

business insurance

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

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Utah mine disaster to cost General Re up to \$10 million

STAMFORD, Conn.—General Re Corp. says its subsidiary, General Reinsurance Corp., will suffer a net loss of no more than \$10 million in connection with the Utah mine disaster last month that killed 27 miners.

General Re reinsures the workers compensation coverage purchased by Emery Mining Co., a subsidiary of Savage Industries of American Fcrt, Utah, according to a General Re executive.

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Tough times in new year

Insurers search for reinsurance

By DOUGLAS McLEOD

Reinsurance brokers, who worked overtime through the holiday season trying to complete placements for ceding companies, say they are finding about what they had expected: higher rates, more stringent conditions and, in some cases, a shortage of capacity.

Some brokers add that a sizable amount of placements were not completed by year-end.

"All in all, it was probably the tightest market in the last 15 years," summed up E.W. Blanch Jr., chairman of E.W. Blanch Co. in Minneapolis.

"From the standpoint of brokers and their clients, reinsurers are being extremely unreasonable," adds Gene Taylor, chairman and chief executive officer of John F. Sullivan Co., the reinsurance brokerage unit of Fred S. James & Co. Inc.

Some reinsurers were apparently more reasonable than others, though. A few companies were still "pretty aggressive" in their pursuit of business while others were "timid," demanding higher rates or smaller lines, according to one broker who asked not to be named.

"There was a tremendously inconsistent reaction in the marketplace," the broker said.

Some reinsurers, for their part, agree there is room for the market to tighten further.

"It tightened, but it did not tighten enough," said the president of one reinsurer, who expects tougher conditions to prevail during the July renewal season.

The market is already tough enough for many reinsurance brokers.

One day during renewals, Mr. Taylor says, he was up working until 1 a.m. and then up again at 4:30 a.m. to call London.

"We had a lot of people in on days we were closed. We had people in on Christmas Eve," said Kenneth A. Hecken, chairman

and chief executive officer of Willcox Inc. Reinsurance Intermediaries, the reinsurance brokerage unit owned by Johnson & Higgins and Willis Faber. "The thing that's really demoralizing to us is that some of our markets are closed."

Despite these efforts, most brokers say they still have placements to complete.

Mr. Taylor estimated that as much as one-third of the total business in the marketplace may not have been fully subscribed by the Jan. 1 renewal date.

Ward B. Gordon, chairman of Intere Intermediaries Inc. in New York, says the firm has finished about

80% of its renewals. "I have no doubt we are going to finish, but whether it will be Jan. 1 or Feb. 15, we don't know," Mr. Gordon commented.

Of the unfinished business, he added, "We have a pretty good idea what it's going to cost but not who the participants are going to be."

"There is tremendous congestion in the market" caused by reinsurers cutting back on certain risks or pulling out of the market altogether, Mr. Blanch said. "The people were working like hell but the quantity of stuff they had to look at increased geometrically."

Capacity has shrunk in some areas, Mr. Gordon said, including casualty pro-rata treaty business and all types of reinsurance for risks like professional liability.

An executive for one reinsurer said the company had declined to renew the reinsurance on a municipal liability policy for a California municipality, and that the municipality is still looking for replacement coverage 60 days later.

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Buyers see rates rise, limits fall

By MICHAEL BRADFORD and STACY SHAPIRO

For many risk managers and brokers, the current insurance renewal season is the worst ever.

Brokers report that the rapidly constricting reinsurance market is causing direct insurers to boost some liability rates dramatically—as much as 300% to 500% in some lines (see related story). In addition, a lack of reinsurance is causing insurers to slash the capacity they offer in some lines, especially for high-layer excess and umbrella liability coverage.

While some brokers did believe that the year-end renewals were not as difficult as had been predicted,

others were still negotiating renewals that were to be completed by Dec. 31.

"There are clients with renewals not completed," summed up Richard E. Meyer, senior vp of Johnson & Higgins in New York.

"This is the most volatile market we have ever experienced. It is more serious than the '70s crunch. Rates are going up fast," Mr. Meyer said.

"I do not think we have seen anything as intense as this ever because of the conditions we were in," said Earl Lanning, vp at The Crump Cos. Inc. in Memphis, Tenn.

"It is like the tight market in the '60s, except this time (the market) went so far down that, as it comes back up, the effect is much more drastic," Mr. Lanning said.

"Capacity has dried up overnight," added an Atlanta broker who asked not to be named. "It is no longer a question of pricing. Even at exorbitant rates, we are finding it difficult—if not impossible—to place risks."

Some brokers said they would hold off

completing some renewals until mid-January, hoping that insurers will line up additional reinsurance and be able to supply more capacity. Others chose to complete some renewals with lower limits than the policyholder had sought, hoping that more capacity will become available as the year progresses.

At Robinson-Conner Inc. in Erie, Pa., year-end renewals were "going right down to the wire," according to William B. Conner, the company's president.

Mr. Conner said last week that two of the broker's significant accounts that renew on Jan. 1 were still uncompleted. "And of those that are resolved, I don't think there was one that we didn't have problems with."

"We're scrambling around," Mr. Conner reported. "I've been around 27 years, and I haven't seen it like this. I've seen it tough, but before it was sort of a sustained tough, not in one fell swoop like this."

Robinson-Conner received a lot of quotes that are contingent on the underwriter placing its reinsurance, said Mr. Conner. "It happens in about one of every four accounts where there would logically be reinsurance. The reinsurance is coming through, but the carriers are having to revise their rates, make them higher."

But, he noted only one instance—an account involving a manufacturer's product liability coverage—in which an insurer reneged on a firm quote because of a lack of reinsurance.

Andrew Marks, senior vp of Reed Stenhouse Inc., the U.S. brokerage arm of Reed Stenhouse Holdings Ltd. of Toronto, said the lack of reinsurance capacity has affected his company's business.

"I'm sorry to say, yes," Mr. Marks replied when asked if the New York-based broker was feeling the capacity crunch. "We're

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... MARKET ALERT ...

The top stories of 1984

For the second consecutive year, *Business Insurance* readers have selected what they consider the most important risk management and employee benefit stories of the past year. And this year, the *BI* Risk Management and Employee Benefit Boards both came up with clear-cut winners. Stories on both board surveys begin on page 3; synopses of the top risk management stories appear on pages 9-12; and summaries of the top benefit stories appear on pages 19 and 20.

Complete vote calculations for 1984's most important stories
Page 3

Risk management winners

1. Rising rates and shrinking capacity
2. ISO's revised CGL form
3. No tax deductions for self-insured loss reserves
4. EIL insurance market shrinks
5. Asbestos claims facility proposed

Employee benefit winners

1. New rules for FSAs
2. Reagan re-election threatens benefit plan tax breaks
3. New rules proposed for 401(k) plans
4. 'Flat tax' bills proposed in Congress
5. New rules for cafeteria plans

update

General Re hit by mine loss

Continued from previous page

utive who asked not to be named. Emery operated the mine and employed the miners killed in the accident.

According to another source, Emery's workers compensation was written by Southern American Insurance Co., a unit of The Crump Cos. Inc.

General Re also writes facultative and treaty property reinsurance for Utah Power & Light Co., which owns the mine, according to the General Re executive.

Total claims for both workers compensation and property coverages have not yet been determined, according to the executive, but under agreements that General Re has with its retrocessionaires, its net loss will not exceed \$10 million.

Total workers compensation claims, he says, will depend on a number of factors, including the number of surviving family members. General Re, he says, has estimated the "highest loss we could have" and now plans to "sort out all the details as we go along."

A spokesman for Utah Power & Light said late last week that a fire still burned in the mine and that it would be a "matter of weeks" before the extent of property damage could be determined.

Neither Utah Power & Light nor Emery Mining would discuss their insurance coverage.

The General Re executive would provide no information on the direct insurers involved in the property coverage. However, a spokesman for the Utah Insurance Department says Utah Power & Light owns four small insurance companies licensed only in Utah. Two of them, Electric Mutual Benefit Assn. and Energy Mutual Benefit Insurance Co., write casualty business. The insurers' only clients, says the spokesman, are the utility and its affiliates.

IRS proposes benefit tax rules

WASHINGTON—The Internal Revenue Service last week proposed rules that would require employers to begin withholding taxes later this year on some taxable benefits.

The proposals require employers to withhold income and Social Security taxes on benefits like personal use of company cars and travel on corporate aircraft. Taxes would have to be withheld at least once a quarter at a flat 20% rate.

The rules are required by the 1984 tax law that details which benefits not previously covered by a specific section of the Internal Revenue Code are taxable. The rules are meant to avoid squabbles between employers and the IRS over the fair value of benefits for tax purposes.

The rules, printed in a question-and-answer format, provide specific examples of the values of taxable benefits.

For example, employees that use company cars for personal use will be taxed based on the car's lease value. If a car has an annual lease value of \$3,100, and 10% of its use is for personal purposes, the employee would be taxed as if he received \$310 in salary.

The proposed rules are retroactive to Jan. 1, but withholding would not have to begin until July 1 to give employers time to comply. The rules do not apply to certain "non-statutory" benefits, like free travel passes for airline employees, that Congress agreed to exempt from taxes last year (*BI*, July 2, 1984).

Verdicts upheld in Hyatt case

KANSAS CITY, Mo.—A state appellate court has upheld a \$12.75 million award to Sally Ann Firestone, considered the most badly injured plaintiff in the July 17, 1981, collapse of the skywalks at the Kansas City Hyatt Regency Hotel (*BI*, Oct. 8, 1984).

In addition, the appellate court upheld a \$3.75 million award to Kay Kenton, who suffered a crushed vertebra and other injuries in the collapse, which killed 114 people and injured about 200 others.

Tim Brake, an attorney for Ms. Firestone with the Kansas City firm of Lantz Welch, said a three-judge panel ruled that the verdicts were not excessive and that the trial judge did not commit errors on various evidentiary and other issues.

Michael Waldeck, an attorney for defendants that include Hyatt Corp., Crown Center Redevelopment Corp. and its parent, Hallmark Cards Inc., said that the defendants plan to seek a rehearing by the Court of Appeals and, if denied, to seek review by the state Supreme Court.

"The decision by the court was not unexpected," said Mr. Waldeck of the Kansas City firm of Niewald, Waldeck, Norris & Brownbro. But, defendants are pursuing the matter because of a strong dissent in both the Firestone and Kenton decisions, he added.

Eastern covered for crash

MIAMI—Eastern Airlines has in excess of \$400 million of liability and hull insurance to cover the crash of a Boeing 727 last week in a rugged mountainous area of Boliva in which all 29 people aboard apparently were killed.

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Asbestos defendant may gain \$350 million in insurance cover

By STEPHEN TARNOFF

WASHINGTON—Asbestos defendant Owens-Illinois Inc. stands to reap about \$350 million in insurance coverage following a two-pronged victory in U.S. District Court for the District of Columbia.

First, U.S. District Court Judge Thomas F. Hogan ruled that the broad triple-trigger theory of coverage first handed down in *Keene Corp. vs. Insurance Corp. of North America* applies in Owens-Illinois' insurance dispute with Aetna Casualty & Surety Co.

Secondly, Judge Hogan ruled that the manufacture and sale of asbestos by Toledo, Ohio-based Owens-Illinois constituted a single occurrence. Therefore, "O-I's coverage under a policy for asbestos-related claims is subject to payment of a single deductible," according to the court papers.

This is the first court ruling on the definition of an occurrence in an asbestos insurance litigation case.

Aetna had contended that each claimant's exposure to an Owens-Illinois product was a separate occurrence, requiring a separate deductible to be paid for each claim.

Union Carbide shareholders file four suits

By STEPHEN TARNOFF

NEW YORK—Union Carbide Corp.'s directors and officers face four separate shareholder lawsuits charging that the company and its officials misled investors before the Dec. 3 poisonous gas disaster in Bhopal, India.

The suits seek to recover unspecified damages for losses stemming from the gas leak that killed an estimated 2,500 people and injured as many as 150,000.

After the accident, the value of Union Carbide's stock plunged 28%, or \$13.025 per share, two suits say.

The lawsuits, filed on behalf of thousands of shareholders, contend that Union Carbide was aware of numerous dangers and safety problems at the Bhopal plant before the tragedy but failed to disclose that information to investors in company reports.

One suit also alleges that Union Carbide's actions "artificially inflated" the price of the common stock intending to deceive the public and to sell it for a "grossly excessive consideration."

According to attorneys for the shareholders, the loss to shareholders as a result of the Bhopal accident could be at least \$100 million to \$200 million.

"We believe the shareholder

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Insurer solvency is major issue on 1985 agenda for regulators

By CAROL CAIN

WASHINGTON—Insurer solvency will remain a major issue for state insurance regulators in 1985.

One of the specific solvency issues the National Assn. of Insurance Commissioners plans to look at this year is the distribution of financial information about insurers to the public.

A working group to study this issue and to look at improving general self-regulatory incentives will be appointed soon.

Insurance agents and others, notably the U.S. Treasury Department, want the NAIC to release financial information it obtains about insurers.

The NAIC has denied such requests and took no action when the U.S. Treasury Department asked to use information from the NAIC's Insurance Regulatory Information System (IRIS) to evaluate insurers that want to be considered for contracts with the federal government.

However, the NAIC decided at its winter meeting last month in Washington, D.C., to consider releasing to the Independent Insurance Agents of America and

This position effectively would have left Owens-Illinois without any insurance coverage for asbestos injuries because the \$100,000 and \$250,000 deductibles required of Owens-Illinois are larger than the amount of any of the asbestos claims against it, the court said.

Aetna provided excess liability coverage to Owens from Sept. 1, 1963, through Sept. 1, 1977. Limits on the policies ranged from \$20 million under the 1963-1966 policy to \$50 million under the 1976-1977 policy. Below these excess policies, Owens-Illinois was self-insured for each occurrence resulting in personal injury up to the "per occurrence deductible" set forth in the policies, the court papers explain. It had no primary insurance policy.

The deductible was \$100,000 for policy years 1963 to 1971 and \$250,000 for 1971 to 1977.

Above the deductible, the policies provided that Aetna would cover Owens' "ultimate net loss" up to the "aggregate annual" and "per occurrence" limits set in the policies, the court papers add.

So far, Owens has paid more than \$60 million in out-of-pocket expenses for asbestos injury litigation while

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Mr. Burcke



Ms. Gibson



Ms. Antelis

Burcke named managing editor

James M. Burcke is the new managing editor of *Business Insurance*, succeeding Lorrie Gibson, who assumes the new position of deputy editor.

Mr. Burcke, who joined *BI* in April 1981 as a copy editor, was promoted to assistant managing editor in January 1983. As managing editor, Mr. Burcke is now responsible for coordinating the news reporting, editing and production of the magazine.

Mr. Burcke, 28, is a 1978 graduate of the master's program at Northwestern University's Medill School of Journalism in Evanston, Ill.

In her new post of deputy editor, Ms. Gibson, 34, will continue to edit news stories and to be responsible for the development and execution of spotlight reports, the in-depth analyses of current trends that appear regularly in *BI*. Ms. Gibson also assumes responsibility for the content of the Perspective section of the magazine.

Ms. Gibson, who joined *BI* as managing editor in June 1980, is a 1972 graduate of The College of St. Francis in Joliet, Ill.

"With Jim as managing editor and Lorrie as deputy editor, the talents of two excellent editors on our editorial staff will be directed to further improve our coverage of news events and the content of our spotlight reports," said Editor Kathryn J. McIntyre.

Also, two new people also have joined the staff of *BI*. Marla Antelis, a 1978 graduate of Northern Illinois University in DeKalb, is the new assistant copy editor of *BI*. Most recently, Ms. Antelis, 28, was assistant copy desk manager of Pioneer Press Inc. in Wilmette, Ill., a chain of community newspapers.

And, Donna DiBlase, 22, a 1984 graduate of Loyola University of Chicago, is the new proofreader at *BI*.

errors and omissions

• First State Insurance Co. writes the primary \$1 million layer of general liability insurance for Santa's Workshop in North Pole, N.Y. It was incorrectly reported in the Dec. 24-31, 1984, issue that Naughton Insurance Co. of Providence, R.I., underwrites the coverage. However, Naughton is the broker.

The current liability coverage for Santa's Workshop is different from that previously underwritten by Hartford Insurance Co.

Top stories of 1984

Rate hikes, capacity cuts tops risk managers' list

By ALISON KITTRELL

The votes are counted and the choice is clear: Rising rates and tightening capacity in the property/casualty insurance market is considered by risk managers to be the top risk management story of 1984.

The story was an overwhelming winner. For instance, 29 of the 53 risk managers responding to a *Business Insurance* survey voted for the market change as the 1984 top story, while only six risk managers cast first-place votes for the story that was judged the runner-up: The Insurance Services Office's new revisions to the comprehensive general liability form.

In addition, the hardening market attracted seven second-place votes, five third-place ballots and two fourth-place votes.

The pricing and capacity changes that occurred during 1984 came suddenly for many buyers. In fact, rate cutting by insurers was ranked by risk managers as the second most important story of 1983 (*BI*, Jan. 2, 1984).

In 1984, several years of declining rates and widespread capacity came to a screeching halt. Spurred by rising rates and shrinking capacity in the reinsurance markets, rates in some lines soared more than 20%. Some insurers stopped writing certain lines of coverage or drastically cut limits, while others dropped out of the market altogether (see synopsis, page 9).

The effect the hardening market has on risk managers is clearly seen in the comments that the members of *Business Insurance's* Risk Management Board gave in the survey. When asked to comment on 1984, virtually every response centered around the changes in the market (see story, page 8).

"The year 1984 could be described as the year when realities resulted in action," said one risk manager who responded to the *BI* survey. "The realities of unacceptable ratios have existed for some years, but it wasn't until late in 1984 when the reinsurance community had its survival instincts awakened."

Two other stories ranked among the 10 top risk management stories of 1984 also involved property/casualty insurance capacity. Risk managers voted the withdrawal of several insurers from the environmental impairment liability insurance market as the No. 4 story. And, they ranked the decision by Northbrook Excess & Surplus Insurance Co. to stop underwriting as the sixth most important story of the year.

Although the story that captured the No. 2 spot in the poll, the proposed CGL form revisions, is not directly linked to rising rates and tightening capacity, the proposal could increase insurance buyers' costs and could create coverage problems for some companies (see synopsis, page 10).

That story received six first-place votes, 13 second-place votes, nine third-place votes, seven fourth-place votes and seven fifth-place votes.

The latest CGL revisions proposed by ISO include a retroactive date for the new claims-made form that would give underwriters the power to exclude coverage for bodily injury or third-party property damage that occurred prior to a date selected by the underwriter.

Also, the revisions eliminate all pollution coverage stemming from the insured's premises or ongoing operations under both the claims-made form and the occurrence form. Under CGL forms now in use, sudden and accidental pollution exposures are generally covered.

Besides the ISO proposal, the London market also proposed a "first-claims-made form," under which the policy in force at the time a claim is filed would respond to that and all subsequent claims stemming from the same cause, regardless of when the claims are filed, up to the policy limit.

Risk managers were particularly upset by the ISO's elimination of pollution coverage, especially in light of increasing legislative and social pressure on pollution issues. One risk manager who responded to the survey said that 1984 was important because it was "the last year of sudden and gradual pollution coverage (under the CGL)."

The third-place story was the passage of legislation by Congress that denies employers tax deductions for reserves for self-insured losses payable in future years, including workers compensation claims (see synopsis, page 11).

This legislation takes away the victory that self-insured companies won in the Kaiser Steel Corp. decision, which was voted the top risk management story of 1983.

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Top risk management stories

Story	Number of votes					Total points*
	1st	2nd	3rd	4th	5th	
Rising rates and shrinking capacity	29	7	5	2	0	192
ISO's revised CGL form	6	13	9	7	7	130
No tax deductions for self-insured loss reserves	7	11	3	6	6	106
EIL insurance market shrinks	0	5	11	3	4	63
Asbestos claims facility proposed	2	3	5	8	2	55
NESCO stops underwriting	0	6	4	3	3	45
M&M bond trading losses	1	2	4	3	5	36
IRS' hard line in Mobil captive tax case	1	2	3	2	3	29
Lloyd's reinsurance scandals	1	2	1	3	5	27
New Jersey surplus lines guaranty fund	2	0	1	3	1	20

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

Top employee benefit stories

Story	Number of votes					Total points*
	1st	2nd	3rd	4th	5th	
New rules for FSAs	24	10	8	7	8	206
Reagan re-election threatens benefit tax breaks	24	6	8	7	6	188
New rules proposed for 401(k) plans	9	8	12	13	13	152
'Flat tax' bills	11	9	9	9	7	143
New rules for cafeteria plans	8	14	7	5	5	132
Retirement Equity Act	3	15	4	12	6	117
Courts rule retirees entitled to health benefits	5	7	11	9	9	113
Health care costs begin to moderate	5	7	12	9	6	113
Limits placed on VEBA tax deductions	2	8	8	3	8	80
FASB rules on pension/retiree health liabilities	1	3	10	5	10	67

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

Washington influence felt in the top benefit stories

By JERRY GEISEL

It was the heavy hand of Washington that produced the top employee benefit stories of 1984.

The stories that the *Business Insurance* Employee Benefits Board selected as the top stories of the past year all involve new rules issued by federal regulatory agencies, the re-election of a president who supports taxing employee benefits and Congress' introduction or passage of bills with sweeping implications for employee benefit plans.

For example, the story voted the most significant of the year was the IRS announcement of rules significantly limiting the use of flexible spending accounts (see synopsis, page 19).

The second-most significant story of the year was the increased vulnerability of employee benefit plans to administration and congressional attacks in the wake of President Reagan's re-election in November (see synopsis, page 19).

Third was new regulatory or congressional restrictions on the rapidly growing 401(k) salary reduction plans, which now allow employees to defer up to \$30,000 in pretax wages annually and funnel those deferred wages into special tax-sheltered savings accounts (see synopsis, page 20).

The introduction of "flat-tax" proposals, which attack the tax-favored status of many employee benefits, was voted as the fourth most important story of the year (see synopsis, page 20).

And, congressional approval of legislation that restricts the kinds of taxable benefits that can be offered by cafeteria benefit plans came in fifth (see synopsis, page 20).

To determine the top five benefit stories of the year, *Business Insurance* sent a list of the major stories of 1984 to the members of its Employee Benefit Board. Board members were asked to rank in order from 1 to 5 the most significant news stories of the year.

When the survey, which was answered by 96 board members, was tallied, votes were given 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.

This is the second consecutive year that benefit managers have selected Washington-based events as the top benefit stories of the year.

Last year, when *Business Insurance* conducted a similar survey, benefit managers selected the top stories of 1983 based on court decisions and federal legislation and rules for four of the top five slots (*BI*, Jan 2, 1984).

The top benefit story in 1983 was the Supreme Court's decision in the Norris case that sex no longer can be a factor in determining retirement benefits. If men and women make equal contributions to a retirement plan, they must receive equal monthly benefits.

The second most significant story in 1983 was President Reagan's Social Security commission's recommendations to shore up the Social Security program. And, also during 1983, Congress enacted most of those recommendations into law.

The third most significant story of 1983 focused on the regulations drafted by the Equal Employment Opportunity Commission that required employers to offer workers between ages 65 and 69 a choice of enrolling in corporate group health plans or sticking with Medicare as their primary health insurer.

The fifth biggest story of 1983 concerned congressional proposals to tax employees on employer health insurance contributions above certain levels.

The only non-Washington story in 1983 to make the *BI* top five benefit stories of the year was employers' efforts to control health care costs, which ranked fourth.

The importance of Washington to employee benefit plans is a trend that benefit managers expect to continue.

One benefit manager this year, for example, described 1984 as "the year in which clear signals were given announcing the next upheaval in the way benefits will be designed, administered and financed" (see story, page 16).

The clear winner as top story of 1984 focused on the IRS rules that said that unless

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Risk managers pick top stories of 1984

Continued from preceding page

The new law says a tax deduction for a self-funded reserve cannot be taken until the claim is actually paid, which takes away a major tax advantage for self-insurers.

But, despite the blow dealt by the new law, most observers don't expect a stampede from self-insurance to the commercial insurance market. As one expert said, "There are just too many other reasons to self-insure" (BI, July 23, 1984).

The tightening of the environmental impairment liability insurance market was ranked by the risk managers as the fourth most important story of the year (see synopsis, page 12).

The EIL capacity shrinkage was mainly caused by a lack of reinsurance support.

Recently, two major EIL markets—underwriting manager Shand, Morahan & Co. Inc. and American International Group Inc.—drasti-

cally cut their EIL limits (BI, Dec 24-31, 1984).

And, earlier in the year, the Hartford Steam Boiler Inspection & Insurance Co., Environmental Risk Assessment Service (International Ltd., a London pool and Dryden & Co. pulled out of the EIL market altogether because of a lack of reinsurance support.

Risk managers said they were distressed by the huge price increases in EIL coverage and many reported having trouble finding adequate limits.

The No. 5 story of the year, as ranked by the risk managers, was the proposal by asbestos producers and their insurers to form a claims-handling facility (see synopsis, page 12).

The facility, known as the Wellington Group, is designed to end the expensive coverage litigation between the producers and their insurers and be a cheaper, faster

and more efficient way of handling the thousands of asbestos-related claims pending against the producers.

Although the story was judged as one of the most significant of the year, the asbestos claims facility still faces many problems before it can begin operation. Some asbestos producers, fearing that coverage under the agreement would not be as broad as that already granted by some court decisions, balked at joining the facility. And some insurers with major asbestos exposure also have refused to sign the agreement.

To determine the top five risk management stories of the year, *Business Insurance* sent a list of major stories that occurred in 1984 to members of its Risk Management Board. Board members were asked to rank in order from 1 to 5 the most significant risk management news stories of the year.

When the survey, which was answered by 53 board members, was

tallied, the votes were assigned weighted value. Total points were figured by assigning five points for a first-place ranking, four points for a second-place ranking, three points for a third-place ranking, two points for a fourth-place ranking and one point for a fifth-place ranking.

The market tightening was the clear top choice, garnering 192 points. It ranked far ahead of the proposed CGL form revisions, the second-place story with 130 points.

The legislation denying deductions for self-insured reserves received 106 points to rank third, including seven first-place votes.

There was a large drop in points to the fourth-place story, the EIL capacity crunch, which had 63 points and no first-place votes. The fifth-place story, the asbestos claims-handling facility, garnered 55 points and two first-place votes.

The huge point total amassed by rising rates and shrinking capacity makes it clear that the market

hardening is the main thing on risk managers' minds. Another indication of their concern about the tightening market was their choice of the sixth-place story: the decision by Northbrook Excess & Surplus Insurance Co. to halt underwriting Jan. 1.

The risk managers gave that story 45 points, though none of the risk managers thought it was the most important story of the year.

NESCO was the nation's fifth-largest surplus lines insurer, ranked by 1983 premium volume. The company said it decided to stop underwriting because it did not feel that the surplus lines market would improve quickly enough to offset its poor combined ratio, which had risen to 228% in 1983, up from 157.2% in 1982.

Other surplus insurers said that NESCO's withdrawal would further tighten the excess/surplus market, although some pointed out that underwriting limitations by NESCO even before its decision to cease writing had made the insurer less important as a market force (BI, Nov. 19, 1984).

The seventh-place story, with 36 points and one first-place ballot, was the \$90 million after-tax charge taken by Marsh & McLennan Cos. Inc. after it discovered massive bond trading losses. The unauthorized trading also resulted in \$165 million in pretax losses.

M&M, the world's largest insurance broker, said the losses were generated when some members of its treasury department, acting against company rules, accumulated more than \$2 billion in intermediate and long-term government bonds.

Risk managers also were carefully watching as the battle heated up between the Internal Revenue Service and Mobil Corp. over Mobil's deduction of premiums paid to its captive insurance subsidiary. The BI Risk Management Board ranked that story, which could affect hundreds of other companies with captive insurers, as the eighth most important of the year with 29 points and one first-place vote.

The IRS contends in the case that insurance transactions among related companies are not insurance for tax purposes and therefore, Mobil cannot deduct the premiums. The IRS estimates it loses \$2 billion a year in tax revenue as a result of corporate risk funding through captives.

Mobil, however, says that insurance transactions among subsidiaries should be tax-deductible, because other financial transactions among related companies are.

The No. 9 story, with 27 points and one first-place vote, was the continuing scandal at Lloyd's of London over underwriters' questionable reinsurance arrangements.

For instance, a scandal involving Lloyd's syndicates and Fidentia Fire & Marine Insurance Co. of Bermuda came to a head last month with the expulsion of Lloyd's underwriter Thomas Raymond Brooks and the 21-month suspension of deputy underwriter Terence John Dooley as Lloyd's members. They were accused of profiting from reinsurance placed on behalf of their syndicates (BI, Dec. 17, 1984).

Interestingly, risk managers selected the suspension of Lloyd's underwriter Ian R. Posgate as the No. 9 story in 1983.

Rounding out the Top 10 risk management stories of 1984 was the formation by New Jersey of the nation's first surplus lines guaranty fund. The story received 20 points and two first-place votes.

The New Jersey fund was designed to pay at least \$12 million in claims to New Jersey policyholders of Ambassador Insurance Co., which has been ordered liquidated by Vermont court.

The law setting up the fund, *Continued on page 8*

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opinions

We hereby predict. . .

WITH VARYING DEGREES of fear, hope and wild conjecture, we hereby predict the following events in 1985:

- Property/casualty insurance prices will rise faster than risk managers consider fair, but slower than insurers say they need to regain financial stability.
- There will be more risk managers looking for brokers who can find them insurance capacity than brokers looking for challenging new clients at the annual Risk & Insurance Management Society conference.
- Two of the Top 20 U.S. brokers will merge.
- Congress will impose a tax on the value of employee health benefits exceeding a certain ceiling, but employees will hardly take notice.
- The Asbestos Claims Facility will be activated.
- Risk managers will rediscover loss control as an important aspect of their jobs.
- Risk managers who can't negotiate needed insurance or develop suitable alternatives will be out of their jobs.
- Employee benefit consultants will develop a new benefit plan that is a must for every progressive employer to implement.
- One of the privately held reinsurance brokers will sell to a publicly held company, or go public.
- Insurers will dump financial guarantee products.
- Despite protests from policyholders, most insurers will adopt the more restrictive general liability insurance forms proposed by the Insurance Services Office.
- Mobil Corp. will win its case for tax refunds related to the use of its captive insurance company.
- The number of licensed captive insurers in Ber-

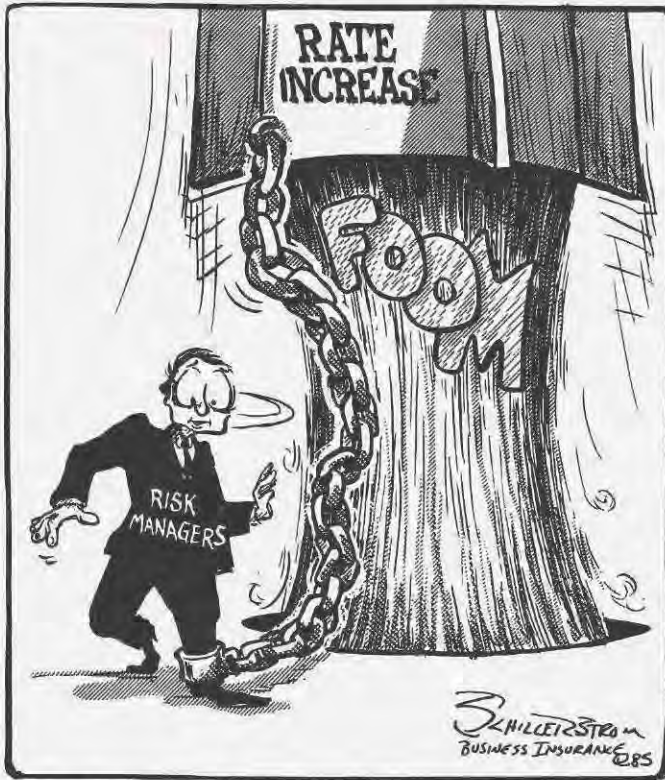


Illustration: Roger Schillerstrom

muda will decline for the first time.

- At least one U.S. reinsurance executive will propose that the U.S. enter into discussions with representatives of the Soviet Union and The People's Republic of China to form a trilateral reinsurance exchange for Third World countries.

letters

Providers must share in task of curbing health costs

To the editor: I feel the article, "Right Programs Can Help Control Health Care Costs" (BI, Dec. 10, 1984), deserves a comment.

First of all, if benefit consultants are doing their job, small employers (100 to 500 employees) should not experience proportionally greater problems in the containment of costs than their larger counterparts.

We would take issue with those "experts" who intone that "making employees pay a larger share of costs is clearly the most effective way for small business to limit its health benefit outlays."

It would appear that some of these "experts" have their heads buried in the sand of the cost-containment debate. Containing health care costs does not rest on "shifting" or increasing the financial burden to those least able and equipped to assume and manage that current burden, i.e., the employee.

Meaningful cost containment will only occur once those very costs are attacked at the point of delivery, that is, the doctors and hospitals. The concept of sharing the financial burden among all of the "players" in the health care delivery system

must be introduced if balance and reason are to reign over the system.

If the preferred provider organization movement means anything, it is the fact that the providers are willing to accept their proper share of the financial burden, where once they merely consumed the health care dollar. The hope of the PPO movement is that there are many providers willing to help payers reduce their health care expenditures before the services of the provider are actually required.

It is that kind of pre-arranged program that will make more sense to the employee and help him to be cost-conscious. An employer need do no more than to direct the employee to the contracted provider network rather than expect him to negotiate a reasonable fee for service for himself and his employer.

The mixture of spreading the financial burden, where it once was laid on the back of the employer, and attacking the costs of medical services at the point of delivery makes more sense than asking the employee to shoulder more of the financial risk.

And how much more acceptable will

Insurers take shortsighted view of eye surgery

To the editor: The attitude of the various insurance companies quoted in your article, "The Eyes of Texas Frown on Surgery for Nearsighted" (BI, Dec. 17, 1984), is appalling to say the least. As anyone who suffers from the vision defect known as nearsightedness can tell you, it is most unpleasant going through life not being able to see as normal people do. Ms. Reeves' comment was more on target: It is no less necessary than "correcting a muscular dysfunction so that an employee can walk without a cane."

Metropolitan Life's ruling is more realistic: i.e., the procedure should be classed as corrective surgery, for that is exactly what it does. . . helps someone who has always relied on contact lenses or glasses to have 20/20 vision, as God intended us to have. After all, we are not born with contact lenses and wearing glasses. What a

joy it would be to people who are nearsighted to wake up in the morning and be able to see without the aid of lenses or eyeglasses.

Also, contact lenses are not the total answer, either. They are subject to damage, such as tearing. Every time lenses have to be replaced or eyeglass prescriptions strengthened, it costs the wearer money. The RK procedure is a one-time expense. Surely it is worth the investment for the permanent improvement to vision that it offers. Even Texas Eastern's answer to coverage for this procedure—offering a flat rate benefit—is better than simply disallowing it altogether.

It's really too bad that insurance companies cannot see a need and respond to it without taking a shortsighted view.

Diane Riffie
Millersville, Md.

that burden be to the employee once our good friends in Washington make employer-paid health premiums taxable income? We need some more common-sense advice from the benefits consulting community than has been represented in this article.

We commend *Business Insurance* for its coverage of this issue and appreciate its leadership in the debate.

Ralph N. Galascione
Principal
Westland Benefits
San Diego

Small firms can use cost-containment plan

To the editor: In your "Spotlight on Small Business" (BI, Dec. 10, 1984), you reported that small businesses suffer from an inability to obtain health care cost-containment programs.

Groups with as few as 200 employees are participating in our Pre-Admission Certification, Concurrent Utilization Review and Second Surgical Opinion programs. With minimal or no implementation costs, small-employer, union and trade groups are able to obtain these services at the same monthly capitation rates per employee as major corporations.

On a capitation basis, the costs of operating such programs are proportionately lower and the resultant cost-to-benefit ratio is often significantly higher. There really is no reason why the small employer cannot derive success from these programs.

B. Marc Allen
President
Medical Review Corp.
Morristown, N.J.

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Tightening market worries risk managers

By ALISON KITTRELL

Risk managers agree that 1984 was not a very good year. In fact, according to many risk managers, the only bright spot was that 1984 was better than they expect 1985 to be.

Virtually all the members of the *Business Insurance Risk Management Board* who responded to the question, "How would you describe 1984?" reflected concern about the hardening insurance market, which was the overwhelming choice as the top risk management story of 1984 (see story, page 3).

One risk manager called the year "unsettling in anticipation of a worsening insurance environment."

The consensus was that 1984 was, as one respondent said, "a year of

change—from soft to tight markets—from excess to shrinking capacity—and from broad to more restrictive coverage."

Another risk manager said: "It has been the beginning of a new, difficult cycle for buyers in terms of capacity and price, and for insurers in terms of potential tax-related impairment of their ability to do business and to maintain capacity."

Even those few respondents who thought 1984 was a good year tempered their comments. The year was "good for risk managers overall; however, year-end renewal problems portend 1985 as a disaster," one risk manager said.

Another respondent agreed that 1984 was "a good year for risk managers when compared with expectations for 1985."

A few noted the increased corpo-

rate pressure on risk managers, especially in light of tightening capacity and rising rates. They explained that risk managers had been able to buy insurance at relative cheap prices for several years and managements had come to expect low costs. In addition, more risk management departments are being asked to become corporate profit centers, they said.

One risk manager said 1984 was "a year of market tightening while pressures on the role of risk management intensify as a positive source for corporate revenue."

Many of the respondents, although worried about rising prices and shrinking capacity, realized the soft market they had enjoyed was bound to end sometime.

For one risk manager, "1984 has been a year of transition in which

the long-anticipated tightening of the commercial property/casualty markets finally materialized, perhaps even more than had been expected."

And, one respondent said 1984 was "the end of the 'good days.' No more cut-rate insurance. Perhaps this is a needed change. I just hope (insurers) don't try to recoup all their losses in 1985."

Some of the respondents pointed out that risk managers must be ready to respond to the challenges posed by the tightening market.

One said 1984 was "very tough—nine months of anxiety over financial results and security capped by three months of the most dramatic market change in the last 20 years."

But, he continued, "The hardening market and deteriorating

legal/social environment present risk managers their most significant challenges in years."

Another said 1984 was "a turnaround year in pricing and availability of coverage... a year to look into the future, laying the groundwork and planning alternatives due to restrictions in the marketplace."

One of the few risk managers whose comments were not about the hardening market focused his attention on the courtroom. He said 1984 was "the year of mass tort litigation... perhaps a turning point, with the courts beginning to realize they simply cannot effectively deal with these suits."

This risk manager chose the asbestos claims-handling facility—designed to end long, expensive litigation—as the year's top story.

But, most of the risk managers had only negative things to say about the market hardening in 1984. Some were angry, like the risk manager who said the year was "very disappointing in that I believe the manner in which (property/casualty) insurers have handled the current rate increases and underwriting restrictions will cause senior management of industries other than insurance to seriously question their logic and their reliability. Insurers either have no talent for planning within their industry or hide it so cleverly it can't be detected."

Another said it was "an extreme cyclical turnaround year by insurers and underwriters. The extreme changes by all insurance companies in their underwriting rates may prompt insurance users to press for a federal inquiry into the process or request more federal legislation over insurance companies."

Most of the responses were more brief, however. Some called the year "grim," "depressing" and "disappointing." Some said that 1984 was "the gathering of clouds before the fury of the storm arrives" or "the tip of the iceberg."

"A year or two from now we will refer to 1984 as the 'good old days,'" one respondent said.

"Good times are over!" said another. "Risk managers will sweat blood in future years."

One respondent suggested that, in light of the problems that will be presented by the tightening market, 1984 was a "time to retire and rest on your laurels!"

And, one risk manager said grimly, "I am waiting for the other shoe to drop." ■

Tightening market top story of 1984

Continued from page 4
which has already been amended, has caused several surplus lines insurers to leave New Jersey.

Two of the 23 stories listed on the ballot sent to the risk managers received no votes from the risk managers: Keene Corp.'s agreement with its insurers over coverage for asbestos injury claims and the settlement by three polyvinyl chloride producers of a 1980 lawsuit triggered by a Des Moines, Iowa, department store fire.

Two of the risk managers responding to the survey cast write-in votes for the deadly gas leak at the Union Carbide plant in Bhopal, India, as the top story of the year. The disaster occurred after the ballots had been mailed.

The leak, which killed an estimated 2,500 people, has spawned several lawsuits which demand damages far in excess of the company's net worth.

With two first-place votes, the gas leak had a total of 10 points, which ranked it above 10 of the stories included on the survey. ■

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Top risk management stories of 1984

Long-predicted market hardening arrives with a fury

After years of fierce competition among insurers, the long-predicted deluge of rate hikes, coverage restrictions and capacity shortfalls hit commercial property/casualty insurance buyers in 1984.

It all started early in the year, with a tightening by reinsurers and underwriters of surplus and specialty lines.

By the end of the year, the trend had accelerated in both the reinsurance and direct markets and spread across a broader range of property and casualty coverages.

As bad as things are for some buyers, most industry observers expect things to get even worse after the latest round of reinsurance renewals Jan. 1 (see story, page 1.)

An early sign of the tightening reinsurance market was the loss of at least one property treaty by Baccala & Shoop Insurance Services Inc. of Newport Beach, Calif., an underwriting management unit of Corroon & Black Corp.

Among Baccala & Shoop's specialties was earthquake insurance, one of the first lines to be squeezed by shrinking reinsurance capacity.

More reinsurers had pulled in their horns by July 1 renewals, and observers saw tougher times ahead.

New England Reinsurance Corp., for example, canceled all its facultative treaty contracts, which produced 50% to 75% of its total facultative volume. They combined aspects of facultative and treaty reinsurance (BI, Aug. 20, 1984).

Other reinsurers withdrew altogether, including Universal Reinsurance Corp., an Armco Insurance Group unit; Commercial Union Reinsurance Co.; Rochdale Insurance Co.; United Americas Insurance Co.; Sentry Reinsurance Co.; and Presidio Insurance Co. (BI, Nov. 12, 1984).

Still others stopped writing cer-

tain types of business. Gerling Global Reinsurance Corp., for instance, stopped writing casualty reinsurance, while three companies—PMA Reinsurance Corp., Signet Reinsurance Co. and Folksamerica Reinsurance Co.—stopped writing all facultative business.

At year-end, reinsurance brokers said capacity reductions and higher rates were evident in almost all property/casualty lines.

The story was the same in direct insurance markets.

It started with surplus and specialty lines—including professional liability, earthquake, trucking and excess and umbrella property/casualty coverages—where buyers

were hit early with rate hikes of 10% to 25%.

In addition to rate hikes, underwriters started to insist on higher deductibles and tighter policy conditions and—as with the reinsurance market—some withdrew altogether from certain classes.

Last August, for example, Commercial Union Insurance Cos. stopped accepting new business for its special risks division (BI, Aug. 20, 1984).

Finally, some companies pulled out of the market altogether. Northbrook Excess & Surplus Insurance Co., the nation's fifth largest surplus lines underwriter ranked by 1983 premium volume,

announced in November that it would stop writing business as of Jan. 1 (BI, Nov. 19, 1984).

Buyers of almost all types of direct insurance saw rates rise and capacity shrink during 1984, including buyers of:

- Airline hull and liability, where rate increases early in the year hit nearly 200% for some buyers (BI, May 28, 1984).

- Satellite risks, where one major market—Orion Insurance Co. P.L.C.—withdrew after three major losses (BI, July 2, 1984).

- Directors and officers liability insurance, where rates jumped 15% to 50% and coverage for some financial institutions was canceled (BI, Sept. 3, 1984).

- Fidelity bonds for financial institutions, where insurers have

boosted rates by as much as 50%, increased deductibles and restricted capacity (BI, Oct. 1, 1984).

- Medical malpractice insurance, where rates have gone up by as much as 100% and several insurers and reinsurers—including General Reinsurance Corp.—have stopped writing the business on an occurrence basis (BI, Oct. 22, 1984).

- Liability insurance for public entities, where rate hikes have ranged from 15% to 400%, policy cancellations have become more frequent and insurers have withdrawn (BI, Oct. 8, 1984).

- Pollution liability, where capacity among the few markets still writing the coverage has been drastically reduced because of a lack of reinsurance support (BI, Nov. 12, 1984; Dec. 24, 1984).



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ISO proposes big changes in its revised CGL policies

Early in 1984, risk managers got a look at what was to be the final version of the Insurance Services Office's two new general liability insurance forms (BI, Jan. 9, 1984).

Those new forms, one of which featured a claims-made trigger and the other an occurrence trigger, appeared to provide coverage comparable to the existing comprehensive general liability form.

(Under a claims-made form, an insurer is responsible for only claims filed during the policy period. Under the occurrence form, insurers are liable for losses that occur during their policy period, regardless of how long after a policy's expiration date a claim is brought. Thus, the occurrence form can provide policyholders with more coverage, but leaves insurers with open-ended liability.)

Most CGL insurers support the action, but it shocked risk management and agent/broker groups.

By September, however, the picture had changed.

As a result of pressure from reinsurers to cap liability under the CGL policy and based on their own poor loss experience with the existing CGL form, the ISO board of directors decided Sept. 20 to eliminate all coverage for both sudden and non-sudden pollution from the new CGL forms. Current CGL forms generally cover sudden or accidental pollution risks (BI, Oct. 29, 1984).

In addition, the new claims-made form would include a retroactive date provision. The provision will give underwriters the power to exclude coverage for bodily injury or third-party property damage that occurred prior to a date selected by the underwriter.

Most of the major CGL insurers, many of whom sit on the ISO board, voiced support for the two moves.

But, the action shocked risk management and agent/broker groups, several of which charged that ISO members were taking advantage of the rapidly tightening insurance market.

Risk managers, insurance agents and brokers say that they are concerned that the implementation of the new claims-made form will cause a major shift in the marketplace from the existing occurrence form to the new claims-made contract.

And some fear that insurers could use the retroactive date on the claims-made contract to eliminate coverage for past liabilities—leaving the policyholders high and dry.

ISO's decision to eliminate all pollution coverage from the new CGL forms also has raised concerns among policyholders, who fear that pollution coverage will not be available in 1985 as the insurance market continues to harden. And, it appears that that fear is well-founded, considering the rapidly shrinking environmental impairment liability insurance market (BI, Dec. 24, 1984).

ISO officials have said the group will make available a pollution liability endorsement that could be added to the CGL contract. The endorsement has yet to be made public. And, CGL insurers have not publicly committed themselves to making the endorsement available.

The effective date of the new CGL forms, if approved by state insurance departments, will be in January 1986. But some insurers, responding to pressure from reinsurers, are planning to begin using the new ISO forms in 1985. The revised forms already have been approved by 11 state insurance departments.

Besides ISO's proposed revision of its CGL form, London underwriters last year also proposed a new "first claims-made" liability form under which the policy in force at the time a claim is filed would respond to the claim and all subsequent claims stemming from the same cause, up to the policy's limits, even if the subsequent claims are filed in later policy years (BI, Aug. 13).

CGL policies written in subsequent years by the London market would specifically exclude from coverage all claims stemming from the same cause that triggered coverage under the prior-year policy. ■

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Congress issues the final defeat on tax deductions for loss reserves

Employers won the battle for tax deductions for self-funded loss reserves in court in 1983, but they lost the war in Congress last year.

The Senate and House of Representatives last June passed the Deficit Reduction Act of 1984 which, among other things, supported the Internal Revenue Service's longstanding position on the question of tax deductions for self-insured loss reserves.

Under the new law, employers will not be allowed to deduct reserves established for self-insured property/casualty losses that are known in the current year but are not payable until some point in the future.

Instead, employers will be limited to deducting losses as they are paid.

In passing the law, Congress snuffed out a glimmer of hope on the deductibility issue that had been kindled by a federal appeals court a year earlier.

In that October 1983 ruling, the 9th Circuit U.S. Court of Appeals in San Francisco had upheld a lower-court decision granting Kaiser Steel Corp. a deduction for reserves

The new law also doesn't affect other, more important advantages to self-insuring such risks as workers compensation, they add.

These advantages include:

- Cash flow. Rather than paying premiums to an insurance company, self-insurers have the use of money set aside for claims that are often paid over a period of several years.

- Cost savings. Self-insurers avoid having to cover the administrative expenses and profits of a commercial insurer.

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In passing the law, Congress snuffed out a glimmer of hope that had been kindled by a court in 1983.

set up in 1964 for uncontested workers compensation claims payable later for injuries suffered that year.

The appeals court agreed with a lower-court finding that Kaiser had met the two-pronged test governing tax deductions:

- That all events determining the fact of a liability occur during the tax year.
- That the amount of liability be determined with "reasonable accuracy."

Following the lower court's ruling, the appeals court found that the only event governing Kaiser's liability for workers compensation claims was a worker's injury itself, and that subsequent events affecting the amount of final liability needn't be determined.

The court also found that the reasonable accuracy test is met by accuracy in the aggregate and that reserves need not be justified on a case-by-case basis, as the IRS had argued.

The aim of the IRS was to permit deductions only for losses that are actually paid during the tax year, and while it lost its point in the 9th Circuit, it found sympathetic ears last year in a Congress that was searching for new sources of tax revenues.

As might be expected, employers lobbied hard against the measure barring deductions for self-funded reserves.

They argued, for example, that removing the deduction would drive employers back to buying commercial insurance, for which premiums may be deducted.

But after the law was passed, employers and risk management experts asserted that interest in self-insurance would not be dampened. One went as far as to call reserve deductibility "a great big non-issue."

Many self-insuring employers weren't even taking a deduction for loss reserves in the first place, the observers said.

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Asbestos facility gets initial OK

After 17 months of negotiations, some major asbestos defendants and some of their insurers finally agreed last year on a proposal to address the horrendous social and legal costs of asbestos litigation (*BI*, April 9, 1984; May 28, 1984).

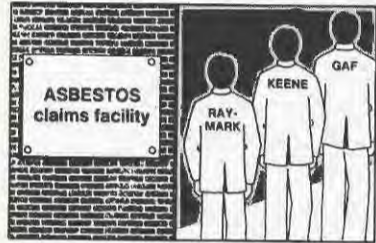
The agreement, called the Wellington agreement after Yale Law School Dean Harry H. Wellington, who chaired the negotiations, would establish a facility to handle asbestos claims more fairly and efficiently while ending the coverage litigation between asbestos defendants and their insurers.

Resolving injury and insurance disputes outside of court, proponents say, will reduce the legal costs of the litigation by millions—and perhaps billions—of dollars.

The agreement's provisions would provide extensive coverage to insureds while ending all punitive damage claims brought by the asbestos defendants against their insurers.

The agreement would allow asbestos producers to tap all of their available coverage from policies that were in force at the time claimants were exposed to asbestos through the time the disease manifested itself, including policies in force during the period between exposure and manifestation.

And, the agreement would give



policyholders substantial defense coverage and would place a cap on insurers' costs under policies that have no aggregate limits and would cap policyholders' deductibles under policies with no aggregate deductibles.

The proposal was negotiated under the auspices of the Center for Public Resources, a New York-based legal program designed to foster alternatives to litigation. It included negotiators for several major insurers and insureds.

Despite the initial agreement, the facility still has a long way to go before it actually handles claims. While the initial steps for its operation are now being taken, enough defendants and insurers must sign the agreement for it to work.

In addition, plaintiffs' attorneys also have to agree to bring their cases before the facility.

So far, at least 28 asbestos producers and 20 insurers have conditionally signed on, but some large insurers and asbestos defendants have not signed.

The insurers yet to sign include Travelers Indemnity Co., which helped spearhead the creation of the facility, Commercial Union Insurance Co. and The Home Insurance Co.

Travelers and The Home last year settled coverage disputes with Manville Corp., the largest asbestos defendant that is currently mired in bankruptcy court in New York.

And, major asbestos defendants such as Raymark Corp. and GAF Corp. also have yet to sign.

The deadline for conditionally signing the agreement has been postponed on at least two occasions, while during the past months members of the facility have amended the agreement in an effort to attract more insurers and defendants (*BI*, Nov. 19, 1984).

However, the hopes of the facility members were buoyed recently by the conditional subscription of Manville and Keene Corp., which had criticized the facility as it was originally set up.

EIL capacity slashed by reinsurers

Domestic and foreign reinsurers turned a cold shoulder to the environmental impairment liability insurance market in 1984, virtually eliminating existing EIL capacity.

In just 11 months, three insurers dropped out of the EIL market altogether, while most of the remaining companies cut back on their policy limits (*BI*, July 9, 1984; Nov. 12, 1984; Dec. 24, 1984).

One of the first EIL markets, Environmental Risk Assessment Services (International) Ltd., a London-based pool of 15 insurers, collapsed when its London reinsurers decided that insuring pollution liability exposures in North America was too risky. The Jan. 1, 1984, collapse of the ERAS facility, which offered limits of \$20 million per

occurrence/\$40 million aggregate, sent risk managers scurrying to place their companies' EIL policies with domestic pollution liability markets.

But the domestic EIL markets also had been affected by reinsurers' concern over pollution risks.

The Hartford Steam Boiler Inspection & Insurance Co. was forced to with-

draw from the EIL market on Jan. 1 when its reinsurers backed out. Two surplus lines markets that had planned to offer EIL coverage—broker J.H. Blades & Co. of Houston and California Union Insurance Co., a CIGNA Corp. unit—simply could not fill out reinsurance treaties; therefore, their programs never got off the ground.



By November, Dryden & Co. had become the third EIL market to stop writing the coverage. As was the case with the other markets, a lack of reinsurance support was cited as the reason behind the withdrawal of Dryden & Co. from the EIL business.

Meanwhile, other EIL carriers were cutting back on policy limits and shifting their business to smaller companies with moderate pollution exposures from larger buyers.

By November, only two of the eight remaining EIL markets were willing to write coverage for larger pollution risks, like hazardous waste disposal and transportation operators, and had the capacity to serve Fortune 500-sized companies: underwriting manager Shand, Morahan & Co. Inc. and American International Group Inc. Both markets offered limits of \$20 million per occurrence/\$20 million aggregate.

But, in December, Shand

shooked the EIL market when it announced that its limits would be only \$2.5 million/\$2.5 million in January 1985, which would be too low to make Shand a viable market. Shand officials said the new lower limits reflected a lack of reinsurance support for its program. (*BI* Dec 24, 1984).

Shand said it plans to continue to try to put together more reinsurance that would allow it to offer higher limits, but an official admitted it is unlikely they will be able to do so.

AIG also announced last month that it would have to reduce its current EIL policy limits, possibly to \$10 million per occurrence/\$10 million aggregate.

EIL experts say that the reinsurers' distaste for pollution risks is likely to continue through 1985, largely as a reaction to the tendency of U.S. courts to broadly interpret insurance policies in coverage disputes involving pollution incidents.

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FSA rules voted 1984's top benefit story

Continued from page 3

an FSA required advance selection of benefits and forfeiture of unused benefits, it was invalid.

The IRS rules on FSAs garnered the highest cumulative score, 206 points, and tied with President Reagan's re-election for the most first-place votes, 24.

However, it edged out the re-election story (206 points to 188 points) by receiving 10 second-place votes, compared with the six Reagan's re-election received. Both stories received the same number of third and fourth-place votes—8 and 7—but the FSA story also got two more fifth-place votes, 8 vs. 6 for the re-election story.

The high interest in the FSA story is a result of the impact the rules have on corporate benefit plans as well as the outrage em-

ployers expressed when it originally appeared that the rules would be enforced retroactively.

While President Reagan's re-election garnered enough first-place votes (24) to make it the second most significant story, it received fewer second-place votes than any other story in the top five.

In fact, the third-place story on 401(k) rules received more actual votes than the re-election story. Counting all the votes the two stories received for first, second, third, fourth or fifth place, the 401(k) story garnered a total of 55 votes compared with only 51 for the Reagan re-election story.

The 401(k) story amassed 152 cumulative points, but received only nine first-place votes compared with the 24 cast for FSAs and President Reagan's re-election.

The rules on FSAs garnered the highest cumulative score and tied for most first-place votes.

However, it received the most third-, fourth- and fifth-place votes of all the top five stories—12, 13, and 13 respectively. And overall, it received only two votes fewer than the top-ranked FSA story when all the votes received for first, second, third, fourth and fifth place were tallied. The first place FSA story received 57 votes and the 401(k) story received 55.

The fourth-place story—the pro-

posed flat tax bills that attack the tax-free status of employee benefits—received a total of 143 points. However, it received more first- and second-place votes than the third-place 401(k) story. Flat tax received 11 first-place votes compared with nine for 401(k) and nine second-place votes compared with eight for 401(k).

The flat-tax story also received more second-place votes than the Reagan re-election story, 9 vs. 6.

The story probably won such a comparatively high number of first-place votes due to the sweeping impact that some of the flat-tax proposals would have on employee benefit plans.

For example, the Treasury Department plan, unveiled in late November, would wipe out 401(k) plans and tax-free cafeteria benefit

plans.

The Treasury plan, now under review by President Reagan, also would tax employees on employers' health care contributions that exceed \$70 a month for individual coverage and \$175 a month for family coverage.

The fifth-place story—Congress's decision last year to bar cafeteria benefit plans from offering many taxable benefits—garnered a total of 132 points, with eight first-place votes.

It also received the most second-place votes of all the top five stories—14.

Business Insurance also calculated the sixth through 10th most important stories, based on the Employee Benefit Board votes.

The sixth most important story of the year, with 117 points, was congressional approval in August of the Retirement Equity Act (*BI*, Aug. 20, 1984). It received 15 second-place votes—the most of any story in the Top 10. However, it received only three first-place votes, which kept it out of the Top Five.

The Retirement Equity Act, designed to give women a better chance to earn pension credits and collect benefits, lowers the minimum participation age—the age at which a worker can join a retirement plan—to 21 from 25.

It also lowers to 18 from 22 the minimum age at which an employer must give vesting credit to employees.

Finally, the new law says employees who have vested must have the option of selecting survivors' benefits. Previously, many pension plans only offered survivors' benefits to vested employees who also had reached the plan's early retirement age, which is usually 55.

Tied for seventh place, with 113 points each, were stories on court decisions affecting post-retirement medical benefits and the moderation of health care cost increases.

The most significant court ruling affecting post-retirement health care benefits came in September, when a federal judge ruled that Bethlehem Steel Corp. could not unilaterally reduce medical benefits for retired workers (*BI*, Oct. 1, 1984).

That decision, which Judge John T. Elfvin later slightly modified to allow Bethlehem to make retirees pay health care deductibles and co-payments while the case is on appeal (*BI*, Oct. 15, 1984), is considered important because it suggests that companies that make ambiguous promises on providing post-retirement health care benefits may not be able to reduce or eliminate benefits.

In another court ruling on the issue, U.S. District Court Judge Ann Aldrich in Cleveland ruled in September that employees have a vested right to continued health care coverage when they retire (*BI*, Oct. 29, 1984).

As a result, White Farm Equipment Co. violated federal law when in May 1981 it cut off post-retirement medical, life and prescription drug coverage to more than 700 employees as a cost-containment step.

White Farm Equipment is appealing Judge Aldrich's ruling.

The other seventh-place story described the moderation of health care costs after years of double-digit increases (*BI*, July 23, 1984).

The story reported that, during the first six months of 1984, group health insurers predicted rate hikes of 12% to 16% for large groups during renewals, compared with three years of rate increases that hovered around 30%.

A factor in the moderation of health insurance rate hikes was a slowdown in health care costs, as

Continued on page 16



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Congress makes year hectic for benefit managers

By JERRY GEISEL

It's no surprise that several benefit managers summed up 1984 with the same word: "hectic."

It was the year Congress passed the Deficit Reduction Act of 1984, which among other things, limits tax deductions employers can take for contributions to Voluntary Employee Beneficiary Assns.

It was the year Congress approved the Retirement Equity Act, a comprehensive and often confusing law designed to make it easier for women to collect pension benefits.

It was the year several so-called "flat tax" bills were introduced.

And, it was the year that the Internal Revenue Service proposed restrictive rules governing the use of flexible spending accounts.

While these proposals varied considerably, all the proposals would tax some benefits that currently are tax-free to employees.

It was a year of such vast changes we have yet to assimilate it all or get answers from our consultants on how to change our plans," wrote one benefit manager responding to a *Business Insurance* Employee Benefit Board survey that asked the board members to rank the top stories of the year (see story, page 3) and to comment on 1984 in general.

"An administrative headache," another benefit manager agreed. "Two major pieces of legislation—DEFRA and REA—passed and a promise of more to come."

"A year of attacks on employee benefits by the federal government that will take benefit plan adminis-

trators at least another year to completely implement," a third added.

"A year that had benefit managers scrambling because of continued legislation changing benefits and uncertainty of (the tax status) of benefits in the future because of the need to reduce the (federal) deficit," another said.

This increased congressional and regulatory activity clearly has angered many benefit managers, as evidenced by several comments:

"It appears as if Congress and the regulatory agencies aren't quite sure what they want to do with employee benefits—so they try all options."

"One big administrative hassle."

"Over-legislation is making benefits design and administration too difficult for the small and medium-size employer."

"Our being put on the defensive for our benefit programs in an unexpected, unpleasant surprise."

"A year of trial balloons, changes in directions. . . This makes benefits planning extremely difficult and shaky, to say the least."

"Year of uncertainty in Congress and the IRS in which innovative planning is hindered not only for employers, but for employees as well."

Some benefit managers viewed 1984 as the start of a continuing wave of attacks on benefits:

"Federal involvement in employee benefit plans was extensive in 1984 and is a harbinger of expected activity in 1985."

"The year in which clear signals were given announcing the next upheaval in the way benefits will be designed, administered and fi-

nanced."

"1984 could signal the beginning of a successful assault against the tax shelter of most employee benefits."

"It (1984) is a prologue for the future. Plenty of changes, new legislation, new tax rules, adverse court decisions."

Several benefit managers said the significance of 1984 was that it marked the start of increased federal interest in taxing benefits.

"A year of continued government attempts to tax employee benefits, a trend that is likely to continue on into 1985," one benefit manager commented.

It was a year "in which the federal government discovered employee benefits as a revenue source," another manager said.

One benefit manager agreed that 1984 was a year of significant change, but the manager wasn't sure in what direction benefit proposals are going.

"It was a year of change, but it will take 1985 to show us what direction this administration is taking us," the benefit manager said.

As bad as 1984 was for benefit plans, the coming year could be even worse, several benefit managers warned.

"While 1984 was a bad year, benefit managers shouldn't forget the saying, 'You ain't seen nothing yet'—1985-86 will make the last 10 years seem like a piece of cake," one manager predicted.

"I can hardly wait to see what mind-boggling challenges await us in next year's Pandora's box," another manager commented.

But not all benefit managers said they were dismayed by 1984. Several managers, for example, were encouraged by the slowdown in group health care cost increases:

"Many strides were made in the area of cost containment."

"Tough year for flexible benefits, but at least health care costs seem to be stabilizing."

"The only real good news (was) the moderation of health care costs."

One manager said that 1984 could be the "beginning of the 'lean and mean' decade with focus on cost containment."

And perhaps summing up the feelings of benefit managers who have had to contend with a plethora of complex legislation and regulations, one manager described 1984 this way: "A year in which it became less fun to be an employee benefit manager." ■

Benefit managers pick top stories

Continued from page 13
measured by the Consumer Price Index. The CPI for medical care climbed just 6.2% from October 1983 to October 1984 (*BI*, Dec. 24-31, 1984).

That compares with a 7.1% increase recorded at year-end October 1983 and is a significant improvement over the 11.1% increase at year-end 1982 and the 11.7% increase at year-end 1981.

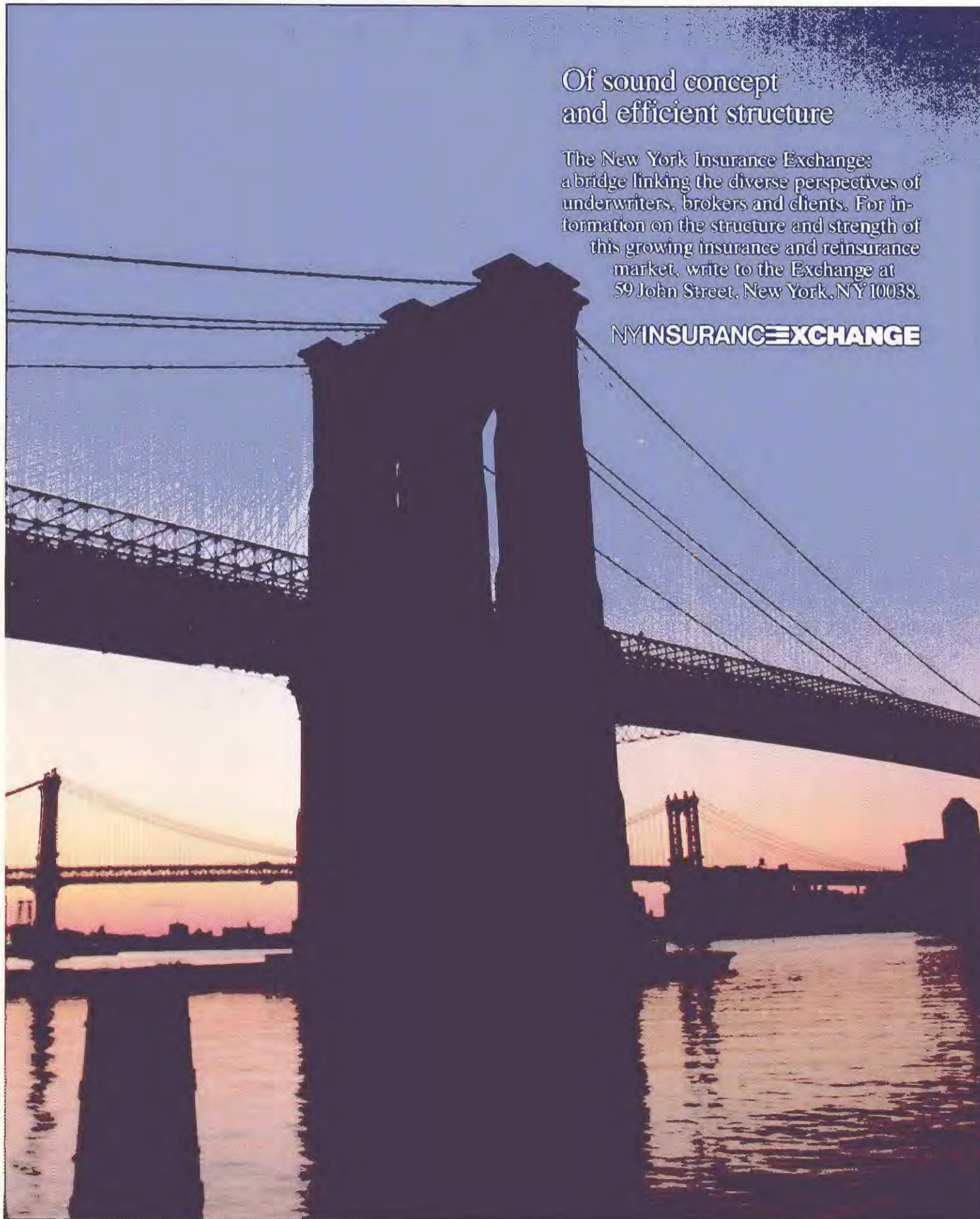
The ninth-ranked story of the year, with 80 points, centered on provisions Congress incorporated into the 1984 tax law that prohibit deductions employers can take for contributions to Voluntary Employee Beneficiary Assns. if reserves for benefits exceed certain limits (*BI*, July 2, 1984).

Finally, the 10th-ranked story of the year, with 67 points, pertained to proposals made by the Financial Accounting Standards Board to make employers account for their pension liabilities and the cost of post-retirement health care and life insurance benefits on their balance sheets (*BI*, Jan. 23, Nov. 12, 1984). ■

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THE HONEYMOON IS OVER

1985 will see high property/casualty prices, restrictive policies

By Robert A. Wilson

ALL SIGNS INDICATE that the honeymoon of unusually low property/casualty premium levels is over.

For the past five years, premiums have, with rare exceptions, been steadily declining. This is a result of several factors:

- Insurance companies' underwriting profits were relatively high in 1977 and 1978 after major rate increases in 1975 and 1976.

- Investment income was extremely high, which resulted in "cash-flow underwriting." Cash-flow underwriting was a term coined to reflect the fact that insurance company underwriters were mandated by management to increase the cash flow without regard to intelligent pricing and sound underwriting principles. Management simply wanted more cash flow from new accounts so they could increase the funds available for investment purposes. As a result, management was not overly concerned when underwriting loss ratios reached 110% and higher.

However, in 1983 there were, in addition to normal losses, major catastrophic losses that increased loss ratios to 115%, 120% and 130%.

This condition continued to deteriorate in 1984. For the first time, we saw major reductions in the surplus of leading insurance companies.

For example, one leading insurance company's surplus was reduced by almost 25%. Other major companies also suffered declines. This situation could lead to insurance company bankruptcies in 1985 and 1986. It also will lead to significantly higher prices, more-selective acceptance of policyholders, more-restrictive insurance policies and more-stringent loss control. Here is our prognosis in each area:

- Higher prices. With the diminished underwriting profits in 1983 and 1984, you can expect higher prices in several key areas. The areas where you may expect the greatest increases are where losses have been the highest: automobile, general liability, property and workers compensation. The severity of the increases

You will have to adjust your goals to respond to the dramatically tighter marketplace by balancing costs with coverage requirements. Your skills as a risk manager. . . must be honed as sharp as possible.

will depend on how bad your losses have been, how good you are in complying with loss-control recommendations and whether you have a good track record with the insurance company.

For example, one company with severe losses has seen its property/casualty premiums increase from \$60,000 to \$145,000.

- More-selective acceptance. In the past few years, underwriters would accept coverage on almost any risk. The underwriters would not often insist on compliance with loss-control recommendations. They also would frequently ignore sound underwriting practices. You could just about dictate your terms and prices to the insurance companies.

You can expect this to change dramatically. Underwriters will be more selective in accepting new accounts and renewing existing policies. Underwriting guidelines will be more closely followed. If your business is in an undesirable class, insurance coverage will be more difficult and more expensive to buy. In a few cases, you might not be able to buy adequate coverage, or you might be able to buy it only at tremendously higher premiums.

- More-restrictive insurance policies. Again, in recent years, insurance companies readily agreed to broaden coverages and policy conditions. They removed exclusions and/or restrictions. They more readily provided "all-risk" coverage. They agreed to conditions that enhanced the policies for the insured,

often at no additional cost.

However, the tide is rapidly changing. Underwriters are now reviewing any special provisions or changes in policy conditions with the utmost care. Many are simply refusing to accept any modifications of standard forms.

In addition, underwriters may increase their underwriting requirements before they broaden your policy to an all-risk basis. In fact, you might even be faced with that problem at renewal time. Underwriters, for example, may require a better alarm system, a guard service or even physical alterations to your building.

- More-stringent loss control. Underwriters have been very lenient in insisting on compliance with their engineering departments' loss-control recommendations.

As the companies return to tougher underwriting standards, loss-control recommendations will begin to play a more-important role in their decision-making process. They may begin to insist that you comply with optional recommendations, which hasn't happened in the past five years. You should prepare yourself to become more accommodating to their requests.

In conclusion, 1985 and 1986 will be difficult years for implementing a cost-effective insurance program. You will have to adjust your goals to respond to the dramatically tighter marketplace by balancing costs with coverage requirements. Your skills as a risk manager and negotiator will have to be honed as sharp as possible. You must be prepared to explore alternate non-traditional methods of insuring the assets and liabilities of your company. ■



Robert A. Wilson is president of Corporate Risk Management Inc. in Hinsdale, Ill. Mr. Wilson also is the author of the book, "Save 30% on Casualty Insurance—Yet Improve Coverage."

Global programs can offer world of advantages

By S. Robert Beane

THE THESIS BEHIND global insurance programs is that ultimate consolidation yields ultimate benefit.

This concept is not new; in the United States, risk managers have for years recognized the advantages of consolidating their companies' exposures and insuring them in one or a few policies.

Most risk managers of U.S.-based multinational companies embrace the concept to the extent of coordinating the insurance of their foreign subsidiary companies.

The move toward truly global programs has been relatively slow, however. Figure 1 on page 18 illustrates how multinationals have traditionally insured their domestic and foreign property and/or casualty exposures. As the diagram shows, the domestic program is entirely segregated from the international program.

Global interdependencies and contingent business interruption exposures are presumably handled separately. However, these exposures are often difficult to identify and even more difficult to quantify. Too often, they are inadequately addressed.

Figure 2 illustrates the first move toward global consolidation. Primary domestic and international programs are still written separately, but the difference-in-conditions exposure is now covered by one insurance contract.

This solution has obvious benefits. The scope of the all-risk coverage is now uniform in its application to domestic and foreign exposures. The interdependency

international issues

and contingent business interruption exposures can be covered with little opportunity for a loss "falling between the cracks." Pricing should be improved by presenting one underwriter a greater spread of risk, which enables him to offer his product at a lower unit cost.

A single underwriter should be selected to provide local admitted coverage as well as non-admitted DIC coverage to avoid arguments among underwriters when a loss falls in the gray area between local admitted and the non-admitted DIC.

It is extremely important, therefore, to select the DIC underwriter with care, taking into account what relationship, if any, the DIC underwriter has with the foreign insurers providing the local admitted coverage.

Figure 3 represents a further move toward consolidation, with the DIC underwriter now insuring the primary domestic program as well. The DIC underwriter will either issue the paper directly or use a fronting insurer and reinsure most or all of the primary domestic risk.

Because some countries, predominantly those in Western Europe, permit non-admitted or unlicensed insurers to provide insurance, it might be possible to extend a global program even further. Figure 4 shows a global underwriter now providing primary all-risk coverage in the United Kingdom and Australia, primary cover in the United States and DIC insurance

worldwide.

There are numerous advantages to this format. First of all, the insured obtains uniform all-risk cover wherever possible. And, the greater spread of risk may reduce the cost and cushion losses more effectively.

Most importantly, however, the risk manager now exerts the greatest possible control over the program, whether it is a monoline program (that is covering either all property, or liability, or crime, or marine or cargo), or a multiline program covering a combination of exposures.

This progression seems to indicate that a full-scale "global" is the most desirable program, one that the risk manager of every multinational would like to develop.

There are, however, a number of factors that must be considered in contemplating a global insurance program, and there are many hurdles to be overcome in effecting one. These hurdles include:

Continued on next page



S. Robert Beane is vp and manager of the New York international department of Johnson & Higgins. His column on international issues appears the first Monday of every month. This article is based on a presentation made at the 1983 Risk & Insurance Management Society conference by Michael Linde, a vp in J&H's New York international department.

Global program can offer a world of advantages

Continued from preceding page

- The limited number of qualified brokers available.
 - The difficulty of assembling the necessary underwriting information on overseas operations.
 - The limited number of markets available to underwrite global programs.
- In contemplating a true global program, the selection of the broker or brokers is critical. The broker must meet basic criteria. It must have a presence in the domestic and international markets, and expertise in global program and coverage design. An established network of wholly owned, partially owned or correspondent offices overseas will let it provide the same level of service for overseas subsidiaries as for domestic facilities.

Failing that, it should at least be able to help the client obtain essential services such as property loss control, safety engineering and claims handling.

Given these requirements, the selection of a broker may be limited to a handful of multinational firms. Smaller firms, or those without an established international network, may have difficulty providing the necessary local service overseas.

Another important consideration is information gathering. While underwriting information on a multinational's domestic facilities is generally readily available, similar information for overseas operations often is not.

The most effective way to obtain this information is to use the facilities of the broker you have selected to carry out a survey. This survey should provide you with underwriting information such as protection levels, interdependency exposures and contingent plans, product liability exposures, automobile fleet sizes and makeup, transportation exposures for both inland and ocean, loss experience and existing local insurance programs.

In addition, a broker's survey should address other relevant issues, including:

- Local regulations governing insurance, such as treatment of admitted vs. non-admitted insurance.
- Compulsory insurance, such as fire insurance in Brazil.
- Local customs of the market in which you operate.
- Exportability of reinsurance.
- Existing relationships with local brokers, underwriters and banks.

This information is rarely available in-house, but it is just as important in putting together a program as the underwriting data.

The broker conducting the survey must have an established overseas network because, except in the United States and perhaps the United Kingdom, the person most-often responsible for insurance is not a trained insurance professional. This person's responses to a written questionnaire may not provide you with the kind of information you need. For example, "actual cash value" is not the same to an accountant as "ACV" is to an insurance person.

The survey should, therefore, be carried out through personal interviews with local management. It should include a physical inspection of the facilities by a qualified engineer. The local broker should be schooled in U.S. risk management techniques in order to be able to explain the survey questions. Conducted properly, the survey should give the corporate risk manager reliable and useful information.

Once the results of the surveys are in, the stateside broker coordinating the exercise will help the risk manager extract the necessary information for analysis.

Whether a global program will benefit the corporation as a whole can be determined at this point. If the corporation operates in the countries of Western Europe, a global program may provide the opportunity to impact local pricing, because these countries generally do not insist on an adherence to a government-regulated tariff rating structure. Pooling all the risks with one underwriter should, because of sheer economies of scale, provide the opportunity for premium reductions.

If, however, a corporation's non-U.S. operations are predominantly in Latin America or in Third World countries, the probability of significant front-end premium reduction is diminished. These countries tend to enforce adherence to tariff rating structures.

Furthermore, reinsurance from these countries is controlled, and sometimes prohibited entirely. Without the reinsurance vehicle, it is very difficult to persuade an underwriter to allow price concessions in one country in consideration of premiums paid elsewhere. If the controlling underwriter is unable to book premium and realize a spread of risk by reinsuring the overseas placement, the underwriter generally will be unwilling to grant premium reductions.

Pricing, however, is not the only argument favoring coordinated global or international insurance programs. Increased control in communications alone often will justify the move toward consolidation.

A discussion of global programs would not be complete without briefly addressing the marketplace. While many U.S. insurance companies claim international capabilities, only an experienced international network of underwriters can effectively administer a global program. Unfortunately, there are only a handful of truly international underwriters capable of writing such a program (BI, Oct. 15).

Only property and casualty insurance are underwritten on a global basis by these insurers, but political risk, boiler and machinery and marine coverages may be

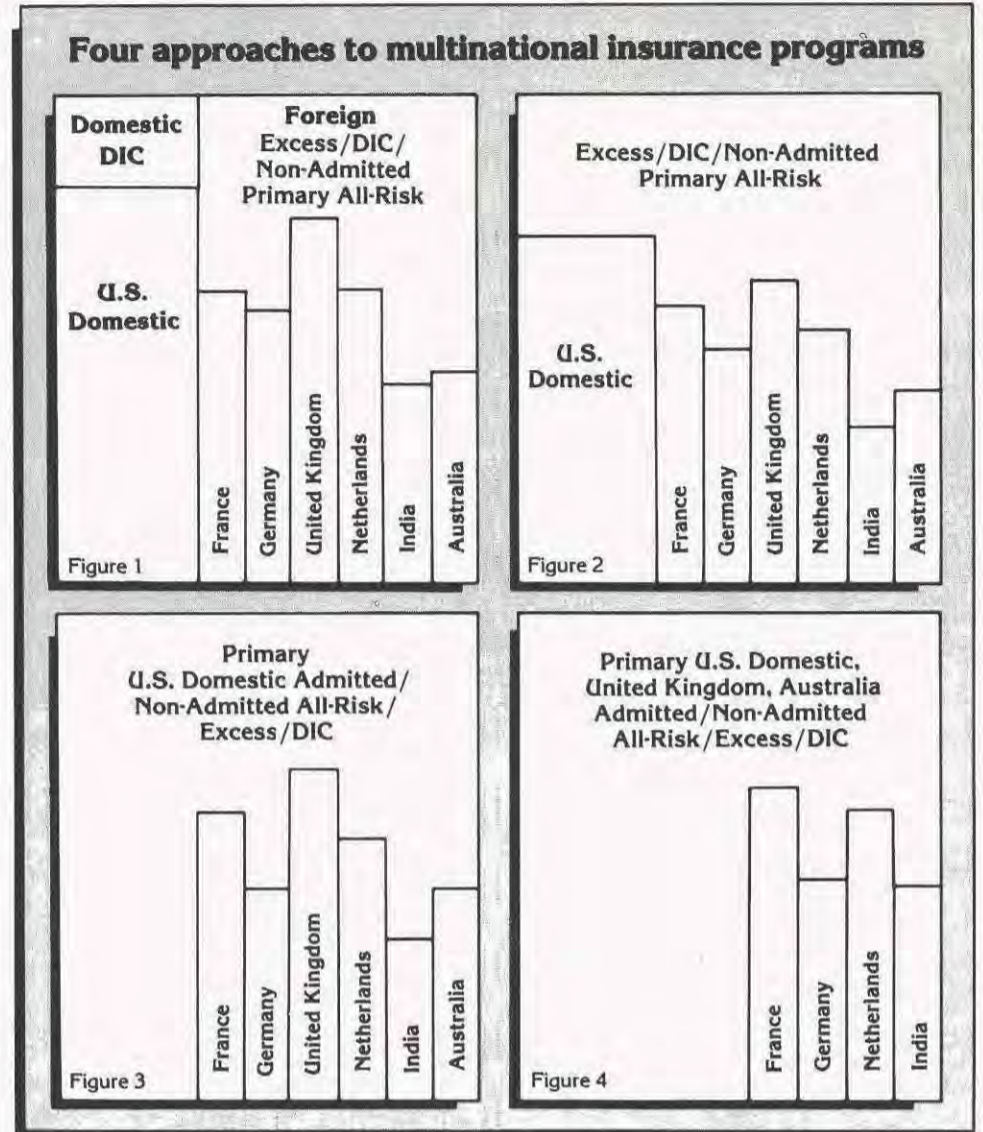
Delay in notification doesn't always void claim

Inexcusable delay in notifying an insurer of a loss or claim did not relieve the insurer of its policy obligations if the delay did not materially prejudice the insurer and the insured acted in good faith, according to a ruling by a North Carolina appellate court.

B&H Supply Co. Inc. was insured under a policy issued by Insurance Co. of North America protecting B&H against losses occasioned by employee dishonesty. An employee of B&H embezzled payments he collected from various B&H customers.

On May 25, 1979, the employee confessed to embezzling about \$9,500. On May 29, B&H notified its insurance agent of the loss.

The employer, however, requested an opportunity to retain the employee and deduct the losses from his commissions. The agent allegedly obtained INA's permission to try to collect in this manner. In fact, B&H did recover about \$2,800 from the employee but then discovered in December 1979 a second embezzlement for



included before long. One market addresses global insurance on an all-lines basis, including employee benefits.

Because all of the major insurers have extensive international networks, they have adequate admitted or licensed facilities to issue local policies. Companies contemplating global programs will want to examine the U.S. and overseas service facilities of the insurer carefully, however. While all insurers seem to have extensive engineering and claims-handling services, all the traditional factors of pricing, service commitment, flexibility, etc., should be considered in selecting the market for a global program.

In summary, the global program has both advantages and disadvantages that the risk manager must review carefully in determining whether such a program is right for his or her company. Based upon the corporate structure and philosophy, the risk manager may want to place all the insurance with one insurer under one program. He or she may find equally compelling reasons, however, to remain with integrated but separate domestic, international and DIC programs.

Global programs are not for every company, but understanding the options is the best way to ensure risk management of the highest professional caliber.

legal briefs

\$5,500. The employee was immediately terminated.

The employee gave B&H a note for the loss and a trust deed on his home. About \$1,600 was later retained by B&H and applied on the loss from the employee's salary and commissions. It wasn't until February 1980 that B&H filed a formal proof of loss with INA.

INA refused to honor the claims, indicating untimely proof of loss on the first embezzlement and saying that the policy did not cover the second because by then the employee fell under an exception from coverage for employees with known dishonesty.

B&H sued INA for both losses. The trial court found in B&H's favor on the first claim but ruled against it on the second.

The appellate court noted that the delay in filing a proof of loss actually had worked to INA's benefit rather than to its

prejudice because of the partial recovery from the employee and that this established B&H's good faith. Also, the court concluded that INA, through its agent, had waived the timely filing of notice or proof of loss.

The court, however, did allow INA a set-off of \$4,391, the amount B&H had collected from the employee after the first embezzlement was discovered and reported. The court upheld the denial of recovery on the second embezzlement because of the exclusion for dishonest employees. *B&H Supply Co. vs. Insurance Co. of North America*, Court of Appeals of North Carolina, Feb. 21, 1984 (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.

Top benefit stories during 1984

IRS release on flexible accounts

The Internal Revenue Service's first swipe at flexible spending accounts comprised just 2½ pages, but it had the impact of a 10-ton bomb.

In a strongly worded news release published Feb. 10, the IRS announced that most forms of FSAs were invalid and that employers and employees who had taken advantage of the tax savings offered through FSAs would be retroactively liable for additional taxes, interest and penalties.

Within a day of the publication of the IRS news release, benefit consultants were flooded with calls from employers, upset because FSAs had emerged as one of the most successful cost-containment weapons.

Many employers had started FSAs to make employees more willing to share a larger slice of health care costs, which employers contend will make workers more conscious of their overuse of health care and eventually hold down costs.

FSAs—also called flexible reimbursement accounts, employee spending accounts, benefit banks or flex funds—are individual employee accounts that provide for pretax reimbursement of certain non-taxable benefit expenses.

The employee can spend these pretax dollars on items like health expenses—like deductibles and co-payments—that are not covered under the group plan, vision and dental care, dependent care and legal expenses.

Following up with proposed rules released in May (BI, May 7; May 14, 1984), the IRS spelled out what it considered to be a valid flexible or cafeteria benefit plan under Section 125 of the tax code. These rules stated:

- Participants must forfeit unused benefits in an FSA at the end of the year.

For example, if an employee had his salary reduced by \$500 to pay for uncovered medical expenses and \$250 remained in the account at the end of the year, it must be forfeited. Similarly, if the employer contributed \$500 to the employee's account and \$250 was left, it must be forfeited.

- Employees enrolled in FSAs must make irrevocable benefit selections prior to the start of the plan year.

The rules said employees must determine at the beginning of the plan year the specific amount to be allocated for each type of benefit offered.

It was this "use or lose it" provision that benefit experts said would kill FSAs as a cost-containment weapon. Since employees knew they could "cash out" a balance in an FSA or roll over the excess into a savings plan, they had a powerful incentive not to overuse health care.

The "use it or lose it" provision could actually make FSAs counterproductive to cost containment, experts said, because employees would be likely to spend all the money needlessly rather than forfeit the balance.

Employers began a campaign to have Congress overturn the rules. Rep. Barber Conable, R-N.Y., unveiled a plan to allow employees to roll over unused benefits into a benefits bank for use the next year (BI, May 7, 1984).

Rep. Conable failed to convince a congressional conference committee to attach his proposal to a pending tax bill. But the committee, in passing what became the Deficit Reduction Act of 1984, did delay the effective date of the IRS rules covering most FSAs to July 1, 1985 (BI, July 2, 1984).

At year-end, final IRS rules covering FSAs and other flexible benefit arrangements still had not been published. ■



President Reagan's re-election

The Reagan administration is the first that has actively backed curbing the tax-favored status of employee benefits, and Ronald Reagan's landslide victory in November will make employee benefits even more vulnerable to administration and congressional attacks, experts believe.

In its first term, for example, the administration drafted and urged passage of legislation to include as taxable income to employees their employers' contributions toward group health insurance that exceeded \$70 a month for individuals and \$175 for family coverage.

While the proposal died in committee, Congress did enact an administration-supported plan to limit tax deductions employers can take for contributions to Voluntary Employee Beneficiary Assns. (BI, July 2, 1984).

Congress also accepted the administration-supported freeze on increasing maximum pension benefits and contributions. The freeze now expires in 1988.

It appears efforts to cut the tax-favored status of benefits will increase during Mr. Reagan's second term.

For example, three weeks after the president's re-election, the Treasury Department unveiled a tax simplification plan that would, among other things, eliminate rapidly growing 410(k) plans and cafeteria plans.

The Treasury's plan again proposes a tax on corporate health care contributions that exceed \$70 a month for individuals and \$175 a month for family coverage, and it would tax other benefits (BI, Dec. 3, 1984).

The administration's attacks on the tax-favored status of employee benefits are, to a large degree, revenue-motivated.

The 1981 Economic Recovery Tax Act substantially cut basic tax rates. Those cuts are politically popular, but they also have resulted in massive federal budget deficits.

As the Reagan administration has promised not to raise basic tax rates to reduce the deficit, employee benefits is one of the few areas left where a huge amount of revenue could be generated by altering the tax status.

For example, the Treasury Department estimates the proposals to tax employer-paid health care contributions would generate an additional \$34.2 billion from 1987 through 1990, while taxing employer-paid premiums for the first \$50,000 of group term life insurance would raise \$9.8 billion between 1986 and 1990.

The search for revenue is only one reason for the attempts to tax employee benefits. The administration believes that, for example, if there were a lid on tax-free health benefits, employees would become more "disciplined" consumers of health care. That, in turn, could lower demand for health care and help hold down costs, the administration says.

The Reagan administration also says tax-favored employee benefits are unfair to workers who are not covered under such arrangements. ■

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401(k) plans face several threats

Few benefits have grown as fast in recent years as 401(k) salary reduction plans.

A survey of 869 employers released in October by Hay/Huggins Inc., a Philadelphia-based consultant, found that 32% of respondents now offer a 401(k) plan, up from just 13% only a year ago. Another 32% of companies said they are either setting up a 401(k) plan or are considering doing so (BI, Oct. 8, 1984).

Under 401(k) plans, named for that section of the Internal Revenue Code that authorizes them, employees can contribute pretax dollars to an account where the money earns tax-free interest until withdrawal. And, since they use pretax dollars, employees' federal tax liability is reduced.

But during 1984, 401(k) plans faced several threats.

The Internal Revenue Service began drafting final rules that could significantly reduce the appeal of 401(k) plans to employees.

The rules would make it much tougher for employees to withdraw funds from the plans to pay for extraordinary expenses, like a child's education or a new home.

For example, instead of allowing funds to be withdrawn to pay college tuition bills, a worker would have to prove that he or she had no

other way to pay them.

The Treasury Department wants to go even further. Its tax simplification plan proposed wiping out 401(k) plans (BI, Dec. 3, 1984).

The department said it opposes 401(k) plans because they are not available to all workers, and the higher-paid employees are more able to take advantage.

Instead, the Treasury wants to expand annual contribution limits to Individual Retirement Accounts, which are available to everyone.

But, 401(k) plans appeal to both employers and employees.

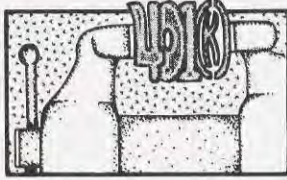
For companies, setting up a 401(k) is a way of adding a benefit at a low and predictable cost.

And, employees can reduce their salaries and contribute pretax dollars to a savings plan where the assets can grow and not be taxed until they are withdrawn. Funds can now be withdrawn when employees reach age 59½, terminate employment or face hardship.

If the Treasury's proposal to wipe out 401(k) plans is enacted, employers would likely face new pressures from workers to beef up their defined benefit pension plans.

At year's end, there was no indication when the IRS is going to publish its final 401(k) rules. But Rep. Charles Rangel, D-N.Y., a member of the House Ways and Means Committee, said he would introduce most of the Treasury's tax plan, including the scrapping of 401(k) plans, this month.

Experts worry a Congress that is looking for more ways to reduce the federal deficit could be receptive to a ban on 401(k) plans.



Benefits jeopardized by flat tax proposals

The nation's tax laws have become so confusing and complex that few people can understand them, a number of congressmen and members of the Reagan administration say.

That growing concern was translated in 1984 into a number of proposals, known as "flat tax" bills, to simplify the Internal Revenue Code.

The flat tax bills, introduced by members of both parties, all promise to lower basic tax rates for many Americans, but also would wipe out or curb the tax-favored status of many employee benefit programs as part of their effort to broaden the tax base.

One of the flat tax proposals, introduced by Sen. Bill Bradley, D-N.J., and Rep. Richard Gephardt, D-Mo., would simplify the tax structure by applying flat tax rates of 14%, 26% and 30% to all incomes. Under the proposal, four of five taxpayers would be in the 14% category (BI, Sept. 3, 1984).

But, to broaden the tax base in order for tax rates to be slashed, many current tax deductions and exclusions—including benefit tax preferences—would be eliminated or reduced.

For example, the Bradley-Gephardt Fair Tax Act proposed that employer contributions toward health care (medical, dental and vision), group term life insurance, child care, van pooling and legal services benefits be included as taxable income to the employee.

Besides taxing employer-provided benefits, the Bradley-Gephardt bill would permanently restrict the maximum annual benefit payable under a defined benefit pension plan to \$45,000 from the current \$90,000, while the maximum annual contribution that could be made to a defined contribution plan would be reduced to \$15,000 from \$30,000.

Under current law, maximum pension benefits and contributions can be indexed to the cost of living beginning in 1988.

The second major flat tax bill, introduced by Rep. Jack Kemp, R-N.Y., and Sen. Robert Kasten, R-

Wis., would set flat tax rates of between 20% and 25%.

The Kemp-Kasten "Fair and Simple Tax," also known as a fast tax, is more lenient in its treatment of tax-free benefits. It would only tax employers' contributions toward legal and van pooling benefits, but would include as taxable income all workers compensation benefits an injured worker receives.

After more than a year of study, the Treasury Department in late November proposed the most draconian changes in the tax treatment of employee benefits as part of its flat-tax plan (BI, Dec. 3, 1984).

The Treasury proposal would, in a single stroke, wipe out 401(k) salary reduction plans and tax-free cafeteria benefit plans.

In addition, employers' health care contributions that exceed \$175 a month for family coverage and \$70 a month for individual coverage would be included as taxable income to employees.

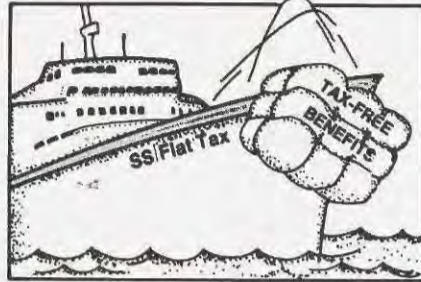
Other changes include taxing workers compensation benefits, imposing special taxes for pre-retirement distributions from pension plans, slapping an excise tax on asset

versions from terminated overfunded pension plans and taxing interest earned on reserves held by Voluntary Employee Beneficiary Assns., also known as 501(c)(9) trusts.

The flat tax proposals aren't likely to go away this year. Sen. Bradley and Rep. Gephardt will reintroduce their bill, while the Kasten-Kemp fast tax proposal also is expected to be reintroduced.

While the Reagan administration has not yet endorsed the Treasury Department proposal, Rep. Charles Rangel, D-N.Y., says he will introduce major portions of the proposal this month.

Few experts expect that Congress is ready to adopt a flat tax bill. But there is mounting fear among employers and consultants that the employee benefit provisions in the proposals could be incorporated in a deficit reduction bill.



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Congress limits cafeteria benefit plans' offerings

The menu of benefits offered by employers with cafeteria benefit plans was reduced by Congress last year.

As part of the Deficit Reduction Act of 1984, Congress barred cafeteria plans from offering most taxable benefits like financial counseling, group auto and group homeowners insurance (BI, July 2, 1984). While few plans offer such benefits, their popularity was expected to increase in the future.

While employers had to reduce the number of entrees from which

employees could choose, some congressmen initially wanted to impose far more severe restrictions.

Two members of the House Ways and Means Committee, Reps. Fortney (Pete) Stark, D-Calif., and Barber Conable, R-N.Y., had originally proposed to bar cafeteria plans from including all taxable benefits as options (BI, Aug. 1, 1983). That proposal was part of a much broader bill that would have set new rules on the tax treatment of so-called non-statutory benefits, like employer-provided park-

ing spaces, that are not covered under specific sections of the tax code.

That would have meant that all taxable benefits, like group term life insurance with limits exceeding \$50,000 and dependent term life insurance exceeding \$2,000, no longer would have been able to be offered through a cafeteria plan.

Unlike other taxable benefits like group homeowners and auto insurance, whose popularity was extremely limited, group term life and dependent term life insurance are offered by most cafeteria plans, experts say.

Later, however, Reps. Stark and Conable agreed that cafeteria plans should be allowed to offer unlimited group and dependent term life insurance as well as extra vacation days, whose status wasn't clear in the original proposal.

The tax bill approved by the House in 1984 incorporated the Conable-Stark proposal setting rules for non-statutory benefits, including the provision on cafeteria plans (BI, March 12, 1984).

However, the Senate declined to consider permanent rules for non-statutory benefits and did not accept the Stark-Conable limitations on cafeteria plan offerings. Instead, the Senate tax bill barred the Internal Revenue Service from imposing rules on non-statutory benefits through Dec. 31, 1985 (BI, April 23, 1984).

A congressional conference committee that ironed out the differences between the House and Senate tax bills eventually accepted the Stark-Conable proposal that prohibits cafeteria from offering many taxable benefits but allows them to offer unlimited group and dependent term life insurance and extra vacation days.

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Meeting face to face

Insurer's executives work alongside independent agents

By LINDA J. COLLINS

LAWRENCEVILLE, N.J.—Top executives at American Reliance Insurance Cos. know what it's like to be an independent agent: They visited agencies for two months last year to get acquainted with the agents' side of the business.

In July, American Reliance, formerly known as The Farmers' Reliance Insurance Cos., announced it would conduct a major field operation, dubbed EZ-One. Top company executives and department heads would spend several days in agencies and observe their operations firsthand.

The company, which has an A-plus Best's rating, writes property/casualty lines in seven Eastern states: New Jersey, Pennsylvania, Delaware, Maryland, Virginia, Florida and Georgia. Gross premium volume totaled \$31.5 million in 1983, and the company posted a combined ratio of 107.5% that year.

Nineteen American Reliance executives, including President Bruce W. Herrick, and 19 agencies in five states participated in the initial project. The agencies' premium volumes ranged from \$600,000 to \$10 million.

The executives spent more than 1,150 hours in agencies and studied almost all areas of agency operations, including accounting, agency management, automation, claims, sales, service and underwriting.

"Each executive visited more than one agency—one no one less than two," Mr. Herrick said. "Each one concentrated on at least one discipline, some more. For example, underwriting executives looked at pure salesmen, customer service representatives and placers (who determine through which insurer to place a risk)."

The program was a learning experience for the company officials, they said.

Some of the problem areas the American Reliance executives anticipated they would find during their visits turned out not to be problems.

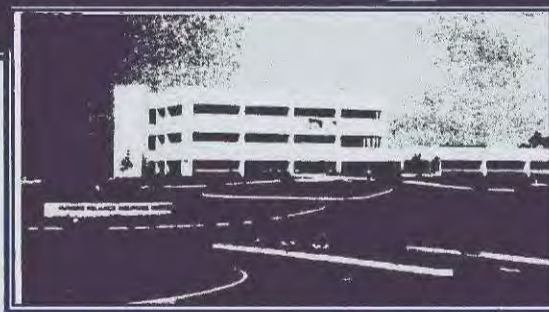
"Companies think they know what the problems are," explained William T. Stinson, assistant vp of claims. "We anticipated what the end results were going to be, and we had a different finding altogether. What we thought they needed, they didn't need at all."

"I learned more than I thought I was going to learn, so you can turn that around and say I didn't know as much as I thought I did," said John Easter, American Reliance's vp of administration.

"You never really know what's going on until you have the opportunity to get out there. . . . Some of the things became very vivid after my visits to the agencies."

Mr. Easter said that of all the operations he observed, three things impressed him the most:

- The clerical intensity of agencies. "They have a tremendous amount of procedures to go through to process business, answer questions and service claims."



American Reliance President Bruce Herrick journeyed from company headquarters, left, to work with Willard Young and Brenda Boraski at Young & Perry Insurance in Bridgewater, N.J.

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- The fact that agencies handle personal lines business and commercial lines business separately. "CSRs handle almost everything in personal lines. Agents get much more involved in commercial lines."

- The difference it makes when you know the person on the other end of the phone. "The personal rapport that develops between two people over a period of time is impressive. We are now addressing this need. Every agency will be designating certain underwriters with whom they will be able to build a rapport."

Agents who participated in the program say they were surprised and pleased that the insurer had taken the time to learn their problems.

"This was the first time in all my years of business that a company executive has come out to see how an agency is actually operated," said Ralph M. Lord, president of Hardesty Insurance Inc. in Dover, Del., one of the agency participants.

"Our initial reaction (to the EZ-One program) was one of anticipation," said John V. Crowell, vp of

Boynton & Boynton Inc. in Red Bank, N.J. "We wanted to cooperate and thought it would be fun. When they came out and the significance and scope of what they were doing sank in, we became very proud of our agency."

"I'm an eternal optimist. I keep hoping someone will take the time to listen," said Karl Gebhart, president of Records Gebhart Agency Inc. in Smyrna, Del., another agency involved in EZ-One. "American Reliance is basing its operations on firsthand experience rather than a board meeting."

Mr. Gebhart does not think that traditional agent councils formed by insurers are nearly as effective as the American Reliance approach.

"I've served on a lot of agency/company councils. They (the company participants) talk for two hours, buy you lunch, give you a cigar, maybe play golf and then send you home."

"These people are not like that. Everything (American Reliance does) is geared to 'What can I do to get you to write more business?'" he added.

Continued on next page

Should you link with a bank? . . . See story, page 20C

Insurer executives hit the road to work with agents

Continued from preceding page

John T. Abram, president of John T. Abram Inc. in Oreland, Pa., also agrees that the EZ-One program was much better for agents than the agent councils. "Agent councils are a hand-picked ego trip. They are like putting salve on a wound—not much is done.

"I give (American Reliance) credit for taking a bona fide interest in trying to find out what (agents) need. They should be commended for undertaking the program. It has created a better understanding between our agency and the company."

"I think it was a very affirmative move on the part of American Reliance to take on such a program," said Thomas L. Glen Jr., president of the Crema-Hammell Agency Inc. in Absecon, N.J., and chairman of Glen Insurance Inc. in Northfield, N.J. Both agencies participated in the EZ-One program.

"They want to be a survivor, and with this program, I'm sure they will be."

Although the American Reliance executives participating in the program admitted that at first some of the agency employees were a little uncomfortable about the prospect of being observed by an insurance company executive, the initial discomfort gave way when they realized that the executives were not there to make personal judgments.

"Once I assured the people that I was purely there to observe and not to report any problem areas to their principal, it was fine," said John Danka, American Reliance's manager of operations. "I told them the information was for the company, to determine any problem areas or needs.

"We found there were many commonalities—in gathering information, etc.," Mr. Danka added. "We found out we wanted the same thing—to improve the processing of information in the office."

Agency employees were not the only ones to feel slightly uncomfortable at times. At least one company executive experienced similar feelings.

"When you sit next to a commercial un-

derwriter and you are dying for (a particular piece of business) that comes in, you find out how (that agency) views your company. It's kind of a self-cleansing experience," said Robin Van Bruggen, American Reliance's Salisbury, Md., branch manager.

"In that situation," he explained, "when your company does not get the business, you wonder why. I wanted to ask for (the account), but instead I just took notes."

The personal visits, according to Mr. Van Bruggen, were very beneficial to the insurer. "It's hard for someone to get their point across on the phone. When we go out and sit down with them, not only do we get more business, but the quality is much better. The whole image of the company has been changed."

The EZ-One program has been met with such enthusiasm by company and agency personnel that Mr. Herrick said it "is becoming a permanent part of our job description for underwriters and a number of executives and management people."

For instance, Karen Fulton, the insurer's vp and comptroller, notes: "It has been extremely positive for American Reliance. It gave us a good knowledge of what was going on, and a lot of feedback from agents. It showed us the way they plan, the way they organize and a lot of little things that are going on."

Mr. Easter echoed Ms. Fulton's sentiments. "We got (our agents') attention. What we're doing here is different," he said. "We are actively determined to make our company easier to do business with. We are getting aggressive to show agents that we are a good company."

Mr. Herrick said that American Reliance is also considering the possibility of turning the program around so that agency personnel will be able to visit the insurer and observe its operations.



'I give (American Reliance) credit for taking a bona fide interest in trying to find out what (agents) need. They should be commended for undertaking the program,' says John T. Abram, president of John T. Abram Inc.

Alicia Demil, sales coordinator at Young & Perry Insurance in Bridgewater, N.J., explains the agency's sales procedures to American Reliance President Bruce Herrick.

Program spawns changes at American Reliance

LAWRENCEVILLE, N.J.—American Reliance Insurance Cos. knew the job wasn't over after its top executives visited independent agencies for two months last year.

After the field study was completed, the executives formed interdepartmental task forces to study the information gathered and to determine how to help solve agents' problems.

But, American Reliance wanted agency input in this phase of the project, too, so it invited all of its 625 agents to give suggestions on certain issues through what were dubbed EZ-One Talk Backs.

EZ-One Talk Backs are bulletins that were sent to agents when the insurer was not clear what step to take to help agents with a particular problem, explains American Reliance President Bruce W. Herrick. An issue was explained on one side of the bulletin, and the agents could write their ideas on the flip side.

"We got better than a 50% response ratio" to the bulletins, Mr. Herrick explained. He said the insurer was surprised by the high response rate, which indicated that agents are very interested in making their thoughts known. "We will (continue to) use this type of vehicle to solicit their input on a broad basis," he added.

The task forces identified several problem areas and then determined methods of solving those problems. Some of the problems identified by the task force and their proposed solutions include:

- Agents are drowning in paper work. To help reduce the amount of paper work, the insurer streamlined its direct billing system; simplified its renewal system; announced the availability of an auto policy with an annual policy term; is providing its agents with floppy disk rating programs for homeowners and auto policies and is considering developing disks for other lines; and is guaranteeing 96% error-free policy issuance.

Mr. Herrick said that to reduce policy-issuing errors, "Each department has set up quality-control sampling procedures, where we pull samplings from each department to check their quality. Records of any problems are kept permanently in employees' files."

According to Mr. Herrick, either someone from within the department or a supervisor is appointed to check quality. The procedure is set up differently for each department. Sampling is done on a daily basis, although

American Reliance

"each employee might not be sampled every day." Mr. Herrick said that if too many errors are found, the company will increase the quality control procedures or retrain the employee in question.

- Insurance companies often are not consistent when it comes to accepting risks and writing business, and agents suffer the consequences.

To solve this problem, American Reliance has put its underwriting strategy in writing by means of a simple chart that quickly explains to agents which lines of business American Reliance desires, which it does will not write and which it will consider on an individual basis.

The insurer has committed itself to maintaining this strategy for a minimum of one year and is communicating this strategy to its employees.

- Agents lose time and business because of their inability to provide fast and accurate quotes.

To address this problem, the insurer has implemented a new quoting system.

Agents themselves can now rate automobile, homeowners and business owners policies. The insurer has also set up Dial A Quote, a 24-hour phone-quoting system

agents can use in special cases. American Reliance is averaging 50 calls a week across all lines on the Dial A Quote system, according to Mr. Herrick.

The company also is promising agents 10-day turnaround time on all quotes.

"I was impressed with their follow-through, both on the 24-hour quotes and on the 10-day turnaround time on all quotes," said Jerry Elliott, president of Henderson, Elliott & Pryor Insurance Agency Inc. in Salisbury, Md.

- Agents often must spend more time selling an account to an insurer than they spend in selling to their clients.

American Reliance plans to combat this by assigning underwriters to specific agencies with which they can build a good rapport. Underwriters now will be required to spend more time in the field with agents to develop a better understanding of the problems agents face.

The insurer also is increasing its underwriting staff and expanding underwriting training programs.

- The number of manuals and supplemental materials an agency must keep on hand to service all the companies it represents can be overwhelming.

To address this problem, the agency has redesigned its manuals.

According to Jack Scott, manager of field marketing for American Reliance, "Our method of computing rates for easy accessibility of agents—specialty rating in particular—was not as good as it should have been. Manuals are hard to work with. We reduced the size of these to facilitate their ease of operations."

The insurer has also designed a Fast Facts information distribution system. Communications from the insurer are generally printed on a single sheet of paper in an information mapping technique, which

allows an agency employee to quickly scan the notice to get the most essential facts. Mr. Herrick said Fast Facts sheets are sent directly to all agency employees who need the information.

American Reliance is now designing easy-reference guides that will be available to agents by April 1 and will be updated each year. The guides will outline the insurer's products and state its pricing structure and the classes of business that it writes in a small, easy-to-handle format.

- Agents generally do not have the time or money to develop effective marketing tools and must conduct these efforts on a "hit-or-miss" basis.

To address this problem, American Reliance is designing marketing materials for agents to use on specific company product promotions.

American Reliance will make available to agents—in return for a volume commitment from the agency—advertising materials, sales training programs, expiration date and prospect lists, direct mail campaigns and telemarketing programs.

In order to avoid making unrealistic production demands of agencies, Mr. Herrick said the insurer has introduced Joint Business Planning, a program in which executives go out into agencies and plan production goals for each year.

The plan represents an "informal contractual agreement between us and the agency," Mr. Herrick explained.

"Agents have been pleased with this approach."

American Reliance's new programs are winning the praises of its agents.

"The additional services they are implementing are fantastic," said Laura J. Cummins, personal lines coordinator for Insurance & Risk Managers Inc. in Hackettstown, N.J., an EZ-One participant.

"It's more than we had hoped for," Ms. Cummins noted.

—By Linda J. Collins

Agents can increase sales through bank ties: Expert

By LINDA J. COLLINS

CHICAGO—Insurance agents are finding themselves in the midst of a "distribution revolution" and must find newer, less expensive methods of reaching prospective clients if they want to remain competitive, an agent and consultant says.

One way to achieve this goal is to form an alliance with a financial institution like a bank or a savings and loan, says Ken L. Williams, president of Alabama Insurance



Mr. Williams

Exchange, an independent agency, and Banclines Programs Inc., a consultant that arranges ventures between agents and financial institutions. Both are based in Birmingham, Ala.

Mr. Williams explained the advantages of forging these alliances at a series of seminars presented by consultants Insurance Marketing Services of Santa Monica, Calif. At a seminar held recently in Chicago, Mr. Williams noted that, according to statistics compiled by consultant Russell Miller Inc., independent agencies with less than \$6 million to \$7 million in premium volume only control 15% of the U.S. property/casualty market. The rest is in the hands of larger agents and brokers and direct writers.

Smaller agents can increase their market share by tapping the customer base of a financial institution, he suggested.

"While I understand why the IIAA, PIA and Canadian agent associations are trying to fight (the entry of banks into the insurance business), they are largely shadow boxing," Mr. Williams said.

"The financial community is much more advanced in recognizing the resources they need than are the potential resources," Mr. Williams added. "If the insurance fraternity does not step forward with the help, banks are going to create it on their own and steal from the insurance community."

"In developing a marketing program, we have to understand that we are in a distribution revolution," Mr. Williams said. "It's a distribution revolution because the cost of commodity lines of insurance must come down, both on the agency and direct-writing sides."

He said that linking with financial institutions can cut an agency's costs substantially, since the agency can take advantage of the collection mechanisms the institutions already have in force.

"Financial institutions bring a premium collection system to the table that is immediate and efficient" through use of automatic credit card payments or checking account withdrawals.

The customer lists of banks offer a second advantage to agents, according to Mr. Williams.

"Demographics are vital... Financial institutions bring the best list to the table of anyone. The bank list is current," he said, noting that other types of client lists, even those provided by professional list compilers, are not as up-to-date or complete as financial institutions' lists.

A third advantage of linking with banks is their perceived credibility. Mr. Williams alluded to studies that say consumers assign financial institutions a credibility factor of eight on a 10-point scale, while insurance salespeople only rate a two.

"Our marketing plan is what got us a two," Mr. Williams added. "If we adopt one that is uncommon, we can raise this rating."

Banks are also eager to form alliances with agents. "Banks want agents in their offices because they have lobbies they could shoot a cannon through and not hit anybody," Mr. Williams said, noting that other businesses could increase lobby traffic.

In addition, banks do not have the technical staff or the marketing know-how to properly sell insurance, he said.

Independent agents and banks can form a mutually beneficial relationship, provided the arrange-

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Expert tells how to form alliances with bank

Continued from page 20C

ment is carefully planned and tested through the proper authorities before being finalized, Mr. Williams said.

The Garn-St. Germain Act of 1982, which is perceived to have blocked banks from engaging in insurance activities, "put banks in the insurance business," Mr. Williams said. "It just limited the size of the players."

Agents, he said, can construct deals with banks through the "Swiss cheese" of the regulations. "You structure your deals through the holes."

According to Mr. Williams, the law says bank holding companies with less than \$50 million in assets "can do just about anything in insurance marketing they want to do," noting that 2,300 of the nation's 3,500 bank holding companies have less than \$50 million in assets.

In addition, 16 major regional banks with pre-existing insurance operations come under grandfather clauses in the act, he said, adding that 15,000 banks in population areas of under 5,000 are also permitted to sell insurance.

Also, bank service corporations, such as savings and loans and credit unions, can invest up to 5% of their assets—jointly or severally—in insurance services operations. This may affect some 10,500 additional banks.

Another way agents and banks can forge an alliance is through Small Business Investment Corporations, through which banks can invest venture capital into an organization, such as a new corporation formed by a bank and an insurance agency.

The bank is permitted to own from 24.9% to 49% of a new insurance agency venture through an SBIC, depending upon how the deal is structured, he said, noting that both Citibank and Bank of America have entered the insurance business through SBICs.

In addition, 27 states currently have no prohibitions on state bank insurance sales, according to Mr. Williams.

"Unless (new) regulations hit, there's a way to structure a bank deal with any financial institution. There are more financial institutions ready than there are agents prepared to enter the business," he said.

Any arrangement between agencies and financial institutions should be structured with the recognition that regulations are going to change, according to Mr. Williams.

In structuring a deal with a financial institution, "You have to pick your partner carefully," Mr. Williams warned agents. "These deals will lose money the first year."

He said by the second year, the agency will have regained what it lost in the first year, and it will break even in the third year. It will begin to make a real profit in the fourth and fifth years.

"Will the financial institution still be there (in five years)?" Mr. Williams asked. "These have to be long-term relationships."

Before approaching a prospective financial institution, Mr. Williams told agents they should have already formed a basic marketing plan, complete with the type of arrangement they intend to make with the bank, the products they will sell, the insurers they will represent and timetables and production forecasts.

Other agents may have already contacted the institution and, for an agent's offer to stand out, it must be backed with a game plan. "An agent who comes in and shows a

bank actual numbers is going to have an advantage," he said.

An agency should also stress to the bank that it will locate viable prospects through direct-mail or telemarketing efforts, and that the agent will only personally contact those customers who reply and ask to be contacted. In this way, the financial institution will not risk lowering its credibility to its clients.

There are several methods of structuring a deal between a finan-

cial institution and an agency:

- The bank can own a new agency that is formed as venture between the bank and the original agency. The old agency would perform the insurance operations for the "paper company" (the newly formed agency) as a contracted manager, drawing a percentage of the profits in payment for this function, while the bank would control the new corporation.

All transactions involving the client base of the financial institu-

tion would take place through the new entity, while the old agency would conduct its pre-existing business from within its original operations.

According to Mr. Williams, this is the most desirable arrangement.

"In structuring a deal, the financial institution should own the agency that is formed. One way is to set up a new corporation with a name identity closely akin to the financial institution's. It can't be the same (because of regulations), but it

should have an affinity with the original," Mr. Williams said. "If an eagle faces left on the financial institution's logo, have the new corporation's logo show an eagle facing right."

The only problem with such an arrangement is that such ventures may be prohibited by future regulations.

"The uncertainty of future regulations will potentially affect the existing agency, if the new agency

Continued on page 20E

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Continued from page 20D
is bought by the financial institution," Mr. Williams pointed out.

- The bank can gain "beneficial control" of 100% of the new corporation through a loan and/or contractual agreement. For example, Mr. Williams said the bank can purchase 24.9% of the new company through an SBIC and have the contractual right to purchase the rest of the agency when regulations permit.

- The bank can simply rent its customer list to the agency.

Mr. Williams noted there is "no privacy law on name and address distribution." But, he added that if he were a banker, he would not

enter into such an arrangement, because the bank would have no control over what the agency does with the list.

- The agency can rent space in a bank's lobby. "These are the easiest deals to make," Mr. Williams said. "They take the least amount of structure."

Bank lobbies require "an appearance of presence" from the agency, Mr. Williams noted, but that does not mean that the agency actually has to place staff members in the bank. He suggested the agency could install a sign, a desk, brochures and a phone in the bank lobby that automatically rings the agency.

"Nothing says you need a person there."

Whatever arrangement an agency decides to make with a financial institution, the agency "needs to go to all proper regulatory authorities before finalizing any deal," including the state insurance commissioner and the attorney general's office.

He also warned agents to not attempt to contact a financial institution's installment loan clients. In this way, they would avoid any threat of regulators accusing them of making credit tie-ins. "Don't touch installment loan people with a 10-foot pole.

"If you challenge this, you will

probably get nipped!"

Mr. Williams also told the agents that "financial institutions are not the only game in town," noting that similar deals can be struck with any organization that has "a customer base and premium collection mechanism.

"Any time you have a third-party center of influence, a customer base and a way to sell more than one-on-one, you've got a (potential) deal," he said.

The consultant also told agents that "all deals aren't good. A deal with a bank is not going to make an unhealthy agency healthy or a healthy agency rich, but good deals are out there." ■

How to make venture work

CHICAGO—Once an agency has formed an agreement with a financial institution, how should it market its products?

The most-effective way to accomplish this, according to agent and consultant Ken E. Williams, is through a well-planned direct-mail and telemarketing campaign.

A computer is essential to such an approach, both in producing the mailers and in processing the subsequent business, he says.

"Computer capabilities today were unheard of three years ago," he notes. "The improved technology makes telemarketing more effective. . . . Long distance 800 numbers and direct mail will dominate insurance marketing by the end of the 1980s."

Before designing a direct-mail campaign, an agency should create products that are unique enough to "defy 'apples-to-apples' price comparisons," Mr. Williams urged. If an agency's products are similar to every other agency's products, their availability isn't likely to trigger much consumer response.

Before trying to send product information to a bank's clients, Mr. Williams suggests the agency engage in some advance promotion, leaning on the credibility of the bank by emphasizing the partnership between it and the agency.

Mr. Williams suggests the agency initially conduct a 90-day institutional advertising campaign, including newspaper ads, institutional brochures (not product brochures), envelope stuffers sent with bank statements, outdoor advertising and radio ads.

A desk in the bank lobby, with brochures and a phone that directly dials the agency, should be set up at this point as a reminder to the bank customers that your agency's services are available.

After this advance promotional effort, a direct-mail campaign should be conducted "very, very carefully," Mr. Williams said. An agency should enlist the assistance of a direct-marketing expert to compose promotion letters.

Agencies should set up a monthly timetable for mailings and design a direct-mail package complete with a sales letter, a brochure, a response card and a carrier envelope to attract consumers' attention.

The direct mail pieces should be followed by telemarketing efforts to prospects who reply.

"Direct mail is a developer of (expiration) dates. It preheats," Mr. Williams said, adding a telemarketing follow-up closes the sale.

Customer service representatives can service between 2,500 and 8,000 policyholders. On new business, if the proper arrangement exists between the agency and the insurer, information for a quote can be taken over the phone.

A CSR can enter information into the computer and, with the appropriate software, can give the prospect an initial quote immediately. Mr. Williams suggested that the CSR quote both monthly and six-month amounts.

If the initial quote is acceptable to the prospect, the CSR can calculate the necessary additional information to send a final quote and application to the prospect by mail. The prospect can then sign and return the forms to the agency or simply phone the service center. If automatic payment withdrawal through a checking account or credit card is authorized, the coverage can be bound immediately.

Claims, Mr. Williams says, can be handled two ways. They can be reported directly to the insurer or to a CSR in the service office. If the agency is large enough, the insurer may put an adjuster in the financial institution to handle claims. ■



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Finding right insurer is critical for agency/bank arrangement

CHICAGO—Choosing an insurer to represent is an essential step in any successful arrangement between an independent agency and a financial institution, says agent and consultant Ken E. Williams.

"The most critical thing in any deal is to choose the right company partner," he stressed. A desirable client base furnished by a bank or savings and loan is no good to an agency without products that will attract prospects' attention, competitive pricing and solid company support.

Mr. Williams said an agency should only write homeowners and auto programs sold to a bank's clients with a single insurer, preferably one it does not currently represent.

'Agents ought to call a beauty contest... bringing in one of each type of insurer,' says agent and consultant Ken E. Williams.

If the business is written through an existing insurer, he said, the insurer probably will want to keep the same type of an agreement for the agency's bank business that it currently has in force with the agency, rather than negotiating a separate arrangement.

Since all income must be split between the agency and financial institution, and since the agency must be able to provide a consistent market availability to the financial institution's clients, Mr. Williams said it is important that the arrangement with an insurer is structured differently from a normal agency/company agreement.

He stressed that the company and agency need to have a market consistency arrangement down in writing to guarantee that neither the company nor the agency can violate their agreements for a stated time period, preferably for five years up-front and annually renewable thereafter.

Mr. Williams added that using a single insurer on this business is essential because using more than one insurer "doubles the problems" for customer service representatives and delays quotes and policy processing.

Two important questions for an agency to ask in choosing the right insurer, Mr. Williams said, are:

- Does the insurer have a written marketing strategy that is supported by management?
- Is there the product capability to stay within a competitive price range?

"There aren't 15 or 16 insurance companies in that shape right now," Mr. Williams said. "Their mind might be willing, but the body is not capable of producing what needs to be done."

It's important to find an insurer that will agree to an arrangement that will benefit both parties. Mr. Williams said that, as a rule of thumb, "Most insurers in this marketplace right now want to cut acquisition costs three points, either through the agent doing more work or taking less commission."

The consultant said he has seen no bank/agency arrangements where the insurer's commission to the agency for auto insurance is less than 12% or more than 17%, or where the homeowners commission is less than 17% or more than 22%.

Mr. Williams noted agents looking for a company can choose from four different types of insurers:

- Direct writers, like Sentry Insurance Cos., that will deal with independent agents.
- Life insurers, like Metropolitan Life Insurance Co., that will also deal with independent agents.
- Large, national property/casualty insurers.
- Regional companies.

"Agents ought to call a beauty contest... bringing in one of each type of insurer," he said, noting the agent will be able to examine four different approaches. Then the agency should "choose the best one" for its particular needs, Mr. Williams said.

Agents should have a contractual guarantee that the insurer will provide market consistency over a five-year period, if the agency meets its stated production requirements.

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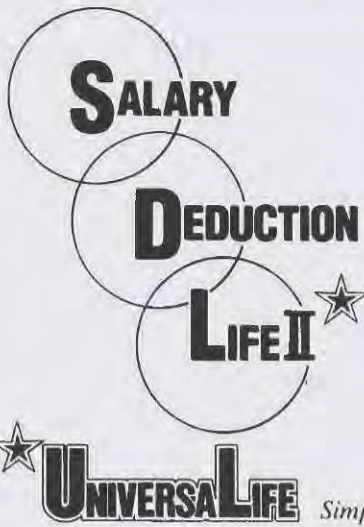
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• "The Captive Insurance Company" examines the growth of **off-shore insurance captives**. Off-shore locales such as Bermuda and the Cayman Islands are described in the 80-page book, which also discusses why to form captives, how they are managed and their potential for profit. The book lists more than 650 captives, their locations and who owns them. It costs \$12.95 and can be obtained from Interstate Service Corp., P.O. Box 1725, Oklahoma City, Okla. 73101.

• A five-part videotape program has been designed by the Independent Insurance Agents and Brokers of Calif. for use as a training aid for dealing with **agency management issues**. The program is accompanied by a 64-page workbook with data on agency cost analyses, a company rating sheet, job descriptions, producer compensation packages, an agency action plan, market segmentation and a linear responsibility chart. The program, "Vaughan at AMC: The Agency Profit Plan," is designed so that an agency can show different segments of the film to different members of the staff. The three-hour tape is available in VHS or Beta. Rental for 14 days is \$75, plus \$7.50 for additional workbooks. The tapes can be purchased for \$345. Contact Darrell Gwynn, IIABC,

465 California St., #600, San Francisco, Calif. 94104; 415-981-2714.

• The National Assn. of Professional Insurance Agents has a brochure for agents to distribute to clients who are considering or now use **woodburning stoves**. The brochure, "Woodburning Stove Safety," gives tips on how to select a well-constructed stove, how to make sure the chimney is sound and clean, what to do in case of a chimney fire and how to safely install a stove. PIA members can obtain copies for \$5.95 for 100, \$16.95 for 500 and \$29.95 for 1,000. For non-members, the cost is \$6.95 for 100, \$18.95 for 500 and \$32.95 for 1,000. State and local tax should be included. To order, contact the PIA, P.O. Box 98, Glenmont, N.Y. 12077; 518-434-3111.



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Firm helps small agencies develop marketing plans

STONEHAM, Mass.—Many insurance agencies lack a cohesive marketing plan but do not have the money to hire a full-time marketing person.

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Through MarkeTemp, agencies can rent an insurance marketing professional "by the day, week or project."

The firm's founder and president, A.R. (Gus) Eovine, spent the last 21 years as head of Commercial Union Insurance Co.'s Beacon Advertising Agency, which offered advertising assistance to agents representing the insurer. When Beacon was closed as a cost-cutting measure, Mr. Eovine decided to form MarkeTemp to continue of-

fering marketing assistance to agents.

The first step a MarkeTemp professional takes in developing a marketing program for an agency is to conduct an in-depth interview within the agency to examine the overall situation. The marketing professional will gather information on the agency's history, goals, any special services or areas of expertise it has developed, as well as on its past marketing and advertising efforts.

Other things the firm takes into consideration during the interview are the agency's:

- Staff experience.
- Market share.
- Account analysis.
- Competition.
- Growth trends.
- Image.
- Level of automation.

The marketing professional then assigns a team of MarkeTemp employees to the account to analyze the information gathered.

The team determines how balanced the agency's book of business is, not only by commercial and personal lines, but also by the age of the insureds, types of businesses insured and the income levels of clients.

"Agents generally sell to people of their own age and income level," says Mr. Eovine, suggesting this creates problems when an agency principal is ready to retire and sell his or her business, and most of his or her clients are also nearing retirement.

"We may suggest that they hire producers of different ages" to avoid such a situation, he said.

Mr. Eovine says his staff evaluates the agency's past advertising and marketing efforts. It conducts research to determine the population, housing, number of auto registrations, employment distribution and status, business growth trends and average income in the agency's region to determine the agency's growth potential.

After this research and analysis is complete, the MarkeTemp staffer returns to the agency and provides both a short-term and long-term goal for balancing its book and expanding its business.

Mr. Eovine said that if MarkeTemp determines an agency is experiencing difficulties because of its location, it might suggest that the agency relocate, but the firm does not make suggestions regarding reductions or changes in an agency's staff.

The company's staff members work with the agency in developing a successful advertising program, he said, noting they help the agency create artwork and copy for ads as well.

The firm also conducts research to determine the most effective medium and schedule for the agency's advertising campaign. MarkeTemp will then monitor the results of the ad campaign and make adjustments in the program, if necessary.

Mr. Eovine says MarkeTemp may enter an arrangement with an insurer so that the insurer can subsidize its agencies that want MarkeTemp services.

MarkeTemp is currently concentrating its efforts on the East Coast, because agencies located in other regions would have to reimburse consultants for travel expenses, which could make the firm's services too expensive for a small agency.

Mr. Eovine stressed that MarkeTemp will not offer its services to two agencies that compete. "If they were geographically close, I could not represent both," Mr. Eovine explained.

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Shareholder suits

Continued from page 2

suits are without merit and that insofar as the accident in Bhopal is concerned, we believe that fair compensation can be provided to the people affected by the accident with no adverse effect on the company's financial condition," said William Krohley, Union Carbide outside counsel with the New York firm Kelley Drye & Warren.

A Union Carbide spokesman said the firm would not comment on the litigation or its insurance.

However, Gene Mesh, a plaintiff's attorney with the firm of Gene Mesh Co. of Cincinnati, said that he understood that Union Carbide has around \$50 million of directors and officers liability insurance.

The names of the insurers could not be learned, but two leading D&O insurance underwriters—Harbor Insurance Co. of Los Angeles and underwriting manager Shand, Morahan & Co. Inc. of Evanston, Ill.—said they did not underwrite D&O insurance for Union Carbide, and American International Group and International Surplus Lines Insurance Co. of Chicago would not comment.

The shareholder suits are in addition to several personal injury suits filed against Union Carbide.

Those suits, filed in various courts around the country, are seeking billions of dollars in damages. Union Carbide has \$200 million in comprehensive general liability insurance (BI, Dec. 10, 17 and 24-31, 1984).

All of the shareholder suits name as defendants Union Carbide Corp., its Chairman and Chief Executive Officer Warren M. Anderson and President and Chief Operating Officer Alec Flamm.

Two of the suits also name Executive Vp and Chief Financial Officer J. Clayton Stephenson and Vp and Controller Louis G. Peloubet. One complaint also names other members of Union Carbide's board.

The four lawsuits were all filed in U.S. District Court for the Southern District of New York.

Attorneys also say a derivative action is being prepared. In a derivative action, shareholders sue the officers and directors of a corporation on behalf of the corporation for the failure of the directors or officers to act in a prudent manner to the detriment of the corporation.

Plaintiffs in the suits include shareholders who purchased Union Carbide stock between December 1981 and Dec. 10, 1984. However, the number of shareholders involved in each potential class and the time period covered differ in the complaints.

One suit was brought by an investor who reinvested dividends from stock in the Union Carbide Dividend Reinvestment and Stock Purchase Plans.

That suit says more than 27,000 people purchased Union Carbide common stock in the class period under the Dividend Reinvestment Prospectuses and Registration Statements.

Another suit that names shareholder Newell Mason as plaintiff was brought on behalf of shareholders who purchased stock between June 1, 1982, and Dec. 10, 1984.

On June 1, 1982, the firm received findings of an operational safety survey on the Bhopal plant that detailed numerous safety hazards. On Dec. 10, 1984, those findings were disclosed to investors and the public.

The suits were brought under various theories of liability citing sections of the 1933 Securities Act and Rules 10b and 10b-5 of the Securities and Exchange Act of 1934.

In the complaints, the shareholders contend that Union Carbide knew of the dangers at the Bhopal plant but failed to disclose them to investors in quarterly and annual reports in 1982, 1983 and 1984.

According to the lawsuits, the information Union Carbide allegedly had but did not disclose to investors included that:

- An "operational safety survey" was conducted in May 1982 and 10 major deficiencies at the plant were specified.

- Union Carbide was manufac-

turing methyl isocyanate (MIC) and storing it in huge quantities at the Bhopal plant and that it was "so ultrahazardous and poisonous that it could cause catastrophic effects if it were accidentally released in the nearby urban environment..."

- The Bhopal plant safety systems and procedures were inadequate and/or substantially less adequate than the automatic safety systems used in a similar Union Carbide plant in West Virginia.

- In the event of an MIC accident, Union Carbide would be exposed to billions of dollars of losses in punitive damages and personal injury lawsuits, that its insurance coverage may be inadequate to cover such claims and that its corporate image, good will and reputation would be seriously damaged.

- Several serious accidents had occurred at the Bhopal plant involving the release of MIC gas, including one after the May 1982 report, and corrective measures were not taken or were inadequate to remedy the major deficiencies listed in the 1982 report.

"Defendants knew or should have known that since Union Carbide was in the business of handling, storing and processing ultrahazardous chemicals, a serious leak of such ultrahazardous chemicals would cause the assets of Union Carbide to be exposed to pay for damages resulting from the liability of Union Carbide," says the Mason suit.

"However, defendants did not disclose that they had insufficient insurance to cover the damages they would incur as a result of such an incident.

"Defendants knew or should have known that such an incident would cause the shareholders of Union Carbide to be left with little or no equity in the corporation and expose the company to the possibil-

ity of bankruptcy," the suit adds.

As a result of the defendants' dissemination of "false and misleading" reports and failure to disclose information, the market prices of Union Carbide common stock were "artificially inflated" during the class period, two other suits add.

"At the time of the purchases by plaintiff and the class of said securities, the fair market value of said securities was substantially less than the prices paid by them," the suits say.

The Mason suit also quotes Union Carbide's 1982 Annual Shareholder's Report, which says the firm has "exceptional qualifications for meeting rough environmental and safety standards associated with agricultural chemicals."

"The above statements were false and misleading in that they did not disclose the risks involved in producing insecticides from highly toxic substances and that many safety problems that had already been experienced by Union Carbide India Ltd. and not disclosed to the shareholders or investing public at the time of the publication of the 1982 Annual Report," the suit adds.

According to shareholder attorney Mr. Mesh, companies have a duty to advise the marketplace about information that is material to the company.

He estimated that investors could lose \$100 million to \$200 million because of the drop in value of the Union Carbide stock.

Meanwhile, in the personal injury litigation, plaintiffs' attorneys have filed petitions before the panel on multidistrict litigation in Washington seeking to consolidate discovery proceedings in one federal court for all of the Union Carbide cases.

A spokesman for the panel said the plaintiffs' attorneys who are

seeking the consolidation are asking that the discovery proceedings be consolidated in federal courts in either the District of Connecticut or the Southern District of West Virginia.

Union Carbide is headquartered in Connecticut and has a plant that makes MIC in West Virginia.

According to plaintiffs' attorney Stanley Chesley, the attorneys petitioned the panel because "it makes no sense for the corporation (Union Carbide) to submit information to all the courts."

The spokesman for the panel said a hearing date will be set to consider the petitions but it will probably be several months before there is a decision.

Also last week, the state government of India said it would file suit in the United States on behalf of the state, state employees and victims of the gas leak. It also appealed to the general public not to enter into individual agreements with foreign lawyers for bringing suits. ■

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Insurers scramble to find reinsurance

Continued from page 1

Another broker who asked to remain anonymous said that casualty treaty capacity overall is shrinking fast. The broker added that large limits aren't necessarily evaporating, but he said that facultative contracts will have to replace the lost treaty capacity.

"The available facultative capacity will determine what limits can be built," he explained.

Mr. Blanch says he hasn't had any problems completing required limits, but that rates have risen substantially.

"The gist of the situation was that we were dealing with new price levels associated with completing those limits," he said.

Hardest hit were upper-layer umbrella coverages, where rates increased by as much as 300%, and medical and non-medical professional liability, according to Mr. Blanch.

Some contracts, however—including property catastrophe-layer reinsurance—renewed at last year's rates. In these cases, Mr. Blanch said, reinsurers relied on price increases imposed by underlying primary insurers.

Rates on upper-level workers compensation reinsurance have jumped 200% to 300%, and one ceding company was hit with an overall 72% price increase in its workers comp reinsurance program, accord-

ing to Mr. Taylor.

Employers Reinsurance Co. of Overland Park, Kan., is getting rate increases of 50% to 300% on facultative hospital malpractice reinsurance, according to Executive Vp G. William Gunnison.

On facultative casualty risks, excluding hospital malpractice, rate increases are ranging between 25% and 50%, while rates on property facultative risks are up between 100% and 200%, he said.

Along with higher rates, most brokers and reinsurers report that more restrictive conditions are being imposed in the latest round of renewals.

One such restriction is a demand by many reinsurers for higher net retentions.

"You either raise the bridge or lower the water," said one reinsurance company president, explaining that on casualty business either rates or retentions must go up. In some cases, he added, both must rise.

However, Mr. Blanch said that while he has seen some retention increases, "there haven't been as many as I suspected there might be."

Following the London market's lead, reinsurers are also adding restrictive clauses to contracts, including a clause in property contracts intended to limit reinsurers' exposures to winter storm losses. The clause defines as a single occurrence losses arising over a single 168-hour period.

In addition, brokers and reinsurers report that reinsurers are cutting the ceding commissions paid on some contracts.

Commissions on pro-rata treaty business have declined as much as

25% to 35%, according to Mr. Taylor.

American Re-Insurance Co. has replaced flat commissions paid on some property pro-rata contracts with commissions based on a "swing plan," according to Executive Vp Edward B. Jobe.

Under the new plan, minimum and maximum commission levels are based on an account's underwriting experience. With the latest round of renewals, the calculations have included the underwriting deficits experienced in the past few years and have resulted in lower commissions paid to ceding companies by American Re, Mr. Jobe said.

Among the toughest renewals this year are the retrocessional agreements that protect reinsurers, especially proportional retrocessions, sources agree.

Proportional retrocessions "just

cannot be renewed. Period," Mr. Taylor observed.

Renewals are possible on an excess-of-loss basis, but not on a pro-rata basis, Mr. Blanch added.

The retrocessional market appears to be just as congested with uncompleted submissions as the direct reinsurance market.

American Re was still working on filling out its retrocessional program last week, according to Mr. Jobe. Meanwhile, when the company is asked to quote on a treaty participation that would not be covered by its automatic retrocessional capacity and would require an additional specific retrocessional agreement, American Re is offering its quote contingent on its ability to find the retrocessional capacity, Mr. Jobe said.

"That's not unusual, particularly with respect to specific retros," he explained.

datebook

JAN. 21-22. Health Care Cost Containment Workshop in Miami, sponsored by the Health Research Institute; \$395. Also Feb. 11-12 in Los Angeles. Workshop Coordinator, Health Research Institute, 49 Quail Court, Suite 200, Walnut Creek, Calif. 94596; 415-676-2320.

JAN. 21-25. Industrial Ventilation Fundamentals course in San Diego, 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. 90089-0021; 213-743-6523/6524.

JAN. 22. Data Workshop & National Statistical Data Base Briefings workshop in Miami, sponsored by the Health Research Institute; free. Also Feb. 12 in Los Angeles. Workshop Coordinator, Health Research Institute, 49 Quail Court, Suite 200, Walnut Creek, Calif. 94596; 415-676-2320.

JAN. 23. Health Improvement/Prevention workshop in Miami, sponsored by the Health Research Institute; \$195. Also Feb. 13 in Los Angeles. Workshop Coordinator, Health Research Institute, 49 Quail Court, Suite 200, Walnut Creek, Calif. 94596; 415-676-2320.

JAN. 23-25. 10th Annual Enrolled Actuaries meeting in Washington, sponsored by the American Academy of Actuaries and the Conference of Actuaries in Public Practice; \$215 for members; \$240 for non-members. Sue Hendrickson, AAA, 1835 K St. N.W., Washington, D.C. 20006; 202-223-8196.

JAN. 23-25. Antitrust in the Health Care Field conference in Washington, sponsored by The National Health Lawyers Assn.; \$340 for NHLA members, \$390 for non-members. Registrar, Program Division, NHLA, 522 21st St. N.W., Suite 120, Washington, D.C. 20006; 202-833-1100.

JAN. 23-25. Fourth Annual Public Agency Risk Managers Assn. conference in Sacramento, Calif., sponsored by PARMA; \$65 for members; \$85 for non-members. Michael Fleming, CSAC—EIA, 1127 11th St., Suite 326, Sacramento, Calif. 95814; 916-441-3624.

JAN. 28-31. Physical Security Workshop in Las Vegas, Nev., sponsored by the American Society for Industrial Security; \$445 for members; \$535 for non-members. Registrar, ASIS, 1655 N. Fort Myer Drive, Suite 1200, Arlington, Va. 22209; 703-522-5800.

JAN. 29-30. "Where Do We Go From Here?" Annual Flexible Compensation conference in Washington, sponsored by Charles D. Spencer & Associates Inc.; \$400. Registrar, Charles D. Spencer & Associates Inc., 222 W. Adams St., Chicago, Ill. 60606; 312-236-2615.

FEB. 1. Advanced Post-Graduate Cost Containment workshop in Los Angeles, sponsored by the Health Research Institute; \$195. Workshop Coordinator, Health Research Institute, 49 Quail Court, Suite 200, Walnut Creek, Calif. 94596; 415-676-2320.

FEB. 1-3. Third Annual Southwest Head Injury Symposium in Costa Mesa, Calif., sponsored

by Northridge Hospital Medical Center; \$200; Pamela W. Schiffmacher, Northridge Hospital Medical Center, 18300 Roscoe Blvd., Northridge, Calif. 91328; 818-885-8500.

FEB. 4-8. Occupational Health Nursing: Basic Theory Update course, offered by the University of Southern California; \$550. USC, Institute of Safety and Systems Management, Office of Extension and In-Service Programs, Los Angeles, Calif. 90089-0021; 213-743-6523/6524.

FEB. 4-8. Reinsurance Practice Course in London, sponsored by Risk Research Group; 595 pounds (about \$716), plus 15% value-added tax. Susan Moore, Risk Research Group Ltd., 181 Queen Victoria St., London, England EC4V 4DD; 01-236-2175.

FEB. 4-MARCH 10. Systems Reliability and Risk Analysis study program, offered by Massachusetts Institute of Technology; \$7,700. Director, Advanced Study Programs, Center for Advanced Engineering Study, MIT, Cambridge, Mass. 02139; 617-253-6128.

FEB. 6-8. Health Cost Data Management: Joint State and Business Applications trade show/conference in Miami, co-sponsored by the Washington Business Group on Health, the National Governors Assn. and the South Florida Health Action Coalition; \$150 for members; \$300 for non-members. Ellen Menton, WEGH, 922 Pennsylvania Ave. S.E., Washington, D.C. 20003; 202-547-6644.

FEB. 7-8. Atlanta Risk Management: Educational Conference in Atlanta, sponsored by the Atlanta Chapter of the Risk & Insurance Management Society; \$100 for members; \$115 for non-members; \$25 for students. Al Nesmith, Southern Co., Risk Management, 64 Perimeter Center East, Atlanta, Ga. 404-399-4062.

FEB. 7-10. Early Identification and Management of Workers Compensation Shock Losses workshop seminar in Sarasota, Fla., sponsored by the Statutory Workers' Compensation Group in association with Frank B. Hall Re of New York and Waters Insurance Management Corp.; \$545. Waters Insurance Management Corp., 2540 S. Tamiami Trail, Sarasota, Fla. 33579; 813-365-1898.

FEB. 11-12. How to Audit & Check Insurance Policy Costs & Coverages course in New York, sponsored by the American Management Assns.; \$620 for members, \$715 for non-members. Also, March 14-15 in Chicago, March 28-29 in Boston. Registrar, AMA, P.O. Box 319, Saranac Lake, N.Y. 12983; 518-891-0065.

FEB. 11-15. Basic Risk Management Techniques seminar, in Tucson, Ariz., sponsored by the Public Risk & Insurance Management Assn.; \$350 for members; \$400 for non-members. Tina Robinson, PRIMA, 1120 G St. N.W., Suite 707, Washington, D.C. 20005; 202-737-7556.

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NAIC meeting

Continued from page 2
model regulation that would establish commissioners' authority and standards to follow to determine and deal with insurers in financial trouble.

"It was our purpose to provide the regulator with a list of proper tests, inquiries and events, which might indicate serious problems in a company before those problems rise to a level requiring orders of supervision or rehabilitation," said Texas Insurance Commissioner Tom Bond, who chairs the group.

Some 37 states already have laws that set criteria for dealing with insurers in financial trouble, he added.

But, financial solvency is not the only concern of state regulators, who discussed many other matters during the December meeting. Many of the topics are already listed on the NAIC's agenda for 1985, including:

- Hazardous waste and asbestos.

The NAIC's Commercial Property and Liability Insurance Committee will examine the availability of liability insurance for firms contracted to remove asbestos from structures.

"Not only our company, but others in the nation can't get general liability insurance," Fred C. Neumeyer told the NAIC Hazard-

ous Waste Task Force last month. He is president of Amaral & Neumeyer Inc., an asbestos abatement contractor in Pittsburgh.

Former Arizona State Insurance Commissioner J. Michael Low, who now is director of the state's Department of Administration, also had asked that NAIC task force to appoint a special advisory committee to work with the National Assn. of Attorneys General and the National Governors' Assn. to deal with property-damage asbestos claims relating to public buildings.

Much has been done recently in the area of personal-injury asbestos claims, Mr. Low said. "But there's another issue...the property damage issue... We feel states will spend millions of dollars to test for asbestos and abate."

Rather than appoint a separate advisory group, the NAIC's executive committee decided to appoint a working group to study this issue and others tied to asbestos cleanup.

Some state regulators, notably Alaska Insurance Commissioner John George, questioned the NAIC's role in this area.

"Is this something that the NAIC, as regulators of insurance, want to get involved in?" he asked.

But Mr. Low and others believe the outcome of these asbestos issues will have a significant impact on the future financial stability of insurers, so insurance regulators

should take a role.

The availability of pollution insurance also was discussed, especially since the Hazardous Waste Task Force was recommending an increase in minimum coverage requirements (BI, Sept. 17, 1984).

"The pollution market is fast becoming a non-market," said Patricia Borowski, vp of government and industry affairs for Professional Insurance Agents in Alexandria, Va. She chairs the advisory committee to the Hazardous Waste Task Force and asked the task force's parent committee to defer adoption of the resolution for higher coverage requirements because of the tightening market for pollution coverage.

The Commercial Property and Liability Insurance Committee agreed, and the task force was asked to re-examine the issue.

- Commercial premium payment plans.

The NAIC's Commercial Lines Property and Casualty Insurance Committee next year will study commercial premium payment plans and investigate abuses that may be tied to unusual premium collection plans.

These plans can be referred to as "cash-flow premium programs," "deferred premium collection payment plans," "cash-flow or paid-loss retro plans" and "compensating balance insurance programs," said Gil McCarty, Kentucky insurance commissioner and a member of the committee.

They are often used for workers compensation coverage, commercial auto coverage and other lines to allow employers to defer payment of part of their premium.

Regulators are concerned about the underwriting and rating aspects of such plans, as well as the legal aspects.

- Coordination of benefits.

The ad hoc advisory committee to the Coordination of Benefits Task Force was asked last summer to rewrite the NAIC's "Regulations and Guidelines Relating to the Use of Overinsurance Reduction of Benefit Provisions in Group Health

Insurance Policies and Group Service Plan Corporation Contracts"—commonly called COB guidelines.

The committee came up with new language, unveiled last month, that clarifies the regulation, said Jack B. Helitzer, assistant vp of Metropolitan Life Insurance Co. in New York and chairman of the ad hoc committee.

But, it also revised certain sections to show how group plans can be coordinated with other plans, including health maintenance organizations.

This new version, which clearly authorizes HMO participation in coordination of benefit practices, is a "major breakthrough for HMOs," said Erling Hansen, general counsel for Group Health Assn. of America, an HMO trade association.

The exposure draft of the rewritten guidelines will be before the task force again this summer for final adoption. The NAIC's first version of the guidelines was published in the early 1970s. The guidelines were amended in 1980, 1981 and last summer (BI, June 18, 1984). The major changes adopted in June affect the order of benefits when a claim for a dependent child is involved and permit plans that coordinate benefits to preserve the deductibles and coinsurance features most generous to the employee.

In November, Arizona became the first state to hold public hearings on changes in its COB rules that would allow insurers to reduce benefits to less than 100%.

S. David Childers, Arizona's insurance director, said that many people, including many from the general public, attended the meeting. Most, he said, were "outraged."

At the hearing, the Arizona department and members of the advisory committee who testified were unable to satisfy the public that the result of such a coordination of benefits would be a quantifiable reduction in premiums, he said.

And, the Arizona Hospital Assn. also spoke in opposition of the amendment, which it said could increase costs to hospitals through a higher level of uncollectible ac-

counts, he said.

After the hearing, Mr. Childers decided to delay action on the proposed changes.

• Reinsurance.
The NAIC was expected last month to adopt model guidelines for the regulation of managing general agents that cede reinsurance or assume it on the part of an insurer, but some concerns raised by the New York Insurance Department and others led the Reinsurance and Anti-Fraud Task Force to table adoption until the June meeting.

The guidelines, which first were presented by the task force's advisory committee in 1983, apply only to MGA contracts that have authority to cede and assume reinsurance and not to MGAs that hold direct underwriting authority for insurers, said Andre Maisonpierre, president of the Reinsurance Assn. of America and a member of the advisory committee (BI, Nov. 12, 1984). However, Dwight B. Demeritt Jr. of Thacher, Proffitt and Wood in New York wanted an even more specific definition of an MGA.

Mr. Demeritt also said the marine insurer community, which places insurance through pools, managers and syndicates, has had exemptions in many state codes and would like this exemption to be included in the guidelines.

But some regulators, notably Alaska Commissioner George, said, "in Alaska the problem is marine."

And Stewart Keir, chief of the Insurance Exchange and Excess Insurance Bureau of the New York Insurance Department, who also sits on the task force, raised a concern about the exemption provided an MGA that is under common ownership with the insurer or is the manager of the U.S. branch of an alien insurer. He felt the exemption was broader than intended.

The advisory committee, chaired by Wes Kinder, president of Fremont Reinsurance Co. in San Francisco, is expected to resolve these questions and put the guidelines into policy format for adoption by the task force this summer.

District of Columbia hikes comp benefit

WASHINGTON—Maximum weekly workers compensation benefits in the District of Columbia increased to \$413.26 Jan. 1 from the previous maximum of \$396.78—a 4.2% hike.

The hike, approved by the district's Department of Employment Services last month, was prompted by an increase in the district's average weekly wage during fiscal 1984, upon which the benefits are based, said Bruce Eanet, associate director of the department.

The new maximum benefits will affect new claims and current payments to injured workers who are

totally and permanently disabled. It won't apply to federal employees who work in the district.

The increase also applies to dependents of workers who died from a work-related injury.

About 300 insurers and employers that self-insure their work comp risks in the district will be affected, Mr. Eanet said.

This is the first increase in maximum weekly benefit payments since the department took over the administration of the work comp program in July 1982, he said. Before that, it was administered by the U.S. Department of Labor.

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*Source: Business/Occupational breakdown of qualified circulation, May 7, 1984 issue, as submitted to BPA for June 1984. BPA Publisher's Statement.

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Owens decision

Continued from page 2

Aetna has paid "not a cent," said Paul C. Warnke, an attorney for Owens-Illinois with the Washington firm of Clifford & Warnke.

About 18,000 asbestos claims have been filed against Owens-Illinois.

An attorney for Aetna said that the insurer will appeal.

From 1948 to 1958, Owens made and sold a thermal insulation product, Kaylo, that contained asbestos and began tendering asbestos injury claims to Aetna in 1978.

In rejecting the "multiple occurrence" formula advocated by Aetna, the court looked to the definition of "occurrence" and Aetna's "limits of liability" in the policies.

"The term 'occurrence' is generally defined in the policies as an accident, including continuous or repeated exposure to conditions, which results in personal injury... which is neither expected nor intended from the standpoint of the insured," the court papers say.

Furthermore, according to the court papers, the policies' limit of liability provisions state "regardless of the number of... persons or organizations who sustain injury or damages or claims made or suits brought on account of personal injury... (Aetna's liability) resulting from any one occurrence shall be limited to the amount stated in Section 1 as applicable to 'each occurrence'... and 'aggregate limit'..."

And, "for purposes of determining the limit of (Aetna's) liability, all personal injury... arising out of continuous or repeated exposure to substantially the same general conditions shall be considered as arising out of one occurrence."

Based on these definitions, the number of occurrences must focus on the underlying "circumstances" that resulted in the personal injury and claims for damage rather than each injury, the court said.

In its decision, the court cited the recent case of *Michigan Chemical Corp. vs. American Home Assurance Co.*, which noted that the vast majority of courts have concluded that the number of occurrences for purposes of coverage limitations are determined by reference to causes of the damage and not the number of claims or injuries.

The policy language "makes it clear that the number of injuries or claims, even if temporally removed from their causes, are irrelevant when determining the number of occurrences," the court said.

It also rejected Aetna's contention that the court should examine factors like a claimant's time, place and length of exposure to asbestos, and the type of product involved to determine whether claims can be aggregated into a single occurrence before determining whether there could be one occurrence or many.

"Aetna implies that the rights and obligations created by the 'occurrence' provisions cannot be determined without consideration of the facts of a particular claimant's exposure to asbestos," the court said.

"The court has before it, however, the terms of the insurance policies, the fact that asbestos-related disease developed after exposure to O-I's product and the fact that O-I can be held liable for the injuries.

"The court is not aware of any facts that would come to light in an underlying claim that would be relevant to the interpretation of the retained limit/per occurrence provisions in the context presented here."

Even more importantly, Aetna's interpretation would require determining the conditions of exposure to asbestos for thousands—and possibly tens of thousands—of cases, which would be an "administrative nightmare," the court concluded.

The court also said that requiring

just one deductible was in accordance with Owens' reasonable expectations of the policy. This also was one of the principles in *Keene vs. INA*.

"O-I did not expect, nor should it have expected, that its security would be undermined by the arrival of a proliferation of products litigation virtually unprecedented in the history of the American judicial system," the court said.

"If O-I were obligated to pay a deductible on each claimant's lawsuit, O-I would be deprived of the security for which it paid..."

"On the other hand, the single occurrence interpretation maintains O-I's reasonable expectations."

The large annual and per-occurrence limit provisions of Owens' liability policies also support the conclusion that the parties reasonably expected the company would have to pay only one deductible for claims like those from asbestos-related injury, the court said.

In 1972, for example, Owens had limits of \$20 million per occurrence/aggregate and a per occurrence deductible for products of \$250,000.

"If, as Aetna initially argued, each separate claim constituted one occurrence, then Aetna's limit of liability provisions would be rendered meaningless as it strains the imagination to conceive of a single claim that would generate \$20 million of damage," the court said.

"On the other hand, it is reasonably foreseeable that a manufacturer, who is principally engaged in the manufacture and sale of glass containers, would be involved in a causative event producing multiple injuries and resulting in total damages of \$20 million or more.

"The court finds that in order to preserve O-I's reasonable expectations, the manufacture and sale of Kaylo must be regarded as the single occurrence triggering liability for asbestos-related injury.

"The court concludes, therefore,

that O-I's coverage under a policy for asbestos-related claims is subject to payment of a single deductible. 'Occurrence' is interpreted to mean all personal injury arising out of the asbestos contained in O-I's Kaylo products."

In addition to its ruling on the meaning of occurrence, the court determined what triggered coverage under the Aetna policies. The court, relying on the triple-trigger theory it handed down in *Keene vs. INA*, said Aetna had a duty to indemnify Owens for asbestos claims if a policy was in effect at any time between a claimant's initial exposure and the manifestation of asbestos-related injury.

Aetna, on the other hand, subscribes to the manifestation theory, which says that coverage is not triggered until a disease is manifested in the victim.

In the Owens case, Aetna sought to invoke Ohio law instead of the Keene decision, but the court rejected the insurer's argument.

Ohio law would permit outside evidence to be submitted to show that Owens had previously intended manifestation to be the trigger of coverage, which would also render summary judgment inappropriate, Aetna argued.

But, the court said the Keene law applied in the Owens case.

"A searching review of Ohio law reveals that the Ohio courts have yet to decide the specific issue before this court," the court said.

"However, because the basic principles underlying the Keene decision find general acceptance in Ohio precedent, this court finds that it is bound by the decision in Keene as to what these general principles mandate"

"Accordingly, this court must hold that coverage was triggered if the claimant was exposed to asbestos during the term of the policy, or if the disease was developing during the term of the policy or when manifestation occurred," Judge Hogan added. ■

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Tough renewal

Continued from page 1

finding it difficult because so many carriers haven't finalized their own reinsurance arrangements. As a result, we're having a hard time getting them to make commitments."

Many brokers report that cuts in capacity—especially in casualty lines—forced them to work harder than ever before to complete renewals by year-end.

At Frank B. Hall & Co. of New York, for example, brokers worked on New Year's Eve to fill out excess liability layers even though the rest of the office was closed, said President William A. Quinn.

Brokers at Marsh & McLennan Inc. had to work doubly hard to complete renewals, according to Managing Director Lawrence J. Drake in M&M's New York office.

For example, Mr. Drake cited one client that last year had bought \$25 million excess liability coverage from one insurer over a \$10 million primary layer.

"Now the (insurer) only comes in at the upper layers—\$50 million to \$100 million," said Mr. Drake. "It took five players to replace the underwriter and five to 10 times the work. We put five people where one had been."

Brokers generally agreed that a lack of excess and umbrella liability capacity has posed the biggest problems.

"What is happening in the umbrella liability insurance industry is a black eye to the entire insurance industry," said Hall's Mr. Quinn. "They waited too long to get their (reinsurance) treaties in place. . . Everybody expected the price to go up. But, the magnitude of the increases has caught people by surprise."

"It goes back to the reinsurance market," Mr. Quinn continued. "The direct writers didn't have reinsurance lined up in time to take Jan. 1 renewal business in an orderly manner. This is true in the U.S. and England. As of now, they can only give the capacity they have squared themselves."

"So, some companies that traditionally gave \$15 million now can offer \$5 million. Some with \$5 million to \$10 million don't have any insurance to give at all. And, some did a super job and did reinsure early and received the capacity they needed."

Generally, according to M&M's Mr. Drake, buyers searching for extremely high liability limits aren't finding what they want.

"The chemical and pharmaceutical companies which had \$300 million to \$500 million last year may only get \$150 million this year," he said.

Other brokers agree. According to a broker in Atlanta, a chemical manufacturer that had liability limits of \$100 million last year could only find \$15 million during renewals. And, unlike other accounts, the broker said the capacity cut had nothing to do with last month's poisonous gas leak at a Union Carbide Corp. plant in Ehopal, India (see related story).

The broker added that a construction company that had \$100 million in liability coverage last year could only get \$25 million upon renewal.

"Anything with products won't end up with the same limits," he said. "Frankly, the industry is acting irresponsibly. The underwriting community has an obligation to provide capacity at a price."

Excess coverages for trucking risks and aircraft products liability have been the toughest to place, said Mr. Conner at Robinson-Conner. One trucking firm wanted to increase its excess liability limits to \$25 million from \$15 million, "and we had a very difficult time getting those layers," he said.

"Usually when you get to the high layers, people will take a good bit of it because there is so much (coverage) underneath," Mr. Conner said. "Now they're not taking nearly as much. . ."

For instance, "Nobody is responding" to a particular aircraft product liability account that is seeking higher excess limits, Mr. Conner said. "It's like everybody shut down."

Mr. Conner noted that rates for umbrella layers have risen anywhere from 20% to 300%, depending on the risk, but added that a 300% rate increase only "puts the cost just about where it was four years ago."

A competitive marketplace had beaten umbrella prices down "until they became ridiculous," he said. "And now some companies are trying to get it all back in one year. I thought it would work its way up, but obviously that's not the case."

Such fluctuating rates "don't do anything for the credibility of the insurance business," Mr. Conner said.

Thomas Etling, senior vp of Lawton-Byrne-Bruner Agency Co. in St. Louis, said "most prices are at least doubling" for umbrella layers. "That's where the reinsurers have really increased their prices."

William Poe, chairman of broker Poe & Associates Inc. of Tampa, Fla., agreed that umbrella rates are "going way up."

"What might have cost \$5,000 before might cost \$40,000 now," he explained.

Mr. Poe said that his brokerage has not faced the capacity crisis

other brokers encountered because most of the accounts handled by his company involve limits of \$10 million or less.

"So far we have been able to find what we want, but at a much higher price."

Besides rising rates and tight capacity in high excess and umbrella layers, brokers also agree that buyers are seeing large rate hikes—sometimes as much as 300%—in the working excess liability layers, the layers in which claims are likely to be incurred.

In addition, brokers note that many general liability policies that have been renewed specifically exclude both sudden and non-sudden pollution risks. Previously, general liability policies have included coverage for sudden or accidental pollution risks (BI, Oct. 29, 1984).

The brokers also agree that generally there's enough property insurance capacity to cover the largest risks, though earthquake coverage is a different matter.

"So far, with very limited exceptions, (capacity problems) are in casualty lines," says Thomas D. West, senior vp at Alexander & Alexander Inc. in Dallas.

Mr. West only noted "isolated instances in property (lines) where capacity is not there—such as earthquake coverage. When there is a need for earthquake insurance, the capacity is very limited."

Earthquake insurance has "shrunk dramatically," said M&M's Mr. Drake. Insurers are worried about the accumulation of earthquake risks in areas of California and Japan and are cutting back on what they will write this year.

So, a company looking for \$100 million dollars of earthquake insurance may have to settle for only \$5 million to \$10 million this year, said Mr. Drake.

Mr. Marks at Reed Stenhouse concurs, noting that earthquake coverage for property on the West Coast is especially hard to locate.

"There's been a major increase in price, whereas before it was almost a throw-in. Now it's three, four, maybe five times more."

Even at those rates, he said, "It's not a question of price. It's a question of whether you can find it. I'd say there is a worldwide limit of \$250 million available for earthquake coverage and you'd have to scrounge to find that."

Reed Stenhouse places property insurance for a chain of television stations on the West Coast and "we had a lot of difficulty putting that one to bed," Mr. Marks noted.

While some brokers admitted they could not place all the coverage their clients had requested—especially on the casualty side, others maintain the capacity is there—although it's not necessarily easy to get.

"We have customers who are very concerned about who will be without insurance or how expensive it will be," said J. Patrick Gallagher, area executive vp of Arthur J. Gallagher & Co. in Rolling Meadows, Ill. "But in general, we will have insurance for everybody."

A&A's Mr. West said, "I don't know if crisis is a proper term" for current market conditions.

"Yes, it is a very difficult market, but I don't think things are falling down around our ears."

Mr. West noted that the "vast majority" of the year-end renewals handled by A&A have been completed "or I would be hearing screams right now."

Mr. Etling at Lawton-Byrne-Bruner agreed that while capacity for certain lines has shrunk, his company didn't feel the pressure that other brokers report.

"We have enough markets to go to so that we can usually find what we need. The smaller agent with 10 markets may have a problem," he said.

Most of Lawton-Byrne-Bruner's

Gas leak affects coverage

Although brokers say that almost all policyholders had a tough time during recent year-end coverage renewals, some were especially hard hit because of the recent poisonous gas leak at a Union Carbide Corp. plant in Bhopal, India, which killed 2,500 people.

Thomas Etling, senior vp of Lawton-Byrne-Bruner Agency Co. in St. Louis, said repercussions from the Union Carbide disaster affected "a long-term relationship with a profitable account" that his brokerage handles.

The client, a chemical manufacturer whose processes involve chlorine gas, was seeking to renew a liability policy with limits of \$500,000, explained Mr. Etling. However, the insurer that had written the plant's coverage for 30 years decided not to renew because of the risk of escaping chlorine gas.

The decision not to renew the coverage was a fear of the repeat of the Bhopal tragedy, said Mr. Etling. "After 30 years on a profitable account, that's why they want out—because of the Union Carbide incident."

Shortly before the end of the year, Mr. Etling said Lawton-Byrne-Bruner was still trying to find coverage for the manufacturer.

Although broker Robinson-Conner Inc. of Erie, Pa., does not have a chemical manufacturer for a client, it still experienced some fallout from the Bhopal tragedy, says President William B. Conner.

For instance, he noted that a quote for products liability coverage for a trucking company was withdrawn because the company transports hazardous chemicals. Coverage was finally written through the assigned risk pool.

Jan. 1 renewals were finished, Mr. Etling reported a few days before year's end. But, he noted that many other accounts were up for renewal later this month.

"We're not always getting the limits we want," Mr. Etling conceded. "If we are renewing with a company that's been on the risk, most of the time we get what we want. If it's a new piece of business, then we may have a problem."

But problems stemming from a lack of reinsurance capacity haven't been as bad as he expected, Mr. Etling said.

"We've had a few individual instances where underwriters couldn't give a Jan. 1 quote because they didn't know if they could get the reinsurance. But I think most of the paranoia about reinsurance

has passed."

Reinsurance hasn't caused a lot of grief at Emmett & Chandler of Northern California, said Executive Vp Jeff McKinley. "We've had several quotes contingent on reinsurance, but that's true every year," he noted.

Most of the firm's 50 Jan. 1 renewals were finished by Dec. 28, Mr. McKinley noted.

Some brokers also believe that the recent renewal season was not as bad as during other years when the market turned.

"I have seen many, many cycles, and no, this one is not as bad," added Robert E. Gallagher, president of Arthur J. Gallagher. "This one is just starting. We're just going into this; it could be a two- to three-round fight."

NAIC silent on ISO proposed forms

WASHINGTON—The National Assn. of Insurance Commissioners will remain silent on the Insurance Services Office's new versions of a proposed comprehensive general liability policy that call for the elimination of both sudden and non-sudden pollution coverage (BI, Oct. 29, 1984).

ISO's new CGL policy, which includes an occurrence form and a claims-made form, was outlined earlier this month to the NAIC during its winter meeting in Washington by Carole Banfield, ISO's vp of government relations.

C. Courtney Wood, the state-national director of the Independent Insurance Agents of Oklahoma, urged regulators to delay approval of the new forms in their states. The group is concerned about the confusion that could arise from the introduction of two forms at the

same time. He also said the elimination of all pollution coverage from the form would result in a form of "reverse discrimination."

However, Andre Maisonpierre, president of the Reinsurance Assn. of America, supported the removal of the pollution cover and said "specialized coverage should be handled specially."

ISO has been working on the new form for about nine years. Ms. Banfield said, and it was filed and approved earlier this year in 22 states.

But, the recently revised forms, with the elimination of pollution cover, have only been approved by 11 state insurance departments, and the NAIC recently decided to receive a report on the proposal without taking a position.

The implementation date of the new form is Jan. 1, 1986.

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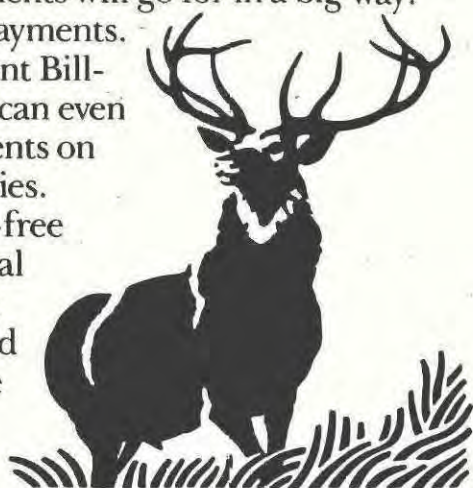
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