

# Business Insurance

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## Louisiana regulators seize physician risk retention group

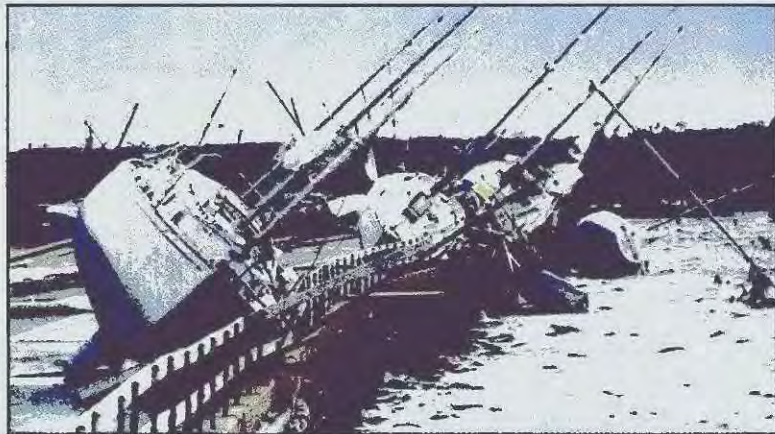
BATON ROUGE, La.—Louisiana regulators have placed Physicians National Risk Retention Group in conservatorship.

The order earlier this month follows cease-and-desist orders and other actions against the malpractice insurer in about 14 other states, said a Louisiana Insurance Department spokeswoman.

The spokeswoman would not comment on the reasons for the conservation order, the terms of which are confidential. But, many regulators have been concerned about

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## Insurers spared Bob's wrath



Hurricane Bob brought winds of more than 100 knots to a Padanaram, Mass., marina and beached dozens of sailboats.

## Hurricane's damage much less than feared

By MICHAEL BRADFORD  
and MICHAEL SCHACHNER

Insurers and property owners dodged a bullet named Hurricane Bob last week, as the windstorm packing 125-mph winds lashed directly at New England but caused less damage than feared.

The first claims to come from Hurricane Bob's march up the East Coast stemmed primarily from damage to boats, houses and cars, insurers said.

While most insurers could not estimate claims, they did not regard the storm as a major disaster.

"It wasn't as bad as it could have

been," said Allstate Insurance Co. spokesman in Northbrook, Ill. "It was nothing like Hugo," he said, referring to 1989's Hurricane Hugo, which caused \$4.2 billion in insured damage in the United States.

In fact, many doubt insured damage from Bob will top the \$418.8 million caused by Hurricane Gloria in 1985, the last major hurricane to hit the Northeast.

"As far as heavy storms go, I'd say that this was less destructive than Hurricane Gloria six years ago," said M. Renwick Severance, vp-specialty services with Republic Hogg Robinson Inc. in Boston.

The Property Claim Services division of the American Insurance Services Group said it would not estimate insured damage from the storm until later this week.

The damage caused by Hurricane Bob "was widespread but it's all very small," said a spokesman for Hartford Insurance Group in Hartford, Conn. The insurer expects its gross claims from the storm to total \$15 million to \$25 million.

While Massachusetts Gov. William Weld early last week announced damage to that state totaled as much as \$1 billion, "we expect that insured property dam-

*Continued on page 4*

## Maryland court upholds key D&O policy exclusion

By STACY ADLER

ANNAPOLIS, Md.—Insurers nationwide are breathing a sigh of relief in the wake of state supreme court ruling that upholds a key directors and officers liability policy exclusion that protects many insurers from claims from savings and loan failures.

The Maryland Court of Appeals, the state's highest court, on Aug. 16 unanimously upheld the exclusion found in many D&O policies that bars coverage for claims resulting from regulatory action against a failed thrift.

Reversing two lower courts, the Court of Appeals found that there were no public policy reasons to strike down the so-called "regulatory" exclusion.

In addition, the court found that there were no public policy arguments to strike down the "insured vs. insured" exclusion in D&O policies, which bars coverage when institutions sue their officers.

However, the court found that the wording of the insured vs. insured exclusion was ambiguous in suits by the receiver of a failed thrift against its directors and officers and, therefore, does not bar coverage in such cases where no regulatory exclusion existed.

"This was not a total win for the insurers," said Neil Dilloff of Piper & Marbury in Baltimore, who re-

presented the Maryland Deposit Insurance Fund, an S&L insurance fund that sued a failed thrift's officers.

"We won one out of two," said Mr. Dilloff, noting that while the court upheld the regulatory exclusion, it did not uphold the insured vs. insured exclusion in this case.

The ruling stems from the insur-

*If the opinion had been upheld, it would be very difficult for financial institutions 'to buy D&O insurance in Maryland or anywhere else.'*

—Ed Armstrong

ance fund's 1987 lawsuit against officers of First Maryland Deposit Insurance Assn. in Silver Spring, Md., which the fund took over in November 1985. After winning \$387 million in judgments against the officers, the MDIF sued to recover some of this amount from the S&L's D&O insurer, American Casualty Co. of Reading, Pa.

The CNA Financial Corp. unit wrote \$3 million in D&O coverage for the thrift from Oct. 1, 1984, to Oct. 1, 1986. There was a \$5,000 deductible.

D&O insurers nationwide have closely watched this case because they fear that D&O policies could be tapped to help bail out failed savings and loans. The cost of the bailout could reach \$500 billion.

"If the lower court opinion had been upheld, it would be very difficult" for financial institutions "to buy D&O insurance in Maryland or anywhere else," said Ed Armstrong, a risk management consultant in the Washington, D.C., office of The Wyatt Co.

"It is very difficult for an insurer to sell its product if it doesn't know if the language will be upheld by the courts," Mr. Armstrong said.

American Casualty attorney Thomas S. Schaufelberger agreed: "Prior to this recent ruling, there was a growing concern among D&O insurers. Insurers didn't feel they could underwrite if they didn't know if the policy provisions would be upheld.

"This decision alleviates that concern," said Mr. Schaufelberger of Drinker, Biddle & Reath in Washington, D.C.

"We are pleased the highest court has reversed" the lower court's ruling, said Bob Cox, assistant vp-financial institutions at Chubb & Son Inc. in Warren, N.J., which has been closely following the Maryland case.

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Muscovites crowd the plaza in front of the Moscow City Hall last week to call for Mikhail Gorbachev's return to power.

## Insurers still wary of Soviet risks

By DOUGLAS McLEOD

Political risk underwriters and companies doing business with the Soviet Union are waiting to see how the dust settles from last week's failed coup before resuming Soviet activities.

The abortive attempt to oust Soviet President Mikhail Gorbachev stopped Western exporters and investors dead in their tracks and sent credit and political risk underwriters scurrying to assess their Soviet exposures.

Many exporters were advised to discontinue shipments, while companies considering joint ventures or other investments in the Soviet Union put their plans on hold.

With the Soviet economy deteriorating, credit and political risk insurance markets had been severely restricted for months. When the hard-line Putsch was announced last Monday, the insurers closed out Soviet risks entirely.

By midweek, though, as the coup leaders fled Moscow and Mr.

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Texas federal judge reverses controversial comp ruling

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New HMO premium rules to give employers flexibility

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Insurers promise to fight latest Proposition 103 rules

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Update

Malpractice insurer restricted

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the risk retention group's discounting of loss reserves.
When Physicians National was licensed in 1987, then-Insurance Commissioner Sherman Bernard allowed it to discount reserves, the department spokeswoman confirmed. Regulators have since negotiated a three-year phase-out of the discounting practices.
Regulators in Arizona obtained a temporary restraining order Aug. 16 barring Physicians National from writing new or renewal business in the state because of its reserve discounting practices, Deputy Insurance Director Joseph M. Hennelly Jr. said.
Physicians National, based in Marietta, Ga., reported writing \$10.5 million in direct premiums in 44 states in the first six months of this year, with Texas and Arizona each accounting for more than \$2 million in premium volume. Direct written premiums for 1990 totaled \$22.8 million.
Physicians National reported surplus of \$8 million as of June 30.

Aetna mortgage problems grow

HARTFORD, Conn.—A 49.4% hike in mortgage loan impairment reserves made at midyear by Aetna Life & Casualty Co. may not adequately shield it from more real estate losses, the company admits.
Hartford, Conn.-based Aetna, whose mortgage investments are among the industry's largest, increased mortgage loss reserves to \$466 million as of June 30 from \$312 million at year-end 1990. A spokesman said that \$244 million of the total is designated for losses that have not yet occurred but probably will.
"Increasing reserves is only a prudent thing to do considering the conditions in the real estate market," the spokesman said.
Aetna would not comment on how much more it may have to add to reserves if the commercial real estate market continues to deteriorate. Areas of concern include mortgages, foreclosures and commercial real estate holdings, the spokesman said.
But, Aetna Chairman James T. Lynn pointed out that over the past four quarters the company reported gross income of nearly \$500 million and more than \$300 million in net earnings.
Citing Aetna's heavy exposures to bad real estate investments, Moody's Investors Service Inc. last month downgraded the financial strength rating of two of the insurer's units—Aetna Life Insurance Co. and Aetna Life Insurance & Annuity Co. (BI, July 29).

Phillips 66 to pay record fine

WASHINGTON—Phillips 66 Co. has agreed to pay a record \$4 million fine to settle Occupational Safety and Health Administration charges that willful and serious violations of federal safety rules led to a 1989 explosion at its Pasadena, Texas, petrochemical plant.
The catastrophic explosion killed 23 workers and injured 130 others (BI, Oct. 30, 1989).
OSHA originally had proposed a \$5.66 million fine against Phillips 66, a subsidiary of Bartlesville, Okla.-based Phillips Petroleum Co., charging 575 willful and serious safety violations.
As part of the settlement, Phillips 66 has agreed to implement corporate-wide safety measures, including developing processes for identifying potential safety hazards at its plants and developing systems for handling those problems.
In addition, Phillips 66 agreed to improve safety training for its employees and for contractor workers to help them better understand the specific hazards posed by chemicals at worksites. OSHA had charged that Phillips 66 failed to prevent the release of flammable gases and was inadequately prepared to respond to the release of the gases.
Phillips 66 President B.M. Thompson said: "We felt it was best to try and reach a settlement to allow both parties to avoid potentially long and costly litigation."

'Alliance' lawyers sentenced

SAN DIEGO—The first criminal sentences have been handed down against two lawyers accused of being part of a network known as the "Alliance" that defrauded California insurers by manipulating and prolonging litigation to inflate legal bills.
Barry J. Krasner, 42, of New York, pleaded guilty to a single felony count of lying on an income tax return and was sentenced to 16 months in a federal prison and 200 hours of community service.
And, Mark M. Geysers, 41, of Encino, Calif., pleaded guilty to two misdemeanor tax violations and was sentenced to three years of probation and 200 hours of community service.
Still awaiting sentencing are more than a dozen other lawyers who either have been found guilty or have pleaded guilty to various charges.
Many of the same attorneys also are named in a massive civil fraud lawsuit in which Fireman's Fund Insurance Co., Allstate Insurance Co. and State Farm Insurance Co. allege they were bilked out of more than \$200 million (BI, April 2, 1990).
The government is searching for fugitive attorney Lynn Boyd Stites, who allegedly conceived and organized the Alliance, said Assistant U.S. Attorney William Q. Hayes.

Building manager liable in rape

CORPUS CHRISTI, Texas—An apartment management company is considering appealing a \$17.1 million Texas state court jury award to a woman who was raped by a man who entered her apartment using a key that he stole from the company's office.
The judgment is unusual because it includes \$3 million in actual damages awarded under the Texas Deceptive Trade Practices Act.
The rape victim charged Berry Property Management Inc. of Corpus Christi violated the act because she was unfairly denied an extra
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Errors and omissions

Keith Like is executive vp of Kemper National Insurance Cos., not Kemper Corp. as reported in the Aug. 19 issue.

Texas ruling that bars employee suit reversed

By MICHAEL BRADFORD

DALLAS—A federal judge reversed his own decision that had blocked an injured worker from recovering tort damages against her Texas employer that had opted out of the state workers compensation system.
Texas employers considering abandoning the state system had been encouraged by the earlier ruling, believing it would protect them from tort claims filed by injured employees.
The May 16 ruling involved Wyatt Cafeterias Inc., which provided benefits for employees injured on the job through a special employee benefit plan rather than through the workers comp system.
U.S. District Judge Barefoot Sanders ruled in May that Wyatt was exempt from negligence and breach of contract claims filed by an injured worker because the benefit plan was subject to the federal Employee Retirement Income Security Act of 1974, which prohibits such employee suits.
The Texas Attorney General and the U.S. Labor Department filed briefs objecting to his decision, prompting the judge to review it.
In reversing the decision last week and remanding the case—Eurine vs. Wyatt Cafeterias—to state court,

Judge Sanders wrote that the worker's claims "are within areas of traditional state authority and do not implicate the federal concerns underlying ERISA pre-emption."
The worker and Wyatt have both a relationship governed by ERISA and a "separate and distinct employer-employee relationship," the judge wrote. "The state law claims at issue here...arise out of their employer-employee relationship. The claims do not arise out of the parties' ERISA relationship."
Judge Sanders also pointed out that "the issue of liability does not depend upon the existence of an ERISA plan; plaintiff may assert a negligence claim against defendant regardless of whether there is an ERISA plan."
The judge cited as precedent a 1989 federal trial court ruling in Hartle v. Packard Electric. As in that case, the Wyatt case does not "implicate the federal regulation of employee benefit plans...is not an action to recover benefits under a plan (and does not)...encompass the processing of claims for benefits under a regulated plan," he wrote.
Joe Williams, president of Risk Analysts Inc., a Houston firm that advises Texas employers on whether to become "non-subscribers" to the workers comp system, pointed out that businesses shouldn't base their

decisions solely on the Wyatt case.
"Anybody that made a decision based on that ruling was making a faulty decision," he said. "The issue of whether or not a plan is an ERISA plan should not be a determining factor" in an employer's decision to pull out or stay in the system.
"There are much more serious issues involved," Mr. Williams noted. Among them are employee morale, senior management's philosophy of caring for injured workers, and the risk management and safety programs that are in place.
Several pending cases could be affected by Judge Sanders' decision, said Texas Assistant Attorney General Fred Lewis.
Another ruling involving Wyatt was overturned last Wednesday. U.S. District Judge Jerry Buchmeyer granted an injured employee's motion for reconsideration and vacated his July decision to dismiss a charging negligence. Judge Buchmeyer's July decision, like Judge Sanders' first ruling, stated that Wyatt's benefit plan was subject to ERISA and thus exempt from state law claims.
Wyatt also was named in at least two other similar lawsuits in Texas, Mr. Lewis said.
Texas, New Jersey and South Carolina are the only three states that allow employers to opt out of the workers comp system.

Info needed for global directories

Deadlines are approaching for two Business Insurance directories.
One will list global property/casualty insurers and another will include multinational employee benefit networks. These directories will be published in the Oct. 7 issue, which will contain a Spotlight Report on trends in international risk management and employee benefits.
Companies must complete a BI questionnaire to be listed in the directories; there is no charge to be included.
If your company is a global property/casualty insurer or a participant in a multinational benefit network and you have not yet received a questionnaire, please contact Karen Armaganian at 312-280-3195, or by fax at 312-280-3174.
Completed questionnaires are due Sept. 9.

New group to fight health care mandate

By JERRY GEISEL

WASHINGTON—A new lobbying group is being organized to give business a stronger and more powerful voice to oppose proposals that employers be required to provide health care benefits.
The Healthcare Equity Action League was formed this month by several major Washington, D.C.-based trade associations: the Food Marketing Institute, the Healthcare Leadership Council, the National Assn. of Wholesaler-Distributors, the National Federation of Independent Business and the National Restaurant Assn.
"Our organizations decided to create HEAL because we believe there is a vacuum in the business community relative to formulating a unified agenda for reform of the American health care system," HEAL said in a letter to prospective members.
"Business will benefit by a coalition that brings together as many

parties as possible. Health care is of such importance that individual employer voices probably will not be loud enough to make a difference," said NAW President Dirk Van Dongen.
"HEAL will provide an opportunity for business groups to join together so their influence can be felt by policymakers. This coalition can make a difference," Mr. Van Dongen said.
While business groups had been informally discussing forming a lobbying group on health care issues for about two years, the introduction in June of universal health care access legislation by the Senate Democratic leadership was the catalyst that led to the formation of HEAL, said Carolynn Miller, legislative representative at the NFIB.
That legislation, among other things, would require employers to offer health care coverage or be hit with new federal taxes (BI, June
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Inside

- Rep. Dan Rostenkowski's health care access plan is a refreshing—yet troubling—break from myriad other proposals, this week's editorial says. PAGE 8
Captive insurers express concern about federal insurance regulation proposals during the Vermont Captive Insurance Assn. conference. Coverage begins on PAGE 12
A lack of understanding between insurers and health care providers leads to inefficient use of resources and higher insurance premiums for employers, says Ryland P. Davis of Synergos Inc. in Perspectives. PAGE 19
Chilington Intermediaries Ltd. has canceled plans to establish a commercial asbestos information service, rather than compete with a similar non-profit venture. PAGE 23

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# Insurers protest Prop. 103 rules

By LOUISE KERTESZ

SACRAMENTO, Calif.—Insurers maintain that new regulations to implement Proposition 103's rollback provision and the proposed rate of return on which rollbacks would be based are both illegal and unfair and will be challenged in court.

Insurers contend the regulations and proposed rate of return violate both the mandate of the controversial voter initiative and a California Supreme Court decision that modified Proposition 103 by declaring that insurers are entitled

to a fair rate of return.

In particular, insurers say the new regulations unfairly limit the amount of surplus that California regulators will consider when determining an insurer's rate of return for rollback purposes.

The regulations also give the insurance commissioner authority, when determining rollbacks, to restrict insurers' profitability for one line of business but allow them to make up those lost profits in another line, which insurers say is inequitable. Some say Mr. Garamendi may penalize commercial lines insurers to ensure larger roll-

backs for personal auto insurance.

Insurers and brokers warn that Proposition 103-related costs might again cause insurers to consider withdrawing from the California market.

Insurance Commissioner John Garamendi said earlier this month that the new regulations and proposed rate of return would result in \$2.5 billion in refunds to policyholders (BI, Aug. 19). The department expects to issue the first rollback orders in a couple of weeks, a spokeswoman said.

Most insurers *Business Insurance* contacted would not speak for

attribution. Because the commissioner has yet to issue specific rollback orders, "no one wants to bring the commissioner's attention to themselves," one insurer said.

"Since he has limited resources to single out companies" for the first rollback orders, "why holler in his face?" he added.

"All of the companies are waiting to see what comes out of the black box, besides political witchcraft," another insurer said, referring to the regulations.

Insurers say their challenge to Mr. Garamendi's regulations may proceed through individual suits.

But, a challenge also may come through an appeal that 84 insurers have filed over a Los Angeles County Superior Court ruling that denied their petition to halt Insurance Department hearings on implementing Proposition 103 (BI, April 15).

Since Mr. Garamendi became the state's first elected commissioner in January, a position created by Proposition 103, political rhetoric has intensified, with the commissioner pitted against the insurance industry.

The new regulations "follow no  
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## Risk Manager of the Year

### Nominations sought for 1992 competition

Would you like to see the outstanding achievements of a risk manager you know recognized by his or her peers and the public?

Nominate that risk manager for the 1992 *Business Insurance* Risk Manager of the Year award.

Your nominee could be named the 15th *Business Insurance* Risk Manager of the Year, or named to the *Business Insurance* Risk Management Honor Roll.

The honorees will be selected based on information reported in a nominating form, which is available from *Business Insurance*. The deadline for submitting nominations is Nov. 19.

"Anyone who plans to nominate a candidate should request a nominating form from us immediately," advised Kathryn J. McIntyre, associate publisher and editor of *Business Insurance*.

"Obtaining all the information required to prepare the best nomination takes time, so it's advantageous to begin the nominating process as soon as possible," she explained.

Ten independent judges will select the honorees. The judges will include the four 1991 honorees:

- Arnel L. Davenport, vp-risk management for Marriott Corp. in Bethesda, Md., the 1991 Risk Manager of the Year.

- Donald D. Batchelor, risk manager of Union Planters Corp. in Memphis, Tenn., who was named to the 1991 Honor Roll representing financial insti-

tutions.

- Mary L. DeCampi-Stewart, risk manager for the Metropolitan Washington Airports Authority in Washington, D.C., who was named to the 1991 Honor Roll representing government entities.

- Rod Umschied, risk management director at the University of California in Berkeley, who was named to the 1991 Honor Roll representing non-profit institutions.

"These leaders in risk management, who were honored for their accomplishments last year, will now contribute to selecting the 1992 honorees," Ms. McIntyre said.

The other six judges for the 1992 award—leaders in the insurance business, consulting and education—will be announced shortly.

The 1992 honorees will be announced in the March 30, 1992, issue of *Business Insurance*, which will coincide with the annual

Risk & Insurance Management Society Inc. conference to be held in Anaheim, Calif.

*Business Insurance* created the Risk Manager of the Year award in 1977, on its 10th anniversary of publication, to recognize outstanding achievement in the field. In addition, a Risk Management Honor Roll was created to recognize outstanding achievements in risk management in different types of organizations.

The judges score each of the candidates on 10  
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Mr. Davenport



Ms. DeCampi-Stewart



Mr. Batchelor



Mr. Umschied

## Companies employ managed care in mental health plans

By SARA J. HARTY

Employers are using many managed care tools to control mental health and substance abuse costs, according to a new survey.

Nearly eight out of 10 employers surveyed require precertification of inpatient treatment for mental and nervous disorders and for alcohol and substance abuse, while about seven of 10 employers use case management in these cases, says the survey of 341 employers nationwide.

In addition, 60% of employers sponsor employee assistance programs, according to the survey, "Employer-Sponsored Alcohol/Substance Abuse and Mental/Nervous Disorders Treatment Benefits," conducted by Buck Consultants Inc. of New York.

"We are seeing more and more companies going to a managed care program" in an effort to control mental health and substance abuse treatment costs, said Richard J. Sinni, director of the health care management practice for Buck Consultants in Secaucus, N.J.

It is important for companies to offer substantial mental health and substance abuse benefits, Mr. Sinni said. "If you don't offer these benefits, those problems will end up manifesting themselves somewhere else in your benefit plan, somewhere on the medical side," he said.

However, the cost of providing these benefits can rapidly escalate if they are not properly managed, he said.

Almost 99% of the survey respondents sponsor plans that cover inpatient mental or nervous disorder treatments, the survey found.

Among the employers that spon-

sor plans covering inpatient care for mental or nervous disorders, 77% require some precertification, with 66% of those employers requiring precertification for all mental health and nervous disorder admissions and 11% requiring precertification for only non-emergency admissions.

The survey also found that 73% of the respondents vary their benefits for mental and nervous disorders based on whether covered lives meet precertification requirements or whether the company's preferred providers are used.

When precertification is required and obtained for treatment of mental and nervous disorders, 51% pay a flat percentage of charges subject to a deductible, 17% of the respondents pay a flat percentage of the charges and 32% use some other method.

When precertification is not obtained, 36% of the survey respondents pay a flat percentage of charges subject to a deductible, 8% pay a flat percentage of the charges, 51% base benefits on some other method; and 5% pay no benefit at all.

The survey noted that 32% of the respondents offer a PPO for inpatient treatment of mental and nervous disorders.

If a PPO provider is used for a mental or nervous disorder, 41% of the respondents pay a flat percentage of charges subject to a deductible, 35% pay a flat percentage of the charges and 24% use some other method of payment.

If a PPO is offered but a non-network provider is used, 54% of the respondents pay a flat percentage of charges subject to deductible, 8% pay a flat percentage of the

*Continued on page 22*

## Relief for HMO costs

### Proposal relaxes rules governing employee contributions

By JERRY GEISEL

WASHINGTON—Proposed federal rules will give employers broad flexibility in determining how much of the premium charged by health maintenance organizations they can require their employees to pay.

Those proposed rules, issued by the Department of Health and Human Services, implement a key change in federal law made by 1988 amendments to the federal HMO Act.

That change modified the so-called—and much criticized—equal contribution rule, which had

required employers to make the same premium contribution toward the premiums charged by federally qualified HMOs as they make toward their largest non-HMO health care plan, like an indemnity plan.

Federally qualified HMOs must meet certain federal standards governing, among other things, the types of benefits they offer.

Under the equal contribution rule, if an employer contributed \$200 a month toward the cost of family indemnity coverage, it would be required to contribute \$200 toward the cost of family coverage provided by a federally qual-

ified HMO, as long as the HMO premium was \$200 or more.

Noting that younger, healthier employees tend to select HMOs over indemnity plans, employers complained that the equal contribution rule forced them to pay a far greater percentage of HMO premiums than their claims experience would justify.

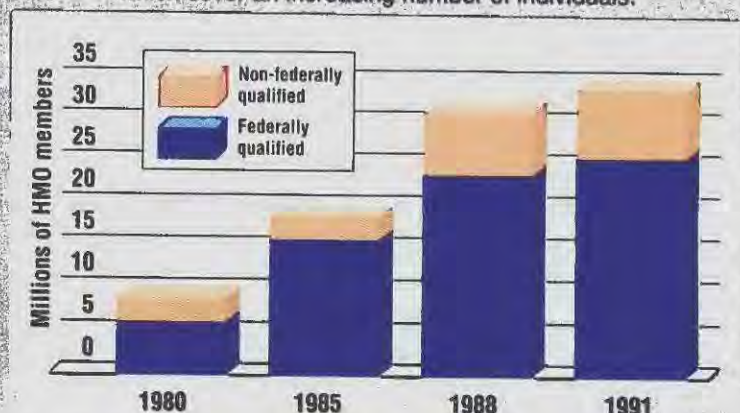
Employers also complained that HMOs employed "shadow pricing," in which HMOs tie the premiums they charge to the cost of indemnity plans.

Under the new HHS regulations, employers can continue to comply

*Continued on page 27*

### New rules to impact most HMOs

Employers likely will apply new federal rules on how to determine contributions to federally qualified HMOs to non-qualified HMOs, which cover an increasing number of individuals.



Source: Interstudy

GRAPHIC BY HOLLY SEGUINE

## Hurricane Bob

Continued from page 1

age won't be that great. We were expecting the storm to hit a lot harder than it did," Mr. Severance said.

"I'm not sure where (Gov. Weld) came up with that. They must have included everything under the sun, including lost tourism revenues. I think this was much less of a storm than was predicted," he said.

Most storm-related commercial claims probably will be business interruption claims from businesses that suffered extended power outages, Mr. Severance noted.

Denise Doyle, a commercial claims specialist in RHR's Boston field office, which also handles claims from Rhode Island and Cape Cod, said commercial claims received last week were relatively mild.

"So far, we have only received some food spoilage claims from restaurants whose refrigerators haven't been working," he said.

The area hardest hit by the storm

was the southern coast of Cape Cod, the islands of Nantucket and Martha's Vineyard, and coastal areas of Massachusetts and Rhode Island.

"The Cape got hit with some severity," said Peter Folan, a property claims specialist with Corroon & Black Corp. in Boston. "I know of about 50 to 75 boats that were harbored on the Cape that got clobbered. A number of 20- to 35-foot boats got beached and, although damage to them in most cases was only cosmetic, it's expensive to get them back in the water."

Possibly the worst, and certainly the most dramatic damage, was in Padanaram, Mass., a village below New Bedford, where 96 large yachts were torn from their moorings and bashed against a bridge or washed ashore. Some sank, some are damaged beyond repair, but others can be salvaged.

Even with the damage to boats and homes, insured losses throughout all of New England are expected to be much less than feared.

Boston, which was bracing for a major hit, was subjected only to 48 hours of heavy rain and sustained very little storm-related damage.

Damage was "milder than expected," Mr. Folan summed up. "There haven't been too many commercial losses reported. It's mostly water damage to homes that had their roofs blown off or trees that crashed through garages."

"From our early observations, it doesn't seem as though there are a lot of property losses. Most commercial losses will stem from the extended loss of power," said Rich Friedline, co-owner of Friedline & Carter Adjustment Inc. in Hyannis, Mass. "But there are literally thousands of residential losses, the vast majority of which are minor."

Personal pleasure boats took the worst beating. Boats "were ripped off their moorings and found their way either to a sandy or rocky beach, said Mr. Friedline. "Those that avoided the rocks have a better chance of being salvaged."

Commercial fishing boats fared well, because their crews are experienced at tying up the vessels, he said.

Tom Pochman, general manager of the Nantucket Yacht Club, said several members' boats were damaged, but damage to the club was limited to a single broken window pane.

Insurers agreed that the claims they received last week—both commercial and personal lines—could have been much heavier.

Amica Mutual Insurance Co. in Providence, R.I., had received around 3,000 claims, mostly from homeowners. Frank Honey, home office property examiner, said a "rough guess" is that Amica will see around 3,500 claims totaling \$3 million.

A spokeswoman said Amica was surprised it did not receive more claims from boat owners. "We figured that being on the coast, there would be quite a few marine losses. There haven't been that many."

Allstate estimates it will receive around 15,000 claims totaling about \$20 million. Most of that damage is to

homes and cars on Long Island.

Philadelphia-based CIGNA Corp. is projecting about 8,500 claims totaling about \$20 million. A small portion will be from commercial policyholders, a spokesman noted.

Industrial Risk Insurers in Hartford, which specializes in large commercial risks, had received about a dozen claims of a "minimal amount."

Claims were trickling in at Allendale Mutual Insurance Co. in Johnston, R.I., last week and a spokeswoman said that slow pace probably will continue. However, she added "it's early and there could be some business interruption losses" that have not been reported.

A spokeswoman for Rhode Island Gov. Bruce Sundlun, said state authorities and crews from the federal Emergency Management Agency were still assessing wreckage from the storm late last week and had not made an official damage estimate.

Naval and commercial shipyards as well as numerous marinas and yacht clubs were spared major damage, she said. "Many of the vessels were grounded by the high winds, but very few were seriously damaged."

Much of the hurricane-related problems centered around downed power and telephone lines.

New England Electric System of Westborough, Mass., which operates three separate utilities serving more than 1.2 million people in Massachusetts, Rhode Island and Connecticut, said about 400,000 clients were left without power.

NEES buys catastrophic transmission and distribution insurance from Hartford Insurance Co. The coverage responds to all property damaged in a storm or fire as well as expenses related to repairing damaged equipment and restoring power. NEES declined to provide details on limits.

A spokeswoman said NEES received help from about 290 line crews from 10 major utilities, including two from Canada, to get power up and running to most of its customers by Friday, though some would be without power throughout the weekend.

A spokeswoman for the Potomac Electric & Power Co. in Washington, D.C., said that PEPCO dispatched about 30 contractor crews to help the NEES. PEPCO is one of 97 utilities that belong to a mutual assistance program sponsored by a utility trade group.

## Block joins BI staff

Lori Block has joined the *Business Insurance* staff in Chicago as an associate editor, Associate Publisher/Editor Kathryn J. McIntyre announced.

Ms. Block, 28, most recently was news editor for *American Nurseryman*, a Chicago-based magazine covering the nursery and landscape industry. She also has been a reporter and researcher for the *Dallas Business Journal* and a sports reporter and columnist for the *Dallas Times Herald*.

Ms. Block received a bachelor of arts degree in broadcast journalism from Southern Methodist University in Dallas.

Ms. Block, who will report on a variety of risk management and employee benefit topics, can be reached at 312-649-5482.

In another staff development, Associate Editor Mark A. Hofmann has moved to *BI*'s Washington, D.C., bureau.

Mr. Hofmann, who will report on Washington-based property/casualty insurance developments as well as other risk management topics, now can be reached at 202-662-7244.



Ms. Block

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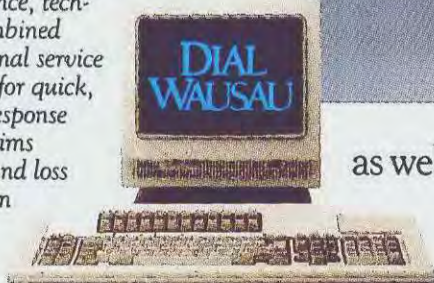


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# Kodak to offer early retirement package

## Benefit beat

As part of a continuing effort to streamline its workforce, Eastman Kodak Co. will soon begin offering an early-retirement package to 8,000—or 14.5%—of its Rochester, N.Y., employees.

Employees eligible for the program will receive their full pension benefits; extended health, dental and life benefits; a so-called Social Security bridge benefit; a rich severance payment; and other incentives, like a retraining allowance.

Approximately 8,000 of Kodak's 55,000 employees in Rochester, where the company is based, will be eligible to receive the benefits beginning Oct. 1 under the voluntary plan, which is scheduled to run through Dec. 1, 1992.

Kodak hopes the program will allow it to reduce its Rochester workforce by 3,000 workers by year-

end 1992.

The plan is not open to the remainder of Kodak's 30,000 domestic employees.

"We think that over the course of the plan, we'll be able to entice enough employees to leave the company voluntarily so that layoffs won't be necessary," a Kodak spokesman said.

"Eight thousand people meet the criteria for full pension benefits, and the program is very generous, especially if they leave before Dec. 1 and take the severance pay."

The Kodak spokesman said most of the eligible employees work in Kodak's imaging group, which consists of the company's information systems and photography units.

Under the plan, Rochester-based workers with 75 years of combined age and service, as well as employees who are between the ages of 55 and 62 and have been with Kodak for at least 10 years, are eligible to retire with full defined benefit pension benefits.

Normally, an employee would need 85 years of combined age and service to retire with full pension benefits. Employees who retire before age 62 and who do not meet the 85-year requirement normally receive 50% of their defined benefit pension benefits.

Eligible early retirees under the new plan also will continue to receive their health and dental benefits through Kodak's self-insured health plan as well as their life insurance benefits.

In addition, Kodak will give early

retirees a monthly so-called Social Security bridge payment until they reach age 62, when retirees become eligible for early Social Security benefits. The bridge payment will equal \$700 to \$900 per month, based on the retiree's earnings over the past three years.

Many Kodak units also have committed to offering eligible employees who opt for the plan prior to Dec. 1, 1991, a service-based severance benefit equal to two weeks of their final salary for every year of service, capped at one year's salary. Most Rochester Kodak divisions are expected to offer this benefit, a spokeswoman said.

Kodak provided an example of the total package a 50-year-old employee with 25 years of service would receive under the plan:

- Full pension benefits, based on

age and years of service.

- Twelve years of monthly Social Security bridge payments.

- A lump-sum payment equal to 50 weeks of final salary.

- A \$5,000 retraining allowance and outplacement counseling.

Kodak has not estimated how much the early retirement plan will save the company.

But, the spokeswoman said that the plan and other one-time charges are expected to reduce third-quarter earnings by \$375 million.

Kodak has trimmed nearly 30,000 employees from its domestic workforce since 1983, mostly through similar early-retirement programs.

—By Michael Schachner

## Wellness programs rise

Twice as many companies adopted a health and wellness program in the first six months of 1991 as had each year for the previous seven years, according to a recent study.

In the first half of 1991, 14 employers out of 135 surveyed, or 10.4%, adopted a health and wellness program, according to a study conducted by the Employee Benefit Information Center of TPF&C, the employee benefits division of Towers, Perrin, Forster & Crosby Inc. of New York.

An average of only seven surveyed employers adopted a health and wellness program annually between 1984 and 1990.

The study also found that:

- Fifty-two percent of respondents provide wellness programs to their employees, and 12% more plan to offer a program.

- Of the companies that already offer or plan to offer a wellness program, 70% make or plan to make the programs available to 100% of employees; 17% make or plan to make the programs available to 70% to 90% of employees; and 13% make or plan to make the programs available to between 10% and 65% of the workforce.

- Among the employers that offer or plan to offer a wellness program: 93% feature or plan to feature special programs like smoking cessation, nutrition or weight loss, stress management; 92% feature or plan to feature health screening for factors like high blood pressure or cholesterol; 92% reported that the program features or is planned to feature educational material; and 51% feature or plan to feature an on-site exercise facility.

- Almost half of the programs allow spouses to participate, and about 40% of the programs allow retirees to participate.

Copies of the survey are available at no charge from Keith Freeman, TPF&C Employee Benefit Information Center, 914-745-4190.

—By Sara J. Hartly

## Maternity costs reduced

Overall claims costs associated with sick and premature infants dropped 40% in 1990 for Blue Cross & Blue Shield of South Carolina group health insurance policyholders, a spokeswoman said.

And, the total number of claims involving sick and premature infants dropped 25% last year, according to the Blues plan.

BC/BS of South Carolina attributed the drop to Maternity Outcome Management, a program implemented by the South Carolina plan's Health Cost Management Services Division in August 1989 to monitor high-risk pregnancies as soon as the mother contacts Blue Cross & Blue Shield.

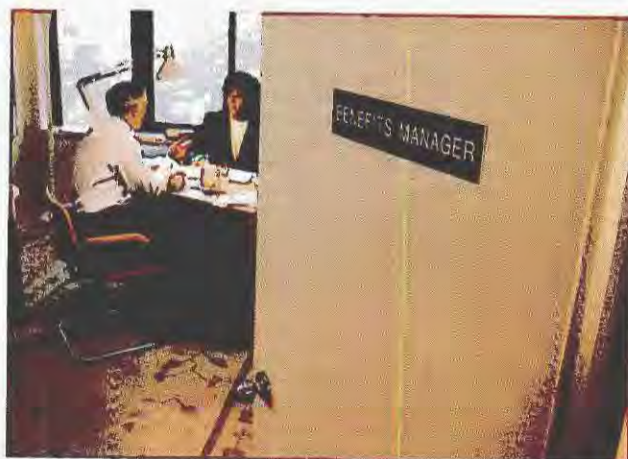
Case managers can help set up doctor appointments, arrange transportation to physician offices for expectant mothers and provide for home health care services.

Charges to the employer are incurred on a flat-fee, per-case basis.

—By Sara J. Hartly

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## Opinions

## Health care promise, problems

**E**VEN IF HIS approach is wrong, the universal health care access legislation introduced by House Ways and Means Committee Chairman Daniel Rostenkowski, D-Ill., is a refreshing break from the myriad other health care access proposals.

Under the bill, the nation's 34 million uninsured would be assured of basic health care coverage, either through their employers or through a new public plan. In addition, the Medicare eligibility age for retirees gradually would be lowered to 60 from 65 (*BI*, Aug. 19).

While other proposals, like the one advanced last year by the Pepper Commission, promise universal coverage, no mention is made of how health care costs would be controlled or how large a tax bite would be required to fund a politically popular but expensive health care system.

Rep. Rostenkowski, to his credit, doesn't dodge either issue.

Under his bill, an 11-member commission would be established to set annual national health care expenditure limits. Increases in these limits would be linked to the growth of the gross national product with a small and steadily decreasing adjustment for inflation.

After the limits were set, the secretary of health and human services would determine reimbursement rates for health care services that would result in expenditures equal to the national limits.

These cost control provisions are, benefit experts earlier noted, the toughest of any of the major access bills that have been introduced.

Through those cost containment provisions, Rep. Rostenkowski recognizes a fundamental fact often overlooked by policymakers: Improving access to health care only is possible if costs can be controlled.

It does no good to mandate coverage or slap employers with taxes to support a public health plan for the uninsured if the cost of health care coverage or an escalating tax bite drives companies into bankruptcy. Indeed, we believe that the reason many employers now do not offer health care coverage is not because they don't want to, but because they can't afford to.

We also commend Rep. Rostenkowski for his honesty in laying out the cost of providing universal health care coverage and lowering the Medicare eligibility age.

At the first level, employers that do not offer a basic health care plan would be slapped with a tax equal to 9% of employees' wages, up to the Medi-



care wage base. If that 9% tax was inadequate to fund universal health care coverage, individuals and employers would be hit with a new income tax surcharge. Finally, the Medicare tax rate and the amount of wages subject to that tax would be increased substantially.

Rep. Rostenkowski is letting the public know the huge price of universal access to health care. By contrast, the Pepper Commission promised a wide array of benefits to all Americans, but made no mention of how those benefits would be funded.

But Rep. Rostenkowski's bill falls short in other areas. His requirement that employers notify the federal government each time someone joins a health care plan or terminates coverage simply is not workable. We don't know how big, national employers with high employee turnover could keep up with the paperwork triggered by such a requirement. And, we doubt that anyone in government would read the tens of millions of health care notices that it would generate.

While Rep. Rostenkowski's proposal to lower the Medicare eligibility age would reduce employers' retiree health care liabilities, we don't think such a proposal, which everyone would pay for through higher taxes, is good public policy. With future labor shortages likely when the baby boom generation reaches retirement age, employees should be encouraged to stay on the job longer, not retire sooner.

## Letters

## Rating agencies report symptoms, not cause

To the editor: In response to your Aug. 5 article, "Rating Agencies: Do They Do the Job?," policyholders are losing confidence in the insurance rating agencies. For such companies as Executive Life Insurance Co., Mutual Benefit Life Insurance Co., Baldwin-United Corp. and others, downgrades have been too little and too late.

All of the rating agencies use leverage ratios and target surplus formulas of one form or another. But declining surplus ratios are the symptom of a problem, not

the root cause. By the time ratios deteriorate, it's usually too late.

Insurance companies fail because they run out of cash. They may or may not run out of surplus. Fatal weaknesses develop over a period of many years, so it should be possible to predict—years in advance—which companies are likely to experience problems. And it is.

Using a mathematical formula developed by our firm, we ranked 46 large companies based on Dec. 31, 1988, financial statements. These companies were rated by Moody's Investor Service Inc. at the time.

Looking at the bottom one-third based on our ranking, most received a rating of Aaa or Aa. Two years later, 10 of our bottom-tier companies have received rating downgrades, including Mutual Benefit, Executive Life and Equitable. None of the low-ranked companies received upgrades.

Of companies in the upper two-thirds of our rankings, only four have received downgrades and three have received upgrades.

Our ranking system is criticized by those who are familiar with methods used by the insurance rating agencies. Unlike the rating agencies, we don't interview top management or use internal management reports and projections. Our system is based on the idea that if a company is in trouble now, things aren't likely to get better.

We expect the life insurance, health insurance and annuity markets to experience further rating "surprises." In spite of recent downgrades, most of our bottom-tier companies still enjoy Aa or Aaa ratings. We agree that insurance buyers shouldn't rely solely on the rating agencies. They should perform an independent analysis of insurers or else avoid the market.

Richard K. Kischuk

Crown Point Management Consultants Inc.  
Pendleton, Ind.

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To the editor: As the president of a firm that performs insurance company analysis

Continued on page 10

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## At issue

Has your entity taken specific steps to control litigation costs?



**Joe I. Banda**  
Director of Risk Management  
City of McAllen,  
McAllen, Texas.

We maintain an index file of law firms with areas of expertise. We prefer small firms with no more than 12 attorneys. We maintain and require itemized statements. Large billings on well-established legal issues are questioned, since some firms tend to educate young attorneys at the defendant's expense.



**Sikha Bhattacharya**  
Risk Manager  
County of Peoria,  
Peoria, Ill.

There is no substitute for risk management involvement. We follow our claims closely. When we hear from an attorney, we always make our own response quickly. Taking good care of injured employees also is important. If employees have confidence that you will work with them and follow up on their care, they do not think of hiring an attorney right away.



**Stanley B. Fayne**  
Director of Risk Management and Safety  
Oakland County,  
Pontiac, Mich.

Yes. First we introduced a loss control program to prevent litigation. If litigation does start, we manage the case. If it should be settled, we settle early rather than build up defense costs. Our field investigators investigate the claims so that attorneys only handle the actual litigation. We pay a flat rate and make sure that a senior partner is handling our cases rather than a law clerk.



**Scott Babcock**  
Risk Manager  
Metro Risk Management Agency,  
Elk Grove Village, Ill.

We have implemented an attorney reporting procedure requiring reports on monthly billing and formats, rates for staff, strategy for discovery and budgets. Additionally, I receive copies of all court papers and our defense attorneys are directly accountable to us, not the TPA. Finally, any legwork—investigations etc.—that can be handled in-house, is.

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## Letters

Continued from page 8

and financial stability ratings, I suggest that consumers, agents, policyholders and others interested in insurance company ratings spend more time reading the prefaces to the raters' publications and less time relying on the rating.

Further, those interested in insurance company ratings should discern between an insurer rating and an insurer financial rating. Whenever qualitative criteria are utilized, discretion is introduced into the equation; discretion is not a quantifiable factor.

The problem facing insurance companies is not the promulgation of numerous, possibly diverse, insurance company ratings. Rather, the problem is that some rating companies seem to be unable to evaluate the economic conditions that currently are prevalent in the general economy as well as the insurance sector.

Those interested in insurer ratings should be more concerned about the ability of the rating service to be a leading indicator of solvency rather than a mirror image of the insurer's current financial situation. If it takes several years for liability insurance claims to wind their way through the judicial process, then the current year's rating, which is based on year-old data, should be stringent enough to be a leading rather than coincident indicator of financial soundness.

Regulators appear to have a legitimate interest in the quality of insurer ratings. In the life and health sector, insurer ratings might create a run on the bank. However, the regulators, not the rating agencies, are the final authority on the financial soundness of insurers.

If a rating agency creates a run on an insurer, my hunch is consumers, agents, policyholders and others interested in insurance company ratings were already taking a break.

**Joseph L. Petrelli**  
President  
Demotech Inc.  
Columbus, Ohio

## Rating agencies should be liable for oversights

To the editor: The last time I found it necessary to take issue with a *Business Insurance* editorial was in 1971. Over the 20-year interval, I have been impressed by the quality of your reporting and your editorials. Your Aug. 12 editorial, "Assessing the Insurer Ratings," on the whole is a balanced comment. However, I take issue with, "We are not ready to hold them liable every time they fail to spot a deteriorating insurer."

And also, "If the agencies were to be held liable for policyholder losses when an A-rated company goes broke the next year, or five years later, the rating agencies could not stay in business."

You miss the point. The public has every right to expect the rating agencies to spot the deteriorating insurer and report the results of their investigations on a timely basis.

Further, the rating agencies should be held accountable for their misdeeds to every person that relies on their ratings. You state that to hold the rating agencies accountable would mean that they could not stay in business. That concept went out in the 19th century.

Accountants, doctors, lawyers, directors and officers and many other professionals and businesses solve the problem by purchasing insurance that protects their assets and at the same time funds the payment of losses to their victims. The rating agencies should not do less.

**Thomas F. Sheehan**  
President  
Thomas F. Sheehan Inc.  
Boca Raton, Fla.

# What really constitutes financial strength in today's insurance marketplace?

## An impeccable balance sheet. And profits.

If you're concerned about the financial strength of your insurance organization, here are some questions you should ask.

### What's the clearest indicator of financial health?

A balance sheet of impeccable quality, conservatively managed. Look at AIG's financial statements. You'll find \$10 billion in capital funds; \$15 billion of general insurance loss reserves; and \$1.4 billion in after-tax profits in 1990.

### How important are the designations awarded by the rating agencies?

Very important. They provide an impartial, thoroughly researched

#### AIG Ratings:

Standard & Poor's **AAA**

Moody's **Aaa**

A.M. Best Co. **A+\***

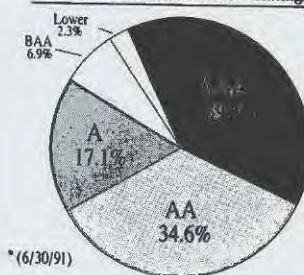
\*Domestic Property-Casualty Companies

measure of a company's financial strength. AIG holds the highest ratings awarded by the principal agencies. They are a prized asset, enabling us to capitalize on business opportunities not open to those without these credentials.

### Are there substantial differences in the way insurance organizations are managed?

Yes. Take investment and underwriting philosophies. In investing, AIG has an insignificant exposure to high-yield securities and commercial real estate, which have lately caused so many problems for other companies. The overall quality of

AIG Domestic Bond Portfolio Ratings\*

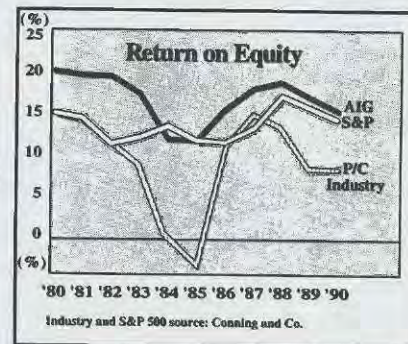


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# Captives dread federal regulation

By STACY ADLER

BURLINGTON, Vt.—Captive insurer executives have expressed concern that federal insurance regulation proposals unveiled in Congress earlier this month would hamper—if not eliminate—the use of some captives.



Proposals by Sen. Howard M. Metzenbaum, D-Ohio, and Rep. John D. Dingell, D-Mich., would introduce federal oversight of insurer solvency regulation (*BI*, Aug. 12; Aug. 5). Among other things, the proposals would require all insurance companies—including captives and risk retention groups—to meet minimum solvency standards.

"To the extent state regulation is recast, risk retention groups and other groups will be dramatically affected," said John Salisbury, chief executive officer of Housing Authority Risk Retention Group, a Vermont-domiciled insurer that writes property insurance for public housing authorities.

An outline of Rep. Dingell's proposed legislation calls for the federal government to impose: minimum capital and surplus requirements; limits on the use of reinsurance; standards for investments, reserves and asset valuation; requirements for independent audits and actuarial certification of loss reserves; national standards for state guaranty funds; procedures for determining when an insurer is impaired or insolvent; and national liquidation procedures for insolvent companies.

Sen. Metzenbaum's bill, dubbed the Insurance Protection Act of 1991, calls for similar federal solvency standards for insurance companies. In addition, Sen. Metzenbaum's bill would create a national guaranty fund that would supersede state guaranty funds.

Captive insurance company executives discussed the impact these solvency requirements would have on their industry during the Sixth Annual Vermont Captive Insurance Assn. conference, held Aug. 14-16 in Burlington, Vt.

Mr. Salisbury said risk retention groups currently operate in a "comfortable regulatory structure" that enables them to comply with the regulations of a single state and operate nationwide with minimal regulation from other states.

"This is about to change," Mr. Salisbury warned.

Jon Harkavy, general counsel of Vermont Insurance Management Inc., a Montpelier-based captive manager, said that "every aspect of a captive or risk retention group's operations is fair game" for federal regulatory oversight.

And, stiff federal solvency regulations could "knock out some captives," said Mr. Harkavy, a former director of governmental affairs for the Risk & Insurance Management Society Inc.

For example, if federal solvency standards precluded the use of letters of credit as a means of meeting minimum capitalization requirements, many small captives would find themselves undercapitalized, he said.

In addition, the proposals "will put tremendous pressure on state insurance departments to get accredited," said Mr. Harkavy, referring to a component of both the Dingell and Metzenbaum proposals that would require state insurance departments to meet minimum standards for solvency regulation and to gain federal accreditation.

He noted that under both propos-

als, if a captive insurance company or risk retention group is domiciled in a non-accredited state, the insurer would be precluded from writing any business outside of the state in which it is domiciled.

"That means a captive domiciled in a non-accredited state would be prevented from operating nationwide," said Mr. Harkavy.

"For example, if Vermont did not receive accreditation, Vermont captives could only service Vermont policyholders," he explained.

In addition, the federal regulation proposals could cause many offshore captives and alien reinsurers to move onshore, according to Mr. Harkavy.

He pointed out that both Rep. Dingell's outline and Sen. Metzenbaum's bill call for a federal regulatory office to regulate both domestic and offshore reinsurers.

"They have set up such hurdles for direct placement with offshore insurers and reinsurers that it may lead" to many companies moving onshore, he said.

Finally, Mr. Harkavy said captive insurers and risk retention groups are especially vulnerable to adverse federal regulation, because their industry is not fully understood by congressional legislators.

"Vermont has flourished as a captive domicile because it has recog-

nized the differences" between captives, risk retention groups and traditional insurers, he said.

"There is no guarantee federal insurance legislation would recognize these differences," he said.

"If this bill goes through, (captives) will be thrown in the same pot (as traditional insurers) and it will be much more difficult to operate," said Mr. Harkavy.

He suggested that captive and risk retention groups take a "pre-emptive strike" against these proposals by forming their own regulatory body.

Since Rep. Dingell's outline and Sen. Metzenbaum's bill both would allow for accreditation of self-reg-

ulatory bodies, captive and risk retention trade groups may fare best if they form their own regulatory body, said Mr. Harkavy.

"I would urge the Captive Insurance Companies Assn. or the National Risk Retention Assn. to form one solid entity," he said.

And, he urged all captive associations to begin a joint lobbying effort to explain to legislators the needs of captives and risk retention groups.

"Congress must be sensitized to the difference in these markets," said Mr. Harkavy.

Mr. Salisbury agreed: "We are going to have to be very vocal to survive." ■

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# Best details risk retention group ratings

By STACY ADLER

BURLINGTON, Vt.—A.M. Best Co. is reporting on the financial strength of 42 risk retention groups and is encouraging others that want ratings to approach the rating company.

John H. Snyder, vp of the Oldwick, N.J.-based rating agency, discussed the process by which a risk retention group or a captive can receive a rating from Best during the Sixth Annual Vermont Captive Insurance Assn. Convention held in Burlington Aug. 14-16.

Best also reports on a modest number of captives, according to Mr. Snyder.

For a traditional property/casualty or life/health insurer to receive a letter rating from Best, it must have at least five years' experience and \$1.5 million in policyholder surplus, he explained.

However, early last year, Best introduced the Financial Performance Index as a means of rating new companies, particularly the fast-growing number of risk retention groups that do not yet qualify for one of Best's letter ratings (BI, Jan. 22, 1990).

To receive an FPI rating, a company needs only three years' experience and there is no surplus requirement, Mr. Snyder explained.

"All information is based on the

NAIC blank," he said, noting that Best relies on insurers' statutory annual filings with the National Assn. of Insurance Commissioners to develop its FPI rates.

Those insurance companies that report on the NAIC blank can submit a current annual statement and the two previous years' statements to Best to become eligible for an FPI rating, Mr. Snyder said.

Under the FPI rating system, Best assigns a number to a company's financial strength:

- An FPI rating of 9 or 8 indicates the company is in strong financial health. Mr. Snyder said this is comparable to an A+ or an A rating.

- An FPI rating of 7 or 6 indicates the company has above-average financial health, which he said is comparable to an A- or a B+ rating.

- An FPI rating of 5 or 4 indicates the company has average financial health. The rating is comparable to a B or B- rating.

- An FPI rating of 3 or 2 indicates the company has below-average financial health. That rating is comparable to a C+ or C rating.

- An FPI rating of 1 means an FPI rating has not yet been assigned to the company. This designation is often given to companies that do not yet have three years' experience or, in a few cases, that

have requested not to have their FPI rating published.

"The FPI is quickly becoming a recognized and useful measure of an insurance company's financial strength prior to becoming eligible for a Best's rating," Mr. Snyder said.

It is particularly useful for gauging the strength of risk retention groups, many of which have been formed in the last three years, he said.

In computing the FPI ranking for a captive insurance company or a risk retention group, the rating agency will analyze three years' worth of data from NAIC convention statements, Mr. Snyder said.

Best will assess the insurer's profitability, leverage and liquidity in relation to norms Best has established, he explained.

Best also will adjust the rankings for adequacy of a company's reinsurance protection, geographic spread of risk and loss exposure by product line, he said.

"The rating process involves both a quantitative and qualitative analysis" of an insurer's financial statements and operating methods, Mr. Snyder said.

In particular, he said, risk retention groups and captives should be aware of several key areas Best examines, including:

- Capital structure. Best generally does not assign a favorable rating when more than 50% of an insurer's capitalization is in the form of letters of credit or surplus notes.

- Net retention of business. Best requires a company to retain a minimum of 25% to 30% of its total volume to be eligible for a rating. Therefore, companies that are fronting operations will not qualify, he said.

- Concentration of assets. To receive a favorable rating, Best requires a company to have "a concentration" of assets that are liquid, well-balanced and of investment-grade quality.

"We don't like to see any individual asset be more than 5% of a company's total assets," Mr. Snyder said.

Once a company satisfies the five-year experience requirement and meets the \$1.5 million policyholder surplus requirement, a Best's letter rating is assigned, according to Mr. Snyder.

A couple of risk retention groups already receive letter ratings from Best, including:

- HOW Insurance Co., which is a Virginia-domiciled risk retention group that underwrites home warranties for building contractors, has a B- rating.

- Podiatry Insurance Co. of America, which is a Tennessee-domiciled risk retention group that insures members of the American Podiatry Assn., has an A- rating.

If a company does not wish to be rated by Best, as in the case of a single-parent captive, Best will list the company in the directory section of its publications along with basic information like its address and phone number.

Mr. Snyder also noted that Best now publishes a one-page guide that outlines what is necessary for an insurance company to pass the quantitative tests.

For more information about A.M. Best Co. ratings, write to John H. Snyder, Vp, A.M. Best Co., Ambest Road, Oldwick, N.J. 08858; 908-439-2200, extension 5449.

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# Snelling nurtured captive industry

BURLINGTON, Vt.—Vermont's captive insurance community is mourning the death of Vermont Gov. Richard A. Snelling, who died unexpectedly shortly before the state captive industry's annual conference.

Gov. Snelling, 64, was found dead, apparently of a heart attack, at his home on Aug. 14.

A long-time supporter of the state's thriving captive insurance industry, Gov. Snelling was scheduled to be a keynote speaker at the Sixth Annual Vermont Captive Insurance Assn. convention held Aug. 14-16 in Burlington.

Instead, each session during the three-day conference began with attendees bow-

ing their heads in silent prayer for Gov. Snelling. He had served a total of 8½ years in office during two non-consecutive terms, longer than any Vermont governor since 1820.

"The governor played a vital role in the growth and development of the captive industry in Vermont," remarked Jeffrey P. Johnson, commissioner of the Vermont Department of Banking, Insurance and Securities.

"His involvement in the captive industry never lagged," Mr. Johnson said.

"Gov. Snelling was a great supporter to the captive industry," agreed John Primmer, an attorney with Primmer & Wilson in

St. Johnsbury, Vt. "He lived to see this industry grow and flourish."

Gov. Snelling was serving his first term in office when the Legislature passed the Vermont Special Insurers Act in 1981, which enabled captive insurance companies to form in the state.

Mr. Primmer recalled how Gov. Snelling opposed the use of the term "captive" while the act was wending through the Legislature, because Iran was holding U.S. citizens hostage at that time. Gov. Snelling begged legislators to call these insurance companies anything but "captives," Mr. Primmer said.

Lt. Gov. Howard Dean assumed the office

of governor and will serve the remainder of Gov. Snelling's two-year term, which ends in January 1993.

Captive insurance company executives last week expressed hope that Gov. Dean also will support the state's captive industry.

Mr. Johnson, who said he had spoken with the new governor about the state's captive industry, assured conference attendees that Gov. Dean "is interested in holding the course" regarding captives. "In Howard Dean you will find another friend of the captive industry," he told conference attendees.

—By Stacy Adler

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# Domicile marks 10th anniversary

By STACY ADLER

BURLINGTON, Vt.—Vermont is celebrating its 10th anniversary as a captive domicile.

Captive insurance executives looked back on 10 years of captive growth and forward to many more during the Sixth Annual Vermont Captive Insurance Assn. conference held here Aug. 14-16.

"From the innocence of 1981, we have transformed ourselves into a sophisticated captive domicile," said George Chaffee, president of Skandia International Risk Management (Vermont) Inc. in Burlington and a former commissioner of the Vermont Department of Banking, Insurance and Securities.

The Vermont Special Insurers Act, which enabled captives to become licensed in the state, was signed into law in 1981, said Mr. Chaffee, who is a founding member of the Vermont Captive Insurance Assn.

The first captive licensed in Vermont that year, First Charter Insurance Co., was sponsored by BF Goodrich Co. of Akron, Ohio. Its premium volume was just \$84,540.

In 1982, when Vermont had just four captives, total premium volume generated by Vermont captives climbed to \$4 million.

In 1983, premium volume rose to \$29.2 million and then increased to \$43.6 million in 1984.

Continued on page 16

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## Vermont history

*Continued from page 14*

In 1985, premium volume generated by captives rose above the \$100 million mark to \$111.6 million and more than doubled in 1986 to \$258.6 million.

"By the time of our adolescence, the hard market hit and we had 120 new captives," said Mr. Chaffee, explaining the surge in growth in 1986.

In 1987, premium volume increased to \$439.1 million and jumped sharply to \$643.1 million in 1988 and \$818 million the following year.

Last year, premium volume generated by captives crossed the \$1 billion mark for the first time, rising to \$1.33 billion.

As of last week, there were 194 captive insurers in Vermont. Since Dec. 31, 1990, 10 new captives have been licensed and one captive has been dissolved.

The size of Vermont captives is also growing, according to Mr. Chaffee.

The first few captives in Vermont generated an average premium volume of \$1.5 million, he said. Today the average is \$6.8 million.

"What we have now is a mature environment," said Mr. Chaffee.

"We have a superior infrastructure; we should call it a 'superstructure,'" Mr. Chaffee quipped.

Another testimonial to the growth of the Vermont captive industry is the attendance at the annual Vermont Captive Insurance Assn. conference.

The first conference in 1986 drew fewer than 40 people. More than 400 attended this year's conference.

In fact, the large size of the conference is coming close to outstripping the capacity of Vermont convention facilities, according to conference organizers.

Next year's meeting is tentatively scheduled for Aug. 12-14 at the Sheraton Burlington Hotel & Conference Center.

For more information about the 1992 meeting, contact Diane Leach, Executive Director, Vermont Captive Insurance Assn., P.O. Box 39, Burlington, Vt., 05402-0039; 802-253-2263; fax: 802-253-2353. ■

## Insider trading

**American International Group Inc.:** John J. Roberts, officer and director, exercised an option for 3,697 shares of common stock and sold 12,000 common shares at between \$33.95 and \$90 per share from May 17 to May 31. He now directly holds 561,963 common shares.

Nicholas Okulich, officer, purchased 100 shares of common stock at \$85.50 per share on June 17 and now directly holds 100 common shares.

AIG stock was trading at \$84.12 per share on Aug. 16.

**NAC Re Corp.:** The Elizabeth K. Belfer Trust, beneficial owner, purchased 1,000 shares of common stock at \$37.25 per share on June 24 and now directly holds 1,000 common shares.

The Laurence D. Belfer Trust, beneficial owner purchased 1,000 shares

of common stock at \$37.25 per share on June 24 and now directly holds 1,000 shares.

NAC Re stock was trading at \$38.00 per share on Aug. 16.

**Transamerica Corp.:** James R. Harvey, chairman, indirectly exercised an option for 13,444 shares of common stock at \$22.57 per share on May 10 and now directly and indirectly holds 69,765 common shares.

Frank C. Herringer, president, indirectly exercised an option for 4,112 shares of common stock at \$22.57 per share on May 10 and now directly and indirectly holds 46,494 common shares.

Kent L. Colwell, vp, indirectly exercised an option for 9,000 shares of common stock at \$22.57 per share on May 7 and now directly holds 20,307 common shares.

Blair C. Pascoe, vp, indirectly exercised an option for 9,000 shares of common stock at \$22.57 per share on May 9 and now indirectly holds

27,535 common shares.

Transamerica stock was trading at \$33.88 per share on Aug. 16.

**Trenwick Group Inc.:** Stephen H. Binet, officer of a subsidiary, sold 1,890 shares of common stock at \$29 per share on May 1 and now directly holds 5,513 common shares.

Paul A. Jacobs, director, sold 500 shares of common stock at \$28.50 per share on May 2. Mr. Jacobs indirectly sold 3,000 shares of common at \$28.50 per share that same day. He now directly and indirectly holds 10,000 common shares.

Trenwick stock was trading at \$27.00 per share on Aug. 16.

*Insider Trading, compiled by Invest/Net Trading Group Inc. of Fort Lauderdale, Fla., from reports filed with the Securities and Exchange Commission, tracks stock sales and purchases by insurance industry directors and officers. The column is distributed by Tribune Media Services Inc.*

**"We have a superior infrastructure; we should call it a 'superstructure,'" Mr. Chaffee quips.**

"We are the premier U.S. captive domicile," he said, noting that 73% of all domestic captives are based in Vermont.

Meanwhile, as the captive industry celebrated its 10th anniversary, the state of Vermont celebrated its 200th.

"Vermont has all the right ingredients" to be the premier captive domicile, said Jeffrey P. Johnson, the current commissioner of the Department of Banking, Insurance and Securities in Montpelier.

Specifically, Vermont has been able to flourish as a captive domicile because it is small and because it has a favorable regulatory environment, according to Mr. Johnson.

"The small size of the state means that the captive insurance industry does not go unnoticed," he said. Because the industry is important to a state as small as Vermont, it has had no difficulty passing legislation that benefits it, he pointed out.

For example, Vermont is the only captive domicile that devotes a portion of premium taxes paid by captives to a captive insurance division.

In fact, Vermont is the only state that devotes a division exclusively to captive regulation, according to Mr. Johnson.

And, in 1989 Vermont reduced captive premium taxes to make the state more attractive to larger captives.

These laws show how Vermont regulators have responded to the needs of the captive insurance industry, said Mr. Johnson.

Vermont regulators have always been willing to take the necessary risks when it came to supporting the captive insurance industry, he said.

Mr. Johnson also praised Mr. Chaffee and Edward Meehan, Vermont's deputy insurance commissioner, for their work in promoting the captive insurance industry in Vermont.

"We must continue to look to the future," Mr. Chaffee said.

He said Vermont's strong captive infrastructure will enable the domicile to continue to flourish.



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## D&O decision

Continued from page 1

"The decision reflects sound reasoning both in terms of the policy language and the intent of the parties," he said.

Despite this enthusiasm, it is "too soon to tell" how the law will develop in this area, Mr. Cox said. As a result, Chubb "has not reacted either negatively or positively to any individual court decision," he said.

However, because the Maryland Court of Appeals is so far the highest court to rule on the two D&O policy exclusions, its decision will be influential nationwide, experts say.

"A decision as visible as this one will have an impact on other litigation," Mr. Armstrong predicted.

Mr. Schaufelberger agreed: "The pure reasoning of this decision will cause it to be followed in other jurisdictions."

"We at CNA hope that the Maryland precedent is followed in other jurisdictions," said Ken Wollner, se-

nior manager in the D&O area.

"The resolution of this issue will provide us with greater certainty that the risks we assume are the ones we bargain for with the insured," added Mr. Wollner.

"The trend in the more recent cases has been to uphold the regulatory exclusion," said Lena Mkhitarian, senior vp at National Union Fire Insurance Co. of Pittsburgh, Pa., an American International Group Inc. unit in New York.

"In a number of other cases, courts have interpreted the insurance contracts in light of existing law" and upheld the policy exclusions, agreed Mathew Street, associate general counsel for the American Bankers Assn. in Washington, D.C.

He said the ABA finds itself in the unique position of supporting the insurance industry on this issue.

"The alternative would be reduced coverage at higher costs," said Mr. Street.

Ms. Mkhitarian agreed: "If the lower court opinion had been up-

held, it would have had a significant impact on the marketplace."

Mr. Dilloff noted that the MDIF does not plan to appeal the decision. Instead, it will pursue coverage under policies purchased by First Maryland that do not contain a regulatory exclusion.

In its decision, the Maryland Court of Appeals first examined the regulatory exclusion, which most D&O policies now include (BI, July 8).

The regulatory exclusion bars coverage for "any action or proceeding brought by or on behalf of the Federal Deposit Insurance Corp., the Federal Savings & Loan Insurance Corp. or any other depository insurance organization."

It also bars coverage for costs stemming from regulatory action taken by a state agency.

The MDIF argued that "application of (the regulatory exclusion) to MDIF would impair significantly MDIF's ability to perform its statutory responsibilities."

Specifically, the MDIF argued that

use of the exclusion would impede its ability to recover the maximum amounts for state taxpayers. The agency also pointed to state laws giving it broad powers to collect funds from insolvent thrifts.

Both the trial court and the Maryland Special Court of Appeals agreed with the MDIF and struck down the regulatory exclusion as a violation of public policy.

The appellate court held that the exclusion was void because it would circumvent "the public policy of the state: to empower MDIF to recover from the assets of failed savings and loan associations every dollar available in order to protect not only the depositors and creditors of those associations but, ultimately, to protect the taxpayers" (BI, May 14, 1990).

But, the Maryland Court of Appeals ruled 7-0 to reverse the lower courts. It noted that the right of private parties to determine their obligations to each other by contracts supercedes any public policy favoring the collection of funds.

"Stripped to its essentials, MDIF's argument is that the taxpayers of Maryland will have to pay any deficit in the insurance fund... and that is it socially desirable to reduce that deficit to the maximum extent possible," wrote Judge Lawrence F. Rodowsky.

"The citizens of this state, and this court, certainly endorse that concept in the abstract. But the problem presented here is the clash of that appealing result with the established policy of freedom of contract," he wrote.

The court said allowing the MDIF to succeed in its public policy argument could lead to disastrous results.

"If the regulatory exclusion is unenforceable because it prevents the state from collecting money, then the \$3 million limit of D&O coverage in the ACCO policy is likewise invalid and ACCO would stand with the promise to pay unlimited sums for which the directors and officers are liable," the court said.

Thus, the court ruled that there is no public policy basis for striking down the regulatory exclusion.

Next, the court examined the "insured vs. insured exclusion," which states: "The insurer shall not be liable to make any payment for loss... which is based upon or attributable to any claim made against any director of officer by any other director of officer or by the institution."

The court said that for the same reasons there is no public policy basis for striking down the regulatory exclusion, there is likewise no public policy basis for striking down the "insured vs. insured" exclusion.

However, the court found that the exclusion was ambiguous when applied to regulatory action taken against a failed thrift.

The clause does not specifically exclude claims made by a receiver of a failed thrift, the court explained.

Since the clause was ambiguous, the court interpreted the contract in favor of providing coverage.

"Looking at the policy as a whole, the purpose of the exclusion is to prevent collusive claims," the court said. "ACCO runs no risk of a collusive suit when a regulatory agency brings the underlying actions as a receiver of the association."

The court held, therefore, that the insured vs. insured exclusion does not bar MDIF's claim.

It then remanded the case for further proceedings.

The MDIF will now file an amended complaint against American Casualty in an attempt to recover under a D&O policy in effect in 1984-85—before regulators took over the thrift—that did not contain a regulatory exclusion, Mr. Dilloff explained.

The policy in effect in 1985-86 contained both the regulatory and the insured vs. insured exclusion, while the policy in effect in 1984-85 contained only the insured vs. insured exclusion.

Since the Court of Appeals has already ruled that the insured vs. insured exclusion is not an obstacle to coverage, Mr. Dilloff is optimistic the MDIF will be able to recover the \$3 million policy limits under the 1984-85 policy.

"We have an opportunity to collect the full proceeds under the earlier policy," Mr. Dilloff said.

American Casualty, however, may still have other defenses it has not yet used. One is its argument that the MDIF did not give timely notice of a claim under the 1984-1985 policy, explained its lawyer, Mr. Schaufelberger.

While the MDIF sued under both 1984-85 policy and the 1985-86 policy, the litigation until now has not addressed whether the regulators gave timely notice of claim under the earlier policy when the suit was filed in 1987.

Michael Finci vs. American Casualty Co. of Reading, Pa.; and American Casualty Co. of Reading, Pa. vs. State of Maryland Deposit Insurance Fund Corp.; Maryland Court of Appeals, No. 81.



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# Truce in health cost war

## Cooperation required in planning care

By Ryland P. Davis

A FEW WEEKS AGO I had the opportunity to sit down with executives from three major insurance companies in the state of Michigan, and I got an earful. I knew that the relationship between insurers and health care providers had turned sour during the course of the past decade or so, but never had I heard the complaints of the payers so forcefully presented. I had, in fact, found myself on the front lines of the payer-provider war.

Like all wars, this one has its share of victims caught in the middle. The most important, undoubtedly, are those who foot the bill for the cost of medical insurance and, for the overwhelming majority of insured Americans, that means employers.

A lack of understanding between insurers and health care providers can only lead to an inefficient use of resources and result in higher insurance premiums for the nation's businesses. Perhaps it's time that

**A lack of understanding between insurers and health care providers can only lead to an inefficient use of resources and result in higher insurance premiums for the nation's businesses. Perhaps it's time that those who pay had a chance to eavesdrop on one of our verbal battles.**

those who pay had a chance to eavesdrop on one of our verbal battles.

First, there is our side of the picture, the grievances of health care providers against payers: Insurance companies are slow to pay. Patients are transferred inappropriately, sometimes discharged from care or downgraded prematurely to another facility just when they are making good progress. And to top it off, there's the problem of retrospective denial of payment. Ours must be the only business where we can provide full service and wind up being paid much less than the agreed-upon price.

Our frustration in dealing with payers is intensified by what we perceive as their myopia, their short-term view of patient care. Particularly in the kind of patients I see—neurological cases—a little more money spent in the present can save a very large sum later. An additional 30 days of therapy, at a cost of \$15,000 or \$20,000, might enable a patient to live at home rather than require permanent nursing home care. A lifetime spent in a nursing home could cost an insurer \$2 million.

These were the problems I wanted to convey to the insurance executives. Instead, what I got was a lesson from

Insurers, I learned, have as many frustrations in dealing with providers as we have with them. They believe that we have excessive capacity and that we give unnecessary treatment over long periods of time. They think we keep patients who are ready to go home in the hospital—in effect, holding them against their will. And they believe that we may overcharge them.

What we have here is a classic failure to communicate, and with this failure we are exacerbating the problem. Something must be done—and can be done—to reverse this situation.

As a place to start, I propose that health care providers and payers work together to initiate what I call a prospective process for care. By that I mean that the care of each patient should begin with an agreed-upon, realistic assessment period whose final product is a detailed, long-range plan of care to which both provider and payer are committed.

The situations that are most familiar to me involve neurological patients, but the principles could be applied to anyone requiring long-term care. For neurological patients, a two-week assessment period would generally be appropriate. At the end of this two-week period, the provider would present a well-defined treatment plan.

The critical task in developing such

plans is to fully understand the patient's capacity for recovery and to identify the treatment regimen that will allow him or her to reach full recovery potential within the bounds of his or her capacity.

But isn't that exactly what we are doing today? Sadly, the answer is no. Today's typical therapeutic plan is based on an ideal level of recovery, rather than a real assessment of the patient's needs and potential.

So what is the difference?

First of all, a real plan of care considers not only the patient's post-injury physical condition, but also weighs fundamental psychological and motivational issues. For example, patients who were unhappy in their jobs prior to sustaining a neurological injury are not likely to be motivated to undergo a painful therapeutic process designed to return them to that workplace.

And some patients who were perfectly happy in their old job may not be motivated to return to that job. For example, a painter who fell off a ladder may understandably be reluctant to work at great heights again—nor should he or she be forced to do so. In either case, it is senseless to design a therapy program whose goal is to return the patient to his or

her old job.

Here we go again, you think. In the name of reform, we are going to spend more money. Isn't this going to require hiring psychologists and other mental health professionals? In most cases, not at all. Existing staff members in quality facilities are already sensitive to the psychological dimension of treatment and are quite capable of making accurate evaluations. For

**Flexible therapy plans are seldom instituted today, because insurers are skeptical of such readmissions. If the patient was healthy enough to go home a month ago and there has been no deterioration, why should he or she be readmitted to a facility, they ask.**

those few patients who have exhibited complex problems, it might be necessary to engage outside experts. In those cases, doing so will probably be less expensive in the long run than starting down the path of a fruitless therapeutic regimen.

Psychological considerations are not the only factor that separates real and ideal plans of care. Care providers too often ignore the patient's physical capacity for rehabilitation. An extreme example can illustrate the problem: If a young baseball player lost both legs in an accident, no one would adopt a therapeutic plan whose goal was to return him to the ball field. Instead, his care would be designed to prepare him for employment in a new field. Or it might be possible to focus his goals on becoming a coach rather than a player.

Sadly, such an obvious concept is forgotten when the relationship of the patient's injuries to his or her work is not so clear. Particularly in cases that involve workers compensation claims, therapeutic programs invariably struggle to return patients to their old positions in their old settings. Only after a protracted period of treatment results in failure are alternative plans adopted that retrain the patient for employment in a new position.

These misguided efforts at achieving an ideal outcome are often undertaken with full knowledge that the patient is not going to succeed. As a result, the patient suffers from a depressing failure, and substantial treatment time and resources are wasted. Ultimately, we providers end up fighting with insurance companies to pay for these failures.

A real—as opposed to ideal—treatment plan should also include a time line that identifies each stage of the treatment process. Insurers can then verify whether program goals have been met as measured by specific objectives.

This, too, would represent a welcome change from current practice. Status reports today are, quite frankly, nothing more than pages of gobbledegook. Insurers are not interested in learning that the patient has made a 0.05% gain by writing the letter "H," which is one step toward being able to write. That's a

smokescreen. Let's just say that the patient has shown a real potential to be able to write and continues to make progress toward that goal.

The sort of cooperation I envision, based as it is on the real needs and conditions of each patient, can also create a framework for more flexible care schedules. For the typical neurological patient, therapy should begin as soon as his or her medical

condition is stabilized. Later on, the patient might reach a point when he or she requires a "time out" from the rehabilitation process to allow more time to heal.

The prospective plan of care for such a patient might call for two weeks of care in one facility, followed by an additional two weeks in a more specialized unit. The patient might then go home for a month to heal before coming back for an additional two weeks of intensive therapy.

Such flexible plans are seldom instituted today, because insurers are skeptical of such readmissions. If the patient was healthy enough to go home a month ago and there has been no deterioration, why should he or she be readmitted to a facility, they ask. So, the patient spends the time needed for recuperation in an expensive facility, and the insurer pays a premium rate.

The overriding consideration behind my proposal is the need to create a dialogue between provider and payer that is based on trust and integrity. Reaching that goal requires a three-step process:

- Create a detailed and realistic plan for treating the patient.
- Reach an agreement between the payer and the provider on the plan.
- Implement the plan faithfully.

Only winners will emerge if the adversarial relationship that has developed between insurers and health care providers can be replaced with a team effort. Patients can expect more focused and effective treatment, payers will experience reduced costs and the entire health care system will operate more efficiently. And businesses might finally see some progress in another war: the one against out-of-control premiums. ■



Mr. Davis

Ryland P. Davis is president and chief executive officer of Synergos Inc., which operates neurological treatment centers in Washington, California and Arizona.

# Crackdown raises the stakes

By Randall Johnson

**T**HE EMPLOYER FILED the standard form to report on the company's retirement plan. The Department of Labor proposed a penalty of \$50,000.

The problem? The employer's auditors didn't specify that their audit opinion letter was also an opinion on the *attachments* to the plan's financial statement.

The employer is fighting back, but the costs of the appeal may ultimately be as much as the original penalty.

Government regulators are putting employee welfare and pension benefit plans under a magnifying glass. Closer scrutiny and stricter enforcement are aimed at pushing employers to report corporate benefit plan activities in minute detail.

Until recently, only a few government regulators took a careful look at corporate benefit plan reporting under the Employee Retirement Income Security Act of 1974.

Now the Department of Labor has decided to step up enforcement of ERISA reporting requirements.

**Until recently, only a few government regulators took a careful look at corporate benefit plan reporting under the Employee Retirement Income Security Act of 1974.**

Penalties for non-compliance can total as much as \$1,000 per day.

More than 5,600 plan administrators have been notified that their plans' Form 5500, the standard filing form, seems to require an audit report for 1988.

These employer plans have been singled out because they include a trust or had invested assets, yet lacked an audit report as required by ERISA. Generally, plans that have 100 or more participants must file audited financial statements along with Form 5500.

To avoid having to conduct an audit, a pension plan must invest only in fully allocated insurance contracts. The insurance company must assume all risk for benefits.

Most pension plans don't meet this test.

For example, if the insurance company merely invests the assets held by the plan under an "administrative services only" arrangement, the plan still bears the risk for paying benefits. This is not a fully insured arrangement, so an audit is required.

When welfare plans—like an employer-sponsored health plan—include employee contributions but not a trust, an audit is required unless contributions are used only to pay insurance premiums. The employer must pay premiums within 90 days of withholding by the company.

In the midst of this flurry of increased enforcement, employers are frustrated because many of the government penalties are based not only on Form 5500, but also on the attachments to the form.

Many employers are also confused by the technicalities of Form 5500 and whether audited financials are required.

But even as enforcement has increased, regulators often allow one or more grace periods before assessing penalties.

Typically, the IRS asks for a correction when it detects errors, inconsistencies or missing information in a 5500 filing. The correction could include audited financial statements if these were omitted originally.

The Department of Labor says that most deficient audit reports fail to pass muster in one of four main

## Employers confront tougher U.S. stance on ERISA reporting

areas:

- The auditor's report doesn't refer to the supporting schedules—the attachments—as required by ERISA.

This includes a separate schedule of assets held for investments, even if the information is included in financial statements or footnotes. Also required is a schedule of asset transactions during the year and a list of loans in default.

- The filing fails to compare net assets available to pay benefits.

This problem often arises, for example, in multiple-year audit reports that include a short plan year.

If the audit covers the year ended Dec. 31, 1989, and a short plan year ended June 30, 1990, statements of net assets available to pay benefits must include both those years and the year ended Dec. 31, 1988.

- The company incorrectly applies ERISA's limited scope audit exception.

The exception applies only to assets held by an insurance company, bank, thrift, trust company or similar corporation that is regularly examined by federal or state agencies. It doesn't apply to assets held by registered brokers/dealers or registered investment company advisers.

- The company doesn't report in detail plan assets held for investment at "current value."

Plans other than employee stock ownership plans can determine the value of non-publicly traded employer securities under a stockholders' agreement formula or other specific method.

The report should fully describe in a footnote how the value of these non-publicly traded securities was determined.

Employers should realize that the company hasn't

**Employers should realize that they haven't met their filing requirements until the increasingly rigorous formats are followed in full and any questions from regulators have been answered.**

met its filing requirements until the increasingly rigorous formats are followed in full, and any questions raised by federal regulators have been answered.

Here are some additional elements to consider:

- Who's in charge?

Although Form 5500 is issued by the Internal Revenue Service, enforcement of the ERISA requirements falls to the Department of Labor's enforcement division.

A notice from the IRS about shortcomings in filing Form 5500 will be backed up with enforcement by the Labor Department. Both agencies can assess penalties for failure to comply. The IRS penalty is up to \$25 a day with a \$15,000 maximum. A penalty assessed by the Labor Department can reach \$1,000 a day—with no maximum.

- Communicate constantly.

An employer that responds quickly to IRS or other inquiries about Form 5500 will often find the bureaucrats responsive as well.

A little communication early in the process, for example, can pinpoint what additional information is needed, or help the employer negotiate deadline

extensions of up to several months. When regulators have requested that an employer's plan be audited, they will often agree with reasonable extensions of the deadline.

- When is the filing due?

The basic deadline for filing Form 5500 is seven months after the end of the plan year.

However, if the employer requests an extension for filing its federal tax return and the plan's year is the same as the employer's tax year, the plan filing date is automatically extended to the filing date of the employer's return.

The plan can also file for its own extension, but only during the seven months following the close of the plan year before the filing deadline.

- When all else fails, reading the directions will only help a little.

Form 5500 has never been more complicated or difficult to understand. The form is six pages long, accompanied by 18 pages of instructions. Many of the instructions refer to sections of the Internal Revenue Code or ERISA regulations.

Only a few companies can easily obtain or interpret materials related to ERISA—and the

**If your plan is legitimately exempt from an audit, count your blessings. If not, prepare thoroughly. . . Get expert help. Follow the formats, talk to regulators, and meet the deadlines.**

intricacies of both the law and the forms beg for mistakes by amateurs.

- Experience is always a cheap insurance policy.

Despite potential problems, smaller companies often shy away from incurring extra costs to complete Form 5500. As a result, an auditor who is inexperienced with these reporting requirements may increase the risk of error and resultant penalties.

Employing a highly qualified ERISA expert to complete a detailed Form 5500 should cost a maximum of \$1,500 and is money well spent. If and when a full-scale audit of the plan is required, a professional familiar with the many ERISA reporting pitfalls can avoid false starts, delays and missed deadlines.

A plan audit is very different from the annual financial audits familiar to most corporate managers. A plan audit is less concerned with financial information—its main focus is verifying that the plan is administered as required by ERISA and the Internal Revenue Code.

For example, an audit of a 401(k) plan reviews not only the plan's assets and liabilities but also various discrimination tests that must be met if the plan is to maintain its qualified status.

- Keep it simple.

Take a hard look at your plan. If it legitimately meets the rules exempting it from an audit, count your blessings.

If not, prepare thoroughly for a plan audit. Get expert help. Follow the formats, talk to the regulators, and meet the deadlines.

You can avoid being among the thousands of companies who will learn first hand what it's like to deal with the enforcement side of the government. ■



Mr. Johnson

Randall Johnson is manager-compensation & benefits practice at Arthur Andersen & Co. in Dallas.

# Controlling pension costs

## Hiring practice, retirement age, vesting come into play

By The Insurance Institute of America

The following question and answer are drawn from the curriculum for the Associate in Risk Management designation awarded by the Insurance Institute of America. They represent the type of question asked—and the possible answers—as part of one of the three examinations for the A.R.M. designation.

This month's exercise, drawn from a recent national exam in ARM 54—Structure of the Risk Management Process—demonstrates that risk management and employee benefit management share many basic techniques. In this case, the techniques are exposure analysis and forecasting as related to pension costs.

**Q:** Providing pensions to retired employees can be a major expense for many organizations. However, most employers have several means of at least partially controlling their costs of providing monthly pension benefits.

• Explain how an organization can control its ultimate pension costs through each of the following:

- ✓ Its hiring practices.
- ✓ Its policy on mandatory retirement.
- ✓ The vesting provision of its pension plan.
- ✓ Its policy on pension credit for prior service.

• Identify and briefly explain the significance of three factors any organization should consider in deciding whether to retain or transfer to a commercial insurer the financial obligation of paying pension benefits

### A.R.M. exercises

to retired employees.

• A company's risk management professional is attempting to project future costs of providing pension benefits to its retired employees. Without repeating any answers, identify one way in which probability analysis and regression analysis would be useful in forecasting these costs.

**A:** • For each of the pension practices or provisions dealt with here, an organization has a number of legitimate options for reducing the

**A firm can exert some control over its pension costs by hiring young, potentially long-term employees.**

expected present value of its eventual pension costs.

Although federal law and many labor union contracts regulate an employer's hiring practices, a firm can still exert some control over its ultimate pension costs by hiring young, potentially long-term employees for whom pension funds can be accumulated over many years. Alternatively, an employer may seek to hire those persons who will accumulate few pension credits, like part-timers or those who are likely to quit before qualifying to participate in a pension plan or before their employer-financed benefits will vest.

By deferring mandatory retirements, employees are able to work beyond normal retirement age, which reduces an employer's ultimate pension costs by increasing the average accumulation period for each employee and decreasing each employee's expected life span after retirement.

Similarly, deferring vesting often reduces an employer's pension costs because fewer employees who resign before retirement become entitled to the employer's pension contributions. The funds set aside for those former employees can then be used to meet other pension costs, thus reducing the employer's total pension outlay.

The fewer pension credits an employee receives for prior service (that is, for working for a particular employer before any pension plan was installed), the lower the employer's pension costs. For any employee, years of work for which no pension credits are earned add nothing to the employer's pension costs.

• An employer is likely to retain pension costs when these costs are predictable and when retention tends to lower the expected present value of the employer's ultimate pension costs; an employer tends to transfer these costs when the opposite is true. Therefore, among other factors which may be relevant, three of the most important considerations for an employer are the age distribution of current employees (because a greater dispersion of ages makes pension costs more easily budgeted); the number of

employees (because a larger employee population makes aggregate pension costs easier to forecast); and the employer's administrative ability to operate a pension plan, which affects the employer's ultimate cost.

• All forecasts of costs or other variables presume that past patterns will be repeated in the future. When these patterns are of the static, unchanging world, probability analysis—which assumes that the future will exactly duplicate the past—is appropriate. When there are several factors interacting to generate complex patterns of change, regression analysis is more appropriate.

Probability analysis is usually superior to regression analysis for forecasting mortality and morbidity rates (death and sickness, respectively) for an organization's current and retired employees. Such forecasts assume that death and disability rates remain unchanged over the years.

In contrast, interest rates earned on pension reserves tend to fluctuate in patterns that are related to other economic variables that are easier to predict than interest rates, and therefore, more readily forecast than are ultimate pension costs. Thus, an employer should rely on regression analysis that relates interest rates to other changing economic factors. ■

The sample questions and answers used in this column are taken from the Associate in Risk Management designation curriculum of the IIA. For more information on the content of the A.R.M. program, write Dr. G.L. Head, Vp, Insurance Institute of America, P.O. Box 314, Malvern, Pa. 19355.

# Defective workmanship not compensable

The Court of Appeals of Michigan ruled—in a case of first impression in that state—that a subcontractor's allegedly defective workmanship was not an "occurrence" within the meaning of a comprehensive general liability insurance policy.

A general contractor entered into a subcontract with Vector Construction Co. for concrete work on a wastewater treatment plant. Vector then contracted with Boichot Concrete Co. to provide concrete meeting certain specifications, but the concrete supplied failed to comply with those specifications. The project owner required Vector to remove and repour 13,000 yards of concrete. Several lawsuits were commenced between the various parties. Vector notified its insurer, Hawkeye-Security Insurance Co., of the incident and filed a claim.

The policy protected Vector for damages arising from injury or property damage caused by an "occurrence," which was defined as an accident neither expected nor intended. Hawkeye denied coverage and filed a suit seeking to have the court declare that no such coverage existed for Vector's claim. The trial court ruled for the insurer.

The appellate court said that the fortuity implied by reference to accident is not what is commonly meant by a failure of workmanship. According to the court, it was unable to find in the policy language a reasonable basis to expect coverage for defective workmanship. Therefore, the court said that the defective workmanship of Vector, standing

### Legal briefs

alone, was not the result of an occurrence within the meaning of the insurance contract. The trial court decision was affirmed.

*Hawkeye-Security Insurance v. Vector Construction*, Court of Appeals of Michigan, Sept. 11, 1990 (BI/03/My. \$10).

### Murder on work premises compensable

The question raised before the U.S. Court of Appeals for the 3rd Circuit was whether the phrase "on authorized business" in a group life insurance policy could be interpreted reasonably to apply to an employee who completed her work shift but had not left the premises when she was murdered. The court ruled the phrase could be so interpreted.

The plaintiffs in this case were the children of Alma McMillan, who was murdered by her estranged husband while leaving the business premises of her employer, Trans World Airlines Inc. Ms. McMillan finished her work shift at 10 p.m. She left her office on the third floor, descended to the first floor and exited the lobby onto a covered walkway connected to the office building, where her estranged husband stabbed her to death.

She was covered under a group life policy issued by State Mutual Life Assurance Co. of America,

which provided for payment of \$100,000 in the event of death resulting from a "felonious assault while on authorized business of TWA." The policy did not define "on authorized business." Ms. McMillan's children sued State Mutual and won in trial court.

The appellate court noted that State Mutual's failure to define the phrase "on authorized business" resulted in the common meaning of the phrase being open-ended. According to the court, the meaning of the phrase was not self-evident. Since State Mutual failed to use more distinct language, the court's conclusion that the phrase was ambiguous was reinforced. The court said that the earliest point of separation from her employer's "authorized business" could have occurred only once Ms. McMillan fully left TWA's premises, because until that point she would be found to be in an area required by her employer and for its benefit. The trial court decision was affirmed.

*McMillan v. State Mutual Life Assurance Co. of America*, U.S. Court of Appeals for 3rd Circuit, Dec. 28, 1990 (BI/02/S. \$10). ■

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

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## Mental health

*Continued from page 3*  
charges, 28% use some other method and 10% pay no benefit.

The survey also found that 69% of the respondents use case management for inpatient treatment of mental and nervous disorders, while 54% use case management for outpatient treatment of these disorders.

Patients whose outpatient care is not managed well tend to end up in the hospital later on, making outpatient case management especially important, Mr. Sinni said.

The survey found that 39% of respondents paid a flat percentage of outpatient charges subject to a deductible, while 33% based their outpatient benefits on precertification requirements or the use of PPOs. Eleven percent paid a flat percentage of charges with no deductible, while 17% used some other method.

Nearly all respondents—97%—also sponsor plans that provide alcohol and substance abuse benefits.

Among the employers that offer inpatient alcohol and substance abuse treatment benefits, 78% require precertification, with 67% requiring precertification for all admissions and 11% requiring precertification for non-emergency admissions only.

The survey also found that about three-fourths of the respondents—74%—vary their alcohol and substance abuse benefits based on whether precertification requirements are met and whether the company's preferred providers are used.

When precertification is required and obtained, 51% of the respondents will pay a flat percentage of charges subject to a deductible, 16% will pay just a flat percentage of charges, and 33% use some other method.

When precertification is required but not obtained, 36% of the respondents pay a flat percentage of charges subject to a deductible, 8% pay just a flat percentage of charges, 50% use some other method and 6% do not provide any benefit.

The survey also noted that 32% of the respondents offer a PPO for inpatient treatment of alcohol and substance abuse.

When care is obtained through a PPO, 41% of the respondents pay a flat percentage of charges subject to a deductible, 34% pay just a flat percentage and 25% use some other method.

When inpatient treatment is obtained from non-network providers, 53% of the respondents pay a flat percentage of charges subject to a deductible, 8% pay just a flat percentage, 29% use some other method and 10% pay no benefit.

The survey also found that 71% of the respondents use case management for inpatient treatment of alcohol and substance abuse, while 55% use case management for outpatient treatment.

The survey found that 36% of respondents pay a flat percentage of charges for outpatient treatment subject to a deductible, while 35% vary their benefit levels based on whether employees meet precertification requirements or use a PPO. Twelve percent pay a flat percentage of charges, while 17% use some other method.

The survey also found that six of 10 employers offer an employee assistance program, with 99% geared to assisting employees with alcohol or substance abuse problems and 98% designed to assist employee with emotional disorders.

However, these EAPs generally are available to help employees with a wide variety of other problems as well, like family and marital problems.

For most employers, EAPs serve as a "gatekeeper" to their mental health and substance abuse treatment benefits.

For instance, 82% of the companies use the EAP for assessment and referral purposes.

In addition, 11% used the EAP to perform utilization reviews, 10% used it to perform all precertifications, 5% used it to manage their PPO network and 3% used it to perform all required inpatient precertifications.

Seventeen percent of the respondents did not use their EAPs as a gatekeeper in any way.

The percentages do not add to 100 because some employers used their EAPs to perform more than one function.

Nearly three quarters of responding employers with EAPs—72%—use an outside vendor to administer their EAPs. An in-house staff administers the EAPs for 25% of the respondents and the remainder use some combination of outside and in-house administrators.

Copies of "Employer-Sponsored Alcohol/Substance Abuse and Mental/Nervous Disorders Treatment Benefits" are available for \$75 from Carolee Martin, manager of marketing, Buck Consultants Inc., 500 Plaza Drive, Secaucus, N.J. 07096; 201-902-2555.

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## INTERNATIONAL

# ARIG results socked by Gulf war losses

## But offshore, aviation accounts on upswing

By MARIA KIELMAS

MANAMA, Bahrain—Arab Insurance Group B.S.C. is predicting improved results this year following last year's unprecedented losses in the wake of the Iraqi invasion of Kuwait and a soft commercial insurance market.

ARIG General Manager Nooruddin A. Nooruddin told *Business Insurance* that conditions are improving for offshore oil and aviation coverages. "Actually, aviation business is still lagging a little but we will know for certain by November," he said, referring to upcoming renewals for the world's major airlines.

Bahrain-based ARIG is the largest Middle Eastern reinsurer, although Mr. Nooruddin stresses it regards itself as an international—rather than specifically Middle Eastern—reinsurer.

The company is jointly owned by the governments of Kuwait, the

United Arab Emirates and Libya.

ARIG's 1990 results showed a \$25.6 million loss compared with record profits of \$20.9 million the previous year.

The company's total assets fell by 5.2% from \$537.7 million at the end of 1989 to \$509.9 million at year-end 1990.

ARIG's total investable funds fell by 7.6% from \$463.2 million to \$428.0 million.

An increase in provisions for claims raised the level of technical reserves to \$235.3 million from \$227.1 million.

The company charged the reported loss of \$25.6 million to retained earnings and general reserves and transferred \$5 million to its investment reserve account. This resulted in a \$20.6 million drop in surplus.

The high incidence of large losses in most classes of business coupled with ARIG's prudent reserving policy resulted in a marked deterioration in the company's technical results, falling to a \$17.7 million loss in 1990 from a \$700,000 profit in 1989.

At the same time, there was a significant drop in investment in-

come to \$11.4 million in 1990 from \$43.1 million in 1989.

ARIG's reduced investment income is mainly attributable to the sharp downturn in the major stock markets as a result of the Gulf crisis, according to the report.

This caused a substantial net capital loss in ARIG's equity portfolio.

A breakdown of reinsurance results by class of business reveals a deterioration in all classes except fire, which was the only class to show a profit in 1990. Aviation, which was very profitable in 1989, produced a loss in 1990 and energy business recorded a substantial loss.

Reflecting the market performance, marine hull continued to be unprofitable and "other classes," which mainly covers engineering and casualty business, showed larger losses than in 1989.

Because of marketing strategy and diversification, premiums earned in 1990 rose 4% from 1989 to \$99 million compared with \$95.1 million the previous year. Operating expenses in 1990 increased by 12.1% to \$15.8 million, due largely

*Continued on next page*

# Insurers back spaceport plan for Australia

By KATE McILWAINE

BRISBANE, Australia—Australia's aerospace industry may receive a boost from two Australian insurers that pledge to write coverage for satellite launches from Australia if a proposed private spaceport is built on remote Cape York in northern Queensland.

GIO Reinsurance, a division of the New South Wales state government-owned insurer GIO Australia, and Australian Space Insurance Group, a pool of 18 insurers and five reinsurers, both currently underwrite launch and in-orbit coverages for international satellites.

ASIG is a division of the Melbourne-based Australian Aviation Underwriting Pool Pty. Ltd., which writes aviation coverage on behalf of 20 major insurers and has an agreement with leading satellite insurer Assicurazioni Generali S.p.A., under which the Italian insurer provides additional capacity on a facultative basis.

The Australian government has asked its Industry Development Corp., which investigates problems in particular industries and government projects, to conduct a feasibility study for a privately funded spaceport at Cape York. If the \$700 million Australian (\$545.7 million at current exchange rate) project goes ahead, about five launches would be conducted annually, said Kirby Ikin, business development and aerospace officer for GIO Reinsurance.

The Australian government set up the Australian Space Office to coordinate development of space projects in 1987. It has held talks with two consortiums of Australian companies interested in contracting to build and operate the spaceport.

Arch Morrison, director-launch services for the ASO, said that when the Industry Development Corp.'s feasibility report is finished, the office will meet with companies and consortiums to start phase one of the project. That would involve the preparation of environmental impact assessments for the Cape York region.

Warwick Jones, technical manager for ASIG, said if the spaceport goes ahead, the underwriting pool would be "very interested" in writing a portion of the coverage for Australian-launched satellites.

While ASIG has written some space coverages in the past, it has not written any third-party liability coverage, he said, but the company would "be prepared to put a proposal" to insurers in the group. "We wouldn't be willing to cover it all on our own," Mr. Jones said. "But because it's an Australian project, I would see us taking major lines."

Mr. Ikin said GIO also was keen to be involved. He said he met with companies interested in using an Australian spaceport while he was on a recent trip to the United States.

Mr. Jones said GIO and ASIG would be able to work together to provide significant portions of the coverage, including property coverage at the site, as well as in-orbit coverage and launch insurance—which covers the payload, replacement launch costs and lost revenue from ignition through to initial satellite operations. "It would be a bit stupid if we were cutting each other's throats," he said.

*Continued on next page*



GRAPHIC BY JOHN HALL

# Designated chief resigns at Allianz

MUNICH, Germany—The Allianz A.G. Holding executive designated to succeed retiring Chairman and Chief Executive Office Wolfgang Schieren has resigned only months before he was to take over.

Allianz has not provided details on why Friedrich Schiefer, who currently is director of finance, is leaving Allianz, but it's speculated that losses stemming from Allianz's Eastern Germany operations are responsible.

Henning Schulte-Noelle, who currently serves on the executive board, has been named to succeed Mr. Schieren in October.

Mr. Schieren, who announced in January that he would retire from Allianz after 20 years with the in-

## GLOBAL BRIEFS

surer, will continue to serve on the insurer's advisory board (*BI*, Jan. 7).

Allianz expects to report a loss this year, confirmed Uwe Haasen, a member of the insurer's executive board.

Allianz's acquisition of the former state monopoly insurer in what was East Germany and the formation of a new company, Deutsche Versicherungs A.G., to write business in the nation's eastern region is expected to lead to a 500 million deutsche mark (\$277.8 million) loss in the insurer's 1991 results.

Half of that amount will be paid by the Treuhandanstalt, which is the agency set up to dismantle and privatize Eastern Germany's Communist-era economy and the owner of a 49% stake in Deutsche Versicherungen.

Allianz also expects losses related to its acquisition of Fireman's Fund Insurance Co.

Those losses related to Fireman's Fund could range from 500 million to 800 million deutsche marks (\$277.8 million to \$444.5 million), depending in the exchange rate for the U.S. dollar.

However, Fireman's Fund will add about 5.5 billion deutsche marks (\$3.06 billion) to 1991 gross premiums for Allianz, the German

*Continued on next page*

# Chiltington shelves asbestos data plan

By GAVIN SOUTER

HAMBURG, Germany—London insurance consultant Chiltington Intermediaries Ltd. has canceled its plans to establish a commercial asbestos information service.

The decision comes weeks after Cologne Reinsurance Co. announced it will set up a non-profit organization to provide the same service.

However, Chiltington announced it will continue with its plans to set up a service to provide in-depth analysis of asbestos claims for individual clients.

The moves by Chiltington and Cologne Re stem from concerns that many small and medium-sized

**Chiltington's decision comes weeks after Cologne Re said it will offer the same service.**

reinsurers lack the resources or information base to conduct negotiations with the London market over hundreds of millions of dollars of asbestos claims.

In May, Chiltington announced that it would form two for-profit companies to help deal with the problem: International Reinsur-

ance Advisory Service GmbH, to gather and summarize information on asbestos claims, and Chiltington International Reinsurance Advisory Service GmbH, to provide in-depth analysis for reinsurers (*BI*, June 3).

And, three weeks later, Cologne Re asked the 130 reinsurers negotiating with the London market over asbestos claims if they would support a similar but non-profit service (*BI*, June 17).

By the end of June, Cologne Re had secured support from more than 50 reinsurers and decided to proceed with the venture.

The new organization will be called the International Alliance of Asbestos & Pollution Reinsurers,

or Intap, and should be in place early next year, according to Cologne Re. Consequently, Chiltington has decided to shelve IRAS but continue with CIRAS.

"As it did not appear to be in the interests of Chiltington's clients or the reinsurance market in general that the very detailed analyses of cedants' presentations be duplicated by IRAS and Intap, discussions have taken place between Chiltington and Cologne Re with a view to rationalizing the situation," according to a statement released by Chiltington.

As a result of the discussions, Chiltington's sister reinsurer, Hamburger Internationale Ruckversicherung A.G., will join Intap

as an active member and provide Intap with information, analysis and computer capacity, said Wolfgang Eilers, Chiltington's director.

Chiltington and Hamburger Internationale are owned by both companies' managing director, Ivor Kiverstein.

Jack Koepke, director of legal and claims at Gerling-Konzern Globale Reinsurance A.G. in Cologne, Germany, was to join Chiltington as head of the new companies but will remain with Gerling. He said the decision to stay with Gerling was not related to the formation of Intap.

Mr. Koepke will now return to New York as an executive vp in Gerling's New York office. ■

# INTERNATIONAL

## Space risks

*Continued from previous page*

The two underwriters also are interested in providing insurance for another aerospace project in the feasibility study stage: a plan to build Australian launch vehicles that would be used to launch satellites from the Woomera launching facility in southern Australia.

ASO's Mr. Morrison said a consortium of private businesses currently is preparing to determine the cost and feasibility of the project. The first launches would take place in 1993 or 1994, he said.

Mr. Jones said space risks are unusual in that there is a low number of launches, but a high probability of total losses. "If a launcher blows up, it's a whole bunch of pieces. There's nothing left."

The sums insured are also large. "You're looking at a big chunk if you have a payout," he said. "It's not an area for the faint-hearted."

GIO began underwriting space-related risks in 1986 when the first Aussat Australian communications satellite was launched.

"Over the last four years, we have insured about 30 satellites worldwide," Mr. Ikin said.

GIO's net capacity per risk is \$5 million. ASIG, which began underwriting space risks on Jan. 1, 1989, has a net capacity per risk of \$7.5 million.

Mr. Jones said ASIG has written launch coverage for 35 satellites and has 11 more projects pending.

Initially, GIO provided in-orbit and launch insurance for small satellites and launch vehicles but has been insuring small portions of major satellite risks since October 1989, according to Mr. Ikin, who also is president of the National Space Society of Australia.

"We will look at any commercial space project. We need to be able to assess the risk and determine an appropriate rate. We're hard-nosed about assessing the risk; if there's a 10% to 20% chance (the satellite's) going to fail and we can't get the party to agree to a rate of, say, 20% plus, we won't write it," Mr. Ikin said.

Most satellites are valued at between \$150 million and \$200 mil-

lion, and Mr. Ikin said GIO's \$5 million capacity is "a small, but not insignificant part of the worldwide capacity."

"We have a theoretical capacity of \$10 million on any one risk at the moment, but we don't want to do that because it would unbalance our portfolio," he noted.

GIO underwrote \$5 million in property coverage on the Canadian satellite Telesat Anik E2, which was successfully launched but failed to function once in orbit. It had been feared that the satellite, insured for a total of \$220 million, could be declared a total loss (BI, May 27; April 22). However, Mr. Ikin said that claims probably will be only minor because the problem with the satellite had been repaired.

GIO's other losses stemming from space underwriting also have been "relatively minor," he said.

"We've been profitable every year we've been writing. We like to attribute it to good underwriting, but I think there's also a good measure of luck," he said.

However, he added, "Anik may have changed things completely. There's still the potential for a partial loss."

Mr. Ikin said launch insurance "rates were moving back up" from a competition-driven low of 16.5% of the insured value of the satellite last year.

After a series of failures in 1985 and 1986, rates rose as high as 35% and capacity diminished. But when rates dropped to 16.5%, Mr. Ikin said it was not economical for GIO to write any launch business.

"There was a lack of failures, and people are shortsighted. Up until February last year, there had been 18 Ariane launches without a single failure. Statistically, the rates should still have taken into account a 10% failure rate for the launch and commissioning."

"Commissioning" covers the period directly after launch and ranges from 90 days to a year. Satellite owners then purchase in-orbit coverage—also known as satellite life insurance coverage—which is renewable annually.

"People get too shortsighted; they forget that in the overall his-

tory of the thing, 10% to 12% of launches are going to fail," Mr. Ikin said.

"In my opinion, the rate should be around 19% to 20%. At that level, you could maintain stability over a period of time, and that would be useful for people entering into contracts to build satellites; it would be useful for the insurance community and the space industry generally," he said.

ASIG's Mr. Jones said a rate of 18% to 20% was "supportable based on failure rates to date." But he said higher rates were required for some satellite owners and launch companies.

Satellite technology is constantly changing and new, untried satellites and launch vehicles are always being tested, making rating difficult.

"As an underwriter, we can't compare the launch history of an earlier vehicle to the current vehicles. The launch vehicle manufacturers are saying they've only had a 2% failure rate, but you just can't say that."

Mr. Ikin said GIO would not leave the satellite insurance market, even if a string of failures made the coverage unprofitable.

"We're a significant player. We're there for the long haul," he said.

While launch insurance rates and losses grab the most attention, Mr. Ikin noted that in-orbit insurance rates are falling, with rates currently at about 1.75% of insured value.

"We won't write the business unless it's around 3% to 4%. One failure at a premium rate like that and it takes 100 flights to recover. It's not attractive at those really low rates and not realistic," he said. "There will undoubtedly be failures, but the market just scrambles for the cash, and that's unfortunate."

Mr. Jones said ASIG had written "a fairly sizable line" on Superbird A, a Japanese satellite that failed in orbit in December 1990 (BI, Jan 14).

He said that loss had resulted in a hardening of in-orbit rates worldwide, taking them back up to 2% to 3%. ■

## GLOBAL BRIEFS

*Continued from previous page*

insurer estimates. Overall, Allianz expects gross premiums from foreign business to increase by 48% this year, compared with a 42% increase in 1990. And the insurer's overall gross premiums, including operations in Eastern Germany, should increase by 25% to 48 billion deutsche marks (\$26.67 billion) in 1991, the insurer predicts.

Last year, the insurer reported gross premiums increased 20% to 38.3 billion deutsche marks (\$25.63 billion at year-end 1990 exchange rates) from 31.9 billion deutsche marks (\$18.88 billion at year-end 1989 exchange rates) in 1989.

However, profits were down 22.1% to 187 million deutsche marks (\$125.12 billion) in 1990 from 240 million deutsche marks (\$142.03 billion) in 1989.

The insurer this year also will include in its balance sheet its stake in Hungaria Insurance, one of Hungary's largest insurers. Allianz recently increased its equity in the Hungarian insurer to 58.5% from 49%.

—By Don Lewis Kirk

## CU executive murdered

ISTANBUL, Turkey—A Commercial Union Assurance Co. P.L.C. underwriter was shot and killed last week in Istanbul by the terrorist group Dev Sol, which has mistakenly targeted the London-based insurer, a CU spokesman said.

Andrew Blake, an underwriter for CU Istanbul affiliate Commercial Union Sigorta, was shot Aug. 19.

The CU spokesman in London said Turkish authorities suspect that the Dev Sol terrorist group was responsible for the killing, believing Mr. Blake was an American.

Dev Sol, a Turkish terrorist group that has been active since the 1970s, has claimed responsibility this year for killing two Americans in Turkey and wounding a

third.

Dev Sol evidently has compiled a list of potential targets in Turkey, the CU spokesman said. "According to our information, police raids on Dev Sol discovered that Commercial Union was included even though we are not a U.S. company," he said. "The shooting was a tragic case of mistaken identity."

The U.S. Embassy in Istanbul had alerted CU's offices in Turkey to the threat shortly before a July visit from U.S. Secretary of State James Baker, the spokesman said. The insurer maintained armed guards in its offices from before that visit until Aug. 5, he said.

After the shooting, an individual claiming to represent the Lebanon-based Islamic Jihad called Istanbul newspapers saying the killing was in protest against U.S.-led multinational forces stationed in southeast Turkey to protect Kurdish regions in Iraq.

But Turkish authorities discounted the caller's claim because the Islamic Jihad is not known to be active in Turkey, the CU spokesman said.

The murder could dampen CU's plans to open a life insurance office in Turkey, since it could be difficult to find executives to work there, the spokesman said.

—By Maria Kielmas

## Banesto/AGF deal

MADRID, Spain—Banco Espanol de Credito, one of Spain's largest banks, and Assurances Generales de France, France's second-largest insurer, have signed a wide-ranging agreement aimed at developing their mutual insurance interests in Spain.

The agreement was scheduled to take effect at the end of June but has not because the deal is still under scrutiny by Spain's economy minister, a Banesto spokesman said. "We don't know what will happen," he said.

Banesto's diverse collection of industrial interests—including real estate, cement, petroleum and insurance—were brought together last year under a separate affiliate, Corporacion Banesto, in which the

*Continued on next page*

## ARIG results

*Continued from previous page*

to expansion of overseas branches and unexpected costs incurred in implementing emergency plans related to the Gulf crisis.

Although Bahrain is still depressed as a financial center following the Gulf crisis, ARIG is prospering, according to Mr. Nooruddin.

"Our business is actually better than last year," Mr. Nooruddin commented.

One factor in the improvement is

slightly higher demand for engineering-type coverages—for which rates are on the upswing—like the energy and aviation classes.

"It's exceeding our expectations slightly but we are not really expecting it to pick up," says Mr. Nooruddin.

ARIG is keeping an eye on any new business possibilities related to post-war reconstruction in Kuwait, though Mr. Nooruddin says an overall rebuilding project has not yet started.

Mr. Nooruddin acknowledged that ARIG's Tunisian office, which taps offshore business from the North African region, has noticed a downturn due to regional economic problems. "Premium volume is down and activity is slow," he said. But certain countries—like Algeria—have recently mandated increased retentions in order to curb currency outflow, and this has reduced ARIG's business, he explained.

Mr. Nooruddin said ARIG has not been affected by the United States' economic boycott of Libya, which is one of ARIG's owners.

ARIG is pleased with the performance of its new London office, which opened in April, and is bullish on future European prospects, he pointed out.

"We think we are entering the market at the right time because all indications show the market has bottomed out. We will concentrate on developing our presence in London" and expanding in Europe, Mr. Nooruddin said. ■

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# INTERNATIONAL

## GLOBAL BRIEFS

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bank holds a 76% stake. This group holds 52.6% of Spain's second-largest insurer, La Union y El Fenix Espanol Cia de Seguros y Reaseguros S.A.

The agreement with AGF—which is 75% owned by the French government—will result in the formation of a new insurance holding company. Corp. Banesto will hold a 55% stake and AGF will hold 45%.

In addition, La Union y El Fenix will acquire a 20% stake in AGF's Spanish affiliate, AGF Seguros S.A.

And, a new insurer will be established as a joint venture between AGF and Banesto, which will focus on life insurance and personal lines and take advantage of Banesto's network of bank branches for distribution.

An AGF spokeswoman in Paris said that contrary to reports in the Spanish press, AGF has no plans to later increase its present minority position in the new holding company. She also said AGF does not plan to acquire control of the new personal lines insurer.

The agreement with AGF allows Banesto to dispose of some shares in La Union y El Fenix while still maintaining control of the insurer, the spokesman for Banesto said.

Last year, La Union y El Fenix registered a profit of 2.56 billion pesetas (\$26.8 million at year-end 1990 exchange rates), a 31.4% increase from 1989. Gross premium income was 53.63 billion pesetas (\$561.4 million), up 3.1% from 1989 premiums.

AGF last year reported gross premiums of 48 billion francs (\$9.43 billion at year-end 1990 exchange rate). Its then-100% owned Spanish subsidiary had 1990 gross premiums of 26 billion pesetas (\$272.2 million).

—By Maria Kielmas

### Guernsey regulation

ST. PETER PORT, Guernsey—Guernsey's insurance industry is examining a proposal to regulate insurance intermediaries and insurance representatives operating in Europe's leading captive domicile.

But, the proposal would have little, if any, impact on Guernsey's captive insurance industry, according to Steve W. Butterworth, the superintendent of insurance. The rules are particularly designed to govern the island's life insurance industry, he said.

The proposals, which were drawn up by the Guernsey Insurance Assn. and an ad hoc working group, are outlined in a discussion paper distributed by the Guernsey Financial Services Commission.

The paper notes that any regulations "should take into account the special situation existing in Guernsey resulting from its offshore insurance activities. Although intermediaries and representatives selling Guernsey products overseas might be expected to be regulated in that overseas territory, this is often not the case. In the absence of such regulation, any publicity caused by negligence or fraud by these offshore intermediaries or representatives is liable to damage the reputation of Guernsey."

The proposals, therefore, suggest making "all insurers and insurance intermediaries fully responsible for the actions of their representatives, including those operating overseas."

Currently, insurance intermediaries and representatives on Guernsey, one of the Channel Islands between England and France, are required only to abide by a professional code of conduct set out in the Insurance Business (Guernsey) Law 1986, among other statutes. That code covers principles like dealing in good faith with clients, satisfying the insurance requirements of clients, and avoiding misleading or "extravagant" advertising.

The discussion paper defines an insurance intermediary as "any person bringing together the buyer and seller of insurance for remuneration other than an insurance representative."

An insurance representative is defined in the paper as "employees of, subsidiaries of, and individuals or bodies acting under agency contracts with... a registered or exempt insurer, a registered insurance intermediary or an authorized insurance manager."

The paper proposes, among other things, that insurance intermediaries be required to register with the Guernsey Financial Services Commission and pay an annual fee of about 650 pounds (\$1,100).

Insurance representatives would not be required to register with the commission under the proposal.

However, representatives would have to hold a certificate from the  
*Continued on next page*

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# INTERNATIONAL

## GLOBAL BRIEFS

Continued from previous page  
insurer or intermediary they represent designating their authority to conduct business on its behalf.

Insurer representatives also would have to abide by a code of conduct similar to that established for intermediaries.

Insurers on the island have complained that the proposal may cause overseas brokers to place

business elsewhere to avoid compliance with the regulations, Mr. Butterworth noted.

Otherwise, comments on the paper have been mostly favorable, he said.

The commission is seeking comments on the proposals in writing no later than Sept. 1. Comments can be sent to Steve W. Butterworth, Superintendent of Insurance, Guernsey Financial Services Commission, Valley House, Hirzel Street, St. Peter Port, Guernsey, Channel Islands. The commission's

facsimile machine number is 0481-712010.

—By Paul D. Winston

## New M&M office head

ROTTERDAM, The Netherlands—Marsh & McLennan Inc. has named Managing Director Eric Dorhout Mees to head Marsh & McLennan Nederland bv, the firm's new brokerage unit in Rotterdam.

Before joining Marsh & McLennan in 1987, Mr. Mees had been an

executive board member of Hudig-Langeveldt Group bv from 1975.

Marsh & McLennan, the world's largest insurance brokerage, has previously announced it is selling its 30% stake in Hudig-Langeveldt, which Rollins Burdick Hunter Group Inc. of Chicago has offered to purchase (BI, Aug. 19).

## Buck acquisition

WIESBADEN, Germany—U.S. benefit consulting firm Buck Consultants Inc. acquired a controlling

interest in German consultant Heissman/IPC.

The firm, headquartered in Wiesbaden, provides actuarial, compensation, communication and international consulting services, specializing in German multinationals.

Heissman/IPC also has an office in Magdeburg, which is located in the Eastern Germany.

Buck also opened a new office in Melbourne, Australia, headed by Stan Bates, consulting actuary and office manager.

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## Business Insurance

### Circulation Breakdown\*

#### Commercial Consumers

Administrative:  
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Vice-Presidents, General Managers and Other Administrative Personnel ... 4,489

Financial:  
Chief Financial Officers and Vice-presidents of Finance ... 2,581  
Secretaries, Treasurers, controllers and other Financial Personnel ... 4,349

Risk/Employer Benefits:  
Vice-presidents, directors, managers, and other related department personnel of: insurance, risk, employee benefits, personnel, compensation, pension, safety, security, industrial relations, human resources and employee/labor relations ... 10,606  
Sub-total ... 24,591

Associations ... 488  
Government, Unions and Educational Institutions ... 1,275

#### Commercial Consumers

Sub-total ... 26,354  
Insurance Agents and Brokers ... 9,651  
Insurance Companies ... 8,074  
Accountants, Actuaries, Attorneys & Consultants ... 3,438  
Adjusters, Appraisers, TPA's, Captive Managers & Health Care Providers 1,294  
Others Allied to the Field ... 1,365  
TOTAL ... 50,176

\* Source Business/Occupational breakdown of qualified circulation, November 26, 1990 issue, as submitted to BPA for December 1990 BPA Publisher's Statement.

## Risk Managers of the Year

**Arnold L. Davenport**  
Vp-Risk Management  
Marriott Corp.

**Stephen M. Wilder**  
Director of Corporate Risk Management  
The Walt Disney Co.

**Jeffrey W. Pettegrew**  
Risk Manager and Chief Administrative Officer  
Contra Costa County Municipal Risk Management Insurance Authority

**William L. Mather**  
Administrator of Risk Management  
The Gillette Co.

**Edith F. Lichota**  
Senior Vp  
Irving Trust Co.

**Donald Nelson**  
Director of Risk Management  
ARA Services Inc.

**Harold C. Lang**  
Director of Insurance and Risk Management  
LeaseWay Transportation Corp.

**Richard M. Inserra**  
Director of Insurance and Risk Management  
American Can Co.

**John A. O'Connell**  
Executive Director and Risk Manager  
Holy Cross Shared Services Inc.

**Eckhart Russell**  
Risk and Insurance Manager  
Alcan Aluminium Ltd.

**Duane E. Allen**  
Assistant Treasurer  
Hanna Mining Co.

**Thomas V. Hallett**  
Risk Manager  
General Motors Corp.

**Edward L. Erickson**  
Director of Insurance  
American Broadcasting Cos. Inc.

**Howard T. Weber**  
Director of Insurance  
Minnesota Mining & Manufacturing Co.

BY KIMBERLY MART

## HMO regulations

Continued from page 3

with the equal contribution rule. But the regulations also provide examples of other ways that employers can structure their HMO premium contributions without violating the 1988 law's requirements that company contributions not discriminate against employees enrolled in HMOs.

Employer premium arrangements that would not be considered financially discriminatory include:

- Making the same percentage contribution toward the HMO premium as toward an indemnity plan premium.

For example, if an employer paid 90% of the premium for each non-HMO plan it offered, the employer could make the same percentage contribution to the HMO.

- Basing contributions on age, sex, family status and other factors that are reasonable predictors of utilization.

The HHS rules provide an example of how demographic factors could be used by an employer to set the premium contribution.

"If the employer's cost for the single class of single males under age 30 in an indemnity plan or self-insured plan is \$60, and the employer's contribution for HMO enrollment for each employee in that particular class were \$60, there would be no discrimination," HHS said.

"The employer would follow this methodology for each of the other classes. By calculating the contribution for HMO enrollment for each class in this way, the employer would determine its total payment on behalf of all employees enrolled in the HMO," according to the HHS rules.

- Requiring employees to make a reasonable minimum contribution to the HMO as long as the em-

ployee contribution does not exceed 50% of the required employee contribution to the principal non-HMO plan.

Under an HHS example of this method, the HMO charges a monthly premium of \$80, while the cost of another health care plan option is \$100 a month. The employer pays 80%, or \$80, of the cost of the other health plan option, while employees pay a monthly premium of \$20.

Under the HHS rules, the employer in this example could require employees with HMO coverage to pay a monthly premium of up to \$10, or 50% of the employee contribution to the non-HMO plan.

In addition, the HHS rules say employers and HMOs may negotiate mutually acceptable contribution arrangements as long as those agreements do not cause the HMO to violate any other federal rating requirements.

The HHS rules on HMO premium cost-sharing arrangements currently apply only to those federally qualified HMOs that employers must offer under the "dual choice" provision of the HMO law.

Under that provision, employers with more than 25 employees must offer an HMO if the employer is properly approached by the HMO and the HMO can demonstrate that it can serve the employer's workforce.

However, in 1995—the year that the dual choice provision expires—the HHS premium cost-sharing arrangements then would apply to all federally qualified plans that an employer agrees to offer.

As of Jan. 1, the nation's 307 federally qualified HMOs had 25.9 million enrollees, while non-federally qualified HMOs had an enrollment of 8.2 million, according to statistics compiled by InterStudy, a managed care research or-

## Risk Manager of the Year

Continued from page 3  
criteria (see box).

The overall highest-scoring candidate will be named Risk Manager of the Year, and the highest scoring candidate in each of the categories not represented by the Risk Manager of the Year will be named to the Risk Management Honor Roll, subject to the judges' discretion.

The employment categories are: corporations with sales exceeding \$300 million; corporations with sales of less than \$300 million; government entities; tax-exempt or non-profit institutions; financial institutions; and self-insurance funds and pools.

"Risk managers honored as Risk Manager of the Year and members of the Risk Management Honor Roll serve as an example to other risk managers to excel in their field," Ms. McIntyre said.

"In addition, we have seen over the last 14 years that the awards permit risk managers to recognize the contributions of their staffs to their successful risk management programs," she said.

However, successful candidates have not always had large staffs.

A candidate also need not handle risk management functions full time, but he or she must be a full-time employee of the organization for which he or she directs the risk management program.

A candidate can be nominated by anyone familiar with the candidate's work. For example, any employee or group of employees may nominate the organization's risk manager. A broker, insurer, consultant or some other service supplier can nominate a client. And, a risk manager can nominate a colleague.

Nominations of risk managers

based anywhere in the world are invited.

In addition to the completed nominating forms outlining the candidate's accomplishments, each nomination must include a letter from the sponsor nominating the candidate and a letter of endorsement by an executive of the candidate's organization, who may be the candidate's superior or any higher officer. The letter must certify the accuracy of the information submitted in the nomination.

All nominations will be kept in the strictest confidence, with only the honored candidates' names announced.

To request a Risk Manager of the Year nomination form, write Karen Brown, Assistant to the Editor, *Business Insurance*, 740 N. Rush St., Chicago, Ill. 60611-2590; or call 312-649-5398. ■

## 10 criteria used to judge nominees for 1992 award

Ten criteria will be used to score the nominations submitted for the 1992 *Business Insurance* Risk Manager of the Year Award and Risk Management Honor Roll.

The 10 independent judges of the nominations will score each candidate according to how well he or she:

- Established and implemented an effective risk management program within the organization.
- Tackled and solved one or more major problems for his or her organization.
- Innovatively applies the diverse tools of risk management and insurance.
- Creatively and effectively uses

the insurance markets to structure an insurance program that serves the needs of the organization.

- Established a workable intelligence system inside and outside the organization, culminating in a flow of information about events and activities that affect the organization's risk management and insurance.

- Skillfully performs the functions of management in the overall organization and within the risk management/insurance depart-

ment.

- Achieves the most effective program at the optimum cost over the long term.

- Developed technical expertise in any or all of the broad categories included within risk management, leading to a better managerial grasp of the operations aspects of the job.

- Exhibits an attitude and performs activities fostering the advancement of the risk management profession.

- Develops in his or her career. ■

## Insurance services guide

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**SEPTEMBER CLOSINGS**

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issue: September 16 — Reader Service  
 closing: September 3  
 editorial feature: Workers Compensation — Directory: Safety Consultants & Rehabilitation Services  
 demographic section: Insurer Topics: Compensation & Benefits

issue: September 23  
 closing: September 10  
 editorial feature: Reinsurance: Monte Carlo Rendez-Vous Report

issue: September 30 Bonus Distribution: IIAA  
 closing: September 18

issue: October 7 Bonus Distribution: AEA/RIMS & NACSA-NACSE  
 closing: September 24

editorial feature: International: Benefits & Risk Mgmt. — Directory: Intl. Insurers & Benefit Networks  
 demographic section: Agent/Broker Topics: Contracting For Services

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**Health care lobby**

*Continued from page 2*  
 10; June 31.

Some press accounts of the legislation that were based on interviews with a few large corporations, like Chrysler Corp., that are sympathetic with the concept of a federal health care mandate gave the incorrect impression that the entire business community supports mandated employer-provided health care coverage, Ms. Miller said.

"Our members are major employers and we are against mandated coverage," Ms. Miller said.

Since a letter was sent out earlier this month announcing HEAL's formation, more than 200 organizations, including individual employers as well as trade associations, have signed up as members.

"That underscores the level of interest in health care issues in the business community," Mr. Van Dongen said.

"A lot of people have wanted to

do something in this area, but until now no one has taken the lead. There is a real desire to participate in a coalition" within the business community, said Elaine Graham, director of federal relations for the National Restaurant Assn.

Membership is open to any business or trade group that supports HEAL's statement of basic principles. Those principles include opposition to national health insurance or mandating that employers offer health care plans or pay taxes through a "play-or-pay" approach.

"We strongly believe in the free enterprise system. You can't successfully transplant a foreign system, such as the British national health care program, onto an entrepreneurial nation like the United States," Ms. Miller said.

And, the trouble with implementing play-or-pay-type approaches in an effort to improve health care access is that they do not deal with soaring health care costs, she said.

"If business can't afford health care coverage or higher taxes, you pay a very hefty price," Ms. Miller said, noting that companies unable to pay for coverage or taxes would lay off workers.

While HEAL strongly opposes national health insurance or mandated coverage, it believes that certain steps can be taken that would improve access to health care and would better control costs.

Those steps include:

- Pre-empting state laws that require insurers to offer specific benefits in their health insurance policies.
- There are currently 800 state mandates which impose a myriad of requirements on health insurance policies, thus significantly increasing the cost of health care for all business. Freeing all policies from these well-meaning but counterproductive mandates would immediately and significantly lower the cost of health insurance for all firms and increase access for small business and individuals alike," HEAL said.
- Pre-empting state laws that restrict managed health care.

While managed care systems have proven effective, many states have passed laws that interfere with the implementation of innovative managed care systems, HEAL said.

A recent survey conducted for the Health Insurance Assn. of America by The Wyatt Co. found that state managed care laws, like those eliminating the use of "gatekeeper" physicians in preferred provider networks, can substantially increase the cost of managed care (BI, Aug. 19).

- Reforming health insurance underwriting.
- "To assure health care access, health insurers, HMOs and third-party administrators should guarantee the availability and renewability of health insurance to those who wish to purchase it, regardless of size, status or geographical location of the purchaser," HEAL said.
- Reforming medical malpractice liability laws.
- "Prudent malpractice reform will reduce the need for costly defensive testing and other forms of health care delivery used to avert malpractice claims," HEAL said.
- Increasing the tax deductibility of health insurance premiums for the self-employed to 100% from the current 25%.

In addition, HEAL says health care consumers must take more responsibility for their own care. To encourage this, they need more information on fees, treatments, physician practices and hospital ratings.

HEAL also says incentives are necessary for government, providers and private insurers to pursue innovative techniques.

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For more information about HEAL, write to the Healthcare Equity Action League, 1725 K St. N.W., Suite 710, Washington, D.C. 20006. General membership is free. A \$1,000 contribution is required for membership on HEAL's steering committee.

## Soviet risks

Continued from page 1

Gorbachev reasserted control, underwriters and brokers expressed hope that economic activity with the Soviets—difficult enough before the coup—would resume.

Some predicted that the coup's collapse will reduce the risk of any future takeover attempt and ease future investment and political risk underwriting decisions.

"I do see companies going in with a little more confidence, a little less uncertainty," said David Avasthi, president of UIC Ltd., a Miami-based political risk insurance managing general agency.

"The potential of (a coup) happening again is reduced substantially," he commented.

"The long-term effect on U.S. business will be negligible," said Price Lowenstein, director of political risk services with Frank B. Hall & Co. in San Francisco. "Those that are there will stay there, and those that are looking to get in may find it an even better investment climate now."

"This is the last gasp of the hard-liners and the Communist Party," he said.

At the same time, though, growing autonomy in the Soviet republics and moves toward a market economy may make credit risks more difficult to gauge than when the central government was the only debtor, observers add.

Underwriters and companies with interests in the Soviet Union held their breath last week as the coup ran its roller-coaster course.

U.S. exports to the Soviet Union reached \$3 billion last year, boosting the total amount of U.S.-Soviet trade to \$4 billion in 1990, according to statistics compiled by the U.S. Department of Commerce.

Most of the U.S. exports to the Soviet Union—\$2.2 billion—were food and food products. Grain accounted for roughly two-thirds of that amount, according to Eric Olson of the U.S.-U.S.S.R. Trade & Economic Council in Washington, D.C.

Meanwhile, private U.S. investment in the Soviet Union is estimated to have totaled a relatively small \$360 million through 1990.

Early in the week, when it appeared that the Soviet move toward democracy would be stalled if not destroyed, exporters were being advised to halt any shipments.

The Confederation of British Industry, a trade and lobbying group that represents British firms, advised member companies on Tuesday to "hold any goods they are shipping until the situation becomes clearer."

U.S. exporters were likewise advised not to make shipments unless they had received advance payment, Mr. Avasthi said.

The Washington-based Export-Import Bank suspended its loan guarantee and credit insurance program for Soviet business after the coup, an Eximbank spokeswoman said.

Eximbank has not completed any Soviet deals to date, but three export transactions totaling \$78.6 million that were in the works were stalled as a result of the coup, the spokeswoman said.

Congress has limited Eximbank's total exposure on all Soviet transactions to \$300 million, though President Bush had said before the coup that he would ask Congress to repeal the limit, she said.

Meanwhile, companies considering joint ventures or other investments in the Soviet Union also put plans on hold.

Frank B. Hall was set to place political risk coverage with a Lloyd's of London line slip it represents for three deals—an oil industry joint venture and two consumer products manufacturing joint ventures—but the deals were up in the air last week, Mr. Lowenstein reported.

San Francisco-based Chevron Corp. has been discussing for more than three years the possibility of setting up a joint venture to tap an

oil field in the Soviet republic of Kazakhstan, but it was waiting for the signing of the Union Treaty between the Soviet central government and most of the 15 republics before proceeding with any further meetings, a Chevron spokeswoman said.

Mr. Gorbachev had been scheduled to sign the treaty, which would have ceded significant Kremlin power to the republics, on Tuesday, the day after the coup was announced.

The coup also threw into question a planned joint venture between German insurer Colonia Versicherungs A.G. and Rossja, a Soviet insurer that was to receive financial backing from Colonia for a push into commercial insurance.

As the takeover stalled in the face of resistance led by Russian republic President Boris Yeltsin, observers were hopeful that business would return to normal, though some remained cautious.

For instance, by Thursday, the Confederation of British Industry's advice to exporters had changed to "business as usual."

"Business was interrupted for a short period, but now we are carrying on business as usual," said Stanislav Konshin, deputy chairman of Ingosstrakh, the Russian insurer. Ingosstrakh's chairman, Mikhail Safranov, was on holiday during the coup, but "he is not ill," Mr. Konshin joked.

Trade Indemnity P.L.C., one of Britain's largest credit insurers, advised clients at the beginning of the week to "make no further deliveries until the position clarifies itself," said Associate Director Charles McCar-

coverage have, in fact, been in short supply for Soviet risks for several months.

Six months ago, limits of \$20 million to \$40 million were easy to obtain for credit risks, including non-payment and unfair calling of letters of credit, Mr. Avasthi said. But by shortly before the coup, this capacity had dwindled to \$3 million or \$4 million, he said.

Available limits for political risk insurance covering confiscation, expropriation and nationalization stood at between \$200 million and \$300 million six months ago but had fallen to about \$50 million before the coup for many Soviet risks, he added.

"There was a major, major reduction," Mr. Avasthi observed, triggered by the deteriorating Soviet economy, growing foreign exchange difficulties, withdrawal of credit by Western banks and the reluctance of Western nations to provide the economic aid that Mr. Gorbachev had requested.

"It has not been non-existent, but it has been very difficult to find capacity" for credit risks, agreed Jack Willyard, senior vp of Sedgwick James Financial Products in New York, a unit of Sedgwick James Inc. Noting that payments from Soviet entities had slowed markedly in the months before the coup, Mr. Willyard said underwriters had focused available capacity on "high-priority" items, like badly needed industrial equipment and medical supplies.

Capacity had shrunk dramatically because "no amount of additional premium will turn a bad risk into a

good risk," Trade Indemnity's Mr. McCartan noted.

"Generally speaking, the market has always been rather nervous of the U.S.S.R. because of the weak underlying economy," agreed Anthony Richardson, deputy underwriter for Lloyd's syndicate 33, managed by Roberts & Hiscox Ltd.

"It's been extremely difficult to obtain any cover at all for the U.S.S.R.," even before the coup, said Leo Gibbons, a director of financial and political risk for Sedgwick Group P.L.C. in London.

Underwriters have accepted contract frustration and non-payment risks only if backed by irrevocable LOCs through the Vneshekonombank, and only "at very high premium levels of about 7% to 8%," Mr. Gibbons said.

"It was difficult for us to place any business for new customers," he added, estimating that there was capacity of up to \$1 million available for "essential goods."

Leading Lloyd's political risk underwriter Miles Wright said he stopped writing Soviet Union risks last year and last week's events further reduced the chances of him returning to the market in the near future.

The market has moved from "being quite positive to very negative over the last six months with very few underwriters prepared to take a Soviet risk," said Robert Barlow, regional director of London broker Jardine Credit Insurance Ltd.

Even before last week's coup, the market for Soviet contract frustration risks "was virtually non-existent," partly due to "an overhang of claims from the U.S.S.R. during the past year or so," said Charles Berry, managing director of Lloyd's of London broker Berry Palmer & Lyle Ltd.

"Underwriters still have a lot of exposure there and there is concern about the financial condition of the country," Mr. Berry said.

More capacity had been available for expropriation and property con-

fiscation coverages, though "underwriters were being very selective due to demand exceeding supply," Mr. Berry noted.

"Confiscation insurers had been more bullish, but rates had trebled or quadrupled since last year to about 3%" of value, agreed Jardine's Mr. Barlow.

Mr. Berry estimated that projects valued up to about \$10 million could have found confiscation insurance in London. But projects of about \$100 million would need participation from all the major players in London, and many leading political risk underwriters had withdrawn from the Soviet market before last week, he pointed out.

Ironically, underwriters and brokers point out that it has been Mr. Gorbachev's policies of perestroika and democratization, as well as the opening of the Soviet market, that have made the Soviet Union a poorer credit risk.

"Before perestroika, the Soviet Union were good payers. The market was state-controlled and there was one payer: the government," Mr. McCartan said. Now, newly formed Soviet companies purchasing Western goods and technology "have no track record to assess the risk in the normal way. Meanwhile, there is roaring inflation and a deteriorating economy."

Lowenstein.

Hall's political risk facility with Lloyd's still has \$350 million of its \$400 million aggregate capacity available, and Mr. Lowenstein said he hopes within the next few weeks to complete the three deals put on hold by the coup.

The U.S. government's Overseas Private Investment Corp., meanwhile, is working on completing the bilateral agreement and gaining the congressional and presidential approvals it needs before inaugurating a new political risk insurance program for U.S. investors in the Soviet Union, an OPIC spokesman said.

OPIC already has about 50 coverage applications for projects involving potential total investments of \$3 billion, not counting several billion dollars more in possible oil and gas joint ventures, the spokesman said.

Mr. Berry predicted that Mr. Gorbachev's return to power could prompt an easing in the political risk market.

"Next week is a different matter, but the climate may have eased a bit. One of the great concerns of underwriters had been what would happen if there was a reversal" of the Soviet democratization process, he said.

The removal of many hard-liners and the rise of Mr. Yeltsin could also speed the breakup of the Soviet Union into independent states.

"If the republics become independent, capacity could increase as political risk capacity is set on a per-country basis," Mr. Berry pointed out.

Meanwhile, British companies last week were watching the situation with interest.

British insurer Royal Insurance P.L.C. has recently completed a feasibility study of a proposed joint venture with Moscow-based Promstroy Bank.

Under the proposal, Royal would establish a marine and commercial insurance underwriting unit in the bank's main Moscow branch.

"Tension between the Soviet Union and Russia had been taken into account in the study," said a Royal spokesman, adding that last week's events would be considered before making a final decision on the proposed venture.

The decision will be announced in the next six weeks, he said.

The failed coup should not affect the proposed joint venture between British Airways P.L.C. and Soviet airline Aeroflot, said a BA spokeswoman.

The "agreement was signed July 26 and we see no reason why it should not go forward as agreed," she said.

The joint venture entails the establishment of a new international airline to be called Air Russia and the construction of a new international terminal at Moscow's Domodedovo Airport.

BA has a 31% stake in the venture and will invest about 20 million pounds (\$33.9 million) in it, said the spokeswoman, who would not comment on BA's insurance arrangements.

But, Ford Motor Co. Ltd., based in Brentwood, England, did not know whether its plans to supply 20,000 diesel auto engines through Deutsche Lada to Moscow would be scuttled last week.

The 24 million pound (\$40.6 million) deal was announced just three weeks ago.

The company also did not know how its plans to set up a network of Ford dealerships throughout Eastern Europe would be affected by the recent turn of events.

"It is very difficult to be certain of anything in the present circumstances," said a Ford spokesman, who would not comment on Ford's insurance arrangements.

Carolyn Aldred and Maria Kielmas in England, Lori Block in Chicago, and Don Lewis Kirk in Germany contributed to this story.

**'The long-term effect on U.S. business will be negligible,' says Price Lowenstein of Frank B. Hall. Those that are looking to get in may find it an even better investment climate now. 'This is the last gasp of the hard-liners and the Communist Party.'**

tan. But, by Thursday, it was confident enough of President Gorbachev's return to power to tell customers to go ahead with shipments.

However, "we are still extremely cautious regarding new policies, bearing in mind continuing political uncertainties and the continued deterioration of the Soviet Union economy," Trade Indemnity said.

Mr. Avasthi—who had advised exporters to hold up shipments to the Soviet Union—had not changed his advice by Thursday and said he would probably wait a week or two before giving the green light.

The U.S. Commerce Department has advised companies to take a careful approach to new Soviet business until the situation settles, a spokeswoman said.

The British Department of Trade and Industry also advised caution at the end of last week. "The situation had been difficult in the Soviet Union for a long while, especially for small companies, because there hadn't been the hard currency" for payments, a spokeswoman said.

"There's no reason so far to indicate that companies with contracts should not ship to the U.S.S.R., but companies are advised to trade with secure terms such as an irrevocable letter of credit backed by the Vneshekonombank," the Soviet Bank for Foreign Economic Affairs, the spokeswoman said.

The Export Credit & Guarantee Department, Britain's government-backed credit insurance agency, maintained the cautious position it adopted toward the Soviet Union in January. For short-term coverage, up to 180 days, the ECGD will accept only risks backed by an irrevocable letter of credit backed by the Vneshekonombank.

Meanwhile, medium-term coverage has been "under review" since Jan. 1, which effectively means all medium-term coverage for Soviet risks is suspended.

Credit insurance and political risk

coverage have, in fact, been in short supply for Soviet risks for several months.

Six months ago, limits of \$20 million to \$40 million were easy to obtain for credit risks, including non-payment and unfair calling of letters of credit, Mr. Avasthi said. But by shortly before the coup, this capacity had dwindled to \$3 million or \$4 million, he said.

Available limits for political risk insurance covering confiscation, expropriation and nationalization stood at between \$200 million and \$300 million six months ago but had fallen to about \$50 million before the coup for many Soviet risks, he added.

"There was a major, major reduction," Mr. Avasthi observed, triggered by the deteriorating Soviet economy, growing foreign exchange difficulties, withdrawal of credit by Western banks and the reluctance of Western nations to provide the economic aid that Mr. Gorbachev had requested.

"It has not been non-existent, but it has been very difficult to find capacity" for credit risks, agreed Jack Willyard, senior vp of Sedgwick James Financial Products in New York, a unit of Sedgwick James Inc. Noting that payments from Soviet entities had slowed markedly in the months before the coup, Mr. Willyard said underwriters had focused available capacity on "high-priority" items, like badly needed industrial equipment and medical supplies.

Capacity had shrunk dramatically because "no amount of additional premium will turn a bad risk into a

good risk," Trade Indemnity's Mr. McCartan noted.

"Generally speaking, the market has always been rather nervous of the U.S.S.R. because of the weak underlying economy," agreed Anthony Richardson, deputy underwriter for Lloyd's syndicate 33, managed by Roberts & Hiscox Ltd.

"It's been extremely difficult to obtain any cover at all for the U.S.S.R.," even before the coup, said Leo Gibbons, a director of financial and political risk for Sedgwick Group P.L.C. in London.

Underwriters have accepted contract frustration and non-payment risks only if backed by irrevocable LOCs through the Vneshekonombank, and only "at very high premium levels of about 7% to 8%," Mr. Gibbons said.

"It was difficult for us to place any business for new customers," he added, estimating that there was capacity of up to \$1 million available for "essential goods."

Leading Lloyd's political risk underwriter Miles Wright said he stopped writing Soviet Union risks last year and last week's events further reduced the chances of him returning to the market in the near future.

The market has moved from "being quite positive to very negative over the last six months with very few underwriters prepared to take a Soviet risk," said Robert Barlow, regional director of London broker Jardine Credit Insurance Ltd.

Even before last week's coup, the market for Soviet contract frustration risks "was virtually non-existent," partly due to "an overhang of claims from the U.S.S.R. during the past year or so," said Charles Berry, managing director of Lloyd's of London broker Berry Palmer & Lyle Ltd.

"Underwriters still have a lot of exposure there and there is concern about the financial condition of the country," Mr. Berry said.

More capacity had been available for expropriation and property con-

fiscation coverages, though "underwriters were being very selective due to demand exceeding supply," Mr. Berry noted.

"Confiscation insurers had been more bullish, but rates had trebled or quadrupled since last year to about 3%" of value, agreed Jardine's Mr. Barlow.

Mr. Berry estimated that projects valued up to about \$10 million could have found confiscation insurance in London. But projects of about \$100 million would need participation from all the major players in London, and many leading political risk underwriters had withdrawn from the Soviet market before last week, he pointed out.

Ironically, underwriters and brokers point out that it has been Mr. Gorbachev's policies of perestroika and democratization, as well as the opening of the Soviet market, that have made the Soviet Union a poorer credit risk.

"Before perestroika, the Soviet Union were good payers. The market was state-controlled and there was one payer: the government," Mr. McCartan said. Now, newly formed Soviet companies purchasing Western goods and technology "have no track record to assess the risk in the normal way. Meanwhile, there is roaring inflation and a deteriorating economy."

"Because of decentralization, there are many more buyers trading (within the Soviet Union) rather than one central body," an ECGD spokesman said, explaining the agency's decision to require Vneshekonombank LOCs for short-term non-payment covers.

The high cost and lack of availability of political risk insurance has led many U.S. corporations to go without it.

For example, Los Angeles-based Occidental Petroleum Corp. no longer purchases political risk insurance, said Michael Shelton, assistant treasurer and director of risk management. "It just got too expensive for the type of exposures we have," he said.

Mr. Shelton added that while Occidental had been a leader in U.S.-Soviet business under former Chairman Armand Hammer, the company has scaled back its Soviet activity since Mr. Hammer's death.

PepsiCo Inc. of Purchase, N.Y., supplies soft drink concentrate to Soviet-owned bottling plants and operates two Pizza Hut restaurants in a joint venture with the Soviet government but buys no political risk coverage, according to Steven H. Lawrence, PepsiCo's director of risk management and insurance.

Asea Brown Boveri Inc. of Stamford, Conn., and subsidiary Combustion Engineering Inc. operate three manufacturing and engineering joint ventures with Soviet ministries and have a fourth project in the site- and project-development stage.

However, much of ABB's contribution to the joint ventures has been "know-how," and the company has not bought political risk coverage, an ABB spokesman said.

The rapid collapse of last week's coup and expected ascendance of the democratic reformers should put U.S.-Soviet business relations back on track and could spur new U.S. investment and an easing of the tight political risk market, insurers and brokers say.

U.S. companies have been slow and methodical in developing business relationships in the Soviet Union, and this slow, steady course may resume if reforms continue in the wake of the coup, said Maura Garych Edgar, a political risk specialist with Johnson & Higgins in Wilmington, N.C. "They have been extremely cautious all along," she said of U.S. companies.

U.S.-Soviet joint ventures still face the daunting challenges of the Soviet economy, bureaucracy and infrastructure, but "liberalization and decentralization of the Soviet Union will continue, and that's good news for investors," said Hall's Mr.

## Update

## Building manager liable in rape

Continued from page 2

deadbolt lock on her apartment door.

Berry Property Management has general liability insurance that could cover a portion of any award that is upheld, said defense attorney Richard W. Crews Jr. of Brin & Brin in Corpus Christi, Texas. However, he would not provide coverage details.

## Guilty pleas in 1988 fraud

LOS ANGELES—The former chairman of a defunct brokerage has pleaded guilty to six counts of mail fraud, embezzlement and income tax evasion related to a multistate scheme to defraud employers and multiple employer trusts out of millions of dollars in premiums.

Michael A. Rubell, former chairman of Rubell Helm Insurance Services Inc. of Irvine, Calif., faces up to 30 years in prison and fines of up to \$1.5 million. Mr. Rubell entered his plea Aug. 12 in U.S. District Court in Los Angeles, says the U.S. Labor Department, which has been investigating the scheme. A sentencing date has not been scheduled.

Rubell Helm, which was shut down by court order in 1989, has failed to pay about \$10.4 million in medical and life insurance claims in Florida and California.

Between March 1988 and July 1988, Mr. Rubell promised to purchase life, health and stop-loss coverage for employers and METs in California, Florida, Texas and Louisiana (*BI*, March 20, 1989). But, rather than buying the coverage, Mr. Rubell used more than \$500,000 to buy a condominium at a ski resort, an \$18,500 diamond and a \$12,000 Caribbean cruise, among other things.

In addition, Mr. Rubell gave \$50,000 to Charles McGuirk, director of marketing for Diamond Benefits Life Insurance Co., and \$24,500 to a MET chairman for their help in perpetrating the scam, according to charges filed against Mr. Rubell by the U.S. Attorney's offices in Los Angeles and Orlando, Fla. A federal investigation of these participants is continuing, said William L. Teich, special agent-in-charge in the Labor Department's Office of Labor Racketeering in Miami.

Besides Diamond Benefits, Mr. Rubell claimed he also purchased coverage from American Trust Insurance Co. Ltd., a Turks & Caicos-domiciled firm formerly run by insurance consultant Alan Teale (*BI*, July 25, 1988). Mr. Teale, also the former president of the now-defunct Insurance Exchange of the Americas, has been under investigation by various state and federal authorities.

## Reinsurance volume rises

WASHINGTON—U.S. property/casualty reinsurers wrote \$5.52 billion of net premiums in the first half of 1991, an 11.5% increase from \$4.95 billion in the first six months of 1990, according to a survey of 61 reinsurers by the Reinsurance Assn. of America.

Their combined ratio of 106.4% in the first half of this year is an improvement over the 107.2% reported by a similar group of companies in last year's first half. The loss ratio fell to 75.4% from 75.9%, while the expense ratio dropped to 31% from 31.3%.

RAA Chairman Paul D. Hawksworth, president of Mercantile & General Reinsurance Co. of America in Morristown, N.J., said the higher premium volume was the result of "specific company situations, not an industrywide trend." He said the lower combined ratio so far this year takes into account "that the 1989-1990 catastrophes are behind us."

## Insurers leave hull syndicate

NEW YORK—Three insurers intend to withdraw from the American Hull Insurance Syndicate, which writes hull and other marine coverages on behalf of its insurer members.

Marine Office of America Corp. of Cranbury, N.J., which held 111 shares in the syndicate, and Royal Insurance Group of Charlotte, N.C., which held 64 shares, plan to discontinue their ties with the syndicate, said syndicate President John A. Hickey. Together the companies account for 35% of the syndicate's shares.

MOAC has "verbalized its intent to withdraw," Mr. Hickey said, adding that the syndicate must receive written confirmation of MOAC's withdrawal by Sept. 1.

A spokeswoman for MOAC, a unit of New York-based Continental Corp., would not confirm that MOAC is leaving the syndicate.

Royal expects to "remain a major marine insurer," said Mike Taylor, director of marine insurance. However, Royal will no longer write the highly specialized "blue-water" hull coverages for large international vessels that the syndicate had underwritten on Royal's behalf.

The Nippon Fire & Marine Insurance Co. Ltd., whose U.S. offices are in Hartford, Conn., also is leaving the syndicate. Nippon held less than 1% of syndicate shares. "Involvement in the syndicate is no longer viable due to unfavorable experience" in the market, a spokeswoman said.

The departures, which will leave 21 member companies in the syndicate, will not affect capacity or coverages offered, Mr. Hickey said. The syndicate probably will not try to replace the companies, he said.

## Briefly noted

Moody's Investors Service Inc. has downgraded the financial strength ratings of two insurers, citing concerns about real estate holdings. Moody's on Aug. 16 downgraded Northwestern National Life Insurance Co. to A3 from A1 and State Mutual Life Assurance Co. of America to Aa3 from Aa1. . . . New Jersey regulators named Victor H. Palmieri deputy rehabilitator and chief executive officer of Mutual Benefit Life Insurance Co., subject to court approval. Mr. Palmieri was responsible for the mid-1980s reorganization of Baldwin-United Corp., which was the largest life insurance insurance rehabilitation project prior to Mutual Benefit. . . . A federal jury in New York has awarded \$91.3 million to 45 electrical substation workers who claim they suffer from asbestos-related diseases. The workers are among 700 former power plant employees whose asbestos bodily injury claims have been consolidated before U.S. District Judge Charles Sifton. In the next phase of the trial, 24 defendants—including asbestos manufacturers, utilities and contractors—will litigate how the damage award should be apportioned.

## Proposition 103

Continued from page 3

consistent logic other than political logic," one insurer asserted.

Insurers complain that despite extensive testimony on Mr. Garamendi's proposed Proposition 103 regulations, he has made only superficial changes to the rules he proposed in January.

Mr. Garamendi "is misleading the public terribly and has raised their expectations" that insurance costs are about to go down, even though Proposition 103 does not address the costs driving up rates, another insurer said.

"He has created an awful image of the industry," one insurer complained. "He has the whole populace believing the industry ripped them off by \$2.5 billion. We don't need this kind of rhetoric when everyone knows the California market is in trouble."

"Proposition 103 was the first clue to politicians that insurance could be a viable issue to work with, and they're painting with a broad brush. . . . even if it means it makes business less competitive in California," said Charles Skinner, senior vp-sales at broker Alexander & Alexander Services Inc. in Los Angeles.

Mr. Garamendi's regulations, first issued in January and modified through a process involving written filings and hearings (*BI*, April 1; Feb. 18; Jan. 14), were approved by the Office of Administrative Law earlier this month.

But the commissioner's proposal to allow insurers an aggregate 10% rate of return on California business in determining rate rollbacks was submitted to the state agency just last week. The agency has 10 days to review that proposal.

Proposition 103 originally mandated that insurers roll back insurance "charges" to 20% below November 1987 levels. The law granted relief from the rollback to any insurer that could prove the rollback would substantially threaten it with insolvency.

The California Supreme Court subsequently upheld the rollback provision but struck down the relief provision. The court instead ruled that insurers are entitled to a fair rate of return, which it did not specify (*BI*, May 8, 1989).

Following months of administrative hearings, former Insurance Commissioner Roxani Gillespie determined that a fair return for rollback purposes would be 11.2% (*BI*, June 18, 1990).

However, Mr. Garamendi now proposes allowing insurers an aggregate 10% rate of return on business written between November 1988 and November 1989. Formulas detailed in the regulations state that "what exceeds the 10% would be rebated to a maximum of 20% below 1987 rates," said Steven Miller, deputy commissioner in charge of Proposition 103 implementation.

But, the process for determining rollbacks is not that simple, he said.

The rebate also would be based on other factors applied to the rollback period of November 1988 to November 1989, Mr. Miller said. Those factors include:

- Imposing efficiency standards on insurers, under which the ratio of underwriting expenses to earned premiums is capped. This cap varies by line of coverage.

- Determining an insurer's allowable surplus by line of coverage using benchmark premium to surplus ratios the department has developed. Again, these benchmarks vary by line.

Only the surplus allocated to a given line will be considered in calculating refunds.

To allocate surplus to a given line, the department will consider the amount of net premiums the insurer has written in the state for that line and calculate the amount of surplus necessary to meet its benchmark premium to surplus ratio. Again, the ratio varies by line of coverage.

If an insurer is found to have had more surplus in the rollback period than allowed, the ordered refund will be greater to reflect that excess surplus, Mr. Miller said.

Other factors that will be considered in determining rate rollbacks are new rules on proper reserve strengthening; caps on the amount of executive salaries that insurers can charge against rates as an expense; and new rules prohibiting insurers from charging political contributions, lobbying costs and fines, and penalties for unfair and discriminatory conduct as an expense against rates.

Some insurers contend their rates were already 20% below November 1987 levels in the rollback period and that they lost money in 1988-89. Yet they may very well be required to make a refund under the regulations, said a spokesman for the Assn. of California Insurance Companies.

"You could literally have a company that lost money in 1989 and have a liability as a result of what Mr. Garamendi has done in the regulations," agreed an insurer.

Insurers "filed rates in 1988 and, having every reason to believe they were approved, they made their business decisions based on that approval," he said. "Now, three years later, they are told those rates can't include certain expenses" and must reflect other factors like caps on salaries and allowable surplus. "I don't think the courts will find that is a fair approach," he added.

Insurers say the 10% rate of return is not supported by testimony at earlier hearings and is lower than the 14% return allowed for public utilities in the state.

Insurers also denounce as arbitrary the limits placed on surplus for determining rollbacks because "the reason an individual company might elect to have a given percentage of surplus really relates to their perception of a rainy day fund," said Delia Chilgren, California regional counsel for Allstate Insurance Co. in Rancho Cordova.

Under Mr. Garamendi's regulations, "an insurer with billions of surplus nationwide can't charge the California policyholder for that protection," an insurer pointed out.

In addition, even though it is technically illegal for rates charged for one line of insurance to subsidize another, "these regulations allow the commissioner to order any one group of consumers to subsidize other consumers at his whim," the American Insurance Assn. said in a statement.

The regulations state: "The commissioner shall require that each line and coverage pay for itself and make the same proportional contribution to the insurer's profits, except where the commissioner finds, based on legal requirements or sound public policy, that it is necessary to deviate from the principle of inter-line equality."

As a result, even if rates for a line of business are unprofitable for an insurer, rather than allow it to raise rates, the commissioner could permit higher rates in other lines to give the insurer an overall 10% rate of return in the state.

Since personal auto rates are the political "hot button," Mr. Garamendi may try to keep auto rates low, an AIA spokesman agreed. That will mean policyholders in other lines—like commercial lines—will pay the highest premiums allowable under the regulations, the spokesman said.

For the rollback orders, "I would guess the department would have a hell of a time finding a company that's getting 10% on its auto business. They make their money on other lines. So if the department orders a refund for a company, it will be taking what was paid by a commercial policyholder and refunding it to the auto policyholder," said Peter Rice, legislative counsel for Liberty Mutual Insurance Co. in Boston.

"That approach is more troubling because of its implications for future rate increases," he added.

As a result of the rate of return insurers will be allowed in California, "I don't see any other way thar. for

companies' non-California business to subsidize California business," one insurer said.

"Doing business in California will become more difficult. Remaining in California will become more difficult," he said.

The argument that California is such a large market that no insurer can afford to abandon it may not be true, an insurer said. Subsidizing a large unprofitable market can jeopardize an insurer's business nationwide, he explained.

And, refund orders for commercial lines will hit some insurers doubly hard because of the long-tail nature of the business, said Michael O'Brien, a senior vp with Johnson & Higgins in Los Angeles.

Insurers that wrote medical malpractice, general liability and professional liability coverages in the rollback period might be ordered to make a refund and later be presented with claims for that period, he explained.

Other observers believe the regulations and the proposed rate of return may cause additional problems for insurers.

Because of the uncertainty surrounding the expected refund orders due to anticipated challenges by insurers, there could be "a dramatic impact" on insurers' financial statements, Allstate's Ms. Chilgren said. "The thing will have to be carried as a liability on the balance sheet, and it may impair them. It's just like an environmental liability—just like carrying the Exxon Valdez as a potential liability," she observed.

Some insurers, including Allstate, Liberty Mutual and Farmers Group Inc., say they do not believe they will have to make refunds to comply with Proposition 103's rollback provision based on the rates they charged in the rollback year.

But insurers stress they have not fully studied all the new formulas.

The department spokeswoman said that most of the data required from insurers is already stored in the department's computer, but some manual calculations still are necessary.

Overall, the process of determining the rollbacks is expected to be arduous, she said.

While Mr. Garamendi's regulations have thus far been applied only to Proposition 103's rollback provision, they also will be applied to future rate requests. Under Proposition 103, the Insurance Department must give prior approval to all rates.

The department has not yet determined the rate of return insurance companies will be allowed for future rates.

Meanwhile, Mr. Garamendi filed suit last week to ask a San Francisco Superior Court to order state Attorney General Dan Lungren to approve a \$750,000 contract between the Insurance Department and two former state Justice Department attorneys, Michael Strumwasser and Fred Woocher.

The attorneys are defending the department in all Proposition 103-related litigation.

Mr. Lungren has alleged that the contract violates the state's "revolving door" statutes prohibiting former state employees from profiting from state contracts. While at the Justice Department, both attorneys had been deeply involved in defending Proposition 103 and in an antitrust investigation of the insurance industry (*BI*, May 20).

Mr. Garamendi accused Mr. Lungren last week of "carrying the ball down the field for the insurance industry," because Messrs. Strumwasser and Woocher are "the best, most experienced team in the nation to represent the people and go toe-to-toe with the insurers' hordes of high-priced lawyers."

"This dispute is not about Proposition 103 or consumer protection; it's not about football either," Mr. Lungren replied. "In my view, this is about state contracts given to private lawyers in violation of the revolving-door statutes. This is about ethics in government."

# Ongoing soft market hurts brokers

By **LEONARD M. WILSON**  
Special to Business Insurance

**SECOND-QUARTER RESULTS** for the publicly traded insurance brokers were clearly depressed by the soft market.

Several of the brokers posted earnings that were generally regarded as falling short. At Marsh & McLennan Cos. Inc., earnings were flat; Alexander & Alexander Services Inc. and Arthur J. Gallagher & Co. experienced declines; only Hilb, Rogal & Hamilton Co. managed a small gain in earnings per share. Analysts are now shaving their estimates for the full year, a sure sign of disappointment.

No one is much surprised that the soft market persists. It is interesting, though, to note the comments of some contacts to the effect that underwriters are still willing to grant steep rate cuts to secure or retain a good risk. This reckless pricing behavior is usually associated with the earlier stages of a soft market rather than the supposedly benign later phase. These competitive inclinations seem to preclude a turn in insurance markets anytime soon.

Premium rates in the quarter probably declined in the range of 3% to 5% across a book of business. We hear of firming in marine and aviation rates, but in mainstream commercial lines competition has not materially abated.

Domestic retail commissions, as a consequence, typically increased in the low single digits for the public brokers.

Reinsurance brokerage also displayed rather anemic revenue momentum. We believe that reinsurance rates are flattish. Unlike retail brokerage, new business tends to be less important to the progress of reinsurance brokerage. Consequently, commission growth is dependent mostly on rate increases, at least in the current environment. In addition, there is not so much as a hint of primary companies moving in the direction of lower retentions.

Consulting, which for most brokers centers almost entirely on benefits, has provided a counterweight to the sluggishness of insurance brokerage for many quarters. But in the second quarter, consulting revenues decelerated to a rate of gain in the area of 8% to 10%. This contrasts with strong double-digit growth in preceding quarters. The recession is the culprit as clients postpone elective benefit projects.

In consulting sectors that are most sensi-

tive to the economy, revenues actually may have declined from year to year.

Investment income in the quarter ranged from flat to down compared with last year. The decline in short-term interest rates has reduced yields on invested funds materially. Without a clear-cut recovery in the economy, short-term interest rates are likely to remain at lower levels that will likely prove burdensome for investment income comparisons over the balance of the year.

International brokerage, whether retail or reinsurance, also achieved narrow gains. The abundance of insurance capital remains a worldwide phenomenon, notwithstanding the publicized problems of Lloyd's of London.

The depreciation of the dollar from the second quarter of 1990 to the second quarter of 1991 hurt profit margins on North American business whose costs are denominated in pounds sterling. Some relief from the vagaries of currency should be occurring in the upcoming quarter with the recent strength of the dollar against the pound.

Measured as a percentage of the previous year's commissions, new business varies from one broker to the other. Yet, as we have discussed in recent columns, new business production has eased somewhat for most of the public brokers. Lost business, well contained, has held roughly constant in percentage terms. Net new business—the total of new business less attrition in the existing book—can be pegged at about 6% to 8% now.

Several brokers cited the recession, now seemingly drawing to a close, as a factor in restraining second-quarter commissions on commercial lines. Economic activity generally is a muted influence on the operating performance of commercial property and casualty brokerage since clients do not reduce coverage in recessions. Reduced payrolls, inventories and other economically sensitive variables are currently depleting insurable values.

With a persistence that parallels the soft market, brokers again maintained a tight rein on their costs. Low single-digit increases in expenses were a partial buffer against reduced profit margins.

Narrowing profit spreads are the inevitable consequence of soft markets, and over this soft market profit margins have undergone compression.

A pronounced slowdown in its fast-grow-

ing consulting business marked the quarter for Marsh & McLennan. Belt-tightening on the part of clients affected most phases of consulting. Economic consulting was more severely constrained than the benefit segment. M&M's pretax margins remained above 20% for the quarter, a notable performance in light of the soft market's longevity and pressures on profitability.

Alexander & Alexander mustered very creditable new business gains in the quarter, but results suffered from flat investment income, soft rates and the effects of adverse currency on international brokerage.

Gallagher continues to show substantial gains in its self-insurance activities through its Gallagher Bassett Services subsidiary. Fees from this area rose 14% in contrast with a decline of about 2% in brokerage commissions.

Hilb, Rogal & Hamilton appears to have benefited from its focus on smaller commercial accounts. This segment of the market may be a trifle less competitive than larger commercial lines.

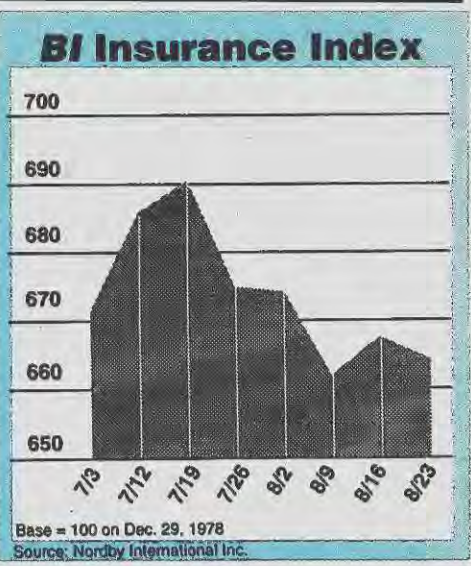
In the course of our normal activities, we encounter a variety of professionals within the insurance industry. Recently, we were surprised by the almost general agreement that insurance markets have become more competitive. One contact cited large commercial risks as a sector that had recently become more difficult.

Impressions of the rate environment tended to be anecdotal, qualified by analysis of the rate of change in the insurance brokers' quarterly commission growth.

Based on our latest soundings, we were not encouraged by the course of the markets or the timing of change in the environment. This focus on rates at times seems oppressive, but for insurance brokers seeking to weather the impact of the soft market, premium rates rank as the key factor in the outlook for stock prices.



Leonard M. Wilson is a senior vp with Lazard Asset Management Inc. He is a member of the New York Society of Security Analysts.



Insurance industry stocks remained flat last week as the *Business Insurance Index* fell 3.2 points to 664.1 on Aug. 23, from 667.3 on Aug. 16. Advancing issues for the week were led by CNA Financial Corp., up 8.9%; Safeco Corp., up 8.4%; and Statesman Group Inc., up 7.1%. Declining issues for the week followed Chubb Corp., down 5.4%; Hartford Steam Boiler, down 5.4%; and Harleysville Group, down 5.3%. The most active issue for the week was U.S. Healthcare, with 5.6 million shares traded. The *BI Index* was down 0.5%; the Standard & Poor's 500 climbed 2.2%; the Dow Jones 30 Industrials were up 2.4%; and the New York Stock Exchange Composite rose 2.0%.

Aug. 22 Companies	Price pence	P/E	Div. pence	Yield %	1 Week	
					High	Low
Comm Union	517	NM	30.7	5.9	517-507	
Genl Accident	538	NM	35.7	6.6	542-533	
Gdn Royal Exch	186	NM	15.9	8.5	186-180	
Royal	405	NM	34.7	8.6	415-390	
Sun Alliance	366	NM	18.7	5.1	376-366	

Company	Price	P/E	Div.	Yield	High-Low
Bradstock	170	19.3	6.0	3.5	170-165
CE Health	465	16.2	34.5	7.4	465-458
Hogg Group	208	12.4	10.7	5.1	208-201
Lloyd Thompson	393	26.1	10.0	2.5	393-381
PWS Holdings	76	9.3	4.7	6.2	76-76
Sedgwick Grp	273	26.0	16.0	5.9	273-266
Steel Bri Jones	309	16.3	16.3	5.3	309-304
Willis Corroon	311	16.5	17.6	5.6	312-295

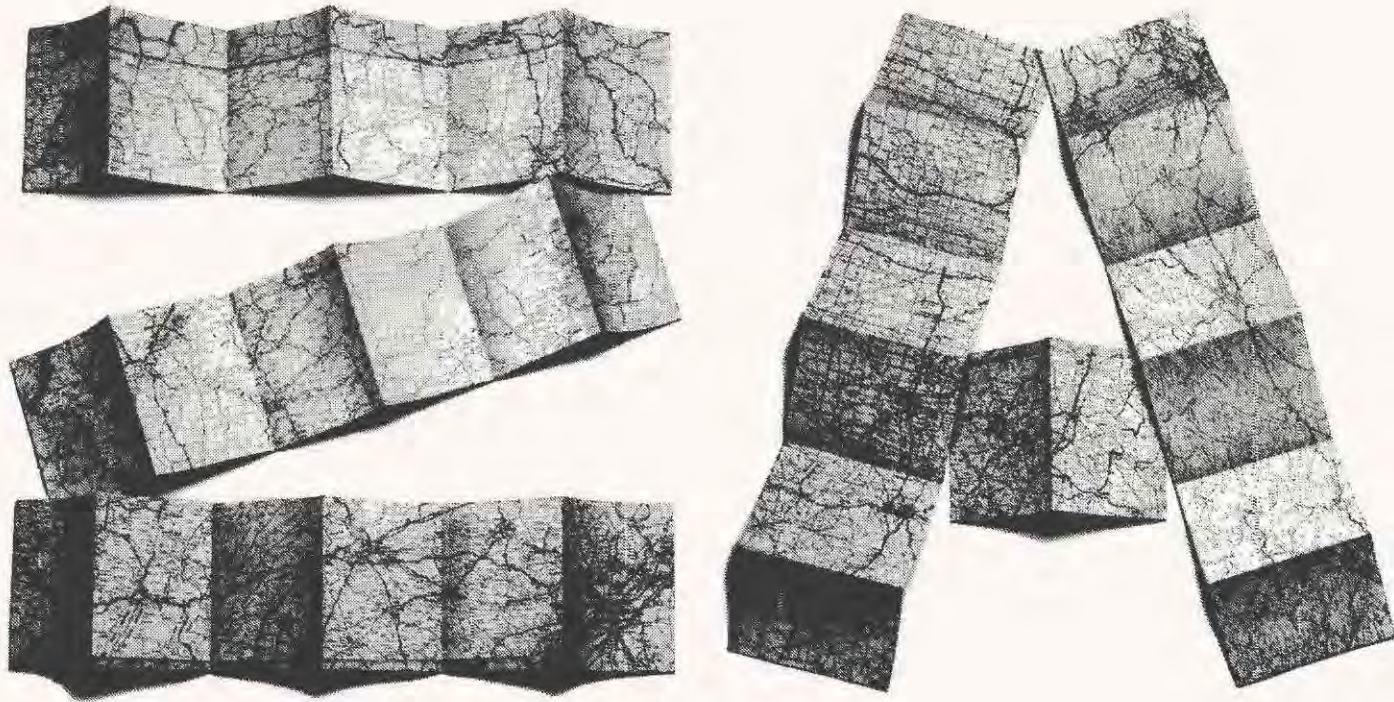
Source: Philip Olsen, Insurance Industry Analyst  
London

## BI Industry Stock Report

AUGUST 19, 1991 THROUGH AUGUST 23, 1991

	Weekly Price % change	Year to Date % change	Annual		Vol.(000)	\$ Div.	% Yield	P/E	Book value	Mkt/Bk. value		Weekly Price % change	Year to Date % change	Annual		Vol.(000)	\$ Div.	% Yield	P/E	Book value	Mkt/Bk. value					
			High	Low										High	Low											
<b>BROKERS</b>																										
Alexander & Alexander	NYS	21.25	-2.86	-8.11	27.63	16.13	665	1.00	4.71	17	9.77	2.18	NAC Re Corp.	OTC	26.00	2.46	-21.21	28.34	17.00	91	0.12	0.46	14	18.90	1.38	
Gallagher Arthur J. & Co.	NYS	20.25	-2.22	-12.90	28.38	19.50	30	0.64	3.16	16	5.88	3.44	Navigator's Group	OTC	32.50	5.69	48.85	34.50	16.50	17	0.00	0.00	19	13.52	2.40	
Frank B. Hall	NYS	3.63	0.00	0.00	4.13	2.00	110	0.00	0.00	-7	-5.24	-0.69	Nobel Insurance LTD.	OTC	3.75	0.00	25.00	4.38	2.50	156	0.00	0.00	5	7.76	0.48	
Hilb, Rogal & Hamilton	OTC	13.63	-1.80	-7.63	17.50	11.25	24	0.36	2.64	21	3.56	3.83	NWNL Companies	NYS	23.75	2.15	40.74	32.88	11.75	675	1.40	5.89	6	42.73	0.56	
Marsh & McLennan	NYS	78.25	2.96	0.32	87.25	59.75	591	2.60	3.32	19	14.77	5.30	Ohio Casualty Corp.	OTC	46.25	2.21	12.80	50.25	26.75	302	2.48	5.36	9	36.38	1.27	
Poe & Associates	OTC	12.00	0.00	87.50	12.50	6.25	4	0.32	2.67	14	2.09	5.74	Old Republic Int'l	NYS	30.75	-2.38	34.43	31.88	17.38	93	0.72	2.34	7	33.09	0.93	
BROKERS AVERAGE																										
-0.4																										
8.5																										
<b>CONGLOMERATES &amp; HOLDING COMPANIES</b>																										
Berkley W.R. Corp.	OTC	26.63	-4.05	-29.00	32.25	19.00	177	0.32	1.20	15	23.89	1.11	Provident Life	OTC	19.00	-5.00	8.57	24.50	12.00	415	1.00	5.26	5	25.88	0.73	
Berkshire Hathaway Inc.	NYS	8800.00	-0.28		31.84	8800.00	171.88	1	0.00	0.00	27	4612.00	1.91	Re Capital Corp.	ASE	17.13	-1.44	33.01	18.63	11.75	14	0.20	1.17	12	15.05	1.14
ITT (Hartford Group)	NYS	60.38	2.99	25.78	63.00	40.25	1547	1.72	2.85	9	64.01	0.94	Reliance Group Holdings	NYS	4.75	-5.00	2.70	7.50	4.25	28	0.32	6.74	-8	1.32	3.60	
Sears (Allstate)	NYS	43.13	3.60	69.95	43.50	22.00	3492	2.00	4.64	15	37.38	1.15	RLI Insurance Corp.	NYS	14.50	1.75	0.00	16.38	9.63	47	0.48	3.31	7	14.41	1.01	
CONGLOMERATES AVERAGE																										
0.6																										
24.6																										
<b>INSURERS/REINSURERS</b>																										
Aetna Life & Casualty	NYS	36.63	-2.66	-6.09	49.13	29.00	1887	2.76	7.54	8	64.23	0.57	Seibels Bruce Group	OTC	7.63	5.17	79.41	8.88	4.25	67	0.36	4.72	153	7.35	1.04	
American General	NYS	39.13	-1.26	27.24	43.13	23.50	708	2.00	5.11	9	37.14	1.05	Selective Ins. Group	OTC	15.63	-0.79	17.92	18.00	12.50	25	1.04	6.66	9	18.91	0.83	
American Heritage	NYS	29.00	2.65	38.10	32.25	19.63	3	1.08	3.72	12	19.25	1.51	Statesman Group Inc.	OTC	5.63	7.14	259.88	5.69	1.25	777	0.00	0.00	-281	2.48	2.27	
American Indemnity/Fin1	OTC	7.50	3.45	130.77	7.75	2.75	2	0.08	1.07	4	12.93	0.58	Tokio Marine & Fire	OTC	48.50	4.30	2.65	56.50	34.50	5	0.00	0.00	-	70.93	0.68	
American International	NYS	83.63	-0.59	8.78	102.00	57.00	1765	0.48	0.57	12	45.34	1.84	Torchmark Corp.	NYS	50.00	2.68	6.77	74.25	47.00	733	2.60	3.88	7	52.00	1.29	
Aon Corp.	NYS	38.25	-1.29	10.07	41.75	26.75	314	1.60	4.18	11	18.50	2.07	Transamerica	NYS	36.00	6.27	10.34	38.38	23.25	1096	1.96	5.44	13	36.56	0.98	
Argonaut Group	OTC	25.50	-1.92	19.53	33.38	17.75	41	0.68	2.67	8	48.26	0.53	Transatlantic Holdings	NYS	34.00	-1.81	24.20	39.38	18.88	66	0.20	0.59	12	18.38	1.85	
AVEMCO Corp.	NYS	21.75	1.16	29.21	22.88	14.13	30	0.40	1.84	16	9.55	2.28	Travelers Corp.	NYS	19.98	-4.91	16.54	26.38	11.50	727	1.60	8.26	-10	41.44	0.47	
Baldwin & Lyons Inc.	OTC	22.75	-4.21	21.33	25.25	17.00	3	0.28	1.23	7	24.29	0.94	Trenwick Group Inc.	OTC	26.50	-1.85	14.59	30.00	16.25	63	0.60	2.26	10	21.71	1.22	
Belvedere Corp.	ASE	3.38	0.00	35.00	3.38	1.75	2	0.04	1.19	23	7.65	0.44	United Fire & Casualty	OTC	44.25	-2.75	25.98	58.00	28.75	4	1.32	2.98	11	35.39	1.25	
Chandler Insurance	OTC	3.19	6.27	-53.63	7.25	2.75	470	0.00	0.00	-2	5.95	0.54	USF&G Corp.	NYS	6.88	1.85	-8.33	23.50	6.13	2330	0.20	2.91	-1	11.96	0.57	
Chubb Corp.	NYS	63.25	-5.42	16.59	75.25	34.63	1595	1.48	2.34	10	35.19	1.80	UNUM Corp.	NYS	63.25	-1.56	35.66	70.25	32.13	322	1.04	1.64	11	37.25	1.70	
CIGNA Corp.	NYS	43.13	0.29	5.50	56.75	33.25	595	3.04	7.05	11	73.15	0.59	USLIFE Corp.	NYS	42.00	3.38	50.00	42.75	23.25	99	1.64	3.90	9	60.34	0.70	
CNA Financial Corp.	NYS	85.50	6.92	24.59	92.50	49.50	149	0.00	0.00	12	70.23	1.22	Unitrin	OTC	37.63	-0.99	22.36	41.50	24.50	360	1.00	2.66	14	30.70	1.23	
Continental Corp.	NYS	27.25	-1.36	9.55	30.63	15.75	841	2.60	9.54	9	37.83	0.72	Washington National	NYS	14.13	0.89	29.89	18.63	9.38	43	1.08	7.65	-5	26.86	0.53	
Durham Corp.	OTC	33.25	3.91	18.75	34.13	23.00	18	1.00	3.01	19	26.04	1.19	USLICO Corp.	NYS	20.00	-0.62	25.98	21.75	14.75	21	1.00	5.00	11	29.44	0.68	
Ford American Corp.	NYS	63.75	-0.39	22.89	65.25	41.63	68	0.68	1.07	19	36.11	1.77	Zenith National Ins.	NYS	16.75	-1.47	22.94	18.50	9.88	56	1.00	5.97	-88	13.14	1.27	
Fremont General Corp.	OTC	23.63	-0.53	62.93	25.25	10.13	212	0.88	3.72	7	19.13	1.23	INSURERS/REINSURERS AVERAGE													
Frontier Insurance Group	NYS	25.13	4.69	32.24	26.38	16.75	23	0.00	0.00	9	11.20	2.24	0.4													
General RE Corp.	NYS	86.75	-1.42	-6.72	102.50	69.00	1288	1.68	1.94	12	37.50	2.31	28.5													
Harvester Insurance Co.	OTC	30.50	4.27	15.09	30.75	21.00	77	0.44	1.44	11	37.44	0.81	<b>HEALTH MAINTENANCE ORGANIZATIONS</b>													
Harleysville Group	OTC	27.00	-5.26	18.03	32.00																					

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