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Update

Continuous trigger ruling issued for asbestos property damage

SAN FRANCISCO—Asbestos in buildings constitutes insurable property damage from the time it is installed until it is removed or a claim is made, California Superior Court Judge Ira A. Brown Jr. ruled last week.

Although the landmark ruling only involves Armstrong World Industries Inc. and its insurers, it is expected to set precedent in asbestos property damage litigation nationwide.

The ruling is the broadest ever ren-

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New IRS test adds complexity to 401(k) plans

By JERRY GEISEL

WASHINGTON—A proposed new Internal Revenue Service rule for non-discrimination testing would add yet another layer of complexity to 401(k) plan administration.

The rule would establish a new testing procedure in employee savings plans where there are both 401(k) deferrals and either employee aftertax and/or employer matching contributions, which are covered under 401(m) of the tax code.

The rules, which also deal with a variety of other 401(k) issues, such as hardship withdrawals, will bar employers from making maximum use of a liberal test now used to determine if their savings plans discriminate in favor of the higher-paid (*BI*, Aug. 29; Aug. 15).

The new rules were published Aug. 8 in the Federal Register.

Employers, under the Tax Reform Act of 1986, have been able to use the liberal non-discrimination formula—known as the 200%/2 percentage points test—to separately test for non-discrimination in both 401(k) deferrals and 401(m) contributions.

But, the IRS, making full use of the authority Congress provided in the 1986 tax law, says that employers, effective Jan. 1, no longer will be able to use the 200% test twice.

Instead, the rules establish a complex and tougher testing procedure that combines and compares 401(k) deferrals and 401(m) contributions of the higher- and lower-paid employees (see story, page 35).

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Italians likely to be liable for claims from air show

By STACY SHAPIRO

LONDON—The Italian government, which owned the jet aircraft that crashed into a crowd at a West German air show last week, is liable for claims under German civilian aviation law, observers say.

Under a provision in West Germany's Air Traffic Law, "the keeper of the Italian military aircraft will be liable for all the damages," said Alfred Urwantschky, senior partner and aviation attorney at Urwantschky, Dangel, Borst & Partners in Neu-Uln, West Germany.

However, others point out that confusion over applicable laws and legal agreements between the West German, U.S. and Italian governments make it unclear which of the governments will actually compensate survivors of at least 49 people who died at the show at the Ramstein Air Base in West Germany. More than 350 others who were injured also will be seeking compensation.

The base is owned by the U.S. Air Force, which does not purchase liability insurance.

And, while the Italian government did purchase liability insurance for the ill-fated precision flying team, the limits of the coverage will fall far short of meeting all claims, observers say.

Some estimate that claims from the disaster could range from $70 million to $300 million, while the applicable limits of the Italian team's coverage totals at most $4.8 million.

Meanwhile, U.S. aviation experts say that government regulations and other safety precautions make it unlikely that a similar tragedy involving spectators could occur at a U.S. air show (see story, page 37).

A provision in Section 53 of the German Aviation Traffic Law that applies to military aircraft in West German terri-

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Photo: AP/Wide World

At least 49 people were killed when an Italian fighter slammed into the crowd at the Ramstein Air Base.

Maxicare 'slims down' to regain health

By DONNA DiBLASE

LOS ANGELES—Despite more than $335 million in losses in 18 months and a negative net worth, Maxicare Health Plans Inc. will remain a viable player in the fiercely competitive health maintenance organization marketplace, a top Maxicare official asserts.

But, to survive, the huge national HMO company—which grew principally through two large, highly leveraged acquisitions in 1986—is reversing its strategy.

"We intend to stay in business as a series of core HMOs. We just need to slim down and concentrate on plans and areas that already are successful," said David M. Hallis, senior vp of marketing and a member of Maxicare's board.

To "slim down," Maxicare is selling some unprofitable HMOs and closing others that it cannot sell. In addition, it is raising premiums an average of 15% this year, even though competitors are demanding smaller increases.

However, "we're going to have some of the more meaningful national networks and our membership still will be around 1.7 (million) or 1.8 million" following the company's restructuring, he said. Maxicare had about 2.3 million members at year-end 1987.

Health care industry observers say Maxicare's new strategy will help it overcome its current financial turmoil. But, they are quick to point out that both Maxicare and the entire HMO industry are realizing that rapid, national growth is not the best recipe for success.

"Obviously, Maxicare will become more of a multi-regional HMO instead of a national firm. I think Maxicare's problems show how difficult it is to be a national HMO firm," observed Kenneth S. Abramowitz, a senior research analyst with Sanford C. Bernstein & Co. Inc., a New York stockbrokerage.

"They bought too much, too fast and

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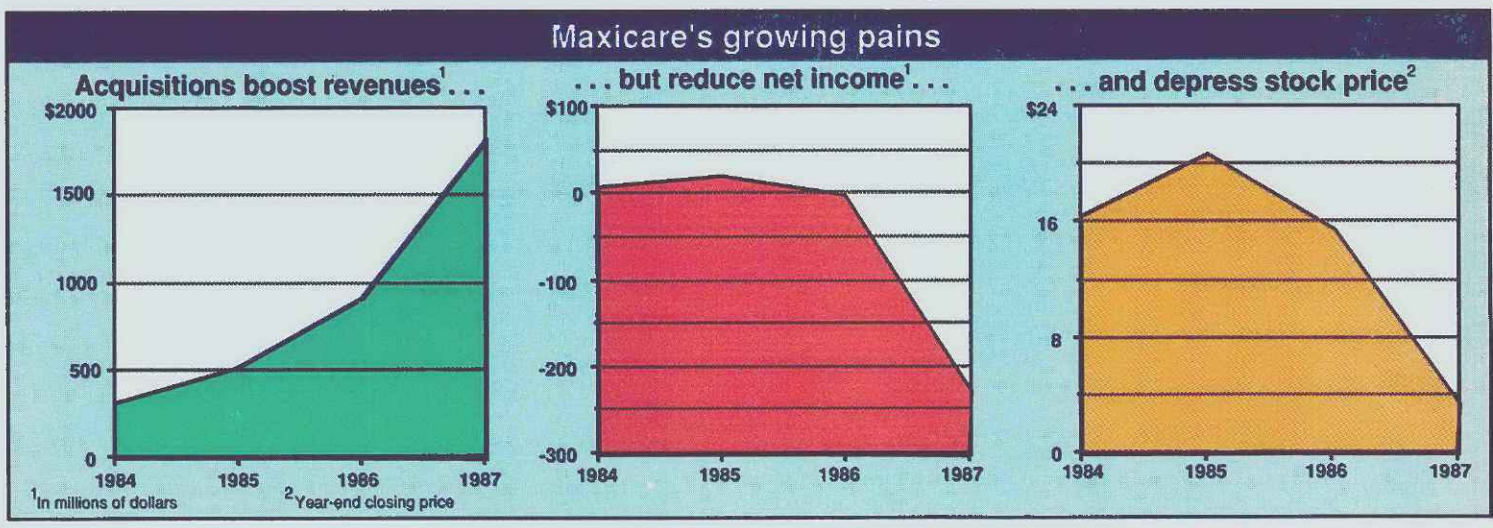

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Update

Asbestos rulings issued

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dered in an asbestos property damage coverage dispute. In May 1987, Judge Brown issued what is considered the broadest coverage interpretation applying to asbestos bodily injury claims (*BI*, June 1, 1987).

"Property damage alleged in the complaints triggers policy coverage on a continuous basis from the time that the asbestos-containing building material is installed to the time it is removed or the date of claim, whichever occurs first," Judge Brown wrote in the Aug. 31 ruling.

The property damage ruling came in Phase Five of the massive consolidated asbestos coverage litigation in San Francisco.

Judge Brown also ruled on various coverage issues relating to asbestos bodily injury claims filed against Armstrong, Fibreboard Corp. and GAF Corp., which were part of Phase Four of the trial.

The judge held that the asbestos producers' liability insurers—which include Commercial Union Insurance Co., American International Group Inc., CNA Financial Corp., Continental Insurance Co., Fireman's Fund Insurance Cos. and Travelers Corp.—must:

- Provide policyholders with full annual aggregate limits even if policies were canceled midterm.
- Provide coverage even though the definition of "occurrence" in many policies states there is no coverage for bodily injury that is "expected or intended." Judge Brown said that "injury from exposure to asbestos was neither expected nor intended."
- Provide full coverage for each claim filed where there is an exposure during the policy period, up to the policy's aggregate limits, if any. "Each individual claim is a separate occurrence," he ruled.
- Provide coverage even under those policies that contain a pollution exclusion. Judge Brown ruled, "The pollution exclusion does not exclude asbestos-related bodily injury claims from coverage."
- Provide coverage regardless of "other insurance" clauses. The judge decided to disregard these clauses and establish a system of allocating coverage among triggered policies according to the number of years an insurer is on the risk and the limits of coverage.

California OKs health care plan

SACRAMENTO, Calif.—California residents without health insurance can obtain coverage for catastrophic illnesses under a program approved by the California Legislature last week.

S.B. 6 sets up a non-profit state agency to provide health insurance for at least some of an estimated 6 million uninsured residents. Approved Wednesday, the last day of the legislative session, the bill was sent to Gov. George Deukmejian for signature.

The plan will be financed by premiums paid by participants and funds diverted from other state programs, such as MediCal, the state's Medicaid program, said Sal Bianco, consultant for the Senate Committee on Insurance, Claims and Corporations. Other funding sources could include up to $200 million annually from a 25-cent-a-pack tobacco tax that California residents will vote on this fall, he added.

However, the legislation does not call for additional taxes or surcharges on employers.

Monthly premiums, which are limited to 150% of the statewide average for private health insurance, are projected to be about $200 for individuals, he said.

Under the plan, the state pays 80% of medical expenses after a $1,000 individual deductible. After an out-of-pocket maximum of $3,000 for individuals and $5,000 for families, the plan picks up 100% of participants' health care bills.

About 100,000 to 250,000 individuals are expected to be covered under the plan in its first year, but the number is expected to grow to as many as a million in following years, Mr. Bianco said. The first policies will be issued in January 1990.

Waxman long-term care plan

WASHINGTON—Employers would be tapped for about $3.5 billion annually in additional Social Security payroll taxes under a long-term health care bill Rep. Henry Waxman, D-Calif., plans to introduce this month.

Under the legislation, which is estimated to cost $32 billion annually, Medicare payments toward home health care, adult day-care and nursing home care would increase.

Rep. Waxman's proposal would be financed by a combination of increased payroll and estate taxes and an income tax surcharge imposed on all taxpayers.

The proposal would extend the Medicare portion of the FICA tax to all wages earned. This would raise about $7 billion.

The Medicare portion of the 7.51% Social Security payroll tax—paid by both employers and employees—currently is 1.45% of the first $45,000 of wages.

One significant difference between the financing of Rep. Waxman's bill and long-term care proposals submitted by Sen. George Mitchell, D-Maine (*BI*, May 2), and Sen. Edward Kennedy, D-Mass. (*BI*, March 28), is that it does not raise Medicare premiums to help pay for the program.

Under Rep. Waxman's proposal, all taxpayers would pay an income tax surcharge of $5 per $100 of income tax liability. This would raise approximately $20 billion, Rep. Waxman estimates.

Howden criminal trial set

LONDON—Four former executives of Lloyd's of London broker Alexander Howden Group P.L.C. accused of stealing millions of dollars in funds will be tried after a magistrate ruled last week that the prosecutor had sufficient evidence.

The trial is expected to be held at the Central Criminal Court in the Old Bailey in London sometime in the middle of next year, seven years after original allegations were made against the execu-

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Regulators say officers, parent firm looted Quality

By DOUGLAS McLEOD

CHARLESTON, W.Va.—The liquidator of Quality Insurance Co. is charging Quality's former management and parent company with numerous illegal acts after having dropped some of the same allegations from Quality's 1987 liquidation order.

In a civil racketeering complaint filed in U.S. District Court in Charleston July 20, the West Virginia Insurance Department accuses directors and officers of Quality and its parent, Saudi Egyptian American Reinsurance Co., with systematically stripping the insurer's assets and driving it into insolvency after its acquisition in 1982.

The fraud allegations focus on several books of assumed and ceded reinsurance business, including contracts with syndicates on the now-defunct Insurance Exchange of the Americas in Miami; Lincoln National Reinsurance Corp.; Dependable Insurance Co.; Union America Insurance Co.; and Omaha Indemnity Co.

According to the complaint, SEAR and Quality officials conspired to divert reinsurance premiums and siphon fraudulent management fees from Quality while assuming "massive volumes of business in lines of insurance Quality and SEAR were not qualified to manage."

The racketeering complaint expands on allegations originally leveled in the Insurance Department's September 1987 liquidation petition and an earlier rehabilitation petition.

The petition had charged that Quality's management knowingly filed a false 1985 annual statement that failed to report numerous reinsurance transactions, including transactions with SEAR. The petition also alleged that Quality violated conditions of an agreement with the West Virginia department that allowed SEAR to acquire the insurer in 1982.

The department and Quality agreed last year that these allegations would be dropped from the liquidation order at Quality's request in exchange for the insurer's consent to be liquidated (*BI*, Oct. 5, 1987).

Inclusion of the charges was not necessary to obtain the order, according to Betty Cordial, special deputy insurance commissioner.

Quality, based in Fairmont, W.Va., was ordered liquidated after the Insurance Department found it insolvent by $15.1 million as of June 30, 1987. The company reported earned premiums of $13.7 million in 1986.

In addition to Panama-based SEAR, the West Virginia department's complaint names:

- Saudi Egyptian American Reinsurance Agency, a SEAR subsidiary based in Cincinnati.
- Mamdouh M. Abdallah, a director and officer of SEAR and former Quality treasurer.
- Abbas S. Yousri, a SEAR director, executive vp of SEAR Agency and secretary of Quality.
- Helal S. Elsewedy, chairman and president of SEAR and a Quality director.
- James Cordle, a Quality director from February 1985 to September 1986. Mr. Cordle was also president of Citadel Management Corp., a syndicate manager on the Florida exchange.
- Mahmoud Abu Saud, a Quality director.
- Luther L. Britt, former president of Quality.
- James E. Moody, former vp and comptroller of Quality.

According to the complaint, SEAR acquired Quality, formerly known as Stonewall Casualty Co., in May 1982 after agreeing to an "order of acquisition" that

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RIMS blasts proposed hike in reinsurance excise tax

By DEBORAH SHALOWITZ

WASHINGTON—A proposal to increase the federal excise tax on premiums ceded to foreign reinsurers and to eliminate treaties with foreign countries that waive the excise tax would increase costs for U.S. insurance buyers, says the Risk & Insurance Management Society Inc.

The new proposal, developed by the Washington-based Reinsurance Assn. of America, will be introduced in Congress next year, said RAA President Andre Maisonpierre.

Because of the mammoth federal deficit, Congress probably would favor the revenue-producing aspect of the proposal, observers say.

However, RIMS last week issued a statement criticizing the proposal, calling it "nothing less than a kick in the teeth to insurance consumers, who will ultimately have to pay the tab for the tax increase."

Under current law, direct insurance premiums paid to foreign insurers are subject to a 4% excise tax, while reinsurance premiums paid to foreign reinsurers are subject to only a 1% tax.

The excise tax is imposed in the form of a withholding tax. For example, if a company owes a premium of $1 million for reinsurance to a Swiss reinsurer, under current law the Swiss reinsurer would receive $990,000 and the U.S. government would receive $10,000 in excise taxes.

Under the RAA's proposal, the ceding company would pay the Swiss reinsurer $960,000 and the United States government $40,000.

However, eight countries currently have treaties with the United States that waive excise taxes on reinsurance ceded abroad. These countries are: Barbados, Cyprus, France, Hungary, Italy, Romania, the Soviet Union and the United Kingdom.

Also, the Senate Foreign Relations Committee is expected to approve a treaty with Bermuda that would waive until Jan. 1, 1990, the excise tax on reinsurance ceded to reinsurers domiciled on the island.

To equalize the status between Bermuda and Barbados, the Treasury Department has agreed to renegotiate the Barbados treaty to eliminate the excise tax waiver by Jan. 1, 1990, according to Mr. Maisonpierre.

These excise tax waivers are a "loophole" that allows foreign reinsurers to sell reinsurance at lower prices in the United States than domestic reinsurers can, Mr. Maisonpierre contended.

Before the Tax Reform Act of 1986, the tax treaties the United States had with other countries did not

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Inside

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Cost-sharing plans are successful: Study

By ALISON KITTRELL

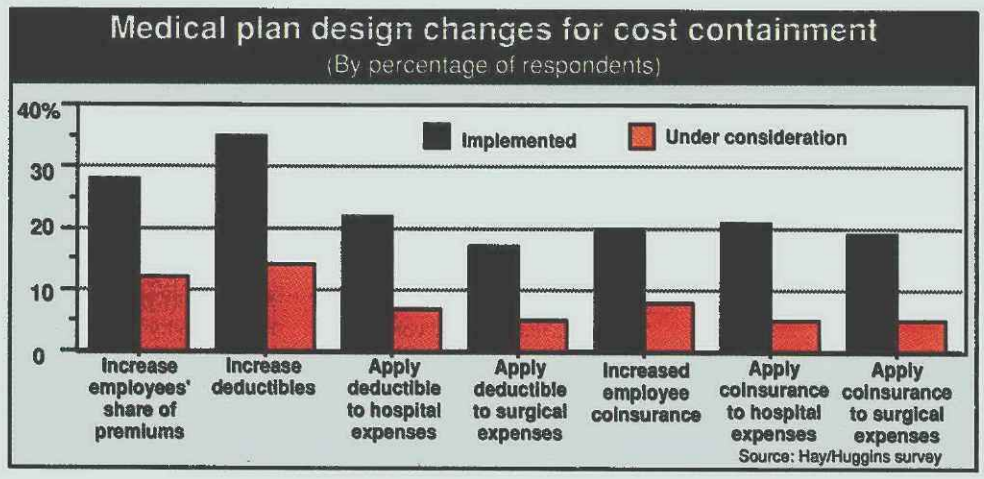
Health care cost-containment measures—already used by many employers while still under consideration by others—seem to be a success, according to a recent survey.

"The survey data suggests that cost-containment measures, such as increased cost sharing, preadmission certification programs and health promotion campaigns, have succeeded in limiting premium increases and in making employees more efficient consumers of health care," the authors of the "1987 Hay/Huggins Benefits Report," conclude.

However, the survey conducted by the Hay Group, which questioned more than 900 employers nationwide about their 1987 benefit plans, shows that costs are starting to creep upward again. The average employee premium grew 6% from 1984 to 1985, and 3% from 1985 to 1986, but it increased 9% from 1986 to 1987. And, average family premiums increased 3% from 1984 to 1985 and again from 1985 to 1986, but ballooned 8% from 1986 to 1987.

Employers have been using a number of weapons in the battle against health care costs, the survey shows. But the most common has been shifting more of the cost of the programs to employees.

"That (cost shifting) is a continuation of a trend we've been seeing for several years. The 1980s seems to be the time period" for cost shifting, said Michael Carter, senior vp of Hay/Huggins Co. in Philadelphia.



For example, in the 1987 survey, 57% of the employers paid the full cost of employee health care coverage—down significantly from 67% in 1982.

In fact, although 100% of the employers in the 1987 survey provide health care coverage for their employees, 58% said they had made some plan design "cutbacks" during the last two years. The most common change, enacted by 35% of the respondents and under consideration by an additional 14%, has been to increase employees' deductibles under the plan.

In addition, 28% of the employers have increased the percentage of premium paid by the employee, and an additional 12% are considering such a move.

Twenty-two percent have changed their plan to make hospital expenses subject to the deductible and 7% are considering doing so. Seventeen percent have made surgical expenses subject to the deductible, while 5% are considering such a change.

Employers also have changed the coinsurance levels of their health care plans. Twenty percent have increased the employee coinsurance and 8% are considering such action. Twenty-one percent have made hospital expenses subject to coinsurance and 19% have made surgical expenses subject to coinsurance; in each case, an additional 5% are considering such a change in their health care plan.

In addition to shifting more of the cost to their employees, employers have made other changes to their plans.

"The escalating cost of hospitalization and surgery has led employers to search for less costly alternatives in providing health care. Home health care, skilled nursing facilities, hospice care and outpatient surgery are among the most commonly used alternatives for cost containment," the survey reports.

Most plans provide some type of financial incentive for employees to use such alternatives to hospitalization: Of the plans that provide hospitalization coverage at less than 100%, 62% provide full coverage if an employee opts for home health care, hospice

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Court's decision could force Citibank to divest AMBAC

By JUDY GREENWALD

WASHINGTON—A U.S. appellate court decision could ultimately force Citibank to divest itself of its 97% ownership of AMBAC Indemnity Corp., a major municipal bond insurer.

Whether New York-based Citibank will have to sell AMBAC will depend on a subsequent decision by the Federal Reserve Board and the possibility of congressional action.

And even if AMBAC, which has more than $1 billion in assets, should be sold by Citibank, its viability as an insurer will not be affected, observers say.

"AMBAC is going to be around for a long time," said Barnet Sherman, a municipal bond analyst with Smith Barney Harris Upham & Co. in New York.

Last month's decision by a three-judge panel of the U.S. Court of Appeals for the District of Columbia is the result of a suit brought in May 1985 in federal court by the American Insurance Assn. to prevent Citibank's June 1985 acquisition of AMBAC.

The American Insurance Assn. decided to fight to block the acquisition, said Michael Lovendusky, the AIA's counsel, because "the underwriting of municipal bond insurance is not closely related to the business of banking."

Federal banking laws generally prohibit banks' insurance activities unless they are closely related to the banking business. Insurance industry organizations have vehemently opposed bank participation in the insurance business.

A U.S. District Court in Washington originally rejected the AIA's objections to the sale.

Last month's appellate ruling, which overturned in part an earlier decision by the District Court, focused on the comptroller of the currency's decision to approve the Citibank acquisition.

The appellate court said the comptroller correctly decided the

Continued on next page

Fibreboard unveils plan to settle asbestos claims

By STACY ADLER

CONCORD, Calif.—In a novel attempt to avoid bankruptcy, former asbestos manufacturer Fibreboard Corp. wants to offer claimants deferred settlements in the hope that it can eventually recover millions of dollars from insurers.

Because Fibreboard has only $115 million in undisputed insurance remaining to pay an estimated half-billion dollars in asbestos bodily injury claims, it is hoping to defer payment of the settlements for five to eight years so it can resolve coverage disputes with two of its insurers.

Fibreboard maintains that policies written by Continental Casualty Co., a unit of CNA Financial Corp., and Pacific Indemnity Co., a Chubb Corp. subsidiary, between 1956 and 1959 have no aggregate limits and should respond to the bulk of the tens of thousands of asbestos bodily injury claims now pending against the company.

Fibreboard is litigating with insurers as part of the coordinated asbestos coverage trial in San Francisco before Judge Ira A. Brown Jr.

Last week, after Fibreboard released its offer, Judge Brown ruled that each claim filed against Fibreboard constitutes an occurrence, making the Continental Casualty and the Pacific Indemnity policies responsible for an infinite number of claims where the first exposure to asbestos was prior to 1959 (see update, page 1).

"Each individual claim is a separate occurrence under the circumstances of this case," said Judge Brown in his Aug. 31 ruling. "Since each individual claimant has a unique work history, each claimant's exposure must be viewed as a separate occurrence."

Continental Casualty had argued that since all of the asbestos produced by Fibreboard was manufactured in only two plants, there were only two occurrences, limiting the insurer's liability to $2 million.

Pacific Indemnity did not raise a similar argument.

Both the Continental Casualty and the Pacific Indemnity policies had limits of $1 million per occurrence with no aggregate limit.

Judge Brown's decision is almost certain to be appealed, so Fibreboard won't have a definitive picture of its insurance for five to eight years, which is why it is proposing the deferred settlement plan.

If Judge Brown's decision is upheld on appeal, Fibreboard estimates that 85% of the asbestos bodily claims that have already been paid and 75% of the claims currently pending would be covered by the policies written by Continental Casualty and Pacific Indemnity.

"We are very encouraged by the favorable decisions by the court as it involves our asbestos insurance coverage," said Lawrence C. Hart, Fibreboard's chairman and president. "These decisions eliminate much of the uncertainty that Fibreboard has faced regarding the extent of its coverage."

Michael Douglas, Fibreboard's general counsel, added that it is impossible for the company to estimate how many claims eventually may be filed against it. However, he did note that the company is currently named in about two-thirds of the 70,000 claims pending in the Asbestos Claims Facility.

Fibreboard says if it fails to win the coverage litigation or if enough claimants do not opt for the deferred settlements, it will be forced into bankruptcy.

"Based on the number of pending claims and anticipated future claims and on historical claims settlement costs. . .general assets will not be sufficient to pay settling claimants more than a small fraction of the principal amounts and (Fibreboard) will be forced to seek the protection afforded by the bankruptcy laws," ac-

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Insurer can resume political contributions

By STACY ADLER

LOS ANGELES—A state court judge has lifted a temporary restraining order barring State Farm Mutual Automobile Insurance Co. from using policyholder surplus to contribute to a statewide political campaign to bring no-fault auto insurance to California.

Los Angeles County Superior Court Judge Barnet Cooperman—who had granted the restraining order—also refused to instate a permanent injunction against Bloomington, Ill.-based State Farm, saying these forms of relief were too broad and too drastic.

However, the judge did indicate he would consider more limited forms of relief, such as enjoining State Farm from using that portion of its surplus proportionate to the number of policyholders who oppose no-fault auto insurance.

The policyholders' attorney, William Shernoff of Shernoff, Scott & Bidart in Claremont, Calif., said he will now ask the judge for this pro-rata form of injunctive relief.

In his Aug. 26 ruling, Judge Cooperman said State Farm has a constitutional right of free speech, but also noted that policyholders—many of whom oppose the no-fault proposition—also have a right of free speech. The judge said there is, in essence, "a clash of constitutional rights."

The judge said corporations have a right to be involved in the 'marketplace of ideas' and that imposing an injunction would be 'contrary to the fabric of the law,' said a State Farm spokesman.

The ruling was the result of an Aug. 15 class-action lawsuit brought on behalf of State Farm policyholders alleging the insurer is violating policyholders' First Amendment guarantees of free speech by using policyholder surplus to participate in political campaigns they may not support.

The suit also charges State Farm, the largest insurer in California, with conducting unfair and misleading business practices and of breaching its fiduciary duty to policyholders (*BI*, Aug. 22).

This suit is not affected by Judge Cooperman's most recent ruling.

"The court recognized State Farm's right to be involved in these initiatives," said a spokesman for the insurer.

The judge said corporations have a right to be involved in the "marketplace of ideas," and that imposing an injunction against State Farm would be "contrary to the fabric of the law," according to the State Farm spokesman.

State Farm is the largest contributor to the Insurance Industry Initiative Campaign Committee, the group sponsoring the no-fault measure. As of July, State Farm had already contributed some $2.3 million to the committee.

The insurance industry has said it will spend some $43 million to win approval of the no-fault initiative, Proposition 104, and to fight three consumer-sponsored initiatives scheduled for the Nov. 8 ballot that would limit or roll back auto insurance rates (*BI*, Aug. 1).

Mr. Shernoff said Judge Cooperman called insurers' contributions to the no-fault campaign "repugnant." ■

AMBAC ruling

Continued from previous page
Citibank acquisition did not violate provisions of the National Bank Act, which regulates banking activities.

But the decision also agreed with the AIA's contention that the comptroller should not have approved the AMBAC acquisition without first requiring New York-based Citicorp, the bank holding company that controls Citibank, to obtain the Federal Reserve Board's approval.

The Fed administers the Bank Holding Company Act, which limits the non-banking activities—including insurance activities—of bank holding companies.

"The upshot is that Citicorp must obtain (Federal Reserve) Board approval," states the decision. "The comptroller did not consider what effect the applicability of the BHCA would have on his decision because he mistakenly thought the BHCA did not apply."

Citicorp may now decide to appeal the decision to the U.S. Supreme Court, said the AIA's Mr. Lovendusky.

However, it is unlikely that the high court will hear the case, Mr. Lovendusky said, in which case the issue will eventually be brought before the Federal Reserve Board. Any action before the end of the year is doubtful, he added.

Spokesmen for Citibank and AMBAC had no comment on their plans.

Mr. Lovendusky said he was confident the Federal Reserve Board would decide the acquisition was not in compliance with the Bank Holding Company Act.

That act requires a "much higher standard of analysis" than the National Bank Act to determine whether municipal bond insurance is closely related to the banking business, he said.

Under the National Bank Act, he said, the comptroller was required to determine only if municipal bond insurance was incidental to other banking activities. The comptroller decided it was, because it performed a function equivalent to the use of standby letters of credit.

'The upshot is that Citicorp must obtain (Federal Reserve) Board approval,' states the decision.

But Ed Armstrong, a consultant with The Wyatt Co. in Washington, is not so sure the Fed will decide against Citibank.

"I've got to believe that the Federal Reserve Board probably would allow" Citibank to retain its ownership in AMBAC, Mr. Armstrong said. The Fed has traditionally been "very generous" in its policies to the banks, he added.

The key phrase in the BHCA that the Fed must interpret states that for an activity by a bank holding company to be permissible "it must be so closely related to banking. . .as to be a proper incident thereto," Mr. Armstrong said.

"That's where interpretation comes in," he noted. A liberal interpretation of this phrase would permit Citibank's continuing ownership of AMBAC, while a conservative one would not.

"I'm optimistic they'll be liberal," he concluded.

Citibank also could retain AMBAC through legislation, Mr. Lovendusky said. A provision in the Financial Modernization Act that the Senate approved in March would specifically permit Citibank to continue ownership, he said.

In addition, a banking bill that includes a broader provision permitting all bank holding companies to become involved in financial guarantee insurance is now pending in the House Energy & Commerce Committee, said Mr. Lovendusky.

Mr. Armstrong said he believes legislation permitting greater involvement in financial guarantee insurance by banks is inevitable, although not necessarily this year.

"I think it's just a matter of time," he said.

Meanwhile, even if Citibank is eventually forced to sell AMBAC, the divestment is unlikely to have any impact on the municipal bond insurers' operations, observers say.

Officials of both Standard & Poor's Corp. and Moody's Investors Service, for instance, said a sale would not necessarily endanger the triple-A rating both agencies have given AMBAC.

"The ownership of AMBAC is not in and of itself a central issue to the rating," said Dan Heimowitz, vp and managing director-public finance for Moody's. "It would not in and of itself present a problem for AMBAC."

"There's no reason we would have any great concern about their continued strength," agreed Roy Taub, managing director at S&P.

However, both officials said they would be concerned about who would purchase AMBAC.

"One big issue would be who ended up owning it," said Mr. Taub. While AMBAC has no need of capital now, S&P would want it to have an owner willing to provide infusions if the need arose.

Divestment "is something anyone has to be careful of," said Sylvan Feldstein, a manager of municipal credit analysis at Merrill Lynch Pierce Fenner & Smith in New York. "One of the positive features of the company is that it does have Citibank involved," he said.

Jeffrey Noss, vp and a municipal bond analyst with the Bank of New York, said he does not believe a sale would matter, noting that AMBAC must meet statutory requirements as well as the rating agencies' standards. "Who the shareholders are, I don't think is that significant," he said.

The only problem, he said in agreeing with Mr. Taub, would be if the company were sold to the "Fly By Night Financial Corp.," which might be unwilling to provide needed capital. However, "I don't think that's the direction they would go," Mr. Noss said.

For the six months ended June 30, AMBAC reported net revenues of $88.6 million, up 30.7% from $67.8 million for the comparable period of 1987. The company's $1 billion in assets is the largest among U.S. municipal bond insurers, the company says. ■

Excise tax

Continued from page 2
matter much because U.S. reinsurers paid little in federal income taxes, Mr. Maisonpierre said. But, following tax reform, "the domestic reinsurance industry will have a big tax burden" that makes them less competitive than foreign reinsurers, he concluded.

Jon Harkavy, RIMS' director of governmental affairs, contends that the domestic reinsurers want to increase costs for foreign reinsurers but at the same time are not willing to increase their own capacity.

Insurers have increased their net retentions dramatically over the last few years because of reduced capacity offered by reinsurers, Mr. Harkavy added.

The RAA's proposal "presumes there is an abundance of capacity out there. We don't consider that to be the case," Mr. Harkavy said.

If your insurer isn't doing enough to help reduce risks, better sit down and read this.

"I remember seeing a Wausau film on workers compensation. It was an extremely dramatic presentation of their abilities. I'll never forget it," says Fred Barth, President of Indiana-based Jasper Chair Company.

"At the time, I couldn't believe one insurer provided that much help in loss control.

"Now we look to Wausau for guidance and suggestions throughout our operation. And we've gone along with just about everything they've recommended — because their ideas have been good ones," concludes Mr. Barth.

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P&G shifts health care costs to workers

By GLENN HUNTLEY

Benefit beat

About 17,000 Procter & Gamble Co. employees in the Cincinnati area will pay part of their health care costs for the first time under a new benefit plan that begins Sept. 15.

Deductibles and/or monthly plan contributions will be required for coverage under P&G's new FlexibleCare program, which also offers the employees a choice among three options:

- A basic indemnity plan that allows employees to choose any health care provider. While P&G employees will make no contribution to the plan, they will be subject to annual deductibles of $125 for individuals and $250 for families.

The FlexibleCare plan will pay 80% of the first $3,000 in medical expenses and 100% of expenses greater than $3,000, up to a lifetime maximum of $1 million per plan participant.

- A preferred provider network. For a small monthly premium ($5 for individuals and $10 for families), employees that choose network providers receive 100% coverage with no lifetime maximum benefit limit. If employees choose non-PPO providers, the basic indemnity plan benefit limits are apply; however, there still is no deductible.
- The basic indemnity plan with higher deductibles. Under this option, employees who accept annual deductibles of $500 for individuals and $1,000 for families will receive rebates at the end of the plan year. The rebates, which are paid whether or not the coverage is used by the participant, are $120 for individuals and $240 for families.

Procter & Gamble's current self-insured health care plan pays 100% of hospitalization and surgical costs for all employees, the spokeswoman said. The plan requires no contributions from employees, who also are not subject to annual deductibles.

The revised plan, which is to be administered by MetLife Health Care Network, a division of Metropolitan Life Insurance Co. of New York, is intended to reduce P&G's rising health care costs by shifting some of the burden to employees, according to a Procter & Gamble spokeswoman.

P&G's annual employee health care expenditures had nearly doubled to $113 million in 1987 from $60 million in 1982, the spokeswoman continued.

"What we hope to do is hold down the level of increases in coming years," she said.

Initially, FlexibleCare will be instituted for about 12,000 office employees at P&G's Cincinnati headquarters, and 5,000 sales personnel based in Cincinnati.

The plan eventually will be offered to most or all of the company's 44,000 employees as the MetLife PPO—which currently includes 13 hospitals and several hundred physicians in the Cincinnati area—expands to other areas of the country, the spokeswoman said.

P&G employees not located in areas serviced by the MetLife network will continue to receive hospitalization and surgical coverage under P&G's current self-insured indemnity plan.

Shipyard ESOP

About 400 shipyard workers in Seattle became the majority owners of an ailing marine services company Aug. 23 when it emerged from nearly two years in Chapter 11 reorganization.

The employees gained control of longtime family-owned WFI Industries Inc. through an unleveraged employee stock ownership plan that assures them ownership of no less than 73% of the company, according to company officials.

The current value of the ESOP is about $5 million, according to Darryl L. Schall, associate with Drexel Burnham Lambert, the investment banking firm that negotiated the deal.

Shares will be distributed to employees based on annual salaries up to $50,000 per year, he said, explaining that the cap is intended to keep ownership from being concentrated among higher paid workers.

The exact formula for distribution was still being worked out, he added.

In taking over the company, the new owners renamed it Unimar International Inc.

Unimar International remains a privately held company under the new ownership arrangement, he said.

Also, the ESOP has a unique feature—periodic buybacks of worker-held stock—which will assure that new workers have access to company ownership as well, Mr. Schall said.

While other ESOPs distribute shares to workers over a set number of years, the Unimar International plan turns shares over to employees over an indefinite number of years and allows the company to buy shares back at current value for distribution to newer workers, Mr. Schall said.

The ESOP was structured without any further debt by the trust. Instead, unsecured creditors who had claims against the former majority owners of the company dropped their claims in exchange for 7% of the new shares, Mr. Schall said.

Also as part of the bankruptcy court settlement, the company turned over some of its assets to secured creditors and has set up a leasing agreement for assets, such as equipment, with the creditors.

WFI Industries, stung by lagging shipyard business, filed for protection under Chapter 11 of the Federal Bankruptcy Act in 1986. Since then, the company has cut about 1,100 jobs from its payroll.

The company, which was founded in 1946, operates shipbuilding and repair yards and harbor and ocean towing services in the Puget Sound region.

Total assets, including equipment and shipyards, are valued at about $55 million, according to Mr. Schall.

•

Benefit beat keeps insurance and employee benefit managers informed on what other companies are doing and of current developments in the employee benefit field. We'd like to know if you've made any changes. Write Glenn Huntley, Business Insurance, 6404 Wilshire Blvd., Los Angeles, Calif. 90048; 213-651-3710.

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Opinions

What's the use?

EMPLOYERS ARE probably asking why it took the Internal Revenue Service seven years to draft and publish 401(k) plan regulations.

We don't pretend to have the answer. However, one has to wonder if the IRS used every day of those seven years to write regulations that couldn't possibly be more complex.

We're not suggesting that the gamut of 401(k)-related issues could have been dealt with in a few paragraphs or even a few pages. But was it really necessary for the IRS to produce 203 pages of proposed and final regulations that seem designed to intimidate rather than elucidate?

For example, the regulations lay out a lengthy series of tests that an employee must satisfy before making a hardship withdrawal of funds from a 401(k) plan while still working.

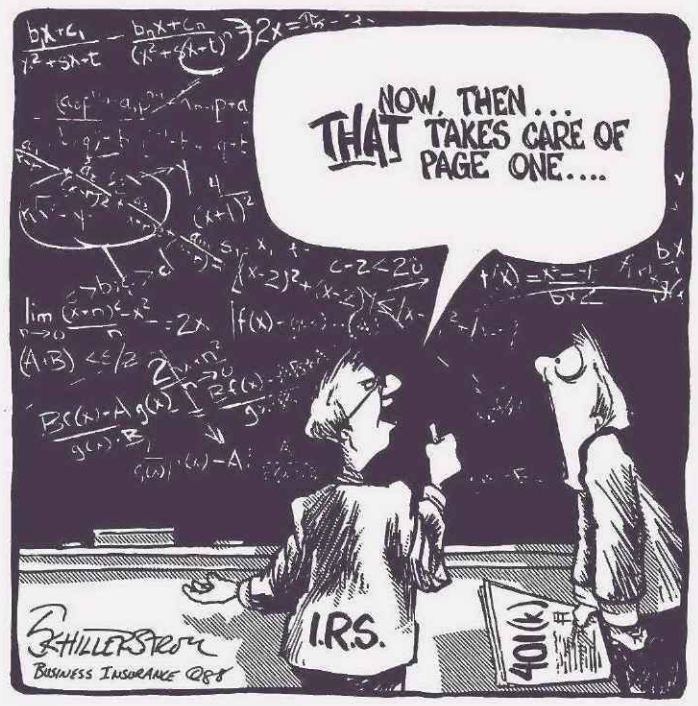
If the employer doesn't want to go through the time and expense to determine whether the employee is in financial need, the regulations set down an even more complicated set of safe harbors governing hardship withdrawals. Among other things, an employee would be barred from making any contributions to an employer's plans for 12 months, while the employee maximum deferral also would be reduced once this prohibition expires.

Why are such complications needed? Why couldn't the IRS simply have said that a plan participant must have a valid reason for withdrawing funds—like uninsured medical expenses or a child's college tuition bill—and left it at that?

No one could argue that those situations do not represent hardship. And, we doubt that employees would withdraw funds unless they absolutely had to because of the tax consequences. Plan participants that withdraw funds from 401(k) plans before retirement generally are slapped with a 10% excise tax over and above other federal taxes that would be due.

Similarly, the new proposed non-discrimination testing procedure that is to be used when a 401(k) plan offers employer matching contributions and/or aftertax contributions is a paragon of complexity.

Again, we wonder why a new complicated testing procedure is needed. The basic rules governing 401(k) arrangements, such as the current $7,313 maximum employee deferral limit, by themselves ensure that the plans will not discriminate in favor of higher-paid workers.



The new complicated rules will not kill 401(k) plans; the plans have become so popular that they are an established part of the employee benefit plan arena. But companies, especially smaller firms considering whether to offer a retirement plan for the first time, could be intimidated by the new rules and decide against offering a 401(k) plan.

The great appeal of 401(k) plans for employers has been the plans' ability to offer highly appreciated benefits at a low and predictable cost. And, for employees, 401(k) plans offer tax incentives, accessibility of funds when hardships strike and usually employer matching contributions. No wonder 401(k) employee participation rates often are as high as 80%.

The IRS has done its best to make the plans unattractive for both employers and employees. Fewer plans and smaller savings mean workers will have less savings for retirement, hardly a way to reduce dependence on public programs like Social Security.

Letters

Greed should not be industry's defense

To the editor: If I've read or heard it once, I've read or heard it 10 times in the last several months. The often-uttered defense by the insurance industry against allegations of conspiracy by attorneys general is: "Not possible, the insurance industry is *too greedy*."

Let's cut it out! We have a lot better defense than that. To sanctimoniously make such irresponsible statements in defense of the litigation, however casually, is irresponsible, untrue and feeds ammunition to insurance industry critics.

The lawsuits provide an excellent opportunity for the industry to explain itself, its process and its problems. The public will never have any better perception of the industry than the industry invites.

Little wonder the property/casualty insurance industry is misunderstood.

James H. Bryson
Bryson Associates Inc.
Jenkintown, Pa.

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Circle K *can* avoid federal regulations

To the editor: It appears that Circle K Corp. has reconsidered its position concerning lifestyle exclusions (*BI*, Aug. 22; Aug. 15). It is pragmatic, given the state of the AIDS controversy, to leave this issue alone for the time being. Circle K's attempt to influence lifestyle through its benefit plan is, however, very interesting.

In the current legislative climate, the proposals put forward by Circle K run contrary to the Consolidated Omnibus Budget Reconciliation Act of 1985 and Section 89 of the Internal Revenue Code. Circle K can, however, achieve exactly what it wants to achieve through its benefit program simply by becoming more creative.

I suggest that Circle K cancel its benefit plan entirely, then increase each employee's compensation by the equivalent of the corporation's benefit costs. Circle K then should invite insurance companies to submit proposals on individually underwriting each of its employees. The proposals from the insurance companies would have to guarantee that each applicant who applied within 31 days would be guaranteed coverage, but modified based on various demographic and health considerations. You could set limits such that the rate would not exceed three times the average rate, for example.

This type of program would guarantee that all employees had access to medical insurance coverage. It would also free Circle K from the burden of onerous government regulations.

Mark A. Mitchell
President
U.S. Benefit Consultants
Marietta, Ga.

Settlement by AIG was not $7.5 million

To the editor: I was amazed and shocked at the headline on page 29 of your Aug. 22 issue, "AIG Unit Settles Suit for $7.5 million."

The settlement by American International Group Inc. was not $7.5 million as the headline states.

I strongly believe that structured settlements, sensational headlines like these and the failure to try cases with thin or

Continued on page 10

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Letters

Continued from page 8

non-existent liability is what is causing verdicts to be so unreasonable.

C.T. Taylor
Director-Personnel Services
Illinois Power Co.
Decatur, Ill.

■ *Editor's note: As the article stated, it was a structured settlement valued at $7.5 million, costing $960,000 in cash.*

Few public entities are savvy buyers

To the editor: In response to Michael Natale's comments (*BI*, Aug. 15) on my article (*BI*, July 11), I can heartily agree that professionalism now exists in governmental risk management much more than it has in the past. The entire profession of risk management has made fantastic strides in the last few decades.

However, to say that the *majority* of public entities now bid their insurance intelligently is a somewhat more optimistic statement. Most public entities have never hired a risk manager. Their specifications and bidding procedures reflect that fact.

Reasonably priced liability insurance available during the hard market was not purchased eagerly by public entities because they perceived the price to be excessive. Compared with non-insurance competition—pools, plans, captives and other means of retaining risk—it was expensive, at least in terms of initial cost. What the final cost will be was not reckoned then and is not now. Against such competition, buyers comparing apples to kohlrabies, insurance was not purchased and more than one company withdrew its programs from the marketplace.

I am certain that a high level of competence would be evident among the attendees at the Public Risk Management Assn.'s annual meeting. However, what tiny portion of the public entities in the country are represented in such forums?

Public entities are not unique. One of the nice things about the insurance and risk management business is that progress can be noted but the amount to be done seems scarcely reduced. We still have a long, long way to go.

Charles A. McAlear
Arcadia, Mich.

Hunter and lawyers part of the problem

To the editor: Your Aug. 8 article, "Activists Declare War on Insurers," describes J. Robert Hunter as calling on trial attorneys to strike insurance companies with a barrage of lawsuits charging everything from bad faith to fraud to false advertising.

Mr. Hunter's simplistic cops and robbers, good guys vs. bad guys mentality obviously enables him to effectively pander to the apparently equally juvenile mentality of trial lawyers.

The vicious diatribes of Mr. Hunter and the plaintiffs' lawyers against the insurance industry point out a major source of the liability problems in the United States.

In their eagerness to milk dry the golden cow of liability insurance, Mr. Hunter and the plaintiffs lawyers lose sight of fair play and reasonable solutions to tort situations by seeking to defame the insurance industry and by perverting the law by continually and needlessly expanding the number of lawsuits.

It is appalling that the plaintiffs' bar, a group of people with above-average intelligence, chooses to overlook entirely their contribution to the worst liability environment in the world—a purposeful oversight arising out of their insatiable thirst for more contingency dollars.

It is understandable why some people refer to the practice of law as "the world's second oldest profession."

Frank C. Cavignac
Insurance Consultant
San Diego

Lawyers, insurers each are to blame

To the editor: The lawyers say the insurance companies are at fault and the insurance companies say the lawyers are at fault.

Your Aug. 15 editorial, "Unreconcilable Differences" gives your reasons for reporting about the Assn. of Trial Lawyers of America convention: You want risk managers and insurance companies to know what is being said about them in the opposing camp.

I submit that risk managers need to know that *both* the insurance companies and lawyers are at fault. The big noises each of these two groups make conceal from risk managers the fact that 75 cents out of every premium dollar they pay for personal injury liability insurance goes to lawyers and the insurance industry.

The lawyers are right about the insurance industry and the insurance industry is right about the lawyers. The tort/insurance system is outrageously expensive.

Eugene R. Anderson
Anderson Russell Kill & Olick P.C.
New York

Insurers' net income falls

NEW YORK—U.S. property/casualty insurers' net income decreased 7% in the first half to $7 billion from $7.5 billion in the first half of 1987.

However, pretax operating income increased 15% in the first half to $7.5 billion from $6.5 billion in the corresponding period of last year, according to consolidated industry estimates prepared by the Insurance Services Office Inc. and the National Assn. of Independent Insurers. The operating profit consists primarily of a pretax underwriting loss of $5.4 billion and pretax net investment income of $13 billion.

Underwriting losses grew 13% in the first half compared with a pretax underwriting loss of $4.8 billion in the first six months of 1987. Investment income in the first half rose 13.6% from $11.4 billion in the corresponding period of 1987.

The insurers reported a first-half aggregate combined ratio of 104.8% after policyholder dividends, a deterioration from 104.1% in the first half of 1987.

Net written premiums for the first half of 1988 totaled $99.9 billion, up just 3.6% from $96.5 billion in the first half of last year. Net written premiums grew by 13% in the fist six months of 1987.

Property/casualty insurers' surplus rose about 3.4% to $110.6 billion as of June 30 compared with $104 billion at year-end 1987.

The Tax Reform Act of 1986 helped account for the decrease in insurers' bottom-line earnings, ISO and the NAII point out. Property/casualty insurers reported a federal income tax liability of $2.1 billion in the first half, compared with $1.8 billion in the first half of 1986, despite a decrease in pretax net income. ■

London may set minimum rig rates

By CAROLYN ALDRED

LONDON—London marine underwriters may introduce advisory minimum rates for underwriters insuring North Sea oil rigs following the explosion of the Piper Alpha platform in July.

A minimum rating level is one option currently being discussed by the London market's Joint Drilling Rig Committee in an effort to bring some stability to the offshore insurance market following the explosion of the $790 million Piper Alpha platform, which killed 167 people (*BI*, July 11).

Nearly nine weeks after the disaster, the offshore insurance market still is in turmoil with widely differing rates quoted throughout the market, underwriters and brokers say.

'The drilling rig committee is considering a whole series of options including improving surveys of rigs as well as the possibility of introducing a minimum rate for rigs in the North Sea,' says Chris Rome of Lloyd's of London's Underwriters' Assn.

"There is complete confusion. The market is in turmoil," said Stephen Catlin, underwriter for marine syndicate 1003, managed by S.J.O. Catlin Underwriting Agencies Ltd. "The reality of the situation hasn't come home to roost."

Members of the joint rig committee, which includes underwriters from Lloyd's and the Institute of London Underwriters, have "spent hours in meetings with regard to rig ratings, terms and conditions," according to one underwriter.

"The drilling rig committee is considering a whole series of options including improving surveys of rigs as well as the possibility of introducing a minimum rate for rigs in the North Sea," said Chris Rome, chairman of Lloyd's of London's Underwriters' Assn., which represents marine underwriters.

Currently, minimum rating levels are used in the London marine market only for cargo insurance that is classified as a war risk and for cargo carried on ships more than 15 years old, said Geoffrey De'Ath, deputy secretary of the ILU.

For example, the Cargo War Risks Rating Committee advises minimum rates for cargo transported through war zones depending on how and in which area of the world the cargo is being transported.

The rates, although non-compulsory, usually are adopted by most London underwriters.

Peter Wingett, chairman of the drilling rig committee, and Deputy Chairman Peter Evans were unavailable for comment.

Other marine underwriters are divided over the merits of minimum rating levels for offshore risks.

"The question of rating levels is under discussion at the moment. One of the problems in trying to introduce a minimum rating level is that it ends up becoming a maximum rate," said Peter Chandler, underwriter for marine syndicate 483 managed by Methuen (Lloyd's Underwriting Agents) Ltd.

"It is totally impossible for us to impose a minimum level in a market where underwriters are free to undercut and commit suicide if they wish," said Richard Webb, underwriter for marine syndicate 1023, managed by Mander Thomas & Cooper (Underwriting Agencies) Ltd.

"A minimum rating level never works in a soft market. I don't believe that is the right way of approaching the problem," said Mr. Catlin.

However, "in some areas minimum rating would be feasible," argued Mr. Rome, adding that London underwriters probably would not introduce minimum rating before the International Union of Marine Insurance meeting in Sydney, Australia, later this month.

Meanwhile, some underwriters already are adopting individual minimum rates for North Sea oil rigs, brokers say.

"Many underwriters won't look at North Sea risks below a rate of about 1.2%" of insured value, said one broker.

In some cases this means a 100% rate increase, the broker said, adding that rate increases for North Sea risks typically are averaging about 25%.

However, most underwriters agree it is still too early to generalize about rating levels, pointing out that there is widespread confusion and disagreement in the market.

Many underwriters fear that North Sea rates are not increasing as much as they had hoped, while some underwriters are struggling to get any increase in offshore rates outside of the North Sea.

For example, while in the last few weeks a British oil company paid about 30% more for a North Sea rig renewal and a Norwegian rig construction company was hit with a 100% rate increase, a policy covering a drilling rig based off West Africa was placed at last year's rate, said Mr. Rome.

"We have led the (West African) risk for about seven years and there has never been a claim. In normal circumstances the policyholder would have expected a 25% reduction," he explained.

"One has to remember rates have dropped dramatically in the last two years, so we need to impose rate increases of about 50% to 100% just to get back to where we were," said Mr. Rome.

Meanwhile, one underwriter doubted whether the Piper Alpha has had any significant effect at all on direct rates.

"The North Sea insurance market is stabilizing a bit, but rates in some areas are still falling rapidly. I don't believe there has been any significant halt," said Mr. Webb.

However, "it is absurd to suggest Piper Alpha has had no affect. Rate reductions have been arrested," another underwriter countered.

"Everybody in the market is confused, the underwriters, the brokers and the clients," said Mr. Catlin. "Frankly, I believe the market's going to remain in a turmoil until people really realize the

Continued on next page

Minimum rates

Continued from previous page
full extent of the loss and underwriters start finding their reinsurance renewals are costing much more."

Meanwhile, compensation for victims of the Piper Alpha disaster could be higher than expected following agreement by the rig's operator to pay larger compensation payments than would be awarded in British courts.

Representatives of Occidental Petroleum Ltd. told lawyers representing most of the victims and their families on Aug. 24 that the company was prepared to offer compensation higher than liability awards normally handed out by British courts, though less than typical U.S. court awards, said David Burnside, a Scottish lawyer representing Piper Alpha victims.

Details of the likely compensation payments will be further discussed at a Sept. 13 meeting, he added.

Compensation for victims of the Piper Alpha disaster could be higher than expected.

Although Mr. Burnside would not go into details, observers suggested that individual payments would range between 300,000 to 600,000 pounds ($504,000 to $1 million).

Meanwhile, Mr. Burnside did not rule out litigation if claimants are not satisfied.

"We would probably sue for negligence in the state of Texas, where Occidental has operations," he said.

Occidental, meanwhile, has stated that it will resist any litigation in U.S. courts. ■

Two rulings cloud hazard rule

By DEBORAH SHALOWITZ

WASHINGTON—Although the Occupational Safety and Health Administration began enforcing the newly expanded federal hazard communication standard Aug. 1, controversies about the standard are still raging.

Both OSHA and one panel of the 3rd U.S. Circuit Court of Appeals maintain that employers in the construction industry currently do not have to comply with the hazard communication standard, based on a July 8 decision of the panel (*BI,* July 18).

However, a different panel of the 3rd Circuit, apparently unaware that some members of the 3rd Circuit in Philadelphia already had ruled on the issue, said Aug. 19 that the construction industry is not exempt.

Representatives of the construction industry Aug. 23 filed a motion to amend the second panel's judgment, arguing that a valid decision had already been made regarding a temporary exemption for the construction industry.

"It is a very confusing situation," commented Robert Peyton, safety and health services director for the Associated General Contractors of America in Washington, one of the parties that filed the suit. "Somebody's going to have to untangle this mess."

An OSHA spokeswoman said the agency, abiding by the first appellate panel's decision, is not enforcing the standard for the construction industry.

According to a clerk for the 3rd Circuit, the second panel of judges issued its opinion in a case originally brought in 1983 against OSHA by the United Steelworkers of America.

The first panel of judges issued its order staying the standard for the construction industry in a 1988 case against OSHA by Associated Builders & Contractors Inc. That suit, originally was filed in a federal court in Washington, D.C., was sent to the 3rd Circuit for consideration.

The federal worker right-to-know rule, which was expanded last year to include non-manufacturers, requires employers to inform workers of potential hazards in the workplace and to label all potentially hazardous materials (*BI,* May 16).

The second panel of the 3rd Circuit also ruled Aug. 19 that OSHA should begin enforcing three provisions of the hazard communication standard that the federal Office of Management and Budget did not approve when it reviewed the rule in October 1987.

The 3rd Circuit panel said the OMB, in rejecting the three provisions of the rule, had overstepped its authority to review federal regulations.

The Justice Department, on behalf of OSHA and the OMB, last Friday filed a petition for rehearing.

Meanwhile, the OSHA spokeswoman said that "at this point, we are not enforcing (the three provisions), although the court said to."

OMB deemed the following regulations would create undue paperwork:

- A requirement that material safety data sheets be provided at multiemployer worksites.

An MSDS details a substance's properties and the nature of the hazard presented by the substance.

- A requirement that certain consumer products that are not considered "hazardous chemicals" under the Superfund Amendments and Reauthorization Act be covered by the standard.
- A requirement for the nonmanufacturing sector that drugs regulated by the Food and Drug Administration be covered by the standard.

At the OMB's direction, OSHA on Aug. 8 published in the Federal Register several clarifications to the hazard communication rule and asked for comments on the three disputed provisions.

In that notice, OSHA suggested:

- Clarifying that retail distributors do not have to maintain material safety data sheets for hazardous chemicals unless employees use the chemicals themselves or unless the distributor supplies those chemicals to commercial accounts, generally in large quantities and at below-retail prices.
- Changing the definition of a material safety data sheet so that a package insert approved by the Food and Drug Administration or an entry in the Physicians Desk Reference, a guide to pharmaceuticals, would meet the requirement for an MSDS for a drug product in the non-manufacturing sector.
- Broadening the exemption for retail food and alcohol to include food and alcohol prepared for consumption, as well as those packaged for sale.

Despite the second appellate panel's ruling, OSHA is continuing with the formal rulemaking process it began last month.

Comments on the proposal must be submitted in quadruplicate by Oct. 7 to the Docket Officer, Docket H-022D, Occupational Safety and Health Administration, 200 Constitution Ave. N.W., Room N-2439, Washington, D.C. 20210; 202-523-7894.

There also will be a hearing on the proposal Nov. 15 at 9:30 a.m. in the Labor Department auditorium at the address above. Notices of intent to appear at the hearing must be received in quadruplicate by Tom Hall at OSHA's Division of Consumer Affairs, Room N-3647 at the address above. The phone number is 202-523-8615.

Markets

Reliance establishes risk management unit

Reliance Insurance Cos. of Philadelphia is creating a new risk management division.

Reliance Risk Management will provide a variety of risk management services to Fortune 1,000 companies.

The division was formed by spinning off the section of the Reliance Specialty Programs division that provided risk management services. Previously, Reliance Specialty Programs was known as Reliance Risk Management (*BI*, Nov. 16).

The new risk management division is targeting its services at insurance programs that generate high premiums, require relatively large self-insured retentions, high deductibles, unbundled claims and specialized loss control services and include high-hazard exposures.

Senior Vp Mario P. Vitale, who will direct the new operating unit, previously was vp-underwriting at Reliance Specialty Programs.

"We are willing to look at potential insureds' requests in a non-traditional fashion, and we're committed to approaching each insured's problems—which, at this level, are inevitably different from those of any other insured—in creative ways," said Mr. Vitale.

The new division is located in the Reliance Group headquarters at 4 Penn Center Plaza, Philadelphia, Pa. 19103; 215-864-4000.

New intermediary

Cooper Gay Steele & Co. Ltd., a unit of London broker Cooper Gay (Holdings) Ltd., has been licensed in New York to act as a reinsurance intermediary.

Cooper Gay Steele will place all classes of reinsurance for clients in North America and overseas.

The company was licensed by the New York Insurance Department in May and began operations on Aug. 1.

R. Patrick Steele, who most recently was senior vp at Thomas A. Greene & Co. Inc., the reinsurance brokerage subsidiary of Alexander & Alexander Inc. in New York, has been named president of the intermediary.

Mr. Steele, who has more than 20 years' experience in the industry, began his career as a Lloyd's broker.

Cooper Gay Steele is located at 120 Wall St., New York, N.Y. 10005; 212-248-1150.

MM&D expands

Employee benefit consultant Miller, Mason & Dickenson Inc., a unit of Aon Corp. of Chicago, has established its first West Coast operation.

The employee benefits departments of Rollins Burdick Hunter Co., Aon's brokerage subsidiary, in San Francisco, Palo Alto and Oakland, Calif., are now MM&D offices.

The new MM&D offices will not change location; however, they will now be run under the auspices of MM&D.

For more information, contact Jerald Kleinberg, head of the Palo Alto, Calif., office at 2595 E. Bayshore Blvd., P.O. Box 51110, Palo Alto, Calif. 94303; 415-856-6500.

New group life unit

Blue Cross & Blue Shield of Florida has formed a new group life insurance company, Florida Combined Life Insurance Co.

Based in Jacksonville, Fla., the new company has $1.75 million in capital and surplus and expects to write $10 million in premium volume by the end of 1989.

"Our products will be packaged with Blue Cross & Blue Shield of

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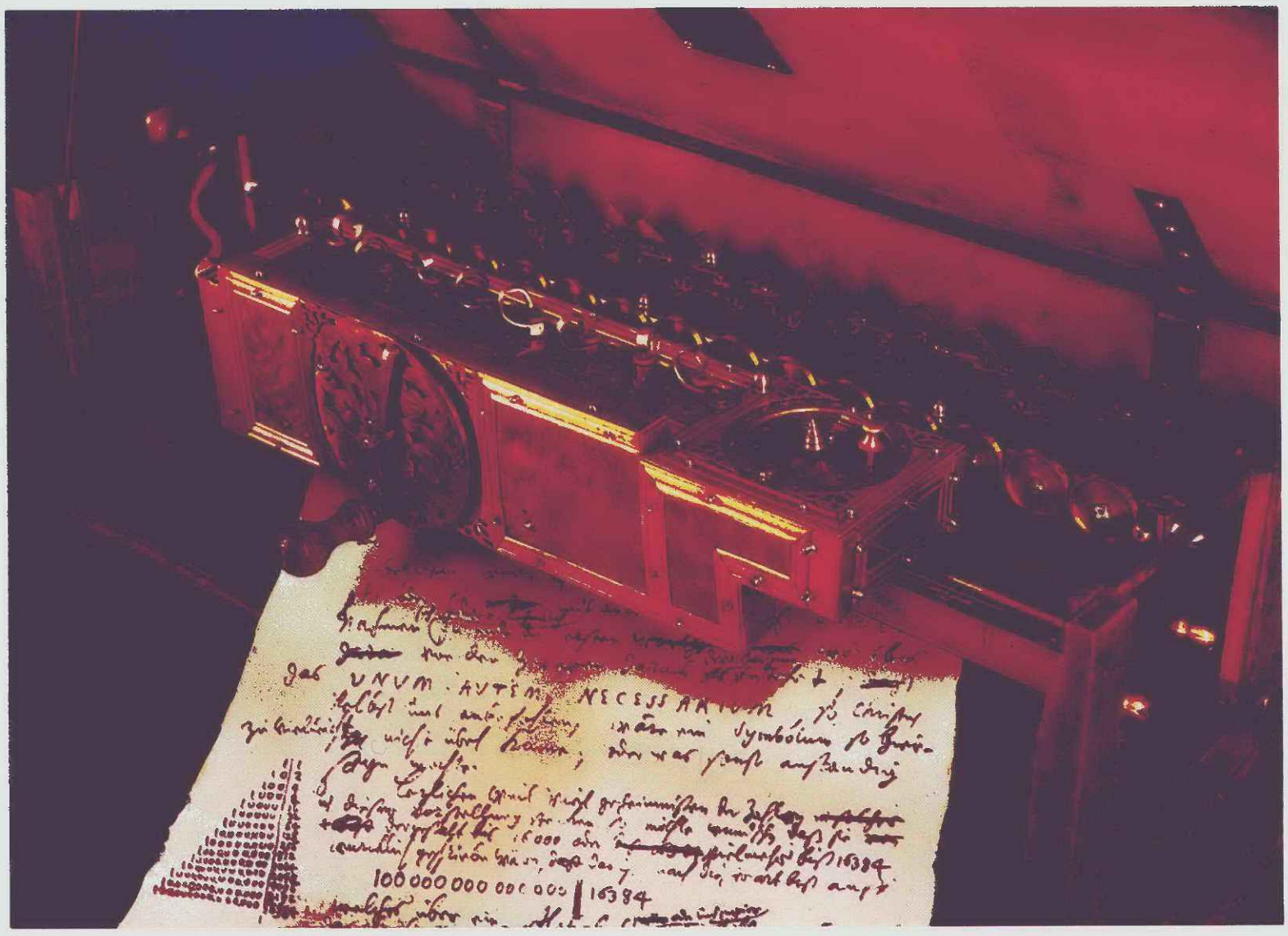

Markets

Continued from previous page
Florida's health products to enhance the company's ability to meet the needs of its customers," said Walter T. Liptak, president and chief operating officer of Florida Combined Life.

Florida Combined Life will market its products to Blue Cross & Blue Shield of Florida's existing employer groups as well as to new customers. Employers will have the choice of purchasing the employee health and life benefits as a package or separately.

For more information, contact Mr. Liptak at 532 Riverside Ave., Jacksonville, Fla. 32231; 904-791-6111.

New consultant

Gene C. Witherspoon, formerly assistant director of insurance company regulation at the Florida Department of Insurance for eight years, has opened his own consulting practice in Coral Gables, Fla.

International Insurance Associates Inc. will help clients form and manage captive insurance companies, as well as assist in reinsurance placements. In addition, the company also will offer consulting services to insurance companies in Florida and other states.

Prior to working for the Florida Insurance Department, Mr. Witherspoon served as an insurance examiner with the Tennessee Department of Insurance for more than two years.

International Insurance Associates is located at City National Bank Building, 2701 LeJeune Road, Suite 403, Coral Gables, Fla. 33134; 305-448-9319.

Travelers expands

Travelers Corp. of Hartford, Conn., has expanded its preferred provider network to four regions.

Travelers Preferred-Dallas/Fort Worth has 19 hospitals and more than 450 physicians in its provider network.

Travelers Preferred-Pittsburgh/Southwestern Pennsylvania has 13 hospitals and more than 650 physicians in its provider network.

Travelers Preferred-Hampton Roads has seven hospitals and more than 400 physicians.

Travelers Preferred-Twin Cities in Minneapois/St. Paul has 12 hospitals and more than 900 physicians.

All the Travelers PPOs include the Patient Advocate utilization review program and the Taking Care wellness program.

For more information about Travelers Preferred-Dallas/Fort Worth contact Bill Phelps, 433 E. Lascolines Blvd., Suite 750, Irving, Texas 75039-9990; 214-506-0000.

For information about Travelers Preferred-Pittsburgh/Southwestern Pennsylvania, contact Marilyn Nixon, 1 Chatham Center Office Building, Pittsburgh, Pa. 15219; 412-456-4750.

For information about Travelers Preferred-Hampton Roads contact Dr. Claude A. Smith, 100 W. Plume St., Norfolk, Va., 23510; 804-622-6711.

For more information about Travelers Preferred-Twin Cities contact Margaret Foster, associate director, Travelers Health Network, 2600 Michelson Dr., Suite 600, Irvine, Calif. 92715-1507; 714-553-9444.

Name changes

Yukon Indemnity Co. of McPherson, Kan., has changed its name to **Alliance Indemnity Co.**

Bankers Life Nebraska in Lincoln, Neb., has changed its name to **Ameritas Financial Services.**

Multicontinental Reinsurance of Brussels, Belgium, has changed its named to **Lincoln European Reinsurance Co.**

Mergers/acquisitions

Alternative Health Care Systems Inc. of Naugatuck, Conn., has acquired a controlling interest, 51% of the stock in **Columbia Management Co.**

W.R. Berkley Corp. of Greenwich, Conn., has acquired the business of **North Star Risk Services Inc.**

North Star is a Minneapolis-based consulting firm that specializes in the development and administration of alternative risk financing techniques.

Bertholon-Rowland Corp., a New York-based brokerage, has acquired **Safe Passage International**, a Washington, D.C.-based brokerage that specializes in insurance for the travel industry.

New offices

Computations Inc. and **Dyer Wells & Associates** have merged their offices to a single location at 2500 Windy Ridge Parkway, Marietta, Ga. 30067; 404-952-7854.

The North American Co. for Property & Casualty Insurance, the operating subsidiary of NAC Re Corp., has opened its first office at 90 State House Square, Hartford, Conn 06103; 203-293-6200.

The Indianapolis branch of **Crum & Forster Commercial Insurance** has moved to 5750 Castle Creek Parkway N., Suite 300, Indianapolis Ind. 46250; 317-577-1787.

Alexander Howden North America has opened a new office at 101 California St., Suite 4650, San Francisco, Calif. 94111; 415-362-4195.

F&G Markets Inc. has relocated its Hartford, Conn., branch office to the USF&G headquarters at 100 Light St., Baltimore, Md. 21202; 301-547-3000.

Surplus Underwriters Casualty Insurance Co. has relocated its offices to 3131 Eastside, Suite 545, Houston, Texas 77098 713-522-6533.

California Interactive Computing Inc., an insurance software maker, has moved its headquarters to 8550 Balboa Blvd., Suite 180 Northridge, Calif. 91325; 818-895-5500.

The New Hampshire Insurance Group of Costa Mesa, Calif. a unit of American International Group Inc., has opened a new office at 695 Town Center Drive Suite 400, Costa Mesa, Calif 92626; 714-540-8777.

Brougher Insurance Group Inc. has relocated its corporate headquarters to 525 S. Meridian, Indianapolis, Ind. 46225; 317-634-7566. ■

Vermont captive conference

Vermont growth continues unabated

By JERRY GEISEL

STOWE, Vt.—Despite the softening commercial property/casualty insurance market, Vermont continues to add to its lead as the largest domestic captive insurance company domicile.

Since the start of this year, the Vermont Department of Banking and Insurance has licensed 25 captives, including 12 since April (*BI*, April 18).

Excluding several captives that were previously licensed but never began operations, Vermont now has 133 captives, a roster that far and away overshadows the other domestic domiciles.

Colorado, the second-largest domestic domicile, has 27 captives, many of which didn't write any business in 1987. Other states with captive statutes, including Delaware, Hawaii, Illinois and Tennessee, have a combined total of about 20 captives.

"We are the preferred domestic domicile for captives," Vermont Gov. Madeleine Kunin said before the annual meeting of the Vermont Captive Insurance Assn. held Aug. 23-24 in Stowe, Vt.

"Captive insurance companies are our pride and joy" as part of Vermont's rapidly growing financial services industry, Gov. Kunin added.

And, there are no signs that captive growth in Vermont is likely to trail off anytime soon, experts say.

"This is an industry that will keep growing. I see nothing but a bright future for Vermont captives," said Edward Meehan, director of financial examinations for the Vermont Department of Banking and Insurance.

"The growth is continuing. Employers and organizations are continuing to form captives in Vermont," said Johnson & Higgins Vp Arthur Koritzinsky.

Mr. Meehan

In fact, during recent months, the Department of Banking and Insurance has been licensing new captives at a rate of three to four per month.

Insurance Commissioner Gretchen Babcock says it is quite possible that another 15 captives could be licensed in the remaining four months of the year, bringing to 50 the number of new captives licensed in 1988.

If that happens, the 1988 licensing activity would tie the 1987 record when 50 captives also were licensed.

Ms. Babcock

Judging by the attendance at the Vermont Captive Insurance Assn. meeting, there are plenty of service providers who are betting that Vermont's captive growth will continue.

Indeed, the meeting was awash in representatives from banks, investment managers, accountants and law firms all eager to do business with a captive community that should produce a premium flow this year of more than $500 million.

Changes, though, are expected, in the type of captives that will be organized, state officials and captive managers say.

During the first three months of the year, five of Vermont's 13 new captives were risk retention groups —special types of multiple owner captives that, under provisions of the expanded federal Risk Retention Act, can do business nationwide after being licensed in one state.

However, of the 12 captives licensed since the start of April, just three have been risk retention groups, a downward trend that is expected to continue.

Indeed, even in a tight property/casualty market, the cooperation needed to make group arrangements, such as risk retention groups, succeed can be elusive.

In a soft market, interest in risk retention groups really falls off, Ms. Babcock said.

And, the soft market has taken its toll on risk retention groups already established.

Of the 25 risk retention groups that have been licensed in Vermont, at least five, or 20%, have either withdrawn or are inactive because they could not raise sufficient capital.

But other risk retention groups, especially those that had an established track record, have thrived in Vermont and have become some of the state's largest captives.

For example, MEDMARC Insurance Co. Risk Retention Group Inc., which, on the last day of 1986, became the the first captive insurance company to come ashore under the expanded federal Risk Retention Act (*BI*, Feb. 2, 1987), produced net written premiums of $23.7 million during its first year in Vermont.

That premium volume makes MEDMARC, which provides product liability coverage to some 420 medical equipment manufacturers, one of the largest Vermont captives. It also compares favorably to 1986 net premiums of $13 million when

Continued on next page

Vermont captives

Continued from previous page

the company—then known as MEDMARC Ltd.—completed its last year of operations in Bermuda, where it started in 1979 as a group-owned captive.

Relocating to Vermont from Bermuda has reduced the logistical and communications problems that MEDMARC experienced offshore, said MEDMARC President Jaxon White.

Mr. White

Single-parent and small group captives, though, are expected to comprise the bulk of Vermont's growth—at least in the near future—captive managers and state officials say.

J&H's Mr. Koritzinsky expects captives to be set up in speciality areas where coverage in the commercial market still is tight, such as errors and omissions, surety and directors and officers liability insurance.

While Vermont officials are proud of the captive growth that has occurred—in both tight and soft markets—they are not resting on their laurels.

"We are very satisfied with the growth that has taken place, but we know we have to work harder to stay No. 1," Ms. Babcock said.

She said Vermont is boosting the resources needed to support a growing captive industry.

Over the last year, Ms. Babcock told the VCIA, Vermont has gone from essentially a one-person regulation of captives—Mr. Meehan—to creating an entirely new section within the Department of Banking and Insurance with captive regulation as its sole responsibility.

Since the start of the year, six new positions in the captive section have been created and filled, including four examiners.

"We have made the commitment. We have the resources to support the growth," Ms. Babcock said.

"This is no longer a one-person operation. Captive regulation has a full identity of its own," she added.

Ms. Babcock commends Vermont's banks, an industry once criticized by risk managers for its insensitivity to captives insurer' needs, for taking a much more active interest in providing captives with necessary financial services.

Aside from having such a large staff whose only responsibilities are captive insurer licensing and regulation, the Vermont captive section actually has offices separate from the Department of Banking and Insurance.

The new captive offices, totaling about 2,500 square feet including a large conference room where risk managers and captive managers can meet with state examiners, are located in a new office building in Montpelier, the state capital.

This impressive state regulatory infrastructure is supported by a financial base that makes Vermont unique as a domestic captive domicile

Under a 1987 law, the department receives 7.5% of the premium taxes paid by captives. These funds can only be used for captive regulation.

This financial base assures that as the number of captives grows, the state will have the funds needed to hire additional staff.

At the same time, Vermont is doing more to publicize what the state has to offer as a captive domicile Ms. Babcock said.

There are plans, for example, to publish a newsletter to keep current and prospective captives abreast of the latest captive developments in Vermont, she said.

In addition, Vermont officials have had more discussions with captives and managers to fine-tune the captive application process.

At the same time, plans are being developed for Vermont colleges and universities to offer courses and symposiums on captive and other insurance issues, she said.

Ms. Babcock commended Vermont's banks, an industry once criticized by risk managers for its insensitivity to captives' needs, for taking a much more active interest in providing captives with the necessary financial services.

"The banks have done a tremendous job in serving captives" she said.

In addition, Vermont now has a number of law firms that have developed captive expertise, she said.

However, Ms. Babcock said the state still needs to attract more actuarial firms.

Looking back over the seven years since Vermont enacted its captive statute, and the huge growth in captives, Ms. Babcock said the Department of Banking and Insurance's guiding philosophy toward captive regulation has not changed.

"There has been stability over time. Fairness and objectivity. That will never change," she said.

Mr. Chaffee

"The captive law and its implementation has worked pretty much the way it was supposed to have," added George Chaffee, a former Vermont insurance commissioner and now president of Champlain Risk Services Inc., a captive management company in Burlington, Vt. ■

Captive meeting attracts 200

STOWE, Vt.—Overcast skies and light showers didn't dampen the enthusiasm of the 200 people attending the Vermont Captive Insurance Assn. conference held Aug. 23-24 at the Topnotch Hotel in Stowe, Vt.

Captives have become one of Vermont's fastest growing industries. Indeed, Vermont's current captive roster has swelled to 133 since the state's captive statute was enacted in 1981.

Membership in the VCIA, which now has about 85 members, is open to Vermont captives and managers. Annual dues are $100.

The VCIA represents the state's captive industry on regulatory and legislative issues. The association also has helped sponsor booths at annual Risk & Insurance Management Society conferences.

"The VCIA can serve you better than any other organization," Vermont Insurance Commissioner Gretchen Babcock told attendees.

More information about the organization is available by writing the Vermont Captive Insurance Assn., Box 13, 7 Burlington Square, Burlington, Vt. 05041.

—By Jerry Geisel

Guaranty funds may tap captives: Greene

STOWE, Vt.—Captive insurance companies could be targeted to share some of the commercial property/casualty insurance industry's growing assessments from state guaranty funds, a prominent attorney warns.

"The commercial industry will challenge your freedom from their burden," Donald J. Greene, a senior partner with the New York law firm of LeBoeuf, Lamb, Leiby & MacRae, told the Vermont Captive Insurance Assn. at the group's annual meeting in Stowe, Vt., last month.

State guaranty fund assessments, which have hit record levels, are expected to continue increasing. These assessments will further reduce insurers' surpluses, which already are being shrunk by the higher tax burden faced under the Tax Reform Act of 1986, Mr. Greene said.

As guaranty fund burdens rise, commercial insurers will try to focus attention on captives to "help with the social burden they are now absorbing alone," he said.

"Keep your eyes open" to such proposals, Mr. Greene said, predicting that such proposals would most likely surface first in the larger, more commercial states.

Mr. Greene

It would be an ironic twist, though, if the industry does exert pressure on legislators and regulators to tap captives to help pay for guaranty fund assessments.

The insurance industry successfully lobbied Congress in 1986, when legislators were drafting the expanded federal Risk Retention Act, to keep risk retention groups out of guaranty funds. At the time, insurers said they did not want to pay for the failures of RRGs.

Another speaker told the VCIA that even the most astute financial observers have been taken by surprise when an insurance company fell into financial difficulties.

Douglas Olson, a managing director with the Philadelphia Insurance Research Group Inc., cited Baldwin-United Corp. of Cincinnati, and GEICO Corp., the Washington, D.C.-based insurer, as examples of insurers that were a hit with most stock analysts and Wall Street before encountering severe financial problems. However, GEICO, after flirting with insolvency in the mid-1970s, later went on to a spectacular financial recovery.

Mr. Olson said there is plenty to be learned from the past failures of insurance companies. A common theme to many failures is what Mr. Olson described as management ambition.

Management may be unable to resist calls from advisers that go along these lines: "I have this great opportunity for you to grow. We've been in this business for years and never paid a claim," he said.

Ambition, within reasonable limits, is not bad, Mr. Olson said. But too much ambition may lead a company into lines of business that it has no experience in and that it cannot handle.

"A company may not have the administrative systems to stay on top of the business and know what is going on," Mr. Olson said.

In fact, a good warning sign that an insurer may face future financial problems is rapid expansion into new lines.

"It could be a case of a California workers compensation insurer suddenly offering umbrellas," he said.

Another tell-tale sign of looming financial problems is consistent rate cutting. Mr. Olson cited the example of an insurer that quoted a $10,000 premium on a $10 million policy when others were quoting premiums in the $60,000 range. That insurer later went insolvent, he said.

When an insurer's quotes are out of line, risk managers should be skeptical. "Can you believe that one company's underwriting was superior and knew something that the rest of the industry did not?" Mr. Olson asked.

Other signs of possible future financial problems are heavy debt incurred by an insurer and changes in established relationships, such as major changes in reinsurers, Mr. Olson said.

—By Jerry Geisel

Investments need attention

STOWE, Vt.—Selecting an investment manager for a captive can be a tedious but important process, says an investment consultant.

In view of the large amount of assets held by captives, "Investment management is vital," Donald Hardy, senior vp with Frank Russell Co., a Tacoma, Wash.-based investment manager consultant, told attendees of the Vermont Captive Insurance Assn.'s annual meeting in Stowe, Vt., last month.

When reviewing investment managers, employers with captives first should obtain some basic information about the firms. Such information, Mr. Hardy said, should include:

- The amount of money the investment manager manages.
- The profitability of the organization.
- The firm's growth pattern.

"Too much growth can be damaging if (the firm is) not staffed to take on the additional business. New business should not overwhelm the company," he said.

In addition, an employer should ask an investment manager for a copy of its code of ethics. Such a code should be in writing and given out upon request, he said.

"If it doesn't exist, you should ask why," he said.

Of course, an employer also will want to use objective criteria, such as a common stock market index, like the Standard & Poor 500, to measure the investment manager's performance, he said.

Still, there should not be a "blind" reliance on performance standards. "A firm could simply be lucky over a short period," he said.

For example, the investment manager may have invested heavily in new issues at a time when new issues were hot.

In general, though, objective measurements are most useful when gauging performance over longer periods of time.

"The longer the measurement, the more indicative it will be of management ability," Mr. Hardy said.

In addition, an employer should get a sample—with a wide range of size—of how managed accounts performed.

"It is a lot easier to show impressive results with a $200,000 account than a $200 million account," he said.

—By Jerry Geisel

56th annual ARIA meeting

Push to increase regulation may spread, insurers fear

By MARK A. HOFMANN

The insurance industry faces an 'accountability and credibility crisis,' asserts John B. Crosby, senior vp and general counsel of the National Assn. of Independent Insurers. 'We talk about who the proponents are rather than the issues.'

RENO, Nev.—Attempts to subject insurers to greater regulation, such as the auto insurance reform movement in California, are likely to spread to other states, insurers fear.

If the pro-regulation forces prevail in California, "we'll probably face another assault on state regulation," predicts John B. Crosby, senior vp and general counsel of the National Assn. of Independent Insurers in Des Plaines, Ill.

And, even if the propositions calling for greater industry regulation are defeated in California, the push for restraints on the insurance industry will continue on other fronts, he warned.

At a session held last month during the 56th annual meeting of the American Risk & Insurance Assn. in Reno, Nev., Mr. Crosby and other speakers urged the gathering of insurance and risk management educators to research such topics as insurer profitability and the effects of regulation on insurance availability.

Three of the four insurance-related propositions slated for the November ballot in California reflect mistrust of the insurance industry, said Richard J. Haayen, chairman and chief executive officer of Allstate Insurance Co. of Northbrook, Ill.

By signing petitions to get initiatives—including one proposed by the insurance industry—on the ballot, "the people of California are saying, 'We've given all of you time to solve these problems, and you've failed us,' " he said.

But, being under fire from so many quarters has not been all bad for the industry, according to Mr. Haayen. Insurers have now learned to band together as a result of the California ballot questions, he said.

The industry is simply not very cohesive, Mr. Haayen observed. "Because we couldn't agree among ourselves and other key groups, we now face open warfare," he said.

In dealing with the California situation, Mr. Haayen said, insurers must remember that "the customers are not the enemy of the companies. If our proposals are to be accepted, we must get the support of the consumers; we must champion the customers' cause."

The four propositions seeking insurance reform in California are:

- Proposition 100, supported by the California Trial Lawyers Assn., which—among other things—would mandate a 20% discount for good drivers and roll back personal automobile rates 20% below January 1988 levels. In addition, the proposition would require prior approval for rate increases of more than 7.5% for personal lines and 15% for commercial lines.
- Proposition 101, sponsored by Assemblyman Richard Polanco, D-Los Angeles, which—among other things—would cut auto bodily injury insurance rates in half and tie future rate hikes to increases in the Consumer Price Index.
- Proposition 103, sponsored by the Santa Monica, Calif.-based consumer group Access to Justice, which—among other things—would roll back all property/casualty rates to 20% below November 1987 levels for one year and require prior approval for rate increases after that.
- Proposition 104, sponsored by the Assn. of California Insurance Companies, which—among other things—would cut auto insurance rates an average of 20% under a new no-fault system (*BI,* June 20; June 6; Feb. 29).

The insurance industry faces an "accountability and credibility crisis," asserted Mr. Crosby, who is currently on leave from the NAII to serve as executive vp of the San Francisco-based Insurance Industry Initiative Campaign Committee, which backs Proposition 104.

"We talk about who the proponents are rather than the issues," he added.

Continued on page 20

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Regulation

Continued from page 18

Mr. Crosby called upon his audience to help the industry clarify what he called the "real issues" by gathering and interpreting data to show that, contrary to public belief, insurer profits are relatively low when compared with those of other industries.

In addition, there is a misperception that the industry is undertaxed, according to Mr. Crosby. In fact, the Tax Reform Act of 1986, which requires insurers to pay at least a minimum tax, will cost insurers an additional $15 billion in taxes over the next five years, he said.

Scott E. Harrington, professor of insurance and finance at the College of Business Administration at the University of South Carolina in Columbia, agreed with Mr. Crosby's assertions that the industry is not making excessive profits at the expense of insurance buyers.

"There's a strong case to be made that we've got a very competitive industry," he said, adding that he knew of no academic study that showed insurers earning excessive profits.

If the propositions backed by the California Trial Lawyers Assn. and Access to Justice pass, insurance pricing will move from the marketplace to the political arena, Mr. Harrington warned.

Mr. Harrington was particularly critical of Access to Justice's Proposition 103, which has the backing of consumer activist Ralph Nader. That proposition's proponents "reject cost-based pricing," he said.

"I think these types of provisions are an invitation to a disaster," he said. If the no-fault initiatives are passed, insurers could withdraw from the private auto insurance market, he said.

But, according to Allstate's Mr. Haayen, it is "very unlikely" that insurers will pull out of California, as some did in Massachusetts (*BI,* Nov. 23, 1987; Oct. 19, 1987).

While Mr. Harrington favored the insurer-supported, no-fault proposition over the others, he added that the insurance industry is not without its shortcomings.

"I think, to some extent, the industry could be faulted for waiting until there was a crisis in California" to present its case to the public, Mr. Harrington said in an interview after the panel discussion. "Once premiums go up, all consumers want is relief."

The affordability problem in California can only be resolved by controlling claims costs, he said, and insurers find themselves in a bit of a conflict of interest when they find controlling claims costs may also mean reducing premium income.

Still, if insurers face particularly vocal opposition to no-fault plans and tort reform efforts, they ought to take the long-term approach and promote legislative efforts to reduce claims costs—even if it means lower premium income—Mr. Harrington asserted.

Insurers need to find ways to provide real premium relief through reduced claims cost without saddling consumers with extra, unwanted coverage costs, he said.

The fourth speaker, Nevada Insurance Commissioner David A. Gates, also asked the insurance and risk management educators for help—help in devising better regulatory models for those overseeing the industry.

The issues being decided in California will not vanish, even if the pro-regulation initiatives win, said Mr. Gates, who is also president-elect of the National Assn. of Insurance Commissioners. Instead, they will be faced throughout the country, again and again, he said.

The discussion was moderated by Terrie Troxel, senior vp-information and data division for the NAII. ■

Demographics to influence insurers: Panel

By MARK A. HOFMANN

RENO, Nev.—The life/health insurance industry will increasingly decentralize during the next decade as it seeks to tap hitherto ignored markets.

That was the consensus of a panel projecting the state of the life and health insurance industry in the 1990s during the 56th annual meeting of the American Risk & Insurance Assn. in Reno, Nev., last month.

In the past, "we insured traditional families like the Nelsons and Cleavers of TV fame," said William E. Kingsley, executive vp of the American Council of Life Insurance in Washington, D.C. But changing demographics have rendered that simple family obsolete, Mr. Kingsley said.

Several major population shifts will affect the life insurance industry in the 1990s and beyond, Mr. Kingsley said. These include the transformation of the so-called Baby Boom generation from a youth-oriented market to a middle-aged one.

The aging of the Baby Boomers means that the "coming decade will be one of greatly expanded income for them," Mr. Kingsley said. Life insurers cannot afford to ignore this market, which encompasses about 75.8 million people or roughly one out of every three Americans, he said.

Many Baby Boomers will achieve their peak earning power in the 1990s, Mr. Kingsley said. These people also will hit the peak of their asset-building ability, he said.

"As the Baby Boom enters middle age, many will start to worry about preparing for their children's college education and at the same time be worrying about their own retirement," he said.

"This presents a growing opportunity for the financial services business to provide products that meet the needs of the various Baby Boom segments," he predicted.

The lengthening of the average American's lifespan and the consequent growth of the elderly population is another demographic change that will have a profound impact on the nation's life and health insurance industry, Mr. Kingsley said.

The major challenge of increased longevity is helping people "prepare for the financial consequences of living too long," he said. For example, there were about 1.2 million Americans in nursing homes in 1980, according to Mr. Kingsley.

By the year 2000, that number will increase by 1 million, he said.

Other population trends affecting the life/health insurance industry are changes in the make-up of American households to include more working mothers, and more non-traditional families led by single parents and those in which both parents work, Mr. Kingsley said.

Continued on next page

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The development of new marketing strategies will be accompanied by streamlining home office staffs and services, pointed out Henry J. Brink, insurance consultant for International Business Machines Corp. in Atlanta.

"We will see the traditional home office diminish in importance," he said.

"We will take layers of management out of insurance," Mr. Brink said. The increasing sophistication of electronic data processing equipment will allow insurers to transfer more and more tasks to expert systems relying on artificial intelligence, he said. Artificial intelligence will perform an ever-increasing role in claims, underwriting and investment decisions, Mr. Brink said.

William H. Rabel, senior vp of the Atlanta-based Life Office Management Assn., agreed that automation will play an increasing role in the future.

After reviewing the results of a joint LOMA/Arthur Andersen & Co. study titled "Insurance Industry Futures: Setting a Course for the 1990s," (*BI*, Aug. 1), Mr. Rabel said that insurers will invest heavily in expert systems and computer-aided software to remain competitive.

At the same time, an increasing amount of decision-making authority will flow to the field offices from the home office.

People simply like dealing with local people when they are buying insurance, Mr. Rabel said. The successful insurer, he said, will rely on a combination of "high-tech, high-touch" in meeting the needs of its markets.

Harold D. Skipper, professor of insurance at Georgia State University in Atlanta, moderated the session. ■

ARIA members requested to push insurance classes

By MARK A. HOFMANN

RENO, Nev.—Members of the American Risk & Insurance Assn. should work to attract more college students to insurance and risk management courses, said the group's new president in his inaugural address.

"A number of programs have grown remarkably during the last decade," said John H. Thornton, professor of insurance at the University of North Texas in Denton, during ARIA's 56th annual meeting in Reno, Nev., last month.

That growth occurred "primarily because of the teaching excellence of the faculty (who) have acted as a magnet drawing both graduate and undergraduates to learn about insurance, risk management and employee benefits," he said.

But, despite prospering insurance courses at some schools, Mr. Thornton said "many other programs have withered during the past decade and some seem to have disappeared altogether. Still more, I believe, are in danger of even more curtailment—or even extinction—during the next decade."

Low enrollment in insurance-related courses leaves teachers with little defense against the elimination of those courses and, "over time, a student's abilities to choose insurance and insurance-related electives declines," he said.

Mr. Thornton succeeds Michael L. Murray, professor of insurance at Drake University in Des Moines, Iowa, as president of ARIA.

Mr. Thornton cited several reasons for the threat to insurance education. "In some schools, other faculty members view insurance as involving only a review of personal insurance policies. . . .In other schools, faculty in other disciplines may dictate the use of their own courses as prescribed electives, effectively denying your students the opportunity to select a course in risk and insurance as a business elective."

Possibly the most significant reason, though, is the "continuing growth of the business foundation," to the exclusion of insurance-related courses, said Mr. Thornton. The business foundation, or common body of knowledge, spells out a number of required subjects—although not courses—that must be included in business degree programs at schools accredited by the American Assembly of Collegiate Schools of Business (*BI*, Aug. 29).

Mr. Thornton noted that ARIA attempted to get AACSB to require insurance-related course material in its core curriculum earlier in the decade. He said a written submission had been made to the AACSB, but little one-on-one lobbying had accompanied the effort.

Mr. Thornton considers more aggressive lobbying crucial to achieving AACSB inclusion.

The new ARIA president made clear that he considers more aggressive lobbying crucial to achieving AACSB inclusion.

And, getting risk and insurance material included in the AACSB core curriculum is more than worth the effort, Mr. Thornton said. Inclusion means that students at leading business schools would be exposed to insurance-related topics during their academic careers, thus increasing the likelihood of drawing top-notch students to insurance careers.

Insurance companies as well as scholars need to get involved in the promotion of college-level insurance education, Mr. Thornton said. Insurance professionals ought to join professors in lobbying for the inclusion of risk and insurance courses in the AACSB core curriculum, he said.

In addition, he asked ARIA members to recruit membership more aggressively. Previous campaigns to increase general, academic and institutional membership "have not generated a significantly sustained increase," he said. He called on each member to bring in one new member during the next year.

ARIA currently has about 800 members, said David R. Klock, executive director of the Orlando, Fla.-headquartered organization. Mr. Klock said that the membership is roughly divided between academic members and general members. Academic members teach insurance at accredited colleges and universities while the general membership is open to others in the insurance industry.

ARIA was formerly called the American Assn. of University Teachers of Insurance. The association publishes the Journal of Risk & Insurance, a quarterly magazine of scholarly papers. ■

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Professional Liability and Specialty Insurance

Insurance in Egypt

U.S. multinationals wary of local insurance market

By Jerome Karter

TODAY, THOUSANDS OF YEARS after the reign of the pharaohs, Egypt is concentrating its economic strategy on the free transfer and investment of foreign currency in the country.

Initially, Egypt's "open door" policy relied on commercial legislation, Investment Law No. 43 of 1974, to encourage economic development within its private sector. Amended by Investment Law No. 32 in 1977, Egypt has continued to lure foreign investors with financial stimuli that allow:

- Exemption from labor laws regulating labor participation in management, profit distribution among employees and make-up of the company's board of directors.
- Foreign exchange accounts.
- A minimum five-year tax exemption on project profits.
- Repatriation of profits.
- Repatriation of invested capital five years after its importation.
- A customs exemption for capital assets.

The United States has long been an investor in Egypt. U.S. private sector investments in Egypt frequently take the form of joint ventures that permit the free transfer of valuable management systems and technologies to Egyptian partners.

However, notwithstanding the fact that many U.S. multinationals are represented in Egypt, U.S. risk managers are wary of insuring corporate assets through Egyptian insurers.

Although Egypt's insurance industry has followed the country's general economic fortunes, the scene has changed dramatically in recent years.

By 1956, when the Egyptianization law was enacted, more than 100 insurance companies were operating in Egypt. Between 1956 and the early 1960s, the number dwindled to 13. When the Egyptian insurance industry was nationalized in 1961, the number of licensed local insurers was reduced even further.

Today, the market is dominated by three direct-writing, government-owned insurers that are licensed to underwrite all classes of insurance and reinsurance: Misr Insurance Co. S.A.E., Al Chark Insurance Co. and National Insurance Co.

Three private sector companies also operate in Egypt: Suez Canal Insurance Co., Al Nohandes Insurance Co. and Delta Insurance Co.

Furthermore, two joint-stock companies are licensed to write business in legally established Egyptian free-trade zones and also to write insurance and reinsurance outside of Egypt: Arab International Insurance Co., a unit of Misr; and Egyptian American Insurance Co., a unit of Al Chark.

The international relationships created by the two free-trade zone insurers are well-known. Arab International represents CIGNA Corp., while Egyptian American represents American International Underwriters, a unit of American International Group Inc.

Unlike Egypt's nationalized companies, the free-trade zone companies are not tariff regulated and may write direct business in hard currency only. Unfortunately, few American companies operate in the free-trade zone today.

International issues

Each of the eight licensed insurance companies must cede 30% of their direct business to the Egyptian Reinsurance Co. The remaining portion of the risk may be reinsured abroad, although first priority must be given to the locally licensed companies.

Foreign brokers are allowed to receive commissions for placing both facultative and treaty reinsurance as well as for placing policies with the two free-trade zone companies. Otherwise, local market business is "brokered" by insurance company salesmen or independent agents, since Egyptian law defines a broker as an "Egyptian national resident in Egypt."

The rigidity of the local insurance market also is illustrated by the role played by various government organizations.

For example, the national companies operate under the supervision of the Egyptian General Insurance Organization, an administrative unit of the Ministry of Economy and Foreign Trade. The EGIO administers and supervises the Insurance Institute for the Training of Middle Management as well as the Insurance Institute of Egypt, an affiliate of the Chartered Insurance Institute in London.

In addition, the EGIO is responsible for licensing of all independent average and general loss adjusters and for renewing the licenses of independent adjusters who have complied with the loss control standards laid down by the organization. While Egyptian insurers rely on in-house claims personnel to adjust minor losses or to provide surveys and pre-attachment risk inspections, outside adjusters handle complex risks and major losses.

The national companies also finance and sit on the board of the Cargo Supervision and Surveying office. Established in 1968, the office is responsible for providing marine cargo loss prevention services in Egyptian ports. Its services are available on a fee basis to non-subscribers.

Moreover, each of the eight licensed Egyptian insurers is represented on the Technical Committee of the Insurance Federation of Egypt. The committee promulgates tariff rates while the federation itself sets out policy wording for the following regulated lines of insurance: fire and allied perils, business interruption, automobile, inland transit, ocean marine and fidelity guarantees.

U.S. multinationals operating in the free-trade zone are exempt from the insurance tariff and, thus, may obtain more competitive rates by placing their business with Arab International or Egyptian American.

Except for business in the free-trade zone, policies must be written in Arabic but, alternatively, may be issued bilingually.

U.S. dollar coverage is available with premiums and claims paid in the same currency. Most U.S. corporations favor U.S. dollar coverage because it protects corporate assets against the erosion of inflation and the devaluation of the Egyptian pound. Unfortunately, coverage written in U.S. dollars can create administrative problems through the medium of tight foreign currency controls.

For example, the Egyptian government fixes the official exchange rate at 70 piastres to the U.S. dollar. All U.S. currency entering Egypt through official channels is exchanged at this rate. Often, however, a U.S. multinational that buys U.S. dollar coverage will have to pay a rate that is 50% higher than the official rate, thereby reducing the economic advantage of using hard currency.

U.S. multinationals involved in a construction project in Egypt must purchase decennial liability coverage with a third-party liability limit of 2 million Egyptian pounds ($1.4 million) per occurrence and a bodily injury sublimit of 50,000 Egyptian pounds ($35,000). Exemptions are granted to U.S. multinational projects that are funded by the United States Agency for International Development but only if the exemption is stipulated within the contract.

The typical decennial liability policy will indemnify third parties, including tenants, for damage or injuries resulting from collapse due to faulty design or workmanship. The policy also will cover the liability of the designer, executive architect and contractor toward the owner of the building, but no coverage is afforded for the owner's interest in the property.

The gross policy rate, fixed by the Insurance Federation of Egypt, is applied to the total project value. However, the federation usually allows large-scale projects to be rated on the basis of maximum probable loss.

Unlimited automobile liability coverage also is mandatory. Property damage coverage does not exist. Although this practice causes a problem when a serious accident occurs, most Egyptians rely on "Malesh"—meaning "never mind"—to resolve minor accidents.

Fire legal liability coverage also is statutory. Tenants liability and neighbors recourse are usually insured under the fire policy with recovery based on actual cash value.

Furthermore, Act 78 mandates that policyholders carry unlimited third-party liability for elevators and electrical lifts.

Employers must contribute 15% and employees 10% of total salary to the national social security system for old-age pension, total disability and death coverage.

The system also provides health coverage for companies that have more than 50 employees and are located in a government-designated "full service" area, such as Alexandria. The contribution is 2% by the employer and 1% by the employee. Otherwise, the employer can contract health coverage through a licensed insurer or can self-insure.

Employers also must contribute 2% of total salary for unemployment insurance and 3% for workers compensation coverage, which is administered by the government. Employees can opt to contribute 1.5% of salary for a savings plan.

In summary, while the Egyptian insurance market poses problems born of limited capacity and a rigid tariff system, some flexibility does exist, especially in the free-trade zone.

U.S. risk managers, however, need not rely on "Malesh" to resolve local problems. Instead, an understanding of local market conditions, as well as innovative risk management planning, should make it possible for any U.S. multinational to operate in Egypt with full insurance protection.

By 1956, when the Egyptianization law was enacted, more than 100 insurance companies were operating in Egypt. Between 1956 and the early 1960s, the number dwindled to 13. When the Egyptian insurance industry was nationalized in 1961, the number of licensed local insurers was reduced even further.

Jerome Karter is senior vp and manager of the New York International Department of Johnson & Higgins. His column appears the first Monday of every month.

ASK A CASUALTY ACTUARY

Calculate pool assets before a need arises

Q **Some years ago when coverage was difficult and expensive to obtain, we joined a risk sharing pool. That decision has turned out well for us, but I am increasingly concerned about how the costs of possible assessments or the equity in any surplus might be shared among members. What would you recommend that I do to address these concerns?**

A Self-insurance pools are a relatively new phenomenon in the marketplace and there has not been a clear set of standards developed for the distribution of costs (liabilities) and equity (assets) among members.

Many pools have very different approaches that reflect equally different objectives. It is also true that many pools do not have well-developed methods to allocate liabilities or assets of a pool at all.

It is important for a member—or for any potential member—to understand just how the costs and equity of a pool will be distributed.

This has been true for public agency pools that have flourished in the last decade as well as for some captive programs. We suspect this may also be the case for many risk retention groups.

The first step in investigating these concerns is to review the rules—if any—that currently govern the distribution of equity and possible assessments. Most pools have at least some general statement in their bylaws or other forming agreements that members may be assessed. This, though, is not sufficient to assure that assessments or accumulated surplus will be equitably distributed. Putting off the decision of how these issues will be faced until a member departs and wants an accounting of future obligations or assets—or—or until there is a substantial surplus or deficit—is bound to strain even the best of cooperative working relationships.

There also is the possibility that your pool has no assessment features at all. This may seem to be an advantage to members of such pools. However, should the funding of these pools prove to be inadequate for incurred losses, the pool may face insolvency and the return of liability for losses back to the individual members. This is clearly not something any member would want to face.

An effective technique that can be used to ensure that you understand any existing rules on assessments and distributions is to devise three or four scenarios and see if the current rules clearly define the impact of each of these scenarios on various pool participants. This exercise may raise a number of questions, highlight areas needing clarification and suggest changes to current rules. Scenarios should include one where a very large loss occurs or a large upward reserve revision that happens after a member leaves or accumulated surplus has already been distributed.

Should your pool not have clearly defined methods of allocating costs and equity, you may wish to bring this issue to the attention of the governing body of your pool. Most likely, the pool was formed to address the more immediate and severe problems of coverage availability or price. Not infrequently, the formulation of rules to govern allocation of equity or losses is not seen as a high priority item in such a crisis environment. If attention was focused on it at all, it could easily be viewed as a decision that could be delayed. As a pool matures, however, such issues assume increasing importance.

Most pools operate with technical assistance provided from a broker, risk manager, actuary or administrator. Any of these should be able to assist you in defining and establishing equitable methods to allocate costs and equity. The time to undergo this process is during a soft market because the existing membership then will be most likely to review the wisdom of remaining with the pool.

The lack of such rules creates obvious problems for members or potential members; it also may present other consequences. Should a pool develop a deficit, or even a perceived funding deficit, potential new members may become concerned about picking up a share of that deficit should they join. And, current members may be encouraged to leave if there is a chance that their leaving will reduce the possibility of assessments. Likewise, an accumulated surplus may provide an unwarranted incentive for new entities to join, so that they might possibly share in some of the surplus (to which they did not contribute).

Given that your pool has clearly defined methods of allocating costs and surpluses (deficits), understanding how they may affect your costs is the next issue.

Equity, like beauty, may be in the eye of the beholder. The methods employed to establish equitable sharing of costs among members of a pool vary greatly from organization to organization. Such methods vary not only in terms of how they achieve their goals, but they also vary greatly in terms of the goals they were designed to achieve. The different methods can be placed into four categories:

- Banking plans.
- Experience-rated retrospective plans.
- Experience-rated prospective plans.
- Exposure-rated plans.

The essential difference between these types of plans is the extent to which members' actual loss experience is used—as opposed to general measures of exposure to loss—in allocation of costs. A measure of exposure to loss can be any general measure of size that is expected to be highly correlated with loss experience. For example, payroll is often used as a measure of workers compensation exposure and replacement value may be used for gauging property loss exposure.

A banking plan is characterized by charging charges each member the total costs of its own losses over the long run. These plans provide no sharing of costs but do allow a member to amortize the costs of his losses over some period of time. Thus, the risk that a large loss will occur and require untimely payment is shared; the costs are not.

An experience-rated retrospective plan usually identifies the premium paid as a deposit premium and the costs charged a member are determined in the future after the costs for a program period are well-known. This looking back at a prior program year gives the plan its retrospective designation. Costs are shared in relation to the exposure to loss measure for the program period and by some modified loss experience. The modified loss experience is used to share the risk of uncommon loss experience while it charges members with the actual costs of common loss experience.

Differentiating between common and uncommon loss experience can involve a number of approaches used individually or in harmony. These approaches include limiting loss amounts for rating purposes, measuring the statistical credibility of the reported loss experience or simply looking at frequencies of loss in determining the manner of sharing costs.

An experience-rated prospective plan typically uses an experience modification factor for determining members' premiums. The loss experience of a member may be used to adjust the premium but, once paid, there is no modification to a member's costs based on its individual loss experience. Any surplus or deficit in the plan would be allocated among members in relation to their exposure to loss or amount of premium paid. Thus, the premium paid is looking forward to expected loss experience.

Exposure-rated plans simply employ a general measure of exposure to loss as a means of allocating costs. A member that has, for example, 10% of the exposure of the pool would pay a like percent of the costs or any assessments. The same share of any surplus would also accrue to this member.

These different approaches are not mutually exclusive. Most plans employ one or more of these techniques to strike a unique balance between the sharing of costs and charging costs to members in proportion to their own loss experience. There is no one best answer to the cost allocation issue. A plan can be designed to reflect the management objective of the members of the pool.

Another issue that must be addressed is which members will be liable for loss costs. It is relatively clear that a member of a pool should be liable for only the loss costs that were incurred while it was a member of a pool. However, the implementation of that policy can be a bit more difficult when there are long lags between the occurrence and the reporting of some claims and long lags between the reporting and settlement of the same or other claims.

Many pools have had very stable membership over the years, but the costs of a program are commonly not completely known for some time. For example, long-tail lines like workers compensation and professional liability take a particularly long time to develop their ultimate costs. In these intervening years, members often change and adverse development in loss costs can become the liability of members who were not around when the losses were incurred. Likewise, members who leave may have a share of accrued surplus or deficit long after they stop participating in the program. Accounting for which members should be charged with which losses can be a complicated process that is best dealt with through advance planning.

The accurate allocation of liabilities and surpluses among members of a pool is likely to become more important in the near future than in the past. Accounting standards have been increasingly aimed at requiring the identification of assets and liabilities of self-insured programs in the financial reports of both public and private organizations.

A clear plan for allocating costs among members of a pool may be necessary in the future to maintain an ongoing accounting of these potential assets and liabilities.

These issues relating to the allocation of liabilities and assets from self-insurance pools are a growing concern among many participants. Many pools were formed in reaction to the tight market several years ago. Perhaps these issues are emerging now in reaction to members seeking alternatives to pool membership during a soft market and to the significant accumulation of assets and liabilities over the years.

Would you like advice from an experienced colleague on a risk management, benefit management or actuarial problem? Four features in the Perspective section of Business Insurance can give you some answers.

Ask A Casualty Actuary, Ask A Benefit Actuary, Ask A Benefit Manager and Ask A Risk Manager answer written questions from readers on risk and benefit management issues and actuarial problems.

Mr. Sherman

This month's column on actuarial issues in the casualty field is written by Richard E. Sherman, a principal with Coopers & Lybrand in San Francisco. William J. Miner, an actuary with The Wyatt Co. in Chicago, answers actuarial questions in the benefits field. Susan M. Werner, director of risk management at Hardee's Food Systems Inc. in Rocky Mount, N.C., answers risk management questions. And, Joseph W. Duva, director of employee benefits at Allied-Signal Inc. in Morristown, N.J., answers benefits management questions.

Mr. Sherman's and Mr. Miner's columns appear alternately on the first Monday of each month. Ms. Werner's and Mr. Duva's columns appear alternately on the second Monday of each month. Mr. Sherman's next column will appear in November.

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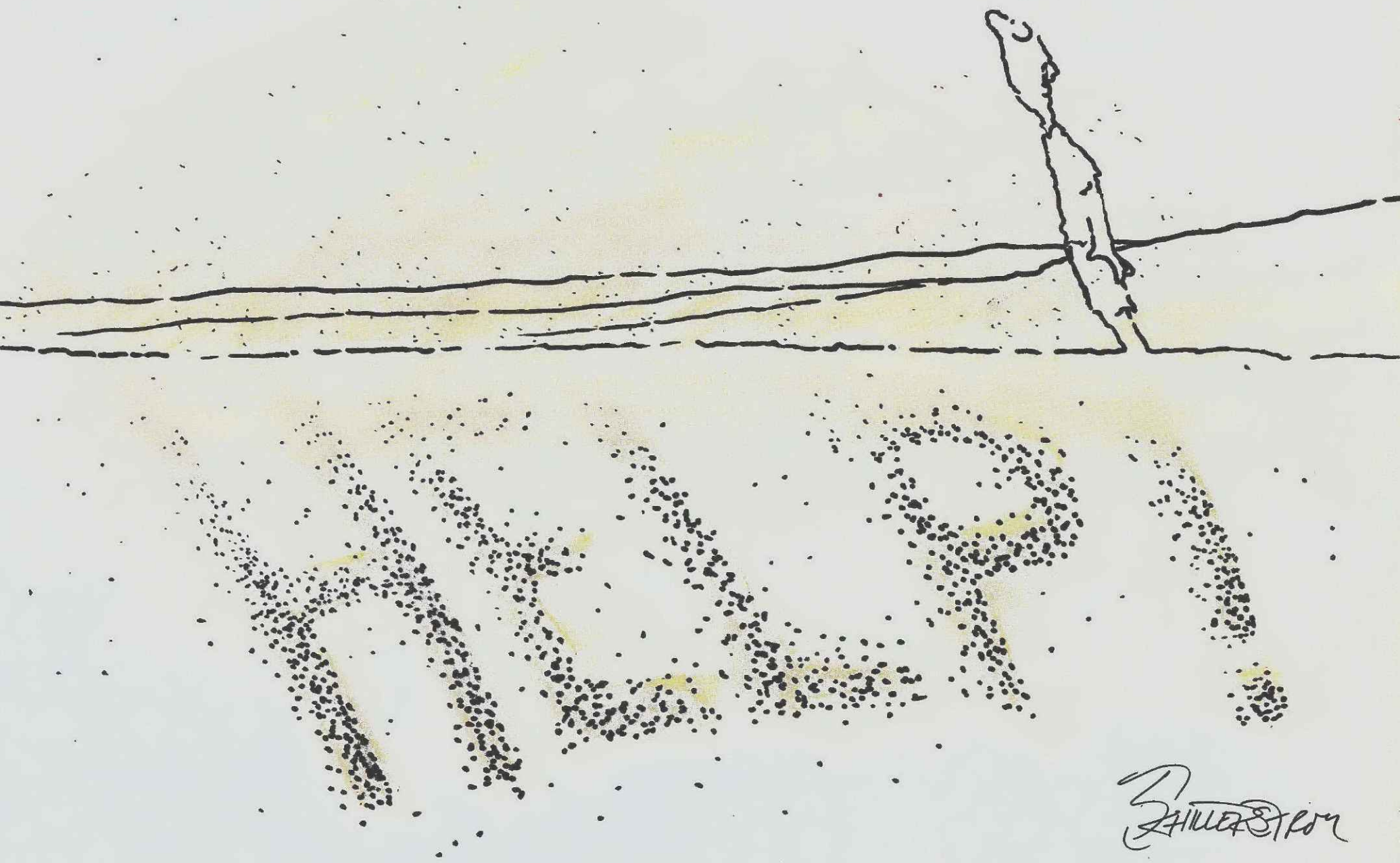

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EEOC soliciting comments on age discrimination rules

By DEBORAH SHALOWITZ

Washington

WASHINGTON—The Equal Employment Opportunity Commission is soliciting comments from benefit managers and other interested parties about how the Age Discrimination in Employment Act of 1967 should be interpreted.

The request for comment is part of the EEOC's effort to develop regulations on age discrimination in early retirement incentive programs and group health insurance plans.

"Since the use of early retirement has expanded greatly in recent years" and "in light of. . .several cases dealing with early retirement, questions have arisen regarding the legality of early retirement plans in general and of specific plans," said the EEOC.

For example, last year the EEOC issued a controversial amicus curiae brief in a pending New York case saying that under certain circumstances. an employer can offer early retirement incentives to a select group of workers based on their age, provided every employee is at some point eligible to receive the full benefit (*BI*, Nov. 23, 1987). A decision in that case, *Cipriano vs. Board of Education of North Tonawanda*, is expected this fall.

The EEOC's position in the case generated significant criticism and was called a major departure from existing interpretations of federal guidelines affecting early retirement plans.

Four months later, however, the EEOC sued American Telephone & Telegraph Co. and its subsidiaries, charging age discrimination because AT&T limited an early retirement incentive it offered to older workers. The lawsuit was interpreted by many as narrowing the the commission's statements in the Cipriano case on what constitutes an acceptable early retirement plan.

The EEOC is asking for comments, among other things, on how various early retirement plans currently are structured; how many companies offer early retirement plans; the demographics of those who accept the early retirement incentive; whether eligibility for the early retirement incentive based on age should be allowed; and whether "window" plans, which are available to employees for only a limited amount of time, should be limited.

The EEOC also is seeking comments on a proposed regulation to address the general prohibition under ADEA of age discrimination in group employee benefit plans.

The EEOC is asking for comments, among other things, on how to determine when a plan is a "subterfuge" to avoid ADEA compliance; and how costs should be defined in group health insurance plans.

Comments on both proposed regulations should be submitted in quadruplicate by Oct. 13 to the Executive Secretariat, EEOC, 2401 E St. N.W., Washington, D.C. 20507.

For more information, contact Paul E. Boymel, Office of Legal Counsel, Room 214, at the EEOC address listed above or 202-634-6423.

OSHA violations

The Occupational Safety and Health Administration has fined a Chicago plating company $300,000 for alleged violations of federal safety and health standards.

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Chicago Modern Plating Co., according to OSHA, did not train its 55 employees about the hazards of the chemicals they routinely were exposed to, about proper cleaning techniques of cyanide tanks or about proper tank entry procedures.

OSHA entered the case in February when a physician reported that an employee of the firm had become ill while cleaning a plating tank containing cyanide. The employee, who had a high level of cyanide in his blood when examined by the doctor, died three days later.

Chicago Modern Plating also did not label most of the cyanide tanks, or, if the tanks were labeled, they did not contain sufficient or accurate information, OSHA alleges.

Furthermore, OSHA charged that the company's employees have little or no understanding of the hazards of the various chemicals being used or the dangers of mixing hydrochloric acid with cyanide.

OSHA also noted that personal protective equipment was not required by the company and few employees know the purpose or location of material safety data sheets.

Material safety data sheets provide information on chemicals in the workplace, their hazards and how to deal with those hazards. All employers except those in the construction industry are required to maintain material safety data sheets in all facilities under the federal hazard communication standard (*BI*, July 18)

An official of Chicago Modern Plating said the company is contesting the fines but declined to comment further.

Lockout/tagout rules

Employers interested in a proposed federal rule regarding how dangerous machinery and energy sources should be turned off and reactivated have until Sept. 22 to submit comments to the Labor Department.

Certain industries—such as paper mills, textile factories and bakeries—already are subject to "lockout/tagout" rules, which prevent the unexpected energization, start-up or release of stored energy. OSHA's proposed rule would establish lockout/tagout rules for most employers and would cost employers approximately $212 million in the first year and $135 million in subsequent years (*BI*, May 9).

OSHA already has received 87 comments on the proposal. The agency is extending the comment period from June 28 because of numerous requests.

Written comments must be submitted in quadruplicate to the OSHA Docket Office, Docket No. S-012A, Labor Department, 200 Constitution Ave. N.W., Washington, D.C. 20210. Comments must by postmarked by Sept. 22.

Also, a hearing on the proposal will be held in Washington Sept. 22 at 9:30 a.m. in the Labor Department auditorium, 200 Constitution Ave. N.W. Another hearing on the proposal will be held in Houston Sept. 27 at 9:30 a.m. in the Guest Quarters Suite Hotel, 5353 Westheimer Road.

Notices of intention to appear at either the Washington or the Houston hearing should be postmarked by Sept. 8 and sent to Tom Hall, OSHA Division of Consumer Affairs, Docket S-012A, Room N-3647 at the Labor Department address above.

Hazard standards

A free booklet explaining the newly expanded federal hazard communication standard is available from the Labor Department.

The 20-page brochure covers hazard evaluation, written hazard communication programs, container labels, material safety data sheets and lists of hazardous chemicals. The booklet also describes requirements for employee training and information and handling of trade secrets.

A directory of state and regional offices of the Occupational Safety and Health Administration and a list of related publications and audiovisual materials also are included.

Single copies of "Chemical Hazard Communication" are free by writing OSHA Publications, Labor Department Building, 200 Constitution Ave. N.W., Room N3101, Washington, D.C. 20210. Include a self-addressed mailing label. ■

London reinsurers planning central underwriting center

By CAROLYN ALDRED

London

LONDON—More than a dozen London reinsurance companies are planning to establish an underwriting center in the heart of London's financial district.

Between 12 and 20 companies are considering basing their London underwriters in a centralized site near the Lloyd's of London building, according to Victor Blake, chairman and chief executive officer of CNA Reinsurance of London Ltd.

A reinsurance underwriting center will increase brokers' access to the reinsurance company market by providing a more convenient trading environment, said Mr. Blake.

Currently, reinsurance companies in the London market are located throughout London's financial district.

A central location also could reduce reinsurers' expenses, said Mr. Blake. In addition, companies will be able to retain underwriting and claims staff in London while moving support and administration staff out of the city, thus reducing accommodation costs, he said.

Mr. Blake hopes the trading center will be in operation by the end of next year. A building has not yet been identified, since the group is uncertain how many companies will participate.

Many London insurance companies already have an underwriting center for marine and aviation underwriters through the Institute of London Underwriters, which has its own underwriting slip and unified claims handling and premium accounting office (*BI*, Aug. 29).

However, the reinsurance trading center simply will provide a location for independent trading rather than any formal organization, said Mr. Blake.

Judge calls for report

Lloyd's of London must release a disciplinary report it prepared that led to the suspension of three former executives of Oakeley Vaughan (Underwriting) Ltd. in 1981, a judge has ruled in a preliminary hearing.

More than 40 members of syndicates formerly managed by Oakeley Vaughan are seeking to examine the report, prepared by Lloyd's underwriter Henry Chester, as a preliminary to litigation they are pursuing against Lloyd's.

The members are suing Lloyd's for breach of duty claiming Lloyd's "failed to take any satisfactory steps to protect the" members.

The members also claim they would not have remained on the Oakeley Vaughan syndicates if the Chester report had been made public, thus avoiding heavy losses incurred by the syndicates in the 1982 and 1983 underwriting years (*BI*, Feb. 15).

Losses of three Oakeley Vaughan syndicates already total 20 million pounds ($33.6 million at current exchange rate).

Lloyd's has refused to publish the report claiming that making internal reports public would discourage witnesses from providing evidence in disciplinary proceedings.

Lloyd's has until Sept. 22 to appeal the decision, confirmed a Lloyd's spokesman.

Harrap to head division

Lloyd's of London broker Gibbs Hartley Cooper Ltd. is forming a division to handle North American non-marine business under the direction of Simon Harrap, who was formerly a director of Willis Faber P.L.C.

Mr. Harrap resigned from Willis Faber last month when it merged the North American non-marine department of Willis Faber & Dumas Ltd. with that of Stewart Wrightson P.L.C., the Lloyd's broker Willis Faber acquired last year (*BI*, June 20).

Mr. Harrap, who had been a senior director of Stewart Wrightson, was "unable to agree with" the decision to restructure the departments, according to a statement from Willis Faber. He is the latest in a string of former Stewart Wrightson executives to leave Willis Faber.

James Anderson, who previously worked with Mr. Harrap at both Stewart Wrightson and Willis Faber, also will be joining the new North American non-marine brokerage division towards the end of the year, Gibbs, Hartley reported.

North American business is one of the areas Gibbs, Hartley, a subsidiary of the Hong Kong & Shanghai Banking Corp., has pinpointed for expansion. ■

Agent/Broker Topics

A monthly editorial section sent exclusively to agents and brokers

Exploring the benefits

Agencies seek strength through mergers

By LAURA MAZZUCA

More and more insurance agencies—hoping to capitalize on economies of scale—are seeking mergers or acquisitions since the time is ripe to take advantage of combining operations, agency experts say.

Changes in the tax laws, demands for increased premium volume commitments by insurers and the need to increase efficiency and profitability are some of the main reasons for the growing number of mergers and acquisitions in the past several years.

In addition, merged companies can benefit from increased risk management consulting expertise, larger client rosters and a wider geographic presence.

A merger or acquisition can increase an agency or broker's revenue stream, expand its available expertise and maximize clout with both clients and insurers.

But experts warn that unless these transactions are carefully planned and structured by both buyer and seller, the results can be disastrous, culminating in employee tension, loss of clients and financial drain.

The best-known agency and brokerage mergers have occurred between publicly held brokers, like the combination of New York-based Fred S. James & Co. Inc. and Memphis, Tenn.-based Crump Cos. Inc. in November 1986 (*BI*, Nov. 3, 1986) and the merger of Los Angeles-based Emett & Chandler Cos. Inc. and Jardine Insurance Brokers Inc., the U.S. brokerage unit of Jardine Matheson & Co. Ltd. in May 1986 (*BI*, May 26, 1986; Feb. 3, 1986).

Agency mergers and acquisitions continue to flourish among the top brokers: The seven largest public brokers completed 68 acquisitions from 1983-1987 and a total of 26 in 1987 alone (see chart, page 28B).

But the urge to merge transcends size. According to industry observers, smaller agencies are increasingly approaching larger brokers, asking to be purchased.

"The bulk of what we do comes to us," said Robert H. Hilb, president of Hilb, Rogal & Hamilton Co. of Richmond, Va., the 12th-largest U.S. broker based on 1987 revenues (*BI*, June 20).

HRH, which has acquired 27 agencies since Jan. 1, 1984, is not actively seeking these acquisitions; rather, an "enormous" number of agencies are pursuing the broker, at a current rate of five times the activity it saw in 1986, Mr. Hilb said.

And many consultants agree that the merger and acquisition game is not just for the big boys anymore. In fact, major brokerages are more likely to compete with smaller local agents than with another large broker to acquire an eligible agency, said Mr. Hilb (see story, page 28F).

Since the local agent is motivated by a desire to keep the large broker out of its market, this competition can become fierce and, if done impetuously, the small agency can end up bidding for—and owning—an agency it can't afford, he said.

According to a 1987 Future One survey that polled 1,331 independent agencies, 15% reported that they had bought another agency between 1984 and 1986; 3.5% purchased two agencies; 2.2% bought three agencies; and 1.2% bought four or more agencies.

In fact, the survey—conducted by several insurers and agent trade associations—indicated that the total number of agencies has declined as more agencies are sold or merged, said Todd A. Muller, assistant director of technical affairs for the Independent Insurance Agents of America Inc. in New York.

The 1987 Future One survey estimated there were 53,500 independent agencies nationwide, a 22.5% decline from an estimated 69,000 agencies in a 1983 Future One report. This is attributable in part to the "graying" of agency principals, many of whom are retiring and selling their businesses, Mr. Muller explained.

According to the 1987 Future One survey, the average independent agency is business with a premium volume of $1.3 million and six full-time employees, representing seven insurers. The major principal is age 50 or older.

Some brokerages, like Boston's Mahoney & Wright Insurance Agencies, are aggressively seeking out these retiring agency principals to buy their agencies. Mahoney & Wright instituted a mass mailing program last year, targeting small local agencies, and is now "talking to twice as many" agencies as last year, and about three times as many as two years ago, said Richard D. Forrest, executive vp for the brokerage, who oversees the program.

Mahoney & Wright acquired nine agencies in 1987 and three so far in 1988; of those, six were acquired because their principals were retiring and two were purchased following the death of a principal, he said.

The decrease in the number of agencies nationwide also reflects a reaction on the part of principals to the increasing demands of many insurers, which are seeking more premium volume from fewer agencies, he said.

With most large insurers instituting preferred agent programs, many smaller agencies feel pressured to expand premium volume, meet automation and perpetuation demands and maintain stringent loss ratios in order to continue representing the insurers. In some cases, acquisition by a larger agency or brokerage is a realistic alternative to going under.

A buyout by a major brokerage "could be damned near instrumental for a local guy," said Mr. Hilb.

"The smaller and weaker agents that specialize in personal lines and very small commercial accounts are dinosaurs," said Stephen A. Crane, senior vp, chief financial officer and chief planning officer of New York-based Corroon & Black Corp, the fifth-largest U.S. broker.

Mr. Crane noted a doubling of eligible agency "merchandise" on the market over the last three years. "The larger insurance companies have been propping (these agencies) up over the last several years, but they can no longer pay high commissions for an inefficient distribution system."

The Tax Reform Act of 1986—which will inflict "double taxation" on the owners of all agencies sold after Dec. 31—is also "accelerating the paperwork" of agencies that are interested in selling, said IIAA's Mr. Muller (see story, page 28H).

And, while Mahoney & Wright's Mr. Forrest believes that the change in the tax law is the major reason for the increase in acquisitions, others think its importance is exaggerated and instead attribute the increase in mergers and acquisition activity to the current soft industry market.

While noting an increase in larger agencies purchasing smaller ones, this is less a result of the tax law and more because of the "frustration many feel in trying to run an agency today," said Fredrick J. England Jr., president of ISU/Hastings-Tapley Insurance Agency Inc. in Cambridge, Mass.

In fact, since a principal would normally get a higher price for his or her agency in a harder market, and because some large brokers already have a presence in their desired marketing areas, "you won't see as many acquisitions as you'd

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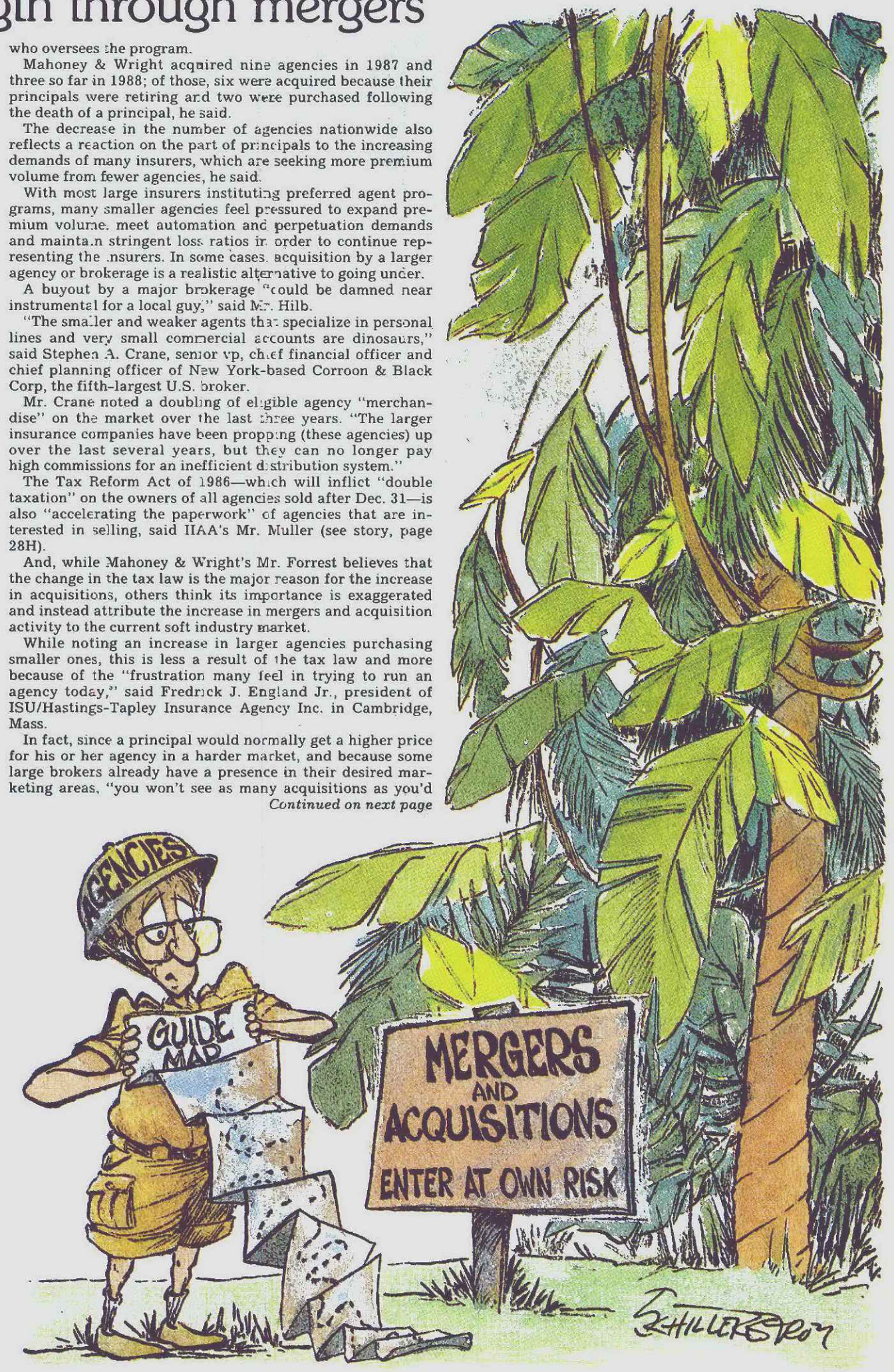


Mergers/acquisitions

Continued from previous page

think," said Sidney A. Stewart Jr., vice chairman of Fred S. James & Co. Inc. in New York.

"We have seen fewer agencies coming to us and we've been buying fewer agencies," said Robert V. Hatcher Jr., chairman and chief executive officer of Johnson & Higgins in New York.

Although most of J&H's growth is generated internally, it sometimes seeks to acquire agencies in order to expand into new geographic locations, said Mr. Hatcher. But, he believes that the changes in the tax laws are actually deterring agency sales because an agency is worth less now.

Although Arthur J. Gallagher & Co. is concentrating on "medium-sized, well-run insurance brokers" with commissions of $3.5 million to $10 million, there doesn't seem to be a glut of them on the market, said Michael Cloherty, vp of finance for the Rolling Meadows, Ill.-based brokerage.

Rather than a buy-sell cycle for the brokerage, Mr. Cloherty sees a "constant growth pattern" of acquisitions, as Gallagher continues to take on partners to expand into new geographic areas.

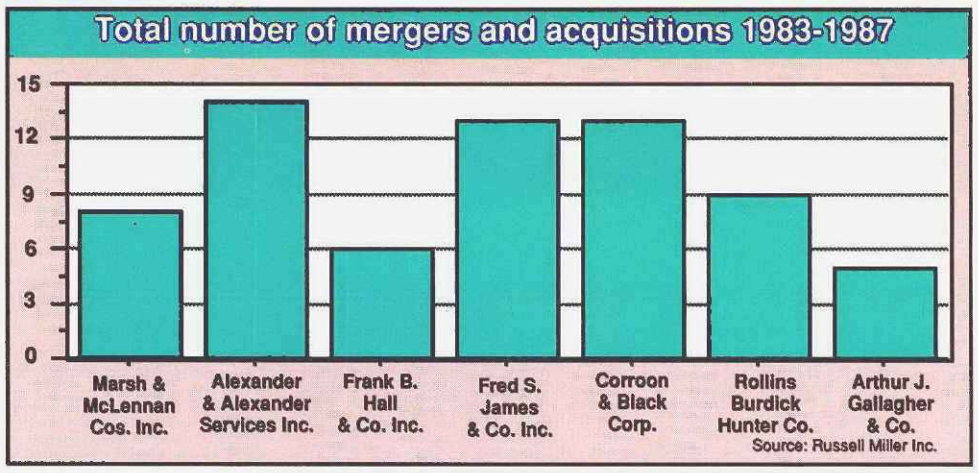
Some maintain that there has been a leveling off of merger and acquisition activity, at least for the major brokerages, possibly because the brokers are still feeling the reverberations of last October's stock market crash, said Frederick E. Dopfel, managing director of mergers and acquisitions for agency consultant Russell Miller Inc. of San Francisco.

Because of reduced stock values, publicly held brokers are less likely to issue the additional shares necessary for a pooling transaction, he explained.

In a pooling arrangement, "The seller is trading the ownership of his company and its cash flow for a more liquid asset of similar value: the shares of a publicly traded firm. If one is uncertain about the value of what is being traded—i.e., the shares—then it is much more difficult to arrive at a fair deal," Mr. Dopfel explained.

In a pooling arrangement, the seller receives stock from the acquiring agency in exchange for the entity, with no cash being exchanged. A purchase involves a direct cash payment from buyer to seller.

Mr. Dopfel of Russell Miller, which has tracked merger and acquisition activity by major brokers since the early 1980s, says merger activity was high at the beginning of the decade, subsequently declined and then gradually increased to current levels.



When executed correctly, a carefully considered merger can benefit both buyer and seller, according to agents, brokers and consultants. However, acquiring agents or brokers often have different philosophies on how to combine the operations.

"We can offer an agency the opportunity to share in the overall growth of revenues and profits of Corroon & Black," said Mr. Crane. "We make them into Corroon & Black people."

For the purchased agency, this means increased name recognition and financial clout with both insurers and clients, he said.

Although an acquired agency retains its original staff, it must work with C&B's regional managers to establish a business and management plan. After that is established, the acquired agency runs essentially as a C&B branch.

But other purchasers take a more laissez-faire attitude toward the acquired agency. After HRH acquires an agency, for example, it is operated "as autonomously as we can possibly make it," said Mr. Hilb. "They hardly know we exist."

HRH's retention rate of acquired employees is generally quite good, since they get better benefits and the security of working for a large brokerage, added Mr. Hilb.

Client retention also is important, and an effective merger or acquisition should inspire confidence in clients and personnel.

For example, Mr. Hilb noted that a recently acquired agency that had been actively courting a large corporate account landed it because of HRH's name value.

However, in spite of the perceived benefits, no merger or acquisition should be a rush job. Most consultants suggest that both the buyer and seller examine at least three years of the other party's financial information before taking any legal action.

This disclosure process is very important in any potential deal, both to examine the feasibility of a sale or merger, and to foster a sense of trust in the other party, said Richard C. Shaw, a consultant and chairman of American Brokerage Corp., a Hartford, Conn., agency.

"Unless you're attempting to snooker someone, the more information you provide, the better your chances of a successful sale," Mr. Shaw added.

Even in a successful transaction, internal problems following a merger can trigger mistakes that lead to lawsuits from customers. Thus, it is crucial that both the buyer and seller have sufficient errors and omissions liability coverage, said Mr. Hilb.

He added that it is particularly important that the agency being acquired purchase additional tail coverage under its E&O policy to cover any potential exposure. After the deal is finalized, the acquired agency is usually added to the purchaser's E&O policy.

If an agency or brokerage is overzealous in its acquisition posture, it can have problems trying to control the various operations, said Mr. England.

On the client side, Mr. England said ISU/Hastings-Tapley had underestimated the importance of the acquired agency's principal, especially if the agent is young and well-liked by clients.

After factoring this relationship into the equation, Hastings-Tapley has let acquired agencies operate more autonomously and has never lost more than 20% of an acquired agency's clients, he said.

Although acquisitions are generally less of a problem because of the buyout nature of the transaction, mergers can be ticklish on a personal level, said David A. Bakst, senior partner with Morrison Mahoney & Miller, a Boston law firm.

"You're not just bringing a business together but human beings, and there are often personality clashes," he said. "A lot of people don't spend the time to get to know each other to discover individual business philosophies. The biggest problems in mergers are on the people side," he said.

Because due diligence procedures are so thorough, few legal problems erupt after a deal has been completed, said Mr. Bakst. However, operational troubles can begin to sprout if methods of compensation and other details are not worked out between the principals beforehand, he said. To avoid this, merging principals should discuss details like building space, lease arrangements, expense costs, and which employees will remain with the new company.

"These things should not be done after the fact," added Mr. Bakst.

Another frequently overlooked area during a merger is that of a stockholders agreement, said Mr. Bakst. In their pre-merger ardor, principals may fail to take into account what will happen if one of them dies, becomes disabled or decides to leave the company. By determining how the corporate estate should purchase the former principal's stock in advance, such problems are averted, he said.

And to make a smooth transition, it's important to keep clients and employees apprised of what's going on before and during negotiations as well as after the acquisition is completed, said James' Mr. Stewart.

"The most important aspect of a merger or acquisition is a positive attitude on everyone's part that this is going to be a better thing for the employees and clients," he said. ■

Purchase price may not be No. 1 concern

By LAURA MAZZUCA

The agency merger or acquisition process frequently is compared with a romance, starting with a courtship, continuing through the honeymoon and finally settling into reality.

And, like a suitor looking for a mate, agency principals seeking to sell their businesses should look first for compatibility, said Stephen A. Crane, senior vp, chief financial officer and chief planning officer of New York-based Corroon & Black Corp.

"We encourage our new partners to kick our tires very carefully," Mr. Crane commented. "We believe in long courtships, not love at first sight."

And, as any soap opera aficionado will tell you, those who marry for money don't necessarily get a happy ending. In fact, agency principals selling their business should put the selling price far down on their list of priorities, said Richard C. Shaw, agency consultant and chairman of Hartford, Conn.-based agency American Brokerage Corp.

Instead, the seller should first concentrate on whether he really wants to sell and then determine what his goals are in selling so he can match those goals with a buyer who can give him what he wants, Mr. Shaw explained.

For instance, an agent planning to retire or leave the business can simply sell to the highest bidder, because he is less concerned with what happens to the business after it's sold, said Mr. Shaw.

In this case, potential buyers could include: another local agency three to five times larger than the seller that would absorb the agency's book of business, strip down the staff and concentrate on cash flow; a public broker or other entity willing to buy the agency with overvalued stock, which would increase in value as the agency's earnings rise; or a non-brokerage business.

But for a principal who plans to stay at the agency after it is sold—or one who will continue to have a financial or personal interest—price is less important than the rapport between buyer and seller, said Mr. Shaw. This calls for a "courtship" process, during which the two agree on such details as: who will run the agency; the compatibility of the operations and mix of business; and how many of the acquired agency's personnel will be retained.

In these situations, "money is like sex," he said. "It's fun, but it's more important (in a marriage) to agree on where you're going to live and how many children you want."

Careful consideration of compatibility kept William Pilcher II from making a hasty decision when suitors were vying for the hand of his family-run agency, Olliver-Pilcher Insurance Inc., in June 1985. While price and other elements were serious considerations, Mr. Pilcher was more interested in a buyer who would be "a good fit" with his agency.

Phoenix-based Olliver-Pilcher was the oldest and largest insurance agency in Arizona, tracing its roots to 1903. The agency specialized in placing personal lines, small to medium-sized commercial accounts and specialized commercial business heavy in construction and contracting.


Mr. Pilcher

Because of its success in the region, Olliver-Pilcher was courted by several suitors, including Alexander & Alexander Services Inc. and Corroon & Black, Mr. Pilcher said.

"In fact, we were down to letter-signing time with A&A," said Mr. Pilcher. "But the culture was a little different at C&B and I thought that our people would fit better with them."

The attraction was mutual. C&B was impressed by Olliver-Pilcher's strong presence in Arizona and its solid employee benefits department, "our ace in the hole in soft markets," said Mr. Pilcher.

The offers from both brokerages were "close," but the decision finally came down to personalities, said Mr. Pilcher. Negotiations with C&B began in October 1985, and the deal was consummated for $12 million on Jan. 31, 1986 (*BI*, Feb. 10, 1986).

From the start, C&B didn't interfere with the agency's operation, said Mr. Pilcher. "New York said: 'You call the shots,' " he recalled.

"We have regular meetings on a regional level and one national meeting a year. They don't bombard me with paperwork," Mr. Pilcher added.

Since the merger, Olliver-Pilcher's commissions and fees have increased 20% to a projected $13.7 million at year-end 1988 from $11.5 million at the merger. The office generates $2 million in personal lines revenues, more than any C&B branch in the country, said Mr. Pilcher.

At the time of the purchase, C&B had a 24-person office in Phoenix, which was not operating to the broker's expectations. Following the acquisition, the personnel from that office were brought into the Olliver-Pilcher office, he said.

But "they didn't force any people on me," he added. And when it came to thinning the ranks, "there weren't any sacred cows." Today, all but three of those 24 employees have voluntarily left, Mr. Pilcher observed.

To retain Olliver-Pilcher's own salespeople, C&B set aside "golden handcuffs"—stock grants for the key sales people, said Mr. Pilcher. Stock ownership offers top people an incentive to stay after a merger, he added. The average producer now is 35, female, "young and aggressive," he said.

The employee benefits department has grown, too: It is now C&B's second-largest, said Mr. Pilcher.

Client retention, a potential problem in an acquisition, has been no problem. Because the agency still carries the Olliver-Pilcher name—and because its clients were informed of the acquisition process from the beginning—it has lost only a few clients since the changeover, said Mr. Pilcher.

In fact, the entire arrangement has worked out so well that Olliver-Pilcher is encouraged to look for other agencies for C&B to acquire in the region, he said.

Mr. Pilcher attributes the success of the merger to the fact that C&B "left us alone" and took the attitude of "if it works, don't fix it."

If the Corroon & Black/Olliver-Pilcher marriage was an example of a traditional courtship, the relationship between Crawford & Mitchell Insurance Services and Richmond, Va.-based Hilb, Rogal & Hamilton Co. was more like Sadie Hawkins Day: The small agency, rather than the national brokerage, did the pursuing.

Crawford, an Irving, Texas-based partnership established in 1975, had been active in acquiring agencies for the past 10 years in the Dallas-Fort Worth area, predominantly agencies with small to medium-sized commercial property/casualty accounts, said President Brook B. Crawford. But he had aspirations for national growth, and reasoned that acquisition by a large broker would be the best way to achieve that goal.

So, two years ago, Mr. Crawford decided to pick himself a potential mate.

He first eliminated any brokerages in Dallas or elsewhere in Texas because he feared the agency would lose autonomy if taken over by a local entity. "We weren't just looking to sell but wanted to stay in the driver's seat," he said.

This left seven or eight brokers, only two of which appealed to him because of similarities in books of business and management philosophy. After a process of elimination, Mr. Crawford decided on Hilb, Rogal & Hamilton.

He contacted Chairman Robert Hilb, who subsequently

Continued on next page

Continued from previous page
visited the agency. HRH made an offer, but Crawford was reluctant to accept the offer because HRH was still a privately held broker.

After HRH went public in July 1987, Mr. Hilb again contacted Crawford in September.

"Bob called back out of the blue," saying the broker was now public and still interested in acquiring the agency, said Mr. Crawford. The wheels were set into motion, and the deal was closed on Jan. 1.

HRH offered to acquire the agency through cash, stock, stock options, or a combination of the three, said Mr. Crawford. The agency chose cash, with an option on stock.

The agency averaged $1.2 million in annual commission and fee revenue when it was bought, said Mr. Crawford; since then, its volume has risen to the $2 million level, and he estimates that projected annualized revenues will hit $3 million—with $20 million in annual premium volume—by Sept. 1, after Hilb completes two other acquisitions now pending, said Mr. Crawford.

HRH also has acquired six more agencies that were scouted by Mr. Crawford in the Dallas-Fort Worth area since HRH bought Crawford & Mitchell, he added.

Mr. Crawford is now the president of the agency, overseeing 40 staffers, up from 21 at the time of acquisition. All new employees were absorbed from other agency acquisitions, he added.

Mr. Crawford attributes the agency's success to HRH's arm's-length management style. The agency is overseen by HRH's Richmond, Va., headquarters, but day-to-day operations are handled internally.

"We have a great deal of autonomy on a local level. . . .Bob (Hilb) gives us a great deal of latitude and authority," Mr. Crawford said.

While observers suggest it may be easier for a smaller company to be acquired by a much larger partner, two huge brokerages can marry and live happily ever after.

For example, the November 1986 combination of The Crump Cos. Inc. with Fred S. James & Co. Inc. "went as smoothly as any merger could possibly go, said Sidney A. Stewart Jr., now vice chairman of James and formerly chairman and chief executive officer of Memphis-based Crump.

Crump, which at the time was the eighth-largest U.S. broker, became part of James, formerly the nation's fifth-largest broker, when James' parent company, the Sedgwick Group P.L.C., paid Crump stockholders $307 million (*BI*, Sept. 1, 1986).

The James-Crump marriage is a perfect example of strong growth by merger.

In 1987, James reported pro forma gross revenues of $468.5 million, a 19.7% increase from the previous year, which was partially attributable to the addition of Crump (*BI*, June 22, 1987).

Mr. Stewart said that Crump employees were "very involved" in the transition after the merger, with responsibilities evenly distributed on both the executive and branch office levels, he said.

Crump's clients were included in the process as well. During the merger proceedings, regular discussions were held on a branch office level to keep clients informed of what was happening and how it would affect them.

When the clients understood that they would still be dealing with Crump people—backed by James' clout—"they were very positive about it," said Mr. Stewart.

This same open-door policy was applied to both brokers' employees, which kept spirits up during and after the merger. Very few employees defected, he said.

Since then, the brokerage's growth has shifted from acquisitions to internal growth. "Absorbing all those mergers has been the thrust of 1987," said Mr. Stewart. According to figures provided by consultants Russell Miller Inc. in San Francisco, James acquired a total of 13 agencies in the five-year period from 1983 through 1987 (see chart, page 28B).

And, even though today's softening market may make the seller's profits less attractive than in a tight market, Mr. Stewart believes that well-planned sales will continue to be beneficial, as agency principals search for a "place to take better care of their clients."

But, like marriages, not all mergers or acquisitions are happy: The inevitable personality clashes that occur when two different operations are combined is one of the biggest risks of a merger or acquisition.

One agency official involved in a not-so-happy merger said the key problem with the combination was duplication: Essentially, there were two people for every position, and it was simply a matter of time before politics and pressure forced one of them out.

Another frequent complaint of acquired agencies is a loss of autonomy.

The relationship between the buyer and the insurers represented by the acquired agency can be a touchy matter as well, since "companies vary tremendously" on how they deal with a changing relationship, said Fredrick J. England Jr., president of ISU/Hastings-Tapley Insurance Agency Inc. in Cambridge, Mass.

To avoid problems in this area, Mr. England suggests buyers examine an agency's loss experience with each insurer to ascertain the relationship between insurer and agency before a purchase. ■

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CHUBB

Small brokers step up acquisition activity

By LAURA MAZZUCA

Large, publicly held insurance brokerages are losing their appetite for acquiring smaller agencies, observers say.

Instead, the national brokers are exercising more caution in their purchases and abandoning growth-at-any-cost acquisition strategies.

In fact, as many big brokerages reduce their level of acquisitions, smaller regional agencies anxious to achieve rapid growth are increasingly buying other agencies. In many cases the smaller regional agencies are actually competing with the nationals for acquisitions.

An example of a regional brokers' acquisition program can be found in Boston-based Mahoney & Wright Insurance Agencies, which was ranked the 51st-largest commercial property/casualty broker in *Business Insurance's* ranking of the Top 100 U.S. brokers based on 1987 revenue, primarily due to a direct mail acquisition campaign initiated two years ago.

Since 1986, Mahoney has acquired a total of 13 agencies. Its gross revenues increased 18.4% in 1987 to $10.8 million from $9.1 million in 1986 (see story, page 28F).

In contrast, many of the larger brokerages now are concentrating on internal growth as they digest the record number of acquisitions made since 1986.

For example, although still acquiring agencies, Richmond, Va.-based Hilb, Rogal & Hamilton Co. gradually is shifting its focus to internal growth as part of a five-year plan that calls for half the brokerage's growth to be generated internally, said President Robert H. Hilb.

Mr. Hilb

HRH, which has made 27 acquisitions since Jan. 1, 1984, now is looking at smaller agencies—those with a value of less than $5 million—to be melded directly into the brokerage's existing offices.

Corroon & Black Corp. also is gradually shifting its emphasis from acquisitions to internal growth, though the New York-based brokerage will continue to acquire agencies to enhance client services, said Stephen A. Crane, senior vp, chief financial officer and chief planning officer.

"I expect our acquisition activity to remain high into the foreseeable future," Mr. Crane said.

Corroon & Black's acquisition activity has been "basically consistent" over the last several years, averaging five to six acquisitions per year, he said. These purchases run the gamut in value, from $1 million to $15 million, with the average deal in the last few years involving an agency generating between $5 million and $6 million in revenues, he said.

However, recently, Mr. Crane has noticed that the "hit ratio" for acquisitions has been lower than normal as Corroon faces stiff competition for the agencies it pursues. Corroon's competitors for acquisition targets have been more aggressive and the broker can't compete over price "as aggressively as some agencies anticipate," he explained.

Another reason large brokerages are slowing their acquisition activity is the threat of making a mistake, noted HRH's Mr. Hilb. For example, the acquired agency's income tax liabilities and receivables problems can haunt the acquiring broker if not handled carefully, he explained, noting that is part of the reason HRH has become less acquisitive.

If the face of merger activity is changing, so is the profile of the typical purchased agency.

Frederick E. Dopfel, managing director of mergers and acquisitions at consultant Russell Miller Inc. in San Francisco, points to a trend toward agencies for sale being increasingly headed by younger principals. Buyers are looking for a selling principal in his early 40s who will stay with the agency after it is acquired, rather than an owner in his 50s to 60s who is seeking a retirement plan, Mr. Dopfel said.

"The whole acquisition game is to get the right people, in spite of pricing," Mr. Hilb said.

Corroon & Black is looking for agencies with "young quality management, good product capability and specialized expertise," rather than a high premium volume, Mr. Crane said, stressing: "We're not in the business of buying books of business; we're looking for good people to make our partners."

The broker is not interested in acquiring agencies from retiring principals, he said. Instead, it seeks principals in their 40s or early 50s with good successors in place, "people with the smarts to call upon our resources," he explained.

Purchasers also look for good financial information, good relationships with insurers, quality staff, continuity of management and a history of growth. But, "most important is the rapport we have with their people," said Mr. Hilb.

Potential acquisition candidates are found in several ways. Sometimes a broker is approached by agencies anxious to be bought, but for the most part managers in the field tip off brokerage management to possible candidates.

Consultants like Russell Miller; Marsh, Berry & Co. Inc. of Mentor, Ohio; and Hales & Associates Inc. of Oak Brook, Ill., sometimes act on behalf of an agency hoping to be acquired, said Mr. Crane. When consultants contact Corroon & Black, they are referred to regional managers to determine how well the candidate would blend with those operations.

After this is determined, a close, mutual scrutiny begins. In most transactions, this entails each side offering the other at least three years of financial records for examination, Mr. Crane explained.

The examination process also includes visits back and forth and confidential inquiries to insurers, clients, etc., said Mr. Hilb.

If there is mutual interest, HRH gives the targeted agency a written proposal containing basic information about the history of HRH, etc. HRH then sends its own certified public accountants to conduct a due diligence examination of the acquisition candidate's agency, including a study of such documents as leases, employment contracts and noncompete agreements, Mr. Hilb said.

HRH's attorneys also check for liens and other outstanding legal problems. If this exam goes smoothly, the stage is set for a sale.

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At HRH, this sizing-up period typically takes from 90 days to six months before any actual negotiations take place, Mr. Hilb estimated.

The actual acquisition usually occurs 30 to 45 days after HRH's in-house attorney draws up a contract. This contract is generally around 70 pages, with 15% tailored to the specific acquisition and the remainder standard contractual wording.

HRH requires the acquired agency to provide warranties stating that it will be liable for any outstanding income taxes or collectible receivables incurred before or during the acquisition process.

Like public brokers, some privately held agencies and brokerages are are reducing their acquisition activities.

ISU/Hastings-Tapley Insurance Agency Inc. of Cambridge, Mass., formerly very aggressive in agency acquisitions, has followed a more subdued acquisition strategy in the past year or two, said President Fredrick J. England Jr.

Traditionally, a purchaser felt it could purchase an agency out of the revenues generated by the acquired agency, with the price of the agency being based on the revenue stream, explained Mr. England. But this also means that the buyer must run the agency more efficiently than the seller did, which is increasingly difficult in today's marketplace.

ISU/Hastings-Tapley went through a period in the late 1960s when it was the only agency in the region buying other agencies. Prices were low, and "you could make a lot of mistakes and not get hurt," he said.

But about five or six years ago, other agencies began to move in, and prices on available agencies became inflated.

In particular, Brewer & Lord and Mahoney & Wright, two Boston agencies, began to heavily compete with Hastings-Tapley for acquisitions, Mr. England said.

Hastings-Tapley subsequently became more selective in its acquisitions. Although Mr. England estimates that the agency has made 70 acquisitions over the past 20 years, it has only made about 10 acquisitions in the last five years.

Other agencies that were acquisition-happy several years ago also are beginning to pull in the reins on purchases—and in some cases are even involved in divestitures.

"Acquisition does not necessarily correlate with good performance, and some firms have more recently been involved in divestitures," said Russell Miller's Mr. Dopfel. For example, the consulting firm recently assisted broker Frank B. Hall & Co. Inc. in divesting its brokerage operations in Alaska and a managing general agency in Stockton, Calif.

One reason brokers may want to divest themselves of an operation is because of a failure to reach financial goals in a "critical center of mass," usually located in a major geographic area, said Mr. Dopfel.

However, the price brokers receive for divested operations may be lower because of rate competition in the commercial property/casualty market and last fall's stock market crash, Mr. Dopfel said.

Since the crash, both the price-to-earnings multiple—the value of the agency divided by its earnings over the previous 12 months—and price-to-revenue multiple—the value of the agency divided by its revenues over the previous 12 months—of privately held firms have declined, said Mr. Dopfel. However, he noted that there has been some recovery in most publicly held companies.

Johnson & Higgins, the largest privately held U.S. brokerage, avoids many of the hazards of agency acquisitions by generally staying out of the fray. Instead, J&H prefers to increase its revenue base through start-up offices over which it has more control, said Robert V. Hatcher Jr., chairman and chief executive officer.

J&H's growth is 95% internally generated, with only 41 agency acquisitions in 143 years of operation.

Mr. Hatcher estimated that the broker's larger competitors, New York-based Marsh & McLennan Cos. Inc. and Alexander & Alexander Services Inc., "probably bought 10 times that number" from 1970 to 1984.

In addition, because privately held J&H cannot use publicly traded stock with which to acquire agencies, there is less emphasis on acquisitions, Mr. Hatcher added.

However, on the infrequent occasions when J&H does acquire an agency, it looks for a desirable geographic location, then "we look for the people" compatible with the broker's existing structure, he said.

And, although J&H is currently negotiating with several small to medium-sized agencies in cities where it does not have offices, the brokerage still is not particularly interested in aggressive acquisitions, stressed Mr. Hatcher.

"Sooner or later," he said, "you'll run out of money." ■

Requisites of an agency acquisition

Because an agency merger or acquisition is complicated, consultants agree that certain information—uncovered in the process of due diligence—is absolutely essential in deciding whether to enter into an agreement with another party.

"At a minimum, you should always get all of the facts and materials listed below," said Richard C. Shaw, consultant and chairman of American Brokerage Corp. in Hartford, Conn. "If you don't, you're flying blind and will probably live to regret it."

These essentials include:

- Three years of profit and loss statements.
- Three years of balance sheets.
- Three years of full tax returns (to cross-check financial statements).
- Five years of contingent commission statements from the insurers represented by the selling agency.
- A detailed breakdown of the entity's most recent revenue by source (by line noting non-recurring revenue).
- A listing and analysis of the 10 largest accounts, and any other account producing 1% or more of total commission.
- Copies of all leases, employment contracts, employee benefits and other contractual obligations to be assumed.
- A brief resume, job description and compensation description for each employee who will be (or may be) retained after purchase.

Common sense should be "an active ingredient" in any merger or acquisition. "Nothing is sure in life, but if you ask reasonable questions and use good judgment, you'll be all right," he added.

And, it is customary for both parties to sign non-disclosure and confidentiality agreements to keep such information between the parties, added Mr. Shaw.

In such agreements, which are usually drawn up by the buyer's attorney, the buyer agrees to keep confidential the information gleaned about the seller, and to return to the seller any written information received should the deal fall through.

The seller, who may have less access to confidential information about the buyer, is typically expected to sign a warranty declaring that all information disclosed is correct, added Mr. Shaw.

—By Laura Mazzuca

Tax changes fuel mergers, acquisitions

By LAURA MAZZUCA

Provisions in the Tax Reform Act of 1986, which make it less attractive for agents and brokers to sell their businesses, are contributing to an upswing in agency mergers and acquisitions, consultants agree.

Although "mergers and acquisitions have been hot for years," activity has become particularly intense in the two years since the tax law was enacted, said David A. Bakst, senior partner with Morrison Mahoney & Miller, a Boston law firm.

The two tax law changes with the most impact on agency mergers and acquisitions are:

- An increase in the capital gains tax rate to 28% from 20%, effective Jan. 1, 1987.
- The imposition of double taxation on sale of assets by corporations, which went into effect for larger corporations two years ago and will go into effect for all companies on Jan. 1.

Under the old tax law's General Utilities Doctrine, corporations could sell assets without being subjected to capital gains tax, then pass those assets on to stockholders, who would pay taxes on the gains, explained Mr. Bakst.

Because tax reform eliminated the GUD, a corporation that sells its assets must pay taxes on the sale. Then, shareholders must pay taxes on the remaining proceeds when they are passed on by the company. And they are taxed at the higher capital gains rate.

Merger activity has become particularly intense since the tax law was enacted, says David A. Bakst.

These changes took effect for corporations with market values of $10 million or more on Dec. 31, 1986, and already are partially in effect for corporations with values between $5 million and $10 million. The law is fully effective after Dec. 31, 1988, for all corporations, including those with values of $5 million and less; thus, there is a definite tax advantage for agencies in selling before that date.

As an example, Mr. Bakst pointed to the principals of the fictitious Oldco Insurance Agency Inc., a small agency, who decided to sell their business this year. The following federal income tax computation would apply:

Total Purchase Price: $1 million.

Tax owed by Oldco: $0.

Balance distributed to Oldco shareholders: $1 million.

Tax to shareholders at 28%: $280,000.

Net proceeds to shareholders: $720,000.

However, if the agency were sold after 1988, the following computation would apply:

Total purchase price: $1 million.

Tax owed by Oldco at 34%: $340,000.

Balance distributed to Oldco shareholders: $660,000.

Tax owed by shareholders at 28%: $184,800.

Net proceeds to shareholders: $475,200.

In short, the aggregate tax for a sale after 1988 is 52.5%, an increase of 24.5% ($244,800) from taxes levied in 1988.

One way a corporation can avoid double taxation is to change from a "C"—or corporate—structure, to a Subchapter "S"—partnership or sole proprietorship—structure, in which the entity's shareholders are taxed individually.

This switch became extremely popular shortly after the 1986 tax law was passed. However, to qualify for a Subchapter S election, the corporation must have a limited number of shareholders, no subsidiary corporations and the shareholders must be individuals rather than trusts, said Bill Wieland of Hales & Associates Inc., an agency consultant based in Oak Brook, Ill. This means that corporations with employee stock ownership plans and other trusts are ineligible for Subchapter S status, he said.

Historically, corporations choosing Subchapter S status had a three-year waiting period during which time Subchapter S benefits were not applicable. Under the 1986 law, this waiting period has been extended to 10 years for Subchapter S elections made for fiscal years beginning Dec. 31, 1986.

Meanwhile, although income tax on profits from the operation are immediately available for individual taxation after filing for Subchapter S status, assets from the sale of the agency will still be taxed on a corporate basis until the 10-year waiting period elapses.

To avoid double taxation on the sale of a corporate insurance agency after 1988, Mr. Bakst suggests that principals either:

- Sell the stock of the corporation rather than its assets, which would result in a single tax to the selling stockholders at the current 28% tax rate.
- Liquidate the corporation during 1988 and operate as a sole proprietor or partnership until the sale of assets is completed after 1988. This means that generally there would be no capital gains tax on the value of the agency's book of business.

Tax law changes will also affect buyers.

Under the old tax laws, a buyer could revalue the corporation's assets based on their current market value to be able to depreciate the value over its useful life and reduce future taxable income, said Mr. Wieland.

However, under the new law, taxes must be paid on the increases in the value of the assets (usually meaning the book of business) before a depreciation can be made, he said. Because most valuation increases at an agency arise from the book of business, the value of book of business determines the taxes paid, Mr. Wieland added.

This provision went into effect Dec. 31, 1986, with the same incremental phase-in period as the GUD removal.

While tax law changes have made it more attractive for smaller agencies to sell before year-end, the number of acquisitions this year will not approach the acquisition activity that occurred prior to tax reform, said Mr. Wieland.

However, if an agency is interested in buying or selling, it's a good idea to begin the transaction as soon as possible, since the procedure generally takes three to six months, he added. ■

Maxicare

Continued from page 1

choked," said David P. Rahill, a vp with benefit consultant A. Foster Higgins & Co. in Princeton, N.J.

"We think the Maxicare situation is really symbolic of what's happening in the HMO industry overall," said Tom Billet, a managing consultant in the New York office of A. Foster Higgins.

And, some benefit consultants say that benefit managers are learning that they must more carefully analyze the quality and financial stability of the HMOs with which they contract (see story, page 31).

Maxicare attributes its huge losses primarily to the cost of integrating the operations of its two large 1986 acquisitions with existing Maxicare operations, combined with escalating health care costs and increasing competitive pressures.

In 1986, Maxicare acquired Orange, Calif.-based HealthCare USA and Nashville, Tenn.-based HealthAmerica Corp. for an aggregate purchase price of about $445.6 million. HealthCare USA operated HMOs in three states, while HealthAmerica operated HMOs in 17 states, 11 of which were states in which Maxicare did not previously operate.

The acquisitions, which had an aggregate enrollment of about 1.2 million, more than doubled Maxicare's previous enrollment.

Fueled by the acquisitions, Maxicare's premium volume increased 106% to $1.8 billion in 1987 from $875.6 million in 1986.

However, Maxicare was forced to take a $185 million charge against its 1987 earnings when the valuation of the two acquisitions was reduced "as a result of depressed conditions in the HMO industry and of the company's estimate of its inability to recover such value," Maxicare said in documents filed with the Securities and Exchange Commission.

Including this charge, Maxicare reported a $255.9 million net loss in 1987, compared with net income of $4.3 million the previous year. And, even without the charge, the loss would have totaled $70.9 million, Maxicare says in documents filed with the SEC.

In addition, the company's shareholders' equity—or net worth—plummeted to a negative $29.2 million at year-end 1987 from $227.8 million on Dec. 31, 1986.

Maxicare's results have deteriorated so far this year. Maxicare reported a net loss of $80.8 million in the first half of 1988, compared with only a $21.9 million loss in last year's first half. And, shareholders' equity stood at negative $109.4 million as of June 30.

The financial turmoil also is reflected in the price of the company's stock, which like other HMO firms was a darling of Wall Street several years ago. Maxicare shares were trading at less than $1 on the over-the-counter market last week compared with as much as $21 a share in 1985.

The problems came to a head last month when Maxicare's board of directors ousted the company's founders: Chairman Fred W. Wasserman and President Pamela K. Anderson (*BI*, Aug. 15).

And last week, the California Department of Corporations, which regulates HMOs in the state, ordered Maxicare's California HMO subsidiary to stop lending money to the parent company.

While the California HMO is the most profitable in the Maxicare system and in the state, the HMO's liabilities now exceed its assets because of such loans, even though California law requires HMOs to maintain a "tangible net equity."

The California HMO, which has 415,000 members, reported a net equity of negative $172.4 million, up from negative $120.4 million on March 31.

Several operating factors are contributing to parent company's losses, observers agree.

'We think the Maxicare situation is really symbolic of what's happening in the HMO industry overall,' says Tom Billet, a managing consultant in the New York office of A. Foster Higgins & Co.

For example, because of the acquisitions, Maxicare reported interest expenses of $47.5 million in 1987, up 184% from $16.7 million in 1986.

Health care expenses also increased. Health care expenses jumped to 87.9% of operating revenues in 1987 from 86.6% in 1986.

As a result of its 1987 loss, Maxicare fell out of compliance with various covenants in its $175 million revolving line of credit established in conjunction with the HealthAmerica acquisition. The company then adopted—under pressure from lenders—a restructuring strategy that includes the divestiture of unprofitable operations, further integrating the acquired operations with existing Maxicare operations and premium increases.

"We're continuing to consolidate our position in markets where we have strong networks. But, we certainly will close non-profitable plans and in regions in which we don't feel there is the possibility of an upswing," Mr. Hallis of Maxicare explained.

Indeed, this metamorphosis already is well under way. As a result of the sales or closures of unprofitable HMOs, Maxicare's network of HMOs currently stands at 20 HMOs in 18 states, down from 30 HMOs in 26 states at year-end 1987.

"On a state-by-state basis, the plans that we are going to continue to operate are themselves healthy plans. Maxicare Health Plans, the holding company, does have a great deal of debt. So, the problem is with the holding company's difficulties with its current bank loans and other debts. But, that will not affect the individual plans," he added.

Maxicare's most profitable HMOs are in California; Chicago; Ohio; Arizona; and Houston and Irving, Texas, company officials say.

So far, the company has sold HMOs in Florida; Georgia; Kentucky; Nevada; Maryland; San Antonio, Texas; Omaha, Neb.; Philadelphia; and Pittsburgh.

Sale of Maxicare's Virginia plan is pending.

In addition, Maxicare also has sold the physician groups that contracted with its Harrisburg, Pa., and Indianapolis independent practice association-model HMOs. In an IPA-model HMO, the HMO contracts with various physicians and specialists to provide services to HMO enrollees. The physicians provide the HMO services out of their own offices and still maintain private practices.

Maxicare also recently announced the closure of its Salt Lake City HMO after it was unable to find a buyer for the operation. The IPA-model HMO had lost nearly $5 million since it was launched in 1982, losses Maxicare attributes to offering coverage for pre-existing conditions, high obstetric care utilization and insufficient discounts with hospitals (*BI*, Aug. 22).

Many of the HMOs Maxicare has sold so far have lower enrollments than Maxicare's largest, most profitable HMOs.

For example, Maxicare's Baltimore HMO had about 36,500 enrollees and its Virginia HMO had about 21,000 enrollees. In comparison, Maxicare's California HMOs have more than 330,000 enrollees and its

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Maxicare

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Chicago HMO has about 116,000 enrollees.

In restructuring its operations, Maxicare is helping employers cope with the changes, Mr. Hallis said.

"Our biggest effort has been keeping our accounts informed of what we are doing. We have a national accounts department that is working closely with employers," he said. That department offers employers the contract with Maxicare HMOs in multistate locations consolidated administration of contracts and premium bills.

"In a situation where a Maxicare plan is being acquired by another HMO, then the acquiring company will continue the contract currently in force between the employer and the Maxicare HMO. In these cases, employers usually get together with the buyer of the plan," he explained.

However, "the problem is in cases where we close a plan, like we did in Utah. But, that's an infrequent occurrence," he said.

As in most instances when an HMO becomes insolvent or decides to cease operations, Maxicare is working with state regulators to develop a transition plan for the Utah HMO's enrollees.

"Although we realize that our restructuring activities create added work for our employer clients, it really has not been a major problem," Mr. Hallis observed.

Maxicare's restructuring plan now calls for an average HMO premium increase of 15%. In December, the company had predicted premiums would increase an average of only 6% in 1988 (*BI,* Dec. 21, 1987).

In announcing its 1987 loss, Maxicare pointed to competition that forced it and other HMOs to charge rates that were insufficient to cover costs.

"I think the competitive pressures that have been put on HMOs, insurers and the health care industry overall have artificially held rates down," Mr. Hallis observed. "The inflationary factors generated by prescription drugs, coverage of out-of-area health care services and hospital costs all drive health costs much higher than the rates that are being charged."

Maxicare is raising its rates on a "market-by-market basis," Mr. Hallis said. Since all but one of its HMOs are federally qualified, all employers served by a Maxicare HMO receive the same rate increase.

One Detroit employer reported a 29% increase in both individual and family coverage premiums, while a Chicago employer's Maxicare premiums increased 12% for individual coverage and about 9% for family coverage. However, Maxicare is now the most expensive HMO that that employer offers.

While Maxicare will survive, 'I don't think you'll ever see a national growth situation like Maxicare's again. Their timing wasn't very good on their acquisitions in terms of the rate of health care inflation,' says Lynn Gruber, vp for managed care research at Interstudy.

As another part of its restructuring plan, Maxicare will further integrate the administrative procedures of its acquired HMOs to bring them more in line with corporate operating procedures.

For example, prior to the acquisitions of HealthAmerica and HealthCare USA, Maxicare reimbursed its physicians on a capitated-fee basis. Under such a system, the physician receives a pre-determined amount per patient per month, regardless of utilization. This arrangement gives providers an incentive to deliver cost-efficient care.

However, the reimbursement methods used by some of the acquired HMOs, particularly the HealthAmerica HMOs, differed from plan to plan and in some cases contained no real cost control incentive, Mr. Hallis said.

The added costs stemming from this plan contributed to the company's losses following the 1986 acquisitions.

Maxicare now is concentrating on implementing a uniform, capitated fee provider reimbursement structure companywide, he said.

"We've been able to emphasize risk assumption by providers by continuing to develop strict capitation arrangements." In addition, the company is implementing its utilization review and quality assurance programs throughout its entire network of HMOs, he said.

These steps could help Maxicare survive, though with streamlined operations.

"Maxicare will survive, but will be much smaller," said Lawrence B. Leisure, national practice leader for group benefits for TPF&C, the benefit consulting unit of Towers, Perrin, Forster & Crosby Inc.

"Maxicare thought it wanted to be in every state.

"The company basically has a capital problem now, but that doesn't mean bad things for the whole network or for the whole HMO industry," he said.

While Maxicare will survive, "I don't think you'll ever see a national growth situation like Maxicare's again. Their timing wasn't very good on their acquisitions in terms of the rate of health care inflation," observed Lynn Gruber, vp for managed care research at Interstudy, an Excelsior, Minn.-based HMO research group.

Mr. Abramowitz of Sanford C. Bernstein predicted that "Maxicare will be all right in 1989, thanks to insurance carriers, whose premiums are going to go through the roof. The lid is off health care costs, so even the worst managed HMO should be able to raise rates lower than the best-managed insurer."

Observers also point out that Maxicare's problems are not unique in the HMO industry and that its recovery strategy should be shared by other HMO operators.

"Our impression from interviewing executives at 41 large HMO firms is that they are looking at Maxicare as an isolated case. However, it is clear that HMOs know that they must run their businesses better," said Ms. Gruber, who worked on a report that describes 41 major HMO companies and their competitive strategies.

"Many HMOs now are concentrating on strengthening their internal management procedures and have put their growth plans away on a shelf for now," she said.

"I think there will be a slowdown in the growth trend in the HMO industry. I hope people are learning the right lessons from Maxicare," said Mr. Leisure. ■

Maxicare has lesson to teach

Employers as well as health maintenance organization operators can learn from the problems at Maxicare Health Plans Inc.

"I hope people are learning the right lessons from Maxicare," said Lawrence B. Leisure, national practice leader for group benefits at TPF&C, the benefit consulting division of Towers, Perrin, Forster & Crosby Inc. in New York.

"HMOs should be learning that they must better manage their finances and employers must learn to view HMOs as employer-sponsored plans instead of just as separate plans over which they have no control," he said.

Indeed, "between the upcoming changes in the HMO Act and the consolidation and turbulence in the HMO industry, employers are going to have to stop contracting with everyone and must start qualitatively evaluating HMOs. Employers have to think about consolidating the number of HMOs they offer," said Tom Billet, a managing consultant in the New York office of A. Foster Higgins Inc., the benefit consulting division of Johnson & Higgins.

As a result of Maxicare's problems, "employers will pay a little bit better attention to how financially sound HMOs are," said David P. Rahill, a vp with A. Foster Higgins.

Some employers, like San Francisco-based Pacific Telesis Group, have performed extensive analyses on the HMOs they contract with in an effort to consolidate the number of HMOs they offer.

The communications concern now offers 20 HMOs to its 70,000 employees. But, as a result of its analysis, seven HMOs, including plans owned by Maxicare, will be dropped effective Jan. 1, 1989, according to Neil Austin, the company's staff manager of health care cost containment.

Employers have to make HMOs more accountable for the care they deliver as well as for their prices, said Lynn Gruber, vp for managed care research at Interstudy, an Excelsior, Minn.-based HMO research group.

"The HMO industry can't do it alone. They're trying, but payers—or employers—have got to get involved in managed care plans," she said.

Just as employers must pay more attention to HMOs, the plans must listen to employers to succeed, another observer suggests.

HMOs, including Maxicare, "do not concentrate enough on selling to the employer," said Ruth Stack, president and executive director of the Miami-based National Assn. of Employers for Health Care Action.

"Marketing efforts often are targeted to the employee," Ms. Stack said, explaining that HMOs must effectively communicate with employers because they pay the bulk of the premium.

—By Donna DiBlase

Maxicare profitability short-lived

Following is a brief history of Maxicare Health Plans Inc.:

Dec. 23, 1980: Maxicare Health Plans Inc. is incorporated in California as a holding company for "California HMO" and other entities California HMO was created in 1973 and operated as a non-profit corporation through 1980, when it was converted to a for-profit corporation.

June 1982: Maxicare Health Plans begins interstate HMO operations by purchasing CNA Health Plans Inc. of Chicago, now known as Maxicare Midwest Health Plans Inc.

July 1986: Maxicare agrees to purchase HealthCare USA Inc., an Orange, Calif.-based HMO with 200,000 members in California and Michigan, for $67 million.

August 1986: To further its plans to become a national HMO power, Maxicare agrees to purchase Nashville, Tenn.-based HealthAmerica Corp. for $379.2 million. HealthAmerica had about 850,000 members in 17 states.

Maxicare's total enrollment is doubled as a result of the two acquisitions, and the company now operates HMOs in 23 of the 30 largest metropolitan markets across the United States.

September 1986: Maxicare offers $125 million in 11.75% senior subordinated notes to help finance the acquisitions of HealthAmerica and HealthCare USA. Moody's Investors Service Inc. assigns the notes a rating of Ba3. And, Moody's lowers its ratings on the company's 7% convertible subordinated debentures offered in July 1985 to Ba3 from Ba1.

Moody's downgraded the debt rating because it believed the protection of Maxicare's debt would decline substantially as a result of the borrowing needed to finance the two acquisitions.

December 1986: Maxicare reports net income of $4.6 million for the year, down from $20.4 million in 1985. Revenues in 1936 were $914.4 million, up from $523.3 million in 1985.

March 1988: Maxicare reports a pretax loss of $60.9 million for 1987, citing high costs associated with integrating the HealthAmerica and HealthCare USA with existing Maxicare operations, combined with health care inflation and competitive pressures in the HMO industry.

June 1988: Maxicare restates its 1987 results after writing off $185 million in good will, swelling its total loss for the year to $255 million and creating a negative shareholder equity of $29.3 million as of Dec. 31, 1987.

Aug. 8, 1988: Maxicare's board of directors ousts co-founders Fred W. Wasserman, chairman and chief executive officer, and Pamela K. Anderson, president and chief operating officer. The husband-and-wife team are replaced by Peter J. Ratican, a director who is named chairman, president and CEO.

Mr. Ratican most recently was chief financial officer of DeLaurentis Entertainment Group, a financially troubled filmmaker in Beverly Hills, Calif.

Aug. 22, 1988: Maxicare announces a loss of $59.5 million for the second quarter of the year, swelling total losses for the first half to $80 million, on revenue of $956.47 million. Shareholder equity stood at negative $109.4 million. ■

Hay/Huggins survey

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care, skilled nursing care or outpatient surgery.

Employers also are keeping close track of hospitalization and claims. Some 66% of the respondents said they have some kind of hospitalization review.

The most common type reported is preadmission review, which has been implemented by 57% of the respondents and is under consideration by an additional 15%. And, 14% have an admission review, conducted at the time of hospital admission if precertification is not required; an additional 9% are considering such an option.

Forty-three percent of the respondents have a concurrent review program, which is conducted during hospital stays, and an additional 20% are considering implementing such a program. Twenty-seven percent have a retrospective review program, which is performed after the employee is discharged from the hospital; an additional 7% are considering retrospective review.

In addition to hospitalization review, many employers are reviewing claims, either to determine general trends or to check for accuracy. Almost two-thirds—63%—of the respondents said they perform a general claims analysis to determine trends and problem areas, and 9% are considering such analysis. And, 51% conduct an internal claims review to check accuracy of payment; 11% are considering such a program.

"What you are going to see in the future is a move to managed care," including utilization and claims review and case management, Mr. Carter said.

Employers also are trying to control health care costs by helping employees to avoid getting sick. Some 78% of the respondents said their company has some kind of program to promote employee health, and many employers have more than one program.

"We have found that large employers have become sold on wellness programs," Mr. Carter added.

The most common program is a drug and alcohol assistance program, in place at 60% of the companies surveyed and under consideration at an additional 7%. And, half the companies offer a smoking cessation program while 9% are considering such action.

Some 78% of the respondents said their company has some kind of program to promote employee health, and many employers have more than one program. 'We have found that large employers have become sold on wellness programs,' says Hay/Huggins' Mr. Carter.

Forty percent of the companies have a weight reduction program and 7% are considering implementing one. Thirty-eight percent of the companies provide exercise facilities or subsidize health club memberships for employees, and an additional 8% are considering such sponsorship.

Other health promotion programs reported by the respondents were: high blood pressure control, sponsored by 36% and under consideration by 8%; stress management, offered by 34% and under consideration by 10%; diet counseling, offered by 33% and under consideration by 8%; lifestyle analysis, provided by 21% and under consideration by 8%; and stress testing, conducted by 20% and under consideration by 9%.

Finally, employers are banding together to try to fight escalating health care costs. Some 31% of the respondents said their company participates in a coalition with other organizations for the purpose of medical care cost containment.

The most common activity sponsored by these coalitions is claims analysis, cited by 43% of the respondents involved in a coalition. Some 35% of the respondents said their coalitions are involved in negotiations with hospitals or other providers.

Twenty-eight percent of the respondents involved in employer coalitions said their group operated a peer review program.

In addition to the cost containment efforts of employers, the survey revealed other trends in health care plans. "Health maintenance organizations continue to be a strong presence in employer-sponsored health care programs," the survey reports.

Some 68% of the respondents offer their employees one or more HMO options in their health care plans, and an additional 3% offer only HMO coverage; 29% of the respondents do not offer any HMO coverage to their employees.

In addition, 16% of the employers offer a preferred provider plan as part of their medical care coverage.

In other survey findings:

- All but 14% of the respondents offer coverage to their retirees, and most—63%—offer coverage to both early retirees and those who retire at the normal age. Seventeen percent offer coverage only to employees who retire at the normal age, and 6% cover only those employees who retire early.

Among those companies that provide medical coverage for early retirees, 90% provide the same level of coverage for retirees under age 65 as for active employees under age 65. Almost half—43%—of these employers pay the cost of hospital and medical care coverage for employees who retire before age 65. The employer and retiree share the cost of the coverage in 39% of the companies that provide early retirement coverage, and under-65 retirees foot the whole bill at 13% of the companies.

Some 79% of the companies that provide medical coverage for retirees over age 65 provide the same benefits for these retirees as for active employees, after any offsets for Medicare are considered.

Medical coverage for retirees over age 65 is fully employer-paid at 52% of the companies that provide such coverage. At 29% of these companies, the employer and the retiree share the cost; at 19%, the retiree pays the whole amount.

- "Prevalence of dental plans continues to increase," the authors report. Some 87% of the respondents now have dental coverage for employees: Eight percent cover dental expenses under their major medical plan and 79% have a separate dental plan.

Employers also pick up most of the bill for dental care: Sixty-five percent of the plans are fully employer-paid for individual coverage.

Under most dental plans offered by the respondents, benefits are set at a percentage of reasonable and customary costs, after a deductible is reached. And, most plans tend to provide the most liberal coverage for preventive care, while providing less extensive coverage for areas such as orthodontics.

- Eighty percent of the respondents provide prescription drug coverage for employees under their major medical plans. Twelve percent provide a separate plan covering prescription drugs, and 7% cover employees under both the major medical plan and a separate plan. Only 1% of the respondents do not provide any coverage for prescription drug costs.

Seventy-four percent of the employers that offer a separate prescription drug plan pay the entire cost for employee coverage; 23% share the cost with the employee.

Almost all—89%—of the respondents with a prescription drug plan require a copayment per prescription, and an additional 3% have an annual deductible under the plan. More than three-fourths of the plans with a copayment set the amount at between $1 and $3 per prescription.

- Vision care is offered much less often than dental or prescription drug care. Less than 20% of the respondents offer a separate vision care coverage plan for employees.

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Copies of the survey are available only to those companies that provided data for the survey. Companies that are interested in participating in the survey should contact Hay Client Services, 229 S. 18th St., Rittenhouse Square, Philadelphia, Pa. 19103; 215-875-2660.

Federal regulations tarnish defined benefit plan appeal

By ALISON KITTRELL

Employers are shifting away from defined benefit pension plans due to federal legislation, especially the Tax Reform Act of 1986, according to the "1987 Hay/Huggins Benefit Report."

"Since (the 1982 Tax Equity & Fiscal Responsibility Act), the legislation governing defined benefit plans has continually changed. Possibly the most sweeping changes occurred with the passage of the Tax Reform Act of 1986 and the Amendment of the Age Discrimination in Employment Act," the survey authors say.

"In response to the constant changes in legislation and the increased cost of defined benefit pension plans, it appears that more organizations are shifting toward defined contribution plans as their principal retirement plan," the authors say.

For example, the survey shows that the percentage of employers providing defined benefit pension plans fell to 87% in 1987 from 91% in 1983.

And, in 1987, only 22% of those respondents provided only a defined benefit plan; the remaining 65% provided both a defined benefit plan and a capital accumulation—or defined contribution—plan.

Eleven percent of the respondents provided only a capital accumulation plan, and 2% provided no pension plan (see story, page 33).

"The reports of the death of the defined benefit pension plan have been greatly exaggerated, but the fact is that it is ill," says Michael Carter, senior vp of Hay/Huggins in Philadelphia.

The survey also shows that few changes are being made in defined benefit plans offered by employers, except changes required by law.

For example, the majority of defined benefit pension plans continue to base the benefit on the employee's final average earnings: Eighty-one percent used this benefit formula in 1987, compared with 84% in 1985 and 1983.

And, 98% of the plans that used a final average earnings formula in 1987 used the highest-paid five or fewer years in determining the employee's average earnings.

Almost half—45%—of the respondents require employees to be at least 21 years of age and have one year of service before being eligible for the pension plan. But, 24% report that employees are immediately eligible for participation in the defined benefit pension plan.

Other eligibility requirements are: minimum age of 21, reported by 5%; minimum age of less than 21, reported by 2%; minimum service of one year, reported by 14%; minimum service of less than one year, reported by 4%; and some other requirement, reported by 6%.

A strong majority—87%—of the respondents with defined benefit pension plans do not require or allow employees to contribute to the plan, and 2% say employees are allowed but not required to make contributions.

The most-common vesting schedule in 1987 was 10-year cliff vesting, reported by 66% of the respondents with a defined benefit pension plan. Thirteen percent said they allowed partial vesting to begin after a certain number of years of service, usually five, and then reached full vesting after another number of years. The remainder used some other vesting formula.

However, most of the employers are going to have to change their vesting formulas in response to the Tax Reform Act of 1986. Beginning in 1989, vesting schedules must be changed to five-year cliff

Continued on next page

401(k) leads capital accumulation boom

By ALISON KITTRELL

Capital accumulation plans, especially 401(k) plans, are picking up the slack as employers become increasingly disenchanted with defined benefit pension plans, says the "1987 Hay/Huggins Benefit Report."

"There have been no additional resources spent on defined benefit plans and instead, those resources are going to 401(k)," said Michael Carter, senior vp of Hay/Huggins in Philadelphia.

Capital accumulation plans often are being used to supplement defined benefit pension plans, with some 65% of survey respondents offering both, the survey shows.

In addition, the plans also add a savings opportunity that both companies and workers find attractive, the survey says.

"Employers find capital accumulation plans appealing because of their relatively low and predictable cost compared with defined benefit pension plans, while employees find them attractive due to their individual account balance and investment selection features," the survey authors say.

The fastest-growing type of capital accumulation plan is clearly the 401(k) salary reduction plan, especially plans in which the employer matches employee pretax contributions.

The survey shows that, in 1987, 54% of the respondents offered a 401(k) plan with employer matching contributions, compared with only 43% in 1985.

And, 10% of respondents offered a 401(k) salary reduction plan only, with no employer contribution, compared with 6% in 1985. Five percent offered a 401(k) plan with a fixed employer contribution in 1987, compared with 6% in 1985.

The authors also note that "As the prevalence of 401(k) matching plans has rapidly increased over the past few years, the prevalence of traditional, aftertax matching savings plans has decreased just as dramatically. . . .Clearly, the vast majority of traditional thrift plan sponsors have amended their plans to give employees the opportunity to save on a pretax basis."

For example, the number of respondents offering aftertax thrift plans with an employee match dropped to 6% in 1987 from 12% in 1985. And, the number of public company respondents offering an employee stock ownership plan plummeted to 7% in 1987 from 47% in 1985.

'Employers find capital accumulation plans appealing because of their relatively low and predictable cost compared with defined benefit pension plans,' the survey authors say.

A strong majority—84%—of the 401(k) plans with an employer match provide a specified percentage match for all employees. For 11% of the 401(k) matching plans, the match varied according to the company's profits, and for 5%, the match varied according to the employee's length of service.

Fifty-five percent of the 401(k) plans with an employer match provide the match on an amount equal to up to 6% of employee compensation. Fifteen percent of the plans match up to 5% of compensation, 12% match up to 4%, and 7% match up to 3%. Other levels of compensation eligible for the employee match were: less than 3%, reported by 2%; 7%, reported by 1%; 8%, reported by 2%; 10%, reported by 5%; and more than 10%, reported by 1% of the respondents.

Just more than half—51%—of the respondents with a 401(k) match said they match employee contributions at 50 cents on the dollar. Eighteen percent said they provide a dollar-for-dollar match on employee contributions up to the specified limit.

Other matching levels reported were: less than 25 cents on the dollar, cited by 2% of the respondents; 25 cents, cited by 8%; 26-40 cents, cited by 4%; 51-74 cents, cited by 7%; 75-89 cents, also cited by 7%; and more than $1, cited by 3%.

In most cases, the vesting requirements for 401(k) plans are liberal. The survey authors note, "To encourage employee participation in the plans and to use the employer matching contribution in the anti-discrimination tests, nearly 32% of the plan sponsors offer full and immediate vesting. The vast majority of plans that do impose vesting requirements fully vest employer contributions at five years or less of service."

Nine-tenths of the respondents with 401(k) matching plans give their employees a choice among investment vehicles. Of these, 62% allow employees to choose the investment for both employee and employer contributions, 36% allow them to choose for employee contributions only, and 2% allow them to choose for employer contributions only.

Forty percent of respondents allow employees to change investment options on an annual basis. Twenty-six percent allow them to change investment options semi-annually, 23% allow a change to be made quarterly, and 11% have some other requirements for making an investment change.

In addition, 51% of respondents have plans that permit employees to take out loans on their 401(k) plans.

Finally, the survey shows that, while 401(k) plans have increased dramatically and aftertax thrift plans have declined, the incidence of profit-sharing plans has remained about the same. Thirteen percent of the respondents in 1987 reported offering a profit-sharing or stock bonus plan, compared with 15% in 1985.

All classes of employees are eligible to participate in the profit-sharing or stock bonus plan offered by 73% of the respondents that offer such a plan. Eligibility is open only to salaried employees at 13% of the plans, only to non-bargaining employees at 11% of the plans and only to salaried exempt employees at 3% of the plans.

More than half—56%—of the profit-sharing or stock bonus plans do not allow employee contributions. But, 44% of the plans allow voluntary employee contributions on an aftertax basis. About three-fourths of the plan sponsors set a minimum voluntary employee contribution of 1% of compensation, and a maximum of 10%.

At 56% of the profit-sharing or stock bonus plans, the employer contribution is at the discretion of the company's board of directors; at the remaining 44%, the contribution is according to a predetermined formula. ■

Defined contribution plans

Continued from previous page

vesting; 20% annual vesting from years three through seven; or full vesting after two years of service.

Slightly more than half—51%—of the respondents with a defined benefit pension plan reported that they had granted a cost-of-living adjustment at least once during the last seven years. However, only 9% have a formal cost-of-living adjustment provision in their pension plan.

Most of the COLAs provided during the last decade by plans without a formal provision were given in the 1980s: Some 24% of these respondents said their most recent pension benefit increase was given in 1979-81, 27% said it was in 1981-82, 22% said it was in 1983-84, and 21% said it was in 1985-86. Only 4% said their last increase was given between 1977-78, and 2% said their last increase was in 1987.

Ninety-percent of the employers with defined benefit plans offer a reduced benefit to those employees who retire before the normal retirement age, if certain requirements are met. And, 44% provide full benefits for early retirees under certain conditions.

The most common requirement for unreduced early retirement benefits is meeting age and service requirements, cited by 40% of the respondents that offer such benefits. ■

Demographics dictate benefit changes

By ALISON KITTRELL

Changes in American society are having a profound effect on the benefits U.S. employers offer, according to a recent survey.

"Changing workplace demographics—as evidenced by the increase in the number of single parents and two-income families, and the decrease in the number of 'traditional' family units—are expected to have a continuing effect on the design of personnel policies in the coming years," says the "1987 Hay/Huggins Benefits Report."

In addition to changing demographics and family makeup, the survey says, benefits are being affected by other social trends, such as concern about drug use, acquired immune deficiency syndrome and the need to help employees lead healthier lives.

Part of the motivation, according to Hay/Huggins Senior Vp Michael Carter, is that, as the baby boomers age, the pool of entry level workers is shrinking, and employers must compete more for employees, especially in certain areas.

Demographic changes are the most dramatic, and are being felt in several ways. "Employers have implemented a number of policies in recent years designed to assist the growing number of single parents and working mothers on their payrolls," the survey reports.

For example, 96% of the respondent companies allow employees to take unpaid leaves of absence for several reasons, and 81% of these grant maternity leave to their employees.

Of the employers that grant leaves of absence, two-thirds allow a leave of up to six months, and 27% grant leaves of up to a year; the remaining 6% will grant unpaid leaves of absence of more than a year.

And, the authors note, "Although still not common, child care programs continue to grow." Nine percent of the respondents to the 1987 survey provided some child care benefit for employees and an additional 12% are considering such a benefit. In contrast, fewer than half that number—4%—offered a child care benefit in 1985 and in 1983.

Of the employers who offer a child care benefit, 30% provide an on-site child care facility and an equal percentage provide referral service for parents looking for child care.

In addition, 28% subsidize an off-site facility, and 11% said they have banded together with other employers to finance one or more off-site centers.

Twenty-three percent use a voucher system, in which the employer directly reimburses either the employee or the child care provider and 8% use a vendor system, in which the employer contracts for guaranteed slots in an outside child care facility. Thirteen percent of the respondents with child care benefits use some other method of providing those benefits.

Forty percent of the respondent companies have some form of flexible hours, which also often is seen as a boon to working mothers and single parents. Eighteen percent of the respondents have flexible hours for salaried exempt employees in all departments, and 22% have flexible hours for those employees in certain departments.

'Employers have implemented a number of policies in recent years designed to assist the growing number of single parents and working mothers on their payrolls,' the survey reports.

Among employers with flexible hours, virtually three-fourths said their reason for introducing the schedule was employee satisfaction.

Health concerns also are high on employers' benefit lists. For example, 9% of the respondents have implemented a formal policy on AIDS. Of these, 89% do not restrict the duties or work areas of employees with the disease.

Employers also are concerned about the use of drugs and alcohol in the workplace. Twenty-one percent of the respondents to the 1987 survey said their company tests employees for drug use. The highest incidence of drug testing is in the South, where 35% of employers test employees for drugs. Drug testing was reported by 22% of the employers in the Central states and in the Mountain and Western states, by 18% of employers in the Mid-Atlantic and the Plains states, and 11% of the employers in New England.

"The overwhelming majority of companies with drug testing programs test only new employees, while 6% use random testing of the workforce," the survey reports.

And, "Further expansion of drug testing may depend on the outcome of pending litigation to restrict drug testing in the workplace," it adds.

Employers not only are taking a hard-line approach toward problems like drugs, but also are implementing programs to help their workers deal with these and other problems.

"A recognition that increasing societal, personal and economic pressures often take their toll on employees has encouraged many employers to establish employee assistance programs," the authors say.

Some 49% of the participants in the 1987 survey sponsor an EAP, compared with 43% in 1985 and only 37% in 1983.

"There is a different attitude emerging among employers: 'Hey, we have people working for us, and people have problems,' " said Mr. Carter.

In addition to the formal EAPs, 13% of the 1987 survey respondents said they provide employee assistance on an ad hoc basis, 3% said they are currently developing an EAP, and 7% said they are considering sponsoring an EAP.

The most common assistance provided through the EAPs is help with drug and alcohol-related problems, provided by 93% of the EAPs. Eighty percent provide personal counseling, 76% help with family problems, 70% provide assistance for employees in coping with stress and 64% provide financial counseling.

Forty-two percent of the employers with a formal EAP provide assistance through an outside facility, 38% have an in-house program and 20% use both in-house and outside resources.

Other survey findings about benefits include:

- Five percent of employers provided coverage for adoption expenses in 1987, up slightly from 4% in 1985 and 1983. "However," the authors say, "more organizations may begin to consider this benefit as employee interests and perceptions of benefit plan limitations change."
- Eleven percent of respondents in 1987 offer individual insurance, including auto, homeowners or renters coverages, funded through payroll deductions.

And, 6% of the respondents offer group auto insurance to their employees. Some 75% of these plans are fully employee-paid, 8% are employer paid, and 17% share the cost.

- Thirty-nine percent of the respondents had a formal benefits communication program in 1987, compared with 33% in 1985. Most of the programs use more than one means of communication, including booklets, memos, group meetings, audiovisual aids, bulletin boards and benefit statements.

"Increasingly, employers are developing formalized employee benefit communication programs. Most are designed to address issues of cost containment in medical insurance programs and to generate greater cost efficiency in employee benefit programs," the authors say.

- Fifty percent of the respondents have a formal policy regulating smoking in the workplace. Almost half of these employers—47%—have designated areas in which smoking is allowed; 35% have designated areas in which no smoking is allowed.

Eleven percent do not allow smoking in the workplace, and 15% allow an employee to request a no-smoking area. Five percent have some other policy regarding smoking.

"As our society becomes more health-conscious, today's organizations are seeing the results of a healthier workforce and are taking an active role in supporting this lifestyle. This is evidenced by the fact that half of the responding organizations have adopted smoking policies and 14% are considering adopting a policy," the authors say. ■

401(k) tests

Continued from page 1

As a result, a plan that would have passed the current rules allowing double use of the 200% test could now flunk and be deemed discriminatory.

For example, a plan in which the average deferral percentage (ADP) of the higher-paid was 6%, while the lower-paid's ADP was 4% would pass the 200% test. And, if the plan matched deferrals dollar for dollar, the 401(m) portion also automatically would pass the 200% test. In that case, the average contribution percentage (ACP) would be 6% for the higher-paid and 4% for the lower-paid.

But, under the new testing procedure, such an arrangement would automatically fail and be considered discriminatory because the 200% test would have been used twice.

Some benefit experts are angered by the new testing procedure. They note that arrangements, for example, in which employers equally match workers' 401(k) deferrals, should be considered inherently non-discriminatory.

'The regulations strain credibility. Where is the unfairness and injustice in a matching situation?' Asks Edward J. Davey, a principal with A. Foster Higgins & Co. Inc.

"The regulations strain credibility. Where is the unfairness and injustice in a matching situation? Yet, because of this mechanical formula, a plan could be in trouble. That does not make sense," said Edward J. Davey, a principal with A. Foster Higgins & Co. Inc. in New York.

"This is another swipe at the higher-paid," noted Harry Gross, a partner with benefit consultant Kwasha Lipton in Fort Lee, N.J.

Some savings plans will not be affected. For example, the rules will have no impact on employers offering "stand-alone" 401(k) plans in which employers do not make matching contributions or where employees are not allowed to make aftertax contributions. Employers sponsoring such stand-alone plans, which are not common, can continue to use the 200% test.

But many employers with 401(k) and 401(m) features in their savings plans that have been making double use of the 200% test will need to make changes.

"The new rules are going to be tough," said Gary Blank, a consultant in the San Francisco office of The Wyatt Co. and chairman of Wyatt's defined contribution plan practice committee.

For example, Mr. Blank found that three of the first five client savings plans that he studied after the 401(k) rules were published last month could not pass under the new testing procedure.

Companies sponsoring savings plans with 401(k) and 401(m) features that cannot pass the new test have a number of options open to them, most of which will hurt the higher-paid. Those options, according to benefit consultants, include:

- Cut back on 401(k) deferrals by the higher-paid to reduce the difference in the higher and lower-paid employees' ADP.

Even prior to the IRS rules, though, companies with 401(k) arrangements have had difficulty passing the ADP tests.

For example, an upcoming Hewitt Associates survey will report that 50% of companies with 401(k) arrangements failed the ADP tests last year. The typical action taken by the employer after its plan was unable to pass the ADP tests was to place new limits on deferrals by the higher-paid.

The new IRS rules could mean yet more cutbacks for the higher-paid.

- Realign matching contributions. For example, an employer could match a greater percentage of lower-paid employees' deferrals than deferrals by the higher-paid.

Alternatively, a company could "cap" matching contributions at a fixed dollar amount, such as $500.

Such a cap would help the plan pass the nondiscrimination testing procedure since the capped matching contribution would amount to a lower percentage of salary for higher-paid employees than for the lower-paid.

- Restructure matching contribution formulas to give the lower-paid more incentives to make deferrals.

For example, a company could decide to fully match the first 3% of deferrals rather than match 50% of the first 6% of deferrals.

- Eliminate or sharply reduce the amount of aftertax contributions, especially for the higher-paid.

"With these new limits, an employer may decide it is not worth having an aftertax feature," said Henry Saveth, a managing consultant with Foster Higgins in New York.

If companies do have to cut back on contributions and deferrals for the higher-paid, they are likely to consider new programs, such as so-called non-qualified plans, for top executives to make up for the highly paid employees' cutbacks.

"Non-qualified plans will be a way of addressing these new limits," said Mr. Saveth.

However, non-qualified plans are more costly for an employer, while the benefits are less secure for employees. Employers cannot take tax deductions for advance-funding the plans, though they can take a tax deduction when a benefit is paid. Employees' rights to these benefits also are not guaranteed.

Aside from having problems passing the new test, companies with 401(k) and 401(m) provisions will have a much more complicated testing procedure to follow.

"The recordkeeping changes required will be quite significant. There will be a fair amount of reprogramming that will have to take place," said Frederick Rumack, director of taxes and legal services for Buck Consultants Inc. in New York.

"The rules are tough, both literally and administratively," said Karen Frost, a consultant with Hewitt Associates in Lincolnshire, Ill.

"Testing will be more complicated, though it will not be a monumental task," added Gerald Uslander, a principal in the Louisville, Ky., office of William M. Mercer-Meidinger-Hansen Inc.

Employers shouldn't take any comfort that the IRS rules on testing procedures are proposed rather than final.

In the preamble to the regulations, the IRS says it will apply the proposed regulations when auditing tax returns and savings plans.

"Employers should take these proposed regulations very seriously," advises Kwasha Lipton's Mr. Gross. ■

Complex tests await employers with 401(k) plans

By JERRY GEISEL

WASHINGTON—While the tax Reform Act of 1986 allowed employers to use the more liberal 200% test on both 401(k) deferrals and 401(m) contributions, it also granted the Internal Revenue Service authority to draft rules eliminating this double use.

As a result, under proposed IRS rules published Aug. 8 in the Federal Register, an employer effective Jan. 1 will have a choice of using the 200% test on either the 401(k) or 401(m) feature of its plan.

But, rather than simply requiring another test to be used on the feature of the plan not subject to the 200% test, the proposed IRS rules establish a new combination test in which ADPs and ACPs—average contribution percentages for 401(m) contributions—are combined and subsequently compared.

The regulations lay down the following sequence of steps in testing arrangements with 401(k) deferrals and 401(m) contributions:

Effective Jan. 1, an employer will have a choice of using the 200% test on either the 401(k) or 401(m) feature of its plan.

- First, the non-highly compensated employees' ADP or ACP, whichever is higher, is multiplied by 125%.
- Second, the employer would determine the lesser of the non-highly compensated employees' ACP or ADP.
- Third, the employer would take the percentage in the second step and determine which is less: that percentage multiplied by two, or that percentage plus two.
- Fourth, the employer would add the percentages reached in steps one and three. The total is the aggregate limit for the highly compensated.
- Fifth, the employer would add the sum of the ADP and ACP percentages for the highly compensated employees.

If the sum of the ADP and ACP percentages for the highly compensated employees does not exceed the aggregate limit for the highly compensated, the plan has not made double use of the alternative 200% test and passes muster.

An example, which was developed by The Wyatt Co., illustrates how these calculations would be carried out.

The example assumes that the 401(k) ADP for the highly compensated is 6% and the ADP of the lower-paid is 4%. In addition, the example assumes that the 401(m) ACP for highly compensated is 3.8%, while the lower-paid's ACP is 3%:

- Step one: Multiply 125% times 4%. The result equals 5%.
- Step two: The lesser of the ADP or ACP for the non-highly compensated is 3%.
- The lesser of two times 3% or 3% plus 2% is 5%.
- Add the result of step one (5%) and step three (5%). The result is 10%, which is the aggregate limit for highly compensated employees.
- Add the ADP of the highly compensated (6%) and the ACP of the highly compensated (3.8%). The sum is 9.8%.

Since 9.8% is less than 10%—the aggregate limit for the highly compensated employees—the plan has not made double use of the 200% test and would be considered nondiscriminatory.

The Byzantine IRS rules do, however, give employers a new opportunity to pass the non-discrimination tests even if the highly-paid employees' ADP or ACP initially flunks the 200% test.

Under this aspect of the IRS regulations, employers are allowed to transfer or move "excess" ADP or ACP not necessary for discrimination testing purposes.

For example, if the highly compensated employees' ADP was 4.5% and the lower-paid employees' ADP was 4%, the employer could transfer 1.5% of "excess" 401(k) lower-paid deferrals not needed to pass the 401(k) test to help the company pass the 401(m) test.

Currently, such transfers are not allowed.

However, after such a transfer occurred, the employer still would have to run the new combination test that compares ADPs and ACPs to determine if the 200% test has not been used twice.

Fibreboard proposal

Continued from page 3

cording to company documents.

In addition to the $115 million in undisputed insurance Fibreboard has remaining, the company listed $251.9 million in assets as of March 31.

Fibreboard's pending claims alone could deplete its available insurance and assets.

The company now faces some 46,000 pending asbestos bodily injury claims totaling at least $357 million. Fibreboard says it costs about $7,770 to defend and settle each bodily injury claim. During the first three months of 1988 alone, Fibreboard spent more than $19 million to settle or defend 2,460 asbestos bodily injury claims.

To date, Fibreboard has paid approximately $229 million to resolve approximately 27,640 claims, not including defense costs.

Of that $229 million, all but approximately $16 million was paid by Fibreboard's insurers. The company's main primary insurer until 1985 was Fireman's Fund Insurance Cos. of Novato, Calif.

Both Fibreboard and Fireman's were members of the Asbestos Claims Facility, which is being dissolved (see story, page 2).

Several other asbestos producers faced with an overwhelming number of asbestos bodily claims have been forced into bankruptcy, including Manville Corp., UNR Industries Inc. and Nicolet Inc. Manville is currently attempting to emerge from reorganization, UNR has proposed a plan of reorganization and Nicolet is being dissolved.

In the event Fibreboard files for bankruptcy, the claimants' settlements are not secured and would be treated the same as all other creditors.

Under the deferred settlement program, claimants would release Fibreboard from "any and all liability associated with any asbestos claim against Fibreboard," in return for notes payable on Sept. 1, 1993, or Sept. 1, 1996.

Claimants, in agreeing to the settlement, also agree to free Fibreboard from any liability for claims they are not yet aware of. In addition, claimants release Fibreboard's distributors from any liability for distributing asbestos-containing products.

'We understand Fibreboard's situation, and we think we can work with them,' according to plaintiffs' attorney David McClain with the law firm, Kazan & McClain of Oakland, Calif.

Fibreboard says it may pay claimants sooner if it resolves its insurance disputes.

Claimants could receive extra money if Fibreboard is successful in bad faith litigation it has brought against Continental Casualty and Pacific Indemnity.

Fibreboard says it would use half the money garnered in either bad faith action to pay bonuses to settling claimants and half to replenish costs of administering the settlement program.

Plaintiffs' attorneys are guardedly optimistic about the plan.

"We understand Fibreboard's situation, and we think we can work with them," according to plaintiffs' attorney David McClain whose firm, Kazan & McClain of Oakland, Calif., organized a group of 15 West Coast law firms to examine the plan. The firms represent thousands of Fibreboard claimants.

"However, significant modifications are necessary," said Mr. McClain.

For example, plaintiffs' attorneys say the settlements should be secured by Fibreboard property in the event the company does file for bankruptcy.

And, they believe Fibreboard should use the $115 million it has in uncontested insurance and any corporate profits to make partial payments on the settlements.

"We need time to review all the details of the plan," said Mr. McClain, adding that plaintiffs attorneys might not be ready to act on the plan until Dec. 1.

Fibreboard insurers contacted last week had no opinion about the plan.

Fibreboard, which stopped making asbestos-containing insulation products in 1971, also produces and sells wood and insulation products and operates a Lake Tahoe, Calif., ski resort. ■

Quality suit

Continued from page 2

imposed several conditions on SEAR and Quality.

The order also required Quality's president to report any changes in the insurer's operations that could lead to a change in its economic condition, and required prior insurance department approval of reinsurance agreements with SEAR.

In addition to fraud and other allegations, the West Virginia department charges the defendants with violating the acquisition order in a series of transactions with several other insurance companies.

For example, Quality—primarily an auto insurer before its 1982 acquisition—in 1985 started writing animal mortality risks produced by Triple Crown Insurers Inc. of Miramar, Fla. Quality reinsured the risks with IEA syndicates, SEAR, Dallas-based Lloyd's U.S. and Jordbrukets, a Belgian insurer, the complaint says.

Also, the suit says that SEAR and Quality's management failed to obtain a written reinsurance contract from IEA; failed to obtain adequate security from the syndicates on the program; reinsured part of the program with SEAR in violation of the acquisition order; and allowed Triple Crown to bind mortality risks in Florida before Quality was licensed in the state.

Citadel Management, which was involved in managing the mortality program, was also owned in part by Messrs. Cordle, Abdallah and Yousri, and these ownership interests represented a conflict of interest that violated state insurance law, the complaint charges.

Quality sustained heavy losses on the program, the complaint indicates: apart from a $297,828 commutation with W.F. Poe Syndicate, other IEA syndicates have paid only $558,226.11 on total estimated reinsurance obligations of $4.2 million.

IEA syndicates have refused to honor payment demands from Quality, questioning the accuracy of reports submitted by Triple Crown and Quality, the suit says.

Court papers filed before Quality's liquidation estimated the insurer's total premium volume on the program at more than $7 million.

SEAR and Quality's management defrauded Quality and its policyholders in transactions with several other insurers, the suit says, including:

- Lincoln National. Under a complex series of contracts, Quality agreed to reinsure three other insurers, retroceding a majority of the business to Lincoln National, which in turn retroceded a majority of the risk to SEAR. Quality, Lincoln National and SEAR agreed that Quality would handle premium payments to and loss collections from SEAR.

While Quality paid SEAR its portion of the reinsurance premiums, SEAR did not pay its share of the losses to either Quality or Lincoln National, the suit alleges.

In addition to this diversion of funds to SEAR, SEAR and Quality's management also defrauded Lincoln National by submitting false billing invoices they knew to contain duplicate entries, the suit says.

Lincoln National currently is suing SEAR and directors and officers of SEAR and Quality in U.S. District Court in Cincinnati. The suit is set for trial on Nov. 7.

- Forum Insurance Co., Calvert Insurance Co., Mead Reinsurance Corp. and Universal Reinsurance Corp. These insurers ceded reinsurance to Quality, which in turn ceded 100% of the business to SEAR.

Quality was not compensated for acting as a fronting reinsurer for SEAR, and SEAR later failed to pay claims to the ceding companies, the suit says. Quality's management failed to report the transactions in its 1985 annual statement, and violated the acquisition order requiring prior approval for reinsurance with SEAR.

- Union America, which ceded automobile risks to both Quality and SEAR. When SEAR realized the business would prove unprofitable, however, it transferred its risk to Quality for 100% of the premium it received, the complaint says.

- Dependable, which ceded 50% of a book of Puerto Rican auto business to Quality starting in January 1984. The two companies did not execute a formal reinsurance treaty, but relied on a two-page cover note, the suit says.

Quality management claimed it canceled the agreement as of Sept. 30, 1984, by oral notice to Mr. Cordle, who was then the managing agent representing Dependable, the suit says.

However, when Dependable later insisted on a written reinsurance treaty, Quality officials signed the treaty Feb. 4, 1986, with no mention of the alleged cancellation.

Dependable maintains that the treaty was never canceled. Arbitration of Dependable's demands has been stayed by agreement of the parties, according to the suit, which adds that Quality's share of losses and unearned premiums on the business amounts to more than $6 million.

- Omaha Indemnity. Through managing general agent Royal American Managers Inc., Omaha Indemnity reinsured Quality on a book of workers compensation and liability risks for lumbermen.

However, Omaha canceled the agreement after four months and SEAR did not follow through on a promise to find replacement reinsurance or fully reinsure Quality itself, the suit charges.

In addition to allegations of fraud and mismanagement relating to these transactions, the complaint charges that SEAR drained funds from Quality through a "sham" service agreement, under which SEAR received 2% of Quality's net premiums for advising the insurer and monitoring its reinsurance programs. SEAR provided no such services, the suit says.

Knowing in late 1985 that Quality would be placed in receivership if its true financial condition were known, SEAR and Quality's management filed a false 1985 annual statement, the complaint says. Among other things, the false statement failed to report transactions with the IEA and SEAR and understated Quality's liabilities by more than $10 million, the suit says.

The suit seeks total damages of $15 million, which could be trebled under the federal Racketeer Influenced and Corrupt Organizations act. The complaint also levels charges of negligent mismanagement, breach of fiduciary duty, fraud and fraudulent concealment.

In addition, Mr. Britt is charged with embezzlement for allegedly buying a salvaged Quality-insured auto and selling it back to Quality at a higher price; and for selling a similarly salvaged auto to his daughter for a fraction of its value (*BI*, Oct. 12, 1987).

None of the defendants has yet filed an answer, and all but SEAR, SEAR Agency and Mr. Yousri have received extensions to respond.

In an interview, Mr. Cordle denied any conflict of interest on either the animal mortality business or the Dependable book.

Citadel did not receive any compensation on the mortality risks other than a 1% override from W.F. Poe Syndicate, which did not cover the manager's expenses, Mr. Cordle said.

He added that the Dependable business was bound before he became a Quality director, and that he later resigned as a director because he saw what could have been construed as a conflict stemming from his former representation of Dependable.

"I don't think they have any case at all against me," Mr. Cordle said.

James Burke, a Cincinnati lawyer representing Messrs. Abdallah, Saud and Elsewedy, said that his clients "disagree with the allegations in the complaint" and have "meritorious defenses," but he declined to comment on specific suit allegations.

The other defendants or their lawyers could not be reached for comment. ■

Air show disaster

Continued from page 1

tory will hold the Italian government liable for unlimited losses from the Ramstein disaster, said Mr. Urwantschky.

The West German government will be expected to settle all claims on behalf of the government of Italy, he said. Then, under diplomatic agreements between countries belonging to the North Atlantic Treaty Organization, the German government is expected to seek recovery from the Italian government, he said.

Section 53 applies only to military aircraft that fly in West German territory, said Mr. Urwantschky. Under the provision, the government that owns the military aircraft is unlimitedly liable "irrespective of negligence."

Under other sections of the law, the liability of an owner of a civilian aircraft that caused third-party injury or damage is limited based on the weight of the aircraft at takeoff. "But these limitations do not apply to military aircraft," he said.

Under the law, compensation for victims of West German airline disasters receive a maximum of 320,000 deutsche marks ($170,464) per individual. Under this formula, total claims from Ramstein would be about $70 million if all of the injured received the maximum compensation.

However, Mr. Urwantschky says compensation from Ramstein will not be that simple.

"If a breadwinner and husband were killed, the Republic of Italy also would pay for the loss of maintenance," less whatever was recovered from life insurance and pension plans, he said. However, the life insurers and pension funds could subrogate against the Italian government, he said.

"If a person wasn't killed, but died later, then the hospital bills will have to be paid," he said, adding that damages for pain and suffering might also be paid.

A U.S. Air Force spokesman at Ramstein said a decision has not yet been made over which government will be responsible for compensating victims. Europeans with claims must file them with the West German Office of Defense Costs in Koblenz, he said. Americans should file claims with the Staff Judge Advocate Office at Ramstein, he added.

The U.S. Department of Defense said last week that six Americans were among those killed and 41 Americans were injured.

The disaster occurred Aug. 28 when the 10-man Freccie Tricolori team flying Italian military MB 339A jet trainers was performing its popular heart-shaped aerobatic maneuvers.

All 10 aircraft had pulled into a vertical climb and approaching 3,000 feet, the team divided. Five aircraft looped over to the left in V formation and four veered to the right in diamond formations, using smoke to make the shape of a heart. The 10th pilot, taking the role of Cupid's arrow, looped his aircraft over the back of the heart.

Flying at 300 mph, the solo plane attempted to pierce the heart with the other planes flying as low as 50 feet above the ground. However, the solo plane collided with two other fighters and hurtled into the crowd below. The other two aircraft crashed near the air base runway, away from the spectators.

The Italian team has liability insurance with limits of about 3 million deutsche marks ($1.6 million) per aircraft written in the Italian insurance market, confirmed Benito Pagnanelli, group aviation and aerospace chairman of Assicurazioni Generali SpA. in Trieste, Italy.

Generali, Italy's largest insurer and a leader in worldwide aviation insurance, did not participate in the coverage, though it may reinsure a portion of the coverage, he said.

Had the Ramstein air show been a civilian event, the organizers probably would have purchased general liability insurance with limits of between 300,000 deutsche marks ($159,820) per accident, if it were a small show, to a maximum of 10 million deutsche marks ($5.3 million), said George Wilking, underwriter for Luftpool, the West German aviation insurance pool in Munich that writes coverage on behalf of 80 German insurers.

And the owners of the aircraft, who are required to be insured under German law, would have purchased about 850,000 deutsche marks ($450,000) to 10 million deutsche marks, he said.

The Italian team's coverage was a "typical" limit, he added.

However, Mr. Pagnanelli pointed out that the insurance for the Italian planes will hardly be enough to pay the losses, which he estimates will total between $200 million and $300 million.

"Italian reports say that the German government should pay for the disaster," added Mr. Pagnanelli. "I don't think the Italian government will pay."

Italian government officials in Rome could not be reached for comment. The Italian embassy in London would not take calls.

The Ramstein disaster brings the total number of people killed at European air shows since 1953 to 185 spectators and pilots. While dozens of pilots have been killed at U.S. air shows, no spectators have been killed since enactment of the Federal Aviation Act in 1958.

On May 6 of this year two British Royal Air Force personnel died at Hannover, West Germany, when their RAF Chinook helicopter hit a loading ramp with its back rotor and burst into flames during an air show.

The RAF has 25 million pounds ($42 million) of liability insurance, purchased by the British Ministry of Defense, covering all military aircraft, says a London underwriter who participates on the coverage.

The policy covers claims from ticketed passengers on Defense Ministry aircraft, third parties at civil flying displays and claims for injuries or damage caused by Defense Ministry parachutists, said the underwriter. However, the policy excludes coverage for air shows outside England and Europe, he said.

The coverage is brokered by Bain Clarkson Ltd. ■

U.S. safety regulations reduce chances of air show disasters

By MICHAEL BRADFORD and STACY SHAPIRO

Safety regulations governing air shows in the United States reduce the chance of a disaster like the tragedy at the Ramstein Air Base in West Germany, experts say.

In fact, since the enactment of the Federal Aviation Act in 1958, "there has never been a performance in which an (aerobatic) accident involved a spectator," said Rick Nadeau, executive director of the International Council of Air Shows in Jackson, Mich.

Major U.S. air show operators commonly purchase liability insurance in case an accident does occur, observers say. And, some operators also require performers to buy coverage.

However, a broker who specializes in air show coverage says that more than half of smaller air shows do not buy liability insurance.

Federal Aviation Administration regulations forced the Italian aerobatic team Frecce Tricolori, which triggered the Ramstein tragedy, to modify its program when the pilots performed in the United States in 1986, Mr. Nadeau pointed out.

The Italians were required to perform at a greater distance from crowds in the United States because of FAA regulations regarding stunt flying near spectators.

"In 1986, the Italian team toured the U.S. and did 12 shows in North America," said Mr. Nadeau. "Their performance was modified before they came to the United States."

Mr. Nadeau and other air show experts claim the FAA regulations that govern the events in the United States are stringent enough to minimize the chances that spectators will ever be harmed by a crash.

The FAA rules, he pointed out, "separate the spectators and the activities."

One FAA rule that required the Italian team to modify its program in 1986 requires all stunts by jets to be completed at a point at least 1,500 feet from spectators.

"If you do a loop or an arcing turn, you have to finish it at least 1,500 feet before the crowd," said George Wedekind, executive director of the annual Dayton Air & Trade Show in Dayton, Ohio.

An FAA spokesman in Washington pointed out that the agency also prohibits any aerobatics below 500 feet or over crowds. Even level flying is prohibited at U.S. shows below 1,000 feet above spectators, he said.

The Italian jets were only 50 feet-100 feet above the ground when they collided.

Mr. Wedekind pointed out that pilots at U.S. air shows are authorized by the FAA to fly at certain altitudes according to their experience. Pilots with the most experience are allowed to fly at lower altitudes.

Although Mr. Wedekind couldn't rule out the likelihood of a disaster at a U.S. air show like the Ramstein tragedy, he said the FAA regulations keep the performers far enough from crowds that the potential for disaster is greatly minimized.

And, he pointed out that the Dayton air show, which attracts crowds of 100,000 per day during the aerobatic performances, has some rules of its own.

"As an added precaution, we do not take a first-time flyer," Mr. Wedekind said. "We only take those that have had two or three years of flying in front of crowds."

Air show officials observe pilots during at least two performances before allowing them to participate in the show, which is held at Dayton International Airport, he noted.

If a plane were to crash into the crowd at the Dayton show, a team of medical and fire suppression experts would be standing ready, Mr. Wedekind explained. "And we supplement that with a secondary team from the Air Force base nearby."

In addition, two military helicopters are on the field if needed to evacuate any injured and a commercial

Continued on next page

Update

Howden criminal trial set

Continued from page 2

tives in 1982 (*BI*, Aug. 2, 1982).

Magistrate James Dunn decided last week that prosecutor Timothy Langdale had a strong enough case against former Howden Chairman Kenneth Grob, charged with 55 counts of theft and false accounting, and former Lloyd's underwriter Ian Posgate, charged with three counts of theft and conspiracy.

"I am entirely satisfied that you both have a case to answer and should stand trial on all charges," Magistrate Dunn told Messrs. Posgate and Grob.

The other two defendants, former Lloyd's underwriter Colin Hart and former Howden Director Jack Carpenter, did not contest whether the case should go to trial.

The four defendants and former Howden Director Allan Page were arrested in July 1987 on charges stemming from the alleged theft of underwriting funds from Howden and Lloyd's syndicates formerly managed by Howden. Charges were dropped against Mr. Page in June because he is ill (*BI*, June 13).

Bendectin ruling upheld

CINCINNATI—The anti-nausea drug Bendectin was not responsible for the birth defects in some 1,150 plaintiffs, the 6th U.S. Circuit Court of Appeals ruled last week.

In upholding a 1985 lower court ruling, the court relied on laboratory studies that indicate Merrell Dow Pharmaceuticals Inc.'s Bendectin did not cause birth defects in children whose mothers took the drug during pregnancy to alleviate nausea and vomiting.

"Merrell Dow believes the safety record of Bendectin is strongly supported by over 35 published epidemiologic studies or reports, by reviews by the Food & Drug Administration in the U.S. and drug regulatory agencies in other countries and by other studies," said President David B. Sharrock.

Bendectin was manufactured and sold by Cincinnati-based Merrell Dow for 27 years before it was discontinued in 1983.

To date, the company has won 22 jury trials concerning the safety of Bendectin and lost only four verdicts.

AIDS policy review extended

PHOENIX, Ariz.—Circle K Corp. has extended indefinitely its suspension of a controversial medical plan provision that would exclude coverage for lifestyle-related claims such as AIDS and drug and alcohol abuse.

The company, which operates the nation's second-largest chain of convenience stores, announced last month that it would review the provision by the end of August (*BI*, Aug. 15). But Circle K officials were not yet ready to make a decision, Senior Vp Ray Cox said last week.

Circle K has 26,000 employees nationally, of which about 8,000 qualify for the company's self-insured health care plan.

Planned Fremont buyout off

LOS ANGELES—A management group's $82 million offer to buy Fremont Insurance Group Inc. from its parent, Fremont General Corp., will not be completed.

In late March, Audemars—a management group led by David L. McIntyre, president and chief executive officer of Fremont Insurance Group—signed a definitive agreement with Fremont General for sale of the insurance unit. In the agreement, Fremont General granted Audemars a right of first refusal to purchase Fremont Insurance Group that expires on Sept. 30 (*BI*, March 14).

Fremont General did not say why the offer fell through. Officials at Fremont Insurance Group could not be reached for comment. A spokesman at Fremont General could not confirm whether the property/casualty unit was still for sale.

Fremont General reorganized its property/casualty units into Fremont Insurance Group in late 1986 and announced it would develop a plan to divest these operations (*BI*, Nov. 24, 1986). Fremont General's principal business is life insurance and financial services.

Two Fremont Insurance units—Fremont Reinsurance Co. and Comstock Insurance Co.—began running off their business in late 1986. In December 1986, Comstock transferred its remaining commercial umbrella and commercial liability business to Los Angeles-based Harbor Insurance Co. (*BI*, Jan. 5, 1987; Sept. 8, 1986).

Briefly noted

A group of about 700 asbestos health claimants dropped their U.S. Supreme Court appeal of Denver-based **Manville Corp.'s reorganization plan** on Aug. 25, which will reduce delay of the plan's implementation. . . .Transamerica Financial Corp. has reached a definitive agreement with **Alexander & Alexander Services Inc.** to purchase the broker's TIFCO Inc. premium financing subsidiary for $73.8 million (*BI*, June 20). Subject to regulatory approval, the transaction is expected to be finalized by early October. . . .Members of the **Asbestos Claims Facility** cast an official vote Sept. 1 calling for an Oct. 3 dissolution of the revolutionary claims handling organization. The vote freed several producers withdrawing from the facility to begin handling their own claims immediately. No decision has been made on whether a new, smaller claims handling organization will be formed (*BI*, Aug. 1). . . .**Maxicare Health Plans Inc.** is selling its 130,000-member Michigan health maintenance organization to Detroit-based Henry Ford Health Care Corp. and its affiliate, Health Alliance Plan. Terms of the agreement were not disclosed (see story, page 1). . . .**Primerica Corp. and Commercial Credit Corp.** agreed to merge last week in a transaction valued at about $1.7 billion. The combined companies will operate under the Primerica name, with Sanford I. Weill, Commercial Credit's chairman and chief executive officer, serving as chairman, CEO and president.

Air show risks

Continued from previous page

operator of medical evacuation aircraft is on call during the show, according to Mr. Wedekind.

"We have a temporary first-aid station on the field," he pointed out, "and we have two physicians here" that direct a team of paramedics.

Although there are no requirements for air show sponsors or performers to purchase liability insurance, Mr. Nadeau said: "I can't think of anyone that would go out and have one without it. I can't imagine any airport letting one take place without a policy."

However, the agency that places most of the air show coverage in the United States says some of the smaller events are likely to be flying bare.

Karen Geldner, vp and director at Shannon & Luchs Insurance Agency Inc. in Washington, said her agency places coverage for around 200 shows in the U.S., or about 90% of those that buy insurance. Mr Nadeau said a total of 377 shows will take place in North America this year.

"We suspect that more than 50% of the small shows don't carry insurance," Ms. Geldner remarked. She described a small show as one that features a few pilots performing a limited number of stunts before sparse crowds.

Shannon & Luchs has been placing air show coverage since 1970 with syndicates at Lloyd's of London, Ms. Geldner pointed out. For the past three years, the coverage has been fronted through the Aviation Office of America Inc. in Dallas and reinsured 100% with Lloyd's underwriters.

The coverage written for air show sponsors is called an "air meet liability" policy, said Ms. Geldner. The coverage insures an air show's sponsor for liability related to injuries or property damage incurred during a show.

Although policy limits vary according to the size of the show, they average around $5 million, she explained, with a minimum limit of $1 million.

However, Ms. Geldner said she expects that last week's accident in West Germany will spur U.S. air show sponsors to seek higher limits.

"I suspect requests for limits will go up dramatically in the future," she remarked. "My feeling is that the lawyers and risk managers at airports will be requiring higher limits. I anticipate a change right away."

She said limits of $5 million or less are routinely purchased because U.S. meets have good safety records. "They haven't had anything like what happened (in West Germany) to remind them that they need high limits."

Most of the shows have small budgets, Ms. Geldner added, and can't afford higher limits. "We write a lot of $1 million policies," she said. "And it's not an expensive coverage."

Coverage for pilots is also available, though it is written on a separate form, said Ms. Geldner.

Most claims from air shows stem from unexciting slips and falls and not the daredevil exploits of stunt pilots, she said.

The Dayton air show purchases $5 million in air meet liability insurance through Shannon & Luchs, said Mr. Wedekind. "And we require performers to carry $1 million."

In the 14 years that the show has been held, there have been only a few small claims, he said. None have related to the performance of pilots.

Although air shows have come under scrutiny since the accident in West Germany, Mr. Nadeau said he does not expect there will be any changes to the events held in the United States because of the stringent FAA regulations and a good safety record for shows in this country.

A spokesman for the Experimental Aircraft Assn. in Oshkosh, Wis., which sponsors a large air show every year, agreed that there will probably be no changes in U.S. shows as a result of last month's tragedy.

"The FAA already has the guidelines in place," he said.

However, aviation experts in the United States will closely follow the investigation into the tragedy, according to Mr. Nadeau.

"Anything like that will cause the air show council and the FAA to take a close look at it to see if there is anything we need to address for the future," he noted.

A British air show operator also requires pilots to adhere to certain flight guidelines and to purchase liability insurance.

The Society of British Aerospace Companies, which organizes the Farnborough Air Show, which will be held this week, requires that every civilian pilot participating in the show purchase 15 million pounds ($25.2 million) of liability coverage, said Ken Batten, secretary for the SBAC in London.

"This wouldn't be sufficient for a disaster, but there has to be an acceptable level for insurance," Mr. Batten admitted. "In fact, many people carry far larger sums of insurance. They have to prove to us, though, that they either carry" the same limit as the aircraft's manufacturer—which could be up to $1 billion—"or 15 million pounds, whichever is higher."

The SBAC also purchases umbrella liability insurance excess of the pilots' limits at Lloyd's, said Mr. Batten. Although he would not comment on the coverage, sources in London say that the insurance, which has a 50 million pound ($84 million) per-accident limit, is brokered by Lloyd's broker Willis Faber & Dumas Ltd.

Published Reports in Britain say that the British Civil Aviation Authority is considering tightening its rules for air shows. However, most of the CAA's proposals are already implemented by the SBAC at Farnborough, where more than 200,000 people were expected to attend, said Mr. Batten.

"We take stringent precautions. . . .We are a copy-book air show and we are not complacent," he said.

Air show safety in Britain is regulated by a voluntary code of conduct, but starting in January the CAA will introduce new regulations to mandate rules covering the competence of pilots and the approval of aerobatic displays.

Already at the Farnborough show, a flying committee controlled by the Royal Air Force investigates all aircraft before the show opens. Flight plans are filed and maneuvers are demonstrated before the committee, he said. And pilots are not allowed to fly toward the crowd.

"Our insurers won't give us cover until they see what we will do at Farnborough. Lloyd's has a huge interest in this and I've just given them details of all the aircraft flying and the time slots," Mr. Batten said.

The Farnborough show—which is held every other year in rotation with the Paris Air Show—is one of the central meeting places for aviation brokers, underwriters, risk managers and manufacturers. "If something like (Ramstein) happened at Farnborough, you could wipe half the (London) aviation market out, I suppose," warned a London broker. ■

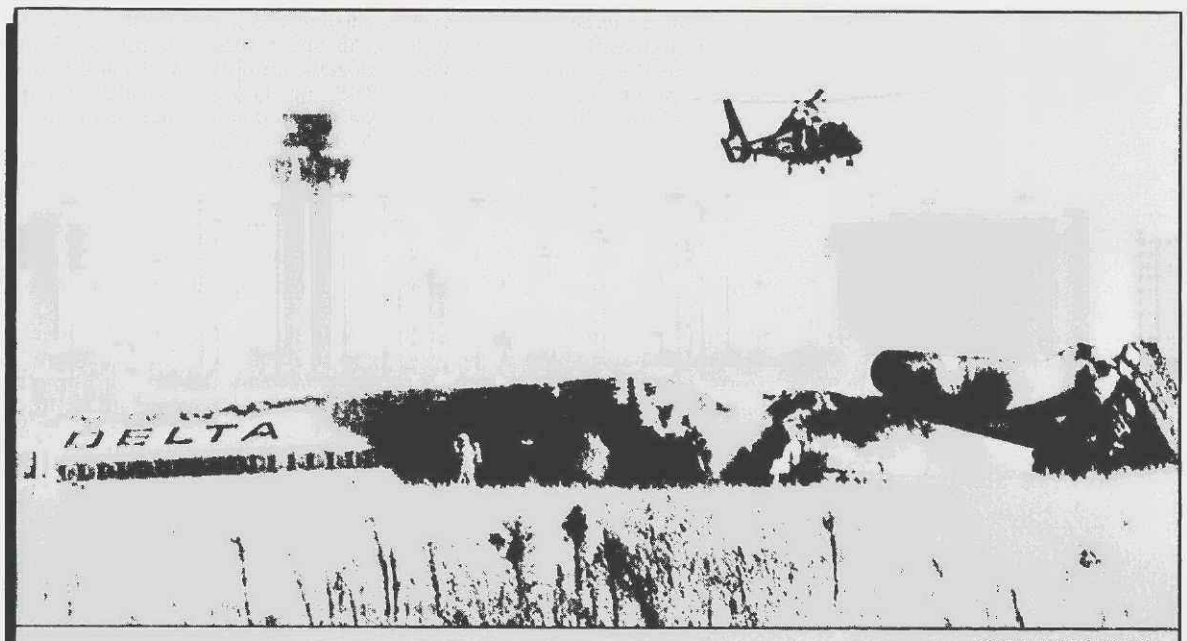


Photo: AP/Wide World

A Delta Air Lines Boeing 727 crashed on takeoff last week from Dallas-Fort Worth International Airport, killing 13 people and hospitalizing 33 of the 105 persons aboard.

Crashes won't reduce competition

By STACY SHAPIRO

LONDON—The crash of two passenger airliners last week and damage to a third will not interrupt competition in the commercial aviation insurance market.

The largest loss occurred Wednesday, when a Delta Air Lines Boeing 727 crashed on take-off and caught fire at Dallas-Fort Worth International Airport. Thirteen of the 105 people were killed, and 33 others were admitted to area hospitals for burns and other injuries.

The jetliner, one of approximately 130 727s in Delta's fleet, probably was not insured for more than $15.5 million, aviation sources in London said. Underwriters, however, were not sure last week which of Delta's 727s it was and could not give an exact value.

Delta has up to $750 million in liability insurance. Underwriters had not established a liability reserve as of last week.

The airline's hull and liability coverage, which was extended July 1 this year until Dec. 18, is placed in the United States by Johnson & Higgins and in London by Willis Faber P.L.C.

The coverage is led in the United States by United States Aircraft Insurance Group in New York, which will coordinate claims settlements. The London portion of the coverage is led by Lloyd's of London aviation underwriter Richard Maylam. French insurers, including La Reunion Aerienne, also participate on the Delta coverage.

USAIG officials would not return phone calls.

An official with Mutual Marine Office Inc. in New York said the U.S. portion of Delta's coverage is spread among "virtually everybody in the domestic aviation market."

Mutual Marine Office wrote "no more than 2%" of the airline's hull and liability coverage, he said. "Our exposure will be limited to about $1 million, no matter what."

Also last week, six people were killed when a Chinese airliner skewed off the runway into the harbor at Hong Kong's Kai Tak International Airport. Those killed were the crew members of the CAAC Trident airliner, which is believed to be insured for less than $1.5 million.

Hull and liability insurance for the airliner is placed with the People's Insurance Co. of China and reinsured in London through Lloyd's broker C.T. Bowring & Co. Ltd.

In a third incident, a Trans World Airlines Boeing 727 was damaged after it made an emergency landing at Chicago's O'Hare International Airport when its landing gear failed to deploy. Seven passengers received minor injuries during evacuation.

New York-based broker Frank Crystal & Co. Inc. places TWA's aviation insurance in the U.S. market. Associated Aviation Underwriters Inc. in Short Hills, N.J., leads the U.S. portion of the coverage, according to a Crystal spokesman.

Last month's losses, however, are not expected to stop competition among aviation underwriters, London brokers and underwriters agree. There is no sign that rates will increase in the near future, broker and underwriters said, despite these crashes and losses earlier this year, including the crash of a $112.3 million Air France Boeing 747, the largest hull loss ever (*BI,* Aug. 8).

Aviation hull and liability insurance rate decreases began last year, even though 1987 was the second worst underwriting year on record with insured airline losses totaling $850 million (*BI,* Aug. 29).

"If you look at last year and the losses there, will (last week's disasters) really make any difference at all?" asked a Lloyd's broker rhetorically.

Meanwhile, Willis Faber confirmed that it has lost the United Airlines account, which the broker acquired when it bought Stewart Wrightson Holdings P.L.C.

United was expected to move its business to Lloyd's broker Nicholson Chamberlain & Colls Ltd., where most of the Stewart Wrightson aviation team moved to after the merger. However, United instead chose Lloyd's broker Sedgwick Group P.L.C. as its broker, a Willis Faber spokesman confirmed. ●

Associate Editor Michael Bradford in Dallas and Agent/Broker Editor Linda J. Collins in Chicago contributed to this story.

Insurer results not as bad as they should have been

By MYRON M. PICOULT

Special to Business Insurance

Price cutting combined with higher retentions will take their toll, and a sharp curtailment in cash flows will help to reverse the pricing lunacy that too many insurers have engaged in. Hopefully, the realization of past moves will become evident as managements fill out their 1988 convention blanks.

AS HAS BEEN THE CASE for several quarters, the 1988 second-quarter numbers in terms of underwriting trends and operating results were a mixed bag. However, the results were not as bad as we thought they might have been or should have been.

This leads us to believe that some of the reported data is suspect: specifically, the insurers' net written premium volume.

Mr. Picoult

It is apparent that more companies have raised their retentions. Premium trends in the reinsurance business underscore this fact. It should be noted that this is occurring despite the continuation of price cutting and meaningful adjustments to terms and conditions. We suspect that the pressure on the underwriting expense ratio and the incentive to prove to the outside world by various management teams that they are not blindly cutting prices has led to this situation. Some insurers may even be after cash flow.

The irony is that unbridled growth without disciplined underwriting results in lower—not higher—cash flow, given the new tax rules.

In any event, underwriting and operating results clearly are headed south. Price cutting combined with higher retentions will take their toll. We still believe that a sharp curtailment in cash flows will help to reverse the pricing lunacy that too many insurers have engaged in.

Hopefully, the realization of past moves will become evident as insurer managements fill out their 1988 convention blanks in early 1989.

If we are wrong on the pricing reversal, the stage will be set for yet another surge in insolvencies within the next few years. It would not be outlandish to assume that one or two major players could be in the group at this time.

Our survey covers 21 insurers and represents about 60% of the stock industry's volume. For the 1988 second quarter, the results were as follows:

- Net written premiums inched up 2.1% vs. a 3.1% increase in the first quarter. As previously noted, this was a somewhat stronger showing than we expected to see. Eleven companies were above the average, one was at the average and nine were below.

The range of premium increases or decreases was quite interesting, with CNA Financial Corp.'s 14.1% increase at the top of the pile and GEICO Corp.'s 32.1% decline at the bottom. The disparity makes it difficult to believe that all the insurers are operating on the same wavelength.

Earned premiums expanded 4.2% vs. a 6.8% rise in the first quarter. This continues to mirror the decline in premium volume that started in 1987. Current written trends portend still lower earned gains in coming quarters. Soon, the insurers will have to contend with both expense and loss ratio pressures.

- The average combined ratio, after policyholder dividends, actually improved a tad to 105.0% vs. 105.1% in the corresponding period of 1987. Eight companies were below the average and 13 were above. Four insurers—American International Group Inc., Chubb Corp., Ohio Casualty Co. and SAFECO Corp.—posted combined ratios below the average. Ohio Casualty's 96.7% was the lowest while Fireman's Fund Corp.'s 114.0% ratio was the highest.

One can rationalize the results of the aforementioned insurers vs. the industry as a whole. Nonetheless, some observers are sure to conclude that there remains plenty of room for rates to be reduced.

All of the improvement in the combined ratio came out of the loss ratio, which averaged 74.9% compared with 76.4%. The expense ratio jumped to 30.1% from 28.7%. Traditional insurers with 30% or higher expense ratios cannot remain competitive and will continue to lose market share to the direct writers in personal lines and other entities in the commercial area. There clearly has to be consolidation within the industry. We will address this in more detail later in our next column.

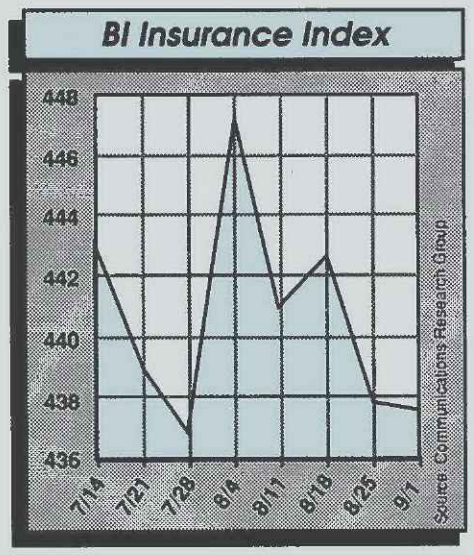
- Net pretax investment income expanded 13.4%, which was a little above the 13.2% gain of the first quarter. This gain continues to reflect the results of portfolio shifting into taxable instruments from the latter part of 1987 through the second quarter of 1988. Seven insurers were above the average, one was at the average and 13 were below. Operating cash flow was mixed for the surveyed companies.
- On average, loss reserves rose 14.0%. This, too, is below the first-quarter increment of 15.9%. Increases to reserves continue to decline. This was occurring as paid losses rose by 11.6%, just under the first quarter increase of 11.7%.

It appears that for some companies the time has again come to pare their reserves and live off the fat. The problem is that there is not as much fat in the reserve base as many believe.

- The premium-to-surplus ratio for a representative group of companies looks to be a tad above the 2.4-to-1 figure that prevailed at the end of March 1988. Consolidated earnings edged up 1.5%. The gain came from other operations as property/casualty results were down about 2.5%. The "Fresh Start" adjustment equaled 13.9% of total per-share earnings vs. 11.0% in the 1987 second quarter. This reverses the first-quarter comparison.

While we do not wish to appear maudlin about the industry's outlook, operating results will clearly deteriorate over the next four to six quarters. Hopefully, the deterioration will occur in a shorter time frame and be more severe. All parties will benefit from this. ■

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



Insurance industry stocks could not reverse their downward slide last week, as the *Business Insurance Index* fell 0.5 points to 437.6 on Sept. 1, from 438.1 on Aug. 25. Advancing issues were led by Frank B. Hall & Co., up 6.7%; NAC Re Corp., up 4.7%; Orion Capital Corp. and Zenith National Insurance Corp., both up 3.3%; and Baldwin & Lyons Corp., up 3.0%. Declining issues were led by Fremont General Corp., down 8.8%; AVEMCO Corp., down 4.8%; and American International Group Inc., Tokio Marine & Fire Insurance Co. Ltd. and Marsh & McLennan Cos. Inc., all down 3.6%. Issues showing the most activity during the period were: Farmers Group Inc., 6.9 million shares traded; Sears, Roebuck & Co. (Allstate) 1.6 million shares traded; and American International Group Inc., 1.2 million shares traded. The *Business Insurance Index* dropped a slight 0.1% for the period, performing ahead of the leading market indicators: The Dow Jones 30 Industrials dropped 0.4%; the Standard & Poor's 500 fell 0.3%; and the New York Stock Exchange Composite lost 0.2%.

British Issues

Sept. 1 Companies	Price pence	P/E	Div. pence	Yield %	1 Week High—Low pence	pence
Comml Union	334	12.7	21.9	6.4	342—332	
Genl Accident	874	10.1	47.9	5.3	877—872	
Gdn Royal Exch	173	12.9	11.0	6.3	176—171	
Royal	379	10.0	26.4	6.8	379—377	
Sun Alliance	947	15.4	43.1	4.4	956—946	
Brokers						
Bradstock	233	13.1	5.0	2.9	234—232	
CE Heath	408	15.6	34.5	8.4	414—407	
Hogg Robinson	153	12.2	9.6	6.1	158—153	
Lloyd Thompson	190	16.5	6.8	3.5	192—185	
PWS Holdings	148	8.7	14.4	9.5	152—146	
Sedgwick Grp	226	14.0	16.4	7.1	231—225	
Steel Brrl Jones	213	13.1	13.7	6.3	219—208	
Willis Faber	230	12.0	15.4	6.7	234—230	

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

BI Industry Stock Report

SEPTEMBER 1, 1988 **8/26/88 THRU 9/1/88**

		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	22.38	0.6	26.1	24.88	17.75	227	1.00	4.5	16.0	3.71	6.03
Baldwin & Lyons Inc.	OTC	17.00	3.0	41.7	16.50	12.00	0	0.20	1.2	6.7	18.31	0.93
Corroon & Black Corp.	NYSE	28.75	1.3	1.8	34.75	28.00	61	1.08	3.8	4.3	5.43	5.29
Gallagher Arthur J. & Co.	NYSE	17.38	-1.4	8.6	18.88	13.88	8	0.48	2.8	12.5	5.16	3.37
Hall Frank B. & Co.	NYSE	4.00	6.7	38.9	5.50	2.88	49	0.00	0.0	12.5	0.00	N/A
Hilb, Rogal & Hamilton	OTC	11.25	0.0	15.4	12.75	9.75	9	0.00	0.0	12.5	0.00	N/A
Marsh & McLennan Cos. Inc.	NYSE	53.13	-3.6	7.3	58.50	45.25	368	2.40	4.5	13.0	6.74	7.88
Poe & Assoc Inc.	OTC	8.50	0.0	21.4	9.25	6.75	0	0.40	4.7	13.0	0.27	31.48
BROKERS	AVERAGE		0.8	20.2					2.7	9.0		
CONGLOMERATES & HOLDING COMPANIES												
Berkley W.R. Corp.	OTC	27.00	-0.9	12.5	29.00	23.50	221	0.36	1.3	6.0	17.63	1.53
Berkshire Hathaway Inc.	OTC	4300.00	-1.1	45.8	4525.00	2755.00	141	0.00	0.0	19.0	69.38	11.64
ITT (Hartford Group)	NYSE	47.13	0.0	4.7	53.38	43.25	758	1.25	2.7	6.5	52.23	0.90
Sears, Roebuck & Co. (Allstate)	NYSE	35.00	-0.4	4.1	39.88	32.25	1612	2.00	5.7	8.7	34.74	1.01
CONGLOMERATES	AVERAGE		-0.6	16.8					2.4	10.0		
INSURERS & REINSURERS												
Aetna Life & Cas Co.	NYSE	46.88	-1.8	3.6	49.88	39.50	586	2.76	5.9	7.3	53.56	0.88
American General Corp.	NYSE	33.25	0.8	4.7	36.38	27.50	833	1.40	4.2	8.9	28.04	1.19
Amer Heritage Life Invt	NYSE	24.75	0.0	2.1	26.00	24.00	4	1.08	4.4	10.8	20.98	1.18
Amer Indty Fin'l Corp.	OTC	11.38	-2.1	26.4	12.00	8.25	6	0.56	4.9	43.8	15.26	0.75
American Int'l Group	NYSE	60.50	-3.8	0.8	65.38	49.00	1181	0.40	0.7	9.4	33.56	1.80
Aon Corp.	NYSE	27.00	0.9	18.0	27.75	21.88	215	1.28	4.7	9.2	15.13	1.78
Argonaut Group	OTC	44.00	-1.7	47.9	49.00	29.50	106	0.00	0.0	7.2	29.19	1.51
AVEMCO Corp.	NYSE	22.50	-4.8	14.6	28.75	17.88	47	0.34	1.5	10.9	7.74	2.91
Belvedere Corp.	AMEX	4.63	0.0	5.7	6.00	4.00	3	0.04	0.9	6.4	7.87	0.59
BMA Corp.	OTC	31.25	-0.8	16.8	36.75	25.50	17	1.20	3.8	28.9	24.45	1.28
Chubb Corp.	NYSE	54.88	0.5	-1.8	63.38	51.25	362	2.16	3.9	6.4	46.13	1.19
CIGNA Corp.	NYSE	49.13	0.8	12.0	51.88	42.75	304	2.96	6.0	7.9	49.19	1.00
CNA Fin'l Corp.	NYSE	53.75	-0.9	-3.4	64.25	51.00	173	0.00	0.0	8.0	46.40	1.16
Continental Corp.	NYSE	39.00	-1.9	0.6	41.63	34.75	370	2.60	6.7	7.9	42.10	0.93
Durham Corp.	OTC	32.00	0.0	48.8	36.25	21.50	4	0.92	2.9	30.2	26.00	1.23
Farmers Group Inc.	OTC	70.13	0.2	74.2	70.38	40.50	6787	1.44	2.1	16.7	22.02	3.18
Fireman's Fund Corp.	NYSE	32.00	2.0	23.1	33.50	25.75	421	0.50	1.6	11.3	26.17	1.22
Forum Re Group	OTC	2.13	0.0	-37.0	4.00	2.13	1	0.00	0.0	3.7	2.58	0.83
Fremont Gen Corp.	OTC	10.38	-8.8	7.8	13.50	8.75	100	0.60	5.8	3.7	16.24	0.64
General Re Corp.	NYSE	53.75	0.9	-3.8	57.38	45.50	686	1.20	2.2	11.5	26.21	2.05
Home Group Inc.	NYSE	11.25	-3.3	-5.3	14.38	11.25	125	0.20	1.8	2.7	17.75	0.63
Hanover Ins Co.	OTC	26.63	0.0	14.5	27.75	20.50	40	0.36	1.4	5.5	25.10	1.06
Harleysville Group Inc.	OTC	15.00	0.0	14.3	16.38	13.38	15	0.48	3.2	6.4	16.65	0.90
Hartford Steam Boiler	OTC	30.00	0.0	30.4	32.75	22.50	90	1.20	4.0	10.8	10.65	2.82
Kansas City Life	OTC	31.75	2.4	21.0	31.38	25.25	0	0.00	0.0	10.8	0.00	N/A
Kemper Corp.	OTC	25.38	1.5	23.8	27.50	20.75	223	0.72	2.8	7.9	26.50	0.96
Lawrence Ins. Group	AMEX	10.75	-2.3	138.9	11.63	4.50	3	0.21	2.0	17.6	2.90	3.71
Liberty Corp. S.C.	NYSE	39.00	0.0	9.9	47.25	34.50	13	0.80	2.1	13.8	17.40	2.24
Lincoln Nat'l Corp.	NYSE	49.75	-2.2	24.0	53.00	40.25	143	2.36	4.7	9.6	36.62	1.36
NAC Re Corp.	OTC	27.75	4.7	56.3	28.00	18.50	185	0.00	0.0	14.2	19.92	1.39
Nobel Ins Ltd.	OTC	5.50	0.0	-37.1	9.50	4.50	1	0.44	8.0	26.2	9.37	0.59
Northwestern Nat'l Life	OTC	30.50	0.8	33.3	30.75	22.63	76	1.12	3.7	7.2	35.05	0.87
Ohio Cas Corp.	OTC	34.25	-0.7	-5.5	38.25	32.25	88	1.88	5.5	6.8	27.86	1.23
Old Rep Int'l Corp.	OTC	23.00	1.1	15.0	25.88	19.13	237	0.74	3.2	5.5	27.82	0.83
Orion Cap Corp.	NYSE	15.50	3.3	14.8	17.63	13.13	35	0.76	4.9	4.9	9.34	1.66
Phoenix Re Corp.	OTC	8.50	3.0	30.8	9.50	6.75	27	0.00	0.0	5.0	11.08	0.77
Protective Life Corp.	OTC	13.50	0.0	10.2	15.13	12.25	94	0.70	5.2	14.7	17.25	0.78
Re Capital Corp.	AMEX	9.38	0.0	-10.7	11.75	9.13	2	0.00	0.0	29.3	11.49	0.82
Provident Life & Acc Ins Co.	OTC	23.38	1.1	49.6	24.25	15.63	621	0.84	3.6	50.8	27.45	0.85
St. Paul Cos. Inc.	OTC	41.25	-0.6	-10.3	51.00	38.25	1067	2.00	4.8	5.9	35.83	1.15
SAFECO Corp.	OTC	25.13	1.0	-9.4	30.00	22.75	888	1.08	4.3	7.8	21.39	1.17
SCOR U.S. Corp.	NYSE	7.75	0.0	-16.2	9.50	6.63	67	0.10	1.3	5.4	9.39	0.83
Seibels Bruce Group Inc.	OTC	13.13	-0.9	16.7	14.25	11.00	47	0.80	6.1	8.8	12.51	1.05
Selective Ins Group Inc.	OTC	24.50	0.0	28.9	26.25	19.25	30	1.24	5.1	5.5	19.52	1.26
Statesman Group Inc.	OTC	3.50	0.0	-25.4	5.56	3.44	19	0.05	1.4	5.5	3.48	1.01
Tokio Marine & Fire Ins	OTC	69.38	-3.6	5.3	85.88	63.25	53	0.22	0.3	61.9	0.00	N/A
Torchmark Corp.	NYSE	31.38	-3.4	28.1	33.50	24.50	84	1.20	3.8	10.0	12.24	2.56
Transamerica Corp.	NYSE	33.88	1.9	13.9	36.75	29.75	666	1.84	5.4	7.1	24.94	1.36
Travelers Corp.	NYSE	33.13	-1.5	-5.7	40.00	33.00	790	2.40	7.2	11.4	45.28	0.73
Trenwick Group Inc.	OTC	13.00	0.9	26.8	13.50	9.75	26	0.16	1.2	10.1	15.41	0.84
United Fire & Cas Co.	OTC	26.00	0.0	0.0	27.00	24.00	4	1.08	4.2	4.7	22.56	1.15
United States Fid & Gty	NYSE	29.75	-0.8	4.4	34.38	28.88	1124	2.64	8.9	7.4	19.53	1.52
UNUM Corp.	NYSE	23.63	1.1	27.7	25.00	17.88	165	0.48	2.0	10.7	28.53	0.83
USLIFE Corp.	NYSE	37.50	0.0	31.6	40.13	28.00	83	1.28	3.4	9.7	46.77	0.80
Washington Nat'l Corp.	NYSE	26.50	0.5	11.0	28.75	24.00	32	1.08	4.1	12.3	32.33	0.82
Zenith Nat'l Ins Corp.	NYSE	19.25	3.3	28.3	23.88	15.00	80	0.80	4.2	9.2	12.53	1.54
INSURERS & REINSURERS	AVERAGE		-0.2	15.1					3.3	12.7		
ALL COMPANIES	AVERAGE		-0.1	15.8					3.2	12.2		

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