsibilities for hospital risk managers mean additional education and training are necessary. And, with so many more people with different areas of expertise entering the hospital risk management field, there is a terrific demand for education programs.

ASHRM is one organization that

satisfies this demand. The 3-year-old society ballooned from a 10-member task force in 1980 to about 1,150 members today with 13 chapters across the country.

"It all started in 1978 when a group of us approached the AHA with the idea of forming a society of hospital risk managers," said Steven L. Salman, director of risk and insurance management at Sisters of Charity Health Care in Cincinnati.

Mr. Salman was one of the society's founding members.

"Although the AHA didn't think there were enough of us to merit a society at first, they said if we could gather enough interested persons, they would go ahead," he said.

"We sent out petitions to see if there were risk managers in hospitals out there who were interested in forming a society. When about 150 petitions were returned in about 15 days, the AHA was convinced and formed a task force to start planning our new organization."

The 10-member task force, appointed in the fall of 1979, quickly elected officers and called the first meeting in March 1980 in New Orleans. About 200 people attended that conference.

This year, more than 500 attended the Boston meeting.

"We were very pleased with the turnout," said ASHRM President William Ryan, insurance and risk manager for the University of Michigan in Ann Arbor, which operates a hospital. "The meetings are what really set us up for success, so we put a lot of time into planning them."

"I think our continued professionalism is what was evident at the Boston conference," said Bill Rogers, president-elect of ASHRM and director of risk management for Conemaugh Valley Memorial Hospital in Johnstown, Pa. Mr. Rogers' term will begin in January 1984.

"I'd like to see the society continue to develop that professionalism, and I'd like to continue Bill's efforts. He wanted to make sure the organization gets closer to its members and makes full use of all its members, not just one small group of people," he said.

The ASHRM organization is led by a board of directors. The board is comprised of a president, a president-elect, a society director and five other voting members of the board; all members serve one-year terms. The immediate past president remains on the board in a non-voting advisory capacity.

While the purpose of the society is to "advance the development... of the professional practice of hospital risk management" through educational activities and professional relationships, the ASHRM conference participants had time for some levity while advancing themselves professionally.

The society hoped to increase risk manager visibility by selling T-shirts screened with the logo: "Risk managers cover your assets." And these risk managers demonstrated their cool in a crisis.

When the hotel fire alarm sounded in the wee hours of the morning of Aug. 29, the risk managers dutifully proceeded to the exits of each floor to await instructions from hotel staff.

The alarm turned out to be the result of an extra-sensitive smoke detector, and guests padded back to their rooms. But, rather than grumbling, one pajama-clad risk manager asked his 23rd-floor neighbors with a smile, "Do you suppose they planned this as a welcome for us?"

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- Explaining Salary Reduction Plans - Robert Penzkover, Dir. of Benefits, The Quaker Oats Company
- Wellness Programs - William E. Hembree, Dir., Health Research Institute; Denise Maleska, Dir. of Human Resources, Agricultural Division, CIBA-Gelgy Corp.; Dr. Joseph C. King, Dir. Employee Health Services, Continental Illinois National Bank & Trust Company of Chicago
- What Makes A Winning Communications Program - Herb Zeltner, Herbert Zeltner Inc., Marketing & Communications
- Innovative Ideas - Andrew Corn, Ad Master; Polly Carpenter, Carpenter Graphic Design, Inc.
- Employee Attitude Survey's - Rhonda Karp, Ed. D., Assoc. Dean, College of Allied Health Sciences, Thomas Jefferson University; James Weitzel, VP, Johnson & Higgins

Breakout sessions afford you the opportunity to zero in on a specific problem you may be facing. Select one session that best meets your needs:

- A Joint Session On: Essential Elements In Your Program/How To Work With Suppliers - J. Frank Swygert, Jr., President, Benefits Media, Inc.; LaRue Foster, Manager, Employee Benefits Communication, Corporate Communications Dept., Boise Cascade Corporation
- Changing Benefits Strategy - Joseph Duva, Director, Employee Benefits & Compensation, SCM Corporation; Dennis McKoy, VP, Johnson & Higgins

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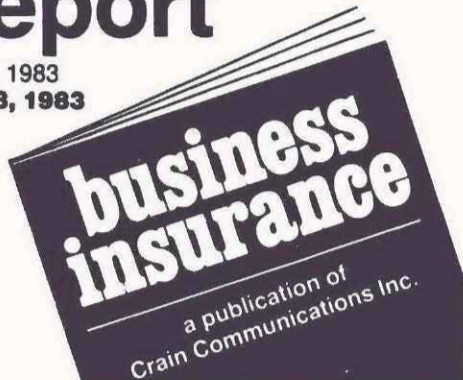
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Ambulatory care centers pose new types of risks

By SALLIE J. DRURY

BOSTON—Hospital risk managers are waking up to a new exposure: the walk-in clinic or ambulatory care center.

More of these ambulatory care centers are springing up. And as utilization of these centers increases, hospitals are anticipating more malpractice claims.

"Until now, hospital risk managers have wondered, 'Why bother with a risk management program in this setting?'" said Sandra L. Read, vp for program development at consultant Affiliated Risk Control Administrators of Pennsylvania Inc. in Pittsburgh. Ms. Read spoke at the American Society for Hospital Risk Management meet-

ing Aug. 29 to Sept. 1 in Boston.

"The risk for care given in the ambulatory setting just wasn't that high in the past," she explained. Now, there are several reasons why the ambulatory care setting demands a risk management program, she said.

"First, there has been an increase in consumer demand for ambulatory care. There is an increase in the number of procedures performed on an ambulatory basis, including surgery. And, there are more centers opening up.

"Second, we anticipate that hospitals will be pushing for earlier discharges because of the new prospective pricing regulation (for Medicare and Medicaid patients) to cut costs. This means increased utilization of outpatient treatment centers.

"Third, the outpatient clinic in the hospital or health maintenance organization is often the first place of contact with a hospital. It is where the first impression of the institution starts, and if that is a bad impression, consumers will be more eager to file suit.

"Because of these things, hospitals are anticipating more claims and lawsuits generated from ambulatory care centers."



Ms. Read

But in these settings, the care providers are more accessible to the risk manager, more vulnerable to risk and, therefore, more educable in preventing risk, she said.

Ms. Read advised that risk management for these centers should be every bit as thorough as that for inpatient settings.

"Jurors will not accept a lower standard of care," she said. "Carry over (from the hospital setting) as many concepts, procedures and forms that you can.

"Be sure to have physician involvement," she added. "If possible, have each department (of the hospital) review the type of care given in this setting, or at least have the (hospital) medical director make the reviews. And, at least one individual from the ambulatory care setting should report to the risk management department."

These reports would include patient or staff complaints; reports from the utilization review coordinator telling how many patients must be admitted to the hospital because of mismanagement in the ambulatory care setting; and quality assurance audits on the care given in the center, including mortality and morbidity figures.

The risk manager also should be informed of requests for medical records by attorneys or patients.

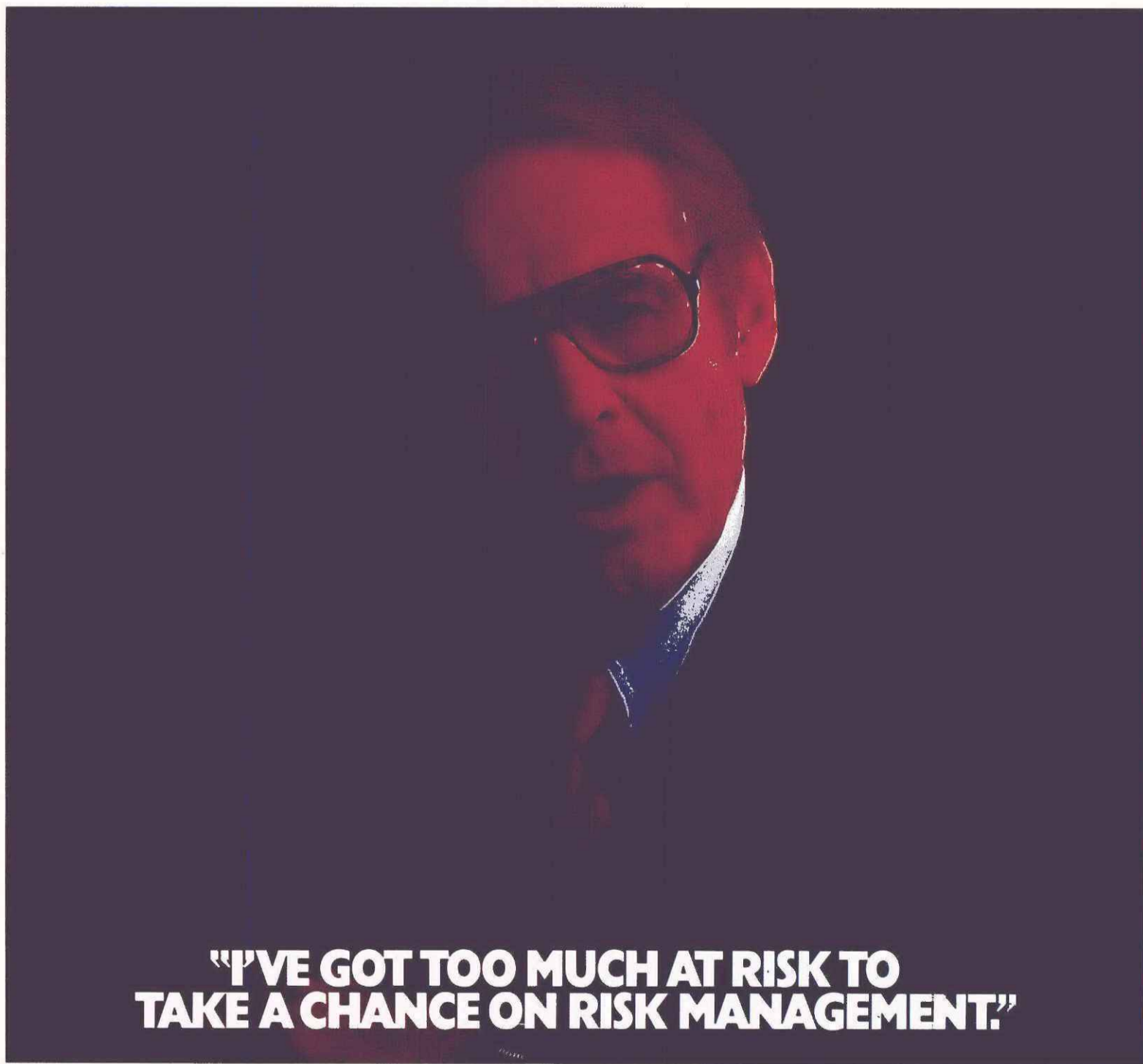
"Find out why someone wants to see the medical record," Ms. Read advised. "Often it will be the first indication of a potential claim and an indication that there has been breakdown in the communication between physician and patient."

Although the risk manager needs a great deal of information from the various physicians and staff of the center, Ms. Read stressed that this information need not be delivered in a formal report.

"Verbal reporting will be your primary method of gathering information from physicians," she said. "They are more likely to pick up the phone than fill out reports.

"But you will also need some occurrence forms filled out. Keep that form simple. And educate—by department—what they should look for and report.

Continued on page 44



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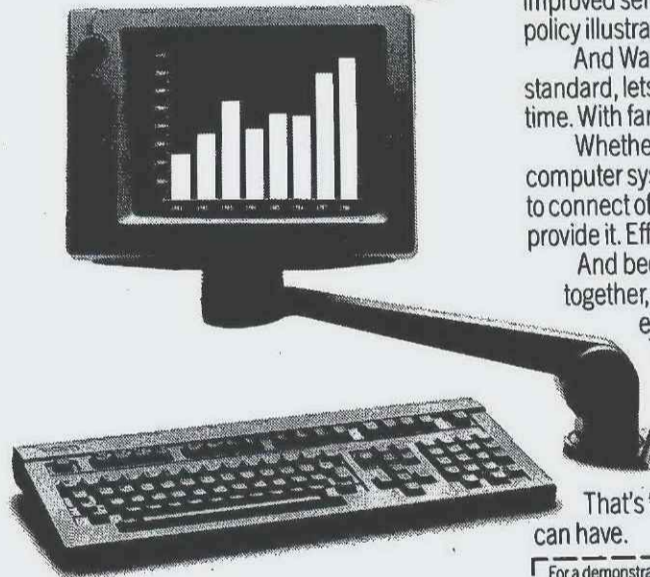
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Ambulatory care centers create new types of risks

Continued from page 42

"Also, develop a system for review of diagnostic reports and consultations. These include reports from pathology and radiology, plus blood chemistries, cultures and records of consultations.

"Telephone triage has its own protocol and accompanying documentation," Ms. Read continued. "The risk manager should receive information on the patient's complaint and telephone advice given. If you call a patient and don't document it, you are going to have a poor defense in the future (if a claim should arise).

"All of these forms, plus those used as care orders, such as prescription forms, should also go into the patient's medical record. If there is an error—for instance, on the part of the pharmacy—it puts you in a better defensible position."

"Whatever forms and methods you use, be flexible," she advised. "It's not how you get the information, but that you get it accurately and in a timely fashion."

Communication between risk manager and ambulatory center staff is essential if the risk manager is to obtain that accurate data, Ms. Read said.

Besides communicating with the caregivers in ambulatory centers, the staffs also must be educated about risk management.

"To reduce risks you must educate the staff," Ms. Read said. "You need to remind them that only properly 'credentialed' people may administer the care. Each department should review who, other than physicians, can perform certain procedures, what their supervision will be and whether you are within the scope of the law. Then they should report back to you."

Ms. Read said she also anticipated an increase in the number of potential and actual claims involving so-called physician extenders, such as nurse practitioners or nurse/midwives, will increase. The scope of duties assumed by physician extenders should be communicated to the risk manager.

"And in the telephone environment, when

care instructions are administered over the phone, nurses sometimes forget they are nurses they forget they still need orders and cannot practice medicine," she said.

"Education is communicating between you and the staff in the ambulatory care setting, but it is also increasing communication between the various departments at the center. Maybe recommend a joint medical conference to increase this communication.

"And, when they communicate to you, provide feedback to the various departments as to how you are handling a situation and how their information is being received.

"At first it may seem like it's not worth the effort in the ambulatory care setting," Ms. Read said. "You'll receive far fewer reports—maybe only 40 a month instead of 200 (in the hospital setting).

"But, you'll find that you need to look at those reports even more carefully. There are very few occurrences in this setting that don't require some action."

Doctors often won't follow hospital policy

BOSTON—To the hospital risk manager, a physician can be a walking time bomb that sets off a medical malpractice suit.

With risk management a relative newcomer to the health care scene, physicians can be less than cooperative when it comes to the risk manager and his wagonful of forms, says one physician.

The hospital risk manager's challenge is to gain the cooperation of physicians so that the risk of malpractice claims is reduced.

"You must work with the physicians because they are the ones who create the big losses. But, you work in a very difficult environment," said Dr. John P. Cossa, vp of medical affairs at St. Agnes Medical Center in Philadelphia.

Dr. Cossa spoke at one of the keynote sessions at the American Society for Hospital Risk Management fifth annual conference Aug. 29 to Sept. 1 in Boston.

"You'll never hear about all the good cases, only the problems. Everybody is uptight. Physicians are uptight," he said.

"Here is the physician/risk manager scenario—the physician wants autonomy, he gets control. The physician wants respect, he gets suspicion. The physician wants independence, he gets someone stressing interdependence. And the physician wants prestige, but he finds he is subject to hospital policies like everyone else," Dr. Cossa said.



Dr. Cossa

Since the hospital risk manager has a number of odds working against him or her in developing rapport with physicians, Dr. Cossa advised a pragmatic approach in dealing with them.

"Try to understand physician behavior," he said. "Even years later, the impact of the medical school's curriculum is not erased. (In medical school, it is drummed into doctors that they are independent agents whose purpose is to heal.)

"That may explain a physician's seemingly illogical reaction to a hospital policy.

"And, don't expect very many doctors to be gung-ho organizational people," he advised. "That sort of approach won't appeal to them.

"Face these facts," Dr. Cossa said, "One, there is a problem in getting doctors to cooperate with hospital management. Two, neither the doctors nor hospital management is blameless in a conflict. And three, you haven't tried everything yet."

Although the doctors may be very resistant to hospital policy, Dr. Cossa urged hospital risk managers not to be discouraged by the "few hard-nosed physicians" who don't work well with anyone.

"Don't approach the troublemakers," he said, "approach those who you think might be willing to listen."

For those hospital risk managers who have had good luck in their dealings with the medical staff thus far, Dr. Cossa told them never to assume that they would never encounter "a truly unreasonable and recalcitrant physician. You will.

"You will never get 100% cooperation," he said, "but you can get enough cooperation to accomplish what you want to do."

One way to gain physician confidence is to make rounds to visit the physicians' work areas. However,

Continued on facing page

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Continued from facing page

Dr. Cossa warned seminar attendees on the timing of these rounds.

"It's not the time to talk to a surgeon about malpractice liability when he is scrubbing before going into the operating room," he said.

Another way is to read the medical staff bylaws so that the risk manager is familiar with the structure of the medical staff. "They will tell you where the muscle is," he said.

Also, the risk manager should hold a physician-orientation program.

"Make this mandatory," Dr. Cossa said. "The house staff should attend, and you should hold sessions for new staff members. This

'If medical malpractice liability is going to improve, there has to be some integration of peer review in the risk management function. After all, the physician is worried about medical malpractice, too,' Dr. Cossa says.

should be part of the initial employment process."

The physician-orientation program is the perfect time to introduce the medical staff to risk management, he said. The risk manager can explain his or her role to the staff and provide them with guidelines for helping the risk manager

carry out his or her functions, such as how to complete physician incident reports.

"Incident reports should be mandatory from a physician," Dr. Cossa said. "Tell the medical staff what they are, assure them of confidentiality and tell them your policy if they fail to fill out a report."

How to enforce a policy with physicians? "Hit them in the wallet," Dr. Cossa suggests. "That makes them sit up and take notice."

But, he warned, policy must be consistently enforced "or word travels fast and no one will respect you."

Although developing lines of communication with physicians is the big first step hospital risk managers must take in tackling the malpractice liability problem, they must also introduce or reform policies.

In this regard, Dr. Cossa suggested a risk management approach which would borrow ideas

from the quality assurance department, whose responsibility it is to make sure the best care possible is always given.

Peer review is one quality assurance tactic.

"If medical malpractice liability is going to improve, there has to be some integration of peer review in the risk management function," Dr. Cossa said. "After all, the physician is worried about medical malpractice, too."

"Physicians are learning that they are going to have to change their ways," he said. "They are learning the importance of risk management in the hospital. And they are going to have to practice defensible medicine." ■

Alaska agents told to report METs to state

JUNEAU, Alaska—Insurance Director Kenneth Moore wants insurance agents in Alaska to notify the Division of Insurance of any self-funded multiple employer health care trusts that may be operating in the state.

Mr. Moore noted that legislation passed last year by Congress makes it clear that states have the power to regulate METs.

That legislation, sponsored by Rep. John Erlenborn, R-Ill. and the late Rep. Phillip Burton, D-Calif., requires self-funded METs to meet certain state insurance laws (BI, Dec. 27, 1982).

If a MET has been certified by the Labor Department as a bona fide employee benefit plan under the Employee Retirement Income Security Act, a state insurance department can require the trust to meet state rules governing reserves and contributions.

And if a MET fails to win Labor Department recognition as an ERISA-approved benefit plan, the trust is subject to all state rules governing insurance operations. Few self-funded METs can meet those rules and could be shut down by state insurance departments as unauthorized insurers.

Mr. Moore also advised agents to fully investigate a MET, including those that are underwritten by insurance companies, before placing risks with the trust. Factors that should be investigated include:

- Are the METs rates substantially less than those charged by commercial health insurers? METs have been known to charge low rates in order to lure small employers. Later, the MET collapses because the rates were inadequate to pay claims.

- Is the MET paying claims on time? Experts note that slow payment of claims is a warning signal that the MET may be in financial trouble.

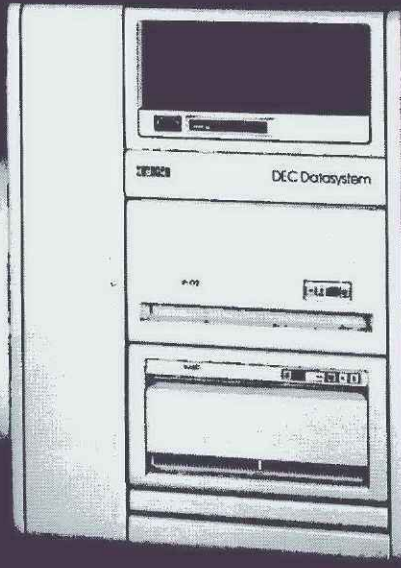
- Have there been frequent changes in insurers underwriting the MET or in third-party administrators running the MET?

Since 1977, a number of self-funded and insured METs have collapsed. Many small employers, who often lack insurance sophistication, have relied on their agents to advise them if a MET is properly managed or if premiums paid to the trust are used to pay for high administrative fees and commissions instead of claims. ■

USC risk manager to head association

LOS ANGELES—Alex J. Ratka, director of risk management and insurance at the University of Southern California, has been elected president of the University Risk Managers Insurance Assn.

He will take office at the association's annual meeting, to be held Oct. 16 in Birmingham, Ala. ■



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OCT. 26-27. Health Care Cost Containment workshops in Los Angeles, sponsored by the Health Research Institute; \$395. Also **Nov. 16-17** in New York and **Dec. 7-8** in Chicago. HRI, 49 Quail Court, Suite 200, Walnut Creek, Calif. 94596; 415-676-2320.

OCT. 26-28. Government Risk Management seminar in Alexandria, Va., sponsored by the Public Risk & Insurance Management Assn.; \$300. Natalie Wasserman, PRIMA, 1120 G St. N.W., Suite 707, Washington, D.C. 20005; 202-737-7556.

OCT. 28. Third-Party Administrator workshop in San Francisco, sponsored by the Health Research Institute; \$395. Also **Nov. 18** in New York; **Dec. 9** in Chicago. HRI, 49 Quail Court, Suite 200, Walnut Creek, Calif. 94596; 415-676-2320.

OCT. 31. The Hay Report conference in New York City, sponsored by Hay Management Consultants; \$490. Doran Twer, Hay Associates, 229 S. 18th St., Philadelphia, Pa. 19103; 215-875-2338 or 800-523-2975.

OCT. 31-NOV. 1. Compliance with the new CAL/OSHA noise standard and establishing an effective program course at the University of Southern California in Los Angeles; \$375. USC, Institute of Safety & Systems Management, Office of Extension & In-Service Programs, Los Angeles, Calif. 90089; 213-743-6523/6524.

OCT. 31-NOV. 1. Managing Offshore International Insurance Companies seminar in New York, sponsored by Tillinghast, Nelson & Warren Inc.; \$600; \$500 for subsequent registrants. Pat Kelley, Tillinghast, Nelson & Warren Inc., 3340 Peachtree Road., Atlanta, Ga. 30026; 404-261-5420.

OCT. 31-NOV. 4. Corporate Safety Auditor seminar in Atlanta, sponsored by the International Loss Control Institute; \$625. ILCI, P.O. Box 345, Loganville, Ga. 30249; 800-544-6001 or 404-466-2208.

OCT. 31-NOV. 4. Pension and Benefits Week in New York, sponsored by the Practising Law Institute; \$700; single-day rates available. Practising Law Institute, Dept. HGC, 810 Seventh Ave., New York, N.Y. 10019; 212-765-5700.

OCT. 31-NOV. 4. Risk Management seminar in Atlanta, sponsored by the International Loss Control Institute; \$625. ILCI, P.O. Box 345, Loganville, Ga. 30249; 800-544-6001 or 404-466-2208.

NOV. 1-2. Communicating Employee Benefits conference in Chicago, sponsored by Business Insurance; \$495; 10% discount for additional participants from the same company. Ann Vazquez, Business Insurance, 220 E. 42nd St., New York, N.Y. 10017; 212-210-0137.

NOV. 3-4. Captives: Making Optimum Use of the International Risk Management Tool seminar in New York, sponsored by the World Trade Institute; \$590. Karin Ford, World Trade Institute, 1 World Trade Center, 55th Floor, New York, N.Y. 10048; 212-466-3162.

NOV. 3-4. Healthcare Risk Management: The Negative Impact of Protective Security seminar in Washington, sponsored by Armand Surprenant Associates; \$425. Armand Surprenant Associates, 1100 17th St. N.W., Suite 1000, Washington, D.C. 20036; 202-466-2803.

NOV. 4-5. Employee Dishonesty: Claims, Bond Coverage and Caveats institute in New Orleans, sponsored by the American Bar Assn.; \$75 to \$375. Roslyn Powell, ABA, 10 W. 35th St., Chicago, Ill. 60616; 312-537-4682.

NOV. 7. Financial Futures: Applications to the Life Insurance Industry seminar in New York, sponsored by the World Trade Institute; \$360. Karin Ford, World Trade Institute, 1 World Trade Center, 55th Floor, New York, N.Y. 10048; 212-466-3162.

NOV. 8-9. Tenth Annual Computer Security conference in New York, sponsored by the Com-

puter Security Institute; \$595; group discounts available. Computer Security Institute Educational Resource Center, Department ERC, 43 Boston Post Road, Northborough, Mass. 01532; 617-845-5050.

NOV. 9-10. Barbados—A New Opportunity for Captives conference in St. Philip, Barbados, sponsored by the Central Bank of Barbados and the Insurance Corporation of Barbados; \$150. David King, Central Bank of Barbados, P.O. Box 1016, Treasury Building, Bridgetown, Barbados, W.I.; 62250.

NOV. 11-16. Design for the Future 29th annual educational conference in New Orleans, sponsored by the International Foundation of Employee Benefit Plans; \$450; \$390 before Nov. 10 \$130 extra for each pre-conference institute selected. IFEBP, 18700 W. Bluemound Road, Box 69, Brookfield, Wis. 53005; 414-786-6700.

NOV. 13-16. Professional Insurance Agents of America annual convention in San Diego; \$75 to \$180. Nicholas J. Matthews, 400 N. Washington St., Alexandria, Va. 22314; 703-836-9340.

NOV. 14. Banks and Employee Stock Ownership Plans seminar in Los Angeles, sponsored by the Employee Stock Ownership Assn.; \$90 for members; \$125 for non-members. Also **Nov. 18** in Chicago. Employee Stock Ownership Assn., 1725 DeSales St. N.W., Suite 400, Washington, D.C. 20036; 202-293-2971.

NOV. 14-16. Advanced Safety Management

seminar in Atlanta, sponsored by the International Loss Control Institute; \$350. ILCI, P.O. Box 345, Loganville, Ga. 30249; 800-544-6001 or 404-466-2208.

NOV. 14-16. Employee Benefit Plan conference in Santa Monica, Calif., sponsored by Charles D. Spencer & Associates Inc.; \$350. Seymour LaRock, Charles D. Spencer & Associates Inc., 222 W. Adams St., Chicago, Ill. 60606; 312-236-2615.

NOV. 14-16. Multiple-Owner Offshore Insurance seminar in Los Angeles, sponsored by Captive & Self-Insurance Services Inc.; \$425; 10% discount for members; \$50 discount for second registrant. Judy, Captive & Self-Insurance Services Inc., 950 Elm Ave., Suite 210, San Bruno, Calif. 94066; 415-871-1670.

NOV. 14-17. National Fire Protection Assn. fall meeting in Orlando, Fla.; \$60 for members; \$85 for non-members. National Fire Protection Assn., Fall Meeting Registrar, Batterymarch Park, Quincy, Mass. 02269; 617-328-9290.

NOV. 14-18. Assets Protection course in Philadelphia, sponsored by the American Society for Industrial Security; \$595 for members; \$650 for non-members. ASIS, Membership & Meetings Services, 1655 N. Fort Myer Drive, Suite 1200, Arlington, Va. 22209; 703-522-5800.

NOV. 14-18. Fundamentals of Industrial Hygiene Monitoring course in Long Grove, Ill., sponsored by National Loss Control Service Corp.; \$425. John Garis, NATLSCO, Long Grove, Ill. 60049; 312-540-2026.

NOV. 14-18. Safety Trainer Training seminar in Atlanta, sponsored by the International Loss Control Institute; \$795. ILCI, P.O. Box 345, Loganville, Ga. 30249.

NOV. 16. Employee Stock Ownership Plan seminar in San Diego, sponsored by the Employee Stock Ownership Association; \$90 for members; \$125 for non-members. Also **Nov. 21** in Tampa. The Employee Stock Ownership Assn., 1725 DeSales St. N.W., Suite 400, Washington, D.C. 20036; 202-293-2971.

NOV. 17-20. National Assn. of Professional Surplus Lines Offices Ltd. ninth annual conference in Chicago; \$300. J. Dale Bohm, 624 Holcomb Bridge Road, Suite 3, Roswell, Ga. 30076; 404-998-9075.

NOV. 18. Update '84: Workers Compensation and the Total Picture seminar in Santa Clara, Calif., sponsored by Self-Insurance Programs; \$90 for clients; \$110 for non-clients. Lucretia Doyle-Marcus, Self-Insurance Programs Inc., 3333 Bowers Ave. #100, Santa Clara, Calif. 95051; 408-980-0210.

NOV. 19-21. Fundamentals of Industrial Exhaust Ventilation course in Long Grove, Ill., sponsored by the National Loss Control Service Corp.; \$350. John Garis, Manager, Industrial Hygiene, NATLSCO, Long Grove, Ill. 60049; 312-540-2026.

NOV. 27-30. Benefits Processing institute in Hollywood, Fla., sponsored by the International Foundation of Employee Benefit Plans; \$390 for members; \$465 for non-members. IFEBP, 18700 W. Bluemound Road, Box 69, Brookfield, Wis. 53005; 414-786-6700.

NOV. 28-DEC. 2. Recognition of Occupational Health Hazards course at the University of Southern California, sponsored by the university; \$650. Office of Extension & In-Service Programs, Institute of Safety & Systems Management, University of Southern California, Los Angeles, Calif. 90089; 213-743-6523/6524.

NOV. 28-DEC. 1. Hemispheric Insurance 19th biennial conference in San Francisco, sponsored by the International Insurance Advisory Council; \$400 for delegates; \$700 for observers. Gordon Cloney, International Insurance Advisory Council, U.S. Chamber of Commerce, 1615 H St. N.W., Washington, D.C. 20062; 202-463-5480.

DEC. 4-7. Corporate Benefits Management conference in Orlando, Fla., sponsored by the International Foundation of Employee Benefit Plans; \$470 for members; \$545 for non-members. IFEBP, Box 69, 18700 W. Bluemound Road, Brookfield, Wis. 53005; 414-786-6700.

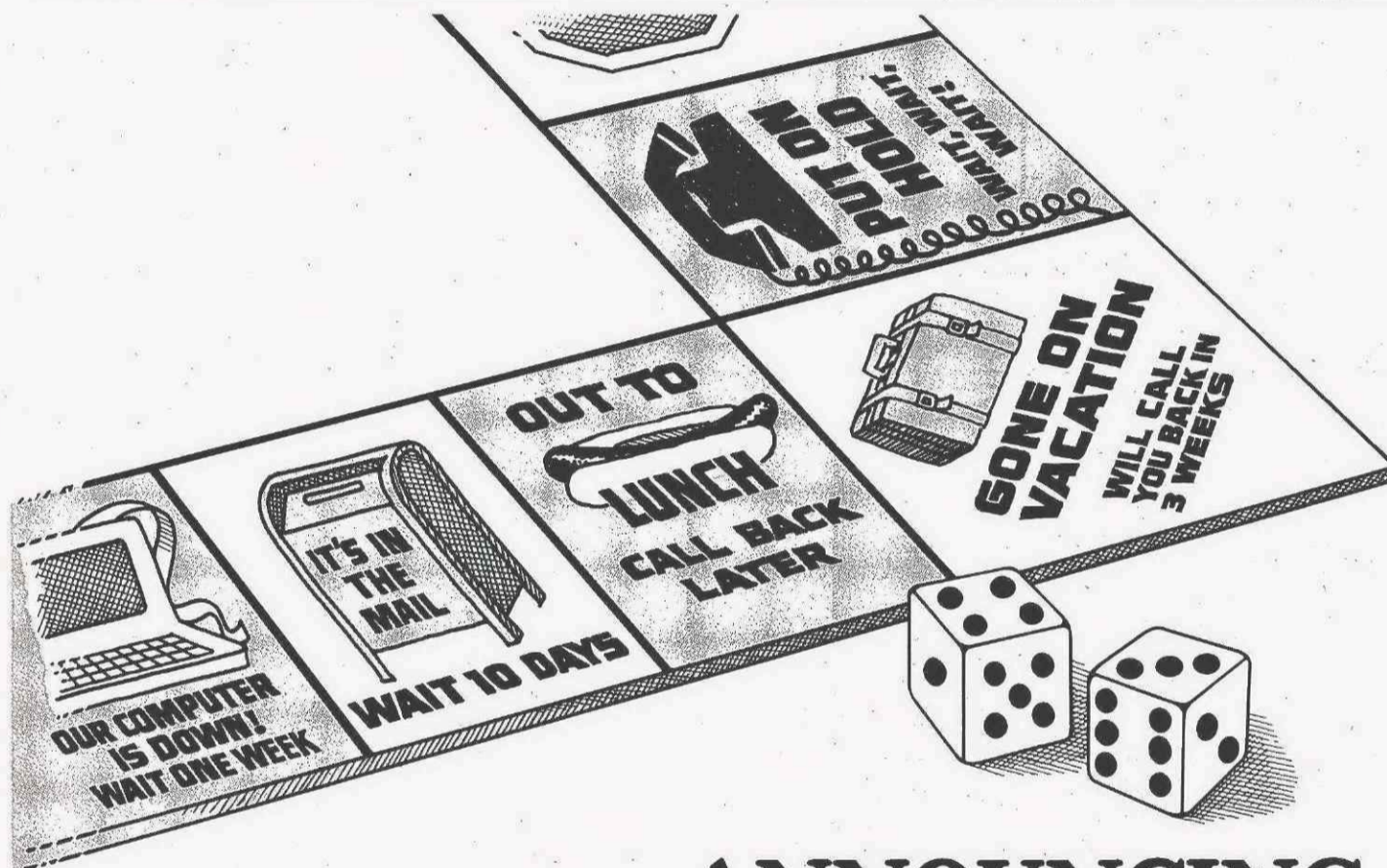
DEC. 5-7. Techniques of Risk Management conference in San Francisco, sponsored by the Risk & Insurance Management Society; \$345 for members; \$445 for non-members. Editorial Department, RIMS, 205 E. 42nd St., New York, N.Y. 10017; 212-286-9292.

DEC. 7-9. Computer Programs for Occupational Health Systems course at the University of Southern California, sponsored by the university; \$400. University of Southern California, Institute of Safety & Systems Management, Office of Extension & In-Service Programs, Los Angeles, Calif. 90089; 213-743-6523/6524.

DEC. 8-9. Corporate Involvement in Developing Country Health Sectors conference in Newport Beach, Calif., sponsored by the National Council for International Health; \$175 for members; \$250 for non-members. Graeme Frelick, National Council for International Health, 2100 Pennsylvania Ave. N.W., Suite 740, Washington, D.C. 20037; 202-466-4740.

DEC. 12-13. Ergonomics course at the University of Southern California, sponsored by the university; \$375. University of Southern California, Institute of Safety & Systems Management, Office of Extension & In-Service Programs, Los Angeles, Calif. 90089; 213-743-6523/6524.

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State regulators overwhelmed: Report

Continued from page 3

deferred annuities issued by six Baldwin life insurance units that are now in rehabilitation (BI, Sept. 19).

In trying to deal with the Baldwin-United controversy, the insurance regulatory system in Arkansas "by its own admission came perilously close to breaking down," the report says.

The Arkansas Insurance Department's investigation of questionable loans and transactions among various Baldwin-United subsidiaries didn't even begin until after the transactions had already been closed out, the COIL report notes.

The Arkansas department also encountered long delays in getting information about Baldwin and its affiliates from the insurance departments in the other 49 states, and had to seek outside help when its own staff couldn't handle the "regulatory overload" imposed by the situation.

In the course of COIL's six-month review of the conglomeration of financial services and the adequacy of current regulatory systems, the 13-member task force, composed of state legislators with an interest in insurance matters, made several other observations.

Among its findings were:

- State insurance departments can't keep up with the transactions of financial services conglomerates because they don't have the computer capability to rival that of the companies they are regulating.

"Many insurers and their affiliates, with the aid of today's computers, perform in split seconds tasks that pile up on the desks of regulators," the task force's report observes.

While a few states—including Illinois, California and New York—have "reasonably current" computer facilities, most regulators are "at a decided disadvantage in monitoring reserve adequacy" and other solvency data.

- The so-called "early warning system" developed by the National Assn. of Insurance Commissioners, a basically manual system for spotting potential solvency problems, "may not spot and relay insolvency information until months after the danger should have become clear.

"A system that furnishes information once yearly and then five months after the fact limits what regulators can do," the report concludes.

- The basis for regulation of insurer solvency is still the triennial examination, a report that takes months of work to produce.

For instance, the triennial examination of the Metropolitan Life Insurance Co. by the New York Insurance Department for the period ending Dec. 31, 1978, is still not complete, the report notes.

- The integration of insurance with other financial services requires state insurance departments to monitor information traditionally outside their normal scope, compounding their disadvantage in keeping pace with the action of the marketplace.

"When face-to-face with insurers, banks and other financial institutions, (regulators) are outmanned and outgunned," the report says.

- Many insurance departments can't offer attractive enough salaries to draw the brightest people away from private companies. Budget restrictions, Civil Service regulations and compensation parity requirements among departments of state government all contribute to the difficulty many insurance departments are having in maintaining adequate staffs to handle their growing responsibilities.

- Because regulators' preven-

tive steps may not always head off an insolvency, the "patchwork quilt" of guaranty fund laws in the various states need to be made more uniform and comprehensive.

Many holes still exist, the report says, noting California's failure to create a fund to cover life, accident and health policies.

In addition, many state guaranty funds only function as to bail a state out of fiscal crisis, as happened in New York last year when the Legislature appropriated \$77 million from the Motor Vehicle Liability Security Fund to balance the state's budget.

- States should make similar efforts to revise insurance holding company and investment laws to make it easier for regulators to monitor solvency and protect policyholders in case of insolvency.

- The kind of aggressive deregulation pursued by some states to attract business and promote economic development "represent the bad side of deregulation and could lead to a deregulatory free-for-all," the report warns.

To help insurance departments cope with some of the problems noted in its review, the task force makes several recommendations. They include the following:

- State insurance departments should be given access to state-of-the-art computer equipment that would allow them to continuously monitor insurance company solvency.

To start, insurance departments might require only relatively simple microcomputers, and the cost of such systems would not be staggering, the task force maintains. The

report estimates that the non-recurring expenses of buying hardware, software and training workers to use a microcomputer might total about \$750,000. Recurring expenses of entering yearly and quarterly insurance company financial data and buying supplies might add up to \$350,000 per year, the report concludes.

After state departments have their own small computers, a larger mainframe computer could be bought to handle larger amounts of information. Operated by the National Assn. of Insurance Commissioners, this central system might cost about \$4 million, including hardware, staff and network charges to individual insurance departments communicating with the system through their own microcomputers.

- Legislatures should increase the budgets of state insurance departments to allow for the purchase of modern equipment and the hiring and training of highly qualified staff.

- State legislatures should strengthen insurance holding company, investment and guaranty fund laws to provide more security for policyholders in cases of insolvency.

- State officials should start communicating with federal officials who regulate financial services outside the insurance industry so that the state regulators can participate in the formation of a national policy and "avoid being squeezed out of their sphere of influence by federal officials who principally regulate the other financial services." ■

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Captives can hike parents' profits: Risk manager

NEW YORK—Many captive insurers are flourishing profit centers for their corporate parents, two captive experts say.

In addition, the formation of a new captive is still a viable idea for companies that have not, they note.

A captive insurance company can solve not only a parent company's risk-financing problems, but also can operate as one of the company's more profitable divisions, according to Bruce L. Fowler, corporate risk manager at Figgie International Inc. of Richmond, Va.

Figgie's decision to form a captive was motivated mainly by a desire to survive in a tight insurance market, Mr. Fowler told an audience at the annual meeting of the Society of Chartered Property & Casualty Underwriters.

Figgie established Bermuda-do-

'A company writing its own risks through a fronting company, unless it underwrites third-party business, is going to be adjudged a self-insurer,'
Trenwick Senior Vp Mark W. Hinkley explains.

miciled Waite Hill Assurance Ltd. in 1976 with \$120,000 in surplus to handle the company's general liability, workers compensation, property, fidelity, surety and other risks.

Insulating Figgie from the swings of the commercial insurance market, the captive has allowed the company to improve its own insurance picture markedly, Mr. Fowler says.

"From a stabilization standpoint, we have substantially increased our limits of liability, we have broadened our coverages and we have lowered our deductibles," he explains.

In addition to using the captive to solve its own insurance problems, Figgie has turned the operation into a major profit center, Mr. Fowler reports.

The company started using its

captive to write outside business, which now accounts for about 50% of the captive's premium volume, and has boosted the insurer's surplus from its initial \$120,000 to about \$25 million, Mr. Fowler says.

While Figgie itself has grown by about 50% over the last five years, the cost of running the captive has not changed and may have actually declined, he adds.

The result is that the captive now ranks second in overall profitability out of Figgie's 40 divisions, he said.

"Unless we make a big mistake, we'll continue to be in the top five divisions of our corporation in profitability," he explained.

Captives are still a viable alternative despite problems created by Internal Revenue Service rulings on the tax-deductibility of premi-

ums and reserves, Mr. Fowler says.

Captives allow greater flexibility in several areas, he said, including:

- Tailoring coverage to suit your company's specific needs.

- Improving the company's cash flow by allowing the investment of premium dollars and the choice of how and when investments are made.

- Allowing greater access to re-insurance markets, an advantage that is especially important when a company can't find the coverage it wants in the direct market.

- Marketing pieces of a corporate account to commercial insurers, since the captive allows greater flexibility in securing limits, insuring conditions and other factors.

Mr. Fowler cautioned that one of the essential requirements of captives is constant auditing, both of tax obligations and underwriting operations.

"I'm almost tempted to let the tax man take up a position in my office," he said. He added that government regulators in both Bermuda and the Cayman Islands are likely to demand increasingly stringent actuarial review of captive operations in coming years.

Mr. Fowler conceded that the competitive commercial insurance market of the past few years has dampened the general enthusiasm for starting captives. He maintained, though, that a shift in the market is all it would take to spark renewed interest in the captive concept.

"The competitive market has lightened the market (for captives) a little, but we are talking to people should the market ever turn," he explained.

The growth of captives in the future will not be confined to Fortune 500 companies, he added. Mr. Fowler expects to see more small companies entering the captive game, either through group captives or rent-a-captive operations.

"We see more and more agency-owned captives, operated either by individual agencies or by agency groups," he said.

Mark W. Hinkley, senior vp of Trenwick Ltd. in Hamilton, Bermuda, stressed that companies, whether deciding to start or continue a captive operation, should realize that they will have to take on third-party business to maintain the tax advantages of a captive.

"A company writing its own risks through a fronting company, unless it underwrites third-party business, is going to be adjudged a self-insurer," he noted.

This may create problems for companies without the underwriting expertise to handle such business, he suggested, adding that some captive managers might want to consider periodic underwriting evaluations of their books.

"Outside business is inside business that somebody else doesn't want," he warned.

Mr. Hinkley also observed that commercial insurers haven't "pushed the panic button" in response to the possibility of captives taking outside business, largely because the commercial insurers have continued to attract investor capital and have maintained profitability through investment income.

Also speaking at the session were Norman L. Spruill, president of NN Risk Management Services of Milwaukee, and William S. Mortimer, a partner in Advanced Risk Management Techniques of Newport Beach, Calif.

—By Douglas McLeod

IMMEDIATE ACCESS TO INDUSTRY INFLUENTIALS

UPCOMING ISSUES

	ISSUE DATE	AD CLOSING
IAA Convention/Employee Benefits Board Survey	SEP 26	Sep 14
	OCT 3	Sep 21
REINSURANCE REPORT/NAI Conference	OCT 10	Sep 27
	OCT 17	Oct 5
	OCT 24	Oct 12
CALIFORNIA MARKET REPORT	OCT 31	Oct 18
Risk Management Board Survey	NOV 7	Oct 26
INTERNATIONAL RISK MANAGEMENT/INSURANCE	NOV 14	Nov 1
	NOV 21	Nov 9
MARKET REPORT: ENVIRONMENTAL LIABILITY & LOSS PREVENTION	NOV 28	Nov 15
	DEC 5	Nov 21
	DEC 12	Nov 30

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Financial guarantee risks pose challenge for insurers

By DOUGLAS McLEOD

NEW YORK—Underwriters are being challenged increasingly to tackle new types of risks or to underwrite those risks that have not traditionally been insured, two experts observe.

One of the latest and riskiest of these areas is financial guarantees, including mutual fund, bond, mortgage and lease guarantees, according to Earl R. Lanning, vp in charge of surplus lines for E.H. Crump Cos. Inc. in Memphis.

Mr. Lanning compared underwriters venturing into financial guarantees with Columbus setting sail for the New World in the face of fears that he would sail off the edge of the earth.

Many underwriters today still harbor fears of sailing into a sea of red ink when it comes to financial guarantees, Mr. Lanning told an audience at the annual meeting of the Society of Chartered Property & Casualty Underwriters.

"We know because of the Depression of the 1930s that if we write financial guarantees, we'll drop over the edge and never be heard from," he said.

Nevertheless, such risks are now being taken on by underwriters who want to "expand their horizons," he noted.

One of the newer products on the horizon is so-called "residual value" coverage for leased equipment, he said. The insurance is designed to cover equipment-leasing subsidiaries of banks for the percentage of the acquisition cost of its equipment that cannot be recouped by leasing it or by including its residual value as an asset on the bank's books (BI, May 9).

The Federal Reserve Board and the Comptroller of the Currency "arbitrarily" limit the amount of residual value a bank's subsidiary can carry as an asset on its books to 20% to 25% of the equipment's value, he said. The volume of loans a bank can make is limited by its assets.

For example, if a company leases a piece of equipment for only 55% of its acquisition cost, the residual value of the equipment would equal 45% of its cost. Federal rules may prohibit the company from carrying more than 25% of the equipment's residual value as an asset, and so the company would lose 20% of the asset value of the equipment.

With residual value insurance, though, the entire 45% could be included as an asset on the bank's books, increasing the volume of loans the bank is able to make, Mr. Lanning explained.

The coverage has generated about \$20 million in 1983 premium volume for the companies that write it, Mr. Lanning said, and is expected to generate twice that much next year.

In the bond area, one of the newer entries is financial guarantee bonds for real estate syndications, Mr. Lanning said.

Recent changes in banking and tax laws have allowed the formation of such syndicates, tax-sheltered investments in which individual investors buy shares in the development of real property, like a shopping center.

"Unit buyers" are allowed to depreciate investments on their tax returns at a 2-1 ratio, and typically sell their shares of the project for long-term capital gains after their tax benefits have been exhausted.

In the past, unit buyers have used individual letters of credit to finance their investments, and syndicators have been forced to collect 30 to 40 of these letters of credit for each project.

The recently developed bond for real estate syndicates reduces the complexity of the projects, though, by insuring the payment by all unit buyers with a single instrument, Mr. Lanning said. The use of the bond also makes things easier on individual investors, he added, since they are no longer forced to provide letters of credit and, thus, do not exhaust their credit limits.

Numerous markets are now willing to write bonds for real estate syndicates, and "lots of reinsurance is available," Mr. Lanning said.

The possibility of a loss for the underwriters is slight, he explained, because if a unit buyer doesn't pay up on a given share of the project, that unit can be sold to

Continued on next page

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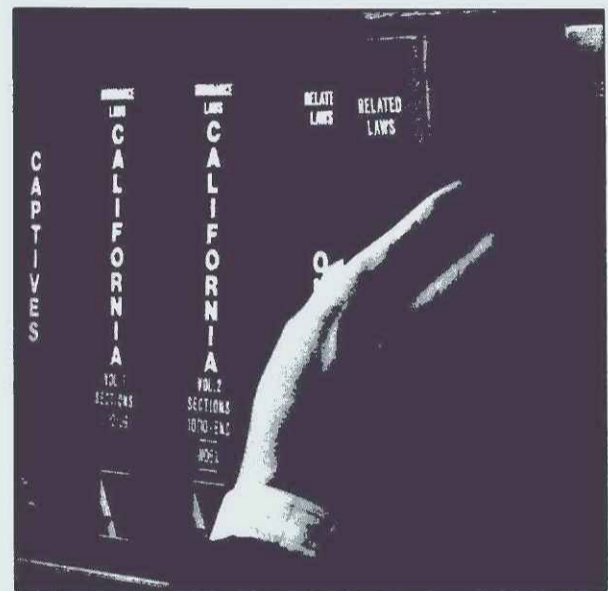
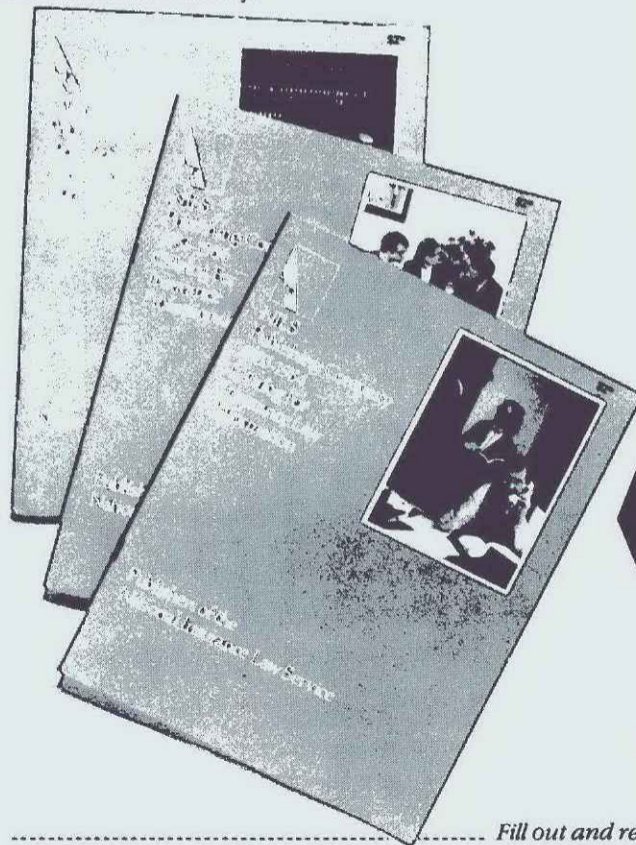
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Insurers tackle new risks

Continued from previous page
the other unit buyers or can be kept by the bond underwriter itself.

Premiums on the bonds typically run about 1% of the total amount to be covered, Mr. Lanning said.

These new coverages, while possibly making the more conservative insurer nervous, are producing big earnings for those that are flexible and creative enough to undertake them, he said.

Another relatively new line of coverage—and one that still may contain some holes—is computer crime, according to Christopher Barr, a vp with American International Group Inc. in New York.

Computer crime can take several forms, Mr. Barr noted.

In one case, he said, a bank employee reprogrammed the bank's computer to round down odd cents when crediting deposits and automatically transfer the difference to his account. This is an example of what Mr. Barr called the "salami technique," in which a large whole is built up out of small slices.

In another case—an example of what Mr. Barr called a "logic bomb"—an employee programmed a bank's computer so that the computer's entire memory would automatically be erased if his name were ever taken off the payroll.

Computer crimes aren't always committed by employees, he added. One man opened an account at a bank and received deposit slips that were encoded with his account number but didn't bear his name or address. He left the slips out on a bank counter, where other bank customers used them to make deposits. Their money was credited to his account by a computer that read the encoded number.

Mr. Barr called this a "form of judo," where a specifically applied pressure "causes the victims' own systems to commit the crimes."

Remedial steps to reduce the possibility of such crimes might include increased physical security surrounding computers and a closer examination of the interface

between the machines and human operators to identify areas where vulnerabilities of the systems might be caught, he said.

Some banks, for example, don't leave blank deposit slips out on public counters and remove slips that are left out.

Most so-called "computer crimes" are covered by standard policies that cover property loss due to employee fraud or provide all-risks coverage of cash and securities in the insured's custody, Mr. Barr said.

"In theory, 99% of computer losses are covered by the standard policies that people have been buying for years," he explained.

These policies may contain some holes to be patched, though. For example, some policies cover fraud by former employees only up to 30 days after the employee has left the company. Insureds may want to extend this period, he said.

In addition, some policies don't address fraud committed by "unidentified employees"—employees who are never caught. The problem, he suggested, is that it's hard to prove that a loss is really attributable to employee theft.

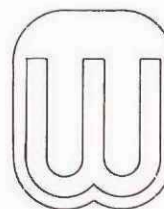
Another risk for which there is so far no insurance available is first-party coverage against theft of trade secrets, Mr. Barr said. Most policies exclude theft of "intellectual property," in part because it is difficult for the insurer and policyholder to agree that any similarity is the result of a theft.

The second problem is determining how much such a loss is worth, he added. To base the amount of loss on the research and development costs for the stolen property would produce too great a moral hazard, especially for companies that want to recoup their expenses before bailing out of a project.

Also speaking were James Barrett, president of Washington-based International Technology Underwriters, and Burt C. Proom, president of American Nuclear Insurers of Farmington, Conn. ■

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Change in financial services not sudden: Insurers

NEW YORK—The financial services "revolution" might be more accurately described as a steady evolution that has simply picked up speed in recent years, three insurance executives agree.

"The change we see is part of a swift and comprehensive evolutionary change," Edwin F. Cutler, chairman and chief executive officer of Fireman's Fund Insurance Cos., said during an address to the annual meeting of the Society of Chartered Property & Casualty Underwriters earlier this month.

"The pace of the change is so swift that our public institutions are having trouble keeping up."

Three forces are powering the integration of financial services like insurance, banking and securities brokerage, Mr. Cutler said. These forces are:

- The growth of financial sophistication among consumers, a sophistication made necessary by the drain on savings caused by 10 years of inflation. The recent popularity of universal life insurance and money market funds are proof of this sophistication, he noted.

- Deregulation, "both formal and informal," of the various financial services sectors.

"On paper, there's still a prohibition against interstate banking," but the reality is that banks are stepping beyond state lines in making acquisitions, he said. For example, New York's Citicorp announced plans earlier this year to buy a state-chartered bank in South Dakota.

In addition, many banking activities, such as extensions of credit and transfers of funds, are already conducted electronically across state lines, he said.

- Improvements in the technology used to deliver services.

"Technology dissolves borders and collapses time," Mr. Cutler said. In addition, he noted, technology also influences the design of new products and services, noting the rise of automatic teller machines at banks as an example.

Mr. Cutler speculated that financial services companies of the future will share two characteristics: They will operate nationally and exploit the "economies of scale" possible with electronic distribution systems.

He hastened to add that this didn't mean that the financial services business of the future would be dominated by one or two huge conglomerates. Instead, Mr. Cutler said, the financial services boom will probably produce greater diversity of both vendors and new products.

The three forces that have created the boom in financial services will also create "a drive to innovation in product design," he predicted.

The boom also will have its casualties, though, and some property/casualty insurance companies are likely to be among them, he said. Demand for financial services in the 1980s will probably not grow as fast as it has recently, and competition is thus likely to be fierce.

"Under those circumstances, a shakeout is inevitable," he explained. "Only one thing is certain: The consumer will be the winner."

Donald F. Craib Jr., chairman and chief executive of Allstate Insurance Group, stressed that financial services integration is hardly a "revolution" of the last decade.

Sears, Roebuck & Co. started granting credit on consumer purchases in the 1920s, an activity traditionally left to banks, and founded its Allstate insurance subsidiary in 1931, he noted.

Sears' recent acquisitions of real estate giant Coldwell Banker & Co. and securities firm Dean Witter Reynolds Inc. are only the most re-

cent moves in a game that's been going on for some time, he suggested, adding that Sears' growth as a financial services company will continue.

The Chicago-based retailer will have opened 130 financial services centers in Sears stores nationwide by the end of this year, and expects to open 150 more in 1984.

Mr. Craib indicated that efficient delivery systems are the key to financial services growth, but that those delivery systems will keep the various services from being too closely integrated.

"We have a distribution system for merchandise through Sears, a distribution system for insurance through Allstate, for securities through Dean Witter Reynolds and for real estate through Coldwell Banker," he said.

The four distribution systems are separate, and Mr. Craib said he doubted that Sears or any other financial services company would be able to combine them successfully.

"Those who attempt it are doomed to failure or at least to mediocre results," he explained.

Rather than describing the financial services boom as either revolution or evolution, David J. Sherwood, president of Prudential Insurance Co. of America, coined his own word, "convolution," which he described as the "twisting, complex, serpentine maneuvering of all companies to find ways to respond to consumer needs and attain competitive advantage."

While seeming to lament the competitive jostling caused by convolution, Mr. Sherwood told the audience that Prudential intends to

compete, mainly by developing banking subsidiaries.

"We are no more willing than anyone else to find ourselves not able to meet our competitors on equal footing," he said.

Regulators have fallen behind in their attempts to oversee financial services integration, he said, and now have to answer questions that never came up when the present banking and insurance laws were written.

Some of the questions are quite broad, he notes, such as how to avoid an undue concentration of economic power in a single company.

Others are narrow, such as why certain "financial intermediaries"—like banks—should have their deposits covered by the Federal Deposit Insurance Corp., while

other non-banking institutions have no such coverage for depositors.

Congress should act to answer these questions, Mr. Sherwood said, but legislation should be comprehensive, covering all the problems raised by integration in all sectors of the financial services industry.

"We are concerned about (deregulation) taking place on a piecemeal basis," he explained.

Prudential, he added, supports a moratorium on further expansion of banks into non-banking activities until a "comprehensive review" of such expansion can be made.

Mr. Sherwood conceded that "a moratorium is generally not in the public interest," but added that it might be best while integration problems are being considered. ■

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For further details, contact Timothy Koo, Vp-Specialty lines marketing, Fireman's Fund Insurance Cos., P.O. Box 777, Novato, Calif. 94998; 415-899-3527. Or contact Peter J. Livaich, Municipal Lease Insurance Managers Inc., P.O. Box 1060, Nashville, Tenn. 37202; 615-361-6075.

Commercial umbrella

A new commercial umbrella policy is being written by Crum & Forster through subsidiaries C&F Underwriters Group and U.S. Insurance Group.

The USIG/CFU Defender policy is now featuring expanded coverage.

The personal injury definition now includes formerly non-qualified injuries and coverage for most events involving a business.

Previously, those events, like slander, libel, etc., were specifically defined in the policy. The coverage now extends to undefined perils and may include discrimination, humiliation, possible Equal Employment Opportunity Commission violations and other acts.

The definition of "occurrence" has also been expanded to include an "injurious event" neither expected nor intended, applying to bodily injury and property damage. And, an offense resulting in personal injury that is committed without actual malice also is covered.

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For more details on the Defender commercial umbrella policy, contact Joe McGrath, Vp-Excess & Special Risks Department at U.S. Insurance Group, at 201-953-3345, or Roger Quigley of C&F Underwriters Group at 201-953-3149. The address of both companies is

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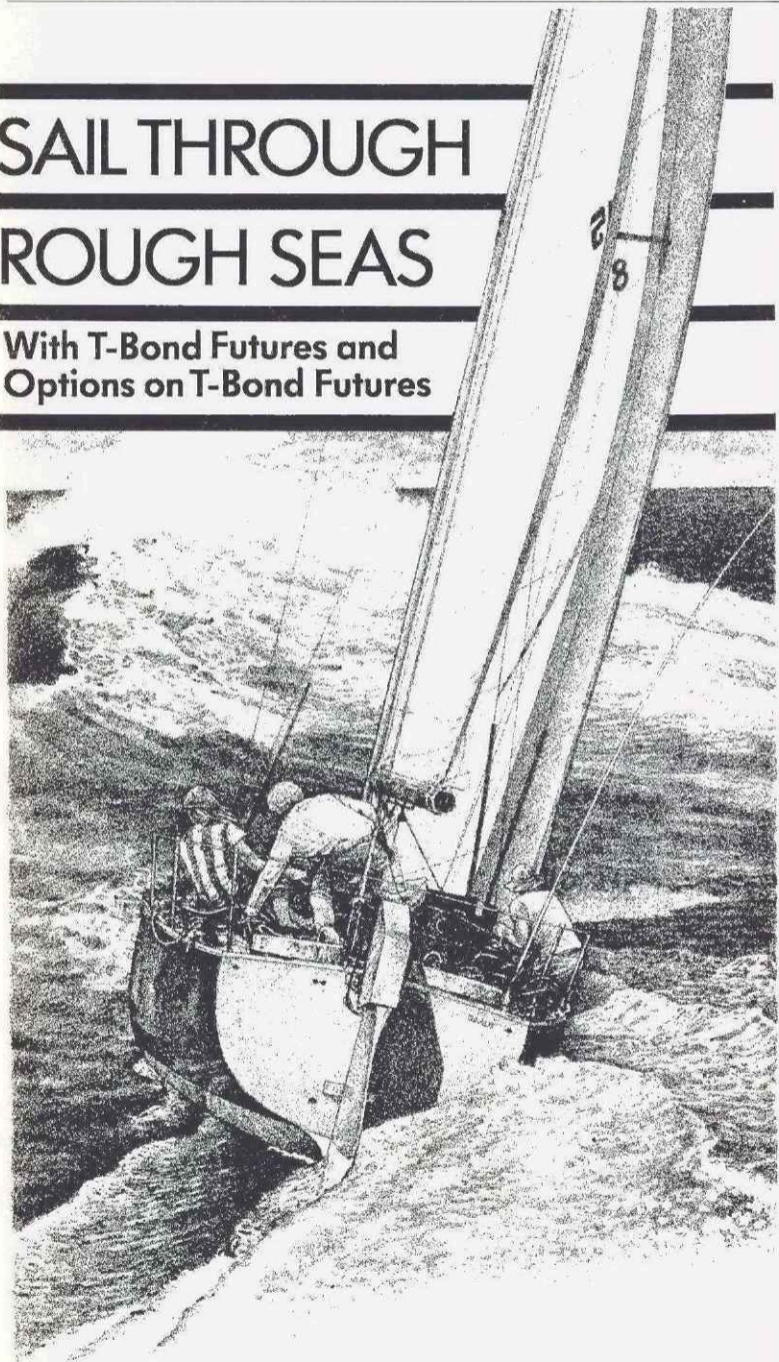
There is a \$250 deductible for all-risk building and contents insurance, with higher deductibles available if requested. Varying deductibles are offered on the automobile liability.

Limits range up to a \$500,000 combined single limit, but lower levels are available. A \$1 million umbrella in addition to the Prime Pak coverage is available from Consolidated.

For more information on the Prime Pak restaurant coverage, contact Don Cook, Marketing Director, Consolidated Underwriters Inc., 650 E. North Bell, #200, Houston, Texas 77060; 713-999-2846.

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Employers study hospital cost information

Continued from page 3

Other, more complex diagnoses—like heart attacks, abdominal pains and pneumonia—were divided into as many as eight case mix groups.

"We chose the most common diagnoses in the (32) hospitals in the Twin Cities," said David Aquilina, vp of policy analysis and public affairs for the council.

Although the 636-page report is being labeled a "wealth of information," no one is quite sure how the information will be used. Even the hospital council admits that the audience for the price data has not been clearly defined.

"Our price reports are not consumer guides," Mr. Johnson notes. "Major buyers of health care—insurers and HMOs—and the hospitals themselves will be the primary users," he said.

"I think employers will add it to their growing data base to make prudent buyers' decisions," says Tom Galligan, manager of employee health services for Control Data Corp. in Minneapolis. The computer and financial services company self-insures and self-administers its employee health care program.

With so much information becoming available, "we must make sure it all fits together," said Mr. Galligan, who also is chairman of the employer program committee for the Minnesota Coalition on Health Care Costs.

"The data is just one important

take some time for people to understand and use (the information)."

Besides employers, health insurers also are scrutinizing the report to see what they can get out of it.

"We hope to get some feeling for the way the hospitals are charging for the services. We would like to be able to use this information for comparing costs, but we're not sure (the report) can be used for this," said Randy Penning, claim consultant with the Minneapolis office of Prudential Insurance Co. of America.

It's possible that the information could be used by insurers as a selling point for a specific plan or to steer employees into using a certain hospital, like in a PPO arrangement.

"But we're really not sure this information would allow us to

make that kind of information available," Mr. Penning said.

He notes that the council's report may be missing specific information to indicate which hospitals are cost efficient. The report indicates low-cost hospitals, but may not take into account case severity or the particular characteristics of a hospital, he explains.

For instance, costs may appear to be higher at a teaching hospital, but that would not necessarily indicate inefficiency, he says.

Despite Prudential's enthusiasm for the report, Blue Cross & Blue Shield of Minnesota says it will do nothing with the information.

"We had a good idea of what was coming out. We will not be using (the report's figures) for any of our business decisions," said Senior Vp Phillip Little.

Instead, the Blues will continue to use similar, but more detailed data it recently collected while designing a preferred provider-type product that appeared in April, he said. BC/BS gathered data to determine which hospitals would be included in the preferred provider arrangement, which it offers as an option to its policyholders.

But another insurer Northwestern National Life Insurance Co. in Minneapolis, believes that the report contains good information that can be used by employers, providers and insurers.

The Council of Community Hospitals first decided to conduct a price comparison a few years ago when a former president rationalized that for health care competition to be effective, buyers and sellers must have good price informa-

tion, Mr. Aquilina said. It plans to publish the comparisons annually.

The data in the report comes from medical records and hospital bills for about 52,000 patients from April 1982 through February 1983. Those patients comprise about 18% of all persons hospitalized in the Twin Cities during the period.

"The case mix groups enabled us to present hospitals' prices for precise types of cases for each diagnosis, thereby allowing more valid and meaningful apples-to-apples price comparisons," Mr. Aquilina said.

Copies of the report are available from the Council of Community Hospitals, 2221 University Ave. S.E., Suite 223, Minneapolis, Minn. 55414. The 175-page summary report is \$20 and the detailed 636-page report is \$100.

'Our price reports are not consumer guides,' the hospital council's Mr. Johnson notes.

building block," said Joan Pearson, manager of benefits and health care management for Honeywell Inc. in Minneapolis and a member of the coalition. "It will certainly help us evaluate PPOs that come to us."

The Twin Cities area already boasts about five PPOs—groups of health care providers that contract with employers, insurers or other third-party payers to deliver health care services at a reduced fee.

Approximately five other PPOs are in the developmental stages in the area.

"The report is an opportunity to be clear about how much variability does occur in pricing," Ms. Pearson says.

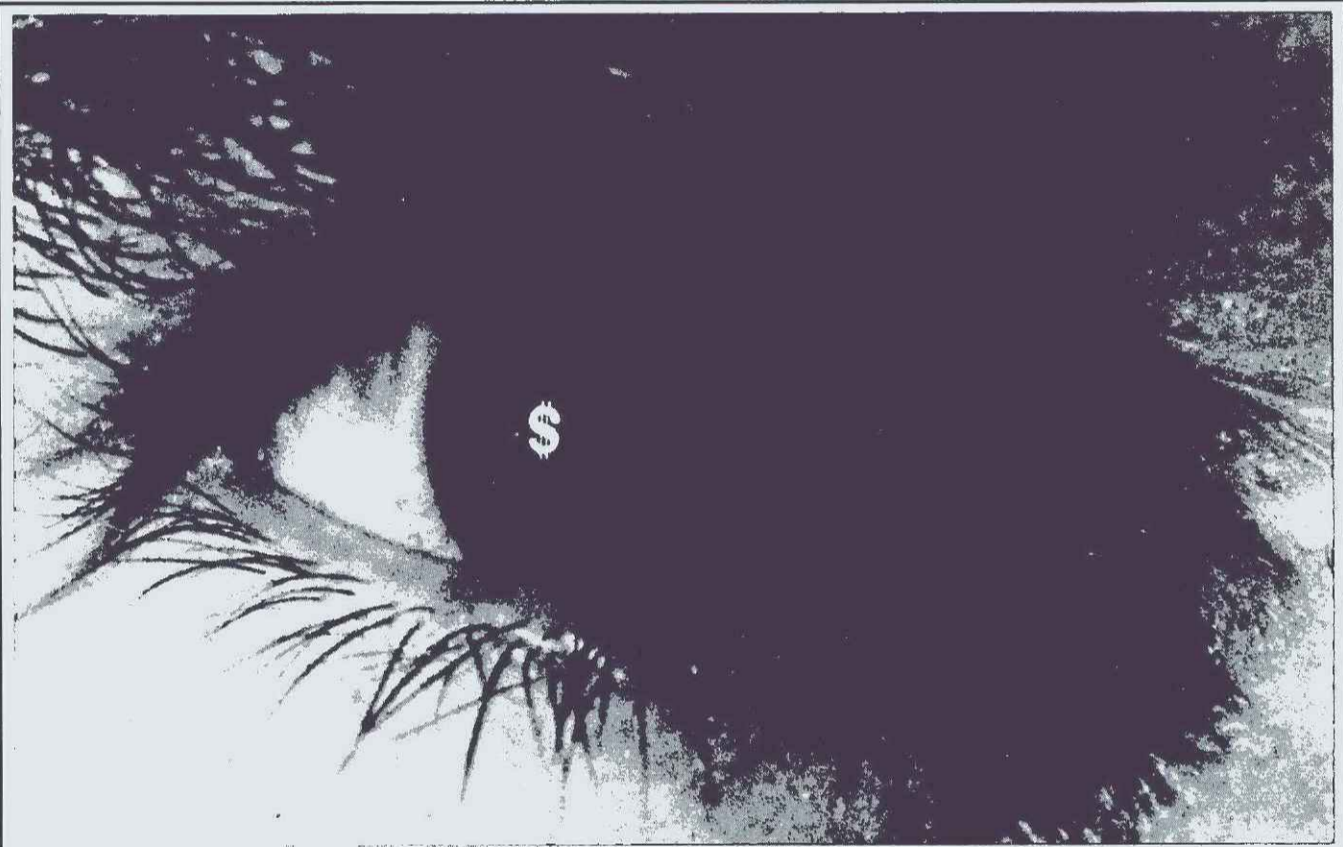
She says she believes the report has a potential to create competition among the hospitals and will slow the growth of hospital costs.

"I think the employers will be using it as another important piece of information for negotiating and purchasing policies," said James Kenney, executive director of the health cost coalition.

Several employers and others admit they have only seen a 175-page summary of the council's report. They are waiting for the entire version, plus a companion report expected late this month by the Minnesota Department of Health.

The health department's report will place the council's information into a different format and give summary information for each hospital, explains Marianne Miller, director of the department's health economics program and the author of the department's report.

Both the Health Department's and the council's reports will be useful to employers that are thinking about revising their health care plans, Ms. Miller said. "But it will



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Employers oppose unisex bills

Continued from page 1

far outweigh any benefits gained in real terms, whether male or female," says the secretary and director of industrial relations for a manufacturer of consumer goods with 1,200 employees.

"Costs will be increased due to an inaccurate reason," wrote another benefit manager. "Both employers and women will have to pay additional, unnecessary dollars.

"It will adversely affect women in more ways than it will help them. Therefore, I can see no advantage to the change," said the benefit manager for a manufacturer with 5,000 employees.

Almost all the survey respondents—even those who support unisex legislation—are against making any unisex rating law retroactive, which would force insurers to equalize benefits under current

policies. Only nine of the 81 survey respondents think unisex legislation should be retroactive.

In fact, 44% predict that retroactive application of unisex rating would bankrupt some insurers.

The American Council of Life Insurance found in a survey of 147 companies that a retroactive equalization of life insurance benefits would cost \$13.4 billion. Some 21 companies would become insolvent, while 50 life insurers would have their reserves cut in half, the ACLI noted (BI, May 16).

The current unisex bills do contain retroactive provisions, but Sen. Packwood's staff says he is considering eliminating it. Sen. Packwood also is not going to call for a vote on his bill until the General Accounting Office issues its report on the cost of unisex legislation, which is not expected until later this fall.

It also is possible that Sen. Packwood will hook his unisex legislation onto Sen. Robert Dole's bill, S. 19, that would—among other things—lower the minimum participation age in retirement plans to 21 from 25. Because Sen. Dole's bill has much support, it could help ease passage of the unisex legislation (BI, Sept. 19).

About 75% of the survey respondents believe the Norris decision will influence Congress to pass the unisex legislation.

While benefit managers must wait to see how Congress reacts to

the unisex proposals before it, they are dealing right now with the effects of the Supreme Court ruling in the Norris pension case, which can affect both defined contribution and defined benefit plans.

But rather than make the mandate for equal benefits retroactive, the court decided that equal benefits would be required only on contributions made after Aug. 1. More than 80% of the benefit managers surveyed agreed that the ruling should not be retroactive.

In Norris vs. Arizona Governing Committee, the high court ruled 5-4 that when men and women make equal contributions to a pension plan, women cannot receive a smaller monthly benefit than men.

The case goes back to 1975 when Nathalie Norris, a 58-year-old Scottsdale, Ariz., resident who worked for the state, agreed to join a 3-year-old voluntary compensation plan.

Ms. Norris requested that her contributions be invested in a fixed annuity contract from Lincoln National Life Insurance Co.

Ms. Norris was told that if her contributions continued at a steady rate, the total value of her account at age 65 would be \$53,890.

At that time, she would receive a monthly annuity of \$320.11 from Lincoln National. However, a man who contributed the same amount as Ms. Norris was guaranteed a monthly payment of \$354.07.

Ms. Norris sued the state in 1978, charging that the unequal annuity benefits violated the Civil Rights Act of 1964, a point with which the

Supreme Court agreed.

The Norris decision affects defined contribution plans that pay employees monthly benefits either directly or through annuities purchased from insurers. It does not affect defined contribution plans that only offer employees a lump-sum payout upon retirement or termination of employment.

When a lump sum is paid out, both male and female employees receive the same benefit, assuming any contribution they made to the company plan was equal. The inequities that were the subject of the Norris case crop up when employees are given the choice of a monthly payout or lump sum.

The monthly payouts, often provided through an annuity from an insurance company, are often smaller for women than men because the payouts are based on mortality tables that reflect the fact that women—as a group—live longer than men. It is reasoned that over time women will eventually receive the same total payout as the men in the pension plan because men die earlier.

Fifteen of the 30 respondents with defined contribution plans explained how they will amend their plans that had paid unequal benefits. Three respondents said they were still working on how to equalize benefits for men and women in their defined contribution plans. Two said they did not meet the Aug. 1 deadline and did not say when they would. Four of the survey respondents specifically stated that they only offer a lump-sum option. Six others answered N/A when asked how they would equalize unequal benefits, suggesting they only pay lump sums.

Only seven of the 30 respondents with defined contribution plans said their company pension plans,

which had directly paid unequal benefits to male and female employees before the Supreme Court ruling, were amended to equalize benefits by the court's Aug. 1 deadline or would soon be amended.

Five of these benefit managers said they equalized benefits by creating a new benefit level somewhere between the benefits formerly paid men and women.

Only eight of those with defined contribution plans indicated that they purchase annuities through insurers and were taking action now to equalize these benefits.

Five said they would find an insurer that offers annuities based on unisex mortality tables; three said they would eliminate the annuity purchase option and pay a lump sum at retirement or termination of employment; and one said it would start paying equal monthly benefits to beneficiaries directly from the pension fund.

When asked what insurers they had found that offered annuities based on unisex mortality tables, two respondents cited Travelers Insurance Co.; two said Lincoln National Life Insurance Co., which was the insurer involved in the Norris case; and one said Teachers Insurance & Annuity Assn. & College Retirement Equities Fund.

Four of the survey respondents that pay their retirees direct monthly payments had adopted unisex benefits before the Supreme Court ruling. Three respondents that purchase annuities through insurers had asked the insurers to use unisex mortality tables before the high court ruling.

While few of the survey respondents with defined contribution plans appear to be affected by the Norris decision or do not know yet what the impact will be, many more have defined benefit plans

Continued on facing page

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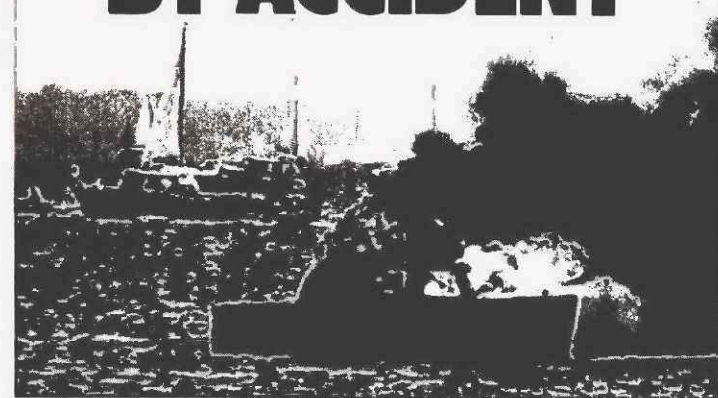
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Continued from facing page that are affected.

Seventy-one of 81 respondents have defined benefit plans that offer equal benefits based on a set formula including salary and length of service, and 30 have defined contribution plans that offer benefits based on contributions. Profit-sharing, 401(k) salary reduction plans and thrift plans fall into this category.

The Norris decision affects defined benefit plans that offer a joint-and-survivor option that charges a male employee more to guarantee part of his pension (usually half) will go to his wife after his death than it charges a woman to guarantee this benefit for her husband.

Men often pay more for a joint-and-survivor option than women because men are likely to die sooner, triggering the joint-and-survivor benefits earlier. In addition, a surviving female spouse is likely to collect benefits over a longer period of time than the husband of a female retiree who dies.

For example, a 65-year-old male who retired with a \$400 a month benefit would have his pension benefit reduced by about 15% to \$340 if he selected a 50% joint-and-survivor option.

In contrast, a 65-year-old woman, who also retired with a \$400 a month pension, would have her benefit reduced by about 8% to \$368 if she selected the same 50% joint-and-survivor option.

Thirty-six, or 44%, of the survey respondents said they had or would amend their joint-and-survivor option to equalize benefit reductions. Another 29 said they already paid equal benefits to employees who chose this option. The remainder did not answer the question.

Of the 36 that are amending their joint-and-survivor plans, 35 will do so by creating a new benefit reduction—between the two current reductions—that is equal for both men and women.

One said his company is decreasing the reduction charged men to equalize the reduction currently charged women.

Forty percent of the respondents said they would hire or had already hired consultants or actuaries to help them amend both defined contribution plans and the joint-and-survivor option in defined benefit plans. About 10% of the respondents said they would use in-house experts to make the changes and 6% were relying on insurers.

Most of the respondents, however, did not seem overwhelmed by the task or the costs incurred.

When asked what it was costing their companies in both dollars and time to overhaul their plans to conform with the Norris ruling, the bulk of the respondents left the answer blank or said information was not available.

Others wrote that costs were minimal or insignificant both in terms of money and time. One benefit manager said all the decision cost him so far was the 15 minutes it took to fill out the BI survey.

Nine of the respondents, however, did cite costs ranging from \$1,200 to \$25,000 and said they spent from 20 hours to six weeks of manpower to conform with the ruling. Another 14% said they thought they would incur some costs but had no idea yet what they would be.

One benefit manager said he was expecting a "large bill from my actuary" and that his company had spent a significant number of hours reworking its pension plan because it was also making plan changes to conform with the Tax Equity and Fiscal Responsibility Act of 1982, which also affected pensions.

Of those who spelled out what their costs would be, the largest cost—\$25,000—was recorded by a benefit manager for a company with 3,500 employees who only indicated on the survey that the com-

pany had to amend its defined benefit plan to correct inequities in its joint-and-survivor option. He did not indicate if his company had hired a consultant and/or actuary to assist with the changes.

The director of benefits planning for a pharmaceutical manufacturer with 14,000 employees in the United States said the Norris decision was costing his company \$10,000 and five or six weeks of work. He, too, only indicated a change in the joint-and-survivor option and also had hired an actuary.

Three benefit managers indicated that compliance with the Norris decision would cost them \$2,000 to \$3,000. Two of these firms were changing both defined contributions and defined benefit plans and one was just amending its defined benefit plan's joint-and-survivor option.

Two other benefit managers for companies with 7,500 to 10,000 employees indicated it will cost them

\$5,000 to amend their joint-and-survivor options. Both indicated they were using consultants to help, but one still estimated his firm also would spend \$10,000 in man-hours on the project.

The benefit manager for a sales firm with 400 employees indicated his firm was changing its joint-and-survivor option at a cost of \$1,200.

Despite the costs incurred to conform to the Norris decision, only three of the survey respondents ever had an employee complain about unequal benefits.

The corporate benefit planning administrator for an electric and gas utility with 13,000 employees said his firm was sued "because early retirement reductions for women were less than for men." Even before the Supreme Court decision came down July 6, this firm had equalized all benefits in its defined benefit plan. It began making equal benefit reductions in its joint-and-survivor option in the early 1960s.

Another wrote that women em-

ployees complained loudly when a defined benefit plan was terminated.

"Most of our female employees were unhappy, especially when they found out that their payout was lower because they were women," wrote the benefit manager for a retail outlet. The firm now has a Payroll-based Stock Ownership Plan, a profit-sharing plan and 401(k) salary-reduction plan.

And, the employee benefits manager for a non-profit religious organization involved primarily in health care wrote, "With an employee force of more than 80% female, we have had many complaints of past practices of paying unequal benefits."

In 1982 it requested that the insurers from which it purchased annuities for its savings plan participants use unisex mortality tables. The same year it equalized benefit reductions for the joint-and-survivor option in its defined benefit

plan. While few employees complain about unequal benefits, they were fairly interested in the effect of the Norris decision. About 20% of the benefit managers surveyed said employees had asked them about how the decision would affect them.

Most of the survey respondents said they were informing their employees of plan changes through memos and additions to their employee benefit handbooks. However, many others said they would explain changes individually to potential retirees when the time comes for them to make a choice.

Employee benefit managers are invited to join the Business Insurance Employee Benefit Board. Just send a card with your name, title, company and address to Kathryn J. McIntyre, Editor, Business Insurance, 740 Rush St., Chicago, Ill. 60611. You will receive four surveys during the year on benefit issues.

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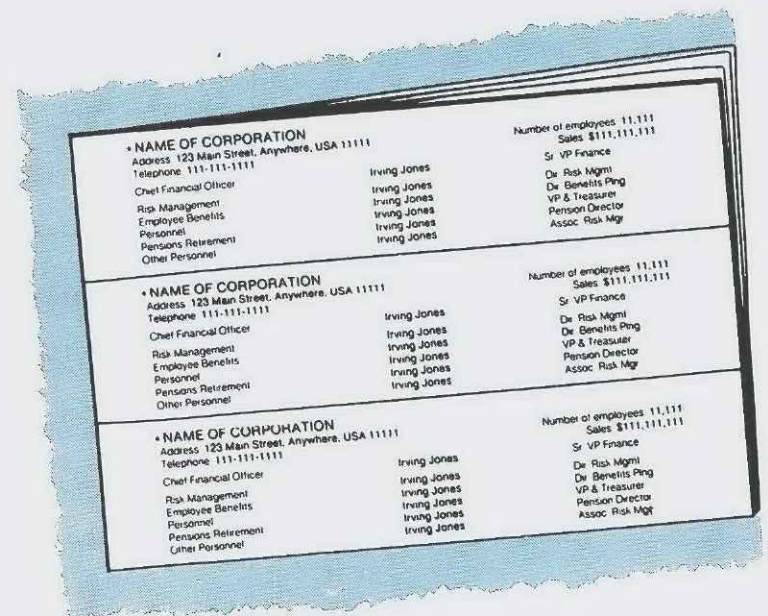
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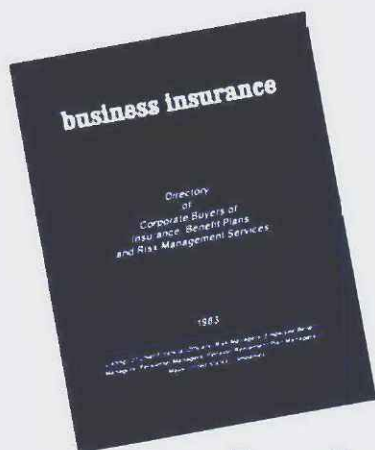
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Medical malpractice rates drifting upward

Continued from page 1
cian and surgeon malpractice policies.

In 1975, a malpractice insurance crisis saw insurers raising their rates as much as 300% and many fleeing the market completely making it impossible for many in the medical profession to ever find malpractice coverage.

Doctors say that their increased insurance costs are part of the reason their charges for care have risen in recent years. Another round of increasing insurance costs for doctors could ignite more increases in the costs of physicians' care, frustrating employers' efforts to control their health care plan costs.

The current rate increases are being reported by doctor-owned insurance companies and captives as well as commercial insurers, and one insurer has pulled out of some markets because of poor loss experience.

"We increased our rates on July 1 an average of 22.5%," says Henry Nussbaum, director of underwriting for the Illinois State Medical Inter-Insurance Exchange, a doctor-owned malpractice insurer with about 8,000 physician and surgeon policyholders. It wrote about \$40 million in net premiums last year.

Last year, ISMIE increased its rates an average of 20%.

But with this most recent rate hike, the exchange added a new rating classification to its seven-class system "to help diminish the overall average rate increase," Mr. Nussbaum said.

Premiums for most policyholders

in the new category, which includes such traditionally low-risk medical professionals as pathologists, allergists and endocrinologists, decreased 3% this year.

Mr. Nussbaum is one of the people warning that this year's rate increases are only a predecessor to more down the road.

"I don't see an end," says Mr. Nussbaum. "Our only salvation is that the public may finally realize that the right to sue someone has to be tempered with practicality and realism."

Donald J. Fager, assistant secretary and treasurer of Medical Liability Mutual Insurance Co. in New York, agrees.

"As long as the awards keep going up, I don't (see an end to rate increases)," he says.

Medical Liability Mutual, a captive of the New York State Medical Assn., raised the rates of its 17,000 physicians and surgeons an average of 25% July 1.

Some of Medical Liability Mutual's policyholders received rate increases of less than 25%, but those in high-risk specialty classes, such as neurosurgeons and obstetricians, face hikes of up to 35%, explains Mr. Fager.

The company raised rates 15% in 1982 and 26% in 1981.

Medical Liability Mutual, the second-largest malpractice insurer in the United States with \$180 million in direct written premium in 1982, had asked the state Insurance Department this year for rate increases of more than 50%, but only a 25% increase was approved, explains Mr. Fager.

"Obviously, we think it (the

need for higher rates) is a little worse than the 25% represents," he says.

Mr. Fager says the severity of the claims his New York policyholders have incurred is the biggest reason for the premium hike.

"It's the severity—the increases in awards just keep going up and up and up," he says.

The Medical Malpractice Insurance Assn. of New York just last week notified the 1,600 New York physicians and surgeons it insures that rates will rise an average of 30%, retroactive to July 1.

MMIA, however, is asking for a hearing with the Insurance Department to dispute the department's rejection of its request to raise rates 180%, said President Philip J. Bies. The state only allowed 30%.

MMIA, which raised its rates 15% last year, took in just less than \$10.9 million in direct written premiums and paid out \$11.5 million in claims.

"Our experience just indicated that we needed it (the 180% increase) in order to break even," Mr. Bies says, citing the size of awards and the number of claims.

An allergist in upstate New York may now pay MMIA an annual premium of \$2,157, and a medical professional in the highest category of risk, such as a neurosurgeon on Long Island, may now pay about \$66,500 a year in premiums, Mr. Bies says.

However, a neurosurgeon who is hit with a surcharge on his premium because of poor loss experience could pay as much as \$199,400.

The St. Paul Cos. Inc., the largest malpractice insurer in the United

States, expects to gradually raise the rates of its policyholders within the year an average of 16%, says Walter Marquis, senior underwriting vp.

The insurer covers about 55,000 physicians and surgeons nationwide, of whom general surgeons and obstetricians present the biggest underwriting risks, he says.

St. Paul posted a 116.3% combined ratio for physicians and surgeons malpractice coverage in 1982 and a 123.9% combined ratio for the first six months of 1983.

The Medical Protective Co. in Fort Wayne, Ind., another leading writer of medical malpractice insurance, also expects to raise rates in the 15 Midwestern states in which it operates.

"There will undoubtedly be an increase, but the specific increase will vary from state to state," says Robert J. Miller, vp of promotions. He says the rate increases will probably range from 15% to 30%, but low-risk policyholders may sustain lesser increases.

One particular problem area he cited is "a steady increase in the average cost of resolving claims over the past 10 years—an inexorable increase that hasn't stopped with anything that's happened."

For example, Mr. Fager of Medical Liability Mutual in New York estimates that his company will spend an average of \$400,000 per case to settle claims filed in 1983 to 84.

Poor loss experience is forcing Aetna Casualty & Surety Co. to slowly withdraw from writing malpractice insurance for physicians and surgeons in Missouri, Maine, Kentucky and Wisconsin.

"A bad loss experience and a decline in our market share led to the decision," a spokesman explains.

In Maine, Aetna's pure loss ratio on physicians' and surgeons' medical malpractice coverage in 1982 was 229%; in Kentucky, it was 184%. In Missouri in 1981, the pure loss ratio hit 1,845%.

The company, which recently raised rates 50% in both Maine and Missouri, will not cancel any of its policyholders, but will not renew existing policies.

The insurer expects to be completely withdrawn from these states within 12 months, he says.

Other insurers are moving in to pick up Aetna's market share so the medical community will not be without coverage alternatives.

Aetna will continue to write medical malpractice coverage in 10 other states but is "no longer a factor" in the physicians and hospital malpractice market, according to a spokesman.

Meanwhile, at The Doctors' Co. in California, rates are being raised for many California specialists beginning Oct. 1.

Doctors in six of the company's specialist classifications will have rates increased, explains Dr. Sabella. For example, premiums for neurologists will increase to \$6,640 from \$3,904 in 1982 for limits of \$1 million per occurrence and \$3 million aggregate.

Pediatricians will pay about 27% more in premiums, while obstetricians and gynecologists will pay about 13% more. Their premiums will average \$28,500, compared with \$25,212 in 1982, he says. Rates

Continued on facing page

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Continued from facing page

also will be increased for general practitioners, internal medicine specialists and certain radiologists.

But rates for dermatologists, ophthalmologists and urologists will decrease an average of 20% to compensate for high rates they faced after an unexpected surge in claims and losses about four years ago, Dr. Sabella explained.

The Doctors' Co. rates are a stronger reflection of an increase in the number of claims its policyholders have seen than in their severity, Dr. Sabella notes. The company now receives almost one claim for every five doctors it insures each year, he estimates.

He notes a particular increase in claims activity in historically low-risk fields, such as pediatrics and neurology. For example, in 1982, the company received 13.2 claims for every 100 neurologists it insured; through the first half of this year, that figure has risen to 20.7.

The Doctor's Co. wrote \$41.1 million in net malpractice premiums in 1982. Its combined ratio jumped to 133.7% from 98.3% in 1981.

State Volunteer Mutual Insurance Co. in Nashville, Tenn., also has seen its claims experience deteriorate. It particularly cites the in-

creasing size of awards.

"The claims climate in Tennessee is deteriorating, both in the numbers of suits against doctors and in the size of court awards," says Steven C. Williams, vp of underwriting at State Volunteer Mutual, which insures about 4,700 doctors.

In 1982, about 800 cases produced about 1,500 claims against the physicians and surgeons the company insures, Mr. Williams estimates.

But between 1980 and 1981, it saw the size of the largest award against a Tennessee doctor triple.

The largest court award against a physician in Tennessee prior to 1980 was about \$300,000, Mr. Williams says. But by December 1981, that reached \$1.1 million.

"We tripled our biggest award in one fell swoop," Mr. Williams notes.

The size of the court award is important, insurers explain, because juries frequently regard the amount of the largest previous award as a standard by which they can determine their own.

State Volunteer raised its rates an average of 15% in May, Mr. Williams says. Rates were raised 25% in 1982, but not at all in 1981.

State Volunteer wrote \$18.2 mil-

lion in net premiums in 1982 and recorded a 111.7% combined ratio.

Mr. Williams expects this year's claims activity to force State Volunteer to increase its rates in 1984, but doesn't know by how much.

The claims that insurers are seeing more of include those alleging misdiagnosis, a failure to diagnose, surgical errors, complications of surgery and errors of omission and delay.

They also cite increases in "lack of informed consent" claims. These claims, which generally stem from complications after elective surgery, charge that the doctor did not properly inform his or her patient about the possible consequences of an operation, and that the patient, therefore, could not make an educated decision about undergoing an operation.

Insurers say aggressive plaintiffs' attorneys are partly to blame for these increasing claims.

"We believe if a doctor is at fault, a deserving patient should be compensated," says Dr. Sabella of The Doctors' Co. "But there are a lot of frivolous claims that don't make any sense, and they're expensive to handle before you can get them off the books."

ISMIE's Mr. Nussbaum agrees. Plaintiffs' attorneys, he says, "are doing their job well, but much too aggressively and not as professionally as they should be in evaluating the merits of the cases they take. They're in the best position to tell a client that (he or she) doesn't have a valid malpractice action."

Meanwhile, insurers are beefing up loss-prevention activity.

Some, like Medical Mutual's Mr. Fager, suggest that doctors carefully maintain all records and lab reports.

Many of the physician-owned insurers are emphasizing loss-prevention seminars. ■

Some OB/GYN specialists hard hit by rate increases

WASHINGTON—If you're a gynecologist or obstetrician in Florida, California or New York, you're probably getting socked with higher premiums for medical malpractice insurance.

During the last two years, New York and California gynecologists and obstetricians report that their annual malpractice insurance premiums have increased on average by more than \$8,000, or almost double the national increase of \$4,583.

In New York, 75.8% of OB/GYNs pay more than \$15,000 annually while nationally only 33.6% pay more than \$15,000. In California, 65.9% of the OB/GYNs and in Florida 62.9% pay more than \$15,000 for coverage.

By contrast, just 5.5% of OB/GYNs practicing in the Middle South and 8.5% in the Great Lakes region pay more than \$15,000 for malpractice coverage.

More than 80% of Florida and New York OB/GYNs said they have been hit with premium hikes in the last two years compared with 61.9% of all OB/GYNs, according to an American College of Obstetricians and Gynecologists survey.

On the other hand, 44.9% of OB/GYNs in the Middle South and 45.8% of Great Lakes OB/GYNs said their malpractice insurance premium has increased in the last two years.

To look at the cost of malpractice insurance, the Washington-based American College of Obstetricians and Gynecologists surveyed some 1,915 OB/GYNs this spring. The survey, conducted by Porter, Novelli & Associates, a Washington, D.C.,-based market research firm, had a response rate of 50.1%.

Despite the high and increasing cost of malpractice insurance, few OB/GYNs are uninsured. Just 2.6% of the surveyed OB/GYNs say they are currently uninsured, although 9.1% of California OB/GYNs and 5.4% of Florida OB/GYNs say they do not carry coverage.

Among OB/GYNs who at some point were uninsured, some 45% said they were bare for between one and five years, while 21.8% said they didn't buy coverage for more than five years. Another 18.1% were without coverage for less than six months, while 15.1% didn't purchase malpractice insurance for between six months and one year.

Just 2.6% of the professionals are now uninsured. Some 46.2% of those uninsured say they can't af-

ford coverage, while 28.8% say they are philosophically opposed to buying coverage and 5.8% say they don't need insurance. Another 19.2% of respondents gave other reasons.

Some 10.7% said they were not covered at some point in their careers. In contrast, 25.6% of California OB/GYNs and 25% in Florida say they once went bare.

The most frequent reasons cited by OB/GYNs for buying malpractice insurance include: Too nerve-racking to go without coverage, 44.1%; inability to obtain hospital privileges without coverage, 31.4%; acquiring enough money to buy coverage, 20.7%; and being sued, 5.6%.

The likelihood that an OB/GYN will be frequently sued varies considerably by the area of the country in which he or she practices, according to the survey.

For example, while 20% of surveyed OB/GYNs say they have been sued at least three times, some 48.8% of New York OB/GYNs and 27.3% of California OB/GYNs said they were sued three or more times. By contrast, just 3.7% of OB/GYNs in the Southeast (excluding Florida) and 10.8% in the West (excluding California) were sued at least three times.

Other areas of the country, where the percentage of OB/GYNs sued at least three times was less than the survey average include: New England, 19.5%; Florida and the Great Lakes region, both 15.8%; and the Middle South, 11.7%.

Among OB/GYNs that have been sued, 31.2% said the basis for the suit involved the delivery. Others, 41.3%, cited gynecological surgery and 18.5% cited other OB care aspects as the suit basis.

In addition, some 23% of OB/GYNs that have been involved in a suit said that the suit was eventually settled out of court, while 23% said the plaintiff eventually dropped the suit. A suit was pending for 23.3%, while 9.7% reported that they won in court and 2.3% said they lost in court.

Single copies of "Professional Liability Insurance and its Effects: Report of a Survey of ACOG's Membership" are available free from The American College of Obstetricians and Gynecologists, 600 Maryland Ave. S.W., Washington, D.C. 20024; 202-638-5577.



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Hyatt charges M&M acted negligently

Continued from page 1

million in excess coverage written by Northbrook; another \$25 million excess layer divided among Pine Top Insurance Co., Centaur Insurance Co. and Inso Ltd., all represented by underwriting manager Baccala & Shoop of Newport Beach, Calif. and a further \$25 million excess layer written by Columbia Casualty Co.

Hallmark carried \$101 million in liability insurance with \$1 million primary and \$10 million first excess policies written by CU; a \$50 million excess layer written by American Insurance Co.; and a \$40 million excess layer divided between Republic Insurance Co. and Continental Insurance Co.

Hyatt filed suit in 1981 in state court asking for a ruling on which insurers should indemnify it and

the order in which they should pay.

Jackson County Circuit Court Judge Timothy O'Leary last October ordered the Hyatt insurers to pay two-thirds of the victims' claims and the Hallmark insurers to pay one-third. Judge O'Leary has not made the order final, though, and motions asking him to reconsider are pending.

CU and American contend that their policies were intended as excess of Hyatt's insurance, and that they shouldn't be forced to pay until the entire Hyatt line is exhausted.

Northbrook, on the other hand, argues that the Hyatt line should be considered excess of Hallmark's insurance, which it says was intended to cover construction-related risks.

Both Northbrook and CU dispute Judge O'Leary's finding that they are responsible for continuing legal costs and expenses of Hyatt and Hallmark.

Marsh & McLennan acted independently as broker for both Hyatt and Hallmark, arranging both lines of coverage. In legal papers filed last year, M&M sided with CU, saying it intended the Hyatt line to provide primary coverage for all liability risks at the hotel.

Hyatt's most recent filing alleges that M&M breached its duty to procure adequate coverage, and seeks to recover \$411,337 in fees and commissions Hyatt paid to M&M in 1980 and 1981, along with Hyatt's costs in defending and settling the injury and death cases and in litigating the insurance coverage dispute.

Hyatt doesn't ask for a specific dollar amount to cover legal costs,

but says that the costs exceed \$1 million "and will continue to accrue," according to Thomas E. Deacy Jr., a lawyer for Hyatt.

In the same filing, Hyatt also seeks to recover its legal costs in settling victims' claims from CU, American, Republic and Continental, charging that their policies named Hyatt as an additional insured and agreed to indemnify it for such expenses.

"We want these claims of ours that remain expedited so we can get out and not have continuing involvement in the contest between these insurance companies that will go on for a long time," Mr. Deacy said.

Northbrook has also filed a cross-complaint against CU and American, charging that the two Hallmark insurers unjustly refused to defend, settle and pay victims' claims until ordered to do so by Judge O'Leary.

Northbrook began paying claims in 1981, and paid 100% of settlement and defense costs until Judge O'Leary's order last October, according to Paul W. Schroeder, whose Chicago law firm, Isham, Lincoln & Beale, represents Northbrook. CU didn't start paying claims until last November, and had exhausted its limit—which it says includes defense costs—by January, at which time the American policy took over, Mr. Schroeder said.

American has since refused to pay any of Hyatt's or Hallmark's defense costs in settling claims, lawyers say, and the three Hyatt insurers represented by Baccala & Shoop are now paying 100% of all legal expenses.

The Northbrook cross-claim

seeks \$3 million in compensatory damages each from CU and American, which mainly represents investment income Northbrook says it lost by paying victims' claims for nearly a year with no contribution from the Hallmark insurers. The claim also seeks \$10 million in punitive damages each from CU and American for what Northbrook calls "malicious disregard for the rights of Northbrook and its insureds."

Attorneys involved in the litigation say the Hyatt and Northbrook actions are only the first in what will probably be a flurry of claims and counterclaims as Hyatt insurers try to recover from Hallmark insurers for litigation expenses and lost use of funds.

Other claims will probably be filed in the next 30 days, the period Judge O'Leary granted for additional filings, said Charles Patterson, an attorney with the Kansas City firm of Watson, Ess, Marshall & Enggas, which represents CU. Mr. Patterson added that it is "highly likely" that CU will move to dismiss the Northbrook claim to recover legal costs.

"The battle lines have not even been completely drawn," said Julian Campbell, an attorney with the Chicago firm of Hinshaw, Culbertson, Moelmann, Hoban & Fuller, which represents Columbia Casualty.

Among the parties Mr. Campbell says will probably file cross-claims are Baccala & Shoop, CU, Ameri-

can, Occidental and Columbia Casualty.

Baccala & Shoop, for example, is likely to demand that American pay one-third of the defense costs and reimburse it for investment income its three insurers have lost while paying all of Hyatt's and Hallmark's legal expenses, Mr. Campbell said.

Mr. Campbell expects that American, in turn, will deny any obligation to pay defense costs and move that payment of the costs be turned over to Columbia Casualty, the next excess insurer on the Hyatt line after the Baccala & Shoop group.

James Benjamin, an attorney for American, would not comment on the proceedings other than to say that he expects a "series" of cross-claims to be filed.

Consideration by the court of the Northbrook and Hyatt claims will probably be put off until all the other claims are in, the lawyers say.

"It would make no sense to proceed alone on the Northbrook claim," Mr. Patterson said. "It's better to take them all as a piece."

He added that the insurance litigation probably won't proceed until victims' damage claims are settled. Lawyers hope to have these underlying claims resolved by Dec. 1.

"We have no idea until that's done exactly how much the expenses have been or what has been paid in judgments and settlements," Mr. Patterson said.

Daredevils' lives, liability insured

Continued from page 2

Nicki Lauda. That plane is said to be the fastest light commercial jet in the air.

Mr. Sayer had been scheduled to fly a privately owned Gnat jet aircraft, similar to those flown by Royal Air Force pilots, but he was forced to switch to Mr. Lauda's plane because of liability questions.

"Leo would have been sitting in the ejection seat," said a BBC spokesman. "And because of this, the owner wanted to be released from all liability by Leo Sayer. But because of all the complexity of his estate, Leo felt he was not allowed to sign any disclaimer."

The BBC spokesman said that the network had purchased about \$10 million pounds (\$15 million) in liability coverage on all the aircraft used in the stunts.

Besides liability concerns, both the pilots and the sponsors of the stunts have taken careful safety precautions.

"These stunts have been professionally done and safety is of the utmost importance," Mr. Boyce said. "For example, I have just been to ejector seat training."

The ejector seats on the Hawker jet aircraft that Mr. Boyce and Mr. Ridgeway were to have piloted were equipped with parachutes, so the brokers could bail out in an emergency and float safely to the

ground.

Each of the stuntmen wore fire-protective flying suits, donned "bone-dome" helmets equipped with communication equipment and was fitted with inflatable flotation harnesses that were illuminated "in case we came down in the sea," Mr. Boyce said.

In case something did go wrong, all three of the men were covered by life insurance policies bought especially for the event.

Mr. Boyce and Mr. Ridgeway were both insured by Lloyd's for 500,000 pounds (\$750,000) for death and personal accident. The coverage was brokered by their employer, Stewart Wrightson.

For a 125-pound (\$187.50) premium, the policy would pay the full amount in case of death, loss of limbs, loss of sight or permanent total disablement. The policies also would pay \$7,500 a week for up to 104 weeks in case either of the brokers was temporarily totally disabled as a result of the stunt, while it would pay \$1,875 a week for up to 104 weeks if they were partially disabled.

About \$3 million of life insurance was purchased for Mr. Sayer through Harvard Associates, a London accounting firm, according to a press aide to the rock star. However, the underwriter of the policy could not be identified.

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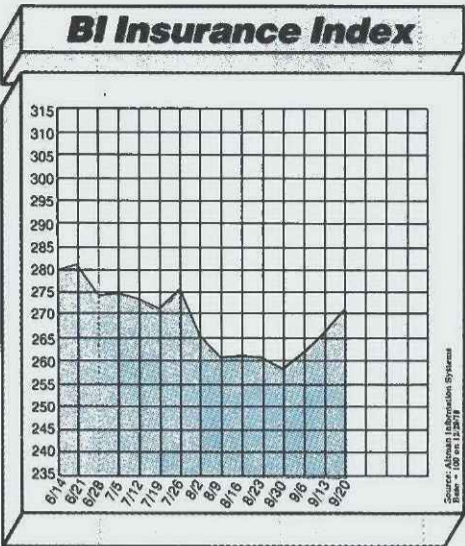
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Tax issues alone not enough to turn the underwriting cycle

By MYRON PICOULT
Special to Business Insurance

THIS MONTH'S episode in the continuing saga of the commercial property/casualty insurance industry, entitled "Cycology' vs. Fundamentals," focuses on some taxing issues.

In reviewing commercial insurers' property and casualty operations on a stand-alone as well as a consolidated basis, we found that in almost all instances tax credits accounted for a greater proportion of operating earnings in the second quarter than in the first quarter.



Mr. Picoult

A study of a representative grouping of companies indicated that, in the first quarter, tax credits appear to have accounted for about 50% of the property/casualty earnings. By the end of the second quarter, this figure soared to approximately 95%.

On a consolidated basis, the comparable numbers were 15% and 45%.

It should be noted that there was a very wide variance among the insurers, with tax credits accounting for as little as 3% of operating earnings for some companies to as much as 200% at others.

The latter figure obviously indicates that pretax operating losses were posted and "operating earnings" resulted only from the use of tax credits.

And, from another perspective, it can be said that the quality of the industry's earnings has clearly deteriorated.

Earlier this year, some industry observers prognosticated that the inability of some cas-

Myron M. Picoult is senior vp and senior insurance analyst with Oppenheimer & Co. in New York. He is the past president of the Assn. of Insurance & Financial Analysts and a member of the New York Society of Security Analysts. His column appears the fourth Monday of every month.

ualty companies to shelter their underwriting losses could be the catalyst that would turn the proverbial underwriting cycle.

Initially, the validity of the theory was impinged by the Securities and Exchange Commission's decision to disallow Aetna Life & Casualty Co.'s attempt to book a deferred tax asset based on the use of tax loss carry-forward income (BI, Feb. 21).

Once insurers have used up their carry-backs, a situation most casualty insurers currently find themselves in, the next alternative is the use of deferred taxes. And, once an insurance company's deferred tax liability is exhausted, underwriting losses flow down to the bottom line rather quickly.

The tax squeeze has several impacts on insurers' operating results and perhaps on the industry's operating environment:

- While the use of deferred taxes aids operating earnings, it has no impact on cash flow. For instance, tax credits cannot be used to pay dividends to shareholders or to pay claims to policyholders.

- The shifting of investment portfolios to generate taxable income penalizes current shareholders. The aftertax yields on current taxable instruments are below the returns available on investments in the tax-exempt arena.

- The sale of loss-reserve portfolios, such as the \$48.3 million medical malpractice reinsurance transaction between Aetna and Fireman's Fund Insurance Cos. earlier this year to again generate taxable income, appears to be tantamount to giving away future profits (BI, May 9).

- Property/casualty insurers that are affiliated with major non-life insurance entities could be in a stronger position than their brethren (who may run out of tax-sheltering capabilities) by having the ability to shelter more underwriting losses over an extended period of time. These companies include Fireman's Fund, which is owned by American Express Co.; Crum & Forster, which is owned by Xerox Corp.; The Home Insurance Co., which is owned by City Investing Corp.; and Hartford Insurance Group, which is owned by ITT Corp.

One other sinister thought is that if the government increases tax rates for life insurance companies—as we expect—without changing consolidation or ownership time frames, the sheltering of underwriting losses will be further aided.

It has been speculated that some type of shock—like a severe hurricane loss, a rash of insolvencies, reserve deficiencies or tax pressure—could be the catalyst that turns the pricing cycle. Individually, we doubt that any one of the above will be sufficient to reverse the industry's underwriting side to any meaningful degree.

However, if several of these events occur in concert, a shift in the market may be a possibility.

The heat in the executive kitchens is rising as underwriting continues to deteriorate, investment income continues to slide and the quality of earnings ebbs. However, market-share considerations still dominate the landscape.

Thus, the "cycology" of the current insurance market may require more than just poor fundamentals to right itself.

The Business Insurance stock index posted a gain for the third consecutive week, rising 5.4 points to 272.1 during the five-day trading period ending Sept. 20. The index had closed at 266.7 Sept. 13. Forty stocks closed up, 13 issues were unchanged and 11 closed down. The biggest gains were reported by USLife Corp., 12.7%; Zenith National Insurance Corp., 10.9%; The St. Paul Cos. Inc., 8%; Washington National Corp., 7.7%; and Bitco Corp., 6.5%. The largest losses were posted by Jefferson National Life Insurance Co., 3.3%; Optimum Holding Corp., 1.9%; CNA Financial Corp., 1.8%; USF&G Corp., 1.8%; and Farmers Group Inc., 1.5%. The BI index posted a 2% increase, which matched exactly the gain posted by the New York Stock Exchange composite over the same period.

British Issues					
20 Sep Companies	Price	P/E	Div. pence	Yield %	1 Week High—Low
Comm Union	168	168.0	16.86	10.0	168—164
Eagle Star	458	16.4	24.29	5.3	458—433
Genl Accident	425	11.0	24.29	5.7	425—418
Gdn Royal Exch	458	11.4	27.26	6.1	458—448
Phoenix	312	13.6	25.00	8.0	312—302
Royal	510	12.8	37.86	7.4	510—498
Sun Alliance	1213	13.9	68.57	5.7	1213—1200

Brokers					
Company	Price	P/E	Div. pence	Yield %	1 Week High—Low
CE Heath	285	7.1	21.07	7.4	300—285
Hogg Robinson	109	8.4	8.57	7.9	111—109
JH Minet	112	9.3	6.50	5.9	112—107
Sedg Grp	201	10.1	10.00	5.0	205—201
Stenhouse Hldg	103	9.4	7.86	7.6	104—103
Stew Wrightson	235	7.8	20.43	8.7	238—235
Willis Faber	543	11.3	25.00	4.6	547—545

Source: Philip Olsen/Alan Clifton, Insurance Industry Specialists Kitcat & Aitken Stockbrokers, London

Financial briefs

British brokers

Currency exchange gains helped at least two of Britain's three largest independent insurance brokerages boost their profits in the first half of 1983.

Sedgwick Group P.L.C., the largest London broker, increased its pretax profits 21% in the first half to 48.3 million pounds (\$73.9 million). Sedgwick Chairman Neil Mills attributed 6.5 million pounds (\$9.75 million) of the gain to the strength of the U.S. dollar compared with the British pound.

Willis Faber P.L.C., the second-largest British brokerage, boosted its pretax profits 36% to 23.2 million pounds (\$35.5 million). Chairman David Palmer said 3.5 million pounds (\$5.35 million) of the advance could be attributed to currency exchanges, while another 1.2 million pounds (\$1.84 million) of Willis Faber's additional profit was derived through the acquisition of broker Carter, Wilkes & Fane.

The third-largest British broker, Stewart Wrightson Holdings P.L.C., reported a 10% rise in pretax profits to 4.62 million pounds (\$7.06 million).

However, Stewart Wrightson Chairman David Rowland did not report how much of the increase was due to currency fluctuations.

USF&G

USF&G Corp. has declared a quarterly dividend of 96 cents per share of common stock, payable Oct. 31 to shareholders of record Sept. 23.

Chubb

Chubb Corp. has declared a regular quarterly dividend of 78 cents per share of common stock, payable Oct. 7 to shareholders of record Sept. 23.

Alexander & Alexander

Alexander & Alexander Services Inc. has declared a regular quarterly dividend of 25 cents per share of A&A's common stock, payable Nov. 30 to shareholders of record Nov. 2.

Nationale-Nederlanden

Pretax profits at Nationale-Nederlanden N.V., the largest Netherlands insurer, increased 5% to \$107.7 million in the first half of 1983. Net profits climbed 7.7% to \$69.1 million, while revenues increased 13.5% to \$2.23 billion.

Nationale-Nederlanden's holdings in the United States include Peerless Insurance Co., Life Insurance Co. of Georgia, Midwestern United Life Insurance Co. and The Netherlands Insurance Co.

BI Industry Stock Report

Insurance Cos.		SEPT. 20, 1983							9/14/83 THRU 9/20/83										
		Price	% Chg.	P/E	\$ Div.	% Yld.	High	Low	Vol. (000)	Price	% Chg.	P/E	\$ Div.	% Yld.	High	Low	Vol. (000)		
Aetna Life & Cas Co	NYSE	38.00	4.1	6.7	2.64	6.9	38.00	36.38	1,033.8	Travelers Corp	NYSE	32.50	5.7	8.4	1.80	5.5	32.50	30.50	1,127.8
American Bankers Ins Group	OTC	12.50	-1.0	9.8	0.50	4.0	12.50	12.38	212.7	United Fire & Cas Co	OTC	32.25	0.0	11.6	0.88	2.7	32.25	32.25	0.2
American Gen Ins Co	NYSE	21.63	0.0	7.4	0.80	3.7	21.63	21.50	423.8	United States Fid & Gty Co	NYSE	55.00	-1.8	10.9	3.84	7.0	56.25	54.75	766.5
American Indty Finl Corp	OTC	17.75	1.4	12.2	1.12	6.3	17.75	17.50	5.9	United Svcs Life Ins Co	OTC	22.50	1.1	6.5	1.00	4.4	22.50	21.75	19.3
American Intl Corp Inc	OTC	70.25	4.1	11.8	0.44	0.6	70.25	67.50	430.5	USLife Corp	NYSE	27.75	12.7	7.7	0.88	3.2	27.75*	24.50	245.6
American Natl Ins Co	OTC	19.25	2.0	8.0	0.84	4.4	19.25	18.88	97.2	Washington Natl Corp	NYSE	27.88	7.7	12.3	1.08	3.9	29.50	27.88	256.9
American Sts Life Ins Co	OTC	40.25	5.9	11.0	0.88	2.2	40.25*	38.00	1.6	Zenith Natl Ins Corp	OTC	17.75	10.9	12.7	0.60	3.4	17.75*	15.75	71.0
Aneco Reins Ltd	OTC	3.50	0.0	116.7	0.00	0.0	3.50	3.50	1.7	INSURANCE COMPANIES			AVERAGE	9.7	3.8				
Avenco Corp	AMEX	23.25	-1.1	13.1	0.58	2.5	23.63	23.13	41.9	Agents/Brokers									
Banks Iowa Inc	OTC	49.00	1.0	17.9	1.52	3.1	49.00*	49.00	1.4	Alexander & Alexander Svcs	NYSE	21.88	0.0	0.0	1.00	4.6	22.25	21.38	273.5
Bitco Corp	OTC	20.50	6.5	8.9	1.33	6.5	20.50	18.00	33.1	Baldwin & Lyons Inc	OTC	38.50	1.3	12.4	0.80	2.1	38.50	38.50	0.6
Carolina Cas Ins Co	OTC	9.25	0.0	0.0	0.32	3.5	9.25	9.25	3.6	Corroon & Black Corp	NYSE	23.75	4.4	12.2	1.80	7.6	24.13	23.00	145.7
Chubb Corp	OTC	63.25	4.5	7.9	3.12	4.9	63.25*	60.50	620.7	Crump E H Cos Inc	OTC	10.00	0.0	14.7	0.40	4.0	10.00	10.00	7.7
Combined Intl Corp	NYSE	37.63	3.8	11.9	2.00	5.3	38.25*	36.00	184.3	Emmet & Chandler Cos Inc	OTC	10.75	0.0	0.0	0.00	0.0	10.75	10.75	2.1
Continental Corp	NYSE	33.75	3.1	20.7	2.60	7.7	34.00	33.25	225.0	Hall Frank B & Co Inc	NYSE	27.88	1.8	21.8	1.70	6.1	28.25	27.13	72.3
Crawford & Co	OTC	17.50	1.4	13.1	0.60	3.4	17.50	17.00	25.4	Integrated Res Inc	AMEX	37.00	5.7	13.8	0.00	0.0	37.00	35.88	183.3
Crown Life Ins Co	OTC	112.00	1.8	7.3	3.10	2.8	112.00	110.00	2.2	Marsh & McLennan Cos Inc	NYSE	43.00	5.8	12.5	2.20	5.1	43.00	40.88	352.4
Employers Cas Co	OTC	32.50	-0.8	6.6	1.20	3.7	32.50	32.25	6.3	Poe & Assoc Inc	OTC	5.00	0.0	0.0	0.00	0.0	6.00	6.00	4.8
Equifax Inc	NYSE	33.50	0.4	14.2	1.40	4.2	33.50	33.00	63.5	Reed Stenhouse Cos Ltd	OTC	13.63	2.8	22.7	0.60	4.4	13.75	13.25	2.9
Excelsior Ins Co	OTC	19.75	0.0	10.3	0.00	0.0	19.75	19.75	0.9	AGENTS/BROKERS			AVERAGE	20.2	3.7				
Farmers Group Inc	OTC	40.75	-1.5	10.3	1.36	3.3	41.38	40.63	305.3	Conglomerates/Holding Cos.									
Foremost Corp Amer	OTC	32.00	0.5	14.8	0.83	2.6	32.00	31.50	71.3	American Express(Fireman's Fd)	NYSE	40.13	4.2	11.7	1.28	3.2	40.13	38.13	2,612.0
Freemont Gen Corp	OTC	17.00	-1.4	80.6	0.48	2.8	17.38	17.00	86.1	Anderson Clayton(Ranger/PanAm)	NYSE	27.88	4.2	15.9	1.32	4.7	27.88	26.50	47.7
Great West Life Assurn Co	OTC	225.00	0.0	8.1	11.00	4.9	225.00	225.00	0.0	Arcco Inc	NYSE	19.88	0.0	0.0	0.40	2.0	19.88	19.38	374.4
Hanover Ins Co	OTC	60.50	2.5	7.5	0.88	1.5	60.50	59.00	6.9	Baldwin Utld Corp	NYSE	5.00	-25.9	2.4	0.00	0.0	5.63	4.38*	2,481.3
Hartford Steam Boiler Insptn	OTC	52.50	-0.9	8.2	3.00	5.7	53.00	51.50	11.0	CIGNA Corp	NYSE	43.50	-1.1	6.6	2.48	5.7	44.25	42.75	658.4
Jefferson Natl Life Ins Co	OTC	44.00	-3.3	13.7	0.76	1.7	45.00	44.00	2.3	City Investing Co. (Home Ins.)	NYSE	36.38	3.6	8.7	1.80	4.9	37.25	35.50	391.7
Kemper Corp	OTC	39.75	0.0	7.4	1.80	4.5	39.75	38.25	114.7	CNA Finl Corp (CNA)	NYSE	20.88	-1.8	7.2	0.00	0.0	21.00	20.88	23.6
Lincoln Natl Corp Ind	NYSE	58.75	4.0	9.3	3.00	5.1	58.75*	57.38	268.1	Control Data (Comm. Credit)	NYSE	52.88	1.7	13.0	0.60	1.1	54.00	52.13	740.7
Mission Ins Group Inc	NYSE	29.25	3.5	10.9	1.00	3.4	29.25	27.88	101.3	General Re Corp	NYSE	65.50	2.4	13.2	1.28	2.0	63.75	60.75	294.9
Nationwide Corp Ohio	OTC	41.75	0.0	15.3	0.70	1.7	0.00	0.00	NOT TRADE	Gulf Utld Corp	NYSE	27.50	1.9	8.4	1.32	4.8	27.50	27.00	317.1
Northwestern Natl Life Ins	OTC	35.50	0.7	23.5	1.50	4.2	35.50	35.38	32.4	ITT (Hartford Group)	NYSE	44.13	2.6	9.4	2.76	6.3	44.13	43.00	1,500.4
Ohio Cas Corp	OTC	49.50	3.1	9.1	2.52	5.1	49.50	48.75	37.7	Optimum Hldg Corp	OTC	6.63	-1.9	21.4	0.00	0.0	6.75	6.63*	4.0
Old Rep Intl Corp	OTC	31.75	0.0	7.3	0.90	2.8	31.75	31.25	156.4	Saars Roebuck & Co. (Allstate)	NYSE	36.75	4.0	12.4	1.52	3.9	38.75	36.00	2,679.1
Orion Cap Corp	NYSE	27.00	1.4	13.5	0.66	2.4	27.00	26.38	30.4	Taladyne Inc (Argonaut)	NYSE	169.63	3.4	15.1	0.00	0.0	169.63	165.50	563.1
Preferred Risk Life Ins Co	OTC	18.75	1.4	7.5	0.67	3.6	18.75	18.50	4.3	Transamerica Corp	NYSE	28.00	3.2	9.6	1.56	5.6	28.00	26.63	858.2
Provident Life & Acc Ins Co	OTC	66.00	3.1	8.4	2.60	3.9	66.00	64.00	16.1	(Occidental & Fred S. James)	NYSE	22.00	3.2	9.6	1.56	5.6	22.00		

How The Hartford helps reduce insurance costs.

"Our leadership in Automation puts you in control of your insurance — and its cost."

Don Frahm, President, Property/Casualty Operations, tells business insurance buyers how they can benefit from The Hartford's advanced Automation capability.

Q. How does The Hartford's Automation capability help brokers and agents meet my business insurance needs better?

A. It enables them to give you faster, more responsive service across the board. Take quotes, for example. Where a nonautomated insurer might take a month or more to get back to brokers and agents with a proposal, we can normally get quotes out in days. That fast turn-around lets you measure the cost-effectiveness of different levels of coverage in actual dollar terms— and right up front. It also gives you more time to make informed decisions on the options open to you, and to balance cost and coverage considerations.

Q. When do you use computerized loss control analysis? And how can it cut insurance costs?

A. Computerized loss control analysis comes into play when a company has complex exposures and multiple claims. By breaking out losses by location, time of day, type of accident or injury, and so on, our Loss Control specialists can detect common denominators which help them pinpoint accident causes. They can then work up recommendations for eliminating or reducing those losses.

In the case of a large New England printing company, for example, computer analysis showed a high percentage of accidents and lifting injuries connected with bindery operations. Guided by clues



contained in the analysis, our Loss Control specialists did a Materials Handling Survey of bundle size and weight, work flow patterns, and the like, and made specific recommendations to improve the situation. The same procedure was followed with other types of accidents and injuries.

The results were dramatic. In the 7-month period following the implementation of the recommendations, incidents were reduced by nearly 60% over the corresponding 7-month period a year earlier, and incurred claims costs dropped by 94%. Naturally, improvements like that can substantially lower future premiums.

Q. How can your automated Claims capability increase my control and limit my losses?

A. Let me first make clear that our automated Claims capability complements our human Claims capability. Remember, many insurance companies rely almost entirely on outside Claims services. At The

Hartford, we handle about 99% of our own claims with our own staff of some 4,200 Claims personnel. We have more than 200 fully automated field Claims offices in the U.S. and Canada, and 52 regional Claims offices.

Our human Claims capability assures you of fast, fair, and expert response to claims. And our computer Claims capability assures you of fast, accurate Claims processing and reporting. You know where you stand at all times. And the rapid resolution and payment of claims can significantly reduce claim costs and thereby improve your company's cash flow and profit picture.

Q. Are your computer-enhanced Loss Control and Claims services available on an unbundled basis?

A. Yes—through our subsidiary, Hartford Specialty. One of their Claims services is a

unique on-line claim reporting system that gives you current, up-to-date information on claims and lets you break out claims anytime in accordance with criteria you select on the spot.

Q. How can my company take advantage of The Hartford's leadership in Automation?

A. Just contact a broker or independent agent who represents The Hartford.



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