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Update

New York court limits ability to cover punitive awards

NEW YORK—A New York-based company cannot tap its liability insurance to pay punitive damages, even when they are awarded by courts in other states, New York's highest court has ruled.

According to the ruling by the New York Court of Appeals, New York-based American Home Products Corp. cannot use its product liability insurance to pay a $13 million punitive damage award.

The decision revolves around a 1988

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CIGNA to acquire EQUICOR

Purchase will expand managed care capability

By JERRY GEISEL

PHILADELPHIA—CIGNA Corp.'s proposed acquisition of EQUICOR Inc. will significantly expand CIGNA's national managed health care network and add to its current lead as the largest HMO operator among commercial insurers.

Concluding months of negotiations, Philadelphia-based CIGNA last Thursday announced it would pay $777 million to acquire EQUICOR, a joint venture for marketing group insurance and managed care plans that was formed in 1986 by The Equitable Life Assurance Society of the United States in New York and Nashville, Tenn.-based Hospital Corp. of America.

The acquisition, believed to be the largest ever in the group life/health insurance business, is subject to state and federal regulatory approval.

While the acquisition will significantly increase the size of CIGNA's indemnity plan operations, the EQUICOR acquisition most notably will expand CIGNA's network of health maintenance organizations available to employers seeking nationwide managed care programs.

The combined companies' HMO operations will serve almost 2 million enrollees, including 115,000 members of Total Health Systems Inc., an HMO in Great Neck, N.Y., that EQUICOR currently is negotiating to buy.

CIGNA reports 1.5 million enrollees in its 31 HMOs, which produced $1.3 billion in revenues in 1988. Including Total Health Systems, EQUICOR reports 450,000 HMO enrollees in 19 HMOs, which generated $300 million in revenues in 1988.

CIGNA reports 5,500 employers contract with its HMOs, while EQUICOR's HMOs serve 1,750 employers.

Combined, the companies wrote more than $12 billion in group indemnity plan premiums and equivalents—including group health, life and disability insurance operations—in 1988, the last full year for which statistics are available. CIGNA wrote $6.7 billion while EQUICOR wrote $5.4 billion.

CIGNA's group indemnity operations serve 7,100 corporate clients; EQUICOR serves 1,500.

CIGNA's Employee Benefits Group employs 18,700 people; EQUICOR has 7,400 employees.

CIGNA's closest commercial competitor in the HMO marketplace is PARTNERS National Health Plans, the joint venture of Aetna Life Insurance Co. and a unit of Voluntary Hospitals of America, which has about 1.2 million HMO enrollees. Aetna announced last week that it would acquire VHA's 50% stake in PARTNERS (see story, page 2).

However, Kaiser Permanente Medical Care Program, which is not owned by a commercial insurer, would remain the nation's largest HMO with 6.2 million enrollees. Blue Cross/Blue Shield Plan HMOs have 4.5 million enrollees, leaving CIGNA the third largest among all HMOs, even after the EQUICOR acquisition.

The EQUICOR acquisition will give CIGNA HMOs in 10 cities, mainly in the South and Southwest, where it does not currently have HMOs.

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AMA to push uniform rules for UR firms

By DONNA DiBLASE

The American Medical Assn. is advocating uniform utilization review practice guidelines to reduce the demands on doctors by UR firms.

The AMA, while asserting that it supports utilization review of health care services, says it wants to develop ways to reduce the "hassle factor" it says physicians encounter when complying with UR programs.

Meanwhile, in a separate effort, a group of UR executives is attempting to create a trade association that would help develop UR guidelines and a voluntary accreditation program for UR firms.

To formalize its efforts, the AMA last month approved a cooperative effort with the UR industry to make the UR process more uniform and efficient.

As part of this initiative, the AMA says it will aggressively work toward persuading UR firms to adopt a set of guidelines it has jointly developed with the Health Insurance Assn. of America and the Blue Cross & Blue Shield Assn.

"The AMA is strongly supportive of the appropriate utilization of health care services and also is supportive of fair and effective utilization review. But, there have been a number of areas of concern that have developed as the extent of utilization review activity has increased," explained Dr. John T. Kelly, director of the Chicago-based AMA's Office of Quality Assurance.

These concerns include the amount of time physicians say they are required to spend on telephone calls to UR firms, the failure of the UR industry to develop uniform practices and the intrusion of non-physician reviewers into the clinical decision-making process, Dr. Kelly said.

Physicians have become increasingly frustrated with the demands of complying with UR programs and with what they feel is an intrusion into clinical decision-making, Dr. Kelly explained last week.

With the proliferation of UR procedures, "there has been a tremendous growth of what we call the hassle factor. The steps physicians have to go through to indicate that the services they want to provide are necessary" often are time-consuming and cumbersome, he

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Benefit bills

Congress to study health plan tax, many other issues

By JERRY GEISEL

WASHINGTON—The second half of the 101st congressional session is only beginning, but lawmakers already are laying the groundwork for what could be explosive legislation affecting employee benefits.

However, observers do not expect fast action on risk management issues (see story, page 23).

Legislators during the next few weeks are set to dig into a slew of benefit issues, including taxation of health care benefits and expanding access to health care coverage.

At the same time, potentially fiery hearings are expected on whether tougher enforcement of ERISA rules governing pension plans are needed and whether Social Security taxes should be cut.

In addition, legislators will take a second look at two benefit issues that dogged Congress during the first half of the session: requiring employers to share control of pension plan assets with employees and restricting or eliminating employers' ability to recover surplus pension plan assets after a plan termination.

Legislators also may break a long deadlock on proposals to require employers to set up lengthy unpaid family leave programs.

Congress also could, following the trend of recent years, pass a major new tax bill or yet another budget reconciliation measure that includes numerous benefit provisions.

Benefit experts warn that employers, believing that Congress is unlikely to act on major benefit proposals during an election year, could become complacent and let down their lobbying guard.

In addition, employers might become lax believing that last year's repeal of Section 89 is a sign that Congress will stay out of the benefits arena.

But such complacency could prove dangerous.

"If employers believe that an election year or the repeal of Section 89 means they don't have to worry about what Congress could do to benefit

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Congress' benefits agenda

- Health care benefits taxes
- Access to health care coverage
- Pension plan enforcement rules
- Social Security payroll taxes
- Control of pension plan assets
- Restricting pension plan reversions
- Family leave legislation

Exxon spill illustrates need to maintain safety systems
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Judge cancels second trial of former Howden chairman
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Canadian system not a cure for U.S. health care ills: Study
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NEWSPAPER

Update

Punitive award ruled uninsured

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Illinois 1st District Court of Appeals decision upholding $13 million in punitive damages and $9.2 million in compensatory damages that a lower court jury awarded to a 2-year-old boy who suffered severe brain damage after using the drug Aminophylline, which is used to treat respiratory problems.

American Home's excess insurer, The Home Insurance Co., an Am-Base Corp. unit in New York, sued in New York, contending that it should not have to pay punitive damages.

In its Jan. 18 decision, the court applied New York common law, which prohibits using insurance to pay punitive damages.

This is another ruling nullifying "insurance bought and paid for by New York policyholders" and confirms that "New York courts are among the most anti-policyholder courts in the United States," said Eugene Anderson of Anderson Kill Olick & Oshinsky, a New York firm representing the Washington, D.C.-based Product Liability Advisory Board.

Retrial in Film Recovery case

CHICAGO—An Illinois appellate court has overturned the murder convictions of three Film Recovery Systems Inc. executives for the cyanide death of an employee, ruling the convictions were inconsistent with convictions of the firm and a parent company on involuntary manslaughter charges.

Convictions of Film Recovery and Metallic Marketing Systems of Elk Grove, Ill., were overturned and the case has been remanded to a lower court for retrial.

Cook County Circuit Court Judge Ronald J.P. Banks sentenced the three Film Recovery officers to 25 years in prison; and Film Recovery and Metallic Marketing were fined approximately $48,000 (*BI*, July, 8, 1985; June 24, 1985). The convictions were believed to be the first against officials of a U.S. corporation in an employee's death.

The appeals court found the evidence "sufficient to prove the defendants guilty," but said it was inconsistent for Judge Banks to "have found a lesser mental state against the corporations than the individuals," said Assistant Cook County State's Attorney Frank J. Parkerson.

The companies were not charged with murder because under state law "the only penalty against murder is prison, so the court wouldn't have been able to sentence a corporation for murder," said Mr. Parkerson. "There was no point in charging them with murder if they can't be sentenced."

Mr. Parkerson and Assistant State's Attorney J.C. Magnuson will ask the Cook County state's attorney for permission to appeal the decision to the State Supreme Court.

Defense attorneys could not be reached for comment.

The appellate court did not address whether federal workplace safety regulations pre-empt a state's right to prosecute firms and their officers in such cases.

N.Y. fines AIG units

NEW YORK—American International Group Inc. has paid fines of $325,000 after New York Insurance Department market conduct examinations found rating and other violations at eight AIG units.

National Union Fire Insurance Co. of Pittsburgh, Pa., was fined $143,300 for various violations on medical malpractice and professional liability policies as well as general liability policies for purchasing groups formed under the Risk Retention Act.

The violations included failure to secure prior approval for policy forms and malpractice rates, improper departures from rating plans, use of malpractice forms disapproved by the department and improper issuance of property insurance in New York's Free Trade Zone.

Similar violations drew fines of $95,700 for six other AIG units: American Home Assurance Co., AIU Insurance Co., Commerce & Industry Insurance Co., Insurance Co. of the State of Pennsylvania, New Hampshire Insurance Co. and Landmark Insurance Co.

And, Birmingham Fire Insurance Co. of Pennsylvania was fined $83,000 for failing to obtain prior approval on motor vehicle insurance rates and policy forms.

Separately, a State Supreme Court judge heard oral arguments last week in Insurance Co. of the State of Pennsylvania's challenge to a May 1988 fine of $348,900 for alleged violations related to policies covering taxi mini-fleets. A ruling is not expected for several weeks.

Constellation Re audits sought

NEW YORK—Creditors of insolvent Constellation Reinsurance Co. are asking a state judge to order an accounting of the reinsurer's estate in the wake of alleged fraud and mismanagement at the New York Insurance Department's liquidation bureau.

State Comptroller Edward V. Regan charged earlier this month that an audit uncovered "major operational deficiencies" at the bureau, including non-competitive selection of consultants and failure to monitor consultants' billings (*BI*, Jan. 15). Outgoing Insurance Superintendent James P. Corcoran has denied the charges.

Citing the allegations, several Constellation Re creditors wrote to New York Supreme Court Judge Walter M. Schackman last Thursday expressing concern about the expense of the protracted battle over how

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Errors & omissions

• Under Potomac Electric Power Co.'s contract with Healthplus, the HMO has agreed to refund to PEPCO a portion of its administration-only fee if total health care costs for PEPCO employees enrolled in Healthplus exceed a certain negotiated amount. The terms of the agreement were incorrectly reported in Benefit Beat (*BI*, Jan. 15).

• Sedgwick Non-Marine Ltd, a company within Sedgwick Broking Services, brokers insurance on a retail and wholesale basis. An article in the Jan. 15 issue incorrectly identified Sedgwick Non-Marine as only a wholesale brokerage operation.

PARTNERS buyout

Aetna to buy VHA's stake in venture

By DONNA DiBLASE

HARTFORD, Conn.—Aetna Life & Casualty Co. will become the sole owner of PARTNERS National Health Plans under an agreement between the insurer and Voluntary Hospitals of America Inc., PARTNERS' current co-owner.

Under the restructuring, Aetna will pay $34 million for the 50% ownership stake in the managed health care venture held by VHA Enterprises, a VHA unit. The agreement, which is subject to approval by regulatory authorities, is expected to be finalized by the spring, said Charles Bell, a senior vp with Aetna and interim chief executive officer of PARTNERS.

However, VHA will continue to provide extensive services to Aetna that will help the insurer manage relationships with health care providers, as well as consulting in such areas as utilization review and quality assurance, Mr. Bell said.

"It is critical to our business strategy that we continue to work with VHA" in establishing and managing health care provider networks. "Both of us are committed to this for the long haul," Mr. Bell said.

"For the most part, our market presence is now well-established. Our emphasis now is on real management excellence and financial and operational performance," he explained.

PARTNERS operates 107 preferred provider organizations covering about 1.3 million people and 33 health maintenance organizations with another 1.3 million enrollees in 33 states.

PARTNERS was created in 1985 by Aetna and VHA as a joint venture, and each partner owned 50%. Each partner also contributed 50% of the costs of developing or acquiring health maintenance organizations and preferred provider organizations under the deal. Both companies also shared equally in losses (*BI*, April 15, 1985).

However, in December 1988, the two entities agreed to a new finan-

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Municipal bond insurers bullish on 1990 volume

By JUDY GREENWALD

NEW YORK—The insured share of the new issue long-term municipal bond market could reach 30% this year, up from about 26% in 1989, predicts an executive with a major municipal bond insurer.

"We foresee the insured portion of the market reaching record levels in 1990, as much as 30% of new issue volume," David H. Elliott, president and chief operating officer of MBIA Inc., said at a seminar sponsored by MBIA earlier this month in New York.

Mr. Elliott attributes his optimism to new opportunities overseas as well as to individual investors' continuing involvement in the municipal bond market.

But more than 500 municipal bond professionals surveyed by MBIA were markedly more cautious, predicting that insured bonds would account for 26.5%—or $32 billion—of the projected $120.6 billion municipal market in 1990.

Bond insurance covered about 25.9%—or about $30 billion—of the $116 billion new issue market in 1989.

In addition, the size of the overall municipal bond market could grow to $200 billion by the end of the decade, predicts R. Fenn Putnam, executive vp and managing director of New York-based Dean Witter Reynolds Inc., who also spoke at the MBIA seminar.

Globalization of public finance may be the "most interesting prospect" for financial guarantees, said Mr. Elliott of Armonk, N.Y.-based MBIA. Until recently, European municipalities have borrowed funds from lending institutions rather than develop municipal revenue bond markets, as in the United States.

"Potential changes in the way public finance is conducted in Europe, we believe, will provide access to a huge untapped market," said Mr. Elliott.

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ASSE targets drug abuse

By MARK A. HOFMANN

DES PLAINES, Ill.—Employers and safety professionals will soon have another weapon in their arsenal in the battle against substance abuse, courtesy of the American Society of Safety Engineers.

The Des Plaines, Ill.-based organization has made drug and alcohol abuse the theme of National Safety Week, to be held June 24-30.

A handbook on drug abuse and other educational materials are designed to promote the theme—"Play It Straight For Safety's Sake"—and impress upon workers the relationship between drug use and workplace accidents.

Organizers made drug use the safety drive theme because "it affects our jobs and how we do our jobs as safety professionals and it affects society as a whole," said Art Murphy, National Safety Week task force chairman.

The National Institute on Drug Abuse reports that up to 23% of U.S. workers use dangerous drugs on the job and that the drug users cause 3.6 times more accidents than do their drug-free colleagues.

On-the-job drug use has "probably generated the most interest" among outside groups of any safety week theme, said Mr. Murphy, the Jacksonville, Fla.-based northern regional safety manager Tarmac Florida Inc. of Deerfield Beach, Fla.

At the center of the program is a drug abuse handbook, which organizers say will be available shortly, containing essays by drug abuse experts; a U.S. Department of Labor booklet with advice to employers; and National Safety Week promotional materials.

An essay on workplace drug and

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Inside

- If employers become complacent, a new set of outrageous benefit proposals may be quickly on their way to enactment, warns this week's editorial. **PAGE 8**
- A.M. Best Co. launches a new system for ranking insurers that do not qualify for its standard ratings. **PAGE 13**
- AXA-Midi Assurances S.A. is preparing for hearings in Illinois and other states on its plan to acquire Farmers Group Inc. **PAGE 15**
- Accident insurance is now a dynamic employee benefit that provides a humane employee service at a remarkably low cost, says Robert Clemens of CIGNA Corp. in Perspectives. **PAGE 20**
- The Manville Personal Injury Trust Fund is proposing new steps to preserve its limited cash flow. **PAGE 25**
- New Jersey is suing Exxon in connection with the recent spill of more than 500,000 gallons of heating oil. **PAGE 28**
- Public brokers' revenues should increase about 6% to 7% for the year, says stock analyst Leonard M. Wilson. **PAGE 31**

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Disco's coverage may be inadequate for fire death claims

By MARIA KIELMAS

ZARAGOZA, Spain—The owner of a discotheque in which 43 patrons were killed during a fire by noxious fumes has sorely inadequate liability insurance to cover potential claims, sources say.

However, authorities say the disco—in which supposedly flame-retardant furnishing caught fire, releasing the noxious fumes—was in compliance with strict city fire codes.

The owner of the Flying Discotheque, who owns four other discos in the northern Spanish city, has 5 million pesetas ($45,935) of liability insurance to cover claims from the Jan. 14 fire, a source says. However other sources note the owner, Faustino Martinez, could have easily obtained 500 million pesetas ($4.6 million) of liability coverage in the Spanish market.

Mr. Martinez's insurance is underwritten by Compania de Seguros Lepanto S.A. of Barcelona. A Lepanto spokeswoman confirmed that the company insures the disco but declined to elaborate about the coverage.

A judge has ordered Mr. Martinez to post a bond of 500 million pesetas to cover liability claims, but it is uncertain whether he has the cash to post the bond.

And, sources say the bond still probably would not cover claims resulting from the fire.

Based on awards to the relatives of fire victims in Spain five years ago, which then averaged 20 million pesetas ($183,740) per person, liability damages stemming from the disco fire could total 860 million pesetas ($7.9 million), according to an insurance executive.

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Canadian health plan

Think tank blasts nationalized system

By CHRISTINE WOOLSEY

U.S. policymakers "should think long and hard before copying" Canada's national health care system, which has created many health care hardships for its citizens, concludes a Canadian think tank.

While health care costs are not rising as rapidly in that country as in the United States, cost control measures imposed by the Canadian system have caused extensive health care rationing and chronic technology shortages, sometimes resulting in "needless deaths," says a report by the Fraser Institute, a free-market think tank in Vancouver, B.C.

In addition, tensions caused by cost controls increasingly have led to work stoppages among health care providers and the "shutdown of virtually all health care in an affected region," pointed out Michael Walker, institute executive director and author of "Why Canada's Health Care System Is No Cure for American Ills."

The report blames soaring U.S. health care costs on a problem it says is also prevalent in Canada: a lack of incentives to use health care services cost-effectively.

However, the private sector U.S. system has reacted with "creative" health care cost controls, which the Canadian health care system should learn from, says the report, sponsored by the Heritage Foundation, a conservative think tank in Washington, D.C.

A health care official with the province of Nova Scotia and two U.S. benefit consultants, though, say the report exaggerates the problems with Canada's national health care system, which they praise for providing universal health care coverage.

The report concludes: "Americans have been led to believe that the Canadian health care system is a model for health care reform in the U.S. To be sure, average Canadians seem content with their 'free' care paid for by taxes. But average Canadians do not require significant medical services. For those who do, the Canadian system increasingly means waiting lists, chronic shortages of new technology and the rationing of many procedures."

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Exxon spill shows need to check safety systems

By MICHAEL BRADFORD

The Exxon Corp. oil pipeline leak in a New York estuary earlier this month—aggravated when warning signals from chronically faulty loss control equipment were ignored—is a costly reminder that loss control systems must be maintained and monitored, experts say.

But Exxon is not alone: Other companies have learned this lesson the hard way.

And risk managers note that resources are not always available to implement optimal system maintenance and monitoring procedures.

The Jan. 2 spill of 500,000 gallons of No. 2 heating oil has fouled the banks of Arthur Kill, which separates New York and New Jersey, and has killed more than 400 birds that nest and feed nearby.

Exxon has acknowledged that it failed to prevent the discharge even when a leak detection alarm sounded, because the system had been falsely signaling since 1978 and was often ignored. Exxon also said that a backup detection system was malfunctioning at the time of the spill (*BI*, Jan. 15).

New Jersey officials now seek to fine Exxon and hold it liable for all damages (see story, page 28).

The company is paying claims related to spill and "the process is going smoothly," a spokesman said. "Exxon has accepted responsibility for the damages for which we are liable."

Maintaining loss control systems should be as ingrained in risk management programs as "motherhood and apple pie" are in American culture, said William D. O'Connell, national director of business insurance consulting for Deloitte & Touche in Dallas. "You're supposed to maintain your systems."

While risk management experts do not offer a sweeping indictment of risk managers' loss control systems a lack of maintenance and monitoring often causes accidents, they say.

"There's not a person in the industry" who cannot cite examples of missed signals or faulty detection, said Walter Luker, senior vp and general manager at Mead Loss Control Consultants Inc. in Dayton, Ohio.

AP/Wide World Photos

Workers try to soak up heating oil from the Exxon Corp. spill that is fouling a bird sanctuary near Arthur Kill.

Losses resulting from a breakdown of loss control systems or a lack of such systems is "an everyday occurrence," said George Lynn, manager of environmental services for John Mathes & Associates Inc. in Columbia, Ill.

Industrial Risk Insurers of Hartford, Conn., also "has seen a number of instances that suggest lack of maintenance played a part" in a loss, said Stanley

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$30 million may be sought

Warrilow sees new cash call

By STACY SHAPIRO

LONDON—Members of the open 1984 underwriting year of Lloyd's of London syndicate 553, formerly managed by C.J.W. (Underwriting Agencies) Ltd., can expect another cash call when the syndicate is audited this spring.

The approximately 1,452 members of the non-marine syndicate formerly underwritten by Cyril J. Warrilow will be asked to pay at least 18 million pounds ($29.9 million) on top of the 31.9 million pounds ($53 million) they have already paid, the agency says.

Should auditors find a deterioration in the 1984 results, members could be asked to pay more, according to John Hume, a C.J.W. Underwriting director who is involved in the syndicate's runoff.

"There will be a cash call this year," said Mr. Hume last week. "We haven't said what it will be, but we have told member's agents that. . .if the numbers stay the same as they were last year, which they won't, (the call) would be around 18 million pounds."

There is also a 1.86 million pound loss ($3.5 million at year-end 1987 exchange rate) on the open 1985 underwriting year that hasn't been called yet, Mr. Hume confirmed. He would not say whether there would be a cash call on 1985 members this year.

Mr. Warrilow resigned as underwriter in 1987, when the syndicate began running off its three-year underwriting accounts.

Mr. Hume said members and their agents will know the size of the cash call only after the syndicate's audit is completed—by April 26 under Lloyd's rules.

Meanwhile, the members continue their fight in British High Court to recover millions of pounds lost by the Warrilow syndicate.

In June 1989, more than 570 Lloyd's members sought unspecified damages in suits against C.J.W., 39 Lloyd's member's agents and two accounting firms.

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Ex-Howden chief won't face second trial

By CAROLYN ALDRED

LONDON—Former Alexander Howden Group Ltd. executives will not stand trial on criminal fraud charges, a London judge says.

Justice Denison ruled that former Howden Chairman Kenneth Grob and former Lloyd's of London underwriter Colin Hart would not receive a fair trial because crimes they allegedly committed took place more than 10 years ago and many witnesses have either died or are too ill to testify.

Other factors taken into account by the judge include Mr. Grob's deteriorating physical and mental condition and the punishment already levied on Mr. Hart by Lloyd's, including a 175,000 pound fine ($290,000 at current exchange rates) and expulsion from Lloyd's.

The decision closes seven years of criminal investigations and legal proceedings surrounding the alleged transfer of tens of millions of dollars of Howden and Lloyd's syndicate premiums through offshore companies. The scheme was unearthed after Alexander & Alexander Services Inc. acquired Howden in 1982.

After a 15-week trial, a jury last August acquitted Mr. Grob and former Lloyd's of London underwriter Ian R. Posgate on charges of stealing or conspiring to steal millions of dollars from Howden and Lloyd's syndicates (*BI*, Aug. 21, 1989). However, a second trial involving Mr. Grob and Mr. Hart, dealing with other aspects of the alleged fraud, was postponed until this month.

Despite their legal victories, Messrs. Grob, Hart and Posgate must pay their own legal costs after courts refused to allow them to recover those costs from the government's central legal fund.

Kenneth Grob would not receive a fair trial because the alleged crimes occurred more than 10 years ago, the judge said.

Messrs. Grob and Hart were accused of diverting Howden funds to trusts allegedly controlled by Howden executives through reinsurance policies placed by Mr. Hart's syndicate. Mr. Grob faced theft charges, while Mr. Hart was accused of conspiracy to steal.

Justice Denison announced his decision to halt the proceedings against Messrs. Grob and Hart last Tuesday at the end of a pretrial review at Southwark Crown Court in London.

The delay in bringing a criminal trial "has so prejudiced the defendants in the preparation and conduct of their defense that a trial would necessarily be unfair," the judge ruled. "It would not be possible for me, as trial judge, to correct that unfairness stemming, as it does, largely from the unavailability of material witnesses."

Messrs. Grob and Hart were charged with diverting funds between 1977 and 1980, though some of the policies in question allegedly were issued between 1968 and 1974, according to the judge.

"Therefore, the trial of these defendants would not only be in respect of offenses alleged to have been committed over 10 years ago, but would necessitate inquiries into matters, some of which took place over 20 years ago," said Justice Denison, adding that the allegations "came to light in the summer of 1982."

"What had been revealed was a large-scale rolling fraud involving the misapplication of money within the Alexander Howden

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Monitoring

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Couvillon, vp of loss prevention.

The degree to which risk managers maintain loss control systems "depends on the account and their experience," Mr. Couvillon said.

A company dedicated to system maintenance or one that has had losses as a result of loss control system breakdowns will likely "maintain its systems meticulously," he explained.

"On the other hand, some say, 'It won't happen to me,' and maybe they are more lackadaisical" about maintenance and monitoring, Mr. Couvillon said.

Richard H. Soper, a principal of Soper & Associates in Palos Verdes Peninsula, Calif., cites a May 1988 fire at an Illinois Bell Telephone Co. switching station in Hinsdale Ill., as a classic case of improperly performing early warning systems (*EI*, June 13, 1988; May 16, 1988).

Phone service in some Chicago areas was knocked out for weeks.

A class-action lawsuit filed by disgruntled businesses charged that the fire alarm at the unstaffed Hinsdale station sounded at an Illinois Bell office in downstate Springfield instead of at a local fire station. That delayed firefighters 30 minutes to one hour, the suit said.

Critics also complained that the switching station's sensitive equipment was not protected by a Halon fire suppression system.

However, a Cook County judge eventually dismissed the suit. An appeal was filed, which is still pending.

An Illinois Bell spokesman said that alarms worked as they were intended, but the system has been changed some because of the fire.

"We've installed a direct alarm to the fire department in Hinsdale," he said. And, a 24-hour alarm monitoring center has been set up closer to the switching station, he added.

William L. Mather, administrator of risk management at The Gillette Co. of Boston, suggested that some risk managers consider inspecting loss control systems more often.

Monitoring loss control systems is "one of the major areas of concern" at Gillette, noted Mr. Mather, *BI*'s 1988 Risk Manager of the Year.

He recommended that companies working with or producing chemicals and flammable liquids have "real time" detection equipment that will sound an immediate alert in the event of a leak or spill, instead of a system that must be checked to determine whether a problem exists.

When flammable substances are involved in a spill or leak, "you want to know about it immediately," Mr. Mather said. Otherwise, "you are just waiting on ignition."

Other risk management experts—citing personal experience—concur that monitoring loss control systems is paramount.

IRI's Mr. Couvillon said utility companies have a particularly tough time with winter maintenance.

Taking a system off-line for maintenance, as firms may need to do, could impede a utility's ability to generate electricity, he said, but "there are some things you really can't fool with."

Mr. Luker of Mead Loss Control, a property loss control specialist, also stressed the importance of frequent system checks.

Boiler accidents at paper plants could generate extensive property and business interruption losses, but Mr. Luker said he has seen cases where workers ignored boiler system warnings from frequently malfunctioning equipment.

"People will get an alarm and cut it off because they think it's an alarm malfunction. You just can't do those kinds of things."

He recalls a Wisconsin paper plant that installed a pump to boost water supplies for its sprinkler system but did not have a monitoring system for the pumphouse thermostat.

The thermostat was not turned up during frigid weather, and pipes burst, flooding the plant and causing $20,000 to $30,000 in damage.

"If they had had a weekly inspection, they would have caught the problem before a loss occurred," he asserted.

Mr. Lynn of John Mathes also pointed out that "right now, one of the big issues is underground storage tanks, which now come under heavy regulation."

Until recently, the tanks have been "out of sight, out of mind," Mr. Lynn said. "If you had a problem, it was hiding. What would happen if it doesn't perform to maximum satisfaction? If you didn't do routine checks, you would never know."

The U.S. Environmental Protection Agency estimates that 20% to 30% of all underground storage tanks leak, but of the several hundred John Mathes inspected last year, 50% to 75% were leaking, he said.

Tanks inspected by Mr. Lynn's firm were older or suspected of leaking, he pointed out. They were checked because EPA guidelines call for upgrading or replacing tanks that are at least 25 years old.

"There were significant problems with some of them," even though "you couldn't see anything or smell anything," Mr. Lynn stressed.

Doug Williams, associate director of corporate insurance at Boehringer Ingelheim Corp., a Ridgefield, Conn.-based pharmaceutical manufacturer, said his company actively monitors and maintains loss control systems.

An outside environmental services firm inspects the company's underground tanks at least annually, Mr. Williams said.

New diesel and gas pumps with sophisticated self-monitoring systems will help Boehringer Ingelheim comply with EPA regulations on self-testing, he added. "All we really have to do is read the dials and it will tell us if the shell has been jeopardized."

The pharmaceutical company also uses infrared imaging to detect metal fatigue in machinery.

Such imaging, done four times a year by Hartford Steam Boiler Inspection & Insurance Co. of Hartford, Conn., "can help detect weaknesses in the equipment long before it goes down," Mr. Williams said. "They take a look at things that are crucial to our operation."

"We've been fairly clean. I can't say we have had any problems, and that makes me rest easy."

Mr. Luker of Mead Loss Control also pointed out that some state and federal codes mandate some protection against loss control system failures.

For example, sprinkler system codes nationwide contain "some redundancies," which are needed, for example, "in case one part of the system fails, there is something of a backup to take care of it," said Mr. Luker.

But, one risk manager pointed out that monitoring systems "is a tough, tough area to deal with, particularly since most risk managers do not have operational responsibility."

He said monitoring loss control systems "comes down to having a group of people executing the responsibilities they should. You have to have systems properly maintained and on the list for maintenance."

And, everyone should be notified of new exposures, he advised.

And, despite their best intentions, risk managers may find that factors such as budgetary limits can make proper maintenance impossible, noted Mr. O'Connell of Deloitte Touche.

"When the squeeze is on profits, one of the easiest things to do is defer maintenance. It's like a car: If the tires look a little worn, you should replace them. But if you don't have the money, you say, 'Well, I can get a few more miles out of them.' Maintenance falls into that category," he said.

Gillette's Mr. Mather also stressed that risk managers should "monitor their monitoring programs."

"You have to take a look at what it is you are doing and ask if this monitoring system is appropriate for the risk," he said. ■

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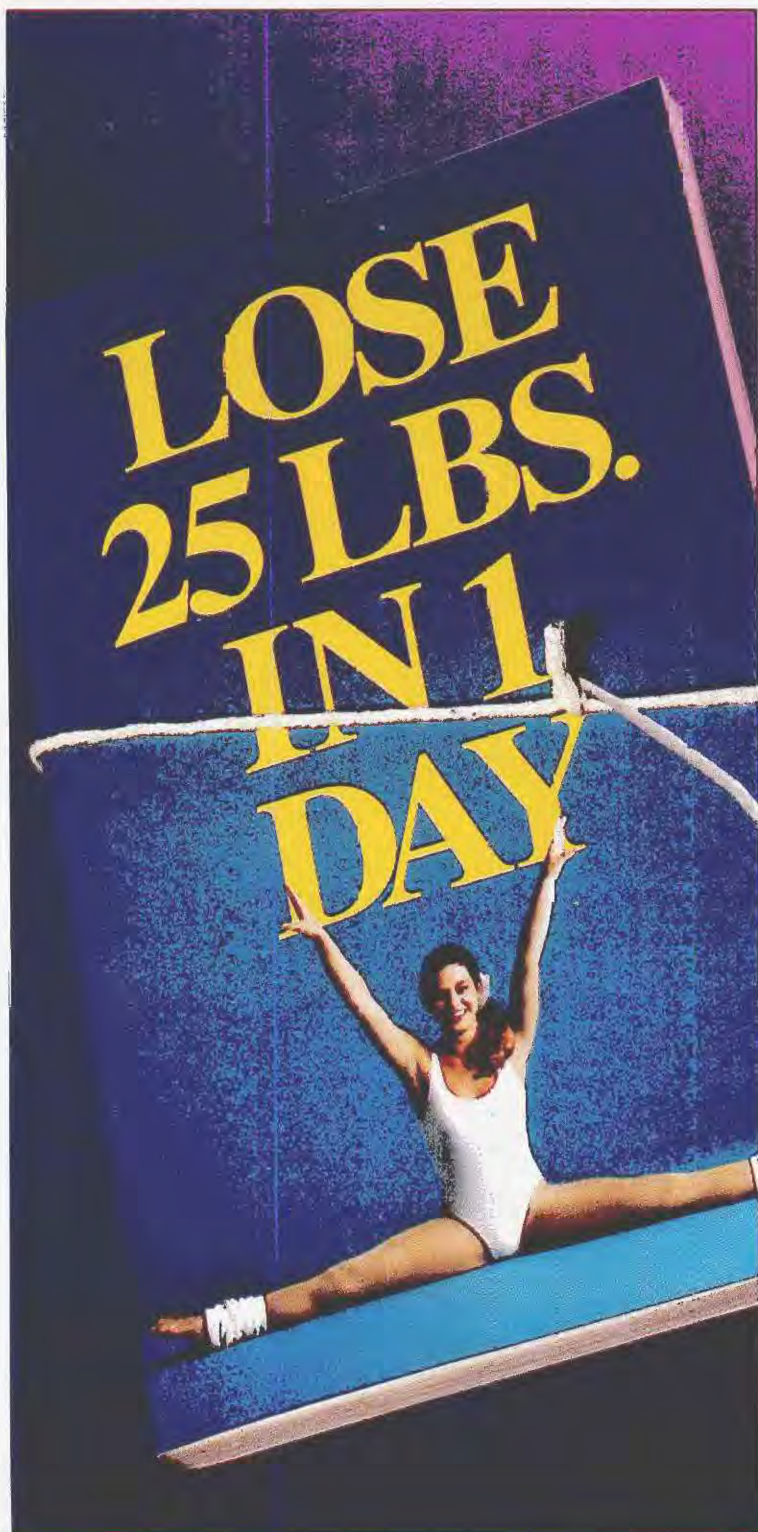

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Kodak extends benefits in takeover defense

In what the company believes is a unique anti-takeover defense, Eastman Kodak Co. adopted a benefit continuation plan for all 80,000 U.S. employees in the event they lose their jobs after a corporate takeover.

Under the plan, employees would be entitled to health, dental and life insurance benefits for up to one year if Kodak is purchased, the Rochester, N.Y.-based company announced earlier this month. The plan would respond to involuntary terminations up to two years after a takeover.

The benefit program helps "remove the uncertainty factor" when corporate ownership becomes an issue, the company said in its employee newsletter.

In addition to extended benefits, employees also would receive lump-sum severance pay ranging from six weeks to two years of salary, depending on length of service; a full share in Kodak's profit-sharing plan for the year in which employment ends; job placement assistance; and a retraining allowance of up to $5,000.

Kodak's plan differs from many other anti-takeover measures in that it protects all employees, rather than just key managers and executives, said a spokesman.

"Consistent with our views, we felt the plan should provide to all regular employees," he said.

The size of employee contributions to health and life insurance coverage currently varies, but the company would pay workers' contributions for these benefits if they are fired after a takeover, the spokesman said.

Dental insurance currently is provided on a non-contributory basis and would remain that way under the protection plan.

Life, health and dental benefits would be extended from four months to one year for employees who have been with the company one to 10 years, depending on length of service.

For example, while employees who have been with Kodak less than a year would receive continued benefits for four months, employees with 10 or more years of service would receive benefits for a year.

Employees receive health care benefits through several health maintenance organizations and two Rochester, N.Y.-based affiliates of the Blue Cross & Blue Shield Assn.: Rochester Hospital Service Corp. and Genesee Valley Medical Care Inc.

Hartford, Conn.-based Travelers Corp. provides dental coverage to Kodak employees, while New York-based Metropolitan Life Insurance Co. underwrites Kodak's group life insurance program, the spokesman said.

Also under the plan, Kodak employees would receive a full wage dividend—similar to profit-sharing—for the year in which they are terminated.

The spokesman said Kodak typically declares a dividend in November that is paid the following March. Under the plan, for example, employees terminated in June would still receive their wage dividends for the entire year.

Terminated employees also would be eligible for free career counseling and a retraining allowance of up to $5,000 to qualify for positions within or outside the company.

A severance pay formula would pay three weeks of salary for every year of service up to 16 years, and four weeks salary for every year of service beyond that.

Benefit beat

Employers form PPO

Seventeen major Connecticut companies have agreed to contribute $1.7 million to help launch a new preferred provider organization called ValueCare Inc.

Most of the hundreds PPOs established around the country since the mid 1980s have been created by insurers, hospitals or third-party claims administrators.

But with ValueCare—whose contributors include Travelers Corp. and United Technologies Corp.—"you have major employers, with lots of purchasing power, who are committed to making this work," pointed out Joseph Brophy, Travelers senior vp-employee benefits.

The PPO will analyze claims data and work with an advisory board of physicians to form a network of high quality, cost-efficient providers, said Ralph S. Pollock, ValueCare chief operating officer.

"We are not interested in the discount approach. We're interested in quality and cost-effectiveness," Mr. Pollock said.

"Providers in the network will be recruited with selectivity and will be independently accountable for the quality of care delivered," according to ValueCare.

Companies contributing to ValueCare are expected to receive discounts like smaller monthly charges for access to ValueCare's provider network, Mr. Pollock said.

The capital contribution is $25 for each employee eligible for health care coverage, but not enrolled in a health maintenance organization.

Mr. Pollock expects the provider network to be in place by January 1991.

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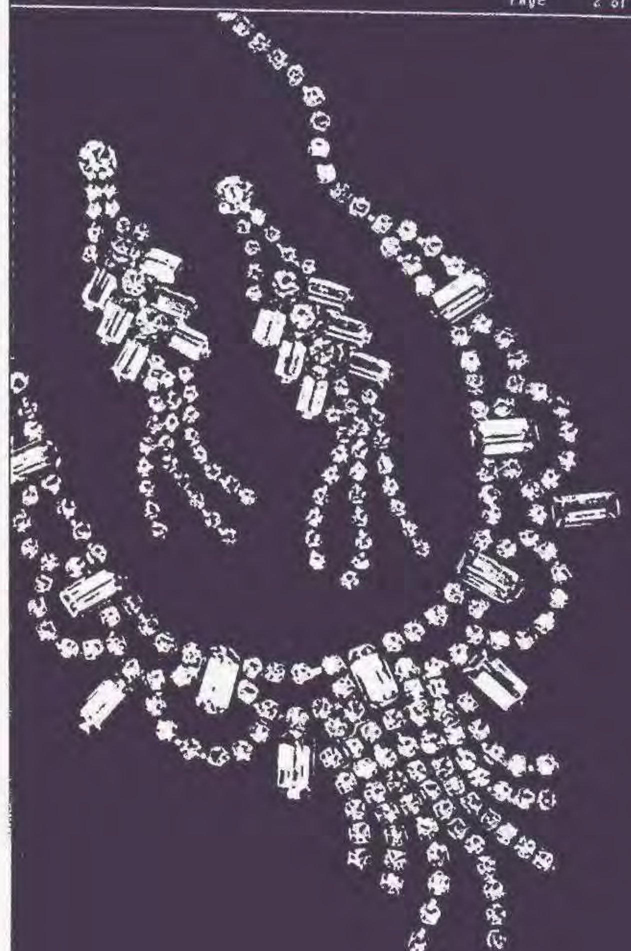

Continued from previous page
cies, is establishing an employee stock ownership plan under which Ayer will begin contributing stock to an existing defined contribution pension plan.

Ayer had previously contributed cash to the defined contribution plan, but the ESOP will give employees a 20% to 25% stake in the agency within five years.

In addition, the agency is creating a new 401(k) savings plan for its 980 U.S employees. Ayer will fully match the first 3% of an employee's pretax salary contribution up to $1,000 per year, said Jerry Jordan, executive vp and director of finance and administration for the New York-based firm.

Mr. Jordan said Ayer is establishing the ESOP to give all employees with at least one year of service a personal stake in the company.

"In a personal service business like this it is desirable for employees to have some stake in the operation," said Mr. Jordan.

Ayer will buy shares from the company's treasury equal in value to the 15% of covered compensation it previously had contributed to the company's defined contribution plan, Mr. Jordan explained. He said Ayer will then allocate the shares—expected to be about 4% to 5% of total shares—to individual pension accounts.

Mr. Jordan said accountants are determining the value of the private company's stock.

Early retirement

NYNEX Corp. is trying to reduce 1990 overhead expenses by offering an early retirement package to 10,000 managers throughout the Northeast, the regional Baby Bell announced last month.

NYNEX will add five years of age and service to the defined benefit pension calculation for managers with at least 30 years of service who choose to leave the company, said a spokesman for the White Plains, N.Y.-based telephone company. Those with at least 30 years of service who accept the voluntary program receive full pension benefits without early retirement discounts.

The spokesman also said managers with fewer than 30 years of service may also take advantage of the offer, but will have their pension benefits reduced through discounts.

NYNEX said it expects 2,500 to 3,000 managers to take the offer, but it would not estimate how much a workforce reduction would save the company.

In December, Englewood, Colo.-based U.S. West Inc., another of the seven so-called Baby Bells, said it was offering early-retirement benefits to 20,000 managers in 14 states (*BI*, Dec. 11, 1989). ■

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Transit unit names Frey risk manager

Comings & goings: buyers

Karen Olsen Frey, 30, named risk manager for the Tri-County Metropolitan Transportation District of Oregon in Portland. In this newly created position she is responsible for property/casualty insurance, employee benefits and a wellness program. She also oversees self-insured liability and workers compensation programs. She reports to Bruce Harder, executive director of finance and administration. Prior to joining Tri-Met, which operates the Portland area public transportation system, Ms. Frey was risk manager for ESCO Corp. in Portland. She holds a bachelor of science degree in finance and law from the University of Denver, and a master of business administration degree from the University of Portland. Ms. Frey holds the Associate in Risk Management designation. She is a deputy member of the Risk & Insurance Management Society and a member of the Self-Insurers of Oregon.

* * *

Constance J. Zimmer, 28, promoted to benefits manager at Kimberly Quality Care in Overland Park, Kan. In this newly created position she is responsible for planning and developing all corporate employee benefits for the company's more than 2,000 administrative personnel. She reports to Mary Miller, director of insurance services. Previously, Ms. Zimmer was benefits administrator at Kimberly. Prior to joining the home health care company, she was a human resources technician with Research Health Services in Kansas City, Mo. She holds a bachelor of science degree from Kansas State University in Manhattan and is now pursuing her Certified Employee Benefit Specialist designation.

* * *

John J. Ryan, 44, named vp-human resources and administration at Parsons Brinckerhoff Quade & Douglas Inc., an international engineering consulting firm based in New York. In this newly created position, he is responsible for corporate benefits and a human resources program and also manages the purchasing department. He reports to Richard Schrader, vp. Prior to joining Parsons Brinckerhoff, Mr. Ryan worked with Ebasco Risk Management Services Inc. in New York in various personnel and human resource positions, including director of human resources. As an adjunct professor at Kean College in Union, N.J., he has lectured and conducted human resources seminars. Mr. Ryan holds a bachelor of arts degree in economics from Iona College in New Rochelle, N.Y., and a master of business administration degree in industrial relations from the City College of New York. He is a member of the American Compensation Assn. and the American Society of Personnel Administrators.

•

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Opinions

Don't let down your guard

WITH LEGISLATORS back in Washington for the home stretch of the 101st congressional session, employers must renew their vigilance against new assaults on their benefit programs.

Some benefit experts worry, as we do, that employers may let their guard down and be unprepared for a new round of congressional attacks on benefits.

There is concern that employers may be lulled into complacency by the belief—a total myth—that major legislation affecting employee benefit programs will not be enacted during an election year.

Recent congressional history says otherwise. In case anyone has forgotten, 1986 alone brought two pieces of tax legislation, a budget reconciliation measure—the infamous COBRA—and the Tax Reform Act. Both had sweeping and largely negative effects on a wide range of benefit programs.

Indeed, in 1986 employers paid so little attention to legislative developments in Washington that many only became aware of the COBRA health care continuation provisions after the fact.

And the passage of a tax reform bill with benefit provisions in 1986 came after Congress passed tax bills in 1982 and 1984—also election years—that damaged benefit programs. The 1982 tax law, for example, cut back the maximum benefits that could be funded through pension plans, while the 1984 tax law curbed the tax advantages of prefunding retiree health care liabilities.

Employer complacency also may be fueled by the belief—also a myth—that Congress, shamed over its rubber-stamping of Section 89, will stay out of the benefits arena for some time.

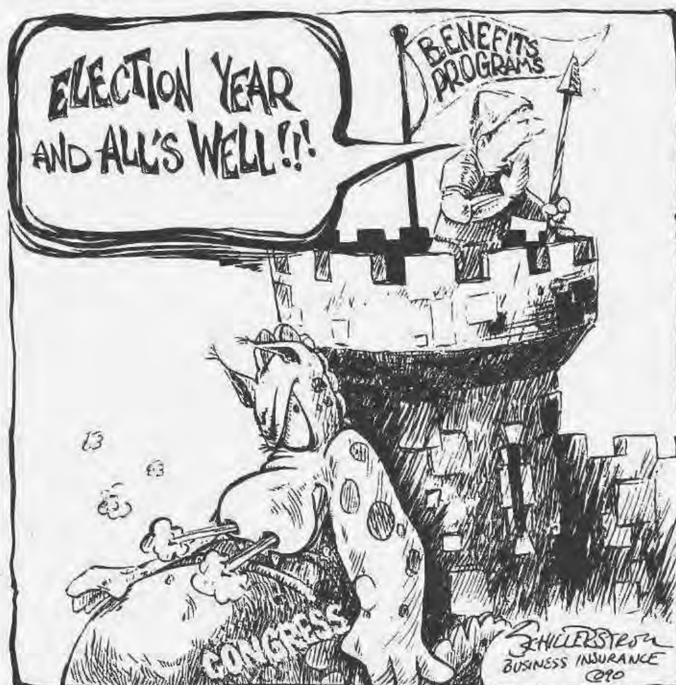
In repealing Section 89 last year, legislators obviously recognized the mistakes in those terribly complicated non-discrimination rules, but only employers speaking out can guarantee that similar mistakes won't be made this year.

Legislators won't know if a benefit proposal is misguided unless they hear from employers.

Finally, no one should consider a proposal dead and buried just because a proposal was defeated in one session of Congress.

Nobody should doubt that some advocates of benefit proposals will keep trying and trying. For example, anyone who knows Sen. Howard Metzenbaum is familiar with his tenacity. The Ohio Democrat is going to fight and fight to restrict or eliminate employers' ability to terminate overfunded pension plans to gain access to surplus pension plan assets. Unless employers continue to forcefully oppose Sen. Metzenbaum, eventually he will succeed.

While the second half of the congressional session has only just started, it is clear that some very damaging benefit proposals will be on legislators' agenda.



Hearings, for example, already have been scheduled on the tax-favored status of employer-provided health care benefits.

Those hearings could be the prelude to the passage of legislation to tax benefits, a long-term goal of some members of Congress, unless employers are prepared to defend their programs.

Similarly, congressional hearings will be held next month on a proposal by Rep. Peter Visclosky, D-Ind., to require employers to share control of pension plan assets with employees. The House of Representatives rejected a similar measure last year.

Obviously, Rep. Visclosky would not have sought hearings if he didn't believe legislators still were interested in his proposal.

Finally, employers must keep their eyes open for and carefully scrutinize budget reconciliation legislation that is likely to emerge within the next few months. Legislators, with distressing frequency in recent years, have tried to sneak pet benefit proposals into these mammoth budget bills in the hope that their proposals will escape public attention.

Employers last year, through strong lobbying campaigns, convinced legislators to remove a number of outrageous benefit proposals, such as imposing stiff fees on employers filing federally required pension and welfare plan reports.

But if employers become complacent and don't track budget reconciliation bills, a new set of outrageous benefit proposals may be quickly on their way to enactment.

Letters

'No-fault' insurance untenable

To the editor: Your Nov. 20, 1989 editorial, "Tort Reform off to New Start," urged support of Project New Start, an effort to offer certain "no-fault" insurance options as an alternative to the common tort system. The advantage, we are told, is reduced cost.

If this advantage is real, why are commercial liability premiums for similar vehicles higher in Kentucky than in Tennessee, when Kentucky is a "no fault" state? Why are personal auto premiums higher in Michigan than in Indiana, when Michigan has one of the country's most complete "non fault" systems? Why did Michigan choose to reinstate a limited amount of tort liability for property damage if "no fault" is so good?

In talking to those who buy personal auto insurance, it is difficult to find anyone who likes "no fault." The answer is to offer substantial first-party benefits, without curtailing the right to sue.

The real problem with the tort system is not an insurance problem. Liability exists regardless of insurance. Tort reforms are needed urgently, but the issue must be addressed separately from insurance. After all, insurance is but one of several mechanisms to cover the financial results of tort liability. We must keep these issues separate so that each can be addressed in its own proper forum.

Stephen Michaels
Indianapolis

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Section 89's demise is welcome news

To the editor: Just a note to pin a rose on Jerry Geisel for his excellent reviews of the demise of Section 89 and the Medicare Catastrophic Act (*BI*, Dec. 25, 1989).

However, one wonders why the bureaucrats in the Treasury Department have not been fired en masse for concocting the Section 89 abomination.

Rep. Dan Rostenkowski, D-Ill., will continue to be re-elected because "you *can* fool all of the people all of the time."

Thom Williams
Vp-Education and Communication
Greenheck Fan Corp.
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Bond insurance

Continued from page 2

Removal of European Community trade barriers in 1992 also presents a "window of opportunity," and the potential is "staggering" if one considers the likelihood of Eastern European participation, he said.

The outlook for credit enhancement is also bright because the municipal bond business is still being driven by the security-conscious individual investor, he said.

"We see no change in the continued domination of the market by retail investors and their proxies, unit investment trusts and mutual funds," said Mr. Elliott. This is particularly true, he said, in light of recent equity market volatility which has left individual investors reluctant to return to stocks.

Individual investors' increased sophistication and interest in tax-exempt financing "bodes well" for relatively new arrangements like municipal equipment leases, Mr. Elliott said.

In 1989, about three-quarters of the $8 billion in new issues sold in the tax-exempt leasing market was insured, he noted. Insurance guarantees investors repayment of principal and interest on these securities in the event of default.

"We expect that the insured market for these securities will grow as municipalities, chafing under tax reform restrictions in bonding, shift into leasing to fund routine expense and individual investors become more informed," Mr. Elliott said.

Describing 1989 as "a year of consolidation and shifting ownership" among bond insurers, Mr. Elliott said, "We think competition will remain stiff throughout 1990 so long as interest rate differentials between higher and lower-rated municipal credits continue to narrow" (*BI*, Nov. 20, 1989).

'Financial guarantors do well under any interest-rate environment,' says David H. Elliott.

Municipal bond insurers confer their own triple-A ratings on the lower-graded municipal issues they insure. The issuer's cost of the insurance is covered by the lower interest rate at which it can issue a triple-A rated bond.

But when interest rates are low, there is a smaller spread between the interest on triple-A issues and lower-rated bonds. As a result, municipal insurers must reduce rates for the insurance to retain some value to the bond issuer. This has generated strong competition among municipal bond insurers.

Mr. Elliott also said, however, that "as an industry, financial guarantors do well under any interest-rate environment."

The economic slowdown that marked last year's fourth quarter could continue this year, he noted.

But "flirting with recession could further spur the growth of credit enhancement. If interest rates increase and spreads widen as they often do during an economic downturn, insurance becomes more attractive," he said.

However, he expects stable rates early in 1990 and a slight decline in the second half, causing an increase in refundings. Refundings involve retiring existing bonds by issuing new securities to take advantage of lower interest rates.

Mr. Elliott said he does not, "at the moment," foresee more insurers joining the market, but that he "wouldn't be surprised if we did have some" new competitors.

The future is bright for "gradual and steady" growth of new issue municipal bonds, he said. "For starters, we expect that issuers who have used up the proceeds borrowed in 1985 and 1986 will reenter the market to fund new projects," said Mr. Elliott. Anticipation of the Tax Reform Act of 1986 created a boom in municipal bonds during those years.

Volume growth will be fueled by the vast U.S. infrastructure needs, said Mr. Elliott. MBIA saw an increase in the number of "bread-and-butter" types of tax-backed issues that were insured in 1989, said Mr. Elliott. "We believe the trend will continue with 1990 being a 'get back to basics' year,'" he said.

These infrastructure needs will be compounded by global warming, which means power plants must be re-engineered to provide greater cooling capacity. Global warming, and the resulting rise in sea levels, also will mean eroding beaches must be restored, said Mr Elliott.

Mr. Putnam predicted the new-issue municipal bond market will reach $150 billion annually by the mid-'90s, before ending the decade at an annual volume close to $200 billion. Key areas, he said, will include education, health care, waste water and transportation.

Municipal bond professionals surveyed by MBIA also predicted that 34.1% of the $120.6 billion in new issues next year, or about $41 billion, will be general obligation bonds, compared to 32.1%—or about $37 billion—of the $116 billion market in 1989.

A total of $2.7 billion in taxable municipal bonds will be issued this year, down from about $3 billion in 1989, according to the survey.

A total of 55% of the respondents also said they do not believe there will be a U.S. recession in 1990.

Also speaking at the seminar was Michael R. Feigeles, group vp of Merrill Lynch Capital Markets, who heads the firm's municipal retail sales department.

J.W. Rayder, executive director of U.S. Rep. Beryl Anthony Jr.'s Commission on Public Finance, also spoke. The Arkansas Democrat's panel of government officials and outside advisers is seeking better ways to finance public facilities. ■

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Airline claims hit near-record in 1989

By CAROLYN ALDRED

London

LONDON—Airline hull and liability claims exceeded $1 billion in 1989, making it the second worst year ever for aviation underwriters, according to preliminary results from London-based Aviation Information Services Ltd.

Twelve Western-built jets were involved in fatal crashes in 1989, which resulted in the deaths of 1,004 fare-paying passengers. Twenty-eight Western-built jets were declared total hull losses.

Hull loss costs totaled $463 million for the year, and reserves and estimates for the total passenger liability exposure from the fatal accidents amounted to $542 million, the AISL estimated.

Total aviation losses were second only to those in 1985, when hull losses hit $476 million and estimated passenger liability losses totaled $850 million, resulting in overall losses of more than $1.3 billion.

1989 also was "a poor year for turboprop airliner and commuter airliner accidents, with at least 40 total losses being known costing some $87 million," the AISL said. About 280 fare-paying passengers were killed in 16 of those crashes, the report said.

Lloyd's computer

London brokers, insurance companies and Lloyd's of London underwriters should develop more joint applications of the emerging London Insurance Market Network that provides computer links between brokers and underwriters in the market, says a London brokerage executive.

"We have an overwhelming need to show the rest of the world that we are more efficient and more cost effective than it is, and this will be best done by sharing services to reduce costs, improve standardization and increase efficiency," said Viscount Chelmsford, a director of broker Willis Faber P.L.C.

Market organizations are already working together on uniform standards and procedures for the LIMNET.

For example, the London Market Coordinating Committee "discusses matters from the point of view of the best interests of the London market as a whole," said Viscount Chelmsford.

The committee includes representatives from Lloyd's; the Institute of London Underwriters; the Policy Signing and Accounting Centre Ltd., which represents London non-marine and reinsurance companies, and the Lloyd's Insurance Brokers Committee.

In a speech to the Insurance Institute of London this month, Viscount Chelmsford also called an agreement among Lloyd's, the ILU, the PSAC and the LIBC to jointly develop a system for placing and processing proportional reinsurance treaties via LIMNET next year "an exciting development."

While proportional reinsurance represents a small percentage of London's overall business "in the context of the extreme concern about London's ability to compete and the deteriorating expense ratios arising out of the London Bureau system, we should attach very great importance. . .to this milestone in the history of the marketplace," he said.

Coordinating committee members also will jointly employ a project manager to oversee London market standards for LIMNET, noted John Garner, market liaison director for Sedgwick Group P.L.C.

While London underwriters and brokers should continue to compete head-to-head for business, they should learn to cooperate and share the costs of developing back office systems to service policies and claims, said Viscount Chelmsford.

PWS Holdings

London-based broker PWS Holdings P.L.C. remains committed to North America and still wants to expand its U.S. and Canadian operations despite losing millions of dollars in a disastrous U.S. acquisition two years ago.

The company, which in 1988 wrote off 5.5 million pounds ($8.9 million) after the acquisition of California-based broker Glenn, Nyhan & Associates Inc. in San Francisco, lost another 200,000 pounds ($332,000 at appropriate exchange rate) for the year ended Sept. 30, 1989, "in concluding the unsatisfactory GNA saga."

PWS Holdings also announced brokerage and other revenues increased 13% to 18 million pounds ($29 million) from 16 million pounds ($29 million), and that pretax profit before extraordinary items increased 7% to 1.6 million pounds ($2.6 million) from 1.5 million pounds ($2.7 million).

Continued on next page

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London

Continued from previous page

"The general picture in the international insurance market remains one of overcapacity, with consequently depressed rating structures and intense competition. Against this background, all our divisions are healthy and trading profitably," said Chairman Malcolm Pearson.

"We plan to expand our interests in North America. . . .We are also on the lookout for new teams of brokers in niche sectors," he added.

Meanwhile, a group of former PWS brokers who are specializing in medical malpractice insurance in North America has bought back a majority share in its own brokerage, ARK Insurance Associates.

ARK was formed in December 1987 when former PWS Director Kevin R. Dower abruptly left the company after an argument with former PWS Chairman Ronnie Ben-Zur about the purchase of GNA.

Mr. Dower, now chairman of ARK, said last week that he introduced Glenn Nyhan to PWS, but when he discovered that the agency was in financial trouble, he suggested to the PWS chairman that the brokerage not buy the California-based company (*BI*, Sept. 12, 1988).

"I told Ronnie Ben-Zur that we shouldn't go through with this," said Mr. Dower. "I challenged him at the board table" and, as a result of the board approving the purchase, "I went."

ARK was organized 24 hours later, with Lloyd's broker J. Besso & Co. Ltd. owning 51% of the company.

Last week, J. Besso & Co. sold its stake for an unspecified amount to ARK management and to Lloyd's broker R. Mears & Co. Ltd. ARK management will now own 75% of the company and Mears will own the remaining 25%, confirmed Mr. Dower.

ECGD reorganizes

Many British exporters are likely to face increased export credit and political risk insurance costs for long-term projects following reorganization of the government's Export Credit Guarantee Department.

Nicholas Ridley, Britain's trade and industry secretary of state, announced last month that the British government is restructuring the ECGD by transferring its short-term credit insurance division to the private sector.

And, while medium- and long-term credit and political risk insurance will remain under government control, premiums will be increased to adequately reflect the risks involved, according to Mr. Ridley.

The recent announcement of the government's plans to revamp the nation's export credit program follows a wide-ranging review of the Export Credit Guarantee Department, an agency formed in 1919 to help British business overcome many of the risks involved in selling overseas (*BI*, July 3, 1989).

As a result of the review by former ECGD Director Robert Kemp, the government decided to separate the two main ECGD businesses: the Insurance Services Group, which handles exports on short-term credit, and the Project Group, which handles exports of projects for capital goods on medium-term credit.

"The government's intention is that Insurance Services be converted into a company and that private capital should be introduced quickly thereafter," Mr. Ridley explained.

Reinsurance for the company will be obtained in the commercial market following the "normal practice of credit insurance companies," he said.

But for some political risks now covered by Insurance Services, there is "insufficient private market capacity," according to Mr. Ridley.

"Thus, in order to maintain facilities for exporters, the government is prepared to see a transitional period of up to three years from the date of the introduction of private capital during which a reinsurance arrangement will be in place between" the government and the company, the trade and industry official explained.

"During this period, the company will work to complete adequate reinsurance arrangements with the private market, with the aim of phasing out residual government reinsurance," said Mr. Ridley.

The government hopes the private company will be established by April 1, according to Mr. Ridley.

Meanwhile, the ECGD's Project Group activities, including medium- and long-term credit and financing support, "should continue to be provided. . .and will remain within government, but the precise form of ECGD's organization will be decided as soon as possible," he explained.

However, "the government is anxious to reduce the costs which have been associated with ECGD support for project exports in recent years. It will, therefore, continue to press hard internationally for a multilateral agreement aimed at eliminating subsidies which distort export credit and aid," said Mr. Ridley.

"In addition, to reduce the risk of losses in the future, radical new methods for managing ECGD's political risk portfolio will be introduced. Substantial premium increases for project business will be necessary, especially for business in the higher risk markets to ensure that ECGD premiums are better matched to risks," Mr. Ridley added.

However, "I believe that exporters will accept the need for this and will regard it as preferable to the withdrawal of facilities," he said, adding that the changes "are essential if ECGD is to be able to maintain and improve the quality of support it currently provides to U.K. exporters."

Medical malpractice

The British government is funding the medical malpractice liabilities of doctors and dentists working for the state-run National Health Service.

The NHS assumed "financial responsibility for negligence by doctors and dentists" working for the service Jan. 1, as a result of spiraling medical malpractice liability insurance costs, according to the British Department of Health.

Under the NHS indemnity program, health authorities will pay claims against medical professionals for negligent acts committed while they are NHS employees.

However, the program does not cover general practitioners, the state-sponsored doctors who provide initial treatment to individuals that use the NHS.

Until now, medical malpractice insurance for NHS medical employees was only available through membership in one of three medical defense organizations: the Medical Defense Union Ltd. and the Medical Protection Society, both of London, and the Glasgow-based Medical & Defense Union of Scotland.

However, "medical defense subscriptions (premiums) rose rapidly in the 1980s because of growth both in the number of medical negligence cases and in the size of the awards made by the courts," according to the Department of Health.

In fact, some members' assessments—which include medical malpractice liability coverage as well as their membership fees—rose to 1,350 pounds ($2,178.90 at year-end exchange rates) in 1989 from 336 pounds in 1986 ($497.28 at applicable exchange rate), according to the department.

Under the new system, NHS doctors will be covered for past incidences as well as for future liabilities.

Initially, the program will be divided into three layers: The first 300,000 pounds ($495,000 at current exchange rates) of any medical malpractice liability claim award will be paid by the government health authority, while 80% of any amount above that will be taken from the reserve funds already established by the health defense organizations. Any remainder will be paid by the health authorities.

After the organizations' reserve funds are depleted, the government will assume all medical malpractice liability costs.

Meanwhile, all NHS medical staff who provide services outside of the national health system have been advised by the Department of Health to maintain their own medical malpractice coverage.

In addition, the medical defense organizations expect to retain most of their membership because of the other services the organizations provide, such as ethical advice and general legal advice, said Dr. John Hickey, assistant secretary of the MPS.

"Up to 75% of our work is unrelated to negligence claims," said Dr. Hickey.

Joint marketing plan

Taisho Marine & Fire Insurance Co. Ltd., one of Japan's largest insurance companies, has signed a joint marketing agreement with London-based insurer Sun Alliance Group P.L.C. to provide insurance for its Japanese industrial clients eager to move into the British market.

Under the agreement, the two companies will work together in both the United Kingdom and Japan.

By using Sun Alliance's network of offices throughout Britain and its expertise in insurance-related services, such as loss control, Taisho will be better able to provide insurance for clients in the United Kingdom, said Michael Warner, manager of overseas operations for Sun Alliance Insurance Overseas Ltd.

In Japan "Taisho will assist Sun Alliance Group subsidiary companies to develop and (both companies) will cooperate to their mutual benefit in such matters as new product development," according to a recent Sun Alliance press release.

However, Sun Alliance will continue its involvement in the British Insurance Group (Japan), he added.

BIG is an underwriting pool in which Sun Alliance, General Accident Fire & Life Assurance Corporation P.L.C. of Perth, Scotland, and Norwich Union Fire Insurance Society Ltd. of Norwich, England, provide insurance for U.K. companies with operations in Japan.

Broker in Yugoslavia

Lloyd's of London broker Kininmonth Lambert Ltd., a subsidiary of Lowndes Lambert Group Holdings Ltd., has begun operating a contact office in Zagreb, Yugoslavia.

The broker formally opened a representative office in Zagreb on Dec. 21, after receiving state approval to do so, said Kininmonth Lambert Chief Executive Mike Caley.

Kininmonth Lambert hopes to be able to provide additional London market reinsurance capacity for Yugoslavia's state insurers and reinsurers following recent relaxation in controls, according to Mr. Caley.

Loss adjusters merge

British-based loss adjusters Graham Miller (Northern) Ltd. and Knight & Co. plan to join forces to offer a nationwide network under the name Miller Knight.

Graham Miller (Northern) Ltd. was formerly part of the Graham Miller Group, which split into several separate companies a few years ago.

The new group, which will be based in London, will have 45 offices throughout the United Kingdom.

The group will generate about 6 million pounds ($9.9 million) in revenues annually, projects Miller Knight Chief Executive Graham Garside, former chief executive of Graham Miller (Northern).

Comings & goings

Dan Fettroll has been appointed a director of London-based Glanvill Enthoven North America Ltd., which specializes in arranging underwriting contacts at Lloyd's of London and in the London market for American and Canadian brokers and agents. Mr. Fettroll will handle specialty arrangements, particularly in the accident and health area, concentrating on the specific and aggregate stop-loss insurance purchased by employers to protect their self-funded employee health care plans.

In addition, **Andrew Allen** has been appointed an associate director of Glanvill Enthoven. Mr. Allen will specialize in binding authority and open market business.

Tim Burrows has been appointed energy underwriter for the marine syndicate of English & American Underwriting Agency Ltd. Energy business accounts of nearly 25% of premiums written by the syndicate.

Frank Horner has been appointed joint chairman of Heath Martens Horner Ltd., a subsidiary of C.E. Heath P.L.C. Also, **Lewin Channing** has been appointed managing director and **Anthony Grove** and **Colin Sprowson** have been appointed deputy managing directors.

Neil Dexter has been appointed managing director of Heath Fielding Insurance Broking (International). In addition, **Malcolm Harvey** and **Jonathon Proctor** have been named joint deputy managing directors.

Meanwhile, **Thomas Coster** and **Trevor Newberry** have been appointed joint deputy managing directors of Heath Fielding Insurance Broking (U.K.). In addition, **Richard Cowling** appointed director and **John Carr**, **David Moss**, **Andrew Scripps**, **Richard Taylor** and **Nigel Bamber** have been appointed associate directors.

At Heath Fielding Financial & Professional Indemnity Broking, **John Mackenzie Green** was appointed chairman and **Jeremy Underwood** was named managing director.

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Bermuda to beef up marketing effort

By ROGER SCOTTON

HAMILTON, Bermuda—Through a combined marketing effort, the Bermuda insurance industry and the island's government hope to get word out that the world's largest captive domicile is still hungry for business.

Spearheading the campaign is a marketing team—including insurance managers, brokers, underwriters and representatives of the lawyers, accountants and bankers that service Bermuda's insurance industry—headed by Robin Spencer-Arscott, chairman of Rollins Burdick Hunter (Bermuda) Ltd.

The campaign's first priority is to coordinate Bermuda's marketing effort for the Risk & Insurance Management Society Inc. conference, which will be held April 29-May 4 in Boston.

The group will promote the country as a whole rather than its component parts, said Mr. Spencer-Arscott.

"In the past when we went to RIMS, we tended to be complacent, to think of ourselves as the world's premier captive domicile and we expected the business to come to us," he said.

But as competing domiciles show no signs of giving up the fight for business that once had limited choices offshore, Bermuda must become more aggressive, said Mr. Spencer-Arscott.

Bermudian representatives cannot afford to staff a booth at RIMS and then just talk shop to each other, he warned.

"This year will be different. This year we'll go to RIMS as a team," he said.

The marketing team, including the Bermuda Finance Ministry, is producing a four-page monthly newsletter that will be sent to Bermuda-based companies planning to exhibit at RIMS.

Bermuda briefs

X.L. relocates

X.L. Insurance Co. Ltd., a Barbados-domiciled excess liability insurer, moved its headquarters to Bermuda from Barbados earlier this month as planned.

Meanwhile, President Brian O'Hara reported that X.L.'s underwriting income fell 39% to $31 million for the year ended Dec. 31, 1989, down from $51 million the year before.

Gross premiums increased 6.6% to $338 million from $317 million.

Mr. O'Hara said the adverse development of case reserves led to X.L.'s total loss reserves being increased 62% to $616.6 million in 1989 from $380.7 million in 1988.

"Our underwriting profit came out lower than we'd expected, but our investment managers did a good job and our investment results came out better than expected," said Mr. O'Hara.

Preliminary figures show that investment income rose 52% to about $140 million last year from $92.3 million in 1988.

Net income for the year increased 27% to $175.9 million in 1989 from $138.6 million in 1988, while net assets grew 36% to $1.9 billion from $1.4 billion.

"We're not entirely displeased with the overall outcome," said Mr. O'Hara.

X.L.'s move to new headquarters in Bermuda was eased because both countries allowed the company to "migrate" to a new domicile, rather than be dissolved and then re-incorporated in a new jurisdiction, Mr. O'Hara noted.

Five staff members are moving to Bermuda, where the company already maintains a brokers' contact office and underwriting and support operations. The Barbados office will be closed.

Among those moving are Brian Walford, senior vp and treasurer; Mike Budge, claims vp; and Diana Downs, newly appointed underwriter.

Previously, all claims, finance, administration and policy issuance work was done in Barbados, but its tax advantages over Bermuda evaporated last year when the United States ratified a similar tax treaty with Bermuda (*BI*, May 15, 1989).

Although Mr. O'Hara expects higher operating costs in Bermuda, he said the move would improve efficiency and eventually lower overhead.

X.L.'s parent, EXEL Ltd., will remain domiciled in the Cayman Islands.

Cox joins BICL board

John R. Cox, chairman of A.C.E. Ltd., has been elected to the board of directors of Bankers Insurance Co. Ltd., a policyholder-owned facility that provides directors and officers liability insurance and additional bond capacity to banking institutions.

Mr. Cox until last year also served as chief executive officer of A.C.E. Ltd. and as chairman and chief executive of A.C.E. Insurance Co. Ltd., the large policyholder-owned excess liability insurance facility.

He also has held top management positions with Associated Madison Cos., INA Corp. and American International Group Inc.

Bermuda-based BICL, which was formed in 1986, has 25 member banks and reported gross assets of $73 million in 1989.

M&M going to Ireland

Marsh & McLennan Inc. is setting up a captive management and related services company in Dublin, Ireland, which will report to the group's Bermuda office.

Andrew Carr, president of Marsh & McLennan (Bermuda) Ltd., which oversees the group's non-U.S. captive activities, said the new unit is being formed with one client in mind. He would not name the client. ■

New Best's index will evaluate 500 small, new insurers

By DOUGLAS McLEOD

OLDWICK, N.J.—A.M. Best Co. is introducing a new system for ranking insurance companies that are too small or have too little operating experience to qualify for the firm's standard ratings of A+ through C−.

The Financial Performance Index will cover about 500 property/casualty insurers on which Best currently reports but gives a "not assigned" rating of NA-2 or NA-3.

Best applies the NA-2 rating to insurers with less than $3.5 million in assets and annual gross written premiums and less than $1.5 million in policyholder surplus. Companies with fewer than five consecutive years of representative operating experience are rated NA-3.

Best developed the new FPI system largely in response to demand by banks and other financial institutions for analysis of property/casualty companies writing coverages such as mortgage insurance for borrowers, said a spokeswoman.

Under the new system, insurers will be ranked on a scale of one to nine:

- One will apply to companies that for various reasons are not eligible for an FPI rating.
- Two will designate weak insurers.
- Three and four will apply to below average insurers.
- Five will apply to average companies.
- Six and seven will designate above-average insurers.
- Eight and nine will signify strong companies.

In computing the rankings, Best will analyze three years of data from National Assn. of Insurance Commissioners convention statements, assessing an insurer's profitability, leverage and liquidity in relation to industry norms established by Best.

Best also will adjust the rankings for adequacy of a company's reinsurance, spread of risk and loss exposure by product line.

However, Best emphasizes that the FPI rankings are not the equivalent of the firm's standard ratings of A+ through C−.

FPI rankings, for example, are based on only three years of financial data vs. the five years required for a standard Best rating.

In addition, FPI rankings do not involve the "qualitative evaluations" performed in assigning the standard Best ratings.

These evaluations include analysis of asset quality and management experience, and adjustment of policyholder surplus to reflect—among other things—loss reserve adequacy and the current market value of a company's investments in bonds, preferred stocks and mortgages.

To receive a 1990 FPI ranking in Best's Insurance Reports and Best's Key Rating Guide, insurers that have not filed annual statements with Best in the past must submit 1987 and 1988 statements by Feb. 15. Statements for 1989 are due by April 1.

Insurers that do not meet these deadlines will have FPI rankings published in Best's weekly Insurance Management Reports.

Separately, Best is expanding reports on insurers carrying an NA-1 rating, assigned mainly to small mutual and stock insurers that are exempt from NAIC annual statement filing requirements.

Reports on NA-1 companies are based on financial information submitted through Best's Data Collector program, run in cooperation with the National Assn. of Mutual Insurance Companies and other organizations.

Expanded reports will include more information on management, operations and underwriting at NA-1 insurers, according to Best.

Insurers that have not submitted Data Collector information in the past must file information for 1987, 1988 and 1989 by April 1 to be included in Best's Insurance Reports and Best's Key Rating

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Delaware eyes health coverage fund

DOVER, Del.—A bill introduced last week in the state Legislature would require Delaware employers that don't provide at least bare bones health insurance for "medically indigent" workers to pay into a state insurance fund beginning in 1991.

A public hearing is scheduled this week on the proposal to assess employers who provide no coverage—or pay less than 75% of an eligible employee's health insurance premium—would be charged up to 50 cents for each hour the employee works. Money in this Medicaid Supplement Trust Fund would be used to provide health care coverage for "medically indigent" employees.

To qualify, workers would need incomes below 300% of the U.S. poverty level and could have no other health care coverage.

Those employees would also contribute to the trust fund at rates based on income and whether an individual or family plan is chosen.

The bill, co-sponsored by state Sen. Herman Holloway, D-Wilmington, and Rep. William Oberle, R-Newark, was prepared by the State Advisory Council for the Coordination of Services to the Handicapped.

If legislators approve the proposal, the state Department of Health and Social Services would set the exact amount to be contributed by employers and employees.

The bill would allow health care insurers bid for state contracts to run the system.

Services provided by the system would include hospital care, physician care, outpatient and emergency room care, routine preventive exams and screenings, X-ray and laboratory work, hospital and outpatient care for the mentally ill, prescription drugs, vocational rehabilitation and therapy services, and eye and ear exams.

Patients would elect a primary care physician to coordinate and oversee all covered services.

A state agency would, in turn, evaluate the primary care physicians to ensure that "adequate care is provided to the patient, and appropriate utilization is made of economical health care service providers," the bill says.

Besides uninsured workers, selected other Delaware residents—including those eligible for Medicaid, Social Security or Aid to Families with Dependent Children—would be eligible and would also pay a portion of coverage costs, based on income.

Some money normally budgeted for state medical programs would go to the trust fund, say the bill's sponsors.

—By Adrienne Locke

Around the states

Ambassador liquidation

MONTPELIER, Vt.—Partial payments to Ambassador Insurance Co. claimants are continuing after the Vermont Supreme Court last month rejected the challenge by former company managers and owners to a 1987 liquidation order.

The state Supreme Court upheld the Washington County Superior Court's liquidation order by rejecting former Ambassador officials' argument that appropriate legal notice was not given to all 300,000 potential claimants, said Elizabeth Costle, general counsel for the Vermont Department of Banking and Insurance.

In addition, the high court took two steps to decide which, if any, of the legal and consulting fees incurred by the former Ambassador officers in their effort to avoid liquidation should be paid from the company's remaining assets.

First, the court established a "good faith" standard for fee reimbursement, saying that fees associated with contesting a liquidation order may be eligible for reimbursement if former company officials prove they had legitimate reasons for contesting the order.

Second, it asked the Superior Court to determine how much of the more than $700,000 in legal and consultant fees met that standard, Ms. Costle said.

Insurance Commissioner Gretchen Babcock, who left office earlier this month, said in a statement that there was no reasonable basis for former company officials to contest the liquidation after management's own experts determined that the company was insolvent.

"Continuing the fight to regain control of Ambassador after the massive insolvency was clearly evident as a desperate delaying tactic," Ms. Babcock said in a statement.

As a result, the department unsuccessfully sought a rehearing to prohibit company officials from recovering any fees for attempting to avoid liquidation in bad faith.

Ambassador was placed in receivership by the department in 1983, declared insolvent by at least $45.6 million in 1984 and ordered liquidated (*BI*, Sept. 17, 1984). Following a three-year appeal, the liquidation order was upheld by the state Supreme Court and the liquidator began paying claims at the rate of 20 cents on the dollar in 1987 (*BI*, March 16, 1987; May 27, 1985).

The Ambassador estate has paid about $28.5 million in claims to policyholders throughout nation. It expects to disburse an additional $3 million to $4 million in the coming months.

—By Meg Fletcher

CHIP director

SPRINGFIELD, Ill.—Illinois' medical insurance program for high-risk individuals is coming of age with the appointment of a full-time director and increased enrollment.

Richard Carlson, assistant director of the Illinois Department of Insurance since August 1981, this month became the first executive director of the Illinois Comprehensive Health Insurance Program.

"This is a unique opportunity to manage what is, in effect, an insurance company operating in the public domain and to have a significant impact on how our state is addressing a major social issue," Mr. Carlson said.

The CHIP board also voted to raise the enrollment cap to 4,500 from 4,000.

CHIP sells health insurance to people who cannot buy it elsewhere because of a physical or medical condition and caps individual premiums at about 135% of a formula-derived market average.

Illinois was the first state to directly allocate state money to help fund any program deficit. Most states assess health insurers to pay the shortfall and offer those insurers some type of tax credit in return (*BI*, Feb. 1, 1988).

Funding problems delayed implementation until last spring (*BI*, April 10, 1989; Jan. 23, 1989.)

Illinois now allocates $12 million for the fiscal year that began last July.

There has been "good, steady growth" in the program, Mr. Carlson said.

Approximately 3,850 people were enrolled by year-end and about 75 are being added weekly, he said. That may require the board to re-evaluate its current enrollment cap in the next few months, Mr. Carlson added.

The CHIP program paid out $1.6 million in claims in 1989, he noted.

The CHIP board plans to seek $29 million—enough for 8,500 people to participate—from the state for fiscal 1991, Mr. Carlson said.

"We want to demonstrate to those people insured by CHIP that it is indeed a permanent program that they can rely on both now and in the future," he said.

Meanwhile, Illinois Gov. James Thompson appointed Stephen Schneider to replace Mr. Carlson as assistant director of the state's Department of Insurance.

Mr. Schneider has been director of government relations since 1984 for Washington National Corp., an insurance holding company in Evanston, Ill. Previously he worked as a legislative analyst for the Illinois Senate Republican staff.

—By Meg Fletcher

New Vermont regulator

MONTPELIER, Vt.—Gov. Madeleine Kunin has named Jeffrey P. Johnson banking and insurance commissioner of Vermont, replacing Gretchen Babcock, who resigned recently to join the Federal Reserve Board in Washington.

The appointment, effective Jan. 13, must be confirmed by the state Senate.

Mr. Johnson, 36, had served as the department's deputy commissioner since October 1987 and was its general counsel in 1986. Between 1984 and 1986, Mr. Johnson was an assistant state attorney general in the tax department.

—By Douglas McLeod

Texas comp hike

AUSTIN, Texas—Texas businesses whose workers compensation insurance is written by the Texas Workers Compensation Assigned Risk Pool are facing rate increases in 1990.

The Texas State Board of Insurance in late December adopted rules that call for a 15% rate hike when policies written in the pool are renewed this year. In addition to the 15% across-the-board increase, employers with bad loss records will face surcharges of up to 100% of their premiums.

The board adopted the measures in its effort to stem the growing pool deficit, which reached about $500 million last year.

Last year, the pool wrote premiums of $800 million, or about 25% of the Texas work comp marketplace. Using that figure, the 15% rate hike would raise $120 million in additional premiums in 1990.

The new cost hikes come on top of a 22% rate hike that went into effect this year (*BI*, Nov. 20, 1989).

Charles R. McKay, general manager of the pool, was unable to predict how much of the deficit would be reduced through both the rate hike and premium surcharges.

Mr. McKay said although employers with bad loss experience will face higher insurance costs, those surcharges could have been worse.

The board in an earlier meeting called for surcharges up to 150% for companies with high losses. "But the order in late December reduced it to 100%," he said.

Dane Harris, president of the Texas Assn. of Business, said the association is "appreciative of the changes" that softened the surcharge blow and praised the State Board for its efforts to bring down the deficit.

But Mr. Harris said the rate hike "is still not a happy story."

"We're very concerned about it," Mr. Harris said. "The 15% across-the-board rate differential means another boost on top of the 22% average increase" approved in 1989. "It is going to mean a serious problem for many employers," he said.

Mr. Harris said the sweeping workers comp reforms passed by the Texas Legislature last month eventually should help lower the cost of coverage (*BI*, Dec. 18, 1989).

—By Michael Bradford

Notification guideline

ALBANY, N.Y.—The New York Department of Labor early next month will issue enforcement guidelines for a state law requiring employers to notify all outgoing employees in writing of the date of their termination and any cancellation of their benefits within five working days of the employee's termination.

The guidelines will set deadlines for filing claims against employers and standards for fines and will clarify whether the law applies to voluntary terminations and retirement, said a Labor Department spokesman.

Claims have been accepted since the law took effect Aug. 15, but no employers have been fined, according to the spokesman. All past complaints will be reviewed and the department will accept retroactive claims for violations that occurred after Aug. 15, he said.

Violators could be fined up to $5,000.

Employers and other critics say the law is burdensome and that they were not notified of the law promptly.

"People just were not made aware of the law by the department or the state," said Fred Rumack, an employee benefit consultant with Buck Consultants of Fort Lee, N.J. "This is really unfortunate for businesses that were unaware of the law."

—By Michael Schachner

N.J. work comp hike

TRENTON, N.J.—The New Jersey Department of Insurance has granted insurers in the state a 4% average increase in workers compensation insurance rates for 1990.

The approved increase, slightly less than half of the 8.5% increase requested by the Compensation Rating and Inspection Bureau, is effective immediately.

The department also will use a new formula to calculate premiums paid by each employer.

Under the new "experience-rated" formula, employers with good claims experience will pay lower premiums while those with adverse claims experience will pay more.

Department regulators will experience rate all employers with annual premiums of $1,067 or more, down from the current $1,433 cutoff.

"The change is being made to promote safety in the workplace by providing a financial incentive for employers to cut down on work-related accidents," the department said.

In another change, the department has proposed a regulation that will require more profitable insurers to file separate rates based on their own expenses. Under the regulation, insurers would have to submit loss cost and expense data to justify requested increases, said a department spokesman.

Currently, all insurers use the same rates established by the Compensation Rating and Inspection Bureau.

—By Collin Nash

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State hearings resume on AXA bid for Farmers

By ISABELLE BERGLAS

PARIS—AXA Midi Assurances S.A., AXA Group's principal insurance subsidiary, is entering the final stretch in its drawn-out effort to buy Los Angeles-based Farmers Group Inc.

In Illinois, one of five states that have scheduled hearings this year on the hostile takeover of Farmers, regulators expect to resume hearings this week that began last November.

The French insurer proposes to buy Farmers, a subsidiary of B.A.T Industries P.L.C., for $4.5 billion from Sir James Goldsmith's Hoylake Investments Ltd. if Hoylake succeeds in its bid to acquire B.A.T. AXA would also buy a 15% stake in Hoylake for $1 billion.

Using a once-secret internal memo detailing discussions between B.A.T and its investment banker, as well as testimony of senior officers, AXA hopes to convince Illinois regulators that B.A.T considers AXA an acceptable parent for Farmers, officials say.

London-based B.A.T, though, says it wants to retain Farmers as part of its financial services operations and maintains it considers AXA an unacceptable owner. The British concern will call at least 10 witnesses in an effort to prove it, according to regulators.

Seven days of hearings on AXA's suitability as a bidder for Farmers already have been held before retired Illinois Supreme Court Justice Seymour Simon. The hearings will be reconvened later this month for another two weeks, said Kirk Petersen, Illinois Insurance Department assistant chief counsel.

A 'secret' memo shows B.A.T's position 'is simply untenable,' says AXA-Midi.

With about 20 witnesses still expected to testify, the Illinois hearings could take more than a month, say regulators.

Four of the other eight states where Farmers is licensed have also scheduled hearings: Feb. 26 in Idaho; March 5 in Oregon; April 2 in Washington; and March 19 in California, where the insurer has asked that the hearing be moved up to Feb. 13. Arizona has postponed its hearing and Kansas, Ohio and Texas have not set dates.

Having filed 33,000 pages of documents with regulators in the nine states where Farmers is licensed, AXA and Hoylake now must defend their bid for Farmers at hearings in each state.

Hoylake's original bid for B.A.T lapsed last Sept. 29, but British authorities will allow Hoylake to make another offer. However, Hoylake's bid is stalled until nine American state insurance commissioners find AXA-Midi a suitable parent for Farmers, the 15th-largest U.S. insurer.

Bidding for Farmers' is a centerpiece of AXA's avowed strategy of joining the ranks of the world's largest insurers through acquisitions in the United States and Asia (*BI*, Oct. 16, 1989).

"At the turn of the century, you will have roughly 20 big insurance companies that will dominate the world market. We want to be among them," AXA's Chairman Claude Bebear said last month.

AXA is now France's third-largest insurer and the ninth-largest in Europe, based on year-end 1988 gross premiums of $6.9 billion. It expects to report 1989 gross premiums of $6.8 billion and revenues of $2.7 billion, with a net profit of $320 million.

If it succeeds in buying Farmers, the new concern would be the world's 15th-largest insurance company with gross premiums of $12 billion, AXA estimates.

Illinois is expected to be the first state to rule on Hoylake's proposal to buy Farmers' parent company and then sell the insurer to AXA, said Mr. Petersen.

To allow the sale, he said, regulators must make sure Farmers' eventual owner:

- Complies with statutory standards.
- Provides proper financing to Farmers.
- Meets integrity requirements for controlling bodies of licensed insurance companies.
- Meets policyholder standards.

This is the second time in two years Illinois regulators have had to rule on the suitability of a buyer for Farmers. After a month-long hearing in 1988, regulators approved the sale to B.A.T (*BI*, Aug. 29, 1988).

Meanwhile, Justice Simon has allowed AXA and Hoylake to introduce depositions relating to an internal Nov. 15 memorandum from Lazard Freres & Co. containing the minutes of a meeting held by investment advisors and a B.A.T employee. At the meeting, the advisers discussed possible takeover defenses, including a joint venture with AXA, officials of AXA and Hoylake said at a press conference last month in Paris.

None of the parties would release a copy of the memo, but in a Dec. 18 statement, British corporate raider Sir James Goldsmith said the memo showed "B.A.T considered luring AXA away from Hoylake by entering a joint venture with AXA to form a large insurance group."

B.A.T's "official position, namely that AXA is not fit and proper to buy Farmers, is simply untenable" in light of the memo concerning joint ventures, said an AXA-Midi spokeswoman.

John Roney of the Los Angeles law firm O'Melveny & Myers, who represents AXA, said the memo "shows B.A.T's total lack of concern for Farmers' shareholders."

At the Illinois hearing, AXA plans to introduce depositions from Patrick Sheehy, chairman of B.A.T; Henry Frign, a director of B.A.T; David Anderson of Lazard Freres; and Michael Butt, chief executive of B.A.T unit Eagle Star Insurance Holdings P.L.C.

However, a B.A.T spokesman says the "stolen" memo did not represent the opinion of senior management but, rather, outside advisers who were simply theorizing about possibilities for defending against a Hoylake bid.

"Certainly none of the proposals were considered by B.A.T management," he said, noting that no B.A.T senior managers attended the meeting.

Meanwhile, Hoylake wants to convince insurance regulators that it has no interest in managing Farmers and will sell it to AXA if the buyout is approved.

"Hoylake is only the conduit to transfer Farmers from B.A.T to AXA and only that," said a Hoylake spokeswoman.

AXA's Mr. Bebear was more succinct: "You have a raider and an insurer, and the insurer will buy the insurance company from the raider if the raider succeeds."

Mr. Bebear said a name change is unlikely if his bid succeeds.

"If the AXA name can help Farmers, we can add it, but the decision" is up to Farmers, he said.

Last month, Standard & Poor's Insurance Rating Services affirmed AXA-Midi's AA+ claims-paying rating, which Mr. Bebear said should it pass regulatory muster.

The chairman says he also wants to convince regulators that, despite the proposed equity stake in Hoylake, his company will remain first and foremost an insurer.

Consequently, AXA-Midi has begun selling off its non-insurance related assets, estimated to be worth $4 billion. Early this month, AXA sold its 76.4% share of Garonor S.A., a warehousing company, to Thomson CSF Finance, for 900 million French francs ($155.7 million). And Brasseries Glacieres Industrielles S.A., a brewery and soft drink company, is expected to be sold this month for 1.3 billion French francs ($224 million).

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International Editor Stacy Shapiro in London contributed to this report.

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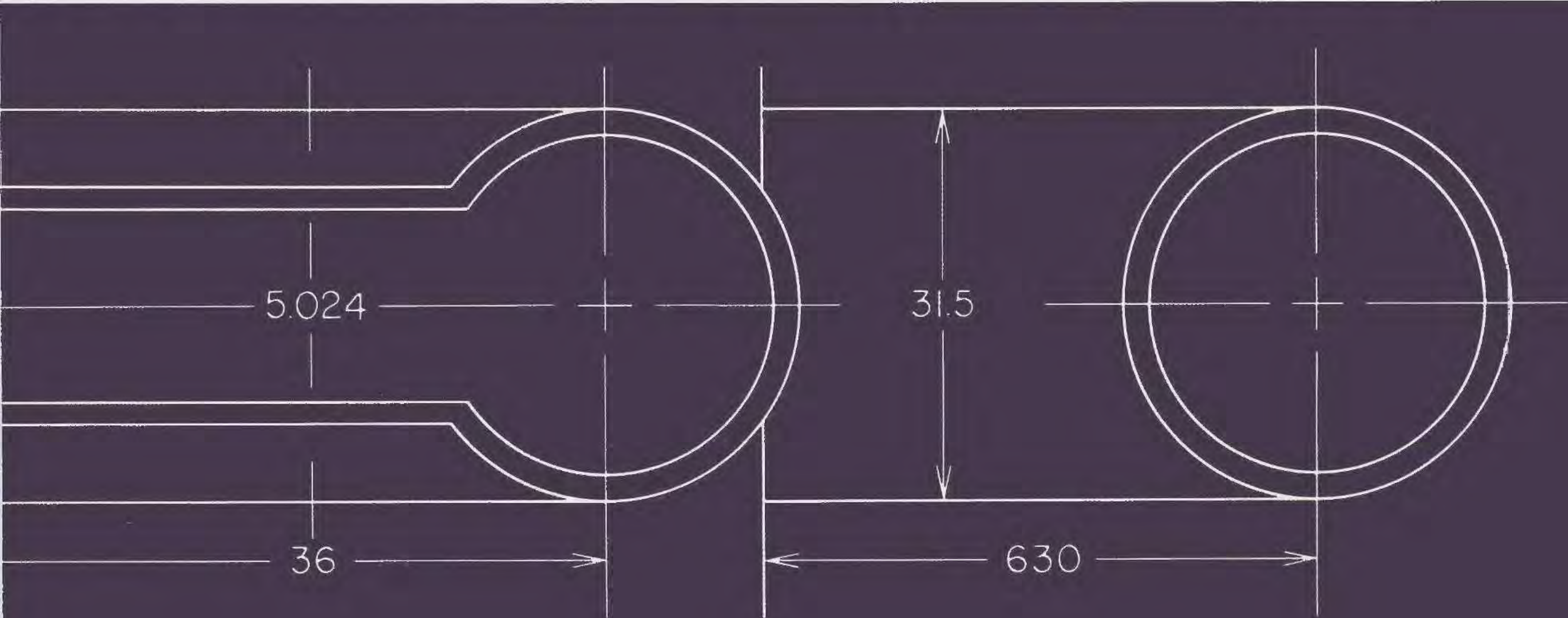

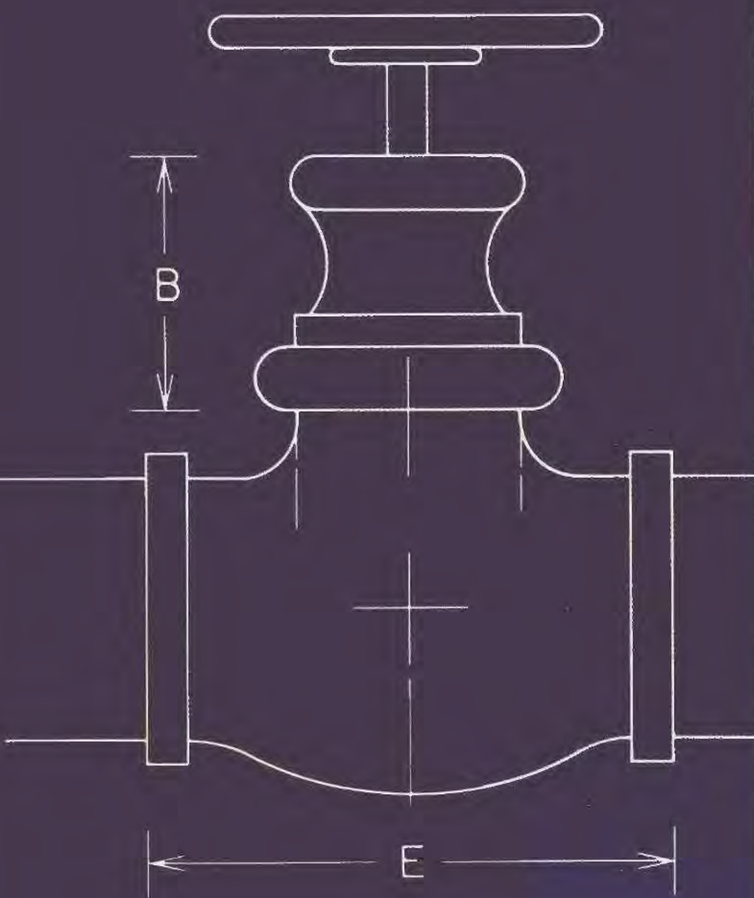

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Canadian care

Continued from page 3

The report, which is based on newspaper reports and books on both the Canadian and U.S. health care systems, government data, public policy statements and direct surveys, adds: "Americans tend to feel that the Canadian system can be introduced in the U.S. without reducing the world-admired quality and availability of American health care. It cannot."

Under Canada's health care system—launched in 1957 and established nationwide in 1971—all Canadians have access without charge to the physicians of their choice. In addition, most tests and treatments, the services of specialists and the cost of any ensuing surgeries or hospital stays are free if recommended by the general practitioner, the report explains.

Federal and provincial governments share the cost. But, to qualify for federal support provincial plans must adhere to certain conditions, including prohibiting user fees and extra billing.

While citizens in some provinces pay premiums covering about 20% of the average cost of the system, "for all practical purposes, health care in Canada is provided free of charge with the federal and provincial governments picking up the tab," the report says.

And, to ensure equitable health care among wealthy and poor Canadians, the federal government prevents citizens from purchasing private insurance for most health care services, and most doctors have no alternative to working within the government-monopolized system, the report points out.

Mr. Walker noted that Canada and the United States each spent 6.1% of their gross national products on health care in 1965. The figure has remained at 8.5% since 1978 in Canada, while the United States now spends about 11% of GNP on public and private health care.

A cursory glance at both systems could reasonably lead Americans to conclude that their northern neighbors are handling health care effectively, Mr. Walker noted. In fact, "an overwhelming proportion of Canadians express satisfaction with their system," he said.

But because patients shoulder little or none of the cost of care, the "predictable" result of this system has been "escalated demands for services," which has "prompted a steady tightening of government regulations to control costs," the report charges.

And, Mr. Walker emphasized, "the Canadian system does not control medical costs by reducing the unit cost of health care, but principally by rationing the health care delivered."

For example, the report notes: "The waiting list for mammograms, to detect breast cancer, can be as long as 2½ months in Newfoundland, while bone scan patients can expect to wait one to 1½ months. Myelograms, used to assess pinching of spinal nerves, require a three- to four-month wait in the province and orthopedic referrals can expect a minimum of two months wait before seeing a specialist."

The report also notes that "at a major metropolitan hospital in British Columbia, there is an average wait of four weeks for elective and urgent surgery and six weeks for orthopedic surgery."

And, the "startling" expansion of the surgery waiting list at Queen Elizabeth Hospital on Prince Edward Island "may indicate how Canada is using waiting lines to ration health care," the report says. Between 1983 and 1988, the waiting list increased 145% to 1,410 patients, the report says.

In addition, citing statistics from the Canadian Health and Welfare Ministry and the U.S. Health Care Financing Administration, Mr. Walker found that state-of-the-art medical equipment is much less available in Canada than in the United States.

For example, there are:

- Seven computerized axial tomography scanners—or CAT scans—available in British Columbia, which has a population of 4.6 million. However, across the Canadian-U.S. border, Seattle, with only about a tenth of that population, has 17 of the sophisticated X-ray machines used to examine the brain.
- Four lithotripters—used to pulverized kidney stones and gallstones—in Canada, or one unit for every 6.3 million citizens. With 228 lithotripters, the United States has one for every 1.1 million citizens.
- Twelve magnetic resonance imagers—a diagnostic device that uses magnetism instead of potentially harmful X-rays—in Canada, or one unit for every 2.1 million citizens. In the United States, by contrast, there are 1,375 MRIs, or one for every 182,000 citizens.

In addition, "there was such a shortage of laboratory testing facilities in Newfoundland in 1988 that Pap smears, used to detect cervical cancer, routinely meant a wait of several months," Mr. Walker found.

"In a system where the service is free to the patient, rationing is accomplished by waiting lists," Mr. Walker said.

And, that rationing has caused needless deaths, the report says.

"From Ottawa to Vancouver, heart patients routinely are kept waiting for months for coronary bypass surgery," the study noted, citing an article in Maclean's, the weekly Canadian news magazine, that detailed several instances of Canadians dying before their turn for life-preserving surgery.

The report also found that Canadians in rural areas generally receive poorer services than urban residents and that patients of prominent surgeons or those with political connections usually receive priority.

In addition, stringent cost controls have prompted the strikes by health care workers that now commonly interrupt health care services in some provinces, the report points out.

For example, "in May and June 1986, doctors in Ontario disrupted service for 25 days to protest legislation that eliminated their ability to bill patients more than the government agreed schedule of fees," the report says.

Mr. Walker pointed out that "systemwide work stoppages" by health care providers in Canada are different from strikes at U.S. health care institutions.

U.S. strikes usually affect only one of several hospitals in a given area. However, because Canada has no competing health care suppliers, "when the nurses' union or the medical association shuts down the health care system in a province, usually only emergency health care is available," Mr. Walker said.

Further exacerbating the problem, U.S. citizens who seek medical care in Canada are treated immediately for the same conditions Canadian citizens may wait months for, the report noted.

To avoid waiting lists, some Canadians travel to the United States and pay for medical services out of their own pockets, Mr. Walker found.

"The key to Canada's success in controlling the total health care budget does not lie in the control of unit costs, as is sometimes believed,

Canada 'does not control medical costs by reducing the unit cost of health care,' says Michael Walker.

but in limitations on the availability of services. The emergence of long waiting lists means that the quality of health care delivery is declining for Canadians, simply because services are not available. And because the incidence of waiting lists is not uniform across regions and hospitals, Canada no longer can be said to have a national system with equal access to all. Instead, the country is moving toward a multitiered health care system based on rationing," the report says.

But, Mr. Walker stressed, Canadian citizens typically do not have to wait to see general practitioners. "Canadians only see the deficiencies of their health care system when they encounter a serious illness—when they need care the most," Mr. Walker said.

"Developments in Canada should be a flashing yellow light, warning of potential difficulties ahead if such a system were created by Congress," he said.

Mr. Walker predicts that the Canadian system is doomed to a widespread deterioration in the quality of health care because, among other things, price is not a factor for most people using the government-controlled system.

"Even when premiums are charged, they bear little relation to actual cost," he said.

As a result, "Canadians have little financial incentive to make sensible economies in their demands for health care. And that forces the government to impose rationing," Mr. Walker said.

The same is true in the United States, the report says.

"Patients who do have comprehensive, private or public insurance coverage in the U.S., together with their doctors, generally regard health care as a free good and they behave accordingly—just as Canadians do. U.S. patients have little or no incentive to economize, and doctors, spurred both by unrestrained demand by patients and by the nightmare of unlimited liability and punitive damages, seek exhaustive testing to eliminate the probability they will mistakenly reject symptoms of a serious disorder," the report says.

"The reason costs have escalated more in the U.S. is that, unlike Canada, the U.S. has no across-the-board cap on health care spending," Mr. Walker said.

But, Canada can learn some cost control lessons from the United States, according to the report.

"The most relevant lesson of the U.S. experience is from private sector strategies to combat rising costs," the report says. "The private response has not been controls and rationing but a search for creative ways to deliver care at a lower cost," the report said.

"This has led to a greater use of alternatives to the fee-for-service medical practice."

For example, preferred provider organizations, health maintenance organizations, utilization review, mandatory second surgical opinions and closer scrutiny of claims "are springing up in the U.S. as patients and firms providing health benefits search for ways to adapt to demand pressures in a constructive, cooperative fashion," the report says.

In addition, employers are exploring "the degree to which U.S. citizens are willing to trade off cost reductions and levels of service."

But, while acknowledging that the Canadian health care system is not perfect, a Nova Scotia health department official and some U.S. benefit consultants defend it.

"From a Canadian point of view, the major benefit of the Canadian system is that health is a right, not a privilege" and that it ensures that all Canadian citizens are insured, said Janet Braunstein, director of community health nursing at the Nova Scotia Department of Health and Fitness in Halifax.

"In the U.S., there are 37 million people uninsured. Canada has a population of 25 million and we're all able to get health care when we need it," she said.

A "real strength" of the Canadian system is universal access to health care, agreed Larry Leisure, vp and national practice leader-group benefits at Towers, Perrin, Forster & Crosby Inc. in New York.

David Brenneman, vp at consultant Noble Lowndes of East Orange, N.J., pointed out that the "queue," or waiting list, is the socialized health care systems' most effective cost containment tool.

But, he said he does not "believe the cap on spending (in Canada) will hold much longer. The Canadian system is in a process of change."

And, "is waiting for elective surgery so bad?" Ms. Braunstein asked. "I see it now as a prudent use of resources."

Ms. Braunstein said that deaths of patients waiting for life-saving surgery will occur under any health care system. But, she noted that there is no wait for emergency surgery in Canada.

And, while "the state of Michigan may have more MRIs than the entire country of Canada, is that appropriate?" she asked. Ms. Braunstein said that having so much sophisticated equipment may be a waste of resources.

Another advantage with Canada's health care system is that one organization—the government—negotiates with the provider community, Mr. Leisure said.

Conversely, "in the U.S., there are very few restrictions regarding the construction of new hospitals or the purchase of very expensive medical equipment," he said. "That is what is negative in the U.S.—supply is driving demand."

Mr. Leisure also noted that HMOs in the United States—cited by the report as a creative approach in controlling health care costs—also ration care and create waiting lists.

"An HMO is like a (Canadian) province: It negotiates fixed fees with providers, the benefits are controlled" and patients often incur long waiting periods for services, he explained.

Mr. Brenneman also noted that while "managed care has the potential to deliver more cost effective services, it isn't doing it yet. I'd say during the 1980s managed care added to the total cost of health care rather than reducing it. It added the costs of marketing and administration to the health care system."

"The Canadian system isn't perfect," Mr. Leisure said. "But what we need to say is, 'How can we learn from their system?' "

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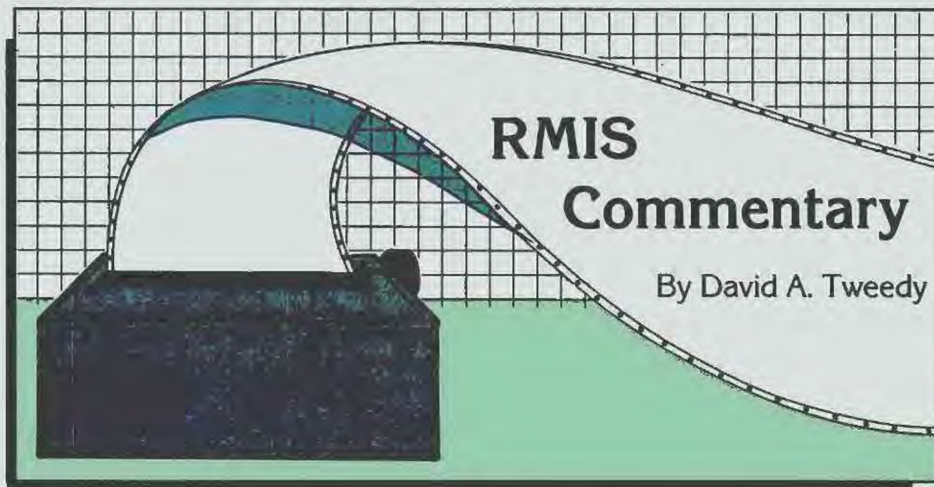

LATELY, I SEEM to be answering a lot of questions about how a good risk management information system request for proposal should be developed.

Essentially, a good RFP will help to differentiate among vendors that are really not qualified, either from a technical or service vantage point, to handle your system needs.

Also, a poorly designed RFP will mislead bidders and cause an unwanted—and expensive—breakdown in the system selection process.

How does one devise a good request for proposal? There really are no standard formats, as RFPs will vary depending on the particular situations. It should clearly and definitively present what the risk manager wants in a system. The RFP sets the proper direction and emphasis for the bidders. It is meant to modify and emphasize (or de-emphasize) parts of the specifications.

For smaller systems, such as an in-house, personal computer-based system, the RFP may include the specifications, combining the general objectives with specific details. For custom built or large, vendor-supported systems, the RFP should provide general guidance and overall concepts. The specifications will be attached to the RFP to provide the details.

Generally, an effective RFP should contain the following elements:

- Clear objectives.

Above all, the RFP is meant to clearly instruct the participating vendors on what is desired by the organization.

To accomplish this end, the objectives must be clearly stated to avoid having the vendor follow up on less significant points in the specifications. The objectives should be stated in the beginning of the RFP. They are to indicate the amount of time the vendor should spend on discussing how their systems can respond to those stated objectives. The specifications, if done properly, will provide the exact details. Without clarity of objectives stated in the RFP, it would be difficult to select from among several proposals because each vendor may have its own interpretation of a loosely defined RFP.

- Vendor credentials.

This section concerns the vendor's own capabilities to provide a system and service to the client. It includes:

✓ Hardware requirements. Your specifications package should comment on this in detail. But, for purposes of the RFP, the vendor should comment on the type of hardware it utilizes, whether it sells hardware or not, and whether there are possibilities of link-ups between the client hardware system and the vendor's system.

The vendor should comment on the type of hardware it uses, whether it sells hardware and whether link-ups are possible between the client's hardware and the vendor's system.

Another good question would be if a vendor can take input from a variety of different hardware sources and input the data into its own hardware environment. If so, is there a charge for this, or is it included in the basic contract price?

✓ Documentation. This should be a basic request of any RFP. Solid documentation on the system structures, codes and regular updates provide a good foundation for the client to begin to understand how to use this new system. Also, it provides a good test of the vendor's capabilities.

At past Risk & Insurance Management Society national conferences, several new systems and vendors have had terrible documentation—or none at all—which should immediately create suspicion in the mind of a potential buyer.

It is recommended that this documentation be reviewed by your internal data processing department for an expert opinion.

✓ References. It is very important to consider the vendor's references on similar projects and clients. The risk manager will want to speak with each of these references to determine the nature of the system's reliability and servicing abilities. It would be even better if the potential buyer could speak to a number of former users of the particular vendor to get a feel for what is potentially wrong with the system.

- Implementation.

The RFP should request specific information on the length of time to fully implement the system. You must clearly identify your time frame for getting the system fully operational.

In addition, depending on the complexity of the RMIS, personnel training costs and time become critical factors. You should ask for a clear statement on initial training costs for the people in your department who will need to know how this system operates.

Also, information on availability and cost of regular system update seminars should be received. Some of the questions normally asked include: Where does the training take place? Is there a training manual? How often is the manual updated? Is there a contact person at the vendor if things go wrong?

- Management issues.

Because much of the information contained on your system may be sensitive, you should expect a confidentiality agreement between the vendor and you. This, obviously, is essential if the vendor is managing your system and handling the claims and personnel data on your behalf. It is also true if there are any tape conversions being performed by the vendor. A reputable vendor will have no problem in signing this confidentiality agreement. If a vendor objects, you should wonder about the quality and professionalism of that vendor.

Another management issue is servicing. Although it was touched in the implementation section, it is important as an ongoing concern. After all, you have not only invested in an RMIS, but a service provider.

The system may only be as good as the people backing it up. Systems change over time, new features are added, modifications are made and problems occur.

For these and other related concerns, good solid servicing agreements should be a part of any relationship between a risk manager and an RMIS vendor.

This is especially true with a vendor-support system, but it is also important for a stand-alone system. Even a stand-alone—with most of the responsibility for operations transferred to the risk manager—undergoes changes and bugs can occur from time to time. It is recommended that the risk manager have easy access to the original providing vendor, if necessary.

- Price.

Last, but certainly not least in the minds of buyers, is the price being charged for the system and related services. Because each vendor may offer the pricing in different forms (price per claims added to the system, price per module, price per 1,000 claims, price per hour of time sharing, etc.), the risk manager is advised to delineate clearly how he or she would like the price quoted.

For instance, a good method is to devise a bid tabulation sheet identifying how you would like the quote to be made. You may be interested in having a price per 100 claims added to the data base or as broad as a price per month of usage of the system.

For stand-alone systems, the pricing methodology is simpler in that you can ask for a price per module (i.e., claims administration) and an estimate of a yearly servicing fee.

The important point is to aid the bidder in conforming to your pricing structure so that comparisons between proposals are easier.

It is very important to consider the vendor's references from similar clients. The risk manager will want to determine the nature of the system's reliability and servicing abilities.

To summarize, a well-designed request for proposal will assist vendors in properly interpreting the specifications and providing the type of proposal sought by the risk manager.

Although there are no set standards for an RFP, it should be structured with clear objectives, concise questions concerning the system vendor's qualifications, description of training and servicing abilities, and system documentation.

Logical references—from clients with situations comparable to that of the prospective buyer—as well as a confidentiality agreement should be standard elements of an RFP. Pricing structures should be as similar as possible to ease the risk manager's decision making in selecting a risk management information system. ■

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

Changing along with the times

Accident insurance meets new needs

By Robert Clemens

BECAUSE IT HAS BEEN around for decades, accidental death and dismemberment insurance might seem like a reliable if unexciting old sedan. But this steady performer has recently gotten a flashy new paint job and had its engine rebuilt: accident insurance is now a dynamic employee benefit that provides a humane employee service at a remarkably low cost.

Such an enhanced accidental benefit can enable businesses to offer their employees something genuinely new and useful at a time when cost constraints have forced a scaling back of medical benefits. In addition, the AD&D benefit can, if properly structured, become an attractive item on the cafeteria-style menu of benefits many companies have begun to offer.

Traditionally, of course, voluntary accident insurance has been an employee-paid benefit that offers a straightforward cash payment in the event of death, dismemberment or the loss of sight or hearing.

The new breed of accident insurance goes far beyond this uncomplicated minimum. It can include not only the traditional death benefit payment, but also sophisticated benefits for ongoing situations that devastate families' lifestyles and pocketbooks. Paralysis, for instance, or a disabling injury to a child will require expensive, lifelong care and equipment.

Today, accident insurance even has the flexibility to offer what are often termed "living benefits"—benefits that recognize modern demographic realities by providing, for instance, funds for the education and training of the surviving spouse and children.

Finally, accident insurance now often comes with what might be termed a risk management component. An increasingly popular example is the seat belt benefit, which encourages employees to buckle up by providing an extra benefit to those injured while wearing lap and shoulder belts.

What awakened accident insurance from its long slumber? The answer is not surprising: the needs of employers and policyholders.

The truth is, over the past several decades, the structure of American families has changed dramatically, with inevitable ramifications for the accident insurance marketplace.

The biggest change, of course, is the rise of the two-income family. Today, only one in four families fits the traditional Ozzie and Harriet model of two parents with one income. More than 50% of families have dual incomes and the remaining families are either headed by single parents or the traditional Ozzie and Harriet-style duo.

Life insurance generally offers adequate protection for any type of death in all these family configurations. But because of a lack of buying power or access to such products, adequate life insurance may not be within the reach of all families. Accident insurance is considerably more affordable, offering coverage at a typical cost ranging from 3 cents to five cents per $1,000 worth of coverage per month. For young families, especially, this coverage addresses a very real risk. For individuals under the age of 38, accidents are the leading cause of death.

To be of genuine use to two-income or single-parent families, accident insurance has had to assume non-traditional forms. For instance, a policy might pay out a fixed percentage of the benefit amount—perhaps as much as 100%—in the event of the death or dismemberment of a spouse who brings in a substantial portion of the family income.

Accident insurance can also protect a young family's financial future in other ways. For example, it can include an educational benefit to pay college tuition for the policyholder's children, or job retraining for the surviving spouse. In the future, benefits might even include day care expenses for young children.

Advances in medical technology also have driven changes in the accident insurance field. Most importantly, accident insurance must now recognize that devastating accidental physical disabilities can occur without the loss of limb, sight or hearing.

In the past, accident victims who suffered brain or spinal cord damage generally died of their injuries. Today, medical science helps many of these victims survive, but with lifelong paralysis. Between 7,000 and 8,000 Americans survive paralyzing spinal cord injuries every year—more than 50% of them working adults.

Although health insurance covers the immediate medical cost of such injuries, the victims typically incur lifelong non-medical costs for items such as attendant care, vocational rehabilitation and physical adaptations to their house and car. On top of that, many victims suffer a drastic diminution, if not total loss, of income.

Here, again, accident insurance can help cushion the impact of such a devastating injury by helping offset these extra non-medical expenses, and at a nominal cost.

Similar logic drives another innovation in the field: The double dismemberment benefit for children. As in the case of paralysis, a child's loss of limb, sight or hearing can burden families with extraordinary expenses. Many medical plans, for instance, do not cover the cost of replacing high-tech electronic prostheses as a child grows. The family may incur extra costs for child care, education and training, or environmental adaptations.

As may well be imagined, these enhanced accident benefits are proving extremely popular with employees. Typically, companies offering them are seeing 50% to 60% participation in voluntary plans. About 75% of those employees who sign up choose to cover their families. And, in the field of employee benefits, that participation rate is considered very positive.

Still, only about 40% of Fortune 1,000 companies and 20% of all other companies with 100 or more employees offer accident benefits, in spite of their popularity and affordability. That means there is room for growth.

And a growth in this benefit will serve employers as well as employees. Employers will get credit for adding at no extra cost a popular benefit, instead of whittling away at existing ones. And employees will secure vital added protection against some of life's most dreaded catastrophes. ■

Robert Clemens is assistant director of special risk products in the special benefits division of CIGNA Corp. in Philadelphia.

Asking the right questions takes skill

Books & ideas

"Smart Questions: A New Strategy for Successful Managers"
By Dorothy Leeds
Published by Berkley Books, 200 Madison Ave., New York, N.Y. 10016
$4.50

By Kevin M. Quinley

One wit's version of history's most enduring questions includes:

- Where do contractors go when the job is half-done?
- Why do they call it *rush* hour when no one is going anywhere fast?

To this list one may add:

- What does risk management have to do with management in general?

However, let's not forget the *management* in risk management. Dorothy Leeds, a management consultant, offers an intelligent little book that provides effective management advice for risk professionals.

Ms. Leeds suggests that all managers should more closely cultivate the art of asking intelligent questions and she offers dozens of examples.

Admittedly, Ms. Leeds did not have risk managers in mind when writing this book. But she did think of management in the broader sense, which certainly includes risk management. Her message is clear: Whether you manage one person or hundreds, asking the right questions at the right time can put you on the fast track to success. She feels that asking questions is a skill that—like a tennis backhand—can be improved with constant practice.

"Smart Questions" is divided into three parts:

- The system of asking smart questions.
- Getting the most from your staff.
- Getting ahead.

Worth almost the price of the book are three self-diagnostic quizzes that assess a manager's strengths and weaknesses in asking questions, staff development and career savvy.

Today, perhaps more than ever, "people skills" distinguish good risk managers from great ones. Risk professionals must manage people as well as risks. They must work with insurance brokers and agents, as well as consultants and their own senior management.

"Smart Questions" also offers a step-by-step guidebook for turning ordinary conversation skills into formidable business skills for any manager. Ms. Leeds shows managers how to reduce mistakes, overcome objections and gain control over volatile situations. Most critical, she reveals strategies of use to all risk managers, including:

- How to ask the right question of the right person at the right time.
- How to enhance "people productivity" through motivation.
- Turning questions into positive actions.
- A "smart question" way to conduct a hiring interview.

Cynics may contend that Ms. Leeds simply guides people in ways to look smart without substance. However, she is not aiming to mass produce "empty suits." Instead, Ms. Leeds insists that one can ask smart questions without being a smart aleck.

This is not to say she ignores the reality of corporate politics. Ms. Leeds does feel that top managers must look the part and not be content to get by on technical expertise.

"Many people feel that hard work will gain them recognition. This simply is not the case. Conveying an easily recognized, dynamic impression is often the key that unlocks the door to success," she writes.

Ms. Leeds' book can help risk professionals make the most effective use of their time to build teamwork, select top-flight staff and motivate others.

For risk managers who made a New Year's resolution to improve their management skills, "Smart Questions" is a smart answer. ■

Kevin M. Quinley is vp of risk services for MEDMARC Insurance Co. Risk Retention Group Inc. and subsidiary Hamilton Resources Corp., both of Fairfax, Va. Mr. Quinley holds the Chartered Property & Casualty Underwriter and Associate in Risk Management designations.

New CEO named at Munich American

John N. Lombardo, president of Munich American Reinsurance Co. of New York, has taken on additional duties as chief executive officer, a new position.

Brian Carlin, an executive vp who assumed responsibility for reinsurance operations Jan. 1, named to the new position of chief operating officer of Munich American; and **Charles D. Troiano**, a senior vp and controller, named to the new position of chief financial officer with Munich American, the U.S. subsidiary of Munich Reinsurance Co. of Munich, West Germany.

Also at Munich American: **James O. Polly** promoted to senior vp; and **Thomas P. Gaughran**, **Thomas J. Kusmierczyk**, **Walter Pitio**, **Lawrence J. Reimer** and **David L. Smith** promoted to vps.

Other reinsurer changes:

Edward C. McBride named vp of Hartford Reinsurance Management Co. of Hartford, Conn.

Jeffrey W. Koenig joins Los Angeles-based G.J. Sullivan Co. as vp to open a new branch of the reinsurance broker in Columbia, S.C.

General Reinsurance Corp. of Stamford, Conn., announced these changes: **Kirby V. Montgomery** promoted to vp in Stamford; and **Gary E. Mehr** promoted to vp in the Atlanta office of Gen Re subsidiary Genesis Underwriting Management Co.

Peter M. Wallner promoted to vp of Toronto-based Great Lakes Reinsurance Co. in New York.

Karl J. Mayr appointed president and manager of the Kansas City, Mo., branch of Frankona Reinsurance Co. of Munich, West Germany.

Comings & goings: industry

Agent/Broker

John P. Olsen has been named executive vp of the corporate risk division of Frank B. Hall & Co. Inc. in Briarcliff Manor, N.Y.

The division's activities include risk financing, loss control, actuarial and risk management information system services.

Mr. Olsen had been an executive vp at Fred S. James & Co. Inc. of New York.

Also at Hall: **Stanford F. Hartman Jr.**, a former vp of John Burnham & Co. of San Diego, named executive vp and director of new business development in Frank B. Hall's San Diego office; **William G. Malone** named senior vp and director of excess liability for Hall's Pacific region, based in San Francisco; **Peter Malito** appointed executive vp in Hall's New York office; **Thomas Wiegand** appointed senior vp and director of business development at Frank B. Hall & Co. of Minnesota Inc.; **Brian L. Marx** named vp and director of casualty risk management in the San Francisco office; and **Jeff Fernhoff** appointed vp for Frank B. Hall & Co. of Missouri Inc. in St. Louis.

Richard C. Lynn named vp at RBH Direct Group, an Aon Corp. unit that provides insurance programs for associations and affinity groups.

Rollins Burdick Hunter of New York Inc. announced these changes: **Douglas B. Brown** named chairman and chief executive officer; **George W. Douglass** named president; and **Thomas V. Morris** and **Robert W. Grella** joined the company as executive vp/chief operating officer and executive vp-risk management, respectively.

Glenn A. Totino named senior vp and director of the account executive division of Alexander & Alexander of New York Inc.

Stephan J. Zierak appointed vp-underwriting for North East Insurance Co. of Portland, Maine.

John B. Sullivan, president of Corroon & Black of Illinois Inc. in Chicago, assumed the additional title of chief operating officer.

J. Ray Taylor named southwest regional director of Alexander & Alexander Inc. He is based in Dallas and had been managing vp of the Dallas/Fort Worth office.

Patrick E. McAleenan appointed vp-account executive at the Lockton Insurance Agency of St. Louis Inc.

Insurers

James M. Felten promoted to executive vp-special risk division from senior underwriting supervisor and manager of Reliance Insurance Co., a Reliance Group Holdings Inc. subsidiary in Philadelphia.

William A. Lee elected president and chief operating officer of Farmland Life Insurance Co., Farmland Mutual Insurance Co., and Nationwide Agribusiness Insurance Co., all Des Moines, Iowa-based subsidiaries of Nationwide Mutual Insurance Co. Mr. Lee succeeds **William P. DeMeno**, who was promoted to senior vp-business operations for Nationwide Mutual.

William T. Friedewald promoted to vp and chief medical director from vp and deputy chief medical director of Metropolitan Life Insurance Co. of New York, which he joined in August 1989.

Glen A. Laffoon elected to the new position of executive vp and chief administrative officer of Central Reserve Life of North America Insurance Co. of Berea, Ohio. In addition, **Yolanda Kalinowski** promoted to vp from assistant vp at Central Reserve Life. Mr. Laffoon had been senior vp/director of corporate development.

George C. Schmid appointed vp-national accounts and agency marketing at RLI Corp. of Peoria, Ill.

Continental Corp. of New York announced these changes: **John H. Loynes** named executive vp in the office of the chairman; he is succeeded by **J. Heath Fitzsimmons**, who was appointed senior vp and chief financial officer; and **John F. Kirby** named corporate senior vp.

Michael Morehouse joined Woodland Hills-based Blue Cross of California as vp in the Large Group Services Division.

Great American Insurance Co. of Cincinnati, an American Financial Corp. subsidiary, announced these changes: **Thomas K. Liguzinski** appointed divisional vp of the company's bond division; **Stephan J. Leaman** appointed senior vp in the commercial division.

Boston-based New England Mutual Life Insurance Co. announced these promotions: **Daniel Kelliher** to senior vp and counsel-law; **Gerard P. Maus** to senior vp and counsel-institutional investment group; **H. James Wilson**, to senior vp and counsel-law; and **Bruce T. Bygate** to vp-employee benefits operations; **Mary V. Dexter** to vp-field assistance and support team; and **Chester T. Lewandowski** to actuary and vp-individual financial reporting.

Jerome D. Monchecourt promoted to vp of from general manager of the Hartford division of American States Insurance Co., a Lincoln National Corp. subsidiary.

Daniel T. Cox, chairman and chief executive officer of The Life Insurance Co. of Virginia, adds the title of chairman and CEO of Union Fidelity Life Insurance Co. Both companies are Aon Corp. subsidiaries. In addition, Mr. Cox was named chairman and CEO of Aon unit Miller Mason & Dickenson, a Chicago-based consultant.

General American Life Insurance Co. of St. Louis announced three promotions to executive vp and the new divisions they will direct: **A. Greig Woodring**, reinsurance; **Michael R. Hogan**, group life and health; and **E. Thomas Hughes**, group pensions.

William J. McGrath promoted to vp-brokerage and multinational business in Hong Kong for American International Underwriters, a unit of American International Group Inc.

James Lynam appointed vp with the U.S. branch of the Zurich Insurance Co. in Schaumburg, Ill.

Robert B. Miller named senior vp-claims at Crum & Forster Corp., a management and service subsidiary of Crum & Forster Inc. in Basking Ridge, N.J.

John H. Flittie elected executive vp and chief financial officer for Northwestern National Life Insurance Co. of Minneapolis.

Maryland Casualty Co., a Baltimore-based unit of Zurich Insurance Co., named five regional vps for its new commercial insurance division: **John Hitchcock**, for the Northeast; **Nay Nassar**, for the West; **William Alexander**, for the Southeast; **Robert Conrey**, for the Midwest; and **Ken Javor**, for the Southwest.

Contractors Bonding & Insurance Co. of Seattle announced these promotions: **Michael L. Johnson**, to senior vp-contract surety; **Gary Bailey**, to senior vp-license and miscellaneous bonds; and **Jack Falskow** and **Ed Shoemaker** to vp.

HMOs/PPOs

Donald E. Simmons announced his retirement effective March 1 as president and chief executive officer of Partners National Health Plans, an Irving, Texas-based joint venture between Voluntary Hospitals of America Inc. and Aetna Life & Casualty Co. (see story, page 2).

Other suppliers

Ruben Maxwell promoted to manager of Tenco Services Inc.'s Nashville, Tenn., claims office. He had been vp. In addition, **Rebe Trickey** promoted to vp from assistant vp of the Nashville-based regional claims handling company.

At Westport, Conn.-based Corporate Health Strategies, **William H. Rosenberg** promoted to senior vp from vp and **Susan Margolis** promoted to vp from assistant vp.

William D. Knepper joined Commonwealth Risk Services Inc., a Philadelphia-based risk management consulting firm, as senior vp.

Joseph J. Stall II appointed chief operating officer of Miller Mason & Dickenson, a Chicago-based consultant and Aon Corp. subsidiary.

Harvey Goldberg and **Ellen Conerly** joined the employee benefits division of Century Financial Services of Boca Raton, Fla. Mr. Goldberg is an account executive, and Ms. Conerly is a senior consultant. ■

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Warrilow syndicate

Continued from page 3

The members claimed in a press release accompanying the lawsuits that the syndicate has lost more than 80 million pounds ($132.8 million at current exchange rates) before reinsurance for the 1984 underwriting year.

The losses stem primarily from U.S. casualty reinsurance or from coverage written under the binding authority of U.S. Lloyd's correspondents (*BI*, Jan. 9, 1989; May 23, 1988).

"We are not complaining because we have lost some money," said Warrilow Steering Committee Chairman Tom Benyon when the suits were filed. "You cannot make money without a risk of loss, and had the loss merely arisen as a true trading loss, we would have no grounds for complaint.

"However, we have discovered prima facie evidence of negligence, overwriting, underreserving and bad management of the syndicate."

In another lawsuit filed the same day against the syndicate's two auditors—Ernst & Whinney and Spicer & Oppenheim—the members claim damages for "negligent acts, errors or omissions" as auditors and "the provision of negligent advice."

Four more members filed similar suits Jan. 2 against C.J.W., their members' agencies and accountants Ernst & Whinney, now Ernst & Young, and Spicer & Oppenheim, now called Spicer & Pegler.

The recent lawsuits were filed separately only because their law firm, Elborne Mitchell, had to wait for the members' approval to file the litigation on their behalf, said Stephen Bailey, a partner with the firm. Elborne Mitchell also represents the 570 members in the original lawsuit.

The writs do not fully explain the claims, which is customary in British litigation. However, Mr. Bailey said that his firm expects to file the "points of claim" detailing the grounds for the case as early as this week.

The writs have been served on the underwriting agencies, Mr. Bailey noted. The plaintiffs will wait to hear the agencies' defense before they decide whether to serve the writs on the auditors, he said. From the time writs are filed, plaintiffs have a year to serve them.

The short synopsis of damages on the writs, however, "wouldn't make us any wiser," said Ernst & Young partner Peter Mendelssohn. The accounting firm will have to wait for the points of claim to learn the details of the suit, he said.

Mr. Hume of C.J.W. would not comment on the litigation. ■

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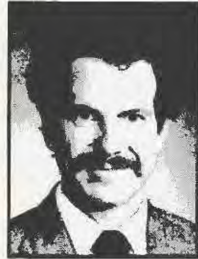
At issue

What is your New Year's resolution regarding risk management?



Michael Lykins
Risk manager
United Gas Pipe Line Co.,
Houston

I resolve to better communicate with operations people the ramifications of entering into unfavorable indemnity agreements that may result in the company assuming more risk than necessary. And I'd like to meet with field personnel to see if the risk management function is providing the level of service they expect.

David B. Kuhnke
Director-risk management
The Stanley Works,
New Britain, Conn.

My resolution for 1990 is to get rid of all the problems that remain on my desk from 1989.

John G. Pinner
Assistant treasurer
Mattel Inc.,
Hawthorne, Calif.

In 1990, I would like to see the major insurance companies recognize that loyalty is a two-way street, and that it includes not only marketing and underwriting but also fair and expedient claims handling. It is no fun to have a loss, but even worse when the insurer's main emphasis is on finding ways to minimize its contractual obligations.

Thomas P. Seuntjens
Director-corporate insurance/risk management
Honeywell Inc.,
Minneapolis

As we look at a new year and decade, future risk in a global environment will become even more difficult to manage with expanding worldwide markets. I resolve to meet this challenge with new programs where necessary, alter old programs when they need change and treasure solid programs with long-term relationships to manage our risks effectively.

Compiled by Christine Woolsey

Frequent flier...

bonus miles

ISSUE	CLOSING*	1990 MEETING/CONFERENCE	LOCATION
Mar 12	Feb 27	International Captive & Reinsurance Forum	Bermuda
Apr 16	Apr 4	Insurance Marketing Services	Orlando, FL
Apr 30	Apr 17	Risk & Insurance Management Society	Boston
May 28	May 15	National Assn. of Insurance Brokers	Sea Island, GA
Jun 4	May 22	National Assn. of Insurance Commissioners	Baltimore
Jun 11	May 30	Group Health Assn. of America/GHI	Los Angeles
Jun 11	May 30	Public Risk Management Assn.	Reno, NV
Jun 18	Jun 5	National Assn. of Insurance Women	Denver
Aug 13	Jul 31	American Risk & Insurance Assn.	Orlando, FL
Sep 3	Aug 21	Monte Carlo Rendez-Vous de Septembre	Monte Carlo
Sep 10	Aug 28	Independent Insurance Agents of America	Chicago
Sep 10	Aug 28	Intl. Assn. of Industrial Accident Boards & Commissions	New York
Oct 8	Sep 25	Self-Insurance Institute of America	Washington, DC
Oct 8	Sep 25	National Assn. of Casualty & Surety Agents & Executives	Greenbrier, WV
Oct 8	Sep 25	Chartered Property & Casualty Underwriters	Washington, DC
Oct 22	Oct 9	Baden-Baden Conference	Baden-Baden, W. Germany
Oct 22	Oct 9	RIMS Singapore	Singapore
Nov 12	Oct 30	National Assn. of Professional Insurance Agents	Atlanta
Nov 12	Oct 30	National Assn. of Independent Insurers	Los Angeles
Dec 3	Nov 19	National Assn. of Insurance Commissioners	Louisville, KY

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Congress

Continued from page 1

plans, they will quickly be proven wrong," said Frank McArdle, a consultant in the Washington, D.C., office of Hewitt Associates.

Indeed, over the last several years, proposals that had a sweeping and largely negative impact on benefit plans—including the Tax Equity and Fiscal Responsibility Act of 1982, the Deficit Reduction Act of 1984, the Consolidated Omnibus Budget Reconciliation Act of 1985 (passed in 1986) and the Tax Reform Act of 1986—all received congressional approval during election years.

In addition, observers point out that many of the benefits issues on Congress' agenda are left over from last year's session.

"This is the beginning of Act 2 of a two-part drama. It's a new year but not a clean congressional slate," Mr. McArdle said.

In fact, one issue now on that slate—whether employees should be taxed on the cost or value of employer-provided health insurance—has been brewing for years.

For example, both the Reagan administration and several congressional leaders, such as Senate Minority Leader Robert Dole, R-Kan., made repeated efforts to win passage of a proposal that would have taxed employees on employer-provided health care benefits exceeding $175 a month for family coverage and $70 a month for individual coverage.

While those efforts proved unsuccessful, legislators are about to take a new look at the issue.

Early next month, the House Ways and Means Committee will hold hearings—as part of broader hearings on the 1986 tax reform law—on the tax-favored status of employer-provided health care benefits.

Those Feb. 7-8 hearings come almost a year after Ways and Means Committee Chairman Daniel Rostenkowski, D-Ill., first warned that repeal of Section 89's non-discrimination rules for welfare plans would put taxation of health care benefits back before Congress.

At that time, Rep. Rostenkowski said: "Bring up repeal (and) you also put the possibility of taxing fringe benefits on the table" (*BI*, March 6, 1989).

In fact, some benefit observers worry that a vengeful Rep. Rostenkowski, smarting from his defeat on Section 89, might make benefit taxation an especially high priority as a way of punishing the business community for its campaign against Section 89.

Even if the Illinois Democrat stays on the sidelines, benefit experts say taxation of health care benefits remains a threat.

"There always is the potential for taxing health care benefits" because of the large amounts of revenue such a tax would raise, said Edward J. Davey, a principal with A. Foster Higgins & Co. Inc. in New York.

But any health tax legislation could differ from previous proposals. While earlier proposals called for taxing all employees on the cost of coverage that exceeded a certain amount, congressional staffers now are discussing proposals under which only highly compensated employees—those earning more than $50,000 or $60,000 annually—would be taxed on their coverage.

Limiting a health care tax to highly compensated employees would be one way of defusing opposition from union organizations that have played a key role in defeating earlier proposals, noted Ken Feltman, executive director of the Employers Council on Flexible Compensation in Washington, D.C.

Still, while a battle could rage on taxation of health care benefits, experts do not see enactment of such a new tax—at least not yet.

Continued on next page

Continued from previous page

"There is not yet a congressional consensus on taxing health care benefits," Mr. Feltman said.

"Is Congress ready to take the heat on a health care tax? I don't think so," said Stuart J. Brahs, vp-federal government relations in the Washington, D.C., office of The Principal Financial Group, a Des Moines-based diversified financial services company.

Congressional interest in another health care issue—expanding access to health care coverage for the nation's 37 million uninsured—is likely to be rekindled when a congressional commission makes recommendations next month or in early March.

The Pepper Commission, named after the late Rep. Claude Pepper, D-Fla., is expected to follow the lead of its chairman, Sen. John D. Rockefeller IV, D-W.Va., and propose that employers be required to provide a health insurance plan or pay a special tax (*BI*, Dec. 25, 1989).

At the same time, the Bush administration, through a Department of Health and Human Services task force, is expected to make recommendations this fall on improving access to health care coverage.

'A FICA tax cut is not something legislators will do willy-nilly,' says Stuart Brahs.

And, Sen. Edward Kennedy, D-Mass., is expected to press for a Senate vote on his legislation requiring employers to offer workers health care coverage that would meet minimum federal standards. That measure, S. 768, was narrowly approved in July by the Senate Labor and Human Resources Committee (*BI*, July 17, 1989).

"There will be a range of initiatives proposed on the health care access issue," noted Dallas Salisbury, president of the Employee Benefit Research Institute, a benefits think tank in Washington, D.C.

While the access issue will command congressional interest, benefit experts say enactment of an employer health care mandate is not imminent.

"There will be a lot of people with spoons in hand ready to stir the pot, but a consensus has not yet developed on the best way to improve access," said Howard Weizmann, executive director of the Assn. of Private Pension & Welfare Plans in Washington, D.C.

"We're still in a gestation period on the access issue," said Mr. Davey of Foster Higgins.

While an access bill may not be enacted in 1990, "the components of eventual legislation may become much better known during the course of this year's debate," said Hewitt's Mr. McArdle.

While consideration of a health care tax and an employer health care mandate have been discussed for some time, other benefit issues are popping up for the first time.

For example, several congressional committees plan to hold hearings on whether there is a need to strengthen pension enforcement rules.

The impetus for the new congressional interest is a report issued last year by Raymond Maria, the Labor Department's acting inspector general, who charged that the department's failure to fully enforce the Employee Retirement Income Security Act of 1974 could expose pension funds to financial problems that could rival the magnitude of the savings and loan industry crisis (*BI*, June 12, 1989).

While benefit experts say Mr. Maria's analogy between pension plans and the thrift industry is incorrect, they note that the Maria report has captured the attention of Congress.

"Enforcement is going to be a very big issue in this session," said Mark Ugoretz, executive director of the ERISA Industry Committee in Washington, D.C.

The outcome of the debate on pension plan enforcement has major implications for employers. Legislators could propose tougher federal penalties for ERISA violations as well as more detailed scrutiny of pension plan transactions by outside parties, such as auditors and actuaries.

At the same time, an explosive congressional debate is expected to erupt on another new issue: the Social Security payroll tax.

Sen. Daniel Moynihan, D-N.Y., is set to introduce legislation this week that would slash the FICA tax. Under the Moynihan plan, the FICA tax, now 7.65% of a worker's first $51,300 of wages and paid by both the employer and employee, would be rolled back to 7.51%.

Sen. Moynihan and other congressmen want to lower the FICA tax to return Social Security to a pay-as-you-go-system. Currently, the surpluses being accumulated by Social Security are not being held in trust to pay for future benefits, but instead are being diverted to pay for other federal programs, masking the size of the federal deficit.

A cut in the Social Security tax—now many employers' most expensive benefit expenditure after health care—could mean billions of dollars in the short term for employers.

The APPWP's Mr. Weizmann said there will be a lot of pressure on Congress to lower the payroll tax. "Washington abhors the idea of a great pot of money out there," he said.

Still, legislators aware of the great political sensitivity of Social Security will move slowly, if at all, on a Social Security tax cut.

"A FICA tax cut is not something legislators will do willy-nilly," Mr. Brahs said.

Returning to the congressional benefit agenda is a proposal, backed by Rep. Peter Visclosky, D-Ind., that would require employers to share control of defined benefit and defined contribution pension plan assets with employees. The proposal calls for new boards composed of equal numbers of employer and employee representatives to control pension assets.

Last year, the so-called Visclosky amendment was killed after the House overwhelmingly voted to strip it from a budget reconciliation bill.

Despite that setback, the Visclosky amendment will be debated this year. In fact, the House Labor Management Relations Subcommittee will hold hearings on the proposal next month.

Benefit experts stress that last year's House vote on the Visclosky amendment, which employers have blasted as irrational and damaging to the private pension plans, was by no means Congress' last word on the controversial proposal.

Indeed, one of the objections to the proposal was that backers were trying to ram it through Congress without hearings.

By scheduling hearings, backers of the Visclosky amendment are responding to that objection, Mr. McArdle said.

It also is a virtual certainty that proposals will re-emerge to restrict or bar employers from terminating overfunded pension plans to recover surplus assets, a long-time goal of Sen. Howard Metzenbaum, D-Ohio.

"Sen. Metzenbaum's interest in stopping reversions appears unflagging," said Mr. Ugoretz of the ERISA Industry Committee.

"When Sen. Metzenbaum sinks his teeth into an issue, he does not very often let go," Mr. Brahs said.

In addition, the second half of the session could bring an end to a congressional deadlock on legislation—passed by House and Senate committees—to require many employers to offer family and medical leave programs.

Awaiting Senate floor action is a measure, S. 345, that would require employers with more than 20 employees to grant up to 10 weeks of unpaid leave for such family-related situations as birth, adoption of a child, or serious illness of a child or parent.

H.R. 770 is a similar proposal pending in the House, except that it initially would apply to employers with more than 50 employees.

Mr. McArdle notes that various compromises are being floated—like reducing the maximum amount of leave that would have to be provided—to break the congressional deadlock.

However, no one foresees congressional action in 1990 on two of the most burning benefit issues of 1989: Section 89 and the 1988 Medicare Catastrophic Act.

Congress repealed Section 89 in November after employers, in a massive lobbying campaign, convinced legislators that the health care plan non-discrimination rules imposed by the law were unnecessary and far too complex.

At the time of the House repeal vote, Rep. Rostenkowski predicted that the issue of non-discrimination rules would return one day.

While that is possible, that day is not likely to be soon.

"It is unlikely that Congress would so soon try to write new non-discrimination rules. The wounds of last year are still too raw," Mr. McArdle said.

Similarly, legislators will be reluctant to take another stab at crafting a new program to expand Medicare to give the elderly more protection from catastrophic health care expenses.

Such an expansion, passed in 1988, was repealed last year after a barrage of complaints from the elderly. They complained about the high cost of the program: Middle and upper-income retirees would have paid up to $800 in additional taxes. And many retirees complained that they already receive similar benefits, at a much lower cost, from employer-provided health care plans.

"Members of Congress are still shell-shocked by the Medicare debacle. They would be very nervous about passing anything that could cost the elderly money," said Helen Darling, a principal in the Stamford, Conn., office of William M. Mercer Meidinger Hansen Inc. ■

McCarran repeal push still lacks momentum

By JERRY GEISEL

WASHINGTON—The congressional drive to repeal or modify the McCarran-Ferguson Act, stalled since a hearing last year labeled by insurance lobbyists as disastrous for repeal advocates, is unlikely to pick up steam soon, the lobbyists say.

In addition, there are no signs that Congress will enact federal product liability reform legislation or alter the federal Risk Retention Act.

Some observers had expected quick action on legislation introduced by House Judiciary Committee Chairman Jack Brooks, D-Texas, that would strip insurers' current limited immunity from federal antitrust law (*BI*, July 31, 1989).

That bill, H.R. 1663—which is identical to a proposal that had cleared a House Judiciary subcommittee in 1988 (*BI*, June 27, 1988)—would, among other things, subject to antitrust law:

- Insurance price-fixing in the development and publication of recommended rates and the sharing of data regarding expenses and profits.
- Allocating specific markets or customers among competing insurers.
- Tying the sale of insurance to customers out of competing markets.
- Activities that would force competitors out of specific markets.

A House Economic and Commercial Law Subcommittee hearing last July was supposed to be a first step toward congressional action on the bill, but so far has had the opposite effect, lobbyists say.

In fact, the House subcommittee hearing was a disaster for supporters of McCarran-Ferguson repeal, said Peter Lefkin, assistant vp and director of federal affairs for Fireman's Fund Insurance Co. in Washington, D.C.

Repeal supporters seemed poorly prepared for the hearing, say their opponents, and did not offer convincing evidence that repealing the 1945 law would ease liability insurance problems.

"The drive toward McCarran-Ferguson repeal has been blunted," said Tom O'Day, associate vp for the Alliance of American Insurers in Washington, D.C.

"There probably is not much wind left in the sails of those seeking repeal," Mr. Lefkin said.

On the product liability front, reform bills have been introduced in the House by Rep. Tom Luken, D-Ohio, and in the Senate by Sen. Robert Kasten, R-Wis., but no hearings have been set on either proposal.

The Senate Commerce Committee has informally indicated that it may hold hearings on the Kasten bill next month, say business lobbyists.

But such legislation still faces formidable opposition from Commerce Committee Chairman Ernest F. Hollings, D-S.C.

"You are talking about a committee chairman who is absolutely opposed" to a federal product liability law, Mr. O'Day said.

Liberty Magarian, co-counsel with The Product Liability Alliance in Washington, D.C., said lobbyists would get a better sense of extent of support for product liability reform after Commerce Committee hearings.

Meanwhile, no congressional hearings have been scheduled on a U.S. Department of Commerce recommendation to overhaul the Risk Retention Act (*BI*, Dec. 11, 1989).

Among other things, the Commerce Department proposed that a single state regulate risk purchasing groups and their insurers and that risk purchasing groups be required to meet certain minimum financial standards. The Commerce report also proposed that risk purchasing groups be controlled by members and not by insurers or agents.

"We will do the best we can to press for hearings on the report. Clearly, there have been problems with the implementation of the act, which need to be cleared up," said James Anderson, senior director of government affairs for the National Assn. of Wholesaler-Distributors in Washington, D.C., and a member of the National Risk Retention Assn.

But Mr. O'Day of the Alliance doesn't think Congress will amend the Risk Retention Act.

"There isn't a critical mass of interest yet," he said, noting that it was a market crisis that drove the last changes to the Risk Retention Act through Congress in 1986. ■

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NOTICES

IN THE CIRCUIT COURT OF COOK COUNTY, ILLINOIS
COUNTY DEPARTMENT, CHANCERY DIVISION

IN THE MATTER OF THE LIQUIDATION OF EQUITY GENERAL INSURANCE COMPANY
NO. 89 CH 9915

NOTICE OF CLAIMS DATE AND PROCEDURES'

PLEASE TAKE NOTICE, that on November 20, 1989 and Order of Liquidation with a Finding of Insolvency was entered against Equity General Insurance Company ("Equity General") by the Circuit Court of Cook County, Illinois. Zack Stamp, the Director of Insurance of the State of Illinois is the statutory and court affirmed Liquidator of Equity General.

TAKE FURTHER NOTICE, that on November 21, 1989 the Circuit Court of Cook County, Illinois entered and order Fixing the Time and Procedure for Filing of Claims, which said Order was amended by the Court on November 27, 1989 (the "Fixing Order"). Pursuant to the terms of the Fixing Order, all policies of Insurance of Equity General are cancelled as of 12:01 a.m. on December 21, 1989, and all rights and liabilities of Equity General and its creditors, policyholders, and stockholders, and all other persons interested in its assets are fixed as of December 20, 1989, unless otherwise provided by a later Order of the Court.

TAKE FURTHER NOTICE, that all insured and all persons who have a cause of action against an insured of Equity General under a liability insurance policy, shall have the right to present and file with the Liquidator proper proofs of claims on or before 4:30 p.m. C.S.T., on:

1. January 19, 1990, for claims arising under "claims-made" forms of liability insurance policies contemplating coverage for the "error and ommissions" of the insured;
2. February 18, 1990, for claims arising under "claims-made" forms of liability Insurance policies contemplating coverage other that of the "errors and ommissions" of the insured;
3. November 20, 1990 for claims arising under "occurrence" forms of liability insurance policies,

and all contingent claims filed by insureds, and persons having a cause of action against such insureds, must be fully liquidated, on or before November 20, 1991. Such claims by insured may be allowed if such claim is liquidated and the insured presents evidence of the payment of such claim to the Liquidator on or before such final date, and such claims to the Liquidator on or before such final date, and such claims by persons claiming against such insureds may be allowed if such persons demonstrate to the Liquidator that the proof submitted to the Liquidator upon such claims satisfies the requirements of ILL. REV. STAT., 1987, ch. 73, Par. 821 by such final date.

TAKE FURTHER NOTICE, that all other persons, other than those contemplated in the paragraph above, having, or claiming to have, any accounts, debts, claim or demands against Equity General are required to present and file such claim with the Liquidator on or before 4:30 p.m., C.S.T., on November 20, 1990.

TAKE FURTHER NOTICE, that the form of, and required contents of, all proofs of claim are described in the Illinois Revised Statutes, 1987, Chapter 73, Paragraph 821. Proofs of claim, together with supporting documents, if any are to be filed with , and may be secured from, the Special Deputy Liquidator, Equity General Insurance Company, In Liquidation, 446 East Ontario Street, Suite 700, Chicago, Illinois 60611. Filing shall occur upon the receipt of Proof of Claim by the Liquidator. The information with respect to any claims as he may deem necessary. The Liquidator further reserves any and all defenses available to the company upon all claims. All proofs of Claim must be duly sworn to before an Officer authorized to take oaths.

THE LAST DATES FOR THE FILING OF PROOFS OF CLAINS WITH THE LIQUIDATOR AT HIS ABOVE MENTIONED OFFICE IS SET FORTH ABOVE. NO PERSON HAVING OR CLAIMING TO HAVE ANY CLAIMS AGAINST EQUITY GENERAL INSURNACE COMPANY, SHALL PARTICIPATE IN ANY DISTRIBUTION OF THE ASSETS OF THE COMPANY UNLESS SUCH CLAIMS ARE FILED WITH THE LIQUIDATOR ON OR BEFORE THE ABOVE RESPECTIVE DATES.

James W. Schacht,
Special Deputy Liquidator.

Howden scandal

Continued from page 3

group of companies for the benefit of a number of individuals, particularly the four men who effectively controlled the Alexander Howden Group, namely, Grob, (Ronald) Comery, (Allan) Page, and (Jack) Carpenter, and two underwriters associated with the Group, namely, Posgate and Hart," the judge said.

Messrs. Comery, Page and Carpenter all were Howden executives.

Since the alleged fraud first was revealed, however, several key witnesses have died or are now too ill to testify, the judge explained.

Mr. Comery died in a 1986 car crash; Mr. Page was declared too ill to stand trial last year; and Mr. Carpenter last year was found to be too ill to continue to stand trial in the case involving Messrs. Grob and Posgate and was dropped from the proceedings.

In addition, several other material witnesses have died.

"In my opinion the unavailability of these witnesses must seriously prejudice the defendants in the preparation and conduct of their defense," the judge concluded.

Messrs. Posgate, Hart, Page and Carpenter were arrested in Britain in July 1987 on charges connected with the misappropriation of funds belonging to Howden and Lloyd's syndicates managed by Howden affiliates.

Mr. Grob was arrested in France at the same time and was extradited to the United Kingdom the following month (*BI*, July 20, 1987).

After a pretrial review early last year, Justice McNeill ruled that although there had been a delay in bringing the case against the defendants to trial, "that delay was justifiable and there was no abuse of process. He ordered the trial to proceed," Justice Denison said last week.

"However, it was obvious to everyone concerned that the indictment, which contained some 70 counts, would have to be severed. The prosecution decided, and plainly it was a sensible and correct decision, to proceed against Grob, Carpenter and Posgate on what was the most serious part of the fraud, namely the acquisition of" the Banque du Rhone et la Tamise, a Swiss bank allegedly acquired by the defendants with misappropriated funds.

"That meant that the part of the fraud connected with the Hart policies was postponed," said Justice Denison.

However, the alleged crimes involving policies written and placed by Mr. Hart's syndicates took place before the acquisition of the bank, which meant that "the oldest aspects of the case would be tried last," the judge said.

A jury deliberated 20 hours and 43 minutes before acquitting Messrs. Grob and Posgate in the four-month first trial, which ended in August 1989.

The second trial was due to begin last October "but for a number of reasons—the principal one being the state of Grob's health—that trial was postponed until January this year," said Justice Denison.

Although Justice McNeill refused a similar application to quash, or at least stay, the proceedings against Messrs. Grob and Hart during a pretrial review early last year, "the position in January 1990 is different from that in February 1989, both as to law and as to fact," said Justice Denison.

"As to law, there are new authorities on the topic of the proper approach to an application to stay proceedings because of undue delay. As to fact, Carpenter is now too ill to give evidence and Grob's health has deteriorated as a result of the strain of the first trial," he said.

Justice Denison stressed, however, that the delay in bringing the case against Messrs. Grob and Hart to court by the prosecution authorities was justifiable.

"I am satisfied that the difficulties experienced in extracting evidence from the Swiss authorities and in securing the attendance of Mario Benbassat and Elihou Zilkha (two former Swiss bank officials) to make statements were real, have not been exaggerated and explain much of the delay," said the judge.

In addition, he said, "a further potential source of evidence" was a post-acquisition audit report prepared by accounting firm Deloitte Haskins & Sells—now Deloitte Ross Tohmatsu—for Alexander & Alexander in 1982 after it acquired Alexander Howden.

But "this was not delivered to the Director of Public Prosecutions until January 1986. The reason for this was that the (lawyers) acting for Alexander & Alexander, for whom the report had been prepared, were not prepared to make it available at any earlier date except under conditions which the Director of Public Prosecutions could not properly accept," the judge said.

The Serious Fraud Office, which handled the investigation, refused to comment. Officials at A&A also could not comment on the report.

However, while the delay by the prosecutors is justifiable, "there can be no doubt that the delay has prejudiced the defendants in the preparation and conduct of their defense. The passage of time means that memory fades although, of course, that applies as much to witnesses for the prosecution as for the defense," said Justice Denison.

Justice Denison said there are two further facts which "come into play," in his decision not to proceed.

"First, in March 1986, Mr. Hart was found guilty by a Lloyd's Disciplinary Tribunal. . .of a number of charges which included the charges he now faces. He was excluded permanently from Lloyd's and he was fined 175,000 pounds and ordered to pay 80,000 in costs ($132,000)," said Justice Denison.

"Second, Mr. Grob's health—both physical and mental—is not good. His mental deterioration is a result of the strain of the trial he has already undergone," the judge said. As a result "the unsatisfactory nature of the trial would be compounded by the facts that Hart has already been convicted and punished for these offenses and Grob is at risk, both physically and mentally, of breakdown," he said.

"In my judgment a trial would be an abuse of process in the sense that it could not be made a fair trial," he concluded.

However, Judge Denison dismissed applications from both defendants' lawyers for the payment of all or part of their legal costs by the government's central legal fund.

"It is, I think, sufficient for me to say that in all the circumstances of this case. . .is not a proper case for the award of costs," he said. ■

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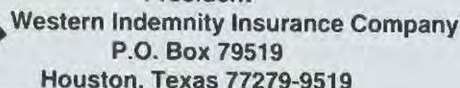
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Safety Week

Continued from page 2

alcohol abuse rules contained in the handbook notes that there are about 500,000 heroin addicts in the United States; 10 million regular cocaine users; 15 million alcoholics; and 20 million marijuana smokers.

About two-thirds of workers entering the workforce have taken illegal drugs, and about 44% of those have used them in the past year, according to the essay.

More than 500 workers are injured, disabled or killed weekly in alcohol- or drug-related accidents, the handbook notes.

The handbook also covers the role of the safety professional, model employee alcohol and drug abuse assistance programs, corporate drug screening programs and resources for additional drug abuse information and educational materials.

The ASSE also is selling safety posters, decals and brochures to bolster its National Safety Week campaign.

Handbooks are free to ASSE members and $7 for non-members. Non-ASSE members buying other materials will receive a free copy of the handbook. Discounts of 15% are offered for orders received before April 1.

The 1989 National Safety Week program on electrical hazards at home and on the job was so popular that the handbook went to second and third printings, said Mr. Murphy.

The ASSE is a professional organization of health and safety engineers, consultants and administrators. It has 24,000 members in 127 chapters worldwide.

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For further information on ASSE National Safety Week materials, contact The American Society of Safety Engineers, Marketing and Public Relations Department, 1800 E. Oakton Street, Des Plaines, Ill. 60018-2187; 708-692-4121, extension 43.

Info

• **"Employee Assistance Programs: Strategies for Local Government Workplaces"** is available from the Public Risk Management Assn. The report includes the results of a survey on local employee assistance programs and recommendations for planning, implementing and evaluating EAPs. The 300-page report, completed under a grant from the Occupational Safety and Health Administration, is $35 for PRIMA members and $55 for non-members. Copies are available from PRIMA, 1117 N. 19th St., Suite 900, Arlington, Va. 22209; 703-528-7701.

• A study of the public policy implications of utilization management has been published by the Institute of Medicine, an advisory group to the U.S. government. **"Controlling Costs and Changing Patient Care? The Role of Utilization Management"** examines the origins of utilization management, the impact of prior review programs and high-cost case management. Single copies of the paperback version are $24.95, and quantity discounts are available. Prepaid orders may be sent to National Academy Press, 2101 Constitution Ave. N.W., Washington, D.C. 20418; 800-624-6242.

• Meadowbrook Insurance Group offers free loans of its six-minute videotape, **"Captive Insurance Programs: User Reactions,"** to public entities, groups, associations and businesses. The tape highlights the experiences of participants in captives, pools and self-insured programs. Arrangements may be made through Meadowbrook's Creative Services Department, 24370 Northwestern Highway, P.O. Box 2054; Southfield, Mich. 48037-2054; 800-482-2726 or 313-358-1100.

• **"The Earthquake Report"** summarizes the first international earthquake conference sponsored by the Society of Chartered Property & Casualty Underwriters in Honolulu in May 1989. Eighteen speakers from seven countries addressed topics including structural design, loss prevention and reinsurance capacity. Copies are $9.95 from the Society of CPCU, 720 Providence Road, CB No. 9, Malvern, Pa. 19355-0709; 215-251-2743.

• In its debut issue, a quarterly magazine published by the **Occupational Safety and Health Administration** describes ergonomic hazards that can be found in any industry and the need to eliminate worker-crippling repetitive motion illnesses. Future issues will feature personal protective equipment and hazards such as bloodborne diseases. Prepaid annual subscriptions are $5.50 in the United States and $6.90 outside the country and are available from the Superintendent of Documents, U.S. Government Printing Office, Washington, D.C. 20402.

• **"How to Find Quality, Reasonably Priced Health Insurance"** is available to small employers from the Bay Area Health Task Force, a business and health coalition in San Francisco. It explains the basics of small group and individual plans and offers sample benefit plans for small employers in the Bay Area and includes a 10-point checklist for selecting health insurance. Free copies are available from the task force, 1435 Market St., Fourth Floor, San Francisco, Calif. 94103; 415-554-2432.

• The **"1990 Pictorial Property/Casualty Catalog"** is available from Pictorial Inc., a producer of training texts, licensing packages and services to the insurance industry. The catalog includes three new courses: Personal Inland Marine and Watercraft Coverages, Umbrella Liability Coverage and Reinsurance Basics. Free copies are available from Pictorial, Department 1091N, 8081 Zionsville Road, Indianapolis, Ind. 46268. Or call 800-428-1324, extension 711. Request priority code 1091N.

• A **"Medicare Quick Reference Guide"** is available to employers for distribution to retirees and to health care providers for their patients. The guide, which is updated annually, outlines important changes in Medicare coverage and explains available benefits. The "slide-chart" guide is published by American Custom Publishing and can be customized with a sponsor's name, program message and logo. The price varies by quantity and personalization. Orders are available from American Custom Publishing Corp., 121 W. Park Ave., Libertyville, Ill. 60048; 800-828-8225.

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Exxon faces suit in N.J., agrees to pay N.Y. damage

By MICHAEL SCHACHNER

NEW YORK—New Jersey is suing Exxon Corp. for unspecified damages for allegedly violating several state environmental laws in spilling more than 500,000 gallons of heating oil into a waterway separating the state and New York.

However, Exxon last week avoided legal action in New York by admitting liability for the spill and agreeing to pay for damage to natural resources and all cleanup costs.

In addition, Exxon avoided daily $10,000 fines by acceding to U.S. Environmental Protection Agency demands to explain by Jan. 17 what caused the Jan. 2 spill, what corrective measures it had in place then and how it plans to prevent a similar occurrence.

Exxon also filed massive amounts of documents with the EPA explaining why Exxon personnel failed to immediately shut down the pipeline and prevent discharge of the heating oil when a leak detection system sounded an alarm.

Exxon on Jan. 10 acknowledged that the system had been falsely signaling since 1978 and was often ignored. Exxon also said that a backup detection system was malfunctioning at the time of the spill (*BI*, Jan. 15).

The EPA last week had not evaluated the Exxon documents.

The spill, which fouled the banks of Arthur Kill, has killed more than 400 birds that nest and feed nearby, according to reports.

Exxon is self-insured for as yet-undetermined damages stemming from the spill, said Brian Davidson, Exxon's insurance coordinator.

"The oil spill in the East is a non-insured event. Losses will be paid for from operating income," he said.

Mr. Davidson said the company has a two-tiered deductible for property/casualty losses.

"Small losses," such as those resulting from the recent spill, fall within an initial deductible, and the second tier is an "enormous annual aggregate which is eroded by a loss that exceeds the initial deductible," he said. Mr. Davidson would not provide specifics on the size of Exxon's retentions.

However, after an Exxon refinery exploded last month in Baton Rouge, La., a company spokesman explained that Exxon had a retention of $10 million for property and occurrence-based liability coverages (*BI*, Jan. 1).

The New Jersey suit, filed Jan. 12 in state Superior Court in Union County on behalf of the state Department of Environmental Protection, alleges that Exxon violated the Spill Compensation and Control Act, the Water Pollution Control Act and state common law by permitting the No. 2 heating oil to leak from an underwater pipeline.

The lawsuit demands that Exxon pay the state $50,000 for each violation of the Spill Compensation and Control Act and the Water Pollution Control Act.

The New Jersey lawsuit also seeks reimbursement from Exxon for all damages to natural resources resulting from the leak, including all cleanup and monitoring costs that the DEP has and will incur.

The New Jersey complaint alleges that the oil has presented a "grave threat" to the Arthur Kill, Newark Bay and to the waters, coastline, lands, natural resources and environment of the state.

The oil caused and will continue to cause extensive damage to the waters, to the aquatic life, to lands and beaches, the mammals, waterfowl and other fauna that feed and rely upon the impacted area, the lawsuit says.

Former New Jersey Attorney General Peter Perretti, who filed the civil suit on his last day in office, said the state is also seeking reimbursement for studies of short- and long-term effects to the natural resources and environment.

In addition, the New Jersey suit is seeking an order that will prohibit Exxon from using the pipeline without obtaining prior DEP approval.

An Exxon spokesman declined to comment on the New Jersey lawsuit, saying the company had not reviewed the complaint.

A spokeswoman for the New York attorney general's office said meetings are scheduled this week with various state, local, federal and New Jersey officials to determine how Exxon should study the long-term impact of the spill and how Exxon should pay for damages resulting from the leak.

As part of its agreement with New York Attorney General Robert Abrams, "Exxon has agreed to front all costs and will pay for all damages and costs related to the cleanup," she said.

The Exxon spokesman confirmed that it had met with New York officials and agreed to assume liability for the spill and pay all costs related to the spill.

A spokesman for the New York State Department of Environmental Protection in Albany said the state agency is still investigating the spill to determine whether it will ask Mr. Abrams' office to begin legal action on its behalf.

PARTNERS

Continued from page 2

cial arrangement under which VHA Enterprises retained its 50% ownership, but Aetna assumed 95% of the financial risk of PARTNERS. This move came after VHA Enterprises incurred 50% or $15 million, of PARTNERS' total loss of $30 million for the year ended Dec. 31, 1987. VHAE lost a total of $36.6 million in 1987.

And, since Aetna financed 90% of PARTNERS' HMO acquisitions in 1988, the December 1988 agreement enabled Aetna to buy 95% of VHAE, he said.

Aetna lost $30 million on PARTNERS in the first three quarters of 1989, Mr. Bell said. Most of these losses were related to HMO operations.

In addition, all shares of VHAE stock held by Aetna and PARTNERS will be returned to VHAE. The value of that stock was not disclosed.

The new agreement also calls for VHA to provide to Aetna services such as the design and composition of hospital provider networks, HMO management and acquisition and managed care product development. These services will be provided indefinitely, Mr. Bell said.

'Under our new agreement, Aetna and VHA will work to sustain PARTNERS' momentum in the marketplace by focusing more directly on the things we each do best,' says Edmund F. Kelly, president of Aetna's Employee Benefits Division.

the equity in all but two HMOs purchased by PARTNERS in 1986 and 1987, when Aetna was contributing 50%.

This deal also called for Aetna to receive 95% of the profits and absorb 95% of the losses from these HMOs.

Under the most recent restructuring agreement, VHAE will receive $26 million in cash at the closing of the deal and up to $8 million in cash payable over the next two years, Mr. Bell said. Aetna also will assume $34 million in debt related to PARTNERS from

"Under our new agreement, Aetna and VHA will work to sustain PARTNERS' momentum in the marketplace by focusing more directly on the things we each do best," said Edmund F. Kelly, president of Aetna's Employee Benefits Division, in a company statement.

"The revised structure emphasizes the critical roles we both play in achieving long-term stability for health care buyers and providers," noted Robert W. O'Leary, president of VHAE. ■

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Business Insurance

EQUICOR buyout

Continued from page 1

Through the EQUICOR acquisition, CIGNA "will be able to enter more markets with managed care products," said David Young, a consultant with The Wyatt Co. in Washington, D.C.

By adding more cities to its base of HMO operations, CIGNA now has an even better opportunity to put together managed care networks for national employers, added Tom Billet, a managing consultant with A. Foster Higgins & Co. Inc. in New York.

Noting CIGNA's commitment to maintaining a leading position in the managed care field, CIGNA Chairman and Chief Executive Officer Wilson H. Taylor said the EQUICOR acquisition will significantly enhance CIGNA's existing managed care capabilities.

"This acquisition would bring together two companies with similar strategic objectives in the group insurance and managed health care business at a time when providing solutions to the continued escalation of employer costs is critical," Mr. Taylor said.

"CIGNA and EQUICOR have made great strides in containing health care costs for customers, while maintaining quality health care services. An integrated organization would provide for further efficiencies," he added.

The purchase is "a once in a lifetime opportunity" that will benefit customers, added Dave Devereaux, president for sales, marketing and underwriting at CIGNA's Employee Benefits Group in Bloomfield, Conn.

CIGNA made waves in the managed care marketplace in 1988 when it put together a huge, innovative managed care network for Allied-Signal Inc., the Morristown, N.J.-based manufacturer (*BI*, Jan. 22, 1988).

Under the CIGNA program, all of Allied-Signal's 80,000 employees are eligible to join the managed care plan, which replaced a multitude of indemnity plans and health maintenance organizations. Under the program, CIGNA guaranteed that Allied-Signal's health care costs would not increase more than a stipulated percentage over a three-year period.

Joseph W. Duva, Allied-Signal's corporate director of employee benefits, said his company's experience has proven that CIGNA "has got its act together" in providing managed care through a national network of providers.

The CIGNA acquisition of EQUICOR should benefit the Allied-Signal program by allowing CIGNA to expand its managed care network into new geographic areas, he said.

Larry Tucker, a consultant in the Santa Ana, Calif., office of Hewitt Associates, commented: "Large employers will have more local service, if they want it, in more geographic areas."

Larry Leisure, a vp and national practice leader with TPFC, the employee benefit consulting division of Towers, Perrin, Forster Crosby Inc. in New York, said, "It is a great match. EQUICOR has some great client relationships. It is good for EQUICOR policyholders, who will have much quicker access to a quality managed care network."

However, Mr. Duva and other employee benefit experts say CIGNA faces a formidable challenge in integrating EQUICOR into CIGNA's operations.

"Meshing the two organizations will be a gigantic task," Wyatt's Mr. Young said.

In fact, in the short term, CIGNA's ability to compete in the group health care market could be weakened because it will be so absorbed in merging EQUICOR's operations, one benefit consultant said.

"How successful the acquisition ultimately turns out will depend on how quickly and efficiently CIGNA can integrate EQUICOR's operations with its own. The next year will be very important for CIGNA," said Mr. Tucker of Hewitt.

"Absorbing this business could take years, but if the merger is successful, CIGNA will indeed be an even more formidable competitor. CIGNA will have significantly enhanced its health care delivery networks," which is something national employers are very interested in, Mr. Young said.

While noting the advantages that EQUICOR will bring to CIGNA, stock analysts Friday also expressed concern over whether CIGNA will be able to integrate EQUICOR's operations efficiently. They also questioned whether CIGNA paid too much for EQUICOR.

The $777 million is payable in cash, which CIGNA said will be generated by internal funds.

"The bottom line is (that) CIGNA's strong suit is employee benefits, and putting money to work on that is a positive move," said analyst Michael A. Lewis, first vp with Dean Witter Reynolds in New York.

However, while the acquisition of EQUICOR could benefit CIGNA in the long run, CIGNA nevertheless paid too much, he said.

"I think CIGNA paid a very full price for EQUICOR, and while it may help their position in the managed health care area on a long-term basis, they left very little room for shortfalls," said Mr. Lewis.

The "critical factor," he said, will be CIGNA's ability to assimilate EQUICOR smoothly "without significant problems developing."

Other analysts noted the purchase will hurt CIGNA's earnings.

CIGNA Corp. reported net income of $369.9 million in the first nine months of 1989, a 13.5% increase from the corresponding period of 1988.

Alex. Brown & Sons in Baltimore now is estimating that the EQUICOR acquisition will lower CIGNA's earnings per share by 20 cents in 1989 to $5.30 per share, said Vp Ira Malis.

Myron M. Picoult, senior vp at Oppenheimer & Co. Inc. in New York, said the acquisition is "going to be dilutive" and CIGNA's earnings will be lower than expected for the next year and a half as a result.

The acquisition's long-term impact on CIGNA will depend upon how well EQUICOR's operations are assimilated, he said.

Gloria Vogel, associate director at Bear, Stearns & Co. in New York, agreed that the deal "makes good long-term sense" for CIGNA, "but near term it's going to cause dilution."

She added it will take time and money for CIGNA to integrate EQUICOR's operation. It will also take time to turn around EQUICOR's now unprofitable HMOs, said Ms. Vogel.

EQUICOR lost $9 million on its HMO business during the first nine months of 1989.

While CIGNA lost $22 million on its HMO operations through the first nine months of 1989, Mr. Taylor projects that CIGNA's HMO business will go into the black this year.

Other HMO operators, meanwhile, are skeptical that the new, larger CIGNA will increase competition in the HMO marketplace.

"I don't think the acquisition will make any changes in the HMO marketplace at all" in terms of competition for other HMOs, said Dr. Robert Gumbiner, chief executive officer of FHP Inc., a Fountain Valley, Calif.-based HMO with 500,000 enrollees and the ninth-largest HMO ranked by *Business Insurance*.

"I don't understand why a company like CIGNA, which has been losing some money on HMOs for a few years, would acquire a company like EQUICOR, which has been losing a lot of money on HMOs for years," he added.

And, Dr. Gumbiner suggested that large conglomerates have not necessarily proven that they can effectively manage HMOs.

"I don't think CIGNA's acquisition of EQUICOR will have that dramatic of an impact in the California HMO marketplace. There is a more significant competitive effect on the marketplace when a large new player enters the market than when an existing player acquires another," noted Stuart Byer, president of the Sacramento, Calif.-based California Assn. of HMOs, which has 38 members.

EQUICOR is a major player in the indemnity and managed care markets, but its reputation has suffered in the last couple of years, according to consultants.

EQUICOR's "claims processing and information systems is not as strong as some competitors," said a benefit consultant.

Mr. Billet of Foster Higgins added, "EQUICOR had difficulty meeting the challenge in providing managed care. The combined firms should be in a much better position to do so."

CIGNA's Mr. Devereaux noted that EQUICOR has many attractions, including its size, executive talent and client base.

And, he pledged CIGNA would move rapidly in the next few months to integrate EQUICOR's operations with CIGNA.

"Our goal is to integrate this business as quickly as possibly to minimize any potential disruption," he said.

Mr. Devereaux also said acquisition costs will not be passed onto customers in the form of higher rates and that customers will benefit through elimination of overlapping operations and reduced overhead.

Officials at Equitable declined to comment on why it wants to withdraw from the group health insurance business.

The sale of EQUICOR "allows us to get back to our core business of owning and operating hospitals" with the proceeds used to reduce corporate debt, said an HCA spokesman.

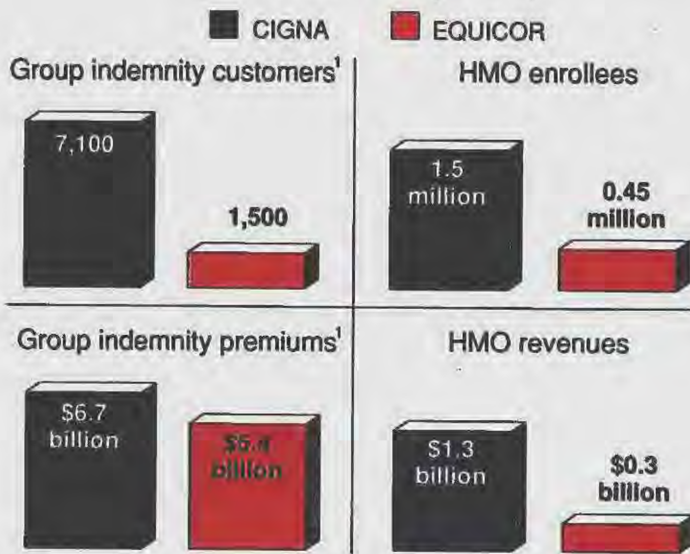
Mr. Devereaux said CIGNA currently is not negotiating to purchase other HMOs, but said the company's door always is open to attractive opportunities.

CIGNA stock was trading at $53.88 late last Friday, up 50 cents from the previous day's close.

Judy Greenwald in New York and Donna DiBlase in Los Angeles contributed to this report.

How CIGNA, EQUICOR stack up

CIGNA Corp's $777 million acquisition of EQUICOR will substantially enlarge CIGNA's employee benefit operations. Revenues are 1988 figures.



[1] Includes group health, life and disability operations.

Source: CIGNA, EQUICOR

B/HOLLY SEGUINE

Reversion tax may not be adequate: GAO

By ADRIENNE LOCKE

Washington

WASHINGTON—A 15% federal excise tax that employers now pay when terminating overfunded pension plans may not be adequate to discourage employers from terminating the plans to recapture surplus pension funds, says the General Accounting Office.

The excise tax is levied because normal income taxes on recovered pension assets may not offset the tax benefits employers receive for contributing to the funds. However, under three different tax scenarios, the GAO found that the 15% excise tax often is not sufficient to offset the tax benefits that employers receive. Employers can deduct contributions made to pension funds, and pension fund earnings accumulate tax-free.

Since 1980, the GAO says, employers have gained access to $20 billion in assets by terminating pension plans.

In the study, requested by Rep. J.J. Pickle, D-Texas, the GAO examined 18 randomly selected pension plan reversions of $1 million or more.

An employer's marginal tax rate is the most important factor in determining what excise tax rate is needed to offset pension tax benefits, the study found. The marginal tax rate is the amount of tax imposed on an additional dollar of income. In other words, marginal tax rates increase as an employer's income rises.

Under the current top corporate income tax rate of 34%, the excise tax rate required to offset tax benefits exceeded 15% in 14 of the 18 cases studied, the GAO said. The necessary offsetting excise tax rate ranged from 7% to 72%, with a median of 29%.

Under statutory tax rates—defined as income tax obligations as a percentage of profits—the size of the excise tax needed to offset tax benefits was greater than 15% in 17 of the 18 cases studied, the GAO said. The size of the excise tax needed ranged from 14% to 84%, with a median size of 34%.

Under effective tax rates, which reflect tax savings from credits and deductions, the excise tax rate needed to offset tax benefits exceeded 15% in 12 of the 18 cases, the GAO said. The offsetting excise tax rate ranged from −7% to 65%, with a median size of 24%.

Data for the GAO report was obtained from the Pension Benefit Guaranty Corp., the Department of Labor, the Department of Treasury and from private pension plan administrators.

Child care liability

Employers face "no significant impediments to obtaining or affording child care liability insurance" for on-site or near-site child care centers, says a Labor Department report.

However, the department's Child Care Liability Insurance Task Force noted that this "favorable environment" may not extend to other child care providers, such as private day care centers.

Many employers sponsoring child care centers told the department that obtaining liability insurance was not a problem, especially if coverage is added to an existing policy, the Labor Department report said.

Respondents also said the cost of liability insurance accounted for 1% to 3% of a center's operating budget.

Employers that implemented risk management programs for the child care facilities found less expensive liability insurance, said Debra R. Bowland, task force director.

Department researchers also found that most child care liability claims do not exceed $1,000 and that a small number of expensive claims account for the majority of losses.

Joint trusteeship bill

A bill that would require employers to share control of defined benefit and defined contribution pension plans will be brought before the House Labor-Management Relations Subcommittee during hearings scheduled for February.

The proposal, which will be introduced by Rep. Peter Visclosky, D-Ind., would require employers to set up joint boards of trustees with an equal number of employer and employee representatives.

Rep. Visclosky introduced similar legislation in the form of an amendment to the budget reconciliation bill last year, however the House of Representatives later voted to strip the amendment from the bill (*BI*, Oct. 2, 1989). Critics of the plan warned that employers would terminate pension plans rather than share control of plan assets with employees.

The hearings will be held on Feb. 21 and Feb. 28 at 10 a.m. in Room 2261 of the Rayburn House Office Building in Washington, D.C. ■

UR guidelines

Continued from page 1

charged.

"Physicians often have to make multiple calls and then face tremendous delays in having those calls returned by the UR firm. And, some of these calls can go on for 15 to 30 minutes," he said.

"Also, the kinds of services and procedures of the different review organizations vary tremendously. A physician may have contact with 15 or 20 different review firms and, as a result, a physician has the enormous task of identifying what the review firm's process is and what he must do to comply. And even if the physician does know the process, the kinds of information they look for and the conclusions the review firms draw also are variable," Dr. Kelly explained.

While benefit consultants and UR executives say that some of these complaints are valid, others may be exaggerated.

"I think that there are some legitimate concerns about the way some organizations perform UR. There are some good performers and some bad ones," said Dr. Robert Becker, chairman of HealthCare COMPARE Corp., a UR firm in Downers Grove, Ill.

"UR can be a very obtrusive process," agreed Dr. Edward Zalta, chairman and chief executive officer of CAPP CARE Inc., a Fountain Valley, Calif.-based UR firm.

The UR process can be time-consuming for some physicians, he said, suggesting that "the medical and clinical questions need to be weighted" so you don't have to answer 50 questions on a case.

But, as for complaints about the turnaround time on pre-admission certification, "typically the larger, better-managed review companies turn these around in 24 to 48 hours," said Larry Goelman, president of Cost Care Inc., a Huntington Beach, Calif.-based UR firm.

"My impression is that UR firms turn around reviews pretty quickly," agreed Larry Tucker, a consultant in the Santa Ana, Calif., office of Hewitt Associates.

Also, "when a UR nurse calls to verify clinical information, she is often talking to a nurse in the physician's office, so the doctor is not on the telephone. Physician-to-physician review usually only occurs when there is a discrepancy," said Joanne Fritsch, a consultant with The Wyatt Co. in Washington.

However, the AMA maintains that "there clearly is a level of frustration experienced by physicians. But there is a sense that we can take steps to make the utilization review process more effective and reduce the hassle factor," Dr. Kelly said.

The "AMA Initiative on Medical Review," adopted in December by the 435-member AMA House of Delegates, includes four main goals intended to address physicians' problems with both private health care plan UR programs and with Medicare Peer Review Organizations.

According to a report by the AMA's Board of Trustees, these goals and the way the AMA intends to achieve them are:

- To streamline and reduce duplication in the review process.

The AMA plans to review various studies and reports on UR's effect on the quality and cost of health care. In addition, the AMA will commission follow-up studies to identify the major problems with UR and suggest possible solutions.

The AMA then will consult with various organizations—like the American Hospital Assn., the federal Health Care Financing Administration and the BC/BS Assn.—to streamline the UR process.

- To assure that UR is performed by physicians.

The AMA plans to work toward increasing the amount of physician input in all levels of review.

In addition, the AMA will encourage the physician community to be more involved in the development of medical review guidelines used by UR firms and insurers, as well as in the development of review policies and screening criteria used by Medicare review programs.

- To remove the secrecy from established medical review guidelines.

For instance, the AMA plans pilot projects with HCFA that would release the screening criteria used by Medicare review organizations to test how compliance with Medicare coverage and payment requirements would be affected.

- To promote uniformity and consistency across reviewing entities.

In particular, the AMA plans to expand its recent joint effort with the HIAA and the BC/BS Assn. to develop mutually acceptable UR performance guidelines and to convince UR firms to adopt these guidelines.

The guidelines include:

- The medical criteria used in UR programs should be developed with input from physician advisers selected by the health plan sponsor.
- Prior authorization programs may be conducted on targeted procedures instead of on every service proposed by a physician.
- All pre-admission review programs should allow the immediate hospitalization of a patient if the treating physician feels emergency admission is necessary.
- In the absence of any contractual agreement between the physician and the benefit plan, the enrollee or employee should be responsible for obtaining a prior authorization of an admission or service. Physicians and hospitals could supply information once the review begins.
- Employee benefit managers and claims administrators should work to alert employees to inform their physician of prior authorization requirements.
- A physician or patient should receive a response from the UR firm within two business days after initiating the review process.
- When a medical service is questioned on the basis of medical necessity, the attending physician should be able to review the necessity of a service with a physician adviser representing the UR firm.
- Additional payment to physicians for complying with the UR procedures should not be necessary if the review process is administered efficiently.

The AMA's initiative on UR shows the group's acceptance of its necessity and is an encouraging step toward making UR more efficient, benefit experts say.

"The AMA knows UR is here to stay, and they are going to have to find a way to live with it," said Cost Care's Mr. Goelman.

"I think that this shows the AMA's recognition that there is a need and a place for UR, but that the AMA and the UR industry have to work together to solve their problems," said Doug Leland, vp of medical review services Intracorp, a UR firm in Berwyn, Pa.

"I think that if the AMA encourages physicians to cooperate in the UR process, this will make the process more efficient," said Tom Billet, a consultant with A. Foster Higgins & Co. Inc. in New York.

"Doctors have some legitimate concerns that UR firms need to be more sensitive to the individual needs of each individual case. And, the physician community needs to realize that the individual decisions they make in different cases can sometimes add up to a total practice pattern" that may not be efficient, Mr. Billet explained.

However, some benefit experts are suspicious about why the AMA is developing UR guidelines.

"Before utilization review was developed, doctors were the ones who controlled who went into the hospital, what treatment they received and how long they stayed. Then, utilization review became a process by which the delivery of unnecessary care was regulated. I find it very interesting that physicians now want to regulate the regulators," observed Wyatt's Ms. Fritsch.

"There must be 200,000 or more doctors contracting with insurers and UR vendors who know that they have to be part of the future evolution of health care. What is happening is that the AMA is trying to jump in front of the parade. But, I'm afraid the parade has already passed them by," said Mr. Goelman of Cost Care.

Apart from the AMA's activities, some UR executives already are working together on guidelines for the UR industry and to eventually develop an industry trade group.

"Some UR firms have been talking about the need for industrywide accountability and a voluntary credentialing process," noted HealthCare COMPARE's Dr. Becker.

A group of UR firms—including HealthCare COMPARE and Intracorp, among others—expects soon to announce development of an independent entity that would establish guidelines and set up a credentialing process for UR firms.

"I would like to see an endorsement by the AMA of our guidelines and to see the AMA get involved in developing these guidelines," said Mr. Leland of Intracorp.

"I think how the AMA reacts to our activities will be indicative of whether there will be a real cooperative effort by the AMA and the industry," he said. ■

Spanish disco fire

Continued from page 3

But the executive said that awards today "could be five times that," which could bring liability damages to as much as 4.3 billion pesetas ($39.5 million).

No lawsuits have yet been filed on behalf of the victims, but a Spanish consumers group has defended relatives' rights to seek damages.

Investigating Judge Javier Seoane released Mr. Martinez provisionally after the disco owner made a statement.

Spanish news reports said that a police investigation has blamed the fire, which began in the disco's ground floor, on an electrical system overload in air conditioning equipment installed above a suspended ceiling.

Authorities believe that toxic fumes and gases from burning furnishings made of flame-retardant materials—as required under the town's fire code—caused the deaths and one injury. The fumes and toxic gases reached the disco's basement, where most of the patrons were gathered.

In 1980, the Zaragoza City Council approved new fire prevention regulations after a fire at the Corona Hotel in the city killed 76 people.

More fire regulations were added in 1984, making the city fire codes the strictest in the country, according to Mayor Antonio Gonzalez Trivino.

The fire prevention chief for the city said the regulations were stiffer than in Madrid and Barcelona.

The fire code does not specify which toxic components are prohibited in fire retardant furnishings used in public buildings, but it does set limits for fire resistance. Zaragoza city regulations require materials to be fire resistant up to 100 degrees Celsius, or 212 degrees Fahrenheit.

However, news reports said that certain flame retardant materials could emit toxic fumes if burned.

A city council spokeswoman also confirmed that the disco had adhered to other fire regulations for fire escapes, emergency doors, fire protection equipment, hoses, extinguishers and emergency lighting. Firefighters arrived at the disco within eight minutes of notification but could not enter the disco for 20 minutes to extinguish the blaze, according to local government and fire officials. ■

Update

Constellation Re audits sought

Continued from page 2

the reinsurer should be liquidated.

The creditors seek disclosure of post-liquidation audits performed on Constellation, a statement of the reinsurer's assets and liabilities, an accounting of expenses incurred in the liquidation and a statement of assumed and ceded reinsurance balances.

Creditors say they need the information to prepare a request to assume Constellation Re's assets and liabilities as an alternative to liquidation. One creditor—Great American Insurance Co.—is pursuing such a plan (*BI*, May 1, 1989; Feb. 20, 1989).

Deputy Insurance Superintendent Kevin Foley refused to comment.

PRMC lawyer denies charges

LOS ANGELES—Pacific Reinsurance Management Corp. is asking a federal judge to reject a motion by six PRMC pool reinsurers to vacate a $94.5 million arbitration award because a PRMC lawyer and the arbitration umpire had a "personal relationship."

The reinsurers' New York law firm, Kroll & Tract, made the allegations against attorney Linda Lasley and umpire William C. McIlwaine Jr. in moving to overturn the award (*BI*, Jan. 15). Private investigators hired by the firm allegedly observed Ms. Lasley and Mr. McIlwaine at a Chicago hotel in December.

However, in court papers filed last week, Ms. Lasley—of the Los Angeles firm Buchalter, Nemer, Fields & Younger—denies any "intimate relationship" with Mr. McIlwaine, calling the "scurrilous and offensive" charges "reiterated misstatement and innuendo."

In a declaration, Ms. Lasley said she and Mr. McIlwaine met to discuss business unrelated to PRMC and that he stayed in a separate room in her suite after she became ill. In affidavits, investigators said Mr. McIlwaine had stayed in Ms. Lasley's room.

U.S. District Judge Terry J. Hatter will consider the motions without a hearing.

The six reinsurers were ordered last year to pay $94.5 million to PRMC after unsuccessfully arguing that their contracts should be voided because of mismanagement by the defunct Mission Insurance Group Inc. reinsurance pooling subsidiary.

Superfund violator sentenced

LOUISVILLE, Ky.—The first individual convicted on felony charges of violating the Comprehensive Environmental Response, Compensation and Liability Act was sentenced to six months in prison and three years' probation in U.S. District Court for the Western District of Kentucky.

Charles A. Donahoo was convicted in September 1989 of not reporting the release of more than a pound of asbestos into the air while removing it from a building in Louisville, Ky.

No other criminal cases involving CERCLA violations, better known as the Superfund Act, are imminent, but others can be expected, a Justice Department spokesman said.

Failure to report the release of a hazardous substance is a criminal offense under CERCLA, which also created a fund, financed by a tax on chemical manufacturers, to pay for cleaning up priority hazardous waste sites. However, when the government can determine those responsible for CERCLA violations, they are held liable for the cleanup. CERCLA holds both past and present owners of hazardous waste sites jointly liable for any cleanup costs.

Briefly noted

Liggett Group Inc., Philip Morris Inc. and Lorillard Inc. on Friday asked a U.S. appeals court in Philadelphia to stay its Jan. 5 ruling in the **Rose Cipollone** product liability case pending a New Jersey Supreme Court decision in a similar case. The court overturned a $400,000 award against Liggett but ruled that a lower court judge improperly dismissed a claim that tobacco companies should be held strictly liable for smokers' injuries and deaths (*BI*, Jan. 15). . . .High winds and flooding caused an estimated **$45 million in insured damage** in the Pacific Northwest and several Rocky Mountain states in Jan. 7-8, according to the Property Claims Services division of the American Insurance Services Group. The first catastrophe of 1990 was assigned Catastrophe No. 25. . . .An Arizona state judge has ordered **Americas Life Insurance Co.** liquidated. Phoenix-based Americas Life was placed in supervision last year after the Arizona Insurance Department rejected an accident and health reinsurance treaty arranged by London-based intermediary Consortium of 89 Ltd. (*BI*, Dec. 11, 1989). . . .A San Francisco Superior Court judge last week stayed new California Insurance Department regulations prohibiting territorial rating and curbing rate increases for private passenger auto insurance until **Proposition 103** implementation hearings under way in San Bruno are completed. The ruling stems from a lawsuit filed by State Farm Mutual Automobile Insurance Co. that charged the regulations were unconstitutional (*BI*, Dec. 11, 1989). . . .French government ministers will not declare the **lack of snowfall** in the French Alps this season a natural disaster, thereby leaving ski industry companies without coverage for loss of earnings under property insurance policies (*BI*, Jan. 15). But the minister of tourism recommended several government measures to aid Alpine resorts and towns, including paying a greater share of unemployment benefits. . . .**London United Investments P.L.C.** has sold loss-riddled excess/surplus lines broker R.L. Jarrett (Holdings) Inc. in Dallas to specialty wholesale broker and underwriting manager U.S. Risk Insurance Agency Inc. of Dallas for $250,000. . . .**Lloyd's of London** will announce its global results at its June 27 annual general meeting. The announcement traditionally is delayed until early September to allow time to collate results of hundreds of syndicates, but a computer system installed last year lets Lloyd's produce the figures more quickly, a spokesman said (*BI*, Aug. 28, 1989). Under Lloyd's three-year accounting system, syndicates will report 1987 results this year. . . .The Indian government is asking the nation's Supreme Court to throw out a $465 million settlement the court approved last month between Union Carbide Corp. and victims of the December 1984 **Bhopal gas disaster**. Danbury, Conn.-based Union Carbide says the agreement is binding and "there is simply no basis for overturning it."

A turning point in 1990

Improvements in earnings may be on tap for brokers

By LEONARD M. WILSON

Special to Business Insurance

IT'S HARD TO believe a year has passed and budgets must be dusted off and refurbished for the new year. Humility is a well-reasoned forecast gone amiss. In that vein, we took a backward look at our efforts of January 1989 before commencing this year's prognosis.

Our 1989 budget for the imaginary broker, Risk Adverse Associates, allowed for a 10% to 12% drop in premium rates, a 2% to 3% advance in commissions and only a slight rise in pretax earnings. We were a shade too optimistic about the shape of 1989. Price cutting surpassed our expectations and pretax earnings were flat or down for the publicly owned brokers. But our comments left no doubt that insurance brokers could not look forward to growth of any meaningful degree in 1989.

Mr. Wilson

Now for 1990. We have assembled the likely constituents of a profit plan for a typical insurance broker using the fictional—but presumably representative—Risk Adverse Associates.

The budget makers at RAA start out with an assumed 2% growth in the gross national product for 1990: no recession but a deceleration in economic growth, front-loaded to the first half of the year. The Federal Reserve's balancing act aims to sustain a long-lived expansion and, at the same time, gradually brake inflation, now running at an annual rate of 4%.

Premium rates on commercial lines are no longer declining sharply, but it may be hasty to count out the soft market. The managers at Risk Adverse are now conditioned to restraint. A premature loosening of the reins on cost might prove highly damaging to 1990's bottom line if the hoped-for stabilization in prices fails to materialize. Therefore, the budget contemplates a decline of 4% to 5% in premium rates for the full year across the book of business. Rates are expected to be down mostly in the first half, and then stabilize in the second half. If prices turn out to be firmer, it will be possible to slacken cost vigilance.

New business was robust in 1989, and there is no reason to doubt continued strength in 1990. Barometers like broker record of letters point toward new business equal to around 15% of the renewal book. New business goals will not be materially burdened by declining rates and their adverse impact on realizations per unit of insurance.

Lost business is budgeted at 5% of renewals, a level consistent with the past two years. Retention of existing clients will enjoy a high priority in 1989 for Risk Adverse. In addition, a more stable market should discourage client shopping for price.

Based on the outlook for premium rates, new business and lost business, Risk Adverse's budget allows for a 7% to 8% advance on direct brokerage premiums, a considerable improvement on last year's performance. Single-digit gains are nothing to write home about, but 1990 could be the transitional year in the cycle, beyond which gains accelerate appreciably.

Reinsurance brokerages, which face decreasing rates and high retentions in 1989, might be the beneficiary of firming rates in 1990. But at budget time, renewals for the most part convey an impression of continuing softness and little change in primary retentions. For reinsurance brokerage, the budget envisions at best a 2% to 3% rise in commissions.

International insurance brokerage cannot be easily pigeonholed because of widely diversified conditions and lines of business. Nonetheless, the general tenor of pricing abroad is not dissimilar to that in the United States, but with perhaps narrower swings. Without much impetus from rising prices, commissions abroad are expected to increase at 5% to 6%, modestly less than the gain budgeted for U.S. operations.

Benefit consulting has enjoyed strong growth, promoted by government fiat and spiraling medical and pension costs. These forces should be very much evident in 1990. Therefore, the budget projects a 15% rise in fees from consulting.

Investment income should receive a boost from increased premium throughout. The average yield on invested funds figures to be lower by perhaps one-half to one percentage point, depending in large measure on the strength of the economy. Risk Adverse anticipates a 5% decline in investment income for 1990.

Revenues in the aggregate, the result of individual forecasts for each business segment, should increase 6% to 7% for the year. It is probable that second-half comparisons will outstrip those of the first half.

Improving gains for revenues should provide a trifle more breathing room for expenses. Risk Adverse fully intends to preserve profit margins in 1990. Production, though, needs to be supported and client service must be sustained. Therefore, headcount might advance 2% to 3%. With inflation in wage costs calculated at 4%, it should be possible to keep the rise in total costs from outstripping revenue growth and, at the same time, achieve desired staffing goals.

Pretax earnings are targeted to expand 6% to 7% in line with revenues. Last year, many brokers benefited from lower rates of tax accrual. In 1990, RAA's corporate tax rate should be unchanged.

There is no certainty in this year's budget. Pricing in commercial lines could prove perverse. The bulging industry surplus does not provide much ammunition for a surge in premium rates. But, a transition to a much firmer and more orderly market is a plausible expectation for this year. In the difficult environment of the past two years, the public brokers generally demonstrated an ability to keep costs under good control. That discipline will help comparisons in 1989.

Risk Adverse's budgeted gains are more conservative than our security analyst's model of last month. This seems appropriate, given the budget's function as a tool of management and control.

In that context, cautious optimism seems just about right in the face of a still to be defined pricing shift. ■

Leonard M. Wilson is a senior vp with Lazard Asset Management Inc. He is a member of the New York Society of Security Analysts.

BI Insurance Index

Base = 100 on Dec. 29, 1978
Source: Nordby International Inc.

Insurance industry stocks continued to slide last week, as the *Business Insurance Index* fell 8.5 points to 591.0 on Jan. 19, from 599.5 on Jan. 12. Advancing issues were led by Lawrence Insurance Group, up 3.6%; American Indemnity Financial Corp., up 3.1%; and Hilb, Rogal & Hamilton Co., also up 3.1%. Decliners followed Re Capital Corp., down 8.6%; SCOR U.S. Corp., down 8.3%; and Corroon & Black Corp., down 7.2%. The most active issue during the period was Sears, Roebuck & Co. (Allstate), 3.5 million shares traded. The *Business Insurance* Index lost 1.4% for the period; the Dow Jones 30 Industrials lost 0.4%; the Standard & Poor's 500 fell 0.2%.

British Issues

Jan. 18 Companies	Price pence	P/E	Div. pence	Yield %	1 Week High—Low pence pence
Comml Union	486	27.0	29.3	6.0	490—486
Genl Accident	1120	16.0	68.0	6.1	1143—1120
Gdn Royal Exch	239	18.8	15.7	6.4	244—239
Royal	523	25.1	34.0	6.5	540—523
Sun Alliance	323	11.2	17.0	5.3	327—319
Brokers					
Bradstock	230	16.2	10.0	4.3	232—229
CE Heath	535	15.1	34.5	6.5	535—533
Hogg Robinson	175	12.2	9.7	5.5	175—174
Lloyd Thompson	279	18.6	9.3	3.3	279—278
PWS Holdings	65	10.0	3.3	5.1	67—60
Sedgwick Grp	286	21.2	16.0	5.6	290—286
Steel Brrl Jones	284	17.7	15.3	5.4	288—284
Willis Faber	273	19.2	15.3	5.6	280—273

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

BI Industry Stock Report

January 15, 1990 through January 19, 1990

		Price	Weekly % change	Year to Date % change	Annual High	Annual Low	Vol.(000)	$ Div.	% Yield	P/E	Book value	Mkt/Bk. value
BROKERS												
Alexander & Alexander	NYS	28.25	-3.83	21.51	34.00	22.63	280	1.00	3.54	17	9.18	3.08
Corroon & Black	NYS	33.75	-7.22	6.30	41.00	31.00	218	1.24	3.67	15	12.73	2.65
Gallagher Arthur J. & Co.	NYS	23.50	-3.09	38.24	26.50	16.25	16	0.52	2.21	17	5.33	4.41
Frank B. Hall	NYS	2.88	-4.17	-4.17	4.63	2.50	50	0.00	0.00	-1	-2.80	-1.03
Hilb, Rogal & Hamilton	OTC	16.75	3.08	20.83	20.63	11.00	25	0.28	1.67	18	4.60	3.64
Marsh & McLennan	NYS	76.50	0.82	37.84	89.75	56.50	466	2.48	3.24	19	10.56	7.24
Poe & Associates	OTC	12.75	0.00	45.71	12.75	8.00	2	0.40	3.14	12	1.89	6.75
BROKERS	AVERAGE		-2.1	23.8					2.5	14		
CONGLOMERATES & HOLDING COMPANIES												
Berkley W.R. Corp.	OTC	39.88	0.31	34.60	46.50	29.25	338	0.40	1.00	9	25.06	1.59
Berkshire Hathaway Inc.	NYS	8175.00	-0.30	75.81	8900.00	4625.00	2	0.00	0.00	-29	2869.00	2.85
ITT (Hartford Group)	NYS	55.50	-0.22	10.72	64.50	51.00	1175	1.60	2.88	9	56.33	0.99
Sears (Allstate)	NYS	38.00	0.00	-5.88	48.13	36.50	3506	2.00	5.26	13	37.75	1.01
CONGLOMERATES	AVERAGE		-0.1	28.8					2.3	0		
INSURERS/REINSURERS												
Aetna Life & Casualty	NYS	53.38	-2.95	13.87	62.50	47.63	924	2.76	5.17	8	58.11	0.92
Ambase Corp.	NYS	10.50	-3.45	-5.62	16.38	10.25	92	0.20	1.90	4	29.08	0.36
American General	NYS	30.63	-3.54	2.08	38.50	29.50	519	1.48	4.83	9	34.68	0.88
American Heritage	NYS	31.25	-1.57	22.55	32.00	25.00	5	1.20	3.84	12	22.60	1.38
American Indemnity/Fin'l	OTC	8.00	3.23	-23.81	13.00	7.50	1	0.56	7.00	-5	17.38	0.46
American International	NYS	96.88	0.13	45.40	112.00	69.38	1597	0.48	0.50	12	41.92	2.31
Aon Corp.	NYS	38.88	-0.96	40.72	43.25	27.63	165	1.40	3.60	11	19.62	1.98
Argonaut Group	OTC	66.25	-.92	52.30	71.50	47.75	67	1.00	1.51	8	36.83	1.80
AVEMCO Corp.	NYS	23.75	0.00	-7.32	27.50	20.38	4	0.40	1.68	14	9.52	2.49
Baldwin & Lyons Inc.	OTC	22.75	-1.09	56.90	24.00	14.63	3	0.28	1.23	7	20.80	1.09
Belvedere Corp.	ASE	4.88	0.00	8.33	6.50	4.25	1	0.04	0.82	15	8.03	0.61
Chandler Insurance	OTC	11.25	-3.23	50.00	13.25	7.00	34	0.00	0.00	6	9.53	1.18
Chubb Corp.	NYS	94.50	0.00	63.64	99.50	59.63	1068	2.32	2.46	10	55.49	1.70
CIGNA Corp.	NYS	53.88	-3.15	16.49	66.75	49.38	1396	2.96	5.49	11	66.64	0.81
CNA Financial Corp.	NYS	85.00	-6.85	44.68	108.75	57.88	176	0.00	0.00	8	54.87	1.55
Continental Corp.	NYS	29.00	-6.45	-9.38	38.63	29.00	778	2.60	8.97	54	41.36	0.70
Durham Corp.	OTC	30.25	-3.97	-5.47	34.75	29.00	3	0.92	3.04	19	26.32	1.15
Fireman's Fund	NYS	32.50	-6.81	11.59	40.75	30.63	448	0.60	1.85	12	32.74	0.99
Fremont General Corp.	OTC	20.13	-5.85	61.00	22.50	13.38	434	0.80	3.98	18	19.09	1.05
Frontier Insurance Group	NYS	17.25	-1.43	54.92	21.75	11.13	19	0.00	0.00	8	7.29	2.37
General RE Corp.	NYS	83.75	-1.18	52.27	96.25	57.00	1425	1.36	1.62	13	29.04	2.88
Hanover Insurance Co.	OTC	29.25	-4.10	10.38	33.00	25.75	121	0.44	1.50	6	32.03	0.91
Harleysville Group	OTC	26.13	-1.42	47.18	28.75	18.63	36	0.60	2.30	9	18.94	1.38
Hartford Steam Boiler	OTC	54.88	-0.90	48.31	59.25	36.75	302	1.60	2.92	15	18.94	2.90
Kansas City Life Ins.	OTC	35.00	-1.41	2.19	36.00	32.75	82	1.04	2.97	18	39.22	0.89
Kemper Corp.	NYS	44.50	-3.00	89.36	51.88	23.75	420	0.92	2.07	10	29.97	1.48
Lawrence Insurance Group	ASE	7.25	3.57	-9.38	8.25	6.50	1	0.28	3.86	15	3.29	2.20
Liberty Corp.	NYS	44.75	1.70	23.02	45.00	32.50	69	0.80	1.79	19	31.82	1.41
Lincoln National	NYS	57.25	1.78	32.37	62.88	45.50	135	2.60	4.54	11	49.19	1.16
NAC Re Corp.	OTC	34.50	-6.12	66.95	41.00	21.25	323	0.20	0.58	15	22.81	1.51
Navigators Group	OTC	27.75	0.00	35.37	28.50	21.00	30	0.00	0.00	10	15.22	1.82
Nobel Insurance LTD.	OTC	1.75	-6.67	-62.16	5.00	1.50	2	0.00	0.00	0	7.76	0.23
NWNL Companies	OTC	40.13	-3.02	30.49	44.13	26.88	289	1.20	2.99	9	37.50	1.07
Ohio Casualty Corp.	OTC	45.50	-3.45	27.27	52.50	38.50	430	2.08	4.57	7	33.30	1.37
Old Republic Int'l	OTC	24.00	-4.00	5.56	30.38	23.38	122	0.72	3.00	12	30.70	0.78
Orion Capital Corp.	NYS	21.88	-1.13	36.72	28.50	18.25	143	0.84	3.84	6	19.72	1.11
Phoenix RE Corp.	OTC	12.75	0.00	30.77	15.50	8.75	5	0.20	1.57	10	12.99	0.98
Protective Life Corp.	OTC	13.75	-0.90	3.77	16.25	12.88	26	0.68	4.95	26	14.54	0.95
Provident Life	OTC	23.63	-2.58	21.94	30.13	20.50	497	0.80	3.39	8	23.24	1.02
Re Capital Corp.	ASE	13.25	-8.62	43.24	15.25	9.13	66	0.00	0.00	12	12.60	1.05
RLI Insurance Corp.	NYS	8.75	0.00	14.75	9.50	6.88	10	0.40	4.57	8	10.71	0.82
St. Paul Companies	OTC	57.75	-2.94	34.30	63.50	45.75	742	2.20	3.81	8	43.47	1.33
SAFECO Corp.	OTC	36.63	-2.01	56.68	42.38	25.63	1038	1.20	3.28	9	24.87	1.47
SCOR U.S. Corp.	NYS	12.50	-8.26	44.93	14.50	7.50	76	0.40	3.20	13	10.61	1.18
Seibels Bruce Group	OTC	10.38	-2.35	-7.78	13.63	10.00	287	0.80	7.71	-49	13.75	0.75
Selective Ins. Group	OTC	18.75	-1.32	-18.48	20.25	14.50	66	0.96	5.12	6	15.72	1.19
Statesman Group Inc.	OTC	2.50	2.54	-13.04	3.63	1.88	118	0.16	6.40	7	4.19	0.60
Tokio Marine & Fire	OTC	69.50	0.00	-24.25	95.50	66.00	4	0.92	1.32	29	70.93	0.98
Torchmark Corp.	NYS	52.00	0.48	70.49	58.75	31.50	246	1.40	2.69	14	13.23	3.93
Transamerica	NYS	42.38	0.89	26.97	48.00	32.75	344	1.92	4.53	10	34.63	1.22
Trenwick Group Inc.	OTC	22.63	-3.72	58.77	26.88	13.75	96	0.36	1.59	11	16.91	1.34
United Fire & Casualty	OTC	33.25	0.00	9.02	34.50	29.00	7	1.20	3.61	9	22.56	1.47
USF&G Corp.	NYS	29.13	0.00	0.43	34.00	28.25	810	2.80	9.61	46	22.87	1.27
UNUM Corp.	NYS	49.63	1.53	85.51	51.38	26.88	470	0.60	1.21	13	31.20	1.59
USLIFE Corp.	NYS	41.50	-0.90	20.73	48.13	36.13	73	1.48	3.57	9	54.34	0.76
Washington National	NYS	26.00	-2.35	-2.35	29.13	24.00	39	1.08	4.15	-	32.90	0.79
Zenith National Ins.	NYS	18.25	1.39	3.55	21.50	16.75	38	0.84	4.60	8	13.81	1.32
INSURERS/REINSURERS	AVERAGE		-1.8	24.4					3.1	10.9		
HEALTH MAINTENANCE ORGANIZATIONS												
FHP International	OTC	20.00	2.56	70.21	26.38	6.38	724	0.00	0.00	18	3.54	5.65
HMO America Inc.	OTC	7.00	-3.45	646.27	10.63	1.00	169	0.00	0.00	-30	1.12	6.25
Pacificare Health Sys.	OTC	23.75	-1.04	90.00	30.38	7.13	230	0.00	0.00	24	6.35	3.74
Safeguard Health Enter.	OTC	7.38	-3.28	37.21	12.50	4.75	35	0.00	0.00	11	2.99	2.47
Sierra Health Services	ASE	8.38	0.00	415.38	9.63	1.75	105	0.00	0.00	-9	0.62	13.51
United Healthcare Corp.	OTC	10.50	1.20	147.06	12.63	4.50	503	0.00	0.00	21	0.34	30.88
United Medical Corp.	ASE	6.50	-1.89	20.93	7.25	5.38	2	0.00	0.00	22	5.70	1.14
U.S. Healthcare	OTC	13.00	-2.80	131.11	15.50	5.75	1190	0.20	1.54	31	3.07	4.23
HMOs	AVERAGE		-1.1	194.8					0.2	11		
ALL COMPANIES	AVERAGE		-1.6	22.2					2.7	9.5		

System design: Nordby International Inc.

Duncanson & Holt.

Didn't they come up with the quantum leap theory?

No, but they definitely took a bold leap forward with their Portfolio Medical Reinsurance program that lets even small, young companies, unable to afford a single large loss, an opportunity to compete in the medical insurance marketplace.

Flexible enough to adapt to any special needs, this program is complemented by our Program for the Rehabilitation of Injured or Disabled Employees (PRIDE) that manages catastrophic medical claims including AIDS and burn cases, provides better care for insureds, develops pertinent information on which to base reserves and saves overall claims costs.

For more information, call our offices in Atlanta, Chicago, Dallas, London, New York, Philadelphia, Portland, Maine, San Francisco or Seattle. Figure out the advantages and you'll leap for the phone.

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