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Update

Sen. Metzenbaum introduces federal solvency legislation

WASHINGTON—State insurance departments would have to meet minimum federal solvency regulation standards and gain federal accreditation under a bill introduced in the Senate last week.

The bill also would create a National Insurance Guaranty Corp., a federal guaranty fund system for both property/casualty and life/health insurers that would supersede current state guaranty funds. The federal guaranty fund would be prefunded by insurer assessments.

Continued on next page

Court reinstates bad-faith action against insurer

By JOANNE WOJCIK

SAN DIEGO—A California appeals court ruling that insurers may be liable for damages to third-party claimants if they delay payment of valid claims does not threaten the so-called Moradi rule that bans most third-party bad-faith actions in the state, many attorneys say.

At least one attorney predicts that the ruling will be decertified by the California Supreme Court, as have two earlier appellate court rulings that would have essentially reinstated the California Supreme Court's *Royal Globe Insurance Co. vs. Superior Court* decision.

The 1979 Royal Globe decision had created a statutory right for plaintiffs to sue a defendant's insurer for violations of Section 790.03 of the California Insurance Code, which deals with unfair claims handling practices.

However, some legal experts believe the recent appellate court ruling will make it easier for third parties to sue insurers under tort law for damages suffered from an insurer's claims handling.

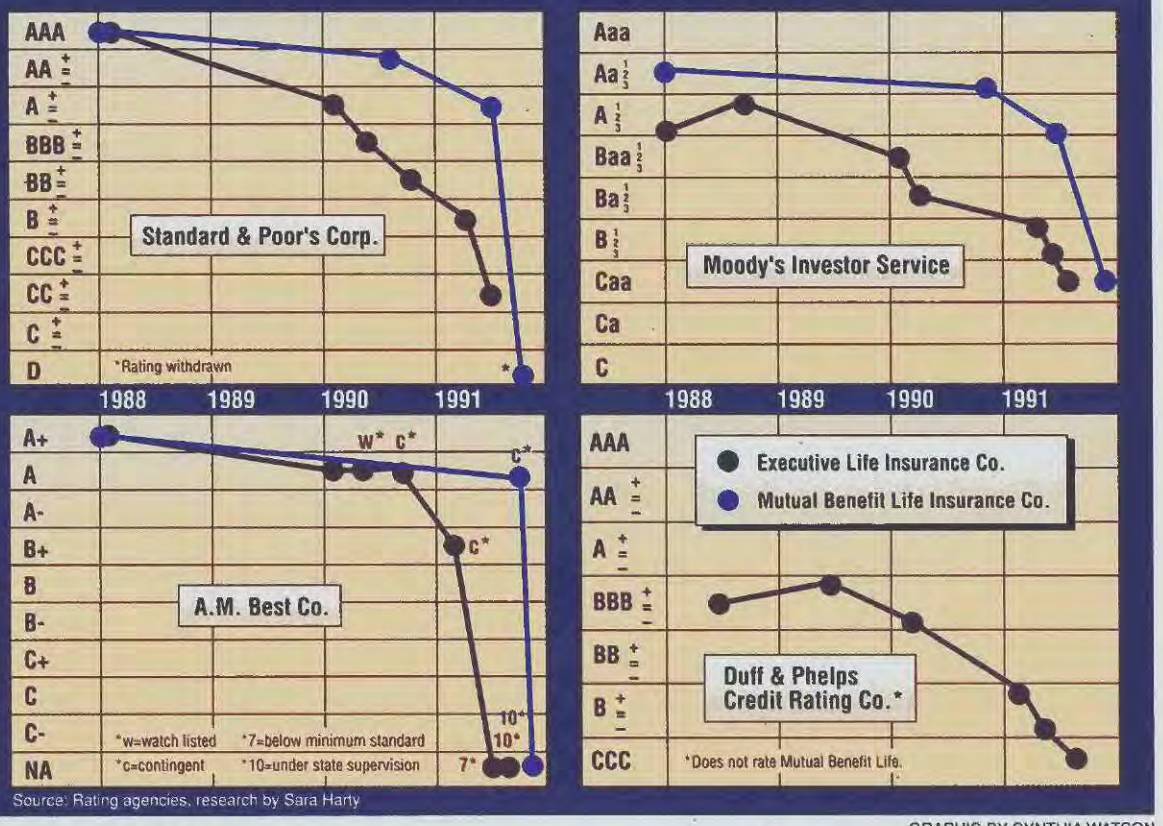
At the very least, the fact that California courts are tackling such legal questions at all should be a signal to insurers to improve their claims-handling practices, some attorneys say.

The 4th District Court of Appeal

Continued on page 24

Comparing the ratings

The four major insurer rating agencies acted at different times and to different degrees in assessing Executive Life and Mututal Benefit Life.



Source: Rating agencies, research by Sara Harty

GRAPHIC BY CYNTHIA WATSON

California law curtails 'ghostwriting' fraud

Workers comp abuse targeted

By LOUISE KERTESZ

SACRAMENTO, Calif.—California employers are hoping that a tough new workers compensation fraud prevention law will curb abuses by some doctors that employers and insurers say are driving up workers comp insurance costs.

Employers and insurers contend that some doctors are placing advertisements seeking workers comp claimants that mislead readers about the cost of care and the workers comp benefits injured employees can expect to receive.

The ads and other solicitations by doctors produce such a great volume of business for the physicians that they hire "ghostwriters"—many of whom have no medical training—to produce medical histories on claimants. The writers use computer software designed to generate medical reports to convince workers comp insurers or self-funded employers to pay the claims, regardless of whether the claims are legitimate.

"I see this as a major problem, which is diverting funds from the needy to the greedy," said Joseph Markey, president of the California Self Insurers Assn., which represents 300 California employers.

"When I look at a forensic medical bill that for an orthopedist is over $800 and for a psychiatrist is over $1,200 for an examination by a professional, and I learn (that the medical report) was written by a screenwriter, then I say there's something wrong," he said.

"I say it's not a medical report if it's not written by a physician," Mr. Markey asserted. "Workers compensation costs in California are two to three times greater than in states where doctors are writing reports," he added.

The ghostwriting of medical reports is "one of the biggest scams in California business today," asserts Gregory Johnson, a principal with consultant William M. Mercer Cos. Inc. in San Francisco.

However, S.B. 1218, the anti-fraud bill signed July 16 by Gov. Pete Wilson, is designed to deter fraudulent activity by workers comp attorneys and physicians, including the use of ghostwriters to mass-produce fraudulent claims.

S.B. 1218—a combination of bills sponsored by Sen. Robert Presley, D-Riverside County, and Assemblyman Burt Margolin, D-Los Angeles—makes it a felony punishable by up to

Continued on page 10

Rating agencies: Do they do the job?

Burned policyholders sue following failures

By MICHAEL SCHACHNER and DOUGLAS McLEOD

NEW YORK—This year's string of spectacular life insurer failures has pushed insurance rating agencies uncomfortably into the public spotlight, facing new questions about their ability to predict insurer financial problems.

A.M. Best Co., Standard & Poor's Corp. and Moody's Investor Service Inc. have been named in more than 20 lawsuits filed by angry policyholders of the failed Executive Life Insurance Co. and the troubled Mutual Benefit Life Insurance Co., both of which carried relatively high ratings until shortly before they were taken over by regulators.

The lawsuits—many of which seek class-action status—charge the rating agencies with negligent failure to warn insurance buyers of the companies' shaky financial condition.

The suits seek to hold the rating agencies and other defendants liable for policyholder losses, and at least one complaint seeks treble damages under the federal Racketeer Influenced & Corrupt Organizations law.

But, rating agency officials deny the allegations and defend their performance, arguing that their ratings in any case are only opinions—not guarantees—of insurers' stability.

Nevertheless, the heat generated by the recent failures is already prompting changes in the way at least one rating agency is going about its work: Best last week announced it will add a "policyholder confidence factor" to its rating analysis, attempting to gauge an insurer's ability to withstand a "run on the bank" by worried policyholders and annuity holders seeking to cash in contracts.

And, though many insurers acknowledge that the agencies have stumbled in some cases, company officials praise the agencies' work as generally thorough and timely.

The agencies are acknowledged to be between a rock and a hard place in evaluating an insurer with problems: A precipitous downgrade could exacerbate problems that otherwise would not be fatal, but postponing the downgrade leaves the agencies open to criticism—and lawsuits—if the insurer fails anyway.

"They're damned if they do and damned if they don't," observed Howard Weizmann, executive director of the Assn. of Private Pension & Welfare Plans in Washington, D.C.

Even some critics question the wisdom of holding rating agencies liable for ratings that turn out to be wrong.

"If rating agencies are forced to

Continued on page 31

State legislators, regulators both seek solvency reforms
Page 3

Health care cost shifting to employees is increasing
Page 3

Walbrook wants to commute policies to remain solvent
Page 2

NEWSPAPER

Update

Federal regulation proposed

Continued from previous page

In addition, the NIGC would serve as the liquidator of all insurers operating in more than one state.

Under the legislation, sponsored by Sen. Howard M. Metzenbaum, D-Ohio, federal regulatory standards would be drafted by a five-member Insurance Regulatory Commission appointed by the president, similar to the Securities and Exchange Commission. Among the areas to be covered by the standards are capital and surplus, consumer disclosure and insurance department "resources."

Insurers domiciled in states that fail to gain federal accreditation would not be able to operate outside that state.

The bill also calls for the establishment of a federal reinsurance regulatory office to regulate both domestic and offshore reinsurers.

Paul Brown, director of governmental affairs at the Risk & Insurance Management Society Inc., called some of the provisions "disturbing." For example, the bill would create dual regulation of insurers as the federal government would take over some regulatory responsibilities while the states would retain others, he said. He said it also would unfairly prohibit insurers from doing business in other states if their domiciliary state does not gain federal accreditation.

"RIMS has not ruled out federal regulation, but there has got to be a more effective way to do it. I don't think that (Sen. Metzenbaum) has it in this bill," Mr. Brown said.

Meanwhile, the House Oversight and Investigations Subcommittee, chaired by Rep. John D. Dingell, D-Mich, released on Friday an outline of legislation that is similar in many respects to the Metzenbaum bill.

The Dingell outline would create a Federal Insurance Solvency Corp. to develop and enforce insurer solvency standards and accredit state insurance departments based on those standards. Insurers operating interstate would have to be licensed by an accredited regulator and obtain a certificate of approval from the FISC.

The FISC would directly regulate professional reinsurers. It also would have the power to suspend or revoke the certificate of financially troubled insurers and would be charged with developing national liquidation procedures for insolvent companies. However, the outline stops short of proposing a federal guaranty fund system.

RIMS backs McCarran reform

NEW YORK—The Risk & Insurance Management Society Inc. last week announced that it supports the concept of modifying the federal McCarran-Ferguson Act, which provides limited antitrust immunity for some insurer activities.

But, a RIMS committee will evaluate how it should be modified.

RIMS has concluded it is "inevitable" Congress will amend the law, said Lucille Gallagher, vp of governmental affairs for RIMS and vp-risk management at Monfort Inc. in Greeley, Colo.

RIMS historically has supported the law, although it recently expressed a willingness to consider new ideas and alternatives.

In a statement, RIMS said it agrees with the National Assn. of Insurance Brokers and the American Insurance Assn. that the "perennial and unproductive" debate over the McCarran-Ferguson Act needs to end so that efforts can be focused on other "critical" public policy issues, like insurer solvency (*BI*, July 29; March 11).

"We need to spend our energies working together to come up with constructive changes or alternatives to McCarran-Ferguson that will benefit insurance consumers while being something that the insurance industry can live with," Ms. Gallagher said.

But, RIMS—like the NAIB and AIA—said it "vehemently" opposes pending federal bills, H.R. 9 and S. 430, to amend the act because they contain "inappropriate and unproductive" reforms.

Asbestos cases consolidated

PHILADELPHIA—Approximately 26,000 asbestos bodily injury lawsuits pending in federal courts nationwide will be transferred to a single court, a panel of federal judges ruled last week.

While the ruling appears to be a bold step toward resolving the overwhelming number of asbestos bodily injury lawsuits clogging the federal courts, it is limited in several respects. The ruling:

- Consolidates the asbestos cases only for pre-trial purposes, like discovery of evidence.
- Does not include asbestos claims against bankrupt asbestos producers, including Manville Corp.
- Does not involve asbestos lawsuits pending in state courts nationwide, estimated at twice the number of federal suits.

"We are persuaded that this litigation has reached a magnitude. . .that threatens the administration of justice and that requires a new, streamlined approach," said the Judicial Panel on Multidistrict Litigation in its July 29 order.

The panel transferred more than 26,000 asbestos bodily injury lawsuits to U.S. District Judge Charles R. Weiner in Philadelphia. Judge Weiner has a reputation among both plaintiffs' and defendants' attorneys for being able to speed complex cases. Among the most significant decisions he will make include appointing lead counsel and deciding how to encourage settlements among the parties.

MONY calls articles misleading

NEW YORK—Mutual Life Insurance Co. of New York is denying press reports that it is in questionable financial health and that a "run on the bank" by policy and annuity holders could break it.

Articles last week suggesting MONY is seeking investment capital to shore up troubled real estate investments are "exaggerated and downright misleading," asserted a spokesman for MONY, the 13th-largest U.S. life insurer with $14 billion in assets.

The spokesman admitted MONY has spoken with American International Group Inc. about a joint venture, as it has with a "number of companies about a wide range of issues. There is nothing to substantiate that something is imminent with AIG." AIG refused to comment.

Last month, Moody's Investors Service Inc. downgraded MONY's financial strength rating to Baa1, or "adequate" from A2 (*BI*, July 29), citing "significant exposure to commercial real estate."

Continued on page 32

Walbrook uncertainty

Commutations needed to maintain solvency

By STACY SHAPIRO

LONDON—The directors of Walbrook Insurance Co. Ltd., which stopped writing business last year, are betting the company's solvency on favorable commutations with the insurer's policyholders.

With favorable commutations, Walbrook would remain solvent by 8.2 million pounds ($15.8 million at appropriate exchange rates), according to its 1990 annual results filed last week with the Department of Trade and Industry.

However, citing uncertainty in the outcome of commutations and other factors in determining provisions for losses, Walbrook auditors KPMG Peat Marwick McLintock qualified the insurer's 1990 financial statement.

Under a commutation, a policyholder and insurer agree to a lump sum payment to settle all pending and future obligations of the insurer under the policy. Policyholders concerned about the future solvency of an insurer may accept less than projected claim costs in return for a certain immediate payment.

If policyholders commute their contracts as expected by the directors, Walbrook needs nearly 345 million pounds ($665.9 million at year-end 1990 exchange rates) in loss reserves, leaving the company solvent by 8.2 million pounds ($15.8 million), according to Walbrook's 1990 returns.

However, if enough policyholders do not agree to commutations at the expected amounts, Walbrook could need as much as 444 million pounds ($856.9 million) in reserves to pay claims, according to a report by Tillinghast, a unit of Towers, Perrin, Forster & Crosby Inc.

The Tillinghast worst-case scenario is 29% more than the Walbrook best-case scenario, the difference between the two being 99 million pounds ($191 million), far in excess of Walbrook's year-end

Continued on page 32

Proposed OSHA reforms not feasible: Employers

By ADRIENNE C. LOCKE

WASHINGTON—Major changes to the federal workplace safety law introduced in Congress last week would boost costs and create unreasonable hardships for employers, business representatives say.

The legislation, for example, would require all employers to establish and maintain a written occupational safety and health program to reduce or eliminate hazards.

These programs would have to include provisions dealing with identification and elimination of hazards, employee training and education. Any employee participation in the program would be considered hours worked.

In addition, employers with more than 10 workers would be required to establish joint safety and health committees, composed of equal numbers of employer and employee representatives, to review the safety and health programs.

Sens. Edward M. Kennedy, D-Mass., and Howard M. Metzenbaum, D-Ohio, as well as Rep. William D. Ford, D-Mich., are sponsoring the legislation to amend the 20-year-old Occupational Safety and Health Act.

Their proposal would place unreasonable burdens on employers, said Peter Eide, manager of labor law at the U.S. Chamber of Commerce in Washington, D.C.

"It's not practical, feasible or logical," he said.

An OSHA official would not comment on the legislation.

Under the legislation, S. 1622 and H.R. 3610, individual employees would be allowed to petition the Occupational Safety and Health Review Commission, an independent government agency that reviews contested fines proposed by the Occupational Safety and Health Administration, to review the settlement agreements between their employers and OSHA.

Employees also would be protected from employer penalties if they refuse to perform work that would require them to be exposed to a hazard that has been cited by OSHA as posing an "imminent danger."

And, criminal penalties would be increased under the reform proposal. For example, the maximum imprisonment for an employer's willful violation that causes death would increase to 10 years from six months for the first conviction and to 20 years from one year for each additional conviction.

Continued on page 31

Mutual Benefit to sell unit

AMEV Holdings plans to purchase group business

By JUDY GREENWALD

NEWARK, N.J.—Mutual Benefit Life Insurance Co. plans to sell its group health, accident and life business to a New York-based company owned by Dutch and Belgian insurers, though the final purchase price will be contingent on how well the business performs.

Mutual Benefit Life was placed into rehabilitation by a New Jersey court last month after thousands of panicky individual annuity policyholders demanded to cash in their policies or transfer funds (*BI*, July 22). The insurer's problems have been blamed largely on poorly performing real estate investments.

New York-based AMEV Holdings Inc., which is acquiring Mutual Benefit Life's group business pending regulatory and judicial approval, is owned by N.V. AMEV, the Netherland's third-largest insurer, and Groupe AG, Belgium's largest insurer.

AMEV and Groupe AG combined their worldwide operations in December, though the companies still are traded separately on their respective countries' stock exchanges. Together, they have $40 billion in assets.

Under the agreement, Mutual Benefit Life is guaranteed $300 million in cash, said a Mutual Benefit Life spokeswoman. Up to another $200 million in notes, however, is contingent on how closely the group business meets the business plan developed before Mutual Benefit Life was placed in rehabilitation, said the spokeswoman.

The deal, which took about three weeks to negotiate and is expected to be completed in about four months, could contribute $175 million to $375 million to Mutual Ben-

Continued on page 32

Inside

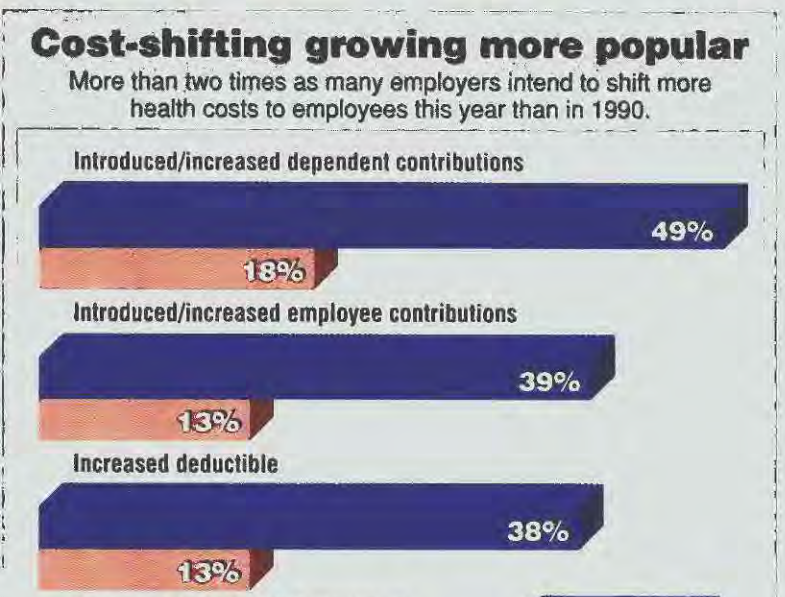
- This week's editorial says employers and workers compensation insurers must vigorously fight the latest abuse by doctors of the workers comp system: ghostwriting. **PAGE 8**
- Two attorneys at the recent Assn. of Trial Lawyers of America convention discuss how they were able to negotiate a multimillion-dollar settlement with Johnson & Johnson for the families of seven people killed in the 1982 Chicago-area Tylenol poisonings. **PAGE 15**
- The Bush administration will support pension simplification legislation introduced by Rep. Daniel Rostenkowski. **PAGE 33**

Departments

Advertiser index 26
Ask a benefit actuary 22
At issue 7
Benefit beat 6
Bermuda 25
Classifieds 28
Comings & goings: buyers 30
Insurance services guide 31
International 25
International issues 21
Legal briefs 22
Letters 8
London 29
Opinions 8
Perspectives 21

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GRAPHIC BY JOHN HALL

More employers shifting health care costs: Study

By CHRISTINE WOOLSEY

More and more employers are shifting health care costs to their workers, a new survey reports.

Employers this year are more likely than in 1990 to introduce or increase employee contributions toward employee and dependent health insurance, according to the survey by Alexander Consulting Group Inc.

And, while employers express confidence in some types of cost control strategies—like utilization review, preferred provider organizations and flexible benefits—the survey found that they are dubious about others, particularly health maintenance organizations.

"We continue to be in search of 'the formula' or 'the solution' and of course it's not that simple," said Richard J. Anthony, managing director of national consulting practices for Alexander Consulting Group, an Alexander & Alexander Services Inc. unit.

"Costs continue to go up and it's perplexing," particularly given the wide array of cost controls employers have implemented, he said.

Total employer costs for benefits last year—including health and welfare, retirement and Social Security, vacation, workers compensation, unemployment and other benefits—averaged $11,059 per employee, according to the survey. Employees contributed an average of $3,002 toward total benefit costs.

Total benefit costs, according to the survey, now represent about 40% of payroll.

Government-mandated benefits and other health and welfare benefits each accounted for 27% of total company benefit costs, and retirement benefits accounted for another 16%, the survey reported. Paid time off accounted for 27% of total benefit costs, while other benefits accounted for 3% of the costs.

Employers are using a variety of strategies to keep health care benefits competitive and affordable, including increased cost-shifting and managed care, the survey found.

Thirty-eight percent of responding employers expect to increase or introduce health plan deductibles this year, the survey found. Only

Continued on page 23

New argument fails

Court rules against cover for cleanup

By STACY ADLER

BOSTON—The first federal appellate ruling addressing what attorneys are calling the "second wave" of pollution coverage litigation deals a devastating blow to policyholders.

A 3-0 ruling last month by the 1st U.S. Circuit Court of Appeals held that a policyholder that discharges pollutants as a regular part of its business practices cannot attempt to prove that there were discrete instances in which pollution occurred "suddenly or accidentally" (*BI*, July 22).

Courts nationwide currently are being asked to interpret the pollution exclusion in comprehensive general liability policies, which bars coverage for pollution that is not "sudden and accidental."

Insurers rigorously argue that the term "sudden and accidental" should be given a temporal definition to bar coverage for all pollution that does not occur abruptly.

Policyholders, meanwhile, argue that the exclusion should be interpreted to bar coverage only for pollution expected or intended by the policyholders.

The battle over how this policy language should be interpreted is considered the "first wave" of pollution coverage litigation.

In the "second wave" of the litigation, policyholders are attempting to prove that an event that can be considered "sudden and accidental"—according to how their own state supreme courts have defined the term—caused the pollution, thus entitling them to insurance coverage.

But in a ruling that is a major defeat for policyholders arguing such cases, the 1st Circuit held that a policyholder that regularly emits pollutants is barred from attempting to show that a "sudden and accidental event" caused the spread of pollutants.

"In the 'ordinary' case, e.g. a case involving a 'clean' operation such as an office building housing company headquarters, insurers were willing to commit to coverage for a possible but unlikely event resulting in the release of pollutants," said the 1st Circuit in its July 16 ruling.

"But in a case of a pollution-prone operations, where the emission of pollutants is part and parcel of the daily conduct of business, there is the possibility of infinite variations on the usual theme, i.e. polluting incidents are likely to occur that are on the

Continued on page 12

State regulators find ally in bid to improve oversight

By MEG FLETCHER

State legislators and insurance commissioners increasingly are working side by side to improve insurer solvency regulation.

Legislators and regulators agree they have common concerns about keeping insurers solvent and avoiding federal intervention in the insurance regulatory system.

The spirit of cooperation, though, is not unanimous. For example, some state legislators resent being told by regulators what laws and rules states need to adopt to meet solvency regulation guidelines set by the National Assn. of Insurance Commissioners.

Nevertheless, those guidelines—which are part of an accreditation program designed to improve state regulation of insurer solvency—generally are being well received.

"Legislative enactment of new solvency regulations is clearly at a historic level," said North Dakota Insurance Commissioner Earl Pomeroy, a former NAIC president who now chairs the group's Committee on Financial Regulation and Accreditation.

In the past year, 36 states have enacted bills or amendments to implement one or more of 16 NAIC model laws or regulations required for accreditation, said Carolyn Johnson, NAIC model laws coordinator.

Minnesota led the pack in adopting 12, she found.

Minnesota legislators were "very supportive" in approving the measures, said Minnesota Commissioner of Commerce Bert J. McKasy, who oversees insurance regulation.

'Legislative enactment of new solvency regulations is clearly at a historic level,' says Mr. Pomeroy.

Ohio legislators had "a very positive" reaction when the NAIC-specified measures were introduced for passage, said Ohio Sen. Dick Finan, R-Cincinnati. Sen. Finan, who is president pro tem of the Ohio Senate, is co-chairman of the National Conference of State Legislatures' Insolvency Task Force.

In addition, insurance departments in several states were able to adopt the NAIC measures without legislative action or already had similar regulations in place.

The Florida, New York, Illinois and South Carolina insurance departments so far are the only ones that formally hold accreditation certificates from the NAIC.

However, individual states are not the only supporters of the NAIC's drive to improve regulation of insurer solvency.

Leaders of the Denver-based NCSL last year urged members to adopt the lengthy list of NAIC model laws, regulations and organizational practices needed for accreditation, said Bill Waren, the NCSL's senior committee director and counsel.

"The safety and soundness of insurance companies operating in the United States is a prime objective of state insurance regulation. To ensure that this objective is met, an effective financial surveillance and regulation system is needed," an NCSL resolution stated. "This will require immediate state action to strengthen state insurance departments and to create standards for financial regulation that will strengthen the safety and soundness of insurance companies."

In addition, the National Conference of Insurance Legislators, a

Continued on next page



Photo courtesy of the HMS Rose Foundation

The H.M.S. Rose is touring the East Coast with its special cargo.

Seagoing show of history sails with insurance

By AMY KATZ

NEW YORK—Rhode Island's original copy of the Bill of Rights is insured for $1 million while displayed aboard a replica of an 18th century ship that is sailing into ports on the Eastern seaboard.

It is the most valuable of the historical items on board the ship, which are insured for a total of $1.4 million under an inland marine insurance policy underwritten by Royal Insurance Co. of Charlotte, N.C.

The ship, a replica of England's H.M.S. Rose, is insured for more than $1 million under a separate policy written for its owner by Cincinnati-based Great American Insurance Co., a unit of American Financial Corp.

The Rose tour with its precious cargo is a celebration of the 200th anniversary of the signing of the Bill of Rights. The tour, which started April 12 in Bridgeport, Conn., will take the Rose to ports in New York state through Aug. 27 and then to cities along the East Coast from Portland, Maine, to Jacksonville, Fla., before concluding in Bridgeport Dec. 20.

Along with the original copy of the Bill of Rights, also on display are a cannon made at Paul Revere's Boston foundry in 1797; an original copy of "The Bloody Tenent of Persecution," a book by Roger Williams published in 1644 that advocates the separation of church and state; and a conceptual painting of the original Rose and its replica painted this year by maritime artist Richard Loud.

Royal underwrote the inland marine policy for the H.M.S. Rose Foundation Inc. of Bridgeport, Conn., winning the bid for the business.

The foundation was set up by H.M.S. Rose owner Kaye Williams to oversee work on the boat and its upkeep.

Rhode Island's copy of the Bill of Rights, which is covered under a valuable papers provision of the inland marine policy, is insured for $1 million based on the selling price of similar documents sold at recent auctions, a Royal spokesman explained.

For example, an original copy of the Declaration of Independence was recently auctioned for $1.2 million, he said.

"The only way you can determine the worth on something like

Continued on page 7

State regulation

Continued from previous page

Brookfield, Wis.-based group of legislators who are concerned with insurance issues, also has been "very supportive" of the NAIC's accreditation program, said New Hampshire Rep. Harold Burns, R-Whitefield. Rep. Burns, who is speaker of the New Hampshire House, is president of NCOIL and also participates on NAIC/NCOIL liaison committees.

NCOIL so far has endorsed 12 of the 16 model laws and regulations needed for state accreditation and its Task Force on Insurer Solvency expects to resolve questions about the four remaining measures this fall, said New Hampshire Sen. Leo Fraser, R-Pittsfield, who chairs the task force.

Those four measures deal with producer-controlled insurers, reinsurance intermediaries, managing general agents and insurance holding companies, he said.

The cooperative attitude between most state legislators and state insurance regulators stems in part from their mutual commitment to preserve state regulation in the face of the threat of federal intervention (*BI*, May 27).

That commitment is the "mortar" that keeps state legislators and insurance commissioners willing to work together to improve communication, said New York Sen. Donald M. Halperin, D-Brooklyn, who chairs NCOIL's State-Federal Relations Committee.

"If we don't work together, the federal government will step in," said New Hampshire's Rep. Burns.

Sen. Finan of Ohio agreed, noting that the Ohio Legislature enacted NAIC-specified measures "as a defensive measure trying to head the federals off at the pass."

In addition, many state legislators welcome measures to enhance insurer solvency because insurance has become a "critical" issue in recent years, said Brenda Trolin, NCSL program principal for labor and insurance issues.

Legislators and regulators hope to maintain their spirit of cooperation by meeting regularly to share ideas and critique proposals that are in the drafting stage. "What we really need to do is get legislators involved earlier," so they can comment on proposed model laws and regulations while they are still being drafted, said Wisconsin Insurance Commissioner Robert Haase, who chairs an NAIC/NCOIL liaison committee.

In addition, the NAIC expects to consider at its fall meeting procedures to ensure there is adequate opportunity for comment from legislators and the public whenever changes are made in the accreditation standards, Mr. Pomeroy said.

The measures that must be adopted to be accredited by the NAIC include model laws and rules affecting regulation of insurance holding companies, managing general agents, reinsurance intermediaries, credit for insurance, examination processes, liquidation proceedings and risk retention groups.

In addition, a state must also follow NAIC-specified regulatory practices and procedures as well as organizational and personnel practices (*BI*, Dec. 3, 1990).

In some cases, state insurance insurance commissioners had to ask legislators not only for more enforcement authority but also more money to add staff members or computer equipment to meet the NAIC standards.

Not all state legislators have embraced the NAIC accreditation program.

"The whole certification process is muddying the lines of authority between who is to make the law and who is to enforce the law," said New York Sen. Guy J. Velella, R-Bronx and Westchester. "I have some very serious concerns and reservations about the NAIC developing a program that goes so far as to seriously threaten the prerogatives of the legislature."

Specifically, Rep. Velella, who is chairman of the New York Senate Insurance Committee, said he is concerned about the NAIC's producer-controlled insurer model law, adoption of which is now one of the requirements for certification.

NCOIL, for example, originally questioned the model law because disputes involving a regulator and a producer-controlled insurer would be decided through an insurance department administrative proceeding. The NAIC has since amended the law so that courts now decide disputes (*BI*, June 24).

New York's Insurance Department became accredited without adopting the producer-controlled measure because NAIC rules in force at the time allowed states to opt out of one of the 16 requirements. States now have to adopt all 16 requirements.

The NAIC has amended the producer-controlled insurer model in response to criticism from the National Assn. of Insurance Brokers (*BI*, June 24). New York has until June 1993 to adopt that model law to maintain its certification.

The New York department currently is finalizing a draft regulation that would fulfill the requirements of the producer-controlled insurer model without requiring legislative approval. That draft takes into consideration comments made by Sen. Velella and other insurance industry representatives, a department spokesman said.

An area of contention with the accreditation program for some state legislators is sanctions adopted by the NAIC to prompt states to adopt its standards.

For example, as of January 1994, accredited states will not accept some reports of insurer financial examinations conducted by unaccredited states. That could subject an insurer based in an unaccredited state to examinations from additional states.

The emergence of sanctions against insurance departments in non-accredited states "was a whole new twist," the NCSL's Ms. Trolin said. That approach drew "mixed reactions" among legislators, she said.

It is reasonable to assume that some legislators felt "resistance" to having the state insurance commissioner "dictating" to the legislature what bills had to be passed so that the state could become eligible for NAIC accreditation, agreed Charles Davis, NCOIL's executive director.

Legislators are more used to their constitutional role as overseer of the operations of a state's administrative branch, which includes the operations of the insurance commissioner, he said.

Mr. Pomeroy acknowledged that some tension developed between legislators and regulators as the NAIC advanced its accreditation program. "In the course of our 1990 solvency policing agenda and the rush to advocate our standards program, we began giving some legislators the feeling that their prerogatives were being encroached on."

However, many legislators' concerns were diminished through increased discussions about the measures at both NAIC and legislative meetings, several observers agree.

For its part, the NAIC emphasizes that the accreditation standards are designed to apply to the regulation of insurers that operate in more than one state. The actions of multistate insurers affect policyholders and insurers in other states who must be protected, Mr. Pomeroy said.

In addition, state legislatures are permitted to make minor changes to NAIC model laws and regulations, though the final versions must substantially comply with the original version, he said.

The two organizations now have a "very good" relationship, agreed Rep. Burns of New Hampshire.

Meanwhile, NCOIL's State-Federal Relations Committee currently is exploring the feasibility of also using "interstate compacts," or legislative-oriented agreements to assure the application of solvency standards in every state. ■

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Hardee's serves up new flex benefits plan

By MICHAEL SCHACHNER

Hardee's Food Systems Inc. is busy explaining its new flexible benefits plan to about 6,500 salaried employees across the country.

"When you have 1,500 locations in 43 states, some of which are 65 miles apart, enrolling people in a totally new plan is a labor-intensive job that entails some heavy travel expenses, but you have to communicate the plan right or it'll fall apart down the line," explained Stephen Wood, director of benefits for the Rocky Mount, N.C.-based restaurant chain.

The new flex plan will begin operating Jan. 1. It will feature a multiple-level self-insured indemnity plan with wellness features, two levels of dental coverage, legal benefits, flexible spending accounts and choices of life and disability insurance.

The company is retaining its several health maintenance organizations, which are available to employees in specific Mid-Atlantic areas.

Mr. Wood said the flex program is designed to promote wellness, eliminate the current confusion over varying coinsurance levels and out-of-pocket maximums and permit better benefits cost management.

"The program at first will be cost-neutral. We won't reduce costs because we're promoting reduced-cost wellness programs and we're eliminating some of the coinsurance features that used to adversely affect members with family coverage. But if people understand the plan's benefits, I think we'll get a better grip on cost management in the future," said Mr. Wood.

Hardee's salaried employees incurred $16.8 million in health care expenses last year, $11.3 million of which was covered by the company's plans. Hardee's is projecting 21% health care inflation this year, but only 15% after the plan takes effect in 1992.

"We're hoping that uniform copayments and better overall cost management will allow us to slow inflation," he said.

Salaried employees at Hardee's headquarters, the company's six regional offices as well as all individual restaurant managers and assistant managers are now eligible to enroll in the plan.

At the center of the program is a self-insured indemnity plan with three levels of deductibles.

Within the indemnity plan, employees use their flex credits to select from $200, $300 or $500 individual deductibles, above which 80% of all medical expenses will be covered by the company up to an individual's deductible plus $1,200.

Family deductibles are $400, $600 and $1,000. The out-of-pocket maximum is also the deductible plus $1,200.

Under Hardee's current self-insured plan, deductibles are $200, $300 or $500 for every person covered under the plan. Hardee's pays 80% of costs above deductibles up to $2,000 per person.

"This is where things got confusing and people couldn't make rational decisions. A five-person family with a $300 deductible could be paying a percentage of expenses up to $10,000. We wanted something uniform, where out-of-pocket costs don't vary by the number of people covered," Mr. Woods said.

The new indemnity plan will also include 80% coverage for wellness features like mammograms, Pap smears, annual gynecological visits, well baby care, prenatal education and immunizations.

Mr. Wood said standard deductibles will not apply to wellness procedures in order to encourage employees to use the programs.

"We really wanted to get wellness features out of an indemnity setting and we want people to use them. Most of our employees are young and they had been asking for more HMOs because they provide the wellness programs free of extra charge. But because we're so spread out, it doesn't make sense to have 1,000 different HMO contracts."

Benefit beat

Mr. Wood said that a free prenatal education program sponsored by Newark, N.J.-based Prudential Insurance Co. of America is one of the plan's most important new wellness benefits. The program is set up to reduce the number of preterm or complicated births. "Last year we covered 550 births, four of which cost more than $75,000, and we're not sure how many preterm births came in at less than $75,000."

In addition, Hardee's is offering wellness bonuses to employees who do not smoke and promise to wear seat belts while driving. Employees receive $50 per year in flex credits for each commitment. This can be used to purchase additional benefits or can be converted into cash.

The company is also offering two levels of self-insured dental benefits to replace the one level of dental coverage that employees currently receive as part of their health care coverage.

Under a basic dental plan, employees pay a $25 annual deductible and 10% of costs for preventive procedures. The basic plan covers 70% of routine restorative procedures and 50% of major procedures above a $50 deductible.

Employees can also select Hardee's supplemental plan, which covers 100% of preventive care as well as 80% of routine restorative work and 60% of major work above a $50 deductible.

The flex plan preserves Hardee's existing flexible spending accounts. Employees will continue to be able to set aside up to $5,000 on a pretax basis for health care or dependent care expenses.

Prudential, which is the medical and dental plan administrator for Hardee's, also underwrites the company's life insurance program.

Under the flex plan, employees will have their basic life insurance benefits lowered to 50% of base salary; however, employees will be given ample flex credits to purchase up to their current life insurance level of 150% of salary. Employees will also be able to purchase life insurance equal to their salary or two, three or four times their salary.

Hardee's is also scaling back the basic long-term disability insurance level to provide a benefit of 50% of salary from 60%. But, like life insurance, employees can use flex credits to purchase a plan that pays a benefit of 66.7% of salary.

Hardee's recently switched its LTD plan to Portland, Maine-based UNUM Life Insurance Co. from Hartford Life Insurance Co. UNUM will insure the LTD component of the flex plan.

One new benefit that will be offered on an employee-paid basis is legal expense coverage through Des Moines, Iowa-based Midwest Legal Services Inc.

The legal expense coverage costs $180 per year and covers an employee and family members for all costs related to an adoption of a child, bankruptcy, marital matters, traffic violations, criminal misdemeanors, the purchase or sale of a home, preparations of wills and plaintiffs' costs in consumer suits. ■

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At issue

Do you expect to see more risk management and benefit departments merging?



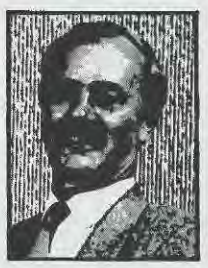
Fred Marshall
Risk Administrator
City of Winston-Salem, Winston-Salem, N.C.

Having been involved in an office where benefit and risk management functions were in one department, I see such a combination as a natural fit. As the corporate world sees a continued need for downsizing, this would be a step in the right direction. Both departments apply some of the same skills to the same types of risks.



Corey R. Stein
Risk Manager
City of Harrisburg, Harrisburg, Pa.

No, though I do see risk management departments increasingly acting as a bridge between the human resource department—with its expertise in employee negotiations—and the finance department—with its expertise in financial auditing. For me, the benefit of all three departments working together on common problems provides a more likely model for success.



Arthur J. Young
Benefits Manager
Hewlett-Packard Co., Palo Alto, Calif.

I think people will be organized differently as companies wrestle with how to deal with health plans and as more companies become self-insured. It is conceivable that there will also be some merging of departments handling Financial Accounting Standards Board financing and retirement plans with risk or benefit departments.



Powell Woods
Vp-Human Resources
Nestle Enterprises Inc., Solon, Ohio

Yes. General management is increasingly seeing the high cost of medical plans as a major cost liability that must be managed, rather than as just a human resource enhancer. The merging of these departments would be a logical consequence of these major costs.

Compiled by Sara Harty



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H.M.S. Rose cover

Continued from page 3

this is to compare it with other items being auctioned," explained the spokesman. "It is not like a TV or a stereo or something that you could go out and replace," he said. "These are historical items that are irreplaceable."

The named beneficiaries of the coverage for the Bill of Rights are the state of Rhode Island, which owns the document, and the H.M.S. Rose Foundation, which paid for the insurance.

"The Bloody Tenent of Persecution" is covered for $10,000 under a valuable papers and articles floater to the policy. The Rhode Island Historical Society and the foundation are the beneficiaries.

The cannon is covered for $250,000 under a valuable papers and art floater. The beneficiaries are the Newport Artillery Co. of Newport, R.I., which owns the cannon, and the foundation.

The painting by Mr. Loud is covered for $15,000 under a valuable papers, personal art and fine arts floater. The H.M.S. Rose Foundation owns the painting.

While the foundation is a beneficiary under the policy, as the premium payer, any claims would be paid to the owner of the lost or damaged items.

Shoreline Insurance Agency of Clinton, Conn., placed the coverage with Royal.

'We've got over a million dollars worth of documents on the ship,' the foundation's Mr. Biebel says.

The original H.M.S. Rose was built in Hull, Yorkshire, England, from 1756-57.

The replica was built in 1970 from almost the same plans, but fell into disuse and was rebuilt in 1985. The rebuilt ship is equipped with modern navigational equipment, diesel engines, generators and fuel tanks.

The Rose is one of the largest operational wooden tall ships in the world, according to Frederick Biebel, executive director of the H.M.S. Rose Foundation.

"It is very safe," he said. "We've got over a million dollars worth of documents on the ship, let alone the ship itself. And we're never very far outside the coastline."

However, "the boat was a floating wreck" until Mr. Williams had it towed to Bridgeport and "brought in craftsman from all over the world and essentially rebuilt it," said Brian Sullivan, an agent with the Atlantic Insurance Co. Inc. in Waterford, Conn., who placed the insurance on the ship. About 40 crew members operate the Rose under Capt. Richard Bailey, who has been master of the Rose since 1978.

The crew is dressed in Revolutionary War period working costumes, Mr. Biebel said.

"They will be wearing blouses and britches and bandanna scarves around their necks. It is a working ship, and they are constantly working about the ship," he said.

Tours of the Rose are free to anyone under 17. Adults are asked to make a $5 tax-deductible donation, which will go directly to the Save the Children Fund and to the U.S. Olympic Committee.

The tour is officially recognized by the Commission on the Bicentennial of the United States Constitution and is sponsored by NYNEX Corp. of White Plains, N.Y.

More information about tour schedules can be obtained from the H.M.S. Rose Foundation at 203-335-1433. ■

Opinions

Exorcise the ghostwriters

EMPLOYERS AND WORKERS compensation insurers must vigorously fight the latest abuse by doctors of the workers compensation system: ghostwriting.

As the name implies, some doctors in California are hiring writers without medical training to take patients' medical histories. Worse still, these writers are using computer software programs designed to help them prompt patients' answers and to insert the magic buzzwords into the patient's medical history to suggest that the worker is suffering from a compensable injury, whether or not that is true (see story, page 1).

California employers and insurers are particularly vulnerable to this swindle because California workers compensation law permits compensation for a job-stress claim based on a personnel action, like an employee termination or layoff. Employees who have lost their jobs are attracted to doctors that advertise in newspapers promoting compensation for job-stress claims.

To keep up with their large volume of patients, the doctors hire the ghostwriters.

Thankfully, California's law against workers compensation claim fraud will be tougher beginning Jan. 1, increasing penalties against doctors who use ghostwriters in the filing of fraudulent claims. They will be subject to five years in state prison for manufacturing a fraudulent claim with the help of a ghostwriter. In addition, the law calls for a maximum fine of $50,000—or double the amount of the fraudulent claim, whichever is greater—and license revocation.

Now it's up to employers, insurers and a new workers compensation fraud unit in the Insurance Department to identify these—and other—fraudulent claims and to press for prosecutions. These con artists cannot be permitted to gouge the workers compensation system, which already is too expensive.



While California cracks down on this type of workers comp abuse, employers around the country should be alert to the spread of ghostwriting in doctors' offices. One clue is a large number of workers comp claims from the same doctor with similar language in the medical reports.

Unfortunately, fraud knows no geographic boundaries.

Letters

Leaving Texas comp system may not be the answer

To the editor: I read with interest the Perspective article, "New Angle in Texas Comp," by John H. Eggertsen and Richard H. Moscicki (*BI*, July 8). I am certain many risk managers in Texas with a significant workers compensation exposure have taken a long look into the consequences of the *Eurine vs. Wyatt Cafeterias* ruling.

My brief research provided me with the following observations:

- The article is subtitled "ERISA May Provide Employers' Defense for Workers' Injuries," and I note the word "may." Texas is one of three states wherein it is not compulsory to carry workers comp coverage. However, by opting out of the system, you forfeit your common law defenses and open yourself to common law litigation from your employees. Without knowing the outcome of the *Eurine* ruling, some form of employers liability coverage would have to be secured to fully protect this exposure.

I looked into employers liability coverage that would cover common law negligence for companies that elect not to subscribe to the workers comp system. Not only was it difficult to secure, but the rates far exceeded the cost of my Texas workers comp premium. This coverage also had inadequate limits for the exposures and substantial deductibles (in the $1 million range).

- The effect of the *Eurine* ruling is not clear. Many risk managers and attorneys believe this ruling will be overturned. Companies that abandon the Texas workers comp system and opt for a plan governed by the Employee Retirement Income Security Act solely on the basis of this ruling and that expect to be protected from common law claims from their employees could be in for a rude surprise.
- Companies that opt out of the work comp system and have master service contracts with customers that require Texas workers comp coverage could jeopardize their business relationships. I was informed by risk managers for major energy-related companies that failure to comply with the insurance requirements set forth in our existing master service contracts would result in the loss of their business.
- Many companies in Texas also cover federal workers compensation coverages, like longshoremen's and harbor workers' and Jones Act coverage. Opting out of the Texas workers comp system in favor of an ERISA plan could result in split coverages. This is not only costly but also could pose problems where you have employees who work both onshore and offshore and their duties move them in between longshoremen's and harbor workers' coverage and the ERISA plan.
- Workers comp self-insurance will be allowed in Texas for those that qualify beginning in 1993. Many risk managers are biding their time and plan to convert their paid-loss and incurred-loss retrospectively rated insurance programs to this option as we have in other states. This option would at least provide companies with the "ultimate remedy" afforded by the workers compensation act.
- Other risks presented by employers that do not subscribe to the workers comp system could expose owners and executives to personal liability for employee illnesses or injuries. There may also be a directors and officers liability exposure if a company sustains a large uninsured judgment resulting from a work-related accident.
- Finally, the negative impact on employee morale and the difficulty in attracting and retaining qualified employees is a factor to consider.

I am the first to admit that the Texas workers comp system and its impact on employers is in a grave state, but employers need to take a good hard look at the ERISA substitute and its long-range financial consequences to the company.

Richard H. Vincent
Risk Manager
M-I Drilling Fluids Co.
Houston

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Cost containment hits wrong group

To the editor: Hobson D. Carroll's letter to the editor, "Physician Greed Plagues Health Care," is right on the mark (*BI*, July 22).

I have often felt that the insurance industry targets the wrong group when it stresses the importance of health care cost containment.

Most employees are very conscious of cost containment. It is the physicians and hospitals that have no regard for the cost of services. Once the medical profession realizes that medical insurance provided by employers is not bottomless, perhaps the escalation of medical expenses will stop.

Sue Strup
Employee Benefits
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SUBSTANCE ABUSE IN THE WORKPLACE— THE BLUE COLLAR VIEW.

One in an ongoing series of conversations between Argonaut Insurance Company, our clients and their brokers, dealing with issues important to their business. The intent is to keep the lines of communication open. We invite your participation.

THE PARTICIPANTS: **CURTIS WESSELN,** *Vice President of Wesseln Construction;* **DENNIS DELUCCIO,** *Superintendent, Wesseln Construction;* **JESS GORMAN,** *Superintendent, Wesseln Construction;* **DICK MURY,** *with Frank B. Hall Corporation, Wesslen's broker;* **STEVE LA SHIER,** *Senior VP Safety Management, Argonaut Insurance Company;* **LARRY EVANS,** *Manager of Safety Management, Argonaut Insurance Company.*

MODERATOR We've been talking about some of the problems a construction company like Wesseln faces in dealing with substance abuse in the workplace. The lack of testing guidelines, the lack of union programs, the difficulty of staying competitive. Does Argonaut have clients in similar businesses that have found a way to deal with the problems?

SL: This is how one contractor deals with the testing problem. I quote from his employee manual: "The company recognizes that alcohol and drug abuse are illnesses. It is with this philosophy that the following guidelines have been established: An employee terminated for violating a policy shall not be eligible for rehire for a period of 30 calendar days. During that period, it will be the individual's responsibility to seek rehabilitation. They will then be required to take a second test at their own expense at the company-approved laboratory which must result in a negative diagnosis." This policy is signed by the president of the company and given to every employee. As a result, they have a reputation as a drug and alcohol-free workplace. And their comp premiums have gone down more than 40% in one year.

CW: What kind of contractor is it?

SL: A general contractor. High rise and low rise.

CW: That's a different story than ours. They might be on a high rise project for two years. Residential is very sporadic. Our guys are in and out, you never know who you're going to have back. That's a big difference.

SL: You said you have a core group of about 200 guys you work with all the time. Are they loyal enough to your company to say to you, "Hey, this guy's drinking." Or "This guy's snorting."? Will they finger him, or is that snitching or a blue collar macho thing?

CW: Snitching. But it's up to the individual. They don't want to work a roof with somebody who's been drinking or taking drugs, and just by their own subtle process, they'll make sure that guy's not going to be employed.

DD: Personally, I think it would be much better if everyone was tested before they were hired, instead of after an accident. That's a nice thought, but I think the directive has to come from somebody above us. We can help initiate it, but we need help from the builder we work for.

CW: We are a framing business. We don't know all the rules and options concerning abuse programs. We need some information and support. That's one of the reasons we went with Argonaut and Frank B. Hall. At least now we're getting feedback from both companies. With our former broker and insurance company, there was very little contact.

> A substance abuse program with a testing policy statement helped lower one contractor's premium 40% in one year.

DD: In a meeting I attended, they were talking about putting a printed safety policy with all the rules in everybody's paycheck. I don't know how effective it would be. I'd be nervous about the reaction. But it would be great if we could do it.

MODERATOR If the unions knew you had a drug-free operation, wouldn't they send you the best people?

CW: We pretty much demand the best people anyway. And then they're screened by their production and what they do on the job site.

JG: What if a guy only goes out drinking every few months? How could pre-employment screening catch him? And even if we do find him and suspend him for 30 days, he'd just go to work somewhere else.

DD: Another problem with a 30 day suspension is that 90% of these guys live paycheck to paycheck. Tell them "You're suspended for 30 days, seek help." and what they're going to seek is another job. They can't afford to be off work for a month. If somebody paid them to attend the program, that's fine. But if they don't get that regular paycheck, they'll lose their house, their wife and everything else.

SL: Curtis, say you put out a flyer that says you're instituting a complete substance abuse program. All future employees will be tested. All current employees will be tested. You are providing access to assistance for anyone who feels they have a problem. They have 120 days to square their act away. As an employer, you're not going to know who uses the program. If they have not squared themselves away in those 120 days, do you really want them around? Because sooner or later, they'll become a statistic.

CW: That's where businesses like ours need help. We don't have the time to investigate programs or ways to set them up. I have to rely on other people for this kind of information.

SL: I agree with you, Curtis. And you don't have to reinvent the wheel. It's just that the industry as a whole is slow to respond. In 1971, the construction industry injured 14.8 workers per hundred every year. We've only reduced that to 14.6 today. Not much of an improvement in 20 years.

JG: Does Argonaut have a substance abuse policy?

SL: Yes. And I'll be honest with you, there was a lot of fear, apprehension and misunderstanding about it, just like in a lot of companies across America. We've instituted the policy and provide access to assistance programs. We also have a Corporate Wellness Program. So you see, we understand a lot of the problems companies face because we're facing them ourselves.

JG: You should tell people "We have instituted the policy..." "This is what we do here at Argonaut." "This is what some of our clients do." That's what we need. Examples. Success stories.

SL: How about this. That contractor I told you about, in the three and a half years he's had that program, there hasn't been one single legal contest.

> You don't have to pay for an assistance program, just provide access.

CW: What does it cost to test someone?

SL: The initial test will cost you about $30 per employee. But if anyone tests positive, you have to confirm it with a $60 GC mass spectrometry test. If you don't, you'll end up in court. A good example: has anyone here taken Advil? I have a bad shoulder. I took two Advil on Sunday before I went out to play golf. Three days later I guarantee you I'll test positive for marijuana. Advil shows up as marijuana on the first screening. GC mass spectrometry would show I took 400 milligrams of Advil within the last 48 hours. So you *must* confirm any positive test.

MODERATOR What would happen if you took the lead and talked to builders about instituting a drug progam? Would they think you'd give them added value, or do they just look at cost?

DD: Cost, cost, cost. And production. If you have a testing program and your bid is the same as someone that doesn't, that's fine.

MODERATOR Wouldn't having a program enhance your reputation?

CW: We already have a reputation for delivering top quality work. Having a testing program might enhance it. But the bottom line is still production and cost. The builders would come back to us and say, "It's nice that you have a program, but so and so is 7% lower and we're going with them."



JG: Last week I bid a job and the guy said we were way too high. When I asked him if the guy with the low bid paid his comp premium, he said "Frankly I don't care as long as I have the certificate." It all comes down to money. That's always the bottom line.

LE: So whether you have a high or low accident rate really isn't considered?

JG: Only if it shows up in our price.

LE: Which is right where it will show up eventually.

Continued next week

We'd like to hear what you have to say about substance abuse in the workplace, and about our discussions on topics that concern your business. Send your comments to Mike Crall, President, Argonaut Insurance Company, 250 Middlefield Road, Menlo Park, CA 94025.

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Ghostwriting

Continued from page 1

five years in state prison for a doctor to manufacture a fraudulent claim with the help of a ghostwriter. The law, which becomes effective Jan. 1, also calls for a maximum fine of $50,000 or double the amount of the fraudulent claim, whichever is greater, and calls for revoking the doctor's license if he or she is convicted of fraud.

S.B. 1218 also will make it easier to identify and fight suspicious claims, employers and consultants say.

The law will impose an assessment of not less than $3 million annually on all employers to fund investigations and prosecution of workers comp fraud cases.

The assessment will be determined by the Fraud Assessment Commission, which the law establishes. The commission will consist of two self-funded employers, one insured employer and one workers comp insurer, as well as the president of the State Compensation Insurance Fund, or his or her designee. This provision of the law will expire Jan. 1, 1994, unless extended by the Legislature.

Half of the revenue generated by the assessments is earmarked for the Fraud Bureau of the Insurance Department. With additional funding, the Fraud Bureau will create a workers comp fraud unit, similar to its motor vehicle insurance fraud unit, to gather the evidence prosecutors need to go after wrongdoers.

The other half of assessment proceeds will go to local district attorneys' offices.

Despite the new assessment that S.B. 1218 imposes on employers, the law had broad-based support from employers, as well as from labor and insurers. Groups that supported the law include the California Chamber of Commerce; the California Manufacturers' Assn.; the California Self-Insurers Assn.; the California Labor Federation, AFL-CIO; the American Insurance Assn.; the Assn. of Calif. Insurance Companies; and Californians for Compensation Reform.

Insurance Commissioner John Garamendi also supported the law.

Employers, insurers and others contend that many ads encouraging workers to visit workers comp physicians and clinics are misleading because they falsely imply that any injury is compensable.

For example, the following ad appeared in a recent edition of the Los Angeles Times: "Job Problems? Emotional Stress? Harassment? Physical Injury? Overwork? Call Our Help lines Anytime!! Free Appointment. You May Be Entitled to Substantial Benefits! $$ Compensation $$ Evaluation. Treatments. No Cost to You!! M.D.s & Ph.Ds."

Misleading television and newspaper advertising, as well as the solicitation of workers by so-called "cappers" at unemployment lines, have funneled large numbers of workers to doctors' offices and clinics, some of which have become "work comp mills," employers and others allege.

Those facilities process workers with the help of marginally trained writers—or "ghostwriters"—who produce the medical histories supporting workers comp claims.

Typically, ghostwriters work with word processing programs comprised of boilerplate narratives that describe injuries in the terminology appropriate to a work-related injury. Those "canned" programs turn out medical histories designed to persuade insurers to pay claims, employers and consultants charge.

But even if a claim is denied, California law requires employers to pay for the employee's forensic medical history. The average charge for a medical-legal report—or the evaluation that a physician provides to an insurer or self-funded employer—in 1990 was $1,194, according to the California Workers Compensation Institute, the research arm for California workers comp insurers.

"The ghostwriters come in because providers are doing such a big volume of business. There's a big profit built into those evaluations, and they're going to make their money from the sheer volume," said Jerry Treadway, supervising criminal investigator of the Los Angeles region for the Insurance Department's Fraud Bureau.

Under state law, "The doctors are guaranteed payment for the reports within 60 days. They are therefore economically encouraged to maximize their gross revenues by aggressively soliciting workers compensation cases and minimize their cost for report generation by using assembly-line multiperson involvement," including ghostwriters, said Clifford D. Sweet II, a founding member of Heggeness & Sweet in San Diego and a workers comp defense attorney.

Beech Street Inc., an independent bill reviewer in Irvine, Calif., has "seen a dramatic increase" in boilerplate reports "in the last three to six months," said Karen Thomas, vp of workers comp.

"Typically, the report comes in at the prompting of an attorney. This patient has typically been terminated and then (goes to see) an attorney who refers (him or her) to a doctor. It always seems to be the same attorney referring to the same doctor," Ms. Thomas said.

"There's one physician we haven't seen any activity from in 10 years, and in the last three months we've had a large volume" of reports from him, she noted. "Usually, his patients are attorney-referred, and the reports use pretty much standard language. They're typically about 10 pages long. They don't have to be that long, but workers comp reports are paid per page."

In addition, many physicians may be performing unnecessary tests on workers comp claimants, Ms. Thomas said, noting that "typically, with a little research, we see that the lab is owned by the physician."

She estimated that nearly half of the medical-legal bills Beech Street reviews "are questionable, and yet again half of those are boilerplate-type reports."

Beech Street has "put together a task force to identify providers" who may be using ghostwriters, and Beech Street analysts are cautioned to "watch for ghostwriting," she said.

Some employers are actively challenging suspect claims involving ghostwriters.

For example, Bullocks Department Stores, a division of R.H. Macy & Co. Inc., is contesting the payment of $1,700 for medical expenses incurred in treating an employee. Treatment was based on a medical report prepared by Professional Consultation Services Inc., owned by Dr. Byron Crawford, a Los Angeles psychiatrist.

The Workers Compensation Appeals Board in November 1990 reversed an earlier decision by a workers comp judge ordering Bullocks to pay PCS $1,700. Bullocks argued PCS must return the payment because it was "obtained. . .through deception," according to a brief prepared by Mr. Sweet, Bullock's attorney.

Such deception involved "psychiatric medical reports. . .generated by unlicensed ghostwriters using a computer program that inevitably finds a work-related injury, disability and need for psychotherapy," the brief said.

PCS petitioned California's Second District Court of Appeal to review the WCAB's decision.

In his brief arguing that the state appellate court should deny PCS's petition, Mr. Sweet claims in a step-by-step analysis that "pre-packaged word processing paragraphs" appear throughout reports prepared by PCS concerning the Bullocks employee.

PCS also was involved in one of the few other ghostwriting cases that has ever come before the WCAB. In that 1986 case, Daniel Brawner, a PCS writer who studied Restoration drama in college, testified about how he wrote medical reports using a word processor.

Mr. Brawner testified that he believed that "the procedure by which Dr. Crawford generated these reports was questionable," according to WCAB documents.

The WCAB subsequently charged Dr. Crawford with contempt based on Mr. Brawner's and others' testimony that revealed "deficiencies in Dr. Crawford's reports," according to appellate court documents.

Court documents say that PCS "employs approximately 30 persons to take medical histories and write the medical evaluation reports. Dr. Crawford is the sole physician employed by the corporation. Some of the employees are psychologists. The corporation generates approximately 50 to 80 reports a week. All of the reports are signed by Dr. Crawford."

Dr. Crawford petitioned the state appeals court to restrain the WCAB from filing further contempt proceedings against him.

When the appeals court refused to restrain the WCAB, Dr. Crawford appealed to the California Supreme Court, which ordered the WCAB to issue an alternative writ.

In July 1990, Dr. Crawford and the WCAB entered into an agreement by which Dr. Crawford pleaded no contest to the contempt charges and agreed to pay $20,000 to the WCAB, mostly to reimburse it for the costs it incurred in the legal action.

Dr. Crawford would not return phone calls.

Continued on next page



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professionals who
offer you and your
employees access to
quality cost-efficient care, by
making it their business to
know the local markets
where you do business?

Continued from previous page

PCS and other doctors continue to advertise in the Los Angeles Times.

The following PCS ad emphasizes that a job-stress claim can be based on a personnel action—like an employee termination or layoff—a right that employers and Gov. Wilson tried to repeal earlier this year in legislation, S.B. 581 (*BI*, May 20). The bill, however, died in committee.

"Harassed at Work/Sick? You may receive Treatment at no cost. Disability Payments. $$$$$ Compensation Even If You've Been FIRED or LAID OFF! Have You Been Injured on the Job, Humiliated or Harassed by Supervisors & Overlooked for Promotions & Raises, Overworked, Abused, Unfairly Terminated or Laid Off! ARE YOU SUFFERING? Headaches. Stomach Aches. Back/Neck Pains. Chest Pains. Poor Sleep. Tense/Depressed. Discrimination. Injury to Back. Job Accident. Free Consultation. Don't Take It. CALL NOW!"

"The trouble with these ads is that they encourage people to file workers comp claims for everything that's wrong with their lives," Mr. Sweet observed.

Yet, "Dr. Crawford does not appear to be doing things much differently than other doctors," said workers comp defense attorney Joseph Truce, a partner with Kegel, Tobin & Truce in Los Angeles.

For example, a free-lance writer told *Business Insurance* that she quit her job as a medical historian/transcriber for a Los Angeles physician after one week because she believed she was asked to perform tasks that were not proper for a writer.

The writer said she "sat in on maybe two patients" as their medical histories were taken by another writer. She then began taking histories on her own. "I was not even given a list defining medical terms," she said.

While taking medical histories, she and a patient would be seated at a word processor.

The writer said she was disturbed that the "boilerplate document" she worked with "was not a questionnaire but a narrative document. If the paragraph said, 'I have sharp, stabbing pains,' I would ask the worker if he had that," she said.

For the conclusion of the report, "I filled in the body parts and the dates. It said, 'I Dr. So and So have examined X.' This is all written before any examination or X-rays," she said. "The conclusion was foreordained and always found a work-related injury," she said.

"At that point, I was supposed to take out the X-ray sheet and circle the particular body part to be X-rayed," she said. Patients received "between three and 10 X-rays" in the doctor's office, "even if they said they had X-rays the day before" at another facility, the writer said. "If they refused X-rays, they would not be accepted as patients."

The writer said the main reason she quit was because she was required to recommend X-rays to patients, which she believed she was not qualified to do.

She said that another factor that led her to quit was that her immediate supervisor—another writer who is an aspiring actress—would edit the reports, adding symptoms that the worker did not complain about and intensifying some symptoms.

The doctor's attorney said the physician did not want to be interviewed for this story.

Yet, because it is cheaper to settle suspicious claims and difficult to prove that a doctor intentionally filed a false report, employers and insurers generally settle rather than fight suspicious claims, observers agree.

"Under 1% of all fraud referrals to the bureau involve work comp fraud," the Fraud Bureau's Mr. Treadway pointed out.

"The proof necessary to establish misrepresentation by a doctor is frankly astronomical," explained Michael McClain, an attorney at workers comp insurer Industrial Indemnity Co. in San Francisco, a unit of Crum & Forster Inc.

But, observers hope S.B. 1218 will change that.

Prosecutors cannot "recall a workers comp case ever being prosecuted from any agency," noted the Insurance Department's Mr. Treadway. "If prosecutors feel the laws are so weak or inadequate to get the offenders, they won't prosecute."

S.B. 1218 will "give us the tools" to investigate and prosecute workers comp fraud, he said.

"Our goal is not necessarily to police every claim but to shut down those organizations that are filing phony claims on a large scale," and thus deter other wrongdoers, said James Morris, legislative aide to Sen. Presley.

If necessary to build a case against providers suspected of filing phony claims, undercover agents from the Fraud Bureau will pose as injured workers and be interviewed by ghostwriters, he said.

Initial effort to combat fraud fell short

SACRAMENTO—The new California law designed to reduce workers compensation insurance fraud is the second attempt in recent years to deter physicians from filing fraudulent claims prepared by ghostwriters.

In legislation enacted in 1989, employers sought to prohibit ghostwriting by amending Section 4628 of the Labor Code. But the language of the amendment is ambiguous.

"Except as provided in subdivision C, no person, other than the physician who signs the medical-legal report, except a nurse performing those functions routinely performed by a nurse, such as taking blood pressure, shall examine the injured employee or participate in the non-clerical preparation of the report, including all of the following: taking a complete history; reviewing and summarizing prior medical records; composing and drafting the conclusions of the report," the 1989 law states.

Though that seems to prohibit ghostwriting, subdivision C of Section 4628 states: "if the initial outline of a patient's history or excerpting of prior medical records is not done by the physician, the physician shall review the excerpts and the entire outline and shall make additional inquiries and examinations. . . ."

"We had hoped Section 4628 of the Labor Code would have made a significant difference, but we see very little improvement," said Joseph Markey, president of the California Self Insurers Assn., which represents 300 California employers.

"There is a loophole (in Section 4628) you can drive a Mack Truck through," agreed defense attorney Joseph Truce, a partner with Kegel, Tobin & Truce in Los Angeles.

If the person taking the medical history is properly trained and if the doctor carefully reviews the medical history taken by the writer and composes the conclusion, "I don't see anything terribly wrong with that," Mr. Truce said. But that process is "not policeable," he said.

"And let's say employers come up with a bill that says all medical historians have to be trained. What do you think the expense factor will be?"

—By Louise Kertesz

A group representing workers comp physicians opposes ghostwriting abuses but says proper use of medical historians by doctors in preparing workers comp claim evaluations can save the system money.

The state's sweeping 1989 workers comp reform law was designed in part to curb physicians' practice of using ghostwriters, an official of the group noted (see related story).

But, as that legislation was being drafted, "we pointed out to legislators and carriers that non-physicians or paramedics could be trained and could do an outstanding job, and their cost to the system could be considerably less" than if medical histories were written entirely by physicians, said Carlyle Brakensiek, executive director of the California Society of Industrial Medicine & Surgery, a group of about 700 physicians who treat injured workers.

"Most of the time, it is intensive, on-the-job training. The process of disability evaluation is quite specialized and unique. There are not a lot of courses that are taught in how to do this. . . Either the doctor or another skilled intake worker will train these people on the job to ask appropriate questions and sensitize them in what followup questions to ask.

"We can't slam editors across the board," he continued. "There are editors who do an outstanding job of correcting grammar, spelling and syntax and doing a lot to improve the readability of a physician's report. Some doctors are not the best writers," he added.

However, "boilerplate" reports should not be used, he agreed. And, some doctors "feel that they can justify a higher fee if the report is longer," Mr. Brakensiek acknowledged.

And, "there is a very small minority of physicians that feel they should put in boilerplate to make the report longer," he said. ■

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Pollution

Continued from page 3

fringe of normal operations but that the company seeks to characterize as sudden and accidental," the court said.

"Determining where along the spectrum of polluting events coverage should begin is a perplexing and, ultimately, unsatisfying endeavor," the court said.

The court concluded that it is not appropriate to engage in such "microanalysis" if the policyholder regularly emits pollution.

"From a microanalytical viewpoint, almost any event can be labeled unexpected, since history probably never repeats itself precisely," the court explained. "But such an approach would eviscerate the exclusion for pollution."

As a result, the court denied coverage to Belleville Industries Inc. of New Bedford, Mass., for $4 million in pollution cleanup costs.

Belleville and another New Bedford-based corporation, Aerovox Inc., owned an electrical capacitor manufacturing plant. Capacitors are devices that accumulate and hold electric charges. One byproduct of the system was polychlorinate biphenyls, or PCBs.

The U.S. Environmental Protection Agency and the state of Massachusetts sued Belleville and Aerovox in late 1983 under the Comprehensive Environmental Response Compensation and Liability Act, better known as the Superfund act, and similar state statutes to recoup the costs of removing PCBs that had spilled into the Acushnett River, which flows into New Bedford Harbor.

Ultimately, Belleville and Aerovox entered into a multimillion-cleanup settlement with the state and federal governments. Belleville's share of the settlement is approximately $4 million.

At the same time it was negotiating with the government, Belleville sought to recoup the cleanup costs from its liability insurer, Long Grove, Ill.-based Lumbermens Mutual Casualty Co., now a unit of Kemper National Insurance Cos.

Lumbermens wrote a total of $30.3 million of primary and umbrella liability insurance for Belleville from 1973 to 1976.

Lumbermens sued Belleville in U.S. District Court in Boston seeking a declaration that it did not owe coverage for the pollution cleanup costs.

The district court certified questions regarding the pollution exclusion in the Lumbermens policy to the Massachusetts Supreme Court, seeking a definitive ruling on Massachusetts law.

In June 1990, the Massachusetts Supreme Court interpreted the term "sudden and accidental" in the pollution exclusion in favor of the insurer. The court said the pollution exclusion bars coverage for all pollution that does not occur abruptly (*BI*, June 25, 1990).

The litigation then returned to the U.S. District Court, where Belleville attempted to prove that two events, a fire and a flood, caused an abrupt release of PCBs.

The court found that a violent rainstorm in 1973 flooded a building containing PCBs and that PCB-bearing water then escaped into the environment. The court found that this release was both "sudden and accidental" and, therefore, coverage was not barred by the pollution exclusion.

Lumbermens appealed that ruling, and the 1st Circuit reversed the district court, saying the entire analysis of whether there was a "sudden and accidental" event is inappropriate because Belleville was regularly in the business of emitting pollutants.

The lower court's decision results in a "very small tail wagging a very large dog," said the 1st Circuit ruling, written by Judge Frank M. Coffin. Under the district court's ruling, "the flow of storm water around a door for a few hours at most would be sufficient to make Lumbermens indemnify Belleville for four years of pollution at a price of $4 million," the appellate court said.

The 1st Circuit added that the nature of a policyholder's business operations determines the applicability of the pollution exclusion, and not the nature of individual polluting events.

"Belleville discharged pollutants as an ordinary part of its business operations. We simply cannot analyze these (pollution exclusion) provisions as if it were a manufacturer of health food that rarely, if ever, experiences a pollution-producing event," the court concluded.

Belleville's attorney would not return phone calls.

However, other policyholder attorneys say that the 1st Circuit decision goes further than any other court to deny coverage to a policyholder facing hazardous waste cleanup costs.

"The opinion can be read to express a judicial hostility to coverage for any type of pollution that occurs as a result of a policyholder's routine business practices," said policyholder attorney William Greaney of Covington & Burling in Washington, D.C.

"However, the very reason companies buy insurance is because there are risks in their routine operations, including pollution," he said.

"The mere fact that pollution arises out of routine operations does not make it intentional," Mr. Greaney said.

Policyholder attorney Richard Fields agreed: The 1st Circuit's ruling expresses a "distorted public policy concept: guilt by association."

"Something can be possible, even probable, but not intentional," said Mr. Fields, an attorney with Howrey & Simon in Washington, D.C.

"The court disregards well-established coverage rules" in reaching this "very unusual" ruling, he said.

"This is a result-oriented decision designed to punish policyholders," he said.

But, insurer attorneys are praising the 1st Circuit's ruling, saying it indicates that insurers will be victorious in this "second wave" of pollution coverage litigation.

"The court rejects a second wave of attempts by policyholders to cut the pollution exclusion to nothing," said insurer attorney Thomas Brunner of Wiley, Rein & Fielding in Washington, D.C.

He predicted the 1st Circuit's ruling would be "very influential" in this "second generation" of pollution coverage disputes.

"The large industrial companies will abandon their attempts to get coverage for pollution cleanup costs in jurisdictions affected by" this ruling, Mr. Brunner said. The 1st Circuit covers Maine, Massachusetts, New Hampshire, Rhode Island and Puerto Rico.

"This decision will have a tremendous effect on the number of lawsuits brought by insureds against their insurers," agreed Lumbermens attorney Andrew Culbert with Drinker, Biddle & Reath in Princeton, N.J.

"This opinion is on the forefront of the next battleground in this dispute," Mr. Culbert said. "It will have a tremendous impact on other courts."

However, policyholder attorneys did not think the 1st Circuit's ruling would be very influential.

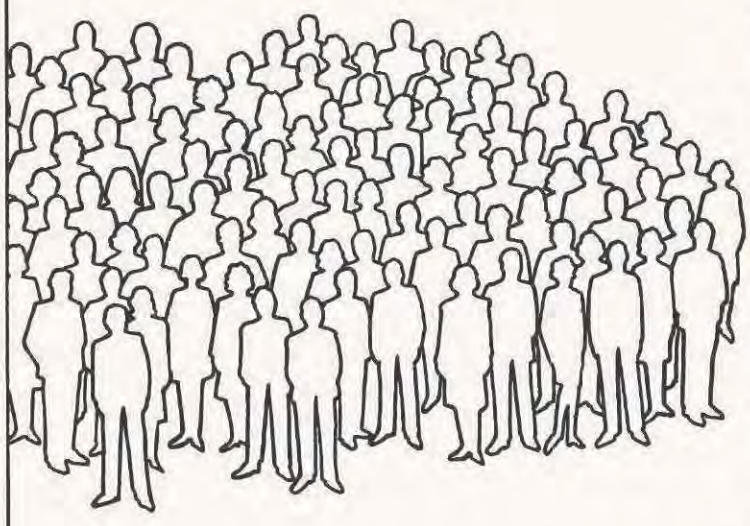
"The 1st Circuit case is going to have very little precedential value because of the weaknesses of the court's arguments," Mr. Fields said.

Mr. Greaney said the 1st Circuit's decision was an example of "bad facts leading to bad law" and, as such, it would not be influential.

"This decision can be read narrowly to say that only if there are hypothetical, unproven allegations of sudden and accidental occurrences that are (insignificant) in the face of a long pattern of intentional pollution" is coverage barred, Mr. Greaney said.

●

Lumbermens Mutual Casualty Co. vs. Belleville Industries Inc.; U.S. Court of Appeals for the 1st Circuit, No. 91-1129, No. 91-1130



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Lawyers discuss Tylenol litigation

Packaging—not poisoning—key to dispute

By STACY ADLER

TORONTO—Packaging—not the product—was the key element in the recently settled Tylenol poisoning case, say two plaintiffs' attorneys.

Chicago attorneys Leonard Ring and Philip H. Corboy told how they were able to negotiate a multimillion-dollar settlement with Johnson & Johnson for the families of seven people killed in the 1982 Chicago-area Tylenol poisonings. Their early-morning program at the Assn. of Trial Lawyers convention here last month was among the best attended.

In May, *Business Insurance* disclosed that the settlement was valued between $35 million and $39 million, including cash and structured settlements (*BI*, May 20).

Messrs. Ring and Corboy would not reveal the exact amount of the settlement but did discuss the evidence they gathered against J&J—evidence they believe forced the company to the settlement table.

The lawsuit was filed in 1982, but the problems underlying the lawsuit began in 1970, the lawyers said. In that year, J&J first marketed acetaminophen, an aspirin substitute. Through its subsidiary, McNeilab Inc., J&J soon "collared" 37% of the U.S. pain reliever market, said Mr. Corboy of Corboy & Demetrio.

The problem, according to Mr. Corboy, was not the product, but how it was packaged. "The bottle of Tylenol could be easily opened," he said.

Further, the capsules that contained the acetaminophen could be opened and closed, he said. In this case, the Extra-Strength Tylenol capsules were opened and filled with cyanide.

While the media "called it the 'Tylenol murder case,' we called it the 'Tylenol packaging case,' " said Mr. Corboy.

No one has ever been charged with the murders, though James E. Lewis was convicted of extortion in 1983 for demanding $1 million from J&J to "stop the killing." Mr. Lewis was sentenced to 10 years in prison.

The poisonings led to a nationwide recall of the pain reliever and prompted the families of the seven poisoning victims to sue McNeilab and McNeil Consumer Products Co. in Cook County Circuit Court in Chicago.

The families' 50-page lawsuit alleged that J&J was negligent in its packaging of Tylenol. The suit asserted that J&J knew or should have known that the capsules required safer packaging.

"There is no such thing as tamper-proof packaging," said Mr. Corboy. "But there are tamper-evident packages."

J&J's defense was that no one in the industry could foresee this type of criminal product tampering.

However, Mr. Corboy said: "As long ago as 1923. . .J&J had notice that this type of tragedy could occur."

Mr. Ring agreed, noting that in 1923 patents were given to inventors of tamper-evident packaging.

Also, "within five weeks of the Tylenol deaths, J&J had taken all of the Tylenol capsules off the market and replaced them in this tamper-resistant or tamper-evident packaging," said Mr. Ring, who is with Leonard Ring & Associates.

"You couldn't do this in five weeks unless this type of packaging was available—and it was," he added.

Furthermore, "within a few days of the reported incidents in Chicago, J&J sent out its middle management people to cover all of the stores. . .and to bring back as many packages as they could find that had tamper-evident packaging.

"They came back in a few hours with a hundred," he said. "This was a key point in our case. We

Continued on next page

AUGUST CLOSINGS

SET YOUR DATES

issue:	August 19	Bonus Distribution: ARIA
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
closing:	August 20	
editorial feature:	Reinsurance: Int'l Markets — Directory: Leading Reinsurers Worldwide	
demographic section:	Agent/Broker Topics: Automation/Most Productive Agencies	
issue:	September 9	
closing:	August 27	

				1	2	3
4	5	6	7	8	9	10
11	12	13	14	15	16	17
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Benefit plans new target of bad-faith claims

By STACY ADLER

TORONTO—Plaintiffs' attorneys are exploring a new arena in which to bring bad-faith claims against insurers: group medical, life and disability coverage.

Describing bad-faith claims in this area as a "new horizon," attorney Frank N. Darras of Shernoff, Scott & Bidart in Los Angeles outlined new theories of bad faith being brought against insurers.

"ERISA has been affectionately referred to as the obituary of bad faith," Mr. Darras said at the Assn. of Trial Lawyers of America convention in Toronto last month.

He was referring to the fact that the Employee Retirement Income Security Act of 1974 pre-empts state laws on employee benefits. As a result, insurers that provide group medical, life and disability coverage through ERISA-qualified plans are immune from state tort law claims alleging bad-faith claims handling.

This obstacle has not stopped all plaintiffs, he noted. Some plaintiffs are able to prove that certain group health plans are not ERISA-qualified plans. And, other plaintiffs have persuaded congressmen to introduce bills that limit the scope of ERISA's pre-emption of state bad-faith laws.

"It is not that insurance companies don't have the money to pay claims," he said. "The longer they keep the premiums, the longer they keep the money, the more they unreasonably deny and delay the benefits, the more interest they're earning on those runaway, snowballing premiums."

As a result, plaintiffs' attorneys are trying to find ways to deter insurers from unreasonably denying claims or delaying payments.

"Remember that the purpose behind ERISA back in 1974 was to prevent the mismanagement of funds accumulated to finance employee benefits. There were fiduciary duty requirements, extensive reporting requirements and disclosure requirements to insure against the possibility that employees' expectations of these benefits would not be usurped by some plan administrator," Mr. Darras said.

But not all group plans meet ERISA definitions.

An ERISA plan is a "plan, fund or program established or maintained by an employer for the purpose of providing medical, surgical or hospital benefits to plan participants and their beneficiaries," Mr. Darras said, quoting from Department of Labor regulations.

Certain plans in which there is

Continued on next page

Tylenol case

Continued from previous page

were able to show that tamper-evident packaging was available and others were using it," said Mr. Ring.

The plaintiffs' lawyers also discovered that J&J sold Tylenol to hospitals in tamper-resistant packaging.

"There was never any adequate explanation for why they didn't do the same thing for the public," said Mr. Corboy.

J&J responded to this allegation by arguing that while tamper-evident packaging was available, it was being used for prescription drugs and not in the over-the-counter drug industry, he said.

Another key piece of evidence was the fact that J&J had received some 295 complaints about Tylenol products, said Mr. Ring.

While many of the complaints were about shortages in the number of pills in a container, other complaints alleged that sleeping pills or antibiotics were mixed in, he said.

"Imagine taking one of those (containing sleeping pills) for a headache and going out to drive," Mr. Ring quipped.

"What did they do with all these complaints?" asked Mr. Ring. "We discovered that what they did was send a form letter telling them that 'We've checked the batch and we don't understand how this could happen. And, here is a free bottle of Tylenol.' "

"That was all they did," Mr. Ring said. "They never did any checking."

There was other damaging evidence suggesting that J&J had notice of product tampering, said Mr. Corboy. The plaintiffs' lawyers had assembled a stable of witnesses:

- A J&J employee who worked in the packaging department for Tylenol and who alleged that someone had tampered with potato chips packaged at another J&J unit. He reported this to his boss, but his superiors allegedly did nothing.
- A witness who had opened a bottle of Tylenol containing a capsule allegedly filled with detergent.

"The case was about to be tried, the jury was in the box—after nine years of preparations—and we settled the case under the requirement that we not disclose the amount of the settlement," said Mr. Corboy.

He conceded that he is a staunch advocate of legislation that would ban secret settlements in product liability actions.

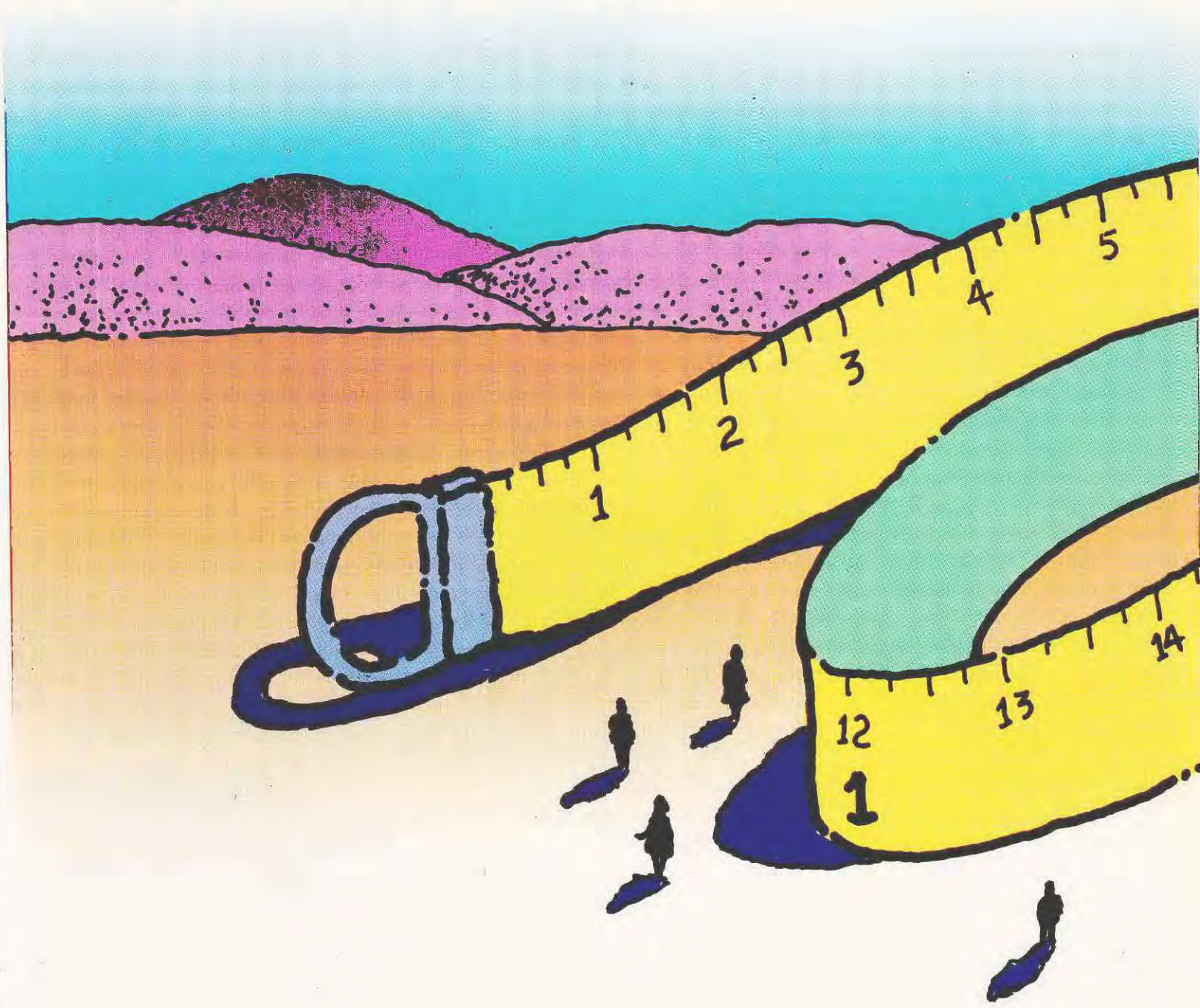
However, he said that this particular settlement was not the type of secret agreement that affects the public.

"Why? Because it is never going to happen again," he said. Five weeks after the deaths Tylenol came out with a sealed box and sealed bottle to discourage product tampering, he explained. And, he said, within one year they changed from capsules to caplets—capsule-shaped tablets that are more difficult to invade.

Most trial attorneys—who usually receive between 30% and 40% of a settlement or jury verdict—spend their entire careers hoping for just one multimillion-dollar settlement like this, said one member of the audience.

"There will probably never be another case" like the Tylenol case, Mr. Corboy said. ■

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Continued from previous page
insufficient employer involvement will not qualify for ERISA protection, Mr. Darras said.

For example, in one case, a plan established by two lawyers who formed a law partnership and hired a secretary did not qualify as an ERISA plan, he said.

Similarly, if the employer does not intend to comply with ERISA, its plan will not qualify as an ERISA plan, Mr. Darras said.

That was the case recently in California. A state appeals court ruled that ERISA does not preempt state law when there is "no formal compliance with ERISA, no employer involvement, no commitment by the employer to continue the benefits."

Mr. Darras quoted from the appeals court's decision: "An employer without any intent to create an ERISA plan simply purchased a group health policy for its employees, yet this insurer now seeks to elevate that fact to a level sufficient to enable the insurer to avoid liability for its alleged bad faith conduct. An insurance company which merely contracts with employers can't hide behind non-existent ERISA plans to avoid California bad-faith law."

ERISA also may not be applicable to sole proprietorships, Mr. Darras said. Some courts reason that sole proprietors are not employees, but rather are self-employed and therefore are neither plan participants nor beneficiaries under ERISA, he explained.

Still, there is little incentive for insurers to eliminate bad-faith practices, according to Mr. Darras.

In 1989, the Department of Labor received more than 67,000 complaints regarding ERISA plans, and 1,581 investigations ensued, he said. Ultimately, penalties were handed down in 28 cases, he said.

Pointing out that fines for ERISA violations are capped at $100,000, Mr. Darras said that "these (small) penalties amount to wholesale license for insurers to continue the ERISA pillage."

But plaintiffs' attorneys continue to seek relief, not only through the court system but also through federal legislation, Mr. Darras said.

One avenue they are pursuing is legislation to limit the scope of ERISA pre-emption.

Legislation that would "put teeth back" in state bad-faith laws and give states a greater right to regulate group health, life and disability plans have been introduced in both the House of Representatives and in the Senate, he said.

These two bills would allow employees covered by group health care plans who believe an insurer has unfairly denied or unreasonably delayed paying a claim to sue under state insurance bad-faith laws. Forty-seven states have such laws.

Specifically, the goal of these two bills is to overturn a 1987 U.S. Supreme Court decision, *Pilot Life Insurance Co. vs. Dedeaux*, which held that ERISA pre-empts state bad-faith laws.

S. 794 was introduced April 9 by Sens. Howard Metzenbaum, D-Ohio, and Edward Kennedy, D-Mass. It is pending before the Senate Labor and Human Resources Committee. Some observers expect a committee vote on the bill later this year.

"The states have identified certain specific acts that constitute bad-faith claims processing," said Sen. Metzenbaum in a statement during hearings on the bill in April. "Because these state laws have been invalidated, insurance companies are free to deny health insurance claims with impunity."

Sen. Metzenbaum told of one example in which an insurer initially approved a complex bone marrow procedure during which the patient's bone marrow was to be removed, treated and then replaced. But, the insurer changed its position and denied the claim after the patient's bone marrow had been removed, but before it could be replaced.

H.R. 1602, which was introduced March 22 by Rep. Howard L. Berman, D-Calif., is pending before the House Education and Labor Committee.

Rep. Berman said when introducing his bill: "By making insurance companies pay for the consequences of their unfair practices, my bill would create a potent incentive for insurance companies to treat their policyholders fairly. And it's about time."

He noted that under the current laws, an employee may successfully sue the insurer that underwrites his or her employer's health care plan for the amount of a claim wrongly denied, but the employee cannot recover any other costs or punitive damages.

"These bills have a real chance of happening," Mr. Darras commented. ■

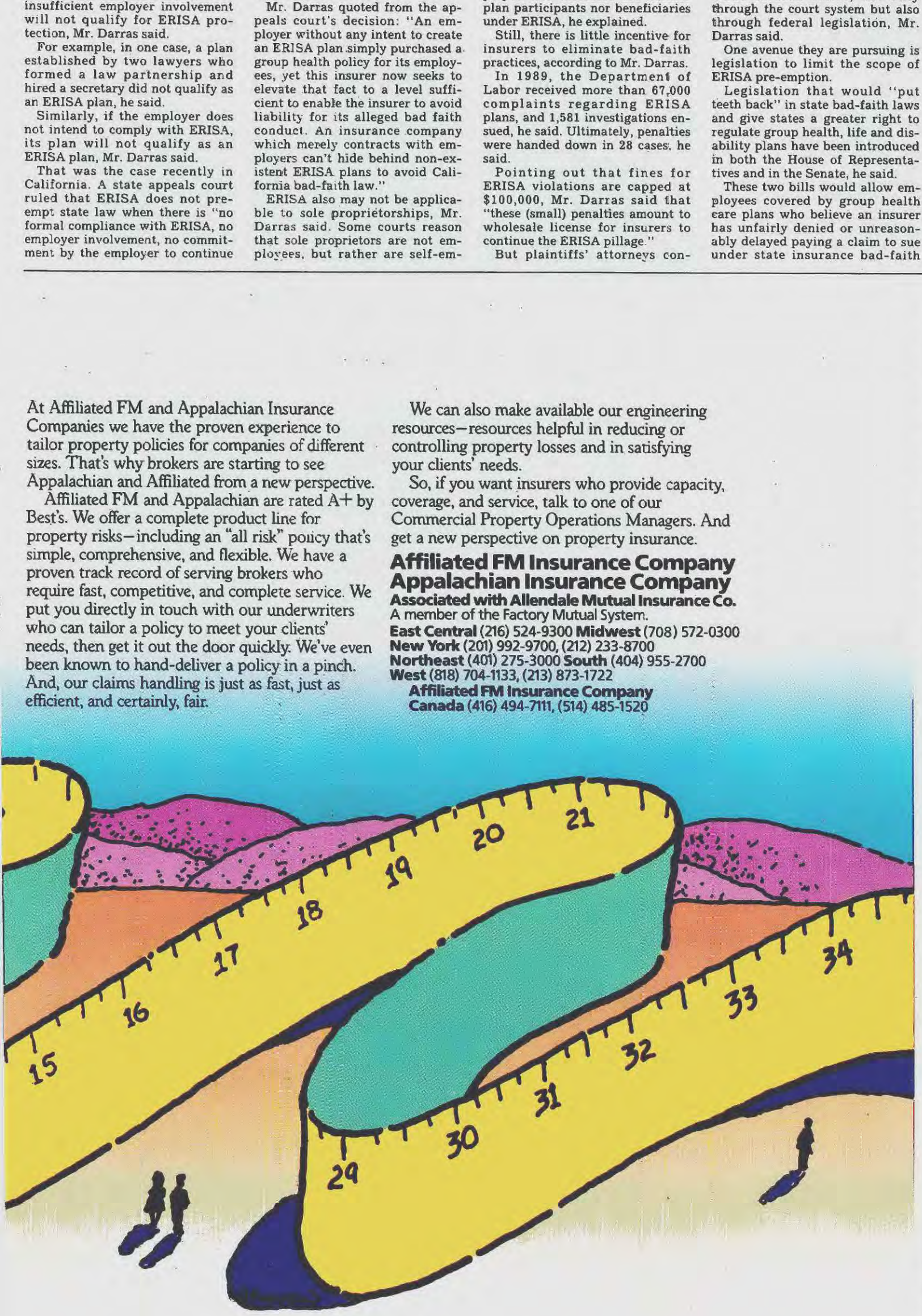
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Asbestos cases are combined

By STACY ADLER

TORONTO—The way that a massive asbestos proceeding is being handled in Baltimore may presage the future of toxic tort litigation.

The case, involving 9,032 plaintiffs in Maryland suing a number of asbestos producers, is believed to be the largest consolidated asbestos bodily injury proceeding ever in a state court, said Deborah K. Hines, an attorney with Connerton, Ray & Simon in Washington, D.C.

"The trend in the law is toward favoring consolidation and class action in the mass tort litigation," she said at the Assn. of Trial Lawyers of American meeting here last month.

Courts are using a myriad of techniques to streamline massive tort cases (See Update, page 2). For example, she said, courts try to get their arms around these giant cases by using master complaints, master interrogatories and case management orders.

With a master complaint, all allegations against a group of defendants are combined.

With master interrogatories, plaintiffs combine all of their questions for the defendants. Or, the defendants

Continued on next page

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Asbestos case

Continued from previous page

combine all of their questions for the plaintiffs.

Case management orders are used to speed along complex litigation by keeping the parties to a rigorous schedule of when documents must be filed with the court.

In the Baltimore asbestos litigation, Circuit Court Judge Marshal A. Levin tried many of these tactics and a few others, said Ms. Hines.

Plaintiffs in that case initially were placed in groups of five for purposes of trial. The plaintiffs were grouped together according to their disease, occupation, lawyers and the date they filed their claims, she explained.

"This cluster allowed for trying 200 cases per year," said Ms. Hines. This device alone, though, was simply not enough, she added: More than 5,000 cases were still pending.

Therefore, the court looked for other ways to streamline the litigation. One was alternative dispute resolution. During a nine-month moratorium on the filing of new asbestos personal injury lawsuits, a mediator tried to help the parties who had already filed lawsuits negotiate settlements, she explained.

But, "ADR was not fruitful for either the plaintiffs or the defendants," said Ms. Hines.

Finally, the judge tried consolidation.

The idea was to try common issues of law and fact, while allowing separate trials on individual issues, explained Ms. Hines.

When examining the pending asbestos bodily injury cases, Judge Levin found that there were many common features, including:

- Common tort liability theories, including failure to warn that asbestos was dangerous.
- Common defendants sued by various plaintiffs.
- Common diseases suffered by plaintiffs.

Still, many issues varied among the plaintiffs.

The areas in which there were great differences included the methods by which each plaintiff was exposed to asbestos and the degree of illness, Ms. Hines explained.

Recognizing the similarities and the differences among the cases, the court formulated a method for consolidating the pending cases, she explained.

In the first phase of the litigation, a jury would determine common issues including:

- Were the defendants' asbestos-containing products capable of causing bodily injury?
- Were those products defective or did they lack an appropriate warning?
- Was the defendants' conduct wanton and reckless for the purpose of assessing punitive damages?

After these common issues were determined, there would then be individual trials to determine the amount of damages each plaintiff should be awarded, she said.

Once the format for the consolidated proceedings was laid out, the attorneys began the complex process of choosing a jury, explained Ms. Hines. It took months to find suitable jurors who had no relationships with any of the 9,032 plaintiffs or the defendants, she said.

Then, on June 5, a mistrial was declared. Judge Levin dismissed the jurors because a confidential defense document was mistakenly faxed to the opposing side.

The misdirected fax contained psychological profiles of prospective jurors prepared by defense attorneys and was held to give the plaintiffs an unfair advantage.

Now the parties will have to select another jury, said Ms. Hines. No trial date has been set. ■

Toronto hosts ATLA meeting

TORONTO—Some 2,500 registrants gathered at the annual convention of the Assn. of Trial Lawyers of America here last month.

The legal association, which consists primarily of plaintiffs' attorneys, has more than 65,000 members. ATLA describes itself as dedicated to safeguarding victims' rights.

Attendance at the convention is generally restricted to members of the association, law professors and law students.

Next year's meeting will be held July 21-26 in Washington, D.C.

For more information, contact ATLA at 1050 31st N.W., Washington, D.C. 20007; 202-965-3500.

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Agent/Broker Topics

A monthly editorial section sent exclusively to agents and brokers



Agents, direct writers: The twain are meeting

By LAURA MAZZUCA

ONCE UPON A TIME, cooperation between direct-writing insurers and independent agents was about as remote as the toppling of the Berlin Wall.

How times change. Today the Wall is rubble and East has met West. So too have direct writers—led by Allstate Insurance Co. and Metropolitan Property & Casualty Insurance Co.—joined with independent agents.

There are benefits to both parties. To direct writers seeking a larger share of the personal lines insurance market, independent agents can be ideal go-betweens. And agents, jilted by traditional agency insurers pulling out of markets, are turning to direct writers for security and stability.

Direct writer-independent agent alliances are nothing new; Allstate first stuck its toes in the water in the 1970s by appointing rural agencies.

But 1988 may eventually be seen as a watershed year. That was when the property/casualty arm of Metropolitan Life Insurance Co. entered the independent agency market. The insurer has since offered contracts to the more than 700 agents left in the lurch when Crum & Forster Inc. dropped personal lines.

"There is no question that other non-traditional agency companies will look to independent agents to gain market share," said R.C. Riley, president of Peel & Holland Inc. of Benton, Ky., and incoming national president of the Independent Insurance Agents of America in Alexandria, Va.

New thinking

Direct writers have changed their tune in regard to independent agents. No longer dismissed as costly and inefficient, independent agents are considered viable marketing sources for personal lines products and as a general foot in the door of a broader insurance marketplace, Mr. Riley said.

Direct writers now control 40.7% of the U.S. property/casualty insurance market, compared with 36.5% in 1986, according to A.M. Best Co. However, independent agents still control nearly 60%.

Because the Warwick, R.I.-based insurer hopes to become one of the top five insurers for personal property/casualty business, it's only natural to make independent agents part of its marketing strategy, said Robert Trombley, director of Metropolitan Property & Casualty's independent agency program.

One direct writer trying to tap into independent agent marketing is GEICO Corp., a Washington, D.C.-based insurer that in April bought Southern Heritage Insurance Co., a traditional agency insurer in Provo, Utah.

In doing so, GEICO is "trying to pick up the business left behind" when agency companies withdrew from markets, says Gloria Vogel, an insurance analyst at Bear Stearns & Co. in New York.

These new ties with direct writers are "simply a matter of compatibility," said Patricia A. Borowski, vp of government affairs for the National Assn. of Professional Insurance Agents in Alexandria, Va.

The direct writers have also focused on appointing smaller and rural agencies, which are frequently neglected by the bigger independent agency companies. Allstate, for example, appoints still only rural agencies, while Met seeks small agencies that are "a good business fit."

As traditional agency multiline companies like USF&G Corp., Travelers Corp. and Crum & Forster continue to pull out of personal lines markets, the direct writers are moving in. "We see this as a real opportunity for us," Mr. Trombley said.

Only three years ago, Met started with 350 independent agency appointments. Now it has about 850—in urban, suburban and some rural areas—and the insurer continues to seek aggressive agencies "who know where they want to go," he added.

Although Met will continue to use direct, or "career," agents and group property/casualty marketing, it intends to sell more personal lines coverage through independent agents.

Newfound trust

Attitudes have changed dramatically on the other side of the old direct writer/independent agent wall, too.

Envy and distrust have long permeated the agents' outlook. But they are now starting to see direct writers as allies filling the void left by traditional agency insurer market withdrawals over the past five years, said Mr. Riley, whose own Kentucky agency recently signed on with Allstate.

Another attraction: respectable, or at least competitive, commission levels.

Allstate reports paying 15% commissions for personal auto, and John Hancock Property & Casualty Insurance Co. of Boston, which has contracted with about 50 independent agencies in nine states, offers 20% commissions for new homeowners business and 15% for new auto business.

For homeowners, Met pays 20% commissions on new business and 15% on renewals; for auto, 15% on new business, 13% on renewal. And a first-year program can sweeten that deal. The program lets agents earn up to three additional percentage points in commission for all new personal lines business after they reach $100,000 in premium volume.

Direct writers can offer above-average commissions and contingencies because their efficient structure and management holds down expenses, observed Mr. Riley of the IIAA.

Many multiline insurers with longstanding ties to independent agents have found that processing personal lines business can be "cumbersome," he noted. So companies that remain in personal lines will have to pare down substantially—hence the decision to cut commissions or pull out of unprofitable markets.

"They just can't continue to do business as usual," observed Mr. Riley.

Direct writers also have an edge in servicing. Their progress in automation and standardization allows them to trim operating costs and offer higher commissions, says the PIA's Ms. Borowski.

'Nice people to do business with'

Lucrative or not, commissions are not the only factor at work.

Asked what they find appealing in direct writers, many agents echo the comments of William E. Nicholas, an agent in Burnsville, Minn.

"I find Met to be an excellent company," said Mr. Nicholas, vp and general manager of

Continued on next page

WHAT'S INSIDE

A new force in brokerage

A surging regional bank is making its mark in insurance–so far, an 'A,' as in aggressiveness.

–Page 18E

Agent/Broker Topics

Diversification

Continued from previous page

Since becoming one of Horst's 16 operating division, the agency has experienced "tremendous growth," says David H. Berndt, president of the Lancaster, Pa., agency.

Just before the buyout, the agency employed six workers and was generating about $3.5 million in annual premium volume, split equally between personal and commercial lines.

Today, the agency has 32 employees and produces $20 million in annual premium volume. Eighty percent of its business is commercial property/casualty coverage, Mr. Berndt said.

While the agency remains a separate entity at Horst, it enjoys the benefits of prospecting business from Horst's other businesses, which over the past five years have averaged between $80 million and $120 million in sales.

Horst's other enterprises include construction, painting, excavating, masonry, equipment sales and rental, property services providing janitorial services to condominiums and businesses and residential property management, Mr. Berndt said.

All of these businesses "feed off of each other to some degree," he said.

"The Horst Group umbrella gives us a high profile for integrity, honesty and doing what we say for our customer," Mr. Berndt added.

All of the operating entities' stock is wholly owned by Horst Group, which offers about 40 top managers the chance to buy the shares, he said.

Each company operates as an individual profit center, paying corporate overhead and other expenses in exchange for Horst's centralized services, such as automation and shared clerical help, Mr. Berndt said. "There is no grandfather up there handing money around."

The conglomerate system offers other benefits as well, such as top-notch credit rating and buying capacity because of Horst Group's size, he said. In addition, Gingrich Stoudt acts as the risk manager for all of the Horst Group's businesses.

Another recent agency purchase notwithstanding, Horst grows primarily by developing relationships with existing clients, Mr. Berndt said.

Lee-Curtis Insurance Services

Like many smaller, family-run businesses, this Fredericksburg, Va., insurance agency likes to get everyone involved.

Run by four brother-partners and their sister, the agency first diversified after one partner and his wife, a travel agent, decided about a year ago to start their own travel agency, recalls John G. Lee, senior vp.

Partners at the agency—which has an annual premium of $3.5 million—put up about $90,000 among them to get the couple started.

The insurance agency partners were convinced that the new business would do well since there are "beaucoup" insurance agencies in the region but only six travel agencies, Mr. Lee said.

Both the travel and insurance agency use each other's client lists for cross-selling, Mr. Lee said. Insurance agency ads feature coupons for $50 or $100 off any seven-day cruise booked through the travel agency. A mass-mailing informed the insurance agency's approximately 4,000 clients of the connection.

For six months, Travel Dimensions, the new travel agency, was housed in Lee-Curtis' offices, though it recently opened its own office, Mr. Lee said.

Lee-Curtis hopes that the travel agency will become self-sustaining at the end of three years, he said. If the business is not making money by then, the insurance agency will simply dismantle it, or move it back in-house as a one-person operation.

Mr. Lee's optimism may be well-founded. Commissions are now paying half of the business's expenses, including the salaries of several full-time staffers and an outside sales person. And the end of the Persian Gulf War and a gradual pickup of the economy are expected to encourage more people to travel.

But Lee-Curtis is not putting all its eggs into a single basket. The insurance agency also owns a non-standard auto insurance agency, which comprises about 10% of its total commissions, Mr. Lee said.

Real estate may be next. The agency already rents out several properties it owns. And the fact that several partners are licensed real estate agents may someday encourage the agency to branch out into real estate sales, he added.

Eagan Cos.

Most agencies diversify by finding a partner in the real estate or travel agency business.

But not this Metarie, La., firm. At Eagan, the non-insurance specialty came first—more than 100 years ago, in fact—in the unlikely form of a funeral home business.

Leitz-Eagan, the original funeral home business, has been operated by the Eagan family for five generations since 1854, said Marc F. Eagan, president of the insurance agency.

The insurance agency—which now generates about $8 million in annual premium volume—was founded in 1954 by Mr. Eagan's father and uncles. They saw commercial property/casualty insurance sales as a natural outgrowth of the funeral home's traditional burial insurance sales, which were done door-to-door in the early days. Today, the agency's business is 74% commercial lines, 24% personal lines and 2% life/health insurance.

One of Mr. Eagan's uncles runs the funeral home, the main office of which is located next door to the insurance agency. This segment of the business generates $1 million in annual revenues.

Two other uncles manage a family-owned life insurance company, First Capital Life Insurance Co. of Louisiana based in New Orleans, while Mr. Eagan's father Maurice runs the insurer's marketing division.

All entities are operated as a single corporation, with a single board of directors, Mr. Eagan said, adding that the units aggressively cross-sell.

The companies' advertising program—which is managed by Mr. Eagan's cousin and is based on the theme, "In times of need, you need us most"—tries to tie together the agency and the funeral home. The group earmarks almost $25,000 annually for advertising on television, radio, print and billboards to get this message across.

The agency still markets old-time burial policies, now known as "pre-need funeral programs," which cover clients' own burials. The coverage is underwritten through First Capital in some states, and through a fronting company in other states, with 50% of the risk reinsured by First Capital.

Eagan has also established its own reinsurance company, Acadian Life Insurance Co., which will not begin underwriting activities until 1992.

For the past five years, Eagan has been marketing this coverage through other funeral homes across the country. Those funeral homes are paid a commission.

Sales of this insurance still comprise a "significant" amount of the Eagan Co.'s volume, Mr. Eagan said. The agency also cross-sells long-term care products and life/health and employee benefits, using a client listing provided by the funeral home, he said. ■

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Surging Norwest is turning aggressively to brokerage

By LAURA MAZZUCA

MINNEAPOLIS—With federal bank reform on the horizon, many independent agents are afraid. They fear competition from powerhouses like Citicorp or being swallowed whole by the new Chemical Bank/Manny Hanny venture.

At Norwest Insurance Inc., though, the attitude is far more sanguine. Acquired by a regional bank decades ago, the Minneapolis agency now counts parent Norwest Corp., considered one of the nation's stronger regional banks, as a best friend, partner and client source.

Only this year the agency broke into the *Business Insurance* Top 100 broker rankings at No. 14 (*BI*, July 1).

Between 1989 and 1990, both annual premium volume and gross revenues shot up more than 200%: premium volume to $400 million from $120 million; and gross revenues to $61.1 million from $16.5 million.

Aggressive acquisitions allowed the agency to add 305 employees—for a total of 535—and 36 branch offices—bringing to 90 its total number of offices.

Doing all right

Such growth, particularly as many agencies struggled just to survive a soft market and a recession, is rare.

But Norwest has been doing nicely, thank you, since 1930, when it was bought as part of a bank acquisition by what was then known as the Northwest Bank Corp., said Stephen L. Byrnes, president of Norwest Insurance.

Over the years, the agency has broadened its focus. Personal lines, which comprised about 80% of its book of business in the 1960s and 1970s, now account for only half of its business.

That shift toward commercial lines, Mr. Byrnes explained, comes in conjunction with the bank's strategy of targeting small businesses.

Norwest Insurance credits ties with Norwest Corp. for much of its success in this area. Since learning that "people liked buying insurance from banks," the agency has used the bank's list of more than 1 million clients as possible prospects, Mr. Byrnes added.

That relationship is a two-way street. Norwest and other banks like investing in insurance agencies because they generate a lot of fee-based income, said Ben B. Crabtree, a bank analyst with Dain Bosworth Inc., a securities firm in Minneapolis.

Although other areas contribute more to bank bottom lines, insurance "is a business they like very much," said Mr. Crabtree. "I don't think there's any question about their desire to do it."

But for the agency, the real benefits of being owned by Norwest Corp. are the efficiency of working within the bank's existing structure and the fact that Norwest's long-standing reputation draws customers. "The Norwest name has value in our marketplace," Mr. Byrnes said.

Growth area

Insurance has long played a bit part at Norwest. Over the years, the company gradually acquired other insurance agencies in the region, which it merged into the original Norwest Insurance. Only recently, though, has the agency become a significant part of the bank's growth plans.

Faced with low margins from banking operations, many banks have turned to non-interest sources of income.

This makes the insurance agency business very desirable "because it doesn't take a lot of capital to support—and a great deal of regulatory and legislative attention is being paid to capital these days," Mr. Crabtree explains.

It was only in 1988, when Norwest Insurance began actively using the bank's client list for prospecting and cross-selling, that the bank realized that "integration was the way to go," he said.

Since the early 1980s, Norwest Corp. has grown from about $20 billion to $37 billion in assets, with most of that growth coming after 1987 and 1988, when the bank began making large agency and bank acquisitions, according to Mr. Byrnes.

Before the early 1980s, Norwest Corp. was a "loose confederation" of banks with a variety of names, Mr. Byrnes explained. "The influence of the holding company was marginal at best."

But in 1982, the bank decided to

Continued on next page



A Midwestern powerhouse

From its Minneapolis headquarters, regional banking power Norwest Corp. is making itself into a brokerage force. Some recent acquisitions are outlined.

September 1988: Fargo Insurance Agency Inc. of Fargo, N.D. Annual premiums: about $7 million.

November 1988: Hopkins Insurance Agency Inc. of Des Moines, Iowa. Annual premiums: more than $5 million.

April 1989: The financial institutions business of Bachman Anderson Inc., of Minneapolis-St.Paul. Annual premiums for that business: more than $1.6 million.

April 1990: American Land Title Co. of Omaha, Neb. Gross annual fee income: $1.8 million.

June 1990: Crop Hail Management of Kalispell, Mont. Annual net premiums: more than $115 million.

October 1990: ANK Agency of Duluth, Minn. Annual net premiums: about $7.5 million.

Source: Company reports

GRAPHIC BY CYNTHIA WATSON

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Sue Beaney, Financial Institutions Underwriter, works with agents to package the right coverages for this specialized industry.



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UNDERWRITING EXPERT

Agent/Broker Topics

Norwest

Continued from previous page

modernize its image. All the branches were brought under the new pared-down name and a single management philosophy, he said.

From 1983 to 1985, performance fell off at Midwestern banks in general. Mr. Crabtree attributes the poor showings to weak local economies and a "willingness to make big loans away from home." Banks ended up in "areas where they had no competitive edge," he said.

To trim costs in those years, many Norwest insurance operations were shifted to a finance company subsidiary in Des Moines, Iowa.

As business improved and Norwest Corp. became more streamlined, insurance and other divisions were brought back into the banking group at the end of 1987, Mr. Byrnes said.

But Mr. Byrnes emphasized that cross-selling is still in its formative stages. "The majority of our customers are not bank customers," he stressed. Only about 7% of the bank's clients purchase insurance from Norwest.

And, over time, the agency plans to penetrate the bank's client list, he added. But, "we have to win that. You don't just automatically walk in" and grab clients.

The bank now operates 94 agencies, 92 of them on Norwest bank premises, as well as six title insurance offices and nine managing general agency offices, all separate from banks, Mr. Byrnes said. Branch offices of the agencies are in 12 Midwestern states.

Because federal law prohibits banks from underwriting coverage, Norwest Insurance is operated like any other independent agency. It has contracts with more than 300 independent insurers, with The St. Paul Cos. Inc. as the primary insurer for both commercial and personal lines. Other major insurers include Great American Insurance Co., CNA Financial Corp., CIGNA Corp., Chubb Corp. and New Hampshire Insurance Co.

But because the agency operates in so many states, it also has contracts with many regional insurers and mutuals as well. "Fundamentally, Norwest is still a rural, small-town business," Mr. Byrnes said.

Rural accounts comprise about 35% of its book of business.

Because of the bank's franchise concept, "our appetite for growth is broad-based," and Norwest will continue to seek acquisitions, predominantly of commercial agencies with good equity, high returns on assets and a net operating income return-to-gross revenues ratio of roughly 30%.

Acquisitions always entail risks. But Mr. Crabtree said he thinks Norwest has "learned a lot" through its recent fast-paced acquisitions and is minimizing its potential for problems through scrupulous due diligence.

Future growth will come from flood and title insurance, Mr. Byrnes predicted, while agriculture, commercial lines and personal lines also will spur growth for Norwest. Another potential growth area is life insurance, where the agency will use the bank's marketing expertise for prospecting.

Coercion not a factor

Norwest dismisses fears of "coercion" in bank sales of insurance.

"We attribute (those charges) to people who really don't know the facts," Mr. Byrnes said.

Bankers are very protective of their customer base, and agents are the ones who must work hard to offer good service so the bank can retain these customers, he said.

In fact, Mr. Byrnes believes banks are the least of agents' problems. He points out that in today's tough insurance marketplace—with its consumerism, declining markets and aggressive direct writers—banks are actually in a position to offer these agencies a market.

"The least stressful point is banks being in competition with them," he said. ■

September

Automation & Most Productive Agencies

How do America's most productive insurance agencies generate huge amounts of revenue per employee? And what do computer hardware and software manufacturers have in their plans to help surge agency productivity? BI will rank and profile the nation's most productive agencies and examine how automation can help agents boost their output.

Issue: September 2
Ad Closing: August 20

October

Contracting For Services

The pressure is on for agents to target commercial accounts. Who are they turning to to handle their personal lines business? Are they using consultants to design perpetuation plans, software systems and help improve their office efficiency? BI editors will look at these issues and whether agents are better off contracting for services or handling things on their own.

Issue: October 7
Ad Closing: September 24

November

Tapping Surplus Lines Markets and IIAA Conference Report

A soft commercial insurance market is shrinking premium volume in the surplus lines business. BI will look at what effects the current market conditions are having on the relationship between retail agents and wholesalers. Are relations still good? And who's courting whom to build volume? Plus, reporting from Honolulu, BI will recap the news from the Independent Insurance Agents of America's annual conference.

Issue: November 4
Ad Closing: October 22

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* An Audience Profile of the Business Insurance 'Agent/Broker' Subscriber, 1990.

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Business Insurance
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Medigap sales fraud is cited by panel

Abuse by agents called widespread

By LAURA MAZZUCA

WASHINGTON—A House investigation of individual long-term care insurance sales has uncovered evidence of widespread misrepresentation and fraud by insurance agents.

Hearings held in June by the House Select Committee on Aging and the House Committee on Small Business indicated that many insurance agents misrepresented the policies they were selling to elderly clients, answered questions incorrectly and were ignorant of coverage details.

House investigators had senior citizens pose as potential buyers of long-term care policies.

Accompanied by congressional staffers who posed as relatives, the senior citizens met with 14 different insurance agents, all of whom misrepresented the coverage, mostly by failing to mention restrictions that ultimately limit coverage. Some of those agents represented established, respected companies like New York Life Insurance Co. and Mutual of Omaha Insurance Co.

"The apparent lack of knowledge about long-term care, Medicare, Medicaid and health insurance in general among the agents interviewed by staff is appalling," concludes a report issued by the committees.

Long-term care insurance is designed to provide coverage for debilitating chronic illnesses and services that are not covered by Medicare or supplemental life insurance, like custodial care. However, the congressional committees found that many policies contain exclusions limiting the insurer's obligation to provide such care, while others needlessly duplicate Medicare coverage.

The report also noted that sales of the coverage are particularly lucrative for agents.

Some 60% to 65% of the premiums paid in the first year of a long-term care insurance policy go to agent commissions, according to the report. Last year, commissions totaled $3.6 billion, or 60% of the $6 billion in premiums that senior citizens paid for long-term care policies, the report said.

Independent agent associations downplay the significance of the report. They note that sales of

Continued on next page

Medigap fraud

Continued from previous page

long-term care coverage represent only a fraction of their members' business.

Steve Brill, director of insurance programs for the Independent Insurance Agents of America in Alexandria, Va., maintains that the hearings are politically motivated by legislators who want long-term health care—like the Medicare program—to fall under federal jurisdiction.

Conceding that agent fraud does exist, Mr. Brill argues that many of these violations are committed by so-called "specialists" who almost exclusively place long-term care coverage.

"You don't hear about the success stories," he added. "It's just a potshot at the industry and the agents."

Independent agents predominantly place commercial lines coverage, so the long-term care issue does not affect them that much, said Patricia A. Borowski, vp of government affairs for the National Assn. of Professional Insurance Agents in Alexandria, Va.

Fraud can persist, she noted, because regulatory efforts to track violations are hampered by constant changes in what is covered by Medicare.

She argues against one possible way to curb long-term care fraud: limiting the high first-year commissions. Doing this would only discourage reputable agents from marketing the coverage, she said.

Instead, Ms. Borowski suggested that the insurance industry and federal government collaborate on a booklet for agents and consumers that would explain the most recent changes made to Medicare and Medicaid coverage.

And to help prevent fraud, the National Assn. of Insurance Commissioners could use its nationwide data base to track agents who have had licenses revoked or denied because of insurance fraud, she said.

Both the IIAA—which markets a long-term care product through Travelers Corp. of Hartford, Conn. —and the PIA offer their members educational programs on long-term product sales techniques, which are available on a state-by-state basis.

In addition, the American Assn. of Homes for the Aging and the Health Insurance Assn. of America are co-sponsoring three upcoming seminars to educate agents further about long-term care insurance policies.

The seminars will be held Aug. 8-9 in La Jolla, Calif.; Aug. 22-23 in Orlando, Fla.; and Sept. 12-13 in Dallas. For registration and fee information, contact Cheryl Russell of the AAHA at 202-508-9434. ■

Guide offers aid on telemarketing

Products & services

The Commercial Insurance Telemarketing Center Guide, offered by National Marketing Services, gives commercial property/casualty agencies the information, guidance and tools to establish a telemarketing campaign.

The guide is a 55-page manual that describes from start to finish how to effectively use telemarketing, whether it is performed by outside vendors or from within the agency.

The manual is designed to teach principals to evaluate the agency's current book of business and the strengths of its markets and insurers. They can then determine the best source of future clients and—referring to the questionnaires, tracking forms and projection worksheets included with the manual—determine how to reach them.

Included are hiring and compensation guidelines, prospect list sources, telemarketing scripts and other sales tools, as well as prospecting letters and a number of tracking forms that monitor the success of the effort.

The Commercial Insurance Telemarketing Guide is $65. For more information, contact Larry Neilson, 23172 Plaza Pointe Drive, Suite 160, Laguna Hills, Calif. 92653; 800-736-9741.

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—By Laura Mazzuca

Agent group joins Alliance for Production Technology

WASHINGTON—In an effort to provide members with single entry, multiple company interface technology, the Independent Insurance Agents of America has joined the Alliance for Production Technology.

That group is a joint venture of several insurance companies and software firms (*A/BT*, Aug. 6, 1990).

The decision was made at the recent annual meeting of the Future One Governing Committee, a panel comprised of IIAA and 28 insurance companies.

However, the action must still be approved by the IIAA's Board of State National Directors, which will meet in September.

The trade group's decision to join the Alliance for Production Technology is a "major step" in implementing the recommendations of the so-called Perot Report, said A. William Bailey Jr., IIAA president.

In a 1990 study, Perot Systems Corp. recommended ways for the industry to achieve single-entry, multiple-user interface (*A/BT*, Jan. 7).

Among the 16 organizations participating in APT are five software firms—Insurnet Inc., Agena Corp., Delphi/McCracken, Redshaw Inc. and CISCO Technologies Inc. as well as Agency Management Services Inc. and Applied Systems Inc., which founded the group last year.

Computer giant International Business Machines Corp. also recently announced its intention to join APT.

As a member of the alliance, the IIAA will hold a seat on the alliance's board of directors and participate on the group's joint producer advisory committee, which will also include representation from the National Assn. of Professional Insurance Agents and the National Assn. of Casualty & Surety Agents.

"Counting (this seat), agents will be assured to having a large hand in APT's decision-making process," Mr. Bailey commented. ■



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Agent/Broker Topics

Experience is ready and waiting

Agents are the insurance industry's best public relations tool

By William T. Hold

ABT perspective

IT HAS BEEN SAID many times before, but the truth always bears repeating: No one knows the insurance customer's needs, feelings and concerns better than America's independent agent, who remains on the front line of public communication as the insurer's strongest and most effective link to the policyholder.

In the face of such an undeniable truth, it is puzzling that the captains of this industry don't invite greater independent agent participation in their quest to restore credibility and improve public understanding of the business.

In all the discussion about how best to achieve this important but elusive goal, one often is left with the impression that the means of attaining it are the sole province of the companies to decide.

Why?

While the movers and shakers in the business continue to seek better ways of communicating directly with policyholders, independent agents have been doing it for years, and doing it quite well.

How else does one explain the survey results that show a more favorable public regard for the agent than for the company or the industry?

If company and association executives were to actively solicit the knowledge and assistance of independent agents, they might gain innovative ideas for more effective communication.

Those executives might also receive some sage advice, though not all of it would be popular.

For example, insurers might be asked to get rid of the old notion that a "common voice" or "designated hitter" who can speak for all of us is the solution to the industry's communications problems.

Such is the chief executive officer's recurring pipe dream, born of frustration whenever times become turbulent.

They might also hear that designated hitters belong on the baseball diamond, not in the insurance business, and that what is required is not one, but infinitely more educated voices explaining insurance to customers in language unencumbered by legalese and technical jargon.

Moreover, they may hear that improved public understanding of the business will not be achieved merely through slick image-advertising campaigns or more expensive public relations programs.

All of that has been tried before, and it hasn't worked well enough to justify the time and money spent. We learned this (didn't we?) from painful experience during the liability crisis of the mid-1980s. And we learned it again in 1988 in California when a plugged nickel would have purchased the result we achieved at a cost of tens of millions of dollars.

Perhaps some surprising questions might be raised as well. Could it be that our problem is really not one of communications? Could it be that our customers actually do comprehend our words but that they simply don't like what we're telling them?

If we're honest with ourselves, don't we have to admit that we already know what our customers want: an available and affordable insurance product, fair and fast settlement of claims, a share of the credit when they have no losses, a halt to the continuing and appalling theft of their premium dollars by malingerers and frauds?

Again, could it be that instead of a communications failure, we are actually confronted with an "expectations gap"—the great difference that seems to exist between what our customers receive and what they expect to receive? In our search for better understanding, shouldn't we focus our efforts more on closing this gap?

Whatever the answers, they will not come so long as the company and independent agent continue to operate at arm's length, or to use only the trade publications to talk to one another.

It is time to work more closely together, and that means reserving a rightful place at the conference table for the independent agent, where, among other things, we might:

- Renew our commitment to deliver and service the insurance product with the highest level of professionalism and public sensitivity.
- Take an introspective look at our basic practices and make the difficult decisions required to change those things that need change.
- Bring informed judgment to bear on lasting solutions to systemic problems.
- Agree to participate in public forums and before the media as educated spokespersons for the business.

No longer is it correct—if it ever was—to consider the independent agent as merely a passenger on someone else's ship.

For years, that's what many of the nation's agents thought of themselves, and what many company executives thought of them.

But times have changed.

While their numbers may have declined slightly in recent years, largely because of market constrictions, America's independent agents today are among the best educated and most experienced this industry has ever known.

Consider the fact that of the 14,000 agents who have earned the Certified Insurance Counselor designation (agents committed to lifelong continuing insurance education):

- 58% have a bachelor's degree.
- 6% hold a master's or doctorate degree.
- 85% have 10 or more years of experience in the insurance business.
- 48% are agency owners.
- 74% are between the ages of 30 and 50, with many more years of service to offer the company and the public alike.

The figures also suggest a growing diversity among agents. Thirty percent (42% of all participants in the CIC educational program) are women, and 11% have the Chartered Property & Casualty Underwriter or Chartered Life Underwriter designation.

Of equal interest is the fact that 16% of the 48,000 active participants in the CIC program are company people.

By accepting our invitation to "meet us at the customer's front door," they recognize the importance not only of keeping informed about the insurance product, but of staying close to the public pulse.

Agents. Are they merely passengers on someone else's ship? Are they passive suppliers and distributors of policies and endorsements?

Hardly.

Captains of the insurance industry would do well to give agents a place at the wheel. They can't afford not to tap into this rich reserve of knowledge.

To search for long-lasting solutions to our problems requires that company and agent come together for a true sharing of ideas and common objectives.

Put it off any longer, and we will all surely miss the boat. ■



William T. Hold is president of the Society of Certified Insurance Counselors in Austin, Texas.

Advertiser Index

Agent/Broker Topics

Issue of August 5

ADVERTISER	PAGE #
ABI Special Risk Inc.	18B
Business Insurance	18F
Environmental & Commercial Insurance Agency	18H
First Nonprofit Trust	18D
Media/Professional Insurance	18C
New Hampshire Insurance Group	18E
Society of C.P.C.U.	18G
Symons International Group	18H

Business Insurance

Trial bar chips away at a defense bulwark

By STACY ADLER

TORONTO—A 3-year-old U.S. Supreme Court ruling that limits the liability of government contractors has become the bane of trial attorneys.

The 1988 ruling in *Boyle vs. United Technologies* "could be the greatest victory ever for defendants," said Joel D. Eaton, a plaintiffs' attorney with Podhurst, Oresk, Josefberg, Eaton, Meadow, Olin & Perwin in Miami.

Mr. Eaton discussed how plaintiffs' lawyers are attempting to get around the ruling during a program at the Assn. of Trial Lawyers of America convention last month.

In its decision, the Supreme Court addressed private contractors that design products for the federal government. Those firms cannot be held liable under state tort laws for accidents caused by defects in the product if they warn the government of any defects they know of and the product meets government specifications (*BI*, July 4, 1988).

"State law is displaced where judgment against the contractor would threaten the discretionary function of the government," said Justice Antonin Scalia, writing for the majority. "State law, which imposes liability for design defects in military equipment, is displaced where:

- "The United States approves reasonably precise specifications.
- "The equipment conformed to those specifications.
- "The supplier warned the United States about dangers in the use of equipment known to the supplier but not to the United States."

While this test would appear to preclude all lawsuits by plaintiffs against government contractors for military products and even some non-military products, it is not a complete shield, explained the plaintiff's lawyer.

"At least a handful of plaintiffs have been successful in arguing that Boyle is not as broad as it would seem," he said.

Mr. Eaton described several exceptions to the government contractor defense that have been carved out by lower courts interpreting the Supreme Court's decision.

For example, the defense does not apply when the government purchases products "off-the-shelf" and has no precise specifications, said Mr. Eaton.

"Boyle does not apply when the government uses only general specifications," he explained.

For example, when the government purchases air conditioners and only specifies cooling capacity, there is no protection for the manufacturer of those air conditioners should they cause injury, said Mr. Eaton.

The defense also does not apply when the government merely gives a "rubber-stamp approval" to design specifications drawn up by contractors, the lawyer said.

In what Mr. Eaton labeled as the most important post-Boyle decision, the 5th U.S. Circuit Court of Appeals held that rubber-stamp approval would not invoke the government contractor defense.

"This adds a subtle wrinkle to the Boyle test," said Mr. Eaton.

To use the defense, "the contractor must prove that the government exercised some discretion in accepting the design specifications," he explained. "If the government delegates its discretion to the contractor, the defense does not apply."

At the time the Supreme Court issued its ruling, many attorneys speculated that the government contractor defense would be applied to product liability cases involving both military and non-military products made for the government.

However, this has not been the case, said Mr. Eaton.

In a recent ruling, the 9th U.S. Circuit Court of Appeals specifically held that the government contractor defense is limited only to military equipment, he said.

"The government contractor defense, for the time being, does not apply to non-military equipment," said Mr. Eaton.

Despite the gains made by plaintiffs in narrowing the government contractor defense, it remains a formidable barrier, he said. In the end, "it is very difficulty to get around this defense," said Mr. Eaton. ■

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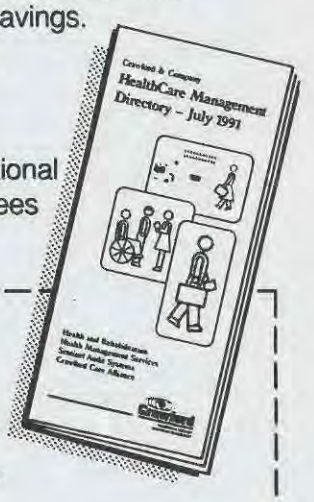
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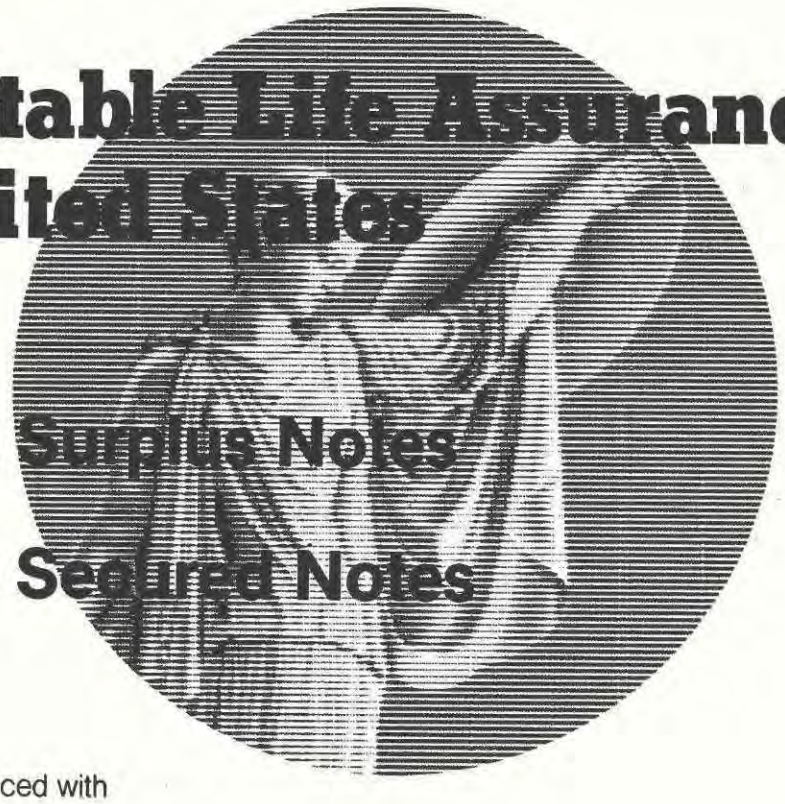
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July 23, 1991

Joint venture companies

Soviet, Western ventures face obstacles of uncertain market

By Douglas N. Smith

MIKHAIL S. GORBACHEV came to the London economic summit seeking direct financial aid in terms of a cash infusion to the Soviet Union's economy. Instead, the Soviet president received promises of technical support.

But support from Western companies has already started. Since joint venture companies were allowed by law in 1988, more than 2,300 have been registered in the Soviet Union. But few of these have actually begun operation because of the uncertainty of operations in the Soviet economy.

Joint ventures, as one may imagine, must overcome the obstacles posed by Soviet bureaucracy—an especially difficult task during this time of great political uncertainty. The current struggle is between the central government and the republics, many of which are striving for greater autonomy. Thus, the potential Soviet partner of any joint venture must obtain approval from the Soviet Union's Council of Ministers as well as the Council of Ministers in the republic in which the operation is to be located. One can imagine that obtaining such approval may be problematic.

Joint ventures that do receive approval must seek to fulfill the following purposes:

- To expand exports and reduce imports.
- To bring advanced technology to the Soviet economy.
- To improve and develop managerial skills and financial resources.

Once a joint venture is approved, its Western managers face a somewhat underdeveloped insurance market. Historically, the Soviet insurance market has consisted of two companies: Gosstrakh and Ingosstrakh.

Gosstrakh, which offers primarily life and personal lines insurance, has a large network of offices throughout the 15 Soviet republics. It also accommodates agricultural risks as well as state and cooperative property. Ingosstrakh provides insurance services to international or internationally related risks like joint venture companies.

But the market is undergoing transformation. The Soviet Union's draft insurance legislation was intended to be completed by early 1991, but the third draft is still under discussion. The balance between central authority and local autonomy has yet to be agreed upon. There is ongoing debate on whether licensing authority will reside with the central regulatory body or will be retained within each republic. And, among other issues, there is debate on which, if any, of the compulsory coverages new insurance companies will be allowed to write. In this vacuum, some republics are not waiting for the central government to act but are introducing their own insurance law. The final resolution will be played out with the larger issues of central authority vs. local control. Insurance will likely follow the outcome.

While the legal and regulatory framework has yet to be finalized, there is some movement to fill the void. Several companies—including American International Group Inc. and Chubb Corp.—have entered into reciprocal agreements with Ingosstrakh for policy issuance for their customers and for the exchange of information and technical assistance. At least one company, Colonia Versicherung A.G. of Germany, is finalizing an equity interest in a fledgling Soviet insurer, Moscow-based Strakhovoe AO Rossiya. Royal Insurance P.L.C. is studying a similar venture with the Promstroybank, one of the Soviet Union's largest domestic banks.

In addition to these moves by Western companies, the Baltic republics already have several insurance joint ventures operating that are usually aligned along mostly traditional cultural lines.

Estonia has three different joint venture companies:

International issues

one involving AIG, one with Trygg Hansa Insurance Group of Sweden, and one with Pohjola Insurance Co. Ltd. of Finland. Latvia has a joint venture involving Baltica Koncemen A.S. of Denmark. The German insurer, Alte Leipziger Versicherung A.G., has a joint venture in Lithuania. Though small, these companies are deemed particularly important because of the higher standard of living in the Baltic republics, and their independent bent seems to be leading the way toward a market economy.

In addition to the formation of joint ventures with Western insurers, some state-owned firms have formed cooperatives for their own insurance needs. These cooperatives are likely to restrict their activities to the needs of their founders and shareholders, but it is interesting to note that even wholly owned Soviet enterprises are finding alternatives. It has even been reported that some Soviet enterprises have sought insurance from outside the Soviet market. The implication has been that market forces that place Soviet enterprises on competitive ground can result in permission from authorities to seek the most cost-effective insurance mechanism.

Gosstrakh and Ingosstrakh are moving to meet the competition, with Ingosstrakh focusing more on domestic insurance. In recognition of the importance of providing quality service, it is seeking to develop a branch office network. Gosstrakh is also responding to the political change by allowing more autonomy at its local offices. In some republics, branch offices have even seceded from the central authority.

Despite this activity, the insurance market remains in a formative state. Not all officials believe the market is sufficiently mature for the transformations that are taking place. One Ingosstrakh official was recently quoted as saying that it was "too early for foreign companies to enter a market which does not exist." Other officials have noted that without firm regulatory actions, the market will see new companies that have very little expertise and will operate under their own financial guidelines. This can be disastrous in the long run, and according to one official, "the important thing now is to speed up the adoption of the new insurance law and supervisory body." In the interim, Gosstrakh may be designated as an interim supervisory body.

For Western risk managers, this fluid state of affairs can seem disconcerting, but if they follow standard procedures of past insurance activities while monitoring current developments, they may minimize—if not avoid—future difficulty.

Currently, joint venture assets are required to be covered with compulsory insurance placed with the Ingosstrakh. These coverages include:

- Property damage (which normally includes business interruption).
- Agricultural insurance.
- State social security insurance.

Interestingly, third-party auto liability insurance is not required by Soviet law.

Non-admitted insurance is allowed for non-compulsory lines. Although construction and erection insurance is compulsory, it can be placed outside the Soviet market. However, it is prudent to include specific provisions in the joint venture agreements that allow placement of insurance with Western companies on a non-admitted basis.

Policies covering joint venture companies can be based in rubles or in Western currency. Under this practice, premium payments must reflect the currency on which indemnity under the policy will be paid. It is always prudent to insure imported equipment in Western currency so that limits will be insulated from currency fluctuations and devaluations.

Fire policies provide cover for the following perils:

- Fire, lightning and explosion.
- Flood, bursting of pipes, storm hail and vehicle damage.
- Burglary and robbery.
- Vandalism.
- Strikes, riots and civil commotion.

Fire policies are rated in accordance with a tariff that, in general, conforms to international market standards.

One point of interest is the rating of plate glass, which Ingosstrakh seems to consider particularly risky. Rates may be 2% to 3% of the insured value.

Business interruption policies follow the same perils as fire policies with the exception of strikes, riots and civil commotion. Risk managers should look carefully at their business interruption exposures and take a jaundiced view of the indemnity period. Given the well-publicized supply deficiencies of the Soviet economy, periods of interruption may be longer than would be readily apparent.

Concurrent with the business interruption exposure, which may be caused by physical damage to the joint venture itself, risk managers should think about interruptions caused in the supply chain. The Western press periodically reports inter-republic disputes causing disruptions in the supply chain. Risk managers would be well advised to plan adequately for these situations, either through alternative suppliers, insurance (if possible) or other risk management techniques.

The liability issues within the Soviet Union are in nascent form as well. There is a lower liability exposure due to the absence of juries, the lack of strict liability and the fact that there is no provision for pain and suffering in tort liability. Policy forms resemble the standard general third-party liability forms available in the United States. Rating, however, is based on the payroll rather than on turnover. Employers liability policies are also available and are rated in accordance with the total annual social insurance contribution.

Risk managers, however, should take particular care in ensuring that suits brought in the United States for occurrences in the Soviet Union are provided for in their liability program.

Ingosstrakh is the official insurer designated for international risks. As such, it can and will reinsure companies outside the Soviet Union. There are few regulations regarding such cessions, which in general conform to practices—like payment of ceding commissions—found in most countries. Reinsurance can be facultative and structured on a proportional, non-proportional or excess-of-loss basis.

The move to develop the Soviet economy may come at a quicker pace following the economic summit. It is clear that the Western nations are not likely to offer any direct financial assistance in the near future. One course of action the Soviet Union could take is to foster a climate that facilitates Western private investment. It remains to be seen whether the Soviet Union can overcome international problems, differences between republics and its own cumbersome bureaucracy.

As Western investment increases, pressure is likely to force change within the Soviet insurance market. There will remain a shortage of capacity, underwriting expertise and local talent for account servicing. Therefore, to the extent possible, risk managers will ultimately have to rely on placements through Western insurers. ■



Douglas N. Smith is vp and manager of the International Department of Johnson & Higgins in New York. His column appears the first Monday of every month.

ASK A BENEFITS ACTUARY

Profit-sharing plan won't oust defined benefit plans

Q **I've heard of a new type of employee benefit plan that may put actuaries out of business: the age-weighted profit-sharing plan. What are its features?**

A The client who asked me this question really knows how to get my attention.

I asked innocently enough what he meant by "putting actuaries out of business." He told me he had heard that age-weighted profit-sharing plans would soon be replacing defined benefit plans.

An age-weighted profit-sharing plan is like any other profit-sharing plan, except that a participant's contribution varies by age, giving older employees a greater company contribution. If a plan sponsor wanted to duplicate the benefits provided by a defined benefit pension plan with an age-weighted profit-sharing plan, the plan sponsor could determine the annual contribution for a participant to the profit-sharing plan as the present value of the benefit which the participant would have accrued under the defined benefit pension plan for that year. For example, if the defined benefit pension plan being replaced provides a lifetime benefit commencing at age 65 of $20 per month per year of service, the plan sponsor might make a contribution of $1,967 on behalf of a 65-year-old employee. The contribution would be $287 for a 40-year-old employee and $91 for a 25-year-old employee. (These amounts assume interest at 8% per year and use the 1984 unisex pension mortality table.)

An obvious concern with this sort of skewing of contributions is whether the plan will meet the non-discrimination requirements of Internal Revenue Code Section 401(a)(4). In general, this portion of the code precludes a qualified retirement plan from discriminating in favor of highly compensated employees with respect to either benefits or contributions provided by the plan.

An age-weighted profit-sharing plan can be designed to meet these requirements if the plan is tested under the proposed regulation for IRC Section 401(a)(4), using the general test, and testing on a benefits basis.

The general test requires that either the benefit or contribution amounts provided to any highly compensated employee during the year not exceed the benefit or contribution provided to any non-highly compensated employee. In lieu of benefit or contribution amounts, benefits or contributions as a percentage of pay can be used in the test. This test is performed by converting the contribution made during the year on behalf of each participant to a benefit commencing at some retirement age, and then determining if the benefit for any highly compensated employee exceeds the benefit for any non-highly compensated employee. If not, the plan passes the test.

If we design an age-weighted profit-sharing plan to replicate the benefits of a defined benefit pension plan and meet the general test described above, the key design considerations for an age-weighted profit-sharing plan are as follows:

- The actuarial basis (mortality and interest assumptions) used in the non-discrimination test and in the determination of the profit-sharing contribution should be the same. For the non-discrimination test, the proposed regulation specifies certain common mortality tables and an interest rate ranging from 7.5% to 8.5% per year.
- The retirement age used for converting the profit-sharing contribution to a benefit for the non-discrimination test should be the same age that is used in determining the profit-sharing contribution (age 65 in the above example).
- The benefit used in determining the contribution ($20 per month per year of service in the example) should be the same for all employees, or should be the same percentage of pay. Because of this constraint, an age-weighted profit-sharing plan can easily duplicate the benefits of a career average pension plan, or a pension plan providing a flat dollar amount per month per year of service.

However, because the benefit accrued under a final average pay defined benefit pension plan in a year is not the same amount of percentage of pay for all plan participants, an age-weighted profit-sharing plan cannot duplicate the benefits of a final average pay plan easily and effectively.

My client was quick to point out the advantages of the age-weighted profit-sharing plan over a defined benefit pension plan:

- There are no minimum funding requirements for profit-sharing plans like there are for defined benefit plans. Consequently, the plan sponsor has year-to-year discretion regarding its contribution.
- There are no actuarial fees. However, I pointed out to the client that there would be account record-keeping fees.
- There would be no Pension Benefit Guaranty Corp. premiums due.

I explained that there are some disadvantages to an age-weighted profit-sharing plan:

- A defined benefit pension plan (career average or dollar-per-month plan) can be amended to provide increases in benefits for past years of service. It is very difficult with an age-weighted plan to duplicate these benefit increase for prior years of service.
- Because of the skewing of contributions by age, it is possible for a non-highly compensated older employee to run afoul of the IRC Section 415 limits—which limit the maximum benefits that can be funded through a defined benefit pension plan and the maximum contributions that may be made to a defined contribution pension plan. This problem is exacerbated if there is another defined contribution pension plan already in place, like a 401(k) plan or an employee stock ownership plan. The IRC Section 415 limits could create problems for the age-weighted plan meeting the non-discrimination requirements. In addition, non-highly compensated employees might cut back on their 401(k) contributions in order to avoid having the IRC Section 415 limits applied against the profit-sharing plan contributions. This cutback in 401(k) contributions could create problems in passing the actual deferral percentage non-discrimination test for the 401(k) plan.
- For the same level of benefits, most companies will find that the age-weighted profit-sharing plan results in greater company contributions than does the defined benefit pension plan. For example, if we compare the company cost for a defined benefit pension plan that provides the $20 per month per year of service benefit with the cost for the analogous age-weighted profit-sharing plan, most companies would find the profit- sharing plan to be more costly. This is so because most companies are able to invest their contributions and earn more than the 7.5% to 8.5% interest assumption which would be used in the age weighted profit-sharing plan. These excess investment earnings reduce the company cost for the plan.

My client expressed disappointment, whether from learning of the new plan's disadvantages or from his inability to throw me into a panic over losing his business. However, we concluded that the idea might have some application for replacing a flat-dollar defined benefit pension plan when the plan sponsor did not want to give benefit increases for past service. ■

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



Mr. Miner

This month's column on actuarial issues in the benefits field is written by William J. Miner, an actuary with The Wyatt Co. in Chicago. Richard E. Sherman, a principal with Coopers & Lybrand in San Francisco, answers actuarial questions in the casualty field. Susan M. Werner, director of risk management at Hardee's Food Systems Inc. in Rocky Mount, N.C., answers risk management questions. Dennis J. Nirtaut, manager of employee benefits at Continental Bank Corp. in Chicago, answers questions on employee benefit plans. Mr. Miner's and Mr. Sherman's columns appear alternately on the first Monday of each month. Ms. Werner's and Mr. Nirtaut's columns appear alternately on the second Monday of each month. Mr. Miner'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.

Awards banquet attendee keeps comp benefit

A worker was within the course of his employment at the time of an injury which occurred while he was attending a company awards banquet, according to a Louisiana appellate court.

Horace Hanks, an employee of Grey Wolf Drilling Co., injured his wrist in 1986 while changing a valve on a pump. As a result of this employment-related injury, he was awarded workers compensation benefits. During his convalescence,

Legal briefs

Mr. Hanks was invited to a company awards banquet at which he was recognized for five years of service.

At the club where the banquet was held, Mr. Hanks slipped and fell, injuring his back. Several days after the banquet, his compensation benefits for the wrist injury were cut off, and coverage for the club incident was denied. Mr. Hanks filed a suit seeking benefits but lost in the trial court.

The appellate court concluded that Mr. Hanks, though temporarily absent from his employment duties, was an employee of Grey Wolf at the time of his accident at the banquet. "Had it not been for Hanks' employment with Grey Wolf, he would not have been invited to the awards banquet," the court observed.

The trial court decision was reversed.

Hanks vs. Grey Wolf Drilling Co., Court of Appeal of Louisiana, Feb. 6, 1991 (*BI*/05/S.-$10).

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

Benefits survey

Continued from page 3

13% did so in 1990.

In addition, 26% of employers say they will increase employee out-of-pocket maximums, compared with 11% that did so last year.

Thirty-nine percent of the employers said they will introduce or increase employee contributions to health care plans, while only 13% did so in 1990. And, 49% plan to introduce or increase dependent contributions, compared with 18% who did so last year.

Mr. Anthony explained one reason for the embrace of cost-shifting: "(Employers) have been reluctant until recently to share a certain percentage of health care costs with their employees. They are now finding out they have two alternatives—either cut benefits or share the costs."

In some focus groups and surveys, Alexander Consulting Group has found that employees want the option of either paying more or having their benefits cut, Mr. Anthony noted. Some surveys also indicate that they "prefer cost sharing over benefit cutbacks," he said.

Most employers—84%—have some sort of utilization review program in place, the survey revealed. And most employers that have such programs believe they are saving money—though the confidence level varies by approach and region.

For example, 79% of Southern respondents believe hospital concurrent review curbs costs, but only 56% of Western organizations agreed.

Larger companies appear more confident of the savings associated with hospital precertification: 87% of those with more than 2,000 employees feel it yields savings, compared with 70% of all respondents. Larger companies also reported that hospital concurrent review, discharge planning and large-case management programs save money.

Altogether, 75% of employers said large case management saved money, compared with 70% for hospital precertification, 65% for concurrent review and 60% for hospital pre-admission savings.

Yet only 41% of respondents feel second surgical opinion programs yield savings, the survey noted.

In addition, "a wide gap exists between the perceived financial advantages of HMOs vs. PPOs," the survey authors note. Only 47% of respondents indicate that HMOs save money, while the comparable figure for PPOs is 70%.

"While 66% of the respondents offer employer HMOs, one-third of these do not believe the HMO program provides cost savings and another 20% are undecided," pointed out Ed Freedman, managing director of Alexander Consulting Group's national health and welfare practice in Lyndhurst, N.J. "For such a pervasive health care option, these are disturbing results."

Again, regional variations appeared: 55% of Western respondents have confidence in HMOs, compared with 40% of those in the Northeast.

One reason for such disparities may be that managed care networks are more developed in the Western and Central regions. For example, PPOs are two to three times more common in the West—where 81% of employers offer them—than in any other region, the survey authors note.

Flexible benefit plans remain popular, though tax savings are becoming less of a factor in setting up the plans. Only 22% of respondents said tax savings was a very important reason for implementing a flex plan. In comparison, 55% cited meeting diverse workforce needs and 58% cited managing health care costs.

But, employers are confident that flex plans work, the survey found. Seventy-eight percent said they believe their flexible benefits program is accomplishing its objectives. The remaining 22%, however, said they "don't know" whether the flex plan is meeting objectives.

More employers are recognizing employee needs when designing flex programs, the survey authors said. More than half—54%—of respondents actively sought employee input while developing programs, most frequently using surveys and focus groups.

Most employers—69%—use internal resources to help design and implement their programs, the survey reported. Fifty-eight percent used outside consultants and 10% use insurance companies. Some companies gave more than one response.

Size was a key indicator of whether a company would go it alone: Plan sponsors with fewer than 500 employees are more likely to use only in-house resources, the survey noted.

In addition, 65% of employers administer their flex programs in-house, the study found. Thirty-five percent use a third-party administrator and 25% use an insurance company. Again, some companies gave more than one response.

Only 25% of companies reported having to hire additional staff to administer a flex program.

The programs have become easier to administer, though not easy enough for some employers, the survey authors say. "Of the 83% of companies not currently offering a flex package, 61% are not considering flex because of their concern for the complexity and administrative expense."

Sixty-six percent of respondents offer health promotion programs, according to the survey. The most common features are first-aid training, smoking cessation classes, high blood pressure screening, cholesterol testing and stress management training.

Employee relations is the most common reason employers implement wellness programs—cited by 83% of companies. Fifty-one percent cited health care cost containment.

Employee assistance programs are becoming more commonplace, the survey found. Fifty-three percent of respondents offer EAPs, with large employers more likely to have them than mid-size or small companies. Seventy-one percent of companies with more than 2,000 employers have an EAP, compared with 49% of firms with fewer than 2,000 workers.

The most common services provided through EAPs are chemical dependency counseling, psychiatric treatment, family or marital counseling and financial counseling, the survey reported.

Most employers with EAPs—91%—offer assessment and referral services through them, and 75% offer short-term counseling.

Most EAPs are not linked to a managed mental health program, the survey reported. Only 22% reported such a link. In practice, however, "we are seeing more appropriate and functional linkages between EAPs and mental health programs," noted Dr. Mick McGarvey, managing director of the Alexander Consulting Group's health strategies group.

In addition, most employers do not currently "carve out" mental health care benefits and manage them separately, the survey found. Ninety-five percent of respondents instead offer mental health benefits through major medical plans.

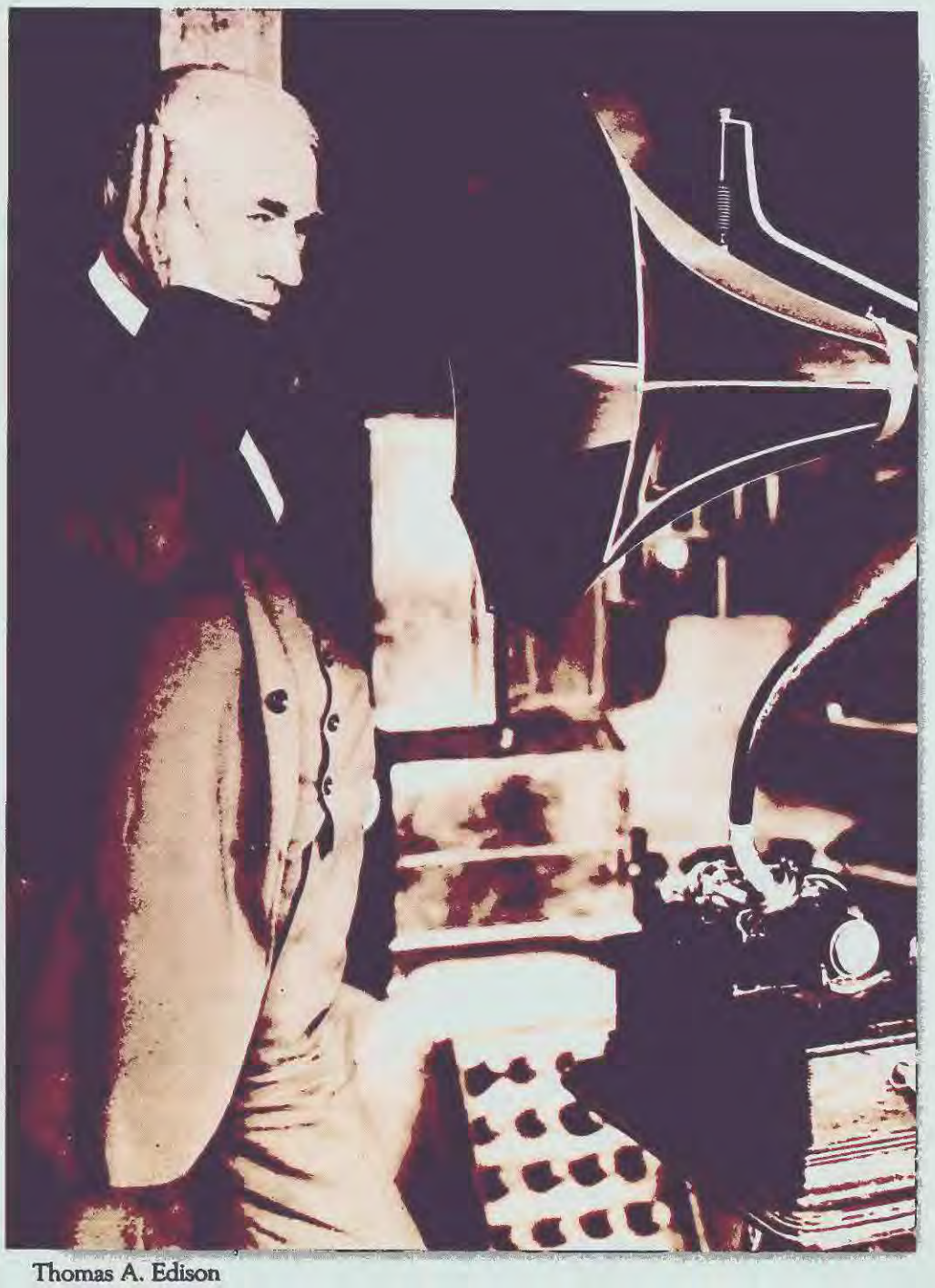
Employers are somewhat split over whether or not EAPs save money, the survey noted. While 53% believe they do control costs, 11% disagree and 36% don't know, the survey found.

In addition, the survey found:

- Only 1% of respondents introduced retiree medical coverage in 1990 or 1991. In that same period, 40% of employers that provide retiree medical have increased retiree contributions.
- Paternity leave programs are offered by 28% of the surveyed companies. Only 6% provide on-site or near-site child care facilities. Some form of elder care leave is provided by 17% of respondents.

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For a copy of "Benefits Survey 1991," call Judy Wilson at Alexander Consulting Group Inc. in San Jose, Calif., at 408-954-0900. The complete survey costs $395.



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Bad-faith ruling

Continued from page 1

in San Diego ruled July 18 in *Weiner vs. Fireman's Fund Insurance Cos.* that insurers that delay payment of valid third-party claims may be guilty of outrageous conduct and liable for tort damages. The decision stemmed from an October 1986 accident in which Herman Weiner, a paralyzed man, was injured.

Mr. Weiner died in the summer of 1987 from injuries he sustained when his wheelchair fell backward while he was being moved onto a bus ramp by an employee of transportation company D.M. Summers Inc. of San Diego.

The Weiner family had filed a claim with Summers in November 1986 for Mr. Weiner's personal injuries. After Mr. Weiner died, the family sued for wrongful death.

Summers was insured for $750,000 under a commercial general liability policy underwritten by Fireman's Fund of Novato, Calif.

The insurer offered to settle the claim in the summer of 1988 for $105,000—an amount less than the $114,000 the family had paid in medical expenses for Mr. Weiner's injuries before he died. Mr. Weiner's family rejected the offer. The insurer doubled the offer two months later but that, too, was rejected.

Ultimately, the case went to trial in the San Diego County Superior Court, and a jury in November 1988 awarded the Weiners $650,000 in compensatory damages after finding that the transportation company was liable for the injuries and complications that caused his death.

During the trial, it was revealed that a D.M. Summers employee responsible for Mr. Weiner's safety had failed to engage the wheelchair's anti-tipping device, which would have prevented the accident.

Fireman's Fund had contended that its policyholder was not at fault because the accident was caused by a defective screen door or that Mr. Weiner could have prevented the accident.

While the Weiner family won compensatory damages, the trial court judge ruled that the family did not have a cause of action under Section 790.03 of the California Insurance Code, which allows policyholders to seek bad-faith damages from their insurers. Therefore, the family was not entitled to bad-faith damages from Fireman's Fund, the judge concluded.

The appellate court, however, remanded the plaintiff's cause of action alleging intentional infliction of emotional distress to the Superior Court, finding that the Weiner family could sue Fireman's Fund under tort law.

Citing the landmark 1988 ruling in *Moradi-Shalal vs. Fireman's Fund Insurance Cos.*, which barred third-party bad-faith lawsuits against insurers brought under the state insurance code (*BI*, Aug. 22, 1988), the court said that a third-party claimant may be permitted to sue an insurer under the state's tort laws "under appropriate circumstances."

"A third-party claimant might state a cause of action against an insurer for intentional infliction of emotional distress arising out of the handling of a claim," the court said.

For example, a third party may have a cause of action if an insurer acts "intentionally or unreasonably with the recognition that the acts are likely to result in illness through mental distress," the appellate court said.

Such outrageous conduct must be "so extreme as to exceed all bounds of that usually tolerated in a civilized society," the court added.

In this case, the court commented that Fireman's Fund had ignored repeated requests for partial payment to the Weiners to ease their financial burden. The financial strain was clearly evident because Mr. Weiner's wife and one of the couple's sons also were confined to wheelchairs, the appellate court said.

However, attorneys connected with the case do not believe the Weiner decision will have a broad impact.

"Rumors of the death of Moradi-Shalal are greatly exaggerated," said Bob Buckley, an in-house attorney for Fireman's Fund. "This action does not plead a cause of action that is barred by Moradi. This complaint is for intentional infliction of emotional distress."

Mark J. Speck, the plaintiffs' attorney in the case with Rosenberg, Shpall & Speck in San Diego, agreed that the ruling is consistent with Moradi. The ruling in the Weiner case permits third parties to pursue claims "in real special circumstances," he said.

While no cause of action is permitted under the California Insurance Code, third parties may pursue bad-faith claims if insurers are found guilty of common tort law, he explained.

Other lawyers concur that the decision's impact will be limited.

The appellate court in the Weiner decision "just recognizes other theories of law that the Supreme Court already recognized under Moradi-Shalal," said Harvey Levine, a partner in the San Diego firm of Levine, Steinberg & DePasquale. The court recognized that there are "other recognized theories of tort liability which might exist for certain insurance company practices," he said.

Leonard Sacks, an Encino attorney in private practice who specializes in bad-faith cases on behalf of plaintiffs, predicted there was "a 90% chance" that the California Supreme Court will decertify the opinion.

"I don't think that what they said here constitutes infliction of emotional distress," a tort, he said.

He also pointed out that two earlier decisions that appeared to circumvent the Moradi rule have since been decertified by the high court and no longer can be cited as precedent.

Beatty vs. State Farm Mutual Automobile Insurance Co., an Aug. 22, 1989, appellate court ruling that a plaintiff may sue a defendant's insurer for unfair business practices under the Business and Professional Code for improperly handling a claim, was decertified on Nov. 16, 1989 (*BI*, Sept. 11, 1990).

And, more recently, a June 5, 1990, decision in *Moukalled vs. Fire Insurance Exchange* that insurers may be sued for intentional infliction of emotional distress was decertified on Aug. 23, 1990.

But, at least one attorney fears that the Weiner decision will open the door to a new wave of third-party bad-faith actions against insurers.

The Weiner decision "creates an exception to Moradi-Shalal that threatens to gobble up the rule," said insurer attorney Royal Oakes of Barger & Wolen in Los Angeles.

"The case could have a dramatic impact on bad faith law because the concept of emotional distress is so vague and so easily asserted that this decision virtually overturns Moradi-Shalal," Mr. Oakes said.

While "Moradi-Shalal contained an off-hand reference to the fact that third parties may sue insurers on common law theories, that hardly supports the conclusion that a sufficient relationship exists between an insurer and a third party to justify an emotional distress claim," he said.

"Weiner conveniently ignores the long grasp of its reasoning," Mr. Oakes said, referring to the court's decision in Moradi. "If intentional infliction of emotional distress may be asserted, why not negligent infliction? If third parties may sue, why not creditors of an insured, who hope for a policy benefit to find its way into their pockets?"

But even if the Weiner decision goes the way of Beatty and Moukalled, the fact that the court is hearing such cases is an indication that certain insurance company claims handling practices should not be permitted, Mr. Levine said.

Fireman's Fund has not decided whether to appeal the decision to the state Supreme Court, Mr. Buckley said. ■



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INTERNATIONAL

Regulator begins Aneco windup

By ROGER SCOTTON

BERMUDA

HAMILTON, Bermuda—Registrar of Companies Malcolm Butterfield has begun winding-up proceedings against Aneco Reinsurance Underwriting Ltd., formerly Bermuda's largest reinsurer of captive companies.

Mr. Butterfield, who has declined to comment on the action, filed his petition July 16 under Section 35 of the island's Insurance Act.

This section allows the regulator to begin winding-up proceedings on the grounds that an insurer is unable either to pay its debts, satisfy a legal obligation under the act or produce statutory financial statements.

Section 35 also empowers the minister of finance to direct the registrar to petition for an insurer's winding up if he considers such an action "expedient in the public interest."

The registrar's is the second move of its kind against Aneco (*BI*, June 10), which has been running off its business since September 1990 when its president, Jonathan Crawley, left to form a rival reinsurer. This move follows a petition started last month by Bermuda-based Mutual Indemnity Ltd., one of three companies in the Insurance Profit Center rent-a-captive program, which is also seeking the winding up of Aneco.

Aneco is the last active unit of a group of Bermuda companies controlled by controversial businessman Mark Hardy. Two other Hardy enterprises—Forum Reinsurance Co Ltd., a financial reinsurance specialist, and Focus Insurance Co. Ltd.—are already in court-ordered liquidation (*BI*, March 18).

Industry sources in Bermuda say the latest action by the registrar may have been triggered by concern over the financial strength of Aneco's principal reinsurer, Channel Reinsurance Co. Ltd. That Turks & Caicos-based company is also controlled by Mr. Hardy.

According to an affidavit filed in the Supreme Court this year by David Lines, the Focus liquidator, Channel replaced Forum as Focus' reinsurer (*BI*, Jan. 28). Mr. Lines served a demand notice of $4.4 million on Channel and said later that, under the terms of an agreement with Channel, Focus stands to recover $21 million from the Turks & Caicos company and retrocessionaires (*BI*, April 29).

Mr. Hardy, who could not be reached for comment, has repeatedly insisted that Channel will meet its obligations as they fall due, but not before.

Since April, Aneco has been operating under the terms of a Section 32 Direction, an Insurance Act order that effectively placed Aneco under the supervision of Bermudian insurance authorities. Section 32 is used when there is a risk of insolvency. It restricts an insurer's ability to transact business and vary its contracts and requires that it keep certain specified assets within the jurisdiction of Bermuda in the custody of a local bank.

Aneco President Peter Wilson,

Continued on page 29

Captives key to global program

Many uses possible, insurer says

By GAVIN SOUTER

DUBLIN, Ireland—Already part of the risk manager's defense against losses, captive insurers, if used wisely, can become the cornerstone of a worldwide insurance program, an insurer suggests.

Captives also cut costs and provide consistency of coverage, he said.

At their most basic, captives can provide advantages by creating a single deductible for a multinational company and, at their most advanced levels, they provide a secure base from which to conduct business, adds Kenneth Davey, regional vp and international sales manager for Arkwright Mutual Insurance Co. in Waltham, Mass.

Profit is not really the central purpose of captives, Mr. Davey said at the 1991 International Risk Management Symposium in Dublin.

"Captives are indeed insurance companies, but their fundamental objective is not so much to make money—as is the case with conventional insurance companies—but rather to provide a focal point for risk control and the whole risk management program."

This is particularly true for decentralized, multinational companies, because it allows them to retain risks of the whole corporation, including those of individual subsidiaries that would normally handle their own insurance pro-

Continued on next page



AP/Wide World Photos

The O'Connell Street Bridge is a landmark in Dublin, site of the 1991 International Risk Management Symposium.

Environmental cleanups gain attention

By GAVIN SOUTER

DUBLIN, Ireland—Concern for the environment has become a critical concern for industries worldwide, according to an environmental consultant.

After centuries of ignorance and inertia, the huge costs of cleaning up the environment are falling heavily on the present generation, he said. And both government authorities and the public are demanding careful planning.

These problems will not go away, and it is cheaper to deal with them sooner rather than later, said Alistair Clark, assistant general manager-Europe at Dames & Moore International, a unit of consultant Dames & Moore of Los Angeles.

"Environmental impairment issues are becoming of increasing concern not only for industry in the United States but also in Europe and the rest of the world," Mr. Clark said here last month at a risk management symposium sponsored by Arkwright Mutual Insurance Co.

Every company involved in real estate transactions must now ask detailed questions about pollution. Among these, he said, are: Is the facility located in an environmentally sensitive area? Does the facility handle harmful chemicals in a secure manner? Does it have underground storage tanks? And, what happened at the facility in the past?

"Clearly, pro-active environmental risk management offers industry clear advantages in limiting financial exposures as a result of property transactions and related industrial operations," Mr. Clark said.

These advantages are:

- Reduction of future environmental liabilities.
- Prioritized and phased environmental capital expenditures.
- Positive public relations.
- Identification of waste minimization opportunities.

But the cost of these projects, Mr. Clark warned, can be huge.

As an example he cited an unidentified U.S. manufacturer with a facility in The Netherlands that used harmful solvents. Cleaning up

Continued on next page

Ingosstrakh planning big hike in capital

By MARIA KIELMAS

MOSCOW—Ingosstrakh, the Soviet Union's international insurer, is planning to increase its share capital to 755 million rubles from 100 million rubles to meet expected demand for coverage for international risks in the Soviet Union, says Chairman Mikhail Safronov.

However, it may take some time —possibly the remainder of the year—to boost that capital, Mr. Safronov said. "We believe in being quite selective in looking for acceptable new shareholders."

Currently, Ingosstrakh shareholders include banks, such as the Soviet foreign trade bank Vneshekonbank; foreign trade organizations like the Soviet tourism agency Intourist; shipping companies; and other industrial groups.

The Soviet Ministry of Finance now holds more than half of Ingosstrakh's shares, but this ownership will be diluted "because we have had so much demand for our shares from other organizations," Mr. Safronov said.

As the Soviet economy evolves into a Western-style system, more organizations will be formed that will look for vehicles in which to invest their money. Ingosstrakh

Continued on page 29

Insurers modify nuclear war risk clause

By GAVIN SOUTER

LONDON—Aviation liability war risk underwriters have agreed on a new policy wording that extends coverage after the detonation of a nuclear weapon.

The new policy wording also will be extended to include hull risks "in due course," according to Peter Hubert, chairman of Lloyd's Aviation Underwriters Assn.

Currently, aviation war risk coverage is automatically terminated when a nuclear weapon is detonated anywhere in the world.

Under the new liability policy wording, aircraft in the air when a nuclear weapon is detonated will retain their war risk coverage until they land.

"Under the old wording, coverage ceased immediately after a detonation, which meant that an aircraft could lose its coverage in midair. This made sense years ago when the exclusion was first included, because the only countries with nuclear weapons were major powers and any detonation could easily have led to Armageddon," Mr. Hubert said.

However, modern tactical nuclear weapons can be confined to one battlefield, so it is now inappropriate to have a worldwide exclusion, explained Mr. Hubert.

The first-landing extension was agreed by the Aviation War Risk Review Body, which was established in June to review aviation war risk coverage in the aftermath of the Persian Gulf War (*BI*, May 27).

Brokers had feared that nuclear weapons would be used in that war, forcing cancellation of war risk coverage worldwide. Some brokers set up facilities that would automatically reinstate coverage—at lower limits—if nuclear weapons were detonated.

The aviation coverage review body is chaired by Anthony Pinsent, chairman of Leslie & Godwin Ltd. Other members include three Lloyd's aviation underwriters: Tim Salmon, underwriter for syndicate 48, managed by Methuen (Lloyd's Underwriting Agents) Ltd.; Brian Beagley, underwriter for syndicate 960, managed by Sturge Aviation Syndicate Management Ltd.; and John Wescott, deputy chairman of the Lloyd's technical clauses committee.

The company market representatives on the aviation coverage review body are: Graham Nichols, chairman of the Aviation Insurance Offices Assn.; Roger Parrish, senior assistant aviation underwriter for The Orion Insurance Co. P.L.C.; and Graham Lilley, underwriter with the British Aviation Insurance Group.

Brokers are represented by Mr. Pinsent and Peter Viccars, executive director at C.T. Bowring & Co. Ltd.

While discussions are still being held with aviation hull war risk underwriters, the extension will be included in hull policies "in due course," Mr. Hubert said.

In another move related to the aviation insurance market, Lloyd's aviation syndicates 580 and 942 will merge on Jan. 1. Both syndicates are managed by Cuthbert Heath Underwriting Ltd.

Syndicate 580 was formerly managed by Lambert Brothers (Underwriting Agencies) Ltd., but Lambert Brothers was acquired by Heath earlier this year.

Syndicate 942 has a capacity of 20 million pounds ($33.6 million at current exchange rates), while syndicate 580 has a capacity of 5 million pounds ($8.4 million).

Tony Avery, underwriter for syndicate 942, will be the underwriter for the combined syndicate.

Also, aviation syndicate 312, managed by Merrett Underwriting Agency Management Ltd., has stopped underwriting airline business due to poor profitability, said Dennis Purkiss, managing director of the underwriting division. The syndicate has a capacity of 9.8 million pounds ($16.5 million).

The syndicate will continue to underwrite general aviation business, Mr. Purkiss said. ■

INTERNATIONAL

Captives

Continued from previous page

gram, Mr. Davey said.

"By retaining more risk, the captive can, if properly set up, reduce the cost of risk transfer," he said.

Captives also reduce the basic costs of obtaining coverage and reduce the cost of purchasing catastrophe coverage through economies of scale, the Arkwright executive said.

"As the market turns, a well-capitalized captive can provide an excellent defensive weapon to ensure consistency of cover and price by filling in the gaps in a program left open by carriers reducing cover or capacity," he asserted.

Captives can be used once a company moves beyond a fragmented approach with separate policies for separate locations or individual subsidiaries, Mr. Davey said.

Captives first come into use as a method for funding local deductibles, he said.

"While this arrangement can allow for access to reinsurance markets, it still is basically made up of a number of local policies providing limited coverage," Mr. Davey said.

Next, companies can, through captives, adopt a consistent worldwide wording, which will cut costs.

The program can be taken a step further by using offshore reinsurance vehicles, Mr. Davey said.

The final stage in captive development is the "all-lines aggregate protected self-insurance" approach, Mr. Davey said. This provides a layer of cover across all classes of business below existing specialist lines of protection. Traditional insurers provide catastrophe coverage, he explained.

"For many large commercial and industrial groups with assets in excess of those of the insurance companies from which they buy insurance, this can make sense," Mr. Davey asserted.

In essence, this program would use the insurance market to ensure that catastrophes do not undermine the stability of a company's main business, he added.

This way, the captive can issue policies directly and retain a specific layer across all lines with an aggregate set slightly above annual expected losses, Mr. Davey said.

Above the captive's retention, a single reinsurer provides coverage across all lines. If the captive's aggregate retention for all lines is exhausted within a policy period, the reinsurer drops down and replaces the captive for the remainder of the policy period, he said.

Catastrophic coverages is written above the second layer.

Under this method, a single deductible can be applied even though a loss may spread over a number of lines of insurance, Mr. Davey said.

This approach "allows the captive to write long-tail business in a way that provides stability and predictability, without which the captive might be precluded from these classes of business," he added.

Although not suitable for all companies, this type of program provides excellent coverage for multinational corporations with a broad spread of risks, he said.

"For the risk manager of a highly decentralized corporation, it enables programs to be designed to suit the needs of an individual operating company as well as the wider needs of the total corporation. It provides a high degree of flexibility and control over an otherwise difficult-to-control area of activity," he said. ■

Cleanup costs

Continued from previous page

the site has cost $8.2 million to date, and the project is only one-quarter complete, he said. The company had no choice but to foot the bill, since the cleanup had been ordered by the local authorities, he added.

Environmental risk management itself consists of three basic steps, he said—identification, evaluation and control.

A study of background information, including aerial photographs when available, opens the identification phase. This is followed by a site inspection, a regulatory compliance evaluation and, finally, data assessment and reporting.

Next comes an evaluation of potential environmental exposures, Mr. Clark said. This process includes stock testing, soil and groundwater investigations, wastewater sampling and asbestos sampling.

The evaluation can act as a "contractual baseline" for the site conditions at the time of a property transfer, Mr. Clark said. "This can protect the liability of the buyer if appropriate indemnifications have been negotiated with the vendor."

The control phase begins with improving environmental security measures at the facility, Mr. Clark said.

"For example, if it has underground storage tanks, you should either make them more secure or use another storage facility, like aboveground tanks, which are far easier to monitor," he said.

It will also be necessary to clean up any soil or water pollution that has already occurred, he added.

To help prevent future pollution, managers should take an active role in preventing spills and leaks, he said. Apart from savings realized by dealing with a problem before it worsens, this approach can also save money by minimizing the loss of materials.

"Although environmental impairment issues are of growing concern to industry and a growing financial challenge, a pro-active response can

Continued on next page

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Advertiser Index

Issue of August 5

Advertiser	Page #
Acceptance Insurance Group	23
Aetna Life & Casualty	6-7
Affiliated FM/Appalachian	16-17
Argonaut Insurance Company	9
ARM International	18
Business Insurance	26
CIGNA	34
Continental Insurance	12
Cover X	27
Crawford & Company	19
Donaldson Lufkin & Jenrette	20
Evandale Publishing Ltd.	27
Goldman, Sachs & Co.	4
Industrial Risk Insurers	30
ITT/Hartford Insurance Co.	24
Revco Drug Plans	13/15
Travelers Insurance Co.	10-11
Travis Software	18
Wausau Insurance Company	5

Business Insurance

INTERNATIONAL

Risk management programs 'go global'

By GAVIN SOUTER

DUBLIN, Ireland—Global risk management programs have become a well-accepted and utilized corporate tool, a broker contends.

However, many risk managers with global programs still are principally concerned with property risks, he said, adding that future progress in global risk management must be devoted to liability risks.

Today, most multinational companies not only practice risk management but have incorporated risk management principles into their overall management philosophy, said Douglas Fay, vp and manager-international brokerage services at Waltham, Mass.-based Hobbs Group Inc., a unit of Arkwright Mutual Insurance Co.

And as companies increasingly "go global," so does the risk management function, Mr. Fay said here recently in a paper delivered to the International Risk Management Symposium sponsored by Arkwright.

"The concept of a global program has at last been accepted and recognized with noted benefits including avoidance of gaps in coverage, uniformity of coverage and the ability to manage cost," he said.

Multinationals also are retaining more of their own risks, he added.

"While the hard market in the United States, as well as the mid-1980s capacity crunch, were possible triggers for companies to assume and control a greater degree of their risk, sophisticated risk management. . .has made risk retention a permanent part of multinational risk management," Mr. Fay said.

The benefits of risk retention include premium reduction and making local management an integral part of the risk management strategy, he said.

A related risk management development is the increase in the number of captives, Mr. Fay said. Historically used solely for U.S. risks, captives have now spread across the ocean to Europe, he noted.

Companies are also incorporating risk control measures in the event of a fire, explosion or other major disaster. However, such loss control measures are not being extended to product liability, product tampering or environmental impairment risk, Mr. Fay said.

"Witness the dilemma which Perrier faced when benzene was found in water distributed in the United States. This situation resulted in a tremendous opportunity for Perrier's competition," he said (*BI*, Feb. 19, 1990).

Still, despite the increasing sophistication of global risk management, its focus is still largely confined to property risks, Mr. Fay said.

"Risk management in today's world is a global all-lines function. It is important, therefore, that as your risk management function in your individual organizations increases in importance, you broaden your overall control of your worldwide exposures and develop risk management strategies for all potential exposures. . .to protect your company's balance sheet and to protect your company's multinational growth objectives," he contended.

To do this, companies should implement a worldwide liability insurance program, he said.

Giving an example of how a company could set up a global liability program, Mr. Fay used a German manufacturer with manufacturing and sales operations in North and South America, Europe and the Far East.

Currently, he said, the German company would typically buy for its German operations premises operations and product liability coverage with a limit of 2 million deutsche marks ($1.1 million) on an occurrence basis, with an 8 million deutsche mark ($4.6 million) excess liability policy placed in the London market.

Each operation outside Germany would buy its own liability coverage with varying limits and conditions. In the United States, separate workers compensation, general and product liability and automobile policies would be bought for the different subsidiaries, Mr. Fay said.

"The limit of liability can range on any of these policies with coverage on a claims-made basis. Features of this structure include no consistency of coverage, duplication of coverage and cost, potential gaps in coverage, insufficient limits of liability, excessive costs, no control and no clear risk management philosophy," he asserted.

A slightly better scenario would be for the German parent to purchase a global 10 million deutsche mark ($5.7 million) liability policy to cover the other European operations as well as the German operation, Mr. Fay said.

Local language contracts would be issued in each of the European countries by the insurer.

The master policy would also act as a difference-in-conditions policy over separate policies issued in the Far East and South America, but it would exclude all liability exposures in North America, he said.

"The next scenario, stage three, finds the German parent's liability policy now including worldwide coverage, excluding the U.S. only, and providing local policies for general liability and products worldwide via a multinational insurance carrier," Mr. Fay explained.

The policy would be underwritten on an occurrence basis with limits of 10 million deutsche marks worldwide, including Canada but excluding the United States, he said.

"The program illustrated here is an example of a true controlled master program whereby local policies, limits and conditions are dictated from the parent operations," Mr. Fay added.

The separate U.S. program can be improved by consolidating different types of liability coverage under one master program covering general liability, product liability, auto liability and workers compensation, he said.

A $1 million primary policy and a $4 million excess policy would give the German firm limits in the United States equivalent to 10 million deutsche marks.

However, the program still can be improved and made more global by extending the German parent program to cover all liabilities on a worldwide basis, including the United States, Mr. Fay said.

This can be done by keeping a U.S. policy underwritten by the insurer of the master program for premises, operations and auto liability and workers compensation exposures.

U.S. product liability risks could be incorporated under the master program, Mr. Fay suggested.

"In addition, due to consolidation under the global program concept, features of this approach can include a worldwide loss control program for both workers compensation and automobile, which again optimizes risk control and minimizes insurance costs," he added.

Also, the German parent can incorporate a worldwide product recall policy and implement a worldwide risk management philosophy, Mr. Fay said.

Finally, the worldwide program cuts the flow of paper, eases communication between the parties involved, gives greater premium leverage, provides a stable insurance source and gives overall program control, he added. ■

Cleanup costs

Continued from previous page

often minimize financial liabilities and provide opportunities for competitive advantages through waste minimization," Mr. Clark said.

Pressure on companies to care for the environment comes from several sources. Insurers, for one, are concerned that they will have to pay for any pollution. And banks that lend the money to buy properties are also becoming increasingly wary about pollution.

Banks are concerned that "a company might go bankrupt if it is forced to clean up a polluted site. The main driving force behind the banks is the concern over whether they are making a good investment," said Mr. Clark during a discussion workshop. "It is the old story of caveat emptor."

Industrial companies themselves should be wary about legal action by local governments and should cooperate with the authorities from the start, he said. "If the local authorities appreciate that you are trying to solve a pollution problem, then they probably will not prosecute," he commented. ■

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INTERNATIONAL

Stagnation in risk management decried

By GAVIN SOUTER

DUBLIN, Ireland—The discipline of risk management has at best stagnated and at worst deteriorated over the past 20 years, one consultant says.

Any advances have been confined to insurance programs rather than loss control or the promotion of risk management as part of a corporate culture, said Paul Bawcutt, managing director of the Risk & Insurance Research Group Ltd. in London.

If risk management is to progress, it must embrace environmental concerns, government lobbying and, most importantly, concentrate on reducing risk rather than financing losses, Mr. Bawcutt contended hat the International Risk Management Symposium sponsored by Arkwright Mutual Insurance Co. of Waltham, Mass.

"I do not believe that it is outrageous to confess that those of us who have been involved in developing and promoting risk management over the last two decades have failed miserably," Mr. Bawcutt said.

In the 1970s there was considerable optimism that risk management would become accepted management practice and would achieve a high status and importance in a corporation's management plan, according to Mr. Bawcutt.

But today, "very few companies have accepted the concept of risk management to the extent of integrating the practice into operating and other management structures, and the term 'risk management' is not only less understood now than it was 20 years ago, but it has also been taken up by other areas of business such as treasury functions," Mr. Bawcutt said.

Although there have been advances made in property loss control, few have been widely introduced over the past two decades, he added.

Instead, the only significant increases in the tools available to risk managers have been in risk financing, Mr. Bawcutt said. These include:

- The growth of captives.
- The setting up of alternative risk financing methods like ACE Ltd. and X.L. Insurance Co. Ltd.
- The increase in the power of the buyer over the decision-making and negotiations involved in insurance programs.
- The growth of truly global insurance programs.
- Acceptance by the insurance and reinsurance markets that buyers should self-insure part of their risks.

"Most risk managers, their advisers and those involved in promoting the concept come from an insurance background and are more comfortable with this area than they are with the other segments of the risk management process," Mr. Bawcutt said.

Although this has helped bring down the cost of commercial insurance, insurance buyers are guilty of stifling the discipline of risk management and of failing to make it more widely understood, he added.

This neglect, Mr. Bawcutt contended, has produced three results.

First, the status and recognition of the risk manager within corporations is low.

Second, within most companies, insurance buying is seen as the risk manager's primary function.

And third, outside the very highest ranks, few people know what risk management is.

As a result of this, risk managers lack confidence. They fail to become involved in lobbying when many issues being settled by governments are at the forefront of risk management concerns, Mr. Bawcutt said.

These areas include environmental regulation; the tax treatment of insurer reserves; product liability laws; and safety laws and regulations.

"This lack of success is serious," Mr. Bawcutt asserted, because the major problems facing business "are still being looked at in the same way as they were 20 years ago, and this is not going to help businesses operate efficiently and safely into the next century."

But all is not gloom and doom, he said, because some organizations how risk management can move beyond mere insurance-buying, he said.

For instance, the Center for Risk Management, a think tank in Washington, D.C., is researching how society should spend the billions of dollars earmarked each year on reducing environmental and other hazards, Mr. Bawcutt said.

This is classic risk management practice, he asserted. The center's examination takes into account the social goals of environmental and safety programs; the measurement of progress toward those goals; the simultaneous management of progress toward the different goals; and what emerging strategies and technologies can be used to reduce risk.

"It is important to note that these initiatives do not appear to have come from the risk management sector as we know it, whereas, if risk management were acknowledged and had a higher profile, surely this would have been the case," he added.

The insurance industry, too, has been holding back the development of risk management, he said.

Brokers, for example, often do not inform clients of direct insurers offering suitable and competitive coverage because they know that doing so would mean forfeiting their commission, he said.

"If risk management is to survive and also make a more important contribution by becoming more influential within industry and society at large, the time is now right for the current approach to be swept away," Mr. Bawcutt said.

He cited several reasons for his assertion:

- Risk management is too important to be left to the insurance-orientated risk manager to develop.
- The development of the global economy and the decentralization of management is making it necessary for risk management to be integrated fully into every manager's job instead of being left to a single corporate risk manager.

There needs to be a strong reaction against thinking only of the short term in decision-making, because if this is applied to risk areas, the long-term effect could be disastrous, he said.

To achieve this, risk managers will have to become well-rounded, Mr. Bawcutt said.

"There is, of course, no rational reason why risk management as a multi-disciplined function should derive from insurance, safety or similar sectors of the company. It needs to have a higher profile, become more accepted and be given the correct emphasis if the responsibility is placed within other functions," he said.

This could include making risk management part of corporate planning, since the corporate planner looks at the strengths and weaknesses of a company but rarely at the management of its risks—"the weakness of which could have far more devastating consequences for the company than a drop in sales or an increase in expenses," Mr. Bawcutt asserted.

Despite the record of risk management over the past 20 years, there are still opportunities for advancement, Mr. Bawcutt said.

"If we believe risk management has value and are committed to its principles, we should be realistic and confident enough to put fresh effort into making another attempt to get the message across. There is no shame in acknowledging failure and starting over." ■

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Circulation Breakdown*

Commercial Consumers

Administrative:	
CEO's Presidents, and Owners	2,566
Vice-Presidents, General Managers and Other Administrative Personnel	4,489
Financial:	
Chief Financial Officers and Vice-presidents of Finance	2,581
Secretaries, Treasurers, contollers and other Financial Personnel	4,349
Risk/Employee Benefits:	
Vice-presidents, directors, managers, and other related department personnel of: insurance, risk, employee benefits, personnel, compensation, pension, safety, security, industrial relations, human resources and employee/labor relations	10,606
Sub-total	**24,591**
Associations	488
Government, Unions and Educational Institutions	1,275
Commercial Consumers	
Sub-total	**26,354**
Insurance Agents and Brokers	9,651
Insurance Companies	8,074
Accountants, Actuaries, Attorneys & Consultants	3,438
Adjusters, Appraisers, TPA's, Captive Managers & Health Care Providers	1,294
Others Allied to the Field	1,365
TOTAL	**50,176**

* Source Business/Occupational breakdown of qualified circulation, November 26, 1990 issue, as submitted to BPA for December 1990 BPA Publisher's Statement.

INTERNATIONAL

BERMUDA

Continued from page 25
who was brought in this year to manage the company's run off (*BI*, April 15), would not comment on the registrar's petition.

Incorporations rise

Bermuda has recorded its first net gain in insurer incorporations in four years.

During the first half of 1991, 36 new companies were incorporated, compared with 26 during the same period last year, said Roger Gillett, deputy chairman of a new industry marketing committee that is part of the government's Insurance Advisory Committee.

First-half liquidations slowed to 27 this year from 30 in 1990, leaving a net gain of nine companies.

As of June 30, 1,321 insurers were registered in Bermuda.

In the first half of 1991, about 55% of all captives incorporated in the United States, Bermuda or the Caribbean were incorporated in Bermuda, said Mr. Gillett. Of the 65 companies formed, he said, 36 were formed in Bermuda, 11 in the Cayman Islands, nine in Vermont, five in Barbados and four in Hawaii.

"This is the fist six-month period for four years that we have seen real growth," said Mr. Gillett. "The trend was one of decline. But for the first time since 1986 we can say we're growing again."

He attributed that decline to "a lot of clearing out of dormant captives over the last couple of years." But he added: "I think the process is complete now. Most of the dormant companies have gone. And those that are in runoff could well become active again once the market hardens."

Mr. Gillett said that breaking the pattern of decline was a fundamental aim of the IAC's marketing committee. "I can't be sure that these statistics are a direct result of our efforts, but what I can say is that they provide just the right kind of springboard for our activities. All insurance managers in Bermuda should be encouraged by them."

To promote the island as a domicile, he said the committee plans to stage three or four seminars in the United States this year. Bermuda's role as an alternative risk financing market will be covered.

New SCOR venture

SCOR S.A. plans to open a Bermuda company by year-end to underwrite financial as well as traditional reinsurance risks (*BI*, April 29).

Commercial Risk Partners Ltd. has already been approved by the Bermuda government and is to be licensed soon. It is to be capitalized at about $100 million.

SCOR is the Paris holding company of Societe Commerciale de Reassurances, the world's 10th-largest reinsurer based on 1989 net premium volume.

Commercial Risk Partners will be run by Dan Marren, a consultant who joined the French group a year ago. No stranger to Bermuda, Mr. Marren in 1988 helped start Centre Reinsurance Holdings Ltd., Bermuda's largest financial reinsurer.

He had been vp and chief financial officer at Centre Re. SCOR initially hired him to help decide whether to get involved in financial reinsurance and to evaluate different jurisdictions.

"Bermuda was chosen after looking at all the usual domiciles," said Mr. Marren. "We need to be close to the United States, and we hope to become a major reinsurer to captive companies, which is the other reason why Bermuda was selected over other domiciles."

Commercial Risk Partners will not be a wholly owned SCOR subsidiary, though the French group is expected to maintain a controlling interest. The new venture is to have six to 10 shareholders, including Mr. Marren and various SCOR affiliates. Further details were not available.

Like Centre Re, the new reinsurer will offer finite risk products, which cap both the reinsurer's ultimate exposure and its profit. But Mr. Marren, who will be doing some of the underwriting as chief executive officer and president, said that finite risk concepts would be combined with traditional reinsurance underwriting, with an emphasis on casualty business.

"We're really more of a hybrid company," he said. "We'd like to be seen as a commercial insurance and reinsurance company that happens to offer finite risk product. . . .We'd probably have more in common with commercial reinsurers than with financial reinsurers."

Asked about staffing needs, Mr. Marren said it was too early tell how big the company's Bermuda operations would be. He added that it was still not clear whether the company would be self-sufficient or whether its operations would be supplemented by local insurance company management services. ■

Ingosstrakh

Continued from page 25
hopes to attract some of that capital.

For now, at least, foreign investors will not be able to acquire stock in Ingosstrakh.

"We are not considering foreign investment yet because we would like to establish new shareholders in our own country. We will decide later what else we need," Mr. Safronov said.

Early last year, Ingosstrakh expanded its commercial insurance operations by offering all types of insurance—including export credit and political risk—to joint ventures between foreign and Soviet companies. Previously, it offered only property insurance to joint ventures.

'Insurance is almost the last (Soviet) area to be subject to foreign involvement,' Mr. Simon notes.

While Ingosstrakh is readying itself for expected growth, Soviet insurance legislation now being drafted and new antitrust laws will dilute its longstanding virtual monopoly, noted Bill Simon, counsel to Cole, Corrette & Abrutyn, an international law firm.

"Insurance is almost the last area to be subject to foreign involvement" in the Soviet Union, commented Mr. Simon, who is also a law lecturer at Leiden University in the Netherlands. "It's the last vestige of state ownership and control."

While Soviet law says only that a Soviet insurer must write property coverage for joint ventures, Mr. Simon argues that because the insurers that have recently been formed in the Soviet Union have very limited capacity, only Ingosstrakh can provide this coverage.

Mr. Safronov rejects the charge that Ingosstrakh is a monopoly, noting that the government is no responsible for Ingosstrakh's liabilities. "We are not a state organization. In all of our history there ha been only one decree, which stipulated we cover. . .property in join ventures."

He said he expects draft insurance reform legislation to be released soon. The first step, he said will be the creation of a supervisory authority that will establish standards like capital requirements. No such regulatory organization now exists either on a national level or among the Soviet republics, he said. The concept o insurance still is not completely appreciated in the Soviet Union though the republic of Lithuania has passed some insurance laws he added.

Ingosstrakh's future also will be affected radically by new tax measures that will be implemented as a result of the new Union Treaty which is similar to a constitution Mr. Simon said. "One of the biggest issues will be taxation, who gets what tax and who collects what."

But Mr. Safronov said neither the Union Treaty nor the question of taxation will have any major impact on Ingosstrakh's operations.

Ingosstrakh has 50 branch offices throughout the Soviet Union and is now working to establish cooperative programs with the new companies that are being formed in the republics, he said.

"Taxes are slightly different in some republics and, in our local offices, we will pay taxes," he said.

Ingosstrakh had a gross premium volume of $500 million last year according to Mr. Safronov. He would not say how much of this volume was reinsured, though a major portion of the insurer's marine and aviation policies are reinsured overseas.

Ingosstrakh was formerly the international department of the state domestic insurance monopoly Gosstrakh, but was incorporated as a separate entity in 1947. "Now we are absolutely free; there is no relationship any more with Gosstrakh," Mr. Safronov said. ■

Panels probe syndicate losses

By STACY SHAPIRO and GAVIN SOUTER

LONDON

LONDON—Lloyd's of London has launched two more independent reviews of the circumstances surrounding millions of pounds of losses reported by two groups of syndicates.

These reviews, and another announced last month, are among the five or six that are expected to be established by Lloyd's this year for syndicates that have reported losses exceeding 100% of their stamp capacity.

One review, to be chaired by Tim Boatman, a partner at Coopers & Lybrand Deloitte, will investigate the reasons for the losses at syndicates managed by Rose Thomson Young (Underwriting) Ltd.

Mr. Boatman will be joined by Michael Payne, senior partner of underwriting agency Michael Payne & Partners and deputy chairman of Janson Green Ltd., and Lloyd's underwriter David King, managing director of KPH Underwriting Agencies Ltd.

The panel will specifically look at Rose Thomson's marine syndicate 255, which has left its 1988 underwriting year open after reporting losses of 63.3 million pounds ($106.5 million at current exchange rates), or 226% of its stamp capacity.

In addition, the panel will examine the open 1982 underwriting year of marine syndicate 345, with losses totaling 350,000 pounds ($588,000), or 219% of its stamp capacity.

The panel also will examine syndicate 1011, which reported a loss of 2.2 million pounds ($3.7 million), or 28% of capacity, for its already closed 1988 underwriting year.

The other panel formed by Lloyd's last week will be chaired by Kieran Poynter, a partner at Price Waterhouse, and will examine the losses at syndicates managed by Gooda Walker Ltd.

Joining Mr. Poynter will be Harvey Simons, senior underwriter for CNA Reinsurance Co. Ltd.; and Peter Terry, former chief executive of Thomas R. Miller (Reinsurance Brokers) Ltd. and now a consultant to T.R. Miller Insurance Group.

This panel will examine Gooda Walker's marine syndicate 298, which reported losses in 1988 totaling 70.2 million pounds ($118.1 million), or 163% of stamp capacity.

In addition, the syndicate will require an estimated cash call for its unclosed 1989 year of 130% of total premium income written. The exact amount, though, will not be known until the end of this year when the 1989 underwriting year closes under Lloyd's three-year accounting system.

As part of the examination of syndicate 298, the panel will also review three other Gooda Walker syndicates:

- Non-marine syndicate 290, whose 1989 open year will require a cash call of 75% of premium volume and whose 1990 year will require a cash call of 40% of premium volume.
- Marine syndicate 299, which reported a 22 million pound ($37 million) loss in 1988, or 53% of stamp capacity.
- Non-marine syndicate 164, which will require an estimated cash call of 30% of stamp capacity for 1989.

"I am very pleased that we have been able to assemble two further panels so quickly," Lloyd's Chief Executive Alan Lord stated last week.

"The (panel) members are all individuals whose knowledge and expertise will be invaluable in conducting these independent and impartial reviews," Mr. Lord said.

Last month, Lloyd's established an independent review panel headed by Sir Patrick Neill, who earlier in the 1980s heades a panel that suggested major reforms at Lloyd's, to examine the losses at syndicates managed by the now-defunct Feltrim Underwriting Agencies Ltd. (*BI*, July 15).

MSL's business sold

Merrett Holdings P.L.C., the parent of one of Lloyd's of London's largest underwriting agencies, says it has agreed to sell its members' agency business to the agency's management.

Subject to approval by the Council of Lloyd's, Merrett Holdings has agreed to sell members' agency Anton Underwriting Agencies Ltd. and the business of Merrett Syndicates Ltd. to the agencies' chairman, John Robson, and managing director, David Robson.

The sale, for an undisclosed sum, is to be completed in time to write 1992 business at the end of the year.

The two members' agencies manage the business of 870 members, with total premium capacity of $308 pounds ($594.4 million at appropriate exchange rates). About 25% of the capacity is devoted to Merrett-managed syndicates.

The independent members' agency, whose Lloyd's names will continue to support Merrett's syndicates, will trade under the name Anton Underwriting Agencies Ltd.

The board of Merrett Holdings said that it decided to sell the members' agency business because it had been operating autonomously for some time and members represented by the agency "would see their interests as best served by a wholly independent agency." ■

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Ace Hardware names risk manager

Karl J. Zimmel, 32, has been named risk and insurance manager at Ace Hardware Corp. of Oak Brook, Ill. He is responsible for the design and implementation of corporate property/casualty insurance programs, claims management and loss control activities. Mr. Zimmel replaces **Jeff Kahl**, who died earlier this year. Mr. Zimmel reports to Jim Jasper, assistant treasurer. Before joining Ace Hardware, he was manager-claims and administration at Whitman Corp. of Chicago. He holds a bachelor's degree in economics from the University of Illinois at Champaign and holds a master's degree in business administration from the University of Chicago. Mr. Zimmel holds the Associate in Risk Management designation and is a deputy member of the Risk & Insurance Management Society Inc.

* * *

Mary Sue Baker has been named risk manager for the city of Monterey, Calif. She is responsible for all risk management programs, including property/casualty insurance, loss control and claims management programs. Ms. Baker replaces **Doug Byrd**, who left the city government. She reports to Dewey Evans, finance director. Before joining the city of Monterey, Ms. Baker was an independent risk management consultant in San Francisco. She holds a bachelor's degree in political science from Arizona State University in Tempe. Ms. Baker is a member of the Public Risk Management Assn. as well as the Public Agency Risk Managers Assn. In addition, she is a deputy member of RIMS.

* * *

Janet Folta, 51, has been named risk manager at the University of Denver. In this newly created position, she is responsible for property/casualty insurance, self-insurance and safety programs, as well as environmental issues. Ms. Folta reports to James Griesmer, vice chancellor. Before joining the University of Denver, she was risk manager for the Fort Collins, Colo., public school system. In addition, Ms. Folta has served as a lobbyist with the Colorado Public Risk Management Assn. She holds a bachelor's degree in education from St. Cloud State University in St. Cloud, Minn. Ms. Folta holds the Associate in Risk Management designation and is a deputy member of RIMS.

* * *

Richard Cox, 32, has been named risk and insurance manager at North American Salt Co. of Mission, Kan. In this newly created position, he is responsible for all property/casualty insurance programs for the company's U.S. salt and chemical processing facilities. Mr. Cox reports to Susan Day, assistant treasurer. Before joining North American Salt Co., he was risk manager for the state of Kansas in Topeka. He holds a bachelor's degree in risk management from Arizona State University in Tempe. Mr. Cox holds the Associate in Risk Management designation and is a deputy member of RIMS.

* * *

Gaylene S. Van Horn, 40, has been named manager-employee benefits at Kimberly Quality Care of Overland Park, Kan. Ms. Van Horn is responsible for the company's group health and retirement savings plans. She replaces **Connie Zimmer**, who left the company. Ms. Van Horn reports to Gordon Smith, senior vp-human resources. Before joining Kimberly Quality Care, which provides home health care services, Ms. Van Horn was manager-benefits administration at United Banks of Colorado Inc. in Denver. She attended Regis College in Denver.

●

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OSHA reforms

Continued from page 2

A new category of offense under the OSH Act—willful violation that causes serious injury—also would be created. It would carry a maximum jail sentence of five years for the first offense and 10 years for each additional offense.

In introducing the legislation on Thursday, Sen. Kennedy said that despite progress in making the workplace safer, thousands of workers still die from injuries sustained on the job. "The stark fact is that as a nation, we continue to pay for the goods we consume and the services we use with the health and lives of the workers who produce them."

"The (OSH) Act has not accomplished what we had in mind for it," said Rep. Ford, one of the original co-sponsors of the OSH Act.

Poor enforcement efforts by previous administrations, inadequately written regulations and insufficient funding for OSHA have hampered the effectiveness of the law, he said.

"It's time that we take the next step that we should have taken 20 years ago," Rep. Ford said.

"The end result is not to increase fines. The end result is to save more working men and women on the job in America," Sen. Metzenbaum said.

However, the Chamber's Mr. Eide said the reform proposal will mean more costs for employers in trying to comply with the proposal. "This bill will cause employers major problems. . .with the expense of setting up safety and health programs, the committees, and the employee training and education."

In addition, he said that involving employees directly in the process of resolving compliance problems between employers and OSHA "will ruin" the settlement process.

Smaller employers will be hit hardest by the proposal because most large corporations already have established formal safety programs, said Donna Costlow, assistant director of risk management at the National Assn. of Manufacturers in Washington, D.C.

"Where is a small employer going to find the time and the resources for this kind of plan?" she asked.

Although NAM has no hard data on the cost of establishing occupational health and safety plans and labor-management safety committees, "I'm sure it is very substantial," she said.

However, Rep. Ford believes that employees should have a say about the outcome of such proceedings.

"It's not acceptable for workers to be left in the dark while OSHA and their employer negotiate whether safety and health hazards must be eliminated," he said.

Labor and workplace safety advocates praised the legislation.

"Twenty years after the passage of the original OSHA law, it's time for a renewed commitment to protect the safety and health of Americans," said Lane Kirkland, president of the AFL-CIO in Washington, D.C.

"If adopted, this legislation will help OSHA jettison its wimpy image, because this has real teeth," said Joseph Kinney, executive director of the National Safe Workplace Institute in Chicago.

Other provisions in the reform proposal would:

- Require OSHA to respond to petitions for new health or safety standards within 90 days. If a standard is warranted, OSHA would have to propose regulations within 12 months of receiving the petition and issue a final rule within six months of the comment period.
- Require the National Institute for Occupational Safety and Health to submit recommendations for revisions of permissible exposure limits for toxic substances at least once every three years. OSHA would be required to draft proposed regulations based on NIOSH's recommendations within six months and a final rule within a year of receiving the recommendations. ■

Rating agencies

Continued from page 1

indemnify (policyholders), there won't be any rating companies. You can rest assured of that," said Kim McCarrel, a consultant with The Wyatt Co. in Portland, Ore., who has faulted the rating agencies.

Criticism of rating agency performance is not new: For example, concerns started to build with the collapse of Ideal Mutual Insurance Co. of New York, which Best downgraded to C+ from A (contingent) only four months before it entered rehabilitation in December 1984.

In hearings last year, members of the House Oversight & Investigations Subcommittee also faulted Best for tardiness in downgrading the now-defunct Mission Insurance Co., Transit Casualty Co. and Integrity Insurance Co.

Questions about rating agency performance have intensified, though, with the more recent failure of Executive Life of Los Angeles and the rehabilitation of Mutual Benefit Life of Newark, N.J., and with rising concerns about the life insurance industry's vulnerability to the deteriorated junk bond and real estate markets.

In a letter to the U.S. Justice Department requesting an investigation of the Executive Life collapse, a Senate panel earlier this year alleged that Executive Life and its New York affiliate "may have been assisted by their rating and auditing firms" in presenting a misleading picture of financial stability.

Executive Life carried ratings of A+ by Best, AAA by S&P and A3 by Moody's until a series of downgrades began in January 1990. Mutual Benefit carried ratings of A+ by Best, AAA by S&P and Aa2 by Moody's until the first downgrade by S&P in May 1990 (see chart, page 1).

The short notice to policyholders reflected in these downgrades has produced a barrage of lawsuits accusing the rating firms of negligence. Best reports it has been named in 17 suits stemming from the Executive Life collapse, while S&P says it has been named in 19 suits. Moody's also has been named in several suits.

Most complaints are similar.

For example, a suit seeking class-action status filed by Executive Life policyholders and annuity holders in California Superior Court in Los Angeles levels fraud charges against Executive Life Chairman Fred Carr, more than 20 other Executive Life directors and officers and auditor Deloitte & Touche. The suit also names Best, S&P and Moody's, accusing the rating agencies of negligence and misrepresentation for failing to warn of the dangers of Executive Life's junk bond holdings.

Executive Life regularly used its top ratings from Best and S&P to promote the security of its annuity products, the complaint notes.

Another suit seeking class-action status has been filed in New York State Supreme Court, naming many of the same Executive Life officials and the three rating agencies, which are accused of misrepresenting Executive Life's condition.

A companion lawsuit filed by the same plaintiffs in U.S. District Court in New York charges the same defendants with RICO violations and accuses the rating agencies of aiding and abetting a fraudulent scheme to conceal Executive Life's financial condition.

"The company used the ratings extensively in advertising. But the (rating) agencies failed dismally in performing their obligation," said plaintiffs' attorney Melvyn Weiss, a partner with Milberg Weiss Bershad Specthrie & Lerach in New York. Mr. Weiss represents plaintiffs in the New York and California lawsuits. "They did an inadequate investigation of Executive Life's condition and acted recklessly in maintaining its rating."

In New Jersey, five lawsuits have been filed in state court over the Insurance Department's takeover of Mutual Benefit Life, similarly accusing Best, S&P and Moody's of negligence.

Best also is named in five more suits filed in California courts over the failure of First Capital Life Insurance Co. of San Diego, which largely wrote personal lines business.

Rating agency officials defend their performance in all these cases.

"It's absurd to hold us financially responsible for publishing our own views. We cannot reinsure the entire industry just because we rate companies," said John Grillos, general counsel with Best in Oldwick, N.J.

"What we do is review the public documents as thoroughly as possible and, with no incentives from the companies, we issue an opinion in the form of a rating," he said. "It's then up to the public to attach as much weight as it wants to our judgment."

Mr. Grillos said that Executive Life's use of Best's rating in advertisements has no legal ramifications. "Any highly rated company will use its rating to sell its products. We don't encourage this nor do we try to stop them from doing it," he said.

"When we give a company a high rating and it performs up to that rating, nobody calls us up saying, 'Hey, you gave my insurer an AA+ rating and it has paid all my claims. Thanks a lot,' " said Robert Mebus, managing director-insurance ratings with S&P in New York.

"But if a company fails for unforeseen reasons, they are quick to say we blew it," he said.

Larry Brossman, vp and chief operating officer with Duff & Phelps Credit Rating Co. in Chicago, called the lawsuits against Best, Moody's and S&P "totally improper and unfortunate."

Duff & Phelps is not a defendant in any litigation arising from the failures of Executive Life and Mutual Benefit Life.

The world has become more complicated for the rating agencies as the poor economy, the deteriorated junk bond and real estate markets and an erosion of public confidence have put unprecedented strains on life insurance companies.

For example, the impact of the junk bond market's rapid collapse took rating agencies by surprise, suggested Larry Mayewski, Best vp-life and health insurance. "We didn't miss what was happening with Executive Life. There were obvious (junk bond) exposures, but they were managing them. But the fact that potential liabilities turned into actual liabilities almost overnight was unpredictable," he said.

"Junk bond problems were anticipated to a degree, but in hindsight it's easy to see that the danger was underestimated," he said.

"So much has happened in the last couple of years to insurer assets," S&P's Mr. Mebus noted. "Nobody could have accurately built junk bonds and commercial mortgages into the rating scenario. We attempt to adjust ratings as conditions change, (but) it's not our job to rate every industry according to depression standards."

Some agencies recognized the junk bond risk sooner than others, though: Duff & Phelps never rated Executive Life above BBB after 1988 because of what it viewed as the "always-existing potential risk related to junk bonds," Mr. Brossman said.

"The agencies are dealing in an environment that is full of pressure," observed Murray Becker, a principal with Becker & Rooney Inc., a financial consultant in Teaneck, N.J. "It's impossible to extract 100% of the information they need to make a totally fool-proof assessment."

The difficulty of forecasting was demonstrated by the takeover of Mutual Benefit Life, which sought protection from New Jersey regulators as it was being swamped with surrenders from worried policy and annuity holders, Mr. Becker noted.

"The situation with Mutual Benefit occurred simply because there was a panic-based run on the bank. The agencies have been criticized, but who could have predicted this?" Mr. Becker wondered.

Predicting such "runs on the bank" is precisely what Best says it will try to do in future ratings. The agency announced last week that it will develop a "policyholder confidence" factor to measure the potential impact of a run on the companies it rates.

Given the weak economy, depressed real estate market, decline in consumer confidence and other factors, "a solvent company's liquidity problems, which in the past were manageable, can develop into a liquidity crisis" today, Best said.

In developing the factor, Best will look at the percentage of an insurer's liabilities composed of guaranteed investment contracts, annuities and other products that can be cashed in on demand and will examine the extent to which this product mix creates the potential for a liquidity problem, a Best spokesman said.

The policyholder confidence factor will be weighed along with five other qualitative measures Best has traditionally used to arrive at a rating, the spokesman said.

An S&P official was skeptical about the Best announcement. "The concept of rating policyholder confidence is too vague a concept for an analytical group to put its arms around," said William O'Neill, an S&P vp.

"Looking at liability structure is not a new issue. It's always been a part of our evaluation. We look closely at the potential of policies being quickly cashed in," he added.

While trying to respond to the recent abrupt life insurer failures, Best is not planning any widespread downgrading of life companies, Mr. Mayewski said.

The agency is "not going to panic and downgrade every company with an exposure to real estate or junk bonds," he said. "We're deliberate in our rating process. We don't make knee-jerk reactions where we lower ratings at a drop of a hat."

Still, the rating agencies appear to have responded to the growing strain on life insurers with a flurry of ratings downgrades.

Moody's last month dropped the ratings of 12 life/health insurers and two property/casualty units of insurance groups. Best also downgraded four life insurers (*BI*, July 29).

"It seems as though the recent downgradings occurred because Moody's and other agencies are nervous about the condition of the real estate market. There's a general feeling that real estate is in turmoil," said Roy Ehrle, executive vp-investments with The Principal Financial Group in Des Moines, Iowa, whose Principal Mutual Life Insurance Co. unit was downgraded last month by Moody's to Aa1 from Aaa.

Some of the downgraded insurers object to the rating agencies' actions.

"Our real estate portfolio is well-diversified and has significantly better-than-industry-average performance," said a spokeswoman for Kemper Corp. of Long Grove, Ill., whose Kemper Investors Life Insurance Co. and Federal Kemper Life Assurance Co. units were both lowered to A2 from Aa3 by Moody's based on their levels of real estate investments.

"The action strongly suggests that Moody's is determined to lump all insurers with real estate holdings into the same category without regard to the characteristics of each company," the spokeswoman said.

However, several insurers—including some of those that have recently been downgraded—expressed sympathy for the agencies' difficult task and say the agencies generally do a thorough job.

"The rating agencies are clearly trying. Their job is not an easy one," Principal's Mr. Ehrle observed. "Because of dramatic developments in the commercial real estate and high-yield securities markets, it's somewhat easy to see how the rating companies missed the magnitude of what could happen. The rapid deterioration of junk bond values and real estate wasn't expected by the agencies or the industry."

Rating agencies also run the risk of being caught in the middle regardless of the action they take with a troubled company: If they downgrade the insurer too quickly, they run the risk of pushing it into insolvency when it might otherwise have survived. But, if they delay a downgrade, they are certain to be faulted afterward for not acting quickly enough, observers note.

"The rating agencies have a rather difficult line to walk," said Paul D. Hawksworth, president of Mercantile & General Reinsurance Co. of America in Morristown, N.J., which S&P downgraded to AA− from AA+ last month. "They have to sit there and do this little balancing act, and it's very difficult."

Not everyone is willing to let the agencies off the hook, though.

One insurance company official who requested anonymity scoffed at the agencies' assertion that their ratings are merely opinions that policyholders must weigh for themselves.

"What the hell does Best put out a rating for if not to advise people and guide them in their actions?" the official asked. "You hold yourself out to be an expert in that area and now you tell me I shouldn't have been foolish enough to believe you?"

Wyatt's Ms. McCarrel said investors and employers feel "let down by the rating agencies" following recent life insurer troubles.

"Twenty-twenty hindsight shows that they didn't look hard enough at some of these companies. With Executive Life, you can blame the agencies. They're supposed to be insiders. They should know the company's financial structure better than anyone. Even people on the outside knew Executive Life was overweight with junk bond holdings," she observed.

"Everyone's looking for a scapegoat, but the truth here is that the rating agencies made a mistake" with Executive Life, agreed John Stettler, director-benefit investments-risk management with Atlanta-based Georgia-Pacific Corp.

Georgia-Pacific earlier this year purchased an Executive Life GIC held by an acquired company to shield beneficiaries' payments (*BI*, May 13).

However, "there certainly was no plot to overrate this company," Mr. Stettler said.

"I believe the analysts just missed it. Executive Life was making money, their capital was high and their book earnings were good. That probably explains the high ratings," he said.

"Sometimes as fiduciaries, we're guilty of looking too closely at ratings when we purchase annuities or GICs. Still, I'd hate to operate in an environment without them. I can't do the evaluations myself," Mr. Stettler said.

"Their job is to give an accurate portrayal of a company's position," the APPWP's Mr. Weizmann observed. "To some degree, they haven't done this. With Executive Life, the agencies seemed to ignore a substantial concentration of junk bond assets," he said.

"With Mutual Benefit, the company's investments in real estate would indicate that any unforeseen run on the bank would cause severe problems," according to Mr. Weizmann.

"Everyone needs to look a little deeper," Mr. Weizmann concluded. "The rating agencies can't be in bed with insurers, and plan sponsors can't start and end their research with a rating." ■

Walbrook results

Continued from page 2
policyholder surplus.

"In light of the inherent uncertainties and those concerning the achievability of favorable commutations, we are unable to express an opinion as to whether the resulting provision (for liabilities) is appropriate," said KPMG Peat Marwick in the accounts.

Walbrook was the leading insurer on the U.S. casualty line slip underwritten by sister company H.S. Weavers (Underwriting) Agencies Ltd. Walbrook, a unit of London United Investments P.L.C., stopped underwriting in March 1990 after six other insolvent LUI-owned insurers—all of which at one time had reinsured Walbrook—stopped paying claims (*BI*, April 2, 1990).

LUI was later placed in administration, which is similar to Chapter 11 bankruptcy in the United States.

LUI administrators Colin Bird and Alan Barrett—both partners of London accounting firm Price Waterhouse—currently are overseeing the preparation of court-approved runoff plans—called schemes of arrangement—for four of the insolvent LUI insurance subsidiaries to allow them to pay claims.

Last week, the British High Court once again gave the administrators more time to work on their plan. The court postponed action on a petition to wind up the four insolvent insurers until Oct. 9 (*BI*, June 17; April 8).

In its 125-page 1990 returns filed July 29 with the British Department of Trade and Industry, Walbrook reports that its year-end surplus increased 58% to 8.2 million pounds ($15.8 million) from 5.2 million pounds ($8.4 million) in 1989.

However, Walbrook's admissible assets and liabilities both dropped substantially in 1990, due mainly to the strengthening of the British pound against the U.S. dollar.

Admissible assets dropped 16% to 390 million pounds from 465.4 million pounds in 1989. The assets, mainly kept in U.S. dollars, remained steady at $752.7 million at year-end 1990 compared with $749.3 million in 1989.

Net liabilities dropped about 17% to 381.8 million pounds from 460.2 million pounds, and marginally in dollar terms to $735.7 million from $740.9 million in 1989.

Walbrook does not keep records of gross liabilities before reinsurance recoveries, but it estimated that its gross liabilities at year-end totaled 663.9 million pounds, 36% less than 913.8 million pounds in 1989. In dollar terms, Walbrook's estimated gross liabilities dropped 13% to $1.28 billion from $1.47 billion.

Claims paid in 1990 totaled 124.8 million pounds ($240.9 million), compared with 104.6 million pounds ($168.4 million) in 1989.

Walbrook reserved for future claims on the low end of estimates made by Tillinghast.

Walbrook's technical reserves in 1990 total nearly 345 million pounds ($665.9 million), down 19% from 426.2 million pounds ($686.2 million) in 1989.

The results for Walbrook 'are more uncertain than for many companies of its type,' Tillinghast notes.

In a note accompanying the accounts, Walbrook said that "Tillinghast has reported that the required provision, net of reinsurance recoveries and after discounting at 7.5% but before making provision for irrecoverable reinsurance, should be in the range of 300 million pounds ($579 million) to 444 million pounds ($856.9 million)."

Walbrook's directors—Chairman Sir Ian Morrow, Director Roger Borley and Secretary Damien Boyle—decided that a provision for claims of 319 million pounds ($615.7 million) "is appropriate," said the note to the accounts.

In addition, the directors made a provision of 26 million pounds ($50.2 million) for unrecoverable reinsurance, resulting in the total reserve for outstanding claims, incurred-but-not-reported claims and runoff costs to be nearly 345 million pounds, the note said.

The directors based their lower reserve figure on commutations of Walbrook's policies.

"In forming the view that a provision toward the low end of the Tillinghast range is appropriate, the directors have considered the main judgmental areas and the likelihood of achieving savings through their strategy of seeking commutations of insurance contracts," said the note.

Based on the the discounted rate of 7.5% over a five-year period, the provision for claims will earn 153 million pounds ($295.3 million), the note said, bringing reserves to pay losses to 472 million pounds ($911 million).

However, Tillinghast pointed out to Walbrook's directors that various factors needed to be considered when assessing the required provisions for liabilities:

- No provision has been made for potential future claims arising from losses that are not recognized in historical data.
- Discounting claim reserves creates a risk that the timing of future claims payments will differ from the estimated pattern and that the future yield on the underlying assets may differ from the assumed discount rate.
- The results for Walbrook "are more uncertain than for many companies of its type." This is due in particular to its greater involvement in the line slip after 1985, meaning that "the company has a high proportion of its reserves in years which are immature and where there have been some material changes in market conditions especially following the introduction of claims-made forms" in 1985.

Meanwhile, the Walbrook directors also pointed out in the accounts that other "uncertainties" exist stemming primarily from "the use of group reinsurance programs and the pooling of assets and liabilities" by three underwriting agents used by Walbrook: Weavers; C.R. Driver & Co. Ltd., which is in liquidation; and London United Marine Agencies Ltd.

Walbrook, for example, paid claims on behalf of other participating insurance companies.

The agents owe Walbrook 30.8 million pounds ($59.4 million), which will be recovered depending on "the legal and practical recoverability of various sums from other participating companies, some of whom are known to be insolvent, and provisions have been made to reflect these matters," the notes to the accounts say. ■

Mutual Benefit Life

Continued from page 2
efit Life's capital base, depending on the eventual purchase price.

Mutual Benefit Life had $374 million in surplus when it was placed in rehabilitation.

The agreement does not include either Mutual Benefit Life's annuity or guaranteed investment contract business, which remain part of the parent company's operations subject to the rehabilitation.

Mutual Benefit Life's group business produced $830 million in revenues last year and $52 million in net income. The group business accounts for more than $1 billion in assets.

"That was one of the strongest operations (Mutual Benefit Life) had," said Gloria Vogel, associate director at Bear Stearns & Co. Inc. in New York. The sale "should help the company maintain and preserve its capital base and allow it to realize value for the group operation," she added.

Tom Sargent, senior vp for Hartford, Conn.-based Conning & Co., commented that the group operation is Mutual Benefit Life's "crown jewel."

However, he noted that one issue will be the amount of group business the insurer has lost between the rehabilitation order and last week's announcement that the group business would be sold. "I would suspect that while some business has moved, the franchise is still intact, and they'll be around for years," he said.

Mutual Benefit Life could not say how much group business has been lost.

The group operation, which is based in Kansas City, Mo., will continue to be headed by Ed Bull as chief executive officer. The operation will drop the Mutual Benefit Life name, but a new name has not yet been chosen.

AMEV Holdings already has considerable interests in the United States.

Its nine units reported $1.7 billion in revenues last year, $63 million in net income and $3 billion in assets. Its units employ about 5,500 people.

Its major units include Woodbury, Minn.-based Western Life Insurance Co., which sells group health and life insurance to businesses with fewer than 500 employees; Milwaukee-based Time Insurance Co., which underwrites health and life insurance for both individuals and small groups; and Atlanta-based American Security Group, which underwrites specialized insurance-related products and services for major financial institutions.

"Our plans are to continue to conduct our merger and acquisition activities," said an AMEV spokeswoman.

Meanwhile, Mutual Benefit Life said last week it will seek to sell its book of corporate-owned life insurance. This line of business produced $1.1 billion in premiums last year.

In addition, 25 large corporations with multimillion-dollar investments in Mutual Benefit Life GICs have filed a petition in New Jersey Superior Court seeking a hearing today on their request that the insurer continue making GIC benefit and interest payments and honor the required cash payments due at intermediate and final maturity dates.

The treatment of GICs was not clear under the rehabilitation plan announced by the New Jersey Department of Insurance. The employers filing the petition would like the court to clarify that Mutual Benefit Life will honor GIC contracts on the same terms as annuities.

Under the rehabilitation plan approved by the court, Mutual Benefit Life will continue to make regular benefit payments on annuities, health benefits and death benefits but will temporarily halt cash surrenders, withdrawals and policy loans.

Employers named in the petition include American Telephone & Telegraph Co., the lead petitioner, Allied-Signal Inc., Bell Atlantic Corp., BellSouth Corp., General Mills Inc., Grumman Corp., NYNEX Corp. and Texas Instruments Inc. ■

Update

MONY calls articles misleading

Continued from page 2
MONY also discounts reports that it has significant junk bond holdings. About 9% of its $5.9 billion bond portfolio is rated below investment grade, the spokesman said.

Safeway settles coverage suit

OAKLAND, Calif.—Safeway Stores Inc. and its liability insurers have settled a coverage dispute over claims arising from a July 1988 warehouse fire.

The fire destroyed about 535,000 square feet of Safeway's regional warehouse facilities in Richmond, Calif., and damaged property of surrounding residents (*BI*, Aug. 8, 1988).

The settlement exhausts the Oakland-based grocery store chain's first $100 million of coverage, including a $5 million self-insured retention, *Business Insurance* learned.

Three insurers—National Union Fire Insurance Co. of Pittsburgh, Pa., a unit of American International Group Inc.; The Home Insurance Co.; and Chubb Corp.—underwrote $95 million in occurrence liability coverage excess of $5 million. Safeway's $200 million layer excess of $100 million is underwritten by ACE Ltd. of Bermuda.

Safeway filed suit in May after its insurers refused to cover a $59 million settlement of 11,800 third-party property damage claims brought by residents living near the facility. An additional 2,400 claims are still pending (*BI*, May 27).

Safeway's liability insurers, which already have paid $39 million in third-party bodily injury and property damage claims, argued their policies excluded coverage for third-party damage resulting from smoke and fumes released by the fire.

Gooda syndicates' fate in doubt

LONDON—The fate of seven syndicates managed by Gooda Walker Ltd. is in doubt as members—who face total losses of at least 221 million pounds ($372.7 million)—meet with Lloyd's of London Chairman David Coleridge today to discuss the syndicates' future.

Three syndicates with huge losses and cash calls outstanding for the 1988, 1989 and 1990 underwriting years have ceased underwriting and are being run off, said John Moir, new managing director of Gooda Walker, at a Gooda Walker Members Action Group meeting last week.

But Mr. Moir said he and new Gooda Walker Chairman D.R. Jewell have been working since they succeeded A.W. Gooda and Derek Walker on June 3 to save four ongoing, well-run syndicates from going into runoff, which would occur if members do not continue supporting the syndicates or if there is no agency to run them.

To save the four viable syndicates, the new directors want to establish a new agency not owned by Messrs. Gooda and Walker to run off the three syndicates with losses and manage the other four, he said.

An attorney representing the members group urged members to support the plan at a scheduled meeting with Mr. Coleridge today.

Shipowner covered for oil spill

OLYMPIA, Wash.—The Japanese owner of a ship that sank off Washington late last month and spilled 100,000 gallons of oil has $500 million of pollution liability insurance, but the firm's liability may be capped at $2.5 million under federal law, says a state assistant attorney general.

The Tenyo Maru, a fish-processing ship owned by Taiyo Fishing Co. of Tokyo, collided with a Chinese grain carrier July 22 and sank in international waters, releasing the oil. The bulk of the spill is still about 20 miles off Washington's coast, but late last week was threatening to move ashore. About 25 miles of coastline in the Olympic National Park has been fouled, and thousands of seabirds have been killed.

The ship carried about 365,000 gallons of oil. About 270,000 gallons of that was medium-weight bunker oil and the remainder was diesel fuel. The ship was still spilling oil late last week.

Taiyo has $500 million of pollution liability coverage written by the Japan Shipowners Mutual Protection & Indemnity Assn. of Tokyo, said a spokesman for the insurer in Tokyo.

But, the state will seek to recover damages under the Oil Pollution Act of 1990, said Jay Manning, state assistant attorney general in Olympia. The federal law established a $1 billion federal trust fund to cover damages beyond an individual company's liability (*BI*, Aug. 27, 1990). Under the formula established by the act, Taiyo's liability is capped at $2.5 million, said Mr. Manning, noting that damages are expected to exceed $2.5 million. But, under the act, liability limitations do not apply in cases of gross negligence or willful misconduct.

The Japan Shipowners Mutual spokesman said that $2.5 million already has been placed in a trust account in Seattle.

Briefly noted

Employers would be required to offer **minimum health care coverage** to employees or pay a tax of 9% of the Medicare wage base under legislation, H.R. 3205, unveiled Friday by Rep. Daniel Rostenkowski, D-Ill. Employees could be charged 20% of premium costs. The bill also would limit the nation's health care expenditures. . . .Zurich Insurance Co. is increasing its stake in Bermuda-based **Centre Reinsurance Holdings Ltd.** to more than 75% from 40% by acquiring stakes held by other shareholders, said Steven M. Gluckstern, president and chief executive officer. . . .Dai Ichi Kyoto Re-Insurance Co. S.A. and Kobe Reinsurance S.A., both of Belgium, have obtained an order from a Georgia state judge enjoining insurance consultant **Alan Teale,** Atlanta-based intermediary World Re Inc. and several others from claiming any affiliation or connection with the two reinsurers. . . .California Superior Court Judge Kurt Lewin has set a Sept. 30 trial date to consider claims from **Executive Life Insurance Co.** annuity contract and guaranteed investment contract holders for declaratory relief (*BI*, July 22). . . .**USF&G Corp.** reported a $56 million net loss in the second quarter, the worst quarterly loss in its history. The insurer reported a $5 million profit in 1990's second quarter. USF&G said catastrophe losses and restructuring charges were primarily to blame for the loss loss. USF&G reported a second-quarter 1991 combined ratio of 122.4%, compared with 111.6% in last year's second quarter.

Pension simplification gains favor

By ADRIENNE C. LOCKE

WASHINGTON—The Bush administration will support pension simplification legislation introduced by House Ways and Means Chairman Daniel Rostenkowski, D-Ill.

The department agrees with Rep. Rostenkowski's assessment that the bill is revenue-neutral, said Kenneth W. Gideon, assistant Treasury secretary for tax policy.

But because other House pension simplification measures are not revenue-neutral, the administration will not support them, he said.

"In the current budgetary environment, any simplification proposals are constrained by the realities of the federal budget," Mr. Gideon said during a House Select Revenue Measures Subcommittee hearing late last month on pension simplification. "The administration must oppose pension legislation that loses revenue."

Others who testified disagreed over the specifics of various pending simplification proposals, including the Labor Department's own proposed Pension Opportunities for Workers' Expanded Retirement—or POWER—package to encourage small employers to establish pension plans (*BI*, May 13). But they generally agree that current law can and should be simplified to encourage employers to offer pension plans.

Besides revenue-neutrality, Mr. Gideon cited another reason for administration support of the Rostenkowski bill: It would simplify pension plans, but would not "alter the fundamental retirement and tax policies."

H.R. 2730, known as the "Pension Access and Simplification Act of 1991," would simplify 401(k) plan administration by changing the timing for running a key non-discrimination test (*BI*, July 1). The test compares contributions by highly compensated and lower paid employees.

Under H.R. 2730, employers would be able compare the contributions made by higher-paid workers during the current year with the contributions made by lower-paid employees during the previous year.

Current rules require employers to compare current-year contributions of both groups. As a result, employers must monitor contributions by lower-paid employees during a plan year to ensure that contributions by higher-paid employees do not exceed those of lower-paid employees by more than the permissible amount.

The bill also would ease the administration burdens of all pension plans by, among other things, making it easier for employers to calculate the maximum contributions they can make to their pension plans. The cost of living adjustment to be applied to these maximums each year would be announced sooner than they are now, which is late January.

Determining which employees would be considered highly paid also would be simpler. A highly paid employee would be anyone earning at least $65,000 annually or who owns at least 5% of a company.

Mr. Gideon testified that he saw similarities in the intent of the administration's POWER proposal and H.R. 2742, introduced by Rep. Benjamin Cardin, D-Md., and H.R. 2641, introduced by Rep. Rod Chandler, R-Wash.

Still, the administration opposes both those proposals because the Treasury Department estimates that they would reduce federal revenues, though a Treasury department spokesman could not say how much revenue would be lost.

The Cardin bill, H.R. 2742, would exempt all employers with 401(k) plans from non-discrimination testing by establishing two safe harbors. To qualify for the safe harbors, employers would have to either:

- Match 100% of employees' contributions that equal up to 3% of compensation. Employers would have to match 50% of employee contributions that equal an amount exceeding 3% but not more than 5% of compensation.
- Automatically make contributions of at least 3% of compensation regardless of whether the employee contributes to the plan. Employer contributions would have to be immediately vested.

Rep. Chandler's bill is similar to Rep. Cardin's bill, which is the House companion legislation to S. 1364, introduced by Sens. David Pryor, D-Ark. and Lloyd Bentsen, D-Texas.

Mr. Gideon said the administration opposes the alternatives to the actual deferral percentage test permitted in the Cardin and Chandler bills. The provision would "seriously erode" existing government policy against discrimination in pension plans because it provides no assurances that benefits would be provided to lower-paid workers, he said.

By contrast, the administration's POWER proposal, unveiled in April, would establish a new pension program for employers that have 100 or fewer employees and do not already offer qualified pension plans. Employers that participate in the program would be exempt from non-discrimination testing if they contribute at least 2% of pay to the plan for all employees. Plan participants would be able to contribute up to $4,200 of pay on a pretax basis, while employers could make a matching contribution of up to 50% of employee contributions.

In addition, to encourage roll-overs of lump sum distributions, all of the proposals would make it easier for participants in defined contribution and defined benefit plans to transfer the distributions directly into an individual retirement account or into a new employer's pension plan, if the plan accepts distributions.

And, all of the bills would repeal the current favorable tax treatment of five- and 10-year forward averaging used to calculate the taxes on lump sum pension distributions.

Pension administrators at the hearing said they support many of the simplification proposals. "We commend the efforts to simplify the non-discrimination testing of qualified plans and to provide safe harbors" for 401(k) plans, said Michael Callahan, chairman of the government affairs committee for the American Society of Pension Actuaries in Washington, D.C.

The American Institute of Certified Public Accountants testified in support of liberalized lump sum distribution rollover requirements. "We strongly support allowing any distributions from a qualified plan. . .to be eligible for rollover treatment," said David J. Kautter, chairman of the group's employee benefits taxation committee in Washington, D.C.

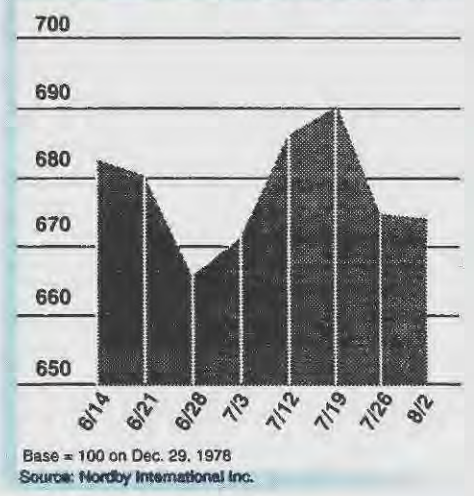
Making rollovers easier in more situations would simplify the tax treatment and administration of these rollovers, while encouraging employees to save retirement funds, he said.

However, Robert Stone, associate general counsel at International Business Machines Corp. in Armonk, N.Y., who spoke on behalf of the ERISA Industry Committee of Washington, D.C., opposed repeal of five- and 10-year forward averaging. "Employees have saved and made their retirement plans on the basis of the lump sum distribution provisions. Congress should not now pull the rug out from under the thousands of employees who have relied on these provisions in choosing to participate in an employee-sponsored savings and 401(k) plans and in making their financial plans."

The Assn. of Private Pension & Welfare Plans, a Washington, D.C., lobbying group that represents primarily large companies, agrees. Kevin P. Flatley, a member of the group's board of directors and vp-employee at American Express Co. in New York, testified that the provision repealing forward averaging forces pension and tax policy into the simplification debate. "Those proposals are not simplification at all. Rather, they change the tax liability of retirees."

By contrast, Mr. Gideon of the Treasury Department argued that the forward averaging is "no longer needed" because of the "changes in the basic structure of the individual tax rates." ■

BI Insurance Index



Base = 100 on Dec. 29, 1978
Source: Nordby International Inc.

Insurance industry stocks fell last week as the *Business Insurance* Index dropped a total of 15.9 points to 674.2 on August 2, from 690.1 on July 26. Advancing insurance issues for the week were led by Kemper Corp., up 9.9%; RLI Insurance Corp., up 8.3%; and CIGNA Corp., up 7.6%. Declining insurance issues for the week followed Pacificare Health System, down 13.6%; United Medical Corp., down 11.6%; and USF&G Corp., down 7.7%. The most active insurance issue for the week was U.S. Healthcare, with 10.9 million shares traded. The *BI* Index was up 1.6%; the Standard & Poor's 500 climbed 1.6%; the Dow Jones 30 Industrials were up 1.1%; and the New York Stock Exchange Composite rose 1.6%.

British Issues

August 1 Companies	Price pence	P/E	Div. pence	Yield %	1 Week High—Low pence	pence
Comml Union	526	N/M	30.7	5.8	526	511
Genl Accident	555	N/M	35.7	6.4	555	539
Gdn Royal Exch	180	N/M	15.9	8.8	183	180
Royal	405	N/M	34.7	8.6	405	395
Sun Alliance	376	N/M	18.7	5.0	376	362
Brokers						
Bradstock	150	17.1	6.0	4.0	150	150
CE Heath	456	15.9	34.5	7.6	456	456
Hogg Group	202	12.1	10.7	5.3	202	195
Lloyd Thompson	381	25.3	10.0	2.6	381	380
PWS Holdings	79	9.7	4.7	5.9	79	79
Sedgwick Grp	269	25.7	16.0	5.9	274	268
Steel Brrl Jones	299	15.8	16.3	5.4	299	298
Willis Corroon	313	16.6	17.6	5.6	315	312

Source: Philip Olsen, Insurance Industry Analyst London

BI Industry Stock Report

JULY 29, 1991 THROUGH AUGUST 2, 1991

		Price	Weekly % change	Year to Date % change	Annual High	Annual Low	Vol.(000)	$ Div.	% Yield	P/E	Book value	Mkt/Bk. value
BROKERS												
Alexander & Alexander	NYS	22 13	0 00	-4 32	27 63	16 13	365	1 00	4.52	18	9 77	2 26
Gallagher Arthur J & Co	NYS	20 25	0 00	-12 90	28 38	19 50	101	0 64	3 16	16	5 88	3 44
Frank B Hall	NYS	3 75	3 45	3 45	4 13	2 00	202	0 00	0 00	-8	-5 24	-0 72
Hilb, Rogal & Hamilton	OTC	13 75	0 00	-6 78	17 50	11 25	29	0 36	2 62	21	3 56	3 86
Markel Corp	OTC	18 75	1 38	59 57	20 00	10 25	168	0 00	0 00	10	3 56	5 27
Marsh & McLennan	NYS	78 38	0 64	0 48	87 25	59 75	706	2 60	3 32	19	14 77	5 31
Poe & Associates	OTC	11 50	0 00	79 69	12 50	6 25	9	0 32	2 78	14	2 09	5 50
BROKERS	AVERAGE		0 8	17 0					2 3	13		
CONGLOMERATES & HOLDING COMPANIES												
Berkley W R Corp	OTC	27 63	-3 9	-26 33	32 25	19 00	514	0 32	1 16	15	23 89	1 16
Berkshire Hathaway Inc	NYS	8600 00	1 18	28 84	8900 00	5675 00	0	0 00	0 00	-28	4612 00	1 86
ITT (Hartford Group)	NYS	59 00	3 51	22 92	63 00	40 25	1107	1 72	2 92	9	64 01	0 92
Sears (Allstate)	NYS	40 88	1 55	61 08	41 00	22 00	2896	2 00	4 89	14	37 38	1 09
CONGLOMERATES	AVERAGE		0 6	21 6					2 2	3		
INSURERS/REINSURERS												
Aetna Life & Casualty	NYS	38 13	4.45	-2 24	49.13	29.00	2293	2.76	7 24	8	64.23	0 59
American General	NYS	39 63	2 26	28 86	45 25	23 50	890	2 00	5 05	9	37 14	1 07
American Heritage	NYS	27 63	1 38	31 55	32 25	19 63	6	1 08	3 91	12	19.25	1 44
American Indemnity/Fin'l	OTC	7.00	3.70	115 38	7 75	2 75	4	0 08	1 14	4	12.93	0 54
American International	NYS	86 63	6 45	12 68	102 00	57 00	2265	0 48	0 55	12	45 34	1 91
Aon Corp	NYS	38 63	1.31	11 15	41.75	26.75	235	1 60	4.14	11	18.50	2 09
Argonaut Group	OTC	26 50	3.92	24 22	33 38	17.75	94	0 68	2 57	9	48.26	0 55
AVEMCO Corp	NYS	20.75	3 11	23 27	22 88	14 13	50	0.40	1 93	15	9.55	2 17
Baldwin & Lyons Inc	OTC	23 00	0 00	22 67	25 25	17 00	11	0 28	1 22	7	24 29	0 95
Belvedere Corp	ASE	3 25	4 00	30 00	3 75	1 75	5	0 04	1 23	22	7 65	0 42
Chandler Insurance	OTC	3.00	-7.69	-56 36	7 63	2.75	49	0.00	0.00	-3	5.95	0.50
Chubb Corp	NYS	72 50	4 50	33 64	75 25	34 63	657	1 48	2 04	11	35 19	2 06
CIGNA Corp	NYS	45.88	7.62	12.23	56 75	33.25	977	3 04	6 63	11	73.15	0.63
CNA Financial Corp	NYS	79 13	-1.09	15 30	92.50	49.50	45	0 00	0.00	13	70 23	1 13
Continental Corp	NYS	29 50	3 06	18 59	30 63	15.75	729	2.60	8 81	12	37 83	0.78
Durham Corp	OTC	32 00	1 59	14 29	34 13	23.00	21	0.92	2 88	16	28 04	1 14
Fund American Corp	NYS	64 50	1 18	24 34	65.25	41 63	68	0 68	1.05	19	36 11	1.79
Fremont General Corp	OTC	23 50	0.00	62 07	25.25	10.13	109	0 88	3.74	7	19.13	1.23
Frontier Insurance Group	NYS	24 63	0 51	29.61	26 38	15 38	51	0 00	0.00	10	11.20	2 20
General RE Corp	NYS	88 38	-5 23	-4.97	102.50	69.00	1464	1.68	1.90	13	37 50	2.36
Hanover Insurance Co	OTC	28 00	2 28	5.66	30.75	21.00	140	0.44	1.57	9	37.44	0.75
Harleysville Group	OTC	30 00	0 00	31 15	32 00	13.50	19	0.64	2.13	9	22.99	1.30
Hartford Steam Boiler	NYS	54 88	-1.57	12 56	63.75	43.50	118	1.80	3.28	15	17.05	3.22
Kansas City Life Ins	OTC	35.25	0.71	14 17	36 50	30 00	10	1.20	3 40	9	39.22	0.90
Kemper Corp	NYS	33.50	9 84	41.05	39.25	17 13	357	0.92	2.75	9	34.20	0.98
Lawrence Insurance Group	ASE	9 25	2.78	32 14	9.50	6 38	1	0.48	5.19	14	4.71	1.96
Liberty Corp	NYS	40 13	-1 53	-2 43	48 50	39 00	6	0 92	2 29	13	23 86	1 68
Lincoln National	NYS	46 13	1 86	7 27	55 25	30 75	309	2 72	5 90	10	45 16	1 02
NAC Re Corp	OTC	39 75	3 25	20 45	42 50	25 50	192	0 20	0 50	16	18 90	2 10
Navigators Group	OTC	31 50	-4 55	44 27	34 50	16 50	24	0 00	0 00	17	13 52	2 33
Nobel Insurance LTD	OTC	3 63	0 00	20 83	4 38	2 38	39	0 00	0 00	-	7 76	0 47
NWNL Companies	NYS	20 63	1 23	22 22	32 88	11 75	749	1 40	6 79	5	42 73	0 48
Ohio Casualty Corp	OTC	47 00	3 01	14 63	50 25	26 75	133	2 48	5 28	10	36 38	1 29
Old Republic Int'l	NYS	30 38	2 97	32 79	31 13	17 38	175	0 72	2 37	7	33 09	0 92
Orion Capital Corp	NYS	29.25	4 93	67 14	29 50	13 00	129	0 92	3 15	9	20 42	1 43
Phoenix RE Corp	OTC	9 25	5 71	19 35	10 00	5 00	47	0 20	2 16	12	13 30	0 70
Protective Life Corp	OTC	19 50	6 85	31 09	22 50	10 25	51	0 84	4 31	8	16 29	1 20
Provident Life	OTC	19 00	-5 00	8 57	24 50	12 00	70	0 92	4 84	5	25 88	0 73
Re Capital Corp	ASE	16 00	-3 03	24 27	18 63	11 75	17	0 20	1 25	11	15 05	1 06
RLI Insurance Corp	NYS	13 00	8 33	-10 34	16 38	9 63	76	0 44	3 38	7	14 41	0 90
St Paul Companies	OTC	62 50	-0 40	-0 40	74 25	47 00	1154	2 60	4 16	7	52 00	1 20
SAFECO Corp	OTC	39 63	0 63	20 53	44 75	25 13	579	1 48	3 74	10	31 50	1 26
SCOR U S Corp	NYS	13 25	1 92	7 07	15 25	8 38	14	0 24	1 81	8	11 19	1.18
Seibels Bruce Group	OTC	8 00	0 00	88 24	8 88	4 25	32	0 36	4 50	-160	7 35	1 09
Selective Ins Group	OTC	15 75	3 28	18 87	18 00	12 50	182	1 04	6 60	8	18 91	0 83
Statesman Group Inc	OTC	5 00	0 00	219 90	5 13	1 25	707	0 00	0 00	-250	2 48	2 02
Tokio Marine & Fire	OTC	46 75	0 00	-1 06	56 50	34 50	3	0 00	0 00		70 93	0 66
Torchmark Corp	NYS	51.25	2 76	4 86	58 50	38 00	228	1 60	3 12	12	16 70	3 07
Transamerica	NYS	32 38	-1 15	-0 77	38 38	23 25	427	1 96	6 05	10	36 56	0 89
Transatlantic Holdings	NYS	34 75	1 83	26 94	39 38	18 88	289	0 20	0 58	12	36 56	0 95
Travelers Corp	NYS	20.25	3 85	21 80	29 88	11 50	586	1 60	7 90	-11	41 44	0 49
Trenwick Group Inc	OTC	28.00	0.90	21.08	30 00	16.25	65	0.60	2 14	10	21 71	1 29
United Fire & Casualty	OTC	46 50	-4.12	32 38	58 00	28.75	3	1 32	2.84	9	35 39	1 31
USF&G Corp	NYS	7 50	-7 69	0 00	25 00	7 00	2204	0 20	2 67	-1	11 96	0 63
UNUM Corp	NYS	64 75	1 17	38 87	70 25	32 13	786	1.04	1 61	11	37 25	1.74
USLIFE Corp	NYS	40 38	-2.42	44 20	42 75	23 25	79	1 64	4 06	9	60 34	0 67
Unitrin	OTC	37.75	-0.66	22 76	41 50	24 50	373	0 80	2.12	14	30 70	1 23
Washington National	NYS	14.00	-1 75	28 74	19 38	9 38	71	1 08	7 71	-7	26 86	0 52
USLICO Corp	NYS	20 25	-1.82	27 56	21 75	14 75	47	1 00	4.94	9	29 44	0 69
Zenith National Ins	NYS	17 38	-2 11	27 52	18 50	9 88	88	1 00	5.76	-72	13 14	1.32
INSURERS/REINSURERS	AVERAGE		1.1	26 9					3 3	0 7		
HEALTH MAINTENANCE ORGANIZATIONS												
FHP International	OTC	26 75	3 88	75 41	29 75	8 88	416	0 00	0 00	23	5 44	4 92
HMO America Inc	OTC	13 50	-3.57	107.69	17.13	4 25	1090	0 00	0 00	15	0 61	22 13
Pacificare Health Sys	OTC	35 00	-13 58	115 38	42.50	12 00	1364	0 00	0 00	18	6 55	5 34
Safeguard Health Enter	OTC	5.50	0.00	15 79	7 25	4 00	36	0 00	0 00	19	3 53	1 56
Sierra Health Services	ASE	23 00	0 00	67 27	29.50	5 50	224	0 00	0 00	10	1 78	12 92
United Healthcare Corp	OTC	50.50	-3 35	117 20	54.63	13.13	2259	0 06	0 12	33	3 76	13 43
United Medical Corp	ASE	7 63	-11 59	-4 69	10 88	6 63	15	0 00	0 00	11	8 79	0 87
U S Healthcare	OTC	31 75	-6 62	8 09	38 00	10 00	10927	0 32	1 01	19	3 38	9 39
HMOs	AVERAGE		-4.4	62 8					0 1	19		
ALL COMPANIES	AVERAGE		0 5	28.7					2 8	4		

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