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Business Insurance®

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Update

Bentsen to propose bill delaying pension non-discrimination rules

WASHINGTON—Senate Finance Committee Chairman Lloyd Bentsen, D-Texas, will introduce legislation this month that would delay for one year the effective date of Internal Revenue Service pension non-discrimination rules.

Sen. Bentsen said in a letter co-signed by Sen. David Pryor, D-Ark., that it was "unrealistic" for the IRS to have set a Jan. 1, 1992, effective date for regulations that are hundreds of pages long, were not finished until November and

Continued on next page

Newspaper, insurer clash over anti-fraud advertising

By STACY ADLER GORDON

LOS ANGELES—"Warning: Commit Workers Compensation Fraud & Face Criminal Prosecution," reads the three-inch classified advertisement from Fremont Compensation Insurance Co.

The ad goes on to quote a newly enacted California statute that makes it a felony to submit a fraudulent workers comp claim.

But the attempt by the Fremont General Corp. unit to fight workers comp fraud through the classified ads was cut short when the Los Angeles Times told the Glendale, Calif.-based insurer that the newspaper would no longer run the advertisement under the "Medical Services" heading in the Times' classified advertising section.

HEALTH

Medical Services 1634

WARNING

COMMIT WORKERS' COMPENSATION FRAUD & FACE CRIMINAL PROSECUTION

California law states:

"Any person who makes or causes to be made any knowingly false or fraudulent material statement or material representation for the purpose of obtaining or denying workers' compensation benefits or payments is guilty of a felony."

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The newspaper maintains that since Fremont was not offering a medical service, it would have to place its ad—which ran Jan. 18, 19 and 20—under another heading in the classifieds. The Times suggested that the "Legal Services" column would be more appropriate.

Fremont disagreed and immediately pulled its advertisement altogether.

The "Medical Services" column "is the place where people injured on the job go to seek assistance," said Jim Little, Fremont's president and chief executive officer.

"To move the ad somewhere else in the newspaper would defeat the purpose.

"The section is labeled 'Medical Services,' but the only service I see advertised is solicitation of work comp claims," Mr. Little said.

For example, a classified ad that appeared in the Sunday, Jan. 19, Los Angeles Times under the "Medical Services" column read: "Job Problems? Emotional Distress? Harassment? Physical Injury? Overwork? Call our Helplines Anytime. Free Appointment. You May Be Entitled to Substantial Benefits $$ Compensation $$$ Evaluation Treatments. No Cost to You!!!"

Calls from *Business Insurance* to the advertiser, Psych Services Center in Los Angeles, and many of the other advertisers listed in the "Medical Services" section revealed that the companies refer injured workers to attorneys.

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House staffers consider new solvency proposal

Two-tier regulation included in outline

By DOUGLAS McLEOD

WASHINGTON—Insurance companies, regulators and risk managers anxiously await federal insurer solvency legislation as congressional staffers consider a new approach.

Staffers from the House Energy and Commerce Committee and its Oversight and Investigations Subcommittee in recent weeks have been considering an approach that differs sharply from an earlier proposal advanced by the subcommittee, *Business Insurance* has learned.

A new discussion outline circulated in December calls for optional federal regulation of U.S. insurers and reinsurers writing certain lines of business.

This differs markedly from a legislative outline released in August that called for federal oversight of state regulation but no direct federal regulation of most industry segments (*BI*, Aug. 12, 1991).

It is unclear whether the December outline indicates the direction Energy and Commerce Committee Chairman John D. Dingell, D-Mich., will take in the final bill—expected sometime this spring—or whether it is merely another trial balloon floated for industry comment.

Some legislative observers point to the December outline and Rep. Dingell's sharp criticism of state regulation in speculating that House staffers may be leaning toward some form of two-tiered regulation of the industry.

The newer outline is similar in its approach

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Slim chance seen for McCarran reform during election year

By MARK A. HOFMANN

WASHINGTON—Congress will have to move swiftly if it plans to reform the McCarran-Ferguson Act or enact a federal product liability law this election year.

"This is going to be a very short session because it's a presidential election year. (Congress is) not going to address a whole lot," observed Paul Brown, director of government and public affairs and general counsel for the Risk & Insurance Management Society Inc. in New York.

Congress also has a wide array of other issues that risk managers, insurers, consumer activists and regulators—as well as the business and labor communities in general—would like to see addressed:

- Insurance solvency regulation (see related story).
- Tougher workplace safety regulation.
- Possible legislative attempts to outlaw a key exclusion in corporate directors and officers liability policies.
- Restrictions on the use of electronic monitoring devices used in investigating possible workers compensation fraud.
- A resurrection of legislation creating federal penalties for insurance fraud.

The issue grabbing the most attention is reform of the McCarran-Ferguson Act, the 1945 law that grants insurers limited exemption from federal antitrust laws and establishes the states as the primary regulators of the insurance industry.

House Judiciary Chairman Jack Brooks, D-Texas, is seeking to limit insurers' antitrust exemptions through H.R. 9, the Insurance

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Bush health package delayed

Congressional outcry dooms benefit tax provisions

By JERRY GEISEL

WASHINGTON—While the details of President Bush's health care reform package still are shrouded in secrecy, the plan probably will not include changes in the tax status of employer-sponsored health care plans.

Details of the administration's proposals to improve access to health care for the 35.7 million uninsured were to have been included in the $1.52 trillion proposed 1993 federal budget President Bush sent to Congress last week.

But the details were removed from the budget at the 11th hour after congressional Republicans warned of political disaster if the administration advocated taxes on employer-provided health care benefits (*BI*, Jan. 20).

While Health and Human Services Secretary Louis W. Sullivan and other administration officials said President Bush will present his health care package soon—possibly in a speech this week in Ohio—they broadly hinted that

Bush budget proposes changes in 401(k) non-discrimination tests. Page 29.

health care plans' tax-preferred status will not be changed.

Only one detail in the health care package was publicly released last week: a provision for low-income individuals to receive tax credits or vouchers to buy health insurance.

President Bush had been expected to end weeks of waiting by including in his budget package proposals for improving access to health care, which has become one of the top domestic issues during this election year.

But details of his plan are nowhere to be found in the six-pound budget document. A brief introduction simply says: "The details of the President's Comprehensive Health Reform Plan are not included in this document."

In fact, the health care section of the budget was rewritten while the presses were already rolling.

Dr. Sullivan last week tried to downplay the omission. The administration is ready to unveil a comprehensive package, he said; the only disagreement is when the proposals would be presented.

But many attribute the delay to the firestorm ignited after congressional Republicans learned that the administration wanted to limit the tax breaks on employer-provided health plans to help finance new federal programs for the uninsured.

Under one proposal the administration reportedly had considered, employer tax deductions for health care

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Update

Pension rule delay sought

Continued from previous page
contain "flaws."

"The retirement benefits of American workers are simply too important to be restructured in a few weeks based on incomplete and complex regulations," Sens. Bentsen and Pryor said.

Delaying the effective date until Jan. 1, 1993, would give employers time to comment and the IRS the opportunity to correct flaws, the senators said.

The IRS last November said companies could retroactively amend their pension plans as late as Dec. 31, 1992, and still be in compliance with the rules. But employers claimed that relief was inadequate (*BI*, Nov. 25, 1991).

With the "certain" threat of congressional action to at least delay the regulations and possibly to revamp them, "I wouldn't be surprised if the IRS doesn't take the initiative and announce its own delay to head off legislation," said Frank McArdle, a consultant with Hewitt Associates in Washington, D.C.

Quick Executive Life sale urged

LOS ANGELES—California regulators are urging the judge overseeing the conservatorship of Executive Life Insurance Co. to quickly approve its sale because the failed insurer's junk bond portfolio is deteriorating rapidly.

Time is critical because the souring bonds are costing Executive Life's buyer, a French investor group led by Altus Finance, "substantial sums," said Insurance Commissioner John Garamendi.

Executive Life policyholders are concerned that if the bond portfolio's value falls below the $3.25 billion purchase price, they will not be paid the amount Altus has promised, said Christine Franklin, an attorney with Thelen, Marrin, Johnson & Bridges in Los Angeles, who represents some of the holders of municipal bonds backed by Executive Life guaranteed investment contracts.

Court rejects pollution case

WASHINGTON—The U.S. Supreme Court is refusing to enter the fray over insurance coverage for pollution cleanups and liability for asbestos-related injuries.

The high court refused to review a July 16 ruling by the 1st U.S. Circuit Court of Appeals that a policyholder that discharges pollutants as a regular part of its business practices is not entitled to coverage under comprehensive general liability insurance policies (*BI*, Aug. 5, 1991; July 22, 1991; June 25, 1990).

The appellate court barred Belleville Industries Inc. of New Bedford, Mass., from attempting to prove that the release of PCBs as a byproduct of the company's electrical capacitor manufacturing process was "sudden" or "accidental." The pollution exclusion clause in CGL policies bars coverage for pollution that is not "sudden and accidental."

The court refused to review the ruling "because it felt there was no constitutional issue," said Dave Sullivan, senior vp-claims at Lumbermens Mutual Casualty Co. in Long Grove, Ill., Belleville's insurer.

The high court also refused to review a ruling by the Federal Circuit Court of Appeals that asbestos producers cannot sue the U.S. government for contributions toward bodily injury claim payments.

The companies sought to hold the government liable based on contract theories that allege the government issued an implied warranty that asbestos was safe by calling for the use of asbestos in Navy ships. Both the U.S. Claims Court and the appellate court denied the insurers' claim.

"These theories have been pursued since 1983, and this is probably the end of the line," commented attorney Paul Gaston of Spriggs & Hollingsworth in Washington, D.C., who represents GAF Corp.

PBGC moves on Blaw Knox

WASHINGTON—The Pension Benefit Guaranty Corp. is moving to terminate and take over a massively underfunded pension plan for hourly steel workers sponsored by Blaw Knox Corp. of Pittsburgh.

The Blaw Knox Pension Plan, covering about 3,100 participants, including 2,200 retirees, has $81.6 million in liabilities and virtually no assets. The PBGC attributed the underfunding in part to recent plant shutdowns that boosted the pool of retirees.

Separately, the pension agency said it hopes that Trans World Airlines, which filed for protection from its creditors last week, will emerge from Chapter 11 with its pension plans intact. The plans are underfunded by $933 million, the PBGC says.

OSHA raps state programs

WASHINGTON—The acting head of the Occupational Safety and Health Administration has given 22 U.S. jurisdictions that operate their own workplace safety programs six months to correct deficiencies in their programs or face possible federal decertification.

All 22 programs were cited for shortcomings in evaluations released Friday by Acting Assistant Secretary of Labor Dorothy L. Strunk. The states have until March 1 to give OSHA a timetable and plan for correcting the deficiencies, she said.

Jurisdictions can operate their own workplace safety programs as long as they are at least as effective as the federal OSHA program.

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Errors & omissions

Due to a production error, a photograph of another person was identified as that of Jock Connell, risk manager for Gwinnett County, Ga., in the Jan. 20 At Issue column. Mr. Connell's correct photo is reprinted here.

Colorado court denies offsets for reinsurers

By MEG FLETCHER

DENVER—A Colorado Supreme Court ruling denying reinsurers' right to offsets in an insurer liquidation is being praised by regulators' attorneys and blasted by reinsurers' attorneys.

Colorado's highest court last month unanimously upheld two lower court decisions denying five reinsurers the right to offset amounts they owed to Aspen Indemnity Corp. by the amount of unpaid premiums that Aspen owed the reinsurers.

Last week the reinsurers were given until Feb. 14 to request a rehearing before the Supreme Court, the only likely avenue for judicial review of the decision, attorneys say.

If the decision stands, reinsurers will pay about $450,000, plus at least six years' interest, to the Colorado receiver of Aspen and A.I.C. Agency Inc., a wholly owned agency, said Thomas Frank, an attorney with Frank & Finger in Evergreen, Colo., who represented the receiver.

The funds from the reinsurers are due under reinsurance treaties that were in effect for 15 months prior to Aspen's 1984 insolvency. Under the contracts, the money is due even though Aspen never paid any premiums to the reinsurers.

The reinsurers that unsuccessfully appealed the lower court decisions are: the former Bluewater Insurance Ltd., now the Tennessee Insurance Co. in Nashville; Camelback Reinsurance Underwriter Inc. in Phoenix; Imperial Casualty & Indemnity Co. in Omaha, Neb.; First Horizon Insurance Co. in Minneapolis; and American Centennial Insurance Co. in Wilmington, Del.

Another of Aspen's reinsurers, Pennsylvania Manufacturers' Assn. Insurance Co. in Philadelphia, was not a party to the litigation, but agreed to abide by its outcome, Mr. Frank said.

The Colorado Supreme Court based its Jan. 13 ruling on the state's Insurance Code, which disallows offsets and gives the insurance commissioner the authority to ban proposed offset provisions in reinsurance contracts, as he specifically did in this case.

The court did not expressly rule

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Insurer ratings examined

Insolvencies trigger request for investigation by GAO

By MARK A. HOFMANN

WASHINGTON—The chairwoman of a U.S. House subcommittee that is investigating insurer solvency issues says she will ask the General Accounting Office to review insurer rating agency practices.

"With the public concerned about the solvency of insurance companies, consumers must be able to rely on the accuracy and fairness of ratings in judging the financial strength of a company. Unfortunately, this has not been the case," Rep. Cardiss Collins said last week at a hearing of the Commerce, Consumer Protection and Competitiveness Subcommittee.

The Illinois Democrat did not say when the study by the GAO, Congress' investigative arm, will be completed or what it will entail. She did indicate that the subcommittee will continue looking into the role of rating agencies as part of its examination of insurer solvency.

Rep. Collins' questions to representatives of four rating agencies—A.M. Best Co., Standard & Poor's Corp., Moody's Investors Service Inc. and Duff & Phelps Credit Rating Co.—revolved around their failure to quickly downgrade troubled insurers like Executive Life Insurance Co. and Mutual Benefit Life Insurance Co.

Both life insurers had relatively high ratings until shortly before they were seized by state regulators (*BI*, Aug. 5, 1991).

Rep. Collins and other subcommittee members also probed the fairness of the ratings, whether ratings are intelligible to the average consumer and the lack of a uniform rating system.

One member, Rep. Michael G. Oxley, R-Ohio, rose somewhat to the rating agencies' defense. "In many ways, these companies attempt to do the impossible" by boiling down an insurer's entire balance sheet to a few numbers and letters, he said.

Rep. Collins asked the rating agency officers whether Executive Life, which is based in Los Angeles, and Mutual Benefit of Newark, N.J., had carried high ratings

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Texas attempt to crack down on employee leasing blocked

By MEG FLETCHER

AUSTIN, Texas—A Texas appeals court is blocking enactment of a state regulation that would ban employee leasing arrangements that regulators claim allow companies to avoid paying their fair share of workers compensation insurance premiums.

The rule promulgated by the State Board of Insurance, which would have disrupted workers compensation insurance arrangements for about 160,000 leased employees statewide, would have shifted the responsibility for obtaining workers comp coverage from leasing companies to all of their client companies as of Feb. 1.

But, the 3rd Court of Appeals in Texas late last week halted enforcement of the rule, which was adopted last October.

State insurance regulators were appealing a Jan. 21 temporary injunction by a state district court delaying enforcement of the rule.

In granting the request of 18 leasing companies that brought three separate lawsuits in state court, District Court Judge Pete Lowry found that the companies had reason to argue that state officials exceeded their authority by attempting "to redefine, amend, restrict or condition the term 'employer' as used in the Texas Workers Compensation Act."

The appeals court issued its own stay of the regulation. It also scheduled a March 4 hearing on state officials' appeal of the district court's temporary injunction, according to Assistant Attorney General Karen Pettigrew. She represents the state board, the state Insurance Department and the state's assigned risk plan in the lit-

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Inside

Departments

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Have consumers prioritize costly health services, expert suggests

Rationing care seen as solution to crisis

By JOANNE WOJCIK

LOS ANGELES—The nation's health care crisis would be solved if it adopted a health care rationing system based on patients' opinions of the most valuable and cost-effective treatments, a health policy management expert says.

Rather than allowing these health care purchasing decisions to be made at the time of delivery, the proposed system would ask a representative group of consumers to balance the value of certain medical services with their cost.

If health care expenditures were limited nationwide, then only the most effective treatments would be paid for under public and private health care plans, said Dr. David Eddy, senior adviser of health policy management to the Southern California region of Kaiser Permanente Medical Group.

The Managed Health Care Congress WEST

"There's no magic financing formula that's going to make health care free," Dr. Eddy told employers and health care experts at the Managed Health Care Congress West in Los Angeles last month.

"We have to achieve a balance between cost and value," he said.

Specifically, it must be decided which health care services are "worth" their cost and which cost "too much," explained Dr. Eddy, who is a professor of health policy management at Duke University in Durham, N.C.

Those decisions, he suggested, ought to be made by patients,

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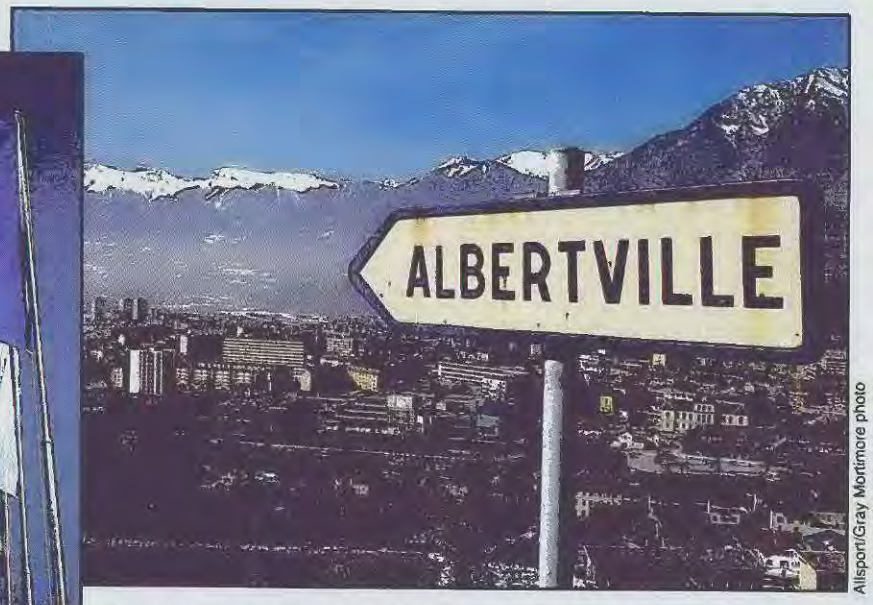
Allsport/Gerard Planchenault photo



Allsport/Gray Mortimore photo

New facilities and spectator stands have been built for all events at the Winter Olympics except for alpine skiing.

A gold medal program to cover Olympic risks

25 policies in place for Games

By GAVIN SOUTER

ALBERTVILLE, France—When the first hockey puck shoots across the ice in the opening event of the XVI Winter Olympic Games on Saturday, 25 property/casualty insurance contracts will be in place.

And although an expected 2 billion television viewers won't tune in to the events in France until then, insurers have had the Olympic program on their screens since 1989.

The 1992 Winter Olympics will be held Feb. 8-23 in and around the small town of Albertville in the French Alps.

Approximately 2,300 athletes from 65 countries are expected to take part, and 5,700 officials and support staff will be on site. About 1 million spectators are expected to attend the Games.

New facilities and spectator stands have been built for all events except for alpine skiing, said an Olympic Organizing Committee spokeswoman.

Although 25 different insurance contracts were placed in connection with the Games, the three principal contracts are: television rights insurance, general liability coverage, and health and personal accident coverage for the competitors and officials, said Patrick Vajda, liability manager at broker Gras Savoye S.A. in Paris, which placed the coverage.

Assurances Generales de France Group, the state-owned French insurer, leads the three major contracts and is the lead insurer on 70% of all the contracts, Mr. Vajda said.

The total premium for all of the contracts was 32 million French francs ($5.9 million), he said.

The TV rights coverage, which accounts for 45% of the premium, covers the Olympic Organizing Committee against loss of revenues from the cancellation or partial cancellation of TV broadcasting contracts, including a $243 million pact with CBS Inc.

Other broadcasters include Japan's NHK International Inc.; the European Broadcasting Union, which will relay the games to channels throughout Europe; and the Canadian Broadcasting Corp. None of these contracts approaches the size of the CBS contract. The Japanese contract is worth about $9 million, the European contract is worth 27 million Swiss francs ($19.1 million) and the CBC contract is worth $10 million Canadian ($8.6 million).

"For example, if an event has to be canceled due to bad weather, the OOC would be covered against the reduced revenues (payable by) the TV companies," Mr. Vajda explained.

The OOC also would be covered for any financial losses if, for example, the United States pulled out of the Games, which could affect the value of the TV contracts, or if the Games themselves were

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BC/BS donating health coverage to members of U.S. team

About 320 U.S. Olympic athletes, trainers, coaches and officials will be protected during the XVI Winter Olympic Games by health insurance coordinated and paid for by the Chicago-based Blue Cross & Blue Shield Assn.

The 1992 Winter Olympics will kick off on Saturday in and around the Alpine city of Albertville, France.

BC/BS, an official sponsor of the U.S. Olympic Team, will provide health care coverage underwritten by Denver-based Rocky Mountain Life Insurance Co., a unit of Blue Cross & Blue Shield of Colorado in Denver and Blue Cross & Blue Shield of South Carolina in Columbia, S.C.

Under the 1992 BC/BS program, athletes and others will receive first-dollar coverage up to a maximum of $1 million per person.

The coverage is effective from the time a team member signs in at the Olympic Village until midnight, Feb. 24, said Duane Carlson, vp of communications at BC/BS.

The BC/BS coverage will act as

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Plan sponsors seek alternatives

Firms reconsider GIC investments

By JUDY GREENWALD

More than half of the funds in maturing guaranteed investment contracts are being reinvested in a wide variety of alternatives other than the traditional GICs issued by insurers, a new survey reports.

And, another survey reports that nearly 60% of employers that invest defined contribution plan assets in GICs either have started or plan to start examining their GIC insurers more closely following the failure of Executive Life Insurance Co. and the takeover of Mutual Benefit Life Insurance Co.

The general perception is that "the insurance industry as a whole is not doing that well," so plan sponsors are diversifying away from it, said Brian Ternoey, an A. Foster Higgins & Co. Inc. principal in Princeton, N.J.

And while plan sponsors may be placing plenty of funds with high-quality GIC insurers, their diversification standards require that they invest in other places as well, Mr. Ternoey said.

The Foster Higgins survey, included in the January edition of its "GIC ROR Report," included responses from 80 plans representing 79 companies. Plan assets totaled $24.4 billion, including $16 billion invested in GICs.

Half of the plan sponsors had GICs maturing between Sept. 30, 1991, and Jan. 1, 1992, which amounted to nearly $761 million.

Of this total, just $372 million, or about 49%, was reinvested in traditional GICs issued by insurers, though two-thirds of the plan sponsors are reinvesting at least some of the funds in GICs.

In one sense, the 49% reinvested in traditional GICs issued by insurers indicates that many plan sponsors are not just putting their funds back into traditional GICs, Mr. Ternoey said. But, he added, "that 49% is still quite a lot of money."

"It's just that they don't have quite the book of business they did

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Amoco Cadiz award increased to $203 million

AP/Wide World Photo

68 million gallons of oil washed ashore in 1978 from the wreck of the Amoco Cadiz.

By DOUGLAS McLEOD

CHICAGO—Amoco Corp. must pay about $203 million to the French government and other claimants damaged by the massive oil spill from the 1978 wreck of the supertanker Amoco Cadiz, a federal appeals panel has ruled.

The appellate decision calls for Amoco to pay 61% more than the roughly $126 million award affirmed by a federal judge in 1990 (*BI*, July 30, 1990).

Virtually all of the increase stems from the court's decision to boost the rate of prejudgment interest payable to the French government and dozens of other claimants damaged when oil from the 68 million-gallon spill washed ashore on the Brittany coast.

Affirming Amoco's liability for the disaster and ruling on a host of other issues, the three-judge panel of the 7th U.S. Circuit Court of Appeals also increased the prejudgment interest rate on an award to Petroleum Insurance Ltd. of Bermuda. PIL is the captive insurer of Royal Dutch/Shell Group, which owned the oil aboard the Amoco Cadiz.

PIL had paid a $22.9 million claim to Royal Dutch/Shell for the lost oil cargo, then sued Amoco to recover the loss.

Amoco has not decided whether to ask the appeals court for a rehearing or seek a review by the U.S. Supreme Court, a spokeswoman for the Chicago-based oil giant said.

Amoco last week announced a $47 million charge against fourth-quarter 1991 earnings to reflect additional reserving for the higher appellate award.

Amoco had $50 million in pollution liability coverage at the time of the wreck through London Steamship Owners' Mutual Insurance Assn. Ltd., a protection and indemnity club.

About $16.8 million of the policy limits went into a fund to cover spill claims, which had grown to about $48 million with interest by mid-1990. Most of the balance of Amoco's policy limits went to cover defense costs, which were included in limits, lawyers involved in the case have said.

The French claimants, meanwhile, do not plan to seek review of any elements of the appellate ruling, according to one of their lawyers, T. Barry Kingham, with the New York firm of Curtis, Mallet-Prevost, Colt & Mosle.

The French claimants had appealed the lower court ruling largely on the grounds that the rate of prejudgment interest should be increased, "so we feel pretty good" about the appellate decision, Mr. Kingham said.

In its Jan. 24 ruling, the appellate panel affirmed numerous elements of a July 1990 ruling by U.S. District Judge Charles R. Norgle Sr.

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Employee leasing

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igation.

Separately, a U.S. District Court has rejected a leased employee's request for a similar injunction. The court was not persuaded by arguments that the rule violated his constitutional rights of equal protection and due process.

Specifically, the regulation would alter state workers comp rules to make clear that "a standard workers compensation policy purchased by a client company provides workers compensation coverage for all workers of the client company, including its leased workers." The rule says that an employee leasing firm's workers comp insurance would cover only "workers that are not leased to a client company."

Other changes emphasize that all state workers comp rules apply to the client company's workers comp insurance "irrespective of the presence or absence of leased workers."

The State Board of Insurance also modified an endorsement for workers comp policies to reflect the changes.

But, many client companies say they will not be able to afford to buy workers comp coverage, say attorneys with Rentea & Whitehead, an Austin, Texas, law firm that represents 16 employee leasing firms and the leased employee who brought the federal suit.

"The state's approach is to throw the baby out with the bath water," said John Moore, an attorney with the firm.

There are other ways to curb abuse, he said. The state Legislature, though, failed during its last session to amend laws to eliminate employee leasing abuses, he said.

Miles Mathews, administrative support manager for the Texas Workers Compensation Facility, the state's assigned risk plan, said the changes are needed because some client employers use the arrangements to misclassify employees and to evade experience rating modifications that would increase their workers comp premiums.

Such abuses caused the state's assigned risk plan to lose $80 million to $85 million in 1990, which was about 15% to 18% of the pool's total $558 million in losses that year, he said.

The employee leasing industry "thrives on subterfuge," said Claire Korioth, chairwoman of the State Board of Insurance. It permits deceptions, like allowing employers with risky operations to evade paying adequate workers comp premiums, which causes the state's assigned risk plan to lose millions of dollars and raises overall workers comp costs for all other employers, she said.

State officials say they have the authority and obligation "to prescribe the uniform policy and endorsements for workers compensation insurance" and "to promulgate a classification system and experience rating plan."

"The (district court) injunction will force the Texas Workers Compensation Insurance Facility to cover thousands of employers at rates far below those justified by their safety records," Ms. Korioth said. "This is unfair to other employers who are paying the rates for their level of risk. Unless higher courts throw it out, this injunction will drive workers compensation rates even higher. This means that the state's good, responsible employers will pick up the tab for those who evade their proper rate levels by engaging in the fiction of employee leasing."

Texas regulators are not alone in their concern about employee leasing programs and the premium shortfall they cause. Several state insurance regulators and workers comp insurers have begun to crack down on illegal and unethical uses of leasing (*BI*, June 25, 1990).

In addition, the National Assn. of Insurance Commissioners adopted model legislation to help states cope with the problem (*BI*, Sept. 30, 1991).

Texas is unusual in that it allows employers to opt out of the workers comp system (*BI*, Sept. 16, 1991). ■

Actuaries plan study of solvency

WASHINGTON—A new American Academy of Actuaries task force will issue a report later this year on how insurers could minimize the risk of failure.

The panel of 18 actuaries from life/health and property/casualty insurers will examine issues like whether U.S. insurers should adopt a system of "appointed actuaries," said James J. Murphy, executive vp of the Washington, D.C.-based group.

Such a system, used in Canada and the United Kingdom, would require insurance company directors to appoint an actuary, from either inside or outside the company, who would report regularly on the company's current and projected financial strength. Appointed regulators would be responsible to both the insurer and to regulators.

Mr. Murphy said the final task force report probably will be released this fall, though some recommendations may be issued earlier.

John H. Harding, president and chief operating officer of National Life Insurance Co. in Montpelier, Vt., chairs the task force. ■

Governor says retired workers must contribute to dental plan

SACRAMENTO, Calif.—California Gov. Pete Wilson is threatening to drop dependents of retired state workers from their dental plan unless the retirees begin contributing toward the cost of the coverage.

The move is in response to a 13.6% increase in premiums for the coverage, which is underwritten by Delta Dental of California, explained David Tirapelle, director of the state Department of Personnel Administration.

The plan's premiums increased to $27.67 per month from $24.37 for single retirees; to $49.79 from $43.82 for retirees with one dependent; and to $72.69 from $63.95 for retirees with three or more dependents.

As part of a $350 million cut in the state's employee compensation budget, Gov. Wilson froze the employer contribution to health care coverage and asked the Public Employees Retirement System, which administers the health and dental plans, to pass the dental plan premium increase on to retirees.

Mr. Tirapelle explained that the retirees' benefit agreement includes a clause that provides for premium contributions when coverage costs exceed state budgetary restraints. However, the state's 54,000 retirees—who currently do not contribute to their dental plan premiums—have resisted the request, he said.

Meanwhile, the governor is appealing last month's Sacramento Superior Court ruling requiring the state to continue paying 100% of dental benefit costs for the 89,000 employees covered by the state government-sponsored dental plan.

Under Gov. Wilson's proposed 1992 budget, state workers would have had to pay about 12% of the cost of their Delta Dental Plan benefits. The premiums for this coverage are the same as those for retirees. But, the court ruled that only the state Legislature has the authority to make such changes. ■

It's not a miracle she survived. It's a miracle she can afford to.

According to statistics, 4 out of 10 people will need long-term care. In fact, 25% of all employees already provide some kind of care for a relative suffering from a chronic illness, physical or mental disability.

And though modern medicine can work wonders, the costs can be equally amazing. Even for in-home care or for a stay in a nursing home.

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35.7 million were uninsured in 1990: EBRI

A decline in employer-sponsored health insurance for workers led to an increase in the ranks of the uninsured in 1990, a new survey reports.

Some 35.7 million people had neither private health insurance nor publicly-financed health care coverage in 1990, up from 34.4 million in 1989 and 33.6 million in 1988, according to the survey by the Employee Benefit Research Institute, a Washington, D.C.-based research group.

Among the non-elderly population, 16.6% lacked health care coverage in 1990, up from 16.1% in 1989 and 15.9% in 1988.

The number of workers with employer-sponsored health coverage has dropped by about 2 million since 1980, according to the survey: 138.7 million workers had employer-sponsored health coverage in 1990, down 1.5% from 140.8 million in 1989.

And that decrease would have been greater had Congress not expanded the Medicaid program, according to EBRI President Dallas Salisbury.

Higher health coverage costs for employers may be responsible for the decline in employer-sponsored health care coverage, according to the report.

Per-employee health care costs, including both employer and employee contributions, rose 12% last year to $3,605, according to a recent survey (*BI*, Jan. 27).

The EBRI report, which analyzed 1991 census data, also provides characteristics of the uninsured, including their employment and income status, as well as variations in the number of uninsured by state.

Among the report's findings:

- In 1990, 64% of Americans younger than 65 were covered by employer-sponsored coverage, down from 65.9% in 1989.
- Workers in large firms are more likely to be covered than those in small firms. For example, 29% of workers at companies with fewer than 25 employees were uninsured, compared with only 9% at companies with at least 1,000 employees.
- Workers in mining, finance, government, real estate and manufacturing were more likely to be covered by employer-sponsored health coverage than were self-employed individuals or workers in the agriculture, construction, retail or services industries.

For example, 39% of employees working in the agriculture industry are uninsured, compared with 7% of government workers.

- Lack of health insurance is directly related to income. Among people with family incomes of less than $5,000, 35.6% lack health insurance, compared with only 5.7% of those with family incomes of at least $50,000.
- Health coverage varies widely from state to state, partly because of different Medicaid eligibility levels.

For example, in Alabama—where 20.5% of the population was uninsured in 1990—residents are eligible for Medicaid only if their incomes are less than 14% of the federal poverty level.

However, in Utah—where 10.2% of the population was uninsured in 1990—residents are eligible for Medicaid if their incomes are less than 86% of the poverty level.

Copies of "Sources of Health Insurance and Characteristics of the Uninsured, 1990" are available for $25 or as part of an annual $224 subscription to monthly EBRI "Issue Briefs" and "Employee Benefit Notes." Write EBRI Publications, P.O. Box 4866, Hampden Station, Baltimore, Md. 21211; or call 410-516-6946.

—By Christine Woolsey

Benefit beat

New options at utility

New Jersey's largest utility is responding to employees' and retirees' requests for more flexible dental benefits and improved vision coverage.

The Public Service Electric & Gas Co. of Elizabeth, N.J., on Jan. 1 began offering its 19,000 active union and non-union employees, retirees and dependents a traditional dental indemnity plan in addition to an existing dental maintenance organization and a direct reimbursement dental/vision plan.

The new self-insured indemnity plan is administered by Prudential Insurance Co. of America, which also provides the utility's dental maintenance organization.

The plan covers 100% of preventive procedures, 80% of basic procedures and 50% of major care up to $1,500 per person per year. There are no deductibles.

PSE&G also began offering a self-insured direct reimbursement plan for both dental care and vision care last summer to non-union employees.

The plan will cover up to $1,300 in dental care and $300 of vision care, but an employee's dental coverage is reduced by the amount of vision care coverage obtained.

Employees pay a $50 lifetime family deductible, above which the first $200 of dental or vision care is fully covered. The plan then pays 80% of the remaining amount of covered care.

Retirees and union employees covered under the direct reimbursement plan are not eligible for any vision coverage.

For retirees, the plan requires a $50 lifetime deductible, above which the first $200 in annual dental treatment costs are fully covered.

The next $800 of annual expenses are covered at 80%, and nothing above $1,000 is covered.

Union employees are subject to the same deductible, but the plan pays 100% of the first $250 and 80% of eligible charges up to $1,350 annually.

—By Michael Schachner

N.Y. suit challenges Hertz surcharges

NEW YORK—A discrimination lawsuit filed jointly by the city and state of New York challenges surcharges that Hertz Corp. assesses against rental car clients living in four New York City boroughs.

A state statute bans surcharges of any kind, said a spokesman for Attorney General Robert Abrams, whose office filed suit Jan. 17 in New York Supreme Court, the state's trial court.

"They can charge whatever rate they want, but they cannot charge a surcharge," the spokesman said. "People should not be singled out for living in certain parts of the city. It's illegal, it's divisive and it's discriminatory."

Around the states

Hertz Corp. says it began imposing the surcharges—which range up to $56 per day—Jan. 2 in response to liability losses from New Yorkers driving in New York. The Park Ridge, N.J.-based company said it paid $45 million in third-party liability claims from 1988-1990, exceeding $25,000 per claim (*BI*, Jan. 13).

No surcharges are assessed against corporate customers.

"We feel we are on solid legal ground," a Hertz spokesman said. "This suit is more politically motivated and more in the line of seeking publicity than legal resolution of the matter."

Hertz blames its losses on a state law that holds a vehicle owner liable for damage caused by any driver. States without vicarious liability laws cap the amount car owners can be required to pay for damage caused by their vehicles.

—By Sara Marley

New head of CWCI

SAN FRANCISCO—Edward C. Woodward will take over the reins at the California Workers Compensation Institute this month, replacing Alan Tebb, the longtime general manager, who is retiring.

Mr. Woodward, who was general manager of the institute from 1981 to 1984, most recently was vp of Enan & Co., a reinsurance intermediary in Burlingame, Calif.

Mr. Tebb joined the institute in 1969 as its first general manager.

CWCI membership includes 173 insurers that account for 95% of the state's work comp premiums.

—By Joanne Wojcik

Workers comp bill

HARRISBURG, Pa.—A workers compensation reform package, passed in December by Pennsylvania's Democratic-controlled House of Representatives, now faces a much bigger hurdle in the Republican-controlled state Senate.

H.B. 2140, originally proposed by Gov. Robert Casey, a Democrat, would establish a competitive rating system and limit health care costs. It was passed Dec. 18, 1991, with a 121-to-80 vote.

The bill would create competitive ratings based on loss costs and individual insurer expenses. Currently, state law requires companies to charge the same rates.

Also, the bill would cap medical benefits at 113% of the Medicare reimbursement rate. Currently, medical benefits are unlimited.

In addition, the bill calls for a renewed emphasis on workplace safety and allows certain small employers like farmers and local governments to self-insure their workers compensation programs.

The four-point legislative package was forwarded by Gov. Casey last fall in response to the Pennsylvania Workers Compensation Rating Bureau's request for a 51.8% rate increase. At the time, Gov. Casey vowed to fight the rate hike and urged business leaders and legislators to consider his package over an across-the-board rate hike.

If the Senate approves the package, the bureau's rate recommendation would be set aside entirely.

As of last week, the bill was still pending in the Senate.

—By Michael Schachner

Opinions

The $300,000 question

WHAT CONSTITUTES a "reasonable accommodation"?

That's a question that thousands of risk managers, along with other corporate executives and public officials, are asking themselves. The problem is that no one has the answer.

Under the Americans with Disabilities Act, portions of which went into effect last month, employers cannot discriminate against a disabled person seeking employment if that person demonstrates he or she can perform the job given reasonable accommodations (*BI*, Jan. 27). That is, the employer must modify the job or the workplace to enable a disabled person to perform the essential elements of the job. However, the employer does not have to make an accommodation that constitutes "an undue hardship."

How far does an employer really have to go? What is an undue hardship and what is not?

At this point, no one is sure. Federal agencies still are drafting guidelines to help employers untangle the ADA, even though public entities now must comply with all aspects of the law, including the employment discrimination provisions. Employers with more than 25 workers will have to comply with these provisions by July.

While clear, final guidelines do not exist, employees who think they have been discriminated against can now sue public entities for wages owed and up to $300,000 in other compensatory and punitive damages.

We certainly do not dispute the intent of the ADA: giving the disabled greater opportunity to hold down meaningful jobs. But employers should not be penalized unnecessarily for failing to comply with a fuzzy law. The only ones who will benefit under such a scenario are lawyers, who will

"SO, IS THIS CONSIDERED 'UNDUE HARDSHIP' OR 'REASONABLE ACCOMMODATION'?"

reap millions in fees as courts—not legislators or policymakers—interpret the law.

As government agencies review the implications of the law, we urge them to pay particular attention to how the law affects employers' workers compensation and safety programs.

The law seemingly limits employers' ability to test workers to make sure they are physically capable of performing a job. While this will lead to increased employment opportunities for the disabled, it also could lead to more workplace injuries as people not suited for a particular job are hired anyway. That's not good for workers or for employers, which will probably face even higher workers compensation insurance costs.

No cause for celebration

THERE'S GOOD NEWS and bad news for employee benefit managers battling against rising health care costs.

The good news is that, according to an A. Foster Higgins & Co. Inc. survey released last month, health care cost increases in 1991 slowed from the torrid pace of recent years.

Overall group health care costs—including employee contributions—rose 12.1% in 1991 to an average of $3,605 per employee from $3,217 in 1990 (*BI*, Jan. 27). That increase compares with jumps of 17.1% in 1990, 16.7% in 1989 and 18.6% in 1988.

The bad news: Employers have been so conditioned to even greater hikes that 12.1% seems like good news.

It must be remembered that the rise in group health plan costs last year was nearly four times greater than the general inflation rate. And, the smaller cost increases may simply have been due to shifting more costs to employees through higher deductibles and increased out-of-pocket limits, according to a Foster Higgins consultant.

In short, the 1991 results are no cause to celebrate. In fact, the Foster Higgins survey should serve as a renewed call for action that employers must do far more to manage their group health plans to bring cost increases down to an acceptable level.

At issue

What employee benefits legislation should Congress pass this year?

James I. Metz
Coordinator-Employee Benefits
Broward Community College
Fort Lauderdale, Fla.

Availability of medical care should not be contingent upon employment or ability to pay. Legislation should be passed to allow for the phase-in of a national program for the uninsured by 1995. An expansion of Medicaid—financed by a personal income tax—with price controls to eliminate cost shifting, including malpractice reform, would seem to be the logical place to start.

Edwin Wyle
Director of Human Resources
Coppus Engineering Corp.,
Millbury, Mass.

None. The role of government needs to be examined and a long-term benefits policy defined before any additional laws are passed. Staff technocrats have yet to exhibit any coherent national agenda or strategy. Meanwhile, we suffer from a continuing stream of complexities that seem a policy for full employment of consultants rather than benefits-related.

Steve Symes
Corporate Manager-Employee Benefits and Information
Sundstrand Corp.,
Rockford, Ill.

Enough is enough! We need legislative stability, not more change. I do favor a presidential line-item veto to encourage more responsible legislation. Congress could aid health care problems with tort reform to fix the medical malpractice mess; small-group insurance reform to limit underwriting meant to deny coverage; universal billing forms to reduce administrative costs.

Compiled by Sara Harty

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Winter Games

Continued from page 3

canceled, he said.

"The case for a claim is based on the TV networks proving that they have suffered a financial loss" and thus pay the OOC less than expected for broadcasting rights, Mr. Vajda said.

The policy has coverage limits of $80 million and there is no deductible, he said.

The TV rights coverage is arranged in three layers: the first $34 million layer and the second layer, $10 million excess of $34 million, are led by AGF. The third layer, $36 million excess of $44 million, is led by Paris-based political risk insurer Pool d' Assurance des Risques Internationaux & Speciaux, better known as P.A.R.I.S.

For the first time in Olympics history, the TV rights coverage is written on an all-risks basis, though the TV rights coverage does have three exclusions found in all insurance contracts for the Winter Olympics, Mr. Vajda said. These are: radioactivity that either directly or indirectly damages property or forces the cancellation of the Games; cancellation due to a unilateral decision by the OOC other than for security or safety reasons; and war between major world powers.

For purposes of the exclusion, the major world powers are: China; the Commonwealth of Independent States, which is made up of most of the republics that formerly comprised the Soviet Union; France; the United Kingdom; and the United States.

Only war between any of these countries is covered by the exclusion. A conflict like last year's Persian Gulf War would not be excluded, because none of the major powers fought each other, Mr. Vajda explained.

All of the contracts would cover terrorist attacks, Mr. Vajda said.

However, the three exclusions were not broad enough for Lloyd's of London underwriters to participate in the TV rights coverage, he added.

"The Lloyd's underwriters wanted all war claims excluded from the TV rights insurance. . .They are not even reinsuring the risk because the exclusion is not broad enough for them," Mr. Vajda said.

For the Calgary Winter Olympics in 1988, the TV rights insurance was led by Lloyd's syndicates managed by Sturge Holdings P.L.C. (*BI*, Feb. 8, 1988).

The coverage period began in March 1990 and runs until the Games' closing ceremony on Feb. 23.

General liability coverage written by AGF for the organizing committee provides all-risk coverage up to 200 million French francs ($36.8 million) with a 5,000 French franc ($919) per claim deductible for bodily injury claims, Mr. Vajda said.

"It's a very large contract because there are so many problems that could arise with such a large event. We could have problems with injuries to people or damage to buildings, or we could have problems with the French authorities over things like providing electricity," he said.

The general liability contract runs from Jan. 1, 1989, to Sept. 1, 1992.

Maintenance work on the facilities is covered for an additional two years after the Games, Mr. Vajda said.

Medical and personal accident coverage for the 8,000 members of the Olympic "family," comprising all officials and athletes, is again led by AGF, he said.

All of the covered individuals will carry a medical pass that will entitle them to free medical care, Mr. Vajda said.

Additionally, the contract gives the members of the Olympic family up to 300,000 French francs ($55,146) in personal accident coverage, he said.

The medical and personal accident coverage runs from Jan. 18, 1992, until March 15, 1992, he said.

Emergency evacuations such as rushing an injured athlete to medical facilities in Paris, will be carried out by Mondial Assistance. a Paris-based firm. The company is supplying its services free of charge in return for permission to publicize its role in its own literature, Mr. Vajda said.

Property coverage for the Games is written under one contract that covers all of the property being used in the Games. That ranges from from the OOC headquarters in Albertville, which will be used by a technical college after the Olympics, to the smallest judges box, Mr. Vajda said.

It is impossible to give a total value to the property insured as new structures are continually being erected, he said. Consequently, the coverage is written on a square-meter basis, which increases the premium as the risk expands, Mr. Vajda said.

The contract is led by Preservatrice Fonciere Assurances Tiard of Paris. The coverage period runs from Jan. 1, 1989, to Sept. 1, 1992, he said.

The property contract is the only part of the coverage that has been affected so far by a serious claim. A fire in the offices of the OOC in Albertville in 1990 caused damages of 1.5 million French francs ($275,700), Mr. Vajda said.

The final insurance contract was placed late last month by Gras Savoye. This policy covers ticket refunds due to delay or cancellation and was led by AGF.

"The coverage includes things like climatic conditions. For example, if you have a ticket for an event at 9 a.m. and it is put back to 3 p.m. because it is snowing in the morning, the insurance will cover the cost of a refund if a person already has a ticket to see another event at 3 p.m.," Mr. Vajda said.

He would not give details about the limits of the coverage.

The only part of the insurance program not placed by Gras Savoye was automobile coverage for the 400 vehicles being used by the OOC, Mr. Vajda said. This coverage is written directly by AGF.

In assessing the insurance risks for the Albertville Games, the insurers and brokers used claims statistics from the last Winter Olympics in Calgary, Mr. Vajda said.

At the Calgary Games, total claims exceeded $1 million Canadian ($855,100).

The largest claim was $500,000 Canadian ($427,550) for property

Continued on next page

Continued from previous page
damage. "This was mainly deterioration caused by the athletes playing jokes on each other," Mr. Vajda said.

Medical claims totaled $400,000 Canadian ($342,040), mainly for minor accidents, and automobile claims totaled $300,000 Canadian ($256,530), he said.

When the Albertville Games begin on Saturday, an 11-person insurance and risk management team will be on site.

The team will be led by Daniel Nicolet, who is the OOC's full-time risk manager for the Winter Games.

Mr. Nicolet previously worked in the mountain insurance department of Preservatrice Fonciere Assurances before spending two years as a broker. In July 1988, he was appointed risk manager of the OOC.

The OOC also employs an insurance consultant, Pierre Mange, who will be on-site during the Games.

The other members of the insurance team are: Mr. Vajda and his assistant; Mr. Nicolet's assistant; three employees from AGF; one member of the 1984 Winter Games' organizing committee; Xavier Parrizas, who is risk manager for the Olympics Organizaing Committee for the Summer Games in Barcelona; and a representative of Mondial Assistance. ■

CBS risk covered by global program

NEW YORK—Although CBS Inc. has purchased some low-level liability coverage from a French insurer, most of its risks associated with coverage of the XVI Winter Olympics will be met by its global insurance program.

"We are used to doing events like these all over the world, and our normal insurance program provides very comprehensive coverage for all of our property and liability risks," said Dennis D'Oca, vp-risk management for New York-based CBS.

Most of CBS' coverage, Mr. D'Oca said, is provided by a global program arranged through Frank B. Hall & Co. Inc. and Alexander & Alexander Services Inc. He declined to identify the insurers.

Low-level liability coverage purchased from a French insurer will cover local workers hired in France, the risk manager said. The coverage was arranged by French broker Societe Generale de Courtage D'Assurances S.A., he said.

The company decided to self-insure its exposure to equipment damage while covering the Games, he said.

CBS has not insured the risk of cancellation of the Games, though its $243 million payment for exclusive television broadcasting rights would be returned by the Olympic Organizing Committee. The OOC is insured for that exposure (see story, page 3).

In addition to the usual risk management concerns of broadcasting a major sporting event, the Albertville Games also will involve some less common concerns.

"For example, we will have to be concerned about things like using helicopters to fly camera equipment into closed-in sites which are inaccessible by road," said Mr. D'Oca.

"We sat down with our insurers and brokers to set out the risk management of the Games, and we have made sure that we have all of the coverages we need in place," he said.

—By Gavin Souter

Collins-Nears is risk manager for '96 Games

ATLANTA—Deborah Collins-Nears today takes the helm of the risk management operations for the Summer Olympic Games to be held in Atlanta in 1996.

She will be responsible for negotiating all the insurance for the Games, according to a spokesman for the Atlanta Committee for the Olympic Games, a local organizing committee.

Ms. Collins-Nears also will be responsible for developing a risk management information system, coordinating claims management and working with the committee's volunteer insurance task force, a group of Atlanta residents who work in the insurance industry.

"I'll be handling the full range of risk management operations, including loss control and safety efforts," she said.

As risk manager, she will report to the committee's senior vp of finance and administration. Ms. Collins-Nears said she expects her stint with the Olympics, including substantial wind-down activities after the games are over, to last a minimum of five years.

Before assuming the full-time position in Atlanta, Ms. Collins-Nears was manager of the risk management division of Riverside County, Calif.

—By Lori Block

Blues coverage

Continued from page 3
secondary health coverage for team members who already have their own health coverage through an individual plan or an employer-sponsored plan, he said.

BC/BS will pay the entire undisclosed premium for the team members' coverage.

The insurer will not provide team members with accidental death and dismemberment coverage this year, Mr. Carlson said. During the 1988 Winter Games in Calgary, Alberta, BC/BS provided each delegate with $10,000 in AD&D coverage (*BI*, Feb. 8, 1988).

In addition to the coverage for delegates, Denver-based BC/BS of Colorado underwrites group health coverage for employees at the U.S. Olympic Committee's center in Colorado Springs, Colo.

The employees pay no deductible or copayment if they use providers in the BC/BS preferred provider organization. Otherwise, there is an annual deductible of $100 per person, $300 per family. Employees pay 20% of all health care received outside the PPO, with no annual out-of-pocket maximum.

—By Christine Woolsey

Offset ruling

Continued from page 2

whether offset provisions give reinsurers an unfair preference in liquidations over other creditors, including policyholders. Upholding the commissioner's authority made it unnecessary to decide the issue, the court said. In its general comments on the offset issue, though, the court said that giving the reinsurers a preference over Aspen policyholders would have been "contrary to public policy."

The 29-page opinion went on to discuss broader issues concerning offsets, which have been the basis for numerous lawsuits around the nation (*BI*, Sept. 16, 1991; Jan. 8, 1990).

Essentially, the court rejected reinsurers' arguments that common law and bankruptcy law precedents entitle them to offsets.

The court also expressed the view that reinsurers have a fiduciary responsibility to the ceding insurer's policyholders.

The amount due under reinsurance contracts "represents a capital commitment to the primary insurer and becomes dedicated to the security of the ceding insurer's policyholders," the court said. "Equity requires that in cases of fiduciary or quasi-fiduciary obligation, the right to offset does not apply."

Attorneys for regulators generally were pleased with the ruling, and a few predicted that the court's public policy arguments against reinsurer offsets would influence courts in other states.

"The decision is significant" and "clearly has precedential value" because it makes clear that various states' statutory schemes for regulating insurance take precedence over common law contract rights, said Henry Jernigan of Jackson & Kelly in Lexington, Ky., who represents the liquidator of Delta America Reinsurance Co.

'There may be dangerous clouds on the horizon for reinsurers,' warns Mr. Frank.

As a result, the decision should make reinsurers better assess the financial condition of ceding companies before doing business with them. This would "flush out" weak ceding companies sooner because they will be unable to find or afford reinsurance, he added.

"There may be dangerous clouds on the horizon for reinsurers if other courts pick up the court's reasoning against reinsurers' rights to common law offsets," said Mr. Frank, who expects other courts to view this public policy consideration "very seriously."

The decision's value as precedent is limited because it interprets specific Colorado law, a receiver says.

"I don't know if Colorado has taken us further forward," said Paul Dassenko, the director of insurance operations for Transit Casualty Co., which is in liquidation in Missouri. "I think it is very unsettled everywhere."

Meanwhile, several attorneys who support broad offset provisions were generally critical of the Colorado court's decision.

"Initially, I was alarmed by this case," said Ronald S. Gass, assistant general counsel with the American Insurance Assn. in Washington, D.C. However, a thoughtful reading revealed that "it ought to have a limited impact on the set-off debate," he said.

One reason, he said, is that the court misunderstood the role of reinsurance when it stated that reinsurers had a fiduciary capacity. "The court's public policy concerns shaped its application of reinsurance law," Mr. Gass added.

"The court didn't have a good understanding of reinsurance," agreed Debra Anderson, vp and general counsel of the Reinsurance Assn. of America in Washington, D.C.

"It's the concern that every lawyer has with a court of last resort: The court can invent new law," said David M. Spector, a lawyer with Mayer, Brown & Platt in Chicago who represents reinsurers.

"I think the court very much invaded the province of the legislature," Mr. Spector said.

One other supporter of broad offset provisions, however, said the ruling is important. It is "significant" because it didn't allow any offsets, said Jerry Bunton, associate counsel with the National Assn. of Independent Insurers in Des Plaines, Ill.

The AIA, RAA and NAII were among the industry trade groups that submitted amicus briefs in the case supporting reinsurers.

While the Colorado Supreme Court interpreted state law at the time the reinsurance agreements were signed, that law will probably be softened soon.

Colorado is one of about 22 states considering a model law that covers offsets and was proposed by the National Assn. of Insurance Commissioners as part of the minimum financial regulatory standards that states need for NAIC accreditation, Mr. Frank said.

The NAIC proposal allows limited offsets. However, premiums owed to an affiliate of a reinsurer cannot be offset against claims owed by the reinsurer itself.

In addition, if the reinsurer also ceded business to the insolvent insurer, the reinsurer cannot offset premiums it owes to the insolvent insurer against the premiums the insolvent insurer owes to the reinsurer.

Reinsurers and insurers are lobbying state legislatures considering the NAIC measures to make them even more favorable to reinsurers. Among the changes most reinsurers want are laws allowing them to offset balances under "assumed vs. ceded contracts" in which reinsurers both cede business to and assume business from the insolvent insurer.

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Bluewater Insurance Co. Ltd. et al. vs. Robert D. Balzano et al., Colorado Supreme Court; No. 90SC417.

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Cronkite lends voice to tort reform drive

By MARK A. HOFMANN

WASHINGTON—The New York-based Manhattan Institute for Policy Research hopes Walter Cronkite can help stir public support for tort reform.

Mr. Cronkite, the former television news anchorman who was once considered the most trusted man in America, narrates the Manhattan Institute's new 30-minute videotape, titled "Liability, Injustice for All."

The Manhattan Institute is a non-profit organization that researches issues like the economic impact of tort law, the efficacy of affirmative action programs and the effect of government intervention on the economy.

The program is aimed at educational television and public access cable television stations, said its producer and writer, Frank Powers.

Mr. Powers, who is president of New York-based Film Counselors Associates Inc., said the tape also will be available to corporations for $100, to educational or non-profit groups for $75, to medical or professional firms for $50 and to individuals for $25.

The video cannot, however, be shown on commercial television stations anytime soon, Mr. Powers said, because of a clause in Mr. Cronkite's contract with his former employer, CBS Inc.

The veteran newsman was not hired simply to act as a mouthpiece, Mr. Powers said. In fact, he added, Mr. Cronkite had to be convinced of the merits of the project before he agreed to appear in the video. Although Mr. Cronkite had the authority to make revisions to the script, he made only minor changes, Mr. Powers said.

In the video, Mr. Cronkite speaks from a wood-paneled courtroom.

"If we were to ask the question, 'Does this country provide free nationwide insurance coverage for accidents and injuries?' most Americans would probably answer 'No,' " says Mr. Cronkite.

"According to most legal experts, however, we do. It's called the tort liability system, 'tort' meaning the law of personal injury," continues the avuncular Mr. Cronkite.

"Rather than one unified national code of law, it is a hodgepodge of federal and state laws that is administered under 53 different jurisdictions. This includes all 50 states, the District of Columbia. Puerto Rico and, overlaying all of them, the federal court system. No other country in the world has ever had anything like it," he says.

Fifteen representatives of the medical, business, legal, sports, government, volunteer and academic worlds offer their observations on the impact of the current tort system.

Walter Cronkite was convinced of the merits of the project before agreeing to appear in the Manhattan Institute's video on tort reform.

The speakers range from Nobel Laureate Milton Friedman to Maria Gomez, director of Mary's Center, a clinic offering maternal and child care for low-income families in Washington, D.C.

Other speakers include Democrats like Atlanta Mayor Maynard Jackson and West Virginia Supreme Court of Appeals Chief Justice Richard Neely, as well as Republicans like former U.S. Surgeon General C. Everett Koop.

But no matter what the speaker's station in life or political leanings, each shares the conviction that the current tort system has run amok and must be changed.

For example, Ms. Gomez says that because of liability costs, Mary's Center has no obstetrician on site.

Therefore, the center "can accept only women who are completely healthy and who are expected to undergo normal delivery," she says.

"There are times we reject about five women a day," says Ms. Gomez.

The weight of the current tort system falls upon amateur sports as well, says Tim Daggett, a 1984 Olympic gold medal gymnast who is now a West Springfield, Mass., businessman and television sports commentator. Mr. Daggett said that rather than face the possibility of huge damage awards stemming from recreational sports programs, municipalities are shutting down their programs.

"I, myself, was the last gymnast to make an Olympic or world championship team that started out in a public—or free—program. They're basically disappearing all across the country because of liability," says Mr. Daggett.

Mr. Daggett points out that all sports involve taking some risk, although he adds that gymnastics is "very, very safe" if taught properly.

"Everyone would like to eliminate all of these risks in sport, but I think if you do, you're basically changing what sport is all about, and I think if you removed all the risks from life, you wouldn't have a very enjoyable situation either," he says.

During a brief address after the video's debut in December at the National Press Club in Washington, D.C., Mr. Daggett noted that he currently charges $150 a month to teach gymnastics to children. He said that if he'd had to pay such an amount for his early gymnastic training, he never would have been able to afford making it to the Olympics.

Another video participant who addressed the premiere audience called attention to what he termed a "very interesting phenomenon" involving the legal system.

Peter Huber, a Washington-based senior fellow of the Manhattan Institute and author of "Liability" and "Galileo's Revenge: Junk Science in the Courtroom," said that while courts have been tightening the standards of conduct required of manufacturers, physicians and virtually anyone else who can be held accountable for someone else's injury, the standards for attorneys and expert witnesses have been relaxed.

As a result, so-called expert witnesses often lack credible credentials and represent fringe views and unproven theories, said Mr. Huber, who is an attorney himself. But these witnesses' testimony, no matter how outlandish, is given equal weight to that of recognized experts in medicine and other fields, he said.

Mr. Huber said that if balance is to be restored to the tort system, lawyers must be held to a common set of reasonable standards.

Demand for the video has picked up with the new year, according to Mr. Powers. He estimated that roughly 250 copies of the film had been shipped by Jan. 20.

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Copies of "Liability, Injustice for All," can be ordered from the Manhattan Institute, 52 Vanderbilt Ave., New York, N.Y. 10017. Copies cost $100 for corporations, $75 for educational or non-profit groups, $50 for medical or professional firms and $25 for individuals.

Corporations that belong to either the Manhattan Institute or the American Tort Reform Assn. are eligible for 20% discounts. In addition, discounts are available on quantity purchases. For further information on discounts, contact Film Counselors at 212-315-3950.

Datebook

FEBRUARY

FEB. 10. Directors & Officers Liability seminar in South Portland, Maine, sponsored by the Society of Chartered Property & Casualty Underwriters and the Maine Chapter; $95 for society members; $105 for non-members. Bonnie Kinsley. Continuing Education Coordinator, The Society of CPCU, 720 Providence Road, P.O. Box 3009, Malvern, Pa. 19355; 215-251-2735.

FEB. 10-12. Environmental Regulation Course in Cleveland and New Orleans, sponsored by Executive Enterprises Inc.; $1,045. **Also Feb. 18-20** in Dallas; **Feb. 19-21** in San Diego; **Feb. 24-26** in Atlantic City, N.J.; **March 2-4** Beverly Hills, Calif.; **March 9-11** in Philadelphia and Washington, D.C.; **March 16-18** in Las Vegas; **March 23-25** in Atlanta; **March 30-April 1** in Chicago; **April 6-8** in Virginia Beach, Va.; **April 13-15** in Boston; **April 27-29** in St. Louis; and Anchorage, Alaska. Executive Enterprises Inc., 22 W. 21st St., New York, N.Y. 10010-6904; 800-831-8333; 212-645-7880.

FEB. 10-11. Small Group Healthcare Insurance...Crisis or Opportunity seminar in Kansas City, Mo., sponsored by the Mass Marketing Insurance Institute; $295 for MMII members; $395 for non-members. MMII, 3101 Broadway, Suite 585, Kansas City, Mo. 64111; 816-561-1920.

FEB. 11. What You Should Know About Environmental Regulations workshop in Chicago, sponsored by the Illinois Chamber of Commerce; $135 for chamber members; $195 for non-members. Illinois Chamber's Center for Business Management, 800-621-4220.

FEB. 12. Medical Provider Abuses: Identifying Atypical Billing and Utilization Practices in Workers Compensation seminar in San Francisco, sponsored by the Medical Care Committee of the California Workers Compensation Institute; $110. CWCI, 120 Montgomery St., Suite 1300, San Francisco, Calif. 94104; 415-981-2107.

FEB. 12-13. Introduction to Insurance seminar in New York, sponsored by The College of Insurance; $395 for college sponsors; $425 for others. **Also May 18-19** and **Oct. 8-9.** The College of Insurance, 101 Murray St., New York, N.Y. 10007; 212-732-6175.

FEB. 13. Payment Options in an Era of Health Care Reform forum in Washington, D.C., sponsored by Lewin-ICF; $595. Registration Secretary, Lewin-ICF, 1090 Vermont Ave. N.W., Washington, D.C. 20005; 800-842-3482 or 202-842-8073.

FEB. 13-14. ERISA Litigation Conference in San Francisco, sponsored by Prentice Hall Law & Business; $675. Prentice Hall & Business, 270 Sylvan Ave., Englewood Cliffs, N.J. 07632; 800-223-0231.

FEB. 17-18. Health Care Cost Containment workshop in Honolulu, sponsored by the Health Research Institute; $595. Workshop Coordinator, Health Research Institute, 1600 S. Main Plaza, Suite 170, Walnut Creek, Calif. 94596; 510-676-2320.

FEB. 17-21. Modern Safety Management seminar in Atlanta, sponsored by Loss Control Management Services; $990 for members; $1,100 for non-members. **Also March 9-13** in Denver, **March 23-27** in Los Angeles and Atlanta. LCMS, 4546 Atlanta Highway, P.O. Box 1898, Loganville, Ga. 30249; 404-466-2208.

FEB. 19. Advanced Cost Containment workshop in Honolulu, sponsored by the Health Research Institute; $295. Workshop Coordinator, Health Research Institute, 1600 S. Main Plaza, Suite 170, Walnut Creek, Calif. 94596; 510-676-2320.

FEB. 19. An Advanced Course on Business Interruption Exposures and Their Treatment seminar in St. Louis, sponsored by the Society of Chartered Property & Casualty Underwriters and the St. Louis Chapter; $55 for society members; $65 for non-members; optional exam fee $20. Tricia Hogan, Continuing Education Coordinator, The Society of CPCU, 720 Providence Road, P.O. Box 3009, Malvern, Pa. 19355; 215-251-2773.

FEB. 20-21. Toxics Use and Source Reduction: Compliance and Beyond conference in San Francisco, sponsored by Executive Enterprises Inc.; $1,090. Executive Enterprises, 22 W. 21st St., New York, N.Y. 10010; 800-831-8333; 212-645-7880.

FEB. 21. Pollution Liability—The Law and Available Insurance seminar in Denver, sponsored by the Society of Chartered Property & Casualty Underwriters and the Colorado Chapter; $119 for society members; $129 for non-members; add $15 after Feb. 7. Tricia Hogan, Continuing Education Coordinator, The Society of CPCU, 720 Providence Road, P.O. Box 3009, Malvern, Pa. 19355; 215-251-2773.

FEB. 22. Health Care, Time Management, You and Your Team: Bringing Them Together Effectively seminar in Los Angeles, cosponsored by The Department of Continuing Education in Health Sciences, University of California at Los Angeles Extension; UCLA School of Public Health; and the California Assn. of Health Maintenance Organizations; $155. P.O. Box 24901, Department K, UCLA Extension, Los Angeles, Calif. 90024; 310-825-9971.

MARCH

MARCH 29-APRIL 3. 30th Annual Risk Management and Employee Benefits Conference in Anaheim, Calif., sponsored by the Risk & Insurance Management Society Inc. $695 for RIMS members; $795 for non-members. Partial week and one-day registration allowed. RIMS Conference Department-Registration, 205 E. 42nd St., New York, N.Y. 10017; 212-286-9292.

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Double-dipped claims

Collateral payments rarely offset: ISO study

By JUDY GREENWALD

Although many people with bodily injury claims also recover money from additional sources like workers compensation or group health insurance, general liability insurers reduce their payouts to these claimants only a fraction of the time, according to a new study.

Reviewing claims data from 37 insurance groups that represent 74% of the commercial general liability market, the study by the Insurance Services Office Inc. takes an exhaustive look at the source of bodily injury claims, how those claims are handled and their ultimate cost.

"Closed Claim Survey for Commercial General Liability: Survey Results, 1991" was conducted by ISO DATA Inc., a subsidiary of ISO, on behalf of the National Assn. of Insurance Commissioners.

The study is a followup to a landmark study of claims payments conducted by ISO in 1988 (*BI*, Dec. 12, 1988).

Another follow-up survey of claims is expected to be released at the end of 1993.

The latest survey reviewed two sometimes overlapping groups of closed claim files:

- 3,549 bodily injury claims that were closed in either the third quarter of 1990 or the first quarter of 1991 with payments of at least $75,000.
- 438 bodily injury clams that were settled by court decision between April 1, 1990, and March 31, 1991, and resulted in payments of at least $10,000.

The study's most significant conclusion "was in the area of the collateral sources offset," said James Surrago, a vp with ISO.

"In many cases, there is the existence of collateral sources of indemnity; however, very few insurers show payments were reduced because of these collateral sources," Mr. Surrago said.

Specifically, the survey found that 64% of claimants in the sample of closed claims of $75,000 or more also recovered money from collateral sources, while 19% did not.

Information on the remaining 17% was incomplete, although ISO projected that they could account for an additional 13% of claimants with collateral sources.

Collateral payment is 'a very good area to investigate more,' according to Virginia Provosto of ISO.

Of those plaintiffs who did recover from a collateral source, workers compensation coverage was the source for 59% of the claimants; group health care plans, 14%; Blue Cross & Blue Shield plans or Medicare, each 9%; and the remainder from various other sources.

Despite the large percentage of claimants who also recovered money from collateral sources, a liability insurer's payment was reduced in only 16% of these cases, with the award unaffected in the remaining 84%, according to the ISO study.

"It points out that it's a very good area to investigate more," said Virginia Provosto, an assistant vp at ISO.

Other major findings of the ISO study were:

- Claims involving lawsuits took far longer to close than cases in which no suit was filed.
- When a claimant sought damages from more than one party, the average final payout was significantly higher than when a claimant sought damages from only one party.
- Punitive damages were awarded in only a small fraction of the cases in which they were sought.
- Among bodily injury claimants who are employed, claims stemming from on-the-job injuries outnumber claims for injuries unrelated to work.
- The most common types of injury were dislocations and fractures, followed by back injuries.
- While recreational liability and product liability cases each accounted for a minority of claims filed, they were the largest type of claim in terms of average amount paid.

The results of this survey are consistent with the results of the more extensive survey of 13,000 commercial liability claims released in 1988, Mr. Surrago commented.

"There really weren't any surprises relative to that particular survey," he said, noting that the earlier survey, which was not done in conjunction with the NAIC, had a broader scope.

Both surveys, however, found that few insurer claim payments were reduced by collateral sources; that a large percentage of liability claims resulted from work-related injuries; and that in claims involving more than one party, the insured was more likely to pay more than their relative fault suggested rather than less, Mr. Surrago commented.

In the sample of claims totaling $75,000 or more, the average loss per claim—which is the amount a primary insurers paid a claimant—was $222,183.

The "average insured loss per incident," which is the amount all insurers pay a claimant, was $333,060, which is nearly 50% higher. And the average total payout per incident, which includes amounts not contributed by insurers, was higher still: $334,228.

The study found, however, that a small number of claims accounted for a disproportionately large percentage of total liability insurance compensation dollars.

For instance, claims of at least $450,000 accounted for just 11% of the total number of claims in the survey, but 37% of all claims payments.

For verdicts resulting in payment of at least $10,000, the survey found the average loss per claim was $159,364, while the average insured loss per incident was $225,230. In addition, the average total payout per incident was $228,514.

Looking at the large claim sample, the study found that claims in which a suit was filed took an average of 48 months to close, while those in which no suit is filed took only 21 months on average.

Within the sample of claims that resulted in a verdict, claims took an average of 50 months to close, according to the study.

The study found that lawsuits were filed in 91% of all incidents in the large claim sample. However, 87% of these lawsuits were settled without even beginning a trial, with only 4% of suits decided by either a court verdict or appellate order.

Of those cases that were decided by a court decision, the average final award was lower than those that went to trial but were later settled, the study found: $401,000 vs. $531,000.

In the sample of claims resulting in a verdict, 10% ended with an appellate court order, although their cost represented 31% of total final awards.

These appellate cases averaged $720,000, compared with just $174,000 for incidents that were concluded with the initial court verdict, the study found.

A total of 56% of the large claims involved only one liable party, while 20% involved two parties and 24% three or more. And the average loss per claim tended to increase as the number of parties involved increased, the study found.

For example, damages paid by insurers averaged $204,000 when only one party was involved, increasing to $244,000 when more than one potentially liable party was involved.

The study also found that an insurer's allocated loss-adjustment expenses—which are not included in claim or incident figures—averaged $23,000 when just one party was involved but increased to $43,000 in multiple-party cases.

The claimants themselves received an average of $513,000 in multiple-party cases, compared with $218,000 in single-party cases, according to the study. However, the study authors note that multiple-party cases often involved more serious injuries or death.

Continued on next page

Agent/Broker Topics

A monthly editorial section sent exclusively to agents and brokers

One notch (gasp!) tighter

Strapped agents seek to generate savings where they once feared to tread

By SARA J. HARTY

AGENCIES ALL OVER the country are tightening their belts in hopes of wringing a profit out of their business—or at least of keeping losses to a minimum.

Many agents have found that controlling costs means increasing salaries only minimally and eliminating some perks that had become routine in better times. Trimming the payroll has been one of the more difficult moves for some managers.

Agents who are cutting back have found that keeping employees fully informed on decisions and the whole decision-making process can help alleviate some of the concerns workers may have. In addition, some agencies have been able to save more money by implementing their employees' ideas on cost control.

For some who rent office space, the slumping commercial real estate market has created a favorable atmosphere in which to renegotiate lease terms and conditions. Still others have decided to take the plunge and buy property.

A little creativity can go a long way in keeping costs down. Cutting some staffers back to part time, for instance, can save benefit expenses and salaries without sacrificing much—if any—productivity, consultants say.

But at least two concepts that have attracted some attention have not caught on with cost-conscious insurance agencies. Among agents, employee leasing arrangements have not been widely used, and customer service centers run by insurers have generally not generated significant savings, consultants say.

Where the real savings are

Personnel may be the key to controlling costs.

Because compensation, including benefits and salaries, take up 60% to 64% of agency revenues, this is where real savings can be achieved, said Carol Hammes, president of The Middleton Group, a consulting firm based in Lisle, Ill.

Agents can "lower their telephone costs and electricity bills, but the real expense and cost controls comes by controlling personnel (costs)," agreed John H. Jaques, president of John H. Jaques Inc., a Petaluma, Calif., agency consultant.

Personnel costs can be affected either by the "number of bodies" or by "how those bodies are paid," he said.

The more people there are on staff, the more space and supplies are needed. More employees also create greater accounting costs, Mr. Jaques said.

Agents are "very reluctant" to hire new people in today's market, he said. Instead, they are trying to increase productivity from people already on staff, he added.

Rather than actually laying staff members off, many agency managers simply do not replace staff members who leave on their own, forcing other employees to absorb the work, Ms. Hammes said.

"The biggest factor is avoiding the negative motivational factor" among remaining staff members if

CONTROLLING COSTS

others are laid off, said Robert C. Harrison, the agency manager of E.W. Barger & Co.

The Waynesboro, Va., agency is using attrition to control labor costs and, thus, maintain profitability, Mr. Harrison said.

As employees leave, agency managers carefully evaluate whether there is a need to replace the employee with either a full- or part-time worker, or whether current employees could be assigned the job duties, he said.

But attrition alone would not suffice for

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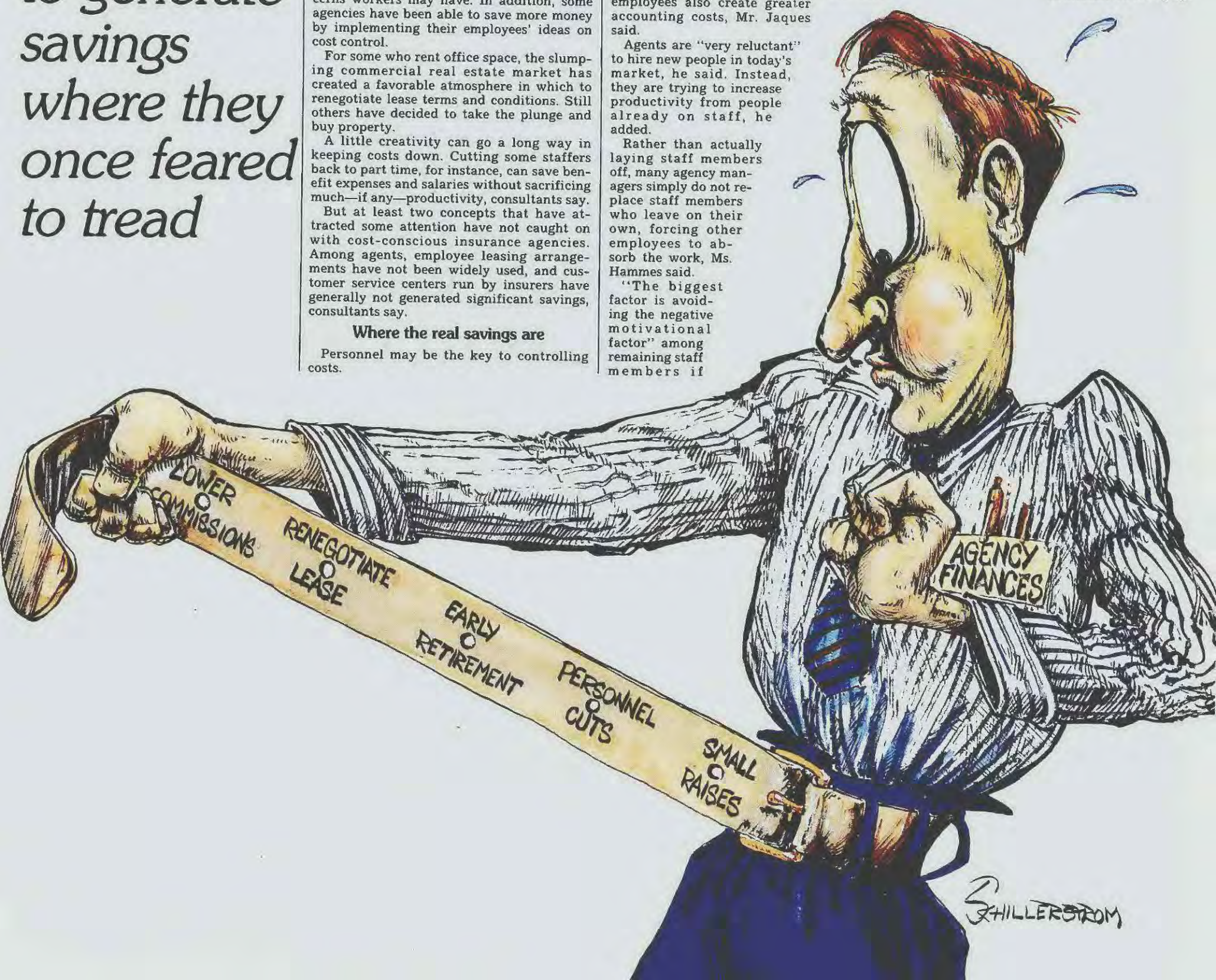

Controlling costs

Continued from previous page

The Gleason Agency. Three staff positions were eliminated since it became clear, about a year ago, that expenses would otherwise run over budget, said Rob Gleason, president of the Johnstown, Pa., agency.

For years, agencies had been told to avoid cutting staff, since a lean staff is pressed to keep up with consumer service demands. In addition, agents do not want to be caught so short on employees that they are unable to meet changes in the market.

However, now some consultants are advising agents to consider staff cuts in at least some circumstances.

Staff cuts should certainly be considered in some cases, Mr. Jaques said, especially if an agency's volume drops 5% to 10%.

First, agencies should eliminate "marginal" producers, he said. Producers who have been on staff for three or more years and are still developing less than $100,000 in gross commissions annually are not pulling their weight and should be dismissed, Mr. Jaques said.

That producer's book of business can then be distributed among the remaining staff: Some accounts could become "house accounts" that are serviced by customer service representatives, while others could go to other producers.

By the same token, customer service representatives who strictly handle personal lines should be handling a minimum of 650 to 750 accounts, or about $80,000 to $100,000 in gross commissions annually, he said.

Commercial lines representatives should be handling a minimum of $150,000 to $200,000 in gross commissions, depending on the agency's location and average premiums per account, he suggested.

By Mr. Jaques's reckoning, an agency whose staff is not handling this level of accounts is probably overstaffed.

Agency managers should also take a close look at workers who neither "bring in business nor deliver service out the door," he suggested.

An agency may not be able to function without bookkeepers, receptionists, file clerks or word processors, but the number of people performing these tasks should be minimized, stressed Mr. Jaques.

Capping pay hikes

Establishing—and adhering to—average annual pay raises is another crucial element in controlling costs.

"All agencies, regardless of size and location, (need) to establish an average pay raise for the year," Mr. Jaques said.

For instance, in the last two years, E.W. Barger has trimmed average raises down to 5% from 8% to 9% in earlier years.

And, maximum increases in salaries, as well as all other personnel expenses, have been capped at 8% at The CIMA Cos., said William R. Henry Jr., director of communications at the Alexandria, Va., agency.

Once the agency has decided on an average raise, steps must be taken to ensure that the average is not increased, Mr. Jaques said. Most agencies are "pretty stagnant" in the current economy and might decide on a maximum average pay increase of 3% to 4%, he pointed out.

To ensure that the agency actually comes in at that level, management needs to set each employee's raise at the same time. If the manager knows that one employee should get a 6% raise, someone else should not receive a raise, or several employees should receive only very small increases.

One mistake managers commonly make is setting and giving out raises on employee anniversary dates, Mr. Jaques said. Halfway through the year, the manager is likely to realize that there is no way to meet the targeted average raise at the going rate.

A little candor goes a long way

Agents who have cut staff positions or given smaller-than-usual raises stress that explaining the reasons behind those moves is necessary to maintain employee morale.

At E.W. Barger, such candor is a regular feature of quarterly employee meetings. Once a quarter, each of its five offices is closed, and employees gather in the agency's main office. As part owners—the agency instituted an employee stock option plan in 1990—staff members are privy to financial information that the agency had previously considered confidential.

Morale is less likely to suffer because better-informed employees are more likely to accept cutbacks, Mr. Harrison said.

In addition to the quarterly meetings, agency managers have begun meeting with producers on a weekly basis. E.W. Barger hopes the weekly meetings will lead to better productivity as problems are solved before they become unmanageable and more time is spent in setting goals with producers.

Similarly, The Gleason Agency uses monthly meetings to keep employees informed of agency expenses.

These meetings have resulted in employees suggesting new ways to save money. Employees whose suggestions are used have been given cash bonuses, said Mr. Gleason.

Seizing the day in real estate

Cost-conscious agents also have found opportunities in the current real estate slump.

Agency managers should "recognize that the relative position of landlord and tenant is different than it was three to four years ago," said Ward Bower, a management consultant at Altman Well Pensa Inc. in Newtown Square, Pa.

For agents hoping to negotiate more favorable leases, location is everything.

Office occupancy is less than 70% in Dallas and "barely over 80%" in Philadelphia, Mr. Bower said. Many cities have conditions like these, which often "creates a lot more flexibility than there had previously been," he said.

"A lot depends on the alternatives available to tenants," he added. Smaller tenants in Dallas have more leverage than those in Seattle, where the occupancy rate is higher.

Still, there are "vacancies in every city in the country these days," and while the larger tenant may be in an ideal position to negotiate, "smaller insurance agents still have leverage in second- and third-class space," Mr. Bower said.

The real estate market hit bottom in Phoenix two years ago, said David Wood, president of the Wood Insurance Group Inc., which is located there.

By renegotiating his lease at that time, Mr. Wood cut rents in half over a five-year period, he said.

But for Mr. Gleason, the Johnstown, Pa., agent, the recession packed an unexpected drawback.

Slumping real estate prices allowed him favorably renegotiate his rent when his lease recently expired. However, plans to expand the agency's offices into some adjoining empty space were scrapped in interest of saving money.

Efforts Instead, the agency is trying to use the current space more efficiently, Mr. Gleason said.

Management at CIMA decided in 1986 that the best way to control occupancy costs—the second-largest item in their budget—was to buy office space. Now the property is appreciating and the company is paying less per square foot than it would be if it were renting, Mr. Henry said.

The Barger agency also owns all of its properties, but the agency is hoping to take advantage of current low interest rates to refinance some of the debt incurred with the purchase of a new computer system.

Counting paper clips

While benefits and compensation generate the biggest expenses in an agency, smaller expenses are not beneath most agents' notice.

To focus employee attention on some minor changes in behavior that could make a difference in expenses, CIMA sends around a memo that picks the "expense of the month," said Mr. Henry.

Employees can learn to "systematically work smarter with less waste," he said. Photocopying costs may seem inconsequential, but at CIMA they total $11,000 a year. Many of those photocopies may be unnecessary, especially if the document is recorded on the computer hard drive, he said.

The Gleason Agency also found that smaller items were worthy of attention—if only to help change employee attitudes toward waste.

The agency overhauled its purchasing system. Now, employees must justify to a supervisor the supplies or subscriptions they want, Mr. Gleason said.

Some agencies view at least some of their secondary expenses as a good thing.

The Wood Insurance Group breaks out those expenses that could potentially increase income. Increases in costs like telephone marketing and postage are expected, while other costs are kept as level as possible, said Mr. Wood.

Two non-starters

While agencies are trying many different approaches to control costs, several ideas have attracted considerable attention, but have not caught on with agents.

One technique that few agencies are using is employee leasing. "Employee leasing was of interest a couple of years ago but I have not seen" much of it lately, said Ms. Hammes, the Middleton Group consultant. Instead, agency managers are making better use of part-time employees, she said.

"I don't really see it as an advantage," added Mr. Jaques. While the selling point of employee leasing firms is that the agency owner will save on benefits and personnel expenses, those costs will be built into the fees that the leasing firms charge, he said.

In addition, leasing employees can lead to a disruption in morale—and a lack of long-term commitment from the "employees," Mr. Jaques said.

Insurance company-run customer service centers can provide a savings for agents, but only if almost all the agency's personal lines business is with that particular insurer, Mr. Jaques said.

If not, the service centers can actually increase costs, because employees must be trained to handle some personal lines business one way, and the rest in a different fashion, Ms. Hammes agreed.

For a customer service center to be effective, 70% to 80% of an agency's personal lines volume must go through the center—a level that the average agency cannot achieve, said Mr. Jaques. ■

Have you considered. . .?

From car phones to collections, 7 ideas to hold down costs

Consultants and agents themselves have no shortage of ideas for keeping agency costs under control.

Among the tools for agents to consider—and their potential benefits and drawbacks—are:

- **Making sure secondary-level managers are not full-time.**

"Very few agencies need a full-time manager who does nothing but manage and train" other staff members, said John H. Jaques, president of John H. Jaques Inc., an agency consulting firm in Petaluma, Calif. Instead, some staff members should be designated as supervisors, but they should continue to be a functioning part of their department with their own active accounts.

- **Salary freeze.**

In lieu of a raise, some agencies have instituted a bonus program, Mr. Jaques said. If the agency hits targeted growth, all employees will receive a bonus equal to 5% of pay. If targeted revenues per employee also are achieved, staff members could receive another bonus.

- **Unpaid vacation days.**

This is one option to consider when agency revenues drop 5% to 10%, said Mr. Jacques.

Unpaid vacation days work best for agents that want to keep their staff at a certain level—perhaps because they feel that when the economy picks up, all those employees will be needed, he said.

Each employee may be required to take one or two unpaid vacation days a month. This can save considerable funds, help the agency to protect those positions and maintain productivity.

- **Job-sharing or part-time employees.**

If the agency has two commercial lines customer service representatives, each working on his or her own book of business, those books could be combined into one large book, Mr. Jaques said.

The CSRs could each work four days a week, with one handling the accounts Monday through Thursday, the other Tuesday through Friday. This can reduce the agency's costs in servicing the accounts by about 20%.

For agencies that are experiencing some account shrinkage, this can be "an excellent solution" for lowering costs, he said. In addition, managers may find that there are employees who are very willing to work with that type of arrangement.

Part-time workers can save the agency employee benefit expenses in addition to salary expenses, said Carol Hammes, president of The Middleton Group, an agency consulting firm in Lisle, Ill. And interestingly, many agents find that an employee working 20 to 30 hours a week is nearly as productive as a full-time worker, she added.

- **Eliminate some producer perks.**

Some agency managers have reduced producer commissions on renewals, while leaving commissions the same on new business to maintain the sales incentive, Ms. Hammes said.

Consider a car allowance that helps to defray the expense of producers' cars without paying for the entire car, Ms. Hammes said.

Eliminating company-provided car phones helped the Gleason Agency Inc. realize considerable savings, said Rob Gleason, president of the Johnstown, Pa., agency.

- **Salary caps.**

Agency managers should identify the maximum value of each staff position.

For instance, a personal lines CSR who has been with the company for 19 years probably should not continue to receive annual increases, Mr. Jaques said. If salary caps are not set, the manager may find that an employee is being paid $35,000 to do a job that someone else could do for $20,000 with minimal training.

- **Encourage producers to bring in their accounts receivable in a timely fashion.**

E. W. Barger & Co., an agency in Waynesboro, Va., used to allow clients to pay at their own comfort level, said the agency manager, Robert C. Harrison.

But agencies cannot "continue to fund the premiums for insureds during these tough times," he said. Producers who bring in receivables more quickly are paid better.

—By Sara J. Harty

Agents can lower their telephone costs and electricity bills, but the real controls come by controlling personnel.

John H. Jaques

Rather than laying people off, many agencies simply do not replace those who leave, forcing other employees to absorb the work.

Carol Hammes

Photo by Michael A. Marcotte

Gabriel Viti, with daughters Anna Maria and Jeannine, in what will be the family agency's new offices.

Helping out old friends

For 50 years, the Viti family has stood by its customers

By LAURA MAZZUCA

HIGHWOOD, Ill.—When Guy Viti died last spring at age 92, hundreds of area residents came to the funeral to pay their respects to a man who had helped them realize the American dream.

Since starting the Guy Viti Insurance Agency in 1938, Mr. Viti had become a sort of George Bailey to the Italian-immigrant community in this blue-collar town of 6,000 people about 20 miles north of downtown Chicago.

Many of his personal and commercial customers were servants, gardeners, maids and landscapers in the nearby affluent North Shore communities of Lake Forest and Highland Park.

When they couldn't read policies written in English, he translated. When they were turned down for mortgages at banks, he came through.

Guy Viti didn't know it, but he was niche marketing long before the term was even coined.

Change with the customers

Today, just down the street from Guy Viti's original storefront, his son Gabriel, the agency president, is continuing that tradition.

Bilingual producers and staffers now market personal lines, commercial lines, life/health and pension products to the area's newest waves of ethnics: Hispanic- and Asian-Americans.

The agency still places coverage for Italians, too. But many of the laborers who began looking to Guy Viti for homeowners and auto coverage in the '30s and '40s are gone.

In their place are their children and grandchildren, professional people seeking high-end personal lines coverage, as well as commercial lines insurance, Mr. Viti said. The agency even places homeowners coverage for the Sun Belt winter homes of its affluent Italian clients.

For these Highwood residents, doing business with Gabe Viti is a natural part of living in the tight-knit community.

"You can have an Allstate policy and never know your agent," remarked Bruno Bertucci, the executive director of the Highwood Chamber of Commerce, who maintains an office in Guy Viti's original storefront. "But we're friends with Gabe, and it's nice to have someone look out for you. Besides, when rates go up, we can argue with him."

Mr. Bertucci's family, which once owned a dairy in town, has been buying its commercial and personal insurance from the Vitis since Guy was at the helm. The tradition continues today: The Vitis place commercial coverage for Mr. Bertucci's son Bruce, who owns a restaurant just down the street from the insurance agency.

But Highwood, like many Middle American towns, is changing. On the town's main street, alongside several popular Italian eateries and a deluxe indoor bocce ball court, sit restaurants and other small operations with Hispanic and Asian owners.

They are moving along the same upwardly mobile path their Italian predecessors took, said Mr. Viti. He plans to have his agency grow with them, and not just by upgrading auto coverage from a Chevy to a Mercedes.

Sixty percent of the agency's business is commercial lines. Big revenue generators, said Mr. Viti, include area Mexican-owned businesses, including cement contractors, restaurants, bricklaying businesses, real estate offices, grocery stores, several tailor shops, and clothing stores.

Reaching out to Hispanics

Three years ago Mr. Viti, whose agency generates about $6 million in annual premium volume and has 14 employees, started specifically targeting Hispanics by hiring several bilingual producers.

Since then, the agency's annual personal lines commissions have grown by $30,000, and its annual premium volume jumped by $1 million to $6 million.

Other employees speak Italian, and the next step Mr. Viti has in mind is to hire an in-house producer who can speak Asian languages to tap that growing market.

Two recently hired producers now make cold calls for health insurance "to get their foot in the door." Two Viti daughters are inside producers, selling personal and commercial lines policies to existing customers.

Although he remains focused on the North Shore area, Mr. Viti says he has not turned his back on those less well-off. When customers can only afford time payments, the agency offers its own premium fin-

Continued on next page

Agent/Broker Topics

As financial advisers, life agents fall short: Test

By SARA J. HARTY

Despite their impressive looking credentials, life insurance agents often are unfit financial advisers, Money magazine recently told its readers.

More than two-thirds of 20 life insurance agents who took Money's insurance test flunked. The main reason for their failing grades, according to the magazine, is that most were too eager to sell policies with fat commissions.

In some cases, a lack of expertise and training also in part caused the poor performance, the magazine said.

The agents who volunteered to take the test were told to give written recommendations for the insurance needs for three hypothetical customers: a single 25-year-old man with no dependents, a married couple with two young children, and a married couple who have no children and are approaching retirement.

Judging the responses were the three founders of the Life Insurance Advisers Assn., a group of consultants who charge flat fees instead of earning commissions on the insurance products they sell.

"I was very surprised at the results," said one judge, Peter C. Katt, an insurance adviser in Bloomfield, Mich.

In its January issue, Money reported that none of the independent or direct agents received a perfect score of 27, and 14 agents flunked, scoring 16 points or less.

Points were awarded for answers that matched the judges' ideal responses and for answers that were deemed sensible, even if they did not match the judges' responses.

Overall, the advice was very poor, said Mr. Katt, adding that part of the problem is that life insurers exert no quality control over the type of advice given by agents.

"Agents are rewarded for selling insurance—period," Mr. Katt said.

Mr. Katt said he expected that "someone taking a test for a national magazine would come in with a white hat" and set aside his or her own interests.

'Agents are rewarded for selling insurance—period,' says insurance adviser Peter Katt.

It would have been interesting to see what kind of advice the agents would have given if they actually thought commissions were at stake, added Mr. Katt.

"Is this representative of the industry? I just don't know," said Stephen Neumeier, whose score of 24 made him one of the three agents who passed "with honors."

Money had a stern warning for its readers: Despite the "seemingly impressive" credentials that often grace their letterhead, many life insurance agents "are first and foremost salesmen, determined to get your signature on an insurance contract that will pay them fat commissions."

"I agree with the comments in the article. Insurance agents do have a tendency to push insurance," said Mr. Neumeier, who is president of the Lincoln Financial Group in Norwood, Mass.

Agents "can get licensed very quickly and start selling before they know anything," he said.

Although Mr. Neumeier has a bachelor's degree in economics and is both a Chartered Financial Consultant and a Certified Financial Planner, he noted that the most important aspect of offering sound insurance advice is to have "a philosophy of doing what's best for the consumer."

Agent recommendations varied widely.

Coverage recommended by the contestants for the hypothetical young couple with two children ranged from $146,000 to $1.6 million; first-year premiums varied from $375 to $8,988.

Suggestions for the young bachelor ranged from buying nothing—also the judges' recommendation—to buying a $250,000 universal life policy. One first-year premium was

Continued on next page

Viti agency

Continued from previous page

ancing program. "We don't turn anything down," he said.

A big believer in advertising, Mr. Viti says his commercials can be heard on Italian radio programming and Mexican television shows aired in Chicago. The radio program, broadcast in Italian, reaches as far as Wisconsin and Indiana, so the agency gets clients from those states as well, he said. Ads in ethnic newspapers and magazines help reach similar audiences.

The agency spends about $10,000 a year on advertising, much of which is co-opted with its insurers, Mr. Viti said.

Today, insurers are supportive

The agency's relations with insurers are as long-standing and stable as ties with customers.

Among its current insurers is Hartford Casualty Insurance Co., the first company with which Guy Viti ever contracted. Other current insurers are Economy Fire & Casualty Co., General Casualty Co. of Illinois, Gulf Insurance Co. and Great American Insurance Co.

The agency's target marketing of ethnic groups has not always been looked upon favorably by insurers, according to Mr. Viti. But those attitudes have changed radically over the past several years.

"Today, all the companies are really supportive, because now they see that's where the market is going. . .and they see that these people are really invested in our country."

Even personal auto coverage, which may seem like a bugbear to many insurance companies, is sought after by specialty insurers like Mercury Insurance Co. and Progressive Casualty Insurance Co., according to Mr. Viti.

Mr. Viti is also a big believer in automation. He's currently enlarging the agency's office space and plans to hire four more producers for both inside and outside sales. The agency runs on the AGENA agency management system and peripheral software that enables employees to cross-sell and provide automated ratings for auto and commercial business owners' policies, he said. ■

Continued from previous page
$1,800.

So consulting more than one agent may only produce further confusion, according to Mr. Katt.

In addition, advice from some agents actually can hurt potential customers, the magazine warned its readers. Three contestants recommended that the hypothetical couple nearing retirement spend all of their $500,000 life savings on an immediate annuity that would leave them "defenseless against inflation," the magazine said.

Some of the explanations agents submitted for their choices were incomprehensible, the judges said. Written responses from the contestants totaled 1,086 pages, but the judges said they couldn't "decipher what some were actually advising."

Scores on the test ranged from four to 26. ■

Modecki named NAIB executive director

WASHINGTON—The National Assn. of Insurance Brokers recently named Carl A. Modecki as its new executive director, replacing Michael J. Mullen, who resigned effective Dec. 31.

Mr. Modecki, who most recently headed his own consulting firm, is no stranger to trade associations. He was executive director of the Massachusetts Bar Assn. from 1971 to 1982, and president of the Consumer Bankers Assn. from 1983 to 1985. He was president of Meritor Savings Bank in Arlington, Va., from 1985 to 1988.

His appointment comes at a crucial time for the NAIB, which in late 1991 also lost its director of state affairs, Coletta I. Kemper. Ms. Kemper now is director of industry and public affairs with the National Assn. of Casualty & Surety Agents, which is based in Washington, D.C.

One of Mr. Modecki's top priorities is to restructure the NAIB's internal operations and fill the position of director of state affairs by the end of this month, he said.

Incoming NAIB President Alan G. Page, senior vp and director at Johnson & Higgins in New York, added that he plans to work closely with Mr. Modecki in increasing membership.

Insurer executive program

The National Assn. of Casualty & Surety Agents is developing an executive management program for insurance agency managers. The program is to be launched by NACSA and the Wharton School of the University of Pennsylvania.

The Executive Education Program for Insurance Agency Managers will be geared toward mid-level managers who seek leadership positions within their agencies.

Continental Corp. and the Wortham Foundation each contributed $25,000 toward the development of the program, which is the first management program specifically designed for insurance agency executives, said Ken A. Crerar, executive vp of NACSA.

The Wortham foundation, based in Houston, was established in 1958 by insurance broker Gus S. Wortham to assist in funding cultural and civic projects.

The management program, scheduled for May 17-22 at the Wharton School in Philadelphia, will focus on strategic planning; human resources; financial and information planning; and sales and marketing force management. Classes will be taught by Wharton professors and senior insurance industry executives.

Tuition for the program, which is open only to NACSA members, is $3,495 per person, payable by April 17.

For more information on the program, contact Coletta I. Kemper at NACSA, 202-547-6616.

A/BT briefs

Citicorp agency venture

An insurance agency owned by banking giant Citicorp is selling homeowners policies in Florida for Aetna Life & Casualty Co.

Aetna and Citicorp both say they hope to extend the arrangement to other states if the Florida program is successful.

For Citicorp, the homeowners insurance program is an extension of the bank's mortgage-loan process, a spokesman said.

Under the program, St. Louis-based Citicorp Insurance Agency Inc. will receive from Citicorp the names of Florida applicants whose mortgages have been approved. The agency will then try to sell those people homeowners policies, the spokesman said.

Aetna is "trying to create another source of distribution, not to replace any existing markets," said a spokesman for the Hartford, Conn.-based insurer.

"The commissions, product and price are all the same. We hope that this is not something that is threatening to our agents—our primary source of business," he said.

"If Aetna is on a level playing field and the rates, product and commission are all the same, then it is no different than if Aetna had just appointed more agents in Florida," agreed Stephen R. Melnick, president of the Professional Insurance Agents of Florida in Tallahassee.

"But, if they make the playing field unlevel, I think it will upset agents a lot more."

In a bulletin to members, the Florida Assn. of Insurance Agents questioned whether the arrangement violates strict state laws on banks selling insurance.

The Tallahassee-based trade group met with officials from Aetna last week to address their concerns about the deal.

In addition, Tom Gallagher, Florida's insurance commissioner, is examining the Citicorp-Aetna arrangement.

Cutro to head alliance

James J. Cutro, former vice chairman of Crum & Forster Inc., has been named the first president and chief executive officer of the Alliance for Productive Technology Inc.

The alliance, a joint venture between several insurers and software firms, aims to develop a standardized software for insurers and agents to exchange data (*A/BT*, Aug. 6, 1990).

Mr. Cutro is also past chairman of both the Insurance Information Institute and Insurance Value Added Network Services.

Richard Janssen, president of Delphi Information Systems Inc. of Westlake Village, Calif., was appointed APT chairman. ■

Agent/Broker Topics

Survival of the fittest agencies

Nine ways to make sure yours is one of them

By John R. Graham

WHY DO SMART insurance agents engage in a variety of community and business activities? The answer lies in the fact that insurance is not sold, it's bought.

Savvy agents make themselves both visible and valuable to place themselves in a position so that someone will want to buy insurance from them. Times have changed and trying to attract customers the way it was done in the '70s and '80s simply won't work.

Insurance agents who want to stay in business should give serious consideration to spending the time and effort to build personal relationships with their prospects and customers, creating the proper buying environment.

Here are nine "survival" strategies—ways to attract new customers, while keeping those you have now:

• Increase your presence in the marketplace.

If you want the business, it is essential to be recognized as the leader. Even if you occupy a narrow niche, make sure you're perceived as dominant in the market. The goal is to take away the initiative from your competitors. Make an impression on the market through carefully calculated advertising, direct mail and public relations.

• Dramatize your business.

Customers are attracted to companies that create excitement. Excitement sells!

But too many management types have gotten to the top by bleeding themselves dry of innovative thinking. And in bad times, businesses tend to become bland and dull.

Problem periods require new ideas, extra flair, added color and imagination. If you don't have innovative ideas, then you'd better find someone who does. Walk into any F.A.O. Schwarz store to see high drama in action. What do you see? Adults—having the time of their lives playing with the toys. Have a little fun and watch the sales climb.

• If you're the owner or manager, drag yourself out in the field.

American business has long been subverted by a horribly destructive myth. When you get to the top, you're permitted to be completely insulated from the two essential elements of business: employees and customers. If you lose touch, you and your agency will be in deep trouble when there are problems with the economy or when competition increases.

The excitement generated by the agency president making himself accessible to customers and prospects will increase sales almost automatically. Remember, big offices are bad for business. The people in them get too comfortable. Worse yet, they begin believing their own ideas. Drag yourself out into the field—it's the only place to win the game.

The excitement generated by the agency president making himself accessible to customers and prospects will increase sales almost automatically. Remember, big offices are bad for business. The people in them get too comfortable.

• Be daring—take a scenic trip inside the customer's head.

When customers stop buying or change insurance agencies, it's time to change your thinking. Realize that no one is interested in what you want to sell—it's what the customer wants to buy that's important. If you're not solving customer problems, you don't deserve to make sales. Remember that your primary job is to make your customer successful. When that happens, people buy. It sounds so simple, but most managers miss the point.

• Assume that no one, including the long-time customer, knows everything you sell.

When all is well and sales roll in, we all get lazy. Has anyone ever said to you, "I've been doing business with you for years, but I never knew you did that"? If even your best customers are ignorant of what you do, then what about everyone else? How many easy sales have been lost because a current customer went elsewhere?

There's a vast, untapped resource readily available inside your own agency. The people who do business with you regularly will buy more if you only let them know how you can help them.

The key to success here is endless repetition. Keep telling your story in new and interesting ways. The successful American Express direct-mail people know that staying in front of a customer is the only way to make more sales. You may not buy today, but you'll have another chance in a week or so. When you're ready, an Amex catalog is exactly where it should be—right there in your mailbox.

• Spend your time communicating your expertise.

What sets one insurance agency apart from its competitors in the customer's eyes? The fact that you may stand far above the competition is irrelevant. Your single most important job is to make sure that the customer perceives that you're the best.

The best way today to shape the perception of your business is by spending the time and effort to educate customers and prospects. They must come to believe that you possess the expertise that will benefit them.

• Find your pot of gold in your prospect list.

If you don't have a prospect list, then you don't have a bank full of money. The major problem in any business, including insurance agencies, is that attention always centers on the hot prospect, the one who's buying now.

If you want to be in business in five years, equal attention must go into taking care of both hot prospects and creating new customers. Establish and maintain an active prospect list. Do it on the computer so you can update daily. Create a log indicating when contacts have been made, the prospect's interests, what your next step will be, etc. Add names as you come into contact with people. Add to your prospect list those individuals and companies you would like to do business with, and cultivate them appropriately over a period of time.

• Stick to your knitting.

Success always comes from staying on track. We all look for scapegoats when business is lousy. The sales manager is tired. The employees are lazy. No one wants to buy.

There are other scapegoats, too: We're selling the wrong products. We're not offering the right services. Getting up to speed is taking too long.

Don't let such distractions deter you and your agency. Stick to your knitting. You know what you do best, so go out and do it.

• The real power is in personal service.

Etch these words in stone above your front door. Put them on coffee mugs, on memo pads and everywhere else. In an impersonal society, personal service counts.

Direct billing may be great for cash flow. The good news is, you don't have to worry about having receivables and collecting money that rightfully belongs to you. The guys at the insurance company do the dirty work for you.

But there's bad news, too. With direct billing, your customers are now dealing with someone else—they're no longer doing business with you. The strong link you've worked so hard to forge with your customer is now broken. You have become far less important in their eyes. Although direct billing may be the wave of the future, it will inevitably erode the agent-customerrelationship.

The most important key to attracting new customers and keeping your current one statisfied is doing everything possible to build strong personal relationships. ■

John R. Graham is president of Graham Communications, a marketing services and sales consulting firm in Quincy, Mass.

Kemper policy has video owner's manual

By MARK A. HOFMANN

LONG GROVE, Ill.—If a picture is worth a thousand words, then 15 minutes of videotape should go a long way in explaining how an insurance policy works.

That's what Kemper National Insurance Cos. is betting on.

The insurer is offering a videotaped "owner's manual" for combined homeowners/personal automobile policyholders. Any agent who sells these policies can purchase the tapes for $1.50 each.

The videotapes pictorially explain just what a policy covers, said William G. Ricker, president of Denis Ricker & Brown, an agency in Montpelier, Vt. Mr. Ricker recently ordered 300 tapes to distribute from the agency's three offices.

"So many people don't understand what they're getting in insurance unless something happens," Mr. Ricker said. "The tape does an excellent job of explaining things, but it's really not boring, either."

Kemper is following the lead of some car manufacturers, said Peter Standbridge, executive vp-personal lines for the Long Grove, Ill.-based insurer. He said that some new cars, like Cadillacs, come with an audiocassette that explains highlights of the owner's manual.

Mr. Standbridge said the idea for the videotape emerged about two years ago in a planning conference discussion about technology and how to use it. During the conference, someone cited the use of the audiocassette car manual, and Kemper decided to explore its implications for insurance.

The result was a 15-minute video designed expressly to explain the "Kemper Insurance Package" policy.

When the tape was tested in agent and policyholder focus groups, the response was overwhelming, according to Mr. Standbridge. Late last year, 2,000 tapes were distributed to policyholders through agents in about 20 states.

User-friendly reassurance

Near the beginning of the tape, the female narrator says that the video is provided to thank policyholders for purchasing the Kemper package and to "show we're standing behind" the package policy.

"Standing behind it means explaining it," the narrator adds.

Throughout the videotape, the narrator stresses that the insurer isn't going it alone in providing service. She emphasizes the role of the independent agents who sell Kemper products, saying, "If there's any way to help, your agent will."

She adds, however, that even with helpful agents, policyholders will want to find out about some of the policy's features on their own. And the video is designed to help them do that.

Policyholders in effect are walked through the package.

Though the policy is a legal document, it also is intended to be "user friendly," the narrator explains. To show just how the policy would respond to a loss, the video highlights specific lines on the declarations page.

For example, on the homeowners portion of the policy, the sample blanket limit of $300,000 is highlighted on a close-up of the declarations page. The narrator explains that this amount is all that Kemper would pay for damage to the sample property, which consists of a house, its contents and a backyard shed.

An inside shot of a freezer highlights coverage for damage to frozen foods. And the explanation of the policy's debris-removal feature comes against the backdrop of a tree that has crashed through the roof of a house.

The narrator also explains exclusions, policy conditions and endorsements. For example, while the video shows a man mowing a lawn, the narrator notes that in California, homeowners must add a workers compensation endorsement to cover people hired to work on their homes and yards.

The explanation of medical payments under the package policy is accompanied by a shot of a visitor leaving a house and falling off the porch onto the sidewalk.

The auto portion of the policy is handled in much the same way, with action and still photographs illustrating the narrator's explanation. When the narrator lists the regions covered, a map of North America appears with the United States, Canada and an enlarged insert of Puerto Rico highlighted in yellow. Then the narrator explains that the policy does not apply to Mexico without additional endorsements.

Claims and the agent's role

Claims also are covered by the video. The narrator stresses the role of the independent agent after explaining Kemper's commitment to claims handling. "Your agent will also be there to represent you if you need to file a claim," she says.

Policyholders also are reminded how to file a claim, noting that they should have the policy number ready when filing. Viewers then are shown where to find that number on the document.

Personal loss-control techniques also are demonstrated. For example, when the narrator urges policyholders to photograph or videotape their valuables, the video portion shows a person scanning property with a video camera.

Mr. Standbridge said that 10,000 copies of Kemper's videotape were

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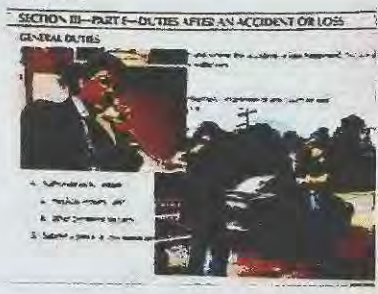

Kemper's videotape explains the policy's coverage and gives tips on how to reduce losses.

No-fault auto insurance system advocated

"Hit Me—I Need the Money!"
By Marjorie M. Berte
Published by ICS Press, 243 Kearney St., San Francisco, Calif. 94108
$18.95

Books & ideas

By Mark A. Hofmann

THE POLITICS OF AUTO insurance reform is the politics of stalemate, writes Marjorie M. Berte in her recent call for true insurance reform, "Hit Me—I Need the Money."

The result is a welter of stand-offs, trade-offs and compromises involving a number of players, including insurers, trial lawyers, auto repair interests, consumer advocates and medical groups, writes the author, who is currently a media relations representative for the Western Insurance Information Service, a Los Angeles-based public relations group supported by property/casualty insurers in 10 Western states. She is also a research fellow for the non-profit Institute for Contemporary Studies in San Francisco, which published the book.

One very important player gets cut out of the compromises, "the one paying the premiums—the driver, the average citizen," she writes.

"The process of political compromise is clearly less effective than we would like it to be for addressing complex economic problems—whether the government's budget or the insurance system. Seldom has a legislature passed a law that effectively lowered costs. Most often, the consumer has received no benefit from such legislation. Thus the crisis deepens," she writes.

However, Ms. Berte writes that while solutions to the underlying cost problems of auto insurance are not simple, effective ways to control costs do exist. Each individual "must be able to take responsibility for handling his own risk in a way that meets his needs. He must be empowered by information to govern his decisions. Even more important, he must see the rewards of responsible behavior, like maintaining a good driving record, in the insurance system itself," she contends.

"Second, changes must be made systemwide to overhaul the way money flows out of the pool of insurance funds. To achieve those broad changes, the political system must be moved out of the classic compromise and stalemate mode, a transformation that will take widespread political pressure, which can come only from informed insurance buyers as constituents," she writes.

Ms. Berte calls upon consumers to "take matters into their own hands, demanding information and a say in where their premium dollars go. If insurance buyers take collective action—especially political action—to make structural changes in the auto insurance system, then consumers will finally be able to set the priorities for where their insurance dollars go. The system should encourage even more individual control over how it compensates those involved in accidents and how it assesses fair insurance rates for those paying the bill."

Ms. Berte has in mind a no-fault system that greatly restricts the ability to sue in return for guaranteeing benefits for drivers. Low-income drivers would receive insurance vouchers to guarantee access to coverage, but the vouchers would not pay additional costs stemming from a poor driving record. Other reforms she advocates include tougher laws against auto theft, insurance fraud and drunk driving.

The current automobile insurance system is riddled with "perverse incentives" that increase claims costs, she writes. Those who are paid through the claims process—including doctors, lawyers and repair shop owners—have little incentive to limit expenses, she writes.

Insurers want to keep costs down, but they also want to settle claims as efficiently and quickly as they can, because doing so is "good customer relations, good claims practice and good business," she explains. Paying claims quickly also helps avoid bad faith lawsuits and cuts the cost of investigating and settling claims, she adds.

But that speed carries a price. "Many claims containing nonexistent expenses, inflated values or small-time cheating are paid," Ms. Berte points out. Insurers then must either pass the additional costs on to their customers or close up shop.

For physicians, the chief aim is to make the patient whole again and to avoid malpractice actions, she writes. Doing so means more testing and increasingly sophisticated treatment.

And, although auto repair shops compete with one another for business, repair shop operators have little incentive to control costs when they know insurers will pay for the repairs. Sometimes, operators also will help claimants inflate prices by charging for work that wasn't made necessary by the accident, she writes. "Auto repair shops are paid for work done, and the more work they do, the greater their income," she adds.

Ms. Berte also writes that lawyers on both sides of an insurance dispute have incentives for preserving the present system. The reason that plaintiffs' counsel resist change is obvious and simple: they get paid a percentage of what they win for their clients. Defense attorneys are paid to hold down settlement costs, but they also have an interest in maintaining the system, because they know that if there were no claims to defend, they'd be out of work, she writes.

After running through a litany of others who benefit from the current system, as well as factors like urbanization that increase the frequency of accidents, Ms. Berte states: "The auto insurance system does not deliver what it was intended to deliver—mending injured people and repairing damaged property—very efficiently. Those paid through the claims process have no motivation to control costs."

Political attempts to bring costs under control haven't worked and in fact have failed miserably in many cases, Ms. Berte writes. Compulsory insurance laws have not only failed to protect the public, but have fueled resentment of the insurance industry among consumers as well, because they mistakenly believe that insurers support such laws, she writes.

Rate controls have also failed, as have state insurance schemes like New Jersey's late, unlamented Joint Underwriting Assn. The JUA ended up insuring about half of the state's drivers at artificially low rates, which were in turn subsidized by surcharges on the insurance bought by drivers who remained in the private market.

In place of the current system—or systems—of providing automobile insurance, Ms. Berte advocates what she calls a "guaranteed benefits auto insurance" system.

"This insurance is a no-fault type that provides every driver with medical benefits and payments for lost wages from his own insurance company, regardless of the circumstances of the accident. It would place limits on the ability to sue through a strong verbal threshold, prohibiting use of the legal system unless an injured person suffered permanent and serious injuries or death. The perverse incentives that drive up costs for economic losses, non-economic damages and legal expenses would be largely eliminated from the auto insurance dollar," she explains.

She advocates establishment of a system of insurance vouchers to guarantee low-income drivers access to coverage. Drivers who met an income test would receive the vouchers, which would be subsidized by the government, while retaining their right to purchase insurance from any company they choose and to choose the level and types of coverage they desire.

However, "the additional cost caused by a low-income driver's poor driving record would not be subsidized," she writes. Such a voucher system "would also assist all other insured drivers by eliminating subsidies for all drivers who do not merit public assistance and by decreasing the number of uninsured drivers on the road," Ms. Berte contends.

Ms. Berte also advocates stricter laws—and stricter enforcement of such laws—against drunk driving, auto theft and insurance fraud, as well as laws that would promote competition among auto repair shops and replacement parts makers.

After advocating that consumers, insurers, agents and lawmakers accept responsibility for changing the current auto insurance system, Ms. Berte calls for a renewal of the trust that has to exist in any insurance contract.

"It is critical that the trust underlying the insurance contract be reconnected as a link between human beings—in the relationship between agent and client, in the contact between claimant and company adjuster, in the communication between company and customer, in the consumer information that enables choice and in the development of community-based approaches to insurance problems."

Ms. Berte's book—combining a call for a freer market in insurance with a safety net for low-income motorists and a guarantee of benefits in exchange for certain changes in tort law—is certain to stir controversy, as is her suggestion that individuals accept greater responsibility for their own actions.

That fact that she pulls no punches in naming those who profit from the current system won't win her friends in certain law offices or legislatures. But that's the beauty of the book: Its uncompromising call to arms could serve as the battle cry for a new and possibly successful push for meaningful auto insurance reform. ■

Video explains CGL policy to agents

Products & services

A new video training program provides insurance agents with an overview of exposures covered in the commercial general liability policy.

The program, developed by the National Assn. of Professional Insurance Agents, includes two videotapes and a workbook for agency staff.

"The Introduction to Commercial General Liability" program is available for $196 for PIA members and $235 for non-members. Additional workbooks are $26 each.

For more information, contact the PIA National's Education Department, 400 N. Washington St., Alexandria, Va. 22314; 703-836-9340; or PIA Member Services, 800-742-6900.

Financial workshop

The National Assn. of Casualty & Surety Agents is sponsoring "Managing Your Agency Finances," a two-day workshop for comptrollers and chief financial officers of larger insurance agencies and brokerages.

Topics include budgeting, balance sheet guidelines, changes in tax laws, legal liabilities, like insolvencies and errors and omissions, and employee benefit management.

The workshop is scheduled for March 7-9 in Irving, Texas. Tuition is $595 per person and the enrollment deadline is Feb. 20. For more information, contact NACSA, c/o Financial Management Seminar, 316 Pennsylvania Ave. S.E., S-400, Washington, D.C. 20003; 202-547-6616.

E&O newsletter

"E&S Market News" is a biweekly newsletter published by The Merritt Co. offering agents and brokers information on insurers writing hard-to-place risks, key contacts and phone numbers, and legal and legislative news.

New subscribers will receive "Strategies for Insurance Coverages," a three-volume reference set on placing business with the surplus lines market; and "Risk Management Review," a monthly newsletter on current risk management issues, from legislation to health breakthroughs.

Subscriptions to "E&S Market News" cost $387 per year. For information, contact The Merritt Co., Department D38906, P.O. Box 955, Santa Monica, Calif. 90406; phone, 800-638-7597. ■

Kemper video

Continued from previous page
prepared, and thousands more can be made as the demand arises. He noted that although the package policy first hit the market seven or eight years ago, it isn't available in all states yet, including two of Kemper's largest markets: North Carolina and Virginia.

Take that, Mr. Nader

Video "owner's manuals" conceivably could accompany other types of insurance—like stand-alone automobile or homeowners policies—in the future, but only if they could be produced in a cost-effective way, according to Mr. Standbridge. Any video that costs more than 1% of the premium would be too expensive, he said.

The tape was produced in-house, but copies were produced through an outside contractor. Each tape costs slightly less than $3 to produce, according to a Kemper spokesman.

Mr. Standbridge also said that with differing state laws on auto insurance, a video produced for all the states in which Kemper writes personal automobile coverage might have to deal with the subject more generally. He said that such a video would remind policyholders to check with their agents on the specifics of state requirements.

The video could have an impact beyond its primary purpose of helping policyholders understand the coverages contained in their policies, said Mr. Standbridge. He noted that a persistent criticism of the insurance industry—made notably by consumer activist Ralph Nader—has been that it makes little or no effort to educate its customers.

The video has "enabled us to answer Mr. Nader and some others' criticisms that we don't explain our policies," said Mr. Standbridge. ●

Associate Editor Laura Mazzuca contributed to this report.

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Agent/Broker Topics

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Business Insurance

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Examining punitive damages, the study found that the average claim payment was about 40% greater when the claimant sought punitive damages—or $292,000 compared with $210,000 when there was no punitive damage claim—independent of the severity of the injury.

However, while claimants sought punitive damages in 16% of the large claim sample, only 2% of these claims ever resulted in a court verdict granting a punitive award, while 4% resulted in a court verdict denying punitive damages. The remainder were settled.

In the sample of claims resulting in a court verdict, 17% sought punitive damages, but only 27% of these were successful.

The claimants themselves were also analyzed in the ISO study. Claimants between ages 21 and 64 accounted for close to 80% of all claims, although they represent just 57% of the total population. In addition, 71% of the claimants were employed, compared to 47% of the general U.S. population.

Among employed claimants, work-related injuries accounted for 63% of their claims. The average loss for claimants injured on the job was $244,000, 24% higher than $197,000 for other claimants, the study reported.

Examining injuries, the survey found that within the large claim sample the most prevalent types of injury were: dislocation or fracture, accounting for 30.4% of the claims; back injury, 18.5%; death, 11.7%; permanent brain damage, 4.7%; emotional injuries, 3.7%; with the remaining 31% of claims from miscellaneous other injuries.

These breakdowns were generally parallel with the experience of the court verdict sample.

The highest average loss within the large claim sample, $454,000, was for paralysis claims, while the lowest average loss was for abrasions and lacerations, $115,000.

Breaking down the bodily injury claims by type, the majority—78.8%—fell into the "all other liability" category, followed by product liability, which accounted for 17.3% of the claims. Other categories included: municipal liability; 1.6%; liquor law liability and public school liability, each 0.8%; recreational liability, 0.5%; day-care liability, 0.1%; and lawyers professional liability, which accounted for less than 0.1%.

However, the study authors note, while "all other liability" claims outnumbered product liability claims by more than four to one, the average payment for product liability claims, $299,000, was 45% more than the $206,000 paid on average for "all other liability" claims. And though it accounted for an even smaller fraction of all claims, the average payment for recreational claims—$302,026—was nearly double the average loss for "all other claims."

•

Copies of the survey summary can be obtained free from Susan Fliegelman, Corporate Communications, Insurance Services Office Inc., 7 World Trade Center, 17th floor, New York, N.Y. 10048.

Statistical compilations of the results also are available to participating insurers at $150 per copy, and to others at $300 per copy, by either filling out a form in the summary booklet or sending a payment made out to ISO DATA Inc. to the same address.

EIL ruling binds liability insurers, state court says

CHICAGO—In an unusual ruling, a judge has found that a jury's ruling that a utility's environmental impairment liability insurers must pay pollution cleanup costs also binds its comprehensive general liability insurers.

A Cook County jury found in October that Central Illinois Public Service Co. did not "expect or intend" to pollute (*BI*, Oct. 28, 1991). The trial involved only American Empire Surplus Lines Insurance Co., which wrote a $15 million claims-made EIL policy for the gas company in 1983.

But Circuit Court Judge Warren Wolfson ruled that because the utility's CGL insurers developed the legal theories and supporting evidence used at the trial, the CGL insurers were bound by the verdict because there would be no new arguments to present in a separate trial.

The litigation between the utility and its insurers is continuing. Both the EIL insurer and nearly 50 CGL insurers argue other defenses, including the owned-property exclusion.

The Springfield, Ill.-based utility is seeking coverage for the multimillion-dollar cleanup at a coal gasification plant it formerly operated in Taylorville, Ill. A by-product of the process that turns coal into gas is tar residue that can contaminate soil and water.

—By Stacy Adler Gordon

WE HAVE MORE YESTERDAYS THAN MOST REINSURERS HAVE TOMORROWS

Many reinsurers would like you to believe they will remain in business forever. That's because reinsurance entails extraordinary long-term obligations. Failure to honor these obligations exposes the insured to major losses. North American Re has provided quality reinsurance for over 80 years. Together with Swiss Re, we offer total reliability and a commitment to endure.

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ASK A BENEFITS ACTUARY

New IRS rules adding to pension administration

Q **What is the new benefit calculation requirement for defined benefit plans?**

A This question comes from the employee benefits manager of a company that sponsors a defined benefit plan. The plan is integrated with Social Security, taking into account permitted disparity. The company intends to comply with the non-discrimination rules under Internal Revenue Code Section 401(a)(4) by having a benefit formula that meets one of the design-based safe harbors. The benefits manager has heard of a new benefit calculation requirement that will significantly increase the administrative burden on the plan.

In the final regulations on permitted disparity issued in September, the IRS included a requirement regarding the reduction of accrued benefits that may require substantial additional calculations and record keeping for all defined benefit plans in which the integration level changes annually. The regulation requires that if the participant's accrued benefit would decrease as the result of an increase in covered compensation, then an accrued benefit determined prior to the covered compensation increase must be preserved as a minimum accrued benefit. This is a position that the IRS has taken informally in the past, but the regulations formalized that position.

Thus, under these regulations, when a participant terminates employment, his accrued benefit based on current pay, service and covered compensation would need to be compared with the frozen benefits as of the end of each prior plan year. In general, the current accrued benefit at termination should exceed the prior frozen benefits due to increases in pay and service. However, this may not be true for participants who terminate in the first few months of the year, have reached the maximum service limit, or have irregular pay or service histories.

Although it may be possible to identify most such participants, the only way to ensure compliance is to calculate and maintain records of the accrued benefit for all participants as of the end of each year.

This requirement creates some significant plan administration issues. First, if a plan sponsor wishes to be ensured of compliance, it seems likely that the benefit calculation process would need to be automated.

This requirement also creates compliance issues for prior plan years. The permitted disparity regulations are effective with the 1989 plan year and it is unclear whether there is a good faith compliance standard available for those prior years. The final permitted disparity regulations do not provide for a good faith standard, although some experts argue that a good faith standard is available under the final regulations of IRC Section 401(a)(4).

What this means for plans with an increasing integration level is that the design-based safe harbors may not be available as a means to comply with the non-discrimination rules for 1989 through 1991, unless a plan provides the minimum accrued benefit for these years. If the plan provided for this minimum accrued benefit, numerous benefit recalculations would likely be required.

Fortunately, following the permitted disparity regulations is but one means of demonstrating compliance with the general non-discrimination requirements of IRC Section 401(a)(4). For example, the plan might show compliance for 1989 through 1991 by performing the general non-discrimination test. The regulations related to the general non-discrimination test are effective for 1992 with a good faith compliance standard for 1989 through 1991.

In his State of the Union message last week, President Bush asked government agencies not to issue regulations for a 90-day period and to review regulations that create an undue burden on business. A regulation that makes it necessary to calculate that accrued benefit for every participant every year would seem to fall under that category. One can only hope that the IRS might lighten the administrative burden on businesses. ■

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, president of Pacific Actuarial Resources (PAR) Excellence in Ashland, Ore., 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 April.

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.

Company objectives affect risk-related costs

By The Insurance Institute of America

A.R.M. exercises

The following question and answer are drawn from the curriculum for the Associate in Risk Management designation awarded by the Insurance Institute of America. They represent the type of question asked—and the possible answers—in one of the three examinations for the A.R.M. designation. This month's exercise, drawn from a recent national examination in ARM 54—The Risk Management Process, focuses on how exposures to accidental loss and decisions about dealing with those exposures affect a firm's costs.

Q: One of the four elements of any firm's cost of risk is its cost of retained losses. Cost of risk is affected not only by the loss exposures the company faces, but also by its choice of risk control and risk financing techniques.

- Identify the remaining three elements of any firm's cost of risk.
- Illustrate each of these three elements for the net income loss exposures facing a clothing manufacturer that has only one plant.
- The clothing manufacturer mentioned above has grown substantially over the past decade despite fluctuations in its overall earnings. Assume that its major stockholder decides to change the basic objective of the firm from growth to stability of earnings. Assuming no other changes are made, explain how—if at all—this change in company objectives is likely to change the relative importance of each of the four components of the firm's cost of risk and the overall cost of risk.

A:

- As usually defined, a firm's cost of risk consists of not only the retained losses mentioned in the question, but also three other elements: insurance premiums; costs of loss prevention and reduction measures; and the administrative costs of operating the risk management department.
- Therefore, this manufacturer's cost of risk arising from its net income loss exposures is likely to include, for example, premiums for business interruption and perhaps extra expense or contingent business interruption insurance coverage, the costs of purchasing and maintaining standby items of equipment to reduce the duration and extent of the net income loss from interrupted operations, and the wage and salary cost of the time that the risk manager and other executives and personnel devote to planning, instituting and practicing emergency response procedures to minimize downtime following any serious accident.
- Shifting the organization's basic objective from growth to stability of earnings means that senior management should now emphasize reducing fluctuations in revenues and expenses. Where necessary, risk management and other decisions should sacrifice some amounts, or some increases in, net earnings—revenues minus expenses—to also reduce fluctuations in those earnings. This is likely to imply some further rigorous expense control throughout the firm.

Focusing only on factors that affect the cost of risk, and ignoring other factors that influence the stability of earnings, the clearest impact of the change in the firm's objectives is that expenditures for insurance are likely to increase. Insurance stabilizes costs by substituting a relatively fixed, known insurance premium for the typically fluctuating costs of retained losses. Consequently, expenditures for retained losses should become relatively less important for an organization focused on stability of earnings rather than on growth. Preventing accidents tends to dampen fluctuations in a firm's costs; therefore, the risk control component probably will become relatively greater, especially because all its income depends on the continued operation of its only plant. Finally, because achieving stability of earnings intensifies both risk control and risk financing activities, administrative costs for risk management should increase in absolute dollars, and perhaps also as a percentage of the total cost of risk.

- This firm's overall cost of risk also is likely to rise as a percentage of its total expenditures. Stabilizing earnings requires much greater attention to all aspects of risk management, especially increased outlays for insurance and risk control, than does organizational growth. Therefore, the total annual dollars expended on risk management should increase. ■

The sample questions and answers used in this column are taken from the Associate in Risk Management designation curriculum of the IIA. For more information on the content of the A.R.M. program, write Dr. G.L. Head, Vp, Insurance Institute of America, P.O. Box 314, Malvern, Pa. 19355.

Rationing

Continued from page 3

rather than legislators, insurers or medical experts.

Patients are best able to make health care rationing decisions because they not only receive the benefits and suffer the harm of those services, but they also ultimately foot the bill as insurance buyers and taxpayers, according to Dr. Eddy.

"We've developed intricate accounting mechanisms that disguise how treatment is paid for," Dr. Eddy pointed out. "But, ultimately, we all pay."

Insurers, for instance, pass on higher health care costs by raising premiums; government finances Medicare and Medicaid bills by raising taxes; and employers pay lower salaries so they can afford health insurance for employees, Dr. Eddy explained.

"Sooner or later, these costs will come home to roost and will be paid by real people," he warned.

Unfortunately, "we are blatantly schizophrenic about health care costs," Dr. Eddy said. "On the one hand, we say, 'Doctors, spare no costs.' But, simultaneously, we say that costs are too high."

To end the health cost spiral, the doctor advocates a patient-directed rationing system in which treatment decisions are made by balancing value and cost of treatment.

Dr. Eddy's system would involve four steps:

- Make available to a representative group of patients information on the benefits, the potential harm and the cost of various medical treatments.

The information provided to patients would be furnished by a government-financed study. He suggested that the government finance this study because it would benefit all U.S. citizens.

- Ask the group of patients what services they want and are willing to pay for.
- Consistently implement these choices in health care practice policies.
- Adhere to those policies.

The last step would be the most difficult step to apply because it inevitably would mean that some beneficial medical services would not be covered by health plans because patients concluded that they cost too much in relation to their value, Dr. Eddy pointed out.

"If budgets are limited, we have to examine the trade-offs of doing various treatments," he said.

To illustrate, he used the example of a woman diagnosed with terminal breast cancer. Should she be given the newest treatment—high-dose chemotherapy coupled with a bone marrow transplant—if that treatment, which would cost $150,000, would enable the woman to live only two more years?

That same $150,000, he suggested, might be better spent on mammograms to detect cancer earlier in 1,000 other women.

"The instinct we all feel is how can we be so cold-hearted as to prevent that one woman from living two more years," Dr. Eddy said. "But if we give in, we eliminate the chance of saving how many other women?"

Sometimes treatment decisions are made by practitioners fearful of malpractice liability, Dr. Eddy also pointed out.

For example, a radiologist may use more expensive non-ionic X-ray dyes rather than ionic X-ray agents because they produce fewer side-effects.

But the $80 additional per-treatment cost for non-ionic X-ray dyes may not be justified if they result in only 2% fewer mild reactions, 0.5% fewer moderate reactions and 0.1% fewer severe reactions, Dr. Eddy said.

"Are the lower reaction rates really worth the cost?" he asked.

The principal logic for rationing health care by patient choice, according to Dr. Eddy, is that it simulates what would have occurred had medical practices functioned properly under the laws of supply and demand.

"Rationing by patient choice, if applied properly, should align value and cost in a way that is acceptable to patients," Dr. Eddy states in a paper that was published in the Journal of the American Medical Assn. and distributed at the conference.

"When patients make their choices, they would be speaking simultaneously about value and cost," Dr. Eddy wrote. "If they want more value, they would simultaneously be expressing a willingness to pay for it through increased premiums or taxes. If they want to spend less money, they would simultaneously be expressing a willingness to settle for less value."

To further illustrate his point, Dr. Eddy said that $4 million could be used to:

- Prevent 40 severe reactions to ionic X-rays.
- Add 3,000 years of life to women if spent on Pap smears to detect cervical cancer.
- Add 500 years of life to women if spent on breast cancer screening.
- Prevent 15 sudden deaths, 120 heart attacks and 280 other coronary/artery events if spent on cholesterol screening and dietary education.

He believes a patient-directed approach to health care rationing will work because patients really do care about costs.

"If people didn't care about costs, we could solve the health care problem by simply increasing costs and taxes," he said.

But, "patients have to develop realistic expectations," he cautioned. "They can't demand to have it both ways." ■

Educating employees

More informed health care choices save money: Consultant

By JOANNE WOJCIK

LOS ANGELES—Teaching employees to be better health care consumers can result in big payoffs for employers, both in dollars saved and workplace productivity gained, wellness experts say.

The Managed Health Care Congress WEST

Employers should realize that when they provide health care benefits, they really are giving employees purchase orders, points out David A. Feffer, chairman of Employee Managed Care Corp. of Bellevue, Wash.

"We give them $1 million and say, 'Go to it,' " Mr. Feffer said, referring to the typical lifetime cap on employee health care benefits.

Mr. Feffer spoke at a session titled "Employee Empowerment—Recreating the Medical Consumer" at the Managed Health Care Congress West, held last month in Los Angeles.

Yet these health care "purchasing agents" have little or no medical training or skills, he pointed out. "What we've effectively done is push our employees into the ocean without a life raft."

As a result, employees simply "step on the medical conveyor belt and let medical procedures be performed on them without question," he said.

To change employees' health care purchasing habits, employers need to focus on two areas: the financial and the educational.

Unfortunately, employers currently are focusing only on the financial by limiting choice and accessibility through managed care and cost containment programs, Mr. Feffer said.

"What we're missing is the knowledge and skill that employees require once they've been given financial responsibility" for health care purchasing decisions, he said.

Employers need to encourage employees to change their behavior from that of being passive patients to becoming educated consumers, he said.

"It's really difficult to be assertive when we're naked," he quipped.

Research has shown that patients armed with questions are healthier in general and have better outcomes when undergoing health care procedures, he said.

Furthermore, "true informed consent may have a significant impact on malpractice claims," he suggested.

In fact, 80% of malpractice claims can be traced to poor communication of the risks involved in a procedure, concurred Cindy L. Kreig, marketing director for Healthwise, a non-profit organization based in Boise, Idaho, that conducts wellness education seminars for employees nationwide. Healthwise also publishes a handbook in conjunction with the American Medical Assn. that helps employees make preliminary diagnoses.

"If we're only spending eight minutes with the doctor (the duration of the average office visit), we need to use that time efficiently," she said.

Wellness programs provide an excellent opportunity for employers to teach their employees doctor-patient communication skills that will make them better health care consumers, she said.

"If we're audited by the Internal Revenue Service, we get prepared, digging up every blank check and receipt we can find," Ms. Kreig said. "But when we go to the doctor, we're not prepared at all."

Americans "need to learn how to recognize illnesses, how to prevent them and how to treat them," she said, because "70% of a correct diagnosis depends on what we tell our health care professionals."

In addition, research has found that 70% to 80% of all health problems can be handled by self-care at home, according to Ms. Kreig.

Instead about 84% of all health problems treated, comprising 40% of total health care costs, are currently treated in doctors' offices, Ms. Kreig said, citing Healthwise estimates.

Another 13% of health care problems, comprising 45% of total health care costs, are treated in a hospital, while the remaining 3% of problems, comprising 15% of total health care costs, are treated in teaching or research hospitals.

Education can turn these figures around, with 80% of all health problems being treated at home, 16.8% treated in the doctor's office, 2.6% in the hospital, and 0.6% in teaching and research hospitals, Ms. Kreig said. She added that health care consumers with resources and training to improve the quality of home-based self-care have been shown to significantly reduce the cost of office-based care.

"What you do for yourself when you are well has much to do with what your doctor does with you when you are ill," she said.

Furthermore, "informed medical consumers would better manage health costs at the hospital level," she added.

To show how wellness education can lower employer health care costs, Ms. Kreig cited the experience of a Montana utility that distributed educational pamphlets and newsletters to its employees, offered self-care education classes and provided access to nurse reviewers who provided medical advice by telephone.

Before the wellness program, 43% of employees said they would call the doctor for a medical problem, while 12% said they would apply self-care first.

After the program was completed, only 15% said they still would call a physician, while 59% said they would first apply self-care.

Such employee attitudes can significantly reduce health plan utilization, Ms. Kreig pointed out.

A study Richmond, Va.-based Continental Health Promotion conducted of its clients found that "for every $1 spent on self-care education, $2.41 to $4.20 was saved in health care costs," she said.

That same study found that employees who received self-care education showed only a 2.4% increase in doctor's visits, compared with an 11.4% increase for a control group that received no education, according to Ms. Kreig.

To be good medical consumers, employees need to be supplied with information and instilled with the confidence to use it, she said.

"Self-care has been around for generations," she said. "But today, it's the most overlooked part of our health care system." ■

Point-of-service plans require extra effort to explain complexity

By JOANNE WOJCIK

LOS ANGELES—Because of their complexity, point-of-service plans generate special communication requirements, benefits experts say.

The Managed Health Care Congress WEST

Not only employees and claims administrators need to understand how the point-of-service plan operates, but health care providers also must be educated, says Judy R. Lerner, a principal at William M. Mercer Inc. in Los Angeles.

To facilitate this process, point-of-service plan vendors should be upfront with employers about how much work it will take to implement the plan, Ms. Lerner said during a session at the Managed Health Care Congress West, held Jan. 16-18 in Los Angeles.

Employers "need to be prepared to provide more communication and administration" than with other benefit plans, Ms. Lerner said. "Because of the rush to market, not all of the (communication) procedures involved in the point-of-service plan have been ironed out."

The most significant communication gaps in point-of-service plan implementation that Ms. Lerner has seen as a consultant are:

- Uncertainty over the so-called gatekeeper or primary-care physician role.
- Lack of procedural details for handling out-of-network claims and self-referrals, in which an employee seeks care from a network physician without first visiting the gatekeeper.
- Lack of provider education.

The point-of-service concept was developed as a transitional model to steer employees still enrolled in indemnity programs into a managed, health maintenance organization-like setting, explained Dr. Thomas Mayer, another Mercer principal in Los Angeles.

In a point-of-service plan, all employees are enrolled in a single network from which they must select a primary-care physician. They still have the option to use outside doctors, but only for a lower benefit.

To keep employees from thinking they've been sold "an HMO in drag," many plan administrators compare

Continued on next page

Conference attendees hear play-or-pay plan

LOS ANGELES—Details of the National Leadership Coalition for Health Care Reform's play-or-pay proposal were unveiled during the keynote address at the Managed Health Care Congress West.

The Managed Health Care Congress WEST

Approximately 800 executives connected with the managed care industry gathered here for the meeting Jan. 16-18.

Those in attendance included human resource directors, corporate benefits managers, financial executives, medical directors, physicians, clinicians, pharmacists, insurance company executives, hospital executives and military officials.

The play-or-pay proposal, which was presented by coalition member Ron Zachary, senior vp-human resources at Oakland, Calif.-based Safeway Inc., calls for all employers that do not provide health insurance to their employees to pay a 7% payroll tax. This payroll tax would be used to fund "ProHealth," a national program that also would include Medicare and Medicaid recipients (*BI,* Nov. 18, 1991).

Additional financing for the program would come from a 1% payroll tax, split equally between employers and employees. In addition, employees enrolled in ProHealth would pay 1.75% of payroll toward the cost of coverage. These requirements would be phased in for start-up firms and small businesses.

The plan also calls for the development of national practice guidelines, a uniform payment structure for providers, medical malpractice reforms and an annual cap on health care expenditures.

While it is gaining support among congressional Democrats, the proposal has been criticized as unwieldy in a study commissioned by the Bush administration and released just before the conference (*BI,* Jan. 13).

The coalition's plan and a similar play-or-pay proposal being developed by a group that includes Dr. Paul M. Ellwood of InterStudy, a managed care research organization in Excelsior, Minn., will be discussed during the upcoming National Managed Health Care Congress, March 29-April 1 in Washington, D.C.

Next year's Western conference will be held Jan. 21-23 in San Francisco.

For more information on either conference, contact the National Managed Health Care Congress, 1000 Winter St., Suite 4000, Waltham, Mass. 02154; 617-487-6700.

—By Joanne Wojcik

Work comp fraud allegations boil over

Insurer's complaint triggers countersuit by medical clinics

By LOUISE KERTESZ

LOS ANGELES—Several workers compensation insurers, medical providers, attorneys and claimants are embroiled in the first racketeering litigation ever filed in California over workers comp claims.

Zenith Insurance Co. of Woodland Hills, Calif., is charging providers, attorneys, five claimants and others with conducting a scheme to file fraudulent workers comp claims, including fraudulent medical-legal evaluations.

In response, the providers—medical clinics that primarily treat job-related stress injuries—have filed a separate action charging Zenith, other insurers and a major hotel chain with antitrust violations and conspiring to drive out of business providers that care for minority workers who suffer from workplace injuries and illnesses, including stress.

Wellington Medical Corp., a named defendant in Zenith's suit and a plaintiff in the provider suit, is owned by Dr. Byron Crawford, a Los Angeles psychiatrist who pleaded no contest to contempt charges by the Workers Compensation Appeals Board in July 1990. Dr. Crawford agreed to pay the board $20,000 in a case that alleged he employed unqualified personnel to "ghost write" medical-legal evaluations of workers comp claimants that were submitted to insurers or self-funded employers.

And last September, Dr. Crawford lost his appeal of a WCAB decision that involved another allegation of ghostwritten medical-legal workers comp reports.

In that case, the WCAB overturned a lower court's order that Bullocks Department Stores, a division of R.H. Macy & Co. Inc., must pay $1,700 to Professional Consultation Services Inc., a clinic owned by Dr. Crawford and which is a plaintiff in the provider suit against Zenith. In challenging Dr. Crawford's appeal, Bullocks argued that the medical-legal reports PCS prepared on behalf of a Bullocks employee were ghostwritten, said Bullocks' attorney, Clifford D. Sweet III, a founding member of Heggeness & Sweet in San Diego (*BI*, Aug. 5, 1991).

Under California law, insurers and self-insured employers must pay for an injured worker's medical-legal reports, at an average cost of more than $1,000 per report, even if a claim is denied.

Besides Wellington and two of its employees, Zenith's suit names American Psychometric Consultants and two of its employees; attorney Glen A. Lintner and the Glen A. Lintner law firm; an interpreting service and its two principals; and five workers comp claimants, who are restaurant workers.

Zenith's suit, filed in U.S. District Court in Los Angeles in November, charges that five workers for the La Serre restaurant in Sherman Oaks, Calif., quit their jobs in June and subsequently filed fraudulent workers comp claims for injuries they contend prevented them from working.

At the time the claims were filed, though, the five former La Serre employees were working for a rival restaurant managed by Eduardo Sanchez, another former La Serre employee, according to the suit.

The suit charges that Mr. Sanchez also had a fraudulent workers comp claim pending against La Serre when his restaurant hired the five employees.

As part of Mr. Sanchez's claim, according to the suit, American Psychometric Consultants had submitted medical evaluations stating that Mr. Sanchez was disabled due to psychological stress, and APC billed Zenith for those evaluations and for necessary treatment.

The suit further charges that APC referred Mr. Sanchez to Wellington. Wellington's reports, which "contained material misrepresentations and were exaggerated and inflated," essentially confirmed APC's diagnosis that supported Mr. Sanchez's "fraudulent" claim and billed Zenith for the reports and for treatment, the suit alleges.

Mr. Sanchez was working at the rival restaurant while he was purportedly disabled, according to the suit.

The suit charges that the five former La Serre employees Mr. Sanchez hired knew about Mr. Sanchez's "fraudulent claim" and agreed to allow APC and Wellington to file fraudulent claims on their behalf as well.

Those claims, which APC certified, contended that the five were "disabled due to psychological stress and trauma."

The defendants were working at the time of their evaluations by APC, but APC's reports indicated "that all five claimant defendants were unable to work and would be disabled" for several months, Zenith's suit alleges.

APC then referred the claimants to Wellington and California Comp Care Medical Corp. for further evaluation, and those firms, as well as A&W Interpreting Services, billed Zenith for unnecessary services, the suit charges.

Wellington and Cal Comp Care also filed false reports on the claimants, according to the suit.

The suit charges that APC and Wellington referred the claimant defendants to the Lintner law firm so that it "would prepare, submit and prosecute claims" for workers comp benefits.

Zenith charges that the providers, attorneys, claimant defendants and the interpreting service were engaged in "a pattern of racketeering activity" and fraud.

The suit seeks compensatory and punitive damages to be determined at trial, as well as an injunction against the defendants to cease their alleged fraudulent activity.

Zenith charges that the defendants engaged in 'a pattern of racketeering activity' and fraud.

The providers, which also include Princeton Medical Corp., American Assessment Medical Corp. and California Comp Care Medical Corp., all of Los Angeles, filed their suit against Zenith and the other defendants in U.S. District Court in Los Angeles Dec. 18.

Besides Zenith, the providers' suit names Unicare Insurance Co. of Irvine, Calif.; California Indemnity Insurance Co. of Burbank, Calif.; and Bethesda, Md.-based Marriott Corp.

The providers' suit alleges that "in response to plaintiffs' success in providing services to patients who otherwise would have not had access to treatment, care and evaluation, and who might otherwise not have filed legitimate workers compensation claims, particularly poor minority group members, defendants have engaged in an illegal conspiracy, fraudulent activity and other wrongful actions to reduce plaintiffs' revenues and to drive plaintiffs out of business. . . ."

The insurers also are unlawfully seeking "to encourage other insurers and employers to join in defendants' illegal practices," the suit charges.

The providers charge that the insurers' unfair business practices "will have a chilling effect upon other medical practitioners providing evaluation and treatment to victims of employment-related psychiatric injuries."

The provider suit charges, among other things, that the insurer defendants and Marriott participated in a "group boycott or concerted refusal to deal with" the providers by refusing to pay liens submitted by the providers.

In particular, the suit charges that Marriott stated that it would not pay any of the providers' future liens for medical-legal evaluations and treatment or answer any of the providers' inquiries about the liens. That means the providers will have to litigate all liens to receive payment, the suit charges.

The providers' suit seeks unspecified treble compensatory damages under the California Business and Professions Code and punitive damages. It also seeks an injunction against the insurers' alleged unlawful practices. ■

Point-of-service plans

Continued from previous page

the primary-care physician to the old family doctor, Dr. Mayer observed.

But using that comparison will backfire, with employees perceiving the so-called choice touted by point-of-service plans as just another restriction, Ms. Lerner warned.

For example, when promoting the plan among employees, employers and plan administrators should explain that the primary-care physician, like an HMO gatekeeper, is the starting point—not the exclusive provider—of health care, she pointed out.

"Clear and open communication is really the answer," she stressed.

Ms. Lerner also advised employers and plan administrators to begin explaining changes in the plan to employees up to six months beforehand.

"This will give employees some lead time to select a (primary care) doctor," she said. "Remember, this plan is geared toward indemnity plan enrollees" who aren't used to selecting a gatekeeper, she added.

"Hot lines" or "help lines" that provide information to employees quickly via telephone also are helpful during the early stages of a point-of-service plan.

The point-of-service plan communication effort also should extend to providers selected for the network, according to Ms. Lerner.

"Make sure they understand the differences between the point-of-service plan and an HMO," she said. "They often think it's just another HMO," which can cause problems when handling self-referrals, she explained.

Unlike an HMO, self-referred visits to a network doctor without the consent of the gatekeeper are paid on an out-of-network basis.

"They need to know how to handle out-of-network reporting," Ms. Lerner stressed.

To make the information more palatable to physicians, she suggested that employers and plan administrators provide it in small doses.

"Divide the information. They won't read it all at once. They don't have time," she said.

She also suggested that employers and plan administrators host orientation sessions for network providers.

Just as educating employees eases implementation, early provider education is essential to a smooth transition, Ms. Lerner said.

"We've had instances where the providers had members showing up in their offices when their contracts had not yet been signed," she said.

Last, but not least, point-of-service plan vendors should be kept abreast of the communications program, according to Ms. Lerner.

"Share internal materials with vendors—the information that employees are receiving," she advised.

This will ensure that plan implementation is consistent with what the communication materials are telling employees and providers, she said. ■

Work comp fraud

Continued from page 1

Marc Reed, a vp at Fremont's advertising agency, Carter Waxman Advertising & Public Relations in San Jose, Calif., said an employee of the agency also called many of the advertisers in the "Medical Services" column.

"Pretending to be laid-off workers, we called other advertisers under the same listing," Mr. Reed said.

"Every one we reached offered a legal service, not a health service," Mr. Reed explained.

Frustrated by what it perceived to be unfair treatment toward Fremont, the advertising agency pressed the Los Angeles Times for the "real reason" the insurer's ad had to be relocated, Mr. Reed said.

"Karen Elton, advertising manager, acknowledged that 'political pressure' had prompted her decision," he said.

However, Ms. Elton flatly denies ever making that statement: "He totally and completely misquoted what I said," she told *BI*.

"It had nothing to do with political pressure; it is just department policy," Ms. Elton said.

The newspaper did not receive any calls from other advertisers regarding the Fremont ad, she said. Rather, the newspaper decided to relocate the Fremont ad based on its policy of allowing only medical service providers to advertise in the "Medical Services" section of the newspaper.

"The (Fremont) ad's verbiage did not offer a medical service," she said. "They could run the ad in another section of the classified or as a display ad."

Ms. Elton said members of the Times' advertising department confirmed that all of the other advertisers in the "Medical Services" listing indeed offer medical services. She suggested that, perhaps after being referred to a lawyer, workers comp claimants are then referred to doctors by these companies.

Mr. Little said Fremont will not press the issue any further with the Los Angeles Times, but instead may turn to the California Legislature for help.

Specifically, the insurer is advocating proposed legislation that would require all companies that solicit workers comp claims in California to notify customers that it is a felony to commit workers comp fraud in the state, Mr. Little said. All advertisements soliciting workers comp claims would have to include the notice: "Any person who makes or causes to be made any knowingly false or fraudulent material statement or material misrepresentation for the purpose of obtaining or denying workers compensation benefits or payments is guilty of a felony."

That same wording was used in Fremont's classified ad.

This wording describes provisions in a new law that took effect Jan. 1 that makes workers compensation fraud a felony punishable by up to five years in state prison and/or a fine of $50,000 (*BI*, Aug. 5, 1991).

In addition, the new law protects insurers from being sued by people whom insurers investigate as being involved in workers comp fraud, as long as the insurers act in good faith, act without malice and use facts obtained through reasonable efforts.

The California law also prohibits the solicitation of false workers comp claims and sets penalties of up to one year in county jail or a $10,000 fine or both (see story, page 21.)

"S.B. 1218 will assist local prosecutors in tracking down and convicting those who are lining their own pockets with money meant for workers in need," said state Sen. Robert Presley, D-Riverside County, in a statement after the bill was signed by Gov. Pete Wilson

"Our goal is to root out those who abuse the system," said Mr. Little, noting that fraudulent workers comp claims are a major factor driving up the costs of the workers comp system.

The Assn. of California Insurance Cos. also supports the legislation suggested by Fremont, said Vp Robert J. Gore.

The legislation, which currently is being drafted, could become part of an omnibus workers comp package now working its way through the state Legislature, or it could be introduced as a separate bill, he said.

While Fremont is dropping its efforts to have the Times reconsider its decision not to run the ad in the Medical Services listings, Mr. Gore still questions the newspaper's action.

"If law offices qualify as medical services, why not insurance companies?" Mr. Gore asked in a Jan. 23 letter to Shelby Coffey III, who is the Times' editor and executive vp.

"Medical services is the logical place to reach the affected audience of providers and potential patients," Mr. Gore wrote.

"The solution posed by a Times' classified ad executive was to run the ad in 'Legal Services,' " he wrote. "This is puzzling. Just as an insurance company is not a medical service, it is not a legal service. Running the ad in 'Legal Services' would render it useless, failing to reach its audience unless, of course, the law offices were also shifted to legal services."

While insurers may not be happy with the Times' action, the newspaper has the right to reject or restrict advertisements, pointed out Chad Milton, vp and assistant general counsel for Media/Professional Insurance Inc. of Kansas City, Mo. Media/Professional is the underwriting and clams manager for media liability coverage written by SAFECO Corp. of Seattle.

"Publishers have nearly an absolute right to reject any advertisement," Mr. Milton explained. "They can refuse ads for nearly any reason or without giving a reason.

"Here, it looks like (the Los Angeles Times) made a business decision to accommodate other advertisers at Fremont's expense," he said.

A spokeswoman for Capital Cities/ABC Inc. in New York says the television network has a policy of not accepting what it deems to be "controversial" ads.

"We feel controversial issues are better handled on our news programs," the spokeswoman said. ■

'If law offices qualify as medical services, why not insurance companies?' asks Robert J. Gore, vp of the Assn. of California Insurance Cos. in a letter to Shelby Coffey III, the Los Angeles Times' editor and executive vp.

Anti-fraud effort continues

GLENDALE, Calif.—While Fremont Compensation Insurance Co. has abandoned its attempt to place anti-workers compensation fraud ads in the classified section of the Los Angeles Times, it is proceeding with a larger anti-fraud campaign launched Jan. 1.

Titled "Fraud Doesn't Work Here," the program involves a statewide multimedia campaign aimed at deterring fraud. Display ads in the Los Angeles Times, other major metropolitan California newspapers and The Wall Street Journal spell out the strict new California penalties for knowingly filing, or assisting another person in filing, a phony workers comp claim.

In addition to the newspaper ads, some of which were full-page ads, the campaign includes workplace posters and a brochure for employers titled "11 Ways to Spot Workers Comp Fraud." This brochure is available to independent agents and brokers for distribution to Fremont policyholders and other employers.

Fremont's Fraud Investigation Unit is working closely with local district attorneys' offices and the California Department of Insurance's Bureau of Fraudulent Claims to prosecute workers comp fraud cases. Included as targets are medical providers and legal practitioners who encourage the filing of fraudulent workers compensation claims.

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Business Insurance

INTERNATIONAL

Lloyd's faces $5.37 billion loss: Analyst

1989-91 estimated shortfalls may deplete deposits

By GAVIN SOUTER

LONDON—Lloyd's of London will post marketwide losses totaling 3 billion pounds—or $5.37 billion at current exchange rates—over the next three years, projects market analyst Chatset Ltd.

These huge losses will wipe out the Lloyd's deposits of the entire membership and scare away anyone considering joining the market, Chatset warns.

To help combat the dire situation, Lloyd's immediately should impose a levy on brokers and underwriters to help bail out members who cannot meet their losses, the London-based analyst says.

The Chatset loss estimates are vehemently contested by Paul Archard, chairman of the Lloyd's Underwriting Agents Assn.

Trying to estimate losses from the 1991 underwriting year, which will not close until year-end 1993, is no more accurate than gazing into a crystal ball, said Mr. Archard, who also questioned Chatset's past record in predicting Lloyd's results.

Meanwhile, a lawyer representing Lloyd's members is advising some members facing massive calls to refuse to pay.

When Lloyd's in July publishes its results for 1989, which closed at year-end 1991 under the market's three-year accounting system, Chatset projects it will show a record loss of 1.3 billion pounds ($2.43 billion at appropriate exchange rates), more than double last year's record loss of 509.7 million pounds ($983.7 million at appropriate exchange rates).

By then, members will already have paid 500 million pounds ($935 million) in advance calls on the 1989 account, Chatset said.

Lloyd's members will keep their checkbooks open to pay losses for the next two years, warns Chatset.

Chatset predicts a 1990 market loss of 1 billion pounds ($1.8 billion at current exchange rate) followed by a loss of more than 750 million pounds ($1.35 billion) when the 1991 year results are published in 1994.

While Lloyd's itself concedes that there will be large losses in 1989 and 1990, the market maintains it is too early to make accurate predictions for 1991.

Nevertheless, Lloyd's last week predicted a pure underwriting loss of 390.5 million pounds ($702.9 million) in 1990 and a pure underwriting profit of 424.5 million pounds ($764.1 million) for 1991. These estimates do not include reserve shortfalls from open years of account.

However, low premiums and large losses in 1991 will keep Lloyd's in the red for the fourth year running, maintains Charles Sturge, joint editor of Lloyd's League Tables, which are published by Chatset.

"In 1991 there was very little increase in premium income and that is why we think that it will be another disaster," he said.

The only sector of Lloyd's that charged adequate premiums in 1991 was the excess-of-loss market, Mr. Sturge said.

And, he said, the Chatset prediction of a 750 million pound loss for 1991 does not take into account four disasters that hit the market in the last quarter of the year: Typhoon Mireille in Japan; a hailstorm in Calgary, Alberta; the fire in Oakland, Calif.; and Hurricane Bob, which hit New England.

Continued on next page

N.Z. firm forms captive in U.S.

Hawaii captive a first of its kind

By LOUISE KERTESZ

HONOLULU—In what is believed to be the first case of its kind, a foreign corporation has formed a captive insurance company in a U.S. domicile primarily to insure some of its non-U.S. exposures.

Telecom Corp. of New Zealand Ltd., New Zealand's national telephone company, officially incorporated its captive, Teleco Insurance Inc., in Hawaii in September.

Linda Chu Takayama, the state insurance commissioner, announced the formation at the 1992 Hawaii Captive Insurance Forum held Jan. 22-24 in Honolulu.

The captive, which is managed by Marsh & McLennan Insurance Management Services in Honolulu, is writing property and business interruption coverage for more than 15 Telecom subsidiaries in New Zealand and the Pacific Basin.

Both regulators and the state's captive insurance industry are pleased that the Wellington, New Zealand-based corporation chose Hawaii.

"We're very pleased and excited about what kind of doors that may open," Ms. Takayama said.

Telecom's move is especially encouraging because the company had a "choice of all of Europe" and has "natural ties to Bermuda," a British Commonwealth country, said Sherman Hee, director of the state's new Captive Insurance Council, a marketing and advisory group. Mr. Hee is an attorney and the owner of Hawaii Captive Insurance Management Inc.

Although a few U.S. multinationals write some coverage for their foreign facilities through U.S.-based captives, Teleco is believed to be the first U.S. captive formed by a foreign corporation primarily to write coverage for its domestic exposures.

Telecom is one of the largest companies in New Zealand and is the

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Outhwaite actions 'prudent': Hazell

By STACY SHAPIRO

LONDON—A deputy chairman of Lloyd's of London says that Richard Outhwaite was "prudent, competent and conscientious" when he wrote 32 unlimited runoff reinsurance contracts in the early 1980s.

These policies—which so far have cost Outhwaite syndicate members $456 million in losses—appear to "be perfectly fair and proper risks to undertake, both individually and collectively," Richard Hazell testified in London's High Court.

Only later were nearly all the runoff contracts hit by a slew of asbestos losses that Mr. Outhwaite could not have foreseen, Mr. Hazell said.

For the past few weeks, Mr. Hazell has testified as the key expert witness for Mr. Outhwaite in the landmark trial that pits 987 members of Mr. Outhwaite's syndicate against R.H.M. (Underwriting Agencies) Ltd. and 80 other members agencies. The members accuse Mr. Outhwaite of misconduct, negligence and incompetence in writing the runoff contracts.

Now in its fourth month, the trial is expected to run until at least mid-April.

Among the other witnesses that have testified in the proceedings before Justice Saville are: Peter Nutting, chairman of the Outhwaite Members Action Group, which brought the suit; Mr. Outhwaite, who testified for 3½ weeks; and key plaintiffs' expert witness Ulrich von Eicken, retired managing director of the London office of Munich Reinsurance Co., who was on the stand for 5½ weeks (*BI*, Nov. 25, 1991; Nov. 11, 1991).

In a statement submitted as evidence, Mr. Hazell took issue with those who say the trial is good for Lloyd's.

"(Underwriters) cannot be expected to have some view of future events which others do not have," said Mr. Hazell.

The trial is really between two sets of members, he said, namely those on the Outhwaite syndicate who are suing and those on syndicates which write the errors and omissions insurance for the members agencies.

Besides, if the Outhwaite syndicate members prevail, Lloyd's as it is now constructed would "cease to operate," he added. "No underwriter would be prepared to write business when. . .(members could someday sue) because they deemed his original writing of the business to be negligent."

U.S. asbestos claims account for most of the losses on the 32 runoff policies, which were written mainly for other Lloyd's syndicates.

Those policies were written before the extent of the asbestos problem was clear, Mr. Hazell said. Most were written in 1982 when the "belief (was) that asbestosis, like many other categories of loss before it, although potentially serious was nevertheless reservable and manageable," he said.

"I am not aware of any syndicates remaining open because of concerns about their inability to reserve for such matters until long after 1982," the deputy chairman said. "I have no recollection of any concern at all about losses arising from property damage related to asbestos or environmental pollution cleanup claims until long after 1982."

In the early 1980s, insurers believed that they could accurately reserve for the asbestos losses for which they had been notified, said Mr. Hazell.

In fact, Mr. Hazell set reserves for asbestosis losses at the end of 1982 at $5.6 million for his syndicate 190, currently managed by Three Quays Underwriting Management Ltd. By the close of the 1988 underwriting year, this reserve had grown to $78 million.

At the time the runoff contracts were written by Mr. Outhwaite, it was unclear whether U.S. courts would interpret liability policies as being triggered by a person's "exposure" to asbestos or when the asbestos-related disease "manifested" itself, which could be many years later.

Then came a 1981 federal appeals court ruling involving Keene Corp., a former asbestos producer. That landmark decision introduced a third

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Optional quake cover rattles market

By KATE McILWAINE

WELLINGTON, New Zealand—The New Zealand government's delay in implementing its proposal to make earthquake insurance non-compulsory for commercial and industrial property is causing uncertainty in the market and forcing many policyholders to place their coverage overseas.

The Corporation of Insurance Brokers of New Zealand has asked that major corporations be exempted from the country's mandatory earthquake coverage program pending the legislation's adoption, but the government seems reluctant to follow that course, said John C. Richardson, chairman and chief executive of Marsh & McLennan Ltd. in Auckland and president of the CIBNZ. The CIBNZ had sought exemptions on behalf of corporate clients with assets greater than $200 million New Zealand ($105 million).

Currently, earthquake risks are insured through a levy paid to the government-owned Earthquake and War Damage Commission, which was established in 1944. A levy of 5 cents per $100 NZ ($53.70) of insured value is paid on residential and commercial property, which goes to the fund. Another levy of 6.5 cents per $100 NZ of insured value is paid for fire services. A goods and services tax is payable on the levies.

Companies placing their coverage offshore can avoid the earthquake levy, although they still must pay the fire levy.

The EQWDC's catastrophe reinsurance program is one of the biggest placed in the global market. The coverage has limits of more than $1 billion NZ ($540 million), and more than 450 reinsurers are on the risk, said David Sargeant, the Insurance Council of New Zealand's chief executive officer.

The legislation allowing commercial property earthquake risks to be underwritten by private insurers was to take effect Jan. 1. But it has not yet been passed by Parliament.

Under the original proposal, the EQWDC would phase out commercial property earthquake coverage over two years, providing coverage up to 66% of insured values in the first year and 33% in the second year. After Dec. 31, 1993, the EQWDC would cease writing commercial risks.

Maurice Tigue, New Zealand's associate minister for finance, said the government wants to adopt the legislation before July 1. The delay is caused by the complexity of the changes and their widespread ramifications, he explained. "It's a very large proposal and requires extensive negotiations with overseas and local insurers."

A New Zealand Treasury spokesman said the two-year phaseout is likely to be retained, but there could be other changes to the legislation. Discussions still are being held with Treasury and EQWDC officers, and a final submission is likely to go to the New Zealand Cabinet in late February.

Risk managers welcome the anticipated change, although its delay has made their planning difficult.

Shaun Wilkinson, group risk and insurance manager for Fletcher Challenge Ltd., New Zealand's biggest corporation, described the delay as "very unsettling."

"We have started trying to protect the capacity we need and restructure our program," he said.

The EQWDC's levy is based on an agreed indemnification value for a piece of property, while most commercial property insurance now is negotiated on a replacement value, he noted. Thus, risk managers have been purchasing excess coverage to cover the full replacement value of their property.

Fletcher Challenge has been purchasing separate policies above EQWDC-insured values for large risks, like its steel smelter in Auckland. The company places most of its insurance in New Zealand, except for petrochemical risks, which are insured globally.

But Mr. Wilkinson noted that some risk managers are going offshore for coverage in markets where underwriters who do not understand New Zealand risks are "throwing in earthquake cover for free."

Mr. Wilkinson said that commercial earthquake insurance rates in the New Zealand market could rise when the legislation is passed, particularly for risks in earthquake-prone zones like Wellington, but private insurers would pay more attention to build-

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Lloyd's losses

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Although it's not yet known how much of these losses will be paid at Lloyd's, Typhoon Mireille alone is expected to cost Lloyd's underwriters another $450 million, Mr. Sturge said.

Most of the 1989-1991 losses will fall on the marine account, predicted John Rew, joint editor of Lloyd's League Tables.

In 1989, the pure loss on the marine account will be 610 million pounds ($1.14 billion at appropriate exchange rates), Chatset said. But when losses stemming from the deterioration of old open years and shortfalls on reserves made for old closed years are added, the marine loss will grow to 802 million pounds ($1.5 billion).

The non-marine account will yield a pure year loss of 385 million pounds ($720 million), with losses from prior year deteriorations and shortfalls bringing the total loss to 630 million pounds ($1.18 billion), said Chatset.

The aviation market will produce a 73 million pound ($136.5 million) profit in 1989, and the motor market will generate a 31 million pound ($58 million) profit, Chatset said.

"The big problem with the marine market is that they see themselves as the senior market, they are arrogant and they think that its their divine right to write any class of business," Mr. Rew said.

Many of the losses that fell on the marine market have arisen from the incidental non-marine account written by marine underwriters, he said. "That has usually been the type of business that the non-marine market did not want to write."

These losses and the large shortfalls from prior years will deter new members from joining Lloyd's, he added. "To get new people in to Lloyd's you will have to let them know that they will not have to shoulder the shortfalls for the losses of the past."

The prospect that up to 40 syndicates will leave their 1989 accounts open also will scare members away, he said

Also, existing members would be "crazy" to increase their underwriting participation until the problems have been addressed, he said.

The losses are bound to exhaust the funds of some members. Consequently, Lloyd's will need to increase its Central Fund and provide increased capital for its own reinsurance company CentreWrite Ltd., Mr. Sturge said.

To achieve this, the market should impose a levy equal to 2% of premium on brokers when they place business at Lloyd's as well as a 2% levy on Lloyd's underwriters, Mr. Rew said. These funds will be needed, he said, in spite of suggestions by a task force to minimize members' exposures (*BI*, Jan. 20).

The LUAA's Mr. Archard disputes Chatset's estimates. Although large losses are expected for 1989 and further losses for 1990, 1991 should be profitable, he said. "Our own market research shows that we turned the corner in 1991."

The catastrophe losses suffered in the last quarter, which are not included in the Chatset figures, will "turn a good year into an OK year," he added.

Mr. Archard also called into question Chatset's record in predicting Lloyd's results.

In January 1991 Chatset predicted that "an overall break-even situation is the best possibility," for Lloyd's 1988 year (*BI*, Jan. 21, 1991). In fact, Lloyd's reported an overall loss of 509.7 million pounds (*BI*, July 1, 1991).

Meanwhile, some Lloyd's members facing cash calls to pay losses are being advised to refuse to pay and take their case to court.

Under the agreements between members and their members' agents signed after Jan. 1, 1990, members' agents have to act in what they see as the best interests of the members, said Michael Freeman, senior partner at Michael Freeman & Co., a London law firm representing members.

Members' agreements signed before 1990 also include a clause obliging members to pay cash calls before disputing the payments in court. However, Mr. Freeman contends this clause is invalid since the members agents have fallen back on their own commitments.

Many members suffering losses were placed on syndicates involved in the "spiral" of London market excess-of-loss risks, Mr. Freeman said at a seminar he organized in London last week. "It should have been clear to the members' agents that there was something wrong with the spiral syndicates."

Also, members' agents are obliged to inform members if they have any conflicts of interest with the syndicates on which they placed members, he said.

For example, names whose membership was handled by now-liquidated Gooda Walker Ltd. were not told of the conflict of interest in placing members on the group's own syndicates, he said.

Gooda Walker members so far have been asked to pay 238.9 million pounds ($430 million) to cover losses (*BI*, Jan. 27).

Mr. Freeman advised these and other members to seek a court injunction to enable them to refuse to pay their calls until they can be adjudicated in court.

The initial estimated legal expenses needed to seek an adjudication are 120,000 pounds ($216,000) and members interested in taking a group action should all contribute 200 pounds ($360) to a fighting fund, Mr. Freeman said. ■

INTERNATIONAL

New Zealand

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ing-construction methods.

Jake E. Lush, insurance manager for Auckland-based Carter Holt Harvey Ltd., a large firm with timber and manufacturing interests, said he favors the changes because they would let risk managers choose insurers. But he said it is too early to assess the impact because the proposed changes are not clearly documented.

Insurance companies also welcome the deregulation of earthquake coverage, but want a lead-time of at least six months to alter computer systems and reinsurance arrangements.

The ICNZ's Mr. Sargeant agreed that the delay is causing uncertainty, prompting much commercial insurance to be written offshore.

Much of this is going to Australian insurers, while other major risks are being placed in London, he said. Mr. Sargeant estimated that since changes in the laws were first discussed in 1988 $200 million NZ to $400 million NZ of premium income has gone offshore each year ($108 million to $216 million).

The government decided to return commercial earthquake insurance to the private market in 1988 after it assessed the EQWDC's maximum probable loss at $17 billion NZ ($9.18 billion) from a quake in Wellington that hit 7.5 on the Richter Scale.

At that time, reserves totaled only $2.1 billion NZ ($1.13 billion). The government had provided guarantees to the fund and would thus be liable for the shortfall, according to Mr. Sargeant.

Several proposals for change have been considered since then.

But, he noted recent estimates of the EQWDC's maximum probable loss put the figure at a more realistic $4 billion NZ to $5 billion NZ ($2.2 billion and $2.7 billion).

Ken J. Sarginson, ICNZ president and managing director of Norwich Union General Insurance (New Zealand) Ltd., said there is "no reason to expect a significant number of firms insured offshore to come back to New Zealand insurers, despite the removal of the earthquake levy."

"There may well be a drift back of those who sustain claims, but a full-scale return will only happen when rates in the rest of the world harden to a level comparable with New Zealand," he said.

The New Zealand market has been hardening faster than some others.

Mr. Sarginson predicted premium rates will rise after deregulation. "Wellington is one of the highest (earthquake) exposures in the world, certainly in the top 10 along with Japan, California, the Philippines and Israel," he said.

He said New Zealand commercial insurers believe they will need at least twice as much premium to cope with the $1.7 billion NZ ($920 million) earthquake exposure that could arise in the Wellington business district alone, calculated on a maximum probable loss of 50% of value.

Mr. Sargeant said the government first tried to have the new bill passed quickly to reduce its liability, but some original proposals were "impossible to implement."

Some of the problems were addressed in talks with the ICNZ, but other issues are still to be resolved. The ICNZ would not approve the final legislation unless the government addressed tax issues, capital requirements and other issues, he said.

Mr. Sargeant said catastrophe reinsurance costs had increased because of the tightening of capacity in the excess-of-loss reinsurance market in London, and it is difficult for New Zealand companies to compete.

The ICNZ wants companies selling insurance to meet certain standards, but does not favor strict regulation like that in Australia.

"It would be easy for a company of straw to set up and sell insurance at present," he said.

New Zealand brokers have supported deregulation.

Malcolm Congdon, executive director of the CIBNZ, said firms would now be able to decide for themselves about earthquake insurance. "The user-pays system will mean bad risks pay more," he said.

M&M's Mr. Richardson said the delays have created serious problems for brokers and clients. "A significant amount of business has gone offshore. I know of at least six major programs which went offshore last year." ■

Outhwaite trial

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alternative, the "triple-trigger" theory, in which all policies would be triggered from exposure through manifestation (*BI*, Oct. 12, 1981).

But the impact of this decision was not known in 1982, said Mr. Hazell.

Not until 1985, when the Wellington Agreement was approved by insurers and asbestos producers to resolve claims using the triple-trigger theory, did underwriters fully realize the impact of the Keene decision, he testified.

"The conviction that the manifestation or exposure debate was going to be resolved in favor of one theory or the other persisted long after the Keene decision," said Mr. Hazell.

However, during cross-examination last week, Mr. Hazell admitted that Mr. Outhwaite and other underwriters, including himself, had used "unsound methodology" to calculate potential asbestos liabilities in 1981 and 1982 when they were closing their 1978 and 1979 accounts.

Underwriters based their reserves on historical data and the asbestos-related claims of which they had been notified, he said.

In hindsight, many syndicates underreserved and closed their accounts even though losses could not be figured with "a reasonable level of accuracy," he admitted.

"Then every single account was wrongly closed?" asked Anthony Boswood, trial lawyer for the Outhwaite members.

"In hindsight," Mr. Hazell agreed. But there is a "world of difference" between what underwriters knew then about long-tail risks and what they know now, he said.

So could the ultimate liabilities have been known "with reasonable accuracy" when the contracts were written—since asbestos had no reliable, quantifiable history? asked Mr. Boswood.

There would have been no other way for Mr. Outhwaite to view the runoff contracts except on past experience, said Mr. Hazell. "There is no way that an underwriter can be a clairvoyant," he said.

But is it "prudent" to write policies with no time or quantity limit when the level of risk is uncertain? asked Mr. Boswood.

Underwriters write many such risks every day, said Mr. Hazell.

"How many risks have you written" like this? asked Mr. Boswood.

Mr. Hazell admitted that he had written one unlimited runoff reinsurance policy for an aviation syndicate for which he had become custodian two years earlier and whose history he knew. He also was one of many underwriters who wrote a voluntary runoff reinsurance contract for the Sasse syndicate to close the syndicate when it lost millions from dubious U.S. arson claims in the 1970s.

"How is it ever prudent" to write unlimited contracts when there is no indication what the maximum loss might be? asked Mr. Boswood.

It is prudent when an underwriter feels confident that, based on the information he receives, his syndicate will not be "overly exposed" to loss, Mr. Hazell replied. ■

Hawaii captive

Continued from page 23

largest listed on the New Zealand Stock Exchange, with a market capitalization of $5.14 billion New Zealand ($2.78 billion at current exchange rates).

The captive insurance program will provide Telecom subsidiaries up to $500 million NZ ($270 million) in coverage per loss with a $500 million NZ aggregate annually, said Ray Good, risk manager for the parent company.

The captive is reinsured primarily in the London market, he said.

Telecom, a holding company, was formed with the split-up of the New Zealand Post Office in 1987. At that time, Telecom took over the assets of the Post Office's telecommunications business. Since 1987, the company has purchased property coverage in the New Zealand market, Mr. Good said. The company has purchased some excess coverage from the London market.

Market conditions were not a factor in Telecom's decision to form a captive, he said.

Telecom's decision to form a captive grew out of its recent implementation of an "overall" risk management program. The company's "excellent" loss experience also emboldened Telecom executives to form a captive.

In selecting a domicile, "we examined various options: Bermuda, Cayman, Singapore," Mr. Good said. "Hawaii met our needs because the legislation made it very easy for us to go there."

Hawaii's captive legislation is "stable," regardless of changes in regulatory personnel, he said.

Another important factor was that Hawaii, which is 23 hours behind New Zealand, is "very close in time difference" so the company's New Zealand and Hawaii staff can easily communicate during business hours, he said.

"Hawaii regulators are willing to work with risk managers and service providers to create a receptive domicile," said Raymond Oberg, a Vermont-based vp for M&M in charge of its domestic captive management operations.

When Telecom inquired about forming its captive, "Hawaii took the time to research it, to ask the correct questions and within a reasonable time allow this company to do it without hurdles," Mr. Oberg said.

Hawaii regulators provided Telecom with "a very imaginative response to looking at the way the risk was financed," said Paul Pinckney, a vp in the Irvine, Calif., office of Tillinghast. The risk management consulting division of Towers, Perrin, Forster & Crosby Inc. advised state regulators on Telecom's captive application.

The captive's retention "is being funded with discounted dollars," he said.

"In simplest terms, Telecom is taking property insurance deductibles and funding them with the Hawaii captive on a discounted basis. It's real simple. It's alarmingly simple.

"They and the broker have found a way to undercomplicate the process and make it work according to the financial objectives of Telecom."

Mr. Pinckney added, "My guess is that Colorado"—the other U.S. domicile that would have been favorable geographically—"would have given a lot cooler welcome" to Telecom's program. Colorado has "a pretty rigid view of capital and reserve requirements," he said.

But Teleco Insurance Co.'s minimum capitalization "went beyond the $250,000 that Hawaii uses as a guideline," Mr. Pinckney said.

The Insurance Department would say only that Teleco's initial capitalization was more than $250,000.

Another factor in Telecom's choice is that Hawaii has the "infrastructure to handle non-U.S. transactions," explained Peter Lowe, Teleco's captive manager in Honolulu.

Banks, accounting firms and insurance intermediaries in Hawaii have "demonstrated success" in financial relations with Pacific Basin countries, Mr. Oberg said. ■

Insurer solvency

Continued from page 1

to a broad proposal floated in December by the American Insurance Assn. Among other things, the AIA suggested granting federal licenses to property/casualty insurers to exempt them from state regulation for both commercial and personal lines.

Regardless of the form the solvency regulation proposal takes, few observers expect it to move through committee hearings for a vote by the House this year.

Given the short election-year session and other pressing legislation before Congress, the bill is unlikely to come to a vote unless new insurer failures create pressure for quick congressional action, observers say.

"In this Congress, there just isn't time," said Barbara Haugen, director of federal affairs for the National Assn. of Insurance Brokers in Washington, D.C.

Very little action on solvency issues is expected in the Senate, despite the introduction last year of a solvency regulation bill by Sen. Howard M. Metzenbaum, D-Ohio.

"I just don't see Metzenbaum moving forward at all for jurisdictional reasons," said Peter Lefkin, vp-government and industry affairs in the Washington, D.C., office of Fireman's Fund Insurance Co.

"Nobody seems to be taking the Metzenbaum proposal as a serious legislative threat," Mr. Lefkin added.

One reason is that Sen. Richard H. Bryan, D-Nev., chairman of the Senate Commerce, Science and Transportation Committee's Consumer Subcommittee, has clearer jurisdiction over insurance matters and has held his own hearings on solvency regulation over the last year.

"It's Bryan's jurisdiction," said Andrew Wright, vp-federal affairs with the American Insurance Assn. in Washington, D.C.

A Senate bill "will be Bryan's bill when it comes out," Mr. Wright commented.

However, "I don't anticipate action as quickly on the Senate side as on the House side," he added.

The new outline of solvency legislation circulated by the House Oversight and Investigations Subcommittee in December differs sharply from the proposal House staffers floated in August.

"Certain fundamental changes in the August 1991 legislative outline seem necessary," the December outline says.

"The program should be scaled back from the earlier model of comprehensive federal standard-setting and oversight of state regulatory activities. Instead, it should be directed far more strongly toward direct federal solvency regulation, where appropriate, as an alternative to state regulation," the December outline says.

The outline also calls for the creation of a Federal Insurer Solvency Corp., which would offer optional federal licenses to U.S. insurers and reinsurers that are writing lines of business "where rates are not regulated by the states."

This part of the outline is not carefully worded, industry observers say, since states generally have some form of rate regulation for most insurance lines—or could adopt such powers—thereby short-circuiting potential federal involvement.

The intent of the outline, observers believe, is to offer a federal licensing option to insurers writing commercial insurance coverages but to exclude personal lines and perhaps workers compensation.

Federally licensed insurers would be exempt from state regulation, the outline notes. There would be no federal guaranty fund, though insurers covering small businesses and non-profit groups would be required to post "adequate financial security" to protect policyholders against insolvency before a federal license would be issued.

The FISC would set solvency standards, perform annual solvency reviews of federally licensed companies, handle liquidations and perform all other regulatory functions except rate regulation, the outline says.

Federal regulators would have no "routine" involvement with state-regulated insurers and reinsurers, but would still have the power to ban from interstate commerce any state-licensed insurer with solvency problems.

Insurers and reinsurers licensed outside the United States would not be directly regulated by the FISC, but it would have the power to also ban these companies from interstate commerce if their solvency were threatened.

Domestic insurers would not be able to take credit for reinsurance with non-U.S. companies unless the reinsurer were to: register with FISC, accept the jurisdiction of U.S. courts and establish trust funds equal to 20% of the reinsurers' unpaid U.S. losses, the outline says.

"This program is not dual regulation because a company would face either a federal or a state regulator, but not both, in the normal course of business," the outline notes.

"The program should be easier, faster and cheaper to implement than the one in the August outline," it adds, describing the system as a "vertical split" of federal and state responsibilities rather than the "horizontal working relationship" proposed in August.

The December draft is in fact a marked departure from the Oversight and Investigations Subcommittee's earlier outline. Among other things, the August outline called for the FISC to:

- Set solvency standards for multistate property/casualty and life/health insurers and oversee state regulatory efforts. The FISC would have directly regulated only professional reinsurers.
- Accredit state insurance departments or industry self-regulatory bodies that meet minimum federal solvency standards.
- Approve all coverage placed with non-U.S. insurers or reinsurers, which would have to meet certain federal standards. The FISC would have the power to reject contracts with alien companies that did not meet standards.

The August proposal was criticized by the National Assn. of Insurance Commissioners, the Alliance of American Insurers and the National Assn. of Independent Insurers, all of which have staunchly opposed any federal regulatory in-

Continued on next page

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Business Insurance

Circulation Breakdown*

Commercial Consumers

Administrative:
CEO's Presidents, and Owners . 2,500
Vice-Presidents, General Managers and Other Administrative Personnel 4,263

Financial:
Chief Financial Officers and Vice-presidents of Finance 2,972
Secretaries, Treasurers, contollers and other Financial Personnel 4,406

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 10,976

Sub-total 25,117

Associations 458
Government, Unions and Educational Institutions 1,234

Commercial Consumers
Sub-total 26,809

Insurance Agents and Brokers . . 9,430
Insurance Companies 8,045
Accountants, Actuaries, Attorneys & Consultants 3,405
Adjusters, Appraisers, TPA's, Captive Managers & Health Care Providers 1,392
Others Allied to the Field 1,518

TOTAL 50,599

* Source Business/Occupational breakdown of qualified circulation, May 27, 1991 issue, as submitted to BPA for June 1991 BPA Publisher's Statement.

Continued from previous page
volvement.

The proposal also failed to generate much support from the AIA or the Insurance Solvency Coalition—a group of brokers, insurers and commercial policyholders—although both expressed support for federal regulation of certain segments of the industry.

In adopting a two-tiered regulatory approach, the subcommittee's December outline moves closer to a longstanding ISC proposal calling for federal regulation of commercial insurance.

The subcommittee's outline also is similar to a sweeping AIA draft proposal that, among other things, would:

- Create a Federal Insurance Solvency Commission to issue federal licenses to property/casualty insurers and reinsurers writing commercial and personal lines.

Federally licensed insurers would be free from most state regulation, including rate and form regulation, guaranty fund laws, exit barriers, market conduct regulations and unfair claims practices laws.

However, federally licensed insurers would still be subject to state residual market laws, workers compensation laws, and auto liability and financial responsibility laws.

- Empower the FISC to set financial standards and reporting requirements for federally licensed insurance companies and to establish minimum regulatory standards that state insurance departments must meet.
- Empower the FISC to place federally licensed insurers under supervision, rehabilitation or liquidation.

The AIA proposal includes a "quick take" provision allowing the FISC to take control of a troubled company by administrative action "without going through protracted and expensive legal proceedings prior to takeover."

- Create a federal insurance guaranty fund covering certain policyholders of federally licensed insurers, with state-licensed companies continuing to participate in state guaranty funds. The fund would be financed by assessments on federally licensed insurers.

However, the federal guaranty fund would not cover "large insurance policyholders," defined as those with full-time risk managers, 25 or more employees, and annual aggregate premiums of at least $25,000.

Instead, a federal trust fund would be created to cover third-party claims against large policyholders in cases where the policyholder is bankrupt and its federally licensed insurer is insolvent. The trust fund would be financed by separate assessments on federally licensed insurers.

AIA representatives confirm they have discussed their proposal with House staffers.

"I'm sure they are looking at it," said the AIA's Mr. Wright. "How much of it they will incorporate (in a bill), I would not dare say."

Several elements of the AIA proposal are likely to encounter resistance from House staffers, some industry officials say. They point particularly to the AIA's inclusion of personal lines insurers among those eligible for federal licensing.

However, the AIA draft "is a significant proposal because they are a major force in the insurance industry," observed the NAIB's Ms. Haugen. "Even someone as powerful as Chairman Dingell has to have a broad base of support for new ideas to win support on the committee for them."

Several industry and legislative observers say House staffers still are struggling with the pros and cons of various legislative options before presenting them to Rep. Dingell for a final decision on how to proceed.

But others say the December outline indicates that a two-tiered regulatory approach may be gaining ground.

"It's an indication that the staff has moved closer" to a two-tiered approach, said one legislative observer.

"It's fair to say it's a snapshot of where their heads are," said another industry official.

Whatever form it finally takes, the solvency bill is certain to trigger a new round of debate.

Several industry groups remain adamantly opposed to any federal regulatory intervention, while some are watching out for more specific interests.

"Any federal regulation would be duplicative and would simply add to the overall cost of regulation," said David Farmer, vp of federal affairs with the Alliance of American Insurers in Washington.

"We've just gone through some rather tragic experiences with federal regulation," he added, referring to the savings and loan fiasco.

State regulators' quick response to the financial woes of Executive Life Insurance Co. and Mutual Benefit Life Insurance Co. may also take some steam out of the push for federal regulation, Mr. Farmer said.

"To have resolved (Executive Life) and to have put it together in less than 12 months proves that state regulation works," agreed James Long, North Carolina insurance commissioner and former NAIC president.

"I don't know what it would take to change (Rep. Dingell's) mind that we are doing a hell of a fine job on the state level," Mr. Long lamented.

"We do not think the case has been made that the states are not doing their jobs," said David Brummond, assistant vp and assistant general counsel with the NAII in Des Plaines, Ill.

The New York-based Risk & Insurance Management Society Inc., meanwhile, is waiting to see how the bill will affect captive insurance companies, said Paul Brown, director of government and public affairs and general counsel.

Following release of the August legislative outline, Mr. Brown had worried that tough federal solvency standards would hamper the use of captives, which he argues should not be treated like professional reinsurers.

One thing on which virtually everyone agrees is that the bill is unlikely to make it to the House floor for a vote this year.

"If there is another major insolvency, Congress will be under tremendous pressure to do something" and may push a bill through, AIA's Mr. Wright said.

Barring this, though, action on the bill will likely be delayed until 1993, legislative observers say. ■

Congress' agenda

Continued from page 1
Competitive Pricing Act.

H.R. 9, which passed the House Judiciary Committee last November (*BI*, Nov. 25, 1991), would:

- Prohibit insurers from "price-fixing," a term the bill does not define.
- Forbid the allocation of regions or customers among competitors.
- Forbid monopolization of any part of the insurance business.
- Prohibit tying the sale of insurance to the sale of any unrelated product.

Insurers say that while the measure would allow them to share historical loss data, it is not clear whether the bill would allow them to jointly trend loss data.

Both proponents and opponents of H.R. 9 expect it to reach the House floor this year, but they disagree on its fate once it arrives.

They agree, though, that a modified version of the bill granting insurers specified "safe harbors" for certain collective practices has a much better chance of winning House approval than H.R. 9 in its current form.

The Washington, D.C.-based American Insurance Assn. has been negotiating with Rep. Brooks' staff for months on safe harbors, including proposals that would allow:

- Joint data collection, including joint analysis and reporting of historical data and information, loss development and trending.
- Development of collective data on the likelihood of fire loss through information gathered from building inspections.
- The development and use of standardized policy forms.
- Joint underwriting and pooling arrangements.

Talks between insurers and Rep. Brooks broke down in November before the Judiciary Committee vote, but discussions resumed a month later and are continuing.

"I think it's fair to say that the insurance industry is united in its opposition to H.R. 9," said Andrew Wright, an AIA federal affairs vp.

"In its current state, there's no way it can pass," predicted Peter Lefkin, vp-federal affairs in the Washington, D.C., office of Fireman's Fund Insurance Co.

"It's a lose-lose proposition" for the House Democratic leadership, Mr. Lefkin said. H.R. 9 has no chance of passing in its current form, he said. And, if the House even considers passing the bill, it will antagonize "hundreds of thousands" of insurance agents, a politically influential group, he said.

"Chairman Brooks holds the key in his hand," said Les Cheek, senior vp in Crum & Forster Inc.'s Washington, D.C., office. "If he rejects the key elements of the AIA proposal, the insurance industry will fight. Does he want to enact a law or does he want to fight?"

Mr. Cheek speculated that House members would prefer to avoid such a fight in an election year.

But, Bob Hunter, president of the National Insurance Consumer Organization in Alexandria, Va., and a proponent of McCarran-Ferguson reform, disagrees.

"I think the House will take it up, and it will pass," he predicted. "Who's going to vote for price-fixing?"

And, if the bill passes the House by a large margin, the chances that the Senate will act this year are greatly increased, Mr. Hunter added.

But Mr. Hunter acknowledged that a "negotiated" bill acceptable to both Rep. Brooks and the insurance industry would have a much better chance of spurring action in the Senate than a companion bill to H.R. 9 in its current form.

Mr. Hunter also pointed to the calendar as a crucial element in the measure's fate.

"If we go more than three or four months, it's going to be more difficult" to get the bill through both the House and Senate, he said.

"It's a tough call," said Pamela Gilbert, legislative director of Public Citizen's Congress Watch in Washington, D.C.

"We're very buoyed by the action in the House Judiciary Committee. We think we'll see some form of McCarran-Ferguson repeal legislation on the floor sometime this year. Public opinion is very strongly in favor of reform," Ms. Gilbert said.

But passage of the measure in the Senate will be "much tougher," she said. Like Mr. Hunter, Ms. Gilbert said that passage of a modified bill in the House would make Senate consideration much more likely.

"The votes aren't there to move parallel legislation through the Senate," said Michael Dineen, vp-federal relations in the Washington, D.C., office of Kemper National Insurance Cos.

David Farmer, vp-federal affairs for the Alliance of American Insurers in Washington, D.C., agreed.

Among senators, there "isn't a great deal of interest" in changing McCarran-Ferguson, he said.

While the House has taken the bulk of the action on McCarran-Ferguson reform, the Senate is taking the lead on another key risk management issue: federal product liability standards.

The Senate Commerce Committee in October approved S. 640, a uniform product liability statute. The bill, known as the Product Liability Fairness Act, is identical to S. 1400, which died without a full Senate vote in the 101st Congress (*BI*, Aug. 20, 1990).

The bill has 36 co-sponsors, including some prominent Democrats, and other Democratic senators have indicated that they will support it, said Victor E. Schwartz, counsel for The Product Liability Alliance, which supports the measure.

"The problem is going to be: Are we really going to need 60 votes? We'd need 60 votes if the bill was filibustered" to allow the legislation to proceed on the Senate floor, said Mr. Schwartz, a partner with Crowell & Moring in Washington, D.C.

S. 640 would, among other things:

- Eliminate joint and several liability for non-economic damages in product liability cases.
- Place varying time limits on when a product liability suit could be filed.
- Make it tougher to recover punitive damages.
- Provide that if a plaintiff declined a defendant's settlement offer, the plaintiff would be required to pay the defendant's legal fees if a court returns a judgment that is less than the settlement offer (*BI*, Sept. 23, 1991).

Mr. Schwartz said that, unlike previous uniform product liability bills, S. 640 is more likely to be voted on by the full Senate.

But the status of the bill's House counterpart is more uncertain, he said. The House product liability bill, H.R. 3030, still must win approval from the Judiciary Committee. Rep. Brooks, the Texas Democrat who chairs that committee, "will be in a very pivotal position" to determine the product liability measure's fate, Mr. Schwartz said.

"All I have is hope that Mr. Brooks will give this bill its day in court," Mr. Schwartz said.

And, even though the Senate Commerce Committee has approved the bill, S. 640 also may have to win the approval of the Senate Judiciary Committee before it moves to the full Senate. Judiciary Committee Chairman Joseph Biden, D-Del., opposes a uniform product liability law, noted Kristen Rand, counsel in the Washington, D.C., office of Consumers Union and an opponent of the bill.

Ms. Rand also said that recent questions about the safety of products like silicone breast implants and the sleep aid drug Halcion may help derail federal product liability legislation.

The fact that questions about the two products emerged as the result of product liability suits "points out the need for a strong tort system to back up the regulatory system," she said.

"We'd very much like to see the Judiciary Committee consider this bill," said Public Citizen's Ms. Gilbert, who opposes uniform product liability laws.

"I predict no Senate vote this year," she added.

The Alliance's Mr. Farmer agreed, saying it is "unlikely" that the product liability bill will pass the Senate this year.

But, Mr. Farmer added that the mere fact that the legislation has come so far serves "to highlight the continuing need to examine our civil justice system."

While the American Tort Reform Assn. is "extremely supportive" of product liability reform, it is more optimistic about enacting some sort of medical liability reform, said Martin Connor, president of the Washington, D.C.-based group.

Both conservatives and liberals realize that the current tort system of deciding medical malpractice is a key cause of rising health care costs, he said.

He also noted that numerous

Continued on next page

Congress' agenda

Continued from previous page

bills, including the Democratic leadership's "play-or-pay" health insurance bill, contain malpractice reform provisions (*BI*, Jan. 27).

Risk managers also are carefully watching the progress of bills that would toughen the regulation of workplace safety, said RIMS' Mr. Brown.

Mr. Brown said that two measures backed by organized labor—S. 1622, introduced by Sen. Edward M. Kennedy, D-Mass., and H.R. 3160, introduced by Rep. William Ford, D-Mich.—would, among other things, require the establishment of labor/management health and safety committees.

The measures, which also would tighten requirements for occupational disease notification, probably will be the subject of considerable attention this year, said Crum & Forster's Mr. Cheek.

Public Citizen's Ms. Gilbert agreed. She observed that last year's fatal fire at a Hamlet, N.C., poultry processing plant has focused attention on the shortcomings of workplace safety oversight (*BI*, Oct. 7, 1991; Sept. 9, 1991).

Meanwhile, directors and officers liability underwriters fear congressional attempts to stick them with at least a portion of the tab for the savings and loan and banking solvency crises.

The Federal Deposit Insurance Corp. last fall joined the Justice Department and the Treasury Department in urging a prohibition of the so-called regulatory exclusion in D&O policies. The exclusion bars coverage for damages awarded in government actions against corporate directors and officers (*BI*, Sept. 30, 1991).

Shortly thereafter, Rep. Richard Baker, R-La., offered an amendment to the Resolution Trust Corp. refinancing bill, H.R. 3435, that would have abolished the exclusion (*BI*, Oct. 21, 1991).

Although the amendment was defeated, it could be resurrected, warned Daniel Conway, vp-external affairs in Chubb Corp.'s Washington, D.C., office. Chubb ranked second in terms of primary D&O premium volume, according to a survey by The Wyatt Co. (*BI*, Jan. 14, 1991).

"The FDIC's extremely aggressive" in seeking a way to tap D&O policies, he said.

Mr. Conway said that although he does not know of any new legislation that would abolish the exclusion, "there's always concern" about new attempts.

"I'm pretty sure given the difficulty the FDIC is having rounding up any money for the banks, they'll be back with that proposal," agreed Crum & Forster's Mr. Cheek.

A bill that risk managers find problematic in its present form is H.R. 1218, the Privacy for Consumers and Workers Act, said RIMS' Mr. Brown. The bill would require that employers disclose the use of electronic monitoring devices to any employee subject to its use and prior to its use (*BI*, Sept. 23, 1991).

"It bothers us because of what it will do to the employer's ability to investigate possibility fraudulent workers compensation claims," Mr. Brown said.

The measure already has passed the House Labor-Management Relations Subcommittee.

A piece of legislation that insurers wish would be resurrected is comprehensive crime legislation that also deals with insurance fraud (*BI*, Dec. 2, 1991).

A provision in comprehensive crime bill H.R. 3371, upon which the Senate failed to take final action last November after passing the House in the face of a threatened presidential veto, would:

- Establish federal criminal penalties for anyone who knowingly files fraudulent financial statements about an insurer with a regulator.
- Embezzles insurance company funds.
- Falsifies records with intent to defraud an insurer or policyholder.
- Criminally obstructs proceedings before a state regulator.

The question is how the measure will be reintroduced.

"There's been talk about reviving it as a separate bill," said the AIA's Mr. Wright.

But, the problem with a separate bill is that it could become the vehicle for unrelated anti-crime amendments that could lead to its defeat, said Melissa Wolford, AIA's director of federal affairs.

The anti-fraud provision was supported by insurers, consumer groups and the National Assn. of Insurance Commissioners.

"No one is against" the idea of imposing federal penalties for insurance fraud, said the Alliance's Mr. Farmer. "It's in everybody's interest that every available tool" to fight fraud is within regulators' reach, he said.

"It's very rare you get a bill that everybody supports," said Mr. Brown of RIMS.

In the midst of all this, insurance industry groups are preparing for the reauthorization of the federal Comprehensive Environmental Response, Compensation and Liability Act, better known as Superfund.

Although Superfund is not due for reauthorization until 1994, insurer groups are already seeking coalition partners to help squeeze some of the transaction costs—particularly litigation—out of the environmental cleanup program.

"We're talking to everybody," said Martha Hamby, the AIA's director of federal affairs.

She said the AIA has met with environmental activists and labor unions as well as more traditional partners, like business groups. "We're trying outreach. We think we have something in common."

"We're looking for comprehensive Superfund reform," said Fireman's Fund's Mr. Lefkin. "It's the A-No. 1 important issue facing the insurance industry."

Insurers are also concerned about new taxes.

A bill introduced last July by Rep. Dan Rostenkowski, D-Ill., could increase that burden. H.R. 3025 would set the period for amortization for all intangible assets at 14 years.

Under current law, the periods vary, and certain intangible assets cannot be deducted for tax purposes.

There is always uncertainty about taxation because Congress is always looking for new sources of revenue, said George Henry, AIA vp-federal affairs. "People in our industry are a little battle-weary," he said. ■

Health care plan

Continued from page 1

contributions would be limited, perhaps to $4,000 or $5,000 per employee.

Under another proposal, employees earning more than $100,000 annually would have been taxed on health benefits from their employers beyond a certain cap.

House Republicans warned the administration that taxing health care benefits—in whatever form—would hurt GOP candidates on Election Day.

The administration was influenced by the Congressional Republicans' strong lobbying effort against a tax on health care benefits, according to Frank McArdle, a consultant in the Washington, D.C., office of Hewitt Associates.

Dr. Sullivan, while not directly commenting on the taxation of health care benefits, said the administration's health care package would be financed without a tax increase. That would suggest that taxes on health care benefits or contributions will not be included in the administration package.

In his State of the Union address last week, President Bush did propose a tax credit of up to $3,750 to help low-income individuals obtain health insurance.

Administration officials last week said the tax credit could, for example, take the form of a voucher to buy coverage. They declined to elaborate further.

Other provisions in the Bush health care package are expected to include greater tax deductions for health care expenses for middle- and upper-income individuals. Currently, individuals only can deduct health care expenses, including insurance premiums, exceeding 7.5% of adjusted gross income.

Even though the Bush health care package has not been uveiled, administration officials made clear their opposition to two widely discussed approaches to improving access to health care: a single-payer Canadian-style national health insurance program or a "play-or-pay" program, under which employers would either have to offer a basic health plan or pay a new payroll tax.

In the introduction to the budget, Richard Darman, director of the Office of Management and Budget, said a Canadian-style program or a play-or-pay plan run against basic Bush administration principles.

"Such approaches necessarily involve comprehensive governmental price controls, governmental rationing or major tax increases. Over time, they threaten to degenerate and require a combination of these undesirable characteristics," Mr. Darman wrote.

And in the State of the Union address, President Bush noted that while many are touting play-or-pay proposals, "that expensive approach is unstable. It will mean higher taxes, fewer jobs and, eventually, a system under complete government control.

"Really, there are only two options" for increasing access to health care, he said. "We can move to a nationalized system, which will restrict patient choice in picking a doctor and force the government to ration services arbitrarily. And what we'll get is patients in long lines, indifferent service and a huge new tax burden."

Or, the nation can "build on our strengths," the president said, in proposing the tax credits for low-income individuals and in promising to release the details of his complete program "shortly." ■

COBRA coverage extension proposed

WASHINGTON—Employers would be required to extend COBRA health care coverage for up to five years under legislation introduced in the House of Representatives.

Employers currently must extend group health care coverage for up to three years in the event of the death of an employee or a marital separation or divorce. Employers also must offer COBRA coverage for up to 18 months for employees who quit or are fired, except those fired for gross misconduct.

Rep. Dan Glickman, D-Kan., who introduced the bill Jan. 24, says COBRA coverage is lapsing before laid-off workers find new jobs and obtain coverage under their new employers' health plans.

"I do not believe it is right for these people to be both jobless and unprotected in the event they need medical benefits," Rep. Glickman said. "This bill is a small but important first step in helping our constituents survive these tough economic times."

But, Mark Ugoretz, president of the ERISA Industry Committee, a Washington, D.C.-based benefits lobbying organization representing large employers, says the bill, H.R. 4109, would substantially increase employers' health care costs and discourage employers from offering health plans.

Employers can charge COBRA beneficiaries a premium of up to 102% of the group rate for continuation coverage. However, those premiums often do not cover claims costs. Because people opting for COBRA coverage typically expect to use medical services, their medical costs typically exceed COBRA premiums collected by employers, according to several studies (*BI*, Jan. 6).

Extending COBRA could strike a responsive chord among congressmen who want to show constituents that they are taking action to ease the impact of the recession, said Frank McArdle, a consultant with Hewitt Associates in Washington, D.C.

"The bill fits in well with the concern shared by Republicans and Democrats to help people who have been hurt by the recession. Employers should take this proposal seriously," he advised.

—By Jerry Geisel

Unistrat switches underwriters

Unistrat Corp. of America will replace Universal Investment Consultants Ltd. as the U.S. political risk underwriter for Unistrat Holding BV.

New York-based Unistrat Corp. of America, formerly Unistrat Services Corp., is assuming the runoff of the political risk portfolio underwritten by UIC on behalf of General Security Assurance Corp. of New York and its parent, SCOR U.S. Corp.

Unistrat Corp. of America will have a capacity of at least $5 million for contract frustration coverage, said Unistrat Holding President Louis Habib-Deloncle. Confiscation coverage limits have not yet been set.

Mr. Habib-Deloncle will be president of Unistrat Corp. of America, while Roger Schwartz will be the underwriter. Mr. Schwartz was formerly a broker with Credit International Associates, the credit and political risk subsidiary of Republic Hogg Robinson Inc.

Pending final regulatory approval, Unistrat also will contract to underwrite political risk coverage in North America on behalf of General Security Assurance's wholly owned subsidiary, United Fire & General Insurance Co.

Unistrat Holding BV is the holding company of three other Paris-based companies: P.A.R.I.S. S.A., a political risk underwriting agency that underwrites on behalf of 14 European insurance companies known as the P.A.R.I.S. Pool; Unistrat Services International; and Unistrat Credit.

The P.A.R.I.S. Pool, which has $14 million in capacity, wrote premiums of $20 million for the fiscal year ending in June 1991, up from $13.5 million the previous year.

Unistrat Holding also has announced a partnership agreement with COFACE, the French government-owned export credit insurance agency, to develop political risk coverage via the international insurance and reinsurance markets.

COFACE has purchased 16.5% of Unistrat Holding. SCOR Reassurance owns 16.5% of Unistrat, plus an additional 2% through a European subsidiary. Segespar Holding, a fully owned subsidiary of Credit Agricole of France, owns 15%.

Mr. Habib-Deloncle, the founder of Unistrat Holding, owns the remaining 50%. He expects to sell another 20% to other European and U.S. insurers or financial services companies soon.

Meanwhile, David D. Avasthi, the founder and president of UIC, resigned in December and plans to form a new international insurance underwriting management firm.

Mr. Avasthi formed Miami-based UIC in 1983 and sold it to Unistrat in 1990. He says he is now in the process of setting up a new underwriting manager in Miami that will focus not only on political risk and export credit insurance but also on a general range of property, marine and other coverages for international businesses, particularly Latin American business.

Markets

HMO acquired

Humana Inc. has purchased HealthChicago Inc., a 65,000-member health maintenance organization headquartered in Lisle, Ill. Terms were not disclosed.

Louisville, Ky.-based Humana last year purchased Michael Reese Hospital in Chicago and its Michael Reese Health Plan, the area's second-largest HMO with 242,803 members.

The addition of HealthChicago would make Humana the largest HMO operator in Chicago. Blue Cross & Blue Shield's HMO Illinois has 292,272 members in the Chicago area.

Aon acquisitions

Rollins Burdick Hunter Co., a unit of Chicago-based Aon Corp., has agreed to acquire San Francisco-based Curtis Day & Co., the 69th-largest U.S. broker based on $10.1 million in 1990 revenues. RBH is the world's seventh-largest broker.

In addition, Aon subsidiary Rollins Specialty Group has acquired the government programs division of Richmond Va.-based Markel Corp. The wholesale division brokers professional liability insurance to public entities.

Ryan Insurance Group, another Aon subsidiary, has acquired Karl Singer Cos. Inc. of Dallas, which brokers credit insurance and warranties sold to consumers through retail automobile dealers. Karl Singer, president and chief operating officer, will become president of the unit, which is being renamed Pat Ryan & Associates Inc. ■

Bush budget plan eases 401(k) tests

By JERRY GEISEL

WASHINGTON—The Bush administration's budget proposes major changes to 401(k) plan nondiscrimination tests that could make it easier for employers to run the tests.

Among other things, the proposal would change the time frame in which the tests must be run and would establish a new, optional non-discrimination test that could allow high-paid employees to contribute more to 401(k) plans.

Several other budget provisions would also affect benefit plans. The administration proposes:

- Eliminating Pension Benefit Guaranty Corp. guarantees for future benefit improvements promised by underfunded defined benefit plans.

The agency, now struggling with a $2.5 billion deficit, only would guarantee benefit improvements when a pension plan was fully funded.

- Requiring employers with underfunded pension plans to speed up and increase plan contributions.
- Eliminating tax advantages for employees who take lump-sum distributions from pension and savings plans.
- Raising the Medicare Part B premiums paid by high-income retirees.
- Spending more to fight health insurance fraud.
- Continuing the 25% tax deduction for health care expenses incurred by the self-employed.

Under the 401(k) non-discrimination proposal, employers could use either of two tests: one quite similar to the current test, the other much different.

The first method would essentially retain the most widely used non-discrimination test, known as the "200% or two percentage points" test. Under this test, the average percentage of salary deferred by high-paid employees—known in benefits jargon as actual deferral percentage or ADP—cannot exceed the lesser of:

- 200% of lower-paid employees' ADP.
- The lower-paid employees' ADP plus two percentage points.

Under the administration's proposal, however, employers would compare salary deferrals made by low-paid employees during the previous year with high-paid employees' current-year contributions.

By contrast, Internal Revenue Service rules currently require employers to compare the current-year contributions of the two groups.

By allowing employers to use the previous year's ADP for lower-paid employees to determine how much high-paid workers can contribute, non-discrimination testing becomes a lot more predictable, noted Gerald Uslander, a principal with William M. Mercer Inc. in Washington, D.C.

Under the other non-discrimination testing option proposed in the budget, the previous year's ADP for lower-paid workers also would be used to determine the maximum ADP for high-paid workers in the current year. However, the second option would significantly change the 200%/two percentage points test.

Under the second option, if lower-paid employees' ADP was 3% of salary or less, no *individual* high-paid employee could contribute an amount exceeding 200% of the lower-paid workers' ADP. If lower-paid workers' ADP exceeds 3%, a highly compensated employee could defer an amount equal to the ADP plus three percentage points.

For example, if lower-paid workers' ADP was 4%, an individual high-paid employee could not contribute more than 7% of salary.

Whether the second option will be attractive to employers will depend on the demographics of individual plans, benefit consultants say.

However, the average contribution among high-paid employees could rise by one percentage point over the current maximum, depending on the lower-paid workers' ADP.

On the other hand, the second option could penalize some high-paid workers. Since ADP tests now are run on a group basis, some high-paid employees now can make very large contributions to a 401(k) plan so long as other high-paid employees contribute nothing or very small amounts.

"An employer will have to look at plan data to see which test makes the most sense," said Mercer's Mr. Uslander.

Under the budget proposals affecting the PBGC, which are aimed at eliminating an agency deficit that could balloon to $18 billion by the end of the decade, the PBGC starting this year would not guarantee benefit improvements made by underfunded pension plans. That guarantee would be restored once the plan was fully funded.

The proposal is intended—among other things—to encourage unions to pressure employers to improve pension funding, explained Rick Davids, a consultant with Hewitt Associates in Lincolnshire, Ill.

But the proposal faces an uphill fight in Congress, according to Richard Raskin, a consultant with The Wyatt Co. in New York.

In addition, proposals in the budget would in certain situations require employers with severely underfunded plans and big benefit payouts to contribute to the plan in a given year an amount equal to benefit payments in the previous year.

In other cases, employers with underfunded plans will have between 10 and 20 years, compared with the current 30 years, to fully fund obligations.

The budget package also includes proposals, announced last year, that would give the pension agency priority in bankruptcy proceedings involving companies with underfunded pension plans (*BI*, Nov. 18, 1991).

These and other changes "will create a new, solid foundation for the PBGC," said James B. Lockhart III, the agency's executive director. Without such changes, employers can expect massive PBGC premium hikes, he added.

Meanwhile, the Bush budget proposal would remove a favorable method of taxation—known as five-year forward averaging—on lump-sum pension distributions. Instead, lump-sum distributions would be treated as regular income.

However, the budget would allow individuals to dip into their Individual Retirement Accounts—without incurring a special 10% excise tax—to pay medical expenses and higher educational expenses.

On the other hand, high-income retirees—individuals earning at least $100,000 or a couple earning at least $125,000—would be charged a Medicare Part B premium of roughly $95 a month compared with the current $31.80., according to the proposal.

The administration proposed a similar premium hike last year, but Congress did not act on it. ■

GIC surveys

Continued from page 3

a couple of years ago," said Mr. Ternoey. Then, about 90% to 95% of funds would have been reinvested in traditional GICs, he said. "That's quite a big change."

The results were in line with Foster Higgins' perceptions, Mr. Ternoey said. "The survey really confirmed our feelings that quite a few people were looking for some sort of change," he said. "I think we'll see even more change than that in '92."

The survey found that the remaining funds were still concentrated in what are considered to be stable investments.

The survey said 27% of plan sponsors not investing funds exclusively in traditional GICs were investing in "synthetic" GICs, which are offered by both insurers and banks.

Unlike traditional GICs, the synthetics offered by insurers, which are also known as separate account products, segregate invested plan assets from the insurers' general investment account, so they theoretically are protected if the insurer fails.

These instruments generally are backed by Treasury bills or other government obligations, but also could be backed by high-grade corporate bonds and credit card receivables.

Several banks offer comparable products (*BI*, Nov. 18, 1991).

Another 27% of surveyed companies were reinvesting in short-term funds, like short-term bond funds or money market funds.

In addition, 9% were investing in GIC pooled funds, which are pools generally designed to accommodate smaller deposits through a pooling arrangement of many plans.

Another 9% were investing in short-term U.S. government funds.

Five percent were investing in intermediate U.S. government funds, including the Government National Mortgage Assn. and the Federal National Mortgage Assn. securities.

Eighteen percent were investing in "other" investments, like mutual funds and balanced funds, which include investments in a combination of stocks, bonds and other assets.

The remaining 5% had not made reinvestment decisions.

The Foster Higgins survey also found that the average maturity for those reinvesting in traditional GICs was 3.5 years, a reduction from the 4.2-year average for the maturing contracts.

Mr. Ternoey explained that plan sponsors are being a "bit conservative" by not staying with any one insurer too long.

Reduced contract lengths also are influenced by low prevailing interest rates, he said.

Meanwhile, a survey by Buck Consultants Inc. indicates that plan sponsors "are definitely doing some things to put a tighter hold" on the GIC selection process, said Betsy Vary, an assistant investment consultant with the New York-based firm.

Yet "they aren't overly concerned," she said.

The results of Buck's survey were based on responses from 80 Fortune 1,000 companies in October.

Sixty-six percent of those firms invest defined contribution plan assets in GICs. The largest portion of those companies—33%—had between 26% and 50% of their total plan assets invested in GICs.

Each plan held an average of 11 contracts from seven different insurers. And 19% of the responding companies reported having a GIC with an insurer that has been seized by regulators.

Respondents that offer GICs were asked what changes, if any, they are either considering or have already made in their investment practices.

The survey found that:

- Forty-eight percent are examining GIC insurers more closely, and 11% more are considering doing so. The remaining 41% said they do not anticipate changing their practices.
- Sixty-six percent either have eliminated the term "guaranteed" from the name of their GIC fund or are considering doing so. Thirty-two percent do not anticipate such a change, and the remaining 2% are unsure.
- Fifty-eight percent either have added or may introduce other fixed-income options in the future. Thirty-eight percent do not anticipate adding them, and 4% are unsure.

A substantial number of surveyed companies, though not a majority, said they also were considering other changes.

- Forty-nine percent either have diversified their GIC insurers, or are considering doing so. But 47% do not anticipate any change in this area. The remaining 4% said they do not know.
- Forty-three percent have raised their credit standards for GIC insurers or plan to do so. But, the remaining 57% said they do not anticipate raising their standards.
- Thirty-eight percent said they have increased documentation on GIC placement decisions, or plan to do so. But 51% said they do not anticipate such a change, and 11% did not know.
- Thirty-eight percent shortened the maturity length of GICs, or plan to. But 52% did not anticipate such a change, and 10% did not know.
- Thirty-eight percent obtained outside assistance in evaluating GICs, or plan to do so. But 60% did not anticipate such a change, and 2% did not know.
- Thirty-six percent have obtained outside assistance in placing GICs, or plan to. But, 62% said they did not anticipate any such change in this area, and 2% did not know.
- Sixty-eight percent have made or plan to make a special effort to communicate general GIC issues to plan participants. Twenty-eight percent did not anticipate such a change, and 4% did not know.

Buck also asked several questions of 79 respondents, including some that do not offer GICs.

Approximately 71% of the companies disagreed with the statement: "Recent insurance company takeovers are indicative of significant widespread financial weakness in the ability of insurance companies to fulfill contractual obligations." Another 20% of the companies agreed with the statement, and 9% had no opinion.

Yet most of the companies—58%—disagreed with the statement that insurers "provide information that is accurate and sufficient to make a decision about placing a GIC based solely on that information."

Only 14% agreed with the statement, and 28% had no opinion.

Companies were somewhat more evenly divided on the role of the rating agencies. Asked to respond to the statement, "Prior to any very recent policy changes, the rating agencies used reasonable standards and guidelines in their assessment of the insurance industry," 42% agreed, 33% disagreed and 25% had no opinion.

Plan sponsors generally are considering a range of rating agency opinions, Ms. Vary said.

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Copies of the January edition of "GIC ROR Report" are available free from Kathy Moore, A. Foster Higgins & Co. Inc., Investment Services Consulting Group, 212 Carnegie Center, Princeton, N.J. 08543; 609-520-2480.

Copies of "Guaranteed Investment Contracts, Employer Practices and Opinions," are available for $25 each from Carolee Martin, Manager of Marketing, Buck Consultants Inc., 500 Plaza Drive, Secaucus, N.J. 07096-1533.

Downgrade not seen as blow to Prudential

By JUDY GREENWALD

NEWARK, N.J.—A major rating agency's decision to downgrade The Prudential Insurance Co. of America's financial strength rating is expected to have little, if any, impact on Prudential's guaranteed investment contract business.

Prudential issued close to $6.2 billion in new contracts last year, making it possibly the nation's biggest GIC issuer.

On Jan. 24, Moody's Investors Service Inc. lowered Prudential's financial strength rating to Aa1 from AAA, the highest possible, citing Prudential's "risk asset concentration" in commercial real estate and "above average" holdings in junk bonds and leveraged-buyout securities, which are bonds issued to finance takeovers.

The move means that Metropolitan Life Insurance Co. is now the only major GIC issuer with a "triple-triple" rating.

Both MetLife and Prudential still have top ratings from Standard & Poor's Insurance Rating Services and from Duff & Phelps Credit Rating Co., with MetLife retaining a AAA rating from Moody's as well.

New York Life Insurance Co. has top ratings from both S&P and Moody's, but is not rated by Duff & Phelps.

Bruce Vane, senior vp at Prudential Asset Management Co., a Prudential unit, said the insurance company has contacted many of its key GIC clients and, "without exception, they're treating it as a non-event." Most clients view it as a change in the rating agency, not in Prudential, according to Mr. Vane.

"We don't think it's going to have an impact on our GIC business," he said. "We certainly don't see anything approaching panic, or anything even close to that." Mr. Vane added that the insurance company expects to do roughly the same amount of GIC business this year as it did last year.

Others agree the downgrade is likely to have little, if any, impact on Prudential.

"The insurance industry flagship seems to be riding a little lower in the water, but it's not in any danger of sinking. My feeling is it's not going to have a big impact on Prudential being able to get new business, particularly on the GIC business," commented Kim McCarrel, a consultant with Wyatt Asset Services in Portland, Ore.

Prudential's business has not fundamentally deteriorated, Ms. McCarrel said. Instead, it is a question of the rating agencies changing their procedures. "They've kind of changed the rules of the game," she contended.

Rather than reflect poorly on Prudential, Ms. McCarrel said, it will more likely validate the position other insurers who were downgraded in recent months. Both Moody's and S&P recently downgraded several life insurance companies (*BI*, Sept. 30, 1991; July 29, 1991).

Scott Sokol, managing director of Charles, Dunhill, Rubin & Co., a GIC manager in Los Angeles, said the Prudential downgrade is "startling everybody, to say the least. It's just a continuation of Moody's losing credibility in the marketplace."

People are shaking their heads and asking how the No. 1 life insurance company in the world can be downgraded, according to Mr. Sokol. "I don't think people will stop buying Prudential."

Mr. Sokol added that it would not be prudent to invest in only those GICs from MetLife and New York Life. "Therefore, I believe people will revisit their guidelines and most people will say, 'the Prudential is the Prudential,' whether Moody's downgraded them to an Aa1 or not," he said.

The Prudential may not gain as much business as it did in 1991, but there will be no major difference, said Mr. Sokol.

Moody's could not be reached for comment. ■

Update

OSHA raps state programs

Continued from page 2

OSHA already has given North Carolina, the only other jurisdiction with its own workplace safety program, until April to correct faults in its program or face federal takeover. That action and OSHA's review of all state programs was taken after a fatal fire in September at a Hamlet, N.C., poultry processing plant (*BI*, Oct. 7, 1991; Sept. 9, 1991).

GM hit with $7.5 million award

MONTGOMERY, Ala.—General Motors Corp. must pay $7.5 million to the family of a boy killed in a GM pickup truck when it stalled in traffic, the Alabama Supreme Court has ruled.

The Jan. 24 award is the largest ever under Alabama's wrongful death law, said Frank Wilson, a Montgomery attorney who represented the boy's family. Under that law, only punitive damages can be awarded in a wrongful death case.

GM has not indicated whether it would ask the U.S. Supreme Court to review the case, Mr. Wilson said. GM would not comment.

Seven-year-old Barton Griffin of Montgomery died in August 1987 when the 1988 Chevrolet pickup truck in which he was riding stalled and was hit by a log truck near Linden, Ala. The boy's family sued, claiming GM knew that problems in electronic engine controls caused sudden stalling in 1987 and 1988 model pickups. A district court jury awarded the boy's family $15 million in 1990 under the state wrongful death law. The high court halved that award.

There is "no indication from anybody" the award is covered by insurance, said Mr. Wilson, of Beasley, Wilson, Allen, Mendelsohn, Jemison & James. Punitive damages generally are insurable in Alabama.

Heart valve settlement offered

NEW YORK—Pfizer Inc. is offering 55,000 recipients of the Bjork-Shiley Convexco-Concave heart valve more than $500 million to pay for physician consultations, cardiac surgery and compensation in case of valve fractures, to settle all product liability claims.

But, a group of 370 plaintiffs plans to reject the offer, said attorney Bruce Finzen of Robins, Kaplan, Miller & Ciresi in Minneapolis.

The offer stems from a complaint filed by another group of about two dozen C/C valve recipients who allege that the possibility the valves will fracture is causing them mental stress. More than 400 of the valves, which were marketed from 1979 to 1986, have fractured, causing about 310 deaths (*BI*, Feb. 11, 1991; March 5, 1990).

Pfizer is offering to create a fund of between $80 million and $130 million to pay for cardiologist consultations for those with functioning C/C valves. Pfizer also would establish a separate fund of at least $75 million to reimburse recipients who need valve replacement surgery. The fund also would finance an effort to identify people whose heart valves are at severe risk of fracturing.

Those two funds would be financed by a combination of Pfizer reserves and product liability insurance, said the company, the parent of Irvine, Calif.-based Shiley Inc., which made the valve.

Pfizer also is offering claimants between $500,000 and $2 million each—depending on their age, number of dependents and income—if their heart valve fractures. Pfizer is taking a $300 million pretax charge against fourth-quarter earnings to cover this offer.

The settlement offer is contingent on acceptance by a "substantial" number of valve recipients and court approval.

MBIA public offering planned

ARMONK, N.Y.—Public ownership of MBIA Inc., the holding company for Municipal Bond Investors Assurance Corp., could increase to as much as 86.6% from 65.5% following a stock sale planned by MBIA's insurer shareholders and by MBIA itself.

MBIA has filed a registration statement with the Securities and Exchange Commission for an offering of 8.2 million shares, which would increase public ownership in the company to 83.5%. Public ownership would increase to 86.6% if an overallotment option of an additional 1.2 million shares is exercised by the offering's underwriters.

MBIA plans to sell 1.5 million new shares. Also selling shares would be: Aetna Casualty & Surety Co., whose sale of 4 million shares would reduce its stake to 9.5% from 20.1%; Fund American Cos. Inc., which would reduce its ownership to 1.9% from 5.3% with the sale of 1.3 million shares; affiliates of CIGNA Corp., whose sale of about 1 million shares would decrease its ownership to 1.6% from 4.4%; and Credit Local de France, whose sale of 400,000 shares would reduce its stake to 3.5% from 4.7%.

CIGNA's, Fund American's and Credit Local's shares would be further reduced if the overallotment is exercised.

The lead underwriters are Donaldson, Lufkin & Jenrette Securities Corp. and Lehman Bros. MBIA shares closed at $68.75 Jan. 30.

Briefly noted

The Hartford Steam Boiler Inspection & Insurance Co. has discontinued its pilot **environmental site assessment insurance program** for lenders and developers (*BI*, Oct. 21, 1991). . . .The Los Angeles district attorney has launched a criminal investigation into the development, production and marketing of **silicone breast implants** by a Dow Corning Corp. subsidiary under the state's new Corporate Criminal Liability Act. The law subjects corporations and managers to fines and imprisonment for knowingly allowing harmful situations to exist (*BI*, Sept. 20, 1990). Dow Corning has hired former U.S. Attorney General Griffin Bell to conduct an internal investigation (*BI*, Jan. 13). . . .A federal court in Maine has dismissed three **Liberty Mutual Insurance Co.** units as defendants in an antitrust suit by employers alleging that insurers conspired to repeal a Maine law limiting workers compensation rate increases (*BI*, Sept. 23, 1991). The Liberty Mutual units withdrew from the Maine workers comp market in 1987. . . .**USF&G Corp.** reported a $40 million net loss in 1991's fourth quarter, compared with a $610 million fourth-quarter loss in 1990. That brought its net loss for the year to $176 million, compared with $569 million for 1990. USF&G says the fourth-quarter charge will be the last significant charge associated with its restructuring.

Insurer ratings

Continued from page 2

only months before their respective collapses.

Roy Taub, executive managing director of Standard & Poor's in New York, defended assigning its highest rating—AAA—to Executive Life from 1986 to 1990. "I believe in the case of Executive Life, we followed appropriate procedures," he said, noting the conclusions reached were "reasonable" at the time.

Mr. Taub said S&P in 1990 downgraded Executive Life's rating to A, the rating agency's sixth-highest rating on a 22-point scale.

But most people think in terms of their school experiences when they see a grade of A, Rep. Collins commented. Because the grading scale with which most people are familiar goes from A to F, they are led to believe that a B-rated company would be in good shape, she said.

But Mr. Taub said that a B on the S&P scale is not good, ranking 15th on the 22-point scale.

"I think we make every effort" to make clear what the ratings mean, he added. "I think any symbol we come up with could be subject to misinterpretation."

Rep. Collins also pointedly criticized A.M. Best for not reacting more quickly to Executive Life's potential problems. "It looks like you just missed the boat," she said.

Larry Mayewski, vp of life/health for Oldwick, N.J.-based Best, defended the agency's rating. Executive Life could have weathered its difficulties, he claimed, if there hadn't been a policyholder "run" on its assets as news of its deteriorating condition became public.

Mr. Mayewski said earlier that "to assume that an insurer is financially sound only if it is able to satisfy a policyholder run is contrary to the fundamental role insurers play in the financial arena."

Other rating agency executives pointed out that rating changes often reflect a change in the general economy, like a decline in the commercial real estate market, rather than problems with any particular company.

Milton L. Meigs, executive vp of Chicago-based Duff & Phelps, said that theoretically the operating environment could become so bad that every insurer would be downgraded, even though this has never happened.

Another subcommittee member, Rep. J. Roy Rowland, D-Ga., asked the witnesses why they charge fees to rate companies.

S&P's Mr. Taub replied that investigating an insurer's claims-paying ability is an expensive proposition. S&P only assigns qualified ratings—no higher than BBBq—to companies that decline to pay for the research (*BI*, April 22, 1991; April 15, 1991).

When Rep. Rowland asked him to confirm whether a company that pays gets a higher rating, Mr. Taub said that some critics have construed S&P's practice in such a manner. Critics have blasted S&P for only assigning BBBq ratings to the highest-quality firms if they do not pay for S&P's full evaluation.

Rep. Oxley asked if smaller companies are at a disadvantage in the rating process.

Best's Mr. Mayewski said that a company would not be precluded from a high rating solely on the basis of size.

Rep. Collins also asked the raters why they don't adopt some type of standardized rating system.

When Mr. Taub replied that the S&P system has been in place since the 1920s, Rep. Collins responded that perhaps it is time for a change. Mr. Taub said that S&P in the past has changed its system in response to market demands by adding plus and minus qualifiers to its ratings.

Chester Murray, assistant vp and associate director of financial institutions for Moody's Investors Service in New York, said that the system Moody's uses has been used for decades.

Mr. Meigs noted that Duff & Phelps initially used a numerical system, but changed to a letter system at customers' request.

Subcommittee member Rep. Frederick Upton, R-Mich., questioned whether consumers have adequate access to their information. But, Mr. Mayewski pointed out that Best's Insurance Guide is available free at public libraries. The company also operates a pay-per-call telephone line that consumers can use, he said. ■

Amoco Cadiz ruling

Continued from page 3

Among these was a finding that Amoco was liable for the pollution disaster.

The 1,095-foot Amoco Cadiz, owned by an Amoco unit and chartered to Royal Dutch/Shell, lost control of its steering systems in heavy weather off the Brittany coast in March 1978.

Despite efforts to tow it toward open waters, the ship drifted onto the rocky coast, breaking apart and spilling its cargo. Crude oil washed up along 80 miles of French shoreline.

The wreck also unleashed a flood of lawsuits, which were consolidated in U.S. District Court in Chicago and led to 14 years of legal wrangling and separate trials to establish liability for the disaster and assess damages.

Judge Norgle issued a final ruling in 1990, adopting the recommendations of retired U.S. District Judge Frank J. McGarr, then serving as a court-appointed special master in the case.

"The evidence establishes that the grounding of the Amoco Cadiz was a disaster waiting to happen," the appeals panel said, echoing findings by Judge Norgle and Judge McGarr that Amoco knew the ship's steering system was poorly maintained and its crew poorly trained.

"Amoco was aware of the ship's various problems—any one of which could have led to the failure of the steering system—yet chose to do nothing," the appeals panel wrote.

"The record is replete with references to the fact that it was Amoco's deliberate policy to defer drydocking and repairs in order to minimize the loss of charter hire that would be incurred by taking the ship out of service during the charter period," the panel found.

The appeals court also:

- Affirmed the jurisdiction of U.S. courts over Astilleros Espanoles S.A., the Spanish shipbuilding company that built the Amoco Cadiz. Astilleros, which unsuccessfully sought to be dismissed from the case on jurisdictional grounds, was hit with a default judgment after refusing to participate in the litigation.
- Rejected Amoco's argument that its liability should be reduced to reflect the degree of fault of the New York-based American Bureau of Shipping, which Amoco charges in a separate lawsuit with negligence for certifying that the ship was properly designed and built.

Reviewing the lower court's damage award, the appeals panel concluded that the 7.22% rate of prejudgment interest was too low. Instead, the panel adopted the French claimants' recommendation of 11.9%, the average prime rate during the 1980s.

Applied to a $61 million damage award against Amoco, prejudgment interest at 11.9% brings the total award to about $203 million.

Of that, the French government will receive about $166 million. Two provincial departments of the government and dozens of municipalities, businesses and associations—including hotel owners and fishermen—will divide the remaining $37 million, according to Mr. Kingham.

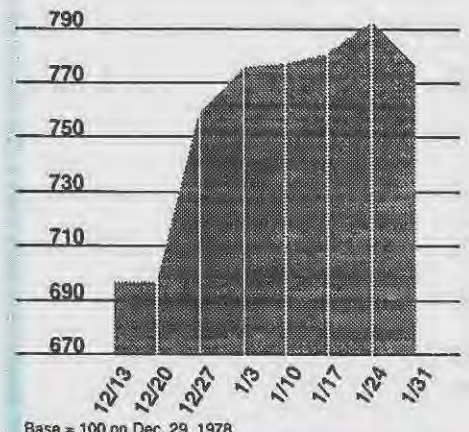
"Amoco has little reason to shed crocodile tears," the appeals court said. "Exxon (Corp.) reportedly spent $2 billion to clean up the oil the Exxon Valdez spilled off Alaska; it has agreed to pay another $1 billion as damages and to pay a criminal fine of $125 million.

"Amoco will be called on to pay only $61 million plus interest to redress a spill that not only was larger but also occurred in a more densely populated area. Calling the $61 million the result of inflated or fraudulent claims taxes credulity," the court found.

In the matter of: Oil spill of the Amoco Cadiz off the coast of France on March 16, 1978; Nos. 90-2832 et. al.

●

BI Insurance Index



Base = 100 on Dec. 29, 1978

Source: Nordby International Inc.

Insurance industry stocks sank last week as the *Business Insurance* Index fell 13.6 points to 778.0 on Jan. 31 from 791.6 on Jan. 24. Advancing issues for the week were led by Safeguard Health Enterprise, up 8.8%; United Medical Corp., up 6.6%; and RLI Insurance Corp., up 6.4%. Declining insurance issues for the week followed American Indemnity/Financial, down 16.4%; FHP International, down 7.5%; and General RE Corp., down 7.4%. The most active issue for the period was USF&G Corp., with 5.6 million shares traded. The *BI* Index was down 1.7%; the New York Stock Exchange Composite fell 1.3%; the Standard & Poor's 500 was down 1.6; and the Dow Jones 30 Industrials were down 0.3%.

British Issues

Jan. 30 Companies	Price pence	P/E	Div. pence	Yield %	1 Week High—Low pence	pence
Commi Union	455	N/M	30.7	6.7	465	455
Genl Accident	452	N/M	35.7	7.9	456	452
Gdn Royal Exch	136	N/M	15.9	11.7	136	128
Royal	255	N/M	34.7	13.6	255	245
Sun Alliance	295	N/M	18.7	6.3	299	295
Brokers						
Bradstock	165	18.6	6.3	3.8	166	165
CE Heath	476	16.7	34.5	7.2	477	476
Hogg Group	178	10.6	10.7	6.0	180	178
JIB Group	194	16.2	10.0	5.1	196	194
Lloyd Thompson	255	25.6	6.0	2.3	255	254
Lowndes Lmbrt	333	16.5	15.3	4.6	333	330
PWS Holdings	63	6.9	5.3	8.4	69	62
Sedgwick Grp	218	20.7	16.0	7.3	226	214
Steel Brrl Jones	305	16.2	16.3	5.3	317	305
Willis Corroon	250	13.2	17.6	7.0	261	250

Source: Philip Olsen, Insurance Industry Analyst, London

BI Industry Stock Report

JANUARY 27, 1992 THROUGH JANUARY 31, 1992

		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	22.38	-1.65	9.15	27.63	18.00	419	1.00	4.47	20	9.77	2.29
Gallagher Arthur J. & Co.	NYS	23.38	-2.60	4.47	28.38	19.00	56	0.64	2.74	18	5.88	3.98
Frank B. Hall	NYS	3.88	-3.13	-8.82	5.50	3.00	76	0.00	0.00	-6	-5.24	-0.74
Hilb, Rogal & Hamilton	OTC	13.13	-0.94	-0.94	17.50	11.25	75	0.40	3.05	23	3.56	3.69
Marsh & McLennan	NYS	75.75	-3.35	-6.91	87.25	70.00	677	2.60	3.43	18	14.77	5.13
Poe & Associates	OTC	12.75	4.08	6.25	12.75	6.50	1	0.32	2.51	14	2.52	5.06
BROKERS	AVERAGE		-1.3	0.5					2.3	12		
CONGLOMERATES & HOLDING COMPANIES												
Berkley W R. Corp.	OTC	33.25	3.50	9.02	33.25	23.50	399	0.32	0.96	14	23.89	1.39
Berkshire Hathaway Inc.	NYS	8850.00	1.72	-2.21	8850.00	235.94	18	0.00	0.00	-38	4612.00	1.92
ITT (Hartford Group)	NYS	58.00	-2.52	0.43	63.00	50.00	1285	1.72	2.97	9	64.01	0.91
Sears (Allstate)	NYS	41.00	0.92	8.25	43.50	29.00	3600	2.00	4.88	15	37.38	1.10
CONGLOMERATES	AVERAGE		0.9	3.9					2.2	0		
INSURERS/REINSURERS												
AEGON N.V.	NYS	69.00	-2.13	-1.43	71.75	54.75	3	2.30	3.33	7	N/A	N/A
Aetna Life & Casualty	NYS	41.50	-6.74	-5.68	49.13	31.88	1973	2.76	6.65	8	64.23	0.65
Allied Group Inc.	OTC	18.50	-2.63	8.82	21.50	12.50	2	0.56	3.03	7	11.50	1.61
American General	NYS	41.38	-2.65	-7.02	45.63	33.75	1339	2.00	4.83	10	37.14	1.11
American Indemnity/Fin'l	OTC	7.00	-16.42	47.37	9.25	4.50	72	0.08	1.14	6	12.93	0.54
American International	NYS	91.75	-2.39	-6.73	102.00	78.63	1773	0.48	0.52	13	45.34	2.02
Aon Corp.	NYS	41.88	-0.59	5.68	43.25	32.13	190	1.60	3.82	12	18.50	2.26
Argonaut Group	OTC	25.88	-4.17	8.95	33.38	21.75	95	0.68	2.63	8	48.26	0.54
AVEMCO Corp.	NYS	25.88	-0.48	3.50	27.25	17.50	24	0.40	1.55	19	9.55	2.71
Baldwin & Lyons Inc.	OTC	26.50	-0.93	2.91	27.50	19.00	2	0.28	1.06	8	24.29	1.09
Belvedere Corp.	ASE	4.50	0.00	38.46	4.75	2.63	7	0.04	0.89	18	7.65	0.59
Chandler Insurance	OTC	4.00	-1.55	23.08	4.75	2.13	172	0.00	0.00	-2	5.95	0.67
Chubb Corp.	NYS	59.13	-4.16	-10.23	78.00	59.50	1158	1.48	2.14	11	35.19	1.96
CIGNA Corp.	NYS	54.00	-5.47	-11.66	61.75	41.25	870	3.04	5.63	11	73.15	0.74
CNA Financial Corp.	NYS	88.25	-6.12	-9.95	104.50	73.50	116	0.00	0.00	13	70.23	1.26
Continental Corp.	NYS	27.38	-2.67	-0.90	30.63	23.25	604	2.60	9.50	12	37.83	0.72
EXEL Ltd.	NYS	33.88	-5.24	-9.67	40.25	27.38	463	0.01	0.03	7	N/A	N/A
Fund American Corp.	NYS	68.75	3.00	-1.61	70.25	53.50	201	0.68	0.99	18	36.11	1.90
Fremont General Corp.	OTC	25.00	1.01	2.56	26.00	14.13	176	1.00	4.00	7	19.13	1.31
Frontier Insurance Group	NYS	27.00	-4.42	0.00	29.00	17.28	60	0.00	0.00	11	11.20	2.41
Gainsco Inc.	ASE	14.25	0.88	1.79	14.63	5.00	39	0.04	0.28	18	3.37	4.23
General RE Corp.	NYS	91.13	-7.37	-10.55	104.75	85.00	1031	1.68	1.84	13	37.50	2.43
Guaranty National Corp.	NYS	16.00	-1.54	10.34	17.00	12.63	465	0.48	3.00	12	N/A	N/A
Hanover Insurance Co.	OTC	37.50	1.35	4.90	42.75	27.13	26	0.44	1.17	16	37.44	1.00
Harleysville Group	OTC	19.88	-3.05	-6.47	23.25	14.16	29	0.64	3.22	9	22.99	0.86
Hartford Steam Boiler	NYS	49.00	-3.92	-14.78	63.75	47.25	392	2.00	4.08	14	17.05	2.87
Kemper Corp.	NYS	40.50	-6.09	6.23	46.13	26.13	439	0.92	2.27	9	34.20	1.18
Lawrence Insurance Group	ASE	10.25	3.80	-7.87	11.13	6.50	4	0.48	4.68	16	4.71	2.18
Liberty Corp.	NYS	22.25	0.00	0.56	24.00	19.50	19	0.48	2.16	13	23.86	0.93
Lincoln National	NYS	57.63	-2.12	5.25	61.00	44.75	478	2.92	5.07	10	45.16	1.28
Markel Corp.	OTC	25.50	5.15	15.91	25.50	13.75	90	0.00	0.00	12	3.22	7.92
Mutual Risk Mgmt. Ltd.	NYS	34.25	-2.49	-2.49	37.50	17.00	157	0.12	0.35	29	-	-
NAC Re Corp.	OTC	29.50	-4.07	-6.35	33.00	21.75	175	0.16	0.54	15	18.90	1.56
Navigators Group	OTC	43.00	4.88	4.88	43.00	24.75	10	0.00	0.00	23	13.52	3.18
Nobel Insurance LTD.	OTC	4.50	5.88	12.50	5.25	2.75	48	0.00	0.00	6	7.76	0.58
NWNL Companies	NYS	32.00	-2.66	2.81	38.50	18.63	506	1.40	4.38	8	42.73	0.75
Ohio Casualty Corp.	OTC	55.00	-0.90	11.11	56.50	40.00	211	2.48	4.51	9	36.38	1.51
Old Republic Int'l	NYS	35.50	-1.05	0.00	36.88	22.88	161	0.72	2.03	8	33.09	1.07
Orion Capital Corp.	NYS	33.38	-1.84	5.53	34.00	18.75	43	0.92	2.76	9	20.42	1.63
Phoenix RE Corp.	OTC	10.75	0.00	2.38	11.50	8.50	54	0.20	1.86	15	13.30	0.81
Provident Life	OTC	23.00	-1.08	-1.08	24.50	16.75	135	1.00	4.35	7	25.88	0.89
Re Capital Corp.	ASE	14.63	-1.68	1.74	18.63	13.25	12	0.20	1.37	12	15.05	0.97
Reliance Group Holdings	NYS	4.63	2.78	12.12	7.50	3.50	46	0.32	6.92	3	5.61	0.82
RLI Insurance Corp.	NYS	18.63	6.43	12.88	18.63	11.88	107	0.48	2.58	10	14.41	1.29
St. Paul Companies	NYS	73.38	2.44	0.69	75.50	57.13	513	2.60	3.54	8	52.00	1.41
SAFECO Corp.	OTC	48.38	1.84	-0.77	50.00	35.50	1072	1.48	3.06	12	31.50	1.54
SCOR U.S. Corp.	NYS	17.38	2.21	13.01	17.38	11.63	5	0.24	1.38	10	11.19	1.55
Seibels Bruce Group	OTC	6.25	6.38	13.64	8.88	5.00	105	0.36	5.76	-89	7.35	0.85
Selective Ins. Group	OTC	17.75	-3.40	5.97	19.00	13.75	101	1.04	5.86	9	18.91	0.94
Statesman Group Inc.	OTC	5.88	-2.08	2.17	6.75	1.81	3483	0.00	0.00	18	2.48	2.37
Tokio Marine & Fire	OTC	47.75	0.00	-7.28	56.50	40.50	76	0.00	0.00	-	70.93	0.67
Torchmark Corp.	NYS	58.13	0.65	0.43	61.50	46.50	388	1.60	2.75	13	16.70	3.48
Transamerica	NYS	41.13	-1.50	3.13	42.38	31.25	729	2.00	4.86	16	36.56	1.12
Transatlantic Holdings	NYS	38.75	0.32	-0.32	39.63	28.50	54	0.24	0.62	13	18.38	2.11
Travelers Corp.	NYS	21.13	-5.06	-2.31	25.38	17.25	2072	1.60	7.57	6	41.44	0.51
Trenwick Group Inc.	OTC	29.38	0.00	3.07	30.75	23.00	86	0.72	2.45	11	21.71	1.35
United Fire & Casualty	OTC	46.25	-0.54	2.78	58.00	35.75	1	1.32	2.85	10	35.39	1.31
USF&G Corp.	NYS	8.50	6.25	17.24	12.50	5.63	5551	0.20	2.35	-1	11.96	0.71
UNUM Corp.	NYS	75.50	0.33	-6.79	81.25	52.00	252	1.04	1.38	13	37.25	2.03
USLIFE Corp.	NYS	45.00	-1.37	-6.01	47.88	31.50	269	1.64	3.64	10	60.34	0.75
Unitrin	OTC	36.00	0.70	0.70	41.50	31.00	110	1.00	2.78	14	30.70	1.17
Washington National	NYS	18.50	-3.27	16.54	19.25	12.00	50	1.08	5.84	-9	26.86	0.69
USLICO Corp.	NYS	19.63	3.29	6.08	21.00	17.00	47	1.00	5.10	-93	29.44	0.67
Zenith National Ins.	NYS	15.88	0.79	-5.93	18.50	12.88	18	1.00	6.30	132	13.14	1.21
INSURERS/REINSURERS	AVERAGE		-1.0	3.0					3.1	10.6		
HEALTH MAINTENANCE ORGANIZATIONS												
FHP International	OTC	15.50	-7.46	8.77	29.75	9.88	876	0.00	0.00	12	5.44	2.85
HMO America Inc.	OTC	21.63	-3.35	29.10	22.50	7.13	1124	0.00	0.00	23	0.61	35.45
Pacificare Health Sys.	OTC	42.00	0.00	6.33	42.50	14.50	816	0.00	0.00	19	6.55	6.41
Safeguard Health Enter.	OTC	10.88	8.75	16.00	11.63	4.38	62	0.00	0.00	25	3.53	3.08
Sierra Health Services	ASE	23.00	-1.08	24.32	29.50	12.38	464	0.00	0.00	12	1.78	12.92
United Healthcare Corp.	NYS	83.25	-5.40	11.74	90.50	27.00	456	0.06	0.07	40	3.76	22.14
United Medical Corp.	ASE	8.13	6.56	16.07	10.88	5.88	7	0.20	2.46	13	8.79	0.92
U.S. Healthcare	OTC	50.50	-7.13	21.69	55.00	21.25	4104	0.44	0.87	26	3.38	14.94
HMOs	AVERAGE		-1.1	16.8					0.4	21		
ALL COMPANIES	AVERAGE		-0.6	6.0					2.7	11		

System design: Nordby International Inc.

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