

business insurance

Reporting weekly for corporate risk, employee benefit and financial executives/\$1.25 a copy; \$45 a year

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Kasten's tort reform bill receives additional changes

WASHINGTON—A bill that would establish a uniform federal product liability law is back on track after another overhaul.

Changes made to the legislation, S. 44, introduced by Sen. Robert Kasten, R-Wis., include:

- Adding a statute of limitations provision that would require plaintiffs to file suit within two years of the time they were injured.

Continued on next page

S&P provides alternative to Best's insurer ratings

By BILL DENSMORE

NEW YORK—Risk managers have a new tool to help diagnose the financial health of insurers they do business with.

Standard & Poor's Corp., the New York-based debt-rating firm, is now analyzing the claims-paying ability of U.S. and overseas insurers, apparently putting S&P in competition with A.M. Best & Co. Inc. of Oldwick, N.J., the traditional source of insurer ratings.

S&P is a subsidiary of McGraw-Hill Inc., the large New York-based book and magazine publisher.

Standard & Poor's says risk managers can check an insurer's rating without charge by telephoning S&P's rating desk in New York at 212-248-2551.

In contrast, a spokesman for Best's says his company does not provide insurer ratings by telephone and charges a minimum of \$42 for a publication that lists the ratings of 1,300 U.S. insurers.

The service was begun by Standard & Poor's a few years ago, but has been formalized and publicized only recently.

"I think it's a nice initial effort, which is complementary to Best's," says Arthur Bostwick, vp of education for RIMS and risk manager at Stone Container Corp. in Chicago.

"Their rating system would be a little different (from Best's). I think they are trying to go a little heavier on checking reinsurance and that's interesting in today's market," Mr. Bostwick notes.

"I see this as just another entry into the field of insurance company rating and in no way is it meant to be derogatory of what Best's is doing," says Donald T. Brown, vp and insurance manager for First Atlanta Corp., a bank holding company.

"I would consider that any additional organization getting into the rating business would be desirable."

A Best's official said he was generally aware that Standard & Poor's has been test-marketing the rating of insurers for several years.

"It's interesting; I'd like to know more about it," said Robert A. Bailey, vp of property/casualty at A.M. Best. He said it was "hard to say off-the-cuff" what Best's reaction might be to the S&P service, adding that it would depend upon what S&P charges insurers for the rating and how many insurers decide to participate.

Best's says its policy of charging the user of information eliminates any bias and leaves it free to rate all insurers whether or not they desire a rating.

In practice, however, Best's acknowledges that it usually omits the ranking of any insurer that refuses to cooperate by sending financial information to Best's. The publisher says this has only happened with small insurers.

S&P says charging bond and insurance sellers for rating services provides greater revenues for in-depth analysis than would be possible through a charge only to users.

It acknowledges, however, that if an insurer rejects a rating, S&P returns one-third of the rating fee. The rating organization says this is done because an unrated insurer does not have to be constantly monitored by an S&P analyst, thus saving staff time.

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Plan to limit tax deductions viewed as a serious threat

By JERRY GEISEL

WASHINGTON—Risk managers had better take seriously Senate Finance Committee proposals to ban tax deductions for premiums paid for backdated liability insurance and captive coverages, observers say.

The committee is studying a list of options prepared by its staff to change tax laws governing property/casualty insurance in a drive to raise more revenue.

One of those options includes a new definition of insurance that would exclude backdated liability insurance coverage and coverage provided by captive insurance companies (BI, Oct. 17).

If these coverages are not considered insurance, companies could not take income tax deductions for premiums paid under these arrangements.

Although Finance Committee staff members have yet to draft specific legislation that would bar the deductions, experts say concrete proposals are near.

"Sen. Dole's staff is determined to make changes," said Les Cheek, the vp of federal affairs for Crum & Forster. Sen. Robert Dole, R-Kan., is chairman of the Finance Committee.

"I'm taking these proposals very seriously," said Jon Harkavy, the director of governmental affairs for the Risk & Insurance Management Society in New York. He says risk managers should be prepared to lobby against them.

He says that the purchase of retroactive coverage is a legitimate risk management technique to protect companies from losses.

Ultimately, if these proposals are drafted into legislative form and passed by Congress, "The question may no longer be under what circumstances the parent can take a deduction for premiums paid to its captive, but whether a deduction will be allowed at all," he added.

So far, the Finance Committee has only prepared a discussion paper that proposes a new definition of insurance that would exclude captive and backdated liability insurance by defining insurance as the spreading and shifting of an "insurance risk."

While a committee discussion paper doesn't clearly define an "insurance risk," the paper does say captive and retroactive arrangements would not be treated as insurance.

The committee's interest in disallowing tax deductions for backdated liability coverage apparently stems from MGM Grand Hotel Inc.'s purchase of a controversial backdated liability policy in 1981.

After a Nov. 21, 1980, hotel fire in Las Vegas, Nev., that killed 85 and injured more than 500, MGM purchased about \$170 million in backdated liability insurance through broker Frank B. Hall & Co. Inc. for losses arising from the blaze.

The additional coverage came on top of \$30 million in

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Lockheed wants D&O insurer to pay costs in bribe scandal

By DOUGLAS MCLEOD

LOS ANGELES—Lockheed Corp. and two former executives are pressing a lawsuit against a former liability insurer even though it could force embarrassing disclosures about bribes it paid to foreign officials in the 1970s.

The Burbank, Calif.-based aircraft manufacturer and the two men have renewed a dormant legal battle in Los Angeles County Superior Court against Unigard Mutual Insurance Co., Lockheed's former directors and officers liability underwriter.

Lockheed says that Unigard should have to pay legal and other expenses the company and officers incurred after Lockheed admitted in 1975 to bribing foreign officials to encourage sales.

Seattle-based Unigard denies it has any liability for those expenses.

To build its case, Unigard has subpoenaed 54 boxes of files collected by the Securities and Exchange Commission. The files are said to contain previously unreleased details of the foreign payments.

Lockheed, however, is trying to quash the subpoena, claiming that the files "are replete with unsubstantiated hearsay and innuendo" that could destroy the careers of foreign officials and damage the foreign in-

terests of Lockheed and the U.S. government.

Lawyers say the fate of the subpoena will soon be decided in U.S. District Court in Washington.

All of the litigation stems from 1975 Senate Foreign Relations subcommittee hearings that revealed employees of Lockheed and other U.S. multinationals routinely paid millions of dollars in "commissions" to foreign officials through middlemen to influence overseas sales. The disclosures forced the resignation or prosecution of several foreign officials who received payments.

Those officials included Prince Bernhard of the Netherlands, who allegedly received \$1 million, and former Japanese Prime Minister Kakuei Tanaka, who was convicted earlier this month of taking \$2 million in bribes.

Mr. Tanaka was given a four-year prison term and a \$2 million fine, though he remains free on appeal and retains his seat in the Japanese Parliament.

Although no U.S. law specifically forbade such payments at the time, the Lockheed incident prompted Congress to pass the Foreign Corrupt Practices Act of 1977.

Disclosure of the payments also prompted investigations of Lockheed by the SEC, the Justice Department, the Internal Revenue Service, the Federal Trade Commission and other agencies.

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STANDARD & POOR'S **CreditPolicy** THE AUTHORITY ON CREDIT QUALITY

CreditPolicy

Insurers' claims-paying ratings

Standard & Poor's has announced an overhaul of evaluating the claims-paying ability of insurers... (text continues)

The following table shows Standard & Poor's claims-paying ability ratings:

AAA	AAA
AA	AA
A	A
B	B
C	C
D	D
E	E
F	F
G	G
H	H
I	I
J	J
K	K
L	L
M	M
N	N
O	O
P	P
Q	Q
R	R
S	S
T	T
U	U
V	V
W	W
X	X
Y	Y
Z	Z

update

Product liability bill altered

Continued from previous page

• Restoring the doctrine of collateral estoppel, which Sen. Kasten wanted to delete from current product liability laws. The doctrine allows a fact to be established in a case by showing that a previous court accepted the fact.

• Barring multiple punitive damage awards against a manufacturer in lawsuits involving the same product. In addition, that portion of a punitive damage award that exceeds compensatory damages paid to a plaintiff must be used for a "public purpose" designated by the court.

The changes were made after Sen. Slade Gorton, R-Wash., a Senate Commerce Committee member, said he could not support it.

Ocean Ranger claims formula

ST. JOHNS, Newfoundland—A formula for resolving the liability claims of 54 Canadian families arising from the capsizing of the Ocean Ranger oil rig could cost insurers for Mobil Oil Canada Ltd. and ODECO Drilling of Canada Ltd. more than \$20 million, says Michael Harrington, a Canadian attorney for the Mobil Corp. unit.

The rig capsized Feb. 12, 1982, in heavy seas, killing all 84 crewmembers (BI, Feb. 22, 1982).

Mr. Harrington said plaintiffs' lawyers reached agreement with the defendants that would yield estimated payments of between \$250,000 and \$1 million in Canadian currency (about \$202,000 to \$810,000 in U.S. currency) for each of the 54 Canadian families with pending claims.

Both the 54 Canadian plaintiffs and representatives of 30 American citizens killed have claims pending before a federal judge in New Orleans, who has tentatively ruled that Canadians must pursue their claims in Canadian courts.

Under the formula, ODECO and Mobil each would compensate the families of their own employees and contractors who died. Mobil and ODECO are believed to be still talking about how to share overall liability. ODECO has \$200 million in liability insurance. Mobil's coverage has not been disclosed.

Employer charged with murder

CHICAGO—Five corporate officials of the defunct Film Recovery Systems Inc., a northern Illinois silver-recovery company, are being charged with murder in the Feb. 10 cyanide-poisoning death of a Polish immigrant who had worked for the firm for 2½ years.

The Cook County Grand Jury indictments, handed down Oct. 19, also charge each of the five officials with 21 counts of reckless conduct, a misdemeanor. FRS of Elk Grove Village and two other companies—Metallic Marketing, also of Elk Grove Village, and B.R. MacKay & Sons Inc. of Salt Lake City—also were charged with involuntary manslaughter.

FRS recovered silver from discarded X-ray film. The process created cyanide fumes and left a residue of the poison on the film pieces. The state's attorney's office charges that FRS officials removed or covered hazard labels on the drums of poisonous chemicals used in the process and did not properly warn employees of hazards.

The dead employee was one of more than 40 who allegedly were exposed to the deadly fumes. The Occupational Safety and Health Administration had fined the firm previously and the state Environmental Protection Agency had cited it for a permit violation and sent the case to the state's attorney's office for litigation.

Charged were Steven O'Neil, 29, president of FRS and Metallic Marketing; Michael T. MacKay, 43, a director of FRS and president of B.R. MacKay & Sons; Daniel Rodriguez, assistant plant manager at FRS; Gerald Pett, vp and manager of FRS; and Charles Kirschbaum, FRS plant manager.

Grocer covered for explosion

SOUTH CHARLESTON, W.Va.—Oakhurst Foodland Inc. has adequate insurance to cover property and business interruption arising from an Oct. 17 explosion at a 10,000-square-foot supermarket, its attorney says.

However, Roger King, Oakhurst's Columbus, Ohio, attorney, could not give the exact limits of the coverage written by Great Central Insurance Co. Inc. of Peoria, Ill., since the policy was one of the records destroyed in the blast, nor could he detail the company's liability insurance.

No one was killed in the incident, but some 15 customers and employees were injured.

Employees injured in the blast will be covered by workers compensation, but attorneys speculate that employees could possibly sue for additional benefits because of a 1978 state Supreme Court case. That ruling, known as the Mandolidis decision, says injured employees who receive work comp benefits may sue their employers if they can show the employer's willful, wanton and reckless disregard for safety led to the injury (BI, Jan. 17).

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Supreme Court to rule on multiemployer law

By JERRY GEISEL

WASHINGTON—The Supreme Court will decide whether employers that left multiemployer pension plans before President Jimmy Carter signed the Multiemployer Amendments Act—but after the law's effective date—can be slapped with withdrawal liability charges.

The high court last week agreed to review a May appellate court decision in San Francisco that struck down as unconstitutional the retroactive provision in the law (BI, May 30).

A ruling by the high court will end more than three years of debate over the issue, which prompted two conflicting appellate court rulings. It is one of several issues affecting risk and benefit managers that the court has agreed to hear (see story, page 32).

The Multiemployer Amendments Act's retroactive provision gives multiemployer pension plans the power to demand withdrawal liability payments from em-

ployers that left the plans during a five-month period between the law's effective date and the date it was signed by President Carter.

A Supreme Court ruling will decide whether the dozens of employers that withdrew from the plans between April 29, 1980, the law's effective date, and Sept. 26, 1980, the date President Carter signed the act, will have to pay tens of millions of dollars in withdrawal liability charges to the plans.

Several months after the 9th U.S. Circuit Court of Appeals in San Francisco struck down the retroactive provision, the 4th U.S. Circuit Court of Appeals in Richmond, Va., ruled in another case that the provision was constitutional (BI, Sept. 18).

The Multiemployer Amendments Act requires firms leaving multiemployer plans to pay a share of the plans' unfunded vested benefits.

By making employers liable for the plans' promised—but unfunded—benefits, Congress wanted to discour-

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Employer to pay half of settlement

By CAROL CAIN

GRANITE CITY, Ill.—National Steel Corp. will pay about half of an estimated \$6.5 million settlement, plus about \$400,000 in workers compensation benefits, to an employee injured in a 1981 explosion at its Granite City Steel division.

Although employers usually are protected from employee lawsuits under the exclusive remedy provisions of state workers compensation laws, National Steel became a third-party defendant in the case after the injured worker sued several other corporations, which in turn sued the Pittsburgh-based steelmaker for contributing to the accident.

The injured employee, Nicholas M. Novosel, 28, of Glen Carbon, Ill., sued the other corporations because "there's a limit to the (work comp) benefits that he recovered from the employer," said attorney Bruce Cook of Cook, Shevlin, Keefe & Chathan in Belleville, Ill.

In January 1982, Mr. Novosel sued Concast Inc., an engineering firm in Montvale, N.J., that designs continuous casting machines for the steel industry; Sumitomo Heavy Industries Ltd., a machine manufacturer in Tokyo; and Sumitomo Metals Industries Ltd., a Tokyo steel company. The two Japanese companies are not related.

Other defendants named in Mr. Novosel's original suit have been dropped and will not participate in the settlement, Mr. Cook said.

Attorneys for both sides refused to go into details about the settlement, which has not been finalized. Most of the attorneys, in fact, would not confirm the \$6.5 million, though one said, "It would not be inaccurate to report that it will be in the vicinity of \$6.5 million."

The settlement was reached earlier this month just before the case

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Animal trainer to get \$25,000 after N.Y. farmer cries wolf

By LEN STRAZEWSKI

ROCHESTER, N.Y.—How much is a member of an endangered species worth?

A timber wolf, which is an endangered species in the United States, is valued at about \$25,000, according to a recent lawsuit settlement.

The settlement, approved and sealed by a U.S. District Court judge in Rochester earlier this month, ends a three-year legal battle over police responsibility to protect both individuals and endangered species of animals, as well as a law-enforcement agency's liability to owners for the destruction of their animals.

Two of the Ontario County, N.Y., Sheriff's Office's liability insurers and a local farmer are dividing a \$25,000 settlement with John Harris, the former owner of Slick, a timber wolf who was shot and killed by a deputy sheriff on May 10, 1980.

Mr. Harris, an animal trainer who had domesticated Slick and exhibited the animal to elementary schools, colleges and other groups as part of an endangered species exhibit, had sued the County Sheriff's Office and farmer Leslie Cole, charging them with negligence, civil conspiracy and violation of animal protection laws in connection with Slick's death.

The suit sought \$2 million in actual and punitive damages.

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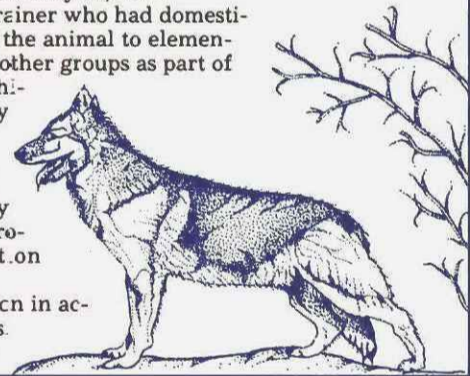


Illustration: Jim Bakasetas

Lawsuits anticipated after Texas fair mishap

By LEN STRAZEWSKI

DALLAS—Texas State Fair Inc., a private company that operates the annual Texas State Fair, is awaiting lawsuits following the second major amusement ride mishap at the fair in four years.



Photo: Wide World

Barricades block off Enterprise ride after fatal accident.

"Nothing's been filed yet, but the vultures have been around," Assistant General Manager Robert Halford said last week. "These kinds of things bring them out."

The latest accident, which occurred Oct. 17, resulted in the death of one person and injuries to five others when one of the gondolas on the fair's Enterprise carnival ride disconnected from its base and fell onto a crowd below.

One of the passengers, William Phillips of Allen, Texas, was killed and his two companions riding in the car were seriously injured, according to fair officials. Three spectators received minor injuries and were treated and released from a nearby hospital the same night.

The cause of the accident is under investigation, according to Mr. Halford, who noted that the fair's tight safety standards should have prevented such a mishap.

"The Enterprise ride was in-

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Manville considering individual settlements

By STEPHEN TARNOFF

NEW YORK—For the first time, Manville Corp. is discussing how to settle asbestos claims against it on an individual basis rather than through a lump-sum system based primarily on type of injury.

Following an Oct. 17 bankruptcy court hearing, Manville Senior Vp Earl Parker said Manville and asbestos plaintiffs' attorneys were taking a different approach in their discussions to settle the estimated 20,000 claims against Manville.

"We're working on the most flexible procedure for achieving these options," Mr. Parker said.

The acknowledgment came as U.S. Bankruptcy Court Judge Burton Liffland granted Manville a 10-day extension to Oct. 27 to file a reorganization plan supported by all creditor groups.

In the past, Manville has demanded that plaintiffs be compensated through a "defined benefits" system, which would take away the claimants' right to trial and provide benefits on a no-fault basis.

For example, last spring Manville suggested in a proposed reorganization plan that particular categories of asbestos-related impairment—like asbestosis or mesothelioma—be assigned a set compensation value, although adjustments could be made for individual factors. This would avoid jury trials to determine the size of each award.

Plaintiffs' attorneys, meanwhile, have steadfastly rejected that approach, demanding that their clients' right to a jury trial be retained even if most of the cases can be settled.

Plaintiffs' attorney Robert B. Steinberg said that Manville had always lumped cases of a particular type together without respect to individual cases, a prospect he called "anathema to trial lawyers and claimants" because of the individual differences in cases.

During the weekend discussions, however, Manville appeared to change its attitude, said Mr. Steinberg of the Los Angeles law firm of Rose, Klein & Marias.

"We felt there was some recognition on the part of Manville that there are differences in these cases," Mr. Steinberg said. "We saw just a glimmer of change."

But he added that the issue of individual claims is only one of many essential issues that must be addressed.

Mr. Steinberg characterized the discussions over the Oct. 15-16 weekend

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Benefit legislation

Will new rules help lower health care costs?

By SALLIE J. DRURY

SAN ANTONIO, Texas—Benefit reform is needed to influence providers to bring down health care costs and to influence consumers to demand those lower prices, experts agree.

However, those experts do not agree on the methods to bring about that reform.

While some advocate regulatory controls, others recommend instituting innovative cost-containment programs. And, some recommend adding no new programs until a company has gotten the most mileage out of its present benefit plan by closely monitoring utilization.

"We need to put the economic incentives in place that will let individuals determine how much they choose to spend on health care," said Dr. Robert J. Rubin, assistant secretary for planning and evaluation at the Department of Health and Human Services.

Legislation and regulation can help put those incentives in place, says Dr. Rubin, who is the major architect of a proposal that would put a cap on the amount an employer could contribute to an employee's health insurance coverage. Contributions that exceed that limit would be taxable (BI, March 14).

Speaking before a session of the Council on Employee Benefits' 37th annual conference, held Oct. 6 and 7 in San Antonio, Dr. Rubin said such a cap would provide the necessary economic incentive to bring down health care costs.

But Dr. Rubin admitted that corporate benefit officers have not responded warmly to the idea of capping benefit contributions.

"According to a recent poll of corporate benefit

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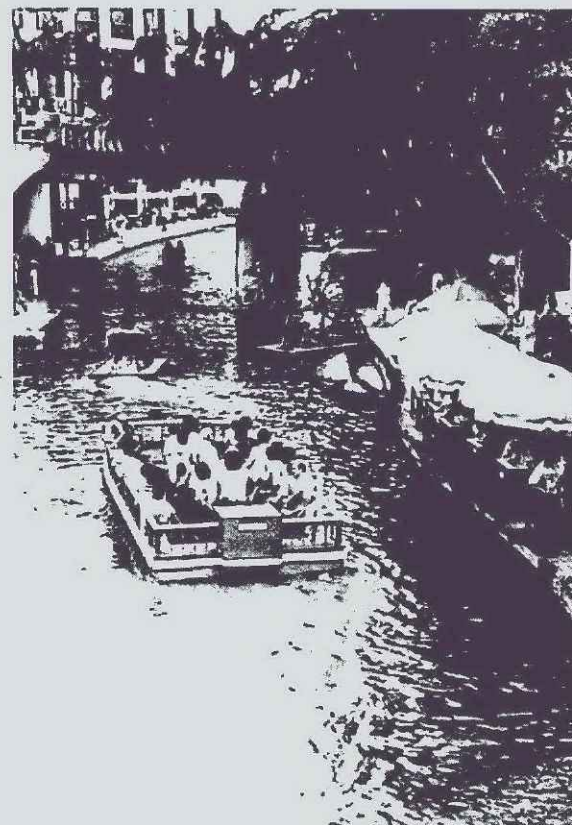


Photo: San Antonio Convention & Visitors Bureau

Benefit managers attending the CEB meeting could enjoy San Antonio's Paseo del Rio.

Speak up now or be sorry, CEB panelists say

SAN ANTONIO, Texas—Businesses must take the initiative in drafting employee benefit legislation. If they don't, they're likely to be sorry.

That was the message delivered at the Council on Employee Benefits' 37th annual conference where legal, governmental and benefit management experts urged those attending to become personally involved in shaping the attitudes of Congress.

"Since ERISA, we have seen the government getting more involved in our private benefits sector, and it's not over yet," remarked Richard P. Seiden, senior vp with Frank B. Hall Consulting Co. in Briarcliff Manor, N.Y.

"It may not be over for a long while unless we can do something about the government's thinking. We have got to have an open dialogue with the government," he said.

"In Washington, as in your own company, perception equates with reality," said Dallas L. Salisbury, executive director of the Employee Benefit Research Institute, a benefits think tank in Washington.

"The effect of one constituent at the perception-building stage is even more important than an organization at the lobbying stage."

"We need to build pension constituents and keep an eye on what's going on in Washington. We need

to build that grassroots support," said Jeffrey Clayton, formerly administrator of the U.S. Labor Department's Office of Pension and Welfare Benefit Programs and currently an attorney with the law firm of Greene, Callister & Nebecker in Salt Lake City.

The government has become increasingly involved with private-sector benefit matters because more dollars spent on non-taxable benefits mean a drain on tax revenues, the experts said.

"Employees' moves toward salary reduction and flexibility of compensation mean fewer tax dollars," Mr. Salisbury said. "And, the government is concerned that the current 16% of compensation now devoted to non-taxable benefits will increase to 30% or 35% or more."

Thus, in the past year, legislation has been proposed that would place a cap on the amount of non-taxable health care benefits an employer could offer a worker, as well as restrict offerings through cafeteria benefit plans and impose other limitations (see above story).

"One senator has proposed a tiered approach to taxing benefits," Mr. Salisbury said. "Retirement would be on the first-taxing tier, then health insurance benefits and finally other statutory benefits,

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Lost Buddhas just baubles, marine cargo insurers say

By DOUGLAS McLEOD

NEW YORK—It may be a total loss, but is it art?

That's just one of the questions bothering nine marine cargo underwriters that recently denied a \$30.6 million claim for a container of Oriental statuary that allegedly sank in the Indian Ocean last February.

Among other reasons for denying the claim, the underwriters—which issued an agreed-value policy without inspecting the shipment—contend that the objects were "fake and highly overvalued."

The underwriters claim that the cargo's owner, an art collector and former insurance agent from the Netherlands, failed to tell them that London underwriters canceled coverage on the same cargo in 1981 after concluding that some pieces might be worth as little as 1% of their declared values.

The insurers have several other questions, all of which will probably be resolved in U.S. District Court in Manhattan, where the cargo owner, Frederick W. A. Knight, is suing to recover under the policy.

Mr. Knight, a Dutch citizen who lives in Bangkok, Thailand, says in court papers that he collected 222 Thai and Cambodian Buddhas and "fab-legods" from several temples in Thailand between 1976 and 1979. The stone and bronze objects date from the 5th to the 15th centuries and include relics from the ancient Khmer ruin at Angkor Wat, he claims.

Mr. Knight says he paid the various temples a total of \$65,000 for the pieces, though a valuation report he ordered in 1981 placed their total worth at \$30.3 million. Lawyers for Mr. Knight concede that he was "for-

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Industry can withstand crisis: Reinsurer

Insurers search for pot of gold

LAS VEGAS, Nev.—There were plenty of self-deprecating jokes made privately among the 1,500 insurers and reinsurers attending the 38th annual meeting of the National Assn. of Independent Insurers in Las Vegas Oct. 9-12.

"You can get better odds at the tables than in the reinsurance business," said one reinsurer.

More than one registrant found a giant sculpture of a pot of gold sitting atop a rainbow outside the Las Vegas Hilton, the conference site, more than a little ironic. The pot of gold sculpture actually is designed to attract gamblers to slot machines in the Hilton, not to signify the insurance industry's hopes.

Talk in lobbies, over lunch and in hospitality suites among insurers and reinsurers for the most part concluded that there would be continued rate competition in the U.S. insurance and reinsurance markets.

One London broker, who asked not to be identified, said he is placing as much of his business in the U.S. market as he can because rates are lower than in London, where he said insurers and reinsurers are raising rates and tightening terms and conditions.

There was some talk, however, that in high-level negotiations between insurers and reinsurers, some U.S.-based reinsurers were demanding higher rates and even canceling treaties.

By KATHRYN J. McINTYRE

LAS VEGAS, Nev.—Absent a major earthquake, the U.S. reinsurance industry is strong enough to handle any major catastrophic property or catastrophic casualty loss, says the president of the second-largest reinsurance company in the United States.

Hurricane losses, casualty losses associated with long-latent diseases and even the insolvency of a reinsurer would not create mass insolvency in the insurance business, contends N. David Thompson, president of North American Reinsurance Corp. in New York.

"The network of retrocessions mitigates losses for any one company," he explains.

"The large number of companies now in reinsurance provides a strong, widely based web supporting the system," Mr. Thompson said during his remarks as a member of a panel at the recent annual meeting of the National Assn. of Independent Insurers.

The panel, addressing "Insurer Solvency and the State of the Reinsurance Industry," included former New York Superintendent of Insurance Albert B. Lewis and Attorney Charles W. Havens III of the Washington office of LeBoeuf, Lamb, Leiby & MacRae.

Spirited discussion concerning the financial strength of Lloyd's of London flew between Mr. Lewis and Mr. Havens (see story, page 12).

Mr. Thompson, however, stressed the strength of the world reinsurance business. Even if one reinsurer were to go broke, it would not create a ripple effect throughout the whole industry because the large insurers are not

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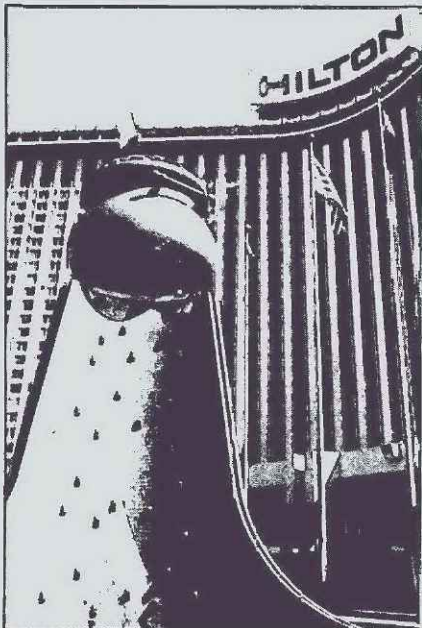


Photo: Kathryn J. McIntyre

Claim questioned

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tunate to obtain (the objects) at a small portion of their value," mainly with the help of relatives of his wife, a Thai native, at a time when such pieces were still widely available.

Last January, Mr. Knight arranged to ship the objects, packed in 57 crates in a container, aboard the S.S. Aliakmon Runner from Singapore to Pireaus, Greece, where he planned to sell them. He insured the shipment for \$30.6 million, including freight and packing charges, with nine insurers through H.E. Yerkes & Associates Inc., an insurance brokerage in New York.

The coverage was "free of particular average," a marine term meaning that partial losses aren't covered unless the vessel meets with one of several named perils, among them sinking.

The underwriters, each of which

carried a proportion of the risk, included Insurance Co. of North America, a CIGNA Corp. unit, which carried \$3.06 million; Centennial Insurance Co., \$2 million; Federal Insurance Co., \$3.06 million; Highlands Insurance Co., \$1.5 million; Continental Insurance Co. through its Marine Office of America Corp. subsidiary, \$5 million; Northwestern National Insurance Co. through Talbot, Bird & Co. Inc., \$3 million; Reliance Insurance Co. of New York, \$4 million; Royal Insurance Co. of America, \$3 million; and U.S. Fire Insurance Co. through International Marine Underwriters, \$6 million.

Mr. Knight paid a total of \$55,135 in premiums on Feb. 1, and the Aliakmon Runner sank in the Indian Ocean a week later, reportedly after a fire and explosion in the engine room. The underwriters, who denied a claim for the loss, tried to return the premium, but Mr. Knight says he refused to accept it.

In his lawsuit, Mr. Knight says the underwriters owe him \$30.6 million plus interest. The underwriters take a different position.

Among other defenses, the underwriters contend that Mr. Knight "failed to disclose facts pertinent and material to the risk," including the fact that he had tried to ship the cargo three times before booking it on the Aliakmon Runner and that in one case London underwriters had canceled a cargo policy because of questions about the art's authenticity.

In 1981, Mr. Knight arranged to ship the same 222 objects from Singapore to an associate in the Netherlands aboard the Nedlloyd Noorn, obtaining cargo insurance from London underwriters through broker Hogg Robinson & Gardner Mountain (Marine) Ltd. in London.

Before the cargo was loaded, however, Hogg Robinson received an anonymous telephone message

"questioning the value of the statues and stating that something would happen on the voyage to Holland that would cause the loss of the goods," according to court papers filed by Mr. Knight's attorneys.

Learning of the anonymous call, the London underwriters hired a loss adjustment firm, Graham Miller & Co. (Singapore) Pte. Ltd., to appraise the shipment. After inspecting 12 of the 57 crates, the surveyor reported that several of the items were of more recent origin than the 15th century and worth only a fraction of their declared values.

Based on this report, the London underwriters canceled coverage, and the shipment was never made.

Mr. Knight tried to ship the objects twice more to France, in May and June 1982. Insurance coverage for the May shipment couldn't be worked out because Mr. Knight could not arrange for armed guards to watch the crates; the June ship-

ment was canceled when the prospective buyer lost interest, according to court papers.

A lawyer for the nine insurers "couldn't say" why the insurers accepted Mr. Knight's valuation of the shipment without inspecting it first.

"The London market wouldn't have (inspected it either) but for the anonymous phone call," said Donald M. Waesche, a partner with the New York firm of Waesche, Sheinbaum & O'Regan. "The U.S. market wasn't that lucky."

Lawyers for Mr. Knight have challenged the Graham Miller report, calling the results "unclear" and noting that the surveyor had no expertise with Thai and Khmer art. Initially, the surveyor considered only one of the statues to be a fake, but in its final report, the company adjudged all of the objects to postdate the 15th century, the lawyers say.

In any case, the earlier denial of coverage by London underwriters has nothing to do with the binding of the present policy, one of the lawyers says.

"The whole thing is immaterial and irrelevant to this matter," said Thomas R.H. Howarth, an attorney with Haight, Gardner, Poor & Havens, which represents Mr. Knight.

Even if the objects are found to be genuine, the underwriters argue that by removing them from Thailand, Mr. Knight violated a Thai statute on historical objects and thus can have no insurable interest in the "unlawfully acquired" cargo.

A provision of Thailand's "Act on Historical Places, Antique Objects, Arts Objects and National Museums" cited by underwriters' attorneys reads, "No one may export or take from the Kingdom antique objects or art objects, whether or not registered, except under license by the (government)."

Mr. Knight knew of the Thai law but had the objects shipped to Singapore anyway, telling his insurance broker in a letter that the objects would have to be taken out "surreptitiously," according to Mr. Waesche.

In court documents, Mr. Knight says he wasn't involved in shipping the objects out of Thailand and doesn't even know who did ship them. He said he is aware only that they arrived in Singapore between January 1980 and June 1981.

Mr. Howarth explained that Mr. Knight left the transportation of the objects to his uncle. He added that Mr. Knight "never read" the Thai law, although he may have known of the existence of some regulations.

Mr. Howarth said he is studying the applicability of the Thai law, but adds that there was nothing illegal about transporting the goods from Singapore to Pireaus.

"Their origin has nothing to do with the risk that materialized, i.e., the sinking of the ship," he said.

The underwriters also are questioning the sinking, though, charging that if Mr. Knight sustained a loss, it was "non-fortuitous."

A Greek shipping organization is investigating the cause of the sinking, but has yet not reached a conclusion, according to Mr. Waesche. Photographs taken as the ship went down show that it sank on an even keel, despite the fact that the claimed cause of the wreck was a fire and explosion in the engine room, which was nearer the ship's stern, he said.

If the ship were intentionally scuttled, underwriters would have to prove that Mr. Knight was involved in the scuttling to deny coverage.

While all of these mysteries may be cleared up, it will take some time. Under a court schedule established for the case, lawyers for both sides have until next September to prepare their cases. A trial will probably not begin until late 1984 or early 1985, Mr. Waesche said. ■



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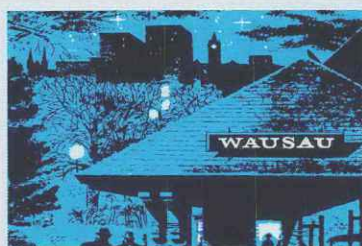
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Manville considers individual settlements

Continued from page 3

as "the first time the parties had gotten into the real issues of reorganization." Manville and plaintiffs' attorneys had not met for weeks prior to the weekend meetings.

Besides not agreeing on how to allocate funds to asbestos claimants, the two sides also have not agreed yet on how much Manville should provide for asbestos claims. Manville has offered \$400 million to settle present claims, but plaintiffs' attorneys want about \$700 million.

An agreement on asbestos claims would clear the way for Manville and all its creditors to file a consensual reorganization plan with the court. Although Manville was prepared to file its own reorganization plan Oct. 17 without the consent of all creditor groups, such a move could spark years of litigation be-

fore creditors would get paid.

The request for the extension came from the unsecured creditors committee, which represents banks, other institutional lenders and others that provided goods and services to Manville. These creditors want to avoid further litigation that would delay their recoveries from Manville.

The Oct. 17 extension was the eighth time Manville has been granted more time to file a reorganization plan. Manville filed for reorganization in August 1982, citing the overwhelming asbestos litigation.

The Oct. 15-16 negotiations marked the first time that Manville Chairman John A. McKinney and other company directors attended negotiations.

"Certain matters were discussed

that were not discussed before," said John P. Jerome, the attorney representing Manville's unsecured creditors.

"It seems to us that there may be enough grist for the mill so something can be accomplished," added Mr. Jerome of the New York law firm of Milbank Tweed Hadley & McCloy.

Attorney Robert J. Rosenberg, representing asbestos plaintiffs in the litigation, agreed there was slight progress in the weekend negotiations that warranted further meetings.

"For the first time in 14 months there was a non-circus-like atmosphere," said Mr. Rosenberg of the New York firm of Moses & Singer. "We could speak directly with those with decision-making power."

It also was the first time the parties agreed to meet again and that the meeting did not break up in acrimony, he added.

But both sides cautioned that they were a long way from agreement on a consensual plan of reorganization.

The meeting is a "very, very small beginning and there should be no conclusion that we made substantial progress on any issue," Mr. Rosenberg said.

"We certainly are a long way from agreement," added Manville bankruptcy attorney Michael Cramos of the New York firm of Levin Weintraub & Cramos. "We seemingly developed a common ground for further discussion if nothing else."

Judge Lifland granted the extension saying it was warranted in

light of the evidence of serious proposals by the parties, and that otherwise Manville would have filed a "hostile plan," opposed by some creditor groups.

Following the hearing, Mr. Parker also said that Manville is continuing to negotiate with three of its insurers, Travelers Indemnity Co., Home Insurance Co. and underwriters at Lloyd's of London, to settle insurance litigation pending in California.

The company expects a proposal very soon from the insurers, Mr. Parker added. The insurers reportedly are ready to give Manville an initial payment of \$250 million (BI, Sept. 19).

Manville claims it is owed more than \$600 million in coverage from approximately 27 insurers and has filed a lawsuit in California over the nature and extent of this coverage.

While a consensual reorganization plan is being negotiated, it also is being decided if Manville's case will remain in bankruptcy court or be transferred to U.S. District Court in New York.

U.S. District Courts oversee the operations of the bankruptcy courts. Recently, a U.S. Supreme Court decision threw into jeopardy the status of the constitutionality of the bankruptcy courts. Some district courts are now deciding bankruptcy matters.

At a recent hearing, U.S. District Court Judge David N. Edelstein indicated he may step into the Manville case. He already is considering a motion by plaintiffs' attorneys that the district court hear a suit brought by Manville asking the bankruptcy court to estimate the number and value of present and future claims.

Manville has sought to withdraw that suit but wants to reserve the right to reintroduce it. Plaintiffs contend that they should not have that right.

Attorneys for asbestos plaintiffs also are asking the district court to consider their motion that Manville's bankruptcy petition be dismissed on bad-faith grounds. ■

OSHA proposes fumigant limits

WASHINGTON—Farmers who use ethylene dibromide, a widely used grain and fruit fumigant, may have to drastically reduce workers' exposure to the chemical as a result of a standard proposed by the Occupational Safety and Health Administration.

OSHA proposed on Oct. 7 that the permissible worker exposure level be reduced to 100 parts per billion of air from 20,000 parts per billion during an eight-hour day.

Ethylene dibromide is strongly suspected of causing cancer and reproductive damage in humans.

It is estimated that more than 100,000 employees are exposed to the fumigant during transportation and storing of fruit on farms and in grain mills and elevators.

The chemical received widespread use in California to combat infestations of the Mediterranean fruit fly.

As a result, the state lowered the permitted occupational exposure level to 130 parts per billion from 20,000 in late 1981 and has since taken further action to limit the fumigant's use.

Public comment will now be solicited on the proposed OSHA standards, and public hearings will then take place. The final federal standard will probably be issued next spring, an OSHA spokesman predicted. ■



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And when they're offered, many are also willing to take advantage of preventive medicine programs such as blood pressure screening.

Of course, we're not suggesting that employee education is the single answer to a problem as serious as this one.

In fact, our programs cover a range of approaches. From funding business coalitions working to reduce local costs, to providing companies with data to track the effectiveness of their own cost containment activities.

But it remains true that even a plan as sophisticated as our cost containment package can't be completely effective unless employees are involved in the effort.

So if you'd like more information about reducing group medical expenses, write to Connecticut General, Dept. A-141-A, Hartford, CT 06152.

Or if you'd like to know how we can specifically help reduce your company's costs, call your broker or your local Connecticut General representative.

After all, this may well be an area in which management could benefit from a little education, itself.

CIGNA

opinions

It's time to hit one out of the park

LET'S HEAR IT for U.S. District Judge Walter Stapleton in Wilmington, Del., the 9th U.S. Circuit Court of Appeals in San Francisco and, while we're at it, the U.S. Supreme Court.

These jurists have given us something to cheer about the last couple of weeks. While risk and benefit managers haven't quite captured a World Series title in these courtrooms, they do have a strong winning streak going.

Take, for example, Judge Stapleton's ruling that federal—not state—law determines the definition of product liability for risk retention groups (*BI*, Oct. 17). Delaware Insurance Commissioner David Elliott had contended that state law prevailed in this situation and, consequently, refused to recognize the risk retention group formed by the Home Owners Warranty Corp.

We hate to say we told you so, Mr. Elliott, but we did in July 1982 when we predicted in an editorial that your arguments against certifying the HOW risk retention group would hold up about as well as a house of cards in a strong breeze.

Score one windy victory for our side.

Meanwhile, in San Francisco, the three-judge 9th Circuit Court of Appeals ruled that employers that self-fund workers compensation risks can take tax deductions for reserves to pay uncontested workers compensation claims (*BI*, Oct. 17).

The case involved Kaiser Steel Corp.'s battle with the Internal Revenue Service. The appellate court's affirmation of a lower-court ruling that Kaiser Steel is entitled to those deductions for the year 1964 opens the door to tax deductions for reserves held by work comp self-insurers in the nine states that comprise the 9th Circuit.

Score two for our side.

And, finally, much to the relief of many benefit and pension managers connected with multiemployer pension plans, the Supreme Court last week agreed to decide the long-hanging question of the constitutionality of the retroactive provision of the Multiemployer Amendments Act (see story, page 2).

Appellate courts have handed down conflicting rul-

ings on this issue and it is time for the high court to make the final decision so that affected employers may finally know where they stand financially.

So, score three for our side.

While risk and benefit managers obviously have three strong victories under their belts, they still, unfortunately, haven't clinched the title in any of these areas.

Take the risk retention case. There may be one victory in Delaware, but it's possible risk retention groups will be pitched 49 more curves before the game is finally over.

The National Assn. of Insurance Commissioners has approved a model bill that says the state definition of product liability applies for risk retention groups. As risk retention groups are formed in states that may adopt the model law, it's probable that the same game played in Delaware will be replayed—maybe 49 more times.

Of course, we hope that the other insurance commissioners have learned from Mr. Elliott's defeat on the mound and the fact that Congress is now considering an amendment to the Risk Retention Act spelling out that federal law prevails. But if they haven't, new risk retention groups had better be in top shape to take their battle to court again and again until the bases are loaded in their favor.

Likewise, in the Kaiser Steel work comp reserve case, the series isn't over. The recent appellate court decision affects work comp self-insurers in only nine Western states and Guam and may well go into extra innings in the Supreme Court.

In the meantime, what is needed are more victories in district and appellate courts.

As we recommended in October 1982 when the district court decision came down in the Kaiser Steel case, more self-insurers should go to bat for their right to take a tax deduction for self-insured reserves for uncontested work comp claims. Each individual company's victory is another man on base, and with luck, there'll eventually be a grand slam in the Supreme Court.

letters

California law has protected insureds since 1972

To the editor: After reading Frederick J. Fisher's Perspective article, "Recent California rulings" (*BI*, Aug. 29), I felt compelled to comment.

Although Mr. Fisher is correct that the two cases cited are important to all insurers doing business in the state of California, he seems to imply that property and casualty insurers that have been doing business in the state have, as a matter of policy, been in violation of the California Fair Claims Practices Act. He is wrong.

Because California courts have spearheaded the tort of "bad faith," insurers that do business in California have been attempting to deal with their insureds fairly and in good faith for some time and, in most cases, with success.

Since 1972 when the California Legislature enacted Insurance Code 790.03(h), contrary to the implications of Mr. Fisher's article, it has been a violation of the public policy of the state of California for any person or entity in the "business of insurance" to "shave" dollars off fair settlements; misrepresent coverages to claimants or insureds; misrepresent facts to claimants or insureds; deal with policyholders or claimants in a manner other than honestly and openly; for counsel retained by insurers to simply drag out lawsuits to drive down settlements (in fact, in my experience, the opposite is usually true); or for counsel to consider that the insurer, rather than the insured they were retained to defend, is their client.

There is nothing new about what Mr. Fisher has said.

My surprise and concern about his article is that it implies that there are still property and casualty insurance people in California that have not heard of the California Fair Claims Practices Act or who believe that it can be ignored. It is, as statutes go, a model of clarity.

If all claims are handled in compliance with this act, litigation will not grow but will be reduced, and the time of counsel and the courts can be more effectively put to resolving real and complex disputes rather than in an attempt to avoid clear liability.

There will always be litigation because even the most reasonable of minds will differ on an interpretation of facts or the law. The amount of litigation will not be increased by court decisions such as those cited by Mr. Fisher's interpreting a statute that is more than 11 years old and has been applied fairly in hundreds of lawsuits.

Litigation, especially "bad faith" litigation, will expand logarithmically, if insurers are still handling claims (for policyholders or self-insurers) as if the insured and the claimant had no rights and must fight with the insurer for every penny due.

I do not wish to say that all claims should be reduced to "holding the claim down to what is asked for by the claimant or the insured." Fraudulent claims are thoroughly investigated and the insured or claimant put to their proof in a fair and expeditious manner.

California has recognized this and has

enacted, in order to assist insurers, statutes creating a Bureau of Fraudulent Claims in its Department of Insurance and has required all insurers to report to the bureau all potential risks suspected of fraudulent claims.

The law in California is now, and has been for more than 10 years, such that the duty to deal fairly and in good faith is mutual. As long as both insurers and insureds or claimants recognize the mutuality of the duty, claims will be resolved expeditiously and fairly. Punitive damage verdicts are designed to stop abuses and have been awarded by California courts against insureds as well as against insurers.

Finally, it should be pointed out that Palmer vs. R.L. Kautz & Co. has been accepted for hearing by the California Supreme Court and is therefore not authority for any proposition in any court in California. We must wait, therefore, for the final word from the Supreme Court before any decision can be made concerning the impact of this case.

Barry Zalma
Barry Zalma Inc.
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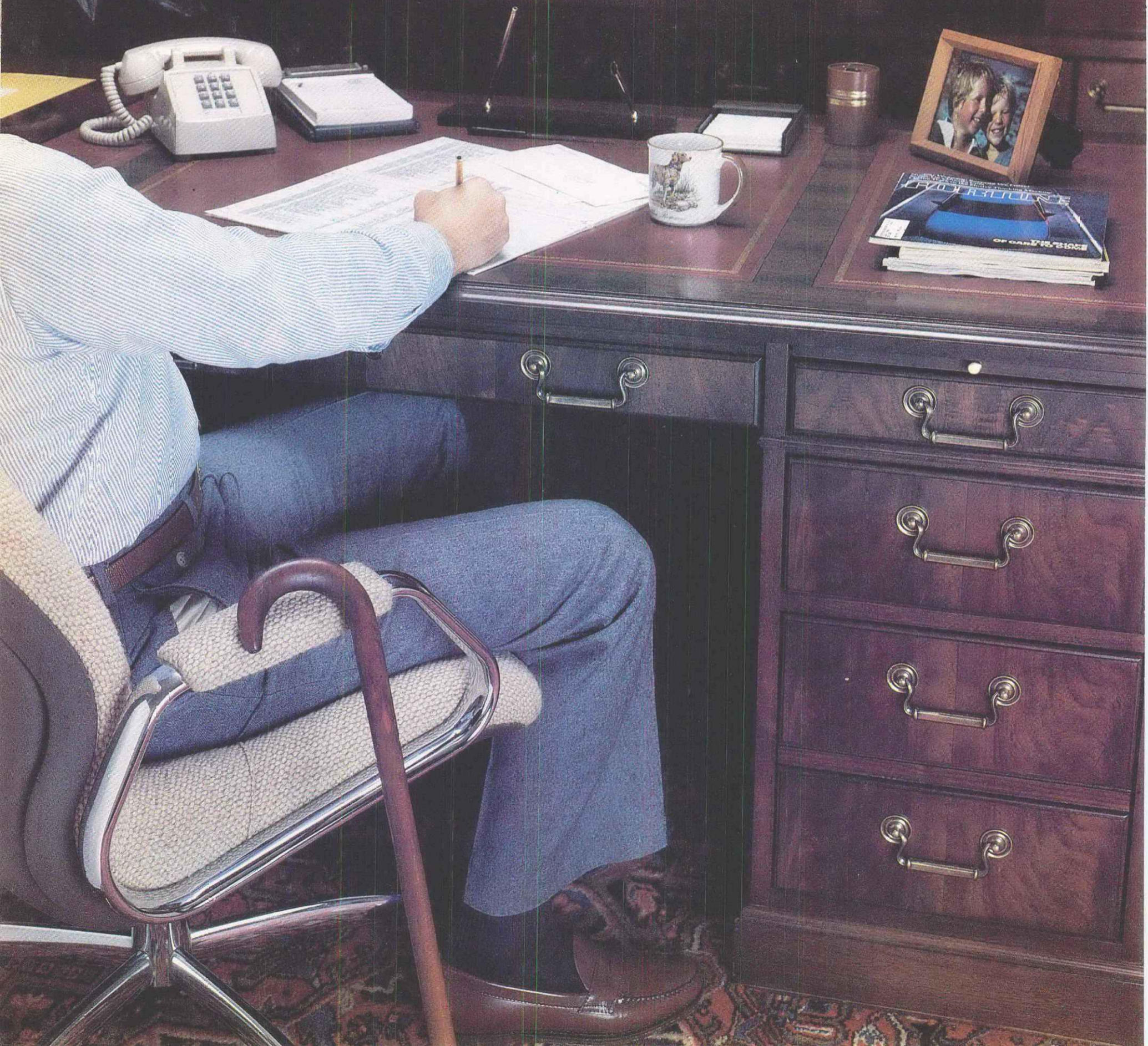
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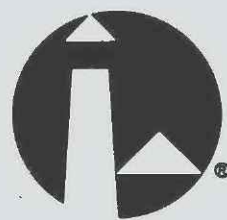
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*Source: Employee Benefit Plan Review, April, 1983



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Former N.Y. superintendent cites Lloyd's 'weak spots'

Continued from page 12

"Are there other weak spots in Lloyd's syndicates?" he asked.

He criticized the Lloyd's system of three-year accounting in which each syndicate closes its accounts for an underwriting year three years later, reinsuring the remaining liabilities into the syndicate.

"Can the syndicates carry this reinsurance?" he asked.

"I don't know if Lloyd's is credible security," Mr. Lewis said. "How does Lloyd's set technical reserves? Who does the objective audit? There is an approved list of auditors, but are they the ones who audited Howden?" he asked.

Lloyd's \$4.3 billion trust fund in the United States is said to be a protection for U.S. business at Lloyd's, Mr. Lewis said. But, he asked, how much in claims is outstanding against the \$4.3 billion?

Of the new accounting regulations at Lloyd's Mr. Lewis asked, "Where were these controls for the last 35 years? Are they too late?"

"I'm trying to get Lloyd's to open up," Mr. Lewis said, adding that he wants Lloyd's to prove that it is "as strong as they say they are."

Mr. Havens, an attorney in the Washington office of LeBoeuf, Lamb, Leiby & MacRae, which represents Lloyd's in the United States, responded to Mr. Lewis's remarks despite, he said, a voice that told him, "Never mind. He's not superintendent anymore. His potshots and cheap shots are irrelevant. There is no need for rebuttal."

Other, louder voices, he said, told him to "Get up and respond to these unjustified picks and bars, these slings and arrows of outraged passion."

Responding somewhat in order to Mr. Lewis' criticisms, Mr. Havens noted that in the Sasse affair, Lloyd's first was concerned that the claims were paid. "And, in spite of embarrassment, Lloyd's turned over every stone" to be sure that the guilty parties were punished. As a result of Lloyd's cooperation in investigations into the business placed with Sasse, some people went to jail, Mr. Havens said. (They were: John V. Goepfert, Allan Assael and Dennis Harrison.)

Regarding the practice of three-year accounting, insurers in the United States use one-year accounting, Mr. Havens observed, which allows less time to analyze loss development.

And, Lloyd's \$4.3 billion U.S. trust fund is invested in relatively liquid assets and is among the single largest concentrated purchasers of government securities in the na-

Guaranty fund directors elected

CHICAGO—The Illinois Insurance Exchange Guaranty Fund has a new board of five directors.

Elected were Richard S. Bakka, vp, American Mutual Reinsurance Co.; John J. McKnight, executive vp, The Bliss Group Cos.; Gerald Myers, chairman, Myers-Baker & Co. Inc.; Michael D. O'Halleran, vp, Thomas A. Greene & Co. Inc.; and Raymond J. White, president, Bowes & Co. Mr. McKnight is from Bloomington, Ill.; the other board members are from Chicago.

The men were elected by the Chicago-based exchange to oversee the trust funds developed by the exchange to meet the insurance obligations of its syndicates.

As a market for excess/surplus lines insurance and reinsurance, the exchange does not participate in state guaranty funds that protect other policyholders.

tion. "It represents Lloyd's commitment to America and its policyholders," he said.

Lloyd's also maintains a security fund in London in excess of \$200 million, Mr. Havens added.

Lloyd's has been accredited by insurance regulators throughout the United States as a reinsurer and as an approved surplus lines insurer, Mr. Havens noted.

"Is it Al's point that he made a mistake? That he shouldn't have accredited Lloyd's?"

"I am troubled by this anti-Lloyd's vendetta," Mr. Havens said. Lloyd's is working hard to overcome its past problems, he said.

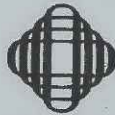
But, ultimately, "Lloyd's is accepted daily in the market around the world. The fact is, Lloyd's delivers," Mr. Havens said.

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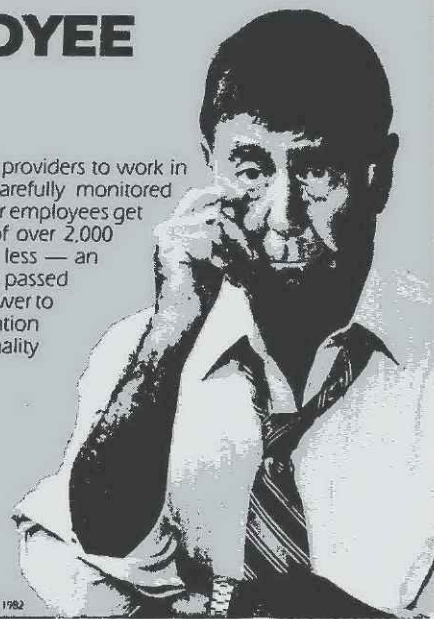
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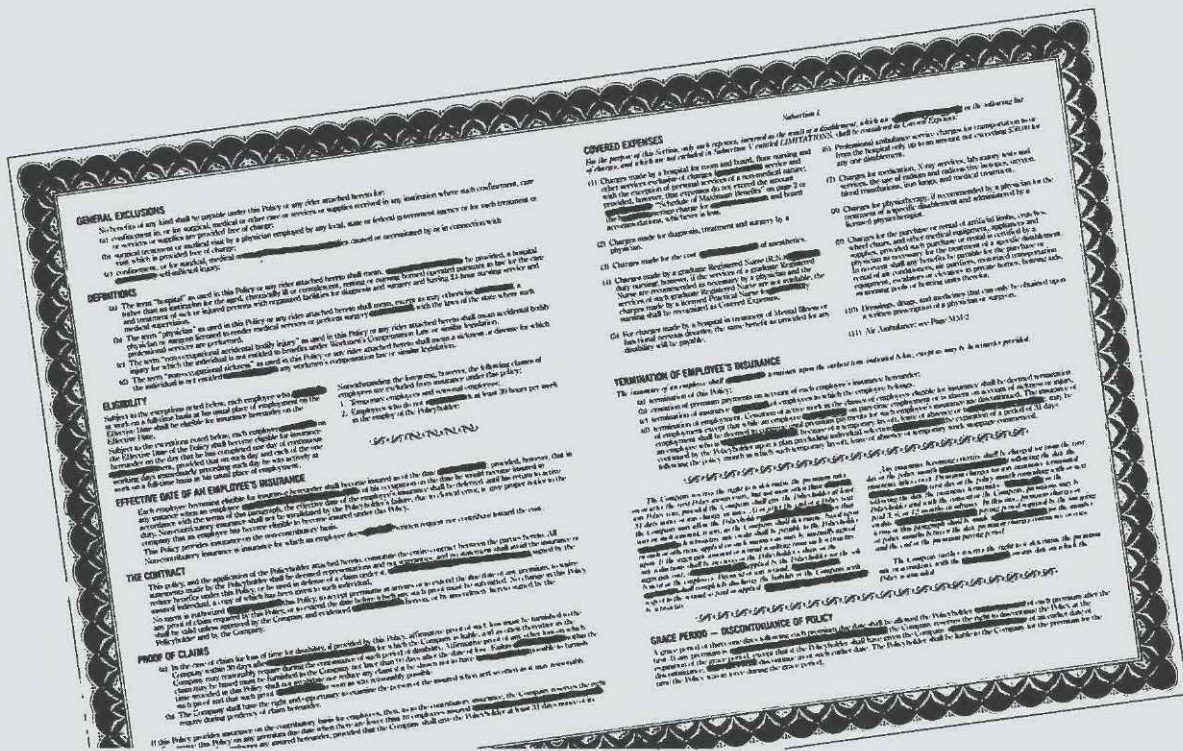
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GMD. BENEFITING THE WORLD WITH COST CONTROL IDEAS.

Tax changes, federal deficit worry insurers

By KATHRYN J. McINTYRE

LAS VEGAS, Nev.—The property/casualty insurance industry should propose changes in the tax law governing its business or else someone in Washington will, warns the past chairman of the National Assn. of Independent Insurers.

"The industry has been accused of not shouldering its tax burden," said Perry D. Inhofe, who also is president of Mid-Continent Casualty Co. in Tulsa, Okla.

"I personally feel that if we don't come up with a plausible, acceptable tax program, someone in Washington will. I've never seen something done in Washington that I didn't think we could do better," he told the membership of NAII at its annual meeting in Las Vegas.

Mr. Inhofe told *Business Insur-*

ance that if taxes paid by insurers are increased, the additional cost will "either reduce the quality of our product, reduce our ability to do it in a sound way or increase the cost of insurance to the consumer."

Mr. Inhofe is concerned that if additional taxes increase insurance costs, "It could chase more commercial business to self-insurers."

The Senate Finance Committee is looking at a list of industries where it can raise taxes and "insurers are on the list," reported Sen. David L. Boren, D-Okla., during a speech at the NAII meeting.

"I hope we can keep the committee from acting too quickly," he said.

The Senate Finance Committee staff has proposed that tax laws governing insurers could be changed to require insurers to dis-

count their loss reserves. This would raise the amount of taxes paid by insurers by decreasing the amount of reserves that could be claimed as deductions.

The staff has also suggested that the committee declare that premiums paid to captive insurance companies and premiums for retroactive liability insurance are not insurance and, therefore, not tax deductible to corporate insurance buyers (*BI*, Oct. 17).

"I'm hopeful we can work out a way to allow you to work out the proposals," Sen. Boren said. "It's time for you to be alert, to discuss how we should proceed."

Sen. Boren's remarks were delivered during a panel discussion on "Can Our Economy Withstand High-Deficit Government?"

Other panel members were Don-

ald Rumsfeld, president and chief executive officer of G.D. Searle & Co. in Skokie, Ill., and Hayres Johnson, a columnist for *The Washington Post*.

The morning panel discussion on the first day of the NAII meeting signaled the NAII's growing involvement in federal affairs in addition to its work on the state level in behalf of its members. NAII members are predominantly regional insurance companies underwriting personal lines and small commercial risks.

All three panel members agreed that the economy cannot withstand high-deficit government indefinitely. Spending must be controlled and revenues raised to control the deficit.

Sen. Boren stressed that high-deficit spending by the fed-

eral government creates uncertainty about interest rates, which in turn creates uncertainty for business and threatens the continued recovery of the economy.

And, at today's rate of spending by the federal government, \$1 trillion will be added to the federal deficit, he said. "What will that do to the economy?" he asked.

Either interest rates will have to rise or the government will need new presses to print money faster than it can today, he answered.

According to a Wharton School study, adding \$1 trillion to the federal deficit would consume 66% of the nation's available credit, Sen. Boren said. "No one thinks our economy could survive this."

He offered as a solution to the growing deficit a combination of scaling back the cost-of-living increases built into the federal entitlement programs and scaling back tax-bracket indexing due to take effect. He proposes that COLA increases be limited to the increase in the Consumer Price Index minus 3% and that tax indexing also be reduced by 3%.

"Until we do something really meaningful" to control deficit spending, Congress will continue to apply Band-Aids to the deficit, such as changing the tax laws for various industries, Sen. Boren warned.

Mr. Rumsfeld, whose experience includes serving as a congressman from Illinois, a number of Cabinet posts and as ambassador to NATO, suggested that the underlying concern about the federal deficit is the extent to which public-sector spending replaces private-sector spending. Liberals, he said, don't want to slow government spending.

He agreed with Sen. Boren that indexing benefits paid under social programs to inflation must be moderated. He also suggested that congressional staffs be cut because there is no need for every member of Congress to be an expert on every issue.

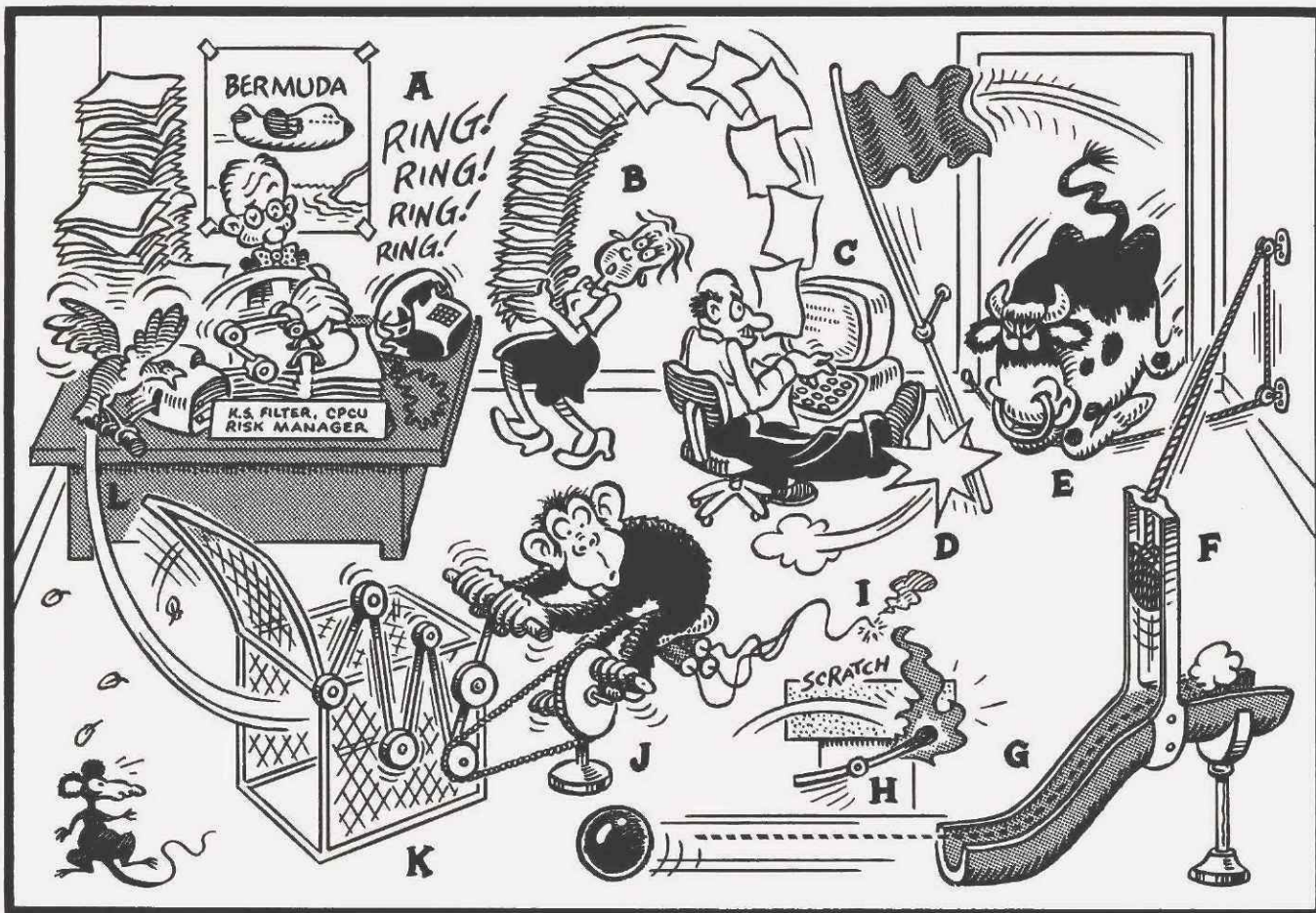
Mr. Johnson predicted that "nothing will happen" to control the deficit until after the 1984 presidential election.

He noted "there is no disagreement that deficits are a problem. It's a question of can the country come together and agree what must be done?"

Based on his reporting around the country, he believes that the American people can reach a consensus on what the country should do to control federal spending.

"The public is waiting for leadership," he said.

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Agent opposes direct billing of large accounts

LAS VEGAS, Nev.—Insurers' efforts to control their costs should not include direct billing of large commercial insurance buyers, advises the president of the Independent Insurance Agents of America.

Direct billing of personal lines clients has proven cost-efficient for agencies, admitted Richard D. Teubner, who also is vp and treasurer of Rich & Cartmill in Tulsa, Okla. And, direct billing would be "OK for small business owners, but if you go beyond that, it will create problems," he said.

Mr. Teubner was a member of a panel addressing "Cutting Costs and Adopting Winning Strategies" at the annual meeting of the National Assn. of Independent Insurers held earlier this month.

Other members of the panel were Richard J. Haayen, president and chief operating officer of Allstate Insurance Group in Northbrook, Ill., and Thomas B. Hagen, president of Erie Insurance Exchange in Erie, Pa.

Direct billing of large commercial clients would create problems because there is usually more than one insurer on an account, Mr. Teubner explained. A commercial insurance client is not going to want to pay direct bills from a multitude of insurers, he said.

Using a finance company would solve the problem of multiple bills, but direct billing of large commercial clients also would give insurers control over the expiration dates of policies. Agents, not insurers, should have that control, he said.

Mr. Teubner also took the opportunity to criticize insurers for using direct billing lists for mailing political messages. "We may agree with the message, but it is a violation of the agency agreement to use direct billing lists for other than direct billing," he reminded insurers.

Direct billing of large commercial clients aside, he said there is duplication of services between

agents and insurers. "We have to decide who should do what."

He predicted there will be more in-house underwriting of programs by agents. "It makes so much sense to cut duplication."

But, when agents underwrite and price commercial risks and perhaps even issue policies, "they will want to be paid for this," Mr. Teubner told the insurers.

Insurers and agents also should reduce "excess representation" that exists today, with insurers represented by too many agents and

agents representing too many insurers, Mr. Teubner said.

"You can't afford excess representation and we can't afford excess representation either," he said.

Yet, when his agency decides to stop representing an insurer because it doesn't place enough business with the insurer to make the relationship economical for either of them, "The insurer begs us not to do it. They will offer us a bonus to move a big book of business to them," he noted.

Mr. Haayen of Allstate said it's

easy to say insurers can cut their expenses by cutting staff and reducing commissions, "but it is really harder than that."

He suggested that insurers, concerned about their costs in the face of continued rate competition, need to work together to control factors that drive up their expenses. He cited public policy decisions that can help reduce insurers' costs, such as enforcing regulations to make cars safer and improve their repairability.

The rising cost of health care

should also be a major concern to insurers, as should the tort liability system, he said.

Erie's Mr. Hagen suggested that insurers could benefit from a little "founder's influence" that exists at his company despite the death of its founder.

"We wouldn't fly first class and we wouldn't have an expensive suite," he said. Controlling the growth of management by asking managers to accept more responsibility as a company grows also controls expenses, he said.

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Will big rewards to shareholders hurt solvency?

DIE-HARD DIVIDEND FORMULA

By Charles McAlear

THE FLIGHT OF capital from the property/casualty insurance business has begun in earnest. Whenever the glut of capital attracted to the business in the late 1970s is mentioned in sophisticated circles, a caveat has been appended. Insurance capital is extremely liquid, it can move out as quickly as it moved in.

When "Best's Key Rating Guide" finally made its appearance in the summer of 1983, it contained few surprises. Most of the data published therein had been available for months.

There were the usual number of undercapitalized companies whose very existence constitutes one of the wonders of the financial world. The relatively few

downward changes in ratings in the face of so much adverse experience was only mildly surprising.

First-quarter 1983 results had looked comparatively better because of a dearth of catastrophes compared with 1982. The second quarter also looked fine to many observers as results were buoyed by capital gains. The insurance business continued to seem uncommonly profitable.

But Best's guide reveals that some people, including managers of some very large companies, may not think that's true. The story is contained in the column labeled dividends declared (see chart).

Classically, a dividend is paid to the shareholder out of profits. It is the rightful share of those profits attributed to the use of capital. Conservative textbooks once suggested that one-half of investment income could be paid to shareholders while the remaining half, plus underwriting profits, was to be used by the company to build its financial base and continue its business.

What the 1983 Best's first-quarter results reveal is that many companies may still apply the classical formula for determining dividends, ignoring the fact that underwriting losses have ravished

investment earnings, reducing net income significantly; or perhaps a new formula for setting dividends has been discovered. Dividends can now represent heavy multiples of earnings. Substantial sums, compared with resources, are paid even when income is negative.

Sixteen stock companies that declared dividends in 1982 are listed in the chart I devised. The list is not exhaustive but merely illustrative; other insurers may show the same pattern. They are listed in the order in which dividends declared were a multiple of earnings.

In the age of the holding company, dividends may be utilized to serve a variety of worthy purposes. The inclusion on the list of any one company is not intended to suggest otherwise, yet the overall pattern seems to have significance.

It could be argued that the capital was not needed in the insurance business or at least not in that particular company. Yet support for unpaid losses—a critical test of financial strength—deteriorated in 14 cases. In nine of these, the ratio of unpaid losses to capital and surplus was pushed past or maintained in excess of 3-to-1, which some consider a critical threshold.

The combined ratios are, mainly, on the

high side of the average, which may have suggested to some that their capital might be better employed elsewhere.

Most interesting in a year when performance was less than sparkling, dividends for these companies were uniformly higher than in the previous year. In some isolated cases they increased by a few percentage points, but in seven cases they increased by more than 100%.

The percentage of income these dividends represent is also a substantial multiple in each case. Income was determined uniformly by subtracting the underwriting loss from investment income.

Other investment gains or losses and federal taxes are ignored as immaterial to the study. Their inclusion would not change the general picture but might well provide an excellent rationale for the dividend policy in individual cases.

Twelve of the 15 companies show a decline in capital and surplus. The chart reveals that in many cases that decline was not insignificant. Including the four companies posting gains, the average was a 9.7% decline in capital and surplus. Excluding the gainers, it was an 18.1%

Continued on next page

Charles McAlear is chairman of McAlear Associates Inc. in Grand Rapids, Mich.



First-quarter 1983 dividend results for 16 insurers

	Best's rating	1982 combined ratio		Shareholder dividend (000)	Percent of 1982 income	Dividend increase 1982-81	Unpaid losses (000)	Ratio unpaid losses to surplus		Surplus gain or (loss) (000)	Percent gain or (loss)
		1982 combined ratio	Income ¹ (000)					1982	1981		
Aetna Insurance Co. (CIGNA Corp.)	A:XV	132.7%	(\$16,559)	\$27,802	— ²	120%	\$2,375,000	5.30	3.03	\$90,270	25.7%
Transamerica Insurance Co. (Transamerica Corp.)	A+:XV	117.3	(14,877)	34,533	— ²	110	512,885	2.56	2.16	(25,673)	11.4
Argonaut Insurance Co. (Teledyne Financial Corp.)	B+:XV	129.2	(12,793)	23,997	— ²	163	878,096	3.11	3.00	20,665	7.9
Ambassador Insurance Co. Inc. (Ambassador Group Inc.)	B+:XI	130.1	(6,755)	2,275	— ²	185	92,326	4.62	2.45	(8,667)	(30.3)
American Motorists Insurance Co. (Kemper Corp.)	A+:XV	108.4	223	34,279	15,371%	108	535,237	3.40	2.62	(19,404)	(10.9)
Fireman's Fund Insurance Co. (American Express Co.)	A:XV	111.7	2,230	81,835	3,669	131	656,044	2.25	2.00	(20,236)	(6.5)
National-Ben Franklin Insurance Co. of Illinois (Continental Corp.)	A:XV	112.1	772	11,142	1,443	104	194,383	2.40	2.00	(14,835)	(15.5)
Great American Insurance Co. (independent)	A:XV	109.7	10,876	155,460	1,429	148	639,166	1.50	1.46	40,369	10.4
American & Foreign Insurance Co. (Royal Group Inc.)	A+:XV	111.1	856	11,733	1,370	899	88,715	3.58	2.50	(6,297)	(20.3)
Newark Insurance Co. (Royal Group Inc.)	A+:XV	111.1	1,148	10,486	913	938	76,041	3.30	2.32	(5,364)	(18.8)
Safeguard Insurance Co. (Royal Group Inc.)	A+:XV	111.1	2,462	18,476	750	992	126,736	3.49	2.40	(10,075)	(21.7)
Aetna Casualty & Surety Co. of America (Aetna Life & Casualty Co.)	A:XV	116.9	25,771	187,556	736	910	4,887,000	3.60	3.95	200,998	17.4
Standard Fire Insurance Co. (Aetna Life & Casualty Co.)	A:XV	113.7	10,110	51,973	514	3,760	268,617	3.79	2.28	(39,674)	(35.9)
Insurance Co. of North America (CIGNA Corp.)	A:XV	115.2	25,934	109,311	422	104	1,922,000	2.62	2.62	(13,710)	(1.8)
Allianz Insurance Co. (Allianz of America Inc.)	Unrated	120.4	1,214	4,737	390	223	80,475	2.74	2.19	(4,671)	(13.8)
Wausau Underwriters Insurance Co. (Wausau Insurance Cos.)	A:XV	106.5	3,277	12,347	377	406	59,022	3.30	2.27	(7,670)	(30.0)

¹Income defined as investment income minus underwriting loss.

²Meaningless.

How to cope with an insurer insolvency

The regulator's job in liquidations

By Albert B. Lewis

MANY U.S. property/casualty companies will be facing impairment and insolvency at the end of 1983 and in 1984.

This is apparent from the loss ratios reported for 1982 and during the first quarter of 1983. These reports indicate an average loss ratio of 100% and projections are even higher.

The reduction of investment income yields has caused and continues to cause higher negative cash flow. This negative cash flow also is resulting from large investments by property/casualty insurers over the past several years in the fixed-asset technology of marketing, delivering and servicing their products. Since some companies undervalue their reserves and loss ratios to hide their predicament from regulators and stockholders, the picture may be even grimmer.

Regulators, therefore, will have to respond to these problem companies. The response is not an easy one since most troubled companies refuse to admit their financial difficulties. They will try to hang on at all cost.

If the regulator is forced to act and take over the insurer, then the political and social problems of the loss of jobs, loss of business entity, unpaid general creditors, etc., must be faced along with the heavy burden a liquidation will place on an understaffed, overworked state agency.

On the other hand, the longer the regulator permits the impaired or insolvent insurer to write business, the larger the insolvency will be, the larger the number of unpaid claims and the larger the total problem.

Many in industry have been predicting that a change in premium pricing is about to occur and that loss-ratio underwriting will stop. These predictions have continued to be wrong and cutthroat premium pricing in commercial lines continues unabated.

It may be some solace to insurers and producers to await that great day when premiums will be adequate and the cutthroat, self-destructive premium policies will end. In the meantime, however, regulators should be prepared to take on the imminent casualties and be ready to act quickly and efficiently.

As New York insurance superintendent for five years, I was involved in liquidating and rehabilitating many companies. Some of my experiences and approaches to insolvent insurers may be of assistance to the industry and commissioners facing these problems.

Naturally, regulators will find standard objections by insurers on the verge of liquidation. They will range from an attack on the correctness of the examination and its actuarial computations to the excuse that finding past underreserving should not be projected because of subsequent changes in the book of business, the reserving policy, etc. All of these approaches have to be examined and dealt with reasonably. Delays, though, must be discouraged; the evaluation should constantly progress.

Among the circumstances that require a regulator to delay a takeover is a bona fide proposal to purchase the troubled company by a new entity that will invest new capital.

In this case a regulator should be armed with a stipulation granting full power to act without a court order if no purchase takes place. The regulator should be further armed with a stipulation that during any delay no increase in officers' salaries, bonuses, pensions or benefits should be approved. It is not unusual for some executives to attempt to benefit before an inevitable takeover.

Regulators should be extremely wary of delaying action where any of these activities have taken place:

- Sudden increase of volume in substandard business.
- Increased producer commission percentages.
- New reinsurance-assumed business.
- High increase in volume in reinsurance cessions.
- A 100% reinsurance position by the subject company.
- A fronting book of business with a large percent of reinsurance ceded to unaccredited reinsurers.
- A large increase in new managing general agents.
- Large overdue accounts receivable from agents or reinsurance recoverables.
- Computer and record-keeping failures and delays that prevent accurate current data.

All of these actions should accelerate the regulator's action to take over the insurer.

In all these actions, before any time is granted to the insurer, a stipulation should limit the amount of new business written or the extension of any existing coverage. Again, the regulator must have the right to act without a court order.

When a takeover is about to happen, the National Assn. of Insurance Commissioners' "Liquidation Task Force Manual" should be used as a step-by-step guide. It is the best approach for both novice and experienced regulators.

Some additional procedures should be considered.

- Employees of the insolvent insurer should be briefed and advised that some of them will be requested to help operate the company after takeover. Whenever appropriate, employees should be informed that the company or some departments may be sold or transferred to other insurers with, if possible, the existing employees.

This approach maintains some positive morale in the work force and reduces the possibility of sabotage or destruction of vital records of the insolvent insurer. In one New York insurer takeover, a rumor circulated that all employees would be discharged the day after the court order was issued. A fire was set in the file room by some employees.

- To obviate any such occurrence and as a preliminary step to obtaining the liquidation order, a group of trustworthy employees of the regulator must be ready to move swiftly to obtain control of records, computer tapes and discs. This group also should secure files and records, change the locks and the confidential computer access control.

They should tag and inventory all office equipment and furniture. Security should be established to prevent any of the records or inventoried equipment from leaving the premises. When this equipment is subsequently sold, a control over this inventory and its proceeds is already provided for the regulator, accountants and the court.

- The liquidator immediately should determine any portion of the book of business that can be sold. Unemployment disability insurance business is valuable to a viable insurer and its sale and transfer should be addressed before insureds obtain new coverage.

- The regulator should next address as quickly as possible the producers' balances. Collection and settlement of these balances are often a problem and should be dealt with and settled while some of the insurer's employees are still on hand.

- The regulator should make a thorough investigation of the reasons for the insolvency, including a specific inquiry as to whether fraud or other irregularities caused or contributed to the insolvency.

If there is such an indication, then the regulator should bring in a fraud bureau. If the regulator has no fraud bureau, there may be a possibility that other states

affected by the insolvency may have one that can be used to assist in the investigation. Local or federal law enforcement also should be used, but their response is not always adequate. The NAIC's central offices should be used to assist the regulator.

Regulators should be aware of the possibility of using the broad remedies and damages provision in the Federal Civil Racketeering Influence and Corrupt Organizations Act, Title 18, which gives some defrauded plaintiffs the opportunity to obtain injunctive relief, treble damages and litigation and counsel costs.

If employee fraud contributed to the insolvency and these employees were bonded, then a timely claim should be made against the bonding company.

If the regulator's staff is unable to handle all the liquidation problems, then the regulator should consider utilizing competent consultants.

In the final analysis, the regulator will be responsible for protecting the industry from its own excesses. In this endeavor, the regulator will need all the help possible. In turn, a successful liquidation can return substantial amounts to claimants and to state guaranty funds. ■

Albert B. Lewis is a partner in the law firm Cole & Dietz in New York.

The industry's die-hard dividends

Continued from previous page

decline. In 10 cases the dividend is in excess of that decline. That is, if the dividend had not been declared, or if it had been smaller, capital and surplus would not have been reduced.

From a distance, at least, this would appear to be deliberate withdrawal of funds committed to the insurance business.

Dividends, particularly those channeled through a holding company, can be put to a variety of uses, including contributions to surplus of other insurance companies. They can also be used to fund dividends to outside shareholders, the proverbial widows and orphans who depend on a flow of income. Additionally, they can be used to fund acquisitions in myriad related and unrelated industries, to diversify from the business of assuming risk into climes that appear more attractive.

Just where these dividends flowed and to what use they were put is beyond the scope of this article. But additional contributions to surplus rarely seemed to be the subject of press releases in 1982. Diversification of holding companies, on the other hand, was constantly in the news.

This seems a safe pursuit since dividend policy is not tested by the National Assn. of Insurance Commissioners Insurance Regulation Information System. Perhaps it is not carefully scrutinized by A.M. Best Co. either. Of the 15 companies listed in the chart, 13 are rated A or better.

Perhaps most startling is the magnitude of the flight of capital. Simple addition reveals that these 15 companies, which may be simply representative, generated only \$33.6 million in income but declared \$777.9 million in dividends (more than 1% of the entire capital and surplus of the business in the United States).

Such massive movements of capital solely on the basis of decisions made by owners or managers of insurance companies must cause some uneasiness among sophisticated buyers.

Decisions as to the quality of security can no longer be based upon historical data or current information.

At any time after the buyer makes a commitment to one company rather than another, the declaration of an unusual shareholder dividend can change the balance sheet completely, reducing the financial strength of an insurer to whom a premium already has been paid. The resources available to meet such commitments may be reduced by companies by deliberate acts beyond the control of the company's policyholders.

It is also an excellent bet that a trend that became overwhelmingly evident in 1982 is continuing in 1983. This may well mark the beginning of the end of excess capital to meet the needs of the American insurance buyer. It can move out as quickly as it moved in.

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Reforms will lower health costs: Experts

Continued from page 3

officers, 4% thought the tax-cap proposal was a good idea, 22% thought it was a somewhat good idea and 72% thought it was not a very good idea," he said.

"This puts you just above insurance executives, who have an important stake in the issue because it could take away their business. For them, 2% thought it was a good idea, 20% thought it was somewhat good and 78% thought it was awful."

However, 100% of the academic economists surveyed "think it's a great idea," Dr. Rubin pointed out. "In fact, they think we are much too timid in the proposal we sent to Congress."

That proposal Dr. Rubin helped formulate would tax employer-provided health insurance contribu-

'If you increase cost sharing with health care, the people with hypertension are not going to stop having their blood pressure checked. What you would cut out are visits to the doctor for the common cold,' Dr. Rubin said.

tions that exceed \$840 a year for individual coverage and \$2,100 for family coverage. "The proposed tax cap would yield \$2.4 billion fiscal 1984," he said.

Essentially, the proposal is intended to inhibit employers from providing expensive, first-dollar coverage and encourage them to offer health plans that promote first-dollar cost sharing while protecting workers from catastrophic

loss.

"A (Rand Corp.) study showed that cost sharing does indeed decrease patient utilization," he said.

"Think about it: If you and I go out to lunch together, and before going out each agrees to pay for his own, we'll probably go to some place like McDonald's. If we decide before going out that we'll split the bill, we'll probably go someplace a little nicer. But if CEB were paying

for our lunch, it would be a hell of a good lunch.

"The point is," Dr. Rubin continued, "at all three places, we would still be fed."

"If you increase cost sharing with health care, the people with hypertension are not going to stop having their blood pressure checked. What you would cut out are visits to the doctor for the common cold."

Such cost-control measures as wellness programs, preferred provider organizations, outpatient care, second surgical opinion incentives and business coalitions are a "hopeful sign" that employers will work to lower costs, Dr. Rubin said.

"The tax-cap proposal is entirely consistent with this trend. Employees will be more cooperative with your efforts to contain costs."

"Our tax-cap proposal is a modest one," he continued. "We view it as a catalyst for effective provider health care cost containment."

But an employee benefit manager disagreed with Dr. Rubin's position, saying legislation is not the way to reduce health care inflation.

"We believe in a company taking a cost-containment approach rather than taking a regulatory approach to cost containment," said Donald R. Margenthaler, manager of health care services for Deere & Co. in Moline, Ill.

"My company believes it is essential the health care system be modified if it's to remain the quality system we have now," he said. "If it's not modified, it will be regulated, and that will possibly jeopardize the quality of care."

Deere's commitment was an essential element in its cost-control success story, Mr. Margenthaler said. "You have to get the support of your management," he said.

Mr. Margenthaler was able to recruit management support in his battle against health care costs because health care is a big budget item.

"In 1977 we spent \$64 million in health care—more than triple what we spent on health care in 1972," Mr. Margenthaler said. "We projected in 1977 that if we continued at that pace, in 1987 our health care expenses would reach \$2 billion."

Deere targeted utilization as the biggest problem area. "Our employees were averaging from 1,300 to 1,500 hospital days per thousand (workers), compared to a community average of 1,100 hospital days per thousand," he said.

"That's a 400-day difference. So, we went directly to our employees with these costs and the apparent unnecessary utilization of health care."

After sharing the cost figures with employees, the overall worker response to the idea of cost-containment programs was quite positive, Mr. Margenthaler said. At that point, the company was ready for action.

First, it joined employer groups. Deere was a charter member of the Washington Business Group on Health and the Midwest Business Group on Health, and also joined the Illinois Coalition on Health and the Iowa Business Labor Coalition on Health.

Then, the company instituted a private utilization review program. In this type of program, a reviewing agency studies each hospital admission to compare the appropriateness of treatment to certain norms.

And the company put a great deal of energy into the development of health maintenance organizations.

The first Deere HMO was started in 1980 in the Quad Cities area of Illinois and Iowa, where many of Deere's operations are located.

That HMO now has 30,000 subscribers who include more than 40% of Deere's workers in that area.

Also, in 1982, the company set up two other HMOs in Waterloo and Dubuque, Iowa, which now have 100,000 Deere workers, dependents and retirees as subscribers. The company also works with 20 HMOs around the country.

The result: Instead of 1,300 to 1,500 hospital days per thousand workers, Deere employees now average 700 days per thousand. Among HMO subscribers that number is even lower—450 days per thousand employees.

Mr. Margenthaler attributes Deere's success to the dedication of management in the utilization review and HMO programs and to the cooperation of workers. "Our unions have been very, very supportive of us," he said.

Half of Deere's 50,000 are unionized, with the largest segment of them represented by United Auto Workers.

Deere is also seeking to influence health care costs in other ways. Company representatives are active in a hospital trustee education program to inform trustees of the Deere's concern over health care costs.

Other Deere employees are active in the Health Policy Corp. of Iowa, "which is attempting to find solutions to the cost-shifting debate" from the government sector to the private sector that has flared as a result of the new Medicare prospective payment provisions, Mr. Margenthaler said.

And, the company also is working to change the procedures through which costly expansions of or additions to hospital facilities are approved.

Deere hopes these programs will increase the savings the company has already enjoyed.

Yet, while Deere found success in such innovations as HMOs, utilization reviews and coalitions, other experts warn that simply implementing so-called cost-containment programs is not enough to insure their effectiveness.

Innovative measures to trim health care costs may actually backfire, increasing benefit expenses, says one consultant. To assure cost savings, cost-containment provisions must be carefully monitored.

"First, make certain you obtain the savings from action already taken by monitoring the results," said Albert Cole Jr., a benefit consultant with George B. Buck Consulting Actuaries Inc. in New York. Nursing home care is one cost-containment measure that can go awry.

Some employers theorize that since nursing home care is less expensive than hospital care, companies that would normally pay \$300 for a day's hospital stay could pay \$100 per day at a nursing home. If hospitalized employees could be moved to the nursing home, savings of \$200 per day would be achieved.

"In most cases it didn't work that way," Mr. Cole said. "What happened was there was greater utilization in nursing homes—whereas the person might have stayed in the hospital for three more days, the nursing home stay was...perhaps 13 or more."

Coordination of benefits is another area where savings provisions can actually become higher costs.

For example, if an employee's spouse incurs expenses of \$4,000, and \$3,500 is covered under the spouse's own health care plan, then dependent coverage under the employee's plan normally would have to pay only \$500, with the em-

Continued on facing page

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Continued from facing page
ployee and spouse incurring no
out-of-pocket expenses.

"But if the spouse accepts a low-
option medical plan that pays
\$2,500 of the \$4,000, your plan pay-
ment increases from \$500 to
\$1,500," Mr. Cole said.

There are three ways to counter
such cost shifting, he said.

"One way is to structure your
plan so you never pay as a second-
ary carrier.

"A second way is to coordinate
your plan with the best plan the
spouse has available," Mr. Cole
said. For instance, even if the
spouse selects a low-option health
plan from his or her employer, the
secondary policy would reimburse
the spouse as though the spouse's
high-option plan were in place.

"If you coordinate with the best
plan, and the spouse elects the low
option, you pay only \$500 and there
is a \$1,000 out-of-pocket expense,"
Mr. Cole said citing the example.
"This might be an incentive for the
spouse to take the high option (in
the primary plan)."

The third way is to change from
coordination of benefits to "a more
restrictive, non-duplication provi-
sion," he said.

For example, if both the spouse's
coverage and your company's plan
pay 80% of charges, the spouse's
primary insurer would pay \$1,600
on a \$2,000 claim. Then, of the re-
maining \$400, your plan as second-
ary insurer would pay only 80%, or
\$320, leaving an \$80 expense.

"It may be a small amount, but at
least it is some out-of-pocket ex-
pense," Mr. Cole said.

"One of the basic reasons for de-
ductibles and coinsurance is to re-
duce utilization," he reminded the
audience.

And, if deductibles and coin-
surance can be offset with a flexi-
ble spending account, this flexible
benefit is another example of how
cost-saving measures can snap back
with cost increases.

"If you now ease the impact of
deductibles and coinsurance by of-
fering the employee the opportu-
nity to recover out-of-pocket ex-
penses through a flexible pay ac-
count, are you affecting the value
of the deductible and coinsurance
(to the company)?" Mr. Cole asked.

"I am well aware that employees
who use flexible pay account
money for medical expenses are
really using their own money... but
what is the perception of the em-
ployees? Might some of them think
they are spending employer money
—and thus be less prone to avoid
overutilization?"

Proper communication can
counter this problem, he said.

Besides new, improved cost-con-
tainment techniques, a benefit
manager also can get cost-contain-
ment mileage out of some old
standby measures.

"Some of these will sound famil-
iar because they are things that
have been in plans in the past and
were removed," Mr. Cole said. In-
cluded in this group are limited
benefits for new employees and
limits on coverage for pre-existing
medical conditions.

"A number of our clients have
recognized benefits paid on new
employees as a high and (often) un-
acceptable area of costs," he said.
One way to limit those benefits is to
have a probationary period for cov-
erage. For example, an employee
may have to work with a company
for 90 days before he or she is eligi-
ble for coverage.

"Probationary periods were very
common in all group life, disability
and medical plans 20 or 25 years
ago," Mr. Cole said. "They've been
eliminated from many on the the-
ory that there is almost a social
need to make certain employees
are not left without medical cov-
erage. Do all of you still agree with
that?"

Another similar cost-contain-
ment technique is the pre-existing
exclusion or limitation under

which an employer's plan would
cover in full only illnesses or acci-
dents incurred after employment
begins. Coverage for pre-existing
conditions would be either elimi-
nated or limited.

Mr. Cole also proposed a freeze
on reasonable and customary
charge schedules and pre-certifica-
tion of surgery as other cost-cutting
changes employers might consider.

"If you now pay surgical and
medical expenses on a reasonable
and customary basis, why not di-
rect your claims administrator to
pay reasonable and customary sur-
gical charges based on the Oct. 1,
1983, allowances?" The adminis-
trator would continue to pay claims
based on that schedule until the
benefit manager requests a change.

"Perhaps in May 1987, you direct
that claims be paid at the July 1986
level." Although this would pro-
duce lower benefits for employees,
"it may serve as a brake on increas-
ing charges since the physicians
will know there is no longer an

open checkbook," he said.

Mr. Cole also told the benefit
managers they should consider cer-
tifying surgical fees before a
worker checks into the hospital.

"Pre-certification of stays in a
hospital is becoming increasingly
common," Mr. Cole said, "but pre-
certification of surgical fees is less
common."

In addition to making, communi-
cating and monitoring plan
changes, Mr. Cole urged benefit
managers to have "greater direct
involvement in providing medical
care," such as having a staff physi-
cian or dental hygienist, or even a
company-sponsored hospital.

Also, benefit managers should
become more involved in govern-
mental activities, he said. "You
can work for malpractice reform, for
an all-payer prospective reim-
bursement system and control of
the building of new facilities. These
can work to reduce provider costs,
and if their costs are lower, your
benefit costs should be lower." ■

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- Regulation & Legal Requirements - Peter Straub, Acting Asst. of Admin., Office of Reporting & Plan Standards
- Explaining Salary Reduction Plans - Robert Penzkover, Dir. of Benefits, The Quaker Oats Company
- Wellness Programs - William E. Hembree, Dir., Health Research Institute; Denise Maleska, Dir. of Human Resources, Agricultural Division, CIBA-Geigy Corp.; Dr. Joseph C. King, Dir. Employee Health Services, Continental Illinois National Bank & Trust Company of Chicago
- What Makes A Winning Communications Program - Herb Zeltner, Herbert Zeltner Inc., Marketing & Communications
- Innovative Ideas - Andrew Corn, Ad Master; Polly Carpenter, Carpenter Graphic Design, Inc.
- Employee Attitude Survey's - Rhonda Karp, Ed. D., Assoc. Dean, College of Allied Health Sciences, Thomas Jefferson University; James Weitzel, VP, Johnson & Higgins

Breakout sessions afford you the opportunity to zero in on a specific problem you may be facing. Select one session that best meets your needs:

- A Joint Session On: Essential Elements In Your Program/How To Work With Suppliers - J. Frank Swygert, Jr., President, Benefits Media, Inc.; LaRue Foster, Manager, Employee Benefits Communication, Corporate Communications Dept., Boise Cascade Corporation
- Changing Benefits Strategy - Joseph Duva, Director, Employee Benefits & Compensation, SCM Corporation; Dennis McKoy, VP, Johnson & Higgins

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Share benefit ideas with legislators

Continued from page 3
such as child care. These proposals are currently being evaluated by the staff of Sen. John Heinz, R-Pa., although they haven't been proposed in legislation yet."

Also, two proposals are now pending in congressional committees that would affect employers' pension plans.

One measure known as the Erlenborn-Clay bill, H.R. 3930, introduced by Rep. John N. Erlenborn, R-Ill., and William L. Clay, D-Mo., would, among other provisions, raise to \$6 per pension plan participant from \$2.60 the annual premium employers with defined benefit pension plans must pay to the Pension Benefit Guaranty Corp., the federal agency that guarantees workers' pensions.

"We are rapidly slipping toward a pay-as-you-go system," Mr. Clayton said, meaning that funds are paid out by the PBGC as fast as they can be collected, leaving no reserves for future needs.

"I think in the long term—if we want the PBGC to remain healthy—a bill like the Erlenborn-Clay bill, which raises the premium and plugs up some loopholes, will have to be put in place. And I think it's in everyone's best interest to keep the PBGC healthy."

"Not that there aren't some bad things in this amendment, which there are," Mr. Clayton continued. "There is the union veto provision, which allows unions veto power to prevent the termination of a collectively bargained pension plan."

Under the bill, an employer would have to collectively bargain the termination of a pension plan up to two years after a union contract expired, he said. A company also would have to give a union 30 days' notice before it could terminate a plan.

"That provision is a real bill-killer. But, it may be worth settling for some of the bad things to keep the PBGC solvent."

Another bill, H.R. 4032, also introduced by Rep. Erlenborn, would lower pension participation and vesting ages, which would increase the number of women who could qualify for a pension (BI, Oct. 17).

"This bill will pass," Mr. Clayton predicted. "It has some things in it for women, and it's an election year. Nobody is going to say no."

While some of the pending benefit legislation could aid employers, the speakers warned benefit managers not to bank on that chance.

"What we are really talking about in the final analysis is money," said Mr. Seiden of Hall. "Regardless of what the government tells us about tax proposals, about giving people tax-break incentives, most benefit discussions on the government's part are totally related to revenues."

Employers, though, must keep one eye on the dollar sign and another on employee morale.

"The need to make decisions on a financial level rather than a human resources level will intensify," Mr. Salisbury said. "The degree to which human resources philosophy conflicts with financial philosophy will affect where employee benefits go in the future."

"Every responsible company is trying to control costs, but in this economic climate we have to think in different terms," Mr. Seiden said. "We have to think about ways to put more value in employees' pockets if we can't put more dollars in them."

"You have to maximize the benefits you have," he continued. "You should think about 401(k) plans and flexible plans, which give employees choices. It's almost got to be essential that you give employees a choice in benefits. If a tax cap goes through and if I, as an employee, am going to be taxed on every benefit you spend on me over \$175, then I want some say in the benefits that are bought."

"You need to be creative. One way is the new trend of 'junior stock.' Essentially, a company could offer an employee stock with limitations, such as that the company must make a certain amount of profit before declaring a dividend on the stock."

"But you must be flexible," Mr. Seiden said. "The real problem is that we don't know what's coming next in the economy or legislation."

Thus, rather than waiting for the legislation to come to pass and changing benefit plans from there, benefit managers should exert influence on those who form this legislation.

"Instead of being reactive, be proactive," Mr. Salisbury urged. "The challenge is to take your perception to the environment, rather than having the environment conflict with your perception."

"Try sooner than later to educate people in Congress," he continued. "Educate them on why you think certain legislation would be a good thing or a bad thing."

While business coalitions as lobbying groups are helpful in this regard, they may enter too late and meet with too much opposition.

CEB meeting attracts 270

SAN ANTONIO, Texas—Benefit managers from major corporations across the country gathered in the 90-degree sunshine of San Antonio Oct. 6 and 7 for the 37th annual conference of the Council on Employee Benefits.

The present membership of the CEB represents 187 companies in diverse industries. Through the council, these companies sponsor benefit research, communicate benefit issues to legislators, assist in the development of all benefit plans and provide a forum for the exchange of ideas among professionals.

One such forum is the annual conference, and more than 270 members and non-members attended the one this year, where nearly 150 of the member companies were represented.

The sessions held during the two-day conference featured speakers from Congress and other governmental bodies, from law and consulting firms, plus fellow benefit managers who shared their challenges and success stories.

Managing health care costs—through legislation, plan innovation and union negotiations—was foremost in the minds of the attendees, and speakers focused on these issues.

The council was founded in 1946. It is governed by 15 delegates who comprise a board of trustees, with each delegate representing a separate membership category. Within the board, a president, one or more vice presidents and a secretary/treasurer are elected annually. Paul M. Millholland, manager of benefits planning and development at The Upjohn Co. in Kalamazoo, Mich., is the current president.

For more information on the Council on Employee Benefits, contact Ray Kase, Director of Employee Benefits, ACF Industries Inc., 750 Third Ave., New York, N.Y. 10017.

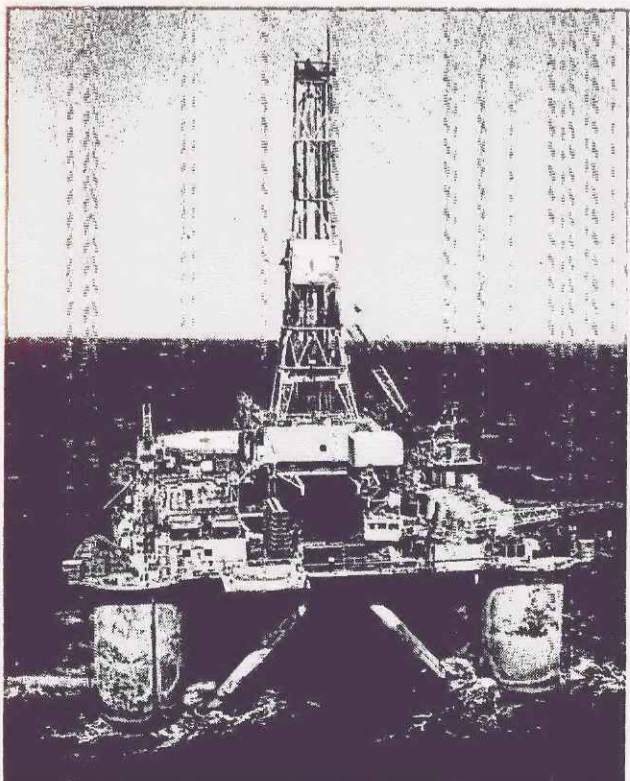
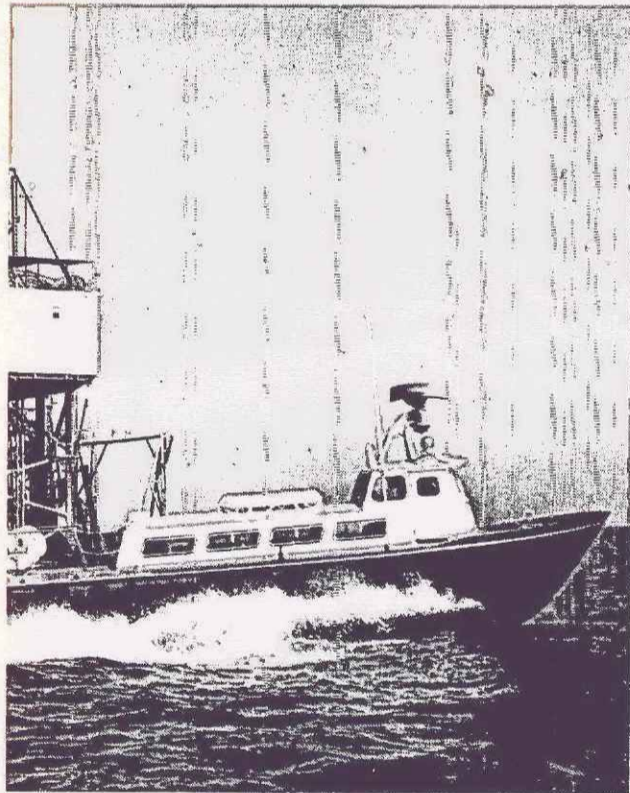
"Don't wait until a bill is pending," he said. "While there is value in supporting those organizations, there is absolutely no substitute for direct communication."

"Arrange to meet with your representatives when they are in your area," Mr. Salisbury suggested. "And do you have a word processor? It only takes 10 or 15 minutes to dictate a letter, and it takes no time at all to produce the 20 letters or so on a word processor to reach the people on your mailing list that you need to educate."

"We need to make sure the information is available. It is even more important at the perception-building stage than at the lobbying stage. And having a letter that says 'Thought you might want to know what this major employer in your district thinks' can be very influential in building those perceptions," Mr. Salisbury said.

But, the benefit managers' communications efforts do not end during the lobbying stage. After they communicate what they want to legislators, benefit managers must communicate the government's response to employees.

"The core of it is the challenge of employers to communicate the why and wherefore of the benefit changes in the years ahead and to maintain employee morale," Mr. Salisbury said.



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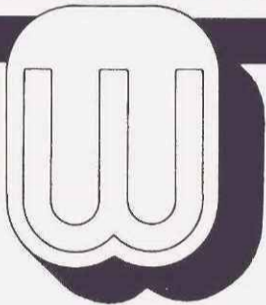
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Financial planning can be offered on a tight benefit budget: Vendor

SAN ANTONIO, Texas—Meeting the financial planning needs of middle-income employees will play a larger role in future benefit plans, a financial planning specialist predicts.

Companies that do not now offer financial planning assistance must begin putting programs in place if their benefit plans are to truly meet the needs of employees, says George E.L. Barbee, executive director of the Consumer Financial Institute, a financial planning service in Newton, Mass.

Mr. Barbee issued his predictions at the Council on Employee Benefits' recent 37th annual conference.

Although Mr. Barbee's recommendation that companies offer financial planning brought dollar signs to the eyes of many of the benefit managers attending the conference, he brought along some encouraging news: A financial planning benefit can operate within the constraints of even the most shriveled budget.

"Financial planning used to be an executive perk. Now it's filtering down to all levels," Mr. Barbee said. "Now middle-income employees have money to invest and there is a lot of confusion about how to invest it."

"As Jane Bryant-Quinn said in Newsweek in the 1970s, 'What we need today is some source of reasonably disinterested advice that could lay out our choices and bring them into a coherent whole at a reasonable cost.'"

"With the consumer trends today, this is needed more than

'The new trend is on the lower-cost, self-help (financial planning) programs,' Mr. Barbee says.

ever," Mr. Barbee said.

Some consumer trends that point to a need for financial planning are:

- The two-income family.
- New tax considerations. For instance, employers can offer employees taxable and non-taxable benefit options, including savings plans with tax incentives.
- The explosion of investment alternatives.
- Social Security considerations. Despite recent legislation strengthening the system, some observers expect the Social Security program to go bankrupt within the next 10 years.
- The changing financial services industry. "No longer is a bank a bank or an insurance company an insurance company," Mr. Barbee elaborated. "Retailers are getting into financial services. The whole industry is changing."

"These things increase the complexities of our lives," he said. "They increase our need for help to eliminate the confusion."

At the same time, employers are facing trends that affect what they can provide employees, including rising benefits costs, the stronger role of government in forming benefits policies and the receptiveness of employees to sharing health care costs.

"Businesses are now in the position of coaching employees to be more self-reliant in planning for their financial security," Mr. Barbee said.

This position is an opportunity for the company to enjoy certain advantages, with no added liabilities, since the financial advice a company provides is not sold to the employees.

One advantage is an improved image among employees that can be achieved simply by communicating the services a company offers.

"A lot of people really don't understand what the company is doing for them," he said. The communication process also integrates the company's benefit program into the vernacular of employees.

Financial planning also fosters an educated selection process, which makes employees more responsible partners in providing for their futures.

And, financial planning programs make employees look ahead earlier in their lives. "Not too many people in their 30s, 40s and 50s will raise their hands and attend a pre-retirement session," Mr. Barbee said. "But everyone wants to know about financial planning and how to have more aftertax dollars."

Finding ways to avoid taxes is the drawing card for a financial planning workshop. "And the program reaches all levels of employees. Even employees you think won't be attracted by tax incentives because their income is maybe only \$20,000 are interested in tax incentives. Chances are his or her spouse works and they quickly approach the 40% tax bracket," he said.

A financial planning workshop offers company resources to employees for confidential charting of personal courses of action.

"Think of financial planning like taking a sailing trip," Mr. Barbee said.

First you get organized. You put your provisions on board; you ready the vessel for the trip by getting out all the documents, dusting off the old stock certificates and gathering the information.

The next step is setting objectives. You decide on your destination. In financial planning, you verbalize wishes and wants and put a dollar figure by each.

Then you plan the strategy. What is the exact route you will take? Likewise, do you want to invest in an Individual Retirement Account, which is a good vehicle for retirement planning but a bad choice for financing an education? "With all the advertising, people forget their objectives when planning strategies," Mr. Barbee said.

Then comes the implementation step when you actually sail. In the financial planning program, the stocks are finally purchased and deposits are made.

Finally, a periodic review is in order to make sure you stay on course.

What resources a company uses to guide an employee and how involved it becomes with each step determines the cost of such a program.

"Generally this is a low-cost benefit, especially in the corporate environment," Mr. Barbee explained. "Administration costs are very low as well."

The cost of a financial planning program can range from \$100 to \$15,000 per employee, he said. Lower-cost programs range from \$100 to \$300, mid-cost plans range from \$300 to \$1,000 and high-cost programs cost more than \$1,000.

One of the factors that affect cost is participation rate.

"Let's say you offer the program to 10,000 workers and get a 20% participation rate," Mr. Barbee said. "If you have 2,000 workers in the financial planning program it might cost you \$75 per worker. Your total expenditure is \$150,000."

"The new trend is on the lower-cost, self-help programs," Mr. Barbee said.

Mr. Barbee's company offers a low-cost planning program, which is a fundamental three-step process, he said. First, a self-administered financial planning questionnaire is sent directly to the employee's home. Then, books and reference materials are provided for self-education. Finally, a customized analysis of the employee's financial situation is provided, which includes the ramifications of his or her goals. The analysis also provides strategic advice in order to attain those goals (BI, Sept. 5).

"Some companies want to provide more than that. Some will handle all the implementation," he said. "Some will handle the brokering for an employee; some will start up a 401(k) plan or flexible benefit plan with savings vehicles built in."

Companies also may offer personalized seminars with interactive computers, audiovisual presentations and guest speakers, he said.

Above all, Mr. Barbee stressed, the time has come for companies to become involved in this issue, to whatever extent they deem financially appropriate.

"We have to tell people that things have changed, that the government or the employer is not the sole caretaker anymore," Mr. Barbee said.

"The individual, the employer and the government are all working together for the employee's future. The individual needs training, and training is the strength of the employer."

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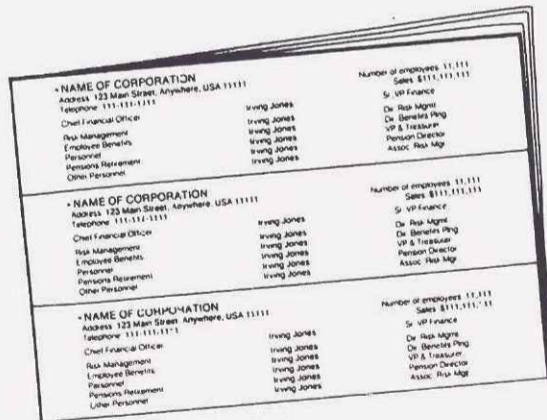
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Xerox teams up with union to control health care costs

SAN ANTONIO, Texas—When Xerox Corp. attempted to do something about its soaring labor costs, including costly health care expenditures, it gave its unions three options:

- It could end U.S. production and set up plants offshore where labor is cheaper.

- It could reduce the company's own manufacturing capabilities and contract manufacturing out to others that could produce the goods for a substantially lower cost.

- It could retain its current manufacturing facilities and work with the unions to cut labor costs—including benefits.

"We were suffering from the Japanese competition, and found that we would have to contain manufacturing costs by about \$150 million a year if we were to achieve market parity by 1985," William S. Asher, director of corporate industrial relations at Xerox, told a session at the Council on Employee Benefits' annual conference.

The Stamford, Conn.,-based company was able to make up \$90 million of its goal by reducing overhead, switching to more efficient materials and making other facilities changes, Mr. Asher said. The remaining \$60 million had to be negotiated with labor.

"Basically, we were saying to the unions 'The company's going to make it with you or without you. We'd like to make it with you, but you've got to work with us.'"

The Amalgamated Textile Workers did work with Xerox, and changes in health care benefits were among the concessions to which the union agreed.

For instance, a \$100 per individual or \$200 per family hospitalization deductible was increased to 1% of each employee's annual earnings. In addition, an 80/20 coinsurance feature for hospital and surgical care was added. Previously, Xerox paid all of these costs.

Also, the old plan limited out-of-pocket expenses for all non-hospital and non-surgical care to 6% of an employee's annual salary. "But that stop-loss was almost a fiction, because the big expenses are in hospitalization and that was (fully) paid for," Mr. Asher said.

Now, the stop-loss feature is set at 4% of salary, and it applies to hospital and non-hospital claims.

Both the new and old Xerox plan was underwritten by Blue Cross/Blue Shield.

"By an increase in the basic deductible we hoped to re-establish consumer input from the employee on the cost of health care," Mr. Asher said. "By having them back as paying partners, we hope they will be cost-conscious (when seeking medical care).

"We also hope to reduce actual costs for employees by bringing them back to that role as consumers, so that ultimately medical costs will be lowered for everyone."

Xerox also agreed to improve dental benefits while instituting cost-sharing. Previously, first-year workers were reimbursed for 80% of the cost of diagnostic and preventive dental care, second-year employees at 90% and all others at 100% with no deductible or maximum. However, an employee had to have an annual dental checkup to be eligible.

In the new plan, all employees are reimbursed at 100% for these basic services, and the annual checkup requirement was abolished, but there is a deductible of 0.25% of a worker's annual salary applicable to dental charges.

Also, Xerox agreed to establish a \$400 per worker flexible spending account in 1984, which an em-

ployee can use to finance health and dental expenses not covered by insurance. Employees can keep any unused portion at year-end.

Despite Xerox's success in negotiating cost-sharing with its workers, many employers are finding that unions will not agree to benefits concessions (*BI*, Oct. 10). However, companies like Xerox have had success when they can convince unions there is an urgent need to cut costs.

"I feel sorry for these companies that are asking unions to talk cost-sharing when they don't have some dire financial need," he said.

The fact that Xerox needed and was determined to cut costs was the most persuasive argument the company had in union negotiations, Mr. Asher said. ■

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Employer will pay half of settlement

Continued from page 2

was set to go to trial in St. Clair County Circuit Court in Belleville, Ill.

One attorney connected with the case, who asked not to be identified, said a portion of the settlement would be paid in cash while the remainder probably would be a structured settlement financed by annuities purchased by the defendants' insurers.

The attorneys were leery of releasing information about the cost of the settlement because of recent interpretations of tax laws concerning structured settlements, they said.

If the injured employee receives a large cash settlement, they explained, and then invests it or purchases annuities for himself or herself, the interest on those investments is taxable. However, if a defendant purchases an annuity for the victim through its insurers and only discloses the amount of future benefit to the claimant—not the purchase price of the annuity—the payments are not taxable, attorneys said.

But if the injured worker or the worker's attorney knows the cost of an annuity and agrees to the final monthly benefits, this "constructive receipt" is as if the employee purchased the annuities and the payments therefore can be

taxed, an attorney said.

"The plaintiff can't know the (accumulated) amount," the attorney said.

Although there is no case law on this conservative interpretation of the tax code, many attorneys now refuse to divulge information about settlements to protect the plaintiffs, an attorney said.

Although the exact amount to be paid is not known, National Steel and Concast will pay the bulk of the settlement in almost equal portions, an attorney connected with the case said, noting that the steel company ultimately will pay a bit more because of the workers comp costs.

The two Japanese companies will pay the remainder of the settlement, he said.

Representatives for National Steel and Concast say both companies have liability insurance, though the representatives would not elaborate.

Mickey Chestovich, manager of legal affairs for Granite City Steel, said he did not want to discuss the explosion or the settlement.

"Our best interests are served by not discussing the case. We settled, but I won't admit to any part of the settlement," he said, adding, "I prefer to make no comment, as if it never happened."

Of the two Japanese companies,

only Sumitomo Heavy Industries carried liability insurance.

Sumitomo Metals, reported to be the largest steel corporation in Japan, is self-insured, said one of its attorneys, Richard E. Boyle of the Belleville firm of Gundlach, Lee, Eggmann, Boyle, Roessler & Nash. But attorneys for the two Tokyo companies would not go into details.

The July 8, 1981, explosion at the plant in Granite City, Ill., across the Mississippi River from St. Louis, occurred after a continuous casting steel process at Granite City Steel that was designed and developed by Concast and Sumitomo Heavy Industries failed to function properly.

At the time of the blast, representatives from Sumitomo Metals, acting as consultants for Sumitomo

Heavy Industries, were stationed at the plant to conduct an "experiment," noted one of the defendants' attorneys.

The blast occurred when molten steel that contained slag, a waste byproduct generated in the making of steel, was sprayed with water, the attorney said. Slag explodes when it comes in contact with water.

Mr. Novosel and two other employees "took a bath in molten steel," said Mr. Cook, the plaintiff's attorney.

Mr. Novosel, who is now 28, suffered second- and third-degree burns on 80% of his body. He became totally blind in one eye and partially blind in the other.

The other two employees, who had sued the same corporations in

federal court, received out-of-court settlements about a month ago.

Richard Bickel, 35, and Burleigh Hawk, 46, both of Collinsville, Ill., suffered second- and third-degree burns on about 40% of their bodies.

Mr. Bickel received a cash settlement of \$2 million and Mr. Hawk received a partial cash and partial structured settlement of \$1.5 million, said their attorney, C.E. Heiligenstein of Belleville.

They also received, between the two of them, about \$400,000 in workers compensation benefits, Mr. Heiligenstein said.

Neither Mr. Heiligenstein nor attorneys for the defendants would comment on those settlements except to acknowledge that National Steel, Concast and both of the Japanese steel corporations all will pay. ■

Lawsuits expected after Texas fair mishap

Continued from page 2

spected by independent safety experts before it was opened for this year's fair and has been inspected daily by its operators," he explains. "Also, our own staff occasionally spot-checked the ride to make sure standards were maintained."

Lawsuits against Texas State Fair Inc. will most likely be defended by CNA Insurance Cos., the fair's general liability insurer. Mr. Halford would not reveal CNA's policy limits but noted that they are significantly more than the \$1 million mandated by Texas law.

Special events insurance experts say that the sponsors of large events, such as a state fair, generally purchase from \$20 million to \$50 million in spectator liability insurance.

Also likely to be involved in the defense of any lawsuits arising from the accident is American Home Assurance Co., an American International Group Inc. affiliate.

American Home confirmed that it underwrites a primary liability policy for Continental Park Attractions Inc. of Farmingdale, N.Y., which operated the ride. However,

the insurer would not reveal the limits or terms of its coverage.

The liability insurer for Huss Ltd. of Berne, Switzerland, which constructed the ride, is not known.

Texas State Fair has become particularly sensitive to lawsuits and liability claims since a similar accident on a ride at the fair occurred in 1979. That mishap, which involved the fair's Swiss Skyride, led to the death of one spectator and injuries to 12 others when two gondolas disconnected from overhead cables.

Lawsuits filed after the accident led to a 1982 judgment of \$5.1 million against the Texas State Fair, as well as the operator and manufacturer of the skyride (BI, July 19, 1982).

Although the liability insurance applicable to the 1979 accident was in dispute at the time of the judgment, the award has since been divided among Zurich American Insurance Co., the liability insurer at the time for the state fair; ride operator Steck & Stafz Attractions Inc. of Dallas; Employers National Insurance Co. of Dallas, the state fair's excess liability insurer; and Gerling Konzern of Cologne, West Germany, the liability insurer for Von Roll Ltd., the Swiss company that manufactured the skyride. ■

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Animal trainer gets \$25,000

Continued from page 2

At issue in this unusual police professional liability suit was whether or not the deputy had been aware that the animal was a member of an endangered species, whether the deputy needed a government permit to shoot the animal and whether the farmer who called the deputy should have known that the wolf was a part of an animal exhibit being housed on a nearby farm.

Mr. Cole, who had called the sheriff's office when he saw an animal attempting to enter his piggery, testified that he did not know exactly what kind of animal he saw, but admitted that he "thought it contained wolf" and that he knew wolves were an endangered species.

Another witness, however, contradicted Mr. Cole and told the court that he had personally informed Mr. Cole that the wolf was touring the area and invited Mr. Cole and his children to visit the animal.

County Sheriff's Deputy Howard E. Sheradin testified that he responded to Mr. Cole's call and attempted to restrain the wolf for "15 or 20 minutes" until the animal grew agitated. He then shot and killed the wolf with his .357 Magnum service revolver.

The court-approved settlement ended the debate without establishing guilt, according to an attorney representing the County Sheriff's Office.

The county's share of the settlement and legal costs, according to Ontario County's agent of record John Parrott, principal of Fink & Parrott-Ratalle Agency Inc., will be split by two insurers: American Home Assurance Co., a unit of American International Group Inc., and Hartford Insurance Group.

American Home's primary police professional liability policy covered personal injury and property damage losses resulting from police action up to a combined single limit

of \$500,000.

Hartford's multiperil package policy for Ontario county, according to Mr. Parrott, included primary liability coverage for personal injury losses of up to \$500,000 per occurrence and \$500,000 aggregate and property damage up to \$100,000 per occurrence and \$100,000 aggregate.

The multiperil policy was subject to a \$1,000 deductible.

It is not known whether or not Mr. Cole's portion of the \$25,000 settlement was covered by insurance. ■



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BI-1083

USF&G starts new division specializing in reinsurance

United States Fidelity & Guaranty Co. is entering the reinsurance business next month.

A new USF&G reinsurance underwriting management company will begin business the first week of November under President Paul Ingrey.

Mr. Ingrey was formerly senior vp of underwriting and marketing at Prudential Reinsurance Co. and president of its subsidiary, Gibraltar Casualty Co. He resigned from Pru Re to become president of the new USF&G subsidiary, which has yet to be named.

"We realize that this is not an opportune time to enter the business, but this realization itself should be indicative of the long-term commitment of USF&G," Mr. Ingrey said. "Our intent is to provide flexible service and unparalleled security."

The new enterprise, which will accept submissions from reinsurance intermediaries, will utilize the resources of USF&G in its underwriting.

Mr. Ingrey hopes to continue to underwrite reinsurance for captive insurance companies, drawing on his experience with captives since the late 1960s.

"My purpose is not to build another Prudential Re but to be small and dynamic and quick-reacting," he added.

The staff of the new company will number five or six by year-end and will grow to 17 to 20 by the end of the first year. Mr. Ingrey declined to make any projections on premium volume.

The headquarters of the reinsurance management company will be located in the Morristown, N.J., area.

Colorado consultant

James A. Jaeger is striking out on his own as a risk management consultant based in suburban Denver.

Mr. Jaeger, who had been president and chief executive officer of Frank B. Hall Management Co. in Denver since 1974, said his specialties will be environmental impairment liability insurance, captive feasibility studies and self-insurance feasibility studies.

His consulting firm, which includes an associate, is located at 7658 S. William St., Littleton, Colo. 80122; 303-794-5887 or 5888.

N.Y. exchange

A new underwriting member, a broker and an associate broker have been approved for participation on the New York Insurance Exchange.

The Hannover Syndicate Inc., a wholly owned subsidiary of Veritas Ruckversicherung A.G. of West Germany, will begin writing property/casualty risks with \$4 million in capitalization Dec. 1.

The new broker participant is Pearson & Georgi International Inc. and the new associate broker is Marine Risks Inc.

The exchange now has 41 underwriting members, 63 broker members and 29 associate brokers.

Intermediary formed

Gill & Roeser Inc., a new intermediary, has been formed to specialize in financially oriented life and casualty reinsurance. The firm is located at 230 Park Ave., Suite 1210, New York, N.Y. 10169. Telephone: 212-953-0802.

AIMU correspondent

The American Institute of Marine Underwriters has announced a new correspondent in Jordan.

markets

SYNCO, an Amman-based firm, will act as an independent loss surveyor and will provide AIMU with information about political, social, economic and port conditions in Jordan.

Blades expansion

Houston-based J.H. Blades & Co. Inc. has formed a new facility specializing in insurance coverage for refineries, gas processing and petrochemical plants. The new operation will be directed by Assistant Vp John Vint.

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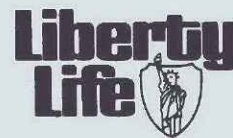
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High court to review risk management issues

WASHINGTON—While pension managers will follow the Supreme Court's action on the retroactive provision of the Multiemployer Amendments Act, several issues of interest to corporate risk managers also will be reviewed by the Supreme Court.

The high court has agreed to decide if:

- A 1954 federal law regulating the nuclear power industry preempts state courts from awarding punitive damages for injuries suffered in a nuclear accident.

- A cap that limits what airline passengers and their survivors can recover in an accident on an international flight can still be enforced.

- The federal government can be held liable for inspections conducted by the Federal Aviation Administration.

- An injured worker can collect workers compensation benefits in two different states for the same injury.

The nuclear liability case involves whether nuclear-products manufacturer Kerr-McGee Corp. is liable for punitive damages in the Karen Silkwood nuclear-contamination case.

Ms. Silkwood, an employee of Kerr-McGee's Crescent, Okla., plutonium fuel rod fabricating plant, was contaminated by plutonium in November 1974 and died in an automobile accident soon thereafter.

A jury in May 1979 awarded Ms. Silkwood's estate \$500,000 in compensatory damages and \$10 million in punitive damages in her suit against Kerr-McGee.

However, in December 1981, a federal appeals court struck down the punitive damage award, noting that federal energy regulations pre-empt state laws allowing punitive damages. Attorneys representing the Silkwood estate then appealed the decision to the Supreme Court (BI, Dec. 21, 1981).

In a brief to the Supreme Court, the Justice Department says the 1954 Atomic Energy Act gives the Nuclear Regulatory Commission

the exclusive power to regulate nuclear facilities.

The Atomic Energy Act also established a detailed system of penalties and fines that the NRC could impose on nuclear plant operators, the Justice Department said.

"Congress left to state law only the power to award compensatory damages," the brief said.

The airline liability case involves the Warsaw Convention, an international treaty that limits airlines' liability to passengers and shippers.

Under the convention, an airline's liability on international flights is supposed to be \$75,000 per passenger.

However, in December 1982, a federal appeals court in New York held that the limit could not be enforced prospectively.

In that ruling, the court said the Warsaw Convention's use of the price of gold as a benchmark for calculating the liability cap in diverse currencies was no longer applicable since the United States abandoned the gold standard.

A Supreme Court ruling will settle what an airline's liability is to its passengers on international flights.

If the court strikes down the limit, that could lead to higher insurance costs for international airlines because the cap on their potential liability would be removed.

At issue in the government liability case is whether the federal government can be held liable for negligence in inspections conducted by the FAA or under its auspices.

The case involves the 1968 crash of a DeHavilland Dove aircraft shortly after the air taxi took off from Las Vegas, Nev., en route to San Diego. The cause of the crash, which killed three people on board, was an in-flight fire in the plane's forward baggage compartment.

A U.S. District Court found that the fire occurred because the gasoline line leading to a heater was not adequately clamped to prevent excessive vibration. The heater had

been installed in 1965 after an engineering firm received a certificate from the FAA authorizing the installation.

The court said the aircraft was not airworthy and that the government was negligent in certifying the heater installation that did not comply with its regulations. The government was ordered to pay the victims \$200,000.

In its brief before the Supreme Court, the Justice Department said if the lower court decision were allowed to stand, the government would regularly be named as a defendant whenever an airplane accident may have been caused by a mechanical or design defect.

"We submit that Congress could not have intended to expose the United States to monetary liability,

essentially as an insurer, as a result of certifications and inspections undertaken to enforce compliance with minimum safety standards," the Justice Department said.

The workers compensation case involves Lawrence Warren, a truck driver for Roadway Express Inc., an Akron, Ohio, transportation firm, who was injured in a 1978 road accident in Indiana while on his regular run between Chicago and Nashville, Tennessee.

Mr. Warren applied for and received workers compensation benefits in Tennessee.

On Oct. 12, 1979, Roadway, which is self-insured for its workers compensation risks, suspended Mr. Warren's benefit. Mr. Warren then applied for and received a supplementary benefit under Georgia's

workers compensation program. Mr. Warren had signed his original work contract with Roadway in Dekalb, Ga.

At issue in the case, which Roadway is appealing to the Supreme Court, is whether a state workers compensation statute, in this case Tennessee's, can prevent another state from issuing a supplemental benefit to a worker.

In another matter, the Supreme Court declined to review a lower court decision on whether the effect of income taxes on an accident victim's salary can be introduced as evidence in a wrongful death case involving a Playboy magazine editor who died in the May 1979 crash of an American Airlines DC-10 jetliner near Chicago.

—By Jerry Geisel

Conflict over multiemployer law to be settled

Continued from page 2

age employers from leaving the nation's 2,000 multiemployer plans, which cover about 8 million employees and are concentrated in the transportation and construction industries.

Before the 1980 law, an employer could leave a multiemployer plan and not pay a single dollar promised to participants as long as the plan didn't fold within five years of the employer's withdrawal.

When the 1980 Multiemployer Amendments Act was passed, Congress feared employers would flee the plans in droves because of the increased pension liability. To prevent this, Congress made the law's effective date retroactive.

Dozens of employers that left the plans before the act was signed, but after its effective date, challenged the constitutionality of the retroactive provision.

The Supreme Court case involves the challenge of R.A. Gray & Co., a Tigard, Ore., general and commercial contractor that left the Oregon-Washington Carpenters Employers Trust Fund in June 1980.

R.A. Gray & Co., an 18-year-old, 65-employee company, was later told by the Oregon-Washington carpenters plan that its share of the plan's \$27 million in unfunded vested benefits came to \$201,359.

The company later filed suit against the plan, questioning the right of Congress to impose withdrawal liability retroactively.

On May 20, the 9th U.S. Circuit Court of Appeals agreed with R.A. Gray and two other small firms, whose cases were consolidated before the court, that the retroactive provision imposed an unfair burden on employers.

In balancing the interests of employers and the plans, the appellate court said the withdrawal liability imposed on the three employers was relatively insignificant in terms of the plans' total unfunded vested benefits.

"The trust funds and covered employees have not relied heavily on these employers' contributions," the court said in May. "The withdrawal liability imposed on the employers... may well be disproportionate to the specific needs of

the pension trust funds."

Employers that withdrew from the plans were required "to pay a sum that seriously threatens their solvency without a specific showing of the proportionate need on the part of the pension trust funds," the court said.

The 9th U.S. Circuit Court decision is being appealed by the Pension Benefit Guaranty Corp., the federal agency that guarantees workers' pension benefits when their companies fail or when insufficiently funded pension plans are terminated.

Storm damage set at \$6 million

NEW YORK—Insured property damages caused by tornadoes, wind and flooding that swept portions of Arizona and California Sept. 30-Oct. 3 are estimated at \$6 million by the American Insurance Assn.

The most extensive damage took place in central and southern Arizona. The storm was assigned Catastrophe No. 16 by the Insurance Services Office.

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Insurance Management: vps, directors, managers of insurance, risk, benefits, compensation, safety, security, etc.	5,865
Government, Associations, Unions, Educational Institutions	1,024
Commercial Consumers Sub-total	23,176
Insurance Agents & Brokers	9,639
Insurance Cos.	5,384
Financial Institutions	385
Actuaries, Attorneys, Adjusters, Appraisers & Consultants	2,779
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TOTAL	42,383

*Source: Business/Occupational breakdown of qualified circulation, May 2, 1983 issue, as submitted to BPA for June 1983. BPA Publisher's Statement.

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Plan to limit deductions viewed as threat

Continued from page 1

liability insurance MGM had in place before the fire. That amount was considered low by experts.

MGM now is suing Hall and 21 insurers of the first \$95 million of the \$170 million in backdated coverage to force them to pay. While the litigation has been going on, MGM has had to borrow money to settle claims (BI, March 21).

After MGM's purchase of the controversial backdated policy was publicized, J. Robert Hunter, the former acting administrator of the Federal Insurance Administration, wrote to the Internal Revenue Service asking the agency to investigate the purchase.

Mr. Hunter, now the president of the National Insurance Consumer Organization in Alexandria, Va., said the backdated coverage was not insurance because there was no transfer of risk.

"All of the major problems associated with this unusual deal stem from the fact that this simply is not insurance," Mr. Hunter said at the time (BI, March 16).

Mr. Hunter wanted the IRS to issue a ruling to bar MGM from taking a tax deduction for its purchase of the backdated policies.

While the IRS has yet to issue such a ruling, Mr. Hunter and other observers believe publicity generated by the purchase prompted the IRS to encourage Finance Committee staffers to write legislation to clarify that backdated coverages are not considered insurance.

"Publicity on the MGM fire had a lot to do with it," said Walter Vinyard, an attorney with Alston & Bird in Washington.

Although Finance Committee staff members are not publicly discussing why they want to wipe out tax deductions for the purchase of backdated coverages, it is clear that they are being urged to do just that by high-ranking government officials.

For example, John Chapoton, the Treasury Department's assistant secretary for tax policy, has told the Finance Committee the Treasury is concerned about the possible revenue loss to the government if backdated policies become widespread.

"These forms of 'insurance' would become far less attractive if the deduction were eliminated..." Mr. Chapoton said.

Risk managers that decide to fight the Finance Committee proposals will find support from insurers.

For example, the National Assn. of Independent Insurers says it doesn't see a need for a new definition of insurance that would exclude captive and backdated arrangements.

"The case-by-case analysis of various arrangements appears to have produced reasonable and workable results. We are not aware of abuses that are not adequately dealt with in principles of current case law," the NAI has told the committee.

Other insurers warn that a new definition of insurance could hamper the ability of the industry to develop new products.

"We believe that nothing more restrictive or more specific would be feasible as a general rule if the courts are to have sufficient flexibility to review the endless variety of products developed to meet today's changing insurance needs," said T. Lawrence Jones, president of the American Insurance Assn.

A fixed definition of insurance could stifle the ability of insurers to meet policyholders' needs, says Andre Maisonpierre, senior vp at the Alliance of American Insurers.

A definition of property/casualty insurance transactions 'would require constant legislative revisions as the need for insurance protection arises,' Mr. Maisonpierre of the Alliance of American Insurers points out.

"Further, it (a definition of property/casualty insurance transactions) would require constant legislative revisions as the need for insurance protection arises," he adds.

Other experts say removing tax deductions for captive and retroactive coverages could have inflationary effects.

"It would make insurance more expensive for risk managers" and

their companies, said Robert Reeves, president of the Health Services Division of Hospital Corp. of America in Nashville, Tenn.

Hospitals, for example, that want to set up captive insurers to cover their medical malpractice risks would lose tax advantages. Those costs would end up being passed onto patients, Mr. Reeves says.

Mr. Reeves believes that a definition that excludes backdated and

captive arrangements as insurance "is a step backward. It seems out in left field."

Congress would be better off if it tried to encourage the most efficient forms of funding risk, which Mr. Reeves believes is through self-insurance and captive arrangements.

Others say that a general definition of insurance that excludes premiums paid to captive insurance companies and the purchase of backdated coverages could have a far greater effect than what the committee staffers may intend.

For example, so-called cash-flow or paid-loss plans—in which a buyer initially pays a certain percent of a premium and then over a fixed period of time pays the insurer for losses—could be considered a form of retroactive cover-

age. "What do they (committee staffers) mean by retroactive?" asked Bruce Wright, a partner with the New York law firm of Turbin, Sillocks, Edelman & Knapp, who believes the Finance Committee's exact definitions of captive and retroactive arrangements could cause problems.

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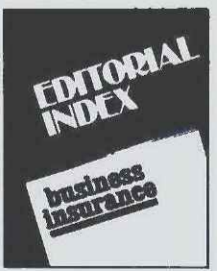
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Lockheed suit

Continued from page 1

Lockheed eventually settled an SEC lawsuit by admitting that it had made about \$38 million in questionable payments to officials in about a dozen countries. It also pleaded guilty in 1979 to criminal charges involving payments to Mr. Tanaka and paid a \$647,000 fine.

Along with submitting to the investigations, Lockheed and its directors had to contend with two class-action lawsuits filed in 1976 by shareholders angered over the company's foreign practices.

Legal and other expenses paid by Lockheed and the two former executives—former Chairman Daniel J. Haughton and former President A. Carl Kotchian—in the course of the investigations and shareholder lawsuits are the basis of the complaint against Unigard.

Between November and December 1973, Unigard provided Lockheed with one primary and three excess "Directors and Officers Liability and Company Reimbursement Liability" policies, according to court papers.

The four policies together provided \$35 million in coverage over a \$400,000 self-insured retention and a \$25,000 deductible per director or officer with a \$75,000 aggregate deductible, says Richard Murray, a lawyer with the San Francisco firm of McCutchen, Doyle, Brown & Enersen that represents Messrs. Haughton and Kotchian.

The policies were to run for three years, but Unigard canceled the coverage in November 1975 after the bribes became public. Lockheed says it paid \$923,451 in premiums before the cancellations.

The lawsuit against Unigard was originally filed in the late 1970s, but Lockheed and the insurer agreed the case wouldn't proceed until the two shareholder suits were resolved. Lockheed eventually won dismissal of those two suits and revived the action against Unigard last November.

In its complaint, the aircraft company says Unigard wrongly refused to pay legal expenses incurred during:

- A 1975 SEC investigation of the questionable payments and the subsequent SEC court action.
- A special IRS audit of Lockheed in 1976.
- A 1976 federal grand jury investigation that was part of the Justice Department's investigation.
- The two shareholder suits.

Attorneys say Lockheed and the two former executives are looking to recover about \$8 million in compensatory and special damages, along with \$10 million in punitive damages.

Lockheed's claim for legal expenses paid after it exhausted its self-insured retention account for

only about \$295,000 of the \$8 million, lawyers say, while the unreimbursed legal expenses of the two executives account for only \$30,000.

The bulk of the damages represent the "lost compensation" of Messrs. Haughton and Kotchian, who were fired in the wake of the payoff scandal.

According to Mr. Murray, the two executives were forced to give up stock options and other benefits in negotiations with Lockheed over the defense of the shareholder suits as they were being fired.

Each of the men relinquished \$520,954 in general compensation, according to Mr. Murray. Other losses include \$467,313 in stock options given up by Mr. Haughton, \$1.4 million in options given up by Mr. Kotchian and attorneys' fees.

Mr. Haughton and Mr. Kotchian contend that they would not have been forced to give up any compensation if Unigard had stepped in to settle the shareholder suits or at least to adequately reimburse legal costs. Unigard's refusal to do so, they add, placed them under "economic duress."

Unigard had a duty under the policies "to reimburse plaintiffs for considerations paid to reasonably settle claims against the directors and officers" in the shareholder suits, they argue.

Unigard, though, says lost compensation doesn't fit the description of payments made to "reasonably settle" claims.

"One of the big bones of contention is that Unigard says that the lost benefits were due solely to an arrangement between (Messrs. Haughton and Kotchian) and Lockheed," explains Scott Conley, a lawyer with the San Francisco firm of Sedgwick, Detert, Moran & Arnold, which represents Unigard.

He added that Unigard paid about \$100,000 of the two executives' legal expenses for the shareholder suits.

Another bone of contention is whether Unigard is entitled to rescind the policies. The insurer has filed a cross-complaint asking that the coverage be voided, claiming that when it wrote the policies in 1973, Mr. Haughton and Mr. Kotchian knew but did not disclose the company's "worldwide system of bribery, 'cumshaw,' kickbacks and other illegal and improper payments."

The insurer says that if it had known about Lockheed's practices, it would never have agreed to provide coverage and that the executives' misrepresentations entitle it to void the policies.

Unigard also argues that Messrs. Haughton and Kotchian should be forced to indemnify it for amounts it may have to pay out under the coverage.

The coverage dispute, although

complicated, probably won't take long to resolve. Under California law, Mr. Haughton, 70, has the right to a quick trial because of his age. The court has ordered both sides to finish pre-trial discovery by Dec. 19 and trial is set for Jan. 18.

Meanwhile, Unigard has embarked on what Lockheed's lawyers call a "massive discovery program" that has landed the parties in U.S. District Court for the District of Columbia.

In attempting to prove that Messrs. Haughton and Kotchian knew about the foreign payments at the time the policies were issued, Unigard wants access to 54 boxes of documents collected by the SEC.

Unigard says it needs the documents to prove that it was kept in the dark about material facts affecting the insurance.

"We have to show that there was misrepresentation amounting to fraud there," Mr. Conley explained. "That's a heavy burden."

Lockheed, however, has filed a motion to block the subpoena, citing previous cases in which access to the files was limited.

When the SEC first subpoenaed these documents from Lockheed in 1975, a federal judge placed them under a protective order that re-

quires a court to approve their release.

Lockheed claims that the files are full of unsubstantiated hearsay about possible payoff recipients and that their release would have a "devastating impact" on the careers of several foreign officials. This would constitute "unwarranted invasion of personal privacy," the company says.

Release of the names could also damage U.S. relations abroad, since some of those named "hold positions of importance to the foreign relations interests of this country," Lockheed claims.

The State Department has already objected in court to release of the documents, saying that U.S. interests would be damaged, Mr. Conley says.

Lockheed also argues that the files include confidential commercial information and could create "resentment" in foreign markets that could damage its interests.

Lawyers for the aircraft company point out that evidence of Messrs. Haughton's and Kotchian's knowledge of the bribery is already publicly available. Both men testified in the mid-1970s that they approved the payoffs.

"If a guy testifies in front of a court that, 'Yes, I killed my

mother,' do you have to go into the files to find out how many times he hit her? The point is that you know he killed her," said Roger A. Clark, an attorney with the Washington firm of Rogers & Clark, which represents Lockheed in the litigation over the subpoena.

Unigard has agreed to a protective order that would limit release of certain information in the files during discovery, but it has indicated that it would not agree to such an order during a jury trial.

"We feel that the whole thing ought to be laid out publicly," Mr. Conley said.

This has led Lockheed to accuse Unigard of "graymail," charging that the insurer wants the SEC files simply to "deter Lockheed from pressing the pending California lawsuit out of apprehension for the injury that could be caused by revelation of information."

Even if Lockheed loses the fight and the files are opened, the company says it will forge ahead with its suit against Unigard.

"I think we would exhaust the appeals process first (if we lose)," said Joseph Twomey, Lockheed's general counsel.

"If we exhaust the appeals process, I think we would go ahead and litigate it."

S&P rates insurers on claims-paying ability

Continued from page 1

S&P has already rated 32 U.S.-based insurers, including most of the large commercial lines underwriters. All of the major commercial property/casualty insurers received the highest possible rating of AAA with one exception—insurers owned by Chicago-based CNA Financial Corp.

The AA rating that was assigned to National Fire Insurance Co. of Hartford, the insurer representing CNA for S&P rating purposes, means the CNA insurers still have what S&P defines as "a strong capacity to meet contractual policy obligations."

The CNA companies are among several major commercial property/casualty insurers to receive an A rather than an A-plus rating from Best's in 1983.

S&P's AAA rating is reserved for companies with an "extremely strong capacity to meet contractual obligations." A D rating, the lowest, is reserved for insolvent insurers or those in receivership.

Some insurers are yet to be ranked on claims-paying ability but already carry strongly favorable S&P bond or commercial paper ratings. Since policyholders' claims would probably be paid before corporate debt, S&P says such companies would likely have claims-paying ratings at least as high as their bond ratings.

Neither S&P nor Best's publish explicit descriptions of their rating processes, although the general guidelines released by S&P are more detailed than what Best's make public.

Best's says its ratings—ranging from A to C—are a measure of the "relative position" of an insurer based on its size and underwriting category. Best's says it relies upon an insurer's annual and quarterly statements, as well as interviews with officers.

S&P says its analysis focuses on seven factors: industry risk; company characteristics; underwriting performance; investment activities; earnings protection; leverage; and financial flexibility. It also notes that "philosophies and practices" of management also are important as they relate to the performance of the insurer.

Officials of both organizations say they attempt to learn details of an insurer's reinsurance arrangements, though neither indicated any particular emphasis beyond what insurers publish in their statements.

Neither organization can say, though, whether they rate insurers on different criteria from the other.

For its part, S&P says it eventually hopes to rate hundreds of major U.S. property/casualty insurers as well as 200 to 300 of the largest overseas insurers.

Lack of an S&P rating can mean any one of at least three things:

- The insurer may have never requested a rating, for which it must pay S&P between \$5,000 and \$7,000 for the research involved.
- A rating may have been requested but S&P has yet to complete research.
- S&P's rating was judged by the insurer's management to be unfavorable and thus S&P is pledged by contract not to make it public.

"You would naturally expect that in the early phases of this sort of program the companies with the best ratings will be the ones listed earliest," says Ronald M. Davidow, the S&P vp who runs the rating program and is a former official of Insurance Co. of North America.

"We're trying to build a system where people will look for the rating," he adds. "A company not being rated should eventually feel the effects of that."

Among major property/casualty insurers yet to be rated on either their debt, commercial paper or claims-paying ability are Chubb Corp., Commercial Union Insurance Cos., Liberty Mutual Insurance Co., Sentry Insurance Cos.

and Wausau Insurance Cos.

Commercial Union, for instance, has not yet been contacted by S&P for a rating session, a spokesman notes. "They probably haven't gotten around to us."

Reaction to the S&P program from insurers that have been rated is difficult to gauge. Spokesmen for several insurers contacted—including some given a AAA rating—seemed unaware of the program. Those that were aware of the rating service said they didn't plan to tout their good rating.

CNA said it had met two weeks ago with Standard & Poor's analysts to argue that its rating should be upgraded and had been promised a reply shortly.

"I think you know that they place great weight on combined ratios," said the spokesman. "We think the system ought to place greater emphasis on reserve strength and operating results, where we compare strongly."

Indeed, S&P's Mr. Davidow notes, it was primarily what he termed CNA's pattern of higher combined ratios than the rest of the property/casualty industry that resulted in the lower rating.

CNA's combined ratio reached 118.2% for the six months ended June 30, according to figures provided by the company (BI, Aug. 29). The aggregate combined ratio of 29 companies surveyed by *Business Insurance* for the same period was 111.9%.

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Industry's latest numbers could contain a scare or two

By MYRON M. PICOULT
Special to Business Insurance

WITH HALLOWEEN just around the corner, we suspect that the upcoming third-quarter underwriting and operating results from the commercial property/casualty insurers will be full of more tricks than treats.

Our estimate is that when all the figures are tallied, the quarter will prove to be worse than industry observers had prognosticated. The industry's intransigence on rates, its shrinking investment income growth and the higher level of catastrophe losses in this year's third quarter, compared with the third quarter of 1982, will have taken their toll on results.

It is difficult to believe that the industry continues to sell its product below cost. Although current returns on equity figures appear acceptable, pricing at the margin is incomprehensible. Logic implies that at some point the industry will stop just giving its product away.

As we dust off our crystal ball, one can sense that some investors may attempt to outguess the property/casualty industry's fundamentals (or lack of them) and bet on the belief that operating trends will have to change... hopefully sooner rather than later. This is a bet that has been made several times over the past few years, only to be later proven wrong. And, so far, none of the traditional road signs marking a turn in the marketplace are in view.

We can only note that this has not been a

Myron M. Picoult is senior vp and senior insurance analyst with Oppenheimer & Co. in New York. He is the past president of the Assn. of Insurance & Financial Analysts and a member of the New York Society of Security Analysts. His column appears the fourth Monday of every month.



Mr. Picoult

traditional underwriting cycle and that the pressure for change appears to be really building in the commercial insurers' executive suites.

And as Oct. 31 approaches and everyone awaits the release of the third-quarter statistics, we hear the insurance industry is preparing for its first annual Halloween party. In order to make it a really gala affair, a committee representing both large and small stock and mutual companies has established certain guidelines.

The event, of course, will be a masquerade party at which all of the guests will have to shed their conservative three-piece business suits for the more traditional Halloween garb of costumes and masks. Given the commercial insurance industry's dismal operating performance over the past few years and the less-than-spectacular outlook for the near future, the use of masks can be readily understood.

And we hear that while the traditional Halloween colors of orange and black will be worn by many of the guests, participants have been urged by the committee to go easy on the black trimmings, given the industry's already maudlin appearance.

It is also our understanding that the party is to be held outdoors, as opposed to in a regular party room. Apparently there is some concern about skeletons in closets and ghosts running rampant. Jack-o'-lanterns will be strategically placed around the periphery of the field where the party will be held to scare off black cats and witches. In addition, goblins will be running amok to snare any gate-crashers.

But, then again, why would anyone want to crash this party? And, we don't quite understand how the jack-o'-lanterns will deter the witches on brooms from sweeping down on their prey.

All of the traditional Halloween fare will be served, including pumpkin pie, candy corn and candied apples. There also will be the usual assortment of party games, including Bobbing for Earnings, Pin the Tail on the Cycle and The Egg Throw Competition.

The latter game will be aimed at those responsible for the current low level of commercial insurance prices. The masks are sup-

posed to conceal the identities of the guilty parties.

However, perhaps all of this implies that the guests will have egg on their faces before the party is over.

Of all these scheduled activities, the bobbing contest will take place after the insurance industry guests have gone trick-or-treating, seeking out specialty markets and niches that hopefully will enable them to ride out this extended competitive market in better shape than heretofore has been the case.

Financial briefs Hurricane losses

The Texas Catastrophe Property Insurance Assn. says that its losses from Hurricane Alicia should be less than half its original \$300 million estimate.

"Fortunately, sustained winds from the storm were considerably less than originally expected," explains TCPIA Chairman Don J. Manthe. "And, although damage was widespread and Alicia generated thousands of claims, we have now paid a sufficient number of claims to reasonably predict that property damage was not as severe as we once feared."

Texas law requires the approximately 360 property/casualty insurers that operate in the state to belong to the TCPIA, a catastrophe pool that underwrites wind and hail risks that are refused by the regular commercial insurance marketplace.

The pool was formed in 1971 after Hurricane Celia hit the Texas coast and many commercial insurers refused to continue underwriting high-risk property along the Galveston shore, the same area that was devastated by Hurricane Alicia in August (BI, Aug. 29).

The TCPIA's original \$300 million loss estimate was based on the fact that the pool had \$1.5 million of exposures in the two-county area hit by Alicia and that losses would equal 20% of the total insured value based on early reports of property damage and the storm's wind speed.

USLIFE

The directors of USLIFE Corp. have voted to continue a stock repurchase program begun in September 1982, under which the company will buy back up to 1 million shares of its common stock in the open market or through negotiated transactions.

The repurchases will be made "from time to time" as market conditions warrant, the company said. The stock repurchase program is due to expire in September 1984.

Meanwhile, USLIFE Credit Corp., a subsidiary, said it has completed the sale of nearly all of its consumer credit receivables to Norwest Financial Inc. (formerly Dial Financial Corp.), a financial services holding company based in Des Moines.

The sale produced \$45 million in cash for USLIFE.

St. Paul

St. Paul Cos. Inc. says it bought 1.36 million shares of its own common stock from American General Corp. at "about \$60" per share. The stock represented 6.4% of St. Paul's total shares outstanding.

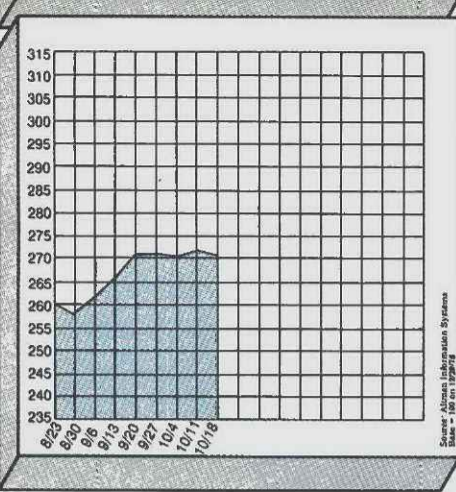
Travelers

Travelers Corp. announced a regular quarterly dividend of 45 cents per common share payable Dec. 10 to shareholders of record Oct. 31.

Northwestern National

Northwestern National Life Insurance Co. has declared a regular quarterly dividend of 37.5 cents per share of its common stock payable Nov. 11 to shareholders of record Oct. 26. The company has 3.52 million common shares outstanding.

BI Insurance Index



The Business Insurance stock index faltered during the five-day trading period ending Oct. 18, dropping 3.2 points to 270.5 from 273.7. Sixteen stocks closed up, 37 issues closed down and 11 were unchanged. The largest gains were posted by Frank B. Hall & Co. Inc., 12.2%; American Bankers Insurance Group, 5.9%; Fremont General Corp., 3.6%; American General Corp., 2.3%; and Marsh & McLennan Cos. Inc., 2.0%. The largest losses were reported by Reed Stenhouse Cos. Ltd., 11.1%; Old Republic International Corp., 10.0%; Alexander & Alexander Services Inc., 6.6%; Equifax Inc., 6.2%; and United Services Life Insurance Co., 5.4%. The BI index of insurance industry stocks posted a 1.2% decrease, while the New York Stock Exchange composite reported a drop of 1.6%.

British Issues

18 Oct Companies	Price	P/E	Div. pence	Yield %	1 Week High-Low
Comm Union	154	154.0	16.86	10.9	154-152
Eagle Star	468	16.7	24.29	6.0	468-445
Genl Accident	398	10.3	24.29	6.6	412-390
Gdn Royal Exch	441	11.0	27.26	7.0	457-433
Phoenix	318	13.8	25.00	8.2	318-308
Royal	478	11.9	37.86	8.2	490-472
Sun Alliance	1175	13.5	68.57	6.7	1175-1150

Brokers	Price	P/E	Div. pence	Yield %	1 Week High-Low
CE Heath	285	7.1	21.07	8.0	288-283
Hogg Robinson	117	9.0	8.57	8.1	117-113
JH Minet	121	9.3	6.50	6.3	128-119
Sedg Grp	217	10.9	10.00	5.3	217-214
Stenhouse Hldg	99	9.0	7.86	8.4	101-98
Stew Wrightson	245	8.2	20.43	9.2	247-245
Willis Faber	560	11.7	25.00	5.4	565-560

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

BI Industry Stock Report

OCT. 18, 1983 10/12/83 THRU 10/18/83

Insurance Cos.	Price	% Chg.	P/E	\$ Div.	% Yld.	High	Low	Vol. (000)
Aetna Life & Cas Co	NYSE	36.50	-4.9	8.9	2.44	7.2	37.75	36.50 1,020.3
American Bankers Ins Group	OTC	13.38	5.9	10.4	0.50	3.7	13.38	12.63 51.2
American Gen Ins Co	NYSE	22.25	2.3	8.1	0.80	3.6	22.25	21.75 702.6
American Intl Finl Corp	OTC	17.63	0.0	12.2	1.12	6.4	17.63	17.63 2.7
American Intl Group Inc	OTC	67.25	-3.6	11.3	0.44	0.7	69.75	67.25 1,199.8
American Natl Ins Co	OTC	20.38	-4.7	8.1	0.96	4.7	21.13	20.38 32.9
American Sts -life Ins Co	OTC	41.50	0.6	11.4	0.88	2.1	41.50*	41.25 1.1
Aneco Reins Ltd	OTC	2.75	-4.3	68.7	0.00	0.0	2.88	2.75 12.4
Avenco Corp	AMEX	20.00	-1.8	12.3	0.58	2.9	21.00	20.00 49.7
Banks Iowa Inc	OTC	49.00	-1.0	17.9	1.52	3.1	49.50	49.00 9.0
Bitco Corp	OTC	20.25	1.2	8.7	1.33	6.6	20.25	20.00 45.8
Carolina Gas Ins Co	OTC	9.00	-2.7	0.0	0.32	3.6	9.25	9.00 11.4
Chubb Corp	OTC	65.38	-2.6	8.1	3.12	4.8	67.75*	65.38 120.2
Combined Intl Corp	NYSE	37.38	-3.5	11.9	2.00	5.4	37.75	37.38 77.6
Continental Corp	NYSE	30.13	-2.8	18.5	2.60	8.6	31.13	30.13 232.0
Crawford & Co	OTC	15.75	-3.1	11.7	0.60	3.8	16.25	15.75* 13.2
Crown Life Ins Co	OTC	125.00	0.0	8.2	3.10	2.5	125.00	125.00 0.5
Employers Cas Co	OTC	33.75	-2.2	6.9	1.20	3.6	34.50	33.75 2.2
Equifax Inc	NYSE	30.50	-6.2	12.9	1.40	4.6	32.75	30.50 25.9
Excelsior Ins Co	OTC	20.50	0.0	17.2	0.00	0.0	20.50	20.50 0.9
Farmers Group Inc	OTC	40.00	-0.3	10.1	1.36	3.4	40.13	40.00 446.3
Foremost Corp Amer	OTC	31.25	0.8	9.6	0.83	2.6	31.25	31.00 97.4
Fremont Gen Corp	OTC	14.38	3.6	65.3	0.48	3.3	14.38	14.00 368.8
Great West Life Assurn Co	OTC	250.00	0.0	9.0	11.00	4.4	250.00	250.00 0.5
Hanover Life Co	OTC	60.50	-2.0	7.5	0.88	1.5	61.50	60.50 8.7
Hartford Steam Boiler Insprnt	OTC	54.00	0.0	11.3	3.00	5.6	54.00	53.50 4.5
Jefferson Natl Life Ins Co	OTC	43.00	-1.1	13.4	0.76	1.8	43.50	43.00 7.9
Kemper Corp	OTC	40.88	-0.3	7.6	1.80	4.4	40.88	40.00 55.8
Lincoln Natl Corp Ind	NYSE	56.00	-1.8	8.9	3.00	5.4	56.50	56.00 45.0
Mission Ins Group Inc	NYSE	28.38	-3.8	10.5	1.00	3.5	29.50	28.38 53.7
Nationwide Corp Ohio	OTC	41.75	0.0	15.3	0.70	1.7	0.00	DID NOT TRADE
Northwestern Natl Life Ins	OTC	36.63	-1.0	24.3	1.50	4.1	37.00	36.63 32.4
Ohio Cas Corp	OTC	49.00	-1.5	9.0	2.52	5.1	49.50	49.00 63.9
Old Red Intl Corp	OTC	30.25	-10.0	7.0	0.90	3.0	33.25	30.25 44.4
Orion Cap Corp	NYSE	29.38	0.4	14.7	0.66	2.2	30.13*	29.38 81.6
Preferred Risk Life Ins Co	OTC	20.50	1.9	8.2	0.67	3.3	20.50	20.13 2.4
Provident Life & Acc Ins Co	OTC	65.00	-0.8	8.3	2.60	4.0	65.50	65.00 6.3
St Paul Cos Inc	OTC	59.13	-1.9	6.8	2.80	4.7	60.38	59.13 267.5
SAFECO Corp	OTC	59.13	1.1	12.1	2.40	4.1	59.13	58.50 76.1
Sri Corp	OTC	19.25	-4.9	7.2	0.56	2.9	19.75	19.25 95.7
Seibels Bruce Group Inc	OTC	24.38	-2.5	14.4	0.80	3.3	24.50	24.38 24.8
Statesman Group Inc	OTC	11.63	1.1	8.1	0.15	1.3	11.63	11.38 165.8
Tokio Marine & Fire Ins Co	OTC	108.38	-0.8	17.4	0.96	0.9	109.00	106.50 5.7

OCT. 18, 1983 10/12/83 THRU 10/18/83

	Price	% Chg.	P/E	\$ Div.	% Yld.	High	Low	Vol. (000)
Travelers Corp	NYSE	32.25	-0.4	8.3	1.80	5.6	33.00	32.13 820.8
United Fire & Cas Co	OTC	32.25	0.0	11.5	0.88	2.7	32.25	32.25 0.1
United States Fid & Gty Co	NYSE	55.50	-1.3	11.0	3.84	6.9	56.13	55.50 252.9
United Svcs Life Ins Co	OTC	21.75	-5.4	6.2	1.00	4.6	22.63	21.75 96.0
Wafco Corp	NYSE	26.50	0.5	7.8	0.88	3.3	27.00	26.38 71.4
Washington Natl Corp	NYSE	27.75	1.8	12.3	1.08	3.9	29.50	27.75 126.3
Zenith Natl Ins Corp	OTC	16.25	-1.5	11.4	0.60	3.7	16.50	16.25 16.6
INSURANCE COMPANIES	AVERAGE		10.0		3.7			
Agents/Brokers								
Alexander & Alexander Svcs	NYSE	19.38	-6.6	0.0	1.00	5.2	20.88	19.38 174.6
Baldwin & Lyons Inc	OTC	38.50	0.0	12.4	0.80	2.1	38.50	38.50 0.0
Corroon & Black Corp	NYSE	24.13	0.5	16.6	1.80	7.5	24.13	24.00 17.0
Crump E H Cos Inc	OTC	9.75	0.0	14.1	0.40	4.1	9.75	9.75 13.2
Ewert & Chandler Cos Inc	OTC	10.63	0.0	0.0	0.00	0.0	10.63	10.63 1.0
Hall Frank B & Co Inc	NYSE	27.50	12.2	21.7	1.70	6.2	27.50	24.88 210.6
Integrated Res Inc	AMEX	35.75	-5.0	13.3	0.00	0.0	36.00	33.75 128.6
Marsh & McLennan Cos Inc	NYSE	44.63	2.0	12.9	2.20	4.9	45.00	43.50 326.2
Poe & Assoc Inc	OTC	6.00	0.0	0.0	0.00	0.0	6.00	6.00 0.6
Reed Stenhouse Cos Ltd	OTC	12.00	-11.1	20.0	0.60	5.0	13.50	12.00* 3.7
AGENTS/BROKERS	AVERAGE		18.0		3.7			
Conglomerates/Holding Cos.								
American Express(Fireman's Fd)	NYSE	33.75	-13.2	9.8	1.28	3.8	38.38	33.75 4,468.4
Anderson Clayton(Ranger/PanAm)	NYSE	27.75	-2.6	15.9	1.32	4.8	28.75	27.75 17.0
Araco Inc	NYSE	19.38	-0.6	0.0	0.40	2.1	19.63	19.38 235.6
Baldwin Utd Corp	NYSE	3.00	-4.0	1.4	0.00	0.0	3.13	3.00* 504.3
CIGNA Corp	NYSE	45.63	-1.9	7.3	2.48	5.4	46.50	45.38 737.0
City Investing Co. (Home Ins.)	NYSE	35.00	-4.8	10.7	1.80	5.1	36.50	35.00 262.0
CNA Finl Corp (CNA)	NYSE	22.25	-0.6	7.7	0.00	0.0	22.50	22.25 32.9
Control Data (Comm. Credit)	NYSE	48.00	-6.8	11.7	0.60	1.3	51.38	48.00 1,350.5
General Re Corp	NYSE	64.50	-4.4	13.4	1.28	2.0	66.50	64.50 275.8
Gulf Utd Corp	NYSE	28.88	2.7	8.7	1.32	4.6	29.13	28.00 282.2
ITT (Hartford Group)	NYSE	42.00	-5.9	9.0	2.76	6.6	43.38	42.00 1,613.7
Optimum Hldg Corp	OTC	6.13	-2.0	19.8	0.00	0.0	6.25	6.13* 1.6
Sears Roebuck & Co. (Allstate)	NYSE	37.88	-5.3	12.1	1.52	4.0	39.75	37.88 2,841.5
Teledyne Inc (Argonaut)	NYSE	166.00	-1.0	14.8	0.00	0.0	169.00	164.00 635.4
Transamerica Corp								
(Occidental & Fred S. James)	NYSE	28.63	-1.3	9.8	1.56	5.4	29.50	28.63 360.1
CONGLOMERATES/HOLDING COS.	AVERAGE		13.2		2.7			

*Record high/low since Jan. 1, 1983

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Other advantages include more effective and efficient use of employer contributions, the opportunity to contain escalating benefit costs, greater employee appreciation of benefits, reduced pressure for across-the-board increases in benefits, and a progressive employer image. Not least, Starscan helps employers recruit and retain employees.

Q. How does the Starscan flexible benefit approach work?

A. In the way best suited to meet the needs of you and your employees. For example, existing benefits might be kept as they are, or

reduced to a standard core for all employees. In either case, employees would be given credits to purchase additional benefits to fit their needs. Benefits beyond those the credits would buy could be purchased through payroll deductions.

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Q. What about cost?

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Q. How can I get a brochure describing Starscan?

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