

business insurance

Reporting weekly for corporate risk, employee benefit and financial executives/\$1.50 a copy; \$52 a year

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Carbide retains \$50 million after general liability renewal

DANBURY, Conn.—Union Carbide Corp., with a \$50 million per-occurrence self-insured retention, will have to pay any liability losses arising from last week's chemical leaks at the company's plants in Institute and Charleston, W.Va., sources say.

When Union Carbide's general liability insurance program expired in March, the company sought excess liability coverage of \$50 million over a

Continued on next page

More benefit bombs detected in tax plan

By JERRY GEISEL

WASHINGTON—Two largely ignored provisions in the Reagan administration's tax reform proposal would disqualify the tax-free status of thousands of corporate benefit plans.

The ticking bombs, uncovered by benefit experts only in recent weeks, target plans in which a disproportionate amount of covered employees are higher-paid employees.

One provision primarily affects large corporations with subsidiaries in different industries that offer varying benefit plans; the other primarily affects smaller employers.

Both, however, have the same result: Higher-paid employees in the disqualified plans would be taxed on the employer's contributions to their benefits.

Large corporations' benefit plans could run into trouble under the proposed uniform non-discrimination rules. They could be saved by only costly amendments to the plans.

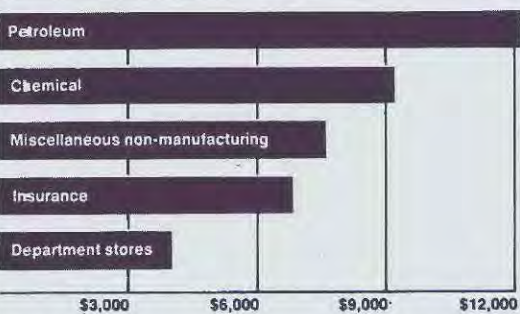
And, small companies' benefit plans could be destroyed by a so-called concentration test.

The effect of both the uniform non-discrimination rules and the concentration test would be far greater on some companies than any other benefit provision in the tax reform package, experts agree.

"For companies affected, the problems created by these provisions dwarf anything

How benefit costs vary by industry

(Annual cost per employee)



Source: U.S. Chamber of Commerce, 1983 data

Chart: Amy Palmer

else in the tax package," said Thomas Butterworth, a consultant with Hewitt Associates in Rowayton, Conn.

The uniform non-discrimination rules establish a formula to determine if a disproportionate percentage of higher-paid employees is covered by a benefit plan compared with the percentage of lower-paid employees in the plan.

Employers that have the most to fear from these rules are corporations with one benefit plan for a subsidiary in an industry where salaries and benefits are high and another benefit plan for a subsidiary in an industry where salaries and benefits are low.

That's because the formula used in the uniform non-discrimination test considers all employees of a corporation—not just those in individual benefit plans.

And, differences in the value of benefits by industry are not uncommon, as the annual U.S. Chamber of Commerce benefit survey shows (see chart).

Here's how the proposed uniform non-discrimination rules work:

A corporation determines the number of its employees in the so-called prohibited group. Prohibited employees are those who earn more than \$50,000, own more than 1% of the company or fall into the top 10% of all employees in compensation.

Then, the corporation must:

- Divide the number of prohibited employees in a benefit plan by the total number of prohibited employees of the company.
- Divide the number of non-prohibited employees in the plan by the total number of non-prohibited employees.
- Divide the percentage calculated in the first step by the percentage calculated in the second step. If the resulting percentage exceeds 125%, the plan would be disqualified.

Many benefit plans offered by Fortune 500 companies would

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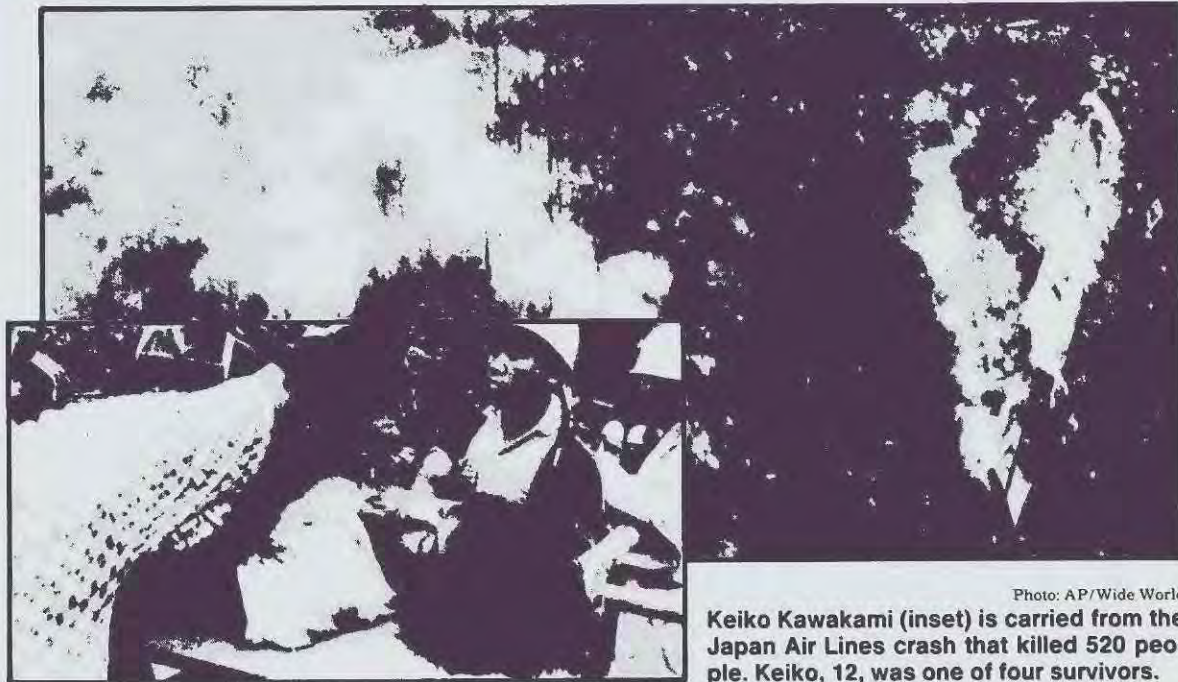


Photo: AP/Wide World

Keiko Kawakami (inset) is carried from the Japan Air Lines crash that killed 520 people. Keiko, 12, was one of four survivors.

Record aviation losses to hike rates for airlines

By STACY SHAPIRO and STEVE TARAVELLA

The tragic crash of a Japan Air Lines Boeing 747 jetliner last week, the worst single-aircraft aviation loss in history and the second major airline disaster in 10 days, is certain to drive up aviation insurance rates as underwriters seek to offset record losses in 1985.

The crash of JAL Flight 123, which killed 520 of the 524 people aboard, increased the amount of hull claims faced by world aviation underwriters so far in 1985 to \$305 million, topping the record of \$302 million set in all of 1983.

Liability losses in 1985 also certainly will be the highest ever, with 1,281 people killed in commercial aviation accidents this year.

Underwriters are reserving \$160 million to pay liability losses from the JAL crash, sources say, or about

\$300,000 per person.

JAL does not expect many liability claims to be filed as a result of the crash, a JAL spokesman in New York said.

Japanese custom dictates that family members will meet shortly with airline representatives to negotiate individual settlements, he said.

The Aug. 12 JAL crash followed by 10 days the crash of a Delta Air Lines Lockheed L-1011 jetliner, which killed 131 people and injured 31 others. Underwriters are reserving \$125 million to pay liability claims resulting from the Delta crash, or about \$770,000 per person. The lost Delta hull was valued at \$24.7 million (BI, Aug. 12).

In addition, an Air India 747 crashed June 23 off the Irish coast, killing 326 people. The Air India hull loss

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Court gives asbestos company broad cover for property claims

By STEPHEN TARNOFF

NEWARK, N.J.—The first federal court decision on the extent of insurance coverage for property damage claims stemming from asbestos in buildings provides broad coverage to a Canadian asbestos company.

Lac D'Aminate Du Quebec of Quebec is entitled to a potential \$103 million in insurance limits provided by three insurers under policies issued from 1975 to 1984 to pay for defense and indemnification costs arising from property damage claims as well as personal injury claims related to asbestos, ruled U.S. District Court Judge Maryanne Trump Barry.

Her ruling was issued in the case of *Lac D'Aminate Du Quebec v. American Home Assurance Co.*

The defendant insurers had argued that only those providing insurance when asbestos was installed in a building or when a worker was exposed to asbestos should be liable for claims.

Judge Barry ruled that the triple-trigger theory of coverage first handed down in *Keene Corp. v. Insur-*

ance Co. of North America in 1981 governing insurance coverage for personal injury claims should apply to LAQ's coverage for both personal injury and property damage claims.

Numerous courts have held that bodily injury caused by asbestos involves continuous injury from the time of exposure through manifestation of the asbestos-related disease and that all the insurers providing coverage during the period are liable for claims. But, this is the first case also to apply the same theory to property damage claims related to asbestos.

Currently, billions of dollars in claims are pending against asbestos producers brought by school districts, city and state governments, private homeowners and corporations.

And, many policyholders are already in litigation with their insurers on the extent of coverage in such cases.

"The decision potentially points toward the salvation of the asbestos industry," says Myron J. Bromberg, an

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Workers at new Saturn plant to have only HMO, PPO plans
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update

Carbide self-insures \$50 million

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\$50 million self-insured retention. Sources estimate the amount actually placed at between \$15 million and \$50 million. Before the March renewal, Carbide had excess liability limits of \$200 million, for which it paid \$1.13 million in premiums (BI, Dec. 24-31, 1984.)

London underwriters—who had provided \$35.9 million of the expired program's \$200 million limits—did not participate at all on the new program, according to a spokesman for C.T. Bowring & Co. Ltd. Bowring is the London-based unit of Marsh & McLennan Cos. Inc., Union Carbide's broker.

Several U.S. insurers on the former program also did not renew their coverage, including Transit Casualty Co., First State Insurance Co., New England Reinsurance Corp., American Centennial Insurance Co., Republic Insurance Co. and Midland Insurance Co.

A Union Carbide official refused to comment on the coverage.

An Aug. 11 leak of aldricarb oxime gas at Union Carbide's Institute pesticide plant sickened 134 people. A leak of another toxic gas, methyl isocyanate, killed 2,000 people at a sister plant in Bhopal, India, last December. Claims stemming from that disaster are covered under the expired program.

The company also reported a spill of non-toxic chemicals at its Charleston hydraulic brake fluid plant last Tuesday.

Eagle Bonds sues Cal-Farm

LOS ANGELES—A lawsuit against Cal-Farm Insurance Co. by its managing general agent seeks \$450 million in damages and charges the insurer with illegally and fraudulently issuing more than \$100 million of worthless financial guarantee bonds.

The lawsuit—filed last Thursday by Eagle Bonds & Insurance Brokers Inc. and its owners, Errol P. and John M. Coughlan, in U.S. District Court in Los Angeles—alleges racketeering, fraud and breach of contract against Cal-Farm.

Eagle Bonds underwrote financial guarantee bond business for Cal-Farm for about 18 months beginning in May 1983.

Others named in the Eagle Bonds suit include Cal-Farm's officers and directors and Barclays Mortgage Corp. of Irvine, Calif. Barclays, a loan broker for commercial development projects, acted as a sub-agent for Eagle Bonds on the financial guarantee bonds.

Eagle Bonds alleges it was duped into being a middleman in a scheme by Cal-Farm's officers and Barclays to defraud the insurer.

Cal-Farm was placed under conservatorship by the California Insurance Department in March because of massive losses on its financial guarantee bonds. Cal-Farm currently has two lawsuits pending against the owners of Eagle Bonds (BI, July 29).

Continental D&O insurers sue

CHICAGO—Three insurers that wrote part of \$100 million in directors and officers liability insurance for Continental Illinois Corp. during the early 1980s are seeking to rescind the policies.

In two suits filed against Continental, its subsidiary Continental Illinois National Bank & Trust Co. and various corporate officers and directors, the insurers charge the defendants misrepresented the bank's financial condition when they increased the corporation's D&O coverage to \$100 million from \$40 million in 1981.

The suits were filed Aug. 9 in U.S. District Court in Chicago by Harbor Insurance Co., Allstate Insurance Co. and National Union Fire Insurance Co. of Pittsburgh, Pa.

Also named as defendants are Continental's auditor, Ernst & Whinney, and the Federal Deposit Insurance Corp.

According to one of the suits, Harbor has conditionally paid \$1.6 million in defense costs associated with shareholder suits against Continental that seek to tap the bank's D&O insurance.

The allegations in the suits include that defendants "falsely and fraudulently" misrepresented the bank's financial condition and failed to disclose material facts when increasing coverage limits in 1981. The suits seek a declaratory judgment rescinding policies in 1981 and 1982 and declarations that underlying claims against Continental are excluded from coverage or that the insurers are not liable under the policies.

A spokesman for Continental declined comment on the suits.

Insurers seek tax alternatives

WASHINGTON—Member companies of the American Insurance Assn. were meeting in Washington late last week to devise an alternative to the Reagan administration's plan to limit insurers' immediate tax deductions for property/casualty loss reserves.

The meeting was called because the insurers now believe the administration's loss-reserve proposal may become law unless insurers come up with an alternative, an insurance industry attorney said.

The specific alternatives to be discussed at the meeting weren't known. However, the attorney said alternatives considered previously by insurance trade groups include a federal tax on property/casualty insurance premiums and barring a company from off-

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Workers at new Saturn plant to have only HMO, PPO plans

By DIANE LYNN KASTIEL

SPRING HILL, Tenn.—Plans for the United States' newest and largest auto plant to open in 1989 in Tennessee include a state-of-the-art employee benefit program.

The 6,000 United Auto Workers members who will be employed by Saturn Corp., the prodigious new \$3.5 billion offspring of General Motors Corp., will be offered health care coverage only through managed care facilities rather than the traditional, fee-for-service system.

"There will be no traditional plan at all. Everything will be either HMO or PPO," said David Beier, administrator of benefit plans for the UAW, noting that employees will have a choice between an HMO or PPO.

In addition to regular medical coverage, workers will receive ancillary health care benefits, such as dental and vision care—also provided through HMOs or PPOs, Mr. Beier said.

GM will work with insurers to establish the HMOs and PPOs, Mr. Beier said. However, he would not comment on which insurers the company might use, and he said details of the HMO and PPO plans have not been worked out yet.

SATURN CORPORATION

Currently, GM uses several health care insurers, including Blue Cross/Blue Shield, Metropolitan Life Insurance Co. and Connecticut General Life Insurance Co.

The total elimination of fee-for-service health care in the benefits program for Saturn workers is dramatically different from the health care benefits currently provided GM workers. And, it eliminates the problem of employees choosing traditional health care coverage over HMOs and PPOs, which GM ran into when it gave employees the choice among all three options.

Earlier this year, GM offered its hourly and salaried employees the option of leaving their traditional fee-for-service health care plans to join an HMO or a PPO. However, few GM employees joined an HMO or a PPO, which generally are considered to be more cost-effective than traditional fee-for-service plans.

Of the 800,000 people who made elections, 671,500 chose the traditional plan, GM says—only 8% less than the 730,000 employees enrolled in a traditional plan before the optional Informed Choice plan was introduced (BI, June 3).

The Saturn agreement also mandates other benefits, Continued on page 30

Third edition of BI directory now available

The third edition of the *Business Insurance Directory of Corporate Buyers of Insurance, Benefit Plans and Risk Management Services* is off the press.

The 1985 edition includes information on more than 2,000 U.S. companies. It lists the company name and address, 1984 gross revenues, number of employees at year-end 1984 and names and titles of the chief financial officer and of executives in charge of risk management, benefits, personnel and pension/retirement plans.

In addition, the 1985 edition lists personnel with responsibilities in related areas.

And, it includes an index ranking companies by number of employees, and a geographic index.

Copies of the BI Directory are \$50 each, or \$40 each for five or more. To order, write Business Insurance Directory, Single Copy Sales Department, 740 N. Rush St., Chicago, Ill. 60611; 312-649-5425.



New York comp benefits to be based on all earnings

By CAROL CAIN

ALBANY, N.Y.—Injured New York workers with more than one job will receive workers compensation benefits based on their total salaries under a new law that employers and insurers say will increase their work comp costs.

The law, S. 2861, which takes effect Jan. 1, was designed to resolve inequities that occurred when a worker who holds both full- and part-time jobs was injured at the part-time job and only received benefits based on part-time income, said Robert Steingut, chairman of the state Workers' Compensation Board, which drafted the law and administers the state workers compensation system.

California, Connecticut, Idaho, Illinois, Kansas, Michigan and Minnesota already have similar laws.

And, courts in a few other states have interpreted workers compensation statutes to allow for calculation of work comp benefits on the basis of combined salaries, says Keith Bateman, associate vp and director of policy resources for the Alliance of American Insurers in Schaumburg, Ill.

Under current New York law, workers compensation benefits in most instances are based solely on the salary from the job where the injury took place.

This system resulted in "a substantial injustice and hardship in the cases where the worker is totally disabled," Mr. Steingut said.

"In the past, injured workers with more than one job have been penalized by the loss of wages from a second job," according to a statement by Gov. Mario Cuomo, who signed the law last month. "This was unfair to workers and their families."

Under the new law, the employer under whose employment

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IRS requiring consent of spouse to collect early retirement benefits

By JERRY GEISEL

WASHINGTON—Employees must obtain consent of their spouses before they can collect early retirement benefits, the Internal Revenue Service says.

If a spouse declines to give his or her consent on a waiver form, retirement benefits cannot be paid to an employee until the worker reaches the employer's normal retirement age, the IRS says in temporary regulations implementing the Retirement Equity Act of 1984.

While the regulations will not lead to direct benefit cost increases for employers, some employers may be caught in the middle of marital disputes when a husband and wife cannot agree on when the working spouse should retire.

"In an unhappy marriage, it gives the spouse a veto over benefit decisions," said Thomas Butterworth, a consultant in the Rowayton, Conn., office of Hewitt Associates. For lack of a spousal consent signature, the employee must work or do without early retirement benefits, Mr. Butterworth added.

The new rule, which consultants say is not explicitly supported by any provisions of the Retirement Equity Act, will force companies to beef up their communications efforts so that employees clearly understand—

well before before they intend to retire—that spousal consent is necessary before they can collect early retirement benefits.

Another section of the regulations that requires spousal consent before an employee can waive the right to receive joint and survivors' benefits, also will cause employers administrative hassles, according to the consultants.

Under a common joint and survivors' option, an employee agrees to have his or her retirement benefit reduced so that the spouse is entitled to a share—often about half—of the benefit if the employee dies. The employee's initial pension benefit is reduced, often by

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errors & omissions

• Chicago City Bank & Trust Co. is enrolled in John Hancock Mutual Life Insurance Co.'s Select Dental Care, a dental preferred provider organization. The bank was incorrectly identified in the July 22 issue.

Pritzkers, Home to pay huge share of D&O settlement

By STEVE TARAVELLA
and BARBARA MARSH

CHICAGO—The Home Insurance Co. and Chicago's wealthy Pritzker family will cover the lion's share of a \$23.5 million settlement with Trans Union Corp. shareholders who sued over the transportation company's 1981 sale to the Pritzkers.

Nine former Trans Union directors who were sued in the action, which charged that the sale was underpriced, will pay only a small amount of the settlement.

The July 30 settlement followed a Delaware Supreme Court ruling in January that held that the Trans Union directors were grossly negligent in failing to prudently evaluate a \$688 million offer by the Pritzkers' Marmon Group Inc. before agreeing to the sale (BI, Feb. 4).

The Delaware ruling, which experts say increases directors' exposure to liability suits, sent the case back to the Court of Chancery to determine damages.

The \$23.5 million settlement was finalized July 30 after lengthy negotiations between attorneys for Chicago-based Marmon and Trans Union's former shareholders. About 10,000 shareholders are expected to share in the settlement.

The settlement is to be paid by Oct. 10, three days after a scheduled hearing on the settlement in the Court of Chancery in Wilmington, Del., according to Robert K. Payson, a Trans Union attorney with Potter, Anderson & Corroon in Wilmington.

Mr. Payson says the cost of the settlement will be borne by the insurer that wrote \$10 million in directors and officers liability coverage for the directors, the Pritzkers and the directors.

He declined to identify the underwriter, but sources say The Home issued the coverage.

The Pritzker family will pay "substantially all" of the uninsured \$13.5 million, according to Jay Pritzker, who spearheaded the negotiations leading to the sale, despite the fact that neither the Pritzkers nor Marmon were cited for any wrongdoing.

But if the Pritzkers hadn't stepped in, the directors could have pursued a case against them—as Trans Union's present owners—seeking reimbursement for damages. A case could be made that the legal damages are now a liability of the Pritzkers.

It is not known how much the former directors will contribute from their personal finances, but it's believed to be very little.

However, still pending against the directors is a similar liability action—this one

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Probing satellite coverage



Photo: Stacy Shapiro

International Technology Underwriters Inc. President James Barrett said the concept of satellite insurance was conceived during a bridge game.

Birth of satellite coverage was in the cards: Barrett

By STACY SHAPIRO

WASHINGTON—Satellite insurance was invented in 1963 during a bridge game by a 32-year-old self-employed broker with time on his hands.

"I was technically unemployed in the afternoon," recalls James W. Barrett, now president of International Technology Underwriters Inc. in Washington.

"So I went to an old restaurant called Alfred's, which was run by two old ladies in their 50s or 60s, and we would play a bridge game in the afternoon."

"One day I was reading about Comsat (Communications Satellite Corp.), and I was thinking about it when I was playing bridge. I ended up being the dummy, so while I was dummying, I went to the pay phone and phoned up Leo Welch, then chairman of Comsat."

"There I was, the littlest insurance broker calling one of the largest industrialists," he explained.

Mr. Barrett says he asked Mr. Welch whether Comsat had considered purchasing insurance for what would become the first commercial communications satellite, Intelsat I, better known as Early Bird. Mr. Welch was interested.

"That was when space insurance began," said Mr. Barrett.

Together with Comsat's broker Marsh & McLennan Inc., Mr. Barrett developed the first insurance policy for commercial satellites.

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Successful repair of disabled probe might ease rates

By STACY SHAPIRO

LONDON—Satellite owners' soaring launch insurance rates might fall closer to earth if astronauts aboard a space shuttle flight scheduled for launch Saturday can repair the \$85 million Hughes Aircraft Co.'s Syncom IV-F3 satellite.

If the repair is successful, launch insurance underwriters' losses for the last 18 months could drop to \$282 million from \$367 million.

But, the same shuttle flight that will attempt to repair the disabled satellite also will launch three more probes, creating the risk of loss as well as gain on the Discovery mission. The three satellites are Hughes' Syncom IV-F4, American Satellite Co.'s ASC I and the Australian satellite AUSSAT KI, all of which are insured.

Underwriters have paid the Syncom IV-F3 loss, but they expect to recover the money if the repair is successful because, under their agreement with Hughes, the underwriters will receive a substantial portion of the revenue when the repaired satellite is leased to the U.S. Navy.

In addition, a successful repair mission also would show not only that satellites can be salvaged from space, but also that they can be repaired in space.

This cut in underwriters' losses coupled with renewed confidence in satellite performance "could bring a possibility of lower rates," from the current 20% of insured value, said Gerald Frick, managing director at Marsh & McLennan Inc. in New York, the broker for Hughes.

Rates were as low as 5% of insured value several years ago.

But, Mr. Frick stresses that rates will go down only if there are no more losses this year, and then the drop will not be dramatic and "not for awhile."

"Rates cannot go up anymore anyway, because no one would buy insurance," he said.

But, even if the Syncom is repaired, satellite underwriters are still losing money, are fearful of any more losses and are reluctant to extend their capacity for satellite risks.

Already, underwriters have been notified of another possible loss, to the Arabsat II satellite launched on the shuttle in May, sources say.

Although the satellite currently is operating, it is experiencing problems with its altitude control system. Arabsat notified underwriters of a possible claim before the 180-day policy ex-

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Benefit communicators touch all bases



Photo: AP/Wide World

Classic misunderstanding

A film of Abbott and Costello's "Who's on First" routine entertained and enlightened attendees of the Business Insurance Employee Benefits Communications Conference in New York Aug. 4-6.

Employers, consultants must have open dialogue

By DIANE LYNN KASTIEL

NEW YORK—"Keeping the lines of communication open" between a benefit manager and a consultant is crucial to creating a successful communications program, a consultant and a benefit communicator agree.

Whether it comes to defining objectives of a benefit communications project or calculating fees, the best way to avoid foul-ups is to keep the dialogue between consultant and client open, free-flowing and honest, they say.

"There can be a tendency not to confront or share certain things openly," says George W. Heiring, managing partner and communication group manager of Hewitt Associates in Lincolnshire, Ill.

"We must level with each other on what's possible, what isn't and what problems lie ahead, and then trust that information," he said.

Stephen Wasserman, director of benefit communication and training for Northbrook, Ill.-based Dart & Kraft Inc., said that "tell all" is among his "Ten Commandments of Selecting a Benefits Communications Consultant."

"Don't hold back information from your consultant," Mr. Wasserman advised. "If you don't feel they can respect confidentiality, you shouldn't be talking to them."

Mr. Heiring and Mr. Wasserman shared their advice on how to work with a consultant at the Business Insurance Employee Benefits Communication conference.

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Informed retirees can help control health care costs

By DANA DAVIS

NEW YORK—Employers can control the rising cost of retiree health benefits by communicating cost-containment information to retirees.

"Even though retiree health care costs are getting larger, you can still take action to reduce those costs," Jeffrey Ostroff, president of Jeffrey M. Ostroff Associates in Wilmington, Del., told the Business Insurance Employee Benefits Communication Conference in New York.

"This can be accomplished by establishing a retiree communication program," added Vivian Anderson, assistant employee benefit manager at Allstate Insurance Co. in Northbrook, Ill.

Ms. Anderson spoke from personal experience: She recently helped implement an ongoing retiree communication program at Allstate that uses various communication methods to relay to retirees specific information about their benefits and general information about health care.

Ms. Anderson decided "Allstate could benefit from a program specifically aimed at the company's growing retiree population" after she heard Mr. Ostroff conduct a retiree cost-containment workshop last year.

As a first step, Ms. Anderson said she sought management support for the program.

"They concurred an ongoing communication device was needed to help retirees become better and wiser health care

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Consultants

Continued from previous page

Each speaker offered checkpoints for benefits managers on the road to a smooth client/consultant relationship.

For example, they suggested that before hiring a consultant a benefit manager should:

- Define the objectives of the project. "A consultant who screws up because your objectives were not clear is innocent," Mr. Wasserman said.

- Before you select a consultant, you should thoroughly define your objectives. Even if you're not a communicator, you should put together a list of the things you feel you'll have to do to communicate your benefits program," he said.

- Set some common expectations," Mr. Heiring agreed. "Determine what it is you want, why, and when you need it. The consultant should know whether you're looking for fresh ideas or a broad, experienced perspective."

Identify the tasks involved.

Mr. Wasserman said this step is a natural offshoot of identifying objectives; it addresses how these objectives will be achieved and outlines responsibilities.

And, to avoid duplicating or skipping tasks "Have your consultant verify this in writing," Mr. Wasserman said. "The best surprise is no surprise."

Mr. Wasserman also suggested determining what work can be completed in-house and what other resources can be tapped.

Then, it must be decided whether it is more cost-effective to produce printed or audio-visual materials using company resources or to hire an outside contractor for these

tasks.

Determining who will be responsible for production of the project is also necessary, according to Mr. Heiring.

If the employer has responsibility, how much assistance can the consultant provide? If the consultant is handling production, can the employer offer assistance that can lead to cost savings?

If the consultant handles production, find out which suppliers and outside production houses it uses, he added.

- Ask "demographic" questions about the consultant's size, like the number of consultants and actuaries and office locations, Mr. Heiring said. Then the benefit manager can assess whether the consultant has the capacity to handle the job, he said.

- I think the majority of consultants in our field will tell you if they are overloaded and can't do it," he said. "Certainly they are the ones you learn to trust. Those that

overreach don't get much repeat business."

- Review the consultant's creative samples, Mr. Heiring advised. Benefit managers should be careful not to get "wowed" by flashy materials that may not be applicable to their needs.

"There are truly excellent communication materials that will never catch the eye of the judge," Mr. Heiring said.

"So, as you review samples, find out the circumstances under which they were created—ask about objectives."

- Determine who will work on the project, Mr. Heiring said. A "consultant" may, in reality, turn out to be the salesperson representing the company, instead of the

person who actually works on the account.

"Don't assume that who you see is who you'll get," he said.

- Check a consultant's references, Mr. Heiring advised.

"Checking references is something relatively few clients do, but almost all should," he said.

Instead of simply asking whether the firm is good or not, look for more descriptive adjectives, like "creative," "expensive," "new," or "well-known," he added.

"When you check references, you may believe that all you will get is glowing reports, so why bother? In reality, you can get useful, objective information," he explained.

Mr. Heiring said this can be achieved by asking specific questions, such as: "Did they miss any deadlines?" "How did they handle problems?" Or, "Would they rehire this consultant again?"

- Plan ahead.

Mr. Wasserman said benefit managers should make a schedule outlining what they expect from the consultant they hire.

- Identify costs.

Mr. Wasserman advised getting the costs in writing. "A properly defined set of objectives and clear task instructions should result in no dollar surprises," he noted.

- When evaluating proposals, look for flexibility in costs, timetables and ideas, and determine whether the proposal answers all pertinent questions, Mr. Heiring said. Also, the employer should look at who makes up the project team, he said.

Once the consultant is hired, there are more ways to improve the relationship:

- Set up an approval process, Mr. Wasserman said.

"One of the things you should always be sure of when dealing with consultants is that the approval process is clear on both sides," he said. This avoids wasting time—and money—because the consultant went ahead with a task that never got approval.

- Don't "cry wolf" with the consultants over deadlines but, at the same time, beware of consultants who set unrealistic deadlines, Mr. Heiring said.

"It's difficult to love a client who continues to set false deadlines that cause the consultant a lot of stress and pain to meet, only to find out that when the work is delivered there were several weeks to spare," he said.

"Conversely, I'm afraid you'll find consultants who characteristically promise deliveries that defy the laws of physics."

- Determine whether the consultant is expected to act as an instructor, not just a contractor, Mr. Heiring said.

"One very legitimate but often underutilized aspect of a consultant's job is teaching," he said. "How can we teach you or your subordinates to communicate so that you won't have to hire us to do the same job next year?"

- Beware of verbal "snowstorms" and don't get blitzed in an avalanche of confusing jargon, Mr. Wasserman said.

"You have a right to understand in simple English what's going on," he said.

- Never let the consultant take over, Mr. Wasserman said. "You should always be in control of the project," he said.

"Remember, the consultant is working for you. Respect his or her advice, but you must be the ultimate decision-maker," he said.

If you don't hire a consultant, Mr. Wasserman urged against stealing ideas included in a consultant's proposal.

"If you decide not to use a consultant, but like the consultant's proposal, don't use it," he said. "Come up with your own ideas or use those of the consultant you select."



Mr. Wasserman



Mr. Heiring

IN BUSINESS, THERE'S MORE THAN ONE RISK. THAT'S WHY YOU NEED A MORE-THAN-ONE-COMPANY AGENT.



Today's businesses face all kinds of risks. From computer losses to pollution liability. From product recall to product liability. From business interruption losses to terrorism. And new risks are emerging every day. That's why so many businesses seek the advice of an Independent Insurance Agent to help them anticipate and manage those risks.

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Retiree program

Continued from page 3
consumers," Ms. Anderson said.

Allstate's program helps inform retirees—and employees—about health care costs and options.

The program was put in place when, faced with premium increases of "18% and 19% annually," Allstate changed its health coverage for employees and retirees from a plan with no deductible and no coinsurance to one with a \$100 deductible and 20% coinsurance, Ms. Anderson said.

The retiree communication program helped retirees understand the plan change and the reasons for it, she explained. Now, it has been expanded to teach retirees how to



Ms. Anderson

be wiser consumers of health care.

The program has incorporated several types of "message vehicles," Ms. Anderson said. In addition to articles about health care cost containment in the company's already-established retiree newsletter, a special quarterly flyer called "Retiree Update" was mailed to retirees' homes.

The first "Retiree Update," mailed in January, covered second surgical opinions. A pamphlet from the Department of Health & Human Services also was inserted in the newsletter with toll-free telephone numbers for health care hot lines, including those of the American Kidney Fund, the Hearing & Health Line of the Better Hearing Institute, the National Women's Health Organization and the Cancer Information Service of the National Cancer Institute.

The topic of April's issue was "Can you talk to your doctor?" and July reviewed Medicare assignment.

Future issues will cover health care alternatives, physical fitness for older people, nutrition, generic vs. prescription drugs, hospice care, weekend admissions and health care legislation.

Through its newsletter, Allstate also is encouraging retirees—and active employees—to use several cost-containment measures the company offers, including alternative care options like health maintenance organizations.

"The savings are substantial," Ms. Anderson noted. For example, she said in a recent pilot program



Mr. Ostroff

in Chicago, nine retirees enrolled in an HMO, saving Allstate \$8,000 in one year.

And, she and Mr. Ostroff both noted savings from HMOs and other measures, like second surgical opinions, are especially important in light of skyrocketing health costs for older people.

"Health care costs for the 55-year-old and above group are soaring," Mr. Ostroff said, partly because "the number of people 55 and over is growing tremendously."

In addition, the ranks of retirees are swelling because many people are taking advantage of early retirement programs.

"Approximately 33% of men between 55 and 64 years old are retired," Mr. Ostroff said.

And, the cost of health care for these retirees is very high.

Per-capita health care spending by people age 55 to 64 is 83% higher than by people age 18 to 54, Mr. Ostroff said.

Medicare also adds to the high cost of health care for retirees, Mr. Ostroff said, because of cost-shifting both by the government and by the medical community.

Since much of this health care expense is paid by employers, employers should teach retirees to be wise health care consumers, the experts agreed.

But, getting retirees to accept and use cost-containment measures and to take more responsibility for their health care can be difficult, especially when they are accustomed to first-dollar coverage.

So, Mr. Ostroff encouraged benefits personnel to begin the education process early, "when employees are pre-pre-retirees."

And, he suggested that companies consider training retirees to help communicate benefit information to active employees, such as by conducting group meetings and manning benefit hot lines.

These retirees also could talk with other company retirees about their benefits, he said.

"What better way to have retirees fully understand their benefit and health cost situation than to learn from other retirees?"

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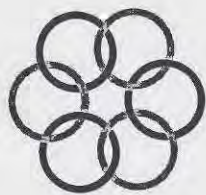
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opinions

A human response would help

COMPARISONS OF THE LEGAL systems in the United States and Japan following the recent tragic airline crashes in each country contrast Americans' rush to the courthouse to sue with the Japanese tradition of accepting settlements.

Many observers contend that Americans have been corrupted into greedy litigiousness following a tragedy by the hordes of lawyers in the United States while the Japanese, with far fewer lawyers, are not so misled.

We think one can also point to the strikingly diverse responses of Japanese and U.S. executives to disasters involving their companies as another reason why Americans sue and Japanese settle.

In Japan, the president of Japan Air Lines stood, with head bowed, to greet in sympathy and apology the arriving relatives of those killed in the JAL crash.

In the United States, corporate executives too often remain invisible and silent in the face of massive human tragedy, or at best are represented by spokesmen who merely utter denials or "no comment."

If U.S. corporate executives instead were to immediately express what should be genuine regret for catastrophes involving their companies and showed sympathy and concern for the victims, they could avert victims' tendency to seek revenge.

A human response to tragedy also could have a beneficial effect on judges and juries, who often view corpo-



rate defendants as cold-hearted and lacking remorse.

The substantial cultural differences between America and Japan admittedly dictate the contrasting response of those struck by tragedy, but that doesn't preclude Americans from learning from the Japanese.

letters

Greedy lawyers compound tragedy of Delta crash

To the editor: Once again it is "open season" on the airlines, aircraft manufacturers and their insurance companies. Regardless of the innuendos, Monday-morning quarterbacks and self-styled experts, Flight 191 crashed in Dallas due to a weather phenomenon that was intense, unexpected and unpredictable at the current state-of-the-art as respects wind shears. This, of course, does not lessen the personal tragedy.

Unfortunately, part of the tragedy that will be ongoing is the result of a system that allows a breed of attorneys to scavenge unjust, unearned dollars based on the contingency fee system which has reached as high as 50% in some cases. Too great a percentage of attorneys is moti-

vated by contingency fees rather than by equitable settlement of cases. This system, coupled with liberal judges that stretch definitions of liabilities and juries that, out of sympathy, hand out outrageous awards without thought to degree of negligence, will force us into a society without insurance. In the meantime, many of Flight 191 victims' families will be caught between companies trying to remain viable and the tort attorneys dragging out their grief over the years by long, painful and expensive legal confrontations.

Ultimately, the price of inflated attorneys' fees and unrealistic awards are borne by the consumers. We end up paying higher prices for goods and services and may lack necessary products, such as

a vaccine many children lacked last fall. The one company still producing it could not meet demand after others went out of business because they could not afford, or in some cases buy at any price, the necessary insurance.

Hope for the aviation and insurance industry's future is bleak, as the population of attorneys continues to grow in relation to the general population. Perhaps, overall, the answer is for each family to have an attorney assigned as a dependent after graduation from law school rather than subsidize him under the current system. It would more truly reflect lawyers' impact on us.

Joseph L. Benero
Richardson, Texas

Double-talk is the language spoken by ISO to back new CGL forms

To the editor: "Regulators question claims-made form" (BI, Aug. 5) confirms two things: First, the regulators who attended that conference did have the right central issues in mind. And, second, the Insurance Services Office should be contracting with Professor Irwin Corey and Casey Stengel to represent them. I have never seen such proliferation of double-talk in my life.

Fred Marcon, ISO senior executive vp and chief financial officer, said, "Some insurers will use the claims-made form so that they may secure needed reinsurance and offer lower prices to insurance buyers and gain market share. . . . However, in general, I expect an orderly implementation of the claims-made form."

It seems to me that anyone even remotely aware of the recent "market share pricing fiasco" followed by "massive rate increases and coverage restrictions" would consider Mr. Marcon's comments about an orderly implementation as ludicrous.

When Tom Bond, Texas insurance

commissioner said, "It seems that you are gaining financial certainty by shifting financial uncertainty to your insureds through this contract," Mr. Marcon's response was "I don't agree there is less risk with the claims-made form; perhaps there is more certain risk." If the first part didn't confuse you, this one surely did, because everything I have ever learned about risk is that it is by definition, uncertainty; therefore, how can you have, in Mr. Marcon's words, "certain" uncertainty?

This logic is certainly in the vein of Professor Irwin Corey and Casey Stengel, and I'm sure the legal community is anticipating a great increase in litigation, not over benefits due to claimants, but over coverage disputes. In the final analysis, I think I'm going to make plans for my 3-year-old son to enter law school as soon as possible.

H. Wayne Foster
Manager Marketing
Corporate Service Inc.
Livonia, Mich.

Loss profiles raise questions

To the editor: The claims-made commercial general liability policy will make detailed loss profiles mandatory. The question is: "Can this be accomplished by the insurance industry for the benefit of the policyholder?"

Many insurance companies do not provide professional loss profiles. The claims data received reflects incorrect information. Insurance agents' loss files are not

professional. Tracking paid and reserved occurrences will become a nightmare.

The agency system is the insurance industry's sales arm. The majority of agents do not retain loss data. Those that do have stale information. This will cause much confusion in an already confused marketplace.

Magnifying the situation is the policyholder's reliance on the insurance company's agent to retain loss data. Policyholders do not retain claims details. The payment of liability claims is rarely communicated to the policyholder.

Underwriters are holding detailed loss data for the past three to five years on all new submissions. Either the information is not available, it will take 30 days to assemble, or the insurer will charge the client for the material. Policyholders are finding themselves in a weak position when negotiating with a prospective underwriter. Direct writers, whose representatives have no idea what claims data consists of, are demanding detailed loss histories. One insurer recently requested \$25 for loss information regarding a previous client. Is the wave of the future?

This "Catch-22" environment is the creation of our insurance industry. Once again the policyholders are the victims. Poor financial management is an industry concern. The handling of claims information will become the major issue of 1986. The circus will get worse.

Samuel L. Rosenthal, CPCU, ARM
Industrial Insurance Management Corp.
Richmond, Va.

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Benefit managers, communicators rate audio-visuals' effectiveness

By DANA DAVIS

NEW YORK—What makes a successful benefit communication presentation stand apart from less-effective counterparts?

Benefit managers and communicators had a chance to judge for themselves during a special session called "You Be The Judge," at the Business Insurance Employee Benefits Communication Conference held Aug. 5 and 6 in New York.

Conference participants viewed four of the audio-visual entries in this year's Business Insurance Employee Benefits Communication Awards competition. And, they rated the effectiveness of the presentations on several levels during the two-hour session led by Herbert Zeltner, president of Herbert

Zeltner Inc., a marketing and communications consulting firm in New York.

Before he turned the session over to the conferees-turned-critics, Mr. Zeltner reminded them that, "The key to effective communication—regardless of subject matter and goal—is for the 'seller' to think consistently and honestly in terms of his target audience."

The judges were asked to rate each presentation in five areas: objectives, strategy, content, presentation and effectiveness.

The areas covered during discussions of the presentations included:

- The advantages and disadvantages of using a celebrity in a benefits communication piece. Several viewers agreed that, though using a movie star was a "real attention-getting device," it could backfire if employees focused on the actor rather than the message.

- The quality of acting. Several members of the audience felt some videos featured inferior acting.

One participant summed it up by saying, "The real-life scenarios were not real life. I don't know of anybody who discusses 401(k) plans while playing tennis."

- Special effects. In one video, whose theme was the future, soft focus and hazy lighting were used throughout. But, several viewers said they found this distracting, especially since they could not make out the actors' faces.

"Here the company is trying to give a clear presentation of what the future has to offer its employees, and yet the blurry focus seems to contradict that. It's distracting," one conferee said.

- Knowledge of audience. The clever animation, combined with a clear, concise script, earned high marks for one video featuring detailed information about the company's overall benefits.

"The message was excellent, and the program stuck to its objectives. It was obvious the company expected its audience to have an above-average intelligence," one member of the audience said.

- Use of music. Every video used music to some extent, but the viewers disagreed about the effectiveness of the music.

For example, one video sparked conflicting comments about its music. One listener said, "The music was enjoyable and served as an excellent accompaniment to the visuals. It prompted my attention and clued me in concerning a point that might be of special importance." But, another found the same music "distracting, redundant, monotonous and was an absolute overkill."

- Content and focus. Several participants felt one video failed to meet its stated objectives. "Here's a company that had recently instituted new cost-effective features concerning its medical coverage. Not once was there any mention of the company's cost in the program or a statement about who would have to pay more," said one expert.

But, another video brought rave reviews: "This video met every single objective cleanly, concisely and beautifully," said one viewer.

Mr. Zeltner concluded with some words of comfort for those companies whose videos were judged less than terrific.

"It's better to get a bad response than no response at all," he said. "The worst thing is to have a non-eventful washout, to have someone remark, 'This is so dull.'"



Mr. Zeltner

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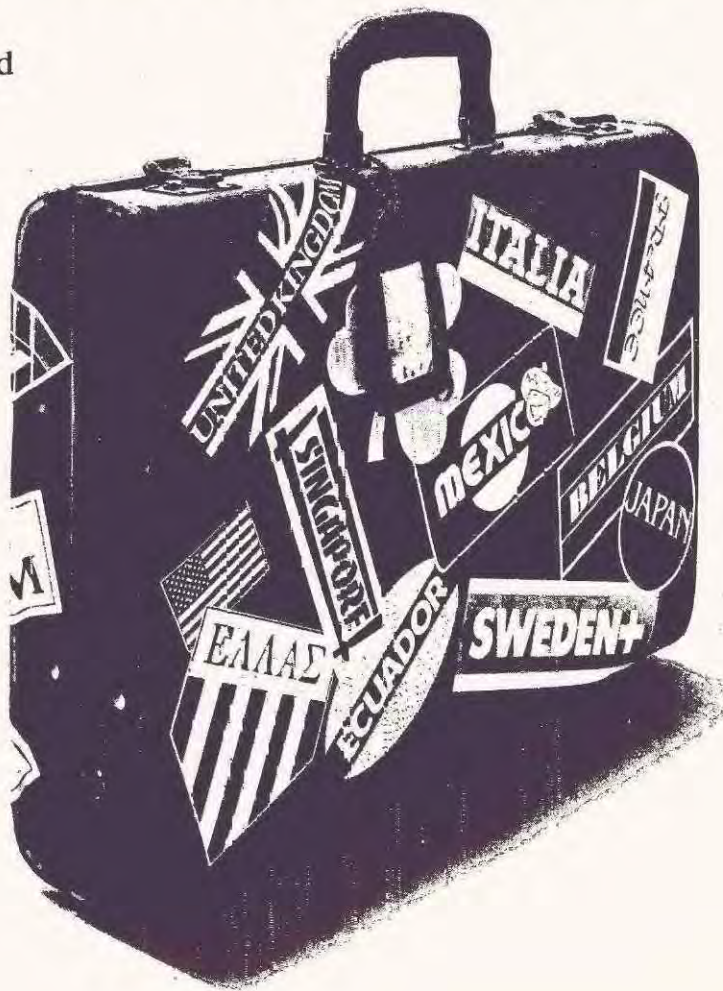
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Listen to employees, consultant advises

By DANA DAVIS

NEW YORK—Asking for employee input and paying attention to what workers say can play a major role in helping employees better understand and appreciate their benefits, a consultant says.

Establishing clear and open lines of communication with employees is essential to this process, said Suzanne M. Kenney, managing partner of employee listening consulting activities at Hewitt Associates in Lincolnshire, Ill.

Management "should make an effort to obtain and listen to employee feedback. How you put feedback into perspective and how you deal with it will aid you greatly in making a more effective communication effort and benefit presentation to employees," Ms. Ken-

ney told the *Business Insurance* Employee Benefits Communications Conference.

The most obvious time for employers to be concerned about communication with employees is when a problem is brewing, Ms. Kenney noted. For example, when a company is forced to cut benefits to deal with rising costs, good communication can help "take the employee from a situation of not knowing or understanding the total problem to understanding management's point of view."

But, Ms. Kenney also stressed the



Ms. Kenney

importance of listening to employees even if there is no problem.

"It's good to know what people are thinking. And it is definitely worth the time and effort," she said.

One way to generate employee feedback and open channels of communication is through employee surveys. Different kinds of surveys can be used to obtain a variety of information, she said.

For example, "You can conduct a census or a random sample" on general employee attitudes, she said. This helps benefit communicators to take "a telescopic view of the employee population."

Surveys also can help benefit managers "focus their view similar to that of a microscope" and isolate and examine recurring problems, Ms. Kenney said.

Ms. Kenney said surveys not only help management find out about problems, but also let employees know that management cares what they think.

"If the employees know that management has their best interest at heart, they are more likely to have an open mind" regarding changes in benefits, she said.

"But if there is a more adversarial atmosphere, if there have been layoffs or the environment is negative, their acceptance of some types of information is going to go according to the prevailing attitude," she said.

To illustrate the importance of listening, Ms. Kenney cited data from a survey of 100,000 employees conducted by Hewitt over the last five years.

Sixty percent of the employees surveyed felt "they did not receive enough information to satisfy them about their benefit package."

And, 71% said they did not have a good idea of how their benefits compared with those offered by other employers.

Ms. Kenney told her audience that management could look at this statistic in two ways.

"For those companies with packages below par, this information can be comforting. But for those company's whose employees suffer from 'the grass is always greener elsewhere' syndrome, this may not be the case," she explained.

Hewitt found that 66% of the employees estimated the cost of their benefits as lower than the actual cost. Only 25% correctly estimated the cost of their benefits, while 9% estimated the cost as higher than the actual cost.

"This shows that employees definitely underestimated the worth

of their own benefits. Benefits personnel need to communicate where this money is coming from," Ms. Kenney said.

It is important to communicate clearly and frequently not only the amount that the company is paying toward benefits, but also the rising costs the company is facing and any other problems that may make it difficult for the company to meet its benefit obligations, she said.

For example, she noted that 58% of the employees surveyed by Hewitt said that, if it were up to employees, they would not institute cost-containment measures or benefit reductions.

However, many of these employees said their answer might depend on whether the "company was facing tough times when this issue was explained to them," she said.

Above all, Ms. Kenney encouraged benefit communicators to remain positive and not emphasize the negative.

"Nothing but the facts often makes for less-effective communications," Ms. Kenney said.

"At one company I know of, they were instituting a 401(k) communications piece about tax savings. Throughout the voluntary meetings, the leader kept telling employees, 'Don't invest in the plan if you ever think you may need this money.'"

Because of this "fear factor," enrollment in the program showed little growth, Ms. Kenney said, and consultants eventually were called in to "present the information in a manner that would be received more positively by employees."

"We need to know what employees are thinking," Ms. Kenney stressed. "We can accomplish this by listening to employees."

Employers should lobby now against benefit taxes: Brahs

By DIANE LYNN KASTIEL

NEW YORK—Employers that oppose proposals to eliminate the tax-favored status of employee benefits should now let their legislators know their feelings, one expert says.

Congress is scheduled to reconvene Sept. 9 and until then, a "window of opportunity" exists for employers to rally in support of benefits' tax-favored status, suggests Stuart Brahs, executive director of the Washington-based Assn. of Private Pension & Welfare Plans.

"As we speak, the Congress is in their home states and districts to find out what people are thinking," Mr. Brahs told benefits and communications professionals at the annual *Business Insurance* Employee Benefits Communication Conference in New York.

Although employers and employees generally oppose taxation of employee benefits, most have not made legislators aware of this opposition, Mr. Brahs said. All legislators—not just those responsible for drafting tax proposals—should be targeted by employers, Mr. Brahs said.

This is the time for employers to contact representatives, even if they're not on the House Ways and Means Committee to let them know what they think about the tax proposals, he said.

Mr. Brahs also reminded employers, employees and employee benefit consultants of how much clout

they can wield.

"The members of Congress are very interested in the opinion of the folks back home that renew their contracts every two or six years," he said.

"Yes, there will be a tax bill," he continued. "But I am not going to presume, on the 6th of August, to tell you what the final bill will be. And that's where you come in—you have to communicate to employees and to members of Congress exactly what impact these proposals will have on your benefits."

In fact, the role employers have in educating legislators about the impact of their proposals is extremely vital, Mr. Brahs said.

"You sit down and talk with members of Congress on employee benefit issues for 10 or 15 minutes and their eyes glaze over," he said. "On a good day, maybe five out of the 535 of them know what they're talking about on employee benefits."

Legislators are ignorant on benefit issues because "it's not a very sexy issue," Mr. Brahs said. Legislators would rather become experts in such high-visibility areas as national defense or foreign policy, he said, adding that it is up to employers to "raise legislators' awareness."

He also admonished employee benefit professionals not to buy arguments that employee benefit taxation is less of a threat than proposals for higher corporate taxes, or that fighting either of these taxes will detract from attempts to thwart the other.

"Whatever we do in the area of employee benefits is not going to undermine our position on other tax issues," Mr. Brahs said.



Mr. Brahs

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Computers can untangle benefit questions

By DIANE LYNN KASTIEL

NEW YORK—As employee benefits become more advanced, employers are using high-tech systems to make benefits more understandable to workers.

"It was apparent to us that employee benefits were getting more complex," Pamela Keeler, director of advanced benefit communications at Metropolitan Life Insurance Co., told the *Business Insurance Employee Benefits Communication Conference*.

This realization led Metropolitan in 1983 to develop a computerized communications system, later dubbed Showcase, to communicate the insurer's benefits to its employees.

The system, which has been used by the insurer as a prototype for

similar computerized communications systems it now designs for clients like American Express Co., initially was available to 10,000 employees in Metropolitan's New York home office.

When the system was first installed, employees had access only to information on the company's savings and investment plan, she said. Since then, Showcase has been made available to 16,500 employees and expanded to include information on other benefits, including medical, life and disability plans, as well as information on



Ms. Keeler

company loans and paid holidays.

Ms. Keeler said that with the exception of a few employees at small offices in remote locations, all of the company's 36,000 employees will have access to Showcase by the end of October.

In the future, the system will also be adapted to allow employees to make benefit changes by computer during enrollment periods, rather than having to go through the personnel office, she said.

One of Metropolitan's concerns in developing Showcase was the phenomenon of "computerphobia," which Ms. Keeler said afflicts people who see computers as complex and difficult to use. "Focus groups" of employees who never had worked with computers were asked to provide input during development, she explained.

Emphasis throughout development was on clear, concise communications—both in the explanation of benefits and in the use of the computer terminal, she said.

To use Showcase, an employee sits at one of the 14 computer terminals located in high-traffic areas like lunchrooms and lobbies at company locations throughout the country. The employee first punches in his or her Social Security number and employee badge number, then selects the benefit he or she wants to learn about from a benefits "menu."

The employee then runs through the program he or she selects by following instructions that flash on the terminal's display screen. The terminals also are "interactive," allowing employees to key in pertinent data and receive immediate

feedback.

From the company's standpoint, computerized benefit information is easy to update, Ms. Keeler said, adding that after the initial start-up costs, computerized communication can be less expensive to maintain than many traditional forms of communication.

Start-up costs to program Showcase were \$380,000, Ms. Keeler said, an amount that excludes research and development and hardware.

Showcase costs about \$67,500 a year to operate, or 35 cents a month for each employee, Ms. Keeler said, an amount she considers "minimal, considering the number of people using it." While utilization rates vary from office to office, Ms. Keeler estimated that, on the average, about 35% of the employees use the system at least once a month. ■



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PROVIDENT MUTUAL
SECURITY THROUGH FINANCIAL SERVICES

Personal touch returns with high-tech printing

By DANA DAVIS

NEW YORK—Employers can use a variety of high-tech tools, including laser printing, to bring old-fashioned personalization back to benefits communications, a consultant says.

"Although face to face is still the best method used to communicate, in today's companies it is inefficient," according to Deborah A. Huffman, who is vp of communications with Frank B. Hall Consulting Co. in Hawthorne, N.Y.

But, Ms. Huffman told the *Business Insurance Employee Benefits Communication Conference*, employers must add a personal touch to their communications since workers are bombarded with information from all kinds of sources.

"The personalization of generic information becomes more and more necessary, considering the growing amount of information people are constantly receiving," she said.

"A few years ago, the average human was bombarded with 50,000 'bits' of information a day. They also received an average of 250 pounds of junk mail a year. Today, via computers, many people have access to 500,000 more pieces of information."

"How do we get someone to notice one letter in the midst of 250 pounds of junk mail? How do we even get them to open the envelope?" Ms. Huffman asked.

The answer, she said, is to provide "more accurate, personalized and specific data to employees. We need to sort through the maze and get their attention."

Laser printing can be a vital tool for getting employees' attention, she said, because it allows individualized information to be incorporated in benefits communication material.

Such personalization "enhances readability," Ms. Huffman said. "If I open up my benefits statement and on page 17 see specific figures and information pertaining just to me, I'm more likely to read from page 1 up through 17."

Laser printing produces images and type by using electronic impulses programmed by computers.

Because the computer can command the printer to print specific information on each piece of material, laser printing allows employers to personalize benefits statements with such data as employee's name, address, date of birth, date of hiring, Social Security number and the amount of money the company spends on his or her benefits.

The statement also can show an employee what kind of coverage he or she has elected.

In addition, it can include information, like projected retirement income under various options, to help an employee make more-informed decisions.

"The purpose of all this is to make our reference documents more precise and to target the material to a specific audience or individual," Ms. Huffman said.

"Laser printing entails few of the pre-production steps offset (printing) requires and they work quickly and quietly," explains Phil Soper, a specialist in customer technical services with Eastman Kodak Co. in Rochester, N.Y.

"There are fewer mechanics because most forms are software-controlled and unlike a typewriter, the printer never actually puts an imprint on the paper," Mr. Soper said.

But, laser printing is not the only way to make benefits information personal and immediate, Ms. Huffman said.

For example, the benefits information can be designed to be "interactive," to encourage employees to make decisions, through things like self-quizzes.

"You've seen these," Ms. Huffman said. "They appear in all different magazines. They're designed to help you personalize generic information. You can rate yourself by the amount of points you score. The same technique can be applied to benefits information."

Other media, including videotapes, personal computers and teleconferencing, can be used to encourage employee interaction, she said.

Whatever communications media an employer chooses, the important thing is to give employees the personal information they expect and need, she stressed.

"Remember, for effective communication results, we need to think in terms of the employees' expectations," Ms. Huffman said. ■



Ms. Huffman



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RISK CONTROL ■ CLAIMS SERVICES ■ HEALTH AND REHABILITATION ■ INFORMATION SYSTEMS ■ EDUCATION

Print media can ease bad news: Expert

By DIANE LYNN KASTIEL

NEW YORK—Employee benefit managers today are often bearers of bad news, one consultant says.

The advent of cost containment, with its concomitant cost shifting and benefits reductions, has left the benefits communicator with a challenge: communicating bad news in the best light possible, explains Martin Lapidus, a consultant with Towers, Perrin, Forster & Crosby.

Mr. Lapidus, who spoke at the annual *Business Insurance Employee Benefits Communication* conference in New York, advised corporate benefit officials on ways to use print media to communicate both good and bad news.



Mr. Lapidus

The best strategy in communicating any news—good or bad—is to be honest, straightforward and to not sugar-coat anything, according to Mr. Lapidus.

"Associated with credibility is acceptability," Mr. Lapidus said, pointing out that employees are more apt to accept bad news if they believe the company is being honest with them.

However, there are ways to cushion the blow of bad news. Mr. Lapidus recommends telling employees the "bad news" honestly, but putting it in perspective so that the employee understands the need for the employer's action.

For example, he said, if the employees' contribution to their medical plan is going to increase, the employer may want to point out that the company's premium contribution is high or even higher than the employees'.

Or, the company may want to communicate the employees' contribution increase concurrently with an increase in the company's contribution, Mr. Lapidus suggested.

Printed material should be tasteful, Mr. Lapidus said, especially when a benefit manager has bad news to communicate.

For example, don't use a flashy, four-color brochure to announce benefit cutbacks, he advised. Simple, blue or black ink on white or cream paper is most appropriate in this situation, he said.

"Sometimes the nature of the benefit helps determine the type of print communication used," he said.

Benefit communicators can be the bearers of good news as well, however. One challenge today, in fact, is communicating to employees the availability of 401(k) plans, he said.

Convincing employees to join 401(k) plans that don't offer matching employer contributions can be a difficult task, he said. But, if used correctly, print media can generate employee interest in the plan, Mr. Lapidus believes.

"You have to build to a peak," Mr. Lapidus said. "You begin with the simplified communication and build to more complete print information."

For example, "teasers" sent to employees that announce the new plan without giving much detail, arouse employees' curiosity. This method also increases the chance employees will read more detailed information on the plan when it is sent and that, based upon their reading, will decide to participate in the plan.

Print communications can be "jazzed up" graphically to get employees' attention, Mr. Lapidus said.

Another attention-getting strat-

egy in print communications is to use employees' pictures, Mr. Lapidus said.

"One way to get people to pay attention to the print communication is to use their pictures in it," he said, adding that an employee's permission to use his or her picture always should be obtained before the picture is printed.

Employers should look beyond the standard forms of print communications, like pamphlets and booklets, to communicate benefits information, according to Mr. La-

pidus.

For example, a "calculator wheel" can be used by employees to determine the return on investments in savings and profit-sharing accounts.

The wheel also may motivate employees to participate in such plans because it can calculate how much employees earn when they invest their money in these plans, Mr. Lapidus said.

A variation on the calculator wheel can be used to show employees different options that are avail-

able in flexible benefits plans, he added.

Changing or updating print communications should be a gradual process to maintain a sense of consistency, he advised.

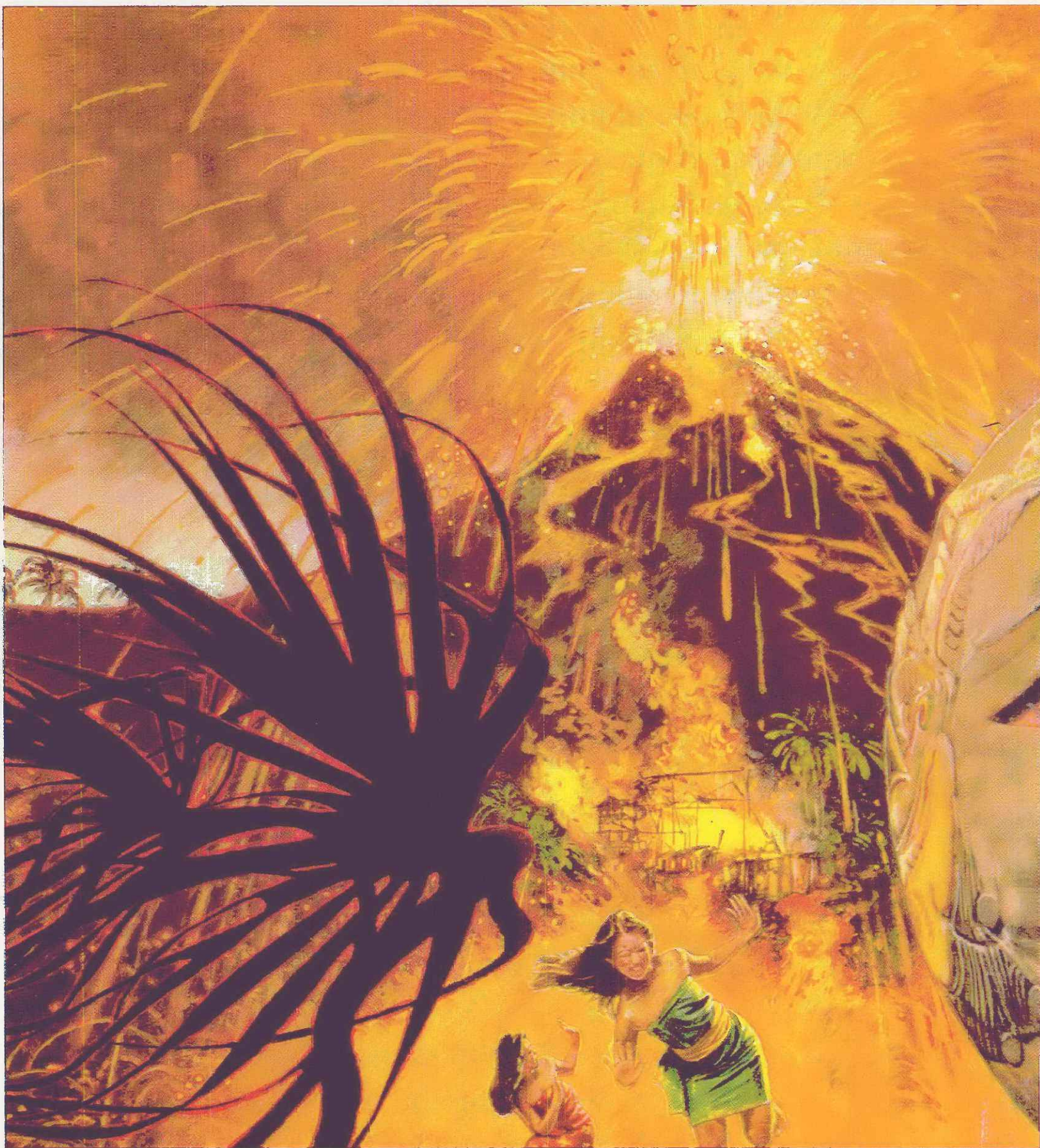
For example, a company that decides to change the overall appearance of a benefit booklet may want to retain a previously used symbol in the corner of the booklet, Mr. Lapidus said.

Above all, benefit professionals should not underestimate the value of print communications in the face

of videotape and computerized communications, according to Mr. Lapidus.

"You have to have employees appreciate the value of the benefits dollars, and you have to use communication to support effective administration of benefits," he said. "Print communication does this very well."

"What employees need to know is very similar to what management needs to say—'What's the value of this and what's in it for me?'" he said. ■



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Benefit communicators need to plan ahead

By DIANE LYNN KASTIEL

NEW YORK—Benefit communicators must be well-prepared in order to avoid the sleepless nights and headaches associated with communicating benefit changes, says one corporate benefits communicator.

"Certainly things can be crunched into a week or two," says Stephen Wasserman, director of benefit communications at Dart & Kraft Inc. in Northbrook, Ill. But, from the time a benefits communicator learns of a

possible benefit change and its implementation, "six months is not a loose time frame."

For example, "a month is a good amount of time to do a writing project—eight weeks for an audio-visual," Mr. Wasserman told benefits and communications professionals at the *Business Insurance* Employee Benefits Communication conference in New York.

Other time-consuming tasks include obtaining needed approvals, the actual production or printing time and the training of employees

to help present the information.

Mr. Wasserman suggested several steps the benefits communicator should take when designing and communicating a revamped benefits program:

- The communicator should make himself or herself part of the team that works on the entire benefit overhaul. By working closely with the orchestrators of the overhaul, the communicator can identify early indicators of changes or problems, and develop a contingency plan.

"Keep your sensors up," Mr. Wasserman said. "When you get an inkling, stick your nose in—find out what's being considered."

- When the benefit changes are determined and the communications project gets rolling, develop a task force made up of key benefits and communications personnel, as well as representatives of other corporate departments, to develop the communications campaign.

"Employees will be a lot more enthusiastic about implementing the new benefits plan when they

think it's their plan and not the ivory tower's plan," Mr. Wasserman said. "The trick is to get people to buy in to your ideas or make them think it's their idea."

- Develop a chart that shows the interrelationships and outlines responsibilities of the benefits and communications staff, along with other departments involved in the change.

- Distinguish between the communications and benefits objectives of the plan. "Communication objectives are not necessarily what the benefit objectives are," Mr. Wasserman said.

For example, Mr. Wasserman said, a benefits communicator may have to communicate a benefit change that asks employees to make a higher contribution to their health coverage. However, the true communication objective could be to convince employees to be wiser consumers of health care, he said.

- Use the communications objectives when "packaging" the media.

For example, if the objective is to make employees think a new 401(k) savings plan is a generous, desirable offer, you may want the communications campaign to look very slick and expensive. But, an expensive-looking campaign would be inappropriate to communicate benefits reductions or cost-shifting, Mr. Wasserman said.

- Seek approval for each step while developing the campaign and communicate regularly with top management.

The benefits communicator should periodically check in with these decision-makers and inform them of his or her progress, Mr. Wasserman said. This is especially important at key times in the program, such as after the plan's "packaging" has been formulated.

"You can't be too careful in this area," he said. "Once you package the approach, go back to the decision-makers and make your recommendations. Tell them, 'This is your program. These are your recommendations,' and most of the time it'll go over pretty well."

- Once a budget is set, line up communications resources immediately. For example, have a printer lined up in advance, instead of starting to look after the decision to hire one is made, Mr. Wasserman said.

- Define all tasks and make a clear assignment of who will do what. Make sure people know when and from whom to get approval along the way, he suggests.

- Train departmental supervisors about the revised benefit program and how it's to be communicated.

"If the corporate office presents the program, it's probably not going to be effective," Mr. Wasserman said. "Employees are much more comfortable dealing with people they know."

"Also, there's nothing worse than having an employee go to a supervisor and say, 'I don't understand this benefit,' and having the supervisor say, 'What are you talking about?' And, train supervisors on what to do when they don't know an answer, which is to say, 'I don't have the answer but I'll get back to you.'"

"Never let them wing it—that'll always get you in trouble," he said.

- If you're showing an audio-visual presentation, have on hand printed copies of the script, graphs and other instructional aids. The benefits communicator can then avoid having to rerun the presentation for an employee who has questions on something he or she saw.

Finally, he advised, "Evaluation is very important. Find out what was weak, what could be done better, to help you the next time." ■



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ASK A RISK MANAGER

Self-insurers must meet governmental requests

Q There seems to be a growing tendency on the part of some state workers compensation agencies and other governmental entities that have approved self-insurers to require those self-insurers to submit their safety and health plans and procedures for approval. Have you encountered this, and what are you doing about it?

A Yes, we have had these requests. And, to keep our self-insurance approval effective, we comply. For example, one Western state has requested an elaborate application outlining our safety program. A federal agency has required our facility to take over the formal safety inspection program formerly handled by federal agency employees.

The Western state's "safety" application is detailed and broad in the scope of information it requires, including:

- A copy of the safety and emergency program. The safety program must be outlined and management involvement described. Other items considered important are record-keeping requirements, how the safety policy is being followed, training requirements, inspection/accident correction procedures, workers involved in the process and the names of outside consulting services used.
- The names and titles of senior management at the facility.
- How the plant/facility stays on top of requirements of the Occupational Safety and Health Administration, how risk priorities are established and how supervisors' qualifications are determined, including the scope of their training.

The governmental agency has decided to eliminate its own inspection service and transfer all these duties and obligations to those companies occupying and operating the facility.

This makes sense, we think, and should result in a more effective and meaningful program.

Reports keep officials informed on big claims

Q What type of reports do you use to keep top management informed on large claims activity—and to show your control in supervising the handling of claims in litigation?

A There is no doubt that senior operations management is continually interested in those large claims that can cause havoc with their profit-center forecasts and invite questions from home office staff.

We attempt to solve the communications problem in several informal ways and with four quarterly reports.

Informally, we phone division presidents and their financial officers to personally discuss large settlements. Any and all information is shared.

Following an understanding and acceptance of the case facts, the question of how this affects "my insurance expense" must be answered. An analysis of the division's combined retro plan and the status of premiums paid to losses incurred must be made to

answer this question.

While the financial effect of large claims is paramount in the mind of every division president, our question is really centered on how we communicate this activity over time and show control in the supervision of litigated cases.

Our first quarterly report is titled "Large Claim Report" and shows the number and current incurred value of all workers compensation cases of \$50,000 and above and all general and auto liability cases of \$25,000 and above.

Attached to each quarterly summary is a detailed listing of these open claims, providing such specifics as location, date of accident, claimant's name, a brief description of the accident, total incurred estimate, payments to date and outstanding reserve. The report rolls over the last eight quarters, showing growth in the numbers and value of these claims. It is a real eye-opener.

An interesting statistic here is that the bulk of the claim expense—perhaps 80% of the total—is made up of claims below these levels of loss. From a risk-control standpoint, this lower level is where local management needs to focus its loss-control programs.

Additional quarterly reports include:

- An approved defense counsel list, showing the firms approved to litigate our cases by line of coverage.
- A litigation schedule for senior counsel, showing by division the type of action, date action was filed, attorney involved, subject matter, amount in controversy, counsel and state of the proceedings. This quarterly report is prepared by our claims administrators.
- A quarterly schedule of fees paid to outside attorneys.

Together these reports provide a listing of large claims for operations management and, with the additional reports to senior counsel, a communication of their involvement in and approval of our claims-handling and litigation activity.

It's worthwhile to figure savings of self-insurance

Q Have you measured the premium and expense difference between a 100% insured property and casualty insurance program and one principally self-insured. If so, how?

A Yes, we have done this in a general way, measuring the savings in expense if we manually insured our property program using bureau rates. Then, for the liability program, we based our "insured" estimates on the ultimate value of known claims grossed up to cover those expenses needed to cover taxes, fees and brokerage expenses.

Our master property program, with some 700-plus locations, is manually rated using bureau rates. The principal reason for doing this was to develop an equitable allocation method to spread the cost of our property insurance premiums, for both the insured and the self-insured expense. This exercise has developed into an almost-unmanageable job, but one for which my broker gets very high grades. To measure the difference in cost, we compare one-half the bureau-rated expense with our package program expense, and still measure the savings in the several millions of dollars.

For the liability program, we average the combined workers compensation, general and automobile liability known claims for the past 3½ years. Before averaging these claims, we apply actuarial factors to develop ultimate values.

Then we gross up these claim values for taxes, fees

and brokerage expense. This percentage is held to a modest plus 23% and does not include claims administration expense, which we handle separately. We do not make any calculation for cash-flow savings, use of money or investment income from reserves. Comparing our self-funded/insured program to a conservative insured program produced for us a savings in excess of \$2 million.

We then reduce these savings by our department expense to arrive at a net savings. It generally looks good.

Tenants can take steps to protect themselves

Q How can tenants in leased buildings protect themselves when they are required to sign leases obligating them to be responsible for building damages to such items as overhead garage doors, interior walls and piping—items not installed by them? The landlord's coverage has large deductibles, and the general liability contract has a care, custody and control exclusion.

A There is no easy answer, but here are several approaches. One risk management solution to this problem would be to have an attorney, along with the insurance broker/agent or risk manager, review these leases and attempt to limit the responsibility for damages to an amount that is reasonably available in the insurance marketplace.

An insurance solution, which would require establishing a legal obligation, would be for the tenant to buy an umbrella liability policy with the lowest self-insured retention available. We have one actual case here where this has worked.

If this is still unsatisfactory and a group of tenants has any leverage with the landlord, they collectively could ask the landlord to buy coverage with the lowest deductible possible and divide among all the tenants the difference in cost between the landlord's current coverage and the low-deductible coverage. This might require some lease amendments and naming the tenants on the landlord's policy as additional insureds.

Using this approach, the "tenants' association" could collect the difference in cost between the higher- and lower-deductible plans and run a small self-insured plan for all tenants. This, of course, would require some special documentation and agreements, which could be made part of the association membership.

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

Ask A Benefit Manager and Ask A Risk Manager answer written questions from readers on risk and benefit management issues.



Mr. Perry

This month's column, on risk management issues, is written by Ralph F. Perry Jr., vp and director of risk management at Amfac Inc. in San Francisco. Next month, Joseph Duva, director of employee benefits and compensation at SCM Corp. in New York, answers benefit management questions.

Mr. Duva's and Mr. Perry's columns appear alternately on the second Monday of each month. Mr. Perry's next column will appear in March.

Address your questions to ASK, Business Insurance, 740 N. Rush St., Chicago, Ill. 60611.

Please give us your name, title and employer; however, Business Insurance will consider accepting unsigned letters.

Computer only as accurate as its data

TO MANY PEOPLE, reports and information derived from a computer has an almost divine quality associated with it. The feeling is, "If it comes from a computer, it must be right."

No assumption could be more dangerous. Although risk management information systems are desired for their ability to evaluate vast quantities of data, perform separate analyses and consolidate the data into meaningful information, much care must be taken about how that data is fed into the computer.

And, once inside the computer, much care also must be taken that adequate checkpoints and validation procedures are employed to confirm what is generated from the computer is accurate.

Imagine a hospital risk manager presenting a financial projection on losses for the upcoming year based on erroneous information.

His superiors take his recommendation on reserve projections for workers compensation, for example, and establish a trust fund based on that projection.

But, in actuality, the data entered into the computer was off by 30%, causing a severe undercutting of projected reserve adequacy and thereby generating a significant deficit that must be made up at year's end.

Too many mistakes like that may result in either a new career path for the risk manager or a greatly undermined credibility with his or her superiors.

The purpose of an RMIS is to assist the risk manager in the analytical/evaluation process, not to undermine the risk manager's effectiveness. This month's column will discuss steps that one can take to assure that the data input into the RMIS is accurate.

Next month, we will discuss how to maintain the accuracy and integrity of that input data.

Assurance that data is sound before it is put into the computer is paramount. If data is gathered or reported erroneously

by the claims organization—whether that is an insurance company, claims administrator or internal claims department—then it will not matter how good the internal audits and validation procedures of the RMIS are.

A breakdown of data accuracy at this point would render the RMIS essentially useless. Although some systems have well-defined editing fields designed to catch obvious mistakes, such as "Feb. 32, 1984"-type entries or abnormally high reserves entered without verification and re-entry into the system, even the best system cannot detect errors such as data that says a claimant suffered a

next month's article.

However, the most common procedure is the loading of the data onto a floppy disk or magnetic tape by the claims organization. The data is then supplied to either the risk manager, in the case of an internally managed RMIS, or to an RMIS vendor, like Corporate Systems or Anistics Inc., for another transfer of that information to a format acceptable by that RMIS configuration.

The key stage during this process occurs at the claims organization, transferring the raw information—claimant name, date of injury, description of injury, initial

organization.

Proper claims management is not only necessary for generating good data for use in the RMIS, but it is essential to the client/insured as well.

Finally, a most important element in this pre-RMIS stage is in the risk manager's hands. It is absolutely essential that accurate location listings are on file with the RMIS vendor and claims organization so that the claims values can be allocated to the proper area. Most providers of claims administration/RMIS services point out that it is here that most errors occur.

It becomes even more difficult when a corporation has many subsidiaries in many locations.

Omitting locations that have incurred claims can disrupt the continuity and accuracy of cost allocation and produce erroneous results.

Even a sophisticated RMIS with good edits and validation checks cannot tell whether a claim that is being assigned to the Milwaukee location actually happened in Chicago. The risk manager, therefore, is responsible for making sure that both the claims organization and RMIS vendor, or the internal RMIS manager, is aware of all locations and the proper codes.

The risk manager's responsibility increases even more for data integrity maintenance if he has a stand-alone RMIS in the form of a microcomputer or a minicomputer.

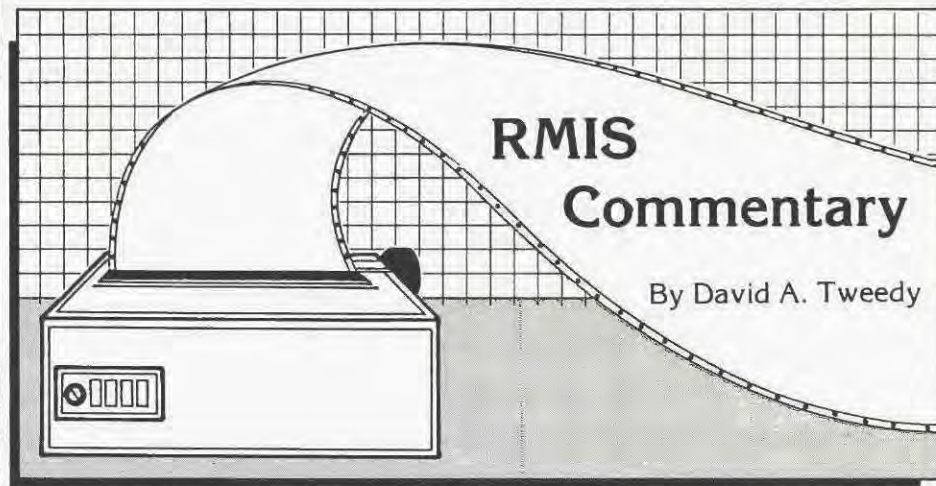
If he does not have outside vendor expertise, monitoring and guaranteeing the accuracy of the data, he must assume this responsibility himself. If there are a small number of claims occurring per year, which are simply fed into a personal computer, that task is not quite as onerous.

However, as claims volume increases and the size of the data base increases as well, there is greater chance for error in data entry and coding for location and injuries.

Therefore, it would be wise for the risk manager to implement a series of quality control checks to measure the accuracy of data entry into the RMIS and coding verification. He may want to hire an outside expert or have his corporate data processing department be involved in this process.

A risk management information system is a great asset to the risk manager in gauging his company's exposure to risk and in mapping potential solutions.

But, its usefulness depends on the accuracy of gathered claims information that eventually is transferred to the RMIS.



fracture of the left elbow when, in reality, he suffered a broken leg.

Nor can the computer detect subtleties in reserving practices. Whereas it might pick up and question a staggering reserve increase, such as the difference in reserve between a minor back injury and a ruptured disc, it may not pick up \$10,000 to \$15,000 in additional reserves on several claims that are unjustified, and thus the risk manager would not be prompted to question the increases.

Therefore, the gathering of accurate data, resulting from sound claims investigation and reporting, must precede the introduction of the data into an efficient RMIS.

And, the adjusters and supervisors of the claims organization have a key responsibility in preparing the information for eventual use by the RMIS and risk manager.

The next step comes in the transformation of that field information into a computer-acceptable format. If you already utilize a full-service vendor providing claims services and the RMIS, like Crawford & Co. or Gallagher Bassett Insurance Service, the transfer of the data to their own risk management information system takes place immediately. That will be discussed in

reserves, etc.—into a computer format. It is important that the claims organization be as accurate as possible in entering the written data into their own computer.

In that regard, the claims adjuster and/or supervisor on the particular account should have regular access and even a quality control methodology to ensure that the information gathered in the field is the same that is entered into their own system. That information will be used by the RMIS vendor and the risk manager to make important projections and evaluations; it must be accurate.

Although much maligned and accused as the weak spot in the data integrity chain, statistics show that data entry clerks are very accurate.

According to Michael Keating of Risk Sciences Group, it's generally the location coding area, which will be discussed later, that causes the most problems.

Nevertheless, having the adjuster and supervisor of the claims organization oversee and monitor the quality of the data that is entered into their own system for eventual transfer to the risk manager's system is quite important.

It is recommended that the risk manager perform regular audits on the efficiency and accuracy of his claims

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



Insanity can negate suicide exclusion in group policy

Insanity, for the purposes of defeating a group life insurance exclusion, may be either a mental incapacity to understand what the physical consequences of one's act will be or a mental incapacity to resist influence to cause one's own death, the Supreme Court of New Hampshire ruled.

The Combined Insurance Co. of America issued a

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.

legal briefs

group life insurance policy under which Mr. Cole was an insured. The policy excluded coverage in the event of suicide within two years from the effective date of the coverage. Within that period, Mr. Cole killed himself by shooting.

His widow sought death benefits under the policy. Combined refused.

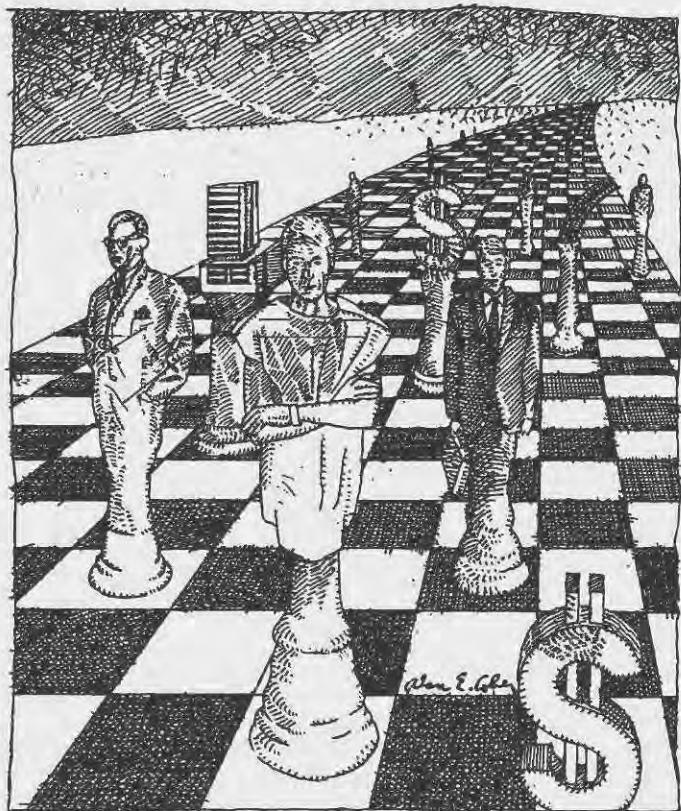
Mr. Cole's widow then brought this suit in federal court, and the court requested the Supreme Court of New Hampshire for an opinion as to

whether, under New Hampshire laws, a suicidal death exclusion can be avoided by proof of the insured's insanity.

The court concluded that the policy here should be read to define suicide as deliberate and intentional. Since insanity in the present context is thought of as a mental condition inconsistent with the capacity for suicide, the court said that the characteristics of insanity should at the least negate the possibility of one or the other elements of understanding and choice that suicide presupposes. *Cole v. Combined Ins. of America*, Supreme Court of New Hampshire, Aug. 10, 1984 (BI/01/Au.-\$5).



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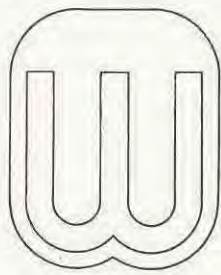
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Satellite coverage

Continued from page 3

pired, in case the probe stops functioning, sources say. Arabsat is insured for \$25 million.

Syncom IV-F3, also known as Leesat, has been disabled since April, when its rocket engine failed to fire after deployment from the space shuttle (BI, April 22).

The decision to try to repair the satellite was reached by Hughes and its lead launch insurance underwriters. The insurers agreed to pay Hughes for the \$85 million loss, on the condition that Hughes bear the cost of the repair and that, if the repair is successful, the underwriters receive part of the revenues from leasing the satellite to the U.S. Navy, sources say.

If the repaired satellite is accepted by the Navy, underwriters will receive \$32 million 30 days after the acceptance, said James W. Barrett, president of International Technology Underwriters Inc. in Washington, lead U.S. underwriter on the coverage. In addition, underwriters will receive 50% of the revenues from the Navy for each of the next four years. This total should amount to almost \$85 million, Mr. Barrett said.

U.S. insurers represented by Intec wrote \$27 million of the Syncom risk. Intec is the underwriting manager for 85 insurance companies led by CIGNA Corp. and including Kemper Group and Prudential Insurance Co. of America.

Underwriters in London, led jointly at Lloyd's of London by Merrett Syndicates Ltd. and the Ariel Syndicate, insured about \$35 million of the loss. The remainder of the risk was insured in France and in other U.S. markets.

Syncom IV-F4, scheduled to be launched this week, was insured two years ago under the same program as the lost Syncom IV-F3 and two earlier probes. The rate paid by Hughes for the four-satellite program was less than 6% of insured value, sources say.

American Satellite Co.'s ACS I satellite also was insured before the latest string of losses, sources say. Coverage for the satellite was placed by Corroon & Black Inspace Inc. American Satellite said the value of the probe is about \$50 million, but other market sources say additional coverages, such as for lost revenue, may push the total value of the ACS I coverage close to \$95 million.

Coverage for Aussat K1, the third satellite to be launched Saturday, was placed this year by Johnson & Higgins and Willis Faber P.L.C. in London. It is one of three satellites insured by a program led at Lloyd's by Merrett Syndicates Ltd. and the Ariel Syndicate.

Aussat K1 is insured for \$58 million, sources say, adding underwriters reserved the right to revise the rate for the coverage up to 90 days before launch. The final rate was about 18% of insured value, they say.

The Syncom IV-F3 loss was the latest in a series of losses that have plagued the satellite launch insurance market in the last 18 months. Those losses have forced several insurers and brokers out of the market and left those that remain to

sort out how much coverage is available, at what price and under what conditions.

"I believe the market is uncertain at this time where space insurance is going in the future," said Mr. Barrett.

"It is a cold day in the world when profit is shot to hell and work is just for fun. Space insurance is just coming into maturity and coming out of adolescence, and we have to be mature about it," he said.

From April 4, 1964, when the first launch insurance premiums were recorded by underwriters, to June 1985, the satellite insurance industry has paid approximately \$600 million in claims but has collected only about \$320 million in net premiums, said Alden M. Richards, vp of Johnson & Higgins.

(His figures do not include undisclosed premium from three probes launched in June.)

In the last 18 months, underwriters have paid \$367 million in losses, including the Syncom loss. And, they have paid an additional \$10.5 million to salvage two satellites valued at \$185 million that failed to reach proper orbit on a February 1984 shuttle flight.

The satellites were retrieved last November, but underwriters have not sold them yet, said leading underwriter on the salvage, Stephen Merrett, chairman of Merrett Syndicates Ltd. (BI, Nov. 19, 1984).

Underwriters hoped that raising launch insurance rates to the current 15% to 20% of insured value—from as little as 5% several years ago—would produce more premium and help balance the staggering losses. But, they have found that satellite owners are not purchasing enough coverage at the higher rates to substantially narrow the gap, sources say.

"People are buying less insurance at higher rates, so the premium flow remains the same and the growth underwriters were looking for isn't what they thought it would be," said William N. Lloyd, vp of Johnson & Higgins in New York.

In addition, satellite launch underwriters and brokers agree that one of the major problems facing the market is a lack of capacity, especially when more than two probes are insured on the same launch vehicle.

The worldwide satellite insurance market can provide about \$200 million in capacity for satellites to be launched on the same launch vehicle, Mr. Frick said, although other market sources said the total is only about \$130 million.

In the United States, Intec can underwrite about \$35 million in coverage for satellites on one launch vehicle, while U.S. Aircraft Insurance Group can write about \$30 million, said Mr. Frick.

But, a serious capacity problem exists if more than two satellites are to be launched on a single flight of the U.S. space shuttle or a French Ariane rocket, he said.

He said that to cope with this capacity problem, M&M is negotiating with underwriters to divide launch insurance into two different coverages.

The first would provide coverage from the time the satellite is in the launch vehicle until the time it is deployed. Rates for this coverage,

which would protect the satellite owner against a crash or fire on the launch vehicle, could be about 11% of the insured value, sources say.

The second portion of the proposed coverage would cover the satellite from deployment until it reached a geostationary orbit and remained there for up to 90 days.

Rates for this portion probably would be about the same as current rates for launch coverage, sources say—20% of insured value.

Splitting the coverage in this way would end up costing the buyers more, although details of how the coverages would be split are still to be worked out.

However, satellite underwriters hope that splitting launch coverage into two policies would open up capacity, because some insurers that are reluctant to provide coverage in case the satellite itself malfunctions—which has been the cause of most of the losses so far—might be willing to write a portion of the first policy covering accidents aboard the launch vehicle.

"I think that if we offer underwriters the ability to write the shuttle portion from ignition to deployment, there will probably be more underwriters to write this coverage," Mr. Frick said.

At least one important satellite insurance underwriter is skeptical about writing two separate policies for launch coverage. Mr. Merrett, a leading satellite underwriter at Lloyd's, doubts he would write this type of coverage.

"I haven't seen a proposal along those lines, but there would be problems," Mr. Merrett said. "With two policies, I can't see how it could be done without a gap in policies or an overlap in coverage."

In addition to pursuing the possibility of splitting launch coverage into two separate coverages, underwriters are considering changes in the wording of satellite launch policies to address how to distribute costs and the rights of underwriters and owners in the case of satellite salvage and repair.

"The subject of salvage and repair must be addressed," said Mr. Barrett of Intec. "The language of the policies must accommodate these occurrences. And, the extra expense for salvage and repair costs must be addressed. In the future, the new policy language will include this need."

Other coverages associated with satellites are also increasing in cost and declining in availability.

For example, shuttle third-party liability insurance—which covers owners of satellites launched aboard the shuttle—has been hit hard by the overall liability insurance rate hikes in the U.S. liability insurance market.

Limits are down to \$700 million per flight from \$750 million formerly available from Intec, which manages the shuttle liability insurance facility. And, the premium charged each satellite owner are up to \$200,000 from \$100,000.

And, rates also have risen for in-orbit or life insurance, which covers the satellite against malfunctions for a period of from 60 to 90 days after deployment to up to seven years of its life. The coverage now costs 2% to 3% of insured value, up from 1% of insured value early last year.

Texas comp rates to rise an average of 31%

AUSTIN, Texas—Workers compensation rates in Texas for all classifications will increase an average of 30.9% beginning Oct. 1.

Rates will increase an average of 37.9% for contracting classifications; 32.1% for oil classifications; 31.4% for manufacturing classifications; and 26.9% for all other classifications, said Charles Porter, an actuary with the Texas State Board of Insurance.

The insurance board approved the rates Aug. 9, following a hearing July 23.

At that hearing, insurance industry representatives testified that workers compensation underwriters' pure loss ratios in Texas increased to 95.9% in 1984 from 68% in 1980.

The 30.9% average rate increase was primarily due to loss experience, Mr. Porter said. Only about 2% stems from statutory benefit increases.

The Insurance Board staff had recommended that workers compensation rates be increased 27.5%, while the National Council on Compensation Insurance had recommended an average increase of 40.8% in Texas.

The NCCI, a New York-based national ratemaking and research organization, acts in an advisory capacity in Texas. In most other states, however, the organization files rates on behalf of member insurers.

Workers compensation rates had been increased an average of 8.6% last Jan. 1, and an average of 2% on Oct. 1, 1984 (BI, Dec. 10, 1984).

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CIGNA

James Barrett

Continued from page 3

Since then, Mr. Barrett has been a major force in developing policies, personnel and clients for the commercial satellite industry.

In 1974, he developed the first satellite insurance policy without what had been the standard one-launch deductible. The policy was sold to Western Union Corp. to cover its Westar I and II probes.

Under a one-launch deductible, a satellite insurer would pay claims only if two or more in a series of satellites were lost.

In addition, Westar I and II also were covered by the first in-orbit coverages, which insured the satellites against malfunction for 90 days after they were deployed.

The rate for the Westar coverage was 12% to 12.5% of the insured value of the satellite, Mr. Barrett recalls.

Mr. Barrett also notes that he was aided in developing the coverages by Richard Nausch, now president of broker Nausch, Hogan & Murray Inc. in New York.

Mr. Barrett moved to Corroon & Black Corp. in 1977, and in 1980 he established Corroon & Black Insurance Inc. in Washington, which has become one of the nation's leading satellite insurance brokers.

In 1982, Mr. Barrett left Inspace to form International Technology Underwriters, an underwriting manager that specializes in satellite insurance.

Intec was started in the basement

"I didn't know four months ago that a satellite could be repaired in space," Mr. Barrett says.

of Mr. Barrett's home, "with me, John Higginbotham, a secretary, an Apple computer and my bird dog," Mr. Barrett remembers.

Now, three years later, Intec employs 15 people in plush offices on L'Enfant Plaza in Washington.

Intec is the underwriting manager for 85 U.S. insurers that have a combined satellite launch insurance capacity of \$30 million per launch vehicle.

Insurance Co. of North America, a CIGNA Corp. unit, serves as the lead underwriter for coverage written by Intec.

Reinsurance for the group is placed by broker John F. Sullivan & Co. a subsidiary of Fred S. James & Co. Inc., said Mr. Barrett.

Intec is considered by industry observers as one of the two leading satellite insurance underwriters in the United States, along with U.S. Aircraft Insurance Group, a New York-based pool.

And, Mr. Barrett is piloting his latest company to further advances in the satellite insurance market.

For instance, last year, Intec played an integral role in negotiations for the salvage of two satellites—Western Union's Westar VI and the Indonesian government's Palapa B2—that failed to reach proper orbit after being launched from the space shuttle in February 1984.

Underwriters, including Intec, paid a total of \$185 million in claims for the loss of Westar and

Palapa. After taking title to the satellites, they financed the space shuttle rescue mission that retrieved the probes and had them repaired when they were brought back to earth (BI, Nov. 19, 1984).

Mr. Barrett and Lloyd's of London satellite underwriter Stephen Merrett, who spearheaded the rescue effort, currently are trying to find buyers for the two used satellites.

Intec also wrote the largest portion—\$27 million—of the recent \$85 million claim on Hughes Aircraft Co.'s Syncom IV-F3 satellite. That satellite also failed to reach proper orbit, but astronauts aboard a shuttle mission scheduled to be launched this week will attempt to repair the probe in space.

If the probe is successfully repaired and redeployed, Intec will share in the revenues when the satellite is leased to the U.S. Navy (see story, page 3).

Intec also administers the liability insurance facility for satellite owners using the shuttle. The National Aeronautics and Space Administration requires each satellite owner to purchase \$500 million of third-party liability insurance or be insured under Intec's program.

The program was renewed in April and the hardening liability market forced Intec to cut the limits per launch to \$700 million from \$750 million, while the premium per satellite was doubled to \$200,000 from \$100,000.

Intec also constantly is working to upgrade policy language to reflect the changes in the satellite market. For example, Intec currently is working on new language to address the subjects of salvage and repair in space.

"I didn't know four months ago that a satellite could be repaired in space," said Mr. Barrett. "In a way it is good to have losses because the policies will reflect them."

Mr. Barrett says he is ready to meet the challenges brought by the commercial expansions of space. And, meeting those challenges will take the cooperation of underwriters, manufacturers and satellite owners, he adds.

"Underwriters are going to have to be convinced that manufacturers and satellite owners and launch agencies are doing everything in their powers to make sure that shortcuts are not being taken and things are done right."

"We will get this right," he said. ■

REA regulations

Continued from page 2

10% to 12%, to pay for this option.

For example, in order for his spouse to be eligible for a survivors' benefit, an employee's \$500 monthly benefit might be reduced to \$450. If the employee died, the spouse then might receive a monthly survivors' benefit of about \$225.

The Retirement Equity Act and the IRS regulations say joint and survivors' benefits automatically will be provided unless the spouse waives his or her right to receive the benefit. This waiver must be notarized.

But such waivers can be difficult for an employee to obtain when a couple is having marital problems, consultants point out. And, the problems become even worse after a couple has separated because of marital problems.

"It gives the spouse power to use the pension as leverage over other issues," said Hewitt's Mr. Butterworth.

While the Retirement Equity Act was enacted to give women a better chance of earning a pension benefit, the provision giving spouses automatic joint and survivors' coverage is hurting some women, experts say.

"Women resent the fact that they have to provide this coverage to spouses" that have left them, said Frederick Rumack, director of tax and legal services for Buck Consultants Inc. in New York.

"A lot of women employees are upset that this coverage has been foisted upon them," Mr. Rumack said.

"You have situations where husbands won't sign," added Theresa Stuchiner, a partner with benefit consultant Kwasha Lipton in Fort Lee, N.J.

The cost of the law's provision on joint and survivors' benefits affects women more greatly than men because women's pension benefits tend to be lower than men's. The average annual pensions paid to women were 56% lower than those paid to men, according to a Labor Department study of 1977 and 1978 retirees.

As a result, the cost of the provision will further reduce some women's already small pension benefits.

Further, the law requires that profit-sharing benefits also be auto-

matically assigned to the spouse if the employee dies. Only if the spouse specifically waives his or her right to the benefit can another person other than the spouse be named as the beneficiary of an employee's profit-sharing account.

The law was passed to protect the retirement income of wives, but Ms. Stuchiner says working women complain about automatic assignment of benefits, asking, "What business is it of my husband what I do with my pension?"

However, these spousal consent requirements do not apply to employees who are legally separated or divorced.

Other provisions of the Retirement Equity Act clearly will help women and men qualify for retirement benefits. Some of those other provisions include:

- Lowering the minimum participation age—the age at which a worker can join a retirement plan—to 21 from 25.

- Lowering to 18 from 22 the minimum age at which a company must give vesting credit to employees.

- Offering to all employees who have vested the option of selecting a joint and survivors' benefit.

Prior to the enactment of the REA, pension plans often only offered the joint and survivors' benefit option to employees who also had reached the plan's early retirement age, which is commonly age 55.

However, one provision in the REA does help employers. Companies are allowed to pay in cash the full value of a retirement benefit if the benefit is worth less than \$3,500 to a participant who leaves after vesting.

Such cash-outs had previously been restricted to benefits with a value of less than \$1,750.

Cashing out a benefit and removing a former employee as a plan participant reduces an employer's administrative costs because, among other things, the company no longer has to keep sending pension plan reports to the participant.

Comments from employers on the Internal Revenue Service's regulations implementing the Retirement Equity Act should be sent to the Commissioner of Internal Revenue, Washington, D.C. 20224, Attention: CC:LR:T (EE-35-85).

The deadline for comments is Sept. 17. ■

Insurer suspends writing new risks

LOS ANGELES—Associated International Insurance Co. is not writing new property and casualty insurance policies under a self-imposed temporary moratorium that began July 1, according to President D. Michael Polizzi.

And, the Los Angeles-based insurer, a surplus lines subsidiary of London-based Stewart Wrightson Group P.L.C., currently will consider renewing only property insurance policies, not casualty insurance, Mr. Polizzi says.

Associated International, with \$11 million in capital and surplus, wrote gross premiums of \$27 million in the first six months of 1985, Mr. Polizzi said. The insurer's gross premiums written in all of 1984 totaled \$30 million.

When the insurer imposed the moratorium, it projected it would last about three to four months. Now, halfway into the moratorium, Mr. Polizzi says the projection still holds.

During the moratorium, Associated International will process the business it wrote in the first six months of this year. The insurer also will continue to negotiate its treaty reinsurance renewals.

And, the insurer is preparing to underwrite liability insurance next year under the claims-made policy form. ■

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update

Insurers seek tax alternatives

Continued from page 2

setting profits from one corporate unit with underwriting losses from a property/casualty company for tax purposes.

The administration's proposal would require insurers to set up so-called "qualified reserve accounts" for unpaid losses, which reflect the insurer's estimate of the amount needed to pay future claims, less the aftertax investment income that would be earned on the reserves before the claims are paid (BI, June 3). Thus, an insurer would not be allowed to deduct the full amount of unpaid losses.

Insurers currently now do not have to discount their loss reserves to take investment income into account.

Government to appeal award

BOSTON—The federal government will appeal a \$1.25 million award made last week by a federal judge to families of three lobstermen who were lost at sea off the Massachusetts coast in a 1980 storm the National Weather Service did not predict.

U.S. District Court Judge Joseph Tauro in Boston said the Weather Service, which is part of the government's National Oceanic and Atmospheric Administration, was liable because it did not repair a malfunctioning weather buoy.

If the buoy had been working, the Weather Service might have been able to predict the intense storm, Judge Tauro ruled.

The federal government is self-insured for the award, a Justice Department spokesman said.

Wellington board is elected

WASHINGTON—Asbestos insurers and producers have elected a board of directors for the asbestos claims-handling facility, and the board named Princeton, N.J., the facility's headquarters.

The 12 board members are representatives of insurers and producers that negotiated the Wellington agreement, which created the facility (BI, July 1).

Princeton will be the facility's East Coast regional office as well as its headquarters. The West Coast office will be in San Francisco.

Facility representatives also met recently with about 90 plaintiffs' attorneys to try to resolve the attorneys' objections.

UAW, Chrysler talks continue

DETROIT—The United Auto Workers union is willing to consider giving workers greater choice between traditional fee-for-service health care and managed care in current negotiations between the UAW and Chrysler Corp., a union representative says.

However, the union will not consider eliminating the traditional health care delivery option, as is the case in the new agreement between the UAW and General Motors Corp. covering workers at the new GM Saturn plant (see story, page 2).

"Our demands are that we have a continuation of the present structure," said Jack Horne, international representative in the UAW's Chrysler department.

But, he said the union will consider additions, such as a preferred provider organization option, to the current contract, which offers workers the choice between a health maintenance organization and a traditional first-dollar indemnity plan.

Chrysler and the UAW began negotiations Aug. 12; their current contract expires Oct. 15.

The union's priority is to restore wage and benefit parity between UAW workers at Chrysler and at GM and Ford Motor Co., Mr. Horne said. Including increases due in September, UAW's Chrysler workers earn from 7 cents to 26 cents an hour less than those at Ford and GM, he said.

And, since many benefits—such as life insurance, sickness and accident pay, accidental death and disability insurance and extended disability insurance—are based on pay, benefits for Chrysler workers are less than for workers at GM and Ford, he said.

Record aviation losses

Continued from page 1

was valued at \$100 million, a record, while underwriters are reserving about \$25 million for liability claims, or about \$75,000 per person (BI, July 1).

While the liability reserves for the three crashes differ greatly, the combination of the JAL, Delta and Air India losses within a short period of time will increase aviation rates later this year, experts agree.

This year's losses will have "an absolute dramatic" effect on the aviation market, says Charles Binford, general manager of Johnson & Higgins' Tokyo office.

"Rates should go up substantially," added one London aviation underwriter who asked not to be named.

The JAL and Delta losses closely followed the summer aviation insurance renewal season, during which rates stayed flat or increased slightly, compared with renewals during the summer of 1984, when rates doubled and sometime tripled.

"It would be logical for rate increases to continue, but they don't have to be huge ones," says Peter O'Grady, president of Aviation Office of America in Dallas. AOA wrote a portion of Delta's coverage but was not on the JAL risk, Mr. O'Grady said.

Richard Maylam, aviation underwriter for Lloyd's syndicates managed by Alexander Howden Underwriting Ltd., agrees that rates will rise in the fall, "but I can't put my finger on" the rate of increase.

Brokers say most U.S. airlines renewed their aviation coverage earlier this year and for the most part benefited from the mild rating environment, but at least three major air carriers must renew later this year: Trans World Airlines, American Airlines Inc. and United Airlines Inc.

"Until someone goes in and tests the waters," it's difficult to predict whether aviation underwriters will "push the panic button and do what they did last year" when rates doubled and sometimes tripled, said Joe Lombardo, vp of Alexander & Alexander Inc. aviation and aerospace division in New York.

Predictions on how much aviation underwriters will increase rates were imprecise last week because many of the world's leading aviation underwriters in London were unavailable for comment. They were out of their offices, away on the traditional European August holiday.

The cause of the JAL crash remained a mystery last

week. Pieces of the 747's tail section were found 80 to 90 miles away from the crash site, and investigators last week were probing why the tail of the Boeing Co.-manufactured jetliner came apart before the airliner crashed (see related story).

According to sources in the United States and London, Japan Air Lines' hull and liability coverage was written by Tokio Marine & Fire Insurance Co. Ltd. in Tokyo.

Fifty-seven percent of the risk was reinsured with the London market, led at Lloyd's of London by the Ariel Syndicate, sources in Britain say.

Other portions of the risk were ceded by Tokio Marine & Fire to U.S. and other world aviation markets. In the United States, Associated Aviation Underwriters in New York said it reinsured a portion of the risk.

JAL's hull and liability insurance policy was renewed on Aug. 1, less than two weeks before the crash, sources say.

JAL's \$3.4 billion fleet is insured for up to \$120 million per hull at a rate of 36 cents per \$100 of insured value, the same rate that JAL paid in 1984, underwriters in London said.

JAL has up to \$600 million in liability coverage for any one loss, the underwriters said. JAL paid a rate of 19.5 cents per 1,000 revenue passenger kilometers, up slightly from 19 cents in 1984.

JAL placed its insurance directly with Tokio Marine & Fire and did not use a broker, according to sources in Tokyo. Lloyd's of London broker Willis Faber P.L.C. brokered the London portion of the reinsurance.

According to one London underwriter, the JAL account has been profitable for underwriters over the past six years. From 1978 through 1984, the airline paid a total of \$68.6 million in premium, while paid claims totaled \$44 million and outstanding claims stood at \$1.7 million.

JAL has suffered nine total losses and one major partial loss since 1972, according to Air Claims Information Digest, a London-based publication.

Before last week's disaster, the most recent JAL claim occurred in 1983, when a JAL Boeing 747 hit a truck while landing in Anchorage, Alaska. Damage to the hull totaled \$5 million, but there were no injuries.

In 1982, a JAL captain with mental problems crashed a DC-8 airliner on landing in Tokyo, killing 23 people. The hull loss totaled \$6.5 million; the liability loss is not known (BI, Feb. 15, 1982).

Boeing coverage has \$1 billion limit

By ROBERT A. FINLAYSON and STACY SHAPIRO

SEATTLE—Boeing Co., which built the Japan Air Lines 747 jumbo jet in which 520 people died last week, has \$1 billion in aviation product liability insurance, according to London sources.

Investigators last week had not determined why the plane crashed, and Boeing officials last week refused to speculate on the cause of the crash or the likelihood the company would be sued for liability for the accident—the worst single-plane crash in aviation history.

Boeing officials also declined to discuss the company's aviation product liability insurance. However, sources in London say the \$1 billion program is in three layers and was renewed Aug. 1.

Robert E. Butler, corporate director of insurance at Lockheed Corp. in Los Angeles, says that \$1 billion is probably the maximum aircraft product liability limit available, although capacity shortages generally have forced available limits down to about \$750 million.

Lockheed, which renewed its aviation product liability program in July, was able to maintain limits of \$1 billion, but at a "substantial rate increase," Mr. Butler says.

Lockheed's program is underwritten by London and U.S. insur-

ers, Mr. Butler said.

Just what caused the ill-fated aircraft to veer off course and plow into a mountainous region 70 miles northwest of Tokyo was still under investigation late last week.

However, aviation experts said that discovery of tail section fragments 80-90 miles from the crash site supports theories that the tail of the 747 was somehow torn off, causing the plane to fly out of control before it crashed. Investigators, though, last week had not determined why the tail broke apart.

The Japanese Transport Ministry last week ordered inspections of the tail sections of all 747s flown by Japanese airlines.

Boeing dispatched five of its top aircraft safety experts to Japan to help Japanese officials investigate the cause of the JAL crash. In addition, two aircraft safety experts from the U.S. National Transportation Safety Board also are participating in the investigation.

Introduced in commercial service in 1970, the Boeing 747 jumbo jet has been involved in 15 major accidents, but the aircraft has never been cited as the cause of any of the accidents, a Boeing spokesman said.

A spokesman for the NTSB says investigations by the safety board into accidents involving 747s have turned up only "positive conclusions" about the aircraft.

However, insurance underwriters note that two 747s have crashed inexplicably within two months: last week's JAL crash and the June 23 loss of an Air India 747, which killed 326 people.

"One's reaction to the losses is one of horror, and one is concerned that there is a structural problem to the aircraft," said Richard Maylam, aviation underwriter for Lloyd's of London syndicates managed by Alexander Howden Underwriting Ltd.

"One thinks that there should be testing of all 747s," Mr. Maylam said. "Before this recent disaster, I thought the Air India loss was caused by a bomb. Now I am not so sure."

At the time of the Air India crash, investigators theorized that a terrorist bomb on board the 747 exploded, and aviation war risk insurers were alerted to the claim (BI, July 1).

However, last month, after the flight data recorder was recovered and the remains of the aircraft and victims were examined, forensic experts were unable to conclude the crash was caused by an explosion.

As a result of the uncertainty over the cause of the Air India loss, underwriters have withheld payment of the hull claim, which was set at a record \$100 million. But, London broker C.T. Bowring & Co. Ltd. has paid a "substantial" amount of the claim to cover the reinsurance owed to General Insurance Corp. of India, which wrote Air India's aviation coverage, a Bowring spokesman confirmed.

There has been some question about which reinsurers will pay the claim—Air India's all-risk aviation reinsurers, which normally would pay the hull claim, or its war risk reinsurers. Sources in London say the reinsurers have agreed that both sets of reinsurers will split the hull loss 50-50.

It's not known which reinsurers will pay the liability loss, which is estimated at \$25 million.

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Work comp law

Continued from page 2

the injury occurred is responsible for the payment of the full benefit to an injured worker, including benefits related to the worker's salary from other jobs.

However, this employer then can be reimbursed for the amount of the benefit attributable to the

worker's other job by the state's Special Disability Fund, New York's second injury fund.

Also under the law, only the employer's part of claims costs will be included in its loss experience.

Gov. Cuomo said in the statement that the new law benefits workers without increasing the liability of employers. But, employers and work comp insurers disagree.

"To recoup that money from the disability fund will be pretty complicated," said George Cooper, vp of state governmental affairs for the New York Chamber of Commerce and Industry.

Also, because the Special Disability Fund will now pay a new type of claim, additional claims will be filed, resulting in higher fund assessments against insurers and self-

insurers, said attorney Patrick Harnedy, administrator of the fund.

Currently, work comp insurers and self-insured employers are assessed a \$1.75 fee for every \$1 paid in benefits by the fund, he said.

While the New York-based American Insurance Assn. doesn't anticipate a great number of claims under this new category, Counsel Charles Coakley warns that some

workers might abuse the new law.

For example, a worker injured at a part-time job might file a work comp claim, but then return to his or her full-time job and continue to receive work comp benefits from the part-time employer. The part-time employer, who is paying benefits on a combined salary, would be unaware that the worker had returned to the full-time job. ■

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Financial:

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Secretaries, treasurers, controllers and other financial personnel...6,886

Risk/employee benefits:

Vice-presidents, directors, managers, and other related department personnel of: insurance, risk, employee benefits, personnel, compensation, pension, safety, security, industrial relations, human resources and employee/labor relations...8,048

Sub-total

Associations...804
Government, unions and educational systems...1,030

Commercial Consumers

Sub-total

Insurance agents and brokers 9,548
Insurance companies...6,089
Financial institutions...536
Actuaries, attorneys, adjusters, appraisers and consultants...3,464
Others allied to the field...1,320

TOTAL

44,878
* Source: Business/Occupational breakdown of qualified circulation, May 6, 1985 issue, as submitted to BPA for June 1985. BPA Publisher's Statement.

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Asbestos ruling

Continued from page 1

attorney for LAQ with the Morris-town, N.J. firm of Porzio, Bromberg & Newman.

"The industry could not bear the enormous cost of defense and indemnification."

"It's a very important decision for policyholders because it is always important to have the first decision in an area be highly favorable. . .," said Jerold Oshinsky, an attorney for policyholders with the Washington, D.C., firm of Anderson Baker Kill & Olick, who was the attorney for Keene in the landmark Keene decision.

At least one of the three insurers—named defendant American Home—intends to seek an appellate court review of the decision.

Under the July 31 decision, LAQ's insurers are liable for defense and indemnification costs of all asbestos claims if they were on the risk from the time products with asbestos were installed in buildings until the products are removed or contained.

LAQ is currently facing more than 50 property damage suits and several thousand personal injury suits.

The asbestos company has not paid any property damage claims, but at the end of 1983, LAQ says in its suit, it had spent \$163,000 on defending them.

Also at the end of 1983, LAQ had paid \$4.5 million to settle personal injury cases and \$11 million to defend them.

The Quebec-based LAQ, which is a wholly owned subsidiary of the American Smelting & Refining Co., has mined and sold asbestos since 1958.

LAQ sued three of its insurers during the years 1975-1983 for coverage of asbestos property damage and personal injury claims: American Home, Highlands Insurance Co., and Midland Insurance Co.

The asbestos company has other excess insurance coverage, but those insurers were not named in the litigation.

American Home wrote excess indemnity or umbrella policies from 1975 until 1984. The policies had an annual aggregate limit of \$3 million except for 1976-1977 when the limit was \$4 million.

From 1976 until 1984, LAQ had self-insured retentions that ranged from \$1 million to \$3 million.

In 1975, LAQ also purchased an additional \$20 million in excess insurance from Highlands above American Home. Highlands left the risk six weeks later and LAQ then obtained virtually the same coverage from Midland.

Midland also wrote \$30 million in coverage for LAQ in 1976 and \$5 million in 1977.

In all, American Home wrote \$28 million in coverage, Midland wrote \$55 million and Highlands wrote \$20 million.

In making all these limits available to LAQ for both personal injury and property damage claims, the court dealt with both the issue of when property damage and personal injury occurs under the policies and also the extent of the coverage.

And, the court's comments on the property damage issue break new ground.

LAQ had argued that the continuing presence of asbestos products in a building caused continuing damage. Therefore, coverage should be triggered during the entire period from installation through removal or containment of asbestos.

The insurers, however, argued that the damage occurred at the time the asbestos products were installed in the building.

The continuing presence of asbestos was a consequence of installation and did not constitute new damage so as to trigger coverage any more than does containment or

removal, the insurers argued.

The insurers also contended that unlike bodily injury, property damage claims have no latency period.

The court noted that adoption of Keene would maximize LAQ's coverage while adoption of the exposure theory based on installation would minimize its coverage because most installations occurred long before coverage by American Home began.

Asbestos products first began being installed in buildings shortly after World War II and continued until the early 1970s.

In its decision, the court noted that the parties agreed that damage occurred at installation.

The only question was whether the damage was complete at installation or that installation was the initial step in a single continuous injurious process.

Noting that it had ruled there was continuous injury in bodily injury cases, the court said it would be "illogical and impractical" not to apply the same theory to property damage cases.

"What is before the court strongly suggests that the Keene theory would be adopted by the Supreme Court of New Jersey in the property damage context as well," the court said.

The court said it was not true, as the insurers argued, that at issue were two points in time: installation and repair or removal, with everything in between only a "continued presence" causing no new damage to the property.

Quoting government reports, the court said that there is a natural deterioration of asbestos-containing materials resulting in the release of fibers that may occur by a slow, continuous degradation of the insulating surface, which may be accelerated by the air movement and vibration which occurs in most buildings.

Moreover, friable or flaking asbestos material breaks down due to vibrations, deterioration, or direct contact and damage and it can lose its cohesive strength.

"Fallout of fibers from deteriorating material is continuous," the court said.

In addition, the court said that when more than one policy has been triggered, the insurers are jointly and severally liable for the total amount and that the settlement or judgment cannot be prorated over the policy years.

Recoveries can be claimed from any insurer whose coverage is triggered, subject to the "other insurance clauses" contained in the policies, the court said.

The insurers have the responsibility to determine their appropriate shares of liability.

One reason for not prorating claims over several policy years, the court said, is that LAQ had substantial deductibles and self-insured retentions during the policy years.

Prorating each claim over many policy periods would trigger those retentions over many years, and only a small portion of each claim would go toward exhausting the self-insured retention. Thus, the insurers would be insulated from paying any money.

"This, I predict, the Supreme Court of New Jersey would not permit," Judge Barry said.

Last week, attorneys for policyholders hailed the decision while those for the insurers criticized it.

Other policyholders will seek to rely on it, Mr. Oshinsky said, noting he was "very confident" courts would reject the insurance industry's arguments.

"There's no question the policies were intended to apply to the types of allegations in the school district cases," he added.

"It is significant in that it is apparently the first asbestos property damage coverage case," said John Buchanan an attorney for LAQ with the Washington, D.C. firm of

Covington & Burling.

But he added that it was not that surprising because Judge Barry applied to the property damage area well-established insurance principles from the asbestos personal injury area.

The decision is important because it should help clarify the insurance disputes over property damage and should assist risk managers by making it simpler to administer claims, according to Mr. Buchanan.

However, an attorney who represents insurers questioned the application of asbestos personal injury insurance theories, often based on medical evidence, to the property damage cases.

"The problem I have with the decision is that the Keene theory and other bodily injury asbestos theories can't be applied to each new toxic tort situation," said John Sullivan, an attorney with the Philadelphia firm of Frumkin & Manta.

Another attorney for insurers points out that many more courts will consider the issue of coverage for property damage claims, and they will not necessarily reach the same conclusion.

Insurers in subsequent cases may argue for a manifestation theory of coverage, which was not presented in this case, the attorney said.

"My guess is that the decision will focus the attention of insurers on fighting this issue," the attorney added.

In addition, Judge Barry did not define what constitutes property damage, the attorney pointed out. For example, whether inspection charges are recoverable under insurance policies is not answered, he said.

So far, few suits seeking recovery for property damages caused by asbestos have gone to trial. In April 1984, U.S. Gypsum Co. settled in mid-trial with Lexington County School District No. 5 in Columbia S.C. for \$675,000 (BI, April 16, 1984).

But, in March of this year, a U.S. District Court jury in Knoxville ruled that National Gypsum Co. and U.S. Gypsum Co. were not liable for the costs of removing asbestos and repairing walls and ceilings in two local school buildings (BI, March 18).

Earlier this month, a case brought by the Spartanburg School District No. 7 against U.S. Gypsum and National Gypsum went to trial in Greenville, S.C.

Francis X. Garrity, the attorney for American Home with the Bloomfield, N.J., firm of De Gonge, Garrity & Fitzpatrick, said the insurer intends to seek review of the LAQ case by the U.S. Third Circuit Court of Appeals.

Attorneys for Midland and Highlands would not comment on the decision nor whether they would appeal.

Manville pushing for OK to new reorganization plan

By STEPHEN TARNOFF

NEW YORK—The next hearing on Manville Corp.'s new reorganization plan will be held Sept. 4 in U.S. Bankruptcy Court.

Although Manville's new reorganization plan gives asbestos claimants far more than the company had envisioned when it filed for bankruptcy in 1982, the asbestos company is pushing for the plan's speedy acceptance.

The original plan provided only about \$1 billion for asbestos health claimants and prohibited jury trials and punitive damages for asbestos bodily injury claims, for example. The new plan is valued at more than \$2.5 billion and provides \$5 million to cover punitive damage awards.

During the next 2½ weeks, Manville and its creditors are meeting in an attempt to agree on details of the new plan (BI, Aug. 12).

At a hearing in U.S. Bankruptcy Court last week, representatives of Manville, future asbestos health claimants and other creditor groups told Judge Burton Lifland that discussions on the plan were continuing.

"We are meeting and will continue to meet on an accelerated basis with various constituencies," said Leon Silverman, an attorney for future claimants with the New York firm of Fried, Frank, Harris, Shriver & Jacobson who hammered out the reorganization plan with Manville.

Manville's board of directors approved Aug. 6 principles of a reorganization plan proposed by Mr. Silverman that would pay off creditors, including present and future asbestos claimants, and enable Manville to emerge from bankruptcy.

The plan could require Manville to provide more than \$2.5 billion over 25 years. It includes establishment of a trust fund made up of an initial payment of \$846.5 million in cash and insurance, a \$1.65 billion bond issue and 50% of Manville stock, plus preferred stock that could be converted to the equivalent of an additional 30% of the company's common shares if needed to pay claims.

The plan also limits Manville's liability to \$50 million for property damage claims for the cost of removing asbestos from buildings.

While the plan initially was criticized by representatives of shareholders and property damage claimants, these creditors withheld criticism at last week's hearing, pending the outcome of meetings with Mr. Silverman.

An attorney representing state governments with property damage claims against Manville said after the hearing that their initial position was that the \$50 million set aside for property damage claims was "unsatisfactory and unacceptable." Property damage claims against Manville currently are estimated as high as \$80 billion.

But, "we're all very cautious and there is a basis for guarded optimism," the attorney representing the property damage claimants said.

G. Earl Parker, senior vp for Manville, said after the hearing that he senses a desire among the creditor groups to move from confrontation toward cooperation on working out a reorganization plan.

While the new reorganization plan differs substantially from the plan filed by Manville in 1983, Mr. Parker maintained Manville is satisfied.

The new plan, as well as the old plan, allows Manville to take full tax advantage of payments made to the trust. The tax law allows taxpayers to deduct product liability costs in computing taxes.

"We don't expect to pay significant federal income taxes for the next decade," Mr. Parker said.

He also said the proposed reorganization plan is consistent with Manville's intention when it filed for bankruptcy and submitted its earlier reorganization plan. That plan was not approved by creditor groups.

The new plan provides funds for future claimants while limiting Manville's future liability.

The new plan provides that Manville will contribute 20% of future profits to pay future claims if the trust fund runs out of money. Also, the trust would receive Manville stock equaling 50% of the company's outstanding shares, plus preferred stock that could not be converted unless the trust's common shareholding falls below 20% of total outstanding common shares.

The plan's fixed costs, such as the more than \$600 million in insurance coverage, were contemplated in Manville's original plan.

While acknowledging that shareholders are unhappy with the dilution of their stock value under the new plan, Mr. Parker said he hopes shareholders and all other creditors accept the plan. Under the bankruptcy law, a reorganization plan can be approved even without the approval of all creditor groups. But, Mr. Parker would prefer that agreement is reached soon to avoid further delays in Manville emerging from bankruptcy.

Mr. Parker denied, however, that Manville accepted the new plan because it wants to proceed with a more than \$20 million investment in a platinum mine in Stillwater, Mont., that some creditors had opposed.

Manville can't invest in new ventures without the approval of creditors while it is in bankruptcy court.

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Tax proposals

Continued from page 1
flunk the uniform non-discrimination test in the Reagan administration's tax proposal, experts say.

"Large numbers of established plans, some of which have been in existence for decades and which collectively cover tens of millions of workers and their families, are finding they would not qualify under this proposed scheme," said Robert Stone, chairman of the ERISA Industry Committee, a benefits lobbying group representing large employers.

If a company's plan flunks the non-discrimination rules, it has two basic choices: do nothing and allow the higher-paid employees to be taxed on the value of their benefits, or create a uniform benefit plan for all company employees.

A uniform plan for all employees would always pass the test because the result of applying the formula would be 100%.

Employers' first option of doing nothing is unrealistic, experts say. The second option may be realistic, but it's also expensive.

If employers whose plans fail the discrimination test do nothing, prohibited group employees would face new, hefty taxes.

Under a generous health plan, for example, an employer's cost of providing family coverage to a worker can exceed \$300 a month. That means that prohibited group employees' taxable income would increase by more than \$3,600 if the plan is disqualified.

On the other hand, if employers equalize benefit packages for all corporate units, their expenses will increase. A company's benefit expenditures for a unit in an industry with relatively low benefit costs would be much higher than competing companies' benefit expenses in the same industry.

As a result, the subsidiary's operating costs would increase, possibly meaning it no longer could compete effectively in the industry.

"Companies have different plans for different segments of their workforce in order to reflect competitive labor markets, different lines of business, different geographic locations, different worker needs and for similar reasons," ERIC's Mr. Stone testified last month before the House Ways and Means Committee.

"This mechanical coverage test does not allow for these differences. The test could distort business decisions, (and) result in the establishment of uniform plans which do not suit any segment of an employer's workforce well."

Indeed, consultants say enactment of uniform non-discrimination rules could affect the normal course of corporate acquisitions.

Companies with generous benefit plans might be reluctant to acquire companies with less-generous plans because the acquisition could lead to the company's failing the uniform non-discrimination test.

For example, oil companies, with among the most generous benefit plans in the country, might not want to buy a company if the would-be acquisition doesn't offer as generous a benefit package.

'Large numbers of established plans, some of which have been in existence for decades and which collectively cover tens of millions of workers and their families... would not qualify under this proposed scheme,' said Mr. Stone.

Conversely, a company might have to divest a unit with a less-generous benefit plan if it couldn't pass the non-discrimination test.

"You get into situations where companies couldn't buy firms or would have to sell subsidiaries. It would be terribly disrupting," said Edward J. Davey, vp-technical analysis at Johnson & Higgins.

"It would be difficult to overemphasize the harm that would be caused by passage of this mechanical rule," said Mr. Stone.

"It is a cockamamie rule," charged John Baitzell, chairman of the policy committee at the ERISA Industry Committee and manager of industrial relations and regulatory affairs at Mobil Corp., a company that would fail the uniform non-discrimination rules.

Mobil would fail the test because about 79% of its prohibited employees are in its generous oil plan but only about 21.2% of its non-prohibited employees are in the plan. Mobil, with a 373% result under the formula, flunks the 125% test.

Most of Mobil's non-prohibited employees are employed by its retailing unit, Montgomery Ward & Co. Inc., where benefits are much lower than in the oil company.

Bringing Montgomery Ward's employees into Mobil's generous oil plan would be very costly.

Another provision in the Reagan tax plan would strike at small companies' benefit plans covering too many higher-paid employees.

Small employers would be walloped by the tax package's so-called concentration test. That test says benefit contributions made on behalf of the 20 most-highly compensated members of the prohibited group cannot exceed 25% of the company's total contributions for that benefit.

For instance, if a law firm had 25 employees, including 20 attorneys earning more than \$50,000, its benefit plans would not pass the concentration test since most of the firm's benefit contributions would be made on behalf of the 20 highest-compensated employees.

By flunking the concentration test, the law firm's benefit plans would lose tax-qualified status.

If a welfare plan, like a health care plan, fails the concentration test, the 20 highest-compensated employees would be taxed on the employer's contribution toward the benefit. If a retirement plan fails the test, the proposal says all employees covered by the plan—including non-prohibited employees—would be taxed on the value of their benefits.

Unlike larger companies, which could amend their plans to pass the non-discrimination test, small employers have no options. And, consultants say small employers would probably scrap their plans rather than have employees pay taxes on

benefits.

"What incentive would there would be for a company to have a medical plan... if the employees can't get any mileage out of it?" asks Kevin O'Brien, counsel for the Employers Council on Flexible Compensation in Washington.

But if plans are scrapped, lower-paid employees would lose their coverage. These employees would have fewer resources to buy individual policies than highly-compensated workers, experts say.

"This isn't going to help the expansion of (benefit) coverage," says Sophie Korczyk, a research associate at the Employee Benefit Research Institute in Washington.

If the concentration test is enacted into law, highly compensated employees would be discriminated against based on the size of their company, Mr. O'Brien points out.

For example, while the top executives of a family owned business would likely be taxed on their health benefits, the president of a major corporation might escape taxes because its unlikely the corporation would make more than 25% of contributions to a health plan on behalf of the 20 highest-compensated members of the prohibited group.

In the face of these tax plan provisions, "You would think people will be standing up and down shouting their disbelief," said EBRI's Ms. Korczyk.

But that hasn't happened. Representatives of trade associations with small companies as members haven't attended meetings sponsored by benefit lobbying groups during which the concentration test and uniform non-discrimination rules were discussed, said Kenneth Feltman, director of government relations for the Employers Council on Flexible Compensation.

"A lot of us have been shocked that people haven't focused on these issues," said J&H's Mr. Davey. "If employers don't lobby now, we will lose the war."

The uniform non-discrimination rules were largely overlooked by benefit experts and employers when the administration's tax proposal was released in May because of their sheer complexity, consultants say.

In addition, some benefit experts did not focus on the non-discrimination rules because they felt they were so unrealistic they would not be considered by Congress.

Companies thought the rules were so overwhelming that they wouldn't "fly politically," said Mr. Butterworth.

It is also easy to see how the concentration test was initially overlooked: The test is ambiguously described in one paragraph of the 461-page tax package.

In addition, the paragraph is written in such a way that some experts may have thought the test only applied to a few benefits, such as educational assistance and dependent child care.

But Treasury officials have made it clear to consultants that all non-taxable benefits will be covered by the concentration tests.

At the same time, Treasury officials have justified the concentration test by saying companies should not be able to provide tax-favored benefits if most of the benefits go to the highly compensated.

"Treasury is saying: 'The tax expenditures (revenues lost to the government) are not worth it' if they go to the highly compensated," Mr. Davey said.

Saturn and UAW agree on benefits

Continued from page 2

some of which more closely resemble the benefits of salaried GM employees than those of GM's UAW workers.

The resemblance to salaried benefits could reflect the fact that UAW Saturn workers will be paid a salary rather than an hourly wage.

The agreement calls for the establishment of a 401(k) savings plan that will allow Saturn workers to save up to 15% of their pretax earnings in a special account, Mr. Beier said. Saturn Corp. will match the first 6% of savings at 50 cents on the dollar, he said.

GM's current salaried workers can save up to 15% of their pretax earnings in a 401(k) account, and they receive a company match of 65 cents on the dollar on the first 10% saved, a GM spokesman said.

But, under the current UAW contract, UAW workers at GM can save only up to 5% of their pretax earnings in a 401(k) account and there is no company match.

Sickness and accident benefits for UAW workers under the Saturn agreement are identical to those of GM's current salaried employees, Mr. Beier said: For the first 30 days of sick leave, Saturn workers will receive 100% of their regular pay. For the next 30 days, they will receive 80% of their pay, and then they will receive 60% of their pay for up to a total of one year.

However, under their current contract, UAW workers at GM receive 65% of their regular pay for up to one year as sickness and accident benefits. And, unless they are the victim of an accident or are hospitalized for illness, they must wait for seven days before they can receive sickness and accident pay.

Mr. Beier said that although it has not yet been determined whether UAW members employed by Saturn will have a defined contribution or defined benefit pension plan, they will be guaranteed an annual contribution of at least 5% of their salary to a pension plan.

GM's current defined benefit pension plan for salaried workers pays a benefit equal to \$22.80 per month for every year of service, the GM spokesman said.

Currently, UAW workers at GM have a defined benefit pension plan that pays between \$19.75 and \$20.50 a month per year of service, based on a worker's job classification, wage and years of service.

Life insurance benefits for Saturn workers will be the same as the benefits salaried GM workers receive: twice their annual salary.

UAW employees at GM receive between \$13,500 and \$37,500 in life insurance coverage, depending on their wage.

However, the transition from traditional to state-of-the-art benefits at the plant, which is projected to manufacture 500,000 subcompact Saturn cars annually, is already meeting opposition.

The agreement between the UAW and Saturn Corp. that will be the basis for wages and benefits for the UAW members at the Saturn plant is being challenged by the National Right-to-Work Legal Defense Foundation in Washington.

The agreement, which was negotiated by GM, the parent of Saturn Corp., and the UAW, was approved July 26 by the union's executive board. On Aug. 6, the non-profit Right-to-Work Foundation filed a complaint with the National Labor Relations Board against both GM and the UAW, charging that the agreement is illegal because it was made without the consent of the workers it will govern.

"It's illegal because it's a pre-hire agreement, which has been ruled illegal by the courts," said Rex Reed, executive vp and legal director of the foundation.

"It was entered into between the union and the employer before any employees have the opportunity to voice their views, let alone ratify any agreement," Mr. Reed said.

While Mr. Beier of the UAW said that workers hired at the Saturn plant will be governed by the agreement, a spokesman for GM called the agreement "a framework" for the eventual contract with the Saturn workers.

Mr. Reed also contends that the agreement between the UAW and Saturn providing that only UAW members will be hired by Saturn discriminates against non-UAW workers and violates Tennessee's Right to Work law and Section 8 of the National Labor Relations Act, both of which prohibit unions and employers from interfering in a worker's decision whether to join a union.

Trans Union

Continued from page 3
brought in federal court—which is scheduled for hearing Oct. 15 in Chicago.

The Delaware Supreme Court ruling in the state action is expected to increase the liability of directors and officers for their actions, experts say.

The ruling may be the first instance in which corporate directors have been held personally liable for not thoroughly investigating a takeover offer, observes Warren G. Brockmeier, vp-risk management services at The Wyatt Co. in Chicago and a recognized authority on D&O insurance.

The ruling casts a shadow over what is known as the "business judgment rule," in which the courts have recognized that all business executives sometimes err in decision making. The court in this case did not actually address the decision the directors arrived at, but the means by which they came to their conclusion.

The ruling is "a further erosion" of the business judgment rule, Mr. Brockmeier says.

The decision urges directors to take precautions such as retaining an independent investment banker when evaluating a merger transaction.

Others agree with Mr. Brock-

The ruling is 'another straw on the back' of already reluctant D&O underwriters, Mr. Alcorn says.

meier.

"The court is eroding the prior protections the directors had if they had acted in a normally prudent way, and opening the door for new standards of care in major actions," observes Samuel Alcorn, senior vp-operations at broker Bayly, Martin & Fay International Inc. in Fort Worth, Texas.

The court held the Trans Union directors to a standard of care that is "far more severe" than the business judgment rule that courts have previously relied on, Mr. Alcorn explains. The business judgment rule is sometimes known as the "prudent businessman rule."

Mr. Alcorn sees the ruling as "another straw on the back" of insurers that are already reluctant to underwrite D&O coverage.

Both Mr. Alcorn and Mr. Brockmeier surmise that the ruling is contributing to underwriters' reluctance to provide corporate D&O insurance because they fear growing losses.

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London optimistic about insurer results

By ALAN H. CLIFTON
and PHILIP V. OLSEN

Special to Business Insurance

AT MIDYEAR there is a clear underlying optimism in London toward the state of the international insurance market, although it also is evident that the financial results posted by multiline British insurance companies won't improve immediately.

Outsiders may presume professionals at Lloyd's of London and other British insurance markets are deeply engaged in resolving internal disputes, breaches of good conduct and the like. But in reality, brokers and underwriters are so inundated with business during the tight market that resolving past misdemeanors is of little concern.

The volatility of currency rates this past year is causing far more problems than past scandals. The weakness of the British pound against the dollar has diminished London's capacity to write the burgeoning flow of U.S. risks. Now, available capacity and a willingness to use it is the name of the game.

However, as far as the British multiline insurance groups are concerned, buoyant stock prices in recent years, coupled with earlier equity-raising operations, have left these companies in very comfortable surplus positions. A review of the capital and surplus positions of overseas subsidiaries, however, shows that, in some instances, overseas operations are not as well-funded.

Commercial Union Assurance Co. P.L.C.'s U.S. subsidiaries are operating at a 3-to-1 premium-to-surplus ratio, which is inferior to both CU's overall surplus position and to the ratios at which other U.S. arms of British insurance groups are operating.

But, for the most part, British insurers are in a good position to benefit from the tightening insurance market, and we believe that a major financial recovery is under way for the leading British insurance groups. According to our projections, the pretax earnings of General Accident Fire & Life Assurance Corp. P.L.C., for example, could well exceed their previous peak level of 105 million pounds (\$145 million), although this will not occur until 1986. In Royal Insurance P.L.C.'s case, past record earnings may not be surpassed until at least 1987. And, Commercial Union may have to wait awhile longer.

Before record-setting results are seen, Brit-

Alan H. Clifton and Philip V. Olsen are analysts with London-based Kitcat & Aiken. They report quarterly on the British insurance industry for Business Insurance, in addition to supplying weekly stock reports for British insurers and brokers.

British Issues

13 Aug	Price	P/E	Div.	Yield	High—Low
Companies	pence		pence	%	pence pence
Comm Union	216	N/M	16.9	7.8	221—213
Genl Accident	647	35.9	28.6	4.4	655—633
Gdn Royal Exch	747	22.0	37.1	5.0	755—735
Royal	683	85.4	33.9	5.0	683—670
Sun Alliance	500	27.8	21.1	4.4	502—478

Brokers	Price	P/E	Div.	Yield	High—Low
	pence		pence	%	pence pence
CE Heath	620	8.3	30.0	4.8	620—618
Hogg Robinson	256	10.7	11.4	4.5	256—252
JH Minet	186	10.3	8.9	4.8	192—186
Sedg Grp	373	14.1	14.3	3.8	375—372
Stew Wrightson	600	12.2	25.7	4.3	600—597
Willie Faber	665	17.1	18.6	2.8	665—657

Source: Philip Olsen/Alan Clifton, Insurance Industry Specialists Kitcat & Aiken Stockbrokers, London

ish insurers must negotiate some pretty hostile territory, as current results are even worse than last year's. While analysts and investors have the luxury of looking far beyond the valley and its troubled waters to the lush ground on the other side, insurance company managements must grapple with the everyday job of problem solving.

Not helping the situation are Mother Nature, in the form of still-heavy weather losses, and the U.S. legal system, in the form of ever-spiraling court awards.

The chief impetus to better results among British insurers now can be found in the U.S. commercial insurance market, where rate increases are continuing at a pleasing pace. The U.S. personal lines market also is exhibiting encouraging signs on the rate-relief front.

Other areas of activity for British insurers, however, are not so inspiring. Severe weather losses have occurred in a number of countries, including the United States. Other overseas markets such as Canada and Australia, which are important to British underwriters, are showing worrying signs of increased competition. And, the British market itself, though showing signs of improvement, currently is experiencing a deterioration in claims frequency.

Therefore, the underwriting picture remains decidedly cloudy. Insurers remain dependent on investment income and, in the case of the multiline groups, on strongly rising life insurance earnings, to see them through. Stock prices are starting to signal a restoration of underwriting earnings, but this recovery will not become evident until next year.

On the other hand, the publicly held Lloyd's brokers, like their U.S. counterparts, stand a good chance of recording some

healthy profit improvements before next year—though it may be too optimistic to expect all Lloyd's brokers to match the performance of Marsh & McLennan Cos. Inc.'s C.T. Bowring (Underwriting Agencies) Ltd. in the first half of calendar 1985.

In the first half, Bowring's operating revenues increased 31%, operating income advanced by about two-thirds and aftertax earnings rose 86%.

Bowring's eye-catching growth is one of the few available indications of progress by Lloyd's brokers this year, although C.E. Heath P.L.C. has disclosed a 30% increase in brokerage revenues in the quarter ending June 30, while Minet Holdings P.L.C. reported a 17% increase in revenues and a 30% increase in profits in the first quarter.

Undoubtedly, when all the major publicly held British brokers come to reveal their first-half performances in September, their results will display, as in recent years, useful benefits stemming from the strength of the U.S. dollar, even allowing for the now much more commonplace strategy adopted by the Lloyd's brokers of minimizing the level of their exchange risk through the use of currency futures.

Currency factors certainly played a significant part in Bowring's revenue growth, but underlying double-digit revenue growth and the company's ability to hold expense growth to 14% helped account for improved profits.

Whether other Lloyd's brokers will be so successful remains to be seen. One of the major challenges facing the brokerage community at the present time takes the form of pressures that could force up brokers' expenses. In some respects, this is a tight-market phenomenon. When underwriters start rationing their capacity, more brokers are required to stand in line. And, at the higher-paid end of the brokerage workforce, competition for talent is bringing its own inflationary strains.

The pressure on brokerage expenses also can be attributed to the soft market of the late 1970s and early 1980s having its revenge on these supposedly risk-adverse insurance middlemen. Brokers' own past attempts to enter the underwriting game have yielded little but cash calls. And, generally overenthusiastic brokers operating in the producer-oriented soft market have given rise to such an array of errors and omissions claims that brokerages' own E&O coverage is now an extremely costly item.

Insurance capacity problems have not made life easy for the brokerage community. But, the ability of the front-line players to place risks in a tough market should ensure continued growth for these brokerages.

Meanwhile, if the environment for insurance brokers is indeed improving, there may be further examples of merger and corporate activity to stimulate interest.

Sedgwick Group P.L.C.'s merger with Fred S. James & Co. Inc. and Alexander & Alexander Services Inc.'s merger with Reed Stenhouse Cos. Ltd., have now, together with Marsh & McLennan, created three truly huge groupings. Mergers among the smaller groups may follow, if Citicorp's acquisition of a small Lloyd's broker last year and Bank-America Corp.'s recent moves in this direction are any indication.

Mission Insurance Group

Mission Insurance Group Inc. is receiving a \$40 million infusion from Cincinnati-based American Financial Corp., according to a Mission spokesman. The funds are to be transferred by the end of next month.

This is the second substantial contribution AFC has made to Los Angeles-based Mission in five months. In a complicated transaction in March, AFC provided Mission with \$75 million and received a warrant to increase its stake in the group to a maximum of 91.3%, up from the current 49.9% (BI, March 18).

Mission reported a \$41.9 million net loss for the second quarter, compared with a \$39.4 million loss for the same period last year.

The 1985 loss principally reflects substantial additions to loss reserves, says the spokesman. The company added \$39 million to reserves during the first half, he says.

The Travelers Corp.

The Travelers Corp. reported second-quarter operating income of \$78.5 million, up 2% from \$76.6 million in the second quarter of last year. For the first half of 1985, operating income grew 5% to \$151.6 million, compared with \$145 million during the same period last year.

Gross premiums in the second quarter of 1985 totaled \$2.7 billion, up 2.6% from \$2.6 billion during the same period last year. Premiums for the first half of 1985 totaled \$5.6 billion, compared with \$5 billion during the first six months of 1984, an increase of 10.5%.

Kemper Corp.

Kemper Corp. reported second-quarter operating earnings of \$14.6 million, compared with an operating loss of \$3.8 million during second-quarter 1984. Operating earnings for the first half of 1985 amounted to \$22.1 million, compared with an operating loss of \$4.9 million during the same period last year.

BI Industry Stock Report

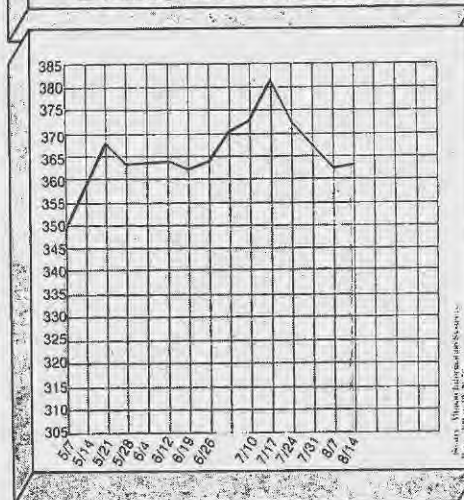
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Brokers	Price	% Chg.	P/E	Div.	% Yld.	High	Low	Vol.(000)
Alexander & Alexander Svcs	NYSE 27.00	-2.3	0.0	1.00	3.7	27.38	26.13	460.7
Baldwin & Lyons Inc	OTC 60.00	0.0	9.9	0.80	1.3	60.00	60.00	0.2
Corroon & Black Corp	NYSE 48.75	2.1	0.0	1.00	2.1	48.75*	48.13	20.7
Crump E H Cos Inc	OTC 32.00	-3.0	20.6	0.50	1.6	32.75	32.00	14.6
Emett & Chandler Cos Inc	OTC 14.25	5.6	36.5	0.00	0.0	14.25	13.75	18.7
Gallagher Arthur J & Co	OTC 39.25	1.3	21.9	0.28	0.7	39.25	38.75	3.6
Hall Frank B & Co Inc	NYSE 30.38	2.5	0.0	1.00	3.3	30.88	30.38	431.8
Marsh & McLennan Cos Inc	NYSE 70.38	0.9	18.0	2.40	3.4	70.50	69.88	249.2
Poe & Assoc Inc	OTC 8.00	0.0	0.0	0.80	10.0	8.00	8.00	1.3
Reed Stenhouse Cos Ltd	OTC 20.50	-3.5	26.6	0.00	0.0	21.50	20.00	21.6
AGENTS/BROKERS	AVERAGE		37.9		2.2			
Conglomerates & Holding Cos.	Price	% Chg.	P/E	Div.	% Yld.	High	Low	Vol.(000)
American Express(Fireman's Fd)	NYSE 42.25	0.9	15.0	1.28	3.0	43.88	43.25	2,608.5
Anderson Clayton(Ranger/PanAm)	NYSE 39.75	-0.6	34.3	1.32	3.3	40.63	39.75	39.8
Armco Inc	NYSE 10.00	-2.4	0.0	0.00	0.0	10.38	9.75	254.8
Berkley W R Corp	OTC 19.13	-1.3	56.2	0.32	1.7	19.38	19.00	118.7
CIGNA Corp	NYSE 56.00	2.3	73.9	2.60	4.6	56.75	55.88	558.9
City Investing Co. (Home Ins.)	NYSE 27.88	-1.8	4.3	0.00	0.0	28.50	27.88*	410.2
CNA Finl Corp (CNA)	NYSE 55.50	8.3	19.2	0.00	0.0	55.50	53.13	102.1
General Re Corp	NYSE 86.88	0.3	137.9	1.56	1.8	88.63	86.88	259.9
ITT (Hartford Group)	NYSE 32.75	-1.1	9.5	1.00	3.1	33.00	32.63	1,723.5
Sears Roebuck & Co. (Allstate)	NYSE 35.38	0.7	9.5	1.76	5.0	35.38	35.25	1,776.2
Teledyne Inc (Argonaut)	NYSE 250.50	-0.9	5.4	0.00	0.0	253.38	247.25	124.9
Transamerica Corp	OTC 28.75	0.9	14.8	1.64	5.7	28.75	28.25	842.2
(Occidental & Fred S. James)	NYSE 28.75	0.9	14.8	1.64	5.7	28.75	28.25	842.2
CONGLOMERATES/HOLDING COS.	AVERAGE		10.5		1.7			
Insurers	Price	% Chg.	P/E	Div.	% Yld.	High	Low	Vol.(000)
Aetna Life & Cas Co	NYSE 46.25	1.1	19.0	2.64	5.7	46.50	45.88	1,298.3
American General Corp	NYSE 32.75	0.4	10.2	1.00	3.1	33.00	32.75	985.5
Ameri Heritage Life Invst Co	NYSE 33.00	-2.2	9.6	1.20	3.6	33.75	33.00	1.6
American Indty Finl Corp	OTC 20.25	-3.6	0.0	1.12	5.5	20.75	20.25	3.9
American Intl Group Inc	NYSE 84.88	-0.7	22.7	0.44	0.5	87.25	84.88	489.7
Aneco Reins Ltd	OTC 1.25	0.0	0.0	0.00	0.0	1.25	1.25	0.2
Avenco Corp	NYSE 29.88	0.0	13.1	0.60	2.0	29.88	29.50	53.9
Business Mens Assurn Co Amer	OTC 25.75	0.0	7.5	1.04	4.0	25.75	25.38	18.2
Chubb Corp	NYSE 70.25	2.2	17.2	2.20	3.1	70.38	69.63	179.0
Combined Intl Corp	NYSE 45.25	-5.5	8.5	2.16	4.8	47.50	45.25	303.1
Continental Corp	NYSE 41.50	-0.6	20.3	2.60	6.3	42.50	41.50	345.7
Crown Life Ins Co	OTC 175.00	-0.3	10.6	0.00	0.0	175.00	175.00	0.1
Durham Corp	OTC 39.13	-0.9	7.3	1.28	3.3	40.00	39.00	4.0
Farmers Group Inc	OTC 61.63	-2.2	10.6	1.76	2.9	63.00	61.50	458.2
Freeston Gen Corp	OTC 24.75	3.7	0.0	0.48	1.9	24.88	24.13	659.1
Great West Life Assurn Co	OTC 420.00	-1.2	10.8	1.60	0.4	425.00	420.00	0.6
Hanover Ins Co	OTC 46.50	6.9	63.7	0.56	1.2	46.50	44.13	70.2
Hartford Steam Boiler Insnptn	OTC 49.75	-0.5	15.7	1.60	3.2	49.75	49.50	7.0
Kans City Life Ins	OTC 25.50	-1.0	10.0	0.87	3.4	25.75	25.50	11.8
Kemper Corp	OTC 56.63	-0.4	16.3	1.80	3.2	57.00	56.63	48.3
Liberty Corp S C	NYSE 29.50	0.0	13.0	0.72	2.4	29.50	29.25	35.9
Lincoln Natl Corp Ind	NYSE 42.00	-1.5	10.1	1.84	4.4	43.00	42.00	154.1
Mission Ins Group Inc	NYSE 5.88	-6.0	0.0	0.00	0.0	6.25	5.88*	169.3
Monumental Corp	OTC 33.13	1.9	12.1	1.40	4.2	33.13	32.25	12.4
Hobel Ins Ltd	OTC 12.25	16.7	16.1	0.25	2.0	12.25	10.50	75.5
Northwestern Natl Life Ins	OTC 23.00	-12.4	5.9	0.80	3.5	24.63	23.00*	1,727.8
Ohio Cas Corp	OTC 60.38	-0.2	22.6	2.80	4.6	60.63	60.25	53.2
Old Rep Intl Corp	OTC 36.00	1.8	9.7	0.74	2.1	36.13	35.75	277.9
Orion Cap Corp	NYSE 26.00	3.0	0.0	0.76	2.9	26.00	25.00	25.2
Protective Corp	OTC 19.50	5.4	7.2	0.66	3.4	19.50	18.00*	577.7
Provident Life & Acc Ins Co	OTC 24.00	-1.5	6.5	0.76	3.2	24.50	24.00	345.1
St Paul Cos Inc	NYSE 70.50	-2.4	10.0	3.00	4.3	72.13	70.38	378.5
SAFECO Corp	OTC 40.00	2.2	13.0	1.60	4.0	40.00	39.25	275.1
SRI Corp	OTC 21.00	5.7	61.8	0.80	3.8	21.00	20.13	224.3
Seibels Bruce Group Inc	OTC 17.00	-5.6	0.0	0.80	4.7	17.00	16.25*	111.0
Statesman Group Inc	OTC 4.00	0.0	0.0	0.15	3.8	4.13	4.00	44.3
Tokio Marine & Fire Ins Co	OTC 177.50	-0.4	30.7	1.05	0.6	179.00	174.75	18.8
Torchmark Corp	NYSE 43.63	-5.4	9.1	1.20	2.8	45.75	42.13	560.4
Travelers Corp	NYSE 44.13	0.6	10.7	2.04	4.6	44.25	43.88	538.9
United Fire & Cas Co	OTC 25.50	0.0	22.2	0.80	3.1	25.50	25.50	0.5
United States Fid & Gty Co	NYSE 34.63	-1.4	144.3	2.20	6.4	35.88	34.63	671.7
USLife Corp	NYSE 36.63	-3.6	8.2	1.04	2.8	37.63	36.50	75.6
Washington Natl Corp	NYSE 25.13	-0.5	7.3	1.08	4.3	25.88	25.13	26.1
Zenith Natl Ins Corp	OTC 18.50	2.8	0.0	0.68	3.7	18.50	17.75	58.5
INSURANCE COMPANIES	AVERAGE		17.0		2.4			

System design: Altman Information Systems

BI Insurance Index



The Business Insurance stock index, after declining for three consecutive weeks, reversed that trend during the trading period ending Aug. 14. The index closed at 364.0 points, up 0.9 points from 363.1 points on Aug. 7. A total of 22 stocks posted gains, 27 stocks declined and eight stocks were unchanged. The biggest gains were posted by Nobel Insurance Ltd., up 16.7%; CNA Financial Corp., up 8.3%; Hanover Insurance Co., up 6.9%; SRI Corp., up 5.7%; and Emett & Chandler Cos. Inc., up 5.5%. The biggest losses were posted by Northwestern National Life Insurance Co., down 12.4%; Mission Insurance Group Inc., down 6%; Combined International Corp., down 5.5%; Torchmark Corp., down 5.4%; and USLife Corp., down 3.6%. The BI index rose 0.2% for the period.

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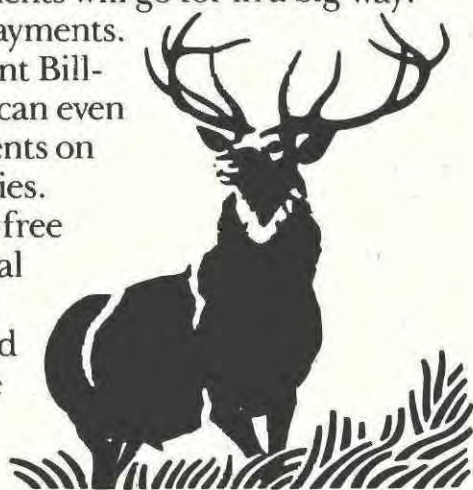
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