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Update

Insurers blast Garamendi for order to refund $2.5 billion

LOS ANGELES—Insurer groups are calling California Insurance Commissioner John Garamendi's plan to order property/casualty insurers to refund $2.5 billion to meet the Proposition 103 rate rollback mandate "a sham" that sidesteps the problems driving up insurance costs.

Individual insurers are likely to mount court challenges once they receive their rollback orders, say the Assn. of California Insurance Cos. and the American Insurance Assn.

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Court revamps claimant priority

Feds lose precedence in insolvency

By DOUGLAS McLEOD

CINCINNATI—The federal government does not have priority over other policyholders when pressing claims against an insolvent insurer's estate, a federal appeals court has ruled.

A panel of the 6th U.S. Circuit Court of Appeals ruled 2-1 that the Ohio Insurance Department's liquidation of American Druggists' Insurance Co. constitutes regulation of the "business of insurance" under the McCarran-Ferguson Act, meaning that state liquidation law takes precedence over a federal statute that would make the government a top-priority claimant.

The U.S. Treasury Department—which filed between $7 million and $9 million in claims against American Druggists' in connection with various performance, payment and immigration bonds—will now have to stand in line with other creditors, said James R. Rishel, a lawyer representing Ohio Insurance Commissioner Harold T. Duryee.

"It's a significant decision for the liquidator," said Mr. Rishel, who is with the Columbus firm of Rishel, Myers & Kopech. "If

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Huge tax hikes to fund Rostenkowski's plan

By JERRY GEISEL

WASHINGTON—Universal health care legislation introduced by Rep. Daniel Rostenkowski, D-Ill., would sock both employers and employees with billions of dollars in new taxes and add enormous administrative burdens on employers.

But, the proposal also would give the federal government new authority to hold down hospital and physician cost increases and would shift a substantial-but-unknown amount of retiree health care costs from employers to the government.

Rep. Rostenkowski, the powerful chairman of the House Ways and Means Committee, introduced his measure, H.R. 3205, earlier this month. Its full text only became widely available last week.

Rep. Rostenkowski acknowledges that the proposal is not his final word on universal health care legislation.

As benefit experts scour the fine print of the 196-page bill, the "Health Insurance Coverage and Cost Containment Act of 1991," they are discovering buried bombshells that would prove explosive for employers.

Notification standards are one example. Employers with health care plans would be required to inform the federal government each time an employee dropped the coverage—like when a person changes companies—and each time an employee joined their plan.

In addition, employers would have to provide employees with a detailed accounting of how much of their deductible and coinsurance requirements had been when coverage is dropped.

The measure would impose a slew of new taxes on both employers and employees to pay for basic health coverage as well as expanded Medicare benefits.

Under the "play or pay" provision, employers not offering a health care plan with certain federally specified benefits would face a new tax. This tax, intended to help fund a new public health plan for the uninsured, would be set at 9% of employee wages, up to the Medicare wage base. And employees could be required to pay up to 20% of the new tax.

But if the 9% tax proves inadequate to pay for universal coverage for uninsureds, the measure calls for a surtax, initially set at 6% and gradually rising to 9%, on corporate and individual taxpayers.

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'A new global broker'

Hudig acquisition would boost RBH to No. 6 in world

By DOUGLAS McLEOD and GAVIN SOUTER

CHICAGO—Rollins Burdick Hunter Group Inc. will vault into the ranks of the global insurance brokerages when it completes its proposed acquisition of Hudig-Langeveldt Group bv of the Netherlands.

"This is the creation of a new global broker," said Patrick G. Ryan, chairman of RBH and its parent, Aon Corp. of Chicago.

RBH last week formally offered to purchase Hudig-Langeveldt. While terms were not released, securities analysts estimate the value of the deal at $150 million to $200 million.

The offer has been approved by the Rotterdam-based broker's executive and supervisory boards. The two companies hope to draft a definitive acquisition agreement within three months.

The agreement still must be approved by Hudig-Langeveldt's shareholders, which include Marsh & McLennan Inc., the world's largest brokerage. M&M, which announced it would sell its 30% stake in Hudig-Langeveldt after the Dutch broker rebuffed M&M's offer to purchase a controlling interest, said last week it had reached a preliminary agreement to sell its shares to RBH.

The Hudig-Langeveldt buyout would create the world's sixth-largest brokerage, propelling RBH, which is now ranked No. 7, past Frank B. Hall & Co. Inc. Combined, RBH and Hudig-Langeveldt reported 1990 revenues of $516.9 million, compared with Hall's $443.1 million (see chart).

However, the RBH/Hudig-Langeveldt combination would fall far

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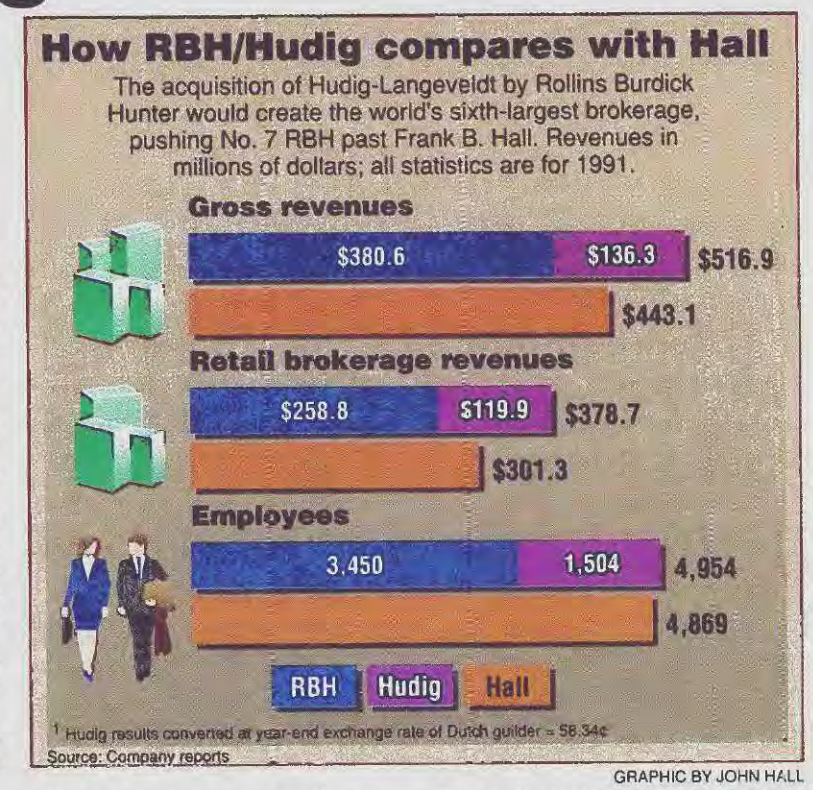

GRAPHIC BY JOHN HALL

Sour economy, soft market hurt brokers' profits

By MICHAEL SCHACHNER

Another semester of soft commercial property/casualty market conditions combined with reduced consulting revenues caused midyear earnings to drop at all but two of the major publicly traded U.S. insurance brokers.

Brokerage executives and securities analysts say the deadly combination of low premium rates and the recession, which has caused many clients to cut back on insurance-related products and services, severely hampered broker earnings throughout the first half of 1991.

And, experts agree that a swing in market conditions, which would certainly improve brokers' fortunes, will probably not occur until well into next year.

Although reinsurance operations and acquisitions helped fuel increases in first-half gross revenues at all of the major brokers, low commissions, reduced consulting income and high expenses ate into the earnings of most of the companies.

Only Marsh & McLennan Cos. Inc., the world's largest broker, and Poe & Associates, the smallest of the publicly held brokers, posted increased profits in the first half of 1991.

Other brokers saw net income plummet by 4% to 30%.

"Aggregate pricing was flat to down 5%. Unfortunately, there have been no positive changes in the commercial insurance environment," said J. Michael Bischoff, vp of corporate development with M&M in New York.

"We're trying to operate as sane people in an insane world," observed Donald R. Bell, chairman and chief executive officer of New York-based Frank B. Hall & Co. Inc. "As brokers, we have to look

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Court denies cleanup cover despite earlier, contrary ruling Page 2

Insurers applaud Bush plan for reforming tort system Page 3

Risk managers helping frats reduce their loss exposure Page 3

Update

California seeks big rate refund

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Mr. Garamendi said last week that he has asked the Office of Administrative Law to approve regulations requiring insurers to issue refunds if the rate of return on their combined business between November 1988 and November 1989 exceeded 10%.

Under Proposition 103, the ballot initiative spurred by high auto insurance rates in California and approved by voters in November 1988, insurers were mandated to roll back most property/casualty insurance "charges" to 20% below November 1987 levels. The California Supreme Court subsequently upheld the rollback mandate but ruled that insurers are entitled to a fair rate of return (*BI*, May 8, 1989).

When Mr. Garamendi took office in January, he threw out regulations that his predecessor had issued to implement Proposition 103, which set a benchmark 11.2% rate of return for rollback purposes and a range of 11.2% to 19% in determining future rates (*BI*, June 18, 1990).

Highlighting the politically charged problem that gave birth to Proposition 103, Mr. Garamendi said that the average auto insurance portion of the refunds will be "something over $100 per car."

But these regulations "ignore legal and economic reality while needlessly raising the expectations of consumers that relief from high auto rates is on the way," the AIA said, calling the rules "a sham."

Mr. Garamendi's regulations are "a doomed attempt to paper over the real auto insurance crisis: skyrocketing legal and medical costs," agreed Thomas Aceituno, ACIC vp and general counsel.

Harvey Rosenfield, head of Voter Revolt, the organization that sponsored Proposition 103, applauded the proposed order but said he will "press the commissioner for larger rollbacks" because related regulations to improve insurers' efficiency are not tough enough.

Insurer with BCCI link restricted

LOS ANGELES—California regulators have ordered a small insurer linked to scandal-plagued Bank of Credit & Commerce International S.A. to stop writing new and renewal business and barred unapproved transactions with its parent company.

Tri-Star Insurance Co. of Studio City, which regulators say is threatened with insolvency, and its parent, American Specialty Insurance Co. of Atlanta, are ultimately owned by Ghaith Pharaon, a Saudi Arabian financier whom the Federal Reserve alleges was BCCI's U.S. front man.

"We have moved quickly to avoid the risk of Tri-Star's capital flowing to Ghaith Pharaon's empire and to protect the innocent policyholders who would have unwittingly become entangled in the scandalous BCCI web," said Insurance Commissioner John Garamendi.

But, Tri-Star President Noshir Lackdawalla called the department's action "quite misleading." He said the company decided in March to voluntarily run off its business and had informed regulators.

The insurer, which reported $9.7 million of direct written premiums in 1989, mostly wrote multiperil coverages for auto dealerships and auto repair garages. It wrote only $1.85 million of workers compensation business in 1989, but recent workers comp losses were "disastrous," Mr. Lackdawalla said.

Tri-Star reported having 1,364 policyholders as of July and $1.5 million of "adjusted" surplus. Regulators adjusted the surplus after re-evaluating its real estate holdings, "questionable receivables from affiliates" and goodwill. California sets a minimum surplus of $2.5 million.

Railroad hit with suit over spill

REDDING, Calif.—Local sports fishing organizations have filed a "junk bond toxic spill" lawsuit against Southern Pacific Transportation Co. and other defendants in connection with a train derailment near the Sacramento River last month.

The suit, which seeks class-action status, charges that the railroad curtailed maintenance because it was not producing enough revenue to pay debts related to its highly leveraged buyout by Denver billionaire Philip Anschultz.

The 1988 purchase was accomplished with the sale of $200 million in junk bonds and a $700 million bank loan, according to the suit, filed in Shasta County Superior Court by the law firm Cotchett, Illston & Pitre in Burlingame, Calif.

The suit calls for the railroad to set up a public trust fund administered by sports fishing organizations to pay for cleaning up the environmental damage caused when a tank car derailed and was punctured, dumping 13,000 gallons of metam-sodium—a soil fumigant used on farms—into the river. The spill destroyed insect, plant and aquatic life, including 100,000 rainbow trout (*BI*, July 29).

A Southern Pacific spokesman said that "to suggest that the method of financing the company has anything to do with safety is the classic apples and oranges comparison."

In fact, Southern Pacific has spent more than $1.2 billion on upgrading equipment since 1988, he said. And the railroad has received the American Assn. of Railroads' Harriman Award for safety in three of the last five years, he added.

In addition to Southern Pacific, other named defendants include AMVAC Chemical Co.; its parent, American Vanguard Corp. of Los Angeles; GATX Capital Corp., a subsidiary of GATX Corp. in San Francisco and the tank car leasing company; J.M. Huber Co., a New Jersey company with offices in San Francisco that leased the tank car; and the as-yet undetermined designer and maker of the tank car.

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Errors & omissions

• The London Agency Inc.'s Tampa, Fla., office—not the office of subsidiary Floyd West & Co.—was closed in 1990, with some of its underwriters relocated to Atlanta (*BI*, Aug. 12). Also in 1990, The London Agency's New Orleans office began operating as a branch of Floyd West, servicing Louisiana retail brokers, not wholesalers.

• Midwest Indemnity Corp. of Skokie, Ill., is a managing general agent for five companies, including Indiana Lumbermen's Mutual Insurance Co., National American Insurance Co. and Connecticut Indemnity Co. These three companies were excluded from the Aug. 12 directory of surplus lines wholesalers.

Court reverses itself in cleanup cover ruling

By MICHAEL BRADFORD

PHILADELPHIA—A federal appeals court now says that the costs of cleaning up polluted property are not covered by a comprehensive general liability policy even though it earlier ruled that such costs were covered by another policyholder's policy.

The 3rd U.S. Circuit Court of Appeals applied Pennsylvania law in unanimously upholding a lower court ruling that Meadville, Pa.-based Aardvark Associates Inc. has no coverage to pay the cost of cleaning up two sites.

Yet, only four months earlier, the 3rd Circuit had ruled in a case applying Delaware law that the costs of cleaning up polluted property are "damages" as the term is used in the CGL policy (*BI*, May 6).

One judge, U.S. Circuit Judge Richard L. Nygaard, participated in both rulings.

Aardvark's attorney calls the two rulings a "baffling" development for policyholders.

However, the policyholder attorney in the Delaware case blames differences in Pennsylvania and Delaware state law—not the 3rd Circuit—for the opposing rulings.

In the Aardvark case, the U.S. Environmental Protection Agency notified the waste hauler in 1983 that under the Comprehensive Environmental Resource, Compensation & Liability Act, better known as Superfund, the company was a "potentially responsible party" for the costs of cleaning up two sites.

Aardvark disposed of drums of industrial waste produced by Hugson Chemicals in Seagertown, Pa., at two Ashtabula County, Ohio, sites in 1977 and 1978.

After the EPA notice, Aardvark sought coverage from two of its CGL insurers, Northern Insurance Co. of New York, a unit of Zurich Insurance Co., and Insurance Co. of North America in Philadelphia, a subsidiary of CIGNA Corp.

INA wrote Aardvark's CGL coverage from from 1977 to 1981, while Northern Insurance wrote the coverage from 1981 to 1985.

Northern Insurance, though, denied coverage. It sued Aardvark and INA, seeking a summary judgment that it was not obligated to indemnify Aardvark. INA also later filed suit seeking summary judgment. Both insurers cited their policies' pollution exclusion clauses, which bar coverage for pollution that is not "sudden and accidental."

Aardvark argued for a more restrictive interpretation. It contended that the clause bars coverage only when the pollution is

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Directory of Buyers available

The ninth edition of the *Business Insurance Directory of Corporate Buyers of Insurance, Benefit Plans and Risk Management Services* is now available.

The 1991-1992 edition provides updated information on 2,150 U.S. corporations, including each company's address, telephone number, 1990 sales or assets, number of employees and type of business. Listings identify the chief financial officer, general counsel and executives in charge of risk management, employee benefits, personnel, pension/retirement plans, safety and other related functions.

The directory also includes a geographical index and rankings of companies by number of employees and 1990 sales or assets.

The 1991-92 edition of the *BI* directory costs $95.

To order, contact Dorothy Wood, *Business Insurance*, Directory Copy Sales, 965 E. Jefferson Ave., Detroit, Mich. 48207; 313-446-1623 or 800-992-9970.

The directory also is available on computer tape. For more information, call Denise Matthews, 313-446-1625 or 800-992-9970.

NAIC won't act on plan to review rating agencies

By MICHAEL SCHACHNER

BISMARCK, N.D.—The National Assn. of Insurance Commissioners does not plan to consider North Dakota Insurance Commissioner Earl Pomeroy's suggestion that it impose controls on insurer rating services, a spokesman said.

However, several rating agencies said they do not object to the idea of NAIC oversight, first publicly broached by Mr. Pomeroy earlier this month at a Chicago conference sponsored by rating agency A.M. Best Co.

Mr. Pomeroy, the NAIC's immediate past president, recommended that the regulatory group develop core criteria that rating agencies must use in developing ratings for insurers. Rating agencies that comply would be NAIC-certified raters. The NAIC could withhold computerized insurer financial information from raters that do not comply with the NAIC's rating methodology.

But, the NAIC spokesman noted that "the NAIC is not in the business of talking about rating agencies. From what we have heard, this is only Earl Pomeroy's position and there is no current plan for moving on these proposals."

Individual regulators were reticent to discuss Mr. Pomeroy's recommendations.

A spokesman for New York Insurance Superintendent Salvatore Curiale said Mr. Curiale could not comment on the proposals because Mr. Pomeroy's suggestions are "too new, have been made informally and must be discussed in further detail."

A spokesman for North Carolina Insurance Commissioner and current NAIC President James E. Long also said that Mr. Long could not comment on Mr. Pomeroy's suggestions because of their "informal nature."

And, a spokeswoman for New Jersey Insurance Commissioner Samuel Fortunato said that Mr. Fortunato would only say that he believes the rating agencies should "sharpen their pencils."

Mr. Pomeroy, who stressed in an interview that his proposals are "my own views that not all NAIC members agree with," said that the NAIC does not know as much about how the rating agencies formulate their opinions as it should.

The NAIC "needs to better investigate the rating companies because ratings play a significant role in insurer solvency and consumer confidence," he said.

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Inside

✔ Employers and insurers must act quickly to stem the tide of state laws that curb managed health care plan options, says this week's editorial. **PAGE 8**

✔ Employers in the 1990s must focus on human resource issues because 'people will be the assets' that differentiate companies in the next few decades, a consultant says at the Corporate Benefits Management conference. Coverage begins on **PAGE 12**

✔ Candidates seeking the Chartered Property & Casualty Underwriter designation will have to fulfill some new requirements beginning in 1992. **PAGE 21**

✔ In Perspectives, Douglas C. Cave and Lesa M. Vidovic of Hewitt Associates look at the impact of the new Medicare fee schedule on medical plan costs. **PAGE 24**

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Quayle calls for civil justice changes

Proposal ties tort reforms to competitiveness

By CARY ROBERTS

WASHINGTON—The insurance industry is applauding the Bush administration's civil justice reform recommendations, though a few tort reform advocates say that many of the proposals are either impractical or offer nothing new.

Vice President Dan Quayle highlighted some of the 50 civil justice reform recommendations made by the President's Council on Competitiveness, which the vice president heads, in a speech at the annual American Bar Assn. meeting last week in Atlanta last week.

"Let's ask ourselves: Does America really need 70% of all the world's lawyers? Is it healthy for our economy to have 18 million new lawsuits coursing through the system annually? Is it right that people with disputes come up against staggering expense and delay?" asked the vice president.

John J. Curtin, Jr., president of the Chicago-based American Bar Assn., wasted little time in responding.

"Anyone who believes a better day dawns when lawyers are eliminated bears the burden of explaining who will take their place —who will protect the poor, the injured, the victims of negligence, the victims of racial discrimination and the victims of racial violence," Mr. Curtin argued.

Mr. Quayle responded, "Nobody is talking about eliminating lawyers. Nobody is talking about not allowing for individuals to have their day in court. So, let's not be extreme about this.

"Let's focus on the very fundamental problem, and that is that we should challenge the status quo. And, I'm convinced that we can have a better legal system in America if we sit down and work together," the vice president said.

The administration's civil justice reform proposals calls for changes in several areas, including:

• Punitive damages. Plaintiffs should not be allowed to sue for specific dollar amounts. Trial judges—rather than juries—should

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AP/Wide World Photo

Vice President Dan Quayle's call for tort reform proposals receives a cool reception from American Bar Assn. President John J. Curtin.

Photo by Mary Herlehy

The Lambda Chi Alpha chapter at Northwestern University.

Fraternities get lessons in risk control

By CARY ROBERTS

College fraternities—notorious for mischievous pranks, consuming huge quantities of alcohol and hazing pledges unmercifully—can be a risk management nightmare.

However, many national fraternities are trying to shed those stereotypes and minimize their liability exposures with the help of full-time risk managers.

Up until the mid-1980s, most national fraternities did not purchase liability or property insurance for their various undergraduate chapters, leaving each individual chapter responsible for its own coverage.

Then, "the hard market conditions and increased liability claims of fraternities" created sky-high premiums that individual chapters could not afford, and those that could purchase coverage were often canceled after a year, explained Geoffrey Carter, program director of Sigma Chi Fraternity's Risk Management Foundation, a non-profit educational foundation based in Evanston, Ill.

In addition to the hard market of the mid-1980s, "fraternities were the targets of increased criticism and lawsuits when states began raising their drinking age to 21. After the age increase, at any given fraternity party, two-thirds to three-fourths of the college students were underage," observed Thomas Schneider, assistant executive director of Champaign, Ill.-based Alpha Tau Omega Fraternity and head of its risk management program.

"Fraternities wanted to be responsible and respond to the change," he said.

Joseph Giordano, president of Reliance Special Risks in Philadelphia, a unit of Reliance Insurance Co., said the insurer has in the past accepted fraternities, including Alpha Tau Omega and Sigma Alpha Epsilon National Fraternity, as underwritable risks if they have a strong national risk management program with the ability to communicate risk management policy to local chapter presidents. However, he said, Reliance Special Risks has "identified the four or five fraternities and sororities that meet our criteria. We are not looking for any more."

Many national fraternities came to the rescue of their individual chapters by purchasing general liability and property policies that covered the chapters and their individual members. Previously, most national organizations only covered their own property and directors, officers and alumni volunteers.

At the same time, many national fraternities hired risk managers to coordinate and manage the new fraternity-wide insurance poli-

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New 401(k) plan rules to hike employer costs

By JERRY GEISEL

WASHINGTON—Final Internal Revenue Service 401(k) rules will complicate administration of the plans and add new costs for employers that cover both union and non-union employees in the same 401(k) plan.

When union and non-union employees are covered under the same 401(k) plan, a "disaggregation" provision in the new rules will require employers to separately run the basic 401(k) non-discrimination test—known as the actual deferral percentage or ADP test—on the two different groups.

And, if a 401(k) plan covers employees represented by different unions, the ADP test would have to be run separately on each collectively bargained unit.

For example, if a 401(k) plan covered salaried employees as well as employees represented by four different unions, the ADP test would have to be run five times.

"Disaggregation is a double whammy. First, you have to separate the collectively bargained employees. Then, you have to test each collectively bargained unit," said Henry Saveth, a principal with A. Foster Higgins & Co. Inc. in New York.

The IRS rules, published in the Aug. 15 issue of the Federal Register, also will eliminate, effective in 1992, a popular technique that has made it easier for 401(k) plans to pass the tough IRS non-discrimination tests and for highly paid employees to contribute hundreds of dollars more to their 401(k) plans (*BI*, Aug. 12).

That technique, known as 401(k) restructuring, has been used by between 15% and 20% of 401(k) plans since last year when the IRS gave employers the go-ahead to restructure their 401(k) plans.

Other provisions in the new IRS rules, though, will simplify 401(k) administration as well as increase the attractiveness of the plans to employees.

For example, proposed IRS regulations issued in 1988 said that in-service hardship withdrawals of 401(k) contributions for educational expenses only could cover tuition for one semester or academic quarter.

The final rules, though, permit hardship withdrawals to cover educational expenses for an entire year, which will reduce the number of hardship withdrawal requests.

In addition, when calculating the amount of money that needs to be withdrawn to meet a financial hardship like educational expenses, uninsured medical bills and the downpayment on a primary residence, the amount can be "grossed up" to offset taxes that

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Impact of state laws on quality in dispute

Curbs on managed care hike health costs: Study

By JOANNE WOJCIK

A new study confirms employers' suspicions that pro-consumer state laws governing some managed care activities can boost the cost of health care.

However, supporters of such laws maintain that the measures are necessary to assure that cost containment features of employer-sponsored health care plans do not jeopardize the quality of care.

The study, "Cost Analysis of State Legislative Mandates on Six Managed Health Care Practices," is believed to be the first effort to quantify the potential financial impact of legislation that would restrict managed care activities, according to Dr. Roger Taylor, national health care leader at The Wyatt Co. The benefit consulting firm conducted the study, which was sponsored by the Health Insurance Assn. of America, an insurer trade group in Washington, D.C.

The study's findings were based on 1991 data from five employers, 29 preferred provider organizations and seven utilization review organizations.

Among Wyatt's findings were that legislation:

• Mandating that "any willing provider" be permitted to join a managed care network could increase the network's administrative costs by 34% and claims costs by 8.8%.

'The study substantiates what some employers have suspected all along,' says Ms. Canner.

• Eliminating the use of "gatekeeper" physicians in preferred provider organizations would erase the 6.8% cost savings associated with the utilization management function of the primary care physician.

• Requiring that local utilization review be performed by professionals licensed in that state and that denial reviews be conducted by physicians of the same specialty as the attending physician would increase administrative costs for centralized UR firms by 42.5% in the first year.

• Mandating that operating hours of UR organizations be extended to 24 hours a day seven days a week would increase overall UR administrative costs between 44% and 47%, depending on how many hours a firm currently operates.

• Requiring state-specific statistics on the activities of UR organizations would increase annual UR administrative expenses by $10,000 to $50,000 for each state requiring such reporting.

• Limiting the reduction in reimbursement when care is obtained from non-preferred providers rather than network providers to 20% instead of the current average of 30% would reduce the number of patients steered to network providers and, thus, increase claims costs.

"The study substantiates what some employers have suspected all along," said Sharon Canner, assistant vp-industrial relations for the National Assn. of Manufacturers, a business lobbying group in Wash-

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Tort reforms

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determine the amount, which should not exceed the level of compensatory damages awarded.

- "Loser pays" rules. In some federal cases, the loser should pay the winner's court costs.
- Alternative dispute resolution. Litigants should be able to resolve their disputes outside of the courtroom through other means like mediation and arbitration. Out-of-court settlements should be encouraged by penalizing parties who refuse reasonable offers.
- Discovery. The amount of information that attorneys can gather from their opponents before trial should be limited. After exchanging certain basic information, parties should have to cover the costs of additional fact finding. Mandatory sanctions should be imposed on attorneys who use discovery to delay trials or harass their opponents.
- Summary judgment. When a case has no disputed facts, judges must grant summary judgment or explain why they didn't.
- Expert witnesses. Experts should be supporting theories that carry some degree of acceptance in the relevant field. Contingency fees paid to experts in return for their testimonies should be eliminated.

While many of the proposals would require changes in state or federal law or amendments to the Federal Rule of Civil Procedure, some of the proposals could be implemented by individual federal judges.

"Overall, the recommendations are positive and should be implemented at the state and federal level," said Patrick Bates, vp of public affairs at the Des Plaines, Ill.-based National Assn. of Independent Insurers.

"The recommendations are pretty common sense and overdue," agreed Keith Like, executive vp at Kemper Corp. in Long Grove, Ill.

"Our problem is not so much with the academic foundation upon which our legal system is based, but with some current practices" like punitive damage awards that are thousands of times greater than compensatory awards, he said.

Insurers would stand to gain from a cap on punitive damages and also from the restrictions on pretrial discovery, which is "big-dollar stuff and requires large sums each year," Mr. Like asserted.

But most important to insurers may be a "loser pays" rule, which would deter many suits, he said.

Insurers will immediately feel some effects of the administration report, said Tom O'Day, associate vp in the Washington, D.C., office of the Alliance of American Insurers.

It will "focus needed attention on the root causes of loss costs for insurers and businesses alike," he said. More than 50% of liability costs can be attributed "not to the awards granted" but to legal expenses, he said.

Also, the report will "direct attention away from the almost unhealthy preoccupation with insurance regulation as a panacea" for all of the industry's troubles, showing that there are other "underlying problems," Mr. O'Day added.

Specifically, the recommendations governing out-of-court settlements and summary judgments "are absolutely crucial" for saving money, said Judy Pendell, assistant vp of public affairs at Aetna Life & Casualty Co. in Hartford, Conn. Overall, the proposals would help "preserve our legal system for people who have legitimate claims and help rid the waste," she said.

The American Tort Reform Assn. is very pleased with the report, said President Martin Connor. Calling it an "extremely broad" but "mainstream" proposal, he said the package contains nothing radically new.

Among the individual recommendations, Mr. Connor said stricter discovery rules would have the most impact on the tort system. "The greatest cause of cost and delay in court today is the overuse and abuse of discovery."

He supports the administration's suggestions, but added that similar limitations are currently moving through committees of the Judicial Conference of the United States, a body of federal judges—headed by the chief justice of the United States—that studies legal issues.

Also, "punitive damages are important, but the whole subject has been in ferment for quite a while," he said.

ATRA advocates limiting the amount of punitive damages to $200,000 or four times the amount of compensatory damages, whichever is greater. Mr. Connor called that fair and politically achievable.

However, the best alternative, he said, would be to "measure or calculate a cap on punitive damages by reference to the defendant's benefits" from the tort "and not the plaintiff's harm."

Support for the Bush administration plan was hardly unanimous. In fact, its critics include a pair of strange bedfellows: risk managers and trial lawyers.

Although "it sounds great to hear this from a presidential panel," the recommendations will have "no impact on the insurance industry," said Paul Brown, director of governmental affairs at Risk & Insurance Management Society Inc. in New York.

Voluntary dispute resolution, for example, is not practical for the insurance industry, he claims. "Trying to find an impartial third party in the insurance industry is a joke."

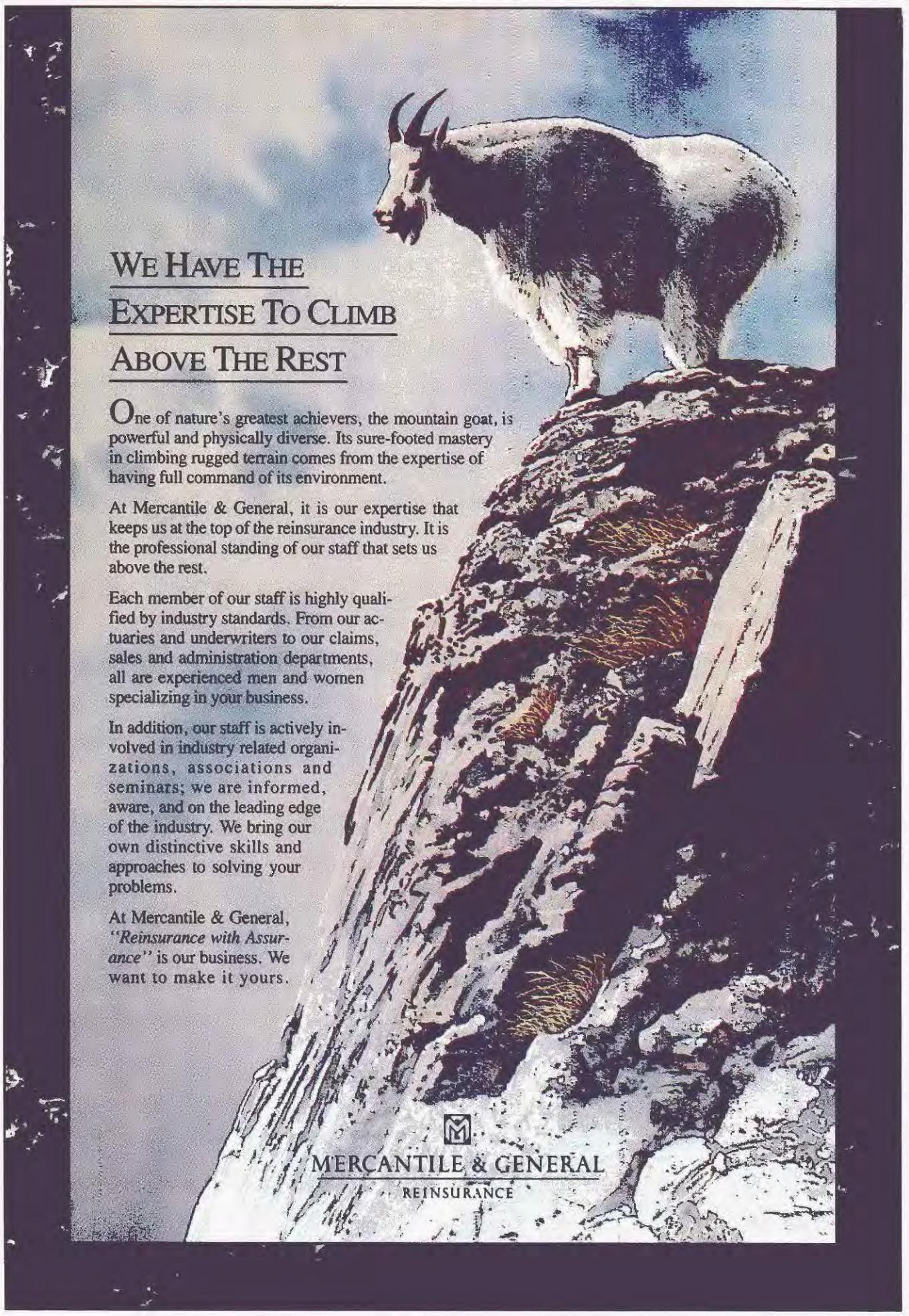
Tort reform, he added, "is really a grassroots movement" and many of the proposals are already in the works due to the efforts of organizations like ATRA and the Product Liability Alliance, another business-backed group seeking reform of product liability laws.

Instead of trying to change the legal system, "We need to make the system we've got now more efficient. Judges must actively monitor and sanction attorneys who abuse it" by holding them in contempt or fining them, he said.

Trial lawyers, for their part, strongly oppose at least two of the recommendations: limiting punitive damages and the "loser pays" rule.

"Capping punitive damages means putting a lid on safety. Why curtail a deterrent that, although rarely applied, can serve to punish those who trade safety for profit, or harm the public through extreme carelessness?" said Bob Gibbins, president of the Assn. of Trial Lawyers of America in Washington, D.C.

And requiring losers to pay winners' legal fees "would also seriously compromise American justice," he said. ■



Rehab, safety listings due

Companies that provide either rehabilitation management services or safety consulting services have one last chance to be listed in separate directories in the Sept. 16 issue of *Business Insurance*, which will feature a Spotlight Report on workers compensation topics.

Rehabilitation management services are defined as all services included in medical management or vocational rehabilitation for employers in workers compensation or liability cases. It is not the delivery of physical rehabilitation or treatment or case management for group health and life cases.

Safety consultants specializing in protecting workers from injury also will be listed.

Companies wishing to be listed in either directory must fill out and return a questionnaire provided by *Business Insurance*. To request one, please call Karen Armaganian at 312-280-3195; fax 312-280-3174. The extended deadline for returning questionnaires is Aug. 26.

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INTRACORP

Ameritech rings in managed care plan

Ameritech is introducing a managed health care plan at six of its major metropolitan centers in an attempt to curb health care cost increases.

The new self-insured indemnity plan with a preferred provider feature is expected to reduce the Baby Bell's rate of projected health care inflation by as much as 24%.

The network is being developed and implemented by Blue Cross & Blue Shield of Illinois and several other Midwestern Blue Cross & Blue Shield organizations.

The Blues also are administering the plan.

More than 7,000 non-union Chicago-area employees are now receiving coverage through the managed care network.

And, by June 1992, the network is scheduled to be up and running for all non-union employees in Detroit; Cleveland and Columbus, Ohio; Indianapolis; and Milwaukee.

Benefit beat

Chicago-based Ameritech has not set a date for when the network will be available to all of the company's non-union employees in Illinois, Indiana, Michigan, Ohio and Wisconsin.

Eventually, 90% to 95% of Ameritech's management personnel are expected to be enrolled in the PPO, according to Roy Leet, Ameritech's director of benefits.

Mr. Leet said the initial metropolitan programs should cover about 65% of the company's non-union workers, with remaining non-union employees in rural areas gaining access to network providers based on availability.

Employees without access to the plan will continue to receive coverage through the company's existing self-insured indemnity plan.

"We're hoping to trim about four or five percentage points off our growth trend," Mr. Leet said.

"Costs have been increasing by 13% to 14% per year in recent years, and we're projecting 17% inflation this year. Our hope is that the network providers will be able to keep inflation down at 13%," he said.

Approximately 7,300 Chicago-based non-union employees—and about 2,000 members of the International Brotherhood of Electrical Workers, who agreed to voluntary enrollment in the managed care plan during past contract negotiations—began receiving care through a network of doctors and hospitals Aug. 1.

Under the plan, non-union employees retain the right to opt out of the network at any time and pay substantially higher costs. However, the union employees enrolled in the PPO do not have opt-out rights.

Plan participants who seek care through a network provider pay a $10 fee for an office visit and $60 toward the cost of a hospital admission. An emergency room visit costs $25, but the fee is applied to the hospital admission cost if the emergency room visit leads to an admission.

The annual out-of-pocket maximum cost for employees who receive care from network providers is $300 for individuals and $600 for families.

Non-union employees who opt out of the network must pay salary-based deductibles and copayments.

For example, a non-union employee earning less than $50,000 pays a $250 deductible for individual coverage and $500 for family coverage.

An employee earning between $50,000 and $85,000 pays a $350 deductible for individual coverage and $700 for family coverage.

For an employee earning more than $85,000 annually, deductibles are $450 for individual coverage and $900 for family coverage.

When non-union employees obtain care from providers outside of the network, Ameritech pays 70% of the network-negotiated fee above the deductibles.

Out-of-pocket maximums above deductibles for non-union employees earning less than $50,000 annually who obtain care from non-network providers are $1,000 for those with individual coverage and $2,000 for those with family coverage.

For non-union employees earning between $50,000 and $85,000, the out-of-pocket maximums are $1,250 and $2,500, respectively. For non-union employees earning more than $85,000, the out-of-pocket maximums are $1,500 and $3,000, respectively.

The new plan also carves out prescription drug benefits, which are currently covered under the indemnity plan.

Deerfield, Ill.-based Baxter Healthcare Corp. will administer the new drug plan, under which 90% of all prescription costs are covered above a $25 individual or $50 family deductible. The out-of-pocket maximum for prescription drugs is $200 for individuals and $400 for a family.

Mail-order maintenance drugs are covered at 100% under the plan.

The new plan replaces a self-insured traditional indemnity plan, under which Ameritech pays 90% of all costs above a $150 individual deductible and a $300 family deductible. Maximum out-of-pocket costs under this plan are $500 for individuals and $1,000 for families.

"We feel that we're giving employees a better medical plan for less money. We looked at the alternatives and this is the plan that doesn't shift costs," Mr. Leet explained.

Ameritech has hired the National Committee for Quality Assurance in Washington, D.C., to perform annual audits of the plan.

Mr. Leet said the Blues have offered financial guarantees on savings as well as performance guarantees on employee satisfaction. However, he declined to provide details of those guarantees.

—By Michael Schachner

New service provider

United Behavioral Systems Inc., the mental health and substance abuse services subsidiary of United HealthCare Corp., will provide counseling and benefit management services to members of plans covered by Blue Cross & Blue Shield of Virginia.

Richmond-based BC/BS of Virginia is the state's largest health insurer, covering more than 1.8 million people. It plans to offer United Behavioral System's services as a product option on group and individual contracts.

Initially, 550,000 enrollees in Blue Cross & Blue Shield of Virginia's PPO products will be eligible for the option.

Minneapolis-based United Behavioral Systems offers assessment and treatment services, health promotion services, education and utilization review.

—By Christine Woolsey

WHEN EMPLOYEES HAVE TROUBLE WITH HEALTH CLAIMS, GUESS WHO GETS STUCK WITH THE BLAME?

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Opinions

Defending managed care

EMPLOYERS AND INSURERS must act quickly to stem the tide of state laws that curb the options of managed health care plans.

As The Wyatt Co. reports in a recent survey, the numerous proposals to restrict the operations of managed care plans would drive up the cost of these plans (see story, page 3).

For example, mandating that "any willing provider" be permitted to join a managed care network could increase the network's administrative costs by 34% and claims costs by 8.8%. Mandating that operating hours of utilization review organizations be extended to 24 hours a day seven days a week would increase overall UR administrative costs between 44% and 47%, depending on how many hours a firm currently operates.

These are just two of many efforts to restrict the operation of managed care plans.

Proponents of these restrictions maintain that they are needed to protect patients and assure quality care. We couldn't disagree more.

The basis of a managed care plan is not discount medicine but quality medicine at a reasonable price. Every health care plan provider recognizes that delivering poor quality care will only drive up plan costs in the long term. A person who receives poor care will become sicker, requiring more care at additional cost.

Managed care plans also seek quality care providers, recognizing their potential liability for directing people to those who fail to deliver proper treatment.

Furthermore, managed care plans that fail to deliver quality care will soon find themselves without members. People will simply leave plans that do not provide care that meets their standards.

Efforts to restrict the operation of managed care plans may be veiled in the guise of protecting consumers, but they really are efforts by health care providers to thwart any controls on their rising fees.

As employers and insurers struggle to provide health care coverage with health care costs rising at nearly three times the rate of overall consumer prices, it is no time to restrict successful efforts to deliver quality care with reasonable cost control features.

Letters

Simple tinkering won't cure what ails U.S. health care

To the editor: Whenever I read a letter like "Canadian System Not Acceptable" by James T. O'Connor (*BI*, July 22), I wonder whether I am living on the same planet. Anyone who can describe the U.S. health care system as "world-admired" and "working effectively" must either be writing with tongue in cheek or else trying to protect investments in medical stocks. How can anyone admire a system that:

- Spends more per capita on health care than most other developed countries, but denies access to quality health care to large parts of the population, including the indigent and the elderly.
- Leaves a third or more of its working-age citizens uncovered by medical insurance.
- Causes many chronically ill elderly patients to use up their life savings to obtain proper medical care.
- Has one of the highest infant mortality rates among developed countries.
- Encourages doctors to carry out unnecessary medical procedures, like Caesarean births and circumcisions.
- Results in 30% to 40% of private hospital facilities being unused at any time, while county hospitals are overloaded, underfunded and understaffed.
- Results in private hospitals competing for patients by buying the most expensive new gadgets available and passing the cost on to their customers.

The much-admired "quality of care" that Mr. O'Connor is referring to only applies to that privileged and rapidly shrinking portion of the population that is either independently wealthy or is covered by private medical insurance. Even these people are frequently left short when they get sick and find out exactly what their insurance policies do not cover.

As someone who has lived in both Canada and the United Kingdom, I can honestly state that I would much rather be taken ill in either of those countries than in the United States. I am particularly glad that, even though I have lived in the United States for 12 years, I have retained my Canadian and U.K. citizenships so that I can move back to either country when I retire, assuming that the U.S. system has not had some radical surgery in the meantime.

I don't think the U.S. system is ever going to provide an acceptable level of care to all its citizens until the profit motive is removed from it. There are too many people at present making a fat living out of the health care industry, all the way from drug manufacturers to hospital corporations to medical professionals. Perhaps the idea of the state running anything is anathema to some people, but urgent situations require a draconian response, particularly where lives are literally at stake. Simply tinkering with the existing system, as Mr. O'Connor suggests, is not going to work. Another 10 years and the United States is not going to have a health system of any kind at the rate we are going.

Malcolm R. Carden
Piedmont, Calif.

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

Liability claims can be self-managed

To the editor: Michael Schachner's July 29 report, "Some Claims Tough to Tackle Alone: Experts," may have done a disservice to readers of your magazine considering self-administration of liability losses.

The thrust of the article appeared to be that self-administration of workers compensation is fairly easy and that risks are low compared with self-administration of other types of liability losses.

Based on many years of experience, both as an in-house administrator of various types of claims and losses and more recently as a consultant helping companies evaluate, set up and administer self-insurance programs, I do not disagree with the basic comments of the article. However, I have come to expect a more balanced presentation from your publication.

Specifically, companies that want to self-administer liability losses have tremendous advantages over TPAs or insurance companies. They are closer to the losses. They can focus resources as needed. They know their plants, their personnel and their products. Decision making (settle? litigate?) can be adjusted to match a company's situation and objectives, which are often far different from those of the TPA or insurer.

Self-administration takes a plan of action. It takes management with knowledge or a willingness to learn. It also takes discipline and a commitment to work harder and smarter than a TPA or insurance company if it is going to be fully effective.

Given the right approach, self-administration of any type of loss for almost any size company can have very positive results in terms of awareness, loss prevention, quality of claims management and overall cost control. Self-administration of claims is not for everyone, but it is an option in many liability programs that should be thoroughly and carefully explored without the preconceived notion that the experts are against it or that expensive extra help is essential.

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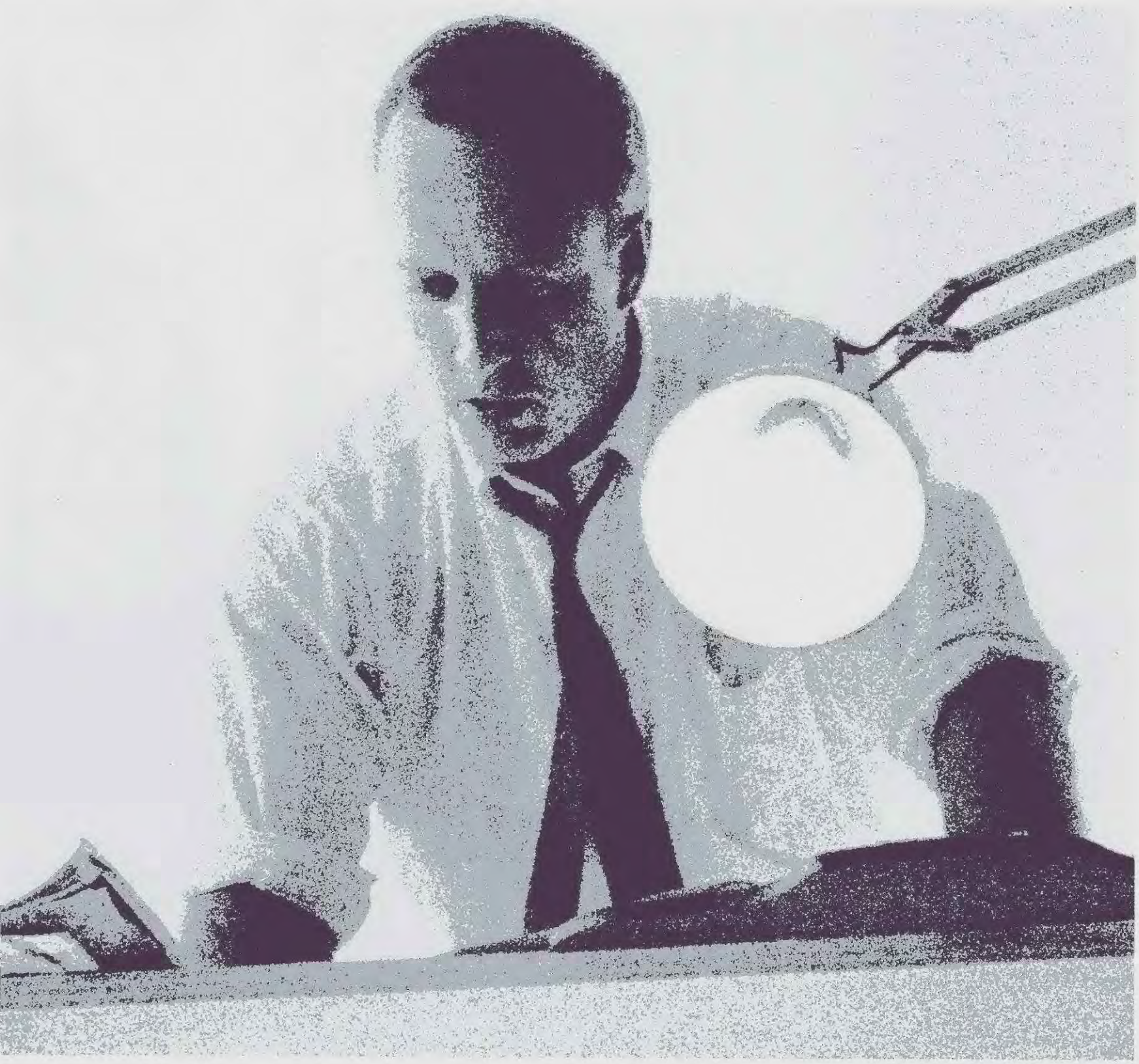

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Human resource issues key: Consultant

By LOUISE KERTESZ

SAN FRANCISCO—Employers in the 1990s must focus on human resource issues—especially employee benefit issue—because "people will be the assets" that differentiate companies in the next few decades, a consultant says.

"Human resource management will be at the center of efficiency, quality and competitiveness in the 1990s," said Stephen C. Caulfield, managing director of William M. Mercer Inc. in Boston.

And, employee benefits "are at the heart of management of human resources," Mr. Caulfield said last month in the keynote address at the Corporate Benefits Management Conference sponsored by the International Foundation of Employee Benefit Plans.

Mr. Caulfield urged benefit managers in the audience to "feel empowered" as human resource issues become more important in the decade ahead.

He reminded them that "survey research indicates the status of the human resource manager is rapidly rising in institutions and becoming comparable to that of the chief financial officer, because people are beginning to realize that human resource managers are a major asset" to the corporation.

Employers must particularly focus their human resource efforts on "health cost management and benefit communications," Mr. Caulfield emphasized. "I believe that those two areas are prerequisites for successful management of the human resource agenda for the 1990s." He also cited retiree benefits, flexible benefits, and dependent and elder care benefits as chief employer concerns in the coming decade.

Health care costs will be the chief human resources issue of the 1990s, Mr. Caulfield said. "In the year 2000, almost 60% of corporate profits will go to health care costs."

But employers should be encouraged because there is "a much greater openness now in the bargaining environment" with labor in connection with health care costs and redesigning benefit plans, he said.

In combatting rising health care costs, employers should remember that "the single controlling variable in annual expenditures for health care is volume, not price. It does you no good to get it cheap," if the volume of services continues to increase, Mr. Caulfield said.

"Driving volume is supply. The population is growing slower than the number of physicians. In the U.S., physicians don't drive cabs," he quipped.

A vivid example of how the volume of health care services is driving costs is the fact that all procedures—whether performed on an outpatient or inpatient basis—are on the rise, Mr. Caulfield said.

Borrowing a line from the musical "Gigi," he asked, "How did I miss it? Was I standing up too close or back too far? My thesis is that in the management of health care costs in the 1980s, we've missed it and I think we've got a new challenge in the 1990s. How did we miss it?"

Mr. Caulfield noted that "our existing course has been to shift costs, to pick risks, to pass dependents."

For example, 11.4% of one large employer's dependents recently withdrew from its benefit plan. "Was it good for the company? Yes. For the system? No," he said. Those dependents went elsewhere for health care and continue to drive up costs, he said.

"We've shadow-practiced medicine under the guise of utilization management," with the result that overhead has been increased: Medical overhead costs in the United States are 60% higher than in Canada and 90% higher than in the United Kingdom, he said.

In attempting to manage costs, employers, providers, insurers and others in the industry have "missed three fundamental truths about the health care system that you people have to address in the next decade," Mr. Caulfield told benefit managers. They are:

- Physicians do not know what "best practice" is.

"You have data that physicians don't have. You have the data for your populations and you have to begin to feed that data back to doctors," he said.

Physicians "don't understand total quality management or what their consumption of cost is. They have no data systems," he said.

- Patients do not know how to effectively consume health care.
- Society does not know how to allocate health care resources.

Employers must focus their efforts on 'health cost management and benefit communications,' Mr. Caulfield says. 'I believe that those two areas are prerequisites for successful management of the human resource agenda for the 1990s.'

Another key human resources issue this decade will be benefit communication, particularly the sensitive issue of telling employees that benefits are being cut, Mr. Caulfield said.

Explaining benefit changes would be easier if employers educate their workers about some of the "facts of life" of health care costs, he said.

One of those facts: At most large companies, health insurance is paid for with company's money—not "insurance company money."

"They still believe it's somebody else's money—even if they work for self-insured companies," said Mr. Caulfield.

He cited one large company's efforts to combat this perception. Its benefit manager was told to print benefit checks on paper resembling

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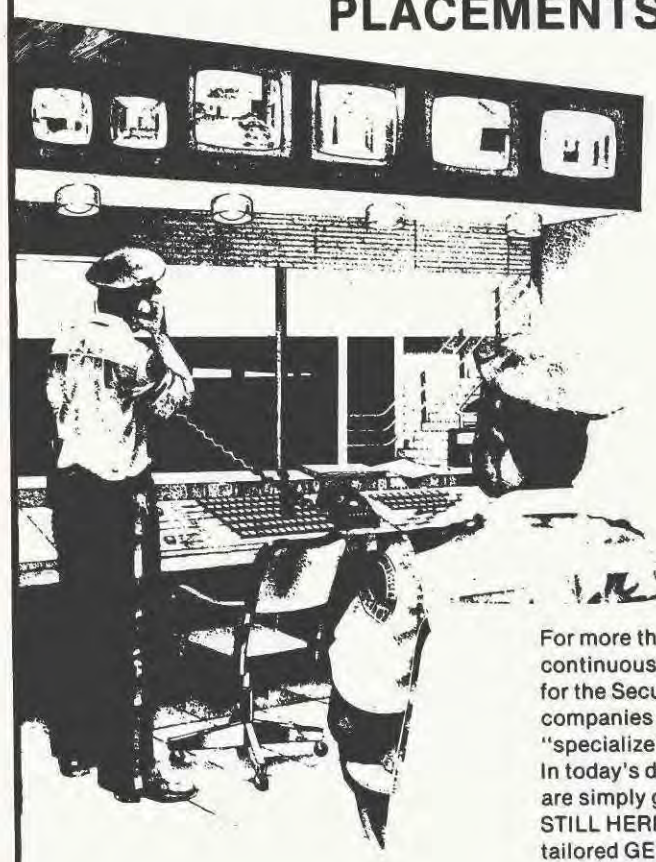

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Continued from previous page

company stock certificates, so that "the doctors and the patients see it is not the insurance company's money" but the employer's money, Mr. Caulfield said.

Self-insured employers also should stop calling an employee's contribution to the company health benefit plan a premium, he said. "It's not insurance. It is a contribution," he emphasized.

And, anytime they are trying to explain benefit plans, companies should avoid cliches and health care industry jargon, Mr. Caulfield recommended.

"Remember that what we're trying to do here is simplify the communication so employees understand the message, buy into the solution and ultimately change their behavior," the human resources consultant said.

Retiree health care benefits will be another human resources management issue in the '90s, Mr. Caulfield said.

Though employers are preoccupied with meeting Financial Accounting Standards Board requirements for accounting for retiree health care liabilities on their financial statements, employers also should be asking what they should be doing to provide adequate benefits while limiting liabilities, he said.

Retiree health care programs "should have some fixed-dollar features as well as fixed-benefit features, to bring some consumerism in," he said.

Retiree health care programs also should "increasingly provide some level of flexibility and choice" as well as "some long-term care."

And, Mr. Caulfield said, employers should not forget that health promotion and disease prevention programs can benefit retirees as well as active workers, citing exercise programs like low-impact aerobics for retirees.

Flexible benefit plans will be another important issue for employers in the '90s, according to Mr. Caulfield.

Employers should be aware that employees may be a little cynical when a flexible benefit program is established, he cautioned.

The cynicism on the part of employees will arise because "in your flex benefits, you're going to be slam-dunking people into managed care," explained Mr. Caulfield. "There will be the appearance of freedom of choice, but in truth there will be real strong economic incentives for people to get into managed care."

Employers in the 1990s also will have to focus on child care, elder care and dependent care benefits, because an increasing number of their employees will need assistance in caring for family members.

The problem of adequate child care exists because "we still have a de facto sexist society in the American workplace," Mr. Caulfield asserted. "That has to be corrected."

The problem of elder care also has reached the workplace, Mr. Caulfield said.

Citing statistics from the American Assn. of Retired Persons, he said, "31% of care givers of elderly persons are management employees; 40% have been employed with their company more than 11 years; 18% lost time from work during the past six months due to a crisis related to the person receiving care; and 22% of care givers have not had a vacation away from their care-giving activities for a year or more." ■

110 attend benefits conference

SAN FRANCISCO—The International Foundation of Employee Benefit Plans' Western Corporate Benefit Management Conference, held here July 22-24, drew 110 attendees. Last year's conference in San Diego drew 118.

Next year's Western conference is scheduled for Aug. 10-12 at the Westin Hotel in Seattle.

The conference for the Eastern United States is scheduled for March 30-April 1 at The Greenbrier in White Sulphur Springs, W.Va.

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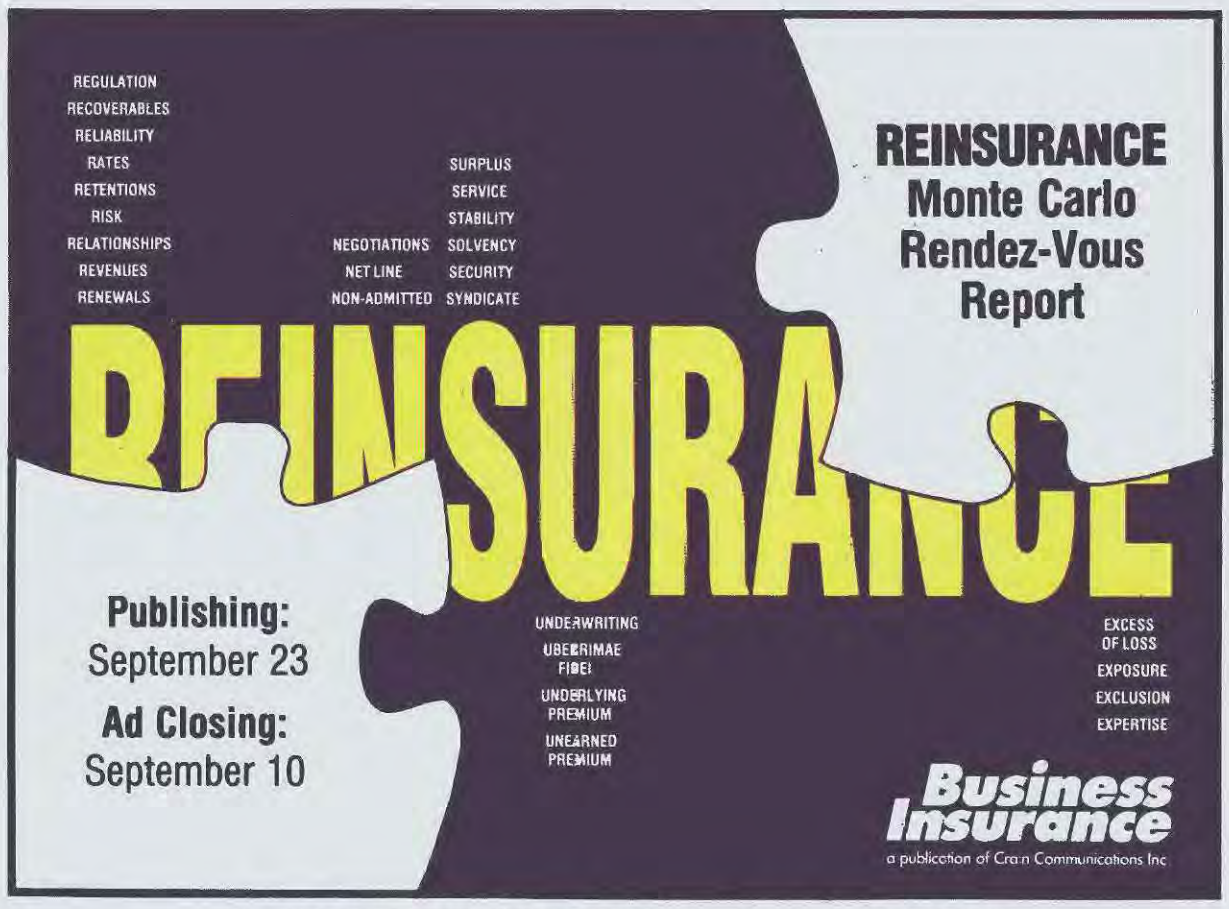

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Utility phases in retiree health benefit cuts

By LOUISE KERTESZ

SAN FRANCISCO—By the end of 1992, Southern California Edison Co. will have saved about $50 million from cuts the company began phasing into its retiree health care plans two years ago.

Those reductions will hold down projected increases in retiree health care costs to 15% annually, or to $33 million in 1992, said Larry Neumeister, division manager-budgets and administration in Edison's health care department. Without the cuts, the company projected a 27% increase.

Because the cuts are viewed as "devastating" by some Edison employees who see any cuts in retiree benefits as "a broken promise," the Rosemead, Calif.-based public utility is phasing them in.

Reducing retiree health care benefits is a "very emotional" issue, though Edison's benefits are "still very rich," observed Mr. Neumeister, who spoke last month at the Corporate Benefits Management Conference sponsored by the International Foundation of Employee Benefit Plans.

Mr. Neumeister, who has served as an auditor, accountant, senior analyst and budget supervisor in the controller's office, asked his audience rhetorically: "What's an accountant doing in health care?"

He responded, "I was recruited to health care to try to straighten up the cost control mechanisms within the health care department, so that we would be able to track costs, to actually be able to understand where the costs are going which black holes they are disappearing into."

Faced with rising medical costs and a recent Financial Accounting Standards Board rule—FAS 106—that requires companies to report their retiree health care liabilities on their financial statements, Edison set up committees involving treasury, accounting, ratemaking and legal staff.

By way of background, Mr. Neumeister explained that the regulated public utility has territory covering 50,000 square miles. With 17,000 employees, 5,000 retirees and 55,000 total covered lives in its benefit plans.

Edison owns and operates 10 clinics and first-aid stations and a corporate pharmacy (*BI*, March 5, 1990). The company has its own preferred provider network of 7,500 physicians, 85 hospitals and 155 pharmacies under contract. It also performs its own utilization review (*BI*, April 23, 1990).

"We're self-funded and self-administered—so we own the data. That's been a tremendous advantage to us—owning the data which otherwise would be in the hands of the insurance companies," Mr. Neumeister said.

Once the company began thinking about reducing retiree benefits, though, problems surfaced. One was balancing the company's roles in the health care system, he said. "Is the management of the company sitting in the doctor's office or is the management of the company sitting in the insurance office, trying to influence what claims are paid and not paid, in order to control costs?"

Prior to 1989, Edison paid 100% of retiree health care costs. There were no contributions, deductibles or copayments and lifetime benefits were not capped. "We also reimbursed the retiree for all of the Medicare Part B premium contribution," which provides supplemental insurance for physician services, Mr. Neumeister said.

About 80% of the health care costs of retirees' dependents were covered by the company.

The biggest problem with the system, Mr. Neumeister said, was that the first 100 days of hospitalization were free—both for active employees and retirees—"and that led to quite a bit of abuse."

The biggest abuse was that treatment of substance abuse and mental and nervous conditions was delivered as "standard inpatient care," he said. "It's not surprising that our health care costs were rising at a fairly substantial rate," he said, noting that retiree health care costs at Edison rose to $18 million in 1988 from $4 million in 1981.

"We developed a strategy to phase in the retiree health care (cutback) program over a five-year period. One of the things we really agonized over is the tugging back and forth between what we think we owe our retirees who have long and faithful service—what we have promised in the past—and whether or not we would break that promise," he explained.

Another consideration was "what kinds of legal action might be taken" by employees if retiree benefits were cut. Phasing in the pared-down program seemed a solution.

For those employees who retired prior to 1989, Edison established PrimeCare, a comprehensive plan that includes dependents, which actually improved dependent coverage, he said. PrimeCare includes a PPO network with utilization review, precertification and case management components that retirees and dependents must use in order to obtain 100% coverage. Out-of-network coverage is reimbursed at 80%.

Retirees do not have to make premium contributions.

Employees who retired in 1989 and 1990 also receive PrimeCare and are not required to make a contribution, but their Medicare Part B reimbursement is capped at 1992 levels.

Employees retiring in 1991 and 1992 are enrolled HealthFlex, the managed care program offered to Edison active employees, without the monthly contributions required of active employees.

In this plan, Edison pays 90% of in-network costs and 70% of out-of-network costs after various deductibles.

Employees retiring in 1993 and later will also be covered by the HealthFlex plan. But, they will be required to make premium contributions indexed to increases in health costs and based on years of service. Edison also will not reimburse Medicare Part B premium payments for these retirees.

Edison's case management strategy involves monitoring active employee, retiree and dependent coverage through its preferred provider network. A unique feature of that network is Edison's "corporate pharmacy" along with 155 contracted pharmacies.

With all prescriptions "flowing through the corporate pharmacy, we have as much as possible a complete drug profile of all of our employees, retirees and dependents, which has been a lot of help to us," Mr. Neumeister said.

In addition, Edison established a geriatric program called Genera-

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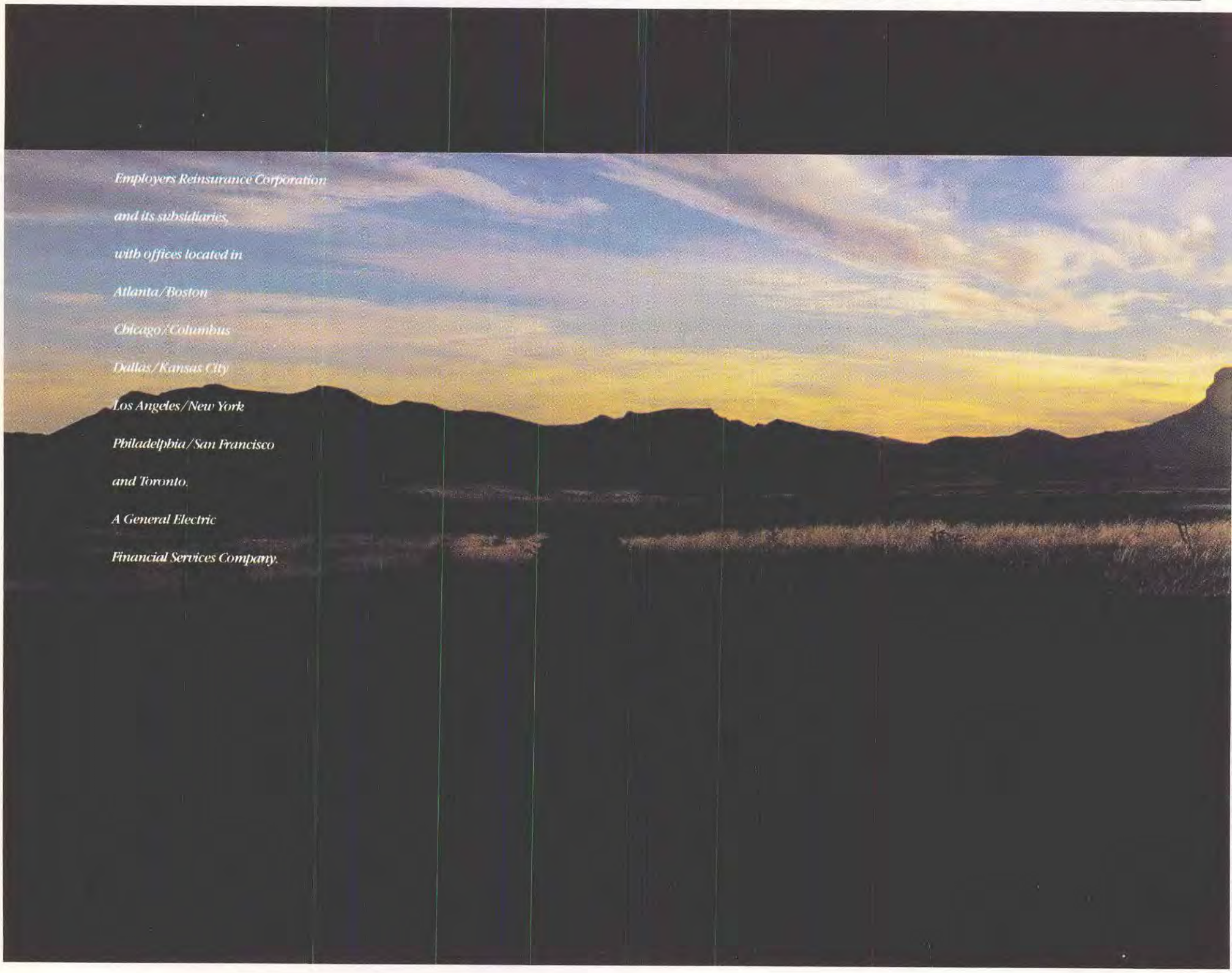

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tion to assess the health of retirees, integrate community resources into care of Edison retirees and contribute to academic research in geriatrics.

When Edison first set up the Generation program, which is voluntary, "we saw the retirees who jogged into the office." But now, "the more frail retiree" is being seen and helped through the program, Mr. Neumeister said.

Edison is gratified that "we've achieved some short-term success in controlling retiree costs," he said. But, "people are living longer. In 1993, out of approximately 11,000 lives in the Edison retiree population—including dependents—9,400 will still be in our most expensive coverage—PrimeCare," he said. In 2003, 50% of retirees and their dependents will be in PrimeCare and in 2013, between 15% and 20% will be in Edison's top-of-the-line plan.

But Edison predicts that the medical trend—or medical component of the Consumer Price Index—for retirees will drop from 16% to about 5.5% over the next 15 years. Mr Neumeister noted that the projection was made with the assumption that "the country will respond over the next 15 years to a national health care policy that involves a great deal of cost containment, managed care and PPO types of arrangements."

On the other hand, over that 15-year period, "we believe we'll continue to have cost-shifting from Medicare," he said. ■

Pitching flexible benefits

Plan must be sold to management

By LOUISE KERTESZ

SAN FRANCISCO—Implementing a full-fledged flexible benefits plan requires not only a great deal of work, but several obstacles also must be overcome, the biggest of which may be selling management on the concept.

Management support is crucial to the proper implementation of a flexible benefit plan, but "a lot of chief executive officers have come up through the ranks in paternalistic organizations where employee choice was not considered," said Kathleen Goeppinger, assistant professor at Loyola University of Chicago's Institute of Human Resources and Industrial Relations.

There are many difficult "philosophical" issues to tackle in persuading management to accept a "true cafeteria plan" that includes a basic package of benefits and allows employees to select from a range of additional options, Ms. Goeppinger said at the Corporate Benefits Management Conference sponsored by the International Foundation of Employee Benefit Plans in San Francisco last month.

For example, "it may not be so difficult to decide how many health plans to offer. But how will your employer feel about employees buying and selling vacation time? What about the newer employee who decides to take six weeks of vacation instead of additional life insurance or make 401(k) contributions? Some employers will handle this well, and others will not," she observed.

To help benefit managers who want to try to move their companies toward accepting flexible benefit programs, Ms. Goeppinger presented some arguments that executives could "take back to work."

The chief reason many employers are offering flex plans is that they are "trying to unify their benefit plans—trying to pull it all together" into a package of basic benefits and optional benefits designed for the company's employees in a specific location or region, she explained.

Another argument for a flex program is that it is a "wonderful opportunity" to get employees to understand their benefits and the cost of their benefits, Ms. Goeppinger said.

Giving employees flex plan credits to spend on the types of benefits that fit their needs makes them aware of the cost of their benefits, both to themselves and their employer. "And, it makes them smart consumers," she said.

Ms. Goeppinger related that she was "chagrined" recently when she found herself in a situation in which she realized how little she knew about "free" benefits offered by Loyola University.

She explained that she was participating in the hiring of a new faculty member at Loyola and one candidate asked her what benefits the university offered. "Now, I can tell you what I pay for health care, for dental, for dependents. But what about all the rest? They're free, and I'm not sure what they are. I know I have life insurance and long-term disability, but I don't pay for them and I don't get involved in the selection."

In contrast, a flex program allows employees to select the details of their coverage, like the level of life insurance they need beyond the core coverage, Ms. Goeppinger explained.

"We are also finding we are getting more family involvement in selecting pieces of the flex plan," she said. Employers increasingly

Continued on next page

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Flex plans

Continued from previous page

are taking home materials that explain the plan. One employer even sent a video home so that the family could be involved in selecting benefits, she said.

That company found that the videos—which cost less than $6 per employee—were an inexpensive alternative "to having massive meetings all over the country, having to send a corporate team to 295 locations," Ms. Goeppinger said.

Another reason to implement flexible plans is that research shows flex plans cost employers less than traditional benefit plans.

Although a flex plan may cost more the first two years it is offered, employers are finding that flex plans result in long-term savings, Ms. Goeppinger said, noting that one recent study estimated the annual savings to employers to be 9% compared with the cost of traditional plans (*BI*, July 15).

Another recent study by the Benefits Division of the AFL-CIO found that 95% of contracts that include flexible benefit plans shifted benefit costs to employees. Ms. Goeppinger said that while that would be a sore point in trying to sell flex plans to a union, more unions are accepting the plans.

One way employers are keeping down the cost of flex plans in the long term is by holding down the number of credits employees may use to buy options.

"As the costs go up, they don't increase the credits employees are allowed. So employees have to spend four credits next year instead of the three they are using this year for health options" beyond the core package, Ms. Goeppinger explained.

"In the long term, employers believe employees will downshift their expectations" and "the employer will also educate them" about how to get the coverage they value the most, she said.

Another argument for flex plans is that they help prevent employers that want to "keep adding new benefits" from becoming "their own worst enemy," she said.

Many employers that sponsor traditional benefit plans want to offer a full range of benefits, including child care, Ms. Goeppinger explained. But, other employees that do not use those benefits often view this type of benefit as an inequity. Those employees want benefit dollars spent on their own needs, too, she explained.

But a flex benefit program "is perceived as an equitable benefits program" because those who need specialized benefits have to buy them, she said.

And, if an employer implements a flex plan, it can add new benefits pretty easily, she said. "Just add a new module and people can decide if they want it." For example, some employers even offer legal services and personal auto insurance through their flex plans.

For employers with locations in many areas of the country, flexible benefit plans also deal with the problem of addressing different employee needs in different geographical locations, Ms. Goeppinger pointed out.

This is "a really major issue for some employers." For example, employers that offer health maintenance organizations in one area of the country may not have HMOs to offer in another area. "Employers that are trying to have a centralized benefit package are finding out that the only way to make up for regional differences is to go into a full flex plan, because then they can offer what's available in the region without skewing the dollars that are available for every employee."

A final argument for flexible benefits is that it is a way to start looking at total compensation," Ms. Goeppinger said.

"If you, in fact, are giving your employees a set dollar amount to spend—$7,000 or $10,000 in credits—literally what you are doing is saying those benefits are worth $7,000 or $10,000. Employees don't have to figure out how much their benefits are worth. You're giving them cash and saying, 'Spend it wisely,' " she said.

Ms. Goeppinger also pointed out that the fastest growing trend among employers that offer flex plans is making the plans available to part-time employees who work more than 20 hours per week. Research shows that about 25% of employers offer flexible benefits to their part-time workers, Ms. Goeppinger said.

Research also shows that only 3% of small employers offer flex benefits, she said. Most do not offer the programs because they do not have the necessary administrative and management support and do not offer enough benefits to make up a full flex program, she said.

For instance, one small company that offered a single health plan polled its employees and found that the only option they wanted was the ability to make their contribution to their health plan on a pretax basis. That company decided it was not necessary to offer a full-fledged flexible benefit plan to accomplish that, Ms. Goeppinger said.

By contrast, a large employer with 36,000 employees decided that "the flex program that would best meet its employees' needs had six health care options, one of which was no coverage at all," Ms. Goeppinger said. ■

Digital devises own standards to judge HMO performance

By LOUISE KERTESZ

SAN FRANCISCO—Digital Equipment Corp.'s approach to health care cost containment involves developing its own standards of performance for the health maintenance organizations with which it contracts.

Before Digital, no other company had tried to develop its own standards for HMOs, said Edward J. Brady, U.S. employee benefits program manager for the large computer manufacturer, which is based in Maynard, Mass.

Mr. Brady spoke about Digital's health care program last month at the Corporate Benefits Management Conference sponsored by the International Foundation of Employee Benefit Plans. He later made available a detailed explanation of the company's HMO standards.

Digital is encouraging the 72% of its employees who were in indemnity plans last year to switch to HMOs (*BI*, July 29).

Since a point-of-service plan was introduced Jan. 1, 5.1% of its domestic workforce has enrolled in the four HMOs with that feature.

Enrollment in other HMOs also increased to 36.9% of the workforce, while indemnity plan enrollment has dropped to 51.2% from 72%.

The remaining employees have elected not to be covered under any of the plans provided by Digital.

With HMOs growing more popular with employees, it was imperative to develop "performance benchmarks," according to the company.

Performance was broken down into three categories: quality of service, cost and technical quality of care. Although Digital felt it could analyze costs and some aspects of quality itself, the company said it recognized that it was not qualified to make clinical judgments.

But it still insisted on assessing how HMOs made those decisions. So Digital asks HMOs for "information and evidence of organization structure, quality assurance processes and the existence of outcome measures."

Digital has formal standards for HMOs in four areas: access; quality; mental health and substance abuse; and financial stability.

Continued on next page

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• Access standards govern the availability, accessibility and consistency of health care.

The HMO must be available to at least 90% of employees in a defined geographic area. In addition, all ZIP codes in the defined service area must be within 30 minutes of at least two primary care physicians.

Digital also establishes ratios of several physician categories to the enrolled population.

Accessibility standards include limits on the maximum number of days members must wait to see a physician, both for office checkups and symptomatic visits. Office visits for urgent problems must be available within 24 hours. Emergency care must be available for all covered services on a 24-hour basis.

In terms of consistency, an HMO's primary care physician turnover must not have exceeded 7% in any of the past three years. The HMO must also report physician groups or centers that have had to freeze enrollment in the past 24 months and also must report the duration for which enrollment was closed.

Family members and employees must be able to select primary care providers at different centers.

• Quality standards cover the HMO's organizational structure and philosophy, credentials and privileges of professional providers, medical records and information systems, performance of providers, appropriateness of care, continuity of care and health care outcomes.

Digital, for instance, wants the HMO to have a defined quality assurance program with an identified director, as well as quality assurance committees both for internal departments and for the organization as a whole.

In addition, Digital requests the details of the quality assurance programs, including whether "quality results" are reported along with financial results at board meetings.

At least 90% of an HMO's physicians must be board-certified or be eligible for state board certification for a maximum of 18 months.

All HMO hospitals must be accredited by the Joint Commission on the Accreditation of Healthcare Organizations, making them eligible to receive state and federal health care funding.

Digital prefers an HMO to have computerized medical records and requires the HMO to tabulate data according to its own detailed formats.

Digital requires the HMO to have a provider performance evaluation program—that includes patient input—and to inform Digital of all corrective actions taken against physicians in the past two calendar years.

Appropriateness of care is also covered by these Digital standards.

An HMO must "maintain and communicate a mechanism for monitoring and evaluating variation in provider practice for all provider categories," according to the company.

Continuity of care must be maintained by, among other things, "a program for the initiation, coordination and follow-up of home health, skilled nursing, durable medical equipment and other services."

The HMO must also "have a system for tracing results and follow-up of health screening tests and procedures," according to the standards.

Digital's health outcome standards require health maintenance organizations to track and review

Digital requires the HMO to have a provider performance evaluation program that includes patient input. The HMO also is required to inform Digital of all corrective actions taken against physicians in the past two calendar years.

deaths and surgical complication and morbidity rates.

The HMO must also provide annual satisfaction survey data.

• Mental health and substance abuse standards.

Digital seeks improvement in a number of problem areas that "appear to be fairly common" in mental health and substance abuse services provided by its HMOs. These include: "limited flexibility in approaches to treatment"; "barriers for initial access to treatment"; "lack of specialty staff"; "no outcome data"; and "overuse of group therapy."

Working with the HMOs, Digital says that by Jan. 1 it hopes to develop a "set of expectations" focusing on the delivery of mental health care, benefit design and outcome measurement.

• Financial stability.

Participating HMOs are required to report how they performed against certain standards for the past three years. Any variances must be explained.

The HMO must also "maintain adequate provisions against insolvency which provide for the continuation of benefits for the term of the agreement for which premium payments have been made and until enrollees' discharge from inpatient facilities."

In addition, "the HMO shall maintain adequate liability insurance to protect the HMO against losses arising from professional liability claims against the HMO or providers without adequate professional liability insurance coverage."

The HMO should also require its providers "to maintain professional liability coverage in an amount satisfactory to the HMO," Digital said. ■

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Managed care

Continued from page 3

ington, D.C. "Now we have the data to back us up."

The study's findings "essentially support our position of opposing anti-managed care legislation," said Wendy Haesler, resource manager in the managed care division of the HIAA.

"The bright promise of managed health care—quality services at lower costs—is being dimmed by laws designed to cripple these programs," said HIAA President Carl J. Schramm.

"Admittedly, managed care is a new concept that requires some adjustments, but the solution is not to legislate it out of existence," asserted Steve Lamb, director of state affairs for the American Managed Care & Review Assn., a managed care trade group in Washington, D.C., that provided some of the data used in the study.

However, a spokesman for the Chicago-based American Hospital Assn. counters that some state laws are needed to protect patients from managed care requirements that could jeopardize the quality of care they receive.

"In trying to cut costs, we have to be careful not to disregard quality," he said.

'Efficient managed health care plans do not have every provider included,' asserts Brian Marcotte of Marriott Corp. Including everyone would 'defeat the competition we're trying to create. . .It's not managed care anymore.'

For example, "limiting a patient to an unsuitable gatekeeper could be detrimental to care," he said. "A person should have at least two primary care physicians."

But, the law that Wyatt found presents the greatest threat to managed care is the "any willing provider" law, which requires preferred provider networks to include any provider willing to participate.

Besides the 8.8% hike in claims costs and the 34% hike in administrative costs, Wyatt found that the current average discount of 19.5% among PPOs studied—compared with indemnity plan costs—would be reduced to 9.4% if network participation increases to 60% of physicians and 80% of hospitals in a network area from the current average of 25.5% of physicians and 44% of hospitals.

In addition, the added administrative costs caused by such a measure would lead to a 12.6% hike in the average premium for family coverage to $4,350 from $3,864.

The administrative costs would rise to cover increased expenses of credentialing, contracting and monitoring quality of care for each physician added to the network, the study says.

Proposals to permit "any willing provider" to participate in a network can have a "detrimental effect" on desired savings, Ms. Haesler said. "The managed care network concept is founded on the principle of participation by a limited number of physicians."

"If you have everybody in town, you have less ability to control costs," agreed Alan Peres, manager-benefit planning at Ameritech in Chicago.

Ameritech already is feeling the pinch in Indiana, which has an "any willing provider" law, he said. "The Blues' PPO down there includes virtually every doctor and hospital in the state," he said, referring to a Blue Cross/Blue Shield plan.

"Efficient managed health care plans do not have every provider included," asserted Brian Marcotte, manager of health plan contracts and services for Marriott Corp. in Washington, D.C. "They have a reasonable percentage."

Permitting any willing provider to join "defeats the competition we're trying to create," he added. "It's not managed care anymore."

Mr. Marcotte also pointed out that employers that self-fund their health care plans are not immune from state legislation governing network participation among insured plans because self-insurers usually contract with established networks.

Only by developing their own networks can self-insured employers escape the reach of these laws completely, he cautioned. "And that could be expensive."

Permitting any willing provider to participate in a managed care network also would create an administrative nightmare, he said.

"Mandating that all providers be permitted to join a network thwarts the network's ability to select the higher quality, more cost-effective providers that are the backbone of every managed care organization," said Brant Kelch, chairman-elect of the American Assn. of Preferred Provider Organizations and president of Reston, Va.-based MedStrategies Inc.

The Wyatt study also found that laws prohibiting the use of primary care physicians PPOs would eliminate the 6.8% savings on average generated by these "gatekeepers."

Banning the use of gatekeepers in PPOs contradicts the premise on which the managed care programs were founded, according to Marriott's Mr. Marcotte.

When no single physician is monitoring a patient's treatment, "you lose control over quality as well as control over cost," he said.

And "without the gatekeeper, there's no continuity of care," he said.

Requiring UR firms to use only professionals licensed in the state where they are conducting reviews would increase administrative costs by 42.5% in the first year, 31.9% in the second year and 25.6% in the third year, the study said.

Many health care experts maintain that such legislative restric-

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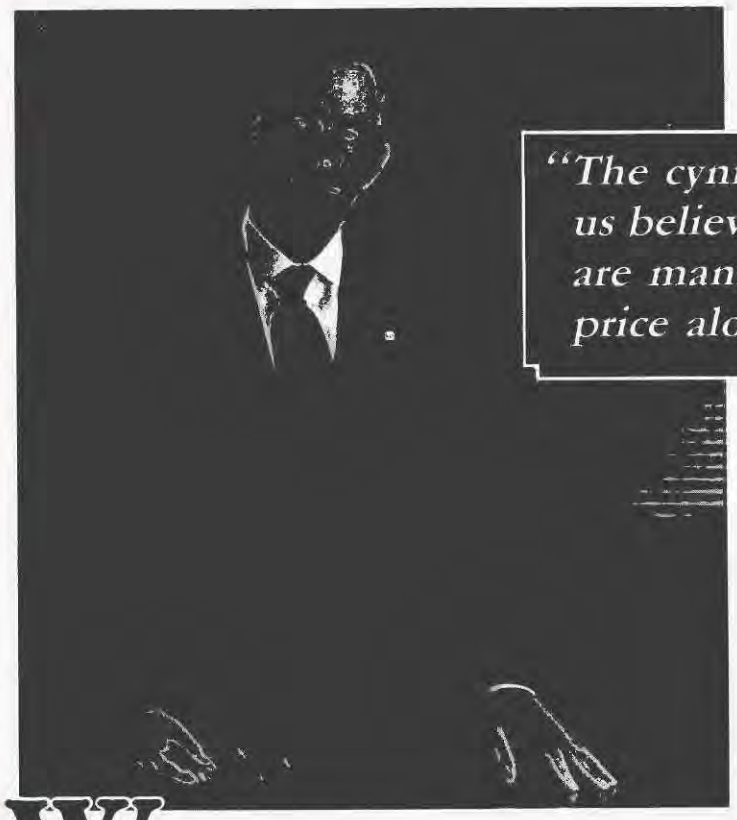

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Continued from previous page

tions on UR procedures are designed to make managed care more cumbersome.

As an example, Mr. Lamb of AMCRA cites a Hawaii law enacted this year. The law, which requires reviewers of chemical dependency treatment to be licensed in the state, is "protective measure" backed by local chemical dependency experts, according to Mr. Lamb.

Such limits do not make sense in a state that sits in the middle of the ocean, he said. "It has a certain element of protectionism in it."

The study also found that overall administrative expenses would increase 44% to 47% if UR firms begin operating 24 hours a day seven days a week, rather than 11 hours a day seven days a week, which is typical now.

No state as yet requires round-the-clock operations, though four states considered doing so last year and one state—Maryland—"came close" to passing such a law, according to Mr. Lamb. A 24-hour operation clause was edited out of a state health care bill before it was passed, he said.

While having a UR provider on call 24 hours a day would provide continuous managed care, it is not necessary, health care experts say.

"From the pure administrative point of view, you really do not gain a lot from 24-hour staffing in order to pick up the occasional emergency room case," Wyatt's Dr. Taylor said.

Some supporters of 24-hour UR operation argue that sick individuals may not seek treatment "after hours" out of fear it will not be covered without review.

However, Ameritech's Mr. Peres contends that "if somebody needs care in the middle of the night, there's no UR company in the world that would deny treatment."

UR is designed to provide a check and balance in the system, not to deny necessary care, Mr. Peres said.

Legislation requiring UR firms to provide information on their activities within a particular state would cost UR firms between $10,000 and $50,000 per state for the first year such a law is effective, Wyatt estimates. That figure is projected to be $3,000 to $5,000 per state in subsequent years.

But, while legislation requiring state-specific statistical reporting on the activities of UR organizations may appear to take aim at UR firms' quality of care goals, it falls far short, health care experts say.

Generally, states require UR firms to track the number of employers or insurers with which they have contracted in the state, Wyatt's Dr. Taylor explained.

"I don't think the kinds of reports being required have anything to do with monitoring quality," said Dr. Taylor, who also serves as president of the Utilization Review Accreditation Commission. That body, which represents UR firms, employers, insurers, doctors and hospitals, has developed national standards to encourage efficient and effective UR (*BI*, Feb. 19, 1990).

"The real motivating factor is just an attempt to obstruct UR," claims AMCRA's Mr. Lamb.

Managed care experts are particularly troubled by legislation that would restrict the difference in health care benefits paid when care is obtained from non-preferred providers rather than preferred providers.

According to the Wyatt study, reducing that difference to 20% from the current average of 30% would reduce the number of patients steered to network providers by 6.1% and increase claims costs 1.3%.

Reducing the benefit differential to 15% would reduce the number of patients steered to the network 9.4% and increase claims costs 1.9%, the study estimated.

According to Ms. Haesler of the HIAA, differentials are now limited to 20% in six states: Florida, Georgia, Maryland, Massachusetts, Missouri and North Carolina. And the limit is set below 20% in eight other states: Arkansas, California, Kentucky, Maine, Montana, Nevada, Texas and Utah.

Most managed care programs are designed to steer employees into networks by providing much lower benefits if care is obtained from providers outside of the network, Ms. Haesler said. So limiting differentials "defeats the point of the network," she said.

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A copy of "Cost Analysis of State Legislative Mandates on Six Managed Health Care Practices" is available free of charge from the Health Insurance Assn. of America, 1025 Connecticut Ave, Ave., Washington, D.C. 20036-3998. 202-223-7839.

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Rostenkowski bill

Continued from page 1

Even companies that offered health plans would have to pay.

A third round of taxes—again imposed on both employers and employees—would jack up the current Medicare tax and wage base. The current 1.45% Medicare tax—paid by both employers and employees—is imposed on the first $125,000 of an employee's wages. Under the Rostenkowski bill, the tax rate gradually would rise to 1.65%, while the amount of wages subject to the tax would be lifted to $200,000.

Rep. Rostenkowski has not disclosed how much in new taxes would be need to finance his proposal. However, a more modest health care access proposal introduced in 1989 by Sen. Edward M. Kennedy, D-Mass., would have cost an estimated $18 billion annually, about 80% of which would have been borne by employers with the rest shouldered by employees (*BI*, April 17, 1989).

But the measure also has appealing features to employers.

It has the potential to control soaring health care costs by giving the secretary of health and human services authority to set rates for the nation's hospitals and physicians.

And, the measure would gradually lower the eligibility age for Medicare to 60 from 65, which will cut costs for firms that provide health care benefits to those retiring before age 65. Active employees over age 60 would still be covered by employer plans.

In addition, the bill would eliminate the health care continuation provisions of the Consolidated Omnibus Budget Reconciliation Act of 1985, while lifting to 100% from 25% the federal tax deduction the self-employed can take for their health insurance premiums.

On the other hand, small employers—those with fewer than 101 employees—could no longer self-insure their health care programs. The bill does not define self-insurance and does not explain why small firms would not be allowed to self-insure.

Benefit experts describe the Rostenkowski proposal as a decidedly mixed bag for employers.

"The Rostenkowski proposal holds out the promise of cost containment and reduced retiree health care liabilities. But it does so at the price of higher taxes for employers and employees and a significantly bigger administrative burden," said Frank McArdle, a consultant with Hewitt Associates in Washington, D.C.

The measure would assure coverage for 34 million uninsured Americans, either through employers or a new public plan. For older workers, enactment of the bill would mean they could retire sooner and still receive Medicare benefits.

No one believes the measure will be passed in the current congressional session.

"You are unlikely to see a groundswell of support for the bill" because of its tax bite, said Dallas Salisbury, president of the Employee Benefit Research Institute, a Washington, D.C.-based benefits think tank.

"Politically, it is very tough to imagine enactment because of the tax provisions and the provider reaction to price controls," agreed Henry Saveth, a principal with A. Foster Higgins & Co. Inc. in New York.

Rep. Rostenkowski himself acknowledges his bill is not his final word on the subject and that he is open to suggestions for change.

"As chairman, I intend to remain flexible regarding modifications that undoubtedly will be necessary as we seek to develop a political consensus and broaden public acceptance," he said on the House floor.

Washington observers aren't surprised that Rep. Rostenkowski is so amenable to change. They say the bill was hastily put together—in order to be introduced before Congress' August recess—and therefore does not represent his final thoughts on health care reform.

"This is a Scotch-tape effort. Much of it has been pieced together from other proposals previously advanced," said Stuart J. Brahs, vp-federal government relations with The Principal Financial Group in Washington.

For example, a similar play-or-pay mandate is included in a health care reform package proposed last year by the Pepper Commission (*BI*, March 12, 1990) and in comprehensive health care access legislation introduced in May by Senate Democratic leaders (*BI*, June 3).

By introducing the bill, Rep. Rostenkowski hopes to highlight the difference on a key domestic issue—health care access reform—between Democrats and the Bush administration, observers say.

"Introducing a bill gives Chairman Rostenkowski the opportunity to say, 'Look this is what I'm doing,' while explaining nothing will actually happen until we have presidential leadership," Mr. Salisbury said.

"Rep. Rostenkowski wants to advance the debate in the 1992 presidential campaign. He wants health care access to be debated by the presidential candidates. And, through that debate, the differences between the two parties on health care access reform will be accentuated," said Hewitt's Mr. McArdle.

Certainly, the debate will focus on how much universal health care coverage will cost—measured both in new taxes as well as employers' increased administrative expenses—under the Rostenkowski bill.

Under the bill, employers with health care plans would have to notify the Health and Human Services Department each time an employee's insurance is terminated, such as when an employee quits a job.

Health insurance could not be terminated unless the HHS was notified at least seven days before the last day of the month in which employment is terminated. In addition, whenever an employee joined a new company's health care plan, the employer would have to notify the department.

"The net result is a huge new increase in employers' reporting burdens," Mr. McArdle said.

At the same time, under the bill's benefit portability section, employers would have to provide an account statement to employees who drop coverage detailing how much of the plan's deductible or coinsurance requirement has been exhausted. The unused deductible, for example, would be the maximum deductible that a new employer could impose for the remainder of the year.

For instance, if an employee left his job on June 30 and had used $250 of the plan's $500 deductible, the worker's new employer could only impose a $250 deductible for the remainder of that year.

As a result, employers and plan administrators would need to refine record-keeping systems to keep track of workers' deductible levels.

Under the bill, employer health care plans could not include deductibles exceeding $250 for individual coverage and $500 for family coverage. The maximum out-of-pocket expense for an individual could not exceed $2,500 per individual and $3,000 per family. Employees could be required to pay up to 20% of the premium.

No cost-sharing requirements, though, could be imposed for pregnancy-related procedures, including pre-natal care and inpatient delivery.

While Rep. Rostenkowski did not disclose how much revenue would be needed to guarantee access to health care for the uninsured and to expand Medicare, his measure lays out the tax hikes that would be imposed on employers and employees.

For example, employers that do not offer a health care plan meeting the bill's standards would be hit with a new tax, initially set at 9% of wages, up to the first $200,000 of an employee's wages. Employers could require employees to pay 20% of the tax. This 9% tax would increase annually, under a complex formula, in tandem with health care costs and wage increases.

While companies offering health care plans could avoid the 9% tax, all companies and employees would be liable for a new universal health surtax if there were not sufficient funds to finance coverage for the uninsured.

The new surtax would, starting in 1993, be set at 6% of an individual's and an employer's income tax liability. The surtax, though, would rise to 7% in 1995 and 9% in 1996.

In addition, both the Medicare tax rate and wage base would increase. Currently, a 1.45% tax is paid by both employers and employees on the first $125,000 of an employee's wages.

Under the bill, though, the taxable wage base, effective in 1993, would increase to $200,000, while the tax rate would be increased to 1.55% in 1993 and to 1.65% in 1996.

The proposed tax increases certainly would trigger opposition, especially from employees who now receive generous health care coverage, said EBRI's Mr. Salisbury.

"The haves—those with health insurance—would be hit with all kinds of new taxes," he said.

Others, though, say at least Rep. Rostenkowski is being straightforward on the real costs—in terms of higher taxes—that expanded health care access requires.

"The tax hikes illustrate to everyone who wants to reform the health care system how truly expensive" it could be, Mr. McArdle said.

"The Rostenkowski bill is upfront about the tax costs," agreed James Klein, deputy executive director of the Assn. of Private Pension & Welfare Plans in Washington, D.C., a lobbying group that represents primarily large companies.

But the measure also contains what Mr. McArdle describes as "sweeteners" for employers.

Under the bill, a national 11-member commission, with members appointed by the president and subject to Senate confirmation, would set national health care spending limits. These limits could be increased by the growth of the gross national product plus 4% in 1993 and 1994, GNP growth plus 3% in 1995 and 1996, GNP growth plus 2% in 1997 and 1998, and GNP growth plus 1% in 1999 and 2000. Starting in 2001, the increase would be limited to the rise in the GNP.

Total U.S. health care spending rose 26.4% last year, while the GNP rose only 1%.

After these limits were set, the HHS secretary would set specific payment rates for health care services that would result in expenditures equal to the national limits. While physicians and hospitals could charge less than the set rates, they could not charge more.

Benefit experts note that the cost containment provisions in the Rostenkowski bill are the toughest yet in a health care access bill.

"This is the first proposal that has a clear, easily understandable statement on how health care costs will be controlled and how much of an increase will be tolerated," said Roger Taylor, national leader for health care consulting at The Wyatt Co. in Washington, D.C.

"These are the toughest cost containment provisions to date. The doctors and hospitals will certainly be strongly opposed," said Mr. McArdle.

Indeed, a spokesman for the American Medical Assn. in Chicago warns that the limits could result in health care rationing.

Employer groups, though, are divided on the bill's government-imposed cost controls.

Mark Ugoretz, president of the ERISA Industry Committee, a Wash-

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InsurerTopics

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Custom-built training programs

In-house education programs give insurers highly trained technicians and managers

By MARK A. HOFMANN

Given America's reputation as a nation of do-it-yourselfers, it should come as no surprise that insurers are finding it increasingly attractive to put together their own in-house education programs.

It's not that respected packaged programs aren't available nor widely used—they are. And it's not that insurers think they know everything about education—they don't. It's just that property/casualty insurers have found that an in-house educational approach allows them to mold employees in a way that promotes corporate goals much more effectively than any packaged program can, according to insurance training experts.

In addition, in-house educational programs allow training to be tailored to reflect constantly changing industry conditions.

In-house training programs also allow insurers to choose from a wide variety of tools. Some are purely homemade, like internal underwriting manuals and in-house produced training videos. Others are widely known, like the texts prepared by the Malvern, Pa.-based American Institute for Property and Liability Underwriters Inc. for professionals seeking its Chartered Property & Casualty Underwriter designation. And some tools might seem a bit esoteric, like excerpts from the writings of 16th century political philosopher Niccolo Machiavelli.

"A program tailored to your own environment is always superior," says Linda Christopherson, manager-corporate training for Royal Insurance Group of Charlotte, N.C.

"We can develop a program that meets the needs of our staff more effectively than anything we can find on the street," she said. At Royal, "virtually all" technical training—in areas like claims, underwriting, loss control, engineering and marketing—is internally designed.

"There's no place to get (specialized training of an equal caliber) on the outside," said Russ Rado, assistant vp-property/casualty division training for CIGNA Corp. in Philadelphia. "It gives us an opportunity to mold our people around CIGNA's philosophy and operations," and "it's an opportunity to introduce concepts" that guide the company's operations, he said.

To promote a strategic view of its educational needs, The Home Insurance Co. formed a company-wide training council in 1990, said Richard Coskren, vp-training and development with the New York-based subsidiary of Trygg-Hansa SPP Holding A.B.

The training council, which meets at least three times a year, is composed of representatives from four underwriting departments: personal lines, commercial lines, major accounts and specialty lines. The council also includes representatives from the loss control, electronic data processing, human resources departments as well as two regional representatives, currently from the insurer's New York and Western regions.

The council identifies areas where the company needs trained staff, and then makes training a priority in that area, said Mr. Coskren, himself a council member. The council basically "serves as a board of directors for the training programs," he said.

"We want to make sure we're spending the right money in the right places," said Mr. Coskren.

One "right place" is video training. This year, The Home produced a video for personal lines underwriters explaining the company's market strategy, Mr. Coskren said. Two other videos explained changes in employee savings and benefit plans that followed Home's purchase earlier this year by a group of Swedish investors (*BI*, Feb. 18).

Mr. Coskren said that sales training is the "most exciting" use of video technology. Video is used to "create scenes that depict certain behaviors" encountered in sales, he said. Also, video allows a company to get its training message out to the field in a consistent manner, he said.

Another dramatic tool—role-playing—is part of CIGNA's underwriting training program. About 18 months ago, the insurer embarked on a new three-phase training program for new underwriters, Mr. Rado said.

Trainees spend two to three months in a regional marketing center learning basics like rating techniques and different types of coverage through a self-study program. Next comes seven weeks of intensive training in Philadelphia, during which students are immersed in all aspects of underwriting.

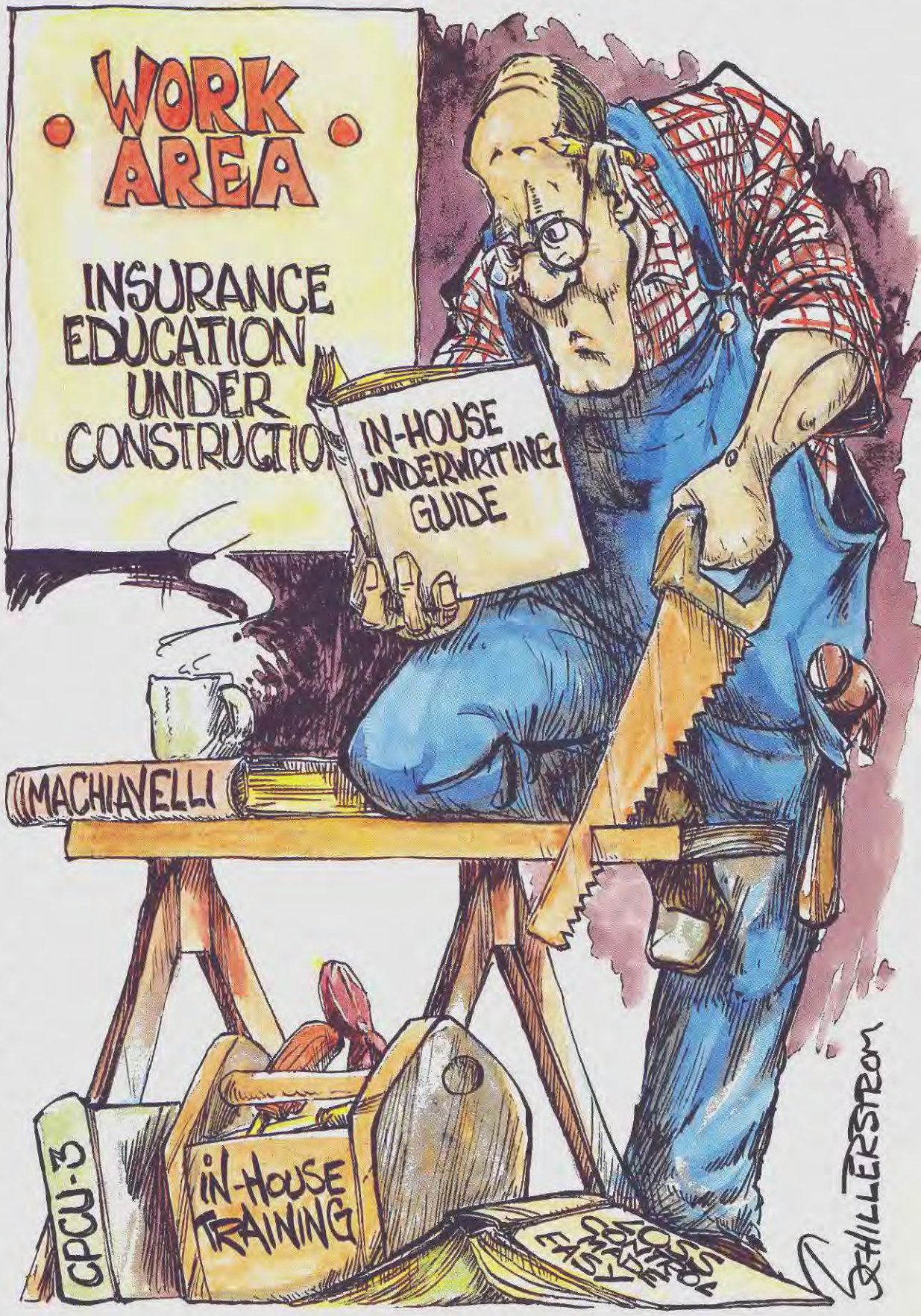
Finally, trainees go through simulated underwriting. Sitting at a computer terminal, they handle underwriting applications submitted by instructors playing various roles, like producers, Mr. Rado said.

After the simulation, students receive scorecards on their performance. Copies of those scores are also given to their regional managers so that perceived weaknesses can be corrected, Mr. Rado said.

Of the 120 or so new underwriters that have gone through the school, only two or three have dropped out. "They came to the realization that they really weren't cut out for this," he said. "They really opted out. We really don't fail a person."

The students who complete the training go back to their branch office and, under the guidance of their manager, work on understanding the conditions that are unique to their particular branch. The manager is also charged with correcting any deficient skills in students, Mr. Rado said.

In-house education also is important at Arkwright Mutual Insurance Co. The Waltham, Mass.-based insurer has sponsored its own "Arkwright University" three times since its launch in 1988.



"We had a staffing need for underwriters. We decided in effect to grow our own," said Patricia Roll, assistant vp and director of training.

In the past, Arkwright generally had hired experienced professionals rather than recent college graduates, she said. A decision to "grow our own" meant that the company had to create a new resource, which turned out to be a seven-month training program, she said.

The underwriter trainees attended formal classes at the company headquarters from June to around Labor Day, she said. The first class was composed of newly hired recent college graduates, but the second class was open to all Arkwright employees who wished to become underwriters.

Internal instructors, who are experienced Arkwright underwriters, taught students what Arkwright is and what it does, Ms. Roll said. Instructors also coached students on coursework needed to complete two of the 10 courses needed to earn the CPCU designation—CPCU 1: "Principles of Risk Management and Insurance," and CPCU 3: "Principles of Commercial Property Risk Management and Insurance."

The school was a "full-time, intense" experience, Ms. Roll said. While studying the CPCU portions, students met in the classroom for four hours each morning and studied in the afternoons. During their CPCU 1 studies, they were quizzed every day.

After completing the home office portion of the Arkwright program, students began an internship at the field offices that had hired them. They also read case studies that reinforced their academic training, Ms.

Continued on next page

Insurer Topics

Newborn institute has grown-up aspirations

By MARK A. HOFMANN

BURLINGTON, Vt.—The Vermont Insurance Institute is open for business at Champlain College, representing the culmination of several years' study and work by a partnership of public, private and educational interests.

Growth in Vermont's captive insurance industry has created demand for qualified employees familiar with the industry. However, the institute, which opened in April, will serve as a training resource for commercial insurers as well as their alternative market counterparts.

About four years ago, a committee consisting primarily of captive managers began looking into setting up an insurance educational program in the state, explained Leta C. Finch, director of the insurance institute. The group approached the state Agency of Development and Community Affairs with the idea. The development agency and the Vermont Captive Insurance Assn. sponsored a feasibility study in 1989.

Ms. Finch.

The study, conducted by consultants Milliman & Robertson Inc., concluded that there was a need for an insurance education institute in Vermont, said Ms. Finch. The nearest similar institute is The College of Insurance in New York.

Additional meetings with insurance agents and representatives of life and property/casualty insurance companies reinforced the survey's conclusion.

Champlain College in Burlington was chosen as the site of the new program. The private, non-profit college—which has been a two-year college specializing in business-oriented programs since its founding in 1878—will begin offering a four-year program leading to a bachelor's degree in business administration this fall.

While the institute is still in its infancy, it currently will offer workshops, seminars, and professional education courses as part of the new bachelor's degree program at Champlain. Ms. Finch, then risk manager for the University of Vermont in Burlington, was asked to head the new institute.

The institute's first course offerings will coincide with the college's changing curriculum, said Ms. Finch. The first course, "Essentials of Risk Financing," will be the Insurance Institute of America's Associate in Risk Management 56 course, to be followed by ARM 54—"Essentials of the Risk Management Process"—in the spring. Successful completion of each course will result in three college credits, said Ms. Finch. The institute's faculty are insurance industry professionals.

The courses will also promote insurance as a career, she said, noting that they will provide credits toward the Associate in Risk Management designation.

Ms. Finch said the reasons for using the IIA materials as a basis for the formal academic program are simple. "The IIA courses are excellent. They're respected and they're certainly well-known."

The Vermont Insurance Institute will also sponsor a two-track series of seminars beginning next month. The lecturers will be insurance professionals chosen by the institute. The first track is a general-topic lunchtime series directed toward consumers. A different subject will be discussed each month, starting with personal automobile insurance in September.

A more comprehensive series geared for captive managers is also scheduled for this fall, said Ms. Finch. These monthly half-day seminars will deal with subjects like the McCarran-Ferguson Act, reinsurance questions and surplus lines matters, she said.

Ms. Finch wants the institute's influence to extend to high school classrooms. She would like the institute to offer an introductory course in which college-bound students could earn three credits toward their eventual college degrees. For students not intending to go on to college, the course would act as an introduction to jobs in the insurance industry, she said.

In addition, the institute plans to sponsor at least two teleconferences dealing with life insurance. And, next June, it will host an all-industry event featuring an update on state and national legislative topics, she said.

"There's tremendous interest and support from all sectors of the insurance industry," Ms. Finch said.

But the new institute still must clear several hurdles, she commented. One of the biggest, of course, is funding and support. The institute has start-up pledges from insurance companies, captives, brokers, agents and other sources totaling roughly $225,000, Ms. Finch said. But the pledges will be paid over a three-year period, which means that "fund raising will be an ongoing process," she said. "We are a shoestring operation."

Another hurdle is correctly identifying needs and priorities for the institute, she said. This will depend in part on what the institute's student body ultimately becomes, whether it is full-time college students, professionals seeking continuing education, agents and employees of agencies, or a mixture of all those and others.

Yet another challenge is finding "qualified and exciting faculty," Ms. Finch said. "It takes some effort to identify good faculty."

The Vermont Insurance Institute "first must meet the needs of Vermont," Ms. Finch said. But she believes that if the institute flourishes in Vermont, its programs will be extended to other areas of New England, making it a regional institution and a resource for professionals throughout the area, much like New York's College of Insurance. That college serves a far wider area than Manhattan and does more than simply offer insurance courses.

"I'd like to see as many people as possible benefit from the institute," said Ms. Finch.

For more information about this institute, contact Signe Kastberg, Champlain College, P.O. Box 670, Burlington, Vt. 05402-0670; 802-658-0800. ■

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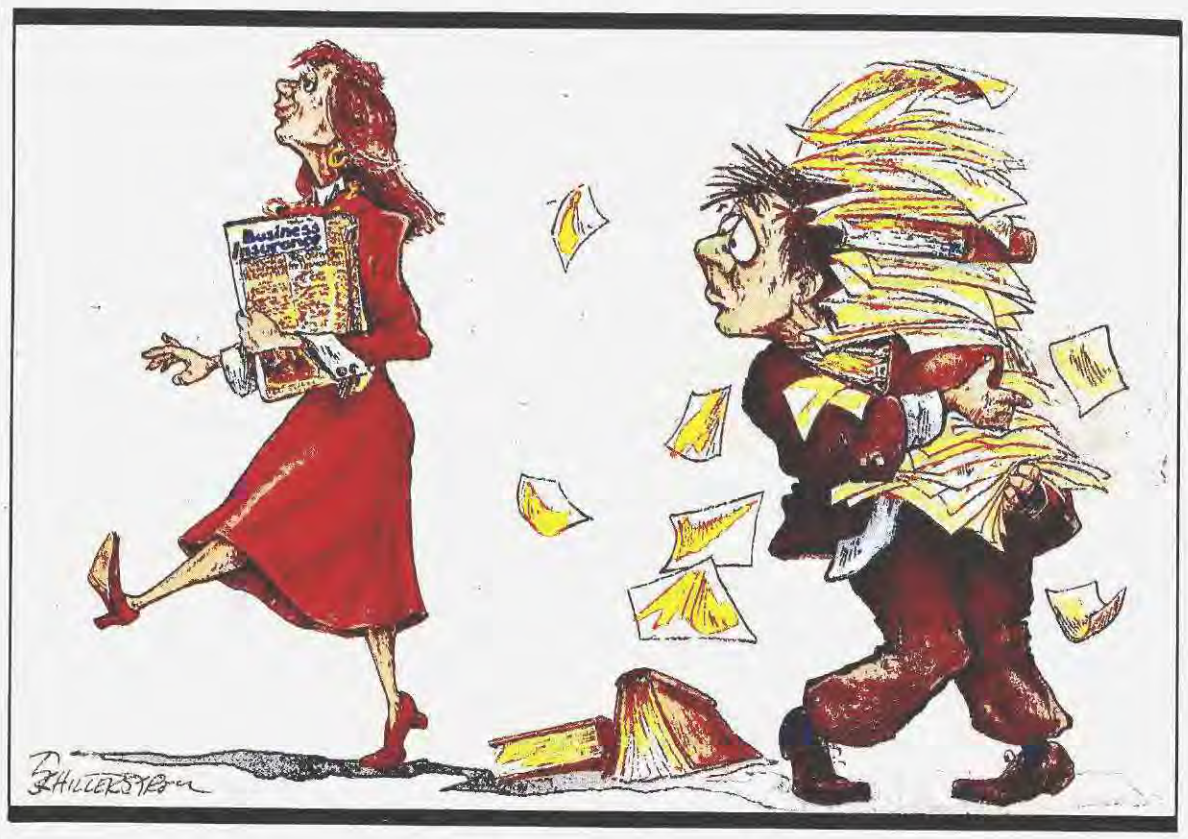

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Insurer Topics

Students rate industry's reputation

Results are 'surprisingly' positive

By MARK A. HOFMANN

BLOOMINGTON, Ill.—Mona Gardner decided the best way to find out what college students thought about the insurance industry was to ask them directly.

And what Ms. Gardner, the director of the division of business and economics at Illinois Wesleyan University, found out surprised her: Students' views of the industry were not as negative as she had suspected.

However, she's quick to point out that the perceptions of students involved in her study might have been influenced by the location of the school. Bloomington, Ill., is also the headquarters of State Farm Mutual Automobile Insurance Co.

Ms. Gardner's study grew out of a speaking invitation. She had been asked to address the local chapter of the Society of Chartered Property Casualty Underwriters on, among other things, college students' perception of insurance.

She asked the university's marketing students to survey 109 students last April. After a few questions about their own insurance buying habits, students were asked: "What do you think most *students* think about the reputation of the insurance industry?" regarding four different aspects of the industry.

Students were first asked to rank the value of insurance on a five-step continuum ranging from one, signifying "sound investment," to five, signifying "waste of money."

"Sound investment" was the response of 10.3% of the students. More than half of the respondents—52.3%—assigned insurance the positive rank of two. Slightly more than a quarter of the students—26.2%—gave insurance a neutral ranking of three and 9.2% gave it a negative rating of four. Only 1.9% called insurance a "waste of money."

But insurers didn't fare nearly as well on the next question. Students were asked to assess students' perception of the insurance industry's degree of honesty, ranging from one, signifying "honest," to five, signifying "dishonest."

Only 4.6% gave insurers the highest honesty ranking. An additional 25.9% gave them a two ranking. The neutral three ranking drew the highest proportion of support—42.6%. Twenty-five percent of the students gave insurers the negative four ranking, and 1.9% of the respondents branded insurers "dishonest."

Insurers also didn't score all that well on a continuum ranging from one, signifying "caring," to five, signifying "insensitive." Only one student—0.9% of the entire sample—rated insurers as caring.

An additional 13.1% gave insurers a positive two assessment, while 51.4% gave insurers neutral marks. More than a quarter—26.2%—assigned insurers a negative four rating and 8.4% called insurers insensitive.

The fourth reputation question asked students to rank insurers on a continuum that ranged from one, standing for "manipulative," and five, standing for "neighborly."

Insurers received a "manipulative" rating from 6.6% of the students. Slightly more than a fifth—20.8%—gave insurers the two rating, while nearly half—49.1%—offered a neutral assessment. A little less than a quarter of the students offered positive assessments of insurers, with 21.7% giving them a positive rating of four and only 1.9% calling them "neighborly."

Acknowledging that the results were more positive than she had anticipated, Ms. Gardner offered two possible explanations.

"My opinion is that there may be some halo effect from the presence of State Farm," she said. The insurer—the nation's largest—is the biggest employer in Bloomington and has a reputation for both "outstanding benefits" and job security in its home office, she said. That reputation is known on campus, because a significant portion of the student body comes from the Bloomington area.

She also noted that State Farm recruits actively on campus. In addition, Edward B. Rust, State Farms's president and chief executive officer and an Illinois Wesleyan alumnus, has spoken to Ms. Gardner's classes about education, careers in general and on the insurance industry, she said.

One other factor may be the risk management major offered in the university's business administration program. Some of the students surveyed might have an enhanced view of the insurance industry from having taken risk management and insurance courses, she said. This same perception might not arise on campuses without insurance courses, Ms. Gardner said.

The survey also asked students to name the "entry-level position in the insurance industry that comes first to your mind." Sixty-five of those who answered said agent or salesperson, 10 said underwriter, eight said claims adjuster and two said accountant. Six more respondents offered other job titles, including "weasel."

In her address to the local Society of CPCU chapter, Ms. Gardner said that the experience of professionals at IWU's career center "confirmed my own impression that college students' interest in employers about which they have little first-hand knowledge is greatly influenced by the image or mystique of the industry."

"Although a particular company may have little difficulty attracting qualified applicants in geographic areas in which it has a strong presence, its fate outside those regions is influenced by the information or misinformation reported on television and radio and in other media," she said.

"Companies should not assume that just because their names are well-known or respected among the business community or even among adult consumers, they will be well-known to students," she warned.

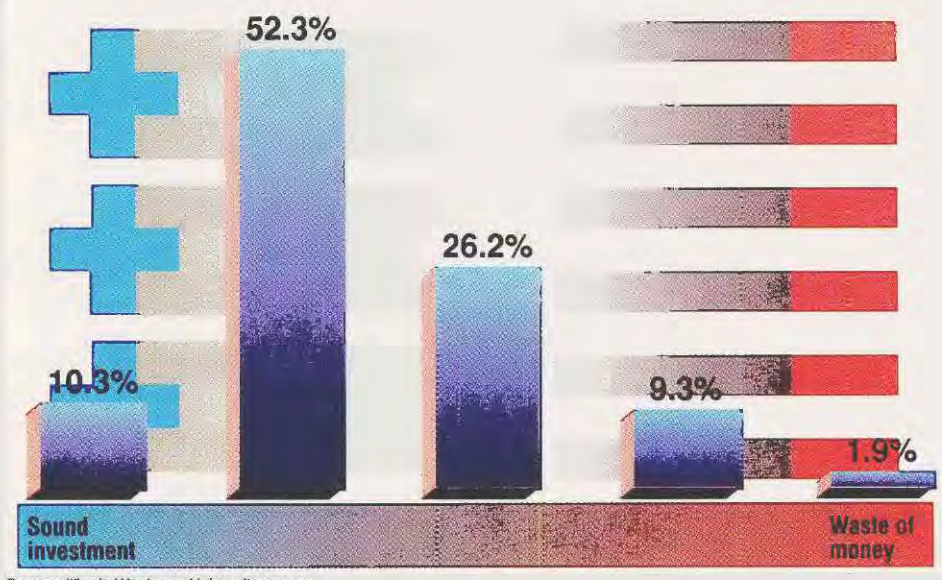
She repeated advice that the director of IWU's career center gave to a life insurer whose recruiters were surprised that more students were not clamoring for interviews. The career center director advised the company to "develop an on-campus identity before coming to recruit," Ms. Gardner said.

"Sponsor a speaker for a campus organization, send an employee who is an alumnus of the school to speak to classes, join with other firms in the industry to hold a career fair and so forth," said Ms. Gardner.

"Most of all, insurance recruiters would do well to identify the extent to which working in the industry can be exciting and stimulating, because few students, going into their interviews with insurers, expect the excitement to be there," said Ms. Gardner. ■

Is insurance a...

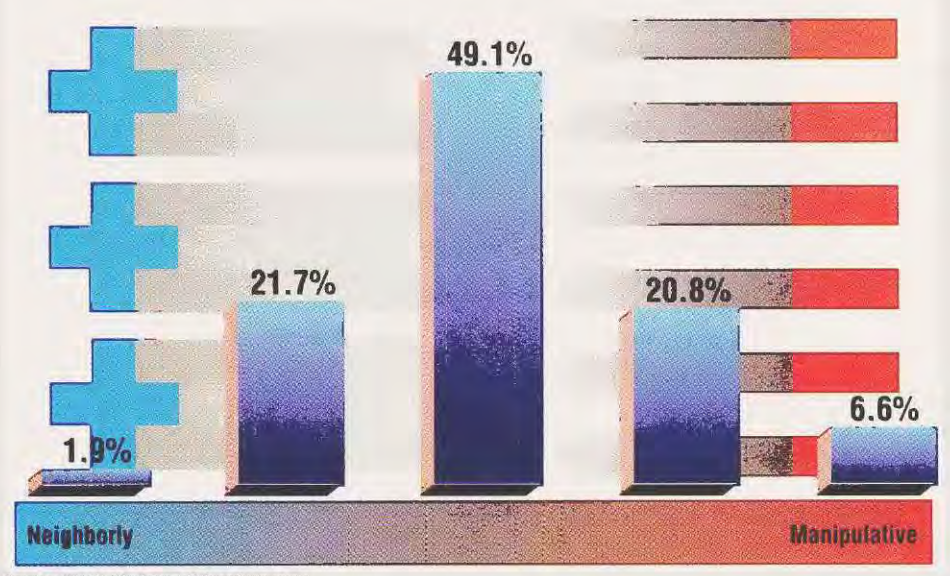
Sound investment or waste of money?



Source: Illinois Wesleyan University survey

Are insurers...

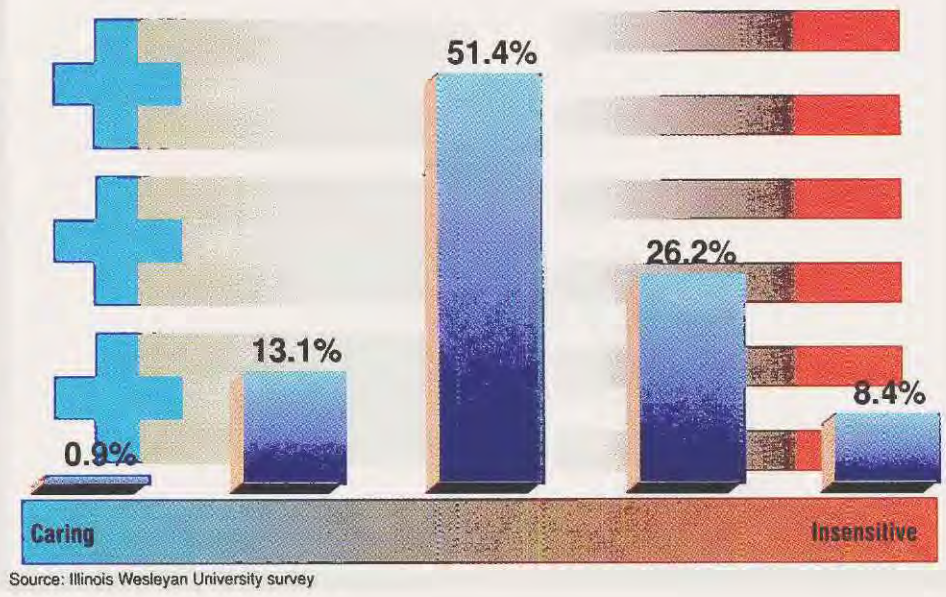
Neighborly or manipulative?



Source: Illinois Wesleyan University survey

Are insurers...

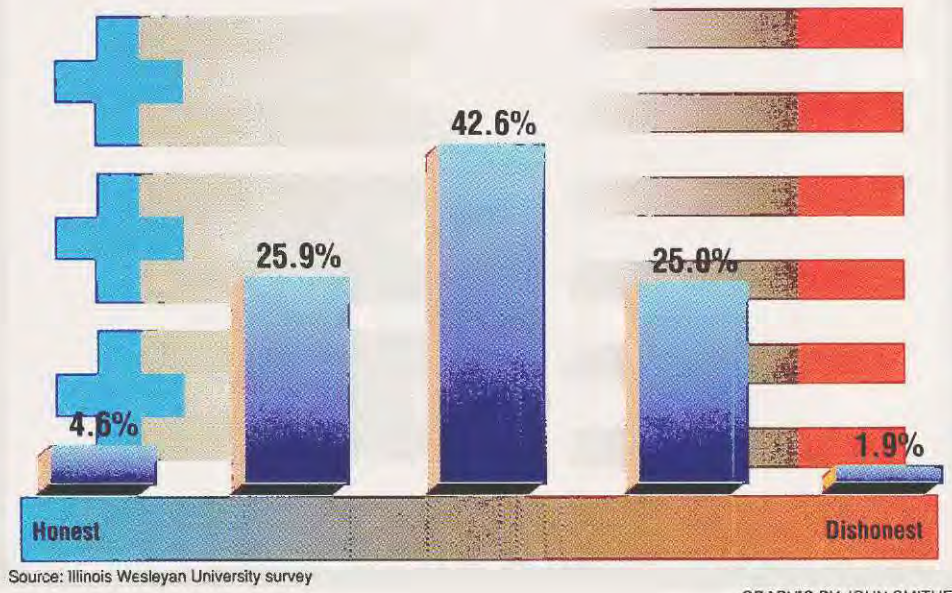
Caring or insensitive?



Source: Illinois Wesleyan University survey

Are insurers...

Honest or dishonest?



Source: Illinois Wesleyan University survey

GRAPHIC BY JOHN SMITHER

Insurer Topics

IIA's parent assumes enhanced role in 90th year

By MARK A. HOFMANN

PHILADELPHIA—The Insurance Society of Philadelphia is like a parent whose own remarkable accomplishments have been overshadowed by the even higher-profile achievements of its child.

Established in 1901, the society is one of the oldest insurance professional education organizations in the nation. And the society was the driving force behind the creation of the Insurance Institute of America.

The IIA, now based in Malvern, Pa., has since become the country's best-known administrator of professional property/casualty insurance educational programs and will administer its millionth examination sometime this year.

But the IIA probably would not exist in its present form were it not for the Insurance Society of Philadelphia. In 1908, members of what was then called the Fire Insurance Society of Philadelphia proposed the formation of a national insurance education organization. Members of the Fire Insurance Club of Chicago, the Insurance Institute of Hartford, Conn., the Insurance Library Assn. of Boston and the Insurance Society of New York journeyed to Philadelphia in 1909.

The meeting resulted in the foundation of the Assn. of Insurance Societies & Institutes of America, which later became the IIA. It set up shop in downtown Philadelphia, remaining there until the early 1970s, when it moved to suburban Malvern.

The IIA's ascendancy paralleled the Philadelphia society's decline. "For a long time, (the society) was the heart of the insurance industry" in downtown Philadelphia, said Mariellen Whalen, president of the society. It provided members, most of whom had offices in a relatively small area of downtown Philadelphia, with both educational and social opportunities, she said.

Its first meeting was Nov. 18, 1901, at the Engineers Club. W.H. Stratton, manager of the Factory Insurance Assn., spoke about mill fire protection. During the society's first year, speakers addressed matters including chemical causes of fires, hazards of electricity and smoke explosions. The society also established a library. By the end of its first year, the society had attracted 220 members.

Ms. Whalen points out that Philadelphia's concentrated insurance marketplace helped promote cohesiveness among members. Nearly 90 insurers and nine agencies had offices within an approximately 40-block area bounded by Market Street to the north, Second Street to the east, Locust Street to the south and Ninth Street to the west. During the first third of the century, the society could draw members for seminars even on Friday nights, she said.

But by the 1950s, the insurance industry had spread beyond downtown Philadelphia. The managers, underwriters and executives who formed the backbone of the society moved offices and homes to the suburbs. "The social end of the society declined," Ms. Whalen said. As a result, the group grew less and less active.

During the late 1970s and early 1980s, the society re-examined its role. Under the leadership of James Bryson, president of Bryson Associates Inc., a Jenkintown, Pa.-based surplus lines broker, the society hired a new director: Ms. Whalen, a former business professor at Rosemont College in Philadelphia's western suburbs.

During the 1980s, the society renewed its focus on professional education. It held workshops, started programs for people not previously exposed to insurance education and acted as a resource for professionals taking IIA courses and courses leading to the Chartered Property Casualty Underwriter designation bestowed by the IIA's sister, the American Institute for Property & Liability Underwriters in Malvern.

Daniel F. Crough, the society's current chairman, said that the society's current direction reflects goals originally set out in the group's bylaws. Mr. Crough, who is also president and chief executive officer of Mutual Assurance Co. in Philadelphia, said the goals are to provide:

- Continuing education.
- Education of the general public.
- A meeting place for the membership and the insurance community at large.

About 2,500 students currently attend society-taught courses leading to various associate designations granted by the IIA and courses leading to the CPCU designation.

Although the society's goals were set decades ago, the society often finds it necessary to promote them in non-traditional ways. For example, Ms. Whalen said the society is considering expanding the society's course offerings beyond the classroom walls.

The society "is raising some questions" about improving self-study tools like videotapes and audiotapes, she said. If, for example, society faculty recorded audio highlights of courses, students could listen to them on the way to and from work, she said.

The society also has begun a partnership with the Philadelphia public school system, she said. Designed to be a bridge between the public school system and the insurance industry, the "Insurance Career Opportunity Program" was begun in 1989. At that time eight insurers and agencies offered 19 high school students a year-long internship during their senior year.

Ms. Whalen said the program tries to help students, many from the inner city, make the transition from school to workplace. "We're focusing on kids who aren't going to college," she said.

It has proved a success, she said. Students work full time during the first summer and then part time during their senior year. About half of the original 19 accepted jobs within the companies where they worked as interns.

Another area in which the society has become increasingly involved is continuing education, said Ms. Whalen. Delaware, Maryland and New Jersey—portions of which are served by the society—have adopted continuing education requirements for insurance agents and brokers. "I think continuing requirements are going to" promote the recent growth of the society's efforts, she said.

Mr. Crough added that the society is "getting ready to put together a data processing system to keep track of the continuing education requirements" for producers, regardless of whether they are members of the society.

Continued on next page

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INovember

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Insurer Topics

Society

Continued from previous page

The society's approximately 70 instructors conduct classes and workshops at more than 40 locations in Delaware, New Jersey and Pennsylvania. Using professionals as part-time instructors gives the society's programs "an edge," said Ms. Whalen. Someone out of the day-to-day workings of the market for two years may lose touch with important developments, she said.

Practical information is particularly valued during the current soft market, she said. Insurers and agents are being forced to cut back the money spent for education at a time when professionals are being asked to work longer, harder and smarter, she said. Managers are loathe to part with employees for long-term training and more interested in workshops lasting a day or less.

The society recently began extending its influence beyond the Philadelphia area. It contracted with the Loss Executives Assn. to run the group's first "claims college" earlier this year in Princeton, N.J. The claims college is a four-day training program for entry-level claims professionals.

The society also helped develop and administer a three-day annual educational program for surplus lines insurance professionals. The program, developed under a contract with the National Assn. of Professional Surplus Lines Offices Ltd., was held at the University of Vermont in Burlington in 1990 and at Washington University in St. Louis this past July.

The society is planning a formal 90th anniversary celebration Sept. 24 featuring a panel discussion on the state of the U.S. property/casualty insurance marketplace from a European perspective. Cokie Roberts of National Public Radio is scheduled to give the luncheon address.

Regarding the society's mission after 90 years, Mr. Crough said, "If you look back at its history, I know everybody speaks in terms of education." He added, however, that the group has functioned as more than a formal institution of learning or a social club.

"It serves the purpose of passing the baton from one generation to another," he said. "We talk about artificial intelligence and computers and the need to capture that expertise electronically," he said. But in the meantime, the society provides its younger members a chance to tap the expertise first hand, he said. ■

College sends classes to work

By MARK A. HOFMANN

SCHAUMBURG, Ill.—A streamlined curriculum designed specifically for insurance professionals is allowing adult students in the Chicago area a chance to earn bachelor's degrees while working full time.

The program, called professional studies for the insurance industry, was designed by Chicago's Roosevelt University in conjunction with local insurance educators and the Zurich-American Insurance Group in Schaumburg, Ill. Students who complete the program receive a bachelor of general studies degree from Roosevelt.

Zurich-American was the driving force in creating the program. "We had been looking for an opportunity to extend our relationship with the educational community," said Wayne Bossov, director of training and development at the insurer.

"We wanted something that was relevant to our industry. We wanted something that was business-related. We wanted something on-site," he said.

Zurich-American found those qualities through Roosevelt University's Partners in Corporate Education program. Under the 2-year-old program, Roosevelt faculty conduct classes at work sites. Schedules are arranged to meet the needs of the students, who receive full student services—including registration, counseling and textbook sales—at the work site.

Originally designed for Zurich-American employees, the program now extends to all insurance professionals in the Chicago area.

More than 30 concentrations have been created for the Partners in Corporate Education program, explained Adrienne N. Hirsch, its director at Roosevelt. About 500 students have entered the program since its inception two years ago, she said.

Because the bachelor in general studies program is designed for

Mr. Bossov

Ms. Hirsch

working adults over the age of 25, "we've stripped the electives away," Ms. Hirsch said. The bachelor in general studies program was established 26 years ago, with classes conducted at Roosevelt's campus in downtown Chicago.

The bachelor's program in insurance requires completion of 81 credit hours, she said. However, students can receive up to 12 hours of credit by earning the Chartered Property & Casualty Underwriter designation. And, students who have earned one of the associate designations granted by the Insurance Institute of America in Malvern, Pa., receive three hours of credit for each associate designation, up to a total of 12 hours.

In addition, students receive credit for college-level courses already completed, she said.

Mr. Bossov said that Zurich-American's participation, which began with about 20 employees in the fall of 1990, has drawn "a broad mix of people," including supervisors. He said most students will probably take several years to complete the program because they do so at their own pace and on their own time.

Still, "it beats a dozen years" spent getting a bachelor's degree, Ms. Hirsch said.

Roosevelt also plans to hold classes at the Insurance School of Chicago later this year, Ms. Hirsch said.

"I really think this is a unique partnership between academia and business," said Diane Barton, director of the insurance school. "I'm very supportive of their efforts."

Ms. Barton said that some colleges allow students who have earned IIA or CPCU designations to apply for credits based on their achievement. The catch is, students have to negotiate with professors for the credits. "Now, they can apply it directly against a bachelor's degree."

Ms. Hirsch predicted that programs like the new insurance curriculum will grow increasingly popular as employers find the search for qualified workers ever more difficult. "Companies are beginning to invest in the human capacity," as a means of competing, she said. ■

Grassroots lobbyists start with the basics

By MARK A. HOFMANN

OAK PARK, Ill.—Writing a letter to your elected representative doesn't do much good if you don't know who represents you.

Yet, points out Agust Gudmundsson, president of Public Affairs Technologies, national surveys have shown that only 12% of registered voters know the identity of their state senators and representatives. Considering that roughly 40% of eligible voters don't bother to register, the percentage of people who know whom to contact to give their opinion on matters of public policy is quite small, said Mr. Gudmundsson, a political consultant based in Oak Park, Ill.

Thus, when insurers want to rally their employees or agents to support or oppose a bill, they face a daunting task, said Mr. Gudmundsson. The job becomes even more confusing during the early years of any given decade, when legislatures redraw district lines following the U.S. census. A voter doesn't have to move an inch to find himself or herself being represented by a new legislator.

Mr. Gudmundsson is in the business of matching voters with their representatives. "We offer a service whereby we will match addresses of names you have on your file to their legislators," he said. Although the service is not aimed exclusively at insurers, it has been used in Illinois to promote industry interests.

One example is a bill that would greatly restrict the use of sealed settlements in product liability lawsuits. Business groups argue that such laws would make information like product formulas and previous settlement awards too readily available.

A coalition of business, manufacturing and insurance groups called the Illinois Product Liability Project hired Public Affairs Technologies to orchestrate the opposition campaign. Letters went out to Illinois manufacturers and businesspeople, urging them "to take two minutes and call your state senator," after which the senator's name and telephone number appeared.

Running these grassroots campaigns is "one of the most dynamic and powerful" methods of influencing lawmakers, he said. Traditional methods—like delivering petitions or deluging a lawmaker's office with preprinted letters—no longer have the impact they once did. A more personalized approach like the one used by the Public Affairs Technologies is both more sophisticated and more effective, said Mr. Gudmundsson.

So effective, in fact, that the Illinois proposal was defeated earlier this year. Customized mailing certainly could not be credited with the entire victory, but its response rate of about 12% was impressive, he added. Successful direct mail campaigns often have a response rate in the low single digits.

He said that part of the reason for the high return rate was a well-written letter spelling out exactly what recipients stood to lose if the bill became law. Any successful appeal "has to have a sense of urgency," he said.

Mr. Gudmundsson said that he began working on the process about 18 months ago. The system, commercially known as LegisLock, is a computerized matching process using the most current legislative districting data, he said. It codes addresses with legislative district information. Mr. Gudmundsson said previous systems often relied on ZIP code information—which does not necessarily coincide with legislative district lines.

The Illinois campaign was "a chance for us to test that all of our theories would function," he said. He added that, to the best of his knowledge, his service is unique, though other consulting firms offer similar services.

The system is currently programmed to deal with legislative data from Illinois, New York and several New England states, he said. With new census material and legislative redistricting plans being drawn, Mr. Gudmundsson says he anticipates having the entire nation on the data base by January. ■

FAIR plan losses up sharply

BOSTON—The nation's Fair Access to Insurance Requirements plans reported statutory underwriting losses of $54.4 million in fiscal 1990.

These losses represented a 53.2% increase over the $35.5 million loss registered in 1989, according to the Property Insurance Plans Service Office, a division of the National Committee on Property Insurance, both of which are based in Boston.

Written premiums for the FAIR plans, which provide property coverage to people and business that can't easily obtain such coverages, stood at $245.8 million in 1990, compared with $269.9 million a year earlier, an 8.9% decrease.

The plans also registered a 7.6% drop in new applications to 244,824 in 1990 compared with 264,824 in 1989. The plans issued 147,950 new policies in 1990, a drop of 8.7% from 1989's 162,059.

Vairo, Isom elected

MALVERN, Pa.—Robert J. Vairo was recently elected chairman of the board of trustees of the American Institute for Property & Liability Underwriters Inc. and the Insurance Institute of America Inc.

Mr. Vairo is chairman, president and chief executive officer of Crum & Forster Inc. in Basking Ridge, N.J.

Gerald A. Isom, president and chief executive officer of the Woodland Hills, Calif.-based Transamerica Insurance Co., was elected vice chairman of the two institutes.

IT briefs

University program

ANN ARBOR, Mich.—The University of Michigan will offer insurance and risk management classes as the result of a new $1 million insurance and risk management endowed professorship.

The university has raised private donations from both individuals and companies, said Anneke Overseth, associate dean for external relations.

The endowed chair will mark the beginning of the university's insurance and risk management program, Ms. Overseth said. The endowment will provide for both undergraduate and graduate business classes.

The university hopes to hire the new professor by the fall of 1992, Ms. Overseth said.

AAIS conference

BENSENVILLE, Ill.—The American Assn. of Insurance Services is focusing on legislation and regulation at its fall conference in Baltimore Oct. 13-15.

Speakers include Michael E. Dunn, a Washington, D.C.-based political consultant who has worked with the Alliance of American Insurers and the Assn. for the Advancement of Life Underwriters; Paul A. Equale, senior vp-government affairs at the Independent Insurance Agents of America Inc.; and Sarah Weddington, an attorney and lobbyist best known for her defense of "Jane Roe" in *Roe vs. Wade*, the decision that legalized abortion.

AAIS is a rating, statistical and advisory organization. Its members are primarily small and medium-sized property/casualty insurance companies.

For further information on the conference, contact Carol Poynter at 708-595-3225. ■

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Business Insurance

CPCU candidates face curriculum changes

By MARK A. HOFMANN

MALVERN, Pa.—Candidates seeking the Chartered Property & Casualty Underwriter designation will have to fulfill some new educational requirements beginning Aug. 1, 1992.

The changes, announced recently by the American Institute for Property & Liability Underwriters in Malvern, Pa., include the expansion of one CPCU course, an overhaul of another course and an end to the practice of allowing CPCU candidates to substitute the completion of designated Insurance Institute of America courses for CPCU courses.

The non-profit American Institute confers the CPCU designation, while the IIA offers 16 certificate or designation programs in property/casualty insurance.

This is not the first time the CPCU curriculum has undergone revision, said Norman Baglini, president of the two Malvern, Pa.-based institutes. For example, textbooks are revised every three to four years, he said.

The whole curriculum is reviewed every 10 to 12 years, he said, noting the current review began in 1988.

As part of the review, a survey by Landy & Associates, a Lexington, Ky.-based market research firm, asked 600 active and inactive CPCU students and recent CPCU designees about their perceptions of the program, said Robert J. Gibbons, vp of the institutes.

The survey found that people pursued the CPCU designation because they wanted a broader understanding of the property/casualty insurance industry and because they had a "high regard" for the designation.

The American Institute revised the course work based on the results of the survey. People currently enrolled in the program or who enroll before Aug. 1, 1992, may complete their course work under either the new or the existing curriculum, and all credits earned before then will remain valid. Those enrolling after Aug. 1, 1992, must complete the new course work to obtain the designation.

The changes to the program are:

• CPCU 1, now called "Principles of Risk Management and Insurance," will be expanded to include the study of ethics and professionalism, now included in CPCU 10, "Insurance Issues and Professional Ethics." The new CPCU 1 will be called "Foundations for Insurance Professionalism." It will be introduced in the fall of 1992, with the first examinations given in January 1993.

Mr. Baglini explained that the current CPCU 10 course has two parts: ethics and issues. Ethics shifted to CPCU 1 because "we're treating ethics as a principle of insurance," he said.

• CPCU 10 will become "CPCU 10/Related Studies," which will allow students to select a particular field within insurance for further study. Until June 30, 1997, students also will be permitted to fulfill the requirement by completing the existing CPCU 10.

Students also can fulfill the CPCU 10 requirement by passing any of 17 examinations related to the fields for further study. These are: AIC 35, "Property Loss Adjusting"; AIC 36, "Liability Claims Adjusting"; ARM 55, "Essentials of Risk Control"; ARM 56, "Essentials of Risk Financing"; AU 63, "Commercial Liability Underwriting"; AU 64, "Commercial Property and Multiple Lines Underwriting"; ALCM 74, "Accident Prevention"; ALCM 75, "Property Protection"; ALCM 76, "Occupational Health and Hygiene"; AAI 83, "Agency Operations and Sales Management"; APA 92, "Premium Auditing Applications"; ARP 102, "Strategic Management for Insurers"; AIAF 112, "Insurance Information Systems"; AIAF 113, "Insurance Company Finance"; AMIM 121, "Ocean Marine Insurance"; AMIM 122, "Inland Marine Insurance"; and ARe 142, "Reinsurance Practices."

Candidates also may fulfill the CPCU 10/Related Studies requirement by completing the IIA program in General Insurance—INS 21, 22 and 23. Candidates who have earned the Bryn Mawr, Pa.-based American College's Chartered Life Underwriter designation also will meet the CPCU 10/Related Studies requirement.

• CPCU requirements no longer will be waived when a CPCU candidate has completed comparable IIA programs.

Mr. Baglini said that eliminating the waivers reflects changes in the various IIA course requirements. When waivers were instituted in the mid-1970s, the institutes sought to recognize overlaps between CPCU courses and IIA courses and eliminate duplicative course work, he said. But as IIA courses have been revised over the years, the amount of overlap has decreased, he said.

• The rest of the CPCU courses will be revised to stress the relationship of other business disciplines to the property/casualty insurance industry. The remaining courses are CPCU 2, "Personal Risk Management and Insurance"; CPCU 3, "Commercial Property Risk Management and Insurance"; CPCU 4, "Commercial Liability Risk Management and Insurance"; CPCU 5, "Insurance Company Operations"; CPCU 6, "Legal Environment of Insurance"; CPCU 7, "Management"; CPCU 8, "Accounting and Finance"; and CPCU 9, "Economics."

Mr. Gibbons said the courses will be updated to include study of current issues. And, "general business courses CPCU 6, CPCU 7, CPCU 8 and CPCU 9 will be moving even more toward bridging these subjects to the insurance environment."

Mr. Baglini said that a new course dealing with current issues in insurance also is under development for those who have already earned their CPCU designation.

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Further information about the CPCU curriculum is available from the American Institute for Property & Liability Underwriters Inc., Field Services Department, 720 Providence Road, Malvern, Pa., 19355-0770; 215-644-2100, ext. 8520.

Rostenkowski bill

Continued from previous page

ington, D.C.-based benefits lobbyist, says the cost control provisions don't go far enough. Because those provisions only apply to physician and hospital services, the cost of other services, like prescription drugs, could shoot up, he said.

But Sharon Canner, assistant vp at the National Assn. of Manufacturers in Washington, D.C., worries that cost controls could limit medical innovation. "The bill fails to recognize there are health care providers who perhaps should be paid more."

Labor organizations strongly support limits on health care cost hikes.

"Purchasers simply cannot stand much more in the way of health care cost increases," said Karen Ignagni, director of employee benefits at the AFL-CIO in Washington, D.C.

Employers with retiree health care plans that provide benefits before Medicare kicks in at 65 would be big winners: The measure would lower the eligibility age for Medicare to 60 from 65. Beginning on Jan. 1, 1993, the eligibility age would be lowered to 64, and then would drop by one year over the next four years until it drops to age 60 on Jan. 1, 1997. ■

Cost Container

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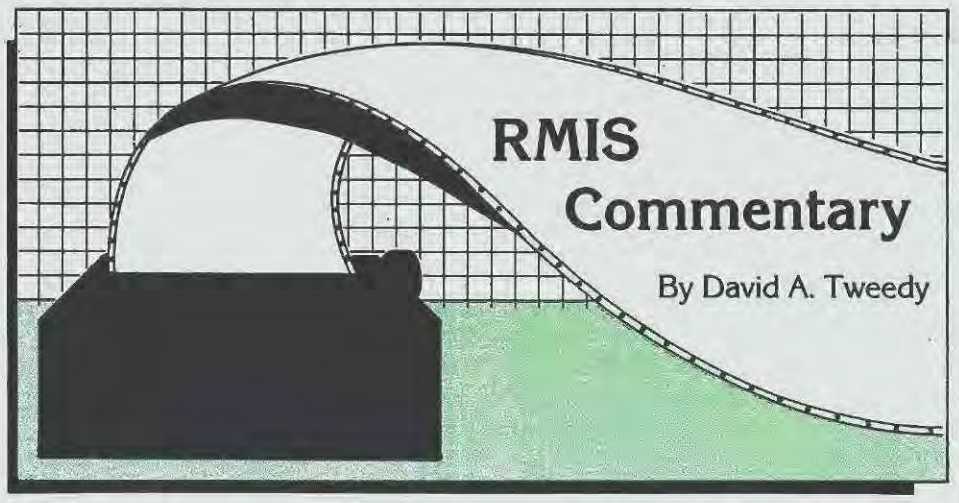
Medical cost management

Latest software can scrutinize fees for their reasonableness



MEDICAL COST MANAGEMENT is the fastest growing and most popular area of expense management today.

Last month, I introduced the topic of expense management as part of my series on risk management information systems and effective claims management (*BI*, July 29). Remember that expense management is a subdivision of claims management, which is part of risk control: those activities designed to reduce/control the frequency and severity of property/casualty claims against a firm.

Expense management really does not center attention on how well a claim is investigated, reserved and settled but rather on the subcomponents of a claim. Usually, those are the medical and legal expenses associated with that claim. Lately, these subcomponents of the claim have gone out of control.

This month, I would like to discuss medical cost management. Differentiating among the various types of services offered, let alone picking the right organization, is a significant challenge for any prospective buyer.

At this year's Risk & Insurance Management Society conference, the vast majority of the more than 280 exhibitors offered some type of workers compensation-related service—whether insurance, self-insurance, claims management, medical-related or system-related.

Why is there such intense interest? Two obvious reasons present themselves:

First is spiraling medical costs. According to Crawford & Co., one of the largest property/casualty third-party administrators, workers compensation medical costs are rising 50% faster than group heatlh benefit costs. Between 1980 and 1988, workers compensation medical costs rose 98%, more than triple the 31% rise in indemnity payments. About half of every claims dollar is medical-related.

Most experts agree that it is the medical component that drives the workers compensation claim.

Indemnity costs are really a function of how long the injury or disorder persists. The employee's physician is obviously a key figure; usually he or she recommends the length of disability as well as the actual treatment.

Understanding the true nature of the disability, as well as the specific limitations or alternate patterns, not to mention the reasonableness of the expense charged, has been difficult for the workers compensation claims person. Most challenges made to the employee's physician—usually through an independent medical examiner—are denied by a state workers compensation commission—hence, one of the reasons for continually rising workers compensation medical and, therefore, indemnity expenses.

Another reason for the interest in workers compensation is the opportunity for significant savings. This is worth emphasizing, for I can think of no other component of an RMIS that can nearly guarantee cost reduction through identification of unnecessary, duplicative or excessive medical treatment. Many clients using a medical cost management firm can cut their medical costs up to 30% to 40%.

This column will provide an overview of the types of medical cost management software available today by feature, not necessarily by provider. Many of the major RMIS vendors provide such software within

Continued on next page

ASK A RISK MANAGER

Reports to bosses describe risk management successes

Q **With many companies reducing staff in these tough economic times, we risk managers have to demonstrate our value to our employers. I would like to prepare a formal report on risk management activities for our executive management. Do you have any suggestions on what to include?**

A Preparing a report on risk management activities for your company's executives is an excellent idea. Over the years our responsibilities have expanded into many critical areas, all of which have a direct impact on our employers' performance and profitability. We find ourselves entrenched in safety, environmental and legal issues, to name but a few, and are expected to be experts in these areas. Furthermore, we accomplish our objectives with relatively small staffs and conservative budgets.

A formal report not only increases management's awareness of our value to the company but also causes us to focus on our departmental strengths and areas for improvement. For those risk managers who publish a risk management manual, the report I will describe is considered separate from the manual, because it provides an ongoing status report of risk management activities and is not intended to be viewed as a policy statement.

I like the idea of an annual report to the executive level. There is also a need for more regular—perhaps monthly—written updates to direct superiors. The annual report should cover the following areas:

- Statement of purpose.
- Overview of the risk management organizational structure.
- Departmental objectives from the prior year.
- Major achievements.
- Opportunities for areas of improvement.
- Ongoing objectives.

Your statement of purpose should clearly explain the reason for the report, which is to inform executive management about the role risk management plays in supporting the entire organization's goals. Keep the preface short, because the body of the report will elaborate on the various activities.

The overview of the risk management organizational structure provides a means of highlighting the major responsibilities of your staff. Most risk management departments have claim specialists, analysts and safety personnel. If you rely on professionals outside of the organization to furnish a particular service, identify their involvement in your risk management program.

This category also includes third-party administrators, health care management personnel, occupational rehabilitation specialists and your risk management information system vendor. In fact, with today's trend toward downsizing staff, companies are increasingly using outside service providers.

The ultimate goal of every department is to support the objectives of that organization. Your report should mention your department's objectives for the prior year and how they benefited the organization as a whole. Perhaps one objective was to self-insure a particular exposure or initiate a new loss prevention program. Both of these objectives, when effectively implemented, can positively affect the performance of your company.

It is important for you to list the major achievements of your department over the past year. It's not important to focus on routine, day-to-day activities, but rather on those that resulted in a significant positive impact for your company. Keep in mind what your objectives were and how you met them. Were you successful in implementing a self-insurance program? Did you reduce the number of lost-time accidents? Were you able to initiate a light-duty back-to-work program? This is the place to tell your executives how well you performed.

Although there are many accomplishments to mention, there are disappointments as well, as one would expect. Each of us has a wish list of matters that perhaps should be referred to as unfinished "opportunities." For one reason or another, a project was not completed or a desired change in the risk management program's administration was not accomplished. It is important to list these items as well. Your reporting on such issues may be the catalyst needed for senior management to buy into a particular concept and approve the resources needed to seize a new opportunity.

Many risk management activities are carried over from year to year. Loss prevention inspection programs and employee training programs are examples. Your report should provide a status of such activities, since their level of effectiveness will influence the financial health of your company.

Over the past few years, we have seen Occupational Safety and Health Administration guidelines expanding into new areas like the "employee right to know" standard. To

Continued on next page

Medical expenses

Continued from previous page
their systems. TPAs, insurers and specialty vendors offering a wide range of risk control services also have a variety of software products all aimed at the reasonableness of medical services rendered and the resulting costs.

Medical expense examination software can be roughly subdivided into bill audit software and medical review software.

Bill audit software is the most common and oldest software package in the medical expense management area. Most of the major RMIS vendors and TPAs have this capability, or have access to it. Essentially, bill audit software will evaluate each medical bill, whether from a hospital or other provider, and compare it either against a state fee schedule or usual and customary tables. Many states have fee schedules built into their laws; the other states utilize reasonable or usual and customary schedules.

Quite simply, bill audit software packages compare actual charges to the state fee schedule or usual and customary schedule for that procedure. The deviation is then noted on a printout either in an "explanation of benefit" format or a line item expense report, depending on the particular package.

Most major TPAs have some type of fee schedule/bill audit system combined with their claims information system. CIGNA/ESIS uses ACUMED, the bill audit service of Intracorp, a CIGNA subsidiary in Berwyn, Pa. This system can review all or part of the medical bills associated with a company's workers comp exposure.

Crawford & Co., which has several systems, including Risk Sciences Group Inc.'s Sigma+, has a separate stand-alone system called Sentinel Medical Review Systems. Crawford has the capability of evaluating 100% of all medical bills through this system. By their estimate, introducing this service cuts provider bills at least 10% to 20%.

Other third-party administrators or self-insured, self-administered firms use vendors like Corporate Systems Ltd. or David Corp., each of which makes similar promises of minimum savings.

Not all bill software, though, is created equal. Each bill review system provider will usually claim a unique or more thorough capability to identify errors or deviations from approved fee schedules. Many perceive these systems, however, as a commodity without much variation.

That is not the case. For example, Crawford recently released a study comparing its Sentinel system against four nationally known bill review firms. The names were not released. Researchers provided each of the five firms with photocopies of medical bills totaling $37,607.61 from several different states. The results were interesting: Savings ranged from 35% for Crawford to a low of 24.4%.

Why this deviation? Although some may be attributable to a more aggressive stance by Crawford on fighting a bill in a jurisdiction known to be difficult, clearly the software has something to do with it. Important factors are extensive audits, more detailed knowledge of local billing practices and up-to-date schedules. The buyer must study the specifics of each medical bill software package.

Meanwhile, a sophisticated and complex system is now being made available to clients across the United States by selected firms: medical review software. Not only are client medical bills reviewed against medical fee schedules, the reasonableness of the procedure being performed is scrutinized, considering the nature of the injuries declared in the first report of injury on a workers comp claim.

I will look at this in next month's column. Further opportunity to replace costs exists here. Again, though, not all software packages have equal capabilities. ■

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

Preparing status reports

Continued from previous page
comply with this and other OSHA standards, we must continuously monitor the results of established programs and make adjustments whenever necessary.

Because virtually all classes of employees are affected by OSHA regulations, your report should provide executive management with meaningful information on this subject.

I also mentioned the need for regular written updates of risk management activities to direct superiors. For several years I have prepared a monthly status report for my boss that keeps him updated on past, current and future projects. Like most busy executives, he is not directly involved in my routine activities, and he finds the report useful in evaluating my performance.

Keep in mind that the objective in preparing your report is to focus on the vital function you and your staff fulfill. When the economy is tight, controlling risk becomes more critical to the survival of your company. Informed management can make educated decisions. You have the opportunity and responsibility to communicate with your executives and therefore positively affect the decision-making process. ■

Ms. Werner

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 Benefit 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, a principal with Coopers & Lybrand in San Francisco, answers actuarial questions in the casualty field.

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.

Physician payment reform

New fee schedule may shift costs to private plans

By Douglas C. Cave and Lesa M. Vidovic

EMPLOYER MEDICAL PLANS will be affected by the new Medicare fee schedule, which takes effect this year.

The Medicare fee schedule—a combination of a resource-based relative value scale and the Medicare customary, prevailing and reasonable system for physician reimbursement—represents a comprehensive reform of Medicare physician payment.

The medical profession was in favor of the CPR system when it was implemented in 1966, largely because the system recognized individual provider charge differences—like length of training or level of skills—in addition to prevailing charges in a geographic area.

Over the past decade, however, the CPR system came under increasing scrutiny because of its inflationary nature. Because future reimbursement levels are based upon past charges, prevailing charges increase over time as physicians submit bills higher than the current prevailing level, thus rewarding physicians who increase their customary fees significantly.

Also, the CPR system tends to overvalue procedural services like surgical and diagnostic tests and undervalue maintenance services like office visits and consultations. Many procedural services are reimbursed at two to three times the rate of maintenance services, even though both generally consume the same level of resource inputs—a term for the time and intensity of physician effort, use of office and equipment, plus malpractice insurance expenses. For this reason, physicians remain inclined to provide care using more elaborate and expensive practice systems.

The new Medicare fee schedule, part of the Omnibus Budget Reconciliation Act of 1989, was designed to address the fee and utilization problems of the CPR system and to control future government spending on physician services. The schedule includes three components, to be phased in between 1991 and 1995:

- **Balance billing limits.** Balance billing is the practice of charging patients the difference between the amount approved by Medicare for a service and the physician's prevailing fee. This caps the amount of money physicians can bill patients over the Medicare-approved fee. These limits became effective Jan. 1 this year and full implementation is expected by Jan. 1, 1993.
- **Relative value unit scale.** This scale differs from the CPR system in that the value of medical services is expressed in units rather than dollars. A dollar-based conversion factor is then used to translate unit values to actual payments. One advantage of the relative value unit scale is that it severs the relationship between current physician fees and future reimbursements.

Physicians may increase their customary charges, but payments for services increase only when the dollar-based conversion factor is updated. Also, the relative value unit scale is based largely on the resource inputs required to perform a service, thus eliminating many of the payment inequities between procedural and maintenance services found in the current system. The scale takes effect Jan. 1, 1992, with full implementation expected by Jan. 1, 1996.

- **Volume performance standards.** A volume performance standard is a mechanism for controlling the volume and intensity of services. Volume refers to the number of services ordered to

Continued on next page

Medicare fee schedule

Continued from previous page

treat a medical condition. Intensity refers to the shifting from less expensive to more expensive services to treat medical conditions.

The secretary of health and human services sets a growth performance target based on what is considered to be a reasonable physician volume and intensity increase.

If this target is exceeded, physicians will forfeit a portion of their future income through limits placed on future conversion factor increases. This is designed to control total medical outlays, not through direct controls on volume and intensity, but indirectly through lower payments for future services.

Previously published studies have examined the expected impact of the new Medicare fee schedule on both physicians' income and Medicare beneficiaries' out-of-pocket expenses. Results showed that primary care physicians and those physicians practicing in rural areas will receive substantially higher payments under the new Medicare fee schedule, while most specialists and physicians located in urban areas will receive lower payments.

In addition, the studies found that Medicare beneficiaries' out-of-pocket expenses will be lower on average than under CPR reimbursements. While the relative value unit scale raises out-of-pocket expenses, this effect is more than offset by the new balance billing limits.

Hewitt Associates has studied the potential impact of the new Medicare fee schedule on post-65 retiree and pre-65 active employee plans.

Both the relative value unit scale and balance billing components of the Medicare fee schedule will affect an employer's post-65 medical plan liability. Our simulations isolated the effect of the scale and compared it to the charge component of the CPR system. No balance billing limits were employed under either payment system.

The relative value unit payment scale alone would actually *increase* many employers' post-65 retiree medical plan costs. However, this effect is more than offset by the. . .balance billing limits.

The accompanying table shows the expected impact of the new Medicare fee schedule on employer post-65 retiree medical plan costs. According to our simulations, it appears that employers would not save money, but would incur significantly higher costs with the relative value unit scale if no balance billing limits were applied.

We found that, compared to CPR payment, total post-65 plan costs under the relative value unit scale would be approximately 3% higher by 1992 and 11% higher by 1995. The compounded impact between 1991 and 1995 would be about 30% higher.

Our simulations found that the balance billing limits, though, have the potential to save employers a significant amount in costs for post-65 retiree medical plans. The table shows that under the new limits, total post-65 plan costs would be about 6% lower by 1992. The compounded impact between 1991 and 1995 would be about 35% lower.

And, our results show that the combined effect of the relative value unit scale and balance billing limits would make for significant employer savings, primarily because of the balance billing limits. The table shows that total post-65 plan costs would be about 7% lower by 1992, and 11% lower by 1995. The compounded impact shows that between 1991 and 1995, total plan costs would be about 35% lower.

Thus, the balance billing limits represent the main source of savings potential under the new Medicare physician reimbursement system. In fact, our simulations showed that the relative value unit payment scale alone would actually *increase* many employers' post-65 retiree medical plan costs.

Relative impact of Medicare fee schedule on employers' post-65 retiree medical plan

Cost comparisons of customary, prevailing and reasonable method vs. Medicare fee schedule

Cost comparisons	Area of service	Percent change by year 1991	1992	1993	1994	1995	Compounded impact 1991-1995
Charge component	Physician services	0%	12%	23%	34%	45%	168%
	Overall post-65 medical	0%	3%	5%	8%	11%	30%
Balance billing limits	Physician services	-6%	-27%	-44%	-45%	-45%	-88%
	Overall post-65 medical	-2%	-6%	-11%	-11%	-11%	-35%
Overall Medicare fee schedule	Physician services	-2%	-31%	-46%	-47%	-47%	-90%
	Overall post-65 medical	0%	-7%	-11%	-11%	-11%	-35%

Relative impact of Medicare fee schedule on employers' pre-65 employee medical plan

Volume performance standard effectiveness	Area of service	Percent change by year 1991	1992	1993	1994	1995	Compounded impact 1991-1995
Relatively ineffective	Physician services	1%	2%	5%	8%	11%	31%
	Overall post-65 medical	0%	1%	2%	2%	3%	9%
Moderately effective	Physician services	1%	2%	7%	11%	16%	42%
	Overall post-65 medical	0%	1%	2%	3%	5%	11%
Very effective	Physician services	1%	2%	7%	12%	17%	43%
	Overall post-65 medical	0%	1%	2%	3%	5%	12%

Source: Hewitt Associates

GRAPHIC BY CYNTHIA WATSON

However, this effect is more than offset by the significant savings generated by the new balance billing limits.

Employers should see some savings in their post-65 retiree medical plan costs by 1992, compared to what their costs would have been had the Medicare CPR reimbursement system remained in effect. Our simulations show these savings are expected to continue at least through 1995.

To maximize potential savings under post-65 retiree plans, employers should ensure that the claim payment system is working appropriately. They should ask their third-party claims payer the following questions:

- Is the relative value unit scale stored in the claim payment system?
- Are balance billing limits being properly enforced?
- In order to make sure retirees are not balance billed, is the Medicare allowable amount being displayed on retirees' explanation of benefits statement?

Also, employers should educate retirees on the new system. They should explain the balance billing limitations so that retirees understand what they should and should not be billed for, and provide directories of Medicare-participating physicians.

The other table shows the impact of the new Medicare fee schedule on employers' medical plans for active employees younger than 65. Our results show that employers are likely to incur higher costs under the new system compared with the CPR system. Using varying assumptions as to the effectiveness of the volume performance standards at controlling volume and intensity increases in the Medicare sector, we would expect some cost shifting to employers' pre-65 medical plans to occur.

Specifically, if the volume performance standard is relatively ineffective at controlling volume and intensity increases in the Medicare sector, by 1992 total employer pre-65 plan costs could be about 1% higher due to the new Medicare fee schedule. Costs would be about 3% higher by 1995. The compounded impact on plan costs from 1991 to 1995 could be 9% or more.

However, if the volume performance standard is moderately to very effective at controlling volume and intensity increases in the Medicare sector, total pre-65 plan costs still might be about 1% higher by 1992 and almost 5% higher by 1995. The compounded impact from 1991 to 1995 could result in an increase of more than 12%.

Implementing the new Medicare physician payment system will likely result in significant cost shifting to employers' pre-65 active medical plans. The assumed effectiveness of the volume performance standard does not appear to have a significant impact on the amount of cost shifting that will occur in the early years of the fee schedule implementation. However, in later years, the more effective the volume performance standard is at controlling volume and intensity increases in the Medicare sector, the more cost shifting will occur to private employer plans, mainly in the form of higher fees and increased volume and intensity of services.

Interestingly, in comparison to the large cost-shifting differences that occur when the volume performance standard is moderately effective compared with ineffective, only small cost-shifting differences result if the volume performance standard is very effective compared with moderately effective. This finding suggests that the effectiveness of the volume performance standard will eventually have a diminishing impact on the amount of cost shifting to employers' pre-65 active medical plans.

Fortunately, there are steps employers can take to minimize cost shifting to their pre-65 medical plans. Employers should:

- Consider implementing a relative value unit-type payment system.

While this could limit employer costs, the absence of balance billing limits may result in increased cost shifting to employees.

- Offer medical care through managed care networks.

In many health maintenance organizations and other arrangements, physicians are paid a capitated or scheduled fee. With fixed rates, employers can shield themselves from the cost-shifting effects of the new system, at least in the short term.

- Enhance utilization management, especially for outpatient surgery.

This can be done by implementing a targeted outpatient surgical review program.

- Implement volume performance standards into managed care networks. ■

Douglas C. Cave is a health care consultant and Lesa M. Vidovic is a group benefits consultant, both at Hewitt Associates in Santa Ana, Calif.

Insolvency ruling

Continued from page 1

the government prevailed, they were going to get their $7 million to $9 million first, before anybody gets anything."

The ruling also is important because it concludes that liquidation is a state regulatory activity covered by McCarran-Ferguson, thus exempting regulators from the federal "superpriority" statute, lawyers familiar with liquidations say.

State regulators have been concerned about a provision of the superpriority statute that could make them personally liable if distributions from an insolvent company's estate leave it unable to cover the federal government's claims.

"Some liquidators have been concerned with the potential of personal liability," observed Jonathan Bank, a lawyer with Buchalter, Nemer, Fields & Younger in Los Angeles.

It was unclear last week whether the Treasury Department would seek a rehearing or petition for review by the U.S. Supreme Court. Government lawyers have been given more time to appeal while the matter is reviewed by the U.S. solicitor general, Mr. Rishel said.

Officials with the U.S. attorney's office in Columbus, representing the government, could not be reached.

The 6th Circuit opinion conflicts with rulings by appeals panels in the 4th and 9th Circuits, which have found that McCarran-Ferguson does not exempt state liquidators from federal laws.

This disagreement increases the chances that the Supreme Court may agree to review the case, observers note.

"Now we have a conflict in the circuits and perhaps the U.S. Supreme Court will take the issue up," said Lawrence Trent, another lawyer with Buchalter, Nemer.

American Druggists', a Blue Ash, Ohio-based unit of Armco Insurance Group, was declared insolvent by $26.3 million and placed in rehabilitation in March 1986 (*BI*, March 24, 1986). It was ordered liquidated the following month.

The government filed claims in the liquidation proceedings to collect payment under various American Druggists' bonds and notified the Ohio department in August 1986 that it would seek first priority for its claims under the federal superpriority statute.

The Ohio department, in turn, filed a declaratory judgment action in U.S. District Court in Columbus, arguing that the Ohio liquidation statute—which sets claim payment priorities—constitutes regulation of the "business of insurance" under McCarran-Ferguson and that the federal superpriority statute therefore doesn't apply.

A federal judge ruled in favor of the federal government, finding that while the state liquidation priority law governs the business of defunct insurance companies, it doesn't regulate the "business of insurance" within the meaning of McCarran-Ferguson.

In a 2-1 ruling, however, a three-judge panel of the 6th Circuit on July 17 overturned the lower court ruling.

In attempting to define the "business of insurance," the appeals panel found that "neither the (McCarran-Ferguson) Act nor its legislative history is particularly enlightening as to the meaning of that term."

The panel turned to a trio of Supreme Court cases dealing with the term. The most recent of these, a 1982 decision in *Union Labor Life Insurance Co. vs. Pireno*, established a three-prong test for deciding whether an activity constitutes the "business of insurance." Under this test, the activity must:

- Have the effect of transferring or spreading a policyholder's risk.
- Be an integral part of the policy relationship between an insurer and a policyholder.
- Be limited to entities within the insurance industry.

The appeals court concluded that the Ohio liquidation priority statute is a law regulating the "business of insurance" as defined by this test.

The Ohio law sets out several claimant classes, and claims in each class must be covered before those of subordinate classes can be paid. Classes one and two cover administrative, salary and other expenses; class three, policyholders and investors; class four, general creditors; and class five, claims of any federal, state or local government entity.

Regulators are exempt from a federal 'superpriority' statute that could have left them personally liable, the court ruled. 'Some liquidators have been concerned with the potential of personal liability,' observes Jonathan Bank.

The Ohio department is classifying the federal government as a class five claimant.

The liquidation law meets the first prong of the *Pireno* test because it guards against a policyholder's risk that an insurer will become insolvent by "spreading that risk among all those policyholders and non-policyholders who are entitled to a statutorily specified priority," the appeals court ruled.

The court rejected the government's argument that the statute merely provides a means of payment after an insured event occurs, rather than spreading or transferring risk.

The appeals court also rejected the government's contention that the Ohio law has no impact on the insurer/policyholder relationship because it applies only to insolvent insurers that are no longer in the "business of insurance."

Instead, the court found that the law meets the second part of the *Pireno* test: While insolvent insurers suspend new underwriting, a liquidator continues to adjust claims and therefore has a major impact on the insurer/policyholder relationship, the court concluded.

The court also found that the Ohio law meets the third part of the test, since it applies largely to

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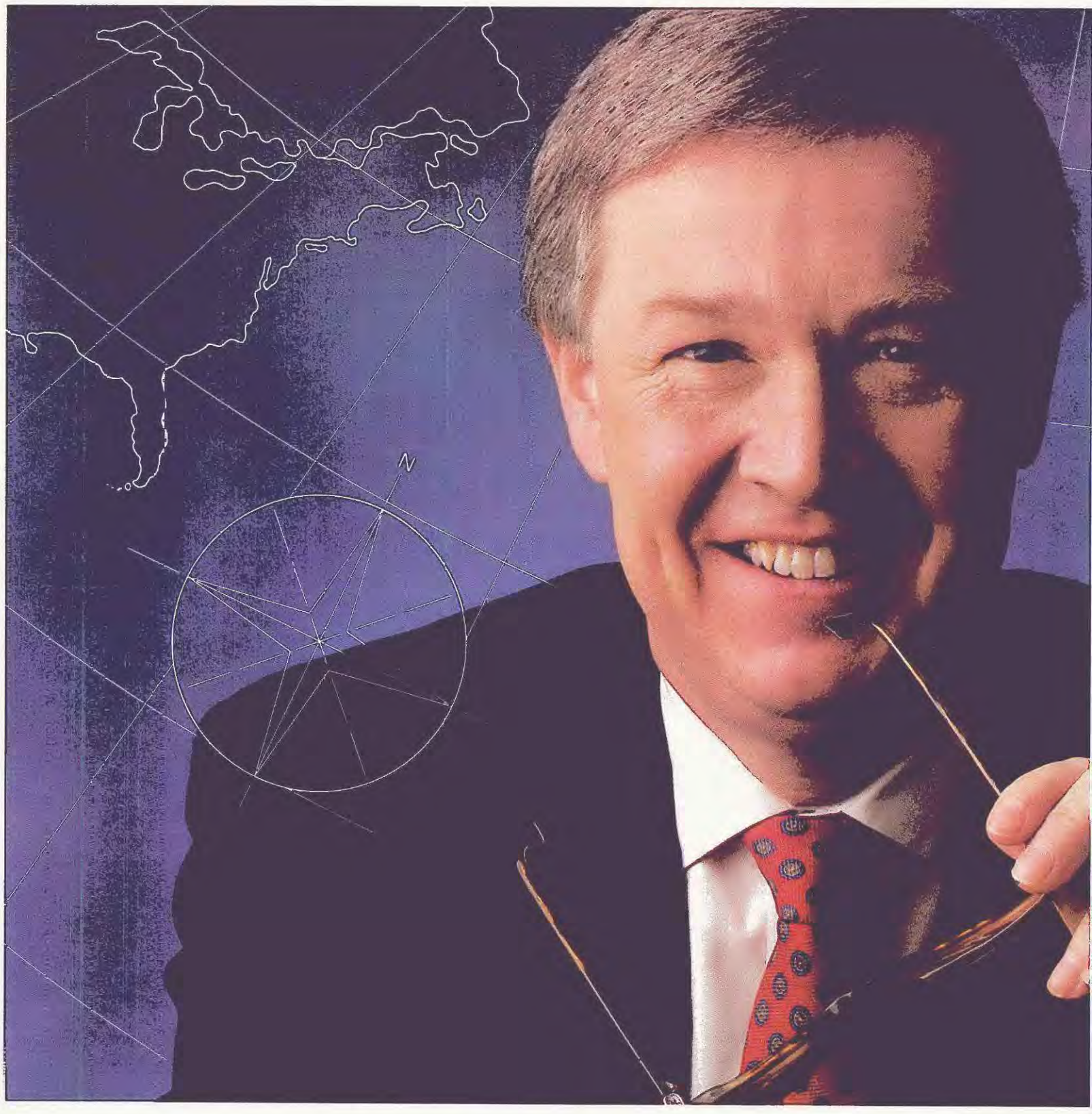

OLD PROS ON

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entities in the insurance industry, including policyholders.

"Although the liquidation of an insurance company necessarily involves the claims of non-policied creditors," the Ohio law is clearly intended to protect policyholders "by diverting the scarce resources of the liquidated entity away from any non-insured creditors, toward policyholders," the court noted.

While conceding that the 4th and 9th Circuits have found that liquidators are not exempt from federal laws under McCarran-Ferguson, the 6th Circuit opinion noted that federal courts have cited McCarran-Ferguson in abstaining from exercising jurisdiction in several cases involving state insurance liquidation proceedings.

Meanwhile, one member of the three-judge panel dissented from the opinion, citing the 4th and 9th Circuit rulings and labeling the abstention cases cited by the majority as being of "questionable relevance." The dissenting judge also questioned the majority's view that the Ohio law meets the three-pronged *Pireno* test.

"Although Ohio's liquidation priority scheme may be characterized as a transferring of risk of loss to some extent, the ordering of creditors' claims does not effectuate a transfer of risk vis-a-vis the policyholder," the judge wrote.

Regarding the test's second part, he added that "simply because the insured's right to receive payment under the initial contract of insurance continues after the insurer is placed in receivership does not indicate to me that the statute at issue is 'an integral part of the policy relationship between the (now-defunct) insurer and the insured."

The judge also questioned whether the Ohio law is limited to entities in the insurance industry, since it clearly covers non-policyholder creditors, including local, state and federal governments.

It is not clear whether the 6th Circuit ruling could be a factor in the conservatorship of Executive Life Insurance Co. of California.

While California Insurance Commissioner John Garamendi has proposed a rehabilitation plan through which two investor groups would inject $3 billion into Executive Life, he said that a demand by the Internal Revenue Service for $643 million in back taxes from Executive Life could affect the deal.

While the 6th Circuit ruling notes that the Ohio case does not involve tax claims, Mr. Rishel, the Ohio department's lawyer, said the 6th Circuit ruling could be cited in cases involving tax claims.

However, California is part of the 9th Circuit, which has ruled that McCarran-Ferguson does not exempt liquidators from federal laws. ■

Court rules on priority of surety claims

HACKENSACK, N.J.—Surety bondholders have the same claim priority status as other policyholders in the liquidation of Integrity Insurance Co., a New Jersey judge has ruled.

The New Jersey Insurance Department, Integrity's liquidator, had sought a ruling that bondholders—who have filed 856 of the roughly 26,000 claims against Integrity's estate—are lower-priority claimants than other insurance policyholders.

In a July 18 ruling, however, New Jersey Superior Court Judge William C. Meehan rejected the department's arguments, concluding that state law defines insurance to include surety bonds.

The New Jersey department had argued, for example, that the state's property/casualty guaranty fund excludes coverage of surety claims. And, pointing to a Pennsylvania case dealing with the same issues, the department said this was evidence of legislative intent to afford surety bondholders a lower priority in insolvency proceedings than other policyholders.

Judge Meehan, however, found there is no evidence that the New Jersey Legislature "intended to remove surety bonds from the class of insurance policies or insurance contracts. This specific exclusion is to this court strong evidence that the Legislature considers surety bonds a form of insurance, and for that reason specifically excluded it from the guaranty fund."

The judge also noted that guaranty fund claims against the Integrity estate are given the same priority as insurance claims, and that other states' guaranty funds cover surety claims. To accept the department's argument could create a situation where other state guaranty fund claims relating to surety losses are granted the same priority as insurance claims, while surety claims filed by New Jersey residents are granted a lower priority, the judge found.

"This court does not find this the desired and intended result of the Legislature's affording guaranty funds the same priority status as insurance policies and contracts," Judge Meehan wrote.

The judge also found that New Jersey insurance statutes "uniformly define insurance to encompass surety bonds."

The department will not appeal the ruling, said its lawyer, Thomas S. Novak, with the Newark, N.J., firm of Sills, Cummis, Zuckerman, Radin, Tischman, Epstein & Gross.

Integrity was ordered liquidated in March 1987 and has been estimated to be insolvent by more than $300 million.

The value of bond claims against the estate depends largely on whether certain of the claims are ultimately judged by the courts to be recoverable from the estate, Mr. Novak said.

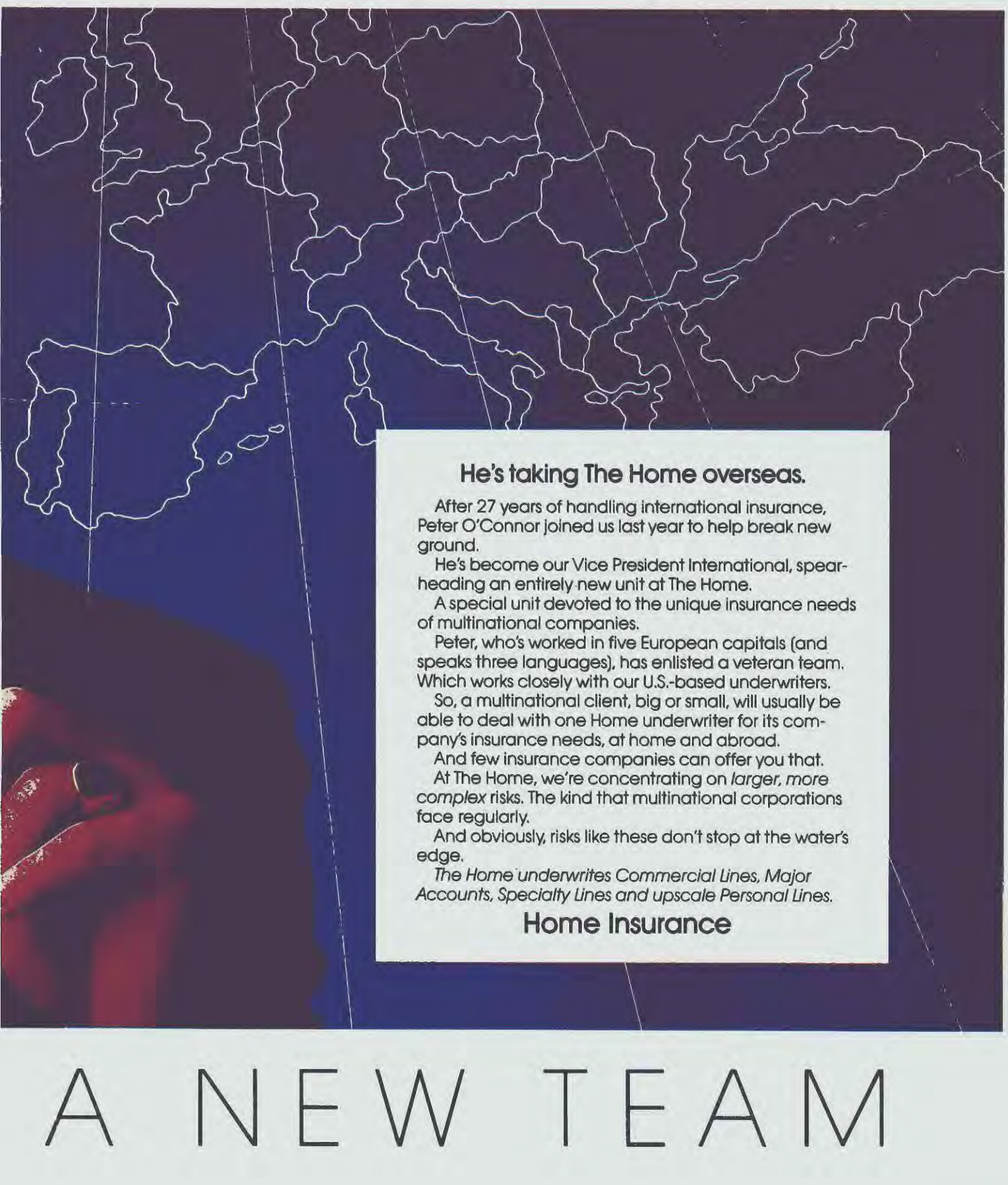
Most of Integrity's bond business, he explained, consisted of financial surety bonds securing loans made to tax-shelter limited partnerships, many of which later failed. One of the largest bondholders is Ingersoll-Rand Financial Corp. (*BI*, Oct. 9, 1989).

One issue in the liquidation has been whether the Integrity estate must pay accelerated claims for future loan payments by limited partnerships in default, he said. A court-appointed special master has ruled that these accelerated claims are not recoverable, though this finding is on appeal to Judge Meehan, Mr. Novak said.

If the accelerated claims are disallowed, the Integrity estate will owe about $10 million to financial surety bondholders. If they are allowed, though, the claims will total $110 million, he said.

—By Douglas McLeod

E TODAY



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A NEW TEAM

Golf event raises green for scholarships

By MARK A. HOFMANN

MEMPHIS, Tenn.—Sponsors of this year's annual golf tournament fund-raiser for Memphis State University's risk and insurance management scholarship fund already have pledged more than $40,000.

"It's our best year ever. I can't say enough good things about the sponsors," said Millie Workman, president of the Memphis Chapter of the Risk & Insurance Management Society Inc., which has orchestrated the event.

The pledges—mostly from brokers, insurers, and risk management service providers—will fund more than 30 scholarships at MSU, said Bob Puelz, an associate professor of insurance at the university who also oversees the scholarship program. All but two of the scholarships will be $250 per semester grants used to draw promising students who have not declared a major to the risk management and insurance program, Mr. Puelz explained.

The $41,500 pledged as of last week already is nearly 75% greater than the $24,000 sponsors pledged last year, according to Ms. Workman, who also is director of corporate risk management for Belz Enterprises, a Memphis real estate development firm.

The chapter initially hoped to raise $30,000 this year, according to Don Batchelor, past president of the Memphis RIMS Chapter, risk manager of Union Planters Corp. in Memphis and a member of *Business Insurance*'s 1991 Risk Management Honor Roll.

The fact that total pledges now exceed $40,000 is particularly impressive given the prolonged soft property/casualty insurance market, Mr. Batchelor said.

The first tournament in 1987 raised $8,500 for MSU's risk management and insurance program (*BI*, April 29; March 19, 1990).

This year's tournament is scheduled to take place Sept. 12 at the Holiday Golf Club in Olive Branch, Miss.

A maximum field of 144 golfers can participate in the event, Ms. Workman said, noting that past tournaments have had to turn away some golfers. RIMS members and sponsors pay an entrance fee of $60, and all others pay $80, she said. Fees increase $20 on Aug. 27, she said.

Atlanta-based GAB Business Services Inc. will sponsor a reception the evening before the event, and the Atlanta office of American International Group Inc. will sponsor a brunch the morning of the tournament.

The entrance fees "essentially take care of expenses," Ms. Workman said. Money raised from pledges that do not have to cover expenses goes to MSU's risk management and insurance department.

The university offers one $2,500 annual scholarship in risk management and insurance and one $1,000 annual scholarship in addition to the approximately 30 $250 per semester scholarships, Mr. Puelz said.

Mr. Puelz said that the availability of a large number of small scholarships has been instrumental in attracting qualified students to the risk management and insurance program. Last fall, before the expanded scholarship program began, there were eight students majoring in the risk management and insurance program, he said. This fall, about 50 students will be majoring in the program, he said. The grade point average of the group as a whole is approximately 3.1 on a four-point scale, he said.

Mr. Puelz hopes the MSU program eventually will attract as many majors as does the University of Georgia in Athens, where he studied. The Georgia program attracts hundreds of students and serves as host to one of the largest collegiate insurance career days in the country.

Mr. Puelz said the MSU risk management and insurance department plans to hold its first career day in February.

Both Ms. Workman and Mr. Batchelor also noted that one of the Memphis RIMS Chapter's long-term goals is to raise enough money through golf tournaments to eventually endow a chair in insurance at MSU. ■

Over $40,000 in pledges, mostly from brokers, insurers and risk management service providers, will fund more than 30 scholarships at Memphis State University, says Bob Puelz, an associate professor of insurance at the university.

AUGUST CLOSINGS

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closing:	August 7	
demographic section:	Insurer Topics: Employee Development & Education	
issue:	August 26	
closing:	August 14	
issue:	September 2	Bonus Distribution: Monte Carlo Rendez-Vous de Septembre
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editorial feature:	Reinsurance: Int'l Markets — Directory: Leacing Reinsurers Worldwide	
demographic section:	Agent/Broker Topics: Automation/Most Productive Agencies	
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INTERNATIONAL

GRAPHIC BY HOLLY SEGUINE

Pension plans under scrutiny in Latin America

By MARGARET PRICE
Crain News Service

New pension arrangements are emerging in Latin America as governments seek to create pools of new capital and to bolster retirement systems.

Mexico, for example, which already has roughly $4 billion in pension assets, is considering a new mandatory pension system. Experts say a tentative proposal for an employee-funded defined contribution plan may be sent to Mexico's Congress by this fall.

Despite differences in approaches, various Latin American countries are attempting to bolster ailing retirement benefit programs. Many social security programs are bankrupt, and although severance indemnity programs required by labor law are meant to supplement social security, the two programs often fail to meet benefit requirements.

Officials in a number of countries believe they should shore up employee benefits in a way that would boost their entire economies: by creating new capital pools from funded employee benefit programs. They're taking a cue from Chile's popular, privatized social security system.

"Many of these countries have

Continued on page 32

Court delays hearing on Aneco Re windup

BERMUDA

HAMILTON, Bermuda—The Bermuda Supreme Court has adjourned for 30 days the winding-up proceedings against Aneco Reinsurance Underwriting Ltd., formerly Bermuda's largest reinsurer of captives.

The request to postpone the hearing was made by attorney Julian Hall, who represents Forum Re Group (Bermuda) Ltd., the parent of Aneco.

Over strong objections from the lawyer representing Malcolm Butterfield, the Bermuda registrar of companies who recently began the winding-up proceedings, Chief Justice Sir James Astwood granted the adjournment.

Prior to the adjournment, the registrar's lawyer, Nariander Hargun, outlined the government's reasons for Mr. Butterfield's winding up petition.

"The primary ground is insolvency of the company," Mr. Hargun said. "The principal reason, but not the sole reason, for the insolvency is that the registrar has no reason to believe that a company called Channel Reinsurance Co. Ltd. . . .would be able to live up to its contractual obligations."

Channel Re, based in the Turks & Caicos Islands, is controlled by embattled insurance executive Mark Hardy, who also controlled Aneco and two other two enterprises now in court-ordered liquidation: Forum Reinsurance Co. Ltd., a financial reinsurance specialist; and Focus Insurance Co. Ltd. (*BI*, March 18). Mr. Hardy was not present in court.

"The obligations of Channel Re to Aneco represent $14 million. If Channel Re can't live up to its obligations, then the company is clearly insolvent, insolvent by some $7 million," Mr. Hargun argued.

Aneco's auditors, he continued, "are not prepared to say that the obligations of Channel Re can be considered as an asset of the company. In other words, they are not prepared to say that the $14 million can be considered as an asset."

The lawyer added that Aneco "has no information as to the financial position of Channel Re. Channel Re, for the last 12 months, has failed to provide security under its contractual obligations."

That left the registrar of companies "little choice" but to petition for a winding up, Mr. Hargun said.

After Mr. Hall, the Forum law-

Continued on next page

Exemption expected to boost number of captives

Guernsey OKs tax relief

GLOBAL BRIEFS

ST. PETER PORT, Guernsey—Captive insurance companies registered in Guernsey can now opt out of paying the island's 20% income tax.

The move should help boost the number of captives established in Guernsey, according to Steve Butterworth, the island's superintendent of insurance.

The approximately 120 captives that are expected to opt out of local taxation could collectively save around 2 million pounds ($3.4 million) a year, he said.

Captive insurers previously were taxed at the island's corporate tax rate of 20% on the first 250,000 pounds ($423,250) of investment income. Insurers then paid a 1% tax on the next 250,000 pounds; 0.5% on the next 500,000 pounds ($846,500); 0.3% on the next 2 million pounds ($3.4 million); and 0.1% on any remaining investment income (*BI*, April 29).

Guernsey, which is one of the Channel Islands that lie between England and France, has targeted captive insurance management as a prime growth area for commercial development, Mr. Butterworth said.

But the captive domicile, Europe's oldest and largest, has been losing out to tax-free domiciles, like the Isle of Man in the Irish Sea, he said. Nineteen new captives were registered in Guernsey in 1990, compared with 23 in the Isle of Man.

"We saw that we were bottom of list for the number of new captives incorporated in captive domiciles, so we conducted an in-depth study into the reasons why and we found that a lot of tax advisers were advising companies to choose tax-exempt domiciles," Mr. Butterworth explained.

Mr. Butterworth expects around 60% of the island's 195 captives to take the local income tax exemption route.

Some, though, may prefer to continue paying the tax in Guernsey rather than defer payment until funds re-enter their parent's home country, Mr. Butterworth said.

"Some people want to contribute to the economy of Guernsey and be good corporate citizens, and others may want to prove to their home tax authorities that they are using a captive for insurance reasons and not to avoid paying taxes," he said.

Other companies may find that there are fiscal benefits in the old sliding scale scheme that they would want to retain, Mr. Butterworth added.

The tax exemption, which has been passed by the Guernsey government, is effective immediately.

—By Gavin Souter

Munich Re results

MUNICH, Germany—U.S. liability business took a heavy toll on the profits of Munich Reinsurance Co. in the year ending June 30, the world's largest reinsurer reports.

Precise figures were scarce in a statement released at the end of July, but Munich Re admitted that "the negative result in (foreign) li-

Continued on next page

BCCI scandal may hike regulators' liability

By WILLIAM PITT

LONDON—The fallout from the rancorous debate here over government responsibility to assist customers of the seized Bank of Credit & Commerce International S.A. may eventually reach European Community insurance regulation.

Planned reforms in E.C. regulation would broaden the powers of insurance regulators in each member nation, said Patrick Devine, a London attorney specializing in E.C. law.

And policyholders could become just as willing as BCCI customers to sue when they suspect regulators of being lax, he predicted. Regulators in 20 nations seized BCCI last month.

"It's a variation of the deep pocket theory," said Mr. Devine, who is with Barlow Lyde & Gilbert. "No one has deeper pockets than the government."

He based his argument on the third non-life insurance directive drafted by the European Commission. It would enable an insurer licensed in any E.C. nation to write business in other member nations without further local authorization.

Regulators in an insurer's home country would assess the company's fitness. But regulators would also be empowered to investigate branch offices in other states—something they cannot do now. The "financial supervision" of insurance companies becomes, under the directive, the "sole responsibility of the home member state."

Mr. Devine suggested that "attached to that duty may also be a legal duty of care" toward policyholders in other E.C. member states. "If regulators are negligent and fail to comply with the directive, they may find themselves being sued."

Alan Beadle, secretary of the British Insurer's International Committee, which represents both U.K. insurers and the Lloyd's market, agreed that government regulators might find themselves more exposed. But, he added, it is "premature" to come to any firm conclusions.

"The directive won't be up and running until 1994" at the earliest, he said.

Mr. Beadle expressed confidence that "people in Brussels (home of the European Commission) recognize that very close cooperation (among member states) will be vital." Insurance supervisors would be able to consult regularly with one another through a new Europe-wide insurance committee, he added.

Such consultation may help bridge the widely differing perceptions of insurance regulators' roles that Mr. Beadle identifies with the European Community now.

He pointed out that Germany employs hundreds of officials to approve insurance companies' policy wordings and premium rates. He contrasted this with the British approach: Just more than 100 officials at the U.K. Department of Trade and Industry monitor insurers' financial condition, but impose no restrictions on premium rates or policy conditions.

Anne Lambert, who heads the international branch of the Department of Trade and Industry responsible for insurance regulation, said she did not expect the new regime to impose a heavy strain on the department. "We already supervise (insurance companies) on a global basis," she said.

INTERNATIONAL

BERMUDA

Continued from previous page
yer, requested an adjournment of the Supreme Court hearing, Mr. Hargun objected.

"This state of affairs has been going on for a year. No one is putting up any money and the only solution would be for Channel Re to live up to its contractual obligations," he said.

But two other lawyers, representing Aneco and London underwriters, also favored adjournment. Talks between Aneco and the London underwriters, aimed at resolving conflicts outlined in the petition, had been proceeding up until the start of the high court hearing in Bermuda, the court was told.

Meanwhile, an affidavit submitted to the court by Mr. Butterfield includes background details about the winding-up petition. His "particular concerns" about Aneco, the petition said, included:

- Its "liquidity" and solvency.
- Aneco's "failure to comply" with Bermuda regulations requiring an auditor's report and opinion to be attached to the 1989 statutory financial returns.
- The failure of Aneco and Mr. Hardy to ensure Channel Re's compliance with an escrow agreement it was to enter with a Lichtenstein trust company. Aneco was also to have been a party to that agreement.
- The failure of Aneco and Mr. Hardy to provide financial information about Channel Re.

Also included in the department's affidavit were letters from Mr. Hardy to the registrar of companies.

In one, written in April, Mr. Hardy said that "Aneco is not now, nor ever has been, in possession of any documents or details of the financial condition of Channel Re, save for the representation made by me that (1) Channel Re is validly incorporated in the Turks & Caicos Islands and (2) Channel Re is ready, willing and able to comply with all contractual obligations to Aneco."

Mr. Butterfield replied in the affidavit: "It is the view of this department—and, in my respectful opinion, industry practice—that no prudent insurer would reinsure with a company about which it has no financial information, no security and where the recovery of that reinsurance so completely determines the solvency of the insured."

—By Tony McWilliam

BF&M profit edges up

Despite 1990 operating income of $8 million—double its 1989 level—Bermuda Fire & Marine Insurance Co. Ltd., the island's largest domestic insurance company, reported net profits rose only 9% to $2.4 million last year from $2.2 million in 1989.

Nearly wiping out the profit was a $7.5 million provision to cover the continued deterioration of a book of business written for BF&M by H.S. Weavers (Underwriting) Agencies Ltd. between 1968 and 1983.

In the company's annual report, Chairman Charles Collis wrote: "Once again we must report that the discontinued business has not developed in accordance with actuarial projections. The annual actuarial study points to further deterioration calling for substantial additional reserving."

According to the annual report, the insurer's total provision for claims from the Weavers business was $41.8 million as of Dec. 31, 1990.

Bermuda Fire & Marine also reported net premiums earned of $28.2 million and investment income of $9.3 million.

It also realized a net gain of $1.9 million last year from the sale of subsidiaries Mercantile Indemnity Co. Ltd. in the United Kingdom and Marine Indemnity Insurance Co. of America in the United States.

Selling those units will enable the insurer to focus on its core domestic business. The insurer also operates brokerage, rent-a-captive and captive management subsidiaries.

In the annual report, Mr. Collis said the company is working on a reorganization "to present a new and more modern image while further developing the concept of separate and distinguishable profit centers."

—By Roger Scotton

GLOBAL BRIEFS

Continued from previous page
ability (business), which had improved in the previous year, increased again."

In the 1989/1990 fiscal year, Munich Re's improved losses for this class of business exceeded 500 million deutsche marks ($288.7 million at current exchange rates).

A spokesman for Munich Re confirmed that the loss was indeed "more in the direction" of the 647 million deutsche mark ($373.6 million) loss suffered on foreign liability business in fiscal 1987/1988.

The company will release its actual results, along with consolidated figures for the entire Munich Re group, in November.

At Munich Re, "as everywhere," U.S. liability business was the "main source of trouble," said the spokesman, who did not elaborate.

Those losses rose despite what Munich Re termed a "cautious acceptance policy" that had led to a "further drop in premium income" from liability business.

Munich Re said it also had to contend with "exceptionally large burdens" from the storms that hit Northern Europe last winter.

Again, no figure was given in the official statement, but the spokesman said the company had paid out more than 1.1 billion deutsche marks ($635.1 million) in gross claims as a result of the storm and "more than half of that figure" after reinsurance.

These payouts, one of the largest in Munich Re's history, did not affect the 20% dividend paid at year-end, "thanks to the company's reserving policy in previous years," which helped smooth out the 1990/1991 results, the reinsurer said.

The Munich Re announcement is likely to give renewed impetus to British insurers' campaign to change the tax treatment of catastrophe reserves. Unlike in Germany, these reserves are not tax-deductible in Britain.

Lloyd's of London recently has argued that this difference in tax treatment allowed German insurers to write catastrophe reinsurance more easily than British companies or Lloyd's syndicates.

Munich Re said that as a result of the winter storms, its reinsurance business has recorded a deficit "both at home and abroad." Had the storms not occurred, the domestic result would have been positive and the deficit on foreign business would have been "smaller than in the previous year," the reinsurer said.

Munich Re's premium income in 1990/1991 rose 4% to 13.1 billion deutsche marks ($7.56 billion). In

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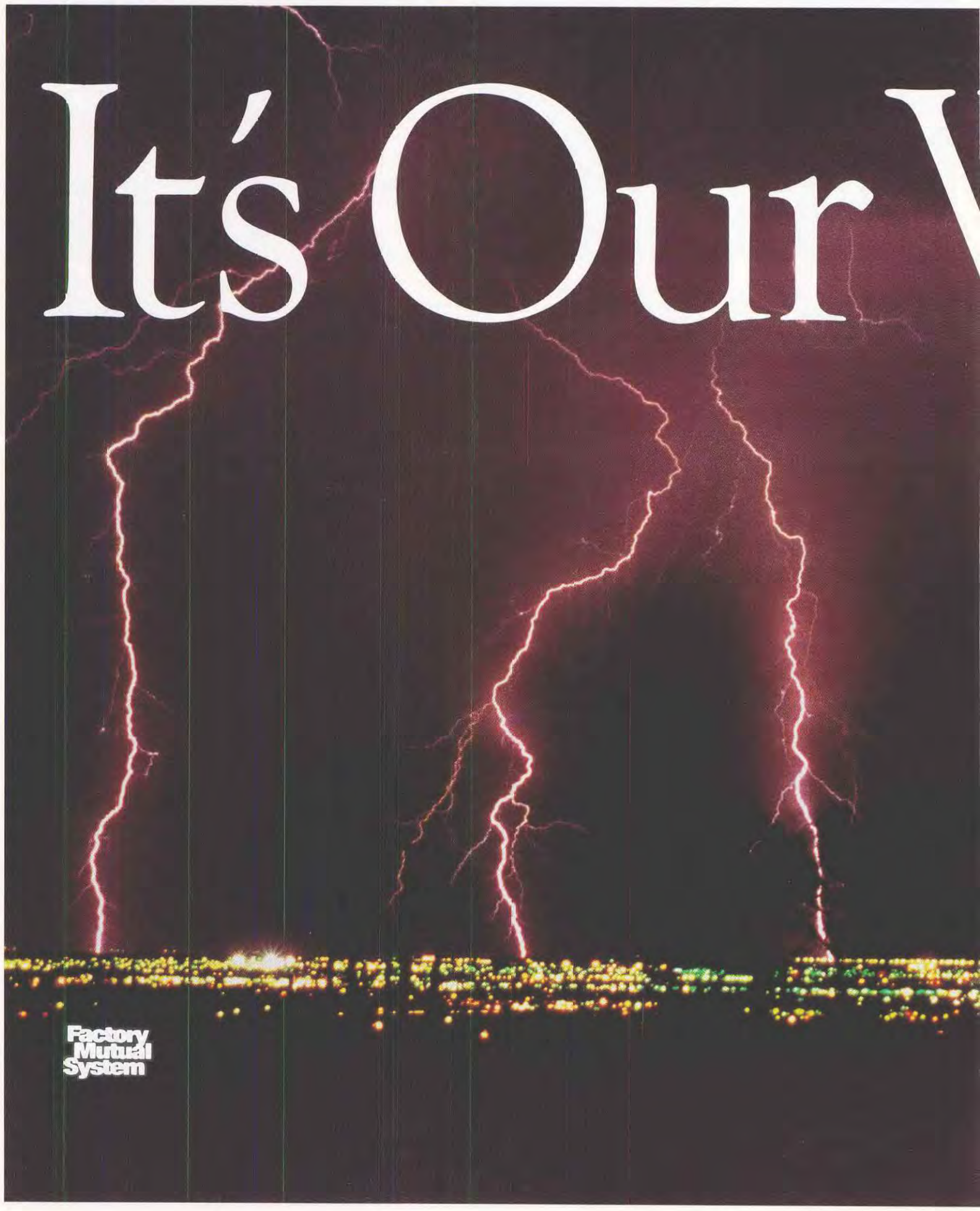


INTERNATIONAL

Continued from previous page
original currencies, the increase was closer to 7%, but the strength of the German mark meant that the real growth in foreign business was not fully reflected in the converted figure. Munich Re said foreign business accounted for "approximately 45%" of premium income.

The biggest class of business Munich Re wrote in 1990/1991 in terms of premium income was life business, which produced premiums of 2.6 billion deutsche marks ($1.5 billion), up 18% from 2.2 billion deutsche marks ($1.27 billion) in 1989/1990.

Among the highlights of the fiscal year mentioned by the reinsurer in its report, was the opening of a representative office in Moscow. Soviet authorities granted Munich Re permission in April to open the office, which is now up and running, the Munich Re spokesman said. He added that the office is "establishing connections with the new (insurance) companies being founded in the Soviet Union."

Munich Re is still considering whether to write reinsurance denominated in rubles, the spokesman said.

—By William Pitt

Allianz ups bank stake

MUNICH, Germany—Allianz A.G. Holdings has increased its stake in Dresdner Bank to 23%.

Allianz Chairman Wolfgang Schieren said the increased holding reflects the extent of business ties between the insurer and Germany's second-largest bank, denying that Allianz plans to eventually take over the bank.

Allianz and Dresdner entered into a reciprocal agreement to promote each other's products two years ago.

"This kind of cooperation has more future," Mr. Schieren said. "We are not interested in acquiring or founding a bank."

Dresdner Bank revealed last May that it had acquired a 10% stake in Allianz worth 4 billion deutsche marks ($2.31 billion at current exchange rates).

Allianz's 23% stake in the bank is worth about 3 billion deutsche marks ($1.73 billion).

A spokeswoman for Allianz said new business generated by the bank ties accounted for small to moderate growth in its insurance business.

Nevertheless, Allianz is stepping up similar agreements with regional banks in Southern Germany, including both Raiffesein & Volksbanken and Hypotheken & Weschel Bank, in which Allianz has 24% stakes.

Allianz also has stakes in Germany's largest bank, Deutsche Bank, as well as in a major regional bank, Bayerische Vereinsbank. But, Mr. Schieren said Allianz's stake in each bank is "much less" than 10%. "This is existing stock from the past. We haven't increased this substantially."

It is unlikely that Allianz will further increase its stake in Dresdner, the insurer's spokeswoman said. Only an additional 2% share in the bank would give the insurer greater influence over bank strategy and decisions, she said.

"Cartel authorities would likely block anything above 23%," she said. "Our current stake is being examined closely, but we got the go-ahead for what we are doing."

—By Don Lewis Kirk

Irish liability costs

DUBLIN, Ireland—Liability insurance premiums are likely to rise by more than 10% in Ireland this year, after insurers reported that losses increased by nearly 50% in 1990, says an executive of the Irish Insurance Federation.

Liability losses rose to $98.6 million last year from nearly $66 million in 1989, according to John Forde, chief executive of the Irish Insurance Federation.

Federation members underwrite 92% of the non-life premiums in Ireland.

But, the rise in liability premiums "will tend to make companies underinsure," said Frank Mulcahy, director of the Small Firms Assn., an affiliate of the Confederation of Irish Industry. "Claims are four times the level of the same type of claim in the U.K.," Mr. Mulcahy said. But, "because of the high cost of liability insurance here, there has been a tendency to underinsure and this will probably grow as premiums rise."

But Mr. Mulcahy said his association had some good news, too. The Small Firms Assn. launched its own group insurance program last January.

"We can now offer members a savings of 20% to 40% on their liability insurance cover. Some 500 companies have joined this scheme so far, and we are getting new members at the rate of 20 a week," he said.

The group program is organized by a Dublin broker and a Lloyd's of London underwriter, which Mr. Mulcahy declined to name.

But for those companies not covered by such a program, Mr. Mulcahy and other industry observers foresee trouble.

"We expect rates to harden," said Jim Collins, area manager for Celtic International Insurance Co. in Dublin. As a result, "some business will go out of Irish insurance companies to the Lloyd's agencies, some of which have Dublin offices," he said.

The anticipated rise in premiums will be a serious business development for policyholders, said Alan Childs, sales director of liability insurance fro Dublin insurance broker McDonagh & Boland.

"Business has little choice but to pass the premium increase on to their customers. They can't afford to be without cover, though employer's liability cover is not compulsory in Ireland as it is in Britain," he said.

"An added problem with this rise is that it will make companies more liability conscious. Firms will want to know if companies they are doing business with have cover. In this brokerage, we spend a lot of time checking up on whether companies have cover and to what extent," Mr. Childs said.

"For example, a subcontractor will want to know whether the main contractors, say on a building site, has cover," he said. "The owner of an office block will want to know whether the window cleaner has cover, and for how much."

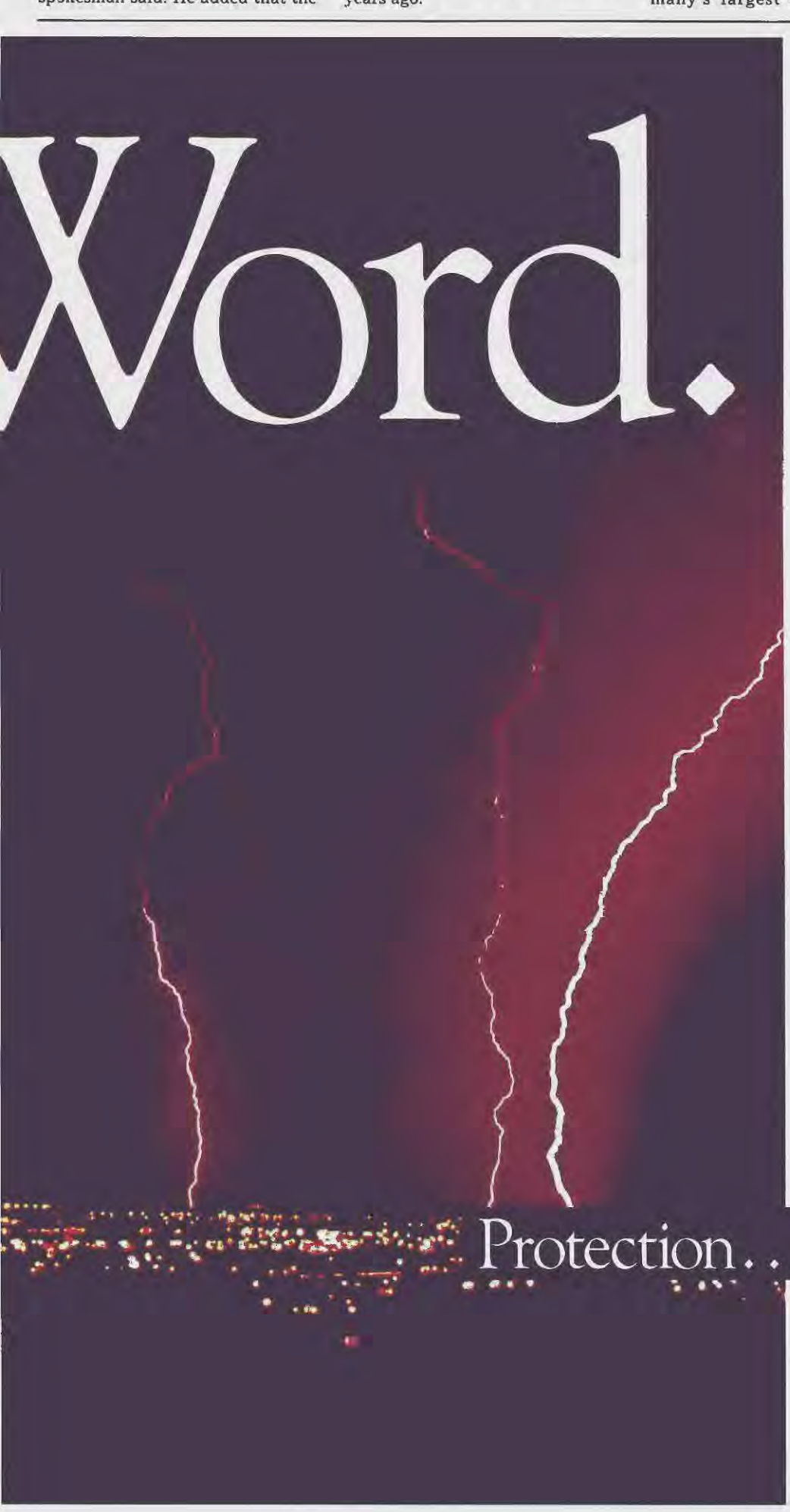
The rise in liability rates comes despite efforts to reduce the size of liability awards in Ireland. For example, the Courts Act three years ago gave judges sole authority to award damages, based on the theory that judges would order smaller awards than juries had been ordering.

So far, though, quite the opposite has happened.

But the Irish Insurance Federation's Mr. Forde said there is still hope. He said the justice system will take some time to work out its problems and that he expects government proposals will soon address the high liability insurance premiums.

In addition, "while 1990 was a bad year for insurance companies, the lowest point in the underwriting cycle may have been reached," Mr. Forde said.

—By Aidan O. Sullivan



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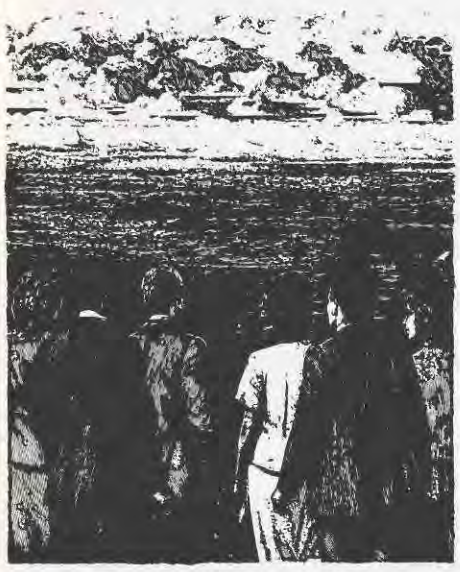

A new decade brings new uncertainties and challenges to the benefits field: taxation of benefits; nondiscrimination; universal health care access; demographic changes; and plan terminations. In the 1990s, benefit professionals can count on the Certified Employee Benefit Specialist (CEBS) program to provide the solid background they need to make progress in the face of uncertainty.

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INTERNATIONAL

Latin America

Continued from page 29

sent delegations to Chile to study its system" but haven't adopted quite so dramatic a change, said Chet Kutchinad, a consultant with TPF&C, a division of Towers, Perrin, Forster & Crosby Inc. in New York.

In 1980, Chile created a defined contribution program that has met with workers' approval and has aided the national economy. Each month employees place 10% of their salary in the program, up to a limit of about $1,200 a month. The money goes to the privately run Asociacion de Fondo Pensiones, which operates like a mutual fund and provides individual accounts for each employee.

Since 1989, the law has allowed up to 30% of the social security funds to be invested in the Chilean stock market, up from a previous 5% cap. The social security program is a major support for Chile's stock market, which has risen 58% a year in dollar terms between 1985 and 1990, according to Satyen Mehta, a vp with J.P. Morgan Investment Management Inc. in New York.

While Chile's social security funds cannot be invested internationally, pending legislation would allow some foreign investment.

The investment proposal will probably pass, said Jaime Gonzalez, human resources manager of the Andean Division of Coca-Cola Export Corp. in Santiago.

A few private pension funds exist in most countries of the region, and Mexico and Brazil have relatively sizable pension industries. But the common practice in Latin America is for companies to provide termination —or severance—indemnity plans that give lump sums for various reasons, including retirement. These programs often are financed through the book reserves system, in which companies keep the money in-house to fund these benefits and note the liability on their balance sheet.

One key reason for preferring book reserves is the perception that investing benefit assets externally is imprudent given the ravages of high inflation in many areas.

Aside from a "small fund in Brazil," E.I. du Pont de Nemours & Co. "typically has termination indemnity plans that pay a lump sum when employees retire" for its pension arrangements in Latin America, said Jack Stair, a senior consultant with Du Pont in Wilmington, Del. In Argentina, Venezuela, Colombia and Mexico, the company's benefits are funded through book reserves. So far, the system has worked well "given the (region's) long-term inflation rates and the difficulty finding long-term investments," he said.

Companies can expect to face changes in at least some of these areas. Beginning this year, for example, severance indemnity programs must be funded in Peru and Colombia. Venezuela is considering legislation that would require financing of severance entitlements outside of book reserves and would create a new pension system.

In Peru, recent legislation requires companies to shift from using book reserves to funding the severance indemnity plans by depositing funds into employees' individual bank accounts. To counter the effects of inflation and currency devaluations, employees can choose to have deposits denominated in local currency or in a foreign currency of their choice.

Companies would have up to 10 years to convert benefits accrued to the new program.

"Peru also has the intent to set up a private corporate benefit system that would presumably be tax-exempt. But where that idea will go, nobody knows right now," said Fred Kenyon, a consultant with The Wyatt Co. in Stamford, Conn.

In Colombia, the new funding program calls for placing the benefit assets into separate investment funds, similar to mutual funds. While these funds would be administered privately, the government would oversee the overall severance indemnity program, Mr. Kenyon explained.

As in Peru, the new program replaces the former book reserves system.

Higher-paid employees, those earning more than 10 times the minimum salary, could opt out of the funded system and receive a settlement on their owed severance indemnity as a salary increase.

In Venezuela, the government has released draft legislation that would require the establishment of individual employee trusts, according to Mr. Kenyon. Under the proposal, employers would have to place 50% of an employee's severance entitlement in an individual trust, with employees deciding the disposition of the remaining 50%: The money may be placed in the employee's trust or in new private pension funds.

In the latter case, draft legislation would create the new defined contribution pension system. While companies and employees could contribute to it, employers would be required to contribute 10% of employees' pay. Those payments would be in addition to companies' funding requirements for the severance payment system, said Mr. Kenyon.

The new funding rules would be onerous for some companies that have been using book reserves. But a more stabilized system also would benefit both the countries and investors.

Coca-Cola Export Corp. last year set up a separate private pension program in Chile, mainly to supplement the social security benefit for higher-paid workers. Assets from its former severance indemnity fund went into the new pension fund.

Coca-Cola also is planning to set up private pension funds in Peru, Ecuador, Paraguay and Bolivia that will supplement local systems that "are broke," said Mr. Gonzalez. "It takes forever to deliver pensions, which have deteriorated in purchasing power because of inflation by the time employees retire," he explained.

Compared with Chile's prior social security system, the current benefits are not only twice as large, but beneficiaries get them more quickly. Today, retirees can receive the benefit "between one and two months after they retire—at the latest," Mr. Gonzalez said.

"Pensions are also indexed, so you get an adjustment to inflation every month," he added. ■

Oil platform explosions not a serious loss: Shell

LONDON

LONDON—The Royal Dutch Shell Group of Companies is anticipating "fairly minor" damages from a series of explosions that rocked the Fulmar Alpha oil platform in the North Sea Aug. 8, a company insurance specialist says.

The resulting loss would be "considerably less than 1 million pounds ($1.7 million)," said Martin Black, who handles captive insurance arrangements for the company's Shell U.K. Ltd. unit, which owns the platform.

Mr. Black added that the expected loss would not exceed the company's retention and would not trigger a claim against the companies that reinsure Shell's captive, Mytilus Insurance Co. Ltd. of London.

He also said that no insurance was in place to cover the business interruption loss arising from the stoppage of oil production after the explosions. "We elect not to cover that exposure," he said.

Three workers who were on the platform when the explosions occurred required hospital treatment for superficial burns, but there were no other casualties.

The cause of the explosions had yet to be determined last week, said Mr. Black. He predicted that it would be "some weeks before the cause of the incident can be properly ascertained."

British government inspectors visited the platform the day after the explosions to begin their investigations.

Mr. Black declined to speculate about the cause of the explosion because of the sensitivity of the topic of oil rig safety. There has been a "lot of tension" over safety in the North Sea following the 1988 explosion of the Piper Alpha North Sea oil rig, which caused a heavy loss of life and was one of the largest man-made disasters ever to hit insurers.

—By William Pitt

Gulf cargo premiums

The diminishing threat of war risk losses since the end of the Persian Gulf War has prompted London underwriters to withdraw special marine and aviation cargo war risk premium loadings for Kuwait, including the neutral zone between Kuwait and Iraq, and Jordan.

The joint Lloyd's/Institute of London Underwriters cargo war risk rating committee last week returned the two areas to the standard 0.0275% rate one year after Iraq's invasion of Kuwait. Additional war risk premiums for marine and aviation cargo risks had been imposed on vessels and aircraft visiting Kuwait and Jordan since August 1990.

—By Gavin Souter

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Business Insurance

Fraternities

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cies and minimize exposures.

The results have been positive. Many national fraternities report lower loss ratios and fewer claims since they started their risk management programs.

For example, over the past three years, Lambda Chi Alpha Fraternity Inc.'s liability loss ratio has been about 33.7%, while over the past 10 years it was 71.9%, said Michael Manouel, director of finance and insurance at the Indianapolis-based fraternity.

However, that 10-year figure may drop to 48% if two liability lawsuits pending against the fraternity are suspended.

Lambda Chi Alpha's property loss ratio has plummeted to about 25.2% in the past two years from 62% over the past 10 years, he added.

Alpha Tau Omega has a liability loss ratio of 35% so far in 1991, Mr. Schneider said. He predicted, though, that the year-end ratio will be closer to 25%.

The fraternity's three largest claims this year have stemmed from accidental injuries.

Two injuries were sustained during 1990 homecoming festivities when one student fell from a human pyramid and another fell off a parade float that came apart.

The other claim occurred when a student fell down a flight of stairs in a chapter house, Mr. Schneider added.

Sigma Chi has had 11 liability claims so far in 1991, said Mr. Carter. The fraternity's largest claims stem from injuries sustained in fighting among undergraduate members, Mr. Carter said. There are four such claims pending against the fraternity.

However, that is an improvement over the chapters' claims experience before the fraternity's Risk Management Foundation was launched in mid-1988, according to Mr. Carter, though he does not have any figures on Sigma Chi's earlier claims experience, since it then was handled by individual chapters.

"In the past few years, fraternities have realized that in order to obtain coverage, they had to lose their 'license to kill' attitude," said Thomas Seeberg, an account executive with Arthur J. Gallagher & Co. in Itasca, Ill.

The risk management programs many have adopted have made them more attractive to insurers, Mr. Seeberg said.

Although the specific responsibilities of the risk managers vary from fraternity to fraternity, they all have developed loss prevention strategies focusing on education at the chapter level.

When Lambda Chi Alpha experienced an alcohol-related death in 1988 at its Rutgers University chapter in New Brunswick, N.J., a more aggressive risk management strategy ensued, Mr. Manouel explained.

An undergraduate risk management officer was elected in each undergraduate chapter and, by 1990, the fraternity made the position mandatory.

The risk management officer ranks fifth behind the chapter's president, vp, secretary, and treasurer, said Mr. Manouel.

The duties of the chapter risk managers include: "event planning, crisis planning, chapter house inspections and educating other members about risk management through videotapes, workshops and programming," Mr. Manouel added.

For example, undergraduate risk managers oversee all Lambda Chi chapter events to ensure that they comply with the national office's risk management criteria. The national office must approve events 30 days in advance if:

- A contract is signed.
- It will be held one or more miles from the chapter house and will involve transportation.
- The number of participants will exceed three times the number of chapter members.
- It will last more than five hours.

"If the chapters don't use this event-planning system, they pay $10 extra per man per year for (liability) insurance. Those who do utilize it save $4 per man per year," explained Mr. Manouel.

Other fraternities have instituted similar risk management programs.

Sigma Alpha Epsilon hired its first national risk manager in the summer of 1988 due to "an increasing necessity to monitor our insurance needs and policies," said John C. Perkins Jr., director of risk management and housing for the Evanston, Ill.-based fraternity.

Sigma Alpha Epsilon recommends that its chapters elect undergraduate risk management officers, though the position is not mandatory, he said.

The fraternity educates its undergraduates about risk management through videotapes addressing alcohol abuse, hazing and acquaintance rape, as well as a comprehensive risk management manual, quarterly newsletters and workshops at its regional and national leadership conferences, he explained.

Enforcing fraternity risk management policies is vital, said Alpha Tau Omega's Mr. Schneider. Once the national fraternity gets wind of potential violations, it does not hesitate to shut down a chapter or to suspend chapter officers. Then it conducts a thorough investigation, he said.

In the past few years, fraternities have realized that in order to obtain coverage, they had to lose their 'license to kill' attitude, says Thomas Seeberg, an account executive with Arthur J. Gallagher & Co. in Itasca, Ill.

Strict alcohol policies are a key part of fraternities' risk management programs.

Sigma Alpha Epsilon's alcohol policy has undergone a major overhaul in recent years, Mr. Perkins said.

In 1986, the fraternity forbade the sale of alcohol in chapter houses. In 1988, the fraternity outlawed purchasing alcohol with chapter funds, and in 1990 it forbade kegs of beer on chapter premises, Mr. Perkins said.

Lambda Chi Alpha's risk management program contains a strict alcohol policy patterned after alcohol and drug guidelines developed by the Fraternity Insurance Purchasing Group Inc.

Members of the fraternity are no longer allowed to purchase alcohol with chapter funds and alcohol is only allowed at Lambda Chi events if it is supplied by individuals or sold at a licensed cash bar, Mr. Manouel said.

The purchasing group was formed in 1987 and provided liability coverage to members underwritten by New Hampshire Insurance Co., a unit of American International Group Inc., Mr. Manouel explained.

Although the group no longer provides coverage, partly because fraternities with better loss records stop buying the coverage, fraternities and sororities still participate in the group to devise consistent risk management policies.

In addition, members of the FIPG are currently looking into the viability of forming a risk retention group, said Sidney N. Dunn, president of the Indianapolis-based group.

When a fraternity or sorority joins the FIPG, it agrees to adhere to guidelines covering alcohol and drug abuse, hazing, sexual abuse, fire, health, safety and education, Mr. Dunn said.

Many of Alpha Tau Omega's risk management guidelines come from the FIPG, said Mr. Schneider.

The FIPG permits "all of us to work together and gain uniformity. We can understand each other better," said Thomas Desjardin, director of programs for Lexington, Ky.-based Phi Gamma Delta Fraternity, which joined the FIPG in 1989.

Most national fraternities now purchase liability coverage, and some purchase property coverage for their individual chapters. However, the extent of coverage and the system for billing each chapter varies significantly.

For example, the Sigma Chi Risk Management Foundation purchases liability coverage on behalf of all of its chapters and property coverage for some.

Both policies are underwritten by syndicates at Lloyd's of London. The general liability policy has a $2 million limit per occurrence per chapter, while the property coverage has a maximum $5.5 million limit per chapter, Mr. Carter explained.

The foundation carries a $50,000 self-insured retention per occurrence for both property and liability risks, he said.

Individual chapters' liability premiums are based on the number of members multiplied by the square footage of the house, Mr. Carter said.

Payments for property coverage depend on the full replacement value of the fraternity house, he said. The property policy covers all chapter-owned property but not individual goods, he added.

Lambda Chi Alpha also purchases general liability and property coverage from Lloyd's syndicates on behalf of its chapters. In addition, individual undergraduate members are covered under the general liability policy, for which chapters pay an annual fee to the national fraternity and which provides limits of $1 million per occurrence/$5 million aggregate per chapter.

The fee a chapter pays for liability coverage is based on several factors, including: the state where the chapter is located, the type of construction of the chapter house, the chapter's risk management program and its loss history.

Participation in the property insurance program, which provides a maximum of $3 million in limits per location, is voluntary, said Mr. Manouel. Lambda Chi has, however, developed some incentives to persuade chapters to purchase the property coverage from the national fraternity (see story, page 34).

Lambda Chi has a $100,000 per occurrence and $100,000 aggregate self-insured retention for liability claims, he said.

"We have the financial strength to have that size retention and, depending on our loss experiences, we may go higher. We can fund that amount annually without touching our reserves," Mr. Manouel added.

Although many fraternities are reaping benefits from their risk management programs in the form of lower premiums, claims and losses, they are not resting on their laurels.

"We are going to continue our efforts to educate our members about risk management. We're starting to see freshmen, sophomores and juniors who are used to our new rules. A new generation is starting that has grown up with the precautions," said Mr. Schneider of Alpha Tau Omega.

Eventually, the fraternity would like to self-insure its exposures or

Continued on next page

Fraternities

Continued from previous page

join a risk retention group, he added.

Sigma Alpha Epsilon's main goal is to "continue letting individuals know how their actions can affect the whole group and their own lives. We would like not to have to pass any more policies per se," said Mr. Perkins.

"You will never hear me say that we can't have a big tragic loss. It is the nature of this risk. There's a big catastrophic loss out there waiting to happen. The irresponsible actions of one person can do terrible things in our environment. We're pursuing an active defense through an aggressive risk management and loss control program, and we want to continue," according to Lambda Chi Alpha's Mr. Manouel.

Other specific goals for the fraternity are reaching a $500,000 self-insured retention and continuing to educate individual undergraduate members "so they'll practice active loss control" and show care and responsibility for their fraternity brothers and their chapter facilities, Mr. Manouel said. ■

Fraternity adopts sprinkler program

An average of six to 12 fires occur at fraternity and sorority houses per year, says Michael Manouel, director of finance and insurance for Indianapolis-based Lambda Chi Alpha Fraternity Inc.

Mr. Manouel does not want his fraternity's chapter to become one of those statistics.

While paying his annual visit to insurance broker James R. Favor & Co. in Aurora, Colo., "I saw a sprinkler analysis Mr Favor had done for a sorority house and said, 'Let's target four or five houses and see' " if a sprinkler-retrofitting program would be feasible for Lambda Chi, said Mr. Manouel.

The fraternity's board of directors subsequently approved a loan program to allow chapters to borrow money to have their houses retrofitted with sprinklers. Five locations were chosen for analysis.

"We targeted older facilities where we're most worried about a tragic fire loss," Mr. Manouel said. These houses cost "$7,000, $8,000 or $10,000 per year to insure due to wood frame construction and original wiring," he added.

The chapter locations negotiating sprinkler installation are: Michigan State University in East Lansing; the University of Michigan at Ann Arbor; the University of Illinois in Urbana-Champaign; Samford University in Birmingham, Ala.; and Pennsylvania State University in University Park.

Lambda Chi Alpha will loan money at competitive rates—about 6.4%—to those chapters that want to install sprinklers and thereby lower their property insurance premiums, said Mr. Manouel.

So far, "Lambda Chi is the only fraternity to have a sprinkler-loan program," he said.

James R. Favor performed the preliminary cost/benefit analyses on each of the chapter candidates to determine whether a sprinkler system would save money. In performing the study, the broker examined a variety of factors, like the existing water supply and the location's fire rates, said President James Favor.

Lambda Chi chapters have a strong incentive to take part in the retrofitting program. The cost of the loan for the sprinkler system will not exceed savings from their current property insurance contributions to the national fraternity, Mr. Manouel said. Each loan will be customized for each location depending on "the size and condition of the house," he said.

'Lambda Chi is the only fraternity to have a sprinkler-loan program,' says Mr. Manouel.

Once the sprinklers are installed, the chapter repays the loan with its insurance premium savings. The chapter continues to pay the same property insurance premium that it did before the installation, and the difference between the pre-sprinkler premium and the post-sprinkler premium goes to the national office to pay back the loan, explained Mr. Manouel.

Loans must be repaid within 10 years at most. Typically the payback period will be five to seven years, he added.

Meanwhile, Lambda Chi also uses property insurance as an incentive for chapters to improve their houses.

Many fraternity houses are owned by house corporations, usually groups of local alumni.

Although chapters are not required to purchase their property coverage through the national organization, Lambda Chi provides loans for needed house improvements to house corporations that agree to insure their properties through the national property insurance program. "Any location which is not in our program is underinsured," Mr. Manouel said.

Lambda Chi's national program provides a maximum of $3 million of property coverage per chapter underwritten by syndicates at Lloyd's of London.

About 80 of Lambda Chi's 110 houses are now covered under the program, he said.

—By Cary Roberts

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Broker results

Continued from page 1

at revenue gains, add value to our customers and wait for the market to turn."

"We have been fighting a constant trend all year," said Frank Wieczynski, corporate secretary with Alexander & Alexander Services Inc. in Owings Mills, Md. "Rates were flat or down in almost all cases."

Analysts who track brokerage stocks said brokers will continue to have a difficult time maintaining earnings until the market turns.

"The brokerage industry can only control expenses for so long. They can't control revenues because they can't control the market cycle. So, I feel their earning capabilities are suspect for the foreseeable future," said Ira H. Malis, vp of Alex. Brown & Sons Inc. in Baltimore.

"There just isn't much positive to say about the industry," added Michael A. Smith, vp of Lehman Bros. in New York. "Their assets are generally all right, so I don't think there are any major stability problems. But rates are terrible, and there are no encouraging signs out there for an early turn. And consulting revenues are way down."

And Walter Fitzgerald, of Baird, Patrick & Co. in New York, said, "You won't see any significant change in numbers out of this group until they get decent pricing. Who knows when that'll be?"

Meanwhile, brokers are taking some solace in the fact that the second quarter is traditionally the poorest for renewals.

"Most of our renewals come up in the third quarter, so we haven't given up on the year yet," said Michael J. Cloherty, vp-finance with Arthur J. Gallagher & Co. in Itasca, Ill.

And, brokers point out that most made strides during the first part of 1991 toward controlling expenses.

"The competition among insurers is still heated. If they don't realize that they need to firm up pricing we have to get very lean in order to wait out the cycle," explained Robert H. Hilb, president of Hilb, Rogal & Hamilton in Glen Allen, Va.

Following are summaries of the publicly held brokers' second-quarter and midyear results:

First-half 1991 broker results

Results are reported in thousands of dollars

Broker	Gross revenues	% change	Net income	% change
Marsh & McLennan	$1,434,000	4.5%	$177,000	1.3%
Alexander & Alexander	676,400	4.6	17,600	-23.1
Frank B. Hall	236,636	9.3	2,995	-17.2
Rollins Burdick Hunter	201,400	0.5	24,900[1]	-5.0
Arthur J. Gallagher	106,340	3.6	4,585	-29.2
Hilb, Rogal & Hamilton	58,632	6.1	3,922	-5.2
Poe & Associates	29,500	2.6	2,200	4.8

[1] RBH reports only pretax income.

Source: Company reports

GRAPHIC BY JOHN HALL

Marsh & McLennan

Marsh & McLennan reported a 4.5% gain in gross revenues for the first half of 1991, while second-quarter revenues increased only 1.9%.

First-half revenues totaled $1.43 billion in 1991, compared with $1.37 billion in 1990. Second-quarter revenues increased to $690.2 million this year from $677.3 million for the same period in 1990.

Net income, however, remained virtually unchanged. Earnings for the first half of 1990 increased by 1.3% to $177.3 million from $175 million in the first half of 1990. Second-quarter net income dropped by less than 1% to $80.7 million from $80.8 million in 1990.

"Earnings were flat because we're operating in a very difficult environment. Based on this, we hold our performance in high regard," said Mr. Bischoff. "Short-term interest rates on a worldwide basis are down anywhere from 250 to 350 basis points. That made for a neutral quarter at best."

M&M's first-half insurance services revenues grew 4.9% to $832.6 million from $793.4 million in 1990. Second-quarter insurance services revenues increased 2.8% to $390.4 million from $379.8 million in the second quarter of 1990.

Mr. Bischoff noted that reinsurance brokerage operations "continued in a stable state." He said reinsurance pricing has stabilized as have the ceding habits of primary insurers.

Consulting revenues also remained fairly static throughout the first six months of the year. Consulting revenues increased 3.1% to $457.1 million for the first half of 1991 from $443.3 million in 1990. Second-quarter consulting revenues actually fell 1.1% to $225.9 million from $228.4 million last year. This compares with double-digit consulting growth for most of the past several years.

"Approximately 30% of our consulting fees are generated outside the United States, so we we're greatly affected by the rate of foreign exchange. Right now, the dollar is very weak. Combine this with the recession in North America and it affected us. Eighty percent of our consulting is benefits consulting through William M. Mercer, and that has slowed down, too," Mr. Bischoff explained.

He said M&M increased investment management revenues by 7% to 8% during the second quarter. The company's Putnam Inc. subsidiary finished the quarter with a record $45.2 billion in assets under management.

"M&M was really hurt by the drop in consulting revenues," pointed out Alex. Brown's Mr. Malis. "They had grown accustomed to 10% to 15% quarterly revenue growth from their consulting operations. Consulting was up 7% in the first quarter, but it fell by 1% in the second quarter."

"Consulting revenues at M&M came to a screeching halt," added Mr. Smith of Lehman Bros. "This is a pure indication of the extent of this country's economic decline."

Mr. Malis said M&M made strides during the second quarter to get a better grip on expenses. "Their expense categories were down substantially. Salaries and benefits went down in the second quarter compared with the first quarter. The drop was marginal, but we have never seen these expenses decline as the year goes on. It has always been the opposite."

Compensation and benefits at M&M totaled $355.2 million in the second quarter, down 5.3% from $375.2 million in the first quarter.

"And, their head-count is down, too. That means less travel and less entertainment. I'm sure this is tied to lower consulting revenues," Mr. Malis pointed out.

Alexander & Alexander

New York-based A&A reported first-half gross revenues of $676.4 million in 1991, up 4.6% from $622.1 million in 1990. Second-quarter gross revenues grew 2.5% to $344 million from $335.7 million last year.

Mr. Wieczynski said A&A's 1991 performance to this point has been "reasonable considering the difficult environment we're operating in."

Retail brokerage revenues increased only 2% for both the first half of the year and the second quarter.

Its reinsurance brokerage revenues, however, increased 15% in the first half of the year, while consulting revenues were up by about 8% during the first half of 1991 compared with 1990.

Still, net income fell 23.1% in the first half of the year to $17.6 million from $22.9 million in 1990. Second-quarter earnings dropped 23.7% to $13.5 million from $17.7 million the previous year.

A&A's profits fell primarily because of reduced premium-based commissions and increases in expenses, according to Mr. Wieczynski.

"Unfortunately, our expenses rose at a faster pace than expected. Due to expense control programs, expenses had been increasing by about 3% to 4% annually for the past three years. But during the first half, expenses increased by 5%," he explained.

Mr. Wieczynski also attributed the drop in earnings to soft market conditions. "Rates throughout the first part of the year have remained flat or have fallen by about 5%. This trend has been constant."

"I think A&A did well to increase consulting revenues. It helped them offset second-quarter commission-based revenue growth of only 1.2%," said Mr. Malis of Alex. Brown.

"The numbers for A&A are basically what we expected," said Mr. Fitzgerald of Baird, Patrick. "Their earnings were down and their revenues were flat."

Frank B. Hall

Frank B. Hall reported first-half gross revenues of $236.6 million in 1991, up 9.3% from $216.5 million in 1990. Second-quarter revenues grew 9.9% to $115 million from $104.6 million last year.

"It was a business-as-usual quarter in that we had above-average revenue growth. Our commissions and fees grew by more than 13%, which is way above industry average," said Mr. Bell.

Midyear net income, though, dropped 17.2% to just less than $3 million from $3.6 million in 1990. And, the broker reported a second-quarter loss of $675,000 after posting earnings of $569,000 in the second quarter of last year.

Mr. Bell said he is not distressed about the second-quarter loss, explaining that Hall invested in "several" start-up operations that have yet to produce large-scale revenues.

"I consider a bottom-line loss of $675,000 breaking even," Mr. Bell said. "What happened is that we have not seen the revenues come in from a number of start-up operations. But I don't run the company on a quarter-by-quarter basis. What happens is that we make investments, we then hit a plateau and then the revenues come in. There's always a void between the initial investment and returns."

And, Mr. Bell said he was very pleased with Hall's 13.3% increase in second-quarter brokerage commissions and fees. Commission- and fee-based revenues climbed to $108.7 million in the second quarter from $95.9 million in the second quarter of 1990.

"New business growth is at a record pace in spite of the market. We're implementing all the strategies that we wanted and they're working. We're very happy about that," Mr. Bell said.

First-half expenses were $231.8 million, up 10.4% from $210 million last year. Second-quarter expenses increased 12.3% to $116.3 million from $103.6 million in 1990.

"We had significant expenses for all of the projects we began, and that has affected income. But we expect that this will turn around and pay off. Also, compensation costs have risen substantially. You have to pay for talented revenue producers," said Mr. Bell.

Mr. Smith noted that Hall has led the pack in terms of revenue growth in recent years, "but this growth has come at substantially high costs."

He expressed concern over Hall's second-quarter loss, but stopped short of saying it would damage the broker.

"I don't think the loss is too significant. They have a benefactor in (Reliance Group Holdings Inc.) that could bail them out if necessary. But they shouldn't need any help. They're an absolutely viable broker with good people," Mr. Smith said.

Baird, Patrick's Mr. Fitzgerald agreed that with Hall, the key is the company's top line.

"I don't think their bottom line matters much. You know they won't see a turnaround in profitability until the market swings. They're doing more business, as evidenced by their increase in commissions. I'd say they broke even despite the book loss," he said.

Rollins Burdick Hunter

Rollins Burdick Hunter Group, a subsidiary of Chicago-based Aon Corp., reported gross revenues of $201.4 million for the first half of 1991, up 0.5% from $200.4 million in the corresponding period a year ago.

Second-quarter revenues increased 3.6% to $102.4 million from $98.8 million in 1990.

RBH's mid-year and second-quarter pretax earnings, however, decreased because clients simply aren't purchasing as much insurance as they did during healthy economic times, according to Patrick G. Ryan, Aon's chairman, president and chief executive officer.

"The companies we rely on have fewer people, they're functioning on low inventory and they're cutting back. This all translates into lower insurance premiums. And with insurance and benefits consulting, it's the same thing," said Mr. Ryan.

RBH reported first-half pretax income of $24.9 million, a 5% drop from $26.2 million in 1989. For the second quarter, pretax income dropped 2.5% to $11.9 million in 1991 from $12.2 million a year ago.

RBH's results are reported with those of Aon Corp., which does not break out net income for its individual units.

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Broker results

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Arthur J. Gallagher

Arthur J. Gallagher & Co. of Rolling Meadows, Ill., reported first-half gross revenues of $106.3 million in 1991, a 3.6% increase from $102.7 million in the previous year.

Commission-based revenues for the first six months of this year declined 1.4% to $59.8 million from $60.7 million in 1990. But fee-based revenues increased 14.8% to $39.7 million from $36.6 million in the first half of 1990.

Gallagher's second-quarter revenues rose 2.2% to $52 million from $50.9 million in 1990.

During the second quarter, commission-based revenues declined 1.6% to $29.5 million from $30 million for the same period in 1990. Second-quarter fee-based revenues, however, increased 14.4% to $19.9 million from $17.4 million in 1990.

The growth in fee-based revenues came primarily from the Gallagher Bassett Services unit, which specializes in claims administration, risk management consulting and safety engineering, said Mr. Cloherty.

Gallagher's first-half net income fell 29.2% to $4.6 million from $6.5 million in 1990. Second-quarter earnings tumbled 72.6% to $795,000 from $2.9 million in 1990.

'It's safe to say that competition among underwriters hasn't ceased one bit,' says Mr. Cloherty.

"Certainly, we're disappointed in our second quarter, but it's always our smallest quarter of the year. Most of our renewals come up in the third quarter, so we're not out of it yet," Mr. Cloherty explained.

He noted that commercial insurance prices continued to fall during the second quarter. "It's safe to say that competition among underwriters hasn't ceased one bit. Combine that with the recession and decreasing insurable values and what you get is much lower commissions."

Gallagher purchased three general agencies during the second quarter. Mr. Cloherty said the agencies will add $20 million in annual revenues and 200 staff to the company's payroll.

The fact that the new agencies are providing immediate revenues is consistent with Gallagher's expense-controlling philosophy of not adding new staff without corresponding revenues.

"Overall, expenses are under tough scrutiny. Seventy percent of our expenses are from salaries and benefits. So, we're not adding any new people without corresponding revenue growth," he explained.

Expenses during the first half of 1990 increased 6.7% to $99.9 million from $93.6 million for the same period of 1989. Second-quarter expenses grew by 8% to $50.7 million from $46.9 million in 1990.

"Gallagher had a very disappointing quarter. I thing they're getting beaten up pretty bad by the competition. They posted weaker-than-expected revenues both for the quarter and the first half of the year," said Mr. Smith.

Hilb, Rogal & Hamilton

Hilb, Rogal & Hamilton reported first-half gross revenues of $58.6 million, up 6.1% from $55.2 million for the same period last year. Second-quarter revenues increased 8.4% to $28.6 million from $26.4 million in 1990.

Net income increased 45.5% to $1.37 million during the second quarter of this year from $745,000 in 1990. However, midyear earnings fell 5.2% to $3.92 million from $4.14 million in 1990.

"Our results were satisfactory, but they still were not what we'd like," Mr. Hilb said. "We're happy that earnings increased significantly in a tough market. All in all, it was a good quarter. We pulled out all the stops and we should have done better if not for the economy and the soft market."

Mr. Hilb said the company made eight agency purchases during the second quarter of this year, which contributed to the revenue increase.

Hilb was also able to improve earnings by tightening up on expenses.

"We have become very lean at the headquarter level. We control our expenses here, which makes it much easier to get a handle on our offices. We can react rapidly if we spot a problem," according to Mr. Hilb.

Mr. Malis said Hilb, Rogal & Hamilton is currently one of the shining stars of the brokerage industry. "They're the only broker on our buy list right now. They have boosted revenues through a series of successful acquisitions. It's encouraging to see a company increasing its revenue base at the trough (of a cycle). And, they're doing a great job of controlling expenses. Their expenses increased only 1% this past quarter."

Poe & Associates

Tampa, Fla.-based Poe & Associates' first-half gross revenues increased 2.6% to $23.5 million from $22.9 million in 1990. But second-quarter revenues declined by 4.3% to $11 million from $11.5 million the previous year.

Meanwhile, net income for the first six months of 1991 increased by about 4.8% to $2.2 million from $2.1 million in 1990. Second-quarter profits were up 5.2% to $894,000 from $850,000 a year ago.

Donald E. Howery, vp and treasurer, said Poe & Associates is pleased with its midyear and second-quarter results, "though we'd like them to be a little better."

Scaled-back bonuses let Poe & Associates boost earnings in the second quarter despite lower revenues, he explained. "We cut back on expenses, primarily through cutting back on bonuses. We had to refine the bonus program and make it more realistic in relation to market conditions."

In May, the company completed a 5-for-4 stock split and acquired Farr Insurance Inc., a general agency in Palm Beach, Fla. "We're very happy so far with the results of this acquisition, although it's still considered a long-term investment," said Mr. Howery.

Securities analysts do not track Poe & Associates. ■

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Hudig acquisition

Continued from page 1

short of surpassing the fifth-ranked broker, Johnson & Higgins. *Business Insurance* estimates 1990 revenues for privately held J&H at $833.1 million.

Besides making RBH one of the world's six largest brokerages, the acquisition will transform it into a truly global broker with operations throughout Europe and a presence in the Far East. In addition, the deal will give Hudig-Langeveldt additional resources to expand its European network of offices.

Mr. Ryan noted that Hudig-Langeveldt, now the world's 14th-largest brokerage, is the largest broker based in continental Europe.

"We think they are a first-rate organization and quite advanced in handling risk management for major corporate clients," Mr. Ryan said.

Hudig-Langeveldt has handled RBH accounts in Europe for several years as a correspondent, he noted, adding that Hudig-Langeveldt will continue to operate under its current name and with its current management.

While RBH has functioned largely through such overseas correspondents in the past, this strategy has changed, Mr. Ryan suggested. "We believe in the 100% ownership as opposed to the network" approach, he said.

Hudig-Langeveldt is no stranger to expansion in Europe. Over the last year it has acquired German broker Hanseatische Assekuranz-Vermittlungs A.G. and the Belgian operations of French broker Groupe Le Blanc de Nicolay (*BI*, July 1).

This expansion will continue with financial support from RBH, though Mr. Ryan said no specific expansion or financing plans have been developed.

"The goal is to grow and develop our professional services throughout the major countries of Europe," he said.

The acquisition by RBH will give Hudig-Langeveldt additional resources to carry out expansion plans in Europe, which include buying operations in France and Italy, according to Hudig-Langeveldt Chairman Dirk Verbeek.

Hudig-Langeveldt already has 125 million guilders ($63.8 million) in reserves, mainly from the sale of its insurance underwriting interests to AMEV Nederland nv in January 1990.

The combination with RBH will enable the Dutch broker to reach its often-stated aim of becoming the leading broker in continental Europe, Mr. Verbeek said. That would not be possible, he added, if Hudig-Langeveldt had been transformed into the Dutch branch of M&M.

"M&M already has a large presence in Europe through other subsidiaries such as Gradmann & Holler in Germany," which it acquired last year, Mr. Verbeek explained. "So we would not have been able to achieve our goal of becoming the No. 1 broker in continental Europe and expand in the way in which we want to," he added.

By linking with RBH, Hudig-Langeveldt loses its independence, though it will retain its identity and management, Mr. Verbeek said.

"Our main object has always been to pursue our corporate strategy, and although we have said before that we wish to remain independent, we cannot allow this to become more important than achieving our aims," he said.

Shortly after M&M in March announced its intent to sell its stake in the company, Hudig-Langeveldt officials realized that the brokerage probably will have to seek a parent rather than a U.S. partner, Mr. Verbeek pointed out. "Today, minority interests tend not to fit in with global expansion plans of the major brokers."

Hudig-Langeveldt has held discussions "with a number of major brokers" besides RBH, Mr. Verbeek noted.

For example, talks were held with Sedgwick Group P.L.C., the world's third-largest brokerage. "We have had a long relationship with Hudig-Langeveldt and consequently we were keen to become more involved with the company but only at the right price," said Jeremy Pinchin, Sedgwick's group secretary.

Sedgwick is the principal London broker for Hudig-Langeveldt's wholesale account, Mr. Pinchin said.

Mr. Ryan pointed out that the acquisition will not mean that Nicholson Chamberlain Colls Ltd., a London brokerage in which RBH has a 40% interest, will automatically become the London wholesale broker for Hudig-Langeveldt.

"The business goes where it's most appropriate, irrespective of ownership. We start with what's best for the client," he observed.

"All of (RBH's) business doesn't go to NCC. That's the way the business is run," he said. Hudig-Langeveldt "will be operating the same way. . . . A judgment will be made as to what's best for the client."

While there is some overlap between RBH's and Hudig-Langeveldt's operations, it is minor, Mr. Ryan noted.

RBH, for example, has "small representative offices" in Paris; Frankfurt, Germany; and Amsterdam in the Netherlands. And Hudig-Langeveldt has a relatively small office in Bermuda, where RBH has been active for many years.

"I don't think that's a big issue," Mr. Ryan said of the overlap.

Besides its Dutch operations, Hudig-Langeveldt currently has offices in Belgium, Spain, France, Germany, Hungary, Austria, Bermuda, Japan and the Netherlands Antilles. It also has offices in the Far East through a joint venture with London-based broker C.E. Heath P.L.C. called Heath Hudig-Langeveldt.

Mr. Ryan said that it's "my hope and expectation" that Hudig-Langeveldt will continue its joint venture with C.E. Heath in the Far East and that RBH will continue its venture with Choei Co. Ltd., a Tokyo-based agency. Hudig-Langeveldt has its own office in Japan.

The Hudig-Langeveldt acquisition will be an all-cash deal that will "probably" require RBH to incur some debt, said Mr. Ryan, who wouldn't disclose the cost of the acquisition or the amount of debt that might be required to complete it.

The acquisition will also produce a "very modest" dilution of Aon's earnings—less than 5%—for a "relatively short period of time," Mr. Ryan said.

"We have every reason to believe that they are going to have good growth and that they are going to continue to improve their margins," he said of Hudig.

However, "It is such an unusual deal, because it is the only major European broker up for sale, so there is nothing to compare it with," said Chris Pountain of Morgan Stanley International in London.

Other analysts said the acquisition was a wise move by RBH.

The acquisition of Hudig-Langeveldt 'certainly gives RBH a better position all over Europe, especially in Germany, which is the fastest-growing insurance market in the world,' Mr. Smith says.

"It's real positive for RBH," said Michael A. Smith, a vp with Lehman Bros. in New York.

The move increases RBH's brokerage revenues, dilutes Aon's earnings only slightly and positions the brokerage for a turn in the insurance cycle and for expansion in Europe, he noted.

"It certainly gives RBH a better position all over Europe, especially in Germany, which is the fastest-growing insurance market in the world," Mr. Smith said.

"In a business sense, it seems like a logical and worthwhile acquisition for them to make," said James Wolf, an analyst with Conning & Co. in Hartford, Conn. He cautioned, however, that the value of the deal can't be definitely determined until the terms are disclosed.

"This gives them access to (the European) market, which they did not previously have," he noted.

M&M, meanwhile, announced last week that it has signed a preliminary agreement to sell its 30% stake in Hudig-Langeveldt to RBH. As part of the deal—which is expected to close within 90 days with approval of Hudig-Langeveldt shareholders—M&M will repurchase Hudig's 16% stake in M&M's Italian brokerage subsidiary.

M&M is planning to open its own office in Rotterdam. "We believe that we can best serve our clients through having our own company in the Netherlands," Chairman Frank J. Tasco said in a statement. "This decision. . .is consistent with our strategy to operate as a single integrated insurance broking firm throughout Europe."

Besides M&M, other shareholders in Hudig-Langeveldt include Nederlandse Participatie Maatschappij nv, a Dutch investment firm, which owns 38%; Amsterdam-Rotterdam Bank nv, which owns 20%; and Hudig-Langeveldt employees and other shareholders, which own 12%.

Hudig-Langeveldt's gross revenues rose 16.5% to 233.6 million guilders in 1990 from 200.5 million guilders in 1989. After currency conversion, the broker's revenues increased 29.8% in dollar terms to $136.3 million from $105 million. And net income increased 18.1% to 26 million guilders ($15.2 million) in 1990 from 22 million guilders ($11 million) in 1989.

RBH's gross revenues rose 20.3% in 1990 to $380.6 million from $316.4 million in 1989. Pretax income increased 44.8% to $36.6 million from $25.3 million. Aon does not report individual units' net income.

RBH's proposed acquisition comes almost a year after Aon failed in its attempt to acquire Corroon & Black Corp. for $840 million in a challenge to the previously announced merger between C&B and Willis Faber P.L.C. (*BI*, Sept. 24, 1990).

Aon dropped its bid after it was rejected by the C&B board. C&B later completed its merger with Willis Faber to form Willis Corroon P.L.C. ■

Ratings criteria

Continued from page 2

"I know we have no authority to regulate rating agencies, but the industry is facing a crisis in confidence, where any rumor or unfair rating can trigger a run on the bank. Our job is to oversee solvency, and if a third party influences solvency, then it becomes our business," Mr. Pomeroy said.

"The NAIC has the most extensive data base in the industry. I don't think we should provide that information to a rating agency that doesn't confer with us on the components of its ratings. I favor providing all financial data possible because the public deserves that, but the rating agencies have to come under review," Mr. Pomeroy said.

But, among the major rating services, only Standard & Poor's Corp. regularly purchases the NAIC's computerized insurer financial information, the NAIC spokesman said, though other services buy NAIC data on an irregular basis.

An S&P spokesman in New York said that while S&P was not completely clear on Mr. Pomeroy's proposals, "if there were NAIC requirements placed on ratings, we're sure we could fulfill those standards."

He also said that while S&P does purchase NAIC data, "we could function without it if necessary. We don't even use that information for our claims-paying ability ratings."

A.M. Best in Oldwick, N.J., which purchases computerized NAIC data only to compare it with information it obtains directly from the insurers, "shares Mr. Pomeroy's concern" about the effect ratings have on insurer solvency, said Vp Paul Wish.

"We support his suggestion that the NAIC should consider developing evaluatory criteria and impose limitations on access to financial data if in their opinion the data is being used to the detriment of the industry. We have no problem with any evaluation of raters," Mr. Wish said.

And Joseph Petrelli, president of Demotech Inc., a Columbus, Ohio-based firm that rates insurer strength, said that while he personally is receptive to listening to NAIC rating criteria, he questioned whether the NAIC would, in essence, be endorsing a rating agency that meets its standards.

"If they want to review these services, they should also be ready to offer opinions and endorsements of rating agencies. The regulator is the ultimate authority on solvency, not the raters," Mr. Petrelli said. ■

West Branch Administrators, Imperial Lloyd's seized

Health, auto insurers to be liquidated

HARRISBURG, Pa.—The Pennsylvania Insurance Department has obtained a liquidation order against West Branch Administrators, a Williamsport, Pa., company that regulators say acted as an unlicensed health insurer.

West Branch—originally seized by the department in October 1990—sold health insurance primarily to small businesses in the Williamsport area and had as many as 120 policyholders. The firm's president, Paul Mangiardi, previously ran two other unlicensed insurers shut down by Pennsylvania regulators in the last two years, the department said.

Separately, the Louisiana Insurance Department has obtained a liquidation order against Imperial Lloyd's of Opelousas, La., an auto insurer that wrote substandard risks. Imperial has $2 million in outstanding claims and $190,000 in assets, the department said.

—By Douglas McLeod

South Carolina work comp rates rise

COLUMBIA, S.C.—South Carolina Chief Insurance Commissioner John G. Richards has approved increases in workers compensation rates for both the voluntary and assigned risk markets.

The insurance commissioner approved an average 2% increase for voluntary market rates and an average 12% increase for assigned risk rates.

The Boca Raton, Fla.-based National Council on Compensation Insurance earlier had sought a 15.9% increase for voluntary market rates and a 48.5% increase for assigned risk rates.

However, Martin M. Simons, chief casualty actuary for the insurance department, noted that Mr. Richards also approved the elimination of assigned risk premium discounts. Removing those discounts amounted to an additional rate increase of about 8% for risks in the residual market, he said.

The rate increases took effect last month.

—By Mark A. Hofmann

Smoking, poor diet are bigger hazards, AMA says

Learning to live with asbestos

CHICAGO—Asbestos can never be entirely eradicated and society should learn "how to live safely with this valuable material," says an American Medical Assn. committee.

While acknowledging that asbestos poses health risks—especially for custodians, firefighters and demolition workers—the AMA Council on Scientific Affairs said hazards to the public caused by asbestos and other industrial pollutants "often pale by comparison" to hazards, like smoking, poor diet and lack of exercise.

In a report published last week in the Journal of the American Medical Assn., the panel said that developing better ways to manage and contain asbestos—as well as disposing of it when necessary—offers "the only realistic prospects for the prevention of asbestos-related injuries and disease."

The council—in what it called a clarification of a common misunderstanding—also noted that the Environmental Protection Agency does not require removing all asbestos material from buildings. The EPA requires that asbestos be removed only when "material damage is extensive and severe, and other actions (such as special maintenance, repair, encapsulation or enclosure) will not control fiber release."

—By Christine Woolsey

401(k) rules

Continued from page 3

would have to be paid on the withdrawal, according to the final rules.

For example, if an employee needed $3,000 to pay for tuition and the taxes owed on the withdrawal were $1,000, the employee could withdraw $4,000.

"That is a big plus for employees," said Frederick Rumack, director of taxes and legal services at Buck Consultants Inc. in New York.

The final rules also will give employers more flexibility in refunding investment income earned on contributions by highly paid employees that must be returned to the employees because those contributions would have caused the 401(k) plan to fail the IRS non-discrimination tests.

With the exception of the disaggregation provision and the end to restructuring, benefit experts say the final rules are an improvement over the 1988 proposals.

"In these regulations, the IRS has cleared up a number of administrative issues. From that perspective, they are an improvement. But the restructuring ban is one big disappointment," said Gary Blank, a consultant in the San Francisco office of The Wyatt Co.

"There has been a general relaxation of nit-picking requirements. There has been slight to moderate relief compared to the proposed rules, though nothing to be euphoric about," said Harry Conaway, a principal with William M. Mercer Inc. in Washington, D.C.

"I think overall, with the exception of restructuring and disaggregation, employers will view the final regulations as an improvement," said Frank Roque, a legal consultant with Hewitt Associates in Lincolnshire, Ill.

Despite the administrative complexities, 401(k) plans are immensely popular with employers and employees. The plans can be offered at a predictable cost and provide a benefit that employees understand and appreciate.

The popularity of 401(k) plans—the fastest growing employer-provided benefit during the 1980s—is made evident by surveys conducted by Hewitt Associates.

In 1982, a Hewitt survey found that only 11% of 250 employers offered 401(k) plans. A larger Hewitt survey of 944 major employers last year found that 93% of the firms offered 401(k) plans to their employees.

Employees like the plans because they can make pretax contributions, while employers usually match a portion—typically 50%—of the workers' contributions.

Benefit experts say the IRS regulations, while complex in many areas, will not dampen the enormous popularity of the plans.

"401(k) plans continue to be alive and well," said Wyatt's Mr. Blank.

But the "disaggregation" provision affecting 401(k) plans covering union employees will complicate and increase administrative costs.

The provision would be implemented in two steps over the next two years. In 1992, union employees would have to be disaggregated from other employees. During that year, the basic 401(k) non-discrimination test that compares contributions by higher- and lower-paid employees only would have to be run on non-union employees in the plan.

In 1993, though, the ADP test would also have to be run on union employees.

And, if a 401(k) plan covered employees from multiple unions, the ADP test would have to be run separately for employees covered by each union, adding to employers' administrative costs.

"There could well be some additional charges. Disaggregation is an administrative complication," said Gail Mohr, a consultant in Foster Higgins' Princeton, N.J., office.

"This is particularly true if union and non-union status is not noted in the benefits computer system," said Mr. Saveth.

Depending on plan demographics, disaggregation of union employees also could make it harder for some 401(k) plans to pass the ADP test, which is run to compare salary deferrals of higher- and lower-paid employees.

For example, assume a 401(k) plan had many lower-paid union employees who on average made substantial contributions to the plan and also had a substantial number of hourly non-union employees whose contributions were very low. The plan also covers salaried employees, all of whom are highly paid.

If the union employees were disaggregated and removed from the plan, the deferrals of the highly paid employees only would be compared with the small deferrals of the lower-paid non-union employees.

That would increase the likelihood that the average deferrals of highly paid salaried employees would exceed the maximum difference between deferrals of lower-paid employees that is allowed under the ADP test.

'The IRS has cleared up a number of administrative issues,' says Mr. Blank.

Under the most widely used IRS non-discrimination test, the ADP of highly compensated employees—those earning more than $60,535 in 1991—cannot exceed 200% of the ADP of lower-paid employees or the ADP of the lower-paid workers plus two percentage points, whichever is less.

Still, the disaggregation provision is not a complete surprise. Indeed, the IRS calls the provision a clarification. IRS rules published in 1989 and 1990 made clear that disaggregation of union employees was mandatory for non-discrimination testing purposes in other types of pension plans, like defined benefit plans. But those earlier rules did not explicitly address whether disaggregation for ADP testing purposes also applied to 401(k) arrangements.

Benefit experts also were not surprised by the IRS decision to eliminate 401(k) restructuring; the agency had earlier warned that it might ban the technique, which it proposed only last year as part of its massive pension non-discrimination rules.

Under the 1990 IRS restructuring proposal, employers running the 401(k) non-discrimination tests no longer had to compare, on a plan-wide basis, average deferrals by highly compensated employees with other employees.

Instead, a plan could be restructured—just for testing purposes—into separate components or groups of participants. Under this approach, a 401(k) plan could be broken down into separate plans covering employees at different locations or in separate job categories. These components would then be tested separately.

That was allowed under the 1990 IRS rules as long as the percentage of non-highly compensated employees covered by a component plan was at least 70% of the percentage of highly compensated employees covered by the plan.

With the end of restructuring, employers can take two approaches in trying to pass the ADP test, each with its own set of disadvantages.

Employers could go back to testing their 401(k) plans on a plan-wide basis. But if the plans had trouble passing the ADP tests before restructuring was allowed, the plans probably still will have difficulty passing the tests.

As a result, employers again would have to scale back contributions by highly paid employees, making the plan less attractive to those employees.

Alternatively, employers could set up separate 401(k) plans for different groups of employees and achieve the same results on the ADP test as through restructuring.

But companies taking this approach would face higher administrative costs since they would have to, among other things, file multiple Form 5500s—the annual plan financial report—with the federal government. Restructuring allowed employers to file one Form 5500, even if a plan had been broken into several components.

"An employer has to balance the reduction in what the higher-paid can defer because of the loss of restructuring against the added costs of establishing separate plans," said Gerald Uslander, a Mercer principal in Washington, D.C.

Meanwhile, benefit experts welcome changes in the IRS rules regarding hardship withdrawals for educational expenses.

One change will allow a hardship withdrawal to cover educational expenses for an entire year; the 1988 proposed rules said the withdrawals only could cover an academic quarter or semester.

In addition, the 1988 rules defined educational expenses as tuition. The final rules say withdrawals can be made for tuition as well as related educational fees.

Under this broader, though still somewhat vague definition, lab fees, like those charged by medical schools, clearly would be an eligible expense for a hardship withdrawal. But benefit experts aren't sure if room and board expenses would be eligible.

Consultants now are seeking clarification from the IRS on this issue and informal guidance is expected soon, said Jeff Croyle, a partner with Kwasha Lipton in Fort Lee, N.J.

Employers will also welcome a new provision in the final regulations that gives companies more flexibility in returning investment income earned on "excess" contributions made by highly paid workers during a so-called gap period—the period between the end of a plan year and the date the contributions are actually returned to employees.

Under IRS rules, excess contributions must be returned to highly compensated employees within 2½ months after the end of the plan year without special penalties. The returned contributions are added to an employee's taxable income for the year he or she made the contribution.

Under the 1988 rules, the excess contribution, the investment income earned during the year the excess contributions were made and the investment income earned during the gap period all had to be returned to the employee and added to the employee's taxable income.

Under the final rules, the employer has the option of keeping the investment income earned on the excess contribution during the gap period in the employee's account balance. This will cut down on the administrative effort needed to calculate investment income earned during the gap period, benefit experts say.

"It was an extra administrative hassle for a small amount of money that was involved," said Mr. Rumack of Buck Consultants. ■

Update

Barge owners covered for loss

LONDON—Owners of a derrick pipe-laying barge that capsized in the South China Sea last week killing as many as 27 people have about $300 million of liability insurance to respond to the loss, which London underwriters fear could reach $100 million to $150 million.

However, the owners retain at least $2 million of the risk.

The Panama-registered McDermott Derrick Barge No. 29 is ultimately owned by McDermott International Inc. of New Orleans. When the barge capsized off the coast of Hong Kong during Typhoon Fred, most of the 195 people on board were thrown into the sea. Rescuers saved 168 people, but four were trapped in a diving bell that was lost on the seabed and others were either dead or missing as of late last week.

Survivors reportedly criticized the company, saying the barge was given repeated typhoon warnings. Others cited slack safety standards, saying heavy anchors that were left unsecured pierced the vessel.

McDermott's liability coverage is written in various layers, with the company retaining at least the first $2 million, London sources say. It is unknown whether the company retains the next $10 million or has coverage outside of the London market. The next $140 million layer of excess coverage is placed in London, led in the Lloyd's of London market by syndicates managed by Janson Green Ltd. The next $50 million excess layer is placed either in the Scandinavian or U.S. market; A.C.E. Insurance Co. Ltd. writes the following $50 million excess layer; and the next $50 million excess layer is led in London by Lloyd's syndicates managed by Janson Green.

The barge is insured for $30 million, led in Lloyd's by syndicate 52, which is managed by Paul Hunt & Others Ltd.

Neither McDermott nor its London broker, Bain Clarkson Ltd., would comment.

Best cuts CIGNA units' ratings

OLDWICK, N.J.—A.M. Best Co. has downgraded 19 property/casualty units of CIGNA Corp. to A (contingent) from A, citing continued underwriting losses and a drop in the insurer's 1990 policyholder surplus.

"The contingency rating reflects a modest decline in our current performance, which we believe is a reflection of a very difficult competitive marketplace—but not enough of a decline to warrant a lesser rating," a CIGNA spokesman said.

Best downgraded the ratings of: Alaska Pacific Assurance Co., Atlantic Employers Insurance Co., Bankers Standard Fire & Marine Co., Bankers Standard Insurance Co., Century Indemnity Co., CIGNA Employers Insurance Co., CIGNA Fire Underwriters Insurance Co., CIGNA Insurance Co., CIGNA Insurance Co. of the Midwest, CIGNA Insurance Co. of Texas, CIGNA Property & Casualty Insurance Co., Indemnity Insurance of North America, California Union Insurance Co., Pacific Employers Insurance Co., CIGNA Insurance Co. of Illinois, Illinois Union Insurance Co., CIGNA Insurance Co. of Ohio, CIGNA Lloyds Insurance Co., and INA County Mutual Insurance Co.

Moody's Investor Service Inc. also has downgraded CIGNA's debt rating to A1 from Aa2 and lowered the insurance financial strength rating of its Connecticut General Life Insurance Co. unit to Aa2 from Aaa. Moody's cited Connecticut General's "large commercial mortgage exposure." As of June 30, Connecticut General had about $10 billion of its $40 billion in total assets in commercial mortgages.

The downgrading reflects the agency's negative view of the real estate market rather than its opinion about Connecticut General's financial strength, said Phil Ward, a managing director in CIGNA's real estate investors division.

Ex-regulator sues over firing

NEW YORK—A former New York deputy insurance superintendent charges in a lawsuit that he was fired because he objected to preferential treatment of state Blue Cross organizations and affiliated health maintenance organizations by a department official.

Donald Lundgren is suing the Insurance Department, Superintendent Salvatore R. Curiale, First Deputy Superintendent Wendy Cooper and former Superintendent James Corcoran, charging that he was wrongly terminated. The complaint charges that Ms. Cooper stymied Mr. Lundgren's efforts to take action against "predatory pricing practices" by Blue Cross organizations against competing HMOs. Ms. Cooper also showed favoritism by not challenging Blue Cross refusals to comply with department directives, the complaint alleges.

Mr. Corcoran relieved Mr. Lundgren of his duties as deputy superintendent in July 1989, and Mr. Curiale terminated his employment in April 1991, says the suit, which seeks unspecified compensatory damages and $500,000 of punitive damages.

In an answer filed in federal court in New York, the defendants deny the allegations and assert they acted lawfully. The New York department also has filed a motion seeking to dismiss a charge that the department violated a state whistle-blower statute.

Empire Blue Cross & Blue Shield declined to comment.

Briefly noted

Crum & Forster Inc. has indefinitely postponed an initial public offering of Constitution Re Corp., a holding company for Crum & Forster subsidiary **Constitution Reinsurance Corp.** (*BI*, May 27). The insurer cited market conditions for the postponement. . . .Insurance Solvency International Ltd., a unit of **Standard & Poor's Corp.**, has introduced a new service examining the financial condition of **Lloyd's of London syndicates**. . . .**Upjohn Co.** has settled a product liability suit charging that the firm's Halcion sleeping pills caused violent behavior in a Salt Lake City woman who killed her mother. Terms of the settlement were not disclosed. . . .The Labor Department last week sought a preliminary injunction in U.S. District Court in New York to immediately force **LTV Corp.** to make $13.2 million in contributions to the Jones & Laughlin Hourly Pension plan, one of the three underfunded pension plans sponsored by LTV. The Department also is seeking a permanent injunction to force LTV to make more than $617 million in contributions to the plans, which have $3.1 billion in unfunded liabilities. LTV, which is in Chapter 11 bankruptcy, says it cannot make the contributions without the U.S. Bankruptcy Court's permission.

Cleanup coverage

Continued from page 2

intended and expected and that the exclusion applies only to "active" polluters, or those companies "that actually release pollutants."

A U.S. District Court in August 1990 granted the insurers summary judgment, relying primarily on two previous decisions by the Superior Court of Pennsylvania. The district court held that the pollution exclusion bars coverage unless the discharge of pollutants is "both sudden, meaning abrupt and lasting only a short time, and accidental, meaning unexpected."

Aardvark appealed the ruling to the 3rd Circuit, which upheld the decision on Aug. 8.

Applying Pennsylvania law, the appellate court ruled that Aardvark failed to show that the pollution was sudden and accidental as defined in its CGL policies.

That decision differed greatly from the 3rd Circuit's April 10 decision in the Delaware case, which involved pollution at a landfill owned by the city of New Castle, Del. In that ruling, the 3rd Circuit had reversed a lower court decision and ruled: "The common, everyday meaning of the word 'damages' encompasses liabilities arising from. . .the cost of repairing the property damage caused by pollution."

The appellate court also ruled in the New Castle case that the pollution exclusion applies only when the policyholder expected the pollution. Insurers contend that the clause bars coverage for pollution that does not occur abruptly.

The 3rd Circuit remanded the New Castle case to the U.S. District Court in Delaware for a factual determination of whether the city expected or intended to discharge the pollution. If the city eventually wins the case, it will be able to tap its CGL cover to pay the estimated $8 million in cleanup costs.

In explaining why it did not follow the New Castle decision when ruling in the Aardvark case, the 3rd Circuit pointed out that it was not absolutely bound by precedent set by Pennsylvania state courts. However, "we are instructed that such decisions are 'not to be disregarded by a federal court unless it is convinced by other persuasive data that the highest court of the state would decide otherwise,' " the 3rd Circuit ruled.

The judges wrote that in the New Castle case, "without any specific guidance in Delaware case law, we predicted what the highest court of that state would do. Here, with strong guidance in decisions of the Superior Court of Pennsylvania, we feel constrained to reach a different conclusion.

"We therefore hold in accordance with the decisions of the Superior Court of Pennsylvania, that the exception for 'sudden and accidental' discharges applies only to discharges that are abrupt and last a short time. We reject Aardvark's argument that this phrase, under Pennsylvania law, includes other discharges that are unintended and unexpected."

The 3rd Circuit also rejected Aardvark's argument that the pollution exclusion clause applies only to "active" polluters and not to "passive" polluters.

A lawyer for Aardvark, Stephan G. Weil of Anderson, Kill, Olick & Oshinsky in Washington, D.C., said the two rulings are "baffling" to policyholders.

The different rulings indicate to policyholders that insurance on one side of a state line does not cover the same risks on the other side, he said.

The rulings indicate that insurance on one side of a state line does not cover the same risks on the other side, Mr. Weil says.

Mr. Weil said the CGL policies in both cases contain "absolutely the same language" and were drafted by the Insurance Services Office Inc. as standard-form policies that were approved by both states.

The decisions mean that "where the courthouse is located does not necessarily determine which way the law is applied," Mr. Weil said. "Fighting the battle of which law applies may end up determining the outcome" of such cases in the future, he said.

"We may see suits filed by insurance companies in Pennsylvania and by policyholders in Delaware courts," he observed.

Aardvark had not decided last week whether to seek review of the 3rd Circuit decision.

But a policyholder attorney in the Delaware case said that the differing decisions should not create any confusion among policyholders or lawyers because the appeals court followed the proper procedure in reaching its decisions.

William F. Greaney of Covington & Burling in Washington, D.C., pointed out that the federal court must act based on how it believes a state supreme court would rule.

And although he disagrees with decisions that served as precedents in the Pennsylvania case, Mr. Greaney said the appeals court acted properly in considering those earlier decisions.

"The significance is it tells policyholders if they want changes in Pennsylvania law, they're not going to get it from the federal court. They'll have to get it from the Pennsylvania Supreme Court."

Aardvark's appeal failed because it could not prove its argument that the pollution exclusion contained ambiguous language, said Thomas W. Brunner of Wiley, Rein & Fielding in Washington, D.C. and an attorney for Northern Insurance.

"In Pennsylvania, you can only look to the four corners of the contract to determine whether language is ambiguous," he said.

But in Delaware a court may consider "the context and circumstances surrounding the meaning of what otherwise appears to be clear and unambiguous language," the 3rd Circuit explained in its decision in the Aardvark case.

Pennsylvania's treatment of how contract language that is determined to be unambiguous must be applied is the general rule in other states, according to Mr. Brunner, "which makes New Castle a pretty isolated ruling."

However, Mr. Weil, pointing to the 3rd Circuit's ruling in the New Castle case, contends that the 3rd Circuit ignored Pennsylvania law that states that "decisions interpreting the same language in different ways is evidence in itself that the language is ambiguous."

The New Castle decision was an "aberration," according to Laura A. Foggan, counsel for the Insurance Environmental Litigation Assn. in Washington, D.C., a group of 20 insurers that presents the insurers' views on environmental liability issues. The organization filed an amicus curiae brief in the Aardvark case.

Ms. Foggan said the 3rd Circuit's decision in the Aardvark case "is particularly significant because it says that the court is not inclined to do away with the pollution exclusion clause."

The New Castle case was unique because the appellate court had no previous cases to rely on for guidance, Ms. Foggan pointed out. "There is case law in most states by now," she added, explaining that federal courts in most cases can more easily predict how state supreme courts would rule.

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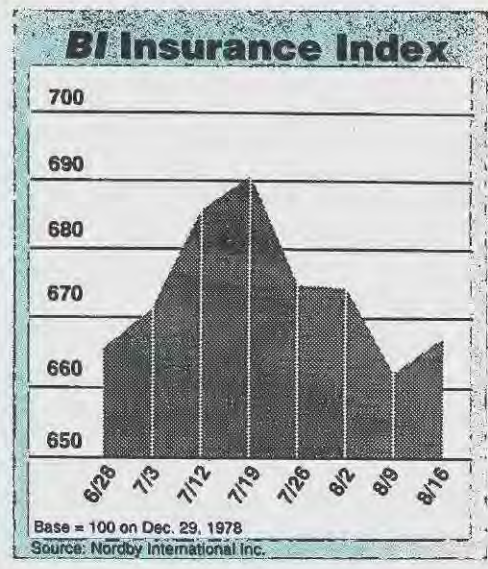
Northern Insurance Co. of New York vs. Aardvark Associates Inc. and Insurance Co. of North America; U.S. Court of Appeals for the 3rd Circuit, No. 90-3687.



Insurance industry stocks posted gains last week as the *Business Insurance* Index gained 5.2 points to 667.3 on Aug. 16, from 662.1 on Aug. 9. Advancing issues for the week were led by NWNL Cos., up 15.5%; Statesman Group Inc., up 13.5%; and Safeguard Health Enterprises, up 13.0%. Decliners followed Sierra Health Services, down 12.6%; Pacificare Health Systems, down 9.3%; and United Medical Corp., down 5.0%. The most active insurance issue for the period was Sears, Roebuck & Co. (Allstate), 4.5 million shares traded. The *BI* Index was up 0.8%; the Dow Jones 30 Industrials were down 0.9%; the Standard & Poor's 500 dropped 0.4%; and the New York Stock Exchange Composite lost 0.3%.

British Issues

August 15 Companies	Price pence	P/E	Div. pence	Yield %	1 Week High—Low pence	pence
Comml Union	528	N/M	30.7	5.8	535	528
Genl Accident	554	N/M	35.7	6.4	555	551
Gdn Royal Exch	185	N/M	15.9	8.6	185	180
Royal	419	N/M	34.7	8.3	419	405
Sun Alliance	388	N/M	18.7	4.8	389	384
Brokers						
Bradstock	160	18.2	6.0	3.8	160	150
CE Heath	469	16.3	34.5	7.3	469	455
Hogg Group	208	12.4	10.7	5.1	208	206
Lloyd Thompson	378	25.1	10.0	2.6	381	378
PWS Holdings	78	9.6	4.7	6.0	79	78
Sedgwick Grp	278	26.5	16.0	5.7	278	269
Steel Brrl Jones	307	16.2	16.3	5.3	307	307
Willis Corroon	317	16.8	17.6	5.5	320	315

Source: Philip Olsen, Insurance Industry Analyst London

BI Industry Stock Report

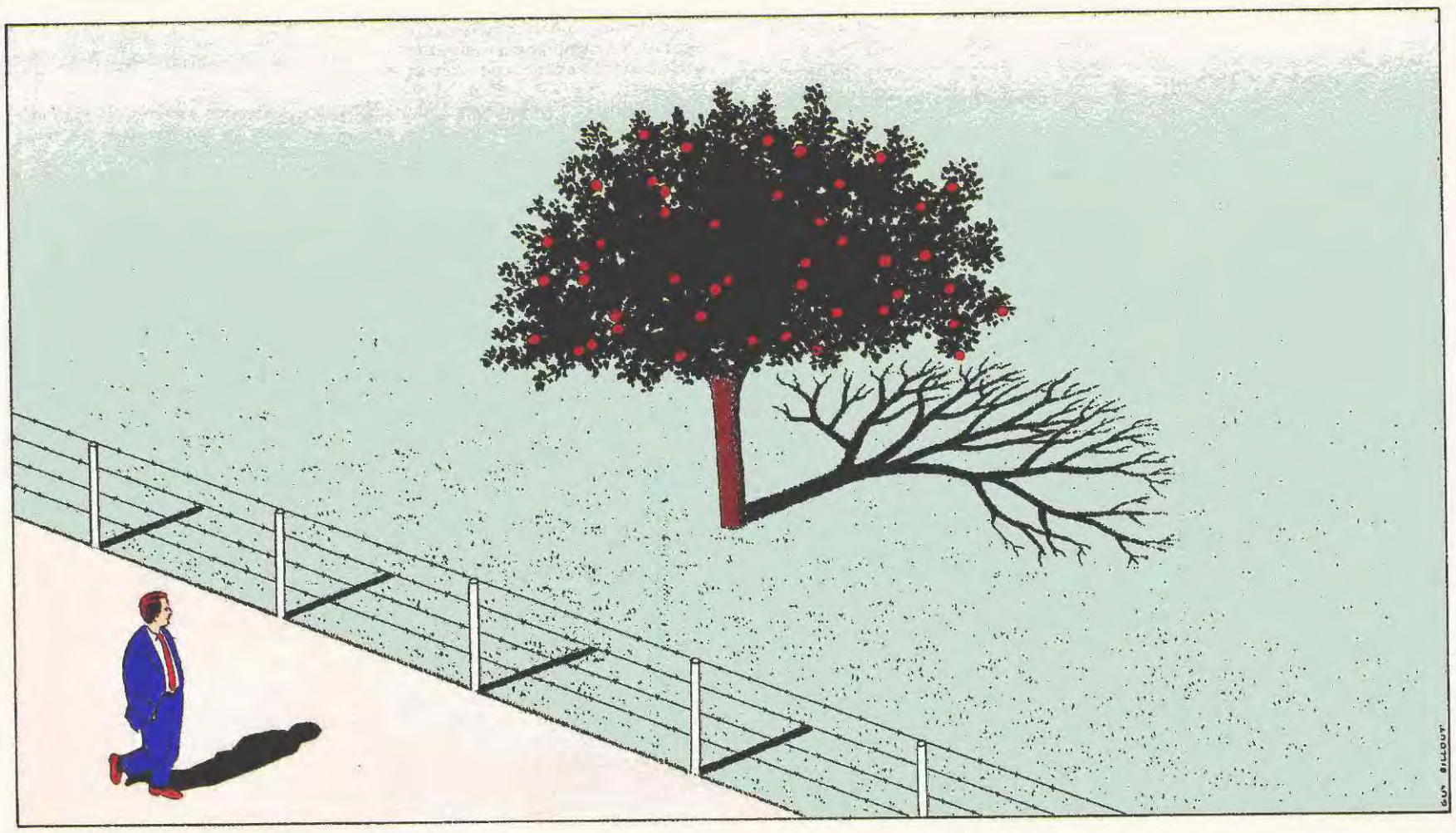
AUGUST 12, 1991 THROUGH AUGUST 16, 1991

BROKERS		Price	Weekly % change	Year to Date % change	Annual High	Annual Low	Vol.(000)	$ Div.	% Yield	P/E	Book value	Mkt/Bk. value
Alexander & Alexander	NYS	21.88	0.57	-5.41	27.63	16.13	293	1.00	4.57	18	9.77	2.24
Gallagher Arthur J. & Co.	NYS	20.50	0.00	-11.83	28.38	19.50	81	0.64	3.12	16	5.88	3.49
Frank B. Hall	NYS	3.63	0.00	0.00	4.13	2.00	105	0.00	0.00	-7	-5.24	-0.69
Hilb, Rogal & Hamilton	OTC	13.88	-0.89	-5.93	17.50	11.25	9	0.36	2.59	21	3.56	3.90
Marsh & McLennan	NYS	76.00	-0.16	-2.56	87.25	59.75	398	2.60	3.42	18	14.77	5.15
Poe & Associates	OTC	12.00	4.35	87.50	12.50	6.25	123	0.32	2.67	14	2.09	5.74
BROKERS	AVERAGE		0.6	8.8					2.3	12		
CONGLOMERATES & HOLDING COMPANIES												
Berkley W.R. Corp.	OTC	27.75	1.37	-26.00	32.25	19.00	122	0.32	1.15	16	23.89	1.16
Berkshire Hathaway Inc.	NYS	8825.00	0.17	32.21	8825.00	171.88	1	0.00	0.00	27	4612.00	1.91
ITT (Hartford Group)	NYS	58.63	-1.88	22.14	63.00	40.25	1467	1.72	2.93	9	64.01	0.92
Sears (Allstate)	NYS	41.50	-0.30	63.55	43.50	22.00	4529	2.00	4.82	14	37.38	1.11
CONGLOMERATES	AVERAGE		-0.2	23.0					2.2	16		
INSURERS/REINSURERS												
Aetna Life & Casualty	NYS	37.63	4.15	-3.53	49.13	29.00	1623	2.76	7.34	8	64.23	0.59
American General	NYS	39.63	0.96	28.86	43.13	23.50	496	2.00	5.05	9	37.14	1.07
American Heritage	NYS	28.25	1.35	34.52	32.25	19.63	2	1.08	3.82	12	19.25	1.47
American Indemnity/Fin'l	OTC	7.25	3.57	123.08	7.75	2.75	2	0.08	1.10	4	12.93	0.56
American International	NYS	84.13	2.75	9.43	102.00	57.00	1736	0.48	0.57	12	45.34	1.86
Aon Corp.	NYS	38.75	3.33	11.51	41.75	26.75	264	1.60	4.13	11	18.50	2.09
Argonaut Group	OTC	26.00	0.00	21.88	33.38	17.75	33	0.68	2.62	8	48.26	0.54
AVEMCO Corp.	NYS	21.50	-3.37	27.72	22.88	14.13	48	0.40	1.86	16	9.55	2.25
Baldwin & Lyons Inc.	OTC	23.75	1.60	26.67	25.25	17.00	1	0.28	1.18	8	24.29	0.98
Belvedere Corp.	ASE	3.38	8.00	35.00	3.63	1.75	11	0.04	1.19	23	7.65	0.44
Chandler Insurance	OTC	3.00	4.35	-56.36	7.25	2.75	76	0.00	0.00	-2	5.95	0.50
Chubb Corp.	NYS	66.88	-3.60	23.27	75.25	34.63	1580	1.48	2.21	10	35.19	1.90
CIGNA Corp.	NYS	43.00	-2.82	5.20	56.75	33.25	1048	3.04	7.07	11	73.15	0.59
CNA Financial Corp.	NYS	78.50	0.96	14.39	92.50	49.50	129	0.00	0.00	11	70.23	1.12
Continental Corp.	NYS	27.63	-0.90	11.06	30.63	15.75	754	2.60	9.41	10	37.83	0.73
Durham Corp.	OTC	32.00	4.92	14.29	34.13	23.00	54	1.00	3.13	18	28.04	1.14
Fund American Corp.	NYS	64.00	-0.19	23.37	65.25	41.63	43	0.68	1.06	19	36.11	1.77
Fremont General Corp.	OTC	23.75	3.26	63.79	25.25	10.13	234	0.88	3.71	7	19.13	1.24
Frontier Insurance Group	NYS	24.00	-1.54	26.32	26.38	15.38	55	0.00	0.00	9	11.20	2.14
General RE Corp.	NYS	88.00	2.03	-5.38	102.50	69.00	1186	1.68	1.91	13	37.50	2.35
Hanover Insurance Co.	OTC	29.25	1.74	10.38	30.75	21.00	50	0.44	1.50	10	37.44	0.78
Harleysville Group	OTC	28.50	-1.72	24.59	32.00	13.50	8	0.64	2.25	9	22.99	1.24
Hartford Steam Boiler	NYS	56.13	1.58	15.13	63.75	43.50	64	1.80	3.21	15	17.05	3.29
Kansas City Life Ins.	OTC	35.25	0.00	14.17	36.50	30.00	1	1.20	3.40	9	39.22	0.90
Kemper Corp.	NYS	34.00	6.25	43.16	39.25	17.13	460	0.92	2.71	9	34.20	0.99
Lawrence Insurance Group	ASE	9.00	0.00	28.57	9.50	6.38	1	0.48	5.33	14	4.71	1.91
Liberty Corp.	NYS	40.50	1.57	-1.52	48.50	39.00	26	0.92	2.27	13	23.86	1.70
Lincoln National	NYS	47.38	4.12	10.17	55.25	30.75	453	2.72	5.74	10	45.16	1.05
Markel Corp.	OTC	18.75	1.35	59.57	19.25	10.25	34	0.00	0.00	9	3.56	5.27
NAC Re Corp.	OTC	38.00	-4.70	15.15	42.50	25.50	91	0.20	0.53	14	18.90	2.01
Navigators Group	OTC	30.75	1.65	40.84	34.50	16.50	4	0.00	0.00	17	13.52	2.27
Nobel Insurance LTD.	OTC	3.75	0.00	25.00	4.38	2.50	50	0.00	0.00	5	7.76	0.48
NWNL Companies	NYS	23.25	15.53	37.78	32.88	11.75	688	1.40	6.02	6	42.73	0.54
Ohio Casualty Corp.	OTC	45.25	-0.55	10.37	50.25	26.75	179	2.48	5.48	9	36.38	1.24
Old Republic Int'l	NYS	31.50	2.44	37.70	31.88	17.38	104	0.72	2.29	7	33.09	0.95
Orion Capital Corp.	NYS	28.25	-1.74	61.43	29.75	13.00	45	0.92	3.26	9	20.42	1.38
Phoenix RE Corp.	OTC	10.00	6.67	29.03	10.25	5.00	63	0.20	2.00	12	13.30	0.75
Protective Life Corp.	OTC	21.25	2.41	42.86	22.50	10.25	74	0.84	3.95	9	16.29	1.30
Provident Life	OTC	20.00	5.26	14.29	24.50	12.00	79	1.00	5.00	5	25.88	0.77
Re Capital Corp.	ASE	17.38	2.21	34.95	18.63	11.75	31	0.20	1.15	12	15.05	1.15
RLI Insurance Corp.	NYS	14.25	4.59	-1.72	16.38	9.63	39	0.48	3.37	7	14.41	0.99
St. Paul Companies	OTC	65.25	-1.95	3.98	74.25	47.00	690	2.60	3.98	7	52.00	1.25
SAFECO Corp.	OTC	37.13	-3.57	12.93	44.75	25.13	1225	1.48	3.99	9	31.50	1.18
SCOR U.S. Corp.	NYS	13.88	4.72	12.12	15.25	8.38	71	0.24	1.73	8	11.19	1.24
Seibels Bruce Group	OTC	7.25	0.00	70.59	8.88	4.25	52	0.36	4.97	145	7.35	0.99
Selective Ins. Group	OTC	15.75	3.28	18.87	18.00	12.50	73	1.04	6.60	9	18.91	0.83
Statesman Group Inc.	OTC	5.25	13.51	235.89	5.25	1.25	1255	0.00	0.00	-263	2.48	2.12
Tokio Marine & Fire	OTC	46.50	-1.06	-1.59	56.50	34.50	1	0.00	0.00	-	70.93	0.66
Torchmark Corp.	NYS	48.75	-2.50	-0.26	58.50	38.00	279	1.60	3.28	11	16.70	2.92
Transamerica	NYS	33.88	3.04	3.83	38.38	23.25	585	1.96	5.79	12	36.56	0.93
Transatlantic Holdings	NYS	34.63	0.00	26.48	39.38	18.88	26	0.20	0.58	12	36.56	0.95
Travelers Corp.	NYS	20.38	2.52	22.56	26.38	11.50	616	1.60	7.85	-10	41.44	0.49
Trenwick Group Inc.	OTC	27.00	0.00	16.76	30.00	16.25	23	0.60	2.22	10	21.71	1.24
United Fire & Casualty	OTC	45.50	0.00	29.54	58.00	28.75	0	1.32	2.90	11	35.39	1.29
USF&G Corp.	NYS	6.75	-1.82	-10.00	23.50	6.13	4158	0.20	2.96	-1	11.96	0.56
UNUM Corp.	NYS	64.25	0.78	37.80	70.25	32.13	203	1.04	1.62	11	37.25	1.72
USLIFE Corp.	NYS	40.63	-0.91	45.09	42.75	23.25	56	1.64	4.04	9	60.34	0.67
Unitrin	OTC	38.00	0.33	23.58	41.50	24.50	380	1.00	2.63	14	30.70	1.24
Washington National	NYS	14.00	2.75	28.74	18.75	9.38	79	1.08	7.71	-5	26.86	0.52
USLICO Corp.	NYS	20.38	-0.61	28.35	21.75	14.75	33	1.00	4.91	11	29.44	0.69
Zenith National Ins.	NYS	17.00	-1.45	24.77	18.50	9.88	19	1.00	5.88	-89	13.14	1.29
INSURERS/REINSURERS	AVERAGE		1.7	28.4					3.3	5.9		
HEALTH MAINTENANCE ORGANIZATIONS												
FHP International	OTC	20.25	-1.22	32.79	29.75	8.88	3316	0.00	0.00	17	5.44	3.72
HMO America Inc.	OTC	13.50	5.88	107.69	17.13	4.25	1066	0.00	0.00	15	0.61	22.13
Pacificare Health Sys.	OTC	29.25	-9.30	80.00	42.50	12.00	919	0.00	0.00	15	6.55	4.47
Safeguard Health Enter.	OTC	6.50	13.04	36.84	7.25	4.00	165	0.00	0.00	22	3.53	1.84
Sierra Health Services	ASE	16.50	-12.58	20.00	29.50	5.50	508	0.00	0.00	7	1.78	9.27
United Healthcare Corp.	OTC	50.00	3.09	115.05	54.63	13.13	2691	0.06	0.12	28	3.76	13.30
United Medical Corp.	ASE	7.13	-5.00	-10.94	10.88	6.63	17	0.00	0.00	10	8.79	0.81
U.S. Healthcare	OTC	31.25	6.84	6.38	38.00	10.00	3832	0.32	1.02	19	3.38	9.25
HMOs	AVERAGE		0.1	48.5					0.1	17		
ALL COMPANIES	AVERAGE		1.3	27.7					2.8	8		

System design: Nordby International Inc.

Knowledge Without Action Is Wasted.

Every group insurance company promises the fruits of its knowledge and resources. But we put our knowledge and resources to work on practical ideas for employers and employees. ◆ For example, we identified early one of the great



emerging issues in employee benefits -- the provision of practical, economical group long-term care coverage -- and moved to implement it. Today, those we serve have this coverage available to them -- because our experience and the resources we command made it possible early. ◆ Clients who depend on your advice want to know how well group insurance companies know the industry. Now you can tell them how we make our experience and expertise work for them. For more information, call Tom McKellar, Director of National Accounts, at 1-800-877-1052.

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