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update

Asbestos liabilities block sale of GAF to Allied Corp.

NEW YORK—Allied Corp. will not purchase GAF Corp.'s chemicals division because of GAF's uncertain asbestos-related liabilities.

Earlier this year, the companies had preliminarily agreed to a $410 million sale pending a "satisfactory resolution" of GAF's potential liability.

A GAF spokesman said the company also was concerned that asbestos litigation might prevent it from distri-

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Mobil pleads captives' tax case

By RHONDA L. RUNDLE

NEW YORK—More than the $35 million in tax refunds sought by Mobil Corp. is riding on the outcome of a two-week trial in New York last month.

Mobil Corp. is fighting the federal government over tax deductions for premiums paid to its captive insurance companies.

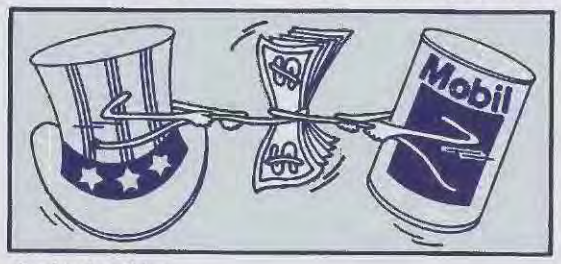
A court ruling in the dispute, which has been heard in the U.S. Court of Claims, could finally answer the long-debated question of whether captives are bona fide insurance companies for tax purposes or merely fancy forms of self-insurance.

It could be a year before the Court of Claims reaches its decision. And then the case could go to the Supreme Court, which is the next court of appeal.

At stake are billions of dollars—either in tax revenues for the U.S. government or in tax refunds for owners of captive insurance companies.

Surprisingly, observers say, both Mobil and the federal government are arguing the case on the basis of broad economic and tax law principles along with the usual citation of tax code sections and presentation of technical facts.

"A routine tax fight has been turned into a real life-and-death struggle," said one observer.



Graphic: Amy Palmer

While it is possible that the Court of Claims may eventually decide the case on highly technical grounds—and likely further confuse an already convoluted area of tax law—both Mobil and the government are aggressively arguing the theoretical positions that have divided the Internal Revenue Service and the captive insurance industry since the early 1970s.

This approach by the parties opens the door to a sweeping decision that could set a powerful precedent for corporate financial officers, captive managers, independent auditors, attorneys, the courts and others that must consider or evaluate the tax status of premiums paid to captives.

A very broad decision might even move beyond the critical facts in the Mobil case to tackle the burning question of whether a preponderance of outside underwriting business changes the character of a captive insurance company from a tax standpoint.

Mobil is contesting the IRS' refusal to allow tax deductions for at least $35 million in premiums paid to four overseas Mobil captives by 35 subsidiaries during tax years 1961-69. The oil company paid the disputed taxes, but filed suit five years ago in the U.S. Court of Claims for a refund (*BI*, April 19, 1982).

Although the litigation started in 1978, the dispute dates back 12 years, Mobil attorneys say. Besides the captive insurance company issue, the Court of Claims is considering a host of other tax issues worth about $60 million to the oil company.

Pertaining to its four offshore captive insurance companies, Mobil argues that they are separate entities operating at arm's length from the parent corporation. They were formed for valid business purposes "and not for the purpose of enabling Mobil of any of its affilates to avoid or evade federal income tax," Mobil says in a court document that outlines its position.

When the parent or one of its affiliates purchases insurance from another affiliate, it should get a tax deduction because "the Internal Revenue Code requires separate tax treatment of separate although related corpo-

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Property insurers, MGM step up coverage battle

By BILL DENSMORE

LAS VEGAS, Nev.—New allegations of fraud are intensifying the fight between MGM Grand Hotels Inc. and one of its excess property insurers over coverage for the 1980 fire at MGM's Las Vegas hotel.

MGM now wants punitive damages assessed against American Protection Insurance Co., a Kemper Group company, because of the delay in paying its claim.

MGM originally sued American Protection in early 1982 in U.S. District Court in Las Vegas for $33 million in additional excess property coverage but did not seek punitive damages (*BI*, March 1, 1982).

In turn, American Protection now is seeking to void MGM's insurance contract and retrieve the $92 million in advances the insurer made to MGM to help restore the Las Vegas MGM Grand Hotel after the fire. It also wants interest on that $92 million.

American Protection contends that MGM fraudulently included in its property loss claim the cost of upgrading its property to meet fire codes.

MGM also is battling the broker and insurers of its controversial back-dated liability coverage purchased after the November 1980 fire (*BI*, July 18). In that litigation, the lead underwriter also is asking the court to rescind its policy.

In the latest development this spring in the property litigation, U.S. District Judge Roger D. Foley ruled that MGM is entitled to claim damages against other Kemper companies that to-

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Bill would limit types of benefits to be offered in cafeteria plans

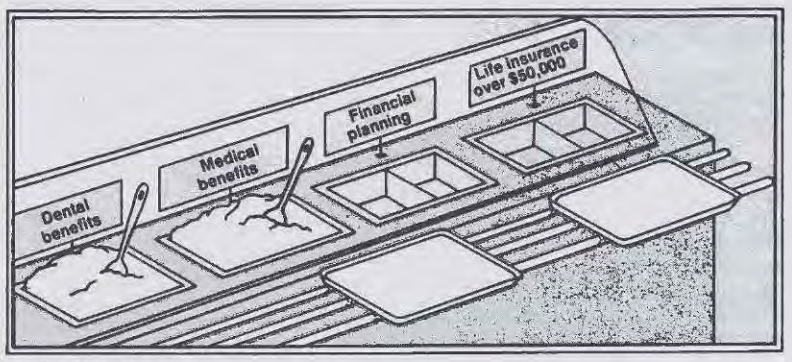
By JERRY GEISEL

WASHINGTON—Two congressmen want to remove some of the entrees from cafeteria-style employee benefit plans.

Legislation introduced by Reps. Fortney (Pete) Stark, D-Calif., and Barber Conable, R-N.Y., would bar cafeteria plans from including taxable benefits as options in a flexible benefit plan.

Taxable benefits include group term life insurance with limits exceeding $50,000 and dependent term life insurance exceeding $2,000—benefits offered by almost all of the dozens of cafeteria plans now operating.

In addition, other taxable benefits—like financial counseling, group automobile and group homeowners insurance—could not be offered as part of a cafeteria plan. The popularity of these benefits is expected to grow in the future.



Graphic: Amy Palmer

Furthermore, the bill could also prohibit vacation options in such plans, experts say, though it does not explicitly state that it would.

"It (the legislation) would have an immediately negative effect on nearly every cafeteria plan," warns William Chip, an attorney with the Employers Council on Flexible Compensation in Washington.

The legislation "would narrow the employer's opportunity to respond to the employee's needs for flexibility," adds Peter Hutchings, a partner with benefit consultant Kwasha Lipton in Fort Lee, N.J.

"It would cut down on the range of options employers could offer. If we lost these two (group term life insurance and vacation benefits), it would be a serious loss to employees."

Cafeteria plans are so named because they allow employees to choose from an assortment of benefits. They are becoming more popular because they can meet the benefit needs of an increasingly heterogeneous workforce.

For example, cafeteria plans allow a young worker with a family to trade in a benefit that might not be needed, like vision care, for extra life insurance.

Besides affecting employers with cafeteria plans, the bill would also resolve some of the confusion over taxation of so-called non-statutory benefits.

Non-statutory benefits include company-provided parking spaces, employee discounts for products sold by the employer, free travel for airline employees and employer-provided recreational facilities.

Since the mid-1970s, the Treasury Department has wanted to issue rules to clarify the tax status of non-statutory benefits.

But Congress decided in 1978 that if there were to be rules addressing the tax treatment of benefits, it—not the Treasury Department—would draft and ultimately enact those rules.

As a result, Congress in the last five years has passed a series of moratoriums prohibiting the Treasury Department from issuing new benefit taxation regulations until it considered its own rules.

The latest moratorium is set to expire Dec. 31. Before the moratorium expires, Reps. Stark and Conable, both members of the

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Crime wave could cause jewelers block rates to rise
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update

Asbestos suits block GAF sale

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buting to shareholders proceeds from the sale. GAF, which is seeking to liquidate the company, is in the middle of a proxy battle with dissident shareholders.

As of last March, GAF faced 12,300 asbestos claims. It says its insurers are paying the claims, even though GAF is engaged in litigation with its insurers in California.

Ford vp sues other Ford officers

DETROIT—A job discrimination suit by one Ford Motor Co. officer against other officers of the company may raise questions for Ford's directors and officers liability insurer.

Thomas J. Feaheny, 51, Ford's vp for vehicle research, has sued top Ford executives alleging that his involvement as a Ford witness in the widely publicized 1980 criminal trial against Ford involving the design of its Pinto subcompact car has cost him stock options, promotions and future opportunities. Ford won that case.

Ford's D&O insurer, believed to be a unit of American International Group Inc., should respond to such a discrimination suit. But, asked a D&O underwriter at another insurance company: Who defends Mr. Feaheny if the defendant Ford executives counterclaim? Mr. Feaheny, as an officer of Ford who says he has no plans to resign, also is entitled to the D&O coverage.

Mr. Feaheny says other Ford executives consider him "tainted" by his involvement with the Pinto trial and the design of the car and failed to offer him stock options worth $1 million granted since then to all other key Ford executives. He says his salary has been frozen at $165,000 since 1979.

Henry R. Nolte Jr., Ford's general counsel, said, "We believe the actions of the company and its officers were entirely proper and there is no basis for any claims." The company suspended Mr. Feaheny on Thursday. AIG would not comment.

Projection hurts CIGNA stock

PHILADELPHIA—CIGNA Corp.'s stock skidded $4.75 a share in one day after the big property/casualty insurer said last week it expected a 25% decline in second-quarter earnings. Results so far from other insurers are mixed.

"In spite of being at or near expectations in the other segments of our business, the impact of the continuing weakness in the property/casualty area could produce a moderate year-to-year decline in 1983 operating results compared to the $490 million reported in 1982," CIGNA President Robert D. Kilpatrick said.

CIGNA stock fell July 27 to $42.75 from $47.50 in heavy trading. CIGNA's complete quarterly results are due Aug. 10.

Chrysler interested in using PPO

DETROIT—Chrysler Corp. says the United Auto Workers must agree to work with a preferred provider organization or expect to start sharing the cost of health benefits, a company spokesman said last week after preliminary contract negotiations broke off.

Walter B. Maher, Chrysler's director of employee benefits and health services, said talks will not resume until November but work on setting up a PPO network will continue. The current contract expires Jan. 14, 1984, and the union has said it would like to improve its compensation package in light of Chysler's recent profits.

He said the company does not plan to cut health benefits for its 140,000 U.S. active employees and retirees, but hopes to reduce benefit costs. Chrysler will spend $373 million for benefits in 1983.

Mr. Maher terms the current dispute over the establishment of a PPO as a "chicken-and-egg problem." The company cannot set up a PPO until it can guarantee a volume of users and the union will not commit until Chrysler supplies more concrete details.

OSHA to focus on benzene

WASHINGTON—The Occupational Safety & Health Administration will not issue an emergency standard for workers' exposure to the chemical benezene but is giving top priority to revising the current benezene standard.

Under a "accelerated rulemaking" procedure, OSHA is giving companies until Aug. 4 to contribute information on the use of benzene in the workplace. OSHA then will formulate proposed permissible exposure limits for this substance, which has been linked to leukemia. The proposal is scheduled to be released in November.

A public health and labor coalition, including an organization headed by consumer advocate Ralph Nader, and the AFL-CIO, had petitioned OSHA for an emergency standard, reducing the permissible exposure limit to 1 part benzene per million parts air from the current permissible exposure limit of 10 ppm.

In response to OSHA's denial of the emergency standard, the AFL-CIO telegrammed Vice President George Bush, who heads the administration's task force on regulation, urging him to reverse OSHA's decision.

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Egg farm buildings insured, but 210,000 chickens aren't

By SALLIE J. DRURY

ACME, Ind.—A southern Indiana egg farm is insured for the $3 million in buildings and equipment destroyed in a fire last month, but not for the 210,000 chickens that died in the blaze.

The July 22 fire destroyed six chicken houses and an egg processing building at Egg Acres, an egg-laying division of Acme-based Rose Acre Farms. Half of the complex—six chicken houses—remains.

"It took about 10 to 15 minutes to burn everything down," said Jack McCory, controller for Rose Acres. "Then the firemen were there the rest of the night to keep the rest of the complex from burning."

The Jackson County, Ind., sheriff's department said the fire was caused by faulty electrical wiring.

Rose Acre Farms has $13 million in all-risk coverage after a $100,000 deductible. The first $10 million was written by Industrial Indemnity Co., a San Francisco-based affiliate of Crum & Forster, through Industrial Underwriters Inc., a specialty lines marketer also owned by Crum & Forster.

A $3 million excess policy was written by Pacific Mutual Marine Office Inc., also in San Francisco. Both policies were brokered by Williams Insurance Agency in Brownsburg, Ind.



Photo: UPI

A fire investigator works his way across roof that collapsed following a fire at Egg Acres farm.

However, the policies do not cover lost chickens or eggs nor business interruption expenses, says Mr. McCory.

"We didn't think it was feasible to insure the chickens," said Mr. McCory, who could not estimate the value of the poultry killed in the fire. "Things like this happen once in a lifetime. . .or maybe twice."

Mr. McCory added that Rose Acre Farms does not plan to insure its chickens in the future, despite its loss.

"You can pay $200,000 or

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Indiana Jones down this time

By STACY SHAPIRO

LONDON—Hazard seems to plague Indiana Jones wherever he goes.

Harrison Ford, who plays the handsome hero of "Raiders of the Lost Ark," was able to wrestle with snakes and pull himself up from a speeding truck with a bullet in his arm in the first film adventure.

However, production of the sequel, "Indiana Jones and the Temple of Doom," has been delayed in London until Aug. 8 because Mr. Ford has been forced to return to Los Angeles to receive treatment for a bad back.

Sources at Lloyd's of London estimate that the loss of three weeks of production will probably cost underwriters insuring the film's

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A&A sues accounting firms that audited Howden, affiliates

By STACY SHAPIRO

LONDON—Alexander & Alexander Services Inc. is suing accounting firms that audited Alexander Howden Group P.L.C. and several subsidiaries before and during A&A's 1982 acquisition of Howden.

A&A executives have hinted since last year that the company planned to sue the auditors, but a suit was not filed in London's High Court until July 11.

However, the suit, which alleges breach of contract and negligence, sheds little light on the specific charges A&A has against the firms. The suit informs the defendants that they have been sued, but does not specify monetary damages or the exact grounds for the complaint.

A spokesman for Peat Marwick International in New York, whose Bermuda operation is named in the suit, says the complaint is only a device to meet statute of limitation requirements and that A&A and the defendants are still engaged in negotiations.

A&A's London law firm, Denton, Hall & Burgin, would not comment on the suit, and A&A Chairman John A. Bogardus Jr. failed to

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Asbestos defense expenses total 60% of overall costs

By STEPHEN TARNOFF

Of the $1 billion employers and insurers spent in the last decade on asbestos litigation, 60% went to defense costs and only 24% to the injured claimants.

Those are the findings in the first major study on asbestos litigation costs released last week by the Rand Corp.'s Insititute for Civil Justice, a Santa Monica, Calif., think tank.

Of the $1 billion spent since the early 1970s when the first asbestos lawsuits were filed until the end of 1982, $600 million was spent on employers' and insurers' legal fees and claims administration costs; $236 million was spent to pay damages to injured plaintiffs or their survivors; and $164 million was paid to plaintiffs' attorneys, the report shows.

And, about $330 million of that $1 billion came directly from employers' pockets—not their insurers.

The study, entitled "Costs of Asbestos Litigation," makes no recommendations and is one of two planned by Rand on the topic. The second one to be released later this year will analyze individual asbestos injury cases.

Seventeen major asbestos defendants, 12 major insurers and 27 plaintiffs' attorneys were surveyed for the first study, which included a review of 3,800 closed cases and 17,000 pending claims.

The study concerns only asbestos-related product liability litigation. It does not include costs incurred by the government, costs of claims filed under workers compensation laws or the reorganization costs incurred by companies that have filed for bankruptcy.

The study looks at overall asbestos litigation expenses for both closed and pending cases and for closed cases alone.

Of the $1 billion total spent on asbestos litigation in the last decase, $661 million was spent on cases now closed and $345 million on cases still pending.

When only closed cases are considered, the difference between defense costs and plaintiffs' actual compensation is narrowed. In closed cases, the plaintiff actually received 37% of the money spent.

Employers and insurers paid an average $95,000 per closed claim, including $60,000 in compensation and $35,000 in litigation costs.

Allocated defense costs are significantly higher in asbestos cases than in other litigation, the study shows.

Applying a formula used by the Rand researchers, allocated defense costs (outside legal fees) for asbestos

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Delta Holdings buys small underwriter to begin network

By RHONDA L. RUNDLE

FORT LEE, N.J.—Delta Holdings Inc., an organization owned by 26 U.S. and European industrial corporations, is launching the first phase of its planned insurance network with the acquisition of a small insurance company.

Last month, Delta purchased the assets of NGM Fire & Casualty Co. from National Grange Mutual Insurance Co. in Keene, N.H., for $6 million. Besides its investment portfolio, the insurer's key asset is its licenses to underwrite direct insurance in 12 states.

National Grange agreed to retain the liabilities of the insurer, which will maintain its domicile in New Hampshire but will be renamed Delta America Insurance Co.

Delta will soon establish business offices in New York and begin underwriting multiline treaty reinsurance and, eventually, direct insurance.

The acquisition is the first of several that Delta Holdings has said it would make to develop a worldwide network of insurance and reinsurance companies. All of the holding company's 26 shareholders are owners of captive insurance companies that want to expand their underwriting of risks unrelated to their parent companies.

Delta Holdings was formed in April with $24 million in cash contributed by the 26 shareholders, which include some parent companies and some captives (*BI*, April 25). The holding company is expected to make perhaps three or four more acquisitions—including one in the United Kingdom—to complete the network.

"Delta presents us with an opportunity to further diversify our existing third-party business," explains Tom A. Caldwell Jr., who is chairman of Delta Holdings and director of corporate risk management at American Cyanamid Co. in Wayne, N.J., one of Delta Holding's shareholders.

American Cyanamid also hopes to reduce the ultimate cost of its own insurance through profitable third-party underwriting, he added.

Substantial amounts of Delta America's reinsurance and insurance premiums will be retroceded to the captive insurance company affiliates of Delta Holdings' shareholders, giving them a controlled source of third-party risks.

"Delta will permit these captives to penetrate the domestic marketplace and obtain good-quality reinsurance business to boost their share of unrelated underwriting business," notes Lawrence R. Bell, executive vp of Delta America. Mr. Bell also is a vp with American Risk Management Inc. in Fort Lee, N.J., which will manage Delta America.

American Risk Management is a part of the Fred Reiss Organization, which owns risk management consulting and captive management companies in the United States, Bermuda, Cayman Islands and Ireland. The Delta Holdings project is a brainchild of the Reiss group and the shareholders are all Reiss clients.

Eventually, Delta America is expected to transmit risks back and forth among itself, its shareholders' cap-

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Tarnished market

Crime wave forces U.S. insurers to hike rates for jewelers block coverage. . .

By STEVE TARAVELLA

U.S. jewelers aren't having problems finding affordable insurance for their inventories despite the withdrawal of some insurers—including the lead Lloyd's of London underwriter—from the jewelers block insurance marketplace.

But, U.S. insurers say jewelers may be paying higher premiums—up to 50% more—unless they beef up security measures to combat a sharp increase in robberies and burglaries.

U.S. insurers consistently report they've been hit with high losses on jewelers block coverage, but unlike Syndicate 640 at Lloyd's of London, most of them are determined to stick it out (see related story).

In fact, some underwriters like American International Group Inc. are putting their foot in the door for the first time, hoping to mine a profit on jewelers block coverage where others have failed.

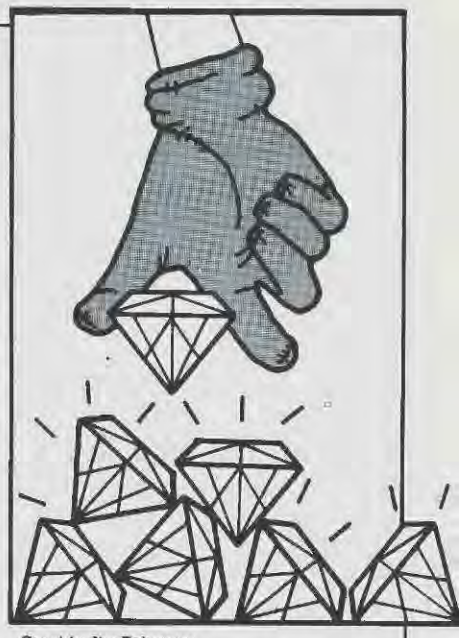
The withdrawal of London underwriters from the jewelers block market "so far has had no real impact (on the avalability of insurance in the U.S.)," says Michael D. Roman, chairman of Jewelers of America, a 12,000-member industry organization in New York City.

"There's still a sizable market," Mr. Roman says, adding that he is not aware of any JA members facing difficulties obtaining adequate insurance.

Al Schwartz, comptroller of Van Cleef & Arpels, the New York retail jewelry giant, agrees, explaining that his company has not encountered recent insurance difficulties or premium hikes.

"What some jewelers may not have seen, especially in the more remote, outlying areas where crime is less, are the dramatic rate increases, curtailments of coverage, and limitations placed upon them that the city-type jeweler is up against," says James J. Buttitta, vp of United California Insurance Agency in North Hollywood and a 10-year specialist in jewelers block coverage.

"But I think we've only now begun to see—or will in the next six months or so begin to see—increases in premiums," Mr. Buttitta explains. But Gerald C. Whiteford, branch property manager for Allianz Underwriters Inc. in Los Angeles, estimates that rates could rise as much as 25% to 50% if crime rates continue to climb and more underwriters withdraw from the market.



Graphic: Jim Bakasetas

Current jewelers block rates average 1.5% to 3% of the policy limits.

However, Mr. Buttitta adds, "If he (a jeweler) improves his physical security system and demonstrates loss control and risk management, he can be assured of premium reductions."

Jewelers block insurance typically covers most types of losses—including thefts or burglaries—that affect jewels and precious or semi-precious stones. It also sometimes includes other stock, furniture or fixtures. The coverage is bought by retailers, wholesalers, jewelry manufacturers and organizers of jewelry trade shows.

As a general rule, jewelers block is the most important protection a jeweler purchases, Mr. Buttitta says. "It's his priority coverage, and the most expensive."

Premiums vary depending on the insured's individual circumstances, but a large, California retailer with several locations and as many as 75 employees might pay $20,000 an-

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. . .While some London underwriters give up altogether

By STACY SHAPIRO

LONDON—A recent rash of jewelry heists is forcing some leading Lloyd's of London underwriters to stop marketing jewelers block insurance and others to hike rates.

As a result, some jewelers may go uninsured because they cannot find coverage because they cannot afford to pay premiums charged by insurers that still offer the coverage, underwriters say.

In June, Leonard Toomey, senior underwriter for Lloyd's Syndicate 640 managed by A.D. Dick-Cleland (Underwriting Agencies) Ltd., stopped leading jewelers block insurance policies, something he has done for almost 17 years.

"We tried to get increased rates to pay for our growing losses, but (since) the jewelers market is depressed, it is harder to get rate increases," says Mr. Toomey.

"So, we packed it up. We lost too much money on it," he explains.

Although Mr. Toomey says he has seen many underwriting cycles in the years he's been a lead on jewelers block coverage, never before have things been so bad.

"There is more crime and more holdups and this applies all over the world," says Mr. Toomey. "We are not in the market to subsidize the jewelry industry while it goes through a rough patch."

"The jewelers block business has taken a caning," agreed Malcolm Blair, Lloyd's underwiter for syndicates managed by M.V. Spratt & Others.

"The business has eroded so quickly, it is now dramatically bad—from 15% loss ratios to 200% loss ratios overnight."

Instead of pulling out of the market, however, Mr. Blair says he is raising jewelers block insurance rates by about 30% and choosing his clients carefully.

"Premiums are going up, but not enough," said Mr. Blair.

"We are being highly selective on the clients we take in and on the producing broker we take it from," Mr. Blair explained.

Underwriters in London say there is good reason why they must take caution. In the last 18 months, a wave of jew-

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Workers compensation's problems bared

Reforms in all states should concentrate on occupational disease: Insurer report

By STEPHEN TARNOFF

State workers compensation systems should be overhauled to handle occupational disease claims in a uniform manner nationwide.

That is what a Crum & Forster Insurance Cos. task force on occupational disease recommends in a report released in June. The report rejects a federal solution to the growing problem of compensating long-latent workplace diseases and instead recommends 12 statutory and administrative changes to be made on the state level.

Keys to overhauling the system, according to the report, are the adoption by states of a broader, standard definition of compensable occupational disease, the creation of a new system for evaluating workers' injuries and the establishment of a reinsurance pool to fund claims and take pressure off individual insurers.

Because the insurer's two-year study is the most comprehensive attempt by the insurance industry to evaluate the work comp system in relation to occupational disease, it has generated quite a bit of interest among work comp experts, insurers, employers and labor groups. However, many of these groups still believe a federal solution is needed and criticize certain deficiencies they found in the report (see related story).

The report already has received the support of the American Insurance Assn. and state legislation to implement it may be introduced by next year, according to Crum & Forster officials.

The changes recommended in the report will increase the number of workers eligible for benefits and the size of benefits.

But, any increased costs to employers could be offset by various factors, including the significant reduction in litigation over claims that is expected by the authors of the Crum & Forster report.

"We recognize that implemementing many of our recommendations will result, at least initially, in an increase in the number of paid claims for occupational disease in a number of jurisdictions," the study says.

"However, we believe that today, statutory limitations and administrative challenges notwithstand-

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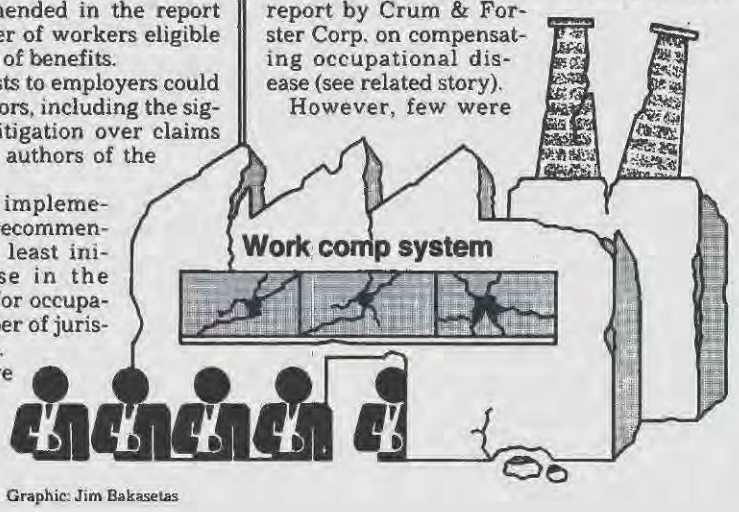
Federal program is only way to repair broken system: Symposium participants

By CAROL CAIN

ORONO, Maine—The workers compensation system in the United States is broken.

That message was underscored repeatedly by speakers at last month's Seventh Annual National Symposium on Workers' Compensation as they discussed a recently released report by Crum & Forster Corp. on compensating occupational disease (see related story).

However, few were convinced that the report's recommendations could mend the system.



Graphic: Jim Bakasetas

The report calls for a restructured workers compensation system that will be the exclusive remedy for occupational disease claims. Currently, most of these claims are filed in the courts.

"The Crum & Forster report is a public service. They demonstrated that the emperor doesn't have on any clothes. The emperor is the workers comp system and that system is broken," said Michael L. Goldberg, chief counsel for the House Labor Standards Subcommittee.

But Mr. Goldberg, like several other speakers at the symposium believe it is probably impossible to get the 50 states to change their workers comp laws at the same time and in the same manner, as recommended by the report.

"You can't move those 50 state legislatures fast enough," he said.

Instead, Mr. Goldberg favors a federal solution, like H.B. 3175, introduced by Rep. George Miller, D-Calif. That bill would establish a single administrative mechanism under the Labor Department for delivering benefits and create a special task force

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A&A sues Howden's former auditors

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return phone calls last week.

A&A did release an internal memo that read: "The suit arises out of matters relating to the acquisition of Howden by Alexander & Alexander and services rendered to Howden prior to the acquisition."

Named in the lawsuit are three London accounting firms: DePaula Turner Lake & Co., Arthur Young McClelland Moore & Co. and Josolyne Layton-Benner, which Arthur Young acquired in 1981. Also named are the Bermuda partners of Peat Marwick Mitchell & Co.

Specifically:

- Capital Marine Insurance Co. Ltd., a Bermuda underwriting subsidiary of Alexander Howden Group, is suing Peat Marwick for breach of contract and negligence.
- Sphere Drake Insurance P.L.C., a Howden underwriting subsidiary based in London, is suing DePaula Turner Lake for breach of contract and negligence.
- Alexander Howden Insurance Brokers Ltd., Howden's Lloyd's of London brokerage subsidiary, is suing Josolyne Layton-Bennett for breach of contract and negligence.
- Alexander Howden Group is suing Peat Marwick Mitchell and DePaula Turner Lake for negligence only. It is also suing Josolyne Layton-Bennett and Arthur Young McClelland Moore for breach of contract and negligence.
- A&A is suing Peat Marwick Mitchell, DePaula Turner Lake and Josolyne Layton-Bennett for negligence only. It is suing Arthur Young McClelland Moore for breach of contract and negligence.

Victor Earl, general counsel for Peat Marwick International in New York, said he was told by A&A before the suit was filed that the action is just a "protective measure" to meet statute of limitation requirements. That's why it does not specifically state claims or specify damages, he said.

Peat Marwick and the other defendants are still negotiating with A&A to resolve the dispute amicably, Mr. Earl said. "Discussions are still going on, but we think the claim has no merit."

Mr. Earl admitted that Peat Marwick had audited Howden subsidiaries in Bermuda, which A&A later discovered were undercapitalized, but said that Howden's problems were not his firm's responsibility.

"...Auditors in Bermuda do not have X-ray vision for what goes on in London and elsewhere," said Mr. Earl. "Certain transactions occurred at Howden's Bermuda subsidiary which the auditors did not know about and were not told."

The other defendants would not comment on the suit last week.

A&A raised the possibility that it might sue the auditors after it revealed last fall that at least $55 million in Howden funds had allegedly been diverted by former Howden officers (*BI*, Sept. 27).

Within months, the U.S. Securities and Exchange Commission forced A&A to take a $40 million extraordinary charge against third-quarter earnings to account for Howden's reduced value and the $25 million A&A transferred to Sphere Drake and Capital Marine to strengthen reserves.

Overall, A&A suffered a $25.8 million net loss in 1982, compared with net income of $57.6 million in 1981.

Although the problems at Howden were apparently severe, none of Howden's accountants told A&A there was anything wrong with Howden's books at the time of the acquisition, A&A said last year.

A&A discovered the missing assets and Howden's other financial problems only through a special fair-value audit by its own accounting firm, Deloitte Haskins & Sells, conducted last summer after the acquisition was finalized.

A&A, Howden and several Howden units later filed suit against four former A&A officials—Chairman Kenneth V. Grob, Chief Financial Officer Alan J. Page and Directors Ronald C. Comery and Jack H. Carpenter. The suits alleged the four men had used Howden assets to set up one or more companies in Panama to accept reinsurance from Howden underwriting units in Bermuda, including Captial Marine and the Bermuda office of Sphere Drake.

That suit is currently in arbitration.

In addition, A&A charged that Ian R. Posgate, a former Howden director and its chief Lloyd's underwriter, shared in the ownership of at least one of the Panamanian reinsurers and placed reinsurance for his syndicates with Sphere Drake as part of a conspiracy to divert funds to the reinsurers.

In addition, A&A alleges all five men were secretly involved in a syndicate that bought a Swiss bank, the Banque du Rhone et de la Tamise, from Howden in 1980. ■



Delta Holdings

Continued from page 3
tives and reinsurance pools managed by Reiss affiliates like United Insurance Co. in Cayman and Hopewell International Co. Ltd. in Bermuda.

"One of my current assignments is to prepare a business plan for Delta America," reports Mr. Bell, who also will oversee the insurer's underwriting activities. Mr. Bell has 20 years of underwriting and marketing expertise gained at CNA Insurance Cos., Excess & Casualty Reinsurance Assn., Skandia America Reinsurance Corp. and most recently with broker Marsh & McLennan Inc.

The volume of initial underwriting by Delta America will depend upon market conditions, Mr. Bell noted. However, he pointed out that Delta America has about $6 million in unassigned assets. If market conditions were ideal, those assets would translate into underwriting capacity of up to $12 million.

Delta America will concentrate initially on multiline treaty reinsurance but will eventually assume direct risks. The company will focus underwriting on specialized property/casualty programs, said Mr. Bell. There are no present plans to become a fronting insurer.

Other shareholders of Delta Holdings besides American Cyanamid Co., according to Mr. Bell, include Aluminum Co. of America in Pittsburgh; Kellogg Co. in Battle Creek, Mich.; Eaton Corp. in Cleveland; Thomas J. Lipton Inc. in Englewood Cliffs, N.J.; and Sperry Corp. in New York.

Delta America is currently licensed in the following 12 states: Delaware, New York, New Hampshire, New Jersey, Tennessee, Vermont, Virginia, Wisconsin, Rhode Island, Maine, South Carolina and Iowa.

Within the next one to two years, the company plans to acquire licenses in the remaining 38 states. ■



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opinions



Spoiling the pot

TWO CONGRESSMEN are threatening to wreck cafeteria benefit plans—for no valid reasons.

House Ways and Means Committee members Reps. Fortney (Pete) Stark, D-Calif., and Barber Conable, R-N.Y., want to restrict the type of benefits employers can provide through cafeteria plans (see story, page 1).

Under their bill, the menu of benefits employers could offer in cafeteria plans would be limited to cash and those benefits recognized as non-taxable under specific sections of the tax code like health care, group legal services and child care assistance. Taxable benefits would be barred from a cafeteria benefit plan.

Thus, in a single stroke, two key taxable benefits—group term life insurance over $50,000 and dependent term life insurance above $2,000—no longer could be part of the benefit choices offered to employees enrolled in the plans. In addition, other taxable benefits—such as group homeowners and group automobile insurance and financial counseling—could not be included in cafeteria plans. It's also possible that extra vacation days, a popular feature in cafeteria plans, might be eliminated.

No revenue will be gained in restricting the type of benefits offered in cafeteria plans. Employers prepare wage statements and include the value of taxable benefits employees might choose, so employees are already paying their taxes.

Much could be lost, however, by restricting the type of benefits offered in cafeteria plans. Anything that limits employees' choices erodes the foundation of the cafeteria concept: to allow employees to design benefit packages that meet their needs. And, specifically, employees could lose access to an important benefit—term life insurance exceeding $50,000. Consultants warn that employers with a cafeteria plan might drop term life insurance over $50,000 if the benefit had to be offered separately.

We agree with the two congressmen that clear rules on the taxation of benefits not already exempted in the tax code are needed. Frankly, though, we can hardly get excited about the taxable value of a parking place.

But we can get excited about cafeteria benefit plans. This is the second time this year Congress has tried to interfere with cafeteria benefit plans. Thankfully, in March, employers prevented Congress from subjecting participants in cafeteria plans to new FICA taxes. Now, employers must rally against this latest assault on innovative benefit planning.

letters

Unisex legislation will discriminate against men

To the editor: Judy Goldsmith's collection of misleading statements, half-truths and non-truths started right off in the headline of the Perspective article, "Sex-based rating benefits only insurers" (*BI*, July 4).

No doubt she feels that insurance companies with all those billions of dollars are rich founts of money—corporate oppressors motivated by greed and stinginess. Actually, all of the billions in assets owned by mutual life insurance companies belong entirely to the company's policyholders, beneficiaries and pensioners who have entrusted their money to the insurance companies, and most of the assets in profit-making stock companies also belong to the same group. The amount of assets belonging to investors and profits paid to them are relatively tiny except in small new companies.

Thus, for all practical purposes, the "insurers" benefiting from sex-based ratings are the people to whom the billions of dollars belong: the people who buy life insurance and annuities and their beneficiaries! So what's wrong with that?

The Goldsmith article contains more distortions than I have space to rebut, but one passage in particular is characteristic of her approach to alleged discrimination:

"In. . .May, GEICO Corp. told its policyholders. . .that women pay less than men for life insurance. The same month GEICO sent sales prospects a price list for term insurance showing women pay ing. . .more than men. . .through age 37."

The insurance GEICO was selling is not just life insurance, but a combination of life and health insurance because it includes the waiver-of-premium benefit. Experience justifies the higher charge to women for this health insurance benefit.

Ms. Goldsmith concludes that the only hope for "eliminating sex discrimination" is an "increased consumer sophistication." I fervently wish the public in general would become more sophisticated about life insurance, because then it would see that a fancied unfair discrimination against women pensioners has been replaced by a *real* unfair discrimination against men pensioners.

There is no *unfair* discrimination in life insurance and annuities when the differentiation is based on firm statistics such as male-female longevity differences. The dollar amount of monthly pension payments times a woman's life expectancy is the same amount of money male co-workers receive—therefore there is nothing unfair about the difference in the size of a woman's annuity installments compared with those paid to men.

Now, in addition to using anti-male unisex tables in the Social Security system and some non-federal pension plans, *all* pension plans must pay the same dollar amounts of pension installments. Thus, if I have $40,000 accumulated at the time of my retirement and a female employee also has $40,000 when she retires at the same age, we will both receive annuity installments of equal dollar amounts. She will live longer than me and therefore will collect more than me. *That* is unfair discrimination.

It is unfair that women have longer life spans. It is doubly unfair that they are allowed to force men to pay for their extra years of life. I resent and regret that I have no organization to bring suit on my behalf against my government and my employer who are unfairly discriminating against me by using unisex tables in calculating pension annuity installments.

John R. Crane
Atlanta

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Indiana Jones can't overcome bad back, so insurer will pay

Continued from page 2

producer, Lucasfilm Ltd., more than $1.5 million.

The production was insured with Fireman's Fund Insurance Cos. and brokered through Albert G. Ruben & Co. Inc., a subsidiary of Alexander & Alexander Services Inc.

The policy covers additional costs that may be incurred if production is aborted for any of a number of reasons, including illness or injury to an actor, says Don Cass, a Ruben vp.

Mr. Cass says it is too soon to predict the loss to the production company and says he does not know when the actor will be well enough to return to filming, though British sources said Mr. Ford would return to the set next Monday.

Mr. Ford's injury comes at a crucial time during production and any delay could prove to be costly.

"Later in a film's production, there are fewer alternatives to shoot if the actor takes ill," said a Lloyd's of London underwriter who has insured Lucasfilm in the past. "There is little to work around if the actor takes ill, so you have to shut down.

"Then there are the costs of keeping all the rentals, the studio and equipment and props. You have to pay the crew and all the artists to keep them on.

"This is a major loss. With a budget of their size, then $1.5 million is not an unreasonable estimate for the loss," he said.

A spokesman for Thorne-EMI studios, where the film was being shot when production was halted, admits that Lucasfilm has been trying to shoot around Mr. Ford for a while, hoping that his back injury would subside. And, in the spirit of the fearless character he plays, Mr. Ford had been doing some stunts despite the injury.

When Mr. Ford returns, shooting will continue in London. Then the production will be moved to the United States for one week of shooting.

In addition to the locations in Britain and the United States, the film has also been shot in Sri Lanka and Macao.

The premier of the "Raiders" sequel is still scheduled for next June, says the Thorne-EMI spokesman. ■

Layoff benefits OK'd by panel

WASHINGTON—An employer would have to extend group health insurance coverage for three months to employees it laid off under legislation, S. 951, approved last month by the Senate Finance Committee.

At the end of the 90-day period, the employee would have the option of converting the health care benefits offered by his employer into an individual policy at the same premium the company was paying for the coverage.

Under the measure, the laid-off employee also would have the right to be covered as a dependent under the group health insurance program sponsored by his spouse's employer during an open enrollment period.

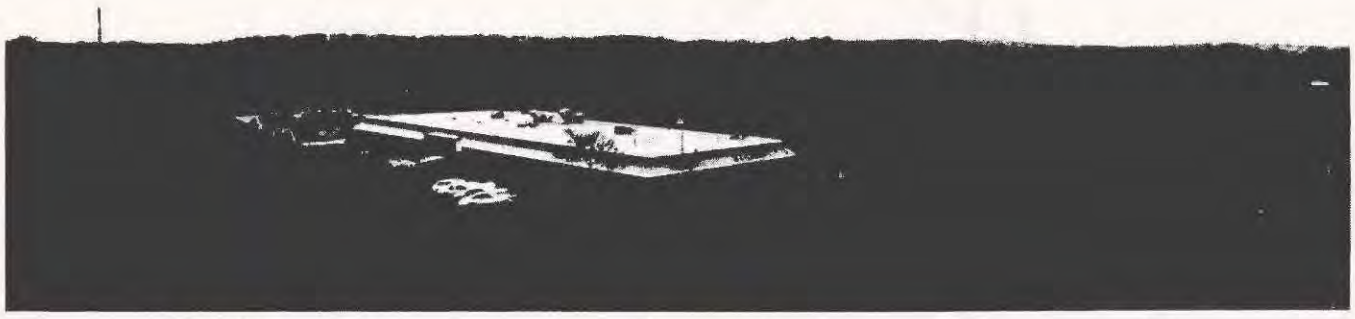
Employers that fail to offer an open enrollment period would be subject to an excise tax equal to $500 per violation. However, employers with fewer than 25 employees would be exempt from the bill's open enrollment and conversion requirements.

The measure, introduced by Senate Finance Committee Chairman Robert Dole, R-Kan., and now pending on the Senate floor, faces an uncertain future.

Even if it clears the Senate, President Reagan has threatened to veto the legislation. He opposes provisions in the bill that create state health insurance pools for laid-off workers who do not convert their group health care policies into individual policies.

The administration opposes any health care plan for the unemployed that does not provide some kind of financing.

Another bill, H.R. 3021, passed by the House Ways and Means Committee also would require firms to extend coverage to laid-off workers for at least 90 days as well as provide the same conversion and open enrollment privileges that Sen. Dole wants. ■



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Report recommends work comp overhaul

Continued from page 3

ing, courts and state agencies are progressively broadening the definition of compensable injury."

According to the Crum & Forster report, the definition of compensable disease should be broadened to make the workers compensation system respond whenever the nature of employment or the workplace environment is a "predominant cause" of the employee's illness.

"It is our judgment that we should seek to standardize the process by incorporating within the system claims not traditionally found compensable as work-related injuries—for example, cumulative trauma and occupational health claims, including heart and back cases," the study says.

A uniform definition of compensability would eliminate many contested claims, says Les Cheek, vp for federal affairs for Crum & Forster Insurance Cos. in Washington, D.C., and a member of the task force.

A broad definition also recognizes the trends in the courts to award compensation where it is uncertain how much workplace exposure contributed to the disease, he says.

To implement this broad plan for compensation, the report recommends creating within states a separate Compensability Evaluation Unit and Disability Evaluation Unit.

The CEU, which would be composed of medical and administrative personnel, would initially evaluate the compensability of all claims. Its decision that a disease is compensable likely would stand in any further judicial or administrative proceedings.

After the CEU rules that a disease is compensable, the DEU—composed of another panel of doctors—would evaluate the degree of disability.

The creation of these compensation and disability units would speed up the claims process and cut down on litigation, Mr. Cheek says.

Litigation is far higher in occupational disease cases than in traumatic injury cases, he said, and "we felt that essentially lawyers were arguing about medical questions," he explains.

If medical personnel could make a decision through the CEU, which would have presumptive weight with other administrative and legal bodies, a lot of litigation could be eliminated, he adds.

Once it is decided that the disease should be compensated, the report recommends that states mandate that the employer *that last exposed* the worker to an injurious substance or condition in the workplace and the insurer on the risk at *that* time be liable for paying all benefits.

For example, if a worker was last exposed to a toxic substance in a chemical plant in 1950 but only manifests a disease 30 years later when he is at a different job, the employer that last exposed the worker would be solely responsible for paying the benefits.

Benefits would be based on a formula that considers what the employee would have received if the disability had occurred at last exposure and current benefit levels. However, benefits are much higher now than they were in 1950, and the insurer of the employer that last exposed the worker would be hit with a higher loss.

To cushion the blow to the insurer on the risk when the employee was last exposed to a hazardous substance, the report proposes a voluntary reinsurance pool funded by insurers and self-insurers be established, Mr. Cheek said.

Through the reinsurance pool, the insurer could recoup the amount paid above the cost of the benefits he would have paid in 1950, explained Mr. Cheek said. Therefore, participants in the pool would never have to pay more than the prevailing benefit level at the time of the worker's last exposure.

Elements of the reinsurance pool as described in the report would include:

- All occupational disease premiums collected by member companies would be ceded to the pool, and all occupational disease losses would be reinsured by the pool.
- The pool would be established on a similar basis as the National Workers' Compensation Reinsurance Pool, which is managed by the National Council on Compensation Insurance. This pool includes insurers writing residual work comp risks which reinsure each other.
- Member companies would receive ceding commissions from the pool to cover expenses, such as underwriting expenses directly related to occupational disease premiums and loss adjustment expenses directly related to occupational dis-

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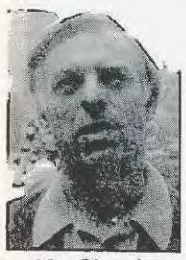


Insurer study recommends comp changes

Continued from previous page
ease losses.

Other recommendations in the study include:

- Reinforcing workers compensation as the exclusive remedy of employees injured at work and eliminating the dual capacity doctrine, which allows a worker to sue an employer for injuries under certain circumstances.
- Basing the statute of limitations for filing a workers compensation claim on when the employee discovers or should have discovered the disease and its relationship to employment rather than the time the victim is last exposed.
- Making workers compensation benefits the primary source of benefits for occupational diseases, except for workers receiving Social Security retirement benefits. Those receiving partial or total disability benefits at the time they receive Social Security retirement benefits should have disability benefits offset by Social Security.
- Determining benefits for occupational disease by multiplying the maximum benefit payable at the time of disability by a percentage of previous benefits. That percentage would be found by dividing the employee's eligible benefit at the time of last exposure by the maximum benefit payable at the last exposure.
- Eliminating any apportionment of disability between employer and employee in cases involving both work-related and non-work-related injuries if the work-related factor was the predominant cause of disability or death.


Mr. Cheek

The Crum & Forster study notes that the 12 recommendations are interrelated and should be taken as a whole. A state should not make modifications in one area without considering the impact on the rest of the recommendations, the study stresses.

Many states have already implemented one or more of these proposals as part of their workers compensation systems.

The study also admits the main obstacle to implementation of the plan will be states' resistance to restructuring their systems.

But Mr. Cheek warns that while the recommended changes will cost more, they will be less costly and more workable than attempts to federalize the workers compensation system.

"Anything the federal government does would be much more expensive than if it were done at the state level," he says.

The occupational disease task force study was begun in February 1981 at the prompting of Crum & Forster Chairman B.P. Russell.

An in-house task force undertook the $25,000 study with the assistance of Dr. Ronald Gots of the National Medical Advisory Service and the late Andrew Kalmykow, an expert in workers compensation and a member of the 1972 National Commission on State Workmen's Compensation Laws.

Before the final report was issued, a draft was critiqued by about 25 insurance industry experts. Their comments were used to amend, expand and fine-tune the report, says Robert J. Sullivan, vp of government affairs for Crum & Forster Corp. ■

Symposium labels system as 'broken'

Continued from page 3
within the department to expedite processing of asbestos claims (*BI*, May 30).

"It troubles me whether you can develop a generic definition (of occupational disease) and apply it in all states and for all circumstances," said Mike Forscey, minority counsel for the Senate Labor and Human Resources Committee.

A labor representative at the symposium agreed.

"We want to see an occupational disease registry in the federal government. . .done with the best scientific minds," said Marrion A. Parsons, director of education for the Laborers International Union of North America.

David Malino, assistant legislative director of the United Steelworkers union also called for a federal law.

"We want a federal occupational disease law. . .The only ball game in town is Miller's bill," he said.

Manville Corp.'s manager of U.S. government affairs, David E. Pullen, also believes there needs to be a new federal system.

"There is not a soul in this room who would argue that the explosion of asbestos-related disability claims does not merit attention and correction. We producers are convinced that there must be a fairer and more efficient system by which to compensate those thousands of workers who are in fact injured as a result of their occupational exposure to asbestos. . .

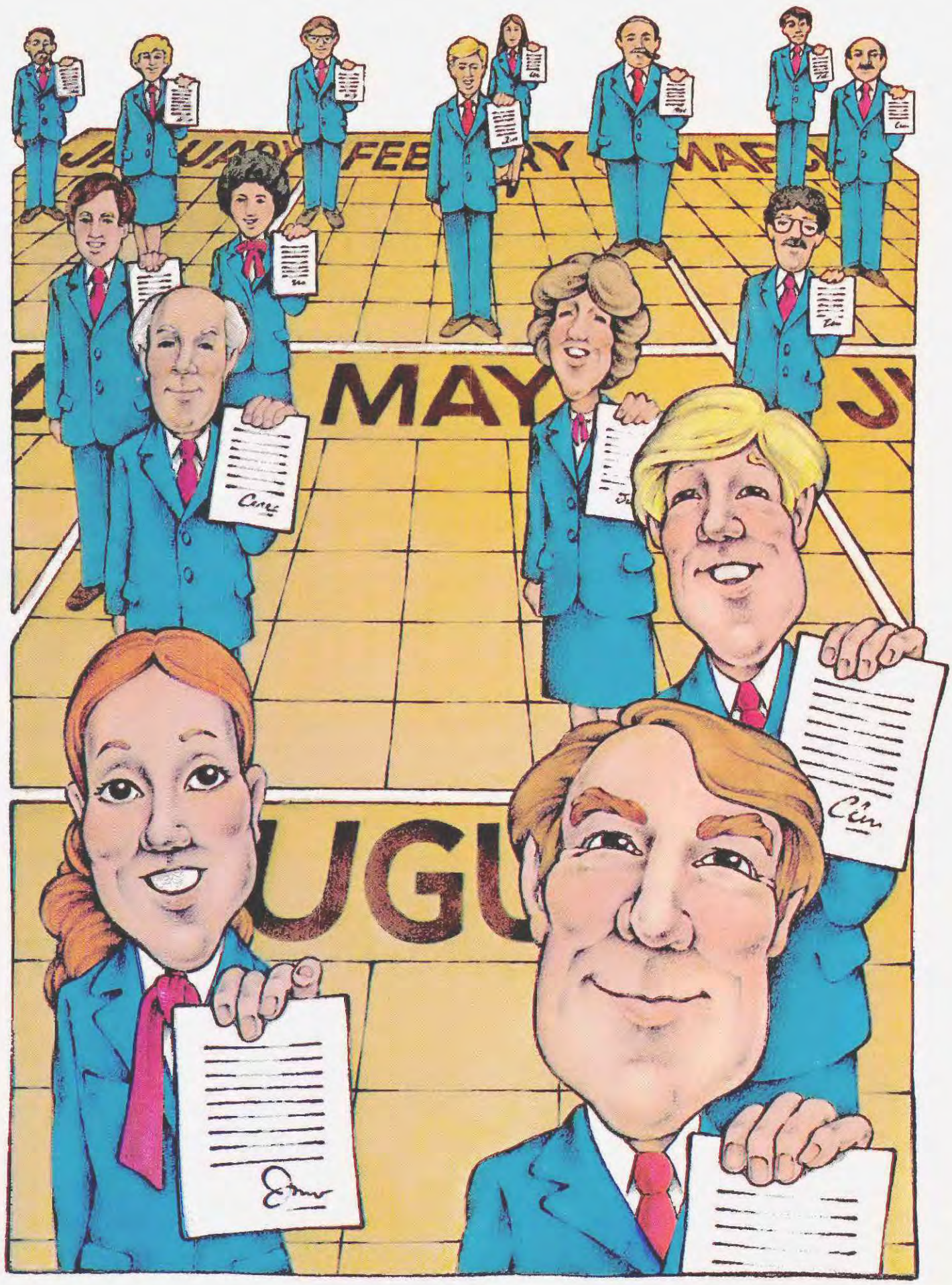
"It seems clear that there is only one practical answer—federal legislation."

Manville is closely looking at the Crum & Forster proposal and hopes it and other employers will be able to endorse the plan and help effectuate it in the states, Mr. Pullen said.

"But the Crum & Forster regimen is not in and of itself an alternative that will resolve the asbestos-disease issue, since responsible non-employers would not be involved and the third-party litigation, which dominates the asbestos issue, would remain," he said.

The fact that Crum & Forster ignores the tort system in its report

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was repeatedly criticized.

"They are looking at only part of the problem. . .It's also a tort problem. . .The two are interrelated," Mr. Goldberg said.

"You can't fix one and make the other go away."

It doesn't make sense to look at workers compensation separately from the tort system, agreed attorney Mr. Forscey.

But Crum & Forster says the omission was intentional.

"Our report is 'green eyeshades.' We specifically wanted to address the comp system only, not the tort system. . .That's another study," said Robert Sullivan, vp of government affairs for Crum & Forster in Morristown, N.J.

"We originally thought we would go much broader, but the bite was bigger than we could chew," he added.

The report was also criticized because it lacks a detailed plan for funding the new system.

However, Crum & Forster noted that at least three other groups are looking at this aspect, including the National Assn. of Insurance Commissioners, the National Council on Compensation Insurance and the International Assn. of Industrial Accident Boards & Commissions.

Several speakers at the work comp symposium also criticized the report because it does not say how any of its proposals should be implemented.

"The Crum & Forster report publicly recognizes for the first time by the industry that there is a problem. . .but there's no section on enforcement or implementation," said John F. Burton, a professor at Cornell University's School of Industrial and Labor Relations.

"The void in the report is how it's sold and implemented," noted Peter Barth, professor of economics at the University of Connecticut.

Crum & Forster realizes that the report is not written in legislative language, but it is more flexible the way it is, Mr. Sullivan said. However, presenting the proposal to state legislatures will be the next step, he added. This could happen as early as 1984.

And after that, the next big project will be pilot programs involving the report's proposed Compensability Evaluation Unit and Disability Evaluation Unit, which will develop medical guidelines and procedures for determining the compensability of occupational disease claims.

"I can see us going into states that have good administrative programs and, without legislation, putting in a CEU," Mr. Sullivan said, citing Wisconsin and New Jersey as good examples.

"In order to bring in employers, we'll have to show that a CEU is done," Mr. Sullivan said.

"The cost of implementing what we've recommended will fall on the employer community," said Donald H. McComber, senior executive vp for Crum & Forster Corp.

But it will cost less under a state workers comp system rather than a federal program, he added. "And we need cooperation between the labor and employer community," Mr. McComber said.

Employer and labor representatives said they could not enthusiastically support the recommendations because they believe a federal solution is necessary. "But they said they would not oppose it," Mr. Sullivan said. ■

EBNR: New work comp buzzword

ORONO, Maine—There's a new buzzword in workers compensation circles: EBNR, or exposed-but-not-reported losses.

The phrase is not used in the Crum & Forster Corp. occupational disease report (see story, page 3), but was coined at the Seventh Annual National Symposim on Workers' Compensation in Orono.

Writers of the report created it later as they looked for a shorthand term to describe the losses from long-latent occupational diseases discussed in the report, said Leslie Cheek, vp for federal affairs for Crum & Forster Insurance Cos.

The workers compensation system already has IBNR (incurred-but-not-reported) losses, but actuaries for Crum & Foster believe there is a significant difference between IBNR and EBNR losses, said Robert Sullivan, vp of government affairs at Crum & Forster Corp.

Occupational disease losses can't be considered IBNR losses because there are no statistics, Mr. Sullivan said.

IBNR losses are calculated on the basis of historical data, Mr. Cheek said.

"You know that there will be a certain dollar amount of claims that will come in during a certain year from a policy written in another year."

But there isn't enough occupational disease experience assembled to calculate losses from long-latent diseases, though it seems inevitable that there will be claims in this area at some future point, Mr. Cheek added.

"With EBNR losses, you're looking at a longer period of years.

". . .We don't have enough workers comp information to project now what kinds of dollars of claims or the number of claims there would be in the next year from exposures that occurred 15 to 20 years ago," Mr. Cheek said.

The voluntary reinsurance pool recommended in the Crum & Forster report to spread occupational disease risks calls for the development of statistical systems to facilitate identifying and reporting data for each classification having an identified occupational disease exposure, thereby providing a basis for needed changes in the rating system.

Mr. Sullivan suggests that if statistics were developed for exposed-but-not-reported, then reserves set aside to pay them could be tax-deductible like reserves for IBNR are under Internal Revenue Service rules.

"We're suggesting that reserves for EBNR be deductible. . .you may not be able to deduct EBNR individually, but perhaps collectively, by the voluntary pool," Mr. Sullivan said. ■

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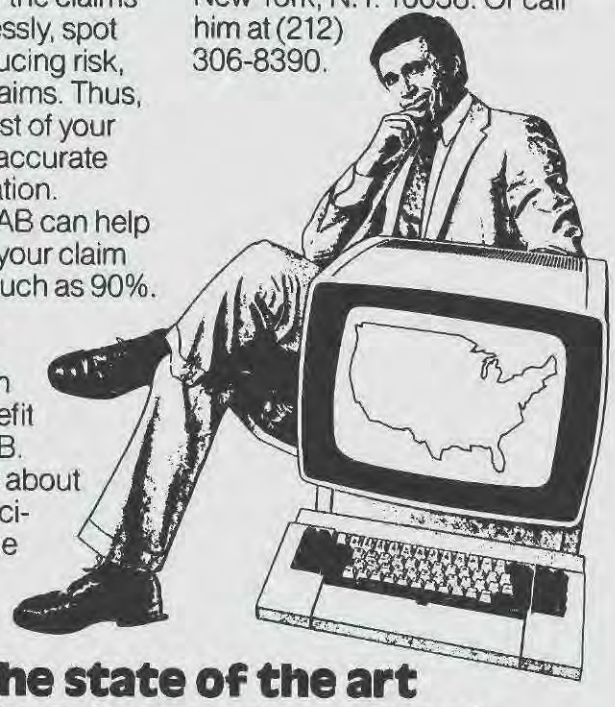
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Symposium focuses on occupational disease

ORONO, Maine—They came from as far away as Alaska—some 155 of them—scholars, administrators, employers, labor representatives, insurers, attorneys and legislators.

And, they shared their ideas at the Seventh Annual National Symposium on Workers' Compensation on the campus of the University of Maine, paying special attention to occupational disease exposures.

In the process, they concluded that the 72-year-old workers compensation system is "broken," even though just one year ago at the symposium the word was that the the system for compensating workers' injuries was still intact.

"For those who call the workers compensation system a zoo, let us not be the ostrich," said Donald H. McCombe:, senior executive vp of Crum & Forster Inc. He was the keynote speaker of the five-day symposium and presented his company's two-year report on compensating occupational diseases (see story, page 3).

Other proposals to fix the system and fund a new one also were discussed, as well as reinsurance, self-insurance, coordination of workers comp benefits with health care benefits and recreational injuries.

"There are 425 reinsurers worldwide. Twenty-five years ago only 25% of those companies were around," said Ralph Milo, vp of General Reinsurance Corp. in Greenwich, Conn. He presented an overview of reinsurance grammar, where that market is today and its pricing and underwriting techniques.

In a brief discussion on self-insurance, Harry Tipper, a General Re assistant vp, said that a working definition for self-insurance is "managing your losses yourself."

But employers should not self-insure if:

- The corporate future is uncertain.
- The employer's future losses are indeterminable.
- Management is adverse to taking the risk.

Regulation of group self-insurance, including a recent study by a committee of the National Assn. of Insurance Commissioners (*BI*, April 11, July 4), also shared the spotlight.

The annual symposium is an outgrowth of the considerable attention drawn to workers compensation in the 1970s by a report of the National Commission on State Workmen's Compensation Laws, congressional proposals and the activities of the federal Interdepartmental Task Force on Workers' Compensation, said Howard Bunn, vp of the National Assn. of Independent Insurers and organizer of the symposium.

If enough knowledgeable people could be brought together in a hermetic environment, crucial questions concerning workers compensation could be collectively addressed in a casual, unhurried atmosphere and possible solutions might well develop, Mr. Bunn said.

Next year's symposium will be held July 8-13 at the university.

Professor says cancer needs special plan

By CAROL CAIN

ORONO, Maine—Work-related cancer deaths should be compensated under a no-fault insurance scheme outside the workers compensation system but funded by a payroll tax on employers.

That was one of the alternative solutions for dealing with occupational diseases presented during the Seventh Annual National Symposium on Workers' Compensation last month.

The core of the occupational disease dilemma is the long-latent disease problem, said Peter S. Barth, a professor of economics at the University of Connecticut in Storrs. He also was formerly executive director of the National Commission on State Workmen's Compensation Laws.

"It is this issue that is basically insoluble with the current structure. Some other matters involving diseases are tough to be sure, but the long-latent disease area is the one that is near-impossible.

"While there are a number of diseases to contend with, the overwhelming number appear to involve cancer," he said.



Mr. Barth

"If cancer did not exist as a disease, the problem of the ticking time bomb—be it in workplace hazards, DES, Agent Orange, successors to the Love Canal and Times Beach, asbestos and former nuclear test sites—would look to be a lot more manageable than any of these is currently," he said.

Mr. Barth suggests creating a no-fault insurance scheme to pay benefits to survivors of those who die of cancer.

Under Mr. Barth's proposal, the survivors of anyone who dies of work-related cancer after five years in the workforce would be eligible for a special lump-sum benefit to be administered by the Social Security Administration and totally funded by a payroll tax on employers.

This proposed program would apply only to cancer fatalities and would be the exclusive remedy for the survivors. However, workers compensation and the tort system would still be avenues open to persons with non-fatal or non-cancerous injuries.

Benefits paid for cancer deaths would not be based on earnings but would be based on the age of the deceased. For example, for persons with surviving spouses or dependent children or parents, a sum of $40,000 would be paid if death occurs by age 59.

Only $10,000 would be paid if death occurs between ages 75 to 79 and no benefits would be paid to survivors of persons aged 80 or older.

Mr. Barth predicts that the payroll tax on employers would decline as cures for cancer are discovered. He also points out that while the tax will be an added cost for employers, it will be predictable and limited.

He also says such a plan would make future costs more predictable for insurers, asbestos companies and users of asbestos.

And, "For workers, there is some security provided for dependents. Problems of proof disappear. The situation where a few lucky survivors get windfalls while others get little or nothing is replaced. For those who currently do not seek

Continued on facing page

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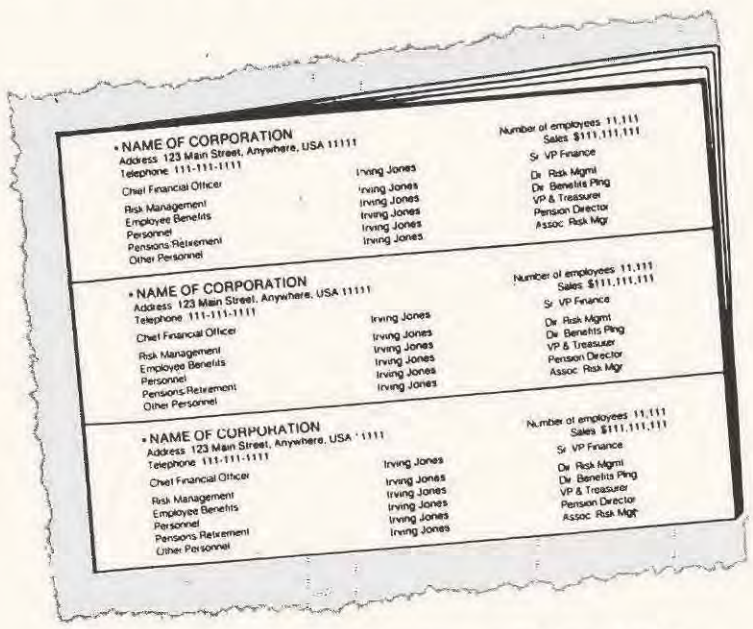
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Continued from facing page
compensation, the program would be much fairer," he said.

But there are potential problems with this scheme, Mr. Barth admits. Some say employers will lose their financial incentive to remove carcinogens from the environment if the only cost they will face is the payroll tax. Mr. Barth, however, discounts this fear because he says there is no great incentive now to remove carcinogens.

This proposal, however, may cause some persons to reduce their life insurance coverage, Mr. Barth said.

"To the extent that cancer is only one possible source of death, this ought not to cause the wholesale cashing in of life policies. It clearly is a threat to companies selling cancer insurance," he said.

Unions might object because the package may look inadequate to them, especially since only life insurance is provided, Mr. Barth said.

"Realistically, however, we know that most survivors receive little or nothing for deaths due to cancer, and only the tiniest handful leave survivors with a windfall," he said.

Symposium participants were not enthusiastic about the proposal, with a few criticizing a "cancer-only" solution.

"We're not seeing the cancer cases now. I'm not certain that a cancer-only program is a method to be used at this time," said David Pullen, manager of U.S. government affairs for Manville Corp.

While Mr. Barth strongly endorses the cancer death benefit, he also offered other proposals for changing the workers compensation system "for the sake of provoking some thinking and discusion."

For example, he proposed eliminating from an employers' loss experience for work comp rates any claims for long-latent diseases, including stress-related diseases, heart cases and cancer.

"The issue here is not whether to depart from experience rating entirely but, instead, to drop its application for disease claims when the present employer bears no responsibility for the disease, nor could he or would he take steps to prevent future claims from arising.

"If experience rating serves neither to punish for past behavior nor directly lead to an improved work environment, it has no benefits that warrant retention," he said.

This is only a small step, said Mr. Barth, who admits it does nothing for self-insurers and doesn't eliminate all motives for firms to withhold information about risks incurred by past or present workers.

"It does not assure that insurers will contest only unreasonable claims. But it is a step forward. In place of experience rating such claims, costs can be assessed against an entire insurance class or against all firms buying insurance in the state," Mr. Barth said.

A third proposal of Mr. Barth's is to create a workers compensation program paid for by the employer, but in which the employee chooses the insurer.

Mr. Barth believes that the work comp system is really a relationship between the employee and the insurer, with the third party being the employer.

The insurer virtually always identifies with the interests of the employer—the party that selects the insurer—and workers view the insurer as the representative of the employer and not as the provider of an essential service to the worker and his family, Mr. Barth said.

"Workers do not perceive that increased compensation costs affect them. This creates certain attitudes toward claims, insurers and the legislative changes that they seek," he said.

"Perhaps it is time that we cut through this odd arrangement and allow insurer and insured to deal directly with each other. Imagine the usual situation where the worker directly purchases home, auto, disability or life insurance and is treated as a valued client of the insurer.

"Obviously, dissatisfied customers are a fact of business life and in a market system they exercise their choices by shopping elsewhere," Mr. Barth said.

Under the plan, the employee would indicate to the employer which insurer is providing compensation insurance for him. This choice would be limited to insurers approved to write the insurance in that state, and the employer would continue paying the premiums.

The plan also would let employers and employees benefit directly from a good loss record by allowing both to share in any dividends paid by the insurer. ■

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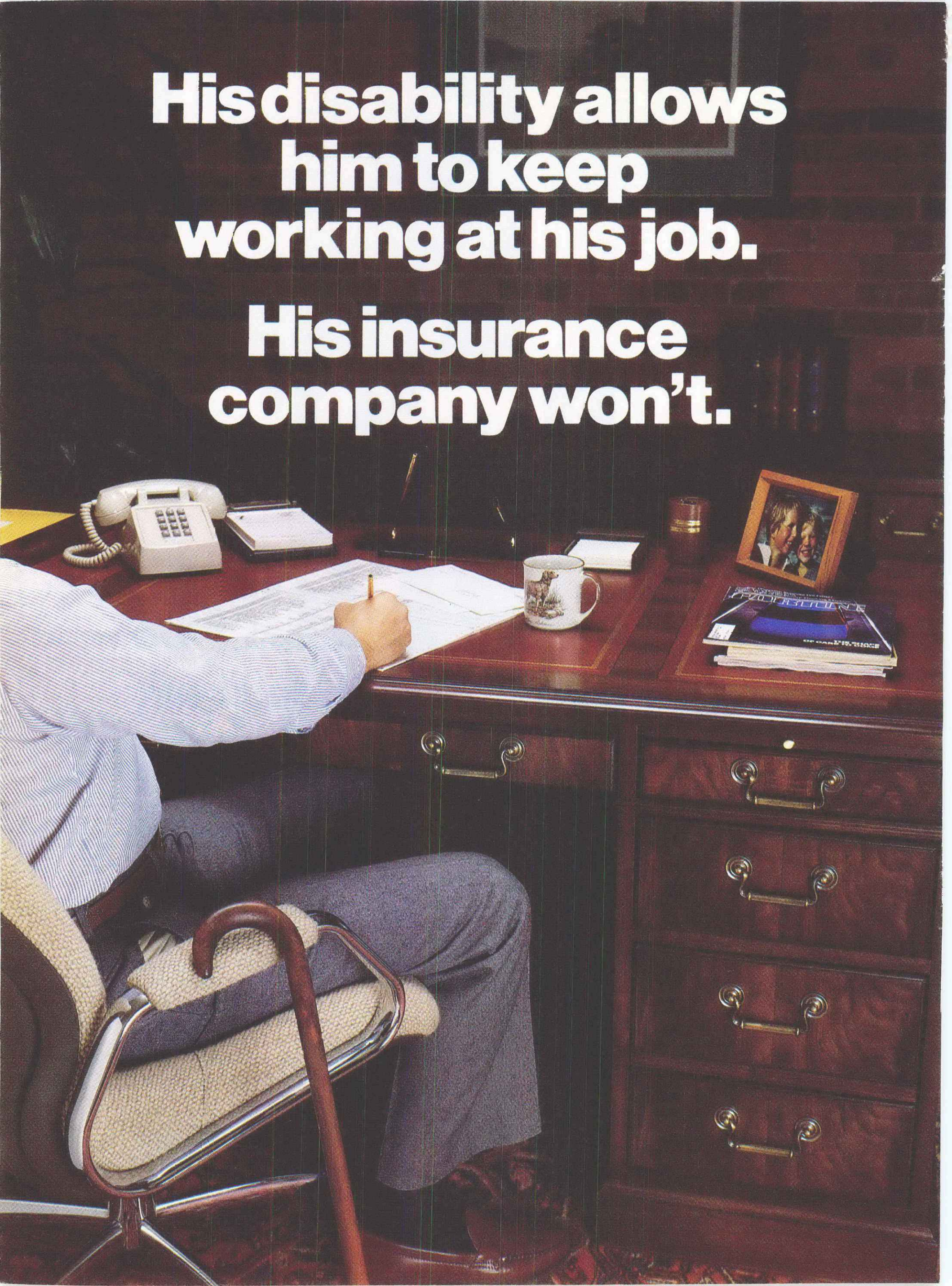
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*Source: Employee Benefit Plan Review, April, 1983

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BI 8/1/83

The games people play can cost employers

By CAROL CAIN

ORONO, Maine—Employers that sponsor fun and games for their workers could end up paying a high price: workers compensation claims for recreational injuries.

Although such injuries can occur after work hours and take place on public property, they still may be compensable, Merton E. Marks, a Phoenix, Ariz., attorney with the law firm of Lewis & Roca, said at the Seventh Annual National Symposium on Workers' Compensation.

Mr. Marks is also chairman-elect of the American Bar Assn.'s committee on workers compensation and employers' liability litigation.

Risk managers from self-insured corporations often contact their attorneys to ask if these injuries are compensable. Mr. Marks says he frequently gives the common law school reply: "It's close, with legal cases on both sides."

One such question involved the senior vp of a company who sustained a leg injury during an impromptu softball game at the annual picnic. Is the injury compensable?

Or, an employee has too much to drink at the company Christmas party and is injured in an automobile accident on the way home. Is that kind of injury compensable?

Or a worker breaks an arm while playing on a company-sponsored team. The games are played Saturdays on public property, but the employer pays entry fees and buys the shirts. The employee does not have to play on the team, though schedules and scores are given prominent coverage in the company newsletter. Is this injury compensable?

Cases with similar circumstances are decided differently around the country because of differences in state statutes and case law, Mr. Marks said.

He noted that three states— California, Illinois and Nevada—have tried to cover such occurrences in their statutes.

The California statute says courts should consider whether the recreational event was reasonably expected or required as a consideration of employment.

The Illinois statute establishes criteria to determine whether an employee was ordered or assigned to participate in an activity and reimbursed for expenses.

And in Nevada, the statute allows compensation for injuries that are sustained by employees who are paid to participate in the event.

In other states, Mr. Marks continued, if there is clear evidence that attendance at the function is mandatory, an injury that occurs at the function is more often than not compensable.

Mr. Marks noted that Arthur Larson, the law professor at Duke University who is considered the national leading workers compesation law expert, devised a system to analyze whether a recreational injury is compensable.

In Mr. Larson's treatise on workers compensation, he poses six questions:

- Did the employer really sponsor the event?
- To what extent was attendance really voluntary?
- Was there some degree of encouragement to attend? For instance, are attendance records kept?
- Did the employer finance the occasion to a major extent?
- Did employees regard the event as a benefit to which they are entitled?
- Was the event held, not merely to improve employee morale, but for such activities as business presentations.

Mr. Marks took the situation of the ballplayer who broke an arm while playing on the company team. If the six questions were applied to that situation, the injury probably would be considered non-compensable, he said.

The critical factors in cases involving injuries sustained while playing on a company team include the degree of formality about the game, the time and place of the event and whether the event is used by the employer for advertising purposes, Mr. Marks said.

In an Arizona case, an employee was injured while playing during an informal softball game held during lunch hours on the company's premises. One employee always had to stay on the property during the lunch hour, so the game made that responsibility more acceptable, reasoned the employer, which encouraged the game.

That injury was held compensable.

Recreational injuries that are found to be non-compensable have little or no employer connection, he said.

One New York case involved a ball team that wore sweatshirts with the employer's logo. The games were played in public parks after work hours. Team managers were allowed to hold conferences on company time, but ball players were docked pay if they arrived late to work because of a game.

Even though all the equipment was stored on the employer's premises, the case still was found to be non-compensable, Mr. Marks said.

Injuries at company picnics have been found compensable in some states and non-compensable in others, Mr. Marks said.

For example, an employee died at a softball game during a company picnic. Since a speech was delivered at the picnic, giving it a business atmosphere, a New York court ruled the fatality was compensable.

In a close Arizona decision, a court ruled that a drowning that occurred at a company picnic was non-compensable, even though the employer closed the plant for the picnic and paid for the food.

Injuries resulting from Christmas parties, dinners and dances also fall into a gray area, Mr. Marks said.

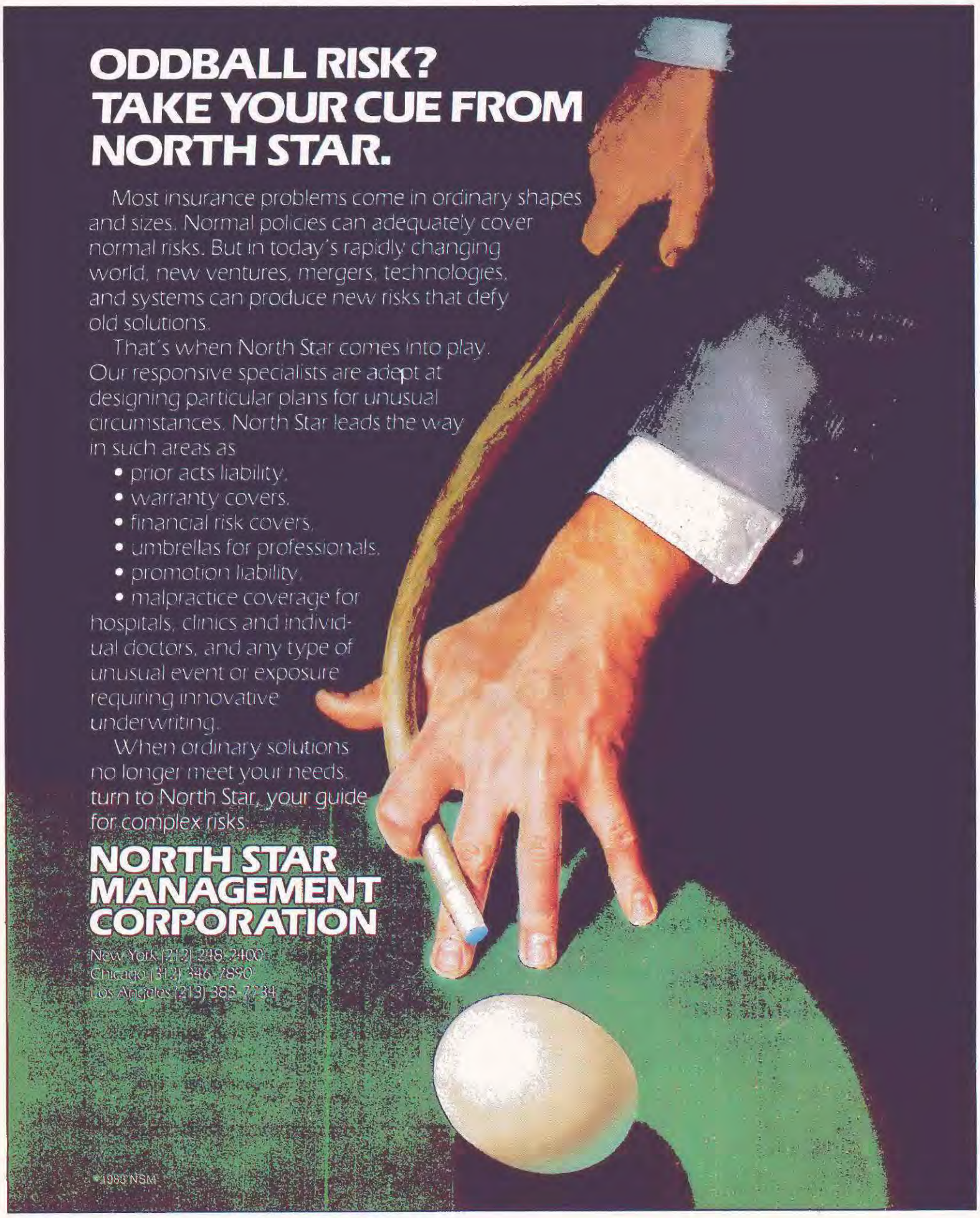
A compensable incident in New York involved the stabbing of a male employee by another male employee at a company dance. The claim went against the employer because it was a company-sponsored event where liquor was served.

Injuries sustained while traveling to a recreational event also raise questions.

One standard used by some courts is that if an accident at the event could be considered compensable, so could an accident occurring on the way to or from the event, Mr. Marks said.

Some courts have ruled that deaths and injuries occurring on trips won through a company-sponsored sales contest are compensable. Others deny claims.

For instance, a North Carolina employee drowned while on a fishing trip he won in a sales contest. Because there were no wages paid nor clients on the trip, the injury was non-compensable. ■



SELF-INSURING HEALTH BENEFITS

Why employers should consider it now

By Ralph N. Galascione

THERE COULD NOT be a better time than now to self-insure health benefits!

Far too few employers and practitioners are prepared to embrace the notion that an employee welfare plan can be more than an act of corporate responsibility to the manifold needs of its employees. As a private vs. public assistance program, the goals of an employee welfare program encompass the socially accepted idea of income security in the face of the awful financially crippling contingencies of premature death, disability and medical infirmity (*BI*, March 14).

Starting as a benefit, the character and magnitude of private welfare plans have taken on the importance associated with the statutory benefits grudgingly accepted by employers over the years.

In the 20-year period since 1960, national health expenditures rose from slightly less than $50 billion to nearly $300 billion in 1981, or from 5.5% of gross national product in 1960 to nearly 10% of GNP in 1981, as pointed out by Peter B. Walker in "The Group Insurance Myth Revisited" in the March 1983 issue of Best's Review.

During this epoch, the treatment given to this "stepchild" of employment practices and policies by middle- and upper management was no more than a lesson in benign neglect. The growth of the welfare plans was accelerated even more by the economic turmoil of the 1970s and their financial enormity can no longer be ignored.

On the heels of this increased financial growth are numerous articles on savings to be found in self-funding the plans. The host of articles extolling the virtues of self-funding are not only too late but woefully one-dimensional for what is, empirically, a multifaceted headache.

Some telling statistics clarify the issue. Between 1970 and 1981, the "average annual growth" in medical care costs was 8.7%, while the Consumer Price Index (excluding medical care costs) rose an average 8.1% per year. As Mr. Walker notes, in the more recent period of 1975 to 1981, the figures are 10% vs. 9.1%, respectively. And for 1980-81, medical care costs rose by 12.5% per year on average while the CPI only rose an average of 8.8% annually.

It is no wonder that in the years from 1976 to 1981, Mr. Walker writes, the growth of administrative services only/minimum-premium equivalents for insurers was 42% while the growth of group health premium was only 10.7%. If there is any correlation between these sets of statistics, it may be that self-funding was perceived as a rational way to mitigate the financial ravages of the 1970s.

Now, as then, for those pursuing self-funding, these factors have to be evaluated:

- Finance.
- Actuarial.
- Legal and tax.
- Health and environment.
- Political action.
- Competition.

Each of these factors influence the decision to self-fund, and each can be quantified in real dollars.

With this common thread of money, especially during tough economic times, finding and allocating corporate dollars for an item that contributes little to profit and productivity is an unenviable task. Nevertheless, the task is undertaken and self-funding is instituted.

Some benefits commentators have opined that employers should not consider self-funding techniques "during sluggish economic periods" because the employee is more apt to "take care of any health-related conditions." In short, those employers staring Chapter 11 in the face should not "wince or cry aloud" for relief from the unprecedented and inexorable pressure of premium increases.

speaking out

> Who should self-fund? It is too confining to say that only employers with 1,000 or more employees and $1 million in claims should even consider the alternative. It is based on how comfortable the employer is with the attendant financial risk, determined after a careful, comprehensive analysis.

The dialectic that advocates waiting for the "good times" to self-fund is specious and timid if the expectation of economic recovery is merely wishful thinking, as some economists suggest. The point is that the decision to self-fund is purely an individual matter, plain and simple. In fact, due to the absence of any positive assistance from the insurance community to contain medical costs, the decision to self-fund may already be cast in stone.

Who should self-fund? It is too confining to say that only employers with 1,000 or more employees and $1 million in claims should even consider the alternative. More times than not, it is based on how comfortable the employer is with the attendant financial risk, determined after a careful and comprehensive analysis. One need only to listen to the pitches of the insurance industry to realize that the plan size is not as material as we are led to believe.

What makes self-funding so alluring? For one, the leakages of an insurance arrangement. They can include:

- State taxes.
- Commissions.
- Overhead expenses.
- Risk charges.
- Profits.
- Non-competitively priced services.
- Trend factors.
- Actuarial conservatism.
- Pre-funding premiums.
- Loss of tax-favorable mechanisms/benefits.

Granted, an insurance company is due a profit. It is also expected to accept the risk. In another recent study conducted by Mr. Walker from 1977 to 1981, four out of the 14 largest group insurers (excluding the Blues) did not lose any money, and a few of the remaining insurers lost money in only one year during that period.

Significantly, four of the 14 companies actually achieved more stable profit margins during those years.

State premium taxes are a necessary expense to subsidize the regulatory authorities, particularly those that are aggressively pursuing Employee Retirement Income Security Act plans. Too, and true, there is a cost to deliver the claims services. But if you add up all of the excess in the above items, then the financial worth of an insured plan is somewhat debatable.

Lest tempers flare, one cannot ignore the purpose of any these leakages, but their magnitude begs some thought as to their current validity.

The insurance contract is not as pristine in reality as it appears in theory. The significant Ross vs. Odom case in the 5th U.S. Circuit Court of Appeals gives us a better practical and legal understanding of insurance when it defined the contract elements as the distribution of risk and the shifting of risk. For any number of benefit managers who have recently suffered through a renewal, it is hard to accept that there is much transference of risk when the insurance company strenously argues for a "deficit recovery."

It is not cynical to conclude that there is no apparent or real transference of risk in a group medical policy as long as the insurer can recoup its aggregate losses, real or otherwise.

One would concede that the true financial risk in a group medical policy is the individual catastrophic claim and not the aggregate exposure. Yet, we all seem to accede to this fiction even though the popular rebuttal to self-funding, i.e., minimum premium plans, contracturally allows the insurer to recapture any aggregate losses above the stated stop-loss limit. Thanks to the deficit recovery provision and individual stop-loss insurance "pooling," an insurer can escape the financial disaster of risks assumed.

Some have suggested that a "premium drag" is as financially rewarding as self-funding. Yet, few among us would hesitate to suggest that the device also bears a financial penalty, i.e., increased retention charges.

Taking each leakage, examining its materiality or challenging its underlying financial relevance in today's economic climate are not without its rewards.

Determining whether the costs for the purely administrative aspects of the program are competitively priced, without sacrificing quality, can be a pursuit with pleasant consequences. Naturally, the ability to make this judgment rests on a solid foundation of knowledge, understanding and fact.

Lest one should proceed on the impression that there is no real value in excess stop-loss coverage, one need only to negotiate a deductible that reflects the previous claims experience under such a policy. Also, set a level at which the cost of premiums and self-assumed losses are acceptable. Patience will yield instructive lessons.

As some know, reinsurance companies do have underwriting losses for this coverage and they do have to pay the legitimate claim.

Finally, far wiser people have found that the spiraling costs of health care will continue unabated unless and until employers realize that they are the ones that control the dollars and that they can help control the increasing size of the health care bill in this country. The insurance industry has merely played a passive role in cost-containment research and not because it has not had the tools.

In reality, an effective cost-containment program is a local issue and the insurance industry, along with the federal government, needs to recognize and encourage employers to band together to tackle this question.

These two primary influences, the government and the industry, have to provide the incentive and resources to assist local employers and health providers to develop effective cost-reduction programs. The efforts of an employers' coalition in Birmingham, Ala., and the Foundation for Medical Care in San Diego, are models to duplicate.

Preferred providers organization legislation, wellness programs and more employee communications by themselves will not be effective cost-containment tools.

It will take the realization by those that control the money that a true cost-reduction program can only be achieved when they step forward and accept the total challenge. Admittedly, self-funding in and of itself is not a panacea, but ignoring the issue and seeking a single solution for a most complex problem is no answer. ■

Ralph N. Galascione is vp-life and employee benefits at Bayly, Martin & Fay of San Diego Inc.

perspective

Anticipate snags in 'other insured' clauses

By Ronald R. Boggs

ONE AXIOM OF risk management theory is that an exposure transferred is a claim avoided and thus is a reduction in the cost of risk. Additional insured status and independent owners' and contractors' protection policies are excellent first steps toward the removal of liability exposures from your program.

These techniques, however, may prove totally ineffective or may only apportion responsibility among insurers—including yours. A principal snag in this program is the "other insurance" condition.

While each legal jurisdiction has its own precedents and rules for apportioning liability where insurer conflicts arise, the roots of all judicial opinions here lie in policy language. Three opinions show problems arising with "other insurance" clauses in contractual transfers of liability. The opinions point the way to avoiding such problems.

The first is a 1982 Illinois appellate court decision, Honeywell Inc. vs. American Motorists Insurance Co. The owner, in hiring a contractor to do work at its building, flexed its negotiating muscle and required that the contractor have it included as an additional insured under the contractor's comprehensive general liability policy.

The owner was added to the contractor's policy.The agreement provided that the owner was insured by the contractor for any and all claims that might arise from the contractor's activities on the owner's premises.

A contractor's employee was injured on the owner's premises due to the established negligence of the owner. The employee sued the owner. The owner tendered its defense to the contractor's insurer. The contractor's insurer rejected the tender and declined to defend. The owner's insurer defended the owner and ultimately paid a $75,000 judgment.

Using its subrogation rights, the owner's insurer sued the contractor's insurer. The trial and appellate courts reviewed the two general liability policies' other insurance clauses and interpreted them to the effect that the owner's insurance was primary and the contractor's was excess.

The other insurance clauses acted to nullify the owner's diligent risk-transfer efforts "for any and all claims." The court went so far as to suggest that the owner did not really intend the contractor to insure this type of claim.

The owner's CGL policy provided that it applied on a primary basis except when endorsed to be excess. If the owner had special excess insurance such a provision would not affect the primary insurer's liability. The contractor's CGL policy also indicated that it was primary, but if there was other valid and collectable insurance, it would be excess and not contribute.

While both policies professed to be primary, the courts did not find duplicate coverage because the owner's CGL policy did not anticipate other primary coverage.

In the second case—again, an Illinois appellate decision—Truck Insurance Exchange vs. Liberty Mutual Insurance Co., the lessee rented a truck.

The written agreement to lease the truck provided that the lessor would furnish up to $500,000 in liability insurance for the lessee. The lessee then agreed to indemnify and hold harmless the lessor for any and all claims in excess of that amount. The lessor's insurance policy had manuscripted endorsements, which extended coverage to lessees in general, as required by the leases.

An accident occurred while the lessee was using the vehicle. The lessor's and lessee's insurance policies each had other insurance clauses, which provided that they applied in excess of any other applicable policies. The lessor's insurer argued that since the two insurers had similar other insurance clauses they should prorate the claim—the general rule for such cases in that jurisdiction. The appellate court considered the manuscript endorsements in the lessor's insurance policy and ruled that the lessor's insurer was liable for the claim up to $500,000.

The lessee was fortunate that language in the lessor's policy came to the rescue. Without it, the lessee would have been unexpectedly hit with half the loss.

A third decision in 1975 involved a federal court's interpretation of Louisiana law in Gulf Oil Corp. vs. the mobile drilling barge, Margaret, etc., Ocean Drilling Exploration Co. and Shell Oil Co. The case is quite complex, but worthy of review for it highlights a number of important considerations.

Shell hired an offshore drilling company to drill a well. Shell requested that it be named as an additional insured for operations involved in the drilling contract under all the driller's general liability policies and that the drilling contract be amended to reflect the agreements to do so. The president of the drilling company agreed to the proposed amendment.

Two days later, it was discovered that the driller had damaged an underwater pipeline owned by a third party. In the subsequent lawsuit, it was agreed that the driller was without fault; it apparently was following Shell Oil's instructions on where and how to drill. Shell and the pipeline owner settled the loss for $1.2 million.

Shell had a $5 million primary legal liability policy. There was a question, though, as to which of two other insurance clauses applied.

The first, issued as an underlying policy for insurance regulatory filing purposes, provided that the policy was primary except where endorsed to apply as excess. A second, negotiated manuscript policy provided that it was excess over any other valid and collectable coverage available to Shell.

The driller had a $250,000 primary policy that included Shell as an insured by virtue of an omnibus insured clause, which included parties to whom the driller was obligated by contract to provide insurance. The policy provided that it was primary, except where stated to apply as excess.

The driller had an excess policy with a $2 million limit. Shell was an additional insured under the policy. The policy provided that it was excess of other valid and collectable insurance and would not contribute with such other insurance.

Shell sought reimbursement of its $1.2 million settlement under the driller's policies. Both the driller's insurers contended that their coverage for Shell only applied to claims arising out of the driller's negligence; and since Shell was solely responsible for the pipeline damage, there was no coverage under either policy. The court considered the driller's primary policy. It found, because there were no coverage restrictions that would eliminate coverage for Shell's sole negligence, that Shell had full coverage.

The court then considered other insurance clauses. It had no problem finding the driller's primary policy (unless stated as excess) as providing the first $250,000 for a loss because the policy did not consider the situation where more than one insurer was primary.

However, between the driller's excess policy and Shell's primary policy, the court's finding was not so straightforward. The decision focused on the fact that the driller purchased the policy to apply in excess of its primary policy as opposed to the purpose of Shell's policy.

The court ruled that Shell's primary policy—regardless of which other insurance clause was considered—should apply over the $250,000 limit of the driller's primary policy. The driller's excess policy would apply in excess of the driller's and Shell's primary policies if the claim exceeded $5.25 million, the total limit of the two primary policies.

Thus Shell, which negotiated to have special insurance apply to its liability arising from the drilling operations and which also secured status as an insured under both of the driller's policies, failed to find complete protection and had to have its insurer pay more than $900,000 on this $1.2 million claim.

What do these decisions tell us? The dominant theme is that additional insured status may not be enough to ward off claims under your program.

To secure the transfer, your own coverage must have stronger, more specific excess language providing coverage for you. An additional option is to raise the ante and seek full indemnification from the transferee, regardless of the insurance provided. This requires greater negotiating strength.

Transferring insurance responsibility requires careful thought, a clear and detailed understanding of your intent, conveying that intent as explicitly as possible to your transferee and follow through on the details of insurance policy language—both your own and the transferee's.

Judges won't know what you want to accomplish unless you tell them. ■

Ronald R. Boggs is a risk management consultant at The Wyatt Co. in Chicago..

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

Insurer must defend policyholder charged with negligence

DOES A GENERAL liability insurer owe to its insured, a municipal utility authority, a duty to defend and indemnify when the authority has been charged with negligently contaminating and polluting groundwater? A New Jersey court concluded that there was a duty to defend.

A suit was brought by a township utility against several insurers that refused to defend it in suits brought by residents for water pollution.

The utility collected liquid wastes and hauled and dumped them at designated landfills. Its general liability insurance policies over the years covered bodily injury or property damage. However, the policies excluded claims for pollution unless it arose suddenly and accidentally. The insurers claimed there was no duty to defend the utility in the suit as the discharge was not sudden or accidental.

legal briefs

The court concluded that the policy exclusion was ambiguous. The court said the policy exclusion can be interpreted as covering claims where the injury was "neither expected or intended."

While the function here of the utility was to intentionally deposit wastes, the court said it was never expected or intended that the waste would seep into the water, resulting in injury to others. Since an ambiguity existed, the court said the insurers had a duty to defend. *Jackson Township, etc. vs. Hartford Accident & Indemnity Co.*, Superior Court of New Jersey, Aug. 20, 1982 (*BI*/05/A.-$5).

Recovery under a bond

Loan origination fees paid by a bank in a false loan scheme pulled off by a bank employee were recoverable by a bank from its insurer under a blanket fidelity bond, according to a federal court ruling.

A bank was covered under a blanket fidelity bond issued by Glens Falls Insurance Co. Inc.

An employee made 161 false installment loans in a scheme to embezzle funds from the bank.

Each loan carried with it, in addition to principal and unearned interest, a loan origination fee of $25.

The bankers bond contained no clause excluding potential income to the bank. The bank and the insurer agreed that its losses came within the policy except for $4,025, the combined loan origination fees.

The court said that if the bond had a clause excluding potential income, the insurer would have "stood" in the unfaithful employee's shoes and a recovery would have been limited to the amount that went into the employee's hands. Since the policy contained no such limitation, the court said that recovery should be allowed for unpaid principal, accrued interest and the loan origination fees. *United Southern Bank of Sumner County vs. Glens Falls Insurance Co. Inc.*, U.S. District Court for the Middle District of Tennessee, Aug. 26, 1982 (*BI*/02/A.-$5). ■

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

U.S. jewelers still able to buy coverage

ontinued from page 3
nually in jewelers block premium, about half of the merchant's total premium output, he says.

Mr. Buttitta uses as an example the coverage that he placed for a medium-sized, Southern California retailer requesting limits of $750,000. This particular jeweler, he says, pays an annual premium of $9,000 for coverage with a $2,500 ductible.

For this premium, he also receives "window limits" of up to 35,000—coverage for jewels taken from show windows facing the treet. Also included is up to 25,000 insuring jewels in transit, rincipally local transit like pickup nd delivery services or those sent by registered mail.

The retailer also receives $25,000 coverage for merchandise on onsignment to others in the indus-y. And, any cash taken from the e or otherwise stolen either on off the premises is insured for up 5,000.

"Of course, the location of the k, the loss frequency and other nilar factors greatly influence he premium," Mr. Buttitta xplains.

Why does interest in jewelers ck continue among U.S. un-writers when experienced yd's syndicates are pulling out?

That's the $64,000 question," Geoffrey S. Molina, director of mercial inland marine under-ting at Insurance Co. of North erica in Philadelphia, a CIGNA p. subsidiary. "We've made a mitment to the jewelers market we want to underwrite appro-ately and remain in tune with industry.

Jumping in and out of the mar-isn't servicing (our clients) ," he says. "We need to stay as sistent as we can."

NA's jewelers block under-iting was "substantially unprof-ble in 1982," Mr. Molina admits, ugh he would not discuss fig-s.

It's too early to say if we'll make ey this year, but it's better than 1 and '82."

ireman's Fund Insurance Cos. experienced the same under-ting frustrations as INA.

t's been pretty bad," says Bruce rymple, field director in the mercial lines department in Francisco. He estimates the pany has lost $6 million writing line over the past five years.

We think we can make money his—we just haven't found the ic formula yet," Mr. Dalrymple s. "We're trying our darndest to e money at it."

Fireman's Fund continues to un-write the coverage "because we ve to be an all-lines market for thing brokers may need to e," Mr. Dalrymple says.

he American Home Assurance affilate of American Interna-al Group does not currently te jewelers block policies, but it es to be in the market on the onal level in about six months.

ob Pulka, an American Home tant vp in New York, thinks the company can record a profit, based on Insurance Services Office advisory rates. "There's a significant amount of inquiries in Boston already," he says, explaining that the company has based one of its two jewelers block underwriters in its Boston office.

However, some U.S underwriters, like Chubb Corp., are getting out of the jewelers block market, though Chubb's decision is not a recent one.

Chubb is on the last leg of a gradual, 3½-year withdrawal from the market, after writing jewelers block policies for about 20 years. The insurer has only three or four policyholders left, and gradually intends to divest itself of those.

"Even with very good underwriting expertise, the net result over a long period of time was only a break-even run," says Art O. Birkenstock, national manager of commercial inland marine insurance for Chubb in Short Hills, N.J.

It is characteristic of the line, Mr. Birkenstock notes, that one or two good years will be followed by one with severe losses, wiping out any previous profits.

"I don't think it (withdrawing from the market) was a bad decision," he says. "No matter what advances are made in protection, our friends in the underworld always seem to go one better."

Recent increases in crime involving jewelry merchants have made underwriters increasingly more selective in assuming these risks.

In 1979, for instance, a jewelry safe was burglarized once every nine days; in 1982, the same crime occurred once every five days, according to the Jewelers Security Alliance, a 5,000-member industry crime-prevention organization in New York.

In addition, underwriters in London note that more than $44 million in jewels have been stolen in the last 18 months. And that just includes large-scale heists.

"We're a lot more selective today than we ever were five years ago, not only on who we insure, but on how we insure them," says Mr. Buttitta of United California.

Each risk Mr. Buttitta places is evaluated by an inspector who examines the books, security measures and layout of the establishment. He also carefully looks at the attitude of the policyholder toward security and protection.

Mr. Buttitta has used this thorough examination program for about a year, and says, "I think it's going to pay dividends." Spot-checks are performed every six weeks, and if the insured does not comply with security recommendations within 30 days, coverage may be either canceled or restricted until he does.

"Our aim is not to cancel people, but truly to get them to understand why we ask for what we ask," he adds.

Client selection is the key to a jewelers block underwriter's success, says Mr. Whiteford of Allianz, which only writes coverage brokered by United California's Mr. Buttitta. Allianz began heavily writing jewelers block policies early this year.

"I don't write every jewelers block that comes along, even for this one broker," Mr. Whiteford says.

The inspection demanded by Mr. Buttitta helps Allianz decide which risks are worth keeping, Mr. Whiteford says. "He (the inspector) has been in the business a long time, so he's basically our eyes and ears. If we don't feel comfortable with it because of what he says, we'll get off the account.

"We're a little more selective than most, and probably do a little more work as far as getting inspections and loss control," Mr. Whiteford says.

"(Jewelers block) is an exposure that can be underwritten to a profit —I sincerely believe that. It's just a matter of being very, very careful with it.

"We've been very fortunate but we could get burned tomorrow. That's just the type of business it is," he said.

Last year, Allianz lost money—about $150,000—writing jewelers block on a limited scale, Mr. Whiteford estimates. So far this year, he says, the company has written about $300,000 in premium and has lost only $6,000.

"Right now, we're making money hand over fist, but the year's not over yet."

Like London underwriters, Mr. Whiteford says some jewelers, especially those who aren't making a lot of money, will attempt to stage a robbery to collect from their insurers.

"There's a certain degree of moral hazard in jewelers block—you have people stealing from themselves," he says.

"It's almost like an arson. It's not commonplace, but it happens enough that an inspector should go in there and get a good idea of how legitimate this person's operation is."

In contrast to jewelers that try to illegally collect on their insurance, many jewelers do not even buy jewelers block coverage. And, if rates climb, more could go uncovered.

But Mr. Buttitta says the fact that some jewelers buy little or no coverage isn't anything new. "There has always been a relatively high percentage in the jewelry trades that goes bare or close to bare," he says, estimating that between 20% and 30% of the nation's jewelers are either uninsured or inadequately insured.

"It happens quite a bit," agrees Mr. Whiteford. "In fact, I just picked one up that was bare for quite a while."

The businesses most likely to not purchase coverage are jewelers that are just starting in business and those that specialize in loose diamonds. Merchants handling loose gems sometimes have a tough time finding coverage since they travel more frequently with their inventories than others, which puts their inventories at greater risk.

"It's very dangerous when these folks are uninsured—they're really exposed to going out of business on any sizable loss," Mr. Buttitta adds. ■

orm damage costs $75 million

EW YORK—Several storms in e and July combined to cost in-rs about $75 million in prop-damage, according to C.E. manson, property claim ser-vp of the American Insurance n.

ind, hail and tornadoes that ck north-central Texas June 3-aused insured losses of $21.5 mil-. This storm was assigned Ca-rophe No. 96 by the Insurance vices Office.

combination of wind, torna-s and hail in portions of Colorado, Kansas and southern Texas June 4-6 caused insured losses of $36 million: $15.5 million in Colorado, $12 million in Texas and $8.5 million in Kansas. This storm was assigned Catastrophe No. 97 by ISO.

In addition, wind, hail and tornadoes caused estimated insured losses of $20 million, mostly in the Minneapolis-St. Paul area, Mr. Hermanson said.

ISO assigned Catastrophe No. 99 to the Minnesota storm. ■

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Insurers stress loss prevention

LONDON—Underwriters are prepared to offer jewelers block insurance at cheaper rates only when jewelers' losses decline through good loss prevention, says Malcolm Blair, underwriter for Lloyd's syndicates managed by M.V. Spratt & Others.

Mr. Blair says underwriters insist that their policyholder take a variety of security measures, including:

- Keeping strict hours.
- Removing only a small amount of jewelry from the vault.
- Refusing to let others handle jewelry.
- Restricting the amount of stock placed in any one showcase. Higher-priced pieces should be displayed in the rear of a showcase.
- Taking only one piece out of a showcase at one time.

Mr. Blair says he and other underwriters send inspectors to check jewelers' premises for security before writing coverage. But no matter how good a security system, not all thefts can be stopped.

For example, earlier this year thieves stole $16 million of jewelry from safe deposit boxes at Lloyd's Bank. One of the claims received by underwriters was from a jeweler that followed all the underwriters' security tips, Mr. Blair said.

"We had an insured—a diamond dealer—who was going on holiday for more than a month and decided to move all this stock down to Lloyd's Bank rather than leave it unprotected. And he informed underwriters he was doing so, which is a good tactic."

British react to growing jewel thefts

Continued from page 3

elry thefts and robberies has hit the major jewelery centers in the world, mainly in North America and London.

Experts blame the increase in crime to two economy-related problems. First, more thefts than normal occur in hard times, they explain. In addition, jewelers pinched by the poor economy are not maintaining proper security in order to increase sales.

Since January 1982, between 10 and 20 armed robberies at U.S. jewelers have cost more than $1 million apiece, London underwriters say. About 15 million pounds (about $24 million) in jewelry has been lifted in London during the same period.

If the underwriters' problems are bad, the jewelers' may be even worse.

Some jewelers cannot afford the increased premiums in the jewelers block insurance market or cannot find underwriters to insure their risks, sources in the London market say.

But, even if they are uninsured, they still face the same theft exposures.

Last month, Bond Jewelers in London lost an estimated 2.2 million pounds (about $3.5 million) of uninsured jewelry when robbers hit a new store that had not even opened.

Bond had been insured by Lloyd's brokers Halford Shead & Co. Ltd., a subsidiary of the Alexander Howden Group P.L.C., but the policy was canceled before the heist, Halford Shead confirmed.

Business Insurance tried to contact Bond Jewelers, but the telephone had been disconnected.

"A lot of jewelry companies are going uninsured," said John Evans, divisional chief executive of Alexander Howden Insurance Brokers, Howden's main brokerage unit.

"Retailers spend a lot of money on protection equipment and on how the interior part of the store looks, but insurance is far too far down on their list of priorities."

However, some jewelers may also not buy coverage because they think the underwriters will try to avoid paying losses, Mr. Evans admits.

When jewelers block underwriters think a claim is suspicious, they won't pay until it is thoroughly investigated, Mr. Blair explains.

"It happened in this country, I know, where an assured had some stock that he could not sell, so he actually contracted on the open market to arrange a robbery," Mr. Blair said, noting that the underwriters on the risk did not pay the claim.

The underwriters say jewelers have only themselves to blame for the lack of capacity and the high rates because some are ignoring security procedures to increase sales.

"Someone arrives well-dressed and the manager puts aside all sense of security," said Mr. Blair. "He thinks it is a sale and the guy comes through the doors after working hours and, before you know it, the store is cleaned out."

Besides robberies and thefts from jewelry stores and from courier services carrying jewelry, Mr. Evans also reports that underwriters are suffering losses of from $15,00 to $30,000 each from the theft of jewelry that is sent through the mail. ■

IMMEDIATE ACCESS TO INDUSTRY INFLUENTIALS

UPCOMING ISSUES

	ISSUE DATE	AD CLOSING
	AUG 1	Jul 20
Risk Management Board Survey	AUG 8	Jul 27
	AUG 15	Aug 3
EXCESS/SURPLUS	AUG 22	Aug 9
Distribution at Monte-Carlo, Rendez-vous	AUG 29	Aug 17
EMPLOYEE BENEFITS: HUMAN RESOURCES	SEP 5	Aug 23
	SEP 12	Aug 30
MARINE/AVIATION	SEP 19	Sep 7
IIAA Convention/Employee Benefits Board Survey	SEP 26	Sep 14
	OCT 3	Sep 21
REINSURANCE REPORT/NAII Conference	OCT 10	Sep 27
	OCT 17	Oct 5
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FASB delays hearing on rule

STAMFORD, Conn.—The Financial Accounting Standards Board has delayed its public hearing on proposals that would change how employers account for pensions until Jan. 11-13 in New York.

The proposed rules would move the unfunded liabilities of employers' defined benefit pension plans to the corporate balance sheet.

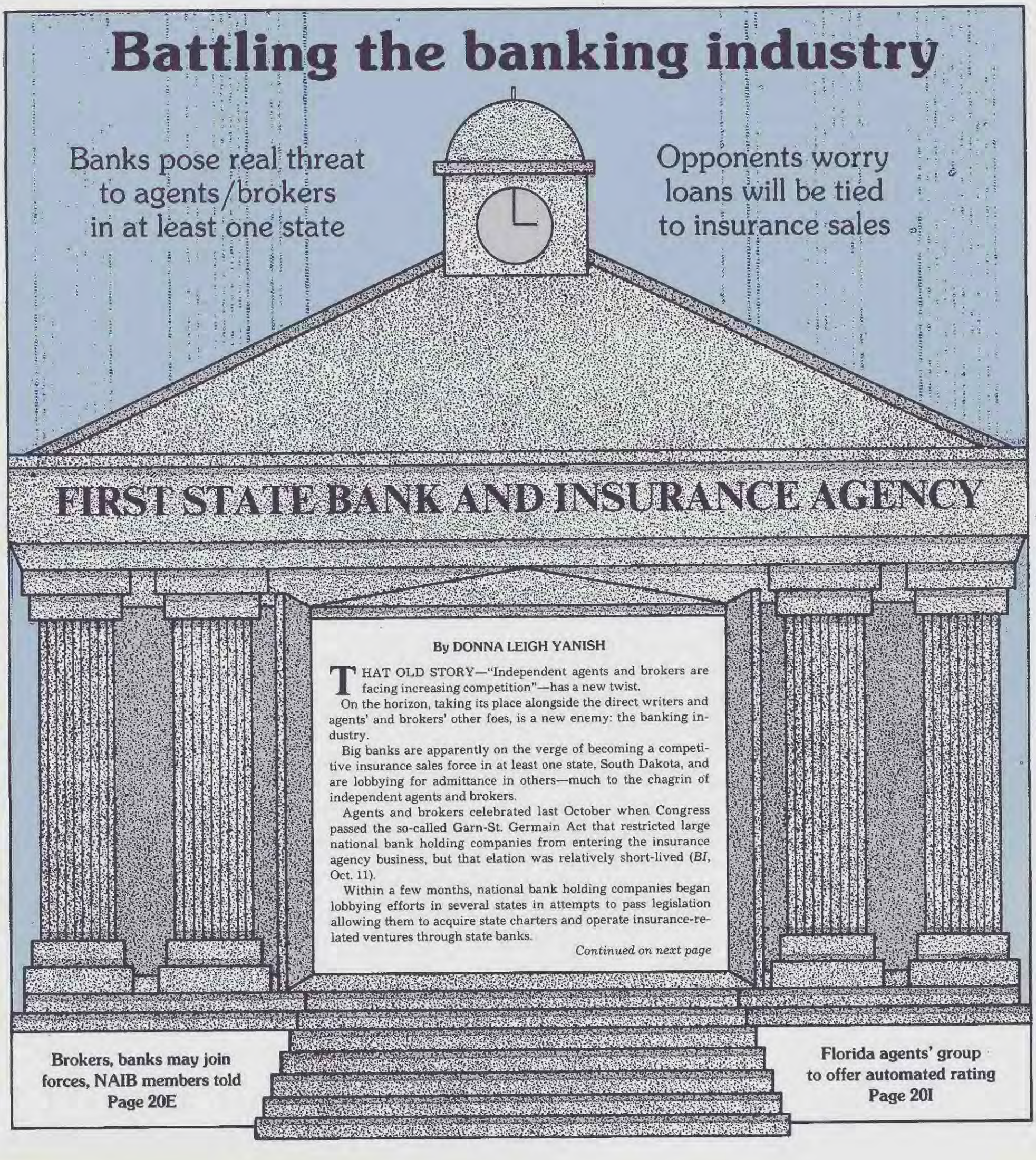
The hearing, which had been set for Oct. 26-28 (*BI*, May 30), was rescheduled to give the public more time to comment on the board's preliminary views and recently published discussion memorandum and to consider results of a field test of the preliminary proposal.

The field test, the results of which are expected to be available Sept. 1, is studying the results after the board's preliminary views on pension accounting are applied to a number of companies associated with the Financial Executives Institute.

In addition, the deadline for written comments from employers on the FASB's preliminary views and discussion memo has been extended to Dec. 1. ■

agent/broker topics

A regular editorial section exclusively for agents and brokers



By DONNA LEIGH YANISH

THAT OLD STORY—"Independent agents and brokers are facing increasing competition"—has a new twist.

On the horizon, taking its place alongside the direct writers and agents' and brokers' other foes, is a new enemy: the banking industry.

Big banks are apparently on the verge of becoming a competitive insurance sales force in at least one state, South Dakota, and are lobbying for admittance in others—much to the chagrin of independent agents and brokers.

Agents and brokers celebrated last October when Congress passed the so-called Garn-St. Germain Act that restricted large national bank holding companies from entering the insurance agency business, but that elation was relatively short-lived (*BI*, Oct. 11).

Within a few months, national bank holding companies began lobbying efforts in several states in attempts to pass legislation allowing them to acquire state charters and operate insurance-related ventures through state banks.

Continued on next page

Brokers, banks may join forces, NAIB members told
Page 20E

Florida agents' group to offer automated rating
Page 20I

Banks trying to sell insurance despite agents' opposition

Continued from previous page

Using a state charter to enter the insurance business would, in effect, circumvent the federal prohibitions against such activity contained in both the Bank Holding Company Act and Title VI of the Garn-St. Germain Act. Neither specifically prohibits state-chartered banks from engaging in insurance activities if state law permits it.

Agents and brokers have continued their own lobbying efforts to prevent banks from selling insurance, this time on a state-by-state basis. With most legislatures currently adjourned for the summer, statehouse lobbyists on both sides of the controversy have time to retrench and review their results so far this year.

Agents and brokers applauded the results in some states.

For example, the Independent Insurance Agents of America praised Delaware Gov. Pierre S. du Pont in June when he announced he wouldn't seek legislative action on a proposal to allow Delaware banks to engage in the business of insurance.

IIAA President Jack Payan said Gov. du Pont's action "clearly demonstrates his realization that such legislation is not supported by the majority of citizens in his state. We are very pleased that the governor has chosen not to submit the proposal."

However, another governor—William Janklow of South Dakota—successfully campaigned for legislation that would allow national bank holding companies to acquire state charters and subsequently act as both insurance underwriters and brokers (*BI*, Feb. 28, March 7). He was joined in the campaign by the South Dakota Bankers Assn. and Citicorp, the huge New York bank holding company.

Opponents to the legislation came from several industries, including some banks. Joining the Independent Insurance Agents of South Dakota in opposing the legislation was a group of South Dakota bankers, which split with the South Dakota Bankers Assn. over the issue and formed the Coalition of Independent Business People of South Dakota, says IIASD Executive Vp Roland Benson.

Among this group of banks were many that already had the ability to sell insurance in South Dakota and that wanted to block the entry of Citicorp.

The Garn-St. Germain Act allows all banks in communities with populations of less than 5,000 to sell insurance. South Dakota, a state comprised mainly of small towns, has hundreds of "bank agencies"—insurance agencies housed in small banks. In fact, bank agencies account for more than half of the IIASD's membership.

Opponents to the recent legislation from the small banking/insurance agency community say that the law will actually hurt small banks' interests while furthering the interests of the large national banks that can come into the state under the new law.

Since the legislation was enacted, Citicorp is the only national bank to aggressively try to use the new law. The bank holding company has purchased American State Bank of Rapid City, S.D., and is waiting for approval of the acquisition from the Federal Reserve Board. Owning the state-chartered bank would allow Citicorp to underwrite and sell insurance in the state.

If approved by the Fed, the state-chartered bank won't be Citicorp's first business enterprise in the state. Citicorp moved its massive credit card operation to Sioux Falls, S.D., from New York two years ago after the state passed a law allowing national banks to issue credit cards within its boundaries.

Allowing national banks to issue credit cards in a state and lifting the usury rates for credit cards to make the operations more profitable appear to be the first steps in allowing banks to enter the insurance business, notes Celeste Relyea, director of state government affairs for the National Assn. of Professional Insurance Agents.

Such legislation has preceded bills to allow national banks to sell insurance under a state charter in states like South Dakota and Delaware, she says.

In other states, like Maine and Minnesota, legislators' refusal to approve an increase in the usury limit has blocked introduction of bank-insurance legislation, she adds.

Once the usury limit has been increased and credit card operations are allowed, then banks begin pressing to expand the presence in the state to include insurance sales and underwriting, Ms. Relyea says.

Such legislation is frequently pushed as a jobs bill. Such was the case, for instance, in South Dakota.

Citicorp became the state's second-largest employer when it moved its credit card operation to South Dakota in 1982. The bank holding company employs about 900 people for the credit card operation and says it will double that employment figure once it has a state charter that allows it to market insurance.

But others say employment opportunities shouldn't be a consideration in deciding whether to allow national banks to acquire state charters, which in turn could lead to the ability to sell insurance.

"Banking in a unique part of the economy. Its impact is tremendous," says Roger Levy, director of federal government affairs for the IIAA.

"It's not enough to think about whether or not (changing the law) will bring jobs into the state. We're taking about the federal banking structure. To begin to put at risk depositors' money for the sake of jobs is irresponsible," Mr. Levy explains.

But agents and brokers say there's an even more important reason why banks should not be allowed to sell insurance. They say the power over consumers that banks could wield would allow them to compete unfairly in the insurance distribution system.

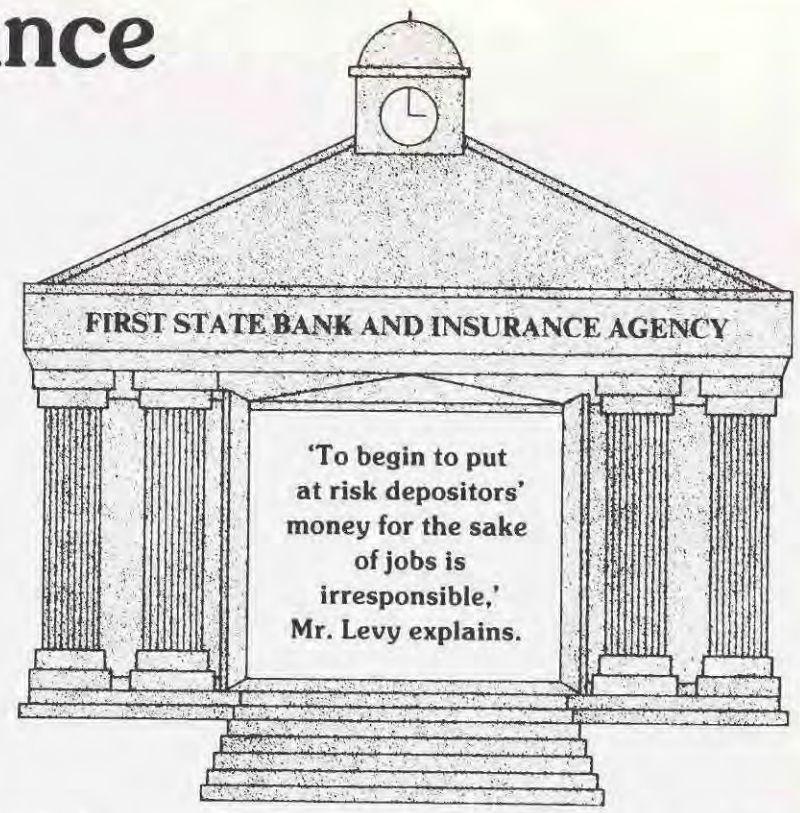
J. Knox Hillman Jr., chairman of the PIA's federal/state affairs committee, explains that banks control one of the keys to success in today's economy: credit.

"In the granting of credit, a consumer must qualify on various financial grounds. This is no different from the underwriting process in insurance. However, with few exceptions, the final element needed to secure the loan is an assurance provided by the consumer that the lender's interest will be protected for the amount and duration of the loan," Mr. Hillman says.

"While collateral and/or co-signatures are acceptable on some loans, for the vast majority of these loans the most available instrument to the consumer and most desirable to the lender is an insurance policy."

The fundamental relationship between credit and insurance raises potential conflict-of-interest questions if lenders are allowed in the insurance business, Mr. Hillman says. "Such a relationship is laden with opportunities to induce borrowers to purchase the lender's insurance products.

"The connection need not be explicit. It is implied in the very nature of the transaction. Consumer and business borrowers are anxious to protect their available line of credit, particularly in tight money markets.



"As a practical matter, consumers' freedom of choice is lessened, thus precluding them from an otherwise highly competitive insurance market," Mr. Hillman contends.

But those that think banks should be able to expand into the insurance industry don't see these potential problems as severe enough to deny the banks access.

The possibility of banks coercing clients into insurance purchases is a "legitimate" concern, but one that is not borne out by experience in Delaware, where some banks that received state legislative charters early in this century are allowed to have some insurance operations, according to Irving Shapiro, a partner in the New York law firm of Skadden, Arps, Slate, Meagher & Flom who is based in Wilmington, Del. He is also a Citicorp director.

Mr. Shapiro has lobbied in Delaware on behalf of Citibank in its so-far unsuccessful attempt to pass legislation that would allow it to sell insurance in the state. Citicorp already has a state-chartered bank in Delaware.

Worry about banks having an unfair advantage in selling insurance is theoretical rather than established in fact, he adds.

The real objection of the insurance industry groups is that they're worried about keeping their market share as the financial services industry evolves, he charges. Members of those groups, he says, will just have to keep up with the changing market, or fall by the wayside.

Gov. du Pont failed to push for the legislation, despite Mr. Shapiro's considerable clout. Mr. Shapiro was formerly chairman of E.I. du Pont de Nemours & Co., the huge chemical firm based in Wilmington.

Although the latest skirmishes between the banks and agents and brokers have been fought on the state level, the battle is beginning to resume in Washington.

The best bet for agents and brokers opposing bank involvement in the insurance industry is legislation—four separate bills—now pending in Congress that would place a moratorium on banks entering the insurance business.

The bills are very similar, according to a Patricia A. Borowski, director of administration government industry affairs for the PIA. The major differences among them concern when the moratorium would begin and end.

However, other pending legislation would accomplish exactly the opposite. The Financial Institutions Deregulation Act, H.R. 3537, introduced last month at the request of the Treasury Department by Rep. Fernand St. Germain, D.-R.I., would permit all banks to engage in insurance underwriting and brokerage activities.

The bill essentially would repeal last year's Garn-St.Germain Act, which Rep. St. Germain also sponsored. ■

So far, it's business as usual at bank-owned agency

MADISON, Wis.—If you don't think an insurance agency can effectively operate while being owned by a bank, take a look at Reitan-Lerdahl Agency in Madison.

The agency was purchased last February by M&I Bank, a state-chartered bank subsidiary of Marshall & Ilsley Corp., a Madison-based bank holding company.

To date, it's been business as usual at the agency, which places a few million dollars in premium volume, according to Glenn Onsager, general manager of the agency and one of its previous owners.

"We haven't been interfered with yet, but I do think it will come. I don't think M&I Bank would buy us if they don't want to get into the insurance business."

M&I Bank, however, says it currently doesn't have any plans to meld the agency's operation with the bank's. "We want (the agency) to continue operating as it had before we bought it," says Peter Boss, president of M&I Insurance Services, a subsidiary of M&I Bank.

The entry of banks into the insurance business is inevitable, Mr. Onsager says. Banks as well as savings and loan associations are going to be active players in all aspects of the financial services industry, he contends, adding that insurance is just part of the equation.

For the agency, the purchase by the bank offers tremendous opportunities since the bank can provide capital for expansion that the agency could not generate on its own.

The agency principals were looking for a buyer when M&I approached them, notes Mr. Onsager, who is planning to retire soon. Several other suitors also were interested in the agency, but the owners determined the bank offered the best opportunity for the agency to expand, he says.

Reitan-Lerdahl is unique, not because its parent is a bank, but because of the location of the agency. Like several other states, Wisconsin has many bank-owned agencies, but they are all in communities with populations of fewer than 5,000, notes Bob Jartz, executive vp for the Independent Insurance Agents of Wisconsin.

Banks in communities of under 5,000 are exempt from the Bank Holding Company Act, which generally prohibits banks from participating in the insurance industry.

Bank ownership of agencies is essential in those small communities, Mr. Jartz says. There generally isn't enough business in a town to sustain a freestanding agency, he says.

Without a bank-owned agency, consumers in small towns would have to sometimes travel more than 100 miles for their insurance needs, he says, explaining that in these situations, bank ownership of agencies does not harm competition.

However, the situation is different with Reitan-Lerdahl in Madison, the state captial with a population of more than 100,000. There's competition for the insurance dollar in Madison, so bank ownership could potentially give the bank-owned agency an unfair advantage, some independent agents say (see story, page 20A).

State-chartered M&I Bank's purchase of Reitan-Lerdahl could seriously undermine the intent of Title VI of the Garn-St. Germain Act passed last year, according to the IIAW. It has petitioned the Federal Reserve Board in an effort to stop M&I's insurance activities.

The Wisconsin banking commissioner is also examining the impact of state chartered bank insurance activities on the public, as well as the banking and insurance industries. But neither the Fed nor the commissioner have so far issued a ruling in the matter.

—By Donna Leigh Yanish

Agents in Ohio claim S&L, bank are breaking law

COLUMBUS, Ohio—Agents in Ohio are bypassing the Legislature in favor of state insurance regulators in their efforts to make sure financial institutions don't encroach on their turf.

Following a complaint by several groups and individuals, including the Professional Insurance Agents Assn. of Ohio, the Ohio Department of Insurance is investigating alleged insurance activities of Diamond Savings & Loan Assn. in Findlay, Ohio.

The complaint alleges that Diamond is soliciting insurance on behalf of Cherokee Insurance Co. in Nashville, Tenn., and Hylant-McLean Insurance Agency in Toledo, Ohio. All three entities—Diamond, Cherokee and Hylant-McLean—are owned by Dana Corp. in Nashville.

Ohio insurance regulators have requested information from the insurer and the savings and loan association about their business relationship. The department hasn't requested information from Hylant-McLean because it hasn't found any possible violations of the law by the agency, according to a department spokesperson.

Specifically, the department has asked for all written information relative to the relationship between the S&L and the insurer, a detailed description of any oral agreements between the organizations and a statement describing anything of value being given to employees of either organization by the other.

The last request stems from a complaint that employees of Diamond Savings and Loan have been offered gifts, including trips to Hawaii, as incentives for bringing in business to Cherokee, according to George Haenszel, director of public affairs for the PIA.

A spokesman for parent company, Dana Corp., says no incentive program to bring customers to Cherokee has ever been offered to Diamond employees.

If the allegations are true, Diamond may be soliciting or advertising insurance on behalf of Cherokee, in violation of Ohio law.

Ohio law prohibits certain types of insurance solicitation by unlicensed entities and precludes the payment of finder's fees, lead fees, commissions, or anything else of value to an unlicensed person in relation to the solicitation.

"Part of the problem here is that the state law defining solicitation is unclear," notes Mr. Haenszel.

Also complicating the matter is that a new administration is running the Ohio statehouse. Democrats are now in control after many years of Republican administrations.

"We've had a great increase in the number of complaints against (activities of) S&Ls. They appear to be testing the waters since the change in administration. In the past, Ohio has had fairly good success in keeping banks out of the insurance business," he says.

Meanwhile, the Independent Insurance Agents Assn. of Ohio has filed a complaint alleging that the trust department at Ameritrust Co., a bank in Cleveland, is soliciting insurance business, according to IIAA of Ohio Executive Vp Thomas H. Hardy.

The complaint alleges that the trust department is sending letters to the owners of property held in trust recommending that the property owners place their insurance on the property through the same independent agent as the trust department's policy.

The trust department allegedly claims that the property owners could save money on the insurance if the coverage becomes part of the bank's master policy.

The state Insurance Department says that it has not yet begun an investigation into these allegations.

A bank spokesman would not comment on the charges. ■

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Travelers offering bank services to agents

HARTFORD, Conn.—Insurance agencies and brokerages can take advantage of The Travelers Corp.'s attempt to do the banks one better.

Travelers is offering a cash management service, which resembles common bank services, to businesses with less than $10 million in sales, including independent agencies and insurance brokerages.

The Agency Capital T account, available to independent agencies, and the Business Captial T service, a similar product for small businesses, will be marketed through independent agents, according to Tony M. Ettinger, director of the Capital T program.

Each account requires a minimum investment of $10,000.

Both Capital T services were designed for businesses that don't have a full-time treasurer, Mr. Ettinger explains. Key features include a choice of two money market funds for investment of idle business funds and a high-yield, no-minimum checking account.

In addition, the Agency Capital T has an optional premium funds account with its own checking privilege, whereby agencies can separately invest their fiduciary funds.

Both services offer a business a gold MasterCard program with up to 30 days of float. Business owners can also request individually coded MasterCards for their employees.

The credit limit on the cards is limited to the size of the investment, and firms can specify lower limits for employees' credit.

Both the agency and the small-business programs also include two types of short-term credit.

First, $5,000 in overdraft protection automatically comes with the service, he says.

The second, more extensive type of credit—which the customers can apply for when they sign up for the service—is optional. Customers opting for this service can access a special line of credit it at any time. The line, however, must be cleared for 30 consecutive days during a calendar year, Mr. Ettinger says.

There's no extra charge for the optional line of credit unless the agent or small business owner accesses the fund.

The structure of the Capital T accounts for agencies and small businesses are different, and therefore the optional loan programs are not exactly the same.

For an agency, the optional line of credit is secured against the firm's book of business. Travelers will evaluate the book and set a credit limit. Interest rates for agents will probably be the prime rate plus one or two percentage points, Mr. Ettinger says.

Small-business owners' lines of credit aren't secured and therefore will come with an interest rate that is a few points higher than for the agents' line, he says. The application for the line will be evaluated by Connecticut Bank & Trust.

Both accounts feature a monthly statement designed to help monitor and control cash flow. The first page of the statement is a consolidated report to serve as an executive's summary, Mr. Ettinger says.

Agency or small-business executives want to know "What can I write a check for today and how much money flowed through the account last month?" he explains. They can answer both these questions from the first page of the monthly statement, which also includes a tax summary.

The rest of the statement is an in-depth analysis of the monthly transactions within the account, he says. The information is designed for use by the firm's accountant.

Both types of accounts can also include pre-authorized payments of Travelers life, health and property/casualty insurance premiums. By using this option, customers can integrate all financial and insurance-related activities under one comprehensive service, he says.

The monthly service fee is $20 for Agency Captital T and $30 for Business Capital T.

Agents have expressed an interest in the program for several reasons, Mr. Ettinger notes.

"Some callers say, 'If I'm going to be a business advisor, I'd better have one myself.' The smallest number of callers ask if they have to buy it themselves. They say they'd rather just sell it."

Agents don't necessarily have to be Travelers' agents to buy the program or sell it, Mr. Ettinger says. The insurer's policy is that agents marketing or buying the program either must be doing business with the insurer or have the potential for doing business with it. It's up to the field managers in Travelers' branch offices to decide what companies are eligible.

To sell the product, agents must be licensed with the National Assn. of Securities Dealers and be registered with a securities broker or dealer, Mr. Ettinger adds.

Travelers owns a broker/dealer subsidiary, Securities Settlement Corp., that will help agents become licensed and will serve as broker/dealer for the agents. ■

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NAIB annual meeting

Bankers, brokers may form joint ventures: Panelists

By PAMELA DeFIGLIO

SOUTHAMPTON PARISH, Bermuda—Joint ventures between banks and insurance brokers will be a viable solution to banks' increasing attempts to sell insurance, according to panelists at last month's National Assn. of Insurance Brokers annual meeting.

Two bankers and an insurance broker said their respective industries would become more and more integrated.

"What you may see," said Charles L. Ruoff, senior vp of Fred S. James & Co. Inc. in New York, "is joint ventures, an unholy alliance to combine the resources of a banking institution with an insurance enterprise."

"I believe a lot of joint ventures can be developed which will serve both (insurance brokers') needs and banks' needs," said Anat Yalif, director of corporate planning for Marine Midland Bank in New York.

John R. Torell III, president of Manufacturers Hanover Trust Co. added, "You want to get into our business—we want to get into your business to cross-sell products. We are going in the exact opposite direction, but in time we'll have a little bit of each.

"We'd like to be in a full-service insurance business with a spectrum of products," said Mr. Torell. Manufacturers Hanover already owns two credit life insurers.

Ms. Yalif of Marine Midland Bank noted she headed an Arthur Young & Co. study on possible areas in which banks could expand their business ventures.

"We found that the insurance business is a good one to be in," she said. "Your business is people- and skill-intensive, not capital-intensive. Brokerage requires expertise, but doesn't necessitate lots of capital. So, it's a good candidate for banks, provided they can get the right people to work for them."

Banks have a retail and commercial customer base, Ms. Yalif pointed out in listing why banks would operate well in the insurance industry, as well as a distribution network of buildings and branches. She said the public sees banks as the primary, most trusted provider of financial services. Certain banking products such as letters of credit and municipal guarantees are similar to insurance, she added.

On the minus side, though, banks would have to pay insurance brokers higher salaries than they are accustomed to paying to banking employees, she said.

In his speech, Mr. Torell outlined three major areas of change in the banking business—geographic expansion, product diversification and delivery mechanism—which have created greater opportunities for banks to enter other financial service fields, including the insurance business.

In the first area of change, geographic, Mr. Torell said several states are allowing banks to come into their states to increase jobs and tax revenues. South Dakota and Delaware are among these states, and Manufacturers Hanover has opened a bank in Delaware which is expected to accumulate more than $1 billion in assets by the end of this year (see story, page 20A).

The second major area of change is product diversification. Besides petitioning state legislatures for permission to enter the insurance business, banks are hoping to be able to act as real estate brokers and expand into the growing discount securities brokerage field. Also, federal lawmakers are now debating whether banks should be allowed to sell mutual funds and revenue bonds.

But even without branching into these areas, Manufacturers Hanover has already created a a network of non-banking subsidiaries. By the end of 1983, this network, which includes some insurance activities, should be near the bank's stated goal of $100 million in after-tax earnings.

"We own an insurance company. In fact, we own two. And we like them very much," Mr. Torell commented.

The two insurers owned by Manufacturers Hanover are Ritter Life Insurance Co. and Tempco Life Insurance Co., both credit life reinsurers. They are the single most profitable product line within Manufacturers Hanover's operations.

Despite the general federal prohibition on banks entering the insurance business, they are allowed to participate in the credit life, disability and involuntary unemployments segment of the insurance industry (*BI*, Oct. 11, 1982).

Distribution systems are the third major area in which banks will see changes, Mr. Torell advised.

Instead of expensive branch banks, Mr. Torell sees toll-free long-distance phone numbers, direct mail sales and in-home computers serving bank clients. These innovations will allow business to be conducted without the restrictions of natural geographic barriers.

What will happen to banks' competitors, especially insurance agents and brokers, if the banks succeed in broadening their product, geographic and technological bases?

"There will be winners and there will be losers, but there will also be a large middle ground that survives the process," Mr. Torell told the brokers.

"Your customers are not bound by the loyalty and tradition that once were the hallmarks of the business," Mr. Torell told the insurance brokers. "Your distribution system is changing dramatically...Your investment programs have changed...Your products and your markets have changed as well.

"I would not stand before you and be so impolitic as to say you must also change. But, as you look at subtle changes in your industry, beware of the Trojan horse.

"I believe," he continued, "that we are not in the banking or insurance business but in the financial services business. And I believe that competition might appear very subtle on the surfaces." ■

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Brokers must respond to changes, executives say

SOUTHAMPTON PARISH, Bermuda—Brokers who change with the times will survive and profit, counseled three industry leaders at the National Assn. of Insurance Brokers' annual meeting.

The insurance industry is awash in changing currents, they said, and brokers must respond.

Rates will never again rise to what they were before high interest rates and competitive market prices. So, agents and brokers must find other ways to survive and profit—by making management more efficient and trying new tactics ranging from direct sales to insurer-sponsored support programs.

William Pollard, president of Reliance Insurance Co., commented, "Being in the fifth year of a three-year cycle, it seems to me that the game is changed—and it's changed permanently."

"I don't think we'll see dramatic upturns in rates as in the '70s," added Albert J. Tahmoush, president and chief executive officer of Frank B. Hall & Co. Inc. The third panelist, Harold H. Hines Jr., executive vp of Combined International Corp., said he believes rates already have changed but won't rise much more. "They're higher in 1983 than in 1982 or 1981."

"If you accept my premises—that rates will firm up only a little and that the high returns we've had won't come back—then it becomes imperative we adopt bold, innovative strategy," said Mr. Pollard. "And this must focus on the customer and the distribution channels to meet the customer.

"For all of us, the name of the game is fast becoming marketing skills," he commented. He envisions multiple distribution channels in the future.

Recently, Reliance conducted a through-the-mail direct-response study. When respondents bought policies from the insurer, they were sent quotations bearing both the name of the insurer and a local agent or broker. The local producers handled some claims for these policyholders and, as a result of the mailing, were able to solicit them to buy other kinds of insurance and received a small commission.

"We only wrote a limited amount of direct-response insurance," Mr. Pollard said, "but we concluded that it is buyable. We did go through agents and brokers and it does satisfy many, certainly not all, customers on the basis of price and convenience of sale."

Another source of new business for agents and brokers, Mr. Pollard suggested, will be employers, many of whom will institute payroll-deduction programs for employees to buy personal lines insurance in the future.

"And you all (place insurance for) a lot of employers," he told the brokers.

Offering personal lines insurance is just another step for employers that are already offering cafeteria-style benefit programs and Individual Retirement Accounts, for example.

Agents and brokers looking to Reliance for innovative products will find that Reliance has a two-fold strategy, Mr. Pollard explained.

The first is to be all things to some agents and brokers. Forty-one percent of the agents and brokers the insurer deals with provide it with 80% of its business. This is Reliance's preferred segment of producers, and it intends to provide them with underwriting capability and financial support and allow them to sell its full range of products.

The second strategy is to be some things to all brokers. Reliance will sell products in its areas of expertise to all agents or brokers. These areas include bond underwriting, commercial mass marketing, special risks, risk management services and surplus lines.

While dismissing a change in market prices, Hall's Mr. Tahmoush suggested, "I don't think NAIB should be so concerned about whether rates are high, low or medium—it's counterproductive," he said. "Let's not think about what underwriters should do, but what we should do."

In the current squeeze, Mr. Tahmoush suggested, brokers should cut inefficiencies out of their management structures.

And, brokers should move toward charging fees for their services instead of relying on ever-shrinking commissions, Mr. Tamoush suggested. Hall, he estimated, derives half its income from service fees.

Brokers also should make full use of their human resources, Mr. Tahmoush said. "Our industry handles billions of dollars and it's trouble-free when you think about it, compared to other industries that are always under investigations," he said.

Credit for this goes to the employees involved and Mr. Tahmoush encouraged brokers to communicate with thier employees in order to strengthen their motivation.

Mr. Hines of Combined International also noted the importance of a broker's employees. "We believe that people in an organization *are* motivated. Give them a chance and they'll do their jobs well."

Mr. Hines said that the insurance industry will determine its own fate: "We have to be much less bureaucratic and much more entrepreneurial."

He suggested direct marketing, cost cutting and value-added services should be brokers' game plans for the future.

"The risk manager is looking for value added and a cost structure of services provided," he said. "We must get costs down—we can't provide extra value-added services if we're earning the minimum."

He also said that brokers should more aggressively market coverage to existing affinity groups and perhaps even create affinity groups for marketing purposes.

Mr. Hines expects brokers' business to grow faster in the future. In the 1960s and '70s, he explained, brokers increased their market share of commercial property/casualty insurance at a compounded rate of between 1% and 1.5% annually. In the late 1970s and the '80s, however, growth slowed drastically.

"But I expect it to continue to grow as brokers increase their share of the market," he predicted. "The rate of growth could go up to 1%. That's significant because the market is so big. Destiny is indeed in the brokers' hands.

"By becoming more aggressive, they'll capture more of the market, taking business away from small agents and direct writers."

—By Pamela DeFiglio



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Environmental issues need broker input: Jordan

By LEN STRAZEWSKI

SOUTHAMPTON PARISH, Bermuda—Brokers, underwriters and insurance buyers must work together to be prepared to work with Congress to amend the federal Superfund act, says the executive director of the National Assn. of Insurance Brokers.

Donald Jordan told the NAIB's annual meeting that agents and brokers must work to change liability problems in the existing Superfund law before Congress extends the pollution cleanup act to other problems besides environmental wastes.

"From NAIB's perspective, the question is not if the Superfund will soon be extended to cover victim compensation and further to possibly cover on-site containment of toxic substances.

"The question is only how soon and through what mechanisms will Superfund be extended," he said.

"We certainly haven't seen the last of dioxin, acid rain or communities like Times Beach and Love Canal. The next victim's cry could well be the linchpin that transforms federal victims' compensation now in Congress into a reality."

Under the current Superfund legislation, known officially as the Comprehensive Environmental Response, Compensation and Liability Act of 1980, the president has the power to order responsible parties to clean up hazardous wastes.

If the responsible parties fail to respond, the government can clean up the waste with a special fund, financed primarily from a tax on oil and chemical companies. However, the government can sue the responsible parties for reimbursement and punitive damages up to triple the cost of cleanup.

These strict liability clauses have caused insurers to refuse to cover Superfund liabilities.

"The Congress for its part has already given us Superfund legislation that is unworkable from an insurance perspective with liability provisions that make even the most ardent trial lawyer breathe heavily with anticipation," Mr. Jordan said.

If Congress does extend the Superfund act to other exposures, it will once again reopen the conflict among the public, the federal government and the insurance industry, which has generally avoided dealing with catastrophic environmental issues, Mr. Jordan said.

The conflict, Mr. Jordan explained, is like an irrestible force meeting immovable objects—something must give.

"The irresistible force is initially the alarming recognition that our environment has very serious problems with hazardous waste and pollution. The resulting expectation is that a great deal more must be done by the federal government to clean up, restore and compensate those who have been harmed.

"The immovable objects are on one side, the U.S. Congress, which so far has refused to make Superfund regulations and liabilities insurable," he continued. "On the other side, it is the insurance industry itself, which has generally treated Superfund cleanup, restoration and victim compensation like the proverbial Tar Baby, giving it a wide berth."

Mr. Jordan recommended that the insurance industry and its corporate clients no longer oppose involvement in environmental liability issues, but work together to make realistic whatever changes are enacted.

"I'm suggesting that we should look at the environmental impairment problem as a challenge and as a once-in-a-lifetime opportunity to harness our industry's creativity and capital for the public good. This opportunity should not be allowed to be treated as an anathema or with disdain.

"Brokers, carriers and client groups must work together to find ways to create new coverages, utilize excess underwriting capacity and commit our intellectual horsepower to organize insurance markets that assume environmental risks—risks which industrial chief executive officers cannot hope to retain on their own," Mr. Jordan said.

"In fact," he said, "it's a unique and unparalleled opportunity for the insurance industry to position itself on the side of the angels; that is, if essential modifications can be made in the Superfund regulations."

If the insurance and risk management community can win some moderation in the development of environmental liabilities and get Congress to recognize the insurance industry as a provider of corporate financial responsibility, the insurance industry as a whole may reap some ethical and practical rewards, Mr. Jordan pointed out.

"The insurance industry would have the opportunity to service client interests, to meet pent-up demands for coverage and manage a huge new multibillion dollar insurance market, a new market ready to absorb today's excess underwriting capacity," he said.

And this market will be tapped, he continued, by corporate buyers ready and able to buy the insurance products it designs.

"We already have national economic recovery under way. We'll soon see risk managers with newfound purchasing power as corporate profits increase an estimated 30% this year alone and corporate liquidity improves commensurately.

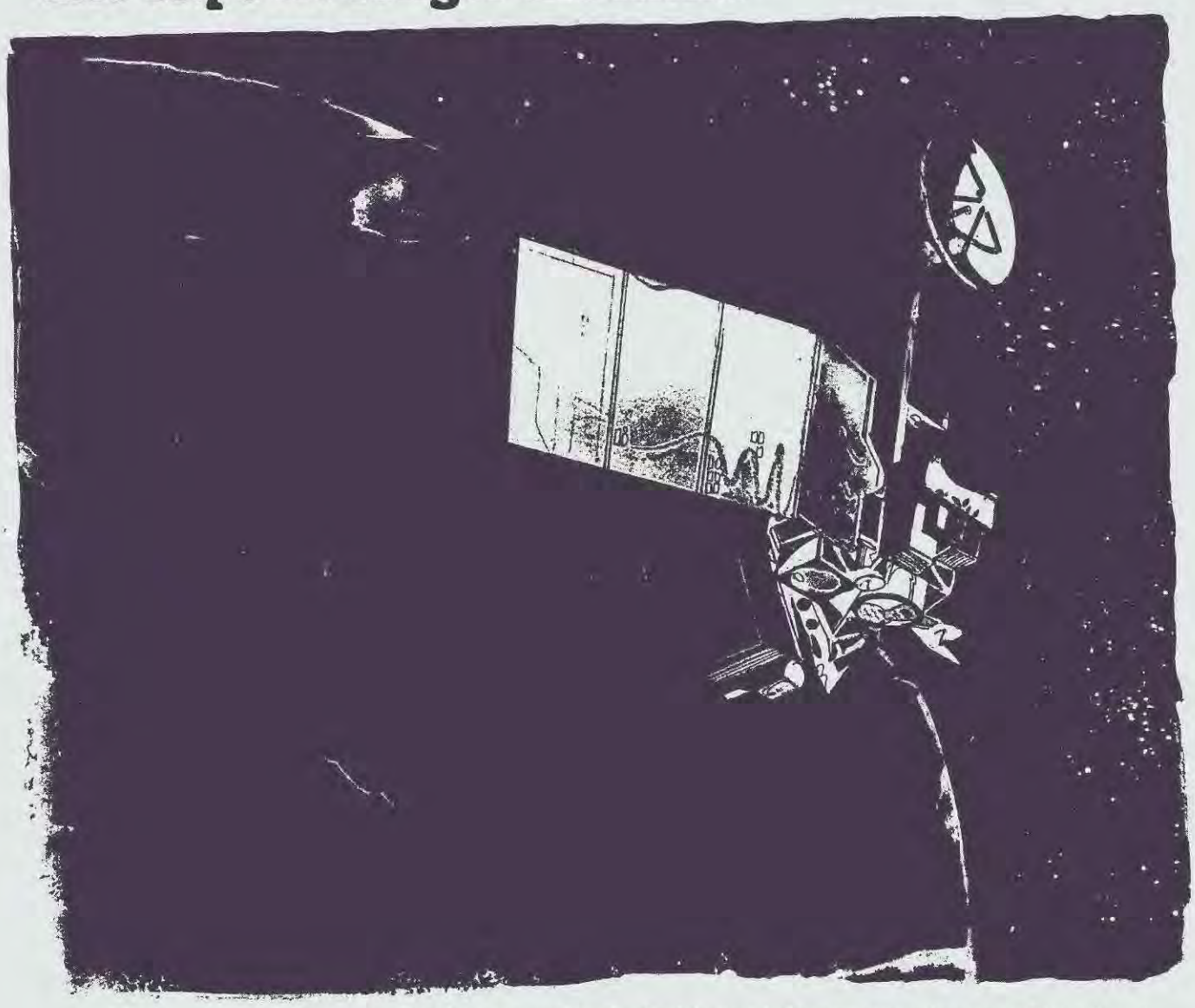
"Then the bottled-up discretionary purchasing power of our business community will be unleashed, ready to satisfy existing demands for needed insurance products and services," he said.

The insurance and risk management community also would win a much-needed public image victory, too, according to Mr. Jordan.

"Let's face it: The public and the media today are demanding that environmental exposures be put under a magnifying glass and handled more effectively. The Congress will continue to bow to those political pressures and the administration will continue to be under the gun for more effective enforcement, but without busting the budget. So they must rely on private sector approaches," Mr. Jordan said.

"Finally, clients themselves want to sleep nights and to know that their net worth is not riding on the next toss of the dice where toxic pollutants are concerned. There's got to be a way to make environmental impairment risks insurable and use our collective resources in the insurance industry for the public good." ■

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Brokers forming political action committee

SOUTHAMPTON PARISH, Bermuda—The National Assn. of Insurance Brokers plans to expand its scope to become more involved in the political scene in the coming year.

The group plans to establish a political action committee as well as increase its lobbying efforts, primarily in Washington.

Walter Derk, executive vp of Fred S. James & Co. of Illinois in Chicago and past NAIB president, will oversee the new Political Action Committee, for which the groundwork was laid during Mr. Derk's term as president.

The NAIB will solicit funds for the PAC from about 10,000 employees of member firms that have approved the concept. The PAC should be ready to begin its work by autumn of this year, says Donald Jordan, the NAIB's executive director.

A selection committee composed of member brokers will choose the political candidates that the PAC will support, Mr. Jordan says, adding that it will concentrate on congressional races.

"Of course we're involved with issues, but we're supporting candidates with the general philosophy we'd like to see espoused in political office. We won't link up with candidates on specific issues," Mr. Jordan said.

"The PAC will be like putting teeth behind our legislative program," he added.

The NAIB will lobby on a wide variety of legislative issues that affect brokers including financial services deregulation; environmental issues, especially the federal Superfund law (see story, page 20G); workers compensation and occupational disease problems; proposed taxes on some employee benefits; and the continuation of state regulation of the insurance industry.



Photo: Pamela DeFiglio

William Quinn, left, of Frank B. Hall & Co. of New York assumed the NAIB presidency from Walter Derk of Fred S. James & Co. of Illinois.

"We support state regulation of insurance in the firm belief that federal regulation will add a confusing, costly burden to the risk transfer process," said William Quinn, the new NAIB president. Mr. Quinn is also president of Frank B. Hall & Co. of New York Inc. in New York.

"There's always the threat of a federal regulatory move, however," he admitted.

Other issues that NAIB continues to monitor include discrimination in insurance, especially unisex insurance rating proposals.

"We also want to work together with other industry groups to resolve multidefendant litigation—that is, suits and countersuits among insurers, brokers and our clients," said Mr. Quinn. "These suits result from varying coverage interpretations of liability policies. The wordings must be clarified so clients, producers and insurers can do business in an orderly way."

Last year, NAIB joined IIR/ACORD Inc., an organization formed by agents, brokers and insurers in an attempt to create a uniform computer interface between underwriters and marketers.

The NAIB plans to gather a group of data processing and insurance experts to evaluate a demonstration of IVANS, the sophisticated computer program being developed by IIR/ACORD that will standardize communications between insurers and producers (see story, page 20I).

The group also plans to continue monitoring the Insurance Services Office, the insurance industry's rate and policy advisory group, on its rewrite of the comprehensive general liability policy (*BI*, Jan. 4).

Last year, the brokers' group voiced its opposition against proposed changes in the CGL form. After listening to the criticism leveled by the NAIB and other groups representing agents, brokers and risk managers, ISO went back to the drawing board and hopes to unveil another proposal later this year.

The NAIB also plans to work closely with other groups representing agents and brokers through the National Insurance Producers Conference. The NIPC—which is made up of the NAIB, the National Assn. of Casualty/Surety Agents, the National Assn. of Surety Bond Producers, the Independent Insurance Agents of America and the National Assn. of Professional Insurance Agents—meets four times a year.

"Getting our group together with the others forms a synergy and gets the ball rolling," Mr. Jordan says, pointing out that all of the groups have Washington offices.

The NAIB also plans to work closely with state agent and brokerage organizations that look to it for help or information on the national level.

Membership in NAIB now stands at about 100 companies, although one of its largest members, Corroon & Black Corp., dropped out just before the annual meeting in Bermuda last month. A C&B spokesman said the move resulted from an overall review of corporate expenses and general belt-tightening.

"We feel very badly that C&B decided to resign from the association," said Mr. Quinn. "We're going to increase our efforts to communicate with members and prospective new members. And we're certainly going to try to convince C&B to reenlist," Mr. Quinn said.

The NAIB's membership committee is planning to launch a drive to increase membership by 25% in the coming year. Although the smallest NAIB member has just one employee, the group is predominantly composed of large brokers. The membership drive will try to increase the ranks of small and mid-sized brokers.

In addition to Mr. Quinn, the officers elected at the annual meeting were: first vp, Timothy Reath, managing director of Marsh & McLennan Inc. in Stamford, Conn.; vp, Herbert Berkeley, executive vp of Alexander & Alexander Inc. in London; secretary, Raymond L. Hayes, senior vp, Rollins Burdick Hunter Co. in Chicago; and treasurer, David B. Adams, executive vp of Adams & Porter Inc. in New York.

Mr. Derk is past president. William S. Jennings, vp of Johnson & Higgins of New York, and Mitchell LaMotte, president of Johnson & Higgins of Illinois in Chicago are ex officio officers.

—*By Pamela DeFiglio*

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FAIA annual convention

Agents' group to offer electronic rating service

WALT DISNEY WORLD, Fla.—A new participant is about to enter the ranks of providers of automated systems for agencies and brokerages.

The Florida Assn. of Insurance Agents will offer a package of automated services, principally electronic rating. The package will initially be available to FAIA members only, but with an eye toward exporting it to agencies in other states, announced Robert S. Smith, director of continuing education, at the association's recent convention.

The FAIA, however, will not compete with the agency system vendors, he stressed, adding that the association wants to supplement rather than duplicate services offered by the vendors.

"We perceive our role as being one to provide those services that others cannot, will not or have not in a way that meets with the approval of FAIA members," he said.

Current systems offered by the vendors, which are all owned by insurers, don't offer multi-insurer rating information, he noted.

Multi-insurer rating is the principal service agents and brokers want from a system offered by the agents' association, according to one in a series of surveys the FAIA conducted.

Another survey showed that most of the FAIA-member agencies that had some kind of automation system were dissatisfied with their computerized rating capabilities, Mr. Smith noted.

> Most Florida agents say they're dissatisfied with current computerized rating.

The final survey in the series showed that member agents and brokers would prefer that the FAIA offer a rating system and from 40% to 50% of the respondents said they would purchase a package of automated services from the association.

Although the FAIA will compete with other companies offering automated rating services, the competition isn't new. Since the 1960s, the association has offered its member agents a manual rating service called Rapidrater.

The new system is an automated version of that service, Mr. Smith said. The FAIA is currently negotiating with Policy Management Systems in Columbia, S.C., to develop the program. Other functions the FAIA plans to offer through the system include electronic communication, a specialized Florida information bank, automated agency financial information, commercial risk analysis, computerized sales proposals and property evaluations.

The FAIA automation system may be the first for many member agencies and brokerages, Mr. Smith said. Another FAIA survey shows that about 70% of the state's agencies and brokerages haven't taken the first step into automation yet. About 60% of those agency and brokerage principals, however, say they'll purchase a computer system in the next three years.

To tap into the FAIA's system, agents and brokers must have either the personal computer manufactured by International Business Machine Corp. or a comparable system, Mr. Smith explained. The association intends to deliver the services over a network into the personal computer in the agency or brokerage.

The FAIA hopes to use the IVANS network currently being developed by IIR/ACORD Inc., Mr. Smith noted. However, several terms must be met before an arrangement can be established between IVANS and the FAIA system, he said (*A/BT*, Oct. 4, 1982).

For example, IVANS must be ready when the FAIA system is set to go on-line, there can't be any technical restrictions on the use of the network and the cost of using IVANS for the services can't be prohibitive.

Uncertainty over how much IVANS' services will cost makes it difficult to estimate the amount agents and brokers will have to pay for the FAIA system, Mr. Smith said, adding that an IBM personal computer system will cost an agency about $5,000.

Agencies and brokerages that have a minicomputer can adapt the FAIA program to their system, Mr. Smith noted. The FAIA will provide the necessary information to form a bridge between the minicomputer and the association program.

Whether through the converted minicomputer or an IBM unit, an agency or brokerage will be connected to the network through a telephone line, Mr. Smith explains. Agents and brokers will be able to dial up the system and receive any information that has been already stored on a computer disk. For example, they could receive any rate changes, information on a new regulation and messages from other subscribers to the system.

Subscribing agents and brokers can then call up a list of what was received and retrieve or store the information.

Throughout the day, they can enter information they want to send over the system, like messages, rating requests and sales proposals. At the end of the day, they would again dial the network and send their messages and requests.

The FAIA program should be open to agents, brokers and insurers outside Florida, Mr. Smith said, because FAIA members shouldn't bear all the costs of the services.

Funding for the service, which will cost from $10 to $20 million to develop, will come from investors in a corporation set up to market the system.

The FAIA will own a portion of the corporation. The other portion will be available to FAIA members and staff through a private offering. The service's initial success depends on subscriptions and investment from FAIA members, Mr. Smith noted. ■



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The FAIA's Frederick Karl, standing, moderated the panel of 18 top insurance company executives.

Insurers will tap other distributors, underwriters say

WALT DISNEY WORLD, Fla.—In the insurance market of the future, agents and brokers will have closer ties with their insurers, but they'll share those ties with non-traditional members of the insurers' distribution system, insurance company officials predict.

Agents attending the Florida Assn. of Independent Agents convention received a glimpse of how 18 top insurance company executives, participating in a panel discussion, paint the insurance marketplace of the future.

Some members of the panel, who represent long-standing agency insurance companies, say agents will have to share their ties with insurers with non-traditional insurance distribution mechanisms.

Many of those unconventional ties are being woven right now, noted panel moderator Frederick B. Karl, vp and general counsel of the FAIA.

Continental Insurance Cos. has established perhaps the most non-traditional arrangement to sell its insurance products: the New York-based insurer has made an agreement to market property insurance through Century 21 real estate agents, according to Continental President John H. Bretherick Jr.

Mr. Bretherick defended Continental's arrangement by noting that it opens doors to a market that has been unavailable to the insurer through its current distribution system.

"It's not what we are doing in other markets that we should be discussing, but what we're doing in working with independent agents to expand their market share. That's what's important, and we're increasing our support for independent agents."

Independent agents can indirectly benefit from a program The Hartford Insurance Group has established that markets a product exclusively through a national broker rather than through independent agents, Hartford President Donald Frahm said.

Mr. Frahm came under fire from both the panel moderator and from agents in the audience for establishing an agreement with the American Assn. of Retired Persons to directly market personal lines coverage to AARP members through Alexander & Alexander Inc.

"The techniques we develop in this program will allow us to be much more effective in marketing our other mature products through independent agents," he responded.

"But if the AARP program is so great, how can we think you won't get into other non-agent agreements?" one member of the audience asked Mr. Frahm.

"The program is just another mass-marketing program. If we don't write this business, it'll go to direct writers. There is no intent to move out of the agency system," he told the audience.

Hartford's deal with the AARP, however, isn't just an experiment with an alternative distribution system, Mr. Frahm said. Rather, it's a major commitment to this segment of the market.

The alternative distribution systems at both Hartford and Continental are attempts to increase market share, which virtually every insurance company executive on the panel noted was being eroded.

"We have to face up to the facts. The market is driving up to the point where a risk-bearing company will be willing to do business with anyone it can. But agents will be doing the same. There's nothing wrong with that," said B.P. Russell,

Continued on facing page



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Continued from facing page
chairman and chief executive officer of Crum & Forster Inc.

Agents, however, appear to be reducing rather than increasing the number of insurers they represent. Many agents are participating in programs, sponsored by insurers represented on the panel, that offer the agents special deals in return for volume commitments. To meet those commitments, agents are chosing a smaller number of insurers with which to do business.

Most insurance executives noted that an increasing number of agencies are participating in their high-volume agency programs. Among the programs noted by the panel were Aetna Life & Casualty Co.'s Prime Agent, Continental's Insurance Center, CIGNA Corp.'s 1-Compar Agent and CNA Insurance Cos.' High Performance Agent (*A/BT*, March 7).

Premium volume generated by CNA's high-performance agents represents about 27% of the insurer's total volume, said Edward J. Noha, chairman and chief executive officer. That volume is generated by slightly more than 400 agents, or 10% of the insurer's agency force, he added.

High-performance agents don't agree to an exclusive arrangement with CNA, Mr. Noha noted. They agree to a business plan negotiated by the agency and the insurer, which includes a commitment to provide CNA with up to 40% of the eligible business produced by the agency in commercial and personal lines, including life insurance.

Although high-performance agents make a deal with CNA, they remain independent because they still have a choice of where to place business, Mr. Noha said.

The choice of where to place business doesn't define independence, disagreed Wilson H. Taylor, executive vp of CIGNA. The insurer's 1-Compar agents are still independent even though they sign an agreement to give CIGNA the right of first refusal on all business, he said. They're independent because they can represent other insurers for business CIGNA doesn't want.

CIGNA's high-volume agent program was the only one represented on the panel under which the insurer has the right of first refusal on all business—a characteristic many agents say does strip them of their independence. Mr Taylor noted, however, that the 1-Compar program is growing both in terms of the number of participating agents and in the premium volume placed.

The 1-Compar programs, like all the other insurers' high-volume agency programs, are experiments, said panelist Edward H. Budd, chairman and chief executive officer of The Travelers Insurance Co. They represent an attempt by all insurers to try to be more competitive, he noted.

Another experiment with insurers' distribution systems came under fire from the moderator, Mr. Karl of the FAIA, and members of the audience. "Why are you buying agencies?" Mr. Karl asked the panelists.

Most of the executives denied that their companies owned any agencies, with a few exceptions.

Mr. Budd, for example, said Travelers owned a few agencies but they were purchased to bail out the owners who wanted to retire but didn't have a perpetuation plan.

Aetna, however, had ideas other than perpetuation in mind when it purchased agencies, according to President William O. Bailey.

"We bought three agencies because the independent agents asked us to buy them. We also wanted to use them to experiment with automation. Companies have taken too much pride in the fact that they don't know anything about our distribution system," Mr. Bailey said.

> 'It's not what we are doing in other markets that we should be discussing, but what we're doing in working with independent agents to expand their market share,' says Continental President John H. Bretherick Jr.

But isolated examples of insurers buying agencies isn't an indication of a trend toward captive agency distribution forces, most insurers agreed. The cost of buying an entire distribution system would be astronomical, they pointed out.

Despite all the experimentation, however, a few panelists said their companies would continue using independent agents in the traditional distribution system.

William R. Bruce Jr. chairman of the board of Seibels, Bruce & Co., an insurance holding company in Columbia, S.C., noted that there are many agents that aren't willing to sell out to one insurer, nor are they able to meet the requirements of some insurers' high-volume programs. "We plan to stay traditional."

Another panelist agreed. Joseph E. Luecke, chairman and chief executive officer of the Kemper Group, said there will be a niche for regional insurers in the future of the insurance industry.

Other panelists included H.J. Bremermann Jr., chairman and chief executive officer of Maryland Casualty Co.; James C. Corcoran, chairman and chief executive officer of General Accident Insurance Co. of America; William A. Pollard, chairman and chief executive officer of Reliance Insurance Co.; and F.W. Purmort Jr., chairman and president of Central Mutual Insurance Co. in Van Wert, Ohio.

Also, Robert J. Haugh, president and chief executive officer of St. Paul Fire & Marine Insurance Co.; James J. Meenaghan, president and chief operating officer of Fireman's Fund Insurance Cos.; Paul J. Scheel, president and chief operating officer of United States Fidelity & Guaranty Co.; and Howard H. Ward, chairman and chief executive officer of Commercial Union Insurance Cos. participated. ■



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Staffers' advice can improve your agency

WALT DISNEY WORLD, Fla.—Hiring consultants to show you how to increase the efficiency of your agency or brokerage may be expensive and unneccessary, one agent says.

In fact, you have a great source for suggestions on increasing productivity right in your agency or brokerage.

That's the message agents attending the Florida Assn. of Independent Agents convention in late June heard from Robert L. Cook, president of Cook Insurance & Financial Services Inc., an agency based in Martins Ferry, Ohio.

An agency's or brokerage's support staff follows the day-to-day operation of the firm, he noted. They are faced with the defects in the operation that hurt efficiency, and they may know how to correct the problems.

Poll your support staff, Mr. Cook suggests. Ask them to list six items that can help make the agency run more smoothly. Then ask them to list three ways the agency or brokerage owners can help the staff accomplish these objectives.

Results from such a survey at Mr. Cook's agency revealed several efficiency-building steps:

- Cross-train personnel. Every member of the staff should be familiar with another's job so that work isn't left to pile up if someone is out of the office for an extended period.

Evaluate the extent of your agency's or brokerage's departmentalization, Mr. Cook said. Unnecessary departmentalization may frustrate your attempts to increase staff members' awareness of various jobs within the firm.

Cross-training can also help reduce errors and omissions exposures that can arise if an untrained person must fill in for someone who leaves abruptly.

- Consider closing the office during the lunch hour. Although callers can't have their questions answered immediately if an agency or brokerage is closed at midday, the agency operates more smoothly if the office is temporarily closed than if it remains open with a partial staff.

Consider what happens during lunch breaks if your agency has a four-person support staff, Mr. Cook continued. At full strength, that staff operates at about 80% efficiency. If two staff members go to lunch for an hour, the efficiency level drops to about 30%. The same will be true for the second hour when the other two staff members leave.

If the agency or brokerage closed for an hour to allow all four members of the staff to leave at once, the firm would make more efficient use of employees' time, he suggested.

- Keep all files in one place; don't split them among service representatives. Keeping files in one place that is easily accessible to everyone allows anyone to reach them quickly.

Also, don't pull all the files of the current month's expirations, Mr. Cook said. With all those files missing from their proper place, employees would be constantly searching everyone's desk for them. And the problem would grow with the agency. The larger the agency, the more files would be pulled each month.

- Eliminate color-coded file folders and index cards. That system, hailed over the last several years as a way to increase support staff efficiency, easily breaks down, Mr. Cook told the audience. You end up with so many different colors of file folders that the colors become meaningless and everyone becomes confused.
- Send thank-you cards to sources for referrals. People are more likely to refer others to you if they know you appreciate the help.
- When agency or brokerage personnel recommend increasing coverage or limits and clients don't accept the advice, ask the clients to sign a note acknowledging your recommendation. The note may protect the agency or brokerage from an errors and omissions claim in the event of a loss.
- Don't forge signatures. Most agencies and brokerages allow assistants and other personnel to forge the signatures of producers and principals on a variety of paperwork. The practice can lead to chaos for the firm, since documents leave the office without the supposed signator knowing what's being sent.
- Arrange for your service staff to visit other well-organized agencies and brokerages. Other organizations can be a valuable educational tool because many agencies and brokerages share similar problems and concerns.
- Insist that employees continue their training. Training sessions are vital for maintaining and increasing efficiency.

"Mandatory education is a must for building productivity. Continuing education should be mandatory law in all states," Mr. Cook told the audience.

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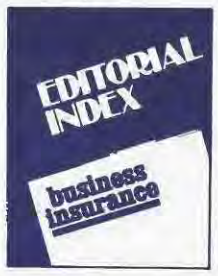
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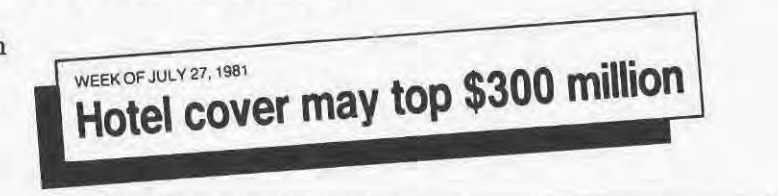
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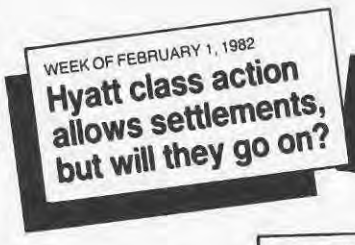
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Kemper unit acquires 10% of Redshaw

HARTFORD, Conn.—A property/casualty affiliate of the Kemper Group has joined three other insurers as co-owners of Redshaw Inc., a supplier of agency automation systems.

Lumbermans Mutual Casualty Co. has signed an agreement to purchase 10% of Redshaw, which originally was a wholly owned subsidiary of Hartford Insurance Group.

However, earlier this year, Crum & Forster Inc. and St. Paul Fire & Marine Insurance Co. both purchased 10% shares of Redshaw.

"Kemper's partnership continues the expansion of the availability of Redshaw systems to independent agents," said DeRoy C. Thomas, Hartford's chairman and chief executive officer. "It underscores The Hartford's pledge that Redshaw will continue as the premier agency system on the market."

Redshaw, founded in 1976, has installed more than 1,700 agency systems. ■

Egg farm buildings insured, but 210,000 chickens aren't

Continued from page 2

$300,000 a year to insure chickens," he said. "If nothing happens in 10 years, you already have $2 million or $3 million invested. It's not feasible."

Mr. McCory also noted that business interruption losses are not covered by the policies. "It's difficult to say how much business was lost. We'd just put in two houses of hens that hadn't started laying yet."

Both Rose Acre Farms and Industrial Indemnity say the facilities at Egg Acres had undergone fire safety inspections, although neither company could say when the latest inspection was made.

But, fire extinguishers were the only form of fire-suppression equipment in the chicken houses and the processing building that burned. These extinguishers were not accessible to employees because the fire burned out of control so quickly, Mr. McCory said.

The company now says it plans to step up fire safety measures.

"The problem with a fire on our facilities is that it spreads so fast. Now with our existing buildings, and any future buildings we may add, we're going to look for (construction features that would) contain any fire that breaks out," Mr. McCory explained, though he said the company was not considering installing sprinklers in its buildings.

Rose Acre Farms is comprised of one breeder facility, five pullet farms, two feed mills and four laying facilities, of which Egg Acres is the smallest.

"We may rebuild on that (the Egg Acres) site, or at another site or not at all," Mr. McCory said. "We haven't decided what we're going to do—but of course, it's been pretty hectic around here." ■

datebook

SEPT. 7. Accident Investigation and Analysis seminar in Los Angeles, sponsored by the International Safety Academy; $165. International Safety Academy, P.O. Box 8527, 1600 Arch St., Philadelphia, Pa. 19101; 215-241-3176.

SEPT. 7-9. Product Safety and Liability Prevention workshop in Madison, Wis., sponsored by the University of Madison-Extension; $495. Richard A. Moll, Engineering Department, University of Wisconsin-Extension, 432 N. Lake St., Madison, Wis. 53706; 608-263-4712.

SEPT. 8. Effective Safety seminar in Los Angeles, sponsored by the International Safety Academy; $165. International Safety Academy, P.O. Box 8527, 1600 Arch St., Philadelphia, Pa. 19101; 215-241-3176.

SEPT. 11-14. National Assn. of Mutual Insurance Companies annual meeting in Kansas City, Mo.; $120. National Assn. of Mutual Insurance Companies, 3707 Woodview Trace, Indianapolis, Ind. 46268; 317-875-5250.

SEPT. 11-14. Society of Chartered Property and Casualty Underwriters 39th annual meeting in New York; $225. Society of CPCU, Kahler Hall, Providence Road, Malvern, Pa. 19355; 215-648-0440.

SEPT. 12-13. Disaster Planning and Recovery workshop in Baltimore, sponsored by Bank Administration Institute; $425 for members; $550 for non-members. Also **OCT. 24-25** in Dallas-Ft. Worth. Stephen M. Rowe, Bank Administration Institute, 60 Gould Center, Rolling Meadows, Ill. 60008; 312-228-6200.

SEPT. 12-14. Risk Research Group Captive Insurance Company Course in London, sponsored by sponsored by Risk Research Group Ltd.; $550. Sue Moore, Risk Research Group Ltd., Bridge House, 181 Queen Victoria St., London EC4V 4DD, England; 01-236-2175.

SEPT. 12-14. Techniques of Risk Management conference in Chicago, sponsored by the Risk & Insurance Management Society; $345 for members; $445 for non-members. Editorial Department, RIMS, 205 E. 42nd St., New York, N.Y. 10017; 212-286-9292.

SEPT. 12-15. American Society for Industrial Security 29th annual seminar and exhibits in Washington, D.C.; $275 for members; $365 for non-members; for single day only, $105 for members, $150 for non-members. Pati Ellars, American Society for Industrial Security, 1655 N. Fort Myer Dr., Arlington, Va. 22209; 703-522-5800.

SEPT. 13. Health Care Cost Containment seminar in Detroit, sponsored by the International Foundation of Employee Benefit Plans; $390 for members; $465 for non-members. Also **Sept. 14** in Chicago. IFEBP, 18700 W. Bluemound Road, P.O. Box 69, Brookfield, Wis., 53005; 414-786-6700.

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Mobil decision could be far-reaching

Continued from page 1

rate entities," the document continues.

No, the government counters, because no true risk transfer occurs within the corporate "economic family" when a captive insurance company assumes the risk. If there is no risk transfer in an economic sense, then there is no insurance transaction. If there is no insurance transaction, there can be no tax deduction.

This is the substance of IRS Revenue Ruling 77-316, which the government has long cited as its official position on captive tax issues. Mobil's position challenges this dictum head-on.

And so the battle lines are drawn.

"A captive is the epitome of formalized self-insurance," said Irving H. Plotkin, vp and senior economist for consultant Arthur D. Little Inc. in Boston, who testified for the government in the Mobil case.

"The transaction between Mobil and its affiliates on the one hand, and its insurance subsidiary on the other, does not give rise to risk transfer or insurance as a matter of economic reality," he testified.

The weight of the government's case appears to lie largely on Dr. Plotkin's courtroom testimony, which was expected to conclude last week.

In his opening statement, William B. Barker, a Justice Department attorney, stressed that "the essential issue in this case is whether this (parent company and affiliated risks transferred to a captive) is insurance."

Mobil called to testify two of its former captive insurance company managers—H. Clayton Chambers, the first manager of General Overseas Insurance Co. Ltd. in the Bahamas from 1958 until 1960, and George M. Sandeman, who was manager of GOIC from 1962 until 1968 and then manager of Bluefield Insurance Ltd. in Bermuda until 1969.

> 'It seems to me that the government and the Justice Department are taking a much harder line by saying that third-party risks don't aid in establishing the credibility of a captive,' says Coopers & Lybrand's Gerald I. Lenrow.

Their testimony—along with that of two independent insurance experts—supported Mobil's contention that its captives employed professional underwriting, claims and management practices similar to other non-admitted insurance companies. The witnesses also answered questions about the rating of risks by the captives, which were used as a basis for premiums charged to Mobil and its affilates.

One of the side issues in the litigation has been the government's contention that Mobil allowed its captives to charge excessively high premiums in order to transfer funds abroad and then claim them as a deduction against its U.S. tax liability.

As the trial was winding down last week, it was unclear whether the question of third-party underwriting would emerge as a major issue in the Mobil case. This is important because many major corporations that have conceded to the IRS position on tax deductions for captives that underwrite only parent-company risks have turned to outside business to strengthen their claim that their captive is a true insurance company.

Dr. Plotkin, the government's key expert witness, was expected to testify in court late last week that in his opinion the existence of risks unrelated to the parent within the captive does not change the complexion of the parent's and affiliates' premiums for tax purposes.

Mobil did insure some unrelated risks in at least one or two of its four captives during the tax years under scrutiny, but the oil company does not appear to have leaned heavily on this fact to build its case.

However, the existence of unrelated risks in even one of Mobil's captives might permit the admission of Dr. Plotkin's testimony that "third-party business doesn't matter" into evidence, several legal authorities agreed. Mobil and government attorneys declined to discuss this point while the trial was still in progress.

The readiness of the government to address the third-party underwriting issue through the testimony of its expert witness has led some observers of the litigation to suggest that there has been a fundamental change in the government's attitude toward captives.

"It seems to me that the government and the Justice Department are taking a much harder line by saying that third-party risks don't aid in establishing the credibility of a captive," said Gerald I. Lenrow, director of insurance tax operations for Coopers & Lybrand in New York.

If the Court of Claims decision were to adopt this approach, it would be a landmark decision, Mr. Lenrow added.

"I am greatly concerned about what this could mean for my clients and for the whole business of insurance. Would it mean that The Hartford could not insure IT&T (its parent); or that Allstate could not insure Sears?"

Many tax attorneys and consultants have counseled their clients that third-party business does establish a captive as a bona fide insurance company in the eyes of the IRS based on a number of IRS technical and private letter rulings.

If the government is arguing that third-party business doesn't matter, then it has definitely changed its position, observes Bruce Wright, partner in the New York law firm of Trubin Sillocks Edelman & Knapp.

Two private letter rulings, a published internal IRS memorandum and other technical advice memoranda clearly demonstrate that the issue of percentage of unrelated business is relevant, he says.

The Mobil trial is only the third on the issue of tax deductions for premiums paid to a captive and the first in the U.S. Court of Claims. The other two trials involved Carnation Co., which lost its case to the IRS, and Stearns-Roger Corp., an engineering and construction firm in Glendale, Colo., which is awaiting a decision from the U.S. District Court in Denver.

Both the trial and appellate courts ruled in favor of the IRS in the Carnation case and the Supreme Court declined to review the decision (*BI*, March 16, 1981; Jan. 8, 1979).

But, the lower courts largely skirted the issue of whether a captive is a bona fide insurance company for tax purposes. Instead, they focused on the structure of Carnation's captive, which they decided canceled out any insurance transactions.

Carnation promised that it would make an additional capital contribution to its insurance subsidiary, Three Flowers Assurance Co., at the request of its fronting insurer. The court ruled that this guarantee negated the insurance transaction, leaving only a self-insurance program that is not tax-deductible.

This approach made it unnecessary for the court to rule on Three Flowers' status as an insurance company.

But, there were no such capitalization agreements between Mobil and its captives, so it is more likely that the court will decide the case on the larger issue of whether there can be risk transfer from a parent company and its affilates to a captive.

Besides Bluefield and GOIC, Mobil's two other captives at issue in the case are American International Reinsurance Co. Inc., licensed under the laws of the Republic of Panama, and The Bishopsgate Insurance Co. Ltd., domiciled in the United Kingdom. ■

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Commercial Consumers Sub-total	**23,176**
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Bill would restrict cafeteria benefit plans

Continued from page 1
House Ways and Means Committee, want Congress to enact their proposed benefit tax rules.

The Permanent Tax Treatment of Fringe Benefits Act of 1983, H.R. 3525, represents "a fair and pragmatic approach to a permanent solution," says Rep. Stark, chairman of the Ways and Means Select Revenue Measures subcommittee, which begins hearings on the bill this week.

"The bill attempts to fill a vacuum that has existed for many years in the tax treatment of various fringe benefits provided by employers to their employees," says Rep. Conable, the Ways and Means Committee's ranking minority member.

If employers do not receive guidance on the taxation of benefits that are not specifically covered under the tax code, employers will provide more non-cash compensation leading to a shrinkage in the tax base, according to Rep. Conable.

The legislation offers plenty of guidance in several major benefit areas. They include:

- Parking. The fair market value of free or reduced-cost parking would be included as part of an employee's taxable income unless the parking were available on a non-discriminatory basis to all employees.

For example, if a medical center offered free parking spaces only to doctors, not nurses, the market value of those spaces would be considered taxable income for the doctors.


Rep. Stark

- Discounts. Discounts to employees that exceed 20% of the goods' or services' regular selling price would be taxable to the employee.
- No-additional-cost services. These benefits, like free standby air travel for airline employees, would be excludable from taxable income.

To qualify as a no-additional-cost service, a benefit cannot result in lost revenue to the employer and it must be offered on a non-discriminatory basis to all employees. In addition, the service must be provided to the employer's customers as part of its business.

- Recreational facilities. Employers could not deduct depreciation and operating expenses of a free, on-premise recreational facility unless the employees paid fees or if the value of the benefit were included as taxable income to the employee.

Benefit experts agree that rules like these are needed to clear up confusion on which non-statutory benefits should be taxed.

"The bill is an attempt to clarify a gray area," said Ed Davey, executive director of the Assn. of Private Pension & Welfare Plans in Washington. "The law needs consistency."

But, benefit experts and lobbyists don't understand why there should be a blanket exclusion of taxable benefits from cafeteria plans.

"If the employee is willing to pay (taxes) on a benefit, it is hard to understand why they would not want them to receive it," said Mr. Chip of the Employers Council on Flexible Compensation.

Benefit experts note that since taxable benefits, like high levels of group term life insurance, already are part of an employee's wage base, their elimination from cafeteria plans will not raise new revenues.

"I'm not sure there is a logical reason to eliminate them from cafeteria plans. What is gained?" pondered Arnold Malasky, a consulting actuary in the Washington office of The Wyatt Co.

"They (Reps. Stark and Conable) were trying to codify what is taxable. But they appear to have created some unintended consequences and complications for cafeteria plans," Mr. Malasky added.

Employers with flexible plans could continue to offer group term life insurance exceeding $50,000 to employees, but not as part of the cafeteria plan, consultants note. That could increase administrative costs and complexity for employers that now offer all their benefits in one cafeteria plan.


Rep. Conable

"It would be making it harder for employers to offer a choice," said Mr. Malasky.

Rather than offer extra life insurance outside the cafeteria plan, some employers might simply stop offering term insurance over $50,000. "Who would gain by that?" one consultant asked.

In addition, the experts aren't sure whether vacation benefits could still be offered in cafeteria plans under the Stark-Conable bill.

"I wish the bill was clearer on vacations," Mr. Malasky said.

Under the bill, a cafeteria plan can only offer cash or employee benefits that are excluded from employees' gross incomes by a specific section of the tax code.

However, it's never been determined if vacations are a form of cash remuneration or an employee benefit. If vacations are recognized by the Internal Revenue Service as a form of cash payment, employers would be allowed to offer vacation options in flexible plans. If they are considered benefits, they would not be allowed since they are not specifically mentioned in the tax code.

Currently, employees covered by cafeteria plans are frequently offered vacation options. For instance, an employee may decide to "trade" a week of vacation for a benefit like additional health insurance. Alternatively, an employee may exchange another benefit for more vacation time.

"Employees have different vacation needs. Cafeteria plans should be able to meet those needs," Mr. Hutchings says.

The implementation of cafeteria plans would continue to grow even if the Stark-Conable bill were enacted, experts say. "But they would not be as attractive," he says.

The Stark-Conable legislation is the second attack this year on cafeteria plans. Earlier, Congress defeated an amendment in the Social Security bail-out bill that would have imposed FICA payroll taxes on cafeteria plans that give employees a choice of cash and tax-free benefits (*BI*, March 14, April 4).

For example, if a cafeteria plan offered an employee a choice of family health insurance coverage or $500, the employee's taxable wage base would have been increased by $500—even if the employee selected the insurance.

In contrast to this, employees presently enrolled in cafeteria plans pay taxes only if they select a taxable benefit. ■

Asbestos defense costs studied

Continued from page 2
cases average an additional 42 cents for every dollar paid out in compensation.

This compares with 35 cents for product liability cases, 28 cents for malpractice cases and 5 cents for auto liability cases.

Of the average $60,000 in compensation to asbestos victims, $25,000 went to pay the plaintiff's legal fees and other expenses and the plaintiff actually took home only about $35,000.

Put another way, for every $2.71 an employer or insurer paid out on a closed claim, $1 went for defense expenses, $1 to the plaintiff and 71 cents to the plaintiff's attorney, the study says.

In closed cases, average defense costs were 58% of total compensation. This included a range from as low as 29% of total compensation to as high as 209%.

The study further notes that plaintiffs' attorneys charge legal fees of 33% to 45% of the total compensation in tried cases and 28% to 40% of total compensation in settled cases.

Another section of the study confirms that a plaintiff stands a chance of getting a substantially larger award if he goes to trial rather than settle out of court. However, only 4% of the closed cases were tried.

The average award in tried cases decided in the plaintiff's favor was $275,000, including an average of $30,000 in punitive damages.

In contrast, the average award in cases settled out of court in the plaintiff's favor totaled only $64,000.

These figures do not reflect any cases that were dismissed or decided in the employer's favor. Overall, 18% of the asbestos claims filed in the last decade were dismissed without compensation and of those that were tried, 30% resulted in no award to the plaintiff.

Overall, 78% of the closed claims were settled before trial.

The study shows that the bulk of asbestps litigation falls on a very small number of defendants and their insurers.

As of March 1983, about 24,000 claims had been filed naming more than 300 defendants. But the same 16 companies were named in about 12,000 of those claims and another 15 companies were named in 6,000 to 12,000 of those claims.

Plaintiffs generally sue an average of 20 defendants.

About a dozen major insurers are deeply involved in the litigation and another 15 to 20 have made significant payments to date. About 50 insurers have some involvement in the litigation.

The study notes that asbstos-related lawsuits have been filed in at least 48 states, but 69% were concentrated in five states—California, Massachusetts, New Jersey, Pennsylvania and Texas.

Twenty-nine percent of all the asbestos cases were filed in California.

Ninety-five percent of asbestos claimants are males whose former jobs brought them into contact with asbestos.

Most claims are brought by former shipyard workers. Others were brought by asbestos product factory workers and insulation workers. Fourteen percent of the closed claims involved workers who had died.

Insurers and defendants say the study's conclusions do not suprise them, but that the study is valuable because it presents documented figures by an objective organization and will bring more attention to the problem of asbestos.

"Its a significant contribution," said one spokesman for a major insurer who asked not to be identified. "It memorializes numbers, percentages and statistics. It brings to the fore the numbers we're talking about. It simply articulates it."

The spokesman said that the figures are not out of line with his company's estimates of litigation costs.

However, a spokesman for Keene Corp., a major asbestos defendant, said his company spends much more on defense costs compared with plaintiffs' compensation.

"Our experience is considerably worse than that," said Howard A. Mileaf, Keene's vp and general counsel.

He estimates that plaintiffs receive only 10% to 20% of every dollar spent on asbestos litigation. "The figures show there is a real problem out there.

"In our experience, it is even worse." ■

33% of employees steal on the job: Study

ROCKVILLE, Md.—One-third of the employees surveyed at retail, manufacturing and service organizations said they stole company property, according to a recently released National Institute of Justice study.

The study also reported that almost two-thirds of the 9,175 employees responding said they had engaged in sick leave abuse, drug or alcohol abuse or other misconduct causing "counterproductive workmanship."

Employee pilferage is costing American businesses from $5 billion to $10 billion per year, said James K. Stewart, director of the National Institute of Justice, who announced results of the study, "Theft by Employees in the Work Organization."

Companies could substantially reduce employee theft and related behavior, the survey found, by:

- Establishing, publicizing and strictly enforcing policies against employee pilferage.
- Using inventory control systems.
- Evaluating job histories during pre-employment screenings.

Theft and counterproductive behavior could also be minimized through a consistent policy that makes clear that misconduct will be punished, and that higher- and lower-level employees will be punished equally, the study said.

The survey also found employees engaging in so-called counterproductive behavior—including extra-long lunch hours and work breaks—were the workers doing most of the stealing.

Dissatisfied employees were more frequently involved in property theft and counterproductive practices, the study found.

"Employees who felt their employers were geniunely concerned with the workers' best interest reported the least theft," the report noted.

The study, which ran three years and cost $249,987, was conducted by the University of Minnesota's Department of Sociology and was based on surveys conducted in the Dallas-Fort Worth, Minneapolis-St. Paul and Cleveland areas.

Forty-seven businesses were studied, including 16 retail deparment store chains, 21 general hospitals and 10 electronic manufacturing firms. ■

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MGM property coverage battle heats up

Continued from page 1
gether reinsured 100% of American Protection's policy.

Timely resolution of the property coverage dispute is becoming more crucial to MGM as it nears a Sept. 2 deadline for repaying a $54 million reconstruction loan that MGM had intended to cover with insurance payments.

MGM is fighting in court for a total of $69 million more in property coverage. Besides the additional $33 million it wants from American Protection, it also is suing Insurance Co. of North America for $36 million under the policy it wrote above American Protection's excess layer. However, MGM has not added punitive damage claims to the damages sought in the INA suit.

Overall, MGM had $215 million in property insurance at the time of the Las Vegas hotel fire. American Protection wrote a $125 million policy excess of $50 million, which has already been paid out by six other insurers. And INA wrote a $40 million policy excess of $175 million.

MGM filed claims for $211 million in property losses stemming from the hotel fire. So far it has received $142 million in insurance payments, including $62.8 million for business interruption losses and $79.2 million for property losses. Therefore, it contends it still has $69 million coming to cover losses above $142 million.

In its most recent attack against American Protection, MGM Grand —in court papers filed at various times this spring—has accused Kemper Corp. and its affiliates of oppression, fraud, malice, harassment, delay, breach of contract and bad faith for not responding to MGM's $211 million property loss claim to the full $125 million limit of the American Protection policy.

American Protection, in turn, accuses MGM Grand of "cleverly orchestrated" fraud in filing a false claim. It charges "cost overruns" by contractors and "willful concealment and misrepresentation" of non-covered expenses by MGM in its claim filed in October 1981.

"These overcharges and mischarges involved millions of dollars," says American Protection.

Each side denies the other's fraud claims.

Basically, insurers are arguing that they are not liable for all of MGM's $140 million in rebuilding expenses.

After the MGM Grand fire, Clark County building officials in Las Vegas ordered MGM Grand to significantly improve the fire safety of any reconstructed hotel.

In depositions, MGM Grand officials say they disagreed with these orders but decided it would be better to make the requested changes rather than face the large business interruption losses that would have resulted from a prolonged court battle with fire officials.

Among the changes were numerous additional exits from the hotel and the installation of a multimillion-dollar, state-of-the-art fire detection and suppression system in the 2 million-square-foot hotel and casino (*BI*, March 30, 1981).

MGM says these changes were required to resume operations at the "same quality of service" as before the fire and, therefore, should be covered by insurance.

However, changes required to bring a damaged building into conformance with building codes are specifically excluded from coverage under MGM's American Protection and INA policies, the insurers say.

MGM says in court papers that American Protection "represented" to the hotel owner after the fire that the insurers would pay the "actual expenditures" of restoring the hotel rather than the "cost to repair, rebuild or replace on the same site with new materials of like kind and quality...."

American Protection says it made no representation about paying actual expenditures.

The cost dispute is complicated by a disagreement over exactly how much of the $211 million claimed by MGM Grand consists of costs for code-related changes or other upgrading of property and how much for actual replacement work.

MGM Grand let at least 48 contracts involving 100,000 purchase orders for both repair and additional work on the damaged hotel, according to court documents.

The first contracts, called "RP" contracts, were let on a time-and-materials basis, meaning a contractor could charge to the project whatever time and materials it incurred.

The second, called "A" contracts, were let at fixed prices.

The insurers argue that this mix of fixed-price and time-and-materials agreements allowed non-insured work to be charged to insured projects.

They say MGM should have stopped this situation. But MGM says it had no way of checking if contractors were misbilling and argues that Kemper—which had claims adjusters at the hotel site daily during restoration—should have been aware of the situation.

"MGM, with the intent to defraud its fire insurers, failed to take adequate measures to prevent the mischarging of costs and expenses to RP contracts," says American Protection in a May 31 pleading.

The insurer says this "willful concealment and misrepresentation of material facts" by MGM made it impossible to discover the mischarges submitted by MGM with its insurance claim. It calls the effort "cleverly orchestrated fraudulent scheme" on MGM's part.

INA has hired a Morristown, N.J., consultant to help it sift through the MGM claim. So far, INA admits in court papers that about $74 million of the $211 claim is valid. Most of that represents the $62.8 million paid by insurers to resolve MGM's $70.4 million business interruption claim for the period the hotel was closed between the fire and the reopening of the hotel July 29, 1981.

But at least $22 million of the other $137 million sought by MGM is being disputed by INA. It says this figure includes $9.3 million in interest payments on bank construction loans issued to repair the gutted hotel and the cost of alleged "upgrades" in the hotel's quality or fire safety provisions.

If by settlement or court action, INA can whittle MGM's claim from $211 million to less than $175 million, it would not be liable for any property losses because they would not pierce its layer of excess coverage.

Meanwhile, Judge Foley ruled that MGM is entitled to claim damages against three other Kemper insurer companies that together reinsured 100% of American Protection's policy.

MGM is challenging the legal independence of the Kemper Group companies that bound together in what MGM calls a "unique, intertwined and interwoven structure."

MGM argues a "reinsurance certificate" attached to its policy makes all four Kemper companies as well as the Kemper Corp. itself responsible for its claim. MGM calls the certificate "a clear, concise, simple and unambiguous assumption of direct obligations to MGM."

It says the certificate states that the other three Kemper companies "shall pay any unpaid incurred loss directly to the insured" in the event American Protection becomes insolvent.

Kemper says the claim is an "empty charade" that is among MGM's "futile attempts to circumvent the general rule that a reinsurer does not have any direct libility to the original insured."

It says the reinsurance certificate is a standard device giving an Illinois insurer the right to reduce required reserves by the amount of reinsurance collectible and thus realize tax advantages. And it argues only American Protection was a party, or signator, of the MGM policy.

The issue could be important, MGM's lawyers point out, if their punitive damage claim is successful because American Protection has only $5 million in assets, few employees and reinsures 100% of its coverage with other Kemper companies.

Unless American Protection's affiliated reinsurers cover punitive damages, MGM could theoretically be left trying to assert a large punitive judgment against a nearly assetless company, they suggest.

American Motorists Insurance Co., one of the Kemper reinsurers, has $892 million in assets, says MGM in court papers, and Lumbermen's Mutual Insurance Co., another Kemper affiliate, has $2 billion in assets.

Kemper's lawyers don't dispute the asset figures, but say such a theory is ridiculous because MGM's punitive claims are groundless. They say MGM's other arguments about reinsurance have been "repeatedly rejected by the courts."

The other Kemper companies "did not agree to assume liability to the insured in all circumstances, but only 'in the event' of (American Protection's) actual insolvency or financial inability to meet its obligations," argues attorney Robert A. Downing of the Chicago law firm of Sidley & Austin in a brief filed for the other Kemper companies. Thus, Mr. Downing concludes, MGM's claims against those companies are premature.

As long as the property coverage is withheld, MGM says it is in a "precarious" financial position.

"In effect, MGM is suffering the substantial and adverse consequences of the very catastrophe it purchased insurance to avoid," the company says in court papers filed July 20.

MGM's attorneys say the hotel and casino operator faces a Sept. 2 deadline for repaying a $54 million reconstruction loan, which is guaranteed by insurance proceeds and a second deed to the MGM Grand Hotel held in trust to First Interstate Bank of California.

The terms of the loan currently require repayment on Sept. 2 regardless of any insurance proceeds.

A court-ordered settlement conference is scheduled for this week and a trial has been set for early next year. MGM is focusing current legal efforts on speeding up the trial date.

"The parties are a long way apart at this point," says Charles H. McCrea Jr., an attorney in the Reno, Nev., office of Lionel Sawyer & Collins, which represents MGM.

"And I really think a settlement before Sept. 2 is unlikely...There's certainly a serious threat of default if the debt cannot be renegotiated."

MGM said it expects to make an announcement on the loan situation within a month, but would not comment now.

"If MGM finds itself in a position where it has a bank loan to meet that it cannot meet, quite frankly, that's their tough luck," said Stephen A. Cozen of the Philadelphia law firm of Cozen, Begier & O'Connor, attorneys for INA. "They have always found enough money to do everything else they wanted to do, to buy retroactive liability insurance, which they are now litigating about, and do everything else they want to do." ■

Insurers to merge Canadian operations

markets

New York-based Continental Corp. and Phoenix Assurance Co. of London have announced plans to merge their Canadian property/casualty insurance operations to form a new, jointly owned company called Phoenix-Continental Services Ltd.

The new company, whose formation is subject to Canadian regulatory approval, would have $250 million (Canadian) in combined premiums.

The Canadian life, marine and aviation insurance operations of Continental and Phoenix would continue to operate independently.

J.B. Murch, chief executive officer of Canadian operations for Phoenix, will serve as chairman and chief executive officer of the new firm. William W. Ward, vp and manager of Canadian operations for Continental, will serve as president.

Continental owns 24% of Phoenix.

Cost containment

Connecticut General Insurance Co., a subsidiary of CIGNA Corp., and Health Systems International Inc. of New Haven, Conn., have agreed to jointly market medical cost-containment services to large employers and business coalitions, CIGNA announced.

Connecticut General's claims processing and data collections systems will be combined with HSI's expertise in analyzing medical data to offer new cost-containment strategies to customers, the company said.

Among such strategies would be medical claims screening systems based on diagnosis-related groups, the use of which HSI pioneered; medical cost reimbursement systems modeled on the Medicare prospective payment system; and the pooling of insurer-generated data for clients that use more than one health insurer. ■



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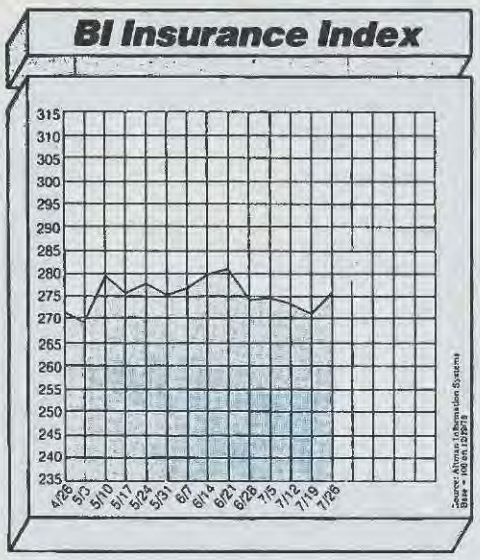
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Investors are again bullish on insurance industry stocks as the *BI* stock index climbed 4.7 points in the five-day trading period ending July 26, to 275.2 from 270.5. Thirty-five issues posted gains, 19 declined and 10 were unchanged. Among the largest gainers were United Services Life Insurance Co., 18.1%; Avemco Corp., 16.7%; Zenith National Insurance Co., 16.5%; Old Republic International Corp., 7.7%; and Lincoln National Corp., 6.2%. The largest losses were posted by Crawford & Co., 6.3%; Corroon & Black Corp., 5.6%; Aneco Reinsurance Co. Ltd., 5.4%; SAFECO Corp., 4.9%; and Alexander & Alexander Services Inc., 4.4%. Although the *BI* index rose a hefty 1.7%, industry stocks were outperformed by the market in general.

British Issues

26 July Companies	Price pence	P/E	Div. pence	Yield %	1 Week High	1 Week Low
Comml Union	155	155.0	16.86	10.9	155	151
Eagle Star	425	15.9	24.29	5.7	426	423
Genl Accident	436	11.3	24.29	5.6	438	433
Gdn Royal Exch	475	12.2	27.26	5.9	478	466
Phoenix	314	15.0	25.00	8.0	316	308
Royal	508	13.4	37.86	7.5	508	496
Sun Alliance	1169	13.0	68.57	5.9	1200	1169
Brokers						
CE Heath	296	7.4	21.07	7.1	305	296
Hogg Robinson	106	8.1	8.57	8.1	111	106
JH Minet	115	9.6	6.50	5.7	117	115
Sedg Grp	209	10.7	10.00	4.8	215	209
Stenhouse Hldg	104	9.5	7.86	7.6	107	104
Stew Wrightson	231	7.9	20.43	8.8	240	231
Willis Faber	528	12.4	25.00	4.7	536	528

Source: Philip Olsen/Alan Clifton, Insurance Industry Specialists Kitcat & Aitken Stockbrokers, London

Financial services push prompts insurer changes

By MYRON M. PICOULT

Special to Business Insurance

THE EXOGENOUS operating environment is beginning to foster significant structural changes in the property/casualty business in terms of the products offered, how they are distributed and how profits will be derived. The entire process will no doubt pick up speed.

As we noted some time ago, premium growth for the property/casualty industry has traditionally exceeded the increase of the gross national product. While we still expect the industry to maintain an above-average growth rate in the years ahead, growth will likely fall short of prior years because of a secular decline in inflation, shifts in the way business is written and the commodity nature of the product. This prospect of a slowdown in premium growth has longer-term implications for cash flow and, hence, investment income growth, expense control and distribution methods.


Mr. Picoult

Over the past few years the integration and expansion of financial services have become increasingly apparent. As consumers, both large and small, have become more affluent, they have become increasingly sensitive to interest rates and have sought (and are receiving) the unbundling of services.

Hence, many "traditional" property/casualty insurers may seek to become financial services entities. The incentive to become such a corporation is fostered by the need to spread overhead costs over a larger range of operations and the incentive to resume and/or bolster sagging earnings growth.

Myron M. Picoult is senior vp and senior insurance analyst with Oppenheimer & Co. in New York. He is the past president of the Assn. of Insurance & Financial Analysts and a member of the New York Society of Security Analysts. His column normally appears the fourth Monday of every month.

To begin with, the term "financial services" is a rather loosely used term that seems to have eluded a more practical definition. While the term is usually meant to connote a company that sells financial services, perhaps a better definition is that a financial service company is really a combination of companies that sell different kinds of services and avail the parent the opportunity to assemble a significant base of assets.

Many property/casualty insurers will likely diversify, notwithstanding past miscues into related financial entities without really understanding these businesses. Arguments about surplus management talent will no doubt proliferate. The end result for many could be a loss of business to competitiors in their main business as they become entangled in the financial services web.

The cross-selling or cross-fertilization of products may not be achieved as easily as believed. The products will have to be tailored to specific consumer attitudes and income levels. Furthermore, not all products lend themselves to direct selling methods or forms of mass merchandising. Agent interface will be needed in many instances.

89While we have already noted why insurers want to become financial services entities, some specifics are useful:

- The key to a company's survival and ability to prosper is expense control. While this statement may sound like a broken record, it is absolutely critical and cannot be emphasized enough.

Expense reductions must relate to both home-office as well as field operations. Productivity gains related to technological changes, like telecommunications and the development of more sophisticated electronic data processing systems, will become necessary elements of a company's strategic planning processes.

- To the extent that the product is becoming more of a commodity, the ability to affect price averages will become increasingly difficult except for those instances where a company has a true proprietary niche or where a vacuum develops. Hence, the accumulation of assets and more aggressive and innovative ivestment techniques will be needed to develop improved returns on allocated capital. Equating a more aggressive investment policy with the industry's inherent risk quotient becomes an interesting challenge.
- Last, but not least, are the changes that are and will be occurring in the distribution system. In our last column (*BI*, July 4), we briefly noted the contraction in the independent agency system. The ability to distribute products on a cost-efficient basis will be one of the determinants on whether a company survives and prospers.

In order to compete with the direct-response insurers and the direct writers, agency companies will have to avail themselves of various group merchandising techniques, which will involve mass-marketed, "modified group" and "true group" merchandising methodologies. Mass merchandising fits in with the pro-consumer argument of the affordability and the availability of coverages.

In assessing the prospect for the implications of these group-marketed plans, numerous insurer characteristics will have to be reviewed. They will include such factors as policy form, whether individual underwriting rules are applied, the rate basis, size of participation needed for success of a program, whether experience rating comes into play, rate averaging if employer contributions are involved, the administration programs needed and, in the case of automobile coverages, how the residiual market fits in.

While there are some mass-marketed programs in existence, like group umbrella policies and some modified group automobile coverages, the surface has just been scratched.

The mass marketing of some property/casualty coverages could emulate what has been done to date in the life insurance field. More will come. It will not be easy, but it is inevitable and to the victors who develop the means of cross-selling—intermingled with sophisticated information and data retrieval systems —will go the spoils. ■

BI Industry Stock Report

JULY 26, 1983 7/20/83 THRU 7/26/83

Insurance Cos.		Price	% Chg.	P/E	$ Div.	% Yld.	High	Low	Vol. (000)
Aetna Life & Cas Co	NYSE	38.88	2.6	6.8	2.64	6.8	38.88	37.63	951.8
American Bankers Ins Group	OTC	15.63	-0.8	12.3	0.50	3.2	15.75	15.63	81.7
American Gen Ins Co	NYSE	23.00	2.2	8.8	0.80	3.5	23.25	22.75	376.9
American Indty Finl Corp	OTC	20.13	0.6	14.9	1.12	5.6	20.13	20.13	2.1
American Intl Group Inc	OTC	66.75	-1.5	11.5	0.44	0.7	67.75	66.50	794.7
American Natl Ins Co	OTC	20.13	1.9	8.4	0.84	4.2	20.25	19.75	148.2
American Sts Life Ins Co	OTC	30.00	0.0	8.4	0.88	2.9	30.00	30.00	0.2
Aneco Reins Ltd	OTC	4.38	-5.4	145.8	0.00	0.0	4.50	4.38	16.6
Avemco Corp	AMEX	21.88	16.7	11.8	0.58	2.7	21.88*	19.50	16.9
Banks Iowa Inc	OTC	47.00	1.1	12.4	1.52	3.2	47.00*	47.00	3.5
Bitco Corp	OTC	20.00	5.3	6.3	1.33	6.7	20.00	19.00	52.2
Carolina Cas Ins Co	OTC	9.50	0.0	12.5	0.32	3.4	9.50	9.50	0.8
Chubb Corp	OTC	61.88	2.7	9.6	3.12	5.0	61.88	60.25	273.9
Combined Intl Corp	NYSE	31.75	5.0	10.6	2.00	6.3	33.00	31.75	239.5
Continental Corp	NYSE	29.75	4.4	18.3	2.60	8.7	29.75	28.63	493.9
Crawford & Co	OTC	18.50	-6.3	13.8	0.60	3.2	19.75	18.25	25.8
Crown Life Ins Co	OTC	110.00	5.8	7.2	3.10	2.8	110.00	104.00	0.4
Employers Cas Co	OTC	37.00	0.7	7.6	1.20	3.2	37.00	36.75	3.9
Equifax Inc	NYSE	34.50	3.8	14.6	1.40	4.1	35.00	34.50	42.1
Excelsior Ins Co	OTC	15.00	0.0	9.6	0.70	4.7	15.00	15.00	2.1
Farmers Group Inc	OTC	37.25	-0.7	9.8	1.36	3.7	37.50	36.75	944.6
Foremost Corp Amer	OTC	50.75	5.7	15.6	1.24	2.4	50.75	49.25	82.3
Fremont Gen Corp	OTC	26.25	1.4	875.0	0.48	1.8	26.75	25.88	153.3
Great West Life Assurn Co	OTC	225.00	0.0	10.9	10.00	4.4	225.00	225.00	0.0
Hanover Ins Co	OTC	59.00	1.7	7.3	0.88	1.5	59.00	58.50	11.9
Hartford Steam Boiler Insptn	OTC	53.00	0.0	11.6	3.00	5.7	53.00	53.00	6.5
Jefferson Natl Life Ins Co	OTC	49.00	-3.9	15.4	0.76	1.6	50.50	49.00	4.8
Kemper Corp	OTC	49.50	2.9	9.3	1.80	3.6	49.50	48.38	48.0
Lincoln Natl Corp Ind	NYSE	53.13	6.5	9.7	3.00	5.6	53.13	51.25	183.5
Mission Ins Group Inc	NYSE	35.38	5.2	9.8	1.00	2.8	35.38	34.25	115.2
Nationwide Corp Ohio	OTC	43.75	0.0	15.3	0.70	1.7	0.00 DID NOT TRADE		
Northwestern Natl Life Ins	OTC	34.38	1.5	22.8	1.50	4.4	34.38	34.25	39.8
Ohio Cas Corp	OTC	51.88	1.7	9.8	2.52	4.9	51.88	51.38	45.3
Old Rep Intl Corp	OTC	29.75	7.7	7.3	0.90	3.0	29.75	28.38	73.8
Orion Cap Corp	NYSE	29.88	5.3	15.1	0.66	2.2	30.00*	28.13	48.3
Preferred Risk Life Ins Co	OTC	31.00	0.0	8.5	1.00	3.2	31.00	31.00	3.8
Provident Life & Acc Ins Co	OTC	58.50	-0.8	8.3	2.60	4.4	59.50	58.50	6.8
St Paul Cos Inc	OTC	61.63	-1.8	6.3	2.80	4.5	62.88	61.63	117.5
Safeco Corp	OTC	51.25	-4.9	10.7	2.40	4.7	53.63	51.13	250.1
Sri Corp	OTC	43.00	1.8	8.0	1.12	2.6	43.00	42.00	79.5
Seibels Bruce Group Inc	OTC	29.25	0.4	16.0	0.80	2.7	29.25	29.13	52.6
Statesman Group Inc	OTC	10.00	3.9	7.4	0.15	1.5	10.25	9.63	80.2
Tokio Marine & Fire Ins Co	OTC	96.88	-1.1	15.5	0.92	1.0	98.13	96.88	8.0

JULY 26, 1983 7/20/83 THRU 7/26/83

		Price	% Chg.	P/E	$ Div.	% Yld.	High	Low	Vol. (000)
Travelers Corp	NYSE	30.00	-2.0	8.0	1.80	6.0	31.25	30.00	1,073.1
United Fire & Cas Co	OTC	33.50	0.8	9.9	0.88	2.6	33.50	33.00	1.0
United States Fid & Gty Co	NYSE	54.13	4.1	12.7	3.84	7.1	54.13	52.00	106.2
United Svcs Life Ins Co	OTC	23.63	18.1	6.8	1.00	4.2	23.63	22.50	69.0
Uslife Corp	NYSE	24.75	1.0	6.8	0.88	3.6	24.75	24.75	146.9
Washington Natl Corp	NYSE	31.25	-2.3	14.2	1.08	3.5	31.88	30.63	87.4
Zenith Natl Ins Corp	OTC	23.00	16.5	11.0	0.80	3.5	23.00	22.75	114.7
INSURANCE COMPANIES	AVERAGE			10.1		3.7			
Agents/Brokers									
Alexander & Alexander Svcs	NYSE	24.50	-4.4	0.0	1.00	4.1	25.50	24.50	384.2
Baldwin & Lyons Inc	OTC	42.50	-1.2	7.8	0.80	1.9	43.00	42.50	4.2
Corroon & Black Corp	NYSE	23.00	-5.6	12.2	1.80	7.8	24.00	23.00	59.2
Crump E H Cos Inc	OTC	10.63	0.0	15.4	0.40	3.8	10.75	10.63	11.5
Emett & Chandler Cos Inc	OTC	10.75	0.0	0.0	0.00	0.0	10.75	10.75	1.6
Hall Frank B & Co Inc	NYSE	29.25	-2.5	16.6	1.70	5.8	29.75	29.25*	234.2
Integrated Res Inc	AMEX	39.00	6.1	15.3	0.00	0.0	39.00	37.63	141.6
Marsh & Mclennan Cos Inc	NYSE	43.00	-0.3	12.5	2.20	5.1	44.88	43.00	394.1
Poe & Assoc Inc	OTC	6.75	0.0	0.0	0.40	5.9	6.75	6.75	1.1
Reed Stenhouse Cos Ltd	OTC	14.25	6.5	14.2	0.60	4.2	14.25	13.38	4.2
AGENTS/BROKERS	AVERAGE			16.5		3.7			
Conglomerates/Holding Cos.									
American Express(Fireman's Fd)	NYSE	69.63	2.4	13.6	1.92	2.8	70.00	69.00	1,488.2
Anderson Clayton(Ranger/PanAm)	NYSE	30.00	5.3	20.0	1.32	4.4	30.00	28.50	10.8
Armco Inc	NYSE	18.50	3.5	0.0	0.40	2.2	18.50	18.13	508.7
City Investing Co. (Home Ins.)	NYSE	34.88	3.7	8.3	1.80	5.2	35.50	34.50	474.0
CNA Finl Corp (CNA)	NYSE	22.00	6.0	8.7	0.00	0.0	22.75*	22.00	35.1
Control Data (Comml. Credit)	NYSE	59.50	4.4	14.6	0.60	1.0	61.38	58.25	823.3
General Re Corp	NYSE	55.50	-0.9	11.7	1.28	2.3	56.75	55.50	872.4
Gulf Utd Corp	NYSE	27.38	2.3	8.5	1.32	4.8	27.75	26.50	729.5
Cigna Corp	NYSE	47.50	0.8	6.8	2.48	5.2	48.25	47.13	573.2
ITT (Hartford Group)	NYSE	47.25	6.8	10.2	2.76	5.8	47.25*	46.00	1,918.6
Optimum Hldg Corp	OTC	7.25	-3.3	11.9	0.00	0.0	7.50	7.25*	15.0
Sears Roebuck & Co. (Allstate)	NYSE	44.88	11.1	16.4	1.52	3.4	44.88*	42.00	3,228.3
Baldwin Utd Corp	NYSE	7.38	28.3	3.5	0.00	0.0	7.63	6.00	1,217.5
Teledyne Inc (Argonaut)	NYSE	167.38	2.5	14.9	0.00	0.0	167.88	165.00	403.1
Transamerica Corp (Occidental & Fred S. James)	NYSE	29.25	11.4	10.0	1.50	5.1	29.25	27.63	300.7
CONGLOMERATES/HOLDING COS.	AVERAGE			14.0		2.5			

*Record high/low since Jan. 1, 1983

System design: Altman Information Systems

Financial briefs

WPPSS default

Insurers as a group appear to be one of the bigger losers in last week's bond default by the Washington Public Power Supply System. However, it appears no single insurer holds enough of the bonds to feel any significant effect.

At Aetna Life & Casualty Co., which owns bonds for WPPSS projects Nos. 4 and 5 with a par value of $50 million, J. Heath Fitzsimmons, vp and deputy corporate controller, says the bonds will probably be carried by property/casualty subsidiaries at market value, which was 12 cents to 15 cents on the dollar last week.

But since Aetna's total assets exceed $44 billion, the change won't significantly affect the insurer's balance sheets, Mr. Fitzsimmons added.

Aetna also holds $17.3 million of WPPSS bonds from projects Nos. 1, 2 and 3, which are still paying interest. Analysts say it is too early to tell whether the default by WPPSS on the last two series of bonds will affect the first three.

In total, a study of insurer statements by state insurance regulators found that $348 million of the $2.25 billion par value of the bonds in default—about 15%—were held by insurers. The insurers also held $1.5 billion of the project Nos. 1, 2 and 3 bonds that are not in default.

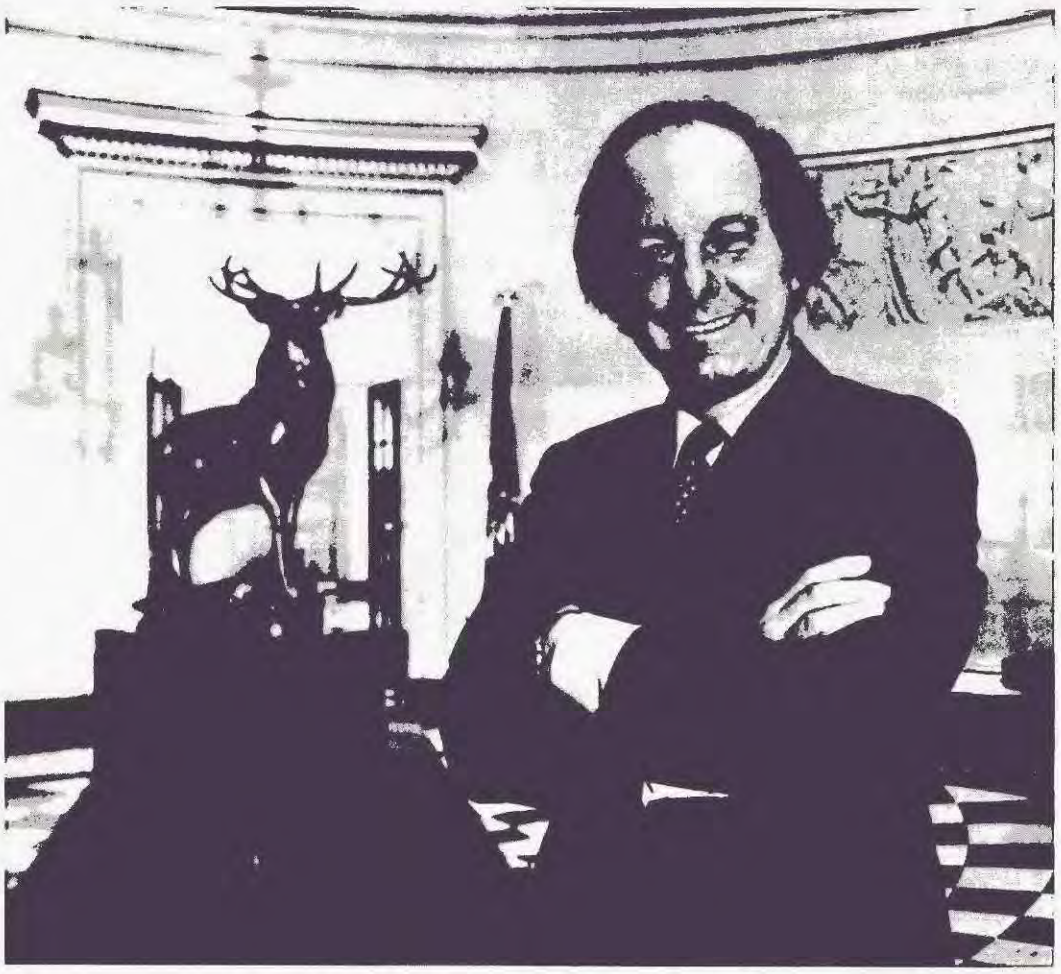
The study found Aetna was the largest holder of the questionable bonds, followed by Fireman's Fund Insurance Cos., $48.9 million; CIGNA Corp., $40 million; CNA Financial Corp., $25.9 million; and Kemper Corp., $24.2 million.

In another footnote to the WPPSS default, the financial statements of troubled Baldwin-United Corp. show that a Baldwin subsidiary insured the timely payment of principal and interest on $23.7 million worth of Nos. 4 & 5 bonds. The total amount that would possibly have to be paid by the subsidiary, American Municipal Bond Assurance Corp., is $76.4 million over the next 35 years. ■

How The Hartford helps reduce insurance costs.

"Our leadership in Automation puts you in control of your insurance—and its cost."

Don Frahm, President, Property/Casualty Operations, tells business insurance buyers how they can benefit from The Hartford's advanced Automation capability.



Q. How does The Hartford's Automation capability help brokers and agents meet my business insurance needs better?

A. It enables them to give you faster, more responsive service across the board. Take quotes, for example. Where a nonautomated insurer might take a month or more to get back to brokers and agents with a proposal, we can normally get quotes out in days. That fast turnaround lets you measure the cost-effectiveness of different levels of coverage in actual dollar terms— and right up front. It also gives you more time to make informed decisions on the options open to you, and to balance cost and coverage considerations.

Q. When do you use computerized loss control analysis? And how can it cut insurance costs?

A. Computerized loss control analysis comes into play when a company has complex exposures and multiple claims. By breaking out losses by location, time of day, type of accident or injury, and so on, our Loss Control specialists can detect common denominators which help them pinpoint accident causes. They can then work up recommendations for eliminating or reducing those losses.

In the case of a large New England printing company, for example, computer analysis showed a high percentage of accidents and lifting injuries connected with bindery operations. Guided by clues contained in the analysis, our Loss Control specialists did a Materials Handling Survey of bundle size and weight, work flow patterns, and the like, and made specific recommendations to improve the situation. The same procedure was followed with other types of accidents and injuries.

The results were dramatic. In the 7-month period following the implementation of the recommendations, incidents were reduced by nearly 60% over the corresponding 7-month period a year earlier, and incurred claims costs dropped by 94%. Naturally, improvements like that can substantially lower future premiums.

Q. How can your automated Claims capability increase my control and limit my losses?

A. Let me first make clear that our automated Claims capability complements our human Claims capability. Remember, many insurance companies rely almost entirely on outside Claims services. At The Hartford, we handle about 99% of our own claims with our own staff of some 4,200 Claims personnel. We have more than 200 fully automated field Claims offices in the U.S. and Canada, and 52 regional Claims offices.

Our human Claims capability assures you of fast, fair, and expert response to claims. And our computer Claims capability assures you of fast, accurate Claims processing and reporting. You know where you stand at all times. And the rapid resolution and payment of claims can significantly reduce claim costs and thereby improve your company's cash flow and profit picture.

Q. Are your computer-enhanced Loss Control and Claims services available on an unbundled basis?

A. Yes—through our subsidiary, Hartford Specialty. One of their Claims services is a unique on-line claim reporting system that gives you current, up-to-date information on claims and lets you break out claims anytime in accordance with criteria you select on the spot.

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