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Update

Congressional agency targets benefits to increase revenues

WASHINGTON—Taxing a portion of employer-paid health insurance premiums, slashing maximum pension benefits and contributions and cutting maximum deferrals to 401(k) plans would raise some $45.7 billion in federal revenues over the next five years, the Congressional Budget Office said last week.

Of those three options, taxing group health care premiums would generate the most revenues. Taxing employer contributions exceeding $225 a month

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Businesses blast new plan to share Medicare savings

By JERRY GEISEL

WASHINGTON—A revised Medicare proposal sent to a congressional conference committee would create more administrative headaches for employers than the proposal it would replace, business groups charge.

The latest proposal by Sen. Donald Riegle Jr., D-Mich., would require employers with retiree health plans to pass along to retirees for several years any cost savings reaped by employers as the expansion of the Medicare program is phased in, the groups contend.

As Medicare is expanded over several years to cover more acute care catastrophic expenses, employers will be able to reduce the amount they spend on Medicare supplemental plans that cover medical expenses not picked up by Medicare.

Under the original Riegle amendment, which was attached to a Senate-passed Medicare bill, employers would have to pass any cost savings on to retirees (*BI*, Nov. 16, 1987). Retirees would be entitled to additional cash or new benefits that equal the "actuarial value" of any company-provided health care benefits that are eliminated because they duplicate Medicare benefits.

For example, both the House and Senate bills would limit retirees' annual out-of-pocket expenses for acute care services to less than $2,000, compared with a potential limit today of tens of thousands of dollars.

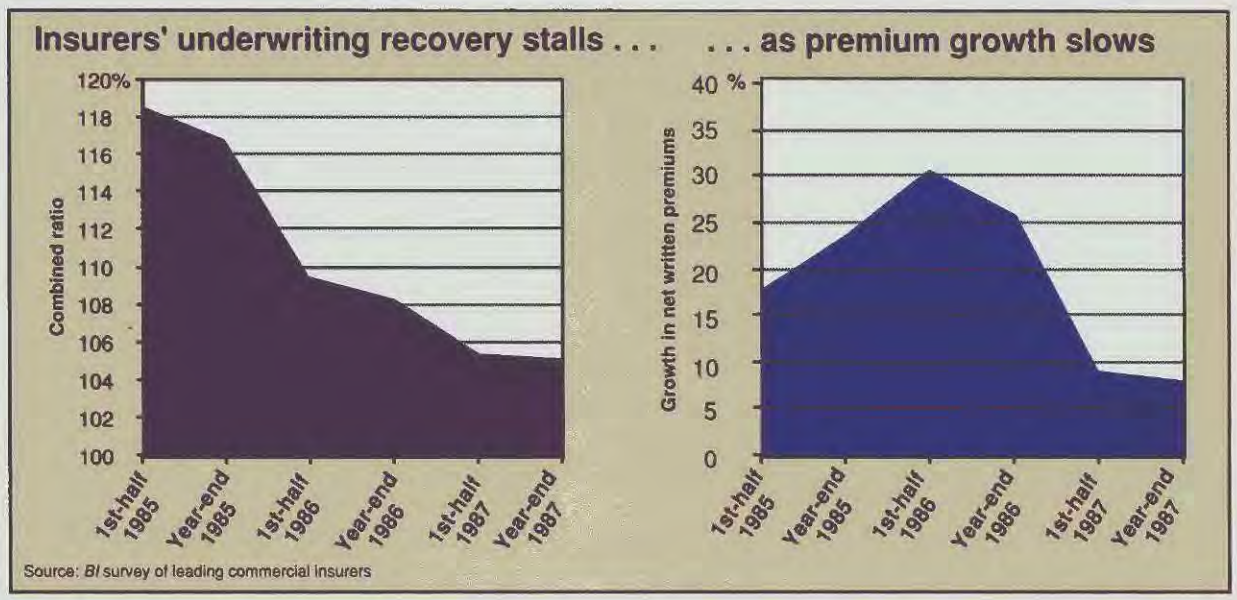
Under the original Riegle proposal, most employers would have to distribute savings to retirees for only one year after the bill is enacted.

But, in a letter sent this month to members of a congressional conference committee that is hammering out differences between the House- and Senate-passed Medicare bills, Sen. Riegle urged the conferees to clarify his so-called "maintenance of effort" amendment.

In that letter, Sen. Riegle said: "The effective date of this provision should be specified as the date each benefit improvement under Medicare becomes effective."

Sen. Riegle also said cost savings should be distributed not only to retirees but also to retirees' spouses and dependents covered by an employer's retiree health care program; the original

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Source: *BI* survey of leading commercial insurers

Competition to pressure insurers' 1988 results

By JUDY GREENWALD

Commercial property/casualty insurers are bracing themselves for a downward slide in underwriting results and, possibly, profits in 1988.

With premium growth declining as price competition intensifies, combined ratios almost certainly will deteriorate this year.

And, while some believe insurers may show some earnings improvement in 1988, others say profit erosion is inevitable given the market conditions.

And, to exacerbate the worries of multiline insurers, poor results from group health insurance business also continue to plague profits (see related story).

Major commercial insurers' property/casualty underwriting results already have leveled off and premium growth has been slowing for several quarters, according to *Business Insurance's* survey of 26 major insurers' year-end results.

The insurers reported an aggregate 105.1% combined ratio as of Dec. 31, the same as was reported after the first nine months of 1987. The insurers had reported a 105.4% combined ratio for the first half and a 105.3% ratio for the first quarter.

Meanwhile, the surveyed insurers reported that net written premium volume increased only 7.6% last year to $84.1 billion. The insurers had reported a 9.1% increase in net written premiums during the first nine months of 1987, an 11.5% jump in the first half and a 12.8% increase in the first quarter of last year.

"It's going to be a very challenging year," predicted Bernard C. Hlavac, vp and treasurer at Sentry Insurance Cos. in Stevens Point, Wis., adding it is "problematical"

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Reinsurers propose claims clearinghouse

By CAROLYN ALDRED

LONDON—In a historic move, leading European reinsurers are proposing a clearinghouse to gather and process claims information for all reinsurers around the world.

The clearinghouse—which has been dubbed the International Reinsurance Advisory Service—initially would concentrate on gathering information concerning major U.S. asbestos losses. However, IRAS ultimately could process information for other types of claims, including pollution cases.

Centralizing asbestos claims information would speed reinsurance payments to ceding companies, the proposal's proponents say.

While reinsurers are giving the proposal strong support, London underwriters and brokers—who contend slow payment of asbestos claims by reinsurers is causing cash-flow problems for ceding companies—say the facility would only slow claims payments further.

IRAS was proposed last week by Jack E. Koepke, a deputy director of Gerling-Konzern Globale Reinsurance A.G. of Koln, West Germany, at a London conference organized to discuss reinsurers' response to asbestos claims.

"An International Reinsurance Advisory Service would of necessity have a worldwide responsibility to research once and for all the ins and outs of each major asbestos loss presentation," said Mr. Koepke.

The proposal was welcomed by other reinsurers at the conference, including representatives from Cologne Reinsurance Co. in Cologne, West Germany; Swiss Reinsurance Co. of Zurich, Switzerland; and Mercantile & General Reinsurance Co. P.L.C. of London.

As a result, an initial meeting to set up the "advisory service" will be called within the next month, said John Butler, chairman of the conference and legal officer for Mercantile & General. Reinsurers from around the world will be invited, he said.

However, the proposal caused an uproar among other London market officials, many of whom declared they will have "nothing to do" with IRAS.

One Lloyd's of London underwriting executive described IRAS as a "stalling tactic devised by the reinsurers to put off paying asbestos claims for another two years."

London underwriters contend they are facing critical cash-flow problems because European, U.S., Japanese and other overseas reinsurers still have not paid asbestos claims submitted by the London market underwriters as long as four years ago (*BI*, Jan. 25; Nov. 16, 1987).

Furthermore, London underwriters allege that reinsurers and retrocessionaires ask unnecessary questions regarding individual asbestos claims and the wording of specific policies to avoid paying claims.

However, reinsurers and retrocessionaires, particularly those in continental Europe, argue that they do not have adequate information and documentation to assess the claims. These reinsurers also dispute London underwriters' interpretation of policy wordings.

Some reinsurers also say that the compromises in the Wellington Agreement that settled coverage disputes between asbestos producers and their insurers often provide members of the Asbestos Claims Facility with coverage beyond the terms of the insur-

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Observers are optimistic that market for pollution liability cover will improve
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Update

CBO targets benefit cuts

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for family coverage and $90 a month for individual coverage would raise some $30.6 billion in revenues from 1989 through 1993, the CBO said in a report to Congress laying out options for reducing the federal deficit.

Some $12.9 billion could be raised over the next five years by lowering the maximum annual contribution that can be made to a defined contribution plan to $15,500 from the current $30,000 and lowering the maximum annual benefit that can be funded through a defined benefit plan in 1989 from the estimated limit of $98,600 to an amount equal to the Social Security wage base, which is projected to be $46,500.

Reducing the maximum annual deferral to 401(k) plans to $4,000 from the projected 1989 limit of $7,700 would raise $2.2 billion over the next five years, according to the CBO.

AIDS cover eyed under COBRA

WASHINGTON—Employers would be required to extend health care continuation coverage for up to 29 months to former employees with acquired immune deficiency syndrome under legislation introduced in the House.

The AIDS Health Care Financing Act of 1988, H.R. 4135, introduced by Rep. Nancy Pelosi, D-Calif., would extend COBRA continuation coverage to 29 months from the current 18 months for ex-employees disabled by AIDS when employment terminates.

Currently, under the Consolidated Omnibus Budget Reconciliation Act of 1985, employers are required to give all former employees—except those fired for gross misconduct—the right to continue health care coverage for up to 18 months. Employers can charge a premium equal to 102% of their costs.

Under the Pelosi legislation, employers would be required to extend coverage for an additional 11 months to former employees with AIDS. An employer could charge these employees a premium equal to 152% of the cost of coverage during this period.

The measure would not change the 36-month period that employers now must extend COBRA health care coverage to employees' divorced, separated or widowed spouses.

Health bill goes to conferees

BOSTON—A bill that would require all Massachusetts employers to provide minimum health benefits to most employees by 1992 is expected to be reconciled by a conference committee this week.

The Senate last week passed its version of the legislation, S. 1551, 23-11 following House passage the previous week.

Under the Senate bill, all employers—regardless of size—would be required to provide health coverage valued at $1,680 per employee annually to all employees that work 27 or more hours a week. The House version, re-numbered H.B. 5210, would exempt employers with fewer than nine employees (*BI*, March 7).

Employers that do not comply by Jan. 1, 1992, would be assessed a per-employee surcharge on their state unemployment insurance equal to 12% of the first $14,000 of payroll, or $1,680 per employee. This revenue would support a state fund to provide coverage for employees not insured by their employers (*BI*, Dec. 28, 1987).

Risk group, two states settle

FRANKFORT, Ky.—Wisconsin and Kentucky will recognize motor carriers liability insurance written by an Indiana-domiciled risk retention group as meeting financial responsibility requirements under separate settlements reached last week.

The American Inter Fidelity Exchange filed suit against the Wisconsin Insurance Department and Kentucky's Insurance Department and Transportation Cabinet after the states refused to accept AIF insurance certificates presented by motor carriers because AIF is not an authorized insurer in the states (*BI*, Feb. 29).

Under the Wisconsin settlement, expected to be signed this week, AIF must maintain $2 million of net surplus, maintain a $250,000 cash deposit and file quarterly statements with the state Transportation Department, according to AIF attorney Simon Karter, of McBurney, Pernia & Wyngaard in Madison, Wis.

Under the Kentucky settlement, signed last week, AIF agreed to maintain net surplus of $2 million; maintain a cash deposit of $225,000 in Indiana; provide the Kentucky department with information on the group's reinsurance arrangements upon request; and file annual financial statements with the Kentucky department and quarterly financial statements if requested.

Reiss to keep Transnational

HAMILTON, Bermuda—Swiss Reinsurance Co., which is expected to complete its purchase of Fred Reiss' majority interest in the Bermuda-based Reiss Organization next month, will not acquire all of Mr. Reiss' business interests, Bermuda sources say.

Mr. Reiss is expected to retain control and ownership of Transnational Ltd., a Cayman-based underwriting manager. Transnational in 1986 managed 35 captives that produced $420 million in premium. Transnational is also one of the founding shareholders of United Insurance Co. of Cayman, which in turn owns Universal Insurance Co. of Ireland.

Although no official announcement has been made, sources also say Arthur Deters, currently vice chairman of the Reiss Organization, will become chief executive officer following the sale.

HMO firm loses $61 million

LOS ANGELES—Maxicare Health Plans Inc. last week reported a pretax loss of $60.9 million for 1987, including a $31.8 million pretax loss for the fourth quarter.

Maxicare attributes the losses to an "unexpected explosion in

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California health plan tax to hit employers, insurers

By DONNA DiBLASE

SACRAMENTO, Calif.—California employers and group health insurers could be forced to pay about $400 million in back taxes following the U.S. Supreme Court's refusal to review an appellate decision upholding the state's authority to tax benefit payments made under minimum premium health care plans.

Some observers say that although the premium tax actually would be levied against insurers, employers with minimum premium plans could end up bearing the brunt of the cost.

Besides the $400 million owed in back taxes, employers and insurers could be liable for up to $100 million annually in new taxes on minimum premium plans.

Most observers say the back tax due will not come as a great surprise to many employers with minimum premium plans because they probably have realized they would have to pay the tax and, as a result, have set up reserves.

And, some employers and benefits experts say the tax may not dramatically affect large California employers, since most big companies now completely self-fund their plans instead of using minimum premium arrangements.

In addition, some insurers predict that fewer California employers will purchase minimum premium plans now that the state will aggressively tax the plans.

The controversy began in October 1983 when General Motors Corp. and the American National Red Cross fought the California State Board of Equalization's authority to tax their minimum premium plans on the grounds that the Employee Retirement Income Security Act of 1974 pre-empts all state laws that regulate or tax self-funded benefit plans (*BI*, June 8, 1987).

However, the 9th U.S. Circuit Court of Appeals last year upheld the state's authority to impose taxes on minimum premium plans. And, the U.S. Supreme Court earlier this month denied a petition to rehear the appellate decision.

The Board of Equalization's authority to tax benefit payments made under minimum premium plans first was upheld by the California Supreme Court in 1982 in *Metropolitan Life Insurance Co. vs. the State Board of Equalization*, better known as the Minimet case.

While observers of the GM case disagree on the cost implications for employers as a result of the premium tax, at least one attorney points out the decision still leaves unanswered the question of exactly what types of benefit plans may be taxed by the state.

Some say the tax could also be levied against insurers providing stop-loss insurance to employers with self-insured benefit plans. Under this scenario, only the premium paid to the stop-loss insurer would be taxed.

"The question that's still unanswered is what plans

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Liquidators of Pine Top take conciliatory approach

By DOUGLAS McLEOD

CHICAGO—The Illinois Insurance Department is trying something new in its attempts to deal with reinsurers and policyholders of the defunct Pine Top Insurance Co.: conciliation.

While liquidators in general have been criticized for being too quick to sue those involved in an insolvent company's affairs, Illinois department representatives say they are trying a more businesslike approach in Pine Top's liquidation.

Instead of suing reinsurers with past due balances payable to Pine Top, for example, Insurance Department liquidators are asking the reinsurers to pay outstanding balances into trust accounts pending completion of a review of the insolvent insurer's records.

The liquidator will not draw on these interest-bearing trust funds until reinsurers agree on the amounts actually payable. Any excess funds in the trust accounts will be returned to reinsurers with a pro-rata share of the interest earned, Illinois department representatives say.

The liquidator also is negotiating with ceding insurers that drew down Pine Top letters of credit after the insurer was declared insolvent in December 1986. The draw-downs included funds in excess of amounts actually due on paid losses, and the Illinois department is asking ceding companies to re-create LOCs or trust accounts to hold these excess funds, interest on which the department says is the property of the Pine Top estate.

While proposals similar to these may have been used by insurers privately running off their own business, this may be the first time such an approach has been attempted officially by the liquidator of an insolvent insurer, sources familiar with liquidations say.

The point of the Insurance Department's approach is to avoid costly litigation while it pursues Pine Top's liquidation.

"The history of liquidations has been shoot first and ask questions later," observed Joseph T. McCullough IV, a lawyer representing the Insurance Department. He noted that the liquidator is trying to foster a spirit of "cooperation rather than confrontation."

"We are trying to take a commercial approach. We are trying to avoid litigation," said Mr. McCullough, with Sidley & Austin in Chicago. "In the end the estate wins because it does not eat up a lot of money in legal battles."

While Insurance Department representatives say the approach has been well-received so far—particularly among Pine Top's foreign reinsurers—its ultimate success or failure has yet to be seen.

Rather than pay money into trust funds, for example, some reinsurers are expected to stall on making any payments until the liquidator's review of Pine Top's records is complete, probably at the end of this year.

These reinsurers may feel that "the longer they sit back and do nothing, the longer they enjoy the benefits

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- Every effort should be made to save the Asbestos Claims Facility from folding, despite the withdrawal of major asbestos producers, says this week's editorial. **PAGE 8**
- Indiana has enacted a workers compensation legislation increasing disability benefits. **PAGE 10**
- Increased state regulation of public sector pools is inevitable, say consultants and pool officials at a recent pooling conference. Coverage of 'Intergovernmental Risk Sharing Pools: Survival for the Long Term' begins on **PAGE 14**
- In Speaking Out Thomas S. Bloom, president of McAlear Associates Inc., says the National Assn. of Insurance Commissioners must develop a more effective method of identifying potential insurer insolvencies. **PAGE 27**
- Bankrupt Lodderhose Inc. maintains it had an agreement with the Insurance Exchange of the Americas that allowed it to offset claims against reinsurance policies underwritten by IEA syndicates with reinsurance premiums collected on their behalf. **PAGE 32**
- The traditional defined benefit pension plan remains the most popular pension plan offered to salaried employees, a recent study shows. **PAGE 35**
- Congress next year should consider a tax to finance the cleanup of hazardous waste sites, says the president of American International Group Inc. **PAGE 40**

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Market for EIL coverage is 'improving'

By DEBORAH SHALOWITZ

The market for environmental impairment liability insurance is marginally better than it was a year ago, and brokers and consultants are optimistic that the market soon could improve even further.

The EIL market's largest U.S. insurer, American International Group Inc., is offering increased limits this year, while Reliance National Risk Specialists, a new underwriting division of Reliance Group Holdings Inc. of New York, began writing EIL coverage late last year on behalf of other Reliance affiliates.

Capacity offered for pollution risks written by other markets—like the Pollution Liability Insurance Assn., the London marine insurance market and offshore excess liability insurance captives—remains stable.

A risk retention group being formed by Alexander & Alexander Services Inc. and a new association captive sponsored by Rhulen Agency Inc. hope to begin writing coverage for both gradual as well as sudden and accidental pollution incidents later this year.

"The market is improving," said Lynne M. Miller, president of Environmental Strategies Corp. in Vienna, Va.

There are "alternatives to no insurance or conventional insurance," added Karen G. Bellus, vp and director of the Project Planning National Marketing Group for Alexander & Alexander of New York Inc., a subsidiary of Alexander & Alexander Services Inc.

"There is pollution insurance available," agreed William Kronenberg, president of Environmental Compliance Services Inc., in Downingtown, Pa. However, "it is not cheap, it is not broad and it is not easy to get."

However, the likelihood that any more conventional insurers will soon enter the EIL market is "very slight" because insurers cannot adequately assess pollution risks, according to Deeohn Ferris, counsel to the American Insurance Assn. in Washington, D.C.

Ms. Ferris explained that insurers cannot estimate pollution liabilities because of numerous obstacles, including the long latency period for damage to occur, multiple causation and joint and several liability.

Observers point out that companies with substantial pollution exposures are increasingly turning to the EIL market since "sudden and accidental" pollution incidents are specifically excluded under the Insurance Services Office's new commercial general liability policy forms.

Currently, there are three stand-alone U.S. EIL markets: New York-based AIG; PLIA, which is a voluntary association of 20 insurance companies based in Downers Grove, Ill.; and Reliance. Each offers claims-made, third-party liability coverage for sudden and gradual pollution on a per-site basis. And, all exclude coverage for known prior pollution.

AIG is writing limits of $15 million per claim and $15 million aggregate, up from $12.5 million last year.

The minimum premium for a $1 million policy with a $25,000 self-insured retention is $17,500, according to Robert Patterson, corporate secretary of American Home Assurance Co. and National Union Fire Insurance Co. of Pittsburgh, Pa., both units of AIG.

He noted that rate increases on renewals averaged 5% in December, down from an average rate increase of 25% the previous year.

The insurer's clients include all types of manufacturers, companies that manage hazardous waste, petrochemical companies and utilities.

However, Mr. Patterson pointed out that many other industries—hospitals, universities, laboratories and testing facilities—have smaller pollution exposures and may not be aware that they need EIL coverage.

AIG's EIL policy does not cover policyholders' third-party liability arising from hazardous waste disposal sites the policy-

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Photo: Jack Parsons

Southwestern architecture greeted insurance commissioners at their zone meeting in Santa Fe.

Car troubles

Residual markets running out of gas

By MEG FLETCHER

SANTA FE, N.M.—The withdrawal of insurers from residual markets for commercial auto insurance is threatening the programs in several states.

At least six of the dozen servicing insurers for the Commercial Automobile Insurance Procedure—an insurer-organized assigned risk pool operating in 39 states to insure commercial car fleets, trucks and buses—plan to withdraw from the program unless more companies join.

Problems with the CAIP program were hot discussion topics at the National Assn. of Insurance Commissioners' spring zone meeting last week in Santa Fe, N.M.

Without more insurer support, the CAIP program will collapse, said John J. Corbley, president of the Automobile Insurance Plan Service Office in Johnston, R.I., a rate-making organization for automobile assigned risk plans.

The CAIP program differs from other assigned risk plans because only large insurers, rather than all insurers, participate.

As a result, buyers benefit from access to nationwide markets and sophisticated claims handling and loss control services.

The CAIP also differs from other residual markets because insurers can choose the states in which they will act as servicing insurers.

Continued on next page

NAIC panel seeks abolition of CDWs

By MEG FLETCHER

SANTA FE, N.M.—Rental car companies should not be allowed to hold customers liable for accidental damage to a rental car, a task force of the National Assn. of Insurance Commissioners proposed last week.

The proposed NAIC model law would be a simple yet powerful solution to consumer complaints about the rental car industry's marketing of collision damage waivers.

Under the proposal, a renter or any other person allowed to use the vehicle could be found liable for damages and loss-of-use charges if a car is damaged due to "willful and wanton misconduct," or while driving under the influence of alcohol or any drug, or while engaging in any "speed contest."

The proposal, which applies only to private passenger vehicles rented for less than 30 days, was adopted last week by the Market Conduct Surveillance Task Force, which is composed of nearly half the nation's insurance commissioners. The full 55-member NAIC is expected to approve the measure in June.

"This is the cleanest way to do it," said William McCartney, Nebraska's insurance director, who chaired the task force at the NAIC's zone meeting last week in Santa Fe.

The proposal eliminates the need for rental car

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Work comp issues on RIMS' agenda

By GLENN HUNTLEY

Risk managers will learn innovative strategies for managing and preventing workers compensation claims at the 26th annual Risk & Insurance Management Society conference next month.

Already, more than 3,500 people have registered for the conference, to be held April 17-22 in Washington, D.C., said Barbara Parker, assistant conference director for RIMS.

"We expect registration to be 1,000 more than last year," when registration totaled a record 3,700 people, she said.

One of the workers compensation sessions, "How to Deal with New Occupational Disease Exposure," S 59, will discuss how stress, use of computer terminals and poorly designed work stations, among other things, are contributing to workers compensation claims.

This session is intended to help risk managers identify the most threatening occupational disease exposures, deal with insurance coverage questions, comply with new government requirements and control losses.

"I think it will be an interesting session. I'm looking forward to it," said Dave Mettler, director of risk management at Hillhaven Corp. of Tacoma, Wash., the session's moderator.

Speaker Charles Caronia, president of the Caronia Corp. in Jericho, N.Y., will address related issues of claims management, medical management and loss control.

William Stafford, assistant vp of risk control at Industrial Indemnity Co. in San Francisco, and Ken Pinkston, senior vp of Corroon & Black in Nashville, Tenn., also will participate in the panel discussion.

The use of health care cost-containment techniques—such as pre-

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Preferred agent plan discriminatory: Broker

By STACY ADLER

LOS ANGELES—A small California broker is suing CIGNA Corp. in federal court, alleging that the insurer's COMPAR preferred broker program is an unfair trade practice that violates federal and California antitrust laws.

Stone Insurance Brokers of Pasadena charges in the suit—thought to be the first of its type filed against an insurer—that COMPAR broker Chandler Insurance in St. Paul, Minn., was able to woo away Stone's largest property/casualty account by offering to place the account with CIGNA at a $300,000 premium discount and with greater coverage than Stone could obtain from the insurer.

Stone, which is seeking $60 million in damages, alleges the insurer's preferred broker program violates provisions of the Sherman Antitrust Act and the California Business and Professional Code. Damages can be trebled under the provisions of both laws.

Philadelphia-based CIGNA has not filed a response to the complaint and would not comment on the allegations.

But Chandler President Duane Cooksey said Stone lost the account because it performed poorly. He added that his ability to place the account with CIGNA had nothing to do with being a COMPAR broker.

While the lawsuit, filed Feb. 25 in U.S. District Court in Los Angeles, is limited to facts surrounding CIGNA's COMPAR program, it raises many long-standing criticisms of preferred agent programs.

Through these programs, insurers may give certain brokers access to special programs, training and technical assistance in return for a portion of an agent's or broker's business.

The lawsuit, which also names several CIGNA units and Chandler, could expose insurers to more antitrust litigation, said attorney Bryan Sheldon, with the firm of Allan A. Sigel in Los Angeles, who represents Stone.

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CAIP insurers

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In addition, servicing insurers pool losses with other major commercial auto insurers in proportion to their market share, rather than bearing the losses of the individual policyholders it writes, said James Rabenstine, vp of intercompany and government relations for Liberty Mutual Insurance Co. in Boston.

CAIP's nationwide premium volume leaped to $819 million in fiscal 1987 from $370 million in 1986, primarily because federal laws began requiring owners of some vehicles engaged in interstate commerce to purchase up to $5 million in liability insurance, Mr. Corbley said.

The six insurers say that unless they receive help from other underwriters, they plan to stop writing new CAIP business in more than two dozen states starting Aug. 31.

Continental Casualty Co., a unit of CNA Financial Corp., notified regulators in February that it was withdrawing from CAIP because its resources had been 'strained' because of 'rapid growth' in the number of CAIP policies it writes.

It's not clear whether the withdrawing insurance companies could reject renewal business, Mr. Corbley said.

The servicing insurers, or their parent companies, that have announced their intent to withdraw from CAIP are:

- Continental Casualty Co., a unit of CNA Financial Corp., which intends to withdraw as a servicing insurer in 17 states.
- Liberty Mutual Insurance Co., which plans to withdraw in 14 states.
- United States Fire Insurance Co., a Crum & Forster unit, which plans to withdraw in 11 states.
- Aetna Casualty & Surety Co., which intends to withdraw in six states.
- Hartford Accident & Indemnity Co. and Twin City Fire Insurance Co., both units of Hartford Insurance Group, which intend to withdraw in four states.

The CAIP programs in some states have more than one servicing insurer.

More insurers are expected to announce plans to withdraw from CAIP in some states, NAIC officials say.

"If they won't participate, the regulators will have to regulate," said Richard Rogers, deputy director of the Illinois Insurance Department.

Regulators at last week's NAIC meeting said the problem surfaced when Continental Casualty notified regulators in February that it was tendering the required 180-day notice to withdraw from CAIP.

CNA "has totally supported the program and was in the forefront in volunteering," said a draft of a letter from NAIC officers that will be sent to the chief executive officers of major commercial auto insurers.

CNA undoubtedly anticipated that "the other major carriers would follow their lead and also volunteer as servicing carriers to equally distribute the assignments without overtaxing the resources of any one individual carrier," the letter says.

However, CNA's staff resources have been "strained" because of "rapid growth" in the number of CAIP policies it writes, a company spokesman said.

CNA wrote 28,000 CAIP auto insurance policies generating more than $135 million in premium last year, compared with 833 policies generating about $1.36 million in premium in 1983.

"While a few carriers have come forth on a limited basis in certain jurisdictions, the resignation of CNA has unmasked the problem of getting commercial carriers to bear their fair share," states the letter from John Washburn, NAIC president and Illinois insurance director, and David Gates, NAIC vp and Nevada insurance commissioner.

Gene Flynn, Hartford's director of involuntary automobile markets, said Hartford has reached the point where physical limitations of manpower, space and claims handling abilities prevent the company from taking on any more CAIP applicants.

Other large commercial auto insurers that currently act as CAIP servicing insurers, according to Mr. Corbley, include: American International Group Inc.; Travelers Corp.; USF&G Corp.; Fireman's Fund Insurance Cos.; Industrial Indemnity Co., a unit of Crum & Forster Inc.; and Progressive Casualty Insurance Co.

Some insurers, like Liberty Mutual, write a disproportionately large percentage of CAIP premium relative to their overall share of the commercial auto insurance market, Mr. Rabenstine said.

However, four of the top 15 commercial auto insurers do not act as servicing insurers in any states, Mr. Corbley said: Nationwide Insurance Group; CIGNA Corp.; Zurich-American Insurance Co.; and Royal Insurance Co.

Mr. Corbley said that several companies are considering the CAIP's appeal for help and at least one of the withdrawing insurers is willing to expand operations in one state while withdrawing from others.

In their letter to insurers, Messrs. Washburn and Gates praise the efforts of Mr. Corbley's group to address the "serious" problem through a special coordinating conference, but "it appears the support is far short of what is needed as commitments are still insufficient to make the CAIP program viable in the 17 jurisdictions" from which CNA is withdrawing.

"The NAIC is totally dedicated and supportive of industry voluntary programs as opposed to mandatory programs to address insurance availability issues," the letter says.

"We strongly urge you to commit the resources necessary to continue CAIP on a voluntary basis," Messrs. Washburn and Gates say. ■

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- Automatic Generation of Letters and Forms
- Premium Delay Capability
- Monthly Premium and Eligibility Reports to Vendors
- Monthly Premium Notices or Coupons
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BI adds Reid to sales staff

NEW YORK—Nora Reid has joined the *Business Insurance* advertising sales staff in New York as a district manager, announced Advertising Director Donald A. Walsh.

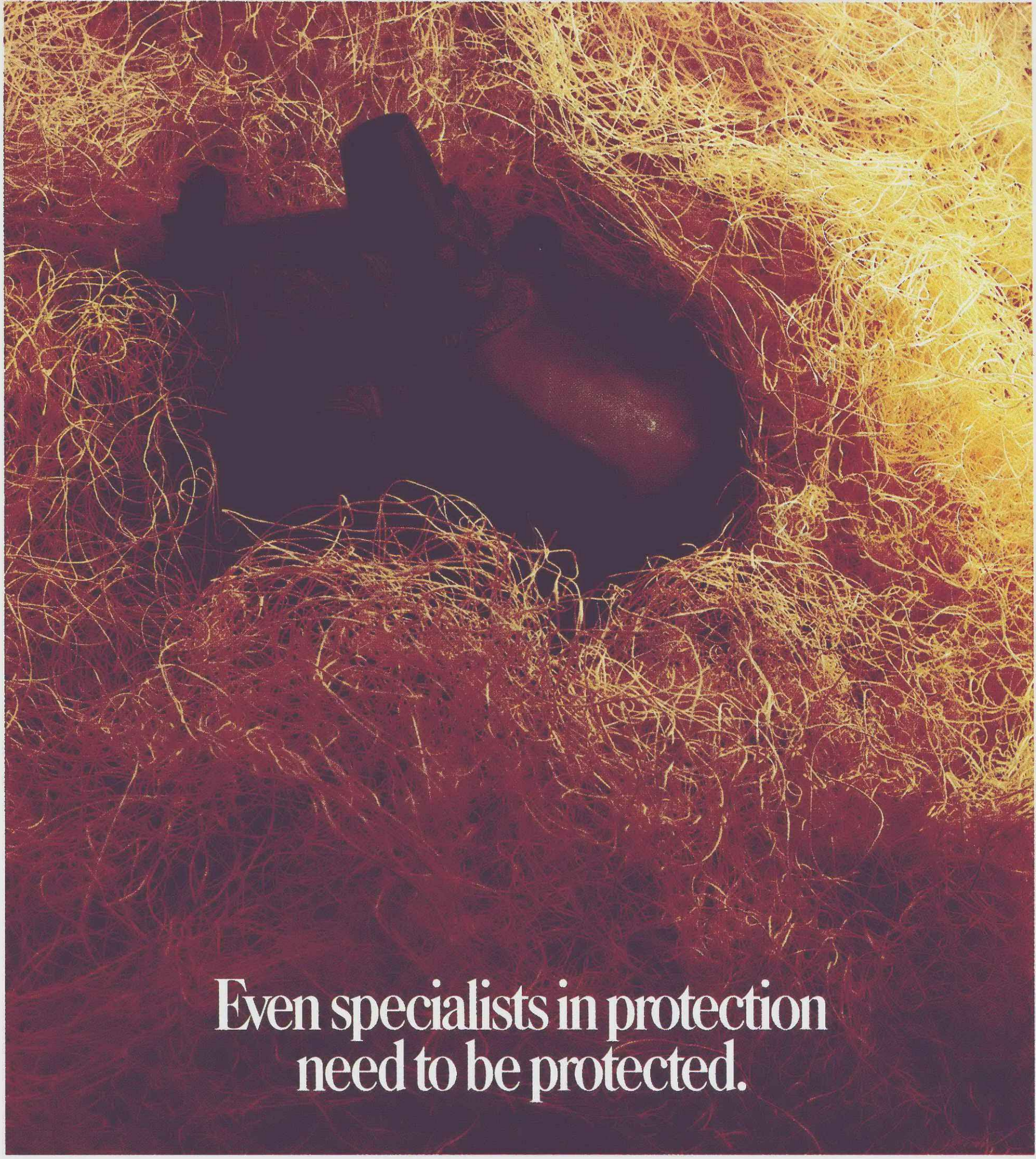
Ms. Reid, 24, will have responsibility for selected accounts in New England and the Northeast.



Ms. Reid

Prior to joining *BI*, she held advertising sales positions at Adventure Publishing Group and Ziff Davis Publishing in New York. Ms. Reid is a graduate of Manhattan College in New York, where she received a bachelor of arts degree in marketing.

Ms. Reid may be reached in New York at 212-210-0757. ■



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Flex plan participants opt for few changes

Faced with a multitude of new benefit options, most employees at Fleet Financial Group Inc. have opted for health benefits that mirror those provided by the company's former benefit plan.

But the Providence, R.I.-based company hopes that as employees become more comfortable with the "Fleet Flex" flexible benefit package, which became effective in January, they will dare to be more innovative with their options, said Joseph K. Cembrola, assistant vp-employee benefits.

The plan developed for Fleet Financial by The Wyatt Co. in Wellesley Hills, Mass., includes an array of medical, dental, life insurance, long-term disability and vacation benefits.

Fleet Financial expects its benefit costs to be "slightly higher" than its costs for the previous benefit program primarily because of the addition of dental coverage, Mr. Cembrola said.

Benefit beat

In part, the shift to flexible benefits was spurred by Fleet's generally younger employee population, which wanted benefits to suit its needs, he said. In a survey of Fleet Financial employees that Wyatt conducted in 1986, 57% of the surveyed employees said they wanted to select their own benefits options and 61% said they would take less of one benefit to gain greater coverage in another area.

But, after the Fleet Flex plan was implemented, about 88% of the company's 2,700 eligible employees were "very conservative" with their choice of medical coverage and stayed with a high option that best replicated their previous benefits, Mr. Cembrola said. "We were surprised by that."

However, other employees already have traded one benefit, such as vacation days, for other benefits, he said.

Employees are allowed to buy or sell one to five vacation days annually, but most who have exercised that option have sold just a day or two to gain improvements in other benefits.

The flex plan offers similar coverage to that provided in the previous benefit package, but by popular demand it adds dental insurance for the first time, he said.

Employees can choose from two dental options: one that covers basic and restorative services and another that also covers other major restorative services such as inlays, crowns, bridges and dentures. The maximum annual benefit under the basic plan is $500 per person and the maximum under the expanded coverage is $1,000 per person.

Fleet employees can choose from three medical plan options, which all pay 100% of outpatient surgery and pre-admission testing costs. The plans pay differing amounts on eligible hospital and surgical expenses:

- Under Plan I, after a deductible of $500 for single coverage or $1,000 for family coverage, a 20% copayment is required on the next $7,500 of expenses. The annual maximum out-of-pocket expense is $2,000 for single coverage and $4,000 for family coverage.
- Under Plan II, after a deductible of $250 for single coverage or $500 for family coverage, the required copayment is 20% of next $3,750. The annual maximum out-of-pocket expense is $1,000 per individual or $2,000 per family.
- Under Plan III, an employee pays a $100 deductible per hospital admission, after which the plan pays 100% of eligible expenses. For non-hospital expenses like prescription drugs and doctors' visits, a $200 per person deductible applies. The plan pays 80% of all costs beyond the deductible. The lifetime maximum benefit is $1 million.

The medical and dental coverage is underwritten by Metropolitan Life Insurance Co. of New York.

Life insurance benefits, underwritten by U.S. Life Insurance Co. of New York, equal 200% of an employee's salary. Employees have the option to trade half of that amount for credit toward other benefits.

Additional life insurance from $10,000 to $300,000 is available in $1,000 increments. Optional coverage may be purchased for spouses and dependent children.

Drug testing survey

Just fewer than half of the companies responding to a recent survey reported they have drug testing policies for employees, according to TPF&C, a division of Towers, Perrin, Forster & Crosby.

The consulting firm recently surveyed 249 U.S. companies and found that 111, or 44.5%, have some form of drug testing policy in effect.

Most of the companies with testing procedures, about 84%, combined testing with counseling and treatment programs, according to the survey.

Three-quarters of the companies with testing policies said they use drug tests to screen job applicants, while 66% reported tests were required when it is suspected that an employee has a drug dependency problem.

Long-term care

Employees of American Express Co. can elect to buy long-term care insurance under a new plan sponsored by the company and underwritten by Travelers Life Insurance Co.

The plan offers two levels of coverage and includes long-term care at home or in nursing homes and adult day-care facilities, said Karen Manning, vp-employee benefits for the New York-based company.

One option pays $50 per day for nursing home care or $25 per day for home or adult day care. The maximum benefit is $75,000.

The other option pays $100 per day for nursing home care or $50 per day for home or adult day care. The maximum benefit under this option is $150,000.

Employees pay the full premium for the coverage based on the age of the covered individuals, Ms. Manning said. Employees' spouses and parents of employees and spouses also are eligible for coverage.

Coverage can be extended after an employee leaves American Express.

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Indiana increases workers comp benefits

By LINDA J. COLLINS

INDIANAPOLIS—Indiana employers are likely to pay more for workers compensation insurance following enactment of a work comp reform law that increases disability benefits over the next three years.

However, exactly how much more employers will pay is still being computed by the National Council on Compensation Insurance, according to Larry Hochstetler, director of government, consumer and industry affairs for the NCCI in Springfield, Ill.

Insurers in Indiana use NCCI advisory rates for determining workers compensation premiums.

In addition to the workers comp benefit increase, legislation signed earlier this month by Gov. Robert D. Orr also changes language in the state's work comp statutes, amends the state insurance code to implement the National Assn. of Insurance Commissioner model risk retention law and increases state guaranty fund coverage limits.

Gov. Orr also signed a tort reform measure that caps prejudgment interest at 10% and prohibits the awarding of prejudgment interest for punitive damages in judgments made after July 1.

The first workers compensation measure, S.B. 402, increases maximum weekly disability benefits 35% to $256 from $190 on July 1. The maximum benefit will rise to $274 on July 1, 1989, and $294 on July 1, 1990.

The law also increases the benefit payment period to a maximum of 78 weeks from 52 weeks after July 1.

The maximum weekly permanent partial impairment benefits will increase to $100 from $75 on July 1. It will then rise to $110 on July 1, 1989, and $120 on July 1, 1990.

Maximum total benefits for those periods will be increased to $128,000 this year, $137,000 in 1989 and $147,000 in 1990 from the current $95,000.

The law also increases the statute of limitations for filing asbestos claims to 35 years from 20 years if the last exposure occurs on or after July 1.

And, in an emergency provision effective immediately, S.B. 402 extends the period for filing all asbestos claims until July 1, 1990.

Another bill, S.B. 223, effective April 1, closely tracks the language of the National Assn. of Insurance Commissioners' model statute on the federal Risk Retention Act (*BI,* June 29, 1987).

The new law allows purchasing groups to buy insurance only from admitted insurers or risk retention groups chartered in Indiana unless it is purchased through a licensed surplus lines agent or broker.

The amendment also requires the insurance commissioner to report annually to the General Assembly on the status of the state's FAIR plan.

Further, the law prohibits insurers from canceling policies in effect for more than 90 days except in certain cases. In those cases, the law requires: 10 days' written notice by the insurer before cancellation for failure to pay a premium; 20 days' notice before cancellation when "an insured has perpetrated a fraud or material representation on the insurer"; and 30 days' notice before cancellation for other stated reasons.

A second insurance-related bill, S.B. 378, increases the state property/casualty guaranty fund's coverage limits to $100,000 from $50,000 and limits the filing of claims to within one year of liquidation orders executed after June 30.

Also under S.B. 378, the state guaranty fund cannot be tapped to pay claims if: a claimant's net worth at the time of an insured event is more than $5 million; the net worth of the policyholder insured by an insolvent insurer exceeds $50 million; or the claimant "directly or indirectly controls, is controlled, or is under common control with an insolvent insurer on Dec. 31 of the year before" liquidation.

H.B. 1037, signed Feb. 29 by Gov. Orr, caps prejudgment interest at 10% and prohibits the awarding of prejudgment interest for punitive damage awards made after July 1. Indiana previously had no parameters for awarding prejudgment interest in tort cases.

The law also prohibits the awarding of prejudgment interest if a defendant's pretrial settlement offer was at least two-thirds of the final judgment, or if a plaintiff had agreed to accept a settlement offer of more than 133% of the final judgment.

Other measures signed into law earlier this month include:

- H.B. 1069, which makes the state workers comp law gender neutral and changes the name of the Industrial Accident Board to the Workers Compensation Board.

H.B. 1069 also permits hearings to be held in a county adjoining that in which an injury occurs and allows doctors to submit detailed written reports instead of appearing in court for depositions.

- H.B. 1170, effective March 1, 1990, which will raise the financial responsibility requirements for most intrastate common carrier truckers and private truckers to $100,000 per occurrence/$300,000 aggregate from $25,000 per occurrence/$50,000 aggregate for bodily injury and to $50,000 from $10,000 for property damage. Interstate common carrier truckers in Indiana already must meet these requirements.

Trucks transporting hazardous materials or chemicals already must comply with tougher federal financial requirements.

H.B. 1170 also will transfer authority for motor carrier regulation to the Department of Revenue from the Utility Regulatory Commission on July 1 this year.

In addition, the law will require truckers to file annually certificates of insurance or proof of financial responsibility with the Department of Revenue

- H.B. 1070, which increases the Insurance Department's filing and licensing fees and empowers the insurance commissioner to take court action against insurers violating state insurance laws. Previously, that authority rested with the state attorney general.

The law also requires preferred provider organizations to file an annual statement with the Insurance Department listing the names and addresses of organizers and providers, describing the geographical area in which the PPO operates and listing the number of enrollees in the plans.

Another section in H.B. 1070 requires the insurance commissioner, the director of the Department of Financial Institutions and the securities commissioner to submit a consolidation plan to the General Assembly by Sept. 1, 1989. ■



CIGNA suit

Continued from page 3

"A favorable ruling could cause the COMPAR program, as well as other similar preferred agent programs, to be substantially modified or to cease to exist," he said.

According to the lawsuit, Stone received a $1.7 million quote from CIGNA on Jan. 20, 1987, for a property/casualty policy for Birtcher, a Laguna Niguel, Calif.-based real estate developer, that excluded certain coverages the policyholder sought.

On Jan. 30, Birtcher informed Stone that CIGNA offered to write the coverage described in the Jan. 20 quote, plus the coverages it previously said it would not write, for a $1.4 million premium if the risk were placed by Chandler, the suit alleges.

Stone demanded that CIGNA offer the same coverage to Birtcher through its agency, but CIGNA refused, according to the suit.

Birtcher subsequently purchased the coverage through Chandler.

Stone alleges that CIGNA, through its COMPAR program, has:

- Created and enforced boycotts of certain insurance brokers, including but not limited to Stone, "who insist upon remaining independent and retaining the ability to offer insurance to their clients from any one of a number of different insurance carriers, depending upon which can provide the best value, and who refuse to offer CIGNA the first opportunity to provide or reject insurance policies for their clients."
- "Conspired and combined (with Chandler) and other brokers of its policies. . .to deprive plaintiff of its ability to arrange for insurance coverage for its clients at competitive rates."
- Written certain risks placed by preferred brokers and then denied the same risk when brought by non-preferred brokers.
- Offered premium discounts to preferred brokers.
- Provided a higher commission to preferred brokers than to non-preferred brokers in exchange for COMPAR agents' agreement that they would attempt to convince each of their clients "to purchase insurance through CIGNA and would grant CIGNA the right of first refusal for all new business produced."

Stone charges the COMPAR program violates the Sherman Antitrust Act, which makes it illegal for any company to interfere by contract, combination or conspiracy with the ordinary and competitive open market in interstate trade. Although the Supreme Court has ruled the act excludes service companies like insurers, Mr. Sheldon said the facts of this case are unusual and warrant action under the law.

The COMPAR program also violates the California Business and Professional Code, which states that secret rebates, unearned discounts, boycotts and collusion are illegal, he pointed out.

Stone is seeking $10 million in compensatory damages for the loss of the Birtcher account, which it had for seven years, the loss of other property/casualty business generated because Stone handled the Birtcher account and for the broker's damaged reputation.

Mr. Sheldon said the loss of the Birtcher account—Stone's largest property/casualty account—severely damaged the broker's reputation because buyers no longer felt Stone was able to get the best deal. Stone now only places life insurance in California.

In addition, Stone is seeking $50 million in punitive damages.

Chandler's Mr. Cooksey contends he was able to place the Birtcher account with CIGNA because of the way he approached the insurer.

"The only reason we take business away from another broker is because we either find a new way to do it or a more cost-efficient way to do it," Mr. Cooksey said. "In this case, we did both."

He said he treated each piece of real estate owned by Birtcher as a separate risk, while Stone lumped them together. Mr. Cooksey said his method of placing about 200 policies instead of 10 saved Birtcher $300,000.

"The broker in California could have done the same thing."

Mr. Cooksey also pointed out that he did not solicit the Birtcher account, but rather Birtcher was referred to Chandler by a business partner who was a longtime Chandler client.

However, in its suit, Stone alleges Chandler received information from CIGNA about the account.

"We believe information supplied by Stone (to CIGNA) found its way to the preferred broker, because they were able to generate a quote very rapidly," Mr. Sheldon said.

If CIGNA provided Mr. Cooksey with this information, he said, CIGNA breached an article of the agency-company contract that forbids the insurer to use any of the records of any account produced by the agent except in the interest of the agent.

Preferred broker programs, which were first instituted about 10 years ago, are offered by many major insurers.

While each program is different, most insurers offer their preferred brokers, among other things, special underwriting authority, marketing privileges and other help, as well as higher commissions.

To qualify, brokers must promise the insurer a minimum premium volume, a certain percentage of their book of business or a certain standing in their agency.

As a COMPAR agent, 90% of Chandler's business is placed with CIGNA, said Mr. Cooksey. CIGNA also has the right of first refusal on all of the agency's business.

In return, CIGNA gives the agency underwriting authority on certain risks. "This gives us a competitive advantage, because we can place the risk faster," he said.

Preferred agent programs benefit insurers by enabling them to generate a large book of business from fewer brokers, reducing administrative expenses dramatically.

For example, CNA Insurance Cos.' 670 HPA agents generate more than 50% of the insurer's field-produced property/casualty business. The Highly Preferred Agents program, established in 1977, was the first preferred agent program.

Not all insurers, however, support the preferred agency concept. James V. Harrington, executive vp of USF&G Corp. in Baltimore, which does not have a preferred agent program, said, "We believe it is unfair because it creates two classes of agents and we do not believe we have two classes of agents. All of our agents are preferred."

Because insurers demand a large volume of business from preferred agents, many small agents and brokers cannot qualify.

And, in some instances smaller agencies are forced out of business by these programs, representatives of small agents and brokers say.

"We have lost many agencies due to carriers that get 80% of their business from 20% of their agents," said Jerry O'Kane, executive vp with the Independent Insurance Agents & Brokers of California.

Mr. O'Kane charged that preferred broker programs, depending on how they are run, are "either illegal or highly unethical."

Because many of these programs require a very high commitment from the broker "it puts them in the same situation as a direct writer," Mr. O'Kane said.

Lawsuits similar to the one filed against CIGNA will surface regularly, predicted Mike Cabbot, executive director of the Western Assn. of Insurance Brokers in San Francisco. ■



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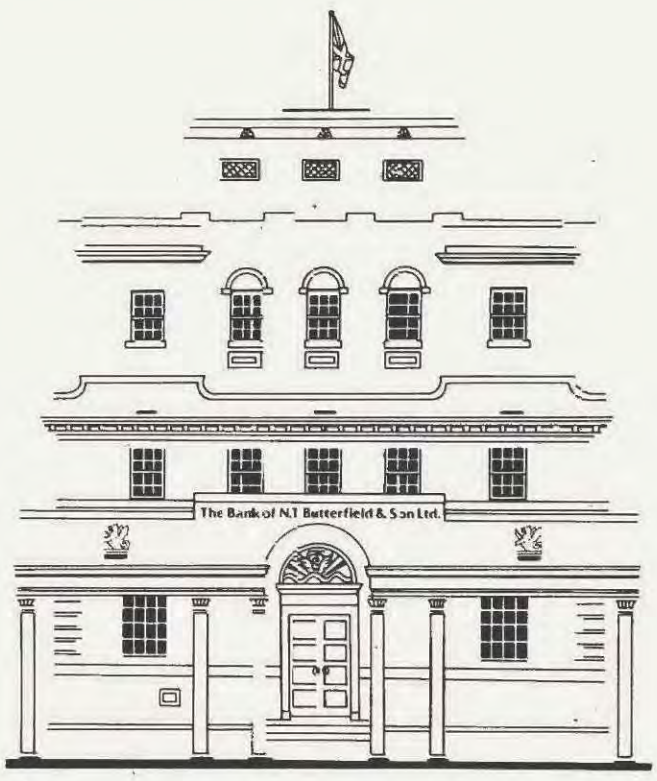
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London

Archer Holdings shares trading on exchange

By CAROLYN ALDRED

LONDON—Shares in A.J. Archer Holdings P.L.C. began trading earlier this month on the London Stock Exchange, making Archer the second Lloyd's of London managing agency to be publicly quoted.

Almost 6 million shares, representing 26% of Archer's issued share capital, were placed on the exchange for 130 pence each, giving the company a total value of more than 30 million pounds ($53.4 million at current exchange rate).

Archer manages eight Lloyd's syndicates with a total 1988 premium capacity of 258 million pounds ($459.2 million).

Shell insured

Operating companies of the Royal Dutch/Shell Group around the world are insured for any claims for automobile engine damage allegedly caused by Formula Shell Petrol gasoline, according to a company spokesman.

He would not comment details of the insurance.

The company could face up to 2 million pounds ($3.7 million) in claims if all 10,000 complaints received so far prove valid.

Additives contained in Formula Shell, which was never marketed in the United States, have been removed following claims that it damaged engine valves. So far, the company has received 10,000 complaints worldwide of damage. Shell estimates the average cost of repair is 200 pounds ($369.60) per car.

Most of the complaints have come from Norway and Denmark, where the gasoline additives were taken off the market at year-end. The additives, which were supposed to improve engine performance, were removed from the leaded gasoline in other countries last month.

Broker to be listed

London-based broker Fenchurch Insurance Holdings Ltd. will soon be listed on the London stock exchange under parent company GPG P.L.C.'s "demerger" proposal.

GPG, the former Guiness Peat investment banking company, last month announced plans to separate into three separate operations, including Fenchurch.

"This would involve, subject to the necessary consents, shareholders obtaining shares in three listed groups in proportion to their existing shareholdings in GPG," a statement said.

The two other operations are investment banking group Guiness Mahon Holdings Ltd., and GPG's offshore operation, which includes Management Compensation Group, a U.S. executive benefits advisory group and U.S. fund manager Forstmann-Leff Associates.

Fenchurch Insurance Holdings Ltd. contributed profits of 7.6 million pounds ($12.5 million) for the year ended Sept. 30, 1987, according to the company.

Shareholders are expected to vote on the final demerger proposal in April.

Commercial Union

Commercial Union Assurance Co. P.L.C. has received claims totaling 70 million pounds ($124.6 million at current exchange rates) so far from the wind storm that ripped through southeast England in October.

However, the net cost to CU was 15 million pounds ($28.4 million at year-end 1987 exchange rate) after reinsurance, said John Carter, director and general manager for the CU's trading operations in the United Kingdom.

CU has recently reported 1987 pretax profits increased 42.8% to 170.1 million pounds ($321.5 million) from 119.1 million pounds ($176.3 million at year-end 1986 exchange rate) in 1986. Premium volume rose to 2.85 billion pounds ($5.4 billion) from 2.77 billion pounds ($4.1 billion) in 1986.

The improved profits were partly due to higher property/casualty insurance premium rates and reduced exposure in the United States, which now accounts for less than 30% of CU's business.

However, while rates in the U.K. non-marine insurance market are remaining firm, London market marine and aviation rates are softening with increased competition from Lloyd's of London and overseas insurers, Mr. Carter said.

Meanwhile, CU plans to write more non-marine business in Europe and will soon open an additional underwriting office in London, he added.

Comings & goings

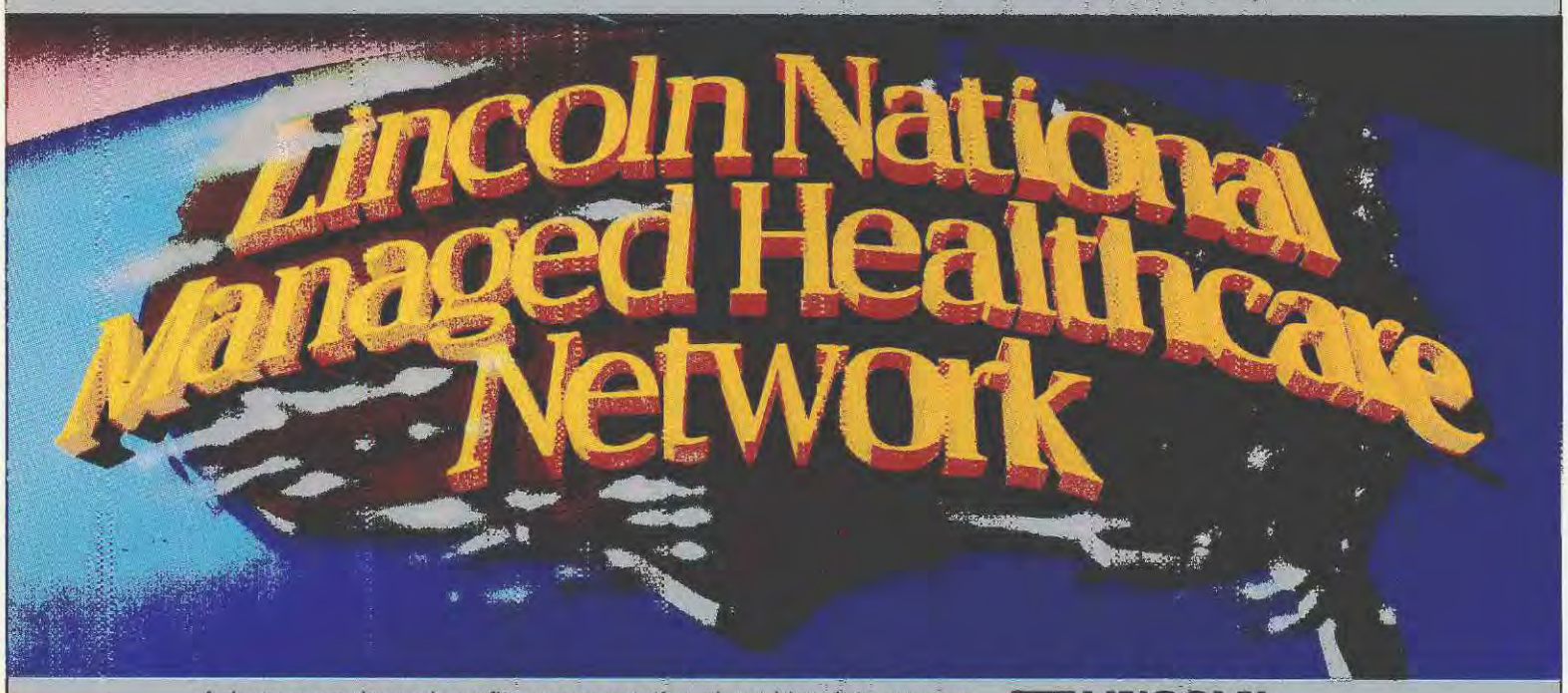
Robert Brandon appointed managing director of C.T. Bowring Reinsurance Ltd.'s new marine brokerage division.

Michael Barrett, chief executive officer of Alexander Stenhouse Europe Ltd., appointed a director of Alexander & Alexander International Inc.

Jonathon Baker appointed director of the marine division of Jardine Thompson Graham Ltd. and **Simon Sampson** appointed a director of Jardine Reinsurance Holdings (U.K.) Ltd. ■

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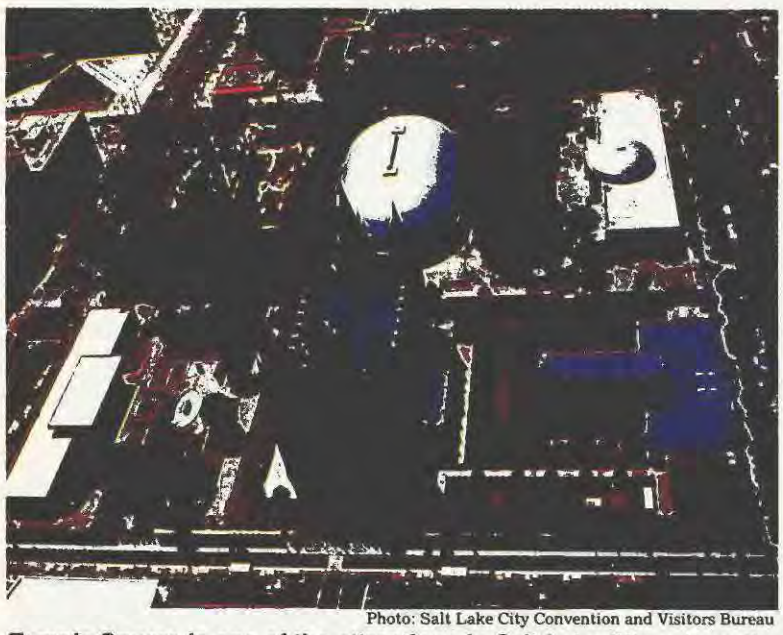


Photo: Salt Lake City Convention and Visitors Bureau

Temple Square is one of the attractions in Salt Lake City, where the conference on public entity risk sharing pools was held last month.

Pooling conference

Public entity pools facing increased state scrutiny

By MEG FLETCHER

SALT LAKE CITY—Increased state regulation of public sector pools is inevitable, consultants and pool officials say.

To prepare for this, pool officials must adopt financial reporting and operating standards that will meet the new demands of legislators and regulators.

"Public sector pools are entering a period of accountability," said Francis J. Fey, vp of The Joseph Ivy Co., a risk management consultant in Austin, Texas.

Mr. Fey made his remarks at a conference titled "Intergovernmental Risk Sharing Pools: Survival for the Long Term," held in Salt Lake City last month. The conference was sponsored by Ivy and Advanced Risk Management Techniques, a consultant based in Laguna Hills, Calif.

Public sector pools "ought to expect to be regulated," warned Harold Pumford, chief executive officer of the OML Municipal Assurance Group. Mr. Pumford is also president of the Public Risk & Insurance Management Assn.'s Pooling Section.

Mr. Pumford pointed out that public sector pools are creatures of the state and state's powers over smaller local governments have expanded in the past 20 years.

Mr. Pumford also noted that a 1985 U.S. Supreme Court decision removed the courts as the arbiter of issues involving public entities and leaves this type of regulation to state legislative or administrative actions.

Increased interest in state regulation of pools may also stem from the insurance industry, which is "becoming much more envious of the niches which we made for ourselves," said Ivy President William Martin.

"All pools operate in a goldfish bowl and individual detractors are waiting for the first one to fall," he added.

Mr. Pumford noted that most states already provide limited regulation of pools.

Specifically, the Michigan Legislature last month passed the nation's "most comprehensive disclosure legislation" for public entity pools, according to the bill's drafter, Rep. Mary C. Brown, D-Kalamazoo (*BI*, Feb. 22).

The bill, which Gov. James J. Blanchard signed on March 3 and is effective July 1, requires public entity pools to submit insurance contracts, annual audited financial statements and actuarial certification of loss reserves to the state insurance commissioner.

The bill also requires each pool to maintain aggregate excess insurance protection of at least $5 million or submit a $5 million cash deposit with the state treasurer. The bill allows a combination of aggregate excess insurance and a cash deposit. However, the bill authorizes insurance or cash deposits of lesser amounts if approved by the insurance commissioner.

The bill gives the insurance commissioner authority to fine or place into receivership pools that fail to comply with these requirements.

The bill was prompted, in part, by the disclosure of significant underreserving for future losses by the Michigan Municipal Risk Management Authority, a pool serving approximately 256 public entities in Michigan (*BI*, Dec. 21, 1987; Feb. 16, 1987).

Well-operated pools should not have trouble complying with the state's new regulations, Rep. Brown said.

Eugene F. Berrodin, director of insurance services for the Michigan Municipal League's self-insurance pools and programs, described the final version of the bill as an acceptable compromise that nearly all pools in the state support.

Rep. Brown told conference attendees that the Michigan law reflects the concerns of insurance agents, regulators and the public about the lack of information about some new pools. Currently, Michigan only requires pools to file an annual financial statement with the state Treasury Department.

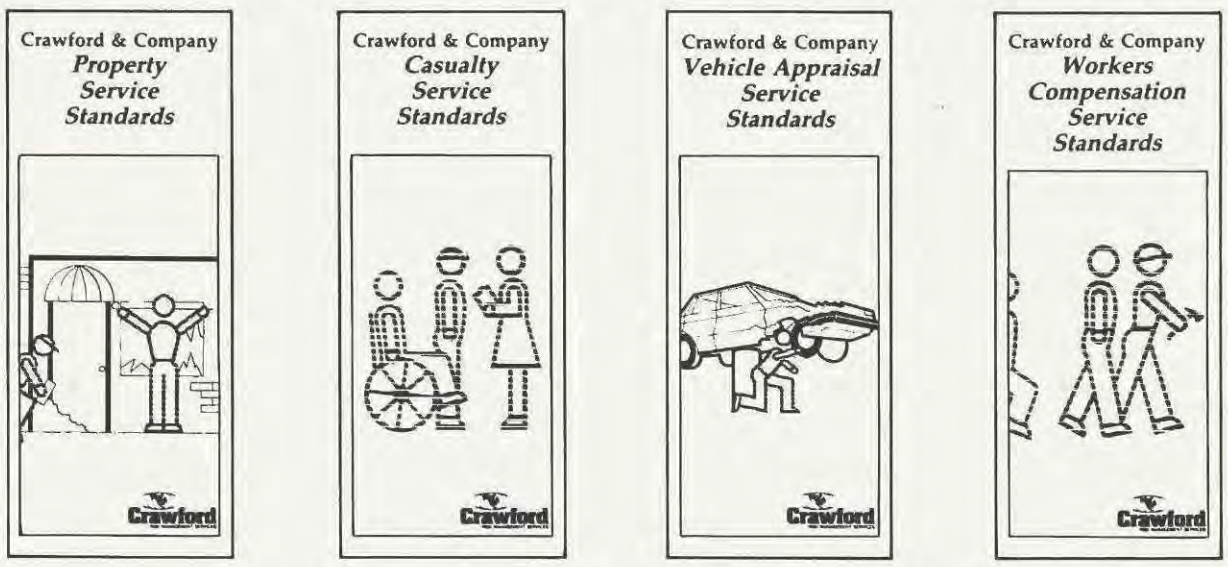
According to OMLMAG's Mr. Pumford, typical regulatory concerns related to public entity pools include: solvency, control, costs, conformity of policy language and financial reports and public scrutiny of operations.

However, while he said he understands the importance of those issues, Mr. Pumford emphasized that regulators should be aware of pooling entities' own concerns, which include: availability and cost of coverage, maintenance of the public sector and the services it offers, risk control and public benefit to taxpayers and claimants.

Continued on page 1

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Pool regulation

Continued from page 14

And John Salisbury, executive director of Housing Authority Risk Retention Group Inc. in Cheshire, Conn., questioned whether state regulators have sufficient staff to regulate pools in addition to their already mandated duties.

Mr. Pumford said that anyone contemplating tougher regulation of public sector pools should deal with the issue of what public entities should do when no coverage is available.

For example, in Oklahoma, which does not regulate public entity pools, 357 cities and towns would have been without any insurance coverage in 1984-85 if OMLMAG had been required to meet capital and surplus requirements, he said.

In the absence of state regulation, OMLMAG at one time operated at a $3 million deficit, Mr. Pumford said. However, he added, the pool now is operating in the black.

Because he sees increasing regulation as inevitable, Mr. Pumford urged pools to:

- Adopt operating standards that meet typical state requirements for insurance companies as a basic component of pool policy.
- Require rigid financial auditing, accept the auditor's findings on behalf of the organization and report them to the pool board.
- Inform members and state officials about the pool's operations.

While OMLMAG is not regulated, Mr. Pumford said he communicates closely with the Oklahoma Insurance Department.

- Be prepared to distinguish the pool from an insurance company.

For example, Mr. Pumford emphasized that he does not perceive himself as a "market" for insurance, but rather as an official of the public entities he serves.

Public entity pools differ from other businesses because of their stability, says Mr. Pumford.

Public entity pools differ from other businesses because of their stability, he added. This stability is due, in part, to public entities' inability to "skip town," their taxing authority and existing governmental immunity to some types of claims, he explained.

Another way public entities can distinguish themselves from insurance companies is to emphasize to legislators and detractors any existing state regulations that require accountability and allow for public scrutiny.

- Explore the feasibility of involving the state in alternative financial plans to fund catastrophic losses.

This could include having the state act as guarantor for any amount due, he said.

In addition, the public entity policyholder could ask that some of its state tax funds be withheld over a period of time to repay the state for any payment on the pool's behalf or put that money into reserve for future claims.

Other issues of interest to public entity pools that were raised at the conference include:

Tax status

Private letter rulings from the Internal Revenue Service are a way for public entity pools to ensure their tax-exempt status, an accountant says.

A pool seeking such an optional ruling, which will help protect it from future problems with the IRS, needs to demonstrate only that it is a governmental unit performing an essential governmental function and that any proceeds accrue to it, said J. Patrick Beattie, a partner in Peat Marwick Main & Co.'s Anchorage, Alaska, office.

In addition, the IRS recently said public entity pools can be tax-exempt even though participants reside in more than one state, he added.

However, a public entity pool being pressured to admit non-profit, non-governmental entities should avoid including them because they may taint the pool's tax-exempt status, unless the IRS approves of the arrangement in advance, Mr. Beattie said. An alternative would be to place the non-governmental entities in a separate pool, he added.

And, a public entity pool that has funds siphoned off by abusive outside management services or reinsurance arrangements could also place its tax-exempt status in jeopardy, he said. Such arrangements could violate the IRS's requirement that all proceeds accrue to the pool.

Financing alternatives

Public entities should not be swayed by the novelty of some products available for financing catastrophic losses, a consultant says.

These products—including letters of credit, bonds and certificates of participation, which are bond-like instruments that are designed to circumvent most states' requirements that public entities do not incur debt—are "new and exciting," but pools have to decide whether the instruments are appropriate and, if they are, use them "at the right time and objectively," said Michael M. Kaddatz, a principal with ARM Tech.

One pool that used such financial instruments is Independent Cities Risk Management Authority, which sold $30.2 million in certificates of participation in January 1987 to capitalize a liability pool.

Irwin B. Bornstein, city controller for Whittier, Calif., who acted as treasurer for ICRMA, told attendees the main advantage of capitalizing reserves with bonds, which were sold during very favorable market conditions, was to create an immediate capital reserve that provided the public entities participating in the pool with the peace of mind of knowing they could pay immediate catastrophic losses.

In addition, ICRMA hopes it may be able to earn interest by investing some bond proceeds at a rate of interest higher than the bonds are paying out, he said. It also hopes that the capitalization will make ICRMA more attractive to reinsurers, but this remains to be seen, he added.

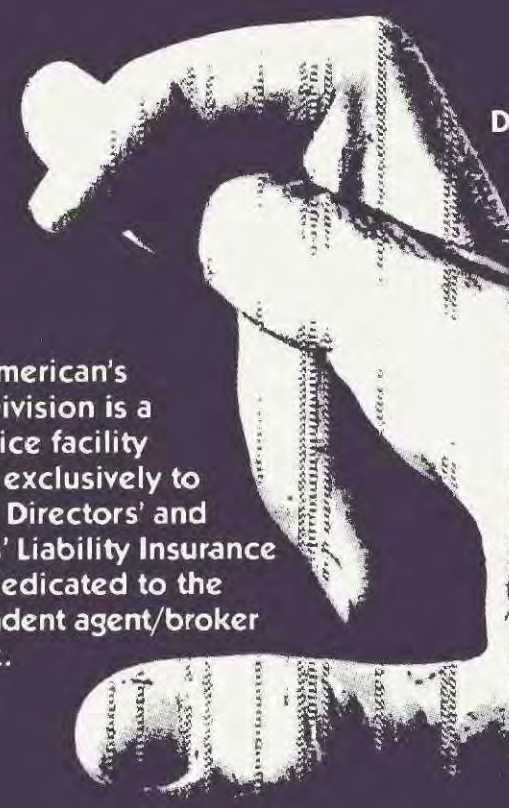
However, ICRMA's program is very complex and contains some built-in rigidity because of the bonds' 20-year maturity, he said. In addition, it required a lot of staff time to prepare for the bond sale and the pool will have to rely on staff members to maintain the program with marketing, risk management and investment activities, he said.

Although some securities brokers are reassessing their involvement in the municipal bond market, bonds are still available as other options, said Robert Hedrick Jr., vp of J.P. Morgan Securities Inc. in New York.

Depending upon state regulations, another alternative risk financing option is a proposed seven-state risk retention group in the Southwestern United States, which hopes to offer excess liability coverage to large public entities or above coverage provided by a pool.

Representatives of Joseph Ivy and broker Marsh & McLennan Cos. Inc. are among those working on a contingency basis to establish the program, which has no clients at this time, Mr. Hedrick said. ■

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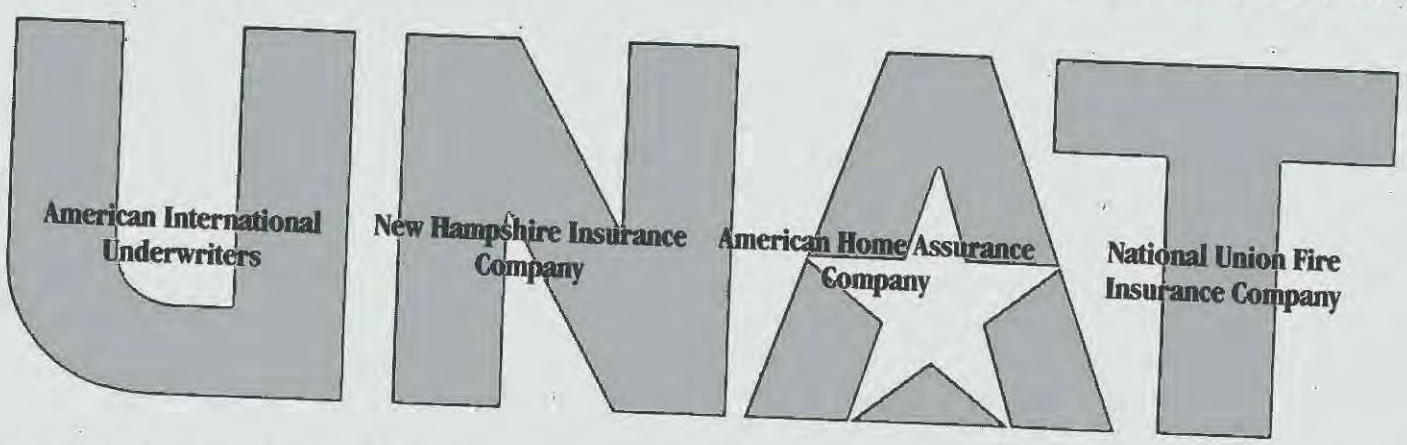
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RMIS for pools near fruition: Consultant

By MEG FLETCHER

SALT LAKE CITY—A breakthrough in the development of risk management information systems for public and private risk-sharing pools may come by year-end, a consultant predicts.

Vendors are expected to develop a system that can process a pool's data on a collective as well as an individual basis by the end of the year, says Richard S. Betterley, president of Betterley Risk Consultants Inc. in Worcester, Mass.

In addition, the system ideally should prevent pool members from gaining access to other individual members' data, he added.

Currently, risk management information systems typically process data either collectively or individually but not both ways, he said. And, it is difficult to keep individual members' data confidential with some systems, Mr. Betterley explained at a two-day conference in Salt Lake City last month.

The conference was sponsored by two independent consulting firms: The Joseph Ivy Co. in Austin, Texas, and Advanced Risk Management Techniques, based in Laguna Hills, Calif.

Francis Fey, an Ivy vp, said that many pool managers have found that RMIS "are not suited to pools," and they have turned to computerized systems that are designed for third-party administrators.

Mr. Betterley said pools could also turn to computer systems in non-insurance fields like banking to process information both collectively and individually while preserving a member's confidentiality. However, that would be like "going from the frying pan into the fire," because these systems' cannot provide risk management functions, he said.

RMIS vendors 'are realizing that pools are probably big users,' says Mr. Betterley.

The "tremendous" development of risk retention groups is spurring the development of better risk management information systems that will help pools, Mr. Betterley said. "System providers are realizing that pools are probably big users and they are adapting," he added.

However, Richard F. Denning, president of Atlanta-based Risk Sciences Group Inc., commented from the audience that the key limitation pools face is not RMIS software capabilities. Instead, he said inaccurate reports are being generated from information that is either inappropriate or improperly coded.

The problem of inaccurate or incomplete data is one of the most frequent RMIS mistakes that users make, Mr. Betterley said. Other mistakes include poor planning, inadequate training, lack of recognition of total costs and too much paper output, he said.

In addition, many problems stem from systems that are inadequate in size and scope, as well as from graphics and "ad hoc" report capabilities. Problems are also caused by systems that are not user-oriented or not consultant-oriented, which means consultants and actuaries cannot use the information as discharged.

Mr. Betterley said pools should seek RMIS with sophisticated analytical capabilities so the systems can generate the following reports for pool members:

- Loss reports.

The system should be built around what pool members know their needs to be, Mr. Betterley said. "I think you know more about your members' claims experience than anyone else."

Loss reports should be issued on a monthly basis and sorted by categories that meet members' needs like, for instance, by department or by supervisor.

In addition, a summary should be prepared that relates information using a standard like "cost per employee." That summary also should include trend analysis, Mr. Betterley said.

- Reserve analysis reports.

Monthly reserve analysis reports should reflect all changes in reserves and highlight claims for which reserves have changed frequently.

Allowing for explanations can also be useful, he said.

- Litigation analysis reports.

Litigation reports should monitor claims handling by defense counsel and include expenses by case, a list of experts used and the schedule of defense activity including filing deadlines, Mr. Betterley said.

This will help provide a check on attorneys' activities.

- Ad hoc reports.

Computer systems should have free-form search capabilities so a pool manager can obtain "ad hoc" or non-standard reports to answer new questions, Mr. Betterley suggested.

For example, a manager reviewing the work shift schedules might want to see accidents reported by time of day.

This capability can be "wonderfully powerful," he said, explaining that producing ad hoc reports requires that the data be captured and that the system be flexible enough to work with it.

In addition to reports for members, pool managers should also receive the following:

- Underwriting management reports.

A good underwriting management report should analyze the causes of losses using specific standards that are tailored to the needs of an individual pool, Mr. Betterley said.

- Loss reports.

A pool manager's loss report should stratify losses by size of reserve as well as list major new losses, reserve changes and loss dispositions.

In addition, a pool manager should be able to compare the current period's performance with prior periods, Mr. Betterley said.

- Claim management reports.

These should include claims information including the adjuster's report of first contact, legal costs as well as the status of subrogation activity and litigation management information, Mr. Betterley said.

"More and more clients want to be on-line," Mr. Betterley said, so pool managers can draw on claims information as soon as an adjuster puts it into the system. However, most pools cannot justify the expense of on-line capabilities for members, he added. ■

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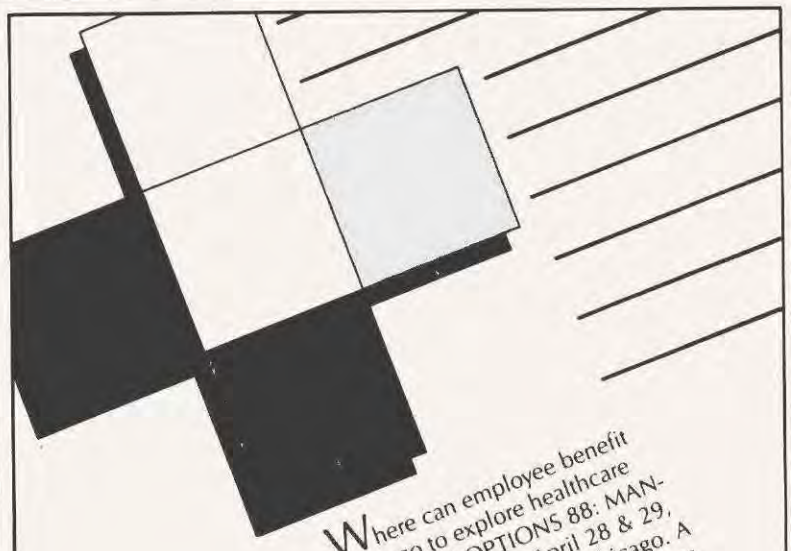
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Professional Liability and Specialty Insurance

GASB proposal to hit self-insured cities

By MEG FLETCHER

SALT LAKE CITY—Proposed accounting rules would force most public entities that retain a significant amount of risk to change the way claims are reported, an actuarial consultant says.

In addition, the proposed accounting rules would spotlight previously unreported liabilities for many public entities.

The first of two new standards proposed by the Governmental Accounting Standards Board would make all governmental accounting more like accrual-based business accounting by requiring that income and expenditures be reported as they occur, said Oakley E. "Lee" Van Slyke, director of actuarial services for Coopers & Lybrand in Los Angeles.

The first standard requires that any non-capital debt, such as a claim from an accident on public property, be recognized 'in the year in which the accident happened, not in the year you think you will pay the loss,' says Mr. Van Slyke.

The second standard would provide guidelines to help public entities implement the first standard.

Mr. Van Slyke spoke at a recent conference in Salt Lake City on the financing of intergovernmental risk-sharing pools.

The first standard, which is expected to take effect after Dec. 15, 1989, will have an important impact on some public entities' risk management activities because it requires that any non-capital debt, such as a claim by a citizen from an accident on public property, be recorded and recognized "in the year in which the accident happened, not in the year in which you think you will pay the loss," he said.

This is a "big change" for many public agencies that recognize such liability losses only when they think they will be paid or report those liabilities in their general long-term debt account (*BI*, June 1, 1987).

The new standard limits the use of general long-term debt accounts to capital-related debt, Mr. Van Slyke said.

"It has the potential to have a really big impact for cities that have a significant self-insured liability," he said.

For example, the city of Los Angeles, which budgets $20 million annually for liability claim payments, will experience "a tremendous change" if it has to recognize all of the unpaid claim liabilities each year, he said.

An exposure draft of this nearly completed standard, "Measurement Focus and Basis of Accounting—Government Funds," is available for final public comment until April 13 from Stamford, Conn.-based Governmental Accounting Standards Board.

Mr. Van Slyke is a member of the task force helping to draft the second standard, which will implement the new risk management accounting reporting requirements.

In addition, the Washington, D.C.-based Public Risk & Insurance Management Assn. is not only helping draft the implementation standard, which it plans to endorse, but also is drafting its own optional financial reporting guidelines for public entity pools.

The goal of PRIMA's guidelines is to develop a format for both a condensed financial statement and a comprehensive annual financial report.

PRIMA also is concerned about helping a pool evaluate its financial and management performance, providing information about members' obligations, developing comparative information about pools and exploring the feasibility of developing a national data base.

The implementation standard, "Accounting and Financial Reporting for Risk Management Activities," is designed to show public entities that retain a significant amount of risk how to value liability claims.

The standard also sets special standards for public entity self-insurance pools (*BI*, May 11, 1987).

The drafters currently are reviewing the 89 responses they received to a discussion memorandum on the implementation guidelines, according to Mr. Van Slyke.

The memorandum generated considerable controversy, particularly over the possible application of Financial Accounting Standards Board Statement No. 5 to public entities' claims liabilities.

FASB 5 states that a liability is accrued: when the accident or event has occurred, when later information will show the amount of the loss and when the amount of the loss can be reasonably estimated.

Significant losses that cannot be reasonably estimated are included in footnotes.

Currently only "a small fraction" of pools and a few municipalities regularly report claims liabilities consistent with FASB 5, Mr. Van Slyke said. Consequently, application of FASB 5 would be "a major change" in their claims reporting practices.

The loudest outcry came from public entity representatives who fear they will be required to estimate claims liabilities with incomplete or uncertain information, Mr. Van Slyke said.

Critics also questioned the fairness of making taxpayers bear the total cost of a serious claim in the year in which an accident occurs.

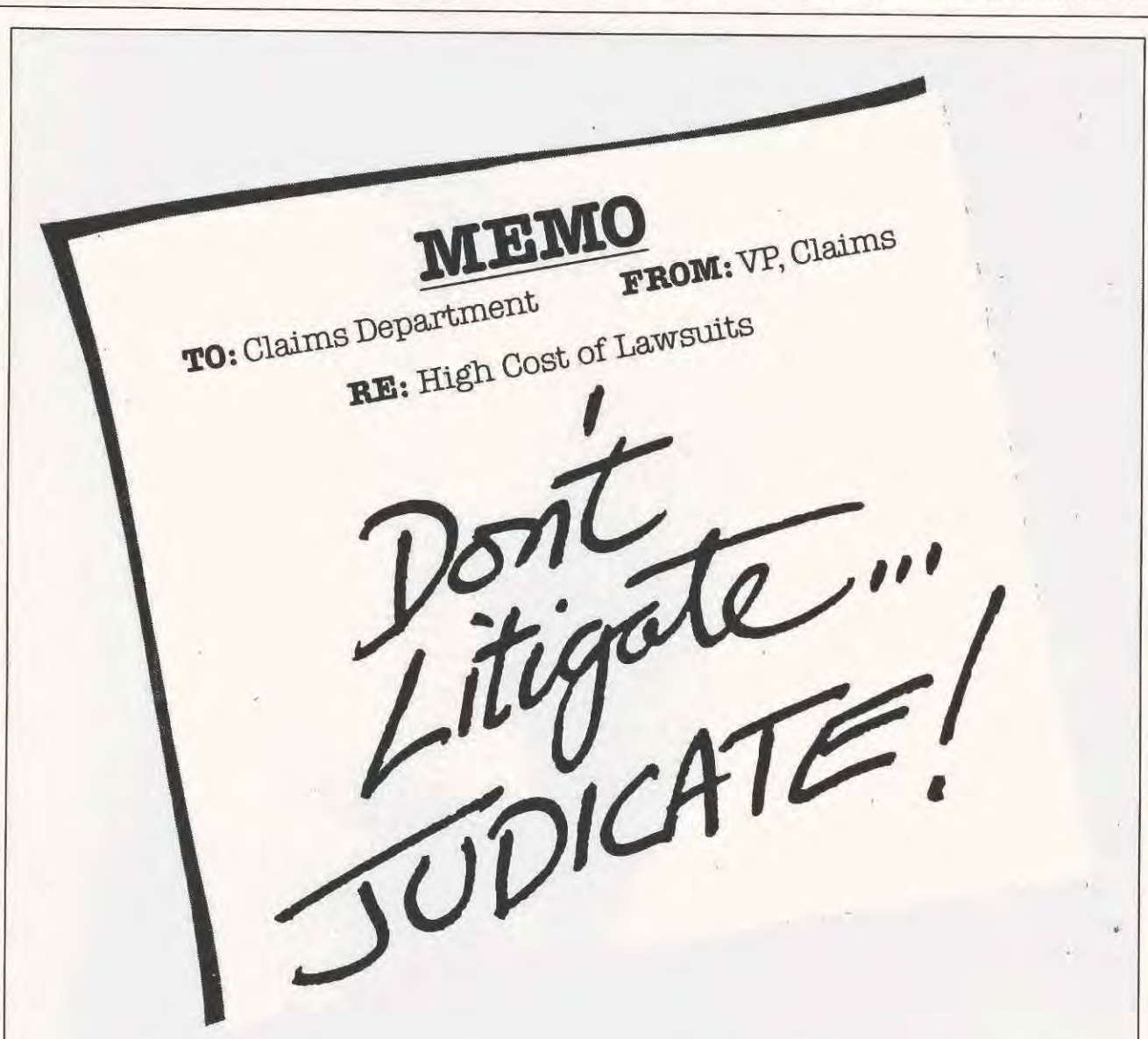
Mr. Van Slyke explained that claim costs typically rise in subsequent years during processing because the public entity's case may erode, for example due to the death of a witness.

In addition, applying FASB 5 could significantly increase a public entity's claims liabilities and affect public entities' reserving practices, he said.

It also could cause "a real political brouhaha" in cities or other public entities that never paid particular attention to unpaid claims liabilities. In those cases, controllers will have some very difficult explaining to do about increased amounts of reported liabilities, he predicts.

Respondents to the discussion memorandum also disagree over:

Continued on next page



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Continued from previous page

- Whether an accountant should view a public entity broadly or narrowly.

For example, should all of a governmental body's assets be included in a risk management evaluation, or should only risk management program assets such as reserves be considered?

- Whether risk can actually be transferred to a pool or similar entity.

Several respondents, including some accountants, contend that the public entity's general fund is responsible for claims, no matter what risk transfer agreements have been made, Mr. Van Slyke said.

"A lot of us who spend a lot of time writing these agreements are shocked by that," he said.

However, he predicts drafters will recognize those properly documented agreements and require accountants to acknowledge risk transfer.

- Whether the typically small deposit premium paid by pools with retroactively rated policies must be reported.

Although those points were controversial, respondents achieved consensus on others, Mr. Van Slyke said.

For example, they recommended that drafters:

- Be cautious about which public entity accounts must be audited because of the difficulty in collecting data and paying for the audit.
- Keep disclosures to a minimum, but require a public entity to report its self-insured retention.
- Require pools to account for risk management operations more like a private-sector insurance company rather than through the use of enterprise accounts.

Mr. Van Slyke said the proposed standards will not threaten the well-being of most public entity self-insurance pools in California, the state that has generated the greatest number of pools.

The pools have been positively reviewed by experts, he said. And, even if some of the pools are not fully funded for all future liabilities, they have concrete plans to do so.

The GASB proposals 'could be a surprise' for some pools, says Oakley Van Slyke of Coopers & Lybrand.

However, the GASB proposals "could be a surprise" for some pools that have been around for some years "and never found out what their financial condition is," he said.

But, because most California pools are "closely held," he doubts that changes resulting from the proposed standards will prompt regulatory problems.

However, pools elsewhere and the more visible "superpools" may come under more scrutiny, Mr. Van Slyke said. ■

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Bill would stall pension asset reversions

By DEBORAH SHALOWITZ

Washington

WASHINGTON—Employers terminating overfunded defined benefit pension plans would be temporarily barred from taking asset reversions under legislation introduced earlier this month.

The bill, H.R. 4111, would require any pension plan assets not distributed to plan participants following the termination of an overfunded plan to be held in escrow until at least Oct. 1, 1989.

According to a congressional staff aide, the legislation—which imposes a temporary moratorium on asset reversions—would be effective retroactive to its date of introduction. The bill was introduced March 9 by Rep. William Clay, D-Mo.

"Temporary suspension of the ability of employers to recover plan assets will give Congress sufficient time to consider and enact a permanent solution to this serious threat to retirement income security," Rep. Clay said. "Temporary suspension of reversions will stem the tide of plan terminations."

Rep. Clay emphasized that the bill "is but a first step in dealing with this problem."

He added that since 1981 employers have been "prematurely terminating pension plans solely to recover 'excess' or 'surplus' assets to use for other corporate purposes."

"This use of pension plans as corporate piggy banks to finance takeovers or other corporate priorities is a serious threat to benefit security," he states.

An identical bill was expected to be introduced in the Senate last week by Labor and Human Resources Committee Chairman Edward Kennedy, D-Mass., and Sen. Howard Metzenbaum, D-Ohio.

Federal retirement

Federal employees would have another chance to join the Federal Employees Retirement System under legislation introduced earlier this month by Rep. Stan Parris, R-Va.

The bill, H.R. 4030, would create a second election period for federal employees to transfer out of the Civil Service Retirement System.

The election period for the new federal retirement system ended Dec. 31, 1987, but only a tiny percentage of eligible federal employees elected to join the new program (*BI*, Jan. 11; Jan. 5, 1987).

FERS' failure to attract more federal employees is attributed to a combination of factors, including employee confusion about the comparative benefits of FERS and the previous retirement system, apathy, suspicions about the government's motives in offering the new plan and inadequate communication about the plan.

FERS contains two main elements: a pared-down defined benefit plan and a 401(k)-type thrift plan.

HMO contributions

Employers and federally qualified health maintenance organizations would have more flexibility in negotiating rates under legislation approved earlier this month by a Senate committee.

The House approved similar legislation in November 1987.

Under the House bill, H.R. 3235, employers would have more flexibility in interpreting a federal rule requiring equal contributions to HMOs and other health plans.

For example, under the bill employers would be allowed to pay the same percentage of the cost of an HMO and an indemnity plan. Currently, the equal contribution rule has been interpreted to require employers to contribute the same amounts—dollar-for-dollar—for HMOs and other health plans.

Also under the legislation, HMOs could take into account an employee group's previous use of the health plan when developing rates. Currently, HMOs must base their rates on communitywide data.

The bill also would allow HMOs:

- To set up other health subsidiaries, such as preferred provider organizations and indemnity plans.
- To provide up to 10% of its basic physician services with doctors not affiliated with the HMO.

Smelter to pay fine

The largest lead smelting facility in North America will pay the Labor Department $1.25 million—less than half the proposed penalty—for alleged violations of federal job safety and health standards.

In addition, Doe Run Co. will pay back compensation and benefits to contract employees who were fired when lead levels in their blood exceeded minimum standards, according to the Occupational Safety and Health Administration.

OSHA last month cited the Herculaneum, Mo., smelting facility for 147 allegedly willful health violations, 136 allegedly willful record-keeping violations and 30 other alleged violations, including allegedly rotating contract employees in and out of high-lead exposure areas to minimize levels of lead in their blood and then firing the employees when their blood lead levels exceeded minimum standards (*BI*, Feb. 15).

The agency originally proposed near-record penalties of $2.78 million for the alleged violations.

Doe Run, a joint venture of St. Joe Minerals Corp. and Homestake Mining Co., agreed to correct record-keeping practices to comply with OSHA standards, establish a new policy regarding contract employees, reduce airborne lead levels and provide interim protection until the levels of airborne lead are reduced to permissible limits.

Aviation liability

The liability of general aviation manufacturers would be limited in product liability cases under a bill passed by a House subcommittee earlier this month.

The legislation, introduced by Rep. Dan Glickman, D-Kan., passed the House Public Works Aviation Subcommittee March 3.

The bill, H.R. 2238, would:

- Subject all general aviation cases, whether filed in state or federal courts, to the limitations and standards of the federal law.
- Allocate damages on a percentage basis among parties commensurate with their degree of responsibility.
- Establish a state-of-the-art defense for manufacturers.
- Limit the liability of manufacturers and suppliers of repair and replacement parts or components to 12 years from date of manufacture.
- Hold only airplane manufacturers, not other parties involved in the production process, jointly liable for a product defect.

Bank bill

Banks would be allowed to sell insurance in some circumstances under a bill approved by the Senate Banking Committee this month.

The legislation, S. 1886, would repeal sections of the Glass-Steagall Act and allow banks to establish securities affiliates.

Under the bill's insurance provisions, if permitted by state law:

- Independent state-chartered banks could sell insurance in their own states.
- Banks owned by federally chartered bank holding companies headquartered in the same state could sell insurance in that state.

However, bank holding companies may not sell insurance through a state bank subsidiary that is not in its home state. A limited number of bank holding companies that made interstate acquisitions of banks prior to March 2, 1988, are grandfathered. The insurance activities of their out-of-state banks are limited to the state where the bank is located.

National banks may continue to sell insurance in towns of 5,000 or fewer people.

Sen. Christopher Dodd, D-Conn., led the negotiations on the insurance provisions of the bill.

Construction rules

A Labor Department proposal to overhaul safety standards for the construction industry will be the subject of an April 19 hearing.

The hearing begins at 9:30 a.m. in the auditorium of the Frances Perkins Building, 200 Constitution Ave. N.W., Washington, D.C. A letter of intent to appear at the hearing must be postmarked by March 21 and sent to Tom Hall, OSHA Division of Consumer Affairs, Docket S-204, Room N-3647, at the same address.

The Occupational Safety and Health Administration plans to address proposed regulations published in the Federal Register April 15, 1987, covering excavation work, including trenching.

OSHA estimates that more than 100 fatalities occur in cave-ins each year, primarily in trenching. The agency estimates the fatality rate for trenching alone to be 112% greater than in construction as a whole. ■

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IC Industries appoints Gano to oversee risk management

Comings & goings: buyers

C. Wayne Gano Jr., 46, has been promoted to assistant vp-risk management at IC Industries Inc. in Chicago. In this newly created position he oversees the company's risk management operations and serves as president of IC's insurance subsidiary, IC Industries Insurance Co. Ltd. He reports to Ralph J. Switzer, vp-financial operations. Mr. Gano previously served as director of risk management. He joined IC—a diversified manufacturer with $4 billion in 1987 sales—in 1981, after 14 years with Sundstrand Corp. of Rockford, Ill., where he most recently was general insurance manager. He holds a bachelor's degree in physics from Grinnell College in Grinnell, Iowa, and a master of business administration degree in finance and management from the University of Iowa in Iowa City. Mr. Gano is a member of the Machinery & Allied Products Institute's Risk Management Council and the Railroad Insurance Management Assn., as well as a deputy member of the Risk & Insurance Management Society.

Also at IC Industries: **Karl J. Zimmel**, 29, named manager of claims and administration at IC. In this position he is responsible for administration of property/casualty claims. He replaces **John J. Walsh**, who retired, and reports to Mr. Gano. Mr. Zimmel, who joined IC in 1984, most recently was manager of claims. He received a bachelor of science degree in economics from the University of Illinois in Urbana and is completing his master of business administration degree at the University of Chicago. He holds the Associate in Risk Management designation and is a deputy member of RIMS.

E. Pierce Walsh, 56, has assumed all risk management duties for fleet operations at IC Industries. Mr. Walsh, who is manager of fleet operations and held the same title prior to joining the risk management department, previously oversaw IC's fleet management department. He reports to Mr. Gano. Mr. Walsh, who joined the company in 1982, served with Gelco Corp. and Borg-Warner Corp. prior to joining IC. He holds a bachelor of arts degree from the University of Notre Dame in Notre Dame, Ind., and is a member of the National Assn. of Fleet Administration.

* * *

Cheryl V. Meyer, 33, promoted to vp-human resources at Merchants Insurance Group in Buffalo, N.Y. In this newly created position she oversees employee benefits, compensation, safety and health, training and placement. She reports to President James F. Marino. Ms. Meyer previously was assistant vp of human resources for Merchants. She received a bachelor's degree and a master of business administration degree from the State University of New York at Buffalo.



Ms. Meyer

* * *

Leonard Resto, 34, named manager of corporate risk management at The Dun & Bradstreet Corp. in New York. In this newly created position he oversees the business services and publishing company's property/casualty insurance programs. He reports to John F. Riley, director of corporate risk management. Previously, Mr. Resto served as manager of Ernst & Whinney's risk management consulting practice in New York. Mr. Resto received a bachelor of arts degree from Jersey City State College in Jersey City, N.J. In addition, he holds the Chartered Property & Casualty Underwriter designation.

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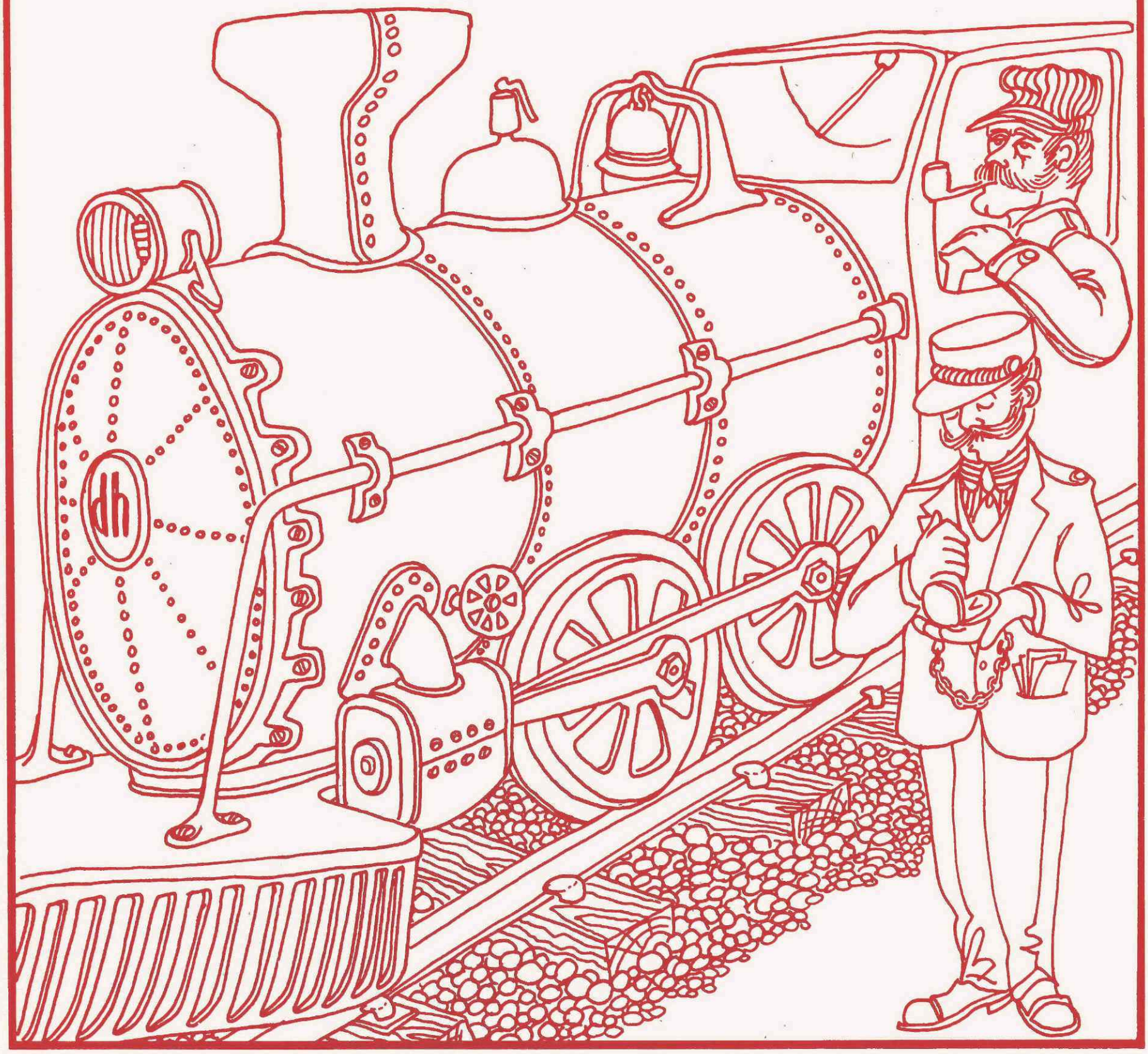
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PASSING THE TEST

Regulators need new way to measure strength of insurers

By Thomas S. Bloom

Speaking out

GIVEN THE STAGGERING number of insurance company failures over the last several years, it is apparent that one of the industry's priorities must be to develop an effective method of identifying potential insurer insolvencies so that they can be either prevented or, at the least, their effects be mitigated.

The individual state insurance departments charged with this responsibility depend heavily on a system developed by the National Assn. of Insurance Commissioners called the Insurance Regulatory Information System, the so-called IRIS or "Early Warning System." IRIS is a set of 11 ratios drawn from a company's annual statutory statement, which, when taken together, are supposed to give the first indication that a company is experiencing financial difficulties. Any company failing four or more of the tests in any one year becomes a "candidate for immediate examination."

There are three serious deficiencies in this system. First, some of the measures used are inadequate, immaterial, arbitrary or misleading. In addition, the system does not include several more meaningful statistics or ratios. Finally, the system loses much of its potential impact because the NAIC refuses to share the results with the industry at large.

A summary of the 11 ratios, with comments on each, follows:

• Change in net premium writings. The NAIC has declared that any change in net writings in excess of 33.3% will cause a company to fail this test. This standard assumes that any increase in writings results from a corresponding increase in exposure units and ignores the possibility that the larger writings can come from an increase in premium per exposure unit. A company writing one-third more exposure units in a single year may, in fact, be increasing volume faster than it can properly underwrite and service it. However, most increases in the last few years have come as a result of companies doing exactly what should have been done—getting substantially more premium per exposure unit. This is certainly true of the industry as a whole. This IRIS test can easily penalize an insurer for correcting past pricing mistakes.

These year-end rushes to get the fiscal house in order so that the statutory statement will look good distort the true picture of collection practices.

Likewise, a drop of one-third in volume could come either because management chose to eliminate an unprofitable part of its book or chose not to follow the market down in a soft cycle. Both decisions could be the most prudent under the circumstances.

In other words, the test is basically meaningless unless the reasons for the change in volume are known, a fact not necessarily discernible from the statutory statement.

• Change in surplus. This is the most difficult IRIS test to justify. Any company with surplus increases of more than 50% or decreases of more than 10% in one year will fail this test. (Surplus is adjusted to reflect deferred acquisition costs.)

With respect to the first criterion, it seems wholly counter-productive to penalize an insurer for increasing its solvency and protection to policyholders. The NAIC's weak explanation for this standard is that some companies that have previously become insolvent have shown an inordinately large increase in surplus prior to their demise. Perhaps so, but there must have been a host of other signs indicating that something was wrong with the numbers besides this single item. Any number of insurers failed this test in 1985 or 1986 because the owners did exactly the right thing under the circumstances: They made additions to surplus in order to absorb the huge increase in premium volume that flowed into the market over this period.

There are many good reasons why a company would want to increase surplus. To suggest that such action is improper is irresponsible.

• Surplus aid to surplus. The computation for this test is too convoluted to summarize, but the purpose is to penalize a company that relies too heavily on reinsurance support to maintain or increase its book of business. In certain circumstances—the opportunity to write substantial volume at adequate prices—an increase in writings supported by reinsurance might be the most prudent step for management to take.

This test does nothing to measure the quality of the reinsurance. Also, the test penalizes quota-share arrangements, as excess-of-loss reinsurance frequently does not involve ceding commission, which is the principal factor in the equation.

There are many good reasons why a company would want to increase surplus. To suggest that such action is improper is irresponsible.

• Agent's balances to surplus. Any company allowing agents' balances to exceed 40% of surplus will fail this test. Although certainly a legitimate concern, failure to collect premiums from producers has not been the reason behind any of the recent string of company failures. This ratio certainly is not critical and does not differentiate as to what percentage of balances are past due. A company giving its producers a normal 45-day account current—premiums due 45 days after the end of the month in which they are booked—will have about 2½ month's premium outstanding as of every due date. This represents about 21% of annual premiums.

Assuming a premium to surplus ratio of 2-to-1, such an insurer will always be near the point of being penalized. Heavy reinsurance leverage will only exacerbate the problem, in effect penalizing the company twice for the same phenomenon, given the previous test for surplus aid.

This test can also penalize a rapid increase in writings twice, as a company with rising premium levels will find it doubly difficult to keep agents' balances below the 40% level.

Every agent and broker has had the experience of receiving a frantic call from a company in early December seeking the prepayment of an account, payment of an account past 90 days due (as such, not an admitted asset) or the resolution of some accounting discrepancy. These year-end rushes to get the fiscal house in order so that the statutory statement will look as good as possible distort the true picture of a company's collection practices and point out the weakness in measuring any balance sheet item only once a year.

• One-year reserve development to surplus, two-year reserve to development to surplus and reserve deficiency to surplus.

These three ratios are related. They are also the most difficult to understand and interpret. In the one-year development test, reserves outstanding one year ago are compared with the sum of current reserves and losses paid during the last year on the same book of business. The same exercise is then performed on reserves outstanding two years ago. The results are then combined and used to create a predicted deficiency or redundancy in those reserves currently outstanding.

The results of this test can be completely distorted when an insurance increases rates to correct a previous pricing deficiency. In that case, the previous deficiency percentage is applied against reserves arising from the new, increased, writings. It is assumed that the insurer has underreserved as much on the new book, at the increased rates per exposure unit, as it did on the previous book.

Many insurers that were writing a relatively small and underpriced book in the early 1980s failed this test when they drastically increased both rates and writings in the period 1984 through 1986. If their surplus is restated to take into account the indicated deficiency, they not only fail the reserved deficiency test (any adjustment causing a decline of more than 25% of surplus) but they show a negative net worth. This is a patently ridiculous result for those familiar with the overall operations of these insurers. Once again, the IRIS test has penalized an insurer for doing the right thing: raising its rate per exposure unit to correct an unacceptable loss ratio. The effect is exacerbated if the company is able to write more exposure units at the higher price.

• Net premiums to surplus. This is the single best-known ratio in the industry, yet the one probably most misused and abused. The NAIC has declared that any premium-to-surplus ratio in excess of 3-to-1 will cause the insurer to fail this test. There is no particular actuarial logic for this criterion. It is simply a convenient number that has come to supplant the old "Kinney Rule" that an insurer's writings should not exceed twice its surplus.

Another obvious weakness in this test is that it makes no distinction between classes of business. An insurer writing only property and short-tail liability with a stable book of business and a profitable history could easily exceed this ratio at no great danger. A new insurer specializing in long-tail exposures on occurrence forms should not approach it.

This test encourages insurers to fail the surplus aid test by giving them cause to seek additional reinsurance support, another example of the IRIS tests working at cross-purposes.

This test would be far more meaningful if it involved some measure of the average premium per exposure unit. To the extent that any increase in writings arises from an increase in premium per unit, the insurer should not be penalized at all.

• Liabilities to liquid assets. This is the old "net quick" ratio slightly disguised. To pass this criterion, an insurer must have liquid assets—cash and equivalents, with some adjustments—that exceed liabilities by at least 5%. This test assumes that liabilities, which are predominantly made up of loss reserves, are adequately stated. Most insurers in the last decade have proved this assumption to be untrue.

Note that there is no effort to use in this test the restated reserve amounts generated in the reserve deficiency to surplus ratio discussed above.

Continued on page 30

Thomas S. Bloom is president of McAlear Associates Inc., a wholesale broker based in Grand Rapids, Mich.



NAIC needs new gauge of solvency

Continued from previous page

• Investment performance. This is a basically meaningless test that fails any insurer that realizes less than a 6% return on invested assets. It is a backhanded endorsement of cash-flow underwriting and penalizes an ultra-conservative management that might decide that it does not wish to gamble on the investment side of the ledger while it is also gambling on the underwriting side.

Further, the test does not penalize extraordinarily good results. An insurer enjoying a return of two or three times that of its peers might be wholly invested in junk bonds, wheat futures, heavily leveraged options or South American emerald mine stock. The downside risk does not match the fiduciary nature of the obligations.

• Two-year overall operating ratio. This test subtracts the investment income ratio—net investment income divided by net premium earned—from the combined ratio to produce a so-called operating ratio for the previous two years. An insurer must enjoy a result of less than 100% to pass this test. In effect, the test endorses successful cash-flow underwriting as it allows an insurer to cover underwriting deficits with investment gain.

It should be noted that operating ratios and operating results are not the same thing. As these ratios are a function of both written and earned premium, they are subject to distortion. Companies stay solvent with dollars of profit, not favorable ratios.

There are several highly meaningful tests of an insurer's solvency and profitability that the NAIC has chosen to ignore in its early warning system:

✔ Reserves to surplus ratio. This is frequently the single most revealing statistic about a company's financial stability. The more the book is skewed toward long-tail business, the more this is true. It is an indication of how wrong an insurer can afford to be about its single most meaningful balance sheet entry, loss reserves, and still survive. No standard has been established here, but that any ratio in excess of 3-to-1 for an insurer with a normal mix of business, can indicate a potential weakness.

Given the consistent record of underreserving by most of the industry during the last decade, the importance of this ratio can not be ignored.

✔ Cash flow. One of the best indications of terminal illness in an insurer is the onset of negative cash flow from operations. This event should automatically lead to immediate regulatory investigation. The IRIS ratios do not measure this activity at all, a serious shortcoming.

✔ Quality of reinsurance. The IRIS tests accept reinsurance at face value, a serious deficiency in a time when it is agreed by most industry analysts that billions of dollars of reinsurance funds recoverable—still shown as assets on the books of U.S. insurers—are uncollectible. Nor does IRIS differentiate between balances secured by letters of credit or trust funds and those which are not.

✔ Paid-to-incurred ratios. One of the earliest signs of balance sheet shenanigans is a change in the ratio of paid to incurred claims, not matched by a corresponding change in the mix of writings. Other things being equal, an increase in the ratio of paid to incurred claims is a sure sign of underreserving on the part of management. The IRIS tests do not measure this activity.

✔ Percentage of long-tail business. Given the history of the industry over the last several decades, companies choosing to write comparatively large books of long-tail business must be willing to accept stricter standards of solvency. All of the ratios referred to above, IRIS's or otherwise, must be applied more stringently to such insurers. IRIS makes no distinction regarding the mix of business of subject insurers.

✔ Reserves-to-premium volume ratio. Again, other things being equal, this ratio should stay about the same. As writings rise, so should total loss reserves. Any insurer showing a rise in premium volume without a corresponding increase in reserves is suspect. The NAIC system does not examine this relationship.

The NAIC has consistently maintained that it would be irresponsible to release IRIS ratios on the theory that to do so could start a "run on the bank" and thereby create the very event being regulated against. A better reason would be that the IRIS system does not do the job for which it was designed.

The NAIC readily admits that the IRIS results are only tentative and are to be used an an indication of which insurers require further investigation. Were the IRIS tests more complete and more meaningful, the argument for their suppression would have less validity.

In any case, the formulas for computing the IRIS ratios are well-known. All the necessary information is public knowledge and anyone with the time and the will can do the computations. In fact, the National Assn. of Professional Surplus Lines Offices publishes these figures quarterly for more than 100 surplus lines insurers.

It is assumed that most insurers compute the IRIS ratios on their own figures and on some of their principal competitors.

In other words, everyone has the information except those most in need of it: the insurance buying public and the brokers and agents who represent them. Those brokers and agents are subject to an increasing legal obligation to place business only with solvent companies. Given that responsibility, they should have access to all available information.

There is another reason to advocate the release of IRIS data. If it were regularly promulgated, it would be more available for analysis and discussion. Such critiques would serve to improve the quality of this NAIC service over time.

In preparation for this article, opinion was solicited from A.M. Best Co., the leading organization in the promulgation of financial data and ratings for the U.S. insurance industry. Through a spokesman, A.M. Best had the following comments on the IRIS system:

"A.M. Best supports the decision not to release the IRIS results, agreeing with the NAIC position that because the ratios are tentative and subject to interpretation, any publication of the results would be premature and/or irresponsible. Best feels that the IRIS ratios are a proper attempt by regulators to fulfill their regulatory duties as respects measuring company solvency."

It should be noted, however, that were the IRIS ratios to be released, they would become, in effect, a competing rating service to Best.

On the other hand, Best points out that the IRIS ratios are not a complete or adequate measurement of an insurer's financial condition. Best compares IRIS with its own rating system, which takes into account a number of results and ratios (including most of those mentioned immediately above) not considered by the NAIC system. In particular, Best points out the need to better measure liquidity, leverage (a function of surplus, reserves and reinsurance) and the need for many balance sheet adjustments.

Best also criticizes the IRIS system for not differentiating between the results of a freestanding company and an insurer that may be pooling with other companies in the same group or be 100% reinsured by another company. In such situations, Best will evaluate the group as a whole, or rate the ceding insurer based on the rating of the reinsurer. In any case, Best will always evaluate the quality of the reinsurers for any insurer that it rates, a distinction not at addressed at all by the IRIS system.

In summary, the recent history of the individual members of the NAIC is not hung with glory as respects their record in anticipating or preventing insolvencies. If the IRIS ratios were published and appropriate action not taken in a timely fashion, the NAIC would have to answer many embarrassing questions.

Supposedly, any company failing more than four IRIS ratios in any one year is placed on a "watch list" for priority review or examination. Are not the industry and the public due some accounting of how many such companies exist and what action is being taken to ascertain their true financial condition? If it is found that a large number of such companies do not warrant regulatory action, then is that not an argument to improve the quality of the IRIS tests? If such companies are not being investigated in a timely fashion, does not the public have a right to know?

A consistent failure on the part of state regulators to meet their responsibilities regarding insurance company solvency will only invite more investigation the the part of those legislators in Washington who are looking for excuses to replace or supplement state regulation.

An improvement in the Insurance Regulatory Information System would both help to preserve the present method of state regulation and increase the public's protection against insolvent insurers.

Workers not told of group policy cancellation

Legal briefs

A group health insurer, which canceled a restaurant's policy for failure to pay premiums, was not required to notify the employees of the termination of insurance, a Michigan appellate court ruled.

In 1975, Presley and Virginia Jones owned a restaurant and obtained group health insurance for themselves and the restaurant's employees. The policy was issued by Equitable Life Assurance Society of the United States. In 1980, the Joneses sold the restaurant to Robert and Kathleen Larsen. Pursuant to the sale, the Joneses continued to be listed as employees for purposes of insurance coverage. Thereafter, the Larsens ceased paying the insurance premiums.

In May 1981, Equitable notified the Larsens the policy had been terminated May 15, 1981, due to non-payment of premiums and directed the Larsens to notify employees. The Joneses were not notified. In July 1981, Mrs. Jones was hospitalized and incurred substantial bills. She submitted the bills to Equitable; the claim was denied. The Joneses sued for breach of contract, but the trial court ruled for Equitable.

On appeal, the Joneses maintained that Equitable was required to provide the employees with a notice of termination of the insurance. However, the court disagreed, noting that the contract here did not itself require Equitable to notify employees that the insurance had been canceled. The court emphasized that while employees are beneficiaries of a group policy, the policyholder is the employer and the contract is between the insurer and employer. *Jones vs. Equitable Life Assurance Society of the United States*, Court of Appeals of Michigan, Oct. 20, 1986, *released for publication* Feb. 20, 1987 (*BI*/01/Nov.—$10).

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



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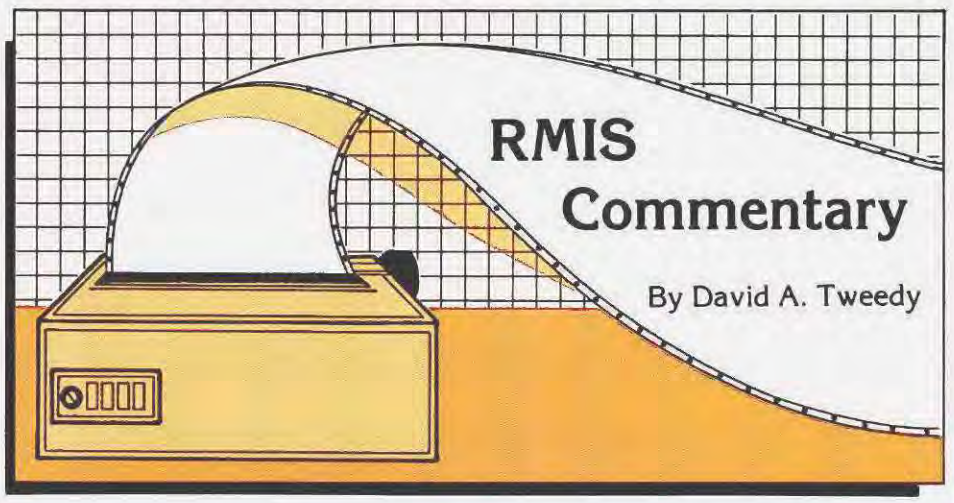
American Excess Insurance Association

*Note: A few classes are restricted to $50 million in excess of $50 million.

Each member is severally and not jointly liable for its share, as specified in the policy, of any assumed risk. Terms and conditions of coverage are as stated in the policy.

Ætna Life & Casualty; American International Group; CNA Insurance Companies; Chubb Group of Insurance Companies; The Continental Corp.; Crum and Forster Insurance Organizations; General Accident Insurance; General Star National Insurance Company, Subsidiary of General Re; The Home Insurance Company; Insurance Company of North America, a CIGNA company; Maryland Casualty Company, a subsidiary of American General Corporation; NAC Re Group; Royal Insurance Company of America, a member company of Royal Insurance group; The Travelers; Zurich-American Insurance Group.
(Underwriting member companies: The Ætna Casualty and Surety Company; American Home Assurance Company; Continental Casualty Company; Federal Insurance Company; The Continental Insurance Company; United States Fire Insurance Company; General Accident Insurance Company of America; General Star National Insurance Company; The Home Insurance Company; Insurance Company of North America; Maryland Casualty Company; North American Company for Property and Casualty Insurance; Royal Insurance Company of America; The Travelers Indemnity Company; Zurich Insurance Company, U.S. Branch.)

Comparing the variety of RMIS



WITH THE ANNUAL Risk & Insurance Management Society conference right around the corner, I feel compelled to provide the attendee with a tool to assist in differentiating from among the many risk management information system vendors and systems that will be displayed in the exhibition hall. This tool will divide the various systems and vendors into usable categories.

Thomas Seligman of Seligman Information Systems in Roslyn Heights, N.Y., has developed one categorizing method. By using this approach—or similar ones—to select an RMIS, you can reduce the number of systems to examine, save much time and effort and choose the RMIS that most closely matches your needs.

Mr. Seligman suggests three comparison continuums: small vs. large; independent vs. dependent; and "insured" vs. self-administered. To his list I add one more continuum: claims vs. other orientation.

Each of the above categories is a continuum and not an "either/or" choice. There are no right or wrong ends of the spectra. In using this method each part is examined separately and then all four are combined into an overall matrix evaluation.

• Small vs. large.

This can be considered the basic category: the one against which the remaining three are measured. Here, the size of the organization the RMIS is designed to serve is analyzed, not the size of the RMIS itself.

However, traditional measures of business size—sales, payroll, market share—may not always be useful in categorizing systems. The billion-dollar business with no claims does not have as much of a need for a claims-oriented RMIS than the million-dollar contractor with many workers compensation claims.

Mainframe and minicomputer systems are well-suited to handle large claim volumes. If your organization has thousands of claims per year to process, a mainframe or mini is recommended, although microcomputers, with their increasing power and sophistication, are a growing option. They are now powerful enough to handle organizations with up to several thousand claims each year.

Another size criterion is the number and complexity of your organization's cost centers. A simple business may be organized with only a few cost centers and one or two levels of management. The more complex business may have many cost centers and levels of management. There may be separate structures for financial and safety reporting as well as the need to keep up with reorganizations that seem to come along all too often.

The ability of an RMIS to serve these varied but specific needs is a function of the design of the RMIS software, not the type of computer it runs on. There are mainframe RMIS that can handle large numbers of claims but are limited to one simple cost center organization chart. Some micro-based systems are much more sophisticated, handling up to five different organizational structures at the same time. Therefore, where an older mainframe-based, insurer-provided RMIS may only provide a simple one-level, organization/cost system, micro-based products like Seligman's Access-The Claims Information System can provide multiple levels.

• Independent vs. dependent.

Mr. Seligman's next point, the question of independence or dependence, is really the question: "Whose system is it, anyway?"

A totally independent RMIS—a stand-alone system—means you own the data, hardware and software and it is physically under control in your office. At the other end of the spectrum are the completely dependent—vendor-supported or time-share systems. The hardware and software are owned by others who also have physical possession of the system as well as the data.

An RMIS developed by the user is the most independent. Last summer, I discussed the advantages and disadvantages of the homegrown system (*BI*, June 15, 1987; May 25, 1987). The more obvious danger is that it requires constant upkeep. Since you designed it, you alone are responsible.

The stand-alone, vendor-supplied systems running on microcomputers are very independent. These RMIS have been designed to be easier to use and require less support and maintenance. You have physical control over the system and the data. The negatives here are that you have more responsibility in maintaining the system unless you have a good vendor service agreement or an in-house data processing expert.

As you move toward mini- and mainframe computers for an RMIS, you lose independence because these systems are more complex to run and maintain.

Time-sharing systems from an independent RMIS vendor, like Corporate Systems, or an insurance broker are more dependent from the user's perspective. The time-sharing system is under the control of someone else. Although you are dependent on the time-sharing vendor, these systems can be used to integrate data from several insurance companies or your own self-administered program. Switching insurers or brokers does not necessarily impact upon the RMIS.

Insurance company systems, such as CIGNA Corp.'s CRIS or Hartford Insurance Group's OSCAR, are the most dependent for the user. They are attractive because they provide little additional cost above your premium and they reduce the amount of work required of the risk manager because the insurance company generates the data and maintains the system. You get the output from the RMIS in the form of reports—loss runs—or terminals with which you can examine the data on-line. However, you are completely dependent on the insurer for the data.

Also, mainframe-based insurer systems are not really user-oriented and do not always capture the data risk managers need. Similarly, it is sometimes difficult to obtain your data if you switch insurers and systems.

• "Insured" vs. self-administered.

The third continuum of Mr. Seligman's categorizing method is the spectrum of insured vs. self-administered. Here, he defines an "insured" program to include all organizations that are either traditionally insured or have their claims handled by someone else, such as a third-party administrator. A fully insured program is obviously in this category. But so are some self-insured programs. A retrospective plan or a program with a large self-insured retention falls within the "insured" category if claims are handled by an outside entity, like an insurer or TPA.

These outside vendors must or should have RMIS able to track and pay claims, allocate their costs among different cost centers as well as to their client's/policyholder's accounting system. Further, their RMIS should be able to produce a variety of functional and management reports based on the claim and exposure information they are supposed to track.

If you have a self-insured/self-administered program, your RMIS also must have the ability to support these functions. The risk manager running a self-administered program also manages claims, makes appropriate payments, reconciles them with corporate accounting and provides risk management information analyses and reports.

Some existing RMIS are designed to serve the self-administrator. These track the progress of a claim and help the claims adjuster each step of the way. Vendors, like California Interactive Computing Inc., automatically calculate benefits due the claimant, send customized letters to claimants and doctors and verify that doctor bills are correct and have only been submitted once for payment.

Other RMIS, such as Access or Travelers Corp.'s PC CARMA, have been designed to serve the "insured" business. These systems are generally easier to use and purposefully eliminate the complex procedures required for issuing checks. These systems help you monitor your insurance company or TPA when you do not have the task of claims adjusting.

A few systems have added check-issuing abilities to an otherwise "insured" RMIS. Some of these hybrid systems have developed over time and reflect the move toward self-administered programs that have occurred in recent years. Having their origins as "insured" systems, these systems usually have excellent reports that monitor your claims. However, they are not as strong in the claims administration functions, such as benefit calculations, letter writing and follow-ups.

• Claims vs. other orientation.

To Mr. Seligman's three continuums, I also would add this one. Over the last few years, I have had the opportunity to be involved in several non-claims RMIS projects. While it is true that RMIS evolved out of the need for better management and control over high-volume claims programs, there are increasing examples of clients with RMIS needs in other areas.

Last month's column on the banking industry's RMIS needs is an example (*BI*, Feb. 15). For many banks and real estate developers, the greatest RMIS need may be on another exposure base, such as property management. Other companies may require an emphasis on quantitative decision support applications for risk financing.

Here, the variety of RMIS vendors is broad. Some systems have a more plain-vanilla claims orientation while others are very quantitative, like those offer by Risk Sciences Group or Cantor & Co. Also, the hardware environment is no clue as to where each vendor/system fits within this continuum.

In next month's column, I will tie together these four continuums graphically, placing some of the vendors/systems within graphs for your reference. It should be a handy tool as you wander up and down the exhibit hall aisles next month!

David A. Tweedy is a senior consultant for D.A. Betterley Risk Consultants Inc. in Worcester, Mass. He is the editor of Betterley Risk Management Commentary and the author of RMIS Update, a yearly publication analyzing major risk management information systems and vendors. Mr. Tweedy's column on risk management information systems appears the third Monday of the month.



Markets

Confederation Life to halt group health underwriting

Confederation Life Insurance Co. of Toronto will stop underwriting group health insurance policies as of May 31, but will continue administering policies and writing stop-loss coverage for self-insured group health plans.

According to A.M. Best Co., Confederation's group accident and health line lost $3.9 million Canadian ($2.82 million) in 1986.

The Toronto-based company wrote $411 million Canadian ($297.6 million) group accident and health premiums in 1986, according to Best. The company's wrote $1.6 billion Canadian ($1.2 billion) in total premiums that year.

The company reported new group premiums of nearly $1.3 billion ($1 billion) Canadian in 1987, of which $394 million Canadian ($303.4 million) was U.S. business produced through its Atlanta-based unit, Confederation Life Insurance & Annuity Co., according to a statement from the company.

The company will continue to write group life, accidental death and dismemberment, dental, long-term disability and stop-loss policies.

ACMAT buys insurer

ACMAT Corp., a Hartford, Conn.-based asbestos abatement contractor, has signed a letter of intent to acquire John Hancock Property & Casualty Co., a licensed surety bond underwriter.

ACMAT has been plagued with insurance problems since March 1985, when CIGNA Corp. refused to renew its coverage (*BI*, March 25, 1985.) In April 1985, the company was able to secure new coverage, but at much higher premiums (*BI*, April 8, 1985). Then in June, ACMAT and several other investors launched a new insurer, United Coastal Insurance Co., to write coverage for asbestos removal contractors (*BI*, June 3, 1985).

Henry W. Nozko Sr., ACMAT chairman and chief executive officer, said buying Boston-based John Hancock Property & Casualty "is a key element in our strategic business plan."

The purchase price, which will be paid in cash, will equal the market value of the property/casualty company's financial assets at the time of closing, plus $7.5 million.

"We intend to utilize the insurance company for the purpose of offering bonding to qualified asbestos abatement and other specialty trade contractors," said Mr. Nozko, who added that "bonding is critically needed in the asbestos abatement industry."

The acquisition is subject to regulatory approvals. Henry Nozko Jr., Acmat's executive vp, predicted it would take at least 60 days to finalize the acquisition.

Accountants E&O

Professional Indemnity Management Co. has been formed in Chicago to offer primary professional liability coverage for accountants.

The company will act as a managing general agent for Homestead Insurance Co. of Philadelphia, which writes on a surplus lines basis in 33 states and Puerto Rico. and is admitted in Pennsylvania, New Jersey, Louisiana and the District of Columbia.

The PIMCO program will offer accountants $100,000, $250,000 or $500,000 in claims-made professional liability coverage limits. The minimum premium is $1,150.

For more information contact Michelle A. Duffett, Professional Indemnity Management Co., 120 S. Riverside Plaza, Suite 960, Chicago, Ill. 60606; 312-876-1666.

New intermediary

A new reinsurance intermediary, Industrial RE-International, has been formed in New York to place treaty and facultative reinsurance worldwide.

Continued on next page

REORGANIZED. STREAMLINED. STABILIZED.

James L. Bentley, former Georgia Insurance Commissioner and past President of the NAIC, has announced that he and his family have taken over 100% control of the Atlanta based Stone Mountain Insurance Company.

Five million dollars has been added to the company's surplus; the company's staff has been streamlined and company expenses reduced by more than $3 million annually. Computer contracts have been renegotiated; rent payments have been cut by 75%; and, most importantly, heavy reinsurance has been obtained to reduce the company's risk and exposure.

READY FOR BUSINESS

Expecting $40 million in premium dollars in 1988, the company plans to operate privately in commercial lines—including pest control, recreational equipment and small bank coverage in the Midwest.



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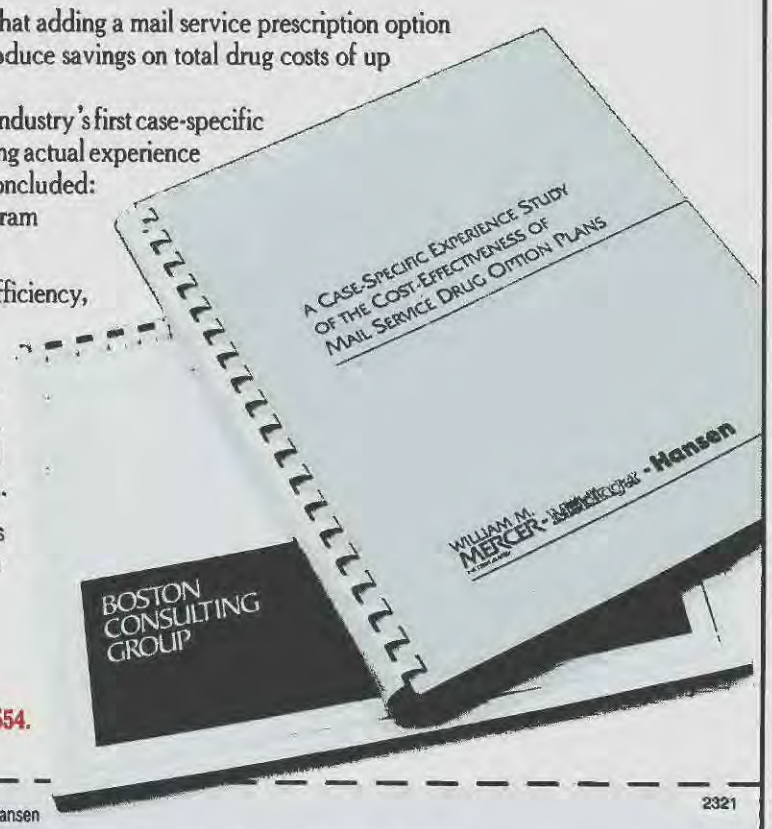
- The Boston Consulting Group concluded that adding a mail service prescription option to traditional prescription coverage can produce savings on total drug costs of up to 25 percent.
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Number of Employees in Company (Check one)

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Lodderhose claims right of offset with IEA

By DEBORAH SHALOWITZ

CHICAGO—A bankrupt Illinois reinsurance broker maintains it had an agreement with the Insurance Exchange of the Americas that allowed it to offset claims against reinsurance policies underwritten by IEA syndicates with reinsurance premiums collected on their behalf.

Chicago-based Lodderhose Inc. is claiming a right of offset involving business transacted with all 15 IEA syndicates, many of which are now in rehabilitation, attorneys say.

But, the syndicates claim they did not sign such an agreement with Lodderhose and that the nearly $600,000 of premiums Lodderhose allegedly withheld involved excess liability insurance policies rather than reinsurance contracts.

Three IEA syndicates filed a lawsuit in Cook County Circuit Court in Chicago in August that charges the broker had a fiduciary responsibility under Illinois law and insurance regulations to hold the premium funds in a trust account for the underwriters (*BI*, Jan. 11).

The Illinois Department of Insurance is investigating the case and is expected to release its report on Lodderhose later this month.

The IEA syndicates suing Lodderhose are B.G.H. Syndicate Inc., First Inter-Continent Insurance Syndicate Inc.; and Miami Savings Insurance Syndicate Inc., which has since been split into two syndicates: Pacific Insurance Syndicate and American Royal Syndicate Inc.

The syndicates are managed by IEA underwriting manager Global Underwriting Management Inc., which also is a plaintiff in the suit.

Lodderhose is incorporated in Illinois and licensed in New York as a reinsurance intermediary. Lodderhose Chairman Daniel Lodderhose is licensed in Illinois as a casualty, fire and surplus lines producer, according to state records.

According to Donald Engel, with the Chicago law firm of Schwartz, Cooper, Kolb & Gaynor, which represents Lodderhose, each IEA syndicate signed an agreement allowing Lodderhose to offset reinsurance claims with outstanding reinsurance premiums. Most of the premiums Lodderhose allegedly has withheld were reinsurance premiums, he said.

Mr. Griffiths of Global Underwriting claims the agreement does not exist and maintains that Lodderhose 'can't take money from my syndicates to offset what Hispano American owes him.'

The agreement is in the custody of the Richard Mason of Levit & Mason Ltd. in Chicago, the court-appointed liquidator for Lodderhose, according to Mr. Engel.

Mr. Mason declined to discuss the case.

But, Michael Griffiths, president of Global Underwriting, claims the agreement does not exist.

Gene Witherspoon, vp of the IEA, said he and other IEA staff do not know of such an agreement. He added that offsetting premiums owed to some syndicates by the amount of claims owed by other syndicates with which Lodderhose did business under a different contract is "generally not done."

An audit of the IEA performed last October by a certified public accountant at the request of Mr. Griffiths showed that Lodderhose owed the three syndicates almost $600,000.

However, other syndicates on the IEA—all of which are in rehabilitation—allegedly owed Lodderhose significant amounts of money. For example, according to Mr. Griffiths' audit, Hispano American Insurance Syndicate Ltd. Inc. owed Lodderhose $175,000; Syndicate One Inc. owed more than $25,000; and AIB Syndicate Inc. owed more than $14,000.

Mr. Griffiths maintains that Lodderhose "can't take money from my syndicates to offset what Hispano American owes him."

David M. Spector, an attorney and reinsurance expert with Mayer, Brown & Platt in Chicago, said that agents and brokers often conduct business on a "net" basis by offsetting payments from debtors and creditors to simplify their accounting. "That's fine until one of the parties becomes insolvent," he said. At that point, "you've got a terrible mess," he said. "The broker discovers to his horror that the netting it's been doing as a normal part of business does not constitute offsetting under the law."

Mr. Griffiths further claims the majority of the premiums Lodderhose allegedly withheld were for excess liability insurance policies, not reinsurance contracts.

Separate contracts between Lodderhose and various syndicates on the IEA involved reinsurance, Mr. Griffiths claimed.

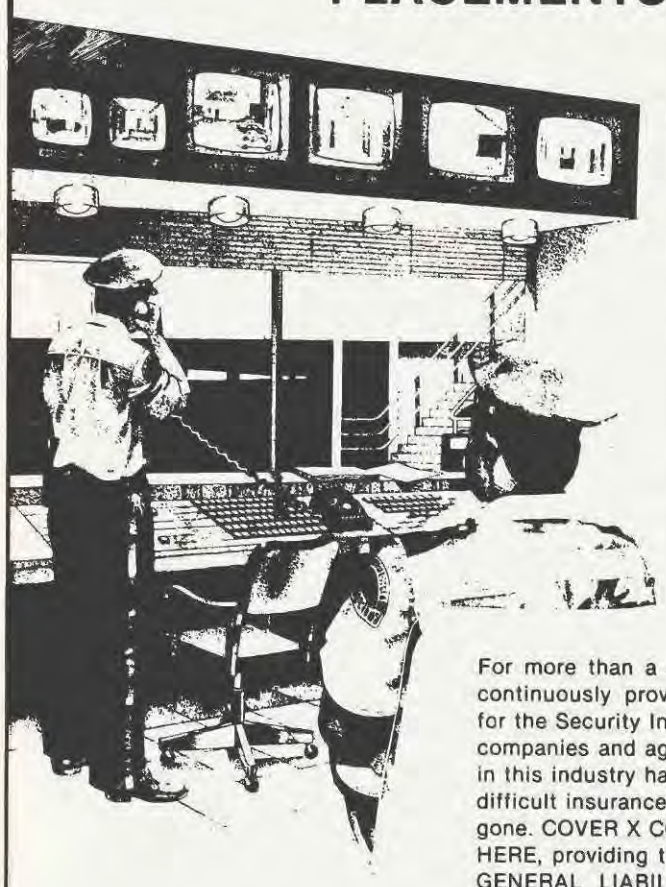
Under Illinois insurance regulations, premiums for direct business must be held in a fiduciary capacity in a trust account. There is no such regulation for establishing a trust account for reinsurance premiums, however.

However, James Stephens, a supervisor in the producer regulatory division for the Illinois Insurance Department, pointed out that Mr. Lodderhose is licensed as a producer in Illinois and "was operating in the capacity of an agent or a producer."

"As such, we think he does have some fiduciary responsibility" with regard to the premiums, whether they were for direct business or reinsurance, Mr. Stephens said.

But, Mr. Engel maintains that "those moneys are not insurance premiums, and therefore they don't have to be treated with the same trust requirements" as direct insurance premiums. ■

A BRIEF MESSAGE ABOUT INSURANCE PLACEMENTS FOR



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Markets

Continued from previous page

In addition, Industrial RE-International will consult on the formation and management of captives.

"Industrial RE-International's philosophy is to deliver to our client sound and effective risk funding vehicles as well as specific reinsurance programs tailored to management's financial goals," said President Rene A. Gutierrez.

The company, which started business in November, specializes in property, marine and casualty reinsurance.

Industrial RE-International is located at 45 John St., Suite 400A, New York, N.Y. 10038; 212-233-7651.

Surplus lines broker

Landers, Minner Underwriting Inc. has been licensed as a surplus lines broker in Maryland, Virginia and the District of Columbia.

According to President Harry J. Landers, the company is a "surplus lines generalist."

Previously, Mr. Landers was a vp with Horan, Goldman Cos. in Columbia, Md. He was also a Lloyd's of London broker for one year.

Edwin J. Minner, secretary/treasurer of the company, was also a vp with Horan, Goldman in Columbia.

For more information contact Mr. Landers or Mr. Minner at 5950 Symphony Woods Road, Columbia, Md. 21044; 301-997-0662.

PruCare HMO

Prudential Health Care Plan of New York Inc. has received approval to market its PruCare Health Maintenance Organization to New York state employers and their employees.

Initially, the PruCare HMO will be available in New York City, Long Island, Westchester County and nearby Hudson Valley County. Prudential also is seeking to establish an HMO subsidiary in Connecticut. The company has been operating an HMO in northern New Jersey since 1986.

Thirty New York hospitals and more than 1,000 primary care and 600 specialty physicians have agreed to participate in the PruCare of New York provider network.

Executive search

Avery Crafts Associates Ltd. has added a new specialization: recruitment of risk managers.

Avery Crafts now specializes in the selection and placement of middle-, upper middle- and senior management executives, including risk managers.

Bobbie Stone, previously director of research and development and now a consultant at the company, specializes in the placement of risk managers.

For more information, contact Ms. Stone at Avery Crafts Associates Ltd., 116 John St., New York, N.Y. 10038; 212-285-1074.

Name changes

Mattei-Webber Inc. of Seattle has changed its name to **R.F. Mattei & Associates Inc.** R.F. Mattei & Associates is the exclusive underwriting agency for Houston General Insurance Co. of Fort Worth, Texas.

Crump H&W Insurance Services Inc. has changed its name to **Crump E&S of California Insurance Services Inc.** In addition, the company has consolidated its Encino and Long Beach, Calif., offices into a new office at 3800 Alameda Ave., Suite 1650, Burbank, Calif. 91505; 818-846-3644.

Healthgroup International, a health maintenance organization in Los Angeles, has changed its name to **EQUICOR Health Plan of California Inc.**

Mergers/acquisitions

Republic Hogg Robinson Inc. of Boston has acquired Cleveland-based **Garson-Blau Inc.** through its subsidiary Republic Hogg Robinson of Ohio.

New offices

Lemac & Associates Inc. has opened a new office at 3100 Oak Road, Suite 350, Walnut Creek, Calif. 94596; 415-935-1212.

Efficient Health Systems Inc. has opened a new office at 3000 Ocean Park Blvd., Suite 1050, Santa Monica, Calif. 90405; 213-399-1336. ■

Small rate hikes seen from EC liability rule

By DOUGLAS McLEOD

NEW YORK—The new European Community product liability directive is expected to cause only modest liability insurance and reinsurance rate increases, and probably will not result in capacity restrictions, a panel of experts says.

Estimates of eventual rate increases tied to the new product liability law range from 5% to 20%, and demand for higher liability insurance limits probably will be gradual, thus easing the burden on insurance markets, experts predict.

Meanwhile, risk management and quality control will be even more important for companies that manufacture or distribute products in EC member countries, panelists told an audience at a recent seminar sponsored by Johnson & Higgins in New York.

The product liability directive is meant to supplement existing law in EC member countries, which include Belgium, Denmark, France, Germany, Greece, Ireland, Italy, Luxembourg, the Netherlands, Portugal, Spain and the United Kingdom.

The only country to have adopted the directive so far is the United Kingdom, which enacted its Consumer Protection Act last May. The law was implemented March 1.

The EC directive states that implementing legislation must be adopted by member countries by July 30, and draft legislation is being discussed in most of the countries.

However, it is unlikely that all EC members will have passed legislation by the July deadline, said Jean Russotto, managing partner of the law firm of Oppenheimer, Wolff & Donnelly in Brussels, Belgium.

In general, the product liability directive imposes strict liability on producers of defective products.

Producers may include manufacturers, importers or distributors placing their own trademarks on products manufactured by someone else, Mr. Russotto noted. A defective product is defined as one that does not provide the degree of safety that a person is entitled to expect.

The directive covers all movable products and excludes real property. At the option of the individual EC member countries, agricultural products and game also may be excluded.

The directive also applies only to individual consumers; corporate consumers are not covered by the directive's provisions.

Producers may argue that they are exempt from strict liability under the directive by asserting one of several defenses, Mr. Russotto said, adding that producers bear the burden of proving that such defenses are applicable. The defenses include:

- That the producer did not put the product into circulation.
- That the defect did not exist when the producer put the product into circulation.
- That the product was not manufactured for sale or distribution, nor manufactured or distributed in the course of the producer's business.
- That the defect resulted from compliance of the product with mandatory regulations imposed by public authorities.
- That the state of scientific and technical knowledge at the time the product was placed into circulation was not such that the existence of the defect could have been discovered. Individual EC members may vote to bar this defense, though so far only France and Luxembourg seem inclined to do this, Mr. Russotto said.
- For the manufacturer of a component part, that the defect resulted from the design of the product into which the component part was placed or to the instructions furnished by the manufacturer of the product. EC members also have the option of imposing a limit of 70 million European currency units ($86.1 million at current exchange rates), on bodily injury liabilities, though it is unclear exactly how this limit would be applied.

The product liability directive is not likely to cause any radical change in European insurers' approach to liability underwriting in

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EC directive

Continued from previous page
the immediate future, according to Bruno Zingg, assistant vp with Zurich Insurance Co.

While the new directive is intended to be implemented this year, but its impact on the 1987-1988 renewals has been "nil," he observed.

Mr. Zingg cited three reasons for insurers' "wait and see" attitude:

- The directive imposes strict liability, but not absolute liability—i.e., consumers must still prove that they suffered an injury caused by a defective product—and EC members still have the option of adopting the "state-of-the-art" defense and other limitations on strict liability.
- After national legislatures adopt the directive, courts in each EC member country must interpret the new law and establish precedents. It also remains to be seen how consumers will react to the new laws and what the impact on claims frequency and severity will be.
- The extent to which policyholders will improve product safety and quality control measures also has yet to be seen.

"Even in the worst-case scenario, we are still not likely to see anything remotely like the U.S. courts' approach to product liability," Mr. Zingg predicted.

Nevertheless, he said, the directive eventually will have an impact on underwriting. For example, insurers will be more selective about the risks they assume, encouraging policyholders to place greater emphasis on quality assurance and control.

Liability insurance rates also may rise an estimated 5% to 20%, with the greatest increases in those countries that are shifting from a negligence standard to the new strict liability standard, Mr. Zingg pointed out. These include the United Kingdom, Ireland, Italy and Portugal.

Insurers will be more selective about the risks they assume, predicts Zurich's Bruno Zingg.

Insurance pricing also will be affected by whether an EC member nation adopts the optional limitations on strict liability and the extent to which individual countries are the targets of forum-shopping by plaintiffs' lawyers, he said.

Mr. Zingg also said that he does not expect the directive to be a significant drain on insurance capacity, especially if most EC members adopt the state-of-the-art defense. Few policyholders will maintain limits equal to the optional 70 million ECU maximum under the directive, he said.

The best way to avoid product liability claims, Mr. Zingg advised, is to maintain a rigorous quality assurance program.

He added that producers and distributors always should keep a record of when a product is placed in circulation; this information could be used later in statute-of-limitation or state-of-the-art defenses, he noted.

The directive generally is expected to produce a gradual increase in the frequency and severity of claims over a period of years, as more European consumers become aware of the laws' provisions, according to Sylvain Boueil, manager of special risk underwriting and claims for Sté Commerciale de Réassurance S.A. in Paris.

SCOR's Mr. Boueil added that it will be difficult to determine how much of this increase results from the directive and how much relates to "usual social and judiciary inflation."

The complexity of claims and their settlement also will increase—with a resulting increase in defense costs—partly because producers bear the burden of proving that they should be exempted from strict liability under the directive's various defenses, and partly because plaintiffs' lawyers are expected to engage in forum-shopping, he said.

The demand for higher insurance and reinsurance limits is likely to increase, since most medium-sized European manufacturers maintain the equivalent of only $1 million to $2 million in liability limits, he said.

A sudden call for higher limits would strain the current insurance and reinsurance capacity, he observed. However, it is more likely that the demand for higher limits will increase gradually.

Such a gradual increase, built on a steadily rising volume of insurance and reinsurance premiums, would preserve an orderly market for liability coverages, Mr. Boueil noted.

While increasing frequency, severity and complexity of claims may produce rate hikes, these may be partially offset by credits for better product and packaging design and quality control measures, he said.

Luk Van Berckelaer, manager of the international and marine departments with Johnson & Higgins in Pittsburgh, also stressed the need for safer products, better labeling, directions and warnings, and better and safer packaging.

Mr. Van Berckelaer noted that the directive creates a need to institute "U.S.-style risk management standards," primarily the need for documentation of a product's history.

In order to take advantage of the various defenses available under the product liability directive, producers should be able to document:

- Who manufactured the product or component.
- Who put it into circulation and when this occurred.
- Where the product was manufactured.
- Whether it was made in compliance with mandatory specifications.
- What the state of scientific and technical knowledge was at the time the product was placed into circulation.
- Whether the product was made in accordance with someone else's design.
- The provisions of the sales contract for the product and whether the product carried any warranties.

Mr. Van Berckelaer agreed that if claims gradually become more frequent, policyholders will need to increase the aggregate limits on their working-layer casualty programs.

Working-layer casualty coverages should be written on an admitted basis, and U.S. multinationals may want to consider involving European insurers, particularly since U.S. insurers may not be able to issue admitted policies for $5 million or even $3 million in some countries, he said.

Other advantages of using European insurers, he added, include:

- Insulating U.S. excess programs from European exposures.
- Testing the competitiveness of the European market.
- Obtaining broader coverages almost exclusively available in Europe, including sudden and accidental pollution and product recall coverages.

Other speakers discussing the EC product liability directive at the J&H seminar included Gerhard Groh, a partner with Jauch & Hubener in Hamburg, West Germany, a brokerage correspondent of J&H; and Peter Madge, managing director in the corporate liability department with Willis Wrightson Ltd. in London, another J&H correspondent. ■



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Capital accumulation plans gain popularity

By ALISON KITTRELL

About equal numbers of U.S. employers offer capital accumulation plans and defined benefit pension plans to their salaried employees, a recent survey shows.

Eighty-five percent of 763 surveyed employers nationwide offer a capital accumulation plan or defined contribution plan, while 83% offer a defined benefit pension plan, according to "1987 Survey of Retirement and Capital Accumulation Plans: Plans Covering Salaried Employees of U.S. Employers."

The study was conducted by The Wyatt Co. using plan data from year-end 1986.

In addition, 68% of the employers surveyed offered both a capital accumulation plan and a defined benefit plan to their salaried employees.

"Larger employers were more likely to sponsor both plans than smaller ones," the survey authors say. For instance, the 68% of the employers that offer both types of plans represent about 90% of all employees involved in the survey.

Although defined benefit pension plans remain an important means of securing retirement income (see related story), experts at Wyatt say that capital accumulation plans continue to be popular with both employers and employees.

Employers like these savings plans because "they are simple to operate in many respects, and the cost is predictable," says Gary Blank, chairman of Wyatt's defined contribution plan practice committee.

"Employees like them because they understand the plans. And if they understand the plans, they appreciate the benefits," Mr. Blank says.

Employers like defined contribution plans because 'they are simple to operate in many respects, and the cost is predictable,' says Gary Blank of The Wyatt Co. 'Employees like them because they understand the plans. And if they understand the plans, they appreciate the benefits,' he says.

The most prevalent type of capital accumulation plan was a plan with a 401(k) salary deferral feature, which were offered by 78% of all the employers with capital accumulation plans.

In fact, Mr. Blank calls 401(k)s "the single most popular retirement plan ever created in the U.S."

Some 36% of the respondents offered a thrift plan with a 401(k) feature, while 7% offered a thrift plan with no 401(k) feature.

Other types of capital accumulation plans offered include stand-alone 401(k) plans, offered by 17% of the employers; profit-sharing plans with a 401(k) feature, offered by 16%; profit-sharing plans without a 401(k) feature, 12%; employee stock ownership plans with a 401(k) feature, 1%; and ESOPs without a 401(k) feature, 2%.

Also, payroll-based stock ownership plan with a 401(k) feature, 3%; PAYSOPs without a 401(k) feature, 2%; stock bonus plans with a 401(k) feature, 1%; stock bonus plans without a 401(k) feature, 2%; and some other type of capital accumulation plan, 8%.

Almost half the employers with a capital accumulation plan offered employees more than one such plan.

In most of the capital accumulation plans, employee contributions were allowed or even required for participation. For example, 89% of the plans allowed employee contributions and 401(k) deferrals, and 73% required such employee participation.

Among plans that required employee contributions, the amounts required ranged from less than 1% of the employee's compensation to 6% of compensation. But, about two-thirds of the plans that required employee contribution set the minimum contribution level at 1%, and only 4% of salary of the plans set required contributions at more than 2% of salary.

In addition, many plans allowed voluntary contributions by employees above any levels matched by the employer.

Most employers' contributions to capital accumulation plans, when measured as a percentage of compensation, averaged between 2% and 4%. Most of the plans with substantially higher contribution rates were profit-sharing plans.

In some 80% of the capital accumulation plans, the employer's contribution was based on a formula that matched to a certain percentage of either employee aftertax contributions to the plan or employee 401(k) deferrals, up to a certain level. The most common match, reported by 41% of those employers matching 401(k) contributions and 36% of those matching aftertax contributions, was 50% of the employee contribution.

And, virtually all these plans matched employee contributions at a single rate up to a maximum percentage of compensation. The most common maximum contribution matched by employers was 6% of compensation, reported by 59% of the plans for aftertax contributions and 56% for 401(k) deferrals.

In other survey findings:

- Seventy-one percent of the capital accumulation plans allowed participation by employees at any age, while 29% required employees to have reached a specific age, usually 21, to be eligible for participation.
- Sixteen percent of the capital accumulation plans had no service requirement for participation.

Some 77% of the plans required a year or less of service for participation, while 3% required more than one year but less than three years, and 4% required an employee to have three years of service to be eligible for participation.

However, the survey authors note, "For plan years beginning after 1988, tax reform requires most plans to allow eligible employees to participate after no more than two years of service. In addition, tax reform requires that 401(k) arrangements permit elective deferrals by employees after no more

Continued on next page

Majority of firms continue to offer defined benefit plan

By ALISON KITTRELL

The traditional defined benefit pension plan remains the most popular pension plan—as opposed to savings plan—offered to salaried employees by U.S. employers, according to a recent study.

Eighty-three percent of the 763 employers that responded to The Wyatt Co.'s "1987 Survey of Retirement and Capital Accumulation Plans" offered some type of pension plan, and 90% of those were defined benefit plans. Only 8% were what Wyatt terms "defined contribution plans," which are better known as cash balance or money purchase pension plans, while the remaining 2% were combination plans.

And, although capital accumulation plans provide retirement income to a substantial number of U.S. employees (see related story), the traditional defined benefit pension plan continues to be a vital part of most retirement planning.

Pension plans generally are open to virtually all employees. For example, 25% of the plans covered in the Wyatt survey had no age or service requirement for participation. Forty-four percent required employees to have up to a year of service and attain an eligibility age between 18 and 21. The rest had either the minimum age or the minimum service requirement.

Twenty-five percent of the plans had no age or service requirement for participation.

In addition, pension plans are funded almost entirely by employers. Only 5% of the defined benefit plans surveyed required employee contributions for participation, and only 6% allowed voluntary employee contributions.

Employers made a wide range of contributions to their pension plans. For example. 24% of the employers with defined benefit plans contributed an amount equal to 3% of total compensation to their plan.

Nineteen percent of those with defined benefit plans reported contributions of between 3% and 4.99% of total compensation. Contributions between 5% and 6.99% of compensation were reported by 14% of employers with defined benefit plans, while 19% of those with defined benefit plans made pension contributions that were 7% or more of total compensation.

In addition, 24% of the employers with defined benefit plans said they had made no plan contribution during the previous year. But, the survey authors note, "Employers' contributions in any year to a defined benefit pension plan may be affected by factors other than the plan's cost. For example, contributions to fully funded plans are not tax-deductible. Thus, some employers may not make contributions in a given year."

In other survey findings:

- The most common vesting schedule for pension benefits was cliff vesting, reported by 76% of the respondents. And for 91% of those, full vesting was reached after 10 years.
- Fifty-four percent of the defined benefit plans did not require employees to meet any minimum service requirement before collecting nor-

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Defined benefit plans

Continued from previous page
than one year of service."

- Forty-four percent of the plans used a graded vesting schedule, while 24% used cliff vesting, 15% used class-year vesting and 4% used a combination of vesting requirements.

Thirteen percent of the plans had immediate vesting for employer contributions.

And, the survey authors explained that about 35% of the plans will have to change their vesting rules to meet the faster vesting schedules required by the Tax Reform Act of 1986.

- Most of the plans offered employees a variety of investment options. A single investment option was offered by only 11% of the plans for employee contributions, and by only 38% of the plans for employer contributions.

According to the survey authors, "The preferred investment choices offered by capital accumulation plans were, in order of frequency, equity funds, company stock, fixed income funds and guaranteed investment contracts."

- Overall, only 48% of the plans included a loan provision, though plans with a 401(k) element were much more likely to include a loan provision than plans without a 401(k) feature.

Only 48% of the plans included a loan provision, the survey notes. And 86% of the plans with a loan provision reported they had outstanding loans against the plans.

Of the plans with a loan provision, 89% allowed loans up to the maximum amount allowed by law, and 99% required no collateral other than the balance in the employee's capital accumulation plan account.

Some 86% of the plans with a loan provision reported they had outstanding loans against the plans. But, the survey authors say, "Though many plans had outstanding loans, the average number of loans was not a large percentage of the number of participants in the plan."

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Copies of the survey, "1987 Survey of Retirement and Capital Accumulation Plans: Plans Covering Salaried Employees of U.S. Employers," are available free from The Wyatt Co., Research and Information Center, 1850 M. St. N.W., Suite 400, Washington, D.C. 20036; 202-887-4600.

Savings plans

Continued from previous page
mal retirement benefits.

Minimum service requirements of five years or less were set by 28% of the defined benefit plans, while 17% of the defined benefit plans required employees to work six to 10 years before being eligible for normal retirement benefits.

In addition, 1% of the defined benefit plans had a minimum service requirement of more than 10 years.

- For 93% of the pension plans surveyed, 65 is set as the normal retirement age.

Four percent set the normal retirement age at between 60 and 62, and the remaining 3% had a normal retirement age of less than 60.

- Almost all defined benefit plans provided at least reduced benefits for employees who retire before the normal retirement age. And 47% provided unreduced benefits for early retirees who met certain age and service requirements.
- Seventy percent of the pension plans included long-term disability benefits in the event that an employee was disabled before retirement.

And, 97% of the plans offered such benefits either through the pension plan itself or through another plan.

- Some 85% of the pension plans were integrated with Social Security.

Finally, the survey shows that employees who retire with only pension plan benefits do slightly better than those who retire with only capital accumulation plan benefits. Those who retire with both types of benefits do best of all.

The survey looked at three hypothetical employees who retired at age 65 with 30 years of service. The final salaries of these employees were 33%, 100% and 200% of the Social Security wage base.

The employee who retired at 33% of the Social Security wage base and had only capital accumulation plan benefits had a retirement income equal to 56% of his pre-retirement income, including 38% from Social Security, 6% from his employer's contributions and 12% from his own contributions.

This same employee retiring with only pension benefits replaced 66% of his pre-retirement income, including 38% from Social Security, 27% from employer contributions and 1% from his own contributions.

Almost all defined benefit plans provide some benefits for early retirees, the survey shows.

But, if this employee had both types of plans when he retired, he replaced 84% of his pre-retirement income, including 38% from Social Security, 34% from employer contributions, and 12% from his own contributions.

An employee retiring at 100% of the Social Security wage base with only capital accumulation plan benefits replaced an average of 48% of his pre-retirement salary, including 24% from Social Security, 8% from employer contributions and 16% from his own contributions.

If he retired with only pension plan benefits, he replaced an average of 56% of his pre-retirement income, including 24% from Social Security, 31% from employer contributions and 1% from his own contributions.

But, if he had benefits from both plans when he retired, he replaced an average of 81% of his income, including 24% from Social Security, 40% from employer contributions and 17% from his own contributions.

Finally, an employee who retired at 200% of the Social Security wage base and had only capital accumulation plan benefits replaced an average of 38% of his pre-retirement income, including 13% from Social Security, 8% from employer contributions and 17% from his own contributions.

If he had only pension benefits, he replaced an average of 48% of his pre-retirement income, including 13% from Social Security, 34% from employer contributions and 1% from his own contributions.

But, with both types of benefits, he replaced an average of 75% of his pre-retirement income, including 13% from Social Security, 44% from employer contributions and 18% from his own contributions. ■

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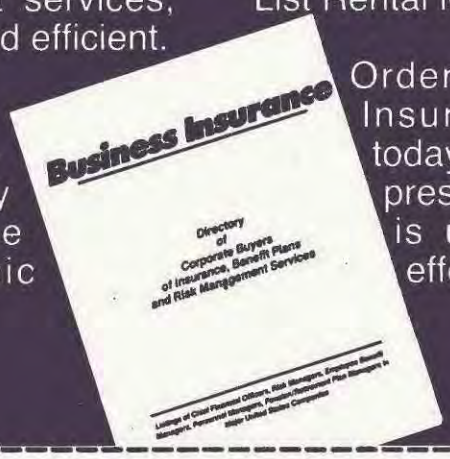
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Medicare proposal

Continued from page 1

amendment was not clear whether savings had to be distributed only to retirees.

Some business groups are interpreting the changes proposed in Sen. Riegle's letter to mean that as Medicare is gradually expanded through the early 1990s to cover new benefits, employers that cut back on their supplemental plans will have to calculate and distribute savings to retirees each year.

For example, under the Senate bill, the Medicare program starting in 1990 will cover certain prescription drugs, like home intravenous drugs, after a $600 deductible. In 1991, cardiovascular drugs and diuretics would be covered, while in 1993 all prescription drugs would be covered.

Other benefit improvements contained in the legislation also have different effective dates.

"You have a multiyear administrative headache, not a one-year problem," under the revised proposal, said Howard Greene, associate legislative director for the Risk & Insurance Management Society Inc. in New York.

Referring to Sen. Riegle's latest proposal, the Washington-based Assn. of Private Pension & Welfare Plans said in a statement: "This amendment would further exacerbate the problems employers would experience under the original proposal."

"There is an effort being made to expand the Riegle amendment to beyond one year. It is the old foot-in-the-door approach. We are very concerned and angry about it," said Cathy Amkraut, director of public policy for the Washington Business Group on Health.

But a Senate committee staffer, acknowledging that Sen. Riegle's letter could have been clearer, says business groups are misinterpreting the letter to mean that employers would have to pass along savings for more than one year.

The intent of the letter is to ensure that savings are passed on to retirees for a full year, regardless of when the Medicare legislation is enacted, the staffer said.

The staffer admits, though, that it is possible that some members of the conference committee could propose that cost savings be distributed annually to retirees as Medicare is expanded.

Sen. Riegle is not a member of the Medicare conference committee.

Rather than waiting for the dust to settle and see which interpretation prevails, business groups are writing to conferees to urge them to resist any effort to make the savings distribution an annual requirement.

"The Chamber is concerned especially that the conferees now are being asked to consider additional changes to the 'maintenance of effort' provision that will make it applicable to spouses and dependents of employees and retirees and for longer than one year, as originally proposed and approved by the Senate," said the U.S. Chamber of Commerce in a letter to the Medicare conferees.

"The amendment applies to only one year. Under no circumstances should this be extended," the Washington Business Group on Health said in a letter to conferees.

Regardless of how long such savings have to be distributed, business groups say merely calculating the savings would create big administrative problems for employers.

The Riegle amendment, which is not found in the House-passed Medicare bill, would require the Labor Department to develop regulations on how employers would determine the actuarial value of the duplicate benefits to be eliminated.

Many experts doubt that the Labor Department has the expertise to quickly develop such regulations.

The Treasury Department, for example, has been struggling for more than a year to develop benefit valuation regulations to help employers with multiple benefit programs comply with the 1986 tax law's non-discrimination rules for welfare plans. Those non-discrimination rules are scheduled to go into effect next year, but business lobbyists say that Treasury officials have privately suggested they would not oppose a delay because of the difficulty in valuing benefits.

Without regulations, employers would have no guidance on assigning a value to the duplicate retiree benefits.

"None of this makes any sense," said Mark Ugoretz, executive director of the ERISA Industry Committee, a Washington-based benefits lobbying group representing large employers. "How do you value a prescription drug benefit or a portion of a prescription drug benefit? There are no standards to measure these benefits."

Continued on next page

California minimum premium plan tax

Continued from page 2

can be taxed in California," said Paul D. Inman, a senior associate in the Washington law firm of Gibson, Dunn & Crutcher and GM's attorney in the case.

"Only the state knows this and I'm not even sure they know. The state's attorney general's office has taken the position that the tax applies only to insured plans and that GM's plan is insured. But nobody knows what makes the plan insured or not insured in the state," he explained.

"The theory behind this is that it's a gross premium tax on the amounts paid out of an employer's funds to provide health insurance for employees. The tax is on insurance, not self-insurance," explained David Levine, tax counsel for the Board of Equalization.

However, "we're not entirely sure how the board will decide which plans will fall under the tax law. But, administrative-services-only arrangements—those that involve no insurance whatsoever and are completely funded by the employer—probably won't be taxed at all," he said.

The amount of tax an insurer must pay because of the state's 2.35% tax on an insurer's gross premiums is determined by the Insurance Department through audits. The department then recommends a tax assessment to the Board of Equalization. Insurers have the right to file for a re-determination of their tax assessment if they believe the assessment is inaccurate.

Observers say the state may collect the taxes on plans in force as far back as 1982.

"We have been assessing many insurers lately. We are just now figuring the assessments for 1985 and 1986, and it could amount to about $400 million by the end of this year," explained Levy Lacuesta, deputy insurance commissioner in Los Angeles.

Insurers may end up absorbing the tax either because they do not have a contractual agreement with their policyholders requiring the policyholders to assume the tax or because inaccurate records of terminated plans prevent them from identifying the policyholders from which they can collect, observers say.

While minimum premium arrangements vary, they usually require the employer to pay a fixed minimum premium to the insurer to cover the insurer's administration of the plan and a profit allowance. The minimum premium generally is about 10% of the employer's expected claims costs under the plan. The employer is then responsible for paying all claims above 10% until a certain trigger point, when the insurer then is responsible for financing claims payments.

Most minimum premium arrangements also involve a contractual agreement in which the employer agrees to assume any premium taxes imposed on the insurer. In fact, "this situation exists in probably 100% of minimum premium arrangements," estimated Joseph A. Thomas, senior vp and general counsel for Pacific Mutual Life Insurance Co. in Newport Beach, Calif.

Because of these agreements and the fact that insurers will be able to collect this tax retroactively from their employer policyholders, California employers could end up assuming much of the tax, some observers say.

"We understand that some insurers are getting the bills ready to send out to employers," said Lawrence C. Clark, a principal in the Los Angeles office of William M. Mercer-Meidinger-Hansen Inc.

And, the cost to employers could be significant, he said.

"Let's say your premium under a minimum premium plan was $1 million. With a 2.35% tax, you would pay $23,500 and that's not peanuts," he said.

In addition, "about 99% of employers with these arrangements probably have not funded or reserved for this cost," he added.

However, some benefit consultants say that most employers using these funding arrangements have already realized they could be liable for the tax.

"I believe most employers have asked for and received an adequate idea of what their liabilities could be for this tax and have expensed for it," said Donald Sanderson, a vp in the Los Angeles office of TPF&C, the benefits and actuarial consulting division of Towers, Perrin, Forster & Crosby.

Also, "most employers that made the choice to fund with a minimum premium arrangement already knew that the risk of paying a premium tax existed," said Laird Post, a consultant and leader of The Wyatt Co.'s flexible benefits practice in Sherman Oaks, Calif.

"The real issue for employers here is if there is a retroactive call for the money in one big lump sum. But, most probably knew that was a possibility anyway. The issue most employers are and should be more concerned about right now is the 40% increases in overall health care costs," he added.

In addition, since the tax applies only to benefit payments for health care of employees in California, some employers in that state with employees in other states will not have to pay as great of a tax, explained Larry Tucker, a consultant in the Santa Ana, Calif., office of Hewitt Associates.

"We have some clients based in California that have most of their employees in other states. So, the tax could really be almost a non-issue for them since it would be 2.35% of a small portion of their health plan," he said.

In addition, employers may not be hit with the back taxes depending upon the ability of insurers to search their records to identify the employers from which they need to collect the tax.

"I think there's going to be some question and confusion on the part of insurers as far as tracking down their terminated minimum premium plans. It's a question of how accurate insurers' records are and how aggressively they will pursue back taxes from these terminated plans," explained TPF&C's Mr. Sanderson.

While some benefit consultants estimate that some 20% to 25% of California employers currently fund their benefit plans through minimum premium arrangements, they note that these generally include employers with from 300 to 4,000 employees.

Some large employers, including San Francisco-based BankAmerica Corp. and Los Angeles-based First Interstate Bancorp—which have about 68,000 and about 34,000 employees, respectively—say they are completely self-funded and therefore will not be liable for any premium tax.

The premium tax issue may have partly contributed to a decline in the use of minimum premium plans and a greater trend toward self-insurance and ASO arrangements, said Gerard Talbot, counsel for New York-based Metropolitan Life Insurance Co., which underwrote GM's minimum premium at issue in the court case.

GM's plan is now self-insured, with Metropolitan providing administrative services only, he said.

Mr. Thomas of Pacific Mutual predicts the tax brouhaha could have other implications.

"This could in fact reduce the premium tax revenue to the state because more employers will move to complete self-funding to avoid any premium tax," said Mr. Thomas.

While he could not estimate the percentage of Pacific Mutual's business generated by minimum premium arrangements, Mr. Thomas said it has steadily declined since the Minimet case in 1982.

But, some consultants say employers will continue to evaluate minimum premium arrangements, despite the tax.

For example, Mr. Clark of Mercer pointed out that "there are some excellent cash advantages to minimum premium plans for some employers. I would be surprised if this tax issue really did hurt minimum premium plans."

Although the GM decision stands for now, Mr. Inman said litigation on premium tax issues will continue. "There is both existing and prospective litigation in this area on the federal level," he said. ■

Challenge #2

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Continued from previous page

And, calculating what employers would save by eliminating duplicate benefits could cost more than the savings to be distributed to retirees.

While there has been discussion among House conferees of having the Treasury Department set "safe harbors" that employers could use to determine how much in savings they should distribute to retirees, benefit lobbyists say such an approach would not provide much help.

"Even if a safe harbor were included, it could not be an accurate reflection of the costs. Requiring an employer to accept the Treasury figure or run actual calculations is a Hobson's choice: i.e., no choice at all," the APPWP said.

Sen. Riegle originally proposed his amendment to prevent employers from reaping a "windfall" when Medicare is expanded to cover more expenses. "This amendment will not result in increased costs to employers but, rather, will prevent an unintended windfall for employers at the expense of our nation's retirees," he said last year.

Supporters of the Riegle amendment point out that both the House- and Senate-passed Medicare legislation require retirees to pay a greater premium for expanded Medicare coverage.

For example, under the House bill, upper-income retirees would pay a new special supplemental premium of $580 a year while the annual supplemental premium under the Senate bill could be much as much as $800. And both measures would sharply increase the Medicare Part B premium, which covers physicians costs, from the current $24.80 monthly charge.

While retirees' costs would rise, employers' costs would decline as they cut back duplicate benefits, supporters of the Riegle amendment note.

"There would be a cost shift from employers to retirees. That cannot be what Congress intends," said Alan Reuther, associate general counsel with the United Auto Workers union in Washington.

But business groups, while not denying that companies with retiree health care plans would achieve some savings when Medicare is expanded, say Congress showed little concern when costs once covered by Medicare were shifted onto employers.

For example, laws enacted in the early 1980s required employer health plans to be the primary source of coverage for employees who stay on the job after 65. In addition, continued increases in Medicare's deductible and coinsurance requirements have increased the cost of employer-sponsored retiree health plans that pick up costs not covered by Medicare.

"Some are crying foul now that employers are getting a bit of a break. But no one cared before when Medicare costs were shifted to employers," said APPWP Executive Director Howard Weizmann.

"In this case, there appears to be something of a double standard," said Sharon Canner, assistant vp-industrial relations for the National Assn. of Manufacturers in Washington.

While House and Senate conferees met last week to work out differences in the two Medicare bills, no one is predicting when they will complete their work. Because there is a congressional consensus that Medicare should be expanded, it is almost a certainty that a compromise bill will be approved by the conferees and passed by Congress this year.

"If you had to predict benefits legislation that will pass in 1988, Medicare catastrophic legislation would be the one to bet on," said Edward J. Davey, a principal with A. Foster Higgins & Co. Inc. in New York. ■

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Clearinghouse

Continued from page 1

ers' reinsurance policies.

As a result, the reinsurers are refusing to pay claims relating to settlements negotiated by the facility.

Reinsurers were never a party to the Wellington Agreement and are not bound by the terms under which the facility pays claims to the extent that the terms fall outside the scope of the reinsurance contracts.

Mr. Koepke and other European reinsurers point out the establishment of IRAS will speed up the claims payment by reducing the duplication of information that ceding companies currently are asked to provide to each reinsurer.

IRAS "could assemble all necessary asbestos claims information and clarify issues of general interest, thus accelerating payment" of reinsurance claims, Mr. Koepke told the conference, adding that IRAS would alleviate the current need for "every cedant, reinsurer and retrocessionaire around the world (to) ask and answer the same duplicative questions and present the same voluminous documentation repeatedly studied and analyzed by others."

IRAS "would do the groundwork necessary for efficient and uniform claims handling through consistent standards of contractual interpretation, thus achieving greater reliability, clarity and universality and trust than the present situation allows," he continued.

The cost of establishing IRAS could be funded by the world's largest reinsurance companies, which would become founding members of the facility, Mr. Koepke said in an interview last week. Other smaller reinsurers could contribute funds as associate members.

The amount of money required to set up IRAS hasn't been determined.

The services provided by IRAS could be paid for on a fee basis, he suggested.

A clearinghouse like IRAS is necessary because of the "enormity of the asbestos problem facing the reinsurance industry in terms of the money and amount of information involved," said Mr. Koepke.

"We cannot survive without some form of advisory service. When a monolithic loss becomes splintered into thousands of pieces around the world, it becomes impossible for (reinsurers) to sort out the whole loss," he noted.

Most individual reinsurers do not have sufficient resources to assimilate and process all the information required to assess their liability for the thousands of asbestos claims filed by ceding companies, he said.

Other speakers at the conference welcomed the IRAS proposal.

"I would welcome such a body to take away some of the burdens from reinsurers. From Portugal to Japan, reinsurers need a degree of counseling," said Otmar Schmidlin, senior vp of Swiss Re.

"It is clearly essential that some centralized information service be set up to provide at the very least a starting point for the dissemination of information," agreed John F. Powell, an attorney with Holman, Fenwick & Willan in London.

However, London underwriting executives and brokers reject the IRAS proposal, emphasizing that reinsurers are offering no solution to the growing dispute between ceding companies with asbestos losses and their reinsurers.

London market observers specifically argue that:

- The formation of IRAS will further delay payments to ceding companies.

"All it will achieve is a delay in payment of claims for another two years or so while (the reinsurers) set it up. No reinsurer will be prepared to make payments before (IRAS) is operational," said Jim Ayliffe, non-marine claims director for Merrett Holdings P.L.C., a Lloyd's underwriting agency.

- Reinsurers should be responsible for servicing their own claims and should staff accordingly.

"London market companies, syndicates and brokers have had to increase resources substantially in order to service the mass of U.S. asbestos claims. If a company is prepared to write business, it must have adequate facilities to then service any claims that arise as a result of that business," said Keith Rayment, non-marine director responsible for claims at Sturge Holdings P.L.C., another Lloyd's underwriting agency.

- The establishment of IRAS would bypass London brokers, who traditionally have been the line of communication between London underwriters and their reinsurers worldwide.

In fact, the observers point out that London brokers have been passing information about asbestos claims and explaining policy wordings to reinsurers for more than four years.

"The brokers have performed a valiant role already in trying to educate underwriters worldwide," said Mr. Ayliffe.

In 1985 and 1986 London brokers and underwriting agency claims managers organized seminars in Cologne and Hamburg, West Germany; Stockholm, Sweden; Vienna, Austria; Bombay, India; and Tokyo to explain asbestos claims to reinsurers, pointed out Richard Rutty, a director of Lloyd's broker Winchester Bowring Ltd.

"The broker's role is of vital importance in this issue. We already have direct communication with the reinsurers and the possible establishment of IRAS can only be an unnecessary duplication of the information and communication network already in existence," said Mr. Rutty.

- IRAS would be confronted with legal problems surrounding disclosure, since pooling information could break confidentiality agreements between ceding companies and their individual reinsurers.

"IRAS would inhibit the flow of information from a privileged standpoint, creating another layer to exacerbate the situation," one attendee noted.

- IRAS would be unable to collect and collate asbestos claims information without the London market's support.

- Even if IRAS were successful in gathering the information, the decision whether to pay a claim would still have to be made by individual reinsurers.

Many reinsurers that have received all the information about asbestos claims they have requested still have not paid any claims, brokers and underwriting agency claims managers say.

However, Mr. Koepke said that IRAS offers an opportunity to show the London market that reinsurers are not avoiding the payment of claims.

"I realize that the London market is disappointed and that dialogue in some instances has broken down. London now feels the time for discussion has passed and the moment for payment is at hand," Mr. Koepke said in the interview.

"If we can get a claims information service set up fast and efficiently, we will be able to persuade London that we are serious in getting this situation resolved and to better provide the cooperation expected of us," he said, adding that he hoped London would support the project.

However, many people from the London market believe last week's conference has further polarized ceding companies and reinsurers.

In a series of speeches, attorneys in private practice and staff counsel for reinsurers presented legal interpretations of policy wordings that were later disputed by London market officials at the conference.

"The conference cannot be considered to have been of any practical help. The views (on policy wordings) expressed by some of the speakers were misguided and totally incorrect," said Mr. Rutty of Winchester Bowring.

"As far as I can tell, the underlying intent of the conference was to draw up battle lines instead of constructively going forward," said Sturge's Mr. Rayment.

The policies in question that now are being scrutinized by lawyers "were drawn up by underwriters, not lawyers, and their intent is quite clear as far as the London market is concerned," said Lloyd's underwriter Charles Skey, the only London market underwriting executive to address the conference.

Reinsurers are questioning wordings that have been used successfully in the insurance industry for many, many years, noted David Turner, director of the non-marine division of Lloyd's reinsurance broker E.W. Payne (U.K.) Ltd.

The issue of asbestos reinsurance payments has become so serious that London is now "reaching the conclusion that legal action is the only remaining course of action open," warned Lloyd's underwriter Robin A.G. Jackson, a Merrett director, in a memorandum sent to reinsurers this month.

Copies of the memo, written by Mr. Jackson in his role as chairman of the London Asbestos Working Party, were sent to the chief operating officers of select reinsurers worldwide by chairmen of four London brokers: C.T. Bowring & Co., E.W. Payne Cos. Ltd., Alexander Howden Reinsurance Brokers Ltd. and Willis Faber P.L.C.

"The letters were sent to ensure that this problem is reviewed by reinsurers at the highest level and that the settlement problems are dealt with urgently," said Bill Sheridan, deputy chairman of E.W. Payne.

Mr. Jackson pointed out in his memorandum that although "a number of retrocessionaires have responded in accordance with their contractual obligations, there is now a hard core of reinsurers who have been delaying their responses, which in some cases are up to three years overdue. It is unfortunate that other professional reinsurers in the United States, Europe and Japan seem to be associating with this group."

The integrity of the reinsurance industry "may be severely impaired if the problem is not solved equitably and quickly," wrote Mr. Jackson.

The London market has paid asbestos claims totaling some $500 million, according to the memo.

"When this fact is considered in conjunction with the potential cost to the insurance industry just to address known outstanding claims, the enormity of the problem becomes more clear," says Mr. Jackson, adding that the claims paid do not take into account "the financial impact of asbestos property damage." ■

The International Reinsurance Advisory Service 'could assemble all necessary asbestos claims information and clarify issues of general interest, thus accelerating payment' of reinsurance claims, according to Gerling's Jack E. Koepke.

EIL market

Continued from page 3

holders do not own. AIG also does not cover underground storage tanks.

AIG requires applicants for EIL coverage to undergo a rigorous environmental engineering survey before it will consider writing coverage. These surveys can cost between $5,000 and $8,000 per site. The insurer has authorized six engineering firms to conduct the surveys.

AIG's claims-made pollution liability policies do not have a retroactive date, Mr. Patterson noted, explaining that during the period the policy is in force "you have coverage back to infinity."

Looking to the future, Mr. Patterson said AIG "may approach the market mid-year" to see if it can develop an excess EIL program.

PLIA provides EIL coverage with limits of $2 million per claim with a $2 million aggregate.

Deductibles range from $2,500 to $500,000, and premiums vary widely depending on the risk, according to Doug Hamilton, manager of product development for PLIA.

PLIA's coverage is written by member insurers and reinsured through the association. An EIL policy must be written as part of the policyholder's general liability coverage, noted James C. Morrow, PLIA chairman and vp of Nationwide Insurance Group.

The policy retroactive date is the first day of the first policy written by a member of the association.

Mr. Morrow said that an "important function" of PLIA's coverage is that it covers the policyholder if it sends waste material for treatment, storage or disposal to a site it does not own.

Two-thirds of PLIA's premium volume is generated through coverage of underground storage tanks, Mr. Morrow said (see related story.)

PLIA members also target small manufacturers, he said.

Reliance, the newest EIL market player, writes limits of $1 million per claim and $2 million aggregate through underwriting manager Environmental Compliance Services Inc. Reliance began offering this coverage in October 1987.

Reliance charges a minimum premium of $20,000 for a $1 million policy with a $25,000 self-insured retention. It requires an engineering survey prepared by Houston-based Pilco & Associates Inc. before it will write EIL coverage.

David Rosenberg, executive vp of ECS, said the company hopes to raise limits within two months to $3 million per claim with a $6 million annual aggregate.

In London, major U.S. energy companies usually can obtain pollution liability coverage through the marine market if they place their entire property/casualty insurance package with marine underwriters, according to London sources (*BI*, Dec. 7, 1987).

If the insurance package is big enough, some underwriters will offer limits up to about $200 million and will offer "generous" sudden and accidental pollution coverage terms, like occurrence-based coverage, according to London brokers.

However, many brokers and other pollution liability experts point out that most marine market liability packages cover only sudden and accidental pollution risks, not gradual pollution.

"The marine market has always provided pollution coverage as part of the energy packages," noted Peter Evans, underwriter for Indemnity Marine Assurance Co. Ltd. in London.

Roy Oddy, chairman of Maclean, Oddy & Associates Inc., a Dallas surplus lines broker, agreed.

"How much they are prepared to offer depends on type of client, how large the overall premium income is and what he needs," he explained. And, "occurrence wordings are available, although underwriters aren't prepared to cover gradual seepage and pollution."

A London broker who did not want to be named said that "some major oil companies have bought types of seepage and pollution coverage on an occurrence basis but with aggregated limits." However, he continued, "most underwriters are now so terrified of seepage and pollution they won't even look at it, particularly in the non-marine market."

And, coverage written through H.S. Weavers (Underwriting) Agencies Ltd.'s non-marine line slip excludes pollution coverage, policyholders can buy sudden and accidental pollution coverage as part of their total property/casualty insurance program.

Weavers will offer pollution limits of up to $25 million to $30 million, depending on the size of the policyholder's entire insurance package, according to Weavers Managing Director Peter Wilson.

In addition to the primary-layer markets, several alternative facilities writing excess liability insurance offer sudden and accidental pollution coverage to their members, but do not offer gradual pollution coverage.

The facilities describe sudden and accidental incidents as those they are notified about within a specific time period, usually three to seven days.

The market for catastrophic coverage for sudden and accidental pollution is an area "where maybe we can give you a little bit of relief and hope," said John P. Brady, vp of Johnson & Higgins of New York.

Some of the offshore captives offering substantial excess liability coverage for sudden and accidental pollution include:

- A.C.E. Insurance Co. Ltd. in Bermuda. A.C.E. offers claims-made sudden and accidental pollution liability coverage as part of its excess liability program, with limits of up to $150 million excess of $100 million.
- X.L. Insurance Co. Ltd. in Bermuda. X.L. offers claims-made sudden and accidental pollution liability coverage as part of its excess liability coverage, with limits of up to $75 million excess of $25 million.
- Primex Ltd. in Barbados. Primex offers excess liability insurance for chemical manufacturer members with limits of $15 million excess of $1 million.
- Tortuga Casualty Co., domiciled in the Cayman Islands. Tortuga offers claims-made sudden and accidental pollution liability limits of up to $25 million excess of $50 million.

The EIL market could receive a boost later this year if two planned EIL facilities get off the ground.

One is a risk retention group being formed by Alexander & Alexander.

The group, called Environmental Protection Insurance Co., plans to be licensed in Illinois when it has $11 million in start-up capital.

Harry Shuford, vp of A&A Services, said three financial institutions have offered to loan EPIC $5 million, and capital contributions from initial policyholders would generate $4.5 million. Mr. Shuford said he is talking to potential policyholders about lending the group the remaining $1.5 million.

EPIC initially would write both sudden and gradual EIL coverage on a claims-made basis with limits of $1 million per claim with a $2 million aggregate, according to A&A of New York's Ms. Bellus.

For each additional $10 million in the facility's capital, limits would increase by $1 million, up to a maximum of $5 million per claim with a $10 million aggregate, she said.

Based on the maximum limits of $5 million/$10 million, the minimum premium would be $20,000, Ms. Bellus said.

Of the 127 companies that have requested information about the risk retention group, 55 are industrial concerns; 35 are petroleum, mining and chemical firms; 14 are waste management firms; nine are schools and municipalities; nine are service firms; three are hospitals; and two are agricultural concerns.

In addition, Hypercept Insurance Co. (A Risk Retention Group) was licensed as an association captive in Tennessee late last year and hopes to begin writing EIL coverage on a claims-made basis with initial limits of $1 million per claim with a $2 million aggregate as soon as it raises $10 million capital, according to Clayton Cook, projects director for Monticello, N.Y.-based Rhulen Agency.

Rhulen and Aralie Inc., a Pequannock, N.J.-based environmental consulting firm, are sponsoring the group.

Hypercept has not raised any capital yet, Mr. Cook said, admitting that "it's going to be tight" to raise $10 million by the group's July 1 target.

The minimum premium for a $2 million aggregate limit policy would be $25,000, with a minimum deductible of $25,000, according to Mr. Cook.

Hypercept plans to increase EIL limits by $1 million per claim and $2 million aggregate for every $10 million of capital it raises, up to a maximum of $3 million per occurrence with a $6 million aggregate when the group has $30 million in capital, he said.

In addition to covering third-party liability for both sudden and gradual pollution, Hypercept plans to cover first-party expenses to stop a leak in progress. Mr. Cook also noted that Hypercept would cover third-party liability for pollution from non-owned sites.

Hypercept has a lengthy application process that includes extensive risk assessments.

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Also contributing to this story was Associate Editor Carolyn Aldred in London.

EPA may ease requirements for underground tank cover

By DEBORAH SHALOWITZ

WASHINGTON—Owners and operators of underground petroleum storage tanks may have to meet less stringent financial responsibility requirements than the U.S. Environmental Protection Agency proposed last year, an EPA official says.

"There's a good chance" the EPA will lower the aggregate insurance requirement in the final regulations, which will be issued in mid-July, said Sammy K. Ng, chief of the regulatory analysis branch for underground storage tanks.

The EPA proposed last April that owners and operators of underground tanks buy at least $1 million per claim/$6 million aggregate of environmental impairment liability insurance, depending on their number of tanks. Alternatively, the proposals state owners and operators must demonstrate through one of several alternative financial responsibility mechanisms the ability to pay for cleanups and any other damages arising from tank releases, (*BI*, April 27, 1987).

However, Mr. Ng pointed out that the per-claim requirement of $1 million in insurance cannot be changed because Congress mandated it in the Superfund Amendments and Reauthorization Act of 1986, which also established a trust fund to pay for cleanup of a site contaminated by a leaking tank when its owner or operator is insolvent or cannot be located.

In addition to insurance, the EPA regulation would permit one or a combination of the following methods for demonstrating financial responsibility:

- A tangible net worth of at least 10 times the annual aggregate amount of insurance coverage required.
- A financial guarantee by another company.
- An indemnity contract between the underground tank owner or operator and a firm with a substantial business relationship.
- A surety bond.
- A letter of credit.
- A state-required risk financing mechanism that differs from the federal requirements.
- A state fund or cleanup pool.

However, the U.S. General Accounting Office says in a report released earlier this year that some of these options are not suitable for many underground tank owners or operators for various reasons: Some of the alternatives are more expensive than insurance; others do not transfer the risk as insurance does; and others do not establish an organized system for providing damages to third parties.

Currently, several facilities write EIL insurance specifically for underground tank owners and operators that would meet the reduced EPA financial responsibility requirements, and pollution insurance experts say more insurers are considering entering the market.

Two of the largest EIL markets for underground tanks are members of the Pollution Liability Insurance Assn., a Downers Grove, Ill.-based voluntary association of 20 insurance companies.

Houston-based Ranger Insurance Co. and Detroit-based Michigan Mutual Insurance Co., the lead company of Amerisure Cos., are among the most active of the PLIA members that write this type of coverage.

Ranger-Allied Underwriters, a Houston managing general agent for Ranger Insurance, writes sudden and gradual EIL coverage on a claims-made basis with limits of $1 million per claim with a $2 million aggregate, a company spokesman said.

Self-insured retentions range from $2,500 to $1 million and premiums vary widely, the spokesman said.

Continued on next page

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Dallas

February 8, 1988

Storage tanks

Continued from previous page

Ranger's coverage is reinsured through PLIA.

Michigan Mutual will write claims-made coverage for sudden and gradual pollution risks with limits of $1 million per claim/$2 million aggregate, according to Stan Klosezewski, vp of Poe & Associates Inc., the Tampa, Fla., managing general agency for Michigan Mutual's underground tank program.

Deductibles range from $2,500 to $250,000, and premiums vary widely depending on the risk.

In addition to Ranger and Michigan Mutual, at least two other markets are providing EIL coverage for underground storage tanks.

The Petroleum Marketers Mutual Insurance Co., A Risk Retention Group, currently writes sudden and gradual EIL coverage for owners and operators of underground tanks on a claims-made basis with limits of $500,000 per claim/$1 million aggregate.

PETROMARK plans to raise limits to $1 million per claim/$2 million aggregate by June 1, said Diane Schwartzers, vp of The Planning Corp., the Reston, Va., underwriting manager for PETROMARK. Deductibles range from $5,000 to $25,000, and premiums for each tank location range from $350 to $2,000, Ms. Schwartzers said.

Federated Mutual Insurance Co. of Owatonna, Minn., writes sudden and gradual EIL coverage on a claims-made basis if the policyholder insures all of its property/casualty risks with the company, according to Paul Droher, casualty underwriting manager.

However, Mr. Droher said maximum limits were reduced to $500,000 per claim this year from $1 million per claim last year, with an annual $2 million aggregate. In addition, policyholders must maintain a self-insured retention of $25,000, up from a maximum deductible last year of $10,000.

Furthermore, premiums on average are nearly double what they were last year, Mr. Droher said, and range from between $300 and $3,000 per location, depending on the risk and location.

Federated writes the coverage in 38 states but does not plan to expand into the Northeast, Mr. Droher said.

Mr. Droher said Federated has not decided whether it would raise its per-claim limit to satisfy the EPA financial responsibility requirement.

In addition to the existing markets, numerous groups are considering forming risk retention groups to provide EIL coverage, pollution liability experts say.

However, most of the potential markets are waiting to see the EPA's final rules before acting, according to Dennis Lang, a broker with Wm. Rigg Co. Inc. in Dallas.

He also related that he has spoken to more than 700 owners or operators of underground tanks and "99.9% of them are going to wait and see" what EPA's final rule requires "and only carry it if you have to."

Approximately 1.4 million underground storage tanks are located at about 500,000 facilities in the United States, hundreds of thousands of which have corroded and are leaking, according to EPA estimates.

About half of these tanks are located at facilities that sell or produce motor fuel, and the remainder are located at facilities owned or operated by local governments and utility, mining, construction, manufacturing, transportation and communications firms.

Underground tanks that would be exempted from the EPA requirements include farm or residential tanks holding fewer than 1,100 gallons or all residential tanks that store heating oil.

The new EPA rules also would require underground tank owners to install leak-detection monitoring equipment within five years and to replace older metal tanks with new corrosion-resistant models within 10 years.

The EPA also plans to issue financial responsibility requirements for operators of underground tanks in which hazardous substances are stored. The agency, which estimates that there are about 54,000 underground tanks that contain hazardous substances at 21,000 facilities nationwide, will accept comments on what the rule should include until April 11.

Comments should be mailed to Docket Clerk, Office of Underground Storage Tanks, U.S. Environmental Protection Agency, 401 M St. S.W., Washington, D.C. 20460. ■

AIG president asks Congress to consider waste cleanup tax

By STACY SHAPIRO

LONDON—Congress next year should consider a tax to finance the cleanup of hazardous waste sites before pollution claims destroy the insurance industry, says the president of American International Group Inc.

The tax could be levied against all companies in all industries or be paid as a value-added tax, according to AIG President Maurice R. Greenberg.

"I would say that pollution liability is probably the single-largest major issue that the insurance industry will confront in the next decade," Mr. Greenberg told a packed audience at the U.S. Embassy in London earlier this month during a speech to the British-American Chamber of Commerce.

For years, chemical companies and other firms dumped waste in compliance with regulations in force at the time, Mr. Greenberg said, adding that no one realized the waste would harm the environment.

Now, the cost to clean up known waste sites under Superfund is $125 billion "and that's just the known sites," said Mr. Greenberg.

The companies that dumped the waste now are turning to their insurers to pay cleanup costs, and some courts have concluded that general liability policies must respond to these costs, even though insurers never intended to cover pollution incidents in the policies, he explained.



Mr. Greenberg

"It is ludicrous to think that the insurance industry can bear any important part of" the $125 billion price tag to clean up the sites, Mr. Greenberg told reporters before his speech. "That exceeds the capital of the insurance industry."

"It seems to me that it is everybody's problem and we ought not to single out one industry or another and dispose of them along with the waste," he added.

Mr. Greenberg called for a national debate on taxation for pollution cleanup costs. "That is what the new Congress" to be elected in November "ought to be concerned with. Maybe it ought to be a tax on all corporations. Maybe it ought to be some kind of value-added tax on anything you do."

Mr. Greenberg also said he has reservations about a recent proposal to finance pollution costs.

Hartford Insurance Group chairman DeRoy Thomas has proposed establishing a fund called the Comprehensive Environmental Response Authority to pay pollution cleanup costs and bodily injury claims. CERA would be financed by annual assessments from companies responsible for pollution incidents, insurers, reinsurers and the federal government (*BI*, Feb. 29).

"I'd like to say this so it isn't misinterpreted," said Mr. Greenberg. "I think that before I could agree to any plan, (it) has to first acknowledge that the insurance industry does or does not have any legal responsibility" to pay pollution claims.

"To begin a dialogue which acknowledges responsibility—or, if not responsibility, a willingness to contribute—seems to me being ahead of ourselves," he said. "I think the first issue should be somewhat further back than that. The whole issue of pollution has got to be put into clearer focus for the American public."

Mr. Greenberg also told journalists, "If we excluded pollution, it is rather hard for us to be warm toward such a claim. Now I recognize that the courts have tortured the language of what is or isn't covered. That's part of the problem. But, if we have excluded pollution, it is rather difficult to say that we should contemplate a claim. And most coverages excluded pollution."

In his speech at the U.S. Embassy, Mr. Greenberg remarked on some of the other issues likely to impact the U.S. insurance industry in the coming decade.

For example, developments in insurance regulation will have a "major impact" on the insurance business, he said. Although state regulation originally was designed to protect the solvency of insurers, "consumerism" has instead driven regulation, said Mr. Greenberg. As a result, "we have a record number of insolvencies during the last downturn in the underwriting cycle."

"Given the increase in technology and the speed with which business is done, the regulatory process in my view is far behind the ability to regulate," said Mr. Greenberg. "It's in a horse-and-buggy mode when everything else is in the Space Age."

Mr. Greenberg suggested that deregulation of the insurance industry should be considered in the next decade. Also, regulators should consider whether commercial insurance transactions that cross state borders should be regulated by a federal entity rather than by the states, he said.

And, regulators should discuss whether guaranty funds should be necessary for commercial lines of insurance, especially since the funds play an important role in the industry cycle by allowing solvent companies to bail out insolvent insurers that had offered cheap rates. "Why are insurance solvency funds for commercial insurance a necessary part of the process? Wouldn't it aid stability if that weren't true?" he said.

Other factors that Mr. Greenberg cited that will affect the U.S. insurance industry in the next decade include:

- Vertical integration of companies, so that insurance underwriters own brokers and vice versa.

"Our own view has been, by and large, that separation was a good thing," Mr. Greenberg said. "I think the issue will certainly undergo a great deal of debate in the next number of years and shake our industry."

- The legal system in the United States, where there is now "virtually an absolute liability system."

While about 40 states have enacted some tort reforms, he said those changes have been "inadequate, splintered and in some cases the courts have reversed the legislature and said that those changes are unconstitutional."

Everyone in society, not just insurers, will pay for the problems in the legal system, Mr. Greenberg said. "The insurance industry understands that. . .we have done a very poor job admittedly as an industry making a case."

- The Tax Reform Act of 1986 and the impact on the insurance industry.

Insurers did themselves a disservice when they approached Congress individually rather than collectively when the new tax law was first discussed, said Mr. Greenberg. Originally, Congress wanted $7 billion in tax from property/casualty insurers over five years, but enacted legislation that will collect twice as much in a shorter period of time.

"The industry went to Washington and behaved like a circular firing squad. They really shot each other and everybody gave in and we have a tax effect on the industry that will indeed shake the future," he said.

The tax act "is hard for me to understand because that means that in 1989. . .the insurance industry will have a tax rate that is much higher than the tax rate of all corporate America" because of provision in the law aimed specifically at property/casualty insurers. "So, if corporate America pays a 34% tax rate and the insurance industry pays a 50%, 60% tax rate and higher, I will find it difficult to write to our shareholders at the end of the year to explain why we have been privileged to be singled out that way."

Mr. Greenberg predicts that insurance companies will consolidate as a result of the tax law, if only to be able to meet the tax burdens. ■



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CERA proposal called premature

LONDON—A proposal by the chairman of Hartford Insurance Group to establish a voluntary fund to pay pollution damage and cleanup costs is premature, some London observers contend.

A fund—which would be financed by assessments from companies responsible for pollution incidents, insurers, reinsurers and the U.S. government—was proposed last month by Hartford Chairman DeRoy Thomas (*BI*, Feb. 29).

However, underwriting executives in London do not believe insurers should contribute to a claims fund until many of the liability issues regarding pollution have been settled.

"Much of the litigation concerning pollution concerns environmental impairment liability. Until these cases are settled, I am not sure that general liability insurers have to respond at all," said Peter Wilson, managing director of H.S. Weavers (Underwriting) Agencies Ltd., one of the major markets in London for excess liability insurance for U.S. risks.

"Until the litigation is sorted out, what's the point of setting up a claims facility?" he added.

Keith Rayment, non-marine director responsible for claims at Sturge Holdings P.L.C., the largest Lloyd's of London managing agency, agreed with Mr. Wilson.

Insurers are denying they are liable for many pollution claims, making it pointless to form a facility in which insurers will be partly responsible for claims payment, Mr. Rayment noted.

It is absurd to consider establishing a claims facility along the lines of the Asbestos Claims Facility created by the Wellington Agreement because the issues are so different, sources in London argue.

For example, many of the disputes regarding asbestos claims revolve around deciding what insurer is responsible for paying a particular claim, observers point out.

On the other hand, insurers who wrote general liability policies are denying all responsibility for hazardous waste cleanup costs.

—By Carolyn Aldred

RIMS conference

Continued from page 3

ferred provider networks and hospital bill auditing—to control worker compensation expenses will be the focus of "Workers Compensation: Innovative Cost Containment Applications."

The session, S 73, will show how risk managers can apply proven health care cost-containment techniques to reduce work comp costs, said Thomas J. Wander, a consultant with the Tillinghast division of Towers, Perrin, Forster & Crosby in San Francisco and moderator of the session.

Speakers include: Patrick Sullivan, marketing manager of Community Care Network in Los Angeles; Will Murphey, vp-cost containment at Industrial Indemnity of San Francisco; Burt Anderson, vp-risk management of Safeway Stores Inc. of Oakland, Calif.; and Dr. Arnold Millstein, president of National Medical Audit of San Francisco.

Risk managers and others responsible for administering workers compensation programs "should be there," Mr. Wander said, because the speakers "are on the cutting edge."

Risk managers will learn not only how stress contributes to workplace injuries, but also how stress itself can become a compensable injury during "Managing Stress in the Workplace: Labor Relations' Impact on Disability Costs," S 72.

Insurers have become more concerned about the role of stress because it is being cited as a contributing factor in an increasing number of workers comp claims, the seminar organizers said.

"More employers have had to face the issue (of stress at work) in the last several years" because stress claims are compensable under some states' workers compensation laws, said Claire Skinner, claims control manager at Barry Wright Corp. in Newton, Mass.

Robert G. Lasky, associate professor and director of rehabilitation psychology at the University of Cincinnati Medical Center, will provide an overview of stressful situations and teach the latest techniques for reducing stress.

Mr. Lasky will emphasize a "proactive approach" that identifies sources of stress and seeks to overcome them before they lead to illness or injury.

Often, an important contributor to stress is "a distorted perspective" that causes a person to put too much weight on one aspect of his or her life to the exclusion of other balancing factors, he said.

Donald Shrey, research associate professor and director of vocational rehabilitation at the University of Cincinnati Medical Center, also is scheduled to speak.

A session moderated by Sol Wolchansky, risk manager at The Dallas Corp. in Dallas, will feature procedures for reducing workplace conditions that can cause back injuries.

"Back Injuries: Fact or Fraud," S 70, also will help risk managers determine when injuries are real and when employees are trying to defraud their employers, he said.

A large part of the program will be devoted to loss-control techniques developed by Nancy Selby, director of the Spine Education Center in Dallas.

The Dallas Corp. has used her methods, including pre-employment screening and matching employees with the physical requirements of a job, to minimize back strain and injuries, he said.

Back injuries have become prevalent in the country because many people are out of shape, not used to physical labor, have poor diets and carry too much weight, Mr. Wolchansky said. "The overall result is you have many back problems."

"Disability Management: Closing the Gap Between Medicine and Business," S 71, will help risk managers better manage workplace injuries after they occur by fostering communication between those who treat worker injuries and those who pay for them.

"I think it's going to be very dynamic. I'm very excited about it," said Lucille A. Gallagher, vp-risk management at Monfort of Colorado Inc. of Greeley, Colo., and the seminar's coordinator.

Dr. Joel S. Seres, associate professor of neurological surgery at the University of Oregon Health Sciences Center, a leading expert on debilitating injuries, will offer his insight during the program.

Other speakers are Richard A. Steig, assistant professor of anesthesiology and neurology and medical director of the center for pain evaluation and treatment at the University of Pittsburgh Medical School; and Jeffrey A. Wunder, clinical instructor at the University of Colorado Health Sciences Center and medical director of the Colorado Rehabilitation Institute Inc.

"We're excited because we have these top people in the disability and pain management fields," Ms. Gallagher said.

Other risk management issues on this year's RIMS conference agenda include government regulation of the insurance industry, insurer solvency and establishing risk retention levels.

Environmental liability also will be the focus of numerous conference seminars this year, as well as the subject of a mock trial during which the judge will literally roll dice to show how quickly the situation changes during coverage litigation, said RIMS' Ms. Parker.

This year's RIMS conference seminars also will address the latest employee benefits issues, including proposed legislation to mandate minimum levels of health care, managed care liabilities and the effect of the Tax Reform Act of 1986 on employee welfare plans.

One of two special sessions—which this year are replacing the general session held in previous years—will include a dialogue on mandated health benefits featuring Sen. Orrin Hatch, R-Utah, on Wednesday at 9 a.m. in the Regency Ballroom of the Omni Shoreham Hotel.

A second special session, beginning at 11 a.m. Wednesday, also in the Regency Ballroom, will provide an update on the state of the property/casualty insurance market.

Both special sessions are open to all conference registrants.

The Sheraton Washington Hotel will host the 1988 exhibition hall, featuring 225 exhibitors. It also will be the site of many of the seminars and meetings, as well as registration, a message center and hospitality suite listings. Other sessions and registration will be held at the Omni Shoreham and the Washington Hilton and Towers.

An updated conference program, including the locations for the numerous conference sessions, will be provided upon registration.

Registration fees for the 1988 conference are $695 for RIMS members and $795 for non-members. For a partial week, the fees are $575 for members and $675 for non-members. The cost for one day is $195.

Because attendance is limited, RIMS encourages conference attendees to register and make seminar selections before arriving in Washington. The deadline for registering through RIMS is March 25. After that time, attendees must register at the conference.

Late registrants are advised to call one of the 15 RIMS hotels directly to reserve rooms at the special conference rates.

For more information contact the RIMS Conference Department, 205 E. 42nd St., New York, N.Y. 10017; 212-286-9292. ■

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* Source Business/Occupational breakdown of qualified circulation, Nov. 30, 1987 issue, as submitted to BPA for Dec. 1987 BPA Publisher's Statement.

Pine Top liquidation

Continued from page 2

of liquidation," noted Frank DeMaria, reinsurance operations manager for the Illinois special deputy receiver.

So far, the Illinois department has not sued or demanded arbitration of any of Pine Top's reinsurers, according to Mr. DeMaria.

Only one suit has been filed against a Pine Top policyholder: the liquidator sued Republic Western Insurance Co. in U.S. District Court in Chicago earlier this month seeking recovery of $2.4 million in LOC proceeds and trust deposits drawn down by Republic Western.

The Illinois department argues that the Republic Western draw-downs represent a "voidable preference" under state insurance law, since the funds were posted within the four-month period before Pine Top entered rehabilitation.

However, the liquidator's conciliatory approach won't last forever, Mr. McCullough observed.

"We are doing everything we can to be reasonable and avoid arbitration and litigation. But when push comes to shove, we are going to arbitrate or litigate," he said.

Pine Top, a unit of Greyhound Corp. of Phoenix, Ariz., was ordered into liquidation by a Cook County Circuit Court judge in January 1987, after the Illinois department concluded that the insurer could not be rehabilitated (*BI*, Jan. 26, 1987; Dec. 29, 1986).

At the time of its liquidation, the Insurance Department estimated Pine Top's policyholder surplus deficit at more than $70 million. The surplus deficit ultimately will amount to between $77 million and $100 million, Mr. DeMaria said.

In 1985—the last year for which it filed an annual statement—Pine Top reported gross written premiums of $41.9 million, including $10.3 million in direct insurance premiums and $31.6 million in assumed reinsurance premiums. Net written premiums in 1985 amounted to $27.4 million.

Last fall, Illinois Insurance Director John E. Washburn sent a letter to roughly 140 reinsurers and retrocessionaires of Pine Top and about 30 brokers, outlining some of the Insurance Department's plans for the liquidation.

Among other things, the letter noted that:

- A third-party administrator —Claims Management Corp. of Evergreen Park, Ill.—has been retained to handle Pine Top's direct insurance claims.
- Reinsurance accountants and consultants are involved in processing accounts received from ceding insurers, reviewing the accuracy of reports on key treaty reinsurance assumptions, performing an underwriting review and checking the accuracy of large loss aggregations under the treaties.
- The results of these efforts will be reviewed by another third-party consultant—not yet named—who will perform a technical review of Pine Top's assumed reinsurance business.

Separately, Chiltington Intermediaries Ltd., a London-based consultant, will review the assumed reinsurance book and investigate assumptions "where apparent irregularities could materially affect the liability of Pine Top's retrocessionaires."

Insurance Department representatives also are examining business produced by several of Pine Top's managing general agents, though these examinations are not mentioned specifically in the letter.

Among other things, the examinations are looking for claims handling problems and possible violations of MGA contracts.

Pine Top's biggest producer, sources say, was Baccala & Shoop Insurance Services Inc., a surplus lines underwriting management unit of Corroon & Black Corp. that was shut down in 1985.

Other Pine Top MGAs included John H. Crowther Inc. of Minneapolis, a unit of Swett & Crawford Group, and Reinsurance Underwriting Agency of Switzerland, a unit of Alexander & Alexander Services Inc.

"Through all these efforts, we trust you will gain sufficient confidence that amounts billed your company are properly due and owing the Pine Top estate," Mr. Washburn's letter to the reinsurers reads. "In this way, any queries you may have about Pine Top's accountings should be answered in a timely manner, and your company and the Pine Top estate will be spared the considerable effort and expense of records inspections and litigation over amounts due the Pine Top estate."

The letter goes on to request payment by the reinsurers of amounts already billed by Pine Top, net of any lawful offsets available to the reinsurers. The letter notes that only mutual debts and credits are offsettable, and that money due from two Pine Top affiliates—Pine Top Insurance Co. Ltd. of London and Pine Top Syndicate Inc., a New York Insurance Exchange underwriting member—may not be used to offset balances payable to the liquidator.

Most of Pine Top's billings, Mr. DeMaria said, are as of Dec. 31, 1985, or Dec. 31, 1986.

In order to encourage the reinsurers to forward the payments, the letter proposes the creation of the special trust accounts to hold funds from reinsurers until an accurate calculation of net outstanding balances can be agreed on.

Mr. McCullough and Mr. DeMaria said that they hope to have a current accounting of Pine Top's reinsurance balances by the end of this year.

Any trust funds established by reinsurers, then, theoretically would be drawn down at year-end except in cases where the liquidator and reinsurer cannot agree on the amount owed. In such cases, the trust fund would be maintained pending settlement of the dispute.

Mr. Washburn's letter also notes that reinsurers are expected to continue to fund reserves where required with LOCs or trust fund deposits.

In return for this, though, the liquidator will agree not to draw on any new documentary LOCs or trust deposits until balances payable are agreed on, except when an LOC is about to expire and is not renewed or when a reinsurer has not paid outstanding balances for paid losses and expenses as of Dec. 31, 1985.

The letter also apologizes for the "error" Pine Top made by previously drawing down LOCs and trust funds posted by reinsurers and retrocessionaires that were current in their loss payments.

The mistake occurred in a few cases because of errors in the reconciliation of some accounts or because brokers had held onto funds that were actually paid by the reinsurers, Mr. DeMaria said, adding that the amounts were "insignificant."

Once an internal reconciliation of the accounts is finished, the liquidator will re-establish the LOCs and trust funds and pay an appropriate amount of interest, according to the letter.

Representatives of the Illinois department have held two meetings to discuss the proposals with reinsurers and brokers: one in London last October and one at the National Assn. of Insurance Commissioners meeting in Phoenix last December, according to Mr. McCullough.

So far, about 60% to 70% of the 170 reinsurers and brokers receiving Mr. Washburn's letter have responded, though only about a dozen have agreed to make payments into the proposed special trust accounts, Mr. DeMaria said.

Most of these reinsurers have significant offsets against amounts owed Pine Top, and have said they will pay net balances into the special trusts once an assessment of their net positions is complete, Mr. DeMaria said.

Mr. McCullough conceded that not all Pine Top's reinsurers will jump at the proposal, noting that some will delay payments until Pine Top's records are brought up to date at the end of this year.

"Some reinsurers are telling us, 'We'd rather wait until the end of the day,' " he said.

However, the liquidator is looking on reaction to the proposal as a kind of test of the reinsurers' good faith, separating those that want to meet their obligations from those that intend to delay as long as possible or are unable to pay, he said.

According to its 1985 annual statement, Pine Top's most significant reinsurers included Belvedere Insurance Co. Ltd. of Bermuda; Employers Reinsurance Corp. of Overland Park, Kan.; INA Reinsurance Co., a CIGNA Corp. unit; Manitoba Public Insurance Co. of Winnipeg; New England Reinsurance Corp., a Hartford Insurance Group unit; Prudential Reinsurance Co.; Puritan Insurance Co.; Republic Western; and Universal Reinsurance Corp., an Armco Insurance Group unit now running off its business.

Once Pine Top's accounting records have been brought up to date, the liquidator will begin to pursue commutation agreements with the reinsurers, Mr. DeMaria added. Only a few commutations have been negotiated to date, mainly with reinsurers that were in severe financial trouble themselves.

"It's better to get 50 cents on the dollar than get 100% of nothing," he observed.

Meanwhile, Insurance Department representatives say they expect Pine Top's ceding insurer policyholders to draw on Pine Top LOCs and trust funds only to cover paid losses.

Of roughly 174 insurers that ceded business to Pine Top, 54 drew down a total of about $30 million in LOC and trust fund proceeds after the insurer was ordered into rehabilitation in June 1986, according to Mr. DeMaria.

The liquidator has approached most of these ceding insurers to discuss creating new LOCs or trust accounts for funds in excess of actual paid losses recoverable. The liquidator considers these excess LOC proceeds and the interest earned on them to be the property of Pine Top's estate.

So far, only four or five of the ceding insurers have agreed to re-establish the LOCs or trust accounts, Mr. McCullough said, adding that in most of these cases the ceding insurers' security constituted voidable preferences in any case.

Despite the Illinois department's attempt to take a "commercial approach" to managing Pine Top's liquidation, Mr. McCullough suggested that the liquidator is likely to end up suing various parties.

Such suits may include challenges to the enforceability of some reinsurance contracts assumed by Pine Top, voidable preference litigation against ceding insurers' draw-downs of Pine Top LOCs, actions to collect from non-paying reinsurers and suits against brokers, he said. ■

Insurers won't reopen case following Shell disclosure

By STACY ADLER

SAN BRUNO, Calif.—The insurers locked in coverage litigation with Shell Oil Co. will not reopen their case to respond to Shell's latest argument that insurance must respond when damages, rather than acts that cause damages, are unintended.

In a letter to San Mateo County Superior Court Judge William Lanam, Houston-based Shell claims that events that led to the pollution at the Rocky Mountain Arsenal near Denver and at a dump site in Fullerton, Calif., do not have to be unintended to be insurable, but rather the damage has to be fortuitous.

"Shell's position is that there must be an element of fortuity in insurance coverage and that this means there is coverage for unintended damages, whether the act causing the damage is unintended or unintentional," said Shell attorney William Boyd in the Feb. 23 letter to the judge.

Judge Lanam said in court that he was "astonished" by Shell's statement. He said he and the attorneys representing Shell's insurers had been operating under the assumption that Shell maintained it did not know it was polluting.

The judge gave the insurers' attorneys until March 9 to reopen their defense in response to the new information.

"It is not necessary to dignify" Shell's statement, said Barry Ostrager, with the New York firm of Simpson, Thatcher & Bartlett, who represents Travelers Insurance Co., Shell's primary insurer.

Some 260 liability insurers are litigating with Shell over million of dollars of coverage for the cleanup of the two hazardous waste sites. The U.S. Army agreed in February to pay the bulk of cleanup costs at the Rocky Mountain site (*BI*, Feb. 8; Oct. 12, 1987).

Shell is attempting to prove that it is entitled to insurance coverage despite the pollution exclusion clause in its comprehensive general liability policy, which states that a policyholder is not covered for "expected and intended" events.

Insurers have said all along that Shell knew it was polluting the sites. Because such acts are not fortuitous, they are not covered by insurance, the insurers charge.

While courts are still grappling with how to interpret the pollution exclusion clause, several courts have ruled in support of Shell's contention.

The 1st Appellate District Court of Ohio in Cincinnati ruled in September that "an event is 'sudden and accidental' and thus not excluded from comprehensive coverage if the damaging result is neither expected nor intended by the insured."

Florida regulator pushes HMO guaranty fund plan

Around the states

TALLAHASSEE, Fla.—Florida Insurance Commissioner Bill Gunter will ask the state Legislature in April to pass a package of medical reforms that will create a guaranty fund for insolvent health maintenance organizations and strengthen the authority of the agency that monitors hospital costs.

'I consider it a legislative priority to put an HMO guaranty fund in place before the next legislative session is over," Mr. Gunter said.

"Five HMOs failed last year, an experience that revealed holes in our system that can mean financial ruin for HMO members," he pointed out.

Under a bill sponsored by Sen. Gwen Margolis, D-North Miami Beach, and Rep. Mike Abrams, D-Miami, such a fund would be built with a 1% annual assessment on HMOs' gross premiums. The assessments would continue until the fund contained 5% of the annual gross premiums of the state's HMOs. An additional 1% assessment would be triggered if the fund fell below 4% of premiums.

Apart from paying the debts of insolvent HMOs, the fund would provide continuing medical care for members of failed organizations. The fund would place the medical coverage with another insurer and pay any difference between the premium charged by the new insurer and the failed HMO until the member found coverage from a new insurer.

Minimum net worth requirements for HMOs would be increased to $400,000 or 5% of total liabilities. Current standards call for HMOs to have a minimum net worth of $100,000 or 5% of liabilities, and those already operating would have three years to comply with the new requirement.

The bill calls for health care providers under contract with an HMO to give at least a 60-day notice to the Department of Insurance before canceling contracts.

Regarding the state's hospitals, Mr. Gunter said he wants to put more teeth into the Hospital Cost Containment Board's budget-monitoring authority.

The board will undergo a sunset review this year, and the insurance commissioner is pushing for new legislation that he says can help control health care costs in Florida.

"It has been the Legislature's intent in the past to allow competition to control hospital costs and to set loose the state's watchdog—the Cost Containment Board—only on those hospitals that are grossly out of line," Mr. Gunter said.

"As a result, more than half of Florida's hospitals escape detailed review and enjoy the luxury of having their budgets automatically approved. . . .Hospitals account for 40% of health care costs; that's why it's crucial that we get them under control."

Mr. Gunter will ask the Legislature to tighten the current requirements on which hospitals are subject to budget reviews.

Other reforms Mr. Gunter will encourage legislators to pass include bills that would:

- Require group Medicare supplement policies to return 75 cents in benefits for every dollar paid in premiums and
- Prohibit long-term care policies from being canceled or non-renewed because of the age or

Continued on next page

Around the states

Continued from previous page
declining health of the policyholder.

Policies would have to provide a minimum of two years of coverage for nursing home or convalescent center stays or home health services. The coverage could not exclude benefits for persons with Alzheimer's disease and would be required to provide at least 60 cents in benefits for every premium dollar.

- Require health insurers of adoptive parents to cover the medical care of adopted infants from birth if an agreement to adopt the child is made before the baby is born.

—By Michael Bradford

Aetna sues regulator

BOSTON—Aetna Casualty & Surety Co. is suing Massachusetts Insurance Commissioner Roger Singer and Commonwealth Automobile Reinsurers, the state's assigned risk auto insurance pool, alleging that it will be "irreparably harmed" if it must pay a share of CAR losses not paid by insurers withdrawing from the state.

One suit seeks relief against responsibility for a portion of losses incurred by the departure of General Accident Insurance Co. of America, which wants to withdraw from CAR (*BI,* Feb. 1). The second suit seeks general protection against the future withdrawal of other insurers.

Additionally, both suits challenge the constitutionality of the pool, in which participating insurers must accept the underwriting losses incurred by companies withdrawing from the state.

Both suits were filed March 3 in Suffolk Superior Court.

Under state laws governing CAR, insurers writing any line of business in the state must also participate in CAR. Any insurer withdrawing from CAR must also withdraw from all lines of business in the state.

The litigation directly arose from GAIC's Feb. 1 announcement that it planned to withdraw from the Massachusetts market, said Mark S. Masling, an attorney with Foley, Hoag & Eliot, the Boston law firm representing Hartford, Conn.-based Aetna.

Aetna says that GAIC incurred a CAR assessment of $16.3 million in 1987 alone, or 2% of CAR's total losses. If GAIC is allowed to withdraw from CAR, Aetna will be forced to assume 6% of GAIC's assessment, or approximately $975,000.

GAIC is writing business in the state pending the settlement of a suit filed by Mr. Singer and CAR that charges the insurer has not complied with mandated procedures for withdrawing from the market.

—By Laura Mazzuca

Tort reform challenge

SEATTLE—A pre-trial ruling by a King County Superior Court judge that a Washington law limiting non-economic damages is unconstitutional probably will not lead to a challenge of the law because an out-of-court settlement of the underlying litigation is likely, attorneys say.

Judge Edward Heavey's ruling would become a legal precedent only if the case goes to the jury and any damage award exceeds the cap.

The judge opened the door for a jury in a wrongful death case to award non-economic damages that exceed the cap set by the state's 1986 tort reform law by ruling the cap violated the state's constitutional right to equal protection under the law.

In the underlying litigation, filed against several asbestos producers, Joyce Carter of Everett, Wash., alleges that her husband died last year of mesothelioma after being exposed to asbestos during his career as a heating and ventilation worker at various construction sites in the Seattle area.

"We're about 90% certain that the case will settle or we will win it," said Kent T. van den Berg, an attorney with Gibson Dunn & Crutcher in Seattle, who represents several asbestos producer defendants that are members of the Asbestos Claims Facility, including Fibreboard Corp.

Plaintiff's attorney William Bailey of Schroeter Goldmark & Bender in Seattle agrees there is a good chance the case will be settled.

The case is scheduled to go to trial April 18.

Under the state's 1986 tort reform law, non-economic damages are capped according to an inflation-adjusted sliding scale based on the claimant's life expectancy, ranging from $117,000 to $573,000 (*BI,* March 31, 1986).

The tort reform law would set non-economic damages at a maximum of about $167,000 in this case, Mr. Bailey said.

"In the Carter case, the $167,000 just doesn't cut it," he said. They suffered much grief as Mr. Carter struggled with the disease and eventually died in July 1987, Mr. Bailey said.

Mr. Carter was disabled by the asbestos-related disease at age 55, cutting off his annual income of $40,000 and resulting in medical bills nearing $100,000, Mr. Bailey said.

Mr. van den Berg said Judge Heavey's pretrial decision was "too early" and should have been made after a jury ruled on the merits of the case.

—By Glenn Huntley

Kentucky comp system

FRANKFORT, Ky.—Kentucky Gov. Wallace G. Wilkinson recently appointed a new three-member board to administer the 1987 changes to the Kentucky Workers Compensation Law.

The new Workers Compensation Board members are Larry Greathouse, an attorney from Berea; William A. Miller, a Louisville attorney; and Fayette County Circuit Judge Armand Angelucci. The final appointments were made in late February.

The new, full-time board replaces a five-person, part-time board that decided workers comp cases after a review by hearing officers.

Under the new system, hearing officers will decide the cases, and the Workers Compensation Board will review the hearing officers' decisions.

The board also will establish rules and regulations governing the new workers comp law, such as forms, filings and basic claims processing details. The board will operate from the office of Kentucky's insurance commissioner in Frankfort, after the dissolution of the current five-person system in July of this year.

The changes to the workers compensation law, which were part of H.B. 1 of the 1987 special session, became effective Oct. 26, 1987, and include a higher assessment on the state's coal industry for the maintenance of a fund that pays black lung benefits (*BI,* Nov. 9, 1987).

In related Kentucky news, Gov. Wilkinson appointed Leroy L. Morgan to replace Gil McCarty as insurance commissioner. Mr. McCarty was dismissed in late January and Mr. Morgan was installed as part of the new governor's administration.

—By Laura Mazzuca

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Update

HMO firm loses $61 million

Continued from page 2

health care costs. . . .Maxicare had the added impact of completing the integration of its 1986 acquisitions," explained President Fred W. Wasserman in a statement.

Maxicare intends to increase premiums an average of 15% for the year. The HMO operator had predicted in late 1987 that it would raise rates only about 6% (*BI*, Dec. 21, 1987). The firm also plans to sell some operations. So far this year, Maxicare has sold a Florida HMO and the health care facilities and physician group used by an Indianapolis HMO for a total of $23 million.

Maxicare plans to cut its administrative costs through layoffs, said a spokeswoman. In addition, Maxicare hopes to negotiate an amendment to its $175 million revolving bank credit line, said the spokeswoman, who would not elaborate.

Lilly faces more Opren suits

LONDON—Indianapolis-based Eli Lilly & Co. faces at least 230 lawsuits in British High Court—and could face up to 1,000 others—following the failure to compensate all British claimants who allegedly suffered side effects from the anti-arthritic drug Opren.

The suits were filed by claimants who did not take part in a settlement offered by Lilly last year, said Kathleen Grasham, chairman of the Opren Action Group (*BI*, Jan. 25).

Some British claimants say the settlement, which totaled 2.25 million pounds ($4.2 million) and was accepted by 1,354 plaintiffs, is too little. They note that claimants in the United States, where the drug is known as Oraflex, received much higher settlements.

Last week, 117 members of the House of Commons and the House of Lords signed a letter to Lilly calling for the establishment of a trust fund for Opren claimants, Ms. Grasham said. Lilly replied that such a fund is "unnecessary."

Judge overturns Audi award

ELIZABETH, N.J.—Plaintiffs' attorneys plan to appeal a New Jersey Superior Court judge's decision last week to throw out a $100,000 punitive jury award against Audi of America Inc. and its parent, Volkswagen of America Inc.

In addition to punitive damages, the jury awarded Germaine Gibbs $14,000 in actual damages, 80% to be paid by Audi and Volkswagen and 20% to be paid by the driver of an Audi 5000 C2 that crashed into her home.

Volkswagen and its subsidiaries are self-insured for the award.

The suit stems from a September 1983 accident in which the Audi's driver simultaneously pressed the brake and gas pedals while attempting to stop, causing the car to crash into Ms. Gibbs' apartment. She and her three daughters received minor injuries.

The plaintiff attempted to prove that Audi was aware of a design defect that permitted drivers to simultaneously press the two pedals, yet did not correct it until October 1983, said attorney David L. Kervick of Westfield, N.J.

Mr. Kervick said the punitive damage award would have set a precedent by establishing that Audi was negligent in failing to correct the defect in a timely fashion.

However, in overturning the award, Union County Superior Court Judge A. Donald said that Audi did not disregard public safety and did, in fact, recall the autos in question.

Mistrial voids asbestos award

WILMINGTON, Del.—A Delaware Supreme Court judge last week declared a mistrial eight days after a jury awarded $22 million in punitive damages to two plaintiffs who had sued Raymark Industries Inc. for allegedly engaging in an industrywide conspiracy to conceal asbestos dangers.

The March 9 judgment against Raymark came after the jury on Feb. 29 also awarded two former employees of E.I. du Pont de Nemours & Co. compensatory awards totaling $1 million.

The judge declared a mistrial because he did not agree with the apportionment of the compensatory damages.

Another jury in the same court before the same judge last year returned a $75 million punitive award against Raymark (*BI*, Nov. 16, 1987).

Briefly noted

A U.S. District Court jury has ordered Celotex Corp., a unit of Tampa, Fla.-based Jim Walter Corp., to pay $134,000 to an elementary school in Aurora, Colo., for the cost of removing **asbestos-containing insulation for pipes and boilers.** The March 4 verdict marks the first time a jury has ruled against a manufacturer of asbestos pipe and boiler insulation. . . .**Blue Cross/Blue Shield of Illinois** lost $32 million in 1987 and another $7 million in January 1988. A spokesman predicted the plan would break even in 1988. . . .Joe Fogarty, who has served as receiver for the seven syndicates on the **Insurance Exchange of the Americas** that are in rehabilitation, has been named special deputy receiver of the IEA. He will oversee affairs of the exchange, which has been in receivership since early this year (*BI*, Jan. 11). . . .The Senate passed its version of the **Price-Anderson Amendments Act** last week. The law would limit the liability of the nuclear power industry in the event of an accident to more than $7 billion from the current $720 million. . . .A federal judge in Richmond, Va., approved **A.H. Robins Co.**'s merger proposal with American Home Products Corp. after Robins agreed to increase the amount it will pay to start a trust fund for Dalkon Shield victims to $100 million from $10 million. . . .Avianca airlines, owner of the **Boeing 727 jetliner** that crashed last week near Cucuta, Colombia, killing 131 passengers and six crew members, has $3.8 million in hull coverage and $400 million in liability coverage. The insurance is written by local companies led by La Nacional de Seguros and reinsured by underwriters worldwide.

Insurer results

Continued from page 1

whether investment income will make up for any erosion in underwriting results.

"We're not looking for many companies to have up earnings in the property/casualty areas. We're looking for more to be flat, or slightly down," said David Seifer, vp at First Boston Corp. in New York.

"We think '87 was the peak of the earnings," said Joanne Morrissey, a principal with Firemark, an investment banker in Morristown, N.J.

Most standard-line property/casualty insurers face "a very rough couple of years. For some of these companies, earnings may have peaked already," said Udayan D. Ghose, an analyst with Shearson Lehman Hutton in New York.

When the flattening premium volume, as well as the unusually low level of catastrophe losses in 1987 are taken into account, "it's hard to make a case you're going to see a decrease in combined ratios" this year, said C. David Mencer, controller at Hamilton, Ohio-based Ohio Casualty Co.

However, the fact that the underwriting cycle apparently has reached its peak does not mean the industry is headed toward disaster, observers say.

"I think it will be a reasonably good year, not a great year," said David Anthony, senior insurance analyst with Fox-Pitt, Kelton's New York office.

The severity of the down cycle must be taken into account, said a CIGNA Corp. spokesman. "It is not in a state of total collapse. It is a gradual decline."

While combined ratios leveled off in 1987 and premium growth declined, the major commercial property/casualty insurers surveyed by *Business Insurance* reported:

- A 12.3% increase in investment income to $10.5 billion in 1987 from $9.4 billion the previous year. This was a slight decline from the 12.9% increase in investment income after the first nine months of 1987.
- Improvement in underwriting losses continues to slow. For the year, the insurers reported that underwriting losses decreased 34.9% to $4 billion from $6.2 billion. This compares with a 35.9% decline for the nine-month period, a 38.7% decline for the first half and a 44.9% decline for the first quarter.

Hartford Steam Boiler Inspection & Insurance Co., Chubb Corp. and American International Group Inc. reported underwriting profits for the year.

- Policyholder surplus among the 22 companies reporting this data increased 8.5% to $26.9 billion. This is a sharp drop from the 24.7% boost—to $28.6 billion—reported after the first nine months, reflecting the October stock market crash.

Four companies—The Home Group Inc., Continental Corp., Fireman's Fund Corp. and Ohio Casualty Corp.—posted declines in their surplus for the year.

- Operating income increased 37.6% to $7.4 billion for the year, down from the 49.4% increase as of Sept. 30, the 59.7% increase as of June 30 and the 72.3% increase as of March 31.

Three companies—Fireman's Fund, Royal Insurance Group and Travelers Corp.—reported a decline in operating income for the year.

Industry observers almost uniformly labeled the insurers' results "disappointing."

"I think they stunk," said Myron M. Picoult, senior vp and senior insurance analyst with Oppenheimer & Co. in New York, citing both premium growth and underwriting results.

"I think in general fourth-quarter earnings were somewhat disappointing," said Shearson's Mr. Ghose. "There really wasn't any company that reported a solid home run," he said, pointing to price competition in the market. "The volume numbers just weren't there."

'I think in general fourth-quarter earnings were somewhat disappointing,' says Shearson's Mr. Ghose. 'There really wasn't any company that reported a solid home run,' he adds, pointing to price competition in the market.

"Generally, most of the companies' earnings were lower than expected," agreed Fox-Pitt's Mr. Anthony, who attributed the poor results to a combination of higher taxes and, in some cases, overly optimistic expectations.

"The cycle deterioration is happening faster than I thought and most people thought," said Gloria Vogel, associate director at Bear, Stearns & Co. in New York.

"Some say it's the shortest up cycle in history," commented First Boston's Mr. Seifer.

"The customer has just gotten too smart, particularly in commercial insurance," said Joyce L. Culbert, vp with Warburg Securities in New York. Policyholders now know they can shop around, said Ms. Culbert, pointing to the growth of alternative financing mechanisms like risk retention groups and captives.

Observers stress, though, that they do not anticipate a sharp downturn in the underwriting cycle resembling that of the early 1980s.

The soft market cycle will be "fairly short and fairly shallow," predicted Gordon D. Luce, assistant manager at Brown Bros. Harriman & Co. in New York.

Mr. Luce said interest rates are not high enough to stimulate cash-flow underwriting and, unlike the previous cycle when insurers reduced their loss reserves, company managements are not operating under the illusion that their reserves are redundant.

Some observers expect the higher taxes insurers must pay under the Tax Reform Act of 1986 also to serve as a brake on sharp price cutting.

"I think (the tax law) is going to take a lot of money out of the industry and reinforce price discipline," said Mr. Luce.

"The tax act will require companies to price for a lower combined ratio to make an adequate rate of return," agreed John H. Fitzpatrick, vp-finance at Kemper Corp. based in Long Grove, Ill. "This reality may not set in immediately, but it will set in over time."

The new tax law will encourage better underwriting standards and better insurance company management because insurers now must pay taxes regardless of whether they generate an underwriting profit, pointed out John Snyder, an analyst with Smith Barney Harris Upham & Co. in New York.

"I think the tax situation is very misunderstood," said Shearson's Mr. Ghose. Many insurers still have not worked through the law's implications and have not realized the extent to which rates may have to be boosted to match pre-1987 profits.

Continued on next page

Rental car liability

Continued from page 3

companies to sell collision damage waivers releasing customers from liability if the car is damaged.

CDWs, which cost from $7 to $13 per day, offer "tremendous potential for abuse," because courts have ruled that CDWs are not insurance and therefore are not under the regulatory control of state insurance officials, said NAIC President John Washburn, the Illinois insurance director.

In addition, consumers have complained that CDWs duplicate existing personal auto coverage or contain significant exclusions (*BI*, March 9, 1987). In addition, customers who don't buy the damage waiver complain about the way damage costs are calculated and assessed and about charges for loss of use assessed by the car rental company while a damaged car is being repaired.

Collision damage waivers offer 'tremendous potential for abuse,' says John Washburn.

Hertz Corp. has admitted to overcharging rental car customers more than $1[illegible] million for damage to rental cars prior to 1985 (*BI*, Feb. 1).

If the NAIC's proposed model law is enacted by state legislatures, rental car companies would calculate physical damage and loss of use costs into their base rates. That would increase those rates while perhaps "leveling the playing field" through increased standardization, said Alan Kay, an attorney with Bregman, Abell & Kay in Washington, D.C., who is knowledgeable about rental car operations.

Base rates would probably rise "minimally" due to the spread of risk, agreed Richard Rogers, deputy director of the Illinois Insurance Department. But he said it is impossible to calculate the effect because car companies have declined to reveal their loss data.

Large employers that currently self-insure this exposure for their traveling employees would no longer be able to do so. However, greater standardization should foster competition and employers should still be able to negotiate favorable rates with rental car companies, said Peter Synnott, executive director of the Society of Chartered Property & Casualty Underwriters in Malvern, Pa. Mr. Synnott chaired the task force advisory committee that in[illegible] the proposal.

[illegible]osal becomes formal [illegible]t would supersede [illegible]odel law adopted in June [illegible] car companies to ob[illegible]tain [illegible]erms and avoid making [illegible] customers.

The NAIC's new proposal does not affect other optional types of insurance sold by rental car companies, including accidental death and dismemberment or personal effects coverages. These policies generally are exempted from most state insurance code requirements because they are written on a group basis, Mr. Rogers said.

Ticker

Insurer profits threatened

Continued from previous page

Some property/casualty insurers will actually have to pay taxes for the first time, said Mr. Ghose. "That's going to be a real shock to the system for some of these companies."

The tax act also will affect cash flow and lead to a reduction in investment income, observed Ms. Vogel. "The effect could be quite dramatic," she said.

The law is causing some insurers to shift their investment strategies. Because all insurers will have to pay some tax under the alternative minimum tax provision in the law, some insurers are moving funds from tax-exempt investments to higher-yielding taxables.

SAFECO, for instance, announced in the fourth quarter it was selling $400 million of tax-exempt securities and putting that money into taxable bonds, said Assistant Controller George P. Yonker.

Mr. Hlavac pointed out, however, that there is still a slight advantage for Sentry to invest in intermediate tax-exempt bonds.

"I don't think we're going to see tremendous differences in strategies for most of these companies," agreed Shearson's Mr. Ghose.

Observers agree the Oct. 19 stock market crash has had little impact on insurers.

"The industry hasn't been hurt apparently by the events of Oct. 19," said Herbert Goodfriend, an analyst with Prudential/Bache Securities in New York.

The U.S. property/casualty insurance industry lost about $10 billion—or 10%—of its surplus following the crash, but that was made up to a large extent by a strengthened bond market, Mr. Goodfriend said.

Some observers point out, however, that the vagaries of accounting may paint a distorted picture of the crash's minimal impact on insurers' financial condition.

Shearson's Mr. Ghose pointed out that stocks are reported on insurers' books at their market price, while bonds are carried at their amortized cost. This means that while the decline in stock prices was reflected in insurers' year-end policyholder surplus, the subsequent jump in the bond market was not.

"On the whole, it may have been a little better than a wash," said Robert Arvanitis, an analyst with L.F. Rothschild & Co. Inc. in New York, discussing the crash's impact.

"It basically gave back the gains that had been accomplished in the early part of the year," said Bear Stearns' Ms. Vogel.

Many companies launched stock buyback programs last year, and most observers expect these to generally continue (*BI*, Oct. 26, 1987; Aug. 31, 1987).

Stock prices have been on the rise in recent weeks, which means that buying back insurer stocks that had been selling at or below book value now is less appealing than it had been, said Mr. Goodfriend. However, a number of buyback programs still will go forward, he said, pointing out the buybacks consume surplus that would otherwise be used to cut prices.

Stock buyback programs are an intelligent approach to reducing the industry's capital base, said Smith Barney's Mr. Snyder.

"I think it's a plus for the marketplace," said Ms. Vogel, who predicted the programs will continue.

"Long term, I think the surplus can be used better," said First Boston's Mr. Seifer, though he said he also believes the programs will continue.

The future of buyback programs "depends on the mind set of the companies," said Brown Bros.' Mr. Luce. "I guess I have a hunch they will continue. I think some companies may go slow until they see what the business situation looks like as the year develops. You may see more announcements than real action."

Ohio Casualty's Mr. Mencer said that while the insurer repurchased 320,000 shares in the fourth quarter and has the authorization to buy more, it has not made any recent significant purchases. "It's a function of the stock price.

"We also keep one eye on our surplus ratios," he said, adding that "we have to be careful we don't shrink our capital too fast."

Ohio Casualty's 2.2% decline in policyholder surplus to $442.4 million at year-end 1987, was primarily attributable to its repurchase last year of $20 million in stock, Mr. Mencer

Continued on next page

Group health results hurt multiline earnings

By JUDY GREENWALD

Declining profits—and in some cases year-end losses—from group health insurance operations are putting a big dent in some multiline insurers' operating earnings.

And, most observers warn that insurers should not expect their group health insurance results to improve before the end of the year—if then.

Among the major commercial property/casualty insurers surveyed by *Business Insurance* with substantial group health insurance business:

- Travelers Corp. reported a 3.4% decline in its overall operating earnings to $428.6 million last year on the heels of a $54.5 million loss from its employee benefits business.
- Hartford Insurance Group reported a $6 million loss from worldwide life, health and employee benefits operations in 1987, compared with a $108.8 million profit in 1986.
- SAFECO Corp.'s group operations, which include group health insurance, posted profits of $3.2 million last year, down 86.4% from $23.5 million in 1986.
- CIGNA Corp., whose employee life and health benefits segment posted $80.1 million in operating income last year, a 53% decline from $170.3 million in 1986. 1987 results include $78.7 million in losses from CIGNA's prepaid health care business.
- Aetna Life & Casualty Co. reported its employee benefits division earned $267.1 million in 1987, a 19.1% decline from $331.1 million in 1986.

Analysts say the problems plaguing the insurers' group health insurance operations are twofold:

- Rapidly escalating hospital and medical care costs, which are triggering losses in health insurers' indemnity plan business.
- Heavy initial investments, as well as tight competition and inflation, are producing losses in alternative health care operations, like health maintenance organizations and preferred provider organizations.

While the overall Consumer Price Index rose 4% for the 12 months ended January 1988, the CPI's medical care cost component climbed 6.2% during the same period, according to the Bureau of Labor Statistics.

And the gap between the overall CPI and the medical care cost component appears to be widening. Based on the three-month period that ended in January, the compound annual increase in the overall CPI is 3.2%, while the compound increase in the medical care component is 6.8%.

And despite recent rate hikes for group health indemnity plans, "prices have just not kept pace" with rising medical costs, said Udayan D. Ghose, a securities analyst with Shearson Lehman Hutton in New York.

Among contributing factors, he said, is that many hospitals suffer from excess capacity, which means that once a patient is admitted, they perform "every procedure known to man." As long as insurers were paying for the services, he added, "no one seemed to care."

In addition, reforms in the Medicare program last year caused more costs to be passed on to private payers, including group health insurers, Mr. Ghose said.

High utilization rates, on top of high medical inflation, are like a "one-two punch," said John Snyder, an analyst with Smith Barney Harris Upham & Co. in New York. "It's adding up to a lot of dollars."

However, Mr. Ghose said insurers are willing to suffer "short-term losses for long-term gains" in their HMO and PPO operations because they are convinced these alternatives are the "health care deliveries of the future."

However, insurers face tough competition from hospital management companies that also sponsor HMOs and PPOs and are willing to make the same cost sacrifices to funnel business into underutilized facilities, said Mr. Ghose.

Analysts do not expect profits from group health insurance operations to rebound soon.

While a number of insurers recently have instituted sharp rate increases, they probably won't help 1988 results because rate increases can only be enacted as contracts expire, noted Herbert Goodfriend, an analyst with Prudential/Bache Securities in New York. He said 1988 will be "another tough year for health services," while 1989 should see some improvement, although "how much is conjecture."

"I don't think it's going to be quick recovery," said Gloria Vogel, associate director at Bear, Stearns & Co. in New York, who said there could be some improvement in late 1988 or 1989. "It's going to take a long time before you see any real profits," she said, adding that the impact of the AIDS epidemic on group health insurers has not yet been determined.

This year may be the "low spot" in group health insurance earnings, agreed a CIGNA spokesman. Price hikes are continuing, he said, but "the need to raise prices is still very great."

Back in September SAFECO had hoped that 30% to 40% rate hikes in its group health business would be manifested in improved results by the end of the 1987 or the end of 1988's first quarter, pointed out George P. Yonker, assistant controller.

But now, he said he expects the rate hikes' "real, positive benefits" will not appear until the second half of this year.

While 1988's group health results may not be worse than 1987, "I don't think they're going to be rebounding dramatically," commented Smith Barney's Mr. Snyder. "It's not going to be that easy" for rates to catch up with rising costs, he said.

"Eventually, the employers will say that's it," Mr. Snyder said, adding that "at some point, they can get very stubborn." ■

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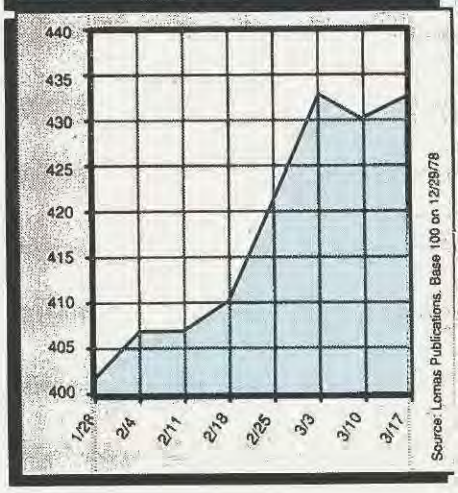
British Issues

March 17 Companies	Price pence	P/E	Div. pence	Yield %	1 Week High—Low pence	pence
Commi Union	340	12.9	21.9	6.4	340	325
Geni Accident	907	10.5	47.9	5.3	911	902
Gdn Royal Exch	930	13.7	56.2	6.0	943	930
Royal	410	10.8	26.4	6.4	415	404
Sun Alliance	940	14.7	43.1	4.6	954	939
Brokers						
Bradstock	225	12.6	6.8	3.0	228	225
CE Heath	373	13.8	34.5	9.2	376	373
Hogg Robinson	136	10.5	9.6	7.1	136	135
Lloyd Thompson	158	15.8	6.0	3.8	158	155
PWS Holdings	188	7.9	14.4	7.7	197	188
Sedgwick Grp	205	12.7	16.4	8.0	212	205
Steel Brri Jones	164	10.1	13.7	8.4	172	164
Willis Faber	212	12.1	15.1	7.2	213	210

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

The *Business Insurance Index* climbed 3 points to 433.0 on March 17, from 430.0 on March 10. The leading gainer was Aneco Reinsurance Ltd., up 27.8%; the biggest loss was posted by Nobel Insurance Ltd., down 33.3%. The *BI Index* gained 0.7% for the period, trailing the leading indicators: The Dow Jones 30 Industrials gained 3%; the Standard & Poor's 500 gained 2.8%; and the New York Stock Exchange Composite rose 2.5%.

BI Insurance Index



Summary of eight property/casualty insurers' 1987 results

Rank 1987	Corporate: Consolidated revenues 1987	Corporate: Aftertax[1] operating income 1987	Corporate: Percent increase (decline) 1986-1987	Property/casualty operations: Combined[1] ratio 1987	Combined[1] ratio 1986	Net premiums written 1987	Percent increase (decrease) 1986-1987	Pretax underwriting income (loss) 1987	Percent increase (decline) 1986-1987	Pretax investment income 1987	Percent increase (decrease) 1986-1987	Policyholders surplus 1987	Percent increase (decrease) 1986-1987
1 The Home Group Inc.	2,495,400	119,200	689.4	109.0[2]	116.0[2]	2,031,700	3.5	(210,100)	30.2	363,100	(4.5)	769,500	(0.2)
2 Reliance Ins. Co. & subs.	3,212,921	185,399	375.7	101.5[2]	116.4[2]	1,506,141	0.2	(28,200)	89.3	185,069	26.0	N/A	N/A
3 Crum & Forster Inc.	4,070,400	136,500	208.4	108.2	111.4	3,415,700	14.8	(285,600)	21.8	493,700	12.9	1,198,400	4.1
4 Fremont General Corp.	99,966	22,110	162.5	106.7	115.8	267,239	(12.6)	(17,827)	64.5	39,762	(21.2)	110,560	9.3
5 The St. Paul Cos. Inc.	3,365,785	324,315	110.8	105.3[2]	110.5[2]	2,704,165[2]	5.8	(127,066)	53.8	504,051	14.9	1,200,064	27.4
6 Old Republic Int'l (incl. life)[3]	1,094,500	93,200	97.5	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
7 General Re Corp.	3,448,388	486,051	74.1	99.9[2]	103.3[2]	2,250,558	(9.4)	(7,425)	92.5	482,346	22.8	2,008,906	9.2
8 CNA Financial Corp.	7,121,000	421,200	61.6	111.1	114.6	4,648,000[2]	11.1	(541,200)[2]	14.8	747,700	12.9	1,903,000	3.5
9 Chubb Corp.	3,714,400	344,700	60.8	97.8	100.1	2,675,600	5.1	68,700	150.7	278,800	20.7	1,200,000	22.2
10 Continental Corp.	5,801,000	329,800	60.6	102.8[2]	105.3[2]	3,981,700[2]	10.5	(88,700)	46.5	375,300	9.5	1,338,400	(7.5)
11 USF&G Corp.	4,826,084	372,755	53.7	104.2[2]	109.0[2]	3,845,278[2]	4.0	(96,179)	65.0	606,842	7.4	1,240,200	-
12 American International Group	11,278,300	944,528	43.9	99.5[2]	101.2[2]	7,602,207	20.4	17,464	123.1	681,613	30.7	N/A	N/A
13 Ohio Casualty Corp.	1,444,935	97,219	42.3	102.9[2]	104.4[2]	1,359,620[2]	4.5	(39,606)	30.5	156,898	12.1	442,402	(2.2)
14 Sentry Insurance Cos.[2]	1,353,059	54,896	38.6	105.2	107.9	1,090,052	22.7	(56,290)	11.9	162,151	39.8	469,183	35.3
15 SAFECO Corp.	2,725,182	210,302	33.2	101.4	106.0	1,437,745	4.9	(19,698)	74.6	179,837	18.3	674,103	8.3
16 Kemper Corp.	3,663,482	194,761	31.5	104.8[2]	107.4[2]	738,284	(1.4)	(35,296)	33.7	77,169	(4.7)	442,642	22.2
17 CIGNA Corp.	16,909,300	616,500	24.1	105.1	109.2	5,827,700	2.8	(300,900)	39.5	757,700	6.5	2,015,000	11.5
18 Aetna Life & Casualty Co.	22,114,100	867,400	21.4	106.1	107.0	6,515,600	9.3	(370,400)	(10.6)	831,200	12.1	2,292,247	22.6
19 Hartford Steam Boiler	421,663	53,385	17.8	85.7	86.0	289,143	3.5	40,426	7.6	33,627	11.3	216,745	0.2
20 Hartford Insurance Group	9,507,195	345,572	14.2	103.7	104.8	6,351,263	11.9	(266,669)	10.9	647,087	11.7	2,440,946	3.6
21 American General Corp.	7,157,000	555,000	3.2	101.6[2]	104.6[2]	1,669,000	9.7	(23,000)	56.6	162,000	9.5	922,000	7.8
22 Travelers Corp.	17,459,100	428,600	(3.4)	103.0	107.9	5,259,300	5.0	(119,500)	65.5	548,100	20.4	1,860,600	7.7
23 Royal Group (U.S. subs.)[2]	N/A	103,600	(35.9)	101.4	102.0	2,252,000	4.6	(19,500)	61.7	260,700	8.4	N/A	N/A
24 Fireman's Fund Ins. Cos.	3,927,101	57,460	(63.1)	114.9	108.5	3,365,437	0.3	(517,662)	(87.6)	444,739	(3.2)	1,229,926	(6.1)
— Nationwide Mutual Ins. Co.[2]	N/A	N/A	N/A	106.6	114.6	5,665,491	(0.1)	(380,984)	55.6	567,751	10.8	2,393,410	15.3
— Commercial Union Ins. (U.S.)[2]	N/A	N/A	N/A	106.9[3]	111.0[3]	1,110,000	8.8	(92,600)	24.4	153,100	(2.4)	538,400	9.7
— Liberty Mutual Ins. Co.[2]	N/A	N/A	N/A	111.8	113.4	6,245,835	16.2	(518,505)	(0.2)	784,788	14.8	N/A	N/A
Cumulative	137,210,261	7,364,453	37.6	105.1	108.2	84,104,758	7.6	(4,036,317)	34.9	10,525,130	12.3	26,905,634	8.5

[1] After dividends. [2] Statutory. [3] Before dividends. N/A—Company did not provide data

Continued from previous page

said, though he added the stock market crash also was a factor.

While Ohio Casualty will buy stocks "when the price is right," Mr. Mencer said, "we're not aggressively pursuing the buyback at this point."

Kemper Corp. has repurchased 2.5 million shares, or about 4% of its common stock, since Oct. 19, while its board has authorized the repurchase of another 500,000 shares.

In addition, Lumbermens Mutual Casualty Co., which is Kemper Corp.'s primary shareholder, has authorized the repurchase of up to 3 million shares. In all, about 10% of Kemper's initial share base is involved.

Mr. Fitzgerald noted that with the market crash, Kemper "saw an opportunity to distribute capital to shareholders on a very cost-effective basis." The company decided to take advantage of the reduction in its stock price to reduce the company's capital position, "which should boost reported earnings per share and book values per share," he explained.

Many observers believe the industry's reserve position has improved over the past year.

Prudential/Bache's Mr. Goodfriend said his firm estimates the industry's reserves are 5% to 10% below desirable levels, as opposed to the 10% to 12% reserve deficiency a year ago.

"Most companies are still probably underreserved, although probably not as much as the year before," said Fox-Pitt's Mr. Anthony.

"I don't think the balance sheets have been brought up to snuff yet," said Oppenheimer's Mr. Picoult. He warned that massive toxic waste claims are a looming problem that will have a "massive, material cash-flow impact" on the industry.

But, Smith Barney's Mr. Snyder was more optimistic. "I think (reserves are) certainly the best they've been in the last eight years." He added, however, that "there's no real absolute answer as to whether they're inadequate or not."

"Most of the inadequacy has been addressed by now," said Brown Bros.' Mr. Luce. In 1988 and 1989, he said, insurers will be reserving more for current than for past losses. ■

BI Industry Stock Report

MARCH 17, 1988 — 3/11/88 THRU 3/17/88

		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	21.88	0.0	23.3	23.00	17.75	181	1.00	4.6	14.3	3.61	6.06
Baldwin & Lyons Inc.	OTC	13.50	3.8	12.5	15.00	12.00	0	0.20	1.5	5.1	18.66	0.72
Corroon & Black Corp.	NYSE	33.50	4.3	18.6	34.75	28.00	103	1.08	3.2	15.9	6.82	4.91
Gallagher Arthur J. & Co.	NYSE	14.75	0.0	-7.8	18.00	13.88	12	0.48	3.3	10.2	4.81	3.07
Hall Frank B. & Co.	NYSE	4.88	2.7	69.4	5.50	2.88	139	0.00	0.0	10.2	0.00	N/A
Hilb, Rogal & Hamilton	OTC	11.50	-8.0	17.9	12.75	9.75	29	0.00	0.0	10.2	0.00	N/A
Lawrence Ins. Group	AMEX	10.13	12.6	50.1	10.13	6.88	12	0.32	3.2	10.3	4.10	2.47
Marsh & McLennan Cos. Inc.	NYSE	54.75	0.9	10.6	55.63	45.25	490	2.40	4.4	13.5	7.27	7.53
Poe & Assoc. Inc.	OTC	7.00	0.0	0.0	7.00	6.75	0	0.40	5.7	6.8	0.57	12.28
BROKERS	AVERAGE		1.8	21.6					2.9	10.8		
CONGLOMERATES & HOLDING COMPANIES												
Berkley W.R. Corp.	OTC	25.25	-7.3	5.2	29.00	23.50	199	0.28	1.1	6.2	17.31	1.46
Berkshire Hathaway Inc. DEL	OTC	3125.00	-2.3	5.9	3250.00	3000.00	140	0.00	0.0	16.7	96.82	5.24
CIGNA Corp.	NYSE	48.75	-0.8	11.1	51.88	43.88	748	2.96	6.1	6.0	50.12	0.97
CNA Fin'l Corp.	NYSE	57.38	0.7	3.1	61.00	51.00	173	0.00	0.0	8.8	42.71	1.34
General Re Corp.	NYSE	51.38	-2.1	-8.1	56.38	49.50	1246	1.20	2.3	10.7	26.60	1.93
ITT (Hartford Group)	NYSE	47.00	1.1	4.4	49.25	43.25	2607	1.25	2.7	9.2	44.08	1.07
Sears Roebuck & Co. (Allstate)	NYSE	38.25	0.7	13.7	39.88	32.25	2309	2.00	5.2	8.8	32.94	1.16
Transamerica Corp.	NYSE	36.63	5.4	23.1	36.38	29.75	440	1.84	5.0	6.7	30.32	1.21
CONGLOMERATES	AVERAGE		-0.6	7.3					2.8	9.1		
INSURERS												
Aetna Life & Cas Co.	NYSE	45.75	-2.1	1.1	49.88	43.50	751	2.76	6.0	6.1	44.75	1.02
American General Corp.	NYSE	35.63	1.4	12.2	35.50	30.75	1056	1.40	3.9	9.3	27.13	1.31
Amer Heritage Life Invt	NYSE	25.25	-2.9	4.1	26.00	24.00	2	0.96	3.8	11.8	21.70	1.16
Amer Indty Fin'l Corp.	OTC	9.13	-1.3	1.4	9.75	8.25	4	0.56	6.1	11.8	20.30	0.45
American Int'l Group	NYSE	57.88	0.2	-3.5	65.38	54.25	1478	0.30	0.5	10.1	34.54	1.68
Aneco Reins Ltd.	OTC	4.00	27.8	18.3	1.88	1.56	68	0.00	0.0	10.1	1.93	2.07
Aon Corp.	NYSE	26.00	0.0	13.6	27.00	21.88	176	1.20	4.6	9.3	15.23	1.71
Argonaut Group	OTC	46.00	-1.6	54.6	49.00	29.50	294	0.00	0.0	8.2	27.54	1.67
AVEMCO Corp.	NYSE	24.75	0.5	26.1	25.00	17.88	14	0.28	1.1	12.8	8.50	2.91
Belvedere Corp.	AMEX	5.13	-6.7	17.1	6.00	4.38	16	0.04	0.8	12.2	7.65	0.67
Business Mens Assurn Co.	OTC	35.50	1.4	32.7	36.00	25.50	101	1.20	3.4	95.9	27.39	1.30
Chubb Corp.	NYSE	60.88	-2.6	8.9	63.38	52.00	1610	2.16	3.5	7.3	39.52	1.54
Continental Corp.	NYSE	38.88	0.3	0.3	41.63	37.00	544	2.60	6.7	7.2	41.62	0.93
Durham Corp.	OTC	26.50	-2.8	23.3	28.00	21.50	16	0.92	3.5	22.6	26.93	0.98
Farmers Group Inc.	OTC	61.63	2.7	53.1	63.25	40.50	4011	1.44	2.3	15.9	22.15	2.78
Fireman's Fund Corp.	NYSE	29.75	0.8	14.4	31.00	25.75	532	0.50	1.7	32.7	29.81	1.00
Fremont Gen Corp.	OTC	11.38	-3.1	18.2	13.50	9.25	235	0.60	5.3	32.7	16.75	0.68
Home Group Inc.	NYSE	13.13	1.9	10.5	14.38	11.50	268	0.20	1.5	2.7	17.65	0.74
Hanover Ins Co.	OTC	24.00	2.1	3.2	26.25	22.50	166	0.36	1.5	5.3	26.62	0.90
Harleysville Group Inc.	OTC	15.88	0.8	21.0	16.13	13.38	45	0.55	3.5	7.8	16.18	0.98
Hartford Steam Boiler Insp	OTC	29.00	0.9	26.1	29.25	22.50	144	1.00	3.4	11.1	11.87	2.44
Kans City Life Ins	OTC	28.25	-0.9	7.6	28.50	25.25	0	0.00	0.0	11.1	0.00	N/A
Kemper Corp.	OTC	24.00	-2.0	17.1	25.25	21.00	529	0.72	3.0	7.5	27.11	0.89
Liberty Corp. S.C.	NYSE	42.00	3.1	18.3	41.50	34.50	14	0.80	1.9	16.0	20.90	2.01
Lincoln Nat'l Corp.	NYSE	47.25	3.8	17.7	48.63	40.25	176	2.36	5.0	9.1	44.85	1.05
NAC Re Corp.	OTC	24.25	0.0	36.6	24.25	18.50	67	0.00	0.0	16.7	19.43	1.25
Nobel Ins Ltd.	OTC	5.50	-33.3	-37.1	9.50	5.00	523	0.40	7.3	26.2	9.37	0.59
Northwestern Nat'l Life	OTC	26.75	2.4	16.9	29.25	22.63	141	0.96	3.6	7.2	35.18	0.76
Ohio Cas Corp.	OTC	35.25	-6.0	-2.8	38.25	33.50	161	1.88	5.3	8.2	30.94	1.14
Old Rep Int'l Corp.	OTC	24.50	-1.5	22.5	25.75	20.00	141	0.74	3.0	5.3	19.80	1.24
Orion Cap Corp.	NYSE	16.75	0.0	24.1	17.25	13.13	26	0.76	4.5	5.3	9.39	1.78
Phoenix Re Corp.	OTC	8.25	3.1	26.9	8.75	6.75	27	0.00	0.0	5.1	10.15	0.81
Protective Corp.	OTC	14.75	3.5	20.4	14.75	12.25	73	0.70	4.7	14.5	16.98	0.87
Provident Life & Acc Ins Co.	OTC	19.88	-3.6	27.2	21.88	15.63	179	0.84	4.2	49.7	27.00	0.74
St. Paul Cos. Inc.	OTC	45.25	0.0	-1.6	51.00	41.50	1346	2.00	4.4	6.7	36.34	1.25
SAFECO Corp.	OTC	24.50	-2.0	-11.7	30.00	24.00	1180	0.96	3.9	7.9	22.33	1.10
SCOR US Corp.	OTC	9.00	16.1	-2.7	9.25	7.25	145	0.00	0.0	6.9	9.20	0.98
Selbels Bruce Group Inc.	OTC	12.25	-2.0	8.9	14.25	11.00	32	0.80	6.5	8.2	12.88	0.95
Selective Ins Group Inc.	OTC	21.25	0.0	11.8	22.00	19.25	87	1.08	5.1	5.7	19.47	1.09
Statesman Group Inc.	OTC	4.75	5.6	1.3	5.56	3.81	119	0.05	1.1	5.7	5.19	0.92
Tokio Marine & Fire Ins	OTC	82.75	5.1	25.6	82.00	63.25	13	0.19	0.2	70.1	0.00	N/A
Torchmark Corp.	NYSE	30.00	2.6	22.4	31.00	24.50	254	1.00	3.3	10.1	13.01	2.31
Travelers Corp.	NYSE	37.00	1.0	5.3	40.00	34.50	1889	2.40	6.5	9.0	45.28	0.82
Trenwick Group Inc.	OTC	11.75	2.2	14.6	11.75	9.75	112	0.16	1.4	11.2	14.65	0.80
United Fire & Cas Co.	OTC	26.00	2.0	0.0	27.00	24.00	15	0.96	3.7	5.0	21.64	1.20
United States Fid & Gty	NYSE	33.25	2.3	16.7	34.38	28.88	3830	2.64	7.9	6.8	22.36	1.49
UNUM Corp.	NYSE	21.88	0.0	18.3	22.75	17.88	335	0.40	1.8	12.6	28.84	0.76
USLIFE Corp.	NYSE	36.88	2.4	29.4	38.25	28.00	202	1.28	3.5	8.8	43.09	0.86
Washington Nat'l Corp.	NYSE	28.00	-0.5	17.3	28.50	24.00	56	1.08	3.9	22.0	32.80	0.85
Zenith Nat'l Ins Corp.	NYSE	19.63	1.3	30.9	21.25	15.00	198	0.60	4.1	9.4	12.26	1.60
INSURERS	AVERAGE		0.4	14.8					3.3	14.8		
ALL COMPANIES	AVERAGE		0.5	14.8					3.2	13.6		

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