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Update

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IRS again delays compliance with non-discrimination rules

WASHINGTON—The Internal Revenue Service is again delaying compliance with its massive pension non-discrimination rules.

The IRS last week said it would delay the rules by one year until Jan. 1, 1994. In February, the IRS, under congressional and employer pressure, delayed the effective date of the rules to Jan. 1, 1993, from Jan. 1, 1992 (*BI*, Feb. 17).

In its latest delay notice, expected to be published this week in the Federal Register,

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Health care reforms stalled

Officials fault HHS analysis of Oregon plan

By LOUISE KERTESZ

SALEM, Ore.—Oregon officials maintain that the state's proposed universal health care plan is being stymied by presidential politics.

U.S. Secretary of Health and Human Services Louis W. Sullivan last week ruled that Oregon cannot proceed with its plan—which hinges on a system of rationing Medicaid services—until it conforms with the Americans with Disabilities Act.

In an analysis of the plan given to Oregon officials, Dr. Sullivan stated that he could not grant the necessary waiver of Medicaid rules because elements in the state's plan would discriminate against persons with disabilities.

"I urge Oregon to submit a revised application which addresses these concerns, and I look forward to approving such a demonstration," Dr. Sullivan said in a letter to Gov. Barbara Roberts.

Oregon officials are "disheartened" by the decision, which they view as a political move by the Bush administration.

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States decry lack of reforms at federal level

By MICHAEL SCHACHNER

WASHINGTON—Congress should put aside election-year politics and pass health care reforms where agreement exists, according to several state lawmakers.

The majority of state lawmakers in leadership positions on health care committees believe the federal government should implement some reforms now, rather than wait—perhaps infinitely—until there is a consensus on a comprehensive overhaul, according to a survey by the Washington-based Healthcare Leadership Council.

And if Congress will not enact partial reforms, then it should at least grant waivers from the Employee Retirement Income Security Act of 1974, Medicare and Medicaid so that reforms can be made at the state level, surveyed officials insist.

The state lawmakers lament that "gridlock" in Washington is holding up meaningful, albeit simple, legislation that could help pave

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Senate improves on House pension relief

By JERRY GEISEL

WASHINGTON—Tax legislation awaiting Senate approval would provide more relief to employers that administer pension plans than an earlier House-passed bill.

And the Senate bill, H.R. 11, would make 401(k) plans more attractive to employees, while also opening up to millions of employees the opportunity to

make tax-deductible contributions to individual retirement accounts.

The two bills share many provisions to ease pension plan administration, including an easier way to run the 401(k) plan non-discrimination tests.

A number of those provisions also were part of tax legislation Congress approved earlier this year, but President Bush vetoed. That veto was unrelated to the

pension provisions. The administration has sent signals that it isn't happy with the new Senate tax bill, but officials have said they believe legislators—after reconciling differences between the House and Senate bills—will produce a compromise measure that the president will sign.

While the latest tax bills, like the legislation earlier vetoed, only would snip the mass of

complex pension laws and regulations that have sprouted over the last decade, the changes nonetheless would be welcomed by employers.

"It is not wholesale simplification, but it certainly is a change in direction from increased complexity toward simplification. That will be welcomed by employers," said Henry Saveth, a principal with A. Foster Higgins & Co. Inc. in New York.

"There has been a real effort on the part of legislators, especially in the Senate, to respond to the concerns of employers," added Gerald Uslander, a principal with William M. Mercer Inc. in Washington.

Of the two bills, though, the Senate measure includes more benefits-related provisions that will help employers and employees.

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Bush, Clinton trade barbs

By JERRY GEISEL

WASHINGTON—The presidential campaign hasn't even entered the home stretch, but the mud already is starting to fly when the candidates discuss health care reform.

Last week, President Bush, Gov. Bill Clinton and Senate Democrats all traded charges on who is most capable to lead the drive for health care reform.

President Bush launched the attack by charging that the election of Gov. Clinton would lead to the creation of an inefficient and ruthless health care system.

"Understand what's at stake here," President Bush said at a fundraiser in suburban Chicago. "If the governor of Arkansas is elected with a Democratic Congress... within a year the government will run the health care in this country,

and our health care system will combine the efficiency of the House Post Office with the compassion of the KGB."

Returning the fire, the Democratic nominee said President Bush lacks credibility to take any kind of position on health care reform.

The Bush administration, Gov. Clinton said, "presided over the biggest explosion in health care costs in history." The administration is "trying to raise fears instead of solve problems," Gov. Clinton said in Little Rock, Ark.

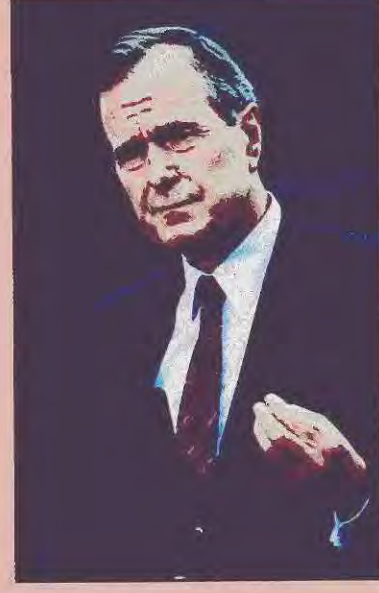
Gov. Clinton has proposed the "play or pay" approach that would require employers to either offer a health plan or pay into a public fund to cover the uninsured. Gov. Clinton also favors the creation of a national board to help control health care spending (*BI*, July 20).

In February, the Bush administration proposed

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AP/Wide World Photo



AP/Wide World Photo

Update

IRS delays pension testing date

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the IRS said it wants to give employers more time to comply and the service more time to consider suggestions for simplifying the rules.

"This is very good news for employers. It gives employers more time to develop compliance strategies and for the IRS to develop simpler rules," said Frank McArdle, a consultant with Hewitt Associates in Washington.

Prior to last week's delay, the IRS had proposed several steps to simplify the regulations once they go into effect, including a proposal to allow most employers to run the non-discrimination tests every three years instead of annually (BI, May 18).

New York Blues look at merger

BUFFALO, N.Y.—Blue Cross of Western New York Inc. may take over ailing Blue Shield of Western New York Inc., which has reported a \$25.5 million reserve deficit.

The Blues plans on Aug. 4 signed a letter of intent to merge, but officials from both companies stressed that the letter does not constitute an agreement.

Among the details to be ironed out before a deal could be finalized is the financial backing that Blue Cross would promise to Blue Shield, said a Blue Shield spokeswoman. And, Blue Cross officials want to nail down the amount of the ailing plan's debt, which they say may be "substantially higher" than Blue Shield's reported \$25.5 million shortfall as of Jan. 1.

The proposed merger was announced after New York's Department of Insurance directed Buffalo, N.Y.-based Blue Shield to make up its reserve shortfall or seek a strong merger partner, the Blue Shield spokeswoman said. Blue Cross has reported \$52 million in reserves.

There is no set timetable to complete the merger, which would require state and federal approval, said Walter Brown, acting chief executive officer of WholeHealth Insurance Network Inc., Blue Shield's parent company.

Blue Shield covers about 540,000 lives in Buffalo and Albany, N.Y., roughly 95% of which are under group contracts. Blue Cross covers about 637,000 lives in western New York, of which 92% are under group contracts. The intent to merge has no immediate impact on business operations, officials said.

Showdown set on family leave

WASHINGTON—House and Senate conferees last week set the stage for a showdown with President Bush when they approved legislation that would require employers with 50 or more workers to provide up to 12 weeks of unpaid family leave annually.

The Family and Medical Leave Act, S. 5, would restrict eligibility for leave to employees who have worked at least 25 hours per week, or 1,250 hours, during the previous year. So-called "key employees," those in the highest-paid 10% of a company's workforce, would not be covered by the bill. Employers would have to continue medical coverage for employees on leave, but they could try to recover the premiums from employees who do not return.

Corporations oppose the bill, saying it would decrease their flexibility in benefit offerings. By requiring certain benefits, the bill would discourage firms from offering other benefits, argued Sharon Canner, assistant vp and director-employee benefits for the National Assn. of Manufacturers in Washington.

The House and Senate each must pass the conference bill before it is sent to President Bush. Ms. Canner said Congress may act on the bill next month.

The House and Senate each passed similar versions of the new family leave bill last year but took no further action after the president threatened a veto (BI, Nov. 18, 1991).

Blood bank to appeal verdict

DENVER—A New Mexico blood bank will appeal a Colorado state court jury verdict that it pay \$6.7 million in damages to a woman who contracted AIDS from tainted blood she received during a 1983 transfusion.

The woman, Susie Quintana, died a day before the sequestered panel returned its verdict against United Blood Services of Albuquerque, N.M. The jury—which did not know Ms. Quintana had died—awarded her \$6.6 million in negligence damages and \$105,000 for emotional distress. The jury also awarded \$1.5 million to her husband for loss of companionship.

The blood bank will appeal the verdict, arguing that the judge should have declared a mistrial after learning of the plaintiff's death, said Arthur H. Downey, the Denver attorney for United Blood Services.

Mr. Downey believes the damage award will be set aside on appeal and that any subsequent damages will be based on wrongful death rather than injury. He estimated that such an award would probably be less than \$1 million because there would be no award for pain and suffering.

Mr. Downey said the blood bank maintains adequate insurance to cover the original \$8.2 million award.

Flood suit seeks to tap insurers

CHICAGO—A restaurant denied coverage for business interruption losses it contends resulted from the April 13 underground flood here has sued its insurer and is seeking class-action certification both of plaintiffs and insurance company defendants.

Ronny's Steak Palace Inc. filed the suit in Cook County Circuit
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Comp policyholder sues insurer for lack of service

By STACY GORDON

PHILADELPHIA—The first policyholder lawsuit against a workers compensation insurer for allegedly failing to provide promised loss-control services is scheduled for trial within the next month.

HGO Inc. of Wayne, Pa., is suing Liberty Mutual Insurance Co. in federal court in Philadelphia, alleging the insurer "failed to provide professional-level, or even marginally adequate, services" in the areas of loss con-

trol, claims processing, loss prevention and loss reporting.

HGO also alleges that Boston-based Liberty Mutual mishandled workers comp claims and overreserved for claims.

The 1990 lawsuit states that Liberty Mutual breached its contract with and fiduciary duties to HGO and acted in bad faith.

If HGO wins its case, it could pave the way for similar policyholder actions in the future.

HGO says it has been damaged in several ways, including having to pay higher retrospectively

rated premiums and having its experience modifier increased. The company is seeking more than \$500,000 in compensatory damages as well as unspecified punitive damages.

A spokeswoman from Liberty Mutual said: "We believe we provided HGO with excellent service. Out of the hundreds of workers compensation claims we've handled and continue to handle, they've only come up with a handful to base their complaint on."

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Court finds Florida law's exemptions unconstitutional

Self-referral cap undone

By MICHAEL SCHACHNER

TALLAHASSEE, Fla.—A Florida law that caps fees for specific health care services is unconstitutional because it does not apply to all providers, a federal judge has ruled.

U.S. District Court Judge William Stafford's decision is a victory for solo practitioners as well as several types of specialized health care facilities.

It also is a defeat for critics of doctors who refer patients to

treatment centers in which the doctors hold an interest.

Insurers and employers generally object to so-called self-referrals (BI, July 6). A California study revealed that self-referrals of injured workers in that state created an estimated \$356 million in unnecessary workers compensation medical costs (BI, Feb. 17).

Judge Stafford ruled unconstitutional a provision in the Patient Self-Referral Act that caps fees for five types of outpatient

service, including physical therapy and diagnostic imaging. As of October 1995, the law will prohibit doctors from referring any patients to outpatient facilities in which they have an interest.

Exempting hospitals and group practices from the fee caps violates the 14th Amendment guarantee of equal protection under the law, the judge ruled.

In his July 21 opinion, Judge Stafford said Florida lawmakers
Continued on page 27

Dingell questions financial reporting after Consecro flap

By DOUGLAS McLEOD

WASHINGTON—Rep. John D. Dingell is asking the Securities and Exchange Commission and other regulatory bodies to investigate the adequacy of financial disclosures by life insurance holding company Consecro Inc.

In July 30 letters, Rep. Dingell, D-Mich., also asks the SEC and other regulators about the overall adequacy of financial reporting rules for insurers and reinsurers, including reporting of financial reinsurance transactions.

The inquiry follows a critical article about high-flying Consecro in the June 15 issue of *Baron's*. The article charged that the Carmel, Ind.-based insurer, which reported nearly \$12 billion in assets at year-end 1991, inflates its earnings through misleading procedures for consolidating and accounting for acquisitions.

Consecro operates three life insurers which were acquired by a minority-owned affiliate, CCP Insurance Inc., and write mainly personal
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Ruling may widen insurers' liability for pension assets

By JUDY GREENWALD

NEW YORK—A federal appellate court ruling gives insurance companies fiduciary responsibility for some of the pension plan assets they manage.

The ruling by the 2nd U.S. Circuit Court of Appeals is a significant victory for employers, say attorneys who represent employers.

Insurers, though, say that giving them this fiduciary responsibility would create administrative headaches by forcing them to segregate hundreds of billions of dollars in plan assets from their general accounts.

They also contend that making them fiduciaries would subject them to conflicting regulations. State laws, insurers point out, require them to act in the best interest of all their policyholders, while the Employee Retirement Income Security Act requires fiduciaries to act "solely" in the interests of plan participants.

The 2nd Circuit's ruling—in *Harris Trust vs. John Hancock Insurance Co.*—runs counter to a 1991 de-
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- ✓ Solving the health care crisis requires bold ideas, this week's editorial says. **PAGE 8**
- ✓ Most state workers comp systems protect workers better now than they did 20 years ago, but problems still exist, experts conclude at the National Symposium on Workers Compensation. Coverage begins on **PAGE 10**
- ✓ EXEL Ltd. wants to invest up to \$100 million in a property catastrophe reinsurer being organized in Bermuda. **PAGE 23**
- ✓ The appointment of provisional liquidators last week may expedite payment to Walbrook Insurance Co. Ltd.'s U.S. casualty policyholder creditors. **PAGE 23**
- ✓ Insurers' second-quarter earnings were better than expected, in light of the heavy catastrophe toll, says analyst Myron M. Picoult of Oppenheimer & Co. **PAGE 31**

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HMOs get satisfaction

Consumers Union ranked 46 HMOs based on an index of participants' satisfaction levels, ranging from 0, completely dissatisfied, to 100, completely satisfied. Even the lowest-rated HMO scored a 63, indicating participants are moderately satisfied.



GRAPHIC BY JOHN HALL

HMO survey reveals participants content with doctors, plans

By SALLY ROBERTS

If Mick Jagger "can't get no satisfaction," he must not belong to an HMO.

Members of most health maintenance organizations, in fact, are getting satisfaction, at least according to a recent survey.

Of 46 HMOs surveyed by Consumers Union of the U.S. Inc., 31 scored 74 or better on a 100-point "satisfaction index," and even the lowest-rated HMO scored a 63. A 100 rating would mean that 100% of an HMO's members are "completely satisfied."

Additionally, 91% of surveyed HMO members were satisfied overall with their primary-care physician, 86% were satisfied overall with medical specialists and 79% were satisfied overall with HMO administration.

"Most people were satisfied even with the lowest-rated HMO," said Mark Kotkin, a senior research associate with Consumer Reports, which published the results of the survey by Consumers Union, its Yonkers, N.Y.-based parent, in its August issue.

There is, however, a significant difference between the top-rated HMOs and those at the bottom, according to Mr. Kotkin.

The report pointed out that differences of less than five points on the satisfaction index are not meaningful.

Even so, the 63 rating is still well behind the two leaders'

scores of 83, Mr. Kotkin said.

Not surprisingly, the HMO industry welcomed the results. They dispel the myth that members are unhappy, said a spokeswoman for Group Health Assn. of America Inc., an HMO trade group in Washington.

Consumers Union sent its questionnaire to 5.1 million subscribers to Consumer Reports. Of those responding, 48,000 were members of HMOs across the country. CU analyzed 20,000 of the responses and came up with 46 HMOs that had at least 150 responses each.

Those plans were rated according to respondents' overall satisfaction with the plan, as well as satisfaction with the HMO's physicians, medical specialists and administration. With the satisfaction ratings, Consumers Union also listed, among other things, the settings in which HMOs provided care, whether they had Medicare contracts and, if so, the type of contract and the monthly Medicare premiums. Responses were based on members' experiences from spring 1990 through spring 1991.

At the top of the ratings, tied with an overall "satisfaction index" rating of 83, were Heritage National Health Plan Services Inc., which serves Illinois, Iowa, Wisconsin and Tennessee, and Pilgrim Health Care Inc., which serves Massachusetts and Rhode Island.

Both HMOs also had above-

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Coloradans may vote to widen safety liability

By SARA MARLEY

DENVER—Colorado employers may face an increased exposure to tort lawsuits from injured workers if a proposed ballot initiative is approved and wins voters' support in November.

The initiative would introduce a constitutional amendment enabling injured workers to sue employers "who knowingly maintain an unsafe work environment."

Safe Workplace Colorado, a Denver-based coalition of organized labor and attorneys for injured workers, last week filed 83,000 signatures with the secretary of state in an effort to place the proposal on the November ballot. The secretary of state has 21 days to verify the signatures, 50,000 of which must be valid.

Advocates claim the amendment is needed to give injured workers greater remedies against employers with unsafe workplaces and to counteract benefit reductions contained in a sweeping workers compensation reform package enacted last year.

But insurers and employers say the amendment would cost business and taxpayers \$1.5 billion, according to a University of Denver study released last week.

The ballot initiative "guts the workers comp system as we

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Verdict in California not viewed as threat to 'exclusive remedy'

By JOANNE WOJCIK

OAKLAND, Calif.—California employers should not be alarmed by a \$4.7 million jury award to a factory worker who sued his employer and its parent outside of the workers compensation system over a workplace illness, attorneys say.

The verdict does not erode the exclusive remedy doctrine, they say. Instead, it reflects exceptions to the doctrine that have existed since the state labor code was amended in 1982.

However, a significant aspect of the case is that the parent company—which earlier had directly employed the injured worker—was found liable for damages both as an employer and a non-employer, attorneys say.

And, the case underscores the necessity of fully informing employees about hazardous substances in the workplace and the harm they can do, attorneys warn.

An Oakland jury awarded \$4.7 million in damages on July 28 to a retired employee of a subsidiary of Diamond Shamrock Corp. The jury found that the plaintiff had contracted cancer while working from 1967 to 1984 at a Redwood City, Calif., plant Diamond Shamrock owned.

The retired worker, Samuel Rosario, who now lives in Puerto Rico, was exposed to the chemical bis-chloromethyl ether, or BCME. In the early 1970s, BCME was determined to be carcinogenic, said his lawyer, Aaron H. Simon of Kazan, McClain, Edises & Simon in Oakland.

Mr. Rosario sued both Diamond Shamrock of San Antonio and subsidiary Duolite International Inc. Diamond Shamrock formed Duolite in February 1981 to serve as plant operator.

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Voting with their feet

Pension sponsors shifting GIC assets to other products, new survey shows

By DOUGLAS McLEOD

Growing numbers of employers sponsoring defined contribution pension plans are moving away from traditional guaranteed investment contracts to other investments, a new survey concludes.

Meanwhile, the average GIC rate of return for the first quarter of 1992 slid 14 basis points to 8.59% from 8.73% in the last quarter of 1991, according to the survey by A. Foster Higgins & Co. Inc.

In its report on GIC returns

in the first quarter, Foster Higgins compiled investment and rate-of-return information on 96 employer-sponsored plans with total assets of \$34.3 billion. Some \$21.3 billion of that total was GIC investments.

Among other things, the survey sought to gauge how many plans are reinvesting assets in traditional insurer-issued GICs vs. other alternatives. These alternatives include "separate account" GICs, which segregate plan assets from insurers' general investments; other "synthetic" GICs, including products offered by banks; and other short-term investment funds.

About 36% of the responding plans had GICs maturing during the first quarter. The contracts were worth a total of \$930 million.

Of those with maturing GICs,

only 39% reinvested all of the funds in traditional GICs, down from 49% in a fourth-quarter survey last year.

By contrast, 42% said they were not reinvesting any maturing assets in traditional GICs, up from 33% in the earlier survey. Another 19% of the first-quarter respondents said they would reinvest some assets in traditional GICs, compared with 18% in the fourth quarter.

Of \$785 million in maturing GIC assets reinvested by respondents, \$294 million went back into traditional GICs, \$247 million into GIC alternatives like separate account and other synthetic products, and \$244 million went into other investments like short-term instruments or government securities, the survey found.

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Penny-pinching buoys brokers' income

By JUDY GREENWALD

Insurance brokers are struggling to make do in an apparently endless soft market—and, in general, they are succeeding.

Despite continuing rate decreases and a far-from-robust economy, six of the seven publicly held insurance brokers reported higher income for the first half. None reported a loss, despite generally modest revenue increases and some declines.

Brokerage officials and other observers point to continuous efforts to restrain or cut expenses as a major factor in their success.

"On balance, you can say results were better than one might really have expected given the lousy revenue growth," and that is attributable to tight expense controls, said Michael Smith, an analyst with Lehman Bros. in New York.

Brokers clearly do not expect a market turn soon and are "really clamping down on spending, which is pretty much to their credit," said Mr. Smith.

"I think all of the brokers have had to look carefully at their expense structure," agreed Vanessa Wilson, an analyst with First Boston Corp. in New York. And their recent hard work "is clearly going pay off when

the cycle turns."

Generally, the "significant or very strict expense controls are becoming more apparent in the results," said Alice Cornish, an analyst with investment research firm Northington Partners Inc. in Avon, Conn.

At Hilb, Rogal & Hamilton Co. in Glen Allen, Va., net income rose 37.9% despite a 1.1% decline in gross revenues. "We had excellent expense controls in our system, and we were able to maintain our revenues at about the same level as a year ago," said President Robert H. Hilb Sr.

The vigilance will continue, he said. "I think it's going to be the

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First-half 1992 broker results

In thousands of dollars

Broker	Gross revenues	% change	Net income	% change
Marsh & McLennan	\$1,501.8	4.7%	\$182.0	2.7%
Alexander & Alexander	668.3	-1.2	37.7	144.8
Rollins Burdick Hunter	338.7	68.2	48.7 ¹	95.6
Frank B. Hall	241.5	2.0	8.2	172.2
Arthur J. Gallagher	118.7	8.0	6.5	8.7
Hilb, Rogal & Hamilton	64.7	-1.1	4.9	37.9
Poe & Associates	24.5	4.3	1.6	-27.5

¹ Pretax
Source: Company reports

GRAPHIC BY RICHARD CARTON

Reform survey

Continued from page 1
the way for large-scale health care reform.

The Healthcare Leadership Council, which conducted the survey, consists of more than 50 health care industry executives working to solve the problems affecting health care. The group surveyed 38 state legislative leaders and 12 health care committee staff members.

Respondents identified legislation that Congress could pass now that would help improve access for the 37 million uninsured in the United States, including:

- Making health care coverage more portable.
- Banning exclusions in health care coverage for pre-existing conditions.
- Placing limits on how much insurers can raise premiums in a

given year.

• Providing premium tax credits to small employers that offer group health insurance to their employees.

Seventy-eight percent of respondents said passage of federal legislation to accomplish these reforms would create a "significant" impact on widening access to health care coverage.

Such legislation was passed earlier this year by the Senate and was included in a larger tax bill approved by Congress that president Bush vetoed for reasons unrelated to the health care issues (see related story, page 1).

"These are key issues that would go a long way toward improving access to insurance. The Senate has passed such a reform package; the President supports it; and we think the House would pass it, too, if it weren't for all the political posturing that's

going on," said Pamela Bailey, president of the Healthcare Leadership Council.

Congress should enact some type of health care reform legislation as soon as possible, said Rep. Joe Carothers Jr., D-Dothan, chairman of the Alabama House Health Committee.

"Even if it's small and even if it doesn't work, it's worth a shot. Hell, it's better than what's happening now, which is absolutely nothing," said Rep. Carothers. "Something has to give here."

"Significant reform can be enacted this year. Agreement exists on legislation that will ensure that affordable insurance is available to America's working families. Unfortunately, all this is likely to go undone because of political gamesmanship," complained Ms. Bailey.

"Congress shouldn't be holding up passing meaningful re-

form that they all agree on in hopes of more than 500 legislators agreeing on a single comprehensive package. This just isn't going to happen," she said.

All survey respondents echoed this sentiment, saying health care reform is either "very important" or "fairly important" for people in their state.

However, 82% of respondents said that despite their desire for federal leadership, it is unlikely Congress will enact any health care reform legislation this year.

"The only way we'll ever get everyone on the same page is for the federal government to take things over. The whole reform movement should be coordinated," said Rep. Peter Rodosovich, DFL-Faribault, chairman of the Minnesota House Health and Human Services Committee. "Sadly, I feel we'll never get this consensus."

"My hopes are for the federal government to do something. We could all benefit from mandatory community rating, as well as concessions on portability of insurance," said Sen. Dorothy Eck, D-Bozeman, chairwoman of the Montana Senate Public Health, Welfare & Safety Committee. "Few people in Washington oppose these ideas in principle, but we all know that once they become part of a sponsored bill, it will be opposed by someone from the other side."

It's this "political gridlock" between Democrats and Republicans in an election-year that's holding up progress on health care reform, said 78% of the survey respondents.

Accepting that reform is not likely at the congressional level, some states have been more willing to take the lead in health care reform. However, state lawmakers say this is happening more out of necessity than desire.

"I think the states are enacting grass-roots reform as a driving force for something bigger," said Minnesota's Rep. Rodosovich. "But we'd all like a federal movement. If this isn't going to happen, I'd like to see the government grant the states more waivers on ERISA, Medicare and Medicaid so that we can at least do what we can."

Florida, Oregon and Vermont have passed state reforms aimed at improving access to health care. However, Congress or the administration must approve waivers from ERISA and other federal laws to implement their reforms.

The Bush administration last week denied Oregon's request for a waiver of Medicaid regulations (see story, page 1).

Any state law that "relates" to welfare or pension plans is generally pre-empted by ERISA. And although ERISA does restrict states from regulating health insurers, most state reforms would require a congressional waiver so that reforms would also apply to self-insured employers.

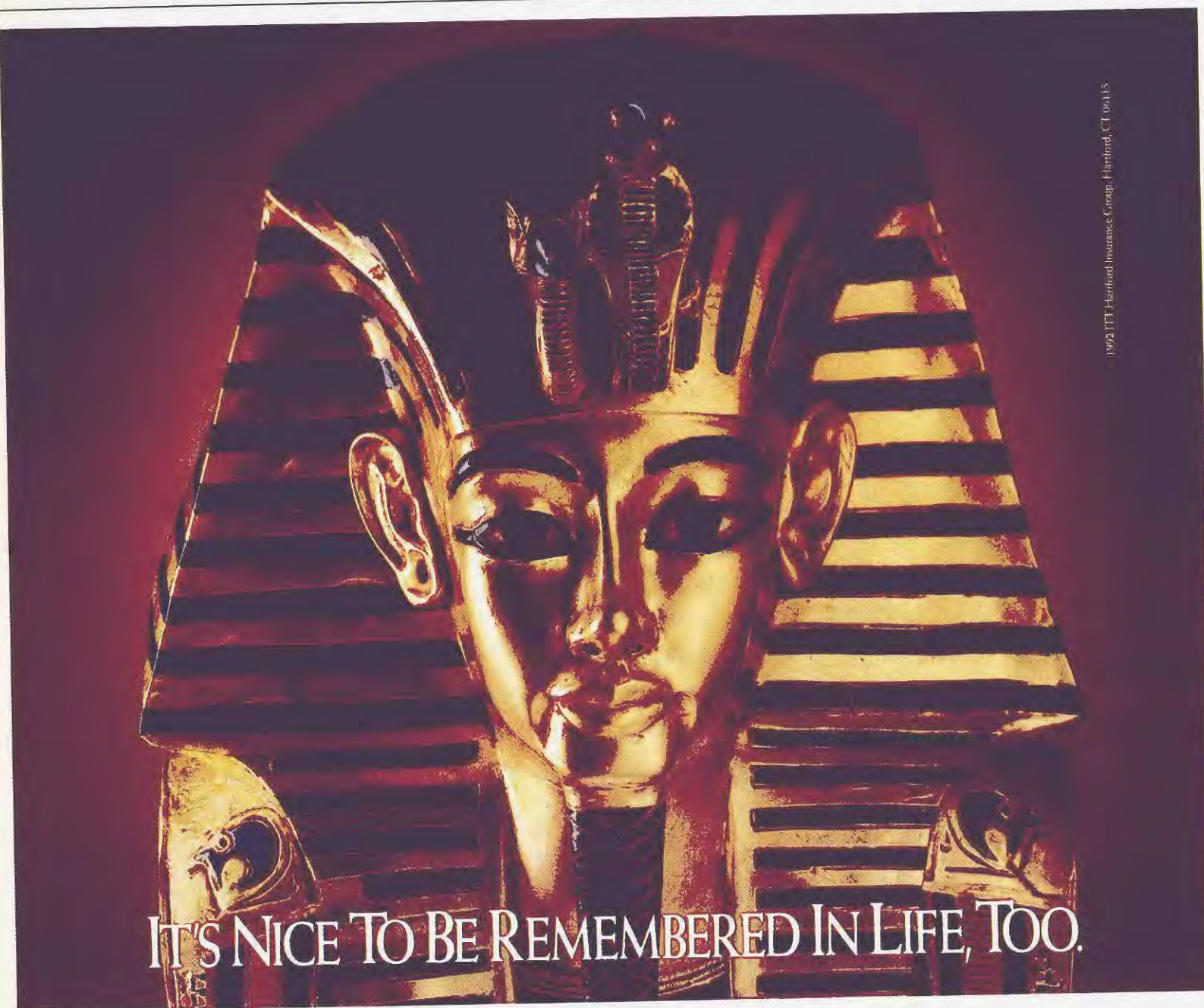
In addition, the administration must approve waivers for reforms that affect the Medicare or Medicaid programs.

"We definitely need more waivers from the feds so we can implement our own initiatives," agreed Sen. Eck of Montana. "Another thing that would be very helpful would be federal funding for state-run pilot projects. Basically, if Congress doesn't want to enact reform, they should let us do it."

Not all health care observers, though, believe the states are so willing to act on reform as the survey respondents intimate.

"State health care officials have been saying for the past three years that if the federal government isn't willing to reform the system, they will. But a closer look at what states have actually done shows that the view of health care committee members is far different than what other legislators feel," said Dallas Salisbury, president of the Employee Benefit Research Institute in Washington.

"I suspect that if you asked 50 members of Congress who are active in health care issues, most would say that reform legislation must be passed immediately. But the views of (Sen.) Jay Rockefeller (D-W.Va.), (Rep.) Pete Stark (D-Calif.) and (Sen.) George Mitchell (D-Maine) aren't representative of all of Congress," Mr. Salisbury explained.



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Benefit Beat

Maintaining health care quality is one of the most significant issues that human resource executives say they now face and will face tomorrow.

Maintaining quality, though, is complicated by the single most significant issue, health care cost containment, according to a recent survey.

Nearly half of the executives surveyed are in favor of a federal requirement that employers provide some type of health insurance. But most of the surveyed executives oppose a national health insurance program.

And, while most of those surveyed did not consider issues like elder care, child care and alternative work arrangements critical for immediate action, they said

such issues would require more attention in the future.

Retirement issues were thought to require only marginally more attention in the future than now.

The survey, "Directions for Tomorrow," was conducted by William M. Mercer Inc. in St. Louis. Seventy-three human resource managers from the St. Louis area filled out written questionnaires. Mercer consultants then conducted face-to-face interviews to gather additional comments.

The executives ranked issues according to their importance for both today and in the future on a scale of one to five, with five de-

signed as "very important to take action."

Health care quality assurance received a 3.6 rating for today, but the executives felt that the issue will require more attention in the future, receiving a 4.2 rating for tomorrow.

When asked how important it was to take action on health care cost containment, participants gave the issue a 4.5 rating today and a 4.7 tomorrow. Cost containment was the highest-rated issue covered by the survey.

"We employ managed care restrictions but still have difficulty controlling costs. Controlling health care costs is a major problem and will continue to be in the future," observed one human resource executive.

When asked if they favored a national program requiring employers to provide basic insurance coverage, the participants were almost evenly split in their response: 53.1% were opposed while 46.9% were in favor.

Interestingly, responses varied widely by industry. More than three-fourths of those in the health care industry, 78.6%, favored requiring coverage, compared with 40% of those in retail sales; 37.5% of those with financial or "professional" firms and 36% of those with manufacturing, processing or distribution companies.

Most respondents, 72.1%, oppose a government-run national health insurance program.

Respondents felt that it was relatively important to take action on health care cost shifting now, giving the issue a 3.5 rating, as well as tomorrow, assigning it a 3.8.

And, flexible benefits are expected to be a bigger concern in the future, receiving a 3.9 rating for tomorrow, but only a 2.8 today.

"Flex benefits is not the answer. All it does is shield the employees from figuring out that they have to pay more," said one executive.

Another respondent, though, commented that "we have done as much cost shifting as possible. We look to flex to help us in this area as it will allow employees to choose what they want."

In the area of non-traditional benefits, employee training and education was ranked the most important issue by far, with a 3.9 rating for today and a 4.5 for tomorrow.

"Only through training can we empower our employees to be competitive in the market," one participant suggested.

The belief that child care issues, with a 2.2 rating now and 3.6 for the future, will become more important was reflected in one participant's comment that "child care will increase in importance to recruit employees and to meet the needs of an increasingly female workforce."

Financial planning received a 2.0 rating for today and a 2.7 for the future; alternative work arrangements received a 1.7 rating now, and a 3.0 for the future; and elder care was given a 1.5 rating now, but a 3.1 in the future.

"The demands of home and family will require employers to be more flexible with their employees in order to retain and attract good people," one executive said.

Respondents considered pension and 401(k) plans as the retirement issues that are most important to take action on both now and in the future. Pensions received a 3.1 rating now and 3.5 for tomorrow; 401(k) plans received a 3.6 today and a 4.1 tomorrow.

"Employees will be asked to provide more of their retirement pay. We will heavily promote our 401(k) plan in the future in order to encourage our people to prepare for retirement," one executive said.

On the other hand, employee stock ownership plans and non-qualified plans were considered less pressing issues. ESOPs received a 1.2 rating today and a 1.5 for tomorrow; non-qualified plans received a 2.3 today and a much higher 3.2 for tomorrow.

For a free copy of the survey, contact Don Sanford, Communications Practice Chairman, William M. Mercer Inc., 10 S. Broadway, St. Louis, Mo. 63102; 314-982-0200.

—By Sara J. Hartly

Retirement savings

The percentage of workers that save for retirement is dropping, according to a new survey.

Sixty-three percent of 1,000 non-retired Americans surveyed said in 1992 that they have started to save for their retirement, down from 66% in 1991 and 69% in 1990.

The Employee Benefit Research Institute, which conducted the survey with The Gallup Organization Inc., also found that only 20% of those saving for their retirement are using 401(k) plans. Half the respondents plan to use personal savings for retirement and 33% plan to use their individual retirement accounts.

"Either those individuals who are saving don't fully understand available tax-favored savings options or they want savings to be immediately available," said Dallas Salisbury, EBRI president. "Otherwise, they would make heavier use of 401(k) plans, because the deferral of taxes and employer-matching contributions would allow much faster accumulations than non-tax-favored options."

Fifty-one percent of survey respondents said neither their employer nor their spouse's employer offered a 401(k) plan.

Among respondents who are eligible for an employer-sponsored savings plan, the average amount that employees contribute is 8% of pay. Similarly, of those respondents whose spouse's employer offers a savings plan, the average contribution is 8% of the spouse's pay.

Employees who are most likely to have started saving for retirement include those with annual incomes of \$75,000 or more, those age 35 or older and those who are married, the survey found.

Employees who are least likely to have started saving for retirement include those with annual incomes of \$20,000 or less, those with less than a 12th-grade education and minorities, according to the survey.

The survey, "Public Attitudes on Retirement Age and Planning, 1992," is available from Kim Thorpe, Employee Benefit Research Institute, 2121 K St. N.W., Suite 600, Washington, D.C. 20037-1896; 202-775-6315. For EBRI members, a summary is \$25 and the full report \$75; for non-members, the summary is \$75 and the full report \$275.

—By Deborah Shalowitz

Child and elder care

More than a dozen major companies are providing funding to increase the supply of child and elder care services in the United States.

Recognizing that employees face a critical shortage of such services, the consortium—led by International Business Machines Inc.—wants to help create a coast-to-coast "network" of providers.

The group's goal is to raise as much money from its members as it can by September to build and expand as many child and elder care facilities and programs as possible.

Companies in the consortium—known as the American Business Collaboration for Quality Dependent Care—will not operate or manage child care facilities, but will provide funding to private and public organizations, like daycare centers, after-school programs and elder daycare services, to expand their services.

—By Christine Woolsey



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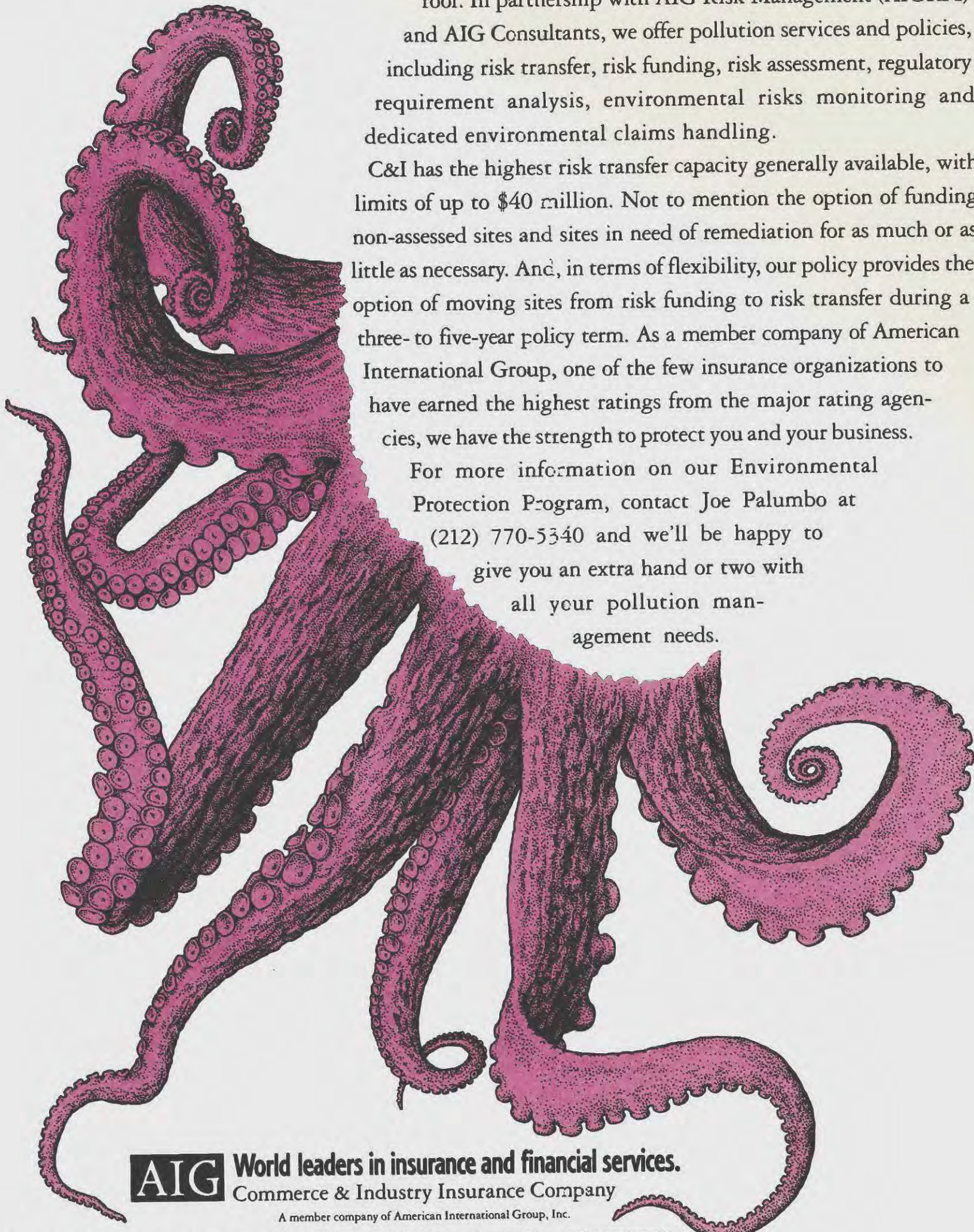
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Opinions

Wanted: More bold ideas

PROOF THAT HEALTH care reform is one of the thorniest issues that the United States faces appears on page 1 of this week's issue.

One story reports that Oregon's novel health care reform experiment, under which Medicaid services would be rationed, has been vetoed by the Bush administration over fears that it could discriminate against people with disabilities.

In addition, a separate story reports that health care has become a hot issue in the presidential campaign, with both President Bush and Gov. Bill Clinton making bold accusations that the other's health care reform plan is doomed to failure.

The rejection of the Oregon health care plan is distressing, particularly because the administration apparently is giving the state no guidance in how to reshape the plan.

We obviously are not in favor of withholding necessary medical services from the disabled. However, as realists, we accept that genuine health care reform is not possible without causing some hardships. Rather than reject the plan outright, the wise course for the Bush administration to follow would have been to approve the Oregon program for a limited period—two years, for example—during which the problems created by rationing could have been studied.

While many leaders in Washington have been encouraging the states to take the lead in reforming the health care system, the administration's decision sends a different message to the states: Don't plan on adopting reforms that are too radical.

Meanwhile, it is a positive sign that the presidential candidates already are squaring off on health care issues, though we would prefer a more intellectual debate than the charges and innuendos



that were hurled last week.

As the campaign progresses, we hope both President Bush and Gov. Clinton will attack the health care issue head-on. While President Bush has proposed a detailed health care reform plan, it falls far short of guaranteeing access to health care for all Americans or doing anything to control health care costs. And, while Gov. Clinton has embraced a play-or-pay approach to health care reform, his proposal still lacks many details.

Solving the health care crisis requires bold ideas. The Oregon proposal was just that—a bold idea that has been struck down. The ball is now in the presidential candidates' court.

Letters

Ensure quality care when controlling costs

To the editor: I read "PPO Reduces Florida Utility's Health Costs" (*BI*, July 13) with great interest and some dismay.

Florida Power Co.'s plan to pay Blue Cross & Blue Shield of Florida Inc., its plan administrator, "based solely on the amount of money it saves" is indeed "unusual." My concern is the impact such purely cost-driven policies may have on patients.

Reimbursing medically necessary and appropriate care that meets the needs of the individual patient should be the goal of any benefit plan. Efforts to ensure that patients get the appropriate level of care, like appropriate

managed care; efforts to contract with quality providers, like PPO arrangements; and efforts to expand coverage to a full range of treatment settings ranging from inpatient to outpatient and including such alternatives as partial hospitalization, halfway houses and home health care, are all incentives that are, if done correctly, patient-centered.

Denied treatment, too early discharges and high recidivism are some of the potentially harrowing implications of a health care program driven solely by cost. While managing health care costs clearly must be a priority, quality also must be part of the equa-

tion. Inadequate or inappropriate care can be far more costly in the long run.

Robert L. Trachtenberg
Executive Director
The National Assn. of Private
Psychiatric Hospitals
Washington

Disney comp plan attracting interest

To the editor: The Walt Disney Co. appreciates your article describing our workers compensation legislative reform proposals and your supporting editorial (*BI*, July 20). We have received numerous letters requesting copies of our proposals. As the article pointed out, workers compensation is an issue of serious and growing concern to employers both inside and outside of California.

We can't make this change happen by ourselves, and your article has helped us to reach a base of support that otherwise would be unreachable.

For the record, we would like to clarify that Disney has not actually drafted its own bill. Our list of suggested reform measures has been sent to key legislators in Sacramento for consideration, but they haven't yet been specifically incorporated into legislative language.

Stephen M. Wilder
Assistant Treasurer-Risk Management
Ellen B. Cooper
Financial Analyst-Risk Management
The Walt Disney Co.
Burbank, Calif.

Chicago flood coverage debated

To the editor: "Coverage Questions Abound" (*BI*, April 30) quotes a risk management consultant as stating that for a policyholder to collect on a business interruption policy, the "insured property" must first sustain physical damage. He goes on to cite an example of a tenant on an upper floor that did not sustain any damage from the Chicago flood and therefore did not have a valid business interruption claim.

Most business interruption policies contain a statement that there must be damage to the "property described herein." It always has been our position that the phrase "property described herein" refers not only to the insured property but to the premises generally. Therefore, if any portion of the insured address suffers physical damage that impacts the policyholder's operations, then it is our opinion and

has been our experience that coverage is so provided.

In addition, the coverage provided by most business interruption policies for interruption of operations because of orders of civil authority has been held by some courts not to require any physical damage, even to the insured premises. Further, when business interruption coverage is blanketed over many locations, the impact of a fire in one location is covered as it affects other undamaged locations.

Thus, at the very least, it is difficult to make facile conclusions concerning damage for business interruption losses where physical damage is not directly present.

Bruce Swerling
Marvin Milton
Swerling, Milton & Winnick
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A look back at landmark work comp report

By MEG FLETCHER

Recommendations spurred change, but many shortcomings seen

EAST LANSING, Mich.—Most state workers compensation systems protect workers better now than they did 20 years ago, but problems still exist, experts conclude. Twenty years ago, a report by the National Commission on State Workmen's Compensation Laws concluded that state laws were generally "inadequate and inequitable," said John F. Burton Jr., a Rutgers University professor and administrator who chaired the commission in 1972.

The commission's research showed that injured workers two decades ago faced an uncertain future in 19 states where some employers, especially small ones, were exempt from state workers compensation laws.

In addition, benefit levels "were surprisingly—if not appallingly—low," Mr. Burton said. For example, more than half the states capped weekly temporary total benefits below the 1971 national poverty level for a non-farm family of four, which was \$79.56.

Created by the Occupational Safety and Health Act of 1970, the commission consisted primarily of Republican appointees.

After 13 months of work, it developed a 151-page report, which Mr. Burton and other experts revisited at the recent 16th National Symposium on Workers' Compensation at Michigan State University in East Lansing.

The commission's 1972 report outlined 84 recommendations for state action, including 19 that were considered "essential."

Following release of the report, many states changed their workers comp laws. Today, states comply with an average of 12 of the 19 "essential" recommendations. Jurisdictions leading in compliance are: New Hampshire, which complies with an average of 18.75 of the recommendations;

the District of Columbia, 15.75; and Iowa, 15.50. At the other end are: Mississippi, 7.25; Wyoming, 8.25; and Arkansas, 8.5.

Among the most widely adopted recommendations were: to make workers comp laws compulsory for most employers; to increase temporary total disability, permanent total disability, death and survivors' benefits; and to eliminate limits for medical care or physical rehabilitation services.

Other recommendations considered "essential" by the commission were largely ignored. For example, only 15 states extended workers comp benefits to farm workers, and only New Hamp-

shire extended workers comp to household workers, according to the U.S. Department of Labor.

In its report, the commission stopped short of advocating a new federal workers compensation system. Instead, it recommended "creative federal assistance" in the form of a new commission to conduct a 1975 review of states' compliance records.

"This review should culminate in federal mandates if necessary to guarantee compliance," the report said.

Subsequent efforts to establish federal standards as a remedy for states' failure to adopt recommendations were unable to garner much political support, especially during the Carter administration, said Don Elisburg, an attorney in Potomac, Md., who represents labor unions.

"Workers compensation is in much better shape (now) than it was in 1972, but there are still problems with adequacy and equity (of benefits)," Mr. Burton said.

The commission's work "let the genie out of the bottle," and prompted discussion and legislative changes that continue today, Mr. Elisburg said.

However, two decades after the report was released, it still is subject to criticism.

Hindsight reveals several "shortcomings" in the report, said Peter S. Barth, the commission's former executive director who is now an economics professor at the University of Connecticut at Storrs.

The "major shortcoming" in the report was a failure to adequately discuss the controversial issue of permanent partial disabilities. Avoiding the topic, he said, was a "trade-off" to prevent "a bloodletting" that would have made a unanimous report impossible.

While Mr. Barth may consider this "a finesse," others might call it "a cop-out," charged Alan Tebb, outgoing general manager of the California Workers Compensation Institute, a non-profit research and education organization operated by workers comp insurers in California. Mr. Tebb, who attended the commission's meetings 20 years ago as an observer, is now vice-chairman of the CWCI.

Other problems that the commission failed to adequately address two decades ago, said Mr. Barth, include the impact of medical cost increases and the significance of occupational diseases, which the report urged all states to cover. In addition, the tax-free status of temporary total benefits has made them so high in some states that injured employees have little incentive to return to work, he said.

Mr. Barth contends that the commission "lost sight" of the key goal of workers compensation: Restoring injured workers so they can go back to work.

"Return-to-work should be the basis of evaluating how well insurers, employers and employees do," he said.

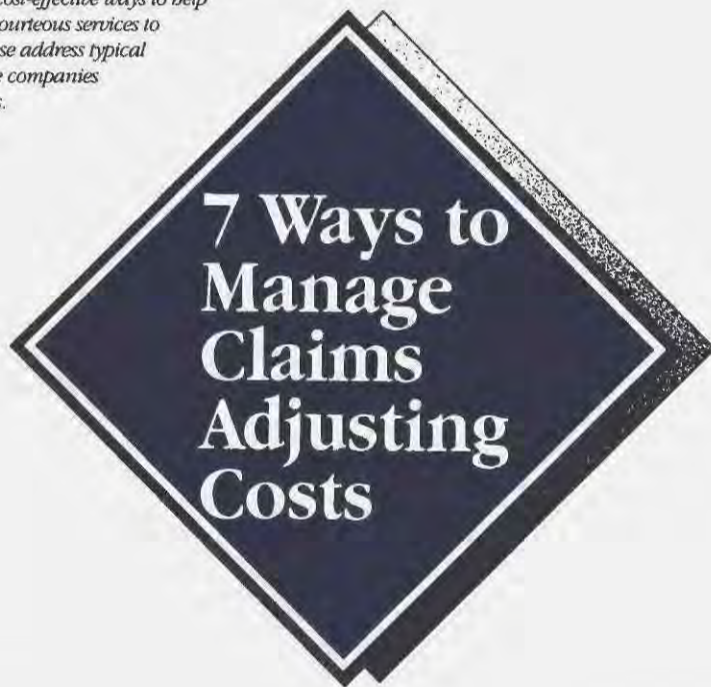
Unfortunately, Mr. Barth added, the focus of the report's follow-up was on state compliance with the 19 essential recommendations rather than on how well employers were getting injured workers back on the job.

"I believe we should have forced (state) policymakers to

Continued on page 12

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Safety diligence protects profits as well as workers

By MEG FLETCHER

EAST LANSING, Mich.—It will soon be easier for risk managers to show that a caring corporate culture emphasizing safety can save money as well as workers' lives.

Preliminary findings of a three-year study indicate that companies in high-hazard industries could reduce some workers compensation costs with only modest improvements in areas like safety or return-to-work programs.

Specifically, the study of Michigan companies used questionnaire responses to compare companies' performance on several measures. One key measure was "safety diligence," which reflected companies' responses to

14 questions about the frequency with which managers and workers followed traditional safety practices, including good house-keeping and appropriate record keeping.

The study found that improving "safety diligence" by 10% can reduce: wage-loss claims by 31%; accidents and illnesses that must be reported under federal law by 27%; and lost work days per 100 employees by 15%.

The study's preliminary results also indicate that a 10% improvement in the quality and effectiveness of a company's return-to-work programs resulted in about a 29% reduction in the number of wage-loss claims and an 8% reduction in lost work days, both per 100 employees.

"We think the magnitude of these impacts is staggering," said researcher H. Allan Hunt, assistant executive director of The W.E. Upjohn Institute for Employment Research in Kalamazoo, Mich.

Preliminary results of the study were discussed at the National Symposium on Workers Compensation, held July 12-16 at Michigan State University in East Lansing.

Researchers expect to finish the study this year and publish it in 1993.

They contacted companies in seven of the state's 20 most hazardous industries: food production, furniture manufacturing, rubber and plastics, fabricated metals, non-electrical equipment, transportation equipment and health service. Companies were categorized by the number of employees, ranging from 100 to more than 500. Differences between the largest and smallest companies still are being evaluated.

Some 220 randomly selected firms in those seven industries filled out questionnaires. Researchers then verified responses and results by making lengthy visits to 36 companies, which were equally split between high- and low-performance firms based on the number of lost workdays per 100 employees.

The study was funded by the Michigan Department of Labor; the Upjohn Institute; and Michigan State.

The other lead researcher, Rochelle V. Habeck, an associate professor in rehabilitation counseling at Michigan State, said the

Symposium examines workers comp system

EAST LANSING, Mich.—The 16th annual National Symposium on Workers Compensation was held July 12-15 at Michigan State University's Kellogg Center in East Lansing, Mich.

A diverse group of about 120 participants and speakers—including college professors, state administrators, employers, insurers, labor representatives and claimants' attorneys—heard presentations and discussed at length key issues in workers comp.

The gathering marked the 20th anniversary of a report by the National Commission on State Workmen's Compensation Laws and featured members of the commission discussing current workers comp conditions.

In addition, symposium speakers and participants discussed other topics, including the role of state funds, permanent partial disability, opportunities for improvement by individual employers and the role of claimants' attorneys.

Since 1991, the symposium has been directed by Edward Welch and John Burton.

Mr. Welch, a former claimants' attorney, was director of Michigan's Bureau of Workers' Disability Compensation from 1985 through 1990. He is now an assistant professor at Michigan State's School of Labor and Industrial Relations. In addition, he edits "Ed Welch on Workers' Compensation," a bimonthly newsletter.

John F. Burton Jr., who was chairman of the national commission, is director of the Institute of Management and Labor Relations at Rutgers University in New Brunswick, N.J., where he is also a professor. He is the editor of "The Workers Compensation Monitor," a bimonthly newsletter.

The 17th annual symposium is expected to be held next summer, though date and place have not been set. For information, contact Mr. Welch at 517-332-5266.

case management.

- Expand their return-to-work programs beyond just "light duty" posts.

By following these guidelines, employers with good safety records create the climate for suc-

cess, Ms. Habeck said. Such a climate can only be created from within the company, she said.

To do it, "you need to get everybody involved" through cooperative labor-management relationships, information sharing and opportunities for employee participation, she added.

Potential difficulties include: obtaining useful workers comp data; winning supervisor commitment and participation; and implementing programs effectively.

The study is an outgrowth of an earlier study of differences in employers' workers comp claim rates in Michigan done by researchers including Mr. Hunt; Ms. Habeck; Michael J. Leahy, an assistant professor at Michigan State; and Edward M. Welch, an assistant professor at Michigan State and a director of the national symposium.

That study found that:

- There are "very substantial intrastate differences" among employers in the same industry, which by some measures are "significantly larger" than interstate differences found in other studies.
- Three important factors distinguishing companies with frequent claims from those with less frequent claims are: safety and prevention of work-related accidents; managerial style and culture of the organization; policies for the prevention and management of disability.

"Those employers which most frequently engaged in safety and prevention efforts, which tend to have an open managerial style and a corporate climate that shares decision making, and which make the most effort to prevent and manage disability are the employers which most likely will have low workers compensation claims frequency," the earlier study concluded. ■

Workers comp report

Continued from page 10

confront the underlying issues of their workers compensation systems," said John H. Lewis, a Miami attorney who was the commission's associate executive director and chief counsel. Instead, the report's format gave states the impression they "could do something very significant without thinking about it," by passing the recommendations.

Labor unions fault the commission's report for not advocating that increases in workers comp benefits be indexed to inflation, said labor attorney Mr. Elisburg.

These experts are divided on whether substantial change in the workers comp system could occur now.

Some current factors favor change, like rising medical costs and insurers' willingness to experiment with alternative approaches like 24-hour coverage.

But other factors are inhibiting change. Among these are the lack of support for a new commission to provide guidance to states, as well as an increase in the number of professionals—like lawyers and rehabilitation specialists—who earn their living from the current system.

"Each has sufficient influence to veto anything," he said, and not one has enough strength to accomplish any real change.

"No one is happy with the system, but they don't have the votes (to reform it)," Mr. Tebb said. ■

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'You need to get everybody involved' in successful safety management through cooperative labor-management relationships, information sharing and opportunities for employee participation, Ms. Habeck says.

findings indicate that employers generally can control their workers comp costs if they:

- Engage top managers to participate actively.
- Analyze the real causes of disability.
- Respond immediately to identified problems.
- Link safety programs and disability prevention efforts.
- Move hazard control "upstream" by focusing on loss prevention efforts like ergonomics.
- Maintain an active role in

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Continuous safety process beats out gimmicks: Experts

By MEG FLETCHER

EAST LANSING, Mich.—Employers can best prevent workplace accidents by developing a framework to identify and reduce hazards on a

continuing basis, experts say. That approach will prevent more accidents than targeting unsafe acts independently, said Albert A. Mangone, director of retail customer training and service for Liberty Mutual Insurance Co. in Boston.

He outlined key points of Liberty Mutual's "Quality Safety Process" recently at the 16th National Symposium on Workers' Compensation at Michigan State University.

Too often, companies try to depress claims through "gimmicks" or less comprehensive safety programs, Mr. Mangone said.

For example, many companies try to promote safety by primarily focusing on the number of days employees have worked without a lost-time injury, said Edward Welch, an assistant professor at Michigan State, workers compensation newsletter author and co-director of the symposium.

Employees get prizes like windbreakers when the goals are met. But this approach encourages employees to underreport small accidents and problems that may lead to larger losses later, he said.

Instead, Mr. Mangone recommends a formal process of surveying for hazards, identifying them and encouraging employees—through training and rewards—to abate them.

The goal is to have workers and managers constantly on the lookout for hazards and either reduce them immediately or report them before accidents occur, he said.

Hazards can be identified by utilizing the expertise of safety and management professionals as well as experienced workers.

In preventing losses, "the key is to carry on the process jointly," Mr. Mangone said. "It's essential to get the employee involved."

Companies also should learn from their experience by analyzing data from accident and loss reports and first aid logs.

Hazard surveillance procedures include monitoring employees' actions as well as workplace conditions, often with the help of safety checklists developed by employees.

Once the checklist is completed, employers should avoid the pitfall of failing to evaluate it, he said.

Mr. Mangone also recommends tracking progress every month or so by tallying hazard rates rather than claims frequency rates. Employers should divide the number of hazards found by some measure of exposure, like sales volume or number of hours worked, he suggested.

Charts could show the employee how the hazard rate has changed over time, for instance. Or photographs could show hazards that have been or will be abated.

Companies can then establish targets and reward those who meet them. Employees should only be rewarded for good performance and not punished for bad, Mr. Mangone said. Rewards should be cash or a substitute, paid as often as possible and to as many individuals and teams of employees as

possible.

Such prizes are "more positive" and more within an employee's control than are—for example—awards for going a certain number of days without a lost-time injury, Mr. Welch said.

Managers, however, should be both rewarded for good performance and punished for bad performance through a credit and debit system or charge backs, he said.

In addition, the data obtained in the hazard surveillance process should be used to periodically revise the entire system, he said.

Liberty Mutual provides the loss control program he outlined to policyholders free and to other companies for a fee, he added. ■

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Weyerhaeuser saves \$200 million

Management gets behind plan to cut workers comp costs

By MEG FLETCHER

EAST LANSING, Mich.—In a feat that would make even Paul Bunyan proud, lumber giant Weyerhaeuser Co. has saved nearly \$200 million in workers compensation costs since 1984.

"It's a true success story" because the company's program also emphasizes treating injured employees "with dignity and respect," said Kenneth L. Gipson, corporate director of safety, health and statutory benefits for the Tacoma, Wash.-based company.

He discussed the company's

cost-cutting measures at the recent National Symposium on Workers Compensation at Michigan State University.

Weyerhaeuser's efforts began in 1982 when a cost-containment study showed that the company could save \$3.5 million to \$6.8 million annually in workers comp costs.

It took several steps to achieve significant savings at the company, which had been self-insured in most states for decades, Mr. Gipson said.

Among the "ingredients for success" were management acceptance of the plan and a conviction that accidents must be prevented, he said.

That point was driven home to operating units, which were made more responsible for the cost of

worker injuries and illnesses.

Weyerhaeuser expanded its program of self-administering workers comp claims in 44 states between 1984 and 1987, rather than relying on an outside service company.

In addition, Weyerhaeuser established an excess insurance program at its corporate level and increased its retention to \$5 million from \$500,000.

Claims administration was centralized, with the number of professional claims handlers tied to the volume of claims administered. And claims handlers were required to understand workers comp regulations and follow the company's one-page statement of corporate philosophy.

Among the principles outlined in that statement is that workers who make claims are to be treated "with dignity and respect." Legitimate claims are to be handled "by swift, efficient and equitable evaluation and payment."

The philosophy statement continues: "If there is any doubt about the circumstances of the injury, all doubts will be resolved in the favor of the employee. The highest stan-

dard of care will be extended to our injured employees to guarantee rapid recovery with the least possible residual disability."

In addition, the full range of required benefits will be provided "in a prompt, fair and equitable manner," according to the statement.

"The company will not attempt to create savings in workers compensation costs by denying or delaying an injured employee's benefits. Savings will come from accident prevention, early return-to-work programs and job modification, which are consistent with medical opinions.

"The decision to deny a claim shall not be made capriciously, but only after there is clear evidence that Weyerhaeuser is not responsible for the injury or disease. The decision shall be unbiased and based on legally sound evaluation of the facts of the case with no consideration made toward compromise until so ordered by the appropriate agency."

The company requires claims handlers to focus on serving one of three "customers," which are identified as the manager of the operating unit, the injured em-

ployee and the state agency, Mr. Gipson said.

By several measures, Weyerhaeuser's workers compensation program has been very beneficial to the company.

Weyerhaeuser estimates that, based on national trend data from the National Foundation on Workers Compensation, the company saved \$196.6 million between 1985 and 1991 by keeping a handle on workers comp cost increases.

In 1991 alone, the company's \$18.4 million in incurred costs, including administrative expenses, was \$62 million less than the \$80.8 million in premium it would have paid under a fully insured program.

Incurred cost per employee dropped to \$300 last year from more than \$750 in 1984, while cost per man-hour dropped to less than 20 cents from nearly 40 cents in 1984.

In addition, the number of industrial-injury claims dropped to about 5,000 in 1991 from about 10,000 in 1982. That drop resulted in marked decreases in the number of full-time employees absent from work as well as paid lost work-days.

"The reduction in the number of injuries is really the driving force" behind the savings, Mr. Gipson said.

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NCCI introduces evaluation plan to shape up assigned risk pools

By DEBORAH SHALOWITZ

NEW YORK—Workers compensation insurers that participate in residual markets in 25 jurisdictions are eligible for rewards and subject to penalties under a new program designed to improve service to employers in assigned risk pools.

The program, announced last month by the National Council on Compensation Insurance and effective immediately, rewards those insurers whose loss experience is better than the average for all servicing insurers in a jurisdiction. Similarly, poor performers will be penalized.

Residual market insurers also are evaluated on how well they manage underwriting, premium audits, loss control, financial transactions and claims. Penalties are assessed for a "marginal" rating and for an "unsatisfactory" rating in any of these categories.

The program aims to counter "any perception that assigned risk servicing carriers perform a 'pass-through' function and may have little incentive to perform effi-

ciently," said NCCI President William Hager. "It is also an attempt to help curtail the disastrous losses suffered by all workers compensation insurers in the residual market."

Critics of residual market administration contend that servicing insurers provide poorer loss control and other services than insurers writing in the voluntary market (*BI*, Sept. 16, 1991).

Residual markets take different forms in different states. Most are administered by the NCCI.

In these states, employers that cannot buy workers comp coverage in the voluntary market are assigned to one of several "servicing insurers," which writes the coverage and handles claims. But premiums paid by a policyholder—and the claims it incurs—are shared by all insurers writing voluntary workers comp insurance in the state.

Residual market insurers in 23 states plus the District of Columbia are covered by the new NCCI standards. These states are: Alabama, Alaska, Arizona, Arkansas, Connecticut, Florida, Georgia, Idaho, Illinois, Indiana, Iowa, Kansas, Kentucky, Mississippi, Missouri, Nebraska, New Hampshire, Oregon, South Carolina, South Dakota, Tennessee, Vermont and Virginia.

The program also has been recommended to four states that have independent administration of the workers comp residual market: Delaware, Hawaii, New Jersey and North Carolina.

The program does not have to be approved by individual states, except for Alaska, before implementation.

Under the first part of the NCCI's new program, the acceptable loss ratio range is set at 90% to 110% for a workers comp insurer with premium volume of more than \$30 million. Insurers with a loss ratio lower than 90% will receive a reward of 20% of the insurer's paid losses below that threshold. Insurers with a loss ratio exceeding 110% must pay a penalty

of 20% of paid losses exceeding the limit.

For insurers generating between \$10 million and \$30 million in premium volume, the range is 85% to 115%. Rewards and penalties are 20% of the insurer's paid losses falling outside those parameters.

For insurers generating between \$5 million and \$10 million in premium volume, the range is 80% to 120%; for those with premium volume of \$2.5 million to \$5 million, the loss ratio range is 75% to 125%. Rewards and penalties are 20% of the insurer's paid losses falling outside those thresholds.

Insurers with less than \$2.5 million in premium volume are exempt from the rules.

Penalties are capped based on a mathematical formula.

Under the second part of the program, servicing insurers are evaluated on 10 key activities that can adversely affect financial results: premium calculations; premium audits; mandatory preliminary audits; additional premium endorsements; cancellation when non-disputed premium is not paid; loss control survey; loss control recommendations follow-up; claim investigation/injured worker contact; disability management through a continuing dialogue with claimant, physicians and the employer; and an integrated medical management program.

On a first evaluation, the penalty for a "marginal" rating in most categories is \$500 per category. The exceptions, with penalties of \$1,000, are the loss control recommendations follow-up and claim investigation/injured worker contact categories.

For "unsatisfactory" ratings, the penalty is \$2,000 per category, except for the loss control categories, which carry a \$3,000 penalty. The maximum penalty on a first evaluation is \$200,000.

On a second evaluation, penalties for "marginal" judgments are doubled, up to a maximum of \$250,000, while penalties for "unsatisfactory" judgments are tripled, up to \$500,000.

AUGUST CLOSINGS

SET YOUR DATES

issue:	August 17 — Reader Service — Bonus Distribution: ARIA
closing:	August 4
editorial feature:	Surplus Lines — Directory: Surplus Lines Insurers & Wholesalers
demographic section:	Insurer Topics: Education/Recruiting & Personnel Development
issue:	August 24
closing:	August 12
issue:	August 31 — Bonus Distribution: Monte Carlo Rendez-Vous
closing:	August 18
editorial feature:	Reinsurance: International Markets — Directory: Leading Reinsurers Worldwide
issue:	September 7 — Bonus Distribution: SIA
closing:	August 25
editorial feature:	Benefits: Pensions/Retirement Plans — Directory: 401(k) Plan Administrators
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Candidates attack

Continued from page 1
new tax credits and deductions to help the poor and middle class buy health insurance (BI, Feb. 10).

Meanwhile, Senate Democrats last week also lit into the president, charging that he has no interest in health care reform.

President Bush is "callous and indifferent," charged Sen. John D. Rockefeller IV, D-W.Va. "I don't know how he can be so callous on such a clear and overwhelming problem."

He "does not care one whit about health care," Sen. Rockefeller added.

The administration's health care package is flawed because it does not ensure that all Americans will have health insurance and it does nothing to control costs, said Sen. Edward M. Kennedy, D-Mass.

"President Bush is playing politics with a life and death issue," said Sen. Bob Kerrey, D-Neb.

Sen. Paul Wellstone, D-Minn., said Gov. Clinton and President Bush have completely different attitudes on access to health care.

"The fundamental difference is that Clinton knows health care is a right, not a privilege," Sen. Wellstone said.

Sen. Rockefeller contrasted President Bush's "indifference" to health care issues to Gov. Clinton's interest. "He (Gov. Clinton) knows health care. We will have comprehensive health care legislation within a year if he is elected," Sen. Rockefeller said.

While Senate Democrats will continue to press for reform legislation, Sen. Rockefeller was not sanguine about the prospects this year. President Bush would probably veto any Democratic proposal, he said, and the Democrats would not be able to override a veto.

Administration officials last week defended the president's health care proposal.

"The president's health care plan

No gag order in Phillips blast

BARTLESVILLE, Okla.—Phillips Petroleum Co. says an internal investigation shows employees were not told to lie or to withhold information during an Occupational Health and Safety Administration investigation of a 1989 plant explosion.

Federal labor officials still are looking into a Phillips employee's charge, made in a letter to the company chairman, that he was told by supervisors to give as little information as possible to OSHA.

Investigators were looking into the explosion at the Pasadena, Texas, plant that killed 23 and injured more than 130 (BI, April 20; Oct. 30, 1989).

Phillips says it sent the results of its investigation to the inspector general's office of the U.S. Department of Labor in Houston and to OSHA.

Meanwhile, Fish Engineering & Construction Inc. has agreed to pay \$100,000 to settle an OSHA citation stemming from the explosion.

Four of the fatalities and 52 of the injured were employees of Fish, which was a maintenance contractor at the plant.

Fish did not admit any responsibility for the blast. As part of the agreement, it will implement a corporatewide health and safety program.

Phillips agreed last year to pay a record \$4 million to settle OSHA charges from the incident (BI, Aug. 26, 1991).

—By Michael Bradford
and Sara Marley

controls health care spending by attacking the cost drivers in health care and not by fiat and government price controls. We believe this legislation provides urgently needed help to millions of Americans, enabling them to have access to affordable health insurance immediately," said Gail Wilensky, deputy assistant to the president for policy development.

Kevin Moley, deputy secretary at the Department of Health and Human Services, said Gov. Clinton's health proposal would lead to rationing of care and a massive tax increase.

Mr. Moley also charged that Gov. Clinton has an outline, not a detailed legislative proposal.

"Three pages does not constitute a plan. We have heard for three days now that this administration doesn't have a plan. We have a plan. Gov. Clinton does not have a plan," Mr. Moley said. ■

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Continued from page 3
know it," said Robert Ferm, an attorney with Hall & Evans in Denver and counsel for the American Insurance Assn. "It will have a serious detrimental impact on employers, employees, the cost of goods and services, the state and local entities."

Mr. Ferm said the AIA plans to examine the signatures.
"It puts us back in the Dark Ages, prior to the advent of workers comp," said Gary Pon, president of the Denver-based Colorado Compensation Insurance Authority, the state's competitive workers comp fund and the largest underwriter of workers comp coverage in Colorado. "It's a giant step backward. Every injury could result in a suit."

However, "Employers have nothing to fear if they provide a safe workplace," said Eldon W. Cooper, president of the Colorado AFL-CIO. "The burden of proof is still on the claimant to prove that the company knew unsafe conditions existed and refused to do anything about it."

"All we want is a safe workplace. We hope no one ever has the opportunity to sue" under the amendment, Mr. Cooper said. The standard of knowingly maintaining an unsafe workplace is the same as the "willful misconduct" benchmark under which injured workers in most states can file tort lawsuits against their employers, contends Craig Eley, the Denver attorney who wrote the amendment.

Colorado courts, though, have not upheld willful misconduct as a valid reason for bypassing exclusive remedy of the workers compensation system, explained Mr. Eley of Eley & Eley, who represents injured workers. "In Colorado, willful, intentional acts have never been a way around exclusive remedy."

The changes made by the amendment would affect "very few injured workers," according to Mr. Eley. However, "There will be fewer injuries, fewer workers on comp. It gives employers an incentive to keep their work area safe," he said.

Safe Workplace Colorado also says the amendment is an attempt to counter a reduction in benefits that was part of a workers comp reform package that went into effect July 1, 1991. The package also precludes workers 65 and older from claiming permanent total disability (BI, July 1, 1991; May 13, 1991).

"Workers comp benefits have been cut so badly. It's not fair. If employers want to have immunity from responsibility, they have to give something in return," Mr. Eley said. The 1991 reform law awards higher benefits to workers with serious injuries and lower benefits to those with minor injuries. It also curbed unnecessary medical costs and streamlined the workers comp system to eliminate litigation (BI, July 1, 1991).

"It's not a perfect law," but a constitutional amendment that would stand for at least two years is too extreme, Mr. Pon said. "A more prudent course of action would be to deal with inaccuracies in the current workers comp law."

Colorado's workers comp reforms prompted the National Council on Compensation Insurance last year to withdraw a request for a 36% rate increase, ending 10 consecutive years of rate increases, Mr. Pon said. Next year, in fact, rates may fall, he noted.

Meanwhile, preliminary hearings are scheduled in Denver District Court next week on a lawsuit that challenges the constitutionality of the reform law. The suit was filed by the Workers Compensation Education Assn., a group of attorneys who represent injured workers. ■

Diamond Shamrock

Continued from page 3
Duolite was dismissed from the case during the trial.

However, the jury found that Diamond Shamrock fraudulently concealed from Mr. Rosario the results of medical tests that were performed while he worked at the factory. Those tests showed that he had precursors to lung cancer.

Since 1982, California law has made fraudulent concealment an exception to the exclusive remedy doctrine of workers compensation.

That exception was added after a 1980 state Supreme Court ruling in *Johns-Manville Products vs. Superior Court*. The court ruled the workers compensation law does not bar a worker from suing an employer for aggravation of a compensable in-

jury when the employer fraudulently conceals a worker's disease.

The jury in the Diamond Shamrock case also found that Diamond Shamrock could be held liable for negligence as the premises owner during the period Duolite operated the plant and Mr. Rosario was directly employed by a Diamond Shamrock subsidiary.

The jury found that Diamond Shamrock could be sued as an entity separate from the employer because it relinquished direct management of the facility to Duolite in 1981, three years before Mr. Rosario retired.

Of the \$4.7 million of damages, \$2.28 million was awarded for non-employer negligence; \$2.07 million was awarded for aggravation of injury caused by the employer's fraudulent act; and \$300,000 was awarded to Luzmi-

lia Rosario, Mr. Rosario's wife, for loss of consortium.

No punitive damages were awarded.

Diamond Shamrock will file post-trial motions asking the judge to set aside the verdict. If those motions fail, an appeal is likely, said one lawyer for the company, Robert Eassa of Hardin, Cook, Loper, Engel & Bergez in Oakland.

Mr. Eassa declined to provide information about Diamond Shamrock's general liability insurance. But, he noted that the company—and not its insurer—hired him to defend the Mr. Rosario's suit.

Mr. Rosario also has filed a workers comp claim against his former employer.

Several management lawyers said the case broke no new ground.

Continued on next page

This Day

20 Years Ago

The city park department, operating in the red for several years, borrowed \$3,000 from the city council fund. The city council fund was carrying a surplus due to the rapid growth of the city. A Cedar Rapids club for Britain, Inc., was organized. Weaver Wiltner as president. E. Blake as secretary. A fresh head football coach named Ray Donels, named head football coach. University to succeed James had accepted the position of the University of Colorado.

FINANCIAL STATEMENT OF AMERICAN RE-INSURANCE AS OF DECEMBER 31st, 1921

Assets	\$4,500.00	Workers Legal	
Bonds and Stocks - Book Value	2,702,120.91	Reserve	
Premiums in Office and Banks	79,024.09		
Less (less commissions)	157,673.82		
Net Interest	47,533.34		
Due	\$2,991,452.22		

FINANCIAL STATEMENT

Total Cash Receipts.....\$157,414.61

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Bank Balance.....\$157,272.27

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In 1917, American Re was formed to underwrite Worker's Comp for seven coal mining families in Pennsylvania. Seventy-five years later, one of our first clients is still with us. In fact, over half of our clients have been with us 20 years or longer. It takes enduring quality to maintain financial strength and client relationships through hard and soft markets. In 1985, when capacity got tight, we didn't close offices or reduce coverage. Our record of constancy helped our clients through

the tough times. Some reinsurers didn't make the same constant commitment; some didn't make it at all. With stability, we offer innovation. Systems and services especially designed to meet our clients' needs. We bring together specialists from across divisional, corporate and geographic lines to provide customized solutions for our clients. We have actually restructured our company to give full access to the best minds in the business with a flexible, coordinated response

Diamond Shamrock

Continued from previous page

"This is not a precedent-setting case," said Mr. Eassa, the lawyer for Diamond Shamrock. "The proposition that the case stands for is that an employer that commits fraud can be sued outside of the workers compensation system. It's akin to an intentional tort."

"I don't see this case as having any precedential value," said Armen George, an employer attorney with Wunsch & George in San Francisco. Both liability findings are based on existing law, he said.

"It appears from the verdict that Diamond Shamrock was found to be wearing two hats at different points in time," permitting it to be held liable for fraudulent concealment as an employer and for negligence as a property owner, he explained.

Mr. George said he was heart-

ened by the fact that no punitive damages were awarded, "which shows that juries do draw a distinction between evidence theories."

For punitive damages to be awarded, there must be clear and convincing evidence, while negligence must be proven by only a

edy doctrine, you have to establish fraud."

Still, Mr. Miller admonishes employers not to conceal from workers evidence of possible exposure to hazardous substances in the workplace.

"It would appear that the ver-

apparently wasn't the employer," Mr. Cronthall said that existing law already provides injured employees a remedy through the tort system when they can prove "the parent company doesn't have day-to-day control over the employer."

However, Mr. Simon, the retired worker's attorney, said the case may have some value as precedent.

Because the jury found that the parent company could be sued for premises liability separately from its subsidiary, the case may open the door for other similar suits, he said.

"The court said, 'If you abdicate responsibility for operating the facility, you still can be held responsible,'" Mr. Simon said. "This could subject other decentralized corporations to increased liability exposure."

Rosario vs. Diamond Shamrock Corp., Alameda County Superior Court, No. 687219-1.

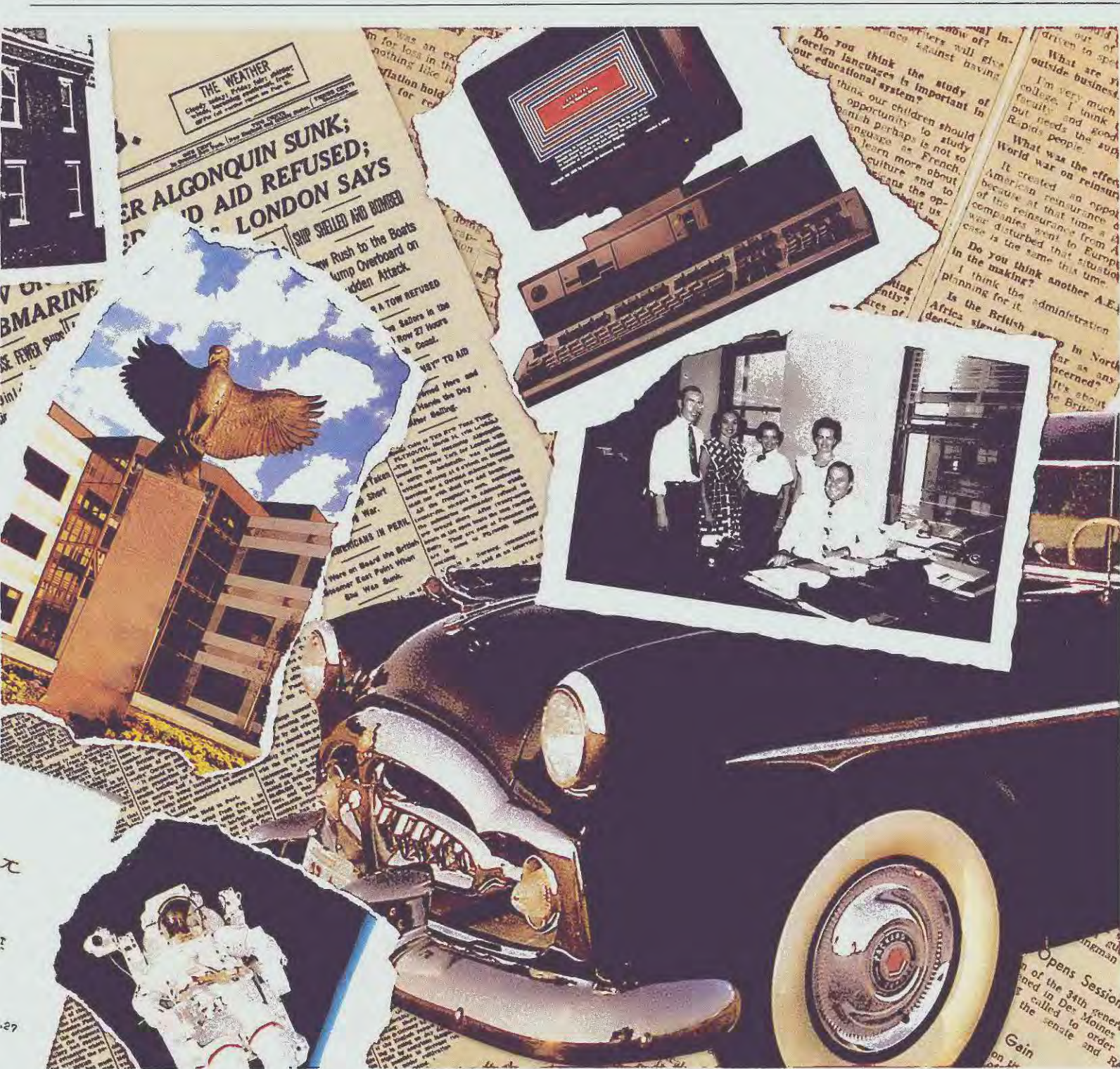
'It appears from the verdict that Diamond Shamrock was found to be wearing two hats at different points in time,' permitting it to be held liable for fraudulent concealment as an employer and for negligence as a property owner, explains Mr. George.

preponderance of evidence.

"I don't see anything new here," concurred Joe Miller, an attorney with Seyfarth, Shaw, Fairweather and Geraldson in Los Angeles. "In order to get past the exclusive rem-

dict does not break any new ground," concurred Andre Cronthall, a workers compensation attorney with Sheppard, Mullin, Richter & Hampton in Los Angeles.

Noting that "Diamond Shamrock



State comp fund may be liable for punitive damages

SAN BERNARDINO, Calif.—California employers that buy insurance from a state workers compensation fund may be able to seek punitive damages for improper claims handling if a state appellate court makes permanent a tentative opinion.

Even though the 4th District Court of Appeal heard oral arguments in the case just last week, it already has issued a tentative opinion that a policyholder can sue State Compensation Insurance Fund of California for punitive damages.

And while it is possible that the appellate court will contradict its tentative ruling when it issues a permanent opinion within the next 30 days, it is unlikely, said Nicholas Roxborough, the Los Angeles lawyer who represented the policyholder, Courtney Ambulance Service of San Bernardino, Calif.

An attorney for the state fund is far less certain. "We don't know whether the tentative decision will stick," said Andre Cronthall of Sheppard, Mullin, Richter & Hampton in Los Angeles.

Until the final decision is handed down, Mr. Cronthall said he would not comment on the likelihood of an appeal.

In its ruling, the appellate court found that the state fund lost its statutory immunity in 1979 when Insurance Code Section 11873 was enacted.

That statute states: "The fund shall not be subject to the provisions of the Government Code made applicable to state agencies generally or collectively, unless the section specifically names the fund as an agency to which the provision applies."

Furthermore, according to the ruling, the fund "is authorized to transact workers compensation insurance... to the same extent as any other insurer" in the state. The ruling continues, "Property belonging to SCIF is not considered 'state property' for the purposes of exemption from state taxes, and SCIF is generally subject to the payment of taxes on the same basis as any other insurer."

The fund, however, contends that it is a public entity that cannot be sued for punitive damages.

The case stems from a 1991 lawsuit in which Courtesy Ambulance accuses the fund of failing to return adequate dividends and establishing excessive claims reserves that artificially inflated its experience modification factor.

That lawsuit is awaiting trial, pending a final decision on the immunity issue.

—By Joanne Wojcik

Aon Risk Services acquiring Wexford

CHICAGO—Aon Corp.'s reinsurance and alternative insurance services subsidiary, Aon Risk Services Inc. of Chicago, has agreed in principle to acquire Wexford Underwriting Managers Inc.

San Francisco-based Wexford is a leading provider of excess workers compensation insurance for qualified self-insurers. Coverages developed by Wexford are marketed through a national network of agents and brokers on behalf of Transamerica Insurance Co.

Wexford also has offices in New York and West Palm Beach, Fla.

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Shedding a bad image

Financial reinsurance now a valued financial management tool

By Franklin W. Nutter

FINANCIAL REINSURANCE faces an undeserved image problem. Notwithstanding its alleged checkered past and some current regulatory desires for simplistic explanations of these complex transactions, the \$4 billion U.S. financial reinsurance market has developed a useful product that often is integral to corporate strategic planning and sound financial management.

In the not too distant past—the early 1980s—financial reinsurance was written customarily to cover past obligations of troubled insurance companies. There are reported instances where financial reinsurance contracts were written with little or no underwriting risk by undercapitalized reinsurers, particularly those not admitted or authorized in the United States. Regulators were rightfully concerned about the use of this product to bolster distressed companies or present an inaccurate financial picture.

These types of retrospective financial reinsurance transactions appear largely to have been driven from the market by the adoption in New York of Regulation 108, which restricted certain loss portfolio

arrangements. Now retrospective contracts are written for a variety of common purposes, including commutations, structured settlements, mergers and acquisitions, and for companies withdrawing from certain lines of insurance. All of these transactions traditionally involve appropriate regulatory attention.

Today's financial reinsurance markets offer many prospective financial and coverage uses, including:

- Filling gaps in available insurance capacity (e.g., catastrophe reinsurance).
- Moderating underwriting cycles and stabilizing underwriting experience.
- Protection against the future, such as major financial shocks (earthquake).
- Reducing exposure to future adverse loss development.
- Protection against uncollectible reinsurance.

Regulatory concern and interest is legitimate, of course. Where financial reinsurance might present an incorrect financial picture of an insurer or mask the true loss ratio or loss development pattern of the company—and certainly where it masks an insolvent or impaired financial condition—financial reinsurance deserves

regulatory scrutiny.

But today's financial reinsurance market is dramatically different from just a few years ago.

Much of the financial reinsurance now written is by the traditional admitted and authorized reinsurance marketplace—which is fully subject to regulatory review and analysis—and is placed with one of about 20 highly capitalized insurers, both admitted and non-admitted. In addition, the market has responded to the initiative of the Financial Accounting Standards Board, the American Institute of Certified Public Accountants and the National Assn. of Insurance Commissioners in their proposals or requirements for both underwriting and investment risk in the product.

Regulators and accountants should assess financial reinsurance transactions applying the following guiding principles:

- Take a holistic approach in reviewing financial reinsurance.

Financial reinsurance is designed and written in today's market to embrace both operating performance and the financial outcome of the transactions. Regulators and accountants should look at it the same way. Companies engaged in these transactions focus on the overall

economic effect; regulators and accountants should do the same.

- Regulators should be pleased—not apprehensive—to see the development and use of this product.

Financial reinsurance is now often designed to protect the capital base of an insurer over a period of years. Given this function, it should be encouraged.

- Traditional reinsurance and financial reinsurance are moving closer together.

Since many traditional reinsurance products incorporate financial considerations, and the initiatives by FASB and the NAIC encourage financial reinsurance to incorporate underwriting risk, the financial reinsurance contract, like its traditional reinsurance counterpart, is an integrated one. Regulators and accountants should not try to segregate the transaction.

- Financial reinsurance arrangements should be part of the long-term strategic plan for an insurer.

Regulators should assess the impact of financial reinsurance with this in mind.

- Two recent regulatory and accounting developments, if allowed

Continued on next page

ASK A RISK MANAGER

Overcoming the challenges of finger-pointing mentality

Q Amid the changes you have witnessed in the insurance industry, what has been the toughest issue you've faced, and how have you responded to it?

A Over the years, I have faced many interesting and difficult risk management issues. I have chosen to consider these issues "opportunities," because dealing with them in a positive light was far better than perceiving them as problems. However, some of the "opportunities" I've encountered in the last five years have provided more thrills and chills than I had bargained for.

Pondering an appropriate response to this question has caused me to reflect seriously on the current state of affairs in our industry. And from my vantage point, one of the toughest issues facing risk managers is an apparently predominant attitude in our society that can be summed up as "blame it on the other guy." Our patience and wallets have been drained with the onslaught of litigation which seems to drive the insurance system.

The unfortunate result of this finger-pointing mentality is that decision makers find their good judgment impeded by the overwhelming fear that they will be punished financially for the fault of others. The threat of litigation and the costs of

having to function within the bludgeoning legal system have strangled many an entrepreneur who is struggling to make a profit. I'd like to offer a few examples to illustrate this point.

Perhaps the most appropriate place to start is with the liability area, which includes premises, products and auto exposures. Although I have to reach far back in my memory, I do remember the days when we paid for only "reasonable" complaints. The injured party appeared to have a legitimate gripe, and we felt a moral obligation to compensate him or her for whatever damages resulted from the incident. And the damages were tangible. We paid for "real" medical bills, lost wages or destroyed property. There was little or none of the legal nonsense we now take for granted as a natural step toward settlement.

Today, it seems everyone claims mental anguish and severe emotional distress. How about my mental anguish and emotional distress from having to deal with the stuff? How many of us haven't faced the unsettling experience of informing our senior management that it's in our best interest to settle a claim—although liability was doubtful—because it was the most economical approach? Forget fairness when settlement hinges on the political flavor of the jurisdiction involved or, heaven forbid, the presiding judge's disposition. Let's keep the frivolous claims out of the courts and allow the judicial system to focus on preserving and administering the rights of real victims. Unfortunately, despite a great deal of bravado a few years back about tort reform, the deep pocket mentality is still alive and well.

The second part of the question asked how I have dealt with the issue. I believe in a two-pronged approach—education and control. It is critical for me to understand the dynamics of the liability area.

The continuing educational process centers on reading professional publications, attending seminars and networking with my peers to discuss how they tackle similar matters. And, of equal importance is the need to educate management about the sensitive and serious nature of liability issues. We can avoid liabilities or minimize their impact on our operations if we are conscientious and professional in our conduct. It is easier for management to buy into a "liability avoidance mind-set" when they are aware of the consequences.

The educational process expands into the control area as well. When dealing with outside claims administrators, legal counsel or any other outside party, it is necessary for you to communicate in direct, explicit terms how you want matters handled. I spend a significant portion of my time managing claims. The process includes coordinating activities with outside service providers, designing a claims-monitoring system and communicating the status of cases to the appropriate persons within our organization.

Another area which has been severely impacted by the "blame it on the other guy" attitude is workers compensation. Let me begin by stating that I honestly believe the majority of work-related claims are valid. However, we all know of people who have learned how to use the system to personal advantage. And, there are a good number of attorneys who feed off this system and have helped create the monster that exists today. Workers compensation provides an excellent illustration of how regulators have turned what was a relatively simplistic program into a complicated tangle of bureaucracy.

I do remember the time when an injured person had to describe an accident in order to receive

Continued on next page

Financial reinsurance

Continued from previous page
to work, would alleviate much of the current concern about financial reinsurance.

The NAIC's requirement of incorporating both underwriting and investment risk in financial reinsurance products has been acknowledged by the marketplace and should dispel concerns about products that were the subject of much of the early 1980s concern.

Secondly, the NAIC's requirement to gross up the balance sheet of insurance companies in order to assess the full impact of a company's total reinsurance program should provide a clear picture of the impact and value

of financial reinsurance (*BI*, March 30).

In time, the regulatory and accounting communities must address the inherent stress between statutory and Generally Accepted Accounting Practices accounting methods, particularly as they relate to financial reinsurance. Financial reinsurance is normally written on a multiyear basis treating a company as an ongoing concern. Statutory accounting sees a company as a liquidating balance, i.e., the company's bottom line net worth as of a given point in time, assuming the company was liquidated on that date.

The function of financial reinsurance may be somewhat incompatible with this philosophy of

statutory accounting, but this does not make it an inherently bad product. Instead, it should be recognized by regulators as part of a company's long-term financial picture.

Regulators and accountants should not push for a blanket or a uniform approach to all financial reinsurance. At most, regulators and accountants should approach financial reinsurance through disclosure requirements, particularly for material transactions. It should be recognized that contracts are always customized to the parties. And, in today's market they are generally between two healthy insurers, not the salvage operations of some years ago.

There are many legitimate purposes, prospectively and retrospectively, for

financial reinsurance. For many companies, it has become an integral part of their long-term strategic plan. Regulators should resist the temptation to react in the 1990s to the problem of this market in the early 1980s. Instead, they should recognize financial reinsurance as a creative new product that deserves regulatory oversight but should be allowed to work. ■



Franklin W. Nutter is president of the Reinsurance Assn. of America in Washington.

Finger-pointing mentality

Continued from previous page
compensation, and the accident had to be reported promptly by the injured employee. The present system resembles something on the order of a welfare program. It is now assumed that everyone should be compensated for just about everything.

Who is willing to stand up for the rights of employers? Over the past several months we hear of more and more states that are attempting to initiate workers compensation reforms. I caution you not to be carried away by the euphoria that reform is under way. The system did not go bad overnight, and it will take many months—and perhaps several years—to see positive results.

Our involvement in handling workers compensation issues mirrors what is done in the liability area. The ultimate objective is to prevent a claim from originating by following the safety guidelines contained in our accident prevention program. From an educational standpoint, we strive to inform all levels of management of the importance of prompt reporting of work-related injuries and illnesses.

Our next focus is to return the injured or ill

employee to work as quickly as possible. Our message centers on the fact that a work-related illness or injury affects everyone. Those employees who are out on disability must remain connected to the system and not forgotten until they have a return-to-work release.

Our controls include an aggressive claims management program that includes a wide spectrum of health management services. The goal is to control costs and avoid the cost of litigation whenever possible. We will fight questionable cases and have employed every practical means, such as surveillance, to deny suspect claims.

In many ways, the "blame it on the other guy" mentality has forced us to be more in tune with what we do and how we do it. As someone who has been around for a while, I've come to realize this is a never-ending challenge. But then, that's what the risk management process is all about. ■

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

answers.

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

This month's column on risk management issues is written by Susan M. Werner, director of risk management at Hardee's Food Systems Inc. in Rocky Mount, N.C. Dennis J. Nirtaut, manager of employee benefits at Continental Bank Corp. in Chicago, answers questions on employee benefit plans. William J. Miner, an actuary with The Wyatt Co. in Chicago, answers actuarial questions on benefits issues. And, Richard E. Sherman, president of Pacific Actuarial Resources (PAR) Excellence in Ashland, Ore., answers actuarial questions in the casualty field.



Ms. Werner

Ms. Werner's and Mr. Nirtaut's columns appear on the second Monday of alternate months. Mr. Miner's and Mr. Sherman's columns appear alternately on the first Monday of each month.

Ms. Werner's next column will appear in October. Address your questions to ASK, Business Insurance, 740 N. Rush St., Chicago, Ill. 60611.

Please give us your name, title and employer; however, Business Insurance will consider unsigned letters.

Avoiding the risks of unethical conduct

"What's Ethical in Business?"

By Verne E. Henderson
Published by McGraw-Hill Inc.,
11 West 19th St., New York, N.Y.
10011

\$12.95 (paperback)

By Kevin M. Quinley

"DO THE RIGHT THING" is a refrain heard not just in Spike Lee movies, but increasingly in the boardrooms of corporate America as well. Virtually all agree that businesses should "do the right thing," but exactly what constitutes ethical behavior in today's business world? How should risk and insurance managers—along with other business professionals—respond when they are confronted with ethical issues on the job?

What happens when companies like E.F. Hutton and Drexel Burnham are caught up in ethical controversies? What can risk managers learn from these experiences?

Answers to these and many more challenging questions are found in this probing, provocative new book, "What's Ethical in Business?" by Verne E. Henderson.

Mr. Henderson is the founder and president of Revehen Consultants in Brookline, Mass., specializing in areas like business ethics, consensus

Books & Ideas

development and conflict management. A consultant to many major corporations, he also teaches at the Arthur D. Little Management Education Institute in Cambridge, Mass.

In distinguishing tactics from strategy, some suggest that tactics deal with doing things right, while strategy should deal with doing the right things. Business ethics embraces the latter and might go one step further by adding, "And not doing the wrong things." Examining a wide range of work-related ethical dilemmas, Mr. Henderson presents an informative, non-preachy and highly readable look at some of the knottiest problems faced by business professionals today, including risk managers. As he zeroes in on conduct that ranges from the morally dubious to the legally actionable, Mr. Henderson shows how to determine what is—and is not—ethical business practice.

Since individuals and corporations alike must now conduct business in the harsh glare of public, media and even legal scrutiny, today's standards are strict. To meet this challenge, Mr. Henderson has devised what he calls an "ethical algorithm" for solving ethical problems. Using this algorithm

as an analytical framework, he identifies the variables in different ethical problems, cites concrete examples of companies and executives mired in ethical quicksand and suggests ways to implement action plans.

Interestingly, some of the most prominent business ethics case studies deal with classic risk management nightmares. The author cites the following companies that have been beleaguered by "shifts in the ethical wind": Manville Corp. for asbestos manufacturing, A.H. Robins Co. Inc. for its Dalkon Shield intrauterine device, Procter & Gamble Co. for its Rely tampon, Ford Motor Co. for the Pinto gas tank, and a number of others. Risk managers need not look far for some of these ethical dilemmas.

Without rushing to judgment on the breast implant controversy, it is one of the ironies of modern business ethics that Dow Corning Corp., a firm whose knowledge of implant hazards is alleged to have gone back many years, had a formal corporate ethics program. It raises the question of whether ethics can be taught, either by promoting it within the corporation or by reading books about it.

Mr. Henderson's work investigates many other important aspects of today's business ethics. It describes the most common ethical quandaries

faced by business professionals and tells how they can be resolved; reports on new ways to meet rising public expectations on various ethical issues ranging from sexual harassment to environmental responsibility; assesses the potential effect on business of the present trend in federal regulation continues; and analyzes ways for companies to reconcile ethical considerations.

In a broader sense, unethical conduct may be one "risk" that the well-managed organization will address, in the same systematic fashion that it manages any other insurable or uninsurable peril. For far-sighted firms and risk managers pioneering in this direction, "What's Ethical in Business?" is a sound compass to point them in the right direction. ■

Kevin M. Quinley is vp of risk services for MEDMARC Insurance Co. Inc. and subsidiary Hamilton

Resources Corp., both of Fairfax, Va. Mr. Quinley holds the Chartered Property & Casualty Underwriter and Associate in Risk Management designations.



Broker results

Continued from page 3

same kind of year it was last year. We've got to be very, very, very conscious of all the expenses."

And at Alexander & Alexander Services Inc. in New York, operating expenses rose just 2% in the second quarter—to \$314.2 million—after adjusting for the effect of foreign exchange rates and the expenses of two sold operations.

That is "pretty doggone good, at least by our estimation," said Frank Wiczynski, corporate secretary.

This occurs against a backdrop of continuing price decreases, which brokers anticipate will continue, at least in North America.

"Insanity still prevails and is starting to reign supreme," said Donald Bell, chairman and chief executive officer of Briarcliff, N.Y.-based Frank B. Hall & Co. Inc., which is to be acquired by Aon Corp. (BI, Aug. 3; July 27).

"I think the industry at this point is playing Russian roulette with all of the chambers loaded. It's only a question of time before the trigger's pulled."

New York-based Marsh & McLennan Cos Inc. expects "the same competitive environment that we've seen year-to-date" to continue for the rest of the year, said J. Michael Bischoff, vp of corporate development.

"I don't think there's anybody within this company that's looking at any kind of a turn within the next five months," said A&A's Mr. Wiczynski. "We've got to live and improve our margins in this kind of environment," he added.

"We're not predicting a turn in the short term, short term being the next 18 months," said Michael J. Cloherty, vp-finance for Arthur J. Gallagher & Co. in Itasca, Ill. "Beyond that, nobody knows."

However, HRH's Mr. Hilb said he is a "little more optimistic" than he was a year ago that market conditions are stabilizing. For "giant accounts," the "soft market is still raging," he said, but for the smaller accounts and markets HRH targets, the situation may be different.

At the same time, the recession continues to hurt brokers' results, both because the purchase of insurance is frequently tied to sales and payrolls, and because interest rates are low.

"I think there's still less insurance being bought because of the pace of the economy," said Patrick G. Ryan, chairman and CEO of Aon, the Chicago-based parent of Rollins Burdick Hunter Group Inc.

In addition, low interest rates have particularly affected short-term securities, "and that's where the brokers have all their investments," said Mr. Smith.

At M&M, for instance, the actual yield on average is down 30% on a year-over-year basis, said Mr. Bischoff.

It is difficult to distinguish between the impact of the economy and that of the soft market, commented A&A's Mr. Wiczynski. He noted, however, that the recession's impact is particularly apparent in consulting, an area where clients can more readily put off expenditures.

Two to three years ago, A&A's consulting revenue growth was in the double digits. Through the first six months of the year, he said, growth was down to about 6%, "which is not bad, but certainly not what we've had in the past."

Meanwhile, observers expect no dramatic changes in broker results for the rest of the year.

Lehman Bros.' Mr. Smith said he does not anticipate much "real progress" in domestic results until next year. International business, though, has improved somewhat, helping A&A, M&M and other brokers with significant operations abroad.

"Until U.S. underwriters decide they've had enough of the price competition themselves, it's going to be very tough for the brokers," said Mr. Smith.

Despite their diversification efforts, brokers are ultimately dependent on the cycle, he said. "So long as they're participating in the property/casualty markets, their revenues will be tied into the dollars that run through their hands."

Individual first-half results for the publicly held brokers follow:

Marsh & McLennan

Total revenues rose 4.7% to \$1.5 billion from \$1.43 billion, while net income increased 2.7% to \$182 million from \$177.3 million.

Insurance services reported a 2.5% increase, to \$853.4 million from \$832.6 million, while consulting revenue grew just 0.3% to \$458.5 million from \$457.1 million.

Expenses, however, increased

5.2% to \$1.18 billion from \$1.12 billion, while interest income dropped 35.9% to \$8.2 million from \$12.8 million.

"I think a major issue that continues to affect us is the continuation in decline in prices," said Mr. Bischoff. To offset the impact of lower prices and declining interest rates, M&M is continuing its cost containment efforts, he said. New business has helped offset the decline in premiums as well, he said.

Also helping is The Putnam Cos., M&M's Boston-based investment management subsidiary, which had a very strong first half. Investment management revenues rose 31.3% to \$189.9 million from \$144.6 million. Putnam's assets under management rose to \$57 billion from \$52 billion at year-end 1991. Even if the economy does not grow to any extent, "hopefully we'll still have a very strong operating environment for Putnam," Mr. Bischoff said.

Consulting operations earnings have also grown, said Mr. Bischoff, "but basically because of cost containment."

Alexander & Alexander

First-half revenues declined by 1.2% to \$668.3 million from \$676.4 million, but net income jumped 144.8% to \$37.7 million from \$15.4 million.

A&A's higher income reflects gains from two operations sold in the first quarter.

"The major factors that contributed to the higher-than-expected results in the quarter mainly are our expense control program and the fact we are seeing some favorable impact from our restructuring program," said Mr. Wiczynski (BI, June 29). He also noted that year-to-year comparisons are difficult because of the sale of the operations.

A&A will report relatively modest revenue gains for the rest of the year, predicted Mr. Wiczynski, who noted that despite A&A's reinsurance brokerage, wholesale and consulting operations, retail brokerage still accounts for 64% of A&A's operating revenues.

Rollins Burdick Hunter

RBH results are again boosted by its 1991 acquisition of Hudig-Langeveldt Group by.

Total revenues increased 68.2% for the first half, to \$338.7 million from \$201.4 million. This is largely due to a more than eight-

fold increase in international brokerage revenues to \$45.6 million from \$5 million.

Revenue increases were also reported for its association and program business; reinsurance intermediary and related services; and benefit and other consulting services.

Revenues for its domestic retail brokerage operation, though, increased just 4.7%, to \$57.7 million from \$55.1 million.

Meanwhile, pretax income for RBH's insurance brokerage and consulting services business nearly doubled to \$48.7 million from \$24.9 million.

Pointing to RBH's revenue and income growth, Mr. Ryan said, "Our strategy is clearly working."

"I'm pleased the results are consistent with the plan and the strategic direction we've been taking," he said.

"We've had, I think, some very strong disciplines in our expense controls all year," Mr. Ryan pointed out. "I think everybody is recognizing the competitive price environment and has put significant pressure on cost controls."

Frank B. Hall

First-half revenues grew a modest 2%—to \$241.5 million from \$236.6 million—but net income soared 172.2% to \$8.2 million from \$3 million.

Hall's revenue increase reflects a 3.2% increase in net commissions and fees to \$229.6 million from \$222.4 million, and a 16.5% decline in other income, principally investment income, to \$11.9 million from \$14.2 million.

Operating and other expenses decreased 0.5% to \$230.6 million from \$231.8 million.

"Considering the market and the economy, we are certainly not unhappy with the increase that we had in net commissions and fees," commented Mr. Bell. "I think that our folks did a pretty good job."

The net income gain reflects cost constraints introduced during the latter part of 1991, said Mr. Bell, noting there is always a lag time before these are reflected in the bottom line. "We're starting to see results."

For example, he said, travel and entertainment expenses are down by close to 11% for the quarter. "That means the things really being managed," he said, noting entertainment is discretionary, unlike other expenses like rent where costs are much

more difficult to reduce.

Mr. Bell said Hall should do better after it is acquired by Aon with the elimination of both interest expense, as a result of its loans being paid off as part of the acquisition, and of its preferred dividends to Reliance Group Holdings Inc. "Then our profit changes dramatically," he said.

Arthur J. Gallagher

First-half revenues and net income essentially kept pace, with total revenues increasing 8% to \$118.7 million from \$109.9 million, and net income increasing 8.7%, to \$6.5 million from \$6 million.

Contributing to Gallagher's revenues are a 2.4% increase in commissions to \$64.7 million from \$63.2 million; an 18.2% jump in fees to \$46.9 million from \$39.7 million; and a 1.1% rise in investment and other income to \$7.1 million from \$7 million.

"We are entirely pleased with our results for the first half of the year," said Mr. Cloherty. Gallagher's fee-based risk management services sector, he noted, has grown "substantially and quickly," while the company is very pleased it has been able to hold onto the commission side of the business despite the soft market and recession.

"We're working very hard to continue our profit margins and our overall effectiveness," he said.

Hilb, Rogal & Hamilton

First-half net income rose 37.9% to \$4.9 million from \$3.5 million, despite a 1.1% decline in revenues to \$64.7 million from \$65.4 million.

"It's still a very difficult marketplace, but we're satisfied our company did a very good job in the second quarter," said Mr. Hilb. "Our expense controls are in very good shape, and we're struggling with market conditions."

Poe & Associates

First-half gross revenues for the Tampa, Fla.-based brokerage rose 4.3% to \$24.5 million, but net income dropped 27.5%, to \$1.6 million from \$2.2 million.

William F. Poe, the brokerage's chairman and CEO, said in a statement that "although the first-half results are unsatisfactory to me, I continue to be optimistic about the overall 1992 earnings."

For the Record

County denied cover for pollution cleanup

PHILADELPHIA—New Castle County, Del., cannot tap its comprehensive general liability coverage to clean up chemicals that leaked from two county-operated landfills and contaminated local drinking water.

The 3rd U.S. Circuit Court of Appeals in Philadelphia ruled on July 28 that the pollution exclusion, which bars coverage for all pollution that is not "sudden and accidental," bars coverage to the county.

In April 1991, the appellate court interpreted the pollution exclusion to bar coverage whenever a policyholder expects the pollution (BI, May 6, 1991).

The court then remanded the case to the trial court for a determination of facts.

In the recent appeal, the court rejected the county's argument that it knew it was discharging waste, but

it did not know that the waste was a "contaminant" as defined by its policy. It is enough that New Castle County knew it was discharging waste, the court ruled.

The ruling relieves Continental Casualty Co. of Chicago from paying an estimated \$8 million in cleanup costs. The insurer wrote primary CGL coverage for the county from 1973 to 1975. The county settled with all of its insurers except Continental before the ruling.

The July 28 decision marked the seventh and final ruling in a protracted legal battle between New Castle County and Continental.

As the court said: "The well of issues in this case, as deep as it may have been, has finally run dry."

Louisiana insurer under liquidation

BATON ROUGE, La.—A Louisiana insurer of high-risk automo-

bile coverages is being liquidated.

American Surety & Fidelity Insurance Co. of Kenner, La., was placed into liquidation July 7.

The Louisiana Department of Insurance said the insurer had 3,643 claims pending that totaled between \$10 million and \$11 million when a rehabilitation order was signed in June. The insurer had 16,142 policyholders and \$15 million of premiums in force.

Bill would require list of underfunded plans

WASHINGTON—Legislation passed by the House of Representatives last week would require the Pension Benefit Guaranty Corp. to list companies with more than \$25 million in unfunded pension liabilities.

Reports including that list would be due to Congress each Jan. 31.

Under H.R. 3837, the agency would also have to list all companies that have more than \$5

million in unfunded pension liabilities and have received permission from the Internal Revenue Service to temporarily waive a required minimum plan contribution of at least \$1 million.

Agency's fine tops Louisiana's records

BATON ROUGE, La.—A \$215,000 fine collected from a Michigan insurance agency is the largest amount ever for violating the Louisiana insurance code.

Insurance Commissioner Jim Brown fined G-M Underwriters Inc. of Rochester, Mich., after charging the agency with improperly collecting premiums and paying claims on student health and accident policies offered at two Louisiana universities.

Louisiana regulators said G-M Underwriters initially acted as an agent for Philadelphia-based Colonial Penn Insurance Co., which wrote the coverage until Jan. 1, 1988.

G-M Underwriters continued to collect premiums and pay claims through the 1990 school year, regulators said, even though no insurance company was underwriting the policies.

Agency officials would not comment on the fine or the charges.

Provident Life & Accident seeks NYSE stock listing

CHATTANOOGA, Tenn.—Provident Life and Accident Insurance Co. of America has applied to list its two common stock classes on the New York Stock Exchange. The shares are expected to begin trading by late August or early September, a company spokesman said. Provident Life stock currently trades on the NASDAQ National Market System.

The Chattanooga, Tenn.-based insurance company currently has an aggregate of 45.1 million common shares outstanding, \$14.9 billion in assets and \$1.4 billion in stockholders' equity.

Continued on next page

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June 29, 1992

For the Record

EBRI sees obstacles to state health reform

WASHINGTON—State health care reform efforts face many obstacles, says the Employee Benefit Research Institute.

One such obstacle, EBRI says in a new report, is the Employee Retirement Income Security Act of 1974, which limits states' ability to implement reform by denying them authority to regulate self-insured companies.

In order for most state reform proposals to be effective, Congress would have to waive ERISA preemption, the report said.

Employers themselves are another obstacle, says EBRI. They may just leave a state rather than pay higher taxes or higher labor and insurance costs as part of a reform plan.

And, individual states may not have a sufficient tax base to implement and sustain comprehensive reforms, the report said.

Copies of "State Initiatives in Health Care Reform" are \$25 each from EBRI Publications, P.O. Box 4866, Hampden Station, Baltimore, Md. 21211; 410-516-6946.

Ammonia plant blast likely to be insured

LAKE CHARLES, La.—Arcadian Corp. as of last week still could not yet determine the extent of property damage from an explosion at its ammonia refinery here late last month, but says it anticipates it will be covered.

"We have major catastrophe cov-

erage for each facility. It is our understanding that our insurance will cover this type of accident," said Gwayne Ton, director of investor relations and financial services at the Memphis-based fertilizer firm.

Seven people were injured, one seriously, in the explosion at the refinery that makes ammonia and urea for use in fertilizer. The urea plant "will be down for some time," said manager Paul Moore. The ammonia plant was shut down only as a precautionary measure.

The explosion damaged nearby buildings, and broke and rattled windows for 10 miles, according to news reports. The factory did not catch fire, but dangerous fumes forced the shutdown of nearby Interstate 10.

Occupational Safety & Health Administration officials last week were investigating the blast, preventing the company from sizing up damage.

Triton sues insurers for not settling suit

DALLAS—Triton Energy Corp. of Dallas is suing dozens of insurers to recover \$9.5 million it paid as part of a settlement of a wrongful termination suit by a former Triton executive.

The company's insurers also are paying part of the settlement, though it is not known whether the total approaches the \$124 million that a Texas state court jury awarded in 1991.

The settlement amount "kept faith with the jury verdict," said attorney Julius Glickman of Glick-

man & Barnett in Houston, who represented the executive. "It's a substantial settlement."

Triton is suing in state court in Houston, alleging that the insurers could have settled the dispute for \$5 million before the 1991 verdict. Among the insurers: Chubb Corp.'s Federal Insurance Co. unit, Aetna Casualty & Surety Co. and underwriters at Lloyd's of London.

State rebuffs attempts to settle, railroad says

SACRAMENTO, Calif.—Southern Pacific Transportation Co., the railroad being sued by the state of California over a year-old toxic spill in the upper Sacramento River, claims that the state has rebuffed its attempts to settle the case.

California Attorney General Dan Lundgren has "rebuffed SP time after time in our attempts to participate in solutions or to frame programs to mitigate the impact of the spill," Cannon Y. Harvey, Southern Pacific vp and general counsel, said in response to the state's suit.

Mr. Lundgren filed suit last month in U.S. District Court in Sacramento against Southern Pacific Transportation Co. and others to cover costs related to a toxic herbicide spill in the Sacramento River after a 1991 train derailment (BI, July 29, 1991).

In the year since the spill, Southern Pacific has paid a total of \$12 million, including \$2.8 million to the state, to assist in the recovery of the area, Mr. Harvey said.

The railroad may have at least \$200 million in insurance to pay liability claims, excess of a \$10 million self-insured retention. ■

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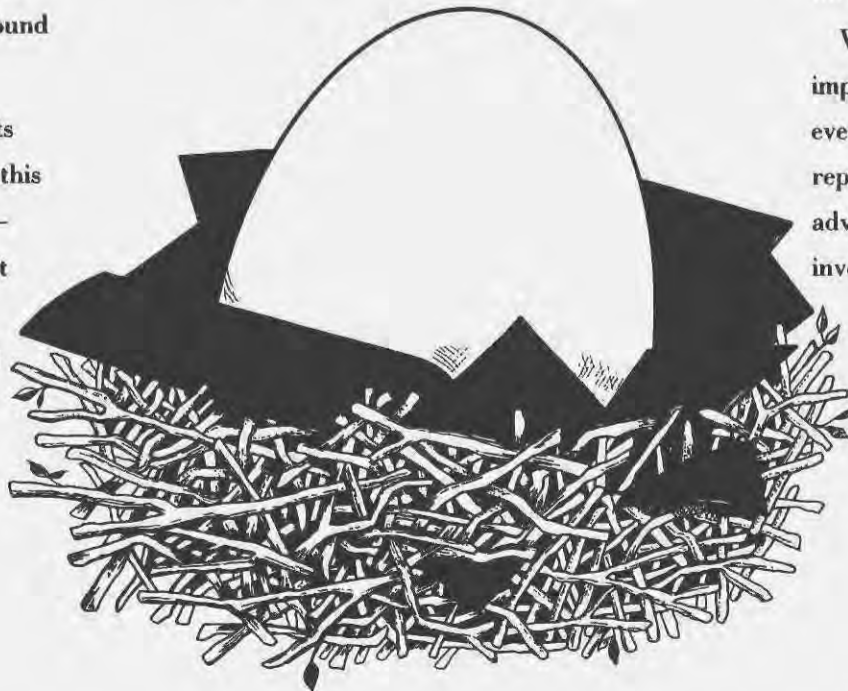
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INTERNATIONAL

Court places Walbrook in liquidation

By STACY SHAPIRO

LONDON—U.S. policyholder creditors of the largest U.K. insurer ever to fail may see some money sooner than expected now that joint provisional liquidators have been appointed for Walbrook Insurance Co. Ltd.

But even if payments are expedited, they likely will take years rather than months. Ultimately, the wait will depend on what provisional liquidators find when they obtain the records of Walbrook and four sister companies.

Walbrook was placed in the hands of joint provisional liquidators last week by Justice Harman in the High Court following several attempts to

keep the company technically solvent (*BI*, Aug. 3; July 27; June 8).

Until it stopped underwriting in March 1990, Walbrook for 20 years was the leading insurer on a U.S. casualty line slip managed by sister company H.S. Weavers (Underwriting) Agencies Ltd. (*BI*, April 2, 1990).

Walbrook and Weavers are units of London United Investments P.L.C., which is in administration. Weavers also is in a "perilous financial condition," according to Justice Harman.

It is estimated that gross liabilities of the Weavers' line slip total \$8 billion, with Walbrook and four LUI subsidiaries known as the "KELM" companies accounting for

\$4 billion to \$5 billion.

The KELM companies are Kingcroft Insurance Co. Ltd., El Paso Insurance Co. Ltd., Lime Street Insurance Co. Ltd. and Mutual Reinsurance Co. Ltd.

Although Walbrook ceased underwriting in March 1990, it continued to pay claims, remaining technically solvent until May 29 of this year when the directors placed a moratorium on payment of claims.

Walbrook's gross liabilities as of Dec. 31, 1991, totaled \$2.4 billion, while its assets totaled \$1.7 billion. Justice Harman said last week that Walbrook was now insolvent by 121 million pounds (\$226.3 million at appropriate exchange rate), though the 1991 year-end shareholder fund

deficit is 169.7 million pounds (\$317.3 million).

Two of the joint provisional liquidators of Walbrook also are serving as provisional liquidators for the "KELM" companies. They are Chris Hughes and Ian Bond, partners in Cork Gully, the insolvency practice of Coopers & Lybrand. The Walbrook directors approved this appointment in court last week.

Also appointed after a challenge in court last week by Walbrook directors is Gareth Hughes, a partner with Ernst & Young.

The Walbrook directors felt that Mr. Hughes would have a conflict of interest because Ernst & Whinney—now part of Ernst & Young—gave advice to Weavers in No-

vember 1986 that could be detrimental to Walbrook.

Justice Harman, though, said Walbrook would have no future case against Ernst & Whinney. In addition, Mr. Hughes was not a partner in the firm in 1986 and therefore wouldn't be personally liable, the judge said. He therefore approved Mr. Hughes' appointment as a provisional liquidator.

Now that provisional liquidators have been appointed, schemes of arrangements for Walbrook and the KELM companies are likely to be drafted, whereby creditors are offered a schedule of dividend payments to cover their claims without liquidating the companies.

Continued on next page

EXEL Ltd. proposes \$100 million investment in property reinsurer

By ROGER SCOTTON

HAMILTON, Bermuda—EXEL Ltd. wants to invest up to \$100 million in a property catastrophe reinsurer now being organized in Bermuda by Marsh & McLennan Cos. Inc. and J.P. Morgan & Co. Inc.

EXEL, the Cayman-based parent of Bermuda excess liability insurer X.L. Insurance Co., has called an extraordinary general meeting of shareholders to vote on the investment proposal.

And, in a notice announcing the Aug. 31 meeting, EXEL's president and chief operating officer, Michael J. Kevany, revealed that EXEL Chairman Ian Heap is expected to become chief executive of the new Bermuda-domiciled reinsurer, Mid Ocean Reinsurance Co. Ltd.

Marsh & McLennan and J.P. Morgan are seeking to raise at least \$300 million in capital for Mid Ocean with the sale of 3.1 million shares in the company at \$100 per share (*BI*, June 22). The minimum subscription is \$10 million.

Mid Ocean will specialize initially in worldwide property catastrophe reinsurance. According to the EXEL notice dated July 27, Mid Ocean also intends to engage in quota-share reinsurance of selected Lloyd's syndicates and may take advantage of other reinsurance opportunities as they develop.

Mid Ocean is expected to write excess-of-loss catastrophe limits of up to \$30 million per occurrence per reinsured, subject to an overall \$250 million limit in geographic zones to be defined by the company.

If EXEL stockholders accept the board's recommendation and approve the investment, the excess liability insurance group will own up to 32.3% of Mid Ocean's common stock.

This stake "would permit the company (EXEL) to include Mid Ocean's results of operations in the company's financial statements on the equity accounting method," said a notice to EXEL shareholders.

It explains: "Because the investment, small as it is in relation to the company's (EXEL's) total assets, is in an entity which will write property reinsurance (which is a class of insurance not currently being written by X.L.), the directors have decided to condition their approval of the investment in Mid Ocean on approval by the company's (EXEL's) shareholders."

The notice said the \$100 million investment would represent "no more than 3.7% of (EXEL's) total assets and 6.8% of its net worth, based on the May 31, 1992, balance sheet of the company."

Continued on page 24

Aviation losses mount

5 recent disasters to put pressure on aviation rates

By GAVIN SOUTER

LONDON—Five air crashes in five weeks may have put aviation underwriters on course for an overall underwriting loss for 1992.

But the combined loss of the five aircraft, which could total more than \$100 million, still might not be enough to push rates up significantly.

Three of the accidents occurred in Asia, one was in South America and the fifth occurred in New York where a Trans World Airlines Lockheed L-1011 insured for \$16 million caught fire at Kennedy International Airport (*BI*, Aug. 3).

The largest hull loss of the five resulted from a Thai Airways International Airbus 300 series which crashed into a mountainside in Nepal July 31.

The aircraft was en route from Bangkok to Katmandu in central Nepal when it crashed 40 miles away from Katmandu airport, according to the Lloyd's of London aviation department.

None of the 99 passengers and 14 crew is expected to be found alive, Lloyd's said.

The aircraft is insured for \$66 million. Brokers are setting a provisional liability reserve of between \$20 and \$25 million, sources say.

The coverage is directly placed in Thailand with Dhipaya Insurance and Devez Insurance. Most of the

risk is reinsured in international markets.

The reinsurance was placed jointly by C.T. Bowring & Co. Ltd. and Nicholson Chamberlain & Colls Ltd. The risk is led by Orion Insurance Co. P.L.C.

Also on July 31, a Civil Aviation Administration of China Yakovlev 42 aircraft crashed on takeoff at Nanjing's airport, according to Lloyd's.

The aircraft was carrying 116 passengers and 10 crew on an internal flight to Xiamen. There were 20 survivors.

The hull and liability coverage was placed directly with People's Insurance Co. of China. The hull coverage was not reinsured, but the liability risk was reinsured into international markets where it is placed by Willis Corroon P.L.C., Lloyd's said.

However, since nearly all of the passengers were Chinese, the liability loss is not expected to be substantial because modest settlements are traditional in China.

On July 25 an Indonesian airliner crashed in Indonesia. The Mandala Airlines PT BAe Vickers Viscount 816 was carrying 70 people and was making its final approach into Ujang Pandang Airport in the Ambon Islands when it crashed into a mountainside. The cause of the crash is unknown.

Insurance for the passenger aircraft was placed in the London market by Jardine Insurance Brokers International Ltd., Lloyd's said.

Jardine would not comment on the loss. Other sources say the aircraft was a total loss and the hull

was insured for \$400,000.

The 63 passengers and seven crew were all Indonesian. Only a small liability claim is expected from the deaths, sources say.

A substantial partial loss is expected to hit the aviation market after a Boeing 767 owned by Condor Flugdienst GmbH, a unit of German airline Lufthansa, was damaged on takeoff June 24 from Margarita Island off the coast of Venezuela, Lloyd's confirmed.

On takeoff, a portion of the craft's left wing was knocked off after it struck a television antenna. The aircraft then jettisoned its fuel, returned to the airport and made a safe landing.

Lufthansa owns a captive insurance company, Delwag, whose reinsurance is placed by Willis Corroon P.L.C.

Willis Corroon says the scale of the damage is unknown, and it is awaiting the loss adjuster's report.

Other sources differ on estimates for the damage. The damage could be more than \$10 million, said one source. However, if the damage was limited to the wing, it will probably only cost between \$3 million and \$4 million, another source said.

The sum of the losses that have hit the aviation market over the past five weeks will put significant pressure on underwriting results for 1992.

"Losses for the half-year at the end of June were standing at the \$325 million to \$350 million mark against an annual premium income of around \$700 million to \$750 million, so things weren't looking too

Continued on page 25

Launch coverage not purchased by owner of wayward satellite

By GAVIN SOUTER

PARIS—The European Space Agency satellite Eureka—which was the subject of rescue efforts late last week after initially failing to reach orbit—was launched without insurance despite two years of negotiations between the ESA and brokers.

Eureka was launched Aug. 1 from the space shuttle Atlantis, which blasted off successfully the previous day. But space agency's only insurance covering the mission was the obligatory third-party liability and crew coverage required of all users

of the space shuttle.

"Eureka's orbital transfer maneuver commenced as planned... but had to be terminated after six minutes owing to indications of a deviation from the planned flight direction of the spacecraft," an ESA statement said.

Eureka was left orbiting at 442 kilometers, which is 65 kilometers (about 40.3 miles) below its target orbit altitude of 507 kilometers (314.3 miles).

Eureka is the first retrievable European space probe. It is due to remain in orbit for more than six

months. The 15 scientific experiments it is scheduled to perform will concern microgravity, life sciences, materials synthesis and fluid dynamics, ESA said.

ESA last week was seeking ways to increase Eureka's altitude. As of Thursday, the agency has succeeded in placing the satellite in an elliptical orbit that was 502 kilometers at its furthest point. At press time, the ESA was still trying to boost the satellite into a circular orbit at that altitude.

If the efforts are unsuccessful, the

Continued on page 25



Walbrook

Continued from previous page

Various factors will determine when those schemes will be proposed and implemented, according to the provisional liquidators.

Cork Gully has been working on schemes of arrangement for the KELM companies since Messrs. Hughes and Bond were appointed. The KELM companies have not paid claims since Walbrook stopped underwriting in 1990.

"As far as KELM is concerned, we have had problems getting access to all the records," Mr. Bond said last week. Now that he and the others have been appointed provisional liquidators for Walbrook, "which owns the company that maintains the records, we will be in control. So we should have no problem getting access to the records. What we don't know is if the records are 100% up to date; indications are that a lot of them aren't.

"Once we know how up to date they are, we can move ahead and say, 'Well, we'll (work on) a scheme.' We have all the structure for a scheme, but we haven't got the figures," said Mr. Bond. The

schemes of arrangement will not be presented to creditors until the provisional liquidators of KELM and Walbrook are sure about the dividend that can be paid, he added.

The role of the Policyholders Protection Board also must be considered, Mr. Bond said. A recent ruling in the Court of Appeal in England and Wales indicates that the board would be responsible for paying 90% of many of the North American professional liability claims incurred by Walbrook and the KELM companies if the companies were placed in liquidation.

That ruling will not sit well with British insurers, who fund the PPB through levies. Members of the Assn. of British Insurers may appeal the Court of Appeal ruling to the House of Lords.

"If there is an appeal, then these schemes can't actually go through until that appeal is known," said Mr. Bond. If the ABI members are allowed to appeal to the House of Lords, "it would be foolish to go ahead with the schemes" until after the court decides.

If the insurers are not liquidated, the PPB would pay the claims as if it were a liquidation, but would

then be reimbursed from the insolvent companies through a scheme of arrangement, saving time and money.

If the Court of Appeal ruling is upheld, the PPB will become the major source of claims payments to Walbrook and KELM creditors, and as a result, "the largest creditor of all" to the insolvent companies, said Mr. Bond.

In the meantime, he said, "The next move is to assess Walbrook's financial position, (to determine) what the total liabilities might be and then, on assumption the provisional liquidators are satisfied with the figures we have, to suggest to the creditors a scheme which will give them some money as quickly as possible."

An informal Walbrook creditors' committee, made up of many of the same names as are on the KELM committee, consists of Transit Casualty Co.; Crum & Forster Inc.; FOJP Service Corp., which administers the insurance and risk management for the Federation of Jewish Philanthropists; GAF Corp.; ITT Hartford Group Inc.; Minet Group P.L.C.; and Schering-Plough Corp.

At least one of Walbrook's major creditors is optimistic that the joint provisional liquidators will be able to propose a timetable for some dividends to be paid as early as next year.

"By the end of the year, hopefully there will be a draft of a scheme," said Jonathan Bank, a lawyer for Transit. "But I don't think it will be up (and running) until the middle of next year."

This is probably the most complex liquidation the United Kingdom has seen and is at least as complex as some U.S. liquidations, said Mr. Bank, who is a partner with Buchalter, Nemer, Fields & Younger in Los Angeles.

"We're quite pleased" with the appointment of the joint provisional liquidators, said Burleigh Arnold, the court-appointed special deputy receiver of Transit, who was in court last week.

"It's a fair thing for all the creditors. We think it will save time and money, and we have confidence in Cork Gully and Ernst & Young. We believe they will do a fair job, whether it ought to be a scheme or go into liquidation or whatever," said Mr. Arnold.

Interested parties pack Walbrook court hearing

LONDON—Accountants, lawyers and major policyholders packed the courtroom last week to hear High Court Justice Harman announce the official insolvency of Walbrook Insurance Co. Ltd., the largest player in the U.S. casualty line slip underwritten for 20 years by H.S. Weavers (Underwriting) Agencies Ltd.

One policyholder that turned out in strength was Transit Casualty Co., which had petitioned the High Court to appoint provisional liquidators for Walbrook.

The Transit delegation included: Burleigh Arnold, the court-appointed special deputy receiver of Transit; Jonathan Bank, a lawyer for Transit who is a partner at Buchalter, Nemer, Fields & Younger in Los Angeles; and Thomas McCarthy, Transit's general counsel in Missouri.

"We wanted to make ourselves available in case there was anything needed," said Mr. Arnold. The lawyers also thought it would be advisable to be in court "since Walbrook is the largest insurer ever to go into this position in England," he said.

Also present was another lawyer, Maria Luisa Galozzi, a partner in Covington & Burling in Washington, representing a dozen policyholder creditors of Walbrook. These policyholders, members of the International Policyholders Assn., include GAF Corp., G.D. Searle & Co., National Gypsum Co. and Pfizer Inc.

Two accounting firms that will work with the joint provisional liquidators were represented. Christopher Hughes and Ian Bond, partners of Cork Gully, were both in court, as was Gareth Hughes, partner of Ernst & Young.

Also in court was William Goodier, a Walbrook director who was appointed after Weavers chairman Roger Borley resigned as a Walbrook director earlier this year (BI, Jan. 13). Sir Ian Morrow, the newly appointed Walbrook chairman, was not seen in court.

Walbrook has been in existence since its sister company H.S. Weavers (Underwriting) Agencies Ltd. was formed in 1962. When it ceased underwriting in March 1990, Walbrook was writing more than 50% of one of the largest U.S. casualty underwriting facilities in London (BI, April 2, 1990).

Justice Harman last week said when Walbrook ceased underwriting in 1990 it had 50 million pounds (\$96.5 million at appropriate exchange rate) in capital. Accounts show that at the end of 1991, Walbrook had assets totalling \$1.7 billion and outstanding gross liabilities of at least \$2.4 billion.

"Sadly, Walbrook is now insolvent," Justice Harman declared last week.

Transit Casualty in June filed the petition to appoint provisional liquidators for Walbrook. Transit is owed \$210,000 and also has outstanding claims of \$80 million against Walbrook.

But hearings on the petition were put off until last week, giving Walbrook directors time to propose a rescue plan to creditor policyholders.

The directors pitched the plan to creditors last month at meetings in Chicago and London.

Walbrook needed major policyholders accounting for \$860 million of claims to approve the plan by July 24, but only received approval from those amounting to \$500 million in claims, the court heard.

But the Walbrook directors failed to garner adequate support among the insurer's major creditors and therefore concluded that "they couldn't oppose" the appointment of provisional liquidators, said Justice Harman.

—By Stacy Shapiro

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CAPITAL RE

EXEL investment

Continued from previous page

It observed that Mid Ocean shareholders will be entitled to share in any net profits of Mid

Ocean paid as a dividend. "However," the notice continues, "during the early years of operations, it is expected that Mid Ocean will retain virtually all profit to provide capacity and to accumulate reserves and surplus for the payment of claims. To the extent, if any, that Mid Ocean is unable to keep its capital employed in a manner deemed suitable by Mid Ocean, it is anticipated that Mid Ocean will declare dividends to its shareholders."

The adoption of the proposed investment at the Aug. 31 meeting "will be by a majority of the votes cast at the meeting by the holders of shares represented in person or by proxy... provided there is a quorum" consisting of holders of at least 50% of EXEL's outstanding 50.1 million ordinary shares.

According to the notice, Marsh & McLennan and J.P. Morgan are each intending to purchase 10% of Mid Ocean's stock. They are also expected to be granted options to purchase respective shareholdings of 7.2% and 4.8% in Mid Ocean.

Each corporation owns stock and options in EXEL which, if exercised, would equal approxi-

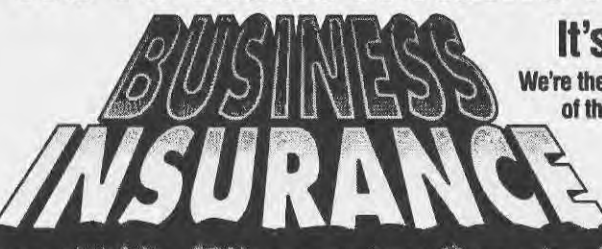
mately 5% of the excess liability insurer's outstanding shares as of June 30.

The notice states: "It is currently anticipated that two current officers of Marsh & McLennan (including Robert Clements, a director of EXEL and president of Marsh & McLennan) and a current officer of J.P. Morgan (Robert Mendoza, a director of EXEL and vice-chairman of J.P. Morgan) will serve on the board of directors of Mid Ocean and that one former officer of Marsh & McLennan will serve as chairman of the board of directors of Mid Ocean."

The notice said it is "anticipated" that EXEL's chairman, Ian Heap, will become chief executive officer of the proposed new reinsurer "if the necessary stock subscriptions for Mid Ocean to commence operations are received."

It adds that Mr. Heap "has announced that in such event, he will resign as chairman of the company's (EXEL's) board." All three EXEL directors—Messrs. Clements, Mendoza and Heap—have abstained from the board vote on the proposed investment.

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INTERNATIONAL

Satellite

Continued from previous page
satellite still will complete its mission and be retrieved next year as planned, an ESA spokesman said.

If the satellite were insured, ESA would probably have a claim if Eureka fails to reach its target orbit, said Hans Schimrock, head of risk management at ESA in Paris.

ESA had held negotiations on the possibility of insuring the project with a consortium of brokers and insurer Assicurazioni Generali S.p.A. in Trieste, Italy, Mr. Schimrock said.

The brokers involved in the discussions were: C.T. Bowring Ltd. and Leslie & Godwin International Ltd., both in London; Faugere & Jutheau, in Paris; and Gradmann & Holler in Stuttgart, Germany.

"There were two main reasons why ESA did not insure the project: First, there were no allocated funds in the budget for insurance when the funding was agreed (upon) four years ago; and secondly, there is no accountability for a return on the investment because it (is) a scientific project, not a commercial one," Mr. Schimrock said.

Previous scientific satellites launched by ESA have been built for special projects and have been irretrievable. They generally would not be replaced, so there was little point in paying the extra cost of insuring them, an ESA spokesman said.

But because this satellite is retrievable, the Eureka incident might prompt some ESA member states to consider insuring future scientific projects, Mr. Schimrock said.

"If Eureka doesn't make orbit, we would probably have been able to make a claim if we had taken out insurance," he said.

Even if all of the member states funding ESA do not agree to buy insurance, some coverage could still be bought in the future, Mr. Schimrock said.

"You don't need agreement from all of the member states to insure because you can just insure a percentage of the project. So if only

Air crashes

Continued from page 23
bad," said Jonathan Palmer-Brown, chairman of NCC Aviation Ltd. in London.

But with hull losses of around \$100 million hitting the market in July and "goodness knows what in liability losses," the market could be on course for a combined hull and liability loss of more than \$800 million by year end, he said.

If further large losses occur in the run up to fall renewals, underwriters may be able to push through the rate increases they are seeking, Mr. Palmer-Brown said.

"Underwriters are saying that they need more than \$1 billion in premiums, but market forces have not allowed that in the past. It's still too early to say whether they will get those increases this time, and a lot depends on (losses) between now and October," he said.

The size of the losses in recent weeks has turned a good year into an average year, said John Westcott, chairman of Lloyd's Aviation Underwriters' Assn.

"If everybody in the aviation market adds up the extent of the losses, then it should have an effect on premiums. But I still think that there are enough people who have not done their sums and will continue to, in effect, sell two dollar bills for a dollar," he said. ■

half of them want insurance, you only buy coverage for that 50% of the value," he said.

Under the insurance program proposed by the broker/insurer consortium, ESA could have bought launch and in-orbit coverage up to a limit of \$184 million for a premium of between 16% and 17% of the insured value, ESA confirmed.

Third-party liability coverage up to a limit of \$500 million was purchased for a premium of \$275,000, and unlimited coverage for the space shuttle crew was purchased for a premium of \$50,000, ESA confirmed. Those coverages are required by the National Aeronautics and Space Administration.

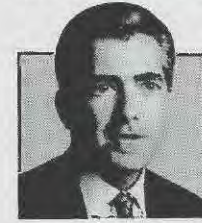
Both policies are led by International Technology Underwriters Inc., which is based in Bethesda, Md. ■

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HMO rankings

Continued from page 3
average satisfaction ratings for their physicians, medical specialists and administration.

Pilgrim Health Care not only tied for first in the satisfaction index but also received the highest rating for member satisfaction with administration.

Minneapolis-based Medica Choice, which received a 79 rating, received the highest rating for member satisfaction with medical specialists.

One reason for the high rating is that Medica Choice members can go to any specialist within the HMO at any time without a referral from a primary care physician, a Medica Choice spokesman said.

How primary care doctors are paid correlated highly with member satisfaction, the survey found. The HMOs at the top of the ratings all paid doctors fees for their services, while most of those at the bottom paid their doctors by salary

or by a per-capita fee.

Additionally, HMO members prefer to receive care in a physician's private office instead of a health center, the survey found.

And no relationship exists between satisfaction and whether the HMO has a Medicare contract with the Health Care Financing Administration, the survey found.

Heritage National Health Plan, for example, contracts under a health care prepayment plan, while Pilgrim Health Care does not contract with HCFA at all. CaliforniaCare HMO/Blue Cross of California, which bottomed out the list, does not contract either.

Among HMOs, responses to the survey depended largely on how they fared.

At No. 1-ranked Heritage National Health Plan in Moline, Ill., President G. Michael Hammes said he was "just delighted with the rating."

But officials at CaliforniaCare, which ranked last with an overall 63, felt differently.

"We believe the ranking is incorrect," said Ron Williams, executive vp with parent Blue Cross of California in Woodland Hills, Calif. The ranking is inconsistent with the HMO's own research, he added. Among his criticisms of the survey: Its sampling of 150 members is not representative enough of the 420,000 members that CaliforniaCare covers.

In addition to the lowest overall rating, the HMO received the worst ranking in satisfaction with physicians, medical specialists and administration. Other criticisms offered by the HMO's members who responded to the Consumer Union survey include a lack of coverage for routine dental care, inadequate examinations and insufficient availability of appointment times.

Rounding out the top five rankings are: Buffalo, N.Y.-based Independent Health, with an overall 81 rating; Rochester, N.Y.-based Blue Choice, 80; and Rochester-based Preferred Care, 79.

Broad review of industry sought

WASHINGTON—The U.S. Commerce Department would undertake a wide-ranging study of the insurance industry under an amended bill approved last week by the House Energy and Commerce Committee, chaired by Rep. John Dingell, D-Mich.

The bill, introduced last month by Rep. Cardiss Collins, chairwoman of the House Subcommittee on Commerce, Consumer Protection and Competitiveness, is a substitute for an earlier version of the bill, H.R. 4731, introduced by Rep. Ben Erdreich, D-Ala., calling for a more limited industry review.

The study proposed by Rep. Collins, D-Ill., would cover the property/casualty and life insurance and reinsurance industries. It would examine the industries' financial health; the adequacy of solvency protection; the effect of changes in federal and state liability laws; the role of insurance in interstate commerce; and the impact of international trade agreements on insurer solvency.

The secretary of commerce would consult with officials of the Treasury Department, Justice Department, Federal Trade Commission, Securities and Exchange Commission and other agencies, and submit a report to the House Energy and Commerce Committee by June 1.

The bill proposed by Rep. Erdreich, chairman of the Subcommittee on Policy Research & Insurance, calls only for a Treasury Department study of the impact of insurer insolvency on business, finance, federal monetary policy and urban development.

—By Douglas McLeod

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Sub-total	25,683
Associations	442
Government, Unions and Educational Institutions	1,261
Commercial Consumers	27,368
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Insurance Companies	8,128
Accountants, Actuaries, Attorneys & Consultants	3,340
Adjusters, Appraisers, TPA's, Captive Managers & Health Care Providers	1,529
Others Allied to the Field	1,580
Single Copies	46
TOTAL	51,099
* Source: Business/Occupational breakdown of qualified circulation, November 25, 1991 issue, as submitted to BPA for December 1991 BPA Publisher's Statement.	

HGO lawsuit

Continued from page 2

In its answer to the lawsuit, Liberty Mutual denied all of the allegations and filed a counterclaim for \$192,524.55 in unpaid premiums.

In addition, the insurer recently won a favorable ruling from U.S. District Judge Clifford Scott Green who held that a 1990 Pennsylvania statute that allows policyholders to sue insurers for bad faith cannot be applied to claims handled before 1990. As a result a majority of HGO's bad faith claims have been knocked out, said the insurer spokeswoman.

"Based on the recent favorable decision from Judge Green, as well as the merits of our case, we feel confident we will receive judgment of the premium owed to us and that the court will find there was no bad faith or intentional mishandling of the files," said the spokeswoman.

Liberty Mutual provided workers compensation insurance to HGO, a janitorial services company that employs about 1,200 people, in 1986 and 1987.

HGO Chairman and Chief Executive Officer Lou Oswald said Liberty Mutual's promise of loss control services was one of the key reasons the company switched to the workers comp insurer in 1986. Previously, HGO purchased its workers comp insurance from Sentry Insurance Group of Stevens Point, Wis.

"Liberty Mutual made a great pitch as to what they would do

for us when they were in a selling posture," said Mr. Oswald. "Then nothing happened. Processing claims became a nightmare."

And Mr. Oswald said when he complained to Liberty Mutual, it "stonewalled" and viewed HGO as "chronic complainers."

"All our efforts to get Liberty Mutual to join hands with us and forge solutions failed," Mr. Oswald said.

"This is the first lawsuit that I am aware of that results from an insurer's failure to provide any loss control services," said HGO attorney Doug Ress.

Mr. Ress of Kaufman, Coren & Ress in Philadelphia commented, "If insurance companies can promise policyholders the moon and stars in the way of loss control services, then not deliver them and be immune from suit, it becomes purely a marketing technique."

Norman Burdick, resident vp-Midwest region for Argonaut Insurance Co. in Chicago, agreed: "An insurance company has a duty to provide the services it promises to the policyholder."

Mr. Burdick says this type of suit would be "healthy for the industry."

"The insurance policy in work comp is the same among all of the carriers, so policyholders are not buying the policy. What the customer is buying is service or the absence of service," he said. "This lawsuit goes right to the heart of these issues."

Lawrence Drake, managing director of Marsh & McLennan Inc. in New York, shares the perspec-

tive that service is a policyholder priority. "We are seeing more cases where the quality of service influences the policyholder's choice of market."

Mr. Drake also pointed out that Liberty Mutual is a direct writer of workers comp, so no broker was involved. He said this type of lawsuit would be unlikely on a brokered account because brokers are more likely to negotiate a resolution between insurer and policyholder.

"They risk losing clients if they fail to do so," he said. "As a result, there are relatively few cases (like this one) involving brokered business."

"If there is a legal theory that holds up in this case, people around the country will look at it," said insurer attorney Kurt Beranek of Frattigio, Best & Beranek in Chicago. "This case is definitely breaking new ground."

HGO's attorney, Mr. Ress, agreed: "I have not uncovered any case that does on a broad brush what we have done here."

"More often than not policyholders just lick their wounds and move on to another insurer," he commented.

Mr. Ress predicted that HGO's lawsuit could prompt other policyholders to take legal action against recalcitrant workers comp insurers.

"This lawsuit will make insurance companies more responsible and make policyholders more aware of the significance of loss control," he said.

And the charges for the in-office procedures were, on average, 4.5 to 7.5 times higher than charges by outside radiologists.

If Judge Stafford finds that the entire law violated due process, he could strike down the whole law, including its core: the October 1995 cut-off point for doctors referring patients to outpatient facilities in which they own a financial stake.

A lawyer for the MRI centers said Judge Stafford's ruling was the only one possible in this case.

"This ruling re-affirms a principle of constitutional law that says no matter how admirable the ultimate intent, it must be achieved by all equally. That's the whole concept behind equal protection," said Barry Richard of Greenberg, Traurig, Hoffman, Lipoff, Rosen & Quentel in Tallahassee, which represented Meditek Inc., a provider of MRI services.

The second issue that Judge Stafford must decide is whether fee caps—even if applied equally—would deny providers substantive due process on the grounds that the state enacted an arbitrary and capricious law that would deny those affected a fair rate of return on their business.

A spokesman for the Agency of Health Care Administration, which oversees the Health Care Cost Board, said abolishing the law would cost Florida health care payers between \$200 million and \$500 million per year.

Lawyers for the state declined to comment on the case, but said they have filed a motion with Judge Stafford to have the exemptions for hospitals and group practices removed from the law.

The state says it would be amenable to having the caps apply to all providers of the five designated services.

If Judge Stafford declines to remove the exemptions, the state may appeal to the 11th U.S. Circuit Court of Appeals, said one of its attorneys. ■

"The way the experience modifier is calculated, the policyholder has excess baggage for many years," Mr. Ress said.

He explained that poor loss experience causes the policyholder's experience modification factor to rise. That will cause a subsequent insurer to charge the policyholder more for its workers comp insurance.

When HGO was using Sentry as its workers comp insurer, the janitorial company had an experience modifier of 0.453, said Mr. Ress. After two years with Liberty Mutual the experience modifier had risen to 1.2, he said.

The problem facing HGO at trial is proving a causal connection between Liberty Mutual's alleged failure to provide loss control services and HGO's poor loss experience.

"This case presents very difficult proof issues," said Mr. Beranek. "The policyholder must show that its losses wouldn't have gone up anyway."

In fact, this is likely to be the main defense raised by Liberty Mutual, according to Mr. Ress.

However, he believes HGO will be able to offer sufficient proof of Liberty Mutual's failure to provide loss control services.

For example, Mr. Ress said:

- "Liberty Mutual promised to perform on-site inspections and make safety recommendations. They performed not one on-site inspection and made not one safety recommendation."

- "Liberty Mutual promised to conduct an in-depth claims analysis to determine what causes losses and pinpoint problems. They per-

formed no in-depth claims analysis.

- "Liberty Mutual promised to provide HGO workers with safety-education materials and conduct safety seminars with HGO workers. They offered workers not one safety booklet and conducted no safety seminars."

There is also anecdotal evidence, according to Mr. Ress.

For example, in order to show that Liberty Mutual over-reserved, Mr. Ress will discuss the case of a worker who injured her back after lifting a trash can. Liberty Mutual reserved more than \$12,000 for this claim file, which was later settled for \$673.22.

In order to show that Liberty Mutual mishandled certain workers comp claims, Mr. Ress will discuss the case of a part-time worker who injured his pinkie finger and was back at his regular job as a police officer within a few weeks, but remained on HGO's workers comp rolls for several years.

Similarly, Mr. Ress will discuss the case of a worker who injured her back and was not seen by a doctor for 18 months. All the while, she received weekly benefits.

Mr. Ress also plans to introduce expert testimony to help the court evaluate in monetary terms the damage done to HGO.

He has hired two experts that will testify that the poor claims-handling and loss reserving caused a total of \$474,067 in damage to HGO in 1986 and 1987.

And, an expert also will testify that the "total absence of loss prevention services" caused HGO damage estimated at \$156,656, Mr. Ress said. ■

Florida fee cap law

Continued from page 2

were within their rights when they passed a law that aims to hold down costs by restricting self-referrals. Lawmakers, though, lacked sound reasoning for exempting some providers from the law at the expense of others, he said.

His ruling stems from a pair of lawsuits filed earlier this year against the state by owners of several Florida magnetic resonance imaging centers.

The owners had argued that the fee schedule is unconstitutional because it affords hospitals and group practices an unfair, unreasonable competitive advantage over non-exempt providers.

The self-referral law limits charges in five areas—clinical laboratory services, physical therapy, comprehensive rehabilitation, diagnostic imaging services and radiation therapy—to 115% of the Medicare reimbursement level.

But that cap applies only to services rendered in a non-hospital or non-group practice setting; hospitals and group practices—those with two or more doctors—can charge whatever they want.

Each fee cap violation carries a maximum \$5,000 penalty.

In striking down the caps, Judge Stafford ruled that the Legislature failed to adequately explain why hospitals and group practices should be exempt.

"Both joint and non-joint ventures are subject to the fee caps. Both joint and non-joint ventures are exempt from the fee caps. If the Legislature meant to target the abuses of physician self-referral, then it missed the mark," he wrote.

Judge Stafford also questioned the Legislature's motives for capping fees. He points out that the caps were added just one day before the law was passed.

In addition, the judge wrote that he believes that the caps were added as part of a compro-

mise that included granting a one-year extension on the effective date self-referral ban.

"The Legislature again missed the mark if it meant for a quid pro quo rationale to explain the classifications set up in (the fee schedule provision)," he wrote.

Lastly, Judge Stafford said the Legislature lacked the factual backing to support a fee schedule that, after further study, was found to deny the MRI centers the chance to earn a profit.

In the lawsuits, the owners argued that they could not sustain a profitable business if required to charge no more than 115% of the Medicare reimbursement level.

A recent study by the Florida Health Care Cost Board supported this claim. The state agency found that to cover their costs, diagnostic imaging centers had to charge from 130% to 170% of the Medicare rate.

"The legislative record was so lacking in facts about price, especially as to the prices charged by group practices and hospitals, that it is difficult to surmise why the Legislature wanted to protect these particular entities," wrote the judge.

"Not until after the act was signed into law did the HCCB present the Legislature with information about the expected impact of the fee caps."

While Judge Stafford noted that the Legislature had few, if any, facts upon which to base its fee cap exemptions, lawmakers did discuss the December 1990 issue of the New England Journal of Medicine, which contained a study concerning diagnostic imaging services performed both in and out of physician offices.

According to the study, physicians nationwide who owned their own equipment ordered from four to 4.5 times as many procedures as physicians who referred their patients to outside radiologists with whom they had no financial ties.

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Oregon

Continued from page 1

"The governor and legislative leaders have to decide what to do. They don't want to go through an exercise" of resubmitting the plan for approval if there is no chance the Bush administration will allow it, according to Cynthia Griffin, manager of provider relations in the state Office of Medical Assistance Programs.

Ms. Griffin said that attorneys for the state have been conferring with U.S. government attorneys, "and from what our attorneys were able to get...they want us to scrap the priorities," which are the heart of the Oregon plan.

By prioritizing medical services, the Oregon plan would be able to extend care to more of the poor, the state says.

The state's Health Services Commission put 709 health care services into 17 categories of care, which then were prioritized as essential, very important or valuable to only certain individ-

uals. The Oregon Legislature has determined there are enough state and federal Medicaid funds to cover the top 587 of these services in a standard Medicaid health plan.

To implement this portion of its plan, Oregon asked the Health Care Financing Administration for a five-year waiver of federal Medicaid rules, which govern which services must be provided under the program.

But according to the HHS analysis of the Oregon plan, the list of medical services priorities "was based in substantial part on the premise that the value of the life of a person with a disability is less than the value of the life of a person without a disability."

Oregon officials disagree. Attorneys for the state have determined that the plan would not violate the ADA, according to Ms. Griffin.

"George Bush has undone four years of work in Oregon" that would have extended medical coverage to virtually all Oregon-

ians "and (the president) has nothing to offer in its place," she asserted.

"Why not let the (Oregon) plan go forward" and allow it to be tested in the legal system? she asked.

"It is clear that the decision by the Bush administration...was not a decision made on the basis of sound public policy, but rather a decision made in the context of presidential election politics. By using the ADA as a smoke screen, President Bush believes he has skillfully avoided confronting any of the fundamental issues surrounding the health care debate," Oregon Senate President Dr. John Kitzhaber, D-Roseburg, said in a statement.

The Bush administration is "following a national consensus" in backing national rather than state health care reform efforts, said Mark Ugoretz, president of the ERISA Industry Committee, which is made up of Fortune 150 companies.

The administration was especially "discomfited" by the rationing aspect in the Oregon plan, Mr. Ugoretz said. To many members of Congress and to most Americans, "it is anathema to think that some bureaucrat someplace is rationing the coverage and benefits that someone would have a need for, based on the amount of revenue available in a state," he said.

For example, under the Oregon plan, Medicaid would provide only comfort care for conditions considered terminal, such as certain cancers.

But Oregon officials maintain the current system of health care allows "silent rationing" of services to those who can pay for them.

"The administration apparently has no qualms about the fact that all health services will be rationed" to the 120,000 poor Oregonians who would otherwise be covered under the plan, Sen. Kitzhaber said.

Observers say the administration's denial of the Oregon plan was influenced by the strong opposition to the plan voiced by members of Congress, including Democratic vice-presidential candidate Sen. Al Gore Jr., D-Tenn.

"Oregon has made a tragic choice and a horrible mistake in responding to the plight of the uninsured by developing a scheme that takes from the poor, and only the poor, to help the poor; a scheme that preys on the limited political clout and powerlessness of poor women and poor children; and whose only answer to skyrocketing health care costs is to ration care," Sen. Gore said at a subcommittee hearing of the U.S. House Energy and Commerce Committee last September.

But Oregon officials say that Democratic presidential candidate Gov. Bill Clinton has lent encouragement to the Oregon plan.

"Clinton has visited the state and he has been very supportive of the plan, both as an experiment" and because of the nature of the plan itself, said a spokeswoman for Gov. Roberts.

"Sen. Gore is not running for president of the United States," the spokeswoman added.

Sen. Kitzhaber told a news conference that perhaps the best course of action now would be to "take the plan to President Clinton," according to a spokesman for the Oregon Department of Insurance.

Clinton campaign headquarters in Little Rock, Ark., did not return phone calls.

But whether Gov. Clinton is elected or not, observers say that states will continue to propose health care reform plans, despite Oregon's setback.

"The Oregon situation is somewhat special, because it would like to attempt Medicaid reforms, as other states have not," pointed out Frank McArdle, a partner and manager of the Washington office of Hewitt Associates.

"There's a wide range of activity going on at the state level now—being fueled by major problems in each state—and those efforts won't subside be-

'George Bush has undone four years of work' to extend coverage in Oregon, charges Ms. Griffin.

cause of this decision," Mr. McArdle added.

About 10 states have asked for waivers of the Employee Retirement Income Security Act of 1974, he said. The decision on the Oregon plan "does not signal that waivers won't be considered and allowed."

ERISA generally prohibits state interference with employee benefit plans.

"The scope of the waiver sought by Oregon was so controversial that the Bush administration was very careful in considering it," Mr. McArdle said. The administration, which had taken a strong position in favor of the ADA, did not want to be seen as taking "any step backward," he explained.

Under the Oregon plan, which was established by the Oregon Basic Health Services Act of 1989, Medicaid coverage would be extended to all state citizens at or below the federal poverty level (BI, March 2; March 18, 1991).

Currently, about 120,000 state residents with incomes beneath the federal poverty level are ineligible for Medicaid because they do not meet certain qualifications; namely, they are pregnant women or are receiving federal Aid to Dependent Children benefits.

While the state would increase the number of individuals eligible for Medicaid, the prioritization component of the plan would eliminate coverage for certain costly, high-risk services and other medical services that do not improve the quality of life. That would free money to extend basic health insurance to all of the state's uninsured, low-income individuals, the state says.

In addition to prioritizing health care services, other components of the plan are a high-risk pool, created in 1987 to cover individuals considered uninsurable; a small-business insurance program, which is scheduled to be implemented at the end of this year, regardless of the status of the Medicaid waiver application; and a play-or-pay system for Oregon employers that would become effective in 1995.

"The most crucial fact overlooked by Sullivan is that the Oregon Medicaid waiver request has no effect on the medical coverage received by those disabled

persons currently in the Medicaid program," according to Sen. Kitzhaber, who cited "errors of fact and faulty logic" in HHS's denial of the waiver.

Persons with disabilities are now exempt from the waiver project and would not be rolled into the program until 1993, he said.

In addition, Sen. Kitzhaber said, the administration "misrepresents the findings of the Office of Technology Assessment," which prepared a report on the Oregon plan for the HHS. "Sullivan claims that the OTA found that the Oregon priority-setting project discriminated against persons with disabilities when, in fact, the exact opposite is true."

The OTA found that "the priority process created a slight preference for services that prevented or mitigated disabling conditions," Sen. Kitzhaber commented.

The HHS analysis also claims that a statewide telephone survey conducted by those drafting the health plan affected the final ranking of health services by allowing "bias against persons with disabilities to be taken into account."

But Oregon's Ms. Griffin counters that the survey "just asked what people rate as most important in their health care; it didn't force them to choose one thing over another, it didn't change the ranking" of services.

In addition, the analysis said that the Oregon plan would not cover life-support treatment for extremely low-birth weight babies and that the plan's distinction between certain categories of those babies "raises similar concerns under the ADA."

"This allegation is entirely unfounded, a fact that would have been apparent had the administration revealed its objections prior to denying the waiver. The only services that are excluded are those which medical research suggests are futile," responded Sen. Kitzhaber.

States receive grants to draft health reforms

By SALLY ROBERTS

Financial barriers to basic health care may be reduced for millions of Americans under a grant program designed to encourage state health care reforms.

Twelve states have been granted a total of more than \$8 million to develop statewide reforms aimed at expanding health insurance coverage and containing costs.

Because there is no national consensus on health care reform, "states are challenged to do this on an independent basis," said a spokeswoman for The Robert Wood Johnson Foundation in Princeton, N.J., which funded the grants.

Proposals from 35 states were reviewed by the foundation and by an independent national advisory committee, the spokeswoman said. The 12 states selected were the "most fundable projects," she added.

The 12 states are: Arkansas, Colorado, Florida, Iowa, Minnesota, New Mexico, New York, North Dakota, Oklahoma, Oregon, Vermont and Washington.

The two-year development grants will allow the states to test many of the health care options now being considered at the national level.

Colorado, Iowa, New Mexico and Vermont propose to establish single-payer or regulated multiple-payer systems.

Iowa, Minnesota, North Dakota and Vermont will explore the effectiveness of dollar limits or targets that would curb total expenditures for health care services annually or restrict fees paid to providers.

Iowa, Oregon, North Dakota and Washington propose to develop a play-or-pay mechanism under which all employers would provide basic coverage to their employees or pay into a state insurance pool.

Arkansas, Florida, Minnesota, New Mexico, Vermont and Washington intend to create a state insurance plan or to subsidize health insurance products that target special populations, such as small businesses or children.

Arkansas, Minnesota, New Mexico and New York propose to develop uniform claims processing and billing systems for insurance.

In addition to the grants, the 12 states will receive technical assistance from the National Governors' Assn.; the Alpha Center and the Urban Institute, two Washington, D.C.-based think tanks; and the RAND Corp., a public policy research organization in Santa Monica, Calif., under an additional \$2.3 million grant made to those organizations by The Robert Wood Johnson Foundation.

Following the first two-year phase during which the funded states will develop their proposed reforms, the states will be eligible to apply for up to three more years of additional funding to support the implementation of their proposals, the spokeswoman said.

Before several of the plans could be implemented, federal authorities would have to grant special waivers of federal laws or regulations.

Play-or-pay plans, for instance, would have to get a federal exemption from the Employee Retirement Income Security Act. And those plans that merge Medicaid with a state-sponsored insurance plan would have to get a waiver from Medicaid, the foundation spokeswoman said.

An Oregon health care rationing plan was recently rejected by the Bush administration when officials decided it does not comply with the Americans with Disabilities Act (see story, page 1).

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Senate tax bill

Continued from page 1

"There are more provisions to like in the Senate bill," said Frank McArdle, a consultant with Hewitt Associates in Washington.

Specifically, the Senate bill would ease problems for employers and employees caused by a new pension withholding law and make it easier for employers to pass certain pension non-discrimination tests. The House bill would do neither.

Under the new withholding law, employers, starting next year, must—at the request of a terminating employee—directly transfer pension distributions to an employee's individual retirement account or to the defined contribution plan sponsored by the employee's new employer.

A 20% withholding tax will be levied on distributions, such as from a profit-sharing plan, that are not directly transferred to an IRA or a new employer's plan.

The Senate bill eliminates this transfer requirement—a big nuisance for employers—for small pension distributions. Employers would not have to offer the direct-transfer option for distributions of less than \$500, and these small distributions would be exempt from the withholding tax.

"This will help for those nuisance situations, though I wish the ceiling would be at least \$1,000," said Frederick Rumack, director of taxes and legal services at Buck Consultants Inc. in New York.

The 20% withholding tax also would not apply to hardship withdrawals from 401(k) plans.

Some 401(k) hardship withdrawals would also be exempt from another tax. The special 10% federal tax that now applies on most pre-retirement distributions would not be assessed on first-time purchase of a home or for tuition and related higher education expenses of an employee, or an employee's spouse or children.

Removing the 10% tax on certain hardship withdrawals will

increase the attractiveness of 401(k) plans and perhaps boost participation by lower-paid employees.

"Knowing when you put the money in that you also can get it (out) without penalty" makes a 401(k) plan more attractive to employees, said Hewitt's Mr. McArdle.

Benefit consultants question, though, whether the removal of the 10% penalty on certain hardship withdrawals from 401(k) plans will be accepted when differences between the House and Senate bills are ironed out by a conference committee.

Removing the penalty, they note, would seem to conflict with previous congressional desires to discourage pre-retirement withdrawals.

Meanwhile, the Senate bill also would allow all employees covered by pension plans to make tax-deductible contributions to IRAs. The 1986 tax law barred middle- and upper-income employees covered by pension plans from making tax-deductible IRA contributions.

However, in the case of employees participating in 401(k) plans, the new legislation states that their total contribution to their IRAs and 401(k) plans could not exceed the maximum deferral limit to a 401(k) plan. That limit, indexed each year to inflation, currently is \$8,728.

The Senate bill also would ease pension non-discrimination testing requirements for employers that cover union and non-union employees under a single plan.

The legislation would make optional the current mandatory use of a so-called pension "disaggregation" rule. That rule says employees covered by a collective bargaining agreement must be disregarded—even if they receive coverage from the same pension plan as other employees—when the various Internal Revenue Service non-discrimination tests are run.

Benefit consultants describe the disaggregation rule, included in IRS regulations, as unfair and illogical.

"An employer provides coverage to unionized workers, but can't take credit for the coverage for non-discrimination testing purposes. That is hardly fair," said Foster Higgins' Mr. Saveth.

The disaggregation requirement can make it difficult for some pension plans to pass the non-discrimination tests.

For example, assume a company offers a pension plan at one location to union employees, who are considered lower-paid employees for testing purposes, and to salaried employees, all of whom are highly paid. In addition, assume the plan is not offered at a second location, which employs primarily lower-paid non-union workers.

Because union employees would have to be excluded, the pension plan would likely flunk an IRS non-discrimination test that requires the percentage of lower-paid employees covered by a pension plan to be at least 70% of the percentage of highly paid employees covered by the plan.

For example, if a plan covered 100% of highly compensated employees, it also would have to cover at least 70% of lower-paid employees.

If the union employees were considered when running the test, the plan would be much more likely to pass the non-discrimination test.

The Senate bill also would liberalize the IRS' minimum-participation rule. That rule says a pension plan must cover 40% of a company's workforce or 50 employees, whichever is less.

Under the Senate bill, the rule would be modified for defined benefit plans so that the plan only would have to cover 40% of employees, or 25 employees, whichever is less. Defined contribution plans would be exempt from the rule.

Lowering the participation standard would help large employers who may have, for example, acquired small units and don't want to merge those units' plans into other company pension plans, said Buck's Mr. Rumack.

Both the House and Senate bills would:

- Give employers a simpler way to run the IRS non-discrimination test for 401(k) plans.

They would be allowed to compare salary deferrals made by low-paid employees during the previous year with the contributions made by high-paid employees in the current year.

By contrast, they now have to compare the current-year contributions of the two groups.

By using low-paid employees' prior-year contributions, employers would know at the start of a plan year how much high-paid employees could contribute without violating the non-discrimination rules.

The two bills also would offer employers two new safe harbors for their 401(k) plans, which, if satisfied, would exempt employers from non-discrimination tests.

Benefit experts say that the requirements set by the safe harbors are so stiff that few companies would qualify.

- Allow non-governmental tax-exempt employers, such as trade associations, to establish 401(k) plans.

- Require the IRS to round up to the nearest \$100 and \$1,000 the annual inflation adjustment in the maximum employee salary deferral made to a 401(k) plan and the maximum benefit that can be funded through a defined benefit plan.

To help employers plan better, the IRS also would be required to announce these changes in inflation-adjusted amounts before the end of the year.

- Simplify the definition of "highly compensated employee" for IRS non-discrimination testing purposes.

Under both bills, highly paid employees would be those who own at least 5% of the company or those earning at least \$62,345—an amount which would be increased annually with inflation and rounded to the nearest \$1,000 in future years.

Current law sets numerous definitions of highly paid em-

ployees.

- Allow employees who return from military service to make retroactive contributions to their 401(k) plans to cover the period while they were in the armed services. Employers would have to match the returning veterans' contributions on the same basis as they matched other employees' contributions during the years the veterans were in the military.

- Extend the tax-favored status of employer-provided educational assistance benefits through Dec. 31, 1993. The tax-favored status of educational assistance benefits expired in June.

But benefit provisions in the two bills differ in a number of other areas. Those differences include:

- Multiemployer pension plan vesting.

Only the House bill would require multiemployer pension plans to adopt more rapid vesting schedules.

The plans could adopt a schedule in which employees were first and fully vested after five years, or a schedule in which employees were 20% vested after three years, with vesting continuing at the rate of 20% annually until an employee was fully vested after seven years of service.

Multiemployer plans now typically offer 10-year cliff vesting.

- The Senate bill would allow employers with fewer than 100 employees to set up a new pension plan, called PRIME account plans, that would be exempt from non-discrimination testing.

A PRIME plan would allow employees to make pretax contributions of up to \$3,000 a year, with a 100% employer match up to 3% of pay.

- The House bill would allow indexing to inflation of a portion of a two-pronged limit in the maximum deferral employees can make to so-called Section 457 plans, a type of pension plan that certain tax-exempt employers can offer.

The \$7,500 ceiling would be indexed to annual increases in inflation. ■

GIC survey

Continued from page 3

The findings are no surprise, confirming that employers—especially those sponsoring large plans—continue to move away from traditional GICs, noted Brian Ternoey, a principal in charge of Foster Higgins' investment services consulting group.

"We expected to see the increase in the move toward other alternatives, and we saw it," Mr. Ternoey said.

He added that he expects the defection from traditional GICs to continue for another year or two, with about one-third of the market eventually staying in GICs, one-third moving to synthetic GICs and one-third to investments like bond funds.

The survey found that respondents using investment alternatives ultimately want 45% of their plans' assets invested in GIC alternatives. Only 7% of current GIC assets are invested in GIC alternatives.

The survey also found that:

- Eighty-one percent of respondents cited "insulation from general—account creditors" as an appealing feature of GIC alternatives.

Separate—account GICs, backed by Treasury bills, high-grade corporate bonds and other investments, are theoretically protected from creditors should

the issuing insurance company fail (*BI*, Nov. 18, 1991).

Meanwhile, 43% of those responding to questions about the advantages of GIC alternatives cited better control over investments, and 33% cited better return on invested assets.

Only 3% of respondents said GIC alternatives offered no advantages over traditional GICs.

- Seventy percent of respondents require alternative GICs to provide a fixed interest rate, and 67% require a fixed maturity date.

While these requirements limit the number of products available to plan sponsors, more issuers are introducing products that offer such guarantees, according to the survey.

Another 41% of respondents said their alternative GIC investments must provide insulation from defaults, while 33% require their own separate investment account and 32% require some say over the investments backing the contracts.

- Insurers and banks are the most popular issuers of GIC alternatives: 59% of respondents reported using insurance companies, 54% reported using banks and 20% reported using investment management firms.

- Nearly all responding plan sponsors said the insurers issu-

ing their GICs are rated AA or better by Standard & Poor's Corp.

Insurers issuing GICs to 29% of the respondents are rated AAA by S&P, while 30% use insurers rated AA+, 33% use insurers rated AA, 3% use insurers rated AA-, 4% use insurers rated A and 1% use insurers rated A-.

- The average GIC rate of return among respondents dropped to 8.59% in the first quarter from 8.73% in the fourth quarter of 1991, while the average remaining time to maturity decreased to 2.55 years from 2.59 years.

The largest GIC-holders showed the largest rates of return: Plan sponsors with more than \$250 million invested in GICs reported an average 9.17% rate of return in the first quarter, while those with between \$50 million and \$250 million reported earning an average 8.70%; those with between \$10 million and \$49.9 million earned an average 8.41%; and those with less than \$10 million earned an average 8.28%.

Copies of the Foster Higgins survey are available only to participating employers. For information on how to participate in future surveys, contact Karen Foley in Foster Higgins' investment services consulting group at 609-520-2280.

Dingell letters

Continued from page 2

lines business. It also is in the process of acquiring Bankers Life & Casualty Co. of Chicago. That deal is expected to close next month.

Conseco attacks the *Barron's* story—written by Abraham J. Briloff, a retired accounting professor—as "opinion and innuendo masquerading as fact." A spokesman said the company's accounting conforms to industry standards and SEC requirements.

But Rep. Dingell, chairman of the House Oversight and Investigations subcommittee, asks the SEC whether Conseco's earnings are an "accounting illusion" and its takeovers "a deliberate strangling of companies producing insurance products and jobs for Americans."

"The conclusions of (the *Barron's* story) are especially disturbing because they bear striking resemblance to the sordid events which caused such havoc with leveraged buy-outs, junk bonds and the savings and loan industry," Rep. Dingell wrote.

The letter requests an SEC opinion on whether *Barron's* was correct in its criticism of Conseco's accounting practices and whether its financial reports represent full and fair disclosure.

Rep. Dingell also asked the SEC generally what actions it is taking to require balance sheet reporting of gross insurance liabilities and "to separate the use and reporting of 'time and distance' financial reinsurance from 'risk sharing' reinsurance."

The letter also asks how accounting rules can be changed to make insurance and reinsurance financial reporting more complete.

Similar letters were sent to the National Assn. of Insurance Commissioners, the Financial Accounting Standards Board, the American Institute of Certified Public Accountants and the New York Stock Exchange.

Rep. Dingell also questioned the SEC about Conseco's accounting practices last year after a Feb. 11, 1991, story on the company appeared in *Barron's*.

New information in the latest *Barron's* story and a public-share offering by CCP Insurance earlier this year revived Rep. Dingell's interest in the company, a subcommittee official said.

The Conseco spokesman said company officials will contact the SEC to respond to the agency's questions.

Fiduciary duties

Continued from page 2
 Court of Appeals—*Mack Boring & Parts Corp. vs. Meeker Sharkey Moffitt, Actuarial Consultants.*

Because of the differences of opinion, many observers believe that the Supreme Court could ultimately decide the issue. John Hancock, though, says it has not decided whether to appeal.

Under ERISA, insurers are not considered fiduciaries for "guaranteed benefit" policies written for pension plans. These policies, issued only by insurance companies, provide annuities to pay retiree benefits. They can be written for either defined benefit or defined contribution plans, although the former is more common, said Maureen Phillips, a John Hancock vp.

In its July 30 decision, the three-judge panel of the 2nd Circuit ruled that despite the exception for guaranteed benefit policies, an insurer has a fiduciary responsibility if a portion of the return on the assets invested with the insurer is not guaranteed. One example: when the rate of return depends on the insurer's investment decisions.

"To the extent that the insurer engages in the discretionary management of assets attributable to that phase of the contract which provides no guarantee of benefit payments or fixed rates of return, it seems to us that the insurer should be subject to fiduciary responsibility," the court said.

The decision—which some observers say is ambiguous—partially overturns a district court decision.

The case centers on a defined benefit plan sponsored by Sperry Corp., now part of Unisys Corp. In 1941, Sperry bought individual deferred annuities from Hancock to guarantee pension benefits.

In 1968, the contract with Hancock was converted into a "retrospective immediate participant guarantee" contract, a precursor of today's guaranteed investment contracts. The annuities were technically canceled and the assets supporting them put in a "pension administration fund."

Premiums paid under the contract became part of Hancock's general corporate funds. The agreement called for an administration fund to be maintained at least 105% of the "liabilities of the (pension) fund." The administration fund is a contractual reserve for the possible purchase of annuities to cover future benefit payments guaranteed by Hancock. Any funds above that 105% threshold were considered "free funds," and are not part of the guaranteed benefit agreement.

In 1977, another revision of the plan entitled Sperry to designate employees eligible for additional non-guaranteed benefits from these free funds. These monthly benefits continued until 1982, when Hancock said it would no longer pay them. Hancock also eliminated a "rollover" procedure under which excess free funds were twice permitted to be withdrawn from the pension administration fund by the designated employees.

Harris Trust & Savings Bank of Chicago, the plan's trustee, in 1983 sued Hancock, contending that the insurer used an artificially low interest rate assumption to calculate the liabilities of the fund. One effect of this, the

'This is going to be a major setback for the insurance industry,' contends attorney Peter Kelly.

suit charged, was a geometrically increasing level of so-called free funds.

In its suit, Harris sought to recover the non-guaranteed benefits withheld by Hancock, profits the insurer made using Sperry funds and other unspecified damages.

The 2nd Circuit said it "seems clear that, at least to the extent it provides for benefits guaranteed by Hancock," the plan "is a guaranteed benefit policy and Hancock does not act as a fiduciary in administering it."

The lower court had ruled that Hancock was totally exempt as a fiduciary for the Sperry pension plan. But the appellate court disagreed.

"We think that the district court erred in concluding that (the plan) in its entirety is covered by the guaranteed benefit policy exception," the 2nd Circuit said.

"In the plain language of the statute, a contract is a guaranteed benefit policy only 'to the extent that' it provides for benefits that an insurer guarantees.

"Although Hancock provides guarantees with respect to one portion of the benefits derived from the contract, it does not do so at all times with respect to all the benefits derived from the other, or free funds, portion," the appellate court said. "The non-guaranteed portion is dependent upon the insurer's investment experience and therefore is variable with respect to the benefits it provides."

Hancock has no fiduciary duty to the pension plan itself, the 2nd Circuit said. Its duty arises "only when Hancock became involved in the administration or management of plan assets not referable

to guaranteed benefits," the court said.

In its decision, the 2nd Circuit did agree with the district court that Hancock properly terminated non-guaranteed benefit payments by giving 31 days notice. The case was returned to the district court to determine whether Hancock had breached its fiduciary duty and what, if any, damages should be awarded.

An attorney for Harris Trust—Lawrence Kill of Anderson Kill Olick & Oshinsky in New York—called the ruling a "very significant victory for policyholders."

It will subject insurers to ERISA's strict fiduciary standards and provide policyholders with more "meaningful protection," said Mr. Kill.

Adding insurers as plan fiduciaries will not create problems because "you always have multiple fiduciaries," he said.

Another lawyer representing plan sponsors on ERISA issues also applauded the decision.

Insurance companies have long been "fighting tooth and nail" against becoming fiduciaries, although ERISA's "clear message" is that they have this responsibility, charged Peter Kelly of Murphy, Smith & Polk in Chicago.

Under ERISA, fiduciaries are to manage funds "solely" for the benefit of participants and for the "exclusive purpose" of paying benefits. This could create "incredible conflicts of interest," said Mr. Kelly. "This is going to be a major setback for the insurance industry."

Hancock's Ms. Phillips commented, "Basically, we think that the court is wrong to the extent that it applied ERISA to any part of the contract." She added, however, the insurer is pleased the court determined that Hancock complied with its contractual obligations.

Insurers complain that making them fiduciaries would disrupt the management and operations of the general accounts that issue general account contracts to pension plans.

As fiduciaries, they would have to separate out a total of about \$560 billion in plan assets that now is commingled in their general accounts, said a spokesman for the American Council of Life Insurance in Washington.

Sandy Koeppel, vp for Prudential Asset Management Co. in Newark, N.J., said he was "somewhat surprised, but not totally shocked" by the 2nd Circuit ruling.

Insurers, he suggested, could do some "damage control" by giving plan sponsors incentives to seek contracts where insurers' responsibilities are more clearly defined, like separate accounts rather than general accounts.

Prudential has already moved in this direction, he said. ■

Update

Flood suit seeks to tap insurers

Continued from page 2

Court July 30 after its undetermined business interruption claim was denied by River Forest Insurance Co.

The suit is seeking class-action status on behalf of all policyholders whose business interruption claims have been denied.

The suit defines the class of defendants for which it seeks certification as "all property and casualty insurance companies doing business in Illinois who issued business income coverage insurance policies containing ISO policy language or language substantially similar to plaintiff and plaintiff's class and who have not paid claims and/or denied claims for business interruption and/or property damage." There are probably at least 50 insurer defendants that could be certified as a class, the lawsuit says.

The Insurance Services Office Inc. is named as a respondent in discovery to determine additional defendants and to interpret policy language.

One of the plaintiff's attorneys, Holstein, Mack & Klein of Chicago, filed a similar suit earlier this year. But that litigation was dismissed June 30, shortly after the only plaintiff in the case settled with its insurer.

Other suits have been filed against the city of Chicago and a contractor whose bridge piling work is blamed for the flood (BI, June 1).

Lloyd's changes approved

LONDON—A restructured Lloyd's of London should be in place by the beginning of 1993, after receiving approval last week from the Lloyd's Council.

The changes in Lloyd's governing structure will largely follow the recommendations of the working party headed by Sir Jeremy Morse, which were published last month (BI, July 6).

The Morse report recommended a new tripartite governing structure of: the Lloyd's Council, still headed by the chairman, but halved to 14 members; a newly formed Market Board, which would oversee Lloyd's business development; and a new Regulatory Board, which would oversee market conduct.

Lloyd's Council last week suggested that the heads of the two new boards also should be made part of the council, whereas the Morse report only recommended that they attend certain meetings.

The smaller council will be installed over three years. The market and regulatory boards will be in place on Jan. 1, 1993.

Also on Jan. 1, all members of the Lloyd's Council and the new boards will be required to disclose all their business interests to members of Lloyd's. Among other things, the information will include their interests in Lloyd's-related companies, as well as holdings of greater than 3% in any other company.

OSHA seeks ergonomics input

WASHINGTON—The Occupational Safety and Health Administration is accepting public comments and information for possible health and safety standards on workplace ergonomics.

In the Aug. 3 Federal Register, OSHA requested information and comments on eliminating or reducing occupational exposures to ergonomic hazards. These could include poorly designed computer workstations; repetitive motions or vibrations from machinery; and compression of the hand, wrist, arm, back, neck, shoulder or leg.

After suggestions are compiled, OSHA will hold public hearings before drafting any standards. Standards could apply to all industries generally or to just specific industries.

The deadline for submitting suggestions is Feb. 1, 1993.

Briefly noted

The Justice Department last week recommended that the U.S. Supreme Court not hear an appeal of the **massive insurance antitrust litigation**. Insurance industry defendants are asking the high court to overturn an appellate court ruling that reinstated the case (BI, March 30). The brief is likely to be an important factor in the court's decision. . . . UNUM Corp. has completed its previously announced acquisition of accident and health reinsurance underwriting manager **Duncan & Holt Inc.** for an undisclosed sum (BI, April 13). . . . ANA Insurance Group, a Louisiana Lloyd's plan, has filed a \$185 million civil rights **suit against California Insurance Commissioner John Garamendi** and members of his staff for ordering surplus lines brokers to stop issuing ANA policies, alleging ANA is in danger of insolvency. . . . **Mutual Risk Management Ltd.** has acquired wholesale broker and captive manager Park International Ltd. of Hamilton, Bermuda, in a deal worth \$1.4 million. . . . Los Angeles Superior Court Judge Kurt Lewin gave final approval last week to the sale of **Executive Life Insurance Co.** The ruling allows California regulators to close the sale of ELIC's junk bond portfolio to a consortium of French investors. The department also can now begin transferring ELIC liabilities to a successor operating company. . . . Two Los Angeles attorneys and two other individuals were arrested for allegedly running an **insurance fraud ring** that involved staging auto accidents and filing as much as \$10 million in fraudulent claims against insurers over a two-year period. . . . **Arkansas workers comp rates** will increase an average of 18.5%, effective July 1, 1992. Separately, the local AFL-CIO failed to obtain enough signatures to place a workers comp reform proposal on the November ballot. . . . Georgia Insurance Commissioner Tim Ryles last week **rejected a 33% workers comp rate hike** requested by the National Council on Compensation Insurance on the grounds that insurers are not losing money in Georgia. . . . **Moody's Investors Service Inc.** lowered **Kemper Corp.'s senior debt rating** to Baal from A2 and the insurance financial strength ratings of Kemper's principal subsidiaries. Moody's cited vulnerability in Kemper's mortgage loan and real estate portfolio.

Official rehab plan for Mutual Benefit filed

TRENTON, N.J.—Rehabilitators of Mutual Benefit Life Insurance Co. have filed an official plan of rehabilitation for court approval.

Under the \$800 million bailout plan presented to the Chancery Division of the Superior Court of New Jersey, at least 42 state guaranty funds over the next seven years will guarantee full death, disability and retirement benefits; full account values; and interest of at least 3.5% to more than 100,000 individual policyholders, holders of tax-deferred annuities and other annuity holders entitled

to full or partial protection under various state guaranty association provisions.

An industry consortium led by the Prudential Insurance Co. of America and Metropolitan Life Insurance Co. will guarantee 100% of principal and 3.5% interest over the first three years of the rehabilitation period to holders of guaranteed investment and guaranteed annuity contracts in any state in which guaranty association coverage does not apply.

Policyholders may opt out of the plan after court approval, but their

account value would be reduced to 55%. They also may make withdrawals, subject to gradually declining penalties.

The plan is contingent on participation of at least 42 state guaranty associations, including those of New Jersey, New York, California, Connecticut, Illinois and Michigan. Policyholders who live in states that do not participate may have their account values reduced to no less than 88%.

Regulators seized Mutual Benefit in July 1991 (BI, July 22, 1991).

—By Michael Schachner

'Hail' of a quarter for insurers

By MYRON M. PICOULT
Special to Business Insurance

MOST INSURERS HAVE reported their second-quarter earnings, although we do not yet have complete backup data.

Two things are fairly obvious: On balance, reported operating earnings were a little better than expected; and it was one "hail" of a quarter.

For the three months ended June 30, catastrophe losses as reported by the Property Claim Services division of the American Insurance Services Group rose 122.7% to \$3.04 billion from \$1.36 billion in the comparable period a year ago. For the six months ended June 30, total catastrophe losses rose 75% to \$3.62 billion from \$2.07 billion in first-half 1991 (BI, July 27). Both the second-quarter and six-month figures were records.

Viewed another way, the 1992 six-month figure is about 88% of total 1991 catastrophe losses of \$4.18 billion. That was the second-worst year on record, exceeded only by the \$7.28 billion drubbing in 1989.

Mother Nature continues to wreak havoc. Through the first two weeks of July, the AISG has reported additional catastrophe losses of \$220 million. This already buries the July 1991 figure of \$75 million and makes one devil of a dent in the 1991 third-quarter figure of \$695 million.

Put another way, the six-month total and the July figures to date approximate 93% of last year's catastrophe losses.

Catastrophe losses are basically property losses that are paid out fairly quickly. While some claims disputes arise from time to time, they are normally soon resolved.

As we have noted in the past, the industry's cash flows in general are under pressure because of the impact of federal tax payments, the poor underwriting trends and a very sloppy pricing environment, primarily in the standard commercial lines sphere. Hence, an increase in catastrophe losses exacerbates the situation,

which we view as a positive. Our sense is that the bulk of the reported catastrophe losses will again be eaten by the primary companies that have raised their retention levels over the past few years.

Some of the losses will flow over to the London market, which is already awash in problems. Reinsurers will also pick up some share of the losses, but again, the bulk of the damage will likely fall on the primary insurers.

It will be interesting to see how many primary insurers will blow through parts of their reinsurance covers, as was the case with SAFECO Corp. on losses incurred from the 1991 Oakland, Calif., fires. This could spur some return to pur-

underwriting cycle is an exercise in futility. Nonetheless, we believe we are going through the bottoming-out process.

It remains to be seen if catastrophe losses for specific insurers will prod them into using the remainder of 1992 to "clean up their acts" in terms of addressing various balance sheet discrepancies. Although no one wants to be the first to hang their dirty linen out on the line, the laundry basket is starting to overflow.

Our investment posture remains unchanged in that we remain positive on a handful of insurers whose common characteristics include a strong balance sheet and underwriting expertise. Relative valuations remain quite attractive and, for the most part, the stocks have underperformed the popular stock market averages.

Quality is really going to count this time around. The risks are lower and longer-term growth is much better. The stock price capital gains potential should be better in the first one or two years of the upward movement in the pricing cycle. And corporate orientation is much more consistent.

The underwriting spreads between the stronger insurance companies and the weaker insurers have widened as the down leg of this underwriting cycle has dragged on. Our guess is that the situation will continue to erode.

Exacerbating the situation are the hidden costs of consolidation and personnel dislocations being experienced by some insurers. We continue to believe that all insurers will not be created equal this time around.

Although no one wants to be the first to hang their dirty linen out on the line, the laundry basket is starting to overflow.

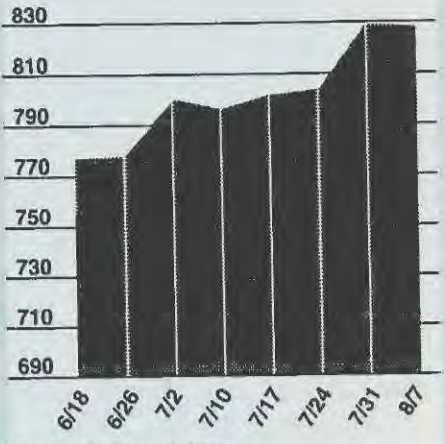
chasing more reinsurance. We expected few positive second-quarter earnings surprises. As previously noted, we were wrong!

Many results have been somewhat better than expected as insurers fiddle with reserve additions. Commutations also appear to be gaining momentum as a means of producing some cash and instant profits.

Notwithstanding some of the shenanigans, some observers are correctly reducing their earnings estimates. Once again, the worse the figures are, the better in that it would seem to portend that we are closer rather than further from a market turn.

The 62-cent question is obviously whether these first-half catastrophe losses will trigger the long-awaited turn in the insurance industry's underwriting (pricing) cycle. Trying to pick the turn in the

BI Insurance Index



Base = 100 on Dec. 29, 1978
Source: Nordby International Inc.

Insurance industry stocks leveled off last week, as the Business Insurance Index dropped 0.5 points to 828.4 on Aug. 7 from 828.9 on July 31. Advancing issues were led by Frontier Insurance Group, up 12.8%; Poe & Associates, up 8.0%; and HMO America Inc., up 7.4%. Declining issues followed Safeguard Health Enterprises, down 18.4%; US Facilities Corp., down 17.8%; and USF&G Corp., down 9.9%. The most active issue was U.S. Healthcare, 4.4 million shares traded. The BI Index was down 0.1%; the NYSE Composite was down 1.0%; the Standard & Poor's 500 was down 1.3%; and the Dow Jones 30 Industrials fell 1.8%.

British Issues

Aug. 6 Companies	Price pence	P/E	Div. pence	Yield %	1 Week	
					High	Low
Comm Union	435	N/M	31.5	7.2	446	435
Genl Accident	385	N/M	35.7	9.3	371	385
Gdn Royal Exch	116	N/M	10.0	8.6	126	116
Royal	184	N/M	15.0	8.2	185	184
Sun Alliance	258	N/M	19.0	7.4	260	257
Brokers						
Bradstock	119	13.4	6.3	5.3	120	119
CE Health	317	18.3	34.5	10.9	319	317
Hogg Group	134	8.1	10.9	8.1	135	133
JIB Group	127	9.4	10.0	7.9	130	127
Lloyd Thompson	187	18.5	6.0	3.2	185	184
Lowndes Lmbt	270	10.5	16.8	6.2	271	270
PWS Holdings	36	4.0	5.3	14.7	39	36
Sedgwick Grp	169	13.2	16.0	9.5	170	168
Steel Brl Jones	204	10.1	17.7	8.7	205	204
Willis Coroon	207	13.1	17.6	8.5	218	207

Source: Philip Olsen, Insurance Industry Analyst, London



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BI Industry Stock Report

AUGUST 3, 1992 THROUGH AUGUST 7, 1992

	Price	Weekly % change	Year to Date % change	Annual		Vol.(000)	\$ Div.	% Yield	P/E	Book value	Mkt/Bk. value	Price	Weekly % change	Year to Date % change	Annual		Vol.(000)	\$ Div.	% Yield	P/E	Book value	Mkt/Bk. value		
				High	Low										High	Low								
BROKERS																								
Alexander & Alexander	NYS	24.38	-0.51	18.90	24.88	18.00	344	1.00	4.10	102	13.10	1.86	26.50	2.91	20.45	28.25	17.50	28	0.00	0.00	7	15.59	1.70	
Gallagher Arthur J. & Co	NYS	24.75	2.06	10.61	25.50	19.00	47	0.64	2.59	18	5.88	4.21	28.88	0.43	-14.23	37.75	21.13	197	0.24	0.80	20	-	-	
Frank B. Hall	NYS	3.00	4.35	-29.41	5.50	2.63	366	0.00	0.00	-3	1.95	1.54	20.88	6.37	N/A	23.63	17.00	80	0.12	0.57	11	N/A	N/A	
Hill, Rogal & Hamilton	NYS	13.88	2.78	4.72	15.50	11.00	109	0.40	2.88	22	3.56	3.90	33.50	-3.60	-18.29	48.25	29.50	11	0.00	0.00	19	13.52	2.48	
Marsh & McLennan	NYS	77.88	0.00	-4.30	83.75	70.00	576	2.68	3.44	18	28.00	2.78	5.00	-2.44	25.00	6.00	3.50	114	0.00	0.00	3	7.76	0.64	
Poe & Associates	OTC	13.50	8.00	12.50	16.00	11.00	0	0.40	2.96	17	2.82	4.79	42.13	2.74	35.34	43.75	20.25	98	1.48	3.51	12	62.65	0.67	
BROKERS AVERAGE																								
2.8																								
CONGLOMERATES & HOLDING COMPANIES																								
Berkley W.R. Corp.	OTC	35.00	-0.36	14.75	36.25	23.50	160	0.36	1.03	12	36.95	0.95	6.00	0.00	0.00	27.50	18.00	192	1.00	3.64	12	39.50	0.70	
Berkshire Hathaway Inc	NYS	9850.00																						
ITT (Hartford Group)	NYS	67.75	-0.18	17.32	70.63	50.00	1297	1.84	2.72	13	112.05	0.80	12.88	-0.96	-10.43	17.50	12.50	15	0.24	1.86	16	16.07	0.80	
Sears (Allstate)	NYS	40.25	0.63	6.27	48.00	32.50	3393	2.00	4.97	11	34.50	1.17	4.88	-2.50	18.18	5.88	3.50	283	0.32	6.56	3	6.40	0.76	
CONGLOMERATES AVERAGE																								
0.9																								
INSURERS/REINSURERS																								
AEGON N.V.	NYS	37.00	0.34	5.71	37.75	27.38	33	1.14	3.08	7	N/A	N/A	21.25	-1.16	19.72	22.50	15.00	255	0.40	1.88	8	33.09	0.64	
Aetna Life & Casualty	NYS	42.75	-1.44	-2.84	47.00	31.88	690	2.76	6.46	13	87.60	0.49	37.88	3.77	19.76	38.13	27.25	94	0.92	2.43	6	43.50	0.87	
Allied Group Inc.	OTC	25.63	5.67	50.74	26.25	18.25	81	0.64	2.50	8	19.85	1.29	11.88	-1.04	13.10	12.25	8.50	10	0.20	1.68	29	13.30	0.89	
American General	NYS	49.38	0.77	10.96	50.25	38.13	747	2.08	4.21	11	60.00	0.82	27.50	5.77	18.28	27.50	18.00	192	1.00	3.64	12	39.50	0.70	
American Heritage Life Ins.	NYS	30.88	-0.80	0.82	32.25	20.81	1	0.84	2.72	15	N/A	N/A	12.88	-0.96	-10.43	17.50	12.50	15	0.24	1.86	16	16.07	0.80	
American Indemnity/Fin'l	OTC	5.75	2.22	21.05	9.25	4.50	1	0.08	1.39	8	12.93	0.44	27.50	5.77	18.28	27.50	18.00	192	1.00	3.64	12	39.50	0.70	
American International	NYS	95.63	-0.39	-2.80	99.38	78.63	1005	0.56	0.59	13	99.30	0.96	12.88	-0.96	-10.43	17.50	12.50	15	0.24	1.86	16	16.07	0.80	
Aon Corp.	NYS	45.50	-2.15	14.83	49.75	34.75	453	1.68	3.69	12	39.70	1.15	4.88	-2.50	18.18	5.88	3.50	283	0.32	6.56	3	6.40	0.76	
Argonaut Group	OTC	29.75	5.31	25.28	30.25	21.75	47	0.84	2.82	8	20.96	1.42	20.75	-0.60	25.78	21.25	13.25	21	0.49	2.31	9	14.41	1.44	
AVEMCO Corp.	NYS	25.13	-1.47	0.50	28.00	21.25	14	0.40	1.59	24	9.55	2.63	20.75	-0.60	25.78	21.25	13.25	21	0.49	2.31	9	14.41	1.44	
Baldwin & Lyons Inc.	OTC	31.50	1.61	22.33	31.88	22.75	3	0.28	0.89	8	24.29	1.30	80.75	-2.93	2.40	80.75	57.13	250	2.72	3.64	7	86.60	0.86	
Chandler Insurance	OTC	4.75	-9.52	46.15	7.63	2.13	24	0.00	0.00	43	5.95	0.80	74.63	-2.93	2.40	80.75	57.13	250	2.72	3.64	7	86.60	0.86	
Chubb Corp.	NYS	77.88	-0.16	1.14	78.00	60.75	945	1.60	2.05	12	72.95	1.07	53.38	-1.42	6.92	53.38	35.50	1344	1.64	3.15	13	51.65	1.01	
CIGNA Corp.	NYS	54.50	-0.46	-10.84	61.75	41.25	409	3.04	5.58	11	117.15	0.47	18.88	0.76	7.32	18.88	13.13	28	0.28	1.70	9	11.19	1.47	
CNA Financial Corp.	NYS	92.38	1.23	-5.74	104.50	76.25	77	0.00	0.00	9	70.23	1.32	6.00	0.00	9.09	6.75	4.00	95	0.36	6.00	-3	10.60	0.57	
Continental Corp.	NYS	34.13	2.63	23.53	34.13	23.25	495	2.60	7.62	29	40.00	0.85	16.50	0.76	6.92	18.88	13.13	28	0.28	1.70	9	11.19	1.47	
EXEL Ltd.	NYS	35.25	-5.69	-6.00	40.25	27.38	952	0.92	2.61	8	N/A	N/A	6.00	0.00	9.09	8.75	4.00	95	0.36	6.00	-3	10.60	0.57	
Fund American Corp.	NYS	68.50	0.00	-1.97	70.50	62.50	67	0.68	0.99	18	36.11	1.90	22.00	-4.35	31.34	23.50	15.00	162	1.12	5.09	9	30.75	0.72	
Fremont General Corp.	OTC	23.75	2.70	-2.56	26.00	17.00	110	1.00	4.21	6	45.55	0.52	22.00	-4.35	31.34	23.50	15.00	162	1.12	5.09	9	30.75	0.72	
Frontier Insurance Group	NYS	39.75	12.77	47.22	39.75	19.91	164	0.56	1.41	15	26.65	1.49	22.25	-1.11	2.89	23.75	17.25	1210	1.60	7.19	8	59.00	0.38	
Gaisco Inc.	ASE	20.13	5.23	43.75	20.13	10.25	149	0.04	0.20	20	3.37	5.97	22.25	-1.11	2.89	30.75	23.00	53	0.72	2.46	10	21.71	1.35	
General RE Corp.	NYS	90.63	3.57	-11.04	104.75	77.50	1411	1.80	1.99	12	78.65	1.15	39.75	-0.60	32.50	41.34	28.00	2	1.00	2.52	11	35.39	1.12	
Guaranty National Corp.	NYS	17.75	3.65	22.41	18.25	12.63	174	0.48	2.70	12	N/A	N/A	39.75	-0.60	32.50	38.50	31.00	580	1.20	3.27	13	37.23	0.99	
Hanover Insurance Co.	OTC	39.25	0.64	9.79	42.75	27.75	127	0.44	1.12	9	37.44	1.05	44.88	1.13	10.80	45.00	28.81	443	0.64	1.43	13	37.70	1.19	
Hartleysville Group	OTC	22.75	1.11	7.06	23.25	16.75	188	0.64	2.81	9	22.99	0.99	9.25	-17.78	-37.82	19.00	8.63	766	0.00	0.00	6	9.58	0.97	
Hartford Steam Boiler	NYS	57.38	2.46	-0.22	58.75	45.13	71	2.90	3.49	17	35.50	1.62	12.50	-9.91	72.41	15.00	5.63	1784	0.20	1.60	-14	12.30	1.02	
Kemper Corp.	NYS	25																						

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