

business insurance

Reporting weekly for corporate risk, employee benefit and financial executives/\$1 a copy; \$40 a year

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Lloyd's, Federal Leasing settle suit for \$11.5 million

BALTIMORE—Federal Leasing Corp. will receive \$11.5 million in damages from Lloyd's of London underwriters in an out-of-court settlement of a suit that charged Lloyd's with refusing to pay computer leasing claims.

Federal, based in McLean, Va., sued Lloyd's for \$600 million in damages in U.S. District Court in Baltimore after Lloyd's refused to pay the claims. A

Continued on next page

Benefit tax would burden self-insurers

By JERRY GEISEL

WASHINGTON—The Reagan administration's plan to tax health care benefit plans would be an administrative nightmare for employers with self-funded programs.

In addition, some employers would be hit with employee demands for salary increases and expansion of other benefits if health insurance premiums were considered part of an employee's taxable income.

For example, some highly paid employees could have their take-home pay cut by more than \$200 annually under the proposal (see chart).

Such a tax also would sock companies with cost increases in other unexpected areas.

For example, employers would have to pay a total of \$175 million more in Social Security taxes if employer health insurance costs were counted as taxable income to the employee.

The administration says its proposal to tax employees on employer health insurance contributions that exceed \$2,100 a year for family coverage or \$840 for an individual coverage will curb medical care inflation by making employees more conscious of the

Effect of capping tax-free group medical plans			
Family income	Percent of people affected	Average increase in federal income tax	Average increase in federal, state and FICA taxes*
\$1 to \$9,999	15.3%	\$ 53.66	\$ 84.75
\$10,000 to \$14,999	16.1	83.65	126.98
\$15,000 to \$19,999	20.1	93.24	137.09
\$20,000 to \$29,999	20.9	107.24	155.78
\$30,000 to \$49,999	29.0	168.52	220.63
\$50,000 or more	28.6	178.63	226.84

Assumes annual premiums over \$2,100 for family coverage and \$840 for individual coverage are taxable.

*Includes employers' share for FICA.

Source: National Center for Health Services

cost of their health care.

At a news conference, an administration spokesman said that the proposal would apply only to medical and hospital insurance premiums, but some insurers say that dental

and vision care insurance costs would be included, too.

Benefit experts, though, doubt if the proposed tax, which would affect about 24% of workers covered under employer-provided

health plans, would have any effect on the cost of medical care.

In fact, costs could increase even more as companies eliminate cost-containment features, like coverage for second opinion surgery, to keep the employer-paid premium below the tax cap, said H. Michael Schiffer, director of government and industry relations at CIGNA Corp. in Hartford, Conn.

Besides that negative effect, experts agree that employers that self-fund their health care plans will face an administrative and regulatory nightmare if Congress enacts a benefit tax.

One key question is how an equitable premium could be charged to individual employees in self-funded plans.

"How could you have a set of uniform regulations that would take in all the nuances of hundreds of thousands of (self-funded) benefit plans?" asks Gary Grove, vp of compensation and benefits with Marriott Corp. in Washington, which self-funds its health plan.

Benefit managers are wondering how administrative costs would be calculated in determining the cost of the employer's self-

Continued on page 22

Some cost-containment efforts may save little

By LEN STRAZEWSKI

CHICAGO—Employer coalitions on health care costs, claims audits and several other popular employee benefit cost containment techniques appear to cost almost as much as they save.

But higher deductibles and coinsurance, retrospective utilization reviews, better coordination of benefits and hospice care benefits are generating significant savings for the few employers that have measured the results, according to a new survey by consultant Towers, Perrin, Forster & Crosby.

The TPF&C 1982 Group Insurance Survey, released last week to participants only, asked 94 Chicago and Milwaukee employers to identify and rate the health care cost-containment measures they have considered, implemented and measured over the last four years. The rating was part of a comprehensive look at corporate attitudes about their group medical, dental and life insurance plans.

The employers, which represent nearly \$800 million in paid claims, 640,000 covered employees and \$36 million in retention or administration charges, ranged in size from 500 employees to more than 90,000 employees and from \$80 million to more than \$9 billion in annual sales.

Individual respondents included A.B. Dick Co., A.C. Nielsen Co., Bally Manufacturing Co., Beatrice Foods Co., the Chicago Sun-Times, Commonwealth Edison Co., Consolidated Foods Corp., FMC Corp., Hyatt Corp., Inland Steel Co., Playboy Enterprises Inc.,

Rand McNally & Co., Tribune Co. and Zenith Radio Corp.

Twenty-seven commercial insurers and administrators also participated by providing information on claims reserves, coordination of benefits credits and the services they are willing to provide policyholders.

As a pilot project for a larger national study to be conducted later this year by TPF&C's Employee Benefit Information Center, the employer participants also were asked to rate the value of data and services submitted by their insurers or third-party administrators, the desirability of other services available and their use of brokers, consultants and other outside advisors. (These results will be revealed in additional stories next week.)

The employers' evaluation of cost-containment measures, however, was particularly startling, according to survey coordinators David Glueck and Ian Abernethy. The results indicated that while most of the employers have attempted at least one cost-containment technique, few have actually measured the results.

And those that have measured what their changes have wrought discovered that some very impressive-sounding cost-containment possibilities have generated very little savings. On the other hand, other rather simple changes have had significant, positive impact on costs.

"Of course, we will know much more about this issue next year when we have completed a national study for comparison,"

Continued on page 4

Effectiveness of cost-containment techniques

Plan design changes

Hospices	4.0
Coinurance	3.8
Deductibles	3.8
Outpatient surgery	3.5
Pre-admission testing	3.4
Voluntary second surgical opinions	2.8

Plan administration

Coordination of benefits improvements	3.7
Reasonable & customary charging	3.6
Hospital audits	3.1
Inside claims audits	2.4
Outside claims audits	2.1

Key

- 1—Cost exceeds savings 3—Slight net savings
2—Cost equals savings 4—Significant net savings

Source: Towers, Perrin, Forster & Crosby

INSIDE:

Argentina scales back reinsurance in London
Page 2

Employers pay workers to audit hospital bills
Page 3

update

Lloyd's to pay computer lessor

Continued from previous page

U.S. Circuit Court of Appeals in Richmond, Va., later ordered Lloyd's to pay Federal more than \$50 million to settle the claims (BI, June 15, 1981). Under the settlement, Lloyd's also agreed to waive any salvage rights on the computer equipment.

Insurer hit with punitive award

NEW YORK—A \$200,000 punitive damage award against Aetna Casualty & Surety Co. for refusing to pay a valid claim will send shock waves through the insurance industry, a competitor says.

Under New York law, a jury had to find that Aetna committed fraud to award punitive damages. Such a finding is unusual in insurance litigation.

Aetna, which has declined comment, has 30 days to decide whether to appeal the jury's award once it becomes final.

The decision was handed down by a U.S. District Court jury in Manhattan Feb. 2 in a case brought by Source Commodities Corp. The jury also awarded \$100,000 in compensatory damages against Aetna, which wrote a \$500,000 brokers blanket bond for Source.

Source lost \$165,000 in October 1980 when a customer failed to make good on some trading losses. The commodities broker, alleging involvement by a then-executive vp at Source, asked Aetna to cover the loss under its bond. Aetna refused. Source alleged in the trial that an Aetna claims representative had twice concluded that the insurer had no prospect of winning the case in court.

"It will send some new shock waves through the industry that there is another after-the-fact way to attack insurer claims handling," says William E. Bailey of Commercial Union Insurance Co.

Insurers to pay for tanker loss

NEW YORK—U.S. hull underwriters will bear the brunt of the \$35 million tanker loss off Bermuda last month.

Underwriters declared the Tifoso, owned by Clockwork Corp. S.A. of Monrovia, Liberia, a constructive total loss on Jan. 25. They decided the vessel was damaged too badly to be repaired for less than its total valuation.

American Hull Insurance Syndicate, the lead underwriter on the policy covering the vessel, will pay 30% of the loss, says Raymond M. Hicks Jr., the syndicate's claims manager.

Altogether, domestic underwriters will pay about 70% of the loss, Mr. Hicks said. Lloyd's underwriters had 24% of the package, and another 6.5% was in the Japanese market.

The tanker was carrying no cargo and surrounding waters were not polluted.

Walton costs Phillips \$65 million

HAMILTON, Bermuda—Additional reserves for losses and future losses at Walton Insurance Co. reduced parent Phillips Petroleum Co.'s fourth-quarter aftertax earnings by \$65 million, the company said late last week on the heels of its announcement that it would substantially reduce underwriting at Walton (BI, Jan. 31).

Walton is cutting 26 people from its staff of 83 under the restricted underwriting order from its parent, Bermuda sources say.

Phillips reported fourth-quarter earnings of \$155 million, down from \$186 million last year. The decline is also attributable to reduced petroleum operations, Phillips said.

Meanwhile, more bad news hit the Bermuda reinsurance market last week when Continental Reinsurance Corp. (Bermuda) Ltd. announced that it would merge its treaty underwriting portfolio with Continental Re of New York and move its operations to New York. Another 30 jobs and most of the \$147 million in premiums written by the Bermuda company will be moved out of the market. About half of the employees will move to New York or London.

Continental Re (Bermuda) President Nigel Harley stressed that his company's decision to pull out of Bermuda is solely for operating efficiency and cost savings.

Continental Risk Services, Continental's captive management subsidiary, remains and will manage Continental Re (Bermuda), which will continue as a corporate entity. Bayside Management, Continental's Bermuda underwriting manager, also remains.

Judge OK's Hyatt fund

KANSAS CITY, Mo.—U.S. District Court Judge Scott O. Wright last week formally approved the federal court portion of the complicated plan to settle claims arising from the 1981 disaster at the Kansas City Hyatt Regency Hotel (BI, Jan. 17).

Under the \$10 million settlement, \$3.5 million will be put in a special damage fund to pay punitive claims and \$6.5 million will be donated to Kansas City charities.

Ten to 15 victims are not represented in the state and federal court settlements, but defense attorneys expect their claims to be resolved soon.

index

Benefit beat	11
Classifieds	24
Comings&goings: buyers	6
Insurance services guide	26
Letters	8
Markets	25
Opinions	8
Perspectives	17
Riskwatch	25
Ticker	3
Washington	12

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Argentina scales back reinsurance in London

Argentina's state reinsurance monopoly is slashing its business with London reinsurers and spreading it around the world in the aftermath of the Falkland Islands crisis.

Argentina's National Reinsurance Institute, known as INDER, annually had placed about 30 million pounds (approximately \$45.3 million) in premiums in the London market, which represented about half of its reinsurance purchases, according to the British Insurance Assn.

Although no one will reveal the exact figure, INDER placed a smaller amount of business in London when reinsurance contacts expired Dec. 31.

Some London underwriters say they wouldn't take the business even if it were offered to them because they fear that new conflicts could interrupt premium payments.

More than 30 brokers, many in London, have negotiated the placements of Argentina's reinsurance with more than 500 entities in 60 countries, including some in the London market, according to an INDER official in Buenos Aires.

"We have not quit working with London," said INDER President Feliciano Salvia, "but in the future we plan not to have so much in one place."

INDER's reinsurance is now distributed to reinsurers

This story is based on reporting by Business Insurance Associate Editor Stacy Shapiro in London and special correspondent Randy Drapeau in Buenos Aires, Argentina.

in countries like the United States, Japan, Switzerland and even the Soviet Union, he said.

No one reinsurance treaty is placed in one country, Mr. Salvia said, adding, "Our relationship is with the world market."

There was no change in the cost

of reinsurance to INDER, its officials say.

Relations between Argentine and British insurers were strained last April when the British government imposed financial sanctions on Argentine business after Argentine troops invaded the Falkland Islands, a British territory.

All Argentine assets in London were frozen and any claims or premiums to be paid were held in a fund by the Bank of England until the sanctions were lifted in September (BI, April 12, 1982).

"You can imagine, you have an important industry and more than 50% of the reinsurance is in one country," said Mr. Salvia. "Suddenly, your funds are frozen and you're left holding the bag if there is a big claim."

Luckily, no major claims were filed during the 72-day conflict and the British reinsurers did not refuse to honor contracts, noted Ronald Gunn of Alexander Ayling-Barrios, a leading Argentine broker representing eight international reinsurance brokers.

Continued on page 26

ISO to offer unlimited tail coverage

By BILL DENSMORE

NEW YORK—The Insurance Services Office is going ahead with its plan to develop a claims-made comprehensive general liability form, and it's adding a feature that could make the coverage more attractive to buyers.

ISO said last week that it will offer "tail" coverage of unlimited duration to buyers who decide not to renew a claims-made policy.

Under a claims-made policy, the insurer on a risk when a claim is filed is responsible for paying that claim. Tail coverage extends the insurer's responsibility for an event that occurs within the original policy period to claims filed after the claims-made policy expires.

Previously, ISO said that tail coverage would be available for three years after the original policy expired and had appeared to say that an insurer had the right not to offer the coverage (BI, July 12, 1982).

ISO, though, would give no indication of how it will recommend that insurers price the proposed tail coverage—a key factor for buyers trying to determine whether to switch from an occurrence to a

Continued on page 24

Injured jock may not collect big payoff from bankrupt track

By SALLIE J. DRURY

GRANITE CITY, Ill.—Coming away from a day at the races with \$3 million is a big win in anybody's book, but a former jockey may be able to collect only \$10,000 of the huge personal injury award she won from a bankrupt racetrack.

Former jockey Mary Bacon, 30, was awarded \$3 million on Jan. 17 by a Madison County (Ill.) Circuit Court in Granite City for injuries she suffered in a May 29, 1979, accident at now-bankrupt Cahokia Downs in East St. Louis, Ill.

The award and how Ms. Bacon secures any of it will shed some light on how insurers respond to judgments against bankrupt companies.

Insurers' liability for judgments against bankrupt companies became a hot issue after three asbestos makers and suppliers facing millions of dollars of claims and judgments for asbestos-related disease injuries filed for bankruptcy.

Ms. Bacon is a good bet to collect \$10,000, the amount of the deductible on the track's liability insurance policy, says her attorney, Gary Peel of the East Alton, Ill., firm of Lakin, Herndon & Peel. U.S. Bankruptcy Judge J.D. Trabue set aside that amount for Ms. Bacon when the track's assets were liquidated by the bankruptcy court last year.

Ms. Bacon will collect the \$10,000 30 days after the state court judgment is made final unless a post-trial motion or appeal is entered, Mr. Peel said.

The track had \$1.5 million in liability insurance with a \$10,000 deductible, Mr. Peel says. Aetna Life & Casualty Co. of

Continued on page 20



Coalition attacks malpractice awards

By BILL DENSMORE

ALBANY, N.Y.—Employers, insurers, hospitals and physicians in New York are readying a legislative assault on huge medical malpractice awards, which they say drive up health insurance costs.

They have formed the New York Medical Liability Reform Coalition to seek legislation that would place a \$100,000 cap on punitive damages awarded in medical malpractice suits, limit attorneys' contingent fees and mandate structured settlements of large malpractice awards.

Capping punitive damages in medical liability cases would be significant. For example, a jury last year handed down a \$29 million verdict against a New York hospital. Most of the amount assessed was for punitive damages, the coalition says.

The verdict came last fall against St. John's Episcopal Hospital in Brooklyn, where a staff physician diagnosed a 6-month-old infant as having a common cold. The child turned out to have cerebral meningitis and is now paralyzed and blind.

The hospital, owned by a church foundation, is self-insured and ultimately settled the case for an undis-

closed sum.

The coalition says that huge malpractice awards, like this one, can be a major financial burden on self-insurers and raise insurance premiums for insured providers. They pass along this cost to consumers, which can raise employers' health care costs.

"Health care costs are a major concern of all employers in the state," says Raymond T. Schuler, president of the Business Council of New York State, a business trade group and a coalition member. "For that reason, the Business Council has made medical liability tort reform a major element of its 1983 legislative program."

If the package is enacted by the state Assembly, it would probably be the most comprehensive plan adopted by any state to curb malpractice claims. As a result, it is virtually certain to face stiff opposition from plaintiffs' lawyers.

The coalition says it also will propose amendments to the state constitution to make sure the program survives legal challenges if it is enacted.

Specifically, the proposal would:

- Cap punitive damage awards at \$100,000 per person and require courts to find "some objective mea-

Continued on page 19

Insurer boosts reserves in case reinsurers fail

By DOUGLAS McLEOD

PEAPACK, N.J.—American Centennial Insurance Co. of Delaware says two of its reinsurers are near insolvency, but it's prepared to cope.

American Centennial, a subsidiary of Beneficial Corp., announced last month that it is forming an \$11 million special reserve fund to pay claims should two of its reinsurers become insolvent.

At the same time, the company will add \$19 million to established reserves to cover losses throughout its book of business.

The \$30 million of reserves, amounting to about \$16.2 million or 73 cents per share after taxes, will be taken as a charge against Beneficial's fourth-quarter earnings, according to Andrew C. Halvorsen, Beneficial's senior vp for finance.

Beneficial expects to post a net loss for 1982 although it expects to report a profit on continuing operations, Mr. Halvorsen says, adding that the loss was not created by the new reserves at American Centennial.

By establishing the \$11 million special re-

ticker

serve, American Centennial has effectively "written off" its potential liabilities should the two unstable reinsurers go under, Mr. Halvorsen said.

The additional reserves reflect "the depressed state of the property/casualty underwriting cycle" and provide for "all known and unanticipated losses in American Centennial's book," according to an announcement released by the company.

The current competitive insurance market has apparently been felt acutely by the two reinsurers in question. Mr. Halvorsen would not name the reinsurers or reveal any details of American Centennial's involvement with them other than to say that one of the companies is an authorized reinsurer while the other is an unauthorized reinsurer.

According to its 1981 Schedule F filed with various state insurance departments, American Centennial cedes reinsurance to 111 authorized companies and to 56 unauthorized

companies. Ceded reinsurance for the first nine months of 1982 totaled \$79.5 million, compared with direct written premiums of \$59.1 million and reinsurance assumed of \$80.7 million.

Neither of the reinsurers has actually gone into receivership, but their condition is precarious enough for American Centennial to be worried, Mr. Halvorsen said.

"There are two companies that are weak, and we think it's prudent and conservative to provide for it," he said.

As required by state insurance regulations, American Centennial has maintained a trust agreement with the unauthorized company and has withheld funds to cover unearned premiums and loss reserves. But the funds set aside as security may not be sufficient to cover incurred-but-not-reported losses if the reinsurer goes under, Mr. Halvorsen said.

The portion of the \$11 million special reserve covering the unauthorized reinsurer would probably be applied to IBNR losses, he said.

Mr. Halvorsen would not say if a state guaranty fund would cover potential losses

should the authorized reinsurer collapse.

The \$11 million that American Centennial set aside in the special reserve constitutes the maximum net amount the company expects to lose if both reinsurers become insolvent, taking into account all funds that could offset the losses, according to Mr. Halvorsen.

American Centennial has been stung by the collapse of a financially unstable reinsurer before. One of its larger authorized reinsurers was Proprietors' Insurance Co. of Delaware, Ohio, which went into receivership in 1981.

Mr. Halvorsen would not comment on American Centennial's eventual loss as a result of that collapse. The company's 1981 Schedule F, however, showed nearly \$4 million in reinsurance recoverable on unpaid losses and \$529,625 in unearned premiums with Proprietors'. The statement also indicates that American Centennial took no reserve credit in 1981 for reinsurance recoverable from Proprietors', and that its gross and net loss reserves were increased to compensate.

Continued on page 27

Arizona, comp insurer battle over dividend cut

By BILL DENSMORE

PHOENIX, Ariz.—The Arizona Insurance Department is challenging a workers compensation insurer's refusal to pay an estimated \$700,000 in policyholder dividends to employers that declined to renew coverage.

The dispute arose over Mission Insurance Co.'s March 1982 decision to cut in half the dividends it would pay to the members of a group of Arizona contractors that decided to switch insurers. Mission did not cut dividends to members of the group that renewed coverage.

Arizona Insurance Director J. Michael Low says his department is close to resolving a similar dispute with Fremont Indemnity Co. of Los Angeles and is discussing the practice with Western Employers Insurance Co. of Santa Ana, Calif.

An Insurance Department examiner has been trying since last fall to hold a hearing on the Mission case, but disputes between Mr. Low and Mission have delayed the departmental review.

Now, the dispute has spread to a state court, where Mission is asking a judge to remove the department's hearing examiner for allegedly being biased against the Mission. The examiner recently denied Mission's request to take a deposition from Mr. Low, but granted the department's request to take depositions from company officials.

A hearing is scheduled for this week in Maricopa County Superior Court in Phoenix.

In the court papers filed by Mission, the insurer accuses Mr. Low of having an "unalterably closed mind" and being a "biased decision maker." Attorneys for Mr. Low respond that Mission's legal actions are "frivolous and made for the purpose of delay."

A Mission spokesman was reluctant to comment on the situation. But, he says, the company did not intend the dividend reductions as a penalty for non-renewal but rather as "an actuarially determined charge." Nonetheless, the company says it has ceased the practice pending the outcome of the regulatory hearing, although it is still withholding a portion of the dividends to the non-renewing contractors.

Mission explains there are valid reasons for reducing dividends for companies that do not renew their policies, although it does not cite reasons for the practice in the court papers and the spokesman refused to elaborate on them. However, the insurer contends other Arizona workers compensation insurers follow similar practices.

"What has transpired in Arizona... involves a difference of opinion on interpretation of laws," says the Mission spokesman, who accused Mr. Low of "regulating by accusation."

The amount of dividends returned to a workers compensation policyholder is based on several factors including the financial performance of the insurer, the policyholder's loss experience and the level of market competition.

In some states, work comp insurers are permitted by regulation to reduce dividends to policyholders that do not renew their coverage to take into

Continued on page 21

Amateur auditors

Employers give workers incentive to review hospital bills

By JAMES C. LAWSON

CHICAGO—The Illinois Central Gulf Railroad is hoping to turn its employees into health claims auditors.

Through a new health care cost-containment program, the railroad, a subsidiary of Chicago-based IC Industries Inc., will reimburse its 13,000 employees and their dependents for 25% of any overcharges they discover in their hospital bills.

The program, which went into effect Jan. 1, is designed to "get the employee more involved in the consumption of health services," while helping the self-insured employer trim hospital costs caused by overcharges, computer snafus and other hospital billing errors.

Company officials contend the so-called CARE (cost-aware recovery effective) program not only can produce savings, but is an attractive, positive cost-containment program that offers employees an incentive for trimming costs.

"Who can be a better claims auditor than an employee? Employees are the best auditors of their hospital bills because they know what care they did or did not receive," explains Kathleen H. Goepfinger, a corporate personnel coordinator for Carson Pirie Scott & Co., which began offering a similar incentive to eagle-eyed employees last September.

Officials at both companies say the incentive programs are designed to police hospital claims under \$10,000. Claims exceeding that amount are routinely examined by the employers or their claims administrators.

Under Illinois Central's new program, employees and dependents are urged to review their bills and work out any disputes directly with the hospital. To

claim a share of the savings from the railroad, the employee or dependent is required to submit copies of the original and corrected bills. The company will then issue an incentive check for 25% of the difference, explains Duane Stech, the railroad's director of compensation and benefits.

However, the railroad will not reimburse employees for catching overcharges of less than \$10.

While company officials say it's too early to determine how much the plan can save, they contend that employees can often reduce their hospital bills by 5% to 10% simply by reviewing them.

Careful review of hospital charges can save a substantial amount for a large employer, according to a recent survey by Equifax Services Inc., an Atlanta-based administrative services firm. That study revealed that 93% of 331 surveyed hospital bills contained some sort of error.

Most of the errors, according to the study, were contained in charges for services like laboratory tests, X-rays and blood work that were never administered to the patient.

"It's not uncommon for a patient to be billed for 100 pills while actually only receiving 10," explains Tony Cuccio, the designer of the CARE program and IC Industries' manager of benefits communication and cost management.

In addition to its new employee self-auditing program, the railroad is trying to restrict costly hospital admissions on weekends by not paying claims for weekend admissions that are not medically necessary.

Carson Pirie Scott's program is similar to Illinois Central's, except the Chicago-based retailer will allow its employees to collect 20% of billing errors

Continued on page 13

Hospital bill	
X-rays	✓ \$335.00
Physicians' visits	✓ \$135.25
Medication	\$25.00 ?? <u>\$75.00</u>
Therapy	✓ \$562.35
Lab tests	✓ \$92.50
Total:	<u>\$1,200.10</u>

Graphic: Jim Bakasetas

Critics say proposed fronting ban is illegal

By LEN STRAZEWSKI

NEW YORK—Insurance Department officials are still evaluating a storm of objections to proposed regulation of unlicensed and fronting reinsurance agreements.

Regulation 82, proposed late last year, would severely limit the use of unlicensed reinsurance in New York and virtually eliminate fronting arrangements between corporate captive insurers and locally licensed insurers without prior regulatory approval (BI, Jan. 10).

At a public hearing last month, 23 witnesses roundly attacked the proposal. And, the insurance department is still accepting comments.

The key question, according to the testi-

mony and comments:

Would such regulation be legal?

Certainly not, Donald J. Greene, senior partner of the law firm of LeBoeuf, Lamb, Leiby & MacRae, told the department.

Mr. Greene, a recognized authority on insurance law, is the general counsel for Lloyd's of London in the United States.

"We have considered the legality of the provisions of proposed Regulation 82 on two separate levels, and it is our opinion that the superintendent has no statutory authority to prohibit reinsurance with unlicensed insurers and that the superintendent's attempt to regulate reinsurance agreements with unlicensed insurers effected outside the state violates the U.S. Constitution."

The proposal, backed by Insurance Su-

perintendent Albert B. Lewis, covers a subject specifically excluded from regulation in several parts of the state insurance code, Mr. Greene pointed out. Thus, the code itself would have to be changed before the regulation could be adopted.

"The superintendent of insurance has no power to legislate by regulation. The power to prescribe regulations, as delegated by the Legislature, is limited to prescribing regulations 'not inconsistent' with the statutory provisions of the law. Regulation 82 is inconsistent with those provisions and thus is invalid," Mr. Greene wrote in a legal memorandum to state regulators.

The proposed rule also violates the due process provisions of the U.S. Constitution, he also pointed out.

"It is well-settled that the due process clause denies to the state (the) power to tax or regulate a corporation's property and activities elsewhere," he explained. "Proposed Regulation 82, as presently drafted, seeks to regulate and restrict interstate and international commerce by dictating the terms under which licensed insurers may reinsure their New York risks with unlicensed insurers."

"It attempts to accomplish this in spite of the fact that the unlicensed insurers are located outside the state of New York and conduct their business outside of the state's boundaries."

Jon Harkavy, director of governmental affairs for the Risk & Insurance Management

Continued on page 10

Some cost-control measures save little

Continued from page 1
notes Mr. Glueck. "But as far as we know, this is the first time anyone has attempted this comprehensive a study. Even considering the geographical limitations, the cost containment revelations seem very significant."

The consultants asked the 94 employers to rate the effectiveness of cost-containment techniques in five broad areas: plan design changes, plan administration, utilization review, data analysis, and other (see chart, page 1).

The employers rated the techniques on a scale of 1.0 to 4.0: one point indicating the cost of the measure exceeded the savings; two, the cost equaled the savings; three, the technique produced a slight net savings; and four, the technique brought significant medical cost savings.

The category of plan design changes showed the most success in saving money.

The most common strategy initiated in this area (and among all areas) was adding benefits for pre-

hospital admission testing. About 46% of the group has implemented this change.

The results have been good but not superior, at a 3.4 rating. But, only about 18% of those who have instituted pre-admission testing have actually measured the financial impact.

But, inclusion of benefits for hospices—non-hospital care for the terminally ill—received the best rating among plan design changes. It was tried, however, by only 5% of

the respondents, or about four employers.

The one employer that measured the success of the program said it generated significant savings for a perfect score of four points. Despite this high rating, about 70% of the total group surveyed said they never even considered hospice care benefits.

Three more popular plan design changes also had high cost-efficiency ratings. Both increases in deductibles, implemented by about 30% of the respondents, and coin-

surance increases, implemented by more than 20%, had nearly perfect scores of 3.8 points.

Both techniques were measured by more than three-quarters of the employers that used them, the survey says. And, a majority of the remaining group of employers reported that they have considered or were planning on trying the increases.

Outpatient surgery benefits, attempted by about 40% of respondents but measured by only a few, also scored well with 3.5 points.

Of the plan design choices, only voluntary second surgical opinion plans did not produce even a slight overall savings, according to those surveyed, even though it was one of the more popular choices and one of the most frequently measured.

Voluntary second opinion plans, chosen by more than 35% of the respondents and measured by several employers, got only a 2.8 rating, over the break-even point, but slightly under a noticeable savings.

Plan administration and utilization review changes also yielded some significant savings, according to the survey, but some serious disappointments, too.

More commonly measured than plan design changes, the plan administration cost containment measures included coordination of benefits improvements, policing of reasonable and customary charges and claims audits of various sorts.

Coordination of benefits changes, implemented by more than 25% of respondents and measured by most of them, scored a high 3.7 points, indicating solid savings. And, R&C policing, used by about 20% and also well-measured, scored an attractive 3.6 points.

Auditing changes, however, produced a more disappointed response. Audits of hospital bills only, implemented by about 40% of respondents and measured by a majority of those who tried it, scored

Continued on page 6

THIS IS THE WRONG TIME TO FIND OUT YOU DON'T HAVE THE RIGHT INSURANCE.

It's too late after your business burns down or your store is vandalized.

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Effectiveness of cost-containment techniques

Utilization review

Retrospective review	4.0
Concurrent review	3.5
Pre-admission certification	3.0

Data analysis

Admission rates	2.5
Surgical frequency	2.5
Length of stay	2.3

Other

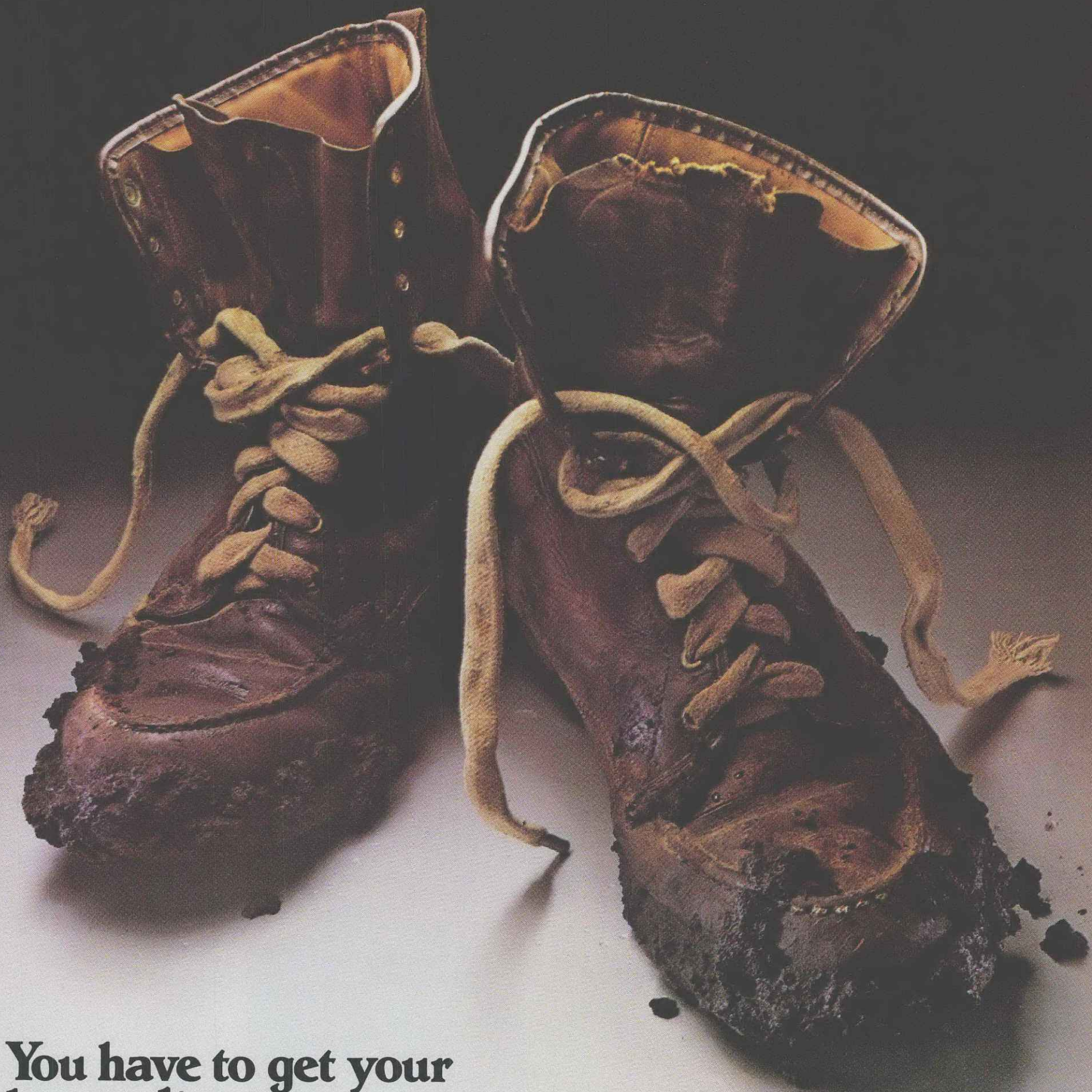
Changes in financing	3.8
Employee communications	3.5
Employee contributions	3.5
System intervention	3.3
Coalition memberships	2.0

Key

- 1—Cost exceeds savings
- 2—Cost equals savings
- 3—Slight net savings
- 4—Significant net savings

Source: Towers, Perrin, Forster & Crosby

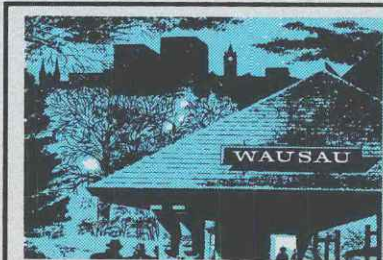
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Some cost-control efforts save little

Continued from page 4

only 3.1 points, indicating only slight savings. General claims audits, conducted either internally or by outsiders for more than 20% of respondents, yielded scores just above the break-even point.

Utilization reviews of various sorts, including pre-admission certification, concurrent reviews and retrospective reviews, all conducted by less than 10% of the survey respondents, received consistently high marks from the employers that measured results.

Though pre-admission certification generated only slight savings for a 3.0 rating, retrospective reviews showed significant cost effectiveness and scored a perfect 4.0 points.

Data analysis techniques, attempted by about 20% of respondents and measured by about 20% of those who tried them, received generally poor marks. Length of stay, admission rates and surgical frequency studies all scored just above the break-even point. In

spite of the generally poor rating, more than 15% of respondents said they planned to implement data analysis techniques in the near future.

Consistent with these plans, nearly 50% of survey participants reported a desire for more assistance from their (insurance) carriers in the area of data analysis, points out TPF&C's Mr. Abernethy. "Companies also requested more assistance with utilization review programs, hospital audits, general plan design changes and

coordination of benefits improvements."

Among other cost-containment techniques, changes in financing, usually representing a switch to self-funding or a minimum premium plan, had a superior rating. Attempted by more than 40% of the respondents and measured by three-quarters of them, financing changes scored 3.8 points, or noticeable savings overall.

Employee communication efforts, attempted by about 30% of re-

spondents, but measured by only a few employers, also scored well with 3.5 points.

Health care cost-containment coalitions were also popular among those employers surveyed, with about 30% joining. However, the employers who measured their cost effectiveness, about 10% of those coalition members, rated the technique 2.0 points, or a break-even investment.

"Surprisingly, most survey participants do not plan major new activities in the area of health care cost containment," noted Mr. Abernethy. "This may be because the majority of participants have already implemented those strategies which they believe are cost-effective at present."

However, the issue of health care costs is far from dead, according to the survey.

About 44% of participants said that they considered health care costs to be high and an additional 17% of participants called health care costs "excessive." Moreover, nearly 60% of the those completing the survey, usually employee benefit managers, said that their senior management considered health care costs to be high and about a quarter said that senior management thought medical costs were excessive.

comings & goings buyers

John Skjoldahl to head safety at Indian Head

John C. Skjoldahl was appointed to the new position of safety and loss-prevention manager at Indian Head Inc. in New York. Mr. Skjoldahl will develop loss-prevention programs for fire, accidents, occupational health hazards and property damage. Prior to joining Indian Head, Mr. Skjoldahl was a senior loss-control consultant with Kemper Insurance Group in Long Grove, Ill., and a staff manager of loss-control administration at Atlantic Mutual Insurance Co. in New York. He received a bachelor of science degree in engineering from Iowa State University in Ames and a master of arts in occupational safety and health from New York University. Mr. Skjoldahl is a Certified Safety Professional and a member of the American Society of Safety Engineering and the Society of Fire Protection Engineers. He reports to Patrick T. Cahill, director of risk management.

Pam Rogers, 21, was appointed liability risk analyst, a new position, at General Motors Corp. in Detroit. She will determine exposure and handle risk for the company. Before joining the company, Ms. Rogers attended the University of Georgia in Athens where she received a bachelor of business administration degree. She is a member of the honorary Gamma Iota Sigma. Ms. Rogers reports to Mike Fuller, manager of corporate risks.

We'd like to report on staff changes in your risk management or employee benefits department. Just drop a note to Sallie J. Drury, Editorial Assistant, Business Insurance, 740 N. Rush St., Chicago, Ill. 60611, or call 312-649-5398. We would also like to receive photographs.

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opinions

It can pay to add them up

THE IDEA IS so simple, so logical and so good that it's hard to believe everyone isn't doing it already.

We don't know who originally came up with the plan, but both Illinois Central Gulf Railroad and Carson, Pirie, Scott & Co. are paying their employees to spot overcharges in their hospital bills and have those errors corrected (see story, page 3).

Basically, at both companies, employees are encouraged to review hospital bills not exceeding \$10,000 before they are paid. If they find overcharges, they are to work out the differences directly with the hospital. The workers then bring a copy of the original bill and the corrected bill to the company benefits department and are paid a percentage of the savings.

What a great idea!

First, the patients or their families are the most logical parties to debate what did or did not happen in the hospital. They will make the better "auditors" because they should have a much better knowledge of what medication was given, what tests were taken and what therapy was ordered.

Second, by offering to pay employees to find billing errors, the program provides the perfect incentive for employees to pay attention to the cost of their health care. How many people simply ignore specific charges on their hospital bills because they are sure their health benefits will cover them?

Third, if the idea really catches on with employees, it will save the company from auditing the bill itself or hiring someone else to do it. Obviously, huge bills will have to be professionally appraised, but an employee review probably will suffice for the average hospital bill—or at least it will be a real good start.

Illinois Central believes the employee audit program will reduce its employees' hospital bills from 5% to 10%. That should be enough incentive for other companies to give a similar program a try.

But before you launch this type of program, we suggest you invest a little time and money to educate your employees about the incentive program, explain the procedure for collecting the "reward" and tell them

how to spot billing errors.

Give them some guidelines on what particular areas of the bills they should check, explain to them what the different abbreviations and codings on the bills mean, tell them the kind of things that would raise the eyebrows of a professional claims auditor, tell them what department to call at the hospital if they find a billing discrepancy and suggest how to effectively deal with the hospital's bookkeeping department.

The best way to communicate this information would be by mailing some written guidelines and tips to the employees' homes, suggesting that they share the information with other family members and then file the memo or brochure in their employee benefits handbook for later reference. That way, if the patient is too sick to care about the specifics of his treatment, another family member will know what to check.

Finally, let local hospitals know that your company has initiated such a program and that they can expect to be hearing from your employees. That gives the hospitals fair warning so they won't try to brush aside queries from your "amateur" auditors.

Too many questions

Why can't Washington benefit regulators do their homework?

The list of quick-fix laws and regulations governing benefits that—no matter how well-intended—raise more questions than they answer is growing weekly.

Now we have a proposed cap on the tax-free status of group health plans without a clue as to how employers who self-fund health benefits should determine the costs of their plans.

Employers already don't know if they must extend equal benefits to the spouses of workers and how they should provide health benefits to workers over 65, just two recent examples of benefit laws that didn't anticipate all the ramifications.

Regulators should ask what-if questions about their regulations and have the answers ready.

letters

Flexibility within certain limits

To the editor: The Perspective article, "Flexibility is key to writing bid specifications" (BI, Dec. 20, 1982), by Jeffrey Segall omits several key points of interest to insurance buyers.

A primary objective of a bid specification should be to outline minimum levels of brokerage experience, insurer security and coverage details acceptable to the buyer. Flexibility is essential, however, only in sophisticated extensions of coverage, services and cost of risk offerings beyond fundamental levels of protection. In the area of fundamental protection, we see flexibility as a threat, not a "key," to well-written proposal guidelines.

Risk identification and exposure data sections, including loss history, should include complete basic information, according to the best efforts of the buyer or independent consultant. Such information cannot be expected to supplant bro-

ker/insurer exposure review, resourcefulness, nor innovation in providing underwriting sources the information they need. The risk bearer ultimately is accountable for determining the scope, character and nature of the risk to be assumed, its ability to accepting such risks and the terms and conditions under which it would provide insurance.

The broker and/or insurer that is willing to accept bid specifications and submit proposals without conducting its own exposure review, loss analysis and coverage form review to tailor coverage to buyer needs is probably selling primarily price, which at the expense of coverage and broker/insurer service, can be disadvantageous to the insurance buyer.

Paul W. Pinckney
Vp

Mund, McLaurin & Co. of Los Angeles
South Pasadena, Calif.

Let's hear it for wage-loss systems

To the editor: Hooray for Louisiana in passing a wage-loss system for workers compensation (BI, Jan. 24). We in Florida have reaped the benefits of this approach for almost four years. Those truly injured receive support under the law. Rehabilitation and the minimizing of "washouts" have helped employer and employees.

Management and labor are still strong supporters of wage loss because premiums have been reduced while benefits have been increased.

C'mon other states...have some fore-

sight and join the bandwagon! Workers compensation was designed initially to eliminate the need to prove negligence, thus reducing adversary employer/employee relationships. Somewhere along the way we lost sight of that.

Thanks to the legislators in Louisiana (and, of course, Florida), we are back on track.

Lawrence J. Babbitt
Director of risk management
Jack Eckerd Corp.
Clearwater, Fla.

Enhancing our reputation

To the editor: In your article "Cayman Secrecy ruling may not affect insurers" (BI Jan. 24) your reporter places emphasis in the wrong place.

Why is it surprising that the Justice Department succeeded in obtaining the information they sought? For the first time, they respected our laws and followed the proper procedures as laid down in our laws. It's yet another illustration that "there's a right way and a wrong way of doing everything."

Rather than having our laws weakened, I would think that our reputation is enhanced. We do not want criminals, either.

Roger Corbin
Absit Insurance Management Ltd.
Grand Cayman, B.W.I.

Absurd jibberish

To the editor: I read with interest your editorial entitled "Snuffing out smokers" (BI, Jan. 17). This has got to be the most absurd jibberish I have seen in your publication.

I'm certain your non-smoking employees have a high degree of respect and regard for their editor who "offers her office as a haven for smokers."

Kenneth L. Bazzle
Atlanta

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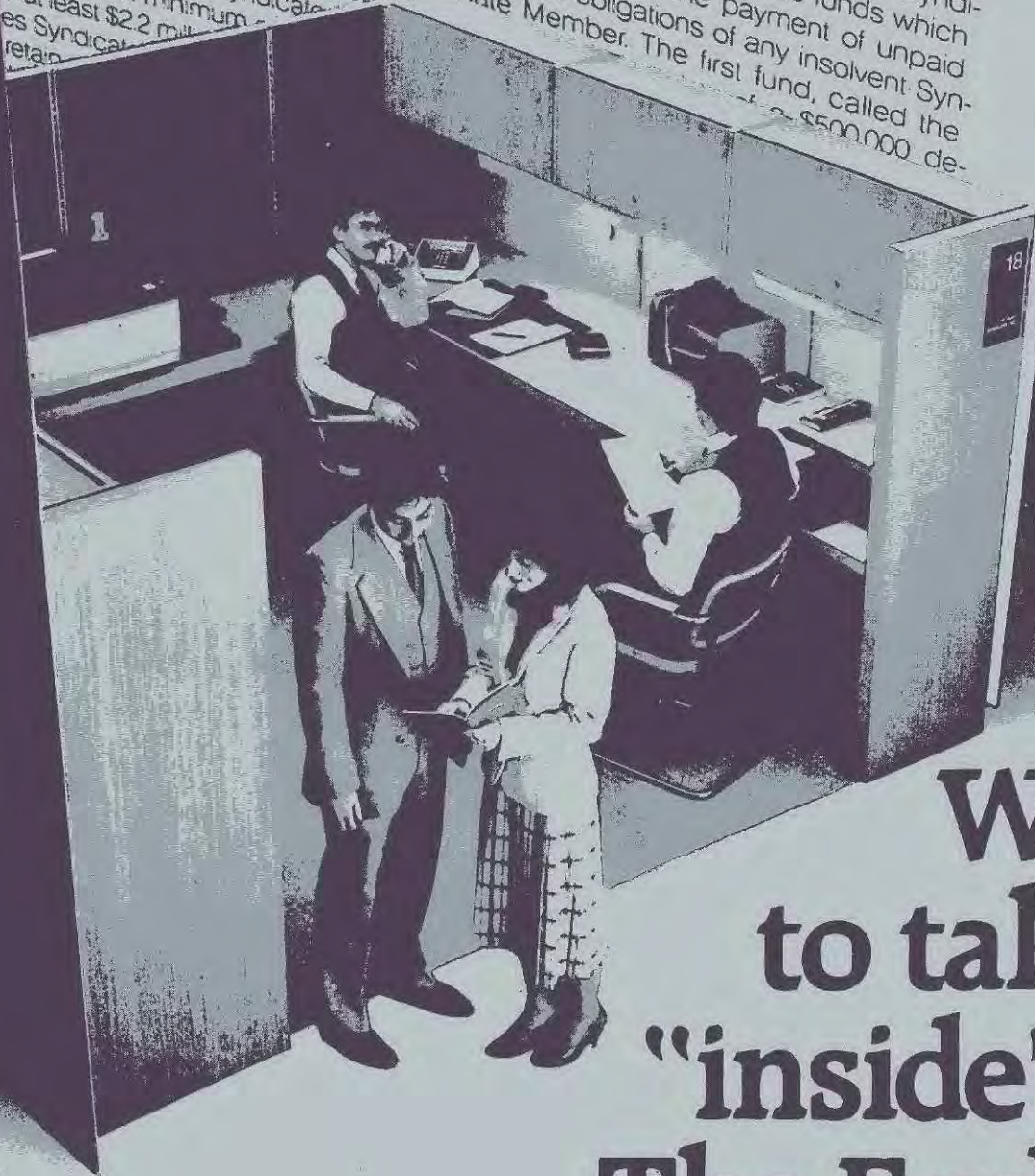
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Reinsurers could accept rule

NEW YORK—Reinsurers, the group that would be most affected by New York's proposed Regulation 82, would be willing to support the rule if changes are made, according to the Reinsurance Assn. of America.

Franklin W. Nutter, president of the trade group, told regulators that his association supports in principle the "philosophical thrust" of the proposed rule, but could not support it in its present form.

"As applied to property/casualty reinsurance, we believe the proposal is vague, overly broad, lacks sufficient standards and is inconsistent with the statutory scheme for the regulation of unauthorized reinsurance," Mr. Nutter testified.

However, the RAA said the regulation deserves reconsideration if these changes are made:

- Fronting should be expressly defined in such a way as to insure that the ceding company is retaining risk in connection with the transaction. This could be accomplished, for example, by regulating how much premium could be ceded to the unlicensed reinsurer.

- The regulation should not be applied to the retrocessions of reinsurers licensed, authorized or accredited in New York.

"With these changes, we believe that the clear problems with the regulation, specifically its vagueness in part, the requirement for approval of contracts, the lack of a clear understanding of what constitutes a New York risk and the applicability of it to multiple reinsurer arrangements, will dissipate," Mr. Nutter said.

Fronting proposal comes under attack

Continued from page 3
Society, agrees.

"The state of New York has the right to regulate such (interstate) commerce only to the extent that it affects New York residents and for the legitimate purposes of protecting New York residents," he noted in testimony on behalf of RIMS members.

"No such legitimate basis exists here. The non-licensed insurers at which Regulation 82 is directed have no contact with the public and are being relied upon by a knowledgeable policyholder to fulfill a financial function beyond the regulatory control of the state.

"If there were an adverse effect on the claims function of the fronting carrier, clearly the superintendent has ample regulatory authority to control the situation through the fronting carrier."

The proposed regulation would also seriously disrupt the use of captives as reinsurers of local policies, Mr. Harkavy added, to the detriment of parent companies that use captives and fronting insurers to fund and service risks that insurers have previously been reluctant to accept.

"The parents of captives are all public companies and, far from being disinterested spectators, they have every incentive and are doing everything possible to make sure these captive insurance companies are solid. Moreover, the fronting company has every incentive for controlling the correctness and the financial soundness of the captive. If it cannot collect the premium, it is responsible for losses."

The Insurance Department, he continued, already has full regulatory control over fronting insurers

to guarantee that the public is protected.

Other speakers told regulators that proposed Regulation 82 also carried other practical disadvantages, not the least of which would be the disruption of insurance market competition.

The National Assn. of Insurance Brokers, for example, called the proposal "totally counterproductive and anti-competitive."

"To promulgate Regulation 82 regrettably turns back the clock on productive efforts throughout the United States to deregulate commercial insurance markets," said Donald L. Jordan, the NAIB's executive director. "And at one stroke, a highly efficient method of structuring risk management programs would be made illegal based on specious administrative reinterpretation of existing and time-tested regulatory language."

The rule would also be ineffective and unnecessary to combat cases of reinsurance fraud, like those that have been attributed to former reinsurance intermediary Jack V. Goepfert, who has been convicted in both New York and Pennsylvania (BI, Dec. 6, 1982).

"Certainly, we've seen visible, yet isolated, instances of insurance fraud and carrier insolvency. We have not seen evidence either to suggest that such problems are widespread or to demonstrate that a major realignment of current regulatory authority is in the public interest," Mr. Jordan said.

Other brokers echoed Mr. Jordan's remarks. Joseph Fahys, senior vp of Marsh & McLennan Inc., the nation's largest insurance brokerage, voiced his company's negative reaction to the proposal.

"We feel very strongly that the existing promulgated statutes and insurance rules on the regulation of solvency adequately protect the insurance-buying public in the state of New York and that current regulations pertaining to recoverable reinsurance are sufficient.

"The unauthorized reinsurance funding requirements provide the insurance market with additional incentive to investigate and monitor the financial conditions of its reinsurers," he continued.

Mr. Fahys also noted that restricting the use of captive reinsurers to situations approved by the superintendent of insurance would also create:

- Unnecessary additional work and expense for insurers.
- Wasteful staffing and administrative costs in the Insurance Department.
- Time delays.
- An additional cost to already-too-expensive insurance.

"Given the broad scope of the proposed regulation, compliance and enforcement would consume thousands, perhaps millions, of dollars," added Robert V. Hatcher, chairman of Johnson & Higgins, in a letter read on his behalf at the Jan. 19 hearing.

Insurers also attacked the proposal, pointing out a potential economic impact on New York and its residents.

"Reinsurance and commercial insurance transactions would grind to a halt in New York or flee the state's borders" if Regulation 82 were adopted, said Wesley S. Caldwell III, regional vp of the American Insurance Assn.

Self-insurance or no insurance would be the likely replacements for disrupted fronting arrangements and reduced insurance capacities, added Frank Snook, special risks officer for Kemper Group.

"We believe that the people of New York are better protected by the insurance and reinsurance in question than by self-insurance and non-insurance," he said.



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Dallas employers offer child care benefit

Several Dallas employers, including Southland Corp., the Dallas Times Herald and RepublicBank Dallas, are offering a new child care benefit program.

The program, offered through Child Care Dallas, a non-profit agency providing child care services in private homes, is partially funded by a \$211,654 grant from the U.S. Department of Health and Human Services.

Child Care Dallas is contributing \$44,000 toward the cost of the program, while participating employees will pay the rest of the cost, \$49 per child weekly. Currently, the participating employers are not contributing directly toward the program's costs.

However, when the grant expires in two years, CCD will ask participating employees to fund a portion of the program, said Roberta Bergman, project director of Child Care Dallas. She added that CCD is trying to line up more employers to participate in the program.

Child Care Dallas collected information from employees at the participating companies on their child care needs. CCD then set up child care arrangements in 36 private homes in the Dallas area to provide care for up to 125 children.

Participating employees at the Dallas Times Herald will pay their share of the program's costs through payroll deduction, said Mary Trossen, employee relations manager. As of Jan. 19, five active employees, plus two other workers on maternity leave, indicated an interest in the CCD program.

The program is open to all 1,500 full-time Times Herald employees.

"We're looking at child care as something employers will have to pay attention to," explained Ms. Trossen.

Only 11 of the 1,200 employees at Southland Corp.'s headquarters, all of whom are eligible for the benefit, have said they're interested in the program, but the company has reserved 25 places in the program, said Dian Boyd, a company personnel specialist. Southland employees will pay CCD directly for the cost of the program.

Southland presented the program to its employees in November and expects the program to commence this month, a company spokesman said.

Southland will weigh several factors—including convenience, improved employee attendance, quicker return to work after maternity leave, quality of child care and employees' peace of mind—to decide whether to continue the benefit after the grant expires, the spokesman said.

Some 3,300 employees at RepublicBank Dallas are eligible for the child care benefit, which it publicized in the company newsletter in October, said Beth M. Brown, employee relations administrator. More than 60 employees attended a meeting explaining the benefit and 27 have shown a real interest.

The bank has reserved 16 spaces in the program, Ms. Brown said. Employees must pay their fees in advance directly to CCD.

Ms. Brown said the bank has not yet decided whether to fund the program when the grant expires.

Early retirement

R.J. Reynolds Tobacco Co. in Winston-Salem, N.C., is asking more than 10% of its full-time cigarette production workers to take early retirement in February.

The company, a division of R.J. Reynolds Industries Inc., said 1,800 of its nearly 18,000 workers are eligible for the one-time early retirement option. The eligible employees, who were notified of the "voluntary separation" option on Jan.

benefit beat

20, have until Feb. 17 to decide to take retirement.

Employees who are 55 years old with a minimum 10 years of service or those age 65 before March 1 may elect to retire by the Feb. 17 deadline. Employees who opt for early retirement will receive a year's salary in addition to their regular retirement benefits.

Benefits vary according to length of service at the time the retirement option is taken. Those employees younger than 65 will receive reduced retirement benefits, although those 55 years old with 30 years of service, as well as those who are 65 or older, are eligible for a full pension.

The company also plans to reduce its production schedules from five to four days a week.

Health cost sharing

Workers at McLouth Steel Corp. in Detroit are now paying a portion of their medical coverage costs.

Under a new contract, members of United Steel Workers now must pay one-third of the monthly premium Blue Cross & Blue Shield of Michigan charges for the coverage—\$31.34 for individual coverage, \$79.34 for coverage for a worker and a spouse and \$86.07 for family coverage. The company pays the remainder.

However, employees can escape monthly premium payments by joining one of three health maintenance organization options the company is offering for the first time. The three providers are Independent HMO, Health Alliance and Health Care Network.

The new medical care options were part of a new five-year contract approved by two USW locals representing McLouth employees. Some 77% of the workers in the two locals voted for the contract, a USW District 26 spokesman said.

The USW members had two weeks to choose between the BC/BS or HMO coverage.

The company currently employs about 1,500 workers, with about the same number of employees on indefinite layoff.

The new contract was negotiated

after the steel company was acquired by Tang Industries Inc. of Elk Grove Village, Ill. McLouth Steel has been operating under provisions of Chapter 11 of the Federal Bankruptcy Act since December 1981.

In exchange for the benefit cut-back and delays in cost of living salary increases, a new profit-sharing plan will distribute 15% of any pretax profits earned to the entire McLouth workforce.

In addition, 900 retirees will once again have their medical insurance premiums paid by the company. The benefit was eliminated early in 1982 by the bankruptcy court.

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Senate committee to consider Social Security bill this month

By JERRY GEISEL

WASHINGTON—Legislation to save the Social Security system from financial collapse is the first bill out of the Senate gate.

The Social Security Amendments of 1983, S. 1, introduced by Sen. Robert Dole, R-Kan., with nine Republican and Democratic co-sponsors, incorporates the recommendations made by President Reagan's bipartisan National Commission on Social Security Reform.

"The consensus reached by the national commission holds the potential for marking the end of a bitter period of political partisanship," Sen. Dole said.

The Senate Finance Committee, which Sen. Dole chairs, will begin hearings on the legislation on Feb. 15. "Moving quickly to shore up the nation's largest domestic program is in all of our interests," he added.

Recommendations made by the Social Security commission include accelerating payroll tax increases, taxing half of Social Security benefits received by those with incomes exceeding \$20,000, mandating coverage for non-profit employers and new federal employees and preventing local and state governments from leaving the program (BI, Jan. 24).

washington

OSHA inspections

The Occupational Safety and Health Administration conducted 61,225 worksite safety inspections in fiscal 1982, up 7.4% from the 56,998 inspections in fiscal 1981.

OSHA said it reduced the number of follow-up inspections in fiscal 1982, which ended Sept. 30, to 11,587, down from 11,670 in 1981.

"This was a planned reduction because past experience shows that more than 99% of follow-up inspections do not reveal 'failure to correct' violations," OSHA says.

Older worker bonus

Employers would have to give pension credits to workers who stay on the job after age 65 under legislation introduced last month by Sen. Alan Cranston, D-Calif. Currently, many pension plans do not give employees added pension benefits for working past a company's normal retirement age, which is usually 65.

In addition, the Employment Opportunities for Older Americans Act, S. 2, also would eliminate mandatory retirement at any age.

Under 1978 amendments to the Age Discrimination in Employment Act, companies currently can force workers to retire at age 70.

"An older worker's ability to perform a job and the desire to continue working—not his or her birth date—should be the determinative factors in retirement decisions," Sen. Cranston said.

A Labor Department study says that 200,000 workers would stay on the job after 70 if mandatory retirement ages were abolished.

Health care costs

The cost of medical care continues to outpace the Consumer Price Index.

During 1982, medical care costs jumped 11%, nearly three times as much as the 3.9% rise in the CPI,

the Bureau of Labor Statistics says.

Among individual medical-care components, hospital room rates climbed 13.3%, prescription drugs rose 12%, while physician fees increased 7.5%.

Plan terminations

Employers that want to terminate their pension plans now have to file an official notice with only one federal agency.

Under a new regulation, a plan administrator can file IRS/PBGC Form 5310 with the Pension Benefit Guaranty Corp. to inform the federal pension agency that it intends to terminate a plan.

Previously, plan administrators were required to furnish 26 items of information, without the benefit of a form, when notifying the PBGC of its intent to terminate a plan. In addition, a separate notice had to be filed with the Internal Revenue Service.

Copies of the form may be obtained from the PBGC, Branch of Control (542), 2020 K St. N.W., Washington, D.C. 20006.

Pension coverage

Employers would have to cover workers between 21 and 25 in their pension plans if Congress passes a bill, S. 19, proposed last month by Sen. Robert Dole, R-Kan.

At the present time, employers with pension plans only have to cover workers who are at least 25 and have worked at least one year on the job.

A lower pension participation age would particularly benefit women, who often begin working after high school or college and then take time off several years later to have children before returning to work.

"Although they (younger women) work faithfully for their employer on a full-time basis, they are not earning any credit for retirement benefits," Sen. Dole said. ■



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Companies pay workers to check hospital bills

Continued from page 3
they find, up to a maximum of \$100 per hospital stay.

Carson's, like Illinois Central, will not reimburse employees for billing errors of less than \$10.

Carson's plan, which currently is being offered to 7,000 of its Midwest retail employees, is just a portion of its new self-insured health care program that went into effect Sept. 1, 1982. The incentive program, though, may be extended to employees of other Carson's units in the future.

Also, Carson's could increase the amount of the incentive depending on the success of the program, says Ms. Goeppinger.

The claims-auditing program is just one of several health care cost-containment strategies the retailer is employing.

In December, for example, Carson's added a mandatory second-surgical opinion program. Under that program, Carson's self-insured plan will only pay 50% of the cost of certain elective surgeries if a second opinion has not been received. If the employee seeks a second opinion, the plan will cover the usual 80% of the cost the procedure.

Carson's also is giving employees an incentive to have certain surgeries performed on an outpatient basis. The company will pay 100% of the cost of procedures like cataract operations, tonsillectomies, breast biopsies, tubal ligations and some circumcisions if the employee does not check into the hospital.

Meanwhile, two other large Midwestern firms are putting the final touches on employee audit incentive programs they hope to introduce later this year.

Pillsbury Co., a Minneapolis employer of 60,000, expects to introduce its employee audit incentive program in about two months.

Pillsbury officials decline to discuss details of the program until it has been communicated to employees, but they indicate their program will be simple and will offer employees an attractive incentive for scrutinizing their own hospital bills.

In addition, a Midwestern-based Fortune 500 employer of 71,200 is planning to give 6,000 of its Chicago-area employees 50% of any billing errors they find, up to a maximum of \$1,000.

The firm, which asked not to be identified because it has not revealed details to employees, says that if this pilot phase is successful, the program could be extended to employees across the country.

"We're not looking for dramatic

cost reductions," the company's benefit manager says, "but we feel this will help trim some costs. We see it as a more positive cost-containment measure than introducing higher deductibles and more coinsurance. By introducing this to our employees, we feel we will be involving them in the cost of health care."

"This is just one piece of our total effort to save dollars."

The company, the benefit manager explains, is considering other cost-containment measures. It recently completed a move to self-insure health coverage for employees of the parent company and may eventually self-insure health programs for employees at its subsidiaries. ■

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The First Boston Corporation

January 21, 1983

RIMS to offer course in Atlanta

ATLANTA—The Risk & Insurance Management Society will offer its "Techniques of Risk Management" course March 21-23 in Atlanta.

The course, a survey of the principles of risk management, is ideal for those desiring a comprehensive review of risk management principles through practical applications.

The course will be taught by Larry D. Gaunt and William R. Feldhause, two insurance and risk management instructors at Georgia State University.

The registration fee for the course is \$345 for RIMS members and \$445 for non-members.

For more information, contact Claudia Schnider, RIMS Schools Administrator, Risk & Insurance Management Society, 205 E. 42nd St., New York, N.Y. 10017; 212-286-9292. ■

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ONCE AGAIN THE ANSWER IS AIG.

FUTURE INSURANCE REGULATION

By W.H.L. Woodyard III

This memo, now public record, is part of the examination into the affairs of National Investors Life Insurance Co. and National Investors Pension Insurance Co. conducted by the Arkansas Insurance Department (BI, Nov. 1, 1982).

The recent examination of National Investors Life Insurance Co. and its principal reinsurer, National Investors Pension Insurance Co., both domiciled in Arkansas, brought to light situations and practices of general interest to insurance regulation. The purpose of this memo is not to explicate the reports of the examination, which speak for themselves and which were prepared solely by the Arkansas and zone examiners and filed Dec. 31, 1982. It is to call attention to practices and issues of possible importance to insurance regulation in the future.

The concept of capital in an insurance enterprise is that of a cushion against misfortune. It is also a restraint, through regulatory accounting, upon very rapid growth, itself often a source of misfortune.

The most rapid growth of the life insurance industry was in the 19th century, before statutory accounting, indeed, before meaningful regulation of insurance. Some of the great life insurance companies of today grew so fast during that period that they would have fared badly under today's regulatory accounting.

Today, we have an accounting system that charges immediately against earnings all costs of putting a policy on the books, while spreading income from that policy over its duration. That rule has many important implications for the life insurance business today, only one of which is for single-premium deferred annuities.

Since SPDAs are sold with a front-end commission, as well as the usual costs of putting a new account on the books, the faster a company sells SPDAs the more it invades its own surplus.

The rules about growth and surplus are significant because SPDAs have sold very fast, perhaps faster than any life insurance product since the preregulation days of the 19th century. People, some unsure about Social Security and private pension plans and others anxious to shelter investments from taxes, wanted to buy them to annuitize their savings. Stock brokers, then in a slow market, wanted to sell them to earn commissions which, although low by life insurance standards, nonetheless looked adequate by the standards of the investment world.

The effect of all those forces and rules was an unexpectedly large sale of SPDAs and, accordingly, an unexpectedly large drain on the surplus of the insurance companies selling them.

As is often the case with insurance companies selling new coverages, the big sellers of SPDAs were not the large, established companies. They tended to be smaller and unconventional companies, among them the Baldwin-United Corp.

W.H.L. Woodyard III is the former Arkansas insurance commissioner and is now with the law firm of Mitchell, Williams, Selig, Jackson & Tucker in Little Rock, Ark.



As the industry becomes more complex, regulators will have to improve methods

companies of NILIC and NIPIC.

The companies did not have accumulated surplus to support the SPDA growth, nor did they have a mature book of SPDAs or other life insurance business to balance it. Hence they needed to create new capital. The reports show that the companies had a combined surplus of \$114 million as of Sept. 30, 1982.

They used four methods, and the emphasis of one over another has been at the heart of the Insurance Department's work, and occasional clashes, with the Baldwin-United management over the past year.

First, they invested in conventional, marketable and unrelated assets. That caused no problems for the Insurance Department. Such assets cover the cash values of the SPDAs, although not the full reserve liabilities (when the SPDAs annuitize) or the supporting surplus.

Second, they issued securities from one Baldwin-United affiliate to another, where the value of the affiliate would be independent of the circumstances of the insurance company. Our concern was about the value of the affiliate's stock or debt if the need to liquidate them arose. For example, MGIC Corp. and Baldwin Piano Co. are valuable businesses standing on their own. Our general practice was to accord such securities some value, but to follow the valuations of the Securities Valuation Office of the National Assn. of Insurance Commissioners.

Third, the companies issued securities to each other whose value seemed to us entirely dependent on the viability of the Baldwin-United enterprise as a whole. In that category were parent debt to insurance subsidiaries and reinsurance between affiliated insurers. That is not to say the transactions were illegitimate or illegal, but we were concerned about their value and liquidity under pressure. We either did not admit them or referred them to the Securities Valuation Office and abided by its valuations.

Fourth, the companies entered into or proposed transactions designed to generate present surplus at the sacrifice of future income. In insurance regulation, such transactions are known as "surplus relief" transactions. They include actual or proposed reinsurance, rerouting of cash flow, commission financing, real estate partnerships and the sale of assets. Some of Baldwin-United's ideas in this field are the most ingenious we have ever seen. We approved some transactions and disapproved others.

There clearly is a limit to how much future profit can be foregone to generate present surplus. The duty of any regulator is to make sure such transactions do not impair the ability of any company to honor its obligations to policyholders.

Because it took time to analyze and evaluate the various transactions, there were periods of uncertainty as to the surplus positions of the insurance companies. When these uncertainties arose the Insurance Department and Baldwin-United, for the protection of policyholders and to provide a readily available source of additional surplus for NILIC and NIPIC, established an escrow account, from Baldwin's other assets, of

approximately \$200 million. The escrowed assets were dedicated to the insurance companies for the benefit of their policyholders, to be transferred as needed.

Beyond the Arkansas context, we respectfully suggest to the commissioners that there are lessons of general applicability here. They spring from the fact that it is not the role of good regulation to suppress innovation simply because it is difficult to regulate. Nonetheless, we can freely acknowledge that innovation is, indeed, difficult to regulate. The specific lessons emerging from this episode seem to be:

- First, the holding company laws of the late 1960s and early 1970s may not be adequate to deal with this sort of financial creativity and motivation. It is neither better nor worse, but we ought to recognize that it is different.

- Second, the laws of many states, including ours, on insurance company investment in subsidiaries seem far too liberal. Along with the fresh look at the intercompany-dealing sections of the holding company laws, the NAIC might want to consider quantitative or other limitations on investment in the securities of related companies.

- Third, if the essence of surplus relief is the sacrifice of future profit to generate statutory surplus, then in dealing with it and the attendant question of the long-term health of insurance companies, we should recognize that the techniques of relief range far beyond reinsurance and the sale of loss portfolios.

- Fourth, interstate communication may need to be improved. The zone examination and the standard blank are masterpieces of interstate cooperation, and the Baldwin-United episode may be telling

us that a similar achievement is now needed in the field of timely data transfer. The Arkansas efforts involved honest people in our state. If we were dealing with other kinds of people in a number of states, the implications become staggering.

- Fifth, because of their size—and even more because of the novelty, complexity and the systems problems brought along by rapid growth—the examination of NILIC and NIPIC was extremely difficult, as was the continuing process of making sure their capital was adequate in amount and quality. For extended periods, two-thirds or more of the top professional resources of the Arkansas Insurance Department were taken up by those two companies. If, as many believe, unconventional operations will play expanding roles in the insurance business of the future, then the insurance departments will have to anticipate and prepare for the problems of regulatory overload.

To help deal with our own immediate problem of regulatory overload, the department appointed Richard E. Stewart, chairman of Stewart Economics Inc. and a recognized expert on insurance management, finance and regulation, to consult with the department. He actively participated in the complex questions raised by the examination and by the efforts of NILIC, NIPIC and the department to strengthen the capital position of the companies. Mr. Stewart's assistance was absolutely vital and I am glad for this opportunity to express the department's, and my own, appreciation and gratitude. Additionally, I thank Mr. Stewart for his participation in the preparation of this memorandum (except for this paragraph).

I hope that this memorandum, along with the examination reports, will help the commissioners deal with what is, in my judgment, a significantly new regulatory phenomenon.

Get the complete story before setting up an ESOP

Continued from previous page

that time and effort must be spent making sure employees understand just how the ESOP works and what's in it for them. That requires a real commitment.

Hundreds of studies also strongly suggest that ownership will work best if employees are treated with respect and given a meaningful role in the company. As the Japanese are teaching us, it makes sense for employees to participate in decisions concerning their jobs. Companies with ESOPs that go beyond this to allow employees to vote their shares and participate in management are uniformly pleased with their decisions. They say that productivity and morale increase because of their more democratic approach. Each company requires a different approach, but it makes little sense to tell employees they are owners on the one hand and treat them as ordinary employees on the other.

ESOPs do one thing very well: They raise expectations. If you fail to meet those expectations by not treating employees as owners, you may be in for trouble.

If you passed the test and answered yes to all the questions, then an ESOP is probably a good idea for your company. There is every reason to believe that in your case it will improve productivity, create a very meaningful employee benefit, generate important tax savings and, our studies show, make your entire work atmosphere much more cooperative and satisfying for everyone. Imagine how much nicer it would be to go to work and have everyone pulling together. In a good ESOP, that is exactly the feeling firms with successful ESOPs report.

If you answered no to some of the questions, then ESOPs probably aren't for your company now. Maybe you need to rethink the assumptions that made you answer no, however. The economy and the workforce are changing; they are both more demanding. An Employee Stock Ownership Plan can help meet these new demands.

Group wants to deter medical malpractice suits

Continued from page 2
sure" for awarding punitive damages below that cap.

- Require structured settlements of court awards exceeding \$100,000. The coalition argues that such awards are intended to compensate for loss of earning power and thus should be paid over time as a salary would.

- Modify the current contingent fee system under which plaintiffs' lawyers generally agree to be paid a fee equal to one-third of any ultimate award.

The coalition proposal would cap such fees at 50% of the first \$3,000 of a court award, 33% of the next \$7,000, 20% of the next \$50,000, 15% of the next \$40,000 and 10% of any amount greater than \$100,000.

The coalition says its proposal would chop the average fee received by attorneys in successful malpractice cases to about \$34,000 per case from an estimated \$83,000 per case.

- Require a plaintiff to post a bond equal to a hospital's or a physician's likely defense costs if the plaintiff decides to pursue a claim that a three-member panel, consisting of a judge, doctor and lawyer, says is without merit.

- Establish several other mechanisms aimed at resolving malpractice disputes before they reach a jury, including standards for the use of expert witnesses.

The program's focus, its backers say, would be to shift the legal system away from punishment and toward a system of fair compensation for victims of medical mistakes.

The coalition says that malpractice law has gone beyond protecting patients from poor practice of medicine. It now attempts to pay punitive damages to patients who are treated through state-of-the-art medicine but are not healed.

"The big part of it is a totally new thing—to remunerate people for results they didn't expect from the medical system," says Dr. G.H. Collings Jr., corporate medical director for New York Telephone Co., which employs 80,000 people statewide.

"The difference between expectations and the state of the art isn't really malpractice," says Dr. Collings, who is chairman of the Business Council's health committee.

He points out the malpractice boom is partly responsible for the increase in New York Telephone's basic health and major medical insurance to \$48.76 per \$1,000 of payroll in 1982 from \$36.03 in 1975.

Another coalition member is the politically powerful Medical Society of the State of New York, representing the state's 46,000 doctors.

"There is nothing new in this bill," says Gerard L. Conway, a lobbyist for the medical society with the Albany law firm of Rice & Conway. "These concepts have been discussed by medical groups, legal groups and governmental groups."

The coalition, which unveiled its detailed proposal at an Albany news conference last month, says that state Sen. Tarky Lombardi, R-Syracuse, chairman of the Senate Health Committee, has agreed to introduce a bill modeled after the plan.

Prospects for sponsorship in the Democrat-dominated Assembly are still uncertain, the coalition says, acknowledging that any proposal to cap damage awards and contingent fees will face stiff opposition from plaintiffs' lawyers.

"The Legislature has seen (similar proposals) before and to one degree or another has not seen fit to pass them at the same time in both houses," says Donald J. Boyle, an Albany lobbyist for the New York State Trial Lawyers Assn. However, "this is the first time there

has been a coalition working with the medical insurance industry and perhaps more people will take their presentation seriously because of that."

Mr. Boyle says the trial lawyers will oppose the coalition's package, but he could not predict whether they will be successful. He says trial lawyers are willing to consider "creative solutions" to rising medical malpractice premiums but says the solutions may involve the "methodology of the insurance industry" rather than claims restric-

tions.

Other states, though, have legislated some deterrents to filing malpractice suits.

For example, Massachusetts and Illinois have enacted screening programs that force plaintiffs to pay defense costs after unsuccessful malpractice claims, says Jeff Palca, Eastern regional manager for the Insurance Information Institute.

Ohio sets some requirements on the use of expert witnesses, he says, adding that plaintiffs in California are supposed to obtain a "certificate

of merit" before taking their claims before a judge. Two states, Wisconsin and California, require structured settlements of malpractice awards above certain levels.

Contingent fees are subject to statutory limits or court rule in at least seven states: California, Delaware, Indiana, Kansas, Michigan, New Jersey and Pennsylvania. In New Hampshire, however, an attempt to regulate contingent fees was declared unconstitutional by the state's highest court.

Limits on punitive damages in

medical malpractice cases have been enacted in at least 13 states: California, Illinois, Indiana, North Dakota, South Dakota, Ohio, Virginia, Wisconsin, Idaho, Nebraska, New Mexico, Hawaii and New Hampshire. The limits range from a low of \$150,000 in Idaho to a high of \$1 million in Hawaii.

However, courts in three of those states—Illinois, Ohio and New Hampshire—have declared the limits unconstitutional, Mr. Palca says. A \$250,000 limit is now being challenged in California, he adds. ■

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Jockey tries to collect claim

Continued from page 2

Hartford, Conn., wrote \$500,000 in primary liability coverage and Northeastern Fire Insurance Co. of Pennsylvania, based in King of Prussia, Pa., wrote \$1 million in excess umbrella coverage.

However, the two insurers disclaimed coverage after the track filed for bankruptcy and did not file for a declaratory judgment before the trial, Mr. Peel says.

"We tried to settle out of court for \$1.5 million," Mr. Peel says, "but the defendant didn't show up for anything. When the suit was initially filed, the insurers hired an attorney who withdrew after bankruptcy was declared."

"After bankruptcy was declared, we had to wait for approval from the bankruptcy court before proceeding with this state court case. When we received approval, we sent letters by certified mail to con-

tact the defendant, the insurers and the prior attorney. We never received any response except from one or two attorneys who wrote to say they were involved in only the bankruptcy case."

Although bankruptcy proceedings have ended and the track's assets have been liquidated, its former president or another person appointed by the bankruptcy court could assign its right to sue its insurers to Ms. Bacon, Mr. Peel says.

If the track does assign those rights, Mr. Peel says Ms. Bacon could file a garnishment suit in Madison County Circuit Court against both insurers for the \$1.5 million policy limits. She could also sue the insurers in the same court for bad faith for not defending Cahokia Downs in the original suit to request the other \$1.5 million of the award, he adds.

Truxton Bob Ryan Jr., North-

eastern's vp of claims, says the insurer, which is currently undergoing rehabilitation by Pennsylvania insurance regulators, disclaimed coverage on April 15, 1981, based on policy exclusions.

"Saying that we never responded and did not defend the case is a gross distortion," Mr. Ryan says. "We sent a copy of our disclaimer letter to the plaintiff's attorney and he should have it in his file."

"We disclaimed coverage in response to a February 1981 note from the underlying carrier (Aetna) that there had been a claim based on a letter by the plaintiff's attorney dated Dec. 18, 1980," Mr. Ryan said.

"To my knowledge, according to our files, the disclaimer was not contested," Mr. Ryan said, adding that indicates Cahokia Downs acknowledged the policy exclusions.

Aetna also disclaimed coverage based on policy exclusions, according to Northeastern's records.

Mr. Peel says those exclusions

stated, "It is agreed with respect to operations described below or designated in the policy as subject to this endorsement, the insurance does not apply to bodily injury while practicing for or participating in any contest or exhibition of an athletic or sports nature sponsored by the named insured."

Aetna officials could not be reached for comment.

However, Mr. Peel says the insurers should have been represented by an attorney at the trial to defend the disclaimer, even after the track filed for bankruptcy.

"The proper progression of events would be this: After the insurance companies receive a copy of the claim from the track, they should investigate the claim to determine whether it will be covered by the policy. Then, if there is any doubt in their minds as to whether the claim is included, whether a defense is owed the insured, the insurers investigate under reservation of rights."

"Then, if they determine they do not owe the insureds a defense, they write to the insured and say, 'We do not owe you a defense; we disclaim coverage for this claim. However, we will hire an attorney to defend you under reservation of rights until the court determines that our disclaimer is valid.'"

Cahokia Downs Inc. owned the track and leased it to East St. Louis Jockey Club Inc., which operated it, according to Dave Hooper, executive secretary of the Illinois Racing Board, which regulates thoroughbred racing in Illinois.

Cahokia Downs and East St. Louis Jockey Club jointly filed for bankruptcy, Mr. Peel says, adding that both were named in the suit and both were named on the policies.

Since neither the defendants nor its insurers appeared in court, Mr. Peel argued Ms. Bacon's case with no one defending the claim.

Ms. Bacon's suit, which requested \$5 million to \$7 million, alleges that she suffered a fractured pelvis, two fractured pubic bones, nine broken ribs and a ruptured spleen because the track's gate crew mishandled her mount, South Ruby Lane. The horse reared in the gate and fell back upon Ms. Bacon, it says.

One of Ms. Bacon's legs is now shorter than the other, causing a permanent limp, he says. She also has a scar from her chest to her abdomen.

Because of the injuries, she lost income from horse racing, modeling and endorsements, the suit claims.

Mr. Peel says that Ms. Bacon's doctor would not approve a return to racing for Ms. Bacon because another fall could paralyze her. She did, however, attempt to race in early 1982, but a fall at a California track left her in a coma for eight days.

Ms. Bacon, a former model for the Charlie line of Revlon cosmetics, was once one of the 15 most photographed women in the world, her attorney says. Her picture appeared in magazines including Genesis, Harper's Bazaar, Newsweek, Playboy and Sports Illustrated, as well as racing publications.

Ms. Bacon currently does not receive workers compensation benefits, her attorney says, although she does receive a "small disability of less than \$100 a week" from the Jockey Guild, a welfare organization for jockeys, and disability payments from Golden Gate Fields, the Albany, Calif., track where she was injured.

"Jockeys are generally considered independent contractors, and thus are not bound to the same state requirements for workers compensation," says Kathy Adams of the Illinois Racing Board.

"We do not require tracks to carry work comp for jockeys, although we do ask them about their property/casualty insurance for the physical structure," Ms. Adams adds. "Any liability insurance they may carry or employee insurance is a private contract that we cannot regulate."

"Self-employed is the insurance company's term for ducking the work comp issue for jockeys," says Nicholas Jemas, national managing director of the Jockey Guild. "This is the most dangerous career in professional sports."

Ms. Bacon lives in San Leandro, Calif., and is negotiating with TV networks for rights to a movie based on her life, Mr. Peel says.

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agent/broker topics

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E&O avalanche

How to avoid being rocked by clients' claims

By DONNA LEIGH YANISH

Look out!

Agents and brokers are being overwhelmed with an avalanche of errors and omissions lawsuits. And, clients are basing their claims on a variety of agent mistakes, some of which you may not be prepared to defend.

Cal-Surance Associates Inc., in Torrance, Calif., a brokerage that places E&O coverage for about 50,000 commercial and personal lines agents, says that the number of such claims filed against agents and brokers is spiraling.

In 1982, one of every 80 agents who purchased coverage through Cal-Surance was hit with an E&O suit, almost double the rate of one claim for each 150 agents in 1978.

Three general foul-ups are responsible for the influx of E&O claims against agents and brokers, Cal-Surance says. They are:

- Switching policies from one insurer to another at renewal, which, if not handled carefully, can lead to improper coverages or miscommunication about what exposures are covered.
- Selling sophisticated policies without fully understanding them, which can lead to a misunderstanding between the agent and the client.
- Selling group health and accident plans without fully explaining their details to the sponsor and group members. The pitfalls included in this error can be multiplied by the number of participants covered by the group plan.

These trouble areas can also be couched in some of the traditional causes of E&O claims against agents, including improperly filled-out applications, alleged misleading statements concerning the effective date or the nature of coverage and controversy over coverage termination.

But the three primary trouble areas outlined by Cal-Surance trigger an estimated 50% of the errors and omissions claims filed against agents, the brokerage says.

However, William S. Scott, vp for professional liability for Cal-Surance, stresses that these are just general trends and says it's difficult to single out specific causes of errors and omissions claims.

Agents, though, must be aware of these trends so they can evaluate their risks and act accordingly, Mr. Scott adds.

Although agents who buy their E&O coverage through Cal-Surance report a marked increase in claims, claims haven't risen for all insurers writing agents' E&O coverage.

San Francisco-based Fireman's Fund Insurance Cos. says that it has seen a reduction in claims against agents covered by the program it writes for California members of the Independent Insurance Agents of America, one of the six state agent programs it handles, says Lee W. Hand, program manager for specialty products.

In addition, "the number of claims has remained steady in New York. In general, E&O results have

been very good lately," he adds.

Mr. Hand did not reveal how many agents are covered in Fireman's Fund's programs.

Fireman's Fund's experience appears to be the exception rather than the rule. Other marketers agree with Cal-Surance and say E&O claims against agents are increasing.

Shand, Morahan & Co. Inc., an underwriting manager in Evanston, Ill., that administers the Professional Insurance Agents of America's E&O coverage program, expects to process 13 claims for each 100 agents participating in the program in 1983, says Manager Robert Dominiak.

The program processed about 9.8 claims per 100 agents in 1979, he adds.

Shand, unlike Cal-Surance, does not keep detailed statistics concerning the roots of the claims.

Most claims that fall into the three primary categories outlined by Cal-Surance are lumped together under failure to place proper coverage or failure to place coverage by Shand, Mr. Dominiak says. Those two areas account for 50% and 20% of all agent E&O claims, respectively, he notes.

Errors and omissions claims against agents usually increase when competition in the marketplace climbs, Mr. Dominiak notes.

"Agents shop around for everything (looking for the best price), and all of the insurance companies have different forms to contend with. Sorting through all of that is at least twice as much work, but agents are getting less income. There's an increase in the chance for error."

Shopping around may lead an agent to place a client's risk with a different insurer than in the past. And these replacements can be potential E&O exposures for agents.

"Today, the insurance agent can be sued if he does or does not recommend replacement," Cal-Surance's Mr. Scott says. "And, the aggressive agent, wanting to sustain his livelihood, finds himself in a replacement market."

"As a general statement, every policy sold longer than two years ago

Continued on next page

Botching replacements

Confusing policies

Fumbling group plans

Common errors trigger clients' E&O claims

Continued from previous page
needs to be reviewed for replacement."

If the agent hasn't shown his or her client such a review, in writing, (the agent) is open to an errors and omissions action, Mr. Scott says.

While not all reviews result in replacement, many do, especially when insurers are aggressively pursuing risks by drastically decreasing rates.

There are potential E&O exposures for agents recommending replacement coverage as well, Mr. Scott notes. In this situation, the exposures result from two types of circumstances: when replacement was allegedly not in the client's best interest and/or when replacement caused a loss or decrease in coverage, he notes.

Lost or decreased coverage that goes unnoticed can cause some unwanted surprises.

"Not explaining what accrued benefits will be lost due to replacement, and/or not making a thorough comparison between the old and new plans are excellent ways to help a plaintiff's attorney win a case against an agent," Mr. Scott says.

As agents place more complicated policies, they are more likely to leave particular exposures uncovered. For example, sometimes a vital coverage is not included in an umbrella liability policy, notes Joe J. Thackaberry, a vp at Shand, Morahan.

Although Mr. Thackaberry says one particular exposure is not more likely to be forgotten than another,

he notes that agents should particularly pay attention to coverage for indirect losses, like business interruption, and coverage that satisfies leasing requirements.

Agents should also be especially careful when placing coverage for risks that they haven't handled before, he adds.

Agents trying to attract new business may have to venture into previously untouched territory. That may mean having to work with unfamiliar and sometimes more sophisticated policies than in the past, which triggers an increasing number of E&O suits, Cal-Surance's statistics note.

Mr. Scott notes several common practices by agents working with unfamiliar policies that may lead to errors and omissions suits. These

practices include:

- Coordinating unfamiliar, sophisticated insurance plans with existing programs.

- Utilizing the services of outside experts to help place the client's insurance package.

- Either knowingly or inadvertently holding yourself up as an expert in particular kinds of coverage.

Coordinating new and existing coverages may be particularly troublesome, Cal-Surance's Mr. Scott says.

"Plus, he must be able to show (in writing) his full disclosure to his client as to what the comparative features the new plan has or doesn't have." That means a full, complete description of all the pluses and minuses, Mr. Scott em-

phasizes.

Unfamiliar policies, particularly those with tax or legal intricacies, may require more than insurance expertise.

Most agents, rather than trying to become experts in many areas, rely on help from other specialists. That reliance, although a proper plan of action for agents, can cause a potential E&O exposure for the agent in charge of the client's insurance program, Mr. Scott says.

"As the insurance agent of record, he is individually responsible for all of his associates' actions," he explains.

Although that responsibility shouldn't dissuade agents from using experts, they should be aware of the potential liability and act accordingly, another industry source notes.

An agent's alternative, trying to become an expert in several different areas, causes E&O exposures as well.

While most agents have a good general grasp of certain basic concepts, policies and types of coverage, trying to delve into highly

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Mr. Scott

technical specifics can lead to E&O problems.

A lack of expertise in an area can become a much larger problem when the agent works not only with the client but with experts hired by the client, like lawyers, accountants and tax consultants.

Statutory and tax regulations are constantly being changed, Mr. Scott notes. Establishing pension funds and tax-shelter, profit-sharing and other investment plans requires the use of experts who stay current with almost daily updates, he adds.

But, Mr. Scott notes, "there's a Catch-22 associated with agents preparing themselves for the more sophisticated plans. An ambitious agent will earn for himself higher professional accreditations in order to prove his ability to handle complicated programs. The courts, however, will then hold the agent to higher standards, magnifying his liability exposure."

Becoming a more professional insurance agent is often equated with providing risk management services to clients rather than just placing their insurance needs.

Providing risk management services to clients may be more than a marketing tool for agents, notes Frederick J. Fisher, president of The Fisher Associates, an insurance adjusting firm in Torrance, Calif. Such services can serve as preventive medicine against errors and omissions suits, he says.

With risk management becoming an integral part of agents' functions, agents who don't perform those services may not be living up to the standard in the industry.

"The question is 'what was the (agent's) duty?'" Mr. Fisher asks.

Continued on facing page

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To what extent must an agent give suggestions to improve a client's insurance program to protect against a future E&O claim?

An agent who recommends policy limits to a client can also be a target for E&O suits, Mr. Fisher adds. Several industry sources also note that agents are increasingly wondering about what limits they should recommend to ward off E&O claims.

Agents may be held liable for a failure to recommend higher limits if a client's coverage falls short of a loss, notes Shand, Morahan's Mr. Dominiak. "While that isn't always the case—not all agents are held liable—the claim may be made.

"A client who has a loss is looking for someone to pay the bill. It often becomes a swearing contest. Then it becomes a question of who's better able to document."

Making recommendations on limits, however, is not necessarily performing risk management functions, clarifies Shand's Mr. Thackaberry. Agents should be careful about trying to be risk managers without having the necessary expertise, he warns.

While an agent's primary area of expertise remains placing insurance, some insurance programs are becoming nightmares to place. Cal-Surance's statistics on the causes of E&O suits puts the problems associated with placing group health and accident plans at the top of the list, Mr. Scott says.

Alleged errors and omissions in placing these policies usually stem from three areas, he explains:

- Misleading statements made to the group's sponsor.
- Improper group applications procedures.
- Failure to extend all coverages in the plan to all group members.

The first problem, misleading a sponsor, can develop when trying to replace existing coverage. "The most damaging statement that is all too frequently made by the agent—or, the sponsor claims that the agent made—is, 'this coverage is just the same as the old, only better.' No two policies are the same," Mr. Scott notes.

"Plan difference may or may not be better—that's not the point. When a suit is brought against an agent, what counts is whether the agent made a full and complete comparison between plans—not just listing the benefit schedule—and the agent caused the sponsor to publish the schedule."

Agents have even been held responsible for misstatements that the sponsor has made in the benefits handbook, Mr. Scott adds. "The agent is supposed to have proofed and supervised the entire procedure. The theory is that the agent is the agent of record to every (policyholder), not just the servant of the sponsor."

The agent is also responsible for making sure that all applications by members of the group are properly filled out, Mr. Scott says.

"A number of E&O incident reports result from a person supposedly covered by the new group plan being refused coverage or receiving a reduced benefit payment because of an improperly filled out application."

Realistically, it may not be possible for the agent to take each application him or herself, since groups can include thousands of members, Mr. Scott admits. But, "The prudent agent will carefully supervise the sign-up process, and will with equal care look over each application," he advises.

Checking the applications and special circumstances of all members of the group can help avoid the most often cited problem associated with group health plans: surprised beneficiaries who discover they aren't covered, Mr. Scott says.

Agents should note, for example, that employees with prior medical

histories covered under an old policy may not be automatically covered under the new, he says. And specific conditions, such as maternity, which may have been covered under the old program, may not be included under the new one.

In these and other circumstances, plaintiffs have found cause to sue the agent along with others, including the employer and the insurer.

Suits don't necessarily mean the agent is at fault, several industry experts stress. Agents win E&O suits, and plaintiffs often drop their claims before a trial ever begins.

None of the data gatherers had statistics on how many E&O claims actually result in an award.

But, whether or not agents or their insurers ever pay a claim, agents want to avoid errors and omissions claims when possible.

Most agent associations and publications, as well as insurers, hold seminars and publish tips on how to avoid errors and omissions claims. ■

Consumer awareness fuels increase in claims

Are agents really making more errors now than they did in the past?

Or, are they just being forced to defend themselves against (or to admit) mistakes that someone else would have paid for in previous years?

Whether or not the agents are increasingly at fault, industry experts point to several factors that may explain why more insurance buyers are filing E&O claims against their agents.

General consumer awareness—both of insurance and of the courts—is one reason, they say.

"Consumers are more aware of coverages and how the insurance industry works," contends Richard Kasyjanski, director of research for the Independent Insurance Agents of America. "In this more litigious society, people are turning to agents when they find out something isn't covered."

Agents, however, don't want to pay for a mistake, particularly if they don't think it's their fault, another industry observer says. "In the past, agents were more concerned about an E&O claim damaging their standing in the community. They would

pay for the claim because they didn't want anyone to make noise about it," he says.

The prospect of a long court battle doesn't deter clients in filing claims against their agents and brokers, according to William S. Scott, vp for professional liability at Cal-Surance Associates Inc., a Torrance, Calif., brokerage that has placed errors and omissions liability coverage for about 50,000 insurance agents.

"However one wants to view it, the consumer has a greater awareness of his privilege to seek redress for real or imagined injuries," he contends.

Consumers may be filing E&O suits against agents because insurers may be less likely to pay a claim that was not covered in the policy because of an agent's mistake.

"The relationship between an agency and an insurance company has changed," Mr. Kasyjanski says. "Ten years ago, insurance companies helped out clients and the public. If there was an uninsured loss, the insurer would have stepped in and said that it would pick up the tab."

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BI-2/7

Agency mergers can produce E&O claims

If you don't consider what effect a merger with another agency could have on your errors and omissions coverage, you could be hit with some unpleasant surprises.

An association of Florida agents says that many members are calling with questions about what implications mergers and acquisitions can have on E&O coverage.

"We're seeing many more mergers (than in the past) and problems have come up with E&O policies," says Linda Pate, insurance programs administrator for the Florida Assn. of Insurance Agents.

"We're telling agents to think about the E&O implications before, not after, the transactions."

The merger contract should spell out who is responsible for errors and omissions claims, Ms. Pate

explains. The E&O policy shouldn't be expected to fill the holes in the merger agreement.

"The E&O policy cannot be redesigned to suit individual circumstances and needs, but the sales contract can be designed just the way (the buyer and seller) want."

Many E&O policies are written on a claims-made basis, she notes. Coverage sometimes ends when an agency is sold, so claims reported after a merger would normally be uninsured, she explains.

Agents who purchase their E&O policy from the association's program, however, can cover those delayed claims, she adds. An extended discovery E&O policy provides coverage for acts, errors or omissions that occurred during the policy period but reported after the

policy expired.

The Florida program is marketed by The London Agency Inc. in Atlanta, Ga., and underwritten by International Insurance Co., a subsidiary of Crum & Forster.

Although an extended discovery policy may cover the seller of the agency, buyers had better check their own E&O coverage to determine whether it will protect the agent against errors committed by an acquired agency's employees.

The problem could be serious. An agent who buys another agency's book of business may be liable for those errors and omissions, confirms Jeffrey M. Smith, a lawyer with the firm of Bondurant, Miller, Hishon & Stephenson in Atlanta.

In *Butler vs. Scott*, the 10th U.S. Circuit Court of Appeals ruled that

an agent who purchased another agency was liable for actions relating to policies issued before he purchased the firm, Mr. Smith notes.

In that case, the Scott brothers, the plaintiffs, operated a mining company. They had purchased a property policy covering their drilling equipment. However, the policy excluded damage to the equipment during drilling. To cover this exclusion, their agent was told prior to drilling to buy expanded coverage. However, the agent failed to place this coverage.

Mr. Butler, the defendant, purchased the agency that had handled the plaintiffs' coverage and continued to service their account. He never knew of the restrictive endorsement on the plaintiffs' insurance policy. However, the plaintiffs

continued to request additional coverage for their equipment whenever they began drilling.

"Butler's response to the request was the same as his predecessor; certificates of insurance were issued but he never obtained expanded coverage," Mr. Smith notes. "As a result, when a fire occurred at one of the drilling operations, the loss incurred was not covered and the plaintiffs sued Butler for their damages."

"Butler's defense was that he had no duty relating to any policies issued before he purchased the insurance agency," Mr. Smith says. The court, however, rejected this argument, "saying that the duty did not derive from individual contracts but rather out of the nature of the defendant's profession."

One agency's E&O nightmare

The following is a fictitious illustration of a common agency E&O problem.

Producer Star of Aggressive Insurance Agency Inc. has been successful in retaining the Lots of Equipment Construction Co. account despite fierce competition from other agents.

When last year's insurer raised the rates on coverage for the client's equipment by 30%, producer Star combed the marketplace and found a much lower rate from Wonderful Insurance Co.

What equipment should be covered under the policy is described on a list in producer Star's file for the account. The risk manager for Lots of Equipment calls producer Star when the policyholder wants to add or subtract specific pieces of equipment from that list. Producer Star then scribbles the request on a piece of paper, handles the transaction with the insurer and puts the note aside to be placed in Lots of Equipment's file.

However, one piece of paper, noting the addition of a tractor, was misplaced before the coverage was renewed with Wonderful.

When preparing the new policy application, producer Star compiled all of the pieces of paper from the file, except the one noting the tractor, to make a list of what equipment should be covered.

He called Lots of Equipment's risk manager and asked if he had been notified of all changes in the list of covered equipment. The risk manager said yes. Producer Star gave the list to the underwriter.

Six months later, a 2-year-old tractor was damaged, resulting in a partial loss, and Lots of Equipment filed a claim.

Wonderful Insurance, however, said the tractor wasn't included in the coverage and denied the claim. Lots of Equipment sued Aggressive Insurance Agency.

What could producer Star have done to avoid the problem? The producer could have:

- Requested that the risk manager send written notices for changes in the list of equipment.
- Requested a confirmation after notifying the insurer of the change.
- Sent the confirmation to the policyholder.
- Kept an up-to-date, clean list of covered equipment, with dates specifying when equipment was added to or deleted from the list.
- Carefully reviewed the list of equipment with the risk manager, when arranging for the change in insurer, to make sure the risk manager knew what was and what wasn't on the list.

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Mass marketer recruits Quebec insurance agents

MONTREAL—What's the French-Canadian word for commercial insurance mass-marketing groups?

For some Canadian commercial insurance agents, it's GCA Ltd.

That Montreal-based marketing group was established more than a year ago to create a more competitive force of independent agents, according to President John Tourangeau. Like their U.S. counterparts, Canadian independent agents are losing market share to large brokers, he says.

Fifty-seven agents throughout Quebec hold exclusive marketing rights to sell GCA products in one of the 60 territories created by the marketing group, Mr. Tourangeau explains.

GCA's staff of 12 has developed commercial insurance packages for specific industries—like farm implement dealers, dairy farms, restaurants and retailers—and has solicited endorsements from trade associations in those industries.

Unlike members of some of the U.S.-based mass-marketing groups, GCA members do not help prepare the programs. The products are ready to sell when they're introduced to the agents and are underwritten by a variety of Canadian insurers, Mr. Tourangeau notes.

In addition, unlike many of its U.S. counterparts, GCA isn't owned by an insurer, although it is managing general agent for a few Canadian insurers.

The mass marketer, however, doesn't necessarily solicit its own insurers when searching for an underwriter for its programs, Mr. Tourangeau adds.

Member agents are given a list of all members of a trade association when the mass marketer introduces a program for that industry. Agents are expected to contact members in their territories within three months, he says.

"We then check to see if our agents have contacted the association members in their territories. If there's a problem, we'll have to look into changing agents."

"We established territories so we would know who should have called on an association member that wasn't contacted," he adds, acknowledging that members sometime fail to contact target clients.

"We haven't had that problem yet," Mr. Tourangeau adds.

GCA principals select which agencies within a territory they want to represent the group, he says, noting that in general they hope to sign up the largest agency within the territory.

"We look at volume, staff and experience with insurers. We also ask

for financial statements. I know most of the agents in the province, though," says Mr. Tourangeau, who was an underwriter for several Canadian insurers for 12 years.

Agents pay a one-time fee of \$2,500 to join GCA, Mr. Tourangeau says. They receive full commissions when they sell package policies.

GCA hopes to offer member agents other non-insurance programs as well, Mr. Tourangeau adds. Along with increasing the number of association-sponsored insurance products, the mass marketer hopes to offer a group car-leasing rate to members. It's also exploring group rates on computer equipment sales and leases.



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• A quote by Richard Nausch, president of Nausch, Hogan & Murray Inc., in the Jan. 3 issue of *Agent/Broker Topics* concerning insurance capacity for satellite risks should have read: "USAIG (United States Aviation Insurance Group) has capacity but hasn't exercised it yet."

• Majorie C. Kennedy, author of an article in the Jan. 3 issue of *Agent/Broker Topics*, is director of services for RIMCO Licensing Service, a division of RIMCO Risk Management Inc. in Dallas.

Agents' group forms IRA program for members

By DONNA LEIGH YANISH

NEW YORK—More than 600 agents and agency employees are now participating in the Independent Insurance Agents of America's group Individual Retirement Account program that started in July.

Contributions to the IRA program, which the IIAA says is the first to be offered through a trade association, total more than \$1 million, according to Richard Ka-

syjanski, the IIAA's director of research.

One of major advantages of the program is its flexibility, Mr. Kasyjanski notes. Most IRA programs penalize a depositor for withdrawing funds and transferring them to another IRA vehicle before the account matures. But participants in the IIAA program aren't penalized for early transfers of their funds, he says.

The IIAA also offers attractive rates of return, Mr. Kasyjanski

says. Participants, who can contribute a minimum of \$100 a year, have two investment options under the program: a guaranteed interest program and a variable account, both of which are administered by Connecticut General Life Insurance Co., a subsidiary of CIGNA Corp.

The guaranteed interest plan, which invests in Connecticut General commercial paper, paid 14% on funds deposited in 1982, and will pay 13.5% in 1983 and 13% in 1984,

he says.

Investors who are willing to take a chance on the stock market can choose the variable account. This option, which Connecticut General established especially for the IIAA program, invests solely in stocks.

So far, the variable account has performed exceptionally well, Mr. Kasyjanski says.

"An agent who invested \$1,000 on July 1, 1982, has seen this investment grow to a value of \$1,416.11. That's a 41% return," he

says. An annualized rate, however, cannot be computed since the program has only been in existence for six months.

The unusually high rate of return, is somewhat misleading, Mr. Kasyjanski notes, because it's based on stock market variations and the market has sustained record gains since the program was established.

The summary of the performance for the stocks in the IIAA variable account illustrate the market's rise. In August, the portfolio's value rose an average of 11.09%. It was up 2.09% in September, 16.21% in October and 15.31% in November, he says.

However, Mr. Kasyjanski points out that the program cannot guarantee such an attractive rate of return this year.

Agents who did not start an IRA last year or have not contributed the full \$2,000 allowed by law can still do so and have their contribution apply to their 1982 income taxes, Mr. Kasyjanski says.

"Agents (and agency employees) who already have an IIAA/IRA ac-

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Mr. Kasyjanski

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count but have not yet contributed \$2,000 can bring their total contribution up to \$2,000 and deduct this amount from their 1982 taxes."

Agents and agency employees who have established other IRAs on their own, however, can't transfer those funds to the IIAA program, Mr. Kasyjanski says, noting one of the drawbacks of the program.

There are other regulations, too. Under Internal Revenue Service rules, participants can only contribute \$2,000 a year to an IRA even if they do not plan to deduct the excess contributions from their taxes.

"We're actively working to get the IRS to make a ruling to allow for rolling funds over (and accepting contributions over \$2,000), but right now we don't have that authority," Mr. Kasyjanski says.

"We also can't accept spouses' (contributions) into the IRA program unless they are employed in an agency," Mr. Kasyjanski points out.

Employees or agency principals who invest in the IIAA plan and later leave the insurance agency business must withdraw their money from the program, Mr. Kasyjanski says. Such a situation hasn't arisen, he adds, and the program administrators haven't developed a procedure for dealing with participants who are technically no longer eligible for the program.

However, under the program, people who are forced to withdraw their funds would not be penalized, he notes.

Arizona, work comp insurer at odds over dividend cuts

Continued from page 3

consideration incurred-but-not-reported losses. However, Mr. Low disputes the right of insurers to do that in Arizona.

The contractors say the amount of the dividend is to be determined by their loss experience during the policy period. They say they should not be penalized for their decision to switch insurers.

But Mission argues it is entitled at any time to establish whatever rate of "dividends to policyholders" its board of directors chooses.

That position is usually correct, says a spokesman for the National Council on Compensation Insurance. While many work comp insurers use dividends as a way to compete with other insurers and may publish varying dividend rates and formulas, the final policy generally contains a disclaimer that dividend rates are not guaranteed.

A former Mission agent says, though, that the insurer went a step farther in its dealings with the contractors, lumping them into a single "safety group" for loss-control and rating purposes.

"They created a special safety group and then they said in a policy endorsement that everyone would get the same dividends," says Fred B. Fruchthendler, president of Jacob C. Fruchthendler & Co., a Tucson, Ariz., agency.

"Then they cut by 50% the dividends paid to members who non-renewed."

Mr. Fruchthendler says he asked Mission to restore the reductions and the insurer declined.

After Mr. Fruchthendler refused to back down on the issue, he says Mission canceled his agency agreement without telling him why.

"They canceled my contract in April," says Mr. Fruchthendler. "I didn't really expect them to respond the way they did...we had been very profitable for them."

Mr. Fruchthendler and another agent also contend Mission wrote the non-renewing employers acknowledging that the dividend reduction reflected the non-renewal.

Group plans cost-control workshops

BROOKFIELD, Wis.—Eight one-day programs on health care cost containment will be held around the country by the International Foundation of Employee Benefits Plans.

The programs, tailored for labor-management benefit trusts, will be held March 8 in Seattle; March 9 in San Francisco; March 30 in Toledo, Ohio; March 31 in Chicago; June 7 in Kansas City, Mo.; June 8 in Milwaukee; June 28 in Pittsburgh; and June 29 in Tarrytown, N.Y.

At each briefing, cost-containment experts will present an overview of health care cost problems, discuss how funds can use plan design and administration to control costs and explain how funds can work together.

Each session costs \$130 for foundation members and \$155 for non-members.

For more information on the cost-containment workshops, contact the International Foundation of Employee Benefit Plans, Box 60, 18700 W. Bluemound Road, Brookfield, Wis. 53005; 414-786-6700.

"The Mission Insurance Co... has acknowledged including charges from 5% to 8% (of premium) for IBNR claims," Jesse E. Rowe of Rowe Insurance Inc. of Tucson said in a letter to the insurance director.

So far, Mr. Low has sided with the employers and agents, arguing that Mission's decision to reduce expected dividends to non-renewing policyholders violates Arizona law.

He says the practice constituted a non-approved deviation from Mission's filed rates and forms and discriminates against a certain class of policyholders: those that choose not to renew.

Mr. Low says any final decision of what should be done has to await conclusion of the department's hearing on the matter, adding that the dispute involves about \$700,000.

The dispute between Mr. Low and Mission was triggered last June when Mr. Fruchthendler asked the department for a formal hearing on matter.

On July 8, Mr. Low ordered a departmental hearing on Mission's "reduction of dividends when a workers compensation policy is not renewed." More than six months later, the hearing has still not been held as attorneys for Mr. Low and for Mission battle over scheduling of witnesses and other matters.

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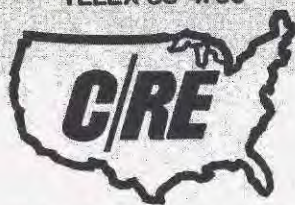
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Benefit tax would affect self-insurers

Continued from page 1
funded health care program.

"How should my time be factored in when I have responsibilities other than health care?" Mr. Grove said.

In addition, employers that self-fund often don't know their total health care costs until many months after the end of a year. That's because many claims are incurred near the end of the year and are not reported and paid until the next year.

As a result, the employer would not be able to calculate the cost of its health care program on a per-employee basis until several months following the end of the year.

"If I don't know what my costs are until April or May, how can I provide a W-2 income statement form (indicating by how much the employer's health care contribution exceeded the limit) to my employees by the Jan. 31 deadline?" one benefit manager asked.

Even if regulations specified that the cost of an employer-provided benefit plan would be based only on claims paid during a calendar year, there would still be problems.

A large percentage of health care bills paid during the year would be for services provided to employees during the previous year. As a result, if an employer laid off a large number of workers, remaining employees would be penalized if health care costs were divided by a much smaller workforce to determine a per-employee premium, notes Blue Cross/Blue Shield.

"The government doesn't seem to realize that there is such a thing as self-funding and the problems a tax cap would cause employers that self-fund," said Fred Hunt, executive director of the Society of Professional Benefit Administrators in Washington.

Only self-insurers that fund their health plans through a 501(c)(9) trust would be spared these headaches should the proposal win ap-

proval.

Experts cite many other arguments against the tax. They include:

- Employees who work in high-risk occupations would be penalized. Since some groups, like coal miners, are considered a higher risk, they are charged higher health insurance premiums.

"These groups would be unfairly taxed while other groups, such as clerical workers, would be unaffected," according to the Health Insurance Assn. of America, an industry trade group.

In fact, according to federal researchers Amy Taylor and Gail Wilensky, 40.1% of miners are covered by group health insurance plans where the employer portion of the health insurance premiums exceeds the \$2,100 and \$840 caps, compared with 14.4% of workers employed by personnel firms.

- The tax cap discriminates against employees who work in areas of the country where the cost of health care is high. Their employers naturally must pay more for their health coverage compared with employers in other areas.

Similarly, employees at small companies would pay higher taxes than workers at giant corporations because the smallest firms pay the highest rates due to proportionately greater administrative expenses.

"It is the employee at the small firm that would be hurt," said CIGNA's Mr. Schiffer.

In announcing the benefit tax proposal, which would go into effect Jan. 1, 1984, if it is approved by Congress, the administration said employees will become wiser consumers of health care if they face tax liabilities.

The administration believes that employees, if given a choice, will choose low-cost health plans with high coinsurance and high deductibles to stay under the tax-free limits. As a result, because of greater cost sharing, employees will have a personal stake in con-

trolling health care costs.

But benefit experts doubt this will happen. For example, the Blue Cross/Blue Shield high-option plan, which is one of the most generous and costly health plans offered to federal employees, is also the plan most frequently selected by government workers.

In addition, when Marriott Corp. surveyed its employees, it found that workers would rather pay more to keep the same level of benefits rather than have benefits reduced.

"Most employees would rather pay the tax than lose the protection," said Theodore Allison, a vp of government and industry relations at Metropolitan Life Insurance Co. in New York. "People are risk adverse."

In addition, experts point out the overall increase in individual taxes that will result from a benefit tax would not be large enough to make generous, high-cost plans unattractive. In general employees with very rich health benefits will come out ahead by keeping the benefits and paying the extra tax, they say.

For example, federal researchers estimate a worker earning between \$15,000 and \$20,000 would pay an average of \$93.24 more in federal income taxes if he or she were enrolled in a plan with company-paid premiums that exceed the tax-free limits.

"The tax would be a rather minimal sum since only the amount over the cap would be taxable income to the employee," said Metropolitan's Mr. Allison.

Already, insurers, employers and unions are joining forces to try to defeat the measure. "There is no constituency for it," said David Glueck, a vp with Towers, Perrin, Forster & Crosby in Chicago.

Yet, benefit experts warn that the tax cap is just the sort of proposal that could slip through Congress. "I hope it will be defeated, but they (the administration) are looking everywhere for revenues," said Ted Hale, president of Self-Retention Systems Inc. in Palmyra, N.J.

The administration estimates the limits on tax-free health insurance would generate \$2.3 billion in new federal income tax revenues. In addition, employees and employers together would pay \$352 million more in Social Security taxes, assuming that the FICA tax rate stays at 6.7% of the first \$35,700 of wages.

Du Pont posts best safety stats

WILMINGTON, Del.—Du Pont company employees recorded the best safety performance in 1982 in the company's history.

For Du Pont, excluding the Conoco subsidiary, the performance represented a lost workday case rate of 0.019 injuries per 200,000 hours worked.

Du Pont's international operations led the 1982 safety performance. In 77 sites abroad, 31,000 employees worked 144 consecutive days without a single lost workday case. In the company's U.S. and overseas operations combined, employees worked a record 52 days without a lost workday case during that same period.

Forty Du Pont operating units, with fewer than 20 employees to more than 1,500 employees, have operated for 10 years or more without a single lost work day injury reported.

For Conoco, 1982 also was a record safety performance year. The subsidiary showed a 20% improvement in the lost workday case rate over 1981 and a 41% improvement over the subsidiary's five-year average.

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Reagan asks for cuts in federal pension plan

By JERRY GEISEL

WASHINGTON—One of the nation's most generous retirement programs will have its sails trimmed if Congress approves the Reagan administration's budget.

The Reagan budget for fiscal 1984 would require federal workers covered under the Civil Service Retirement System, the nation's largest retirement program, to stay on the job until age 65 to receive full pension benefits.

Currently, a federal employee with 30 years of service can retire at age 55 with a benefit equal to 56% of his or her highest average salary over a five-year period.

If Congress approves the Reagan proposal, federal workers would have their annuities reduced by 5% of that average salary for each year under age 65.

For example, a federal employee who retired at age 64 would receive a benefit equal to 51% of average salary.

This change only would apply to federal workers now under age 55.

Federal employees also would have to contribute more of their salaries to the Civil Service trust fund, which covers about 9 million people. Currently, federal workers contribute 7% of their salary. That would be raised to 9% in 1984 and 11% in 1985.

In addition, pension benefits for federal and military retirees would be frozen next year, despite increases in the cost of living.

Currently, federal and military pensions for retirees age 62 and older are increased annually to match the rise in the Consumer Price Index, up to an increase of 6.6%. Retirees under 62 receive slightly smaller increases.

For example, in May, retirees 62 years and older will receive a COLA adjustment of 3.9% to reflect the rise of living costs in 1982. Pension benefits for retirees under 62 will be increased 3.3%.

The proposed cutbacks, the administration says, are necessary to slow the explosive growth of federal retirement benefits. For example, the federal contribution to the Civil Service plan will jump to \$29.9 billion by 1988 from \$12.9 billion in 1979 unless changes are made.

The administration also says benefits provided under the federal plan should be overhauled so they are comparable with those provided by private pension plans.

Most private plans do not provide full benefits until a participant is age 62 or 65, compared with age 55 under the federal plan.

OSHA

The Occupational Safety and Health Administration says it will issue more safety and health rules next year, but its field officers will visit the same number of worksites.

In the administration's proposed budget, OSHA says it will issue 12 health and safety standards in fiscal 1984, compared with 11 this year.

However, the 12-year-old agency estimates that it will conduct a total of 63,500 inspections at employer worksites, about the same number it expects to conduct this year.

To conduct those inspections and write new safety rules, the administration wants Congress to appropriate \$210.9 million for OSHA, up from \$206 million in 1983.

Pension office

The Office of Pension and Welfare Benefit Plans, which administers the Employee Retirement Income Security Act along with the Internal Revenue Service, anticipates a slight decrease in agency investigations next year.

In fiscal 1984, the pension office

says it will conduct a total of 3,194 reviews and investigations, down from 3,206 this year, according to the Reagan administration's proposed federal budget.

The pension office, though, says it will issue 2,406 ERISA exemptions, variances, interpretations and regulations in fiscal 1984, up from 2,338 in fiscal 1983.

In addition, in line with the administration's drive to reduce employers' paperwork burden, the Office of Pension and Welfare Benefit Plans estimates that companies will file 915,000 ERISA-related reports next year, down from 965,000 in 1983.

To monitor and regulate the nation's 500,000 private pension plans, Congress has been asked to give the pension office \$29.7 million in fiscal 1984, up from \$27.5 million.

PBGC

The Pension Benefit Guaranty Corp., which guarantees workers' basic pension benefits, estimates that employers will fold 145 pension plans in fiscal 1984 that won't have enough assets to pay promised benefits.

The PBGC predicts that income from termination insurance that employers with pension plans must purchase from the agency will rise to \$192 million in 1984 from \$92.5 million this year.

However, that estimate assumes that Congress will approve the agency's request to raise the annual premium to \$6 per plan participant from the current \$2.60. Congress failed to heed a similar request last year.

In addition, the PBGC says in

1984 it will pay out \$114.8 million to workers and retirees enrolled in pension plans that failed and were taken over by the agency. In 1983, benefit payouts will total \$75.2 million.

OPIC

The Overseas Private Investment Corp., which provides political risk insurance to U.S. companies investing in less-developed countries, says in the proposed federal budget its insurance revenues will rise to \$35.7 million in 1984, compared with \$35.3 in 1983.

Insurance revenues collected by the Overseas Private Investment Corp. have risen steadily in recent years as more companies tap the federal insurance market to protect their foreign investments.

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RIMS chapter sets seminar for March

SEATTLE—The Washington Chapter of the Risk & Insurance Management Society will hold an all-day seminar March 8.

Topics to be covered include improving communications, personal computers, directors and officers coverage and property insurance.

The luncheon speaker will be Joseph E. Morahan, vp of Alexander & Alexander Inc. in Chicago.

The cost of the program is \$30. For more information contact Mark Edlund, Univar Corp., 1600 Norton Building, Seattle, Wash. 98104; 206-447-5911.

ISO to offer tail coverage

Continued from page 2
claims-made form.

Although buyers and brokers are reacting favorably to the offer of unlimited tail coverage, those interviewed by *Business Insurance* said they thought most would still opt for a version of the "occurrence" form ISO currently offers.

Buyers are expected to stick with the occurrence form because it involves a lot less uncertainty of cost than the claims-made and tail coverage. The buyer knows upfront what the cost of his occurrence policy is, but if he buys the claims-made policy with the idea of purchasing tail coverage later to cover later claims, he doesn't know at the outset what the tail coverage will cost when he needs it.

ISO said late last year that it would offer a claims-made general liability policy as well as modernize and simplify its current occurrence

policy (BI, Jan. 3). Earlier, it had unveiled a proposed "first-discovery" trigger that was met with a buzzsaw of opposition from brokers and buyers and later discarded.

Under a first-discovery form, coverage would be triggered by injuries "first discovered" and documented during the policy period.

"The dropping of first-discovery is a positive step," says Norman Chanzis, risk manager at American Standard Inc., a New York-based manufacturer of building products. Mr. Chanzis is chairman of the Risk & Insurance Management Society's liaison committee with ISO.

Mr. Chanzis said the committee has not had time to react to ISO's announcement.

However, he did say personally he wonders about coverage questions that could be raised when tail coverage overlaps with current coverage that has an other-insur-

ance clause.

Although Richard R. Savage, ISO's senior vp-insurance lines, admits the combination of a claims-made policy with unlimited tail coverage may be practically the same as an occurrence policy, there are important differences between the two coverage triggers for insurers.

Currently, insurers that primarily write occurrence policies must keep a claims file open indefinitely on every policy they write, Mr. Savage says, since it is theoretically possible that claims may be made two decades after a policy expires.

Under a claims-made system, he explains, an insurer could close the files on any policy for which an insured buys either no tail coverage or tail coverage of a limited duration. This, he says, would reduce insurer paperwork.

Moreover, a claims-made policy would have certain pricing advantages for an insurer, industry offi-

cials say.

An underwriter could base the premium for a claims-made policy only on the claims it actuarially expects to pay during the policy year without worrying about future claims. The cost of those future claims would be figured into the premium for tail coverage.

"I still think that occurrence would be what the buyer will seek," says Walter T. Derk, current president of the National Assn. of Insurance Brokers and an executive vp at Fred S. James & Co. of Illinois. "It's good news, however, that the tail extender is now without limitation."

Both Mr. Derk and Mr. Chanzis expressed hope that ISO officials will continue to receive comments on their proposals before the industry's advisory rating and form-drafting office begins filing the new CGL forms with regulators.

But Mr. Savage indicated that ISO considers the comment phase of its effort to rewrite the CGL

form more or less closed.

"We've received valuable comments on the technical accuracy of the policy drafts as well as their potential acceptance by the marketplace," Mr. Savage says. "We thank all those who gave considerable amounts of time and energy in their reviews to provide us with sound advice. After we fully review that advice and complete our revisions, the new policies will be introduced and the marketplace will make the ultimate decision on their use," he says.

"We will submit those two commercial general liability policies (occurrence and claims-made) to the real test in the crucible of the marketplace," ISO President Daniel J. McNamara said last month.

"In keeping with ISO's new role, we have concluded that the concept of alternative ISO products for insurers to use as they see fit—and not one mandatory ISO product—reflects the realities of the new world."

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Circulation Breakdown*

Commercial Consumers

Administrative Management:
owners, presidents,
vps, etc. 6,483

Financial Management:
chief financial officers,
vps of finance, secretaries,
treasurers, etc. 10,138

Insurance Management:
vps, directors, managers of
insurance, risk, benefits,
compensation, safety,
security, etc. 5,299

Government, Associations,
Unions, Educational
Institutions 1,034

Commercial Consumers
Sub-total 22,954

Insurance Agents
& Brokers 9,771
Insurance Cos. 5,217
Financial Institutions 352
Actuaries, Attorneys,
Adjusters, Appraisers
& Consultants 2,603
Others allied to the field 937

TOTAL 41,834

*Source: Business/Occupational breakdown of qualified circulation, November 1, 1982 issue, as submitted to BPA for December 1982, BPA Publisher's Statement.

riskwatch

Now I ask you, 'Do you really think we need reinsurance?'

By LEN STRAZEWSKI

There's an American tradition demanding that politicians running for re-election stand up for solid, old-fashioned values: apple pie, a chicken in every pot and a good 5-cent cigar. Some are ready to bring back the horse and buggy.

In New York, Superintendent of Insurance Albert B. Lewis, now up for reappointment, has proposed Regulation 82, a rule that would practically eliminate the practical use of captive insurers and alien reinsurers in the state of New York. Never mind that not one person testified in favor of the regulation during a recent hearing and never mind that most of the insurance buying and selling community views the proposition as a smoking cigar that could set fire to centralized corporate risk management programs.

Some observers say that Regulation 82 is Superintendent Lewis' soapbox—one last campaign to show newly elected Gov. Mario Cuomo that he is not about to be fast-talked by the insurance industry.

I don't know if that's true or not, but for the sake of a good debate, I'll climb up on the soapbox with him. I've got my straw campaign hat, a loud tie and my "Dewey for President" button. I'm ready to tell you a thing or two about the way you should run this here insurance business.

And, by gum, you won't be able to fast-talk me, either, with them fancy words like reinsurance, fronting and

Mr. Strazewski

"utmost good faith."

Uh-oh, before I go off the deep end with this stunt, let me say a couple of serious things that are not couched in inflated campaign rhetoric.

I sympathize with Superintendent Lewis, "a street lawyer" as he likes to call himself and a person who revels in catching crooks and occasionally lighting up a good cigar. I've seen his desk literally covered with documents relating to the investigation of Jack V. Goepfert and the insurers Mr. Goepfert and his fellow convicted felons defrauded. Superintendent Lewis fought a long, frustrating but successful battle and eventually got his man.

In interviews and speeches to groups like the National Assn. of Insurance Commissioners, I have also heard Superintendent Lewis express his frustration at "pirate-cove" jurisdictions that are reluctant to release information to investigators (whether or not it violates local secrecy laws) and international marketplaces whose own traditional methods of operations can baffle U.S. businessmen as well as the Justice Department.

Superintendent Lewis is partly correct, I think, and few people in the insurance and risk management business disagree. The industry, reinsurance particularly, has had some problems that took plenty of effort to correct.

Puff a little political cigar smoke into those problems and you've got yourself a real down-home issue.

The new New York governor and his aides may even buy it because for the inexperienced, reinsurance, risk management and international business is awfully difficult to understand. Hand them some of the documents collected in the investigation of Kenilworth Insurance Co. and a couple of other belly-up insurers, walk them through the first six layers of intermediaries and they'll wish reinsurance was never invented.

Trace through with them a major corporate risk management program, complete with varying self-insured retentions, retrospective rating and other cash-flow devices, a captive insurer and a dozen or so excess liability insurers, and they'll be ready for some old-fashioned simplicity. You know, like good ol' whole life insurance. Now there's something anybody can understand.

Whoops, it's happening. You just can't stop that old-time rhetoric from creeping in.

OK, here's my soapbox speech, friends and neighbors. I'm here to ask you, why can't these here insurance companies do business like you and I, with good down-home companies right here in our state? Why can't a Fortune 500 corporation just buy first-dollar coverage from Hartford Fire Insurance Co. or Aetna Casualty & Surety Co.? OK, so they're not based in our state. But they are licensed and that's got to mean something, don't it?

So what if a few corporate risk management programs get thrown to the winds, as the Risk & Insurance Management Society seems to think? Corporations don't vote.

And who cares that reinsurance transactions would probably grind to a halt, as them brokers and insurers say? Reinsurance is too confusing, especially if it means going out of state.

And who cares if Regulation 82 drives corporations and insurers out of state? What's a few jobs. . . .Oops, better take that part back.

Anyway, wouldn't it be nice to buy insurance my way? So what if it costs a bit more? So what if it costs lots more?

Why can't the insurance industry be run like the good ol' corner store? Why can't we have a good 5-cent cigar?

Nice speech, but I think the campaign hat missed the ring.

CIGNA Corp. developing national computer network

CIGNA Corp.'s property/casualty group is developing a computerized data base network that will provide risk managers, brokers and other clients with direct access to risk management, claims handling and loss-control programs.

The network is a joint development between CIGNA and Corporate Systems, a leading supplier of risk information systems and software.

Clients of certain CIGNA units will be able to link directly with a new computer system at Corporate Systems' Amarillo, Texas, service center through the company's risk information network that serves more than 70 cities in the United States.

As part of the system, CIGNA has purchased the rights to use Corporate Systems' library of more than 1,000 risk-management, claims-administration and loss-control computer applications.

In addition, CIGNA will transfer all of its risk-management systems programs to the new operation.

The service will be available to risk managers and brokers through CIGNA's special risk division. It will also be offered to customers of ESIS, the CIGNA unit that offers risk-management services to self-insured organizations.

The first accounts are expected to be on-line in early March.

New syndicate

The Illinois Insurance Exchange has approved the Comprehensive Ensurers Markets Syndicate Inc. as an underwriting member of the exchange.

CEM, an "investor-type" syndicate in which individual investors contribute capital for underwriting, is the first member of the exchange that is not a subsidiary of an insurance company.

Health care consultant

American Institute of Management Services Inc., a consulting firm based in Winston-Salem, N.C., has formed a new subsidiary, AIMS Consulting Services Inc., to offer insured and self-funded health care plans to large corporations.

AIMS has also formed a new special risk and financial planning division to assist brokers with special risks and estate planning.

markets

New IRI member

The Centennial Insurance Co., a wholly-owned subsidiary of The Atlantic Cos., has joined Industrial Risk Insurers, an international

property insurance organization.

Acquisitions

Broker Johnson & Higgins has acquired Sibson & Co. Inc., an executive compensation consulting firm with offices in New York, Los Angeles and Princeton, N.J.



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Argentines shift business from London

Continued from page 2

At least one policy came up for renewal in London during the height of the Falklands conflict: aviation coverage for the Argentine airlines. INDER switched brokers from Sedgwick Payne Reinsurance Brokers Ltd. to Frank B. Hall & Co. Inc. in the United States, and the policy was moved from London to the American and French insurance markets.

Since the fighting in the Falklands ended, INDER has been dragging its feet on renewals that should have been completed by Dec. 31, sources in the London market say. Some risks had not been renewed in London, with no reason given by INDER. Other contracts that had been offered in London are taking a long time to complete because INDER is not readily giving statistics on risks that underwriters require.

"My impression is that not as much business is being placed in London from Argentina," said Leslie McKinnis, manager for The Mercantile & General Reinsurance P.L.C. "M&G, which has been doing business with INDER since its inception, has not been getting as much business this year."

M&G is waiting to hear from INDER about certain policies that are still being negotiated, said Mr. McKinnis. "But we haven't been

offered any new business. One has not been able to figure out INDER's wishes on whether or not to insure with British companies. It is a delicate situation."

Mercantile & General has reinsured Argentine risks since the 1930s and has built up contacts in the country over the years. Just about every year, M&G representatives meet with INDER representatives in Buenos Aires to examine statistics and negotiate renewals.

Last year, however, Mercantile & General did not send a representative to Buenos Aires. "The latest negotiations with INDER have been done by telex," said Mr. McKinnis. "In normal circumstances, insurers and brokers would visit Buenos Aires to see the books and check if the business was properly rated. That was not possible this year."

"There has been a silence from Buenos Aires and that must be looked at in the background of politics and the fact that it is a state-owned reinsurance company," he said.

"INDER is a state-controlled company which must have considerable regard for the wishes of the Argentine government," Mr. McKinnis speculated. "Perhaps it has had to wait for approval from the Argentine government before placing business here."

Some Lloyd's of London underwriters say they would refuse risks from Argentina even if they are offered.

"I would not touch Argentine risks," said one aviation underwriter. "I saw some about a month ago, and the policies were good risks, but I would not touch them. The situation between Argentina and Britain may blow up at any moment because we are in the same position we were in before the Falklands Islands. I don't want to be stuck with any Argentine policies."

"I would not touch the stuff, though I do not like South America in the best of times," said one Lloyd's non-marine underwriter. "There is no security that we will get the premiums from the country. We may not be able to investigate losses. I don't like it."

Some underwriters are also worried that Britain may impose sanctions against Argentina again, leaving them with Argentine risks but no premiums with which to pay claims.

"Why insure something that may not be here tomorrow?" asked the aviation underwriter. "It probably takes six months to a year to get premium out of Argentina. The risk may even expire before you get your premium."

"The situation may blow up again before you get paid," he said. "In my opinion—no thank you."

"Premiums do tend to be so slow that you must be a masochist to underwrite it," said Stephen Merrett, chairman of Merrett Holdings P.L.C. He adds, however, that some Lloyd's underwriters are probably accepting Argentine risks, "though not with enthusiasm."

Daily reports of new diplomatic tensions between Argentina and Britain reinforce underwriters' reservations to continue business between the two countries.

"I do not think Maggie's (Prime Minister Margaret Thatcher's) visit to the Falkland Islands helped boost morale in Argentina, do you?" asked a Lloyd's underwriter.

Argentina's unstable economy and political climate fuels the reluctance of London underwriters to accept Argentine risks, sources in the market say.

The remaining link between the Argentines and the London insurance market seems to be the half-dozen or so Lloyd's brokers that still place much of INDER's risks in the world insurance markets.

"We are doing lots of business with INDER," said Charles Maller, deputy chairman of Clarkson Puckle Group Ltd. "Even last Friday, a big risk came through with a

very substantial figure in the several hundreds of millions of dollars."

This risk will be reinsured in the Lloyd's, London and world insurance markets, he added.

Clarkson Puckle's bid to be the insurance consultant on a huge dam project on the Argentine-Uruguayan border were frustrated last year by the Falklands crisis, but negotiations have now resumed, said Mr. Maller (BI, June 28, 1982).

But he would not say how much Argentine business is being placed in London. "Certainly we are placing business with London underwriters generally," he said.

"We are placing business in the world insurance markets which we believe are appropriate. Markets change continuously. Last April, there was a move away from London. As far as I know, however, there has not been any diminution this year."

Clarkson Puckle has a Buenos Aires office, which helps in negotiations with the Argentines, Mr. Maller points out. "I went there regularly until April," he said, explaining that the Argentines now travel to London.

"One or two underwriters are reluctant to insure Argentine business here but on the other hand, business is being placed in London," said Michael Howard, managing director of Sedgwick Payne Reinsurance Ltd. The company's

Buenos Aires office is placing some in the London market, but he declined to say how much.

The renewals for December "have all been straightforward," he said. "Everything has been fairly normal, surprisingly. In fact, it seems that INDER management wants to establish normal links with London."

"It is impossible to generalize about the attitude of London brokers and underwriters," he added, because 30 to 40 brokers handle INDER's business.

"I only know about the business we handle."

However, a broker at Willis Faber Group P.L.C. said he wasn't aware that any of INDER's business had been replaced or renewed in the London market.

Clearly, however, whatever negotiations have been going on between Argentina and London have been frustrated by the Falklands crisis. For example, it has been difficult if not impossible for a London broker to visit Argentina this year. Brokers with offices in Buenos Aires, like Clarkson Puckle and Sedgwick, have a distinct advantage.

"There is a delay in getting visas, apart from anything else," said Sedgwick's Mr. Howard. "You used to be able to show your British passport and walk into Argentina, but not now."

Guatemala, Australia may change leaders

NEW YORK—International corporations should keep a close watch on political developments in Guatemala and Australia, two nations that could experience sharp changes in government, according to Frost & Sullivan Inc.

The political risk forecasting firm believes that Guatemalan President Efraim Rios Montt is unlikely to survive the current political instability. Although a coup by

right-wing forces would set up a regime that is more friendly toward international business than Mr. Montt's government, a takeover would lead to further violence in the nation.

In Australia, a peaceful change to a Labour government is a possibility. However, a Labour majority would create "a restrictive climate for international business," Frost & Sullivan says.

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BI Insurance Index



The Business Insurance stock index rallied to close at 228.4 for the week ending Feb. 1, gaining 2.9 points from 225.5 on Jan. 25. Twenty-nine stocks gained, 22 closed down and 15 were unchanged. The largest gains were posted by Fremont General Corp., 35.4%; Statesman Group Inc., 13.3%; Alexander & Alexander Services Inc., 10.5%; Old Republic International Corp., 8.6%; and Hartford Steam Boiler Inspection & Insurance Co., 7.9%. The largest losses were reported by Corroon & Black Corp., 8.5%; Optimum Holding Corp., 6.1%; Gulf United Corp., 5.1%; Aetna Life & Casualty Co., 4.3%; and Frank B. Hall & Co. Inc., 3.0%. The index leaped 1.3%, compared with a 0.96% rise in the Dow Jones 30 industrials.

British Issues

1 Feb	Price	P/E	Div.	Yield	1 Week
Companies	pence		pence	%	High-Low
Commi Union	145	24.2	16.86	11.6	147-143
Eagle Star	362	14.5	21.43	5.9	367-345
Genl Accident	424	14.1	23.21	5.5	430-408
Gdn Royal Exch	434	12.4	25.00	5.8	446-424
Phoenix	332	17.5	24.00	7.2	336-320
Royal	513	12.5	36.07	7.0	520-492
Sun Alliance	1050	17.5	61.43	5.9	1062-1012

Brokers	Price	P/E	Div.	Yield	1 Week
	pence		pence	%	High-Low
CE Heath	340	9.7	18.71	5.5	340-325
Hogg Robinson	107	8.2	8.57	8.0	107-101
JH Minet	110	10.0	5.43	4.9	111-110
Sedg Grp	220	12.6	8.57	3.9	220-210
Stenhouse Hldg	118	11.0	7.86	6.2	118-101
Stew Wrightson	260	9.3	18.57	7.1	260-250
Willis Faber	530	13.3	21.43	4.0	530-520

Source: Philip Olsen/Alan Clifton, Insurance Industry Specialists Kitcat & Aitken Stockbrokers, London

Insurer increases its reserves to guard against reinsurer failure

Continued from page 3

American Centennial has a "security committee" that reviews the financial condition of the reinsurance companies it deals with, Mr. Halvorsen says. But that committee was not operating effectively until a couple of years ago and the two reinsurers now causing problems were already established with American Centennial by that time, he explained.

"These (two) got in in the past, and they deteriorated," Mr. Halvorsen said. "We shouldn't have been dealing with these companies. We shouldn't have been ceding to these companies at all. We've taken our medicine and are providing for everything."

In addition to the \$11 million prescription, Beneficial is swallowing another \$19 million before taxes to build up established reserves across all lines, the largest of which are fire, inland marine and commercial general liability.

The company decided to build up its established reserves after it recognized that it was under-reserved for the type of business it was writing, Mr. Halvorsen says.

"What we were writing in American Centennial was long-tail business (like general liability). It really comes down the fact that we were light on the IBNRs," he explains.

He added that Beneficial strengthened its reserves for its own business and created the special fund to guard against reinsurer insolvencies of its own accord and the actions did not come at the behest of any regulator. The actions were "entirely our own decision."

Mr. Halvorsen maintains that the effect of the charge against earnings will not be too bitter given Wilmington, Del.-based Beneficial's size.

Beneficial, whose subsidiaries are involved in consumer and commercial finance and merchandising as well as insurance, reported assets of about \$5.8 billion as of Sept. 30. However, it reported a net loss for the first three quarters of 1982 of \$31.1 million or \$1.96 per share. Beneficial attributes most of the loss to a transaction dealing with its former savings and loan subsidiary.

BENICO, the parent company's insurance group consisting of 16 underwriters, posted net income of \$44.7 million for the first nine

months of 1982. American Centennial, the largest member of the group with \$240 million in total assets, posted net income of \$12.8 million for the first nine months.

"It's a small thing in the total picture," Mr. Halvorsen said of the \$16.2 million after-tax charge. "Even in relation to BENICO itself, it's not devastating," he said, adding that he did not know how the charge would affect American Centennial's bottom line.

The insurer produced its \$12.8 million in net income over the first nine months of last year by offsetting a net underwriting loss of \$54,961 and taxes paid of \$1.8 million with investment income of \$14.7 million.

Reinsurance intermediaries and insurance stock analysts contacted by *Business Insurance* said they were surprised that the company was building reserves to protect against potential reinsurer insolvency.

"We have some pretty big programs here, and we haven't seen that kind of reserving," said Fred Kalita, a vp with New York-based intermediary Paul Napolitano Inc. "I think people are building up reserves for IBNR...for IBNR and for claims. Period."

"It's a new item and a scary one," said David Seifer, vp with First Boston Corp. Mr. Seifer added that if other insurers are forced to build reserves in the face of reinsurer instability, the 115% combined ratio forecast for the property/casualty insurance industry for 1983 by First Boston would have to be revised upward.

"Our 115% figure would be out the window," he said.

Most large U.S. insurers generally are not doing business with reinsurers that might collapse under them, says James B. Stradtner, a general partner with New York-based securities broker Alex Brown & Sons.

But, "it lends credibility to the question, 'Does anybody know how expensive cheap reinsurance is?'"

Financial briefs

Kemper Corp.

Kemper Corp. has filed a shelf registration with the Securities and Exchange Commis-

sion covering as much as \$100 million of debt securities. The terms were not disclosed, though Kemper said the proceeds would be used to reduce short-term debt and for general corporate purposes. The managing underwriter is First Boston Corp.

Pine Top

Pine Top Insurance Co. has contributed \$8 million to the surplus of Pine Top Insurance (Illinois), raising its statutory capital and surplus to \$20 million.

Pine Top, a subsidiary of The Greyhound Corp., said it was taking the action to strengthen the unit's competitive position.

USLife

USLife Corp. has declared a quarterly dividend of 22 cents per share of common stock, payable March 1 to shareholders of record Feb. 15.

Travelers

Travelers Corp. has filed a shelf registration with the Securities and Exchange Commission for the sale of as many as 2 million preferred shares. The aggregate offering price of the shares will not exceed \$100 million, the company says.

The proceeds of the sale will be used by Travelers and its units primarily for investment purposes.

The managing underwriters include First Boston Corp. and Goldman, Sachs & Co.

Armco

Armco Inc. has lowered the dividend it will pay on its common stock during the first quarter of 1983 to 20 cents per share from 30 cents. The dividend will be payable March 7 to shareholders of record Feb. 11.

The company has also declared a regular quarterly dividend of 52.5 cents per share of cumulative convertible preferred stock, payable March 31 to shareholders of record March 4.

Because several loan agreements place restrictions on dividends, Armco had to obtain consent of lenders to permit it to pay dividends for the first quarter.

Armco Chairman Harry Holiday said the company lowered its common stock dividend to conserve its cash and because forecasts have shown that 1983 will be a difficult year for the company.

Advisory rates

The difference between advisory rates filed by the Insurance Services Office and commercial property/casualty insurers' recent premium growth shows the insurers' "perilous pricing philosophy," according to ISO President Daniel J. McNamara.

For general liability lines, for example, Mr. McNamara said ISO advisory rate levels increased 3% nationwide in 1980, 4% in 1981 and 8% in 1982, adding that ISO believes that an additional 9% boost will be needed this year. However, despite the advisory rates that would translate into a 14% premium growth over the past three years, written general liability premiums have shrunk 18%.

In the commercial multiperil line, ISO has called for a 30% rate increase over the past three years, while the industry's written premiums have grown only 5%. For commercial auto, ISO has filed advisory rate increases of 47% over the period, while premiums written by the industry have grown only 3%.

Mr. McNamara delivered his remarks at ISO's annual meeting last month in New York.

Mission Insurance

Mission Insurance Group Inc. is offering \$50 million of 11 1/4% notes due Jan. 15, 1993.

The company said the proceeds from the offering will be contributed to one or more of its operating units, with the balance used for general corporate purposes. The underwriting syndicate is managed by Salomon Brothers and Merrill Lynch White Weld Capital Markets Group.

BI Industry Stock Report

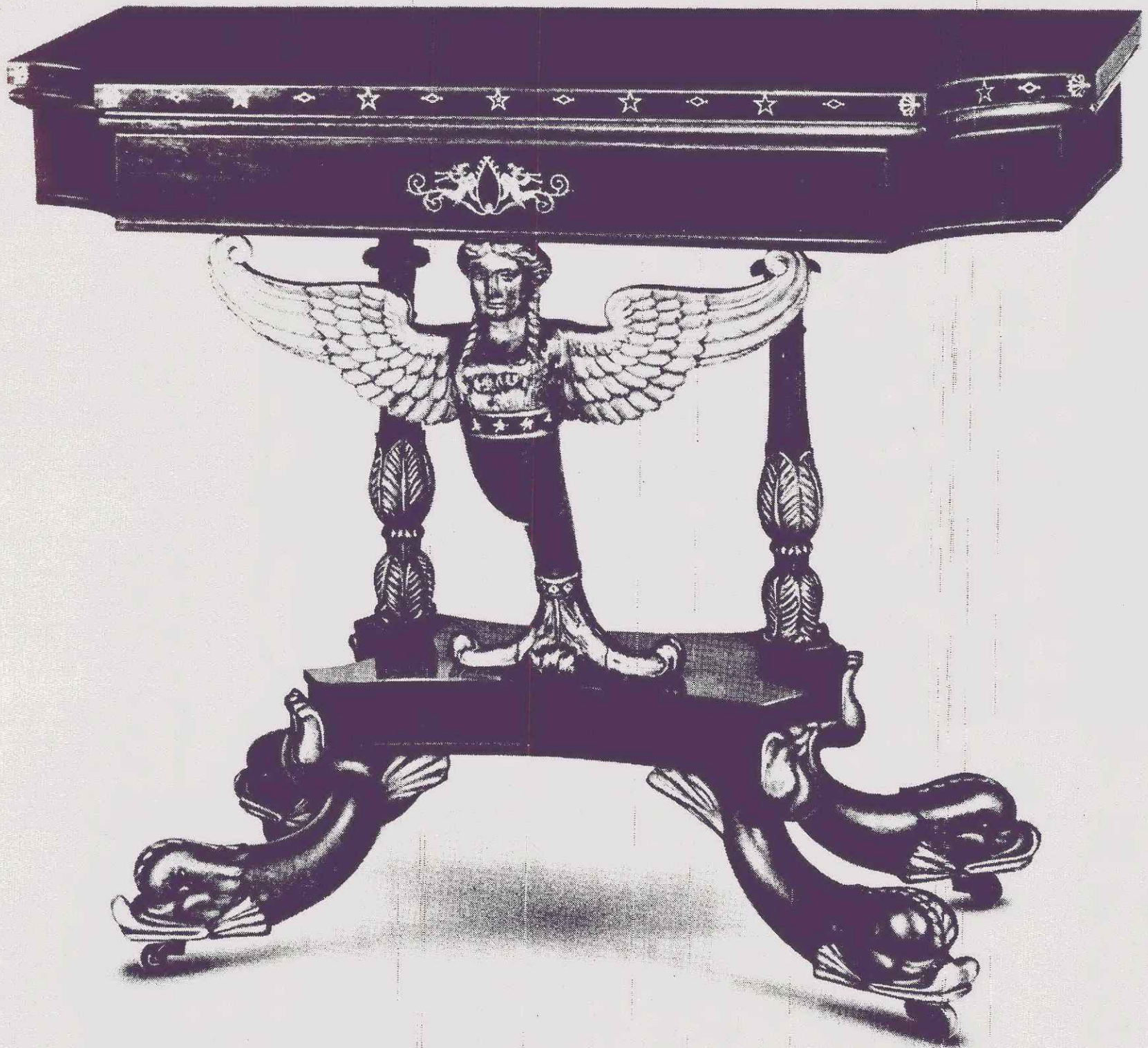
FEB. 1, 1983 1/26/83 THRU 2/1/83

Insurance Cos.	Price	Chg	P/E	S Div	Yld	High	Low	Vol (000)
Aetna Life & Cas Co	NYSE	33.50	-4.3	5.5	2.52	7.5	34.88	33.50 1,426.0
American Bankers Ins Group	OTC	11.00	2.3	8.6	0.50	4.5	11.38	10.88 247.2
American Gen Ins Co	NYSE	62.00	1.6	8.5	2.20	3.5	62.00	61.00 326.0
American Indty Finl Corp	OTC	20.25	5.9	20.0	1.12	5.5	20.25	19.88 13.0
American Intl Group Inc	OTC	70.00	-2.1	10.4	0.24	0.3	72.25	70.00 558.8
American Natl Ins Co	OTC	15.50	0.8	6.9	0.84	5.4	15.63	15.38 37.9
American Sts Life Ins Co	OTC	22.50	4.7	6.4	0.88	3.9	22.50	22.00 2.3
Aneco Reins Ltd	OTC	2.63	0.0	0.0	0.00	0.0	2.63	2.63 13.2
Avenco Corp	AMEX	15.00	1.7	8.6	0.58	3.9	15.00	14.50 8.1
Banks Iowa Inc	OTC	40.00	0.0	9.8	1.48	3.7	40.00	40.00 0.7
Bitco Corp	OTC	30.50	0.0	5.0	1.92	6.3	30.50	30.50 4.6
Carolina Cas Ins Co	OTC	7.25	-1.7	8.8	0.32	4.4	7.38	7.25 1.4
Chubb Corp	OTC	48.50	2.1	7.8	2.92	6.0	48.50	46.38 155.6
Combined Intl Corp	NYSE	28.75	-0.9	8.7	2.00	7.0	29.25	28.75 157.4
Continental Corp	NYSE	28.00	-1.8	8.9	2.60	9.3	28.00	27.00 176.3
Crawford & Co	OTC	19.75	6.8	14.7	0.57	2.9	20.00	18.25 57.1
Crown Life Ins Co	OTC	88.38	0.0	5.8	3.10	3.5	88.38	88.38 0.0
Cum & Forster	NYSE	55.38	0.0	11.4	1.76	3.2	0.00	DO NOT TRADE
Employers Cas Co	OTC	35.25	-0.7	7.4	1.20	3.4	35.50	35.00 34.8
Equifax Inc	NYSE	27.38	1.4	14.5	1.40	5.1	28.00	27.25 24.7
Excelsior Ins Co	OTC	9.50	0.0	0.0	0.70	7.4	9.50	9.50 0.4
Farmers Group Inc	OTC	35.00	-2.8	9.7	1.24	3.5	35.88	35.00 828.6
Foremost Corp Amer	OTC	40.25	3.2	12.2	1.12	2.8	40.50	39.50 54.7
Fremont Gen Corp	OTC	13.38	0.0	30.4	0.48	3.6	13.38	9.88 1,328.3
Great West Life Assurn Co	OTC	200.00	0.0	16.3	10.00	5.0	200.00	200.00 0.0
Hanover Ins Co	OTC	34.75	0.0	5.1	0.88	2.5	35.00	34.50 36.6
Hartford Steam Boiler Insptn	OTC	44.25	7.9	9.8	2.80	6.3	44.25	41.75 17.7
Jefferson Natl Life Ins Co	OTC	63.50	1.2	12.2	0.76	1.7	63.50	63.50 0.3
Kemper Corp	OTC	38.00	-0.7	7.2	1.80	4.7	38.50	38.00 30.9
Lincoln Natl Corp Ind	NYSE	47.00	2.2	8.5	3.00	6.4	47.00	45.88 166.5
Mission Ins Group Inc	NYSE	29.50	0.0	7.0	0.80	2.7	30.50	29.50 229.8
Nationwide Corp Ohio	OTC	41.00	0.6	12.1	0.70	1.7	41.00	40.75 1.8
Northwestern Natl Life Ins	OTC	29.75	-2.9	16.2	1.50	5.0	30.13	29.75 13.6
Ohio Cas Corp	OTC	43.00	-1.4	8.8	2.36	5.5	43.75	43.00 92.8
Old Rep Intl Corp	OTC	23.63	8.6	5.5	0.92	3.9	23.88	22.38 62.0
Orion Cap Corp	NYSE	18.38	0.0	10.7	0.66	3.6	18.38	17.63 84.4
Preferred Risk Life Ins Co	OTC	23.50	0.0	6.9	0.92	3.9	23.50	23.50 3.9
Provident Life & Acc Ins Co	OTC	47.75	3.8	7.3	2.44	5.1	47.75	45.50 48.9
St Paul Cos Inc	OTC	57.50	1.3	5.9	2.60	4.5	57.75	57.00 405.4
Safeco Corp	OTC	46.50	-0.3	8.1	2.40	5.2	46.75	46.50 356.2
Sri Corp	OTC	37.50	0.0	7.8	1.12	3.0	37.50	37.25 50.6
Seibels Bruce Group Inc	OTC	26.00	5.1	23.9	0.80	3.1	26.00	24.88 141.2
Statesman Group Inc	OTC	8.50	13.3	7.6	0.15	1.8	8.50	7.50 50.5
Tokio Marine & Fire Ins Co	OTC	99.50	5.3	15.9	0.92	0.9	99.50	95.00 6.6
Travelers Corp	NYSE	23.38	-2.1	6.4	1.80	7.7	23.88	23.38 612.8

FEB. 1, 1983 1/26/83 THRU 2/1/83

	Price	Chg	P/E	S Div	Yld	High	Low	Vol (000)
United Fire & Cas Co	OTC	29.25	0.0	7.8	0.88	3.0	29.25	29.25 1.1
United States Fid & Gty Co	NYSE	41.38	3.4	10.1	3.60	8.7	42.00	40.25 436.4
United Svcs Life Ins Co	OTC	18.75	4.2	6.6	1.00	5.3	18.75	18.00 16.5
USLife Corp	NYSE	22.50	-2.7	4.9	0.88	3.9	22.75	22.00 302.6
Washington Natl Corp	NYSE	22.88	-0.5	11.3	1.08	4.7	23.00	22.50 54.0
Zenith Natl Ins Corp	OTC	20.25	1.2	10.1	0.80	4.0	20.50	20.00 35.8
AVERAGE			9.0		4.2			
AGENTS/BROKERS								
Alexander & Alexander Svcs	NYSE	21.00	10.5	9.4	1.94	9.2	21.00	19.25 880.2
Baldwin & Lyons Inc	OTC	40.00	0.0	6.6	0.80	2.0	40.00	40.00 1.7
Corroon & Black Corp	NYSE	28.38	-8.5	14.0	1.80	6.3	30.75	28.00 64.4
Crump E H Cos Inc	OTC	10.13	1.2	17.2	0.40	4.0	10.13	10.00 119.8
Eneet & Chandler Cos Inc	OTC	10.75	-1.1	35.0	0.00	0.0	10.88	10.75 0.6
Hall Frank B & Co Inc	NYSE	31.88	-3.0	13.7	1.70	5.3	33.00	31.50 122.2
Integrated Res Inc	AMEX	32.00	-2.3	9.6	0.00	0.0	33.88	32.00 88.0
James Fred S & Co Inc	NYSE	33.25	0.0	16.8	1.60	4.8	33.25	33.25 0.0
Marsh & McLennan Cos Inc	NYSE	39.38	-2.5	11.7	2.20	5.6	40.38	39.38 163.9
PennCorp Fincl Inc	NYSE	13.50	0.0	8.4	0.16	1.2	0.00	DO NOT TRADE
Poe & Assoc Inc	OTC	10.00	0.0	9.8	0.80	8.0	10.00	10.00 2.1
Reed Stenhouse Cos Ltd	OTC	14.38	4.5	14.2	0.60	4.2	14.38	13.63 26.0
AVERAGE			11.0		4.2			
CONGLOMERATES/HOLDING COS.								
American Express(Fireman's Fd)	NYSE	64.13	1.6	10.6	2.40	3.7	66.50	63.25 1,285.8
Anderson Clayton(Ranger/PanAm)	NYSE	26.50	-1.4	7.3	1.32	5.0	27.00	26.13 28.9
Armco Inc	NYSE	16.50	-1.5	0.0	0.80	4.8	17.00	16.50 561.3
City Investing Co. (Home Ins.)	NYSE	28.38	-3.0	7.8	1.70	6.0	29.38	28.38 186.2
CNA Finl Corp (CNA)	NYSE	17.13	-2.8	6.7	0.00	0.0	18.00	17.13 33.1
Control Data (Comm. Credit)	NYSE	43.50	4.8	10.6	0.60	1.4	44.88	41.88 1,356.2
General Res Corp	NYSE	56.50	1.8	12.4	1.08	1.9	57.00	55.13 209.7
Gulf Utd Corp	NYSE	27.75	-5.1	9.7	1.32	4.8	28.88	27.75 291.9
Cigna Corp	NYSE	38.63	-2.2	5.6	2.30	6.0	39.38	38.25 959.3
ITT (Hartford Group)	NYSE	31.63	-1.9	7.1	2.76	8.7	31.88	31.50 678.0
Optimum Hldg Corp	OTC	7.75	-6.1	7.5	0.00	0.0	7.75	7.75 3.9

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