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Update

Chubb refunding drought premiums despite opposition from regulators

WARREN, N.J.—Despite opposition from regulators, a Chubb Corp. unit is proceeding to reprocess rain insurance applications on a first-come, first-served basis up to its $40 million premium volume limit and to return double premiums to farmers who won't be covered.

Federal Insurance Co. of Warren, N.J., offered an inland marine policy with an unusual drought endorsement and received applications for 10 times its ca-

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Ruling transforms claims-made cover into occurrence

By STACY ADLER

LOS ANGELES—A California appellate court ruling essentially rewrites a claims-made policy by requiring an insurer to respond to claims filed after the policy expired, unless the insurer's interests would be impaired, attorneys for the insurer say.

National Union Fire Insurance Co. of Pittsburgh, Pa., is seeking a rehearing of the unanimous ruling, which, according to several attorneys, effectively turns claims-made policies written in California into occurrence policies.

However, other attorneys claim the decision will not affect other insurers because of the unique circumstances of the case.

The decision also is noteworthy because the court, in making the ruling, overrode a settlement between the parties in the case.

National Union, a unit of American International Group Inc., offered the policyholder $90,000 after oral arguments to avoid having the damaging decision on the books, according to the court. However, the settlement offer was contingent on the court not filing an opinion in the case.

Noting the case was "of great public interest," the court decided not to abide by the settlement and filed its opinion on June 22.

The opinion, written by California Appellate Court Judge Earl J. Johnson, said: "To bow to this pressure and refrain from filing our opinion would do disservice not only to the public interest implicated in this case, but to the proper functioning of appellate courts in future cases, for it would send a message to other appellants and respondents that they can wait until oral argument and, if they sense the probabil-

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Three states oust Teale-led insurer

By DOUGLAS McLEOD

ATLANTA—An offshore insurer run by Alan Teale, former president of the now-defunct Insurance Exchange of the Americas, has been declared ineligible to write insurance in three of four states where it wrote several million dollars in premiums last year.

American Trust Insurance Co. Ltd., domiciled in the Turks & Caicos Islands, was declared ineligible as a surplus lines insurer in Illinois and Texas earlier this year. Regulators in the states were unable to confirm the value of $40.5 million of its reported $47 million in assets.

'When somebody questions something, we go off and immediately replace the assets,' says Mr. Teale.

In a confidential report completed last month, an arm of the National Assn. of Insurance Commissioners valued a portfolio of over-the-counter stocks, a portion of which formed the majority of American Trust's year-end 1987 assets, at less than 20% of the $40.5 million in equities claimed by American Trust in a 1987 statutory financial statement, several regulatory sources say.

The Alabama Insurance Department requested the report by the NAIC's Securities Valuation Office after the department learned that American Trust misrepresented itself as a licensed surplus lines insurer in correspondence with a California agency.

Alabama ordered American Trust to cease and desist from selling insurance until it is licensed in the state.

Premiums written by American Trust in 1987, its first big underwriting year, totaled $12 million, almost all of which was written on a direct surplus lines basis for property and liability insurance in the United States.

American Trust's policyholder surplus at year-end 1987 was $35 million, according to a statutory financial statement filed with Texas regulators.

In a series of interviews, Mr. Teale said that American Trust has placed $30.5 million in new assets on its books since the end of last year. The new assets include U.S. Treasury bonds and higher-quality stocks that state regulators should find more acceptable, he said.

"When somebody questions something, we go off and immediately replace the assets," said Mr. Teale, who is president and director of American Trust, which is owned by Houston-based KLK Consulting & Management Corp.

Insurance regulators "have only got to lift a finger and say, 'Do something,' and by God, we are there doing it," Mr. Teale said.

Insurance regulators in Illinois, Texas and Alabama said last week that they have not yet been provided details of the new assets. American Trust will not be allowed to write insurance in the three states until the regulators receive proof of acceptable admitted assets and answers to other questions raised, the regulators said.

An infusion of new assets this year would mark the fourth time since 1986—when it reported total assets of $7.4 million—that the investments of American Trust have been revamped, according to the insurer's financial state-

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London maintains ties to South Africa

By CAROLYN ALDRED

LONDON—While a handful of British insurers and brokers have limited their stake in South Africa, the London market generally maintains a business-as-usual approach to the politically controversial country that anti-apartheid groups seek to freeze out from world trade.

Indeed, as part of the worldwide softening of the property/casualty insurance market, London and European insurers are offering increased capacity for South African risks.

"Capacity overseas, particularly in London, has increased considerably this year," said Des Vernon, risk and insurance manager for Barlow Rand Ltd., one of South Africa's largest industrial and retail conglomerates.

Lloyd's of London and other European insurers "are losing a lot of dollar business to the U.S. market" and are looking to other markets to make up that loss, said Mr. Vernon, who also is chairman of the South African Risk & Insurance Managers Assn.

Many London and European insurers are "looking towards South Africa as South African business is highly regarded" as profitable, Mr. Vernon added.

And, he predicts an overall rate decrease of "at least 20%" for his company's insurance renewals in October.

The London and European markets' position is in stark contrast to that of U.S. insurance companies and brokers, which have quietly divested themselves of South African companies (see story, page 32).

Apartheid, the official South African policy that segregates blacks and whites in many daily business and social activities, has drawn international criticism for decades, but many businesses—including insurance—have felt the impact of widespread outrage most strongly in the last few years.

And, earlier this month, protests against apartheid were held in more than 30 countries on the 70th birthday

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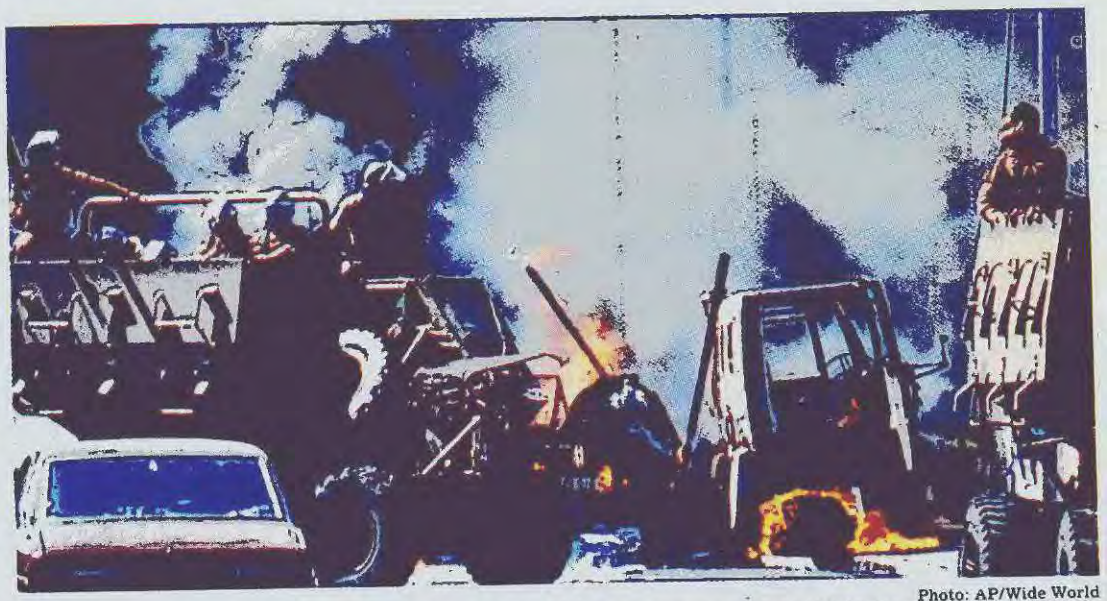

Photo: AP/Wide World

As violent confrontations between the South African government and blacks have increased, many companies have left the country in opposition to its policy of apartheid.

Bank's emergency plan averts ruin following skyscraper fire Page 3

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Employers to lobby Senate for more COBRA changes Page 2

NEWSPAPER

Update

Chubb refunding premiums

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pacity before its June 15 application deadline, said a spokeswoman for Chubb.

In a letter to Chubb Chairman and Chief Executive Officer Dean R. O'Hare written on National Assn. of Insurance Commissioners stationery, nine regulators said they expect Chubb to honor all applications submitted before the coverage deadline.

The coverage was offered in Illinois, Indiana, Kentucky, Michigan, Minnesota, Missouri, Ohio, Tennessee and Wisconsin until June 15, and until June 17 in Iowa. However, demand far exceeded capacity and Chubb informed state regulators that it would return premiums (*BI*, July 18).

A total of 8,007 applications were received requesting limits of $390 million, said Chubb's spokeswoman, who estimated that the average premium was $2,500 per policy. She estimated that about 6,000 farmers would be eligible for coverage under the new terms.

Chubb has already returned premiums to its agents, who were instructed to refund the premiums to the applicants, the spokeswoman said. Farmers who accept the premium refund can then send a copy of their check to Chubb, which will issue another check for that amount, she said. The remaining farmers whose applications ultimately fall outside the $40 million premium volume limit also will receive double refunds. Chubb has reserved $20 million to cover these additional payments, the spokeswoman said.

Chubb mailed letters to applicants explaining these terms and also sent a copy of the letter to regulators, said Chubb's spokeswoman, who noted that Chubb had not received the regulators' notice when it mailed the letters.

"We are not interfering with that offer if a farmer wants it," said Richard W. Carlson, assistant director of the Illinois Insurance Department. "However, we have not accepted that as a settlement" for those that still want coverage.

Legal and administrative action is still pending in some states.

Raymark class-action denied

ATLANTA—Raymark Industries Inc. will continue to pursue a consolidation of all asbestos bodily injury claims against it after a federal appellate court last week overturned a lower court's decision to form a class action.

Raymark "will not abandon the class-action strategy," said an attorney for the asbestos producer, noting Raymark could seek a rehearing with the appellate court, appeal the decision to the U.S. Supreme Court or attempt another class action at the state level.

The 11th U.S. Circuit Court of Appeals in Atlanta overturned U.S. District Judge Robert L. Vining Jr.'s June order creating what would have been the largest-ever asbestos class-action suit and staying all litigation pending against Raymark (*BI*, June 20).

The appellate court criticized Judge Vining for not notifying claimants and for not allowing them to participate in the decision to create the class.

LTV asks to dump another plan

WASHINGTON—Dallas-based LTV Corp. wants the Pension Benefit Guaranty Corp. to take over a small pension plan covering 302 people who worked in an LTV facility in Evansville, Ind., that LTV shut down in 1982.

The plan has $9.3 million in liabilities and just $45,000 in assets.

LTV has petitioned U.S. Bankruptcy Court in New York for permission to establish a new "makeup" plan, which would pay certain supplemental benefits that retirees now receive from the plan, but which they would lose if the PBGC takes over the plan.

LTV said participants in the Evansville pension plan will face financial hardship if the supplemental plan is not approved.

The PBGC opposes LTV's action, saying LTV—which filed in July 1986 for protection from its creditors under Chapter 11 of the Federal Bankruptcy Act—has the resources to make the $110,000 in monthly contributions required to keep the plan going.

However, a federal judge in New York last month denied the agency's request to return to LTV three plans with $2 billion in liabilities. PBGC had attempted to return the plans last year after LTV established new plans to pay non-PBGC guaranteed benefits to participants (*BI*, June 27).

Soviet launch cover considered

TRIESTE, Italy—Western insurers may write satellite launch risks for the Soviet space program, according to leading space insurer Assicurazioni Generali S.p.A.

The Soviet Union, which plans to launch commercial satellites as part of its new launch program, will need the additional insurance capacity of Western underwriters, Generali explained.

Soviet insurer Ingosstrakh invited representatives from Western companies—including Generali, Munich Reinsurance Co. and Lloyd's of London broker Crawley Warren & Co. Ltd.—to watch the launch earlier this month of two space stations.

"From what has been observed so far, no particular difficulties are expected from the insurance market in covering these risks at premium rates, which may come close to those quoted in respect of Western technologies," said Benito Pagnanelli, aviation and space manager at Generali and chairman of the Space Risks Study Group for the International Union of Aviation Insurers, who attended the Soviet launch.

Damages sought in rig disaster

LONDON—Lawyers representing families of the 166 people killed in the Piper Alpha oil platform explosion July 6 have formed an action group to seek compensation—either in Scotland or the United States—from Los Angeles-based Occidental Petroleum Corp., the operator of the platform.

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Employers to lobby Senate for more COBRA changes

By JERRY GEISEL

WASHINGTON—With the House soon expected to approve a legislative package scaling back penalties for COBRA violations, business groups are shifting their lobbying efforts to the Senate to win further COBRA changes.

The COBRA amendments expected to win House approval would tie penalties to the length and severity of violations of the health care continuation provisions of the Consolidated Omnibus Budget Reconciliation Act of 1985.

For example, H.R. 4333, legislation approved this month by the House Ways and Means Committee to correct drafting glitches in the Tax Reform Act of 1986, generally would set a penalty of $100 per day of violation per beneficiary and cap an employer's total annual liability for COBRA violations at either $500,000 or 10% of its prior year's health care costs, whichever is less (*BI*, July 18; July 4).

While employers welcome the new penalties as a vast improvement over the current COBRA penalty—automatic loss of the annual tax deduction for health care expenses for a single violation—they say the proposed penalties still are too stiff.

Business groups will attempt to convince the Senate Finance Committee, which could vote on the technical corrections legislation this week, to add a COBRA penalty provision that places a $100,000 annual cap on total penalties and a $1,000 ceiling for any individual violation.

"A $100,000 penalty would give an employer a strong financial incentive to comply with COBRA without being unreasonable," said Howard Greene, associate legislative director of the Risk & Insurance Management Society Inc. in New York.

And, a $1,000 penalty cap per beneficiary "would be sufficiently severe to encourage compliance without being so high that it imposes costs substantially greater than the cost of coverage," according to a position paper prepared by the Assn. of Private Pension & Welfare Plans, the ERISA Industry Committee, the National Assn. of Manufacturers, the U.S. Chamber of Commerce and the Washington Business Group on Health.

Aside from the COBRA penalties, several other COBRA provisions are included in the House technical corrections legislation, including:

- Allowing employees who quit their jobs to retain COBRA coverage even after they become covered under another employer's health care plan.

This "double coverage" provision, which has triggered a wave of employer protests, is contained in another technical corrections bill, H.R. 4845, which also was approved by the Ways and Means Committee.

Because it makes a series of technical changes to the Employee Retirement Income Security Act, H.R. 4845 still must be approved by the House Education and Labor Committee, which shares jurisdiction over ERISA with the Ways and Means Committee.

H.R. 4845 also makes a purely technical change to COBRA by clarifying that the maximum duration of COBRA coverage for an employee who lost group health coverage because of a reduction in hours worked and then later quit would be 18 months.

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Mentor's assets cover 24% of its $650 million in debts

By ROGER SCOTTON

HAMILTON, Bermuda—Mentor Insurance Ltd. has the cash equivalent of 24 cents on the dollar to pay the failed insurer's debts of more than $650 million owed to approximately 2,700 creditors, according to Mentor's liquidators.

Mentor has $157.7 million available for creditors, an increase of $7.8 million during the year ended June 30, liquidators say.

Based on an actuarial evaluation of Mentor's liabilities, liquidators Charles Kempe and Michael Arnold now estimate Mentor is insolvent by $496.1 million.

The liquidators spent about half of $16.3 million recovered for Mentor during the past 12 months, the bulk of which went toward legal fees and their own remuneration, according to their 1988 financial report to creditors.

Of the expenditures, $3.1 million was spent on legal fees; $2.2 million was paid to the joint liquidators; $1.1 million was paid in salaries and benefits for Mentor's 35-member Bermuda-based staff; and just more than $1 million was spent on general administration and office rental costs.

Investment income of $10.2 million generated the bulk of the Mentor estate's revenues, while net reinsurance recoveries totaled $6.1 million.

The liquidators plan to speed recovery of assets and settle sufficient claims to permit an interim payment to creditors by 1992, instead of waiting more than 20 years for all of Mentor's liabilities to mature.

But the document, which creditors will receive in preparation for their third annual general meeting in Bermuda Sept. 13, warns that the liquidators cannot accurately assess the likely ultimate cash distribution.

An actuarial evaluation by the Tillinghast division of Towers, Perrin, Forster & Crosby Inc. as of June 30, 1986, indicated unpaid liabilities of $686 million, though it described that amount as representing a "selected amount within a wide range of projections."

The liquidators' report says that their expenses of $8.6 million, almost $2 million more than last year, "demonstrates the size and complexity of the liquidation."

Operating costs include rent for office space in Bermuda, communications and computer expenses. Legal fees, which rose by $1.2 million during the past year, cover expenses stemming from 459 open files, according to the report.

And, the report points out that the liquidators' remuneration—about $200,000 higher during 1987-88—stems not only from the cost of specialist insolvency services supplied personally by Messrs. Kempe and Arnold, both of accountant Arthur Young & Co., but also from work carried out in London and Bermuda by their staff and billed at the firm's normal rates.

The 13-page report does not specify legal fees arising from three main actions, two of which were started by the Mentor liquidators, including their 28-month-old suit for $700 million against Mentor's New Orleans-based parent Ocean Drilling & Exploration Co.; Bermuda-based Pinnacle Reinsurance Ltd.; and nine other defendants, mostly directors and officers of Mentor

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RIMS chapter opposes antitrust action

By JUDY GREENWALD

DENVER—Officers of a Risk & Insurance Management Society chapter are encouraging risk managers to write Colorado officials to urge that the state withdraw from the antitrust litigation filed against the property/casualty insurance industry.

While individual risk managers have expressed their opposition to the litigation, the effort by the Rocky Mountain Chapter is believed to be the first campaign by a RIMS chapter against the controversial lawsuits, says Jon Harkavy, RIMS director of governmental affairs.

Colorado Attorney General Duane Woodard was among the 10 state attorneys general that filed antitrust suits in the "second wave" of the litigation last month (*BI*, June 20). Nine state attorneys general had filed similar suits in March (*BI*, March 28).

In letters to the governor and state attorney general written on chapter letterhead, chapter President Samuel Y. Fisher Jr., insurance manager at Denver-based Hamilton Bros. Oil Co., said that not only are the suit's merits dubious, but the litigation also undercuts the state's campaign to attract insurance companies to Colorado.

Samuel Y. Fisher Jr., president of RIMS' Rocky Mountain Chapter, said that not only are the suit's merits dubious, but the litigation also undercuts the state's campaign to attract insurance companies.

Mr. Fisher also distributed two memos, with copies of his letters attached, to all chapter members encouraging them to write to the governor and attorney general—with copies to be sent to Insurance Commissioner John Kezer—to express their "perplexity with our elected officials for deciding to participate in a 'tag-along' antitrust complaint."

Mr. Fisher says that the chapter has not met since he issued his request and, thus, he does not know how many risk managers have written the officials.

However, other Colorado risk managers—who say they have either written letters or plan to do so—are unhappy with the state's participation in the antitrust litigation.

Participation in the lawsuit "is contrary to what the state wanted to do economically," said James E. Crockett, manager of risk and benefits at the Denver Water Department and secretary of the RIMS chapter. "Basically, we just felt it was inconsistent."

The state is trying to attract insurance companies on the one hand, but on the other "we're slapping them in the face," commented Edward L. Heeren, treasurer of the RIMS chapter and director of risk management at Denver-based Ideal Basic Industries.

Even if the attorneys general win the case, the legal costs associated with the case will be passed on to the policyholder, said Mr. Marshall. "We don't see who's going to benefit."

"It seemed like a rather trumped-up thing," he said of the suit. "As far as we can see, there's very little basis for it."

"We feel that it's a little detrimental to go ahead, especially if we're not convinced this antitrust suit is in everyone's best interest," commented Mary Stoik Dymond, risk manager at the Denver-based Apache Corp., who is also a chapter director.

The Rocky Mountain Chapter's stance opposing the anti-

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Pension portability mandate may daunt plan formation

By DEBORAH SHALOWITZ

WASHINGTON—Mandating "portable" defined benefit pensions would be expensive for employers and could discourage the formation of these pension plans, say benefit experts, federal officials, business representatives and a new government-sponsored study.

Employees who often change jobs face retirement income shortfalls, either because they do not vest in a pension plan or, if they do vest, they are guaranteed only small benefits when they leave their jobs.

The solution, according to union representatives, are portable pensions. Under such a system, workers changing jobs would be able to transfer vested pension assets and credits for years of service from their old employer's pension plan to their new plan.

However, Congress should "proceed with caution" in acting on pension portability, said Assistant Secretary of Labor David M. Walker.

C. Eugene Steuerle, deputy assistant secretary of the Treasury Department, cautioned that "mandating greater levels of coverage or benefits for mobile workers could result in fewer pension plans."

And, a new study for the Labor Department conducted by Philadelphia-based benefits consultant Hay/Huggins Co. Inc. points out that "alternatives that would substantially reduce the portability loss would significantly increase the cost of pension plans and could probably only be achieved through fundamental changes in the philosophy currently underlying the private pension system."

Mr. Walker and Mr. Steuerle made their remarks before the House Ways and Means Oversight Subcommittee earlier this month.

Subcommittee Chairman J.J. Pickle, D-Texas, said he called the hearing because "we can expect the current trend toward increased job mobility to continue indefinitely."

"As a general rule, the more times an individual changes jobs among defined benefit plans, the lower the total pension amount will be at retirement," explained Rosemary D. Marcuss, assistant director for tax analysis for the Congressional Budget Office.

An individual who moves from one job to another and is a participant of several defined benefit pension plans probably will have less retirement income than an individual who works for only one

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New pollution endorsements meet with market skepticism

By DEBORAH SHALOWITZ

NEW YORK—A proposed endorsement to the commercial general liability insurance policy form that expands pollution coverage probably will not be widely used by insurers, observers say, even though risk managers say they would buy it.

The proposed endorsement by the Insurance Services Office Inc. would extend pollution coverage to on-site exposures and ongoing operations. Such pollution exposures currently are excluded from ISO's claims-made and occurrence CGL forms, though the forms do cover both sudden and gradual pollution pertaining to product liability and completed operations risks.

Another proposed endorsement that excludes all pollution-related losses from CGL coverage probably will not be widely used either, the experts add.

The two new endorsements, which ISO filed with state insurance regulators earlier this month, are set to take effect Feb. 1, 1989 (*BI*, July 11).

Chester Swalm, vp of Marsh & McLennan Inc. in New York, said he does not think many insurers will use the new CGL endorsements.

"I don't think the form is really going to encourage anybody to get back into the marketplace" for pollution coverage, said David M. Rosenberg, executive vp of Environmental Compliance Services Inc., the Downingtown, Pa., underwriting manager for environmental impairment liability insurer Reliance National Risk Specialists.

"We do not have plans to use either of the endorsements at this point in time," said David C. Sterling, secretary of the Hartford Insurance Group in Hartford, Conn.

However, Eugene Anderson, a partner with Anderson, Russell, Kill & Olick P.C. in New York, speculated that the filing of the endorsements indicates there is interest among insurers in offering pollution coverage for on-site exposures and continuing operations.

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Safety advocates lambaste OSHA

By BRIGITTE MAXEY

CHICAGO—A private workplace safety institute is advocating stepped-up federal criminal prosecution of employers that violate safety laws while criticizing the bureaucracy of the existing federal job safety enforcement system.

The report, released earlier this month by the nonprofit National Safe Workplace Institute, blasts the federal Occupational Safety and Health Administration and the U.S. Justice Department, which prosecutes cases referred by OSHA.

"If we put senior directors in jail for pollution and corrupting foreign governments, we should put them in jail for killing workers," said Joseph A. Kinney, executive director of the Chicago-based institute and author of the study.

The Justice Department has brought only 44 indictments for workplace safety violations since the enactment of the Occupational Safety and Health Act in 1970 and only two indictments since the beginning of the Reagan administration in 1981, the report states.

In addition, while the Justice Department has only successfully prosecuted two job safety cases since 1980, California—which operated its own job safety program until last year—successfully prosecuted 112 cases during the same period, the report says.

An OSHA official explains the agency believes that criminal prosecution won't solve workplace safety problems.

"We believe the best way to get safety and health in the workplace is through civil punishment," said Frank White, OSHA's deputy assistant secretary in Washington.

In his report, "Ending Legalized Workplace Homi-

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L.A. bank collects on emergency plan

By GLENN HUNTLEY

LOS ANGELES—As the first news broadcasts flashed pictures of the inferno raging through the skyscraper headquarters of First Interstate Bank of California in early May, officials already were mobilizing to keep the state's fourth-largest commercial bank in business.

First Interstate's 20-member emergency team began reporting to a bunker-like communications center about a mile from the bank's 62-story headquarters. They were en route within an hour of the first reports of the blaze, which started about 10:30 p.m. on Wednesday, May 4.

"We (members of the emergency team) were fully operational by midnight," said Colen H. Emerson, vp and manager of information management, the bank office that designed the emergency response plan.

Meanwhile, Los Angeles television stations began broadcasting live pictures of the fire before 11 p.m.

"I kept watching it on TV and couldn't believe it was happening," Mr. Emerson said.

The first televised scenes showed smoke rising from the bank's offices, but they did not indicate the extent of the emergency. However, a bank employee who had been dining downtown called Mr. Emerson with an eyewitness account indicating "we had a serious problem," Mr. Emerson said.

As flames still licked the sides of the downtown headquarters, the 20-member response team—composed of representatives of several bank departments including check processing, wire transfers, corporate and consumer lending and real estate—was engaged in a frantic effort to keep the bank, a subsidiary of First Interstate Bancorp, on its feet.

The team members, in turn, spent much of the night calling 200 bank employees and setting up telephone links needed to assure that many millions of dollars in customers' accounts and subsequent customer transactions and transfers of funds from other banks would be accurately recorded.

By midday Thursday, fewer than 15 hours after

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Photo: First Interstate Bank of California

First Interstate's emergency team met in a bunker-like emergency communications center, supplied with telephones, televisions, and other needed items.

Mentor's assets

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(*BI*, March 24, 1986).

Rather, it describes an action Pinnacle started against Mentor last year in Bermuda as costing "considerable sums of money in legal fees to the estate" (*BI*, May 25, 1987).

Although the U.S. District Court in Louisiana in April dismissed the liquidators' suit against ODECO on a forum non conveniens motion and ruled that the dispute should be tried in Bermuda, the liquidators still believe the suit should be heard in Louisiana. Their report says the dismissal will be appealed in October (*BI*, April 25).

In an interview, Mr. Kempe stressed that they would not be proceeding with an appeal if the chances of winning were poor. "That would be a waste of creditors' money," he said.

And, the liquidators said the federal judge's dismissal opinion represents a significant strengthening of their complaint.

"By allowing a stay of six months for discovery purposes and ordering that the defendants submit to the jurisdiction of Bermuda, give evidence at trial, produce documents in their possession and agree to recognize a judgment against them as enforceable in any U.S. District Court, the federal judge in New Orleans has helped us considerably," said Mr. Kempe.

"We are a lot further forward than we were in March 1986, when we started this thing. The defendants didn't have to agree to anything before now," he added.

The liquidators also said they have not ruled out the possibility of an out-of-court settlement.

"Obviously, that would depend on someone being prepared to come along with a big enough checkbook and offer a settlement we feel comfortable with and can recommend to the Mentor committee of inspection," Mr. Arnold said.

'We are a lot further forward than we were in March 1986, when we started this thing,' says Mr. Kempe.

The liquidators also said the suit should not be regarded as a critical indictment of financial reinsurance in general. In the suit, the liquidators allege that Mentor took credit for two reinsurance contracts purchased from Pinnacle without disclosing other agreements providing that Pinnacle would not pay any reinsurance claims for 10 years from the inception of each contract, at which time a single lump-sum payment of a predetermined amount would be made.

"As a product, financial reinsurance has a valid place in the market, but what Mentor was doing by agreeing to contracts with secret side letters that changed the nature of the contracts was not what the market expected," Mr. Kempe said.

The Mentor liquidators said that the biggest single obstacle to making an interim cash distribution to creditors was the cooperation of the creditors themselves. Of 2,713 potential creditors representing 4,500 treaties and 10,500 underwriting years, only 800 proofs of debt for $451 million had been filed by the end of June.

Of these, 425 have come from U.S. creditors representing claims for $357 million and 172 came from the United Kingdom for claims totaling $29.8 million.

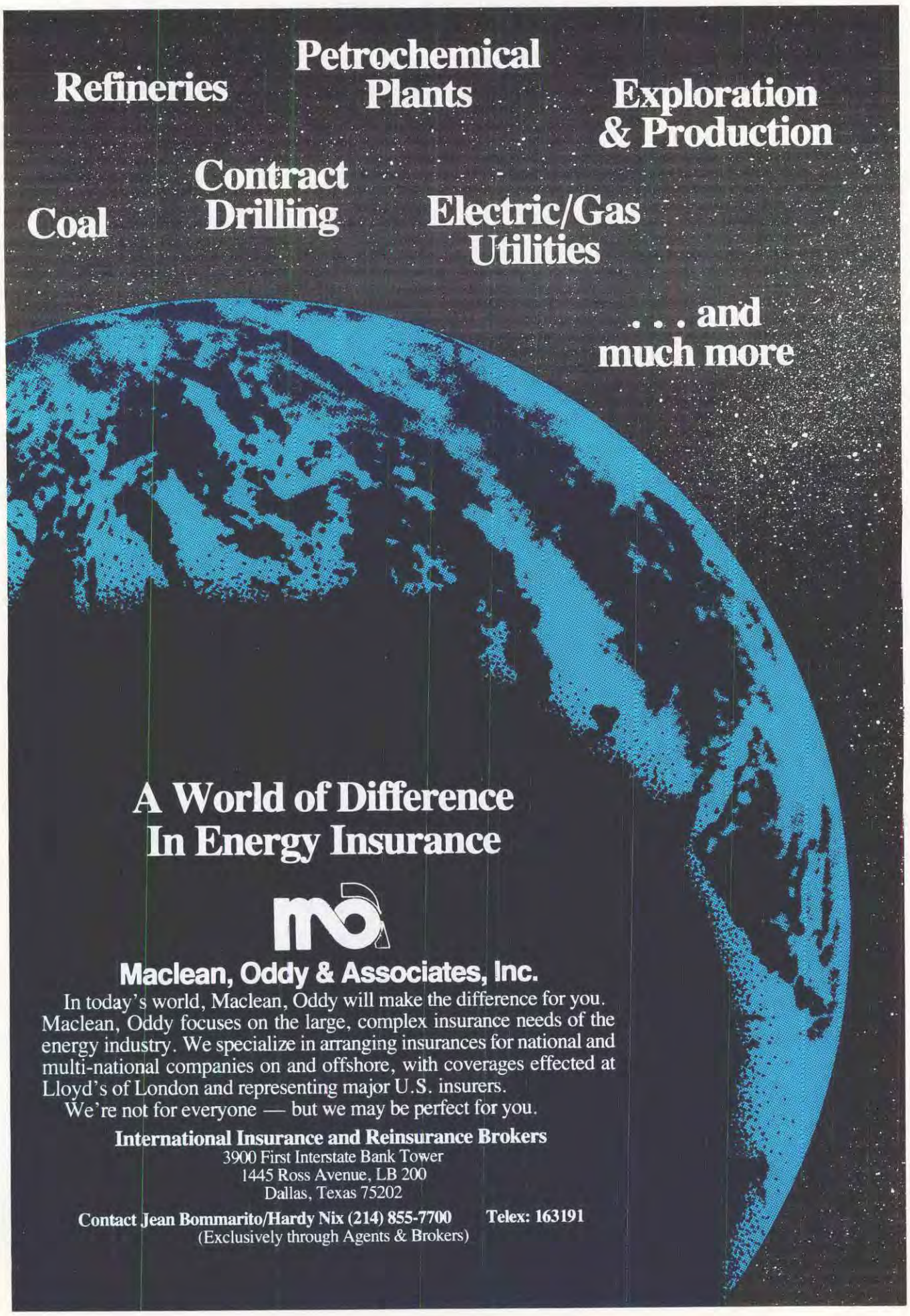
'I think that this reflects busy creditors' general disinterest in a defunct company,' he said.

"But the amount of work and the complexities involved are such that if the creditors do not now submit and negotiate their claims on a full and final basis for both liquidated and unliquidated amounts as quickly as possible, the likely date for a dividend payment to them will almost certainly be delayed beyond 1992.

"After 2½ years, we have built up a well-founded knowledge of Mentor's business and we're ready to accelerate developments, but we need to hear from the creditors," he continued.

Mr. Kempe said that these developments included the release earlier this year of commutation proposals to more than 200 retrocessionaires involved in Mentor's 12 retrocessional programs, one of which is in dispute and subject to arbitration.

The liquidators' report says these proposals covered the commutation of actuarially projected ultimate balances receivable of $77.4 million before offsets. Of these, agreements have been reached to commute ultimate debts totaling $13.8 million before offsets or other discounts. ■



BI promotes Geisel, Wojcik to new posts

Two *Business Insurance* staff members have been promoted, announced Associate Publisher and Editor Kathryn J. McIntyre.

Washington Editor Jerry Geisel has been named senior editor, and Copy Editor Joanne Wojcik has been named copy desk chief.

"Jerry's promotion recognizes the contributions he has made to *BI* during his more than 11-year tenure with the magazine," said Ms. McIntyre. "He has been the first to report many news developments that are important to employee benefit managers and risk managers," Ms. McIntyre said.


Mr. Geisel

"Jerry also assists me in writing editorials and is a wealth of knowledge to the whole staff, especially on benefit topics."

In his new position, Mr. Geisel also will assist in developing story assignments, Ms. McIntyre said.

As copy desk chief, Ms. Wojcik will be responsible for daily copy flow and making sure production deadlines are met. In addition, she will continue to develop spotlight reports.

"Joanne's quick understanding of risk management and employee benefit news makes her a natural leader on the copy desk," said Ms. McIntyre.

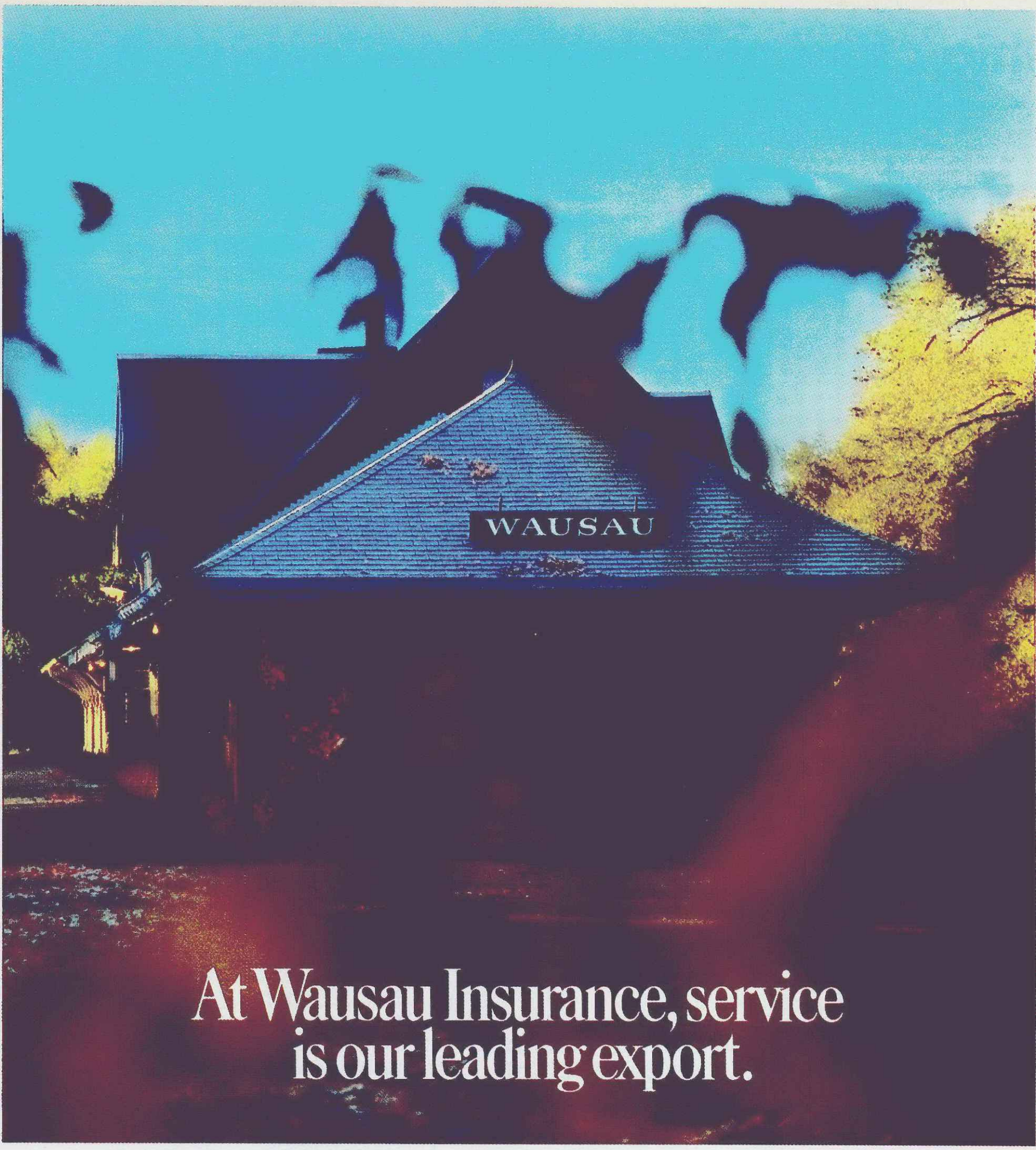

Ms. Wojcik

Mr. Geisel, 36, joined *BI* as an associate editor in 1977 and was promoted to Washington editor in 1979.

He received a master of science degree in journalism from the University of Missouri School of Journalism in Columbia in 1976 and a bachelor of arts degree in history from the University of Wisconsin at Madison in 1973.

Ms. Wojcik, 30, joined *BI* as assistant copy editor in 1985 and was promoted to copy editor in 1986.

Previously, she was assistant news editor at The Daily Sentinel in Grand Junction, Colo., and a reporter at the Delta County Independent in Delta, Colo., both units of Atlanta-based Cox Enterprises Inc. Before moving to Colorado in 1981, Ms. Wojcik was editorial production assistant at *BI*. She received a bachelor of arts in English from the University of Illinois at Urbana in 1979. ■



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Opinions

Overhaul Section 89

WE STRONGLY URGE Congress to delay implementing Section 89's non-discrimination rules for welfare plans and to overhaul the rules.

As most employers know only too well, Section 89, which establishes tax penalties if an employer's welfare plans do not cover a sufficient number of non-highly compensated employees, goes into effect on Jan. 1.

While the date for compliance is nearing, the Treasury Department has yet to issue the regulations that are essential to enable employers to comply with the law.

Even if the Treasury immediately issues regulations, which is not very likely, and if Congress soon passes a technical corrections bill containing relief from some of Section 89's more outrageous requirements, which is likely, employers would have just a few months to digest and obey the new rules.

That is hardly enough time to ensure compliance with a law that is contains some of the most complex benefit rules ever passed by Congress.

Delaying Section 89's effective date would provide time to draft a new set of more reasonable rules and provide the opportunity to do something that should have been done in the first place: Solicit the advice of benefit professionals.

Like so much benefits legislation, Section 89 was hastily put together behind closed doors by a handful of congressional and administration staffers with little or no professional experience with benefit plans.

With that kind of haste, inexperience, indifference and perhaps arrogance, it is no surprise that the resulting rules simply cannot work.

Three of the four major tests for demonstrating compliance with the law are unduly complicated. Section 89 should be overhauled to create tests that achieve non-discrimination without imposing massive and unnecessary administrative burdens on employers. The delay in implementing Section 89 won't result in gutting or killing the non-discrimination rules.

Responsible employers have no quarrel with the intent of Section 89: ensuring that, in exchange for the tax breaks they receive for providing benefit plans, a broad cross-section of employees will be eligible for those benefits.

Employers have proved they can live with workable non-discrimination rules, like those governing 401(k) plans. And, there has been little grumbling over new non-discrimination rules for pension plans, which, like Section 89, are scheduled to go into effect on Jan. 1.

Employers deserve equally understandable and workable non-discrimination tests for welfare plans.

Letters

Primex and Weavers use separate forms

To the editor: We appreciate the article by Stacy Shapiro on the new arrangement between Primex Ltd. and H.S. Weavers (Underwriting) Agencies Ltd. (*BI*, June 27).

I should like to clarify and elaborate one item, lest there be any misunderstanding by your readers. Primex and Weavers are independent facilities and each has its own policy form. The forms are quite similar but, as was noted, there are some differences. For example, in the pollution area, Primex covers certain named perils, time-defined events and limited cleanup costs; whereas Weavers covers only named perils.

The overall program is well-integrated, and we anticipate a smooth relationship with Weavers.

John N. Perham
Vp
Primex Ltd.
Bridgetown, Barbados

A.R.M. examination is not for everyone

To the editor: This is in response to Mr. Drobac's letter regarding the Associate in Risk Management examination (*BI*, June 20).

Although I took my A.R.M. tests using self-study, I did go to an introductory discussion offered as the first session in an informal study group. At that session we were told quite frankly that any answer would be considered if it were supported by a logically built argument. We also were told that about half of our grade would be based on our communication skill. Obviously, this skill is essential to the risk manager, who must communicate his/her vital function and decisions upward to senior management and downward/outward to other people in the organization. A multiple-choice examination would degrade the value of this designation.

Because these questions have absolutely no right or wrong answers, there need be no question of the exam being "properly" worded. As is the case with the other Insurance Institute of America exams, the A.R.M. exam is designed to test skills on many levels. In my limited experience, I have never known anyone with a firm control of the concepts surrounding insurance and risk management who did not sail through these tests.

Although I am a broker, not a risk manager, and although I derived as much from my early on-the-job teachers as from the texts, I found the A.R.M. tests to be interesting, challenging and at the right level to make successful completion meaningful rather than just an obligatory exercise to add some initials after my name or to be able to work in my state. This is not a test for everyone, nor should it become one.

Patrice F. Sobin
Vp
Alexander & Alexander of New York Inc.
New York

Business Insurance welcomes letters from its readers. Please keep your comments as brief as possible. We reserve the right to edit letters for clarity or space. We will not publish unsigned letters. Send your comments to Letters to the Editor, Business Insurance, 740 N. Rush St., Chicago, Ill., 60611.

Abolishing CDWs will hike rental rates

To the editor: "Wave Good-bye to CDWs" (*BI*, June 27), and say hello to higher car rental rates! It's simple economics. Don't be so naive as to think that if you abolish collision damage waivers that the cost won't shift to the up-front rental rate. The consumer will pay the cost of doing business one way or another.

CDWs are a marketing tool to reduce the "apparent" per diem cost of car rental. CDWs are no different than a workers compensation insurance company using a loss-conversion factor in order to reduce its up-front retention charge.

I'm sure some people buy CDWs not knowing that they already have this coverage under their own policies, but don't indict the car rental companies for offering us a choice. Have faith in the American competitive market system to protect the consumer. There's enough competition in the car rental business to keep costs reasonable. If the CDWs were unnecessary, then why hasn't a car rental company dropped or reduced the charge to gain a competitive edge?

The issue is not confusing to risk managers or individuals. They merely need to determine if their commercial or personal policies cover rented vehicles. That's not too difficult. Since my policy covers physical damage to rented vehicles, I decline the coverage. I have that choice. If you have it your way and abolish CDWs, I won't have a choice and the cost of insurance will be added to the rental rate. I will then have paid twice for the same coverage do you also plan to control car rental rates?

Anthony J. D'Asaro
Jackson & D'Asaro Insurance Brokers
Huntington Beach, Calif.

McAlear overlooks lack of cover in crisis

To the editor: Charles A. McAlear's accusation that public entities "refused to purchase liability insurance from reputable insurers offering reasonable prices. . . ." (*BI*, July 11) is a repugnant and inaccurate characterization of the public entities' dire plight during the liability insurance crisis. Indeed, his statement itself is oxymoronic since no "reputable insurer" was offering liability insurance on any terms to California cities and counties for nearly two years.

He further reprobates public entity efforts that have, in his opinion, "embraced a variety of alternatives to insurance that promised, but have yet to deliver, lower costs than commercial insurance." I assume that inference is aimed at the innovative pooling accomplishments of more than 200 public entity pools across the country, covering more than 21,000 local governments. Consider that no public entity pool has failed since its inception in 1974 in contrast to a wave of "reputable" insurance company insolvencies.

The Chinese symbol for "crisis" also depicts the meaning for "opportunity."

Jeffrey W. Pettegrew
Risk Manager
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Hawaii promotes its captive insurer law

By GLENN HUNTLEY

BURLINGAME, Calif.—As many as a dozen captive insurers could be operating in Hawaii by the end of the year, with four companies approved and many other applicants waiting to start business in the latest state to open its arms to captive business.

Hawaii Insurance Commissioner Robin Campaniano made this prediction July 12 to about 55 brokers, insurers and others attending The Hawaii Captive Forum, sponsored by Menlo Park, Calif.-based Argonaut Insurance Co. in Burlingame, Calif.

Although Hawaii's captive trade thus far pales in comparison with domiciles jurisdictions like Vermont and Bermuda, observers say Hawaii has the potential to become a leading U.S. captive domicile.

The state, famed for its beaches, surfing and hospitality, could be home to as many as 200 captives in the foreseeable future, predicted Norman H. Burdick, senior vp of Argonaut and organizer of the one-day session.

While Hawaii has received some attention, many prospective captive owners still have limited knowledge about its potential as a domicile, he said.

The conference was intended to inform brokers and risk managers about captive opportunities in Hawaii.

Also inhibiting captive growth was the fact that the state's original captive law did not include a set premium tax, although the law has since been revised.

Hawaii is looking for the most stable, financially able companies to form captives in its state, Mr. Campaniano said. "We're not looking for (companies seeking) a quick fix."

Mr. Campaniano said he has seen some "flaky" proposals from parties interested in forming a captive there who apparently have little knowledge about captive insurance or simply stop by his office to justify a trip to Hawaii.

"Unfortunately, we have turned away a lot (of unqualified applicants)," he said during a break in the forum.

The benefits of a Hawaiian captive are particularly strong for managers in West Coast companies who can fly to Hawaii on any one of about 40 airline flights daily, said Mr. Campaniano.

By comparison, he quipped, "I think there's about 40 flights to Vermont a month," greatly exaggerating since there are more than 15 flights daily to Vermont.

Mr. Campaniano recommended that risk managers thinking of forming a captive "shop around" for domiciles. Only then can they be confident they have made the best choice, he said. "I believe we have the best, or at least one of the best, programs for an American company," he said.

Interest in Hawaii as a captive domicile has continued to build since its captive law became effective in July 1987.

The first captive insurer, Surety Pacific Insurance Co., a subsidiary of O'Brien Corp. of San Francisco, was approved in December (*BI,* Dec. 14, 1987).

Since then, three other captives have been approved, the most recent being the College Liability Insurance Co., an association captive formed by a group of seven West Coast private liberal arts colleges.

The captive will write up to $10 million in general liability and auto liability coverage for its members.

The other Hawaiian captives are K-M Insurance Co., which provides general liability, auto liability and workers compensation coverage for Kelly Moore Paint Co. of San Francisco; and Royal Hawaiian Insurance Co., which writes surety bonds for Duty Free Shoppers Group Inc. of San Francisco.

A conference held in Honolulu in January attracted more than 100 attendees and publicly launched the state's campaign to become the home to many captive insurers (*BI,* Feb. 8).

But, Mr. Campaniano said the 50th state has serious competition from jurisdictions like Vermont and Colorado, which have shown a renewed interest in promoting the insurance trade.

Vermont, the most active U.S. domicile, had 115 captives licensed by year-end 1987 and Colorado had 26 (*BI,* April 18).

Hawaii also would like to lure captive business from other domiciles, but so far the only captives that have expressed an interest in moving to Hawaii had troubles with regulators elsewhere, he said.

Captives wishing to switch domiciles are "under close scrutiny," Mr. Campaniano said. "We don't want that kind of trouble."

Uncertainty over Hawaii's captive law has been the major obstacle stifling captive growth on the island.

In response to concerns about flaws in the law—most notably a lack of specific premium tax rates—the state Legislature modified it in late April and Gov. John Waihee signed the new law in June (*BI,* June 6).

The amendments clarified several issues:

- The premium tax was set at 0.25% for single-parent captives and 1% for association captives and risk retention groups.

Under the previous law, captives were required to pay the same premium taxes as commercial insurers.

- The insurance commissioner may approve investments by single-parent captives exceeding parameters allowed in the insurance code. Investments by association captives and risk retention groups, however, are bound by statutory limits.
- The assumption and cession of reinsurance are subject to the commissioner's approval.
- Captives may write credit life and credit disability insurance related to loans or other credit transactions between parent companies and affiliates.
- For regulatory purposes, risk retention groups will be treated the same as association captives.
- All captives must file financial statements that conform to generally accepted accounting principles. Also, association captives and risk retention groups must submit annual statements in accordance with statutory accounting practices.

While many risk managers may be interested in forming captive insurers, they may not know what they're getting into, said Raymond Minehan, a partner in the accounting firm of Arthur Andersen & Co. of San Francisco.

Often risk managers are ready to jump into a captive because they are upset with their commercial insurer, but do not understand the complexities of captive management, he said.

"Senior management is going to have to roll up its sleeves to understand this thing," Mr. Minehan said.

Most companies forming captives will need outside help, including actuarial and claims-handling management, he said.

And, in many cases managers have little understanding of reinsurance and don't pay enough attention to it, Mr. Minehan added.

Companies should not form captives for tax reasons, because the Tax Reform Act of 1986 eliminated many of the tax incentives for forming captives, he added.

For example, the tax law includes a provision that makes U.S. shareholders of many offshore group captives liable for current-year taxes on the captives' income from insuring U.S. risks (*BI,* Sept. 15, 1986; Aug. 25, 1986).

Previously, shareholders that each owned less than 10% of an offshore group captive's stock could defer taxes on the captive's income until it was actually paid to shareholders.

Ronald Gamache, also of Arthur Andersen in San Francisco, warned that captives attract the attention of the Internal Revenue Service.

"Captives are very dear to the IRS," he said. "They watch them very closely."

A key way to determine whether premiums paid to a captive are deductible for tax purposes is to determine whether there has been a definite transfer of risk from the insured to the insurer, Mr. Gamache said.

For example, it is difficult to establish tax-deductibility for premiums paid to a single-parent captive, he noted. ■

Argonaut studies 'interim' facility

BURLINGAME, Calif.—Argonaut Insurance Co. is exploring the possibility of setting up a "transition captive" to provide coverage to companies awaiting regulatory approval of a captive but whose commercial insurance has expired.

While Argonaut is considering forming the interim facility in Hawaii, it would be available to companies forming captives in any domicile and fees would be minimal, said Norman H. Burdick, senior vp of the Menlo Park, Calif.-based insurer.

Mr. Burdick presented the idea during a session at the "Hawaii Captive Forum" sponsored by Argonaut on July 12 in Burlingame, Calif.

Argonaut officials began studying the possibility of forming an interim facility last year after clients that expressed interest in establishing captives in Hawaii found they would not have enough time to obtain regulatory approval before their commercial insurance renewed, he explained.

Although Hawaii officials say they can approve a captive application within 29 days, the process can take longer, he said.

Argonaut's proposed transition captive would be similar to a rent-a-captive except that its use would be limited to one company at a time over a brief period.

Rent-a-captive facilities, which are popular in offshore domiciles like Bermuda, provide captive coverage to any number of clients for any duration (*BI,* April 18).

However, Hawaii's captive law does not permit the formation of rent-a-captives.

Argonaut's transition captive idea received only lukewarm response from risk managers and brokers attending the California captive forum.

Hawaii Insurance Commissioner Robin K. Campaniano said it was the first time he had heard of the transition captive concept and had not yet considered it.

And, at least one other participant wondered why Argonaut would not simply "warehouse" policies—or write interim insurance—for prospective captive parents awaiting regulatory approval.

While Mr. Burdick admitted that Argonaut had considered that option, he said many clients may prefer starting with a captive structure while awaiting regulatory approval of their own facility.

A transition captive, owned by Argonaut and leased to prospective captive parents for two or three months at a time, could offer several advantages, he said.

For example, the potential captive owner could quickly transfer its entire book of business from Argonaut's transition captive to its own captive once regulatory approval is received.

And, Argonaut then could serve the new captive either as a fronting insurer or as a reinsurer, Mr. Burdick said.

Argonaut currently writes reinsurance limits of up to $1 million for captives underwriting employers liability, general liability and auto liability risks and up to $5 million for captives writing workers compensation coverages.

In addition, the captive would not have to issue a letter of credit to its fronting insurer, because Argonaut would fill both of these roles, Mr. Burdick said.

Argonaut officials have not yet finalized any plans for its experimental captive and may locate it in a domicile other than Hawaii if it does not receive approval there, according to Mr. Burdick.

—By Glenn Huntley

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The continuing and growing use of risk retention programs has spurred a significant growth in the use of captives to finance insurance coverage. One major item which has provided a great deal of impetus in using captives is the Liability Risk Retention Act of 1986. In addition, the 1986 Tax Reform Act has provided incentive for offshore captives to relocate onshore or to incorporate domestic subsidiaries. Vermont is the most active domestic domicile with 52 companies licensed in 1987, and has a strong infrastructure to facilitate the execution of the goals of the captive. This conference will focus on the use of captive insurance companies and provide insight into new regulations and conditions affecting their use.

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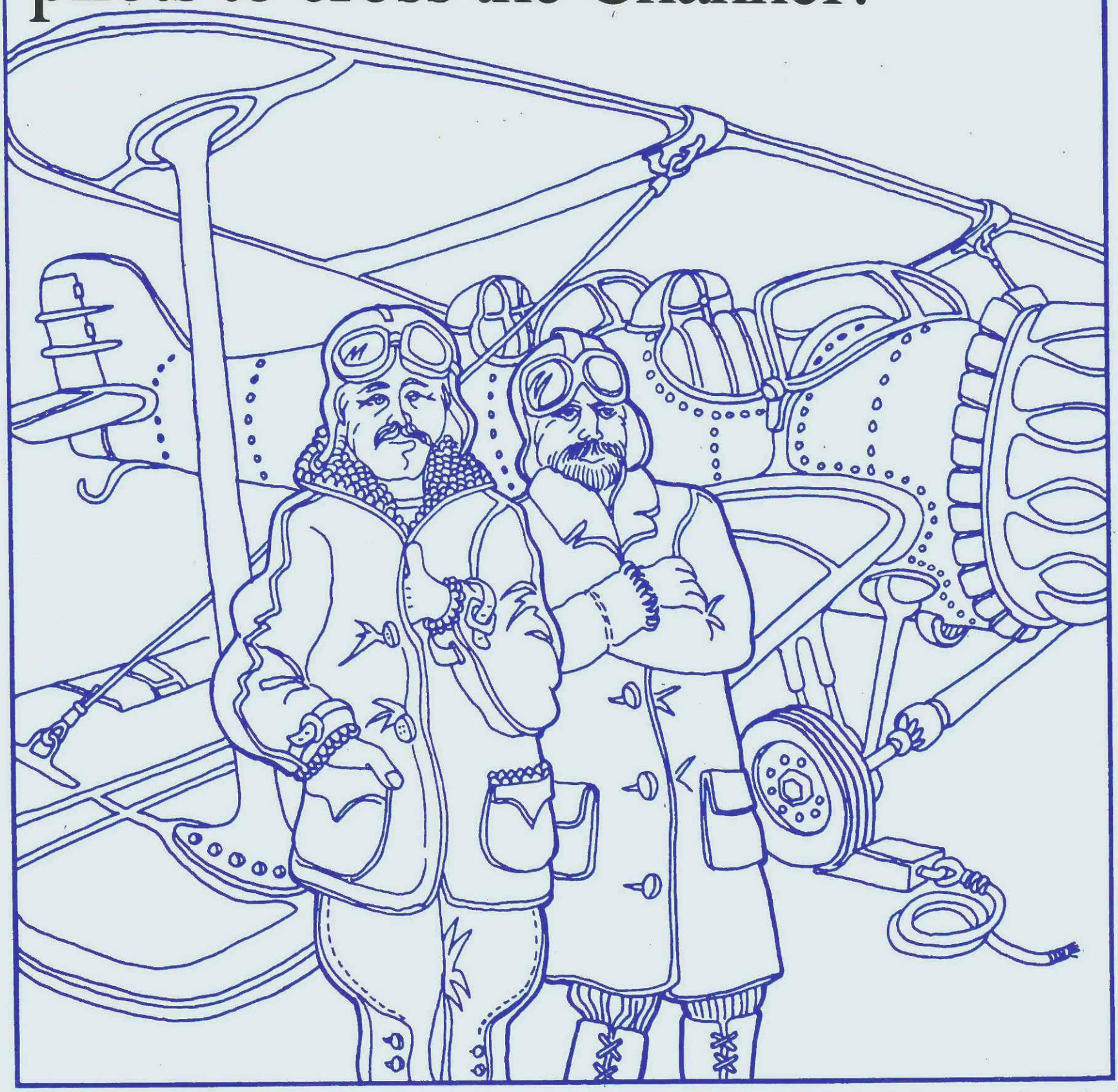

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Louisiana regulator hid source of loans: Suit

By MICHAEL BRADFORD

BATON ROUGE, La.—Louisiana Insurance Commissioner Doug Green and several campaign supporters intentionally hid the source of loans used to finance Mr. Green's election last year, according to a lawsuit filed in a state district court.

The petition filed by the Louisiana State Board of Ethics earlier this month charges that Mr. Green and 25 other defendants took part in a scheme to disguise the true source of $2.2 million in loans to the Doug Green Campaign Committee.

The Board of Ethics states in the petition that it believes the true sources of the loans were not the defendants who reported making them, but United Financial Services of Baton Rouge Inc., one of the defendants and a company whose owner, the court papers say, also owns a property/casualty insurer that is regulated by the Louisiana Insurance Department.

According to the petition, John M. Eicher is president and principal owner of Boardwalk International Inc., parent company of United Financial Services and 90% owner of Champion Capital Corp. in Baton Rouge. Champion Capital owns Champion Insurance Co., a Baton Rouge-based underwriter of automobile coverages.

Neither Mr. Eicher nor Champion Insurance Co. are named as defendants in the petition, which seeks a ruling from Judge Joseph Keogh that the defendants show cause why they should not be found in violation of the campaign finance disclosure law.

The petition also names as defendants Keith D. Jones, chairman of the Doug Green Campaign Committee, and John W. Davis, the committee's treasurer. Other defendants are individuals and businesses that reported contributing from $25,000 to $100,000 in campaign loans.

The petition says Messrs. Green, Jones, Davis and the campaign committee "knowingly and willfully inaccurately disclosed the source of the loans reported as received by the Doug Green Campaign Committee." The other defendants also participated willingly in the scheme, the Board of Ethics charges.

The petition seeks fines of up to $70,000 each against Messrs. Green, Jones, Davis and the campaign committee and fines of up to $500 against each of the other defendants.

Mr. Green said last week he still had not been served with any papers related to the suit and said he first learned of the petition when a Baton Rouge reporter showed him a copy.

"I am assuming at some point in time that this thing will surface in the proper form," he said, adding that he reviewed the reporter's copy of the papers and found the allegations to be groundless.

The charges in the suit "are certainly not violations of anything," said Mr. Green. "Once we get to court, I think the judge will agree to that."

Mr. Green's attorney called the suit "much ado about nothing." None of the provisions in the state's campaign finance disclosure law have been violated, said Jack Dampf of D'Amico, Curet & Dampf in Baton Rouge.

Even if the charges in the petition were accurate, he added, there still would be no violations. "You can make third-party loans under our code," Mr. Dampf said.

And, he said no state laws would be broken even if an insurer regulated by the department contributed directly to a campaign. However, he pointed out, such a contribution would be a violation of a new state ethics code effective next year.

Mr. Eicher was not available to comment on the filing, but Patty King, an attorney for Champion Insurance Co., said: "Our reaction is that neither we nor any of the companies we are associated with have violated any statutes. And we can't wait to get to court to prove that."

The ethics board acknowledged in a memorandum supporting the request for a show-cause order that individuals can borrow funds from a financial institution and, in turn, lend the money to a candidate. In such a situation, the source of the loan reported by the candidate or his campaign committee would be the individual who loaned the funds, the papers state.

However, the memorandum continues, "that is not the situation presented in this case."

The court papers state that based on the ethics board's investigation, "it is the belief of the Board that Mr. Green's campaign was primarily funded through loans from one institution. This was not a case of a number of individuals or companies obtaining funding through whatever methods they chose and in turn lending to a campaign. Rather, these individuals or companies were provided funds from the same institution for the sole purpose of financing the campaign of Doug Green.

"It is the Board's belief that both UFS and these individuals or companies acted cooperatively to cause the loans to be made in the name of another rather than in the name of UFS, the true lender," the papers state. "The transactions described in the petition and this supporting memorandum are extremely serious violations of the Campaign Finance Disclosure Act." ■

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Bernard fails agent exam

NEW ORLEANS—Former Louisiana Insurance Commissioner Sherman Bernard says he has no plans to enter the insurance business after failing the first half of the state's property/casualty agent licensing exam earlier this year.

And, former Deputy Commissioner John Browne, who failed both portions of the test administered last March, said he never actually planned to become an agent and currently is operating his own insurance consulting business.

Passing the test allows the applicant to hold an agent's license to place commercial and personal lines insurance in Louisiana.

Mr. Bernard, who was defeated in his re-election bid last year by Doug Green, blamed his licensing exam score of 44 on a bad back and leg.

"I can't sit down that long," he said. "My back goes out and my leg is bad. That's a three-hour exam."

He added, "I have no intention of going into the insurance business."

A score of 70 is needed on each portion of the test before an applicant can be granted a license.

Mr. Browne, who scored a 67 on the first portion of the test and a 64 on the second half, said, "I never had plans to become an agent. After spending 16 years in the Insurance Department, an agent's license seemed like a good thing to have for the future."

Mr. Browne said the test was "considerably harder" than he expected. ■

Tips on settling EIL coverage disputes

By COLLIN NASH

NEW YORK—Policyholders must work harder to settle pollution liability coverage disputes, says a legal expert.

The prospects for policyholders negotiating settlements with their insurers have eroded, according to Robert N. Sayler, a partner with the Washington, D.C.-based law firm of Covington & Burling.

Pointing out that insurers were buoyed by the 4th U.S. Circuit Court of Appeals ruling in *Maryland Casualty Co. vs. Armco Inc.* (*BI*, July 27, 1987), insurers are taking the position "that the money at stake on environmental coverage matters is too substantial to allow significant compromise," said Mr. Sayler at the "Environmental Insurance Litigation" conference last month in New York, sponsored by Executive Enterprises Inc.

The 4th Circuit ruled in the Armco case that because cleanup costs are essentially preventive, they are not damages covered under general liability policies.

But, Mr. Sayler contended that "corporations have every right to seek help" from their insurers in pollution cases.

"CGLs are all-risk policies," Mr. Sayler said, explaining that because the comprehensive general liability insurance policy provides comprehensive coverage on a comprehensive basis, new risks as well as all existing risks are covered.

The "insurance industry had a choice between scheduled-risk and all-risk. They unequivocally chose comprehensive," Mr. Sayler contended.

Despite this, "significant compromise on both sides makes sense," he said.

Mr. Sayler suggests these approaches to settlement discussions:

- Both sides should sign standstill agreements, which preclude each party from filing suit while negotiations are pending.
- Short of revealing proprietary information, policyholders should provide substantial information about the nature of their liabilities and the company's plans for dealing with them.
- A policyholder can attempt either to negotiate a single, or global, settlement with all primary and excess insurers or a series of individual, or bilateral, settlements with the insurers. However, each type poses a new risk to policyholders, he said.

A global settlement is difficult because insurers typically cannot agree on a fair share among themselves due to varying exclusions, different coverage periods and other policy provisions, he said.

Although easier than global settlements, a series of bilateral accords can present unacceptable risks to the policyholder, he said. For example, to whatever extent the policyholder agrees to less than 100 cents on the dollar, there is a risk that other non-settling insurers may claim that underlying limits have not been exhausted or that the settling insurer's pro rata share of liability is greater than the settlement amount and therefore the difference must be "eaten" by the policyholder.

But, there are a couple factors that often block these settlements, Mr. Sayler pointed out.

For example, policyholders often are reluctant to give insurers unrestrained discovery during the settlement process, because they know that this evidence might be harmful if negotiations fail.

And, there's a premium being placed on winning the race to the courthouse because of courts' "inconsistent response—both on the merits of environmental coverage questions and on venue," Mr. Sayler said.

However, he warned, "there are limitations on the significance of winning such a race." For example, while "the vast majority of courts tend to honor the plaintiffs' choice of forum, so long as jurisdictional requisites are met, the chosen forum may decline to adjudicate some or all of the case," he said.

Also, "the forum court may choose to apply the law of other states to all, or part, of the dispute, thereby minimizing the significance of the law of the forum court," Mr. Sayler pointed out.

Despite these limitations, he asserted, "choice of forum is significant in environmental coverage disputes and may serve to affect the willingness of parties to engage in extensive negotiations prior to the commencement of litigation."

Robert D. Chesler and Michael L. Rodburg of New Jersey-based Lowenstein, Sandler, Kohl, Fisher & Boylan chaired the session. ■

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EIL coverage rulings confusing: Attorney

By COLLIN NASH

NEW YORK—Conflicting rulings in environmental coverage litigation are making an already-cloudy pollution liability insurance picture even more dense for the lawyers, insurers and policyholders who have to sort through it to determine if coverage exists.

As a result, "the historical relationships that existed between" policyholders, insurers, brokers and defense attorneys are eroding, according to Nancy J. Gleason, an attorney with the Chicago-based law firm of Dowd & Dowd Ltd.

Ms. Gleason made her remarks during the "Environmental Insurance Litigation" conference held last month in New York by Executive Enterprises Inc.

"Astronomical sums of money are at stake in these cases," Ms. Gleason said, "and lawyers find themselves hard-pressed to keep up with court rulings that cannot be reconciled, interpret statutes and regulations that are complex and convoluted, and counsel clients who are concerned and justifiably bewildered."

Policyholders 'didn't ask for the trouble they're in, but (insurers) did,' says Eugene R. Anderson.

Despite the introduction of new policy forms and endorsements intended to "eliminate the need to litigate questions" of coverage, pollution coverage litigation is growing, she said.

But insurers asked for it, contended Eugene R. Anderson, a partner with New York-based Anderson Russell Kill & Olick.

Policyholders "didn't ask for the trouble they're in, but (insurers) did," he said.

"They said, 'pay us a premium America, and we'll take care of you,' "—a promise on which insurers increasingly renege, Mr. Anderson said.

"Although environmental insurance litigation started slowly, it is now well on its way to pushing asbestos insurance litigation aside" in terms of dollar value and number of claims, and is raising many complex issues in the process, observed Ms. Gleason.

For example, she noted, policyholders are not only suing primary and excess liability insurers, but also environmental impairment liability insurers and first-party property insurers as well.

In turn, EIL and property insurers are suing general liability insurers.

Captive insurers also are being drawn into the litigation, Ms. Gleason said, citing the Shell Oil Co. case in California. In that case, in which oil industry captive O.I.L. Insurance Ltd. is a party, Shell is seeking coverage from more than 200 of its liability insurers to pay for the cleanup of the the Rocky Mountain Arsenal near Denver and a hazardous waste site in California (*BI,* Oct. 12, 1987).

As illustrated by litigation involving RCA Corp. and Travelers Indemnity Co., in which both CGL and EIL insurers are defendants, the original intent of EIL policies also is being questioned, Ms. Gleason said.

For example, a question as to whether EIL policies were intended to dovetail with general liability policies and provide coverage in cases in which the CGL policies excluded coverage has yet to be answered, Ms. Gleason explained.

While the market for EIL insurance is starting to open up, "the available policies provide very restricted coverage and then only on a claims-made basis," Mr. Anderson pointed out.

The new pollution exclusion for CGL policies proposed by the Insurance Services Office Inc. (*BI,* July 11) also narrows coverage by doing away with coverage for "sudden and accidental" pollution for product liability and completed operations risks and certain offsite pollution.

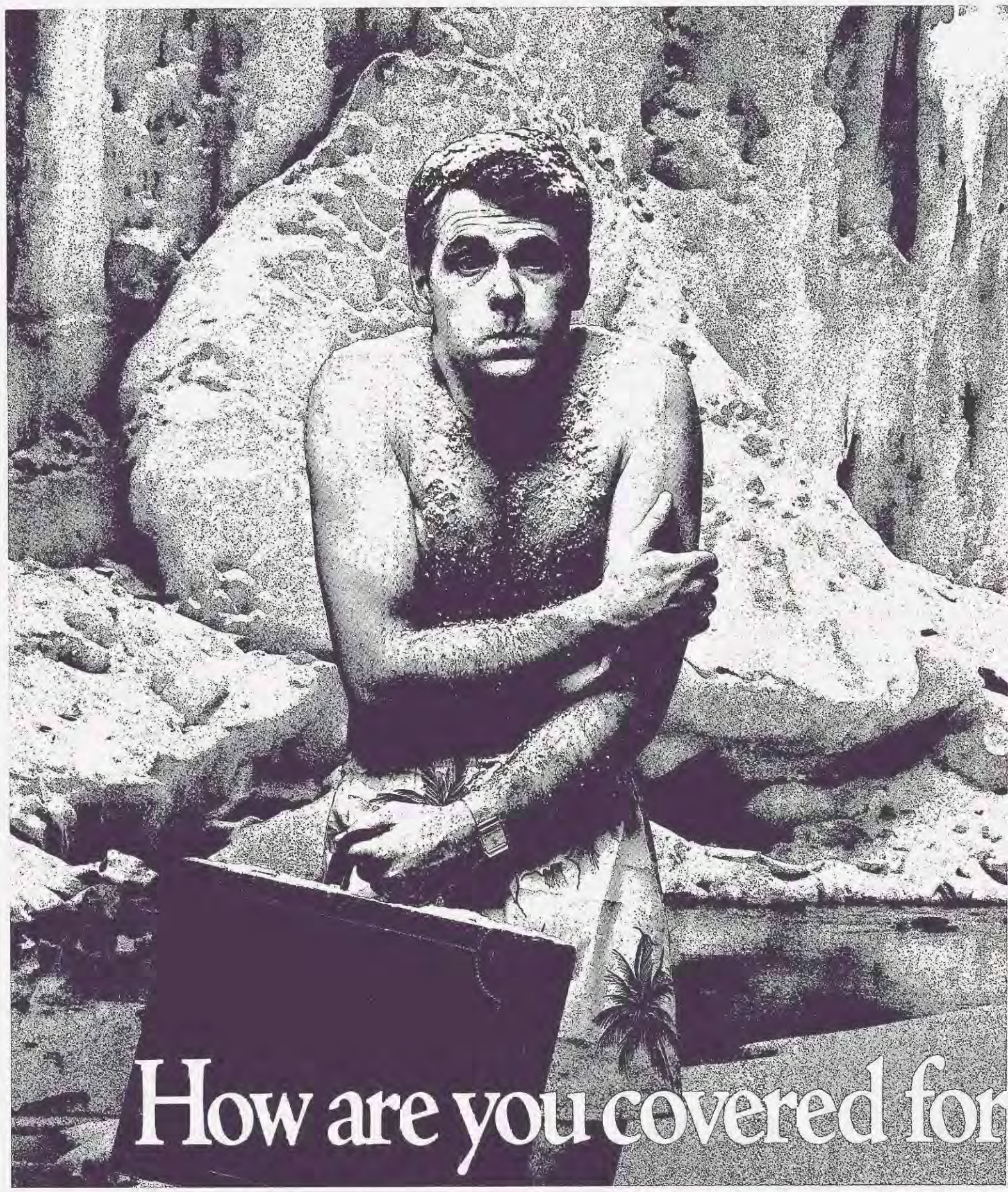
The new endorsements, Ms. Gleason said following the conference, reflect the insurance industry's concern over the mounting claims for coverage against governmental cleanup demands under federal and state statutes such as the Comprehensive Environmental Response Compensation and Liability Act of 1980, better known as the Superfund Act.

But, because the "courts read all exclusions narrowly," Mr. Anderson pointed out that 'the burden of proof is on the insurance company to prove the applicability of all exclusions."

Meanwhile, the U.S. District Court's decision in *UNR Industries Inc. vs Continental Insurance Co.* demonstrated that insurance brokers are no longer exempt from pollution coverage litigation, Ms. Gleason asserted (*BI,* June 1, 1987).

Although the jury found that several former UNR primary insurers and its broker—Corroon & Black Corp.—did not commit fraud against the company when it rejected its claims, according to Ms. Gleason, "brokers are the next logical target for insureds to sue."

Declaring that "issues once considered clear have become muddied and the seemingly unambiguous language of insurance contracts contorted," Ms. Gleason predicted: "What lies ahead may be reminiscent of the Old Chinese curse: 'May you live in interesting times.' " ■



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Avoiding courts saves money: Experts

By COLLIN NASH

NEW YORK—Corporations and insurers locked in costly disputes over coverage for pollution incidents can contain costs and speed settlements by using alternative dispute resolution, legal experts say.

"ADR is proving its worth (especially) in large, complex multiparty disputes," including pollution coverage litigation, said James F. Henry, president and founder of the Manhattan-based Center for Public Resources.

Mr. Henry's remarks came during the "Environmental Insurance Litigation" conference last month in New York, sponsored by Executive Enterprises Inc.

Encouraging alternative dispute resolution in place of the costly and interminable litigation process is high on CPR's agenda. A national coalition of general counsels from major corporations, partners from leading law firms and legal scholars comprise CPR's Legal Program, developed to resolve legal disputes economically and out of court, Mr. Henry said.

Chief executive officers and general counsels of more than 200 major corporations and their subsidiaries have signed an ADR Corporate Policy Statement committing their companies to explore ADR or early settlement before pursuing full-scale litigation with fellow policy signers, he explained. These companies include Aetna Life & Casualty Co., Chevron USA, American Telephone & Telegraph Co. and Chase Manhattan Bank.

Calling the policy "an active and effective tool to avoid intercorporate litigation," Mr. Henry cited a CPR survey of 61 companies that used ADR to resolve disputes. The companies saved an average of $804,000 each by using ADR techniques over a two-year period.

Some insurers also have initiated an ADR policy for their claims disputes, Mr. Henry said.

For example, Kathleen Cullen, director of property and casualty claims at Hartford-based Travelers Corp., reports that 2,700 cases were resolved using ADR, resulting in a total savings of more than $2.5 million in legal costs, said Mr. Henry.

"CPR's Legal Program illustrates that the driving force of ADR is the corporate law department and claims department," Mr. Henry said, adding that these employees have an obligation to become "sensitized" to settlement techniques that:

- Drastically reduce costs.
- Limit infighting among defendants.
- Improve the prospects for a favorable outcome, whether through settlement or trial.
- Provide an ADR procedure to allocate any liability and costs of joint defense activities among participants.

'The driving force of ADR is the corporate law department and claims department,' Mr. Henry says.

ADR practices also eliminate other indirect, yet notable, costs such as diversion of management time, lost market opportunities and unwanted publicity by providing a more "rationale, businesslike approach to dispute resolution," Mr. Henry said.

The minitrial, a non-binding settlement procedure, exemplifies this process, Mr. Henry said.

Collateral legal issues are set aside in minitrials, and attorneys make abbreviated presentations, not to a judge or jury, but to business executives from each side who are empowered to negotiate a settlement, Mr. Henry explained.

After attorneys' presentations, "the business executives meet without their lawyers to negotiate an agreement that more frequently resembles a creative solution to a business problem than a legal judgment that is based on dollars and narrow issues," he said.

And, he added, such techniques will speed the settlement of disputes over pollution coverage.

"Environmental laws are getting tougher. . .and, in the long run, public policy will mean that insurers and insureds will have to share the burden to clean up sites," said Vincent Fitzpatrick Jr., an attorney with the New York-based law firm of White & Case.

There are a multitude of obstacles to settlement of environmental disputes, Mr. Fitzpatrick said.

Citing "differences among insurers" as a major obstruction to settlement, he added that insurers are fearful of settling in one forum while being accused of bad faith in another jurisdiction.

Litigants in a large case involving multiple sites might speed up negotiations by arranging settlements for some sites—the less controversial, for example—with the understanding that the agreement doesn't set a precedent for the remaining sites, according to Mr. Fitzpatrick.

Insurers also might "buy out" of a case by paying an agreed-upon sum for a given site with the hopes of gaining leniency on the others, Mr. Fitzpatrick added.

All parties involved in an environmental coverage dispute must investigate these and other creative approaches to settlement, he said, because "the courts will be looking for someone to pay."

The panel was co-chaired by Robert D. Chesler and Michael L. Rodburg, both with the Roseland, N.J.-based law firm of Lowenstein, Sandler, Kohl, Fisher & Boylan. ■

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Experts assess future of risk financing

By CAROLYN ALDRED

LONDON—Commercial property/casualty insurers must recognize that alternative risk financing techniques represent a permanent structural change in attitudes toward insurance and risk management, experts say.

However, some insurance industry executives speaking at the International Insurance Society Inc.'s conference, held July 11-14 in London, argued that alternative risk financing is a cyclical phenomenon that has yet to prove itself.

"The alternative markets have not been tested. (Insurance is a) long-term business and losses will happen. There is no reason to believe the alternative markets will fare any differently from the regular industry," said Maurice R. Greenberg, president and chief executive officer of American International Group Inc. of New York.

But captive insurance companies have advantages over commercial insurers in that they are more specialized and are not subject to shareholder pressures, countered James V. Davis, chairman and chief executive officer of the Advanced Risk Management Services division of Corroon & Black Corp. in Nashville, Tenn.

And, the increasing sophistication of buyers and continued disenchantment with traditional insurance is "going to lead to greater retentions" by policyholders, he said.

Although the popularity of alternative risk financing methods grew dramatically during the hard property/casualty insurance market of the mid-1980s, the phenomenon is a structural and permanent change, argued Mr. Davis.

"Disenchantment with the insurance industry is widespread as an aftermath of the most recent hard cycle, (but) this disenchantment is fading only slowly with the current softening of the market," he said, indicating that the very cyclical nature of commercial insurance is forcing a structural change.

"It is ironic that a product that was in part created to help an organization stabilize the impact of unforeseen losses on its financial statement has become a major source of cost instability," Mr. Davis explained.

Meanwhile, as more and more policyholders learn more about the fundamentals of risk financing, their ability to choose alternatives increases, he added.

Insurance is a product that has been oversold by brokers and insurers, Mr. Davis argued. But "one result of the last hard market is the number of firms that now retain the first $25 million or more of each product's loss and have found the experience less disconcerting than expected. Several of these firms have indicated that they have redefined their ideas of what constitutes catastrophic loss and will continue to self-insure at previously unthought-of levels," he added.

And, as the four-day conference progressed, attendees continued to debate whether the growth of alternative risk financing mechanisms was a cyclical phenomenon or a fundamental change to which the insurance industry must adapt.

"The fundamental problem is that the multiline approach to insurance business has outlived its usefulness," argued John R. Cox, chairman and chief executive officer of A.C.E. Insurance Co. Ltd. in Hamilton, Bermuda, during an "executive roundtable" session at the conference.

The commercial insurance industry is plagued by "unnecessary overheads" and no longer provides the "best coverage transfer," he said.

"The U.S. marketplace and Lloyd's (of London) have not responded" to industry's needs and have "forced the industry to provide its own capital," said Mr. Cox, adding that the total capitalization of alternative facilities in Bermuda—including captives and policyholder-owned insurers like A.C.E—is now about $12 billion. Risk financing alternatives are the "only solution for many companies," he added.

Mr. Cox demonstrated the importance of the alternative market when he pointed out that alternative facilities will pay claims from most of the major losses this year, including the Piper Alpha rig explosion, the May explosion at a Shell Oil Corp. refinery in Louisiana and the Ashland Oil Co. spill near Pittsburgh.

The "insurance business should be allowed to evolve and not look back to what it used to be," Mr. Cox summed up.

However, other members of the executive panel argued that the insurers must take stock and return to the basics rather than "evolve."

While the challenges facing the industry will increase if it returns to its basic principles, it will survive, said Rudolf Ficker, a member of the board of management at Munich Reinsurance Co. in Munich, West Germany.

"I would like to see a greater reliance on traditional reinsurance, more pro-rata business than excess of loss," suggested David N. Vermont, a director of reinsurance broker E.W. Payne Ltd. of London.

If the insurance industry failed to survive and someone had to invent something to replace it they would probably re-invent insurance, said Peter P. Fryer, director of Charter Reinsurance Co. Ltd. of London.

"We are far too defensive at dealing with outsiders who snipe at the insurance industry with very little knowledge," he added.

Robin A.G. Jackson, a director of Merrett Holdings P.L.C. in London, agreed. "We've been far too defensive," he said.

He added that "at the end of the day the insurance industry has to get back to making a profit," he said. However, "we are going to see some more blood letting first" before the industry gets back on track.

"I am concerned about the financial viability of some insurers and reinsurers throughout the world," Mr. Jackson warned. ■

Photo: Courtesy of British Tourist Authority

Insurance executives and academicians gathered in London for the International Insurance Society conference, which is held in a different city around the world each year.

23rd 'Bickley Circus' a tribute to IIS founder

LONDON—The 23rd annual conference of the International Insurance Society Inc. was in many ways a four-day celebration and recognition of the society's founder, John S. Bickley, who retired as chairman and chief executive officer of the worldwide organization.

The IIS's annual seminars were begun by Mr. Bickley, who has been credited as one of the pioneers of risk management, to allow insurance industry executives and academics from around the world to meet and discuss all aspects of the insurance business.

The "Bickley Circus," as it is often referred to by participants, is held each year in a major city in different countries. This year, 365 delegates from 52 countries gathered July 11-14 in London.

From the opening concert and the recitation of the IIS anthem—whose words were written by Mr. Bickley—to the presentation of a life-size bust of Mr. Bickley at a dinner in London's medieval Guildhall and the formal transfer of the IIS' top office to Kenneth Black, the conference marked a fitting retirement event for the society's "ringmaster."

"Besides the society, Bickley's contributions to the way we all think about the insurance field are pervasive," according to a retrospective booklet about Mr. Bickley that was presented to all conference delegates.

Mr. Bickley also is credited with changing the term "fire and marine insurance" to "property/liability insurance," and also urged that the "American Agency System" be renamed the "Independent Agency System," the retrospective continues.

In 1955, Mr. Bickley founded the Insurance Hall of Fame to "honor the accomplishments of those making significant contributions to the ability of the insurance business to serve the security needs of society," the booklet noted.

Among the early entrants to the Hall of Fame were Benjamin Franklin and Otto von Bismarck.

Ten years later in 1965, the society's first seminar was held, during which "discussion groups moderated by quality academicians met in 15 different rooms." These discussion group sessions are still a central focus of the annual seminars, the booklet states.

Meanwhile, more recently the University of Alabama at Tuscaloosa has offered permanent offices for the Hall of Fame and the society.

Mr. Black, Mr. Bickley's successor, currently is regents' professor of insurance at Georgia State University in Atlanta, where he also served as dean of the College of Business Administration for 15 years.

—By Carolyn Aldred

Greenberg blasts state regulatory system

By CAROLYN ALDRED

LONDON—State regulation of commercial insurance business in the United States has outgrown its purpose and should be replaced by some form of federal regulation, contends Maurice R. Greenberg, president and chief executive officer of American International Group Inc. of New York.

"The state regulatory system is a horse-and-buggy system in a space age," Mr. Greenberg said at the annual conference of the International Insurance Society Inc., held July 11-14 in London.

The system is "simply not up to the job" and is "not doing the buyers of insurance any good," he argued, elaborating on his criticism of state regulation at the Risk & Insurance Management Society's annual conference earlier this year (*BI,* May 2).

Although Mr. Greenberg recognized the need for state regulation of personal lines insurance, he said, "we need a debate over whether we should have a new system" for regulating commercial insurance.

As large commercial risks are placed across state borders, "why shouldn't there be a federal charter based on the federal bank system" to regulate commercial insurance? he asked. In addition, Mr. Greenberg questioned the need for state guaranty funds for large commercial risks.

"Why does a commercial risk need to be bailed out? Does General Motors need something to protect them?" he asked, adding that the removal of such funds "might dampen insurance cycles in the future."

Mr. Greenberg said the insurance industry increasingly is expected to pay the bills left behind by insolvent insurers, including defunct captives.

"A number of captives have become impaired and there are no solvency funds to bail them out. When companies in the U.S. set up an insurance subsidiary and then walk away when the insurance company fails, they expect the insurance industry to pick up the bill," he explained.

However, as it has done with many other issues, the U.S. property/casualty insurance industry has failed to effectively voice its case concerning regulatory problems, according to Mr. Greenberg.

"I think the industry has not done a brilliant job in advocating our view and I fear for the future of the business unless it does," he said. For example, any advances the industry has gained in seeking tort reforms are likely to be lost again unless the industry learns to speak with one voice, he warned.

"As rates soften, the pressure for reform abates and it seems tort reform wasn't necessary. Some states are questioning whether the changes that were made were necessary. Unless the industry speaks with one voice, we will be in trouble," he explained.

In addition, the property/casualty insurance insurance industry will see big changes in the coming years, and only the strongest companies will survive, he predicted.

In recent years "we have failed in our basic business that is underwriting," he said.

With a few sharp rebukes, Mr. Greenberg pinpointed several areas where the insurance industry has failed, namely:

- Technology. "The insurance industry has been the least effective in its use of technology," said Mr. Greenberg.
- Personnel. "There must be continuing investment in personnel. The industry hasn't brought into its ranks the brightest and best of the students," he said.
- Customer service. "In one way or another, the insurance industry has failed to respond to the needs of customers," encouraging the development of alternative risk financing methods, he explained.
- Return on equity. "Our industry has not had a brilliant record on return on equity. In fact, it's been mediocre. We need to provide (a better return) or investors will go elsewhere and reduce our capital," he warned. ■

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DRG dangers

System calls for a new twist to hospital cost containment

By Lisa Garrigan

AS STATES ADOPT diagnostic related group payment systems for all hospital charges, employers may need to adopt new approaches to control health care costs.

DRG reimbursement is essentially a case-payment system, with a case being defined as a hospital discharge. Under this type of reimbursement system, hospitals are encouraged to generate more admissions with shorter lengths of stay and to fine tune their medical coding practices to reflect a case's medical complexity and severity.

Payers, on the other hand, must diligently monitor the appropriateness of admissions and the accuracy of hospital coding.

DRGs have been used nationwide by the federal Medicare program since 1983 to determine patient classifications and their corresponding reimbursement value. Several states also have adopted DRG-like case payment systems for their Medicaid programs. And, three Northeastern states—Connecticut, New Jersey and New York—have adopted DRG "all-payer" systems, in which the DRG system is used to calculate hospital charges for all payers. While each state has a slightly different set of DRGs and methods for calculating payment, they share the practice of all hospitals being paid by the case, rather than according to the number of days in a hospital stay or according to posted charges.

When New York entered into the DRG system as of Jan. 1, 1988, the number of DRG claims submitted to health insurers more than doubled: There are approximately 1.3 million non-Medicare/Medicaid hospitalizations in New York annually, compared with 600,000 in New Jersey and 255,000 in Connecticut.

The introduction of DRGs adds a new wrinkle to employers' cost control efforts.

One tool for monitoring hospital charges is concurrent review, which was designed to ensure that patients did not linger needlessly in the hospital and increase per diem charges. In a DRG system, a hospital's financial interest dictates that a patient leave as soon as is medically possible. As such, concurrent review is a limited tool for monitoring DRG cases because a patient's length of stay is no longer a major financial concern to the payer.

There are, however, two instances where it may be worthwhile for a payer to concurrently monitor a patient's stay. The first instance is the patient with a long length of stay (LOS), who is approaching "outlier" status. LOS outlier status means that the patient has remained in the hospital for an extraordinarily long period of time. In such cases the hospital may be eligible to receive a fee in addition to the regular DRG amount.

The number of days a patient must be in the hospital in order to qualify varies with each DRG. While only a small percentage of claims qualify as LOS outliers, a payer should be alert to reviewing patients who are staying in the hospital longer than average because they may require long-term catastrophic case management.

Thus, concurrent review programs should be modified to focus on those patients remaining in the hospital longer than the statistical norm in order to prevent LOS outlier payments and identify cases in need of intensive management.

Another application for concurrent review in a DRG system is to assure that cases are appropriately assigned a "short-stay" status. Short-stay cases are those patients that stay in the hospital for an unusually short period of time. Short-stay cases do not entitle a hospital to receive a full DRG reimbursement; instead, the hospital receives a lower reimbursement based on a per diem rate.

Each DRG has a set of points, called "trimpoints," at which the claim is considered a short stay, an average stay or a long stay. Short-stay patients usually are those who stay in the hospital from one to three days. Certainly, a hospital would benefit if a patient stayed one day longer than the short-stay trimpoint and, therefore, qualify for a full DRG payment. The differences in reimbursement between a short-stay payment and a full DRG payment can be considerable.

Another cost-containment measure—preadmission review—becomes even more important in a DRG system. Every hospital admission has a good chance of generating a claim for a full DRG payment. A new twist to the preadmission process is incorporating the knowledge that preoperative testing outside the hospital does not always save costs for the employer.

Speaking out

DRG payment was devised to include all ancillary and testing costs required for the care of a patient. In some instances, it may be more cost-effective to have all testing done as an inpatient, so as to avoid paying separate outpatient charges, plus a full DRG payment. A preliminary DRG may be assigned at the preadmission stage to be compared at a later date with the actual DRG assigned to the claim. Discrepancies between the DRG assignment made at the preadmission stage as compared to the DRG assignment made after discharge may serve as a trigger for a DRG validation review.

Once a DRG claim is submitted to the payer, how can the DRG assignment be verified? Hospital charges may have been closely examined and compared with the medical documentation in a traditional bill audit, but this practice is not relevant to a DRG bill. As a result, DRG validation is a critical cost-containment measure.

To see the value of this validation, further explanation of DRG reimbursement is needed.

Each DRG is numerically weighted to reflect the expected level of hospital services required. For example, in New York, DRG 104—"cardiac valve procedure with pump and cardiac catheterization"—has a weight of 8.9695, while DRG 163—"hernia procedures, age 0-17"—has a weight of 0:4524.

The DRG weight plays the most critical role in calculating the hospital reimbursement. Higher-weighted DRGs equal a greater dollar value.

Every case is assigned to a DRG *after* the patient has been discharged. The system is designed so that each DRG group is mutually exclusive, meaning that a case can qualify for placement in only one DRG.

In the three states mentioned above, the number of DRGs ranges from 472 in New Jersey to 518 in New York. New York has the greatest number of categories because it has developed 15 new categories specific to people with acquired immune deficiency syndrome, and another 35 new groups for newborn infants.

In those three states, it is the hospital's responsibility to make the DRG assignment and indicate the DRG number on the claim. A computer program known as a "grouper" is commonly used to make DRG assignments. Although it technically is possible to figure out a DRG assignment without a grouper, it is also extremely time consuming and most hospitals use the computerized method.

The key factors needed to make DRG assignment are: the principal diagnosis; principal procedure; the second, third and fourth diagnoses and procedure codes; and the sequence in which they are ordered.

The grouper formula also needs other data, such as patient age, sex and discharge status. This basic patient demographic information is generally straightforward and easily verified. It is the medical coding that channels the case to the DRG assignment that requires close verification.

A hospital's medical coding can be discretionary, however. As an illustration, the following example was drawn from our case files:

"A patient with lung cancer enters the hospital for treatment. The lung tumor is inoperable so the patient will receive a full course of combination chemotherapy for five days. This infusion chemotherapy treatment will be followed by one dosage of radiation therapy. The patient will then be discharged and the full course of radiation therapy will be given on an outpatient basis."

The hospital may code this case in three different ways, yielding three different DRGs. The above example could appear on a claim coded to fit into any one of the following DRGs:

- DRG 082, "respiratory neoplasms," which carries a weight of 2.1022.
- DRG 409, "admission for radiotherapy," 1.5127.
- DRG 410, "admission for chemotherapy," 0.8331.

If the above case were treated at a hospital with an average DRG payment of $4,000, then DRG 082 would pay about $8,408.80; DRG 409, $6,050.80; and DRG 410, $3,332.40.

One of these DRGs is correct, but which one? Undoubtedly a hospital and payer might arrive at different answers to this question. Hospitals have been suspected of coding in their favor and the results of audits on Medicare DRG payments support this suspicion: A federal study in which a random selection of medical records were reviewed for the correctness of the DRG assignment found that almost 21% of the DRG assignments were in error.

If errors occurred randomly, approximately 50% would favor the hospital and 50% would favor the payer. This, however, was not the finding of the study, which reported that almost 62% of the errors benefited the hospitals. Our own tabulation of randomly selected cases that undergo DRG validation has shown that 70% of the assignment errors favor the hospitals.

One of the most compelling reasons for DRG validation is to address the concerns of health plan beneficiaries with 20% copayment arrangements. Fo those hospital bills where there is a significant difference between the hospital charges and the requested DRG amount—and the difference is in favor of the hospital—patients are prompted to ask, "Why do I have to pay 20% of the DRG bill, when the hospital's actual cost was less?"

The first step in designing an effective DRG validation program is to develop systems to identify claims that should receive DRG monitoring. This involves implementing claim selection criteria so that claims with specific aberrant characteristics are selected for review.

For example, our DRG validation looks for:

- Unsubstantiated second diagnoses.
- Inclusion of secondary diagnosis relating to earlier episodes that have no bearing on the stay being reviewed.
- Designation of principal diagnosis/procedure without a clear medical basis.

Since DRGs are relatively new to non-Medicare cases, payers should examine how this system has been audited in the past and use these techniques as a starting point for improving ways to select cases for review.

With DRG validation complementing existing cost-containment measures like concurrent review and preadmission review, employers in all-payer DRG states are on their way to containing unnecessary health care costs.

Lisa Garrigan is director of corporate planning and development for Island Peer Review Organization in Rego Park, N.Y. IPRO is a national medical review firm that specializes in diagnostic related group validations.

Benefits of coverage limitations

By The Insurance Institute of America

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

This month's exercise, taken from a recent national examination in ARM 56, risk financing, deals with how limitations in insurance policies—such as exclusions and deductibles, which are normally considered to favor insurers at policyholders' expense—may benefit both of these parties to an insurance transaction.

A.R.M. exercises

Q: Some critics of insurance have stated that exclusions in insurance contracts benefit only insurers by reducing their obligations to policyholders, thus raising their underwriting profits. In rebuttal:

- Give two advantages, other than increased underwriting profits, that can be achieved through the proper use of exclusions in policies covering property and net income loss exposures of business firms.
- Explain whether each of these advantages benefits only insurers, only policyholders, or both.

Explain whether you agree or disagree with each of the following statements the president of a small manufacturing company made about the company's property/casualty insurance program:

- "The deductibles in our property insurance policies have so greatly reduced the cost of this insurance that we should have some deductibles written into our liability policies as well."
- "Although reporting form policies on the contents of our buildings and our inventories take time to complete, these forms do increase the efficiency of our insurance program by minimizing the possibility of any overinsurance or underinsurance."

A: For convenience, this answer combines both parts of the question, describing both the advantage of coverage exclusions and explaining the party or parties that benefit from each advantage.

- Among numerous possible advantages of insurance contract exclusions, one is to eliminate coverage of atypical exposures. This limitation benefits most policyholders—who therefore do not need to pay premiums for unneeded coverage—and insurers, who are excused from coverage of the excluded exposure unless they subscribe to, and charge extra for, separate coverage of the normally excluded unusual exposure.

A second benefit of exclusions is to simplify the underwriting process, an advantage usually most appreciated by insurers that normally need not concern themselves with an excluded exposure.

A third group of exclusions clarifies coverage and avoids duplicate insurance, thereby benefiting primarily policyholders—who need not pay for redundant coverage—but also assisting insurers by minimizing potential disputes regarding the existence of coverage and the proper treatment of "other insurance."

- One might agree with some aspects of this statement about deductibles, while disagreeing with other aspects of it.

In disagreement with the notion that deductibles would lower the cost of liability insurance, the quoted statement ignores the need for, and the cost of providing, investigation/defense services that insurers normally furnish without additional cost to policyholders. Furthermore, if an organization were to adopt a substantial deductible for its liability coverages, it might well ultimately retain aggregate losses greater than the premium credits an insurer could feasibly give for a given deductible. Consequently, the policyholder's overall liability risk financing costs would be likely to rise.

To agree with the quotation, one might contend that the cost savings for a policyholder that purchases a liability policy with a deductible would be significant.

These savings could be particularly important with respect to small claims, for which many policyholders can provide more cost-effective claims management than can many liability insurers.

- All aspects of this second quotation appear to be true. Completing the documents required for reporting form coverage can require some time, but proper use of reporting forms does tend to match the value of the policyholder's exposures with the amounts of insurance actually purchased.

The reporting form limits the insurer's liability to the values charged, while charging the policyholder only for coverage equaling these values.

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.

Teaching insurance to children

"My Dad Sells Insurance"
By Richard C. Shaw
Published by Shaw & Co., 18 South Mill, South Glastonbury, Conn. 06073
$33.95

By Alison Kittrell

Books & ideas

It isn't often that we review children's books in these pages, but this one merits a look.

Richard C. Shaw, who has worked in the insurance industry since 1972, wrote this charming book in response to questions from his young son, Richard, about what his father does for a living. Mr. Shaw is president of Phoenix General Insurance Co. in Hartford, Conn., and chairman of American Brokerage Corp., which has 154 employees in Connecticut, New York and Pennsylvania.

In the book—which is based on actual experience—young Richard is assigned a homework project to report on what his mother or father does at work. Richard realizes that he has a clear idea of the jobs held by the parents of his friends John, whose father is a fireman, and Susan, whose mother is an emergency room physician. But he has no idea what his own father does at work.

Richard says, "I knew my Dad sells insurance, but I never really saw him do it." He knows that his father often works long hours and that he has an office with a computer. He knows that his dad talks to people on the phone and that he does a lot of paper work. But, the youngster finally admits, all he knows about his father's job is that, "I think insurance is about papers and money."

So he asks his father to explain. And Mr. Shaw begins by telling his son, "People buy insurance because they love someone that they want to protect, or because they own something that they want to protect." And then he goes on to give young Richard examples of how the insurance he sold to people helped them out in times of trouble.

Finally, Richard is able to write a report that explains to his classmates what his father does. He says, "Insurance isn't something that you can see like a house or a car or food, but it protects you and everybody needs it." And, he concludes his report by saying, "My Dad is proud of what he does, and I'm proud of him, too."

The book does a good job of explaining the theory and practice of insurance in concrete terms that children can understand. And the delicate illustrations reinforce the message.

Despite its title, the book is not sexist and would be just as valuable if it were called "My Mom Sells Insurance."

In explaining why he wrote the book, Mr. Shaw says, "Insurance agents need to be able to clearly explain what they do and why they feel good about it. Certainly popular public opinion about insurance isn't the proper message for our children to use as their learning base."

Phoenix Mutual Life Insurance Co., which owns both American Brokerage Corp. and Phoenix General, agrees and is distributing the book to schools, libraries and its employees.

"My Dad Sells Insurance" is a thoughtful and well-written book that will charm and enlighten the children—and maybe even the spouse or parents—of any dad or mom who deals with insurance.

Excess insurer not liable for primary cover

Legal briefs

The U.S. Court of Appeals for the 5th Circuit held that, under Louisiana law, an excess insurer was not obligated to provide primary coverage or defense to claims covered under the primary policy when the underlying insurer became insolvent.

Steve D. Thompson Trucking Inc. purchased a primary liability insurance policy from Northwest Insurance Co. covering the period May 1, 1982 to May 1, 1983. Thompson also purchased an umbrella liability policy from Twin City Fire Insurance Co. that provided excess coverage for the same period. While both policies were in effect, six personal injury suits were filed against Thompson. Northwest undertook the defense but terminated its defense when it became insolvent. Thompson requested Twin City to indemnify and defend, which it refused to do. Thompson then brought suit against Twin City. The trial court ruled for Twin City.

On appeal, Thompson argued that when the primary insurer became insolvent, the Twin City policy "dropped down" to cover the claims. The court said that an excess insurance policy provides coverage that begins only after a predetermined amount of principal coverage is exhausted. This underlying coverage, the court said, reduces the risk that an excess insurer will have to pay for losses incurred by the policyholder. Furthermore, the court said this reduced risk to the insurer translates into a reduced premium for the policyholder. According to the court, the Twin City policy was clearly intended to provide coverage over and above the coverage provided by the primary insurer.

Steve D. Thompson Trucking vs. Twin City Fire Insurance, U.S. Court of Appeals for the 5th Circuit, Oct. 27, 1987 (*BI*/02/Aug.-$10).

Committee to act on pension portability

WASHINGTON—The House Ways and Means Committee will act on a pension portability bill this year, promises Oversight Subcommittee Chairman J.J. Pickle, D-Texas.

At a hearing earlier this month on pension portability, Rep. Pickle promised bill sponsor Rep. James Jeffords, R-Vt., that the committee would consider the legislation this year.

However, the bill probably will not get to the House floor this year because of time constraints.

The bill, H.R. 1961, unanimously passed the House Education and Labor Committee in April and then was referred to the House Ways and Means Committee (*BI*, May 9).

Under the bill, employers would be required—with three exceptions—to transfer lump-sum distributions from pension plans to an employee's individual retirement account when the employee left the company.

However, the transfer would not be required if the benefit exceeded $3,500, if the benefit is not paid in a lump sum or if the employee was at retirement age when his employment ended.

The assets could remain in the IRA until retirement or could be transferred into another qualified retirement plan.

The bill also would, among other things, allow all employers, regardless of size, to establish a salary reduction feature for simplified employee pension plans. Under the Tax Reform Act of 1986, only employers with 25 or fewer employees may establish a salary reduction feature for SEPs.

Although the Reagan administration has not taken an official stance on the bill, Assistant Labor Secretary David M. Walker said the legislation has "some positive features."

Mr. Walker said the bill is "a modest first step—it's a beginning, not an end."

And, Rep. Pickle called the bill a "good positive approach."

Richard Fay, a partner in the Washington, D.C., office of the law firm of Reed, Smith, Shaw & McClay, representing the Washington-based National Assn. of Manufacturers, said NAM "supports H.R. 1961 as a positive step toward encouraging savings for retirement through expanding opportunities for pension coverage and by providing an alternative to cashing out vested, terminated employees."

However, Alan V. Reuther, associate general counsel for the United Auto Workers union in Washington, said that although the UAW "supports the general policy underlying" the legislation, the bill does not address "the fundamental problem of pension portability—that is, providing some mechanism for workers to carry their credited service from job to job."

—By Deborah Shalowitz

Pension portability

Continued from page 3

employer because the job-hopper's pension benefits upon termination from each plan are frozen and will not reflect salary growth between the time he leaves the plan and the time he retires.

Defined benefit plan participants who have switched jobs "only qualify for a pension benefit that is fixed in amount at the time employment is terminated," explained Alan V. Reuther, associate general counsel to the United Auto Workers union in Washington. "Their pension benefits will then suffer from steadily eroding purchasing power."

In comparison, an individual who changes jobs several times and is a participant of several defined contribution plans will not experience this same retirement income loss if his vested pension assets remain in the plans or are rolled over into an individual retirement account because the assets continue to earn interest.

The Hay/Huggins study, which was released last week, confirmed that retirement income losses among participants of defined benefit plans "are closely related to the number of career job changes."

For example, defined benefit plan participants who held two jobs experienced a 10% loss in the value of their potential private pension benefits, while workers with three job changes had an average loss of slightly more than 20%, the study said. Workers with four job changes lost an average of nearly 25% of the benefits they would have received if they had stayed with the same employer for their entire careers.

The solution to these problems lies in pension portability, said representatives of unions and consumer groups, who outlined ways to make pensions portable.

For instance, Donald S. Grubbs Jr., president of Grubbs & Co. Inc., an actuarial firm in Silver Spring, Md., suggested that a federal portable pension fund be established to permit employers to automatically rollover into the fund the vested pension benefits of a former employee.

This would prevent employees from spending lump-sum distributions from defined contribution and defined benefit pension plans.

Under the Employee Retirement Income Security Act, when an employee leaves a company, the employer may "cash-out" the employee's vested benefits in one lump sum. "Most individuals receiving lump-sum distributions spend these amounts rather than rolling them over" into an IRA, Mr. Grubbs said. "If a portable pension fund were available into which these amounts could be channeled, the pensions could be preserved for the employee while still avoiding the administrative burden upon the employer," he continued.

But, pension experts said that allowing a worker's years of service at one company to be credited toward another company's defined benefit pension plan is not a viable way to make pensions more portable.

The Congressional Budget Office's Ms. Marcuss explained that while "all sponsors of defined benefit plans could be required to recognize a worker's service from a previous employer's plan, such a requirement could work only if all defined benefit plans had very similar rules and pooled their liabilities.

"It is doubtful that businesses and other employers would continue to sponsor single-employer defined benefit plans in such an environment of uniformity," she warned.

Joseph F. Delfico, senior associate director of the human resources division of the U.S. General Accounting Office, pointed out that portability of service credits for defined benefit plans "would pose substantial administrative problems."

For example, "special cost-sharing arrangements would have to be implemented to avoid shifting the entire economic consequences of preventing job mobility loss to workers' final employers," he said.

And, the Hay/Huggins study noted that "it is unlikely that this approach (of service credit portability) could be achieved without also requiring employers to have a pension plan."

"Given the cost of portability of service. . .and the generally heavier regulatory burden borne by defined benefit plans, defined benefit plan continuation and plan formation may be discouraged," Mr. Delfico said.

The Hay/Huggins study said the cost to employers of service credit portability and the improvement in employees' retirement income would depend on the scale on which the proposal is adopted.

For example, one nationwide pension pool that would recognize full credit for all years worked in different jobs could be established. Or, service credit pooling could be instituted on an industrywide or regional basis, the study explained.

Because there is such a wide variation between the effects of these and other service credit pooling proposals, costs could not be estimated, the study said.

Richard Fay, a partner in the Washington, D.C., office of the law firm Reed, Smith, Shaw & McClay, testifying on behalf of the Washington-based National Assn. of Manufacturers, warned that "pension portability, if applied excessively and without regard to employer flexibility, may actually damage the very system it seeks to help."

The Treasury Department's Mr. Steuerle stated that "in evaluating portability proposals, one should remember that pension benefit differentials between mobile and long-term employees may be the result of appropriate employer decisions.

"Pension plans are, first and foremost, an employee benefit offered by the sponsoring employer," he reminded the panel. "In general, the intended purpose of offering any employee benefit is to attract and retain quality employees. Similarly, most employee benefits, particularly company-sponsored pension plans, seek to encourage worker longevity and reward long-term service." ■

ISO pollution endorsements

Continued from page 3

"I'm sure that insurers would be interested in this or we wouldn't put it out," added an ISO spokeswoman. However, she did not know of any insurers who encouraged ISO to develop the endorsement.

Mr. Swalm speculated that the companies that are writing pollution coverage now "are comfortable with what they have"—specially developed EIL forms.

Currently, only three insurers write pollution coverage, and all three write the coverage on a stand-alone basis only (*BI*, March 21).

New York-based American International Group Inc. writes stand-alone EIL insurance with limits of $15 million per claim and $15 million aggregate. The Pollution Liability Insurance Assn. based in Downers Grove, Ill., writes EIL coverage with limits of $2 million per claim with a $2 million aggregate.

Reliance National Risk Specialists, an underwriting division of Reliance Group Holdings Inc. of New York, writes limits of $1 million per claim with a $2 million aggregate.

ECS' Mr. Rosenberg said he is "really leery" of writing pollution coverage on the CGL policy form, noting ECS thinks it is better "to segregate the non-pollution and the pollution" coverage.

However, risk managers like the idea of adding a pollution buy-back to the CGL policy.

"There's certainly a desire to have some options for pollution insurance," said Scott K. Lange, manager of liability and corporate insurance for The Boeing Co. in Seattle.

Lorraine A. Doyle, insurance supervisor for AMAX Inc., a mining company in Greenwich, Conn., said she would prefer to buy pollution coverage on a CGL form because it is easier to deal with one insurer than two.

However, she added that "limits are everything" and questioned how much pollution coverage CGL insurers would be willing to write. The ISO pollution buy-back endorsement specifies it would carry its own aggregate limit.

Mr. Lange said larger companies like Boeing would need to know that excess insurers also would provide pollution coverage above the limits provided by the CGL policy.

Both Mr. Lange and Ms. Doyle said an endorsement totally excluding pollution coverage from the CGL policy is not necessary because the pollution coverage afforded under the current CGL policy is so limited.

"A total exclusion isn't much different than what we've got now," Mr. Lange quipped.

Hartford's Mr. Sterling pointed out that "a number of companies—including Hartford—have their own absolute pollution exclusion" already.

The ISO pollution buy-back endorsement would extend pollution coverage to on-site exposures and ongoing operations and would cover both sudden and gradual exposures. However, neither the current CGL policy or the endorsement would cover government-ordered waste cleanups. ■

Institute blasts OSHA

Continued from page 3

cide. . .Barriers to Job Safety Prosecution in the U.S.," Mr. Kinney pointed out that about 61,000 men and women die each year from work-related injuries or disease.

"Many Americans labor under the myth that the United States has a superior safety record which exceeds most industrialized nations. This is not true; the United States has an annual construction fatality rate of 39 deaths per 100,000," he said, adding that this is higher than the rate in nations like the United Kingdom, Greece, Finland, New Zealand, Spain and France.

The institute cites both OSHA and Justice Department bureaucracy for the lack of criminal job safety prosecutions.

Job safety or health violations are reviewed by seven administrative offices before reaching trial: five within OSHA and two within the Justice Department. "At any step in the process the case can be dropped from consideration," Mr. Kinney wrote.

The report also charges that the lack of prosecutions by the Justice Department reflect a bias toward employers.

However, the report says that job safety prosecutions can be successful, specifically noting the criminal charges filed by the Cook County, Ill., state's attorney's office against the officers of Film Recovery Systems Inc., a now-defunct Illinois firm. The company was fined $24,000 and three of its executives were later convicted of murder and 14 counts of reckless conduct after a worker died from exposure to cyanide.

The three defendants, who were sentenced to 25 years in prison, are appealing the convictions (BI, March 23, 1987).

According to the institute's report, OSHA inspected the Film Recovery plant after the worker's death and fined the company only $4,855 for 20 safety violations.

Where local prosecutors have taken steps to prosecute safety violators, defendants have increasingly argued that OSHA has the sole authority in such matters, Mr. Kinney said.

For example, aggravated assault charges against five Chicago Magnet Wire Corp. executives were dismissed because the firm successfully argued that federal regulations superseded state criminal laws (BI, Dec. 30, 1985). The Cook County state's attorney's office is appealing the dismissal.

Mr. Kinney wants Congress to bar employers from escaping prosecution by claiming that OSHA exempts local laws.

The institute also asks that the OSHA Act be amended to:

- Increase prison terms for safety violators. Criminal violations of the OSHA Act should be a felony offense rather than a misdemeanor. Imprisonment should be increased to up to 20 years from the current six months.
- Mandate that state job safety agencies implement criminal enforcement programs.
- Make assault and reckless management federal crimes. Currently, criminal prosecution is allowed under the OSHA Act only when there is a fatality.

The institute also proposes that the Justice Department:

- Establish an OSHA section to train prosecutors and OSHA inspectors on what is required to build a "sound criminal job safety case."
- Encourage prosecutions by allowing OSHA to refer cases directly to local U.S. attorneys.

And, the institute is asking OSHA, among other things, to:

- Employ criminal investigators.
- Accelerate standards to eliminate occupational diseases and develop strategies to prosecute violators.

In response to the charges in the report, OSHA's Mr. White said the agency has taken the necessary steps to discourage companies and managers from violating OSHA rules.

"OSHA's job is to look at all of the industry and make decisions on a per-case basis. We refer cases to the Department of Justice, but they turned them down. We have ultimately referred to them many more cases than they've prosecuted," Mr. White said.

Copies of the report are available for $15 from the National Safe Workplace Institute, 122 S. Michigan Ave., Suite 1450, Chicago, Ill. 60603; 312-939-0690.

Lloyd's chairman slams Nader report

By STACY SHAPIRO and CAROLYN ALDRED

London

MONTEREY, Calif.—After several weeks of silence, Lloyd's of London Chairman Murray Lawrence is lambasting a report released by consumer advocate Ralph Nader that called Lloyd's "a driving force" behind the liability insurance crisis of the mid-1980s (*BI*, July 11).

The report is full of "misunderstandings, half-truths or straight inaccuracies," Mr. Lawrence said at the 20th Western States Surplus Lines Conference last week in Monterey, Calif.

Mr. Lawrence pointed out what he said were the most important errors in the report published by The Center for the Study of Responsive Law. The allegations in the report parallel many of the charges contained in antitrust suits against the insurance industry filed by 19 state attorneys general.

First, Mr. Lawrence denied the report's allegations that Lloyd's three-year accounting system is a tax break and is used to mislead regulators about profitability.

The three-year accounting system, which is used by other London marine underwriters, "is as valid today as it ever has been," he said. "You will readily understand that to allow that business to develop for 36 months before making that once-and-for-all payment is the shortest practicable period."

Profits cannot be distributed to Lloyd's members for three years after an underwriting year ends, though U.S. investment income is taxed during that period, added Mr. Lawrence, noting the system hardly offers "a tax break."

He also denied the allegation that Lloyd's remains "virtually unregulated in the U.K. and U.S.A." and that "Lloyd's system of self-regulation and limited disclosure has remained essentially unchanged."

Lloyd's is an approved reinsurer throughout the United States, is an admitted insurer in Illinois, Kentucky and the U.S. Virgin Islands and is an eligible surplus lines insurer in all other states, he pointed out. Lloyd's files annual audited financial statements to the U.S. Treasury Department, many state insurance departments and the National Assn. of Insurance Commissioners, he added.

And, in the United Kingdom, Lloyd's must comply with the Insurance Companies Act of 1982 and file audited returns with the Department of Trade and Industry annually, he said. Lloyd's also is required to comply with the Restrictive Trade Practices Act of 1976, Canadian regulations and the European Community directives covering insurance, he said.

And, while Lloyd's regulates itself under the Lloyd's Act of 1982, Mr. Lawrence noted that the Council of Lloyd's has approved more than 60 bylaws since its inception in 1983 and has ratified 43 of the 70 recommendations made by a government reform committee chaired by Sir Patrick Neill.

"Thus I think you will agree that accusation simply does not stand up to an examination of the facts," said Mr. Lawrence.

Finally, the Lloyd's chairman denied that Lloyd's "dominates the world's insurance market," operates "at huge profit levels" and artificially decreases those profits by "mismanaged cash-flow underwriting practices" and "overreserving."

"One really wonders where to start in setting the record straight," said Mr. Lawrence, adding that during 1982 to 1984, the last three years closed under Lloyd's accounting system, Lloyd's total profits were only $855 million. He compared those profits with the huge risks accepted by Lloyd's members, like the Piper Alpha oil rig in the North Sea, the loss of which could cost more than $1 billion (*BI*, July 18; July 11).

He also noted that Lloyd's 1985 results, to be announced in September, will show "that the overall balance will be rather less than we anticipated," later calling Lloyd's profits "hardly a handsome reward for risk run."

Finally, Mr. Lawrence refuted criticism in the report that Lloyd's dominated the U.S. reinsurance market in the mid-1980s when much of the property/casualty industry fled the market.

"Are we to be criticized when in line with our tradition of trying at all costs to provide continuity to our clients, due to the actions of others in withdrawing from the market, we are one of the few or indeed the only market willing to make terms?" he asked.

"What would our critics prefer—a withdrawal of all markets from the business, i.e. a total boycott? I am proud of our underwriters that they still honor the concept of continuity however difficult that might be."

Mr. Lawrence also referred to a July 11 article in *Business Insurance* in which U.S. reinsurance industry leaders refuted that Lloyd's dominates the U.S. reinsurance market.

New syndicates

Lloyd's of London underwriting agencies hope to form 28 new syndicates next year.

Lloyd's Underwriting Agents Registration Committee is processing the applications, which include 23 non-marine syndicates, two marine syndicates, two aviation syndicates and one motor syndicate. Six of the syndicates have been already been approved, a spokesman said.

Neill report

Lloyd's of London is implementing more of the 70 recommendations made in January 1987 by the Neill committee, a government inquiry into Lloyd's self-regulation.

The Council of Lloyd's earlier this month implemented five more regulations regarding the monitoring of underwriting agencies and their shareholding and management structure.

In addition, Lloyd's has published a consultative document regarding the operation of multiple syndicates. The proposals suggest that no parallel syndicate should be allowed to operate beyond a predetermined date without the consent of the council.

However, the proposals say the Underwriting Agents Registration Committee should allow multiple syndicates where "valid reasons are advanced" and where:

- The syndicates have separate active underwriters and underwriting teams.
- The syndicates are mirror syndicates or all business is divided between the syndicates according to a pre-determined formula.
- The arrangement is to provide management for syndicates running off their business.
- The arrangement can be shown to be in the interest of the names. ■

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Coverage ruling against Hartford overturned

By JUDY GREENWALD

ANNAPOLIS, Md.—Hartford Insurance Co. does not have to pay $4.5 million in a business interruption coverage dispute involving a 1985 fire at an Illinois racetrack, says a Maryland appellate court.

The Maryland Court of Special Appeals ordered a new trial in the case, ruling that the jury's verdict was the result of a lower court judge's incorrect jury instructions.

Cheverly, Md.-based Allegheny Beverage Corp. and operating subsidiary Service American Corp. of Stamford, Conn., had sued Hartford and broker Tanenbaum-Harber Co. of New York over business interruption coverage for a food concession at Arlington Park Racetrack in Arlington Heights, Ill. The racetrack was destroyed by fire in July 1985 (*BI*, Aug. 5, 1985).

At issue was whether Allegheny's $5 million business interruption coverage included unscheduled locations. Arlington Park was among those locations not named in Allegheny's all-risk policy, which was delivered to Tanenbaum on July 23, 1985, just one week before the fire.

Allegheny contended in its suit, which was tried in the Circuit Court for Prince George's County in Upper Marlboro, Md., that either Hartford or Tanenbaum was liable for the company's losses. Judge Robert Woods agreed and instructed the jury to determine which of the parties was at fault and for how much.

The jury decided Hartford was liable for $4.5 million in damages (*BI*, July 27, 1987).

However, the Court of Special Appeals decided the judge should never have given those instructions because of evidence "which could have exonerated both defendants," said attorney William J. Cassidy Jr. of Washington, D.C.-based Hogan & Hartson, who represented Hartford. "It was an issue which should have been left to the jury."

Since the original trial, Service American, which is now known as Servam, has been spun off from Allegheny and is proceeding with the case on its own. Donna S. Mangold of Washington, D.C.-based Cooter & Dell, which represented Allegheny and now represents Servam, said no decision has been made on whether to appeal the latest decision to Maryland's highest court, the Court of Appeals.

John Spellman of Washington, D.C.-based Hamel & Park, which represented Tanenbaum, said the brokerage has not decided if it will appeal.

"We're disappointed, naturally, that the jury verdict is reversed," said Mr. Spellman, though he is confident that if the case is retried, "a jury will once again find that Tanenbaum has no liability."

According to the appellate ruling, the case began in early 1985, after Allegheny's previous insurer, Allianz Underwriters Insurance Co., did not renew Allegheny's coverage. Allegheny was then in the process of acquiring Servam.

Allegheny's director of risk management at the time, Lynn Gold, gave Tanenbaum specifications for its policy that stated business interruption insurance was to be provided at "scheduled locations as per attached schedule."

In March 1985, Tanenbaum provided Hartford with these specifications, as well as an incomplete list of several hundred Allegheny locations that did not include the racetrack. Based on this list, Hartford prepared a quotation.

"From this point forward," says the decision, "the testimony is in dispute":

- Mr. Gold says he ordered business interruption insurance in May 1985 for both scheduled and unscheduled locations.
- Tanenbaum claims the specification submitted to it by Mr. Gold did not request such coverage, but that the brokerage asked for it anyway because Allegheny's previous policy included unscheduled locations.
- Hartford says it had stated at an April 15 meeting that it could not provide coverage at unscheduled locations.

Among other evidence in dispute is interpretation of a binder requested by Tanenbaum that removed two locations from the blanket coverage and assigned them individual values. Tanenbaum included the phrase "extra expense and business interruption is blanketed at all locations for $5 million combined limit."

Tanenbaum states this included all non-scheduled locations, while Hartford claims it only describes coverage then in effect for all scheduled locations, the decision says.

The final policy, as submitted, did limit business interruption coverage to specific locations "per schedule on file with the company." But Tanenbaum says that when the brokerage called Hartford to point out this error, it was reassured that there was coverage at unscheduled locations as well.

In calling for a new trial, the appellate decision states that "the effect of the court's ruling is to say that it is manifest that there is no rational basis upon which a verdict in favor of both defendants can be returned. . . We disagree.

"Reviewed in the light most favorable to Hartford and Tanenbaum, there are disputed facts from which a jury could have returned a verdict for both defendants."

For instance, the decision notes there is disagreement as to whether Mr. Gold ever ordered business interruption insurance for unspecified locations.

"Whether Gold's, Hartford's or Tanenbaum's testimony should be credited was a matter for the jury to decide, not the court," says the decision.

Referring to the incomplete list of locations submitted by Mr. Gold, the decision states also that the risk manager rejected Tanenbaum's offer to go to its headquarters and verify the number of facilities involved.

"Whether (Allegheny) through Mr. Gold negligently failed to cooperate with Tanenbaum in obtaining the coverage for locations that would ordinarily be scheduled was a matter for the jury to resolve," the court said. "A jury may well have concluded that ABC's failure to provide underwriting data available to it excused both its broker and the insurer from liability.

"The court's ruling deprived the jury of an opportunity to consider and decide those issues," states the decision.

Ms. Mangold, Servam's attorney, criticized the ruling.

"We say it cannot be the plaintiff's fault," she said. The reason Mr. Gold bought coverage for unscheduled locations, she said, is "because he didn't know what he had out there. I think the opinion just ignores that." ■

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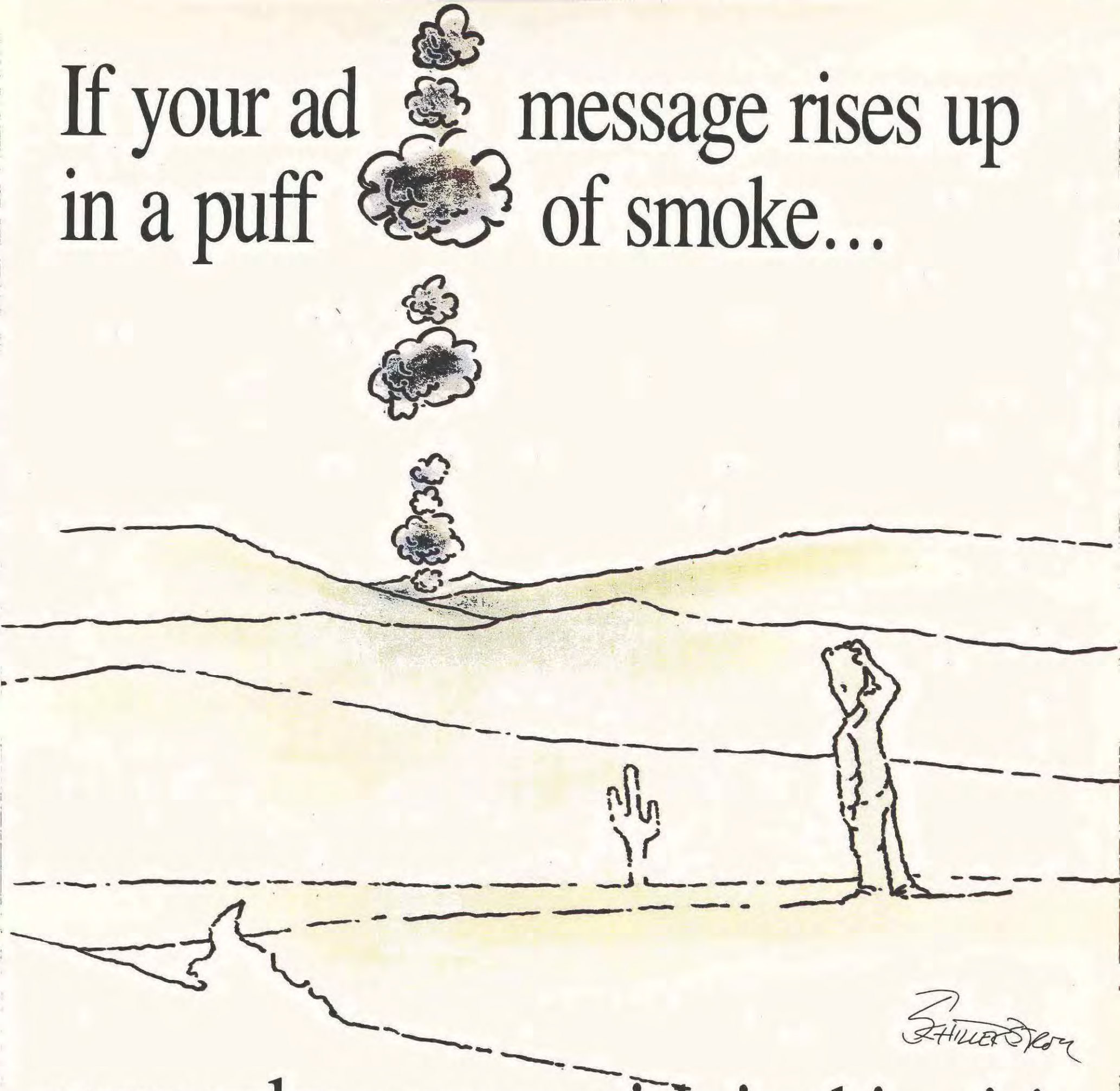

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Contributions sought in memory of Weber

MINNEAPOLIS—The Minnesota Chapter of the Risk & Insurance Management Society Inc. is matching contributions made to a hospice in memory of risk manager Howard T. Weber.

Mr. Weber, formerly director of insurance for Minnesota Mining & Manufacturing Co. in St. Paul, died in April at age 61 after a year-long illness. He had asked that any contributions in his memory be made to Fairview Southdale Hospice in suburban Minneapolis.

The Minnesota Chapter of RIMS is accepting contributions to the hospice in Mr. Weber's memory and will match each contribution it receives. At the very least, the chapter will donate $500 to the hospice in Mr. Weber's memory.

Mr. Weber was a pioneer in the development of risk management during his 30-year career with 3M and was a teacher to many risk managers around the country through numerous speaking engagements and personal contacts. He joined 3M in 1957 as insurance supervisor and was named director of insurance in 1970.

3M's Howard T. Weber was named the first *BI* Risk Manager of the Year in 1978.

His leadership in the development of risk management was nationally recognized when he was named the first *Business Insurance* Risk Manager of the Year in 1978. At the time, he said, "If I spend the rest of my career in the insurance department at 3M, it will be a big enough job that I'll never get bored."

Mr. Weber considered among his greatest accomplishments helping in 1978 to launch Bermuda-based Corporate Insurance & Reinsurance Co. Ltd., a reinsurance facility for captive insurance companies.

"He was the moving force that got CIRCL going and kept it going. He originated a lot of ideas and was a very strong supporter of the concept that risk-sharing was a workable deal," recalled Duane Allen, who worked closely with Mr. Weber in the development and operation of CIRCL when Mr. Allen was assistant treasurer at Hanna Mining Co. Mr. Allen now has his own consulting practice, Applied Risk Services Inc., in Laguna Hills, Calif.

Richard L. Casey, who as director of risk management at Chicago-based Navistar International Corp. also worked side-by-side with Mr. Weber on risk management projects, said: "One of his real contributions was he was one of the real innovators in risk management. He's one of the few that over the years gave back to risk management as much as he got out of it."

Mr. Weber "was always on the leading edge of the changes taking place in the insurance industry, whether it was deductibles, captives or claims-made forms. And he made contributions to each one of these areas," said Mr. Casey, who now is risk manager for The Estes Co. in Phoenix, Ariz.

"His contributions go back ever. before RIMS," Mr. Casey pointed out. "He was very active in the AMA, too," he said, referring to the American Management Assn.'s insurance council.

Contributions in Mr. Weber's memory are being accepted by Minnesota RIMS Chapter Treasurer William Dacus, Casualty Insurance Manager, Land O'Lakes Inc., P.O. Box 116, Minneapolis, Minn. 55440. Checks should be made payable to the Minnesota Chapter of RIMS.

—By Kathryn J. McIntyre

Products & services

A.C.E. to write D&O cover on separate policy form

Bermuda-based A.C.E. Insurance Co. Ltd. now offers a separate excess directors and officers liability policy rather than a D&O endorsement to its excess liability policy.

However, policyholders are still required to buy excess liability coverage from A.C.E. to purchase the separate D&O coverage, said William Loschert, A.C.E.'s executive vp-underwriting.

The separate policy will provide uninterrupted D&O coverage to policyholders whose excess liability coverage is canceled or expires, Mr. Loschert explained.

Among other changes:

- The new form follows the terms of any designated underlying policy. The endorsement followed only the primary D&O policy.
- Multiple claims from the same "wrongful act" are subject to one liability limit.
- Policyholders 30 have days to obtain replacement coverage in the event of an underlying insurer's insolvency. The D&O endorsement stipulated that coverage ceased immediately in such cases.
- A.C.E. will automatically follow any changes made in the underlying policy if the policyholder pays A.C.E. any reasonable additional premium required.
- A policyholder can elect discovery coverage if the policyholder fails to renew or cancels the policy. Previously, a policyholder could elect discovery coverage only if A.C.E. canceled or refused to renew.
- The location of mandatory, binding arbitration is moved to Bermuda from London.
- The D&O liability policy is available on a three-year basis, if a policyholder's entire D&O program is on a three-year basis.

Premiums will be fixed in advance and pre-paid and reserve premium requirements will be waived, Mr. Loschert said.

A.C.E. writes D&O claims-made limits of up to $50 million excess of at least $25 million at a minimum premium of $2,500 per $1 million.

—By Roger Scotton

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Claims-made

Continued from page 1

ity or possibility the appellate court will rule against them, buy their way out of an unfavorable precedent often at a relatively cheap price asked by the single opponent in that appeal.

"This would tend to inhibit appellate judges from asking tough questions at oral argument which might suggest the direction of their thinking. It would result in the squandering of public resources on the research, analysis and writing of opinions which never get filed though they resolve issues of great public import. And it could even distort the law by allowing parties who possess ample means to prevent the filing of adverse precedents while those without means are unable to do so."

However, an attorney for National Union said the policyholder asked for the settlement—originally demanding $300,000 and lowering its request after oral arguments. He said National Union settled the case because it was cost-effective and not to avoid an adverse precedent.

Eugene R. Anderson, a policyholder attorney with Anderson, Russell, Kill & Olick in New York, said "The decision will put a stop to the practice of insurers, when seeing they have lost a case, getting a decision off the books."

Several other rulings that "in effect convert claims-made policies into occurrence policies" have been wiped off the books by insurers through settlements, he noted.

For example, a virtually identical decision by the 9th U.S. Circuit Court of Appeals in a case between National Union and 49 California lawyers was withdrawn because National Union negotiated a settlement after the decision was reached (*BI*, Oct. 19, 1987; Aug. 31, 1987).

Other attorneys, however, are angry with the decision.

"Courts are not in the business of giving advisory opinions of disputes that are resolved" said insurer attorney Royal Oakes with the Los Angeles office of Barger & Wolen. He fears "other courts will begin overriding settlements and rewriting insurance policies."

The controversial ruling stems from litigation between Village Escrow Co. of Rolling Hills Estates, Calif., and National Union. Village Escrow had a $1 million per-claim errors and omissions policy with National Union from March 1, 1983, to March 1, 1984.

Dissatisfied clients of Village Escrow sued the company on Nov. 8, 1983. However, Village Escrow was not aware of the lawsuit until it was served notice on April 18, 1985.

Village Escrow turned to National Union for defense of the claim, but because the claims-made policy had expired by the time Village Escrow notified National Union of the claim, the insurer denied coverage.

As a result, Village Escrow sued National Union on Sept. 12, 1986. But the trial court agreed with the insurer's argument that there was not enough information to warrant a reply and dismissed the case.

In his appellate court ruling, Judge Johnson said: "An insurance company cannot deny coverage under a claims-made policy to an insured who belatedly reports a lawsuit to a company which had been filed during the policy period, but not served . . .until after the policy expired."

Judge Johnson, who was joined by Judges Mildred Lillie and James Reese, relied on a long-standing California case law principle that prohibits insurers from denying coverage because of late notice unless it can prove the late notice prejudiced its ability to defend against the claim.

Furthermore, the judge said the "triple hurdle" policyholders must meet under some claims-made policies, which require the occurrence, the filing of the claim and the reporting of the claim to occur inside the policy period, is too restrictive.

The so-called notice-prejudice rule is based on the public policy that a person injured by the policyholder should not be denied compensation because the policyholder failed to notify the insurer in a timely fashion.

Judge Johnson said, "Where the claim was actually made, that is, the lawsuit filed within the policy period, the insurance company is no more prejudiced by a delayed reporting of the claim under a claims-made policy than if the claims were belatedly filed under an occurrence policy."

The judge also said the facts in this case compel use of the notice-prejudice rule because the late notice was not the fault of the policyholder.

"Here the delay in reporting the claim is not attributable to any laxity on the part of the insured in notifying the insurer about a claim the insured knew about. Instead, if the allegations of the complaint are proved to be true, the delay was the product of the insured's own ignorance about the existence of the claim," said Judge Johnson, who remanded the case to the lower court.

The judge also decided the wording of National Union's claims-made policy was too restrictive.

He interpreted the policy to say that "coverage is limited to cases where the injury occurs rather early in the policy period and the injured party acts expeditiously to file his lawsuit."

However, the judge said, "An occurrence even halfway through the typical policy period of one year is unlikely to generate a lawsuit before the end of the period."

Under California law, "National Union must honor this unknown but 'made' claim," the judge concluded.

Some attorneys say the ruling transforms a claims-made policy into an occurrence policy.

"The court is once again transforming a claims-made policy into one that is liable forever," said insurer attorney Mr. Oakes.

He predicted that insurers, as a result of the ruling, might adjust the policy forms they offer, raise rates or simply not write claims-made coverage in California.

"Real damage has been done to insurers," he said.

Furthermore, the case could be precedential outside California because "courts all over the country follow the lead of California," Mr. Oakes said.

R. Gaylord Smith, an attorney with Lewis, D'Amato, Brisbois and Bisgaard in San Diego, who represented National Union said, "The court has done damage to insurers in two ways: First they have done violence to this form; second, they have given insurers no confidence that the language in policies will be honored by courts."

"The opinion does not convert a claims-made policy into an occurrence policy totally, but it does violence to its intent," he said.

Other attorneys, however, say the decision will have little impact.

"It was a narrow holding because it arises only where a claim is filed but not served," said Thomas Brunner, who represents insurers from the Washington, D.C., office of Whiley, Rein & Fielding.

Policyholder attorney Mr. Anderson praised the decision, saying "it supports a layman's view and a relatively sophisticated insured's views of what the public should be able to buy."

"I think more courts will change claims-made policies into occurrence policies," Mr. Anderson predicted.

Terence McGaughey, an attorney with Tremaine, Shank, Stroud & Robbins in Los Angeles, who represented Village Escrow, said the decision was "very fair" because his client was unaware it had been sued and therefore could not notify the insurer in a timely manner.

"Why should my client and the public in general be prejudiced by something beyond their control?" Mr. McGaughey asked.

Furthermore, he said the decision "is indicative of a number of cases where the court wants an equitable interpretation of insurance policies so the reasonable expectations of policyholders are met." ■

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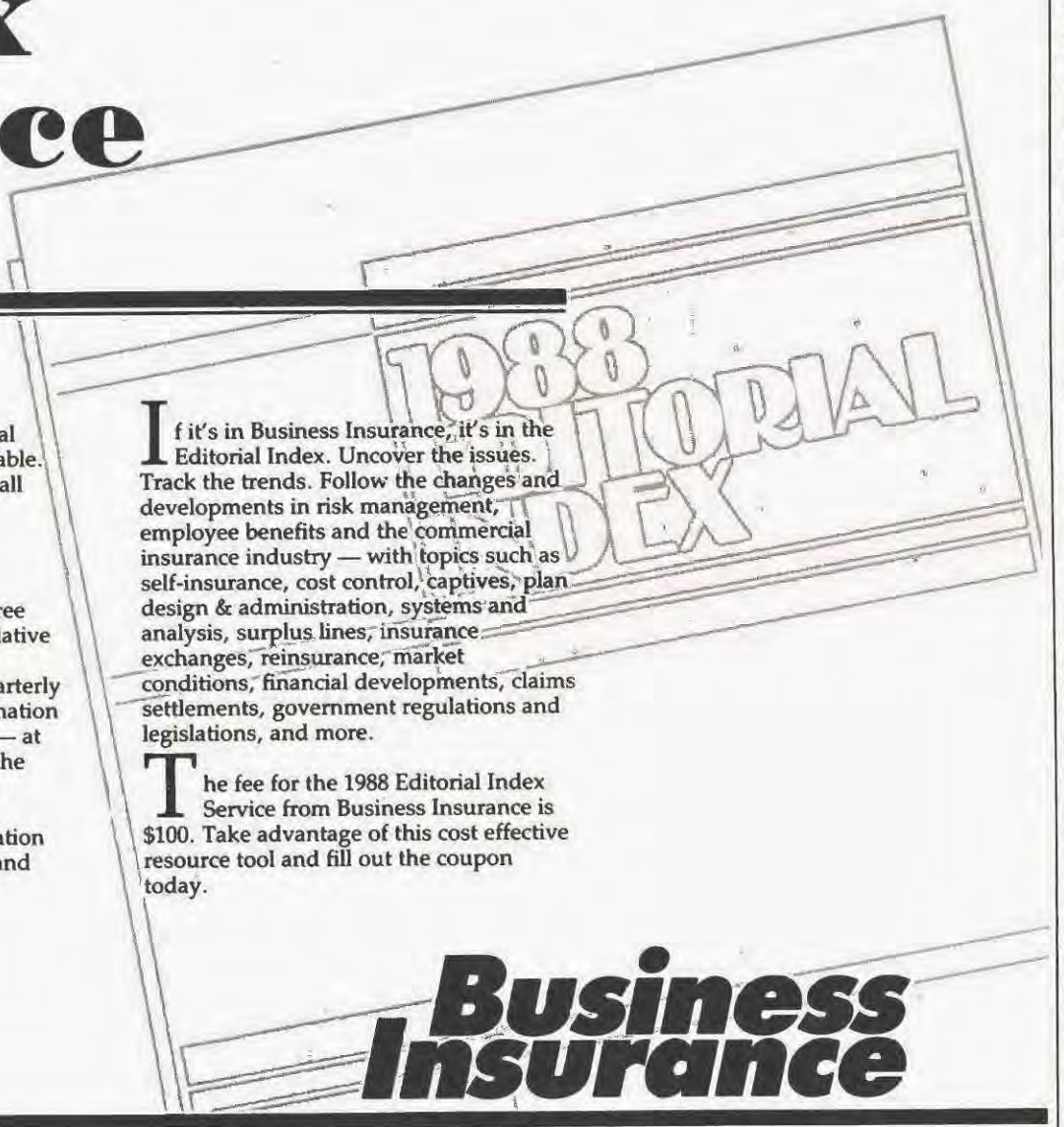

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Business Insurance

First Interstate disaster plan

Continued from page 3

the worst skyscraper fire in downtown Los Angeles history erupted, nearly all bank services were available to customers.

The middle-of-the-night efforts that allowed the bank to provide customer service practically without missing a beat resulted from a $1.5 million plan First Interstate had developed over the past two years to handle the aftermath of the long-predicted major earthquake.

The bank's response to the fire, which caused just a fraction of the damage that a devastating earthquake would cause, returned more value than the bank's investment in emergency planning, Mr. Emerson pointed out.

"None of the managers here would quibble with money spent on it," he said, explaining that the $1.5 million was spent to develop the staffing plan and equip the emergency center with telephones, televisions, copiers, facsimile machines and other needed items.

The outlay also paid for disaster packages, including water, food rations and first-aid supplies, which were distributed to each floor of the headquarters building and to the bank's branch offices.

If the fire had occurred before the response program was in place, it "would have been very painful," Mr. Emerson said, referring to the potential business interruption losses the bank may have suffered.

'None of the managers here would quibble with money spent' on the plan, says Mr. Emerson.

The building owners—First Interstate Bancorp and New York-based Equitable Life Assurance Society of the United States—have not yet announced a damage estimate, but spokesmen say the structure was fully insured (*BI*, May 16; May 9).

Part of the plan included running practice drills, one of which was run less than a month before the fire. On April 14, the 20 key bank managers moved into the communications center for a disaster simulation that was assumed to be a major earthquake, explained Edmund J. Pistey, First Interstate Bank of California vp and director of security.

The drill, which lasted several hours, helped prepare the stage for the real-life drama that would unfold just a few weeks later.

"It's a very complex process. You're looking at literally thousands of tasks that need to be done," Mr. Emerson said, ranging from telephone calls to other employees to extensive efforts to notify other financial institutions, customers and suppliers about the interim communications plans.

The drill taught bank officials that little can be predicted in an emergency and they would have to rely heavily on "good common sense," Mr. Pistey said. For instance, when a designated individual or supplier could not be located, alternatives were needed quickly without bothering other employees who were also burdened with their own tasks.

The communication center, both in practice and in the real emergency, proved to be valuable beyond expectation, bank officials said.

"We had a center for people to go, for people who need to respond," Mr. Pistey said. "It's reassuring to know that you have a structure to build on, somewhere to go."

The communications center is located about seven blocks from the bank in the basement of a building that houses the bank's computer center. The 20 emergency response team members who staffed the center while the fire still raged in the bank's headquarters monitored news and police reports and consulted a prearranged diagram of the bank to identify which functions were disabled or in danger and would have to be handled at another office. It was only after the fire was extinguished that city fire officials determined the entire building would have to be closed.

"During the emergency it was wall-to-wall white boards around the room," Mr. Emerson said. The boards designated which floors were reportedly engulfed by the fire and what banking operations were located on each.

The fire blazed through most of five floors, all of which were occupied by the bank or its parent company. Water severely damaged several lower floors.

One maintenance worker was killed when he rode to the flame-engulfed floors on an elevator. About 40 other people were injured, but none seriously.

Considering the circumstances, the response went smoothly, Mr. Emerson said. Hectic, intense work followed, but most of it was done as a matter of course rather than in in a panic reaction, he said.

"When you have a process in place people don't panic. They know what to do," Mr. Emerson said.

Emergency response team members understood their positions and knew what needed to be accomplished. For days after the fire, they followed a program that was not unlike a paramilitary operation:

- Some 900 telephones were installed within two days at the temporary center, other bank branches and other temporary quarters.
- The bank's approximately 1,500 bank employees were relocated and put back to work within seven working days. They were spread through First Interstate's surviving office space at other locations, branch offices and other space that was leased immediately following the blaze.

Although alternate work locations were not prearranged, bank officials had information about the space required by each department and could track available office space at its own facilities and leased offices in the Los Angeles area.

- The bank first arranged for additional office space throughout the area, but has since reduced the amount of leased space as operations became more routine and, thus, could be consolidated at other locations, Mr. Emerson said.

The idea of an emergency response plan was first seriously discussed about three years ago when several major California banks began to consider how they would operate in the aftermath of a devastating earthquake.

First Interstate commissioned accounting firm Ernst & Whinney in Los Angeles to conduct a complex financial analysis to determine how much money the bank would lose if its various banking functions were inoperable over various time periods, Mr. Emerson explained.

After the firm identified securities trading and commercial accounts as the bank's most critical operations, an in-house team developed a list of actions the emergency response team would have to complete for the bank to continue those operations uninterrupted. Other bank functions—like consumer lending, check processing and real estate—were placed on pri-

Continued on next page

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First Interstate disaster plan

Continued from previous page

ority lists and dealt with as other work was completed, Mr. Emerson said.

A key feature of the response plan was giving lower levels of management important roles. "You have to get your line management involved from the beginning," he said.

Among the many provisions in the emergency response plan, First Interstate set up a redundant data processing system that stores transaction information in seven locations throughout the West.

While First Interstate emphasized data processing security, that was not the most important element of the plan, Mr. Emerson said. Communications between all parties, from clerks to suppliers to top management, was most critical, he said.

In addition to the telephone calls to employees and major clients and the temporary communications links established as the fire raged, the bank developed an employee newsletter on post-fire issues and established a reporting process for displaced employees.

As a result, managers in each banking unit knew what was needed from suppliers, employees and others to resume normal operations, Mr. Emerson said.

Other than the dramatic television coverage of the fire, branch bank customers would have had little reason to know that First Interstate of California was facing its greatest challenge on May 5: All customer services including personal banking and commercial accounts were handled as usual the next day, he said.

A temporary branch was established in a nearby building to handle customers served by offices in the skyscraper.

Measures were taken to assure that investment of bank funds continued, including sending most of its securities trading division to offices as far away as Tokyo, London and New York. About 250 securities traders were dispatched from Los Angeles to other offices. They were soon called back when temporary work space was located in the city, he said.

The bank's operations have slowly returned to some degree of normalcy, even though employees are still working in makeshift quarters without such conveniences as their regular telephone number files.

Cleanup of the 62-story building started in early June with occupancy of upper floors not scheduled until late August.

The bank and First Interstate Bancorp had occupied 62% of the building. About 20% was leased to tenants. The remainder of the building was unoccupied.

The building owners have hired Blackmon-Mooring-Steamatic Catastrophe Inc., a Houston-based company that specializes in disaster cleanups, to restore the building.

The 12th through the 15th floors suffered the worst damage: Little more than the bare building structure was left.

"Four floors will have to be totally rebuilt from the glass in," Mr. Emerson said. He praised the Los Angeles Fire Department, which was "absolutely extraordinary" in stopping the fire before it consumed the entire structure. ■

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COBRA changes

Continued from page 2

Under this provision, the right to obtain COBRA coverage would begin from the date of reduction of hours and continue for 18 months rather than 36 months as under current law.

The House technical corrections legislation also contains several other provisions affecting employee benefit programs. The legislation would:

- Retroactively extend the tax-favored status of employer-provided educational assistance benefits for three more years, but lower the benefit.

'A tax committee is looking for ways to squeeze tax revenues. That is not a good way to set educational priorities,' says Diane Charles, national affairs representative of the American Society for Training & Development.

Under Section 127 of the Internal Revenue Code, which expired on Dec. 31, 1987, employees had been allowed to collect up to $5,250 annually in reimbursement from their employers for tuition and related expenses without being taxed on the amounts.

The technical corrections provision would retroactively extend Section 127 through Dec. 31, 1990, but lower the maximum annual benefit to $1,500.

- Impose higher federal taxes on older employees and future retirees who receive company-paid group term life insurance exceeding $50,000. This would be accomplished by directing the Treasury Department to draw up new tax tables for those over age 64.

The current tax tables, establishing how taxes are to be computed on employer-paid premiums for coverage exceeding $50,000, stop at age 64.

As a result, a 70-year-old employee now is taxed at the same rate as a 64-year-old even though the employer pays a much higher premium for the coverage.

The technical corrections legislation also makes a series of changes to simplify and clarify Section 89 non-discrimination rules for welfare plans, which are scheduled to go into effect Jan. 1 (*BI*, July 11).

On the risk management side, the technical corrections bill would give some retroactive, but temporary, relief for self-funded workers compensation pools that have been hit by big tax penalties from the Internal Revenue Service (see related story).

The proposed changes in COBRA penalties mark the second time that the House Ways and Means Committee has added such provisions to a technical corrections bill.

Last year, the committee and later the full House passed a technical corrections bill with COBRA penalty provisions as part of a deficit reduction package.

However, the entire technical corrections bill, including the COBRA penalty provisions, was later killed by a congressional conference committee (*BI*, Dec. 14, 1987).

At the time, business lobbyists, who have been pressing for revised COBRA penalty provisions ever since the law went into effect in 1986, were not concerned about the setback.

They said the delay would give them more time to lobby congressional staffers to refine the COBRA penalty provisions.

Indeed, employers feel the latest penalty provisions approved by the Ways and Means Committee are an improvement over those approved last year.

For example, while the current measure sets a $500,000 limit on an employer's COBRA liability, last year's technical corrections bill did not limit the penalty.

However, even a $500,000 maximum penalty "can still result in excessive penalties and appear to be out of line with other penalties imposed in the (Internal Revenue) Code and under ERISA," according to the COBRA position paper prepared by the five business groups.

At the same time, $1,000 should be set as the maximum penalty per beneficiary, the business groups say.

Without such a limit, a COBRA compliance failure—assessed at the rate of $100 a day per beneficiary—could result in a penalty that could be more expensive than the cost of health care coverage for an employee for the entire year.

"Significant amounts of human resource dollars that otherwise would be used to meet the health care needs of current employees and dependents would be spent on excessive penalties," the business groups say.

Business groups previously objected to the provision allowing former employees to retain COBRA coverage after they become covered under another employer's health care plan.

That provision was added to the technical corrections bill in April (*BI*, April 11).

Such "double coverage" would allow employees to belt former employers with big health care claims, they say, adding that such a change has no place in a technical corrections bill.

And, while benefits observers are relieved that the technical corrections bill retroactively extends the tax-free status of educational assistance benefits for three more years, they are disappointed that the measure sets the maximum benefit at just $1,500 compared with $5,250 under the now-expired Section 127 of the Internal Revenue Code.

"A tax committee is looking for ways to squeeze tax revenues. That is not a good way to set educational priorities," said Diane Charles, national affairs representative of the American Society for Training & Development, an Alexandria, Va.-based trade group.

Lowering this maximum tax-free educational assistance benefit would have its greatest impact on employees who take courses at private colleges and universities whose tuition is much higher than that at public institutions, noted Denise Georgemiller, a consultant with Hewitt Associates in Lincolnshire, Ill.

In addition, the technical corrections bill would bar the use of tax-free educational assistance benefits under Section 127 to reimburse employees for most graduate work other than for graduate teaching or research assistance.

The group term life insurance proposal would impose some hefty tax increases on the handful of employees who stay on the job after age 64 as well as some future retirees.

Premiums paid by employers for group term life insurance coverage exceeding $50,000 are added to an employee's taxable income.

Treasury Department tax tables explain how the cost of coverage—based on the age of an employee or retiree—is to be computed and added to taxable income.

For example, based on a monthly tax table rate of $1.17 per $1,000 of coverage, an employee between age 60 and 64 with $100,000 of coverage would have an additional $702 in taxable income.

Since the tax tables stop at age 64, those 65 and older receive a tax break since their cost of coverage is computed as if they were between 60-64.

However, the technical corrections bill would direct the Treasury Department to draft new tables—presumably also with five-year age brackets—for those over 64.

As a result, instead of facing the current monthly tax rate of $1.17 per $1,000 of coverage, the new rate for a 65-year-old would be about $2 per $1,000 in coverage, while the rate for a 70-year-old would be about $3.50 per $1,000 of coverage, estimated Larry Tucker, a consultant in the Santa Ana, Calif., office of benefit consultant Hewitt Associates.

However, relatively few employees stay on the job after they reach the age of 64.

In addition, employers often reduce the amount of term life insurance they offer when an employee turns 65 and either eliminate or substantially reduce term life insurance coverage after an employee retires.

Furthermore, a grandfather provision in the 1984 tax law generally exempts retirees who turned age 55 on or before Jan. 1, 1984, from being taxed on group term life insurance premiums paid by their former employers.

"When you add everything up, drawing up new tax tables would have a significant impact, but only on a small number of people," said John Hickey, a partner with Kwasha Lipton in Fort Lee, N.J. ■

Michigan comp pools may get some relief

WASHINGTON—A technical corrections bill now pending before the House would provide limited but important tax relief to self-funded workers compensation pools in Michigan that have locked horns with the Internal Revenue Service.

A provision in H.R. 4333 would bar the IRS from slapping workers compensation pools with deficiency assessments involving tax deductions taken on policyholder dividends. However, the measure would only provide protection for assessments for tax years prior to Jan. 1, 1987.

The IRS and the pools have been battling over the timing of tax deductions the pools take on dividends paid to employer members.

Traditionally, after claims are paid, the pools return excess premiums to employers as a dividend. The pools take a tax deduction at the time the dividend is declared.

However, in Michigan, as in many other states, pools are required to hold any excess premiums for at least one year before returning them to members as dividends to ensure that the money is there to pay claims. As a result, dividends declared in one year are not actually paid until the following year.

Under the IRS interpretation, the pools may not deduct dividends until they are actually paid, not when they are declared.

The IRS, in one case, told the Detroit Tooling Assn. Workers Compensation Fund in Dearborn that it owed about $18 million in back taxes, penalties and interest after a plan audit. The pool is fighting the claim in U.S. Tax Court; a decision is not expected until next year.

The IRS, which had limited its audits to Michigan pools, stopped those audits after Congress in late 1986 passed a moratorium suspending audit activity and barring the agency from taking steps to collect back taxes. The moratorium expired last August.

While the provision in the technical corrections legislation only provides retroactive relief, it is a step in the right direction, said Jim Goldberg, a partner with the Washington law firm of Abrams, Westermeirer & Goldberg.

However, the measure would—apparently starting with the 1987 tax year—eliminate the pools' ability to take full tax deductions for all dividends declared but not paid during a tax year.

According to a committee description, a workers compensation fund could not take an immediate tax deduction for dividends that are subject to state regulatory approval.

—By Jerry Geisel

Antitrust litigation opposed

Continued from page 3

trust litigation is considerably stronger than national RIMS' policy on the litigation. The national organization issued a statement in April that took positions only on the public policy issues raised by the litigation and concluded by calling for greater funding of state insurance departments (*BI*, April 25).

Mr. Harkavy said he does not see the Rocky Mountain Chapter's campaign "as a schism within RIMS. We encourage our local chapters to take positions on state issues, and this is certainly a state issue."

If another chapter were to take a position in favor of the suits, "it would have been fine with us, too," Mr. Harkavy said.

To date, the only official response to Mr. Fisher's letters has been a letter from state Attorney General Woodard rejecting Mr. Fisher's request that the suit be withdrawn.

"I'm not as optimistic now as I was when I first wrote the letter" that Colorado will withdraw from the litigation, Mr. Fisher said. Nevertheless, "It's very important we, the local risk management community, make our views known to the elected officials.

"In the past, we've taken too passive a role in the legislative area. We should be more pro-active in making our views and ideas known to the attorney general, the governor and the Legislature," Mr. Fisher said.

In his June 20 letter to the office of Gov. Roy Romer, Mr. Fisher asked whether the governor concurs with Colorado joining the antitrust suit in light of his previous statements about making Colorado a major insurance center.

Efforts in this direction include the 1987 amendments to the Captive Insurance Company Act, which was intended to make Colorado a more attractive captive domicile (*BI*, March 30, 1987). As part of the effort, Colorado sponsored a booth at RIMS' annual conference in Washington in April.

'In the past, we've taken too passive a role in the legislative area. We should be more pro-active in making our views and ideas known to the attorney general, the governor and the Legislature,' says Rocky Mountain RIMS Chapter President Samuel Y. Fisher Jr., insurance manager at Denver-based Hamilton Bros. Oil Co.

"By having Colorado join in with the other states in this antitrust lawsuit will only further convince the very people we are trying to influence that Colorado is not serious in its efforts," said Mr. Fisher in the letter. "The state can no longer afford to send out mixed signals to the business community."

Mr. Fisher asked the governor to make a "strong public statement" against Colorado having joined in the lawsuit.

To date, there has been no official response to the letter. Chuck Marshall, corporate risk manager at Hamilton and Mr. Fisher's superior, said he was informally told last week by a gubernatorial representative that there would be no response for now because the attorney general has independent constitutional authority to pursue the suit.

In his June 30 letter to Attorney General Woodard, Mr. Fisher noted risk managers are "justifiably resentful of the treatment that we have received from our insurers during the past decade" and have sought alternatives to the traditional insurance market such as captives and risk retention groups.

While risk managers acknowledge the necessity for smoothing out the underwriting cycle, "based on our experience and knowledge of the insurance industry, this lawsuit is definitely not a help, much less the answer to the problem," Mr. Fisher wrote.

"Is there any evidence that Colorado laws were broken?" he asked. "What benefits can accrue to Colorado having joined a minority of states by also filing an antitrust suit? If the insurance industry were found to be guilty of antitrust violation in one of the eight pending suits, would not that be a better time for the state to initiate action, instead of now?"

In his reply to Mr. Fisher's letter, Mr. Woodard said he believes that, in response to financial difficulties caused by cash-flow underwriting, insurers conspired to shrink insurance coverage and their own financial exposure, which created a crisis for insurance buyers.

The suits filed by Colorado and the other states, he continued, seek redress on behalf of governmental entities for the alleged antitrust violations.

If the suit is successful, said Mr. Woodard, Colorado governmental entities will benefit from various forms of equitable relief, including coverage for claims that "were not insured due to the conspiracy" from an "indemnification pool" that the suit seeks.

In addition, the governmental entities could recover treble damages, he said.

The Colorado attorney general's office will pursue the case "in order to vindicate the fundamental national economic policy of competition, which is embodied in our antitrust laws," Mr. Woodard said. ■

U.S. insurers, brokers leave South Africa

By GLENN HUNTLEY

U.S. insurers and brokers have quietly followed in the footsteps of other American companies leaving South Africa in the last several years.

As the stampede of companies leaving the racially divided nation has accelerated over the past two years, the few U.S. brokers and insurers with South African operations have divested or ended their business there.

The one remaining U.S.-based broker with an equity interest in a South African broker—Alexander & Alexander Services Inc.—has been trying for the past few months to find a buyer for its 5% ownership of Priceforbes Federale Volkskas.

"This investment represents less than one-tenth of 1% of the combined assets of A&A," said a spokesman. "A&A expects to make a decision on the possible sale of its PFE stock during 1988."

A&A acquired the stock when it sold its South African operations in January 1986.

Many U.S. companies have felt the pressure of boycotts and anti-apartheid policies adopted by many client companies, local governments and other potential customers.

The U.S. government position, however, is that trade embargoes in general are ineffective and reduce the ability to influence policy by removing an American trading presence.

Marsh & McLennan Cos. Inc. of New York, the world's largest insurance brokerage, was the latest U.S.-based broker to pull out of South Africa. It confirmed in May that it was selling equity interest in a subsidiary there (*BI,* May 16).

M&M transferred its one-third ownership in First Bowring & Associates Holdings Ltd. to South African partners.

The Investors Responsibility Research Center, a watchdog group based in Washington, D.C., has no record of any U.S. insurance companies or brokers that currently have active operations in South Africa. Currently, 150 U.S. companies still have operations in South Africa.

About 145 U.S. companies that had investments or employees in South Africa divested those interests from 1985 through 1987, according to Allison Cooper, a research analyst for the group. Another 10 companies have concluded business there so far this year and at least nine others say they are withdrawing from the country, she said.

The reduction in trade by multinational companies in South Africa led to the end of insurance business by U.S. insurers and brokers.

Brokers say their few multinational clients that still have South African ties are directed to local insurers for policies involving business in South Africa. The local insurers generally reinsure their risks in the London market, they said (see story, page 3).

"With so much divestment, there's so little left for U.S. and international insurance companies there," said Martin Rayner, executive vp at Johnson & Higgins in Los Angeles.

Johnson & Higgins does not have a direct involvement in South Africa, although its British correspondent, Willis Faber P.L.C., has an investment in a brokerage office there: Willis Faber Enthovan Pty. Ltd.

The racial and economic situation now evolving from the government's apartheid policy belies the natural potential of the country, said Mr. Rayner, a native South African who left his homeland 30 years ago.

"It's a tragic situation. It's a country with a lot of potential and with its collective head in the sand about apartheid," he said.

Robin Lamprecht, president of Frank B. Hall & Co.'s overseas division, said South Africa presented little opportunity for U.S. insurers and brokers before the tide of divestiture and even less now.

"There wasn't a whole lot to begin with," said Mr. Lambrecht, also a native South African.

Hall is liquidating its Frank B. Hall (South Africa) Pty. Ltd. The company has not had any employees since 1986.

International condemnation of the South African government's racial policies has become so intense that insurance company and broker executives that have had South African offices generally refuse to talk about former business there.

Even after the companies have ended their relations in South Africa, further inquiries about the situation are met with no comment or terse statements.

M&M, for example, would not comment on its divestment or the reasons for it. "We've said all we have to say about it," an M&M spokeswoman said.

While few would disclose the extent of their involvement in South Africa, all said the trade was limited and insignificant compared to other business.

Other departures from South Africa included:

- American International Group Inc., which announced in March 1987 that it had sold its South African subsidiary, American International Insurance Co. Ltd., to Johannesburg Insurance Holdings Ltd., a company owned by a consortium of shareholders led by Rand Merchant Bank.

The new owners changed the name of the insurer to AI Insurance Co. Ltd.

Otherwise, AIG will make public no other information about the transaction, a spokeswoman said.

- CIGNA Group Inc. of Philadelphia, which sold its subsidiary, CIGNA Insurance Co. South Africa Ltd., to employees in November 1987.

The former subsidiary is now known as Concord Insurance Ltd.

CIGNA's subsidiary had been small, with 97 employees spread among a headquarters in Johannesburg and branch offices in three other cities. All the employees shared in ownership of the divested company, a CIGNA spokeswoman said.

While the parent company was not specific about the decision to sell the subsidiary, it was based on "customer reaction" to its continued presence in South Africa, she said.

"It was economically prudent for us to take the action," the CIGNA spokeswoman said.

CIGNA, Hall and many other companies have subscribed to the so-called Sullivan Principals, guidelines drafted in 1977 to encourage U.S.-based employers to take more progressive stands in the face of apartheid restrictions.

The principles were proposed by the Rev. Leon Sullivan, a Philadelphia minister. They called for relations with black trade unions, desegregation at work, training black employees and other measures.

However, the Rev. Sullivan disavowed his anti-apartheid guidelines last year and called for divestment by foreign companies and stricter sanctions against the racist South African government.

When CIGNA, an early signatory to the Sullivan pact, sold its interest to employees, about 24 of the 97 employees were non-white, the spokeswoman said. Also, the new owners agreed to follow the Sullivan Principals in the future, she said.

Sentry Insurance Group in Stevens Point, Wis., maintains a "shell" insurance subsidiary in South Africa, but does not have any offices in the country, a spokeswoman said.

The subsidiary, Sentry Assurance Co. of South Africa, is 100% owned by Sentry Insurance, according to listings by A.M. Best Co. Inc.

Sentry's business in South Africa has been "insignificant" in the past, the spokeswoman said.

Corroon & Black Corp., which listed a South African office in its 1987 annual report, was citing the subsidiary of London-based Minet Holdings P.L.C. in which Corroon & Black formerly held a 29.9% interest. Corroon & Black sold its holdings in Minet in February to The St. Paul Cos. and has no interests or affiliates in South Africa. ■

London market

Continued from page 1

of anti-apartheid leader Nelson R. Mandela.

Nonetheless, many London underwriters and brokers agree that South African business generally is regarded as high quality and profitable, partly because of the sophisticated risk management techniques used by South African corporations.

Most London underwriters are interested purely in the risk quality, brokers agree.

"I have never come across an underwriter who won't write South African business because it is South African. I haven't detected any reluctance or even any desire to keep participation quiet," said one broker, who noted that "insurance is largely apolitical. There are lots of places in the world underwriters would be more risk averse to than South Africa."

Brokers and underwriters say the British government's position against trade embargoes with South Africa generally is adopted throughout the London-based insurance sector.

The British contend that a trade embargo against South Africa would be counterproductive in ending apartheid and would impose economic pressure on the black community while resulting in a hardening of attitudes in the white community.

"It would result in a worse situation," said a spokesman for the British Embassy in Washington. "Sanctions are not an effective means to end apartheid."

Of the 25 largest foreign companies doing business in South Africa—in terms of number of employees—16 are British, according to the Investor Responsibility Research Center, a non-profit research organization.

"It is up to each and every (Lloyd's) underwriter to decide whether to trade with South Africa. However, if the government declared a boycott of South Africa it would be observed by Lloyd's," said a Lloyd's spokesman.

"We are conscious of the political situation, but we don't choose any of the business we write on a political basis," said one Lloyd's underwriter who leads insurance policies covering many South African risks.

"There may well be a stage when we pull out of South Africa, but at the moment we take the same stance as our government and most businesses in the U.K.," he added.

And, for the most part, British companies with South African operations say those operations promote employment among blacks.

However, Mr. Vernon of South Africa said: "The situation in South Africa has led to a lack of investment. A lot of big parent companies (based in London and Europe) are not investing and providing capital to build up their local operations" in South Africa, referring to insurance company subsidiaries.

Indeed, in the face of increasing calls for trade embargoes against South Africa from anti-apartheid groups and several governments, some leading U.K. insurance companies and brokers have pulled out of the country or are reducing investment in South African subsidiaries—although all but one say their decisions were not politically based.

Most recently, London-based broker Sedgwick Group P.L.C. last month sold its shareholding in a South African-based company.

Sedgwick sold its 30.83% equity interest in Priceforbes Federale Volkskas Holdings (Pty) Ltd. to Rhona Ltd., a subsidiary of the Edmond de Rothschild Group.

"The decision to sell has been taken for commercial reasons (and is not) material in financial terms to the Sedgwick Group as a whole," Sedgwick said in a statement to *Business Insurance.*

However, Sedgwick Chief Executive David Rowland stressed that Sedgwick is "not taking a political stance about South Africa."

Mr. Rowland did not reveal details of the sale but stated that the decision was made for commercial reasons and because it was thought to be in the best interests of Sedgwick's shareholders.

British insurer Commercial Union Assurance Co. P.L.C. also is reducing its shareholding in its Johannesburg-based company to about 35% from 45% for "business considerations," said William Hazelden, assistant group overseas manager. The shareholding is being sold to a local savings and loan.

While Mr. Hazelden would not comment specifically on reasons for reducing shareholding, he said they were not political.

Commercial Union Assurance Co. of South Africa Ltd. writes gross premiums of about 300 million rand ($123.2 million based on the commercial exchange rate). The subsidiary writes both commercial and personal lines insurance.

The company has no plans to discontinue its links with its South African associate company, said Mr. Hazelden.

However, at least one British-based company says it left South Africa for political reasons: Bain Clarkson Ltd. has no shareholdings in any South African companies, according to Financial Director Jonathan Hagger. Although Clarkson Puckle Ltd. held shares in a South African-based associate company, these were sold after the company was acquired by Bain Dawes P.L.C. last April (*BI,* April 13, 1987).

"We did not think it was appropriate to have a holding in South Africa," Mr. Hagger said.

But the London insurance market has traditional ties with policyholders in South Africa and the local South African insurance market, and those links will not be severed lightly, insurance leaders say.

Most brokers and underwriters in London agree that there is little political pressure in the London market to discontinue writing South African business, although most admitted the issue is "sensitive."

The Mercantile & General Reinsurance Co. P.L.C., a London-based reinsurance company, has a South African subsidiary with 1987 premiums of 64.5 million rand ($33.5 million commercial exchange rates) and a pretax profit of 6.5 million rand ($3.4 million).

"We are going to go on doing business in South Africa. Reinsurance is a totally international business," said M&G's General Manager John Lock at a press conference earlier this year to announce the group's results.

"We transact reinsurance in almost every business and area in the world. It doesn't make any difference where it comes from or whether you write it in South Africa or London."

The Mercantile & General Reinsurance Co. of South Africa employs 165 people, half of whom are black, said Mr. Lock.

"We wouldn't be making any useful contribution if we closed our South Africa office down," he said.

British insurance company Eagle Star Holdings P.L.C. also has "never been under any pressure to withdraw from South Africa," said a spokesman.

South African Eagle Star Insurance Co. Ltd. is 60% owned by Eagle Star and employs 1,500 people, 440 of whom are black, he said.

Other U.K. companies with subsidiaries or large investments in South African insurance operations include:

- Sun Alliance & London Insurance P.L.C., which has a 79.7% shareholding in Protea Assurance Co. Ltd. in South Africa. Protea posted premiums of 185.5 million rand ($96.4 million at year-end commercial rate) for 1987, mostly for industrial and commercial risks, according to William Holden, a manager based in Sun Alliance's Horsham, Sussex-based headquarters.
- Guardian Royal Exchange P.L.C., which has a 51% stake in Johannesburg-based Guardian National Insurance Co. Ltd. In 1987, GNIC made an underwriting profit of 2.6 million pounds ($4.89 million at year-end exchange rates) and earned investment revenues of 5.1 million pounds ($9.59 million). "Our reason for being in South Africa is a commercial reason and not in any way a political stance," said a GRE spokesman.
- London broker Minet Holdings Ltd., which owns 50.1% of Minet Insurance Brokers South Africa Propriety Ltd., a specialist in industrial risks.

Minet encourages black employment in its South African subsidiary, said Christopher Keey, Minet's deputy chairman.

"We have no fixed rules about employment, but we do actively encourage black advancement and about 40% of our employees are black," said Mr. Keey.

- Willis Faber P.L.C., which has a 40% shareholding in Johannesburg-based Willis Faber Enthoven Pty. Ltd., a retail broker that places most of its business in the South African insurance market although some business "flows through to London," said a spokesman. The broker handles mainly commercial risks.

"Insurance and reinsurance has always been seen as being essential to human welfare and has tended to transcend political boundaries," said a Willis Faber spokesman.

Among other U.K. brokers, a spokesman for C.E. Heath P.L.C. said that the company holds no investments in South Africa, while a spokesman for Hogg Robinson & Gardner Mountain P.L.C. would not comment on whether Hogg holds shares in any South African companies. No shareholdings are listed in Hogg's annual report. ■

American Trust

Continued from page 1

ments. Mr. Teale described this turnover in the insurer's investments as a constant effort to improve American Trust's asset base (see story, page 34.)

Lawyers for American Trust now are discussing the investment changes and other questions with regulators in Illinois, Alabama and Texas, and the company hopes to resolve the regulatory problems shortly, Mr. Teale said.

"Here is a company that is endeavoring with every ounce of power it's got to resolve questions on an amicable basis," he said. "We just want to plow our own course and get it right."

American Trust, which was incorporated in the Turks & Caicos in 1984, is one of several insurance company members of the International Underwriting Assn., an underwriting consortium organized by Mr. Teale in 1986 (*BI*, Sept. 22, 1986).

Mr. Teale previously had served as the first president of the Insurance Exchange of the Americas in Miami, from 1981-1984. Mr. Teale left the IEA when his contract was not renewed (*BI*, Sept. 2, 1985). Among the 11 members of the International Underwriting Assn., according to promotional material circulated by Mr. Teale's Atlanta-based management company, Fenmar International Insurance Services Ltd., are American Trade Insurance Co. Ltd., American Transportation Insurance Co. Ltd., American Marine & General Insurance Co. Ltd., Old American Insurance Co. Ltd. and American Atlantic Insurance Co. Ltd.

These five companies were American Trust's only reinsurers in 1987, according to American Trust's 1987 statutory statement, which shows $2 million in premiums in force with the five insurers.

American Trust owner KLK also owns Old American and American Marine & General, though Mr. Teale said American Trust is the only one of the three insurers that has written business in the United States.

Mr. Teale would not release any of the insurers' financial statements, saying they are privately owned.

KLK Consulting & Management is a "personal family trust," according to Mr. Teale.

Insurers represented by Fenmar offer a wide variety of coverages ranging from accident and health insurance to professional liability, aviation, bloodstock and greyhound mortality, kidnap and ransom, political risk, product liability, workers compensation, fishing vessel and trucking coverages, according to a Fenmar brochure.

Mr. Teale would not reveal the premium volume of International Underwriting Assn. members.

American Trust's five reinsurers as listed in the 1987 annual statement also are based in the Turks & Caicos, though Mr. Teale said that American Trust and other underwriting association members will be moving to a new domicile because they are "sick and tired of the sniping" about what he described as perceived regulatory shortcomings in the islands.

Mr. Teale declined to identify the new domicile.

Another insurer represented by one of Mr. Teale's companies is Victoria Insurance Co., a Georgia-domiciled insurer.

Victoria has been ordered to stop writing insurance in Florida (see story, page 34).

American Trust's gross premiums of $12 million in 1987 compares with just $2.1 million in 1986 and $169,037 in 1985, according to a convention statement filed with the Texas Insurance Board.

Volume in 1987 included direct insurance premiums of $3.3 million in Texas, $2.1 million in Illinois, $1.1 million in California, $1.1 million in the U.S. Virgin Islands and $1 million in Alabama, the statement says.

The other $3.4 million in premiums included $2.5 million in direct premiums in another 35 states and $949,701 in reinsurance assumed.

American Trust was considered eligible as a surplus lines insurer in Texas in 1987, but changes in the company's agency representation and lines of business prompted the State Board of Insurance this year to ask for additional financial information, according to Richard B. Schroeter, director of surplus lines.

The board received "two or three" financial statements from American Trust that were not acceptable for various reasons, and the insurer was subsequently judged ineligible to write surplus lines business in the state, Mr. Schroeter said.

Mr. Teale, meanwhile, wrote to the insurance board saying the company would voluntarily cease writing in Texas, he added.

Among the questions raised by Texas regulators, Mr. Schroeter said, were whether American Trust is licensed in the Turks & Caicos to write the kinds of business it intended to write in Texas—a requirement of Texas law—and how the board could establish the value of American Trust's portfolio of over-the-counter securities.

Most of the OTC stocks were subject to trading restrictions under Securities and Exchange Commission rules, according to a 1987 financial statement prepared according to generally accepted accounting principles and audited by Hein & Associates in Houston.

Under SEC Rule 144, restricted stocks must be held for two years before any sale. The rule also imposes limits on the amount of stock that can be sold in any three-month period.

If the insurance board were unable to establish the stocks' value, they would not be considered admitted assets for purposes of determining American Trust's capital and surplus, Mr. Schroeter explained.

The Texas board also has questioned whether the stocks are actually held in American Trust's name.

The 1987 GAAP statement reported that the stocks—which were originally contributed by KLK—were placed last December into the "KLK Trust," which is being maintained by a New York Stock Exchange member brokerage.

American Trust "retains a pro-rata equity in all of the investment securities in the trust," the statement says.

If the stocks are not actually held in American Trust's name, they would not be considered admitted assets, regulators say.

Meanwhile, the Illinois Insurance Department on March 1 notified all surplus lines producers in the state not to place any business with American Trust.

Like the Texas insurance board, Illinois regulators were unable to fix the value of American Trust's OTC stocks, according to Etta Mae Credi, supervising insurance deputy. Department officials could not find several of the stocks in newspaper listings of stocks carried on the National Assn. of Securities Dealers Automated Quotations system, she said.

About a month later, the Alabama department ordered American Trust to stop representing itself as being licensed in the state and ordered the company to "cease and desist from the solicitation, sale or distribution of any insurance or materials related thereto, until such time as you become licensed by the Alabama Insurance Department."

The cease-and-desist order followed a March 29 letter Mr. Teale sent to Rubell Helm Insurance Services Inc. in Irvine, Calif., in which Mr. Teale confirmed that American Trust—"a licensed surplus lines carrier in the state of Alabama"—would write health insurance for a multiple employer trust operating in California and Florida.

While conceding that he signed the letter, Mr. Teale said that it was drafted by a former employee who mistakenly used the word "licensed" instead of "eligible."

Although surplus lines brokers—rather than the Insurance Department—are responsible under Alabama law for determining the financial qualifications of surplus lines insurers, the Alabama department also had questions about the value of American Trust's OTC stocks, according to Chief Examiner Paul D. Raadt.

Alabama regulators contacted the NAIC's Securities Valuation Office, which agreed in May to analyze American Trust's OTC portfolio, regulatory sources say.

The SVO's examination focused on stocks held by the KLK Trust rather than just the portion of the KLK portfolio attributable to American Trust, according to sources familiar with the SVO report who requested anonymity.

SVO reports prepared for individual departments on individual companies are considered confidential.

According to American Trust's 1987 GAAP financial statement, KLK Trust owned 10% or more of each of the following companies: American Aircraft Corp., Prime Technology Inc., Continental Benefit Corp., Innstar Corp., Impact Diversified Industries Inc., Beta Tech Robotics Inc., Royal American Films Inc., NGR International Inc. and RAM Industries Inc.

American Trust held shares of all of these companies except NGR International and RAM Industries as of Dec. 31, according to its statutory statement, which reported the market value of the shares at $40.5 million. This represented the bulk of the insurer's reported total assets of $47 million.

American Trust's GAAP statement reported the value of the OTC shares somewhat differently: A note in the statement revealed that after Dec. 31, the quoted value of the securities dropped 41%, mainly because of a 4-1 reverse split of the American Aircraft shares.

The GAAP statement—noting that an investment banking firm that supplied the American Aircraft stock had agreed to compensate KLK for the losses—deducted $10.7 million from the portfolio's quoted value as a reserve to reflect the decline in the stocks' worth, leaving equities valued at $29.8 million on American Trust's balance sheet.

Acknowledging that most of the insurer's "growth-oriented" common stocks are restricted shares under SEC rules and have "thin trading volumes," the GAAP statement reported that the restrictions are to expire in 1988 and 1989 and that American Trust had made arrangements "with various brokerage firms to sell blocks of the securities in the event that funds are needed to pay claims."

American Trust's management estimated that one-third of the portfolio could be liquidated within 12 months at discounted prices, the GAAP statement says.

However, the NAIC Securities Valuation Office assigned significant value to only three of the KLK Trust's OTC stocks: American Aircraft, Beta Tech Robotics and Royal American Films, regulatory sources familiar with the report say.

Five other stocks—Continental Benefit, Impact Diversified, NGR International, Prime Technology and Innstar—were assigned no value by the SVO, one source said. The report did not value the RAM Industries shares, the source said.

The SVO discounted the publicly quoted bid prices of the shares to reflect various conditions, including the impact of the stocks' restricted status on their marketability and the large number of shares held by KLK, trading of which could depress the stocks' prices, the source said.

Market makers in Royal American Films and Beta Tech Robotics stock said last week when contacted by *Business Insurance* that demand for the stocks is not strong enough to allow for the sale of large lots of the companies' shares.

The SVO concluded that the stocks it analyzed in the KLK Trust would ultimately generate about $8.2 million if the shares were liquidated over a period of several years

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Update

Damages sought in rig disaster

Continued from page 2

Led by David Burnside, president of the Aberdeen Bar Assn., more than 90 lawyers met in Aberdeen, Scotland, late last week to discuss compensation for the victims' families. U.S. lawyers also attended the meeting to advise on filing suits in the United States.

Mr. Burnside said the lawyers would consider filing suits in U.S. courts if the amount offered to the families of the victims, who primarily were British, is considered too small.

He called negotiations with Occidental's U.S. counsel "very amicable," adding, "A case settled quickly is worth a lot" to the bereaved who would rather be compensated now than go to court.

He also warned victims' families to ignore solicitations placed in Aberdeen newspapers by U.S. lawyers, saying the lawyers are merely looking to earn contingency fees.

Meanwhile, London marine underwriters, who last week met with surveyors Bateman Chapman to discuss damage to the platform, await a formal claim notice from Occidental and the three other oil companies that own the platform.

"The claim is in limbo," said John Turner, managing director of the oil and gas division of Lloyd's broker Willis Faber & Dumas Ltd., which represents three of the owners of the Piper Alpha.

Underwriters now believe the Piper Alpha will be a total loss and that overall claims related to the disaster will total about $1.2 billion (*BI*, July 18; July 11).

Accountant to challenge ruling

COLUMBUS, Ohio—Accountant Price Waterhouse & Co. says it will challenge a state court ruling that it must pay $15.8 million for negligently performing a financial feasibility study for the Scioto Memorial Hospital Assn.

The study led the hospital to build a retirement center in Lexington, Ky., whose occupancy rates and revenues fell "far short" of Price Waterhouse's projections, according to the suit.

However, Fred Miller, a partner in the Columbus, Ohio, office of Price Waterhouse said, "The fact is, the hospital retirement center project was destroyed by an unfortunate fire during construction. The hospital was not adequately insured and could not recover losses from the contractor that caused the fire."

Gulf war risk rates unchanged

LONDON—London marine underwriters so far are not lowering hull and cargo war risk rates in the Persian Gulf despite last week's decision by Iran to agree to a cease-fire with Iraq.

London underwriters are skeptical of any let-up in the 8-year-old Iran-Iraq war and will not lower rates until a cease-fire is carried out, said an Institute of London Underwriters spokesman.

If the war ends, "there is no doubt that in the long run (war risk rates) will come down" in the Persian Gulf, said Chris Rome, chairman of Lloyd's of London Underwriters' Assn.

Underwriters will not immediately reduce any rates in the marine market, including war risk rates, because the underwriters still must pay the estimated $1.2 billion loss from the explosion of the Piper Alpha platform, he noted (*BI*, July 18; July 11).

Lloyd's of London estimates that insured losses due to the war have exceeded $1 billion since 1981.

Response to guaranty fund suit

ALBANY, N.Y.—Insurers are not legally entitled to the return of $124 million, plus interest, that was transferred from the state's property/casualty guaranty fund to its general revenue fund, New York state says in response to a suit filed by members of the insurance industry.

Six insurance associations and more than 60 insurers filed suit in New York Supreme Court in Albany last month seeking the return of the money, which was taken from the state's Property/Casualty Insurance Security fund between 1979 and 1982 (*BI*, June 6).

The Insurance Department recently began assessing insurers in an effort to replenish the fund, which the plaintiffs contend would not have been necessary had the money not been transferred.

In its response, the attorney general's office said insurers cannot challenge Section 7603(d) of the Insurance Law, which permitted the funds to be siphoned off, because too much time has elapsed.

Briefly noted

The New York Insurance Exchange has agreed not to oppose foreclosure on its downtown Manhattan headquarters and starting next month will pay the mortgage holder—New York State Teachers Retirement System—$88,000 rent per month until March 1989 for the space it is using running off exchange business. . . .The House Ways and Means Health Subcommittee will hold a hearing Aug. 9 on legislation to require all employers to offer a **health care plan limiting employees' annual out-of-pocket expenses** to $1,000 for individual coverage and $1,500 for family coverage. The legislation was introduced last month by Rep. Fortney "Pete" Stark, D-Calif. (*BI*, July 4). . . .An overwhelming majority of claimants and shareholders last week approved **A.H. Robins Co.'s reorganization plan**, under which Robins will be acquired by American Home Products Corp. and Dalkon Shield victims would then either receive a single cash payment of $2.375 billion on the plan's effective date or $2.475 billion paid within one year of that date. . . .A record $1.28 million fine for violations of the **Clean Water Act** was reinstated last week against a Richmond, Va., meatpacking plant. The fine was reimposed by a U.S. District Court judge during reconsideration of the case, *Gwaltney of Smithfield Ltd. vs. Chesapeake Bay Foundation Inc.*, after the Supreme Court last year clarified the circumstances in which citizens may sue companies for violations of the act (*BI*, Dec. 7, 1987). . . .Aon Corp. plans to acquire **Reinsurance Agency Inc.** in Chicago, the ninth-largest U.S. reinsurance intermediary.

Florida bans Victoria from writing insurance

TALLAHASSEE, Fla.—The Florida Insurance Department has ordered Victoria Insurance Co. to stop writing business in the state.

The Florida department issued the cease-and-desist order after finding that Victoria—licensed in Georgia in May 1987—had been insuring Florida equine mortality risks between April 1987 and January 1988, supposedly through a purchasing group program, said Richard W. Thornburg, a lawyer with the Florida department.

The business was written for North American Producers Assn. Inc., purportedly a purchasing group, through Ocala, Fla.-based agency Sandlyn Heaths Ltd. Inc., Mr. Thornburg said.

Victoria is not admitted or approved as a surplus lines insurer in Florida, and Mr. Thornburg noted that the federal Risk Retention Act does not empower insurers to write equine mortality coverage for purchasing groups.

Alan Teale, who resigned as executive vp and director of Victoria last December, denied in an interview that Victoria wrote the risks as part of a purchasing group program, but agreed that the insurer should not have been doing business in Florida.

The cease-and-desist order, issued March 9, "was deserved. Victoria was in Florida incorrectly," he conceded.

Mr. Teale explained that the business was "a mistake on the part of a London broker" who placed the risks with Victoria through contact with another London broker who was a Victoria shareholder at the time.

When Mr. Teale found out about the business, he says, he warned the London shareholder that Victoria was not eligible to write insurance in Florida. By then, he said, it was too late: The Florida department was in the process of issuing its cease-and-desist order.

Mr. Teale, who says he was not involved in producing the equine mortality business, resigned from Victoria to avoid what he calls a conflict between his activities as a producer for the insurer and his duties as an officer and director.

He said that he produces business for Victoria under agreements with two of his companies, Fenmar International Insurance Services Ltd. and T.R.T. Associates Inc., both of Atlanta. Business produced by Mr. Teale is placed through Victoria's office in Amsterdam, he said.

Victoria is also described in Fenmar promotional material as a member of the International Underwriting Assn., a consortium of insurers that includes American Trust Insurance Co. (see story, page 1).

American Trust's investments

ATLANTA—Investments of American Trust Insurance Co. Ltd. have changed dramatically in the last two years as its assets have grown from a reported $7.4 million in 1986 to a reported $47 million as of year-end 1987.

American Trust President Alan Teale insists that, far from denoting instability, the constantly changing investment portfolio reflects the insurer's desire to satisfy state insurance regulators. "The story of American Trust is one of constant improvement by the infusion of better assets all the way through," he said.

Mr. Teale refused to provide financial statements for American Trust and other members of his International Underwriting Assn., saying that the insurers are privately held and that financial data is "not available to the press."

Business Insurance obtained copies of several American Trust financial statements, prepared in accordance with statutory and generally accepted accounting principles, from state insurance regulators and other sources.

In a 1986 GAAP statement, American Trust reported assets of $7.4 million, the largest of which was a $5 million non-interest bearing note from Maranatha Investments Corp., identified as American Trust's parent.

In an interview, Mr. Teale said he did not know if Maranatha was a subsidiary of Houston-based KLK Consulting & Management Co., which he said has owned American Trust since 1984.

The $5 million note was guaranteed by two separate "irrevocable guarantee commitments," each in the amount of $5 million, from unidentified third parties.

In a note reporting subsequent events, the GAAP statement says that American Trust received $9 million in additional capital in March 1987, consisting of:

- $2 million in publicly traded stock, transferred by Maranatha to an escrow agent for American Trust's benefit. The unidentified stock was to be pledged to the National Assn. of Insurance Commissioners to satisfy NAIC requirements for alien insurers, the statement says.
- A $2 million certificate of deposit secured by publicly traded stock held by an unidentified attorney.
- A $5 million non-interest-bearing note from Maranatha guaranteed by a third party and secured by publicly traded stock.

All three capital contributions were made in exchange for surplus notes from American Trust, payable from surplus funds not required for the insurer to meet minimum policyholder surplus guidelines, the statement says.

In a GAAP statement prepared as of July 31, 1987, American Trust reported total assets of $38.6 million.

The largest of these assets comprised $14 million in collateralized cumulative debentures of Fort Worth, Texas-based First Houston Capital Resources Fund Inc. and H. Kendrick Holding Co. Inc., a First Houston unit.

First Houston debentures in the amount of $10 million were collateralized by:

- A mortgage on 90 acres of land at Lake Shore Resort in Franklin County, Ind., valued at $3 million.
- A mortgage on 110 acres of vacant land on Madeline Island, Wis., valued at $3 million.
- 70,000 shares of restricted common stock in Jove Med-Care Inc. and 300,000 restricted common shares of In-Tec International (U.S.A.) Inc.

H. Kendrick debentures totaling $4 million were collateralized by a guarantee from Incapco Inc., another First Houston subsidiary, and "assignment of undivided one-eighth interest in oil, gas and mineral leases" in Harrison and Wetzel counties, W.Va., and Green County, Pa.

Other assets reported in the July 31 GAAP statement:

- A $10 million note receivable from American Trust's "parent company," secured by a financial guarantee bond issued by Rockwall, Texas-based Dallas Dynasty Inc.
- $6 million in preferred stock of First Houston and H. Kendrick.
- $2 million in "certificates of locked-up capital" issued by National Mortgage Investbank Ltd.
- $1.2 million in restricted common shares of First Houston.

Mr. Teale says the First Houston and H. Kendrick investments were subsequently removed because they were "coming under question," adding that "we just thought there were better investments around."

In its year-end 1987 financial statements, American Trust reported the restricted over-the-counter stock that has attracted the scrutiny of regulators in Alabama, Illinois and Texas (see story, page 1).

The year-end 1987 GAAP statement—showing total assets of $48.2 million—shows various OTC stocks, most of them restricted, valued at $29.8 million. Other assets include $5.2 million in real estate and mortgages receivable, $2.7 million in certificates of deposit and $6.3 million in premiums in the course of collection.

The statutory statement—filed with the Texas Insurance Board and showing assets of $47 million—values the OTC shares at $40.5 million. The statement also shows $2.8 million in cash on hand and on deposit, $186,670 in real estate and $2.5 million in premiums in the course of collection. ■

American Trust

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in compliance with Rule 144, sources familiar with the report say.

The SVO report did not estimate the ultimate value of American Trust's share of the KLK Trust portfolio, regulatory sources say.

The SVO also found that some of the stock certificates—including certificates for Beta Tech Robotics, American Aircraft, Continental Benefit and Prime Technology—are not in the name of either American Trust or KLK Trust.

J. William VanDerveer, general counsel of KLK in Houston, said he is sure KLK will dispute the SVO's conclusions about the value of the stocks, but he referred questions to a Denver-based broker who he said is familiar with the OTC portfolio.

Mr. Teale responded to a *Business Insurance* call placed to the broker, saying the broker had called him. Mr. Teale said he had instructed the broker not to return the phone call.

Mr. Teale also disputed the SVO conclusions, and said that $30.5 million in new assets have been contributed to American Trust since the beginning of the year, including $11.5 million in U.S. Treasury securities and $19 million in non-restricted stocks.

"We think that's going to be adequate" to satisfy the objections of state regulators to the insurer's OTC stock investments, Mr. Teale said.

He added that the SVO's review of the KLK Trust portfolio has been a "very valuable exercise," giving American Trust a better idea of assets acceptable to regulators.

Regarding another of the Texas Insurance Board's questions, Mr. Teale said that American Trust has obtained documents from Turks & Caicos regulators showing that the insurer is licensed in the domicile to write the types of business it planned to write in Texas.

American Trust's lawyers are in the process of furnishing additional information to regulators in Texas, Illinois and Alabama, hoping to resolve the questions the insurance departments have raised, Mr. Teale said, emphasizing that the insurer is making every effort to cooperate with state officials' requests.

American Trust and the other members of the International Underwriting Assn. are trying to build themselves into solid, acceptable insurance markets; are operating conservatively, limiting their net premium-to-surplus ratio to 1-to-1; and are not committing more than 1% of surplus to any one risk, Mr. Teale said.

The International Underwriting Assn. is a "very highly regulated and very sophisticated and very carefully controlled group of companies," he said. ■

Reinsurance recoverables

Continued from page 35

sure because we believe that the IBNR reserves for almost all insurers are understated. Nevertheless, we have inserted a column, "total adjusted recoverables," showing the adjustment when credit is given for these deposited funds.

Recoverables declined to 90.6% among the surveyed companies after the adjustment is taken into effect, with the reduction for American International Group Inc. being particularly noteworthy.

It should also be pointed out that some companies have recoverables due from affiliates. Such recoverables should be sacrosanct. Recoverables due from affiliates is most meaningful for Continental Corp., where affiliate recoverables equaled 42.7% of the company's total recoverable base.

This year's report also examined the amount of recoverables that various underwriters have written off over the past two years, as well as any reserves for "bad-debt" reinsurance recoverables.

The most significant write-offs were an estimated 4.3% of total recoverables at CIGNA Corp. and 2.2% at Continental. Twelve of the 27 insurers in our study made no write-offs.

We attempted to obtain this information from managements, since it is not in the convention blanks, and we ended up with somewhat incomplete data. In several instances, the data was not available. In other cases, we found a mixture of statutory and generally accepted accounting principle write-offs partly overlaid with the establishment of a "bad-debt" reserve. Furthermore, the accuracy of the figures may be a bit fuzzy and the nomenclature of bad-debt reserve somewhat obtuse.

Nonetheless, some insurers are attempting to deal with the problem more forthrightly than others. AIG and NAC Re Corp. appear to have taken the lead in this area when relating the bad-debt reserve to outstanding recoverables. AIG's bad-debt reserve equals 5.6% of total recoverables, while NAC Re's reserve is 4% of recoverables.

The unanswered questions about the size and quality of reinsurance recoverables are beginning to come into focus. It is somewhat ironic that the necessary adjustments for some insurers may well coincide with a cash-flow squeeze and the downside of the current underwriting cycle. It is a classic example of "Murphy's Law." We view such a confluence of factors as a plus. The saga of reinsurance recoverables, which started with the concept of "cheap reinsurance," appears to be entering a more pointed phase. While the length of the finale is a bit uncertain, the last line is quite clear: Everybody loves a magic show until the money disappears.

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Leading insurers' reinsurance recoverables*
(In thousands of dollars)

	Statutory surplus	Reinsurance recoverables on: Paid losses	Unpaid losses	IBNR losses	Unearned premium reserves	Total reinsurance recoverables	Total recoverables as % of surplus	Recoverables due from affiliates	Recoverables due from affiliates as % of total recovery
Aetna Life & Casualty	$3,731,778	$234,949	$763,718	$636,301	$364,181	$1,999,149	53.6%	$1,999,149	53.6%
AIG	3,521,516	802,225	3,652,730	1,321,406	1,367,890	7,144,251	202.9	3,721,742	105.7
Chubb Corp.	1,210,118	67,496	460,538	384,122	354,781	1,266,937	104.7	1,194,843	98.7
CIGNA Corp.	1,795,036	562,276	2,506,517	1,259,372	509,795	4,837,960	269.5	3,261,551	181.7
CNA	1,902,459	246,596	1,038,960	285,753	222,409	1,793,718	94.3	1,645,524	86.5
Continental Corp.	1,280,002	217,725	1,368,258	265,237	731,477	2,582,697	201.8	1,836,423	143.5
Crum & Forster	1,191,478	293,069	1,867,154	1,107,134	422,847	3,690,204	309.7	2,978,122	250.0
Fireman's Fund	1,229,926	380,196	1,000,627	1,017,173	540,380	2,938,376	238.9	2,718,845	221.1
General Re	2,008,906	56,224	334,147	447,709	56,773	894,853	44.5	719,764	35.8
Hartford Group	2,440,946	681,416	2,053,516	874,345	223,246	3,832,523	157.0	3,832,523	157.0
Home Group	768,549	222,604	958,582	499,929	211,754	1,892,869	246.3	1,804,268	234.8
Kemper	723,701	15,944	1,319,636	581,281	482,504	2,399,365	331.5	2,076,310	236.9
NAC Re	163,233	2,872	46,921	55,651	8,032	113,476	69.5	85,065	52.1
SAFECO	674,103	11,880	55,947	35,144	44,150	147,121	21.8	143,358	21.3
St. Paul	1,200,064	58,742	599,342	411,513	227,528	1,297,135	108.1	1,156,272	96.4
Transamerica	684,873	59,084	184,029	133,461	98,620	475,194	69.4	447,669	65.4
Travelers	2,943,427	270,016	1,627,927	641,376	416,549	2,955,868	100.4	2,955,868	100.4
USF&G	1,242,970	66,787	826,785	162,788	174,896	1,231,256	99.1	690,563	55.6

* As of Dec. 31, 1987 Source: Oppenheimer & Co. Inc. Chart: Amy Palmer

Recoverables threaten insurers

By MYRON M. PICOULT

Special to Business Insurance

EVIDENCE CONTINUES to mount that reinsurance recoverables remain a gnawing problem for the property/casualty insurance industry. In fact, reinsurance recoverables represent a significant portion of the property/casualty industry's financial underpinnings.

Mr. Picoult

Data reported by the Insurance Services Office Inc. shows that at the end of 1986—the latest available data—recoverables for the industry as a whole accounted for about 85% of statutory surplus. A.M. Best Co. data indicates that recoverables represented 57.2% of the industry's year-end 1986 surplus. The estimated figure for 1987 is about 60%. The apparent discrepancy between the ISO and Best figures relates to the fact that the ISO figure does not include recoverables from affiliated insurers, whereas the Best figure does.

On average, for 27 companies included in our 1987 survey, recoverables equaled 110.9% of statutory surplus. Data for 18 commercial lines insurers appears in the chart.

Given the magnitude of the numbers and the questions regarding the quality of reinsurance recoverables, managements in general have provided little information. The National Assn. of Insurance Commissioners is looking into standards that would provide an "aging process" for recoverables and offer some insight into their quality (*BI*, July 18). Guidelines for writing off past-due recoverables are long overdue. The sooner the problem is addressed the better. The longer it is delayed, the more the credibility of the NAIC is impinged upon.

Meaningful adjustments beyond simple acknowledgment of past due recoverables may be too much to hope for in insurers' 1988 convention statements. The 1989 blanks may be a more realistic target date. Nonetheless, the die has been cast and some "dirty linen is likely to be hung out on the line."

Our study shows that exposure to the recoverable problem is still not evenly shared. More realistic recognition of the problem will underscore the fragility of some insurers' capital bases. Based on the previously mentioned estimate of 60% of surplus, reinsurance recoverables for the industry for year-end 1987 would approximate $62 billion. Our guess is that at least $10 billion of that figure is bad.

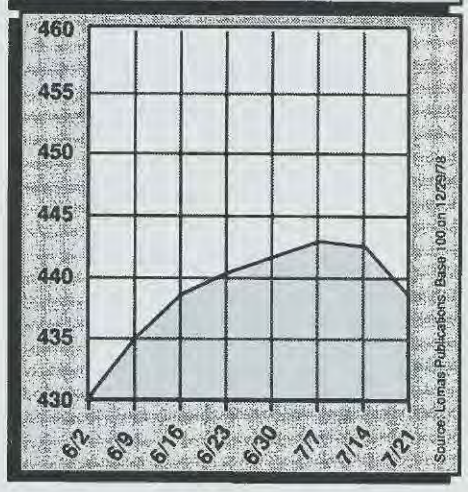
This year's study was expanded to include 27 companies. We reviewed the consolidated convention blanks for these companies and sought out data on both paid and unpaid reinsurance recoverables. In addition, we reviewed incurred-but-not-reported liabilities as well as the estimated unearned premium reserve. As expected, the total figures were very high for several insurers. On average, for all 27 companies in our study, paid losses equaled 10.4% of statutory surplus, unpaid losses 53.3%, IBNR 27.3% and the estimated unearned premium reserve, 19.9%. All told, this equaled 110.9%.

In addition, there is an item called "funds held or retained for the account of unauthorized companies" buried on the liability side of insurers' balance sheet. In essence, these are deposited funds that could be used to offset bad recoverables. The caveat is that the recoverables have to be related specifically to the company for which the deposit is held. We are not convinced that this figure should be used to reduce recoverable expo-

Continued on page 34

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

BI Insurance Index



Insurance industry stocks continued their descent last week, as the *Business Insurance Index* fell 4.2 points to 439.0 on July 21, from 443.2 on July 14. Advancing issues were led by Statesman Group Inc., up 12.9%; Hilb, Rogal & Hamilton Inc., up 4.5%; USLIFE Corp., up 4%; The Home Group Inc., up 3.8%; Selective Insurance Group Inc., up 3%; and Trenwick Group Inc., up 2%. Declining issues, were led by Marsh & McLennan Cos. Inc., down 7.7%; Avemco Corp., down 6.5%; Zenith National Insurance Corp., down 6.4%; Arthur J. Gallagher & Co., down 6.1%; SCOR US Corp., down 5.3%; and Aneco Reinsurance Co. Ltd., down 4.4%. Issues showing the most activity during the period were: Farmers Group Inc., 7.3 million shares traded; Sears, Roebuck & Co. (Allstate Insurance Group), 2.1 million shares traded; and Chubb Corp., 1.5 million shares traded. The *Business Insurance* index dropped 0.9% for the period, faring better than the leading market indicators: The Dow Jones 30 Industrials and the Standard & Poor's 500 both fell 1.3%, and the NYSE Composite dropped 1.2%.

British Issues

July 21 Companies	Price pence	P/E	Div. pence	Yield %	1 Week High—Low pence	pence
Commil Union	382	14.5	21.9	5.6	382—371	
Genl Accident	914	10.6	47.9	5.1	914—895	
Gdn Royal Exch	194	14.5	55.2	5.6	194—187	
Royal	410	10.8	26.4	6.3	412—408	
Sun Alliance	985	16.1	43.1	4.2	988—980	
Brokers						
Bradstock	229	12.9	5.0	2.9	230—214	
CE Heath	446	17.1	34.5	7.7	446—442	
Hogg Robinson	180	14.4	9.6	5.2	180—175	
Lloyd Thompson	180	15.7	6.8	3.7	180—175	
PWS Holdings	205	8.6	14.4	6.8	205—200	
Sedgwick Grp	238	14.8	16.4	6.7	240—238	
Steel Brit Jones	197	13.7	15.4	5.9	265—260	
Willis Faber	262	13.7	15.4	5.9	265—260	

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

BI Industry Stock Report

JULY 21, 1988 7/15/88 THRU 7/21/88

		Price	Weekly % change	Year to Date % change	Annual High	Annual Low	Vol.(000)	$ Div.	% Yield	P/E	Book value	Mkt/Bk. value
BROKERS												
Alexander & Alexander Svcs	NYSE	23.63	-2.1	33.1	24.88	17.75	294	1.00	4.2	15.0	3.71	6.37
Baldwin & Lyons Inc.	OTC	16.00	-3.0	33.3	16.50	12.00	0	0.20	1.3	6.2	18.31	0.87
Corroon & Black Corp.	NYSE	30.75	-2.8	8.8	34.75	28.00	81	1.08	3.5	4.7	5.43	5.66
Gallagher Arthur J. & Co.	NYSE	17.25	-6.1	7.8	18.88	13.88	107	0.48	2.8	12.4	5.16	3.34
Hall Frank B. & Co.	NYSE	4.63	-2.5	60.8	5.50	2.88	53	0.00	0.0	12.4	0.00	N/A
Hilb, Rogal & Hamilton	OTC	11.50	4.5	17.9	12.75	9.75	16	0.00	0.0	12.4	0.00	N/A
Marsh & McLennan Cos. Inc.	NYSE	53.63	-7.7	8.8	58.50	45.25	500	2.40	4.5	13.1	6.74	7.96
Poe & Assoc Inc.	OTC	8.50	0.0	21.4	9.25	6.75	0	0.40	4.7	2.0	0.57	14.91
BROKERS	AVERAGE		-2.5	23.9					2.6	8.9		
CONGLOMERATES & HOLDING COMPANIES												
Berkley W.R. Corp.	OTC	25.50	-0.5	6.3	29.00	23.50	141	0.36	1.4	6.0	17.63	1.45
Berkshire Hathaway Inc.	OTC	4400.00	0.0	49.2	4525.00	2755.00	210	0.00	0.0	21.4	69.38	11.91
ITT (Hartford Group)	NYSE	49.63	-4.3	10.3	53.38	43.25	942	1.25	2.5	6.7	52.23	0.95
Sears Roebuck & Co. (Allstate)	NYSE	35.88	-1.0	6.7	39.88	32.25	2143	2.00	5.6	8.8	34.74	1.03
CONGLOMERATES	AVERAGE		-1.5	18.1					2.4	10.7		
INSURERS/REINSURERS												
Aetna Life & Cas Co.	NYSE	44.38	-1.1	-1.9	49.88	39.50	1196	2.76	6.2	6.3	53.56	0.83
American General Corp.	NYSE	29.88	-3.6	-5.9	36.38	27.50	648	1.40	4.7	8.1	28.04	1.07
Amer Heritage Life Invt	NYSE	25.00	-1.0	3.1	26.00	24.00	1	1.08	4.3	11.3	20.98	1.19
Amer Indty Fin'l Corp.	OTC	10.25	0.0	13.9	11.75	8.25	0	0.56	5.5	15.8	15.26	0.67
American Int'l Group	NYSE	58.88	1.7	-1.9	65.38	49.00	997	0.40	0.7	9.6	33.56	1.75
Aneco Reins Ltd.	OTC	2.63	-4.4	-22.2	4.00	2.63	40	0.00	0.0	4.5	2.58	1.02
Aon Corp.	NYSE	26.38	-0.5	15.3	27.00	21.88	111	1.28	4.9	9.3	15.13	1.74
Argonaut Group	OTC	40.50	-3.0	36.1	49.00	29.50	62	0.00	0.0	6.6	29.19	1.39
AVEMCO Corp.	NYSE	25.25	-6.5	28.6	28.75	17.88	59	0.34	1.3	12.3	7.74	3.26
Belvedere Corp.	AMEX	4.50	0.0	2.7	6.00	4.38	7	0.04	0.9	6.5	7.87	0.57
Business Mens Assum Co.	OTC	34.75	-0.7	29.9	36.75	25.50	21	1.20	3.5	63.2	24.45	1.42
Chubb Corp.	NYSE	53.38	0.5	-4.5	63.38	51.25	1454	2.16	4.0	6.1	46.13	1.16
CIGNA Corp.	NYSE	45.75	-0.8	4.3	51.88	42.75	386	2.96	6.5	6.3	49.19	0.93
CNA Fin'l Corp.	NYSE	54.38	-1.8	-2.2	64.25	51.00	189	0.00	0.0	7.9	46.40	1.17
Continental Corp.	NYSE	38.50	-3.5	-0.6	41.63	34.75	687	2.60	6.8	7.3	42.10	0.91
Durham Corp.	OTC	33.00	-2.9	53.5	36.25	21.50	67	0.92	2.8	34.0	26.00	1.27
Farmers Group Inc.	OTC	51.75	-3.7	28.6	65.75	40.50	7317	1.44	2.8	12.6	22.02	2.35
Fireman's Fund Corp.	NYSE	31.50	-1.2	21.2	33.50	25.75	341	0.50	1.6	525.0	26.17	1.20
Fremont Gen Corp.	OTC	10.25	-1.3	6.4	13.50	8.75	121	0.60	5.9	525.0	16.24	0.63
General Re Corp.	NYSE	54.00	0.9	-3.4	56.38	45.50	403	1.20	2.2	10.7	26.21	2.06
Home Group Inc.	NYSE	13.75	3.8	15.7	14.38	11.50	272	0.20	1.5	2.9	17.75	0.77
Hanover Ins Co.	OTC	24.25	0.0	4.3	26.25	20.50	29	0.36	1.5	5.4	25.10	0.97
Harleysville Group Inc.	OTC	16.00	0.8	22.0	16.38	13.38	21	0.40	2.5	7.1	16.65	0.96
Hartford Steam Boiler Insp	OTC	31.25	0.0	35.9	32.75	22.50	129	1.20	3.8	11.6	10.65	2.93
Kans City Life Ins	OTC	31.00	0.0	18.1	31.00	25.25	0	0.00	0.0	11.6	0.00	N/A
Kemper Corp.	OTC	23.75	-1.0	15.9	25.25	20.75	421	0.72	3.0	7.4	26.50	0.90
Lawrence Ins. Group	AMEX	15.63	-3.1	131.6	17.50	6.88	2	0.32	2.0	16.1	4.35	3.59
Liberty Corp. S.C.	NYSE	39.25	-0.3	10.6	47.25	34.50	12	0.80	2.0	14.5	17.40	2.26
Lincoln Nat'l Corp.	NYSE	46.25	0.0	15.3	48.75	40.25	77	2.36	5.1	8.9	36.62	1.26
NAC Re Corp.	OTC	25.25	-1.9	42.3	27.50	18.50	62	0.00	0.0	14.7	19.92	1.27
Nobel Ins Ltd.	OTC	6.00	-4.0	-31.4	9.50	4.50	209	0.44	7.3	28.6	9.37	0.64
Northwestern Nat'l Life	OTC	29.75	1.7	30.0	30.38	22.63	153	1.12	3.8	7.6	35.05	0.85
Ohio Cas Corp.	OTC	34.88	1.1	-3.8	38.25	32.25	116	1.88	5.4	8.2	27.86	1.25
Old Rep Int'l Corp.	OTC	25.75	0.5	28.8	25.75	19.13	215	0.74	2.9	6.0	27.82	0.93
Orion Cap Corp.	NYSE	16.38	-3.6	21.3	17.63	13.13	29	0.76	4.6	5.6	9.34	1.75
Phoenix Re Corp.	OTC	8.75	-2.8	34.6	9.50	6.75	73	0.00	0.0	6.3	11.08	0.79
Protective Life Corp.	OTC	14.13	-0.8	15.3	15.13	12.25	65	0.70	5.0	13.5	17.25	0.82
Re Capital Corp.	AMEX	10.00	1.2	-4.8	11.75	9.13	11	0.00	0.0	62.5	11.49	0.87
Provident Life & Acc Ins Co.	OTC	20.50	0.6	31.2	21.88	15.63	277	0.84	4.1	157.7	27.45	0.75
St. Paul Cos. Inc.	OTC	42.50	-0.6	-7.6	51.00	38.25	394	2.00	4.7	6.0	35.83	1.19
SAFECO Corp.	OTC	24.75	-2.9	-10.8	30.00	22.75	457	1.08	4.4	7.9	21.39	1.16
SCOR US Corp.	NYSE	6.75	-5.3	-27.0	9.50	6.88	41	0.10	1.5	4.9	9.39	0.72
Seibels Bruce Group Inc.	OTC	13.25	1.9	17.8	14.25	11.00	53	0.80	6.0	8.6	12.51	1.06
Selective Ins Group Inc.	OTC	26.00	3.0	36.8	26.00	19.25	33	1.24	4.8	5.9	19.52	1.33
Statesman Group Inc.	OTC	4.38	12.9	-6.6	2.75	1.75	101	0.05	1.1	5.9	3.48	1.26
Tokio Marine & Fire Ins	OTC	69.38	1.3	5.3	85.88	63.25	25	0.22	0.3	61.9	0.00	N/A
Torchmark Corp.	NYSE	31.75	-0.4	29.6	33.50	24.50	187	1.20	3.8	10.1	12.24	2.59
Transamerica Corp.	NYSE	33.13	-0.4	11.4	36.75	29.75	605	1.84	5.6	6.6	24.94	1.33
Travelers Corp.	NYSE	36.00	-2.4	2.5	40.00	33.00	1257	2.40	6.7	9.2	45.28	0.80
Trenwick Group Inc.	OTC	13.00	2.0	26.8	13.25	9.75	19	0.16	1.2	11.2	15.41	0.84
United Fire & Cas Co.	OTC	26.00	0.0	0.0	27.00	24.00	1	1.08	4.2	4.9	22.56	1.15
United States Fid & Gty	NYSE	30.88	-2.0	8.4	34.38	28.88	672	2.64	8.5	6.9	19.53	1.58
UNUM Corp.	NYSE	23.38	-1.6	26.4	24.63	17.88	310	0.48	2.1	11.6	28.53	0.82
USLIFE Corp.	NYSE	39.00	4.0	36.8	39.38	28.00	269	1.28	3.3	10.1	46.77	0.83
Washington Nat'l Corp.	NYSE	28.00	-0.9	17.3	28.63	24.00	23	1.08	3.9	13.0	32.33	0.87
Zenith Nat'l Ins Corp.	NYSE	21.88	-6.4	45.9	23.88	15.00	31	0.88	4.0	9.8	13.78	1.59
INSURERS/REINSURERS	AVERAGE		-0.7	15.1					3.3	25.2		
ALL COMPANIES	AVERAGE		-0.9	16.3					3.2	22.7		

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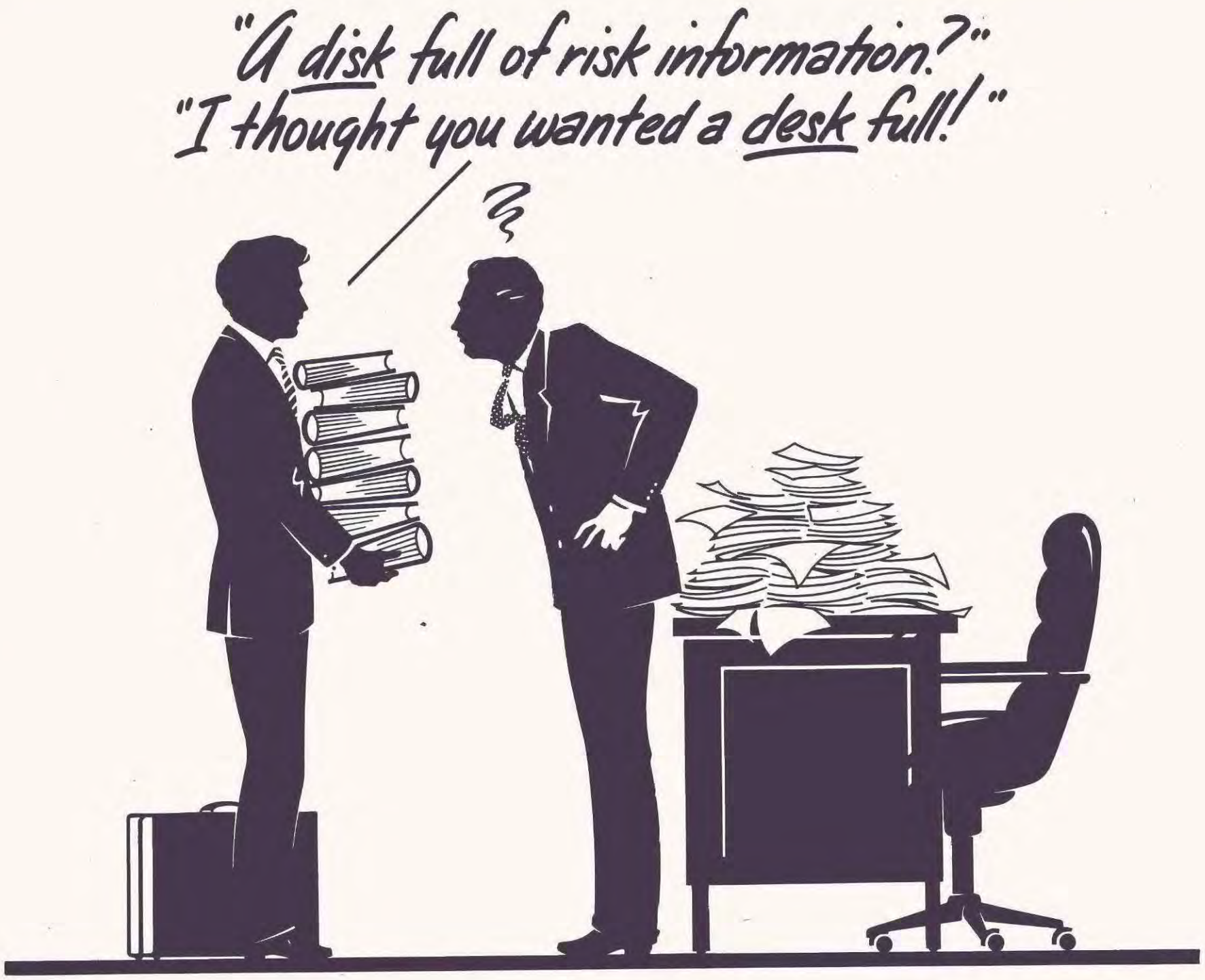

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