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Update

Early retirement incentive offers do not violate federal law: Judge

BUFFALO, N.Y.—A federal judge has ruled that early retirement incentive programs do not necessarily violate federal law but that the portion of a program that denied eligibility to older current workers was discriminatory.

U.S. District Court Judge John Curtin in Buffalo ruled that an early retirement plan offered by the North Tonawanda School System in western New York was valid under the Age Discrimination in Employment Act because it was volun-

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Pan Am liability claims to exceed $250 million

By STACY SHAPIRO and DOUGLAS McLEOD

LONDON—Liability insurers for Pan American World Airways already have reserved $250 million to $300 million for passenger claims arising from the crash last week of a jumbo jetliner en route from London to New York, London and U.S. aviation insurance sources say.

An international agreement that limits an airline's liability for international flights is not expected to hold down liability costs.

Based on the $250 million to $300 million liability estimate, the Dec. 21 crash of Pan American World Airways Flight 103 near the Scottish-English border, which killed all 243 passengers and 15 crew members on board, would be the second most costly aviation loss on record.

The most expensive airline liability loss was the 1985 crash of a Japan Air Lines Boeing 747, which killed 520 people and injured four others. The JAL liability loss is expected to exceed $345 million (*BI*, Oct. 26, 1987).

In addition, about 15 residents of the Scottish town of Lockerbie were dead or missing last week. Fragments of the Boeing 747 jetliner were spread across a 14-mile radius, setting on fire cars, homes and a gas station.

Last week, it was not known whether all-risk or war risk underwriters will pay hull claims arising from the Dec. 21 Pan Am crash.

Authorities last week could not confirm whether the 18-year-old aircraft exploded because of sabotage or because of a structural defect.

A spokesman for Boeing Corp., which manufactured the jetliner, said the plane was modified in 1987 for possible conversion for use as a military cargo plane as part of the U.S. Air Force's Civil Reserve Air Fleet program. After the modifications, which included insertion of a cargo door and structural strengthening of floors and wings, the plane was returned to commercial passenger service, the spokesman said.

The U.S. Federal Aviation Administration gave Pan Am an award earlier this year for developing a "self-inspection audit program" that exceeded minimum FAA requirements for aircraft inspections, an FAA spokesman said.

Pan Am's $750 million in liability insurance, which covers both all risks and war risks, is led by United States Aircraft Insurance Group in New York.

The $32 million insured hull loss will either be paid by hull war risk insurers led by Lloyd's of London marine underwriter Frank Elliot at Janson Green Ltd. or by hull all-risk underwriters led by USAIG, depending on what caused the loss.

Among those who died last week on the Pan Am flight are believed to be at least one client of the London insurance market who was bound home for Christmas after negotiating a year-end renewal; American servicemen from Frankfurt, West Germany, who changed planes at Heathrow airport; and 38 students from Syracuse University in New York.

Because it was bound for an American destination from an overseas airport, liability payments on behalf of Pan Am could be limited to $75,000 per passenger under the Warsaw Convention as amended by the Montreal Agreement (*BI*, Nov. 21).

The $75,000 per-passenger liability limit, which applies only to overseas flights with a stop in the United States, applies to airlines in the absence of "willful misconduct" or "reckless misconduct," said leading British aviation lawyer Peter Martin, senior partner for the London-based law firm Frere Cholmeley.

If this limit is observed, passenger liability losses for Pan Am would be capped at about $18.3 million.

However, there is precedence that the Warsaw Convention

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Consultants dispute survey's analysis of group health costs

By ALISON KITTRELL and DONNA DiBLASE

Group health insurance premiums have not increased as much as media reports suggest if employers facing no premium increase are taken into account, according to a survey released last week.

However, several employee benefit consultants dispute the survey's findings, saying few—if any—insured group health plans have escaped premium increases that at least reflect medical care inflation.

Health insurance premiums rose an average of 12% between spring 1987 and spring 1988, far less than previously reported, according to the survey of 1,665 employers nationwide conducted by the Health Insurance Assn. of America and Johns Hopkins University.

The HIAA explained that part of the reason for the discrepancy between its findings and media reports of health insurance premium increases is that the HIAA figures take into account all employers surveyed —including about one-third of the respondents that reported no premium increases from the previous spring—while media reports generally include only data from employers that have been hit with health insurance premium increases.

When employers that report no increase in health insurance pre-

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Insurers to pay Enron $162 million to settle 1985 political risk claim
Page 2

Shell has no coverage for cleanup, jury says

By STACY ADLER

SAN BRUNO, Calif.—The conclusion of the nation's first pollution coverage jury trial is sending shock waves throughout corporate America.

After spending tens of millions of dollars and half a decade litigating with its insurers, Shell Oil Co. has been told it has no insurance coverage for its share of a hazardous waste cleanup estimated at $2 billion to $4 billion.

The 12-member jury found that Shell knew it was polluting the environment from as early as 1952 and therefore is not covered for the damage.

Houston-based Shell says it will appeal the ruling.

Attorneys say the landmark jury decision validates the "expected and intended" defense that insurers use when litigating with policyholders. Under this defense, insurers argue that policyholders that are aware they are polluting the environment are not entitled to coverage because insurance does not cover expected and intended events.

In addition, the ruling could cause some policyholders to think twice before suing their insurers for coverage of pollution cleanup costs.

In 1983 Shell sued more than 260 of its comprehensive general liability insurers for the costs of cleaning up two hazardous waste sites—one near Denver and one in Fullerton, Calif. (*BI*, Oct. 12, 1987).

This trial involved Shell's right to insurance coverage for the Denver site, by far the larger of the two polluted sites.

A separate trial on insurance coverage for cleaning up the California site will begin early next year.

Shell and the U.S. Army already have agreed to share the cost of cleaning up the Rocky Mountain Arsenal, the Denver site (*BI*, Feb. 8).

The arsenal was used by the Army to manufacture and store chemical weapons, including nerve gas, between 1942 and 1982. Shell leased the site from the government and operated a pesticide factory there from 1947 to 1982.

Under their consent decree, Shell will pay 50% of the first $500 million in cleanup costs, 35% of the next $200 million and 20% of any additional costs. The Army will pay the remainder.

Some estimates place the total cost of cleaning up the 27-square-mile site as high as $4 billion.

This means that Shell is liable for as much as $1 billion in cleanup costs and cannot tap any of its 800 insurance policies for help.

In May, San Mateo County Superior Court Judge William Lanam issued dozens of rulings interpreting Shell's insurance policies. These rulings formed the foundation for the jury trial that began on Aug. 30.

For four months, jurors gathered in a makeshift

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Update

Court OKs early retirement

Continued from previous page
tary and the employer had "legitimate business reasons" for offering the program.

The school system offered teachers who agreed to retire between ages 55 and 60 an option to take a $10,000 lump sum payment or a combination of a lump sum and improved medical benefits with a total value of $10,000 (*BI*, Nov. 17, 1987).

But, Judge Curtin ruled the plan discriminated against the two teachers filing suit because their age did not meet the plan's eligibility requirements. Both teachers were older than 60 when the plan was first offered.

"This is a significant decision. It would seem one could structure an incentive program on a 'graded' basis with incentives decreasing with age as long as that reduction is based on some objective standard," said Seth Tievsky, an attorney in The Wyatt Co.'s Research and Information Center in Washington, D.C.

However, Christopher Mackaronis, an attorney with the American Assn. of Retired Persons in Washington, called the decision largely a victory for workers because the ruling says employers cannot arbitrarily exclude workers from an incentive program based on age.

Rig insured for $90 million

LONDON—A mobile drilling rig that sank off Nova Scotia Dec. 15 is insured for $90 million.

The 5-year-old rig, owned by Houston drilling contractor Rowan Cos. Inc., is expected to be declared a total loss. The rig capsized and sank while being towed from Nova Scotia to the North Sea. All 27 people aboard the rig escaped uninjured.

The rig's $90 million property insurance was placed by Sedgwick Offshore Resources Ltd. mainly in the London and Scandinavian marine markets. About 63% is insured in the London market, much of that through the London Master Energy Line Slip.

ERISA protection upheld

SAN FRANCISCO—The U.S. Supreme Court may be asked to decide whether employees in California have broad rights to recover punitive and non-economic damages in suits against group health care insurers.

The California Supreme Court ruled 5-2 on Dec. 15 that a state law that allows beneficiaries of health plans to sue insurers for delays in or denials of claims does not apply to plans regulated by the Employee Retirement Income Security Act of 1974.

Plaintiff's attorney William M. Shernoff of Shernoff, Scott & Bidart in Claremont said he may appeal the decision "because it's such an important issue to millions of Americans."

In the case, San Diego-area resident Joseph V. Juliano sued Commercial Life Insurance Co. for bad faith and sought non-economic and punitive damages after he was denied payment for eye surgery in 1985.

The ruling closely followed a 9th U.S. Circuit Court of Appeals decision in another case that beneficiaries in ERISA plans cannot sue under state law for delays or denial of benefits (*BI*, Oct. 10).

Both decisions confirm that ERISA plans were intended to avoid the sorts of claims that sometimes entangle other plans, said David L. Bacon of Adams, Duque & Hazeltine, who represented Commercial Life. "Congress didn't want to hamstring employers with punitive damages" when they set up an ERISA-regulated retirement or health benefit plan, he said.

The lawmakers also "did not intend this to be a shield for fraud," Mr. Shernoff said.

Lee resigns from Texas Board

AUSTIN, Texas—A.W. "Woody" Pogue, who as deputy commissioner has directed the Texas State Board of Insurance since early November, will assume the post of insurance commissioner following the resignation of Insurance Commissioner Doyce Lee.

Mr. Lee resigned in the midst of criticism from Texas legislators, who have charged that the State Board is ineffective in regulating insurers. The criticism was first leveled after Dallas-based National County Mutual Fire Insurance Co. in October was declared insolvent by around $54 million—the largest of a Texas property/casualty insurer (*BI*, Nov. 7).

Mr. Pogue took over administrative duties of the State Board last month after Mr. Lee agreed to step aside during an "administrative inquiry" into the handling of the National County Mutual insolvency. Jim Adams, an independent consultant who is heading the investigation, said he has not found any evidence of criminal wrongdoing related to the insurer's collapse.

Chief Liquidator James Odiorne and his wife, Alice, who oversaw legal services, also have resigned from the board.

Court blocks worker drug tests

SAN FRANSISCO—A federal judge last week temporarily blocked implementation of the Transportation Department's random drug testing plan for interstate highway truck and bus drivers until court challenges to the rule are resolved.

The rule is part of a comprehensive drug testing program of transit workers outlined by the Transportation Department last month (*BI*, Nov. 28). The rules were scheduled to take effect in December 1989 for companies with 50 or more employees and a year later for

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Errors & omissions

• John Hancock International Group Program is represented by Seguros La Seguridad C.A. in Venezuela. That office was inadvertently omitted from *Business Insurance*'s Nov. 21 geographical index of multinational benefit networks.

New NAIC rules target reinsurance payments

By MEG FLETCHER

NEW ORLEANS—New accounting rules designed to enhance insurer and reinsurer solvency approved by state regulators earlier this month take one of the strongest swipes yet at uncollectible reinsurance.

The new accounting rules alone could cause ceding insurers to write off up to $4 billion in surplus and shrink capacity as a result, warned a representative of Coopers & Lybrand, who unsuccessfully urged commissioners at the New Orleans meeting to delay action on the accounting rules.

One state insurance department official, however, said there is not enough information available to predict the financial impact of the new rules.

Regulators attending the National Assn. of Insurance Commissioners' winter meeting Dec. 11-16 also decided scrutinize the ratemaking role of advisory organizations, such as the Insurance Services Office Inc.

That decision came a day after representatives of ISO and the Risk & Insurance Management Society Inc. said they are willing to accept a compromise worked out by an NAIC subgroup on ISO's proposed changes to commercial general liability insurance forms (*BI*, Dec. 19).

Also during the meeting, the NAIC released for comment its new Health Maintenance Organization Guaranty Association Model Act, which outlines guidelines for states that want to establish a preassessment guaranty fund to protect members of an HMO that becomes insolvent.

With NAIC approval of a subgroup's proposed reinsurance accounting rule changes, beginning next year ceding insurers will have to write off a percentage of undisputed overdue reinsurance against their capital and surplus.

The change, which applies to insurers' 1989 operations reported in 1990, does not apply to reinsurance ceded to state or federally created residual market mechanisms, such as state auto plans or federal flood insurance programs.

The accounting change imposes a penalty to surplus of at least 20% of undisputed reinsurance from authorized reinsurers if the reinsurance is more than 90 days overdue according to the terms of the contract. However, state insurance examiners could require a greater penalty if the circumstances warrant it, according to the measure.

But disputed reinsurance amounts must merely be footnoted, in keeping with an accounting change the NAIC approved last year for 1989 reporting.

The new procedure also requires ceding insurers to write off 20% of all reinsurance credits from a reinsurer that is determined to be a slow payer under a formula contained in the measure.

According to that formula, a reinsurer is considered a slow-payer if: the amount of paid loss recoverables more than 90 days overdue, divided by the sum of all

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2 directory deadlines approaching

Deadlines are approaching for companies to return questionnaires to be listed in two *Business Insurance* directories: the directory of safety consultants and the directory of third-party claims administrators.

The directory of safety consultants will appear in the Jan. 16 issue, which also will contain a spotlight report on workers compensation.

The third-party claims administrators directory will appear in the Jan. 30 issue, which will focus on trends in self-insurance.

If your company offers safety consulting services or offers claims administration, adjusting or auditing services for self-insured clients and you have not yet received a questionnaire, please request one immediately by calling Christine Woolsey at 312-649-5460.

The extended deadline for safety consultants to return questionnaires is Jan. 3; TPAs have until Jan. 13 to submit completed questionnaires to *Business Insurance*.

Political risk insurers owe firm $162 million

By JUDY GREENWALD

NEW YORK—In one of the largest-ever insurance-related arbitration awards, a group of insurers must pay $162 million to Enron Corp. because of the 1985 appropriation of the company's gas and oil wells by the Peruvian government.

New York-based American International Group Inc., the lead insurer of the group, wrote the bulk of the coverage for Belco Petroleum Corp., a subsidiary of Houston-based Enron, said David Dykhouse, an attorney with Shearman & Sterling in New York representing Enron.

AIG units insured 64.3% of the risk.

"This is one of the biggest awards ever given in an insurance arbitration," said Mr. Dykhouse, a former Michigan insurance commissioner.

Enron, which contended it had lost $363 million in property as a result of the appropriation, claimed the coverage limit of $200 million plus $56 million in interest. Belco had $200 million in limits under three separate but essentially identical three-year political risk insurance policies written in 1983 by AIG; St. Paul, Minn.-based Athena Assurance Co., a subsidiary of the St. Paul Cos. Inc.; and Lloyd's of London.

AIG subsidiary National Union Fire Insurance Co. of Pittsburgh, Pa., wrote 54.3% of the risk on the AIG policy, while AIG Oil Rig, another AIG subsidiary, wrote 10% of the total risk.

Other subscribers on the AIG policy and their share of the risk, according to Mr. Dykhouse, were: New York-based American Offshore Insurance Syndicate, a syndicate of more than 35 insurers, 5%; Norwegian insurer Store Brand Norden, 5%; Arkwright Mutual Insurance Co. of Waltham, Mass., 2.5%; Warren, N.J.-based Pacific Indemnity Co., a unit of Chubb Corp., 1.25%; and Balti-

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Top risk management stories

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✓ It may take some Lloyd's of London syndicates three years to assess their gross losses from the Piper Alpha explosion, a managing agent estimates. **PAGE 32**

✓ New state regulations that cap payments for treatment of work-related illness and injury are expected to significantly reduce work comp costs in Michigan. **PAGE 34**

✓ Insurance industry plaintiffs blast California's Proposition 103 in briefs filed last week asking the state's Supreme Court to strike down the law. **PAGE 39**

Departments

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The top stories of 1988

Government tinkering tops benefit ballots

By JERRY GEISEL

Once again, events originating in Washington dominate employee benefit managers' choices as top stories of the year.

Three of this year's top stories involved news from Capitol Hill, while a fourth story had a partial Washington connection.

The clear winner as the top story of 1988 was the complex Section 89 non-discrimination rules for welfare plans and the employer drive to seek legislative relief from Section 89's massive administrative burdens.

The No. 2 story of 1988—the continued escalation in health care costs—also was one of the top selected stories in 1987. Last year, benefit managers selected soaring health care costs as the fourth most significant story of the year.

The story chosen by benefit managers as the third most important story of 1988 was a Senate panel's approval of legislation introduced by Sen. Edward Kennedy, D-Mass., to require all employers to offer a health care plan that would meet minimum federal standards.

The No. 4 story of 1988 was congressional approval of legislation establishing the biggest expansion ever of the federal Medicare program to give retirees more protection from acute care catastrophic health care expenses.

The story selected by benefit managers in 1988 as the fifth most significant story of the year had a partial connection to the nation's capital. That story was on the soon-to-be-issued rules by the Financial Accounting Standards Board requiring employers to recognize their retiree health care obligations on their balance sheets and the failure of Congress to give employers tax incentives to prefund those enormous obligations.

Washington-related events also dominated benefit managers' selections as top stories of the year in 1987.

Last year, three Washington events were chosen as top stories of the year: Employers protesting the harsh penalties of the Consolidated Omnibus Budget Reconciliation Act of 1985; the introduction of Sen. Kennedy's mandated health care legislation; and an unsuccessful congressional attempt to limit tax breaks for employees participating in flexible benefit programs (*BI*, Dec. 28, 1987).

The only non-Washington stories to break into the 1987 list of top five stories were surging group health care costs and employers' concerns about the costs of their post-employment health care programs.

Business Insurance polled members of its Employee Benefit Board and randomly selected benefit managers to determine the top stories of 1988. A story was given five points for each first-place vote it received, four points for each second-place vote, three points for each third-place vote, two points for each fourth-place vote and one point for each fifth-place vote.

Forty-two benefit managers responded to the survey.

Section 89, that part of the Internal Revenue Code that requires employer-sponsored welfare-type programs to meet certain non-discrimination rules beginning next year, collected 138 total points as the top story of 1988.

Included in Section 89's 138-vote total were 15-first place votes, nine second-place votes, seven third-place votes, two fourth-place votes and two fifth-place votes.

It is not a surprise that Section 89 was benefit managers' overwhelming choice as the top story of 1988 (see synopsis, page 14).

Like much of recent benefits legislation, Section 89 was drafted behind

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Attacks on insurers rouse risk managers

By JAMES M. BURCKE

A double-barreled attack on the property/casualty insurance industry ranked 1-2 as the most important stories of 1988.

The approval by California voters of Proposition 103, which—if upheld by the California Supreme Court—will roll back property/casualty insurance charges in the state to 20% less than November 1987 levels, narrowly was chosen as the most important event of 1988 in a *Business Insurance* survey of risk managers.

Closely following was the antitrust litigation filed against insurance industry defendants by 19 state attorneys general.

Last year's top story—competition in the commercial property/casualty insurance market—finished in third place this year but not far behind the antitrust suits.

The two stories rounding out the top five risk management stories of the year were:

- The election of Vice President George Bush as president of the United States.
- Differing rulings by courts around the country on whether general liability insurance policies cover the cost of government-mandated hazardous waste cleanups.

Many of the members of the *Business Insurance* Risk Management Board and randomly selected readers who participated in the survey pointed to the far-reaching effects that Proposition 103 and the antitrust suits could have on the property/casualty insurance industry and the lack of trust that voters and politicians foster toward insurers.

Proposition 103 and the antitrust suits "reflect the general lack of understanding of the insurance industry and the political/public tendency to blame the industry for conditions it reflects but does not cause," said the senior vp of a commercial banking institution with 10,000 employees. "Carried to its logical conclusion, this attitude will undermine the long-term viability of the market as we know it—bad news, in my opinion."

Many respondents noted that Proposition 103—which insurers say could cost them $4 billion in premiums if the rollback provision is upheld—is only the harbinger of increased consumer scrutiny of the insurance industry. Already, consumer groups in other states are readying similar insurance reform drives (see synopsis, page 25).

"Proposition 103 has the potential to be the first step in a 'consumerist' process which could destroy the insurance industry. Unless stopped here, this process could well lead to the repeal of the McCarran-Ferguson Act, rates established by election and judicially mandated coverages," said Richard E. Davis, insurance manager at Southern Illinois University in Carbondale, Ill.

"The California Proposition 103 situation is a dangerous game being played out by an uninformed and emotional public and is part of a grand strategy by opponents of the insurance industry who will not be satisfied until the private insurance industry is brought to its knees and replaced by some social/governmental program," said Richard C. Heydinger, risk management director for Hallmark Cards Inc. of Kansas City, Mo., and president of the Risk & Insurance Management Society Inc.

Proposition 103 "points up the continuing poor public image our industry has with the general public. The real benefit of insurance to the everyday individual seems lost and ignored," remarked Ralph F. Perry, vp-risk man-

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Top employee benefit stories

Story	Number of votes 1st	2nd	3rd	4th	5th	Total points*
Section 89 non-discrimination rules	15	9	7	2	2	138
Group health care costs continue to soar	13	5	3	1	1	97
Senate panel OKs mandated health benefits	5	3	6	3	6	67
Congress approves Medicare expansion	1	2	8	3	6	49
Retiree health care costs; FASB proposal	0	8	3	1	1	44
401(k) plan non-discrimination rules	1	4	1	3	1	31
HMO Act amendments passed	0	1	1	10	1	28
George Bush elected president	2	2	0	3	3	27
COBRA non-compliance penalties reduced	1	1	3	0	8	26
Benefit costs top $10,000 per worker	0	3	2	3	0	24

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

Top risk management stories

Story	Number of votes 1st	2nd	3rd	4th	5th	Total points*
California voters approve Proposition 103	15	13	6	5	3	158
Insurance industry faces antitrust suits	11	11	13	9	4	152
Property/casualty rates continue to soften	17	7	4	8	3	144
George Bush elected president	5	5	6	5	3	76
Courts issue differing waste cleanup rulings	5	4	4	9	3	74
Regulators give more control over purchasing groups	0	1	7	5	3	38
Jury awards damages against cigarette maker	2	4	0	3	4	36
More firms sue insurers over cleanup costs	1	4	2	1	5	34
Asbestos property damage ruled insurable	0	3	2	7	1	33
House panel votes to amend McCarran-Ferguson	2	1	4	1	4	32

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

Benefit events

Continued from previous page
closed congressional doors. It was tacked on to the Tax Reform Act of 1986, without a single congressional hearing, by staffers who were totally indifferent to the administrative burdens Section 89 would cause employers.

Indeed, companies will have to compile and analyze reams of benefit plan enrollment and participation information.

And, even after that information is dissected, at a huge cost, companies may find that they can't pass Section 89's non-discrimination tests. For example, employees working at least 17.5 hours a week must be counted for discrimination testing purposes. Employers, though, rarely extend benefit coverage to part-time employees working fewer than 24 or 20 hours a week. As a result, companies with a lot of part-time employees would be unlikely to pass the non-discrimination tests.

Benefit managers clearly were outraged by the huge administrative burdens imposed by Section 89 on their benefit programs.

"Section 89 has caused more confusion and non-productive time and expense than any benefit law in history. The end is justifiable but not the means," said Robert Penzkover, director of employee benefits at The Quaker Oats Co. in Chicago.

"It's a benefits nightmare. The rules for compliance and the data requirements and calculations are onerous," said Jack Hargest, director of employee benefits at the American Gas Assn. in Arlington, Va.

"Section 89 is the worst piece of legislation created in a long time. Any relief that Congress would have created would have been most appreciated," said the administrative manager for a food producer with $50 million in sales.

In garnering 97 points, soaring health care costs—the second most significant story of the year—received 13 first-place votes, five second-place votes, three third-place votes, one fourth-place vote and one fifth-place vote.

In 1988, health care costs for indemnity plans increased by 20% to 30%, with 50% increases reported in some extreme cases (see synopsis, page 15).

Employers with managed health care programs, which include health maintenance organizations and preferred provider organizations, were hit with double-digit increases of 10% to 15%.

Benefit managers were alarmed not only by the size of health care cost increases but also by what seems to be no end to the increases.

"The cost of employee benefits continues to increase at an alarming rate with no relief in sight," said the director of insurance for a real estate and investment trust with 175 employees.

"1989 health cost increases may be the harbinger of the next round of medical plan hyperinflation," said Michael McDermott, senior director of compensation and benefits with G.D. Searle & Co. in Skokie, Ill.

The third most important story of the year, approval of Sen. Kennedy's mandated health care bill by the Senate Labor and Human Resources Committee, collected a total of 67 points including five first-place votes, three second-place votes, six third-place votes, three fourth-place votes and six fifth-place votes.

Benefit managers who selected the Kennedy legislation as the most important story of the year warned that it would open the door to other benefit mandates while foisting higher costs onto employers (see synopsis page 15).

"Mandated health care is a major concern. If it is established, it opens the door wide for mandating other benefits," predicted the benefits administrator for a manufacturing company with $95 million in sales.

"Congress has a new way to grant social programs and not take responsibility for the costs: Let employers pay for it. There will be much more of this," said Stuart Larimore, manager of compensation and benefits planning at Boise Cascade Corp. in Boise, Idaho.

The 49 points gathered by the fourth-place story—Congress expanding the federal Medicare program—included one first-place, two second-place votes, eight third-place votes, three fourth-place votes and six fifth-place votes.

The Medicare expansion will mean fairly substantial cost reductions for employers over time as they cut back on those portions of their retiree health care programs that duplicate the soon-to-be expanded Medicare program. However, employers, over the next two years, will be required to share those savings with retirees (see synopsis, page 17).

Over the long haul, employers believe that the expanded Medicare program will ease costs for their own retiree health care programs.

"We have a larger number of retirees than active employees. We hope this (law) will reduce or slow down our costs," said Joe Osborne, corporate manager of benefits and insurance at Tosco Corp. in Santa Monica, Calif.

The fifth most important story of the year, upcoming FASB rules requiring employers to recognize retiree health care liabilities on their balance sheets and the failure of Congress to give companies tax incentives to prefund those obligations, received 44 points including eight second-place votes, three third-place votes, one fourth-place vote and one fifth-place vote.

The soon-to-be issued FASB rules would, among other things, require employers to accrue as an expense against corporate earnings retiree health care liabilities from the date an employee is hired until the date the employee is first eligible for retirement health care benefits. The proposal would have an enormous impact on corporate financial statements (see synopsis, page 18).

At the same time, Congress turned a deaf ear to proposals to give companies tax breaks for the prefunding of retiree health care benefits.

For example, a proposal by Rep. Rod Chandler, R-Wash., that would allow employers to make tax-deductible contributions through their pension programs to fund retiree health benefits failed to move out of the House Ways and Means Committee.

The sixth most important story of the year—employers making bigger-than expected changes to their 401(k) plans to comply with the 1986 tax law's non-discrimination rules and additional rules proposed by the Internal Revenue Service—amassed 31 total points including one first-place vote, four second-place votes, one third-place vote, three fourth-place votes and one fifth-place vote.

A survey by Hewitt Associates found that about half of employers had to adjust the amounts contributed by highly paid employees in 1987 to prevent their 401(k) plans from failing the 1986 tax law's tougher non-discrimination tests for the popular plans (*BI*, Oct. 3).

And, to make things even tougher, the IRS this year proposed further regulations laying down a new, more complex and restrictive formula for running non-discrimination tests on savings plans that allow 401(k) salary deferrals and 401(m) employer matching contributions and employee aftertax contributions.

The rules also laid down new standards on when employees can

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Out here, the problem isn't meeting insurance needs, it's simply meeting.

Along a 4,000-mile stretch of rugged Alaskan coastline, you find the operations of Icicle Seafoods, the largest processor and exporter of seafood in the Northwest.

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Benefit events

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make in-service hardship withdrawals. Conditions for withdrawal included funds needed to make a down payment on a primary residence, a child's college tuition expenses and uninsured medical expenses (*BI*, Sept. 5; Aug. 15).

The seventh most important story—passage this year of amendments to the federal Health Maintenance Organization Act—received 28 votes, including one second-place vote, one third-place vote, 10 fourth-place votes and one fifth-place vote.

Those amendments, supported by both employers and HMOs, allow federally qualified HMOs to set advanced, fixed rates based on an employer's individual past and projected experience (*BI*, Oct. 17).

And, the amendments scrapped the so-called equal contribution rule, which required employers to make the same contribution toward the premium charged by the HMO as the largest contribution made to the largest non-HMO plan, such as a companywide indemnity plan.

Under the amendments, employers only have to make non-discriminatory contributions to HMOs. For example, an employer can make the same percentage contribution toward HMO premiums as for other health care plans, rather than paying equal dollar amounts to both plans.

The No. 8 story of the year—the election of George Bush as president of the United States—received a total of 27 votes, including two first-place votes, two second-place votes, three fourth-place votes and three fifth-place votes.

In his bid for the presidency, Vice President Bush strongly rejected federal benefit mandates, while favoring tax incentives to help individuals fund long-term health care expenses.

Democratic nominee Gov. Michael Dukakis endorsed requiring employers to offer health care coverage (*BI*, Oct. 10).

"We believe that President Bush will not so actively push for mandated benefits, which are destroying private business and industry," said the vp and director of industrial relations at a manufacturer with $30 million in sales who selected the election of Mr. Bush as the top story of the year.

The No. 9 story of the year—congressional action to reduce penalties for COBRA violations—collected 26 points including one first-place vote, one second-place vote, three third-place votes and eight fifth-place votes.

Under the new COBRA penalties, agreed to as part of a technical corrections bill, an employer generally will be fined $100 a day for each day it failed to properly extend COBRA coverage to qualified beneficiaries (*BI*, Oct. 31).

That penalty will replace, starting Jan. 1, current law under which an employer can lose its entire annual tax deduction for health care expenses for a single COBRA violation.

The No. 10 story—a U.S. Chamber of Commerce survey that found that employers spent more than $10,000 per employee in 1986 on benefits—received a total of 24 votes including three second-place votes, two third-place votes and three fourth-place votes.

Since that survey's release, benefit costs continue to climb. The Chamber recently released a survey reporting that benefit costs increased to an average of $10,708 per employee in 1987, up 4.1% from $10,283 in 1986 (*BI*, Dec. 12).

•

Employee benefit managers and buyers of employee benefit plans are invited to join the Business Insurance *Employee Benefit Board. Just send a card with your name, title, company and address to Kathryn J. McIntyre, Associate Publisher/Editor, Business Insurance, 740 Rush St., Chicago, Ill. 60611. You will receive several surveys during the year on benefit issues.*

Benefit pros complain of chaos in '88

By JERRY GEISEL

When benefit managers describe 1988, they are apt to use the words "chaotic," "hectic," "frustrating" and "tumultuous."

"Chaotic—too much help from Washington with no perceived direction. Scary—"Big Brother" appears to be taking over with onerous legislation (Section 89) and severe requirements (possible mandatory health care coverage)," said Kevin Gill, director of compensation and benefits with Spring Industries Inc. in Fort Mill, S.C.

"Chaotic—a year of legislative change without sound reason or direction," said the vp of personnel and labor relations for a health care firm with $120 million in sales.

"A very hectic year for us benefits people," said Joe Osborne, corporate benefits and insurance manager for Tosco Corp. in Santa Monica, Calif.

"Frustrated and apprehensive. Section 89 complexities, COBRA penalties, proposed legislation, dependent care, retiree health are all dynamite issues if you are in the benefits area," said the benefits administrator for a manufacturer with $95 million in sales.

"Confusing and frustrating," said the corporate pension manager for a manufacturer with $500 million in sales.

"Tumultuous, rapid change," said William T. Montone, manager of compensation, benefits and training with A.T. Cross Co. Inc. in Lincoln, R.I.

Certainly, events in the benefits arena, especially in Washington, were constantly breaking during much of the year.

For example, early in the year, Sen. Edward Kennedy, D-Mass., made a major effort to win congressional approval of legislation to require all employers to offer health care coverage.

In addition, Congress completed action on legislation resulting in the biggest expansion ever of the federal Medicare program, an expansion that would force companies to redesign their retiree health care plans that supplement Medicare.

Later, employers made a major push to convince Congress to provide some relief from the administrative burden imposed by Section 89's non-discrimination rules for welfare plans. In the end, Congress approved only some Section 89 changes as part of a technical corrections bill.

Employers won one battle, first launched in 1986, to establish new, more reasonable penalties for violations of the health care continuation provisions of the Consolidated Omnibus Budget Reconciliation Act of 1985.

But, Congress moved quickly and silently in attacking other benefit programs.

For example, in October, without holding any hearings, legislators approved an amendment to a massive welfare reform bill that reduced federal tax credits for employees who use flexible benefit plan reimbursement accounts to fund child care expenses.

That change came just as employees were about to select flexible benefit options for 1989. As a result, employers had to scramble to tell employees how federal tax law was changing so workers could make informed decisions on how to tax-effectively fund child care expenses.

The Internal Revenue Service did its part to make life hectic and demanding for benefit managers.

Continued on page 12

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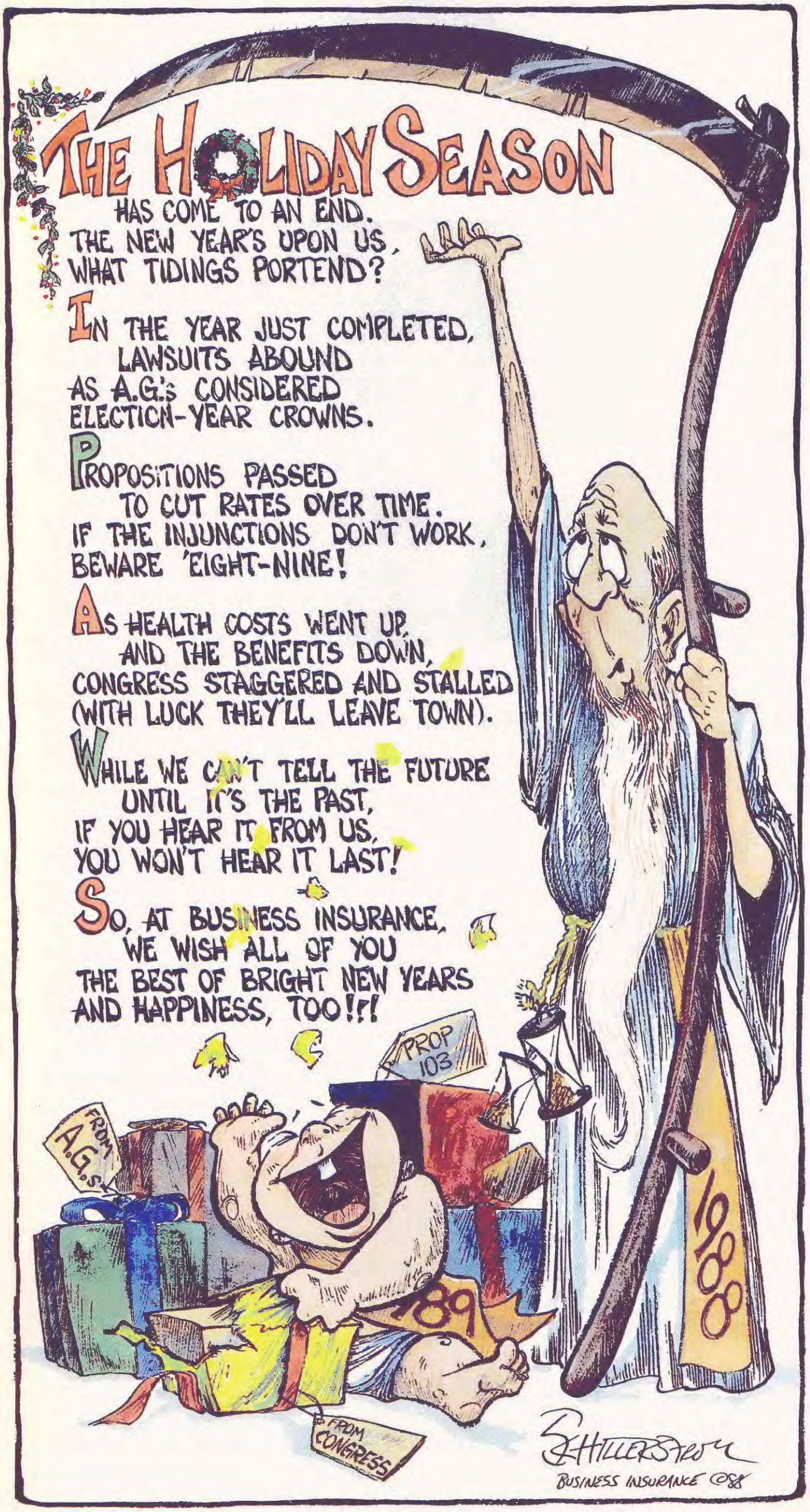

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Benefit pros' complaints

Continued from page 6

In August, for example, the IRS finally came out with sweeping and very complex 401(k) plan rules. Those rules, among other things, detailed under what conditions employees could make hardship withdrawals from their plans.

Then, in November, the IRS, 10 months tardy, issued sweeping regulations to implement the pension/Social Security integration provisions included in the Tax Reform Act of 1986.

At first, the IRS demanded compliance with its rules by Jan. 1, a virtually impossible task. But, following considerable pressure, the IRS in mid-December relented and gave employers adopting special amendments until the end of 1989 to make the needed pension plan design changes.

This breakneck legislative and regulatory pace angered benefit managers who complained that the swirling activity enormously complicated the administration and cost of their benefit programs.

"Turmoil due to Section 89 and COBRA penalties. Congress is most active in employee benefits legislation, resulting in much too complex laws that are unreasonable to administer," said the administrative manager for a Minneapolis food producer with $50 million in sales.

"Difficult year because of cost increases, and more and more federal compliance requirements. COBRA and Section 89 are costly requirements," said Edgar W. Case, director of personnel services with the University of Pacific in Stockton, Calif.

"A year of restrictive legislation," said a vp and director of industrial relations for a manufacturer with $30 million in sales.

Other benefit managers were disappointed that Congress didn't do more to ease administrative burdens.

"A year in which technical corrections bills failed to save the day, much to the chagrin of the benefits community," said Jack Hargest, director of employee benefits with the American Gas Assn. in Arlington, Va.

Others feared that the legislative and regulatory benefit overkill of recent years will continue.

"1988 has been a year of legislative overkill, characterized by election-year posturing, sneaky activity and some legitimate issues. As long as benefits are viewed as nothing more than revenue raisers, we are going to see a continuation of this piecemeal legislation and nickel and diming that will eventually tie the hands of employers and create an overregulated benefits arena," said Nina Lansky Falci, supervisor of benefits and compensation with Engineering Research Associates Inc. in Vienna, Va.

"Congress will continue to hold benefits hostage until the budget deficit is under control, which, of course, will never happen. So, benefits are doomed to a life sentence without a fair trial," said Robert Penzkover, director of employee benefits at The Quaker Oats Co. in Chicago.

Some benefit managers, though, saw some good in the maze of legislative activity, citing newly enacted amendments to the Health Maintenance Organization Act that give HMOs and employers more flexibility in negotiating rates.

"A year of further cost pressures on benefit plans. The lone exception is the 1988 HMO amendments, which offer some promised relief to employers by allowing more competitive rating," said the benefits manager for a non-profit research and consulting firm with a $220 million budget.

Others warned that employers, tired of one change after another being forced upon them, just might say enough is enough and fold their benefit programs if Congress and the regulatory agencies don't stop interfering.

"Another hectic year. They keep this up and employers will decide to drop all benefit coverage," said Diane Miller, corporate benefits manager with Hexcel Corp. in Dublin, Calif.

While Washington dominated benefit managers' descriptions of 1988, other issues, such as the high cost of health care, were on the minds of many.

"A further awakening on the part of management as to the financially uncontrollable nature of providing employee health care benefits," said Richard Thomas, benefits director with the School Board of Broward County in Fort Lauderdale, Fla.

And, one comment from a Colorado personnel administrator perhaps best summed up 1988.

"A survival year for most companies," said Paul I. Newman II, personnel administrator for Transit Mix Concrete Co. in Colorado Springs, Colo. ■

Experts see feds requiring health plans

If benefit managers' predictions prove accurate, the top employee benefit stories of 1989 also will be coming from Washington.

For instance, some 18 benefit managers predicted that federal legislation requiring employers to offer health care coverage will make headlines next year, with some predicting that legislation will become law.

"Some scaled-down type of mandated employer-provided health care, probably for companies of 100 or more employees," could win passage, said Louis Ellison, manager of employee benefits at Material Service Corp. in Chicago.

In addition, 12 benefit managers said Section 89 problems will continue to make news next year.

"Congress will change Section 89 so it makes sense. The concept is fair and I agree, but if companies spend large sums on tests, attorneys and consultants that they could be spending on providing benefits, then we truly have a poor piece of legislation," said Dennis Mitzel, director of compensation and benefits at Fingerhut Corp. in Minnetonka, Minn.

Nine benefit managers singled out retiree health care issues as topics that will make news in 1989.

Philip Christianson, group insurance manager at Times Mirror Co. in Los Angeles, predicts "passage of legislation allowing employers to prefund retiree health care obligations consistent with FASB."

Other benefit managers issued a variety of predictions for 1989.

Paul Christensen, vp-corporate industrial relations at Amity Leather Products Co. in West Bend, Wis., foresees "continued congressional pressure to reap tax revenues from employee benefit programs."

"Continued erosion of health care insurance market with fewer HMOs," predicts Richard Thomas, benefits director of the School Board of Broward County in Fort Lauderdale, Fla.

"AIDS-related issues—either discovering a 'cure' or a major legal case which will set a precedent"—will make headlines next year, said a compensation and benefits manager with a retailer with $175 million in sales.

"A compensation/benefits program will emerge, which, through non-qualified arrangements, will avoid the cost, complexity and cattle manure of today's 'qualified' plans," predicted Robert Penzkover, director of employee benefits at The Quaker Oats Co. of Chicago.

—By Jerry Geisel

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Section 89 presents new set of challenges for benefit managers

Employers in 1988 woke up to the administrative burdens imposed on them by Section 89's non-discrimination tests, while a last-ditch lobbying effort to ease those burdens fell short.

Section 89 had been attached to the Internal Revenue Code as part of the massive Tax Reform Act of 1986.

The concept behind Section 89 was simple: For welfare-type programs, such as group health care plans, to receive favorable tax treatment, benefits would have to be available to a broad cross-section of workers.

As Section 89's Jan. 1, 1989, effective date neared, employers at last began to grasp the administrative challenges they would face in trying to pass the law's non-discrimination tests.

Massive amounts of plan enrollment and participation data, which employers often didn't have, had to be collected and analyzed before the non-discrimination tests could be run.

And, to vastly complicate matters, Section 89 defines benefit plans differently than employers do. Under Section 89, every benefit option, such as different deductible levels in a health care plan, is considered a separate plan. As a result, while an employer may have thought it only had several different health care plans, for Section 89 testing purposes it could have dozens (*BI*, April 18).

Certain provisions in Section 89 also make passing the non-discrimination tests difficult. For example, employees working at least 17.5 hours a week must be counted for discrimination testing purposes. Employers, though, rarely extend benefit coverage to part-time employees working fewer than 20-24 hours a week. As a result, companies with a lot of part-time employees—such as retail firms—face an uphill battle trying to pass the non-discrimination tests.

And, to further complicate things, the Internal Revenue Service, as Section 89's effective date neared, failed to issue regulations to aid employers in complying with the law.

As a result, employers sought relief from Congress. They organized a coalition to try to convince Congress to ease the worst of Section 89's administrative burdens.

Above all, they sought "safe harbors" to exempt companies with multiple health care plans from the nightmare of compiling Section 89 non-discrimination testing procedures if, for example, they gave employees the freedom to select a common health plan and alternative plans like health maintenance organizations (*BI*, July 18).

While the coalition fought long and hard, it achieved only modest success. A technical corrections bill passed by Congress in October did amend some of the most outrageous and perhaps unintended Section 89 administrative burdens, such as daily running of the non-discrimination tests, but it did not include a meaningful safe harbor (*BI*, Oct. 31).

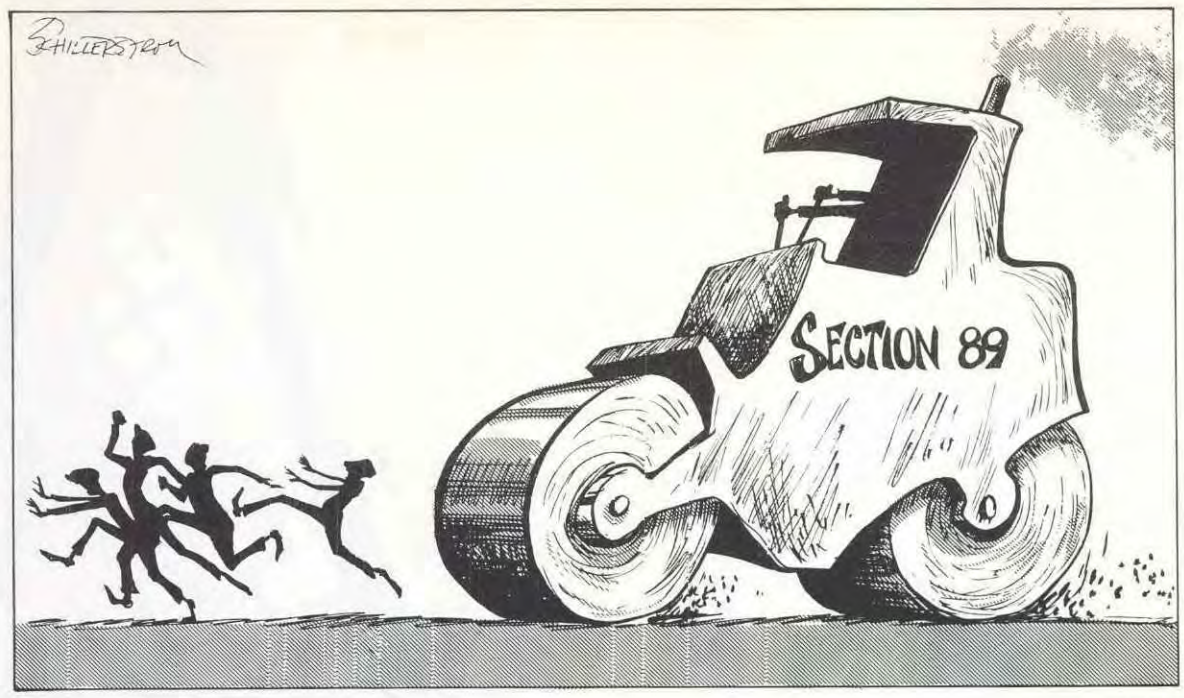
Other Section 89 changes in the technical corrections legislation include:

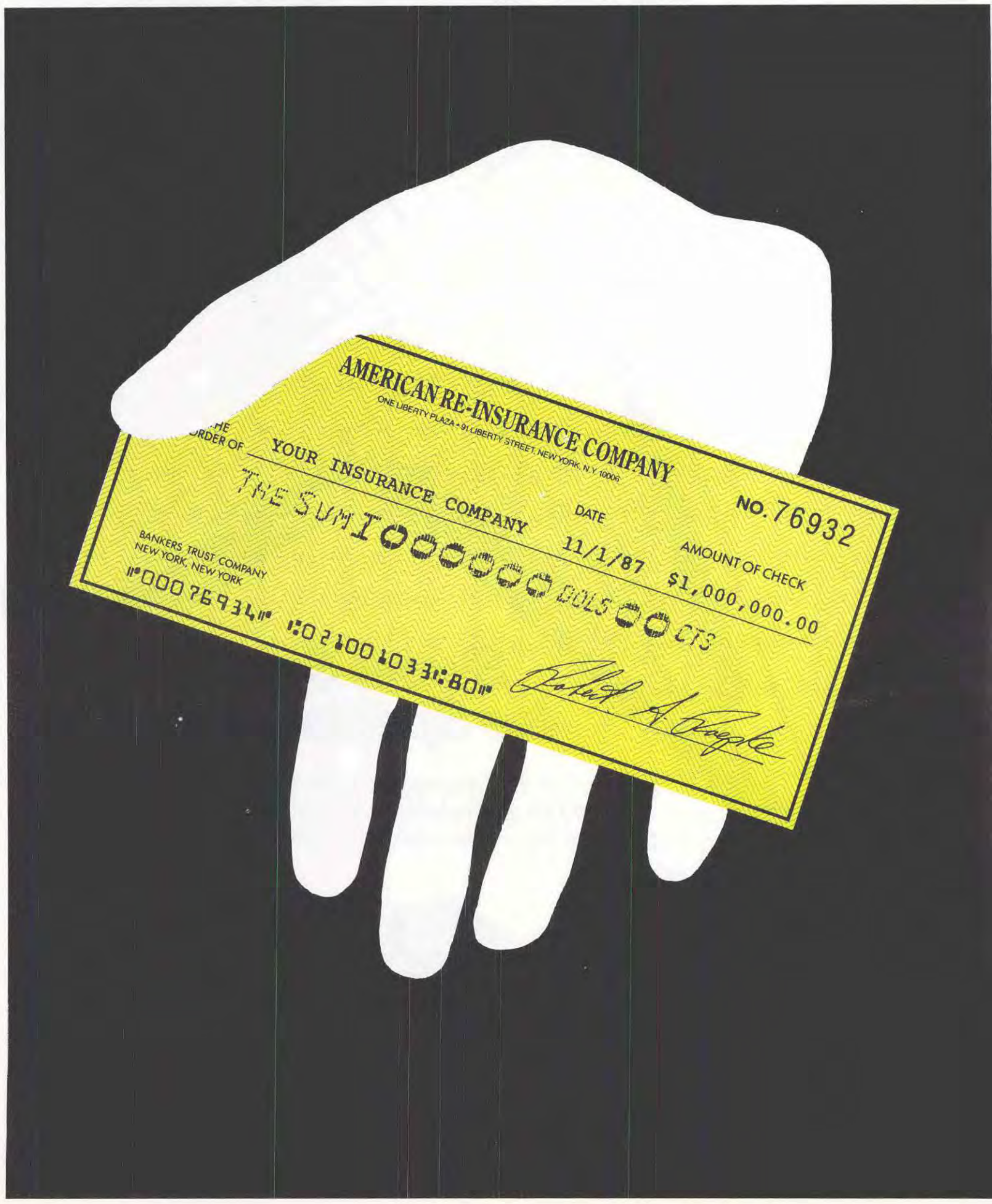
- Making it easier for companies to aggregate different plans as one plan for non-discrimination testing.
- Allowing employers to run the non-discrimination tests on a date of their choosing.
- Clarifying when a geographic unit may be treated as a separate line of business for purposes of running the non-discrimination tests individually on those units' welfare plans, an important issue for companies with diverse operations.

As the deadline for compliance nears, it is evident that Section 89 will be a big problem for companies.

For example, a survey by consultant A. Foster Higgins & Co. Inc. found that 45% of major employers either were unsure or predicted that their group health care plans would fail the Section 89 non-discrimination tests (*BI*, Nov. 14).

—*By Jerry Geisel*





Group health care expenses march upward in '88, into '89

Group health care costs continued on an upward spiral throughout 1988, and experts say there is no relief in sight for 1989.

But, this news does not come as a surprise to most employee benefit managers, especially since many were hit with 20% to 30% premium increases for their traditional indemnity plans in 1988 and are renewing those plans for 1989 at between 20% to 50% more than last year (*BI*, Dec. 19; Sept. 26).

And, despite all of the claims of cost effectiveness by health maintenance organizations, those premiums are increasing as much as 15% to 30% in 1989.

Benefit managers have watched the medical care component of the Consumer Price Index rise at almost double the rate of the overall CPI for much of this year.

For example, the medical care component of the CPI for the first 10 months of 1988 rose at a rate of 7.2%, compared with a 4.6% rate of increase in the overall inflation rate.

Experts point to the usual factors that have driven health care cost inflation for the past few years:

- The increase in utilization of outpatient services, which usually are not subject to the strict utilization review applied to inpatient care.
- Increased medical care technology.
- Increased utilization of health care services as a result of the aging of the population.
- Cost shifting to private payers of health care by health care providers receiving reduced reimbursements from the federal Medicare system.
- Treatment of catastrophic illnesses, such as acquired immune deficiency syndrome.

As a means of dealing with health care cost inflation, benefits experts predict that employers will require employees to share in a greater portion of their health care costs.

For example, employees may pay higher deductibles and copayments under indemnity plans.

Or, they may be required to contribute more toward an HMO premium if they elect an HMO, according to the benefits experts.

Continued on next page

Mandated health care fails in '88

While Sen. Edward Kennedy's drive to win congressional approval of legislation requiring all employers to offer health care coverage fell short in 1988, the Massachusetts Democrat succeeded in making access to health care a national issue.

In February, the Senate Labor and Human Resources Committee approved on a 10-6 vote the Kennedy-sponsored bill, S. 1265, which would have mandated employer-provided health insurance.

The legislation would have required all employers to offer a health care plan that would meet minimum federal standards. For example, annual deductibles for hospital and physician services generally could not exceed $250 per person or $500 for family coverage.

Employers generally would have been required to pay 80% of the premium for individual and family coverage. In the case of low-wage earners—those earning less than 125% of the federal minimum wage—employers would have had to pay the full premium.

And, the bill would have required employers to provide health care coverage to all employees working at least 17.5 hours a week.

Committee approval of the measure came after two hours of often raucous debate.

Ranking minority member Sen. Orrin Hatch, R-Utah, for example, warned that enactment of the legislation would lead to the loss of thousands of jobs and add new fuel to the fires of medical care inflation by stimulating the demand for services.

Continued on next page

Health benefit costs

Continued from previous page

In addition, more employers will design benefit plans that move more employees into a managed care environment, the benefits experts say.

This may involve developing plans that enroll all employees in an open-ended or point-of-service HMO.

Under these plans, employees can elect at the time they seek medical services to receive those services from non-HMO providers and still receive limited coverage. Normally, employees enrolled in an HMO are only covered for services administered by HMO providers.

Morristown, N.J.-based Allied-Signal Inc. earlier this year launched an open-ended HMO that replaces the company's previous indemnity plan and myriad HMO options.

The plan is being phased in over a three-year period and eventually will cover all 80,000 Allied-Signal employees across the country (*BI*, Feb. 22).

Benefit managers also will more aggressively evaluate and negotiate with HMOs in an effort to reduce the number of HMOs they offer to their employees, according to benefit consultants, insurers and HMOs.

It is not uncommon for some employers to offer 10 or more HMOs. However, as a means of increasing their purchasing power, employers will work at having more employees enrolled in fewer HMOs, the benefits experts say.

This way, employers can negotiate with HMOs on benefit plan design as well as on employer contributions and price.

In addition, streamlining their HMO offerings will help employers simplify the administration of benefit programs, according to the experts.

—By Donna DiBlase

Kennedy bill

Continued from previous page

When Sen. Kennedy urged Sen. Hatch to conclude his remarks, the conservative Utah Republican replied: "You are going to listen to me a lot longer."

Indeed, debate on the Kennedy legislation continued long after the committee action.

Some business groups warned that enactment of the Kennedy bill would be just the beginning in a series of benefit mandates.

And there seemed to be some truth to that charge. Just after he promised that he would not enrich the basic health care benefits mandated by his bill, Sen. Kennedy convinced the Labor and Human Resources Committee to accept mental health care coverage as a benefit that would have to be part of an employee benefit package.

Projected costs of the bill varied widely. Sen. Kennedy placed the annual cost to employers at $15 billion, but some estimates circulating in the business community put the cost as high as $100 billion a year.

While there was sharp disagreement on the cost of the legislation, few would deny that enactment of the Kennedy bill would have made a huge dent in the number of uninsureds.

Sen. Kennedy, for example, said passage of his legislation would mean extension of group health care coverage to between 22 million and 24 million of the 37 million uninsured Americans.

Improving access to health care became a major issue dividing the presidential candidates. Democratic challenger Gov. Michael Dukakis said health care coverage was a basic right of employment, while Republican candidate Vice President George Bush said mandated health care could set back the nation's economic recovery (*BI*, Oct. 10).

In the end, Sen. Kennedy didn't even try to bring his legislation to the Senate floor, a sign that he probably didn't have the votes needed for passage.

And, even if the bill had squeaked through the Senate and then won House approval, it surely would have been vetoed by President Reagan, a strong opponent of the mandated benefit approach.

While the measure only cleared one committee in 1988, Sen. Kennedy is likely to renew his battle next year.

Indeed, in a speech before a conference sponsored by the National Assn. of Manufacturers and the Washington Business Group on Health, Sen. Kennedy predicted the eventual passage of mandated health care coverage (*BI*, Feb. 8).

"You may be able to defeat it, but you won't be able to defeat it for long," he said.

—By Jerry Geisel

Expansion of Medicare approved

While Congress approved the largest expansion ever of the federal Medicare program in 1988, at year's end there were growing signs that the new law would face serious challenges in the next congressional session.

The Medicare legislation, signed into law by President Reagan last summer, was intended to give the elderly more protection from health care expenses for acute and catastrophic illnesses (*BI*, June 6; May 30).

For example, as Medicare now is structured, the elderly can be hit with tens of thousands of dollars in hospital and physician bills.

But, the new law, which goes into effect on Jan. 1, cuts down on that potentially hefty liability.

In 1989, Medicare Part A, which covers hospital expenses, will be expanded to limit a Medicare beneficiary's out-of-pocket expense to about $570 a year.

Then, in 1990, Medicare Part B, which covers physician services, will be expanded to limit out-of pocket expenses for doctors' bills to about $1,370 per beneficiary.

Employers will be allowed to cut back their retiree health care programs that supplement Medicare.

Aside from capping retirees' annual out-of-pocket physician and hospital expenses at about $2,000, the Medicare expansion law establishes a new phased-in prescription drug benefit.

That benefit will pay 50% of the cost of outpatient prescription drugs exceeding $600 a year in 1991, 60% in 1992 and 80% in succeeding years.

This expansion of Medicare will allow employers to cut back their retiree health care programs that supplement Medicare and allow employers to eventually reduce the cost of those post-employment health care programs.

However, prior to the passage of the Medicare bill, a conference committee hammered out and approved an amendment to force employers to hand over some of those savings to retirees.

Under that amendment, known as the "maintenance of effort" provision, employers that eliminate the portions of their retiree health care plans that duplicate the soon-to-be expanded Medicare program are required to pass those savings on to retirees in two phases.

In 1989, employers will have to pass on the savings they achieve when they eliminate hospital benefits that duplicate the expanded Medicare Part A.

Then, in 1990, employers that cut back benefits that duplicate Medicare Part B will have to pass on those cost savings to retirees for one year.

Benefit experts estimated that the cost savings passed on to retirees, which could be in cash or improved benefits, would be in the range of $100 to $200 per retiree.

While employers, because of the maintenance of effort provision, will not reap any immediate savings when Medicare is expanded, companies will achieve some fairly hefty savings on their slimmed-down retiree health care programs once the provision expires at the end of 1990.

But as the new Medicare law

Continued on next page

Medicare expansion

Continued from previous page

nears its Jan. 1 effective date, legislators are being bombarded with complaints from the elderly about how much the expanded Medicare program will cost them.

Next year, for example, middle- and upper-income retirees will pay as much as $800 in new federal taxes for catastrophic coverage. In addition, their Part B premiums will rise sharply.

Retirees covered by employer-sponsored health plans will be especially hard hit by these new taxes.

Retirees covered by employer-sponsored health care programs will be especially hard hit by these new taxes.Those retirees often paid little, if anything, for employer supplemental plans that covered health care costs not picked up by Medicare. Now, employers will reduce those programs—so they don't duplicate Medicare—while retirees will be paying big new taxes for coverage they once received free or for a modest cost.

And, the elderly are upset that the new, expanded Medicare program will not cover long-term health care costs, such as extended stays in nursing homes.

With opposition on the rise from retirees, efforts are expected to be made in Congress to delay implemenation of the new higher taxes or to consider alternative financing mechanisms, experts say.

—By Jerry Geisel

Retiree benefit cuts in the offing

Employers in 1988 said they may be forced to cut back retiree health care benefits after a proposed accounting standard requiring companies to recognize retiree health care liabilities on their financial statements becomes effective.

Under the accounting standard proposed by the Norwalk, Conn.-based Financial Accounting Standards Board, employers would have to accrue as an expense against corporate earnings retiree health care liabilities from the date an employee is hired until the date the employee is eligible for retirement health care benefits (*BI*, Oct. 17).

The accounting proposal also would require companies to switch to accrual from cash accounting for post-retirement welfare benefits in fiscal years beginning after Dec. 15, 1991.

Employers now report only their pay-as-you-go costs for retiree health care benefits—such as the premium for a health insurance policy or claims costs if a company self-funds its retiree health care plan—as an expense item on their income statements.

Also under the proposal, employers would be required to amortize on a straight-line basis their accumulated retiree health care liabilities as of the standard's effective date over the average remaining service period of employees expected to receive the benefit or over 15 years.

Another provision of the proposal will require balance sheet recognition of a minimum liability beginning in calendar year 1997.

Employers will be required to record on their balance sheets at least the present value of retirement health care liabilities for current workers who are eligible to retire as well as the liabilities for current retirees.

New estimates place employers' liability for unfunded retiree health care commitments at $221 billion to $247 billion.

In light of these future accounting changes, employers told Congress that without tax incentives to prefund retiree health care liabilities, they would have to reduce retiree health benefits (*BI*, Sept. 19).

When the FASB rule takes effect, "many employers will be under tremendous pressure to reduce their liabilities by reducing or eliminating the retiree benefits they now offer," said Mark Ugoretz, executive director of the ERISA Industry Committee in Washington.

"In the absence of. . .tax code revisions and faced with the financial implications of the FASB requirements, employers will have little choice but to limit their promises to future retirees," said Edward Davey, a principal in the New York office of A. Foster Higgins & Co. Inc.

Although Congress in its 100th session did not pass legislation on prefunding retiree health care costs, several bills were introduced that would have responded—at least in part—to employers' requests.

For example, under a bill authored by Rep. Rod Chandler, R-Wash., employers with defined benefit or defined contribution pension plans could make tax-deductible contributions toward future retiree health care or long-term care costs (*BI*, Aug. 8).

In addition, the proposal would allow employers to transfer excess assets from overfunded pension plans into a fund to finance retiree health care costs or long-term care coverage costs.

However, the proposal would bar companies from recovering excess assets when they terminate overfunded defined benefit pension plans.

—By Deborah Shalowitz

Top stories

Continued from page 3

agement at Amfac Inc. in San Francisco.

Proposition 103 is the most important story of 1988 "because it signals the level of discontent the public has regarding the insurance industry," said the director of risk management for a manufacturer with $726 million in annual sales.

"The insurance industry cannot survive if the public is allowed to control it through the ballot box," observed the director of insurance coverage for a state government with 33,000 employees.

Meanwhile, the antitrust suits filed by the state attorney generals, which contend that the defendants —including major U.S. insurers, reinsurers and the Insurance Services Office Inc.—conspired to block the availability of occurrence-based general liability coverage, shows that public officials as well as consumers are questioning insurance industry practices (see synopsis, page 26).

The antitrust litigation is "another 'black eye' for the insurance industry and insurance companies in particular," said Richard M. Inserra, vp-risk management and business analysis at Triangle Industries Inc. in New York.

"The public's perception of the industry continues to worsen, and (the industry) will find it more difficult to operate without public interference in the future," Mr. Inserra pointed out. "California's Proposition 103 is a forerunner of more to come," he added.

Another risk manager agreed that the antitrust suits will result in big changes in the industry.

"Insurers, underwriters, brokers and agents have been playing fast and loose with the truth for years, and someone finally called their bluff. I think (the antitrust litigation) will change the way insurance policies are written and the way they are marketed in the future," said Lewana Shearer, risk manager for the city of Lafayette, La.

"Resolution of the suits could have far-reaching effects on the industry," agreed the insurance administrator of a health care company with $150 million in annual sales.

"The result will likely be some form of increased regulation, both on the state and federal levels, as well as likely changes in antitrust legislation that will be initially viewed as negative by the industry but will result in greater customer protection and satisfaction," said Don LeMond, risk and insurance manager of the state of Missouri in Jefferson City. Missouri has not joined the antitrust litigation.

Judging from the results of the survey, risk managers had a hard time agreeing on the top events of 1988.

For instance, while Proposition 103 received the highest number of total points, the No. 3 story—the softening market—received the most first-place votes.

In ranking the stories, *Business Insurance* assigns five points for a first-place vote, four points for a second-place vote, three points for a third-place vote, two points for a fourth-place vote and one point for a fifth-place vote.

Proposition 103—which received 158 total points—garnered only 15 first-place votes, while the soft market—which received 144 total points—collected 17 first-place ballots. However, Proposition 103 was ranked as the year's No. 2 story by 13 risk managers, while only seven survey participants cast second-place votes for the soft market.

Meanwhile, the second-place story—the antitrust litigation—finished with 152 total points, collecting 11 first-place and 11 second-place votes.

The soft market, in which double-digit rate cuts for almost all types of commercial property/casualty insurance are commonplace, was named as the top story of 1988 by many respondents because of the bearing it had on all risk managers (see synopsis, page 27).

"Affordability and availability of insurance has an impact on all businesses, both here and abroad. No other product has such far-reaching implications," summed up Joseph E. Rossano, corporate risk manager/insurance coordinator for Santa Fe HealthCare Inc. in Gainesville, Fla.

The soft market represented "a welcome return to reasonable prices after the insanity of 1985-86," according to the insurance coordinator for a manufacturer with more than $300 million in annual sales.

"Rate reduction to counter the outrageous increases of 1985 are still in order," said the manager of insurance for a company with more than $10 billion in annual sales.

But while some perceived the soft market as the best news of the year, others noted that the current soft market could be a sign that another market crisis looms ahead.

The administrative assistant for finance at a non-profit health care company with more than 19,000 employees said he voted for the soft market as the year's top story out of "fear. Will we go through the tremendous rate increases and coverage decreases faced just a few years ago?"

The fourth-place story—Vice President Bush's victory in the November presidential election—received 76 points, including five first-place votes.

Interestingly, risk managers put greater importance on Mr. Bush's election than benefit managers, who ranked the upcoming Bush presidency only as the eighth-most important employee benefit story of 1988 (see story, page 3).

The risk managers that chose Mr.

Continued on page 24

In 1913, when football history was made, Allendale

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Tailoring embezzlement cover

By The Insurance Institute of America

A.R.M. exercises

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—in one of the three examinations for the A.R.M. designation.

This question and answer, taken from a recent examination for ARM 56-risk financing, focuses on several concerns an organization may have in structuring its insurance protection against losses of cash and other property due to employee dishonesty.

Q: A firm has decided to insure against embezzlement losses. Identify and describe the significance of two factors the firm should consider with regard to each of the following concerns.

- Choosing between all-employee and designated-employee coverage.
- Ascertaining insurable values.
- Selecting any deductibles.
- Taking action, before a loss occurs, to minimize difficulties in valuing losses.

(In keeping with the wording of the question, the following answer presents—for each concern—only two of several factors for which full credit would have been given on the examination.)

A: • While the firm could reduce its premiums for embezzlement coverage by selecting insurance applicable to only designated employees, the all-employee option is typically more administratively convenient.

In making this choice, therefore, two of the more important factors a firm may consider in selecting the breadth of its embezzlement coverage are: the number or percentage of its employees that have access to cash or other vulnerable property; and the firm's ability to prove to its insurer which of its employees were involved in a particular embezzlement. If many employees might commit embezzlement, or if the firm would have difficulty documenting which employees were guilty, the broader, all-employee coverage would be more prudent.

• Determining insurable values—values exposed to insured loss—can require considerable judgment.

One factor to consider is the firm's maximum vulnerable ("stealable") values: how much cash or other valuable property one or more employees, under conditions most favorable to them, might be able to take from the firm on one or more occasions without being detected.

This maximum vulnerability can be at least approximated by any of several formulas that take into account the amount of the firm's current assets and of its annual revenues.

• In choosing the amount of any per loss deductible, a firm is likely to balance its ability to retain embezzlement losses against the premium savings it can achieve through accepting various deductibles. Any deductible should be no greater than the firm's per-loss retention capability; moreover, the greater the likely frequency of embezzlement losses, the smaller the deductible for each loss should be in order not to exceed the firm's annual aggregate retention capability.

• To document its insured embezzlement losses, the firm should, first, establish secure procedures for handling cash and other valuable property that may be embezzled, maintaining good records on which clear proofs of loss may be based.

Second, the firm should establish a pattern of full disclosure and businesslike dealings with its insurer so that, after a loss occurs, the insurer will have confidence in the firm's integrity.

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.

Collapse covered by CGL policy

The risk of the accidental collapse of a steel structure, caused by the negligent placement of materials on the top of the partially completed building, is the type of risk for which general liability insurance coverage is intended to protect, a Minnesota appellate court ruled.

Olson Concrete Co. was the general contractor for a warehouse addition. Olson subcontracted with H.D. Engineering Design & Erection Co. to construct the addition. Olson was to provide materials and H.D. Engineering the services.

The structure collapsed when H.D. Engineering employees negligently placed materials on the roof of the partially completed structure. Olson filed a claim against H.D. Engineering for the increased costs caused by the loss of use of the property damaged or destroyed.

H.D. Engineering was covered under a comprehensive general liability policy issued by Western World Insurance Co. that covered property damages caused by an occurrence. H.D. Engineering sought Western's defense of the suit, but Western denied a duty to indemnify or defend. H.D Engineering then sued Western. The trial court ruled for H.D. Engineering.

The appellate court said that it was undisputed here that the cause of the collapse was the negligence of H.D. Engineering in its failure to secure the partially assembled structure against forces of nature over which it had no control such as wind or gravity. The court said that the purpose of the CGL policy here was to provide protection from accidents. This was the type of risk general liability coverage was intended to insure against, the court observed. Thus, the court held that Western owed its policyholder the duty to defend and indemnify it against Olson's claims. *Western World Insurance Co. vs. H.D. Engineering Design & Erection Co.*, Court of Appeals of Minnesota, Feb. 16, 1988 (*BI*/01/Sept.-$10).

Legal briefs

Work-related stress caused death

A workers compensation claimant in a heart attack case must show, by a preponderance of evidence, that work-related stress or exertion precipitated the employee's heart attack, according to the Supreme Court of New Hampshire.

William J. O'Sullivan was a part-owner and general manager of an auto dealership. On Oct. 10, 1984, he died while en route to an automobile auction. The cause of his death was cardiac arrest brought on by acute myocardial arrhythmia.

Testimony indicated that he suffered prolonged stress because of the company's financial difficulties and the difficulty of maintaining an adequate inventory of Toyota automobiles in the face of import restrictions.

Prior to his death, Mr. O'Sullivan's stress became so severe that he underwent personality changes.

He had a prior heart attack and a myocardial infarction in 1979. He was being treated for heart disease at the time of his death. His widow filed for and was awarded compensation.

On appeal, the employer argued that there was no evidence to support the finding that Mr. O'Sullivan's work-related stress was greater than that encountered in normal, non-employment life. The appellate court disagreed.

According to the court, there was evidence that the dealership was having financial difficulty immediately prior to Mr. O'Sullivan's death. His condition had deteriorated noticeably at that time, and the effects were evident in his personality changes, according to the court. The court was satisfied that Mr. O'Sullivan's work-related stress was greater than that normally encountered in non-employment life and affirmed the award. *Cheshire Toyota/Volvo Inc. vs. O'Sullivan*, Supreme Court of New Hampshire, Aug. 24, 1987 (*BI*/02/Sept.-$10).

Injunction does not constitute damages

A suit brought by the federal government against an insured seeking an injunction in connection with hazardous waste contamination did not constitute a claim for damages under a comprehensive general liability insurance policy, according to the U.S. Court of Appeals for the 4th Circuit.

Armco Inc. was issued a comprehensive general liability insurance policy by the Maryland Casualty Co. that was in effect from 1966 to June 1, 1983. The policy indemnified Armco against sums it was obligated to pay for damages because of injury to or destruction of property caused by an occurrence. Maryland Casualty contracted to defend any suit against Armco alleging such injury, sickness, disease or destruction, even if such suit was groundless, false or fraudulent.

The U.S. government brought suit in Missouri against owners of a waste storage facility including the original waste "generator," which included Armco. The suit alleged improper maintenance techniques in sorting hazardous waste resulted in seepage of toxic chemicals into the soil and groundwater. The government sought to compel a remedial program and reimbursement of its investigative costs.

Armco requested indemnification and defense from Maryland Casualty. Maryland Casualty sought a declaration from the court that it had no duty to defend. The trial court ruled for Maryland Casualty.

The appellate court said that this case presented no instance of harm to humans or animal life but merely the prevention of such harm. The fundamental nature of the government's intervention was, according to the court, to prevent or mitigate the occurrences or reoccurrences of hazardous contamination.

"This action is fundamentally prophylactic and is not of the sort that Maryland Casualty contracted to cover," the court said.

Maryland Casualty Co. vs. Armco Inc., U.S. Court of Appeals for the 4th Circuit, July 6, 1987, *rehearing and rehearing in Banc denied*, Aug. 4, 1987 (*BI*/01/July-$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.*

Top risk management stories

Continued from page 19

Bush's election as the top story of the year primarily pointed to his pro-business views (see synopsis, page 28).

"We need a Republican president to offset a Democratic Congress to control insurance costs and spending," said the insurance manager for a manufacturer with $200 million in annual sales.

"Hopefully, Mr. Bush will see the problems the insurance industry is experiencing and take appropriate action," said the director of risk management at an institute of higher education.

"Election of his opposition would have invited disaster for the (insurance) industry and business in general," said the corporate risk manager of an engineering concern with annual revenues of more than $300 million.

Others who selected Mr. Bush's election as the year's top story are less certain about the president-elect's agenda.

The "new administration hasn't made its views known on significant issues," said the risk manager for a utility with $2 billion in annual sales.

The fifth-place story—the differing rulings by courts nationwide on coverage for government-mandated hazardous waste cleanups—trailed Mr. Bush's election by only two points, gathering 74 points. The waste cleanup coverage story attracted five first-place votes and four second-place votes.

Both policyholders and insurers claimed victory in different cleanup coverage cases, but in what many regard as the two most important cases of the year—the dispute over contamination at Times Beach, Mo., and the massive Shell Oil Co. waste cleanup litigation—courts ruled that insurers did not have to reimburse policyholders for cleanup costs (see synopsis, page 29).

It should be noted that the survey was conducted before the Shell decision was reached last week. That development conceivably could have increased the number of votes cast for the waste cleanup coverage story.

But, even without knowing the outcome of the Shell case, several risk managers noted that the subject is very important.

"Hazardous waste disposal and associated liability is of concern to all risk managers," said the insurance manager for a hospital company with $500 million in revenues.

"This is an area that has touched almost every large corporation, involves large costs and continues to be a problem for many," said the manager of risk management and insurance for a conglomerate with annual sales of $8 billion.

A large gap separated the fifth- and sixth-place stories, but No. 6 through No. 10 were bunched closely together.

Finishing sixth was the controversy over regulation of purchasing groups authorized by the Risk Retention Act of 1986. That story tallied 38 total points but no first-place votes.

In May, a federal court in Iowa ruled that state insurance regulators could require an insurer writing coverage for Iowa members of a purchasing group domiciled in another state to be admitted or authorized in Iowa. The ruling was a setback for purchasing group proponents, who argued that only the state in which a purchasing group is domiciled can regulate the group's affairs (*BI,* May 9).

Later in the year, U.S. Commerce Department staff members circulated a proposal that would replace ambiguous language in the Risk Retention Act Amendments to clarify the regulation of purchasing groups (*BI,* Nov. 21).

Finishing in seventh place, with 36 total points and two first-place votes, was the landmark damage award handed down in June against cigarette manufacturer Liggett Group.

A federal court jury in Newark, N.J., awarded $400,000 to a man whose wife died of lung cancer in 1982, ruling that Liggett wrongly implied in advertisements before 1966 for its L&M brand of cigarettes that smoking was safe. Warnings about the health risks of smoking became mandatory in 1966.

The verdict was the first in more than 300 product liability lawsuits filed against cigarette makers, and some observers predicted that the decision could prompt a new wave of litigation against tobacco companies (*BI,* June 20).

One risk manager, who voted for the ruling as the most important story of the year, was critical of the decision.

"It is my personal belief that anyone that is completely in control of all of their mental capabilities would know that smoking is injurious to their health. Therefore, when they smoke for many years, it is at their own risk and as their own choice," said the vp of a public utility with $58 million in revenues.

The eight-place story, which attracted 34 total points, including one first-place vote, was the increase in policyholder suits seeking coverage for pollution damage and cleanup.

More companies during 1988 joined Shell, Westinghouse Electric Corp. and United Technologies Inc. in suing scores of insurers dating back for decades to recover pollution-related losses.

This litigation "demonstrates the seriousness and significance of resolving, once and for all, the issue of coverage for pollution-related losses," said Thomas J. Connell, insurance administrator at Northeast Utilities in Hartford, Conn., who ranked the coverage litigation as the most important story of 1988.

"If underwriters miscalculated the magnitude of the exposure, or were remiss in clarifying the intent of the coverage, they should not be allowed to shift the burden back to the insureds," he said.

The No. 9 story was the ruling by California Superior Court Judge Ira Brown Jr. that asbestos in buildings constitutes property damage from the time the asbestos is installed until the time it is removed or a claim is filed. Judge Brown's ruling received 33 total points but no first-place votes.

Judge Brown's ruling came as part of the coordinated asbestos coverage litigation in San Francisco. The decision created tens of millions of dollars in insurance coverage for three asbestos producers (*BI,* Sept. 12).

Rounding out the 10 top risk management stories in 1988 was the approval by a House subcommittee of a proposal to amend the McCarran-Ferguson Act to virtually eliminate insurers' limited immunity to federal antitrust law. The story received 32 votes, including two first-place votes.

The proposal, approved in June by the House Monopolies and Commercial Law Subcommittee, would among other things prohibit insurance price fixing, the development and publication of recommended rates, and the sharing of data pertaining to expenses and profits (*BI,* June 27).

"The bill could eliminate the ability of the insurance industry to develop loss information and propose various premium rating clauses," said Bill Meyerholt, director of risk management at Lubrizol Corp. in Wickliffe, Ohio, who selected the McCarran-Ferguson legislation as the year's top story.

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Risk managers and other corporate executives who are responsible for risk management functions are invited to join the Business Insurance *Risk Management Board. Just send a card with your name, title, company and address, noting you would like to join the Risk Management Board, to Kathryn J. McIntyre, Associate Publisher/Editor, Business Insurance, 740 N. Rush St., Chicago, Ill. 60611. You will receive several surveys during the year.*

Insurers besieged as buyers prosper

By JAMES M. BURCKE

1988 was a year of contrasts, risk managers point out.

While risk managers generally prospered as a result of competition in the commercial property/casualty insurance marketplace, insurers were besieged by attacks from state attorneys general, who filed massive antitrust litigation against insurers and other insurance industry defendants; by federal legislators, who threatened to eliminate insurers' limited immunity to federal antitrust laws contained in the McCarran-Ferguson Act; and by voters in California, who approved Proposition 103.

That's the general consensus of members of the *Business Insurance* Risk Management Board and randomly selected readers who participated in a survey to select the top risk management stories of 1988.

1988 was "a good year for insurance buyers, (but) many 'impact issues' (McCarran-Ferguson, Proposition 103, etc.) are portending future turmoil in the industry," summed up Richard M. Inserra, vp-risk management and business analysis at Triangle Industries Inc. of New York.

The past year was a "time of continuing problems in the insurance industry but, in general, good for businesses relying on insurance," said Robb Hubbard, principal-insurance and risk management services at Williams & Co. of Sioux City, Iowa.

"1988 was a year that, although it saw property and casualty rates continue to decrease, saw significant unrest and dissatisfaction with the ways the insurance industry operates," observed Don Craft, risk manager at Mobex Corp. of Anaheim, Calif., specifically referring to the antitrust litigation and California's Proposition 103.

Others agreed that the past year has not been one that insurers will remember fondly.

The industry was "under siege" in 1988, said Richard C. Heydinger, risk management director at Hallmark Cards Inc. of Kansas City, Mo., and president of the Risk & Insurance Management Society Inc.

Insurers were "losing ground—and not totally understanding why or how to change it," Mr. Heydinger said.

Overall, though, risk managers are ending 1988 with an upbeat attitude, thankful that most of the challenges of the past year were directed against insurers rather than policyholders.

1988 was "much better for risk managers than the prior several years," said Robert E. Marginot, chief of risk and insurance for Loudoun County, Va.

1988 was "much better than the past two or three years," agreed Gerald W. Raschke, vp of Associates Corp. of North America of Dallas.

The director of risk management for a manufacturer with $726 million in annual sales called 1988 "a year in which the casualty market lowered rates but not in a loose manner. There is still some underwriting going on."

Other risk managers, however, expressed concern over the intensity of insurer competition during 1988.

1988 was "a year where the insurance companies decided to start committing suicide again and where the regulators once again focused on the wrong issues instead of rate regulation to stop the roller coaster," said the insurance manager of a finance and construction company with 240 employees.

The past year marked the "return of the soft cycle and all its negative implications," said Donald J. Davignon, director of risk management for Joseph E. Seagram & Sons Inc. of New York.

Looking ahead to 1989, risk managers were split over whether property/casualty rates would continue to soften or the market would turn.

"Interest rates and a higher stock market will continue to drive an unstable insurance industry pricing strategy," said the risk manager for a publishing company with $400 million in annual sales.

"Increasing interest rates could tempt some shortsighted insurers to revert to some cash-flow underwriting," warned the director of risk management for the manufacturer with $726 million in sales.

"Higher interest rates will benefit the insurance carriers, and competition will be keen for the premium dollar," agreed the director of risk management for a higher education institution with 14,000 employees.

"Continuing rate declines" is the outlook from George Mills, risk manager for the New Jersey Highway Authority in Woodbridge, N.J.

However, Seagram's Mr. Davignon predicts the "return of the hard cycle late in 1989!"

And, Jeff Williams, specialist in the risk management division of Wisconsin Electric Power Co. in Milwaukee, foresees the "tightening of the insurance market due to underwriting losses."

"Rates will rise again," predicted the risk manager for a manufacturer with $60 million in annual sales.

The manager of risk management and insurance at a conglomerate with $8 billion in sales expects "a quick turnaround in premiums due to increases in losses, the new tax law and increased expenses."

Many of the risk management events that will make headlines in 1989 will relate to pollution and hazardous waste cleanups, risk managers predict.

"Pollution liability and hazardous waste cleanups will continue as key issues in 1989," remarked Thomas J. Connell, insurance administrator for Northeast Utilities in Hartford, Conn.

"Hazardous waste management will continue to present controversy regarding laws, coverages (or lack thereof) and employer moral obligations," said the administrative assistant-financing for a non-profit health care organization with 19,000 employees.

1989 will bring "improved 'answers' to the question of whether liability insurers are obligated to reimburse companies for waste site cleanups," said the assistant treasurer for a chemical/pharmaceutical company with sales of $3.4 billion.

A couple of risk managers predicted the demise of risk purchasing groups formed under the 1986 amendments to the Risk Retention Act.

"Purchasing groups will have virtually no place in the industry. The purpose for which they were designed will be destroyed by insurance commissioners playing their usual 'turf war,' " said the risk manager for a manufacturer with $60 million in annual sales.

And, many risk managers predict continued turmoil for insurers in the New Year.

"The victory in California will lead to attempts in other states. The initiative process is a poor vehicle for dealing with such complex technical issues," said Hallmark's Mr. Heydinger.

It's "not a pretty picture—sell those insurance stocks," he added.

Triangle Industries' Mr. Inserra predicts "more Prop. 103 issues across the nation; more militancy on the part of state attorneys general and insurance commissioners."

Mr. Mills foresees "more government intervention in insurance company operations."

Others predict new financial problems for the insurance industry.

The manager of risk management and insurance for the conglomerate with sales of $8 billion predicts that major insurers and brokers will find themselves "in financial trouble."

Dennis C. Doherty, risk manager for Hennepin County, Minn., was more specific. "Two major insurers will go insolvent" in 1989, he predicted.

"Insolvencies will reach a peak, causing major financial repercussions to the world economy," said Eben L. Jones, director of insurance and risk management for Rollins Inc. in Atlanta.

Despite many predictions of doom and gloom, an inspirational prognostication for 1989 comes from Hennepin County's Mr. Doherty: "A risk manager will be nominated for sainthood." ■

Votes reflect self-interest

While many risk managers gauge the importance of the year's events on their impact on the risk management profession and the property/casualty insurance industry as a whole, others cast their votes for those stories that have the greatest bearing on their own companies.

Consider, for example, the general manager of insurance claims and loss prevention of a steamship operator with $100 million in annual revenues who thought the dissolution of the Asbestos Claims Facility and the subsequent formation of a new facility was the top story of the year.

That risk manager explained that his company is "currently involved in a multimillion-dollar suit against asbestos manufacturers for liability stemming from shipboard exposure to asbestos."

The safety director for an electric utility with 1,400 employees also cast his ballot for the claims facility because "we are very concerned with asbestos claims."

Other risk managers have similar, parochial reasons for selecting particular stories among the top events of 1988.

Ben C. Francis, personnel and risk manager for the Santa Clara Valley Water District in San Jose, Calif., ranked the approval of Proposition 103 as the most important story of the year because "I practice risk management in California."

The insurance manager for a financial and construction company with 240 employees cast a first-place ballot for the ruling by California Superior Court Judge Ira Brown Jr. that asbestos in buildings constitutes insurable damage from the time the asbestos was installed until the time it is removed or a claim is filed because "my employer holds title to over $4 billion in buildings, many of which have asbestos in them."

And, predictably, many risk managers said the softening market was the most important happening of 1988 because of the cost savings it provided to employers.

The soft market had the "greatest impact on my company's profitability this year. . .and my position as risk manager," pointed out the risk manager for a publisher with $400 million in annual sales.

"My company's premiums dropped $400,000 from the previous year. This represents a 40% decrease. That's good news, but scary," added the risk manager for a manufacturer with $60 million in sales.

—By James M. Burcke

Insurers warn of disruption by Prop. 103

California's Proposition 103 could disrupt the state's property/casualty insurance market and—if enough states follow California's lead—could prompt federal regulation of the insurance industry, observers say.

The new law's most controversial provision mandates that property/casualty insurers roll back "charges" to 20% below November 1987 levels.

Among other things, the law, which only 51.1% of the electorate approved, also:

- Calls for the establishment of a non-profit insurance consumer-protection corporation.
- Allows the state Board of Equalization to levy additional insurance premium taxes so the state can make up the revenues it would lose because of the mandated insurance "charge" rollbacks.
- Forbids insurers in most cases from canceling or failing to renew auto insurance polices.
- Calls for the establishment of a prior approval rate system in the state for the first time, beginning Nov. 8, 1989.
- Subjects insurers to the state's antitrust and unfair business practices laws.

The Insurance Services Office Inc. suspended some services in California after the law was approved by voters.

Proposition 103—which resulted from California consumers' dissatisfaction with high automobile insurance premiums(*BI*, Oct. 24; Jan. 18)—exempts from its provisions workers compensation, marine insurance and reinsurance.

While the insurance industry failed in its record $60 million campaign to convince voters to defeat Proposition 103 and support the industry's own no-fault auto insurance proposition, the industry succeeded in obtaining a stay on all provisions of the law from the state's Supreme Court on Nov. 9.

And, the court on Dec. 7 decided to rule on the constitutionality of the new law. A decision is expected next spring.

Meanwhile, the court lifted the stay on all but two of the law's provisions: the insurance charge rollback and the establishment of the consumer protection corporation (*BI*, Dec. 12).

Risk managers in California are concerned that if the court upholds the new law, many insurers will abandon their state. But, although some insurers have since declined to write new property/casualty policies, the state's insurance market has remained fairly stable (*BI*,

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Proposition 103

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Nov. 21).

To give insurers more incentive to comply with the law, one state legislator has introduced a bill calling for fining an insurer an amount equal to 50% of its premium volume if it does not renew more than 10% of its policies for any line covered by the law (*BI*, Nov. 28).

Other legislators promise to draft bills mandating that any insurer writing property/casualty business in the state also must write personal auto insurance, which insurers say was a highly unprofitable line in California even before Proposition 103.

Legislators also are pressing Insurance Commissioner Roxani Gillespie to step up enforcement of the law's provisions (*BI*, Dec. 19).

Insurers in the state say they could lose $4 billion in premiums if the rollback provision is upheld, thereby threatening their solvency.

While Standard & Poor's Corp. has said it may lower some insurers' credit ratings if the new law survives legal challenges, Moody's Investors Service Inc. has said systematic credit rating downgradings are unlikely.

Proposition 103 supporters, meanwhile, point out that the new law allows the state insurance commissioner to grant relief to insurers whose solvency is threatened if they comply with the law.

And, some insurers and brokers point out that most commercial property/casualty insurance rates are currently lower than required under the insurance "charge" rollback provision (*BI*, Nov. 14).

State Attorney General John Van de Kamp—whose office leads the antitrust litigation pending against 30 property/casualty insurance industry defendants—staunchly defends the new law.

Caught in the middle is the state's Insurance Department, which sees many problems in enforcing the law. Questions about the law the department must answer include:

- What is the definition of "charges"—filed rates or actual premiums charged? And how should the rollbacks be figured when a policyholder's exposure has changed since November 1987?
- Does the law apply to surplus lines insurers?
- Does the law apply to insurers that write coverage for members of purchasing groups?
- Does the law apply to risk retention groups fronted by insurers?

Meanwhile, insurers nationwide are beginning to see their worst fears realized: Consumer groups and legislatures in states with high auto insurance rates are beginning to push for ballot initiatives or legislation that mirrors Proposition 103.

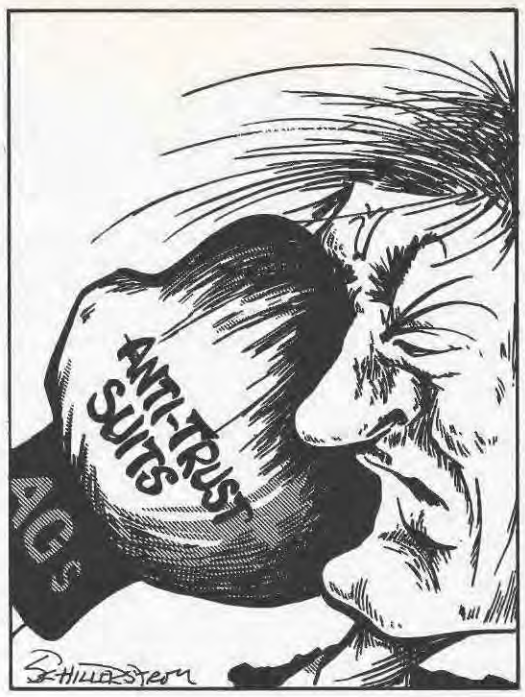
"People in dozens of states" had contacted Voters Revolt to Cut Insurance Rates, the group sponsoring Proposition 103, even before Election Day, according to Chairman Harvey Rosenfield.

In Ohio, for example, a legislator plans to introduce a bill next month based on the California law.

In Iowa, Insurance Commissioner William D. Hager is proposing limiting insurers domiciled in his state from writing business in states with either legal or regulatory environments that cause the insurers to consistently operate at a loss.

And, if other state insurance regulators follow Mr. Hager's lead and hit insurers with conflicting regulations, the argument for federal, rather than state, regulation of insurer solvency may be bolstered, observers say. For example, while Iowa would require its domiciled insurers to pull out of a state where it cannot write profitably, that state may fine insurers that leave.

—By Dave Lenckus



Impact of antitrust litigation worries insurance industry

The entire insurance industry was badly shaken when attorneys general from eight states filed massive federal antitrust litigation against property/casualty insurers, reinsurers, brokers and trade organizations in the spring of 1988.

The suits were filed in U.S. District Court in San Francisco and allege, among other charges, that the defendants conspired to eliminate occurrence-based commercial general liability forms and exclude all pollution coverage from the CGL form (*BI*, March 28). A separate state action was filed in Texas as well.

Defendants and others claimed that not only were the suits without any merit, but that they could also have a devastating impact on the industry by possibly destroying the Insurance Services Office Inc., the group that provides ratemaking, policy forms and statistical services to U.S. property/casualty insurers.

The defendants and others also were worried that even if eventually dropped, the suits could have a devastating impact on an already-tarnished industry image. The massive costs expected to be incurred in defending the suits were a source of concern as well.

And, the antitrust litigation gained momentum when an additional 10 states filed essentially identical suits with the U.S. District Court in San Francisco in June (*BI*, June 20).

Shortly afterward, U.S. District Court Judge William W. Schwarzer in San Francisco decided to limit the discovery process to whether the defendants' alleged conspiracy was exempt from federal antitrust laws (*BI*, June 27).

The next major legal maneuver occurred in September, when 36 separate antitrust suits filed against the insurance industry, including about 20 private class-action suits, were consolidated at the request of the defense (*BI*, Sept. 12).

And, earlier this month, in compliance with a

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deadline set by Judge Schwarzer in June, defendants filed motions seeking the suit's dismissal, claiming their actions did not constitute a boycott, as alleged in the suit.

The McCarran-Ferguson Act, which grants the industry limited exemption from federal antitrust law, does not extend such exemption in cases of boycott (*BI*, Dec. 19).

Among other motions filed by the defendants earlier this month was one contending that state insurance departments' involvement in approval of the claims-made form precluded the industry's actions from being considered in violation of antitrust laws.

Against this backdrop of legal activity involving the industry, ex-regulators, risk managers and consumer advocates, among others, became embroiled in the heated controversy.

A number of former state insurance commissioners criticized the antitrust litigation, although most current insurance regulators remained tight-lipped (*BI*, April 11).

Risk managers became involved when officers of the Rocky Mountain Chapter of the Risk & Insurance Management Society urged its members to write Colorado officials and ask them to withdraw that state's litigation (*BI*, July 25).

Taking quite a different position was consumer activist J. Robert Hunter, who encouraged trial attorneys to ride the coattails of the suits by filing a barrage of lawsuits charging anything from bad faith to fraud to fake advertising.

"Now is the time to go after them," he told the Assn. of Trial Lawyers of America meeting in Kansas City, Mo. (*BI*, Aug. 8).

The litigation also sparked some lively debate.

During a September meeting of the National Assn. of Professional Surplus Lines Offices, for instance, Jesse W. Markham Jr., a deputy attorney general for California, which was one of the original states to file suit, commented that the state attorneys general were pursuing the antitrust suit because the defendants broke the law by engaging in a group boycott (*BI*, Sept. 26).

But William E. Bailey, special counsel for the Insurance Information Institute, retorted at the meeting that the litigation ill-serves the consumers whom the attorneys general purport to represent.

Meanwhile, some observers believe that the antitrust suit filed against the industry defendants in Texas may present an even tougher challenge to the industry than the consolidated federal suits, in part because a Texas jury is more likely to have negative attitudes toward insurance companies based in the North (*BI*, Nov. 7).

—By Judy Greenwald

Property/casualty rates on slippery slide down

The property/casualty insurance rate cuts that ushered in the new year show little sign of abating as 1988 enters its last week.

Factors repeatedly cited as possible brakes on competition—the effect of the Tax Reform Act of 1986 on insurers' bottom lines, the stock market crash of Oct. 19, 1987, and natural catastrophes—seemed to have had little impact on rate decreases.

The lack of firm pricing left some observers uneasy about the possibility that the softening market could lead to another sudden correction such as the one that sent commercial insurance rates through the roof in 1984.

"God knows where this is all going. If the market continues to soften at the rate it has been, it will hit us hard on the way back, too," George B. Netherton, director of risk management for Atlanta-based Coca-Cola Co., mused in mid-spring (*BI*, May 16).

In January, risk managers and brokers reported general liability rates cut by as much as 30% over those of a year earlier, while property rates fell by as much as 40% (*BI*, Jan. 4). The January rate cuts rode a downward trend that was first apparent in mid-1987 (*BI*, Dec. 28, 1987).

Insurers pledged they would not allow price competition to get out of hand as the hardest commercial insurance market in history moderated. Yet, despite increased reliance on underwriting controls and automated management information systems that allow home offices to keep close tabs on branch office pricing practices, the downward rate spiral did not stop.

Risk managers viewed the rate cuts as a mixed blessing. For example, John G. Pinner, assistant treasurer of Mattel Inc., the

Hawthorne, Calif., toy manufacturer, assessed the situation by saying: "We are relieved prices are going down, but—knowing the insurance industry—it seems insurance companies are shooting themselves in the foot again."

Midyear renewals continued the downward trend, with liability rate cuts running as high as 30% while property rates underwent declines by as much as 50% compared with those of a year earlier (*BI*, July 4).

Rate cuts, though, were not spread evenly across the industry. Some lines that had undergone severe price increases during the hard market, notably directors and officers liability insurance, experienced rate cuts of as much as 20% (*BI*, Oct. 10).

On the other hand, rates for some other lines, such as attorneys professional liability coverage, followed no definite trend, with some firms reporting rate increases of as much as 40% while others reported cuts of 15%.

By fall, industry experts were predicting another round of rate decreases of as much as 20% for most liability lines.

U.S. property rates also remained soft despite such massive property losses as the Piper Alpha oil platform disaster (*BI*, July 11) and Hurricane Gilbert's devastation of the Caribbean (*BI*, Sept. 19). Insured losses, including liability, from Piper Alpha alone were estimated at more than $1 billion (*BI*, Sept. 12).

However, the increased competition among traditional insurers

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Rate decreases

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during the year did not spur mass defections from policyholder-owned offshore facilities such as A.C.E. Insurance Co. Ltd. and X.L. Insurance Co. Ltd., both with operations in Bermuda.

As the end of 1988 approached, insurance executives issued gloomy predictions that the soft market would continue for the foreseeable future.

Speaking at the annual meeting of the National Assn. of Independent Insurers in Boston, Robert W. Eager Jr., senior vp of National Reinsurance Co. of Stamford, Conn., estimated that liability rates had already declined 25% to 40% from those of a year earlier. But he added that he did not expect the soft market to last as long as that of the mid-1980s because of the inevitable toll the 1986 Tax Reform Act would take on insurers' finances (*BI*, Nov. 14).

But such optimism was not universal, as exemplified by remarks made by another speaker at the same meeting. R.M. Jamieson, chairman of Schaumburg, Ill.-based Zurich-American Insurance Co., said that the soft market could last for another three years. Insurers, he said, could prove such a scenario wrong only by applying more pricing discipline.

—By Mark A. Hofmann

Bush, business share views on liability issues

President-elect George Bush shares many of the views of business on risk management and liability issues.

For example, Mr. Bush supports tort reform and probably would back product liability reform, while he most likely will oppose a high risk occupational disease notification law.

However, Mr. Bush supports beefing up environmental law enforcement. And his position on repeal or modification of the McCarran-Ferguson Act is unclear.

Based on interviews, the Republican national platform, campaign position papers and responses to questions submitted to the vice president by *Business Insurance*, Mr. Bush's views on several corporate liability issues emerged (*BI*, Oct. 17), including:

- Tort reform.

Mr. Bush is "completely committed to the issue" of tort reform, said Blair Childs, executive director of the American Tort Reform Assn. in Washington.

For example, the Republican platform stated: "We propose to return the fault-based standard to the civil justice system. We support enactment of fair and balanced reforms of the tort system at the state level."

In particular, the Bush campaign recommended "restoration of a fault-based standard of recovery; elimination of the 'deep pocket' rule under which defendants that are only minimally responsible for an injured party's damages can be forced to pay 100% of a plaintiff's claim; and expanded use of alternative dispute resolution mechanisms such as binding arbitration and mediation."

- Federal product liability reform.

Mr. Bush probably will support federal product liability reform, observers say.

For example, the Republican platform called for "a reasonable state and federal product liability standard that will be fair to small businesses, including professional and amateur sports, and to all who are in liability contests."

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Courts disagree on coverage for pollution clean-up costs

State and federal trial courts during 1988 were sharply divided over the issue of whether government-mandated cleanup costs are insurable under comprehensive general liability policies.

"The best arguments from each side have been made and there has not been a consensus among the courts," explained Roger Warin, an insurer attorney with Steptoe & Johnson in Washington, D.C.

Insurers argue that only damages awarded by a court of law are insurable. Damages that are forced upon a policyholder by a government order to clean up polluted sites are not insurable, they say.

Policyholders, on the other hand,

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Bush perspective

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However, in response to a question submitted to the Bush campaign on whether product liability reform should be enacted at the federal level or left to the states, Mr. Bush responded that he supports "individual state authority."

The vice president continued: "Consumers have generally been well-served by the regulatory structures developed by the states. As president, I would urge states to continue to take the lead in product liability regulation. I would encourage the drafting of a uniform state code as a model for the states."

- High risk occupational disease notification.

Mr. Bush probably will oppose a federal law requiring workers to be notified if they are at high risk of contracting an occupational disease because of workplace exposure to certain hazardous materials, observers say.

Earlier this year, a high risk occupational disease notification bill was passed by the House and was debated by the Senate but withdrawn from the floor (*BI*, April 4).

Business "can expect the same type of help from" a Bush administration that it received from the Reagan administration during Congressional consideration of the notification bill, predicted Susan Spangler, director of risk management for the National Assn. of Manufacturers in Washington.

Several Cabinet secretaries lobbied against the notification bill and advised President Reagan to veto the legislation if Congress passed it.

- Environmental liability.

Mr. Bush is expected to be tough on environmental issues.

For example, the Republican platform stated: "We support strong enforcement of our environmental laws and will accelerate the pace of our national effort to clean up hazardous waste sites and to protect our groundwater."

Furthermore, in numerous campaign speeches Mr. Bush emphasized his interest in cracking down on polluters and cleaning up the environment.

- Repeal or modification of the McCarran-Ferguson Act.

Mr. Bush's position on the limited antitrust exemption granted to the insurance industry by this law is not clear.

However, repeal or modification of the industry's antitrust exemption seems to be more of a Democratic issue than a Republican one.

For example, all but one Democrat on a House subcommittee voted earlier this year for a bill that would virtually gut McCarran-Ferguson. All Republicans on the panel opposed the measure (*BI*, June 20).

—By Deborah Shalowitz

Pollution ruling

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maintain that the distinction between damages awarded by a court of law and government orders to clean up a hazardous waste site is merely creative lawyering. Policyholders contend that costs incurred under the Comprehensive Environmental Response, Compensation & Liability Act—better known as the Superfund Act—are insurable.

To date, there has been no consensus among the courts as to which of these divergent viewpoints is correct.

As a result, both policyholders and insurers were able to achieve their share of victories in 1988.

The single most important decision regarding government-mandated cleanup costs came on Feb. 26 when the entire 8th U.S. Circuit Court of Appeals ruled that hazardous waste cleanup costs are not insurable (*BI*, March 7).

In a 5-3 decision, the court said: "The term 'damages' used in the CGL policies refers to legal damages and does not cover cleanup costs."

The single most important decision regarding government-mandated cleanup costs came on Feb. 26 when the entire 8th U.S. Circuit Court of Appeals ruled that hazardous waste cleanup costs are not insurable.

The case involved a dispute over dioxin contamination in Times Beach, Mo., between New York-based Continental Insurance Co. and the defunct Northeastern Pharmaceutical & Chemical Co. of Verona, Mo.

The 8th Circuit's decision was important because it marked the second time a federal appellate court ruled that government-mandated cleanup costs are not covered damages in standard-form CGL policies. The 4th U.S. Circuit Court of Appeals in July 1987 also ruled that CGL policies do not cover the costs of hazardous waste cleanups in *Maryland Casualty vs. Armco Inc.* (*BI*, July 27, 1987).

The U.S. Supreme Court refused to review both federal appellate court decisions (*BI*, Oct. 10).

While the decisions in the nation's highest courts involving hazardous waste coverage litigation have favored insurers, a majority of the lower court rulings have favored policyholders.

For example, the U.S. District Court for the Southern District of California found that insurers must provide coverage for pollution cleanups because most policyholders would interpret their policies to provide such coverage. This case involved a dispute between Boston-based Commercial Union Insurance Co. and subsidiary American Employers Insurance Co. and the now-bankrupt Superior Plating Works Inc. of San Diego (*BI*, Sept. 26).

Similarly, the U.S. District Court for the Northern District of California ruled that Hartford Accident & Indemnity Co. must reimburse Intel Corp. of Santa Clara, Calif., for the costs incurred in a government-mandated hazardous waste cleanup (*BI*, June 27).

The first California state appellate court decision on the issue is expected in 1989. This ruling stems from a multi-million dollar dispute between Aerojet-General Corp. of La Jolla, Calif., and 55 of its general liability insurers.

The first jury trial involving government-mandated hazardous waste cleanup ended last week, when jurors found Shell Oil Co. liable for its share of a $2 billion cleanup. The jury found that Shell knew it was polluting the environment from as early as 1952 and therefore was not entitled to any insurance coverage for a massive waste site in Colorado (see story, page 1).

Shell sued more than 260 of its general liability insurers for the costs of cleaning up two hazardous waste sites—one in California and the other in Colorado (*BI*, Aug. 1; May 30; May 2; Feb. 8).

—By Stacy Adler

NAIC meeting

Continued from page 2
paid loss recoverables due and payments received in the last 90 days, is greater than 20%.

The regulators' aim is to prevent insurer and reinsurer insolvencies by controlling ceding insurers' ability to take credit for reinsurance (*BI*, Oct. 31).

"Unfortunately, there currently is no hard data setting forth exactly how much reinsurance, industrywide, is currently overdue nor how much is ultimately compromised at less than full value," Kenneth W. Smith, Deputy Director of the Property/Casualty Division of the Illinois Insurance Department, said in a memo earlier this year.

However, the NAIC study group that drafted the proposal "is certain that the aggregate amount of overdue reinsurance is significant," said Mr. Smith, who chairs the study group.

The proposal, which the study group has discussed for 1½ years, is "strong medicine" for a serious problem, said Leon Hank, director of the Michigan Insurance Department's financial analysis and examinations division, who serves on the NAIC study group.

Among industry opponents of the changes was the American Insurance Assn., while proponents included the Reinsurance Assn. of America.

The measure is similar in intent to an aging schedule governing reinsurance recoverables which the NAIC's Blanks Task Force approved this fall (*BI*, Oct. 17). This was ratified by the NAIC in New Orleans.

In other related financial measures, the NAIC:

- Adopted a new model law for states to consider that would establish a $10 million minimum policyholder surplus requirement for domestic reinsurers writing property or casualty reinsurance, unless the reinsurer receives prior written approval from a state's insurance commissioner.

  Reinsurance required by law or regulation or assumed as part of a pooling arrangement among members of the same holding company can be written by reinsurers with less than $10 million in policyholder surplus.
- Asked for comments until March 1 on proposed amendments to strengthen and clarify the Model Law on Credit for Reinsurance.

  The proposed amendments would increase the minimum requirements a reinsurer must meet for a domestic ceding insurer to take credit for reinsurance purchased.

  According to the proposal, the reinsurer must be licensed to transact insurance or reinsurance, or be an otherwise accredited reinsurer in the state where the ceding company is domiciled. In addition, most reinsurers will be required to have a minimum of $20 million in surplus.
- Asked for comments until March 1 on a new measure that spells out accounting guidelines for transfers between affiliated companies.
- Asked for comments, without an expressed deadline, on a new Administrative Supervision and Conservation Model Act. The act would, among other things, give a state regulator new authority over insurers that can be considered "commercially domiciled" in his or her state.

  Under the measure, an insurer would be considered "commercially domiciled" in any state where it writes a significant amount of business according to premium percentage thresholds spelled out in the model.

  If adopted, the concept of "commercially domiciled" could have far-reaching implications for state regulation, said Gerald Wester of the Florida Insurance Department.

  For example, a regulator could have jurisdiction over an insurer that writes a significant amount of business in his or her state regardless of where the insurer is domiciled.

The NAIC also dealt with a variety of other topics during its winter meeting, including:

Advisory rates study

NAIC President David Gates said a special committee of commissioners will be appointed early next year to investigate the role of advisory rating organizations.

An unspecified number of public hearings will be held and the special committee will make a preliminary report to NAIC members no later than the NAIC's March 19-21 meeting in Little Rock, Ark.

The committee is being appointed because individual regulators have expressed their concern "about the appropriateness of advisory organizations preparing 'fully developed' rates which are filed on behalf of their members," according to the NAIC resolution authorizing the study.

Such rates reflect not only loss cost data—which NAIC officials view as necessary—but also investment income and unallocated expenses, which include administration, overhead and acquisition costs.

Some states, including California and Michigan, already prohibit an insurer from using fully developed rates for all lines of insurance. They require each insurer to submit its own investment income and unallocated expense information.

The goal of the study is to enhance competition in the marketplace, Mr. Gates said. However, the regulators are treading carefully to ensure they do not inadvertently limit competition at the agent-client level, he said, noting that ISO rates are used as a benchmark to analyze competing quotes.

Model HMO Guaranty Association Act

During debate, some regulators opposed the concept of creating an HMO guaranty fund, as described in the model HMO guaranty fund association act that the NAIC released for comment.

Delaware Insurance Commissioner David Levinson said he op-

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poses such guaranty funds because he thinks HMO enrollees can be better protected by other measures, including requiring providers to sign contracts that prohibit them from trying to collect an insolvent HMO's debts from enrollees.

Those measures also have the advantage of not reducing premium tax payments to a state, Mr. Levinson said. States with HMO guaranty funds typically allow HMOs to offset their premium taxes by the amount of the guaranty fund assessment.

One of Mr. Levinson's suggestions was adopted when the NAIC amended its Health Maintenance Organizations Model Act.

The measure requires providers to sign a hold harmless agreement with the HMO so that subscribers will not be liable for fees owed to them. The measure also also establishes a $300,000 deposit requirement and offers four options for meeting minimum net worth requirements.

Limited health services organization model

The NAIC adopted a new model law that establishes regulatory parameters for various limited health service organizations, such as those offering prepaid substance abuse treatment, pharmaceutical services or dental care.

"Some employers could save money on their health insurance premiums by using limited health service organizations to provide certain benefits because rates for prepaid care often are lower than rates for traditional health care indemnity policies," according to an NAIC statement.

The model states that no health service organization group contract can include coverage already provided by another insurer and allows employers to use limited health service organizations to provide state-mandated benefits.

"The non-duplication provisions would permit a major medical group plan to exclude coverage for mandated benefits if the group members receive equivalent or superior benefits from a prepaid limited service plan," said Nebraska Insurance Director William McCartney, who chairs the working group that developed the model.

Other action

The NAIC also amended existing model laws to:

- Strengthen the Long-Term Care Model Act and regulation by prohibiting prior hospitalization provisions that require a hospital stay for a designated period of time before a policyholder is eligible for long-term care benefits.

In addition, the new amendments prohibit insurers from requiring policyholders to have received a certain higher level of care before they are eligible to be covered for a lower level of care.

They also establish new conversion and continuation provisions that give group policies the same guaranteed renewable provision that is mandatory in individual long-term care contracts.

Some insurers had put retirees and other converted policyholders into a separate risk pool, making the product unaffordable because of the poor experience of the new group, according to the NAIC.

More than 80 insurers offer long-term care insurance, up from 20 in 1986, according to NAIC Vice President Earl Pomeroy of North Dakota, who chaired the working group that developed the amendments.

- Apply the so-called "birthday rule" in cases where parents have joint custody of a child and a court decree does not specify responsibility for the child's health care.

Under the birthday rule, coverage for a dependent would first be sought from the health care plan of a parent whose birthday comes first in a given calendar year.

The NAIC also:

- Established a new uniform notice and consent form to guide states that allow insurers to test life insurance applicants for acquired immune deficiency syndrome.

The measure requires that applicants be informed about pre-testing considerations, disclosure of test results and the meaning of positive test results.

- Urged states to require insurers to file a uniform transmittal form, which is used for requesting changes in rates, etc., instead of, or in addition to, any state's required transmittal form by Feb. 1, 1989.

The goal of the test project is to develop a standard form acceptable to all states.

The NAIC also is releasing for comment drafts of proposals that would:

- Increase the immunity of regulators and their confidants when investigating illegal or fraudulent activity.
- Revise the existing standard trust agreement for alien insurers to allow for third-party claims against the trust, limit trustees' ability to make a lien for operating expenses and broaden the number of banks eligible to participate in the trust process. ■

Eubanks resigns Arkansas post

LITTLE ROCK, Ark.—Arkansas Insurance Commissioner Robert M. Eubanks III has resigned his post shortly before his first term was to end.

Gov. Bill Clinton is appointing Deputy Commissioner Ron Taylor to succeed Mr. Eubanks. He will serve the remainder of Mr. Eubanks' four-year term, which expires Jan. 14, and then be appointed to his own four-year term, according to a spokesman for the governor.

Mr. Taylor, 37, joined the department in 1979 as a liquidation and rehabilitation officer.

Mr. Eubanks plans to remain in the Little Rock area.

Piper Alpha losses tally may take 3 years

By CAROLYN ALDRED and STACY SHAPIRO

London

LONDON—Some Lloyd's of London syndicates will not know their gross losses stemming from the July explosion of the Piper Alpha oil drilling platform in the North Sea for about three years, says the chairman of a Lloyd's managing agency.

"The gross loss to our marine syndicates will be substantial," though "the exact size of our gross loss is impossible at this stage to quantify," said Jimmy Archer, chairman of A.J. Archer Holdings P.L.C.

Total losses worldwide stemming from the destruction of the platform, which killed 167 people, likely will exceed $1.4 billion, underwriters estimate (*BI*, Sept. 12).

Speaking at a press conference to announce A.J. Archer's annual results earlier this month, Mr. Archer explained that "because of the inevitable cycle of the reinsurance market, it will very probably be three years before our final involvement is known."

However, "we have ample excess-of-loss protection and I anticipate that the net loss will be minimal. . .all of our reinsurance programs were in force at the time of this casualty (and) the security is first class," he added.

Contributing to the difficulty in assessing losses from the Piper Alpha disaster is that claims stemming from the loss of the $790 million rig are coming from different sources, including losses on the insurance purchased by the rig's four owners and various reinsurance policies, he said.

Meanwhile, A.J. Archer, one of only two Lloyd's underwriting agents listed on the London Stock Exchange, reported a pretax profit of 6.12 million pounds ($11.4 million) for the year ended Sept. 30 1988, down 25.4% from 8.2 million pounds ($15.4 million) a year ago.

The agency's revenues declined 17.4% to 7.53 million pounds ($14.1 million) from 9.12 million pounds ($17.1 million) in 1987.

The drop in profits is due to reduced investment income and increased operating expenses associated with the reorganization of the company from a partnership to a publicly held company, said Chris Burton, financial director.

Meanwhile, A.J. Archer has formed two new Lloyd's syndicates, bringing to 10 the number of syndicates it manages, said Joint Managing Director David Tudor-Williams.

An aviation syndicate with a capacity of 1.5 million pounds ($2.8 million) began underwriting July 1 and will increase its capacity to 7.6 million pounds ($14.2 million) for 1989. The syndicate primarily writes excess-of-loss aviation reinsurance.

A new marine excess-of-loss syndicate will begin underwriting in January with a capacity of 11 million pounds ($20.6 million).

Honorary member

Edward Ian Walker-Arnott, who retires as the longest serving non-Lloyd's member on Lloyd's of London's Council, has been made an honorary member of the market.

Mr. Walker-Arnott, senior partner of law firm Herbert Smith & Co., was nominated to the council when it was first created in January 1983 following approval of the 1982 Lloyd's Act. He chaired Lloyd's Investigation Committee and the Underwriting Agency Agreements Worker Group.

"Edward Walker-Arnott has played a vitally important part in all that has been achieved," said Lloyd's Chairman Murray Lawrence. "I can think of no one more deserving of honorary membership of the society."

Meanwhile, Sir Maurice Hodgson, one of the eight nominated members of the Council, has been reappointed for a three-year term on the council commencing Jan. 1

Sir Maurice—who has served as chairman of leading corporations ICI P.L.C., British Homes Stores P.L.C. and Dunlop P.L.C. and is now non-executive chairman of British Home Stores—was appointed to the Council in July 1987.

Central fund

Any Lloyd's of London member who refuses to pay losses next year could have his assets seized by the Council of Lloyd's for unpaid debts, according to a new Lloyd's bylaw.

Previously, if a member refused to pay losses and failed to meet the market's solvency test, Lloyd's set aside money in its Central Fund to pay claims until Lloyd's recovered the money through litigation.

The Council earlier this month passed the Central Fund (Amendment No. 2) Bylaw, which allows Lloyd's to require the member to pay the amount earmarked in the Central Fund for his debt within 28 days from the time it is earmarked. If that member fails to pay, the loss will be considered a civil debt and Lloyd's will be allowed to apply to the courts to seize the member's assets for unpaid debts.

Lloyd's Chief Executive Alan Lord said that the council had been considering this measure for about two years and would allow Lloyd's "on the rare occasion" to seize a member's house as collateral for the debt

This new bylaw "should ensure that the vast majority of names who pass the annual solvency test out of their own resources are not, in effect subsidizing the small minority who require the council to earmark assets of the Central Fund on their behalf in order to pass the annual solvency test," Lloyd's announced

Regulation costs

The cost of increased regulation at Lloyd's of London is becoming a burden to underwriting agencies, a recent report concludes.

In addition, the money lost by underwriting agencies, whose executives must divert time from their duties to comply with Lloyd's regulations, cannot be quantified, said the report by London-based accounting firm Peat Marwick McLintock.

Nevertheless, the agents understand that a "substantial" portion of the cost is "commercially necessary and consistent with sound business practice," the report concludes.

Peat Marwick's report on 'Lloyd's Regulation: Cost of Compliance," released by the market earlier this month, was commissioned by Lloyd's Regulatory Services Group to study the cost of underwriting agencies' compliance with increased self-regulation at Lloyd's.

The 76-page report shows that Lloyd's has increased its regulatory staff to 465 people in 1988 from 451 people in 1987 and 189 people in 1982.

In addition, the report shows that the market's net cost of regulation grew to 17.3 million pounds ($32.4 million) in 1987, up 22.6% from 14.1 million pounds ($26.4 million) in 1986 and up 291% from 3.6 million pounds ($6.7 million) in 1981, the year before the Lloyd's Act of 1982 imposed new regulations.

Lloyd's Chief Executive Alan Lord said recently that Lloyd's regulatory costs grew to 22 million pounds ($41.4 million) in 1988 and the market has budgeted 22.8 million pounds ($42.6 million) for 1989.

Certain agents participating in the study thought Lloyd's should be regulated by the British government rather than by self-regulation, according to the report.

However, "we were presented with no conclusive evidence as to whether self-regulation or statutory regulation should in principle be more economic in terms of central costs and costs of compliance," said Peat Marwick.

"Certain agents suggested that under statutory regulation some costs would be borne by the state, but this view was not endorsed by the Department for Trade and Industry," the report said.

In the report, Peat Marwick makes 18 major recommendations to Lloyd's on how to improve its self-regulatory system to reduce costs and make they system more efficient. Some of the recommendations include:

- Consider clarifying "the nature and limitations of its responsibilities for underwriting agencies in documentation available to names and the public."
- Re-examine the regulation of underwriting agencies that are part of a holding company that owns several members' and managing agencies.
- Consider speeding up the investigation of underwriting agency directors and officers, which currently takes five to six weeks.
- Decide whether errors and omissions insurance for underwriting agencies should be mandatory.

The Council of Lloyd's responded to the report by issuing a list of its latest positions on the accountants' recommendations. Many of the points raised are "being considered" or are "already well-advanced" or are currently being "simplified," said a statement from the council.

Comings & goings

Robin Etheridge has been appointed group non-marine underwriter (strategic planning) for English & American Insurance Group P.L.C.

Ken Ross has been appointed president of Rush Johnson Associates in London, with responsibility for the London and Aberdeen, Scotland, offices of the offshore loss adjuster. Mr. Ross joined RJA from The Salvage Assn. in 1982 and has been in charge of the Aberdeen office since its opening in 1984. ■

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Michigan sets work comp health cost caps

By KARI BERMAN

LANSING, Mich.—New state regulations that cap payments for treatment of work-related illness and injury are expected to significantly reduce workers compensation costs in Michigan.

The new rules were accepted earlier this month by the Michigan Legislative Joint Committee on Administrative Rules, according to Larry Horwitz, executive vp of The Economic Alliance for Michigan, a non-profit organization representing business and labor that works for economic development in the state.

The rules, which take effect June 28, implement a 1981 law authorizing maximum fee schedules for health care services and introducing utilization review of health care claims for work-related injuries.

Although the Michigan Legislature approved the concept in 1981, various groups involved with workers compensation until recently were unable to agree on specifics of a new system.

The Michigan State Office of Health and Medical Affairs, which oversees workers compensation, last year asked the Economic Alliance to mediate discussions.

Representatives of health care providers, insurance companies, employers, unions and hospitals submitted their agreed-upon guidelines to the legislative committee for approval.

The compromise "represents a reasonable and balanced response to the sometimes conflicting concerns of recipients, providers, and purchasers of workers compensation health services," Mr. Horwitz stated in a news release.

Previously, Michigan required self-insured employers and insurance companies to pay for "reasonable and necessary" health service costs incurred by employees with work-related illnesses or injuries.

Workers compensation health care costs have been steadily increasing at an annual rate of 20%, leaping to $300 million in 1987, from $250 million in 1986, according to Mr. Horwitz. And 1988 expenditures are expected to reach $350 million, he added.

Mr. Horwitz conservatively estimates that the maximum fee schedule alone should save about 10% of payments for workers compensation health services in the first year of the new program.

"The caps on the fees should yield a savings of at least $35 million from July of 1989 to June of 1990 and that is without calculating the further savings that utilization control will bring," he said.

The newly adopted maximum fee schedule is based on a combination of data from other, existing price scales, according to Mr. Horwitz.

"We looked at fee schedules from other states, Blue Cross & Blue Shield PPO charges as well as commercial health insurance rates," Mr. Horwitz explained.

The utilization review program is designed to function on two levels:

- Technical review to determine the accuracy of a medical bill, making certain that it includes proper charges for the designated procedure.
- Professional health care review, required for claims either more than $5,000 or involving inpatient hospital care, will determine whether the treatment was medically appropriate.

However, any questionable claims can be submitted for additional professional utilization review, according to Mr. Horwitz.

The utilization review can either be conducted by the insurer or by a contracted certified health care agency. Professional review programs must be certified by the Michigan Department of Management and Budget and the Office of Health and Medical Affairs, Mr. Horwitz explained.

Roger Friez, vp of workers compensation claims at the Accident Fund of Michigan, the state's largest workers compensation insurer, covering 34,000 employers, supports the new reforms and believes that "they are a step in the right direction and will be effective measures for cost containment."

"Anything that reduces cost is something that we support. The maximum fee schedule will help because it will show exactly what is being charged at a set price," said John Leary, workers compensation rehabilitation claims administrator at Lansing-based Farm Bureau Mutual Insurance Co. of Michigan.

Also supporting a maximum fee schedule and utilization review program is Nancy Nowak, president of the Michigan Insurance Federation of Lansing, Mich., which represents 27 property/casualty insurance companies with offices in Michigan.

"The establishment of a maximum fee scale seemed like the most responsible thing to do for cost containment purposes. The scale is reasonable but I am sorry that it took so long for consensus," Ms. Nowak said.

"Employers are satisfied with the reforms because the set fees and utilization review will reduce the overcharging and bring a significant savings in the long run," said David Lewsley, manager of workers compensation at Chrysler Corp. of Highland Park, Mich., and chairman of the Michigan Self-Insured Assn. in Detroit.

Although often at odds with one another, organized labor representatives join employers in support of the workers compensation regulatory measures.

"We support the new rules but it was a long negotiating process. A lot of the issues were common sense things that with all of the different views took a while to resolve," said Tim Hughes, legislative director for the Lansing-based Michigan State AFL-CIO, representing 720,000 individuals and 68 labor unions.

While private health care providers and medical clinics have accepted the maximum fee schedule, a separate set of regulations providing for discounts will be applied to inpatient hospital services.

"The hospital sector was the last represented group to agree to the new reforms because they felt that their funds were already whittled away by government discounts and indigent care costs and a maximum fee schedule would not cover their expenses," Mr. Horwitz said.

Under the new rules, each hospital's inpatient charges will be subject to a mandatory discount, averaging 13% statewide. The discount will vary according to the individual hospital's cost, according to Mr. Horwitz.

"We were the last to accept the new regulations but it is a compromise package and we finally agreed to it," said a spokesman for the Michigan Hospital Assn. in Lansing, which represents an estimated 200 acute care hospitals in Michigan.

"It is difficult to predict how successful the new program will be but although we strongly opposed it initially, the hospitals basically accept the situation," the spokesman said. ■

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* Source Business/Occupational breakdown of qualified circulation, May 30, 1988 issue, as submitted to BPA for June 1988 BPA Publisher's Statement.

HIAA study

Continued from page 1

miums are excluded, the average increase was much higher than 12% average, more in line with premiums increases previously reported by the media.

For example, among survey respondents that experienced a premium increase, premiums for indemnity plans with PPO options rose 27%, traditional indemnity plan premiums rose 20%, independent practice association health maintenance organization premiums rose 11% and group or staff model HMO premiums rose 10%.

However, employee benefit consultants and a benefit manager say it is highly unlikely that many employers did not experience a premium increase between spring 1987 and spring 1988.

"First of all, I don't know of any employer that hasn't had a premium increase," observed Lawrence B. Leisure, a principal in the New York office of TPF&C, the benefits and actuarial consulting division of Towers, Perrin, Forster & Crosby Inc.

"Even when inflation was flat, there still wasn't anyone who had no premium increase. It just doesn't smell right," he said.

However, he added that "there's always a certain number of employers that fall into the category where the insurer overreacted to cost trends in the previous year and overcharged the employer." The insurer then will adjust for the overcharge in the next year's premium, he explained.

"We've seen very few employers who've had no premium increase, but even these were fully insured plans that had very good claims experience and who were being overcharged in the previous year," agreed Marika Gordon, a senior manager in the actuarial, benefits and compensation consulting practice of Touche Ross & Co. in Los Angeles.

"I find it hard to believe that one-third of the employers said they had no increases," said Herbert V. Kaighan, a principal with William M. Mercer Meidinger Hansen Inc. in Los Angeles. "Ten percent of the employers might be more believable.

"We know that HMOs have increased their premiums an average of 10% and indemnity plan premiums are increasing at a rate of about 30%," so it is unlikely that employers could have no premium increase at all, he said.

"For an employer not to have a premium increase, you would have to have a 70% loss ratio—meaning that your claims could only be 70% of your premium," said Glenn Meister, a vp in the Los Angeles office of A. Foster Higgins & Co. Inc.

"Plus, around mid-1987 was when costs really jumped to a high level," Mr. Meister added. "The survey's findings can't be (correct), unless they had a small sample and the results of those companies was different from the rest of the universe."

Arthur Young, corporate benefits manager at Hewlett-Packard Co. in Palo Alto, Calif., also agreed that it was unlikely that one-third of the 1,665 employers surveyed reported no premium increase. "It seems very high," he said.

However, some employers may have had low or no premium increases if they had aggressive cost containment programs under their indemnity plans, required significant employee cost-sharing or were overreserved or overcharged by their insurer and then didn't need an increase for the next year, he explained.

Hewlett Packard self-insures its indemnity plan, which experienced a 25% increase in reserves and employee premiums for 1989, he said. In 1988, the increase was between 18% and 20%.

"I don't see any let-up in the rate of increase in the near future," Mr. Young said.

Referring to a recent meeting he attended of benefit managers from large corporations and insurers, he noted that "premium increases were all over the board. Some employers reported no increases, but again, these were largely self-insured, aggressive employers."

Low or no premium increases are "possible, but it's hard for me to believe given our situation," Mr. Young noted.

One consultant agrees with Mr. Young that it may be possible that some employers reported no premium increases.

"I would chalk that up to 1986, which was when many employers substantially increased deductibles, copayments and even premium contributions for their employees in indemnity plans. In return, insurers weren't increasing the employers' premiums," explained Joseph Rosmann, a partner with the Actuarial, Benefits and Compensation consulting practice of Coopers & Lybrand in Chicago.

"The question is: 'Did HIAA have any information on what changes those companies surveyed made in their plans?' I would bet that those companies reporting no premium increases had increased deductibles, copayments and premium contributions in 1986 and 1987," he suggested.

Jon Gabel, associate director-research and statistics for the HIAA, said employers were not asked whether they increased employees' costs.

Mr. Gabel said that the survey results were verified with follow-up phone calls to a "substantial number" of employers that reported that their health care plan premiums remained flat.

"I was very surprised myself and very skeptical" of the survey's results, he said in an interview.

But in the follow-up phone calls, employers whose premiums remained flat listed several reasons for their good fortune, Mr. Gabel said. For example, nearly 30% of the health insurance plans that experienced no premium increases had less than one year of experience with their current insurers.

"Thus, in an industry with numerous sellers, many employers facing increased health insurance premiums shopped for a better buy," the survey said.

Although employers of all sizes reported stable premiums, small employers were more likely to report flat premiums, and these employers are more likely to shop around, Mr. Gabel said. He added that media reports often do not include employers that switch health insurers rather than renew with the same underwriter.

In addition, while many employers' health insurance premiums are recalculated in June, the survey was conducted in the spring. Therefore, premium increased that took effect in June 1988 are not reflected in the survey.

These employers presumably reported their premiums for 1987, when premiums increased by modest single-digit amounts, Mr. Gabel said, citing figures reported by the U.S. Bureau of Labor Statistics.

In all of 1987, the medical care component of the Consumer Price Index increased 6.1%, a four-year low after a high of 7.7% in 1986.

While the average increase reported overall by the employers surveyed between spring 1987 and spring 1988 was 12%, the range varied widely according to the type of health insurance plan offered.

For example, the highest rate of premium increase—17%—was reported by traditional indemnity plans with preferred provider organization options.

The lowest rate of increase—8%—was reported by traditional staff or group model health maintenance organizations.

Premiums rose an average of

Continued on next page

HIAA study

Continued from previous page

11.2% for traditional indemnity plans and 10% for independent practice association HMOs.

Average monthly premiums in 1988 for individual coverage were $98 for traditional indemnity plans, $103 for indemnity plans with PPO options, $88 for IPA HMOs and $93 for staff or group HMOs.

Monthly premiums for family coverage averaged $209 for conventional indemnity plans, $232 for indemnity plans with PPO options, $226 for IPA HMOs and $203 for group HMOs.

The survey suggested that PPOs charged that highest average premiums because they are located in areas with the highest health care costs.

While the survey suggests that overall health insurance costs have risen more slowly than widely reported, the HIAA's Mr. Gabel suggests that the magnitude of increases for 1988 will be much higher than in 1987.

In fact, the HIAA plans to release a follow-up survey next month that Mr. Gabel speculates will show average health care insurance premium hikes will increase to the "upper teens" and that the percentage of employers whose premiums will remain flat will decrease to the "upper teens."

'Insurers were overly optimistic about their ability to control provider costs,' the survey says.

And, high premium increases will continue for the next few years, according to the survey authors.

Mr. Gabel pointed to the increase in the CPI's medical care component for 1988. The BLS reports the medical care component increased 7% through the first 11 months of this year.

"A three-year lull of single-digit premium increases ended in 1988 as the nation's employers awoke to a new round of health care inflation," the survey authors say.

"Historically, the premium cycle consists of three years of double-digit increases, followed by single-digit increases for three years. This suggests that 1989 and 1990 will be years of double-digit increases," the survey says.

The survey authors say they are not optimistic that premium increases will slow, partly because insurers and employers are not taking strong enough steps to contain health care costs.

"True, they adopted preadmission review and other prospective utilization review programs at a breathtaking pace, and other managed care plans continued their growth. But, employers failed to 'prescribe' increased patient cost-sharing while continuing to expand the number of covered services."

For example, the survey showed "virtually no change" in the average deductible or in the coinsurance rate.

Typical deductibles are $100 for individuals and $300 for families, according to the survey. More than 75% of the employees at surveyed companies face the standard 20% coinsurance requirement. And, employers on average contributed 75% of the premium for family coverage in 1987 and 1988, according to the survey.

"Perhaps 1988 to 1989 will prove to be the year of bitter medicine—more patient cost-sharing, increased limitations on patients' ability to choose any willing provider and more stringent utilization review," the survey authors conclude.

In addition, the survey "suggests another culprit—the growing number of services covered by employer-sponsored health benefits."

For example, the survey authors point out that from 1985 to 1988, 14% more employees with employer-sponsored health insurance received coverage for alcohol and drug dependency treatment, an additional 8% received coverage for outpatient mental health care and an additional 6% received coverage for inpatient mental health care.

"Mental health and chemical dependency coverage constitute one of the fastest-growing components of health care costs, with many insurers reporting annual rates of increase exceeding 20%," the survey authors say.

Another reason premiums are increasing is that the health insurance industry suffered record losses in 1987, the survey says. Those losses ranged from about 4% of gross revenues for Blue Cross/Blue Shield plans to almost 6% for commercial insurers.

"Insurers were overly optimistic about their ability to control provider costs—in hospitals and particularly in ambulatory care settings" in 1987, HIAA explains.

The HIAA also points to several other reasons for the increase in health insurance premiums, including the aging of the population; growth of expensive technology; lack of consumer information; and sheltering consumers from the cost of care through third-party payment.

In other survey findings:

- There was little difference in the average premium increase reported by employers of different sizes: 12% for small employers, or those with up to 99 employees; 13% for medium-sized employers, or those with 100 to 999 employees; and 12% for large employers.

There also was little difference in the average premium increase by geographic region: 12% in the Northeast, 11% in the North Central states, 12% in the South and 13% in the West.

- Some 72% of employees covered by group health insurance are enrolled in some type of managed care plan, up from 60% in 1987. These plans include traditional indemnity or managed fee-for-service plans with preadmission certification features, which accounted for 43% of the plans; HMOs, which accounted for 18%; and an indemnity plan with a PPO option, which accounted for 11%.

"The most dramatic growth in managed care. . .occurred among managed fee-for-service plans. These plans covered 50% more Americans in 1988 than in 1987," the survey authors pointed out.

- Employers with IPA HMO plans were the most satisfied with the cost of their plans, with 48% saying they were very satisfied and 38% somewhat satisfied. Only 14% said they were dissatisfied or only fairly satisfied with the cost of their IPA HMO plans.

Among employers with staff or group HMO plans, 23% reported they were very satisfied with the cost of the plan, while 60% said they were somewhat satisfied. Only 18% said they were dissatisfied or only fairly satisfied with the cost of their staff or group HMO plans.

However, among employers with traditional indemnity plans, 34% said they were very satisfied and an equal number said they were somewhat satisfied with the cost of their plans. But, a nearly equal number—31%—said they were fairly satisfied or dissatisfied with the cost of their plans.

The sentiment about plan cost was similar among employers with traditional indemnity plans with a PPO option: 35% reported they were very satisfied, 33% reported they were satisfied, and 32% reported they were fairly satisfied or dissatisfied.

- Regarding employers' overall satisfaction with their health care plans—considering all factors and not just cost—IPA HMOs received both the highest favorable and unfavorable ratings. Half of the employers said they were very satisfied with their IPA HMO, and 30% said they were somewhat satisfied. But 20% said they were only fairly satisfied or dissatisfied.

Among employers with staff or group HMOs, 32% said they were very satisfied, 58% said they were somewhat satisfied, and 10% said they were fairly satisfied or dissatisfied.

Among employers with traditional indemnity plans, 47% said they were very satisfied, 37% said they were somewhat satisfied, and 16% said they were fairly satisfied or dissatisfied.

Some 47% of employers with traditional indemnity plans with PPO options reported they were very satisfied, 44% reported they were somewhat satisfied, and only 9% said they were fairly satisfied or dissatisfied.

"When asked if they plan to renew their current plans, about 10% of employers said they did not plan to renew their conventional indemnity and IPA HMO plans, a figure more than double that for staff or group HMOs and PPOs."

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Copies of the survey, "Employer-Sponsored Health Insurance In America: Preliminary Results from the 1988 Survey," are available free from Jon Gabel, Health Insurance Assn. of America, 1025 Connecticut Ave. N.W., Washington, D.C. 20036-3998; 202-223-7780.

Shell coverage ruling

Continued from page 1
courtroom to hear testimony about Shell's knowledge of the pollution at the arsenal. The jury, which was comprised of six men and six women, were mostly blue-collar workers.

During the trial, some 2 million documents were entered into evidence and more than 200 witnesses testified about what happened at the arsenal.

The entire trial was videotaped and much of the damning testimony was replayed for the jury during closing arguments.

For example, the jurors heard testimony from Jack St. Clair, president of Shell Chemical Co., and G.S. Williamson, manager of the manufacturing division, that they knew Shell was polluting the environment.

Furthermore, the jurors heard evidence that Shell attempted to hide the problem.

A witness from the Colorado Game and Fish Department testified that he visited the site in 1964 and saw dozens of ducks lying dead along the sides of a contaminated pond. A Shell employee then told jurors he was ordered to remove some of the dead ducks from the pond so that it would seem like the pollution problem was being corrected.

Insurer attorneys then showed jurors charts that revealed that Shell projected its profits based on dumping its by-products into unlined basins, which leaked toxic chemicals into the groundwater, and based on using off-site dumping or incinerating its wastes.

Shell chose to continue to use unlined basins to maximize it profits, the attorneys said.

"For more than 30 years Shell polluted the arsenal for profit," said Barry Ostrager, an attorney with Simpson, Thatcher & Bartlett in New York. Mr. Ostrager represented The Travelers Insurance Co. of Hartford, Conn., Shell's primary insurer.

Barry Bunshoft, an attorney with Hancock, Rothert & Bunshoft in San Francisco, told jurors: "The Shell Oil Co. for 30 years gave profits for production of pesticides a higher priority than protection of the environment.

"Shell Oil Co. continued the practices that were polluting the Rocky Mountain Arsenal from the first day it (leased the arsenal) until the day it folded up the tent and left in 1982 leaving behind it the most polluted place on earth," said Mr. Bunshoft, who represented Lloyd's of London underwriters collectively known as Froude & Cos.

Shell responded to these accusations by saying that insurance is purchased to protect those who make mistakes.

"All insurance companies cover people and companies who are at fault, who make mistakes that cause damage, who do things they shouldn't have done and who are liable with or without fault," said Shell attorney William Trautman of Brobeck, Phleger & Harrison in San Francisco.

Mr. Trautman told jurors: "You don't have to judge the morality of pollution. You only have to judge whether or not the insurance companies that have been insuring Shell against liability for 30 years and collecting premiums from Shell for 30 years are finally going to have to provide part of the cost of the extensive cleanup of the environment at the Rocky Mountain Arsenal."

After deliberating for four and a half days, the jury ruled against Shell.

The jury found that Shell expected and intended that pollution would result from its operations at the Rocky Mountain Arsenal from 1952 until 1982.

The jury was told by the judge that "injury is intended and expected and (therefore) no coverage (applies) if Shell possesses the intent to damage the property or if Shell intentionally committed an act wherein it should have reasonably been known by Shell there was a high degree of certainty that damage to the property of another would result from that act."

Eleven of the 12 jurors said based on this direction that Shell had no coverage for its conduct for the first seven years and all the jurors found no coverage for the remaining years.

A jury verdict in a civil suit does not have to be unanimous.

Shell General Counsel Allen Lackey says Shell will appeal the ruling on the basis of evidentiary rulings made by Judge Lanam, such as those limiting Shell witnesses' testimony, and on the basis that the jury instructions were defective.

"We are naturally disappointed with the ruling, but we continue to believe that we have insurance coverage for the Rocky Mountain Arsenal," he said.

"The chances of Shell prevailing on appeal are very remote," said Mitchell Lathrop, an attorney with Adams, Duque & Hazeltine in San Diego, who represents St. Paul Fire & Marine Insurance Co. "I see no basis for a reversal."

Robert Zeavin, an attorney with Buchalter, Nemer, Fields & Younger in San Francisco, agreed.

"The jury instructions were fair and correct statements that reflect California law correctly and correctly reflect the Phase I rulings," said Mr. Zeavin, who represented American International Group Inc. of New York. "There was no reversible error."

All of the insurer attorneys contacted said they strongly believe they would be able to win the case on appeal.

The Shell case has nationwide significance because it marks the first trial focusing on a policyholder's knowledge of pollution.

"This is a giant win for insurers," said Travelers' attorney Mr. Ostrager. "It demonstrates that a jury is prepared to find no coverage in the appropriate case."

"The ruling means where the facts indicate it, 'expected or intended' is a viable defense for insurers," added Travelers attorney Mary Kay Vyskocil of Simpson, Thatcher & Bartlett in New York.

"This case tells the insurance industry that it can win on 'expected or intended' from day one, when the insured knows what is going on in day one," agreed Mr. Zeavin.

"Other policyholders with similar fact patterns won't win coverage" as a result of the Shell ruling, said Lloyd's attorney Mr. Bunshoft.

"It was an enormous win for insurers," said Mr. Bunshoft within hours of the jury's decision, while champagne corks popped in the background.

Attorneys who did not participate in the Shell case also said that the ruling would have widespread impact.

Insurance attorney Thomas Brunner of Wiley, Rein & Fielding in Washington, D.C., said the Shell case "underscores the fact that intentional misconduct issues are serious and will merit attention."

He predicted that the expected or intended defense will be used by insurers more frequently.

"Insurance companies are going to be more willing to go to trial on the issue" agreed Robert Bates, an insurance attorney with Phelan, Pope & John in Chicago.

However, policyholder attorney Peter Kalis of Kirkpatrick & Lockhart in Pittsburgh downplayed the effects of the Shell ruling.

Mr. Kalis, who represents Westinghouse Electric Corp. and United Technologies Corp. in their massive coverage battles with insurers, said the Shell ruling will not impact his clients because the facts of their cases are different.

Pittsburgh-based Westinghouse is suing more than 140 of its property and liability insurers for the costs to clean up 80 polluted sites nationwide and for the indemnity of thousands of personal injury claims (*BI*, June 15).

Hartford, Conn.-based United Technologies Corp. is suing more than 200 of its liability insurers for the cost to clean up 138 polluted sites nationwide (*BI*, Feb. 1).

Policyholder attorney Jim Russell of Winston & Strawn in Chicago said the Shell ruling is part of a recent trend in the courts to find in favor of insurers after finding in favor of policyholders in the mid-1980s.

"The pendulum is swinging back in the favor of insurers," said Mr. Russell.

Some attorneys also predicted the Shell ruling could cause policyholders to be more cautious in filing massive coverage suits against their insurers knowing that they could spend a great deal of money and time and still end up without any insurance coverage.

Shell spent more than five years and as much as $50 million unsuccessfully fighting with its insurers. Shell's Mr. Lackey said that estimate of the company's costs is high, but he would not provide a more accurate number.

Collectively, the insurers are estimated to have spent at least as much as Shell in the litigation. St. Paul, which wrote only $10 million in coverage for Shell, spent at least $1 million in the litigation, according to Mr. Lathrop.

And Lloyd's syndicates spent "less than $10 million," according to Mr. Bunshoft.

"Given the expense that Shell incurred to come away with no win at all will cause other companies to take a hard look at these suits," predicted AIG attorney Mr. Zeavin.

"Policyholders will be more reticent to sue insurers and they will be more realistic in what they expect to get from their insurers," he said.

"Every major American corporation that has decided to sue the insurance industry is going to take a long, hard look at that course of action," as a result of the Shell verdict, said St. Paul attorney Mr. Lathrop.

"No company is knowingly going to subject itself to this without careful consideration," he said.

"The ruling signals a shift away from mass suits against the insurance industry," he predicted.

"The insurance company lawyers have set out to No. 1 make these cases too costly for policyholders to be able to afford to bring them and No. 2 to prove their policyholders are evil wrongdoers and therefore should not get insurance," said policyholder attorney Eugene Anderson with Anderson, Russell, Kill & Olick in New York. "The Shell verdict indicates that this strategy is successful."

"Policyholders are already afraid of their insurers and this lends to that fear," said Mr. Anderson.

However, policyholder attorney Mr. Kalis, disagreed.

"Whatever the case was with Shell, the vast majority of policyholders do not fall into that category (of an intentional polluter) and have nothing to fear from the Shell ruling," he said.

And, insurer attorney Mr. Bates said: "I don't think this result will have a chilling effect on these suits being filed, but it will cause (both sides) to look for alternatives to litigation." ■

Update

Court blocks drug tests

Continued from page 2
companies with fewer than 50 employees.

Judge Marilyn Patel of U.S. District Court for the Northern District of California in San Francisco restrained the government from putting the rule into effect until the court rules on a suit filed by the Owner Operator Independent Truckers Assn. challenging the rule. A hearing is scheduled for Dec. 30.

Earlier in the month, the Railway Labor Executives Assn. also filed a challenge to the random drug testing provision of the rule in the same district court.

The RLEA also argued a case before the U.S. Supreme Court Nov. 2, challenging other provisions of the rule, which had already been proposed for railway employees. RLEA challenged provisions that require testing before employment, during some regular medical exams of employees, when employers have reasonable cause to believe employees are under the influence of drugs and after an accident. The Supreme Court has not ruled in the case.

Court upholds Home decision

SAN DIEGO—A California state appellate court has upheld its earlier decision that the property insurer on a risk at the time damage first becomes apparent is responsible for the entire loss, even if the damage continues beyond the policy term (*BI*, Feb. 22).

After reviewing its earlier decision, the 4th District Court of Appeals in San Diego ruled that The Home Insurance Co. of New York is responsible for all losses stemming from damage to balconies at the Hotel Del Coronado in Coronado, Calif., because The Home insured the hotel at the time the property damage was discovered.

The Home insured the hotel from Sept. 1, 1980, to Oct. 1, 1981.

The ruling requires The Home to pay Landmark Insurance Co. of Chicago, which insured the hotel from Oct. 1, 1981, $100,000. Landmark had paid $100,000 in a settlement with the hotel. The Home paid the hotel $285,000.

Illinois drops Chubb complaint

SPRINGFIELD, Ill.—The Illinois Insurance Department has agreed to drop its complaint against Federal Insurance Co. of Warren, N.J., in connection with the insurer's failure to bind $400 million in drought insurance coverage sold by its agents.

Under the agreement, Federal, a unit of Chubb Corp., will reimburse the state $100,000 for expenses incurred in the investigation of the matter, plus a $50,000 fine, the maximum authorized by Illinois statutes, said Insurance Director John E. Washburn.

The agreement also releases Chubb from any administrative action by the Illinois Insurance Department in connection with the drought insurance case. However, Chubb is still subject to administrative actions in Ohio, Indiana and Iowa.

The negotiations were conducted after a Dec. 7 fairness hearing in Springfield on the proposed settlement of the drought insurance class action suit. Approximately 800 Illinois farmers will receive about $14.5 million under the settlement, which was announced in November (*BI*, Nov. 14).

Anistics drops mainframe RMIS

NEW YORK—Anistics Inc., a leading vendor of risk management information systems, is phasing out its ARIS* mainframe-based RMIS, according to Richard B. Hall, chief executive officer.

The Alexander & Alexander Services Inc. subsidiary, which hopes to complete the move by the third quarter of 1989, will continue to offer microcomputer-based RMIS products and consulting services, Mr. Hall said.

About 100 clients will be affected by Anistics' decision, he said.

"Some of these clients we foresee moving to a microcomputer environment and some to other vendors. But, we are reviewing them on an account-by-account basis and will accommodate the clients," he said. "We're not about to abandon any of our clients, since many obtain other services from us and our parent company," Mr. Hall explained.

Part of the reason for the phase-out was "financial," Mr. Hall said. "We saw it as something that, although we had success selling, was not going to grow in any way. And, there was a lot of competition from insurers on this business," he said.

In addition, clients found the mainframe systems costly to upgrade and maintain since Anistics developed its own computer language when it introduced the ARIS* systems, Mr. Hall said.

Briefly noted

The Florida Insurance Department last week issued a cease and desist order against **Alan Teale's International Underwriting Assn.** and eight insurance company members of the consortium, including Turks & Caicos-domiciled American Trust Insurance Co. Ltd. (*BI*, July 25) The insurers have operated in Florida without authorization, the department said. . . .No pretrial motions were filed by attorneys general in the **antitrust litigation** pending against insurance industry defendants, said Jesse W. Markham Jr., assistant attorney general for California. Several motions had been filed by industry defendants in U.S. District Court in San Francisco by the Dec. 16 deadline (*BI*, Dec. 19). Responses to the motions are due April 28, 1989 (*BI*, June 27). . . .The U.S. **Environmental Protection Agency** fined 25 companies a total of $1.5 million for not submitting toxic chemical release forms to the agency by the July 1 deadline. . . .A New York state judge last week dismissed a New York Insurance Department liquidation petition for **Burt Syndicate Inc.**, a New York Insurance Exchange underwriting member, following completion of a rehabilitation plan that commuted most of the syndicate's contracts (*BI*, Aug 29). The syndicate's assets are expected to be acquired by a new insurer, American Farm Insurance Co. of New York, which is applying for a license to write animal mortality risks.

Pan Am crash

Continued from page 1

liability limits can be ignored, according to London underwriters.

For example, families of the soldiers killed in the Christmas 1985 crash of an Arrow Air Inc. DC-8 jetliner in Newfoundland disputed the $75,000 liability limits and were instead awarded an average of $1 million per passenger, according to a London underwriter who does not want to be named. The disaster killed 256 people, including 248 military personnel (*BI*, Jan. 20, 1986).

About 190 cases have been settled from the Arrow Air crash, with a cost so far to insurers of about $200 million, said the London underwriter.

The $250 million to $300 million liability loss estimate for the Pan Am crash does not include any liability awards or settlements involving Boeing or liability payments by Pan Am for casualties and property damage in Lockerbie.

The Warsaw Convention states that a manufacturer faces unlimited liability if a manufacturing design or defect is found to be the cause of the disaster, said Mr. Martin.

Also, there is no limit on Pan Am's liability for personal injury and property damage claims from victims and their relatives on the ground under the U.K. Civil Aviation Act of 1982, said Mr. Martin.

Last week's disaster came just after Pan Am finished its Jan. 1 renewal of its hull and liability all-risk insurance, though the airline's 1988 insurance program will apply to the loss.

In 1988, Pan Am's fleet—including its aging 747s—was insured for all hull risks, except war risks, for a maximum of $65 million per aircraft, though new Boeing 747's are now valued at about $100 million each. In addition, Pan Am carried a maximum of $750 million in aviation liability insurance, which covered war risks.

Participants on the all-risk hull and liability program, according to London and U.S. sources, include:

- USAIG, which had a 30% participation.
- London markets led by Lloyd's Ariel syndicate, with a 25% participation.
- La Reunion Aerienne of France, with a 20% participation.
- Associated Aviation Underwriters of Short Hills, N.J., with a 17.5% participation.
- CAMAT of France, with a 5% participation.

The remaining 2.5% of the program was placed with other insurers, one aviation reinsurance source said.

About 75% of the airline's hull war risk insurance, also with maximum per-hull limits of $65 million, was placed in the London market. The program was renewed July 1.

Pan Am's insurance program is brokered by Frank B. Hall & Co. Inc.

Hall aviation officials in New York could not be reached, and Hall's London affiliate, Leslie & Godwin Ltd., would not comment on the airline's coverage.

Pan Am's liability insurance program had contained a unique $10 million deductible from 1984 to 1987. However, the deductible was eliminated when this year's coverage was placed because of softening conditions in the aviation insurance market.

In addition, Pan Am's hull insurance rates dropped by 50% when it renewed the coverage a year ago.

Last week's disaster is the third for New York-based Pan Am in the past decade.

In 1982, a Pan Am Boeing 727 crashed after takeoff near New Orleans, killing 154 people.

The U.S. government contributed more than $27 million toward the settlement of liability and property damage claims stemming from the July 1982 crash to avoid litigation. The government feared that international passengers, subject to the Warsaw Convention limitations, would sue the government to recover amounts exceeding $75,000.

Authorities had blamed the crash on wind shear (*BI*, Sept. 2. 1985).

Also, 18 people were killed during the September 1986 hijacking of a Pan Am Boeing 747 in Karachi, Pakistan. However, claims from the incident are not expected to exceed Pan Am's $10 million deductible (*BI*, Sept. 15, 1986).

Last week, many in the London aviation insurance market said it was too early to predict whether the Pan Am loss would reduce the huge rate cuts now common in the aviation insurance market.

"Rates could harden for U.S. trunks," speculated one London underwriter. "But I don't think (the Pan Am) loss will have a serious impact."

The Pan Am crash "could have some effect on rates," said a London broker. "But 1988 is not an extraordinary year one way or the other."

Airlines that recently completed their Jan. 1 renewals generally received a 50% rate reduction for hull insurance and only slightly smaller savings for liability insurance, underwriters and brokers agree.

In fact, London aviation market observers speculate that Pan Am should have received such rate reductions when it renewed its program.

Including losses from the Pan Am disaster last week, total hull and liability losses this year may exceed total 1988 worldwide aviation insurance premiums of $500 million to $600 million, underwriters and brokers agree.

According to Airclaims Ltd., a British aviation information service that tracks hull losses, 1988 will be an "average" year for total losses of Western-built aircraft. Twenty-four Western-built jetliners have been declared total losses this year, costing insurers $240 million in hull payments, Airclaims said.

The average annual cost of total hull losses between 1980 and 1987 was $210 million, according to Airclaims.

This year's hull losses include the $15.5 million loss of a Delta Air Lines Boeing 727, which crashed on takeoff and caught fire at Dallas-Fort Worth International Airport in August, killing 13 of the 105 people on board and injuring 33 others (*BI*, Sept. 5).

In addition, an Air France Airbus A-320 jet crashed during a demonstration flight in Mulhouse, France, killing three and injuring 50 (*BI*, July 4). The hull claim totaled $45 million.

The worst year on record for total hull losses was 1985, when underwriters reported hull claims of about $400 million. In 1983, total hull losses reached $302 million.

Besides the total hull losses, there also have been 22 partial hull losses this year with costs totaling $173 million, bringing overall hull losses this year to $413 million, said Airclaims.

A total of 883 people have died in airline disasters this year, compared with a yearly average of 650 fatalities between 1980 and 1987, according to Airclaims. The worst passenger loss years were 1985, when 1,537 passengers were killed, and 1983, when 1,001 passenger fatalities were recorded.

London brokers and underwriters agreed last week that it is vital to establish the cause of the Pan Am loss. They noted that this is the third questionable Boeing 747 disaster to occur in the last three years, despite the otherwise excellent loss record of the aircraft.

All-risk and war risk underwriters disputed for three years the cause of the $100 million loss of an Air India Boeing 747 in 1985, which exploded over the Irish Sea killing 303 passengers and 23 crew members (*BI*, July 1, 1985).

Although the Indian government concluded that the explosion was caused by a bomb, underwriters questioned the findings and it wasn't until March of this year that an arbitrator ruled that war risk underwriters should pay the entire loss (*BI*, March 28).

Also, a cause has not yet been determined for the 1987 loss of a South African Airways Boeing 747, which plummeted into the sea en route to Capetown. The jetliner's flight recorder has never been found.

Aviation experts speculate, however, that there could have been a fire on board the jetliner, which was carrying mostly cargo (*BI*, Dec. 7, 1987). ■

Photo: AP/Wide World

Rescue workers examine the nose section of the Pan Am Boeing 747 that crashed near the village of Lockerbie, Scotland, Dec. 21, killing all 258 people aboard and as many as 15 on the ground.

Product tampering cost Pillsbury $49.9 million: Jury

MINNEAPOLIS—A Hennepin County District Court jury has ruled Pillsbury Co. sustained $49.9 million in damages as a result of media and government statements in 1984 about the presence of pesticide ethylene dibromide in the company's products.

A trial must now be held to decide whether Pillsbury—which was recently acquired by Grand Metropolitan P.L.C. of Britain—is entitled to coverage under its 1983 product integrity coverage, said Ron Lund, Pillsbury's associate general counsel.

Pillsbury sued five of its liability insurers in 1986 seeking $50 million plus consequential and punitive damages, claiming the insurers wrongfully refused to reimburse Pillsbury under its product integrity policy (*BI*, Oct. 6, 1986). The trial was bifurcated to decide the issue of damages before that of liability.

Pillsbury had a $20 million self-insured retention, according to Mr. Lund. Participating in the $25 million excess of $20 million layer were: National Union Fire Insurance Co. of Pittsburgh, Pa., an American International Group Inc. unit; Royal Indemnity Co.; The Home Insurance Co.; and Employers Mutual Casualty Co.

Federal Insurance Co., a Chubb Corp. wrote the $25 million excess of $45 million layer.

The first-layer insurers claimed that Pillsbury had made misrepresentations and non-disclosures in procuring the policy.

Federal has admitted there is coverage, Mr. Lund said.

The Hennepin County Court judge earlier granted the insurers a summary judgment that punitive damages are unwarranted in the case. That decision, upheld by the Minnesota Court of Appeals, is now before the Minnesota Supreme Court.

Enron award

Continued from page 2

more-based Maryland Casualty Co., an America General Group company, 0.5%.

Athena insured 12.5% of the risk, and the Lloyd's 8.9% of the risk, Mr. Dykhouse said.

An AIG spokeswoman said its share of the Dec. 16 award will be reduced by reinsurance, but she would not provide any details.

Provisions in Enron's insurance contracts called for disputes to be brought to arbitration, said Mr. Dykhouse.

The panel, which heard evidence for 70 days, was headed by Lawrence Cooke, former chief justice of the New York Court of Appeals, New York's highest court.

The case stems from Peru's 1980 reinvestment tax credit law, which allowed foreign oil companies to deduct a portion of their reinvestments in the country from their Peruvian income taxes, explained Ross Workman, an Enron senior vp. The law was opposed by Peru's American Popular Revolutionary Alliance Party. The party's presidential candidate, Alan Garcia Peres, was elected in July 1985, and the law was retroactively canceled the following month.

The foreign oil companies then were assessed for the amounts they had deducted under the defunct reinvestment law.

The oil companies also were informed that their operating contracts with the government, which took into account various provisions of the defunct law, had to be renegotiated, Mr. Workman said.

Negotiations proceeded. But on Dec. 27, 1985, the government informed Belco that its allotted time to renegotiate its contract had expired, and troops seized the Belco facilities off the northern coast of Peru.

At the time, Belco had 625 active wells, 92 platforms, 288 miles of subsea pipelines and 109 miles of onshore pipelines.

Enron filed a proof of loss with the political risk insurers in May 1986 seeking full payment of Belco's political risk policy limits, plus interest.

But in August 1986, AIG, which controlled the claims handling process, and the other insurers on the risk told Enron they were canceling the policies, and they returned all premiums.

In rejecting the claim, AIG said it had not been advised when it issued its policy in 1983 that Mr. Garcia would likely cancel the law retroactively if elected president, Mr. Workman said. The insurer said it would not have insured the risk had the oil company warned it about the law's possible cancellation, Mr. Workman said.

AIG also argued, among other things, that the oil company's insurance application was incorrect. The application listed the value of the Peruvian property according to generally accepted accounting principles, which are used in the United States but are not the Peruvian accounting methods used by its local subsidiary, Mr. Workman said.

The GAAP value of the property was $393 million, while the Peruvian value was just $150 million, he said. However, the policy specifically insured the property's U.S. book value, according to Mr. Workman.

Mr. Dykhouse, the attorney for Enron, said it is expected that the award will be paid by insurers proportionately, according to the share of the risk they covered.

Insurers on the policy may eventually recover at least some of their losses, however, Mr. Workman said. The policies provide that the insurers are entitled to recover 90% of their indemnity payments, net of expenses, should Enron make a recovery from the Peruvian government.

"We've been negotiating for the government to get compensated for the property," Mr. Workman said. The government stated last August that the property it nationalized is worth $147 million, he said.

But with the government now about $15 billion in debt, it is unlikely that Enron would be compensated in cash, according to Mr. Workman. Instead, the government and Enron may negotiate alternative forms of compensation, such as silver mines, or perhaps concessions to drill oil.

"Exactly how it works out will remain to be seen," said Mr. Workman, who has made about 20 trips to Peru over the past few years in connection with this issue.

Once these alternatives earn back the $15 million to $20 million in expenses Enron has incurred in connection with the nationalization of Belco's properties, the insurers would be entitled to income generated by the alternatives, up to 90% of the indemnity payments, Mr. Workman explained.

In a similar case, Occidental Petroleum Corp. sued four of its political risk insurers last year for failing to reimburse it for part of the $68.1 million the oil company paid to the Peruvian government in 1986 to renegotiate petroleum production agreements (*BI*, Feb. 2, 1987).

Among those named in the suit were National Union, Arkwright-Boston, Athena and Aetna Insurance Co., a CIGNA Corp. unit.

That litigation is still in the discovery stages, and no trial date has been set, according to Thomas P. Lambert, Occidental's outside counsel with the Los Angeles firm of Mitchell, Silberberg & Knupp. ■

Industry brief blasts Proposition 103

By GLENN HUNTLEY

SAN FRANCISCO—Proposition 103 was "ill-conceived" and several of its provisions are unconstitutional, claims a group of insurance industry plaintiffs led by Calfarm Insurance Co. in formal briefs they filed last week asking the state's Supreme Court to strike down the law.

The 50-page filing centers on the provision that requires rollbacks of insurance "charges" to 20% below November 1987 levels. The voter-approved law does not define "charges."

The filing was the first one scheduled by the Supreme Court justices when they decided earlier this month to review the constitutionality of the voter-approved law. The court at that time lifted its earlier stay on all provisions of the law except the insurance "charge" rollback provision and another provision calling for the creation of an insurance consumer corporation (*BI*, Dec. 12).

The filing contends the law is confiscatory because:

- Rate rollbacks would "deprive California insurers of billions of dollars" and would not allow them a fair return.
- The law allows the insurance commissioner to provide an insurer with rate relief only if the insurer can prove it is "substantially threatened with insolvency." The brief argues that the provision prohibits insurers from adjusting rates to ensure a fair return.
- The law's rate relief procedures would not ensure prompt relief because the relief may be granted only on a case-by-case basis.
- The provision allowing the state Board of Equalization to raise premium taxes to make up revenue the state would lose because of the insurance "charge" rollbacks is unconstitutional.
- The provision calling for the creation of a private corporation to represent insurance consumers in regulatory proceedings violates the state constitution.

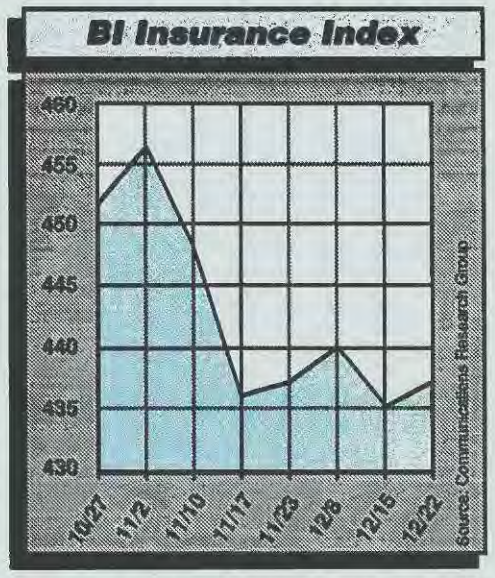
Defendents in the case, including Gov. George Deukmejian, Attorney General John Van de Kamp and Insurance Commissioner Roxani Gillespie, have until Jan. 12 to file a response.

Meanwhile, Security Pacific Corp. of California and First Interstate Bancorp of California have applied to the state Insurance Department for licenses to sell insurance, as permitted by Proposition 103, which repealed a ban on such sales.

Security Pacific expects to sell some personal insurance lines in the first quarter of 1989, said Rick Horn, vp and general counsel for subsidiary Security Pacific Insurance Group. Several units of the group already write credit, life and disability coverages.

Several commercial property/casualty insurers also have asked Security Pacific to sell insurance, but Mr. Horn—who would not name the insurers—said the bank will move cautiously into the area of property/casualty insurance sales.

First Interstate plans to begin selling both commercial and personal lines of insurance in late 1989, a spokesman said. ■



Insurance industry stocks climbed slightly last week, as the *Business Insurance* index rose 1.8 points to 437.6 on Dec. 21, from 435.8 on Dec. 15. Advancing issues during the period were led by Forum Re (Bermuda), up 20%; Zenith National Insurance Corp., up 8.5%; Kemper Corp., up 6.1%; Sears, Roebuck & Co. (Allstate Insurance Co.), 3.7%; and SCOR U.S. Corp., up 3.4%. Declining issues followed Lawrence Insurance Group, down 8.4%; Nobel Insurance Ltd., down 5%; Arthur J. Gallagher & Co., down 3.8%; Liberty Corp. S.C., down 3.6%; and Provident Life & Accident Insurance Co., down 3.3%. Issues showing the most activity during the period were: Sears, 3.5 million shares traded; ITT Corp. (Hartford Insurance Group), 1.4 million shares traded; and American General Corp., 1.3 million shares traded. The *Business Insurance* index gained a slight 0.4% for the period, trailing the leading market indicators: The Dow Jones 30 Industrials grew 1.5%; and both the Standard & Poor's 500 and the New York Stock Exchange Composite gained 1%.

British Issues

Dec. 21 Companies	Price pence	P/E	Div. pence	Yield %	1 Week High—Low pence	pence
Commi Union	331	10.7	25.3	7.7	332—	331
Genl Accident	859	8.5	58.0	6.8	862—	857
Gdn Royal Exch	182	9.8	13.1	7.2	182—	181
Royal	385	12.6	30.0	7.8	388—	384
Sun Alliance	966	7.4	54.7	5.7	966-	964
Brokers						
Bradstock	185	10.5	9.0	4.9	185—	185
CE Heath	418	13.3	34.5	8.3	418—	417
Hogg Robinson	143	13.2	8.0	5.6	143—	142
Lloyd Thompson	190	15.0	8.0	4.2	190—	190
PWS Holdings	138	19.7	6.0	3.8	142—	138
Sedgwick Grp	226	18.8	16.0	7.1	226—	224
Steel Brri Jones	208	18.6	13.3	6.4	208—	208
Willis Faber	224	13.5	16.0	7.1	225—	221

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

BI Industry Stock Report

DECEMBER 21, 1988 **12/16/88 THRU 12/21/88**

BROKERS		Price	Weekly % change	Year to Date % change	Annual High	Annual Low	Vol.(000)	$ Div.	% Yield	P/E	Book value	Mkt/Bk. value
Alexander & Alexander Svcs	NYSE	23.88	2.1	34.5	28.13	17.75	210	1.00	4.2	16.4	3.71	6.44
Corroon & Black Corp	NYSE	29.13	-2.1	3.1	34.75	28.00	46	1.08	3.7	4.4	12.40	2.39
Gallagher Arthur J & Co.	NYSE	16.00	-3.8	0.0	19.13	13.88	84	0.48	3.0	11.0	5.16	3.10
Hall Frank B. & Co	NYSE	2.75	0.0	-4.5	5.50	2.50	219	0.00	0.0	-1.5	0.00	N/A
Hilb,Rogal & Hamilton	OTC	14.75	0.8	51.3	15.00	9.75	43	0.00	0.0	12.4	4.60	3.21
Marsh & McLennan Cos Inc	NYSE	55.75	0.5	12.6	59.63	45.25	515	2.50	4.5	13.6	6.74	8.27
Poe & Assoc Inc	OTC	8.25	0.0	17.9	9.25	6.75	6	0.40	4.8	1.8	0.27	30.56
BROKERS	AVERAGE		-0.4	16.4					2.9	8.3		
CONGLOMERATES & HOLDING COMPANIES												
Berkley W R. Corp	OTC	29.75	0.8	24.0	30.25	23.50	43	0.36	1.2	6.4	17.63	1.69
Berkshire Hathaway Inc DEL	NYSE	4750.00	-3.1	61.0	5050.00	2755.00	49	0.00	0.0	19.1	2492.68	1.91
ITT (Hartford Group)	NYSE	50.75	-1.7	12.8	54.88	43.25	1353	1.48	2.9	6.7	52.23	0.97
Sears Roebuck & Co (Allstate)	NYSE	41.63	3.7	23.8	46.13	32.25	3490	2.00	4.8	10.8	34.74	1.20
CONGLOMERATES	AVERAGE		-0.1	30.4					2.2	10.7		
INSURERS/REINSURERS												
Aetna Life & Cas Co	NYSE	46.75	0.5	3.3	52.50	39.50	865	2.76	5.9	7.7	53.56	0.87
American General Corp	NYSE	29.75	-1.3	-6.3	36.38	27.50	1312	1.40	4.7	7.5	28.04	1.06
Amer Heritage Life Invt	NYSE	25.13	0.5	3.6	27.00	24.00	3	1.08	4.3	10.6	20.98	1.20
Amer Indty Fin! Corp	OTC	10.25	2.5	13.9	12.00	8.25	20	0.56	5.5	18.0	15.26	0.67
American Int'l Group	NYSE	66.50	0.2	10.8	68.75	49.00	1088	0.40	0.6	9.8	33.56	1.98
Aon Corp.	NYSE	26.75	1.4	16.9	28.75	21.88	188	1.28	4.8	8.8	15.13	1.77
Argonaut Group	OTC	45.00	-1.1	51.3	49.00	29.50	62	0.00	0.0	6.2	29.19	1.54
AVEMCO Corp	NYSE	24.38	2.1	24.2	28.75	17.88	41	0.34	1.4	11.3	7.74	3.15
Belvedere Corp.	AMEX	4.50	-2.8	2.7	6.00	4.00	8	0.04	0.9	6.6	7.87	0.57
Chandler Insurance	OTC	9.25	0.0	89.5	10.25	4.25	24	0.00	0.0	4.5	7.18	1.29
Chubb Corp	NYSE	58.00	2.0	3.8	63.38	51.25	214	2.16	3.7	6.6	46.13	1.26
CIGNA Corp	NYSE	46.00	-1.1	4.8	55.38	42.75	725	2.96	6.4	8.6	49.19	0.94
CNA Fin'l Corp	NYSE	59.00	-0.4	6.1	66.13	51.00	157	0.00	0.0	9.3	46.40	1.27
Continental Corp	NYSE	32.13	-2.6	-17.1	41.63	31.88	714	2.60	8.1	10.3	42.10	0.76
Durham Corp	OTC	32.00	-0.8	48.8	36.75	21.50	13	0.92	2.9	37.2	26.00	1.23
Farmers Group Inc	OTC	74.75	0.0	85.7	74.88	40.50	56	1.44	1.9	17.5	22.02	3.39
Firemans Fd Corp	NYSE	28.88	-1.3	11.1	33.50	25.75	194	0.50	1.7	125.6	26.17	1.10
Forum Re (Bermuda)	OTC	1.50	20.0	-55.6	4.00	1.13	7	0.00	0.0	4.2	2.58	0.58
Fremont Gen Corp	OTC	13.25	1.9	37.6	13.50	8.75	725	0.60	4.5	9.0	16.24	0.82
General Re Corp	NYSE	56.00	0.9	0.2	59.38	45.50	816	1.20	2.1	11.4	26.21	2.14
Home Group Inc	NYSE	10.75	0.0	-9.5	14.38	10.50	275	0.20	1.9	1.3	17.76	0.61
Hanover Ins Co	OTC	27.00	1.9	16.1	27.75	20.50	66	0.36	1.3	5.1	25.10	1.08
Harleysville Group Inc	OTC	17.88	-0.7	36.3	18.25	13.38	36	0.48	2.7	7.0	16.65	1.07
Hartford Steam Boiler Insp	OTC	34.75	2.6	51.1	34.00	22.50	139	1.40	4.0	11.9	10.65	3.26
Kans City Life Ins	OTC	34.00	2.3	29.5	39.50	25.25	26	0.00	0.0	9.8	39.22	0.87
Kemper Corp	OTC	24.13	6.1	17.7	27.50	20.75	710	0.72	3.0	7.7	26.50	0.91
Lawrence Ins. Group	AMEX	8.13	-8.4	80.7	11.63	4.50	7	0.24	3.0	18.1	2.90	2.80
Liberty Corp S C	NYSE	33.88	-3.6	-4.6	47.25	34.38	15	0.80	2.4	11.7	17.40	1.95
Lincoln Natl Corp	NYSE	43.75	-0.6	9.0	53.50	40.25	442	2.48	5.7	11.3	36.62	1.19
NAC Re Corp	OTC	30.75	1.7	73.2	31.50	18.50	110	0.00	0.0	13.7	19.92	1.54
Navigators Group	OTC	20.00	0.0	37.9	20.50	14.50	9	0.00	0.0	9.7	12.88	1.55
Nobel Ins Ltd	OTC	4.75	-5.0	-45.7	9.50	3.75	258	0.42	8.8	-33.9	7.76	0.61
Northwestern Natl Life	OTC	30.75	1.2	34.4	34.50	22.63	176	1.12	3.6	7.4	35.05	0.88
Ohio Cas Corp	OTC	35.13	-1.4	-3.1	38.25	32.25	243	1.88	5.4	6.5	27.86	1.26
Old Rep Intl Corp	OTC	24.00	-1.0	20.0	25.88	19.13	74	0.74	3.1	5.6	27.82	0.86
Orion Cap Corp	NYSE	14.63	1.7	8.4	17.63	13.13	61	0.76	5.2	5.0	9.34	1.57
Phoenix Re Corp.	OTC	9.75	2.6	50.0	11.00	6.75	39	0.00	0.0	5.3	11.08	0.88
Protective Life Corp.	OTC	13.25	-1.0	8.2	15.13	12.25	91	0.70	5.3	16.2	17.25	0.77
Re Capital Corp	AMEX	9.00	1.4	-14.3	11.75	7.88	11	0.00	0.0	20.0	11.49	0.78
Provident Life & Acc Ins Co	OTC	18.38	-3.3	47.0	25.00	15.63	614	0.68	3.7	15.4	21.96	0.84
St Pauls Cos Inc	OTC	42.88	0.9	-6.8	51.00	38.25	697	2.00	4.7	6.0	35.83	1.20
SAFECO Corp	OTC	23.63	-2.1	-14.8	30.00	22.75	571	1.08	4.6	7.5	21.39	1.10
SCOR U S Corp	NYSE	7.50	3.4	-18.9	9.50	6.63	95	0.20	2.7	5.4	9.39	0.80
Seibels Bruce Group Inc	OTC	11.25	2.3	0.0	14.25	11.00	85	0.80	7.1	7.6	12.51	0.90
Selective Ins Group Inc	OTC	23.50	2.2	23.7	26.50	19.25	33	1.24	5.3	5.2	19.52	1.20
Statesman Group Inc	OTC	3.00	0.0	-36.0	5.56	2.75	65	0.05	1.7	-300.0	3.48	0.86
Tokio Marine & Fire Ins	OTC	87.75	-1.8	33.2	98.00	63.25	17	0.22	0.3	53.2	0.00	N/A
Torchmark Corp	NYSE	30.50	0.0	24.5	33.50	24.50	191	1.20	3.9	9.9	12.24	2.49
Transamerica Corp	NYSE	34.63	1.1	16.4	36.75	29.75	329	1.88	5.4	8.0	24.94	1.39
Travelers Corp	NYSE	34.38	-2.5	-2.1	40.00	33.00	524	2.40	7.0	12.6	45.28	0.76
Trenwick Group Inc	OTC	13.75	0.0	34.1	14.25	9.75	39	0.24	1.7	13.5	15.41	0.89
United Fire & Cas Co	OTC	30.00	0.0	15.4	30.50	24.00	9	1.08	3.6	5.0	22.56	1.33
United States Fid & Gty	NYSE	28.75	-1.7	0.9	34.38	28.88	686	2.64	9.2	7.7	19.53	1.47
UNUM Corp	NYSE	27.00	1.4	45.9	28.13	17.88	235	0.48	1.8	11.3	28.53	0.95
USLIFE Corp	NYSE	33.13	-0.4	16.2	40.13	28.00	150	1.36	4.1	8.8	46.77	0.71
Washington Natl Corp	NYSE	27.25	1.9	14.1	28.75	24.00	38	1.08	4.0	-7.9	32.33	0.84
Zenith Natl Ins Corp	NYSE	17.50	8.5	16.7	23.88	15.00	80	0.80	4.6	8.2	12.53	1.40
INSURERS/REINSURERS	AVERAGE		0.5	16.5					3.3	6.0		
ALL COMPANIES	AVERAGE		0.4	17.3					3.2	6.6		

System design: Communications Research Group

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