JUNE 3, 1985

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update

N.J. guaranty fund to start paying Ambassador claims

TRENTON, N.J.—New Jersey policyholders of the Ambassador Insurance Co. will initially receive 40 cents on the dollar—up to $120,000 per claim—from the state's surplus lines guaranty fund to pay claims owed by the insurer, which is appealing a declaration of bankruptcy to the Vermont Supreme Court (*BI*, May 6).

A $300,000-per-claim cap was established when the Legislature approved

Continued on next page

Reagan's new tax reform plan

Benefit proposals tempered, but health, 401(k) plans stung

By JERRY GEISEL

WASHINGTON—If the Reagan administration tax simplification plan is approved by Congress, health care benefits will be taxed for the first time in history and 401(k) salary reduction plans will be stripped of their glamour.

While the Reagan administration was forced under political pressure to temper the benefit tax proposals included in a Treasury Department tax reform plan announced last November, the new tax plan still threatens many benefit plans, experts say.

The new plan eliminates the Treasury's first proposal to tax employer-paid health care benefits above a certain level, but it would include as taxable income the first $10 an employer contributes toward health care premiums for individual coverage and the first $25 for family coverage.

And, while the plan also rescues 401(k) salary plans from elimination, it would drastically change the rules to limit tax-free contributions and restrict early withdrawals.

"The Reagan proposals are the most far-reaching employee benefit tax proposals to go to Congress," says Dallas Salisbury, president of the Employee Benefit Research Institute, a Washington-based benefits think-tank.

"This proposal seeks in one document to revise and change 75 years of benefit tax policy," said Stuart Brahs, executive director of the Assn. of Private Pension and Welfare Plans in Washington.

Like its predecessor last fall, the new tax simplification plan also was drawn up by the Treasury Department (*BI*, Dec. 3, 1984). However, unlike the earlier plan, the new proposals have been endorsed by the Reagan administration.

That backing dramatically increases the chances of enactment, said Edward J. Davey, vp-technical analysis at Johnson and Higgins in New York. It is almost certain that there will be employee benefit provisions

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Treasury II

- Taxes a floor amount of employer-paid group health insurance benefits.
- Restricts 401(k) salary reduction plans.
- Eliminates tax-free van-pooling benefits.
- Retains tax-free group term life insurance to $50,000.
- Retains cafeteria plans, tax-free child care benefits, tax-free educational assistance benefits and tax-free group legal benefits.
- Retains tax-exempt treatment of 501(c)(9).
- Adds a new option for deducting property/casualty losses.
- Taxes workers compensation benefits.
- Modifies requirement that property/casualty insurers discount loss reserves to reflect investment income.
- Imposes a per-country limitation on the use of excess foreign tax credits.

New property/casualty rules aid policyholders and insurers

By DOUGLAS McLEOD

WASHINGTON—The Treasury Department's latest tax reform package gives property/casualty insurance policyholders a new tax break and modifies an earlier proposal requiring insurers to discount loss reserves.

Treasury II includes a provision that would allow insurance policyholders to claim deductions for insured losses in the year the losses were incurred and later declare insurance proceeds as taxable income when received.

This provision is intended to compensate policyholders for the lost value of property between the time a loss is incurred and the time it is paid by an insurer, the proposal says.

The Treasury Department modification of the loss reserve discounting proposal may allow insurers to take larger initial tax deductions for loss reserves than first proposed.

But, industry observers aren't sure how to interpret the modifications to the discounting proposal and many groups representing insurance companies and insurance buyers still oppose loss reserve discounting for tax purposes. They worry that the new taxes will force property/casualty rates up, reduce capacity and threaten insurance company solvency.

Other provisions of the first Treasury tax package, however, are unchanged. These provisions would:

- Tax workers compensation and black-lung disability benefits as ordinary income.
- Impose a new per-country limitation on the use of excess foreign tax credits, a move that could further reduce the remaining tax benefits of offshore captive insurance companies.
- Repeal a number of tax exemptions and deductions now available to mutual property/casualty insurers.

Currently, property/casualty insurers can take immediate deductions

Continued on page 29

Policyholders sue Transport Indemnity

By ROBERT A. FINLAYSON

LOS ANGELES—A class-action lawsuit charges that Transport Indemnity Co. wrongly canceled midterm thousands of property and casualty insurance policies, but the California Insurance Department says the insurer did nothing wrong under state insurance laws.

In mid-April, Los Angeles-based Transport Indemnity issued mid term cancellation notices on as many as 2,500 property and casualty insurance policies, according to brokers (*BI*, May 6).

The cancellations apparently stem from the effort by Transport Indemnity's parent, American Financial Group, to use Transport's assets to shore up the financially troubled Mission Insurance Group, also a subsidiary of American Financial Group.

Policyholders and their brokers report that replacement coverage is available only with huge premium increases, and some policies can't be replaced, confirming their earlier predictions.

The class-action suit was filed May 23 by a Los Angeles law firm on behalf of all property and casualty insurance policyholders whose coverage was canceled midterm by Transport Indemnity.

The named plaintiff is Edwin Yates, who, along with others, was issued a $3.5 million excess property insurance policy on a shopping center in Canyon Country, Calif.

The one-year policy, due to expire Jan. 1, 1986, was canceled by Transport Indemnity in April. The premium on the policy, which was brokered by Swett & Crawford of Los Angeles, was $8,291.

The lawsuit alleges that Transport Indemnity breached its duty of good faith and fair dealing owed to is policyholders by:

- Misrepresenting pertinent facts and cancellation provisions relating to the canceled property and casualty policies.
- Reinvesting Transport Indemnity's assets to shore up Mission Insurance Group, "at the expense of policyholders who now have hefty premium increases on replacement coverage or are left uninsured."
- Failing to provide a "reasonable explanation" of the basis relied upon for canceling the policies midterm.
- Failing to warn policyholders, prior to their entering into the insurance contract, that there could be a midterm cancellation.

Further, the complaint alleges Transport Indemnity breached its fiduciary duty to its policyholders and that the insurer defrauded policyholders by not fulfilling written and oral promises to provide coverage.

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Photo: Robert A. Finlayson

Transport Indemnity's five-story Los Angeles headquarters is on the block for $15 million, part of the bailout of Mission Insurance Group.

Insurer braces for claim from 'Rocky' film producer
Page 2

Members may not cover Beckett syndicate losses
Page 2

Health care coalitions can help small firms
Page 3

Acmat's plans

Continued from previous page
on discussions with a consultant that studied the feasibility of a captive, Acmat concluded that a captive would not fill the needs of the asbestos contracting industry.

Acmat's insurance problems arose after CIGNA canceled its coverage (*BI*, March 25).

Acmat charges in its suit that CIGNA canceled or refused to renew its insurance, fearing asbestos liabilities. Acmat has never been named in a lawsuit brought by a victim of an asbestos-related disease since it entered the business in 1973, and its work was cited by CIGNA as state-of-the art.

Acmat subsequently found new insurance with Great American Surplus Lines Insurance Co. of Cincinnati and two other excess insurers, but at substantially more cost (*BI*, April 8).

Liability insurance now costs Acmat 20% of its revenues compared with 2% of revenues charged by CIGNA.

Mr. Nozko said CIGNA's original renewal terms and subsequent cancellation prevented Acmat from working on 200 projects and from bidding on 162 other projects involving asbestos removal.

Because of the cancellation, Acmat did not bid on any asbestos projects between Feb. 5 and April 1, "the greatest bid period," Mr. Nozko said.

He said the company will be working on about one-fourth as many asbestos projects as it had worked on last year.

"We don't see how we can make any money this year. Or, if we do, it will be very little," he said.

Acmat's average net earnings have been about $1 million after taxes in the last five or six years, Mr. Nozko said. Asbestos removal generates about half of Acmat's $50 million in annual revenues.

But, because of the CIGNA cancellation and the high cost of the new insurance, "that's not going to happen (this year)," he said.

Acmat's first-quarter financial results showed net income of $119,960, down 68% from $372,211 earned during the first quarter last year. Quarterly revenues were $8.83 million, down 24% from $11.64 million in 1984.

Acmat's suit names CIGNA and CIGNA subsidiaries Insurance Co. of North America, Aetna Insurance Co., and Aetna Fire Underwriters Insurance.

CIGNA provided Acmat since 1981 with a "broad range" of insurance coverages, including comprehensive general liability, property, business automobile, liability and workers compensation insurance.

Acmat charges that CIGNA changed its position several times on whether it would provide Acmat with liability insurance and that, as a result, Acmat suffered substantial damages.

According to the suit, last December CIGNA granted the company excellent ratings after onsight inspections of Acmat's performance and safety procedures at numerous Acmat projects. It also then told Acmat that it wanted to continue insuring Acmat's business operations, the suit says.

Acmat then issued certificates of insurance to the owners of all its construction and asbestos removal projects, stating CIGNA would provide the required insurance on the projects through Jan. 1, 1986, the suit adds.

On about Dec. 28, however, CIGNA informally notified Acmat that the insurer would not renew Acmat's general liability insurance because of its involvement in the asbestos removal business.

Despite the notification, however, on Jan. 1, CIGNA renewed all policies covering Acmat's business operations.

But at a Jan. 23 meeting, CIGNA told Acmat it would continue to provide insurance for Acmat only if the company agreed to cease bidding, seeking and performing asbestos removal work and only perform such work where it was incidental to other construction work.

CIGNA also said at that meeting that, as a matter of corporate policy, it would cease insuring all companies doing asbestos removal business, the complaint adds.

Acmat says that relying on CIGNA's representation, it then ceased doing business in the asbestos removal field by declining to submit competitive bids or seeking to perform asbestos removal projects it could have pursued.

It also did not try to obtain insurance from other insurers.

Despite CIGNA's representations, the suit charges that on Jan. 28, at a meeting between Acmat's broker—Amins Insurance Inc. of East Hartford—and CIGNA officials, CIGNA said it intended to cancel or refuse to renew all the coverage it was providing Acmat.

When Acmat contacted CIGNA two days later, however, CIGNA "changed its position again," and took the position it had at the Jan. 23 meeting—that it would continue to insure Acmat if the company ceased doing asbestos removal.

The suit says CIGNA confirmed to Amins that it would continue to insure Acmat on Feb. 1. However, on Feb. 5, Acmat received formal written notification that as of April 1, CIGNA would cancel or refuse to renew Acmat's policies.

CIGNA did cancel or refuse to renew all of Acmat's policies on April 1.

The suit charges that contrary to CIGNA's earlier statements to Acmat that it intended to stop insuring all asbestos removal business operations, CIGNA continued to provide insurance coverage for other asbestos removal businesses, including Acmat's competitors.

Acmat charges CIGNA with breaching its contract to provide insurance coverage for Acmat, misrepresentations and deceitful conduct, breach of its obligation of good faith and fair dealings, violating the state Unfair Trade Practices Act, violating the state Unfair Insurance Practices Act, breaching its duty of care owed to Acmat, intentionally and improperly interfering with the performance of Acmat's existing and prospective contractual relations, and being guilty of willful, wanton, reckless, malicious and oppressive conduct.

In its contention that CIGNA violated the state Unfair Insurance Practices Act, Acmat charges CIGNA with intending to boycott providing insurance coverage for Acmat.

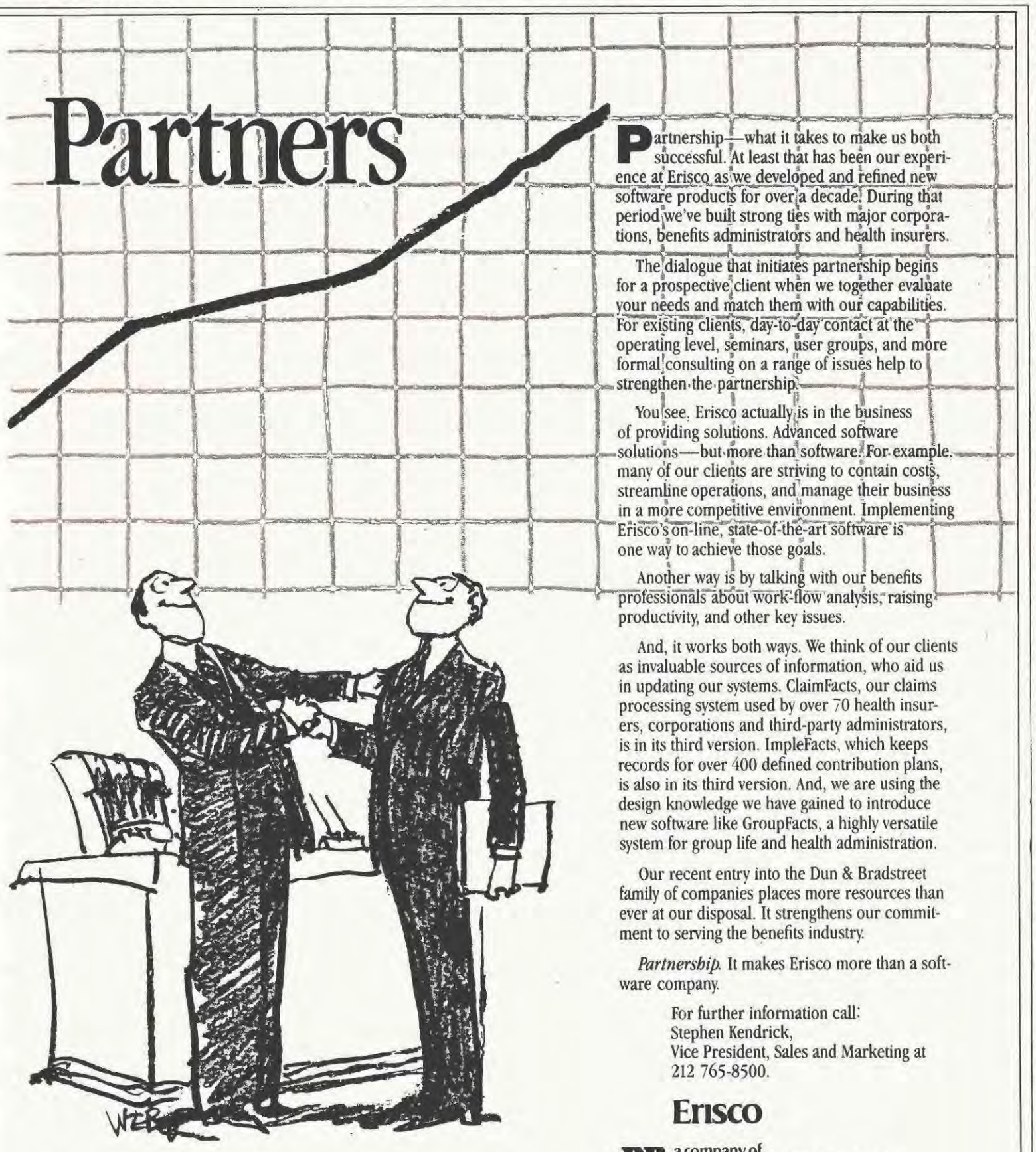
In addition to losing business and paying more for replacement insurance, Acmat reports other "severe financial harm and detriment" due to CIGNA's actions, including:

- Acmat has now been placed in an insurance risk pool for workers compensation, with the attendant high costs and difficulty of obtaining commercial insurance in such a status.
- Acmat's national prominence and excellent reputation as a contractor in the construction and asbestos removal business have been severely diminished and damaged.
- Acmat has not been able to purchase enough insurance.

"As a further result of CIGNA's breach. . .Acmat has been unable to obtain, at any cost, insurance coverage with limits of liability adquate to satisfy all its existing contractual obligations or to permit Acmat to pursue, bid and perform construction and asbestos removal jobs of the size and nature it is capable of and accustomed to undertaking, all to its severe financial harm and detriment," according to the suit.

In addition to asbestos removal, Acmat contracts on heating, ventilation, air conditioning, plumbing and electrical projects.

A spokesman for CIGNA declined to comment on the suit. ■



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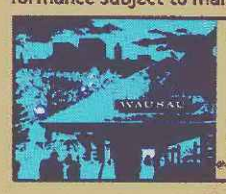
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opinions



Only a relative improvement

THE NEW REAGAN administration tax simplification proposal is somewhat of an improvement over the first draft, but no one should assume that life under Treasury II, if enacted, will be a benefit bonanza.

And, the property/casualty insurance business, and its customers, are in for radical pricing changes if provisions in the plan affecting their business are adopted.

On employee benefit issues, it's certainly a relief to see that group life insurance to $50,000 of indemnity and many other benefit plans will retain their tax-free status.

But, we're not overwhelmed by the generosity of the administration regarding the tax status of employer-paid group health insurance or 401(k) salary reduction plans.

Taxing a floor amount of group health insurance premiums, however small, would represent the first time employees would have to pay taxes on their most valued employee benefit. And, there is no doubt that the ceiling on the floor amount of taxable health benefits will grow in years to come if this provision is enacted.

Limiting contributions to 401(k) salary reduction plans to $8,000—with an offset for any contribution to an Individual Retirement Account—will drastically reduce the amount of money employees save for their retirement.

On property/casualty insurance issues, one would be hard-pressed to overestimate the impact of taxing workers compensation benefits and forcing insurers to discount their tax-deductible loss reserves to reflect investment income.

If employees are taxed on their workers compensation benefits, they will not settle for the conventional 66⅔% of the average weekly wage as a disability benefit. There will be a hue and cry over inadequate benefit levels—justifiably so—that will drive up benefit levels. And higher benefits mean higher costs for self-insured employers and higher premiums for employers that buy workers compensation insurance.

If insurers are forced to discount their loss reserves to reflect investment income, they will certainly raise their rates to maintain their income. Such rate increases will compound pricing problems for corporate insurance buyers that already are in shock from looking at the double- and triple-digit increases in recent renewal premiums for property and casualty insurance.

To the uninitiated in employee benefits and risk management, these tax provisions may appear to be the parochial concerns of only the insurance industry. The challenge facing insurers, employee benefit managers and risk managers is to convince Congress otherwise so these provisions will be given equal consideration with the host of other tax changes proposed.

And that's not going to be easy, because every special interest group that stands to lose under the Reagan tax plan is going to swarm Washington on behalf of its cause.

letters

Sound risk selection must accompany rate hikes

To the editor: Numerous articles over the last few months have indicated that the insurance industry must or will "return to the basics," as did "Panelists see industry returning to the basics" (*BI*, May 20). There seems to be some evidence that this is occurring, but unfortunately, the single basic matter that appears to be receiving most of the attention is pricing. There is another basic principle, which seems to be largely unaddressed but to which we must return: sound risk selection and analysis. Simply increasing prices without incorporating basic principles of risk selection and analysis will, I fear, cause customers to complain, regulators to tighten regulations and legislators to look for "remedial" legislation. Sound risk selection and analysis, however, can enable rates to be increased to levels that are both fair and adequate.

Many underwriters accustomed to recent underwriting policies either never have been taught risk selection and analysis skills or haven't used these skills in recent history.

Yet the resources are available; the loss-control (or engineering) function within the companies is highly capable of assisting underwriters in risk selection and analysis matters, both in terms of providing necessary information and of advising and training underwriters on technical issues.

A return to basics should include sound risk selection and analysis principles. This is best achieved through an underwriting/loss control partnership, where the expertise of both functions can be utilized to improve loss ratios. Insurance management should be as committed to sound risk selection and analysis, and its loss-control support function, as it seems to be to increasing prices.

Gerald E. Lingenfelter
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Halon's chemical reaction snuffs out fire

To the editor: Halon gas does not fight fire by eliminating oxygen (*BI*, April 29). A typical Halon 1301 fire suppression system employs 5% Halon 1301 by volume, which still leaves approximately 20% oxygen in the room. This is critical to the safety of personnel in the room, since they need oxygen to breathe. Halon 1301 chemically reacts with the components of the fire, thus extinguishing the flame.

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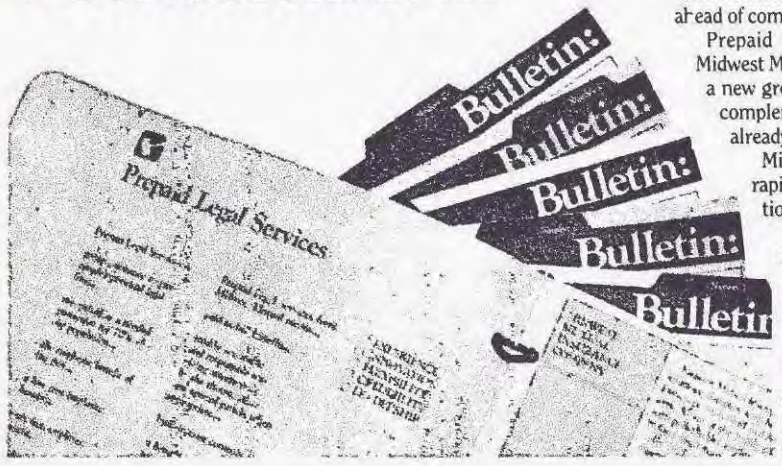
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Beckett losses

Continued from page 2

Now the members must pay 62 million pounds to Lloyd's this year or face suspension (*BI*, May 20).

Also, late last month Lloyd's Chairman Peter Miller announced the Council of Lloyd's had passed a bylaw to allow the appointment of new management of Beckett.

Accountant Price Waterhouse now is investigating Beckett.

Mr. Lawson predicted the audit will show the loss-ridden non-marine syndicates have virtually no reinsurance.

He also said the audit will show the syndicates had reinsurance until last year, when it was dismantled to release about 25 million pounds held in Gibraltar trusts that were part of the Minet and A&A settlement. The trust money allegedly had been misappropriated by former PCW executives.

Mr. Lawson also said the audit will show this dismantling of reinsurance was not made known to members last year when they accepted the Minet offer. As part of the deal, members agreed not to sue Minet, A&A or Beckett.

But, Mr. Lawson said the agreement may be void. "In the offer, no one mentioned that the dismantling of reinsurance was made. We asked lots of questions, but they said, take it or leave it."

Beckett Managing Director Graham White admits that last year—when Beckett took over PCW—it discovered the non-marine syndicates had been subsidized by the marine syndicates over several years in a broad reinsurance program in which marine syndicates reinsured non-marine risks.

But, Beckett believed the program was "inequitable and told the names that it would be stopped," a Beckett spokesman said.

There was no reinsurance to replace this program, Mr. White admitted. The non-marine syndicates do have some reinsurance, he said, but he declined to elaborate.

But, the immediate problem for members is the July 31 deadline. Any claims names don't meet will be paid by Lloyd's Central Fund.

Members may be able to file claims against their stop-loss reinsurance, which indemnifies them for losses above a self-retention, but no one knows how many members have such coverage.

And, Mr. Lawson said about 40 to 45 Beckett members have stop-loss policies that will not pay. These policies were written with then-PCW underwriter Peter Cameron-Webb, now at the Insurance Exchange of the Americas, and the wording is "spurious," he said.

Because of the way the limits are written, these policies will not take effect unless there is a catastrophic loss for all of Lloyd's.

Mr. White applauded the move to appoint a rescue agency and plans to remain on its board. "I welcome a move of this nature," he said. "I hope this (now) can be sorted out without litigation."

But, Mr. Lawson is not so sure.

"I would think there would be a lot of litigation," he said.

And, he said Lloyd's is partly to blame for the debacle. "Lloyd's has failed to police its marketplace."

He also blamed financial standards Lloyd's members must meet.

"My major criticism is that some members have no right to be in Lloyd's. Some can cope, and some will be wiped out completely. Those people who are wiped out had no right to be in Lloyd's." ■

Spicer & White offer

LONDON—A rescue offer to Lloyd's of London syndicate 895, managed by Spicer & White (Underwriting Agencies) Ltd., to cover 10.5 million pounds ($13.2 million) in losses probably will be rejected by many members, says a lawyer for a members' committee.

The offer—by Spicer & White's parent, Willis Faber P.L.C., and backed by the Chase Manhattan Bank—would provide members with an interest-free loan facility to pay 1.1 million pounds in additional losses from 1980 and 9.4 million pounds in losses from 1982.

In return, members must assign to a trust their stop-loss insurance recoveries, tax recoveries and any future profits so 20% of the loan is repaid each year to the bank.

And, the members must agree not to sue any of the parties involved for a five-year period.

If the members accept the deal, they will be able to meet Lloyd's July 31 solvency deadline.

But, at least 40 of the 176 names represented by the steering committee will reject the offer because of the ban on suits, said the lawyer, who asked not to be named.

They have advised attorneys to begin legal action against Spicer & White, claiming over-writing caused the losses, he said. ■


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Small business

Continued from page 3

insurers toward small businesses.

Specifically, small business managers said they had trouble getting health care data and often had to buy "tie-ins," such as life insurance, to get health care coverage from certain insurers.

And, small businesses pay more for whatever health care coverage they can get.

"In general, smaller firms pay higher health insurance premiums and have less flexibility in selecting and designing health care plans and establishing payment schedules," Mr. Swain said.

Moreover, limited finances often prohibit small businesses from developing cost-containment programs.

"Few resources are available in small businesses to develop sophisticated cost-containment programs in-house, such as utilization reviews and wellness programs," Mr. Swain said.

However, these consequences do not necessarily have to befall small businesses, Mr. Wall said.

They should fight back by insisting on better treatment and more services from their brokers and insurers.

"Demand service from your broker," he said. "A small business. . .does have a claim on its broker for certain essential services."

'Leasing companies can obtain lower rates for health insurance,' Mr. Swain said.

The services small businesses should expect from their brokers include a report on their survey of available insurance markets, risk management assistance and support with benefit plan design. In addition, small businesses can ask their insurers for assistance with claims administration, loss data and cost containment, Mr. Wall said.

Small businesses often mistakenly think their limited financial resources prevent them from self-insuring, Mr. Wall said. But, he cited a Self Insurance Institute of America report that shows that one-third of all businesses with 100 to 500 employees are self-insured. The Institute also reports that this group is the fastest-growing segment of the self-insured market.

"Small businesses are sharing a risk exposure, with stop-loss insurance as a back-up, and retaining for their own use the money previously paid up front to insurers as premiums," Mr. Wall said.

"Self-funding may not be right for all companies, but the number of companies self-funding has grown substantially in the past five years," he added. "Along with this trend has been a growth in insurance companies and other firms who will perform administrative services only."

Mr. Wall offered other suggestions for controlling health care costs. "These recommendations are of particular importance for the small business firm with precious few resources to expend and none to expend wastefully," he said.

One thing the small business should consider spending money on is administrative support, Mr. Wall said.

"You can't do the things I've been talking about by yourself," he said. "Every one of you relies upon suppliers and subcontractors for skills and necessary resources not available in-house.

"There are people and organizations similarly skilled in helping businesses to manage health care costs. Call upon that expertise rather than trying to manage the problem on your own. The cost of doing so will be far less, and the effectiveness far greater than if you tried to do it on your own."

Mr. Wall suggested that small businesses group together to hire a health care management company that can serve all their needs.

"As a group of employers, small firms can develop a pool of financial resources needed to hire management support or bring in a management company under contract," he said.

Mr. Swain suggested that small businesses consider leasing personnel from leasing companies that administer wages and benefits.

The small business lessee pays the wages and benefits, as well as a fee for the lessor's services.

"Leasing companies can obtain lower rates for health insurance because they are larger than their clients," Mr. Swain explained. "Small employers also avoid administrative burdens in this ar-

Continued on page 12

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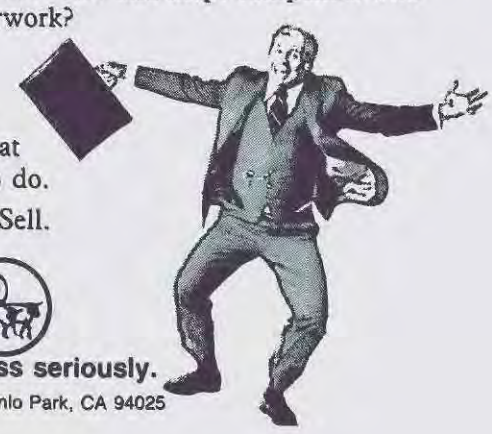
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Small business

Continued from page 9

rangement."

Another way small businesses also can cut the cost of health care insurance is by joining a benefit pool, Mr. Swain said.

"Small firms (can) join an association, a local chamber of commerce, or multiple-employer trust to pool health risks and thereby cut costs by spreading risks and fixing administrative costs," he said.

Small businesses also should have clear, two-way communication with their employees, especially when they ask employees to take on a larger share of health care costs.

"Communicating the changes and their necessity, while preserving employee good will, is important and can be done," he said. "Especially in smaller companies, it's easier to get a better sense of what employee needs are; it's also easier to get everyone together to explain the plan and to explain how their decisions can help control both your and their health care costs."

To reduce health care costs, small companies should stimulate competition among providers, Mr. Wall said.

"Don't be afraid to let hospitals and physicians in your community know that you and many other small firms are considering an alternative health benefit plan," Mr. Wall said.

Stimulating competition among providers can help reduce health costs, Mr. Wall said.

"Especially at this time, when there is a growing surplus of provider resources—hospital beds and doctors—you are in a position as the purchaser to make significant demands and have them met."

Mr. Swain and Mr. Wall both stressed the need to organize and affiliate.

"Coalitions can serve as mechanisms for small firms to urge policymakers, insurers and health care providers within their state to keep costs down," he said. "In addition, coalition members share cost-control information with each other."

As an example of what coalitions can do, Mr. Wall mentioned the New York Business Group on Health, which has developed programs to help small businesses with health care plan design, published a directory of resource and support organizations and devised a health promotion workshop to be delivered on-site to small companies.

"More coalitions should be challenged to take on similar initiatives," Mr. Wall said. "But, do not wait for this to occur—make that challenge yourselves. If your local business coalition does not have a small business forum, start one."

Mr. Wall offered several other suggestions that small businesses should follow, including:

- Restructuring benefits plans so that employees share more of the cost of health care.
- Creating a direct relationship with health care providers, rather than dealing only with an insurer.
- Encouraging the development of alternative health care systems, like HMOs and PPOs, to facilitate competition among providers and hopefully lower rates.
- Using PPOs and HMOs that provide a complete range of services that offer quick and easy access, so that employees have an incentive to use them.
- Polishing up administrative services so that providers are paid, and employees are reimbursed, promptly. ■

Fee-for-service system's end may be near

By DIANE LYNN KASTIEL

NEW ORLEANS—The health care delivery system in this country is undergoing nothing short of a revolution that will soon extinguish the fee-for-service system, experts predict.

"I believe five years from now, every physician in this country will be working under some sort of capitation or pre-payment program," said Sandra Person, executive director of the Houston Area Health Care Coalition, which is part of the Texas Business Group on Health. Ms. Person led a workshop on alternative health care delivery systems at the Fourth Annual Business/Health Coalitions conference.

While waiting for Armageddon, business coalitions can shape—and perhaps catalyze—the outcome by shunning traditional delivery systems, Ms. Person said.

Lawrence Newell, president of the Central Illinois Coalition on Health Care, who also spoke at the session, agreed with Ms. Person.

"It is your responsibility, if not your obligation, to provide some sort of alternative care. So, when coalitions are gone, you leave a legacy—you leave something of value to cost containment," he said.

"I see a true responsibility—a real challenge—to coalitions to make things happen at the local level. Innovation and creativity start at the local level and come up, and that is your opportunity."

However, simply contracting with a health maintenance organization or a preferred provider organization is not enough, Mr. Newell and Ms. Person agreed.

Ms. Person encouraged businesses to continually review existing alternative delivery systems as well as newcomers. By examining all the alternatives continually, businesses encourage providers to operate competitively.

"We want competition," she said. "Whenever there's a new guy in town, I invite them over and say, 'Let's hear about you. What do you offer? How can we help?' instead of treating them like they have leprosy.

"I tell my companies to examine (alternative delivery systems) every year and go out and get new bids. See what's out there. It might mean changing HMOs every once in a while, but it will guarantee you service."

However, most businesses don't know how to effectively and accurately assess the value of an HMO or a PPO, Ms. Person said. Her advice: Don't talk only to salesmen.

"The biggest mistake I see companies make is talking to the marketing people only," Ms. Person said. "When I say analyze (HMOs and PPOs), I don't just mean saying, 'I like the marketing reps.' Marketers have an objective, and that is to get you to like them and like their program and to sell their program.

"The first thing that our coalition did in evaluating HMOs in our area was to ask the senior management to come and talk to us. We wanted to ask them the questions—we didn't want them to give us a presentation. We didn't want a slide show and a lot of marketing. And it was amazing how

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Continued from previous page

frank these senior officers were about the strengths and weaknesses of their businesses."

Ms. Person listed some of the things companies should look at when analyzing an HMO, a PPO or other alternative health care delivery systems:

- Biographies of the management team. These will give you an idea of their qualifications.
- Corporate structure. Know who's in charge and how accessible they are.
- Book of business. This tells you who's "endorsing" the HMO or PPO.
- Benefits plan, contracts and rates.
- Claims filing procedures.
- Employee communications, including written materials and personal communications.
- Financial information, including sources of capital and financial statements.
- Physician and hospital agreements and locations.

Mr. Newell stressed that the HMO or PPO should offer a utilization review program.

"An HMO or a PPO without an effective utilization review program probably should not exist," he said.

Ms. Person also recommended that companies decide exactly what they want from a health care delivery system—and then put it in writing.

"The best advice, as a consultant, that I can give a coalition is, 'For heaven's sake, write a business plan,'" she said. "And, don't be bullied into contracting with an HMO that says you must offer an HMO under federal law," Ms. Person said. ■

Employee education the key to reducing health costs: Stone

By DIANE LYNN KASTIEL

NEW ORLEANS—Educating employees about health care is as vital to controlling health care costs as traditional cost-containment efforts, according to one expert.

"When we talk about benefits, we really have to talk about educating employees on the consumerism of the commodity we're talking about—health care," said Mary Hughes Stone, project coordinator for the Institute for Health Policy Studies at the University of California in San Francisco.

"What we need to do is give employees the knowledge to ask the right questions to assess what is good care."

Ms. Stone, who spoke on employee education and communication at the Fourth Annual Business/Health Coalition conference, sponsored by the Clearinghouse on Business Coalitions for Health Action, advised employers to use the same approach in educating and communicating with their employees as they do in communicating with their customers or clients.

"The task of employers is to use some of the skills they use in industry to communicate on health care," she said.

The Institute for Health Policy Studies recently conducted a study, requested by the United States Department of Health and Human Services, on how companies communicate with and educate their employees on access and use of health care, she noted.

So far, the Institute has surveyed about 175 companies through in-depth telephone interviews.

The companies, with between 100 and 180,000 employees and between 144 and 150,000 dependents, represent several industries, including consumer products manufacturers, industrial products manufacturers, financial services organizations and utilities.

Although the final result of the survey won't be available until this fall, Ms. Stone shared some of the preliminary findings with the conference attendees:

- Some 95% of the companies communicate with their employees on health care issues through magazines or newsletters. About 79% of these are produced in-house.
- About 70% of the companies interviewed offer audio/video presentations on health care.
- Of the companies that have been interviewed so far, 80% are self-insured, and 82.5% use third-party administrators.
- About 17% of the total employees of these companies were enrolled in health maintenance organizations. For individual companies, this percentage varied from no enrollment at companies that don't offer health maintenance organizations to as much as 80% enrollment at some companies.
- About 22.5% of the companies offered a preferred provider organization to their employees.
- About 81% offer employee assistance programs such as smoking cessation, weight control and stress management. About 72.5% conduct health care utilization reviews.

According to Ms. Stone, the survey found that the theme of a communications campaign was important to the companies. All the communications campaigns had a theme. Some were tied into a larger company theme; others were independently developed just for the health care campaign. Many companies used a logo to help the health care communications stand out from the other mail employees received.

Ms. Stone complimented the companies who sent information to the home as well as the office, saying she believed that sending information solely to the office cuts off communication with an important sector of a company's health care recipients.

"The focus (of inter-office communications) is on the employee only," she said. "As a consequence, it doesn't reach spouses, children or retirees. If a company wants people to be prudent purchasers of health care, they must reach all of these people."

Although many of the companies led an excellent communications campaign, most stopped communications after the enrollment period into a new health care plan, Ms. Stone said. "Our contention is that that shouldn't happen."

Ms. Stone also advised employers to give their employees wallet-sized cards that list questions an employee should ask his or her doctor about the necessity and cost of any health care procedure.

"Usually, when you're sitting on a steel table with all your clothes off, in paper wrapping, some of those questions go out of your mind," Ms. Stone said.

She also advised employers to tie their health care communications efforts in with those made by other health care programs, such as those sponsored by the company's union, HMOs or community or national programs. ■



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Medical technology: Is restraint needed?

By DIANE LYNN KASTIEL

NEW ORLEANS—Expanding medical technology is either a boon for mankind or the bane of a benefit manager's existence, depending on whom you talk to.

A father and son debated this issue at the Fourth Annual Business/Health Coalition conference.

Arguing that medical technology utilization should be restricted because of its prohibitive cost was Ronald A. Hurst, manager of health care planning for Peoria, Ill.-based Caterpillar Tractor Co. and executive vp of the Bethesda, Md.-based American Medical Care and Review Assn.

On the other side of the fence was his son, Gregory C. Hurst, a principal scientist at Picker International Inc. in Highland Heights, Ohio.

Ronald Hurst argued that the government should restrict—through Medicare and Medicaid payments—the use of new medical technology in an effort to hold down health care costs.

In response, Gregory Hurst argued, "I believe that this type of governmental regulation is inherently flawed and represents, at best, a short-term, shortsighted solution. If we admit that there is a limit on the quality and/or accessibility of medical care, the best solution is to allow market forces to determine their development and distribution."

While Ronald Hurst acknowledged the value of technology, he said its ever-increasing cost requires restraint on use.

"I'm not some Luddite trying to hold back technology," he said. "I don't want to eliminate high tech in medicine. Clearly, continued technological progress is necessary," he noted.

"But, some tough questions need answers. Have we achieved the right balance between ethics, economics and health care? I don't think so."

Ronald Hurst noted that, according to reports from the U.S. Congressional Office of Technology Assessment, medical costs have increased by 19% annually since 1974. He said OTA reported that almost one-third of that increase was related to the cost of new medical technology. The other factors were expanded use of services and inflation.

"It cannot be argued that big-ticket items are money sinks," Gregory Hurst maintained. As an example, he cited a study by the Rochester, Minn.-based Mayo Clinic that showed use of computer tomography—an X-ray method that photographs internal organs at angles not possible with traditional X-rays—achieved an average net savings of 15% in diagnosis of common diseases.

"But, I am not suggesting that the parallel growth of medical technology and health care expenditures is purely coincidental," he explained.

"Expanding technology is indeed the cause of much of these increased costs. (But) the regulators would have you believe that if the system is simply squeezed hard enough, all the bad stuff will fall out. This is crude and shortsighted economics."

Government should not stand in the way of medical developments that could save lives and maintain health, in the name of cost-savings, he said.

Taking this approach can be equated to turning off the light of a scientist's microscope in order to cut electricity costs, he added.

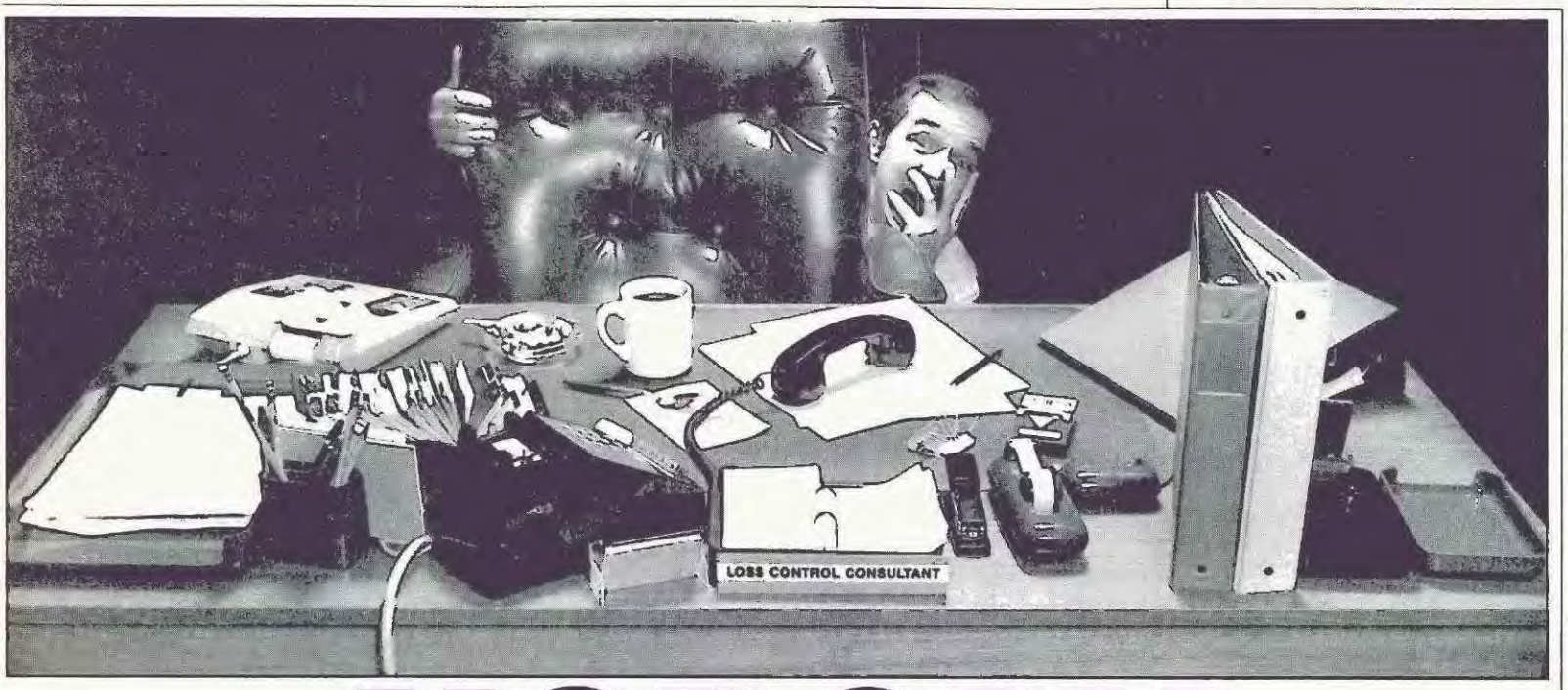
"Most of the easy and obvious technological innovations have been made. If we are going to proceed. . .this is not the time to artificially increase the difficulties and uncertainties of science and technological research and development," Gregory Hurst said."

However, Ronald Hurst, who also acts as a consultant to OTA, argued that the use of expensive, "high-tech" medical procedures should be curtailed. This not only would control health care cost inflation, but also would protect the public from abuses of doctors who employ costly high-tech procedures even when they may not be necessary, he said.

Even medical experts disagree on the usefulness of "high-tech" medicine, he added.

"The Office of Technology As-

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sessment has documented widely varying standards as to whether certain medical technologies are useful. With such widespread differences among the experts, and a massive federal deficit, do we really want to spend so much of our limited resources on technologies of debatable merit?" Ronald Hurst asked.

Gregory Hurst countered that legislation already exists that protects consumers from fraudulent technology and "witch doctors."

"Our (U.S. Food and Drug Administration) has some of the world's strictest standards for demonstrating the safety and worthiness of medical devices and procedures," he said. "Have you seen any snake oil salesmen lately?"

Yet, he didn't propose that scientists be given free rein. Various forces instead must work together to come up with the most-effective compromise between expanding costly medical technology and escalating health care costs.

The debate's finale found the Hursts in agreement on one thing: Finding an answer to the medical technology dilemma will be an uphill battle that requires a joining of forces.

"I don't believe any of us—legislators, businessmen, scientists or administrators—are individually smart enough to dictate a real solution to this dilemma," Gregory Hurst said. "However, a stable and equitable solution will require a true consensus of legitimate market forces."

Ronald Hurst said, "The problem of the high cost of medical technology is like many other current, tough policy questions. It has no simple, easy answer, no quick fix. . . .As with so many tough questions, the answer is also tough: balance.

"Our society can (do this). That is part of the genius of pluralism in our democracy and the free enterprise system," he added. ■

Washington rating plan pays refunds

OLYMPIA, Wash.—A majority of employers that participated last year in a special insurance rating plan of the Washington State Fund are being rewarded for their good safety records with premium refunds.

The Washington Department of Labor & Industries has refunded more than $4.7 million in workers compensation premiums to more than 1,000 employers, some of which purchase their workers compensation insurance as a member of a group.

The refund checks range from $18 for a small employer, to about $1.9 million for an employer group, said a spokeswoman from the department.

"These employers did an outstanding job of promoting safe working habits and avoiding costly accidents. As a result, the state's industrial insurance fund did not pay out as many dollars in medical and disability benefits as was projected," said department Director Dick Davis.

"Therefore, these cost savings can be passed on to the employer in the form of a premium refund," Mr. Davis added.

Employers that received the refunds participated in a special retrospective rating plan that was initiated in 1982 by the State Fund. Under this plan, if the injury costs are lower than forecast for the coverage period, an employer could receive a refund on premium paid. However, if the injury costs were higher than forecast, the employer could be charged a penalty to partially cover the unanticipated costs.

Some 113,000 employers purchase their workers compensation insurance from the State Fund. Last year, 1,841 of those employers, as either individuals or members of a group, participated in the special retrospective rating plan.

Of those, about 60%, or 990, of the group plan enrollees—and 57%, or 108, of the individual employers—received refunds totalling $4 million.

Another $751,436 was returned as second- and third-year adjustments to employers enrolled in the program during 1982 and 1983.

A total of $2.7 million in penalties were charged to employers whose claims costs were greater than originally projected, based on their actual injury claims costs, the spokeswoman said.

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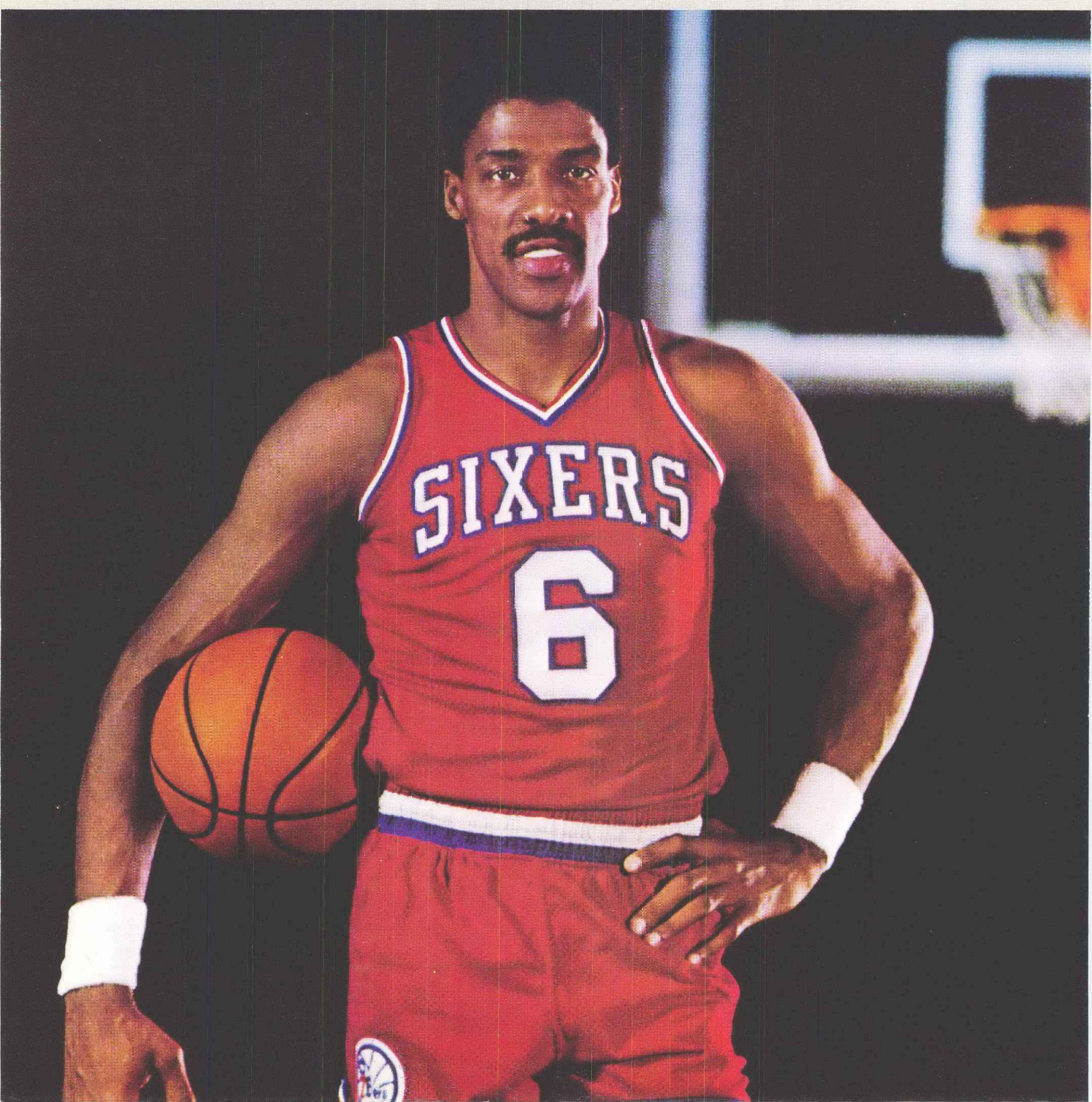
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GROUP LIFE: THE REAL COST

By Arlene Munson

EMPLOYERS: BEWARE of the fallout from Internal Revenue Code Section 79 requirements for group term life insurance. Blissful ignorance or blatant dismissal of these restrictions on the part of employers could condemn employees to a lifetime of additional taxation. Instead of the gold retirement watch, an unwary employer could very well be handing over a tax sentence to a retiree as a reward for faithful service.

The Tax Equity and Fiscal Responsibility Act of 1982—TEFRA—coupled with the Deficit Reduction Act of 1984—DEFRA—and the recently introduced Technical Corrections bill to DEFRA—H.R. 1800—have wrought havoc to Section 79 group term life insurance, which once was a sleepy section of the Internal Revenue Code.

TEFRA imposed non-discrimination requirements with respect to active key employees, and DEFRA extended these non-discrimination provisions to retirees.

Employers have an obligation to analyze their group term life insurance plans and make every effort to conform their program to the new non-discriminatory provisions of the Internal Revenue Code Section 79.

Section 79 originally contained three key provisions governing the tax treatment of benefits provided under an employer's group term life insurance program. The first provision allowed for the exclusion from income of the cost of the first $50,000 of employer-paid insurance; the second established a table for calculating the imputed income for coverage in excess of $50,000 (Table I rates), and the third excluded the cost of all employer-paid insurance for retirees and disabled employees, as defined in Section 72(m)(7) of the Tax Code.

For most 100% employer-financed plans, these statutory boundaries presented neither arduous administration nor onerous compliance requirements. Consequently, group term life was often relegated to the back of many a plan administrator's mind. It was simply there to be provided for employees with imputed income readily calculated for coverage above $50,000.

TEFRA added the first snag to this otherwise facile administrative process. Plan administrators were required to determine as of Jan. 1, 1984 whether their programs discriminated in favor of active key employees.

TEFRA defines key employees the same way as used for purposes of determining whether a qualified retirement plan is top-heavy (see Exhibit 1). The discrimination tests are of a twofold nature—eligibility, and type and amount of benefit (see Exhibit 2). TEFRA did not prohibit group term life plans from being discriminatory. However, plans found to be discriminatory led to a small amount of additional imputed income for active key employees. In discriminatory plans they lost the exclusion for the first $50,000 of coverage. The value of the imputed income was still calculated using the IRS-prescribed Table I rates.

Retirees, whether or not they fell into the key employee category, continued to escape the imputed income rules. Plan administrators had the option of either making their plans non-discriminatory or allowing their plans to remain discriminatory and having key employees pay the cost of a small amount of additional imputed income or compensating key employees for any additional tax liability—the so-called grossing-up solution.

For small plans with relatively few key employees, this latter approach was often the most feasible. On the other hand, some employers that had large plans with numerous key employees and a proportionately larger overall employee base found that they could tailor their plans to TEFRA's non-discrimination provisions without simultaneously providing greater across-the-board coverage for all employees. This could be achieved by meeting the coverage requirement, whereby no more than 15% of the plan participants are key employees. Of course, the benefits for the employees covered under such a plan would have to be an equal percentage of compensation, for example, one or two times pay.

Apparently, Congress and the Internal Revenue Service were not satisfied that TEFRA had gone far enough in bringing about non-discrimination in group term coverage or that sufficient revenue was being raised from tax penalties imposed on active key employees.

It is quite conceivable that the DEFRA amendments to Section 79 were born out of this dissatisfaction, coupled with past congressional failures to tax retiree benefits and the need to seek additional sources of revenue.

Effective on the same date that TEFRA's non-discrimination requirements of Section 79 group term life insurance became effective—Jan. 1, 1984—DEFRA amended TEFRA's non-discrimination requirements in three significant ways.

Whereas TEFRA only required that active employees be taken into consideration for satisfying non-discrimination tests, DEFRA requires that retirees be considered when applying the non-discrimination tests, either now (new plans) or in the future (plans in existence Jan. 1, 1984). According to the Joint Committee on Taxation's Blue Book on DEFRA, retirees could be tested as a separate group to determine the plan's discriminatory or non-discriminatory status, since many companies provide lesser coverage to retired employees. However, H.R. 1800 cautions that the IRS may prescribe regulations on how these discrimination tests are to apply separately.

Secondly, the inclusion in income of the cost of employer-provided coverage in excess of $50,000 would apply to retirees as well as active employees, and the inclusion in income of the cost of *all* employer-provided coverage under discriminatory plans would apply to retirees classifiable as key employees as well as active key employees. Thus, whereas a key employee under TEFRA could have escaped all taxation of group term life insurance under a discriminatory or a non-discriminatory plan as a retiree, this no longer will be possible.

Lastly, DEFRA intended to further penalize key employees in discriminatory plans by eliminating the use of the Table I rates in calculating the imputed incomes for these employees. Employers hold the key as to how much additional income active employees—but more importantly, retirees—will have to pay by maintaining either a discriminatory or a non-discriminatory plan. The tax treatment is different for key employees vs. non-key; age 55 or older vs. 54 or younger on Jan. 1, 1984; and discriminatory vs. non-discriminatory plans. Plan administrators must be careful in creating a policy that rightly credits the proper imputed income for the respective class of employees under specific plans. DEFRA certainly can be credited with having exacerbated the ever-painful administrative headache, in addition to forging the path toward greater taxation of retirees' post-employment benefits.

DEFRA did include a grandfather clause for group term insurance programs in existence on Jan. 1, 1984. Individuals under these plans who were at least 55 years old on Jan. 1, 1984, *and* who were employed during 1983 *or* retired on or before Jan. 1, 1984, would not have to include the value of their group term life insurance above and/or below $50,000 whenever they retire, provided they retire under a non-discriminatory plan. This applies to both key and non-key employees.

In the event a plan is discriminatory, these individuals could escape all future taxation of their group term life insurance coverage only if they retire on or before Dec. 31, 1986.

Although the statute implies that this exception would not apply to retirees under age 55 on Jan. 1, 1984, the Blue Book states that it was congressional intent to grandfather all those retired as of Jan. 1, regardless of age. The Technical Corrections bill further clarifies that it was the intent of Congress to grandfather all individuals retired as of Jan. 1, 1984.

Ironically, active key employees today could be better off under discriminatory rather than non-discriminatory plans. Under a discriminatory plan, key active employees are taxed on the full value of group term coverage according to its actual cost. On the other hand, if the plan is non-discriminatory, the key employee is taxed on coverage above $50,000 computed according to the IRS Table I rates. With today's market premium rates, taxing the full actual costs may produce a lesser liability than taxing the excess over $50,000 according to the Table I rates.

For example:

Jane Doe, a 60-year-old, key employee of AB&C Corp., receives $200,000 of group term life insurance. The AB&C Corp. plan is determined to be discriminatory. Thus, Jane Doe loses the first $50,000 exclusion and is taxed on the actual cost of the whole $200,000 in coverage. AB&C Corp.'s insurer's actual premium for Jane Doe is $1,824. Jane Doe is in the 50% tax bracket, and therefore incurs an additional $912 tax

Continued on next page

EXHIBIT 1
Key employees

- Officers (no more than 10% of all employees with a minimum of three and a maximum of 50). DEFRA further eliminated some members of this category by adding a minimum salary amount, currently set at $45,000 until 1988. The salary amount equals 1½ times the Section 415 limit for annual additions under tax-qualified defined contribution plans.
- More than 5% shareholders.
- The 10 employees with the greatest ownership shares and compensation above $30,000.
- More than 1% shareholders with an annual compensation greater than $150,000.

An individual could retain the designation of "key employee" for four years after ceasing to fall into one of the categories listed, even if the individual is not an employee during some or all of those four years.

EXHIBIT 2
Non-discrimination tests

ELIGIBILTY (one of these provisions must be satisfied)

- The plan benefits at least 70% of all employees of the employer.
- At least 85% of plan participants are not key employees.
- The plan covers a group determined by the IRS to be non-discriminatory in terms of key vs. non-key employees.
- The plan is part of a cafeteria plan meeting the requirements of Section 125.

TYPE AND AMOUNT OF BENEFITS

All benefits available to key employees are available to all other participants. Thus, if a plan offers a standard percentage of compensation to all participants, even though the actual amounts differ, the plan is non-discriminatory.



Arlene Munson is a senior assistant benefit consultant for Buck Consultants Inc. in New York.

perspective

Quake's aftershocks felt in Chile market

By S. Robert Beane

international issues

AT 7:46 p.m. on March 3, 1985, Chile was hit by a severe earthquake. Centered some 40 kilometers from the coast, the 3½-minute quake occurred in the most-populous part of the country, affecting more than 6 million of the country's 11 million people.

The shock was most destructive near the coast, dropping in intensity as it reached the Andes Mountains, where Chile's capital, Santiago, is located. But, in Santiago and in the ports of Valparaiso and San Antonio, the resort city of Vina del Mar, and in smaller cities, the destruction to older buildings was considerable. Many older buildings were rendered uninhabitable, dislocating some 1 million people.

In newer buildings, the most significant damage was to the internal walls. The upper floors of the higher buildings were severely damaged, and many of the buildings suffered serious structural damage.

Old public buildings such as city halls, museums, and churches lost roof ornamentation and steeples.

The access roads to some bridges collapsed; the concrete slabs of others cracked badly enough to make them unusable. Streets and highways were blocked and in some cases damaged but not destroyed. Railroads incurred similar damage.

In the ports, the main damage was to the piers. Loading cranes collapsed and fell into the sea. Port warehouses and administrative offices were also severely damaged.

Public services also were disrupted. Although electricity and telephone service was interrupted, the service was restored and operating normally within 48 hours.

The main difficulty was with public water and sewerage lines that were severed in several places. The subsequent repairs were long and difficult; in certain sections, water was not restored for 30 days or more.

The authorities were extremely effective in dealing with the disaster. Within a week, ports were functioning at 60% of capacity.

This was important, because the earthquake occurred at the peak of the fruit-shipping season. By extending loading operations from two to three daily shifts at piers that were still operational and using the ships' own cranes to load the fresh goods, the emergency was resolved.

Emergency hospitals were set up in populated areas. People gathered in makeshift housing facilities, and provisional dwellings were erected and made available to those left homeless by the earthquake.

Buildings that had sustained major structural damage were demolished. Demolition and debris removal, carried out on a grand scale, gave a Dantesque aura to many areas.

Fortunately, the hour and day of the earthquake—7:46 p.m. on a Sunday—and the warm end-of-summer weather in Chile helped keep the number of casualties down. Only 177 people were killed and 2,000 injured—remarkably low, given the magnitude and duration of the quake.

A series of noticeable aftershocks followed the earthquake. They continued for some time, causing little new damage but increasing existing damage and frightening the people.

Fortunately, although a tidal wave was anticipated and the alarm sounded, no tidal wave ever materialized, possibly because the ocean floor does not drop sharply near the coast.

When the Chilean insurance market abandoned the compulsory minimum tariff and eliminated the reinsurance monopoly early in 1980, the number of properties insured for earthquake increased substantially, mainly because the price dropped dramatically.

The earthquake was the first to affect the restructured market. The number of claimants suffering various degrees of loss made claims settlement difficult and slow. The sheer number of claims in the days after the quake exceeded underwriters' ability to respond promptly to all. There simply were not enough independent adjusters to look into every loss exceeding $1,000, as mandated by law.

When the earthquake struck, the Johnson & Higgins office there had to decide how to reach its clients as expeditiously as possible, in the absence of communications and transportation service. Manager Max Cano called an early morning meeting March 4 to discuss a plan of action with the entire staff. The group divided into four teams, which were dispatched to the four quadrants of the city to visit every J&H client in person.

By Tuesday evening, J&H had met with virtually every client to begin the process of gathering facts to put together claims reports and to help each client return to business as usual.

Once the inspection of claims was complete, other problems arose. Although insureds were required to obtain at least two estimates from contractors for needed repairs and reconstruction, there were not enough contracting firms to handle the demand. Insureds with extensive damage or with possible structural problems had to obtain the services of structural engineers to analyze damaged structures, establish the extent of the damage, and give an estimate of reconstruction costs.

Buildings were most seriously affected by the earthquake. Damage to machinery, building contents, and inventory was less severe. Bulk inventories of liquids stored in tanks that collapsed or lost their foundations were the most vulnerable. Machinery and equipment that had been knocked about had to be checked to ensure that pipes and electrical installations were still intact to avoid further damage, but this was accomplished at relatively little cost.

In private homes, most of the damage was to roofs, chimneys, and internal walls. Glass windows were most affected, especially in steel-frame buildings that were less flexible than wooden buildings.

Housing reconstruction was fraught with problems. Repair costs rose in response to the amount of work needed, and with the approach of winter, there was a threat of further damage from rain if repairs to roofs and outside walls were delayed. The shortage of construction materials further increased costs, and low inventories of imported products ran out completely.

Still, there was a demand to repair buildings, whether insured or not.

The magnitude of the earthquake revealed construction deficiencies in new or relatively new buildings that had not been apparent previously. Defects were discovered in construction materials and poor construction—especially in populous areas where the government had contracted with private companies to build housing.

An interesting aspect of the repair effort was the extent of damage from previous earthquakes that was uncovered. Many buildings appeared to

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.

Retirees could be condemned to life of higher taxes

Continued from previous page

liability. Given the same circumstances, if AB&C Corp.'s plan was non-discriminatory, Jane Doe would incur a greater tax liability of $1,053, based on Table I rates.

The result certainly is contrary to the congressional intent of penalizing key employees of discriminatory plans. Thus, the Blue Book concludes, contrary to the words in the statute, that the higher of Table I or actual cost should be used when calculating the imputed income for key employees.

Discussions with the IRS drafters of Section 79 reveal that the IRS indeed hopes to issue regulations in the form of questions and answers whereby the Table I rate would have to be used if it is greater than the actual cost.

However, this regulatory interpretive approach would have opened the door to legal challenges based on the Treasury Department's attempt to create law rather than administer the law.

To avoid this potential allegation, Congress currently is seeking to amend DEFRA through H.R. 1800, which, when signed into law, will amend Section 79 to provide, for tax years ending after the date of enactment, that the imputed income to key employees in discriminatory plans is the greater of the actual cost of the insurance or the cost based on the uniform premium rate—Table I.

Thus, plan administrators who used actual cost, even if it was lower than the Table I rates, were justified based on the current status of DEFRA and the absence of IRS regulations. Consequently, there will not be any retroactive penalty if H.R. 1800 is enacted in its current form.

Plan administrators concerned with the current ambiguity surrounding the definition of actual cost in determining the value of group term coverage should take note of IRS Revenue Ruling 84-147. Although the situation in Revenue Ruling 84-147 concerns the computation of a gift tax liability resulting from an assignment of a group term life insurance policy, its discussion of the determinants of actual cost could readily be applied to the computation of income tax liability resulting from group term life insurance. It clearly delineates that if a policy covers more than one employee, the cost is to be determined by actuarially apportioning it among the individual members of the covered group.

This finding precludes the use of a blended rate that disregards an individual's age as an actuarial cost factor. What if a corporation merely receives a single blended cost from its insurer? The Section 79 regulation drafters hope to come up with a table suggesting age and mortality factor rates to assist employers who find themselves in such a situation. Is this the beginning of Table II?

If the November 1984 Treasury tax reform proposal had made its way into law, the exclusion for the cost of the first $50,000 of employer-provided coverage would have been a thing of the past for all active employees, non-key as well as key, and eventually for all retirees. However, the latest reports from our nation's capital indicate that President Reagan's tax reform plan will retain the current exclusion for the cost of the first $50,000 of employer-provided group term life coverage. Should this indeed be the outcome, employers that were prematurely resigned to the repeal of Section 79 now must change gears and take a meaningful look at their plans (see tax story, page 1). Perhaps the time has come to allow employees to decide through some flexible benefit arrangement, just how much additional taxation they are willing to incur for insurance coverage.

Although the IRS has yet to issue any direct guidance or regulations on Section 79 group term life insurance as amended by TEFRA and DEFRA, plan administrators have to act now to identify their key employees, analyze their plans to determine their discriminatory or non-discriminatory status, decide whether to amend their existing plan, determine the actual cost or proper Table I imputed rates for employees, and communicate the changes to all current and future affected employees.

A final word of caution: Plan administrators should not rely on the method used this year to calculate imputed income as it may not be permissible for future use.

Continued from previous page
be destroyed by the quake, but it became clear that if these buildings had been in good condition and had been inspected and repaired following prior shocks, it would not have been necessary to contemplate their demolition.

The earthquake also revealed the importance of building terrain and foundations. Some damage surely would not have occurred if foundations had been better situated and properly built.

If the earthquake had occurred in midweek during a workday in winter, the effects certainly would have been more severe. But fortunately, the timing of the earthquake minimized the damage.

There were few fires because people were not using their kitchens late in the day and, in the warm weather, there was little need for gas stoves and kerosene heaters.

Fires were further averted because factories were closed on Sunday. Computers, most of which were shut off for the weekend, escaped the damage they would have suffered if they had been operating. Most stored data was unaffected by the quake.

Because the earthquake caused a minimum of damage to machinery or inventories, business interruption was relatively brief. Electricity was restored quickly, machinery was inspected, damaged equipment was replaced, and most enterprises were soon operating again.

In the wake of the destruction, the insurance market was initially reluctant to offer earthquake coverage to affected areas.

Soon, however, coverage was made available at a price for earthquake-proof buildings that passed inspection.

Buyers of insurance for buildings that were not earthquake-proof had to accept a 25% deductible to obtain insurance.

Deductibles of 1% to 2½% of total insured values were applied to high-quality buildings, up to limits of $80,000 per claim.

Since the earthquake, the local insurance companies have felt pressure from reinsurers who had to absorb a great portion of the earthquake losses through excess-of-loss reinsurance contracts. This, in turn, is forcing a contraction in coverage and an increase in premium costs.

It is too soon to know precisely what effect the earthquake will have on the Chilean insurance market.

The contractions in the world insurance market will certainly be felt in Chile as both insurers and reinsurers try to bring premium income into line with claims. The recent earthquake losses will speed this process along.

Also, there may well be a reluctance among underwriters to commit further capacity in an area that has now become a well-established earthquake zone.

As a result of the quake, Chilean insurers have learned where and why damage occurred, what types of buildings were most vulnerable and what damage most probable, and what conditions tend to aggravate risk of damage.

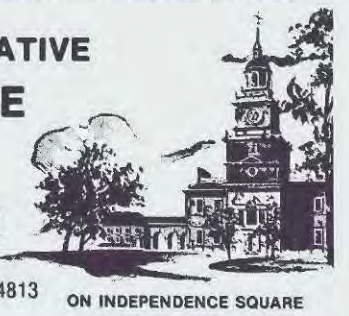
They have also learned what repairs are most difficult to perform, what problems will be encountered in obtaining supplies and how to expedite adjustments of catastrophic claims.

Finally, they have learned the value of making timely repairs and the long-term costs of inadequate construction and repair work.

If they can refine pricing, Chilean insurers will surely find a sellers' market waiting for them, at least among the multinational companies that are operating in Chile. ■

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Conference

Continued from page 3

Hewitt Associates. He will analyze the ever-changing relationship between consultant and client, addressing such issues as what clients should reasonably expect and how clients can get the most out of their consultant.

● "Working with Consultants: The Company Side," by Steve Wasserman, director of benefit communication and training for Dart & Kraft Inc. In this companion session to Mr. Heiring's, Mr. Wasserman will make pratical suggestions about when, where, why and how to use consultants. And, he will recommend what groundwork should be done prior to and while working with a consultant.

● "You be the Judge," by Herbert Zeltner, Herbert Zeltner Consultant Inc. Mr. Zeltner, a popular speaker at previous *BI* conferences, will introduce selected audiovisual programs submitted to the EBC competition and will offer a glimpse at what other industry professionals are doing.

The case studies sessions, which will involve smaller groups and encourage participant interaction, include:

● "Your Retirees: An Untapped Health Care Cost-Containment Weapon," by Jeffrey M. Ostroff, president of Jeffrey M. Ostroff Associates, and Vivian Anderson, director of corporate personnel for Allstate Insurance Co. Providing medical benefits to retirees can be very expensive, and the expense will grow as the retiree population grows. In this session, Mr. Ostroff will present a brief overview of the issue of post-retirement health benefits, and Ms. Anderson will explain a communications program Allstate used to deal effectively with the issue. Attendees will be given strategies for containing health care costs for both retirees and active workers.

● "Benefits Overhaul," by Mr. Wasserman of Dart & Kraft. Dart & Kraft was faced with the problem of redesigning a portion of its benefits package in just three weeks, from start to sign-up. In this informative presentation, Mr. Wasserman explains how Dart & Kraft did it.

● "Computers Can Talk Benefits," by Pam Keeler, director of advanced benefit communications for Metropolitan Life Insurance Co. In an effort to increase employee understanding and perception of their benefits program, Metropolitan Life designed an innovative program that allows Met Life employees to access their benefit and savings plan information directly through interactive computer terminals stationed throughout Met Life headquarters. Ms. Keeler will explain the intricacies of how the system works.

The print workshops will address specific communications needs:

● "The Power of Personalizing Print," by Deborah K. Huffman, senior vp of Frank B. Hall Consulting Co. Ms. Huffman will discuss the advantages and disadvantages of personalizing print communications. And, she will compare traditional and laser print materials, providing examples of good and bad personalized communications using both techniques.

● "Standard Print Communications and Print Enhancement," by Martin Lapidus, consultant with Towers, Perrin, Forster & Crosby. Mr. Lapidus will explain that, to effectively communicate benefits to employees, a benefit manager must understand the issue and also must anticipate what reaction management expects from employees. He will suggest that the nature of the change being made to a benefits program—whether it is positive or negative, for example—helps determine the elements needed for effective communication. And, he will offer a practical look at what management's goals should be in communicating benefits

The task force segment of the conference will provide conference attendees with a challenging professional forum. It is designed to encourage attendees to share their questions and problems and suggestions and solutions, and to work together toward more effective communications strategies. Registrants are encouraged to submit, on their registration forms, any questions, problems or issues on benefits communications they would like to discuss. At the conference, registrants will be divided into groups to permit a "give and take" framework for discussion. Each group then will share its solutions and ideas with all attendees.

The cost of the *BI* conference is $575; a 10% discount is offered to additional registrants from the same company. The fee includes sessions, workbook and educational materials, breakfast, coffee breaks, luncheons and the opening cocktail reception.

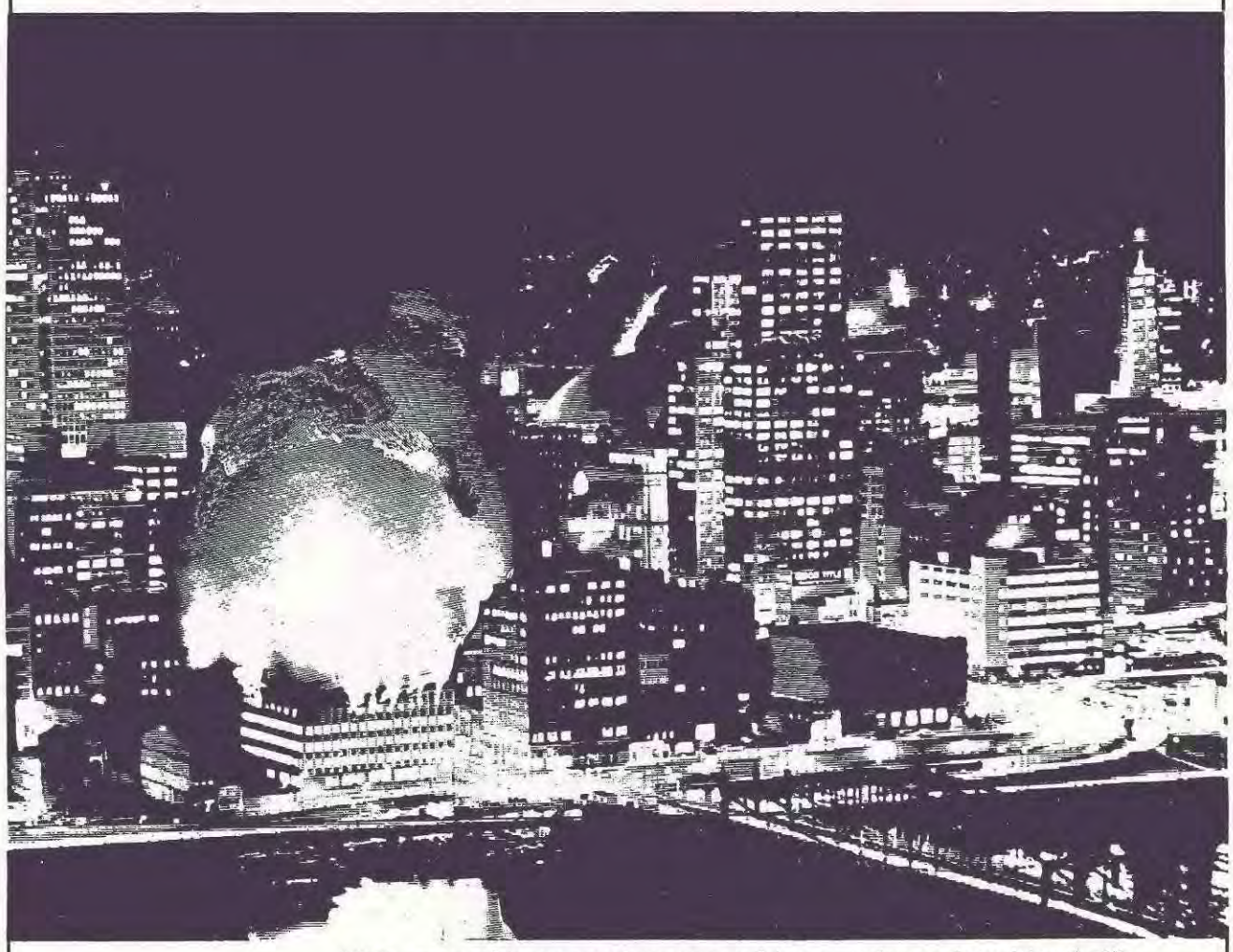
Payment is required with registration, and all cancellations must be made in writing. A full refund will be given to cancellations received before July 5; after that, a $100 service fee will be charged. No refund will be made on cancellations received less than five business days before the conference. However, another person from the same company may be substituted without penalty.

BI has set aside a block of rooms at the Grand Hyatt Hotel at special rates of $100 for a single room and $125 for a double. Registrants must mention the *BI* conference when making their registration at the hotel to take advantage of these rates. The reduced rates will be available until July 22.

For more information or to register, contact *Business Insurance* Communications Services Department, 220 E. 42nd St., New York, N.Y. 10017, or call Ann Vasquez, registrar, at 212-210-0137. ■

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Work comp state fund bill dies in Illinois

SPRINGFIELD, Ill.—A bill calling for the creation of a workers compensation competitive state fund in Illinois is assumed dead for this legislative session, after it was not passed by the House Labor & Commerce Committee by May 3, the deadline for preliminary action on legislation.

Had it passed, H.B. 1515 would have set up a state-run insurance company in Illinois to compete for workers compensation premiums.

Thirteen other states have competitive funds.

No hearings were held on the bill.

Several legislative observers, however, initially had thought that the bill had a good chance of being passed this year (*BI*, April 29).

Another piece of legislation—H.B. 620—which calls for the regulation of video display terminals in the workplace, also would have died in committee, but the Labor & Commerce Committee waived the deadline.

A hearing is expected to be held on the bill this month.

The bill would require employers to provide adjustable chairs and tables for VDT users, pay for eye exams to be taken on company time, provide the option of alternative work for pregnant operators, allow a 15-minute break of alternative work every two hours and install noise-reducing covers on the word processors and printers (BI, April 1).

Another bill, S.B. 320, which would help pay workers compensation costs for certain manufacturers that set up shop in Illinois, passed the Senate last month. ■

comings & goings: industry

Paul to head AIG unit's political risk division

Several management changes have been announced at American International Group Inc:

Douglas A. Paul named president of the Political Risk Division of AIG Specialty Agencies Inc., a unit of New York-based American International Group Inc. Mr. Paul, who joined AIG in 1983, also is AIG vp for strategic planning.

Elmer N. Dickinson named chairman of New York-based American International Group Inc.'s domestic brokerage division. Mr. Dickinson has been with AIG since 1948. Also, **Thomas R. Tizzio**, president of Transatlantic Reinsurance Co., an AIG unit, named president of AIG's domestic brokerage division. He joined AIG in 1967. Succeeding Mr. Tizzio at Transatlantic Re is **Robert M. Huggins**, who also was named underwriting manager. Mr. Huggins joined the company in 1984 as executive vp.

Also at AIG, **Charles J. Bird** named vp of the North American division of American International Underwriters. He also has been appointed manager of AIU's New York brokerage division and will oversee all aspects of AIU's New York regional operation. Mr. Bird most recently was manager of CIGNA's Corp.'s captive department.

Other insurer changes:

Joan E. Herman named vp in charge of group underwriting at Phoenix Mutual Life Insurance Co. in Hartford, Conn. Ms. Herman, who joined the company in 1982, most recently served as second vp-group underwriting. Also at Phoenix Mutual, **Robert G. Chipkin** promoted to vp and group actuary. Mr. Chipkin joined the company in 1972 and has served as group actuary since 1984.

Jerry M. Freeland named resident vp at the Jacksonville, Fla., branch office of Continental Insurance Co. Mr. Freeland, who has been with Continental for more than 25 years, most recently served as resident vp at the company's Philadelphia office.

Paul H. Stewman promoted to vp in charge of Houston branch operations at Chubb & Son Inc. Mr. Stewman previously served as branch manager.

Randall C. Meono promoted to vp and actuary at Alexander Hamilton Life Insurance Co. of America in Farmington Hills, Mich. Mr. Meono has been an executive with the company since 1979.

F.K. Stanley named president and chief executive officer at Beaver Pacific Corp. in San Francisco, parent of Beaver Insurance Co. Mr. Stanley joined Beaver in 1981 and most recently served as executive vp and chief operating officer. Also at Beaver Pacific, **William T. Waste** named vice chairman of the board. Mr. Waste has served as president and chief executive officer since 1975.

J. Robert Krisowaty named senior vp and general claims manager at Reliance Insurance Co. in Philadelphia. Mr. Krisowaty, who joined the company in 1982, most recently served as vp and general auditor.

Robert M. Perite named vp of the group and health division at The Equitable Life Assurance Society of the United States. Mr. Perite, who joined New York-based Equitable in 1954, most recently served as vp in charge of the Central Administration Center.

Robert H. Zinn elected vp in charge of all Florida operations of Chubb & Son Inc., based in Warren, N.J. Mr. Zinn, who has been employed at Chubb for 23 years, will continue as branch manager in the company's Tampa, Fla., office.

Robert L. Pope, executive vp and chief executive officer of Inter-Ocean Insurance Co. in Cincinnati, named president. He replaces **Thomas J. Smart**, who retired in April from Inter-Ocean, a subsidiary of Cincinnati Financial Corp. Mr. Pope, who joined The Life Insurance Co. of Cincinnati, a CFC subsidiary, in 1979, was named executive vp of Inter-Ocean in 1984. He became chief executive officer in February. ■



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~~May 20~~	~~May 8~~
~~May 27~~	~~May 14~~
~~Jun 3~~	~~May 21~~
Jun 10	~~May 29~~
Jun 17	Jun 5
Jun 24	Jun 11
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General Motors changes health plans

Salaried and union workers for General Motors Corp. are switching from traditional health care plans to health maintenance organizations and preferred provider organizations, under GM's new "Informed Choice" health care plan.

The "Informed Choice" plan, which offers employees a choice among the three types of health care delivery systems, was adopted by the United Auto Workers in October and announced to salaried employees in November.

Employees made their choices during an enrollment period that lasted Jan. 15 to Feb. 5.

About 800,000 people made the elections, including GM's 530,000 active employees and 270,000 retirees or surviving spouses. Including dependents, the "Informed Choice" plan covers 2.1 million people, or about 1% of the total U.S. population.

Of those employees making elections, 106,000 chose an HMO, a 51.4% increase over the 70,000 who were enrolled in an HMO before the April 1 effective date for plan membership.

An additional 22,500 chose a PPO, an option that was not available before April 1. The remaining 671,500 chose the traditional plan, an 8% decrease from the 730,000 who were enrolled in the traditional plan before April 1.

Some 128,500 of GM's active employees and retirees—or 16.1% of the total—opted for an HMO or a PPO. Including dependents, the new elections put 350,000 people—or about 17% of the total covered under a GM health care plan—into an HMO or a PPO, which generally are thought to be more cost effective than traditional health care plans.

In Michigan, 349,000 people made elections—246,000 active employees and 103,000 retirees.

Of those, 53,000 chose an HMO, a 40% increase over the 45,000 who were enrolled in an HMO before April 1.

Another 16,700 employees chose a PPO. The remaining 269,300 employees and retirees chose the traditional plan, an 11.4% decrease from the 304,000 who enrolled in the traditional plan before April 1.

Dick O'Brien, general director of

benefit beat

employee benefits for GM, said the Michigan figures more accurately reflect employees' preferences because Michigan GM workers have the highest number of PPOs from which to choose.

PPOs also have been established in Atlanta and Dayton, Ohio. And, the company is organizing PPOs in other states where GM has employees, but they won't be completed until the end of the year, he said.

In the Michigan elections, which Mr. O'Brien feels will reflect national choices once PPOs are established nationally, 22.8% of total active and retired employees opted for HMOs or PPOs. Before the "Informed Choice" plan took effect, only 13% of active employees and retirees opted for an HMO or a PPO.

Those percentages are even higher for active employees only—27% of them opted for an HMO or a PPO, compared with 16% under the old plan.

And, Mr. O'Brien said he expects the percentage of people covered under the alternate delivery systems to grow.

"At first, people may be reluctant or hesitant to change, but I think that as employees begin to see the benefits of HMOs and PPOs, that more will switch to this kind of coverage," he said.

HMO enrollment up

Increasing numbers of state employees in Frankfort, Ky., are opting for medical coverage through health maintenance organizations rather than their traditional health insurance plan.

Earlier this year, Kentucky added three new HMOs to its medical plan. Previously, the 98,000 employees had been offered a choice between traditional coverage and enrollment in HealthAmerica Corp. of Kentucky, an HMO.

The three new HMOs are HMO of Kentucky, a subsidiary of Blue Cross/Blue Shield of Kentucky Inc.; Humana Health Plan Inc.; and Independence Health Plan of Kentucky.

The number of employees who chose HMO coverage under the new plan more than doubled to 5,700, up from 2,500 under the previous plan.

However, the majority of employees—almost 92,000—chose the traditional, comprehensive plan underwritten by Blue Cross/Blue Shield of Kentucky Inc.

Under the Blue Cross/Blue Shield plan, employees pay a $100 individual and $200 family deductible. They also pay 10% of expenses exceeding the deductible, up to out-of-pocket maximums of $300 for individual coverage and $800 for family coverage. The lifetime maximum benefit under the traditional plan is $1 million.

The traditional plan also requires employees to pay the total premium for dependent coverage, which is $80.92 a month, regardless of the number of dependents covered. The state pays the $53.82 monthly premium for the employee.

Employees' costs under the HMOs vary, depending on the HMO the employee joins. Some require deductibles and copayments equal to those of the state's traditional plan, while others provide first-dollar coverage.

In addition, if an HMO's monthly premium exceeds the state's per-employee premium contribution of $53.82, the employee must pay the difference.

The most expensive HMO requires an employee contribution of $8.85 a month for individual coverage and $109.12 a month for family coverage.

County cuts costs

A combination of cost-containment and wellness programs is helping the government of Larimer County, Colo., make substantial cuts in its health care bill, which led to a $200,000 savings in 1984.

The county also was able to reduce employees' average hospital stay by 3½ days in 1984 and reduce employee contributions to health care premiums, according to David R. Duman, personnel director for the county.

The county, whose health care program covers 850 employees and 765 dependents, saw its health care bill increase 270% from 1976 to 1983, Mr. Duman said.

An expected increase of 35% to 45% in 1984 prompted the county to launch its three-pronged cost-reduction program, which included eliminating first-dollar coverage, providing employees with less-expensive health care alternatives and promoting wellness.

Starting Jan. 1, 1984, the county switched from separate basic and major medical health care plans to a comprehensive plan. Hospital Services Inc. in Fort Collins, Colo., is the underwriter for both the old plans and the new plan.

Under the old plans, employees had first-dollar coverage on basic medical care, which included all expenses not associated with hospitalization. The old major medical plan, which covered hospital costs, included a $100 per-person deductible, with a maximum deductible of $200 under family coverage. In addition, employees paid 20% of the next $5,000 in expenses. After that, the plan paid 100% of all expenses, up to a lifetime maximum benefit of $250,000.

Under the new, comprehensive plan, the deductibles are applied to all expenses. In addition, employees with individual coverage pay 20% of the next $2,500 in expenses and employees with family coverage pay 20% of the next $5,000 in expenses. After these copayments are met, the plan pays 100% of all expenses, up to a lifetime maximum of $250,000.

Because the premium for the comprehensive plan was 29% less than than the premium for the two separate plans, the county reduced employees' premium contributions, Mr. Duman said.

Under the new plan, the county contributes $50.70 a month for each employee. Under the old plan, the county's contribution was $65.44 a month for each employee.

Under the new plan, employees' premium contributions are $20.65 a month for themselves and one child, down from $24.39 under the old plan; $42.21 a month for themselves and two children, down from $48.59; $48.80 a month for themselves and their spouses, down from $62.73; and $76.51 a month for family coverage, down from $93.18. Single employees continue to be exempt from premium contributions.

To steer employees toward less-costly health care alternatives, the second prong of the county's plan expanded health care coverage to include 100%, first-dollar reimbursement of expenses for hospice care, home health care and outpatient surgery. In addition, the county will pay 100% of bills for pre-admission testing.

To exert more control over hospital admissions and lengths of stay, the county began a case management program that explores less-costly alternatives to traditional hospital stays. This program cost $7,224 to administer in 1984 and saved $14,524.50 that year, Mr. Duman said.

The third prong of the county's cost-containment effort is an "employee health awareness" program.

"We're attempting to help the employee stay healthy," Mr. Duman said. "We see that as a more positive way to control health care costs and, at the same time, to encourage employees to become more involved in their own well being."

At no cost to the county, staff nurses from the Larimer County Public Health Department conduct quarterly programs in which between 80 and 100 employees receive examinations on company time.

The programs last for about four hours and include health risk appraisals, nutritional analyses and diet profiles of employees.

In addition, employees hear lectures and participate in discussions on topics such as weight management, smoking cessation and stress management. Employees also can discuss their own health concerns individually with the nurses.

"Studies show that those employees who have participated (in the wellness program) have shown improvement in their health," Mr. Duman said.

"They're losing weight, they're more conscious of when they're under stress, they've quit smoking, they're wearing their seat belts. They're just more cognizant of their health and their behavior."

●

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agent/broker topics

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Target marketing: Aim for success

By LINDA J. COLLINS

Target marketing, either through mass-marketed or agent-designed programs, is becoming increasingly important as a way of soliciting small to medium-sized commercial accounts.

By defining a desirable target industry market and becoming familiar with that industry and its needs, an agency avoids wasting time and effort by having agents call on prospects randomly.

"Cold calling is too expensive and creates a shotgun approach," said Roger H. Sitkins, president of Sitkins Group Inc., an agency management consultant in Fort Myers, Fla. "It spreads an agency's base too thin."

Cold calling on random prospects, he explained, is simply not as effective as marketing products to businesses with which the agency is familiar. Knowledge of a prospect's business helps agents get their feet in the door.

Agents looking for an edge on their competition agree with Mr. Sitkins.

"Our effort has been to develop expertise in areas other agents don't have expertise in," explained Donald Lewis, executive vp of Hastings-Tapley Insurance Agency Inc. in Cambridge, Mass. "We try to get an understanding of on what basis the (buying) decision will be made."

And, agents point out that target marketing is not only more efficient than random calling, it is also less expensive in terms of solicitation and processing time.

"On small commercial accounts, agents must target market," says Gary B. Holgate, president of Holgate & Associates Inc. of Fort Myers, Fla., an agency management consultant.

"Agents should pick out classes of business they are knowledgeable in and have competitive products for, then write all the business for those markets they can in their area," he said.

"It takes more time to research and write some commercial lines accounts than the commission is worth," Mr. Holgate explained. Target marketing, he said, "reduces the labor intensity."

When target marketing, the agency already has an insurer or insurers with which to place the risks and is familiar enough with the market to know the kinds of information to supply to the underwriters.

The agent also knows the types and amounts of coverage the prospect needs for that type of business, and whether the business is run properly and represents a viable risk.

Carol A. Hammes, president of The Middleton Group in Naperville, Ill., stressed that agents should always target market business they have written in the past rather than solicit business from markets with which they are not familiar. "This gives (agents)

Continued on page 24B

Telemarketing, direct mail can aid agency effort

By LINDA J. COLLINS

If used correctly, telemarketing centers and direct-mail programs can be a big boost to an agency's target-marketing efforts, experts say.

But, these efforts must be consistent, carefully planned and properly managed, or the agency can expend a great deal of time and money with less-than-satisfactory results.

Telemarketing can be used to gather expiration dates for the existing accounts of prospects in a defined target-market industry.

After the agency defines its target market and gathers names and phone numbers of prospects in that market, it can turn the prospect list over to its telemarketing department.

The telemarketers can then call these prospects to request the expiration dates on their existing policies and to set up appointments for producers to call on the prospects. This relieves producers of these time-consuming responsibilities and allows them more selling time.

Direct mailings can be used to follow up this initial phone call and help the agency to maintain contact with prospects until the producer can pay them a visit.

"A pure direct-mail program doesn't (usually) work well," said Roger H. Sitkins, president of management consulting firm Sitkins Group Inc. in Fort Myers, Fla.

"Direct mail is most useful in the overall follow-up. When an agency gets an (expiration) date, it should follow up with a reminder, etc., to maintain contact," he added.

A direct-mail program becomes much more effective when an agency has identified a target market, Mr. Sitkins said. Then the agency's direct mailings can address the industry's specific needs.

The consultant pointed out two problems that can occur when an agency uses a direct-mail program.

First, if the direct mailings do not include a return response card, the agency must follow up on all prospects that do not take the initiative to call in on their own. This soon leaves the agency with a backlog of call-backs, which can increase clerical expenses, he said.

A second problem can occur if agencies send out direct mailings before the initial phone contact with a prospect, he said. Since the prospects know ahead of time that the agency will be calling to solicit their business, they may instruct their secretary or receptionist not to let the solicitor through when he or she calls.

To be successful, a telemarketing department must be properly staffed. Carol A. Hammes, president of The Mid-

Continued on page 24E



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Target marketing

Continued from previous page

some sort of a feel for the market and some knowledge of what the group's needs are," she said

The key to profit, sources say, is for an agency to gear its new-business efforts to specific prospects, offering a product it understands and for which it has insurers.

Kathleen A. Pasley, president of The Market Planning Group in Boston, said, "A good target marketing program. . .is an effective method for focusing your agency's resources on specific segments of the market—segments that match your particular expertise and competitive advantages in (your) trade territory. . .prospects from which you will reap the greatest reward."

Mr. Sitkins agreed: "There are agency specialties every agent has, whether they realize it or not. They need to go through their books and identify what business they are writing frequently, and then go after more of those accounts."

After an agency selects target markets, there are several ways to implement a program:

- Agents can become members of a marketing association, such as Famex or Marketing Management Inc., or an agency franchise association, like ISU/InsurorsGroup or PrideMark, and use target mass-marketing programs developed by those groups for their members.
- Agents can talk to other agents who have developed and now manage target-marketing programs for specific industries.
- Agents can check with insurers to see what types of packages they have available to agents.
- If there is not currently a package available to address the target industry's needs, agents can research a market and determine if a need exists for a specialized target-market program. Then they can present a proposal to different insurers and brokerages to see if one is interested in designing a package for that industry.
- Agents can design their own package, by themselves or with the help of consultants, and then look for an insurer to underwrite the program (see story, page 24G).
- Agents can locate one or two insurers interested in writing a particular class of business and design individualized programs for each target-market prospect, rather than using a package policy.

In fact, one of the first things any agent interested in developing target marketing programs must do is find one or more insurers that want to write that type of business.

"Now, several times a year I ask my companies which classes of business they are interested in writing," explained Jim Leatzow, owner of the Leatzow Agency in Oak Brook, Ill.

"I try to get a commitment from my companies that they want a particular type of risk, and to determine if they have some (competitive) edge" in that line, Mr. Leatzow explained.

To determine this, Mr. Leatzow asks insurers what businesses they are most comfortable with in terms of coverage, pricing, ease of underwriting, company expertise, etc.

Fred W. Berger, president of Insurance Planning Inc. in Hays, Kan., agreed: "In obtaining new clients, you must sell the insurer on the account as well as the client."

Mr. Berger said his agency formerly hired a placer who called insurers to obtain quotes after they located a prospect. Now, he said, the agency producers call insurers before calling on a prospect to make sure a market is available.

A marketing plan must be thoroughly mapped out before an agency embarks on a program, in order to avoid costly mistakes.

Ms. Pasley said, "Marketing activities require stepping back and looking at entire segments of the market—and then determining what needs to be done to attract them."

There are two steps to developing a target-marketing strategy. First, an agency should find out if a sufficient need exists. The second step is to locate insurers interested in the risk.

Willard R. Young, president of Young & Perry Insurance in Bridgewater, N.J., and chairman of the National Assn. of Professional Insurance Agents' Agency Marketing & Advertising Task Force, said target marketing involves some basic market research.

He suggested that, before starting a target-marketing program, agents ask themselves: What are the geographic trends in the agency's marketing territory? Which markets are expanding and which are contracting? Where is the employment growth? How many prospects are there in the target industry? What

Continued on page 24D

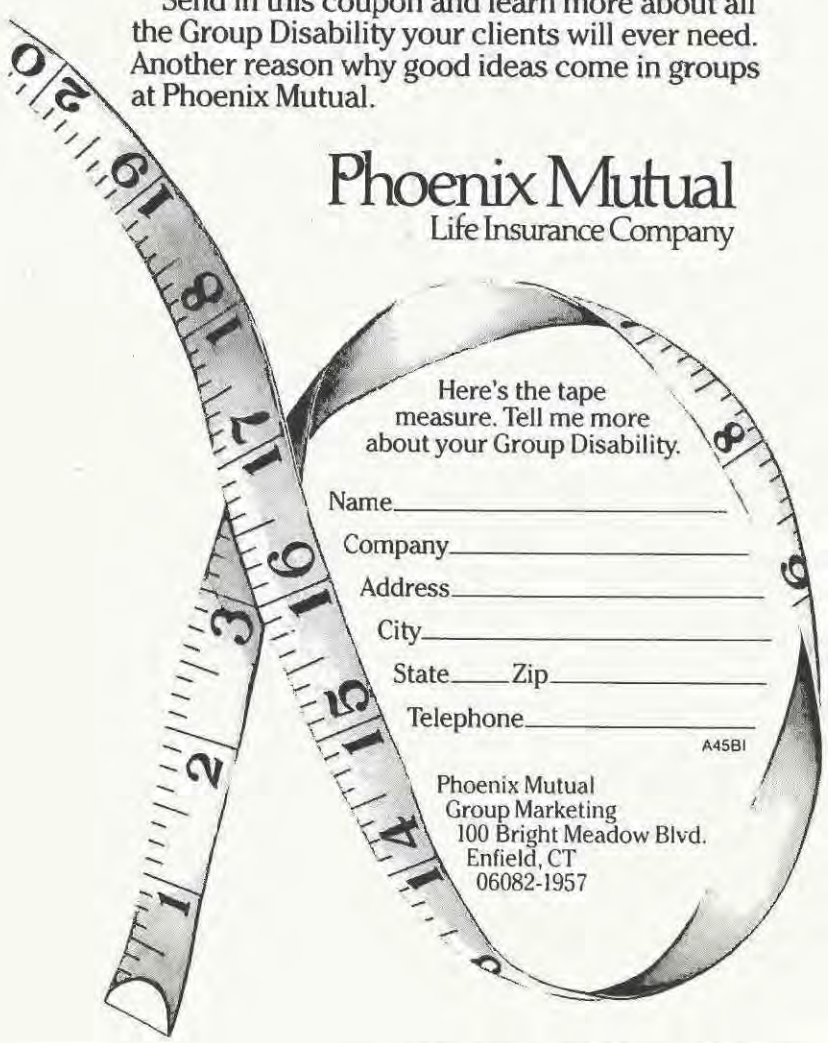
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Target marketing

Continued from page 24B

motivates them to buy? What benefits do they want?

Mr. Young said that after finding out this information, the agency must determine which insurers have products to meet those needs. "Attempt to match up the target market with a carrier, not as an association plan, necessarily, but from an efficiency point of view."

Trying to place target-marketed business through several insurers complicates submissions and negates the time and cost savings gained by target marketing, he said. He suggested working with two insurers "at the most."

He added that if he can find no insurers with products designed for the target market, his agency will create a semi-customized product and try to sell it to an insurer.

Insurers are not the only ones offering target-market programs, however. Sometimes agents design their own programs and locate an insurer to underwrite the program.

Sometimes these programs have national appeal, and if enough demand exists, the agents who design them can become managing general agents for the program and broker it to agents in other areas for part of the selling agent's commission.

Andrew Barile, president of Insurance Agency Programs Inc. in New York, a target-marketing consultant, helps agents design and place target-marketing packages with insurers on a fee basis. The firm also helps agents who have lost an insurer for a target-marketing program find a new one.

Mr. Barile explained that strong financial resources are essential when designing a target-marketing program. For that reason, he said new agencies should consider using programs already designed by insurers, brokers or agents.

Poe & Associates Inc., a major broker in Tampa, Fla., makes extensive use of target mass-marketed programs. Poe often will designate agents as exclusive agents for a product in their areas, and wholesales the business to them on a commission-split basis.

Doug Hudson, a Poe assistant vp, said Poe usually acts as a branch office of the insurer, so the appointment of exclusive agents reduces paper work and gives the agents "more incentive to solicit new business."

Mr. Hudson said sometimes the brokerage firm will take suggestions from agents on potential target-market areas. In these situations, an MGA arrangement will be set up, with the agent receiving an override on all business written.

An excellent way to become known to a desired target market, most sources agree, is to become involved with a trade association that represents that market.

"It is important to go to the association's meetings and even to become an affiliate member if possible," Ms. Hammes urged agents.

Ties with an association can provide an agent with contacts and further knowledge of the industry and its special needs. They also can alert the agent to issues that are important to association members.

And, since the association members have a chance to become acquainted with the agent and observe his or her interest in their industry, they learn to trust the agent.

Ms. Hammes said, "The best approach is to go to the market first and then to go to the carrier. It is important to understand the association. An agent needs some little bells and whistles to make the (association) product unique."

One type of association plan agents can get from insurers is a dividend plan. In this plan, the insurer pools all members of the association to determine the group's potential losses. This helps determine the rates members will be charged for coverage.

A yearly premium is then collected for the association's dividend plan. If there is money left in the plan at the end of the year, each person gets a dividend. If there are insufficient funds, the insureds may be assessed an additional fee.

Ms. Hammes said such a program "offers participants an incentive to keep their losses down. . . .Agents can arrange dividend programs to fit any size association through negotiation with an insurer."

Involvement in a trade association can often lead to the association's endorsement of an agent.

"An endorsement could take as long as a year to obtain, or as little as a month. It depends upon the situation," Ms. Hammes said. "The important point is that it must be an ongoing effort."

Poe & Associates has many association endorsements, including from the American Dental Assn., the American Optometric Assn., the American Pharmaceutical Assn. and the National Assn. of Dental Laboratories.

Several independent agents also have designed insurance programs for industries and have obtained association endorsements on a regional or national basis.

Consultant Mr. Sitkins says the best way to get an association endorsement is to get close to the group's executive director or president and to do research to determine the needs of members.

Only after completing these two steps, he said, should an agency go to an insurer and try to put together a tailor-made program.

"If you don't do a needs determination first, your approach might not be close to what the association is looking for," he said.

Some experts have reservations about endorsements, however.

Ms. Hammes said an agent should "find out how strong an association is with its members."

"Sometimes a national endorsement is not that beneficial when a state association is particularly strong. Find out what the politics are between the local and national associations and get your endorsement from the stronger of the two," she said.

Peter J. Piacentino, president of Rental Industry Services Inc., a Warren & Welsh Co. agency in King of Prussia, Pa., pointed out: "The problem with association endorsements is that you are sometimes expected to insure members who would not normally be accepted. Not all associations do this, but it's important to reach an understanding up front (that this is not acceptable)."

"You must have the ability to decline business," he added. "You can't change your standards. The market is too volatile, and too many agents get 'killed' this way."

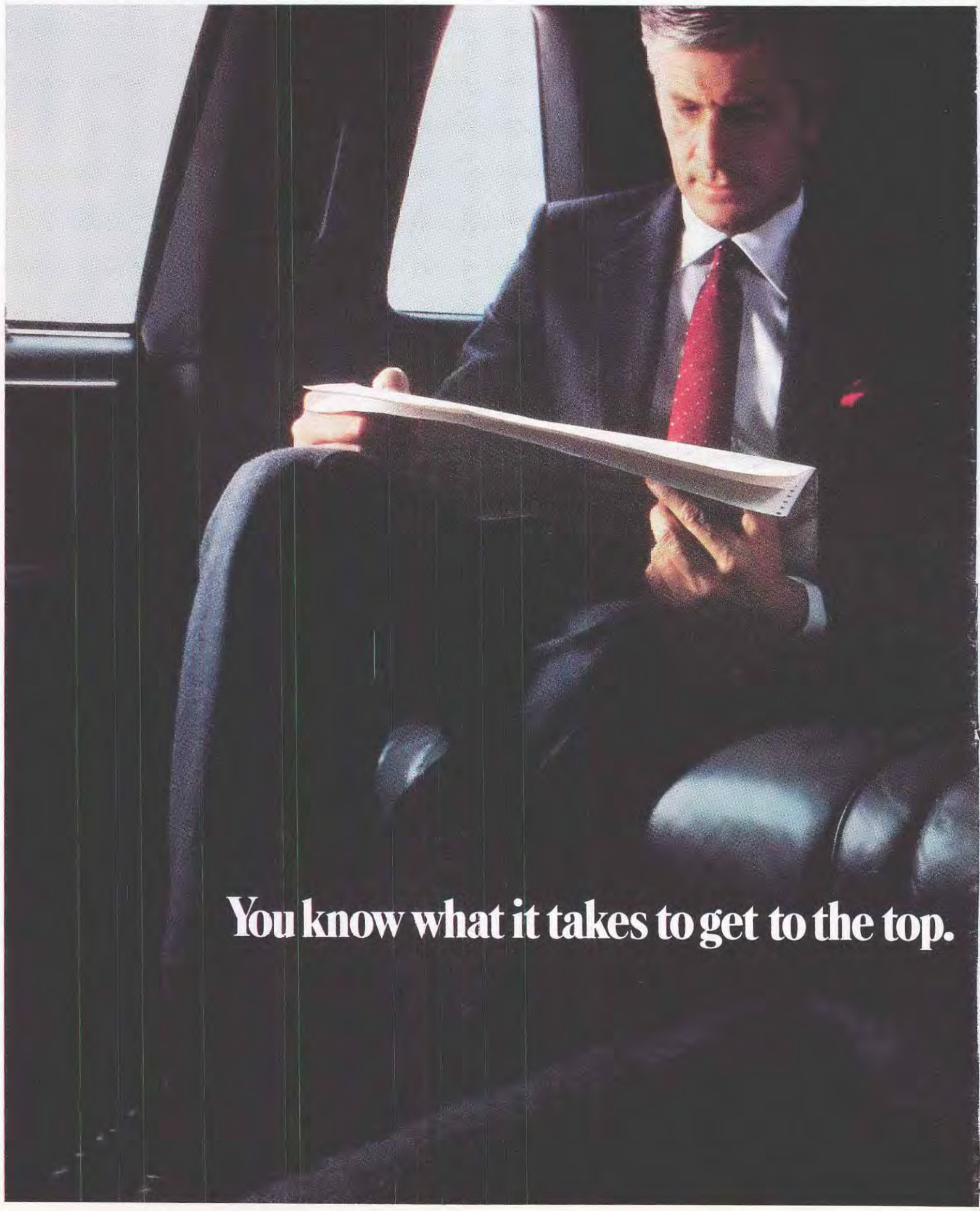
Mr. Barile said most of the programs he helps design combine association endorsements with outside solicitation of the target market. The hardening insurance market is making it increasingly difficult for businesses in some markets to even find coverage.

"One factor to consider," Mr. Barile pointed out, "is if the endorsement of an association is really meaningful in terms of market penetration. Most agents with good programs are getting business with or without association endorsements."

But, whether or not an agent gets an association's endorsement, knowledge of the industry and contact with association members still can be useful.

For example, by volunteering to speak at local meetings or regional or national conventions, agents promote themselves to the target-market prospects as knowledgeable about the industry's needs.

Continued on next page



Continued from previous page

"Get on programs that (target market prospects) normally attend" to let prospects know who you are, Mr. Hales said. "Do it for nothing to get in front of these people."

Mr. Leatzow, who target markets to prospects in the landscaping and greens industry, said: "I now speak in front of national associations, write articles for their trade publications, consult with individual (prospects), and have even been involved with international green work, all because I became involved in target marketing."

Mr. Piacentino's agency offers a national target marketing program for car rental companies. He said the agency promotes the program by attending annual conventions, regional meetings and trade shows held by the trade associations and national car rental chains.

He added that he tries to get on convention programs as a speaker whenever possible.

Robert S. Seltzer, president of Cohen-Seltzer Inc. agency in Center City, Pa., said his agency conducts seminars for accounting firms and law firms to educate them "as to what risk management really is."

Not only does the agency obtain new business from the contacts agents make with prospects at the seminar meetings, but the lawyers and accountants then refer the agency to their own clients.

Mr. Berger uses a booklet to reach his target-market prospects in the oil business. The agency put together the 104-page booklet, called "The Oilfield Manual" to be a reference guide to oil-field operations and procedures.

The manual lists all the workers compensation and liability rating classifications and illustrates and describes oil-field equipment and its uses. A glossary of oil-field terms is included.

This manual serves two purposes, Mr Berger said. First, the agency sells it to insurance company underwriters to help them understand the needs and risks involved in oil operations.

The agency also gives a copy of the manual to oil-field prospects when a producer calls on them. This booklet is a valuable tool for showing these prospects how well the agency understands their industry's needs.

Direct-mail solicitation and telemarketing centers are often used together to reach target-market prospects (see story, page 24A).

For the creative agent, the methods of finding and soliciting target market prospects are many. The primary key to successful target marketing, experts say, is to make yourself recognizable as an authority on the target industry, to have access to good products from a reliable insurer or insurers and to become acquainted with as many prospects as possible. ■

Telemarketing can aid effort

Continued from page 24A

dleton Group in Naperville, Ill., says the most important step for an agency is to make sure it hires a capable telemarketer.

"Telemarketing will work in any market area at any level of sophistication with the right person. However, it can only work with the right person," Ms. Hammes said.

She said that, without the right person, telemarketing simply will end up costing the agency a lot of money.

Ms. Hammes said the right person for a telemarketing department is someone with a strong telephone personality. Among other things, this person should be pleasant, yet aggressive and not afraid of rejection.

She said that agencies obtain better results from their telemarketers if the individuals are paid on an incentive basis rather than receiving a straight salary.

Mr. Sitkins suggested telemarketing coordinators should be paid a set salary for running the telemarketing system and gathering expiration dates. He said this salary should be roughly equivalent to that received by a customer-service representative.

Like Ms. Hammes, Mr. Sitkins said that marketing coordinators should receive pay incentives. However, he added that incentives should only be given for the appointments the marketing coordinator schedules.

"Incentive pay should be based upon appointments rather than x-dates, because x-dates are hard to audit. The true test of success is if the producers are getting their appointments," he explained.

He said bonuses could range as high as 25% of the marketing coordinator's monthly pay.

The marketing coordinator should schedule six appointments per week for each full-time producer in the agency, according to Mr. Sitkins.

Willard R. Young, president of Young & Perry Insurance Agency in Bridgewater, N.J., said his agency uses its sales center to handle both direct mailings and telemarketing to target-market prospects.

"We send (prospects) a letter and follow it up with a phone call, at which time we request x-dates and try to schedule an appointment," Mr. Young said.

"We have a success ratio of about 35% in obtaining x-dates from our prospect lists. . . .The sales center is an excellent vehicle for reaching prospects with account potential ranging up to about $15,000 per year in premium volume," he commented.

He added that the sales center is not as effective for soliciting large commercial businesses "because of the intermediary people involved in the insurance process" at larger businesses, representing more channels the telemarketer must go through.

Mr. Young said his three sales center employees contact an average of 150 to 200 prospects a week.

Young & Perry established its sales center in 1982.

"We expanded it last year in anticipation of a hard market this year," Mr. Young said. "We wanted to have our people trained and ready to take advantage of the hard market."

Jim Leatzow, owner of Leatzow Agency in Oak Brook, Ill., makes extensive use of telemarketing in target-marketing commercial lines risks.

He said, "Essentially, I view telemarketing as the single most-important ingredient in the future to the successful sale of insurance products.

"Face-to-face x-dating is ineffective," Mr. Leatzow said. "You need to weed out the people who want to talk to you as opposed to those who don't."

Mr. Leatzow said his agency initially used telemarketing to gather expiration dates on any commercial lines prospects, but his efforts are now geared to target markets rather than to random commercial lines prospects.

His agency's telemarketing program is very structured and does not take a lot of time. "With it, a person can make 50 calls in an hour to an hour-and-a-half. The person is only after x-dates. Our hit ratio on x-dates is 80%," he said.

The Leatzow Agency ties its direct-mail program in with its telemarketing efforts, sending newsletters to prospects between the time the telemarketer gets an expiration date and the time the

Continued on next page



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Telemarketing tips

Continued from previous page

agency sets up the initial appointment to discuss coverage with the target-market prospect.

"The articles (in the newsletter) are of a non-sales format," Mr. Leatzow explained.

"Prospects don't feel we are blasting them for a sale—rather, we are providing them with a service," he said.

"Most insurance buyers are intimidated by their insurance products. Any time you can reduce this intimidation by explaining coverages in their language, it is beneficial," he said.

Mr. Leatzow added: "Newsletters keep an agency's name in front of clients and point out coverages they might not have considered. This is positive (to the agency) from an errors and omissions standpoint."

Although Mr. Leatzow's agency uses generalized newsletters, Ms. Hammes says that as a rule, newsletters are much more effective for commercial lines prospects when they are addressed to the target industry's specific needs.

"If you are going after commercial risks, newsletters should be addressed to a particular market or they will end up in the trash," Ms. Hammes said.

On the other hand, she said that for personal lines prospects, generalized newsletters are fine for getting an agency's name out.

Ms. Hammes said that direct mailings should illustrate the agency's expertise in insurance and risk management.

For example, she said they could be used to introduce a specialized program or to reproduce press clippings that give testimony to the agency's skills in a particular area.

She said mailings should be done on a monthly basis. And, mailings should not be extended for more than three to six months when used in conjunction with a telephone campaign, she suggested.

Ms. Hammes said that studies show that if prospects are not interested in talking to a producer after six months, further efforts probably will be wasted.

An agency should never put customer-service representatives in charge of telemarketing, Ms. Hammes said.

"Agents don't need to have someone with insurance expertise handling this function, and they don't need to pay for someone with insurance expertise," Ms. Hammes explained.

Mr. Sitkins said that if a telemarketing department is properly run, one marketing coordinator should be able to gather enough expiration dates and schedule enough appointments to keep six producers busy.

He agreed with Ms. Hammes that the telemarketer does not need insurance expertise—just perserverence and a strong phone personality.

Both Mr. Sitkins and Ms. Hammes mentioned that women tend to make better telemarketers than men, because they can usually get through the channels to speak to the business owner or manager more easily.

Tom E. Lane, president and chief executive officer of First American Systems in Rapid City, S.D., said his agency has a sales center telemarketing operation. In addition to making calls to target-market prospects, the agency's telemarketer also screens call-in business, gathering information for producers on all prospects and scheduling appointments.

"We send out an initial letter, and follow up with a phone call requesting an appointment or their x-date," Mr. Lane said.

Most of his agency's target-marketing efforts use mass-marketing programs available through marketing franchises such as MarkeDyne and Famex, he said.

Joseph Asmar, vp of Bowers, Schumann & Welch Agency in Washington, N.J., said his agency does not have an official telemarketing department, but two sales center coordinators gather prospects' expiration dates and set up producer appointments.

He said if a target-market program is particularly good, the agency may not wait for a prospect's expiration date to roll around before they schedule an appointment with a prospect.

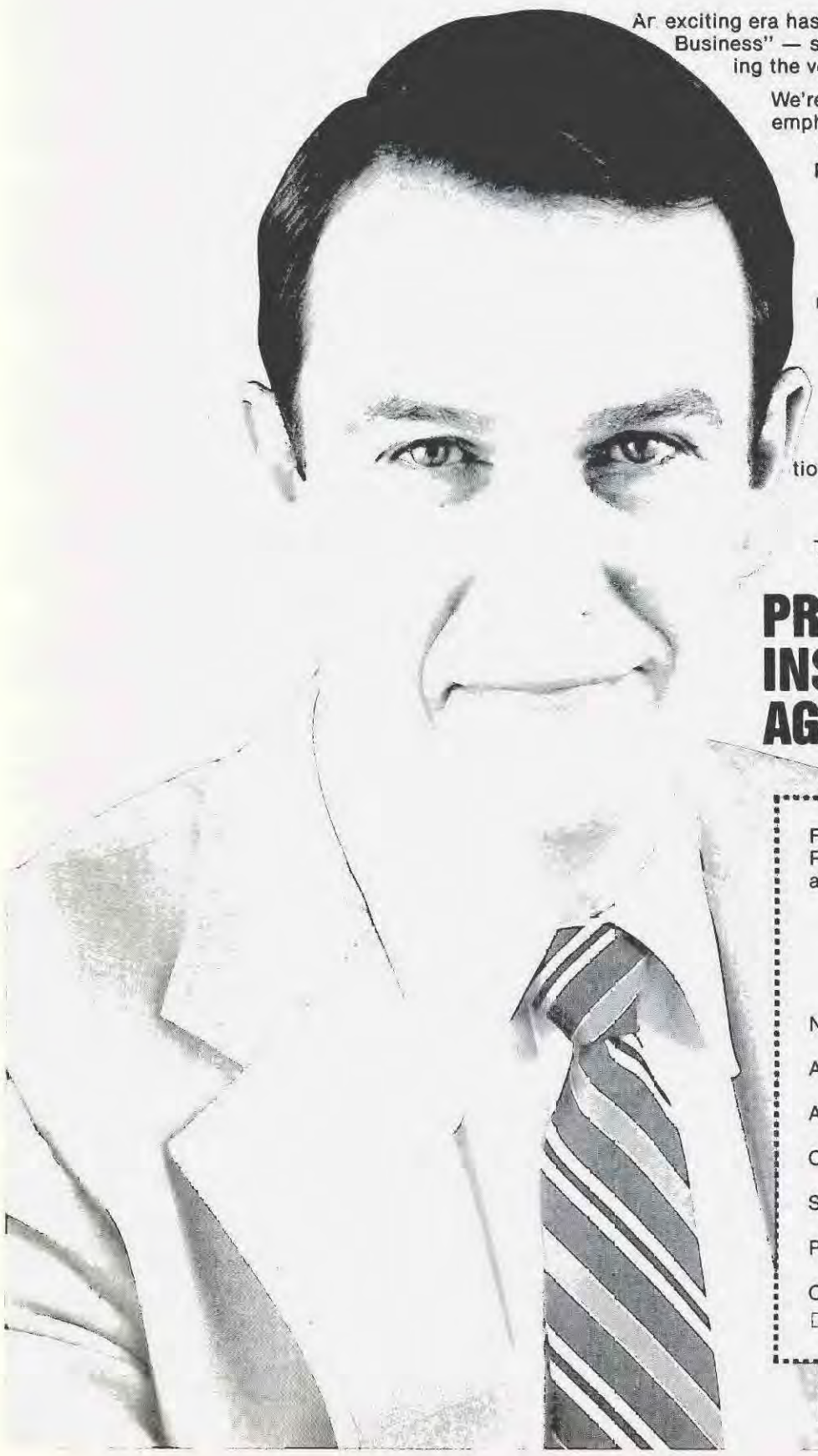
He said his coordinators always schedule appointments at least 120 days prior to expiration.

According to Mr. Asmar, the agency's sales coordinators receive a weekly salary plus incentive pay at the end of each month.

And, the coordinators always send out a pre-solicitation letter to target-market prospects before phoning, he said. ■

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Agents design, market target-market programs

By LINDA J. COLLINS

After developing an understanding of their target-market industry, agents sometimes find no packages available that address the industry's specific needs.

So, some agents have designed specialized programs for their target industry and presented the programs to insurers to find one or more willing to write the business.

In many cases, the programs are offered only regionally through the agencies that developed them. But, sometimes there is a need for a program on a national basis.

If the agency is not equipped to market a program nationally, it can become managing general agent for the program, offering it on a commission-split basis to agents where it does not operate.

Among the target-marketing programs that agents around the country have designed are programs targeted for:

• Ski area operations. Richard L. Williams, executive vp of Kendall Insurance Inc. agency in Rochester, N.H., developed a program with a former partner and American International Group Inc. in 1962 to insure ski area operations. Mr. Williams' agency merged with Kendall Insurance Inc. in 1975. Kendall now administers the program.

There are about 600 ski areas in the United States and Canada, and Kendall places, directly or through other agents, coverage for approximately 300, Mr. Williams said.

"We, under contract with the AIG, are responsible for all aspects of claims handling," he said. "We function as a branch office, not only for underwriting. We also hire attorneys, file suits, defend cases, effect settlements, etc."

He said the package insures every aspect of ski area operations.

AIG is the principal insurer for property, liability and umbrella coverages. The program's work comp coverages are underwritten by the St. Paul Cos. Inc. Commercial auto coverage is placed in various markets, Mr. Williams said.

In explaining the decision to target ski operators, Mr. Williams said that, in the early 1960s, U.S. ski operators formed the National Ski Areas Assn. because they were having trouble finding stable insurance markets.

"The driving force behind that decision was to put together an association-sponsored insurance program," he said. "They looked for an agent to administer the program and for an insurer to write the business. They selected us and AIG."

The agency's U.S. business is written through the association, and its Canadian business is written independently.

The association also set engineering criteria for the design, maintenance and operation of ski lifts, he said. "We use this criteria as a basis for coverage."

He said the agency has independent engineers to inspect the ski sites, following the criteria.

In some areas of the country, the agency deals directly with the ski area operators. In other areas that the agency doesn't service "due to logistics or other reasons," the coverage is sold through other agents. Currently, nine other agents are handling this business, and they get a portion of the commission Kendall gets from AIG.

• Churches. The Bowers, Schumann & Welch Agency in Washington, N.J., has developed a target-marketing program for churches, which it administers through its church division.

Faith Kerr, vp of the church division, said the agency began by designing a special program for one denomination when it could not find a good package on the market.

The agency now services 13 denominations, plus many independent churches and synagogues throughout New Jersey and eastern Pennsylvania.

The basic package covers all-risk property, broad-form general liability, bonds, stained glass and other exposures.

Ms. Kerr said other services performed by the churches can also be covered, including health centers, day schools, soup kitchens, and even church-sponsored colleges. She said the agency will try to cover anything "as long as it is re-

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Agency packages

Continued from previous page
lated to church activities."

The business is written through American Reliance Insurance Cos. of Lawrenceville, N.J., and Preferred Risks Mutual Insurance Co. of West Des Moines, Iowa. 'We are talking to a third insurer," Ms. Kerr said. The agency has underwriting authority with American Reliance, and it can both rate and issue those policies in-house.

Some of the church business is brokered to other agents on a commission-split basis. Ms. Kerr said 15 to 20 other agents in New Jersey now write through the program.

"We solicit extensively in a given area through our sales center. When we call on prospects, we ask if they belong to a denomination. If so, we try to find out who is the head or moderator of the denomination and see how many churches are members," Ms. Kerr said.

She said if the denomination has between 10 and 20 member churches in the agency's marketing area, it is worthwhile for the agency to offer a group discount.

● Landscaping and green industries. Jim Leatzow, owner of Leatzow Agency in Oak Brook, Ill., now writes insurance for the landscaping and green industries in 49 states. Green industries include plant nurseries, corporate landscapers, golf courses, sodders, etc.

The agency starts with a basic package and then tailors it to suit individual businesses.

When Mr. Leatzow began to consider the target industries, he said, "Virtually all the insurers I contacted responded by saying that class can't be written profitably. I maintain that any risk can be written profitably if it is properly underwritten and priced.

"One (insurance) company said that it could not guarantee that it would write the business, but it would look at it," he said. "I wrote through that company, and began to (develop a book of) landscape contracting business."

Mr. Leatzow did not identify the program's insurer.

● Car rental industry. Peter J. Piacentino is president of Rental Industry Services Inc., a division of the Warren & Welsh Co. in King of Prussia, Pa. RISE is a target-marketing division that provides liability coverage to car rental business owners and to the renters, and also provides the owner with both comprehensive and collision property damage coverage.

He said the agency also "provides and strongly recommends garage liability. . .because more and more car rental services are getting involved in used car sales."

The business is written through Reliance Insurance Co. and its Madison, Wis., unit, Planet Insurance Co. Mr. Piacentino said the program involves "a managing general agent arrangement with various levels of authority."

The program started in 1969 with a basic commercial auto policy. It was founded by four agencies in different areas of the country, including Warren & Welsh, which bought out the others.

Under the RISE program, Warren & Welsh insures about 500 accounts, some of which represent multiple rental sites, he said. The program is endorsed by the American Car Rental Assn. and some national car rental chains.

In addition to the main office in Pennsylvania, four regional offices in Georgia, Missouri, Texas and California handle business written through the RISE program.

● Janitorial maintenance contractors. Patterson & Associates Inc. in Washington, D.C., designed a national target-marketing program for janitorial maintenance contractors. The program, the Building Service Contractors Insurance Program, is underwritten by CNA Insurance Cos.

Frank J. Patterson Sr., president of the agency, said the program covers all aspects of the business of janitorial maintenance contractors, which are independent contractors.

The agency designed and began writing this business in 1969. It is managing general agent for the package. CNA-contracted agents can write the business directly through the insurer, and Patterson & Associates brokers the business to other agents.

Several hundred agents throughout the country write this coverage, and the agency gets a commission override on all business written.

The agency is responsible for "overseeing and improving the product continually, reviewing the pricing structure, and playing a continuing role in the national sales effort," Mr. Patterson said.

The maintenance contractor program represents 30% to 40% of the agency's business, he said. ■

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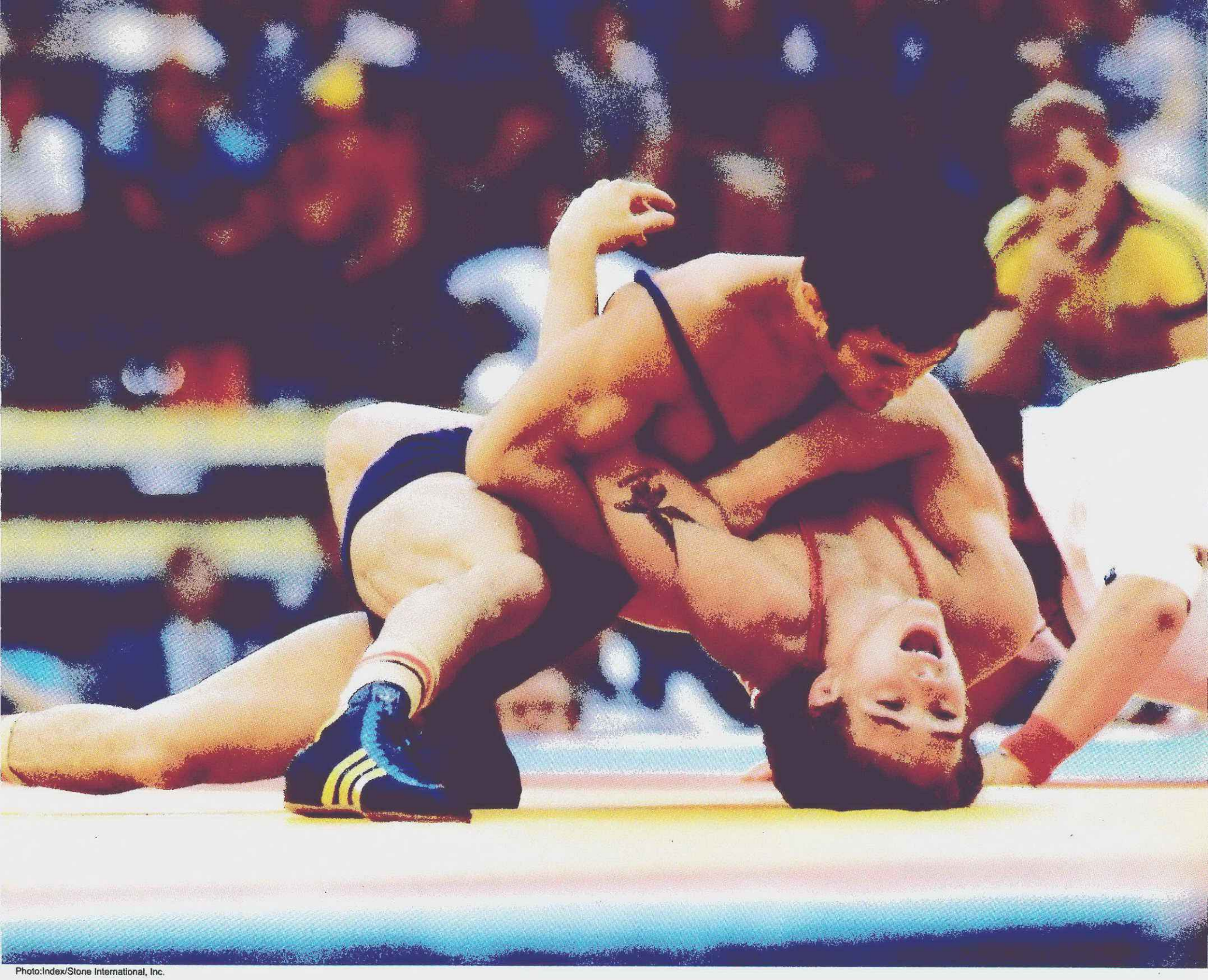


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Transport suit

Continued from page 1

The complaint seeks an unspecified amount of damages for "failure to provide benefits" under the insurance policies, for mental and emotional distress, and for legal fees.

The complaint also asks for punitive damages in an amount "appropriate to punish or set an example of defendants' conduct."

Transport Indemnity will have 30 days to answer the summons, which will be served this week, said Victor Jacobovitz, a partner with Toxey Hall Smith, the firm that filed the complaint.

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It could be several years before the case is ready for trial, he predicted.

Officials with Transport Indemnity and American Financial Group declined to comment on the lawsuit.

Meanwhile, an investigation last week by the the California Insurance Department turned up "no improprieties" in the policy cancellations by Transport Indemnity, according to department officials.

The California Insurance Department sent investigators to review Transport Indemnity's records last week after receiving complaints about the midterm cancellations.

Risk managers and brokers have complained that Transport Indemnity gave them false assurances that their coverage would be continued to expiration, just prior to issuing the cancellation notices.

Brokers and risk managers also say they were told that Transport Insurance of Dallas, another American Financial subsidiary, would pick up most of Transport Indemnity's business on expiration.

Transport Indemnity was merged into Transport Insurance as part of the plan to shore up the financially ailing Mission.

Everett Brookhart, chief of rate regulation at the California Insurance Department, said the department's investigation found that the midterm cancellations did not violate the terms and conditions of Transport Indemnity's policies.

And, the California insurance code does not prohibit midterm cancellations, he added.

"Our investigation found no improprieties at this time," Mr. Brookhart said.

Because most of the cancellations are not effective until mid-June, Mr. Brookhart says it is too early to determine whether Transport Indemnity will return unearned premiums on time.

"I don't think that under our law they've done anything that's clearly illegal," said Norris W. Clark, chief of the Insurance Department's financial analysis division.

He added, however, that it would "behoove them to have the premium refund checks in the mail come cancellation."

American Financial Group did not inform the Insurance Department of its plans to cancel the Transport Indemnity policies as part of the planned bailout of troubled Mission Insurance Group, Mr. Clark said.

"American Financial is totally in control of how the entire transaction takes place. They're calling the shots," he said.

Attorney Jacobovitz maintains that while Transport Indemnity may not have violated provisions of the insurance code by canceling policies midterm, "they breached a duty implied in the law to act in good faith and deal fairly with their policyholders."

"To take these people's money and hold it for four months and then say: 'Sorry, we can't cover you anymore because our other company needs money' is outrageous," Mr. Jacobovitz contends.

Many policyholders and brokers agree, and several say they are considering legal action against Transport Indemnity and American Financial Group.

"They left us in the lurch after we'd been with them for many years," said the president of a hazardous-materials transportation company, who asked not to be named for fear of reprisals by other insurers if he publicly criticized Transport Indemnity's actions.

The company, whose nearly $10 million in primary and excess automobile and general liability insurance was canceled midterm by Transport Indemnity, was able to replace the coverage, but at several times the premium.

The midterm policy cancellation was a "cold-blooded deal," the president charged.

The transportation firm has won several safety awards from the American Trucking Assn. and had an excellent loss record, he maintained.

Motor freight carrier Transcon Lines of El Segundo, Calif., had placed its entire automobile and general liability and workers compensation program with Transport Indemnity, reports Alan P. Schreibman, director of insurance.

The premium for the automobile and general liability coverage, which provided a $10 million per occurrence limit with no annual aggregate and a $250,000 deductible, was $10 million.

But, in the last week of March, Transport Indemnity demanded a nearly tenfold increase in the monthly premium related to the excess liability portion of the coverage, to $63,000 from $6,500. Transport told Transcon that the increase was needed to cover the increased cost of reinsuring Transcon's risk.

Transcon was told it would have to pay the increase if it wanted the excess portion of its policy to continue in force to the May 1 expiration date.

"We were told that Transport Indemnity would insure full coverage until May 1 and that sometime between the end of March and May 1 we would be looked at by Transport Insurance and provided with a quote," Mr. Schreibman recalls.

About a week later, before Transcon could even pay the increased premium, Transport Indemnity canceled the entire liability program, he said.

After the cancellation, Mr. Schreibman said, he began looking for a new insurer for both the liability and workers compensation coverage.

In hindsight, that was a wise move, since he later learned after transferring the workers compensation program that Transport Indemnity planned to cancel that too, before its July 1 expiration date.

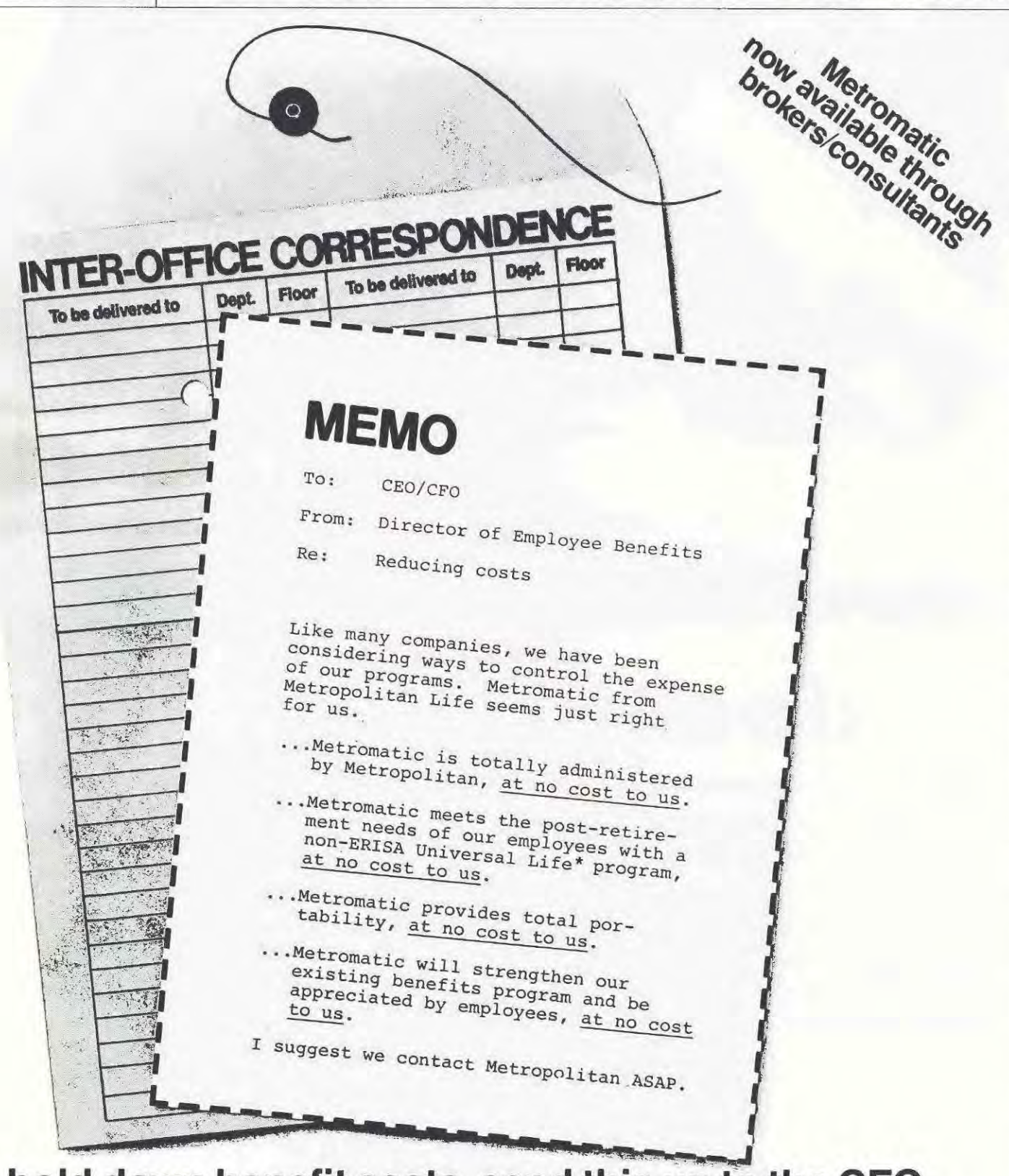
"Despite verbal assurances that our 30-year relationship with Transport Indemnity would be continued with Transport Insurance, those assurances proved to be somewhat less than accurate, since we received our cancellation notice a few days after the assurances were given," Mr. Schreibman said.

Transcon contacted four direct insurance writers and two brokers contacted 20 other markets on its behalf in an attempt to replace the coverage canceled midterm.

In response, Transcon received what Mr. Schreibman describes as "2½ quotes." One insurer, he explains, offered a quote for coverage for all risks except cargo, which is the major risk faced by a trucking concern.

Mr. Schreibman was able to obtain auto, liability and work comp coverage similar to that which he had with Transport Indemnity

Continued on next page



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Continued from previous page
from Liberty Mutual Insurance Co. and at only a minimal increase in cost.

"I do feel we were extremely fortunate," he says.

Transcon Lines also participated in a rent-a-captive arrangement with Transport Indemnity for its general liability and workers compensation coverage. The trucking company has about $10 million in that captive to cover future claims and Mr. Schreibman said he is concerned about the status of those funds now that Transport Indemnity has been merged into Transport Insurance for the purpose of bailing out Mission.

"We were extremely distressed at the apparent misrepresentations that were made as a result of the merger," Mr. Schreibman notes. He says that officials with Transport Indemnity did not live up to their assurances that coverage would be continued by Transport Insurance after the merger of the two American Financial units.

"All during the coverage replacement process, we continued to receive assurances from Transport Insurance that a quote would be forthcoming from them prior to cancellation, and that quote never came," he says.

Transcon, with annual revenues of $350 million, is the 10th-largest national motor freight carrier in the United States, Mr. Schreibman says.

While scrambling to replace canceled coverage, brokers and their policyholders say they will be watching their mail for timely return of unearned premiums and payment of pending claims.

A risk manager for another major transportation concern says that officials with Transport Indemnity took almost four months to respond to requests for a return of several hundred thousand dollars in unearned premium related to a policy the transportation firm canceled in January rather than swallow a 600% midterm rate hike.

Just last week, Transport Indemnity officials promised to refund a substantial portion of the unearned premium to show "good faith," but not until after the transportation company threatened legal action, said the risk manager, who asked not to be named.

The amount of remaining unearned premium is in dispute, the risk manger noted.

The company had about $90 million in coverage with Transport Indemnity, including both primary and excess liability insurance. The transporter was able to replace the guaranteed cost coverage from Transport with a loss-sensitive insurance program. The cost of the new coverage will be about the same as the Transport Indemnity premium, provided the company's losses continue at the same level, according to the risk manager.

But, the risk manager also is now concerned about the handling of outstanding claims under the Transport Indemnity policy. No one is saying who is handling claims for Transport Indemnity, the risk manager complains.

Brokers who placed business with Transport Indemnity are still waiting to hear about their clients' unearned premiums.

John Miller, president of agency Excess House Inc. in Houston, complains Transport Indemnity isn't answering his calls regarding unearned premiums or any other information concerning the canceled policies.

"I've been in the insurance business for nearly 40 years, and I have never seen anything like this in my life," Mr. Miller says.

In a letter to Excess House, Transport Indemnity President Leland S. Thomas said the insurer would continue most existing policies in force until expiration.

"With the exception of some individual risks, it is our intention to allow the current book of business written through Transport Indemnity Co. to run to expiration or anniversary, whichever comes first," Mr. Thomas said in the letter.

Excess House was the exclusive local and general agent for Transport Indemnity in Texas, according to Mr. Miller. Transport Indemnity had specifically given Excess House, as its general agent, a two-year commitment to provide reinsurance on a Texas automobile dealership program that was fronted though a Texas county mutual insurer.

Last month, however, Transport Indemnity officials canceled the entire program without warning, Mr. Miller said.

As a result, Mr. Miller said, the county mutual was forced to cancel some of the policies under the dealership program with just 10 days notice.

Excess House had written about $1 million in premium through the program in the second six months of 1984.

Including other coverage Excess House had placed with Transport Indemnity, the agent lost about $4.5 million in premium as a result of policy cancellations, Mr. Miller said.

Excess House does not have other markets for many of the policies and many of the policyholders have been unable to find replacement coverage, Mr. Miller said.

Gregory W. Econn, vp of James Econn & Co., a Los Angeles-based commercial insurance broker, said several large excess property accounts he had placed with Transport Indemnity that were canceled midterm will be expensive to replace, if it's possible at all.

For example, Transport Indemnity had a $5 million participation in a $45 million layer excess of a $50 million primary property policy for Ashkenazy Enterprises Inc. of Los Angeles, owners of the L'Ermitage hotel chain.

The policyholder will go without that portion of the second excess layer until the entire layer is renewed because short-term replacement of the Transport Indemnity coverage would be prohibitively expensive.

Mr. Econn calls the midterm cancellations "an egregious attempt to renege on a commitment made in good faith on both the part of the insured and the part of the insurer."

Both Dion Riley, chief operating officer for Transport Indemnity, and Karen Horrell, vp and corporate counsel for Great American Insurance Co., the lead property/casualty insurer of the American Financial Group, declined to comment on the lawsuit.

Previously, both Mr. Riley and Ms. Horrell refused to comment on any aspect of the Transport Indemnity cancellations (*BI*, May 6). ■

P&I clubs search for cause of blast

LONDON—Two protection and indemnity clubs that provided third-party liability insurance for two oil tankers that exploded in Spain last month are trying to determine the cause of the blast that killed 32 people—and if they are liable.

Third-party liabilities of the Panamanian-registered Petragen One are covered by P&I club United Kingdom Mutual Steamship Assurance (Bermuda) Ltd., managed by Thomas R. Miller & Son.

Third-party liabilities of the Spanish vessel Camponavia are insured in the Spanish market and reinsured by the P&I club Britannia Steam Ship Insurance Assn. Ltd., said Peter Riley of the club's managers, Tindall, Riley & Co.

Both P&I clubs provide unlimited coverage for third-party liability risks, except for pollution risks, which have a limit of $300 million.

But, the P&I clubs will pay only if their tanker is found liable, Mr. Riley said. ■

HUMAN ERROR

You Can Buy the Most Expensive Fire Protection Equipment, install it properly, and inspect it periodically, but it all goes for naught when someone—possibly with malice aforethought, but more likely from ignorance—shuts a valve, turns off a pump, blocks open a fire door, overrides safety controls, or does any of a myriad of other things that human beings are prone to do because they are unaware of the consequences. Sound familiar? A prime example is the misuse of cutting and welding equipment. All of the fire protection in the world will prove of little value if cutting and welding equipment is used improperly and without the direct supervision of the insured's plant protection people. With the possible exception of natural catastrophes, no single activity has caused more dollars of loss among our insureds than misuse of this type of equipment. Sprinklers turned off, no fire watch, no regard for the presence of combustibles, have all led to tremendous losses in what were supposed to have been well-protected plants.

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Punitive awards

Continued from page 2

The California appellate court also cited several public policy reasons why punitive damages should not be available to plaintiffs in market share liability cases.

Among these were the the potential for "overkill." If early claimants obtain large punitive damage awards, companies' economic resources may be exhausted and thereby preclude compensatory damage awards to future claimants, the court said.

The court added that the objectives of punitive damages—to punish and deter defendants—appear to be sufficiently met by the large present and prospective compensatory damage awards.

The court added that deterrence has little relevance in cases where the product that allegedly caused injury has long since been removed from the marketplace.

The court also considered whether the formulas used to impose and apportion liability for compensatory damages are appropriate to assess punitive damages.

While the basis for apportioning compensatory damages in Sindell was "logical and reasonable," different considerations apply to awarding punitive damages, the court said.

"(Punitive damages) are intended to punish wrongdoers for acting with malice or oppression, not just because they distribute their products in the marketplace," the court ruled.

"The measure of that malice or oppression requires the determination of the state of mind of the particular defendant while committing the alleged wrongful act. While the injury-causing product may be fungible, the states of mind of the different defendants probably are not."

The court also said that there was the question of "basic fairness" to the defendants in considering whether punitive damage awards should be permitted.

For example, suppliers that aren't named as defendants in DES cases but may have acted with malice in manufacturing and distributing DES—and also may have provided the specific substance ingested by the plaintiff's mother—could escape liability, the court said.

Meanwhile, other companies that were not as culpable and may not have caused the plaintiff actual harm, but have been named as defendants, can end up paying punitive damage awards. "This would be grossly unfair," the court said.

"We hold that in the context of the case at bench, in order to impose punitive damages the plaintiff must first identify the defendant who supplied the DES which was ingested by the plaintiff's mother and caused the damage complained of and also prove that that defendant acted with malice or oppression."

An attorney for Ms. Magallanes said that he would probably file a motion for review with the state supreme court.

"We just think it's wrong because it is the only departure in California law from the rule allowing punitive damages in product liability actions" where the plaintiffs have pleaded conscious disregard for the safety of others, according Robert S. Schlifkin with the Los Angeles firm of Schlifkin & Papell.

"It was good for the court to limit the impact of Sindell," according to Michael J. Breining, general counsel for the Sacramento, Cal.-based Manufacturers Assn., which filed an amicus curiae brief with the appellate court on behalf of the defendants.

"As unfair as Sindell may have been, it would have been a gross injustice to include punitive damages. We are very pleased" with the decision," Mr. Breining added. ■

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Circulation Breakdown*

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Vice-presidents, general managers and other administrative personnel ... 2,573

Financial:
Chief financial officers and vice-presidents of finance 2,168
Secretaries, treasurers, controllers and other financial personnel 7,167

Risk/employee benefits:
Vice-presidents, directors, managers, and other related department personnel of: insurance, risk, employee benefits, personnel, compensation, pension, safety, security, industrial relations, human resources and employee/labor relations 8,206

Sub-total 22,627
Associations 1,081
Government, unions and educational systems 944

Commercial Consumers Sub-total 24,652
Insurance agents and brokers 9,524
Insurance companies 5,867
Financial institutions 556
Actuaries, attorneys, adjusters, appraisers and consultants 3,265
Others allied to the field 1,143

TOTAL 45,007

* Source: Business/Occupational breakdown of qualified circulation, Nov. 5, 1984 issue, as submitted to BPA for Dec. 1984, BPA Publisher's Statement.

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P/C taxation

Continued from page 1

for the full cost of future claim payments. For example, insurers can tax deduct this year $1,000 that they reserve to pay a $1,000 loss in a future year.

The Treasury's reserve proposal, however, would require insurers to set up "qualified reserve accounts" for unpaid losses, reflecting the insurer's estimate of the amount needed to pay future claims, less the estimated aftertax investment income that will be earned on the QRA before the claims are paid.

A $1,000 claim that will not be paid for four years would require a current reserve of only $792.09, assuming an aftertax rate of return on the reserve of six percent annually, the Treasury proposal says. Thus, the insurer would only be allowed to deduct a $792.09 loss reserve under the proposal.

Interest income added to the reserve over time would not be deductible, the proposal says.

Insurers would have to set up separate QRAs for each line of business for each policy year.

If a QRA fails to cover an insurer's liabilities, excess claims would be deductible when paid. Conversely, any money left in a QRA after all claims are paid would become taxable income.

The Treasury also would limit the maximum life of each QRA, but the limits have not been determined. Any money left in a reserve at the end of its maximum life would become taxable income, while subsequent claims against a defunct QRA would be deductible when paid.

However, the new Treasury proposal modifies the limitation on the initial QRA an insurer may establish.

Now, Treasury says, the initial QRA contributions could not exceed the combined statutory reserves for unearned premiums, incurred-but-not-reported losses and claims reserves.

While presumably this would permit an insurer to establish a QRA reflecting the ultimate cost of losses, comments elsewhere in the proposal suggest otherwise.

Treasury says insurers would "establish reserve accounts for claims to be paid in an amount estimated by the company to be sufficient to fund payment of the claims, taking into account the company's estimates of the amount of the claims, the time of payment of the claims and the company's after-tax rate of return on its investment assets."

The proposal does not make clear if the government would allow a deduction of statutory reserves, says Gerald I. Lenrow, partner with Coopers & Lybrand in New York.

Indeed, the Treasury Department even insists "this system of qualified reserve accounts does not require the discounting of reserves."

And, the new proposal leaves insurers "free to discount reserves using any set of assumptions as to future interest rates (e.g., the assumptions used in pricing the policies) or even to establish undiscounted reserves."

However, Mr. Lenrow questioned whether undiscounted reserves would pass an IRS "test of reasonableness."

But the new QRA limitation does clearly permit a larger initial tax-deductible reserve than under the original Treasury proposal that said the QRA would be limited to premiums received for individual policies less expenses associated with those policies.

Mr. Lenrow described this change as a "big retreat" by The Treasury. "Clearly, it would not be as damaging to start out with," he said. However, insurers would still not be able to deduct investment income earned on the reserves.

The impact of the new taxes on insurance prices may be less than predicted under the first proposal, Mr. Lenrow added.

Robert A. Bailey, vp of the property/casualty division of A.M. Best Co., calculated that insurance companies would have to raise rates by an overall average of 11% to compensate for lost income resulting from the original Treasury proposal.

Rate hikes in certain lines would have been even higher. Medical malpractice rates would rise by 32%, general liability rates by 24% and workers compensation rates by 15%, Mr. Bailey projected.

While the amount of discounting required under the new proposal is unclear, some observers argue that any discounting could aggravate insurers' financial problems at a time when many are already under-reserved.

Another section in the latest Treasury proposal that remains basically unchanged is the proposal to repeal the tax-free status of workers compensation and black lung benefits.

These benefits would be included in taxable income under the proposal except for payments for medical services, physical and vocational rehabilitation and burial expenses. However, low- and moderate-income disabled taxpayers would be eligible for a credit of up to 15% on taxes due on benefit payments.

This proposal will result in "significant pressure to increase comp benefits, with a resulting increase in the cost of workers compensation, which is an additional cost to employers," said David Farmer, vp for federal affairs of the Alliance of American Insurers.

Another change that could affect captive insurance companies is the proposal to put a per-country limitation on the use of excess foreign tax credits.

Tax credits are generated when foreign countries apply higher tax rates to a corporation's foreign income than would be applied in the United States.

Under current law, corporations are also allowed to apply foreign tax credits generated in one country to taxable income earned in another country where the tax rate is lower than in the U.S. For example, foreign tax credits generated by a corporation's U.K. operations could be used to offset taxes due on income earned by a Bermuda-based captive subsidiary.

Under the Treasury proposal, however, tax credits generated in a given country could only be used against income generated in that country.

In its latest proposal, Treasury also has added a provision that would tax interest income earned on annuities held by third-party assignees of liability in structured settlements. Current tax law effectively exempts this income from taxation, the proposal says.

Other proposed tax changes affecting mutual property/casualty companies include:

- Repeal of deductions for contributions to protection against loss accounts, which have been allowed in addition to deductions for contributions to loss reserves.
- Repeal of several exemptions, tax rate reductions and deductions allowed small mutual property/casualty insurers. Certain of these tax breaks have applied, for example, to companies with gross premiums and investment income of less than $1.1 million and taxable underwriting and investment income of less than $6,000.
- Reducing the deduction allowed mutual property/casualty insurers on policyholder dividends. Currently, these dividends are deductible by the company and are treated by policyholders as rebates rather than taxable distributions.

The Treasury Department argues that these changes are needed to correct what it considers unfair competitive advantages. ■



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business insurance

Benefits taxation

Continued from page 1
in the final tax package that emerges from Congress, he added.

It also remains to be seen if Congress will add any other benefit taxes to the Treasury II plan as the measure winds its way through the tax-writing committees this year.

However, Treasury II does represent victories for employers in several benefit areas.

Retreating from a barrage of criticism of Treasury I, the administration proposes in the new plan to allow employers to offer cafeteria benefit plans. The first proposal sought to eliminate Section 125 of the Tax Code, which allows employees to choose between cash and non-taxable benefits.

And, the administration now says employees will not be taxed on their employers' costs of providing up to $50,000 of term life insurance and dependent child care, educational assistance and group legal benefits; all of those benefits would have been taxed under the Treasury's first proposal.

Further, the administration deep-sixed Treasury's initial recommendation to tax investment income earned by assets held by Voluntary Employee Beneficiary Assns., a widely used benefit funding vehicle.

VEBAs, also known as 501(c)(9) trusts, allow employers to self-fund a wide range of benefit programs. Under current law, employers can take tax deductions for their contributions to the trusts, while trust assets earn tax-free interest.

Despite these advantages of Treasury II over the first Treasury proposal, many believe the floor tax on health care benefits sets the stage for more taxation later and that the new rules on 401(k) plans will hurt their growth.

In the new plan, the administration scraps a much-criticized proposal that would have taxed employees on employers' health care contributions exceeding $70 a month for individuals and $175 a month for family coverage.

Instead, it proposes including as taxable income the first $10 a month of employer health care contributions toward individual coverage and the first $25 a month toward family coverage.

While such a system would be easier for employers to administrate, two major insurer trade associations—the American Council of Life Insurance and the Health Insurance Assn. of America—already have signaled their opposition to the new floor tax proposal. They say the concept is "dangerous" because it could be the first step to future benefit tax increases.

"It could be expanded on in the future," agreed Philip Briggs, executive vp at Metropolitan Life Insurance Co. in New York. If Congress wants more revenue, it could raise the tax floor to $40 or $80, he warned. "Then, we are not talking about a little tax, but a big tax."

However, since a tax floor would not pose the administrative hassles for employers that a tax cap would impose, it is expected many employers will resign themselves to it rather than lobby against it.

"A cap raises a lot of problems. It can be terribly complex," said Theresa Stuchiner, a partner with Kwasha Lipton, a Fort Lee, N.J.-based benefit consultant.

Self-funding employers, for example, often don't know what their total health care costs are—and therefore what their per-employee contribution is—until many months after the end of a year. That's because many claims incurred at the end of the year are not paid until the next year.

But, a health care tax floor would not pose such problems since a self-insured employer would not have to compute its health care costs to determine how much it contributes to each employee's coverage. Employees automatically would be taxed on the employer's contributions—$10 a month for individual coverage and $25 a month for family coverage.

"A common reaction among employers might be: 'I don't like the floor, but it is better than a cap from an administrative point of view,'" said Frederick Rumack, director of tax and legal services for Buck Consultants Inc. in New York.

Insurers also were vocal opponents of the tax cap, but might be less vocal about a floor tax. They feared that if the tax cap were instituted, employers might sacrifice cost-containment features to keep contributions to employees' health care premiums below the cap.

Such an incentive to cut cost-containment features, which may add to the cost of a plan in the short run but can produce long-term savings—wouldn't exist under a health care tax floor, since there would be no way to escape the tax.

A health care tax cap also would have hurt insurers because it would have deterred employers from buying generous—and expensive—benefit packages from insurers, since the amount of taxes their employees would pay would increase with plan generosity.

Mr. Briggs questions whether insurers' opposition to the health care tax cap will be as strong.

"It is hard to get people excited because of the small size of the tax," he said.

Unions also had much more to lose with a health care tax cap than with a health care tax floor.

Union health care plans in some industries, like auto manufacturing, are extremely rich, and monthly premiums—which usually are paid by employers—can easily exceed $300 a month for family coverage, consultants say.

In fact, some say unions participated in discussions on Capitol Hill about alternatives to the health care tax cap, like the tax floor.

"It remains to be seen whether this same coalition (of employers, insurers and unions) can be built," to lobby against the tax floor, said Metropolitan's Mr. Briggs.

Employees themselves may focus more on non-benefit provisions in the tax legislation. For example, employees that live in states and cities with high income tax rates have a lot at stake if Reagan's plan to disallow tax deductions for for state and local taxes is enacted.

Meanwhile, while the administration has agreed to retain 401(k) plans, the plans would hardly resemble those now in use.

The maximum annual contribution limit per employee would be slashed to $8,000 from $30,000. That $8,000 maximum contribution would be further reduced by any funds an employee contributed to an Individual Retirement Account.

A most attractive current 401(k) feature—allowing employees to withdraw funds to pay for a new home, uncovered medical expenses or a child's college education—would be eliminated.

At the same time, a series of cumbersome formulas would replace current anti-discrimination tests for 401(k) plans.

Taken together, these new lower contribution limits, elimination of hardship withdrawals and complex anti-discrimination rules could be enough to discourage employers from setting up new 401(k) plans, experts say.

The administration in Treasury II also has refused to budge at all on some benefit proposals contained in Treasury I.

The administration has retained Treasury proposals to impose special taxes on employees who receive pre-retirement distributions (generally before age 59½) from defined benefit and defined contribution plans. The tax would be 10% if the distribution were used for tuition or for the first-time purchase of a home, while a 20% tax would be charged for distributions used for other purposes.

The administration also agrees with Treasury's original recommendation that employer costs for providing van-pooling benefits should be included as taxable income to employees. Van pooling benefits now can be offered tax-free to employees under a section of the Tax Code that is due to expire at the end of the year.

While the number of employers offering van-pooling benefits is thought to be small, it is expected van-pooling programs would mushroom overnight if the country were hit with another energy crunch.

Finally, the administration has accepted the Treasury's original recommendation that a 10% excise tax be levied on reversions from terminated overfunded pension plans. ■

Politics forced changes

WASHINGTON—Pragmatic politics caused the Reagan administration to reverse itself on a number of benefit issues in the tax simplification plan it released last week, observers say.

Specifically, Senate Finance Committee Chairman Sen. Robert Packwood, R-Ore., had made it clear many times during the last several months that he would oppose any tax reform package that imposed major new taxes on employee benefit plans.

"No member of the tax writing committees was more vocal in opposing Treasury's employee benefit provisions than Sen. Packwood," said Stuart Brahs, executive director of the Assn. of Private Pension and Welfare Plans in Washington.

In particular, Sen. Packwood opposed taxing such benefits as health care, term life insurance, educational assistance, dependent child care and legal plans.

Sen. Packwood has a strong personal interest in these plans, and labor unions—major allies of the Oregon Republican—also have lobbied Congress and Treasury hard to make their opposition known to any new taxes on these programs.

Given Sen. Packwood's opposition to taxing most benefits, the administration had no choice but to make major concessions in the benefit area, experts say.

"Sen. Packwood made it clear that he would not shepherd a tax bill through Congress that endangers our present system of employee benefits," said William Chip, counsel for the Employers Council on Flexible Compensation in Washington.

And, as chairman of the Finance Committee, Sen. Packwood has the power to delay and possibly kill a tax bill.

"It is hard for a president to pass a tax bill without the support of the Finance Committee chairman," Mr. Chip said.

The changes on the benefit sections of the tax plan—continuing the tax-free status of term life, educational assistance, dependent child care and group legal plans—were the administration's way of mollifying Sen. Packwood, some say.

"Political pragmatism means you attempt to accommodate the chairman of the Senate Finance Committee," said Dallas Salisbury, president of the Employee Benefit Research Institute in Washington. "Without Sen. Packwood's input I doubt you would have seen changes as extensive as these."

And if the administration was attempting to appease Sen. Packwood by trimming Treasury's initial benefit provisions, it appears to have succeeded: Last week, Sen. Packwood said he generally was pleased with the benefit provisions in the new tax reform package.

As a result, employers may not be able to count on Sen. Packwood to wrest even more benefit compromises from the administration.

This is especially true since most of the remaining benefit provisions that employers find objectionable—such as the proposed changes to 401(k) salary reduction plans—deal with retirement benefits, in which Sen. Packwood never has displayed much interest.

Nevada measure

Continued from page 2
have to calculate and "file and use" their own workers compensation rates, rather than using cartel rates prepared by a rating bureau.

Nine other states already have some form of competitive rating.

Primary supporters of the legislation include the Nevada Independent Insurance Agents and several employers.

"We think it's high time that businessmen in Nevada had a choice in buying workers compensation insurance," said Larry Kees, legislative chairman for the agents' group.

While insurers strongly support the measure, employers are split on the issue. Some, particularly those that belong to the Nevada Chamber of Commerce Assn., would like to purchase their workers compensation coverage from commercial insurers that offer different types of loss prevention programs, said Fred Davis, executive director of the Chamber of Commerce, based in Reno.

However, others are concerned that opening up the insurance marketplace could lead to higher workers compensation costs, and rates, because the tight controls on claims handling would be weakened.

The State Industrial Insurance System, which also opposes the legislation, is concerned that small employers would be hurt most if rates go up, said Laury Lewis, general manager.

He also believes that a monopolistic state fund, which is a non-profit organization, does a good job of handling claims and serving injured workers' interests.

The governor would not say whether he would veto the current bill. Some legislative observers say that lawmakers might try an override if the measure is vetoed.

If the legislation is killed this session, supporters would have to wait until 1987 to try again, since the Nevada Legislature meets every other year.

Some observers, however, say that supporters may try taking the issue to voters in a referendum, though Mr. Kees said his association isn't considering that move at the moment. ■

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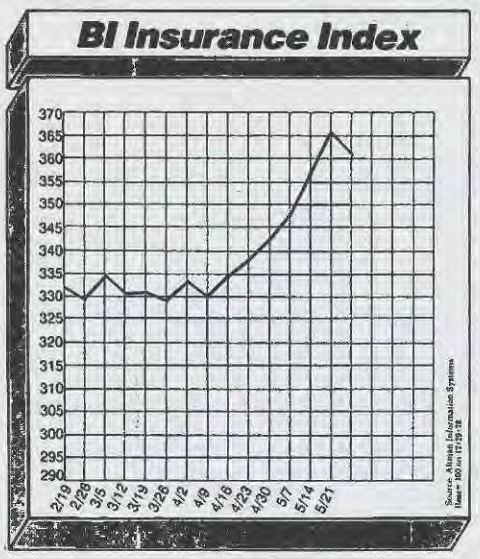
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After setting a record for six consecutive weeks, the *Business Insurance* stock index fell somewhat during the trading period that ended May 28. The *Business Insurance* index of insurance industry stocks closed at 360.1 points on May 28, a dip of 3 points from the record high of 363.1 points set May 21. A total of 14 stocks posted gains for the week, 31 stocks were down, and 12 stocks were unchanged. The biggest gains were posted by Hanover Insurance Co., up 7.1%; Orion Capital Corp., up 5.8%; Emett & Chandler Cos. Inc., up 5%; Frank B. Hall & Co. Inc., up 3.8%; and the Crump Cos. Inc., up 3.7%. The largest losses were posted by Protective Life Corp., down 6.5%; USLIFE Corp., down 6.3%; Mission Insurance Group Inc., down 6.2%; Reed Stenhouse Cos. Ltd., down 5.7%; and Alexander & Alexander Services Inc., down 5.6%. The *Business Insurance* index fell a total of 0.8% for the trading period. In comparison, the New York Stock Exchange composite also fell 0.8%, the Standard & Poor's 500 fell 0.9%, and the Dow Jones 30 Industrials fell 0.6% for the same trading period.

British Issues

28 May Companies	Price pence	P/E	Div. pence	Yield %	1 Week High—Low pence	pence
Comml Union	225	N/M	16.9	7.5	228—225	
Genl Accident	595	100.8	28.6	4.8	600—595	
Gdn Royal Exch	695	20.1	37.1	5.3	700—693	
Royal	635	N/M	33.9	5.3	635—630	
Sun Alliance	460	22.1	21.1	4.8	415—458	
Brokers						
CE Heath	610	10.0	30.0	4.9	615—610	
Hogg Robinson	280	16.0	11.6	4.1	282—280	
JH Minet	209	13.7	8.9	4.3	210—202	
Sedg Grp	390	17.1	14.3	3.7	390—385	
Stew Wrightson	600	15.7	25.7	4.3	600—597	
Willis Faber	682	23.4	18.6	2.7	682—680	

Source: Philip Olsen/Alan Clifton, Insurance Industry Specialists Kitcat & Aitken Stockbrokers, London

Brokers' annuals forecast challenges—and profits

By JAMES M. BURCKE

LIKE the major commercial property/casualty insurers, insurance brokerages are using their 1984 annual reports to herald the advent of higher rates (*BI*, April 29).

While the brokers' chief executives prefer to talk about their own companies' progress rather than industry problems as a whole, their comments on the tightening market and how their companies will react provides an insight to brokers' views on the current state of the industry.

Executives of insurance brokerages comment in their annual reports:

The Crump Cos. Inc.

"There is a phrase I like. It is 'value added.' At a time of rising rates, our customers want to know what value we are adding for them. Added value comes from a lot of things. It comes from the stability of the insurance companies we represent, it comes from the ability to obtain competitive prices, it comes from innovative approaches and supplementary services like engineering. No matter who the agent or broker, rates are going up because insurance companies can no longer sell their product at below cost. The difference between brokers will be the value they add.

"This is a period of great opportunity for Crump. Generally, as premium income has fallen in the past five years, our commission income has also fallen. As premiums are rebounding, our commission income, which is our revenue base, also will rise. This is something which will please our stockholders if our expenses can be kept in line."

—Sidney A. Stewart Jr., chairman and chief executive officer.

Frank B. Hall & Co. Inc.

"This (1984) was another in a series of difficult years for the insurance industry. Property and casualty insurers operating and underwriting results were down from previous years.

"The industry is now emerging for the bottom of its cycle. . . .The industry is presently undergoing a massive correction and, since later 1984, insurance rates have risen significantly and the capacity to accept risks has been curtailed. We expect these conditions to lead to higher revenue for Hall in 1985 and the years ahead. . . .

"In recent months, rates have increased and it appears the commercial premium rates will increase over the next several years. Hall is well-prepared to take advantage of these improved market conditions.

"Our facilities are strategically positioned around the would. Our professionals are among the finest in the industry. We have excellent relations with insurance markets. Our management structure is solid, and we possess a special sensitivity to our profession that distinguishes us from the competition. We are optimistic about the future. . . ."

—Albert J. Tahmoush, chairman, president and chief executive officer.

Marsh & McLennan Cos. Inc.

"1984 will certainly be remembered as the year in which insurance underwriting markets tightened—as premium rates leveled out, and then began to increase, in many cases dramatically. Primary coverages were not affected by rate increases until the latter part of 1984, a trend we see continuing at least through 1985. Rates in the reinsurance markets had begun to firm at the end of 1983 and sharp increases were evident throughout 1984.

"Conditions in the world underwriting markets will continue to make considerable demands on Marsh & McLennan's long-standing expertise in executing brokerage transactions and will test the strength of our international organization. This was vividly demonstrated in 1984 by our insurance brokerage operations as our resources were called upon by our clients to deal with huge, complex claims involving several international risk management situations."

—John M. Regan, chairman, and Frank J. Tasco, president.

Corroon & Black Corp.

"The mid-1980s are bringing widespread changes to the insurance services industry. The soft market of the early part of the decade has turned 180 degrees during the past 12 months. Underwriters are now turning business away, coverage is becoming more restrictive, premiums are going up and we are hearing more and more talk about shortage of capacity. It is the responsibility of this management to consider the potential rewards and the inherent risks in this type of market.

"For Corroon & Black, this market presents opportunities to increase revenues from our product innovations and specialized marketing skills. Our ingenuity, professionalism, aggressiveness and strength will serve us well."

—Robert F. Corroon, chairman and chief executive officer.

Alexander & Alexander Services Inc.

"In mid-1984, the U.S. insurance market, following the London reinsurance market, changed abruptly. Prices increased dramatically as worldwide underwriting capacity began to contract. We expect this trend to continue. Our broking operations, particularly in the U.S. and the U.K., responded to the challenge by performing better than ever.

"While our broking operation prospered in the new market environment, our underwriting business unfortunately shared the fate of many other insurance companies. . . .After an exhaustive study and an evaluation of A&A strategic priorities, the decision was reached in March 1985 to dispose of the underwriting companies acquired as part of Alexander Howden Group. . . .

"The market environment for casualty insurance companies generally should improve during 1985. In this climate, the companies we propose to sell will be advantageously positioned; however, it is clear that our future efforts and capital resources can be better devoted to A&A's brokerage and other operations. . . .

"We began this letter with a reference to the changing market environment. As a broker dedicated to excellence in client service, we are devoting increased attention and resources to evaluating the basic security of the underwriters handling our clients' business. As we look forward, we will continue to work diligently to carefully evaluate available markets."

—John A. Bogardus Jr., chairman and chief executive officer, and Tinsley J. Irvin, president and chief operating officer.

Arthur J. Gallagher & Co.

"No industry can sell its products below cost and last indefinitely. For almost five years, the property/casualty insurance industry has been involved in an unprecedented price war. This finally ended during the last half of 1984. The firming of insurance rates will bring new opportunity and challenges to our company. Our integrated approach of managing all components of the risk management process is ideally suited for a rising premium environment. Our strategy and special products position us to take maximum advantage of the opportunities this will bring. We have just entered phase one of this new cycle."

—Robert E. Gallagher, president.

Industry, RAA first-quarter

The U.S. property/casualty insurance industry had net aftertax income of $287 million in 1985's first quarter, down 32.3% from $424 million a year ago, according to a study by the Insurance Services Office and the National Assn. of Independent Insurers.

The industry's combined ratio was 117.1% for 1985's first quarter and 117.8% for first-quarter 1984.

During first-quarter 1985, the industry had a pretax underwriting loss of $5.73 billion, up $660 million from first-quarter 1984. Pretax investment income was up 9.3%, to $4.46 billion. Realized capital gains rose 0.5%, to $1.02 billion.

Written premiums were up 15.3% during 1985's first quarter, to $32.03 billion; 1984's first-quarter premiums grew only 5.4% over 1983.

Also, 68 U.S. reinsurers reported an aggregate combined ratio of 121.1% for the first quarter of 1985, compared with a combined ratio of 126.8% for first-quarter 1984, according to a survey by the Reinsurance Assn. of America.

The reinsurers generated $1.77 billion in net premiums written for the first quarter, up 31.7% from $1.35 billion during 1984's first quarter, according to the RAA.

A similar, but not identical, group of reinsurers had a combined ratio of 128.2% for the 12 months that ended 1984 (*BI*, May 20). ■

BI Industry Stock Report

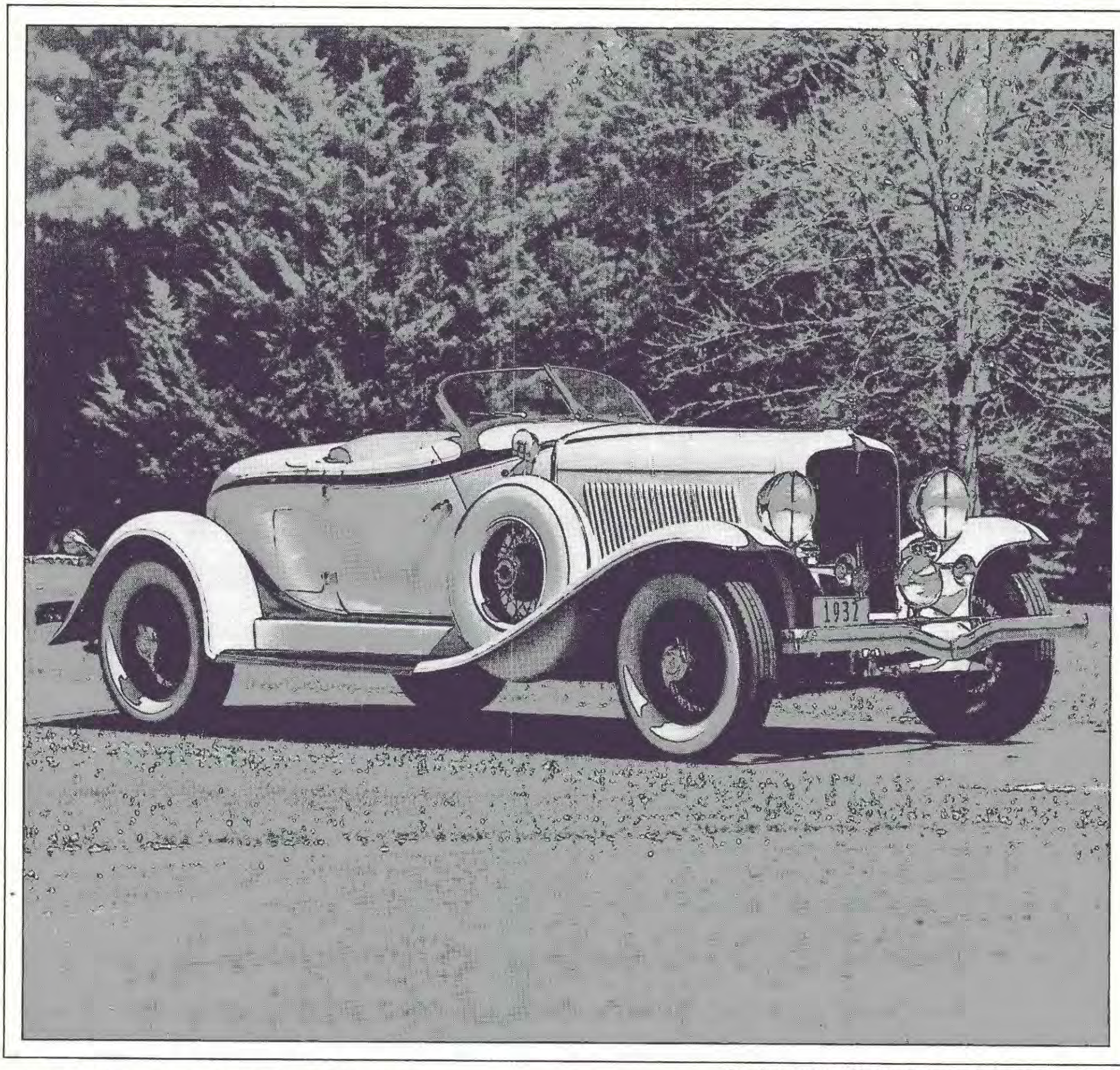
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		Price	% Chg.	P/E	$ Div.	% Yld.	High	Low	Vol.(000)
Brokers									
Alexander & Alexander Svcs	NYSE	27.38	-5.6	0.0	1.00	3.7	28.63	27.25	311.8
Baldwin & Lyons Inc	OTC	65.00	0.0	11.8	0.80	1.2	73.00*	65.00	0.1
Corroon & Black Corp	NYSE	46.25	-1.6	0.0	1.00	2.2	47.25	46.25	173.6
Crump E H Cos Inc	OTC	31.88	3.7	24.0	0.44	1.4	32.13*	31.88	76.3
Emett & Chandler Cos Inc	OTC	21.00	5.0	100.0	0.00	0.0	21.00*	20.50	2.6
Gallagher Arthur J & Co	OTC	43.50	1.8	26.0	0.28	0.6	43.50*	43.00	10.9
Hall Frank B & Co Inc	NYSE	27.00	3.8	0.0	1.00	3.7	27.00	25.75	467.6
Marsh & Mclennan Cos Inc	NYSE	66.00	-2.9	18.3	2.40	3.6	67.50	66.00	102.1
Poe & Assoc Inc	OTC	8.00	0.0	0.0	0.00	0.0	8.00	8.00	0.0
Reed Stenhouse Cos Ltd	OTC	20.50	-5.7	26.6	0.60	2.9	21.25	20.50	43.8
AGENTS/BROKERS	AVERAGE			43.1		2.1			
Conglomerates & Holding Cos.									
American Express(Fireman's Fd)	NYSE	45.38	0.3	15.7	1.28	2.8	45.50	44.13	2,622.4
Anderson Clayton(Ranger/PanAm)	NYSE	39.00	1.6	33.6	1.32	3.4	39.00	39.00	53.5
Armco Inc	NYSE	7.63	-1.6	0.0	0.00	0.0	7.63	7.50	549.8
Berkley W R Corp	OTC	15.50	0.0	0.0	0.32	2.1	15.75	15.50	61.3
CIGNA Corp	NYSE	56.50	-1.1	807.1	2.60	4.6	57.00	55.50	945.0
City Investing Co. (Home Ins.)	NYSE	35.75	3.6	5.6	0.00	0.0	35.75	35.00	1,009.7
CNA Finl Corp (CNA)	NYSE	49.88	-1.2	19.2	0.00	0.0	50.00	49.50	73.8
General Re Corp	NYSE	83.25	-0.7	54.8	1.56	1.9	84.00	83.25	240.7
ITT (Hartford Group)	NYSE	32.75	-4.4	10.2	1.00	3.1	33.75	32.13	2,195.7
Optimum Hldg Corp	OTC	0.50	0.0	0.0	0.00	0.0	0.50	0.50	0.0
Sears Roebuck & Co. (Allstate)	NYSE	36.38	-0.3	9.1	1.76	4.8	36.38	35.63	2,366.1
Teledyne Inc (Argonaut)	NYSE	254.00	2.9	5.5	0.00	0.0	254.00	245.75	174.1
Transamerica Corp (Occidental & Fred S. James)	NYSE	30.63	-0.4	15.0	1.64	5.4	30.75	30.25	376.3
CONGLOMERATES/HOLDING COS.	AVERAGE			11.3		1.7			
Insurers									
Aetna Life & Cas Co	NYSE	45.50	-0.8	23.1	2.64	5.8	45.50	45.00	815.4
American General Corp	NYSE	34.75	-0.4	11.3	1.00	2.9	34.75	34.00	525.2
Amern Heritage Life Invt Co	NYSE	31.50	2.9	9.5	1.20	3.8	31.50	30.63	2.0
American Indty Finl Corp	OTC	20.75	0.0	0.0	1.12	5.4	21.00*	20.75	15.1
American Intl Group Inc	NYSE	82.25	-4.2	24.3	0.44	0.5	84.88	82.25	297.2
Aneco Reins Ltd	OTC	1.50	0.0	0.0	0.00	0.0	1.50	1.50	8.0
Avemco Corp	NYSE	28.00	-0.9	13.0	0.60	2.1	28.38	28.00	8.5
Business Mens Assurn Co Amer	OTC	54.00	-0.5	7.4	2.08	3.9	54.25	53.75	4.0
Chubb Corp	NYSE	68.88	0.0	17.3	2.20	3.2	68.88	68.50	191.7
Combined Intl Corp	NYSE	48.38	1.0	9.4	2.16	4.5	48.38	47.63	78.0
Continental Corp	NYSE	45.00	-5.0	23.0	2.60	5.8	46.38	44.50	359.3
Crown Life Ins Co	OTC	137.00	0.0	8.3	5.00	3.6	137.00	137.00	0.4
Durham Corp	OTC	40.50	0.6	7.8	1.28	3.2	40.50	39.88	25.4
Farmers Group Inc	OTC	62.63	-4.0	10.9	1.76	2.8	65.00	62.63	308.1
Fremont Gen Corp	OTC	27.50	-5.2	0.0	0.48	1.7	28.25	26.88	288.7
Great West Life Assurn Co	OTC	366.00	0.0	9.4	14.00	3.8	366.00	366.00	0.4
Hanover Ins Co	OTC	45.50	7.1	77.1	0.56	1.2	45.50*	43.00	77.9
Hartford Steam Boiler Inspctn	OTC	44.75	0.6	38.6	1.50	3.4	44.75*	44.25	18.3
Kans City Life Ins	OTC	77.00	0.0	8.8	2.88	3.7	77.00	77.00	0.7
Kemper Corp	OTC	58.88	-2.5	25.4	1.80	3.1	59.25	58.50	196.3
Liberty Corp S C	NYSE	31.75	2.8	14.8	0.72	2.3	31.75	31.13	37.9
Lincoln Natl Corp Ind	NYSE	43.75	-3.6	11.5	1.84	4.2	44.75	43.75	172.1
Mission Ins Group Inc	NYSE	7.63	-6.2	0.0	0.00	0.0	8.13	7.63	60.2
Monumental Corp	OTC	33.13	1.9	24.4	1.30	3.9	33.38*	32.75	33.1
Northwestern Natl Life Ins	OTC	30.63	-1.2	7.3	0.80	2.6	31.13	30.63	213.7
Ohio Cas Corp	OTC	59.63	-1.4	22.1	2.80	4.7	61.25	59.63	102.1
Old Rep Intl Corp	OTC	32.75	-1.5	7.9	0.74	2.3	32.88	32.63	38.7
Orion Cap Corp	NYSE	27.25	5.8	0.0	0.76	2.8	28.00*	26.75	71.0
Protective Corp	OTC	21.50	-6.5	7.3	0.66	3.1	22.50	21.50	91.9
Provident Life & Acc Ins Co	OTC	24.25	-3.0	6.6	0.88	3.6	25.00	24.25	332.0
St Paul Cos Inc	OTC	69.75	1.1	0.0	3.00	4.3	70.00	69.13	325.1
SAFECO Corp	OTC	42.13	-2.6	15.0	1.60	3.8	43.25	42.13	263.7
Sri Corp	OTC	19.00	0.7	90.5	0.68	3.6	19.00	19.00	62.6
Seibels Bruce Group Inc	OTC	21.75	-0.6	0.0	0.80	3.7	21.75	21.50	193.2
Statesman Group Inc	OTC	4.75	-5.0	0.0	0.15	3.2	4.75	4.55	79.6
Tokio Marine & Fire Ins Co	OTC	174.50	-1.4	30.2	0.00	0.0	175.13	173.00	9.4
Torchmark Corp	NYSE	50.38	-2.4	11.2	1.00	2.0	50.63	50.25	149.9
Travelers Corp	NYSE	47.75	-0.3	11.5	2.04	4.3	47.75	47.25	370.1
United Fire & Cas Co	OTC	22.00	0.0	0.0	0.80	3.6	22.00	22.00	0.0
United States Fid & Gty Co	NYSE	36.00	-1.4	38.7	2.20	6.1	36.38	36.00	350.2
Uslife Corp	NYSE	37.00	-6.3	8.4	1.04	2.8	38.63	37.00	277.8
Washington Natl Corp	NYSE	26.25	-1.4	7.7	1.08	4.1	26.75	26.25	77.5
Zenith Natl Ins Corp	OTC	14.50	0.0	0.0	0.68	4.7	14.75	14.00	27.8
INSURANCE COMPANIES	AVERAGE			16.2		3.2			

System design: Altman Information Systems

If you were reconditioning this 1932 Auburn, you'd go to an expert.

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Location courtesy of Heritage Plantation, Sandwich, Massachusetts.

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