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Update

California commission calls for competitive comp rating

SACRAMENTO, Calif.—California's minimum rate law for workers compensation insurance should be scrapped and replaced with a system of open competition, with floor rates based on loss costs, a ratemaking study panel says.

In addition, the state should establish an assigned risk pool funded by all workers comp insurers in the state according to their market share, the panel says. Furthermore, it suggests that the Legislature study the feasibility of

Continued on next page

Pollution exclusion enforced

4th Circuit says waste storage bars coverage

By MICHAEL SCHACHNER

RICHMOND, Va.—The intentional storage of waste in landfills over several years triggers the pollution exclusion in comprehensive general liability policies, even if the resulting damage was neither expected nor intended, a federal appellate court says.

Insurer attorneys hail the ruling, pointing out that it affirms insurers' contention that only pollution incidents that occur abruptly are covered under pre-1986 CGL policies.

Insurer attorneys also contend that because the ruling interprets New Jersey law, it will be particularly influential in litigation involving the numerous Superfund sites in that state.

However, attorneys for policyholders say the March 2 ruling will set only limited precedent.

Affirming a lower court ruling, a panel of the 4th U.S. Circuit Court of Appeals ruled 3-0 that three insurers for a unit of New York-based Triangle Industries Inc. are not required to indemnify or defend the company for pollution cleanups because the company repeatedly deposited steel sludge in an Ohio landfill, actions that were neither sudden nor accidental.

Because the discharge of sludge at the landfill was part of the standard course of Triangle PWC Inc.'s business and occurred regularly from 1977 to 1980, the court ruled that the pollution exclusion in the CGL policies, which excludes coverage for pollution that is not "sudden and accidental," bars coverage for Triangle PWC.

The court also said that a "modified" exclusion contained in several of the CGL policies, which barred coverage for damages caused by anything other than Triangle's finished product, is enforceable.

In addition, it ruled that an exclusion in a separate pollution liability policy, which barred coverage for damages occurring at waste sites not approved by government authorities, applies to this case.

As a result of the three-part ruling, Liberty Mutual Insurance

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Fronting act challenged

RIMS, others press for changes to draft as group readies it for NAIC approval

By MICHAEL SCHACHNER

Paul Brown of RIMS (below) wants the NAIC working group chaired by Vincent Laurenzano (left) to further soften provisions of the model fronting act.

Photos by David Lubarsky

NEW YORK—Risk managers and insurers are making little headway in their attempts to soften some of the key language in a National Assn. of Insurance Commissioners draft of a model law designed to limit fronting arrangements.

Risk managers, captive insurer officials and reinsurers want elements of the draft toned down before the working group presents a final draft to the NAIC's Reinsurance Task Force at the association's spring meeting late this month.

But, the chairman of the NAIC working group drafting the model act appears committed to almost all the provisions in the latest draft that limits the conditions under which licensed insurers can cede large amounts of reinsurance to unlicensed and offshore insurers.

While risk managers still object to provisions of the latest draft, it is considered much more palatable than the original draft of the fronting regulation that was unveiled in late 1990 (*BI*, Dec. 16, 1991; April 15, 1991; Dec. 10, 1990).

"We're moving in the right direction. Unfortunately, we're moving in very small increments," said Paul Brown, director of governmental affairs and general counsel for the Risk & Insurance Management Society Inc. in New York.

Mr. Brown acknowledged that RIMS and other parties concerned about portions of the draft are up against the clock in their efforts to persuade the working group to water down what they perceive as overly burdensome restrictions on fronting arrangements.

Time is short, Mr. Brown said, noting that Vincent Laurenzano, chief of the New York Insurance Department's Property Companies Bureau and chairman of the group drafting the model, has said that he would like to have the final draft ready for the NAIC's March 29-31 meeting in Seattle.

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Crum & Forster faces $142 million bad faith judgment

By MEG FLETCHER

MARSHALL, Texas—A Texas judge could order Crum & Forster Inc. to pay Monsanto Corp. nearly $142 million in damages after a jury found that the insurer acted in bad faith in underlying pollution-related litigation.

In assessing the award, which includes $50 million of punitive damages, the state court jury on March 5 ruled that Crum & Forster conspired with other parties to control "the prosecution of claims that were being asserted against Monsanto."

The jury also found that a Crum & Forster unit inappropriately denied Monsanto reimbursement of defense costs in the litigation.

If the presiding judge upholds the jury's finding, Crum & Forster also could be ordered to pay three compensatory awards of $13.1 million each, two of which could be trebled under the Texas Deceptive Trade Practices Act, for a possible total of $91.7 million.

However, Basking Ridge, N.J.-based Crum & Forster, a unit of Xerox Corp., "continues to deny any wrongdoing, strongly disagrees with the jury findings as being contrary to the evidence and Texas law and will vigorously pursue an appeal," the insurer said in a statement.

Crum & Forster also "contends that the three jury findings of approximately $13.1 million constitute the same element of damage and are not additive."

The company would not elaborate.

Crum & Forster units International Insurance Co. and

Continued on page 31

Congress seeks to curb MEWA abuse

By DOUGLAS McLEOD and JERRY GEISEL

WASHINGTON—Congress is taking steps to toughen regulation of self-funded multiple employer welfare arrangements.

In a report on MEWA fraud released last week, the Senate Permanent Investigations Subcommittee calls for several amendments to the Employee Retirement Income Security Act of 1974 aimed at curbing MEWA abuses.

Among other things, the subcommittee wants to clarify the power of state insurance regulators to license MEWAs and any third-party provider of services to employee benefit plans.

Fraudulent MEWA operators have repeatedly slowed state regulatory efforts by claiming to be exempt from state oversight under ERISA, the report notes.

MEWAs slow state regulatory efforts by claiming to be exempt from state oversight, the report says.

Subcommittee Chairman Sam Nunn, D-Ga., plans to introduce a bill incorporating the report's recommendations within several weeks, said Alan Edelman, counsel to the subcommittee.

Meanwhile, Reps. William Hughes, D-N.J., and Sherwood Boehlert, R-N.Y., are drafting legislation to strengthen regulation of self-funded MEWAs.

Under their proposal, which could be introduced in the House as soon as this week, new MEWAs would have to be certified by the Labor Department as meeting newly created federal financial standards before they could operate. The Labor Department would be given up to nine months to certify existing MEWAs.

Although MEWAs would have to meet these federal standards—which still were being ironed out last week—states would retain clear authority to regulate MEWAs for solvency under the Hughes proposal.

And, a state could shut down a MEWA that misrepresented any information in its certification filing.

Rep. Hughes noted, however, that the Labor Department would need more resources if it is to certify MEWAs.

A Labor Department spokes-

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Update

California comp rate reform

Continued from previous page
forcing self-insurers to contribute to assigned risk pool costs.

These recommendations will be included in a report by the Workers Compensation Rate Study Commission that will be submitted to the Legislature by April 1, said Executive Director Richard H. Soper.

If the Legislature does not adopt these proposals, the panel suggests that the premium level required for experience and retrospective rating plans be lowered to permit more employers to participate and that a system of premium rebates and/or deductible plans be instituted for small employers.

Currently, an employer must have premium of $6,900 to be experience-rated, while employers must generate annual work comp premiums of at least $25,000 to participate in retro plans, according to the Workers Compensation Insurance Rating Bureau in San Francisco.

The commission was formed by the Legislature in 1989 to evaluate the state's workers comp rate laws.

Ford, GM lose work comp case

WASHINGTON—Following a U.S. Supreme Court ruling last week, General Motors Corp. and Ford Motor Co. must pay millions of dollars to employees whose workers compensation wage-loss benefits were illegally coordinated with their pension benefits.

Spokesmen estimate that GM owes $15 million plus interest to 5,000 to 6,000 former workers, while Ford owes $7 million plus interest to 270 former employees. Both automakers had asked the U.S. Supreme Court to review the constitutionality of a Michigan Supreme Court ruling calling for the payments.

The litigation stemmed from the way the companies interpreted a 1981 state law. Both said the law allowed them to offset the wage-loss portion of self-insured workers comp obligations against pension benefits paid to injured employees after March 31, 1982, regardless of when the injuries occurred.

In 1985, the Michigan Supreme Court upheld the companies' coordination of benefits policies.

However, the Legislature in 1987 amended the law so it applied only to workers injured after March 31, 1982. The amendments also required refunds to all employees whose benefits had been coordinated during the five years the law was in effect.

One former worker then sued under the 1987 amendments, and the Michigan Supreme Court, reversing its earlier ruling, ordered back payments to 1982.

Car rental surcharge exemption

NEW YORK—New York City residents who are "responsible renters" will be exempt from daily surcharges Hertz Corp. has added to car rentals.

For a one-time fee of $25, Hertz will search renters' driving and employment records. Drivers without any accidents or moving violations for three years and who have been employed for at least one year will be exempt. Hertz will review compliance periodically and remove the waiver if a renter no longer qualifies.

On Jan. 2, the company announced that residents of the Bronx, Brooklyn, Manhattan and Queens had to pay daily surcharges of $3 to $56 when renting in the New York area (*BI*, Jan. 13).

The fees were intended to cover the company's "catastrophic" losses in third-party claims. New York law holds a car's owner responsible for damage or injuries the driver may cause.

FDA seeks heart valve warning

LOS ANGELES—The U.S. Food & Drug Administration wants heart valve manufacturer Shiley Inc. to notify patients and physicians that the risk of fracture for 60-degree Bjork-Shiley heart valves may be higher than previously thought.

Valve fracture is often fatal. About 23,000 people in the United States and Canada have 60-degree heart valves, the FDA says.

Shiley said the new study "is a valuable single study," but it emphasized that "other equally valuable studies have found somewhat different results."

Earlier this month, the 4th District Court of Appeals ruled that plaintiffs outside of California should not be allowed to sue Shiley in California just because the states in which they reside prohibit damages for mental distress caused by fear the valves might fail.

California is the only U.S. jurisdiction that recognizes a cause of action by plaintiffs seeking damages for physical and mental distress caused by the fear that their valves may malfunction.

Shiley in 1986 ceased manufacturing the C/C artificial heart valve after its research found that metal fatigue caused about three of every 1,000 of the devices to fail.

Firm sued over ELIC annuities

WASHINGTON—The U.S. Labor Department is suing a Houston manufacturer under the Employee Retirement Income Security Act for "improperly" purchasing group annuity contracts from Executive Life Insurance Co. of California.

Smith International Inc. used more than $51 million in pension plan assets to purchase the annuities, which provide benefits to about 3,000 plan participants and beneficiaries. About 4,400 other plan participants were given lump sums when Smith terminated its plan in 1985 to recapture more than $23 million in surplus assets.

In a suit filed last month in federal court in Los Angeles, the

Continued on page 30

Rising work comp costs prompt state responses

By MEG FLETCHER

CAMBRIDGE, Mass.—While many states are striving to control medical costs in their workers compensation systems, cost savings are difficult to determine or quantify.

WCRI

Medical costs, which comprise more than 40% of total workers compensation costs, have "accelerated significantly" beyond inflation in recent years, said Richard A. Victor, executive director of the Workers Compensation Research Institute in Cambridge, Mass.

In addition, workers comp medical costs are growing 50% faster than medical costs for non-work-related health care claims, he said during the recent annual conference of the Cambridge, Mass.-based non-profit research organization.

Many states are responding by adopting a variety of cost containment measures, although their effectiveness is not always known or quantifiable, said John Lewis, a lawyer and workers compensation consultant in Miami.

In a 1991-1992 inventory of cost containment programs implemented by all 50 states and the District of Columbia, the WCRI found that states have enacted laws and regulations designed to:

• Limit an injured worker's choice of a physician. This was the most common strategy adopted by the states, the WCRI found.

Currently, 21 of the 51 jurisdictions limit an injured worker's initial choice of a physician, and 40 place limits on changing doctors, the report said.

Despite these restrictions, studies have found that injured workers generally are happy with their medical care, according to Mr. Lewis.

Nevertheless, medical care can become a "very emotional" issue, especially if an injured worker receives poor care or a claim is

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Kinder, gentler lawsuit

Firm seeks good insurer relations despite coverage dispute

By SARA MARLEY

SEATTLE—Like hundreds of other companies, Weyerhaeuser Co. is suing its liability insurers over coverage for pollution cleanup costs. However, unlike many others, it is taking extra steps to maintain good relations with the insurers.

The Tacoma, Wash.-based wood products manufacturer is suing 33 insurance companies and numerous Lloyd's of London syndicates and London underwriters.

The suit, filed March 6 in King County Superior Court in Seattle, seeks a ruling that the insurers, which wrote primary and excess comprehensive general liability coverage, must defend and indemnify Weyerhaeuser in pollution cleanup cases.

The insurers wrote coverage for Weyerhaeuser from 1951 through 1985, when an absolute pollution exclusion was written into the company's policies.

Weyerhaeuser's primary liability coverage was written during that period by Fireman's Fund Insurance Co., now an Allianz A.G. Holding unit, and Indemnity Insurance Co. of North America, now a CIGNA Corp. unit.

None of the insurers has offered to defend or indemnify Weyerhaeuser in the pollution cases except Fireman's Fund, which has defended the company in actions related to the Stringfellow hazardous waste site in California after issuing a reservation of rights notice.

Weyerhaeuser has never before sued one of its insurers, said Cheri J. Hawkins, assistant treasurer and director of insurance at Weyerhaeuser.

Ms. Hawkins, who was the 1990-1991 president of the Risk & Insurance Management Society Inc., personally wrote each of the insurers and enclosed a copy of the lawsuit. She asked that the insurers maintain good relations with Weyerhaeuser despite the suit.

"We wanted to have the complaints in the hands of the key

Continued on page 4

New York court rules 4-3 in favor of excess insurer

Dropdown cover denied

By SARA MARLEY

ALBANY, N.Y.—An excess insurer is not required to drop down to fill a coverage gap left by an insolvent insurer, New York's highest court has ruled in its first decision on the dropdown issue.

The New York Court of Appeals, affirming a lower court decision, ruled 4-3 that The Home Insurance Co. of New York did not have to cover a $10 million gap in a general liability insurance program for a New York property management firm. The gap was created when Mission Insurance Co. became insolvent in 1987.

The firm, Ambassador Associates Management Inc., sued The Home, seeking coverage of defense costs in a $24 million personal injury lawsuit related to a fire in a Queens apartment complex.

Ambassador had a $1 million general liability policy with Public Service Mutual Insurance Co. of New York, a $10 million umbrella policy with Mission and a $15 million policy excess of $11 million with The Home.

Ambassador attorney Alan M. Gelb, a partner with Fischbein Badillo Wagner & Itzler in New York, said it is unusual to have a close vote by the court not go in the policyholder's favor.

"If the court can't tell what's what, how can a lay person?" he said.

"I think that to a degree I was surprised that the vote was so close," said Home attorney Irene Sullivan of Skadden, Arps, Slate,

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Life/health industry sound: Analysts

By CHRISTINE WOOLSEY

SAN FRANCISCO—The prognosis for the life/health insurance industry as a whole remains good, despite some major collapses, three representatives from insurance rating agencies agree.

Mortgage and real estate investments continue to perform poorly, though.

As a result, life/health insurers may want to divest themselves of businesses and investments that are not financially productive or stable, they say.

But the executives agree that—barring any crisis stemming from poor real estate investments—the moves by insurers to focus on their strengths and improve their asset quality will sustain the industry.

"We believe the life and health insurance industry continues to be adequately capitalized," said Milton Meigs, executive vp at Duff & Phelps Credit Rating Co. in New York.

"Standard & Poor's does not believe we are facing a solvency crisis in the life insurance industry," said Roy Taub, executive managing director of Standard & Poor's Insurance Rating Services in New York. "The insurance industry in general is in sound financial shape."

"We do not anticipate that the industry as a whole is likely to fall below an average level of financial strength corresponding roughly to Moody's A or 'good' rating level," said Chester V.A. Murray, associate director at Moody's Investors Service Inc. in New York.

Messrs. Meigs, Taub and Murray discussed the condition of the life/health insurance industry and how their rating agencies assess insurers during a recent symposium sponsored by Russell Miller Inc. March 1-3 in San Francisco.

Even though "a number of major insurance companies are finding their earning power eroded because of poor-quality investments," concerns about asset quality —particularly for companies that hold the high-risk, high-yield bonds used to finance leveraged buyouts—are "yesterday's news," Mr. Meigs said. Such bonds no longer "pose a serious threat" to insurers, he said.

Nonetheless, consumers have been hit with media messages detailing the collapse of huge life insurers and the plight of policyholders left without coverage.

"Insurance company solvency is, without a doubt, on people's minds," said Mr. Taub. In fact, a recent American Council

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Ads for nicotine patches are sparking inquiries from workers, employers say.

Self-funded plans cover nicotine patch, but insurers wary

By LAURA MAZZUCA

Many self-funded employers are giving workers who smoke added help to kick the habit by covering the cost of prescription nicotine skin patches, but many insurers are waiting until the smoke clears on the patches' effectiveness before they will cover them.

Large self-insured employers are more likely than insured plans or health maintenance organizations to provide coverage for the cost of the patches because they are "trying to control lifestyle-related illnesses" by developing smoking cessation and health promotion programs, said Kenneth Sperling, a consultant with Hewitt Associates in Rowayton, Conn.

But, group health insurers and HMOs have been cautious because few clinical studies and virtually no cost analysis data are available on the product, explained Joseph Glinbizzi, group benefits consultant at Kwasha Lipton in Fort Lee, N.J.

In addition, group health insurers and smaller self-insured employers will not cover the cost of the patch because generally "it doesn't relate to a medical condition" requiring that the smoker must quit for health reasons, Mr. Sperling said.

The nicotine skin patch has generated strong consumer interest since the U.S. Food and Drug Administration approved its sale last November.

Manufacturers of the patches—marketed under the trade names Nicoderm, Habitrol and ProStep—claim that when coupled with a behavioral modification program, nicotine patches are highly effective in helping smokers quit their tobacco habit.

The patch controls the physical addiction by releasing into the user's bloodstream a specific amount of nicotine—typically beginning with 21 milligrams daily. Subsequent patches release lower levels of nicotine to help wean the smoker off the drug.

Because the patch maintains a steady level of nicotine in the bloodstream, it is more effective than nicotine gum, another smoking cessation aid, in weaning the smoker from the addictive drug, said Dr. Dan Dragalin, a consultant with TPF&C, the benefits consulting division of Towers, Perrin, Forster & Crosby Inc. in New York.

Using the patch costs about $100 per month, which is slightly more costly than the gum, he said.

But because the product is new, there is little conclusive, long-term data to support its effectiveness.

According to a trial study conducted by Marion Merrell Dow Inc., the Kansas City, Mo., manufacturer of the Nicoderm patch, smokers using the patch alone have experienced a smoking cessation ratio of 2-to-1 over a control group using placebos, a spokesman said.

But in another study conducted by CIBA-GEIGY Corp. of Summit, N.J., which manufactures the Habitrol patch, smoking abstinence success rates varied widely when the patch was used.

Of the 516 moderate to heavy smokers at nine different clinics who used both the patch and a behavioral support program, abstinence rates

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Insurer executive urges ADR support

Decaminada to head American Arbitration Assn.

By MARK A. HOFMANN

NEW YORK—Joseph P. Decaminada will become only the second insurance professional in 66 years to head the American Arbitration Assn. when he becomes the group's chairman early next month.

The American Arbitration Assn. is a non-profit organization that offers and promotes a range of alternative dispute resolution mechanisms, including arbitration, mediation and minitrials.

Alternative dispute resolution is a technique insurers must embrace if they are to hold down the cost of routine claims disputes, said Mr. Decaminada, who is executive vp, general counsel and corporate secretary of Atlantic Mutual Insurance Co. in New York.

"What is the nature of the insurance industry?" he asked. "It is claims, claims, claims."

And, with some indications that insurers' legal costs are growing at a faster rate than claims payouts, ADR is a way to hold down the costs associated with some disputes, he contends.

Mr. Decaminada, who will become the New York-based association's chairman on April 7, has had a seat on the group's 120-member board of directors since 1982.

'I think ADR is the trend of the future. The better we use it, the more society benefits.'
—Joseph P. Decaminada

During the past three years, he has been chairman of the board's executive committee.

Only one other insurance industry executive has ever served as the association's chairman. J. Victor Hurd, the late chairman of Continental Corp., was chairman during the late 1960s.

ADR provides a means to settle claims disputes without going to court, Mr. Decaminada pointed out. But, he stressed that not all insurance disputes lend themselves to resolution outside of the courts.

"There are some times when there are important legal issues" that must be decided in court, he said. But the fact that the vast majority of claims-related suits are settled out of court indicates these disputes don't involve significant ques-

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Doctors debate reform of health care system

By LORI BLOCK

ROSEMONT, Ill.—Few dispute that the nation's health care system is in dire need of reform, but that's where the consensus ends and the debate begins.

Two voices in the health care debate are Dr. Richard Kronick, an assistant professor in the Department of Community and Family Medicine at the University of California, San Diego, and Dr. Quentin Young, the chairman of the Health and Medicine Policy Research Group in Chicago, a health policy think tank and advocacy group.

The two doctors touted different approaches to solve the health care crisis—an employer-funded system with elements of "managed competition" and a Canadian-style universal health care plan—at the Midwest Business Group on Health's 12th annual conference, "National Health Care System Reform at the Company, Local and State Level." The conference was held March 5-6 in Rosemont, Ill.

In addition to these two options, there are other approaches that could be adopted to reform the health care system, noted Dr. Kronick.

According to Dr. Kronick, all health care reform proposals can be categorized by how they address two fundamental issues: cost control and how health care is financed.

Costs can be managed either by establishing price controls or by developing competition among providers, he said. Access can be financed through a public program, through some form of employer mandate like "pay-or-play" arrangements or by individuals, Dr. Kronick explained.

Six different approaches can be crafted based on these two issues. For instance, Dr. Kronick supports a model that would combine employer financing with managed competition, an approach similar to that favored by Democratic presidential candidate Paul Tsongas.

Others advocate a system of price controls and public financing, or the Canadian approach.

In outlining his approach, Dr. Kronick said an employer-financed managed-competition system would "resolve the paradox of excess and deprivation" that currently exists in the U.S. health care

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Weyerhaeuser

Continued from page 2

people in the insurance companies instead through normal service," which could have caught the insurers by surprise, Ms. Hawkins explained. "We didn't want that to happen.

"We would rather have insurance carriers working with the risk management department than attorneys working with attorneys."

The letters expressed Weyerhaeuser's desire to negotiate out-of-court settlements with the insurers, some of which still write coverage for Weyerhaeuser, Ms. Hawkins said.

Weyerhaeuser tried to mediate differences with a few of the insurers before filing the suit, but found the issues were too complex to resolve through mediation.

"We realized that it is extremely difficult to get insurance companies to agree among themselves on allocations of responsibility for payments," Ms. Hawkins said. "We decided to file the suit to establish the ground rules. We absolutely would have preferred to deal with insurers through negotiation."

Insurers who have responded to her letter have been receptive, Ms. Hawkins said.

"They are very interested in discussing resolution (of the case)," she said.

Attorneys point out that more policyholders and insurers are attempting to discuss their differences before filing suit.

While Weyerhaeuser's actions "certainly aren't mainstream," parties on both sides of pollution coverage disputes are more often looking at alternative dispute resolution, said Elizabeth Badger, a partner with Morrison & Hacker in Kansas City, Mo., which represents insurers.

Ms. Hawkins says she 'absolutely would have preferred to deal with insurers through negotiation.'

"The traditional system works, but it should be reserved for those cases when agreement doesn't work," she said.

"Nobody wants to go headlong into a heavy-duty lawsuit," added policyholder attorney David Steuber, a partner with the Los Angeles firm of Hill Wynne Troop & Meisinger. While Ms. Hawkins' letter to insurers might be unusual, the underlying concept is not.

"Risk managers are concerned about bringing suit against their insurers. They think, 'How will this impact my ability to get coverage in the future?' " he said. But "sometimes the only way to get the attention of carriers is to file"

The coverage dispute involves 42 sites where Weyerhaeuser has "identified the need for environmental mediation by some means or has been cited," Ms. Hawkins said. "These sites are being cleaned up or will be, without regard to whether there is insurance."

The sites include ponds, landfills, wholesale distribution centers and underground storage tanks that have been contaminated with substances including ash, diesel fuel, chlorine, PCPs and mercury, court records say.

Eight of the 42 sites have been designated as Superfund cleanup sites by the U.S. Environmental Protection Agency.

Washington courts in the past have favored policyholders in pollution coverage disputes.

In 1990, the State Supreme Court ruled that the costs of a government-ordered pollution cleanup constitute damages and therefore are covered under CGL policies (*BI*, Jan. 15, 1990).

A major issue in the Weyerhaeuser case will likely be identifying when contamination took place and which policies were in effect then, said Gabe Gedvila, Weyerhaeuser's assistant general counsel. Washington courts have held that the policy in place at the time of the initial occurrence of pollution should respond to a cleanup, rather than the policy in place when the pollution is discovered, Mr. Gedvila said.

Washington courts have resolved the "basic pollution issues," said Mr. Gedvila. "What has to be resolved is how you split responsibility among the various carriers."

Mr. Gedvila said the case is one of the largest filed in Washington in terms of the number of sites and the complexity of insurer allocation.

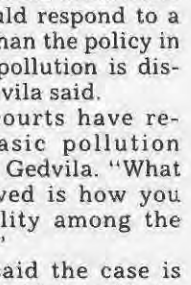
Besides the insurers, the lawsuit also names as a defendant the Washington Insurance Guaranty Assn., the state's property/casualty guaranty fund. The fund, according to the lawsuit, is paying claims on behalf of Central National Insurance Co., which is in rehabilitation, and insurers in liquidation: Holland-American Insurance Co., Integrity Insurance Co., Midland Insurance Co., Mission National Insurance Co. and Pine Top Insurance Co.

Weyerhaeuser is represented by Anderson Kill Olick & Oshinsky in New York and Perkins Coie in Seattle. ■

Loftus joins *BI* sales staff in New York

NEW YORK—Thomas P. Loftus has joined the *Business Insurance* sales staff in New York as a district manager, Advertising Sales Director Martin J. Ross announced.

Mr. Loftus, 41, previously was associate New York sales director for Newsweek, where he was responsible for much of the magazine's insurance and financial services advertising.



Mr. Loftus

Before joining Newsweek, he spent five years as an account executive with advertising agencies Ted Bates Wordlwide Inc. and Dancer Fitzgerald Sample, both in New York.

"We are especially pleased to have Tom join our staff with his extensive background in serving insurance and financial advertisers," Mr. Ross said.

Mr. Loftus succeeds Jack Forrest, who retired at year end.

Mr. Loftus is a 1972 graduate of the University of Notre Dame in Notre Dame, Ind., with a bachelor of arts degree in sociology.

He can be reached at 220 E. 42nd St., New York, N.Y. 10017; 212-210-0134. ■

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Disney to build huge on-site daycare center

The Walt Disney Co. plans to open one of the largest on-site child care centers in the United States at its California headquarters by the fall of 1993, but the company still will not be able to help all employees solve their child care needs.

Burbank, Calif.-based Disney is scheduled to build and open a 19,000-square-foot child care center at its Burbank studios and corporate headquarters that will be open to 120 children between the ages of 6 months and 5 years. The center is scheduled to open in November 1993.

But, a problem facing Disney and its 6,000 Burbank-area workers is the fact that Disney workers currently have about six times as many eligible children as the center will be able to accommodate.

Benefit beat

"We're going to conduct a lottery to make sure that every employee has a fair shot. There'll be no preferences made for employees with titles and high salaries," said Carol Davis-Perkins, director of Disney University, a division of the company's human resources department that handles activities and services.

Ms. Davis-Perkins said employees will pay the entire cost of child care on a weekly basis. But, the rate will not exceed "the going rate at the time." Currently, "quality" child care in California ranges from about $100 per week to $150 per week, she said.

Disney now is selecting an architect to design and build the facility, which will consist of a 10,200-square-foot structure and a 9,000-square-foot playground.

Disney's Florida operations already have several on-site child care centers, Ms. Davis-Perkins said. However, they are staffed by outside child care companies; Disney will hire trained child care providers to operate the Burbank center.

"By making the center's operators employees of the Disney company, we think it will discourage turnover," Ms. Davis-Perkins said. "By offering the staff full benefits and salaries rather than hourly wages, we think we'll get the best people out there."

The future child care center's staff size also will exceed the requirement set by California's regulations, Ms. Davis-Perkins said. The facility will have one counselor for every three children between the ages of 6 months and 2 years. There will be one counselor for every five 2-year-olds; one instructor for every seven 3-year-olds; and one instructor for every eight 4- and 5-year-olds.

—By Michael Schachner

Self-insurance

The number of employers considering self-funding their health care plans is still growing, according to a new survey.

Employers also are instituting a variety of managed care arrangements to contain health care costs, according to the survey conducted by Confederation Life Insurance Co. of Atlanta.

For its "Managed Health Care Survey," the insurer last year interviewed 140 corporate benefit managers at companies with more than 250 employees. The insurer also surveyed 100 independent insurance brokers and consultants that represented employers with more than 100 lives and at least one self-insured employer.

The survey found that 47% of benefit managers with insured plans surveyed last year said they are considering self-funding, compared with 43% in 1990.

"While the nation's largest companies have taken the lead in self-insurance, many smaller companies are now self-insuring, too," the survey also reported.

For example, 67% of firms with more than 1,000 employees are self-insured, the survey found. But, 48% of firms with between 501 and 1,000 employees also are self-insured and more than one-third of firms with 250 to 500 employees are self-insured, the survey reported.

Self-insured employers also are turning to several managed care options to contain health care costs.

Of the firms that self-insure, 89% use utilization review, 65% use case management, 61% use health maintenance organizations and 41% use preferred provider organizations, according to the survey.

The survey also found that 88% of benefit managers with self-funded health care plans modified their plan in the last three years to control costs.

The most frequently cited changes included implementing managed care features, 50%; increasing employee contributions, 48%; restricting eligibility for benefits, 41%; and reducing benefits, 28%.

Among other survey finding:

- Fifty-four percent of respondents felt health care quality could be affected by the selection of a provider network. And, 45% of respondents said they had modified their benefit plan within the past three years to improve quality of care.
- Among self-funded employers, 78% use an outside firm to administer their plan. Sixty percent use a third-party administrator, 16% use an insurer and 2% use a combination.

Thirty-one percent of self-funded employers with more than 2,000 workers administer benefits in-house, compared with 27% of self-funded employers with 1,000 to 2,000 workers and 13% of self-funded employers with fewer than 1,000 workers.

- Forty-five percent of the respondents opposed the concept of mandated employer-provided health benefits, while 38% were in favor and 17% were undecided. Of the brokers and consultants surveyed, 56% opposed the concept, 28% favored it and 16% were undecided.

The survey is available free of charge from Alice McHugh, Confederation Life Insurance Co., P.O. Box 105103, Atlanta, Ga., 30348; 404-859-3738.

—By Deborah Shalowitz

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Opinions

Tough road for tort reform

THE CHANCE THAT Congress will approve any type of federal tort reform legislation in a given year is remote, thanks to the stringent opposition of some key Democrats. In an election year, the possibility that Congress will pass tort reforms does not even merit wishful thinking.

However, it is good to see that the Bush administration, amid the pressures presented by a slumping economy and the November election, is willing to underscore its commitment to reforming the civil justice system.

In unveiling the Access to Justice Act of 1992, the administration has put forward a modest plate of tort reform proposals. In fact, some would say the major provisions in the act—applying the "loser pays" rule to federal court cases, the creation of a so-called multidoor courthouse approach that encourages alternative dispute resolution, and requiring a plaintiff to give notice before bringing a lawsuit as a way of promoting settlements—do not go far enough.

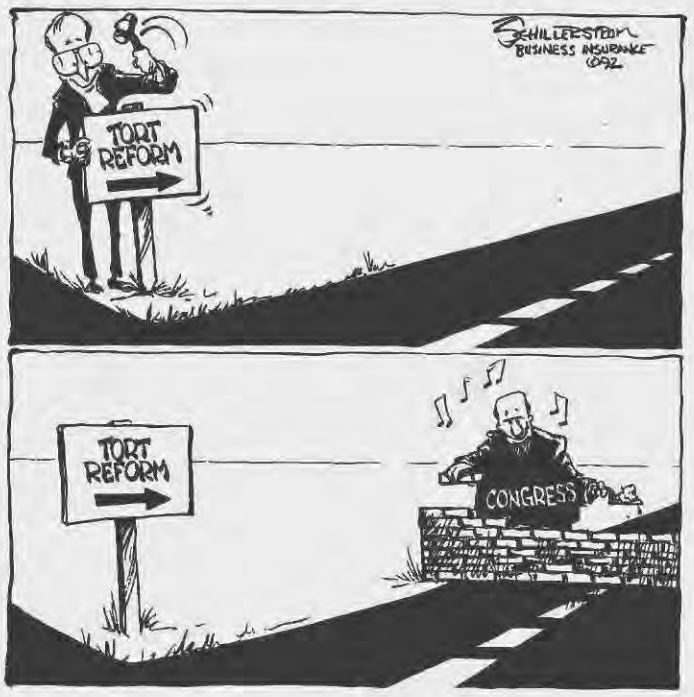
They are probably right; the civil justice system needs much more help than the administration proposal offers. However, if Congress is not willing to buy even this small-scale tort reform package, anything larger is dead on arrival.

While the Access to Justice Act would help solve problems only in the federal courts, the administration has not forgotten that huge problems also exist in the state courts. It has offered another modest proposal, which could be adopted by individual states, that would ban trial testimony based on "junk science" and would streamline the discovery process, an area where abuse of the system runs rampant.

We also are encouraged to see that some innovative ideas to reform the tort system are being tried out on the state level.

For example, in Maine, proponents of an experimental medical practice program hope the program will lower medical malpractice costs and, thus, reduce the overall cost of health care.

Under the program, established as part of a 1990



Maine law, participating doctors will be given an affirmative defense in medical malpractice suits if they agree to follow certain medical practice guidelines designed to eliminate the use of "defensive medicine," whereby a doctor performs every test imaginable on a patient to make sure the patient cannot later allege that the doctor acted negligently.

This program is not without its problems, the greatest of which is that it has not been tested in court. If a judge throws out the affirmative defense, doctors who limit their use of defensive medicine could be exposed to an avalanche of lawsuits.

Yet, the Maine program shows how new approaches to tort reform are possible. We encourage groups in other states, as well as the American Tort Reform Assn., to study and learn from the Maine experiment. Then, with the backing of the Bush administration, they can propose effective tort reforms tailored to problems in their own states.

Letters

Perspective misstated facts of Haslip case

To the editor: A few regrettable errors were contained in my Perspective article, "Judicial Reform on Hold" (*BI,* March 2).

Regarding the noteworthy case of *Pacific Mutual Life Insurance Co. vs. Haslip,* I incorrectly stated that Pacific Mutual issued the health insurance policy in question, canceled the policy and denied Ms. Haslip's claim. In fact, it did none of these things.

To the contrary, Pacific Mutual had declined to write the group coverage for underwriting reasons. A different company, Union Fidelity Life Insurance Co., wrote and then canceled the coverage. An agent who sold life insurance coverage for Pacific Mutual, and who also sold the health insurance coverage in question on behalf of Union Fidelity, then failed to provide replacement coverage. Ms. Haslip became sick, the agent failed to return the premiums, and while Pacific Mutual knew nothing about the Union Fidelity coverage or its cancellation until a lawsuit was filed, it was held to be vicariously liable for the agent.

I regret the misimpression created by the article.

Royal F. Oakes
Barger & Wolen
Los Angeles

CBS should ready Cronkite for prime time

To the editor: How unfortunate that Walter Cronkite's videotaped program on tort reform won't be shown on television (*BI,* Feb. 3). Here is one of the world's most articulate, respected and influential journalists espousing tort reform and the great majority of Americans won't even get to see it because of a contract with his former employer, CBS Inc. What a shame!

CBS should perform a public service and permit its use. Such a program begs for prime time exposure.

Robert L. Wasserman
President/Chief Executive Officer
Southwest Fire & Casualty Insurance Co.
Scottsdale, Ariz.

Seeing health care reform in a new light

To the editor: The best minds in our country—and now every political hopeful—are busy trying to promote a program to provide access to health care and/or health insurance for every American. Time and resources consumed studying this issue are immense.

This is tantamount to being in a darkened room, falling over all the furniture, then sitting down and analyzing darkness as the problem. The only solution is to switch on the light.

Similarly, neither insurance, managed or whatever, nor access to care will solve the crisis. The solution is to define health, attain health and maintain health. Turn on the light!

John J. Iannantuono
Indicon Inc.
Allentown, Pa.

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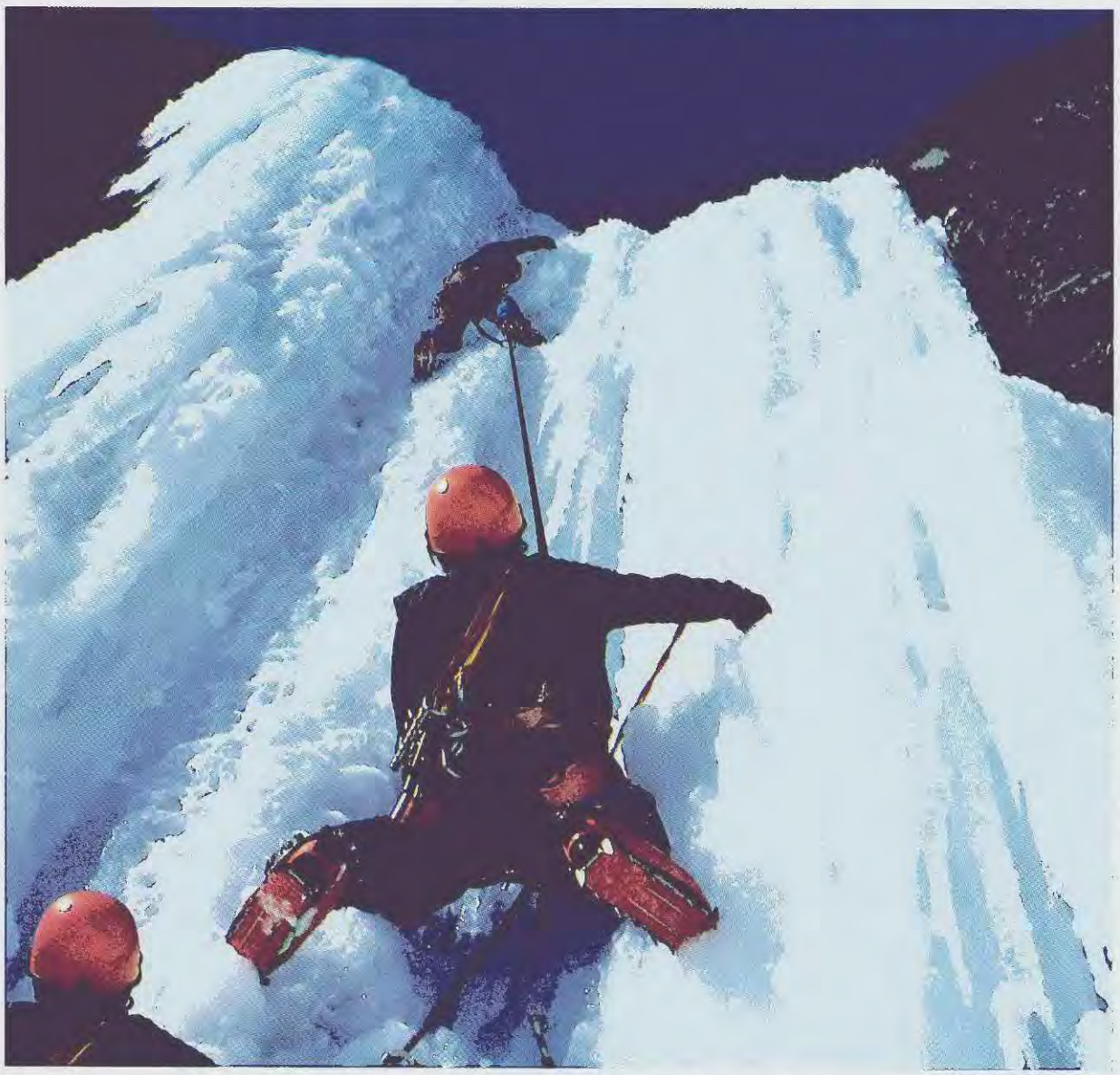

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Cost containment

Continued from page 2

litigated, Mr. Lewis pointed out.

• Use medical fee schedules to limit provider reimbursement.

Twenty-seven states now set maximum reimbursements for various procedures by non-hospital providers, like physicians and rehabilitation therapists, though there is a wide variety of ways in which the schedules work, the WCRI report said.

And, although 36 states have statutory authority to regulate hospital charges, only 22 do so, the report says.

Despite their popularity, fee schedules "don't do much" to cut costs, Mr. Lewis said. Physicians can easily circumvent them by, for example, scheduling more office visits. And setting fees too low may drive good doctors out of the market, he said.

To their proponents, though, fee schedules facilitate claims auditing and provide a benchmark to help determine the appropriateness of fees, he said.

• Adopt managed care programs.

Thirteen states encourage or authorize insurers to contract with selected provider groups at discounted rates, according to the WCRI report.

Despite their popularity, fee schedules 'don't do much' to cut costs, says Mr. Lewis.

Managed care is the "buzzword of the '90s" in workers comp, Mr. Lewis said.

Managed care "seeks to ensure the appropriateness of treatment, the delivery of care in a cost-effective manner, and the prevention of health problems that can be caused by the uncoordinated utilization of medication, radiological services and other medical services," the report says.

Managed care programs vary significantly from state to state, the report noted, but can include: preadmission certification; limitations on provider visits; second surgical opinions; mandated outpatient surgery; independent medical examiners, who settle disputes concerning the course of treatment for an injured worker; and utilization of provider networks, like health maintenance organizations.

Some states recommend general treatment guidelines, while others spell out specific treatment practices.

There is some evidence that some managed care programs help control workers comp medical costs, Mr. Lewis said.

Often, though, barriers stand in the way of effective managed care in a workers comp environment, he said. As an example, Mr. Lewis cited a New Mexico physician who threatened to sue if state officials did not approve his application to become an independent medical examiner.

It also " may be difficult to enforce cost containment strategies, even in jurisdictions with fee schedules, utilization review and other cost containment activities in place," the report said. "In the majority of jurisdictions, the payer ultimately is required to pay for health services despite administrative rules."

Most UR programs in workers comp "have been implemented by large private insurers and exclusive state funds," the report said. "One exception is Michigan's program, which requires payers to conduct a review of some cases and encourages them to use their judgment in instituting other reviews. In this way, the state benefits from private payers' capacity for effective utilization review without imposing a burdensome task."

Meanwhile, two experts said the push to increase access to health care could bring changes to workers compensation programs, which pay 2% of all medical costs nationally.

If access to health coverage is increased but workers comp programs still are responsible for paying medical bills, demand for health care generally would increase and cause workers comp medical costs to rise because of cost shifting and other factors, said Peter Barth, an economics professor at the University of Connecticut in Storrs.

However, it is also possible that the medical care component of state workers comp programs would be "swept up" into a universal health insurance program, said Dr. Alfred Taricco, executive vp and medical director of Medical Claims Review Services Inc. in Bethesda, Md.

•

Medical Cost Containment in Workers' Compensation: A National Inventory 1991-92 (WC-92-1) is available through the WCRI. Members can obtain one copy free. Non-members and members seeking additional copies should send a check for $95 per copy, plus 5% sales tax in Massachusetts, to WCRI at 245 First St., Suite 1402 in Cambridge, Mass. 02142.

WCRI draws nearly 300 to annual conference

CAMBRIDGE, Mass.—Nearly 300 people attended the Workers Compensation Research Institute's eighth annual issues and research conference held March 5-6.

WCRI

The WCRI is a non-profit research organization that seeks to provide objective information about public policy issues involving workers compensation.

Some of the largest insurers and employers in the United States together established the WCRI in 1983 and continue to fund the institute.

Last year, 197 organizations supported the institute as members or associate members. They include insurers and reinsurers, insured and self-insured employers, professional associations, labor associations and workers compensation administrators.

For additional information, contact Richard A. Victor, Executive Director, Workers Compensation Research Institute, 245 First St., Cambridge, Mass. 02142; 617-494-1240.

ADA's effect on work comp largely unknown

By MEG FLETCHER

CAMBRIDGE, Mass.—There still are more questions than answers about how the Americans with Disabilities Act will affect state workers compensation systems and the employers that fund them.

WCRI

The intent of the 1990 law is clear: to prevent discrimination against disabled job applicants or employees who are disabled by work-related injuries.

But many of its key concepts and phrases are not precisely defined. And the degree of effort and expense that will be required of an employer to help a qualified disabled person perform a job will vary from case to case.

In addition, some return-to-work provisions in the law appear to conflict with existing federal labor law.

Questions about the disabilities law probably will be answered only gradually, through administrative and court rulings on individual complaints, explained participants at a Workers Compensation Research Institute conference earlier this month in Cambridge, Mass.

Case law developed under the federal Rehabilitation Act of 1973 may provide some guidance in this area, attorneys say.

Over time, the ADA has the potential to both increase and decrease an employer's workers compensation payouts and related costs.

The employment-related aspects of the ADA went into effect Jan. 26 for all state and local governments (*BI*, Jan. 27). Non-governmental employers, unions and employment agencies with 25 or more employees will not be subject to the ADA's employment-related provisions until July 26. Non-governmental employers with 15 to 24 employees have until July 26, 1994, to comply.

The act figures to have a profound effect on workers compensation. Essentially every employee suffering a work-related injury that causes permanent impairment and results in work restrictions will be protected by the ADA, said Lawrence P. Postol, an attorney with Seyfarth, Shaw, Fairweather & Geraldson in Washington, D.C.

Employers could, though, exclude some workers from returning to work for medical reasons. The exclusion must be based on a medical test or criteria that is job-related and defensible as a business necessity, he said.

As a practical matter, exclusion would be limited to employees with medical conditions that prevent them from safely performing the essential functions of a job even with reasonable accommodation, he said.

"Reasonable accommodation" means modifying or adjusting a job or workplace to enable a disabled person to perform the essential functions of the job. It may include restructuring a job, adopting flexible work schedules and modifying equipment, as well as providing qualified readers or interpreters.

Under the ADA, employers would not be required to make an accommodation that constitutes an "undue hardship," or is unduly expensive or disruptive.

In addition, an employer can exclude an employee from returning to a job for safety reasons if allowing the employee to return would present a "significant risk of substantial harm."

Most likely, that standard means there needs to be a "high probability" of harm, Mr. Postol said. That finding must relate to the employee's medical condition now, rather than in the future, and must be documented by medical personnel using "the best available objective evidence," he said.

Congress set that standard high to prevent employers from using safety concerns to discriminate against disabled people, as they have often done, said Chris Bell, acting associate counsel with the Equal Employment Opportunity Commission in Washington, D.C. Mr. Bell's impaired vision required him to use a white cane to reach the podium.

The law requires that a disabled employee be returned to his job or, if that is not possible with reasonable accommodation, be assigned to another job for which he or she is qualified. However, the law does not require employers to create new positions or replace able-bodied workers with recently disabled workers.

Mr. Postol recommends that employers prepare for the ADA by establishing a good procedure for evaluating the health of recuperating employees and deciding whether they are capable of returning to work.

Typically, the employee's treating doctor sends in work restrictions such as "no bending or no excessive stair climbing."

A foreman should then circle on the employee's job description sheet the essential job duties the worker cannot perform and send that sheet back to the doctor for confirmation, he said.

It may also be necessary for the foreman to advise the doctor of the ADA's "significant risk" standard, he said.

The aim is to clarify the doctor's order, Mr. Postol said. Take the "no bending" order, for example. Does it mean the employee should not bend at all, should not bend his or her back, can bend only once a day, or can bend to lift something that weighs less the five pounds?

In addition, the employer should make sure that the doctor can defend his position in court, if necessary.

Once the medical restrictions are clearly stated, medical personnel and an employee's front-line supervisors should evaluate reasonable accommodation options, Mr. Postol said. Reasonable accommodations to a limitation like "no lifting" can mean having the worker use back supports or reassigning lifting chores to other employees.

Each employer should have a formal process to analyze reasonable accommodation requests, though many currently do not, Mr. Postol said.

Reasonable accommodations

Continued on next page

ADA's effect

Continued from previous page

can include making existing facilities accessible to disabled people, acquiring or modifying equipment, providing qualified readers or interpreters, part-time or modified work schedules, restructuring jobs, or reassigning people to vacant positions.

The landmark legislation may both increase and decrease workers comp costs, speakers at the WCRI conference said.

The ADA may increase costs by forcing the hiring and rehiring of workers who, for a variety of reasons, may be predisposed to work-related or non-work-related injuries or illnesses.

It may also increase costs due to an onslaught of discrimination complaints by disabled applicants and workers over hiring decisions and workplace accommodations.

For lawyers, the stakes could be substantial. The ADA allows plaintiffs to seek up to a total of $300,000 in punitive and compensatory damages, plus wage compensation. Attorneys' fees may also be awarded.

In addition, three bills now on a "fast track" in Congress—H.R. 3975, S.B. 2053 and S.B. 2062—would eliminate any damage cap in ADA litigation, said Peter Gray, an attorney with Epstein, Becker & Green in Washington, D.C.

Lump-sum ADA settlements could prompt 'miraculous recovery,' says Mr. Postol.

But it may not be easy for employees to recover large amounts. In fact, the burden of proof under the ADA makes it "very difficult" to recover large judgments, said James Ellenberger, assistant director of the AFL-CIO's Department of Occupational Safety and Health in Washington, D.C.

Seyfarth, Shaw's Mr. Postol cautioned employers against making lump-sum settlements to settle ADA-related litigation. Such settlements with injured workers could prompt "miraculous recovery," a request for re-employment and additional potential ADA claims if re-employment is not granted.

And lawyers say it is unclear to what extent a lump-sum settlement could require an employee to waive his right to file an ADA claim or to seek re-employment.

Potentially, the ADA could also lower workers compensation costs by encouraging employers to find jobs that employees injured on the job could perform.

The thousands of U.S. workers who suffer permanently disabling injuries or illnesses daily need the protections of the act, Mr. Ellenberger emphasized.

The Workers Compensation Research Institute is researching other "friction points" involving the ADA and workers comp, said panel moderator Stacy M. Eccleston, a WCRI research associate.

These include: ADA lawsuits that challenge the exclusive remedy doctrine in state workers compensation laws, the role of second-injury funds, employers' return-to-work obligations and the ADA's impact on insurer-employer relationships. ■

Demand for comp data increases WCRI's workload

CAMBRIDGE, Mass.—The Workers Compensation Research Institute's reputation is growing—and so is its workload.

WCRI

"As the institute's reputation for objective research has grown, more policymakers are looking to the institute as a source of information to help them make sound, informed decisions about legislation and administrative reforms," the WCRI said in a statement.

Last year, officials from 16 states invited the institute to conduct research or to apply the lessons of its research, according to the WCRI. In addition, the Cambridge, Mass.-based organization has made presentations or given testimony in 30 states.

The demand for information shows that legislators are looking beyond political interests to better understand problems and the consequences of proposed solutions, the WCRI says. That often means that its studies influence the legislative process.

For example, state legislators in Connecticut recently learned of WCRI research showing that 21% of workers in the state receive more in workers comp benefits than they earned before they were injured net of taxes, the group said. "A legislative committee asked the WCRI to analyze several options that would mitigate this problem."

Ultimately, the state limited benefits to 80% of workers' aftertax earnings loss.

Massachusetts also cut benefits based at least in part on WCRI research. And, as WCRI Executive Director Richard A. Victor points out, California and Texas have increased benefits based on its research.

In the early 1980s, he said, discussion of key policy issues related to workers compensation was about 10% "light"—in the form of fact-based information—and 90% "heat." Now such discussions generally are about 20% light and 80% heat, or about halfway to his goal of 40% light and 60% heat, he quipped.

The latest WCRI annual issues and research conference featured labor-management initiatives that have reduced workers compensation problems. One initiative, Project Help, is now a joint project of the Washington State Department of Labor and Industries and the state's Labor Council. Project Help explains the state workers comp system to workers and answers claims-related questions.

In addition, General Motors Corp. and the United Auto Workers have a long history of cooperating to reduce injuries and illnesses through the UAW/GM Center for Health and Safety in Auburn Hills, Mich.

—By Meg Fletcher

Health care reform

Continued from page 3

system. The paradox is that some people can use the health care system wastefully while others have no access to health care.

This situation has arisen due to an overabundance of equipment, staff and physicians in most U.S. hospitals; high administration costs; and, to a lesser extent, higher physician incomes than in the rest of the world, Dr. Kronick said.

"We've got no method of controlling the expenditures that go into the system," he maintained, adding that "other countries use regulatory models" to control health care costs.

Methods of treatment vary dramatically across the United States, having "little to do with the morbidity of the population or the sickness of the population, and more to do with the number of providers in the area," he pointed out.

Furthermore, borrowing a term from basic economics, "price elasticity" is woefully lacking in the current U.S. system, Dr. Kronick argues. Because health care consumers are insensitive to price, providers have no need to compete on price, he said.

While some individual companies and employer coalitions are working to introduce more cost consciousness into the health care system, their efforts have not created true "managed competition," he noted. To illustrate that fact, Dr. Kronick points out that of the employees who receive health benefits, fewer than half have a choice of health plans. Of those that have a choice, fewer than 40% "are fully cost-conscious," he said.

Dr. Kronick's proposal is therefore intended to first create cost-conscious consumers and introduce price elasticity into the system. Under his plan, each employee would receive an employer-based fixed subsidy that he or she could spend to join an employer-approved managed care network. This subsidy would be tied to the cost of providing at least a minimum level of services. Individuals could purchase a higher level of benefits using their own funds.

The unemployed, self-employed and uninsured part-time employees would receive a similar subsidy that would be funded through an additional taxation of self-employed and part-time workers' earnings and on any employer contributions that exceed the standard subsidy, Dr. Kronick said.

However, enabling individuals to shop for their own health care among several network options isn't enough to truly make a dent in health care costs, Dr. Kronick said. To make managed competition a reality, employers must manage the competition among those networks.

Employers—which Dr. Kronick labels "sponsors"—would be assigned the task of ensuring that networks are rewarded for providing high-quality and economical care, while making sure that the networks do not accept only healthy people.

One key task of the sponsors would be to provide information to consumers so that they can make informed choices and to monitor why consumers withdraw from a particular network, he said.

Sponsors also should refuse to contract with networks that consist largely of the same doctors and hospitals that also are members of other networks.

By taking these steps, sponsors would ensure that the marketplace is competitive and that inadequate networks either improve or go out of business, Dr. Kronick said.

For instance, if a sponsor learns that a consumer changed networks because he or she felt that the cost of care did not reflect the quality or amount of services provided, the sponsor need not do anything, Dr. Kronick said. As in any competitive industry, this network will either have to lower prices, enhance services or go out of business.

However, if an employee informs the sponsor that he or she changed networks because the quality of care received was shoddy, the sponsor should take steps to ensure that the quality is improved or that inferior providers are removed from the network.

Dr. Kronick's says a managed competition approach would:

- Match the supply of health care resources to the needs of the population.
- Gain the loyalty and commitment of providers and improve the payer-provider relationship.
- Provide information to providers regarding their practice patterns and outcomes, thus helping them improve the quality of their services.
- Devote more resources to primary care.

Many of Dr. Kronick's proposals and goals are similar to what large employers and employer health care coalitions now are seeking. But, he maintains, real change can only be achieved if enough force is brought to bear on the marketplace.

Because smaller employers would not have the same clout in a managed-competition system as larger employers, Dr. Kronick suggests the formation of health insurance purchasing corporations that would contract with networks on behalf of employees of small- and medium-size business. These corporations would have to be regulated in some as-yet-undetermined fashion, he noted.

Dr. Kronick stressed that the aim of managed competition isn't to force individuals to change providers, but to force "providers to change their behavior."

However, managed competition may not work in a rural setting where their are few, if any, choices among health care providers. People living in rural areas could be covered by a single-payer health care plan, like Canada's, Dr. Kronick said.

Dr. Young of the Chicago health policy group endorses a modified version of the Canadian health care system.

Like Dr. Kronick, Dr. Young sees a need for dramatic change. He cited the myriad of "redundant" resources that exists in the U.S. health care system and noted that "social Darwinism" is now being practiced as providers serving the poor are forced out of business.

He also pointed out that the health care crisis no longer just affects Americans' health. "Our economy has been destabilized by this elephant in the budget" and, as a result, "our government has been destabilized," he said.

Employers would be "better off with a single-payer system," Dr. Young said.

"We have a sickness system, a squeaky wheel system, a wallet

Continued on next page

Health care reform

Continued from previous page

biopsy system, and it's not working," Dr. Young said. But, he adds, by adopting a system modeled on Canada's, "we can have a system that invigorates health and serves as the portal" to an improved society.

Dr. Young said legislation, H.R. 1300, proposed by Rep. Marty Russo, D-Ill., would provide "for most of" the elements now found in the Canadian health care system (*BI,* March 18, 1991).

Dr. Young describes Canada's system as providing universal and portable coverage for a large group of services, funded through a public single-payer plan and allowing for "rational" growth.

Doctors' fees are negotiated by a medical society based in each province. As a result of the cost controls, "a level playing field (exists) where all the attention is focused on the patient. There's no wallet biopsy" performed to determine what the patient can afford, he said.

By solving the cost control problem "in one swoop," a single-payer system eliminates "micro-management" of health care costs while it automatically creates quality assurance and cost consciousness on the part of providers, he said.

For instance, because doctors' fees are paid by a single payer based on the services provided, excessive utilization on the part of individual doctors "sticks out like Mount Everest," Dr. Young said.

Doctors, he said, are penalized for high utilization if there is no legitimate reason for it. Meanwhile, they are still well-compensated.

Canadian hospitals are reimbursed for both ongoing business operations and approved capital improvements, a system that ensures that the hospitals "go slow on high-tech expansion," Dr. Young said, adding that such a policy is "a virtue, not a vice."

Dr. Young maintains that the Canadian system provides both quality care and satisfaction among providers. As evidence of the latter, he noted instances in which Canadian doctors emigrated to the United States only to return after deciding that the headaches of the U.S. system outweighed the monetary rewards.

When the session's attendees asked Dr. Young to comment on the well-publicized long waits for some types of treatment in Canada, he responded that these problems often are taken out of context by the system's detractors.

'What you need to do is take a stand' and be heard, Ms. Bradbury tells employers.

Often, the waits apply for only non-essential services; emergency cases are moved to the front of the line, he said. In addition, waiting lines often only exist for certain providers; other qualified doctors are available to perform the services, he noted.

However, there cannot be any type of meaningful reform until the business community uniformly voices its preferences, said Claudia Bradbury, a policy associate in the AFL-CIO's employee benefits department in Washington, D.C. "What you need to do is take a stand" and be heard, Ms. Bradbury said.

While employers' attempts to use managed care to control costs without actually reducing benefits is a good idea, she noted that managed care has only resulted in short-term results.

Part of the problem with the present health care system is that employees are not provided with adequate information about the system. Employees need information so that they "can consume wisely. Telling them what to do does not make them wise."

Dr. Kronick, Dr. Young and Ms. Bradbury shared their views in three different sessions, all of which were moderated by Henry Webber, assistant vp of human resources at the University of Chicago. ■

Over 200 at MBGH conference

ROSEMONT, Ill.—More than 200 employee benefit managers, human resource executives and others attended the Midwest Business Group on Health's 12th annual conference, "National Health Care System Reform at the Company, Local and State Level."

The conference was held March 5-6 in Rosemont, Ill.

The panel discussions focused on health care system reform and featured speakers from the medical and academic professions, as well as employers and politicians. Workshop topics included employer-directed clinics, public policy community projects, health services data and managed care networks.

This fall, the MBGH will sponsor its National Conference on Health Care Management, "Improve Quality to Reduce Costs." The conference will be held Sept. 29-30, also in Rosemont.

The MBGH is a coalition of 140 employers in 11 states. The group has six chapters throughout the Midwest.

For more information about the group, contact Chuck Ripp, Director of Education, MBGH, 8303 W. Higgins Road, Suite 200, Chicago, Ill. 60631; 312-380-9090.

Groups wield clout to cut health costs

By LORI BLOCK

ROSEMONT, Ill.—Employers aiming to control health care costs while maintaining quality medical care for their employees may be well-advised to remember the adage that "there's strength in numbers."

MBGH

Two groups of employers in the Midwest have learned that lesson by forming separate coalitions designed to purchase health care for members' employees.

The Chicago chapter of the Midwest Business Group on Health "decided there had to be a cost-effective, high-quality way to identify preferred providers" for area employers, explained Wendy Lynn, director of compensation and benefits for Acme Steel Co. in Riverdale, Ill.

The Chicago group in 1989 formed EPIQUAL—the Employers' Purchasing Initiative for Quality—to establish a network of providers for its members. In 1989, EPIQUAL members realized hospital inpatient savings of 32.9% and outpatient savings of 22.4% compared with what those costs would have been had their members purchased health care outside of the network.

At Acme Steel, which covers 100% of its employees' health care costs under its self-insured plan, this resulted in its 1989 health care costs rising just 3% over 1988 costs. And, its health care costs held steady in 1990 compared with 1989 costs.

In 1991, EPIQUAL members' inpatient savings grew to 35.6% compared with out-of-network costs, while outpatient savings slipped from 1990 levels but were still a significant 19.5%, said Ms. Lynn, former chairwoman of EPIQUAL.

The Greater Milwaukee Business Group on Health has had its preferred provider network in place since 1987, and has saved $37.3 million in hospital costs from 1987 to 1991, according to James R. Wrocklage, chief executive officer of the Health Care Network of Greater Milwaukee.

Ms. Lynn and Mr. Wrocklage described their groups' efforts during a workshop at the Midwest Business Group on Health's 12th annual conference, held March 5-6 in Rosemont, Ill.

The Chicago effort began when a group of employers realized that "there's more synergy in a group, that individuals are more potent as a group," and that the group could exert some influence over health care costs once it reached a consensus on what it expected from health care providers, according to Ms. Lynn.

EPIQUAL, which consists of only self-insured employers, established several requirements for itself and its health care provider network. EPIQUAL stipulated that it would:

- Have its own identity, separate from the program's claims administrator, CCN Inc. of San Diego, a health care management company that specializes in working with business coalitions.
- Identify quality vendors and physicians and contract with them.
- Establish a per diem hospital rate as well as outpatient rates. The cost of outpatient care could not exceed the hospital per diem rate for one day of inpatient care.
- Recruit more employers to participate.
- Give CCN a percentage of the savings that EPIQUAL members realize up to a predetermined cap.

There are currently more than 2,000 physicians and 36 hospitals in the network, providing services to more than 30,000 employees and dependents of EPIQUAL member companies.

While the program was initially designed to "give us relief" from rising costs, the emphasis later shifted and a quality improvement council was formed, Ms. Lynn explained.

One of the first projects of the quality improvement council was to focus on particular procedures.

For instance, EPIQUAL facilitated the development of a "critical pathway" of appropriate treatments for a patient who is scheduled for coronary bypass surgery. This pathway "identifies where you would normally expect a patient to be at different checkpoints," Ms. Lynn explained.

The purpose is to make sure patients receive care on schedule, so that they can be released as quickly as possible.

With the use of the critical pathway treatment model, "hopefully there will be fewer avoidable problems," Ms. Lynn said.

EPIQUAL member companies can continue to work with their existing claims administrators and utilization review vendors, she said.

However, Ms. Lynn said that "if you identify the truly high quality physicians and providers, utilization review should fall away."

EPIQUAL also is conducting a patient satisfaction survey "to see how well hospitals in the net-

Continued on next page

Networks

Continued from previous page

work are meeting the expectations of the employees who go into those hospitals." Ms Lynn said

Patients are asked qualitative questions regarding, among other things, the admission procedure; billing and insurance issues; nurse and physician services; privacy; and how well physicians counseled patients being discharged about their medication and activities.

Patients also are asked how they selected the hospital to which they were admitted and other questions that can help employers determine whether network providers are delivering quality care.

The Milwaukee coalition's efforts are similar to EPIQUAL's in some ways, including the fact that both groups use CCN to administer their programs, Mr. Wrocklage said.

However, he noted that the Greater Milwaukee Business Group on Health has placed more emphasis on controlling costs.

The group initially made two assumptions: Providers' current cost structure is inefficient, and providers would reduce their costs per unit only "if you could move market share" over to a group of providers, Mr. Wrocklage explained.

Both self-funded companies and employers insured by selected underwriters can participate in the Milwaukee program. The group currently consists of 92 self-funded employers, which each have an average of 300 employees

Participating employers, which can include local divisions of national companies, must have their own utilization review and case management services and must provide their own incentives or disincentives to entice employees to use the group's preferred providers.

Eight insurers representing 666 small employers also belong to the group. The small employers represented each have 30 employees on average.

In all, roughly 200,000 individuals are enrolled in the network, which is roughly 15% of the Milwaukee-area market.

The network included insurers of small firms, because "when we started out as a coalition of self-funded employers," all the group was doing was shifting costs to smaller employers that bought insured health care plans, Mr Wrocklage explained.

The Milwaukee group has placed more emphasis on controlling costs, Mr. Wrocklage says.

The group decided that the best way to bring small employers in to the network was to see whether insurers would use the network.

Mr. Wrocklage said the group tried to include enough insurers so that the underwriters would have to pass along to policyholders any savings generated by the network. If the group had included only one or two insurers, there would be no competitive pressure for those companies to pass along their savings.

Still, he said, "if we have a disappointment," it is the amount of time the group has spent persuading small insured companies and mid-sized self-funded employers to offer the network to their employees.

Mr. Wrocklage acknowledges that the the program has its disadvantages.

For instance, insurers contend that the program introduces unnecessary and duplicative administrative costs, he said.

And, providers contend that the coalition emphasizes price too much, that discounts come at the expense of quality and that the discounts providers are giving are not proportional to the increased business volume the coalition creates.

The MWBGH workshop was moderated by Gil Acosta, the personnel manager for M&M/Mars in Chicago, a division of Mars Inc. ■

Firms must take lead in health reform: Rep. Johnson

By LORI BLOCK

ROSEMONT, Ill.—If employers are waiting for Congress and the White House to resolve the health care crisis, they may have a long wait, says one member of Congress.

MBGH

"It isn't possible for Washington to be on the leading edge of anything," Rep. Nancy Johnson, R-Conn., said at the Midwest Business Group on Health's 12th annual conference held earlier this month.

Instead, "it's important, as we go forward, that the private sector realize the incredible role it has in leading change," she told the group, which consisted largely of employee benefit managers.

The federal government "cannot lead, (but) we can make a difference," said Rep. Johnson, a member of the House Ways and Means Committee.

She added that employers' "best hope" is that the government "follows your direction and does not screw up your actions."

In discussing the various approaches to health care reform, Rep. Johnson made the following points:

- The government has never been able to fully fund any social need, "so don't talk to me about national health care."
- No reform can ignore the fact that the health care industry now plays a significant role in the U.S. economy.
- Reforms should deal with the problem of access, both addressing the needs of those who currently don't have access to health care and those who fear losing that access.

The access problem can be solved in a multitude of ways, Rep. Johnson noted, including restructuring the small group market, overriding state benefit requirements and restructuring the entire health insurance market.

Of the latter option, the federal government can play a key role, since "it restructures markets all the time," she said. "That's a legitimate role for government."

- Any reform must address social problems like crime, sexual abuse and substance abuse, since they are critical factors in the current health care crisis.
- Cost containment must be part of any reform, since addressing access "in a vacuum" will cause health care costs to skyrocket, she said.

Critical to any savings, she added, is medical malpractice reform.

Rep. Johnson applauded businesses' attempts to control costs using managed care techniques and predicted that the explosion of medical information will help consumers and providers reach better decisions and eliminate inappropriate and unnecessary treatment.

Rep. Johnson said she finds it "exciting" to see companies applying techniques previously used to improve manufacturing production quality to the health care industry, where they enhance the quality and efficiency of the health care delivery system.

"You don't need us," she told the employers. "Get started now. Your approach is valid. You can't afford to wait for us to lead. This is too good an idea." ■

InsurerTopics

A special editorial section
sent exclusively
to insurers and reinsurers

Is it showdown time at the OK corral? Agents' beefs add to soft market woes

40% of surveyed agents dissatisfied

By LAURA MAZZUCA

At a time when insurers are being bombarded with legislative pressures, market upheavals and a lingering soft market, the last thing they need is problems with their distribution system.

Yet in many cases, that is just what they're getting. In a recent survey conducted by *Business Insurance*, agents and brokers complained of strained relationships with the insurers they represent, citing market pullouts, commission reductions and poor underwriting service as some of the reasons for their unhappiness.

In a survey sent to a random sampling of *BI*'s agent and broker readers, 40% of the 52 agents who responded were completely dissatisfied with the relationship. Only 25% say they are satisfied with how insurers treat them, down sharply from the 58% who reported satisfaction in a similar survey last year. Thirty-five percent were both happy and unhappy, depending on the insurer.

Of those surveyed, 38% believe their relations with insurers have worsened during the soft market, nearly three times more than the 14% who said relations have improved.

Twenty-seven percent said there had been little or no change, while 21% were ambivalent about the course of their relations with insurers.

Loyalty and trust between insurers and agents and brokers have given way, agents' responses indicate, leaving only civility between the two sides.

Agent-insurer relationships "are not as friendly," said the president of an agency in Fargo, N.D. "Long-term relationships do not warrant the accommodations as they used to; but it would be worse trying to develop new (relationships)."

"Companies can no longer be relied upon. The only thing that matters is $ $ $," wrote the president of a California agency with $25 million in annual premium volume.

Other agents observed that while relationships may seem civil on the surface, trouble is brewing beneath that calm facade.

"Relations have remained cordial, but insurer service is declining due to staff cuts and inadequate training and selection of employees," observed the vp of a North Carolina agency with $100 million in annual premium volume.

"We tolerate each other," wrote William H. Eastman, president of Brokers General Corp. in White Plains, N.Y. "We have been in this (business) for 30 years, and it has been downhill for most of that time. Where have all the people gone?"

Insurers for their part recognize some problems in their relations with agents, but they also argue that the realities of today's insurance market make it impossible to return to the way business was conducted in the past.

RELATIONS AGENCY

"Both sides would like things to be better," said Rodger S. Lawson, president of the Alliance of American Insurers in Schaumburg, Ill. "There's no malice here, but basic economic realities. The companies just can't afford to do business as they did in the past."

"Agents have to understand that companies are there to make a profit," said Wallace Gardiner, national sales manager for Chubb Corp. in Warren, N.J. "We expect a lot more from our agents. Agencies that continue to exist (in the soft market) will be the very best."

And while recognizing that problems exist, creative insurers are working with their agent forces to address them.

"Both the company and our agents are somewhat frustrated over market conditions," said Charles F. Dudek, director of marketing for Zurich-American Insurance Group in Schaumburg, Ill. "But we're working together to retain accounts and develop new business."

Even though they know that all is not well in their relations with independent producers, insurers are not taking all the blame. Insurers point to direct writers eroding their markets, continuing pressure on insurers to reduce expenses and a more critical consumer.

These realities mean that insurers are stuck with cost cutting, "and agents are going to have to be a part of that," said Mr. Lawson of the Alliance. "They must work closely with companies to attack loss costs that are driving the system."

There is too much emphasis today on short-term results, complains Mr. Lawson, who is active on the Independent Insurance Agents of America's "Future One" panel, which brings together representatives from agencies and insurers.

"If the industry continues to have such a short-term focus, we won't be able to make the changes necessary for long-term success," he said.

For example, agents who place business like workers compensation in residual markets are hurting insurance companies—and ultimately themselves—by perpetuating high costs, Mr. Lawson said.

Insurers point to other ways in which producers hurt the insurer-agent relationship. Some agents overemphasize price, have no business plan for their agency, submit incomplete application data or simply have no selling ability, said Gregory Georgieff, senior vp and managing director at Chubb.

The insurer-agent relationship is "a marriage, not a one-night stand," he added. "You have to

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Agent relations

Continued from previous page

weather a lot of tough times together."

Because they technically represent the policyholder, agents must demonstrate to their customers that they bring a value to the insurance transaction that a direct writer can't offer, he said.

"This is not a complex business," said Mr. Georgieff. "Regarding the customer, the issue is simple: You must listen and solve problems."

Chubb prides itself on maintaining close relations with its 3,800 agents throughout the United States, he said. Because the insurer has no preferred agency program, it is very selective in choosing agency appointments, seeking out producers who focus on markets Chubb also has targeted, like energy, financial institutions, and executive protection, he added.

In spite of an ever-shrinking agency universe, Chubb's agency plant has grown steadily over the last several years. And Chubb agents have staying power: The average tenure of a Chubb agent is almost 25 years, Mr. Georgieff said.

Zurich-American recognized the need for increased input from its agents five years ago, when it introduced its "market driven" approach to getting new business, said Mr. Dudek. Zurich works with 1,500 agents in its 28 field offices nationwide to spot needs and develop specialty business indigenous to the producer's area, like cheese processing plants in Milwaukee and hotel-motel risks in Florida, according to Mr. Dudek.

An ugly situation

Despite efforts like these, it's been a rough year for insurer-agent relations.

The past year saw many insurers pulling out of regions and lines of business (see story, page 16E). Add to that the pressures of expense control in a recession, insurance industry battles with lawmakers and the ongoing soft market, and you've got one ugly situation.

"Relations have deteriorated significantly when measured by our ability to place accounts and insurers' attitudes regarding renewals," wrote a vp with a Louisiana agency. "This is particularly galling because our accounts have been almost uniformly highly profitable," he noted.

"Major national carriers are creating havoc," lamented the treasurer of a $17 million premium volume agency in Massachusetts. "They don't seem to know who or what they want to be, and have a very 'take it or leave it' attitude."

A vp at a Vermont agency with $10 million in annual premium volume succinctly summed up his complaints with insurers: "Failure to provide competitive products. Policy service that borders on the incompetent. Atrocious commercial direct bill."

And agents squarely place the blame for deteriorating relations at the feet of insurers.

"The changes are not due to the market, but (to) the leaders of the companies," wrote a vp of a Michigan agency with $26 million in annual premium volume. "They are moving away from the agency system and using the soft market as an excuse."

"They demand more. Their marketing directions seem to be changing monthly, like they are not sure where they should be headed," wrote M.L. Minor, president of First Insurance Agency Inc. of Washington in Mount Vernon, Wash.

"They do not listen. Ninety-nine-point-nine percent of insurance company personnel have never worked for an agency or broker. I do not believe that management of insurance companies is as empathetic as it was in the '70s and early '80s," complained an executive at a North Carolina agency with $42 million in annual commercial premium volume.

"Relationships are erratic; sometimes markets seem like the proverbial 'pea on a hot griddle,' " wrote James S. Hebb III, senior vp of Jardine Group Services Corp., a unit of Jardine Insurance Brokers Inc. in Washington, D.C.

In itemizing their complaints, agents told *Business Insurance* they are particularly displeased with the quality of underwriting many insurers offer. Nearly a third of the 52 agents and brokers responding cited underwriting problems as a major concern in agency-insurer relations.

"The most important reason for dissatisfaction is the near virtual total void in authority of most underwriters; everything is a 'management' decision," wrote the president of an Illinois agency with $5 million in annual premium volume. "And there is a near total lack of an ethic in honoring commitments made by underwriters. Everyone wants to weasel out of a deal if they can."

Inexperience was a recurrent complaint about underwriters.

The president of a Virginia agency with annual premium volume of $14.3 million blamed poor insurer-agency relationships on rapid turnover among underwriters and a shortage of trained personnel.

Another problem cited by agents: Most underwriters don't understand how agencies work.

"Most agents have company experience. Most underwriters have no agency experience. The companies need to put more trust in their agents," commented a major accounts unit manager of a North Carolina agency with $42 million in annual premium volume.

Unskilled underwriters are shortsighted when it comes to discerning good agent performance in regions where business is mostly bad, several agents complained.

"In commercial lines, our accounts have been highly profitable to our underwriters, but they can't seem to differentiate between us and others. Consequently, we are being painted with the same brush," wrote a vp of an agency in Louisiana, a state which has been plagued with insurer withdrawals, regulatory scandals and high personal lines losses.

"I know there are agents out there who take advantage of companies, but if I was an underwriter I would give an agency that has not lied to me the benefit of the doubt until they do," wrote the president of an agency in Fargo, N.D.

'Companies are losing the ability to underwrite lines of business," wrote the president of a Connecticut agency with $3 million in annual premium volume. "If a line is not profitable, they look to offset

Continued on page 16D

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Insurer Topics

Agent relations

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it with a profitable line rather than improve the loss ratio of the bad line."

Defending their record

But insurers defend their underwriting record.

Agents and brokers who complain about unskilled underwriters may just be upset that their business has declined, said Mr. Lawson of the Alliance. "Toughness can be construed as a lack of skill."

Novice underwriters at most insurance companies go through a training program both at the home office and in the field.

Typically lasting six months to a year, these programs introduce the basics of the business as well as human relations, a combination of "ethics and pure underwriting technical skills," said Mr. Gardiner of Chubb Corp.

Chubb follows this core curriculum with its Chubb Business School, where course work focuses on agency relationships, communications and planning with agents.

The result, according to Mr. Gardiner, is a crack underwriting team whose skill in accepting business means the insurer has not had to withdraw from any regions.

Such training is essential because inexperienced underwriters tend to "go by the guidebook" and reject submitted business rather than judge an individual risk on its face value, Chubb's Mr. Georgieff said. "You never get in trouble by saying 'no,' but you also have to find ways to help the agent and broker bring in new business," he said.

Zurich takes a different approach to improving underwriting quality by rewarding experienced underwriters, which encourages them to stay put, Mr. Dudek said. Most insurance company managers come up through the ranks of underwriters, he noted, which can leave holes in the underwriting force. However, the average tenure of a field underwriter at Zurich is 12 years—"on the high end of industry standards"—because Zurich "adequately compensates" underwriters, Mr. Dudek said.

Such efforts on the part of insurers are more likely to improve relations than is the constant complaining from agents, insurers say.

Mr. Gardiner of Chubb, who acts as the insurer's liaison for agent trade groups, said he's sick of the "company-bashing" he hears at some agent meetings.

Too many agents expect insurers to guide them by the hand, he said. Instead, agents should take the initiative.

Mr. Gardiner pointed out that Chubb offers its agents courses in underwriting, but cannot get enough enrollment for such tuitioned courses because agents expect them to be free. "We're here to help them, but we can't do it *for* them," he added.

Instead of bad-mouthing insurers, agents should get together with companies to address public policy issues, like no-fault auto insurance and the high cost of medical care, said Mr. Lawson of the Alliance.

Despite the problems, insurers insist their loyalties lie with the independent agency system.

"The great value of the independent agent is the service he brings to the customer," said Mr. Lawson. "Value-added needs to be sold to the clients. As with any consumer, if I feel I'm getting my money's worth, anything I'm paying will be worth it to me."

And some agents, too, realize that the only way to survive today is to make an effort to work with their partners in business.

"These are particularly trying times, and it takes a great deal of patience and understanding on both sides of the fence," commented the president of a Kentucky agency with $6.5 million in annual premium volume. ■

Several agents say contract changes made

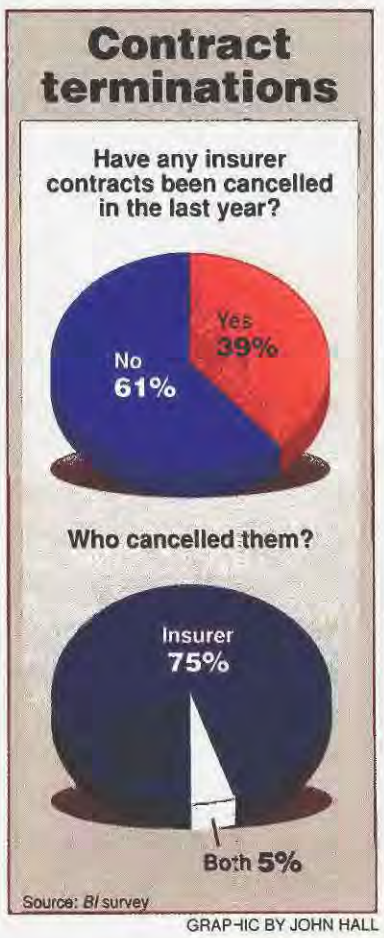
The inconsistency of insurer/agent relationships is reflected in contracts between agents and insurers.

Of the 52 agents and brokers surveyed by *Business Insurance*, 58% said at least one insurer they represent had changed contract terms or requirements in the past year, compared with 51% that had a contract changed a year earlier.

Respondents cited reductions in commission structures as the most common change, followed by: changes in contingent commissions; increased life insurance production requirements; higher volume requirements; and requiring sales of other lines of business.

While some producers experienced contract changes, about 60% reported no contract cancellations in this year's survey. Some 38% of the respondents—about the same as the year earlier—said at least one contract had been canceled.

Like last year, the majority of respondents that had a canceled contract—75%—reported that it was canceled by the insurance company; only 7.6% of these agents canceled the contract themselves; and the remainder said both sides played a part in canceling a contract. ■



GRAPHIC BY JOHN HALL

Insurer pullouts can strain agent relations

By LAURA MAZZUCA

RELATIONS

One of the most obvious strains in agents' relationships with their insurers is the increasing number of underwriters pulling out of individual states and lines of business.

In the last few years, several national insurers have pulled out of major markets. For example, Crum & Forster Inc. totally withdrew from personal lines in 1990; Aetna Casualty & Surety Co. dropped personal auto coverage in 27 states over the past 2½ years; and ITT/Hartford Group Inc., USF&G Corp. and Travelers Corp. have all stopped writing personal lines coverage in some states.

Agents understand that the pullouts are based on hard market realities: poor loss ratios, new state laws or regulations, or changes in marketing plans.

But they note that some insurers do a more humane job than others in preparing their agents for the worst.

Agency relations is "a key subject because some companies are good at it and some have not done it well," said Jeffrey M. Yates, executive vp and counsel for the Independent Insurance Agents of America in Alexandria, Va. "It has been a real source of concern."

When insurers pull out of a line of business or completely withdraw from a state, they are required to comply with state rules—on such matters as notification time and how business is replaced—that are designed to make their departure orderly.

But often these requirements are the bare minimum, and Mr. Yates contends that many departing insurers go no further than the letter of the law to help agents.

Considering the increasing frequency with which some insurers are leaving markets, surprisingly few seem to have a firm policy on how to handle withdrawals.

Take Aetna, for example. Besides trying to help agents place coverage with other insurers, Aetna sometimes simply complies with state notification rules.

"We try to notify agents as far in advance as we can," said Terry Toohey, director of agency relations at Aetna in Hartford, Conn.

Agents have proven much more receptive to the approach taken by Crum & Forster.

Besides giving agents notice "to the letter of the law," it offered agents a choice when it withdrew from personal lines, said a spokeswoman for the Basking Ridge, N.J.-based insurer.

They could renew homeowners coverage immediately with Metropolitan Property & Casualty Insurance Co., with no penalty for midterm cancellation; they could wait until the policy expired and place it with another insurer; or Crum & Forster would continue to write the coverage for one additional year.

Most agents chose to move the business at the end of renewal, she said.

Other insurers Mr. Yates praised included USF&G, which offered agents both plenty of lead time and the chance to renew business for another year, and The Home Insurance Co., which withdrew from the high-value homeowners market but worked with Fireman's Fund Insurance Co. to take over the business.

Agents praised other insurers for sticking with markets through thick and thin.

Like most of the agents participating in the insurer relations survey, Mr. Yates gave good marks to Chubb Corp. as "one of the companies which, in spite of difficulties, works with their agents to stay in a market."

Others cited as "survivors" include CNA Insurance Cos. and Kemper National Insurance Cos., for commercial lines business, and regional companies like American States Insurance Co., Ohio Casualty Insurance Co. and General Accident Insurance Co. of America, for both commercial and personal lines.

Mr. Yates also commended Allstate Insurance Co. and Metropolitan for their efforts in working with the independent-agency system.

Not all insurers go the extra mile, though.

Although he and others declined to name names, Mr. Yates noted that some insurers don't give agents enough time to regroup. Worse yet, some terminate agent contracts, then write the business directly, bypassing the agent who originally drummed up the business.

"This is a real source of friction and concern," Mr. Yates said.

Giving agents short shrift in a pullout is "unconscionable," he added. "It's important for all of our companies to realize they're talking about clients."

That sort of behavior not only alienates agents, it creates a bad public image for an industry that already suffers from a black eye in many circles. And it drives policyholders to direct writers. "This creates a difficult situation for companies remaining in the market," Mr. Yates observed.

Insurers can avert many market withdrawal problems by simply giving agents sufficient notice of its decision to withdraw. The IIAA recommends that insurers leaving a state warn agents at least six months in advance and offer to renew existing business for at least one year, Mr. Yates said.

One state that has been particularly hard hit with market withdrawals is Louisiana, where many insurers did little more than give their agents notice, said James J. Cooke Jr., a partner in Engelhardt/Cooke & Associ-

Continued on next page

Withdrawals

Continued from previous page
ates in Metairie, La.

"The companies were not interested in how this really affected us," he said. "But as an agent, it has impacted me very severely."

Within two years, four insurance companies that Mr. Cooke's agency represented stopped writing some or all coverage in Louisiana.

All the withdrawing insurers gave agents due notice, but some did go beyond minimum requirements.

Mr. Cooke said USF&G and Aetna, for instance, allowed one-year renewals after they announced their withdrawal plans from the state. "I think they did as much as they could for us."

'We have to give them an environment in which to make a profit or they won't return,' Mr. Cooke says.

The withdrawals forced Mr. Cooke's agency to replace almost 20% of its book of predominantly commercial business.

And although the business was good and the agency had little trouble placing the commercial business, there were "inherent problems" in the changeover, including finding new insurers for some personal auto policyholders, Mr. Cooke said.

Regional insurers like Pelican State Mutual Insurance Co. and Automotive Casualty Insurance Co. were able to jump into the fray, though they accept business only on a strict underwriting basis, assessing each account separately.

Although they offered to share loss experience data with him, none of the departing insurers helped Mr. Cooke find new insurers, he said.

Mr. Cooke believes that the long-term answer to the withdrawal problem is for agents to work with insurers and legislators to improve business conditions in the state or region.

"We have to give them an environment in which to make a profit or they won't return." ■

Quality service is a start for improving relations with consumers, says Chubb & Son executive

By LAURA MAZZUCA

CHICAGO—A successful campaign to provide high-quality service must be based on a commitment to nurture positive customer relations on an ongoing basis, according to insurance industry executives.

Insurers that saw their market shares shrink in the 1980s "are now embracing this new religion of quality," stressing a "zero defects" mentality borrowed from manufacturers of consumer goods, said Gregory Georgieff, senior vp and managing director of Chubb & Son Inc., in Warren, N.J.

But unlike cars or other goods, quality of service does not roll off an assembly line, he said. Instead, it is an assessment, opinion and verdict—and, "like beauty, honor, and fairness, it's hard to quantify and pin down," he said.

Mr. Georgieff and four other industry representatives participated in a panel discussion at a Society of Chartered Property & Casualty Underwriters forum, "Building Competence: Insurance and Quality," held recently in Chicago.

Like sensitivity training in the 1970s, the new emphasis on quality could simply be a "corporate fad," partly because it


Mr. Georgieff


Mr. Anker


Mr. Katten


Mr. Beck

cannot be managed quantitatively, Mr. Georgieff said.

"The real purpose of a business is to track and keep new customers, but no one ever talks about that," he said.

People buy features, convenience, trust and price from insurers, "and they buy them generally in that order until you turn them around," he said.

But after the initial sale, "it's how you manage the relationship that determines how well it works," Mr. Georgieff said.

Companies that ignore or forget this will probably disappear in the 1990s, but their failure will be masked by poor market conditions and anti-insurance legislation, he said.

Insurers must address the fact that the public perceives the insurance industry in a negative light, and an emphasis on quality service is a good place to start, panelists agreed.

Over the years, a lack of quality service has created an atmo-

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Insurer Topics

Continued from previous page
sphere in which "our customers come to us expecting to be mistreated," said Robert A. Anker, president and chief operating officer of Lincoln National Corp. in Fort Wayne, Ind.

This attitude is often fostered by insurer personnel, who are frequently lax in their treatment of customers.

For almost 30 years, the insurance industry has built a culture around how to say "no" and "how to keep the customers away," Mr. Anker said. "We are all customers. The first thing we all know is what makes us mad."

Insurers must realize that the client-insurer relationship doesn't end once the contract is signed, Mr. Anker said. Rather, the ongoing process of "people serving people" must be instilled in employees by "de-programming" their negative attitudes and replacing them with "an attitude that you are going to do your best."

Launching a quality service program is not something that can be done instantly, "like turning a light on and off," Mr. Anker said.

American States Insurance Co., Lincoln's Indianapolis-based property/casualty subsidiary, started its quality commitment program in 1981 by giving employees the freedom to make decisions and by training workers to take "every opportunity to do something better" when handling a claim, he said. Five years later, after the program was well-established, a customer outreach component was added.

But management commitment to quality doesn't always mean success.

A real commitment to quality is "not that top management says it, but that people on the firing line deliver it," said Richard L. Katten, vice chairman and chief operating officer of The Ferd. Marks Insurance Agency Ltd. in New Orleans and a former president of the Society of CPCU.

"Quality is hard to define, but you sure do notice when it's absent," he commented.

Quality service is especially important to insurance agents, because they act as a liaison between the public and insurers, Mr. Katten said.

Sometimes an agent's efforts are sabotaged because of the impression conveyed by an insurer's underwriter or claims adjuster, "the person on the firing line," he said. These people must have common sense, decisiveness and empathy in order to serve the customer.

If these front-liners are incompetent, the whole company is judged as poor by the dissatisfied customer, he said.

Quality is also important in developing a positive image among regulators and legislators, said Lowell R. Beck, president of the National Assn. of Independent Insurers in Des Plaines, Ill.

Mr. Beck, who recalled testifying on tax issues before the House Ways and Means Committee in the mid-1980s, noted that many legislators "couldn't wait to go on record as getting at us," criticizing the insurance industry for policy cancellations and other problems. These representatives feel they can treat the insurance industry as the "whipping boy," and they "get by with it because they know the public loves it."

This poor public perception is reinforced by the lack of quality service the public receives from insurers. "The complaints I hear aren't so much with the claims process," but with non-renewal, rate increases or other unexplained changes that insurers introduce, Mr. Beck said.

A real commitment to quality is 'not that top management says it, but that people on the firing line deliver it,' says Richard L. Katten of The Ferd. Marks Insurance Agency Ltd. 'Quality is hard to define, but you sure do notice when it's absent.'

That attitude is now beginning to change, with insurers explaining their marketing and other decisions to agents and clients, he said. Two good examples of successful company-driven quality programs are conducted by direct writers: United Service Auto Association and Allstate Insurance Co., Mr. Beck noted.

At USAA, the philosophy is that "you smother people with attention," he said. The insurer uses sophisticated computer technology to store detailed data, including personal information on the policyholder, which an operator can access each time the client calls. This attention to detail "shows that they care, they're interested and not indifferent," Mr. Beck said.

In its quest for quality, Allstate focuses on intensive training for its personnel, Mr. Beck said. During the course of a three-week training program held at its Northbrook, Ill., headquarters, Allstate field representatives work with a computer system that enables them to simulate "every conceivable situation" they might have to deal with, from a fire in an inner-city apartment building to a client not being able to find his agent in a crisis, Mr. Beck said.

And at Erie Insurance Co., a regional insurer based in Erie, Pa., Chairman Thomas B. Hagen sets aside time to answer phone complaints personally, Mr. Beck added.

"I almost resent it when people say they try things and they're not working," Mr. Beck said. "It may cost money upfront, but it will pay off in the long run."

But in order to be successful, a quality service program must go beyond claims processing and customer service and actually result in a change in company policy, Mr. Beck said.

He cited the example of a customer who had done business with an insurer for 23 years whose homeowners policy was canceled after his home was burglarized several times. While company guidelines might dictate the policy cancellation, insurers should look beyond a guidebook mentality and deal with each policyholder individually, he said.

To do this, the insurer's employee reward system must be driven to demonstrate exceptions to typical company guidelines, "finding reasons why you should keep a piece of business," Chubb's Mr. Georgieff said.

While the panelists agreed that better service would bolster profits and reduce costs, they noted it is difficult to gauge customer satisfaction.

Because "surveys sometimes tell you what you want to hear," the best way is to talk to customers about what they expect, Mr. Georgieff said. The success of a quality service program can also be measured by how much repeat business is generated, he added.

Mr. Anker of Lincoln National said another measure of success is how many new customers are referred by existing customers.

The panel was moderated by Stephen H. Paris, managing partner at the law firm of Morrison Mahoney & Miller in Boston and immediate past president of the Society of CPCU. ■

Service is key to survival

CNA chief says renewed focus on clients will solve many woes

By LAURA MAZZUCA

CHICAGO—The best way for insurance companies to fend off criticism from legislators and consumer activists is to provide quality service to customers, a leading insurance company executive says.

"When consumers are satisfied with our service, it's hard for those demagogues to incite or ignite them," points out Edward J. Noha, chairman, president and chief executive officer of CNA Insurance Cos. in Chicago.

Mr. Noha was the keynote speaker at a recent forum in Chicago, "Building Competence: Insurance and Quality," sponsored by the Society of Chartered Property & Casualty Underwriters.

Because of ongoing regulatory and legislative "assaults" on both the state and national level, "this industry is under siege today and so is its priceless heritage of free enterprise and free choice," Mr. Noha said.

As a result, he and other industry executives are spending more time "fighting political fires" than anyone would have imagined five or 10 years ago, he said. "I'm not pleased at all that it's come to this. . .but we have to confront it head on."

Mr. Noha encouraged CPCU members to get involved in the political process, making legislators aware of "our numbers, our strengths and our cause."

He also recommended working in support of legislation favorable to the insurance industry, like no-fault auto insurance, and informing consumers that external loss costs, like the cost of insurance fraud, drive up premiums.

But, while battling politicians, activists and trial lawyers who sling "unjustified political slurs against our industry" is important in the short run, the best long-term strategy for countering industry criticism is to provide customers with the high-quality service they expect and deserve, according to Mr. Noha. "The customer is the ultimate judge and jury," he said.

And, in spite of popular belief, the lowest premium is not the answer to customer satisfaction, he added.

"What does the consumer want? The knee-jerk reply is the lowest possible price, but that's not the total answer," Mr. Noha said. Rate slashing alone does not satisfy the customer's need for "long-term security and protection," he said.

Mr. Noha cited a survey by The Forum Corp., a Boston consulting firm, that indicated seven out of 10 customers who switched insurers did so not because they could get a lower premium price, but because of poor service.

"They don't like to be neglected," he said. "Price may be an ingredient in quality service, but it's never a synonym for quality."

Insurers should follow the "golden rule. . .treating our customers the way we want to be treated—not just at the point of sale, but in the long run."

Insurers must have a strong internal foundation on which to build a quality service program, he said.

The first step is to see the organization as an "integrated totality," breaking down barriers between units, Mr. Noha said.

It also means that insurers must view their employees as their most valuable asset.

"Quality most of all is people," Mr. Noha concluded. "When we help them bring out the best that's in them, then we bring out quality.

"Employees can't be motivated to give good service without an atmosphere of pride; that's the truth at the heart of quality service," Mr. Noha said. "If employers want more quality, they need more employee dedication. Unfortunately, the opposite seems to be happening. . . .Customers cannot be treated one way and employees treated another way."

Mr. Noha cited CNA's own "painful" experiences in the mid-1970s as an example of how to turn employee morale around.

When he took over in February 1975, CNA was overdiversified and teetering on the brink of insolvency, Mr. Noha said. While the first step for new management was to refocus on insurance, the hardest job was to begin "restoring pride and confidence in a fine workforce that had gone through traumatic times," he said.

During his first six months on the job, Mr. Noha met with groups of 15 to 20 employees at a time, going "floor by floor," through CNA's 44-story headquarters, he said. "The message was always the same: The new CEO was someone who had their interests at heart and wanted them on his side."

Today, CNA recognizes the efforts of its employees by keeping communication channels open through frequent sessions in which employees meet "with their manager's manager" and engage in question-and-answer sessions, Mr. Noha said. And executives still frequently visit branch offices to meet with individual employees.

A "strong financial base" also inspires the confidence of employees, and CNA's internal structure is kept lean "so we don't have to have massive layoffs when the heavy weather hits," Mr. Noha said.

CNA also recognizes the efforts of its agents, "because they're our customers, too," Mr. Noha said. ■

ISO offers electronic access to underwriting information

By MICHAEL SCHACHNER

NEW YORK—The Insurance Services Office Inc. is offering property/casualty insurers electronic access to its new automated commercial lines underwriting manual.

ISO's Commercial Lines Electronic Manual Services, a new data base that features all of the advisory underwriting, rating, forms and related information contained in ISO's paper manuals, will save underwriters time and improve accuracy and speed, said LeRoy Boison, vp-commercial casualty for ISO in New York.

Under CLEMS, which became available to ISO affiliates March 9, insurers can obtain underwriting information on nine separate lines of property/casualty insurance two ways:

- On-line, which insures accurate, instantaneous information.
- Via computer tape, which can be updated once or twice a month and enables the insurer to customize the material to meet its own individual needs.

"The new paperless manual services will change forever the way insurers get the information they need to do business," said Mr. Boison. "CLEMS makes it easier than ever to access accurate rules, forms, classifications and loss costs that insurance professionals need to write and sell policies."

CLEMS includes all the information traditionally contained in ISO's paper manuals, which still are available.

And, the new electronic system will continue to offer a portfolio of sample forms, classification tables, multi-state rules, state exceptions, loss costs and rates.

The program also allows users to look up information much quicker than would be possible using ISO's book-style manuals, according to Mr. Boison. For example, the computer can search for a specific topic by name, rather than the user having to open each book and turn to an index for reference.

"When you factor in the savings in labor, paper and storage space, as well as the accuracy, speed and ease of use, it's easy to see how valuable electronic delivery is. We're truly excited about this," Mr. Boison said.

The system also eliminates the need for ISO to mail its affiliates revisions, which are prepared as frequently as twice a month.

"There are 5 million paper manuals is use in the country, each with 20,000 pages for the 52 states and regions. It's so much easier to send revisions over the system with CLEMS. And, if the insurer buys the tape, it can make notations or personalize the information we publish," he explained.

This year, ISO will charge its affiliates $25,000 for the tape containing information for all states. Next year the tape's price will rise to $50,000. The tape can be run on IBM's BookManager or BookMaster software and can be downloaded onto personal computers.

On-line use, which is available directly from ISO, will cost users a one-time fee of $20 plus $12 to $15 per hour of use.

The system can be bought in unbundled form for less money if users do not need information for all states.

For more information on CLEMS, contact Tom Hintz, Director of Account Marketing, 7 World Trade Center, New York, 10048-1199; 212-898-6718.

Suit charges agency with taking illegal payments

TRENTON, N.J.—New Jersey regulators are attempting to recover more than $22 million that they say a New York agency illegally received from Mutual Benefit Life Insurance Co.

In a lawsuit, regulators charge that Mayer & Meyer Associates Inc. "sought these illegal payments as a condition to continuing to place its new life policies and maintain renewals with Mutual Benefit."

Mayer & Meyer, a Manhattan agency with 120 employees, accounted for more than 15% of Mutual Benefit's individual insurance business from 1985 to 1990, according to the suit, which was filed January in state court in Trenton, N.J.

Mutual Benefit has been in rehabilitation since July 1991. New Jersey regulators took over the Newark, N.J.-based insurer after bad real estate investments prompted a policyholder run (*BI*, July 22, 1991). Mutual Benefit is the largest insurer ever taken over by a state.

The alleged illegal payments to the agency include:

- "Developmental allowances" of $5.2 million in excess of those allowed by law from 1986 to 1989.

While New York allows payments to an agency based on a percentage of its first-year commissions, the suit charges that Mayer & Meyer did not qualify for the allowances it received.

- "Establishment allowances" of $2 million during the same period.

Insurers can make this type of payment only in the first 10 years that an agency sells insurance. Mayer & Meyer had been selling insurance for Mutual Benefit for more than 10 years by 1986.

- Advances exceeding $11.4 million that were never repaid and were concealed from regulators.
- Nearly $2.5 million from January 1989 through October 1991 to pay rent owed by Mayer & Meyer.
- Consulting fees and bonuses of $239,000 that were paid in 1989 to Bernard Mayer, a former agency partner who is now retired.
- Loans of nearly $124,000 for furniture and equipment that were never repaid.
- From 1988 to 1990, loans exceeding $455,000 that were never repaid.

The lawsuit further charges that Mr. Mayer and Marvin Meyer, the agency president, used the money to pay themselves "exorbitant" salaries and to furnish their homes.

Calls seeking comment from Mayer & Meyer were not returned.

New York regulators are in the final stages of an investigation into the agency's relationship with Mutual Benefit. If any wrongdoing is discovered, the agency could be fined or its license to do business in the state could be revoked, said a spokesman for the New York Insurance Department.

Fines also could be levied against Mutual Benefit, but that is unlikely since the company is in rehabilitation, he said.

The investigation should be completed sometime this month.

Neither a Mutual Benefit spokesman nor Victor H. Palmieri, the turnaround specialist hired to run the company, would comment on the suit by New Jersey regulators.

A spokesman for the New Jersey insurance department said its examination of Mutual Benefit is continuing, but that no other suits against agencies were imminent.

—*By Sara J. Harty*

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Issue of March 16

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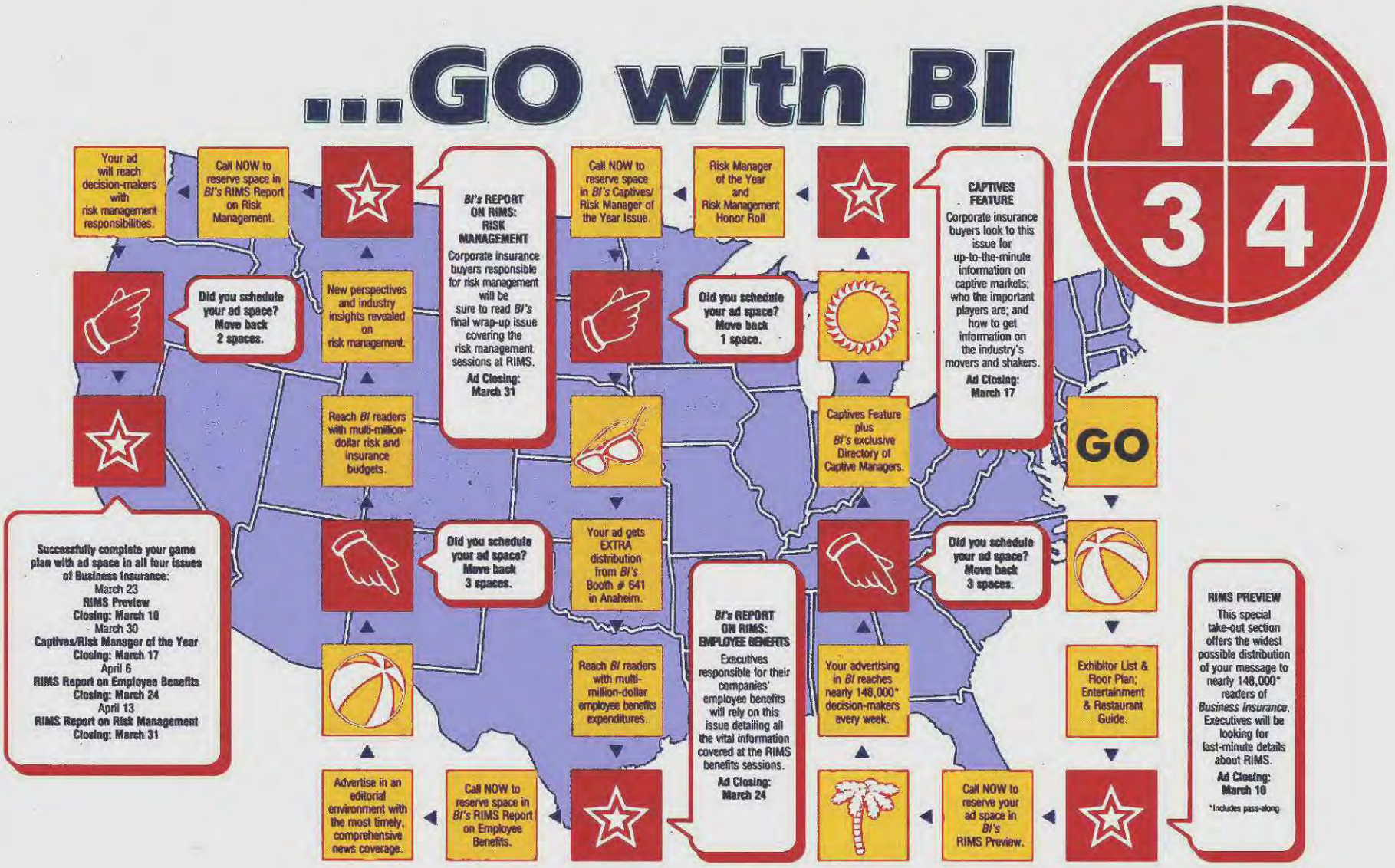

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ASK A BENEFITS MANAGER

Precertification decision is big win for employers

Q **What is the result of the appellate case that examined precertification penalties for health care plans?**

A The case you are referring to is *Nazay vs. Bethlehem Steel.* The plaintiff was Richard Nazay, a retiree who worked for Bethlehem for 37 years prior to retiring in 1986. Mr. Nazay failed to obtain preadmission certification for a non-emergency, week-long hospital stay for a heart condition. The Bethlehem medical plan provided for a 30% penalty for failure to follow precertification procedures. As a result of not meeting the precertification requirement, the plan did not reimburse $2,231 of Mr. Nazay's $7,438 hospital bill.

The case was originally filed in small claims court, but attorneys for Bethlehem petitioned to move the case to federal court. They wanted to ensure the case was tried properly since they saw the potential of an enormous impact from the perspective that losing the case would limit an employer's ability to manage health care costs through the use of incentives and disincentives. The issue was not the $2,000-plus of precertification penalty, but the need to preserve the right to manage its health care plan.

In April 1991, Judge William W. Caldwell for the U.S. District Court for the Middle District of Pennsylvania ruled that the imposition of the 30% penalty for failure to follow the precertification procedures was arbitrary and capricious and violated the fiduciary duty standard of the Employee Retirement Income Security Act. Bethlehem then appealed. Once Bethlehem lost the initial trial, groups representing business and health insurance companies quickly recognized the importance of this case. The National Chamber Litigation Center, the legal arm of the U.S. Chamber of Commerce and the Health Insurance Assn. of America both joined Bethlehem in appealing the ruling.

In December 1991, the 3rd U.S. Circuit Court of Appeals in Philadelphia overturned the initial ruling in the case (*BI,* Dec. 16, 1991). The court stated that imposing penalties on beneficiaries who fail to comply with precertification and other cost control requirements does not violate the arbitrary and capricious or fiduciary duty standards under ERISA. The court further stated that ERISA permits an employer to freely develop an employee benefit plan as it wishes because the creation of such a plan is a corporate management decision unrestricted by ERISA's fiduciary duty standards. This case was a clear victory for Bethlehem and all other employers who provide health care coverage for their employees.

Based on comments from Mr. Nazay's lawyer, it appears that he will not seek Supreme Court review of the 3rd Circuit's decision.

Although the dollars involved in this case were small, the basic issue—preserving employers' rights regarding health care plan design—was significant. Today, the vast majority of employers' health care plans include preadmission certification requirements, as well as other design features that help control utilization and plan costs. According to the 1991 Wyatt Compare Data Base, which includes 828 participants, 79% of health care plans include preadmission certification.

If Bethlehem had lost this case, the majority of employers would have had to rethink the cost containment features of their health care plans and possibly modify any features that penalize employees. Without mandatory precertification requirements in their plans, employers' health costs would certainly increase.

Many employers have seen utilization decrease. Programs like preadmission certification have contributed to this decline. Medstat Systems of Ann Arbor, Mich., a health care information firm, has reported a steady decline in hospital utilization for its clients, which include many large organizations like Ford Motor Co., General Electric Co. and Kraft General Foods Corp. For example, according to Medstat:

- Admissions will decline to a projected 76.2 per 1,000 lives in 1992 from 95.6 in 1987.
- Average length of stay will decline to a projected 5.8 days in 1992 from seven days in 1987.
- Inpatient days will decline to a projected 429.2 per 1,000 lives in 1992 from 672.6 in 1987.

While there may be several reasons for the declines, readmission certification has played a major role.

Although it appears that there have been improvements in utilization as demonstrated by the Medstat data, according to a recent study, "Analysis of Medically Unnecessary Health Care Consumption" by Milliman & Robertson, Inc., it appears we have a long way to go. The study projects that nationwide, 24% of hospital admissions and 53% of hospital days are medically unnecessary based on under age 65 population data.

What are the implications of these figures?

One point that immediately comes to mind regarding this case is the need for consistent administration of health care plan provisions. When employees, like Mr. Nazay, seek to have a decision regarding a penalty overturned, it is important that the employer have a clear and consistent record regarding such decisions.

In the Nazay case, the employee petitioned the plan administrator to reverse the decision regarding the penalty, arguing he did not comply with the preadmission certification requirement because he was preoccupied with his physical condition. Mr. Nazay's request was denied, and the amount of the penalty was not paid by the plan.

The court did review actions taken by Bethlehem in prior appeals. The penalty was waived 14 times, but only in cases when compliance was virtually impossible. The court did note that if the plan administrator had accepted Mr. Nazay's explanation for failing to comply with the requirement, he would be obliged to waive the certification requirement in virtually every instance.

When situations arise regarding the review of penalties, benefit managers should have clear criteria to apply.

Another issue related to application of consistent criteria to precertification cases is the appropriateness of the penalty for non-compliance. The goal of a precertification program is to ensure that employees follow the procedure and receive only necessary care. In most cases, companies probably want enough of an incentive (or disincentive) to ensure that the precertification procedure is followed, but not so severe as to be "arbitrary and capricious."

My personal opinion is that the 30% penalty imposed by Bethlehem in the Nazay case was on the high side—Mr. Nazay had to pay more that $2,000. Bethlehem later changed its penalty to $100, but I'm not convinced that this lower amount is enough to influence behavior in many cases.

A case like the Nazay case also should serve as a reminder for the need to continually communicate any of our programs, especially those to which a penalty is attached. Most organizations do a very good job communicating when first introducing such programs. However, there is often a need to remind employees.

Some communication opportunities to remind employees may include the following:

- Summary plan description. Of course a precertification program must be included in the SPD. Since employees don't typically read SPDs cover to cover, be sure to include precertification requirements in the summary of benefits.
- New employee orientation program. If your organization has such a program, this is another opportunity to mention any penalties. In addition, explaining the reason for the precertification or second opinion program is helpful.
- Medical plan identification cards. The ID cards should note the requirement to call the plan administrator prior to a hospitalization. The card should also include the administrator's telephone number as well as the penalty for not calling.
- Payroll stuffers. All employees are interested in their paychecks. An occasional reminder along with the paycheck is an excellent communication opportunity. One of the real pluses of this approach is that, of necessity, the reminder must be short and, therefore, employees are more likely to read it.
- Company newspaper or newsletter. Brief reminders of such provisions in the company newspaper or newsletter are also helpful.

One group that will need to use precertification programs are those employees going on maternity leave. At many companies, the most common reason for hospitalization is maternity.

Dennis J. Nirtaut is manager of employee benefits at Continental Bank Corp. in Chicago. Mr. Nirtaut's next column on employee benefit issues will appear in May.

Statements of opinion

Continued from previous page

manager or broker who is concerned about the condition of one of his major markets may wish to request a copy of the actuary's report.

It will be interesting to see what impact this has on the marketplace in the future. Brokers and risk managers who have heretofore been able to reasonably fulfill their responsibility for reviewing their insurers' solvency by consulting A.M. Best Co. ratings may someday find themselves accused of not having fulfilled their professional duties if they haven't also reviewed the actuary's opinion letter and perhaps even the actuary's study of loss reserve adequacy.

That would represent a radical change, but it could happen within the next few years.

Would you like advice from an experienced colleague on a risk management, benefit management or actuarial problem? Four features in the Perspective section of Business Insurance can give you some answers.

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

This month's column on actuarial issues in the casualty field is written by Richard E. Sherman, president of Pacific Actuarial Resources (PAR) Excellence in Ashland, Ore. William J. Miner, an actuary with The Wyatt Co. in Chicago, answers actuarial questions in the benefits field. Susan M. Werner, director of risk management at Hardee's Food Systems Inc. in Rocky Mount, N.C., answers risk management questions. And Dennis J. Nirtaut, manager of employee benefits at Continental Bank Corp. in Chicago, answers questions on employee benefit plans.

Ms. Werner's and Mr. Nirtaut's columns usually appear on the second Monday of alternate months. Mr. Miner's and Mr. Sherman's usually columns appear alternately on the first Monday of each month.

Mr. Sherman's next column will appear in May.

Address your questions to ASK, Business Insurance, 740 N. Rush St., Chicago, Ill. 60611. Please give us your name, title and employer; however, Business Insurance will consider unsigned letters.

Pollution ruling

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Co., Zurich Insurance Co. and the New Jersey Property-Liability Guaranty Assn., which is responsible for claims against insolvent Ideal Mutual Insurance Co., are not required to indemnify or defend Triangle for a Superfund-authorized cleanup project at the Ohio site that could end up costing tens of millions of dollars.

The insurers each wrote CGL policies with $1 million in annual limits per occurrence and aggregate from 1981 to 1987. Zurich also issued a claims-made pollution liability policy in 1984-85 with limits of $1 million per occurrence/$2 million aggregate.

The ruling affirms a decision by the U.S. District Court for the Northern District of West Virginia. The district court had been certified by West Virginia's Supreme Court of Appeals under the state's choice-of-laws rules to use New Jersey law to interpret the scope of New Brunswick, N.J.-based Triangle PWC's policies.

The 4th Circuit concluded that "the open dumping of sludge onto the ground, particularly when performed as part of a regular business activity, cannot be considered an accidental discharge of a contaminant."

The ruling stems from a dispute between Triangle and its insurers that began in May 1985, a few months after the Ohio and U.S. environmental protection agencies notified Triangle that sludge that it had transported from a steel treatment plant in West Virginia to a landfill in St. Clairsville, Ohio, was leaking hazardous materials.

Triangle sought a defense from its insurers to avoid or minimize responsibility for an environmental cleanup project at the Ohio site, but Liberty Mutual sued Triangle in federal court in West Virginia to deny coverage.

Triangle then sued Zurich and the insolvent Ideal Mutual.

The appeals court, affirming the trial court's ruling, said that coverage for costs relating to pollution not caused by a sudden and accidental discharge is barred by the standard pollution exclusion.

This exclusion appeared in the CGL polices written by Ideal Mutual and Liberty Mutual until July 1, 1982.

Liberty Mutual then replaced this exclusion with a "modified" exclusion, which aimed to bar coverage not stemming from the policyholder's finished product.

Zurich also issued Triangle a policy containing this modified exclusion from Jan. 1, 1984, through April 1, 1987.

Both courts ruled that the modified exclusion also barred coverage because the pollution resulted from sludge, not one of Triangle's finished products.

Zurich also issued to Triangle a claims-made pollution liability policy with a clause excluding sites not approved by the Ohio or U.S. environmental agencies.

Triangle could not prove that the St. Clairsville landfill was a government-approved dump site, thus the exclusion in the claims-made policy was applicable, the courts found.

Policyholder attorneys contend that the decision will only influence cases within the 4th Circuit —Maryland, North Carolina, South Carolina, Virginia and West Virginia—which they say already has a reputation for siding with insurers in coverage disputes.

"Rulings in the 4th Circuit have always gone the other way," agreed Stephen M. Orlofsky of Blank, Rome, Comisky & McCauley in Cherry Hill, N.J., which represents Triangle.

Mr. Orlofsky declined to comment further on the case, saying he had not decided whether to ask the U.S. Supreme Court to review the case.

"The 4th Circuit has a penchant for issuing decisions that are favorable to insurers. This ruling is consistent with a running saga these justices are developing. They seem to be writing their own contract law here," agreed William F. Greaney, an attorney with Covington & Burling in Washington, D.C., which filed amicus curiae briefs on behalf of the American Petroleum Institute and the Chemical Manufacturers Assn.

However, insurance industry lawyers are lauding the decision, claiming that it is another in a growing series of rulings that establish that only a sudden and accidental event—rather than damage that occurs suddenly or accidentally—is covered under CGL policies containing the standard pollution exclusion.

"This ruling brings the 4th Circuit—and New Jersey by reference—in line with the case law in several other states and circuits," said insurer attorney Thomas A. Brunner of Wiley, Rein & Fielding in Washington, D.C.

Last year, the 1st and 6th Circuits, as well as an Illinois appellate court, ruled that policyholders that discharge pollutants as part of the normal course of business are not insured for cleanup costs (*BI*, Dec. 23, 1991).

"One of the most exciting things about this ruling is that one of the highest courts in the country was willing to address the pollution exclusion topic in New Jersey," said Lee Glickenhaus of Mintz, Levin, Cohn, Ferris, Glovsky & Popeo in Boston, which represents Liberty Mutual, Triangle's CGL insurer during 1982 and 1983.

Several attorneys say the ruling casts doubt on what triggers the standard pollution exclusion in New Jersey, home to the largest number of sites targeted for cleanup by the U.S. Environmental Protection Agency.

While the New Jersey Supreme Court has never ruled on the polution exclusion in CGL policies, the 4th Circuit ruling contradicts numerous lower court opinions in New Jersey.

To date, the highest court in New Jersey to rule on the pollution exclusion is the appellate division of the New Jersey Superior Court. In a 1987 decision favoring policyholders, that court ruled that the pollution exclusion bars coverage only for expected and intended damages (*BI*, July 27, 1987).

In that case, *Broadwell Realty Services Inc. vs Fidelity & Casualty Co. of New York*, the state appeals court ordered Fidelity & Casualty to indemnify Broadwell, which had leased property to a gas station whose tanks later leaked, because Broadwell couldn't have expected the leak to occur.

However, in the Triangle case, the 4th Circuit panel ruled that if the New Jersey Supreme Court were to have heard the Triangle case, the court would "not have concurred with the (Broadwell) opinion" because the plain language of the policy in the Triangle case "makes clear that the exclusion does not apply if such discharge, dispersal, escape or release—as distinct from the damages caused—is sudden or accidental."

"Since the New Jersey Supreme Court won't touch the subject, all we have had since 1982 are lower courts restating the opinion that damage triggers coverage if the damage was unexpected," said Mr. Glickenhaus, Liberty Mutual's attorney.

"Now we have a major court ruling that in New Jersey the pollution exclusion is just what it states. Damage in and of itself is not accidental. It has to be caused by a sudden and unexpected accident," he said.

"This really throws New Jersey up for grabs," said Mr. Brunner, who represents the Insurance Environmental Litigation Assn., an insurance industry group.

"In effect, this ruling turns New Jersey into a true battleground for pollution coverage disputes," he said. "It tells policyholders that *Broadwell* isn't a good predictor of what the New Jersey Supreme Court would rule if it ever hears one of these cases."

Robert Bates of Pope & John in Chicago, which represents Zurich, agreed with Mr. Brunner's assessment.

"Here we have another federal court predicting what the New Jersey Supreme Court will do in future cases. Hopefully, it'll direct New Jersey's appellate courts to better read the plain language of the CGL pollution exclusion," said Mr. Bates.

But policyholder attorney Mr. Greaney disagreed about the scope of the 4th Circuit decision.

"Fortunately, the ultimate arbiter for New Jersey law is the New Jersey appellate courts and not the 4th Circuit. I don't think New Jersey will pay much attention to this," he said. ■

Nicotine patch coverage

Continued from page 3

ranged from 19% at one clinic to 54% at another, a spokesman said.

And, while the Journal of the American Medical Assn. says the patch "shows considerable promise as an aid to smoking cessation," an AMA spokesman said it is most effective when coupled with behavioral modification programs. "It's not simply a matter of slapping on a patch and ending the habit."

Coverage for the cost of the patch is most likely to be adopted by large self-funded employers, many of which are based in the Northeast or health-conscious California, said Kwasha Lipton's Mr. Glinbizzi.

In particular, companies with smoke-free environments are covering the cost of the patches, he added.

Aggressive advertising for the patch has caught the interest of smokers who have failed with other cessation methods, say benefits managers at companies that self-fund their health plans.

"The demand for the patch is very high at this point," said Sandy Shriner, manager of health management services at Adolph Coors Co. in Golden, Colo., which has covered the cost of the patch under its prescription drug program since it received FDA approval.

Currently, between 260 and 300 of the more than 10,000 Coors employees are using the patch, she said.

Southern California Edison Co. in Rosemead, Calif., which implemented a smoke-free environment in January, also began at that time to cover the cost of the patch, as well as nicotine gum, under its prescription drug plan.

As of Jan. 1, the utility expanded its coverage for preventive services like nicotine gum and the skin patch to a $500 maximum annual benefit from $100.

Previously, the nicotine patch was not covered under the preventive services program, though nicotine gum was covered.

Southern Cal Edison began covering the cost of the nicotine patch not only to help employees stop smoking, but also because of the growing expense of medical claims for smoking-related illnesses, said Mary Ellen Courtright, manager-preventive health education.

To date, 304 patch prescriptions have been filled by 175 employees, she added.

Dallas-based Texas Instruments Inc. also has begun covering the cost of nicotine skin patches and nicotine gum under its prescription drug plan to encourage workers to quit smoking.

The coverage coincides with increased employee interest in smoking cessation and the implementation of a smoke-free environment in one of TI's large facilities as of Jan. 1, according to Sue Nelson, health benefits manager.

However, because the patch is still so new, "a lot of employers I've talked to haven't even addressed it yet," Kwasha Lipton's Mr. Glinbizzi said.

He predicts, though, that more self-funded employers will take a position on the nicotine patch in the next six months to a year, as the advertising blitz by patch makers continues and as more employers introduce smoke-free environments.

This time span also gives employers more time to size up how their competitors are handling the issue, he added.

Some insurers and health maintenance organizations also are covering the patch under prescription drug or wellness programs, but many others are not willing to pay for it.

'A lot of employers I've talked to haven't even addressed it yet,' says Kwasha's Mr. Glinbizzi.

For example, insurers like Aetna Life & Casualty Co., Travelers Corp. and Blue Cross & Blue Shield Assn. cover the cost of the patch.

But, most of those insurers, including Aetna and the Blues, have added limitations similar to those imposed on prescription nicotine gum, TPF&C's Dr. Dragalin pointed out.

For example, although Aetna's HMO covers prescription nicotine patches and gum under its wellness program, its traditional indemnity plan covers the patches only when an individual's medical condition—like heart disease, emphysema, cancer, or bronchitis—necessitates that the individual stop smoking, said Kathy Worthington, manager of benefit/claim policy for Aetna Health Plans of Southern New England in Middletown, Conn.

And, while BC/BS covers the cost of nicotine patches and gum under its prescription program, a spokeswoman said it does not cover the behavioral modification programs that are considered essential to a smoking cessation program's success.

Other insurers do not cover the cost of the patch at all.

For example, CIGNA Corp., under its indemnity and managed care programs, specifically excludes nicotine products on its pharmacy rider, a spokeswoman said.

ITT Hartford Group Inc., which pays for only "medically necessary treatment of disabilities," does not pay for smoking cessation programs, since it does not consider smoking a disability, a spokesman said.

Others insurers, including Metropolitan Life Insurance Co. and Prudential Insurance Co. of America, are conducting their own studies on the patch's effectiveness before deciding whether their indemnity or HMO plans will provide coverage.

Regardless of the patch's potential effectiveness, self-funded employers and insurers have to be aware that abuse problems are associated with the patch, which is considered a drug, said Mr. Glinbizzi of Kwasha Lipton.

Some smokers are using the patch—and nicotine gum—as a "short-term fix" if their employers forbid smoking in the workplace. These employees have no plans to stop smoking and are using the patch only as an alternative nicotine product, he said.

These smokers can easily get multiple prescriptions exceeding the six-month maximum usage recommended by the FDA if they go to several doctors for prescriptions, he pointed out.

Such abuses also raise the ethical question of whether nicotine products should be covered under wellness programs, which stress healthy habits, Mr. Glinbizzi said.

But, problems like these can be minimized if limits are set on usage, he added.

National Prescription Administrators Inc. in Clifton, N.J., which packages prescription drug plans for employers, recommends that self-funded employers and insurers adopt a three-month limit, said Richard J. Kuhn, director of marketing.

It also recommends that self-funded employers and insurers encourage users to enroll in a smoking cessation program.

Aetna's indemnity and HMO plans restrict coverage for nicotine patch use based on manufacturer recommendations: typically three or six months, Ms. Worthington said.

BC/BS plans generally follow FDA recommendations, a spokeswoman said.

Coors would consider instituting a three-month limit on patch coverage if usage problems arise, but such a limit is not currently planned. Coors plans to analyze quarterly reports on patch users to head off abuses, Ms. Shriner said. ■

24-hour coverage will be examined at Hines Symposium

CHICAGO—The prospects for controlling workers compensation costs with so-called 24-hour coverage will be examined at the Harold H. Hines Jr. Memorial Symposium next month.

The symposium, which will be held in Chicago April 29, is the seventh annual educational meeting in memory of Mr. Hines for business and insurance executives in the Chicago area.

"24-Hour Coverage: Can the Group Health and Workers Compensation Systems Be Combined to Control Costs?" will feature a trio of panelists who will explore whether combining the two plans can help employers better control workers comp costs.

The panelists are:

- Dennis H. Chookaszian, president of CNA Insurance Cos. in Chicago.
- Raymond B. Werntz, vp-human resources for Whitman Corp. in Rolling Meadows, Ill.
- Dale M. Dunlop, international representative of the International Brotherhood of Electrical Workers, based in Washington, D.C.

Kathryn J. McIntyre, publisher and editorial director of *Business Insurance*, will moderate the discussion and afterward lead an in-depth question-and-answer session.

The symposium is sponsored by the Chicago and Northeastern Illinois chapters of the Risk & Insurance Management Society Inc., the Insurance School of Chicago and *Business Insurance*.

Harold H. Hines served the insurance and risk management community for nearly 30 years. At the time of his death in 1984, Mr. Hines was president and chief executive officer of Rollins Burdick Hunter Co., the brokerage unit of Chicago-based Aon Corp. Before joining RBH, he spent 12 years at Marsh & McLennan Inc., serving as president from 1978 to 1980.

The April 29 symposium will be held from 3:15 to 5:15 p.m. at the Union League Club of Chicago. It will be followed by a reception hosted by the co-sponsors.

Admission is free to invited guests. For an invitation, contact the Insurance School of Chicago at 312-427-2550. ■

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INTERNATIONAL

INTERNATIONAL DIGEST

London sees no claims from Thai ferry accident

The London insurance market does not expect to pay any liability losses stemming from last week's **collision between a passenger ferry and a tanker** in the Gulf of Thailand, which killed more than 80 people, sources said last week. London insurers rarely insure Thai ferries as they are notoriously overloaded, sources say.

South Africa insurance reforms put on hold

Proposed **reform of South Africa's insurance laws** (*BI*, March 18, 1991) has been put on hold until after a referendum this week. White South Africans will vote on whether they agree with the reforms of President F.W. de Klerk, which among other things would eventually allow blacks to be represented in the government. A risk management source in South Africa last week said he was concerned about the future of his country if the reforms are voted down. If that happens, racial violence could break out, and extreme right-wing politicians are likely to take over the government.

Aegon looking for acquisition in Europe

Aegon N.V. is reportedly negotiating with Hungary's state-owned life insurer, Allami Biztosito, to acquire a large stake in the company. A spokesman for Aegon in The Hague, Netherlands, confirmed the insurer plans to make an acquisition in Europe, but would not name the company. "We have a number of possibilities in Europe, including Hungary. It just depends on how good the company looks," he said. Aegon refused to provide additional details "during negotiations."

Names investigate Merrett syndicate losses

The more than 300 Lloyd's of London members belonging to the **Syndicate 418 (1985) Names Action Group** have commissioned an investigation into the 1985 account of the syndicate, which is managed by Merrett Underwriting Agency Management Ltd. The still-open 1985 account so far has posted a 36 million pound ($61.8 million) loss stemming from runoff contracts covering U.S. asbestos and pollution claims, said the group's administrator, Clive Francis. That loss is expected to grow. The investigation will be carried out by law firm Richards Butler and accountant Rodney Smith & Partners.

Stockholm Re (UK) to be run off

Stockholm Reinsurance Co. (UK) Ltd. will be placed into runoff after suffering large losses on its London market excess-of-loss marine account. The London subsidiary of Stockholm Reinsurance Co. Ltd. of Stockholm, Sweden, had 1991 premium income of about 10 million pounds ($18.7 million at year-end 1991 exchange rates).

—By Gavin Souter, Stacy Shapiro and Don Kirk

An ironic legacy

Maxwell scandal fuels call to protect pensions

By GAVIN SOUTER

LONDON—British pension legislation should be overhauled in the wake of the Robert Maxwell pension fund scandal, a House of Commons committee recommends.

Shortly after the media mogul's death Nov. 2, 1991, police were called in to investigate the disappearance of about 426 million pounds ($732.7 million) from Maxwell-controlled funds discovered during an audit. Mr. Maxwell allegedly plundered the funds to shore up his private companies (*BI*, Dec. 16, 1991).

The "medieval" British pension laws must be brought sharply up to date if plan participants are to be protected from similar actions in the future, said a report by the Social Security Committee.

To achieve this, the government should establish a full inquiry into the current pension law and pass a new pensions act, the committee said.

"The single good deed Robert Maxwell has done for pensioners generally is to ensure that this issue of the ownership and control of pension schemes is now high up on the political agenda," the committee said.

By "stealing on a massive scale" from the pension funds of Maxwell Communications Corp. P.L.C. and the Mirror Group Newspapers to prop up his ailing empire, Mr. Maxwell may have forced many participants into poverty, the committee said.

And the growth in Britain over the last decade of "occupational" pension plans, which are provided by employers or other private organizations, and "personal pension plans," which are individual pensions bought by people not covered by an occupational plan, means that a growing number of people might be vulnerable under the current disjointed pension laws, the committee said.

Around half the adults in Brit-

Continued on page 27

Big German fire losses lead to premium hikes

BONN, Germany—German companies renewing their 1992 property insurance are finding premiums substantially increased, as insurers raise rates to cover disastrous fire losses.

In 1991, large industrial fires produced underwriting losses of 2.9 billion deutsche marks ($1.91 billion at year-end 1991 exchange rates) for German insurers, up 70% from 1.71 billion deutsche marks ($1.14 billion at year-end 1990 exchange rates) in 1990.

Business interruption underwriting losses jumped to 1.6 billion deutsche marks ($1.01 billion), nearly double the 803 million deutsche marks ($537.2 million) in 1990.

GLOBAL BRIEFS

An increase in the number of large-scale industrial fires was a major factor behind the poor property results, according to Walter Rieger, director of the German Assn. of Property Insurers.

The number of claims greater than 1 million deutsche marks ($660,100) increased 50.2% last year, rising to 350 claims, compared with 233 claims in 1990, he said.

An 18% increase in premium volume for commercial property insurance to 3.4 billion deutsche marks ($2.24 billion), and a 15% rise in business interruption premiums to 1 billion deutsche marks ($660.1 million), did little to ease property insurers' malaise. "Premium income increased almost exclusively because of companies in eastern Germany" buying coverage for the first time, said Mr. Rieger.

The "bleak situation" has already forced several insurers to increase commercial property rates and "close the door on some risks in order to return to profitability," said Georg Mehl, head of the German Assn. of Transport Insurers and a former official of the property insurance association.

Commercial property and

Continued on page 25

One-two punch staggers British insurers

By GAVIN SOUTER

LONDON—The double whammy of the recession and the soft market has knocked out any prospect of profits for British multiline insurance companies.

Three major insurers have already reported huge losses, and those yet to report don't have a fighting chance of staying out of the red, analysts say.

Insurers large and small also have been hit by an increase in recession-related fire and theft claims, says the Assn. of British Insurers.

Further premium increases will be needed to pull the companies up from the canvas, analysts say.

So far, Royal Insurance Holdings P.L.C. has posted the worst loss among the British multiline insurers.

Royal's pretax losses doubled to 373 million pounds in 1991 ($697.5 million at year-end 1991 exchange rates) from 187 million pounds ($355.3 million at year-end 1990 exchange rates) in 1990.

Nearly 70% of Royal's 1991 loss—257 million pounds ($480.6 million)—came from British mortgage indemnity guarantee business, which accounted for only 10 million pounds ($18.7 million) of losses in 1990.

MIG policies are single-premium policies that indemnify lenders against losses if a borrower defaults on a mortgage loan.

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S&P sees chance of Lloyd's 'liquidity crunch'

By GAVIN SOUTER

LONDON—Lloyd's of London may face a "liquidity crunch" as a result of court action taken by more than 700 members against the market, says Standard & Poor's Corp.

Unless members pay cash calls, some syndicates will have to rely on the Lloyd's Central Fund to pay their losses, the credit rating agency says.

Lloyd's quickly rebutted the S&P analysis, calling it "misleading and potentially damaging."

Around 700 members of Lloyd's facing huge losses are refusing to pay cash calls. They are seeking injunctions in the High Court in London to prevent their members' agents from drawing down on their Lloyd's funds (*BI*, March 9; March 2).

If the action is successful, it could severely hurt Lloyd's finances, S&P said.

Lloyd's will report a 1990 year-end deficit of 1.2 billion pounds ($2.28 billion at year-end 1990 exchange rates), which will have to be met by members, S&P said. Members' funds at Lloyd's stood at 3.8 billion pounds ($7.22 billion at current exchange rates) at year-end 1990. But, if the members prevail in court, the Central Fund at Lloyd's will be called on to pay losses not met by members, S&P said.

At the end of 1990, the Central fund stood at 347 million pounds ($659.3 million). Since then, it has grown to about 500 million pounds ($860 million), according to Lloyd's.

If the members seeking an injunction are successful, others facing large losses will be encouraged to seek injunctions as well, said Stuart Shipperlee, director of business development in Europe for S&P Insurance Rating Services.

"There is the potential for a vicious circle of litigation," he said.

It is unlikely that all members will seek to prevent a drawdown on their funds at Lloyd's because many members who have made profits "have no ax to grind," he said.

But if enough members block the drawdowns, Lloyd's might have to bolster the Central Fund through a levy on all members, Mr. Shipperlee said.

Lloyd's quickly rebutted the S&P analysis.

"I deplore the action of a respected and responsible organization such as S&P in issuing a misleading and potentially damaging statement," said Chairman David Coleridge.

S&P contrasts readily realizable assets with total figures for projected liabilities to arrive at an estimated Lloyd's deficit of 1.2 billion pounds, Lloyd's said.

"These liabilities include substantial amounts which will not fall due for payment until the end of the century and, in many cases, into the next century," Lloyd's said in a statement.

At the end of 1990 Lloyd's had declared resources of 18 billion pounds ($34.02 billion), which is 6.5 billion pounds ($12.35 billion) more than estimated future liabilities, Lloyd's said.

S&P also used 1990 figures of the amount of members' funds at Lloyd's, Lloyd's said. The current figure is 4.7 billion pounds ($8.08 billion). ■

INTERNATIONAL

Loss from Expo fire could total $40 million

By MARIA KIELMAS

SEVILLE, Spain—Insured damage from a fire in the Pavilion of Discoveries at Expo '92, the world's fair scheduled to open next month, could total $40 million.

That estimate includes about $20 million for damage to the pavilion and another $20 million for damage to its contents, according to Spanish insurance sources.

But loss adjusters are still estimating the exact loss from the Feb. 18 fire, which severely damaged the pavilion, considered the centerpiece of the world's fair celebrating the 500th anniversary of Columbus' discovery of America.

Risk management services for Expo '92, which opens April 18 and runs through October, are primarily provided by Gavial Alexander S.A. The Madrid-based broker is 90% owned by Alexander & Alexander Services Inc. and 10% owned by the Spanish bank, Banco Bilbao Vizcaya. BBV has financed a major part of the exposition (*BI*, Oct. 15, 1990).

Manuel Vivas, Gavial Alexander's chief executive and managing director, said he was as yet unable to provide any definitive loss figure.

How the fire started still is unclear, said Mr. Vivas. One theory is that the blaze was ignited by sparks from a welding torch.

Responding to widespread reports and criticism that there were no fire extinguishers in the pavilion, Mr. Vivas said, "Fire extinguishers are the last thing you put in after the contractor finishes work. The fire system was not working as construction had not yet finished."

One unusual part of the Pavilion of Discoveries, the Omnirom circular cinema, has been saved, Mr. Vivas said. But a number of old books, an old car and a replica of a spaceship were destroyed.

Risk management services for Expo '92 are provided by an association of brokers known as Union Temporal de Empresas, which includes Gavial Alexander and Spanish broker Correduria Tecnica Aseguradora S.A. (CTG). CTG is wholly owned by Banco Exterior, the state-owned foreign trade bank.

Expo '92 has purchased $1 billion in property insurance covering the exhibition's infrastructure, with an additional $500 million limits covering the exhibition's pavilions. The fair also has purchased $100 million of liability insurance.

Coverage is placed with a consortium of Spanish insurers: Mapfre Group; Banco Vitalicio de Espana C.A. de Seguros; Hercules Hispano; Aurora Polar; La Estrella S.A. de Seguros; state insurer Musini Sociedad Mutual de Seguros y Reaseguros; Plus Ultra de Seguros y Reaseguros, now part of British-based Norwich Union Fire Insurance Society Ltd.; Union Iberoamericana C.A. de Seguros y Reaseguros, which is half-owned by Zurich Insurance Co.; and the local Seville insurer, Prevision Espanola.

Mapfre writes 30% of the coverage, and Estrella and Hercules Hispano write 15% each. The remaining insurers have minor shares.

The coverage is reinsured with Munich Reinsurance Co. and Lloyd's of London syndicates, Mr. Vivas said.

To date the loss record has been "very good," he added. The first major loss occurred in 1989 after a severe rainfall caused $50,000 in insured damage to a bridge.

The exposition also purchases property insurance covering terrorist acts from the state catastrophe insurance system, Consorcio de Compensacion de Seguros, which is administered by the Ministry of Finance.

Mr. Vivas says that security against terrorist attacks at Expo '92 and the Barcelona Olympics has been a major concern. ■

INTERNATIONAL

GLOBAL BRIEFS

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business interruption claims in Germany cost market leader Allianz Versicherungs A.G. 695 million deutsche marks ($458.8 million) last year, against premium income of 533 million deutsche marks ($319.2 million), the Munich-based insurance company reported.

Allianz Director Uwe Haasen announced that the insurer would take several measures to return the business to profitability, including raising rates and requiring tougher loss prevention measures.

Nevertheless, Mr. Haasen said the insurer's overall picture is "positive."

As a result of insurers' losses, 1992 property insurance renewal rates have been increased substantially for many German companies.

For example, chemical producer BASF A.G. saw its business interruption rates climb to 1.08 deutsche marks (65 cents at current exchange rates) per 1,000 deutsche marks ($598.8) in value, from 0.52 deutsche marks.

In addition, the company raised its self-retention on business interruption risks to 25 million deutsche marks ($15 million) per claim from 10 million deutsche marks ($6 million).

Chemical and pharmaceutical manufacturer Bayer A.G. also witnessed an increase in its commercial property and business interruption premiums, although a spokesman for the company would only say the rate increase is "substantial."

"The situation is not likely to ease in the near future," says Mr. Rieger. "The only thing really helping insurers is their personal lines business."

But even that line is proving difficult for German insurers. Consumer groups in Germany recently alleged insurers are subsidizing their losses by hiking life insurance premiums.

—By Don Lewis Kirk

Turkish mine disaster

ISTANBUL, Turkey—Families of the more than 270 miners killed in a Turkish coal mine disaster earlier this month will likely only receive government social security payments to compensate them for their losses.

The workers were killed when methane gas rapidly accumulated in the mine and exploded. The gas build-up reportedly was too quick for safety equipment to warn of the danger.

The accident occurred at the Incirharmani mine owned by state mining company T.K.I., according to a spokesman for broker Alexander & Alexander Sigorta Musavirlik A.S. in Istanbul.

Turkey has no statutory employers liability or workers compensation insurance requirements, he said.

Social security payments would amount to 50% of a killed worker's monthly salary and would be paid to his spouse if the worker had no other income and the spouse has no other income. And 25% of the worker's monthly income would be paid to dependent children under the age of 20, or to age 25 if the dependents are still in school.

But the overall payments are subject to a salary ceiling of about 350 pounds a month ($600 at current exchange rates), said the A&A spokesman.

Although T.K.I. is a large shareholder of Ankara Insurance Co., with which its insurance coverages are placed, the mining company does not carry employers liability insurance, the A&A spokesman believes.

Employers liability insurance typically is bought by only a few private companies in Turkey. However, that may change, the spokesman said, following a recent court award of about 200,000 pounds ($343,400) to a worker who lost his arm in a workplace accident.

—By Stacy Shapiro

Political risk policy

SYDNEY, Australia—The Australian government's Export Finance & Insurance Corp. has underwritten political risk coverage for the $1.1 billion Kutubu oil well and pipeline under construction in Papua New Guinea.

Kutubu, managed by San Francisco-based Chevron Corp., is a joint venture among Chevron; Australian companies Ampol Exploration Ltd., BHP Ltd. and BP Australia Ltd.; Papua New Guinea-based Oil Search Ltd.; and Merlin Petroleum, acquired last year by Japan-PNG Petroleum Ltd., a subsidiary of Tokyo-based Mitsubishi Oil & Petroleum.

J. Slater Smith, divisional manager-lending at the Sydney-based EFIC, said the coverage was provided to a syndicate of 17 Australian and international banks that are providing financing for Kutubu.

The banks imposed the political risk coverage as a condition for financing the project. The coverage has limits of $260 million, which is the value of equipment and services purchased in Australia by the joint-venture partners, Mr. Smith explained.

The coverage will be in effect throughout the duration of the financing, up to seven years.

Coverages written by EFIC are backed by the Australian government.

Mr. Smith said the Kutubu coverage was the largest policy EFIC had ever provided for a single overseas project.

The initial production of Kutubu, which should be completed by August, is estimated at 128,000 barrels of oil a day, and the project is expected to have a 16-year life span.

—By Kate McIlwaine

U.K. insurers

Continued from page 23

Insurers blame rising claims on high interest rates and rising unemployment (*BI*, Dec. 9, 1991).

"In 1990 the loss was caused by extreme weather conditions. In 1991 it was principally the severe economic recession," said Richard Gamble, group chief executive.

Recession-related fire and theft claims also contributed to the loss, he said.

Those extensive losses "disguised" improvements in property/casualty business outside the United Kingdom, including Royal's first pretax profit in the United States in four years, Mr. Gamble said.

That profit—3 million pounds ($5.6 million)—compares with a 89 million pound ($169.1 million) loss in 1990.

Royal's premium volume in the United States dropped to 847 million pounds ($1.58 billion) in 1991 from 1.07 billion pounds ($2.03 billion) in 1990.

At General Accident P.L.C., pretax losses shot up more than 40% to 171.6 million pounds ($320.9 million) in 1991 from 121.3 million pounds ($230.5 million) in 1990.

Again, recession-related losses were a major culprit.

"Arson and other crime-related claims were a significant factor in the underlying performance of the account," said Nelson Robertson, general manager.

"Results were also affected by the need to strengthen claims reserves to reflect the deteriorating trend in personal injury liability claims for earlier years," he said.

Commercial property losses rose 15.4% to 75.6 million pounds ($141.4 million) in 1991 from 65.7 million pounds ($124.8 million) in 1990.

Although General Accident raised rates for all lines last year in response to the losses, further increases are on the way, said Mr. Robertson.

General Accident's U.S. loss climbed to 120.2 million pounds ($224.8 million) in 1991, from 79.9 million pounds ($151.8 million) in 1990.

Commercial Union P.L.C. posted a loss of 68.6 million pounds ($128.3 million) in 1991, compared with a slender profit of 1.4 million pounds ($2.7 million) in 1990.

Chief Executive Tony Brend blames the loss on the recession and "extreme competition for general insurance business."

Although CU has a relatively low exposure to the MIG market, its losses from this class increased to

Continued on next page

INTERNATIONAL

U.K. insurers

Continued from previous page

14 million pounds ($26.2 million) in 1991 from 4 million pounds ($7.6 million) in 1990.

CU also suffered significant losses on its London market account, Mr. Brend said.

Its U.S. results improved markedly in 1991: a profit of 32 million pounds ($59.8 million), compared with a 12.9 million pound ($24.5 million) loss a year earlier. Non-life profits accounted for 82.5% of the 1991 U.S. profit.

"The non-life result benefitted from the corrective actions which commenced in the 1980s to reduce costs and improve the insurance portfolio. The increased profit contribution was achieved despite a much higher level of weather catastrophes and a difficult trading environment," said Mr. Brend.

The outlook for U.K. insurers that have yet to report results is equally gloomy.

Sun Alliance Group P.L.C. will post a whopping 473 million pound ($884.5 million) loss for 1991, compared with a 180.9 million pound ($343.7 million) loss in 1990, according to Roman Cizdyn, insurance analyst at Smith New Court Securities Ltd. in London.

MIG business will account for much of that loss, but poor claims experience on other lines of coverage will also hurt Sun Alliance, he said.

"Claims inflation has not yet been overtaken by the rise in premium rates," Mr. Cizdyn said.

David Nisbet, an analyst at County NatWest Securities Ltd. in Edinburgh, projects that MIG losses will account for 320 million pounds ($598.4 million) of a total 460 million pound ($860.2 million) loss for Sun Alliance in 1991.

But recession-related losses will depress other business as well, he said.

"The insurers have been unlucky because the downturn in the insurance cycle has coincided with the recession," Mr. Nisbet said.

Eagle Star Group P.L.C. has also been hit hard by MIG and other recession-related losses, both analysts agree.

Mr. Cizdyn projects Eagle Star's 1991 loss at 375 million pounds ($700.3 million), and Mr. Nisbet is even more pessimistic. He estimates Eagle Star's loss at about 400 million pounds ($748 million), compared with a 1990 loss of 127.9 million pounds ($243 million).

Guardian Royal Exchange P.L.C. is less exposed to the MIG market than other insurers, but it is still expected to post heavy losses for 1991.

GRE's pretax loss for 1991 will be around 250 million pounds ($467.5 million), compared with a loss of 157.2 million pounds in 1990 ($298.7 million), Mr. Cizdyn said.

GRE will suffer heavy losses due to its large exposure to the British auto insurance market, which posted a poor year in 1991, and also on its employers liability business, he said.

"Old claims like industrial deafness and asbestosis are coming out of the woodwork," Mr. Cizdyn said.

GRE's 1991 loss should hit 220 million pounds ($411.4 million), according to Mr. Nisbet.

"It has been hit by large claims and claims costs on its motor account and generally its U.K. book of business is not of a very good quality," he said. ■

The Professional Marketplace

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NOTICES

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

IN THE MATTER OF THE LIQUIDATION OF LINCOLNWOOD NATIONAL LIFE INSURANCE COMPANY a/k/a UNITED EQUITABLE LIFE INSURANCE COMPANY

NO. 90 CH 7724

NOTICE

PLEASE TAKE NOTICE than on December 20, 1991 an Order of Liquidation with a finding of insolvency was entered against United Equitable Life Insurance Company by the Honorable Lester D. Foreman, Judge of the Circuit Court of Cook County, Illinois. Stephen F. Selcke, Director of Insurance for the State of Illinois is the statutory and court appointed Liquidator of the United Equitable Life Insurance Company.

TAKE FURTHER NOTICE that pursuant to the order of liquidation, all rights and liabilities of United Equitable Life Insurance Company and its creditors, policyholders and all other persons or entities who may have a claim against its assets are fixed as of December 20, 1991, unless otherwise provided by a subsequent order of the court.

TAKE FURTHER NOTICE that any and all persons, partnerships, corporations, associations, estates, trusts and governmental units having or claiming to have any accounts, debts, claims or demands against United Equitable Life Insurance Company or claiming any right, title or interest in or to any funds or property of United Equitable Life Insurance Company in the possession of the Liquidator are required to file a Proof of Claim with the Liquidator on or before 4:30 p.m. Chicago Time, December 21, 1992.

TAKE FURTHER NOTICE that the form of and required content of all proofs of claim are described in the Illinois Revised Statutes, 1991, 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 of United Equitable Life Insurance Company, In Liquidation, 222 Merchandise Mart Plaza, Suite 1450, Chicago, Illinois 60654. Filing shall occur upon receipt of Proof of Claim by the Liquidator. The Liquidator reserves the right to require such additional information with respect to any claims as he may deem necessary. The Liquidator further reserves all rights to any and all defenses of United Equitable Life Insurance Company concerning such claim. All Proofs of Claim must be duly sworn to before an officer authorized to take oaths.

THE LAST DATE FOR THE FILING OF PROOFS OF CLAIMS WITH THE LIQUIDATOR AT THE ABOVE MENTIONED OFFICE OF HIS SPECIAL DEPUTY LIQUIDATOR IS DECEMBER 21, 1992 AT 4:30 P.M. CHICAGO TIME. NO PERSON HAVING OR CLAIMING TO HAVE ANY CLAIMS AGAINST UNITED EQUITABLE LIFE INSURANCE COMPANY SHALL PARTICIPATE IN ANY DISTRIBUTION OF THE ASSETS OF THE COMPANY UNLESS THE CLAIMS ARE FILED WITH THE LIQUIDATOR ON OR BEFORE DECEMBER 21, 1992 AT 4:30 P.M.

James W. Schacht, Special Deputy Liquidator, Office of the Special Deputy Receiver, 222 Merchandise Mart Plaza, Suite 1450, Chicago, Illinois 60654, (312) 836-9500.

Business Insurance

Circulation Breakdown*

Commercial Consumers

Administrative:
CEO's Presidents, and Owners 2,498
Vice-Presidents, General Managers and Other Administrative Personnel 4,175

Financial:
Chief Financial Officers and Vice-presidents of Finance 2,811
Secretaries, Treasurers, controllers and other Financial Personnel 4,204

Risk/Employee Benefits:
Vice-presidents, directors, managers, and other related department personnel of: insurance, risk, employee benefits, personnel, compensation, pension, safety, security, industrial relations, human resources and employee/labor relations 11,995

Sub-total 25,683

Associations 442
Government, unions and Educational Institutions 1,261

Commercial Consumers

Sub-total 27,386

Insurance Agents and Brokers 9,090
Insurance Companies .. 8,128
Accountants, Actuaries, Attorneys & Consultants 3,340
Adjusters, Appraisers, TPA's, Captive Managers & Health Care Providers 1,529
Others Allied to the Field 1,580
Single Copies 46

TOTAL 51,099

* Source Business/Occupational breakdown of qualified circulation, November 25, 1991 issue, as submitted to BPA for December 1991 BPA Publisher's Statement.

GET RESULTS HERE!

Aon unit buys Media/Professional

Aon Specialty Group signed a definitive agreement last week to acquire Media/Professional Insurance Inc. of Kansas City, Mo.

Aon Specialty Group is a subsidiary of Chciago-based Rollins Burdick Hunter Group Inc., the brokerage and consulting services operation of Aon Corp.

Media/Professional, a specialty underwriting management and claims management firm, provides specialty professional liability insurance products, including errors and omissions coverage, to media and service-oriented businesses. The products are marketed through a nationwide network of brokers and agents, while coverage is arranged through exclusive arrangements with insurers.

Aon Specialty said it plans continue the arrangements. There are no plans to relocate Media/Professional or change its management structure.

"This acquisition affirms Aon Specialty Group's commitment to identify and pursue strategic niche market opportunities among affinity groups and associations," said Michael D. Rice, chairman of Aon Specialty.

Media/Professional's "specialized programs for the media industry, as well as for insurance agents and certain other service businesses, will augment Aon Specialty Group operations," he said.

"Access to Aon's diversified resources will strengthen the many services we provide for our customers and our insurers," Media/Professionals' co-founders, Bill Bauer and Larry Worrall, said in a joint statement.

A&A sells 4 units

Alexander & Alexander Services Inc. has sold four subsidiaries for approximately $58 million in cash.

Lakeland, Fla.-based Summit Consulting Inc., which primarily administers self-funded workers compensation programs, was acquired by Summit Holding Corp., a company formed by the administrator's management.

In addition, A&A's wholly owned Dutch subsidiary, Alexander Bekouw Holding B.V., has sold three units. Wholesalers Schermer Assuradeuren B.V. and B. Franco Mendes B.V., as well as the insurance portfolio of N.V. Algemeene Verzekering Maatschappij Diligentia van 1890 were acquired by Delta Lloyd Verzekeringsgroep N.V., a unit of Commercial Union P.L.C.

The sales, which are part of a previously announced restructuring plan (*BI* Jan. 20), are expected to generate net aftertax proceeds of $40 million. ■

BC/BS Assn. settles West Virginia suit

CHARLESTON, W.Va.—Blue Cross & Blue Shield Assn. has agreed to pay $8.6 million to settle a lawsuit by creditors of the first-ever BC/BS plan to fail.

BC/BS Assn. of Chicago, the umbrella group for 73 independent plans, said it is not liable for any of the plans' debts, but is settling with the creditors to avoid costly litigation.

Subscribers, providers and other creditors filed claims against Blue Cross & Blue Shield of West Virginia Inc. after the plan went bankrupt in 1990 (*BI*, Oct. 29, 1990).

Following the collapse of that plan, 10 West Virginia hospitals filed a $40 million lawsuit against the BC/BS Assn. and Blue Cross & Blue Shield Mutual of Ohio Inc., which took over the operations of the insolvent plan. The suit charged that national executives concealed the troubles of the West Virginia plan (*BI*, Feb. 4, 1991).

The settlement "is contingent upon final court approval and dismissal of the litigation in West Virginia involving the association, and the satisfaction of other conditions," the association said. The payment would come out of its $136 million operating budget.

Blue Cross & Blue Shield Mutual of Ohio has no plans to settle the suit against it, which is still pending, a spokesman said.

Total claims against the West Virginia plan, which was insolvent by more than $37 million, exceed $53 million. ■

Decaminada

Continued from page 3

tions of law, he said.

Explaining three major techniques of alternative dispute resolution, Mr. Decaminada said that arbitration occurs when disputing parties agree to hand their differences to a third party for a final and binding decision.

Mediation involves having the parties attempt to resolve their differences with the aid of a neutral third party.

A minitrial, which can be tailored to the disputing parties' guidelines, allows a third party to listen to the arguments of both parties. The third party then offers his or her opinion of the strengths and weaknesses of each side's case and an opinion on the likely outcome if the case went to trial.

Mr. Decaminada noted that some industries, notably the construction industry, have relied on ADR for decades. Major construction contracts often require the use of ADR techniques to settle disputes, which are nearly inevitable in large building projects with numerous contractors, he said.

"But ADR has not been part and parcel of the insurance industry," said Mr. Decaminada, who said he wants that to change.

"I think ADR is the trend of the future. The better we use it—the more society benefits," he said.

Mr. Decaminada said that every insurance company chooses how much or how little it will use ADR. However, as president of the association, "what I would like to do is carry the message, participate in industry programs and let it be known" that ADR is an option for insurers.

For example, Mr. Decaminada will moderate a panel discussion of ADR in the insurance industry at the annual meeting of the Society of Chartered Property & Casualty Underwriters' in October.

Adapting ADR to the insurance industry is not without its problems, he pointed out. Among some claims adjusters, who are accustomed to knock-down drag-out fights, non-confrontational ADR is almost viewed as the coward's way out, he said.

However, younger claims adjusters are generally more receptive to using ADR than some of the older adjusters who favor confrontational tactics, he pointed out.

Insurer defense lawyers, who know from whence their money comes, also are not always enthusiastic about using ADR, he added.

Mr. Decaminada pointed out that ADR does not mean that insurer claims payouts will necessarily be smaller. The savings come in time and legal fees, he said.

When discussing ADR, Mr. Decaminada likes to quote Abraham Lincoln, who once said: "Persuade your neighbor when you can."

"I think that makes a lot of sense," Mr. Decaminada said.

Robert Coulson, president of the American Arbitration Assn., agreed with Mr. Decaminada's assessment.

"The insurance industry is the industry that's most in need of ADR," Mr. Coulson said.

"The cost crunch of using defense lawyers and the courts is an incredibly high cost of doing business," he said.

For insurers, using ADR where practical "is a plain business decision," said Mr. Coulson.

The American Arbitration Assn., which was founded in 1926, has approximately 8,000 members representing businesses, labor unions, law firms and others. It administers about 50,000 disputes annually and can draw on 55,000 impartial experts to hear cases.

Mr. Decaminada said that many major insurers belong the association. "Most companies, if not all of the major insurers, have used the association's services" at one point or another, he said.

For further information on the American Arbitration Assn., contact the association at 140 W. 51st St., New York, N.Y. 10020-1203. ■

INTERNATIONAL

U.K. pensions

Continued from page 23

ain are covered by these private pension plans, according to the committee.

Of those, 19 million belong to occupational pension plans and 4.6 million have their own personal pension plans, the committee said.

"While it is understandable that the growth in occupational pension schemes should have been piecemeal, it is less understandable why the political parties have allowed a system of pension provisions to arise for which the legal basis is medieval trust law," the committee said.

Trust laws were instituted to prevent the dispersal of large estates and to protect widows and children who were thought to be unable to manage their own assets, the committee said.

"Yet from the early years of this century, employers, when establishing an occupational pension scheme, found the trust law provided a convenient, legal basis on which to proceed," the committee said.

However, trust law provides an inadequate framework for occupational pension plans and should be replaced with a new pensions act, the committee said.

"The drawing up of such a bill should be a priority of the incoming government after the general election" on April 9, the committee said.

A new pension act should also establish clear guidelines on the ownership and the management of pension plan assets, the committee said.

The current law allowed Mr. Maxwell to do as he wished with the Mirror and MCC pension funds without consulting fund members, the committee said.

According to Peter Jackson, a trustee of the Mirror pension fund, Mr. Maxwell was able to force others to follow his wishes at the trustee meetings.

"The style of the meetings was that you would be kept waiting around for hours. . .and suddenly he would whirl in, in his shirt sleeves, and conduct two hours of business in five or six minutes. You just could not raise matters; they were steamrollered through. The helicopter would arrive, and out he would go in a puff of smoke, and you were left asking, 'What was that?' " Mr. Jackson testified before the committee.

In the future, plan trustees should have the right to seek independent expert advice, the committee recommended.

Also, independent trustees should be appointed to serve as custodians of pension fund investment assets, the committee said.

And plan participants should receive an annual statement, approved by auditors, detailing the value of assets in a pension plan and where they are deposited, the committee said.

The professional advisers involved in the Maxwell pension funds were also criticized by the committee.

"Pontius Pilate would have blushed at the spectacle" of so many witnesses coming before the committee and "washing their hands" of their responsibility for this affair, the committee said. In particular, actuaries do not seem to be concerned about reporting to pension fund members on whether the fund is operated in a fit and proper manner, the committee said.

"We recommend that this broadening of the actuaries' role should take place either by raising the profession's current standards or with the support of legislation," the committee said.

The role of the Maxwell funds' auditor, Coopers & Lybrand Deloitte, which is also auditor to all of the Maxwell companies, was also criticized by the committee.

"The same auditor should not be used in any other business activity of the employer while acting as auditor of the pension fund," the committee said.

Also, the banks that hold pension fund "shares," which Mr. Maxwell pledged to secure loans, should return them to the funds on "moral if not legal" grounds, the committee said.

And the activities of the banks that dealt in or acquired these shares should be investigated, the committee said.

The National Assn. of Pension Funds welcomed the report.

"On the whole, we think it is a good idea to have a long-term view of pension legislation rather than come up with instant solutions," said Mike Brown, director of information services for the group.

Meanwhile, Mirror Group Newspapers will stop making pension payments to members of the Maxwell Communication Work Pension Scheme as of June 30.

Most of the plan participants did not work for MGN, according to the company.

The company has kept up the payments since the loss of the pension funds' assets was revealed.

"The future viability of the company prevent the maintenance of benefits to those who had no connection with Mirror Group newspapers," the company said. ■

Rating agencies

Continued from page 3

on Life Insurance survey found that only one-half of consumers considered the life insurance industry financially strong in 1991. "A focus on life insurers' financial strength has been established and consumers will continue to be interested in it," he said.

That concern is not entirely without merit, rating agency executives say.

Commercial real estate exposure "remains a negative" in raters' eyes, said Mr. Meigs. "Losses due to poor performing real estate are a serious problem for some companies."

"There are some weak companies," Mr. Taub said, noting that regulators have had to take some type of action against 350 companies in the last five years because of financial problems, including real estate exposures.

"The life insurance industry is significantly more exposed to commercial real estate than it is to junk bonds, and a near-to-medium-term solution to the problem of declining commercial real estate values is currently not in sight," said Moody's Mr. Murray.

"During the 1980s, the life insurance industry underwent rapid and unprecedented changes," Mr. Murray explained. "The catalyst for these changes came from a variety of sources, including double-digit inflation, high interest rates and increased competition from other financial intermediaries for savings.

"A proliferation of new insurance products during the 1980s prompted a dramatic shift away from stable, traditional life and annuity products, and toward new interest-sensitive, investment-type products," he said. And that product shift led many life insurers to take on riskier assets.

"Asset quality deterioration and policyholder loss of confidence led to seizures of six major insurance companies in 1991, dealing a serious blow to the industry's pristine image," Mr. Murray added.

If the real estate market continues to deteriorate, and more large life insurance companies are seized, the industry's image will be further damaged, he noted.

While worries about the life/health insurance industry did intensify following the collapse of Executive Life Insurance Co., Mutual Benefit Life Insurance Co. and First Capital Holdings Corp., those incidents do not mean the industry in general is beyond repair, Mr. Taub said.

"There is no question that Executive Life and Mutual Benefit had financial difficulties," he said in an interview. But, "none of them became insolvent. . .each of them had a situation where the market lost confidence and then there was a run that resulted in the regulators having to step in."

While the life insurance industry as a whole is in pretty good shape, it will have to "return to basics" in the 1990s in order to strengthen itself, Mr. Murray suggested. A "resurgent conservatism" among company managements has led many to reduce growth expectations in the last six months.

"Most are trying to improve their overall asset quality by decreasing their junk bond exposure and by investing new money in high-quality assets," Mr. Murray said. And, managements "appear to be focusing on what their companies do best" by "divesting non-core operations, withdrawing from unprofitable lines of business and abandoning the idea of being all things to all people," he said.

Still, real estate exposures could haunt insurers. A worst-case scenario real estate slump would "dramatically reduce the financial strength of the industry and lead to sharply lower financial strength ratings," Mr. Murray said.

And, he noted, "it is certainly possible that insurance companies of meaningful size could fail over the course of the next few years."

Meanwhile, Mr. Meigs of Duff & Phelps suggested that "in many respects, the raters of insurance companies have emerged as the de facto regulators of insurance companies."

Given the importance now attached to ratings, rating agencies may have some special responsibilities to insurers, he said.

While rating agencies' primary responsibility is to policyholders and contract holders, "raters must also be cognizant of other key constituencies such as agents and brokers, employees and management of the companies being rated," said Mr. Meigs of Duff & Phelps. Duff & Phelps is the only major rating agency not named in a suit by California insurance regulators over the collapse of Executive Life (*BI*, March 2).

Rating agencies must be aware that their actions directly affect how agents, brokers, employees and the insurer's management perceive the company, Mr. Meigs said. And, agencies must keep in mind that ratings have "a direct relationship to the insurer's ability to write new business," he said, noting that downgrades can significantly hurt sales and operations.

Mr. Meigs suggested that raters "maintain a long-term view of the insurance industry and thus avoid precipitous rating actions." While the industry is clearly sensitive to business and economic cycles, "ratings need to be established in anticipation of such cycles so that rating stability is maintained through cycles," he said.

Also, rating agencies should "avoid rating actions that become self-fulfilling prophecies" and "avoid the herd instinct," he said.

Another session speaker, Eric M. Simpson, assistant vp in the property/casualty department of A.M. Best Co., spoke about the National Assn. of Insurance Commissioners risk-based capital proposal.

Michael R. Pauletich, a senior consultant with Russell Miller Inc.'s Consulting Services Group, moderated the discussion. ■

Meeting focused on redefinition

SAN FRANCISCO—A record crowd of about 160 turned out for the fourth annual Russell Miller Inc. National Insurance Symposium Leadership Conference held in the "City by the Bay" March 1-3.

The theme of the meeting was "The Insurance Industry Redefining Itself." The heads of major property/casualty, life/health and surplus lines insurance companies and top brokers spoke at the meeting.

Panel discussions included advice on successful business strategies for the 1990s and the importance of global business expansion.

In addition, representatives of the leading rating agencies described how they rate insurance companies and offered their views on the overall strength of the life/health industry.

Russell Miller Inc. is an investment banking and consulting firm that specializes in the insurance industry. Its 1993 symposium is scheduled to be held in April in San Francisco.

For more information, contact Alice Berreyesa, Director of Marketing, Russell Miller Inc., 300 Montgomery St., San Francisco, Calif. 94104; 415-956-7474.

—By Christine Woolsey

Washington again finds more workplace injuries

OLYMPIA, Wash.—Workplace injuries and illnesses reported in Washington state increased for the fifth consecutive year, according to statistics compiled by the Department of Labor and Industries.

There were 11.6 injuries or illnesses per 100 full-time workers in 1990, up from 11.3 per 100 workers in 1989, the latest years for which figures are available, the department reports.

Repeated trauma disorder, including carpal tunnel syndrome, was responsible for the greatest number of illness cases: 3,734 injuries in 1990, compared with 2,485 cases in 1989.

The annual survey, which is mandated by the Occupational Safety and Health Administration, tracks an average of 10,000 randomly selected employers by business class, like agriculture, fishing, forestry, mining, retail trade and wholesale trade. The survey is intended to spot emerging trends in workplace accidents and illnesses, said a spokesman for the Washington State Insurance Commissioner's Office.

Manufacturing firms were the leading source of workplace injuries in 1990, the survey found. There were 29.6 cases of injury or illness per 100 workers among fabricated metal products employers, followed by 28.3 cases per 100 workers among primary metal products employers.

Other high-risk industries include lumber and wood products, 25.5 cases per 100 workers; furniture and fixtures, 25.4 cases per 100; and general building construction, 23.7 cases per 100.

Mining was the only industry to report a reduction in its injury rate. Its rate dropped to 8.5 cases per 100 workers in 1991 from 11.6 cases the previous year.

The greatest rate increase came in wholesale trade, for which the injury rate rose to 11.9 per 100 workers in 1990 from 10.6 in 1989.

—By Laura Mazzuca

Fronting proposal

Continued from page 1

"We'll make a last review of what we have now, consider the industry's comments and hopefully have something to present to the Reinsurance Task Force in Seattle later this month," said Mr. Laurenzano at an open meeting held last week in New York to discuss the latest draft of the model act, which was issued Feb. 21.

Mr. Brown, along with about 30 other members of the captive and reinsurance industry, took advantage of the meeting to once again—and possibly for the last time—voice their disapproval with several key restrictions being proposed by Mr. Laurenzano's group.

RIMS and other industry groups represented at last Wednesday's meeting cited three key concerns with the latest fronting proposal:

• The definition of a captive.

Currently, the draft requires that multiple-owner captives seeking to act as reinsurers be engaged in businesses or activities similar or related to the risks being insured.

"As the definition of a captive reads now, a large number of multiple-owner captives with heterogeneous owners would not be permitted to act as a reinsurer. We believe it is unnecessary that owners be required to be involved in the same business as what's being written," Mr. Brown said.

Malcolm Butterfield, Bermuda's registrar of companies and the island's captive insurance regulator, agreed.

"With insurance being such a necessary part of our economy in Bermuda, we are keeping ourselves updated on these issues and strongly suggest that the committee redefine captives to include heterogeneous multi-owner captives," said Mr. Butterfield.

However, the NAIC's Mr. Laurenzano said owners not involved in a similar business shouldn't be forming a group captive in the first place.

"If the companies don't have similar experience, it seems to me that they shouldn't be in the captive business. It's too dangerous," he said.

"We have no problems with six oil companies forming a captive to write reinsurance for oil risks. That's a totally legitimate fronting arrangement. What I'm worried about is an oil company, a car maker and a widget company forming a captive to write liability insurance for taxi cabs. That's not a solid arrangement," Mr. Laurenzano said in an interview following the meeting.

• A clause that would prohibit captives that serve as reinsurers for licensed insurers from setting loss reserves.

The clause currently stipulates that the fronting insurer or an independent actuary must set loss reserves on fronted business.

"We firmly believe the fronting insurer should retain the right to delegate activities such as setting initial loss reserves," said Mr. Brown. "This is very important because the expertise resides with the captive. And we don't believe objectivity will be lost because the reserves must still be audited by the fronting insurer or an independent auditor.

Prohibiting the licensed insurer from delegating reserve-setting responsibilities is "overly burdensome," Mr. Brown insisted.

However, Mr. Laurenzano countered by saying, "We can't have the same company that's setting reserves posting collateral for losses. There's such an inherent conflict of interest under this scenario. You'd be creating a toothless tiger."

He added that the history of licensed companies collecting collateral from offshore captives that have set their own reserves is poor.

"I don't see a lot of room for movement on this issue. We're pretty adamant," Mr. Laurenzano said. "I'm not trying to kill captives, but the licensed company should establish reserves for losses that it's ultimately responsible for, and captives should post collateral. At this point, we're not willing to allow fronting companies to give away the responsibility of setting reserves."

'We firmly believe the fronting insurer should retain the right to delegate activities such as setting initial loss reserves,' says Mr. Brown of RIMS. 'This is very important because the expertise resides with the captive.'

• A requirement that if any minimum contract provisions are materially breached by a captive reinsurer, the fronting company shall immediately draw upon all letters of credit and other collateral held in connection with the reinsurance.

"This is a burning issue for us. Any bill that forces an insurer to call upon all collateral for any breach is extremely harsh. We'd accept the proposal if it *authorized* a fronting insurer to call upon collateral, but to force it to do so is too much," said Mr. Brown in an interview after the meeting.

"In addition, we believe the minimum contract requirements are too burdensome. As they're written now, many captives couldn't even meet them," he said.

Specifically, the draft calls for a captive reinsurer to post collateral in cash or letters of credit equal to 100% of the liabilities it is assuming, as well as comply with one or more of the following provisions:

• The reinsurer must maintain additional security equal to 25% of the ceded liabilities.

RIMS suggests that an additional 15% would be more appropriate.

• Non-life reinsurers must maintain surplus equal to 25% of gross premiums written.

RIMS advocates that captives be required to possess capital and surplus equivalent to 33% of net premiums written.

Life insurers would be required to post not less than 5% of statutory assets in capital and surplus, under the current draft.

• If the reinsurer is a single-parent captive, the parent shall maintain a net worth of at least $50 million.

Mr. Brown recommended that $25 million net worth would be more workable. "Requiring $50 million in parental indemnification is just too high. It would eliminate more than half of the captives in existence," he said.

In response to these complaints, the NAIC's Mr. Laurenzano said the working group would probably be willing to "soften" the language on whether an insurer would be forced to call on all collateral in the instance of a material breach of standards.

"We probably will change this language somewhat," he said. "I don't know if the changes will completely satisfy everyone, but the wording will be softened. I think we'll rewrite the clause to say the insurer may or can call on collateral."

However, as far as the minimum contract requirements are concerned, Mr. Laurenzano said "those requirements are set."

During the meeting, representatives from several large insurer associations also voiced their opposition to the fronting draft, though they did not address specific proposals.

Bradley L. Kading, vp and director-state legislative affairs with the Reinsurance Assn. of America in Washington, D.C., said if the final model act is patterned after the current draft, "the normal course of business transactions would be interfered with. This goes beyond its supposed focus, which is to prevent abusive transactions. We recommend an alternative approach."

And, Robert L. Zeman, assistant vp and assistant general counsel with the National Assn. of Independent Insurers in Des Plaines, Ill., said that while NAII "supports the movement toward a legitimate model for fronting legislation, we don't see it here. Our companies see this proposal as a prohibition of existing arrangements that are both common and successful." ■

City eyes domestic partner benefits

WASHINGTON—The District of Columbia City Council is scheduled to vote Tuesday on a bill that would extend health care benefits to the domestic partners of city employees.

The Health Care Benefits Expansion Act of 1992 would allow unmarried people, including gay couples, to register as domestic partners with the city. City employees who register with the city would be allowed to extend employer-provided family health care coverage to their partners.

The registration process would require domestic partners to state that they have a committed, familial relationship with the city employee and that they are each other's sole domestic partner. Coverage would also be extended to a dependent child of a domestic partner. Domestic partners must be residents of Washington, D.C.

District law already allows private companies that extend health care benefits to domestic partners to take a tax deduction, under certain circumstances.

Several conservative members of Congress have said that they will try to repeal the proposed law if it wins approval. The measure won initial approval on March 3, but the bill must be voted on again because it was amended to allow relatives who live together to qualify for the health care coverage extension.

—By Mark A. Hofmann

17 firms receive URAC certification

WASHINGTON—The Utilization Review Accreditation Commission has certified the first 17 utilization review firms to meet its national performance standards.

URAC certification still is voluntary in most states. However, some states now are mandating URAC approval for firms operating within the state, said URAC Chairman Dr. Robert Becker. Other states will waive state certification requirements for UR firms approved by the commission, he added.

URAC was created in 1990 in an attempt to increase the quality of UR services. Its national standards were jointly developed by organizations including the American Medical Assn., the Health Insurance Assn. of America, the Washington Business Group on Health and the National Assn. of Manufacturers (*BI*, Feb. 19, 1990.)

The certified firms are: Blue Cross & Blue Shield of Georgia Inc.-Custom Care USA in Columbus, Ga.; Blue Cross & Blue Shield of Ohio-Custom Care USA in Cleveland; Blue Cross & Blue Shield of Texas Inc. in Richardson, Texas; Blue Cross & Blue Shield United of Wisconsin-Custom Care USA in Milwaukee; Crawford & Co., headquartered in Atlanta; HHS Inc. in Grand Rapids, Mich.; Health Care Excellence in Naperville, Ill.; Health Economics Corp. in Dallas; Health International Inc. in Los Angeles; Health Risk Management Inc. in Minneapolis; HealthCare COMPARE Corp. in Downers Grove, Ill.; Integrated Psych Care Inc. in Toledo, Ohio; Intracorp, headquartered in Berwyn, Pa.; Medical Claims Review Services Inc. in Bethesda, Md.; Pacific Review Services in Cypress, Calif.; Parkside Health Management Corp. in Park Ridge, Ill.; and TAO Inc. in Philadelphia.

—By Christine Woolsey

Insider trading

Aetna Life & Casualty Co.: John F. Donahue, director, disposed of by gift 245 shares of common stock at an unreported price per share on Nov. 8 and now directly and indirectly holds 451,116 common shares.

Michael E. Mateja, vp, sold 1,000 shares of common stock at $44.38 per share on Jan. 14 and now directly and indirectly holds 8,899 common shares.

Aetna stock was trading at $43.63 per share on March 6.

American International Group Inc.: Patrick J. Foley, officer, disposed of by gift 200 shares of common stock at an unreported price per share on Nov. 27 and now directly and indirectly holds 15,331 common shares.

AIG stock was trading at $88.25 per share on March 6.

CIGNA Corp.: Gary A. Swords, vp, sold 423 shares of common stock at $52 per share on Nov. 4 and now directly holds 1,500 common shares.

CIGNA stock was trading at $56.13 per share on March 6.

Arthur J. Gallagher & Co.: Robert E. Gallagher, chairman, disposed of by gift 9,000 shares of common stock at an unreported price per share on Sept. 3 and now directly and indirectly holds 772,809 common shares.

Gallagher stock was trading at $24.38 per share on March 6.

Frank B. Hall & Co. Inc.: Saul P. Steinberg, director and beneficial owner, indirectly purchased 920,000 shares of common stock at between $3.62 and $5.34 per share from Dec. 2 to Dec. 20 and now indirectly holds 31.36 million common shares.

Frank B. Hall stock was trading at $3.75 per share on March 6.

Ohio Casualty Corp.: Joseph L. Marcum, chairman, disposed of by gift 27,378 shares of common stock at an unreported price per share from Dec. 3 to Dec. 11 and now directly and indirectly holds 734,417 common shares.

Ohio Casualty stock was trading at $53.25 per share on March 6.

RLI Corp.: Gerald D. Stephens, officer, director and beneficial owner, indirectly purchased 700 shares of common stock at between $15.75 and $16.13 per share from Nov. 26 to Dec. 24 and now directly and indirectly holds 456,501 common shares.

RLI stock was trading at $20 per share on March 6.

USF&G Corp.: Norman Blake, chairman, purchased 10,000 shares of common stock at $5.88 per share on Dec. 20 and now directly holds 38,000 common shares.

J. Michael Gaffney, vp, purchased 2,000 shares of common stock at $5.88 per share on Dec. 20 and now directly holds 2,500 common shares.

John Maynard Hart, officer, indirectly purchased 4,000 common shares at $5.88 per share on Dec. 19 and now directly and indirectly holds 14,050 common shares.

Edward G. Pickett, vp, purchased 7,000 shares of common stock at $5.75 per share on Dec. 23. Mr. Pickett also indirectly purchased 470 common shares at $6.38 per share on Dec. 15. He now directly and indirectly holds 17,929 common shares.

USF&G stock was trading at $9.13 per share on March 6.

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Insider Trading, compiled by Invest/Net Trading Group Inc. of Fort Lauderdale, Fla., from reports filed with the Securities and Exchange Commission, tracks stock sales and purchases by insurance industry directors and officers. The column is distributed by Tribune Media Services Inc.

Dropdown ruling

Continued from page 2

Meagher & Flom in New York.

But, she added, "it's the first time the question came up to the Court of Appeals. You can't read anything into it."

The majority decided, without comment, to uphold the lower court decision.

However, the three dissenting judges found that the policy was too vague.

The dissenting opinion said that the majority ruling "serves only to encourage excess insurers to draft policies which fail to inform policyholders in clear and unequivocal language that they —and not the excess insurer— bear the risk of an underlying carrier going insolvent."

The dissenting judges cited precedent that calls for ambiguities in policy language to be resolved in favor of policyholders.

The underlying personal injury lawsuit was stayed while the drop down issue was decided, Mr. Gelb said.

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Ambassador Associates, et al. vs. James P. Corcoran, et al. No. 9, New York Court of Appeals; Feb. 13, 1992.

MEWA legislation

Continued from page 1

man said he couldn't comment on the proposal until it is introduced as legislation.

Rep. Hughes said the legislation would provide a remedy for the MEWA abuses that have continued since the late 1970s.

"Fraudulent MEWAs often operate like classic Ponzi schemes," Rep. Hughes said. Administrators collect premiums, pay themselves hefty administrative fees and leave only a small portion of premiums to pay claims, he explained.

According to the General Accounting Office, MEWA failures between January 1988 and June 1991 left 398,000 participants with $123 million in unpaid claims (*BI*, Sept. 23, 1991). And MEWA failures and fraud will become worse if regulation is not beefed up, said Rep. Hughes.

The Nunn and Hughes proposals would join another MEWA regulation bill introduced in the House last year by Rep. Thomas E. Petri, R-Wis.

Unlike the Nunn proposal, which would leave regulation of MEWAs with the states, the Petri bill, H.R. 2773, calls for direct federal regulation of MEWAs that are certified by the Labor Department as meeting specific funding and reporting requirements (*BI*, July 22, 1991).

Only MEWAs that are not federally certified would be regulated by the states under the Petri bill.

Reaction to last week's MEWA proposals was mixed.

The Senate subcommittee proposals "sound great," said William H. McCartney, Nebraska insurance commissioner and president of the National Assn. of Insurance Commissioners.

"This is an area that has frustrated regulators for a number of years. It is an area that has fallen through the cracks of regulation," he said.

Representatives of self-insurers and benefit plan administrators, however, were unhappy with the proposals' emphasis on state oversight of MEWAs.

"We agree that the current laws create ambiguity, but we believe federal standards are needed to effectively regulate MEWAs," said George Pantos, Washington counsel for the Self Insurance Assn. of America, which supports the Petri bill.

"Most of the states don't like MEWAs," noted Frederick D. Hunt, president of the Society of Professional Benefit Administrators in Chevy Chase, Md., which also supports the Petri bill.

"We like the idea of federal standards and certification for MEWAs. However, we are concerned that some states will interpret their monitoring role as an ability to prohibit MEWAs in the jurisdictions," Mr. Hunt said of the Hughes proposal.

The Senate subcommittee's report and recommendations follow several hearings in 1990 and 1991 on MEWA and insurance industry fraud (*BI*, May 21, 1990; July 1, 1991).

Since the passage of ERISA, "con men, crooks and hucksters have been able to take advantage of a continuing regulatory vacuum. . .in the area of self-insured employer-sponsored health benefit programs," the subcommittee concludes in its March 12 report, "Combatting Fraud and Abuse in Employer Sponsored Health Benefit Plans."

"They have built their lavish lifestyles on the shattered lives of innocent men, women and children while regulators have argued with one another over who has jurisdiction (over MEWAs) and whether the problem already has been solved.

"Unless definitive and forceful action is taken by both the federal government and the states, these tragedies will continue unabated," the report says.

The subcommittee report cited several factors impeding effective MEWA regulation, including:

'This is an area that has frustrated regulators for a number of years,' says Mr. McCartney.

- Continuing uncertainty about the states' authority to regulate MEWAs.

Although the Labor Department has maintained that ERISA does not pre-empt state oversight, fraudulent MEWA operators routinely claim an ERISA pre-emption and many have even challenged the states' right of access to MEWA documents that would determine who has jurisdiction over the plans, the report says.

- The failure of the Labor Department to provide state regulators with timely opinions on the ERISA status of individual MEWAs.

Because MEWAs are not required to notify or obtain approval from the Labor Department before marketing themselves as ERISA plans, state regulators cannot get a quick answer from the Labor Department about a given MEWA's status, the report said.

The Labor Department then can take months or years to provide an opinion on a MEWA's status, and these opinions have often failed to address the questions state regulators raised in the first place, the report concludes.

- The lack of effective criminal prosecution in MEWA fraud cases.

Civil judgments and penalties are rarely collected in fraud cases, and civil suits don't prevent con artists from setting up new MEWA schemes, the report notes.

Only the Office of Labor Racketeering—a section of the Labor Department's Office of Inspector General—has aggressively pursued criminal charges against fraudulent MEWA operators, the report says.

The Senate subcommittee report also notes that loopholes in the definition of MEWAs have created opportunities for scam artists.

For example, a benefit plan set up under a collective bargaining agreement is not considered a MEWA under ERISA, the report notes. This has allowed fraudulent operators to avoid state regulation by offering employees "associate membership" in a union, then enrolling them in the union benefit plan.

Fraudulent operators have also tried to avoid the MEWA label by setting up employee leasing firms, which take over the staffs of small companies and lease the employees back while providing payroll, administration and health plan services (*BI*, May 7, 1990).

By appearing to be a single employer, the staff leasing company gets around ERISA's definition of a MEWA as a plan covering workers of two or more employers.

To deal with these various problems, the subcommittee report recommends that ERISA be amended to:

- State clearly that ERISA does not pre-empt the authority of the states to require licensing of all MEWAs.

Noting that Georgia and Michigan have enacted their own MEWA regulation statutes, the subcommittee also encouraged the National Assn. of Insurance Commissioners to develop model legislation to ensure uniformity of regulation among the states.

- Clarify the authority of the states to license third-party providers of services to benefit plans.
- Provide that staff leasing companies that do not exercise "true control" over their employees should not be considered single employers under ERISA.
- Give states the power to request documents from an employee benefit plan to determine whether the plan is a MEWA.
- Make it a criminal offense to misrepresent a benefit plan's ERISA status.

The report also recommends that Congress examine whether ERISA's exception from the MEWA definition for plans set up under collective bargaining agreements is too broad.

The subcommittee also recommends that Congress clarify the authority of the Office of Inspector General to investigate MEWA fraud.

The proposed Hughes legislation is expected to address many of the concerns raised in the Senate subcommittee report.

For example, it would make it a felony for any person to falsely represent to any employee, employer, the Department of Labor or a state the financial viability or risks associated with a MEWA.

The Hughes proposal also would clearly define what types of group arrangements would be considered MEWAs and arrangements that would be exempt from the definition of a MEWA.

That provision is aimed at curbing abuses involving collectively bargained plans, particularly MEWA organizers that have taken advantage of this exemption by setting up employee organizations that appear to be unions but really are not. ■

Update

Firm sued over ELIC annuities

Continued from page 2

department charges that Smith bought the annuities "without adequately investigating the insurer's financial stability, creditworthiness or claims-paying ability." Instead, the purchase was based "upon the comparative low cost of the bid and the resulting increase in the amount of the reversion," the suit charges.

Neal Sutton, vp and general counsel for Smith, declined to comment except to say the company was forced into bankruptcy after it was hit with a $210 million patent infringement verdict in March 1986. It has since emerged from bankruptcy.

The annuitants are expected to receive full payments after the California Insurance Department wraps up the sale of ELIC to French investors. They now receive 70% of promised payments under the department's conservation order.

Smith is the fourth employer to be sued by the Labor Department in connection with ELIC annuity contracts.

Kaye Scholer settlement cover

WASHINGTON—A New York law firm has coverage for at least $20 million of a more than $41 million settlement of a suit by the Office of Thrift Supervision arising from the firm's work for the failed Lincoln Savings & Loan Assn.

Kaye, Scholer, Fierman, Hays & Handler has at least $20 million in professional liability coverage placed by Minet Holdings P.L.C., sources said. Kaye Scholer partners will have to pay any amount above the policy limits.

The settlement was reached shortly after regulators sued the firm for $275 million for allegedly withholding information about Irvine, Calif.-based Lincoln Savings, the most costly S&L failure to date.

Kaye Scholer agreed to pay $25 million by March 31. Subsequent payments of $4 million will be due from 1993 through 1996. Annual interest payments also will have to be made.

The settlement also bars some Kaye Scholer lawyers from doing any work for banks and thrifts. However, in its release, the OTS noted that "a significant majority of partners of the law firm, including members of its banking practice group, were without involvement in the acts that led to the OTS charges."

A Kaye Scholer spokesman said the firm "denies any wrongdoing," and that the firm is "glad to get this behind us."

Louisiana targets Miro's lawyer

LONDON—The Louisiana Insurance Department is pursuing a London court action against Melvyn A. Stein, a lawyer the department alleges helped Carlos Miro divert as much as $5 million from the now-defunct Anglo-American Insurance Co. of Louisiana.

Mr. Stein, with the London law firm of Finers, formed "dummy corporations" used to funnel money out of Anglo-American and served as a director or officer of some of those corporations, the Louisiana department alleges. The department is seeking to amend a pending discovery action against Mr. Stein to add charges that he is a "constructive trustee" of the Anglo-American funds.

Finers has $9 million of legal malpractice insurance, says the Insurance Department, which did not identify the insurer.

Mr. Stein could not be reached for comment.

Mr. Miro is being held in jail in Madrid, Spain, pending extradition on federal mail and wire fraud charges arising from the 1988 collapse of Anglo-American (*BI*, Sept. 30, 1991).

Briefly noted

Policyholders of failed **Executive Life Insurance Co.** are expected to receive nearly $100 million from last week's $1.3 billion conditional settlement of litigation against convicted junk bond dealer Michael Milken and other Drexel Burnham Lambert Inc. officials. The settlement, still subject to review by government agencies, would remove Mr. Milken and other Drexel figures from a suit filed by California Insurance Commissioner John Garamendi (*BI*, March 2). . . .**Edmund F. Kelly** was named president and chief operating officer of Liberty Mutual Insurance Co. of Boston. Mr. Kelly had been one of two group executives who reported directly to the chief executive officer at Aetna Life & Casualty Co. . . .A federal judge in San Francisco dismissed an insurer suit challenging the constitutionality of regulations implementing **Proposition 103**, ruling the issues already are being litigated in state courts (*BI*, Sept. 9, 1991). . . .Federal labeling laws do not pre-empt the consumer warning requirements under California's **Proposition 65**, the 9th U.S. Circuit Court of Appeals ruled. Prop. 65 requires manufacturers to warn consumers and employees of substances that pose a significant risk of causing cancer or birth defects (*BI*, April 4, 1988). . . .The Senate late last week was expected to pass **tax legislation** that would, among other things, simplify pension plan administration and curb the ability of employers and insurers to deny health care coverage to individuals with pre-existing conditions (*BI*, March 13). . . .The Senate Labor and Human Resources Committee approved the **Equal Remedies Act of 1991**, which would eliminate caps set by the Civil Rights Act of 1991 on damages for intentional workplace discrimination based on disability, sex or religion (*BI*, Dec. 9, 1991). . . .The owner and managers of a North Carolina poultry processing plant have each been charged with 25 counts of involuntary manslaughter. A fire at the **Imperial Food Products Inc.** plant last September killed 25 workers and injured 56 others (*BI*, Oct. 7, 1991; Sept. 9, 1991). . . .The **Resolution Trust Corp.** is seeking more than $250 million in separate suits against Deloitte & Touche and KPMG Peat Marwick, alleging gross negligence in audits of savings and loans that subsequently failed.

Crum & Forster

Continued from page 1

United States Fire Insurance Co. wrote environmental impairment liability and general liability insurance policies for Monsanto, according to court papers.

The judgment, if accepted, would be one of the largest bad-faith awards on record. It would be exceeded by the more than $165 million in awards assessed against an American International Group Inc. unit in bad faith litigation connected with the collapse of Technical Equities Corp. (*BI*, March 18, 1991; July 30, 1990). Those awards are on appeal.

Trial Judge Bonnie Leggat of the 71st Judicial District in Marshall is expected within the next few weeks to decide whether to accept the jury's verdict and to rule on damages. Monsanto also could be awarded attorneys' fees and interest.

The jury verdict centers on a web of underlying environmental liability lawsuits filed by homeowners in subdivisions near Houston against Farm & Home Savings Assn., the Kansas City, Mo.-based savings and loan that developed the subdivisions, and others. Monsanto was subsequently brought into the litigation.

Farm & Home and other defendants also were insured by Crum & Forster, Monsanto alleges.

The suits charged that chemical wastes sent by the St. Louis-based chemical company to a nearby chemical reprocessing plant contributed to pollution at a site near the subdivisions, known as "the Brio site."

Farm & Home and Monsanto both settled portions of the litigation, according to the suit. Crum & Forster paid settlements on behalf of Farm & Home but not Monsanto, the suit alleges. Monsanto then sued its insurer for coverage.

As part of the agreement between Farm & Home and Crum & Forster, Farm & Home gave to Crum & Forster total control over Farm & Home's participation in the litigation, the suit alleges.

Crum & Forster then attempted to influence the litigation that had not yet been settled "to attempt to recoup from Monsanto the cost of these settlement payments (to Farm & Home), the substantial defense and litigation costs expended by the Crum & Forster organization, and any settlement and defense costs that might be incurred by the Crum & Forster organization in other Brio site litigation matters," the suit contends.

In addition, Monsanto alleges that Crum & Forster entered into agreements with plaintiffs in the underlying litigation whereby the plaintiffs "conveyed a substantial financial interest in" their claims against Monsanto to Crum & Forster. In addition, the plaintiffs agreed to drop their claims against "all remaining defendants" except Monsanto, the suit says.

"The Crum & Forster organization orchestrated this web of extra-judicial agreements consciously, intentionally and with furtive design and ill will in order to harm Monsanto," the chemical company charged.

However, Monsanto still successfully defended itself in one of the homeowners suits, incurring nearly $13.4 million in attorneys' fees and costs, said David Snively, Monsanto's litigation counsel.

Corporate chief executives 'would have been much more incensed by Crum & Forster's actions than the average juror,' Mr. Nations says.

The plaintiffs are appealing that decision, he said.

The jury in the bad faith case ruled that:

- Various Crum & Forster units violated the Texas deceptive practices law.

The insurers attempted "to recover money for defendants from Monsanto by acquiring a financial interest in, and directing the prosecution of, claims that were being asserted against Monsanto by persons who were not (Crum & Forster's) policyholders," the jury concluded.

In addition, the jury found that these subsidiaries directed the prosecution of one of the homeowner lawsuits "in an attempt to adversely affect or defeat Monsanto's requests for reimbursement under the EIL policy."

The jury awarded Monsanto $13.1 million, slightly less than the nearly $13.4 million in attorneys' costs and expenses Monsanto incurred by defending itself in one case involving subdivision claimants.

This award can be trebled under the state's deceptive practices act, because the subsidiaries acted "knowingly," Mr. Snively said.

- Crum & Forster "failed to exercise good faith and fair dealing" toward Monsanto in connection with the subdivision litigation. On this issue, the jury awarded $13.1 million, not subject to trebling.
- International Insurance violated the Texas Insurance Code by engaging in "an unfair or deceptive act or practice relating to the terms and conditions" of Monsanto's EIL insurance policy. It awarded Monsanto $13.1 million.

The jury also found that International "knowingly" engaged in that conduct, which entitles Monsanto to treble damages under Texas law, Mr. Snively said.

- The defendants' failure to exercise good faith and fair dealing "was specifically intended to cause substantial injury to Monsanto" and exhibited "such an entire want of care" as a result of "conscious indifference to the rights and welfare of Monsanto."

The jury awarded $50 million in punitive damages on this finding.

Texas law caps punitive damages at the greater of $200,000 or four times actual damages.

The jury also ruled that the conduct of Crum & Forster and its subsidiaries was "a joint venture," and the distinct corporate identities of the defendants should be "disregarded."

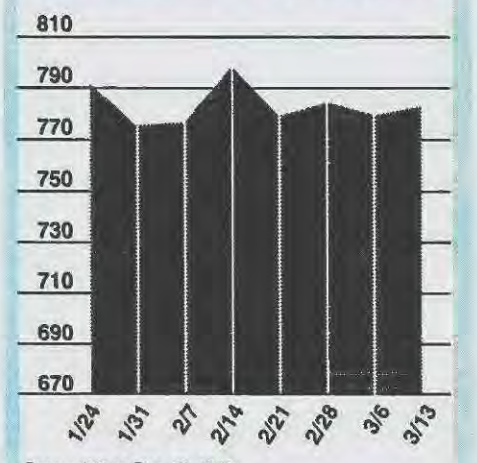
Monsanto is "very pleased" with the jury verdict, though it prefers having a business relationship with an insurer rather than litigating against it, Mr. Snively said.

"Monsanto has actually rendered a very good service for business policyholders all over the country," said Howard Nations, president of the Texas Trial Lawyers Assn. in Houston.

The jury verdict alerts policyholders to be "very careful to make sure that their own interests are being protected" in cases in which its insurer covers more than one defendant or potential defendant.

Mr. Nations also observed: "If this case were tried before a jury of chief executive officers anywhere, the punitive damage award would have been far greater. They would have been much more incensed by Crum & Forster's actions than the average juror." ■

BI Insurance Index



Base = 100 on Dec. 29, 1978
Source: Nordby International Inc.

Insurance industry stocks posted gains last week, as the *Business Insurance* Index rose 3.3 points to 783.1 on March 13, from 779.8 on March 6. Advancing issues were led by Reliance Group Holdings Inc., up 32.3%; Safeguard Health Enterprises, up 14.6%; and Frank B. Hall & Co. Inc., up 16.7%. Declining issues followed Belvedere Corp., down 8.6%; Tokio Marine & Fire Insurance Co. Ltd., down 6.3%; and Re Capital Corp., down 6.2%. The most active issue last week was Sears, Roebuck & Co. (Allstate), 4.4 million shares traded. The *BI* Index was up 0.43%; the Dow Jones 30 Industrials gained 0.44%; the Standard & Poor's 500 was up 0.35; and the New York Stock Exchange Composite increased 0.2%.

British Issues

March 12 Companies	Price pence	P/E	Div. pence	Yield %	1 Week High—Low pence	pence
Commi Union	427	N/M	31.5	7.4	448	427
Genl Accident	437	N/M	35.7	8.2	444	436
Gdn Royal Exch	116	N/M	15.9	13.7	125	116
Royal	188	N/M	15.0	8.0	188	186
Sun Alliance	267	N/M	18.7	7.0	284	267
Brokers						
Bradstock	163	18.3	6.3	3.9	163	161
CE Heath	439	15.4	34.5	7.8	443	439
Hogg Group	185	11.0	10.7	5.8	185	182
JIB Group	190	15.7	10.0	5.3	191	190
Lloyd Thompson	247	24.8	6.0	2.4	247	244
Lowndes Lmbrt	333	16.5	15.3	4.6	333	333
PWS Holdings	62	6.8	5.3	8.5	62	62
Sedgwick Grp	217	16.9	16.0	7.4	220	215
Steel Brrl Jones	299	15.9	16.3	5.5	299	299
Willis Corroon	249	15.7	17.6	7.1	254	247

Source: Philip Olsen, Insurance Industry Analyst, London

BI Industry Stock Report

MARCH 9, 1992 THROUGH MARCH 13, 1992

		Price	Weekly % change	Year to Date % change	Annual High	Annual Low	Vol.(000)	$ Div.	% Yield	P/E	Book value	Mkt/Bk. value
BROKERS												
Alexander & Alexander	NYS	20.88	-0.60	1.83	27.50	18.00	212	1.00	4.79	-84	9.77	2.14
Gallagher Arthur J. & Co	NYS	24.25	-0.51	8.38	28.38	19.00	26	0.64	2.64	19	5.88	4.12
Frank B. Hall	NYS	4.38	16.67	2.94	5.50	3.13	96	0.00	0.00	-4	-5.24	-0.83
Hilb, Rogal & Hamilton	OTC	13.00	0.00	-1.89	17.50	11.25	38	0.40	3.08	21	3.56	3.65
Marsh & McLennan	NYS	73.75	-1.34	-9.37	87.25	70.00	423	2.60	3.53	18	14.77	4.99
Poe & Associates	OTC	15.50	5.08	29.17	15.50	6.88	9	0.40	2.58	17	2.52	6.15
BROKERS	AVERAGE		3.2	5.2					2.4	-2		
CONGLOMERATES & HOLDING COMPANIES												
Berkley W.R. Corp.	OTC	33.25	0.76	9.02	36.25	23.50	218	0.32	0.96	13	23.89	1.39
Berkshire Hathaway Inc.	NYS	8850.00	1.72	-2.21	8850.00	242.50	0	0.00	0.00	-33	4612.00	1.92
ITT (Hartford Group)	NYS	63.38	-0.78	9.74	70.63	50.00	2275	1.84	2.90	10	64.01	0.99
Sears (Allstate)	NYS	45.00	-1.91	18.81	46.25	30.50	4419	2.00	4.44	14	37.38	1.20
CONGLOMERATES	AVERAGE		-0.1	8.8					2.1	1		
INSURERS/REINSURERS												
AEGON N.V.	NYS	68.00	1.30	-2.86	71.75	54.75	20	2.30	3.38	7	N/A	N/A
Aetna Life & Casualty	NYS	44.25	1.43	0.57	49.13	31.88	1144	2.76	6.24	10	64.23	0.69
Allied Group Inc.	OTC	22.00	4.76	29.41	22.25	15.25	332	0.64	2.91	8	11.50	1.91
American General	NYS	42.00	-0.59	-5.62	44.75	36.13	383	2.08	4.95	10	37.14	1.13
American Indemnity/Fin'l	OTC	7.38	13.46	55.26	9.25	4.50	2	0.08	1.08	7	12.93	0.57
American International	NYS	86.13	-0.14	-12.45	102.00	78.63	1426	0.48	0.56	12	45.34	1.90
Aon Corp	NYS	43.63	1.75	10.09	45.25	34.75	254	1.60	3.67	12	18.50	2.36
Argonaut Group	OTC	26.50	-1.85	11.58	33.38	21.75	251	0.68	2.57	8	48.26	0.55
AVEMCO Corp.	NYS	27.00	-0.92	8.00	28.00	19.25	18	0.40	1.48	20	9.55	2.83
Baldwin & Lyons Inc.	OTC	26.50	0.00	2.91	27.50	21.50	0	0.28	1.06	7	24.29	1.09
Belvedere Corp.	ASE	4.00	-8.57	23.08	5.38	2.75	18	0.04	1.00	11	7.65	0.52
Chandler Insurance	OTC	4.25	3.03	30.77	4.75	2.13	164	0.00	0.00	53	5.95	0.71
Chubb Corp.	NYS	64.38	-1.34	-16.40	78.00	60.75	1220	1.60	2.49	10	35.19	1.83
CIGNA Corp.	NYS	56.00	1.36	-8.38	61.75	41.25	564	3.04	5.43	11	73.15	0.77
CNA Financial Corp.	NYS	79.88	0.47	-18.49	104.50	75.50	109	0.00	0.00	8	70.23	1.14
Continental Corp	NYS	27.00	0.47	-2.26	30.38	23.25	836	2.60	9.63	28	37.83	0.71
EXEL Ltd	NYS	35.75	-0.69	-4.67	40.25	27.38	318	0.90	2.52	7	N/A	N/A
Fund American Corp.	NYS	65.88	0.38	-5.72	70.25	59.38	50	0.68	1.03	15	36.11	1.82
Fremont General Corp.	OTC	21.50	-2.27	-11.79	26.00	17.50	318	0.88	4.09	6	19.13	1.12
Frontier Insurance Group	NYS	29.13	-3.32	7.87	31.00	19.22	48	0.00	0.00	11	11.20	2.60
Gainsco Inc.	ASE	14.50	0.00	3.57	15.00	6.00	55	0.04	0.28	17	3.37	4.30
General RE Corp.	NYS	90.50	-3.85	-11.17	104.75	85.00	835	1.80	1.99	12	37.50	2.41
Guaranty National Corp.	NYS	15.38	-0.81	6.03	17.00	12.63	67	0.48	3.12	11	N/A	N/A
Hanover Insurance Co.	OTC	38.25	1.32	6.99	42.75	27.13	219	0.44	1.15	16	37.44	1.02
Harleysville Group	OTC	20.50	-0.61	-3.53	23.25	16.75	10	0.64	3.12	10	22.99	0.89
Hartford Steam Boiler	NYS	46.75	2.47	-18.70	63.75	45.13	134	2.00	4.28	13	17.05	2.74
Kemper Corp.	NYS	32.13	-3.02	-15.74	46.13	28.88	785	0.92	2.86	8	34.20	0.94
Lawrence Insurance Group	ASE	9.25	-2.63	-16.85	11.13	7.75	2	0.48	5.19	15	4.71	1.96
Liberty Corp.	NYS	24.00	2.13	8.47	24.75	19.50	61	0.48	2.00	13	23.86	1.01
Lincoln National	NYS	56.88	1.34	3.88	61.00	45.38	643	2.92	5.13	12	45.16	1.26
Markel Corp.	OTC	27.75	0.00	26.14	28.00	13.75	21	0.00	0.00	13	3.22	8.62
Mutual Risk Mgmt. Ltd.	NYS	33.25	-3.62	-5.34	37.75	17.00	37	0.12	0.36	25	-	-
NAC Re Corp.	OTC	29.25	0.43	-7.14	33.00	21.75	110	0.16	0.55	13	18.90	1.55
Navigators Group	OTC	44.50	-0.28	8.54	48.25	26.75	8	0.00	0.00	24	13.52	3.29
Nobel Insurance LTD.	OTC	4.75	0.00	18.75	5.25	3.00	14	0.00	0.00	6	7.76	0.61
NWNL Companies	NYS	30.13	-3.60	-3.21	38.50	18.63	302	1.40	4.65	11	42.73	0.71
Ohio Casualty Corp.	OTC	56.25	5.63	13.64	58.25	40.75	93	2.68	4.76	9	36.38	1.55
Old Republic Int'l	NYS	39.00	2.30	9.86	40.50	25.13	180	0.72	1.85	8	33.09	1.18
Orion Capital Corp.	NYS	31.50	-3.82	-0.40	34.25	21.75	51	0.92	2.92	5	20.42	1.54
Phoenix RE Corp.	OTC	9.75	0.00	-7.14	11.75	8.50	33	0.20	2.05	39	13.30	0.73
Provident Life	OTC	22.75	2.82	-2.15	24.50	16.75	201	1.00	4.40	9	25.88	0.88
Re Capital Corp.	ASE	15.13	-6.20	5.22	18.63	13.13	4	0.20	1.32	12	15.05	1.00
Reliance Group Holdings	NYS	5.13	32.26	24.24	6.75	3.50	279	0.32	6.24	3	5.61	0.91
RLI Insurance Corp.	NYS	20.13	0.63	21.97	20.38	11.88	8	0.48	2.39	9	14.41	1.40
St. Paul Companies	NYS	70.63	0.89	-3.09	75.75	57.13	520	2.72	3.85	8	52.00	1.36
SAFECO Corp.	OTC	47.38	1.07	-2.82	50.00	35.50	603	1.48	3.12	12	31.50	1.50
SCOR U.S. Corp.	NYS	17.75	-1.39	15.45	18.88	11.63	27	0.24	1.35	10	11.19	1.59
Seibels Bruce Group	OTC	4.75	8.57	-13.64	8.88	4.00	183	0.36	7.58	-2	7.35	0.65
Selective Ins. Group	OTC	18.88	-0.66	12.69	19.75	13.75	160	1.04	5.51	9	18.91	1.00
Statesman Group Inc.	OTC	6.00	10.33	4.35	6.88	2.31	347	0.00	0.00	4	2.48	2.42
Tokio Marine & Fire	OTC	37.50	-6.25	-27.18	55.25	37.50	9	0.00	0.00	-	70.93	0.53
Torchmark Corp.	NYS	57.75	-2.53	-0.22	61.50	46.50	304	1.60	2.77	12	16.70	3.46
Transamerica	NYS	41.75	-0.89	4.70	42.88	31.25	815	2.00	4.79	36	36.56	1.14
Transatlantic Holdings	NYS	35.88	-1.03	-7.72	39.63	29.00	134	0.24	0.67	12	18.38	1.95
Travelers Corp.	NYS	20.25	1.25	-6.36	25.38	17.25	1366	1.60	7.90	7	41.44	0.49
Trenwick Group Inc.	OTC	29.88	-0.83	4.82	30.75	23.00	41	0.72	2.41	11	21.71	1.38
United Fire & Casualty	OTC	56.00	5.66	24.44	58.00	40.75	2	1.32	2.36	11	35.39	1.58
USF&G Corp.	NYS	8.88	-2.74	22.41	12.50	5.63	1590	0.20	2.25	-4	11.96	0.74
UNUM Corp.	NYS	37.25	1.88	-8.02	40.63	28.56	323	0.52	1.40	12	37.25	1.00
USLIFE Corp.	NYS	44.13	-1.94	-7.83	47.88	36.00	92	1.64	3.72	9	60.34	0.73
Unitrin	OTC	34.00	-0.37	-4.90	41.50	31.00	400	1.00	2.94	13	30.70	1.11
USLICO Corp	NYS	18.75	-0.66	1.35	21.00	17.00	22	1.00	5.33	-19	29.44	0.64
Washington National	NYS	17.25	2.99	8.66	19.25	13.38	12	1.08	6.26	-52	26.86	0.64
Zenith National Ins	NYS	16.63	-1.48	-1.48	18.50	13.75	25	1.00	6.02	7	13.14	1.27
INSURERS/REINSURERS	AVERAGE		0.7	2.7					3.2	11.8		
HEALTH MAINTENANCE ORGANIZATIONS												
FHP International	OTC	14.75	0.00	3.51	29.75	9.88	879	0.00	0.00	14	5.44	2.71
HMO America Inc.	OTC	24.25	7.78	44.78	24.88	9.13	611	0.00	0.00	26	0.61	39.75
Pacificare Health Sys.	OTC	60.00	8.60	51.90	62.50	21.50	829	0.00	0.00	23	6.55	9.16
Safeguard Health Enter.	OTC	13.75	14.58	46.67	13.75	4.63	651	0.00	0.00	24	3.53	3.90
Sierra Health Services	ASE	23.50	-6.00	27.03	29.50	12.38	82	0.00	0.00	13	1.78	13.20
United Healthcare Corp.	NYS	79.50	3.08	6.71	93.00	32.38	729	0.06	0.08	33	3.76	21.14
United Medical Corp.	ASE	7.75	5.08	10.71	10.88	5.88	7	0.20	2.58	24	8.79	0.88
U.S. Healthcare	OTC	50.50	8.60	21.69	57.75	21.25	2403	0.56	1.11	24	3.38	14.94
HMOs	AVERAGE		5.2	26.6					0.5	23		
ALL COMPANIES	AVERAGE		2.3	10.8					2.7	11		

System design: Nordby International Inc.

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