

# Business Insurance

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## Ashland Oil's cleanup bills for oil spill pass \$4 million

PITTSBURGH—Ashland Oil Co. already has spent more than \$2 million to clean up the Jan. 2 Monongahela River oil spill and another \$2 million to assess and alleviate water pollution problems resulting from the spill, which has spread into the Ohio River.

In addition, the company has hired Crawford & Co., an Atlanta-based claims adjusting firm, to process spill-related claims from businesses and individuals.

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## Self-funded MET proposals raise solvency issues

By DEBORAH SHALOWITZ

WASHINGTON—A House committee proposal that would make it easier for small employers to band together to self-insure group health care benefits could trigger a new wave of problems involving self-funded multiple employer trusts, benefit experts say.

The proposal, contained in a recent report by the House Small Business Committee, recommends amending the Employee Retirement Income Security Act "to permit small group associations to self-insure and thus be exempted from state mandated benefit laws."

Under an amendment to ERISA passed by Congress in 1982, such arrangements, best known as self-funded multiple employer trusts, are required to comply with state insurance laws, including mandated benefit laws and reserve and capital and surplus requirements (BI, Dec. 27, 1982).

While the report only recommends that self-funded METs be exempted from state mandated benefit laws, observers fear that Congress also could exempt the trusts from state solvency requirements in an effort to encourage formation of self-funded METs.

The committee report, in fact, urges other congressional committees with jurisdiction over ERISA "to explore possible solutions to government regulations that impede the formation of pooling arrangements by small firms."

If self-funded METs were released from all state regulation, they would not have to satisfy any solvency requirements and that could lead to severe financial problems, much the same situation as in the late 1970s when numerous self-funded METs collapsed, some observers say.

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## Gulf tax ruling may permit captive premium deduction

By DOUGLAS McLEOD

WASHINGTON—Captive insurance company experts are cautiously optimistic that a recent U.S. Tax Court ruling could allow parent companies to tax deduct premiums paid to wholly owned captive insurers in some cases.

However, based on this ruling alone—which suggests that parent companies could deduct premiums paid to captives if the captive writes a large volume of non-parent-related business—few captives will rush to write third-party risks, the experts predict.

The optimism is being generated by a November ruling by the tax court in a case brought by Gulf Oil Corp. over the denial of deductions for premiums it paid to its Bermuda-based captive, Inso Ltd., in 1974 and 1975.

Following a line of previous decisions, a majority of the court's panel denied the deductions, pointing out that all or most of Inso's business in those two years was Gulf-related and that there was none of the risk shifting required for premiums to be treated as deductible insurance payments.

However, in a footnote to the decision, the court suggested that a larger volume of unrelated business might render a parent company's premiums deductible.

"If at least 50% (of a captive's premiums) are unrelated, we cannot believe that sufficient risk transfer would not be present," the footnote reads.

"I don't think anybody knows what's going to happen after this, but it's the first bright sign on unrelated business in wholly owned captives that I have seen," said Benedict J. Sciortino, a tax lawyer with Baker & McKenzie in New York.

"Certainly everybody has more reason to be hopeful now than they did before," agreed John W. Weber Jr., an attorney with LeBoeuf, Lamb, Leiby & MacRae in New York.

If the tax court follows the reasoning of the footnote in future decisions, some captives may become more interested in assuming third-party business, particularly from such controlled sources of unrelated premiums as captive risk-

sharing pools, observers say.

One such pool, First Island Reinsurance Assn., discontinued underwriting last July after the number of member captives fell to four from seven at year-end 1986.

Johnson & Higgins, whose Bermuda subsidiary manages First Island, is "seriously considering" reopening the pool, though the renewed interest is not necessarily related to the Gulf decision, a J&H spokeswoman said.

But few experts expect any rush to third-party underwriting on the basis of the Gulf decision, not only because of uncertainties about the direction of future tax court rulings but also because several captives—including Inso—suffered horrendous losses on unrelated business written in the early 1980s.

"There are a lot of people that have been burned—and burned very badly—writing third-party business," observed Richard S. Betterley, president of D.A. Betterley Risk Consultants Inc. in Worcester, Mass.

"I don't think anyone will start writing unrelated business because of this case. They had so many problems with it the last time," Mr. Sciortino predicted.

Inso, formed in 1971, at first wrote only Gulf-related risks, but it later expanded into writing unrelated business until it discontinued all underwriting in 1984 (BI, Nov. 26, 1984).

Gulf carried a \$1 million deductible on property, marine hull and marine cargo risks in 1974 and 1975, according to the tax court opinion. Limits excess of the deductible were written by commercial insurers—principally units of American International Group Inc.—which then reinsured varying amounts within the first \$10 million layer with Inso.

In 1973, Gulf executed guarantees under which it agreed to indemnify AIG if Inso were unable to meet its reinsurance obligations, the opinion says. However, Gulf was never required to pay any claims on Inso's behalf, according to the opinion.

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## Employee benefit costs top \$10,000 per worker

By JERRY GEISEL

WASHINGTON—Employee benefit costs now exceed an average of \$10,000 per worker, the U.S. Chamber of Commerce says.

In a redesign of its annual survey, the Chamber found that benefit costs averaged \$10,283 per worker in 1986. That's equal to 39.3% of payroll, according to the survey released last week by the Chamber.

For its 1986 survey, the Chamber asked employers to estimate costs for several employee benefits that were not included in previous surveys. Those costs include such items as retiree health insurance, benefits for former employees, pension and savings plan administration and parental leave and child care programs.

In addition, the reporting format for certain benefits was changed, making the data more useful to employee benefit managers. For example, for the first time employers' group health insurance costs are now listed in the survey as a separate item; pre-

viously, group health and life insurance costs were lumped together as one item.

The 1986 survey also includes a new category: retirement and savings plan payments, with separate sub-categories for defined benefit plan contributions and defined contribution plan payments.

Previously, the Chamber asked employers to estimate their costs for defined benefit plans that were not funded through insurance contracts. And instead of a separate defined contribution plan category, employers previously had been asked to provide separate cost estimates for two types of defined contribution plans: thrift plans and profit-sharing plans.

Under the former survey format, benefit costs in 1985 totaled \$8,166, or 37.2% of employers' total payroll.

While the new and revamped categories make it difficult to compare benefit costs reported in the 1986 survey to prior years, it does give a more accurate picture of employers' benefits expenditures,

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### Benefit costs per employee

Industry	1986	1985	% change*
Transportation equipment	\$15,448	\$9,649	60.1%
Rubber, leather & plastics products	13,450	8,095	66.2
Primary metal industries	13,402	11,344	18.1
Public utilities	12,712	10,622	19.7
Petroleum	11,755	12,303	-4.5
Chemical & allied products	11,287	10,086	11.9
Machinery (excluding electrical)	10,461	9,406	11.2
Miscellaneous non-manufacturers	9,494	7,731	22.8
Electrical machinery, equipment & supplies	9,380	8,573	9.4
Fabricated metal products	8,497	8,659	-1.9
Insurance companies	8,315	7,608	9.3
Stone, clay & glass products	7,748	7,511	3.2
Food, beverages & tobacco	7,580	8,425	-10.0
Hospitals	7,172	6,745	6.3
Banks, finance companies & trust companies	7,153	6,552	9.2
Printing & publishing	6,919	7,292	-5.2
Trade (wholesale & retail)	6,107	5,697	7.2
Department stores	5,102	4,292	18.9
Textile products & apparel	4,743	4,599	3.1

\*Percentages may be distorted because of changes in 1986 survey.

Source: U.S. Chamber of Commerce Research Center

Chart: Amy Palmer

**Court convicts chemical firm of endangering employees**  
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**Filipino company sues A&A over unpaid political risk claims**  
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**Update**

**Oil spill expenses mounting**

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 Some 1 million gallons of diesel fuel oil spilled into the Monongahela upstream from Pittsburgh when an Ashland storage tank collapsed as it was being filled. Ashland has liability insurance limits of \$400 million to cover damages and cleanup costs, after a \$2.5 million deductible, through Bermuda-based group captive OIL Insurance Ltd. and sister company OIL Casualty Insurance Co. Ltd. (BI, Jan. 11).

Ashland has said it believes its insurance will cover all of its liabilities. However, both the company and a Crawford official declined to estimate total liabilities from the spill.

Crawford opened a 15-person branch office here last week specifically to handle claims for Ashland, which also opened a Pittsburgh office. Both concerns first will address claims from government agencies, municipalities and property owners that suffered property damage from the spill, according to officials.

In federal court here, at least two lawsuits against Ashland have been filed by local businesses—a car wash and a river tour boat operation—and individuals have filed at least two class-action lawsuits against the company.

**B.A.T. bids for Farmers**

LONDON—B.A.T. Industries P.L.C., the British tobacco and financial services company, is bidding \$4.2 billion to acquire Farmers Insurance Group of Los Angeles.

B.A.T., parent of London-based insurer Eagle Star Holdings P.L.C., is offering \$60 a share for Farmers through its U.S. subsidiary, BATUS Inc. in Louisville, Ky.

B.A.T. Chairman Patrick Sheehy, who proposed the deal Wednesday in a letter to Farmers Chairman Leo E. Denlea Jr., seeks a response "no later than the close of business on Friday, Jan. 22." The letter follows Mr. Sheehy's approach to Mr. Denlea in an Oct. 21 letter "suggesting a meeting to discuss a merger." Mr. Denlea "declined the suggestion," said a B.A.T. statement.

B.A.T., which posted a pretax profit of 1.4 billion pounds for 1986 (\$2.1 billion at year-end 1986 exchange rates), will finance the acquisition "out of the group's existing cash resources plus borrowings."

Mr. Denlea said in a statement that he would not comment on the bid until after Farmers' board consults with its financial advisers.

Farmers wrote \$4.99 billion in net written premiums in 1986.

**Cleanup costs are not damages**

WASHINGTON—The Supreme Court last week let stand a lower court ruling that a policyholder's costs for cleaning up a Superfund site are not covered damages under comprehensive general liability policies but rather are restitution.

In the lower court case, *Maryland Casualty Co. vs. Armco Inc.*, Middletown, Ohio-based Armco sought payment from its insurer to cover the costs of the government-ordered cleanup of a hazardous waste storage facility in Kansas City, Mo. The cleanup was ordered immediately after it was discovered hazardous wastes stored at the facility had seeped into soil and groundwater but before any environmental damage had been discerned.

The 4th U.S. Circuit Court of Appeals said it declined "to extend the obligations of insurance carriers beyond the well-illuminated area of tangible injury and into the murky and boundless realm of injury prevention" and ruled that the cleanup costs constituted restitution rather than damages. "Damages are a form of substitutional redress which seeks to replace the loss in value with a sum of money. Restitution, conversely, is designed to reimburse a party for restoring the status quo," the court ruled.

The Supreme Court last week also refused to review three lawsuits filed by veterans and civilians challenging a \$180 million class-action settlement between manufacturers of Agent Orange and Vietnam veterans. A trust fund will compensate an estimated 40,000 to 60,000 Vietnam veterans and their families for injuries suspected to be related to Agent Orange. Monsanto Co. and Dow Chemical Co. were responsible for the largest portion of the settlement (BI, Sept. 8, 1986; May 14, 1984).

**End malpractice trials: AMA**

CHICAGO—The American Medical Assn. and 32 other medical societies propose eliminating medical malpractice jury trials and instead allow state medical boards or new state administrative agencies to decide malpractice cases.

The system would compensate more malpractice victims and limit damage awards, which are "threatening the availability and affordability of insurance coverage and health care in many geographic areas in the United States and in many medical specialties," according to a report by the Medical Liability Project, a group formed by the medical organizations.

The American Bar Assn. said "the (medical group's) report itself contains no data to support a wholesale shift from the courts to an administrative agency" as a means of disposing of medical malpractice claims. But, the ABA supports the goal of strengthening state medical disciplinary boards, an ABA spokeswoman said.

**Hull insurers pay PSA loss**

DALLAS—Pacific Southwest Airlines' hull all-risk insurers have paid the airline \$16.3 million for the loss of a jetliner that crashed Dec. 7 apparently because of an on-board murder-suicide, according to Aviation Office of America Inc. in Dallas, which wrote 20% of PSA's hull all-risk coverage.

U.S. Aircraft Insurance Group of New York, the lead underwriter of the coverage, did not respond to telephone calls.

PSA's all-risk aviation coverage, placed by broker Frank B. Hall & Co. Inc., provides up to \$65 million in hull coverage and

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**Colorado firm convicted for risking workers' lives**

By MEG FLETCHER

DENVER—Protex Industries Inc. faces a maximum \$7.54 million fine for illegal waste-disposal practices, including a landmark conviction for knowingly endangering the health and lives of employees.

The company, which manufactures and sells chemical additives to harden and cure concrete, will be sentenced Jan. 29 by a U.S. District Court judge in Denver.

A jury last month found Denver-based Protex guilty of 16 violations of federal environmental laws, including the Resource Conservation and Recovery Act and the Clean Water Act (BI, Jan. 11).

It marked the first time that a company has been convicted under these laws for endangering human life.

Three of the counts, which carry maximum penalties of \$1 million each, were connected with placing three employees "in imminent danger of death and serious bodily injury," the indictment said.

The employees, who worked in the company's steel barrel recycling unit, were exposed to residues of pesticides and solvents from cleaning and painting the 15,000 used, 55-gallon drums Protex purchased annually to recycle and then refill with its products. The men all had been with the company at least seven years.

"Protex did not inform the employees of the hazards or properly equip them to avoid exposure," according to a statement from the U.S. Justice Department.

Between September 1982 and April 1987 the company either failed to provide respirators and protective

clothing or provided inadequate respirators, said Bill Smith, an investigator with the Environmental Protection Agency's National Enforcement Investigative Center.

As a result, government officials say the men suffered from solvent poisoning, which can be cured if they are removed from contamination, and permanent neuropsychological impairment, including reduced memory.

In addition, experts say the men face an increased risk of developing cancer from exposure to some of the chemicals, which included chlordane; heptachlor; 2, 4-D; pentachlorophenol; methanol; and menthylene chloride.

The Justice Department considers Protex's conviction on the knowing endangerment count "a major prosecution milestone," a department statement said.

The guilty verdict "will have a major beneficial impact in persuading those who are responsible for hazardous wastes to obey fully the law," said Roger J. Marzulla, acting assistant attorney general with the Justice Department's Land and Natural Resources Division.

"Anyone in any company handling any chemical should be scared to death" about facing endangerment charges, said Protex attorney David Palmer, a partner with the Denver firm of Gibson, Dunn & Crutcher.

He said inspection results were turned over to EPA and Federal Bureau of Investigation personnel but not to Protex, although federal law requires inspectors to inform the company as well.

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**Directory features risk consultants**

The annual directory of risk management consultants will appear in the March 7 issue of *Business Insurance*, which will contain a spotlight report on trends in risk management services.

There is no charge to be included in the directory; however, consultants wishing to be listed must fill out and return a questionnaire provided by *Business Insurance*.

If your firm provides risk management consulting services and you have not yet received a questionnaire, you may request one by writing Christine Woolsey, Editorial Assistant, *Business Insurance*, 740 N. Rush St., Chicago, Ill. 60611-2590; or by calling 312-649-5460.

The deadline for returning completed questionnaires to *Business Insurance* is Feb. 5.

**Ferry overbooking would void cover**

By KATHLEEN BARNES

MANILA, Philippines—Liability insurance may not respond to claims stemming from the sinking last month of a passenger ferry in the Philippines if it is determined the ship was dangerously overbooked, underwriters say.

The owner of the ferry, Sulpicio Lines, admits that the Dona Paz ferry was carrying 213 more passengers than allowed by law, but an organization representing victims' families claims the ferry may have been overbooked by thousands.

People claiming to be relatives of about 3,500 victims have filed a \$50 million class-action suit against Philippine-based Sulpicio.

Sulpicio, the second largest shipping company in the Philippines, may have as little as \$1.4 million of liability insurance to respond to the claims, far less than originally estimated, one source says.

And, the M/V Vector, the oil tanker that collided with the ferry, is not insured for any third-party risks.

The Dona Paz, crowded with travelers bound for Manila from outlying islands for the Christmas holiday, sank Dec. 20 off Marinduque after colliding with the tanker, which was carrying 8,000 barrels of oil. Both vessels and the water around them were quickly engulfed in flames after the collision.

Only 26 survivors were pulled from the flaming waters minutes after the collision. The rest of the passengers either drowned or were

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- ✓ Congress can and should do more to make group health care coverage more affordable for small employers, but relaxing the rules governing the operation of self-funded multiple employer trusts is not the answer, this week's editorial says. **PAGE 8**
- ✓ In Perspectives Gerald I. Lenrow, Donald K. Steffen and Craig B. Larsen of Coopers & Lybrand analyze the Gulf Oil Corp. decision, in which the U.S. Tax Court comments on when a captive insurer writing unrelated risks may create a transfer of risk between the parent company and its related insurer. **PAGE 19**
- ✓ In RMIS Commentary David A. Tweedy, senior consultant with D.A. Betterley Risk Consultants Inc. in Worcester, Mass., examines when it may be time to throw in the towel on your current risk management information system. **PAGE 20**
- ✓ Lloyd's of London's competitive position is being threatened by increasing overhead costs, warns former Lloyd's Chairman Peter Miller. **PAGE 23**
- ✓ The new chairman of the Illinois Insurance Exchange, Gordon L. Teach, wants to bolster awareness of the facility and make it a leading financial institution on the order of the Midwest Stock Exchange. **PAGE 24**
- ✓ Property/casualty insurers will pay \$6 billion more in taxes in the next two years than they would have before tax reform, according to new statistics from the Insurance Services Office Inc. **PAGE 27**

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# \$85 million spill

## Amoco Cadiz damage award to be appealed

By DOUGLAS McLEOD

CHICAGO—Amoco Corp. and a group of French claimants are both expected to appeal an \$85.4 million judgment against Amoco for damages arising from the massive oil spill caused by the 1978 wreck of the supertanker Amoco Cadiz off the coast of France.

U.S. District Judge Frank J. McGarr last week ordered Amoco to pay damages of 252 million French francs (\$45.9 million at the current exchange rate) and \$39.5 million in prejudgment interest to the Republic of France and scores of French claimants for costs related to the spill, which marred more than 100 miles of the Brittany coastline.

The damage award, far smaller than the \$2.2 billion the French claimants had originally sought, came 10 years after the plaintiffs filed suit against Amoco and nearly four years after Judge McGarr found Amoco liable for the disaster (BI, April 30, 1984).

Amoco will appeal to the 7th U.S. Circuit Court of Appeals in Chicago both the damage award and Judge McGarr's 1984 ruling on Amoco's liability, said Frank Cicero Jr., a lawyer with the Chicago firm of Kirkland & Ellis, which represents the oil giant.

Amoco also will try to recover damages from Spanish shipbuilder Astilleros Espanoles S.A., which built the Amoco Cadiz, and the American Bureau of Shipping, a New York-based not-for-profit ship classification society



Photo: AP/Wide World

The 1978 wreck of the Amoco Cadiz fouled the coast of Brittany.

that approved the supertanker's design and construction, Mr. Cicero said.

Lawyers for the Republic of France, who were discussing a possible appeal last week, could not be reached for comment.

However, a group of more than 100 French coastal towns, regional governmental bodies and others—collectively known as the "Cotes du Nord" parties—is expected to appeal Judge McGarr's ruling, according to their lawyer, T. Barry Kingham, a partner with the New York firm of Curtis, Mallet-Prevost, Colt & Mosle.

"The amount is clearly not enough," Mr. Kingham said of the award. It will

"hardly recompense my clients for the damages they suffered," he said.

The plaintiffs' original claims of \$2.2 billion were scaled back to \$698.4 million in 1985 before the damage trial started, and Mr. Kingham noted that these claims were cut even further during trial (BI, March 11, 1985).

For example, the Cotes du Nord parties had reduced their claims from \$287.7 million before the trial to 693 million francs (\$115.5 million) by the end of the trial, Mr. Kingham said.

Proceeds from Amoco's pollution liability insurance may come closer than even Amoco had expected to covering

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# Filipino contractor sues A&A to recoup political risk losses

By LINDA J. COLLINS

NEW YORK—A Filipino construction company is suing Alexander & Alexander Services Inc. for more than \$95 million, alleging A&A negligently negotiated political risk insurance policies that were subsequently canceled by underwriters.

In addition, Manila-based Landoil Resources Corp. is continuing to press another lawsuit, filed in 1985 in the Philippines, against Lloyd's of London and Lloyd's underwriters that wrote the policies. That suit, which seeks \$540 million in damages, alleges the insurers failed to pay more than \$40 million in political risk claims (BI, Jan. 20, 1986).

Landoil alleges that it has suffered severe financial difficulties after underwriters denied coverage for claims filed under a \$50 million political risk package policy, placed by A&A with Lloyd's underwriters for a \$2 million premium.

Landoil is no longer actively doing business, says its attorney, Rayner M. Hamilton, a partner with White & Case in New York. Landoil and its subsidiaries had been "unable to meet their financial obligations as they became due and had

to discontinue operations" because of the refusal to pay claims, says the suit against A&A, filed in November in U.S. District Court for the Southern District of New York.

The Philippine Department of Justice last year filed fraud charges against Landoil and several officers, alleging they failed to meet financial obligations (BI, Dec. 7, 1987).

Landoil accuses A&A and subsidiaries Alexander & Alexander Inc. and Alexander & Alexander of New York Inc. with breach of agreement, fraud, misrepresentation and violations of the Racketeer Influenced and Corrupt Organizations Act. Landoil is seeking at least \$45 million in compensatory damages, which can be tripled under RICO, and \$50 million in punitive damages.

A spokesman for A&A said, "We have reviewed the complaint and have concluded that the allegations are without merit. We intend to defend ourselves vigorously and we expect to prevail."

The spokesman said A&A's errors and omissions liability coverage "is adequate to meet any anticipated contingencies," but would not comment further.

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# Insurer panel zeroes in on problems

By KATHRYN J. McINTYRE

NEW YORK—Despite record profits in 1987, the property/casualty insurance business is confronted with a host of problems, ranging from increased tax liabilities and the danger of improperly pricing insurance to poor consumer relations, according to a panel of industry leaders and regulators.

Asked to identify the No. 1 problem confronting property/casualty insurers, Ronald E. Ferguson, chairman, president and chief executive officer of General Re Corp. in Stamford, Conn. responded: In the short term, pricing resolve; in the medium term, the continued movement of business to alternative facilities; in the long term, pollution liability costs and low productivity among white-collar workers.

Maurice R. Greenberg, president and chief executive officer of American International Group Inc. in New York, agreed with Mr. Ferguson, adding the cost of assessments by state guaranty funds and residual markets to the list of pressing problems.

Robert V. Hatcher Jr., chairman and chief executive officer of Johnson & Higgins in New York, stressed the industry's "image" problems.

Joseph E. Luecke, chairman and chief executive officer of Kemper Group in Long Grove, Ill., singled out "maintaining cost-based pricing" as the most important problem.

"Tort law—we're losing that battle," said DeRoy C. Thomas, chairman and chief executive officer of Hartford Insurance Group. in Hartford, Conn., who also endorsed what other panelists had said.

In contrast to the insurance industry executives, the two regulators on the seven-member panel focused on relationships with customers.

"The distance between most insurance companies and their customers" is the No. 1 problem facing insurers, according to California Insurance Commissioner Roxani M. Gillespie.

John E. Washburn, Illinois director of insurance and newly elected president of the National Assn. of Insurance Commissioners, cited "the breakdown in the fabric" of the relationships between property/casualty insurers and their clients.

"Policyholders now are anticipating a lot more out of their companies than they ever bought, or even thought they bought when they bought it," he said.

The panel was assembled at the Joint Industry Conference and annual meetings of the Insurance Services Office Inc., the Insurance Information Institute and, for the first time, the American Insurance Assn.

The Joint Industry Conference, held in New York each January, attracts chief executive officers of the nation's major property/casualty insurers. The strictly business meeting, which spouses do not attend, attracted about 360 people this year for the day-and-half meeting, held Jan. 12-13 at the Westin Plaza.

Panel moderator Robert E. Vagley, president of the AIA, also asked the panelists to comment on the No. 1 opportunity available to the property/casualty insurance business.

While most of the panelists suggested that solutions to the problems they identified were obvious opportunities for the insurance business, some elaborated.

"You are the only ones that understand a very complex system," Ms. Gillespie observed. "If you can translate your knowledge into language that the ordinary

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# Spanish plant loss to spark huge claim

By MARIA KIELMAS

SAN CIPRIAN, Spain—Physical damage and business interruption losses at a Spanish aluminum smelting plant are expected to result in Spain's largest insurance claim to date, insurers believe.

Spanish aluminum producer Industria Espanola del Aluminio S.A., or Inespal, says it will file property damage and business interruption claims worth 18 billion pesetas (\$161.8 million) with state-owned and private insurers following work stoppage at an aluminum smelting plant in San Ciprian, Spain, operated by affiliate Aluminio Espanol S.A.

However, an official of a state-owned Spanish insurer that writes catastrophe coverage for Spanish businesses doubts the insurer will have to pay the claim.

The plant closed after workers walked out, fearing contamination from chemical drums

stored at the plant's harbor facilities. The drums were recovered from a Panamanian-registered freighter, the Cason, that ran aground nearby on Dec. 5.

Panicked employees abandoned their work posts without maintaining what Inespal termed the "minimum services" necessary to maintain the continuous smelting process after it was decided to store 255 drums of toxic chemicals salvaged from the Cason at Aluminio's private wharf in San Ciprian on the coast of the Bay of Biscay. Consequently, the metal under processing solidified, and the now-crippled plant will be shut down for an estimated six months.

The San Ciprian plant is Spain's largest and Europe's third-largest aluminum smelter, according to a plant spokesman.

Inespal is 72.75% owned by the Spanish state holding company Instituto Nacional de Industria (INI), 23.9% owned by Montreal-based aluminum producer Alcan Aluminium

Ltd. and 3.35% owned by various Spanish banks. The affiliate, Aluminio Espanol, is 75% owned by Inespal, 18% by INI and 7% by various Spanish banks.

Inespal has up to \$150 million in coverage for property damage and business interruption for all of its Spanish operations through Spanish insurer and INI subsidiary Musini Sociedad Mutual de Seguros y Reaseguros a Prima Fija, said Alfonso Mulas, head of reinsurance at Musini. The annual premium for the coverage is 243 million pesetas (\$2.2 million), Mr. Mulas said.

He added that Musini wrote 51.5% of Inespal's business interruption risks, the remainder being shared by nine other Spanish insurers, six of which are La Union y El Fenix Espanol Cia de Seguros y Reaseguros S.A.; La Estrella S.A. de Seguros; Banco Vitalicio de Espana C.A. de Seguros; Vasco Navarro; Plus Ultra C.A. de Seguros y

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# BI sales, editorial promotions

Michael J. Sharpe, 37, has been promoted to western advertising manager of *Business Insurance*, announced Advertising Director Donald A. Walsh.



Mr. Sharpe

Mr. Sharpe, previously advertising district manager, joined *BI* in 1985.

Before joining *BI*, Mr. Sharpe was an account executive at Doyle Dane Bernbach Advertising in London and Los Angeles. In London, Mr. Sharpe was an account executive on the Commercial Union Assurance P.L.C. account. Between Doyle Dane and *BI*, Mr. Sharpe was regional marketing manager for American International Group Inc. in Los Angeles.

While in the United Kingdom, Mr. Sharpe played for the renowned Manchester United soccer team in 1969-1970. He now plays semi-

professional soccer with the Los Angeles Soccer Club.

Mr. Sharpe, a native of Ireland, has a bachelor of arts degree in economics and marketing from University College Dublin.



Mr. Winston

Mr. Sharpe can be reached in Los Angeles at 213-651-3710.

Meanwhile, Paul D. Winston and Stacy Adler, both members of *BI's* editorial staff in Chicago, have been promoted to copy editors from assistant copy editors, announced Associate Publisher and Editor Kathryn J. McIntyre.

Mr. Winston, 24, joined *BI* in 1985 as a proofreader and was promoted to assistant copy editor in 1986. He also has worked as a columnist for Lerner Newspapers in Chicago and as an intern for Rolling Stone magazine

in New York. He received a bachelor of arts degree in English composition from DePauw University in Greencastle, Ind., in 1985.



Ms. Adler

Mr. Winston can be reached at 312-649-5442.

Ms. Adler, 23, joined *BI* in 1987 as an assistant copy editor. She previously worked as a reporter for Security and Security Distributing & Marketing magazines in Des Plaines, Ill. She also was a researcher for *Crain's Chicago Business*. *BI* and *CCB* are published by Crain Communications

Inc. Ms. Adler holds a master of science degree in journalism from Northwestern University in Evanston, Ill., and a bachelor of science degree in journalism from the University of Florida in Gainesville.

Ms. Adler can be reached at 312-649-5262.

# Shareholders, Tandon Corp. settle lawsuit

By MICHAEL BRADFORD

CHATSWORTH, Calif.—Concern over the limits of Tandon Corp.'s directors and officers liability coverage prompted shareholders suing the computer manufacturer to agree to an \$18 million settlement fund, says a Tandon attorney.

Tom Bourke, an attorney with the Los Angeles firm of Riordan & McKinzie, said he told plaintiffs in shareholder class-action and derivative litigation against Tandon that delays in reaching a settlement would reduce indemnity payments from the company's D&O insurer.

"The defense costs were eating into the policy limits," said Mr. Bourke.

"We told them that if they settled now, there would be at least \$8 million in cash available for a settlement," he added.

Although he would not name Tandon's insurer, Mr. Bourke said the underwriter provided D&O insurance on a claims-made basis that included defense costs within the \$8 million insurance policy limits.

The insurer contributed \$7.995 million to the settlement fund after paying \$5,000 in defense costs, according to Mr. Bourke.

Tandon paid \$5,000 into the fund.

The settlement, which must be approved by the court, also will include \$10 million of coupons that may be used toward the purchase of Tandon computers by shareholders.

Each purchaser could use up to \$100 in coupons for each computer purchased. If the coupons are not used to purchase Tandon equipment, the coupons can be redeemed at 35% of face value for cash or Tandon common stock at Tandon's option.

To fund the coupons, Tandon will place 930,000 shares of common stock in the fund. Up to 500,000 additional shares may be placed in the fund if the Chatsworth, Calif.-based company's stock does not reach \$5 per share during a 20-month period after distribution of the stock.

Tandon stock was trading at \$1.88 a share last week, making the current value of the 930,000 shares about \$1.75 million.

The first shareholder lawsuits were filed in July 1986 in the Central District Court of California and Los Angeles Superior Court. More than 7,000 shareholders are represented in the suits, which alleged that Tandon and certain former and current directors and officers violated state and federal securities laws in 1983 and 1984 by issuing misleading financial statements.

Mr. Bourke said the suits, which sought undetermined damages, charged that Tandon had "business problems" that its management and auditors should have reflected by "writing down its inventory and accounts receivable sooner."

Sirjang Lal Tandon, the company's chairman and chief executive officer, said in a statement: "Although we continue to believe firmly that the allegations made in this litigation are without merit, litigation of this type is very disruptive and expensive, and it impedes our efforts to concentrate on business at hand."

"The opportunity to put this behind us once and for all and focus entirely on productive matters made it advisable to agree to this settlement," he said.

The company has not admitted any wrongdoing in connection with the allegations by stockholders. ■

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## Captive ruling

Continued from page 1

Insko's gross written premium volume grew from \$1.1 million in 1972 to a high of \$154 million in 1981 before retreating to \$114.1 million in 1983. Net premiums expanded from \$569,000 in 1972 to a high of \$94.8 million in 1981 and dropped to \$83.3 million in 1983.

Insko started writing business unrelated to Gulf in 1975, though third-party risks accounted for only 2% of its premium volume that year. The amount of unrelated business grew markedly through 1983, when third-party risks accounted for 62% of Insko's total volume, the opinion shows.

Insko paid claims to primary insurers of \$1 million in 1974 and \$3.1 million in 1975, the two years at issue in the tax case. However, unrelated business accounted for none of the 1974 claims and only \$48,018 of the 1975 claims, the opinion says.

The Internal Revenue Service later disallowed deductions of premiums paid by Gulf and its domestic affiliates in 1974 and 1975 to the extent they were ceded to Insko. These deductions totaled \$10.2 million in 1974 and \$10.8 million in 1975.

Among other arguments, the IRS contended in court that the Insko coverage did not represent a real risk transfer from Gulf and that there was no risk distribution in Insko's book of business. Therefore, the premiums ceded to the captive were not deductible insurance costs, the IRS said.

The IRS also pressed the "economic family" theory, espoused in earlier revenue rulings.

Under this theory, the IRS contended that a wholly owned captive could never be considered a separate insurance company and that premiums paid by its parent company could never be deductible, regardless of the amount of unrelated business the captive

might write.

A majority of the 17-judge panel reviewing the case denied Gulf the premium deductions, but an opinion joined by 11 of the judges rejected the economic family theory as the basis for denying the deductions.

The opinion concluded that "when the aggregate premiums paid by the captive's affiliated group is insufficient in a substantial amount to pay the aggregate anticipated losses of the entire group, the affiliated and unrelated entities, the premiums paid by the affiliated group should be deductible as insurance premiums and should no longer be characterized as payments to a reserve from which to pay losses.

"Risk distribution and risk transfer would be present, and the arrangement is no longer in substance equated with (non-deductible) self-insurance," the opinion concluded.

In a footnote to this section, the

judges said they would not attempt to determine without expert testimony what proportion of unrelated business would produce deductibility of parent premiums, though they added they "cannot believe" that at least 50% of unrelated business would not result in sufficient risk transfer.

However, in a separate opinion concurring with the result of the review, U.S. Tax Court Judge William A. Goffe assailed the majority's rejection of the economic family theory.

While previous case law has treated the concepts of risk distribution and risk transfer separately—requiring both to be present to allow a premium deduction—the majority equated risk distribution that includes writing third-party risks with risk transfer, Judge Goffe said in his opinion, which was joined by two other judges.

The only expert testimony at the trial supported the economic family theory, maintaining that no

amount of unrelated business written by Insko would result in risk transfer for Gulf, Judge Goffe pointed out.

"I question why, under the majority's theory, some magical percentage of unrelated premium is critical to transform risk distribution into risk transfer," Judge Goffe wrote.

He also questioned the majority's wisdom in adopting a "new and novel theory" without the benefit of further argument by the parties.

Separately, the majority also rejected the IRS's position that premiums paid to Insko by foreign Gulf affiliates and claims paid by Insko to Gulf and its domestic affiliates were "constructive dividends" to the parent company.

While the IRS may appeal the portion of the ruling dealing with constructive dividends, it cannot appeal the section dealing with premium deductibility because the court ruled in the IRS's favor, even though the court rejected the economic family theory, lawyers familiar with the case point out.

Chevron Corp., which acquired Gulf in 1984, will probably press the premium deductibility issue in later tax years, when Insko wrote larger volumes of unrelated business, according to John Ross, Chevron's general tax counsel and former chief tax officer of Gulf.

The IRS is still auditing Gulf's returns from 1978 forward and has not yet disallowed the deductions, Mr. Ross said.

Few captives are expected to make any moves based on the Gulf decision alone.

"Clearly this is not a strong precedent," said Alan Page, a senior vp with J&H. "I don't think anyone would say this is it. It's premature."

Janice Hackett, vp with the research and development division of Corroon & Black Corp. in Nashville, Tenn., also noted that tax considerations have played a smaller and smaller role in captive operations as IRS rulings and successive pieces of U.S. tax legislation have removed the tax benefits of maintaining a captive.

"I question whether one decision is going to change 10 years of history for us," Ms. Hackett observed.

However, some observers predict that if the tax court grants a parent company a premium deduction in another case based on a captive's book of unrelated business, some captives then might step up their third-party underwriting.

"I think for existing captives there will be a lot of attempts to get into third-party business," said William Bradley, a lawyer with Sutherland, Asbill & Brennan in Atlanta.

Captives that already are writing a significant volume of unrelated risks are the most likely to step up this activity in hopes of gaining a premium deduction for their parents, others say.

But, captives that have written relatively little third-party business may be hesitant to assume the volume that may be required to sustain a deduction.

"To go from 20% (unrelated business) to 50% strikes me as doing something totally different," Mr. Betterley observed.

"Third-party business is dangerous. Most underwriters are still a little gun-shy," observed Daniel Dinur, executive vp for American Contractors Insurance Group Inc., the holding company for the U.S. units of Bermuda-based American Risk Transfer Insurance Co. Ltd.

"To get to 50% is a big business diversification and should not be taken lightly," he said.

Mr. Dinur said that the possibility of premium deductions could encourage captives to seek out sources of relatively safe third-party business, like captive pools or the Bermuda-based Risk Exchange Assn., of which ARTIC is a member.

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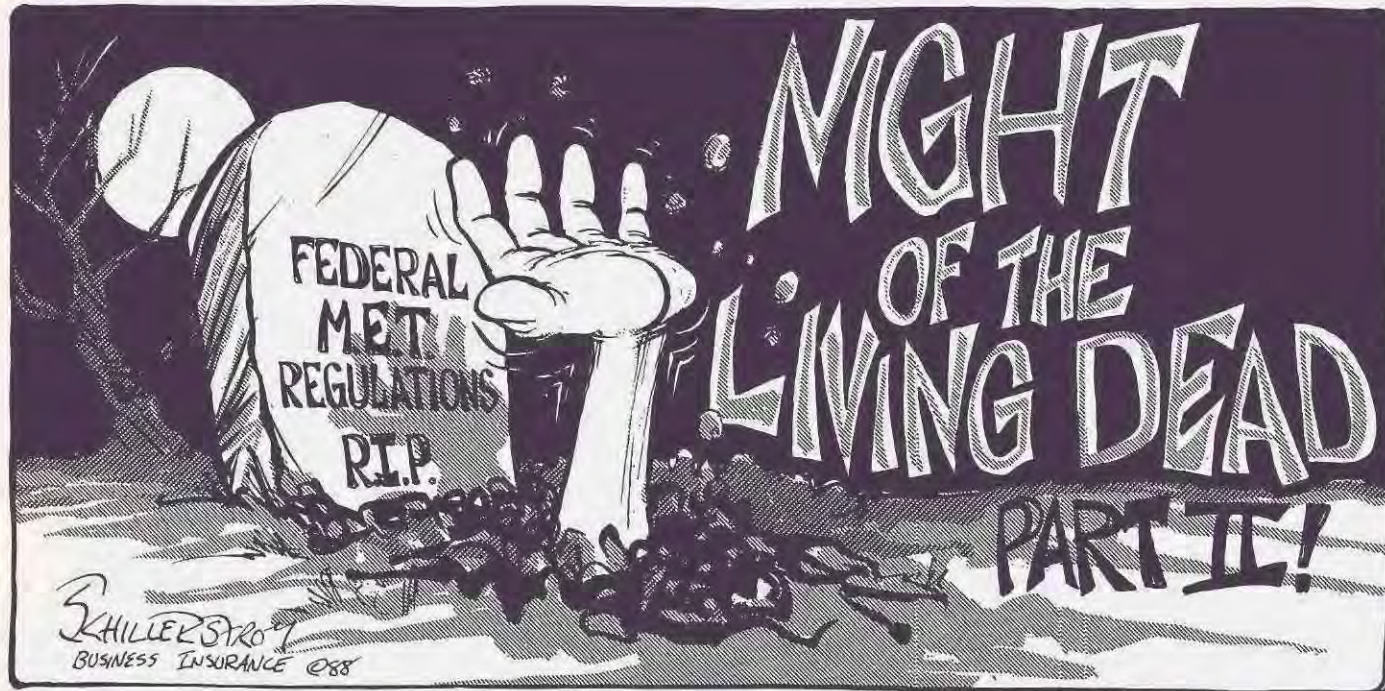
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# Opinions



## Opening Pandora's box

CONGRESS CAN and should do more to make group health care coverage more affordable to small employers, but relaxing the rules governing the operation of self-funded multiple employer trusts is not the answer.

A staff report prepared for House Small Business Committee Chairman John LaFalce, D-N.Y., proposes that the Employee Retirement Income Security Act be amended to make it easier for small groups of employers to self-insure their health care benefits.

According to the report, witnesses who testified before the committee said provisions of ERISA have prevented employers from forming pools to self-fund their group health plans. The witnesses suggested that ERISA be amended to permit all employers to band together to self-fund their group health care benefits.

"We can reduce health insurance costs by removing the regulatory obstacles that discourage small businesses from forming insurance pools," said Rep. LaFalce, noting that the federal government should encourage pooling arrangements, such as METs, rather than impose what he calls costly and burdensome regulations on their operations.

But there is no mention in the report of why Congress imposed tough regulation on these self-funded METs in the first place.

Unlike today, when benefits legislation often is passed in the dead of night with no hearings and little thought given to social policy implications, congressionally imposed restrictions on METs came after years of well-documented abuses.

A decade ago, self-funded METs were promoted as a way of providing affordable group health insurance to small employers. Typically, METs were organized by those with an insurance claims or sales background. Those organizers brought together small employers and established pools—or METs—to provide coverage. Premiums paid by the employers were supposed to cover claims costs.

The METs filed with the Labor Department as employee benefit plans and argued that pre-emption provisions in ERISA barred state regulation of them. The Labor Department, though, failed to set standards for the METs. At the same time, the METs, in some cases, sued to block state regulation after state officials said the METs were unauthorized insurers.

In this regulatory void, poorly managed self-

funded METs around the country went bankrupt, leaving tens of thousands of people with millions of dollars in unpaid medical bills. The failure of the METs often was attributed to poor reserving practices, inadequate rates and exorbitantly high commissions to agents.

Late in 1982, Congress finally took the offensive to put an end to the self-funded MET scandal (*BI*, Dec. 27, 1982). Legislators amended ERISA to make clear that self-funded METs—until they were certified by the Labor Department as bona fide benefit arrangements meeting specific criteria—would have to meet all state insurance regulations.

If not, the state could force them out of business.

And, even if a self-funded MET is recognized by the Labor Department as an ERISA benefit plan, it still is subject to state insurance laws governing contributions and reserves to pay claims.

With the passage of the legislation, poorly managed self-funded METs were put out of business. And fast-buck entrepreneurs no longer could start programs—often aimed at unsophisticated small employers—with little or no regulatory oversight.

We have no doubt that a new round of MET failures—again with devastating results—would begin if Congress turned back the clock and removed many of the restrictions legislators carefully imposed on METs.

Automatically exempting self-funded METs from state regulation and allowing them to be regulated by the Labor Department is not the answer. The Labor Department simply lacks the resources to regulate these plans.

There is an obvious analogy here. The Risk Retention Act of 1986 does not provide for federal regulation of groups of businesses that band together to self-fund their liability risks. It provides for state regulation, albeit too little in the minds of some state regulators.

Congress can act to increase the affordability of health care coverage for small employers.

For example, Congress should, as the report recommends, amend the tax code to allow unincorporated business owners to take a full tax deduction—and not the current 25% limit—for their health care plan expenses.

Legislators also should pre-empt states from mandating what benefits must be offered in group health care plans sold by commercial insurers. These mandates drive up health care costs for large and small employers.

**Poorly managed self-funded METs went bankrupt, leaving millions of dollars in unpaid medical bills.**

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# Self-funded METs

Continued from page 1

"It is suicidal to allow entities like this to self-fund" without imposing specific solvency requirements, because there is "too much unpredictability" about claims, said Claude Dorais, an attorney and an expert on METs with the firm of Dorais & Wheat in Los Angeles.

While the problem of health insurance costs for small businesses is a very real one, "that does not suspend the laws of actuarial science or prudent judgment or good business sense," Mr. Dorais said.

However, Rep. John J. LaFalce, D-N.Y., chairman of the Small Business Committee, said the "government should provide incentives for small group insurance pools, rather than discourage them with costly and burdensome regulations."

And, a committee staff member said the recommendation was not an effort to revoke the 1982 law. He said the report is intended only to suggest options for other congressional committees to consider.

He added that specific legislation would be developed by the committees with jurisdiction over ERISA issues, like the House Education and Labor Committee.

The 1982 law was passed following the failure of many self-funded METs, which resulted in millions of dollars of unpaid medical bills.

In California, for example, two self-funded METs—the Hospital Welfare Assn. Trust and the National Multiple Employers Foundation—collapsed in 1977, leaving thousands of persons with unpaid medical claims that reportedly exceeded \$7 million (BI, May 16, 1977).

In addition, self-funded METs collapsed in Illinois, California, Texas, Idaho and other states during the late 1970s and early 1980s (BI, Sept. 7, 1981).

For more than five years before the Congress enacted the ERISA amendment in 1982, state insurance departments had fought for the power to shut down mismanaged self-funded METs, saying they were no more than unauthorized insurance operations. However, the administrators of the self-funded trusts said the trusts were employee benefit plans that were protected from state regulation by ERISA.

Under the 1982 law, a self-funded MET—also called a multiple employer welfare arrangement, or MEWA—is presumed not to be an ERISA plan until it is certified as such by the U.S. Department of Labor.

For the Labor Department to recognize a self-funded MET as a bona fide employee benefit plan, the plan must prove, among other things, that it is controlled by the participating employers and not by a third-party administrator.

However, even if a self-funded MET is recognized by the Labor Department as an ERISA benefit plan, it still is subject to state insurance laws governing reserves and contributions by participants.

Since the law took effect in 1983, the Labor Department has not certified any self-funded METs as bona fide employee benefit plans under ERISA, according to a department spokeswoman.

The 1982 law "in essence transferred authority over (METs) to state insurance commissioners" and the Labor Department still stands by this, the spokeswoman said.

Employee benefit plans offered by individual employers, rural electric cooperatives or plans provided through collective bargaining agreements are still regulated under ERISA.

If the 1982 law were overturned and self-funded METs were no longer subject to state regulation, some of the trusts definitely would

end up in bankruptcy, asserted David Brummond, assistant general counsel and assistant vp of the National Assn. of Independent Insurers in Des Plaines, Ill.

Mr. Brummond, who worked as a counsel to the National Assn. of Insurance Commissioners in the 1970s on the MET issue, admitted that there is "some legitimacy" to the theory that self-funded METs should be exempted from state regulation to lower their cost of providing health insurance.

"There is a cost to regulation," Mr. Brummond said, adding that the cost of regulating self-funded METs is borne by employers purchasing benefits.

However, "the question is whether it's worth the cost borne by the employee benefit delivery system to ensure that the money is there when claims are due," he concluded.

James Klein, manager of pension and health care policy for the U.S. Chamber of Commerce in Wash-

**'It is suicidal to allow (METs) to self-fund' without solvency requirements, says Claude Dorais.**

ington, D.C., said that the Chamber is "very much in favor of doing whatever can be done to encourage METs."

However, "We do not quibble with the need to ensure that they're adequately backed" with the proper financial resources, he added.

Mr. Dorais noted that state insurance laws that require companies selling direct health insurance policies to have minimum capital and surplus protect employers and consumers from problems they faced when they bought coverage from some self-funded

METs in the 1970s.

He said that state capital and surplus requirements "represent a concrete embodiment of the promise" that if premiums do not cover the cost of claims, those claims still will be paid.

While acknowledging that small employers face high health care benefits costs, he said the committee's recommendation would be "only tracing one problem for another."

The House committee report, in addressing ways to expand health insurance coverage among the uninsured, also recommended increasing the tax deduction on health insurance premiums for the self-employed to 100% from 25%.

Rep. LaFalce already has introduced legislation, H.R. 3065, to amend the Internal Revenue Service tax code to allow a 100% deduction for the costs of health insurance premiums for self-employed persons and owners of unincorporated businesses.

Under the Tax Reform Act of 1986, self-employed persons and owners of unincorporated businesses can for three years beginning in 1987 deduct 25% of the cost of health insurance premiums, provided they extend similar health insurance coverage to their employees.

Previously, these business owners could not deduct any costs related to health insurance premiums.

The report also recommends enactment of legislation twice killed by Congress that would have allowed states to establish employer-subsidized health care pools to provide coverage to high-risk uninsured individuals.

Under the recommendation, all employers with 20 or more employees could be required to participate in their state's health insurance pools (BI, Dec. 28, 1987; July 20, 1987).

A similar proposal died last year in a joint conference committee. ■

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# Environmental conviction

Continued from page 2

It was not until search warrants were issued in March 1986 that the 66-year-old family-owned and operated company learned that any of the company's 95 workers were being endangered, said Mr. Palmer.

However, EPA and health department officials say companies operating hazardous waste sites have an obligation under federal law to monitor their operations, test employees annually for their exposure to hazardous chemicals and train them to use protective equipment and clothing.

In fact, the judge in the case would not allow the jury to be told that Protex was not promptly informed of test results.

In addition to the three endangerment counts, Protex also was convicted of 12 felony violations of federal laws for operating a facility for the treatment, storage and disposal of hazardous waste without a permit and defrauding government officials by "false statement, material omission and concealment" between September 1982 and April 1987.

In addition, Protex was found guilty of one misdemeanor for discharging pollutants into the South Platte River.

No decision has been made on an appeal, Mr. Palmer said.

Protex was found innocent of two counts of knowingly storing hazardous waste on March 10, 1986.

Charles Vesta Hyatt, Protex's comptroller, pleaded guilty late last year to misdemeanor charges of making false statements and illegally discharging wastes. He received one

year of probation and a \$3,000 fine.

And, Donald J. Wilson, Protex's vp and chief operating officer, still faces 11 felony charges, including 10 counts of illegally storing or disposing of hazardous wastes. Mr. Wilson is the son of the company's founder and president.

In November 1980, Protex requested a "Part A" permit from the EPA that would allow it to treat, store and dispose of hazardous waste.

However, in August 1982 it withdrew that request. Instead, Protex told federal officials it wanted only to be "a small-quantity generator" of hazardous waste, which would be disposed of elsewhere, the 11-page indictment said.

Samples collected during government inspections in July 1984 and August 1985 revealed hazardous wastes at the site, where workers sometimes dumped the contents of used drums on the ground, according to government officials.

"It was a chemical nightmare," Mr. Smith said.

An October 1986 inspection by the Occupational Safety and Health Administration found violations including lack of proper ventilation, lack of explosion-proof electrical equipment, lack of an eyewash facility, inadequately fitted respirators, incomplete material safety data sheets and combustible paint residues. These violations resulted in a \$960 penalty, which Protex paid, an OSHA spokesman said.

Although information from the OSHA inspection was presented during the jury trial to bolster the Justice Department's case, OSHA violations were not charged because it would be duplicative, Mr. Smith said.

Protex is now inspecting and cleaning up its site in Denver as part of a plan it was required to file with the Colorado Department of Health, said Nancy Jackson, a compliance and enforcement officer with the department.

Protex has insurance to pay the cleanup costs, said Paul Phillips, a Protex attorney with Holland & Hart in Denver. However, the company would not elaborate.

Protex, which is considering selling the company, also may face civil lawsuits for damages caused by its operations.

Attorney Walter L. Gerash said he notified Protex that a nearby businessman may sue the company, alleging that well water at his business was contaminated by Protex's illegal disposal and drinking the water caused him bodily injury.

In addition, the three Protex workers, who are still employed by the company, have contacted him about possibly suing the company and/or filing workers compensation claims, he said.

The Justice Department is putting "a top priority" on prosecuting white-collar criminals through enforcement of federal laws, including environmental regulations, said Judson Starr, chief of the department's Environmental Crimes Section of the Land and Natural Resources Division.

The section has obtained 356 indictments against individuals and corporations since it was created in fiscal 1983, which so far have resulted in 267 convictions and guilty pleas. A total of 55 accumulated years in jail terms have actually been served and \$6.5 million in fines levied, according to the Justice Department statement.

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## Landoil suit

Continued from page 3

A&A has not filed a response to the Landoil suit because of motions pending to dismiss the case.

The lawsuits filed against the Lloyd's underwriters and A&A center on losses primarily stemming from the termination of contracts and/or withholding of payments for four Landoil construction projects in Libya and Iraq between 1982 and 1983.

The suit against A&A says the broker proposed in December 1981 to consolidate Landoil's various political risk coverages under one package policy that included coverage for loss of profits. A&A sent representatives to Manila in March 1982 to examine Landoil's operations and in late May presented a proposal to Landoil for an integrated political risk program.

Landoil subsequently appointed

A&A as its exclusive worldwide insurance broker, court papers say, and A&A began coverage negotiations with Lloyd's underwriters Ian R. Posgate and Richard M.H. Outhwaite through its Lloyd's brokerage subsidiary, Alexander Howden Insurance Brokers Ltd.

Landoil says it relied on A&A to advise it regarding the information the underwriters would need to properly write the coverage.

The suit further alleges that in the course of Landoil's discussions and correspondence with A&A, the broker "learned or should have learned of various problems and disputes, including difficulties with performance delays, which had arisen with respect to various of the Landoil Group's construction contracts in the Middle East." Landoil charges that it was A&A's responsibility to advise the underwriters of these problems.

In late June 1982, A&A asked

Landoil for authority to terminate its existing political risk insurance on a Libyan road project, court papers say. Landoil says it granted that authority after receiving a July 2 telex from A&A advising the company that a \$50 million worldwide political risk policy was "bound and placed at Lloyd's."

The premium for the contract was \$2 million, "with a provision for upward adjustment based on reported contract billings."

The telex further said that while the precise contract language had not yet been agreed on, "the policy will contain no right of cancellation by either underwriters or Landoil," the suit says.

On July 13, 1982, Landoil says it informed A&A that the Libyan government had terminated a 1981 contract for the training of Libyan students. Landoil estimates the contract termination would cost it \$3.5 million in unpaid fees and loss of future profits.

In response, A&A expressed its concern "that the wording of the policy with respect to loss of future profits had 'not been defined and agreed as yet,' notwithstanding A&A's earlier representation to Landoil on July 8 that, despite the lack of agreed language, loss of future earnings 'should be considered part of contract frustration cover,'" the suit says.

On July 29, A&A told Landoil that the lead underwriter refused to continue discussion about the policy language "until he obtained further information about the Libyan student training claim," the suit says.

"Consequently, A&A set forth specific questions to Landoil about the status of all other Landoil Group projects. A&A now stressed the importance and urgency of a response," the suit adds.

Landoil says it complied with A&A's request for detailed information, but in late August 1982, A&A told Landoil that the underwriters had decided to rescind the July 1 coverage "because of alleged non-disclosure by Landoil of a material fact: delays in payment by the Libyan government in the student training program."

According to the suit, A&A on Aug. 30 persuaded Landoil to "relinquish any rights" it might have under the policy "in exchange for the very broad coverage we would have in effect for existing contracts. A&A did not explain to

Landoil why the waiver was necessary, given A&A's earlier representation that all Landoil contracts were covered by the policy. . . ."

Meanwhile, following the cancellation, A&A appointed a new Lloyd's broker, Sedgwick Group P.L.C., "in place of or in addition to Howden." Landoil alleges that this was done because of disputes among A&A, Howden and Mr. Posgate, who was one of the lead underwriters on the first policy.

(In September 1982, A&A fired Mr. Posgate, who was head of Howden's Lloyd's underwriting unit, charging that he and four other Howden executives had diverted up to \$55 million in Howden funds for their own use.)

The suit states that upon review of the Landoil account, Sedgwick advised A&A and Howden that the placement "had not been conducted in a competent manner" and it refused to handle the account until it received a "hold-harmless" agreement. A&A did not inform Landoil of Sedgwick's stance, the suit says.

At this point, Mr. Posgate refused to reinstate Landoil's original coverage and Mr. Outhwaite became the sole lead underwriter for the account, the suit says.

The suit charged that A&A's ability to reinstate its original policy was "impaired and undercut" because of the disputes among A&A, Howden and Mr. Posgate.

Also, in late August, the underwriters requested a description of each of Landoil's existing contracts, with the purpose of exempting from coverage those projects that were not judged to be "going concerns."

This "vetting process" continued from September to December 1982. Landoil charges that during this period, A&A had full access to all of its files and that Landoil fully cooperated with any requests.

Meanwhile, on Sept. 30, A&A informed Landoil that a second political risk policy led by Mr. Outhwaite's syndicate was bound, subject to the vetting process. The policy contained the same terms and conditions as applied under the first contract except that the underwriters only would be liable in the event of the contract was terminated for breach of contract, the suit says.

In addition, the second policy would cover all projects from Sept. 30, 1982, though coverage—following review of information from A&A—could be denied for any project "that was not viable or was subject to a serious risk of premature termination or other major problem" as of Sept. 24, 1982.

In exchange, Landoil says it waived all claims against the underwriters under the first policy regarding the Libyan student training contract.

A&A continued to proceed with the vetting and sent a report to the underwriters in mid-November, the suit says. The report was "initiated as 'seen' by Outhwaite, the lead underwriter," the suit adds.

The suit says, the report "described explainable delinquencies and 'inherent delays' connected with doing business in the Middle East, but concluded that A&A 'uncovered no evidence of any adverse situations or circumstances that might reasonably be expected to give rise to a loss insurable under the Lloyd's political risks insurance issued to Landoil.'"

Meanwhile, at the end of October, the Libyan government terminated a road project contract "with allegations of default against the Landoil Group member involved." Landoil says it informed A&A of the termination on Dec. 9, 1982, and that A&A had also "learned of problems in respect to two other Libyan projects during its investigation." However, Landoil alleges that A&A did not inform the underwriters of these developments until February 1983.

In late December 1982, Landoil alleges it received a copy of a cover letter from Sedgwick describing the coverage in effect. Attached was an endorsement stating: "It must be recognized, however, that if a contract is in default (due to non- or late payments) or in dispute, this is a material fact, which would cause underwriters to void the contract if a claim arises."

On April 30, 1983, Landoil submitted a \$5.7 million claim on the Libyan road project to its underwriters.

Landoil submitted a second preliminary claim to its underwriters in March 1983 arising from problems involving a separate contract with Libya to construct roads, terraces and irrigation works. In September 1983 Landoil submitted a formal claim of \$11.8 million in losses over wrongful calling of a performance bond and wrongful termination of the joint venture agreement on this project.

Landoil submitted a third preliminary claim to underwriters in June 1983 stemming from the repudiation and termination of a housing construction contract by Iraq. It filed a formal claim of \$2 million in September 1983.

Landoil filed a fourth preliminary claim in March 1983 over a housing subcontract with an Iraqi development agency. Work was suspended on the project due to hostilities between Iran and Iraq in July 1982, and the project was abandoned in November 1982. Landoil submitted a formal \$20.8 million claim in September 1983.

When A&A tried to renew Landoil's coverage in September 1983, Mr. Outhwaite refused to renew the coverage and canceled the expiring policy from its inception due to material misrepresentation and non-disclosure of information about Landoil's Middle East problems, the suit says.

Mr. Outhwaite said in 1986 that he canceled the policy because the claims involved Landoil contracts that were in dispute before the policy went into effect.

In its suit, Landoil accuses A&A of:

- Fraud and misrepresentation for assuring Landoil that it could provide worldwide political risk coverage and breach of obligation for failure to do so.
- Breach of agreement for failure to secure coverage for the student training project in Libya.
- Breach of obligations involving the reports A&A submitted to underwriters during the vetting process.
- Breach of agreement for failure to successfully obtain the second policy.

The suit also accuses A&A of RICO violations, stating that "the misrepresentations, frauds and schemes to defraud Landoil . . . involved two or more uses of the wires and mails constituting a pattern of racketeering activity."

Furthermore, Landoil accuses A&A of civil conspiracy, stating: "Defendants intentionally acted in concert with each other, with Howden, with Sedgwick and with others, and according to a common scheme, to defraud Landoil."

The suit alleges that Landoil was unable to procure political risk coverage from any other source, making it impossible for the company to continue its business.

"Landoil believes that it has very sound claims against A&A and it intends to litigate to a conclusion," says Mr. Hamilton, Landoil's attorney. He estimated that it would take at least two years for the case to reach trial.

Meanwhile, the \$540 million suit filed by Landoil against Lloyd's and the Lloyd's underwriters, including Mr. Outhwaite, is still pending in the Philippines. Lloyd's offered Landoil less than \$5 million to settle the suit in the fall of 1986, but Landoil rejected the offer (BI, Nov. 17, 1986).

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# N.J. doctors may face premium surcharge

TRENTON, N.J.—The New Jersey Insurance Department is proposing a 4% surcharge on the medical malpractice insurance premiums paid by the state's 15,000 physicians, chiropractors and podiatrists to finance claims against a now-deactivated special malpractice insurance association.

The New Jersey Medical Malpractice Reinsurance Assn. had insured 3,750 physicians and podiatrists between 1977 and 1982 and had reinsured commercial medical malpractice insurers, said a department spokesman. Members of the association were the state's property/casualty insurers.

The association, which the Legislature created in 1976, was deactivated in 1982 when medical malpractice insurance became readily available. The association now has anticipated claims of about \$82 million, but only \$22 million in reserves, according to the department.

The department said it wants to order a surcharge on all doctors in the state rather than only on those insured by the association because the facility had helped stabilize the state's medical malpractice market for all doctors.

A 4% surcharge would amount to a \$528 increase for the average New Jersey doctor who paid medical malpractice insurance premiums of \$13,206 in 1987. Insurers currently providing coverage will collect the surcharge and remit the proceeds to the state.

The surcharge may be lowered in future years, according to a department spokesman, who said it is uncertain how long the surcharge will have to be collected.

The surcharge plan was submitted to the State Office of Administrative Law as a "pre-proposal." After a period for public comment, the formal regulation process will begin. It is expected to take several months before the surcharge plan wins final approval, the spokesman said.

Last year, a special task force and the Insurance Department developed a series of proposals on medical malpractice, one of which was the creation of a Medical Insurance Performance Program under which the burden of preventing medical malpractice would fall primarily on hospitals (BI, Oct. 5).

The recommendations are expected to be implemented over the next year through a combination of legislation and regulation, the spokesman said.

—By Judy Greenwald

## California reform

SACRAMENTO, Calif.—Insurers and trial lawyers have proposed conflicting ballot initiatives on insurance reform issues in California—a move that could break down the peace agreement the traditional rivals reached last fall.

The Assn. of California Insurance Companies and the California Trial Lawyers Assn. filed the initiatives with state officials last month in response to an onslaught of insurance reform measures sponsored by consumer groups and individuals.

Although the insurers' and trial lawyers' proposals attack each other's interests, both claim the truce declared in September has not yet been violated.

"Between us we haven't thrown down the gauntlet, quite the opposite," said J. Gary Gwilliam, president of the California Trial Lawyers Assn.

The groups have remained in contact with each other and were informed that each would propose ballot measures protecting their interests, Mr. Gwilliam said.

## Around the states

At stake is an agreement between the lawyers and insurers that led to the enactment of tort reform measures in the last legislative session and promised future cooperation, including a prohibition on sponsorship of initiative campaigns for five years (BI, Oct. 5).

Both sides say they filed their initiative petitions with the state attorney general's office as precautionary moves intended to protect themselves in case a negotiated agreement is not possible.

"We still hope for a legislative solution early next session," said George Tye, executive director of the Assn. of California Insurance

Companies. "The peace, while being strained, has certainly been respected by both sides."

"We feel there's still a reasonable probability of resolving this through the legislative process," Mr. Gwilliam said. "We don't see this as a violation of our truce."

But the groups agree that if satisfactory resolution of insurance issues in California does not emerge in the first month or two of this year's legislative session, the result may be a free-for-all decided by voters next fall.

The Legislature opened its 1988 session on Jan. 4, but did not address the insurance issues during the first days.

The insurers and lawyers association had negotiated a "flex rating" plan with several consumer groups last fall, but state legislators declined to consider the issue during a special session in November. The plan would have allowed the state Insurance Department to reject commercial lines rate hikes exceeding 25% and personal lines rate increases exceeding 15%.

However, legislators were not interested because the proposal did nothing to lower auto insurance rates, Mr. Gwilliam said.

"Auto insurance is really driving the debate right now," he said.

The California Trial Lawyers Assn. has proposed an initiative that would:

- Require "good driver" rates that would be 25% lower than the

next lowest rate for policyholders who have one or no traffic tickets in the past three years. Insurers could not cancel policies for policyholders rated as "good drivers."

- Ban no-fault auto insurance and prohibit limits on attorney fees in auto cases.

- Require one-year suspensions of driver licenses for minors convicted of driving while intoxicated.

Insurance groups, led by the Assn. of California Insurance Companies, proposed an initiative that would:

- Cut liability insurance premiums by an average of 20% by instituting no-fault automobile insurance. Insurance companies would be required to document the mandatory rate reductions and submit them to the Insurance Department.

Continued on next page

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## Around the states

Continued from previous page

• Limit attorneys' fees to 33% of the first \$50,000 of an award, 25% of the next \$50,000 and 15% for amounts exceeding \$100,000.

—By Glenn Huntley

### Illinois malpractice

SPRINGFIELD, Ill.—Medical malpractice insurance rates for some Illinois physicians have been reduced as a part of an agreement between the Illinois Insurance Department and the St. Paul Fire & Marine Insurance Co.

Rates fell 10% on Jan. 1 for physicians in most Illinois counties renewing their claims-made medical malpractice coverage with St. Paul. Meanwhile, rates for physicians in Chicago, its suburban counties and two Illinois counties bordering St. Louis were un-

changed.

The agreement came after the Insurance Department questioned whether a 66.2% medical malpractice rate hike effective July 1, 1987, would also apply to physicians' tail coverage, according to a spokesman for The St. Paul Cos. Inc.

The rate hike request was filed April 27, 1987 by St. Paul Fire & Marine Insurance Co., St. Paul Mercury Insurance Co.—both based in St. Paul, Minn.—and Chicago-based St. Paul Insurance Co. of Illinois.

Under Illinois law, medical malpractice insurers follow a "use and file" procedure in which insurers can put a rate change into effect without state approval, but must file the change within 30 days of its effective date. The state cannot disallow or alter the rate change without holding a formal hearing.

After several discussions, the Insurance Department and the insurers agreed that:

• All policyholders insured by St. Paul June 30, 1987, will be offered tail coverage based on their annual pre-rate increase premium, regardless of whether they initially purchased tail coverage.

• Tail coverage on all future policies will be calculated on the basis of the previous 12 months' premium rather than on the rate in effect at the time of purchase.

• The 1987-88 claims experience will be examined in 1990 as part of a retrospective rating plan. If claims costs are lower than the estimates on which underwriters calculated the increased premiums, physicians could receive a refund with interest.

"We believe the agreement enables us to continue to offer physicians' medical liability insurance in Illinois and is in the best interest of Illinois physicians," said the St. Paul spokesman.

The rate reductions for physicians outside of the two urban areas reflected a reduction in the frequency and severity of claims, the spokesman explained.

St. Paul writes medical malpractice insurance for about 4% of Illinois' physicians and surgeons.

—By Mark A. Hofmann

### Georgia reviews hike

ATLANTA—Georgia Insurance Commissioner Warren Evans is expected to decide this month whether to approve a 28.8% average rate increase for physicians and surgeons professional liability coverage filed by MAG Mutual Insurance Co. in Atlanta.

The rate increase, which went into effect in April 1987, was challenged by Commissioner Evans in August as "unreasonably high." MAG Mutual is the second-largest writer of physicians liability coverage in the state and insures about one-third of all Georgia doc-

tors, according to the department.

The department held a public hearing in December to allow MAG Mutual to justify its rate increase. If the commissioner denies the rate increase, MAG Mutual would be forced to refund the difference to policyholders, according to a department spokesman.

—By Linda J. Collins

### Alaska tort reform

ANCHORAGE, Alaska—Tort reform advocates say they have collected more than enough signatures to put their proposal, which abolishes joint and several liability, on Alaska's November ballot.

The Citizens Coalition for Tort Reform had gathered 23,500 signatures by late last week and expected to turn in a total of 24,500 signatures when it filed the petition with the state Division of Elections, said Mark Dinneen, the group's executive director.

The proposal would restrict liability for damage payments in civil cases to a percentage of fault assigned to each defendant.

The coalition needs 18,256 valid signatures from registered voters to place the issue on the ballot, Mr. Dinneen said. The extra signatures should be adequate to compensate for invalid signatures, he said.

Pure several liability was part of a tort reform package considered by the Alaska Legislature in 1986, but a compromise version was passed in order to secure approval of the other provisions.

Lt. Gov. Stephen McAlpine has 60 days to certify the initiative petition, Mr. Dinneen said.

—By Glenn Huntley

### OSHA fine

LOS ANGELES—The federal Occupational Safety and Health Administration has proposed \$91,300 in fines for safety violations alleged against Pace Setter Inc., a Los Angeles muffler manufacturer.

The December penalties were the result of an inspection instigated after a worker lost half a hand, a thumb and three fingers in a piece of equipment last July, OSHA officials said.

The fines were the largest proposed since OSHA began regulating California work safety programs on July 1. OSHA took over regulation in California after Gov. George Deukmejian vetoed funding for the state program last spring (BI, Nov. 2, 1987).

However, it was not the July incident alone that inspired OSHA to act against the muffler manufacturer, said Hamilton Fairburn, deputy OSHA administrator in San Francisco.

"We were concerned not just by what we found, but by what had transpired before," he said.

The fines included \$10,000 each for eight "willful" cases in which the employer knew or should have known about inadequate safety precautions, a U.S. Labor Department spokesman said.

The federal agency alleges the company failed to install safety guards on punch press machines.

The balance of \$11,300 in fines was due to 54 serious violations of safety regulations that varied from failure to provide guards on equipment start buttons to failure to protect against electrical shock, the spokesman said.

Pace Setter has appealed the findings to the Occupational Safety and Health Review Commission in Washington, D.C., said Vice President Jim Stavits.

Several of the incidents cited by OSHA were "far more minor" than indicated by the agency, he said. Even though the company is appealing the fines and is contesting the allegations, publicity surrounding the case may already have had its effect, he said.

—By Glenn Huntley

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**Comings & goings: buyers**

# New York Archdiocese hires insurance director

**Daniel J. Johnson** has been named director of insurance for the Archdiocese of New York. In this newly expanded position, he oversees insurance and employee benefits for the archdiocese, which includes Manhattan, Staten Island, the Bronx and seven counties in New York state. Mr. Johnson reports to Richard Costello, first deputy of finance. Mr. Johnson served as casualty insurance manager for American Broadcasting Cos. Inc. in New York. He holds a bachelor of arts degree from Fordham University in the Bronx and attended the New School of Social Research in New York City.

as risk/insurance administrator for Oki America Inc. in Hackensack, N.J. Prior to that she was technical assistant for American Risk Management Inc. Ms. Greenhill holds a bachelor of science degree in economics from Rhodes College in Memphis, Tenn.

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**Joseph A. Lewis**, 40, has been named vp and risk manager of Ameritrust Co. National Assn., a Cleveland-based bank. In this newly created position he oversees risk management programs including property/casualty and fidelity insurance. He reports to Daniel A. Pavsek, vp and economist. Mr. Lewis previously served as corporate insurance manager for Leaseway Transportation Corp. in Cleveland. He holds a bachelor of arts degree from Bowling Green State University in Bowling Green, Ohio, and a doctor of law degree from Cleveland-Marshall College of Law at Cleveland State University. He is a deputy member of the Risk & Insurance Management Society and a member of the Cleveland, Cuyahoga and Ohio bar associations.



Mr. Lewis

**Gregory F. Hidden**, 38, has been named risk manager for the St. Vrain Valley School District in Longmont, Colo. In this newly created position he manages the district's participation in self-funded and insured programs, directs safety and security efforts and oversees claims liaison with the district's third-party claims administrator. The school district covers 450 square miles in Colorado, with more than 15,000 students and 1,500 faculty members and staff. Mr. Hidden reports to Roger L. Driver, assistant superintendent for business services. Previously Mr. Hidden served as a loss control consultant to Jefferson County, Colo., and the Colorado County Commissioners Assn. He received a bachelor of science degree in public administration/criminal justice from San Diego State University and is a graduate of the OSHA Training Institute. Mr. Hidden is working toward his Associate in Risk Management designation.



Mr. Hidden

**Rebecca Greenhill** has been named general insurance administrator at Cox Enterprises Inc. in Atlanta. In this newly created position, she advises division and field managers on risk and insurance matters, coordinates Cox's self-insurance programs and provides overall technical support. She reports to Ted Young, corporate risk manager. Prior to joining Cox—which is involved in newspaper publishing, broadcasting, cable television and auto auction—Ms. Greenhill served

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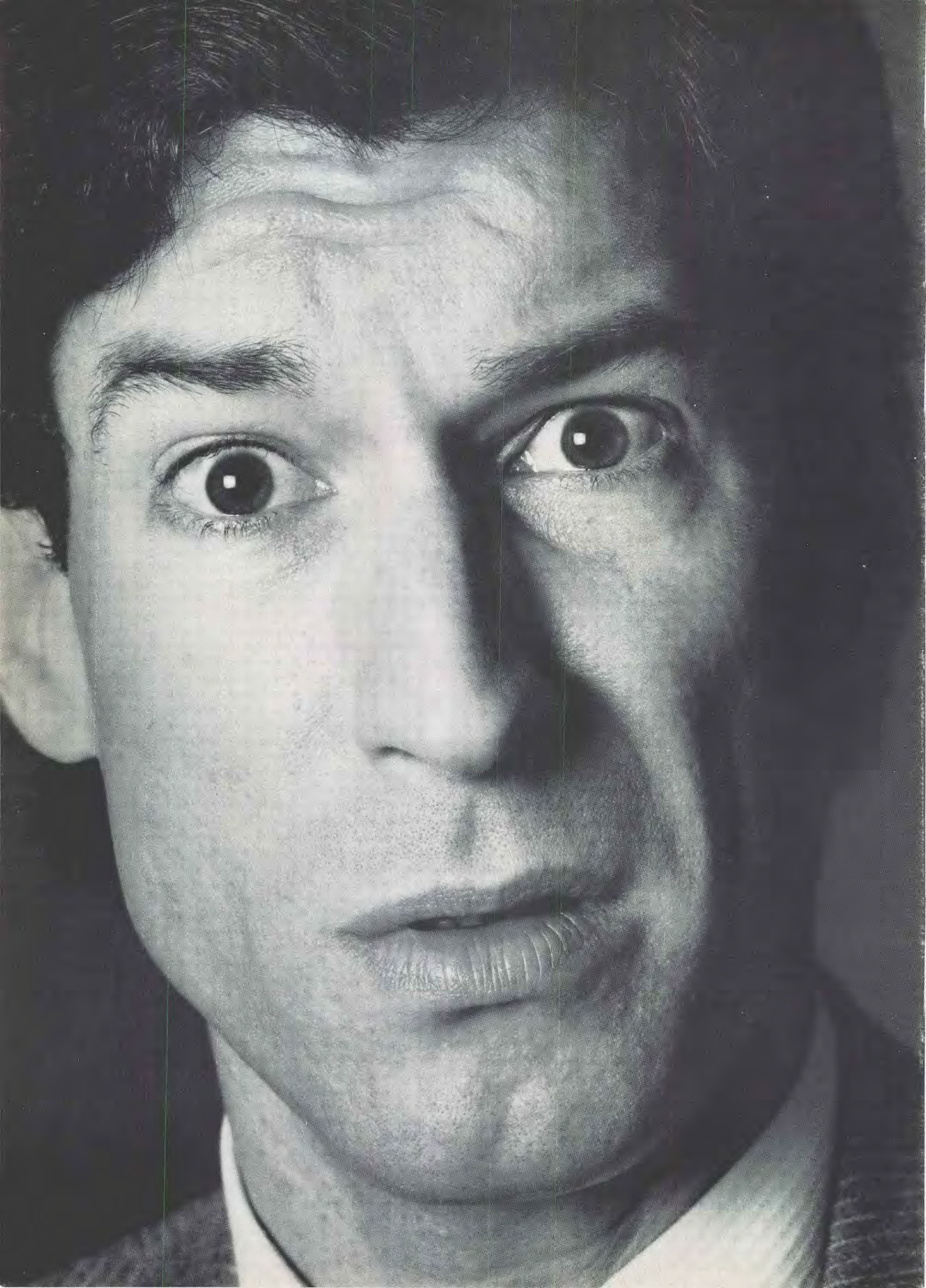
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# Captive taxes

## Gulf ruling delineates when premiums are deductible

By Gerald I. Lenrow, David K. Steffen and Craig B. Larsen

FOR MORE THAN A DECADE, various courts have been struggling with the issue of the tax deductibility of premiums paid by a parent company to a captive insurance company.

The U.S. Tax Court's majority opinion in *Gulf Oil Corp. vs. Commissioner*, 89 T.C. 70 (1987), represents a milestone in that effort. The court delineates, albeit through dicta, a method for determining when the transaction between parent and captive will qualify as a legitimate insurance transaction. Premiums paid to a captive insurer shall be deductible when the captive insurer receives 50% or more of its premium income from unrelated parties. In some circumstances, premiums paid by the parent company could be deducted by the parent when less than 50% of the captive's premiums were received from unrelated parties.

The court rejected the "economic family" concept, which the Internal Revenue Service first enunciated in Revenue Ruling 77-316, 1977-2 C.B. 53. Under that doctrine premiums could not be deducted when paid to a wholly owned captive because a real insurance arrangement could not exist in a transaction within an economic family.

The court noted that it has never endorsed the economic family doctrine. It stated that decisions in cases like *Carnation Co. vs. Commissioner*, 71 T.C. 400 (1978), affd. 640 F.2d 1010 (9th Cir. 1981), were based on the facts before the court, not on the economic family doctrine. The court stated that the focus should be upon the amount of premiums contributed by policyholders, not on the capital structure of the captive.

In 1971, Gulf incorporated Insko Ltd. under Bermuda law. Gulf formed Insko as a wholly owned subsidiary because Gulf and its affiliates were unable to insure their risks at acceptable premiums.

Gulf and its affiliates would enter into contracts of insurance with unrelated commercial insurers. By pre-arrangement, these insurers would reinsure a significant portion of their exposure with Insko. These contracts of insurance related primarily to property and liability risks.

Gulf executed a guarantee in favor of the unrelated insurers, whereby Gulf obligated itself to indemnify the insurers in the event Insko could not meet its obligations regarding the risks it reinsured. However, Gulf was never required to indemnify the insurers under these guarantees.

In its 1974 and 1975 consolidated tax returns, Gulf deducted the premiums paid to unrelated insurers as ordinary and necessary business expenses. The IRS assessed a deficiency for each year, claiming that payments made by Gulf and its domestic affiliates were not deductible insurance premiums to the extent those payments were ceded to Insko.

In addition, the IRS recharacterized the insurance premium payments made by the foreign affiliates as constructive dividends to Gulf to the extent those premiums were ceded to Insko. Payments of claims by Insko to Gulf and its domestic affiliates were also recharacterized as constructive dividends to Gulf.

Insko did not receive any premiums from unrelated parties in 1974. Insko first began insuring the risks of unrelated parties in 1975. Two percent of Insko's net premium income for 1975 was derived from the insurance of non-Gulf risks. Even though the 1974 and 1975 tax years were the only years before the court, evidence before the court indicated that premiums from unrelated parties increased to more than 50% of total premiums by 1978.

In the prior Tax Court decisions of *Carnation*; *Clougherty Packing Co. vs. Commissioner*, 84 T.C. 948 (1985), affd. 811 F.2d 1297 (9th Cir. 1987); and

*Humana vs. Commissioner*, 88 T.C. 197 (1987), the court concluded that payments to a captive subsidiary, designated as premiums, from the parent corporation or from the parent's subsidiaries, did not represent insurance payments. In each case, the court concluded that the essential elements of an insurance arrangement as enunciated in *Helvering vs. LeGierse*, 312 U.S. 531 (1941)—risk transfer and risk distribution—were not present. The court reasoned that if all the policyholders were related, the insurance was merely self-insurance because the group's premium pool was used only to cover the group's losses. By failing to shift the burden of a loss away from policyholders, a transfer of risk did not occur.

Recognizing that the facts before it were similar to those in the above cited cases, the court questioned whether the insurance of unrelated risks should provide a different result. This situation had not been considered by the Tax Court in any of the previous cases. Other courts did have this fact pattern and apparently ignored it since the level of third-party risks was de minimis (e.g., *Mobil Oil Corp. vs. United States*, 8 Cl. Ct. 555 (1985), and *Beech Aircraft Corp. vs. United States*, 55 AFTR 2d 84-6173 (10th Cir. 1986)).

In the Gulf case, the court was not specifically

**The 'economic family' concept, which said premiums paid to a wholly owned captive were not deductible because an insurance arrangement could not exist in an economic family, was rejected.**

concerned with the issue of whether the writing of unrelated risks resulted in a transfer of risk between Gulf (or its affiliates) and Insko. The court held that amounts paid by Gulf and its affiliates to Insko in 1974 were not deductible as insurance premiums. This situation, the court noted, was no different than that in *Carnation* and others previously decided by the Tax Court. With respect to premiums paid to Insko in 1975, the court came to the same result, stating that the addition of 2% of unrelated premiums was de minimis and not sufficient to result in risk transfer.

It is interesting to note that while only the tax years 1974 and 1975 were before the court, evidence was admitted with respect to later years in which the percentage of unrelated premiums was 7% in 1976, 16% in 1977, 51% in 1978, 54% in 1979, 53% in 1980, 54% in 1981, 48% in 1982, and 62% in 1983. The evidence was admitted as bearing on the degree to which Gulf intended its captive to write business for unrelated parties. This intent, Gulf said, demonstrated Insko should be treated as an unrelated insurer.

However, the court did not agree, stating that the character of the payments must be determined based upon the degree of risk shifting and risk distribution present in the tax years that were before the court. The court expressly reserved judgment with respect to the years 1976-1983 on the issue of whether the percentage of unrelated premiums in those years was sufficient to result in risk transfer.

The court stated that transfer of risk may occur when a captive is a separate, viable entity financially capable of meeting its obligations. It is the writing of unrelated risks and the concomitant operation of the law of large numbers that renders a captive such an entity. Hence, the focus is upon the premiums from the policyholders, not the capital structure of the captive.

In using this approach, the Tax Court expressly

rejected the economic family theory found in Revenue Ruling 77-316. The economic family doctrine would negate the presence of an insurance arrangement whenever the policyholder and the insurer are related through ownership.

Focusing on the composition of the premium pool held by the captive, the court stated that at some point a sufficient proportion of premiums from unrelated parties would be present such that the premiums paid by the related policyholders would no longer be sufficient to cover the anticipated losses of all the policyholders. In this event, related policyholders would have to rely on the premiums of unrelated policyholders to cover their losses. The court concluded that in this situation risk transfer and risk distribution would be present and therefore amounts paid should be deductible as insurance premiums and should not be characterized as funds committed to a reserve to pay self-insured losses.

The court indicated that it would need to hear expert testimony concerning what proportion of unrelated premiums would be sufficient before the affiliated group's premiums would be considered as payments for insurance. In a footnote, the court stated "if at least 50% are unrelated, we cannot believe that sufficient risk transfer would not be present." Since the test or standard that the court would apply in determining whether payments constitute insurance is based upon premiums, the court stated that the premiums paid by both related and unrelated policyholders must be based on reliable actuarial estimates of risk of loss and such arrangements must be negotiated on an arm's-length basis.

Judge William A. Goffe wrote a separate opinion that concurred with the result reached by the court majority. However, Judge Goffe took exception to the proposition that there are circumstances under which a captive should be treated as a separate corporation and that premiums paid to the captive should not be deductible. Judge Goffe regards this proposition as one not supported by case law, nor the expert testimony given during the Tax Court proceedings.

Arguing that risk shifting and risk distribution have always been separate and distinct concepts, Judge Goffe states that a transfer of risk "cannot occur by reason of an adequate distribution of risk created by the presence of insured risks of independent third parties."

In another opinion that concurs with the holding of the majority, Judge Goffe's concerns are addressed. Judge Arthur L. Nims III states that it is apparent Judge Goffe's opinion stems from the economic family doctrine. This doctrine, Judge Nims states, has not been and is not one that the Tax Court recognizes. Secondly, Judge Nims states that the majority did recognize risk shifting and risk distribution as separate and distinct concepts. Its decision merely holds that both may be present when a captive insures a substantial percentage of unrelated policyholders.

The court ruled that payments designated as premiums made by the foreign affiliates and the payments of claims by Insko to Gulf and its domestic affiliates did not represent constructive dividends to Gulf.

The court characterized payments made by Insko to Gulf as ones made in consideration for the premiums paid by Gulf and ceded to Insko, not payments made solely for the benefit of Gulf.

*Continued on next page*

Gerald I. Lenrow is a partner with Coopers & Lybrand in Chicago, Donald K. Steffen is a partner with Coopers & Lybrand in Oakland, Calif., and Craig B. Larsen is a manager in Coopers & Lybrand's Chicago office.

# New vendor may be necessary

**A**FTER THE DISCUSSION in last month's article about the pitfalls of switching risk management information system vendors (*BI*, Dec. 21, 1987), you probably think that I never recommend that a client change vendors. If it is a "grass is greener" situation I will dissuade the client. However, if there are serious problems, a change may be warranted.

What follows are certain factors to evaluate in trying to decide whether to make the best of the system and vendor or admit the mistake and start over again:

- A clear mismatch of objectives. If it is obvious that what you need and what the vendor can provide are clearly at odds, a switch may be indicated. For example, if you need a claims management system with a fully integrated check processing system and your vendor/RMIS doesn't have the capability, this is another indicator.

The custom development of a major subsystem or overhaul of an outdated software package requires substantial time and dollars to develop, debug and align to your specific needs. At the same time, you experience downtime and other inefficiencies.

- A lack of service or commitment. This is a key factor. In business, vendor service is as critical as the technical abilities provided by the system. If you are not getting strong or responsive support, this is a significant weakness and a sign that you should test the waters elsewhere.

The warning signs are obvious: How long does it take for the vendor to return your phone call? How quickly are the problems resolved? Does the vendor charge for its mistakes? Are vendor mistakes increasing in frequency?

If you answer affirmatively to many of these questions, you should consider a change.

- Vendor instability. High employee turnover, loss of client base, decreasing service, increasing system problems, slow vendor service response time and just plain old rumors from several unconnected sources may be preliminary

indications of financial distress. These signs should be followed up by frank discussions with the vendor as well as taking protective measures to secure your data. It may be time to think about a change.

Another factor to weigh (or what should have been weighed *before* signing a contract with the vendor) is the uniqueness of the system. If no other vendor can provide your exact system if the present one sells out or goes out of business, you are at significant risk. Be sure you have a solid source code agreement (in escrow) and, better yet, a good backup programmer/troubleshooter to keep you and your system going.

probably ought to leave it.

How should you initiate a change in RMIS vendors?

The first step is to return to the basics. Perform that long overdue needs analysis (*BI*, April 21, 1986) to be sure that you really have a solid understanding of what is needed. Be sure to talk to other departments and external organizations that impact upon your risk management department. Sit down and identify those management and departmental reports on claims, forecasting, modeling, etc., that you are going to need and when you are going to need them.

Identify whether or not you want to

vendors, especially if it's a particularly large and complex system.

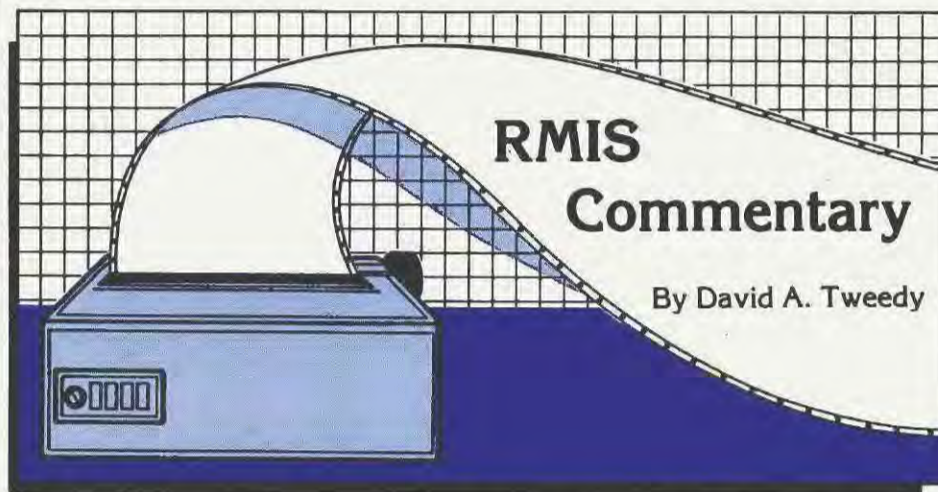
Unless the current vendor is totally irresponsible or negligent, it should also be included in the potential bid project. You may be surprised to find out that better communications with that vendor beforehand would have given you what you needed. Also, the competition may serve to encourage the vendor to be more responsive in both system capability and cost perspectives.

To summarize, the decision to switch vendors should not be made on a whim. Although you may have been guilty of purchasing the first system on a whim, do not make the same mistake twice. Before making any decision, sit down and carefully evaluate what your needs are and determine whether or not the current vendor can first meet these needs without going through a competitive bid process. Try to reduce the "grass is greener" syndrome.

If, however, the situation is intolerable, or the system/vendor is unable to handle your system, make the decision to change as soon as practicable.

Either initiate the bid project or make the change to a vendor that you have thoroughly researched and determined will meet your needs. Manage the conversion process to minimize the negatives. Be certain that the people involved within the system are fully informed and educated every step of the way to reduce any potential complications.

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



- Type of relationship. As discussed before, if the vendor has not provided you with a concise contract identifying the exact terms of you getting your data immediately and providing the systems source code in case of vendor bankruptcy, you should either negotiate the change with him or leave. If not, you are setting yourself up in an extremely vulnerable position.

Let us assume that for one reason or another, you need to go to another vendor but your current vendor will either not permit you to retrieve your data or significantly delays conversion of the data. A clear, upfront agreement with the vendor does much to alleviate these concerns. If he will not provide this contract, it is a good indication of the kind of relationship you have. You

have a system that operates on your premises or if you would rather have the vendor take responsibility for that system via a timeshare arrangement. Define acceptable reporting periods from the vendor on the kinds of fields, loss cause/code relationships, custom programming reports, etc., *before* initiating a bid project or switching to another vendor. Weigh any potential political implications of a change.

In other words, do your homework!

Again, do careful research on potential systems and vendors that best meet the results of your needs analysis. Consider getting your internal data processing department involved if they have the capability. If you are looking to have a comprehensive bid project, try to limit the total number to three or four

## Gulf captive ruling

*Continued from previous page*

Citing *Sammons vs. Commissioner*, 472 F.2d 449 (5th Cir. 1972), the court held that the payments designated as premiums made by the foreign affiliates and the payments of claims made by Inasco to Gulf's domestic affiliates did not constitute constructive dividends.

The *Gulf* case represents a significant development in the captive insurance area. For the first time, the Tax Court has enunciated the circumstances under which the writing of unrelated risks by a captive may be sufficient to constitute a transfer of risk between a parent (and/or its affiliates) and its related insurers. This, of course, is opposed to the economic family doctrine, which would hold the presence of even 1% of related risks to nullify the presence of an insurance arrangement. By rejecting the economic family doctrine and thereby focusing on premium pool composition rather than the capital structure of the captive, the Tax Court has provided a benchmark for determining the rules for recognition of a captive insurance arrangement.

## Interference, libel claims differ: Court

Coverage for personal injury liability, including libel or slander and disparagement of property or slander of title, did not extend to a claim that an insured bank had exercised influence as a lending institution to discourage and interfere with a third party's business and contractual relations, the Supreme Court of New Mexico has ruled.

In 1981, Western Commerce Bank sued Spurlin Properties, Inc. to recover on a promissory note. Spurlin defended and countersued, claiming the bank had used its influence as a lender to discourage and interfere with a third party's business and contractual relations with Spurlin.

### Legal briefs

The bank submitted this countersuit to its insurer, Reliance Insurance Co., to defend. The underlying insurance policy issued by the insurer to the bank covered libel or slander or other defamatory material. The insurer had also issued the bank an excess umbrella policy that covered libel and slander. The insurer denied coverage for Spurlin's countersuit and refused to defend the bank. The bank then sued the insurer for breach of contract. The trial court ruled for the insurer.

On appeal, the court said that the allegations in Spurlin's countersuit did not establish a

claim in libel or slander because no defamatory material was alleged to have been published or spoken. According to the court, Spurlin's countersuit was clearly based on interference with contractual relations and not libel or defamation. The court agreed that the insurer had no duty to defend. *Western Commerce Bank vs. Reliance Insurance Co.*, Supreme Court of New Mexico, Feb. 10, 1987. (*BI*/03/0.—\$10).

*These abstracts were prepared by Cases Unlimited Inc. Copies of these decisions are available by sending a \$10 check payable to Cases Unlimited to Business Insurance, 740 N. Rush St., Chicago, Ill. 60611-2590. List the number for each opinion.*



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# Dona Paz insurance

Continued from page 2

burned to death. Only two of the oil tankers 11 crew members survived (BI, Dec. 28, 1987).

Some 107 bodies were recovered. Of them, only about 40 have been identified, and only one of those was listed on the Dona Paz manifest.

If Philippine authorities investigating the tragedy determine that the number of passengers aboard the Dona Paz when it sank endangered its seaworthiness, Sulpicio's liability insurance may not respond to losses, according to London and Philippine underwriters who asked not to be identified.

The Dona Paz was insured for all third-party liabilities by Steamship Mutual Underwriting Assn. (Bermuda) Ltd., a protection and indemnity club. The coverage was placed by Pioneer Insurance & Surety Co. of the Philippines.

A ship's manifest lists 1,593 passengers and crew aboard the Dona Paz when it sank, 213 more than the limit set by the Philippines Maritime Industry Authority.

But the Coalition of Samar-Leyte Organizations, an umbrella group of 42 organizations representing the victims, has listed at least 3,500 passengers aboard the Dona Paz based on statements from relatives at the ship's point of origin and at its Manila destination.

And, the CSLO estimates there could have been as many as 4,000 Christmas travelers aboard the Dona Paz.

The CSLO class-action suit seeks 300,000 pesos (\$14,472) for each of the 3,500 victims, or total compensation of more than \$50 million.

London underwriters earlier said Sulpicio had \$10 million of liability insurance through Steamship Mutual to respond to losses. Normally, Steamship Mutual would write an unlimited amount of risk, retain \$12 million and reinsure the re-

mainder with Lloyd's of London underwriters through Lloyd's broker Thomas R. Miller & Son (Holdings) Ltd., which runs a reinsurance program for all protection and indemnity clubs.

However, a source in the Philippines last week said it is now believed that Sulpicio had only 31.86 million pesos (\$1.54 million at current exchange rates) of liability insurance written by Steamship Mutual—or the amount of compensation Sulpicio is offering the families of the 1,593 passengers on the ship's manifest.

Sulpicio has offered compensation of about 20,000 Philippine pesos (\$964.80) per victim.

A Steamship Mutual spokesman would not reveal the amount of coverage it would provide survivors.

There is no law in the Philippines requiring owners of commercial vessels to purchase liability insurance, but officials are considering setting a minimum coverage requirement of 20,000 pesos.

Sulpicio's hull and equipment insurance is written by Prudential Guarantee of Manila with limits of 25 million pesos (\$1.2 million) and reinsured in London through Lloyd's broker Willis Faber P.L.C.

The M/V Vector, the oil tanker that collided with the ferry, is not insured for any third-party risks, according to Oriental Assurance, the ship's hull insurer.

Early reports also identified the owner of the tanker as Soriano Industrial Co. of the Philippines, but Oriental identifies the Vector's owner as Vector Shipping Co.

Initial reports also called the oil tanker the Victor, but the Board of Marine Inquiry discovered the vessel was named the M/V Vector.

Vector Shipping has hull insurance limits of 3 million pesos (\$144,720) for the tanker.

Meanwhile, the relatives of victims also are accusing Sul-

picio officials of attempting to persuade illiterate relatives to sign settlement in exchange for burial expenses totaling 5,588 pesos (\$270).

"They are taking advantage of the illiteracy of some of these people," said Alberto Goico, a CSLO official.

Ten relatives were given checks for 5,588 pesos in exchange for their signatures on two documents. One was a "Receipt and Release" for 588 pesos (\$28.37). The other was a "Release and Quitclaim" that says in exchange for 5,000 pesos (\$241.20) the claimant agrees to "remise, release, quitclaim and forever discharge and agree to hold harmless the vessel, M/V Dona Paz, her owners/operators, managers, agents, underwriters, P&I club, vessel's master, officers and crew and all parties with interest therein. . . in full satisfaction, complete settlement and discharge and compromise of my claim for burial expenses and transportation of the remains. . ."

The document further states that "this release may be pleaded as an absolute and final bar to any suit or suits or legal proceedings against any of the persons or things referred to herein."

However, Sulpicio Vp Vicente Gambito said the payments "are not part of the indemnities that may still be adjudicated or arrived at on the lives of the victims."

He explained that the \$270 settlements were only for the burial sites, religious services, transport of remains and round-trip fares of three relatives of each victim.

Mr. Gambito further explained that automatic burial/handling indemnities will be given in cases of manifested-identified bodies, manifested missing passengers and unmanifested passengers whose bodies have been recovered and identified.

Despite an earlier admission that the Dona Paz was overloaded, Mr. Gambito said that indemnifying unmanifested passengers "is not to admit that Sulpicio Lines overloaded or overcrowded the M/V Dona Paz."

## NOTICE

### To all Creditors, Policyholders and Other Persons Having Claims Against AMBASSADOR INSURANCE COMPANY

Notice is hereby given that on March 10, 1987, the Superior Court of Washington County, Vermont, CASE # S-444-83 Wnc, ordered AMBASSADOR INSURANCE COMPANY, a Vermont corporation, liquidated for the purpose of paying its claims and debts under Vermont law.

The Court has ordered that all persons with claims against Ambassador Insurance Company must present said claims, together with proof thereof, to the Commissioner of Banking and Insurance, who is the appointed Liquidator. All such claims must be filed with the Liquidator by March 1, 1988, and must be made on a Proof of Claim form.

Any claimant who fails to file his claim with the Liquidator by March 1, 1988, will be forever barred from participating in any distribution of Ambassador Insurance Company's assets. Claim forms may be obtained by writing:

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Montpelier, Vermont 05602

# Management buys IOA Re from Hall Re of New York

The management of IOA Re Inc. has purchased the Philadelphia-based reinsurance intermediary and underwriting manager from Frank B. Hall Re of New York Inc.

As a privately held corporation IOA Re will continue to specialize in life, accident and health reinsurance, including stop-loss coverage for employers that self-fund their group health plans.

The transaction involved no personnel changes within IOA Re, and all of the company's management and administrative responsibilities remain intact.

John W. Parker, president of IOA Re said, "IOA Re continues to represent the same quality operation. . . Our account executives and underwriters remain dedicated to our high standards of service and market stability."

IOA Re's reported a premium volume of \$47 million in 1986, up

## Markets

34% from \$35 million in 1985.

### Buffalo Re sold

New York-based Continental Corp. has completed the sale of its Buffalo Reinsurance Co. subsidiary to a new company in which Continental has a minority interest.

Woodland Hills, Calif.-based Buffalo Re is now the sole operating subsidiary of newly formed Underwriters Re Acquisition Corp.

Steven H. Newman, who joined Buffalo Re in February 1987 as chairman and chief executive officer, also is chairman and chief executive officer of Underwriters Re.

Other investors in the new company include several other members of Buffalo Re's management and several unaffiliated investors (BI, Dec. 7, 1987; Feb. 16, 1987).

The purchase price was not disclosed. Continental said it expects an after-tax loss on the sale of approximately \$26 million.

Equity in the new company is divided among the management, which holds 15%, Continental with 35%, and a number of outside investors.

For the nine months ending Sept. 30, 1987, Buffalo Re wrote \$140.4 million in net property/casualty premiums.

The company reported a combined ratio of 122% for the nine-month period.

The company has \$130 million in surplus, Mr. Newman said.

### PPOs merge

Preferred Health Network, a Los Angeles-based preferred provider organization, has signed an agreement to merge with Select Health, a San Francisco PPO.

The merger will make Preferred Health the largest provider-owned PPO in the nation, according to Preferred Health. After the merger, Preferred Health will have 97 hospitals and 9,623 physicians in its provider network.

Lowell W. Smith, chairman of the board of PHN and president and chief executive officer of Presbyterian Intercommunity Hospital in Whittier, Calif., explained that "by combining our operations,

PHN will be able to provide an increased level of quality health care throughout the state."

He added, "Our two PPOs are very similar both in philosophy and organizational structure. By creating a single, centralized network of physicians and hospitals, the new PHN organization will be in a strong position to capture a significant share of California's fast-growing PPO market."

Aubrey Serfling, chairman of Select Health and executive vp of Pacific Presbyterian Medical Center in San Francisco, said, "The merger with PHN is the next logical step in the growth of Select Health."

Formed in 1982, PHN has 56 hospitals and 6,077 physicians in its provider network serving Southern California from Santa Maria to the Mexican border.

Select Health's network includes 41 hospitals and 3,546 physicians serving Northern California from Chico to Bakersfield.

Since its inception in 1983, Select Health has worked closely with PHN.

Richard M. Mastaler, president and chief executive officer of the newly merged company said, "Regional hospital/physician networks such as PHN appear to be in the best position to manage quality health care delivery systems into the future."

Previously, Mr. Mastaler was executive vp for marketing sales and corporate development with International Medical Centers, a health maintenance organization in Miami that was acquired by Humana Inc. last year.

Under the agreement, which is subject to regulatory approval, PHN will expand its board of directors to accommodate four new shareholders from Select Health, two from participating hospitals and two from physician groups. All current PHN board members will remain.

PHN has annual revenues of approximately \$4.2 million and Select Health has annual revenues of approximately \$1.7 million.

PHN's headquarters will remain at 4700 Ramona Blvd., Monterey Park, Calif. 91754; 213-261-9066.



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## Spanish aluminum plant

Continued from page 3

Reaseguros; and Aurora Polar.

Ninety-six percent of the coverage written for Inespal is reinsured by American International Underwriters, a unit of American International Group Inc., and by Lloyd's of London syndicates. An AIU spokeswoman in New York could not confirm details of the reinsurance.

Musini's retains only about 1.5% of the risk.

In addition, Alcan obtained a separate \$150 million primary policy covering property damage and business interruption in the international market for its 23.9% interest in Inespal through broker Marsh & McLennan Inc., according to Mr. Mulas.

Inespal said an internal study estimates total losses, including physical damage and business interruption, will be around 18 billion pesetas (\$161.8 million). And, the Inespal claim for business interruption alone will amount to about 10 billion pesetas (\$89.9 million), according to an Inespal spokesman in Madrid and Mr. Mulas.

Inespal also purchases catastrophe cover with state-owned insurer Consorcio de Compensacion de Seguros, although details of the coverage were unavailable.

Consorcio Director General Leon Benelbas explained that the company, part of the Ministry of Economy and Finance in Madrid, primarily covers natural hazard risks, acts of terrorism and similar catastrophic events. Policyholders pay a ca-

tastrophe surcharge on their normal cover, which is collected by the primary insurers and given to Consorcio.

Mr. Benelbas said that he had not yet received official notice of a claim from Inespal and could only comment on the basis of what he had read in the Spanish press. From these reports, he understood that Inespal intends to make a claim on the *tumulta popular* clause in its catastrophe coverage for physical damage suffered at the San Ciprian plant. *Tumulta popular* is roughly equivalent to the civil commotion endorsement on property policies.

On the basis of evidence available to date, Mr. Benelbas and other Spanish insurance observers do not view the work stoppage at San Ciprian as a strike or civil commotion.

"At the moment, we consider that there could be no grounds for a claim," said Mr. Benelbas.

The Cason, which was carrying about 8,300 tons of dimethyl isocyanate and cyclohexane, was en route from Rotterdam, Netherlands, to Shanghai, China, when it ran aground off the coast near Cape Finisterre—locally dubbed *Costa de la Muerte* (Coast of Death)—on Dec. 5.

The next morning, part of its cargo of toxic chemicals exploded, resulting in the death by suffocation of 23 of the Cason's 31-man Chinese crew.

A second explosion occurred on Dec. 10, causing panic among the local population in the nearby coastal towns of Corcubion and Cee. Nearly 14,000 people fled the region, though most have since returned.

The Cason is still stranded off Cape Finisterre, as weather

conditions have not allowed much access to the vessel or its cargo. The local authorities emphasize that there is no danger to the local population but have nonetheless banned fishing and navigation in the area.

On Dec. 11, more than 200 containers of chemicals from the Cason's cargo washed up on the Galician coast during high tide. Government officials decided to transport 255 chemical containers from the Cape Finisterre area on the Atlantic coast to Inespal's wharf at the San Ciprian plant on the Bay of Biscay coast. The containers were then scheduled to be loaded Dec. 15 onto another cargo ship bound for Holland.

A spokesman for the Xunta de Galicia, the governing body for the Galician region, could not clarify who made the decision to transport the containers to the wharf and neither could spokesmen from Inespal or insurers involved.

The Xunta spokesman said the president of the autonomous government had since ordered a study of the Cason incident and its effects on the region, but its findings were not yet available.

Insurers involved said that to date there have been no claims originating from the Galician region linked with the Cason explosions. Sources also say there are no legal proceedings under way against the Cason's owners.

The Cason's liability insurance is written by the London Steamship Owners Mutual Insurance Assn. Ltd., a protection and indemnity club, a spokesman for the club confirmed. He refused to comment on details of the policy or whether any claims have been filed.

## New IIE chairman maps strategy

By MEG FLETCHER

CHICAGO—The new Illinois Insurance Exchange chairman wants to bolster awareness of the facility and make it a leading financial institution.

"The Illinois Insurance Exchange's goal is to become as important to the insurance industry and sophisticated investors as other Chicago financial institutions like the Midwest Stock Exchange and the Chicago Board Options Exchange are to the investment community," says Gordon L. Teach.

Mr. Teach was elected chairman last week to replace Bernard E. Epton, who died in December (BI, Dec. 21, 1987).

Mr. Teach is chairman of the Illinois Co. Inc., a securities brokerage in Chicago. He has been a member of the IIE board since September 1986, representing the public at large.

The IIE, the sole U.S. insurance exchange that is currently writing business, is positioned for growth as the best-capitalized of the exchanges, Mr. Teach said, noting that the exchange last year beefed up capital requirements for syndicates.

"The challenge we face today is to continue our balanced approach in the mix of reinsurance and direct insurance underwriting, with emphasis on the latter for slow, yet steady growth and profits," he said.

The IIE consists of 13 active syndicates that wrote

gross premiums of \$253 million in 1986 and \$157.6 million in the first seven months of 1987 (BI, Aug. 31, 1987). Some 200 brokers place risks in 41 states where the exchange is authorized to do business.

Mr. Teach is concerned about California regulators' recent action to prohibit three IIE syndicates from writing business in that state because of a failure to meet new state requirements (BI, Nov. 30, 1987; Nov. 23, 1987). However, "we are taking the necessary steps to communicate with California officials and ameliorate their concerns, which we feel are totally unjustified," he said.

It is also important to differentiate the IIE from the New York Insurance Exchange and the Insurance Exchange of the Americas in Miami, which have been plagued with problems, he said. That can only be done by educating people, he added.

Mr. Teach is a former member of the board of governors of the Midwest Stock Exchange and former chairman of the board of governors of the National Assn. of Security Dealers. In addition, he served as chairman of a Securities and Exchange Commission disclosure committee, president of the Bond Club of Chicago, trustee of Resurrection Health Care Corp. in Chicago and director of Land of Lincoln Savings & Loan Assn. in Berwyn, Ill.

"His credentials should assist us with two of our most important purposes: attracting non-insurance capital and further setting of high standards in regulating ourselves. He will be able to guide us with valuable insight into the investment community and the regulation of markets," said James W. Skelton, IIE's president.



Mr. Teach

## Insurance industry problems

Continued from page 3

folk can understand, you can do a heck of a lot."

Mr. Washburn suggested that, following the insurance crisis, policyholders realize how much they need insurers and are looking to insurers for "new solutions."

### Tax reform

Proper pricing of property/casualty insurance in the future, a concern to most of the panelists, will be complicated not only by competitive forces but also by the Tax Reform Act of 1986.

"Tax reform will have a profound effect," commented Mr. Ferguson of General Re.

The property/casualty insurance business will pay an estimated \$2.8 billion in taxes in 1987 compared with a \$600 million tax credit in 1986, Mr. Ferguson noted. However, the effect of the new tax law, which among other things requires property/casualty insurers to discount loss reserves, will vary enormously by company, depending on cash-flow characteristics and underwriting results, he said.

"It will shave the return on surplus from one to six points, averaging in the two-to-three-point range," Mr. Ferguson said.

In total, the property/casualty insurance industry will pay \$12.5 billion to \$15 billion in taxes over the next five years, about double what the General Accounting Office had predicted, he said.

"It will affect all of us, but in very different ways depending on our business," Mr. Ferguson said.

According to a study by the National Council on Compensation Insurance, the new tax law will affect insurer profits and, thus, pricing, he said.

Two examples from the study dramatically illustrate his point. Between two different workers compensation insurers, the new tax law would require one insurer to raise rates 2.31% to maintain the same profit while another would have to raise rates 18%. The first insurer's claims were paid more

quickly than the second and it had a 105% combined ratio, compared with a 125% combined ratio for the second insurer.

Furthermore, Mr. Ferguson stressed, in 1990 there will be a dramatic change in the alternative minimum tax that will make it much more onerous. It is programmed to be at least 50% higher in 1990 than it is today, and there are "some loose ends" in the wording of the legislation that confuse experts who are trying to understand it, Mr. Ferguson noted.

"The industry must understand the impact this should have on pricing," said Mr. Greenberg, referring to the higher taxes property/casualty insurers will now pay. He predicted that "when the industry writes the check for taxes in April, that, more than anything, will have a sobering effect on pricing."

"It is important that we educate all of the public" about the impact of the new tax law on insurance pricing, advised Hartford's Mr. Thomas.

### FASB Ruling 96

In addition to the tax law changes, the Financial Accounting Standards Board has issued a ruling, No. 96, that will affect publicly traded insurance companies, Mr. Greenberg pointed out.

The ruling holds that although insurers must discount their loss reserves for tax purposes and pay taxes on that, insurers may not, beginning in 1989, take credit for that prepaid tax on their financial statements.

"That means instead of a 34% tax rate, the industry will have something from 40% to 100%," depending on the company, he said.

FASB's rationale is that "you may not earn the income on which you are currently being taxed," Mr. Greenberg said.

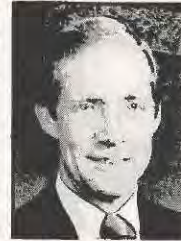
As a result, insurers' financial statements prepared according to generally accepted accounting principles will show a higher tax rate and reduced reported income and reduced net worth.

"The FASB ruling is final, but we should not take it lying down," advised Mr. Ferguson of General Re. An ad hoc group of 16 insurers formed to fight the ruling is looking for more support from other insurers, he said.

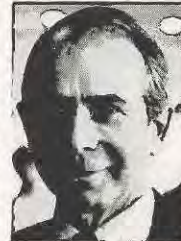
Insurers have interested U.S. senators in the issue, Mr. Greenberg said. "Congress never anticipated insurers paying a higher tax rate. It's a serious issue and greatly misunderstood."

The Securities and Exchange Commission may step in and allow insurers to report discounted income in their income statements to solve the problem, Mr. Greenberg speculated.

Continued on next page



Mr. Ferguson



Mr. Greenberg



Mr. Thomas

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### YOU SHOULD BE INTIMATELY ACQUAINTED WITH AT LEAST ONE, BUT WHICH ONE???

Each of these has appeared in this magazine in the past. Bottom line message is that you should consider taking your group health and disability claims payment "in-house" utilizing their automated systems. The technology is here, it is thoroughly tested and thousands of employers no longer need The Blues, insurance companies or even TPA's to process their claims. You need to investigate this latest and best strategy (although corporations have been self-administering their own plans for all the 36 years I have been in "Benefits").

### BUT, WHO DO YOU TALK TO? CONSIDER, PLEASE....

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3. IT DOESN'T COST A FARTHING (nor a whole lot of your time) for us to prepare a preliminary report roughly comparing where you are and where this strategy can take you, including specific dollar analysis. Send us your business card or a brief note or even call us (we will probably be out of the office, but we'll get right back to you).
4. Any steps along the way after you decide on going further into the idea are nearly all GUARANTEED by the vendor providing the system or by us to the degree we provide continuing service. Can we talk?

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Continued from previous page

"That would be, to some of us, the wrong approach," Mr. Greenberg said, "because that would undermine what little discipline this industry has shown in underwriting and provide a false sense of security."

Forcing insurers to discount loss reserves for tax purposes never should have occurred, Mr. Greenberg said, adding he believes the issue should be revisited.

**Guaranty funds**

Insurance company panelists also expressed concern about the rising cost of guaranty fund assessments, created by the increasing number of insolvencies of large commercial insurers.

The insolvency of five insurers between 1978 and 1986 generated one-third of the \$1.2 billion in assessments levied against insurers by guaranty funds since they were created in 1969 (BI, Aug. 3, 1987).

Guaranty funds pay claims against insolvent licensed insurers by assessing other licensed insurers.

Hartford's Mr. Thomas pointed to the demand by Raymark Corp. for payment of 30,000 claims by the Connecticut Insurance Guaranty Assn. after its insurer, Transit Casualty Co., became insolvent (BI, Aug. 4, 1986). And claims piling up at the rate of 1,000 a month, he added.

"Should sophisticated insureds be granted the protection of this law?" he asked.

An insurance company writing premiums four times its capital and surplus can be hit with guaranty fund assessments in one year that equals 6% of its surplus, Mr. Thomas pointed out.

"We should prefund," Mr. Thomas advised, meaning insurers would be assessed a certain amount of money to build up guaranty funds, instead of assessed as needed to pay claims. Only New York has a pre-assessment guaranty fund.

Mr. Greenberg predicted that the 1987 cost of guaranty fund assessments will be about \$2 billion.

He also questioned whether commercial insurance should be covered by guaranty funds. The cap on individual claims payments imposed by guaranty funds has not protected guaranty funds from large liabilities incurred when a commercial insurer becomes insolvent, he added.

The caps, which generally limit a guaranty fund payout to \$50,000 to \$500,000 per claim, depending on the state, protect the funds from paying large individual claims filed by commercial insurers. But, they do not protect the funds from being deluged by thousands of smaller commercial claims.

Mr. Greenberg contended that the guaranty fund system leads to price instability and churns the marketplace. "Why should you have to lose your business to somebody at cut rates and have to pay for that privilege?" he asked. "That's inconsistent with our economic beliefs in this country."

Mr. Washburn of Illinois responded that regulators are willing to look at the guaranty fund system to consider whether all commercial insurance buyers should be covered and how it might be possible to pierce the corporate veil to recover funds from non-insurance company owners of insolvent insurers.

However, he advised insurers, "you are like banks in the fiduciary capacity in which you take money. It's part of the obligation you get when you get into this business. Policymakers will not allow policyholders to be left holding the bag for insolvent insurers."

Ms. Gillespie of California added: "If you don't have guaranty funds, you are going to have something else. Let's not think that guaranty funds will go away.

Something will be there."

Responding to suggestions that non-insurance company owners of insolvent insurance companies should have to pay, Mr. Washburn commented, "We would like to pierce the corporate veil."

**Solvency regulation**

Mr. Ferguson of General Re emphasized the importance of preventing insolvencies and cited some suggestions of William M. McCormick, president of Fireman's Fund Insurance Cos. in Novato, Calif., to improve industry accounting practices and regulation.

Mr. McCormick has called for insurers to mark the value of their bonds to market value, mandating certification of loss reserves and other accounting changes and encouraging regulators to take tough action against financially troubled insurers (BI, Nov. 2, 1987; Oct. 12, 1987).

"I welcome anything that would bring home to management when they are on a slippery slope," commented Mr. Greenberg.

"The NAIC is keying in a lot more on solvency," Mr. Washburn added.

Ms. Gillespie of California suggested that in regulating insurers for solvency, insurance departments' rate regulators and financial divisions need to be more closely aligned.

"We have to try to instill discipline—to put molasses in the gears," she said.

Since 1985, the California department has performed more vigorous examinations of insurance companies, including examining their rating practices.

In comments to the press following the panel discussion, Ms. Gillespie said that a fine against an insurer will be announced soon. It will be based primarily on lack of documentation for rating decisions, she said.

The California department considers documentation for rating decisions to be very important because "lack of documentation happens to a company on the way down," Mr. Gillespie said, speaking generally.

However, Ms. Gillespie spoke against flex rating, under which a state insurance department requires prior approval before permitting an insurer to lower or raise rates within a certain band. "Flex rating is a mirage. It sounds wonderful, but it puts government in a position it doesn't have the smarts to do."

Mr. Washburn noted that he opposed the introduction of flex rating in Illinois, where the department does not regulate rates.

Mr. Washburn asked if the insurers had noticed any difference in competition in states with flex rating compared with states that do not.

"I don't notice any difference," answered Mr. Greenberg. "Flex rating was a political decision. It was really saying to the buyer of insurance, 'We are going to control rates on the upside.' But how many regulators have complained about rates being too low?"

Ms. Gillespie quickly spoke up: "You know how we are going to do it—and how we are determined we are going to do it—to you on the way down? There is a good way of doing it. It is called 'unfair discrimination' and that's how it's done."

Unfair discrimination in rating

laws basically require insurers to treat all policyholders the same when rating their business. Therefore, an insurer that gives a huge price reduction to one policyholder but not to another similar policyholder could be found to have unfairly discriminated in its rating practices.

Mr. Greenberg responded: "Those laws have been on the books for a long time. How many regulators have used them?"

"After the last cycle, we will see a lot of regulators reading their own laws and dusting them off and looking at them with different glasses," Ms. Gillespie replied.

However, Mr. Washburn observed that regulators do not hear complaints from policyholders about low rates.

Ms. Gillespie suggested: "Maybe that's something that should be considered nationwide: the California system of examination. We don't just look at the financials but on a regular business we look at the rating."

**Pollution liability**

Potentially the most devastating future problem for the property/casualty insurance business is liability for pollution losses, several panelists said. Policyholders in-

creasingly are suing insurers for coverage for pollution losses, including naming as defendants insurers that provided coverage over periods of decades.

"If cases currently in litigation go the wrong way, it would present the industry with a potential bill that would wipe out the surplus of the industry," said Mr. Greenberg, referring to court cases brought by policyholders demanding coverage from many policies written over many years for pollution liabilities levied now.

The Superfund legislation should have provided that pollution cleanup costs be borne by a tax on everybody, Mr. Greenberg said.

"It is the major issue," agreed Mr. Thomas, the new chairman of the AIA. "The attempt to win all the battles in the courts will have at best limited success."

He suggested that a "pay-as-you-go plan" has to be developed.

His proposal, as described to *Business Insurance* after the panel, would involve the creation of a fund to quickly pay for Superfund clean-ups, environmental liability property damage and bodily injury claims. Insurers, excess insurers, reinsurers, those deemed responsible under Superfund and the federal government would participate

in the fund. While participation in the fund would be voluntary, those that contribute would receive a limit on their liability.

"The time to do it is now, before we start losing some of these cases. Then it is going to be too late," Mr. Thomas said at the meeting.

**Alternative markets**

The loss of commercial insurance premiums to alternative insurance facilities and self-insurance also concerned several panelists.

"When clients' needs and problems can't be solved through the conventional mechanisms, they have become ever more willing to accept larger amounts of risk themselves, whether in the form of self-retentions, higher deductibles, captives, reciprocals or whatever it may be," observed J&H's Mr. Hatcher.

These alternative facilities are slicing off "too much" of the premium that ought to be in conventional markets, he said.

Continued on page 27



Mr. Hatcher



Mr. Washburn



Ms. Gillespie

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**Administrative:**  
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Vice-Presidents, General Managers and Other Administrative Personnel ..... 3,210

**Financial:**  
Chief Financial Officers and Vice-presidents of Finance ..... 2,787  
Secretaries, Treasurers, controllers and other Financial Personnel 5,600

**Risk/Employee Benefits:**  
Vice-presidents, directors, managers, and other related department personnel of: insurance, risk, employee benefits, personnel, compensation, pension, safety, security, industrial relations, human resources and employee/labor relations ..... 9,701  
Sub-total ..... 23,868

Associations ..... 500  
Government, Universities and Educational Institutions ..... 914

**Commercial Consumers**  
Sub-total ..... 25,282

Insurance Agents and Brokers 10,858  
Insurance Companies ..... 7,140  
Financial Institutions ..... 989  
Actuaries, Attorneys, Adjusters, Appraisers and Consultants ..... 4,617  
Others Allied to the Field ..... 1,792  
**TOTAL ..... 49,689**

\* Source Business/Occupational breakdown of qualified circulation, May 25, 1987 issue, as submitted to BPA for June 1987 BPA Publisher's Statement.

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# Higher taxes to hurt insurers: McNamara

By KATHRYN J. MCINTYRE

NEW YORK—Property/casualty insurers will pay \$6 billion more in taxes in the next two years than they would have before tax reform, according to the Insurance Services Office Inc.

And, the largest increase in taxes will fall on the largest writers of commercial liability insurance, ISO says.

Some insurers with poor underwriting results may even be driven into bankruptcy, according to ISO.

The reduction in surplus growth and lower return on statutory surplus as a result of the new taxes, however, are not fully anticipated by property/casualty insurers, according to the retiring president of ISO.

But when insurers realize the impact, some may leave the less profitable lines and create new insurance availability problems, warned outgoing ISO President Daniel McNamara.

The alternative is to increase the price of insurance, particularly liability insurance, he advised.

"The new tax law will cut the growth of industry surplus by one-third, or \$6 billion, from the growth we could have expected without the new tax law," Mr. McNamara said last week at the Joint Industry Conference in New York.

"That \$6 billion reduction in surplus growth would put statutory surplus at \$109 billion at the end of 1989," he reported.

The 153 insurer groups with 70% or more of their premium in commercial liability lines will lose 43% of the growth in statutory surplus they could have anticipated by year-end 1989, Mr. McNamara said.

The amount of surplus determines how much in premiums an insurer can underwrite.

In addition, insurers primarily writing commercial liability insurance will find their return on statutory surplus reduced by almost four points to 6.5% in each of the next two years, Mr. McNamara said. "That 6.5% return on statutory surplus, which is less than the current 7% return on 12-month Treasury bills, must give investors and insurers pause in committing capital to the commercial liability lines of insurance."

Furthermore, the loss reserve-to-surplus ratio for these commercial liability insurance underwriters increases to 4.8-to-1 in 1989, compared with a much more acceptable 2.5-to-1 for the overall industry.



Mr. McNamara

Overall, the property/casualty insurance industry's profits will be hard hit by the new tax law, according to ISO.

"Return on statutory surplus will be reduced from the 11.5% it would have been in 1988 under the old tax law and the 9.5% in 1989 by more than two points in each year," Mr. McNamara said.

While the property/casualty insurance industry is enjoying its third consecutive year of financial recovery, "ISO is concerned that in this euphoric period some insurers in their pricing strategies are overlooking—or underestimating—the adverse impact that the 1986 Tax Reform Act will have on their earnings," Mr. McNamara said.

"ISO is also concerned that many insurance interests are not yet fully aware of the dislocations this new law will cause throughout the marketplace."

The new tax law requires insurers to discount their loss reserves for tax purposes. It also subjects insurers to alternative minimum tax and includes other provisions that will

increase insurers' taxes (BI, Jan. 4).

ISO originally had projected that the combined ratios for three long-tail commercial lines of insurance would have to be significantly lower just to produce the same aftertax earnings.

The new ISO study, which will be published in the next several weeks, predicts that the property/casualty insurance industry will pay almost \$3 billion in federal income taxes in 1987, even with the partial offset resulting from the new tax law's "fresh start" provision. That provision says that the initial difference between reserves already existing at the end of 1986 and the newly discounted value of those reserves at the beginning of 1987—when the law took effect—will not be included in taxable income.

"This \$3 billion tax bill, coupled with the \$6 billion industry tax bill over the next two years, indicates that our industry will pay \$9 billion in the three-year period," Mr. McNamara reported.

"The General Accounting Office had estimated that the additional tax burden imposed on the industry over five years would be \$7.5 billion."

Mr. McNamara, who during his 17 years as the first and only president of ISO has warned the insurance industry about unsound pricing trends, said: "Our concern is that all insurers will really feel the tax law's adverse effects at the very time that more aggressive—and some would say unsound—pricing practices will again be pervasive."

Mr. McNamara drove the point home: "And, unlike the old tax law, the new tax law, because of the discounting of loss reserves, particularly penalizes insurers with adverse underwriting results—those least capable of bearing any additional financial burden."

Continued on next page

## Insurance industry problems

Continued from page 25

When clients turn to alternative mechanisms, "the cause is usually unavailability of cover, not price," Mr. Hatcher said.

Mr. Greenberg disagreed: "There's always been a number within the American industrial community who want to pursue an alternative method of risk transfer and there always will be. It's not true a number have formed these because of unavailability. Price has been a moving factor in many classes."

Estimating that 25% of the commercial market is involved in alternative risk funding facilities, Mr. Greenberg also noted that two large losses recently—one of the largest property insurance losses in history, at a Celanese Corp. plant in Pampa, Texas, and the Ashland Oil Co. oil spill near Pittsburgh—will be paid by alternative facilities.

Hopewell International Insurance Ltd. in Bermuda, the giant property insurance pool, insured the Celanese plant (BI, Dec. 28, 1987). Oil Insurance Ltd. a Bermuda-based captive, and sister company OIL Casualty Insurance Co. Ltd. of Bermuda, insured Ashland (BI, Jan. 11).

Responding to Mr. Greenberg, Mr. Hatcher said: "Maybe I should have said unavailability of comparable or competitive terms and cover" is the driving force behind the formation of alternative funding facilities.

### Client relationships

Ms. Gillespie advised insurers that they need to improve their relationships with their customers.

The toll-free number the department pro-

vides consumers who have complaints about insurers receives "an average of 15,000 calls a month from your customers who are not happy," she reported.

And, there are seven insurance-related initiatives heading for the ballot in the fall in California, she noted (see story, page 13).

Four of the initiatives deal with insurance rates across the board, seeking various reductions, and three seek to solve the problem of the high cost of automobile insurance, particularly in Los Angeles.

The high cost of auto insurance is currently the focal point of a consumer revolt in California, she said. A driver with a good record in the inner city pays about \$3,000 annually for auto insurance, which is required by the state.

However, business leaders, who have traditionally been supporters of insurance companies, "have just been made very angry because they still remember what happened to them two and three years ago" when rates were hiked and some insurance was not available.

"The Legislature has until March to come up with solutions that might—might—make the initiatives go away," Ms. Gillespie said.

She noted that she is analyzing the initiative proposals now, which total some 200 pages. And, each voter in California will receive copies of the initiatives, she said, adding: "We can all guess how many voters are going to read 200 pages on insurance."

Ms. Gillespie invited insurers to spend a day with the department's consumer division listening to calls to its toll-free number. ■

## Marcon named ISO chief

NEW YORK—Fred R. Marcon is the new president of the Insurance Services Office Inc., the property/casualty insurance industry's statistical, policy and ratemaking organization.

Mr. Marcon, formerly senior executive vp and chief operating officer of ISO, succeeds Daniel J. McNamara, who will take early retirement March 1 after serving as ISO's president since its inception in 1971.

Mr. Marcon, who has been with ISO since 1975 in various positions, assumed his new duties last week.

Mr. Marcon began his career in 1959 with the Cook County Inspection Bureau in Illinois, and in 1968 became manager of that organization's successor, the Illinois Inspection & Rating Bureau.

In 1972, Mr. Marcon became manager of the Insurance Services Office of Illinois, the successor to the Illinois Inspection & Rating Bureau. In 1975, he was named ISO's Midwestern regional vp, and in 1977, he was named vp-government and industry relations in the New York home office of ISO. Later he was named executive vp, then senior executive vp and chief

operating officer in July 1983.

Mr. Marcon holds a bachelor of science degree in business and economics from the Illinois Institute of Technology in Chicago.

ISO employs 2,700 people to serve its 1,300 property/casualty insurance company members. Among them are 500 data processing employees, 800 field rating representatives and more than 200 actuarial staffers.

The tributes to Mr. McNamara were numerous.

One of the most eloquent was that of Roger W. Gilbert, president of Great American-West Inc. and outgoing chairman of ISO.

"In the 17 years as ISO's president, Dan has contributed more to our business than any other single person I know," he said. "He has been a voice of reason during our industry's crises. Many of us should have listened more carefully to his sound advice."

"His leadership of ISO has mitigated and/or avoided crises and potential crises. And he has built a legacy for our business—an ISO that is strong, sound, professional and cost-effective."

The new chairman of ISO is Dale R. Comey, executive vp-property/casualty operations for Hartford Insurance Group



Mr. Marcon

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# New taxes

Continued from previous page

Emphasizing how much more insurers will pay in taxes—instead of adding to surplus—Mr. McNamara noted: "Until Jan. 1, 1987, our industry operated under a statutory accounting tax formula that had not significantly changed for 25 years. Tax credits of \$7.1 billion in seven of those years almost offset the \$7.2 billion in taxes paid the other 18 years.

"All is now different," Mr. McNamara warned. "The new tax law will have a negative impact on virtually every insurer's surplus and profitability."

And, non-insurer conglomerates owning insurance companies, which once enjoyed tax benefits, will discover the rules have changed for them, too.

These insurers will find that the new tax law will cut growth in statutory surplus by 34% and will reduce return on statutory surplus by three points for each of the next two years, he said.

"Under the new tax law, conglomerate-owned insurers, instead of generating tax losses that shelter some of their parent's taxable income, will become taxpayers themselves," Mr. McNamara said.

These insurers write 15% of the industry's aggregate premium volume, he pointed out.

Furthermore, "the new tax law will have a striking effect on the dynamics of reinsurance," according to

Mr. McNamara. "Contrary to tax and statutory accounting procedures before Jan. 1, 1987, the use of reinsurance under the new law will transfer some of the tax burden from the ceding insurer to the reinsurer—and make it much harder for both parties to determine the aftertax cost of reinsurance transactions."

Nevertheless, "the potentially sobering marketplace dislocations of the tax act do not yet seem to be fully comprehended," said Mr. McNamara.

"Some insurers will experience capital shortages," he predicted. "Lower returns will make attempts to raise new capital difficult and more expensive."

"The tax law's varying impact by product will cause some insurers to shift their capital to new target markets and disinvest in other markets," Mr. McNamara predicted. "Some buyers will face new availability problems. State guaranty funds will see new activity as the increased tax burden takes its toll."

As a result, "the effectiveness of state insurance regulation will be subject to increased attack," he added.

Mr. McNamara urged insurers to take quick action.

"Individual insurers will need to promptly integrate the effect of this new tax law into their individual pricing and investment strategies and not operate under the illusion that this law will not affect them," he warned. "No one should be complacent or reckless because our industry is now briefly enjoying a return to profitability after many lean years." ■

# Insurers start campaign to tackle pricing, image

By KATHRYN J. McINTYRE

NEW YORK—More forcefully than ever, insurance industry leaders are calling for providing consumers with stability in insurance prices and improving the public image of the insurance business.

Every executive of the three insurance associations that held their annual meetings last week in New York in conjunction with the Joint Industry Conference either called for insurers to stabilize their prices or to work to improve insurers' image with the public—or both.

Daniel J. McNamara, the retiring president of the Insurance Services Office Inc., said in his swan song to the industry: "Today, our business

faces skepticism from the customers it serves, the investors and marketing forces it needs and the public policymakers it must account to. This crisis of confidence in our business will not be permanently improved until insurers resolve to maintain consistently stable markets through responsible pricing programs."

Insurers also must succeed in their efforts to "curb some excesses of our civil justice system and rebut the renewed attacks on cost-based pricing by some state insurance regulatory authorities," he added.

Conceding that insurers' "competitive, fragmented structure inevitably produces cycles and volatile earnings," Mr. McNamara warned that "broad industry failure to exercise pricing discipline only encourages further governmental intrusion into our business and further business loss to alternative mechanisms" (see story, page 27).

Outgoing ISO Chairman Roger W. Gilbert, who is president of Great American-West Inc., observed: "The public and public policymakers became frustrated, distrustful and downright unfriendly after insurers moved swiftly to prevent, or avert, financial disaster by raising prices and tightening risk selection criteria over the past three years.

"Events, rather than words, are more likely to leave an impact on people. Therefore, the facts of higher prices and the unavailability of insurance certainly had an impact on people, far more of an impact than the words we offered, sometimes belatedly, in explanation."

Insurers, however, were not entirely to blame for the problems creating the last tight market, Mr. Gilbert stressed.

"Insurers didn't set interest rates, which rose to their highest level in 100 years, then plummeted and stabilized. Plaintiffs' lawyers, not insurers, convinced courts that new and expanded theories of liability were valid, escalating lawsuits, judgments and settlements. Courts, not insurers, expanded insurance contracts, which was never intended and premiums were never charged for. Each of those developments played a major contributory role in destabilizing the insurance market," he explained.

Nonetheless, insurers are responsible for their public image, Mr. Gilbert said. He suggested that insurers could improve that image by also improving:

- Long-term planning. "Short-term goals are often set without a full appreciation of what achieving those goals implies for risk selection, pricing, compromises in strategic objectives or relations with producers and policyholders," Mr. Gilbert said.
- Pricing practices. "Individual insurers need to develop and implement pricing models which ensure that the prices they charge are compatible with the company's long-term objectives, are in tune with the market and will produce a decent rate of return over time."
- Professionalism. "Insurers particularly need to develop an even higher degree of professionalism among their underwriting and claims people."
- Communication. "We must continually and effectively communicate the reasons for our pricing, underwriting and claims philosophy, procedures and decisions to our own employees as well as our customers, producers and the public at large."

Continued on next page

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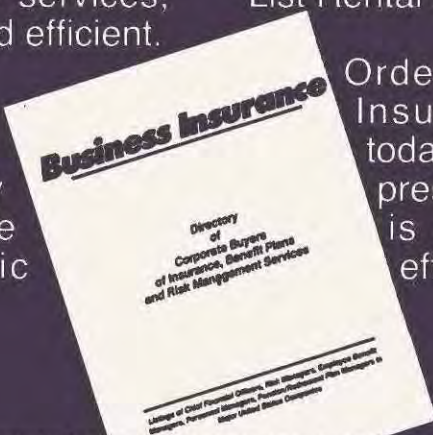
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• Commitment.  
 "Insurers must avoid 'overcommitting' to our customers or the public at large. Once commitments are made, we must deliver."

Edward H. Budd, outgoing chairman of the American Insurance Assn. and chairman and chief executive officer, of the Travelers Corp., was equally forceful in stating his concern about insurers' image.

"Nationwide, the public does not understand how important it is to have strong, solvent insurers as opposed to just competitive rates. We fare little better among political and policy-making audiences," he said.

To educate consumers and policymakers about insurance functions and insurance economics, Mr. Budd called on insurers to:

- Work together aggressively to be heard by legislators and their staffs, other interest groups and the public at large, both directly and through the media.

This effort should include developing better lobbyists, mobilizing grass-roots support, strengthening political action committees and expanding public education materials.

- Keep their own house in order.

"In the long run, how we perform as insurers may be the most important factor in how society perceives us and how successful it permits us to be," Mr. Budd said.

"I believe that the only path to public understanding and support is through stability, quality service and consistent profit that provides security for our policyholders."

AIA President Robert E. Vagley, in his annual remarks, counseled: "We must continue to work on our image and credibility with our external publics: the voters and their elected and appointed representatives.

"Public image equals public credibility," he continued. "And credibility equals political and financial success.

"Our public image still needs work. But the good news for us is that improving our image isn't a matter of distorting ourselves. Our self-interest is frequently aligned with the public interest. We don't have to make agonizing choices between business success and public responsibility. For us, they are one and the same."

Contending that the insurance system is being misused to levy hidden taxes on the public (see related story), Mr. Vagley said, "If voters understand that the underlying social system is generating those costs, then they will act in their own interest. And those actions will also serve our interest."

Among the top priorities of the Insurance Information Institute in the past year was putting insurance industry profits into perspective and restoring public confidence in the industry, said Mechlin D. Moore, the III's president.

The III also was successful in preventing onerous new legislation governing insurers, he said.

The III strategy included presenting insurance industry chief executives and III Senior Vp and economist Sean F. Mooney to the media and at special forums; production of a slide presentation and brochure on the industry's financial performance; productions of special commentaries carried on the ESPN cable network; and a national television advertising program.

This year, the III will launch a print media advertising campaign aimed at furthering the public's understanding of the property/casualty insurance business. And, it will send educational information directly to influential audiences, including CEOs of major corporations.

Re-elected III Chairman Frank E. Walton, who also is executive vp-agency marketing group at Travelers, praised the III's efforts to enlist insurance company personnel to discuss issues. About 500 speakers from 20 member companies were signed up in nine states to talk at public forums about insurance. The states were: Arizona, California, Colorado, Connecticut, Massachusetts, New Jersey, New York, Oregon and Pennsylvania.

This year, similar programs will be launched in another five states: Florida, Virginia, West Virginia, Louisiana and Maryland.

The focus this year will be auto insurance, now that the controversy over the price and availability of commercial insurance has died down.

The III also is rallying the support of insurance company employees to speak on insurance and insurance issues. Insurers seeking to organize their employees to speak out on issues will be provided with communications and technical assistance.

The III is budgeting \$8 million for these efforts in 1988: \$6 million for national advertising and \$2 million to be spent in targeted states.

# Beware hidden tax: Vagley

By KATHRYN J. McINTYRE

NEW YORK—The growing use of the insurance system as a form of "backdoor taxation" is one of the most subtle, yet dangerous, threats to the property/casualty insurance industry, the president of a leading insurer trade association says.

"We're talking about government—at all levels—misusing insurance to satisfy public policy objectives without directly increasing taxes," says Robert E. Vagley, president of the Washington-based American Insurance Assn., which counts among its 188 member companies the largest public property/casualty insurers.

As examples of misuse of insurance, he cited:

- Judicial contempt for the integrity of contracts.

- Legislatively mandated subsidies of high-risk policyholders by low-risk policyholders.

- Legal theories that allow plaintiffs to collect from defendants more in damages than a defendant's proportionate degree of fault for the damages.

"None of this is new, but when it's carried out in a wholesale manner—when courts, legislatures and regulators dictate how much we can charge, who we will pay and how much we will pay without regard to responsibility or fairness—then it is insidious," Mr. Vagley declared in his remarks at the annual AIA meeting last week in New York.

For the first time, the AIA held its annual meeting in conjunction with the annual meetings of the Insurance Services Office Inc. and the Insurance Information Institute.

These trends, Mr. Vagley said, nullify the insurance industry's ability to underwrite. "When our mechanism for assessing risk is weakened, we begin to lose our identity as an industry and become a quasi-governmental entity, a mere vehicle for moving money from one pocket to another as public whimsy decides."

So far, Mr. Vagley observed, "the public often applauds the misuse of insurance, or greets it with indifference. Yet these are actions that will cost average consumers more and more as the costs are passed on to them.

"Consumers should regard these additional burdens not with detachment, but in the same way they view a tax increase. Because that is what they are: indirect, hidden taxes. And our industry gets the thankless responsibility for being the tax collector."

Insurers will continue to "get the blame for these hidden taxes until we demonstrate convincingly that the public should react, not with applause or detachment, but with shock and indignation to court decisions, legislation and regulatory schemes that cause innocent people to be held responsible for the actions of reckless people," Mr. Vagley said.

When informed, the public will "understand that when courts and legislators

and regulators shred the integrity of the insurance mechanism to advance social or individual objectives, adding substantially to our cost of doing business, we must and will pass on those costs," Mr. Vagley said.

This will include the public understanding "the connection between a news story about a court award or a new federal and state proposal and their insurance costs," he added.

Insurers can succeed, Mr. Vagley asserted, reciting a litany of successes in 1987. Among them:

- Tort reforms enacted in 25 states.

- Defeating an effort in New York to enact financial guarantee insurance legislation.

- Substituting a premium tax surcharge for a proposed sales tax on insurance.

- Defeating numerous proposals to tighten control over rates.

- Blunting the attack on the McCarran-Ferguson Act.

- Rallying opposition to the proposed federal High Risk Occupational Disease Notification and Prevention Act.

Some of these issues, such as the attack on McCarran-Ferguson, will be raised again in 1988, Mr. Vagley pointed out. In addition, the AIA's agenda of problems to solve this year includes: reversing insurance industry losses in rating laws; advancing legislation addressing disaster preparedness; and problems in workers compensation and personal lines.

# Execs debate guaranty funds

By KATHRYN J. McINTYRE

NEW YORK—Duplication and expense could be eliminated if the current state guaranty fund system were replaced with a national system, according to the general counsel of a major nationwide insurer.

But, the savings aren't worth the loss of the state system, contends a former president of the National Assn. of Insurance Commissioners who is now an insurance group executive.

Jean C. Hiestand, vp and general counsel of State Farm Mutual Automobile Insurance Co. in Bloomington, Ill., and its property insurance affiliates, squared off with Lyndon L. Olson Jr., president and chief executive officer of Waco, Texas.-based National Group Corp., in a debate over national vs. state guaranty funds at the Joint Industry Conference held last week in New York.

Guaranty funds pay claims on behalf of insolvent licensed insurers. Other licensed insurers in each state are assessed as needed to pay claims, except in New York, which has a pre-assessment guaranty fund.

"We're not suggesting a federal fund authorized by Congress and administered by federal regulators," Mr. Hiestand stressed. Instead, State Farm supports a "national guaranty fund run by the industry," retaining state laws.

Insolvencies of insurance companies that operated in more than one state create duplication and expense, Mr. Hiestand said.

In addition, under a national guaranty fund system, coverage could be uniform, eliminating conflicts and the tendency for policyholders to "forum shop," or seek coverage from the state guaranty fund that pays the most, Mr. Hiestand said. And, a national fund would have more coverage capacity than the current state system, he said.

Any licensed insurer could become a member of the national guaranty fund, Mr. Hiestand noted.

Furthermore, a national guaranty fund could "serve as a vehicle for improved solvency regulation," Mr. Hiestand said, if the guaranty fund had authority to eliminate coverage for an insurer that did not meet certain solvency standards. However, federal legislation

providing the fund with antitrust protection would be needed to accomplish this goal, which Mr. Hiestand admitted would be controversial.

In addition, Mr. Hiestand advocated eliminating guaranty fund coverage for commercial lines policies except workers compensation. Individual's policies and workers compensation should continue to be covered by a guaranty fund because individual buyers do not have the sophistication to gauge the solvency of insurers, and workers have no say in who underwrites their employers' workers compensation insurance, he explained.

However, whether commercial lines coverage is excluded or not, "a single fund would be an improvement," Mr. Hiestand maintained.

Mr. Olson disagreed: "I don't favor a centralized system. You can't impose a centralized system and not end up with a federal mechanism."

The duplication and expense of state guaranty funds are "the trade-offs for the diffusion of power," Mr. Olson maintained.

Noting that he was speaking from the perspective of small, provincial regional insurance group with property/casualty and life insurance companies licensed in 28 states, Mr. Olson maintained: "As long as states have primacy in the regulation of insurance, conflicts and inefficiencies will occur." Steps can and should be taken to minimize the conflicts and inefficiencies, he said.

Mr. Olson called on those who want federal regulation of insurance to "fess up."

Mr. Hiestand countered that there is little danger that the federal government would want to move into the guaranty fund business.

Mr. Olson also took issue with Mr. Hiestand's assertion that state regulators are not always as vigilant as they should be in regulating insurers for solvency because they know the state guaranty fund will pay claims against insolvent insurers.

"It never occurred to me, or most of the regulators I know," said Mr. Olson, formerly chairman of the Texas State Board of Insurance.

# Riverplate yields to liquidation

By ROGER SCOTTON

HAMILTON, Bermuda—Riverplate Reinsurance Co. Ltd. will be liquidated without opposition from its owners.

The 15-year-old property/casualty reinsurer had initially opposed a November winding-up petition filed in Bermuda's Supreme Court by two Lloyd's of London underwriting syndicates (BI, Nov. 23, 1987).

The reinsurer gave no reason for its reversal at a court hearing earlier this month.

John Francis LeMay and Collin William Speckley, acting for and on behalf of Lloyd's syndicates 122 and 546, respectively, filed the petition after they had begun legal proceedings in Bermuda to recover about \$80,000 from Riverplate.

The court then sanctioned appointment of two provisional liquidators: David Lines, a

partner in the accounting firm Coopers & Lybrand Bermuda, and Michael Jordan, a partner with Cork Gully, a unit of Coopers & Lybrand in London.

Riverplate, whose share register shows that it is owned by Buenos Aires-based merchant Carlos A. Goberman, Argentine lawyer Juan Carlos Taboada and Miguel Casavilla, responded by asking its Bermuda lawyers Appleby Spurling & Kempe to begin proceedings aimed at blocking the appointment of the provisional liquidators.

But, at a Jan. 4 hearing in Bermuda's Supreme Court, Riverplate withdrew its opposition to the petition, Mr. Lines said.

"We are now trying to establish both a date and a place for the first creditors meeting, which we hope to hold sometime in March," he said.

Mr. Lines said he did not have full finan-

cial details of Riverplate's insolvency, but believes the company's insurance debts are "at least in excess of \$20 million."

However, "the company is repudiating some of its contracts and says this sum may or may not represent proper debt obligations," he added.

Mr. Lines said he did not know how many creditors were involved because Riverplate's books and records are in Argentina, although attempts are being made to "secure" the books.

Permanent liquidators will be appointed at the creditors' meeting, he said.

The Lloyd's syndicates' initial writ against Riverplate was one of three actions seeking a total of just more than \$200,000. The other two actions were begun at the same time by Orion Insurance P.L.C. for \$89,000 and Berisford Mocatta & Co. for \$40,000.

## Benefit costs

*Continued from page 1*  
Chamber officials say.  
"It is a better snapshot of employee benefit costs," said Martin Lefkowitz, an economic consultant for the Chamber, adding that prior surveys may have understated benefit costs.

The latest survey is based on the responses of 833 employers in 21 industry categories, ranging in size from companies with fewer than 100 employees to employers with more than 5,000 workers. The survey was sent to 8,100 companies and just over 10% responded.

While benefit costs for 1986 and 1985 are not directly comparable because more benefit costs are included in the 1986 survey, it is interesting to see how both the inclusion of the new benefits and higher costs affected benefit costs in different industries.

Industries with the highest benefit costs in 1986 include: transportation equipment, \$15,448 per employee, up 60.1% from \$9,649 in 1985; rubber, leather and plastics products, \$13,450, up 66.2% from \$8,095 in 1985; primary metal industries, \$13,402, up 18.1% from \$11,344 in 1985; public utilities, \$12,712, up 19.7% from \$10,622 in 1985; and petroleum, \$11,755, down 4.5% from \$12,303 in 1985.

Industries with the lowest benefit costs in 1986 include: textile products/apparel, \$4,743 per employee, up 3.1% from \$4,599 in 1985; department stores, \$5,102, up 18.9% from \$4,292 in 1985; trade (wholesale/retail), \$6,107, up 7.2% from \$5,697 in 1985; printing and publishing, \$6,919, down 5.2% from \$7,292 in 1985; and banks, finance companies and trust companies, \$7,153, up 9.2% from \$6,552 in 1985.

Retirement and savings plans were employers' most costly voluntary benefit. Retirement and savings plans cost the average surveyed employer \$1,762 per employee in 1986.

But there was considerable variation in retirement and savings plan payments among employers. Industries in which companies spent the most on retirement plans include: transportation equipment, \$3,317 per employee; public utilities, \$2,663; primary metals industries, \$2,140; instruments and miscellaneous non-manufacturing, \$1,772; banks, finance and trust companies, \$1,612.

Industries that spent the least on retirement include: textile products, \$428; department stores, \$434; trade (wholesale/retail), \$710; electrical machinery, \$966; and rubber leather and plastics products, \$991.

Industries in which employers made the highest contributions to their defined benefit plans in 1986 include: transportation equipment, \$2,258 per employee; public utilities,

\$1,698; primary metals industries, \$1,601; rubber, leather and plastic products, \$825; and insurance companies, \$692.

Those industries in which employers made the smallest contributions to their defined benefit plans in 1986 include: trade (wholesale and retail), \$80 per employee; petroleum \$139; department stores, \$175; electrical machinery, \$183; and instruments and miscellaneous non-manufacturing industries, \$318.

Industries in which employers made the largest payments to their defined contribution plans in 1986 include: instruments and miscellaneous non-manufacturing, \$1,290 per employee; banks, finance and trust companies, \$1,060; food, beverages and tobacco, \$1,036; transportation equipment, \$810; and pulp, paper, lumber and furniture, \$634.

At the low end of the scale, defined contribution plan payments amounted to less than \$200 per employee for employers in five industries: hospitals, \$45; textile products and apparel, \$60; rubber, leather and plastics, \$96; miscellaneous non-manufacturing industries, \$104; and trade (wholesale and retail), \$187.

Even without including life insurance premiums with medical costs, as they were in 1985, medical costs continued to climb. In 1986, surveyed employers' medical benefit payments totaled \$1,604 per employee, up 2.8% from 1985's combined medical and life insurance costs of \$1,561.

Employers in four industries spent more than \$2,000 per employee on medical care benefits in 1986: rubber, leather and plastics products, \$3,259 per employee; primary metal products, \$2,593; transportation equipment, \$2,506; and public utilities, \$2,068.

On the other hand, medical benefit costs averaged less than \$1,000 per employee for businesses in three surveyed industries: department stores, \$538; food, beverages and tobacco, \$873; and printing and publishing, \$876.

In addition to the medical insurance payments, the 1986 survey shows the average employer paid \$127 per employee for life insurance and death benefits.

Dental insurance plan contributions averaged \$148 per employee in 1986, up 70.1% from \$87 per employee the previous year.

Payments for retiree health care expenditures—surveyed by the Chamber for the first time in 1986—averaged a modest \$157 per employee.

However, that number is misleading because employers were asked how much they spent on retiree health care costs on a per-employee basis, not how much employers actually spent for health care per retiree.

In addition, only 34% of surveyed

employers—almost half of which had fewer than 1,000 employees—reported making contributions to retiree health care plans.

Payments for retiree health care showed a huge variation among surveyed employers in 1986. The highest was \$1,637 per employee in the primary metal industry, a unionized industry that generally provides this benefit and has a high ratio of retirees to active employees.

The lowest was \$7 per employee in the wholesale and retail trade industry, where retiree health care plans are not common.

Among the other benefit categories included for the first time in the Chamber survey:

- Employers spent an average of \$159 per employee on child care benefits in 1986. On an industry basis, child care benefit costs ranged from a high of \$554 per employee in the transportation equipment industry to zero in the stone, clay and glass products industry.

- Employers spent an average of \$48 per employee on parental leave benefits. On an industry basis, parental leave costs ranged from a high of \$93 per employee among public utilities to a low of \$9 per employee in the printing and publishing industry.

- Savings plan administration cost employers an average of \$29 per employee in 1986. The highest savings plan administration costs—\$100 per employee—were found in the machinery industry, while the lowest costs—\$5 per worker—were found in the wholesale and retail trade industry.

Other findings in the Chamber survey include:

- Industries with the highest benefit costs as a percentage of payroll in 1986 include: rubber, leather and plastics, 56.9%; primary metal industries, 51.1%; transportation equipment, 50.5%; public utilities, 38.7%; and miscellaneous non-manufacturing industries, 38.3%.

Industries with the lowest benefit costs in 1986 as a percentage of payroll include: textile products and apparel, 28.8%; printing and publishing, 29%; banks, finance and trust companies, 30.4%; petroleum, 31.7%; and stone, clay and glass products, 33.2%.

- Benefit costs, as a percent of payroll, varied by geographic region. For example, benefit costs as a percent of payroll averaged 47% among employers in the eastern North Central states (Illinois, Indiana, Michigan, Ohio and Wisconsin); 36.6% in the Southeast; 36.1% in the West; and 35.5% in the Northeast.

- Individual, major benefit categories as a percent of payroll include: payments for vacation, sick leave, holidays, 10.2%; legally required payments, 8.9%; medical and medically related benefits (such as short- and long-term disability and dental care insurance), 8.3%; retirement and savings plans, 6.7%; paid rest periods, lunch periods, etc., 3.4%; miscellaneous benefits like discounts on good and services, child care benefits and company-furnished meals, 1.3%; and life insurance and death benefits, 0.5%.

- All employers in the United States spent an estimated \$742 billion on benefits in 1986, or 35.5% of payroll, the Chamber says. That's up 7.3% from \$691.3 billion in 1985 and up 209.2% from \$240 billion in 1975, according to the Chamber.

*Copies of "Employee Benefits 1986" are available from the U.S. Chamber of Commerce, Publications Fulfillment (RKVL), 1615 H St. N.W., Washington, D.C. 20062; 301-468-5128. The cost is \$20 per copy. Discounts are available for bulk orders. Prepayment is requested. Sales tax should be included for deliveries in California and the District of Columbia.*

## Update

### Hull insurers pay PSA loss

*Continued from page 2*  
\$600 million in liability coverage.  
Aviation brokers and underwriters immediately after the crash speculated that disputes between the airline's all-risk underwriters and war risk underwriters would develop because of the circumstances surrounding the loss. The crash, which killed 43 people, was believed to have been caused by a recently fired employee of USAir Group, the parent of PSA, who boarded the plane with a .44-caliber pistol (BI, Dec. 14, 1987).

"The language of the policy makes it plain that it is a loss under the all-risk policy," said Stephen Merrett, chairman of London-based Merrett Holdings P.L.C. and lead underwriter of the airline's hull war risk coverage.

### EPA sues Con Ed of New York

NEW YORK—The U.S. attorney in Brooklyn has filed suit against the Consolidated Edison Co. of New York on behalf of the Environmental Protection Agency, charging the utility with 43 violations of the Clean Air Act.

The suit, which seeks more than \$1 million in civil penalties, charges that Con Ed did not properly wet or treat boiler doors containing friable asbestos material before removing them from a Manhattan power plant this summer.

The same incident prompted a utility workers union to sue Con Ed and seven members of its management last year in U.S. District Court for the Southern District of New York (BI, Nov. 23, 1987).

The union suit, which originally was filed on behalf of 139 workers, now seeks \$215 million in compensatory and punitive damages on behalf of 215 workers. The court is expected to rule Friday on a motion by the utility to dismiss the action.

A Con Ed spokeswoman said the utility has until Jan. 28 to respond to the suit.

### Poultry lost in storm covered

PITTSBURG, Texas—Pilgrim's Pride Corp. has adequate insurance to cover an estimated \$8.25 million loss from an ice storm that caused 125 poultry houses to collapse and kill 1.3 million chickens.

A winter storm that swept through northeast Texas and southwestern Arkansas earlier this month left heavy accumulations of ice on the roofs of the houses, which caved in. The property loss amounted to \$5 million to \$6 million and the birds were valued at around \$2.25 million, according to figures compiled by Camp County Judge Phillip Hawkins.

"Our coverage is adequate to pay the losses," said Gary Bryant, risk manager for Pittsburg, Texas-based Pilgrim's Pride.

Replacement-cost property insurance written by Northbrook National Insurance Co., an Allstate Insurance Co. unit, will pay to rebuild the poultry houses, he said. The insurance was brokered by Johnson & Higgins in Dallas.

A "live bird" policy in the form of animal mortality insurance—brokered by J&H and written by Lloyd's of London syndicates—will cover the loss of the broilers and the breeding hens, Mr. Bryant said.

### Firm sweetens bid for Robins

RICHMOND, Va.—American Home Products Corp. of New York has sweetened its bid for A.H. Robins Co. by \$100 million.

Under the new bid, American Home Products would acquire Robins for \$700 million in American Home stock and establish a trust fund that would pay thousands of Dalkon Shield claimants either \$2.15 billion immediately or \$2.475 billion over six years. Its previous bid did not offer claimants an immediate payment option.

If Robins accepts the bid, Aetna Casualty & Surety Co. will sell American Home an excess insurance policy to cover claims if the fund runs dry, an Aetna spokeswoman said without elaboration.

Robins would not comment further on the American Home Products proposal, and American Home Products officials could not be reached for comment.

A group representing Dalkon Shield claimants opposes the American Home Products bid because it offers less than the \$2.48 billion the U.S. District Court in Richmond, Va., has ordered Robins to pay (BI, Dec. 14, 1987).

The American Home Products proposal came in response to Robins' acceptance of a merger proposal from French pharmaceutical maker Sanofi. Sanofi proposes to pay \$600 million for 58% of Robins' stock and to set up a \$2.5 billion trust fund to compensate Dalkon Shield claimants (BI, Jan. 11).

The group representing Dalkon Shield claimants also opposes the Sanofi proposal because it would pay stockholders immediately but string out payments to claimants over more than four years.

A court hearing has been scheduled for Jan. 21.

### Briefly noted

A Los Angeles Superior Court judge says he will grant **Harbor Insurance Co.** a new trial to determine the amount of punitive damages it owes American Motor Inns if AMI does not accept by Jan. 19 \$3 million rather than the \$13 million awarded by a jury. The court ruled that Harbor exercised bad faith in settling a lawsuit with subsidiaries of AMI, which also was awarded \$10.25 million in compensatory damages (BI, Dec. 7, 1987). . . Charles E. Rinsch, formerly vp and treasurer of Teledyne Inc., has been elected president and chief executive officer of **Argonaut Group Inc.** in Menlo Park, Calif. Mr. Rinsch succeeds David W. Schrempf, who has been reassigned to serve as a consultant. . . More than 1,000 British victims alleging injuries caused by an anti-arthritis drug have settled their suit with **Eli Lilly & Co.** of Indianapolis, which manufactured the drug, known as Opren in the United Kingdom. The deadline for the remaining 250 plaintiffs to accept the undisclosed settlement offer has been extended to Feb. 5.

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# Amoco Cadiz

Continued from page 3  
the award.

Amoco had estimated its maximum losses at \$148 million, including the loss of the Amoco Cadiz hull and its cargo.

The insured value of the hull was \$20 million, and Amoco collected \$15 million from London and U.S. hull insurers after applying a \$5 million deductible.

Petroleum Insurance Ltd., a Bermuda-based captive of Royal Dutch-Shell Group, paid \$22.9 million for loss of the cargo to two Shell subsidiaries, which owned the oil. PIL then sought to recover the money from Amoco, and Judge McGarr last October ordered Amoco to pay PIL 11.2 million pounds (\$19.3 million at the appropriate exchange rate) plus interest. Amoco expects to recover the amount of the award under its protection and indemnity policy.

In addition to insurance covering the hull and cargo losses, Amoco had \$50 million in pollution liability coverage as part of its P&I policy written by London Steamship Owners' Mutual Insurance Assn. Ltd., managed by A. Bilbrough & Co. Ltd. The coverage was divided into a \$600,000 primary layer retained by London Steamship; a \$3.4 million first excess layer carried by an international pool of P&I clubs; and a \$46 million layer led by Lloyd's of London syndicates managed by Janson, Green Ltd. and reinsured worldwide.

About \$16.75 million of the insurance proceeds were paid to the French government to establish a fund with the Tribunal of Commerce in Brest, France, to cover oil spill claims brought in French courts.

Sources familiar with the case say that most, if not all, of the remaining insurance proceeds have gone to cover Amoco's defense costs, which were included in the \$50 million policy limit.

An Amoco spokesman would not comment on defense costs.

With interest accumulated over several years, the Brest fund now amounts to 232 million francs (\$42.1 million at current exchange rates), according to Mr. Cicero, who observed that this amount would nearly cover Judge McGarr's \$45.5 million compensatory damage award.

But, the Brest fund is available only to parties who file claims in French courts, and neither the Republic of France nor the Cotes du Nord parties filed claims against the fund, preferring instead to pursue the Chicago litigation. The only claim in France for cleanup costs was filed by Great Britain, and nothing has yet been paid out of the fund, a source said.

Additional claims against the fund may now be time-barred under a six-year limitation on claims, and the money remaining in the fund may eventually revert to Amoco.

If Amoco recovers most or all of the money in the fund and if Judge McGarr's damage award is upheld on appeal, Amoco would have to pay only the prejudgment and post-

judgment interest—now amounting to about \$39.5 million—from its own funds.

The Amoco spokesman could not comment on whether the company had established any reserve for its oil spill liabilities. No such reserve has been reported in the company's financial statements.

Amoco reported consolidated after-tax earnings of \$412 million for the quarter ended last Sept. 30, and \$983 million for the first nine months of 1987.

The Amoco Cadiz, a 1,095-foot Liberian registered tanker carrying 220,000 tons of light crude oil, ran aground off the coast of Brittany on March 16, 1978, after the mechanism controlling its rudder failed.

The ship eventually broke apart, spilling its entire cargo.

The accident created a flood of lawsuits, which were consolidated in U.S. District Court in Chicago before Judge McGarr.

A trial to determine who was liable for the disaster ended in November 1982 after six months of testimony. In April 1984, Judge McGarr ruled that Amoco was responsible

**The \$85.4 million judgment against Amoco will 'hardly recompense my clients for the damages they suffered,' says Barry Kingham.**

for the spill, noting that the oil company had failed both to follow adequate maintenance procedures on the Amoco Cadiz and to train its crew properly.

Judge McGarr also found Astilleros, the builder of the Amoco Cadiz, liable to Amoco for defective design of the supertanker.

Astilleros has refused to participate in the Chicago litigation, contending the court has no jurisdiction over it. The U.S. Supreme Court in 1983 declined to hear an appeal of a 1982 default judgment against Astilleros entered by Judge McGarr.

A separate damages trial ended last May in Chicago after more than one year of testimony.

In his Jan. 11 opinion, Judge McGarr, applying French law, disallowed several categories of damages claimed by the plaintiffs. These included substantial claims for ecological damage, loss of image in the tourist trade for French coastal towns and loss of enjoyment of the coastline.

Judge McGarr also reduced the amount of many claims he did allow, noting that after the 1984 liability decision, "exaggeration of claims became the norm, particularly on the part of the communes," referring to members of the Cotes du Nord group.

"The extent of this exaggeration was dramatically highlighted by a comparison of the final claims for damages with much earlier estimates of damages prepared by the com-

munes or arrived at by governmental agencies," the judge wrote.

To avoid currency fluctuation problems, Judge McGarr awarded damages in French francs.

Several ministries of the French government were awarded a total of 202 million francs (\$36.7 million at current exchange rates).

The 90 French communes were awarded a total of 46.2 million francs (\$8.4 million). Several other parties, including hotels and other businesses, were awarded a total of 4.7 million francs (\$853,000).

Judge McGarr also allowed prejudgment and post-judgment interest at a rate of 7.22% compounded annually.

The opinion also called for a hearing on how liability for the damages should be divided between Amoco and Astilleros.

Astilleros will be notified of the proceedings, although Judge McGarr noted that "the earlier refusal of Astilleros to submit to the jurisdiction of this court is a revealing predictor of Astilleros's response to this opportunity."

James Betke, a lawyer with the Chicago firm of McDermott, Will & Emery, representing Astilleros, said he doubted the shipbuilder will participate in the hearing.

Judge McGarr's opinion will not be entered as a final order until this and other matters are decided, according to Mr. Cicero, Amoco's lawyer, who noted that the parties will then have 30 days to appeal.

In addition to appealing both the 1984 liability ruling and last week's damage award, Amoco will seek to recover 100% of its losses from Astilleros, Mr. Cicero said.

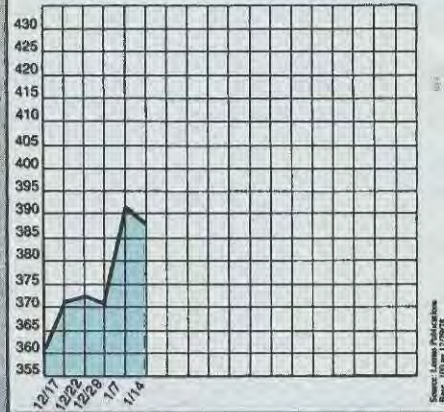
Amoco also is seeking recovery from the American Bureau of Shipping in a lawsuit currently pending in U.S. District Court in Chicago. However, Judge McGarr is expected to decide whether this case should be transferred to a federal court in New York, he said.

Amoco probably will not try to recover damages from Bugsier, Reederei & Bergungs A.G., a West German salvage firm that failed in an attempt to tow the Amoco Cadiz to safety, Mr. Cicero added. Judge McGarr threw out an Amoco cross-claim against Bugsier in 1984, ruling that the parties would have to arbitrate any dispute in accordance with the Lloyd's open-form salvage agreement that Amoco signed with Bugsier. Under the no cure-no pay salvage agreement, Amoco probably has no basis for seeking recovery from Bugsier.

Amoco never commenced arbitration proceedings against Bugsier and probably will not pursue the claim, Mr. Cicero said.

The Cotes du Nord parties also will appeal last week's ruling, said their attorney, Mr. Kingham. He said that Judge McGarr had misinterpreted French law in barring recovery of certain types of damages. Among other things, the plaintiffs will press claims for ecological damages and lost image in the tourist trade, he said.

## BI Insurance Index



Insurance industry stocks followed the rest of the market last week, as the *Business Insurance Index* dropped 5.2 points to 388.4 on Jan. 14 from 393.6 on Jan. 7. Advancing issues were led by: Farmers Group Inc., whose shares shot up 23.1% following a merger offer from B.A.T. Industries P.L.C. (see update, page 2). Farmers was followed by: Seibels Bruce Group Inc., up 10.4%; Northwestern National Life Insurance Co., up 7%; Old Republic International Corp., up 3.4%; and Protective Corp., up 3%. Declining issues were led by Statesman Group Inc., down 14.3%; Belvedere Corp., down 13.6%; Kemper Corp., down 8.6%; Frank B. Hall & Co. Inc., down 7.7%; and ITT Corp. (Hartford Group), down 7.2%. Issues showing the most activity during the period were: Sears Roebuck & Co. (Allstate), 31.8 million shares traded; Aetna Life & Casualty Co., 29 million shares traded; and ITT Corp. (Hartford Group), 25.9 million shares traded. The *Business Insurance Index* dropped 1.3% for the period, faring better than other market indicators: the Dow Jones 30 Industrials lost 135 points, a 6.6% decline; the Standard & Poor's 500 lost 15.2 points, a 5.8% decline; and the New York Stock Exchange composite fell 7.9 points, a 5.4% decline.

## British Issues

Jan. 14 Companies	Price	P/E	Div. %	Yield %	1 Week	
					High-Low	Change
Commi Union	335	13.7	17.8	5.3	340-332	
Genl Accident	828	10.9	38.3	4.6	838-827	
Genl Royal Exch	862	12.0	46.5	5.4	862-856	
Rayd	400	10.0	21.2	5.3	403-395	
Sun Alliance	830	12.8	32.2	3.9	878-830	

Brokers	Price	P/E	Div. %	Yield %	1 Week	
					High-Low	Change
CE Heath	415	13.8	34.5	8.3	417-415	
Hogg Robinson	138	10.6	9.6	6.9	140-138	
JH Minet	460	16.7	12.9	3.1	463-460	
Sedg Grp	228	14.3	16.4	7.2	228-219	
Willis Faber	240	10.9	14.8	6.1	240-233	

Source: Philip Olsen/Alan Clifton, Insurance Industry Specialists Kitcat & Aitken Stockbrokers, London

# BI Industry Stock Report

JAN. 14, 1988

1/7/88 THRU 1/14/88

BROKERS	Company	NYSE	Price	Weekly % change	Year to Date % change	Annual		Vol.(000)	\$ Div.	% Yield	P/E	Book value	Mkt/Bk. value	
						High	Low							
	Alexander & Alexander Svcs	NYSE	18.13	-0.7	2.1	32.00	15.88	651	1.00	5.5	12.7	2.98	6.08	
	Baldwin & Lyons Inc.	OTC	12.38	-1.0	3.2	27.00	12.00	6	0.20	1.6	4.7	16.40	0.75	
	Corroon & Black Corp.	NYSE	26.50	-1.7	0.9	37.50	22.00	132	0.84	2.9	13.3	6.31	4.52	
	Gallagher Arthur J & Co.	OTC	16.00	0.0	0.0	31.00	15.00	0	0.40	2.5	10.6	4.81	3.33	
	Hall Frank B. & Co.	NYSE	3.00	-7.7	4.2	19.00	2.50	296	0.00	0.0	10.6	0.00	N/A	
	Marsh & McLennan Cos. Inc.	NYSE	47.75	-4.0	-3.5	72.00	43.75	519	2.40	5.0	11.9	5.14	9.29	
	Poe & Assoc. Inc.	OTC	7.00	0.0	0.0	13.25	7.00	0	0.40	5.7	6.8	0.57	12.28	
	BROKERS AVERAGE			-2.2	1.0					3.3	10.0			
	<b>CONGLOMERATES &amp; HOLDING COMPANIES</b>													
	Berkley W.R. Corp.	OTC	23.50	-6.0	-2.1	37.00	18.75	596	0.28	1.2	5.9	13.72	1.71	
	Berkshire Hathaway Inc. DEL	OTC	3030.00	1.0	2.7	4400.00	2510.00	132	0.00	0.0	19.0	62.53	3.15	
	CIGNA Corp.	NYSE	48.50	-0.3	10.5	69.50	41.25	777	2.80	5.8	6.0	45.17	1.07	
	CNA Fin'l Corp.	NYSE	54.13	-4.0	-2.7	66.50	47.00	297	0.00	0.0	9.7	42.71	1.27	
	General Re Corp.	NYSE	52.00	-5.2	-6.9	68.88	46.00	1057	1.00	1.9	11.8	23.47	2.22	
	ITT (Hartford Group)	NYSE	45.25	-7.2	0.6	66.38	41.88	2586	1.25	2.8	8.8	44.08	1.03	
	Sears Roebuck & Co. (Allstate)	NYSE	33.50	-4.3	-0.4	59.50	29.75	3181	2.00	6.0	7.8	32.94	1.02	
	Transamerica Corp.	NYSE	31.00	-4.3	4.2	51.38	22.63	544	1.84	5.9	5.9	26.94	1.15	
	CONGLOMERATES AVERAGE			-3.8	0.7					3.0	9.3			
	<b>INSURERS</b>													
	Aetna Life & Cas Co.	NYSE	45.88	-2.9	1.4	68.13	43.50	2895	2.76	6.0	6.2	44.75	1.03	
	American General Corp.	NYSE	30.88	-6.1	-2.7	44.75	27.25	1045	1.25	4.0	8.2	27.13	1.14	
	Amer Heritage Life Inv't	NYSE	24.25	-2.0	0.0	34.00	23.00	3	0.96	4.0	11.6	20.37	1.19	
	Amer Indty Fin'l Corp.	OTC	9.25	-2.6	2.8	19.00	7.75	13	0.56	6.1	11.6	20.40	0.45	
	American Int'l Group	NYSE	59.50	-4.0	-0.8	83.75	53.50	1638	0.30	0.5	11.1	29.02	2.05	
	Aneco Reins Ltd.	OTC	3.38	0.0	0.0	4.38	2.13	45	0.00	0.0	11.1	1.93	1.75	
	ACN Corp.	NYSE	23.50	-2.6	2.7	29.88	20.50	170	1.20	5.1	8.3	15.23	1.54	
	Argonaut Group	OTC	31.00	-3.1	4.2	52.13	21.00	171	0.00	0.0	6.4	14.60	2.12	
	AVEMCO Corp.	NYSE	18.75	-3.8	-4.5	25.25	13.25	44	0.28	1.5	11.2	8.94	2.70	
	Belvedere Corp.	AMEX	4.75	-13.6	8.4	9.13	4.00	16	0.04	0.8	59.4	6.71	0.71	
	Business Mens Assurn Co.	OTC	26.75	-1.8	0.0	48.25	25.25	48	1.10	4.1	37.7	22.15	1.21	
	Chubb Corp.	NYSE	56.13	-1.1	0.4	73.50	50.88	468	1.88	3.3	7.4	39.52	1.42	
	Continental Corp.	NYSE	38.63	-3.1	-0.3	54.88	30.50	549	2.60	6.7	7.3	41.62	0.93	
	Durham Corp.	OTC	22.50	-1.1	4.7	34.00	20.00	9	0.92	4.1	18.1	26.15	0.86	
	Farmers Group Inc.	OTC	55.38	23.1	37.6	60.00	37.75	-1227	1.20	2.2	16.2	19.95	2.78	
	Fireman's Fund Corp.	NYSE	27.50	1.9	5.8	42.75	24.13	522	0.40	1.5	50.9	23.55	1.17	
	Fremont Group Corp.	OTC	10.13	1.3	5.2	20.50	7.88	130	0.60	5.9	50.9	16.75	0.60	
	Home Genl Corp.	NYSE	12.38	1.1	4.2	24.88	10.50	336	0.20	1.6	2.1	16.30	0.76	
	Hanover Ins Co.	OTC	23.50	-5.1	1.1	37.25	21.38	51	0.36	1.5	5.0	21.16	1.11	
	Hartford Steam Boiler Insp	OTC	24.00	2.1	4.3	36.63	20.25	166	1.00	4.2	9.5	10.17	2.36	
	Kans City Life Ins	OTC	25.50	-5.6	-2.9	31.50	21.50	0	0.00	0.0	9.5	0.00	N/A	
	Kemper Corp.	OTC	21.25	-8.6	3.7	38.75	19.25	861	0.72	3.4	6.4	23.48	0.91	
	Liberty Corp. S.C.	NYSE	35.00	-0.7	-1.4	53.00	32.50	14	0.80	2.3	15.7	19.96	1.75	
	Lincoln Nat'l Corp.	NYSE	43.63	-1.7	8.7	60.50	35.75	452	2.36	5.4	8.8	44.85	0.97	
	NAC Re Corp.	OTC	20.63	2.5	16.2	32.25	17.50	32	0.00	0.0	19.1	18.12	1.14	
	Nobel Ins Ltd.	OTC	9.25	2.8	5.7	18.50	7.75	17	0.40	4.3	44.0	9.37	0.99	
	Northwestern Nat'l Life	OTC	26.88	7.0	17.5	32.38	20.75	197	0.96	3.6	7.1	33.26	0.81	
	Ohio Cas Corp.	OTC	35.25	-2.8	-2.8	49.25	33.50	165	1.68	4.8	8.3	26.80	1.32	
	Old Rep Int'l Corp.	OTC	22.88	3.4	14.4	33.63	18.88	169	0.74	3.2	7.2	19.80	1.16	
	Orion Cap Corp.	NYSE	13.75	-2.7	1.9	31.00	11.00	35	0.76	5.5	7.2	9.39	1.46	
	Phoenix Re Corp.	OTC	7.00	0.0	7.7	14.63	5.00	34	0.00	0.0	4.9	9.43	0.74	
	Protective Corp.	OTC	13.13	3.0	7.2	21.25	11.38	122	0.70	5.3	12.4	16.51	0.80	
	Provident Life & Acc Ins Co.	OTC	16.63	-2.2	6.4	28.75	14.25	174	0.84	5.1	41.6			

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