

business insurance

Judge to reconsider ruling on captive tax deductions

DENVER—A recent federal court ruling involving tax deductions for premiums paid to a captive insurance company owned by Stearns-Roger Corp. Inc. in Glendale, Colo., has been withdrawn for reconsideration by the judge who rendered the decision.

Judge Jim R. Carrigan ruled in November that premiums paid by Stearns-Roger to its Colorado captive are not tax-deductible as business ex-

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

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The top stories of 1983

When Business Insurance decided to select the top stories of 1983, we went right to our readers to gauge what were the most significant events of the past year. We asked the members of both the BI Risk Management Board and Employee Benefit Board to rank the key stories of 1983. The results in some cases were

obvious and in other cases very interesting. See if you agree with their choices.

The winners are listed below, stories on both board surveys begin on Page 3 and a synopsis of each of the top five risk management and benefit stories is contained on pages 9-12.

Risk management winners

1. Kaiser Steel allowed deduction for work comp reserves.
2. Competition keeps property/casualty coverage rates low.
3. MGM Grand begins battle for retroactive fire coverage.
4. Regulators tighten rules for workers comp self-insurers.
5. South Dakota law allows banks to underwrite insurance.

Benefits winners

1. Norris decision outlaws sex as factor in retirement benefits.
2. Congress OKs major revamping of Social Security system.
3. Regulations issued on older workers' health care coverage.
4. Employers continue efforts to cap rising health care costs.
5. Taxing of employer-paid health insurance premiums urged.

Township wants coverage for \$15 million pollution award

By DOUGLAS McLEOD

NEW YORK—A New Jersey municipality hit with a \$15.6 million verdict in a pollution lawsuit is gearing up for another court battle with five former liability insurers over coverage for the loss.

About 325 residents of Jackson Township recently won the multi-million-dollar verdict in a lawsuit claiming that toxic wastes leaching from a municipal landfill contaminated their well water.

The award included about \$8 million for future medical surveillance for increased risk of cancer and other diseases; \$5 million for diminished "quality of life"; and \$2 million for emotional distress.

Lawyers say the township will appeal the verdict.

Meanwhile, the township and residents are preparing for a new trial to determine how much of the loss will be paid by insurers.

Like the coverage litigation surrounding asbestos injury claims, this trial is expected to center on the issues of how "occurrence" is to be defined and whether coverage for bodily injury is triggered by exposure to a hazardous substance or by manifestation of the injury.

The insurers, which initially denied coverage on the basis of the liability policies' pollution exclusion, were earlier ordered by an appellate court to pay the costs of defending the township against the residents' lawsuit.

The residents filed their suit in New Jersey Superior Court in Ocean County in 1980, two years after the state Department of Environmental Protection ordered the landfill closed and the residents were warned against drinking their well water (BI, Feb. 25, 1980).

Tests of the aquifer running under the landfill, which was licensed in 1972 to contain mainly septic wastes, found traces of sev-

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Inaccurate reserving costs employer tax deductions

By JERRY GEISEL

PORTLAND, Ore.—An employer's self-insured reserves for workers compensation claims must be within 7% of the claims ultimately paid to qualify for a tax deduction, a U.S. district judge has ruled.

If an employer's reserves are not within 7% of the claims paid, the company has not determined its liability with "reasonable accuracy" and thus is not entitled to take tax deductions for the reserves, says U.S. District Court Judge James Redden.

The average inaccuracy of ESCO Corp. of Portland, Ore., was 10.17% over the three-year period of 1973 to 1975, Judge Redden said. Therefore, the company is not entitled to tax deductions it sought for reserves established, he ruled.

According to the state workers compensation director, ESCO had underreserved by an average of 10.17% during 1973, 1974 and 1975.

Referring to the 9th U.S. Circuit Court of Appeals' decision that said Kaiser Steel Corp. was entitled to take a deduction for reserves for workers compensation claims, Judge Redden noted that the court said in Kaiser that a 7% inaccuracy is within the realm of reasonable accuracy (BI, Oct. 17, 1983).

"In this case, the average inaccuracy is 10.17%. I find that such discrepancies are not sufficiently accurate for tax accounting purposes," Judge Redden said.

"I conclude that the plaintiff has failed in its burden to prove that its reserves can be determined with

reasonable accuracy in the year of injury," he added.

Experts, though, already are labeling Judge Redden's decision as "wrong," even "incomprehensible," and are advising employers that they should not rely on it in deciding whether to take tax deductions for the reserves they establish to pay workers compensation claims.

"It is a wrong decision," said Clarence Greenwood, an attorney with Black, Heltertine, Beck & Rappleyea, a Portland, Ore., law firm that represents ESCO. "He (Judge Redden) is so far off compared with what the 9th Circuit did in Kaiser Steel."

Employers should not attach too much significance to Judge Redden's decision, said Marc M. Levey, a former Justice Department attorney and now an attorney in the San Francisco office of Baker & McKenzie.

Judge Redden's decision, Mr. Levey observed, clashes with a higher-court ruling (the Kaiser Steel decision) in the same circuit. Other appellate courts that will tackle the issue of tax deductions for workers compensation reserves would look much more closely at a decision handed down by another appellate court rather than by a federal district judge.

At best, Judge Redden's ruling could become a footnote in another case rather than the basis of a decision, Mr. Levey added.

But another attorney warned that Judge Redden's ruling could stiffen the Internal Revenue Service's re-

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Judge reconsiders captive case

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penses. However, Judge Carrigan withdrew his decision for reconsideration on Dec. 12, following a Dec. 2 hearing on post-trial motions brought by Stearns-Roger. The judge did not give a reason for this action, said an attorney for the worldwide construction company.

"We are optimistic and hopeful that he will reverse his opinion, but he may just want to revise it," said the attorney. There is no deadline for Judge Carrigan to announce his final decision.

Hall settles shareholder suits

BRIARCLIFF MANOR, N.Y.—Frank B. Hall & Co. Inc. says it has settled four shareholder suits by agreeing to pay plaintiffs' lawyers \$120,000 and revise anti-takeover benefits adopted for directors to thwart a 1981 takeover attempt by Ryder System Inc.

The suits had alleged Hall directors breached their fiduciary duty to shareholders in adopting the anti-takeover measures during October 1981. The suits had been pending in a Delaware chancery court (BI, June 28, 1983).

Under the dismissal agreements, Hall agreed to reinstate agreements with its directors prohibiting them from working for any Hall competitor within three years after they leave the insurance broker unless they are arbitrarily or unjustly fired, said Thomas G. O'Brien III, Hall's general counsel.

Mr. O'Brien said Hall directors had also agreed to revoke a provision that would have allowed them to immediately cash all stock and options following an unfriendly takeover. Instead, directors would receive their holdings in three installments, requiring them to remain up to 25 months following a takeover.

Justice Department gets delay

WASHINGTON—Supreme Court Justice William H. Rehnquist has agreed to extend by one month the deadline for the Justice Department to announce it will file a writ of certiorari in connection with an appellate court decision that gives self-insured employers the right to deduct workers compensation reserves.

The Justice Department had been facing a Jan. 6 deadline to notify the high court that it wants it to review the Kaiser Steel Corp. decision, handed down by the 9th U.S. Circuit Court of Appeals last year (see story, page 3).

The Justice Department wanted the deadline for notifying the court extended to Feb. 18, but Justice Rehnquist agreed to extend the deadline to Feb. 6.

Asbestos defendants win case

CHICAGO—In a decision favorable to asbestos defendants, a federal appeals court has affirmed a lower-court ruling requiring victims of asbestos disease suing in Indiana to bring lawsuits within two years after their last exposure to the substance.

The 7th U.S. Circuit Court of Appeals rejected in a 2-1 decision plaintiffs' arguments that the Indiana statute of limitations only begins after victims discover their injuries.

As a result, plaintiffs who don't become aware of their asbestos injuries until many years after their last exposure, will be barred from recovery. The dissenting judge in the case called the decision a "mockery of justice."

The decision affirmed the dismissals of seven suits brought by former asbestos workers and spouses at a New Castle, Ind., factory operated by the World Bestos Division of Firestone Tire & Rubber Co. Defendants included Flintkote Mines Ltd., Bell Asbestos Mines Ltd. and Raybestos-Manhattan Inc.

An attorney for the plaintiffs has asked for a rehearing before the appeals court.

Trucker told to pay \$11.8 million

CHICAGO—In what may be the largest award of its kind in Illinois, a Cook County Circuit Court jury has awarded \$11.8 million to the survivor of a suburban Chicago family involved in a 1981 accident caused by an employee of an Oklahoma trucking company.

H.J. Jeffries Truck Lines Inc. of Oklahoma City was ordered to pay the award Dec. 20, after a jury found the driver to be negligent.

The jury found that the driver crossed the median line on a local highway and slammed his rig into a car driven by Carol Rickerson of Streamwood, Ill., and her sons Scott and Steven. Ms. Rickerson and Scott were killed, while Steven, now 13, is a quadriplegic confined to a hospital.

The jury ordered the company to pay a total of \$1 million to Carol and Scott Rickerson's estates and \$10.8 million to Steven.

A Jeffries spokesman said the company has a \$25,000 self-insured retention and enough excess coverage to pay the remainder of the award, though he could not disclose the insurers or the limits. A decision has not been made on whether to appeal, he said.

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Classifieds	21	ance (ISSN 0007-6864) is published
Datebook	13	weekly at 740 Rush St., Chicago,
Insurance services guide	22	Ill. 60611. Second-class postage is
Legal briefs	17	paid at Chicago, Ill., and at additional
Letters	6	mailing offices. Postmaster:
Opinions	6	Send address changes to Business
Perspectives	15	Insurance, circulation department,
Ticker	23	740 Rush St., Chicago, Ill.,
Washington	21	60611; 312-649-5221. Copyright
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Companies collect awards for Iranian expropriations

By STEPHEN TARNOFF

THE HAGUE, Netherlands—U.S. companies pressing claims against the Iranian government stand a better chance of collecting following recent decisions by the special tribunal hearing the claims, attorneys say.

The international tribunal last month for the first time authorized awards to U.S. companies for property that was expropriated during the 1979 Islamic Revolution in Iran.

All previous tribunal awards have dealt with non-expropriation claims.

The beneficiaries of the decisions are Starrett Housing Corp. and American International Group Inc., both of New York City. Attorneys involved in the cases say the decisions could establish a precedent for future cases.

"In terms of other companies, the fact the tribunal found there was an expropriation will reflect on the cases behind it," said Starrett President Richard Basuk.

Stephen Kaye, chief counsel for Starrett with the New York firm of Proskauer Rose Goetz & Mendelsohn, added the decision is important because it is the first by the tribunal involving expropriation of a company's property and also because of the large amount of money involved in the case.

In addition, the tribunal's award in the AIG case is

important because it included profits the company would have earned had its interest in an Iranian insurer been expropriated, rather than just the book value of the investment, attorneys for the company said.

Besides the expropriation awards, the tribunal also recently approved one of the largest settlements agreed to so far between the Iranians and a U.S. company: \$42.7 million to E.I. du Pont de Nemours & Co. Inc. of Wilmington, Del.

The DuPont case is different from the Starrett and AIG cases in that it is a settlement, while the other two were awards by the tribunal that were contested by the Iranians.

The claims tribunal was established under the 1981 agreement that freed the U.S. hostages held by the Iranians. About 3,300 claims valued at a total of \$4 billion—including more than 500 individual claims exceeding \$250,000—have been filed with the panel.

So far, the tribunal has handed down 96 decisions that include awards of more than \$173.8 million, said a spokesman for the U.S. State Department's Office of Iranian Claims.

Iran is funding the awards through a \$1 billion security fund established by the hostage agreement. The Iranians have agreed to replenish the fund when it falls below \$500 million.

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Church group seeks benefit, risk management programs

By LEN STRAZEWSKI

WASHINGTON—The Congress of National Black Churches has made its New Year's resolution: a combined property/casualty risk management program by summer for its 60,000 member churches and a group health and retirement program by this fall.

The resolution has a good chance of coming true, says CNBC Executive Director Joseph Eaglin, with the help of the group's new risk management partner, Aetna Life & Casualty Co.

CNBC and the insurer agreed last month to develop one of the nation's largest association insurance programs for churches, aimed at marketing discounted commercial insurance coverage to CNBC members and supplemental employee benefits to their estimated 250,000 employees.

Although the first step in the association program will be a property/casualty package plan designed to cover church, school and related property, liability and automobile risks, the church group's prime goal is health and retirement benefits.

"We are certainly interested in establishing enhanced property and liability insurance for our members," explains Mr. Eaglin, "but our first concern and reason for establishing this partnership with Aetna was employee benefits."

"Everyone knows that churches don't always pay

their employees very well and dedicated workers aren't very concerned that their salaries aren't very competitive. But they and their employers are concerned about employee benefits, particularly retirement annuities and health insurance."

Few CNBC member churches now offer pension plans or individual retirement benefit options to employees, and none of the seven denominations that make up the organization offer a group pension plan to their church employees, Mr. Eaglin says.

"Our members have become particularly sensitive to this need," he says. "We feel that it is absolutely necessary that ministers and their families and church employees be properly provided for upon their retirement. This has been a problem our members have had in the past and a major issue in getting and keeping good career employees."

Group health insurance is also a major issue, he explains. Like any small business, churches are subject to high group insurance rates based upon experience pooled with other small businesses and inflated by the rising cost of health care.

"Often our ministers are married to teachers or other working spouses and can receive coverage under their spouses' health insurance. But many are not and so are forced to pay exorbitant premiums or go without insurance."

"We feel there is a desperate need for comprehen-

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Tut's curse hurts underwriters

By STACY SHAPIRO

LONDON—Is it the curse of King Tut that will force Lloyd's of London underwriters to pay a disputed \$525,000 claim to HTV Ltd., a British television company?

Or, is it just a hole in the wording of the entertainment risk insurance policy that will make underwriters pay?

Whichever, a recent British High Court decision regarding King Tut's curse may prompt Lloyd's to change the wording on its entertainment risk policy.

Lloyd's became involved in the famed curse in 1979 when underwriters agreed to insure HTV's filming of a program called "The Curse of King Tut's Tomb."

Led by underwriter George Lintner of Edward Williams, Coutts & Partners Ltd., Lloyd's insured HTV's production for all risks under an entertainment risk insurance policy, which includes cast insurance, loss to film negatives, props, set and wardrobe and any extra expenses that arise because of a loss.

The film recounts the 1922 British expedition to Luxor, Egypt, to open King Tutankhamen's treasure-filled tomb, which was inscribed with a curse threatening death to all who entered.

Lord Carnarvon, who sponsored the expedition, died from the effects of a mosquito bite while the tomb was

being cleared. And, all but one of the 20 archaeologists on the team died within 10 years of the opening of the tomb.

The curse—if it's real—may have carried over to the production of the film.

During the filming, actor Ian McShane—who was to play archaeologist Howard Carter, the man who actually opened the tomb—was required to drive a 1928 Ford Model A across a 50-foot plateau. But, he was unable to stop the car and drove over the edge of the plateau, breaking his leg in the fall.

HTV filed a claim for 248,047 pounds (\$372,070) for the delay of production, plus the cost of hiring a new actor, Robin Ellis, to play the lead role. But Lloyd's refused to pay.

The underwriters, led by Mr. Lintner, told the High Court that, according to the entertainment risk policy, HTV had to show "due diligence" in order for a claim to be paid. But, the underwriters alleged, HTV did not show due diligence. Underwriters claimed that HTV knew the car had faulty brakes before Mr. McShane began driving it.

"They knew the car was a wreck and knew the car was faulty," said one Lloyd's underwriter on the risk. "As a result, he broke his leg."

But, HTV contended that it did not have to prove due

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Top stories of 1983

Kaiser Steel decision tops risk managers' list

By JAMES M. BURCKE

Risk managers nominated a broad spectrum of events as the top five risk management stories of 1983, but their two overwhelming choices both impact risk management departments' bottom line.

They both also have been many years in the making.

The top story, according to a panel of risk managers surveyed by *Business Insurance*, was the decision by the 9th U.S. Circuit Court of Appeals that Kaiser Steel Corp. had the right to deduct \$425,418 in reserves set aside in 1964 to pay self-funded, uncontested workers compensation claims (see synopsis, page 9).

The ruling allows employers in the 9th Circuit—which includes Alaska, Arizona, California, Hawaii, Idaho, Montana, Nevada, Oregon, Washington and Guam—to take deductions for similar workers compensation reserves.

And, employers throughout the nation could win this right if the Supreme Court upholds the 9th Circuit's decision. The government is expected to ask the high court to hear the Kaiser Steel case.

Although the Kaiser Steel decision could end up saving employers millions of dollars, the second-place story as selected by the risk managers may have saved corporate risk management departments even more money.

The risk managers rated the continuing rate war by property/casualty insurers—which has lowered costs for commercial insurance buyers for the

past seven years, as well as lowering the insurers' profits—as the second most important story of 1983 (see synopsis, page 9).

The third-, fourth- and fifth-place stories did not have as big of an effect on risk managers' budgets, but all could affect how risk management is practiced in the future.

The continuing litigation over the retroactive liability insurance bought by MGM Grand Hotel Inc. to cover losses for the 1980 fire at its hotel in Las Vegas, Nev., and other litigation stemming from the disaster won the third-highest number of votes. The outcome of the litigation could affect the pricing and availability of backdated liability coverage (see synopsis, page 10).

The risk managers' fourth choice was the move by state insurance regulators, in the wake of a rash of corporate bankruptcies, to toughen the regulations that workers

compensation self-insurers must follow. In most cases, states required self-funders to purchase some form of guarantee—such as a surety bond—or increase security deposits to make sure that claims would be funded should the employer go belly up (see synopsis, page 10).

Finally, risk managers rated as the fifth most important story of the past year the law enacted by South Dakota that allows state-chartered banks to underwrite and sell insurance.

Similar banking bills are expected to be introduced in other states this year, despite the opposition of insurance companies, agents' groups and some insurance regulators who say banks could pressure loan applicants into buying insurance written or marketed by the bank (see synopsis, page 10).

To determine the top five risk management stories of the year, *Business Insurance* sent a list of major stories that occurred in 1983 to members of its Risk Management Board. Board members were asked to rank in order from 1 to 5 the five most significant risk management stories of the year.

When the survey—which was answered by 55 board members—was tallied, votes were assigned weighted values. A story was given five points for each first-place vote it received; four points for second-place votes; three

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Benefit managers' choices focus on rule changes

By LORRIE GIBSON

For benefit managers, 1983 was a year of change—but not necessarily of their own choosing.

Not since the Employee Retirement Income Security Act was enacted in 1974 have benefit plans been impacted so hard by new rules and regulations. And, the top three stories of the year, as determined by a *Business Insurance* survey of benefit managers, are all tales of new burdens placed on corporate benefit plans by the courts and Congress.

The top story in 1983: The Supreme Court in early July rules in the Norris case that sex no longer can be a factor in calculating retirement benefits. If men and women make equal contributions to a retirement plan, they must receive equal monthly benefits (see synopsis, page 10).

The second most significant story: President Reagan's Social Security commission releases its recommendations for shoring up the ailing system in January and, by March, Congress approves the changes (see synopsis, page 11).

And, the third most significant story: The Equal Employment Opportunity Commission drafts new regulations that require employers to offer workers between the ages of 65 and 69 a choice of enrolling in corporate group health insurance plans or sticking with Medicare as their primary health insurer (see synopsis, page 12).

So in the first half of 1983, benefit managers were told to change the way they provide benefits under retirement plans, help bail out the Social Security system and offer older workers primary health care coverage.

Although benefit managers continued to struggle with spiralling health care costs in 1983, the story of their cost-containment efforts took a backseat to these mandated benefit changes in the *BI* poll, coming in fourth (see synopsis, page 11).

The fifth biggest story of the year reflects again the undeniable trend of more government interest in corporate benefits: Congress proposes taxing employees on employer health insurance contributions above certain levels (see synopsis, page 12).

To determine the top five benefit stories of the year, *Business Insurance* sent a list of the major stories of 1983 to the mem-

bers of its Employee Benefit Board. Board members were asked to rank in order from 1 to 5 the five most significant benefit news stories of the year.

When the survey, which was answered by 144 board members, was tallied, votes were assigned weighted values. Each story was given five points for each first-place vote it received; four points for each second-place vote; three points for each third-place vote; two points for each fourth-place vote; and one point for each fifth-place vote.

The points each story received were totaled, and the five stories with the highest cumulative scores were designated the top stories of the year.

It was a close race between the Norris decision and the Social Security changes.

The Norris decision, which especially affects defined contribution pension plans that provide benefits through annuities purchased for retirees, received the highest cumulative score: 369 points.

But, the Social Security changes scored an equally impressive 357. And, in fact, the Social Security legislation received more first-place votes than the Norris decision or any other story.

This probably reflects the fact that almost all employers are affected by the

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Top risk management stories

	Number of votes					Total points*
	1st	2nd	3rd	4th	5th	
Kaiser decision	12	9	1	6	5	116
Rate cutting	12	8	5	1	2	111
MGM litigation	5	4	5	1	1	59
Regulation of work comp self-insurers	3	2	5	6	1	51
Bank sales of insurance	3	6	1	2	3	49
Captive/retroactive coverage bill considered	3	3	2	5	4	47
Hazardous substance labeling	4	2	3	3	3	46
Hyatt skywalk litigation	3	3	3	3	2	44
Ian Posgate suspended	5	—	4	—	5	42
Brokers' growth slows	3	4	1	3	1	41

*Five points awarded for first-place votes, four points for second-place votes, etc.
Source: *BI* survey

Top employee benefit stories

	Number of votes					Total points*
	1st	2nd	3rd	4th	5th	
Norris decision	24	35	22	14	15	369
Social Security	36	19	19	13	18	357
Older workers' health coverage	19	21	20	20	25	304
Cost containment	28	13	13	11	18	271
Taxing health care premiums	12	12	11	19	30	209
Unisex rating legislation	7	4	18	12	17	146
Flexible benefits	3	7	5	9	11	87
Stark-Conable bill	3	8	5	8	9	87
Equitable pregnancy benefits	2	4	7	8	12	75
PPOs	2	2	8	7	17	73

*Five points awarded for first-place votes, four points for second-place votes, etc.
Source: *BI* survey

Kaiser decision voted top risk management story

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points for third-place votes; two points for fourth-place votes; and one point for fifth-place votes.

The points each story received were totaled and the five stories with the highest cumulative scores were designated the top stories of the year.

The top two stories of the year—the Kaiser Steel decision and the continued competitive property/casualty insurance marketplace—were by far the highest vote-getters, with the Kaiser Steel decision edging insurer rate-cutting by just five points, 116 to 111.

Interestingly, both of these stories garnered 12 first-place votes apiece, more than double the number of first-place selections earned by any other story. And the Kaiser Steel decision and insurer rate-cutting received nine and eight second-place votes respectively—again more than any other story listed on the survey.

The importance risk managers gave to the Kaiser Steel decision and insurer rate-cutting also can be seen in the wide margin between the second-place and third-place stories (see chart, page 3). The 111 points earned by insurer rate-cutting was almost double the number of points given to the third-place story, the MGM Grand litigation. That story earned only 59 points, attracting five first-place votes.

Ranking fourth was the increased regulation of workers compensation self-insurers, which attracted 51 points, including three first-place ballots. It narrowly edged out the South Dakota law allowing banks to write and sell insurance, which attracted 49 points and three first-place votes.

If competition for the third, fourth and fifth positions in the ranking of the top stories was close, it was even closer among positions six through 10. Only six points separated the sixth-place and the 10th-place stories.

Ranking sixth, with 47 points, was a story that could almost be labeled a “non-event”: a proposal before the Senate Finance Committee that would ban corporate tax deductions for the purchase of back-dated liability insurance and for coverages underwritten by a captive insurance company (BI, Oct. 25).

Although this proposal has never been written into a formal bill, Washington lobbyists say it contains distinct threats to the risk management community.

Several risk managers must have agreed. Even though the proposal was unveiled shortly before the survey was taken, it received 47 points—just two less than were given to bank sales of insurance. It was also named as the top story of 1983 by three risk managers.

Just one point behind, with 46 points, was the seventh-place story: the efforts by a growing number of states and the federal government to make employers tell workers if they are handling hazardous material, including detailing the substances being handled. This story received four first-place votes.

Ranking eighth in the survey of top risk management stories was a multifaceted story: the litigation arising from the 1980 skywalks collapse at the Hyatt Regency Hotel in Kansas City, Mo.

In 1983, federal and state court class-action settlements in the Hyatt case were approved, settling the vast majority of injury claims stemming from the tragedy. With these settlements, insurers expect that liability costs from the disaster will top out at \$100 million (BI, Jan. 17).

While most of the claims were settled, the coverage dispute continues between hotel operator Hyatt Corp., hotel owner Hallmark Cards Inc. and their insurers. And, Hyatt sued broker Marsh & McLennan Inc. over the disputed coverage.

The Hyatt story garnered 44 points and

three first-place votes.

The ninth-ranked story was one of the most-reported of the year: The suspension of one of Lloyd's of London's most successful underwriters, Ian R. Posgate, after he was accused by Alexander Howden Group P.L.C. and parent company Alexander & Alexander Services Inc. of misappropriating \$56 million in Howden assets along with four other ex-Howden officials (BI, Jan. 31).

Although Mr. Posgate's suspension received just 42 votes, five risk managers judged it the most important story of 1983. Only the Kaiser decision and insurer rate-cutting won more first-place votes.

Rounding out the top 10, and receiving 41 points from the surveyed risk managers, was the rough year reported by the nation's top insurance brokers. The 20-largest brokers reported in 1983 that revenues grew only 10% in 1982, the lowest growth rate in the 12 years that *Business Insurance* has ranked the nation's top brokerages (BI, June 27).

Although it did not rank in the top 10, the 11th-ranked story is interesting to note, because it could have a great effect on the second-place story.

The 11th-place story—the desire expressed by world reinsurers to increase rates during year-end renewals—could have a great effect on rate-cutting by primary insurers should the reinsurers get their way.

The reinsurance story attracted 39 points, just two less than the story of the brokers' slow growth. And, most interestingly, the reinsurers' desire to raise rates drew five first-place votes, ranking it with the MGM litigation and Mr. Posgate's suspension, but behind insurer rate-cutting and the Kaiser Steel decision.

Could it be possible that those five risk managers thought the prospect that rates may someday rise was more important than

the reality of declining prices?

Besides noting how many points each of the 10 stories received, their importance can also be rated by the number of ballots on which they were named.

Interestingly, only the two top vote-getters, the Kaiser Steel decision and insurer rate-cutting, were named on a majority of the ballots cast. Thirty-three of the risk managers ranked the Kaiser Steel decision as one of the five most important stories of the year, and insurer rate-cutting was mentioned on 28 different survey responses.

Conversely, the MGM Grand litigation, the third-place story, was mentioned on only 16 ballots. That means that less than one-third of the risk managers voting thought the MGM Grand litigation was one of the five most important stories of the year, which can be seen as a reflection of the diversity of the surveyed risk managers' interests.

Although the MGM story ranked third on the basis of total number of points received, it rated only fifth if the stories are ranked by the number of ballots on which they were named.

Tied for third on this basis, ahead of the MGM story, were the increased regulation of workers compensation self-insurers and the proposal to deny tax deductions for backdated liability insurance and coverage bought from captives. Each of these stories was named on 17 risk managers' ballots.

After the MGM litigation in fifth place, came two stories each named on 15 ballots: the South Dakota law enabling state-chartered banks to write and sell insurance and the effort to force employers to label hazardous substances.

Tied for eighth place, named by 14 risk managers, were the Hyatt skywalk litigation and the suspension of Mr. Posgate by Lloyd's of London.

Finally, receiving 12 mentions, was the brokers' off year.

1983: The pinnacle or the pits for risk managers?

Poll shows differing opinions on the events of the past year

Do you think 1983 was a “great year” for risk managers?

Or, would you classify 1983 as “exciting”? How about “lean and mean”?

Or, are you a supreme pessimist and would agree with the risk manager who summed up 1983 as “the pits.”

You would have some support if you agreed with any of these risk managers' descriptions of 1983.

Business Insurance polled members of its Risk Management Board for their feelings on the events that transpired in the past year, as well as to learn what they thought were the top risk management stories of 1983 (see story, page 3).

The risk managers were simply asked by *Business Insurance*: “How would you describe 1983?”

The question may have been simple, but the answers were not. As the aforementioned responses show, risk managers took very differing views of the past year.

Besides the risk manager who summed up 1983 as simply “exciting,” many other risk managers thought 1983 should be classified as a good year, though many didn't share this risk manager's view that 1983 was full of excitement.

“It was a quiet year; it was a good year,” summed up one risk manager.

“A quiet year on all fronts,” another agreed.

Some of the risk managers considered 1983 a good year because of the continuing competition among property/casualty insurers that has lowered rates for commercial insurance buyers. In fact, the surveyed risk managers voted rate competition as the second most important story of 1983.

“A continued good year for the buyer,” said one risk manager. But, interestingly enough, this risk manager did not think that the continued insurer rate competition was one of the top five risk management stories of 1983.

“A good year that, due to keen competition, saw premium rates fall and insurers offer innovative renewal proposals,” was the thought of another risk manager. However,

this risk manager ranked insurer rate competition as the top risk management story of the year.

In fact, this risk manager was so rate-conscious that he selected as the second most important story of 1983 the desire of reinsurers to seek higher rates during year-end renewals, a story that only ranked 11th on the survey of the top stories of the year.

Another risk manager summed up 1983 as “a soft insurance market; lots of capacity; (insurance) companies wanting to hold onto major accounts and making ‘large’ concessions in the cash-flow areas.” This risk manager also rated insurer rate-cutting as the top story of the year.

Besides low rates, risk managers also noted the advancement of risk management during 1983 as one of the highlights of the year.

The same risk manager who singled out the soft market also noted that in 1983, “Risk managers have begun their climb up the corporate ladder,” although the risk manager added that “males have the advantage over females.”

Another risk manager added that 1983 was “the year that made risk management the trend rather than the fad.”

One risk manager noted that 1983 was not an easy year in which to practice risk management, but he said that it was a good year nonetheless.

“Early 1983 (was) very difficult but encouraging,” the risk manager explained. “As the year progressed, economic improvements were clearly longer-term. The year 1983 has been an exciting, challenging, hard but enjoyable year.”

Others didn't think 1983 was so enjoyable. Some were able to cite a litany of setbacks and catastrophes, but most of the risk managers who didn't think too much of the past year were concise in their remarks—like the

risk manager who termed 1983 as “lean and mean,” or the one who called the past year “the pits.”

Some risk managers were very specific about what they thought were the tumultuous events of 1983.

“Self-insurers (and) captives generally being treated unfairly” was the lowlight of the year for one risk manager.

Interestingly, this person rated the Kaiser Steel decision, in which Kaiser Steel Corp. was allowed to take tax deductions for some reserves for self-insured workers compensation claims, as only the second most important story of 1983. That story was the top vote-getter among the risk managers surveyed.

Another risk manager was quite specific in naming what he thought were the trouble spots of the past year.

“Mind-boggling! What a year!” he noted. “Walton in the Bermuda market. . . ; Baldwin-United in the American market. . . ; A&A, Howden and Posgate in the London market and the new CEO (at Lloyd's of London) installed by the Bank of England.”

This risk manager was referring to:

- Phillips Petroleum Co.'s decision to stop third-party underwriting by its Bermuda captive, Walton Insurance Co. Ltd.

- The reorganization petition filed by financial services conglomerate Baldwin-United Corp., which also sold off its directors and officers liability insurance business that was underwritten by subsidiary MGIC Indemnity Corp.

- The suspension of famed Lloyd's underwriter Ian R. Posgate, after Alexander Howden Group P.L.C. and its parent Alexander & Alexander Services Inc. alleged that he and other ex-Howden officials misappropriated \$56 million in Howden funds. And, as a result of this scandal, Lloyd's hired an outsider as its first chief executive officer, Ian Hay Davison, at the suggestion of the Bank of

England.

One risk manager obviously was disappointed in what transpired in 1983, likening it to the Comet Kahoutek, which was supposed to make a grand appearance in the mid-1970s, but didn't.

“The year of Kahoutek,” the risk manager noted. “The year in which so much was supposed to happen, but never did.”

He did not elaborate on what event he was so eagerly expecting, but other risk managers noted that the property/casualty insurance market did not turn in 1983 as many had predicted.

Instead of summing up his feelings about 1983, one risk manager, again likely referring to low rates, took a gloomy gaze into the future.

“In the village where I grew up,” he said, “one old-timer was heard saying to another, ‘Lovely weather we're having.’ The other replied, ‘Yeah, but we'll suffer for it later.’”

Some risk managers noted that 1983 could be described as a year of change, though their comments could be classified as neither encouraging nor discouraging.

“A year of radical changes in the insurance industry structure,” was the view of one risk manager.

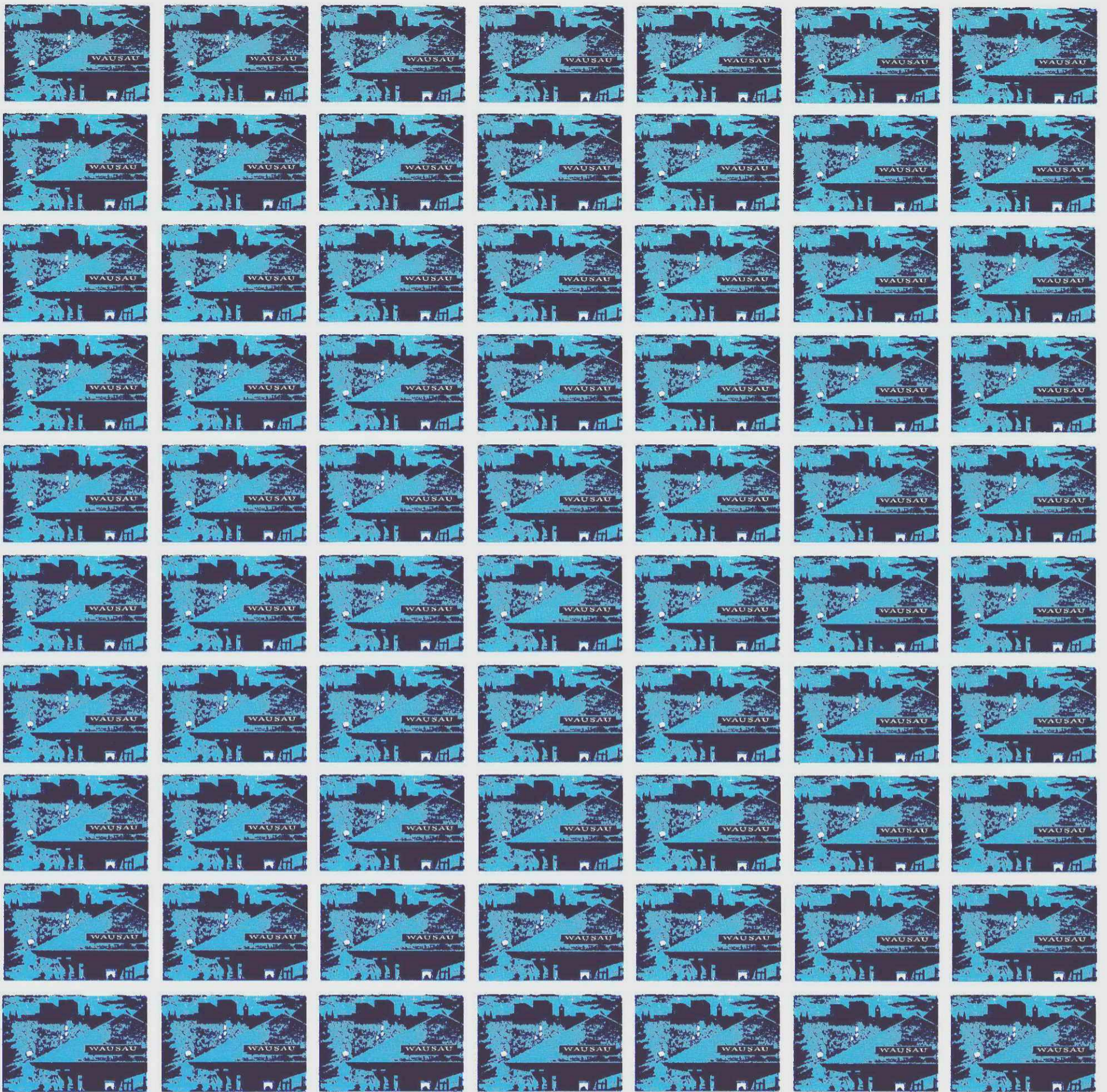
“(The past year) was an indication—a start—of major restructuring in the industry, especially in the large commercial lines and the developing mass marketing of personal lines,” added another.

Other risk managers noted that the events of the year changed how they performed their duties.

“The recession has corporate officers stressing cost-effective management, new benefit programs and better insurance coverage (for less) and claims handling. . . Simply slimming down the excess, whether it be in manpower or ill-spent dollars,” one risk manager noted.

Another called 1983 “a year which required attention to details.”

Finally, there was the risk manager whose thoughts on the past year are the most difficult to gauge. When asked to describe 1983, that risk manager simply wrote, “Yes.” ■



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Really, enough is enough!

THERE ARE SOME stories we read enough—and wrote enough—about in 1983 and would just as soon hear no more about in 1984.

Among the stories we would like to relegate to the annals of history are (in no particular order and not limited to):

- Insurers complaining about competition while they continue to cut rates. Frankly, we're tired of writing about the competitive market and speculating about when it will turn. Yes, risk managers are enjoying rock-bottom insurance prices. But, we are concerned that prices are falling so low that insurers will overreact with exorbitant rate increases that will throw risk management budgets out of kilter. And, we are concerned that insurers may be pricing themselves into financial trouble. If current rates need to be held or adjusted up to maintain solvency, let's see it in 1984. And, if there must be a shakeout of the financially unstable insurers, we wouldn't mind seeing it in 1984—before it becomes a bloodbath.

- The rising cost of health care. Everyone agrees employers, health care providers and consumers must put the brakes on health care cost increases. We'd be quite happy not to print another headline in 1984 declaring "spiraling health care costs."

- Litigation over insurance coverage for asbestos claims. All the decisions to date have been made to provide the individual policyholder with the broadest coverage possible. Insurers should give up their losing battle and settle with their policyholders.

- The financial collapse of self-funded multiple employer trusts. Now that Congress has given states the authority to regulate and to close down financially weak self-funded METs, the states must act to protect employers and their employees.

- Fraud in the insurance, and particularly reinsurance, marketplace that is not detected until the damage has been done. Every person along the insurance distribution line not only must conduct his or her own business honestly but also has an obligation to report to authorities any suspicion of fraud by others.

- Risk managers or benefit managers losing their jobs not because they failed at their efforts but because their employers are reducing staffs to save money.

- Efforts by state insurance commissioners to restrict the development of risk retention pools and risk retention groups.

- Efforts by revenue-hungry congressmen to tax employee health benefits and upset the long-standing social policy that encourages employers to provide for employees' social needs.

- Efforts by revenue-hungry congressmen to ban tax deductions for premiums paid for backdated liability insurance and premiums paid to captive insurers.

- Outrageous jury verdicts awarded to plaintiffs, with amounts for punitive damages exponentially exceeding real damages.

- Lower monthly retirement benefits for women than for men who make equal contributions to defined contribution retirement plans. (The Norris decision handed down by the Supreme Court guarantees that this injustice is history.)

- International barriers to trade that deny some corporate insurance buyers access to the all the world's insurance markets.

- Bankruptcies of otherwise financially healthy companies because pending liability lawsuits appear too ominous or because insurers aren't covering the cost of litigation and claims.

What would we write about without these events? We can think of some specific stories we would like to wind up in 1984 and some general topics that always make good copy.

To name a few stories we'd like to report on for the last time in 1984:

- The litigation between Alexander & Alexander



Services Inc. and the former directors of Alexander Howden Group P.L.C., whom A&A charges misused corporate funds. We'd like to see this one brought to court and all the facts aired rather than quietly settled.

- The litigation over which insurers are responsible for the claims resulting from the tragic collapse of skywalks in the Kansas City Hyatt Regency Hotel.

- The litigation over whether the underwriters of backdated liability insurance sold to MGM Grand Hotels Inc. after the tragic fire in November 1980 must now pay and the litigation over the amount of property damage.

Stories that would make good copy—and benefit our readers if the people involved would act—include:

- Improvements in the regulation of insurers for solvency by state insurance departments.

- Passage of a federal tort reform bill.

- Congressional hearings on the proposed Loss Reserve Deduction Act that would permit corporations to take tax deductions for the cost of reserves to pay self-insured losses and would permit tax deductions for premiums paid to captive insurance companies.

- The divestment of Lloyd's of London underwriting agencies from Lloyd's brokerages, as mandated by the Lloyd's Act of 1982. The sooner these divestments occur, the closer Lloyd's will be to entering the 20th century.

- Congressional hearings on permitting bank holding companies to own insurance agents/brokers and insurance companies.

- Reform of workers compensation laws, including more states adopting wage-loss laws, as well as serious analysis of the problems presented by occupational disease.

- Innovations in corporate employee benefit plans.

- Innovations in risk financing.

- Development of new and more effective loss-prevention and control measures to protect people and property.

- Professional development of men and women in risk management and employee benefit management—including increased financial sophistication and a greater awareness of the needs of people.

- More risk management and employee benefit departments tapping computer power to become more efficient and effective.

But, whatever the nature of the news in the worlds of risk management, benefit management and commercial insurance and reinsurance in 1984—be it inspiring or disheartening, about innovations or failures, welcome or troublesome—you'll get it in *Business Insurance*.

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Norris decision named top benefit story of '83

Continued from page 3

new increases in FICA taxes and may well find their employees expecting more retirement benefits from them to make up for the new cutbacks in Social Security benefits, including raising the age at which retirees can receive benefits, reducing benefits for early retirees, delaying cost-of-living benefit increases and taxing Social Security benefits.

Thirty-six benefit managers said Social Security was the top story of the year, while only 24 said the Norris decision was. However, the Norris decision came back with 35 second-place votes, the most of any story, while Social Security only received 19. Norris also received the highest number of third-place votes, with 22, while Social Security received 19.

Actually, the Norris decision not only received fewer first-place votes than Social Security but was also beat out in first-place votes by employers' health care cost-containment efforts.

Although health-care cost containment placed fourth in overall points (271), it received the second most first-place votes with 28, reaffirming that capping exploding health care costs is of paramount importance to corporations.

When asked in the survey to describe 1983, benefit managers either pointed out what a year of change it was, often criticizing the federal government for its involvement in benefits, or spoke of the battle to contain health care costs (see story, page 11). Many believed significant strides were made in the health care area in 1983.

But even as employers fought to cap health costs, the government

handed them more health care expenses.

Effective Jan. 1, 1983, employers have had to offer their workers 65 to 69 years old a choice between Medicare and their group health insurance plans for their primary coverage.

However, when the Equal Employment Opportunity Commission first drafted its regulations for implementing this change, mandated under the Tax Equity and Fiscal Responsibility Act of 1982 to help cut Medicare costs, they required employers to provide extra benefits to older workers who selected Medicare. That would have made it more advantageous for employees to choose Medicare, which was directly opposite of Congress' intentions in TEFRA.

The Office of Management and Budget rejected these regulations and, although the Medicare provision took effect Jan. 1, no final EEOC regulations were issued until spring.

Besides increasing employers' health care costs, the confusion caused by the hassle over the EEOC aggravated employers, too. Repeatedly in the survey, benefit managers alluded to the confusion in the benefits area in 1983, with some specifically referring to the older worker health care issue.

"Compliance with TEFRA on medical coverage for active employees 65 to 69 caused more confusion than it did good," wrote one survey participant.

Another just criticized the rule in a footnote to the first-place vote he gave the older worker story: "What choice?" If you choose Medicare you get only Medicare. If you

choose the employer plan primary and Medicare secondary, you get both. Who understanding the law would choose Medicare primary? So where is the choice?"

The combination of added costs and total confusion earned the older worker story the third-place spot among the top stories of the year.

It received a cumulative score of 304, compared with the 369 for Norris decision and 357 for Social Security. It received 19 first-place votes, the fourth smallest number among the top five stories, but received 21 second-place votes, the second-highest number among the top stories.

The fifth-place story—Congress proposes taxing employees on employer health premium contributions—received 209 points, with 12 first-place votes.

Other stories on proposed legislation affecting benefits did not rank among the Top Five stories of the year, but they did accumulate enough votes to place among the Top 10 benefit stories of 1983.

Ranking as the sixth most important story of the year with 146 points was the story on legislation, S. 372 and H.R. 100, introduced by Sen. Robert Packwood, R-Ore., and Rep. John Dingell, D-Mich., that would bar sex as a rating factor in determining insurance premiums and benefits (BI, May 16).

While it generated many fewer votes than the related Norris decision, it garnered enough votes—including seven first-place votes—to indicate that employee benefit managers will be closely watching the progress of that bill when Congress reconvenes this month. The bill currently is pending in House

and Senate committees.

Also attracting a lot of attention from benefit managers is the bill, H.R. 4170, proposed by U.S. Reps. Fortney (Pete) Stark, D-Calif., and Barber Conable, R-N.Y., that would bar cafeteria plans from including taxable benefits as options in a flexible benefit plan (BI, Aug. 1). It received 87 points, including three first-place votes, to tie for seventh-place among the top 10 stories.

The bill has cleared the House Ways and Means Committee and is pending on the House floor.

The other seventh-place story and the 10th-ranked story further reflect employers' interest in redesigning health care benefits. Tied for seventh place with the Stark-Conable bill was the move among employers, especially banks, to in-

stitute flexible benefit plans (BI, Sept. 5) Like the story on taxing cafeteria plans, it received 87 points, including three first-place votes.

The emergence of preferred provider organizations as a means of containing health care costs ranked as the 10th most important story of the year, with 73 total points (BI, May 30; Oct. 31).

Rounding out the top 10 stories of the list is yet another court decision affecting benefits. Receiving 75 points to rank ninth among the stories of the year was the Supreme Court ruling that mandates equitable health benefits for spouses of male employees.

The case involved pregnancy benefits for spouses of employees of Newport News Shipbuilding & Dry Dock Co. (BI, June 27). ■

Benefit managers speak out on rule changes

Without a doubt, 1983 will go down in history as one of the key years in the employee benefits field.

Key legislation affecting benefits was passed—or at least introduced—and significant court decisions on benefit issues were handed down. And, 1983 saw intensified government interest in corporate benefit plans.

Furthermore, more corporations last year began in earnest to crack down on rising health care costs.

Benefits activity on Capitol Hill and at the Supreme Court—including the revamping of the Social Security system, the Norris decision that outlawed sex as a factor in calculating retirement benefits and a mandate to employers to offer health insurance to workers between the ages of 65 and 69—left

many benefit managers trying to catch their breath.

"Not since ERISA (1974) has Congress passed so much legislation and the courts rendered so many decisions that impact significantly on the benefits community—often to the detriment of the plan sponsor," wrote one benefit manager responding to a *Business Insurance* Employee Benefit Board survey that asked board members to rank the top stories of the year (see story, page 3) and to comment on 1983 in general.

"It appears to me to have had the most major benefit changes since ERISA was put into effect," agreed another.

Other comments mirrored these benefit managers' feelings that 1983 marked a milestone in the benefits area and set the stage for

more changes to come.

"Most taxing year of all time for benefits."

"The most active year ever for employee benefit planners and administrators."

"A year of dramatic change in the field of employee benefits which focused on new degree of professionalism required. Period of deep recession resulting in cutbacks; heavy legislation; emergence of health care cost management as a major functional responsibility."

"An eventful year for retirement and employee benefits. A precursor of additional and major changes to come in the two areas."

"A year of great significance for the future of employee benefits. Cost is obviously key—equal ben-

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Rule changes irk many benefit managers

Continued from previous page

fits for men and women, containment of health care costs and innovations like flexible benefits and tax-deferred 401(k) plans."

"Insane."
"Uncertain."
"Hectic! A lot of rethinking of how benefit plans should work."
"Too fast to keep up in (the) benefits field."

"Tough on employers."
"A year of headaches in the benefit planning department."
"A time of change—but to what?"

"Hectic! Lots of change, lots of proposals that will bring more change in '84."

"A period that set a number of time bombs in place with the full effects to be felt in the future."

Many of the benefits managers were not pleased with all the government interest in benefits, especially its interest in tapping benefits as a source of additional revenue for the government.

For example, legislation was introduced that would tax employees on employer health insurance contributions above a certain level and that would bar cafeteria plans from including taxable benefits as options in a flexible benefit plan.

The benefits managers, when asked to describe 1983, were quite clear about their displeasure with

activity on Capitol Hill:

"The year that a coalition of government departments decided to raid employee benefit plans' tax status to obtain revenue increases rather than confront their need to spend less."

"Tip of the iceberg on Congress' meddling in employee benefits area."

"The year employee benefits were targeted as easy areas for raising revenues."

"A curtain raiser for a period of stepped-up disastrous congressional meddling in the employee benefits area and my last year in the benefits business."

"More and more governmental regulations making benefit provision and administration a headache as well as a financial burden."

"I would term it as 'The Year the Government Got Even.'"

"Only the beginning of (the) federal government looking for new taxes instead of controlling spending."

"I would describe it as another year of intervention and dictating to the private sector how we should spend our money. Another bad year that could have been worse but could have been better."

"1983 was a very important year with respect to legislation which affects both employer and employee costs. It only proves more so that perhaps government is too heavily involved in matters involving private enterprise!"

"Bizarre, interesting, never a dull moment, but threatening to employers. We thought we were coming out of the recession and already our would-be profits are being taken away! Yes, government!"

"Confused!! More government intervention and their actions not well thought-out or executed."

"A year of charge. Congress is passing legislation that makes it very difficult to plan for the future in benefits. Question of whether to wait or implement now? Imple-

ment now and adjust your plans a later date to take advantage of the tax loopholes available."

"The smoke before the fire.' Congress has and is becoming very active in the once untouchable area of employee benefits. I am afraid that we have only begun see the effects of that interest."

"Troublesome with all the new legislation in the employee benefits area."

"The year preceding the year of legislation governing the taxability of employee benefits. 1983 has been a foundation year for government becoming even more involved in employee benefit field."

"Continuing government intervention."

"Year of clear insight into correcting sexual discrepancies in benefits areas, coupled with immeasurable bureaucratic bungling in other areas, such as the regs on offered 65-69 age group company health insurance coverage."

"A year of change. Old methods and plans cannot compete in today's economy or society. More and more we must examine what we are/are not doing and how it affects us in today's world. The philosophy of what employers must provide and expectations of employees are changing rapidly in today's environment. And often it is not a voluntary change—but a forced issue."

However, among the benefit managers surveyed, at least one was not totally critical about the changes taking place, saying that the changes were good even if they did not please everyone:

"This has been a year of action. The courts, the legislators, the regulators and the employers have identified problems which, if not resolved, have the potential for causing major disruptions in the business of the nation. Most importantly, they have proposed pragmatic solutions that are not universally popular."

When the Employee Benefit Board members ranked the top stories of the year, they gave the highest grades to benefit changes mandated by Congress and the courts. However, the fourth most important story of the year, according to the BI poll, was employers' continuing effort to cap spiraling health care costs.

A good portion of the benefit managers' comments on 1983 reflected these efforts and a hope that efforts are beginning to pay off.

One benefit manager, who said that employers' increased involvement in health care coalitions was the second most important story of the year after employers' general

efforts to control rising health care costs, wrote: "Both employers and individuals have become more concerned about escalating health care costs—concerned enough to finally attempt to do something other than simply moan, groan and the pay annual (premium) increases!"

This same benefit manager thought the third most important story of the year was the emergence of preferred provider organizations.

Another benefit manager shared his feelings about the importance of employer coalitions: "A year that saw private industry come together to contain spiraling health care costs and consider plans to protect business from government regulation adverse to the current tax status of employer-sponsored benefit programs."

He or she also thought the top story of the year was the effort by employers to contain health care costs.

Another benefit manager, who included both cost-containment efforts and the emergence of PPOs in his list of top stories of 1983, saw last year as the beginning of a health care cost-containment era: "The first year of a transition period to a greater health cost-containment era with HMOs, PPOs and other plan alternatives playing a more significant role."

Others echoed this opinion that 1983 was the start of something good in the realm of health care cost containment. The benefit managers wrote:

"The year that everyone became aware of health care costs."

"The year that employers decided to do something about rising health care costs!"

"Another escalating year in the cost of medical benefits. However, a trend for the control of costs was definitely started by not only employers but by providers and insurers as well!"

"A period of increasing concern by employers of the cost of benefits—especially health care plans and increasing complexity of benefits due to actions of Congress, the courts and regulatory agencies."

"Cost-containment measures are setting a tone that will be felt for years to come."

"A year of new direction leading toward containing costs while still providing comprehensive benefit packages and even more choice of benefits (flexible benefit plans)."

"A year of many changes—particularly in attitudes about benefits and benefit reductions. Something I never thought I'd see."

"Within the Midwest, public entities are recognizing health care costs and health awareness as

priorities."

"Seemed to be much more awareness of benefits at all levels of the organization. A definite step in the right direction," concluded Robert Peterson, personnel director of the Automobile Club of Washington, who asked to be quoted even though the survey was conducted on an anonymous basis.

For some of the benefit managers, the pressure to control health care costs was a bit unsettling.

"Scary!!" wrote one benefit manager about 1983. "Wading through cost-containment possibilities and actual and proposed legislation, one could panic in trying to find appropriate solutions to the health care cost crisis in this country."

Echoing similar feelings, another wrote, "Confusion! Money not as easy to obtain and companies having to 'dig in heels' in reference to employee benefits and costs. Much more interest in self-insured plans. That's what we did for health care coverage last year."

Added still another benefit manager: "The year 1983 was a year of conflict in which we saw liberalization—i.e., equalization—in the form of the Norris decision, while (the government tried) to increase tax revenues and, at the same time, attempting to limit the spiraling costs of health care."

Another saw the controls placed on benefit plans as a catalyst to developing cost-containment measures: "I would describe 1983 as the year of imposed controls and innovative alternatives, with controls established by legislation and budget restrictions. Innovative alternatives were the result of budget restrictions and include wellness programs, PPOs and plans that reward employees for being wise users of insurance benefits."

One benefit manager blamed rising health care costs on the government when he or she termed 1983 as "the year of the 'great' medical care cost shift from the government to the private sector."

He or she apparently was referring to the new prospective payment plan for Medicare and Medicaid patients.

Finally, one benefit manager summed up 1983 with a message to all other benefit managers:

"1983 has proven to be a year of rethinking and creativity in all benefit areas. And it has set the stage for further—more drastic—changes. We benefit managers must be on our toes—ready to act/react, improvise/adapt on the spur of the moment."

"We must begin a program of re-education at all levels of the population—not just among ourselves in business." ■

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Top risk management stories of 1983

Kaiser Steel decision

A 1980 federal court ruling that allowed self-insurers of workers compensation risks to deduct certain reserves from their taxes was the first act of a drama that left employers on the edge of their seats.

The ruling by U.S. District Judge William A. Ingram permitted Kaiser Steel Corp. a \$425,418 deduction on its 1964 tax return for reserves for uncontested workers compensation claims that would become payable later for injuries suffered that year.

The judge found that Kaiser had met the two federal requirements governing tax deductions:

- That all of the "events" governing the fact of Kaiser's liability for workers compensation losses occur during the tax year.

- That the amount of liability be determined with "reasonable accuracy."

The decision also cleared the way for Kaiser to take approximately \$15 million more in deductions for reserves established after 1964.

With the scene set, self-insurers eagerly awaited the outcome of Act II, a review of the decision by the Ninth Circuit Court of Appeals.

At stake were not only Kaiser's deductions but many millions of dollars of deductions that could be claimed by other self-insurers in the Ninth Circuit, which includes Alaska, Arizona, California, Hawaii, Idaho, Montana, Nevada, Oregon, Washington and Guam.

Last October, Act II closed to resounding applause, with the appellate court ruling in Kaiser's favor.

Judge Charles M. Merrill, writing for the court, agreed with previous rulings that the only event determining the fact of an employer's liability is the worker's injury itself, and that contingent events affecting the amount of final liability need not be determined.

On the more difficult issue of what constitutes reasonable accuracy, Judge Merrill wrote that accuracy in the aggregate is sufficient to meet the deductibility requirement.

The court rejected the government's contentions that liability be "fixed, definite and determinable by objective facts" and that reserve accuracy be demonstrated on a case-by-case basis.

To require case-by-case accuracy would be to impose such a burden on employers that many would choose simply not to take the deduction, Kaiser's lawyers argued.

Like all well-made plays, this one is expected to have a third act: the government is expected to file a writ of certiorari to have the case reviewed by the Supreme Court. The deadline is Jan. 6.

For many self-insurers, though, the appeals court decision has already removed much of the case's suspense.

Some employers who haven't taken the deduction say they might now take it on the strength of the appeals ruling. Others who are already taking it express relief at the higher court's sanction.

Rate competition catches up with property/casualty insurers

Major U.S. property/casualty insurers entered 1983 optimistic that it would be the year the traditional underwriting cycle turned in their favor.

Instead, they ended the year wondering if any cycle existed at all anymore and trying to figure out ways to terminate employees, save taxes and cut underwriting expenses to keep their cash flow positive.

Seven years of fierce competition for the commercial business of progressively more astute corporate risk managers and buyers has left the property/casualty marketplace a minefield of unexpected liabilities and underpriced business.

For the year, the largest insurers were expected to approximate their nine-month performance—a measly 1.3% gain in aftertax operating income and a combined ratio of about 113%, up at least two points from year-end 1982.

More and more, the results are showing that the largest property/casualty insurers are turning in poorer overall results than their smaller competitors, perhaps because of the heightened competition for the "jumbo" risks offered by the nation's Fortune 500 companies.

There was still the possibility of major surprises as insurers compiled their end-of-year operating and underwriting results for release in mid-February.

For example, Fireman's Fund Insurance Cos., a unit of American Express Co., said it was adding \$230 million to its underwriting reserves to make up for overaggressive pricing earlier in the year. Fireman's Fund said the result would be an operating loss for 1983 compared with a \$244 million operating profit a year earlier.

Insurance stock analysts continue to forecast that other insurers may be forced to make additions to reserves to compensate for underestimating their future liabilities.

If there was any bright light, it shone from the reinsurance sphere, where analysts and some company executives viewed evidence of a firming in rates. And the granddaddy of U.S.-based reinsurers, General Re Corp., reported a third-quarter surge of 33.5% in net written premiums compared with only an 8.9% gain for the nine months.

The months ahead will tell whether the General Re premium upturn is an industry trend or a company anomaly.

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WEEK OF MAY 3, 1982
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MGM fire litigation

The old adage warning an insurer never to write insurance on a burning building was reinforced last year when MGM Grand Hotels Inc. sued the underwriters and broker of its 3-year-old retroactive liability insurance policy.

MGM purchased the much-heralded policy, which provided \$165 million in coverage, through broker Frank B. Hall & Co. Inc. shortly after the November 1980 fire that killed 84 persons and injured about 600 others.

At the time of the fire, MGM had only \$30 million in liability insurance.

But last January, after MGM settled with fire victims for \$75 million, the insurer on the first \$35 million retroactive layer, Union International Insurance Co., refused to pay. The ensuing months have resulted in a flurry of litigation.

The first volley came last March in Nevada state court when MGM sued Hall, Union International, which is a Hall subsidiary, and about 20 other insurers on the first \$95 million of back-dated coverage (BI, Mar. 21).

The complaint asks the court to rule on the extent of coverage provided by the back-dated insurance and contains numerous charges of misconduct against Hall and the insurers for failing to respond.

Hall and Union countered, however, with accusations that MGM breached various brokerage and insurance agreements and have asked the court to rescind the coverage. They contend also that Union isn't required to indemnify MGM because the \$75 million settlement with plaintiffs includes punitive damage payments and also because the insurers' ultimate net loss has not been determined (BI, June 13).

Last June, Union made another attempt to shift liability when it filed a lawsuit against MGM, Del E. Webb Corp., a general contractor at the MGM site at the time of the fire, and Del Webb's 11 insurers (BI, June 24).

The suit contends that MGM should have sued Webb and its insurers before coming to Union and that any insurance Union might owe is excess of Webb's. Webb has approximately \$150 million in liability insurance.

Webb's insurers deny liability and charge that Union is trying to escape liability because MGM settled claims faster than Union expected, reducing the investment income it could make on the premiums paid by MGM for the retroactive coverage.

They argue that Webb was not negligent and even if it were, Union has breached a number of obligations prohibiting it from recovering from Webb's insurers (BI, Oct. 10).

The two lawsuits were recently consolidated and depositions and discovery are continuing.

A trial date has been set for Nov. 5, 1984.

The fighting between MGM and its liability insurers is also being echoed by litigation on the property side.

The litigation stems from lawsuits between MGM and two of its excess property insurers over how much property damage the hotel incurred. MGM contends that it is owed an additional \$33 million in coverage from American Protection Insurance Co., part of the Kemper Group, and also \$36 million from Insurance Co. of North America.

MGM had \$215 million in property damage at the time of the fire and has claimed property losses of \$211 million.

American Property wrote \$125 million excess over \$50 million and INA wrote \$50 million above that. Both contend MGM fraudulently inflated the costs of rebuilding the hotel by including costs of improving and expanding the facility.

American is seeking return of \$92 million paid to MGM and that their insurance contracts be voided.

Earlier this year, MGM sought punitive damages from American Property because of the delay in paying claims.

Recently, the judge in the property litigation—U.S. District Judge Harry E. Claiborne—was indicted for matters unrelated to the MGM case and the law firm representing INA—Cozen, Begier & O'Connor of Philadelphia—was disqualified from representing the insurer (BI, Dec. 19).

Regulation of workers comp self-insurers

Employers that self-insure their workers compensation risks felt the brunt of state regulators' decision to get tough in 1983 in the wake of several corporate bankruptcies.

Regulators adopted a variety of measures to better insure that they wouldn't be left holding a bag of unpaid claims from injured workers when an employer goes bankrupt (BI, July 11).

Approaches taken by regulators included:

- Requiring that self-insurers purchase surety bonds and excess coverage.
- Increasing minimum security deposits.
- Requiring self-insured employers to set up loss-control programs.
- Requiring minimum net worth before a company can self-insure.
- Requesting additional financial information and sometimes conducting financial audits.
- Establishing guaranty funds to pay outstanding claims of insolvent self-insureds.

In Ohio, for example, regulators decided to accept only surety bonds for companies applying for approval to self-insure their comp exposures.

In North Carolina, the bankruptcy of freight carrier Spector Redball Inc. in 1982 prompted the state to increase its minimum security deposit requirement to \$200,000 from \$100,000. Excess insurance also is required and self-insurers must have at least \$500,000 in fixed assets in their North Carolina operations.

In Kansas, the amounts in surety bonds and letters of credit were increased, and in some cases doubled.

And in neighboring Nebraska, regulators required for the first time that a self-insurer purchase surety bonds or excess insurance.

Virginia also tightened its requirements. Now

self-insurers must pay a deposit ranging from \$500,000 to \$2.5 million.

Guaranty funds also became an attractive safeguard that regulators studied in 1983. A bill setting up two separate guaranty funds in Illinois—one to regulate self-insurance

and the other for individual employers—was signed in the fall. Other states plan to look at this type of "protection" again in the 1984 legislative session.

Employers responded to this myriad of regulatory action with frustration and anger.

Said one: "People shouldn't be running in all directions and coming up with requirements that would prevent the self-insurers from going on. We need realistic guidelines."

Others said they are not asking for an absence of regulations, but they want uniformity since many of them had operations in more than one state.

"States are going crazy. It's not a uniform manner. One's saying 'get excess insurance,' another is saying 'Get a bond,'" complained another risk manager.

Others at least want to have some input on the rules they must follow.

Tougher standards were forcing some of them to return to the commercial market for coverage. Risk managers began to re-examine their self-insured operations to see if it still was cheaper and less of a hassle to go that route.

Banks begin entry into insurance field

NEW YORK—The insurance industry field may be crowded with players, but one notable new team is trying to push its way into the fray.

On the federal and state levels, the banking industry has been pushing for legislative changes that would allow its entry into the insurance game.

Most of the legislative action has been on the state level, where loopholes in federal laws—which generally bar insurance activity by bank holding companies—may be circumvented by state law governing state-chartered banks.

The first state to allow such activity was South Dakota, where Republican Gov. William Janklow signed a bill early this year allowing state-chartered banks to sell and underwrite insurance.

New York-based Citicorp lobbied heavily for the bill and after its passage announced its agreement to buy a controlling interest in American State Bank of Rapid City, S.D. San Francisco-based BankAmerica Corp. also indicated it would operate a state-chartered bank.

Citicorp, which hasn't said what kind of insurance its South Dakota bank may engage in, is also lobbying for similar legislation in Delaware. That legislation is expected to be introduced early this year.

Other states studying the entry of banks into the insurance business include Illinois, Michigan, Minnesota, New York and Wisconsin.

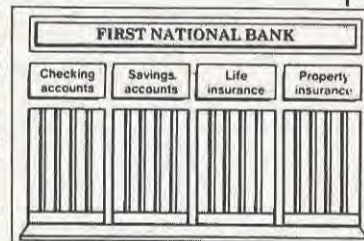
In Connecticut, Maine and Washington, proposals that would have allowed insurance activity by banks were either defeated or removed from legislative consideration.

Along with the swell of state activity, bank lobbyists are also pushing for federal legislation to ease restrictions on their expansion. The Financial Institutions Deregulation Act of 1983, backed by the Treasury Department but opposed by the Federal Deposit Insurance Corp., would allow commercial banks, savings banks and savings and loan institutions to expand into other financial services, including insurance sales and underwriting.

Observers expect pressure for bank expansion to increase on the state rather than the federal level, though, with some states fearing that they'll lose banking business if other states adopt more attractive legislation.

Opponents of such legislation—including insurance agents and brokers and some state insurance commissioners—express other fears, among them that banks might coerce loan applicants into buying the bank's insurance, and that banks might otherwise exercise an unfair competitive advantage with their access to financial information about prospective clients.

Banking industry proponents contend that there would be no abuse of the consumer if banks sold insurance, but rather contend that consumers would be better served.



Top benefit stories of 1983 in review

Norris decision mandates equal pension benefits

Nathalie Norris of Scottsdale, Ariz., didn't think it was fair that she should receive a smaller annuity benefit than a male employee, even though they contributed identical amounts.

Ms. Norris, who worked for the Arizona state government, had agreed in 1975 to join a 3-year-old voluntary deferred compensation plan sponsored by the state.

Ms. Norris was told that if her contributions continued at a steady rate, the total value of her account at age 65 would be \$53,890. At that time, she would receive a monthly annuity of \$320.11 from Lincoln National Life Insurance Co.

However, a man who contributed the same amount as Ms. Norris was guaranteed a monthly payment of \$354.07.

Ms. Norris sued the state in 1978 arguing that the 1964 Civil Rights Act bars discrimination based on sex.

Insurers and many employers said women should receive smaller monthly retirement benefits than men because on average they outlive men and thus collect benefits over a longer period of time.

But in July, the Supreme Court agreed with Ms. Norris. In a 5-4 decision, the high court said the practice of paying women smaller retirement benefits than men—if contributions from both are equal—violates Title VII of the Civil Rights Act (BI, July 11, 1983).

But the court, much to the relief of insurers and employers, said the decision would not apply retroactively. In its July 6 decision, the court said equal benefits must be offered for contributions made to plans after Aug. 1, 1983.

Pension experts had warned that insurers and some public employers could be bankrupted if they had to retroactively boost retirement benefits received by women to those received by men.

The Supreme Court's decision outlawing the use of sex as a factor in calculating retirement benefits will have its greatest effect on defined contribution plans that offer participants an annuity option.

Under such an option, an employer took an employee's accumulated savings in a defined contribution plan and

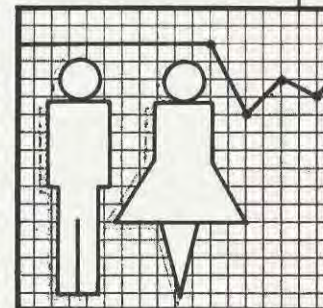
used it to buy an annuity from an insurer to provide a monthly lifetime benefit after retirement.

Prior to the Norris decision, women had to pay between 10% and 15% more for such annuities because they live longer than men and thus collected benefits over a longer period of time.

Annuities based on sex no longer can be offered as part of a retirement plan. Insurers have begun to offer new annuity products that blend the old female and male benefit levels into a unisex rate.

Some experts believe, though, that men will shun the unisex annuity policies and instead use their accumulated savings from a defined contribution plan to buy individual annuity policies because they could get a better deal.

The Supreme Court decision does not bar sex as a rating factor for individually purchased annuities.



Social Security legislation

Just one year ago, the prospects of preventing the bankruptcy of the federal Social Security program seemed slim.

After a year of meetings, a 15-member bipartisan commission—appointed by President Reagan to come up with ways to give the faltering program the \$165 billion it needed to weather a short-term funding crisis—was unable to reach a consensus by its Dec. 31, 1982, deadline.

President Reagan then gave the commission an extension until mid-January to provide the time it needed to break a deadlock and hammer out the recommendations necessary to shore up the Social Security trust funds (*BI*, Jan. 24, 1983).

In late March, Congress, after extensive committee hearings, adopted the bulk of the commission's recommendations when it passed the Social Security Amendments Act of 1983 (*BI*, April 4, 1983).

The Social Security legislation will have dramatic effects on both employers and employees. Key provisions of the measure include:

- Accelerating Social Security payroll tax increases. On Jan. 1, the FICA tax for employers jumped to 7% from 6.7%. That 0.3% increase was imposed a year earlier than origi-

nally scheduled. Then, in 1988, the tax will climb to 7.51% instead of the planned 7.15%. By 1990, the payroll tax will reach 7.65%, as scheduled.

The payroll tax acceleration will cost employers millions of dollars. For example, Prudential Insurance Co. of America in Newark, N.J., said it will pay \$98 million in Social Security taxes for its 72,000 employees instead of \$93.8 million.

- Taxing salary reduction plans. Starting Jan. 1, wages deferred under 401(k) salary reduction are subject to FICA taxes. Previously, money paid into these cash-deferred plans was not counted as part of an employee's income for FICA tax purposes.

- Retirement age. The retirement age for Social Security will gradually increase from 65 to 67. The retirement age will rise to 66 from 65 between the years 2000 and 2009, then to 67 by 2027.

- Early retirement. Workers still can retire at age 62, but their initial benefit will be cut by 25% starting in 2009 and by 30% in 2027. Employees can now retire at 62 and receive a benefit equal to 80% of the full benefit they'd receive at age 65.

- Delayed retirement credit. Between 1990 and 2010, the delayed retirement credit for workers between 65 and 70 will be raised from 3% to 8% per year.

- Benefit tax. Starting this year, individuals whose ad-

justed gross income exceeds \$25,000 and couples whose adjusted gross incomes exceed \$32,000 will be taxed on 50% of Social Security benefits received.

- Taxing non-qualified plans. Benefits payable by open-window non-qualified, deferred compensation early retirement plans are now subject to Social Security taxes.

- Cost-of-living increases. The 3.5% increase in Social Security benefits that retirees were supposed to have received last July was delayed until this week. In addition, all future benefit increases will be paid in January instead of July.

- COLA stabilizer. If the Social Security trust funds dip below a .5% reserve from 1985 to 1988, Social Security benefit increases will be limited to either average increases in wages or the Consumer Price Index, whichever is less. After 1989, the COLA stabilizer will kick in if the reserves drop below 20%.

- Mandatory participation. Full-time federal employees hired after Jan. 1 are automatically covered by Social Security. In addition, non-profit employers that either never joined Social Security or had dropped out of the federal program were required to participate in Social Security on Jan. 1.

Furthermore, state and local governments no longer can drop out of Social Security. However, public employers that previously left Social Security are not required to rejoin.

Firms battle health costs

As employee benefit managers enter the new year, they will still be facing the same nemesis they have been battling throughout the 1980s: rising health care costs.

The health cost spiral cooled a bit in the past year, with health care inflation dropping to a 6.6% annualized rate for the first 11 months of 1983, compared with a 12.5% increase in 1981 and an 11.0% rise in 1982.

But although health cost hikes did not run into the double digits, employers sharpened their resolve to hold the line on expenses.

For instance, a survey of 1,420 U.S. companies conducted early last year by William M. Mercer Inc. showed that 31% had developed a formal cost management strategy within the past two years, while another 37% said they planned to develop one within one year (*BI*, March 14).

Of course, employers have not found a quick cure for the health cost problem. Although many companies adopted similar cost-containment tactics—like raising deductibles, coinsurance and the monthly premium paid by employees—many times employers found that some cost-control devices were not very effective.

After studying Chicago and Milwaukee-area employers, consultant Towers, Perrin, Forster & Crosby said that it had found that some of the most popular cost-containment techniques—including membership in employer coalitions and health care claim audits—barely generated any savings (*BI*, Feb. 7).

However, the study found that changing plan design—like increasing deductibles and coinsurance or requiring preadmission testing and outpatient surgery when appropriate—were big money-savers. And, it noted, changes in administrative procedures—like improving coordination of benefits—could also hold the line on cost increases.

Finally, some employers began to think about contracting with a preferred provider organization: a group of health care providers that promise to deliver health care services at reduced fees. In return, employers usually offer financial incentives for employees to use these providers.

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Older workers' health care

It started out as a relatively obscure provision in the Tax Equity and Fiscal Responsibility Act of 1982.

Congress, in an effort to trim the cost of the federal Medicare program stipulated that workers between the ages of 65 and 69 should be given a choice of enrolling in their employers' health insurance plans or of sticking with Medicare (BI, Aug. 23, 1982).

Because employers' plans are generally more generous than the federal Medicare program, Congress believed that most of the 375,000 older workers affected by the provision would switch to corporate plans, saving the federal government about \$350 million.

The Equal Employment Opportunity Commission was supposed to issue regulations implementing the provision in TEFRA. Those regulations were to have been published in December 1982 so that employees who wanted to switch to corporate plans could do so by Jan. 1, 1983, the effective date of the provision.

But the EEOC, the federal agency whose responsibilities include age discrimination issues, failed to meet its deadline.

The EEOC did submit regulations in mid-December to enforce the Medicare provision in TEFRA, but those regu-

lations were never published and were later withdrawn after the Office of Management and Budget rejected them (BI, Jan. 31, 1983).

The regulations were rejected because they would have required employers to provide extra benefits, like dental care, to older workers who selected Medicare as the primary payer of medical bills. Under these proposed rules, an employer would have been required to spend the same amount on health care for older workers who select Medicare for primary coverage as they spend on all other employees (BI, Dec. 27, 1982).

That would have made it more advantageous for employees to choose Medicare for their primary coverage.

For example, a company that spends \$60 a month per employee for individual coverage would have had to spend \$60 a month on health-related benefits for older workers who stay in the Medicare program.

Because the EEOC's initial rules prohibited an employer from directly supplementing any coverage provided by Medicare, it would have been doubtful if employers could have offered enough supplemental health benefits to equal the amount the company spends on health insurance benefits for younger workers.

Even if employers could have added enough health-related benefits for older workers to bring the cost of their benefits up to the amount spent on younger workers, the

older workers most likely would have selected Medicare as the primary payer to take advantage of the extra benefits the employer would be forced to provide.

As a result, the federal government would not have been able to cut its Medicare costs.

The lack of EEOC regulations created mass confusion for employers around the country. Employers didn't know how they were to offer their older workers a choice between Medicare and their group health insurance plans.

On Jan. 1, 1983, many employers began to enroll older workers in their group health care plans and scrapped the supplemental plans they had offered older workers. Those supplemental plans generally picked up medical and hospital bills not covered by Medicare.

Finally, in the spring, the EEOC agreed to follow Congress' intent when it passed the provision in TEFRA. The agency ended months of confusion by publishing final rules that require employers to offer their older workers the simple choice of staying with the employer's health care plan or enrolling in Medicare for their primary coverage (BI, April 18, 1983).

Employers that now have to cover their older workers in group health plans are experiencing an average cost increase of between 1% and 2%, but companies with high percentages of older workers have been hit with much bigger cost increases.

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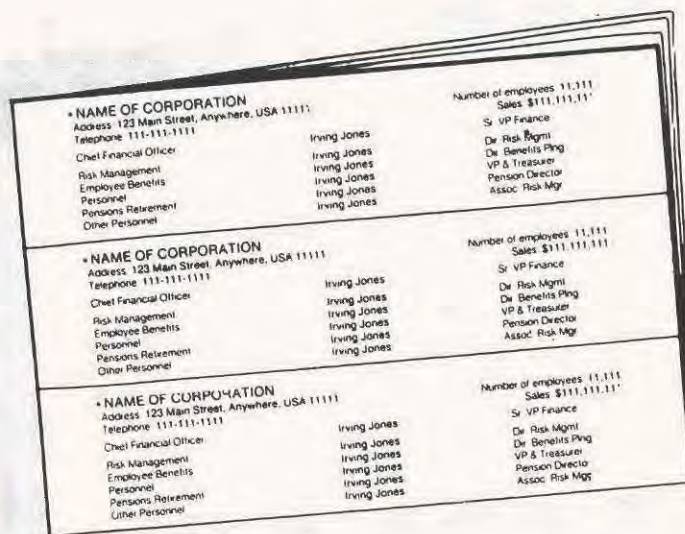
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Efforts to tax benefits

Last year, the Reagan administration and Congress made their first major efforts to tax employee benefits.

In February, the administration convinced Senate Finance Committee Chairman Robert Dole, R-Kan., to introduce legislation, S. 640, that would make employer-provided health care benefits part of an employee's taxable income (BI, Feb. 7, 1983).

Under that proposal, an employee would be taxed on that portion of an employer's health insurance premium that exceeds \$2,100 a year for family coverage or \$840 for individual coverage.

The administration said its proposal would curb health care inflation by making employees more conscious of medical costs. The proposal, the administration noted, also would generate some \$2.3 billion in new revenue.

Employers, insurers and unions banded together to fight the proposal. They questioned whether any new revenues would be gained and argued that it would create an administrative nightmare for benefit managers.

At year-end, the opponents of the tax cap had the upper hand. The Senate Finance Committee still hadn't moved on Sen. Dole's measure or another proposal, informally suggested by Mr. Dole, that would tax health care premiums that exceed \$100 a month for individual coverage or \$250 a month for family coverage.

But the tax caps are still pending in Congress. As one industry lobbyist noted, as long as the administration, the hospital industry and Sen. Dole favor the caps, the proposals will always be alive (BI, Nov. 28, 1983).

In passing legislation to shore up the Social Security program, Congress did impose one new benefit tax, while defeating at the last minute an attempt to tax other employee benefits.

As part of the Social Security bailout legislation, Congress agreed that beginning this year, individuals whose annual incomes exceed \$25,000 and taxpayers filing joint returns with annual incomes above \$32,000 would be taxed on up to one-half of their Social Security benefits (BI, April 4, 1983).

agent/broker topics

A regular editorial section exclusively for agents and brokers



Agency acquisitions

By PAMELA DeFIGLIO

Is one large business better than two small ones? Some agents think so

Although agents who acquire other agencies still excitedly burst with as many resolutions for improvement as the New Year's baby, the fact remains that agency acquisition scene is changing.

Public brokers and larger agencies, who were snapping up agencies right and left in order to expand into certain geographic areas, have cooled down their activity, though they are acquiring a few agencies for other reasons.

Medium-sized and smaller agencies, on the other hand, are fortifying their defenses against present and future threats through acquisitions. These agents are turning to business combinations in a time when the premium rates are competitive and both public brokers and direct writers are nipping away at their marketshare.

These agents are hoping that increased agency size, as well as the increased degree of personnel talent and expertise that usually accompanies greater size, will tide them through difficult periods now and in the future.

They also hope to realize the economies of scale that occur when a larger quantity of similar work is organized and streamlined.

"Many agents smaller than we were (\$7 million in premium volume) haven't felt the squeeze yet, but they really should be thinking about acquisitions, mergers, sales or consolidations," said Charlie Reilly, a Rhode Island agent who sold his family's firm to a larger local agency.

Medium- and smaller-sized agents who were planning on being bought out by a large public broker when it came time to look toward retirement may have their dreams dashed, but there are other things they can do to prepare for acquisition and/or perpetuation. For instance, they can diversify into a specialty or train their personnel in a specific area to become a more attractive prize.

The hectic wave of agency acquisitions of several years ago has slowed, notes Terry Buckley, senior analyst at Russell Miller Inc., an insurance industry consulting firm in San Francisco, Calif.

"This year, acquisitions are fewer and farther between," he comments. "People are thinking longer and harder before they make the decision to acquire."

Mr. Buckley explains that in the 1970s, many of the public brokers sought to buy established local books of business in order to get a foothold in certain geographic areas. But after a buying spree, they seem to have fulfilled these ambitions.

"They're everywhere they want to be," Mr. Buckley said, noting as an example that Alexander & Alexander Services Inc. bought one agency in 1982, compared with 21 in 1981. "At this point, the public brokers are diversifying to get into a specialty or to get good people."

So, an agency looking for a marriage down the road would be well-advised to create a market niche for itself to become more attractive, consultants say.

Carol Hammes, executive vp of Hales & Associates Inc. in Oak Brook, Ill., another consulting firm, says that gaining access to another geographic area and acquiring a specialization are traditional reasons for one firm to acquire another, but adds that brokers are looking to acquire other businesses to increase their sales. These include association or mass marketing businesses, third-party administrators and life insurance agencies.

David Hales, president of Hales & Associates, notes that agencies must get as much business as possible from the same customer base during competitive times.

"If a firm's handling workers compensation, it makes sense for them to acquire a firm that handles workers compensation claims payments. They can get more money from the same clients," he says.

"There's a trend to specialization today, however. Any agency that hasn't specialized would be well-advised to acquire a specialty firm," Mr. Hales recommends.

"If there's any really strong trend, it's to acquire books of business that fit into what's established at the buyer's agency. This helps make up for what's lost in the soft mar-

ket. The agency that's lost commission income because of the competitive market can increase its volume by acquiring a similar business and then fitting it into its own servicing structure. If management is good, this will increase the productivity of the buyer's employees and increase profits."

Mr. Buckley agrees that agencies do well to acquire firms with similar books of business.

"If an agent handles large accounts, he's set up to perform few transactions and receive large commissions. If he buys out that personal lines/small commercial accounts agent that's been friendly to him all these years, he'll be making a mistake."

One agency that took Mr. Hales' advice on acquiring an agency that would fit into and mesh with their own book of business is Charlton-Manley Inc. of Lawrence, Kan. The agency is the product of a merger between the two major insurance agencies in the city of 50,000.

"We knew our competitors," said Bob Johnson, who was a principal of the former Landrath, McGrew & Johnson Inc. agency before the merger.

"Through lunchtime conversations, it became apparent that both of our agencies were the same size and were trying to fight the same battles. It naturally occurred to us to think, 'Hey, why don't we get together?'"

"We saw that one agency merged could accomplish more than two agencies separately, and it would give us more clout with insurers."

The merger was more than a year in planning, and no money changed hands during the transaction. Although one book of business was larger than the other, the percentage of ownership held by the principals was adjusted to reflect the difference.

However, the vote of each director counts the same, which encourages a smooth working relationship, Mr. Johnson explained.

"One-and-a-half years later, we're delighted we merged. We asked ourselves why we didn't do it earlier. And the real benefits are about to happen—they haven't even happened yet."

"It continues to amaze us how much more effective we can be when negotiating with insurers. Going from being a

Continued on next page

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Some agents still grow through acquisitions

Continued from page 12A

\$3 million agency to a \$6 million-plus agency has a synergistic effect."

Charlton-Manley also has a perpetuation plan. Mr. Johnson notes, explaining that stockholders are required to begin divesting themselves of their shares 10 years before their retirement. The firm buys back those shares, which—at some point in the future—may be sold to a new principal or to employees.

"Plan. Be absolutely sure that the principals want to make the transition from being a smaller organization to being a larger organization," he advises agency owners who are contemplating a merger.

"You must become more structured, more organized, delegate authority, be willing to live with what that person decides and move on."

For the personnel of each agency, the move to a new location plus the shift in organization caused by the merger was disruptive and caused a great deal of stress, Mr. Johnson admits. "But it was still easier for the employees than it was for the principals," he laments.

Another agency that acquired a firm with a similar book of business was Bateman, Nugent, Chase, Field & Reilly Inc. in Providence, R.I.

According to Treasurer and Chief Executive Officer H. James Field Jr., the firm—formerly called Davis, Bateman & Nugent Inc.—has been in the general commercial lines business for many years specializing in manufacturing and contracting, before last year acquiring James J. Reilly Inc., owned by James Reilly, who was about to retire, and his son, Charlie.

The Reilly agency, which was one-third the size of Bateman at the time, specialized in the same areas, as well as in shipbuilding risks.

Bateman absorbed almost all of Reilly's 20 employees, boosting its workforce to 65. Premium volume has increased roughly a third since the acquisition.

Mr. Field says that the increased size brings with it efficiencies in terms of personnel.

"People make the difference. We felt the opportunity to make Charlie Reilly part of our management team was good," said Mr. Field, explaining that Mr. Reilly has an MBA degree and is an expert in both shipbuilding and bonds.

Bateman made a substantial down payment to the Reilly agency, and agreed to pay the balance over 10 years. As a protective measure for both parties, some target accounts were not figured into the price. Bateman will pay a slightly higher multiple for these accounts depending upon how well they perform.

"We think we got a good deal, and they think they did, too. That's what you need for both sides to be satisfied," Mr. Field concludes.

Looking at the seller's end of the deal, Charlie Reilly, who is now senior vp of the agency, says he feels that the transaction was "adequate, reasonable and equitable," just like the old adage about insurance rate-making.

Mr. Reilly says that the James J. Reilly agency wasn't in search of a takeover, because its own perpetuation plan would have provided for an orderly transfer of the business from 70-year-old James Reilly, who owned 60% of the shares, to himself, who at the age of 45 owned the other 40%.

However, when the acquisition offer, which Mr. Reilly described as "very friendly," came, the timing was appropriate.

Mr. Reilly says he appreciated his father's offer to bequeath the remaining shares to him, but that that plan would not have financially rewarded his father for his lifetime efforts with the business. Selling the agency, on the other hand, provided his father with cash flow to retire on.

One of the primary reasons the takeover was friendly was that the principals of both firms knew each other outside of the insurance business. Mr. Reilly had been Rhode Island Democratic state chairman at the same time Mr. Field had been Republican state chairman. Fortunately, no antagonism arose from the fact that they were on op

Continued on facing page

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Mr. Pozmantier, left, and Wisenberg Executive Vp Joe Williams flank Robert W. Palmer, previous owner of S.G. Raphael & Co.

Continued from facing page
posite sides of the political fence.

After Bateman first approached Reilly with an offer to buy, Mr. Reilly says that negotiations went through a friendly stage in which principals of both firms discussed the parameters of the deal, such as payment, terms, employees and physical location of the offices. Next came what he characterized the "tedious" part, when lawyers and accountants were called in to identify and verify segments of Reilly's commission income.

The negotiations took nine months altogether.

"I think this is probably a textbook, classical occurrence of the fact that even the big need to get together and become bigger," Mr. Reilly comments. "It can act as a kind of lesson to the small, who may be swallowed up. Both of our agencies were in the top five in Rhode Island before the acquisition, and now we're the biggest in the state by far.

"We saw the handwriting on the wall. Acquisitions or other business combinations help agencies form a stronger financial base in order to be potent in the marketplace."

Meeting the needs of both buyer and seller in an acquisition is crucial, says Irving Pozmantier, president of Sol Wisenberg Insurance Agency in Houston, an agency that has just completed two acquisitions that boosted head count by six staffers to 58.

The first acquisition, S.G. Raphael & Co., was completed May 1, while the second, McRaith Insurance Agency, took effect with the new year. Mr. Pozmantier says he hopes to add 20% to his agency's volume through the acquisitions.

"One must talk about the human needs in the early stages of negotiation," he advises. "Price is secondary."

"Does the seller want to retire, or not? Have the agency problems become too much for him? The two parties should be able to discuss the situation candidly, not just the cold financial outlook," Mr. Pozmantier comments. "I think it's a mistake to just walk in and talk about money."

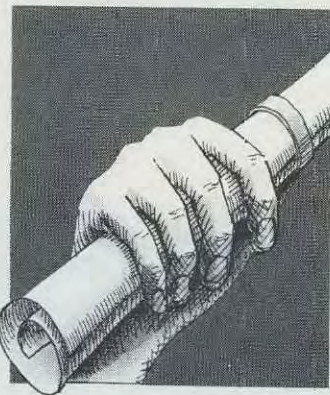
Both of the selling principals will remain with the Wisenberg agency and will receive incentives to maintain and increase their books of business, Mr. Pozmantier says.

"If the seller works hard, he'll earn more," he comments.

One aspect of acquisitions that Mr. Pozmantier feels has not been publicized much is the adjustment of new employees to the acquiring firm.

"Acquired employees view it with fear and trembling," says Mr. Pozmantier. "They have the same fears as a newly-hired employee. We're new at dealing with this situation, but I think we're beginning to get some sensitivity for it." ■

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Group guarantees acquisition loans

An agent trying to finance an acquisition is forced to accept a high-interest loan from a commercial bank, right?

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Previously, if an agent who wanted to acquire another agency requested financing from a bank, the bank would probably slap him with a high interest rate on a loan — if it granted a loan at all.

Banks often fail to recognize agents' renewals as an asset, since they would be hard-pressed to liquidate them quickly. Consequently, they refused to grant agents business loans, which are made at the prime rate or lower, forcing agents to accept high-interest terms.

"You really need some third

party, or Big Brother, to come in and guarantee the loan," says Frank Flood, president of the Professional Resource Organization, a subsidiary of the National Assn. of Professional Insurance Agents.

PRO has come to the agents' rescue. It has revived the concept of getting a co-signer to guarantee the loan, although this time with a new twist.

PRO's new Financial Guarantee Bond Program provides financial guarantee bonds that agency purchasers can use to guarantee an acquisition will be fully funded. If the purchaser should default on a loan, the bond will pay the remaining balance, Mr. Flood explains.

Because the bond guarantees the loan, banks will grant bond holders loans with much lower commercial interest rates, usually at or below the prime rate. The same agency that was having trouble getting a loan shouldn't have any trouble after it buys a bond, he says.

The bonds have advantages for those who are selling their agencies, too.

'You really need some third party... to guarantee the loan,' Mr. Flood says.

Some sellers finance an acquisition themselves, assuming considerable risk. For instance, agency principals approaching retirement often sell their agencies to younger producers, but are left with the risk that the purchaser will not be able to meet payments. If this happens, the principal often must go back to work to straighten out the mess.

And, if a young agent defaults altogether, the seller could be deprived of the funds that were the basis of the seller's retirement.

Should such a scenario occur and the buyer is backed by a PRO bond, Mr. Flood says PRO will enlist consultants to work with the agent and try to get the agency afloat again.

Prospective agency purchasers who buy the bonds also benefit from the leverage they provide, Mr. Flood pointed out. If there are several prospective purchasers who could meet the seller's price, but one of them had proof of ability to pay, the seller would be in a position to negotiate a better deal.

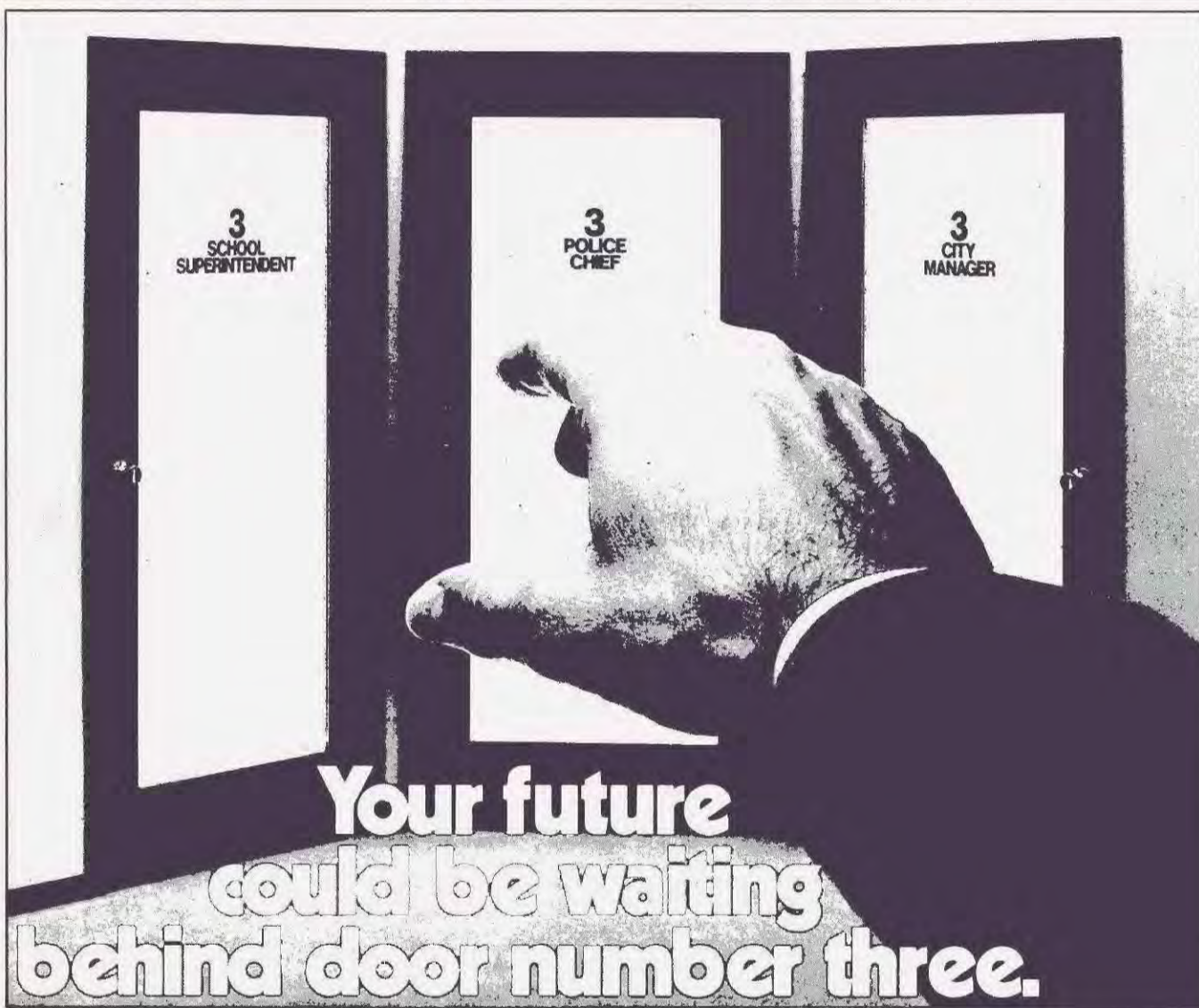
"The buyer would be able to ask, 'What's it worth to you to have peace of mind?'" Mr. Flood explained. "I should think that would be worth something."

The bond program is backed by 18 insurers that have pledged a total of \$50 million. The bonds cost 2% per year on the outstanding balance of the guaranteed portion of the loan or purchase price, Mr. Flood says, adding that the insurers expect to make a small profit on their investment.

And, since each insurer only accepts only 5% of the risk, each company is insulated from a large loss should a default occur. Each bond has a \$2 million limit.

Either the buyer or seller of the agency can purchase a financial guarantee bond to guarantee an acquisition loan. The buyer would have to prepay the cost of the bond, while the seller could pay for the bond on a yearly basis and deduct it as a business expense.

The bonds are available only to subscribers to the PIA's PRO program. Information can be obtained from PRO, 414 N. Washington St., Alexandria, Va. 22314; 800-368-5009.



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Acquisition analysis

	1983*	1984	1986	1988	1990	1991
Total revenues	\$500,000	\$540,000	\$629,857	\$734,664	\$856,912	\$925,466
Total expenses	390,000	421,200	491,287	573,038	668,392	721,863
Operating income	110,000	118,800	138,570	161,626	188,520	203,603
Amortization/expiration list	—	88,000	88,000	88,000	88,000	88,000
Interest on balance due	—	72,600	59,400	40,700	15,950	—
Total acquisition expenses	—	160,600	147,400	128,700	103,950	88,000
Pretax income	—	-41,800	-8,830	32,926	84,570	115,603
Income tax (25%)	—	-10,450	-2,208	8,232	21,143	28,901
Cash flow (net income plus amort./exp. list)	—	56,650	81,378	112,695	151,428	174,702
Principal payments	—	55,000	80,000	105,000	145,000	—
Net cash flow	—	1,650	1,378	7,695	6,428	174,702
Balance due (year ending)	660,000	605,000	460,000	265,000	0	—

* 1983 figures supplied as indication of agency finances before Jan 1, 1984, acquisition.

Source: Russell Miller Inc.

An acquisition's value cannot be set in stone

By RUSSELL R. MILLER

IDON'T KNOW how many times over the years I have heard agents say, "I just lost an acquisition because an agent down the street paid 25% to 50% more than I had offered." Did the buyer overpay? Or is he looking at it differently? How can value be so subjective?

How can an agency with commissions, fees and other income of \$500,000 have a "fair market" value of \$550,000 and yet get an offer of double that? This is far from an easy question to answer.

A good acquisition requires detailed analysis. It is essential that buyers have a solid, down-to-earth understanding of what the overall

marketplace says an agency is worth.

In today's market, acquisitions are measured by two main criteria: a reasonable return on invested capital and the going-concern value paid for most agencies. There are no real average values. Value depends on the circumstances that are at hand in the place and time of an actual transaction.

Every purchaser should first think of himself as an investor. It is reasonable to assume an investor would want a return in the 18% to 20% range on an insurance agency investment. An agency has a much higher risk attached to it than a U.S. government bond, which currently yields about 8%. Reliable corporate bonds for large companies are yielding to 14%.

Thus, if you look at the acquisition of an agency with revenues in the \$500,000 range and you spend \$500,000 on this investment, you would probably want to receive a \$100,000 return on that investment averaged over the year your capital would be committed. This would yield a 20% return on your investment.

Normally, any investment doesn't pay the desired return the first couple of years. Rather, your overall return is projected to be received over a number of years.

The public brokers have averaged over the past few months an aftertax multiple of 13.7 and pretax multiple of 6.8. They try to acquire agencies at some discount of their multiple. They feel they can justify a discount because they have offices worldwide, with large books of business and multiple staff capabilities. In short, they feel they are worth more than any single local agency.

This may or may not be worth arguing in any specific case, but it is in fact the way the public broker will approach the average local acquisition. For example, a broker with a pretax multiple of 6.8 would pay \$578,000 for an agency with:

- Total revenues of \$500,000.
- Compensation and tax expenses of \$290,000.
- Operating expenses of \$125,000.
- A total pretax profit of \$85,000, which equates to a pretax margin of 17%.

You can see that both a reasonable investor value of \$500,000 and current market value of \$578,000 aren't too dreadfully different. Why, then, would someone pay and be satisfied with a much higher price for an agency?

Let's try another example. Assume that a local buyer could take the agency over and reduce costs. Let's assume that office rental costs for the buyer are somewhat less and that there are redundant accounting and clerical functions that could be discontinued, all of which could increase the pretax earnings. This would raise the pro forma pretax earnings by the expenses omitted.

Don't forget, however, that some expenses, such as moving costs, new stationery and telephone charges, will be incurred and that a certain amount of disruption will take place when the two agencies join.

All in all, let's assume a net \$25,000 plus on a pro forma basis. Hence, we have a slightly higher view of what this agency can generate to a specific buyer over the long term.

This is a very important point. Any acquiring agent must examine not only the pro formas of the seller, but must also analyze his

Continued on facing page

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Continued from facing page

own new pro formas in terms of the new additional business. This is true whether it is to be a stand-alone acquisition or one that is merged into an existing agency.

The point to be emphasized here is that there is at least an additional \$25,000 profit for one buyer rather than another, and the purchasing party must have the analysis carefully done so that future events can be reasonably projected. There can be major incremental profits in an analysis involving the new picture of the combined firms.

The chart (see page 12F) shows a possible structuring of a transaction where the purchase price is well above the two previous ones. Here we will assume it to be \$825,000 or 43% more than the highest previous offer, \$578,000.

Assume the buyer's offer is \$825,000 with a down payment of 20%, or \$165,000. The balance is to be paid over seven years with interest on the unpaid balance of 11%. This is designed so that the buyer has no further out-of-pocket costs other than the down payment. You may observe, however, that if even that were borrowed, there is \$174,702 by 1991 to meet such a commitment.

You can easily see that, by calculating the tax-sheltering effect of amortizing expirations, the cash flow will cover the interest payments as well as the remaining debt over the seven-year period.

Why can this be accomplished when, in fact, the price paid appears to be higher than market value—the public broker having offered \$578,000 and the private agency \$825,000? An analysis of the chart shows that the actual return on invested capital for the private agent is a very meager 1.3%.

The agent in this illustration has decided that the value of a book of business is worth more to him than immediate returns. There is a sacrifice of market returns of 8% to 20% to do so. By accepting a much lower return, an agent can pay more than the market would generally provide in such a transaction.

Such an acquisition is risky in the same sense that a buyer is "betting" on the very long term. Deep down the buyer believes the market will gradually improve. The buyer also believes the purchased agency will show a higher capital value than could be anticipated in the early years where the most accurate returns on investment calculations are made.

Besides taking a much lower expected return, the buying agent is also using leverage. Leverage, as we all know, works wonderfully when things are going your way, but not at all well when the reverse is true. If an agent stretches too far and revenues begin to drop, a disaster could easily develop because there is no real capital base protecting the investment.

For example, if revenues grow at a 4% compound rate while expenses remain at an 8% compound rate, the buyer would realize a negative 40.1% return on this investment. However, if revenues grow by a 13% compound rate while expenses remain at 8% annual growth, the buyer would see a 60% return on his investment.

The relative difference between two potential buyers of the agency depends upon the acquisition objectives of each buyer. In the first example, the buyer views the agency

as a stand-alone investment. No operating charges are necessary in order to meet a return on investment, which a public broker may expect.

In the second example, the buyer feels that with a change in operating expenses, he has the potential to receive a much higher return on his investment. These changes in operating expenses depend upon the consolidation of current resources, which may make the book of business more profitable.

This type of change differs from changes in marketing and production goals. Any benefits achieved from these decisions represent the return due to the buyer for his additional efforts.

In order to understand the variables, which determine the value of an agency, a thorough examination of the needs of the acquiring firm and the impact of the pro forma earnings of the new entity should be thoroughly examined. ■

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Prepare before putting agency on the block: Lawyer

BOSTON—Like a used car, an insurance agency should be spruced up before it's sold, an agency perpetuation specialist says.

"Little gimmicks and tips on selling an agency have become more important in this active environment for mergers and acquisitions," explains David A. Bakst, an attorney with the law firm of Morrison, Mahoney & Miller in Boston.

Mr. Bakst, for instance, has advice for agents who are just beginning to look for a buyer:

- One year before the anticipated sale, start making your agency look good on the surface.

- Shorten the age of accounts receivable, pre-bill renewals and practice account selling.

- Maintain good records, especially financial statements.

Selling an agency offers plenty of opportunities for tax savings, Mr. Bakst counsels, because the proceeds from the sale of an agency—including the removal of retained earnings—qualifies as a capital

gain. Under the capital gains rates, these retained earnings would be taxed at a maximum of 20%, rather than the ordinary income tax rates, which may reach as high as 50%.

Mr. Bakst advises would-be sellers to reduce their salary and pass up bonuses ahead of time so they can remove those funds under the more favorable tax rate.

Additionally, sellers should:

- Acknowledge agency weaknesses by identifying target accounts, brokerage business, heavy

auto concentration, slow accounts receivable and poor markets.

- Recognize hidden agency strengths. Show the buyer opportunities for internal growth, such as the possibility that he can sell more policies to clients, many of whom may hold only one policy.

- Search for the right buyer, keeping in mind that large agencies and brokerages operate more efficiently, and thus may be able to pay you more. There are few sellers and many buyers, so sellers should

have plenty of choice in the matter, Mr. Bakst says.

- Aim for a buyer who is compatible with your operation, represents eager, aggressive insurers and has a good reputation and financial background.

Mr. Bakst urged would-be sellers to consult with their attorney and accountant before talking to buyers. Agents also educate these professionals in insurance lingo, because drastic errors can result if

agents are misunderstood.

As far as valuations go, Mr. Bakst explains that the value of an agency—the price for which it sells—may be considerably more than 1½ times annual commissions, a



Mr. Bakst

common multiple used as a benchmark of agency value.

Other methods of arriving at value are fixed-price arrangements, in which both parties agree on a price with no subsequent adjustment allowed, and retainage or earn-out arrangements, methods by which the price is based on the future performance of the business.

In this type of arrangement, the buyer would pay the seller a percentage of commissions on renewal business. This makes the eventual price the seller receives depend on how well the book of business performs.

Mr. Bakst notes that many agency sales are being arranged with a combination of the two methods, such as a minimum price plus a retainage agreement.

The closer the buyer is to the agency—for example, if the buyer is one of the agency's producers—the less concerned the buyer should be about the agency's ability to keep its accounts, Mr. Bakst points out. But a buyer unfamiliar with the business is liable to worry more about losing business. If there are two or three target accounts, a buyer may wish to include those in a retainage agreement, so that the only business to be paid for is the business that is kept.

Mr. Bakst also advises agents to note Revenue Ruling 74-456, by which the Internal Revenue Service acknowledged that insurance expirations are a depreciable asset, since expirations are only valuable to the buyer for a period of time before they are replaced with the buyer's own accounts.

The IRS has never stated how long the useful life of expirations is, however, so agency buyers may depreciate expirations over whatever period they choose. Mr. Bakst says a depreciation period of 10 years is safest in most cases.

Mr. Bakst recommends the typical installment sale of agencies as a tax advantage, since it gives sellers the ability to report income as it is earned, rather than all at once. He discouraged using too heavy a collateral, such as a demand promissory note, which is payable on the seller's demand, because the IRS will apply the doctrine of constructive receipt to it.

According to Mr. Bakst, this doctrine says, "Just because you don't ask for it doesn't mean you couldn't get it." Thus, the IRS will demand that the seller pay tax on the amount of the note, as well as the down payment.

For example, if a buyer paid \$100,000 down and gave the seller a demand promissory note for \$400,000, the IRS would collect taxes on \$500,000. This is probably more than the seller has on hand, since he has only received \$100,000.

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Life insurers drop services offered to pension plans

By DOUGLAS McLEOD

NEW YORK—Many pension plan managers are looking to outside consultants for actuarial and administrative services following the divestiture by several life insurers of their pension servicing operations.

Traditionally, life insurers handling the investment of pension plan assets have included actuarial and administrative services in their overall management programs.

In the past two years, though, a succession of large life insurers have quit offering administrative services, while continuing to handle the investment of plan assets.

Several reasons are offered for the elimination of these services, including the growing complexity and cost of operation following the passage of the Tax Equity and Fiscal Responsibility Act and the Employee Retirement Income Security Act.

In addition, some say, there was a realization that local consultants could often provide better service than their giant insurance company competitors.

For instance, Prudential Insurance Co. of America will discontinue administrative services for 2,000 small, mainly defined contribution pension plans now participating in its Comprehensive Pension and Administrative Services (COMPAS) program, according to Kalman Ketzlach, vp and associate actuary.

Prudential will continue to manage the assets of about 8,000 small plans covering five to 10 lives each. About 6,000 of the plans are already administered by outside consultants.

"We've been losing money on (administration) and that's the prime reason for our change in direction on it," Mr. Ketzlach said.

Another reason, he added, is the difficulty of competing with local administrators from Prudential's centralized offices in the Philadelphia and Minneapolis metropolitan areas.

Prudential may continue to provide specific services for some small plans after the COMPAS package is dropped, but this will be only on a case-by-case basis, Mr. Ketzlach said.

The insurer, though, has no plans to cut back services for large group plans.

For those small plans whose servicing isn't retained by Prudential or by a local provider, the insurer has recommended they take their business to Milliman & Robertson Inc., a national actuarial consulting firm.

M&R was also recommended by The Equitable Life Assurance Society of the United States, Great-West Life & Annuity Insurance Co., New York Life Insurance Co. and Pacific Mutual Life Insurance Co., all of which have spun off their administrative operations for predominantly defined benefit group plans since the beginning of 1982.

M&R has retained about 60% of the cases referred to it by these four companies, according to Fenton Isaacson, M&R's national director of pensions. Most of this business comes from medium-sized plans consisting of 30 to 1,000 lives apiece, he added.

"Bigger cases tend already to have decided to use private actuarial consulting businesses rather than insurance company home office services," Mr. Isaacson explained, noting that many large life insurers had already seen their client base for group pension services erode before they decided to divest the service operations.

M&R has also retained most of a block of 400 small plans referred to it by Northwestern National Life Insurance Co. in August.

Mr. Isaacson blames new administrative complexities ushered in by TEFRA and ERISA for pushing up the costs of pension servicing to the point where many insurers couldn't maintain cost-effective operations.

"They had a heck of a time keeping their pricing up to cover (the costs of) the services," he said. Agents would "scream and holler" as soon as insurers tried raising fees, he explained.

Nevertheless, Mr. Isaacson says he expects "no significant change in fee levels" for employers transferring their pension servicing to M&R, though there may be "some adjustments" after a year or so.

Servicing of small plans typically costs an employer \$800 to \$1,000 per year, while larger group plans may carry service fees of between \$10,000 and \$20,000, he said.

All told, M&R has picked up servicing of 1,000 plans, excluding the Prudential business, generating about \$2 million per year in fees.

Lincoln National Pension Insurance Co. referred servicing of its group pension plans to Buck Consultants Inc., while Connecticut General Life Insurance Co., a unit of CIGNA Corp., and Aetna Life & Casualty Co. made no formal endorsement when they dropped their small plan servicing operations.

Great-West, a Denver-based subsidiary of Great-West Life Assurance Co. of Manitoba, Canada, divested only its defined benefit plan administration services, maintaining service for defined contribution plans. Defined contribution plans constitute the lion's share of Great-West's business in terms of managed assets and present less of an actuarial headache, said Gregory Seller, a pension officer.

Of \$405 million in total group pension deposits, the defined benefit plans affected by the divestiture account for only \$20.1 million, he added.

"The fact of the matter was that for us and for most other insurance companies, the primary reason for getting into administration of defined benefit plans was that we wanted to manage the assets," he explained.

Employers were happy to have their administration "subsidized" as part of a pension management package, but the costs of providing the services mounted to the point where Great-West was only breaking even in the service business.

Great-West clients are better off for the divestiture, Mr. Seller maintains, since they are now receive the localized service most prefer, while freeing Great-West itself to concentrate on pension investment services.

The impetus for insurers to provide administrative services has been further diminished by the trend among pension managers to diversify plan assets among several investment managers, adds Thomas O'Connor, a vp with New York Life, which discontinued actuarial services for group plans earlier this year and is still in the process of eliminating all services, including accounting, for small pension plans.

"The industry trend is away from a full-service provider," he notes.

Not all insurers are bailing out of the pension servicing business, however. Metropolitan Life Insurance Co., for example, still maintains full services coupled to management of its clients' pension assets.

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JAN. 26. Organizing and Operating Agency Captives seminar in Dallas, sponsored by the Society of Chartered Property & Casualty Underwriters; \$80 for members; \$90 for non-members. Also Feb. 7 in Jacksonville, Fla. Coleen Mulhern, Professional Services Coordinator, Society of CPCU, Kahler Hall, Providence Road, Malvern, Pa. 19355; 215-251-2728.

JAN. 26. Development and Participation in a Preferred Provider Organization seminar in Manhattan, sponsored by Health Systems Associates; \$235. John F. Reilly, Health Systems Associates, Box 404, South Salem, N.Y. 10590.

JAN. 27-28. Toxic Tort Litigation seminar in New York, sponsored by the Practising Law Institute; \$350. Also Feb. 17-18 in Houston, Mar. 16-17 in San Francisco. Practising Law Institute, Department KDC, 810 Seventh Ave., New York, N.Y. 10019; 212-765-5700.

FEB. 2-5. National Fire Safety and Burn Prevention conference in Arlington, Va., sponsored by the Federal Emergency Management Agency's National Fire Academy and U.S. Fire Administration in cooperation with International Society of Fire Service Instructors and the National Fire Protection Assn.; \$120. International Society of Fire Service Instructors, 20 Main St., Ashland, Mass. 01721; 617-881-5800.

FEB. 6. Directors and Officers Liability workshop in King of Prussia, Pa., sponsored by the Society of Chartered Property & Casualty Underwriters; \$80 for members; \$90 for non-members. Coleen Mulhern, Society of CPCU, Kahler Hall, Providence Road, Malvern, Pa. 19355.

FEB. 6-10. Basic Government Risk Management seminar at the University of Arizona, Tucson, sponsored by the Public Risk & Insurance Management Assn.; \$360. Joseph Hrabosky, 3920 N. Harrison Road, Tucson, Ariz. 85749; 602-749-3137; or Natalie Wasserman, PRIMA, 1120 G St. N.W., Suite 707, Washington, D.C. 20005; 202-737-7556.

FEB. 6-10. Reinsurance Practice course in London, sponsored by the Risk Research Group; \$1,000. Sue Moore, Risk Research Group, Bridge House, 181 Queen Victoria St., London EC4V 4DD; 01-236-2175, ext. 22; telex 8811636.

FEB. 13-15. International Foundation of Employee Benefit Plans 1984 Trustees and Administrators institute in Orlando, Fla.; \$420. Also May 14-16 in Las Vegas, Nev.; July 23-25 in Monterey, Calif.; Aug. 13-15 in McAfee, N.J. Public Relations Department, IFEBP, P.O. Box 69, Brookfield, Wis. 53005; 414-786-6700.

FEB. 13-17. Loss Control Management seminar in Atlanta, sponsored by the International Loss Control Institute; \$625. Richard Jump, International Loss Control Institute, P.O. Box 345, Loganville, Ga. 30249; 800-544-6001; 404-466-2208.

FEB. 16. Risk Management Information conference in Chicago, sponsored by Corporate Systems; \$50. Matt Davis, Corporate Systems, Box 31780, Amarillo, Texas 79120; 806-376-4223.

FEB. 21-22. Compliance with the New CAL/OSHA Noise Standard and How to Establish an Effective Hearing Conservation Program course in Los Angeles, sponsored by the University of Southern California; \$375. University of Southern California, Institute of Safety & Systems Management, Office of Extension & In-Service Programs, Los Angeles, Calif. 90089; 213-743-6523/6524.

FEB. 22-24. Issues Facing Captives course in London, sponsored by the Risk Research Group; \$630. Sue Moore, Risk Research Group, Bridge House, 181 Queen Victoria St., London EC4V 4DD; 01-236-2175, ext. 22; telex 8811636.

FEB. 25-MAR. 3. Western Assn. of Insurance Brokers Third Annual Winter Conference in Snowmass, Colo.; \$125. Sue Farber, Western Assn. of Insurance Brokers, 235 Montgomery St., Suite 962, San Francisco, Calif. 94104; 415-392-5383.

FEB. 29-MARCH 2. Introduction to International Employee Benefits seminar in Brussels, Belgium, sponsored by the International Benefits Information Service; \$525. Bruce F. Spencer, 222

W. Adams St., Chicago, Ill. 60606; 312-236-2615; or Vincent J. Simone, Orchard House, 7 Little Austin Road, Farnham, Surrey, England; 0252-726416.

MARCH 1-2. Ansil Fire Protection school in Beaumont, Texas; \$450. Also March 5-6, March 8-9, March 12-13. Jill Davis, Ansil Training Services, Marinette, Wis. 54143; 715-735-7411.

MARCH 6-7. International Reinsurance conference in London, sponsored by Kluwer Publishing Ltd.; \$475. Kluwer Publishing, 20/24 Rope-maker St., London EC2Y 9AS; 01-588-4274; telex 8811725.

MARCH 12-14. Advanced Government Risk Management seminar at the University of Arizona at Tucson, sponsored by the Public Risk & Insurance Management Assn.; \$325. Dr. Nestor Roos, 2030 E. Broadway, No. 110, Tucson, Ariz. 85719; 602-622-5174; or Natalie Wasserman, PRIMA, 1120 G St. N.W., Suite 707, Washington, D.C. 20005; 202-737-7556.

MARCH 12-16. Fundamentals of Modern Safety Management seminar in Atlanta, sponsored by the International Loss Control Institute; \$625. Richard Jump, International Loss Control Institute, P.O. Box 345, Loganville, Ga. 30249; 800-544-6001; 404-466-2208.

MARCH 13-15. Reasoning Reinsurance seminar in Irving, Texas, sponsored by the University of Dallas; \$475. Professor Bruce Evans, Reinsurance Management Institute, University of Dallas, Irving, Texas 75061; 214-721-5360 or 214-721-5299.

MARCH 19-21. Advanced Safety Management seminar in Atlanta, sponsored by the International Loss Control Institute; \$350. Richard Jump, International Loss Control Institute, P.O. Box 345, Loganville, Ga. 30249; 800-544-6001 or 404-466-2208.

MARCH 19-21. Society of Fire Protection Engineers annual symposium in Leesburg, Va.; \$375. Marianne Casey, Society of Fire Protection Engineers, 60 Battery March St., Boston, Mass. 02110; 617-482-0686.

MARCH 19-21. Human Resources conference in Boston, sponsored by the American Management Assns.; \$525 for members; \$595 for non-members; group discounts available. American Management Assns., 135 W. 50th St., New York, N.Y. 10020; 518-891-1500.

MARCH 19-23. Highly Protected Risk Property Conservation course in Long Grove, Ill., sponsored by Kemper Group; \$400. Also May 7-11 and Oct. 1-5. W.P. Thomas Jr., Manager of Engineering Research and Staff Development, HPR Development, Kemper Group, A-1, Long Grove, Ill. 60049.

MARCH 19-23. Industrial Ventilation course in Los Angeles, sponsored by the University of Southern California; \$650. University of Southern California, Institute of Safety and Systems Management, Office of Extension and In-Service Programs, Los Angeles, Calif. 90089; 213-743-6523/6524.

MARCH 19-23. Fundamentals of Hygiene Monitoring course in Long Grove, Ill., sponsored by National Loss Control Service Corp.; \$490; group discounts available. Also May 14-18, Sept. 10-14, Nov. 12-16 in Long Grove, Ill. John Garis,

Industrial Hygiene, National Loss Control Service Corp., Long Grove, Ill. 60049; 312-540-2026.

MARCH 26-30. Respiratory Protection course in Los Angeles, sponsored by the University of Southern California; \$750. University of Southern California, Institute of Safety and Systems Management, Office of Extension and In-Service Programs, Los Angeles, Calif. 90089; 213-743-6523/6524.

MARCH 28. One-Day Health Care Cost Containment seminar in Portland, Ore., sponsored by the International Foundation of Employee Benefit Plans; \$140 for members; \$165 for non-members. Also March 29 in Los Angeles; June 6 in St. Paul, Minn.; June 7 in Rosemont, Ill.; Sept. 6 in Boston; Sept. 7 in Tarrytown, N.Y.; Sept. 17 in Dearborn, Mich.; Sept. 18 in Cleveland; and Sept. 19 in St. Louis. IFEBP, 18700 W. Bluemound Road, P.O. Box 69, Brookfield, Wis. 53005; 414-786-6700.

MARCH 30. "Right to Know": Illinois Toxic Substances Disclosure Act of 1983 conference in Chicago, sponsored by the Illinois State Chamber of Commerce; \$80 for members; \$120 for non-members. Illinois State Chamber of Commerce, Center for Business Management, 20 N. Wacker Drive, Chicago, Ill. 60606; 312-372-7373.

APRIL 1-6. 22nd Annual Risk & Insurance Management Society conference in New York; \$495 for members; \$595 for non-members; \$25 additional after Feb. 3. RIMS Conference Department, 205 E. 42nd St., New York, N.Y. 10017; 212-286-9292.

APRIL 9-12. Seventh Annual Conference on Prevention, Behavior, Cleanup of Spills and Waste Sites sponsored by the Bureau of Explosives, the Chemical Manufacturers Assn., the U.S. Coast Guard and the U.S. Environmental Protection Agency; \$200; \$150 for early registration. 1984 Hazardous Material Spills Conference, 1629 K St. N.W., Suite 700, Washington, D.C.; 202-887-1209.

APRIL 9-13. Loss Control Management seminar in Atlanta, sponsored by the International Loss Control Institute; \$625. Richard Jump, International Loss Control Institute, P.O. Box 345, Loganville, Ga. 30249; 800-544-6001; 404-466-6001.

APRIL 12-14. 1984 Employee Benefits Communications institute in Miami, sponsored by the International Foundation of Employee Benefit Plans; \$420 for members; \$495 for non-members. IFEBP, 18700 W. Bluemound Road, P.O. Box 69, Brookfield, Wis. 53005; 414-786-6700.

MAY 13-19. Fourth Third World Insurance Congress in Casablanca, Morocco, sponsored by the Assn. of Insurers of Developing Countries; \$274 for members or delegates; \$550 for others. John D. Thomas, John David Thomas Inc., 401 E. 80th St., Suite 10F, New York, N.Y. 10021; 212-570-2338.

SEPT. 17-19. Fundamentals of Industrial Exhaust Ventilation course in Long Grove, Ill., sponsored by National Loss Control Service Corp.; \$400; group discounts available. John Garis, National Loss Control Service Corp., Long Grove, Ill. 60049; 312-540-2026.

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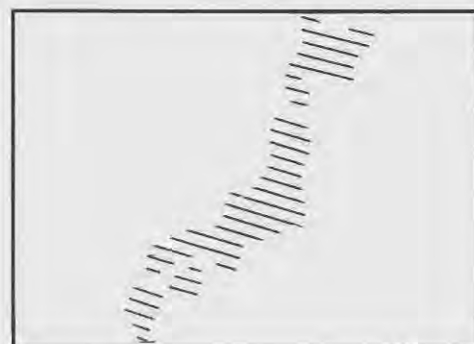
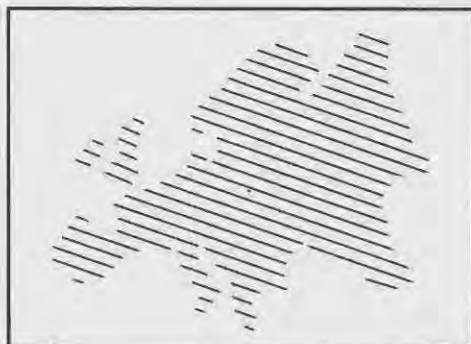
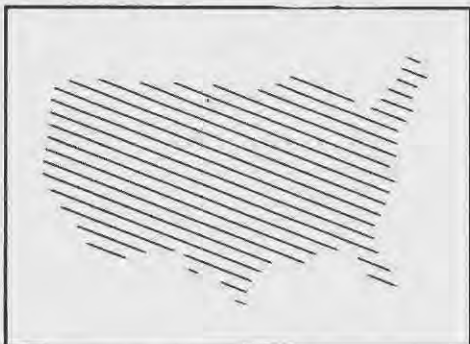
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Jan 23		Jan 11
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Feb 6	Risk Management Services	Jan 25
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The game plan that works.



OVERSEAS PRODUCT LIABILITY

Variety of laws in EEC countries concern manufacturers abroad

By Charles H. Bechtold Jr.

IF YOUR COMPANY offers a product that is manufactured in one European country, packaged in another, sold to a third and exported to a fourth, what legislation and whose jurisdiction would apply if a claim were made against you?

In the face of conflicting product liability laws in many European countries, the answer for most manufacturers simply isn't clear.

In the last two decades there have been a number of proposals for standardizing product liability laws in Europe. That the region will eventually adopt uniform product liability legislation is not in dispute. There is, however, a question of when, and in what form, that legislation will appear.

The vehicle that should be instrumental in resolving the present confusion is the European Economic Community's Directive on the Approximation of the Laws, Legislations and Administrative Provisions of the Member States. After eight years of working on the directive's wording, the EEC's Council of Ministers seems near agreement, but no one knows when the final directive will be adopted.

In the meantime, progress on product liability is at a standstill.

In Europe, as in the United States, product liability law has changed dramatically in the 20th century. Originally, the burden of proof lay heavily with the claimant. Over the years, there has been a steady evolution in the law. Theories of recovery have steadily liberalized as traditional defenses have been eroded.

In the 1960s, birth defects caused by a drug for pregnant women made

Charles H. Bechtold Jr. is vp and manager of the New York International department of Johnson & Higgins. He serves on the Permanent Working Group of UNISON, the international network of insurance brokers of which Johnson & Higgins is a founding member. His column on international issues debuts this month and will appear the first Monday of every month.



international issues

Europeans abruptly aware of the product liability issue and set the stage for the present trend of integrated compensation programs, written within the framework of insurance or social security programs, that are prevalent in Europe today.

Although some form of product liability law has been adopted in most European countries, the region's open borders and constant traffic continue to pose many jurisdictional problems in adjudicating product liability cases.

In 1967, The Hague Convention was called to establish rules to determine what jurisdiction would apply in a product liability suit with international ramifications. After five years, the convention developed jurisdictional rules based on such criteria as place of injury, habitual residence of the injured person, principal place of business of the defendant and where the product was acquired.

To date, The Hague Convention remains inoperative, unfortunately. Only three countries—France, Norway and Yugoslavia—have signed and ratified the agreement, so it is applicable in those countries alone.

With regard to substantive law, two major attempts have been made at reform, both favoring compensation to victims regardless of fault.

The first attempt was made by the Strasbourg Convention of 1970. Nineteen European countries (including the 10 EEC countries as well as Austria, Cyprus, Malta, Norway, Portugal, Sweden, Switzerland and Turkey) advocated a form of "strict liability."

This concept imposed liability regardless of fault by the party made liable, subject to certain prescribed defenses such as contributory negligence on the part of the plaintiff. Only four countries have signed the agreement; none have ratified it. Its impact therefore, has been nil.

The second attempt at substantive product liability reform was the EEC directive mentioned earlier, which attempted to harmonize the laws concerning defective products within member states. Under this directive, an

injured party in any EEC country would be assured of identical rights without regard to the EEC country in which the suit was filed.

There have been modifications of the original EEC directive and there have been compromises. These have been necessary not only to help the EEC members reach an agreement, but to produce a directive to which even the non-EEC nations in Europe will eventually adhere.

What are the key points of the European Economic Community product liability directive?

- Importers and distributors as well as manufacturers can be held responsible for injuries caused by their products.
- They are responsible for bodily injury as well as for damage to a consumer's personal property.
- Responsibility applies to injury or damage caused by a defective product. A product is deemed defective if it does not provide persons or property with the safety one could expect when, in the ordinary course of events, it is used for the purpose for which it was intended.
- A proposed limit of liability of 25 million European units of account (which translate to approximately \$23 million) for all personal injuries caused by the defective product has been rejected. A revised limit has still to be determined by a majority of the council.
- Defenses against claims are restricted to proof that the product was not being used for the purpose for which it was intended; proof of contributory negligence on the part of the claimant; proof that the product was not defective when the manufacturer put it into circulation.
- The final directive will probably provide for compensation for pain and suffering although opponents argue that this should be determined on a national basis.

The chief obstacle to agreement on the European Economic Community directive is that product development risk, or injury that occurs during the test period before the product is approved and registered, has been included within the scope of strict liability.

Although eight out of the 10 member countries propose that product development risk be left to the discretion of individual countries, attempts to remove this risk from the directive have not been successful.

Certain modifications may be necessary before the EEC's Council of Ministers approves the directive, but approval is expected eventually. If the directive is approved, member states must enact supporting legislation within 18 months.

In the absence of consensus on a Europeanwide solution to the product liability issue, various countries in Europe have been working on their own laws. The countries included are:

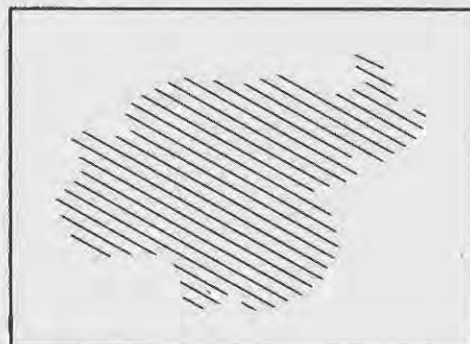
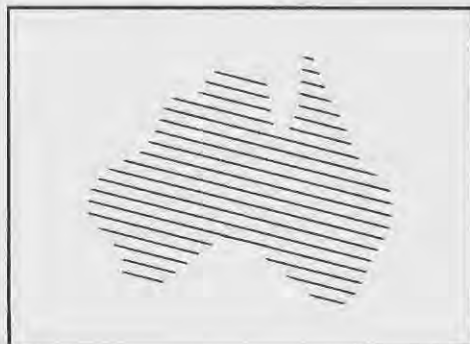
- Sweden. All pharmaceutical manufacturers and importers participate in a voluntary group insurance program for drug-related injuries. The program has limits of 2 million Swedish krona (about \$500,000) per person, 100 million krona (about \$25 million) for all injuries from the same drug and 150 million krona (\$37.5 million) annual aggregate. No serious losses have been reported to date.
- Norway. This country has also sought a nationwide cooperative solution to product liability risk. The Norwegian government has introduced legislation that envisions an insurance fund established by all manufacturers and importers. The fund would be financed by a charge against each company's sales volume. Claims for compensation would be made against this fund rather than against manufacturers or distributors.

Defenses would include contributory negligence and prescription or dispensing error. Unsuccessful treatment that did not result in specific bodily injury would not be covered under the legislation.

The maximum payable by the fund in any one year will be limited to 80 million Norwegian krone (about \$16.5 million), with total claims for any one adverse effect compensated to a maximum of 50 million krone (about \$10.5 million). The government may be asked to contribute compensation for a catastrophic loss.

- West Germany. Since Jan. 1, 1978, the manufacturer, distributors and importers of certain pharmaceuticals have been strictly liable if a drug causes substantial

Continued on next page



SAVING THE BOTTOM LINE

Key-man life insurance can financially aid a company

By Edward G. Sanchez

KEY-MAN LIFE insurance, often overlooked and underutilized, can fill several critical business needs at the same time. It is traditionally used to indemnify the business for loss of a key executive. Even in public corporations, the loss of a key sales or production vp, financial officer or chief executive officer can have a substantial effect upon a company's bottom line.

Edward G. Sanchez is advanced sales director of First Penn-Pacific Life Insurance Co. in Oak Brook, Ill.



In a recent instance, a senior sales vp in a medium-sized manufacturing company suffered an unexpected and fatal massive stroke. For 10 years this man had served as liaison between his company and an abrasive and difficult customer who represented 40% of the company's business.

A well-intentioned chief executive officer, an accountant by training, attempted to fill this gap and soon had antagonized the customer to the point of losing all future business from his company.

Fortunately, the board had previously authorized the purchase of \$1.2 million of key-man life insurance on the sales vp and two other individuals vital to the success of the business. The result: A loss that could have permanently devastated the company was cushioned by insurance money that replaced lost earnings, paid an executive search firm and training

expenses to find a successor and gave "breathing room" to management.

Of course, in the smaller company, a key executive loss is further magnified because of the many and varied duties performed by one key person. Moreover, bank and supplier credit may be tied directly to one individual through personal guarantees of company borrowing and could quickly dry up at the death of a key executive.

Rapidly gaining in popularity, non-qualified supplemental income plans often utilize key-man life insurance.

The arrangement typically would call for a specified cash benefit to be paid by the company to a key executive at retirement, premature death or disability. A separate written agreement is then executed between the company and the executive.

Cash value or death benefits from the key-man life policy are used by the employer to pay tax-deductible benefits to

the key executive or the key executive's spouse.

There are many reasons for companies to look at key-man life insurance.

First, the use of supplemental income plans is becoming more frequent for higher-paid individuals because of Social Security discrimination in favor of lower-paid individuals and tighter restrictions on contributions and benefits for pension and profit-sharing participants.

Without a supplemental income plan, higher-compensated key employees often receive as little as 40% to 50% of pay upon retirement, while lower-paid employees receive 80% to 90% of pay upon retirement.

Secondly, since supplemental plans are non-qualified, participants may be chosen on a discriminatory, pick-and-choose basis. This allows the employer to provide the insurance benefit only to a select few

Continued on facing page

European product liability laws differ

Continued from previous page

been strictly liable if a drug causes substantial bodily injury. There need be no defect in the drug and no negligence by the parties held liable. The limits of liability are 500,000 deutsche marks (about \$250,000) per person and 200 million deutsche marks (about \$100 million) per drug. Defense is restricted to contributory negligence.

There is no liability if the claimant's injuries are minimal, a term that the law does not appear to define precisely. This law does not apply to drugs exported from the Federal Republic of Germany.

An injured party also has recourse against a manufacturer under the Civil Code if negligence can be proven. Liability under the Civil Code is virtually unlimited.

- France. The concept of strict liability prevails, but paradoxically, it does not particularly apply to the pharmaceutical industry because the burden of proof is on the injured party. An injured party can only invoke the manufacturer's liability on the basis of negligence by establishing a causal link between use of the product and the damage sustained.

- Denmark, The Netherlands and Italy. As in France, a victim in these countries has to prove negligence by the manufacturer in order to recover damages for injury.

Denmark has shelved its study of a voluntary pharmaceutical program and all three countries are awaiting the outcome

of the EEC directive.

- United Kingdom. No official action has been taken on recommendations made in the late 1970s to hold manufacturers strictly liable for injury due to product defects. Negligence, therefore, is still the relevant criterion for successful action against a producer.

However, recent court decisions seem to be narrowing producers' defenses, which may reflect a trend toward acceptance of strict liability. The law will probably be modified, but Parliament may wait for passage of the EEC directive before taking action.

Although neither Sweden's voluntary program nor the West German Pharmaceutical Act has produced a significant increase in claim frequency or court awards, cost increases for insurance coverage are on the horizon.

It is doubtful, however, that Europe will experience the difficulties that we in the United States have had recently with product liability suits. The social systems and legal structures in Europe simply do not lend themselves to the litigation prevalent in the United States. More than anything else, perhaps, Europeans have seen the situation in America and know what to avoid.

There has been some concern that strict liability laws will cause an insurance capacity problem. West Germany and Sweden have experienced no problems to date. However, it is well to remember that the German act, the European Economic

Community directive and the Strasbourg Convention all provide for right of supplementary recourse.

If parties outside a particular jurisdiction employ their national laws to make claims against manufacturers for amounts in excess of those provided by convention, capacity problems could develop.

It is more important than ever that multinationals operating in Europe blend general product liability insurance with the separate voluntary and/or compulsory programs that must be arranged in each country locally.

Companies with European operations should obtain a master difference-in-conditions policy carefully integrated with vital local cover. Insureds who have a master arrangement should make sure that it includes Sweden, Germany and the other European Economic Community countries even after their compulsory legislation is adopted.

U.S. companies should not assume that a stateside policy will be broad enough to make an overseas policy unnecessary. In theory, this may hold true. In practice, however, an overseas policy may provide specialized and essential cover not contemplated in a United States policy. For U.S. manufacturers, now is the time to consult with a knowledgeable international insurance broker and legal counsel to head off future liability complications.

Switzerland enacts new accident law

A federal law on accident insurance recently was passed by the Swiss Parliament.

The law, which was implemented Jan. 1, 1984, requires that both non-occupational and occupational accident insurance will be obligatory for all employed persons in Switzerland.

This insurance will be arranged either through SUVA, Schweizerische Unfallversicherungsanstalt, the Swiss national accident insurance fund, or private Swiss underwriters authorized to subscribe to such cover.

Latin America

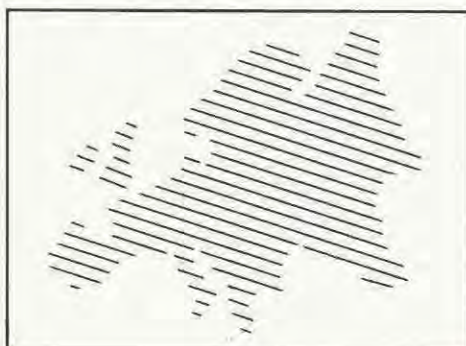
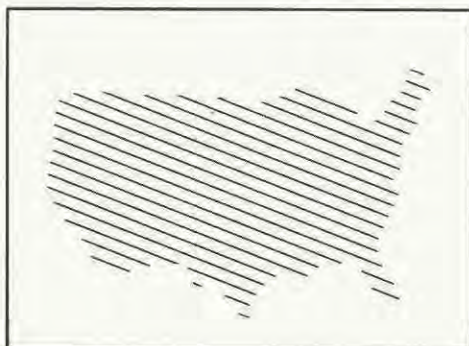
There may be considerable difficulty in obtaining prompt settlement of claims for lost or damaged goods being exported from Latin America, due to the present shortage of foreign exchange in many of the countries in Latin America.

It is recommended that importers of goods from Latin America consider purchasing such imports on cost and freight or free-on-board terms in order to avoid potential claims settlement delays.

C&F, cost and freight, means the seller is responsible for safe delivery to the carrier and for the prepayment of transportation charges.

Usually, prepayment of freight is a requirement of the C&F contract to carry the goods (bill of lading).

F.O.B., free on board, means the shipper is responsible only until the goods have been placed on board the vessel, freight car, truck or other transporter.



Continued from facing page in the executive ranks.

And, when properly arranged, the key executive will not be taxed until benefits are actually received.

A third, but not necessarily final, use of key-man life insurance is to redeem some or all of the corporate stock of a shareholder, thus creating dollars to pay estate settlement costs in the estate of the shareholder. The shareholder may enter into a stock redemption agreement with the corporation.

Shareholder redemptions can come under two sections of the Internal Revenue Code, 302 and 303.

When the insurance death benefit is received by the corporation, it is then paid to the key executive's estate in exchange for stock. A Section 303 redemption is a partial redemption for an amount of stock equal to the decedent's estate settlement costs.

To qualify for Section 303, the executive's corporate stock must comprise at least 35% of his or her adjusted gross estate.

A Section 302 redemption is a complete stock redemption and is often appropriate where two or more unrelated shareholders want to redeem all of their stock upon

death.

In family-owned companies, great care must be taken to comply with the so-called attribution rules in order to achieve favorable tax results under Section 302.

Although premiums for key-man life insurance are not tax-deductible, according to Internal Revenue Code Section 264, there are several significant tax or ownership benefits that are unique to using this type of executive life insurance coverage.

Primarily, cash values of the policy are a company asset and serve to offset premium deposits.

With new low-cost, competitive whole life policies, cumulative cash values often exceed cumulative premium in five to eight years and future premium deposits create a significant credit to corporate earnings.

In addition, taxation of earnings on the cash value is deferred until the policy is surrendered. If the policy is not surrendered and is paid as a death benefit, it is 100% tax-free income to the company.

Since the proceeds of the policy are not formally earmarked for the benefit of the key executive or key executive's family, there is no current income taxation of policy benefits to the key person. Only the

supplemental income plan is taxed. That is because, technically, taxation is for benefits received from the employer, not for benefits created by the key-man life insurance policy.

One longstanding criticism of purchasing keyman life insurance has been the unknown length of time the key executive will be employed, giving rise to the possibility of a high charge to earnings in early policy years when policy cash value does not yet exceed premiums. In recent years, two features have substantially lessened this problem.

First, most major insurers have added, at no extra charge, a key-man exchange rider to business policies.

This enables a new key executive to take over an existing key-man policy, subject to underwriting, without incurring the first-year charges of a brand-new policy. Thus, in effect, the position is insured.

Moreover, underwriting the new insured may be simplified because the policy's existing cash value may reduce the mortality risk.

Second, in recent years, dramatic improvements in whole life insurance policies have substantially reduced the consumer cost of whole life. Thus, cash

value increases rapidly offset policy premiums.

Techniques also have been designed to have a policyowner pay premiums for only a limited number of years. Thus, the company's risk of incurring a large earnings charge has been lessened substantially.

Perhaps the most unique design possibility with key-man life insurance is a plan that pays for itself. In that instance, the policy death benefit can be calculated so that it will be sufficient to meet its primary objective and repay all cumulative premium payments until the date of death.

Since death benefits are income tax-free, this represents a tax-free return of employer money. Skilled business life insurance experts can easily calculate this amount and design plans that pinpoint and meet unique company and executive insurance needs.

In summary, one key-man insurance policy can solve several business needs.

New cash value life insurance policies have substantially reduced insurance costs. They also provide more realistic and current cash value growth while retaining the unique tax advantages of traditional whole life. ■

Employer is not an insurer's agent, according to Tennessee appellate court

AN EMPLOYER was not an insurer's agent for purposes of filing claims, according to a Tennessee appellate court.

Tommy White was employed by Lee Refrigerator Co. and was covered under a group insurance policy issued by Provident Life & Accident Insurance Co. Mr. White ceased working for Lee Refrigerator Sept. 14, 1979.

On Sept. 18, Mr. White's stepson was hospitalized for appendicitis. Mr. White made a claim for benefits under the policy through his past employer. Provident denied coverage claiming that Mr. White was not an employee of Lee at the time of the claim. Mr. White sued.

The court found that Lee was the agent of Provident and had mishandled Mr. White's claim, causing loss to him.

The appellate court, however, ruled that Lee was not the agent of Provident and, thus, Provident could not be vicariously liable for any alleged misconduct of Lee.

The court also rejected Mr. White's claim that he had a 31-day grace period for coverage. The court said the grace period was for the employer to pay the premiums and did not purport to extend employee coverage after employment termination. *White vs. Provident Life & Accident Insurance Co.*, Court of Appeals of Tennessee, Jan. 10, 1983, rehearing denied Feb. 24, 1983, appeal to U.S. Supreme Court April 25, 1983 (BI/01/J.-\$5).

On-the-job death

A newspaper editor's death in an automobile accident returning from a

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

legal briefs

social function was found to be in the course of employment. Therefore, his dependents were entitled to workers compensation benefits, according to the Utah Supreme Court.

Clifford P. Cheney was the managing editor of the Ogden Standard Examiner. The newspaper was owned by Standard Corp.; the president was Wilda Hatch.

Ms. Hatch invited Mr. Cheney and his wife to attend the governor's ball in Salt Lake City because she had extra tickets. Mr. Cheney accepted the invitation, intending to discuss editorial policies.

Yet, no business was discussed during the evening because Ms. Hatch did not initiate any such discussion. Mr. Cheney, apparently, did not find it appropriate to discuss business.

While returning home after the ball, Mr. Cheney was killed in an automobile accident. His dependents filed for and were awarded benefits.

On appeal, the newspaper said the accident did not arise out of Mr. Cheney's job and thus, no benefits were due.

But, the court was satisfied that there was substantial evidence before the Utah Industrial Commission that Mr. Cheney's main purpose in making the trip was to serve the interest of his employer, the newspaper.

"The fact that the employer intended the affair to be purely social," the court said, "does not require a different result, at least when the employer's intentions are not communicated to the employee." *Ogden Standard Examiner vs. Industrial Commission of Utah*, Utah Supreme Court, April 20, 1983 (BI/01/J.-\$5).

Inmate compensation

A prison inmate who sustains injuries

while on a work assignment at an adult correctional institution was not an employee of the state covered by the Workers Compensation Act, according to the Rhode Island Supreme Court.

James Spikes was an inmate and on Oct. 30, 1978, was assigned to an outside work detail. On the day in question, his work vehicle was involved in an accident with another vehicle.

Mr. Spikes was injured and was thereafter assigned to paint walls and ceilings in the minimum security building. Three weeks later, he was injured again when a scaffold he was on collapsed.

Prisoners received \$1 for each day they worked. Mr. Spikes filed for benefits but was denied them.

The issue before the court was whether Mr. Spikes was included within the statutory definition of a state employee. For an employer-employee relationship to exist, there must be an express or implied contract for hire, the court said.

"This implies," the court emphasized, "that services performed must be voluntary on the part of the employees."

According to the court, the law did not pertain to persons confined at a correctional institution doing labor created in an employer-employee relationship during the confinement, thus benefits were denied. *Spikes vs. the State of Rhode Island*, Rhode Island Supreme Court, April 12, 1983 (BI/04/J.-\$5).

Reversed decision

The 8th U.S. Circuit Court of Appeals has vacated an earlier decision (BI, Oct. 10) and now has ruled that the parents of a deceased were the beneficiaries of his group life insurance policy, rather than his wife.

Ronald Briece was covered under a group life policy from Connecticut General Life Insurance Co. His wife Bonnie was the beneficiary. Later, Mrs. Briece sued him for divorce.

While the divorce was pending, Mr. Briece removed his wife as beneficiary and designated his parents in her place. Mrs. Briece requested the divorce court to enjoin her husband from removing her as beneficiary. Mr. Briece was ordered by the court to reinstate his wife as beneficiary.

However, Mr. Briece died before the divorce became final and without knowledge of the order or complying with it. Both his parents and Mrs. Briece sought the proceeds of the policy. The trial court ruled in favor of his parents.

On appeal, Mrs. Briece argued that the equitable doctrine that considers as done that which ought to be done required that she be reinstated as beneficiary.

According to the court, the divorce restraining order should not be recognized as doing what the death of Mr. Briece prevented the trial court from doing in a final decree.

When Mr. Briece changed beneficiaries, the court said, he did so pursuant to the policy terms and, therefore, was not violating any order of the court when he did so.

The court observed that when an insured reserves the right to change a beneficiary, as Mr. Briece did, the beneficiary has a mere expectancy during the insured's lifetime. *Briece vs. Briece*, 8th U.S. Circuit Court of Appeals, March 29, 1983 (BI/05/J.-\$5). ■

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

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JAN 2		Dec 19, '83 M	JAN 2	Dec 12, '83
JAN 9	MARKET PREVIEW/INFO FOR BUYERS	Dec 21		
JAN 16		Jan 4, '84		
JAN 23		Jan 11		
JAN 30	SELF INSURANCE/FINANCIAL SERVICES	Jan 17 T		
FEB 6		Jan 25	FEB 6	Jan 16, '84
FEB 13		Feb 1		
FEB 20	RISK MANAGEMENT SERVICES	Feb 7 T		
FEB 27		Feb 14 T		
MAR 5		Feb 22	MAR 5	Feb 13
MAR 12	EMPLOYEE BENEFITS: CONTROLLING COSTS	Feb 28 T		
MAR 19		Mar 7		
MAR 26		Mar 14		
APR 2	RIMS PREVIEW/CAPTIVES OFFSHORE	Mar 20 T	APR 2	Mar 12
APR 9	RIMS REPORT # 1	Mar 27 T		
APR 16	RIMS REPORT # 2	Apr 3 T		
APR 23		Apr 11		
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MAY 7		Apr 25	MAY 7	Apr 16
MAY 14	SPECIALTY RISKS	May 1 T		
MAY 21		May 9		
MAY 28	EMPLOYEE BENEFITS: CONFRONTING THE FUTURE	May 15 T		
JUN 4		May 22 T	JUN 4	May 14
JUN 11		May 30		
JUN 18		Jun 6		
JUN 25	AGENT/BROKER PROFILES	Jun 12 T		
JUL 2		Jun 20	JUL 2	Jun 11
JUL 9		Jun 26 T		
JUL 16		Jul 3 T		
JUL 23	MARKET REPORT/INSURANCE EXCHANGES	Jul 10 T		
JUL 30		Jul 18		
AUG 6		Jul 25	AUG 6	Jul 16
AUG 13		Aug 1		
AUG 20	EXCESS/SURPLUS	Aug 7 T		
AUG 27	Distribution at Monte Carlo Rendez-Vous	Aug 15		
SEP 3	EMPLOYEE BENEFITS: INTERNATIONAL	Aug 21 T	SEP 3	Aug 13
SEP 10	IIAA Convention	Aug 28 T		
SEP 17	RENDEZ-VOUS REPORT	Sep 4 T		
SEP 24	LOSS PREVENTION	Sep 11 T		
OCT 1		Sep 19	OCT 1	Sep 10
OCT 8		Sep 26		
OCT 15	INTERNATIONAL RISK MANAGEMENT/INSURANCE	Oct 2 T		
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DEC 3		Nov 20 T	DEC 3	Nov 12
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DEC 17		Dec 5		
DEC 24/31*	EMPLOYEE BENEFITS: IN RETROSPECT	Dec 11 T		
1985 ISSUES				
JAN 7		Dec 19, '84	JAN 7	Dec 17, '84
JAN 14	MARKET PREVIEW/INFO FOR BUYERS	Dec 26		

* year end double issue.

NOTE: Editorial information is subject to change.

FULL-RUN AD CLOSING DATES: Last advertising forms normally close in Chicago on Wednesday, 12 days preceding date of publication. However, certain issues will close as indicated: M for Monday, T for Tuesday.

MARKET REPORTS: Special Market Report Sections will be published as integral parts of two issues of Business Insurance during 1984.

AGENT/BROKER TOPICS DEMOGRAPHIC SECTION: The section appears in the first issue of every month. Last advertising forms for this demographic section close in Chicago, on Monday, 3 weeks preceding date of publication.

Township seeks coverage for pollution award

Continued from page 1

eral carcinogenic chemicals, including benzene and acetone, according to Donald I. Marlin, an attorney with the New York firm of Kreindler & Kreindler, which represents the residents.

The suit charged the township and a consulting engineering firm—Ernst, Ernst & Lissenden of Toms River, N.J.—with negligently locating the landfill on a site where earlier mining operations had stripped away a layer of clay. It also accused the township of recklessly operating and maintaining the dump site and deceitfully withholding information about seepage of wastes into the water supply.

The township denied negligent operation of the site and contended, among other defenses, that the toxic chemicals may have come from property adjacent to the landfill, where wastes were disposed, and that it didn't know about the dangerous condition at the landfill in time to have taken any steps to protect residents.

The suit didn't claim that the municipality actually dumped toxic chemicals at the landfill, though.

This became an important point in an early victory the township won against five insurers that covered general liability risks under package policies written between 1972, when the landfill opened, and 1980, when the suit was filed.

The primary insurers included:

- Continental Insurance Co. of New York, which provided coverage between 1972 and 1975 with bodily injury limits of \$100,000 per person and \$300,000 annual aggregate and property damage limits of \$100,000 per occurrence and \$100,000 annual aggregate.

- United States Fidelity & Guaranty Insurance Co. of Baltimore, which provided coverage between 1973 and 1979 with bodily injury limits of \$300,000 per person and \$500,000 per occurrence and property damage limits of \$50,000 per occurrence. The USF&G policy contained no aggregate limits, which lawyers in the case speculate could leave it with the lion's share

of any ultimate liability.

- Insurance Co. of North America, a CIGNA Corp. unit, which provided coverage from 1979 to 1980 with a combined single limit of \$1 million.

In addition, two affiliates of American International Group Inc. provided excess coverage during the same period:

- American Home Assurance Co., which provided coverage from 1973 to 1976 with per occurrence and annual aggregate limits of \$3 million.

- National Union Fire Insurance Co. of Pittsburgh, Pa., which provided coverage from 1976 to 1978 with the same limits.

Three months after the residents' lawsuit was filed, the township filed a declaratory suit asking the court to order the insurers to pay its defense costs and indemnify it for any judgment in the case.

The insurers denied coverage on the basis of the pollution exclusion, added to most CGL policies in the 1970s and intended to preclude coverage for any pollution incident that isn't "sudden and accidental."

In a decision that was later affirmed by a state appellate court, Superior Court Judge James M. Havey ruled that the pollution exclusion was "ambiguous" and that the insurers had a duty to defend the township.

One ambiguity the judge noted was that the clause could be interpreted to apply only to deliberate polluters, meaning that it would not apply to the township, which was not accused of actual waste dumping.

Another ambiguity was the definition of "sudden and accidental." Some courts have ruled that only the suddenness of the initial release matters and not the gradual migration of the pollutants afterward, the judge noted.

On the issue of the insurers' duty to indemnify, the appellate court ruled that a separate trial to determine coverage should precede trial of the residents' lawsuit.

The residents' suit, however, went ahead first with the agree-

ment of the insurers, which decided that the facts brought out in the liability trial would help answer coverage questions, according to Francis H. Wolff, whose Red Bank, N.J., firm of Wolff, Helies & Duggan represents USF&G in the coverage matter.

Continental was dropped from the township's declaratory action after it presented evidence that pollution of groundwater couldn't have occurred during its policy period, lawyers say. New evidence presented at the liability trial calls the earlier evidence into question, though, and a motion is pending before Judge Havey to bring Continental back into the case.

In addition, the township's public officials' liability insurer, International Surplus Lines Insurance Co. of Chicago, was dropped from the declaratory action in part because its policy was ruled not to cover claims for bodily injury or property damage.

In pre-trial hearings last spring, the township's lawyers successfully argued that the residents shouldn't be allowed to collect any compensatory damages for enhanced risk of cancer and other diseases, since there was no "reasonable medical probability" that they would suffer those diseases in the future because of the contaminated water.

The only immediate medical problems linked by trial testimony to the contamination were skin rashes suffered by several residents, Mr. Marlin said. Kidney problems and cancer suffered by some residents could not be medically linked to the well water, he added.

But Judge Havey did allow damages to cover the costs of future medical surveillance and for emotional distress.

After a nine-week trial that ended last October, a jury awarded the residents damages for these claims and for diminished quality of life between November 1978, when they were warned to stop drinking well water, and July 1980, when they were connected to a new municipal water system.

In addition to the \$15.6 million verdict against the township, the residents will receive about \$1.4 million from settlements agreed to during the trial by John Ernst, the engineer who designed the landfill, and several waste haulers.

Mr. Ernst's \$850,000 settlement will be covered by his firm's professional liability policy, written by Design Professionals Insurance Co. of Monterey, Calif., with a \$1 million limit, according to Mr. Ernst's lawyer, Guy H. Haskins of the West Orange, N.J., firm of Haskins, Hack, Piro & O'Day.

On Dec. 16, the judge approved the jury verdict, meaning that it will now accumulate interest at the rate of 12% until paid.

At the same hearing, the judge denied the township's motions for a new trial or reduction of the award.

Among their objections to the verdict, the township's lawyers argue that the jury's method of calculating damages resulted in awards that were "grossly disproportionate."

For example, the jury awarded each plaintiff \$30 per day for the inconvenience of being without a supply of running water before the connection with the municipal water system. In one case, the township complained, a boy born in 1979 was given a \$5,760 quality of life award.

While the appeal is proceeding, Judge Havey may order the start of a separate trial to hammer out the insurance coverage questions, though the insurers themselves oppose such a move before the appeal is completed.

The township, supported by the residents in the insurance case, says that coverage should be triggered by exposure to hazardous substances in the groundwater, not by the manifestation of a particular injury.

Since the exposure of Jackson Township residents began when the landfill opened in 1972, the township adds, all of the insurers on the risk from that time must indemnify it for losses.

The township further argues that the initial exposure of each resident and each piece of property is a separate occurrence under the policies. Here, the township and residents are joined by the two excess insurers, American Home and National Union, whose liability would be cut dramatically if the court took the multi-occurrence approach.

The primary insurers, however, question whether the damages awarded to the residents constitute bodily injury or property damage as defined in the policies. Mr. Wolff, who is representing USF&G, said he is unconvinced of the need for medical surveillance and disputes the award of emotional distress damages in the absence of any medical evidence of physical injury.

"You don't just connect water and kidney problems and worry. There's a gap there that bothers me," he said.

The primary insurers also argue for a manifestation trigger for the liability coverage, which would require evidence of each of the residents' injuries and property damage and a decision on when each incident occurred so that the loss can be assigned to the proper policy.

Further, any leakage from the landfill represents a single occurrence under the policies, and all of the residents' damages represent "continuous and repeated exposure" to the condition, the primary insurers maintain.

This is the first case in New Jersey and possibly one of the first in the country where a court will interpret the occurrence and exposure/manifestation questions in a pollution incident, lawyers say.

Unless the courts decide that insurers must pay, the residents are unsure of their chances of collecting any damages.

The township could not afford to pay the verdict out of its operating budget, which in 1983 was \$7.5 million. Attorneys involved in the litigation say that the township might be able to issue a bond to pay the verdict.

Reserve inaccuracy costs firm deduction

Continued from page 1

solve to prosecute self-insured employers that claim tax deductions for their workers compensation reserves.

ESCO, a privately held, 70-year-old company with about 1,500 employees, based deductions sought for workers compensation reserves on actual payments made to injured workers; an additional amount estimated by Employee Benefits Insurance Co., ESCO's independent claims management company, that would be paid in the future for injuries occurring in a current year; adjustments for updated EBI estimates for injuries that occurred in prior years; and administrative expenses ESCO incurred in operating its self-insured workers compensation program, which covered claims under \$50,000.

For 1973 and 1974, ESCO sought total tax refunds of about \$143,000 for workers compensation reserves it accrued for those years.

It also wanted recognition of its ability to establish reserves for claims incurred in 1975. However, it was not seeking a refund from that year.

The IRS disallowed ESCO's deductions on the grounds that the inclusion of estimates for amounts to be paid in future years did not clearly reflect ESCO's income.

The IRS also disallowed the deductions because it said ESCO had changed its method of accounting

in 1974 without obtaining IRS approval.

After auditing ESCO's tax returns, the IRS required ESCO to deduct its workers compensation expenses when paid, instead of accruing the estimated future expenses.

ESCO paid the claimed tax deficiency and then filed for a refund. When ESCO's request for a refund was denied, ESCO filed suit against the federal government to obtain a refund.

In deciding whether ESCO had met the so-called "all-events test," a federal rule governing tax deductions, Judge Redden said ESCO had to prove two things:

- That all of the events controlling ESCO's liability for workers compensation expenses occurred in a given tax year.

- That the amount of its liability could be determined with reasonable accuracy.

Referring to a 1975 decision handed down by the 9th U.S. Circuit of Court of Appeals in the Crescent Wharf & Warehouse case, Judge Redden said that an injury to an employee fixes the fact of liability for a self-insured employer.

As a result, Judge Redden said, ESCO met the first "prong" of the "all-events" test.

But ESCO failed to establish that its losses could be determined with "reasonable accuracy." As a result, it did not meet the second "prong"

of the all-events test, Judge Redden said.

During ESCO's trial, Roy Green, the director of Oregon's Workers Compensation Department, submitted testimony that "the year-end reserves for ESCO incurred losses for the years under discussion are not only accurate estimates of ESCO's ultimate liability, but substantially better estimates of workers compensation liability than one finds in the industry in Oregon."

But Judge Redden noted that ESCO, according to Mr. Green, underreserved by 5.1%, 9.9% and 18.5% for 1973, 1974 and 1975, respectively, for an average discrepancy during that three-year period of 10.17%.

Experts say it doesn't matter whether a company's estimate is off by 7%, 10.17% or even more when applying the "reasonable accuracy" test.

"If there is a deviation between what was originally estimated and what was paid...that is inconsequential so long as at the end of the year you used facts that were known and applied those facts using objective criteria," said Baker & McKenzie's Mr. Levey.

"There is nothing magic about 7% or 10.17%," added ESCO attorney Mr. Greenwood.

"What matters is how the reserves are established, not the variances."

"A hindsight test, which Judge Redden suggests is necessary, is not relevant," another attorney added.

In setting up reserves, an accounting method should be selected that minimizes errors, the data must be collected carefully and the reserves must be monitored, experts say.

EBI, ESCO's third-party claims manager, based ESCO's reserve accounts on estimates following its

Panel rules city can't self-insure

BATAVIA, N.Y.—A state administrative panel has for the second time rebuffed this community in its bid to terminate a Blue Cross/Blue Shield of Western New York Inc. health plan for its police union members and substitute less-expensive self-insurance.

But the 17,000-population community in upstate New York says it's now taking the issue to a state court.

The long-running dispute involves the question of whether a municipality can, under New York law, substitute an insurer-written health plan with a self-insurance program providing identical benefits (BI, May 2, Feb. 23, 1982).

The Batavia case, however, is complicated by the fact that the contract with the city's police union specified health coverage was to be provided by a particular plan called

own reserving procedures as well the guidelines of the Oregon's Workers Compensation Department.

The reserve includes estimates of medical costs, the time an injured worker will miss work, the cost of any partial or permanent disability and any death benefits payable.

ESCO attorneys said the company is now deciding whether it will appeal Judge Redden's ruling.

the "50-51 Western New York Health Plan." That type of coverage is no longer offered by the Buffalo-based BC/BS plan.

The Batavia Police Benevolent Assn. charged bad-faith bargaining after the city self-insured benefits after a contract expiration in 1982 and took its case to a state administrative hearing officer, who sided with the union.

And, a state Public Employment Relations Board panel sided with the union in an order issued last month that argued the self-insurance program was less secure than that provided by BC/BS.

"This is an economic issue," says Ira M. Gates, the city administrator. "The city's been saving 20% or 30% since the change." He said the city found the three-member board's ruling illogical and would appeal to a state court.

NRC wants nuclear liability limits increased

By JERRY GEISEL

WASHINGTON—Congress should consider increasing the \$570 million limit on a nuclear power plant's liability in case of a nuclear accident as well as give accident victims more time to file claims, a federal agency says.

The Nuclear Regulatory Commission, in a report to Congress, also recommends replacing the current per-accident liability limit for nuclear plants with an annual liability limit.

"This annual limitation on liability would permit the assessment of retrospective premiums in succeeding years until all public liability claims from an accident are paid," the report said.

Currently, a power plant can be assessed only once per accident.

The new annual limitation on liability would apply to the nation's 82 nuclear power facilities as well as future plants.

The NRC recommends that Congress amend the Price-Anderson Act, the federal law that limits the liability of the nuclear industry, to raise the maximum retrospective premiums that can be charged to an annual \$10 million per reactor per incident from the current \$5 million per reactor per incident.

"An increase in the size of the retrospective premiums to \$10 million would substantially increase the amount of funds available shortly after a nuclear accident to

pay public liability claims," the report said.

The \$570 million liability limit is computed this way: Nuclear plant operators must purchase the \$160 million of available primary coverage from private nuclear industry pools.

If the damages exceed \$160 million in a nuclear accident, plant operators must pay a one-time retrospective premium of up to \$5 million.

With 82 nuclear reactors now licensed, the retrospective premium program would bring to \$570 million the coverage that is available to a utility in case of an accident.

If, as scheduled, two dozen more atomic plants begin to operate in the next two years, a \$10 million retrospective premium would boost the amount of insurance coverage to pay benefits to more than \$1 billion a year.

Finally, the NRC also recommends that nuclear accident victims be given an additional 10 years to file claims.

The current 20-year statute of limitations "is probably not sufficient to permit the identification of all latent injuries," the NRC report said.

The period of increased risk for leukemia and bone cancer appears to be limited to 25 years. For other

cancers, the increased risk can persist for several decades, the NRC said.

"Given these long latent periods, the commission believes that it would be appropriate to extend the present 20-year statute of limitations under the (Price-Anderson) Act to 30 years."

OPIC repays debt

The Overseas Private Investment Corp., the federal corporation that sells political risk insurance, has repaid the last of its debt to the Treasury Department.

Late last month, OPIC President Craig Nalen presented Treasury Secretary Donald Regan with a \$56 million check, which represents OPIC's second and last installment payment on the \$106 million loan Congress appropriated when OPIC was established in 1971.

OPIC paid the Treasury Department \$50 million in 1981.

"We're able to return this money because...our business volume for the past 28 months has exceeded the entire total of \$7.5 billion recorded from 1973 through 1980," Mr. Nalen said.

OPIC, which sells political risk insurance to encourage U.S. companies to invest in new projects in less-developed countries, reported

record net income of \$82.7 million in fiscal 1983.

Social Security

Sen. Robert Jepsen, R-Iowa, has introduced legislation, S. 2099, that would delay by two years mandatory Social Security coverage for non-profit religious organizations and non-profit organizations, like hospitals, that are affiliated with religious groups.

Under amendments to the Social Security Act passed by Congress last spring, all non-profit groups, including religious organizations, were required to participate in the Social Security program by Jan. 1 (BI, April 4, 1983).

Congress made Social Security coverage mandatory for non-profit employers because it was concerned that Social Security's financial structure was being weakened by the large numbers of non-profit employers that decided to withdraw from the Social Security program.

In addition, some members of Congress were worried that employees of religious organizations that dropped out of the Social Security program would be left without retirement income when they retired.

Some experts warn that suits may be filed by religious groups who contend that Congress lacks authority to make them join Social Security.

Tort reform endorsed

The National Assn. of Insurance Brokers is the latest trade group to endorse federal product liability legislation, S. 44, introduced by Sen. Robert Kasten, R-Wis.

The NAIB had previously endorsed the need for a uniform federal product liability law, but it had not recommended a specific piece of legislation.

The Kasten legislation, which would in many cases make it more difficult for an injured consumer to recover damages, is pending in the Senate Commerce Committee. Backers of the bill hope the bill will be voted on at the end of the month and sent to the Senate floor.

Publication delayed

The U.S. Chamber of Commerce's latest survey of employee benefit costs will not be published for at least another month.

The annual survey, which usually is published in November, has been delayed by staff turnover, a Chamber spokesman said. For example, Fred Lindsey, a retired economist who had supervised the survey for many years, resigned from the project.

The Chamber survey is a key yardstick to measure benefit costs because the companies surveyed, usually close to 1,000, represent a broad cross-section of American industry and commerce.

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Government, Associations, Unions, Educational Institutions 1,024

Commercial Consumers Sub-total 23,176

Insurance Agents

& Brokers 9,639

Insurance Cos. 5,384

Financial Institutions 385

Actuaries, Attorneys,

Adjusters, Appraisers & Consultants 2,779

Others allied to the field 1,020

TOTAL 42,383

*Source: Business/Occupational breakdown of qualified circulation, May 2, 1983 issue, as submitted to BPA for June 1983, BPA Publisher's Statement.

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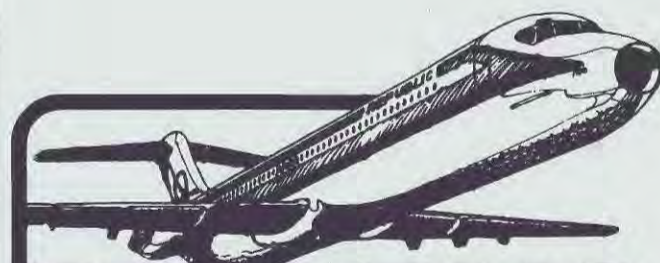
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Church group seeks programs for members

Continued from page 2

sive health insurance at reasonable costs," he says.

CNBC will have to wait awhile for its employee benefits products, Aetna officials say, but there is a good chance that the property/casualty package can be ready by summer and a fair chance that an employee benefit plan can be designed by the end of the year.

Aetna's mass marketers plan to use the development of the property/casualty package to build a data base with CNBC members as a proving ground for its association pooling and marketing technique, executives say. The better the system is refined, the more products the insurer expects to make available to CNBC members.

State laws and group underwriting techniques, however, still may pose some problems.

"We are still in the data-gathering stages and we have already encountered some problems in combining the property/casualty risks involved with the various denominations, but generally we feel that the problems are surmountable," says Clyde H. Fitch Jr., a director of Aetna's commercial insurance division. "What we want to do is set up several pools of churches that can share their loss experience for rate-setting purposes just as manufacturers pool loss experience in safety groups."

However, the individual denominations that make up the CNBC cut across several state lines and may not be easily combined. A few of the states involved simply may not allow pooling for some of the risks Aetna wants to package, Mr. Fitch says.

CNBC was formed in 1973 and has members churches in 45 states. Its member denominations are: African Methodist Episcopal, African Methodist Episcopal Zion, Christian Methodist Episcopal, Church of God in Christ, National Baptist Convention of America, National Baptist Convention USA Inc., and The Progressive National Baptist Convention Inc.

If one or more pools can be established, CNBC members will be offered a comprehensive small business insurance package that would include fire and extended coverage; comprehensive general liability insurance; workers compensation coverage; commercial auto collision, physical damage and liability insurance; and some cash-flow plan design options.

These options could include some self-funding through a group retention or deductible as well as year-end dividends for good loss records, both techniques now offered to small manufacturers that participate in safety groups.

If some risks prove unpoolable, Aetna will offer individual CNBC members a 10% premium discount off the insurer's "best quote" and an opportunity to vary retentions according to the lines of coverage, Mr. Fitch says.

Mr. Eaglin hopes the group in-

surance package will cut members' average insurance cost from \$7,000 a year to about \$5,000 a year and reduce the the financial burden now placed on some urban churches in high-risk areas.

About 50% of CNBC member churches are in urban areas, typically high-rate districts.

"Many of our members are paying premiums in the range of \$5,000 to \$7,000 annually, but plenty are paying \$15,000 or \$16,000 a year for essential property and automobile insurance," Mr. Eaglin says. "We would like to reduce those costs for all of our members."

Although Aetna executives note that most churches purchase comprehensive general liability coverage with limits ranging from \$300,000 to \$1 million, Mr. Eaglin notes that some members of his group may not be purchasing the coverage for cost reasons.

"It's generally unpopular to sue the church, but accidents do happen and lawsuits are filed. If a church is sued, it should have liability insurance," Mr. Eaglin says.

Aetna will also offer ministers' professional liability insurance, Mr. Fitch says. This coverage, already available to Aetna church policyholders, would cost CNBC members \$100 or less per minister.

CNBC members also require extensive commercial auto insurance, Mr. Eaglin says, since many churches also function as community activity centers and provide bus service.

The property/casualty package coverage will be marketed to CNBC members by a managing general agency established just for that purpose, Aetna executives say. The agency, which will be paid an override commission on the sale of the insurance package, is likely to be a joint venture between Howard & Cloud Insurance Agency in Hartford, Conn., and CNBC.

Sanford Cloud Jr., a partner in the agency and a consultant to Aetna on social issues, says the agency approach could also provide additional savings to the churches.

"CNBC will be partners in the agency and participate directly in the management of the program. Any profits over and above expenses could be returned to the association in dividends and eventually contribute to members' savings," he explains.

Mr. Cloud, who initiated negotiations between CNBC and Aetna last spring, also believes that marketing and pooling problems are eventually surmountable and that Aetna will be able to provide the insurance products CNBC has requested.

Insurers, he believes, have a responsibility to provide insurance at reasonable prices to meritorious institutions.

"Bringing these important institutions (Aetna and CNBC) together is a unique opportunity for me and for Howard & Cloud. By working closely with the churches around the country, I'm sure we can develop the products they need," he

says.

Employee benefit coverage, which will also be marketed by the managing general agency, will follow some months behind the property/casualty insurance program, says R. Kipper Janes, director of association plans in Aetna's employee benefits division.

Aetna would like to provide coverage on a large-group or denomination-size basis that would allow member churches to purchase group health insurance subject to both a premium discount and experience rating.

"Most of the CNBC members do not participate in any kind of denomination-size group health insurance program, so there are no

consolidated loss statistics available for the members," he notes. "Right now, what we are studying is the appropriateness of rate-setting for a group this size without consolidated data."

If the group health plan is successful, Aetna will consider adding long-term disability and dental insurance options.

"At the very least, we anticipate serving as a consultant to CNBC and advising them on cost-containment measures applicable to individual plans," Mr. Janes says.

Retirement options may also be available by the end of the year, Aetna executives say, but they could take a bit longer as the insurer's individual financial prod-

ucts division tests individual employee interest and designs a suitable product.

Retirement benefits offered to CNBC members will most likely involve deferred compensation annuity programs, according to Grace Butland, Aetna's assistant director of annuity marketing. But as a large group, CNBC members will most likely have access to several investment options and higher beginning interest rates on more conservative investment options.

Aetna already markets a individual retirement program to the Christian Missionary Alliance, another church group, Ms. Butland notes, so a design for the CNBC should be possible in time. ■

Tut's curse hurts Lloyd's underwriters

Continued from page 2

diligence under the policy wording and therefore did not have to prove whether HTV used a car with faulty brakes.

"We said we had no obligation to show due diligence under the policy wording," said Tim Knowles, assistant managing director for HTV in Cardiff, Wales. "It is purely a legal point on policy interpretation."

The condition on the policy read, "The insured shall use due diligence and do and concur in doing all things reasonably practicable to avoid or diminish any loss of or damage to the property here

in insured."

"We said that this condition refers to the property that is covered in the policy—the wardrobe, and sets," said Mr. Knowles.

"But in this case, we are dealing with an accident of a person and we said that a person is not property," he explained.

During a preliminary hearing in High Court two weeks ago, the judge agreed with HTV that due diligence did not have to be proved under the current Lloyd's policy wording because the loss affected a person and not property.

Therefore, the court ruled, Lloyd's underwriters should pay the claim plus interest, which in-

flates the total to about 350,000 pounds (\$525,000).

Lloyd's underwriters could appeal the High Court's decision, but one underwriter on the risk doesn't think they will.

Instead, Lloyd's underwriters may consider changing the policy wording so there is no mistake that policyholders must show due diligence for both people and property.

"The judge thought that regardless of the case, the policy drafting will have to be changed, so we probably will," said the Lloyd's underwriter. "We're unhappy we lost, though, and the judge surprised us all." ■

Tribunal grants expropriation awards

Continued from page 2

Although the decision by the tribunal in the Starrett case is the first in which an award based on an expropriation claim has been granted, the company has not yet received any money from the Iranians.

Instead, the tribunal authorized an independent accountant to decide the value of the Starrett claim, which totals more than \$136 million.

"We feel the claim is very strong," said Mr. Bassuk, Starrett's president, though he declined to speculate on how much the company would finally receive. He also pointed out that tribunal decisions cannot be appealed.

At the time of the Islamic Revolution, Starrett was constructing eight 26-story buildings that were to house about 1,600 condominium units, many of which had been sold and were ready for occupancy.

Starrett filed its claim with the tribunal in November 1981 and appeared before the tribunal in a five-day hearing in February 1983.

But, unlike many other companies that have pooled information with other firms with claims against Iran, Starrett pressed its case on its own.

Because of the importance of the case to Starrett, the company felt that going it alone would be the most advantageous route, which turned out to be true, Mr. Bassuk

added.

In the AIG case, which was decided shortly after the Starrett claim, the insurance holding company was awarded nearly \$14 million for the 1979 nationalization of Iran America International Insurance Co., in which AIG owned a 35% interest. AIG had sought \$39 million.

Attorneys for AIG said the decision was significant because the tribunal awarded profits the company would have earned had the insurer not been expropriated and rejected Iran's view that only the book value of the company should be considered.

"This aspect of the decision is of major significance to international lawyers and scholars who have long debated the question of whether or not international law recognizes loss of future profits and goodwill in cases involving nationalization or expropriation," said David R. Hyde, AIG's attorney with the New York firm of Cahill Gordon & Reindel.

"This decision should put to rest an issue which has concerned many American companies who have cases pending before this tribunal."

Mr. Hyde also said that the decision will be particularly beneficial to financial services companies that held intangible property, rather

than hard assets, in Iran.

A spokesman for DuPont acknowledged that the \$42.7 million it received in a tribunal-approved settlement with the Iranians is "one of the largest" in the litigation so far.

The company says it has not yet received the award, but hopes to collect the money within the next few weeks.

The company originally claimed \$118 million for its 40% interest in a plant in Iran prior to the revolution in a contractual dispute. The Iranians counterclaimed for more than \$400 million, alleging DuPont breached its contract.

"We're satisfied," the spokesman said. "It was a difficult process. The negotiations were going on for two years."

Despite the recent decisions by the tribunal, one expert notes that the tribunal is not proceeding very rapidly.

Arthur W. Rovine, counsel to the law firm of Baker & McKenzie who formerly represented the U.S. government at the tribunal, said that the awards process was "much slower recently. They have slowed down to a crawl." The Iranians are persuading the tribunal not to move as fast, Mr. Rovine explained, adding that there are a number of cases that have been fully briefed and argued that are awaiting decisions. ■

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Pan Am installs smoke detectors in jetliners

NEW YORK—Pan America World Airways Inc. is the first airline to announce a visible risk management step from a fatal commercial airliner fire last year: It is installing smoke detectors in aircraft lavatories.

The airline says it will install a total of 785 detectors in its 141 aircraft at a cost of \$60,000 over the next few months. Pan Am said the action followed a six-month evaluation of detectors tested on three aircraft.

The airline follows the June 2 emergency landing of an Air Canada DC-9 jetliner at the Greater Cincinnati Airport, in which 23 of 46 people on board died (BI, June 13, 1983).

A lavatory-area fire that broke out during the Dallas-Toronto flight flared upon landing, asphyxiating many passengers before they could escape the aircraft, authorities concluded.

The fire's cause still has not been pinpointed by investigators but

safety critics said earlier detection of the blaze and less-toxic seating-and cabin-interior materials might have saved lives.

The Federal Aviation Administration is currently studying whether to require smoke detectors in commercial aircraft lavatories and galleys.

In a related move, Pan Am also said it planned to install automatic fire extinguishers in each lavatory waste bin. Some airlines already have such systems. ■

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British insurers watch profits waver

By ALAN H. CLIFTON and PHIL V. OLSEN

Special to Business Insurance

THE MAJOR BRITISH property/casualty insurance companies have seen their earnings yo-yo alarmingly so far this year. A good measure of the blame must be attributed to the weather, especially Hurricane Alicia.

The insurers' third-quarter results, which were recently released, tell the tale. Royal Insurance P.L.C., which is by a whisker the United Kingdom's largest general insurer with a worldwide premium income estimated at 1.9 billion pounds (\$2.8 billion) for 1983, typifies the experience.

Royal's first-quarter attributable pretax earnings were 9.2 million pounds (\$13.8 million); for the second quarter, the figure rose to 40.9 million pounds (\$61.4 million), but, in the third quarter, earnings fell to just 12.3 million pounds (\$18.5 million). Our guess is a bounce in the final three months to 38 million pounds (\$57 million).

For once, the earnings pattern displayed by the United Kingdom's other leading insurer, Commercial Union Assurance Co. P.L.C., has been more consistent. Moreover, the view is gaining ground that CU has probably passed its low point in the current insurance market malaise.

Substantial problems remain, however, in the United States where there was a cash outflow of \$55 million in the first nine months of the year even after crediting investment income of \$137 million. But the company has strengthened its management team and most observers are now prepared to say that if the U.S. insurance market has bottomed out, CU is capable of holding its ground.

Aspirations of growth, however, have long since been abandoned. CU's nine-month U.S. combined ratio was 118.5%, broadly in line with its half-year performance.

Under the costly impact of Hurricane Alicia, Britain's other two major insurers with a strong presence in the United States, Royal and General Accident Fire & Life Assurance Co. P.L.C., both saw their combined ratios climb in the third quarter.

Alan H. Clifton and Philip V. Olsen are analysts with London-based Kitcat & Aitken. They report quarterly on the British insurance industry for Business Insurance, in addition to supplying weekly earnings reports on British companies for BI Ticker.

Dec 23 Companies	Price	P/E	Div. pence	Yield %	1 Week High-Low pence
Comm Union	189	31.5	16.86	8.9	190-189
Eagle Star	720	21.8	27.86	3.9	730-715
Genl Accident	457	13.4	26.43	5.8	457-450
Gdn Royal Exch	517	13.6	30.71	5.9	517-507
Phoenix	390	17.0	26.00	6.7	390-385
Royal	503	12.9	39.28	7.8	503-503
Sun Alliance	1450	16.7	78.57	5.4	1450-1425

Brokers	Price	P/E	Div. pence	Yield %	1 Week High-Low pence
CE Heath	327	8.2	22.86	7.0	327-324
Hogg Robinson	128	9.8	9.43	7.4	129-128
JH Minet	140	10.8	7.57	5.4	141-140
Sedg Grp	236	11.8	11.43	4.8	236-234
Stenhouse Hldg	132	12.7	9.43	7.1	132-127
Staw Wrightson	295	9.8	22.57	7.7	295-290
Willis Faber	695	14.5	30.00	4.3	695-695

Source: Philip Olsen/Alan Clifton, Insurance Industry Specialists Kitcat & Aitken Stockbrokers, London

Royal estimated its losses from Alicia at \$9.3 million, with total U.S. catastrophe losses running \$16.5 million. For General Accident, the tally of hurricane damage was even greater at \$14 million.

For the record, Royal's U.S. combined ratio as of the end of September was 116.1%, while General Accident's was lower—though still unsatisfactory—at 111%.

While underwriting results have appreciably worsened during 1983 in the United States, there has been a measure of improvement for British insurers in both the United Kingdom itself and elsewhere abroad.

In the domestic market, the recovery is largely due to less harsh winter weather at the start of the year. Homeowners results consequently are much better, but that good news has been offset by a sharp worsening in automobile-related losses. Claims frequency has climbed alarmingly this year and premium rates are only now belatedly adjusting, led by the market leader in personal auto, General Accident.

For the full year, British underwriting results as a whole are likely to be better than in 1982, but the outlook for next year is still very problematical.

Finally, in other markets aside from the British and U.S. markets, the trends are varied but not unduly disturbing.

Europe is its usual mixed bag of experience, while results in Canada and Australia remain encouraging even if no one expects the news to stay pleasing for a great deal longer. If these territories are taken as a

whole, the three leading British insurers are operating at combined ratios that average about 105%—much better than in either the British or U.S. markets.

Turning to the major British insurance brokerages, it is impossible to give quantitative indications of their performance since mid-year because only one company, Minet Holdings P.L.C., publishes quarterly results. Nonetheless, we can judge that the influence of the pound's weakness, which supported the first six months' results, will have continued to underpin the appearance of the profit performance of the major international Lloyd's brokerages during the second half of 1983.

In addition, as distinct from their U.S. counterparts, the Lloyd's brokers also have a proportionately greater involvement in international, wholesale and reinsurance classes of business, and these market segments have tended to provide better underlying commission growth than the retail brokerage segment. This market presence, thus, should have helped the Lloyd's brokers' profits.

Relatively good progress in the reinsurance field in 1983 will have been achieved without any realistic firming of premium rates—despite hopes to the contrary during the year-end renewals 12 months ago.

This time around, the hopes of rate hikes are even stronger, and with London now witnessing the second tough year-end reinsurance renewal season in a row, the view is growing that a gradual turn in the market is taking place that will probably affect renewals for treaties that commence in 1984.

In proportional reinsurance business, at least, there has been a hardening of terms and a tightening of capacity—a trend that was beginning to emerge during the 1983 renewals. This could lead to a reduction in credit terms, greater resistance to low-interest premium deposits and the imposition of lower ceding commissions.

In addition, there appear to be reasonably clear signs that a flight to good reinsurance security is under way.

These signs may be but straws in the wind, but the consensus view is that they bode well for reinsurance rating structures in 1985.

If the signs are right, then, the Lloyd's insurance brokerages might soon begin to relish the prospect of better trading conditions and higher rates of underlying commission growth, which could show up as increased earnings in 1985.

That being so, the possibility has yet to be

adequately recognized in the brokers' stock market prices.

In the meantime, the flight to high-quality security—those reinsurers and retrocessionaires that are reckoned to have both the ability and the willingness to pay—is a trend that seems bound, in the first instance, to benefit the very largest reinsurance broking companies like Sedgwick Group P.L.C., Willis Faber P.L.C. and Marsh & McLennan Cos. Inc.

Financial briefs

Corroon & Black

Corroon & Black Corp. has declared a quarterly dividend of 25 cents per share, payable Jan. 1, to shareholders of record Dec. 16. The dividend is a 20-cent reduction from the previous quarter's.

General Re

General Re Corp. has declared a quarterly dividend of 32 cents per share of common stock, payable Dec. 30 to shareholders of record Dec. 26.

Hurricane losses

The Texas Catastrophe Property Insurance Assn. has assessed its member companies \$50 million effective Dec. 7.

The assessment is the second since Hurricane Alicia struck Texas in August; the first was made on Aug. 30.

The TCPIA, formed in 1971, provides insurance for policyholders in a high-risk, 14-county area along the Texas coast. It provides hail and windstorm policies to cover losses from hurricanes, tornadoes and other weather-related events.

About 600 different insurers participate in the catastrophe pool.

The TCPIA reports that it has paid \$106.4 million in claims from Hurricane Alicia so far.

"We knew the second assessment would be necessary and this was confirmed after we made a survey of adjusting company files, a review of closings awaiting final payment and an analysis of our claims payment trends," said Don Manthe, chairman of the TCPIA.

"Hopefully, this will be the last one," he said.

BI Industry Stock Report

Dec. 23, 1983 12/20/83 THRU 12/23/83

Insurance Cos	Price	% Chg.	P/E	\$ Div.	% Yld.	High	Low	Vol. (000)
Aetna Life & Cas Co	NYSE 35.63	-1.1	5.7	2.64	7.4	35.75	35.25	713.6
American Bankers Ins Group	OTC 14.00	-2.6	11.3	0.50	3.6	14.00	14.00	29.3
American Gen Ins Co	NYSE 23.50	3.3	8.1	0.80	3.4	23.50	22.88	731.9
American Indty Fint Corp	OTC 22.75	1.7	12.2	1.12	4.9	22.75	22.25	22.3
American Intl Group Inc	OTC 63.75	2.0	10.7	0.44	0.7	63.75	62.50	681.5
American Natl Ins Co	OTC 21.25	-2.3	7.7	0.96	4.5	21.38	21.25	121.1
American Sts Life Ins Co	OTC 49.50	2.1	13.6	0.88	1.8	49.50	48.50	1.1
Aneco Reins Ltd	OTC 3.75	0.0	26.8	0.00	0.0	3.75	3.75	2.3
Avenco Corp	AMEX 20.50	1.2	12.7	0.58	2.8	20.50	20.00	4.4
Banks Iowa Inc	OTC 47.50	0.0	15.3	1.52	3.2	47.50	47.50	3.0
Bitco Corp	OTC 16.75	3.1	0.0	1.33	8.0	16.75	16.50	12.3
Carolina Cas Ins Co	OTC 6.75	0.0	0.0	0.20	3.8	6.75	6.75	0.4
Chubb Corp	OTC 68.25	-1.6	8.9	3.12	4.6	69.25	68.25	154.3
Combined Intl Corp	NYSE 39.63	4.6	11.8	2.00	5.0	39.75	38.00	134.4
Continental Corp	NYSE 27.25	-1.4	36.8	2.60	9.5	27.75	27.25	157.3
Crawford & Co	OTC 13.75	-5.2	10.2	0.60	4.4	14.00	13.75	8.8
Crown Life Ins Co	OTC 125.00	0.0	8.2	3.20	2.6	125.00	125.00	0.8
Employers Cas Co	OTC 31.25	0.0	7.0	1.20	3.8	31.25	31.25	0.8
Equifax Inc	NYSE 27.75	0.9	11.6	1.60	5.8	28.00	27.00	58.7
Excelsior Ins Co	OTC 21.63	0.6	18.2	0.00	0.0	21.63*	21.63	0.5
Farmers Group Inc	OTC 39.88	-0.6	9.8	1.36	3.4	39.88	39.38	508.3
Foremost Corp Amer	OTC 27.00	0.0	8.2	0.88	3.3	27.00	27.00	67.7
Fremont Gen Corp	OTC 13.75	-6.8	0.0	0.48	3.5	14.75	13.75	246.0
Great West Life Assurn Co	OTC 27.00	2.1	9.7	11.00	4.1	27.00	27.00	0.0
Hanover Ins Co	OTC 57.00	7.5	7.3	0.88	1.5	57.25	54.75	24.1
Hartford Steam Boiler Insnptn	OTC 55.00	-0.9	10.7	3.00	5.5	55.50	55.00	4.9
Jefferson Natl Life Ins Co	OTC 42.50	0.0	14.3	0.76	1.8	42.50	42.50	9.6
Kepper Corp	OTC 39.88	0.0	8.6	1.80	4.5	39.88	39.38	79.7
Lincoln Natl Corp Ind	NYSE 67.25	2.3	9.7	3.36	5.0	67.25*	66.00	94.4
Mission Ins Group Inc	NYSE 24.38	-1.5	9.9	1.00	4.1	24.38	23.88*	410.2
Nationwide Corp Ohio	OTC 41.75	0.0	15.3	0.70	1.7	0.00	0.00	NOT TRADE
Northwestern Natl Life Ins	OTC 34.00	-1.4	9.0	1.50	4.4	34.50	33.88	39.9
Ohio Cas Corp	OTC 45.25	-0.8	8.4	2.52	5.6	45.63	44.75	25.3
Old Rep Intl Corp	OTC 33.00	0.8	7.3	0.90	2.7	33.00	32.75	64.3
Drac Cas Corp	NYSE 28.13	0.4	13.5	0.76	2.7	28.25	27.88	42.8
Preferred Risk Life Ins Co	OTC 19.50	-1.9	7.5	0.67	3.4	19.88	19.50	5.3
Provident Life & Acc Ins Co	OTC 65.25	-0.4	8.0	2.60	4.0	65.50	65.25	8.7
St Paul Cos Inc	OTC 59.75	2.4	8.1	2.80	4.7	59.75	58.75	118.8
SAFECO Corp	OTC 55.38	-0.2	10.9	2.60	4.7	55.38	55.38	69.6
Sri Corp	OTC 16.00	-3.0	6.9	0.68	4.3	16.25	16.00	116.2
Seibels Bruce Group Inc	OTC 22.00	-2.8	12.4	0.80	3.6	22.50	22.00	15.5
Statesman Group Inc	OTC 8.88	0.0	7.7	0.15	1.7	8.88	8.88	73.3
Tokio Marine & Fire Ins Co	OTC 114.50	4.6	23.1	0.96	0.8	117.00*	111.75	11.2

Dec. 23, 1983 12/20/83 THRU 12/23/83

Price	% Chg.	P/E	\$ Div.	% Yld.	High	Low	Vol. (000)	
Travelers Corp	NYSE 31.63	2.8	8.0	1.80	5.7	31.63	30.50	372.0
United Fire & Cas Co	OTC 32.00	0.0	11.4	0.88	2.8	32.00	32.00	1.0
United States Fid & Gty Co	NYSE 55.50	1.8	9.7	3.84	6.9	55.63	55.13	112.1
United Svcs Life Ins Co	OTC 23.00	-0.5	6.7	1.00	4.3	23.00	22.63	17.4
UsLife Corp	NYSE 27.63	0.0	7.9	0.96	3.5	28.25	27.63	59.6
Washington Natl Corp	NYSE 24.25	2.1	11.5	1.08	4.5	24.38	24.13	66.9
Zenith Natl Ins Corp	OTC 14.50	0.0	10.2	0.60	4.1	14.50	14.50	5.8
INSURANCE COMPANIES				AVERAGE	10.1	3.8		
Agents/Brokers								
Alexander & Alexander Svcs	NYSE 21.75	8.8	0.0	1.00	4.6	21.75	19.75	202.6
Baldwin & Lyons Inc	OTC 37.50	0.0	15.6	0.80	2.1	37.50	37.50	0.1
Corroon & Black Corp	NYSE 24.00	1.1	15.1	1.00	4.2	24.00	23.63	14.9
Crump E H Cos Inc	OTC 10.50	0.0	14.4	0.40	3.8	10.63	10.50	11.8
Emett & Chandler Cos Inc	OTC 11.88	0.0	32.1	0.00	0.0	11.88	11.88	0.0
Hall Frank B & Co Inc	NYSE 23.25	-3.6	21.1	0.00	0.0	24.00	22.88*	243.7
Integrated Res Inc	AMEX 25.50	-0.5	8.3	0.00	0.0	26.50	25.50*	385.0
Marsh & McLennan Cos Inc	NYSE 49.75	3.9	14.5	2.20	4.4	49.75*	48.25	159.9
Poe & Assoc Inc	OTC 5.00	-4.8	0.0	0.00	0.0	5.00	5.00*	2.5
Reed Stenhouse Cos Ltd	OTC 12.50	2.0	15.2	0.60	4.8	12.50	12.25	1.6
AGENTS/BROKERS				AVERAGE	17.1	2.7		
Conglomerates/Holding Cos.								
American Express(Fireman's Fd)	NYSE 32.63	4.4	9.5	1.28	3.9	32.63	31.25	5,880.1
Anderson Clayton(CNA)	NYSE 28.13	-0.9	13.1	1.32	4.7	28.88	28.00	19.2
Arco Inc	NYSE 20.75	3.1	0.0	0.40	1.9	21.00*	20.38	481.1
Baldwin Utd Corp	NYSE 2.63	5.0	0.0	0.00	0.0	2.75	2.63	623.1
CIGNA Corp	NYSE 44.00	0.9	7.5	2.48	5.6	44.00	43.00	657.4
City Investing Co. (Home Ins.)	NYSE 38.00	-1.9	11.2	1.80	4.7	38.75	37.50	371.8
Optimum Hldg Corp	NYSE 21.50	0.0	7.0	0.00	0.0	21.50	21.00	43.3
Control Data (Comm. Credit)	NYSE 44.25	-0.6	10.8	0.60	1.4	44.63	44.00	469.7
General Re Corp	NYSE 67.63	4.6	14.3	1.28	1.9	67.63	64.75	142.1
Gulf Utd Corp	NYSE 30.00	1.7	9.2	1.32	4.4	30.00	29.75	516.1
ITT (Hartford Group)	NYSE 44.50	2.9	10.0	2.76	6.2	44.75	43.88	1,317.6
Optimum Hldg Corp	OTC 5.00	0.0	38.5	0.00	0.0	5.00	5.00	

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Ray Drury, Vice President, Special Markets Department, tells Benefit Plan Managers how The Hartford's Starscan serves the interests of employee and employer alike.

Q. What advantages does the Starscan approach have over traditional group benefit plans?

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Q. How does the Starscan flexible benefit approach work?

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A. Just write to Starscan, Special Markets Department B, 8 Griffin Road North, Griffin Office Center, Windsor, CT 06095. Or call David Washburn, Director of New Products, at (203) 683-8435.

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