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Update

Louisiana insurance regulator convicted on 31 criminal charges

NEW ORLEANS—A federal jury has convicted Louisiana Insurance Commissioner Doug Green on money laundering, mail fraud and conspiracy charges stemming from his 1987 election campaign.

The jury took about three hours last Wednesday to convict Mr. Green on 31 of 40 charges: three counts of money laundering, 27 counts of mail fraud and one count of conspiracy.

He was acquitted of seven mail fraud charges, and a mistrial was declared on

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Employers support Oregon health plan

Could lead to medical rationing

By LOUISE KERTESZ

SALEM, Ore.—Large employers in Oregon are lending their support to a complex—and potentially far-reaching—plan to widen access to Medicaid coverage while prioritizing and rationing medical care available under the government program.

Withholding payment under Medicaid for certain high-risk, high-cost services will make more funds available to extend basic health care coverage to all the state's uninsured, low-income individuals, lawmakers say.

Large employers believe the plan —which is the most recent phase of the Oregon Basic Health Services Act of 1989—will help stop health care providers from shifting the cost of health care for the 400,000 Oregonians without health insurance to employer-paid plans. And, employers hope the plan eventually will check the proliferation of state-mandated benefits in insured health care plans. Both of these problems drive up employer's health care costs.

State officials also say they intend to use the prioritized list of services as the basis for determining a basic benefit package to be mandated first for companies participating in a small-business health insurance program and later as a minimum package for all employed Oregonians, even those covered by self-insured plans.

That will require a waiver of the Employee Retirement Income Security Act of 1974, though at least one Oregon business group maintains its self-insured members would not oppose such a move. ERISA pre-empts states from imposing specific benefit requirements on self-funded health care plans.

Many employers support the broad application of the prioritized list of services because they expect the basic benefit package developed from the priority list to replace the current list of 23 state-mandated coverages in Oregon.

The large number of mandated

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AP/Wide World Photos

Brokers and underwriters in London already are assembling insurance facilities for contractors seeking to help reconstruct Kuwaiti buildings and oil installations damaged by Iraqi forces.

Capacity is plentiful for Kuwait reconstruction

Companies eager to help rebuild war-torn Kuwait probably won't have to worry about the availability of insurance.

Capacity for construction-related risks remains plentiful and brokers say close ties between the U.S. and Kuwaiti governments after the war mean contractors will have few problems securing political risk coverage.

However, the concentration of high-priced projects in one nation could deplete political risk capacity, one insurer warns.

With estimates of rebuilding costs running up to $100 billion, underwriters and brokers worldwide already are attempting to seize opportunities. London brokers and underwriters, for example, are assembling facilities to underwrite construction risks.

However, the contractors—many of which will be U.S. companies—may be able to tap their existing construction all-risk insurance packages to cover Kuwaiti projects.

An insurance official in Kuwait says that the government will again enforce a rule, which predates the Aug. 2 Iraqi invasion, requiring all Kuwaiti-domiciled assets to be covered by Kuwaiti insurers.

If that is the case, then almost all coverage for companies registered in Kuwait—but not necessarily foreign companies operating there —will have to be written through Kuwait's four insurers.

Foreign underwriters could reinsure the coverage, after it was ceded by the Kuwaiti insurers to Kuwait Reinsurance Co.

Many insurance arrangements for the rebuilding will not be made for some time, brokers and underwriters agree.

However, Alexander & Alexander Services Inc. is close to finalizing a brokerage contract with the Kuwaiti government under which A&A will place marine and war risk insurance for cargo to be shipped from the United States to Kuwait, said another broker involved in the negotiations.

CSX/Sealand Logistics, a subsidiary of CSX Corp. in Richmond, Va., has the contract to supervise shipment of emergency relief materials from the United States to Kuwait, a CSX spokeswoman said.

But before major reconstruction can begin in Kuwait, mines and booby traps left by the Iraqis must be cleared, pointed out Ronnie Capel Cure, a director with broker C.T. Bowring & Co. Ltd. in London, a Marsh & McLennan Cos. Inc. subsidiary.

"It will be months before anything is insured," agreed a Lloyd's of London underwriter. "The damage has to be assessed first, and the mines have to be cleared before you can get any idea of what can be insured. . . .But there's no shortage of capacity."

It will be "months rather than weeks" before contractors can even consider what insurance they need, added Ian Agnew, a Lloyd's marine underwriter for syndicates managed by I.C. Agnew Underwriting Ltd. "No one's geared up today to commence rebuilding."

One brokerage executive points out that Kuwaiti officials could reassess their country's needs, thus changing the type of risks needing insurance.

"They may not wish to reconstruct all that there was before because their needs may have changed. For example, they may want to use offshore oil refineries rather than rebuild onshore ones,"

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Blues tout savings of precertification aided by computer

By JERRY GEISEL

CHICAGO—A new precertification system that combines a computer program with nurse and physician reviews is spotting inappropriate procedures, improving the quality of care and saving money, according to a new study.

An American Medical Assn. official, though, criticized what he called the secrecy of the review system. Without knowing what criteria were used, he said, it is impossible to draw conclusions about how much treatment is inappropriate.

According to the system, physicians proposed inappropriate treatment in more than 11% of 9,125 reviewed cases involving 21 surgical and diagnostic procedures.

The study, coordinated by the Blue Cross & Blue Shield Assn., is among the first to measure whether UR software packages are an effective tool in identifying inappropriate treatment before expensive surgery or diagnostic tests are conducted.

"This is an important study. It tells us that medical review can be done telephonically," said Dr. Roger Taylor, national leader for health care consulting with The Wyatt Co. in Washington, D.C.

"The program has taught us that pre-authorization procedures can be an effective quality utilization and cost management tool," added Mary Ellen O'Donnell, director of utilization management

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NEWSPAPER

Targeting fraudulent MEWAs is government official's goal Page 3

Supporters predict approval of product liability reform bill Page 2

Call for asbestos legal reform expected to fall on deaf ears Page 3

Update

Green convicted by federal jury

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two additional charges.

Sentencing is scheduled for June 12 for Mr. Green, who faces a maximum prison term of 200 years and fines up to $7.75 million, according to Assistant U.S. Attorney Robert Boitmann.

Louisiana Attorney General William J. Guste Jr. notified Mr. Green last week that he was automatically suspended without pay. If the conviction is overturned before Mr. Green's term expires next year, he would be entitled to reinstatement with full back pay, Mr. Guste informed Gov. Charles E. Roemer III.

Mr. Green and his lawyer could not be reached for comment.

A federal grand jury indicted Mr. Green last year, charging him with accepting more than $2 million in campaign contributions from the owners of the now-defunct Champion Insurance Co. in exchange for regulatory favors. His trial began Feb. 19 (*BI*, Feb. 18; Dec. 10, 1990).

Mr. Green still faces state criminal charges related to Champion in Louisiana and Alabama.

Philadelphia fire coverage

PHILADELPHIA—The owners of the downtown Philadelphia skyscraper ravaged last month by a spectacular 19-hour fire have at least $100 million of liability insurance written by five different insurers, *Business Insurance* has learned.

As of late last week, five suits seeking class-action status have been filed in Philadelphia County Court against the building owners. Two suits seek recovery for uninsured property damage and economic losses, one on behalf of tenants and their clients and one on behalf of tenants in surrounding buildings damaged by smoke and water. Among the other suits, two seek recovery for economic losses only, one on behalf of neighboring businesses away from the disaster area and one on behalf of those that serviced affected buildings.

Aetna Casualty & Surety Co. is the lead writer of the multi-layered coverage, writing a $1 million primary layer and the first excess layer (*BI*, March 4). In addition, Federal Insurance Co., a unit of Chubb Corp., wrote $25 million excess of $10 million, *BI* learned last week. The next $15 million layer excess of $35 million is written by Aetna, with $10 million, and The Home Insurance Co., with $5 million.

The Home also wrote the next $25 million excess layer as well as $10 million of a $25 million excess of $75 million layer. Fireman's Fund Insurance Co. insures the other $15 million of the $25 million excess of $75 million layer.

Aetna is the sole insurer of the building owners' $1 billion blanket property policy. An Aetna spokesman said the building has an estimated insured value of $131 million. However, all of the blanket policy limits could be applied to losses stemming from the fire.

The building, One Meridian Plaza, is owned by E/R Assoc. Inc., a partnership consisting of Richard I. Rubin & Co., a Philadelphia real estate firm that also manages the building, Equitable Real Estate Investment Management Inc. and a Dutch pension fund.

Three firefighters were killed and 12 others injured battling the 12-alarm blaze Feb. 23-24, considered one of the worst high-rise office building fires in U.S. history. Eight floors of the 38-story building were destroyed, and 27 tenants have been forced to relocate, as have tenants in one neighboring large building and several smaller buildings.

Hardy contests liquidators

HAMILTON, Bermuda—Mark Hardy, the chairman of Forum Re Group (Bermuda) Ltd., is calling for the resignation of three of the four liquidators for two affiliated companies.

Mr. Hardy contends that the liquidators of Forum Reinsurance Co. Ltd. and Focus Insurance Co. Ltd. have "a horrendous conflict-of-interest problem" because they work for the same firm and the two liquidating companies owe each other money (see earlier story, page 45).

Forum liquidator Kirk Cooper and Focus liquidators David Lines and Peter Mitchell are with Coopers & Lybrand in Bermuda. The Bermuda Registrar of Companies is acting in the Forum liquidation.

"These liquidators have a legal duty to maximize the estate of each company," Mr. Hardy said late last week. "They will be proceeding against each other while working in the same office, which, of course, is ludicrous."

Forum Re Group (Bermuda) owns 57% of Forum, with the rest held by Mr. Hardy, his Bermuda-domiciled family trust and Panamanian-registered Magnolia Trading, according to Mr. Hardy. Forum owns Focus, reinsured Focus and also invested in subsidiaries of Mr. Hardy's U.S. holding company, The Group Inc.

As an owner of the two liquidating companies, Mr. Hardy says he wants to maximize recoveries and suggests that the Bermuda Registrar of Companies take over both liquidations and hire consultants.

Exxon settles in Valdez case

WASHINGTON—Exxon Corp. has agreed to pay a record $1.1 billion —including a $100 million criminal fine, the largest ever for environmental crimes—to settle Alaska's civil suit and federal criminal charges over the massive Valdez oil spill.

However, hundreds of civil suits still pending against Dallas-based Exxon are not included in the settlement.

A U.S. District Court order that the parties guarantee the rights of 5,000 native Alaskans in any settlement briefly stymied talks last

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Errors and omissions

- The March 4 directory of risk management consultants incorrectly listed Commercial Risk Consultants Inc. as accepting commissions. The company is compensated by the project, on retainer and by the hour.

Also in that directory, Margaret W. Tiller was omitted from the listing of principal officers of Tiller Consulting.

- UniPsych Corp. is located in Plantation, Fla., not in North Miami Beach as the Feb. 18 directory of utilization review firms incorrectly stated.

Product liability bill has bright future: Supporters

By ADRIENNE C. LOCKE

WASHINGTON—Supporters of federal product liability reform are confident they can push through reform legislation introduced last week that mirrors a bill that gained support in the Senate during the last session of Congress.

Because S. 1400 cleared several Senate committees during the last session, its supporters contend the new measure, S. 640, will move more quickly through the legislative process.

Like its predecessor, the legislation—again introduced by Sen. Robert W. Kasten, R-Wis., with 29 co-sponsors—would eliminate joint and several liability for noneconomic damages in product liability cases and place time limits on when a product liability suit can be filed. Those limits would depend on the age of the product and when the injury or its cause was discovered.

In addition, the bill would give greater protection to wholesalers and distributors as well as federally certified products.

The bill also would make it harder for plaintiffs to recover punitive damages (*BI*, July 31, 1989).

In announcing the introduction of S. 640, Sen. Kasten said there is something wrong with a product liability system that discourages the development of new and safer products, while increasing the costs of other goods.

"Consumers are being made victims of a system that's supposed to protect them. It's a rip-off, and it's got to change," he said.

Sen. Kasten said he believes that all of the issues surrounding this bill were well debated last year, so he does not expect delays in pushing the bill through the Senate Commerce, Science and Transportation Committee to the Senate floor for a vote.

"Unless some individual feels there is some new information out there, I think it would be unnecessary and counterproductive to have a long, drawn-out process calling back witnesses we have already heard from," Sen. Kasten said.

James. A. Anderson, senior director of government relations

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Coalition leader stresses employer role

Health care reform urged

By CHRISTINE WOOLSEY

ROSEMONT, Ill.—Real and lasting changes to the troubled U.S. health care system require a national reform strategy that incorporates state, local and private-sector—as well as federal—initiatives, says the president of a leading employer health care coalition.

"At the Washington Business Group on Health, we're convinced that the local employer coalitions are important in making a difference in national health strategy," said Mary Jane England, the group's new president.

And, she said, employers have to try to educate congressional leaders about the private sector health care initiatives that are working so those projects can serve as models for an improved health care system.

Ms. England, who replaced Willis Goldbeck as president in February, spoke last week at a conference in Rosemont, Ill. sponsored by the Midwest Business Group on Health.

Discussing some preliminary results from a member survey to be released later this month, Ms. England said, "corporate America (is) so frustrated with the current (health care) situation that it is willing to consider vast changes."

For example, she noted that 89% of respondents said limited reforms would not be sufficient and that broad system fixes are necessary.

Eighty-seven percent said the current level of health care spending is sufficient to provide health care to all Americans. And 90% said employers should continue to be the major suppliers of health benefits to employees.

In addition, 71% strongly or somewhat strongly oppose legislation that would require employers to offer health care benefits, and 87% said managed care should be a part of health care reform.

The survey revealed that employers' health care priorities include universal access to health care, quality outcome measurement, preventive medicine and a

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X.L.'s O'Hara to address WIC

X.L. Insurance Co. Ltd. President and Chief Operating Officer Brian M. O'Hara will address the 1991 World Insurance Congress on the role of private insurers in the commercial insurance marketplace.

Mr. O'Hara replaces John Cox, the retired chairman of ACE Ltd., who withdrew from the program due to a conflict.

Mr. O'Hara has been an executive of X.L. since 1986. Bermuda-based X.L. underwrites excess liability insurance for corporations worldwide, offering up to $100 million in limits excess of $25 million for U.S.-based corporations and excess of $15 million for European corporations. Its gross premiums written in 1990 totaled $394.5 million.

WIC
World Insurance Congress

The 1991 World Insurance Congress is being sponsored jointly July 1-3 in London by *Business Insurance* and Lloyd's of London Press Ltd., an independent subsidiary of Lloyd's of London. Forty-six speakers from 10 countries will address a host of issues confronting insurers, brokers and risk managers worldwide (*BI*, March 4; Dec. 31, 1990).

For complete program and registration information, write to "1991 World Insurance Congress" at either *Business Insurance,* 220 E. 42nd St., New York, N.Y. 10017; phone 212-210-0299, fax 212-210-0704; or Lloyd's of London Press, 1 Singer St., London, EC2A 4LQ, England; phone 071-250-1500; fax 071-253-9907.

Inside

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✓ A state judge has thrown out a $14.7 million award against a reinsurer, ruling it is not liable for claims under contracts obtained through misrepresentation. **PAGE 16**

✓ An attempt to cut employees' benefits after the sale of a subsidiary violates federal law, a judge ruled. **PAGE 17**

✓ In Perspectives attorney Peter H. Bickford challenges some of the myths surrounding insurance liquidations in light of new pressures placed on regulators. **PAGE 35**

✓ Employers should reward doctors who practice effective medicine, a human resources executive says. **PAGE 42**

Departments

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Combining comp, health benefits

Interest grows, but problems still unresolved

By MEG FLETCHER

CAMBRIDGE, Mass.—Interest in merging workers compensation and group health care coverages into "24-hour" insurance programs is heating up among employers, insurers, labor unions and public officials.

However, workers compensation experts point out there are many roadblocks that must be cleared before employers can begin to merge their workers compensation coverage with their group health care plans.

For example, numerous state and federal laws governing workers compensation and group health care plans would have to be amended or repealed to allow wide-scale use of 24-hour programs.

In addition, employers that do not now currently offer health care benefits to their workers would probably resist the idea.

Some workers compensation experts maintain that the two coverages should remain separate. They add that the time being spent exploring the practicality of 24-hour coverage should instead be devoted to trying to solve the many problems plaguing state workers compensation systems.

While the concept of 24-hour coverage has been discussed for years, there is no agreed-upon definition of what it is.

Some consider consolidated administration of claims for separate workers comp and group health insurance policies to be 24-hour insurance coverage.

Others use the term to describe insurance polices that pay medical bills—but not disability benefits—for both occupational and non-occupational injuries and illnesses. Under such a scenario, an employer would buy a separate insurance policy—or establish a self-insured program—to pay disability benefits to workers injured on the job, but not to workers injured outside the workplace.

Still others define 24-hour coverage as a single insurance product that pays both medical and disability benefits for any injury or illness, whether or not the problem is job-related (see story, page 55).

"There are lots of possible definitions" of 24-hour coverage, explained Richard A. Victor, executive director of the Workers Compensation Research Institute in Cambridge, Mass.

"It's a multifaceted concept. It's still a developing concept," said Mr. Victor, who directed a roundtable discussion of 24-hour coverage at the WCRI's annual issues and research conference, held last month in Cambridge.

To examine the pros and cons of

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U.S. official seeks MEWA crackdown

By ADRIENNE C. LOCKE

WASHINGTON—The U.S. Labor Department has tools to crack down on fraudulent multiple employer welfare plans, but they are ineffective unless the department overhauls how it conducts investigations, says the department's inspector general.

Give the Office of Inspector General authority to use all 196 investigators under its supervision, especially the 38 who are assigned to only internal investigations at the Labor Department, and the office can make a big dent in MEWA fraud, Inspector General Julian W. De La Rosa says.

The former FBI investigator, who was sworn in as inspector general last August, also wants OIG investigators to have greater authority, similar to the authority that U.S. Customs Service and Drug Enforcement Administration agents have.

Mr. De La Rosa also wants to facilitate state insurance department investigations of fraudulent MEWAs. As part of that plan, the OIG would establish and maintain a list of federal- and state-regulated MEWAs nationwide to forestall jurisdictional disputes, which can impede prosecution of fraudulent plans.

However, the Justice Department and the Labor Department's own general counsel oppose Mr. De La Rosa's plan, in part because he wants to use his investigators for more than tracking down MEWA fraud.

While the OIG is specifically charged with investigating employee benefits-related fraud and corruption under the Inspector General Act of 1978, Mr. De La Rosa contends the OIG also should begin conducting criminal investigations into alleged violations of regulations issued by other Labor Department agencies.

Those agencies include the Pension and Welfare Benefits Administration, the Occupational Safety and Health Administration, the Mine Safety and Health Administration and the Employment and Training Administration.

That would allow the department to pursue more criminal investigations into fraud and abuse in areas it regulates, Mr. De La Rosa says.

Topping his priority list, though, is MEWA fraud.

The MEWA situation is very serious and becoming more of a prob-

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Julian De La Rosa

Financial reinsurance

Not 'a function of witchcraft': Centre Re chief

By JUDY GREENWALD

HAMILTON, Bermuda—Although there are plenty of good reasons to use financial reinsurance, it should not be mistaken for a cure-all, warns the president of the largest financial reinsurer in Bermuda.

"A lot of things have been attributed to it as a panacea" when financial reinsurance is no such thing, said Steven M. Gluckstern, president and chief executive officer of Centre Reinsurance Holdings Ltd., which, with $1.3 billion in assets, is considered Bermuda's largest financial reinsurer.

Centre Re defines its product as finite risk reinsurance because, although its ultimate risk and profit are capped, it assumes substantial underwriting risk (*BI*, April 30, 1990).

Mr. Gluckstern spoke during a wide-ranging session at the 15th International Captive Insurance & Reinsurance Forum in Bermuda earlier this month.

Also speaking about financial reinsurance at a separate session were John C. Burville, a consultant and principal in Bermuda with the Tillinghast division of Towers, Perrin, Forster & Crosby Inc., and Tom Dixon, a Centre Re underwriter, who presented examples of how financial reinsurance works.

While there are a lot of good reasons to use financial reinsurance, "it's not a function of witchcraft," Mr. Gluckstern said. "These are economic transactions. They're not some kind of magic formula."

Mr. Gluckstern said his concept of financial reinsurance falls somewhere along a "natural continuum" between pure banking and traditional reinsurance.

Time-and-distance policies, for example, fall toward the banking end, Mr. Gluckstern said.

Particularly popular at Lloyd's of London, these policies guarantee ceding companies specific payments at specific times based on the initial premium paid and investment returns expected by the reinsurers. However, they are "not really" reinsurance, Mr. Gluckstern said.

"We look to position our products along the risk continuum," he said of Centre Re. "We believe in risk-taking. We just believe in being paid for risk-taking."

Financial reinsurers can cover both past losses and those that have not yet occurred, Mr. Gluckstern said.

Retrospective financial reinsurance, for example, can

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Photo by Kathryn McIntyre

The Hamilton Princess Hotel hosted the forum earlier this month.

Captives can reinsure underground tanks

By MICHAEL BRADFORD

HAMILTON, Bermuda—A fronting arrangement reinsured by a captive is one of the best ways for owners of underground storage tanks to meet federal financial responsibility guidelines, a risk management consultant says.

Environmental Protection Agency regulations specify how much pollution liability insurance tank owners must have and how they must fund their pollution exposures, said James D. Blinn, a principal in Chicago with Tillinghast, a division of Towers, Perrin, Forster & Crosby Inc.

Depending on the type of business and number of tanks, owners will have to carry at least $500,000 in per-occurrence coverage with a $1 million aggregate. Some owners are required to carry limits of $1 million in per-occurrence coverage with a $2 million aggregate (*BI*, Oct. 8, 1990).

The insurance must cover cleanup costs and third-party liability under a combined single limit. Defense costs must fall outside policy limits.

Owners have several options for meeting those financial responsibility standards, Mr. Blinn pointed out at the 15th International Captive Insurance & Reinsurance Forum earlier this month in Bermuda.

Fronting arrangements are one option, Mr. Blinn said, along with state funds, self-insurance, conventional insurance and risk retention groups.

The EPA is considering a rule that a "generic" public entity risk pooling arrangement would not satisfy the standards.

While risk retention groups are allowed to fund the financial responsibility requirements under EPA regulations, captives "per se" are not, Mr. Blinn said.

"A captive does not directly meet financial responsibility requirements," he said.

Mr. Blinn noted that the experience of some risk retention groups has not been encouraging. The Petroleum Marketers Mutual Insurance Co. A Risk Retention Group entered voluntary rehabilitation (*BI*, April 16, 1990), and Environmental Protection Insurance Co. Risk Retention Group ceased operations after a

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Judges ask for solution to asbestos case jam

By STACY ADLER

WASHINGTON—The recent recommendation of the U.S. Judicial Conference that legislation is needed to cure the mounting backlog of asbestos personal injury cases is expected to fall on deaf ears in Congress.

"There is not the slightest chance Congress will enact legislation," asserted attorney Kenneth R. Feinberg, who assists judges in handling asbestos litigation.

"Congress has been looking at this problem for 15 years" and has steadfastly refused to enter the fray, said Mr. Feinberg, who is with Kaye, Scholer, Fierman, Hays & Handler in Washington, D.C., and has served as a special master in asbestos litigation involving Eagle-Picher Industries Inc. and as a consultant in the Manville Corp. reorganization.

Attorney Victor Schwartz, who represents former asbestos producer Eagle-Picher Industries Inc. in legislative matters, agreed that it is unlikely the judges' report would stimulate congressional action.

"Unless there is significant political pressure from the Bush administration and others, such as the former asbestos producers and representatives of labor, Congress will not act," said Mr. Schwartz, who is with Crowell & Moring in Washington, D.C.

The 27-judge U.S. Judicial Conference voted 26-to-1 last week to recommend that Congress consider creating a national system of compensating present and future victims of illness caused by exposure to asbestos.

The recommendation stemmed from a report prepared by a panel of six federal judges appointed in September 1990 by Supreme Court

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Asbestos report

Continued from previous page
Justice William H. Rehnquist to study the problems created by the more than 60,000 asbestos personal injury cases now pending in federal courts.

The judges met three times before issuing their report to the public March 12.

The 43-page report, which included one dissenting opinion, calls for:

- Congress to consider "legislation recognizing the national proportions of the problem in both federal and state courts and creating a national asbestos dispute resolution scheme that permits consolidation of all asbestos claims in a single forum—whether judicial or administrative—with jurisdiction over all defendants and appropriate assets."
- Congress to review the role of repetitive punitive damage awards in multiple asbestos litigation against a company for the same conduct.
- Congress to enact "back-up" legislation that would expressly authorize federal judges to consolidate asbestos personal injury cases.
- The director of the administrative office of the federal courts to monitor asbestos litigation and collect materials that could assist judges overseeing asbestos trials.
- The establishment of an asbestos litigation clearinghouse to monitor asbestos personal injury cases.
- Amendments to the procedures for creating class-action lawsuits in federal courts to better accommodate the demands of mass tort litigation.

The committee appointed by Justice Rehnquist was led by 5th U.S. Circuit Court of Appeals Judge Thomas M. Reavley, who supported the recommendations. The other concurring judges were: Senior Judge John F. Nangle of the Eastern District of Missouri; Chief Judge Robert M. Parker of Eastern District of Texas; David D. Dowd Jr. of the Northern District of Ohio; and Chief Judge Sam C. Pointer Jr. of the Northern District of Alabama.

'What has been a frustrating problem is becoming a disaster of major proportions,' the report says.

U.S. District Judge Thomas F. Hogan of the District of Columbia filed a dissenting opinion in the report. Judge Hogan objected to proposed changes in the procedures for creating a class-action lawsuit.

The judges' report describes the ever-increasing number of asbestos personal injury cases as a "situation that has reached critical dimensions and is getting worse."

"What has been a frustrating problem is becoming a disaster of major proportions to both the victims and the producers of asbestos, which the courts are ill-equipped to meet effectively," the report says.

The judges summarized the problems surrounding asbestos litigation: "Dockets in both federal and state courts continue to grow, long delays are routine, trials are too long, the same issues are litigated over and over; transaction costs exceed the victims' recovery by nearly two to one; exhaustion of assets threatens and distorts the process and future claimants may lose altogether."

However, the judges admitted that it is easier to describe the problem than fashion an appropriate remedy.

Current techniques being used by judges are not sufficient to cure the problem, the judges say.

Procedures used by judges to streamline pre-trial litigation and trials have met with some success in current cases "but have not resolved the problem of the growing backlog of cases," they say.

In addition, attempts by federal and state judges to consolidate asbestos cases "have not provided any long-term solution to the asbestos problems," the judges say.

Other attempts by federal and state judges to create class-action asbestos lawsuits have been rejected by appellate courts, the judges say.

"Although appellate courts have rejected use of the class-action proceedings in the context of asbestos cases, that format has great appeal," the judges say. "Class action proceedings have the advantages of promoting efficiency and consistency."

The judges also found that attempts by the Judicial Panel on Multidistrict Litigation to consolidate cases for pre-trial purpose are not sufficient to reduce the backlog of asbestos cases.

In addition, the judges found that while legal procedures used to avoid the re-litigation of recurring issues in asbestos litigation are helpful, they are not enough.

And, the judges said that voluntary dispute resolution would not be a cure since a party who is not satisfied with the outcome still can demand a trial.

Thus, the judges concluded: "No adequate procedures exist to enable the justice system to deal with the unique nature of asbestos cases. . . .Congressional action is necessary to enable courts to meet the unique problems presented by asbestos litigation."

However, the committee did not think it was appropriate for members of the judiciary to make more specific recommendations to Congress other than asking lawmakers to consider a method for consolidating all asbestos cases.

But, if Congress does not enact such legislation, it should enact back-up procedures that would allow federal judges to consolidate all of the asbestos cases on their dockets, the judges urged.

The judges also suggested limiting the ability of plaintiffs to recover multiple punitive damage awards from asbestos producers for the same conduct.

"Although there may be grounds to support an award, multiple judgments for the punitive damages in the mass tort context against a finite number of defendants with limited assets threaten fair compensation to pending claimants and future claimants who await their recovery and threaten the economic viability of the defendants," the judges say.

The report noted that 11 of the approximately 25 major asbestos defendants have filed for bankruptcy.

"Congress might well review the role of punitive damages in the mass tort context," according to the report. "Two approaches Congress might consider are provisions to limit or eliminate exposure to punitive damages or to channel punitive damage awards into a trust fund to fund compensatory damages for other asbestos victims."

Asbestos plaintiffs' attorney generally oppose all attempts to consolidate asbestos personal injury cases, believing each plaintiff is entitled to a jury trial.

"There is no need for federal legislation in this area," said plaintiffs attorney Paul Gillenwater of Gillenwater, Nichol & Ames in Knoxville, Tenn.

"The courts are capable of handling this problem," Mr. Gillenwater said. "Congress should not interfere with plaintiffs's rights" to a jury trial. ■

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SM

Tool maker adopts point-of-service plan

By MICHAEL SCHACHNER

Benefit beat

Black & Decker Corp. expects a new self-funded managed health care plan with a point-of-service option to save the company about $23 million over the next three years.

Black & Decker and plan administrator CIGNA Corp. of Philadelphia will use the results from the program's first year to develop a guaranteed savings plan under which CIGNA will be at risk if costs escalate beyond an agreed-upon amount, said Ray Brusca, employee benefits director at Black & Decker.

"Because the plan is so new and because we have a diversified population that includes employees from a recently acquired company, it is too hard to say what our costs would have been without the change," he said. "So, Year One will be our base, and significant guarantees from CIGNA will come after this year."

Black & Decker in 1989 purchased Emhart Corp., a diversified manufacturer where health care costs were rising 30% a year. Black & Decker's own health care costs have been rising about 22% a year since 1988.

Black & Decker implemented the new plan for 15,000 non-union employees and their 25,000 dependents Jan. 1. Another 2,500 employees are union members covered by many different collectively bargained health care arrangements.

The new plan, known as Employee Choice, allows Black & Decker's non-union employees and dependents to enroll in either:

- A self-insured point-of-service plan administered by CIGNA, under which employees are allowed to opt out of CIGNA's provider network in exchange for paying deductibles and significantly higher copayments.
- The company's traditional self-insured indemnity plan, which CIGNA also administers. Travelers Corp. previously administered the plan.

In implementing the plan, Towson, Md.-based Black & Decker eliminated nearly 100 health maintenance organization contracts. All its employees will now be covered under one health care program, something Mr. Brusca said is very important.

"Altogether, we spent about $67 million on health care last year for about 40,000 employees and their dependents in various coverage arrangements. What we really wanted was to get everyone into one managed care plan. We wanted to consolidate, use one insurer and eliminate the adverse selection from our HMOs," he said.

Mr. Brusca said Black & Decker is continuing to offer a traditional indemnity plan with its new point-of-service plan because 5,000 workers do not have access to Employee Choice and the company wanted to make sure all employees had the indemnity plan option.

Approximately 8,000 of the 10,000 employees with access to the CIGNA network opted for the point-of-service plan during enrollment last year, Mr. Brusca said.

About 2,000 opted for the indemnity plan, and the remaining 5,000 work in areas where there is no access to the CIGNA network.

The monthly employee premium for coverage through Employee Choice is $15 for individuals and $50 for families.

Employee Choice enrollees seeking care through a network provider pay no deductibles, a $10 copayment per office visit, and a $5 copayment for generic prescription drugs or a $10 copayment for name-brand drugs.

For those who are enrolled but opt out at the point of service, the annual deductible for individual coverage is equal to 2% of salary, but not less than $300 and not more than $1,000.

Families that opt for coverage outside the network must meet twice the individual deductible.

After individuals and families meet opt-out deductibles, they are responsible for 30% of costs up to an annual out-of-pocket maximum equal to four times the deductible. The company then pays 100% of costs.

The company's indemnity plan offers two benefit levels.

Under the high option, which includes a prescription drug card and vision and wellness benefits, the monthly charge is $25 for individual coverage and $65 for family coverage.

The deductible for individuals equals 1% of salary, while the family deductible equals 2% of salary.

After deductibles are met, Black & Decker covers 80% of medical costs up to four times the deductible. The company then picks up 100% of costs.

Mr. Brusca said about 98% of those opting for indemnity plan coverage selected the high-option plan.

Under the low option, the monthly charge is $15 for individual coverage and $50 for family coverage.

There is a deductible equal to 2% of pay for individual coverage and 4% of pay for family coverage.

After deductibles are met, Black & Decker will pay for 70% of costs, up to four times the deductible.

This option has no wellness, vision or prescription drug benefits.

Mr. Brusca said it is clear why 80% of Black & Decker's employees with access to the point-of-service plan enrolled in it.

"We structured the plans so benefits are highest through the network and monthly costs are less. Also, if you're in the network, vision benefits are free," he said.

Black & Decker also provides dental benefits to its 15,000 non-union employees and their dependents. All except the 5,000 without access to Employee Choice can elect coverage through either the CIGNA Dental Health network or a traditional self-insured dental indemnity plan that CIGNA administers. The remaining 5,000 employees and their dependents are covered by only the dental indemnity plan.

Benefits levels through the network and the indemnity plan are nearly identical, Mr. Brusca said. Thus, about 70% of the company's non-union employees with a choice of plans are enrolled in the indemnity plan. "CIGNA's benefit levels just weren't that much different nor were the costs. I guess people, including myself, figured why change?"

Black & Decker also has carved out mental health and substance abuse treatment from its comprehensive health care program. This program is managed by MCC Inc., a CIGNA unit.

All Employee Choice and indemnity plan enrollees are entitled to benefits through MCC network providers.

Under the plan, all inpatient care is covered at 90%, and there are no deductibles. Outpatient substance abuse therapy requires a $5 copayment per visit, while group psychotherapy carries a $10 per-visit copayment and individual psychotherapy requires a $15 per-visit copayment.

Employees must seek mental health care through network providers to receive benefits. ■

The Workers Compensation System Helps Some People Get Back To Work. And Others Get Back To Life.

The Boston Elbow is a remarkable piece of science that actually helps replace an injured worker's physical strength.

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It's the same system that has also helped generations of workers avoid injury—thanks to extensive injury prevention programs.

What You Should Know

Right now, in many states, Workers Compensation is being threatened by out-of-control costs, unnecessary litigation and under-funded, understaffed state-administered agencies. Obstacles that are spreading, state by state.

Obstacles that could hinder effective worker rehabilitation—like the example you see here. Something we can't let happen.

You should also know that the workplace is changing, and work habits are changing along with it.

For example, heavy machinery injuries are less common today, while back problems, repetitive motion disorders and cumulative trauma are more common. This means we should help implement programs to help workers avoid these injuries.

Why You Should Care

America works best when American workers don't get hurt on the job. But if they do, everyone benefits when they return to work quickly.

Which is why we should learn to prevent more occupational diseases and injuries. We should work closely with workers on-site, so they can be trained in the very latest safety procedures.

We should also give more attention to quality rehabilitation and suitable alternative employment—in the event a worker can't return to his or her original job.

Most importantly, we should get injured workers into the system faster from the very beginning—and insure more efficient, personalized follow-through.

All these things are possible, if we work together to support the system that's been supporting our workers for over 75 years.

What You Should Do

You can help by doing one of two things.

One: Be aware. Find out what's happening in your state, how you're affected, and what you can do to help. Talk to your insurance company or business trade association.

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Opinions

Time to study 24-hour cover

SUGGESTIONS FOR controlling the cost and improving the efficiency of the workers compensation and group health systems deserve fair analysis and exploration.

One very intriguing idea that deserves this attention is so-called 24-hour coverage—meshing workers comp and group health coverages, and perhaps even group disability and workers comp disability programs.

The idea has been bandied about for years, but just recently some efforts to see whether some type of 24-hour coverage will work have been launched (see stories, pages 3 and 56).

We are concerned that these exploratory efforts are being greeted with too much skepticism and commitment to preserve the status quo for those who earn their livelihood from the workers comp system.

Granted, there are plenty of obstacles to making a 24-hour coverage program work, as the Alliance of American Insurers describes in its new report (see story, page 55).

But, we do not want to see enthusiasm for trying something completely new to solve the problem of rising workers comp and group health plan costs smothered by a concentration on why it would be difficult to accomplish.

We also are concerned that workers not be prejudiced against this effort by an initial analysis by some that it would result in diminished benefits for workers.

Rather, we want to encourage those involved in the workers comp and group health systems to invest substantial research and development into how a 24-hour type of program could benefit employers and workers.

Investigations into 24-hour coverage and efforts to reform the current workers comp system are not mutually exclusive.

The efforts can and should be carried on simultaneously.

If 24-hour coverage is not the panacea for the problems confronting the two systems, the research and development efforts applied to the idea could result in other viable solutions.

State regulators should permit pilot 24-hour programs to determine what advantages they offer employers and employees.

Letters

Belco ruling not as influential as suggested

To the editor: I fear that your readers may have been somewhat misled by counsel for the plaintiff in the case of *Belco Petroleum et ano. vs. AIG et al* dealing with the question of first-party punitive damages against property insurers (*BI*, Feb. 4).

Our firm represented the various insurers in the principal cases upon which the New York Appellate Division relied in the Belco cases for its decision to grant the insurer's motion to strike the punitive damages allegation in the complaint. To suggest, as does counsel, that the Belco decision in any way really changes the state of the law on the subject is not quite accurate.

The New York courts have always held that a policyholder may bring a punitive damage claim against its first-party insurer provided that the policyholder could plead ultimate facts, and later on prove that the insurer engaged in conduct of such a nature as to constitute a gross and wanton fraud not only on the suing policyholder but upon the public as well. (See *Royal Globe Insurance Co. vs. Chock Full O'Nuts*, 449 N.Y.Supp.2d 740; *Samovar of Russia Jewelry vs. Generali*, 476 N.Y.S.2d 869; *Holoness Realty vs. New York Property Insurance Underwriting Assn.*, 427 N.Y.S.2d 264; and *Marvex Processing & Finishing vs. Allendale*, 398 N.Y.S.2d 464.)

Citing *Holoness*, the court in the *Belco* case dismissed the punitive damages pleading and stated that if Belco repled, a new pleading must "disclose the sources of (Belco's) information and belief and otherwise come forward with whatever evidence (Belco) has of the alleged pattern and practice."

It may be that Belco will later be able to frame a satisfactory pleading in punitive damages, but the standard to which it will be held has not changed.

Arthur N. Brook
Mound, Cotton & Wollan
New York

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Time has come for limiting provider fees

To the editor: While reading the article "Doctors View Ethics of Cost Control" in the Feb. 25 issue, I found very little to agree with from the two physicians quoted. Not until Dr. Ralph Muller, president of the University of Chicago Hospitals, said, "There has to be some limits on what hospitals and doctors make," did I snap out of my terminal boredom at the drivel I had been reading and nearly shout, "God bless America!"

When one has installed every cost containment feature known to humankind, tweaked and manipulated administrative fees, assumed more specific risk than the company can afford, begged, threatened, cried at employee meetings to hold down costs (at what risk?) and driven a really nice insurance agent to mainline tranquilizers, what else is left but to transfer some costs to employees, limit some areas of care and restrict "pre-existing conditions" and "self-inflicted injuries/under-the-influence injuries" and others from coverage?

I can swap horror stories with the best of benefit administrators about hospital and physician overcharges for services, double billing outrageous prices for items from hospitals and pharmacies, etc.

I certainly agree with Dr. Muller on limiting hospital and doctor fees. We've done all we can to our employees without seriously affecting their access to necessary health care. It is time now to turn the spotlight on the hospital and doctor fees and make them more accountable to those who pay the bills.

Douglas F. Salensky
Human Resources Manager
Michigan Rubber Products Inc.
Cadillac, Mich.

American Airlines, MetLife program on track

To the editor: In the Jan. 28 article, "Exploring Ways to Improve TPA Services," the statements regarding Metropolitan Life Insurance Co.'s lack of performance were taken out of context. Although it is true that the transition to MetLife in 1989 was difficult, this was primarily due to the large number of American Airlines employees and the required claim record transfer.

The performance standards were not *always* met (which is quite different from the interpretation that MetLife "often failed to perform"), but American Airlines and MetLife have been working together to address any problems that arise. This cooperative approach has proven successful for improving and maintaining MetLife's performance at desired levels.

Mary B. Jordan
Managing Director-
Compensation & Benefits
American Airlines Inc.
Fort Worth, Texas

Letters continued on page 12

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At issue

Are you reducing the number of HMOs your company offers?

Linda B. Roskosky
Employee Services Representative
Polychrome Corp.,
Yonkers, N.Y.

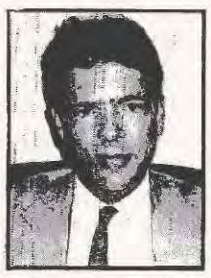
We are cutting down on the number of HMOs we are offering due to the fact that administration is a real burden. Also, rates for some of the HMOs became very exorbitant, higher than rates we were paying on our major medical plan offered to employees.

Roy Leet
Director-Benefits
Ameritech,
Chicago

Ameritech has reduced the number of HMOs offered over the past few years. This is a response to reduced employee interest. As we implement our point-of-service managed care plan over the next couple of years, this trend is likely to continue.

Steven N Schrenzel
Director-Compensation & Benefits
The Rockefeller Group Inc.,
New York

We let our employees' preferences as well as our own judgment guide us. An HMO has to meet our financial and operational standards, but beyond that we look at employee participation in a plan. Our employees have withdrawn from a number of HMOs. By default, we have reduced the number we are currently offering by approximately one-third.



R. Craig Reynolds
Manager-Employee Benefits & Group Insurance
Briggs & Stratton Corp.,
Milwaukee

The fewer HMOs you offer, the greater your bargaining clout. In our case, we have found that by having an exclusive arrangement with a single HMO, we've been able to secure multiyear rate guarantees that fit our cost management strategy.

Compiled by Sara Harty

Letters

Employers are victims, not villains

To the editor: Scapegoating is getting rampant in the general press and on television.

There is an epidemic of gee-whiz, tear-jerker stories about employee benefit plans and insurance companies leaving people uncovered and on the brink of financial ruin. The situations are sad, of course, but instead of being reported as isolated human interest stories, they often appear as business or economic news with the implication that they are representative of a vast trend.

The usual storyline is that the plan has run out of money and the employer or plan manager is cast in the role of being guilty of negligence or inadequate funding.

Much of the blame, of course, rests with the current recession, which is hurting businesses across the country. However, the *real* villains are never mentioned (and probably are unknown by the reporters). This trend of disinformation needs to be challenged!

Insufficient reserves? The Internal Revenue Service and Congress have dictated that self-funded welfare benefit plans should *not* have reserves adequate to carry them through hard times.

If employers and plans had put aside reserves during the booming '80s for the current hard times, they would have been penalized. It is not carelessness nor poor management on the part of the employer or benefit plan, it's the law! (Section 511 of the Deficit Reduction Act of 1984, also known as the Tax Reform Act of 1984, and Section 419 of the Internal Revenue Code.) The IRS and the tax committees of Congress viewed plan reserves held in tax exempt trusts as a loophole and revenue loss. Congress and the IRS plugged that loophole, and now the citizens suffer.

The general media reporters also fail to recognize that Congress and the states have continually undercut and loaded extra costs onto private employee benefit plans. By making itself secondary payer for Medicare and veterans, government has raised the costs for private plans. Meanwhile, repeated cuts in Medicaid and Medicare payments to medical providers have further fanned the flames of phenomenal medical inflation. Congress and the states have also added and extended mandated benefits, which also raise the costs of providing health care coverage. As costs have gone up, employers have had to cut benefits and workers or raise copayments.

Employers and plan professionals are victims, not villains! The trade press usually understands that. This letter is a call for those being slandered to respond in the general press. Write articles and letters to the editor! Ask for equal time for fairness on the TV news. Focus some of the massive public relations might of the insurance/benefits industry toward self-defense. If you don't, these sad anecdotes will be absorbed as representative fact into public opinion and political views. That's the quickest path to some hasty, ill-conceived revolutionary restructuring of the health benefits system. Congress loves to legislate based on emotional, isolated anecdotes. It's put up or shut up time for all of us!

Frederick D. Hunt Jr.
President
Society of Professional
Benefit Administrators
Chevy Chase, Md.

Photo by Elliott Erwitt

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Tank coverage

Continued from page 3

lack of interest from buyers (*BI*, Jan. 15, 1990).

Tank owners, though, could also make arrangements with fronting insurers to provide a certificate of insurance and cede the risk to a captive, said Mr. Blinn.

Simplified administration is one advantage of such a fronting arrangement, he noted. "Rather than trying to apply for self-insurance on a state-by-state basis" and handling the ensuing administrative chores, one insurer can handle all administrative duties in a fronted program, Mr. Blinn said.

Higher limits than those required by the EPA may be available through a fronted program, said Mr. Blinn.

"In addition, you've got the advantage of uniform nationwide coverage. You know that you can have the same coverage, say a $5 million limit, for all states in which you do business by using the fronting insurer backed up by a captive."

And coverage can be broadened to include insurance for aboveground tanks, he said.

Mr. Blinn noted that there are some disadvantages to using a captive, including the cost of using the fronting insurer.

Another drawback is that a firm has to pay a premium up front to a captive, creating a disadvantageous cash-flow situation compared with self-insurance, under which losses can be funded on a "pay-as-you-go basis," he said.

Other alternatives have their own disadvantages, Mr. Blinn said.

State funds offering coverage for underground storage tank exposures are the creation of "very effective lobbying of petroleum marketers in various states," he said.

Many states have created the funds as "mini-insurance companies. . .to cover the liabilities of owners and operators" of underground tanks, Mr. Blinn explained. Several of the state funds have been approved by the EPA to satisfy financial responsibility requirements, while others are under review (*BI*, Oct. 8, 1990).

A state fund is "virtually an insurance company set up and run by the state," Mr. Blinn said. They are often under the jurisdiction of insurance or environmental authorities.

While the state funds appear to be a potential solution for tank owners, there are questions regarding whether they are properly funded.

The insurers are generally funded through premiums or taxes, said Mr. Blinn, and the amounts being collected are far short of what could be needed to pay claims.

To illustrate, he said some states could require around $6,000 per tank to fund potential liabilities and "the most a state is collecting is around $1,500 per tank. Texas is collecting about $100 per tank per year for its fund."

Another problem with the funds is the inexperience of some of the administrators in charge of the insurers, he added.

Tank owners and operators that meet net worth requirements can self-insure to meet the EPA requirements, but it means qualifying annually in all states where tanks are located. "As you can imagine, it can be a bit of a headache to self-insure these liabilities," Mr. Blinn said.

An alternative to self-insuring, of course, is to buy coverage in the conventional market, he said.

However, there are a limited number of key markets and "fringe players" that offer insurance to meet underground storage tank financial responsibility requirements, and some are not "name brand" companies," he said.

Owners of underground storage tanks will find varying levels of regulatory scrutiny, depending on which states they operate in, said Mr. Blinn.

The structure devised to monitor compliance with the EPA financial standards is the first example of franchising the government agency has adopted, Mr. Blinn said.

Because only a handful of EPA employees staff the department that monitors underground storage tanks, he explained, they have "set up in effect a franchise operation in which they have given all the responsibility and all the authority to regulate the tanks to the individual states."

A state fund is 'virtually an insurance company set up and run by the state,' Mr. Blinn says.

"That may sound great until you see. . .the nightmare that has been created," Mr. Blinn said. "It also grants states independent rights to set up what is appropriate for cleanups, too."

That means that some states have more stringent rules than others, he pointed out.

"Having 50 separate states enforcing these regulations is giving rise to 50 different levels of enforcement," Mr. Blinn noted. "To one extreme, we've got the state of Maryland, where we've got 27 people that are out making sure people are buying the right insurance and are following the technical requirements."

Yet some states have put only a couple of people in charge of that oversight.

"In addition, you've got a bit of a political problem associated with what is called the world distribution network," he said.

He explained that shutting down a gas station in a small town with only one station presents a hardship to residents. "There is a concern among politicians that if we enforce these regulations too strongly, we're going to fragment and ultimately destroy this world distribution network." ■

Financial reinsurance

Continued from page 3

cover past exposures like long-latent diseases, pollution or inadequate reserving, he said. "Few insurers or captives overreserve," he pointed out.

Prospective policies can cover such future exposures as unforeseen catastrophes, changes in regulations and bad underwriting by insurers, Mr. Gluckstern said. No insurers believe they are guilty of bad underwriting; "unfortunately, we all do it," he said. And both unforeseen catastrophes and changes in regulations can deplete reserves.

The classical treatment of financial reinsurance today, according to Mr. Gluckstern, is to use future good underwriting to pay for historic bad underwriting.

He noted that a policy recently written by Centre Re for Home Insurance Co. will protect it on both a past and future basis over the next few years. The Home was acquired last month by a group of investors, including Centre Reinsurance (Barbados) Ltd., from AmBase Corp. (*BI*, Feb. 18).

"Stability is extremely important" in financial reinsurance, Mr. Gluckstern said. If you enter into an agreement with somebody, you must know they are going to be there in the future, he said.

Clients need a long-term, stable product, said Mr. Gluckstern, noting that Centre Re enters into few one-year deals.

Another important element of financial reinsurance is risk transfer, he said, adding that true financial reinsurance is accepted for regulatory and other purposes.

Flexibility is another key, he said. "These are tailor-made, manuscripted deals."

Mr. Gluckstern also discussed why Bermuda has become such a successful domicile for financial reinsurance. Among the reasons he cited were:

- Bermuda-based financial reinsurers do not need to use statutory accounting methods, which require that liabilities be stated at their ultimate value, without taking investment income into account.

Otherwise, liabilities "would consume statutory capital at a very alarming rate," he said.

- The better tax situation in Bermuda. Exempt companies in Bermuda will not pay income taxes until 2016.
- The quality of Bermuda's insurance support services.
- The proximity to United States time zones. It would be very difficult, for instance, to work out of Hong Kong, "where when you are awake, they are sleeping," Mr. Gluckstern said.

After speaking, Mr. Gluckstern fielded several questions from the audience.

Asked how much risk constitutes transfer of risk, Mr. Gluckstern said, "I believe you have to have a certain amount of underwriting risk."

In a financial reinsurance transaction there should be a gap between the premium income and the ultimate possible payout that cannot be closed by the timing risk alone, he said.

For instance, a deal where an insurer receives $1, but could pay up to $2 in just a year would qualify as financial reinsurance, he said.

"Underwriting risk is a component of every financial reinsurance transaction," Mr. Gluckstern said.

Mr. Gluckstern also was asked why accountants seem to have difficulty with financial reinsurance. "I think accountants are confused about it," he responded.

Clearly, people have been concerned about abuses in some financial reinsurance transactions that apparently instantly transform sick companies into healthy ones, Mr. Gluckstern said.

Insurers should educate the accounting, tax and regulatory communities about financial reinsurance, and demonstrate to them that there are significant risk transfer elements to these transactions that involve more than just "depository relationships," he said.

Asked about the recent development of insurance futures contracts (*BI*, Feb. 11), Mr. Gluckstern said he does not believe the contracts, which have been compared to financial reinsurance, will work.

Insurance futures are complicated, he said, "and pretty complicated things don't work in general," he said.

Meanwhile, at a separate workshop on financial reinsurance, Messrs. Burville and Dixon discussed what financial reinsurance is and how to use it, providing some practical examples.

"Financial reinsurance is not cash-flow underwriting," said Tillinghast's Mr. Burville. He said his definition of a financial reinsurance or finite risk contract is "a contract where most of the premium is the present value of most of the aggregate limit."

The "risk spectrum" for financial reinsurance includes asset and credit risk; timing risk; and finite risk, he said.

Asset and credit risk, he noted, is embodied in time-and-distance policies, where "there are no unknowns in actual fact," he said. However, the investments made by the reinsurer could fail to produce the expected results.

British tax authorities have accepted time-and-distance policies for Lloyd's syndicates.

Timing risk involves setting expected losses at an aggregate limit, although it's not certain when losses will occur, he said. The financial reinsurer runs the risk that claims will be paid more quickly than expected, depleting funds available to earn interest on the contract.

Finite risk, he explained, occurs when expected losses can fall below or above the aggregate limit established, and there is a timing risk as well.

Among the reasons to use financial reinsurance, according to Mr. Burville, are:

- It permits discounting.
- It demonstrates coverage when

Continued on next page

Financial reinsurance

Continued from previous page
required by regulatory authorities.

- Earnings can be realized by transferring current losses.

"You can get the incurred liability off your balance sheet," said Mr. Burville.

Financial reinsurance also allows a company to recognize its true net worth while protecting it from liabilities, said Mr. Burville, who noted that most contracts are written by and for companies in the United Kingdom, the United States or Bermuda. Elsewhere, he said, "it's very undeveloped and unsophisticated."

Centre Re's Mr. Dixon in particular discussed the uses of financial reinsurance by captives. Financial reinsurance can be used to manage a captive's net retained liability to reduce volatility, he said.

Also, a loss portfolio arrangement, where an insurer cedes loss reserves for known losses on a discounted basis to a reinsurer, can remove old business that sits on the balance sheet but produces no current income, he said.

Prospective "stop-loss covers" also can be useful to captives, said Mr. Dixon. These transactions can protect the captives' loss and income statements, he said.

Mr. Dixon noted that captives tend to develop in stages. During their first two or three years, for instance, captives tend to buy lots of reinsurance. "It really is trying to avoid disruption in a lot of ways," he explained.

Until that stage is passed, he said, captives have little use for financial reinsurance. At that point, however, they start to manage their financial condition and become potential financial reinsurance clients, he said.

Mr. Burville also presented several sample financial reinsurance contracts for self-insured clients that are based on actual policies.

One example, which illustrated a "structured settlement," involved a U.S. manufacturer that wanted to insure a product liability class of business covering claims made over five years.

The contract, which had an inception date of Jan. 1, 1989, had an aggregate limit of $4.75 million excess of $250,000. The premium was $4.25 million payable in five annual installments of $850,000.

"There's not a large expectation of investment income," Mr. Burville said of this deal. "That's a fairly straightforward, traditional financial reinsurance contract."

A second example involved a loss portfolio transfer. The policyholder is a racehorse owners' association with a self-insured credit guarantee class of business. The contract's period is Jan. 1, 1989, to Dec. 31, 1993.

The limits are $5 million per loss per horse excess of $250,000 per buyer per auction. The policy is subject to a $5 million aggregate. The premium is $4.5 million payable in five annual installments of $900,000 each.

This was a case in which insurance coverage is required, and is being provided through this loss portfolio contract, Mr. Burville said. "I don't believe they expect to lose $5 million of coverage," said Mr. Burville. "This is really to prove insurance coverage."

The third example was a prospective aggregate, finite risk contract. The policyholder in this case is a manufacturer with a self-insured general liability class of business and a contract period from Jan. 1, 1989, to Dec. 31, 1989.

The limits are $750,000 excess of $250,000 per occurrence, subject to a $10 million aggregate. The premium is $6.1 million payable in quarterly installments.

Breaking down the premium, Mr. Burville said this reflects $8 million in expected losses that have an expected present value of $5.4 million.

Added to the $5.4 million is $200,000 charged for expenses and profit along with a risk charge totaling $500,000 for the $2 million in coverage excess of $8 million in expected losses. All this adds up to a total premium of $6.1 million.

Unless these losses pay out over a 20- to 30-year period, there will never be enough investment income to pay for the potential loses, said Mr. Burville, explaining the risk element involved.

Mr. Dixon also presented an example of a captive reinsurance program that was modeled on an actual Centre Re contract.

In this example, a captive has assets of $15 million in cash and investments. Its liabilities include $12 million in loss reserves plus $3 million in shareholders' equity, which represents primarily a surplus contribution plus some investment income generated by the reserves.

The captive issues $5 million policy limits for directors and officers, errors and omissions, general liability, and other types of casualty coverages. There is no property or short-term liability insured. The captive retains $3 million per occurrence per insured.

Reinsurance is purchased each year for $2 million excess of $3 million per occurrence. The aggregate limit for this reinsurance is

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Financial reinsurance to cover catastrophes

By JUDY GREENWALD

HAMILTON, Bermuda—Major reinsurers can and will play an active role in providing financial reinsurance to help corporations cope with the impact of major catastrophes, says a Swiss Reinsurance Co. official.

Ernst Baumann, who is deputy to the head of reinsurance at Swiss Re in Zurich, Switzerland, made his remarks in the light of a recent Swiss Re study that shows an increasing number of major catastrophes in recent years.

Mr. Baumann spoke at the 15th International Captive Insurance & Reinsurance Forum sponsored by Tillinghast earlier this month in Bermuda.

"The main area in comprehensive management of catastrophe risks for a major corporation is loss financing," said Mr. Baumann. "Here the strong professional reinsurer can and will play a major role."

Traditional insurance and reinsurance is less important to multinational corporations in their long-term loss financing strategies, Mr. Baumann noted.

"This is true to a certain extent because of the volatility and financial instability of certain insurance markets, as well as the lack of cover, capacity and services for hazardous risks and a costly distribution system," he explained.

Pointing to new loss financing concepts, Mr. Baumann said that "apart from a wide range of services including captive management and claims service, the professional reinsurer will continue to provide long-term capacity for large risks, based on their own financial resources.

"Stable capacity. . .will become more important in the future transfer of the catastrophe type of risk where in the past very often some high cover limits have been cobbled together on a very wobbly construction of insurance, multiple reinsurance and retrocessions which did not necessarily correspond to the security expectations of a corporation," he said.

"With the increase of uncertainty, a corporation should be more inclined to buy stability. This means more careful study of the financial situation of insurers and reinsurers and more long-term contracts," said Mr. Baumann.

Some reinsurers can offer a wide range of "very valuable" alternative loss financing arrangements for special risk situations, unexpected claims developments, uninsurable exposures or specific business situations, said Mr. Baumann.

Examples of the latter would include the sale or acquisition of companies, mergers, and changes in—or termination of—business activities, he said.

The characteristics of financial reinsurance alternatives, said Mr. Baumann, are:

- A risk transfer that could consist of a timing risk, an investment risk, a credit risk and limited underwriting risk that is in excess of the expected losses.
- The inclusion of investment income to fund or pay losses.
- A structured plan for premiums and claims payments and reserves for incurred losses on a cumulative basis, spreading losses over a longer period.

"Since these programs have to be structured according to the specific needs of a client, prospective covers in particular can be very flexible to follow any business and/or risk developments; for example, the inclusion of new risks, coverage of gaps and so on," he said.

Because these alternative risk financing contracts are long-term arrangements and very often involve substantial payments, "the security and the confidence and the confidentiality of the partner are of vital importance," he said.

Mr. Baumann also discussed a 1990 study by Swiss Re of natural catastrophes and major losses for the period 1970-1989 (*BI*, Dec. 17, 1990).

"The study shows clearly the number of large and very large insured events of more than $100 million has increased in recent years, particularly in the case of natural catastrophes, but major man-made losses have also become more numerous," he said.

The extent of damage has also risen more sharply than the actual number of events, he added.

"This latest trend shows that the large corporation not only is more vulnerable to large and heavy risks but seems also to become more exposed to catastrophes due to changes in manufacturing techniques; optimization of plant output governed by the principle of economies of scale; the more intensive use of land prone to natural calamities like flood, windstorm, earthquake; and, last but not least, an increased awareness of the environmental situation and also of product safety.

"Some of these exposures cannot be transferred at all or only partly to the insurers and reinsurers," Mr. Baumann said. ■

Financial reinsurance

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$10 million.

For the limit of the excess-of-loss reinsurance to be reached, the captive would first have to sustain net losses equal to five times its retention of $3 million for a total of $15 million.

In addition, assuming there are some other underlying losses as well, this means the captive, with its $15 million in assets, would be out of business before it reaches that point, Mr. Dixon said.

Another factor to be taken into consideration would be the cost of reinsurance. The reinsurance now costs $1.2 million a year, although it is scheduled to go up to $1.4 million the following year.

Under an alternative reinsurance structure, there would be a three-year program for the $2 million excess of $3 million per occurrence layer, with an aggregate limit of $12 million over the three-year period. The total premium over the three-year period would be $6 million to $7 million.

The profit commission would be based on premium, less a margin and paid losses, plus an interest credit on the average cash balance.

Among the advantages of this approach, Mr. Dixon said, is that it provides budgetable reinsurance costs over three years.

And with the profit commission, the reinsured takes part in the program's profitability, which lowers the reinsured's net cost.

In addition, the reinsurance limit purchased is more consistent with the economics and loss expectations of the captive.

"This can be an extremely low-cost way for the captive to buy reinsurance," Mr. Dixon said. It also protects the captive regardless of whether the market is hard or soft, he said. ■

Shake-up foreseen in Canadian market

By JUDY GREENWALD

HAMILTON, Bermuda—The Ontario government's threatened takeover of the province's automobile insurance industry could cause the entire Canadian property/casualty market to "crash and burn" rather than make the "soft landing" that might normally be expected, warns a consultant.

The additional insurer capital that would be freed by such a takeover could, at least initially, prolong the extremely soft property/casualty market in Canada, said Edward T. Belton, a risk management consultant with the Tillinghast unit of Towers, Perrin, Forster & Crosby Inc.

Mr. Belton, who is based in Toronto, spoke at the 15th annual International Captive Insurance & Reinsurance Forum sponsored by Tillinghast earlier this month in Bermuda.

Also speaking during the session was William E. Toyne, director of risk services for Sedgwick James Inc. in Toronto, who recommended that Canadian captives change their approach from risk financers to risk takers.

In his remarks, Mr. Belton said that "there has been and will continue to be a disturbing degree of volatility in the (Canadian) marketplace" until supply and demand "come into better balance."

Based on his analysis of current conditions, he concluded that the current soft market in Canada "is not likely to culminate in a violent upswing in premium rates or a dramatic shortage (in the) market in the near future."

But, he added, "one dark cloud" is the chaos that could result in 18 to 24 months if the Ontario provincial government takes over auto insurance in the province.

Mr. Belton explained that the newly elected socialist government in Ontario, Canada's largest province, is dedicated to some form of auto insurance nationalization. The reform has been promised for many years, and with the election of the new government, "they're going to have to do something to fulfill the promise."

The options range from a partial to a complete takeover of automobile insurance. In either case, he said, "the implications for the (insurance) industry are very grave" because many companies will no longer be viable.

"There is bound to be a major, major shake-up," with insurers either merging or withdrawing from the market, he said.

One insurer—SAFECO Corp. of Seattle—has already announced its plans to leave the market. Conceding that there is "obviously some degree of optimism," Mr. Belton said that six to eight insurers are lining up to acquire its portfolio of business.

SAFECO acknowledged that the Ontario government was one of several reasons for its withdrawal. "It was a factor, but it certainly wasn't the only factor,' said Rod Pierson, vp and controller.

After a period of losses, Mr. Pierson said, the company came close to breaking even in Canada the past several years after investment income is taken into account. "We just came to the conclusion we had enough, and we wanted to devote our resources elsewhere."

Canadian operations generate slightly less than 10% of the insurer's total business, he added.

Mr. Belton said he bases his predictions on several assumptions:

- That Ontario's government will only take over the personal injury portion of automobile insurance, rather than the physical damage portion as well. This business alone, however, accounts for 15% of all property/casualty insurance written nationwide, he said.
- That the takeover's effective date will be Jan. 1, 1993.
- That the amount of premium income lost to the industry will be about $1.8 billion Canadian ($1.56 billion U.S.).
- That this will free up about $1 billion Canadian ($864.3 million U.S.) of insurers' capital and surplus.

In an "ideal world," said Mr. Belton, given these assumptions, shareholders would decide "enough is enough" and withdraw the freed-up capital from the marketplace. And "while they are in the mood," they would remove a big chunk of the excess capital that has kept the Canadian marketplace oversupplied, hypercompetitive and unprofitable.

The result of all this, said Mr. Belton, would be "nirvana." The remaining companies would be under little pressure to leverage their excess capital and competition would continue, "but not vigorously or unreasonably so."

Under this scenario, the marketplace would be stable and cycles would be all but eliminated because prices would not get hammered down to unrealistic levels that require big increases to correct, Mr. Belton explained.

Reasonable prices would keep the public happy. Brokers would be happy because the market is relatively open, regulators would be happy because solvency is not threatened and the government would be happy because there are no complaints from the public, he summed up.

But, "the problem with this scenario is that it requires a degree of wisdom, foresight and discipline which the owners of insurance companies in Canada have never, ever displayed in the 200-year history of the business," he said.

He quoted one journalist, writing in the Montreal Gazette in 1983, as commenting that the Canadian insurance "business is going to the dogs because of broad policies, low rates and unbridled competition."

"Virtually nothing has changed in the interim," Mr. Belton said. "There is truly nothing new under the sun."

Under Mr. Belton's "crash and burn" scenario for the Canadian market, the $1 billion of freed-up capital is not withdrawn. Instead it is added to the $5 billion of surplus that already exists in the marketplace.

At the center of this scenario, said Mr. Belton, is a prolonged price war. Insurers would fight for market share and, to properly leverage their capital, try to replace the premium volume taken over by the Ontario government.

Competition would grow more vigorous than ever, he said. And results would deteriorate rapidly, with weaker companies faring so badly that regulators are forced to step in and wind them up.

Insurers will subsequently merge or be bought out by better-capitalized companies, Mr. Belton continued. "During the price war, a great big chunk of capital would be lost,

Continued on next page

Canadian market

Continued from previous page

return on equity would be negative and shareholders also would take a terrible beating."

Insurers then will do what they should have done in the first place, Mr. Belton said: They will remove whatever excess capital is left, and a leaner, more disciplined marketplace will evolve. A smaller number of much larger players will remain, he predicted.

The prolonged price-cutting in Canada would put companies so deep in the hole that survival would depend on immediate and substantial price increases, tightened underwriting standards and all the corrective measures that accompany a hard market cycle, he said.

In shock, commercial buyers and risk managers will flock to captives, reciprocals and other alternative risk financing methods, said Mr. Belton.

He further warned of an "unthinkable" scenario if the government takes over the entire automobile insurance business, rather than just bodily injury coverage. In this case, the amount of premium volume lost to the industry would jump to $4 billion and the amount of capital freed up would total $2 billion.

"It would turn out to be an absolute blood bath," said Mr. Belton. "If consistency and stability and predictability are important to you, then you're not likely to find them in the marketplace."

Any marketplace that is sensitive to the supply-and-demand relationship, like the Canadian insurance marketplace, will experience relatively severe cycles until the source of instability—excess capital—is eliminated, he said.

"However, no matter how insurers respond to the loss of Ontario auto (insurance), the longer-term outlook for the marketplace is that there will be far fewer, bigger, stronger insurers and a more orderly and disciplined marketplace," he predicted.

Under a "nirvana" scenario, this transformation would occur with relatively little trauma. Under the "crash and burn" scenario, market convulsions would eventually lead to stability.

But, depending on how the future unfolds, "there could be a crisis which is equal to, or worse than, that which was experienced in 1985-1986," Mr. Belton said.

Mr. Belton also discussed the current oversupply of capital in the Canadian market: As of September 1990, the market had capital and surplus amounting to $10 billion, which would support $25 billion in premium volume, assuming a premium-to-surplus ratio of 2.5-to-1.

Actual net premiums written totaled $13.4 billion, which means the market has $11.6 billion in surplus capacity, or a 53.6% capacity utilization rate, he said.

Mr. Belton also calculated the amount of excess capital. With an estimated $5.4 billion of capital required to support $13.4 billion of net premiums written, and actual capital of $10 billion, the market has $4.6 billion in surplus capital.

Meanwhile, Sedgwick James' Mr. Toyne said in his presentation that Canada has a relatively small indigenous property/casualty insurance market.

For example, he noted that the 42 reinsurers licensed in Canada only account for about 7.3% of the total market. Of those, the three reinsurers that are Canadian owned write only 0.59% of the property/casualty market, he said.

In addition, less than 5% of the direct writing companies in Canada are Canadian-owned.

The result, said Mr. Toyne, is that Canadians have little control over a market that is "very much subject to the vagaries of insurance around the world."

One of the major objectives that Canadian companies have when forming captives is to stabilize their costs.

"Can a captive really do this?" Mr. Toyne asked.

While Canadian companies use their captives primarily to finance predictable losses, Mr. Toyne predicted that when the market hardens, captives' traditional role will be challenged. The opportunity will emerge, he said, for captives to participate in the upper levels of risk financing programs.

Only through this approach, said Mr. Toyne, will captives meet the objective of stabilizing cost of risk.

This will require "new thought," however, on the part of brokers, risk managers and corporate chief financial officers, said Mr. Toyne.

Captives will never be totally able to moderate the market's fluctuations, "but I'm convinced we're going to have to do a lot more of this than we have in the past," he said. ■

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Retiree health benefits, captives may not mix

By MICHAEL BRADFORD

HAMILTON, Bermuda—Captive insurers may be of little value to employers facing stricter requirements for funding retiree health care benefits, a tax expert points out.

The accounting rule that scraps "pay-as-you-go" accounting for retiree health care costs also appears to limit the use of captives as a way to fund the benefits, said Jeffrey Eidson, senior tax manager with KPMG Peat Marwick in Bermuda.

In addition, only captives based in U.S. domiciles—defined as the 50 states, the District of Columbia and the U.S. Virgin Islands—can directly insure retiree health care benefits. The Employee Retirement Income Security Act does not allow employee benefits for U.S. workers to be funded through captives in non-U.S. domiciles and limits the types of captives based in U.S. domiciles that can insure employee benefit plans.

For purposes of its retiree health benefit accounting rule, the Financial Accounting Standards Board does not consider contracts with captives to be "insurance contracts," Mr. Eidson said at the 15th International Captive Insurance & Reinsurance Forum, sponsored by Tillinghast earlier this month in Bermuda.

Last year, the board passed its long-awaited rule, FASB 106. Beginning in 1993, large companies will be required to accrue retiree health care liabilities as an expense from the date employees are hired until they are eligible for benefits (*BI*, Dec. 17, 1990).

That rule was not particularly good news for employers hoping to use captives to finance the liability, said Mr. Eidson.

The accounting rule defines an insurance contract as one "in which an insurance company unconditionally undertakes a legal obligation to provide specified benefits to specific individuals" in return for a premium.

"And that's what we all know an insurance contract to be. However, they go on to say that an insurance contract must be irrevocable and must involve the transfer of significant risk from the employer to the insurance company."

In a footnote, Mr. Eidson added, FASB states that contracts with an insurer that does business primarily with the employer and related employers—in other words, contracts with a captive—will not be considered insurance contracts.

That language may not completely close the door on the use of captives to finance retiree health care liabilities, he said. "You may still be able to treat that contract as a plan asset."

Assets, however, are subject to other regulations. FASB requires employers to have no control over plan assets and requires assets to be structured as a trust or similar vehicle.

"There is some flexibility there, but it is somewhat restricted for having an insurance contract in itself qualify as a settlement of a post-retirement benefit liability," he said.

It is not entirely clear whether an insurance contract could be used to fund the liability if it were fronted by a commercial insurer and then reinsured with the employer's captive whether the captive is located in a U.S. or some other domicile, Mr. Eidson said. But "it's our feeling at this point that fronting arrangements would be treated very similarly to direct programs."

Businesses that participate in multiple-owner captives may have better luck financing retiree health care liabilities through captives than businesses with wholly owned captives, according to Mr. Eidson.

FASB 106 addresses captives only in "very broad terms," he said. "It appears that under the statement a wholly owned insurance company would be considered a captive, but a multi-owned insurance company may not be."

He warned, however, that the regulation is still open to interpretation.

Several other retiree health care liability funding alternatives are more clear-cut than captives, he said.

A company could increase pension benefits for retirees and then make retirees responsible for purchasing their own health insurance, rather than furnish employer-paid retiree health care coverage, he noted. That way, the company can fully deduct its contribution and earnings on the pension contributions can accumulate tax-free.

But, that approach has at least two drawbacks, he said. Pension regulations do not permit firms to reduce pension benefits once they are increased, and employees would be taxed on the added benefits.

Other funding options include:

- Funding retiree health care benefits through qualified retirement accounts under Section 401(h) of the Internal Revenue Code.

Advantages include the fact that contributions are deductible for the employer and retirees receive benefits tax-free. But the cost of medical and death benefits under a 401(h) plan cannot exceed 25% of pension plan costs, which might mean that the plans would not be adequate to fully fund medical benefits.

Also, contributions can be made to retiree health care costs funded through a 401(h) account only if pension contributions also are made through the account. If the pension plan is fully funded, retiree health care contributions cannot be made.

- Voluntary employee beneficiary associations, also known as 501(c)(9) trusts.

VEBAs permit employers to make tax-deductible contributions to retiree health care costs—within certain limits. However, investment income on those contributions generally is subject to tax.

- Funding through medical reimbursement insurance contracts or other arrangements with insurers.

General problems with funding post-retirement benefits have mushroomed, Mr. Eidson noted.

"The issue can be likened to a storm gathering on the horizon. CEOs and CFOs in American corporations have seen it coming for a number of years, but they have been very wary to deal with it. For whatever reason, they have ignored the problem."

Escalating medical costs pose the primary threat to employers offering post-retirement health care benefits, Mr. Eidson remarked. Not only have health care costs risen dramatically, he added, but the number of retirees also continues to climb, "both in actual number and in relation to active employees."

Mr. Eidson referred to a 1984 estimate that total unfunded medical liabilities of the Fortune 500 companies amounted to about $2 trillion. Total assets available to fund these benefits at that time were only an estimated $1.3 trillion.

Employers have several options for limiting their liability for post-retirement benefits, Mr. Eidson said.

Companies could reduce or cap benefits, he pointed out, or require payments from employees or retirees.

While some companies have attempted to terminate retiree health care benefit programs, promises made in labor agreements can make that impossible in some situations and courts have generally upheld employees' rights to the benefits, Mr. Eidson said. ■

Few insurers have 'stomach' for EIL

By MICHAEL BRADFORD

HAMILTON, Bermuda—Insurers' reluctance to underwrite environmental exposures is creating opportunities for alternative risk financing markets, says an environmental specialist.

If capacity for environmental impairment liability insurance is shrinking in the conventional market, "it has to go someplace," said Amy S. Bouska, a consultant in Bermuda with the Tillinghast division of Towers, Perrin, Forster & Crosby Inc.

"This is sort of like the carrion opportunity, but don't overlook it. Somebody has to write that business" she advised.

Some insurers are reluctant to write environmental liability policies because the demand for the coverage doesn't always live up to expectations, she said earlier this month at the 15th International Captive Insurance and Reinsurance Forum in Bermuda.

"It seems like whenever somebody comes along and wants to write it, the demand doesn't really quite come up to expectations," Ms. Bouska said.

As an example, she cited Environmental Protection Insurance Co. Risk Retention Group, which stopped underwriting the coverage in December 1989 (*BI*, Jan. 15, 1990)."EPIC stopped writing not because they had a financial problem, as far as I know, but because nobody wanted to buy it," she said.

Tillinghast's Ms. Bouska cites estimates that environmental services and support service firms have annual sales of $98 billion and provide 3 million U.S. jobs. 'That means there is $98 billion out there that needs insurance,' she says.

Other property/casualty insurers are reluctant to write EIL coverage because they are reserving their capacity for some other line of insurance business, Ms. Bouska said.

Some large insurers and Lloyd's of London syndicates are the rare exceptions. "There are people who are willing to take a chance on it," she said.

There appear to be three types of insurers that are writing EIL coverage or could benefit from current market conditions, Ms. Bouska observed.

"The first is people with iron stomachs who are willing to write true environmental impairment coverage," she said.

"Everyone we talk to who is doing that says it must be highly engineered and it must be very specific—either to the tank or to the site. You don't just go out and tell people: 'You're covered,' " according to Ms. Bouska.

Insurers willing to write coverage in that manner tend to impose major underwriting restrictions, Ms. Bouska noted.

Other types of insurers willing to accept EIL risks are those who Ms. Bouska says write "very specialized coverage related to something you understand very well."

She referred, for example, to Steel Tank Insurance Co., a Vermont-based captive.

Its association parent, the Steel Tank Institute, felt it had the expertise to set standards for the manufacture of underground tanks and therefore the expertise to enter the EIL insurance market.

In addition, there is an opportunity for insurers to write what Ms. Bouska described as "eco-support" insurance for companies that provide support services, like computer programming, for businesses with EIL exposures.

With some additional expertise like engineering and legal help, those insurers might be able to enter the EIL marketplace, Ms. Bouska said.

The size of the "eco-business," including companies that provide some form of environmental services and those that provide them with support services, is "quite astonishing," she said.

Ms. Bouska cited estimates that those companies have annual sales of $98 billion and provide 3 million U.S. jobs.

"That means there is $98 billion out there that needs insurance," she pointed out.

So why aren't insurers scrambling to write coverage for "eco-support" companies? "You don't just do it on your own. You've got to be backed by engineering and legal expertise," Ms. Bouska remarked.

Recent developments related to the Superfund law have made the need for EIL coverage particularly obvious, Ms. Bouska pointed out. Estimates of the cost to clean up the sites identified under the law range from $60 billion to $750 billion.

"When you start with a basic figure. . .and there is a swing of a factor of 10, things are a little uncertain," she said.

Legal fees and pre-cleanup studies push the total cleanup costs even higher, she noted.

And there is the potential of third-party lawsuits—as opposed to government cleanup actions—related to pollution sites, Ms. Bouska remarked.

Because suits will be filed only after pollution-related diseases develop, final costs for third-party suits are unknown, she said.

Also, suits calling for polluters to restore damaged natural resources are beginning to appear, Ms. Bouska said.

"The first natural resource case, to the best of my knowledge, was filed about a year ago," she said.

Natural resource suits call for polluters to restore a site to a pristine condition, she said. Such suits have been filed by the U.S. government, among others, she said.

Despite the growth of those exposures, Ms. Bouska said risk management consultants still are encountering stubbornness among some businesses about purchasing EIL coverage.

Some businesses that don't have EIL insurance simply settle for a site assessment. They say, "Why should I bother" with insurance after paying $3,000 to $5,000 for a study that showed the site to be clean, Ms. Bouska said.

Business owners remark: "I just had someone tell me my site is clean. I don't need insurance," she related. ■

Unrelated business comes in many forms: Attorney

By JUDY GREENWALD

HAMILTON, Bermuda—Following three recent U.S. Tax Court rulings, wholly owned captives should try to secure as much unrelated business as possible without becoming "innocent capacity," says a tax attorney.

James R. Cameron, of Baker & McKenzie in New York, discussed what firms should do in light of recent rulings on the deductibility of premiums paid to captives at the 15th International Captive Insurance & Reinsurance Forum earlier this month in Bermuda.

The three rulings allowed federal income tax deductions for premiums paid to wholly owned captives if the captives write significant amounts of third-party business (*BI*, Feb. 4).

Because the court did not define unrelated business, companies could have some latitude in doing so, Mr. Cameron said.

In a memo distributed at the conference, he said that "unrelated risks are insurance risks of persons or entities which are unrelated by ownership to the insurance company—that is, risk from outside the affiliated group. The Tax Court accepted as unrelated risks of customers and business associates (e.g. franchisees and distributors) of the affiliated group.

"It is also possible that the Tax Court would accept employee risks (e.g. life and health insurance or directors and officers liability) as unrelated risks, although this question was not before the court," Mr. Cameron noted.

In pending tax audits, he said, corporations with wholly owned captives should review any unrelated business the captives write.

" 'Hidden' premiums in rental fees, service fees, shipping arrangements and commissions charged to customers and business associates may qualify as unrelated premiums," he wrote.

The three Tax Court decisions, released simultaneously on Jan. 24, involved:

- Los Angeles-based AMERCO, the parent of an affiliated group of corporations that comprise the U-Haul rental system and its Phoenix-based subsidiary, Republic Western Insurance Co.

Half of Republic Western's business is unrelated to AMERCO.

Among relevant facts in this case, Mr. Cameron said, is that the U-Haul system had 250 subsidiaries. Republic Western's business was licensed in 45 states, with capital and surplus rising from $15 million to $51 million, he said.

Business that the court either said was related or did not rule on included U-Haul corporate policies and insurance on owned trailers.

- San Francisco-based Harper Group and its Hong Kong captive, Rampart Insurance Co. Ltd., whose capital had been increased from $40,000 to $10 million.

The captive, which was owned through two subsidiaries, insured customers, affiliated "brother/sister" companies and the parent company.

Coverage provided to Harper group's customers alone accounted for about 30% of its gross premiums during the years under consideration. That portion, the court decided, was sufficient to allow premiums to be deducted.

- Chicago-based Sears, Roebuck & Co. and its Allstate Insurance Co. unit. About 99.75% of Allstate's business is unrelated to Sears.

Allstate, which is licensed in all states, has capital and surplus exceeding $2 billion.

Discussing the elements of nonrelated business found by the tax court, Mr. Cameron said in AMERCO's case, the court considered non-owned trailers in the U-Haul system and payments by customers for its leased trailers or self-storage units to be unrelated business.

It also considered payments by Harper customers to cover air shipments to be unrelated.

Mr. Cameron said that in its decisions, the tax court established a new three-prong test to determine whether premiums paid to an affi-

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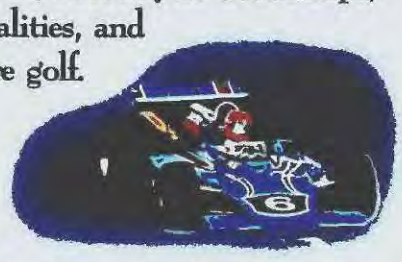

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Captive taxes

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liated insurance company will be treated as insurance premiums for tax purposes.

Such an arrangement, he said, will be treated as insurance for tax purposes if:

- It involves the existence of an insurance risk.

In the memo distributed at the conference, Mr. Cameron said the court explained this prong in the AMERCO decision the following way: "Basic to any insurance transaction must be risk. An insured faces some hazard; an insurer accepts a premium and agrees to perform some act if or when the loss event occurs.

"If no risk exists, then insurance cannot be present.'

- There was both risk-shifting and risk distribution.

In the AMERCO decision, Mr. Cameron said in the memo, the Tax Court said: "That there was technical risk-shifting is apparent from the face of the transaction. Insurance contracts were written, premiums were transferred and losses paid.

"Republic Western (U-Haul's insurance subsidiary). . .was a separate, viable entity, financially capable of meeting its obligation."

Discussing risk distribution in the same decision, the court said, "The concept of risk distribution emphasizes the pooling concept of insurance; that it is in the nature of an insurance contract to be part of a larger collection of coverage, combined to distribute risks among insureds.

"Risk distribution was clearly present in the transactions at issue; Republic Western's insurance business was diverse, multifaceted and, as stated, involved a substantial amount of risk."

- The arrangement between parent and captive was to provide insurance in its commonly accepted sense.

In the memo, Mr. Cameron noted that the Tax Court gave weight to the fact that regulators treated the companies in question as commercial, not captive, insurers. Allstate and Republic Western were regulated as commercial insurers by Illinois and Arizona respectively. And Rampart was subject to supervision by Hong Kong regulators.

'Basic to any insurance transaction must be risk. An insured faces some hazard; an insurer accepts a premium and agrees to perform some act if or when the loss event occurs. If no risk exists, then insurance cannot be present,' a Tax Court ruling says.

Based on those rulings, Mr. Cameron said, parents of wholly owned captives should be entitled to deduct premiums paid to their captives if 30% of the captives' business is unrelated to the parent.

Companies should develop non-related business to qualify for that deduction, he said.

Mr. Cameron also recommended that corporations with captives push premium deductibility as an issue in the tax courts.

Meanwhile, the Internal Revenue Service could still appeal the Tax Court rulings to federal appellate courts.

Appeals are "almost certain" in the Harper and AMERCO cases, both of which would be handled by the 9th U.S. Circuit Court of Appeals, said Mr. Cameron.

He said he is not sure whether the Sears case would be appealed to the 7th Circuit.

Though he didn't explain why an appeal was less likely, other observers note the huge percentage of unrelated business written by Allstate.

Supreme Court review of the deductibility of taxes paid to captives has been an "avowed goal" of the IRS, he noted. Mr. Cameron added that the IRS may seek federal legislation that would effectively repeal the rulings, eliminating deductions for premiums paid to captives. ■

War, economy hit attendance

HAMILTON, Bermuda—The recession in the United States and the fighting in the Persian Gulf took their toll on the 15th International Captive Insurance & Reinsurance Forum earlier this month.

Those that did attend the conference—sponsored by the Tillinghast division of Towers, Perrin, Forster & Crosby Inc.—speculated that many companies' travel restrictions still in effect from the Gulf war helped trim attendance to about 115. That is only half the 1990 figure.

Recession-inspired belt-tightening by many U.S. companies also was blamed for the low attendance figure.

At the March 5-8 conference at the Hamilton Princess in Bermuda, speakers discussed the impact of the current world economy on the insurance market. Other topics included financial reinsurance, captive investments and the future of captive insurers.

Information on next year's conference is available from Eileen Callahan at TPF&C, 100 Summit Lake Drive, Valhalla, N.Y. 10595; 914-745-4611.

U.S. economic recovery

Prosperity has good, bad side for insurers

By MICHAEL BRADFORD

HAMILTON, Bermuda—An economic recovery in the United States would be a mixed blessing for insurers, an insurance company economist says.

Some types of losses are less frequent when the economy is robust, while other losses show up more often during those periods, according to Edward Guay, chief economist with CIGNA Corp. in Hartford, Conn.

"We have a historic pattern of certain types of losses related to high economic activity," Mr. Guay said at the 15th International Captive Insurance & Reinsurance Forum in Bermuda earlier this month.

At manufacturing facilities, for example, machinery tends to break down more often during prosperous times than when production slows during an economic downturn.

In contrast, during an economic slump losses are likely to occur more frequently among businesses like retail shops and restaurants "that tend to burn," Mr. Guay added. "As the economy recovers, those types of stresses will be reduced."

Mr. Guay

Despite the higher frequency of some types of losses, "a healthy economy and a profitable economy tend to be an improving environment for the insurance industry in terms of premiums" and the quality of risks, Mr. Guay remarked.

Mr. Guay said he expects insurance companies to share in the benefits of an economy that he says is on the verge of improving.

As the United States heads into spring, interest in housing has surged considerably, which indicates confidence in the economy, according to Mr. Guay.

"Part of the problem was just getting through the winter," a time of year when consumers are less active, he said.

Manufacturing production should begin to pick up this summer, as shoppers purchase more items like home furnishings and appliances, Mr. Guay said.

On another topic, Mr. Guay said that as the United States heads toward the 21st century, insurance companies can anticipate that banks will compete with them for insurance customers.

A recent banking reform proposal from the Bush administration would let banks establish a universal financial system and provide a range of products, Mr. Guay noted (*BI*, Jan. 28).

Such a system, though, remains several years away, he said. "I don't believe it is going to be a quick development."

Congress could pass a "midnight reform bill" sometime this year, Mr. Guay speculated. "We will wake up some morning and read in the paper that Congress passed. . .a banking reform bill" that includes parts of the administration's proposals.

But such a bill will likely not include removing in the near future barriers between insurance and banking, Mr. Guay said. "Eventually that will happen, but that is five to seven years away, when the banking industry has a healthier and better structure," Mr. Guay added.

He also commented that the much-heralded removal of trade barriers throughout the European Community in 1992 has in a sense, already arrived.

"It's no longer something that is coming, but for all practical purposes has been achieved," he noted.

In fact, Mr. Guay added, "Europe 1992" already is creating problems on the continent.

"Five years ago, when we began to talk about Europe 1992, European businessmen began to position themselves. Businesses began to look at the market as a single market and they began to plan their. . .business strategies for a combined market."

During that time, Europe added significantly to its industrial capacity, driving its "greatest capital spending boom relative to normal needs" since World War II, he said.

During a slump, losses are more likely to occur among firms 'that tend to burn,' Mr. Guay says.

"Every major industry group of which I am familiar in Europe has already assumed it will gain market share in 1993," said Mr. Guay, "and has planned capacity accordingly."

He pointed out that the "capacity plan for the major industry groups in Europe. . .for some strange reason is very much like insurance share-of-market planning. It adds up to more than 100%" of real needs.

Eventually, the excess capacity can be absorbed, but it will likely mean courting Eastern European customers to absorb some of the excess, said Mr. Guay.

A more impressive industrial alliance than that which will be forged in Europe will result from U.S. free trade agreements with Canada and Mexico, Mr. Guay said.

A trilateral free trade agreement is expected to be signed in October 1992, he pointed out.

A demographic comparison of the North American countries with the European Community indicates that the market in the United States, Canada and Mexico will be more "dynamic and more successful in the long run," he said.

Mr. Guay explained that the population of the North American countries will reach 404 million by the year 2000 and will have a 1% total growth rate annually. Of the population, 26% will be under the age of 15 and 9% will be over age 65, he said.

"It will be the ideal distribution that you would derive from an actuarial table that for all practical purposes doesn't exist in any country in North America," he said.

By comparison, the population in Europe, including eastern Germany, is expected to reach 345 million by 2000, Mr. Guay said. Nineteen percent of the population will be under 15 and 14% will be over 65 with an underlying growth rate of zero.

With those demographics, the European market will have to depend on exports if it is to thrive, Mr. Guay noted. ■

Captive owners cautioned to choose brokers wisely

By JUDY GREENWALD

HAMILTON, Bermuda—Captive owners and managers must take precautions when selecting a broker, not the least of which is ensuring that the broker will be around when it is needed, a reinsurer advises.

Nicholas S. Dove, president of Hudson Reinsurance Co. Ltd. of Bermuda, presented the captive's perspective on the relationship between a captive, an intermediary and a reinsurer at the 15th International Captive Insurance & Reinsurance Forum in Bermuda earlier this month.

In addition, Julian Griffiths of Griffiths & Wanklyn, a Bermuda-based broker, presented the intermediary's perspective on the relationship. And Bruce Jones, an underwriter with Sphere Drake Underwriting Management (Bermuda) Ltd., presented the reinsurer's perspective.

Large captive parents with sophisticated risk management departments do not necessarily need intermediaries and can work with reinsurers directly, Mr. Dove said.

But most captives "simply don't have that expertise" and an intermediary becomes necessary, he said.

As a captive manager, Mr. Dove said, "I need someone who's going to be my advocate, who understands the business and its risks."

There are pitfalls to be avoided in choosing a reinsurance intermediary, Mr. Dove warned. He presented three actual examples of an intermediary failing in its duties.

The first case involved a captive that had written a high excess-layer medical malpractice policy that was not expected to be triggered.

The intermediary placed reinsurance for the coverage with eight to 12 reinsurers, ranging from well-known firms to obscure South American companies.

Then, the medical malpractice crisis hit and the excess layer was penetrated, Mr. Dove said. The captive had since hired another intermediary and some of the reinsurers lined up by the previous broker "could no longer be found."

The captive manager spent considerable time tracking down the reinsurers, with no success. As a result, "the captive had a catastrophe on its hands."

In another instance, said Mr. Dove, an intermediary "literally went fishing" and, as a result, questions about the captive's reinsurance program went unanswered. The situation was exacerbated by turnover in the parent company's risk management department, he added.

In the third instance, a large broker consolidated its offices, which resulted in "total confusion" as to where the account was being serviced and by whom, Mr. Dove said. There was also a "complete loss of records."

Thus, it is important to determine that the intermediary will be there when you need it, he said.

However, "not all disasters are totally avoidable," said Mr. Griffiths, commenting from the intermediary's perspective. But most can be partially avoided or mitigated, he noted.

For example, some basic questions should have been asked about the "disappearing" South American reinsurers before the coverage was placed. "This situation still happens frequently today," Mr. Griffiths commented.

To avoid potential problems, spread risk among three or four reinsurers, ask to see reinsurers' financial statements before the coverage is placed and see who has audited the reinsurers, Mr. Griffiths advised. If the information is not sufficient, do not place coverage with them, he said.

As to the second and third cases, Mr. Griffiths said the situations were inconvenient, but not disastrous, if the contracts had been worded properly and the captive had proper documentation.

Mr. Dove also commented that whether or not it uses an intermediary, the captive must still judge the security and pricing of its reinsurance.

While rating agencies can be helpful in determining which reinsurers to avoid, a captive should never rely totally on a rating

Continued on next page

InsurerTopics

A special editorial section sent exclusively to insurers and reinsurers

Examining strained relations

A small group of agents causes big headaches, insurers say

By MARK A. HOFMANN

While freely admitting they have faults of their own, property/casualty insurers complain that a small group of agents seems bent on impairing agent/insurer relations.

These are the agents who do not:

- Prepare perpetuation plans.
- Differentiate among insurers and instead sell strictly on price.
- Understand an insurer's marketing goals.
- Provide value-added service.
- Try to understand that insurers need agent support in the legislative arena.

Insurers believe that the overwhelming majority of the independent agents who represent them are competent, hard-working professionals.

It is the remainder that cause the majority of headaches.

"I think the relationship is changing," observed Mike Policastro, vp-agency support for Travelers Corp. in Hartford, Conn. Good agents are trying to get closer to their companies, while not-so-good agents are taking anti-insurer stands, he said.

The relationship is "somewhat strained" because of marketplace pressures, regulatory burdens and consumer activists, said Robert J. Vairo, chairman of Crum & Forster Inc. of Basking Ridge, N.J.

Meanwhile, while most agents say they are satisfied with how their insurers treat them, they still have many gripes (see stories beginning on page 32B).

Insurers will take some blame for a deterioration in certain agent/insurer relationships. Some insurers freely admit that withdrawing from certain lines of business and territories has put strains on their relationships with agents.

However, insurers point out that agents are not necessarily angels, either.

Many companies have concluded they cannot afford to do business with agents who will not meet company volume requirements, Mr. Policastro said.

"Remember, the company is the one that accepts the long-term risk," Mr. Vairo said.

Some agents seemed to understand this economic fact of life when Crum & Forster announced its total withdrawal from personal lines insurance last spring, he said.

"Obviously, the personal lines agents weren't pleased," he said.

Although some of the personal lines business was sold to Metropolitan Property & Casualty Insurance Co., a Metropolitan Life Insurance Co. unit in Warwick, R.I., agents had to replace much of the Crum & Forster coverage with other insurers, he said.

Mr. Vairo said the decision was made after Crum & Forster decided it could no longer afford to stay in personal automobile insurance. Taking the analysis one step further, the company decided that it "can't make a personal lines market without personal automobile" and began a total withdrawal from personal lines insurance, he said.

Mr. Vairo estimated that less than 20% of the agents handling the insurer's commercial business also represented the personal lines division. Crum & Forster had split its commercial and personal lines business into separate divisions in 1982, Mr. Vairo explained.

Despite the impact on personal lines agents, "we got a lot of understanding of why we had to pull out of personal lines" from commercial agents, he said. These agents realized that "if we had to sell our product at a loss, we're not going to do it," Mr. Vairo said.

Travelers has made every effort to make its intentions known long before it actually withdraws from lines of business in certain states, Mr. Policastro said. "We give a lot of notice. We have agent meetings."

But despite giving agents 120 days' notice that the insurer will not write any more new business in a market as well as writing a year of renewal business after that, "it's not an easy thing for any agent," Mr. Policastro said.

Countering agent complaints about insurer withdrawals, insurers say agents are withdrawing from the business without planning for their agencies' survival.

As a result, insurers have had to compete more vigorously for the survivors, said Charles Dudek, vp-marketing for the commercial insurance division of Zurich-American Insurance Group, a Zurich Insurance Co. unit in Schaumburg, Ill. "We need to grow our producer plant," he said.

"Carriers spend a lot of time and dollars in the development of individual producers," he said. But if an agent dies or retires without a perpetuation plan, those years of investment can disappear quickly if the agency is acquired by another agency that transfers the purchased agency's book of business to other insurers, he said.

"We're looking for survivor agents," he said, explaining that survivors have both perpetuation and business plans. "They need a road map to where they're going with their business."

"Perpetuation is a significant problem in the industry," agreed Frederick H. Jarvis, chairman, president and chief executive officer of Branchville, N.J.-based Selective Insurance Group Inc., a regional insurer that writes primarily in the mid-Atlantic and southeastern states.

"The problem is the owner who refuses to admit he's mortal," he observed.

Agency perpetuation is crucial, agreed Loren Shoemaker, vp-agency and brokerage group for Continental Corp. in Cranbury, N.J. "Who are we going to do business with in the year 2000?" he asked. "We want that book of business to thrive over the years."

Insurers also complain that some agents who sell strictly on price assure that neither their agencies nor the insurers they represent will thrive.

"Many producers really don't sell one company against another," Zurich's Mr. Dudek said.

Those agents present a customer with five insurers that charge five prices for the same amount of coverage and tell the customer to decide, Mr. Dudek said.

Customers are left to decide based on one criterion: price, Mr. Dudek commented

"They really don't understand the product," he said.

"It's a common phenomenon. Quote all companies," agreed Travelers' Mr. Policastro. But as Mr. Policastro sees it, the agent is only hurting himself.

"When you're selling just on price, that client's going to leave the agent when he gets a better price," Mr. Policastro said. The agent and the company just end up wasting time and money, he said.

Zurich has tried attacking the problem by sending an underwriter/marketing representative and sometimes a claims handler or loss control specialist with producers to explain the insurer's product.

The approach lets the insurer sell its value-added services to large insurance buyers—like large-scale commercial farms, apparel manufacturers and jewelry manufacturers—that would generate annual premiums in excess of $50,000, Mr. Dudek said.

The success rate has been about 90% on new and renewal accounts, he said.

Selective's Mr. Jarvis also noted that when the same agents and underwriters work together over an extended period, they develop relationships that enhance understanding. And, agents come to better understand products, he said.

Such stability may give regional insurers, like Selective, an advantage in relations with agents, Mr. Jarvis said.

Selective has exported that philosophy from the home office to its branches, Mr. Jarvis said.

But, a proliferation of branch offices can mean the creation of new corporate subcultures that longtime agents may find unresponsive, he said.

"As regional companies grow, we run the risk of becoming part of the large gray mass," he said.

Failing to prepare for the inevitable and taking a lazy approach to sales were only two of the most common agent failings insurers cited. The list touches on virtually every area of the agent/company relationship.

For example, Zurich's Mr. Dudek said some agents run "off track" with target marketing, though he admits that in large part the problem stems from the insurer not specifying just what target marketing entails.

To illustrate a poor target marketing program, Mr. Dudek offered the example of an insurer that presents an agent with a list of three classes of business it considers target markets. No explanation is given.

With only the list and no explanation, the agent thinks the insurer is interested in writing only those classes. But, the agent soon realizes that there is no great market, or maybe no market at all, for these classes of business in his or her community.

Under the mistaken impression that the insurer does not want any business not on the list, the agent

Continued on next page

Insurer Topics

Agents both praise, criticize insurers

By LAURA MAZZUCA

While the disgruntled partners complained about betrayal, insensitivity, lack of trust and bad communications, they are not taking part in marriage or group counseling.

They are agents and brokers responding to a *Business Insurance* survey on the relationships between insurers and agents and brokers.

And the variety of agent and broker comments called to mind Tolstoy's observation that "all happy families resemble one another; every unhappy family is unhappy in its own way."

Most of the agents and brokers responding to the survey said they were satisfied with how insurers treated them (see story, page 32D).

Their reasons were straightforward: good claims service and underwriting, responsible pricing, responsiveness and flexibility.

One broker put it succinctly. Insurers "offer me the opportunity to earn a good living," wrote Jeffrey H. Jennings, president of Clifton Brokerage Corp. in Greenwich, Conn.

He and other satisfied producers said they could live with lower commissions and other facts of life in a recession, as long as insurers listened to them and treated them fairly.

"While commissions are smaller, they are consistent, and this is far better a state of affairs than many industries are experiencing," he added.

"Our companies are responsive to agency needs and market conditions," wrote Douglas R. Mahon, executive vp of SPWM Insurance Brokers in Sonoma, Calif. "They are eager to retain renewal business in the soft market and they look at risk more openly than in prior years."

Most importantly, wrote the underwriting manager at a New York agency with $80 million in annual premium volume, "We can work together. They have positive rather than negative attitudes."

Unhappy agents were less reserved. They vented their spleens about nuts-and-bolts everyday matters, but their gripes also touched on emotional areas like trust and betrayal, partnership and lack of common goals (see story, page 32E).

"Terrible" policy service, fraught with delays and issuance errors, is the "rule rather than the exception," wrote J. Cliff McCurry, president of Jones, Hill, Mercer & Sheehan Insurance Services, a Hilb, Rogal & Hamilton Co. unit in Savannah, Ga. "You can special-order an automobile through a dealer and have it built and delivered with the options you select quicker than we can get a correct policy from most companies."

Even preferred agency contracts, popular with many agent respondents, were not universally liked. They do nothing to "correct poor service or poor training of underwriters and staff," groused the principal at a small Pennsylvania agency (see story, page 32H).

The "attitudes" of insurers also generally did not sit well with some agents and brokers.

"They are unresponsive, inconsistent and arrogantly belligerent," wrote the president of a California agency with $1.5 million in annual premium volume.

"Companies question my commitment, but will not establish a real commitment or a true bridge themselves," said another producer.

Notions of "equal partnership" between insurers and agencies were roundly dismissed.

"It stinks! It's a glorified 'employer-employee' relationship," griped the president and CEO of a Virginia agency with $20 million in annual premium volume.

"We are the company's customer, and should be treated accordingly," wrote the vp of a New York agency with $25 million in annual premium volume. "Some companies act as though we are subservient and not equals."

And the general manager at an Ohio agency with $25 million in annual premium volume criticized the "dime-a-dozen mentality" of insurers. "Good agents and brokers are hard to find and keep, and turnover ratios are too high."

Like a spouse ready to throttle his or her mate for leaving the toothpaste uncapped, producers were even peeved about minutiae. Impersonal phone mail systems and huffy receptionists both came under fire.

But scratch the surface, and it appears that producers and insurers both want the same things: good business, stable markets and a way to build solid relationships, said Thomas A. O'Day, associate vp of the Alliance of American Insurers in Washington, D.C.

A "series of coverage, cost and availability problems over the last 10 years has created bad feelings" toward insurers, Mr. O'Day said, but "some companies provided markets, tried to stabilize rates, and stuck with their agents through thick and thin."

And although "God knows there are a lot of very upset agents," insurers have their beefs, too, especially about recalcitrant agents who fear change, said Patricia A. Borowski, vp of government affairs for the National Assn. of Professional Insurance Agents in Alexandria, Va.

"But it's not change they hate; it's upheaval that is poorly timed and implemented," Ms. Borowski added.

Dissatisfied agents say they are more concerned about inconsistency and lack of communication than with lower commissions.

Agents can respect even "hard-nosed" insurers that take a "my way or the highway" approach, Ms. Borowski said. "An agent will put up with that, even if it's irritating, because it's consistent," she noted. But they will not take kindly to wishy-washy insurers that lack clear market plans, she added.

Shoddy planning especially rankles agencies that carefully chart their own futures.

"The agency plan has made efforts to perpetuate," wrote the president of an $8.5 million annual premium volume agency in New York. "The companies are not doing anything to bring in new talent and train."

Mr. O'Day, who represents the Alliance on the Independent Insurance Agents of America's Future One panel, agrees that problems can arise when an insurer is unclear on its growth plans and expands into unfamiliar markets. Examples include Mission Insurance Co. and other spectacular insurer failures.

But "sometimes what happens is nobody's fault," he said, noting that insurers cited tough operating environments when withdrawing from states like California, Massachusetts and New Jersey. "It wasn't that (insurers) didn't like the agents, but the legal atmosphere made it impossible for them to stay."

Explaining such a move can be critical. For agents and brokers, communications often determine how an insurer will be perceived.

Respected insurers share one important trait, Ms. Borowski said: "a keen sense of who they are, what they want to do, and who they want to do it with," coupled with a solid way of communicating this to their agents.

Insurers that are well-respected by their producers also listen to what they have to say about market conditions and other topics.

"They recognize that agents have market-floor expertise and they can take advantage of that for free," Ms. Borowski said.

But few do. Often agency visits—roundly criticized in the *BI* survey—are the only forum for such give-and-take between insurers and producers.

"A lot of carriers are only interested in their bottom line," wrote the principal of a Texas agency with $3.5 million in annual premium volume. "They visit and tell us what great things they can do for us, then they go home and forget all about it."

Most agents and brokers responding to the survey reported they met with insurers quarterly. Others met to discuss common concerns annually, biannually or monthly. Only three of the 117 respondents said they never met with insurer representatives.

Most reported meeting at the agency. Others, though, met at an insurance company office or a less formal setting like at a restaurant, golf course or industry event.

Respondents primarily met with branch managers or agency liaisons to discuss topics like market conditions, niches, contract structure, new products and loss ratios or loss controls.

But such meetings may only appear to be a step in the right direction. They may often be a "drain on the agent's time, because the company reps have no authority and don't know what's going on," Ms. Borowski said.

Many survey respondents agree.

"These meetings are not really constructive; they're a routine, a fiction they go through," wrote the principal of a $6.5 million annual premium volume agency in Wisconsin.

"This seems to be a lost art," wrote Otto Wahlrab, president of John P. Slade Insurance, a $4.6 million annual premium volume agency in Fall River, Mass. "At best we would get an inexperienced field person who really doesn't know much."

What accounts for such fumbling attempts at communication?

Richard A. Kasyjanski, president of the Member Services Inc. unit of the Independent Insurance Agents of America in Alexandria, Va., attributes much of the problem to cutbacks at insurance companies. Rather than send their experienced field reps to agents, insurers now send out marketing personnel with little authority on what amounts to a "social visit," he said.

Cutbacks at large insurers may explain why communication with regional insurers goes comparatively well, he added.

But even the best relationships can sour. Partners can change goals and grow distant. So agents and brokers would be wise to represent more than just a few insurers, Ms. Borowski said.

Many agencies pared down their offerings in an early-1980s housecleaning. They focused on the remaining few. But when capacity began to shrink in the middle of the decade "too many people realized they made the wrong choice," she said.

Most of those responding to the *BI* survey say they represent six to 10 insurers. That figure has neither increased nor decreased significantly in the last three years.

And today agencies find themselves unable to hone down the number of insurers they represent. Doing so would be more efficient, but with companies pulling out of markets and lines, agencies are forced to add insurers, she said.

Direct writers have picked up some of the slack. Companies like Allstate Insurance Co. and Nationwide Mutual Insurance Co. are taking some auto and homeowners business that other property/casualty companies don't want, said Mr. Kasyjanski.

Business Link, a PIA agency-insurer referral program begun last year, was designed to help agents cope with insurer withdrawals from various markets. Participants include 1,500 agents and 15 domestic and international insurers, including two direct writers.

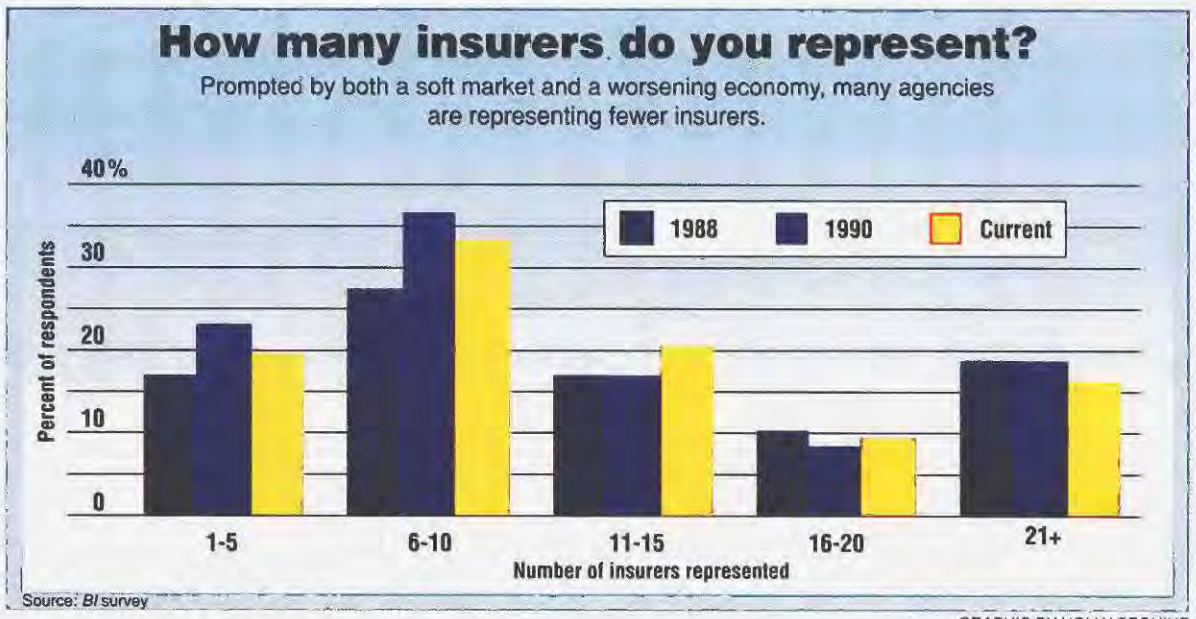
"It was put together to address the 'change of partners' issue," she said. "We realize it's going to go on for awhile."

Set up as a "last resort," the system is now primarily used by agents "looking for a better deal," Ms. Borowski said.

Insurer-agency relations can grow tenuous. But surveyed agents and brokers said they recognize that they, too, have a duty to keep the lines of communication open.

"The critical point has been reached; cooperation, dialogue, and creative solutions are needed, not unilateral action and ostrich-like behavior," wrote the president of a $14 million annual premium volume agency in California.

Insurers, wrote the vp of a New York agency with $8 million in annual premium volume, "need to recognize agents as partners, not enemies." ■



GRAPHIC BY HOLLY SEGUINE

Insurer complaints

Continued from previous page

ignores that insurer and starts pushing the products of a competitor, Mr. Dudek said.

Producers also must start taking a value-added approach to their agencies, said Greg Gerogieff, national marketing manager for the property/casualty units of Warren, N.J.-based Chubb Corp.

To that end, agents must focus on customer needs better, become better problem solvers and work more with insurers to customize products and services to meet customer needs, according to Mr. Gerogieff, who is also senior vp and managing director of Chubb & Son Inc.

"You have to decide: 'What is my agency prepared to offer?' " he said.

"The greatest need most companies see is the need for more sales discipline," according to Continental's Mr. Shoemaker. A lack of discipline is reflected in a lack of focus on targeted classes, a lack of sales management so agents set their own agenda, and high ratios of unsuccessful closes.

"We all seem to be doing business with less," he said. With soft market conditions persisting, both insurers and agents have had to work more closely together or both lose, he said.

But, insurers should be approaching agents with solutions to soft market pressures, Mr. Shoemaker said.

There should be more face-to-face meetings between agents and insurer branch office representatives, so that both sides can better understand the other's concerns, he said.

Another area in which insurers would like to see a strengthening of agent/insurer relations is the legislative and regulatory arena.

"I'd like to see the agent associations take a more statesmanlike view of the industry," Selective's Mr. Jarvis said.

Agents cannot only look at how insurance-related legislation will affect them. They also must consider how it will affect insurance companies, since agents depend on them for their livelihood, Mr. Jarvis said.

"I'd like to see more aggressive activities on the state level," Mr. Shoemaker agreed. Agents have more impact on state legislatures than insurance companies do, he said.

Travelers' Mr. Policastro also complained that a minority of agents "promote an anti-company atmosphere." They fail to educate the public on factors that drive up the cost of insurance, he said. "Sometimes they blame the company for things they know is not the company's fault."

Agents can help by being advocates for the insurance industry, Mr. Policastro said.

"It's the agents who have to be the advocates with legislators, regulators and the public," Mr. Policastro added. ■

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Insurer Topics

Agents, brokers laud insurers' 'positive attitudes'

By LAURA MAZZUCA

Hard work by brokers and agents in cultivating relationships with insurers is paying off, according to a *Business Insurance* survey.

Even while mired in both a recession and a soft market, 58.1%—or 60—of 117 respondents say they generally are satisfied with their relationships with insurers.

"There's a willingness to write business and a positive attitude toward a partnership future," responded Bruce Christensen, president of the Christensen Agency in Minneapolis, which has annual premium volume of $6.5 million.

Many successful partnerships have been built over years of solid communications and clear goals shared by insurers and agents. Those relationships now are helping many agents and brokers who might otherwise be suffering through the cuts in commissions and other problems endemic to the current marketplace (see story, page 32E).

"In times of adversity. . .companies remain committed to working closely and effectively with their agents, to maintain and expand profitable business," wrote Albert R. Counselman, president and chief executive officer of Riggs, Counselman, Michaels & Downes Inc. in Baltimore. "Naturally, unprofitable relationships are in jeopardy."

Many satisfied agents and brokers praised insurers both for what they have done for agents—and for what they haven't done.

"Service is continuing well and not deteriorating in quality and speed," according to the president of an $8 million annual premium volume agency in Washington. "For good risks, there is generally plenty of positive responsiveness to submissions. Although some (insurers) appear to be out of the competitive market, enough others are there."

Other respondents were happy that insurers had not cut their commissions or contingencies or withdrawn from particular markets.

"None of our primary carriers has completely withdrawn from a given market segment or inflicted a serious commission reduction in 1990," commented a vp of an agency with $13 million in annual premium volume.

"Those (insurers) I am satisfied with have maintained markets, not cut commissions and maintained an ongoing communication about their abilities," wrote the president of a Pennsylvania agency with $4.7 million in annual premium volume.

Some insurers' generally "positive attitudes" were lauded by agents and brokers, as were specifics like professional underwriting, sufficient capacity, good products and quick response time on submissions. But open minds were what agents and brokers seemed to value most.

"Most company people are sincerely interested in the agent and his problems or needs," wrote the president of a Wisconsin agency with $6.5 million in annual premium volume.

His counterpart at a Pennsylvania agency said, "There is a willingness to listen, talk and be reasonable."

Insurers "are working to make things work for our clients; they are looking for ways to do things," wrote Malcolm Bernstein, owner and partner of Circular Planning/Bernstein & Co. in Cincinnati.

And how do good insurers "make things work?" Many agents put a good deal of stock in careful planning, especially when targeting business.

"Our agency and the companies we represent have a common target market," wrote David Kendrick, vp of Landers Insurance Inc. in Birmingham, Ala. "We call on the type of business they want to write, therefore limiting the resistance from our underwriters."

Despite all the hearts and flowers, agents and brokers know that such cooperation is more prosaic than altruistic.

"Because of the size and reputation of our agency, we find that most of our companies take initiatives to aggressively pursue business from us," wrote J. Cliff McCurry, president of Jones, Hill, Mercer & Sheehan Insurance Services, a Hilb, Rogal & Hamilton Co. unit in Savannah, Ga.

Being affiliated with a major brokerage, "definitely makes a difference," said Mr. McCurry, whose agency was bought by HRH in 1988.

As agencies grow larger, insurers find that cooperation serves them well, respondents said.

"Insurers wanting to do business with the more successful agencies are going to have to back off on their demands for life insurance, and their demands to be No. 1 or 2 in the agency," wrote R. S. DiMatteo, executive vp of Clauss & Co. in Buffalo, N.Y. Insurers will instead have to "agree on certain volume commitments to warrant preferred agency status, which benefits both agency and insurer."

Communications are very important to agents and brokers.

"A few of our larger carriers remain committed to their chosen marketplace and communicate well with their agents regarding what their plans for growth are," wrote the principal of a $30 million annual premium volume agency in Minnesota.

Others said they believed agents and brokers need more of a voice when insurers develop plans that affect agents.

"Agents' input on decision-making and planning should be utilized much more and on a continuing basis," wrote the president of a Pennsylvania agency with $4.7 million in annual premium volume. "Most companies only give agents' input token lip service."

Preferred agency contracts proved popular in the *BI* survey.

Many said making such deals with a few companies was a good way for both sides to show their commitment. And more than half—64 of 117—of the responding agents and brokers said that preferred agency contracts generally help agents.

"Relationships are still a key part of effective placements, and respective roles and needs are typically better defined in a preferred agency contract," wrote the principal of a $100 million annual

Continued on next page

Insurer Topics

Agents enumerate insurer shortcomings

By LAURA MAZZUCA

Many agents and brokers have no shortage of practical gripes about insurers: Underwriting is shoddy, they say, claims processing is slow and inaccurate and marketing strategies inconsistent.

But beneath that pragmatic surface bubbles a witches' cauldron of ethical, moral and philosophical divisions.

Some of them emerged in a *Business Insurance* survey on agent-insurer relations.

Loss of trust and lack of direction were common refrains among agents.

Another was losing sight of the company's reason for existence. Too many insurers slight their underwriting roots, instead styling themselves "financial institutions," wrote one agent.

Still other agents bemoaned an "ivory-tower" aloofness of top management. "There are too many layers of management, and they're all trying to cover each other's tails," complained a Michigan agent.

Nearly a third—36 of 117—of responding agents and brokers said they were predominantly dissatisfied with the relationships they have with insurers.

Even those who were generally satisfied had their beefs. For example, complaints about poor underwriting and slipshod service were common.

And respondents on both sides of the question recalled bad feelings toward some insurers that they felt had betrayed them in spite of their trust and their efforts to satisfy their demands.

"Some (insurers) are still honoring the commitments carriers have maintained for 100 years or more," wrote the chairman of an Indiana agency with annual premium volume of $10 million. "But most are not and, in fact, appear to be working hard at tearing apart the American agency system."

"The primary area of deterioration is in moral attitudes. With nearly 100% of our contract carriers, adherence is barely within the letter of the contract language. I am referring to commitments of substance as to the 'partnership' relationship, not to claims handling or adjusting," he wrote.

"I believe we are at the low ebb of company-agency relationship," said William H. Scott Jr., president of Henry Holland Inc., an agency in Buffalo, N.Y. "I wish companies had more empathy for the job the agents and brokers do. Most nine-to-five company employees don't have a clue."

"There is no longer any such thing as agency consideration, regardless of the contribution of the agency in terms of profit or volume," wrote the principal of a $13 million annual premium volume agency.

"The carriers only appear to have their best interest in mind and not that of their agents," wrote the president of a $4 million annual premium volume agency in Pennsylvania. "They have quickly forgotten that it is their agency force that has made them what they are today. How soon they forget."

Agents claim that cavalier attitudes by insurers have created a whole range of problems.

The president of a Florida agency enumerated them: "Commission reductions without adequate notice or documented justification; putting much more work onto agents; reducing volume allowances without warning; providing less adequate profit-sharing ability to recoup commission losses; broken promises made by CEOs who vowed they would be around through thick and thin; and (an attitude) that agents were

Continued on next page

Agency praise

Continued from previous page

premium volume agency in Tennessee.

"It creates a partnership and commitment to each other which enables us to meet goals and write business on a profitable basis," wrote Brad Stammler, president of General Insurance Agency Inc. in Columbus, Ohio.

At its most basic level, a preferred agency contract makes it easier for an agency to place business with a given insurer. "No doubt, we are given special consideration on our risks that other companies would not always necessarily give, even though our commercial book has a consistently excellent loss ratio of 30% to 35%," commented Dennis Young, president of Dennis Young Insurance in Texarkana, Texas.

"They take more notice of you," agreed Mr. Bernstein. "Management makes the underwriting staff work with our files."

By offering producers underwriting authority and otherwise recognizing "our capability and skills," preferred agency programs bolster relations even more, said William Cuellar, director of programs for Richter Robb Insurance Services of San Francisco.

Preferred agency contracts also help both parties establish goals for growth, said Bill Thomas, owner of Thomas Consulting Group in Dallas. "It gives you a feeling of being and of longevity. You feel more protected and an integral part of the companies you represent."

The contracts also solidify agency-insurer relations "by making everyone—underwriters and producers—aware of production and loss ratio objectives which result in commission incentives," wrote Mr. McCurry of the HRH affiliate in Savannah.

Through these programs, insurers offer agents and brokers expertise and financial help in areas like advertising, automation and marketing, pointed out John Kinn, president of Kinn & Theobald Agencies of Northwest Ohio Inc. in Fostoria, Ohio.

Preferred agency programs seem most effective for agents when limited to a few insurers. Of the agents and brokers that answered the *BI* survey question, 55% had preferred contracts with one to three insurers; only 19% had preferred contracts with four or more.

"To secure a preferred agency contract, the insurer needs and wants to be (No. 1 or No. 2) in your agency. We cannot do business with only one or two companies. Obviously all our companies cannot be No. 1 or 2," wrote Mr. DiMatteo of Clauss & Co. ■

Insurer Topics

Agency criticisms

Continued from previous page
foolish to represent more than several companies."

Small and medium-sized agencies, especially in rural areas, are hit particularly hard by insurers' changing attitudes, said the commercial department manager of a mid-sized California agency. Such agencies are "becoming less and less important" to insurers, he wrote.

"We are in a small population area where target and/or niche marketing opportunities are scarce," wrote the chairman of a $10 million annual premium volume agency in rural Indiana. "This translates in most of our carrier's attitudes as, 'Who needs you?' In fact, they are cooperating with big-town tele-niche marketing agencies to pick off our accounts."

"Companies have very little interest in the rural areas like South Dakota," agreed Gary Palmer, vp and manager of South Dakota Bankers Insurance Services in Pierre, S.D. "We have numerous small or low-volume locations, and finding providers is a problem."

Even many of the "benefits" that insurers say they offer to agents are a sham, respondents said (see story, page 32H).

"There is no sense of partnership, no matter what they say," said the chief operating officer of an $8 million annual premium volume agency. "Agent panels are a joke, as are lead programs, which are about as useful as a telephone book. It would be unfair to single out one or two (insurers as unresponsive) when the field is so bad."

Worse, agents and brokers are not the only victims, said several respondents. With some insurers, the cavalier attitude extends to policyholders, they said.

"None (of the insurers) have any concerns for the insured beyond their legal requirements—and some don't even care about that," wrote the principal of a $13 million agency.

"They're not responsive to the needs of the agency or our insureds," wrote a vp with a $25 million annual premium volume agency in New York.

With that unresponsiveness reflecting poorly on the whole industry, pressure from consumers and legislators will only increase, many agents and brokers said.

"Insurers are slowly destroying agents' credibility through poor service, both to the insured and to the agent," wrote the vp of a Michigan agency with $3.5 million in annual premium volume.

But rather than working with agents and brokers to improve the system, many insurers "appear to be moving away from the agency system," said Michael M. Cavin, president of Cameron & Roberts Insurance Agency Inc. in Lithonia, Ga.

"Many companies are just not committed to the insurance business. They consider themselves financial institutions," wrote a vp at a Delaware agency with $20 million in annual premium volume. "Rather than resisting the social and political pressures brought against us, they discontinue writing business."

Another agent added that the "political arena, with the push from insurance companies and federal (taxes), will help to change how insurance is delivered." By the year 2000, the agent predicted, self-insurance programs will control 50% of the traditional insurance marketplace, and software will enable insurers to deal directly with risk managers and consultants. Producers would be completely bypassed, he predicted.

No matter what type of service insurers will provide in the future, today's offerings have room for improvement, said most agents and brokers responding to the *BI* survey.

Heading the list of complaints were poor underwriting and bad service.

"Inadequate and inexperienced" was how Albert R. Counselman, president and chief executive officer of Riggs, Counselman, Michaels & Downes Inc. in Baltimore, labeled many insurers' underwriting departments.

"Very few 'underwriters' have any general business acumen and (they) have extremely superficial technical knowledge of their own business," agreed the chief operating officer of an $8 million annual premium volume agency.

They "lack imagination and a sense of urgency," wrote William Cuellar, director of programs for Richter-Robb Insurance Services in San Francisco. "Insurers should staff their companies with underwriters who are authorized and empowered to make decisions, and not the 'Veg-o-matics' many of them now have," he wrote.

Adequately trained underwriters were far from immune from criticism.

Poor organization often means underwriters have "quiet" times when they take no calls and travel schedules that keep them away from their offices too much, wrote David Kendrick, vp of Landers Insurance Inc. in Birmingham, Ala. Recent cutbacks have also left many underwriters overworked, he said.

A lack of underwriting authority at the local level was also targeted in the *BI* poll.

J. Cliff McCurry, president of Jones, Hill, Mercer & Sheehan Insurance Services, a Hilb, Rogal & Hamilton unit in Savannah, Ga., lamented the frequency of "home office 'referral,' which is often just an excuse (not to write business)."

Claims service and other insurer office functions also came under fire from the survey respondents.

Insurers employ incompetent personnel and 'forget their only reason for existence is claims,' says the president of a Michigan agency. 'There are too many layers of management, and they're all trying to cover each other's tails.'

"Service is absolutely horrible. Our industry should be ashamed of the very poor standards for quality, speed and accuracy of delivery," wrote a vp with a $15 million in premium volume agency in New Jersey.

"I wish they would pay their claims as quickly as they require their premiums," wrote Graham G. Grice, vp of Keenan & Associates, a $50 million annual premium volume agency in Torrance, Calif.

"Occasionally you find an exceptional individual or department. . .but most insurers display an arrogant attitude," said the president of a Texas agency with $12 million in annual premium volume. "Few of them encourage professionalism within their own ranks. They make no attempt to build well-trained and motivated staffs.

"They may want to be responsive but can't, because the talent level of their staff has sunk to a deplorable level," wrote the agency president.

"Too many times items are 'lost' in the system, especially endorsements," wrote the commercial department manager of a $20 million annual premium volume agency in California. "Policies are being issued later and later."

Asked what he is dissatisfied with, the general manager of a $5 million annual premium volume agency in New York cited "audit errors, accounting errors, unresponsive service issues and lack of clear direction."

And the president of a $6 million annual premium volume agency in Michigan complained about "incompetent personnel that we have to deal with on a daily basis."

Insurers "forget their only reason for existence is claims," he wrote. "There are too many layers of management, and they're all trying to cover each other's tails."

Many dissatisfied respondents attributed such problems to top insurance company managers.

Top managers are "too bureaucratic and insensitive to their customers, who are really the agents who represent them," wrote Mr. McCurry of Jones, Hill, Mercer & Sheehan in Savannah. "It is difficult to build and maintain relationships with companies" that don't make efforts to know their agents well.

"I believe the upper echelon of company personnel do not really understand the market at street level," agreed David M. Underwood, corporate secretary of the Charles Richmond Agency Inc. in Jackson, Mich.

"Home offices exercise too much field control without knowing what they are doing," wrote W. VanDerwill, senior vp of Saginaw Bay Underwriters in Saginaw, Mich. The result, he added, is "non-competitive pricing and little or no flexibility to respond to agents' needs."

"Strained insurance companies. . .have poor executive leadership and few officers with a strong insurance background," wrote the chairman of a $2 million annual premium volume agency in Pennsylvania.

Victims of an "ivory-tower syndrome," many managers think they can run the whole show from company headquarters, wrote the president of a $6 million annual premium volume agency in Ohio. "Too many companies spend their efforts on programs and systems that don't work. They don't seem to have any direction."

Most bad insurer-agency relationships are attributable to conflicting marketing strategies, said Mr. Kendrick of Landers Insurance in Birmingham. "The best solution would be to find markets which are compatible with the type of business the agent writes."

"Many of our large stock companies simply haven't defined their own marketing goals with any degree of depth and planning," remarked the principal of a Minnesota agency with $30 million in annual premium volume.

"Companies publish target risks, and then when presented with such risks, they seem to find excuses why it doesn't fit," complained the vp of an Indiana agency with $10 million in annual premium volume.

"We are losing new business opportunities due to high declination ratios," agreed the principal of an Illinois brokerage with $300 million in annual premium volume brokerage. "(Although) we submit targeted business in a timely manner, our declination still remains at an undesirable level."

"Many large stock companies are targeting small to medium-sized low-risk accounts, but do not know or understand this market, which is dominated by regionals, mutuals and direct writers," commented a vp with a Minnesota agency that has $30 million in annual premium volume. "They are poor at communicating with their independent agent sales force."

Agents are thus forced to "look to some smaller regional companies, since some of the larger companies are not involving agents and brokers in their 'practical future plans,' " wrote the president of a New York-based agency with $4.3 million in annual premium volume.

In fact, regional insurers won accolades among respondents to the survey.

Despite what they saw as significant problems with insurers, many agents said they were partly at fault for soured relations.

Dialogue between the two sides "is rarely sane or even-handed," said a vp with a New York agency with $12.6 million in annual premium volume. "Both seem to blame each other for failures, but little credit is given for successes."

Clearer communication would definitely help, many respondents agreed.

"Carriers need to 'over-communicate' with brokers on client problems, even if information is bad," noted Dennis Brewick, benefits consultant for Alexander Consulting Group in Dallas, a unit of Alexander & Alexander Services Inc. "Then we can salvage the account for the carrier."

But agents and brokers need to shoulder their share of the burden as well.

"Agents are going to have to become better salesmen, promoting product and service, and put less demand on price," commented Mr. Palmer of South Dakota Bankers Insurance Services. "Company relationships will become very important."

"Companies invariably take the attitude that the agent is not to be trusted. The resulting relationship is not based on trust and a mutual desire to bring a really good product to the buying public," wrote the president of a $12 million annual premium volume agency in Texas.

"Few professional agents exist," the agent noted. But "even fewer professional company people exist. Until this changes, the industry deserves every bit of the criticism that it is receiving from the media, politicians and public." ■

Survey polls 117 brokers and agents

The *Business Insurance* Survey on Producer/Insurer Relations was mailed to 1,000 agents and brokers across the country. The 117 responses represent an 11.7% reply rate.

Nineteen questions included inquiries about which insurers were the most and least responsive to producer needs; whether or not insurers had changed contract terms; how often insurers contact producers, and what topics are discussed; how many insurers producers represent, compared with a year ago and three years ago; and the status of preferred agency contracts.

Responses came from a wide range of agents and brokers. They ranged from large-city branches of major alphabet brokerages like Marsh & McLennan Cos. Inc. and large regional brokers like Hilb, Rogal & Hamilton Co. to rural agencies with less than $1 million annual premium volume. The average respondent had annual premium volume of $1 million to $5 million.

Responses came from 30 states, with California, New York, Pennsylvania, Texas and Ohio providing the most responses.

—By Laura Mazzuca

One-third of agents report canceled contracts

Outright cancellations were not nearly as frequent as contract changes, but more than a third of agents and brokers in a *BI* survey said an insurer contract had been terminated in the past year.

Forty-three of the 117 respondents—36.7%—reported cancellations. A majority of those—27, or 62.8%—were initiated by the insurer, but another 11 respondents, or 25.5%, said the agency was responsible.

Another five, or 11.6%, said the cancellation was bilateral.

Insurers canceled contracts for a variety of reasons, including low volume and poor loss ratios, respondents wrote.

Royal Insurance Group "canceled because of low volume; they had no products to sell. Ohio Casualty Co. wouldn't appoint us as an agent after we bought a small agency because they want to decrease California writings," wrote the president of a $14 million annual premium volume agency in California.

Other insurers simply discontinued certain lines.

Travelers Corp. "withdrew their personal lines because of a change of company direction," wrote the president of a Florida agency. "We were very profitable (for them), and they were No. 2 behind (Aetna Life & Casualty Co.). But Travelers is 'downsizing.' "

Many insurers, agents and brokers charged, ran away from unprofitable lines, regardless of their agency contracts.

Insurers are "retracting from property/casualty coverage in Indiana," commented the principal of a $10 million annual premium volume agency in the state.

But for the 25.5% of the respondents who initiated a cancellation, the shoe was on the other foot.

"They were just not responsive or aggressive enough," wrote the president of a $4 million annual premium volume agency in Pennsylvania.

"They didn't have any niche to help us, so I placed the volume with other carriers to strengthen our position (with them)," said William H. Scott Jr., president of Henry Holland Inc. in Buffalo, N.Y.

"We have too many markets to satisfy them," commented J. Cliff McCurry, president of HRH/Jones, Hill, Mercer & Sheehan Insurance Services in Savannah, Ga.

"We are evaluating all of our companies with less than $500,000 volume to see if we really have a relationship to build on. Contingency income is very important to us, and this volume may help us with someone else," he said.

—By Laura Mazzuca

Insurer Topics

Contract changes strain agent-insurer relations

By LAURA MAZZUCA

Increased volume requirements, the elimination of lines like workers compensation and other changes in agency-insurer contracts appear to be several major reasons for agent dissatisfaction with insurer relations.

Reduced commissions and outright contract cancellations were also mentioned frequently in a *Business Insurance* survey.

"There has been a total withdrawal from some of the major multiple peril programs that had been their strongest suit," wrote the president of an $8 million annual premium volume agency in Washington.

And the principal of a $2 million annual premium volume agency in Pennsylvania cited "freezing markets, canceling and non-renewal of all personal auto insurance and dismissing workers compensation."

A slight majority of respondents—59 of 115, or 51.7%—said at least one insurer changed contract terms or requirements in 1990. Slightly less—55, or 48.3%—said no changes were made. Reasons cited for those changes vary by agency location and size. But many agents and brokers said insurers are becoming extremely selective about which lines they write. Workers comp and personal auto appeared to be the most unpopular coverages.

"They want homeowners but not automobile insurance," wrote the president of a $4.3 million annual premium volume agency in New York. "They also reduced their market niches to industries of no interest to us."

At Kemper National Insurance Cos., the "regular accounts division doesn't want to write unsupported workers compensation," wrote a senior vp of a $100 million annual premium volume agency in California.

And Continental Corp. has reduced both commercial general liability and workers comp, wrote the president of an $8.5 million annual premium volume agency in New York.

Respondents complained of reduced commissions, though they said the cuts appeared to be tied to "undesirable" lines of business rather than across the board.

"There are lower commissions on personal lines auto via Aetna Life & Casualty Co.," wrote W. VanDerwill, senior vp, Saginaw Bay Underwriters in Saginaw, Mich.

"We've seen a reduction in commission scale on personal auto and excess coverage," wrote Jeffrey H. Jennings, president of Clifton Brokerage Corp. in Greenwich, Conn.

And Transamerica Corp. "reduced personal auto commissions in Michigan to an unacceptable level for agents to handle business profitably," said David M. Underwood, corporate secretary of Charles Richmond Agency Inc. in Jackson, Mich.

"We have had commission cuts in workers comp and personal auto," wrote the president of a $4.7 million annual premium volume agency in Pennsylvania. "They are now only interested in writing one line of business instead of a full line."

Some respondents said profit-sharing, contingency and other income have all suffered.

"While (Hanover Insurance Co.) reduced workers compensation commissions, Aetna penalized contingent based on life insurance writings, and (Utica Mutual National Life Insurance Co.) penalized contingent for lack of 'across- the-board' writing," wrote the principal of a $13 million annual premium volume agency.

Insurers then added insult to injury, complained many agents and brokers, by expecting them to do more work even while their commissions and perks were lowered.

"Many have increased production demands and tie-in sales requirements, but for their part have poor support facilities, incompetent staffs and unresponsiveness," wrote the commercial manager of a $21 million annual premium volume Pennsylvania agency.

"Carriers tend to push more administrative service onto the agent, yet continue to push for less commissions. They want more volume to validate, but they're not willing to compete," wrote Mr. VanDerwill.

Some respondents said insurers exercise caution by requiring extensive loss information from agents and brokers. At Travelers Corp., "personal auto commission is tied to loss ratio," wrote John Kinn, president of Kinn & Theobald Agencies of N.W. Ohio Inc. in Fostoria, Ohio.

Another common complaint: continuing requirements for greater sales of life insurance.

"Only one insurer reduced commissions, but several are pushing life insurance," wrote the president of a $6 million annual premium volume agency in Ohio.

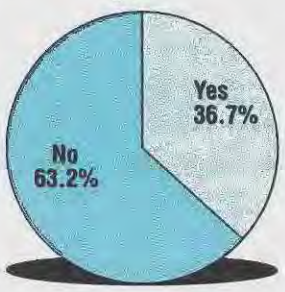
However, in spite of the many gripes, some producers were more concerned about their insurers than angry with them.

Royal Insurance Group "is going through some tough times in Pittsburgh and across the country," wrote the president of a $4 million annual premium volume agency. "They're our lead carrier, and we're concerned about their future."

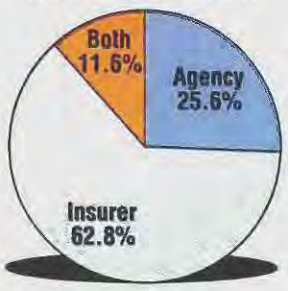
While many agents and brokers were not pleased with the contract changes, most who answered the question said insurers had explained the new terms satisfactorily. Forty, or 67.7%, approved of the explanations; only 17, or 28.8%, did not. ■

Contract terminations

Have any insurer contracts been cancelled in the last year?



Who cancelled them?



Source: *BI* survey

GRAPHIC BY JOHN SMITHER

Insurer Topics

Preferred agency contracts criticized

By LAURA MAZZUCA

The popularity of preferred agency contracts, once hailed as an agency savior, appears to be waning, a *Business Insurance* survey found.

Nearly two-thirds—62 of 98—of those answering a question about preferred agency contracts still said they were generally beneficial. But a fifth of the respondents were ambivalent about the contracts and among the 15% who disapproved, hostilities ran deep.

Many agents and brokers said preferred agency contracts are a good way for both sides to demonstrate their commitment.

"Relationships are still a key part of effective placements, and respective roles and needs are typically better defined in a preferred agency contract," wrote the principal of a $100 million annual premium volume agency in Tennessee.

"It creates a partnership and commitment to each other which enables us to meet goals and write business on a profitable basis," wrote Brad Stammler, president of General Insurance Agency Inc. in Columbus, Ohio.

At its most basic level, a preferred agency contract makes it easier for an agency to place business with a given insurer. "No doubt, we are given special consideration on our risks that other companies would not always necessarily give, even though our commercial book has a consistently excellent loss ratio of 30% to 35%," commented Dennis Young, president of Dennis Young Insurance in Texarkana, Texas.

"They take more notice of you," agreed Malcolm Bernstein, owner and partner of Circular Planning/Bernstein & Co. in Cincinnati. "Management makes the underwriting staff work with our files."

By offering producers underwriting authority and otherwise recognizing "our capability and skills," preferred agency programs bolster relations even more, said William Cuellar, director of programs for Richter Robb Insurance Services of San Francisco.

Preferred agency contracts also help both parties establish goals for growth, said Bill Thomas, owner of Thomas Consulting Group in Dallas. "It gives you a feeling of being and of longevity. You feel more protected and an integral part of the companies you represent."

The contracts also solidify agency-insurer relations "by making everyone—underwriters and producers—aware of production and loss ratio objectives which result in commission incentives," wrote J. Cliff McCurry, president of Jones, Hill, Mercer & Sheehan Insurance Services, a Hilb, Rogal & Hamilton Co. unit in Savannah, Ga.

Through preferred agency programs, insurers offer agents and brokers expertise and financial help in areas like advertising, automation and marketing, pointed out John Kinn, president of Kinn & Theobald Agencies of Northwest Ohio Inc. in Fostoria, Ohio.

Preferred agency programs seem most effective for agents when limited to a few insurers. Of the agents and brokers that answered the *BI* survey question, 55% had preferred contracts with one to three insurers; only 26% had them with four or more insurers.

"To secure a preferred agency contract, the insurer needs and wants to be (No. 1 or No. 2) in your agency. We cannot do business with only one or two companies. Obviously all our companies cannot be No. 1 or 2," wrote R. S. DiMatteo, executive vp of Clauss & Co. in Buffalo, N.Y.

And about 15% of respondents said the contracts generally did little for agents and brokers. Many were blunt in their assessments.

"There are benefits to the extent that they treat you better than those who are not 'preferred,' which isn't saying much," said the chief operating officer of an Ohio agency with $8 in million annual premium volume.

"It's mostly lip service. They promise better service, but we don't see any difference," wrote the vp of a $15 million agency in New Jersey, which maintains three preferred agency contracts.

"We recently terminated two such contracts because one was not beneficial to us and the other placed too much pressure on life insurance production," wrote David M. Underwood, corporate secretary of Charles Richmond Agency Inc. in Jackson, Mich. He added that "the commission incentive is not as good for agents as it should be."

Nineteen percent of the survey respondents maintained no preferred agency contracts, either by fate or by choice. One producer had a simple reason: "None of our lead companies offer one."

Otto Wahlrab, president of John P. Slade Insurance in Fall River, Mass., wrote: "I imagine the squeaky wheel gets the grease, and I haven't squeaked." The agency, with $4.6 million in annual premium volume, has only one contract with an insurer.

Allowing that preferred agency contracts can offer improved underwriting capabilities, higher commissions and other advantages, some agents and brokers said there was inevitably a caveat. Higher volume requirements were mentioned often.

"We had one with CIGNA Corp., but it blew up," wrote the principal of an $8 million annual premium volume agency in Washington. "Such contracts require a disproportionately high volume with that insurer to maintain it. We have philosophical problems with that."

Because volume standards are especially tough on small and medium-sized agencies, they are less likely to get preferred agency contracts, wrote the managing principal of a $3.5 million Texas agency which had no preferred agency contracts.

Other agents said such commitment to a single insurer can be suicidal in today's rocky marketplace.

"The market in general has changed so much in the last five to 10 years that an agent has to have flexibility to survive the swings," wrote the general manager of a $25 million annual premium volume agency in Ohio.

A few producers said they objected to preferred agency deals on principle.

"We don't want false allegiance to carriers; my allegiance is with the clients," said the president and CEO of a $20 million annual premium volume agency in Virginia which maintained no preferred agency contracts. "I don't want to feel 'owned.' If that was the case, then I should not be self-employed!"

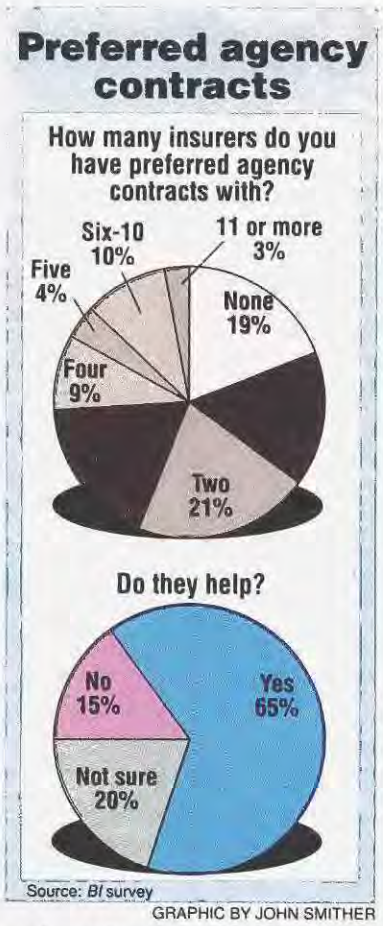
Fully a fifth of respondents were ambivalent about the overall benefits of preferred agency contracts.

"There is not much benefit in marketing or dealing with underwriters, but commissions and profit-sharing are better," wrote W. VanDerwill, senior vp of Saginaw Bay Underwriters in Saginaw, Mich.

"The companies offering special programs seem to be committed to providing greater levels of service, but it doesn't always occur," wrote Albert R. Counselman, president and chief executive officer of Riggs, Counselman, Michaels & Downes Inc. in Baltimore.

Others thought the benefits of preferred agency contracts lie in areas other than increased commissions or profit sharing.

"The principal advantage is in educational opportunities, not in any special underwriting considerations or advantages," commented the chairman of an Indiana agency with $10 million in annual premium volume. ■



GRAPHIC BY JOHN SMITHER

Northbrook offers agents on-line news

SOUTH BARRINGTON, Ill.—Northbrook Property & Casualty Insurance Co. recently launched a program it hopes will set a new standard for electronic communication between insurers and agents.

The program, Northbrook ONLINE, is a joint software venture of the Sears, Roebuck & Co. commercial property/casualty insurance unit and White Plains, N.Y.-based Prodigy Services Co. Prodigy is a joint venture of Sears and Armonk, N.Y.-based International Business Machines Corp.

Catherine E. Buxton, Northbrook vp-marketing, product and customer development, said that the system is designed to provide agents with on-line access to news, training, sales and marketing information. Agents can also use the system to communicate with each other or with Northbrook, she said.

The system also offers Northbrook a means by which to poll its agents on market conditions and on specific products, Ms. Buxton said.

Laurie Gama, the ONLINE editor, said that about 40 agencies were hooked up to the system by the end of February. The first hook-ups were completed in early January, and Northbrook's goal is to have more than 200 agencies participating by the end of the year, Ms. Gama said. She said that the actual installation of the equipment needed to gain access to the service is the most time-consuming aspect of the process.

Ms. Gama said that the insurer has received "very positive feedback" from users, although the level of users' personal computer skills seems to have a direct bearing on which functions they prefer.

"People who are more PC literate seem to be enjoying the electronic communications aspect," she said, and other agents find the on-line news summaries useful. In fact, Northbrook plans to expand its own in-house news services. An industry news service is currently updated daily, while a special Northbrook news service describing products and services is updated each Monday, Wednesday and Friday, she said.

Bill Ieuter of Secure Futures Insurance Agency in Des Plaines, Ill., which is one of the first agencies to have the system installed, said he thinks the electronic marketplace function may prove to be the most useful facet of the system once more agents are hooked up. He said the pool of agents tied into the system now is too small to provide much help in finding markets for difficult-to-place risks.

—By Mark A. Hofmann

Reinsurance group relocates, elects officers

NEW YORK—The Brokers & Reinsurance Markets Assn. has a new address and a new president.

BRMA moved its headquarters to 1 Liberty Plaza, 45th Floor, New York, N.Y. 10006. The organization, formed five years ago as a forum for treaty reinsurance professionals, had been in Olympia Fields, Ill. The new telephone number is 212-732-6200.

In addition, BRMA's board of directors as expected elected Ward B. Gordon to succeed William Gilmartin as president (*BI*, Nov. 12, 1990). Mr. Gordon is the former chairman of Intere Intermediaries Inc. of New York. Mr. Gilmartin, a former senior executive with Chicago-based CNA Financial Corp., announced his retirement as BRMA president late last year.

Also elected was Robert L. Gilligan II, a former associate in the structured finance group at Bear, Stearns & Co. Inc. of New York, to the new position of executive vp.

IEF classroom guide

INDIANAPOLIS—The Insurance Education Foundation has prepared a guide for insurance professionals who wish to become involved with its "Choice-Chance-Control" high school insurance education program.

The guide explains how people who work in the insurance industry should approach school officials about making an insurance-related presentation to a class, how they should prepare a presentation and how to act in the classroom.

For example, the guide stresses: "Avoid a sales pitch. You should be 'selling' concepts and ideas, not policies. Teachers and students will be wary of commercialism. As a guest teacher, you are imparting knowledge and solid information."

The guide also warns readers to be prepared for skepticism and gives advice on how to deal with it.

The "Choice-Chance-Control" program was launched by the Indianapolis-based foundation.

The National Assn. of Mutual Insurance Cos., also based in Indianapolis, established the foundation in 1988 to help high school teachers explain how insurance works (*IT*, Aug. 20, 1990; Aug. 21, 1989). The "Choice-Chance-Control" program consists of printed and video materials that can be used in business, economics, social sciences or other classes.

Single copies of the "Insurance Professionals' How-to Guide for Classroom Involvement" are available without charge from the IEF. Classroom "Choice-Chance-Control" packages cost $50. For further information, contact the Insurance Education Foundation, P.O. Box 68700, Indianapolis, Ind., 46268-0700; 317-875-5250.

Alliance consultant

SCHAUMBURG, Ill.—Daniel C. Plummer has been named a special consultant on regulatory affairs to the Alliance of American Insurers in Schaumburg, Ill.

Mr. Plummer, who has served on advisory committees of the National Assn. of Insurance Commissioners for two decades, is a former vp with Allstate Insurance Co., a Sears, Roebuck & Co. unit in Northbrook, Ill. He is also co-author of "Property-Liability Insurance Accounting."

In his new role as a special consultant to the Alliance, Mr. Plummer will deal with the financial regulation of property/casualty insurance. ■

IT briefs

Advertiser Index

Insurer Topics

Issue of March 18

Business Insurance

Dowd promoted to new posts at Skandia

James F. Dowd has been named president and chief executive officer of Skandia U.S. Holding Corp. of New York and a member of the management committee at parent Skandia Insurance Co. Ltd. of Stockholm, Sweden.

He succeeds **Hans Dalborg**, who resigned to become president of a Swedish banking group (*BI*, Jan. 28).

Mr. Dowd, who had been president and CEO of Skandia America Reinsurance Corp., also was named chairman and CEO of Skandia America.

Also at Skandia America, **Steven J. Bensinger** was named to succeed Mr. Dowd as president and chief operating officer. He had been executive vp and chief financial officer.

Other reinsurer changes:

Dorothy Combes, vp of F&G Re Inc., the reinsurance underwriting subsidiary of United States Fidelity & Guaranty Co., has retired. Ms. Combes was the Assn. of Professional Insurance Women's Insurance Woman of the Year in 1979.

Robert T. McLaughlin named vp in the claims division of American Re-Insurance Co. in Columbus, Ohio. He had been an assistant vp for the Princeton, N.J.-based company.

James B. Wynn named vp in Atlanta with U.S. Re Corp. He had been an assistant vp with Employers Reinsurance Co. in Atlanta.

North American Reinsurance Corp. of New York announced these promotions: **George Casale**, formerly vp and director of claims, named senior vp; **Donald L. Madsen**, formerly vp and director of facultative casualty, named senior vp; **Darrius G. Baker**, formerly group vp, named executive vp-facultative; and **William H. Stempson**, formerly group vp, named executive vp-treaty.

Also promoted at North American Re were: **Maureen B. Moreau** to vp and chief underwriter; **Arthur P. Nanney**, who manages facultative operations in Dallas, to vp; **Andrew W. Kaye**, who manages facultative casualty operations in San Francisco, to vp; and **Raymond L. Osterhout**, formerly senior vp-marketing, to group vp. **Carla D. Shenkman**, former senior vp with Sedgwick James of New York Inc., joined the company as vp and director of alternative markets.

Agent/Broker

Aviation Insurance Services Inc. of Los Angeles announced these changes: **Linda M. Crosby** promoted to president of the Houston office; **A. Stuart Case**, vp, appointed head of a new property/casualty brokerage division in Seattle; and **David D. Barder**, a former vp of aviation with Alexander & Alexander Services Inc., joined as vp in Seattle.

Hilb, Rogal & Hamilton Co. announced these promotions: **John C. Adams Jr.** and **Andrew L. Rogal** to executive vp; **Carolyn Jones** to vp and controller; and **Walter L. Smith** to vp and general counsel. The brokerage, based in Glen Allen, Va., also announced that **Ronald J. Schexnaydre**, president of the New Orleans unit, was named a vp of the company.

Johnson & Higgins announced these promotions to vp at its New York headquarters: **Jossie E. Barcelona**, aviation department; **Dean E. Barnett**, casualty department; **John P. Castro**, international department; and **Christopher Dover**, general administration. ■

Comings & goings: industry

Intermediaries

Continued from previous page

agency, Mr. Dove said. Instead, the agency should be used as a means to make an informed judgment.

Reinsurers can dramatically change their book of business, give their pen to a managing general agent, consolidate or become involved in mergers and acquisitions, Mr. Dove noted. But the captive manager must still be sure the reinsurer is there to pay the claim.

A captive's reinsurance program —and the price it is willing to pay for reinsurance—"should flow from corporate objectives," Mr. Dove said.

A $10 million loss, for instance, won't affect a Fortune 500 company, while one product liability award could put a small manufacturer out of business. Thus, the parent company's and the captive's ability to absorb loss should be considered, said Mr. Dove.

The captive manager should also ask himself, "Do I know what I bought?' Mr. Dove said. It sounds simple, but, as a captive manager, "I must understand what my program is," he said.

"Use the knowledge of your intermediary, your reinsurer and your manager," he recommended.

Choose people who have an interest in your business and who will go out of their way to understand the risk, he advised. And choose companies that will be here "today and tomorrow."

Mr. Griffiths commented, half jokingly, that some people say the reinsurance broker's function is to take the abuse of both the ceding company and the reinsurer.

In actuality, the broker's role is to engage the reinsurer, as well as provide assistance and improve the confidence level of the client "and then make sure both parties are happy with the arrangement," Mr. Griffiths explained.

Sphere Drake's Mr. Jones said that a reinsurer of a captive must be flexible and find out exactly what a parent wants to do with the captive, "and how we can help in structuring a reinsurance program for them."

"Reinsurance is a long-term relationship and can only work successfully on that basis," Mr. Jones explained.

The reinsurer's most important role, he said, is to protect captive assets. "We are here to insure (its) financial viability," he said.

A reinsurer must learn the commitment the parent company has to its captive, which can be shown by the extent to which the captive is used to provide coverage to the parent, Mr. Jones said.

By directing more coverage to the captive, the parent shows its confidence. That, in turn, provides significant comfort to the reinsurer in analyzing the captive risk, he said.

Mr. Jones also commented that the alternative risk financing market—including captives—has been a success because of communication and cooperation of all parties.

"We are all working together to achieve the mutual benefits," Mr. Jones said. This enhances options and opportunities for captives and their parents, he added. ■

ECS and Reliance National Have Just Taken Environmental Insurance Coverage to New Heights.

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Insurer solvency regulation

By Peter H. Bickford

Destroying myths that now surround the solvency issue

EVERYONE IS CLAMORING FOR more effective action to detect and rid the market of insolvent insurers. The report compiled last year by the House Oversight and Investigations Subcommittee, chaired by Rep. John D. Dingell, D-Mich., "Failed Promises—Insurance Company Insolvencies," (*BI*, Feb. 26, 1990), warns of a savings and loan-sized debacle unless strong action is taken, hinting that the task may be beyond the ability of state regulation.

The National Assn. of Insurance Commissioners responds by adopting a number of measures designed to help state regulators detect financially troubled insurers sooner and by adopting minimum standards of proficiency for each state's insurance department to make full and effective use of all these new detection techniques.

Many trade associations and some industry leaders, sensing the political importance of the issue, have publicly supported the cries for greater efforts in solvency detection and action, including the possibility of a federal role in this effort.

Presumably this increased attention to the "insolvency problem" will result in even more companies being declared insolvent and placed in receivership, rehabilitation or liquidation, and the industry critics will be sanguine in the knowledge that they have made the insurance market a better, safer place. But is the detection of insolvent insurers and their swift removal from the market such a panacea? While we are spending all this time looking at the issues of detection and action, are we ignoring the equally important process of dealing with those entities after their removal from the market? Is it enough to look at guaranty funds to cover any shortfall?

Perhaps we need to look more closely at the present system and begin to ask a few basic questions: Is liquidation the best or only answer in

> Industry leaders must recognize that the skills necessary for the conduct of the business of insurance are quite different from the skills necessary to regulate the business of insurance.

dealing with insolvent insurers? Should we be examining methods other than liquidation to deal with insolvent insurers? Are there better, more efficient alternatives to a state-run liquidation?

Before we can look for answers, we must first examine the myths surrounding insurance liquidations—myths that must now be challenged in light of the new pressures being placed on regulators to detect and act upon insolvencies much more rapidly and forcefully than ever before.

- **Myth: Liquidators are regulators.**

Reality: The winding-up of the affairs of an insolvent insurer after it has been removed from the marketplace is a management function, not a regulatory function.

Look at the tasks that a liquidator must perform, and compare them to the definition of the conduct of the business of insurance under any state insurance law. With the exception of underwriting new or renewal business, the job of a liquidator is the conduct of the business of insurance. The liquidator is essentially managing assets, keeping records, pursuing contractual rights of the insolvent company against others and determining the validity of claims against it. Clearly, these are not regulatory functions, which may explain why regulators find it necessary to hire so many consultants in carrying out their function as liquidators.

- **Myth: Regulators are the best parties to act as liquidators.**

Reality: Regulators, by the nature of their purpose, are not and should not be expected to be trained in the business and management skills necessary for the efficient and fair marshaling, management and distribution of assets of an insolvent insurer.

In fact, the background and training of the regulator is not necessarily conducive to good management skills. This is not a criticism of the regulator. Rather, it is a recognition that the skills necessary for the conduct of the business of insurance are quite different from the skills necessary to regulate the business of insurance.

Historically, state insurance commissioners were designated by state insurance laws to act as liquidator as part of an overall scheme of state regulation of the business of insurance. The liquidation of insurers was an infrequent and relatively modest effort that did not raise the necessity for questioning the role of the commissioner as liquidator. The current age of mega-insolvencies necessarily requires that we re-examine this structure. Huge sums of assets still exist even in insolvent estates, and we must ensure that those assets are maximized for the benefit of the policyholders and creditors of the insolvent insurer.

If the commissioners are to continue to act as both regulator and liquidator, we must also review the relative objectives of each to ensure that one function does not interfere with the other.

- **Myth: The interests of liquidators are the same as the interests of regulators.**

Reality: The primary responsibility of the regulator is to regulate the health of the "living" insurer, and protect the interests of policyholders. When a healthy insurer is a debtor or creditor (or both) of an insolvent insurer, their interests may be in direct conflict.

The current offset issue is an example of this inherent conflict of interest. A healthy insurer with large offsets against an insolvent insurer could suffer serious financial difficulties if offsets are not allowed.

Is it appropriate for a commissioner in his role as liquidator to argue against offsets, when in his role as regulator he should be seeking to preserve the health of a solvent company? The issue is not the propriety of offsets, but the conflicting interests of the two roles of the commissioner. Why should the regulator be a primary litigant on a legal issue between contracting parties? Yet that is exactly the position insurance commissioners have assumed regarding the offset issue, and the position they have assumed is contrary to their primary function as regulators.

There are numerous other examples of the interests of the liquidator being contrary to or in conflict with the interests of the regulator. Since the business of winding up an insolvent insurer is akin to the business of insurance, these tensions are nothing more than the natural order of things—the expected interaction between regulators and the entities they regulate.

- **Myth: Liquidators are properly accountable for their actions.**

Reality: Liquidators conduct an insurance business substantially free of all generally recognized standard reporting requirements, and are subject only to limited review and oversight by non-insurance entities: the courts. Thus, the business of liquidation of insurance companies is, in effect, unregulated.

Professionals in liquidation bureaus get quite upset at the suggestion that they are not accountable for their actions. This observation is not intended as criticism of the professionalism or the integrity of the liquidation professional. It is merely a recognition that the system does not engender appropriate management or regulatory accountability.

The courts are certainly in no position to spend any significant time in reviewing the actions of the liquidator. Almost all matters considered by the courts are brought to the court's attention by the liquidator, who controls the flow of information to the court. When others bring matters before the court, the court's attention is usually focused by the regulator because of the restraints of time and the court's limited knowledge of the business of insurance.

Furthermore, the court only has one case before it

> When a healthy insurer is a debtor or creditor (or both) of an insolvent insurer, the interests of the regulator and of the liquidator may be in direct conflict.

at a time. From this perspective, it is not possible for any one court to review overall policy issues with regard to a particular state's liquidation process. Although a court may be able to respond to specific legal issues in a particular estate, it is not possible for a court to adequately oversee an entire state's liquidation process from the vantage point of only one estate, particularly when the liquidation bureau may be controlling dozens of these proceedings.

- **Myth: Liquidation is in the best interests of the policyholders of an insolvent insurer.**

Reality: Liquidation is often the least effective method of maximizing the available assets of an insurer to meet the claims of its policyholders. Yet most other options—managed runoff, reorganization, spinoff, sale, commutation, reinsurance supervision or rehabilitation—are either not considered or are viewed as mere interim steps before liquidation.

Many, if not most, insolvencies involve companies that are currently able to meet their obligations as they accrue. They are deemed insolvent because the estimate of future liabilities is in excess of their current assets. If the effort to detect and act against solvent companies is meaningful and fruitful, the number of companies that are declared insolvent though still able to meet their current obligations will increase as a percentage of the total. In view of that fact, liquidation as an option for the efficient management of assets should decrease proportionately, not increase.

However, most liquidators, by the nature of their charge, are not necessarily focused on restoring companies to the marketplace or in maximizing the return of assets to policyholders or creditors, or to restore companies to financial viability. If anything, the incentives that do exist tend to avoid conclusion of insolvent estates and to keep them open for extraordinarily long periods of time.

The liquidation process need not continue to be an inefficient, time-consuming and costly addition to the problem of insurer insolvencies. The process can be changed to compliment and enhance the effort to detect and deal with insolvencies sooner. Not only would this strengthen the resolve of regulators to deal with the problems of insolvency, it would also demonstrate the ability of state regulation to control and supervise the conduct of the business of

Continued on next page

National health care proposals

Examining four faulty assumptions

By Rebecca S. Fahrlander

WITH HEALTH CARE COSTS rising faster than the overall cost of living, and with about 31 million Americans unemployed, we have seen a proliferation of proposals to address cost and access to health care. Most Americans are probably in agreement with the goals of universal access and cost containment. Consensus breaks down, of course, when we discuss what means we will use to achieve these goals.

Various groups argue for mandated benefits, a national health system, federal or state administration or improving the existing system, which rests on a public-private partnership. Proposals for some sort of national health system have become more widespread and have captured the attention of consumer and congressional advocates. Many of the proposals are patterned after the Canadian system, the pros and cons of which have been widely discussed.

Advocates of a national health system, while diverging on the specifics of their proposals, generally form their arguments around several common assumptions. It is these assumptions that I feel we need to examine more closely before we can effectively make any changes to our health care "system."

• **Assumption: Health care in the United States costs too much.**

How much is too much? We've all read the statistics comparing the percentages of gross national product spent on health care in the United States, Canada and other countries. While there may be a case for some reduction in expenditures (almost any system has some waste and overutilization), I'm not sure the comparison of GNP percentages is all that meaningful. While Canada spends a smaller proportion of its GNP on health care than does the United States, recent articles have pointed to evidence that costs are rising at a higher rate in Canada than in the United States and that overutilization is a problem north of the border as well as here at home (*BI*, Jan. 7).

Perhaps the most important question is how do we control costs effectively? That is, what are the steps we can take to eliminate true waste, yet not reduce needed quality care? The whole cost issue is indeed a complex one, and one that I believe national health proposals have not adequately addressed.

• **Assumption: Current insurance administrative costs are too high.**

National health proposals and consumerist articles frequently make this argument, often making inappropriate statistical comparisons. While administrative costs will vary among insurers, typical administrative costs for efficient group insurers (excluding premium taxes) range between 6% and 7%. Would a state or federal bureaucracy really administer a health care plan for less than this?

• **Assumption: Despite a high level of spending on health care, the United States ranks poorly on many health indicators.**

In looking abroad for answers to our health care problems, we must exercise caution. Apples-to-apples comparisons are complicated by different cultures, each with different values and expectations. Also, other countries calculate their health care expenditures differently. Comparisons of national mortality and infant mortality data can be misleading, because many factors other than the availability of health care affect these outcomes. Nor can quality of life issues be addressed by mortality data alone. Also, if macro-level factors in the economy affect health care expenditures as studies have indicated, we would have to look at economic growth to make accurate comparisons.

• **Assumption: A national health plan would provide universal access to health care.**

First of all, we need to address what we mean by universal access. Universal access can mean many things: Everyone has access to the care he or she needs; equal access without regard to socioeconomic status, but not necessarily universal access; equal access without regard to any variables like socioeconomic status or age.

Truly universal access is a more complicated issue than it appears to be on the surface and is inextricably tied to the cost issue. And none of the national health proposals I have yet seen adequately addresses costs. Shifting the financing of health care from the private sector to the government sector will not necessarily result in universal access. Indeed, if the federal or state health care budget becomes constrained, will we ration by some means—like age—other than socioeconomic status? Would this type of rationing be less reprehensible to us than rationing by socioeconomic status? Will budget constraints mean equal *access* to care, but with reductions in overall quality of care?

As our nation continues to debate the issues of health care, we must look beyond the rhetoric, unexamined assumptions and easy answers. We must understand the history of health care in this country, the multiple variables that affect health care outcomes, the root causes of the cost spiral and the workable options available to us.

In theory, universal access could be achieved by a national health care system. But as long as costs challenge governmental budgets' limited resources, the reality could be far from the theory. ■

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Liquidation process

Continued from previous page

insurance.

The basis for the re-examination and restructuring is simple: Recognize the liquidator as a manager of an insurance business. This would have three major consequences:

✔ The liquidator must be a separate entity from the regulator.

A state insurance commissioner should not act as the liquidator of an insurance company. There should be a separate liquidator for each insolvent estate. The court or the commissioner could be given authority to appoint a specific liquidator for each liquidation occurring in its jurisdiction.

Liquidators could be appointed from any number of sources. Accountants, actuaries, lawyers, former insurance executives and consultants are being hired by liquidators to perform services like those necessary for liquidation. They could easily be the pool from which the courts or the commissioners could select appropriate liquidators for each estate.

These people are currently hired to do the work anyway, but without any of the responsibility for the result. By making them the actual liquidator, rather than a paid consultant, a system of accountability with separation of regulator and liquidator could readily be established from existing pools of talent.

✔ The liquidator should be a regulated entity.

Not only should the liquidator be an entity separate from the regulator, but the estate of an insolvent insurer should be a regulated entity. In other words, companies in liquidation should be required to continue to file statutory statements with insurance regulators and be subject to review and examination by the regulator. These filings would have to be modified to emphasize the status of assets and liabilities rather than such things as adequacy of reserves, premium income and other ongoing business portions of the existing statements.

Presently, there is no adequate means by which policyholders and creditors can ascertain the status of the assets in an estate, the scope and nature of claims against it or the expenses of administering the estate. Examples abound of creditors and policyholders frustrated in their efforts to ascertain the status of estates in liquidation. It is no answer that the courts are overseeing these estates and protecting their interests since the courts do not have the expertise or resources to adequately perform this function. In many instances, no reports are filed with the court at all until there is a distribution, which could be many years after the order of liquidation, and the reports that are filed are usually of minimal value at best.

✔ With accountability goes rewards.

Managers of insurance companies in liquidation should be rewarded for the effectiveness of that management. Systems should be discussed and devised to reward managers for success in marshaling and distributing assets, or in otherwise restoring insolvent companies to financial viability.

It may be abhorrent to regulators to consider such a reward system in the management of insolvent estates. However, if you accept the premise that liquidators are managers and you would like to develop as efficient a system of management as possible, it is necessary to reward those who do so most efficiently.

It also would be a marvelous opportunity to take advantage of all of those "experts" who are offering their services for substantial fees to do the management work for the liquidator without any of the responsibility. Perhaps it's time to let these experts assume some responsibility for their work.

If the industry were to develop a system of liquidation based on the separation of liquidator from regulator, proper accountability and reward for effective management, we would see far more ingenuity and effectiveness in the management of insolvent estates for the benefit of their policyholders and creditors. Such effective management could lead to more companies actually being saved with a greater return to policyholders and creditors, and would allow the regulators to concentrate on what they do best: regulation. The regulators would also be less likely to be looking over their shoulders in determining whether to take action against a particular entity that may be insolvent, knowing that the responsibility for the management of that entity in liquidation will fall on someone else.

Free to perform their primary functions, state regulators would be better equipped to carry out their primary function, and further confirm the effectiveness of state regulation and the lack of need for a federal system. Pressures on the funding of guaranty funds by solvent, well-managed insurers should also be reduced since such funds will be less likely to have to pay for the inefficiencies and waste inherent in the present system. These benefits could ultimately help sustain a healthier, more energetic insurance industry. ■

Peter H. Bickford is an attorney with the New York law firm Bickford Hahn & Haley. He has been active in the liquidation and rehabilitation of insolvent insurers in New York.

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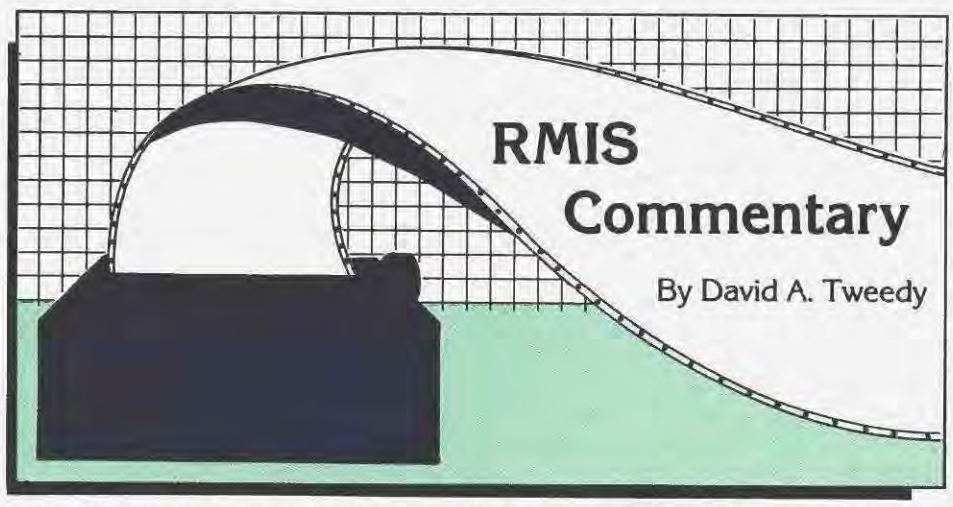
RMIS 'mini-audit' checks claims processing performance



FOR MANY BELEAGUERED risk managers today, claims management is the "kingpin" in controlling overall corporate cost of risk. The variety of exposures, complicated by different state laws, surging medical costs and increased litigation, make this a challenging task. The equation is further complicated by the claims industry itself, which, for many reasons, does not provide the necessary service that clients so desperately need. Claims examiners are buried under caseloads exceeding 300 to 500 claims per person, which turn those individuals into paper processors, not claims adjusters.

How does a risk management information system fit in with this discussion? As we saw last month (*BI*, Feb. 18), the RMIS is a powerful and effective tool in claims management and is touted as such by the RMIS vendor community.

Today, however, I would like to discuss use of an RMIS' claims management analysis ability. Any firm, self-administered or serviced by an insurer claims department or a third-party administrator, can make use of this very powerful application of the RMIS' claims monitoring system function—the ability to conduct periodic performance audits. This is one of the most effective ways of doing unannounced "gut" checks on the claim organization's performance.

In fact, when I do claim management audits for clients, I will utilize the client's RMIS (if it is set up properly) to conduct these reviews as part of a larger analysis. The objective is to check a few critical points in a claims program to get a read on how well or poorly things are going.

In this "mini-audit," one should focus on the following areas, which are easily tracked by an RMIS:

- Claim reporting and responding time.
- Adjuster/examiner productivity (self-administered organizations).
- File closure analysis.

The major missing area is reserve analysis, which I will discuss in an upcoming column because of its importance. Also important are expense analysis (legal, medical), subrogation analysis, as well as the actual process of establishing and resolving the claim itself. These factors also will be discussed in future columns.

The first area where the RMIS can assist in these audits is in claims reporting analysis. A risk manager can use the RMIS to check the critical path of a claim: from its date of occurrence to when the employee reports it to his immediate supervisor, to when that supervisor competes the form and submits it to either another internal department or to the claims organization. Finally, the claims organization receives the claim and actually begins working it.

Depending on the organization, there may be many separate time segments to measure. The bottom line is that the longer it takes for the injured employee to be contacted by the claims organization, the greater the possibility that the claim will go out of control. The claimant may retain an attorney, or become increasingly hostile to any attempt by the employer to return him to light duty.

Frequently, risk managers will level the blame for tardy claim handling at the claims organization. However, we have found that it is often a problem of late reporting by the employer itself, especially if it is a large multi-state, multi-office organization with layers of reporting requirements.

An RMIS is well-suited to this type of analysis. Most claims monitoring systems allow this time lag analysis on an ad hoc reporting basis. For example, one could measure the reporting efficiency of a company's Western division against the Eastern division, comparing the date of claim to the date submitted to the claims organization. In fact, this could be done at the lowest possible reporting hierarchy—like a district or local office—and not just a macro view.

Industry experts note that claims and wine are not alike. 'Wine improves with age; claims do not.'

Once the claim is received by the claims organization, it is important to note the date received by the claim office (usually seen by a date stamp) and entered into the claims monitoring system as date of claim file setup or "date reported." This date is then compared against "date of first action," which usually is a telephone call by the examiner to the injured worker to check progress, take a recorded statement or make an appointment to interview the injured worker in person.

Again, I cannot overestimate the importance of this time analysis. To coin a common saying in the claims profession: "Claims and wine are not alike; whereas wine improves with age, claims do not." In fact, study of the time reporting lag, especially of the 24 to 48 hours after the accident, is most critical in understanding the claims exposure of an organization. This is a subject for another column, but there are consulting firms that are dedicated to performing such studies and charting the financial impact of a delayed response by both management and the claims organization to an injured worker. There is a direct financial correlation.

For the purposes of the mini-audit, it does show a risk manager very quickly where the problems are and may partially answer why claims costs are rising.

This is another very critical area that can be easily evaluated via the RMIS. There is a direct correlation between the effectiveness of a claims examiner/adjuster and his caseload. The industry average in the casualty claims industry is 250 to 300 claims per inside examiner (using the telephone as the primary element of investigation).

However, in many audits that we have done, we have seen TPAs and insured claim departments with average caseloads exceeding 350 per examiner (in one case we saw 700 to 800 per examiner), which essentially reduces that claims professional to a mere processor. Many claims organizations place such burdens on their claims professionals because of competitive pricing pressures. Most clients, in a self-destructive fashion, force their TPAs to lower their charges with the thought that they will get the best overall price; in fact, the reverse is often true as claims costs rise with the examiner's workload.

The RMIS in a self-administered organization usually charts the caseloads of each examiner on a monthly basis. The risk manager or claims manager of an organization should regularly check this to measure effectiveness.

A second function that the RMIS can perform is analysis of the case turnover ratio. This is defined as cases closed divided by cases received.

The ideal in the industry is to achieve a 1-to-1 ratio, meaning as many claims were closed as were received within a given time period, usually a month. Although there are likely to be aberrations on a month-to-month basis (an adjuster may assume the workload of someone else for a short time), the overall ratio should be one of the accurate indicators of performance.

If the case turnover ratio is well over 1-to-1 (say, 1.5-to-1), then that may signal a problem with the adjuster settling cases too quickly with not enough investigation or abusing his authority level.

On the other hand, a turnover ratio of significantly less than 1-to-1 (say, 0.6-to-1), may indicate an excessive workload that is getting worse since more cases are coming in than are being resolved. A ratio like this may also be a signal that some of the cases coming in are more difficult and, therefore, are taking longer to get off the company's pending caseload.

These ratios, as well as caseload count, should not be overemphasized or taken at face value. Indeed, there may be good explanations as to why there are aberrations. However, taken collectively, these ratios may point out symptoms of a malady that needs immediate correction from the company.

The final area in which the RMIS can be of assistance is to analyze the accuracy of the claims count, as compared against the loss runs received every month.

Although it is somewhat difficult to reconcile the total insureds/total paid/total outstanding columns that appear on the loss reports from the TPA/insurer against the RMIS figures (due to different cutoff times in the systems), a macro analysis of the outstanding claims can be done in the open vs. closed area.

For example, if a company is under an incurred loss retrospectively-rated program, and the time for calculating the new retro figures for the upcoming year is approaching, it is critical to make an evaluation of the open and closed cases.

The last thing you want to have are closed cases still appearing as open when the calculations are done, which overstates the total incurred losses at the time and, therefore, costs more money.

These are a few of the critical areas that can be done from the RMIS claims monitoring system on a regular basis. Risk managers who pay careful attention to the information revealed by these mini-reviews can save their company many thousands of dollars in claims costs.

Next month, we will look at how an RMIS will assist the risk manager in performing a reserve analysis. ■

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

Health care reform

Continued from page 2

solution to long-term care problems, Ms. England said.

The need for reform is evident from the ever-increasing share of the gross national product that goes toward health care, Ms. England said.

According to the Commerce Department, the nation spent $675 billion—or 12% of GNP—on health care last year. By the year 2000, the total amount of expenditure is projected to more than double to $1.5 trillion.

These figures illustrate the fact that "health care really is big business today," according to Ms. England.

"We certainly need to convince our colleagues in the health care profession that now that they are part of big business, they need to conduct their business in the same way that we conduct ours in Corporate America—and that is that they are (responsive) to purchasers," she said.

Health care inflation has hit businesses, the nation's largest purchaser of health care, especially hard, Ms. England said.

"When you begin to look at the impact that rising health care costs have had, you see a dramatic increase not only in GNP, but also—as we've seen in our businesses—in spending on health care as a percentage of corporate profits," she said.

Employers' health care costs increased an average of 21% in 1990, Ms. England said, noting that costs rose up to 40% for some employers last year.

And, mental health and substance abuse costs have increased dramatically, rising "somewhere around 47% in 1990," according to Ms. England.

That health care cost inflation has fueled group medical indemnity plan costs. For the first time ever, group health care costs now exceed an average of $3,000 per employee per year, according to A. Foster Higgins & Co. Inc. (*BI*, Jan. 28).

Employers must convince health care professionals that 'now that they are part of big business, they need to conduct their business in the same way that we conduct ours in Corporate America,' says Ms. England.

Total health care costs—including medical indemnity plans, health maintenance organizations, dental and vision plans—leapt 17.1% in 1990 to $3,217 per employee on average from $2,748 in 1989, according to a Foster Higgins survey.

Ms. England explained that cost-shifting probably accounts for about one-third of the increases. For example, decreased payments from government programs like Medicare and Medicaid have translated into increased costs for employer-based indemnity health care plans, according to Ms. England.

In addition, the aging population is contributing to the problem since "there are fewer workers to support the retiree," Ms. England said.

Ten years ago there were approximately 15 active employees available to support one retiree, Ms. England said. "Now, in Fortune 500 companies, there are only three active workers to support one retiree. And, in the steel industry, it's estimated that there is only one active worker per retiree," according to Ms. England.

There is no doubt that employer-based health insurance programs are picking up the tab for these trends, Ms. England said.

During the 1980s, employers sought relief by introducing benefit plan cost controls and shifting costs to employees. And most employers have tried using managed care arrangements to control rising health care costs.

However, in the 1990s, employers will have to work even more closely with employees by sending them the message that they should become prudent purchasers of health care, Ms. England commented.

"This is an area we all have to improve on," she said. "We need to teach our employees that they are part of the purchasing community and they should exercise care as we do as corporations when we purchase other goods."

A handful of employers have introduced some unique solutions, Ms. England said.

But "much of the good news about what employers are doing to solve the health care cost problem is unknown in Washington," she said. "Very few people in Congress and the administration know of the creative and innovative programs you've developed in your corporations."

The lack of communication between employers and government is a problem "I'm very concerned with," Ms. England remarked.

"There are a number of innovative programs across the country that deserve attention," she noted.

Ms. England described the managed care approach that Southwestern Bell Corp. of St. Louis—and several other "Baby Bells"—have embraced (*BI*, Feb. 18; Sept. 25, 1989). And she noted the savings realized from a corporate medical program at Southern California Edison Co. in Rosemead, Calif. (*BI*, March 5, 1990).

Ms. England suggested that companies make a major effort to train executives who have been involved in designing and implementing innovative programs so they can testify about those programs before Congress.

"We need to tell them about the innovative ideas employers around the country are putting into place" so that they can be used as a model for health care system reform, Ms. England said.

However, according to Ms. England, "even if leading employers, like Southwestern Bell and Southern California Edison, manage their own costs, their success is temporary and not sufficient in solving the problem in the long term.

"These realities have led the Washington Business Group on Health to the conclusion that we should develop our own strategy, predicated upon three assumptions," she said:

- Real lasting change requires a national health system reform strategy that involves state, local and private sector initiatives as well as federal government initiatives.
- Reform should be based upon established, long-term principles.
- Reform that will minimize the level of governmental control is not incompatible with a national reform strategy. ■

Does health promotion promote savings?

One firm's plan holds down claims costs

By CHRISTINE WOOLSEY

ROSEMONT, Ill.—Health promotion and wellness programs can help contain costs, but only if certain steps are taken, says a national wellness council director.

To be effective, top management has to be committed to the concept of wellness and must build health promotion into its long-term plans, said Harold S. Kahler Jr., executive director of Wellness Councils of America of Omaha, Neb.

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Mr. Kahler spoke at a Midwest Business Group on Health conference earlier this month in Rosemont, Ill.

He explained that research on the cost-effectiveness of health promotion programs is, at best, inconclusive. Health promotion can be an effective way to control costs, but "you can have the best health promotion program in the world and your (health care) costs may go up."

Benefit managers that must justify costs to top management should emphasize that the goal is to improve employee health. Mr. Kahler said. And better health should—in the long run—reduce group medical plan costs.

Since beginning a wellness program in 1985, Superior Coffee Co. has saved money according to Vince Pellettiere, director of human resources for the Bensenville, Ill.-based company. Mr. Pellettiere would not give any specific figure.

As a way to help benefit managers start their own programs, Mr. Pellettiere offered a "full disclosure report" on his company's wellness plan experience.

Superior Coffee is a division of Sara Lee Corp. About 950 employees are spread throughout 17 locations, though 40% of the workers are in the Chicago area.

During the early 1980s, the company dabbled in "trendy" cost containment techniques, Mr. Pellettiere said. Deductibles and copayments were increased and some health benefits were cut. The company also introduced precertification of hospital stays and required employees to seek second surgical opinions.

About $30,000 it had saved was then put toward a new wellness program.

Given a "charter" to put together a program, Mr. Pellettiere sought advice from his insurance broker, corporate medical doctor and staffers at parent Sara Lee.

Preliminary steps included claims analysis and risk appraisal. Superior Coffee examined health care disability and workers compensation claims to identify frequency and severity trends, he explained. Employees were given "risk appraisals" to identify high-risk behavior like smoking. The process provides "a good snapshot of the risks you are exposed to," he said.

Superior wanted 'a blend of a reactive program and a preventive program,' Mr. Pellettiere says.

Employees also underwent periodic physical examinations to create a current health status baseline that could be monitored over a period of time, according to Mr. Pellettiere.

Once the highest health risk costs were identified, Superior Coffee put together weight control, smoking cessation and stress management programs, along with an employee assistance program, Mr. Pellettiere said.

During the first year, these programs primarily consisted of lectures and seminars in the company's main office. Only Chicago area employees could attend, but eventually a 24-hour hot line let other employees listen to recorded messages.

Dependents were not allowed into the programs, nor were union employees, as they had not been affected by cost control measures in the benefit plan.

After the first year, claims costs dropped 10% at Superior Coffee. However, that decrease "may not be entirely due to the wellness program," according to Mr. Pellettiere.

In 1986, the company added a nutritional counseling program and weight loss and smoking cessation incentives. Overweight employees were given $2 for every pound they lost. And a walking club, which awarded incentives for employees who walked a certain number of miles, was added.

The company's wellness program expenditures increased to $33,000, while claims costs increased only 3% in 1986, Mr. Pellettiere said. Feedback from employees was positive, he said.

In 1987, the program was expanded further to include screenings for high blood pressure, body fat assessments, strength and flexibility programs and lectures on women's health issues. The program's costs increased to $36,000, and again claims costs rose only 3%.

At this stage, some problems arose. Participation in in-house seminars and lectures declined, and employees seemed more interested in the financial incentives from the weight loss program and the walking clubs, Mr. Pellettiere explained.

And employees in other locations began questioning why the program was available only in Chicago, he noted.

Yet no changes were made.

In 1988, when the wellness program budget totaled $40,000, claims costs shot up 23%. A year later, costs rose to $42,000, and claims costs rose 20%.

"In 1990 we came to realize we needed to make a change," Mr. Pellettiere said.

First, the program was opened up to employees at all locations. "We made a commitment that whatever wellness program we were going to introduce would involve all employees, no matter where they were located," Mr. Pellettiere said.

Spouses and dependents were

Continued on next page

Continued from previous page
included, and less emphasis was put on lecture-style programs. Employees instead were encouraged to get involved in the incentive programs, he said.

Two new programs were developed: the Healthier Employee Lifestyle Program—or H.E.L.P.—and the Facility Incentives Toward Nutritional Eating and Stop Smoking—or F.I.T.N.E.S.S.

After revising the program, the firm's health claims costs fell 11% in 1990, Mr. Pellettiere says.

Under the H.E.L.P. program, the company required employees to use money earned through weight loss or smoking cessation to pay for medical expenses or fitness-related costs.

Under the F.I.T.N.E.S.S. program, every facility was provided with a scale, and participating employees were weighed monthly. At the end of the year, the facility with the most pounds lost was given a special gift. A similar facility-wide program was set up for smoking cessation.

In 1990, Superior Coffee's health care claims costs declined 11%, while the wellness program budget totaled $50,000, Mr. Pellettiere said. About 75% of the full-time, non-union employees eligible for the programs utilized some part of the program, he added.

However, the company made further changes to both programs in 1991.

"We realized we were missing some very important groups. We were missing employees already practicing a healthy lifestyle" and employees not in the company health plan, he noted.

Even though those employees did not affect company health costs, their morale was suffering because they were ineligible for incentive programs, he said.

As a result, the company changed the H.E.L.P. and F.I.T.N.E.S.S programs to award all employees and dependents who practiced healthy lifestyles. Participants were required to have an annual physical which was paid for by the company. The physical included six health screening tests: height/weight, total cholesterol, triglycerides, glucose, blood pressure and blood lipids.

Each employee or spouse who successfully passes five of the six tests is awarded $200 to use in a special H.E.L.P. account, which includes the rewards for weight loss and smoking cessation, Mr. Pellettiere explained. If both the employee and the spouse pass the tests, they are awarded $400 toward the account. Employees not covered under the company health plan are awarded $100 toward the account.

Currently, 30% of the H.E.L.P. accounts must be used for medical-related expenses. The remaining 70% can be used for certain non-medical expenses, like membership fees for health clubs and the purchase of exercise equipment. ■

Health coalition meeting draws 130 attendees

ROSEMONT, Ill.—About 130 employee benefit and senior human resource managers attended the 11th annual Midwest Business Group on Health conference, held here March 7-8.

The conference featured speakers from the business, labor, government and medical communities. Panel discussions focused on consumer health care education, employer-employee trust and ways to get organized labor involved in health care programs.

Topics at concurrent workshops included corporate wellness and employee health education programs, claims analysis strategies, outcomes measurements to assess health care quality and retiree medical issues.

The Chicago-based Midwest Business Group on Health is an employer coalition with about 140 members in Illinois, Indiana, Iowa, Michigan, Minnesota, Missouri, Nebraska, Ohio and Wisconsin.

For more information, contact Chuck Ripp, Midwest Business Group on Health, 8303 W. Higgins Road, Suite 200, Chicago, Ill. 60631; 708-380-9090.

—By Christine Woolsey

Pooling can improve health care efficiency

By MICHAEL SCHACHNER

NEW YORK—To hold down health care costs and improve efficiency, companies should try to better reward those doctors that practice conservative, effective medicine, a human resources executive says.

One good way to identify and take advantage of such doctors is through employer consortiums, said Powell Woods, vp for human resources and community affairs at Nestle Enterprises Inc. in Solon, Ohio. Such pools increase companies' bargaining power, he added.

"There's an enormous opportunity out there to save a large amount of money by rewarding higher levels of provider efficiency. We should be paying for what providers do for people, and not to people," Mr. Woods said last month at an employee benefits conference in New York sponsored by The Conference Board.

He faulted the current payment system for rewarding doctors and hospitals that perform the most services.

"We have traditionally reimbursed providers for services rendered; thus, the provider who does the most is rewarded. Meanwhile, the low-volume producer is punished. The conservative doctor who may be the most effective is the one who gets punished which is totally wrong," he said.

Mr. Woods urged employers to "replace quantity rewards with efficiency and quality rewards.'

The conservative doctor 'who may be the most effective . . .gets punished,' says Powell Woods.

Even modest improvements in efficiency could bring major benefits, he said. "A 10% improvement in efficiency could save as much as $75 billion, which could be used to cover the more than 30 million uninsured people in the United States."

To ensure that they get the most for their health care dollar, he suggested that employers form coalitions. These regional coalitions should purchase only top-quality, cost-effective services.

For example, since 1989, Campbell Soup Co. has helped form such health care coalitions in two states, according to John J. Hague, corporate benefits director for the Camden, N.J.-based food processor. Plans are set to form two more employer coalitions in the near future.

Mr. Hague, who also spoke at the conference, explained that through multiemployer coalitions, Campbell has created primary care networks with local general practitioners. The goal: to dramatically reduce what he called unnecessary visits to specialists.

At these networks—now operating in Texas, Ohio and North Carolina—overall costs range from 15% to 34% below the cost of Campbell's traditional indemnity plans in these areas.

"The key to success in these programs is found in the referral process," Mr. Hague said. Under the network system, the primary physician and the specialist hold consultations regarding the patient's care and arrive at a specific treatment plan, he said. All subsequent care by the specialist (beyond the initial visit) must then be approved by the primary physician, Mr. Hague said.

Primary care physicians in these networks also place 10% to 20% of their annual fees at risk. Only doctors meeting an annual budget get paid that portion. This gives doctors a large incentive not to make unnecessary referrals to more expensive specialists, Mr. Hague

Continued on next page

In benefits, one size won't fit all

By MICHAEL SCHACHNER

NEW YORK—Companies are taking a new approach to employee benefits—they're thinking of workers as family—says an employee benefits consultant.

Having realized that "one size fits all" no longer makes sense as a benefit philosophy, companies are turning to an array of life cycle benefits that help employees balance work and family, said Wendy Gray, a consultant with Ernst & Young in New York.

And to help attract and retain quality workers, employers will probably keep introducing such nontraditional benefits, Ms. Gray predicted last month at an employee benefits conference in New York sponsored by the Conference Board.

Benefit planners for two large corporations with growing work and family benefit programs also offered their views on the evolving life cycle benefit market.

"Life cycle benefits help remove the barriers associated with schedules and stereotypes," said Deborah Holt, director of human resource policies and strategic planning for U.S. Sprint, the long-distance subsidiary of United Telecommunications Inc. "It delivers a message to current and future employees that the company cares and is willing to be flexible."

Over the past several years, Westwood, Kan.-based Sprint has introduced several common work and family benefits. It has had to offer a wide range of benefits to satisfy diverse workforce needs, said Ms. Holt.

Among the communication company's 42,000 employees, a quarter are minorities and the average age is 35. "Since nobody has our demographics, we couldn't find (a model for) our life cycle programs. So, in order to make sure all benefits were equitable we introduced our own plan," she said.

Sprint recently introduced company-paid child and elder care resource and referral networks, a working partners relocation program, family leave, an employee assistance program and flexible scheduling.

Usage rates for each now exceed national averages for all of the offerings, Ms. Holt added.

More than 5% of workers have used the child care referral network and 4.5% have used the elder

Continued on next page

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said.

He said the network plans, which are voluntary for employees who have access to them, are similar to Campbell's self-insured indemnity plan.

The only major difference is that 100% of an employee's primary physician care is covered in the network, as is 100% of the cost of a first visit to a specialist. Subsequent visits to the specialist are 80% covered. Under Campbell's regular plan, employees pay 20% of costs above deductibles, Mr. Hague said.

From the company's standpoint, he said, the new plan is by no means a "takeaway" for employees. "In fact, participants get a higher level of benefits. And, for the doctors, they get an increased patient load that will return again and again; their fees aren't capitated like in many network programs; they're in complete control of referrals"; and payments are reliable.

In Ohio and North Carolina, Campbell employees share the network with workers from five other large companies. Only in Texas does Campbell run the network alone.

Savings through the networks have been considerable, Mr. Hague said. Network health care costs in North Carolina are running about 34% below indemnity plan costs; network costs are 23% lower in Ohio; and 15% lower in Texas.

"Partnerships provide employers with pricing leverage with physicians, which leads to cost savings," he said.

Joseph Rosmann, national practice director of managed health care consulting services with Coopers & Lybrand in Chicago, moderated the session. ■

Life cycle benefits

Continued from previous page
care services, she said. And 8.5% of employees have used the confidential employee assistance program, primarily to resolve marital and personal conflicts, Ms. Holt added.

Another popular offering is the working partners relocation plan, according to Ms. Holt. About 900 people have used the program, which provides spouses of relocated Sprint employees resources to help them find work in a new area.

Life cycle benefits are also growing in number at Levi Strauss & Co.

The San Francisco-based apparel company, which already offers free elder and child care resource and referral services and contracts with retiree coordinators in various communities, plans to implement up to 30 new work and family benefits over the next several years, according to Margaret Franklin, manager of benefits services.

'Productivity and results are not tied to presence in the office,' says U.S. Sprint's Ms. Holt.

One current offering is a job-sharing arrangement through which employees who need to take care of older relatives and/or young children can, in essence, work part-time, according to Ms. Franklin.

In addition, Levi Strauss allows all workers—both male and female—to take up to five months of unpaid leave to care for a new child. The jobs of the employees on leave are guaranteed.

Ms. Holt said Sprint, which has a similar family leave plan, would prefer to hold a job for an employee rather than hire someone new. She said the leaves average only 45 to 90 days, and it takes at least that long to train a new employee.

For companies not sure whether to implement certain life cycle benefits, Ms. Franklin recommended starting with pilot programs.

"This is the best way to convince top management that a program is worthwhile. It can show how turnover becomes lower, which keeps training costs down, Ms. Franklin said. "At Levis, we figure one turnover costs between $4,000 and $10,000 in training," said Ms. Franklin.

Higher productivity is one advantage of flexible scheduling, according to Ms. Holt. "Productivity and results are not tied to presence in the office. An employer cannot arbitrarily tie face time in the workplace to results," Ms. Holt said. ■

MARCH CLOSINGS

SET YOUR DATES

issue:	March 18
closing:	March 6
conference report:	International Captive & Reinsurance Forum
demographic section:	Insurer Topics: Insurer-Agency Relations
issue:	March 25
closing:	March 13
issue:	April 1
closing:	March 19
editorial feature:	Benefits: Plan Design & Administration — Directory: Employee Benefit Info Systems
demographic section:	Agent/Broker Topics: Compensation & Incentives
issue:	April 8
closing:	March 27

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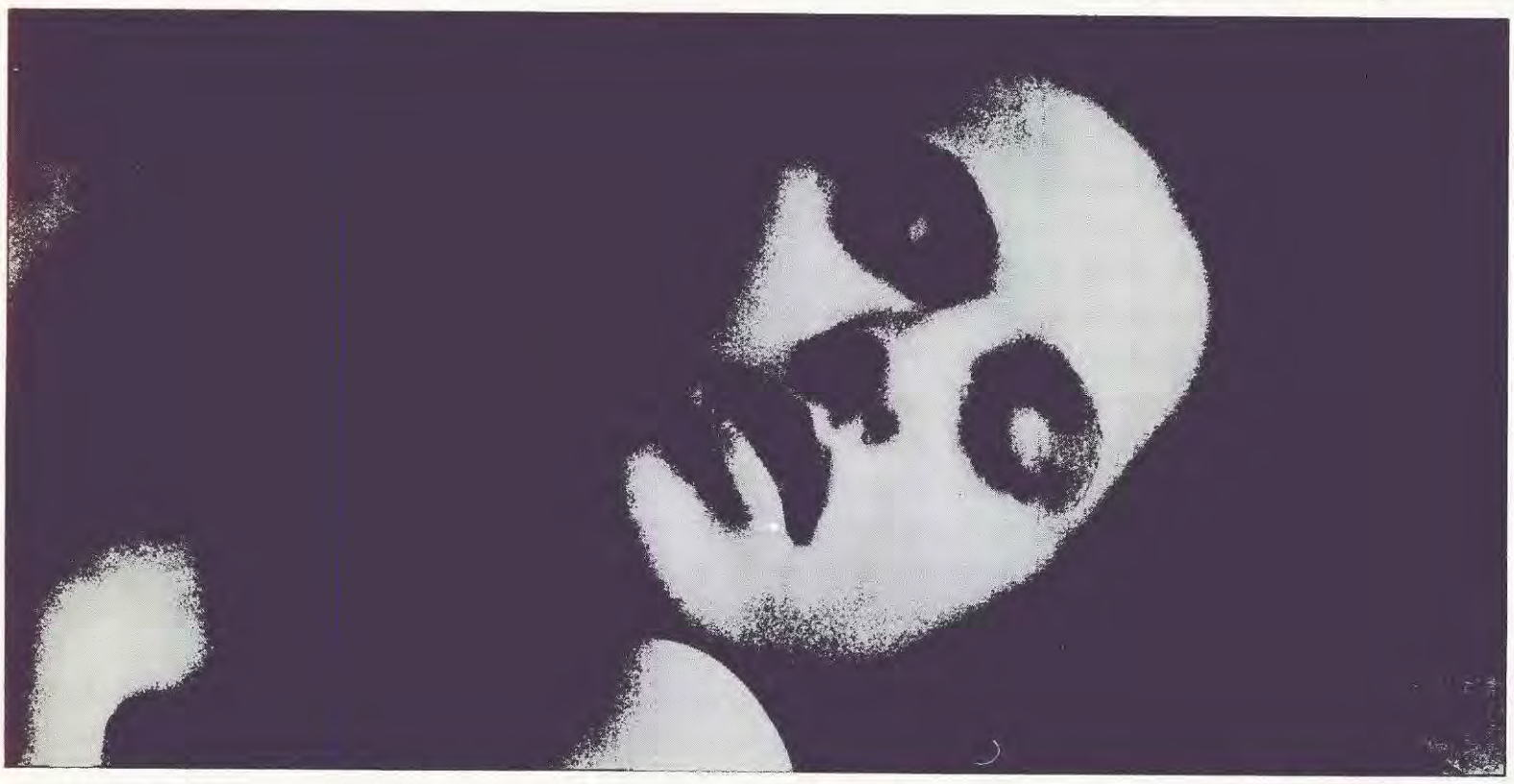

Comings & goings: buyers

Insurer names Belton to top benefits post

Erline Belton, 47, has been named senior vp-human resources of Progressive Corp. of Mayfield Heights, Ohio. She is responsible for managing the human resources department, including employee benefits, health services and employee communications. Ms. Belton replaces **Norton Rose**, who left the company to form his own consulting practice. She reports to Peter B. Lewis, president and chief executive officer. Before joining Progressive Corp.—an insurance and financial services holding company—Ms. Belton was corporate employee relations manager for Digital Equipment Corp. of Maynard, Mass. Before that, she served as project director for the Center for Social Policy and Change at Harvard University in Cambridge, Mass. Ms. Belton holds a bachelor's and a master's degree in education from Tufts University in Medford, Mass. Ms. Belton serves on the board of directors of the National AIDS Coalition.

* * *

Greg Benefield, 28, has been named director-risk management at Shoney's Inc. of Nashville, Tenn. He is responsible for managing the company's insurance program, including risk assessment and control. Mr. Benefield replaces **George Davis**, who left the company. He reports to Craig Barber, treasurer. Mr. Benefield joined the company last year as assistant risk manager. Before joining Shoney's—a restaurant and motel operator—he was director of risk management at Dollar General Corp., a Nashville-based chain of discount stores. Mr. Benefield holds a bachelor's degree in education from Western Kentucky University in Bowling Green. He is secretary of the Cumberland chapter of the Risk & Insurance Management Society Inc. and is a member of the National Restaurant Assn. Risk & Safety Managers.

* * *

Martin Hernandez, 49, has been named vp-risk management at General Rent-A-Car in Hollywood, Fla. In this newly created position, he is responsible for property/casualty insurance, claims management and loss prevention programs. He reports to F. Paul Silicato, president. Before joining the firm, Mr. Hernandez was corporate director of insurance at Budget Rent-A-Car Corp. of Miami. He is a deputy member of RIMS.

* * *

Terry W. Little, 27, has been named casualty insurance administrator at CF Industries Inc. of Long Grove, Ill. Mr. Little is responsible for all aspects of the firm's casualty insurance program. He replaces **Bob Eck**, who left the company. Mr. Little reports to David Haight, director-risk management. Before joining CF Industries—a chemical and fertilizer manufacturer—he was assistant risk manager at Flint Industries Inc., a diversified manufacturer in Tulsa, Okla. He holds a bachelor's degree in business administration from the University of Georgia in Athens. Mr. Little is a deputy member of RIMS.

* * *

Renee Schivera, 30, has been named assistant vp-human resources at Frontier Insurance Co. of Monticello, N.Y. In this newly created position, she is responsible for all employee relations, recruitment and employee benefit programs. Ms. Schivera reports to Walter A. Rhulen, president. She had joined Frontier in 1986 as a consultant and was most recently human resources administrator for Frontier as well as Rhulen Agency Inc., an affiliate that was sold in 1989. Before that, she was executive director of Big Brothers/Big Sisters of Northeast Alabama in Gadsten, Ala. She holds a bachelor's degree in human resource management and sociology from Jacksonville State University in Jacksonville, Ala.

Ms. Schivera is a member of the Society for Human Resource Management.

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We'd like to report on staff changes in your company's risk management, safety and employee benefits departments. Just drop a note to Nancy Johnson, Copy Editor, Business Insurance, 740 N. Rush St., Chicago, Ill. 60611-2590, or call 312-649-7784. Please send a photograph, too.

INTERNATIONAL

Wariness of South Africa lingers

Political, economic woes deter trade

By MARIA KIELMAS

JOHANNESBURG, South Africa —The downturn in the South African economy and political uncertainty are making foreign property/casualty insurers wary of writing business in South Africa, despite moves by President F.W. de Klerk to dismantle remaining apartheid laws, insurers say.

"It's difficult to see companies rushing in there," said Bill Hazelden, assistant group insurance manager of Commercial Union P.L.C. of London.

"It depends on what happens inside the country and if there will be a breakdown of law and order. South African business was profitable up until last year, but now there has been a downturn on the commercial/industrial side," he said.

"There has been a lot of interest from foreign insurers over the last few years, but this is less so now, as we do not expect good results," said Jorg Keel, chairman of Johannesburg-based Swiss South Africa Reinsurance Co., a subsidiary of Swiss Reinsurance Co. of Zurich.

Foreign insurers' interest in the South African market probably would not increase even if trade sanctions against South Africa were removed because of the depth of economic recession in the country, Mr. Keel thinks.

And, even in better economic and political times, it would be difficult to establish a new insurer in South Africa, because the market already is well-served, said Ernst-Friedrich Kahle, chairman of Johannesburg-based Munich Reinsurance Co. of South Africa, a subsidiary of Munich Reinsurance Co.

"I think most groups are waiting to see how the political situation develops and what will actually take place," he said.

"There have been some U.S. multinationals around, but we don't expect a flood until the investment climate stabilizes," said Russell Dickson, insurance manager for Rio Tinto Management Services South Africa (Pty.) Ltd. in Johannesburg, the holding company for the South Africa mining operations

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AP/Wide World Photo

Despite South African President F.W. de Klerk's efforts to dismantle apartheid, insurers remain wary of the market.

LONDON

Weather losses put Fremont into runoff

By STACY SHAPIRO and GAVIN SOUTER

LONDON-Huge weather catastrophe losses have forced another property excess-of-loss underwriter out of the London market.

Fremont Insurance Company (UK) Ltd., the London subsidiary of Los Angeles-based Fremont General Corp., went into runoff March 7 after suffering large catastrophe losses from Hurricane Hugo in 1989 and the European storms in January and February 1990.

Although Fremont said its 1990 results show a pretax loss, it would not disclose the amount of loss. The company reported a pretax profit of 2.14 million pounds in 1989 ($3.44 million) and 3.69 million pounds in 1988 ($6.64 million).

"We sustained losses from 1989 and 1990 underwriting years which have impacted on our capital, and at the moment people are looking for increased security, and it was felt that it was no longer viable to continue trading," said Finance Director Richard Williams, who is administering the runoff.

Fremont has consistently generated gross premium income of around 20 million pounds ($37.2 million) for the past three years, he said.

Fremont, which was established in London in 1979, had a staff of 22 when it ceased trading.

The bulk of the losses are short-term property catastrophe losses, Mr. Williams said, adding that the company has no long-term casualty exposures.

The two underwriters and their eight support staff have been laid off. Underwriter Geoffrey Wrightman, who headed the London operation, has already left the company.

The 12 remaining staff will administer the runoff.

Unusual risk contest

To mark the recent opening of its new champagne bar at Lloyd's of London, restaurateur Corney & Barrow is holding a competition for the most unusual risk placed in Lloyd's during the month of March.

Winners will receive magnums of

Continued on next page

Exxon cleanup spurs P&I club surcharge

By GAVIN SOUTER

LONDON—The Exxon Valdez oil spill is hitting the pockets of all tanker owners transporting oil to U.S. ports.

Protection and indemnity clubs are imposing a blanket per-voyage surcharge for oil pollution coverage for tankers that visit U.S. ports.

A general worldwide increase in marine liability rates also is increasing insurance costs for tanker owners.

The surcharge, which was included in February P&I renewals, reflects the conclusion that pollution cleanup costs are significantly higher in the United States than elsewhere, especially in light of strict cleanup legislation enacted by Congress following the 1989 Exxon Valdez spill in Alaska, said one London broker.

The surcharge is set at 32 cents per gross ton per voyage, up to a maximum of 10 voyages a year.

"Put simply, it is recognized that tankers that go to the United States need to pay more money because of the fallout after the Exxon Valdez spill," said Brian Gaze, financial director of A. Bilborough & Co. Ltd., managers of the London Steamship Owners' Mutual Insurance Assn. Ltd.

The Oil Pollution Act, signed into law by President Bush in August, increased a shipowner's liability to $1,200 per gross ton from $150. Individual states, however, are allowed to set higher liability limits (*BI*, Aug. 27, 1990).

Rising reinsurance costs are another reason for the new surcharge, Mr. Gaze said. Broker say reinsurance costs for P&I clubs have risen nearly 50% this year.

But the main reason behind the surcharge is the need to uphold the principal of mutuality on which P&I clubs are founded, said Luke Readman, a director of Thomas Miller & Co., which manages the U.K. P&I Club.

"The surcharge is something that the clubs have done to preserve the principle that one member should not subsidize another," he said.

Meanwhile, general liability rates for P&I club members have risen anywhere between 10% and 80% in renewal this year.

All renewals are made on Feb. 20, which was historically the earliest date the Baltic Sea was considered sufficiently free of ice for a ship to cross it.

Movement by club members also characterized this year's renewal. "It has been a bit of a merry-go-round," said one broker.

The main beneficiary has been the London Club, which is thought to have retrieved 4 million tons of business previously lost.

Last year, the club lost 7.5 million tons after it imposed hefty supplementary calls on members.

"We have done rather better this year because of the refinancing of the club, which put us ahead of the game," said Mr. Gaze.

While P&I clubs have agreed not to offer potential members lower rates than they pay at their current clubs, the London Club is attracting members because they feel that the supplementary call provided the club with a sound financial base, said Mr. Gaze.

The Gard Club has gained an extra 2 million tons, say brokers.

The Standard Club canceled 2 million tons of poor quality ships, said Director John Rowe.

Tranquilizer lawsuits

Patients say they were never warned against addiction

By GAVIN SOUTER

LONDON—Coordinated litigation alleging that two tranquilizer manufacturers negligently failed to warn doctors of the addictive qualities of their benzodiazepine products is under way in Britain's High Court.

The drug manufacturers may face millions of pounds of liability, since some plaintiffs are seeking in excess of 10,000 pounds ($18,580 at current exchange rate).

This litigation, said one defense solicitor, "is bigger than any (products liability case) that has gone before or is in the pipeline" in the United Kingdom.

Both companies—Roche Products Ltd., which manufactured Valium, and John Wyeth & Brother Ltd., which made Ativan—deny allegations by the nearly 900 plaintiffs in England and Wales.

Separate litigation against the companies is being coordinated in Scotland. And in Northern Ireland plaintiffs attorneys are closely watching the outcome of these cases before bringing suit.

The plaintiffs' solicitors in the England and Wales litigation say more claimants may get involved, noting they have been contacted by more than 3,000 potential claimants. According to some estimates, up to 1 million people in Britain may have been dependant on tranquilizers at some point in their lives.

However, British High Court Judge Ian Kennedy in an initial stage of the case said that new claimants would soon be barred from joining the case.

"Within the next few months. . .a shutter will come down and lately arriving plaintiffs will be unable to have their case carried forward until the lead actions have been decided," Justice Kennedy said.

He added that plaintiffs' solicitors should be sure to include any additional claimants before the deadline, which is to be set sometime in the spring.

The plaintiffs' main allegation in the case before Justice Kennedy is that the drug manufacturers failed to warn doctors of the addictive effects of the drugs, said Paul Balen, a partner at Nottingham solicitors Freeth Cartwright.

The Benzodiazepine Solicitors Group, which Mr. Balen set up in 1988, coordinates the 620 English law firms representing 3,000 claimants.

"We allege that the drug companies could have known or ought to have known that the drugs were addictive. But they gave doctors insufficient warnings," Mr. Balen said.

Both Roche's product, Valium, and Wyeth's product, Ativan, are benzodiazepine drugs. Introduced in the early 1960s, benzodiazepines were widely prescribed for anxiety problems. By the late 1970s and the

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BERMUDA

Forum Re liquidaton ordered by court

By ROGER SCOTTON

HAMILTON, Bermuda—Forum Reinsurance Co. Ltd., a financial reinsurance specialist controlled by Mark Hardy, is in liquidation for failing to pay a bill for about $17,000 from a local travel agent.

The uncontested order was made March 8 by the Bermuda Supreme Court during the hearing of a winding-up action filed by Franklin Travel of Bermuda.

The court's decision comes as good news not only for the travel agency but also for a group of four or five interested parties described in the liquidation proceedings as "supporting creditors." The group included the Bermuda Registrar of Companies and the Ohio Insurance Department.

The Ohio department—acting in its capacity as liquidator of Oil & Gas Insurance Co., formerly part of the U.S. insurance group controlled by Mr. Hardy—says that it may have a "substantial claim" against Forum Re.

OGICO, which ceded reinsurance to Forum Re, was placed in rehabilitation in May 1990. It was ordered into liquidation in August (*BI*, July 23, 1990; May 21, 1989).

It was not clear why the Bermuda officials were involved. Malcolm Butterfield, the registrar of companies, whom the court has appointed joint provisional liquidator of Forum Re along with Kirk Cooper of Coopers & Lybrand, declined to explain why he favored the liquidation.

Mr. Butterfield pointed out that Bermuda's 1978 Insurance Act provides that the registrar "shall be entitled to be heard" on winding up petitions brought by persons other than the registrar.

Forum Re's 1990 results were not available last week. But, according to estimates made last year, Forum Re wrote about $34.6 million in financial reinsurance business in 1989, down from about $50 million in 1988 (*BI*, April 30, 1990). The company had an estimated $40.8 million in capital and surplus, $160 million in assets and $3.8 million in net income as of year-end 1989.

Mr. Hardy did not not appear at the winding-up hearing. He has yet to say why he allowed what was once his flagship company to go

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INTERNATIONAL

LONDON

Continued from previous page
champagne. "We anticipate some intriguing entries, bearing in mind that Lloyd's has insured items like the world's most valuable diamond, 'Premier Rose,' worth 5 million pounds ($9.3 million); Betty Grable's legs; the Olympic Games; and the world's longest cigar," said Chris Brown, managing director of Corney & Barrow.

Most recently, unusual risks have been rumored to include an American doctor wanting to insure his life against being hit by a Scud missile in the United States and a woman who insured her heart from being broken by her boyfriend.

The new champagne bar comes complete with a Lloyd's loudspeaker message system, special storage for brokers' slip cases, a satellite television, a videocassette recorder and a facsimile machine.

New EIL policy

A new policy covering sudden and accidental pollution for firms that are finding it difficult to buy any pollution coverage is now available at Lloyd's of London.

The "controlled risk pollution cover facility" was designed by Lloyd's broker Heath Oil & Gas Ltd., a subsidiary of C.E. Heath P.L.C., and is led in the market by underwriters S.R.P. Edwards of syndicate 207 and Ian Agnew of syndicate 406.

However, the coverage can be accessed by all Lloyd's brokers, said John Wallace, chairman of Heath Oil & Gas.

The claims-made policy offers cleanup and/or third-party liability coverage up to $50 million for damages from land-based pollution that happens suddenly and accidentally. Only current risks—not historical activities or pollution—are covered. Gradual pollution is excluded.

Interested companies must fill out a questionnaire that will be reviewed by environmental engineer Noble Denton Goren Ltd. If NDG agrees that the risk is insurable, the policyholder will go through a detailed evaluation by NDG. The engineer's report and recommendation will then be submitted to the underwriters for review before issuing a policy.

Mr. Wallace noted that several other insurers offer this type of coverage.

"We're not competing against what's already being written," Mr. Wallace explained. "This is for people who can't get cover anywhere else."

First Equity windup

British Secretary of State for Trade and Industry Peter Lilley has petitioned for the windup of First Equity Insurance Corp. Ltd. following an investigation into the company.

The windup petition was presented to the London High Court last month. The official receiver was appointed provisional liquidator until the petition is heard in court April 10.

First Equity, incorporated as an insurer in the British Virgin Islands in September 1989, shortly thereafter acquired all the issued share capital of an unnamed Panamanian asset management company, stated the British Department of Trade and Industry.

"The company operated in this country as an insurance company issuing surety and performance bonds, credit guarantee policies and writing other forms of insurance," the DTI said. The company also acted as an agent for the Panamanian asset management company offering large mortgage loans which were dependent on advance payment of substantial commitment fees, the department said.

The company was based in Hove, East Sussex, England. However, "the company was not authorized in any way to carry on any class of insurance business in the U.K.," according to the DTI.

All inquiries about First Equity should be sent to The Official Receiver, Department of Trade and Industry, 21 Bloomsbury St., London WC1B 3SS, England.

S&L crisis studied

The concern in the London market about the potential liabilities from the U.S. savings and loan crisis extends beyond Lloyd's financial institution underwriters.

Also concerned about the problem is London-based CNA Reinsurance of London Ltd., a unit of Chicago-based CNA Financial Corp. and one of the leading U.S. liability underwriters in the company market.

According to a spokesman, CNA Re has played an active part in setting up an informal committee of leading Lloyd's financial institution underwriters to examine the S&L crisis and its underwriting implications (*BI*, Feb. 25).

Other London insurance companies may become involved at a later stage following the London Insurance & Reinsurance Market Assn.'s study of the market, said the spokesman.

Lloyd's informal committee will discuss at its next meeting whether to extend the committee to make it a London-wide concern or to leave it as a committee of Lloyd's underwriters which may consult with other insurers, said Stephen Burnhope, the head of the committee.

Minster chairman

Anthony Lancaster has left his post as senior vp of CIGNA Insurance Co. (U.K.) Ltd. after 18 years with the CIGNA group to become chairman and chief executive of the Minster Insurance Co. Ltd.

"I'm sad to have left CIGNA," said Mr. Lancaster at his new Minster office. "They've been very kind to me."

Alan L. May, who formerly served as president of CIGNA Insurance Co. of Canada will assume Mr. Lancaster's duties.

Mr. Lancaster said he felt that he'd done all he could at CIGNA and joining Minster "was an amazing opportunity."

Minster, which currently writes about 165 million pounds in premium income annually ($306.9 million), is owned by France's fifth largest insurance group, Groupe des Assurances Nationales.

"I am going to help them expand their international positions (and also) reposition Minster to make it a major force in the U.K. insurance company market," Mr. Lancaster said.

Joining Mr. Lancaster at Minster are Keith Morris, former assistant vp at CIGNA U.K. and now general manager for Minster's U.K. operations excluding business derived from its office at the Institute of London Underwriters; and Nick Parry, who left CIGNA U.K. earlier last year as European room manager, who is now Minster's marine and aviation underwriting manager. ■

Advertiser Index

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Business Insurance

Tranquilizer suits

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1980s, studies indicated that the drugs might be addictive.

Malcolm Lader, professor of pharmacology at the Institute of Psychiatry in London, said Valium and Ativan can become addictive after a few weeks. "Trying to get off the tranquilizers can be a problem. . .you get anxious, you can't sleep, you get over-sensitive to light and you feel physically ill like you have 'flu,' " he said.

Although Valium has been prescribed since 1963 and Ativan since 1972, it is only within the last 10 years that scientists have suspected their addictive qualities, said Mr. Lader. "Before, people did not realize that the symptoms were a result of trying to stop using the tranquilizers. They thought it was just the anxiety coming back."

Following warnings in 1988 about the addictive qualities of the tranquilizers by the Committee for the Safety of Medicines, a government advisory board, the drugs now are prescribed only for up to four weeks, said Mr. Lader.

Prescriptions for the drugs dropped sharply following the warnings, said Ron Lacey, a former assistant director of MIND, a mental health charity, and author of a 1983 report on benzodiazepines.

"In 1990, there were 22 million benzodiazepines prescribed, compared with 40 million in 1977 when they were at their height," he said.

"Not everybody is going to get addicted. But if you took a conservative estimate, around 1 million people could have been addicted," he said.

In the High Court litigation, the crucial date is 1980 when the Committee for the Review of Medicines, another government advisory body, warned of the possible addictive qualities, said Mr. Lacey.

After 1980, the manufacturers must have known of those qualities and should have warned doctors, said Mr. Lacey

"From 1980 right up until relatively recently the drug companies' data sheets on the drugs have not been all that they should have been," he said.

Currently, the legal actions are just directed against Roche and Wyeth. But Mr. Balen of the Benzodiazepine Solicitors Group said that the allegations may well be extended to other manufacturers of benzodiazepines, as other claimants contact the lawyers.

Michael Napier, a partner with plaintiff litigation specialists Pannone Napier, heads the steering committee of solicitors that is coordinating the litigation. Both Mr. Napier and Mr. Balen said it is too early to estimate the potential size of claims.

Plaintiff's attorney Anthony Scrivener said that some could exceed 10,000 pounds.

Mr. Napier would only give broad details of the plaintiffs' allegations: 'The producers' warnings were not adequate. . .It is a very complex history that has to be examined and will be examined."

The litigation in the English courts is accompanied by a parallel action in Scotland, which has its own separate legal system.

The drug companies had an "obligation to research the long-term effects of the drugs before they marketed them, and if they had done that they would have known of the withdrawal symptoms," said Kenneth Hogg, partner at Caesar & Howie and chairman of the group coordinating the Scottish litigation.

Theoretically, this would mean that Scottish plaintiffs who had taken tranquilizers as far back as 1960 could have a claim. But such cases would probably be difficult to prove because of the time lag, Mr. Hogg added.

Plaintiffs who were prescribed the drugs in the late 1970s, though, may have a strong case, he said.

The Scottish lawyers have lodged summonses for more than 200 plaintiffs. The summonses are being sifted, which means that the plaintiffs lawyers are assessing the claims and determining the maximum claim each plaintiff should make. Under Scottish law, the figure for each damage claim is inserted into the summons and any subsequent award may not exceed the amount sought.

Mr. Hogg would say only that the Scottish claims would be significant. He added that the group of 100 Scottish lawyers had been notified of a further 250 potential claimants and were receiving more inquiries everyday.

A group of 30 lawyers in Northern Ireland have not yet started any legal action on behalf of upwards of 250 potential claimants, said Cormac Fitzpatrick, a partner in Vincent P. Fitzpatrick and secretary to the plaintiffs' attorney group in Northern Ireland.

That group is relying heavily on the English research. "The experts which we have approached in Northern Ireland have refused to help, mainly because there are very few independent experts in Northern Ireland; most of them work for the Health Boards," said Mr. Fitzpatrick.

Negotiations are now under way with plaintiffs' lawyers in England and Wales to use their research. The Northern Ireland group probably will be able to use that evidence, said Mr. Fitzpatrick.

"Afterwards, we will be no more than two steps behind the English group," he added.

Although he said it is too early to estimate damages to be sought by Northern Ireland plaintiffs, Mr. Fitzpatrick said damages could be substantially higher than those in England and Wales.

"Our damages are higher than in England and Wales because we only abolished juries for personal injury litigation awards in the mid-1980s, whereas in England and Wales they were abolished in the 1950s. As a consequence of this, our general damages tend to be two to three times higher," said Mr. Fitzpatrick.

The two drug manufacturers strongly deny the allegations in the various suits.

"Roche took adequate steps to warn doctors, and through doctors it warned patients," says its lawyer, Ann Ware, who is a partner at Davies Arnold Cooper.

Roche had received 53 writs covering 270 plaintiffs, she said.

A spokesman for Roche Products Ltd. said the company has not made any special provisions to pay compensation awards because it believes it will be vindicated in court.

"Benzodiazepines were first introduced in 1960, and over the years there were many studies which confirmed both their efficacy and safety," he said.

That changed in the late 1970s. Studies then indicated that tranquilizers may be addictive, he acknowledged.

"In March 1980, we sent a 'dear doctor' letter to all United Kingdom doctors warning them of the possible addictive qualities of Valium," he said.

After the Committee for the Safety of Medicine's 1988 report, the company included in its data sheet both the warning and the recommendation that benzodiazepines only be used for two- to four-week periods, he added.

Roche has product liability insurance through its parent company, F. Hoffmann-La Roche of Basel, Switzerland. Zurich Insurance Co. leads the coverage, said a spokesman at the insurer's Swiss headquarters. He would give no other details.

A spokeswoman for Roche added that its insurance "arrangements ensure that we can meet all our financial arrangements."

Zurich would normally insist on higher deductibles for pharmaceutical companies taking product liability coverage than most other companies, noted Jonathan Harradine, marketing manager for Zurich International in London.

"It is unlikely that we would offer coverage for a pharmaceutical company with a deductible of less than 25,000 pounds ($46,450)," he said.

Although he would not comment on Roche's coverage, Mr. Harradine noted that one drug company covered by Zurich self-insures up to 25 million pounds ($46.5 million).

Major drug companies do retain, by choice, up to and sometimes more than 25 million pounds of risk, said Michael Jones, a director in the London casualty division of broker Bowring U.K. Ltd.

And the major firms usually cannot buy as much coverage as they would like, he added.

"If you are looking at a company with U.S. exposures, they could buy up to $500 million" in coverage, said Mr. Jones.

It is too early to predict what the total compensation claim will be, said Ian Dodds-Smith, a partner at solicitors McKenna & Co., which is representing John Wyeth Laboratories Ltd. "We have only limited information on the majority of those people who are intimating damages."

Most product liability suits in the United Kingdom have involved health care products, Mr. Dodds-Smith noted. "But the benzodiazepines litigation is bigger than anything that has gone before or is in the pipeline," he added.

So far, John Wyeth has received 170 individual statements of claim, Mr. Dodds-Smith said.

Wyeth refused to comment on its insurance program.

In a written statement, the company said, "The benefits of any drug have to be balanced against possible adverse effects and knowledge about both benefits and risks is constantly growing as a result of research and experience."

Wyeth said it "firmly believes that Ativan is safe and effective when used in accordance with the company's recommendations and good medical practice." ■

South Africa

Continued from page 45
of RTZ Corp. of London.

"In the medium term, when the economy recovers and hopefully sanctions are lifted, it will be anybody's guess, but there could be a lull period before foreign insurers return," Mr. Dickson said.

However, given that the South African mining industry poses some of the largest risks in the world and cannot be absorbed by the small local insurance market, it is only to be expected that foreign insurers will be interested in the country, he said.

Rodney Scheeberger, chief executive of the South Africa Insurance Assn., is more optimistic. "We expect the market to expand gradually over the next few years because of a swiftly evolving black middle class, which is financially better off."

Although sanctions like the international oil embargo were first proposed by the Organization of African Unity in the late 1960s and adopted by the United Nations in 1979, it was not until 1986 that foreign insurers operating in South Africa were obliged to react to international political pressure against apartheid.

After enactment of the Comprehensive Anti-Apartheid Act of 1986 in the United States and similar laws in the Scandinavian countries of Norway, Sweden, Finland and Denmark, insurers in those countries pulled out of South Africa (*BI*, July 25, 1988).

There were no equivalent laws enacted by the European Community, which instead attempted to "discourage" companies in E.C. nations from expanding business links with South Africa and left further action to individual governments, said an E.C. official in Brussels.

However, Denmark was the only E.C. country that took such steps to curb business links with South Africa, and it did so as a Scandinavian—rather than an E.C.—state.

As a result, the traditional role of the London and German markets as South Africa's main reinsurers was strengthened, according to insurers.

But while British companies were under no governmental pressure at the time to pull out of South Africa, it was impossible to ignore pressure from shareholders, said Mr. Hazelden of Commercial Union. So Commercial Union cut its stake in Cape Town-based composite insurer Commercial Union Assurance Co. of South Africa Ltd. to 36%.

In South Africa, the term "composite insurer" refers to companies that write both non-life and life coverage.

But Mr. Hazelden acknowledges that this was a painless procedure, because one of South Africa's largest financial groups, the United Building Society, was very eager to buy an interest in the company. He explained that the main reason for this was the collapse the same year of another composite insurer, AA Mutual Insurance Assn. Ltd.

The collapse of AA Mutual has spawned legislation that would reform South Africa's insurance law, including banning composite insurers (see related story).

South African insurers were eager to grab 420 million rand ($160.7 million at current exchange rates) of premium that flooded into the market virtually overnight. Total premium income last year in the South African market was 7 billion rand ($2.68 billion at current exchange rates), about 20% of which is ceded overseas as reinsurance.

"Trade sanctions against South Africa have never affected reinsurance cessions," observed the SAIA's Mr. Scheeberger.

But, given the boost to the South African insurance market in 1986, South African insurers were eager to buy the interest of U.S. and Scandinavian insurers coming into the market as distress sales, Mr. Scheeberger said. "This created another hundred South African millionaires," he said.

Still, the withdrawal of foreign insurers from the South African market in the mid-1980s caused Rio Tinto some temporary problems in acquiring sufficient insurance, Mr. Dickson said. "We used different techniques of layering, but we did not have full value to our loss limit. We managed to cover our maximum probable loss with the loss limit, but now we are back to full value."

But, within a year, some foreign insurers that had left tried to reenter the South African market.

London insurance sources say Scandinavian companies entered into fronting arrangements with other insurers in E.C. countries to maintain their South African business. These arrangements still are in force today, they say.

According to Swiss South Africa Re's Mr. Keel, foreign insurers were keen to target the South African market in 1988-1990 until it became engulfed in a rate-cutting war last year.

Now, South African direct insurers are cutting staff, and some small insurers reportedly are in financial difficulty, Mr. Keel said.

Munich Re South Africa's Mr. Kahle said the greatest rate war last year was in personal lines, resulting in direct insurers showing a substantial loss on their net accounts.

"The reinsurance results are not exactly positive but not exactly negative," he said.

South Africa's economic problems are caused in part by low world prices for gold, the nation's chief export.

In addition, the country has to maintain a balance of payment surplus to service its $20 billion foreign debt. Because of the U.S. anti-apartheid law and U.S. influence on international lending agencies, South Africa cannot tap funds from the World Bank or International Monetary Fund.

Sources say trade and lending restrictions against South Africa will not be lifted until all apartheid laws are repealed and a new constitution is in place.

European bankers also are unwilling to make loans because, in addition to political pressure from shareholders, government requirements make the process unprofitable, said an international banker in London.

However, the SAIA's Mr. Scheeberger said a large number of foreign insurers already are eyeing a future role in the South African market, both by reinsuring South African risks and by ceding reinsurance to South African underwriters.

Swiss South Africa Re's Mr. Keel disagrees. He said the weakness of the rand makes it very unwise for a South African company to acquire foreign liability. "Quite a few direct insurers here have had their fingers burned with currency problems. Not too many people will be interested in hard currency risks until we get a political settlement," he said.

But, in the long term, and if sanctions are lifted, South Africa could be a financial center for the Southern African region, Mr. Keel said.

For example, Swiss South Africa Re administered Angolan and Mozambican risks from South Africa until international trade sanctions were first proposed in the late 1960s. This business has since been run from the company's head office in Zurich.

Munich Re's Mr. Kahle is similarly bullish about prospects on the African continent.

"We are getting a lot of international interest for countries like Namibia, Botswana, Zimbabwe and Mozambique." Munich Re manages its interests in those countries from South Africa.

Botswana in particular is becoming a thriving offshore financial center for Southern Africa because of its stable, democratic government, as well as foreign exchange surplus resulting from the country's healthy mining and live-

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South African insurance changes sought

By MARIA KIELMAS

JOHANNESBURG, South Africa —South African insurers and government officials are discussing two new draft insurance laws designed to replace the existing Insurance Act of 1943: The Short Term Insurance Law and the Life Insurance Law.

The term "short term" in South Africa means non-life insurance.

The impetus for the new law came as a result of the collapse of the AA Mutual Insurance Assn. Ltd. in 1986. The laws include recommendations by the Melamet Commission, which was established to wind up AA Mutual.

Under the draft laws:

- Composite insurance companies, which write life and non-life coverage, will no longer be authorized in South Africa.

Existing composite insurers would have to set up separate life and non-life insurance units.

This provision would apply to insurers and reinsurers.

- Insurers would have to appoint two auditors in an effort to provide extra security for policyholders and shareholders.

In addition, two members of the board must be executives with the company. This recommendation originated with the Melamet Commission, which noted that AA Mutual's board was not properly informed of the company's affairs.

- Insurers must hold technical reserves equal to 15% of gross premium income. Direct insurers may deduct from this an amount equal to the reinsurance cessions to national reinsurers. Cessions to foreign reinsurers are not deductible.
- Insurers must hold contingency reserves equal to 10% of gross premium income.
- The Council of Lloyd's must appoint two individuals—one official and one alternate—to act as representatives for it and Lloyd's of London underwriters in South Africa.
- The Lloyd's representative would have to deposit monthly into a trust account at a South African bank in the name of Lloyd's an amount equal to 130% of gross premiums received by Lloyd's agents in the country. The provision does not state when the funds can be withdrawn.
- Lloyd's agents must keep separate books on their different activities. The provision does not elaborate about this requirement.
- Intermediaries' commissions could not exceed 12.5% of personal lines gross premium volume and 20% of all other business.
- Direct insurers could not pay more than 50% of their premiums to reinsurers not registered in South Africa.
- All insurers and agents would be assessed a monthly tax of 2.5% of gross premium volume.

The South African Insurance Assn. complains about the draft proposals to its members. In a document obtained by *Business Insurance* the SAIA argues that:

- The powers granted to the Registrar of Insurance are too wide. Instead, the insurance industry wants to set up a self-regulatory mechanism.
- The 130% deposit required by Lloyd's agents should be closer to 200% given that non-Lloyd's insurers have to to establish a contingency reserve equal to 10% of gross premiums. The SAIA adds that Lloyd's agents should be subject to a tax greater than 2.5% of gross premium volume.
- There should be no restrictions on payments of premiums to foreign reinsurers, even though the SAIA favors that premiums remain in South Africa.

In written comments to the Registrar of Insurance, the South African Risk & Insurance Management Assn. said the draft legislation would provide required levels of protection for insurance buyers without overregulating insurers.

However, it complained that:

- Insurers' and reinsurers' cessions abroad should not be limited. The Registrar of Insurance, though, should be able to question "excessive overseas treaty participations," it added.
- The draft law does not address the issue of onshore captives.
- There should be more consumer protection provisions.
- There should be an intermediary self-regulatory mechanism on commissions rather than the proposed limits on commissions. ■

INTERNATIONAL

Continued from previous page
stock industries.

In addition, it is a stopping point for much of the capital that has been withdrawn from South Africa, insurers say privately, particularly since the financial sector in Botswana is controlled by South Africa.

Prospects for expansion into West African countries are less certain, Mr. Kahle said. Although there are increasing numbers of contacts between South African government ministers and officials and their counterparts in West African oil-producing states like Angola and Gabon (with the aim of initiating trade with a post-apartheid South Africa), insurance links are unlikely to follow the energy links, he said.

"These markets are controlled by European countries," he said. ■

BERMUDA

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down, ostensibly, for $17,000 in unpaid air fares.

One theory is that this action was the proverbial straw that broke the camel's back. Mr. Hardy recently has been embroiled in a variety of legal scraps. These include a defamation suit against insurance executive Merton Segal (*BI*, Nov. 19, 1990), and a fraud suit filed March 6 against Jonathan Crawley, a former associate, and others (*BI*, March 11).

In addition, Mr. Hardy recently reached a settlement of a mareva injunction that froze the assets of his Aneco Reinsurance Co. unit, which is running off its business (*BI*, March 11; Feb. 18). And, he has been battling the liquidators of his Focus Insurance Co. subsidiary, which was recently ordered into court supervised liquidation (*BI*, Feb. 11).

Bermuda sources cite one other possible reason for Mr. Hardy's lack of opposition: Forum Re's business was secured and its clients protected by U.S. trust funds—money that policyholders may have access to in the event of Forum Re's liquidation.

However, Dana Rudmosc, assistant director of the Ohio Insurance Department, said last week that one of the main reasons OGICO went into liquidation was that it had placed "lots" of reinsurance with Forum Re.

"I seem to recall we found that between $15 million and $20 million of OGICO reserves had been ceded to Forum," he said. "But Forum had taken down its letters of credit and not replaced them with what we considered to be acceptable security. We also found that this company was replete with inter-company transactions and advances to The Group Inc.," a Concord, Mass.-based holding company that was controlled by Mr. Hardy and that was OGICO's parent.

Mr. Hardy refused to comment on the Forum Re liquidation.

Forum Re is not just any failed business venture. It is Mr. Hardy's personal creation, his answer to Bermuda financial reinsurer Pinnacle Reinsurance Co. Ltd.

Incorporated in 1985, Forum Re was modeled after Pinnacle, which is regarded as a highly successful financial reinsurance subsidiary of broker C.E. Heath P.L.C. As treasurer of Heath until 1981, Mr. Hardy assembled the tax and corporate structure of Pinnacle.

At first writing a very limited number of financial reinsurance contracts —mostly time-and-distance policies —Forum Re built up both its client base and balance sheet. In 1987, it went on the acquisition trail. By the end of 1988 had acquired Focus Insurance Co. Ltd., the former Trenwick Reinsurance Co. Ltd., and had bought a 22% stake in Aneco Reinsurance Co. Ltd. It also entered into an underwriting agreement whereby Aneco underwrote certain captive reinsurance business on behalf of Forum Re (*BI*, April 18, 1988).

Forum Re also is believed to have been used to help finance a string of purchases in the United States, starting with OGICO in June 1987.

Forum Re, through a Bermuda-based investment subsidiary, on March 16, 1988, launched a full tender offer for Aneco Re. By July 1988, the takeover was complete and Forum Re held about 72% of Aneco.

The shareholding relationships and

MEWA probes

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lem as the OIG and state insurance regulators become more aware of them, he says, adding that he is not overstating the problem.

Indeed, he notes that the OIG has completed at least three criminal investigations of MEWAs and that the cases have been turned over to the U.S. Attorney's Office in Washington, D.C., for action.

Self-funded MEWAs generally are designed to offer health insurance to small employers that often are unable to purchase coverage from commercial insurers or do not have the resources to self-fund their own plans.

However, there has been a growing problem with unscrupulous MEWA promoters. These promoters offer unusually low premiums to entice employers to participate and initially pay small claims out from their cash flow. But, after a time, premiums that should be set aside for reserves and to purchase stop-loss insurance are diverted by the promoters and the MEWAs collapse with unpaid claims.

While many fraudulent MEWAs have been discovered in recent years in the Southeast and Southwest, the problem is far from a regional concern, Mr. De La Rosa says. New cases are popping up in other parts of the country, says Mr. De La Rosa, whose plan to tackle this problem in large part is adopted from the course set by Raymond Maria, who was acting inspector general from October 1989 to August 1990.

Neither state nor federal regulators have any idea how many MEWAs are operational and how many lives they cover, according to Mr. De La Rosa.

And, the varying levels of MEWA regulation among the states also make fraudulent plans difficult to uncover, he says.

A key initial step in handling the problem should be giving the inspector general greater discretion in assigning duties to OIG investigators, he says.

Under the Inspector General Act of 1978, the OIG can investigate allegations of corruption, fraud and abuse as they relate to employee benefits. However, the act stipulates that those investigations must be conducted by the OIG's Office of Labor Racketeering.

As a result, Mr. De La Rosa said he is "precluded from using the 80-plus investigators in the Office of Investigations," who are charged under the act with investigating only alleged fraud or abuse by Labor Department employees. "I think that it is a disservice to the clientele out there that are suffering the abuse of these fraudulent plans that we can't put more resources against them and protect the American public as much as we can."

Mr. De La Rosa also is seeking broader authority that would allow the OIG to conduct criminal and civil investigations in cases that would usually be handled by other Labor Department agencies.

"I think it is still necessary for us to clarify the investigative responsibilities of the OIG as being one that requires that we look into all areas" for which the Labor Department is responsible, he said. "We have the expertise to do so."

"Sometimes it's much easier for them to pursue what they know best," which is civil violations of their agency regulations, he said.

Mr. De La Rosa says he does not see as many criminal investigations as there should be, mainly because of the inexperience of investigators hired by various Labor Department agencies to conduct compliance-type audits to recognize criminal activity.

Mr. De La Rosa says the result could be overlapping investigations among agencies, particularly if the OIG is looking at a case from a criminal standpoint and another agency is doing a civil investigation.

However, other federal agencies, like the Justice Department, have multilevel investigations going on at once, he said. "You just need a great deal of coordination.

"What we want to do is to make sure that the egregious cases where particular actions are taken for criminal intent are recognized and pursued," he said.

"If we hit them in the pocketbook as well as threaten their freedom, then I think that we will reduce the number of people who are interested in becoming criminally involved with programs administered" by the Labor Department, he said.

Currently, "there is no deterrent because (violators) see the civil action and the resulting fine as a cost of doing business," he said.

Mr. De La Rosa insists the OIG does not want regulatory authority over other Labor Department agencies.

Scott Kyle, assistant director of the Texas State Board of Insurance's division of unauthorized insurance, thinks the OIG should have the powers Mr. De La Rosa is seeking.

"Somewhere in the DOL there should be someone with the broad enforcement powers to help us. The OIG is more equated to the kind of investigations we need and are more adequately trained. The (Pension and Welfare Benefits Administration) just isn't equipped to do that," he said.

However, both the Labor Department's Office of the Solicitor—which acts as the department's general counsel—and the Office of Legal Counsel at the Justice Department—which mediates interagency disputes for federal departments—oppose Mr. De La Rosa's plan.

In a March 1989 opinion, requested by Acting Labor Department Solicitor Jerry Thorn, Assistant Attorney General Douglas Kmiec ruled against the OIG on the enforcement question.

The President's Council on Integrity and Efficiency concurred in July 1990. The eight-member council of representatives from various federal agencies is charged with identifying, reviewing and discussing governmentwide vulnerability to fraud, waste and abuse. Its decisions are only advisory.

Judy Kramer, the Labor Department's deputy solicitor for planning and coordination, says the solicitor's office accepts Mr. Kmiec's ruling.

Ms. Kramer says it is only practical that the powers of the OIG be limited to the authority it was granted under the 1978 Inspector General Act.

If the OIG were given the broader enforcement authority, then "who would be the watchdog—who would look over their shoulders to make sure that they are doing their job?" she asked.

However, Mr. De La Rosa said "there are enough reviews, checks and balances to ensure that we don't abuse our authority or our responsibility."

For example, the Justice Department gives the OIG direction during the course of all of its investigations, and the OIG would be held accountable to the Justice Department for any inappropriate practices during an investigation, he explained.

The OIG also answers directly to the secretary of labor.

The OIG, the secretary of labor and the Justice Department's Office of Legal Counsel continue attempts to resolve the issue, Mr. De La Rosa said.

But, Ms. Kramer believes that only an amendment to existing law could give the OIG the authority it wants.

Others are neutral in the debate.

"I'm just a country lawyer—I don't get involved with interagency disputes. All I want is the resources out of the DOL to help me do my job. It doesn't matter to me which agency they come from as long as they are available," said James E. Long, president of the National Assn. of Insurance Commissioners and North Carolina insurance commissioner.

"That's an issue that I think is best left up to the Office of Legal Counsel and the Justice Department," said Christopher Bowlin, associate director of employee benefits and compensation at the National Assn. of Manufacturers in Washington, D.C.

Mr. De La Rosa also wants OIG investigators to have the same criminal investigative authority as investigators in other federal departments to execute warrants, make arrests and carry guns without being deputized by the Justice Department.

Investigators for the Customs Service, the Internal Revenue Service, and the Drug Enforcement Administration have these powers, he pointed out. "We do not have this law enforcement empowerment, and that hampers our ability to perform as effectively and efficiently as we could."

Rep. Harley O. Staggers Jr., D-W.Va., this month introduced legislation, H.R. 1361, that would give OIG investigators those powers. The bill has eight co-sponsors.

He introduced almost identical legislation—H.R. 4149—last Congress with more than 32 co-sponsors. However, no committee action was taken.

Mr. De La Rosa also envisions greater cooperation between the OIG and state insurance departments.

If federal and state regulators are going to stop MEWA fraud, "it's going to take a consolidated effort, it's going to take a high degree of cooperation, and its going to take a willingness to recognize that the (MEWA) problem is in fact severe and national in scope," he said.

For example, he plans to continue a program Mr. Maria initiated under which the OIG conducts educational seminars for state insurance department investigators on patterns to look for that might indicate criminal behavior in MEWAs.

The OIG also is continuing another program Mr. Maria initiated that assists states with multi-jurisdictional investigations.

Mr. De La Rosa says that the indictments of six officials of employee leasing firm Cap Staffing Inc. of Charlotte, N.C., last year is a perfect example of how well state regulators and the federal government can work together on fighting the MEWA problem (*BI*, Dec. 17, 1990).

According to court papers filed by the Office of Labor Racketeering, Cap Staffing and affiliated firms defrauded more than 120 businesses by causing them to believe the employees they leased were covered by health insurance written by Travelers Insurance Co. But Travelers only provided claims administration services (*BI*, May 21, 1990).

Cap Staffing improperly diverted most premiums that were to be forwarded to Travelers, leaving more than $2 million of unpaid claims, DOL officials said.

It also may take some federal legislation to get the job done, according to Mr. De La Rosa.

Fraudulent MEWAs often fight state regulatory action by claiming that they are exempt from state laws under the Employee Retirement Income Security Act of 1974. But, by the time the DOL can make a ruling or a court can decide on the legitimacy of such a claim, many MEWAs go bankrupt or set up shop in another state.

"With that ability to move interstate, I think that it is necessary to have some federal legislation to assist states in controlling the problem," Mr. De La Rosa said.

Last October, for example, the Labor Department recommended that MEWAs be required to register with the department (*BI*, May 21, 1990).

The NAIC supports the recommendation.

"If we could ever establish a registry of DOL plans and a similar registry for state plans, we can eliminate much of the dispute over jurisdiction," said Mr. Long of North Carolina.

"Its a wonderful step in the right direction," said Oklahoma Deputy Insurance Commissioner Burt Marshall in Oklahoma City.

State insurance regulators acknowledge the improvement in their relationship with the OIG and their MEWA investigations during the tenures of Messrs. Maria and De La Rosa.

"In the last two years we have have seen a great deal of information and support from the Department of Labor and, in particular, the Office of the Inspector General," Mr. Long said.

"The information sharing has been a great deal of help to us at the state level and we have a regular dialogue with the OIG," he said.

Mr. Marshall of the Oklahoma department agreed. "I would concur that there has been an improvement within the last two years."

After Mr. Maria started to "express his concerns and publicizing his position on MEWAs, we immediately began to get information" about MEWAs from the OIG, said Mr. Kyle of the Texas State Board. "Now we have a good working relationship," he said.

Before then, however, there was little interaction or assistance from the OIG, Mr. Kyle said.

"Up until one-and-a-half years ago, not to my knowledge have we had a relationship with the OIG. I would say that cooperation and interest was minimal," he said.

Mr. Marshall of the Oklahoma department remembers sending state insurance representatives to the OIG to ask for help with MEWA problems and coming back empty-handed before Mr. Maria's tenure.

However, while Oklahoma's contact with the OIG is "fairly extensive" now, the agency should not rest on its laurels, Mr. Marshall said.

"Our position is to keep working on it. They are not where they should be with their performance." Mr. De

Continued on next page

De La Rosa prefers quieter approach

WASHINGTON—Labor Department Inspector General Julian De La Rosa supports much of the plan of action outlined by his predecessor.

Yet he tries not to compare himself to his outspoken predecessor, Raymond Maria, or others that have held the office.

"I have taken the position that the issues will define what it is that I do, and if the issues are clear-cut and well-established, then I will pursue them," he said.

Mr. De La Rosa says he takes a quieter approach than his predecessor did.

His handling of outside criminal investigations is one example. The office, he says, is now more willing to sit down and discuss its authority to handle the investigations with other agencies within the department.

"However, if we feel very strongly about our position and we cannot achieve some mutual understanding with the other agency, then we will publish our position" without hesitation in the OIG's semi-annual report to the labor secretary that is publicly available.

"I will not accommodate for the sake of merely appearing to be a good fellow," he said.

As an FBI agent, Mr. De La Rosa says, he gained a reputation for being "tenacious and aggressive." Having broken in as a special agent in San Antonio in 1959, he retired 30 years later as agent-in-charge in St. Louis.

After that, Mr. De La Rosa was appointed to the Board of Police Commissioners in St. Louis.

"It is the IG's job to keep everyone on their toes, and he is doing that and in a very professionally manner," said David G. Ball, the assistant secretary of labor who heads the Pension Welfare Benefit Administration.

He calls Mr. De La Rosa's approach much more "measured and reasonable" than Mr. Maria's.

"One major thing that I have seen recently is that he has been very constructive. There was a time when the OIG took a very high profile approach and made allegations that were simply not supportable," Mr. Ball said.

Charges in a 1990 report, for example, still rankle many observers. Warning of potential widescale pension fraud, Mr. Maria drew an analogy between pension plan regulation and auditing practices and those of savings and loans.

Charging that Mr. Maria "hyped" his claims, Mr. Ball asserts that "there is no evidence to support that allegation. Pension liabilities have little to do with criminal activities—a fact that Mr. Maria did not point out.

Those and other remarks by Mr. Maria "probably weren't the most productive for the pension industry," agreed Christopher Bowlin, associate director of employee benefits and compensation at the National Assn. of Manufactures in Washington, D.C.

"They generated a lot of unnecessary concern from beneficiaries" about the safety of their benefits.

But, Mr. De La Rosa defends the statement. Mr. Maria said "that there needs to be a greater regulation, a greater alertness and awareness of the condition of our pension funds to ensure that those funds don't fall jeopardy to the same problems we saw in the S&L industry. I think those concerns are still valid."

Mr. De La Rosa adds that "we have a history of taking our fiduciary responsibilities for granted. We presume that somebody is taking care of it and, as a result, we have to be more concerned about our investments in our individual plans, who is monitoring these plans, whether they are in good hands, and whether they are properly guarded."

According to Mr. Maria, the statement was blown out of proportion.

The OIG drew the same parallels about pension regulation that the General Accounting Office drew in a study of S&L failures in the Southwest, said Mr. Maria, who now is a partner with the Washington, D.C.-based Philip Manuel Resource Group Ltd., which specializes in investigations, asset recovery and litigation support for corporate victims of fraud and misrepresentation.

"The patterns they found were the patterns we found," Mr. Maria said.

Despite this difference in opinion, Mr. Ball—recalling somewhat adversarial relations with Mr. Maria—calls working with his successor a "refreshing change."

Mr. De La Rosa "is not exaggerating, and not hyping. He has a job to do and is going about it in a reasonable, responsible way," Mr. Ball said.

—By Adrienne C. Locke

Study MEWAs, official suggests

WASHINGTON—Julian De La Rosa has a simple message for companies entering into multiple employer welfare arrangements: Buyer beware.

"The warning that we give is: 'When you are presented with an insurance plan that does seem to be more than you would normally expect to receive from anyone else, research it very carefully,' " said Mr. De La Rosa, the U.S. Labor Department's inspector general.

"Consumers must be aware of what the plan is offering and what they are paying for. All these things can no longer be taken for granted," he said.

He also advises employers to:

- Know the broker they are dealing with.
- Check with the state insurance commissioner to determine the history of the plan, its reserve level and whether there is a reinsurance mechanism to fall back on in case of catastrophic events.
- Investigate the background of the plan.
- Insist that the terms of the plan are very carefully and clearly explained so there is a full awareness of what the policyholder is receiving.

—By Adrienne C. Locke

MEWA probes

Continued from previous page

La Rosa explained that the "limited" budget of the OIG prevents him from doing as much as he would like.

For example, he would like to open an Office of Labor Racketeering in Texas, but the OIG lacks funding and Office of Labor Racketeering lacks the staff to do so. Instead, he has temporarily reassigned investigators from other OIG offices in Texas to investigate employee benefits-related fraud in the state.

"With those limited resources, we can only do so much. We try to focus on issues that most affect the major labor programs and might have to leave some other things uncovered because of the lack of resources," he said.

The OIG is asking for a $51.3 million budget for fiscal 1992, which begins Oct. 1., a 5.2% increase from $48.8 million during fiscal 1991. The DOL's total 1992 budget request is $33.2 billion. The OIG's budget was increased 3.6% in 1991 and 3% in 1990.

The OIG has 553 personnel, 196 of whom are investigators. Although overall staff has grown slightly from 547 since 1989, the number of investigators has remained the same. ■

Oregon plan

Continued from page 1

benefits in the state is one reason even smaller employers in Oregon seek to self-insure their health care benefits, points out Jeffrey Furnish, manager of The Wyatt Co.'s Portland office.

However, while large employers may not have much to fear from the implementation of the Oregon plan, small employers have a lot to lose, said Joe Gilliam, Oregon director for the National Federation of Independent Business in Salem, which represents 15,000 small businesses in the state. The costs of a universal health-care mandate would be "crushing to small business," he said.

The Oregon Basic Health Services Act, introduced by state Senate President John Kitzhaber, D-Roseburg, was enacted in 1989. The act is being implemented through three interrelated pieces of legislation—S.B. 27, S.B. 935 and S.B. 534.

S.B. 27 authorized revamping the state's Medicaid program to extend eligibility to families living at 100% of the federal poverty level. Currently only those whose income is lower than 58% of the federal poverty level are eligible.

S.B. 27 also created the commission that is reviewing health services and ranking them in order of importance. To obtain funding for the increased number of people eligible for Medicaid under the bill, the measure calls for the Legislature to cut off Medicaid funding for lowest-ranked services.

The prioritized list was released last month by the commission and ranks health services "according to their benefit to the entire population," according to the state.

Among the categories of services ranking high on the list are those treating acute conditions that are fatal, where treatment often leads to full recovery; maternity care; and preventive care for children.

The lowest-ranking categories are "non-fatal conditions or self-limiting conditions where treatment would provide minimum or no improvement in the quality of life," said commission member Dr. Paul Kirk, professor and chairman of the Department of Obstetrics and Gynecology at Oregon Health Sciences University in Portland.

For example, the lowest-ranking category of service on the list is life support for infants born with severe deformities of the brain.

Actuaries are currently pricing the 800 items on the list, and their report will be sent to the Legislature next month, which will then determine what services will be funded under Medicaid.

However, before Oregon can limit the services it provides under Medicaid, the state must obtain a waiver from the federal government to suspend certain federal rules that govern the services that must be provided under Medicaid.

A second component of the Oregon Basic Health Services Act, S.B. 935, created a small-business health insurance program, in which businesses employing 25 or fewer workers can buy a "bare-bones" health insurance plan—exempt from state benefit mandates—from one of seven insurance companies selected by the state.

Small employers participating in the program also receive tax credits, which began at $25 per enrolled employee in 1989. The credits are now $18.75 per employee and will be scaled down to $6.25 per employee in 1993.

Each of the seven insurers provides a different benefit package for the small-business program, said Howard "Rocky" King, administrator of the Insurance Pool Governing Board, which oversees the small-business program. The insurers in the program are: Blue Cross & Blue Shield of Oregon; Greater Oregon Health Service Inc.; National Dental Health; Good Health Plan of Oregon; PACC Health Plan; Preferred Health Northwest, a joint venture of BC/BS of Oregon and Capitol Health Care; and Kaiser Permanente Medical Care Program.

About 1,825 employers now participate in the small-business health insurance program, providing coverage to about 7,500 employees and dependents, according to Mr. King.

To encourage more small businesses to voluntarily provide coverage, the Insurance Pool Governing Board has recommended that the program also be made available to businesses employing 25 to 50 workers, said Ed Nieubuurt, chairman of the Insurance Pool Governing Board and employee benefits manager of Tektronix Inc., an electronic equipment manufacturer in Beaverton.

In addition to creating the small-business health plan, S.B. 935 also stipulated that if 150,000 additional Oregonians are not covered by health insurance by October 1993, all employers in the state that do not provide health insurance will be required to pay a payroll tax beginning in 1994. The proceeds of the tax would be used by the state to purchase the coverage for non-covered employees (*BI*, June 19, 1989).

Since most observers do not expect the deadline to be met, the clause effectively mandates that employers will provide coverage or pay for the state to provide it.

The payroll tax would be calculated so that employers pay 75% of employee premiums and 50% of dependent premiums for basic benefit coverage. The coverage purchased by the state would conform to the basic benefit package that the Legislature plans to develop from the priority list.

Another part of the Oregon Basic Health Services Act, S.B. 534, made a high-risk health insurance pool in Oregon a state agency. The pool was created in 1987 to provide coverage for individuals considered uninsurable because of pre-existing health conditions.

The high-risk pool is funded partially by the state and partially by assessments on insurers and policyholders. The premium for the high-risk coverage, though, is limited under its original charter to 150% of the average premium for health coverage in the state.

The pool now writes about 1,000 policies covering about 1,200 individuals. But, if a benefit mandate is triggered in 1994, the pool will have to be expanded because some employees will not be able to obtain coverage under the prioritized benefit plan, Mr. King said.

However, "insurance reform" legislation is expected to be introduced that would require health insurers in the state to make coverage available to some individuals who now must obtain coverage from the high-risk pool, he said.

Not all Oregon employers oppose a mandate on employers in the state—including those with self-insured benefits—to either provide a basic package of health benefits or pay the state to do so, a business lobbying group says.

Associated Oregon Industries—which represents 1,800 large companies in the state, employing about 50% of Oregon's private workforce—"has certainly raised the eyebrows of a number of our sister associations across the nation," since "employers don't like being 'required' to do anything," said Karl Frederick, the AOI's vp and director of legislation.

But the AOI notes that most large employers in the state already provide richer benefits than would be required by a mandated basic package, particularly one that incorporates the prioritized list of services.

In addition, many employers believe the mandate will eliminate cost-shifting, which is driving up premiums for employers that provide coverage.

"Most of the clients we talked to don't really have a problem" with the Oregon plan, said Laird Post, group practice leader in the Seattle office of benefit consultant TPF&C, a unit of Towers, Perrin, Forster & Crosby Inc.

Mr. Post characterized the Oregon plan as "a neat, aggressive approach to managing health care in a proactive way," adding, "I would think most major employers would embrace this kind of effort."

"Self-insureds already provide their employees benefits that are far beyond" those in the proposed basic package, said Lowell Lichtenberg, principal and head of the Portland, Ore., office of William M. Mercer Inc.

And, some self-insured employers in the state even support the effort to waive ERISA pre-emption of state regulation of self-insured plans, according to Mr. Nieubuurt of Tektronix, which self-insures its health care benefits.

"Large employers are continuing to carry the freight for all the uninsured, and they feel if the state can put a well-structured statewide program in effect, they're going to be better off," Mr. Nieubuurt said.

Referring to ERISA, he added, "a federal requirement that started 25 years ago for pension plans shouldn't get in the way, especially since the feds have told the states to solve the problem of health care."

Hawaii so far is the only state that is exempted from the ERISA provision pre-empting state regulation.

But consultants are cautious about the proposed waiver of ERISA pre-emption.

"I would hope that any removal of ERISA pre-emption would be a limited one" and not leave self-insured employers vulnerable to other state benefit mandates, said TPF&C's Mr. Post.

"My thinking at the moment is that the self-insured companies would prefer to see how this plays out before they give up their ERISA exemption," said Dr. Roger Taylor, national leader of health care consulting for The Wyatt Co. in Washington, D.C.

If the Oregon plan "can noticeably result in better access and cost control without undue cost shifting to the private sector, we will see a fair amount of support developing for universal application in the state," he said.

And since employers "don't have any models or solutions for the problem of 20% annual increases in health care costs, they shouldn't be afraid of the fact that this is an experiment," Dr. Taylor maintained.

Nevertheless, Wyatt's Mr. Furnish cautions that a prioritized list of services originally developed for Medicaid that will undergo periodic revision might not be a good fit for employers. The priority list is scheduled to be updated every two years.

Since many employers want to offer catastrophic coverage and the prioritized list emphasizes preventive care, Mr. Furnish noted, "employer priorities tend to stand the list on its head."

Besides, "as they determine the list of priorities, the (cut-off) line can move up and down the list from year to year, so you can absolutely have situations where a procedure is covered one year and not the next," he explained. That is not standard practice with employer-provided insurance coverage, he said.

"Another point the scheme misses," maintains Mr. Furnish, "is that Medicaid pays in full and virtually all employers have deductibles and co-pays." Mr. Furnish said he wonders how that difference will be worked out.

Another consideration for em-

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ployers, he said, is that limiting funds for certain types of medical procedures, especially "where treatments are more rare and exotic," may force some medical specialists to leave the state.

That will result in an accessibility problem for employees covered by private health insurance plans, he contended.

But Dr. Kirk of the Oregon Health Sciences University countered that the prioritized list would not cut off any one category of physician. No category of specialists would need to leave the state to maintain a volume practice, he maintained.

Tektronix' Mr. Nieubuurt agreed that the withdrawal of Medicaid funding for certain services would not have a major impact on any health care specialty, since Medicaid recipients are and will be a small percentage of the population.

And, Larry Leisure, a vp with TPF&C in San Francisco, said Oregonians are "a fairly mobile population," and those that may need services not performed in the state "will go over to Seattle" in neighboring Washington state.

"It's theoretically possible that some services will leave the state, but certain services are so rare, I'm not sure that every state needs the service," Wyatt's Dr. Taylor said.

Several such services, like those for treating specialized spinal cord injuries, already are only available on a regional basis, he added.

"It's time in America that we learn to share services between communities. Right now we have so much unnecessary duplication, we have a fair amount of room to move before we have to worry about being in trouble," he said.

The economics of the Oregon plan "will force a concentration of certain rare services," Dr. Taylor said. "But, in terms of availability and quality of care, studies have shown that the more those services are concentrated, the better they (providers) get at it."

"Some services may not be reimbursed, but the practice of health care will not be adversely affected" by implementing the priority list, said Paige Sipes-Metzler, executive director of the Oregon Health Services Commission.

"The whole program will have a strong emphasis on quality of care and it will be monitored carefully," she said. "The list will be revised every two years, so if problems arise, they can be quickly corrected."

Physicians in the state do not believe that applying the priority list would adversely affect the quality of health care delivery in the state, according to Scott Gallant, director of government affairs at the Oregon Medical Assn. in Portland.

"Often physicians will provide services though they may not be compensated for them," Mr. Gallant pointed out. About $240 million in uncompensated health care services are provided in Oregon annually, he said.

"For a little state like ours with a population of 2.8 million, that's significant," Mr. Gallant said.

While providing care not covered by Medicaid under the priority system would create costs eligible for cost-shifting to employers, others don't think that will be a problem.

Mr. Lichtenberg of Mercer contends that health care providers will receive more compensation because they will be providing care to new Medicaid beneficiaries—an estimated 60,000 to 120,000 people.

The NFIB's Mr. Gilliam, however, maintains the Oregon plan is "missing the point, because you've got to address the cost of services from doctors and hospitals before you increase access to the system."

Mr. Gilliam noted that in the last six months in Oregon, health insurance premiums for small businesses insured by Blue Cross & Blue Shield Assn. plans increased 34%. "You can bet they will be even higher in 1994," when the employer benefit mandate would be triggered, he said.

Most employers represented by the NFIB choose not to participate in the small business program under S.B. 935, even though they meet the size requirements, he said. On average, businesses represented by the NFIB employ 12 people and generate revenues of about $400,000 annually, he said.

Mr. Gilliam said that the policies offered by the seven insurers under S.B. 935 were "hard to work with." Some insurers required "deductibles of $3,000 to $5,000 for some people," he said.

"The managed care programs (offered under S.B. 935) are good, but they're only available in the Portland area," he noted.

The payroll tax to fund coverage for uninsured employees will eat into small employers' already-thin profit margins, Mr. Gilliam also asserted.

Meanwhile, refinements of the Oregon law already are in the works, according to Mark Gibson, executive assistant to Sen. Kitzhaber. "Housekeeping" legislation "to ensure there are no situations where we will not be able to implement" the Oregon Basic Health Services Act is being drafted, he said.

That will include "making sure sufficient mechanisms are in place to provide coverage for part-time and seasonal workers" under S.B. 27, he explained.

S.B. 935 will be "further refined" with "small-group insurance reform" legislation designed "to make the administration and availability of the basic package more efficient," Mr. Gibson said.

"Mostly what we want to do is move the insurance industry back into the premise of spreading risk instead of avoiding it," he said.

That will involve "requiring insurers to sell policies by removing ways they can avoid doing so—such as pre-existing conditions," Mr. Gibson explained.

In addition, legislation, S.B. 790, was introduced last month in the state Senate that would create a single payer, Canadian-style health plan for Oregon to take effect in January 1994.

Sponsored by the Oregon Health Action Campaign, a coalition of labor, senior and community groups, S.B. 790 calls for the creation of a 17-member Oregon Health Board that would administer a single-payer system that "consolidates collection and dispersal of health care dollars," according to Oregon Health Action Campaign documents.

The system would be funded through employer and employee insurance premiums; assessments on non-earned income, including rent and interest; and a pooling of state and federal health care dollars, including Medicare and Medicaid funds, according to the documents.

S.B. 790, dubbed the Health Care for All Act, "builds from components" of the Oregon Basic Health Services Act "and solves its two glaring omissions: cost-containment and the inequities of the private health insurance market," the Oregon Health Action Campaign said.

Another piece of related legislation still in draft form is a bill that would set up an Oregon Health Care Authority to be "chaired by the governor to better coordinate and give direction to the various health programs in the state," Tektronix' Mr. Nieubuurt said.

A tax of less than 0.01% of payroll, levied equally against employers and employees, was proposed to pay for that authority as well as for operating the small-business program and the high-risk pool, he explained. ■

24-hour coverage

Continued from page 3

24-hour coverage, Mr. Victor asked the discussion participants to pretend they were advising a new governor—from the hypothetical state of "New Logic"—who wants to know if the concept of 24-hour coverage is worth considering in light of the state's problems. The state's problems include a fiscal crisis, rising health care costs, a growing number of individuals without health insurance, the need for workers compensation reform and the need to keep the state competitive with other states in attracting business.

For the sake of the discussion, Mr. Victor defined "24-hour" coverage as a broad, new, privately financed program that provides medical and disability benefits to ailing individuals, without regard to whether their injury or illness is work-related.

In addition, he said federal programs like Social Security should be considered primary sources of recovery, if applicable.

Nearly all of the 13 people participating in the discussion said 24-hour coverage was topical enough that the governor should consider it and its potential advantages.

However, several critics emphasized the disadvantages of considering 24-hour coverage, including diverting public officials from considering the root causes of problems within the workers compensation system.

Twenty-four hour coverage "is worth thinking about, although (the governor) should do this very cautiously," said John F. Burton Jr., director of the Institute of Management and Labor Relations at Rutgers University in New Brunswick, N.J., and a workers comp consultant.

Some of the advantages of 24-hour coverage, according to Mr. Burton, include:

- Eliminating the burden of determining whether an injury or illness is work-related.

This determination will become increasingly difficult as ailments like cumulative trauma disorders increase, Mr. Burton said.

Eliminating the need for such a determination should reduce litigation and related "friction" costs and may result in "some substantial cost savings," he said.

- Providing coverage for uninsured individuals.

Implementing 24-hour coverage would mean that employers that do not now offer health care coverage to their workers would have to offer a health care plan.

- Containing costs through greater utilization review and employee cost sharing.

For example, under some 24-hour coverage proposals, like one included in a Florida workers compensation law passed last year, employees injured on the job would be responsible for deductibles and copayments when they seek medical treatment (see story, page 56).

Currently, employees do not pay for medical care for job-related injuries.

'Working people see 24-hour coverage as a euphemism for takeaways,' says Donald E. Elisburg, executive director of the Occupational Health Foundation in Washington, D.C., which is funded by the AFL-CIO.

Other participants in the discussion cited other advantages to 24-hour programs.

Polaroid Corp. in Cambridge, Mass., offers generous disability benefits for both work-related and non-work-related injuries, resulting in unspecified cost savings from a reduction in litigation and an increase in employee loyalty, said Galt Grant, Polaroid's former risk manager. Mr. Galt is now a vp with broker Frank B. Hall & Co. Inc. in Boston.

Thomas J. McCauley, director of workers compensation and rehabilitation services for San Francisco-based Pacific Bell, a subsidiary of Pacific Telesis Group, said experience with a similar disability program covering occupational and non-occupational injuries made him "enthusiastic" about considering 24-hour coverage.

In addition, Philadelphia-based CIGNA Corp. has found that integrating the processing of medical claims for workers comp and group health claims for clients can save money in several ways, including eliminating duplicate payments and lowering claims settlement costs, said Senior Vp John S. Plis.

This holds especially true for difficult—and often expensive—claims like back injuries and cardiac ailments, he said.

Adoption of an integrated health care/workers comp system—similar to Canada's—in the United States would meet "the moral and economic imperatives" of providing for all citizens' health care needs with less duplication of services and at less cost, said Dr. Robert Elgie, chairman of Ontario's Workers' Compensation Board.

However, public officials need to engage in extensive "consensus building" before considering any radical new plan, he said.

Several participants were equally vocal in airing the obstacles to—and disadvantages of—a 24-hour approach.

Problems with adopting a 24-hour coverage plan, according to Mr. Burton, include:

- Convincing insurers, lawyers, doctors and others in the workers comp arena to change the way they have traditionally done business.

"This may be the biggest obstacle," Mr. Burton said.

- Uncertainty about cost savings under such a plan.

While administrative costs decline, the availability of coverage with few questions asked may increase the number of cases in the system.

- Difficulty, especially among workers, in adjusting to a system that no longer gives individuals injured on the job special treatment —like the absence of deductibles and copayments for medical care.

However, Keith T. Bateman, associate vp of the Alliance of American Insurers in Schaumburg, Ill., said most 24-hour coverage proposals still give injured workers some type of special treatment.

Other also voiced criticisms and concerns.

"Working people see 24-hour coverage as a euphemism for takeaways," said Donald E. Elisburg, executive director of the Occupational Health Foundation in Washington, D.C., which is funded by the AFL-CIO.

"You are talking about restructuring the social contract" by implementing provisions like deductibles and coinsurance requirements for medical care for injured workers, said Mr. Elisburg.

Such a trade-off by employees may require changes in the exclusive remedy doctrine in state workers compensation laws, especially when an employer's actions in some way contribute to a worker's injury, he added.

Under exclusive remedy provisions in workers comp laws, employees generally give up their right to sue employers for workplace injuries in exchange for workers comp benefits.

In addition, implementing 24-hour coverage would require a long-term commitment of funds and may create a need for a "health ombudsman" or some other neutral party to resolve disputes, Mr. Elisburg said.

Also, a state vs. federal regulatory conflict could emerge because the group health insurance component of 24-hour coverage currently is regulated under the federal Employee Retirement Income Security Act, while the workers compensation portion is the province of state regulators, said Oregon state Rep. James Edmunson, D-Eugene.

It is not clear if 24-hour coverage plans regulated by the states would run afoul of ERISA, which generally pre-empts state laws governing employee benefit plans.

In addition, assuming that the 24-hour coverage is mandated, the state would have to oversee the cost of the insurance product and many state regulators do not now regulate health insurance rates charged to many employers, pointed out Maine Superintendent of Insurance Joseph Edwards.

However, Edward Welch, former director of the Michigan Bureau of Workers' Compensation Disability, questioned the need for rate regulation for 24-hour coverage.

Providing 24-hour coverage may be "a real problem" for small employers, Frank B. Hall's Mr. Grant said. For example, some small employers do not now offer group health care benefits.

In addition, such a program could be "a false solution" to the workers comp and health care crisis because the cost savings are questionable, said William C. Aldrich, vp-government affairs for Hartford Insurance Group in Hartford, Conn.

A move to 24-hour coverage may "jeopardize" safety incentives, which the workers comp insurance pricing system now provides, and dilute efforts to collect data that help pinpoint what drives the costs in the system, he added.

A switch to 24-hour coverage also could mean an upheaval in the way insurers, regulators and administrators do their jobs, Mr. Aldrich said.

Public officials should focus on the core problems in workers compensation systems before deciding to convert to a new structure, though 24-hour coverage could be politically attractive, he said.

The "worst tragedy" would be if an opportunity for real workers comp reform were lost because public officials concentrated on such a questionable proposal, he added.

However, Mr. Burton and other speakers at the conference urged that states implement pilot programs to test the feasibility of 24-hour coverage programs. ■

Institute helping states formulate comp payments

CAMBRIDGE, Mass.—State officials interested in determining an appropriate maximum benefit for injured workers with temporary total disabilities can obtain help from the Workers Compensation Research Institute.

The non-profit organization is volunteering to run computer analyses of existing or proposed benefit outcomes, said Richard A. Victor, executive director of the Cambridge, Mass.-based group.

Temporary total benefits are paid after a state-specific waiting period as long as an injured employee is totally—but temporarily —disabled and unable to work.

The typical temporary total disability lasts four weeks.

Establishing an appropriate maximum benefit is important if a state wants to offer benefits that are adequate and equitable while still preserving an incentive for an injured employee to return to work.

In its analysis, the WCRI uses the concept of "replacement rate," which is "the percentage of a worker's aftertax income replaced by tax-free workers compensation benefits."

According to Mr. Victor, the rate is a way to measure the amount of an injured worker's lost purchasing power that is replaced by workers compensation benefits.

Most states pay TTD benefits of two-thirds of an employee's gross, pretax earnings, up to the maximum. That may result in inadequate compensation to lower-paid workers and overly generous compensation to a few higher-paid workers, who may receive more than 100% of their gross annual earnings after taxes.

Three states—Michigan, Alaska and Iowa—award TTD benefits of 80% of an employee's aftertax earnings. That scheme can help lower-paid workers while still giving higher-paid employees an incentive to return to work.

A WCRI study found that the spendable approach was "much more equitable," Mr. Victor said. However, he pointed out that the study had limitations, like excluding workers with large families and those whose injuries lasted more than one year.

Several states, including California, New York and Texas, raised TTD maximums significantly between 1988 and 1990, Mr. Victor said.

Texas raised the maximum by 80% to $428 from $238 at the start of this year. That figure is now equal to about 100% of the state's average weekly wage, up from about 60%.

That law has done "a remarkable job," Mr. Victor said. Nearly all employees with temporary total injuries now have 90% to 100% of their purchasing power replaced. Previously, one-third of these employees received either unusually low or unusually high benefits.

Pressure for change could also be felt in states with high maximum benefits like Maine, New Hampshire, Vermont, Connecticut and Illinois.

Or, pressures may build where maximum benefits are low: California, New Mexico, Oklahoma, Kansas, Missouri, Arkansas, Louisiana, Mississippi, Georgia, Indiana and Delaware.

And other factors could prompt changes in temporary total injury benefits in Washington, Minnesota, Ohio and Pennsylvania, said Mr. Victor. ■

Alliance report cool on 24-hour coverage

By MEG FLETCHER

SCHAUMBURG, Ill.-The Alliance of American Insurers advocates improving the existing workers compensation rather than replacing it with any type of "24-hour coverage."

Proposals for 24-hour coverage vary widely, but generally attempt to dissolve the boundary between occupational and non-occupational accidents and/or diseases, according to an Alliance report, titled "Twenty-four Hour Coverage: An Analysis and Report About Current Developments."

While the concept of 24-hour coverage "just sounds so logical," there are many questions about how such a proposal would be implemented and whether cost savings would result, said Alliance Senior Vp Rodger S. Lawson (see story, page 3).

However, the Schaumburg, Ill.-based association of property/casualty insurers does not oppose consideration of 24-hour coverage proposals as long as insurers writing the coverage are not treated differently by regulators than other workers comp insurers, said C. Clarke Imbler, an Alliance senior vp.

The 170-member organization wants to preserve "a level playing field" for all insurers, he said.

One of the biggest problems in discussing 24-hour coverage is that the phrase "has neither a precise, nor a single, definition," according to the 57-page report written by Keith T. Bateman and Cynthia J. Veldman.

In an effort to clarify the proposals under discussion, the Alliance outlined six different categories of 24-hour coverage proposals:

- Marketing products.

Several multiline insurers already offer integrated management of claims from a client's separate workers compensation and group health insurance policies. This typically includes coordinated claims management and/or utilization of discounted provider rates under the group health insurance policy for workers comp claims. However, health insurance and workers comp insurance are still sold separately.

- Medical coverage.

Under this approach, an insurer would provide medical benefits for all of an employee's injuries and diseases—whether work-related or not. However, disability benefits would be provided only for work-related injuries and diseases.

- Disability coverage.

Under this approach, an insurer would provide disability benefits for all of an employee's injuries and diseases, but would provide medical coverage only for work-related injuries and diseases.

- Coverage of accidental injuries.

Under this approach, an insurer would provide medical and disability benefits for all accidental injuries, but would cover only work-related diseases.

- Medical and disability coverage.

Under this approach—sometimes called a universal disability program—an insurer would provide medical and disability benefits for all injuries and diseases.

The Alliance report also discusses in detail what it considers obstacles to adopting a 24-hour coverage program.

Nonetheless, the Alliance points out, 24-hour coverage "is reappearing as a serious public policy issue."

For example, Florida passed legislation last year that allows an employer to satisfy state workers compensation requirements by purchasing a health insurance policy that covers both work- and non-work-related injuries and a another policy providing disability benefits to injured workers (see story, page 56).

In addition to the Florida law, a California Senate committee has recommended the integration of workers compensation, disability and health insurance programs, the study said (*BI*, Nov. 27, 1989). And, governmental panels in Minnesota, Alaska and Oregon have or will examine the topic of 24-hour coverage.

"Current discussions differ from earlier discussions in the greater emphasis on 24-hour coverage as a means of dealing with two distinct concerns associated with health care: The rapid rise in workers compensation medical care costs and the percentage of the population not having group health insurance," the Alliance report notes.

"In addition, the current discussions, more heavily than in the past, involve state legislatures looking for state solutions," the report said.

However, despite this renewed interest in 24-hour coverage, the Alliance concludes the most effective way to curb rising workers compensation costs, especially medical costs, is to improve the existing system, according to a statement by Alliance President Franklin W. Nutter.

The Alliance prefers to work with interested parties to reduce workers comp medical costs through appropriate cost control strategies like effective medical fee schedules combined with an appropriate review mechanism, Mr. Nutter said. In addition, removing barriers to the use of managed care and volume discounts for workers compensation claims also could help, he said.

Other Alliance goals include improving the efficiency of state workers compensation administration and reducing miscommunication and litigation within the workers comp system.

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Single copies of the study (Item No. R-23-0291) are available free by contacting the Alliance of American Insurers, Customer Service Department, 1501 Woodfield Road, Suite 400 W., Schaumburg, Ill. 60173-4980; 708-330-8500.

300 attend work comp conference

CAMBRIDGE, Mass.—A record-breaking 300 persons attended the Workers Compensation Research Institute's sixth annual issues and research conference Feb. 26-27 at the Boston Marriott Cambridge Hotel in Cambridge, Mass.

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 established the WCRI in 1983 and continue to fund the institute.

The group's associate members consist primarily of workers compensation administrators from the United States, Canada, the United Kingdom, Australia, South Africa and other countries.

For additional information, contact Richard Victor, Executive Director, Workers Compensation Research Institute, 245 First St., Cambridge, Mass. 02141; 617-494-1240.

—By Meg Fletcher

Florida to amend comp law to facilitate 24-hour cover

By MEG FLETCHER

TALLAHASSEE, Fla.—The Florida Insurance Department hopes to amend the state's 1990 workers compensation law to encourage employers to establish pilot "24-hour coverage" programs.

The amendment is necessary because there is no practical way to implement the one-paragraph section of the workers comp law that permits 24-hour coverage, said Robbie J. Simpson, project coordinator of the department's Workers' Compensation Managed Care Pilot Program.

A task force of insurers and others that analyzed the law determined that no insurer is offering the type of coverage specified and probably would not because the legal wording can be interpreted to require that an employer provide medical and disability benefits for both work-related and non-work-related illnesses and injuries, which was not the original intent of the law, she said.

The law says employers can "secure the payment of compensation" by obtaining a "24-hour health insurance policy," including health maintenance organization and preferred provider organization coverage.

"In the event an employer obtains a 24-hour health insurance policy to secure payment of compensation for medical benefits, the employer shall also obtain an insurance policy which shall provide indemnity benefits, so that the total coverage afforded by both the 24-hour health insurance policy and the policy providing indemnity benefits shall provide the total compensation" required by the state for injured workers, according to the 1990 law.

Before the regular session of the Florida Legislature ends on May 3, the department will "actively" pursue an amendment to clarify the provision and roll it under another section of the law that permits pilot managed care programs for workers compensation, she said.

If the amendment is approved, the department should be able to design workable benefit parameters that will make 24-hour coverage "more realistic and cost-efficient," she said.

Such a program likely would maintain employers' immunity from most lawsuits by employees injured on the job.

Under the 24-hour coverage provision in the 1990 law, employers would pay the full cost of the 24-hour health insurance premium. But, the program lets employers require employees to pay deductibles or coinsurance payments and obtain care from health maintenance organizations or preferred provider organizations, even for work-related injuries.

Those features should help foster a "team" approach to getting an injured worker back to work, rather than the existing adversarial relationship, Ms. Simpson said.

In a report on 24-hour coverage, the Alliance of American Insurers noted that "employer payment for non-employment-related medical coverage is traded off for the ability to import employee cost sharing into the workers compensation medical portion of coverage."

Florida Insurance Commissioner Tom Gallagher "is very concerned about finding some answers to the spiraling cost of workers compensation," while ensuring that an appropriate level of quality care is provided to injured workers, she said.

Meanwhile, the Insurance Department expects next month to launch pilot programs under which elements of managed health care will be implemented in some employers' workers compensation programs. The managed care strategies include precertification, peer and utilization reviews, provider networks, return-to-work programs and bill audits.

However, Ms. Simpson declined to provide details about the insurers and employers that will be involved those pilot programs.

"It's an incredible opportunity," Ms. Simpson said.

The managed care pilot program will end after two years unless the Legislature acts to preserve them.

Twenty-four hour coverage "is the next natural progression" after the managed care experiment, she said.

Twenty-four hour coverage should reduce workers compensation costs by eliminating controversies about whether an injury is compensable and by reducing duplication of services offered by workers comp and health insurers, she added.

Insurers have expressed interest in participating in a state pilot 24-hour coverage program, which will be awarded on a no-bid basis, she said.

Among the interested insurers is Travelers Insurance Co., which has "a very strong" interest in launching a pilot program offering 24-hour medical coverage in Florida before the end of this year, said Dick Palczynski, vp and actuary with the Hartford, Conn.-based insurer.

Travelers envisions such 24-hour coverage as an optional program suited to large employers and available through large insurers with workers compensation and group health insurance capabilities, he said.

Travelers is attempting to answer questions about how to implement such a program, Mr. Palczynski said.

Eventually, Travelers would like to see the 24-hour coverage concept expanded to include full medical and disability coverage for occupational and non-occupational injuries, Mr. Palczynski said.

Twenty-four hour coverage is "a long-term agenda issue" that will be discussed and researched more in future years, he said.

Meanwhile, a ruling last year that Florida's 1990 workers comp law was unconstitutional will not likely be an impediment to the Insurance Department's pilot 24-hour coverage program, Ms. Simpson said.

A state court judge ruled in November that the law was unconstitutional because, among other things, it deal with more than one subject. Besides its workers comp provisions, the law also contains provisions concerning international trade by Florida companies (*BI,* Nov. 12, 1990).

The Legislature on Jan. 22 passed a restructured version of the workers comp law to comply with the state constitution, Ms. Simpson said.

The Florida Supreme Court will decide whether the law was actually in effect between July 1. 1990, when the original version was passed, and Jan. 22, when the restructured version was passed, she said. ■

Managed care may not be cure for comp costs

By MEG FLETCHER

CAMBRIDGE, Mass.—Certain managed care techniques can trim workers compensation health costs, experts say.

But because the legislative and economic factors that affect workers comp programs are not necessarily the same ones that affect health care programs, managed care techniques are not universally applicable to workers comp, some suggest.

Several studies of managed care programs reported savings of about 30% in employee benefit health care costs. But such savings will not necessarily occur when the techniques are used in workers comp cases, according to Joseph Smith, manager of the Health Policy Research Program for the Workers Compensation Research Institute.

Mr. Smith spoke during a panel presentation at a recent WCRI conference in Cambridge, Mass.

In nearly all states, workers comp is a mandated social program subject to various legislative and administrative rules, like allowing employees to choose their own health care providers.

In addition, workers comp payers purchase only about 2% of the nation's medical benefits. "As a 2% purchaser, you will not drive the system," Mr. Smith said.

He pointed out that medical costs comprise about 40% of all workers comp claim costs and are growing faster than medical costs under group health plans.

That may be due in part to hospitals shifting more costs to workers comp patients. Relatively few employers or insurers, he explained, have negotiated the type of fixed price contracts that have helped hold down employee health care spending.

The workers comp system also entails more complex incentives for participants, he said.

For example, a workers comp claimant's expectations for full recovery may be greater than that of a typical group health plan claimant.

Adding to the complexities, physicians in workers comp programs play multiple roles: they treat the injury or accident, determine disability levels and decide when an employee can return to work.

Other managed care techniques that have helped control group health care cost increases are not necessarily transferable to workers comp, according to Mr. Smith.

For example, prospective utilization review in employee health care programs promotes cost-effective treatment, not return to work.

And, a health care plan's broad-based provider network, which trades lowered fees for higher volume, won't meet the needs of a low volume of workers comp claimants who typically need the services of specialists in orthopedics and occupational medicine. "You may have to pay more for the right providers, instead of less," according to Mr. Smith.

If reimbursement levels for workers comp cases drop too low, good physicians won't participate, emphasized Dr. Gary L. Woods, a hand surgeon with Concord Orthopaedics in Concord, N.H.

And employers must realize that sometimes early expensive treatment can save money later on, Mr. Woods added.

In addition, some states give employees complete control over their medical treatment. This makes it more difficult for employers to channel workers comp claims to specific physicians or hospitals.

Mr. Smith added that from an administrative point of view, group health care benefits are easier to explain to employees, while workers comp benefits typically are not explained until they are needed and require employer involvement to get an injured employee to return to work.

However, Mr. Smith pointed out that certain managed care techniques can help control workers comp medical costs if employers:

- Establish return to work as the goal.
- Collect and analyze data.
- Focus managed care activities in areas in which savings are likely to be made.
- Coordinate the activities of injured workers and providers to get employees back on the job.

Dr. Woods added that employers should accept responsibility for providing light-duty jobs for recuperating or disabled workers and for reducing ergonomic hazards at work sites.

A managed care program that increased the responsibilities of a limited number of "focal" physicians, who either treated or reviewed all cases in a specific geographic area, has saved millions of dollars in workers comp costs for the Armour Food Co., a subsidiary of ConAgra Inc. in Omaha, Neb.

Patrick D. Mahoney, ConAgra's manager of insurance, told the audience that as of year-end 1990, after 18 months of operation, the program resulted in savings equal to 23% of its workers comp costs. It has also cut the number of work days lost after an injury by about 40%.

Focal physicians were typically internists operating as independent contractors, who either treated patients or reviewed their records before they were allowed to return to work.

The review requirement helped eliminate the problem of having a formerly injured employee, who received a lump-sum settlement check for a 25% to 30% permanent partial disability rating on a Friday, receiving a full release to return to work the following Monday, according to Mr. Mahoney.

Often such an employee would come to work either "waving the check around" or be "driving a new pickup truck," which triggered workers comp claims among other production line workers, Mr. Mahoney added.

The review process also helped to ensure that only physically able employees return to appropriate jobs.

Under Armour's program, focal physicians helped establish and continually review in-plant screening programs that help nurses rate the physical capabilities of job applicants so that only the "cream of the crop" are selected for employment, according to Mr. Mahoney.

The physicians also help Armour's claims administrators by periodically evaluating and obtaining claims file data.

Noting that the focal physician program also is part of a comprehensive program that includes self-insurance and making supervisors directly accountable in their budgets for workers comp costs, Mr. Mahoney remarked, "It's been extremely successful for us." More workers comp managed care pilot programs are expected in the future, according to Mr. Smith.

New Hampshire, Florida and Oregon have passed legislation that encourages such projects, although none has been implemented yet, he added. ■

Surge of comp litigation hard to block

By MEG FLETCHER

CAMBRIDGE, Mass.—Workers compensation researchers donned slickers and picked up canoe paddles at a recent conference to demonstrate how state workers comp administrators can best cope with more hearing requests.

"A state's (adjudicatory) system is like a dam," said Duncan Ballantyne, a senior analyst with the Workers Compensation Research Institute in Cambridge, Mass.

He compared hiring more judges to simply increasing the height of the dam so it can retain more water.

Administrators would do better to paddle upstream and explore other ways to prevent and reduce claims. This would slow the flow toward the dam, Mr. Ballantyne said during a panel discussion at the Workers Compensation Research Institute's annual conference.

However, the rising tide of workers comp litigation is not unique to our society and, for several reasons, will probably continue nationwide, said Peter Barth, an economics professor at the University of Connecticut at Storrs.

Increasing administrative efficiency, for example, will attract claimants who had been put off by systemic delays, he said.

In addition, a "critical" issue that a state should consider is the likelihood that a decision will be reversed on appeal, because if reversals occur they provide a "significant" incentive for litigants to pursue a case, he said.

Litigation is often considered a failure of administration. But the reasons for litigation include system requirements and the lucrative nature of the cases, said John Lewis, a Miami attorney and workers comp consultant for several states.

Another expert points out that some litigation is inevitable. There will always be some "very real, good faith disputes," said Edward Welch, former director of the Michigan Bureau of Workers' Compensation Disability who is now a university teacher.

The experts also considered how administrators could reduce backlogs in workers comp claims hearings.

Mr. Ballantyne's comments were generally based on lessons learned from WCRI studies of seven states —Connecticut, Maine, Michigan, Minnesota, Pennsylvania, Texas and Washington.

Those lessons include:

- Delay is the enemy.

Delaying payments of initial benefits can prompt employees to seek legal help. And delays in terminating temporary total disability benefits raise the stakes for both employers and insurers and may cause them to reject initial claims, he said.

Delays can be reduced through a variety of means, including hiring more staff members and judges to handle claims or by using less formal adjudicatory approaches.

- Informal dispute resolution conferences may—or may not—resolve more claims.

"Preparation is key," Mr. Ballantyne said.

In Connecticut, for instance, representatives of both sides are required to share important information before discussing the case. Other rules also help, like using the same adjudicator to oversee the informal contacts and the conferences.

Without such controls, an informal approach will only slow down the process with another procedural layer, he warned.

Mr. Welch recommended that a state administrator question how formal the rules need to be to strike a balance between reducing adversity and protecting the rights of both parties.

Michigan, for example, has very formal rules. Although the state has had success with both formal and informal mediation, it is "a stop-gap measure," Mr. Welch said. "Prevention is the real answer, the only long-term solution," he added.

- Dispute prevention techniques can help resolve claims.

There will always be some 'very real, good faith disputes' in the work comp system, Mr. Welch says.

Possibilities include educating workers about the system; creating toll-free hot lines for workers to obtain claims information; and ensuring that first benefit payments are received on time.

And states can reduce delays by not requiring written releases for employees and insurers to get access to medical records.

Mr. Ballantyne emphasized that state administrators have many ways to achieve the same objective. "No one system works best."

And even a good plan must be properly implemented for it to work, he added.

However, Mr. Barth warned that it is "naive" for reformers to think that improving one piece of a state's administrative system will produce significant change. Systemwide reforms often are needed.

Meaningful changes, Mr. Lewis added, are "getting tougher and tougher" to secure. That is due to a general lack of commitment to doing the right thing, he said.

Mr. Lewis ecommended administrators establish narrowly controlled experiments with sunset provisions to analyze topics like insurer accountability or 24-hour coverage (see story, page 3). ■

Datebook

MARCH

MARCH 24-27. Captive Insurance Companies Assn.'s Annual Meeting in Scottsdale, Ariz., sponsored by CICA; No charge for CICA members; $300 for non-members. Albert Capozzelli or Angela Sabatino, CICA, 205 E. 42nd St., New York, N.Y. 10017; 212-687-4501.

MARCH 25-27. Product Safety and Liability Prevention: The Role of Warnings and Instructions course in Madison, Wis., sponsored by the Department of Engineering Professional Development, College of Engineering, University of Wisconsin-Madison; $895. The Wisconsin Center, 702 Langdon St., Madison, Wis. 53706; 608-262-1299; 800-462-0876.

MARCH 25-27. Environmental Regulation Course in Atlanta, sponsored by Executive Enterprises Inc.; $1,045. **Also March 26-28** in Philadelphia; **April 8-10** in Virginia Beach, Va.; **April 17-19** in St. Louis; **April 22-24** in Boston; **April 30-May 2** in Anchorage, Alaska; **May 8-10** in San Francisco; and Louisville, Ky.; **May 13-15** in Houston; **May 15-17** in Washington, D.C.; **May 21-23** in Denver; **May 29-31** in Orlando, Fla.; **June 3-5** in San Diego, Calif. and Secaucus, N.J.; **June 5-7** in Chicago; **June 17-19** in Menphis; **June 24-26** in Albuquerque. Executive Enterprises Inc., 22 W. 21st St., New York, N.Y. 10010-6904; 800-831-8333; 212-645-7880.

MARCH 26. Benefit Recordkeeping Strategies for the 1990's and Beyond seminar in Washington, D.C., sponsored by GENESYS Software Systems Inc.; No charge. **Also March 27** in Atlanta; **April 2** in Philadelphia; **April 3** in Pittsburgh; **April 5** in New York City; **April 9** in Dallas; **April 10** in Houston; **April 16** in Chicago; **April 17** in Milwaukee; **April 23** in St. Louis; **April 24** in Minneapolis; **April 30** in Tampa, Fla.; **May 1** in Nashville, Tenn.; **May 7** in San Francisco; **May 8** in Los Angeles; **May 14** in Detroit; **May 15** in Cleveland; **May 22** in New York City. Maureen Paradis, GENESYS, 508-685-5400, ext. 3055.

MARCH 26. Maximizing Coverage; Minimizing Costs seminar in Warwick, R.I., co-sponsored by The Society of Chartered Property & Casualty Underwriters and the Rhode Island chapter of the Society of CPCU; $135 for society members; $165 for non-members. Tricia Hogan, Continuing Educatior. Coordinator, The Society of CPCU, 720 Providence Road, P.O. Box 3009, Malvern, Pa. 19355-0709; 215-251-2773.

MARCH 26. Reviewing Possible Gaps in Umbrella/Excess/CGL Coverage seminar in Lancaster, Pa., co-sponsored by The Society of Chartered Property and Casualty Underwriters and the Lancaster Subchapter; $130 for Society of CPCU members; $145 for non-members. Tricia Hogan, Continuing Education Coordinator, The Society of CPCU, 720 Providence Road, P.O. Box 3009, Malvern, Pa. 19355-0709;

MARCH 26. How to Make Effective Use of the Excess/Surplus/Specialty Markets seminar in Kansas City, Mo., co-sponsored by The Society of Chartered Property and Casualty Underwriters and the Kansas City Chapter; $140 for Society of CPCU members; $165 for non-members. Tricia Hogan, Continuing Education Coordinator, The Society of CPCU, Kahler Hall, 720 Providence Road, P.O. Box 3009, Malvern, Pa. 19355; 215-251-2773.

MARCH 26. Employers Council on Flexible Compensation Regional Conference in Denver, sponsored by the ECFC; $185 for ECFC members; $195 for non-members. **Also April 23** in Indianapolis; **April 24** in New York City; **April 30** in Chicago; **May 16** in Morristown, N.J. ECFC Conference Center, Department 5063, Washington, D.C. 20061-5063.

MARCH 26. Controlling Legal Expense seminar in Philadelphia, sponsored by The Society of Chartered Property and Casualty Underwriters; $130 for Society of CPCU members; $145 for non-members. Bonnie Kinsley, Continuing Education Coordinator, The Society of CPCU, 720 Providence Road, P.O. Box 3009, Malvern, Pa. 19355-0709; 215-251-2735.

MARCH 26. Seventh Annual Hazard Communications/Right-to-Know/OSHA Conference in Columbus, Ohio, sponsored by The Ohio Manufacturers' Assn.; $130 OMA members; $155 non-members. Mark W. Uher, Jana Lilly or Lisa Cramer, OMA, 33 N. High St., Columbus, Ohio 43215; 614-224-1722.

MARCH 26. Fleet Driver Improvement Program in Chicago, sponsored by Consolidated Service Corp.; $88; discounts for additional participants from same company. **Also March 28** in Milwaukee; **April 9** in Philadelphia; **April 11** in New York; **April 23** in Rochester; **April 30** in Atlanta; **May 2** in New Orleans; **May 16** in Charlotte, N.C.; **May 21** in Boston; **June 4** in St. Louis; **June 6** in Kansas City, Mo.; **June 11** in Denver; **June 18** in Sioux Falls, S.D.; **June 20** in Detroit. Ron Starr, CSC, 2500 Devon Ave., Elk Grove Village, Ill. 60007; 708-640-2666.

MARCH 26-27. Practical Strategies for Managing a Cost—Effective Injury Prevention Program in Fresno, Calif., sponsored by the Southern California Safety Institute; $385. **Also April 11-12** in Ontario, Calif. Southern California Safety Institute, 3858 Carson St., Suite 210, Torrance, Calif. 90503; 213-540-2612.

MARCH 26-28. Pension and Welfare Plans: The Big Picture seminar in Los Angeles, sponsored by TPF&C Professional Development Institute; $950. **Also July 24-26** in Chicago, **Oct. 16-18** in Philadelphia. TPF&C, a Towers Perrin Co., 800-253-8732.

MARCH 27. Introduction to Risk Management seminar in New York City, sponsored by The College of Insurance; $225 for college sponsors; $275 for non-sponsors. **Also May 23, Sept. 26** and **Nov. 13**. The College of Insurance, Professional Programs, 101 Murray St., New York, N.Y. 10007; 212-815-9201; 212-962-4111.

MARCH 27. Should Banks Be Allowed to enter the Insurance Industry seminar sponsored by the New York City Chapter of the Financial Executive Institute; No charge. Committee Chairman, Fred Hauser, 212-578-5096.

MARCH 27-28. Successfully Obtaining Permits Under the New 1990 Amendments to the Clean Air Act in Orlando, Fla., sponsored by Executive Enterprises Inc.; $1,045. **Also April 8-9** in Denver. Executive Enterprises Inc., 22 W. 21st St., New York, N.Y. 10010-6904; 800-831-8333; 212-645-7880.

MARCH 28. Workers Compensation: Cost Crisis of the 90's seminar in New York City, sponsored by Rollins Burdick Hunter of New York; No charge. Ann D'Amelio, 212-673-6209.

APRIL

APRIL 3. Maximizing Coverage; Minimizing Costs seminar in Utica, N.Y., co-sponsored by The Society of Chartered Property and Casualty Underwriters and the Utica Chapter; $80 for Society of CPCU members; $90 for non-members; add $15 after March 20. Tricia Hogan, Continuing Education Coordinator, The Society of CPCU, 720 Providence Road, P.O. Box 3009, Malvern, Pa. 19355-0709; 215-251-2773.

APRIL 8-11. National Plant Engineering and Maintenance Show in Chicago, sponsored by the National Safety Council; $595. National Plant, P.O. Box 7069, North Suburban, Ill. 60199-7069; 800-255-7798.

APRIL 9-12. The Freedom Factor conference in Cambridge, England, sponsored by the Assn. of Insurance & Risk Managers in Industry and Commerce; 500 pounds ($980) for members; 610 pounds ($1,195) for non-members. AIRMIC Secretariat, 6 Lloyds Ave., London EC3N 3AX; 71-702-3752.

APRIL 28-MAY 3. 29th Annual Risk Management and Employee Benefits conference in New Orleans, sponsored by the Risk & Insurance Management Society Inc.; full week: $695 for members, $795 for non-members; partial week: $575 for members; $675 for non-members. One-day registration, $195. RIMS, Conference Department, 205 E. 42nd St., New York, N.Y. 10017; 212-286-9292.

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The Datebook is compiled from notices sent to Business Insurance. Notices should be sent at least eight weeks in advance to Datebook, Business Insurance, 740 N. Rush St., Chicago, Ill. 60611-2590. Please include the price, if any, of the meeting and information on registration. Business Insurance reserves the right to select meetings of most interest to its readers and cannot guarantee that notices will be printed.

Business Insurance

Circulation Breakdown*

Commercial Consumers

Administrative:
CEO's Presidents, and Owners . . . 2,670
Vice-Presidents, General Managers and Other Administrative Personnel . . . 4,438

Financial:
Chief Financial Officers and Vice-presidents of Finance . . . 3,149
Secretaries, Treasurers, contollers and other Financial Personnel . . . 4,505

Risk/Employee Benefits:
Vice-presidents, directors, managers, and other related department personnel of: insurance, risk, employee benefits, personnel, compensation, pension, safety, security, industrial relations, human resources and employee/labor relations . . . 10,830

Sub-total . . . 25,592

Associations . . . 511
Government, Unions and Educational Institutions . . . 1,289

Commercial Consumers
Sub-total . . . 27,392

Insurance Agents and Brokers . . . 9,815
Insurance Companies . . . 7,891
Accountants, Actuaries, Attorneys & Consultants . . . 3,377
Adjusters, Appraisers, TPA's, Captive Managers & Health Care Providers 1,218
Others Allied to the Field . . . 1,693

TOTAL . . . 51,386

* Source Business/Occupational breakdown of qualified circulation, May 28, 1990 issue, as submitted to BPA for June 1990 BPA Publisher's Statement.

Russo introduces universal health bill

By ADRIENNE C. LOCKE

WASHINGTON—Employers' payroll taxes would be hiked to help fund a single-payer health care system much like Canada's under a universal health care bill recently introduced in the House.

The measure, H.R. 1300, is the "first step toward a system which provides quality health care at a reasonable cost for all Americans," said Rep. Martin A. Russo, D-Ill., its sponsor.

"I want to work with any groups interested in shaping our health care system for the 21st century," he said.

Rep. Russo, who announced his intention to sponsor such legislation earlier this year (*BI*, Feb. 25), contends that the U.S. health care system is in a state of crisis. The working uninsured are "impoverished" by unexpected health care expenses and employers are "bankrupted" by spiraling costs, he said.

"We cannot continue to ignore the problem or put patches on a shredded quilt of health care programs," he said.

The Russo bill would increase payroll and corporate income taxes to help finance a new system, which would be administered jointly by the federal government and the states.

A 6% payroll tax would be levied on employers and the corporate income tax would increase to 38% from 34% for businesses with more than $75,000 in profits.

The Russo bill would also increase personal income tax rates to 30% and 34% from 28% and 31%, respectively. Families with incomes greater than $200,000 would pay 38%.

The taxes included in the bill, which has 21 co-sponsors, would increase businesses' health care expenditures 13.7% to $199 billion from $176 billion in 1989.

Rep. Russo, however, expects the proposal to reduce national health care expenditures 6.8% during the first year to $549 billion from an estimated $589 billion in 1989 due to eased administration.

The National Assn. of Social Workers, in Silver Spring, Md., applauded the "leadership" of Rep. Russo in introducing his bill.

The social workers group, which developed its own health care reform plan, says that both proposals have a "common approach to restructuring an ailing, patchwork system of private and public coverage into a simplified" system that would benefit everyone (*BI*, Jan. 21).

Pollution settlements

Two of the largest settlements ever of fines levied under the Resource Conservation and Recovery Act have been reached, according to the Environmental Protection Agency.

Formosa Plastics Corp. of Florham Park, N.J., agreed to pay a record $3.38 million to settle a variety of alleged violations of RCRA.

And, in a separate settlement, E.I. du Pont de Nemours & Co. of Wilmington, Del., agreed to pay $1.85 million to settle RCRA charges.

Federal officials announced the proposed settlements late last month as part of a crackdown on enforcement of the act.

"These enforcement actions are part of a continuing nationwide campaign by the Environmental Protection Agency and the Justice Department to stop people from illegally putting hazardous wastes in the ground," said William K. Reilly, the EPA administrator.

Formosa will pay the record

Washington

$3.38 million to settle various charges of violating RCRA, including improper disposal of hazardous and non-hazardous wastes and contaminating soil and ground water.

The alleged violations occurred at Formosa's Point Comfort, N.J., facility.

Since October, the EPA and Formosa have been trying to "arrive at an environmentally beneficial and balanced" agreement, an agency spokesman said.

The company neither admits nor denies the charges, but says the settlement "will provide a path for FPC to reach compliance with RCRA without prolonged administrative hearings" with the environmental agency, a spokesman said.

In addition to paying the fine, Formosa has agreed to clean up the contamination, comply with federal regulations and establish pollution prevention programs. The company will also set up a $1 million trust fund for environmental education in the area.

Meanwhile, the EPA filed its complaint against Du Pont at the same time the settlement was announced. The settlement is subject to approval by the U.S. District Court in Camden, N.J.

The allegations involve activities at the company's Chambers Works plant in Deepwater, N.J., the state's largest hazardous waste disposal facility. Charges include:

- Unlawful disposal of toxic solvent waste between November 1987 and November 1988 and unlawful disposal of corrosive acid waste between July 1987 and April 1989.
- Inadequate analysis of hazardous waste before treatment, storage and disposal between November 1986 and November 1988.
- Record-keeping violations for hazardous waste analysis, treatment and disposal between November 1986 and November 1988.

In addition to the fine, the settlement requires Du Pont to perform compliance audits to ensure that all its U.S. facilities that ship hazardous waste meet local disposal standards.

Du Pont also has agreed to implement programs to reduce hazardous wastes. A company spokesman said its violations caused no environmental damage.

Self-funded plans

Congress should give state insurance regulators more enforcement power over self-funded health care plans, which are now exempt from state regulation by the Employee Retirement Income Security Act of 1974, a state regulator says.

"If Congress would vest responsibility with the states for these now unregulated entities, many consumers would get the health care they need," said Tom Gallagher, insurance commissioner of Florida.

Last month, in a letter to Rep. John Dingell, D-Mich., Mr. Gallagher asked the chairman of the House Oversight and Investigations Subcommittee to devote his "considerable interest and energies to helping states like Florida to solve this problem."

Many of the state's problems with health care plans, he said, involve the exemption of self-funded plans from state law.

While many of self-funded single-employer plans and multiple-employer welfare arrangements—or MEWAs—do provide affordable health care benefits to participants, others do not, Mr. Gallagher said (see story, page 3).

"Some of these plans are operated honestly. But they are a magnet to profiteers who see an opportunity to get rich quick at the expense of our citizens," he said.

And some MEWAs "have left a well-marked trail of unpaid bills, ripoffs and insolvencies," he said.

Regulators are often unaware of such plans until desperate participants turn to them for help, he said.

Employees don't realize that self-funded plans are not backed by a state guaranty fund, Mr. Gallagher said. "The vast number of employers and consumers who rely on these unregulated entities to provide health care benefits have little or no knowledge of how unprotected their interests are."

Acknowledging that states have limited authority over MEWAs, he argues that intervention is often delayed when plans challenge jurisdiction in court.

Growing problems with self-funded plans have not slowed their growth. In Florida, as well as nationally, more employees are being covered by self-funded plans, wrote Mr. Gallagher.

More than 30% of Florida residents are covered by single- and multiple-employer self-funded health plans, he said. Nationally, the figure was 42% in 1988, up from 16% in 1980. By contrast, the portion of people covered by commercially insured health plans—which are subject to state regulation—dropped to 34% in 1988 from 68% in 1980, Mr. Gallagher said.

Both Congress and the states must target the problem, he said, adding that the Florida Insurance Department would be willing to submit a model proposal for regulation.

Worker safety bill

A bill in the Senate would stiffen criminal penalties for employers that willfully violate federal safety law in cases of worker death or serious injury.

Introduced by Sen. Howard M. Metzenbaum, D-Ohio, S. 445 would raise the maximum prison term for a willful safety violation resulting in death to 10 years from the current six-month limit.

And willful violations that result in serious bodily injury to a worker would bring up to a five-year term for a first offense and 10 years thereafter. There is no criminal penalty for that violation now.

Sen. Metzenbaum's bill also would reinforce the authority of the Occupational Safety and Health Administration to use a criminal penalty fine structure passed by Congress in 1984. That law raised the maximum fine for a willful violation that results in death or injury to $250,000 from $10,000 for an individual and to $500,000 from $10,000 for a corporation.

A spokesman for Sen. Metzenbaum charges that there is little proof that OSHA has used the higher fines, even though they were available.

The proposal also would prevent employers from using corporate assets to pay any penalties levied against management.

"This bill sends an emphatic message to corporate criminals: If you willfully kill or maim a worker, you will pay a stiff fine and do hard time in federal prison," Sen. Metzenbaum said.

He called OSHA's record of criminal prosecutions "abysmal." In the agency's 20 years, 200,000 workers have died in the workplace, the senator said, but only one employer has gone to prison for willfully violating the law. The sentence of that employer for the death of two workers was 45 days in jail in 1989 (*BI*, Sept. 18, 1989).

Sen. Metzenbaum says the proposal would affect about 2,400 of the 185,000 citations OSHA issues annually.

"The threat of incarceration will force potential violators to think twice before deliberately flaunting our basic workplace safety standards," he said.

Friendlier skies

Flying the friendly skies became safer in 1990, a federal agency reports.

Aviation accidents fell 4% to 2,282 in 1990 from 2,381 in 1989, according to preliminary figures the National Transportation Safety Board released last month. And aviation fatalities decreased 29% to 819 from 1,154 a year earlier.

Twenty-six accidents among scheduled and non-scheduled carriers in 1990 represent a decline from 30 in 1989. Fatalities among those carriers also decreased to 39 last year from 278 a year earlier, the federal report said.

The total number of departures were virtually unchanged at about 7.64 million for both years, the report said.

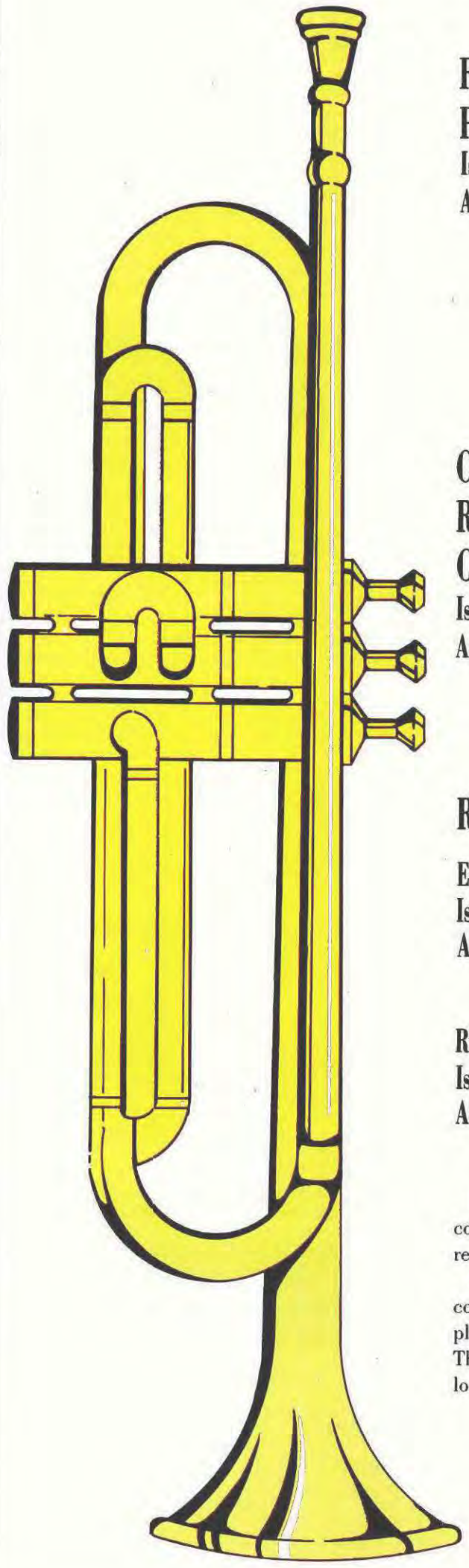
Commuter airlines accounted for part of the drop. Those carriers had 14 accidents and four fatalities in 1990, compared with 17 accidents and 31 fatalities in 1989.

Commuter departures remained constant—about 2.9 million for both years, the report said.

The safety board reported 104 accidents and 40 deaths involving U.S. air taxis last year, compared with 133 accidents and 88 deaths in 1989.

The 1990 accident and fatality rates for the general aviation industry also declined, with 2,138 accidents and 736 deaths in 1990, the agency said. During 1989, the NTSB reported 2,201 accidents and 757 fatalities for this category. ■

1991 RIMS NEW ORLEANS



RIMS PREVIEW
Issue: April 22
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The first note on RIMS '91 will be played by Business Insurance in its annual RIMS Preview 'take-out' section.

Leading with last minute details and updated program and speaker changes, BI's 'take-out' section will contain valuable notes for everyone heading for New Orleans: a floor plan and list of exhibitors; a map of Conference hotels; transportation info; a message center phone number; a New Orleans entertainment and restaurant guide; and weather watch. There will also be highlights on the Spencer Educational Foundation's silent auction, the RIMS softball game, and other major hospitality functions.

Plus — increased exposure — the RIMS Preview 'take-out' section will be distributed from BI's booth #1024-1026.

CAPTIVES/ RISK MANAGER OF THE YEAR
Issue: April 29
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Business Insurance plays an important role — getting news and information into the hands of decision makers whether they're in their offices or attending the RIMS conference.

BI's feature on Captives will announce the 14th annual Risk Manager of the Year and the Risk Management Honor Roll. This issue also includes BI's exclusive Directory of Captive Managers.

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RIMS REPORTS

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BI readers responsible for their companies' employee benefits will rely on this issue. From new perspectives to industry insights, BI editors will detail all the vital information covered at the RIMS employee benefits sessions.

Risk Management
Issue: May 13
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Wrapping up coverage of RIMS '91, BI editors will deliver an information-packed issue on the risk management sessions. Every corporate insurance buyer responsible for risk management will be sure to read this final RIMS feature cover-to-cover.

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Business Insurance
a publication of Crain Communications Inc

Kuwaiti coverage

Continued from page 1

said Christopher Weston-Simons, construction executive director for Willis Corroon P.L.C. in London.

London banking sources also point to the uncertainty, noting that insurance and other technical details will remain unclear until financing is secured. And the financing—which may include borrowing on future oil deliveries—depends upon restoring stability in Kuwait, they said.

Assessments of the tremendous war damages are just beginning.

Refining facilities and at least 800 of the nation's 1,000 oil wells have been damaged, according to Kuwait Petroleum Corp. The company estimates that repairing the petrochemical industry alone would cost $20 billion over five to 10 years.

None of this damage is known to be insured since most property/casualty policies exclude war risk on land.

In addition, many buildings in Kuwait City have been gutted; electricity, communications and sewage systems were damaged; and roads and bridges are in ruins.

Kuwaiti government ministers and business leaders have estimated the total rebuilding cost at $20 billion to $100 billion over five to 10 years.

Regardless of how reconstruction is handled, construction insurance capacity will be adequate, Mr. Weston-Simons said. Even a $100 billion project would not strain the market once it is broken down into individual contracts, he said.

"We're probably going to find it's not all that hard to get," said James Halvorson, a Marsh & McLennan managing director in New York.

"I would think underwriters would not be uneager to write this business," agreed Martin Rayner, a director of Johnson & Higgins based in New York and Los Angeles. "I don't think there will be any shortage of capacity."

Experts generally say that contractors will be able to find political risk coverage for Kuwaiti contracts.

"If I were a (political risk) underwriter, I would look very favorably on a Kuwaiti risk," said Francis X. Boylan, a senior vp with Alexander & Alexander of New York Inc.

Noting that political risk insurance covers losses from a government's arbitrary acts or financial default, Mr. Boylan pointed out that "after all we have done, I cannot imagine the government of Kuwait in the foreseeable future acting in an arbitrary manner and doing a grave injustice to an American firm operating there."

Larger companies involved in the reconstruction may self-insure their political risk exposures, he said. But smaller companies may have to buy political risk coverage to secure the financing they will need.

In a letter to brokers earlier this month, American International Underwriters, a unit of American International Group Inc., warned there would be an overwhelming demand for various political risk-related coverage. Those coverages include: contract repudiation; kidnap and ransom/extortion/wrongful detention; terrorism; and expropriation, nationalization or deprivation of equipment coverages.

"In the past, coverage has become unavailable (from any market) in certain countries due to large demand. It is anticipated that this will be the case in Kuwait some time in the near future," AIG said.

"The reconstruction is going to proceed as rapidly as possible," said John Salinger, president of AIU's political risk division. "The numbers involved here are very, very large. The area continues to be unstable. I'm sure the demand for insurance is going to be very large."

However, David Samuel, vp of the special services division of AIU, said he thinks there will be adequate capacity for the types of coverage offered through his division, including property, terrorism and sabotage, and kidnap and ransom insurance.

Mr. Samuel said he has received inquiries from "quite a few" companies that may be involved in the reconstruction, and recommends contractors planning to work in Kuwait seriously consider special risk coverages because the area is still "extremely unstable."

The first stage of the rebuilding process, already in progress, is the three-month Kuwait Emergency Recovery Program supervised by the U.S. Army Corps of Engineers. Its goal is to restore utilities and basic services and assist in the return of Kuwaiti citizens exiled in Iraq.

Another early priority is repairing the nation's oil fields. The government has already appointed Bechtel Corp. of San Francisco to supervise this mammoth task.

Bechtel's insurance is placed in the United States by Alexander & Alexander and in London by Willis Corroon.

A Bechtel spokesman couldn't elaborate on its coverage for Kuwait because a final contract has not been negotiated. Right now the company is operating under a letter of intent from Kuwait Petroleum, he said.

The company's contractors' all-risk programs that already exist may cover any new projects in Kuwait as long as the leading underwriters were notified, sources at Lloyd's say.

One London marine underwriter, however, cautions that "reconstruction of Kuwait is different than a project in the green fields of Connecticut." Concerned underwriters could force Bechtel to buy separate coverage, he said.

One company that expects to begin work in Kuwait immediately is Red Adair Co. in Houston, which specializes in fighting oil well fires.

Two teams of four to five firefighters will be sent as soon as equipment is in place and housing is arranged, Sharon Putz, head of accounting at the company, said last week.

About $25 million in general liability and property damage coverage written by Americas Insurance Co. in New Orleans and Lloyd's underwriters will cover its work in Kuwait, Ms. Putz said. "Our standard policy already met the limits" required for the work, she said.

Sources in London speculate that either Kuwait Petroleum or the national government on behalf of the petrochemical industry may buy $1 billion in coverage to protect the contractors that will help rebuild the oil industry.

Minet Holdings P.L.C., Kuwait Petroleum's broker in London, would not comment.

An oil industry source in Kuwait noted that many contractors have suggested that the "principals," namely Kuwait Petroleum, should set up one simple program to cover all contractors.

London sources say Minet has set up a facility to offer marine cargo and construction risks coverages to either Kuwait Petroleum or contractors like Bechtel or both.

The marine cargo insurance would cover the transport of reconstruction materials, like pipelines, cement, drilling equipment and mud, one underwriter explained.

Some $75 million in marine cargo coverage is in place, led by General Accident Fire & Life Assurance P.L.C. in the London company market and by Lloyd's syndicates managed by Janson Green Ltd., sources say.

Contractors works and erection coverage to be written through the facility is led by CIGNA Corp. in London, sources confirm. Estimates of the limits vary, though one source put the limit at $1 billion.

A CIGNA official in London would say only that the insurer was involved in the facility.

In the meantime, other London brokers and underwriters involved in energy-related insurance are setting up facilities for contractors.

The facilities "are all hypothetical at the moment" since contractors don't yet know whether they will receive contracts or what the risks will be, said one Lloyd's underwriter. "It will be months before anything is insured."

Lloyd's underwriters, however, have agreed to participate in a couple of facilities arranged by brokers, like London-based J.F.S. Fenchurch Ltd., to prepare for any coverage that might be needed.

J.F.S. Fenchurch is a joint venture between Jenner Fenton Slade Ltd. and Fenchurch Insurance Group.

The J.F.S. Fenchurch facility offers $100 million in limits for offshore and onshore energy-related construction risks, said Larry Blacker, a director of Fenchurch Insurance Group.

It will reinsure coverage written by the Kuwaiti insurance market, he added.

"We are already talking to clients now about the facility," Mr. Blacker said.

Other facilities in London will offer coverage for cargo, liability and construction risks, said a Lloyd's underwriter, adding that he is participating in "one or two of them on the off chance that the brokers do any business."

Mr. Agnew said he also is participating in "one or two (facilities), but at this stage it's just a facility" and no business is being written. He is, for example, participating in the J.F.S. Fenchurch facility.

Leading underwriters still have to agree to declarations, terms and conditions when policyholders finally need to buy coverage, he said.

One of the facilities would provide up to $100 million in coverage for the shipment of equipment, construction and rebuilding of a new complex, he said.

Other brokers, however, believe that contractors may insure their Kuwaiti projects through existing programs or buy coverage with local insurers.

"A lot of reconstruction contracts will be awarded to American companies and some British companies that have their own insurance programs," said Martin Howell, associate director of Leslie & Godwin Insurance Brokers Ltd. in London, a unit of Frank B. Hall & Co. Inc.

"They may sort out something with their own insurance programs or place coverage locally. Kuwait in the past has always insisted that Kuwait customers place insurance in" Kuwait, he said. Most London brokers already have access to construction all-risk insurance facilities that provide up to $100 million per project.

Leslie & Godwin, for example, has established a construction all-risk facility that provides $98 million in limits, said Mr. Howell.

Because Kuwait "doesn't have any nasty exposures," insuring Kuwaiti risks won't be a problem, he said.

Terrorism policies, though, may have to be written separately. "Underwriters at the moment would look at (terrorism coverage) carefully," he said.

Meanwhile, Kuwaiti underwriters believe that coverage for the reconstruction program should be initially placed with them and then reinsured via Kuwait Reinsurance Co. into the world markets.

Fathi Haman, general manager of Kuwait Re and the London-based representative of the Kuwaiti insurance market, said all insurance for Kuwaiti-registered companies participating in the reconstruction should be placed with local insurers, as the law requires.

Kuwait has four major insurers: Kuwait Insurance Co., Gulf Insurance Co., Al Ahleia Insurance Co. and Warba Insurance Co.

"Every non-Kuwaiti broker or insurance or reinsurance company which is trying to attack the Kuwaiti insurance market by getting business and bypassing the Kuwaiti market is doing something unethical," Mr. Haman charged.

Yet some exceptions have already been made. The rule has not been enforced for foreign contractors during the three-month emergency program, said Saleyman Al Dallaly, chairman and managing director of Gulf Insurance Co., which is 60% owned by the Kuwaiti government and 40% by private Kuwaiti investors.

Once the emergency program is over, however, "everything will return to normal," said Mr. Al Dallaly, a government appointee whose company expects to be writing business in Kuwait again by April 1.

"Some commitments had been made before representative offices were established in London and Bahrain. These came as a package deal and include certain interests such as reinsurance and shipping," he said.

When the real reconstruction begins, he said, insurance will again have to be placed with Kuwaiti companies.

Other observers say it is too early to tell whether the existing law will be enforced.

"Nobody knows the state of the insurance companies. . . .A lot of the staff were expatriates, so we don't know who will return," said Bowring's Mr. Capel Cure.

The requirement to use Kuwaiti insurers has been suspended "simply because the Kuwaiti insurance industry is a little bit up in the air," said Hugh Warren, an executive vp with Corroon & Black International in New York, a Willis Corroon unit.

Other underwriters based in the Middle East also are hoping to benefit from Kuwaiti reconstruction.

Arab Insurance Group B.S.C., for one, hopes to write some of the reinsurance for construction projects after the emergency period, said ARIG General manager Nooruddin A. Nooruddin.

"Kuwait is a one-third shareholder in ARIG so we have our own contacts with the Kuwaiti insurance companies," said Mr. Nooruddin. "And, of course, as an international reinsurer we expect ARIG to be involved, not because we are partly Kuwaiti-owned, but because of our international position."

He expects ARIG to be a major participant in construction and oil sector reinsurance programs. "Once (oil) facilities are restored, we will be involved in insuring them."

Saudi Arabia's only registered insurer, the National Co. for Co-Operative Insurance, is also eager for a piece of the pie.

"We participate indirectly (in the Kuwait market) through some reinsurance, but we are in a position to get local contractors to do business in Kuwait and insure them," a spokesman said.

The Saudi insurer participates in Kuwait Petroleum's umbrella reinsurance program and has close ties with AIU and CIGNA.

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This story is based on reporting by International Editor Stacy Shapiro, Associate Editor Gavin Souter and freelance reporter Maria Kielmas in London and Associate Editor Colleen Johnson in Chicago.

Insurers, brokers represented

LONDON—British brokers and underwriters are represented on a committee set up by the British Department of Trade and Industry to serve Kuwaitis looking for financial services in the City of London.

Brokers are represented on the so-called City-Kuwait Group by the Lloyd's Insurance Brokers Committee through Colin Methven, a director of Willis Faber & Dumas Ltd.

Lloyd's underwriters are represented by Stephen Merrett, chairman of the Lloyd's Underwriters Assn. and chairman of Merrett Holdings P.L.C. London company underwriters are represented by Arthur Saunders, overseas manager of the Assn. of British Insurers.

"The members of the group are broadly representative. Their task is to channel information and advice on the needs and opportunities, in both the public and the private sectors, to and from their respective constituencies," a spokesman for the group said.

The group already has met twice and is expected to meet weekly.

Government eases travel advisories

WASHINGTON—The U.S. State Department is easing its suggested travel restrictions for the Middle East, Africa, and Southeast Asia.

Several advisories issued in January cited fears of terrorist attacks in warning U.S. citizens not to travel in these areas (*BI*, Jan. 21).

The revised warnings only urge travelers to exercise caution. "Although there is a cessation of hostilities in the Gulf area, the security situation remains unclear," the department said.

The State Department urges U.S. citizens going to Kuwait not to travel into desert areas because of the threat of unexploded land mines and "booby traps."

Travelers were also urged to be aware of possible health risks from the Kuwaiti oil fires. And the department advises people with respiratory illness to avoid all of the northern Persian Gulf area.

Citizens headed abroad are still advised to check country-specific travel advisories issued by the State Department and to register with the U.S. embassy or consulate after arrival.

Terrorism abroad remains a serious concern, noted a department spokeswoman. "Previous wars in the Middle East region have frequently been followed by a terrorist aftermath," she said.

The department will continue to work with other governments to ensure that the safety measures put into place in airports and other facilities worldwide at the onset of the Gulf war remain in place, she said.

Since Jan. 16, the State Department has recorded approximately 160 terrorist incidents around the world, about half of them directed at U.S. targets. One American died and three were injured in those attacks.

These incidents were largely concentrated in Eastern Europe and the Andean mountain region of northern South America, the department said.

Meanwhile, the department has issued a travel advisory for Thailand. The Thai government was overthrown by the military earlier this month, and martial law has been declared.

Travelers are warned to use caution when visiting Thailand and to register at the U.S. embassy or local U.S. consulate upon arrival.

While there appears to be no increased danger to American citizens in Thailand, the State Department reminds travelers that the threat of terrorist acts in Southeast Asia "is likely to continue for some time."

—By Adrienne C. Locke

BC/BS study

Continued from page 1
with BC/BS in Chicago.

"Based on the conclusions of this study, we believe that evaluating the appropriateness of medical care can be done before the procedures are performed and that doing so is cost-effective," Ms. O'Donnell said.

The pilot study involved five BC/BS plans and one BC/BS health maintenance organization. Each used Medical Review System, a software package which runs on a desktop computer using the Unix system. The software was developed by Value Health Sciences Inc. of Santa Monica, Calif.

Under the program, a physician calls a BC/BS nurse reviewer. Guided by the Value Health Sciences software program, the nurse reviewer asks a series of questions about the patient, such as symptoms, age and prior treatment.

Based on the responses, the program either approves the procedure for coverage or refers it to a physician reviewer for additional discussion with the patient's physician.

If the procedure fails this second review, both the the patient and physician are told that the Blues plan may not provide coverage.

According to the study, 34%, or 3,107, procedures failed the first stage of the review. Two-thirds of those—2,083—were approved after physician review; one-third, or 1,024, were not. Therefore, the recommended treatment was considered inappropriate in 11.2% of the 9,125 cases examined.

Identifying those procedures racked up big savings. At one unidentified pilot site, the program—during a six-month period—saved $265,280 in medical costs compared with $103,804 spent for software licensing fees, computer hardware and staff training and salary expenses.

Those savings, which amounted to $433 per case at that site, come at a time when employers' health care costs continue to increase at double-digit levels, despite nearly a decade of corporate cost containment efforts.

Last year, for example, medical plan costs shot up 21.6% to an average of $3,161 per employee, up from $2,600 in 1989, according to an A. Foster Higgins & Co. Inc. survey. That rise followed a 20.4% increase between 1988 and 1989 (*BI,* Jan. 28).

It is unclear how much of that increase is due to inappropriate or unnecessary treatment. But some experts believe plenty of care is unneeded.

"There is a lot of inappropriate medicine that is being practiced today. There are a lot of things being done that should not be done," said Tom Billet, a Foster Higgins principal in New York.

Rates of inappropriateness vary by procedure, the Blues study found. The highest rates were for tonsillectomies, 27.1%; hysterectomies, 21.5%; and tonsillectomies combined with adenoidectomies, 17.6%.

But, only 1.5% of colonoscopies were found to be inappropriate, while no coronary artery bypass grafts or carotid endarterectomies were rejected. A carotid endarterectomy is a procedure to remove blockage from the large artery in the neck.

Regarding the number of rejected procedures later overturned by physicians, medical experts say it is not surprising, given the limits of just how much information can be put in a computer program.

"We don't know enough to put everything in a computer program. Ultimately, physicians have to be involved," said Wyatt's Dr. Taylor.

"We fully expected a lack of concurrence" between the first and second levels of review, said Dr. Mark Chassin, senior vp at Value Health Sciences. He noted that there are certain factors like levels of pain that are best reviewed by a physician.

And, BC/BS's Ms. O'Donnell pointed out that in the followup review, the patient's physician often gives the reviewer more information.

However, the AMA questions whether the study really sheds any light on how much medical treatment is inappropriate.

"Physicians are subjected to review by computerized 'black boxes.' Without knowing what is inside those boxes, there is no way for the medical profession to know whether the decisions (made by reviewers) are correct or incorrect," said Dr. John T. Kelly, director of quality assurance for the American Medical Assn. in Chicago.

"If the rules are secret, this study only shows the proposed course of action did not meet a secret set of rules. It does not mean a proposed course of action was inappropriate," Dr. Kelly said.

Physicians are free to review the criteria, said Leslie Michelson, president of Value Health Sciences. The criteria are based on medical and scientific literature and were reviewed by more than 100 physicians.

In addition, the Blues' Ms. O'Donnell said reviewers explain to a patient's physician why a treatment is considered inappropriate.

The BC/BS plans taking part in the pilot study were: Blue Cross of California; Blue Cross & Blue Shield of Delaware; Blue Cross & Blue Shield of Massachusetts; Blue Cross & Blue Shield of Minnesota; Blue Cross & Blue Shield of Tennessee. In addition, Columbia Freestate Health System, an HMO sponsored by Blue Cross & Blue Shield of Maryland, also participated in the study, which took place between July 1989 and July 1990. ■

Georgia seeks NAIC accreditation

By COLLEEN JOHNSON

ATLANTA—The Georgia Office of the Insurance Commissioner plans to seek accreditation from the National Association of Insurance Commissioners after legislators unanimously approved a bill incorporating several NAIC model laws (*BI,* Dec. 3, 1990).

The bill was sent to Gov. Zell Miller on March 7, and is expected to be signed. The legislation would be effective July 1.

One key change is that the insurance commissioner will have the same authority to order an insurer based outside of Georgia to stop doing business in the state—pending a hearing—as he does for a domestic insurer, said Dan Champlin, director-regulatory services at the state Insurance Department. At the hearing, the insurer would have to prove it should be allowed to continue to operate, he said. Currently, the department has to show the financial condition of an insurer domiciled outside the state is a hazard to Georgia policyholders before it can order the insurer to stop doing business, he explained.

Other provisions based on NAIC models regulate managing general agents, producer-controlled insurers and insurer credit for reinsurance, Mr. Champlin said.

The department will probably ask the NAIC to send accreditation examiners to Georgia around the middle of the year, he added.

The New York and the Florida insurance departments so far are the only departments accredited by the NAIC. ■

Pregnancy not hurt by VDT use: NIOSH

By ADRIENNE C. LOCKE

WASHINGTON—Pregnant women who work at video display terminals have no greater overall risk of miscarriages than women who do not work at VDTs, according to a government report.

A six-year study by the National Institute for Occupational Safety and Health in Cincinnati found that 14.8% of pregnant women using VDTs had miscarriages, while 15.9% of those who did not use VDTs had miscarriages. NIOSH says the difference is insignificant.

For women in their first trimester of pregnancy who work up to 25 hours a week, 17.2% of those working at VDTs had miscarriages, while 15.6% of those who did not use VDTs had miscarriages, the study found. NIOSH says this difference also is insignificant.

NIOSH studied 730 full-time telephone operators in the Southwest, half of whom worked at video terminals.

All of the women were married, age 18 to 33, worked the same number of hours, experienced at least one pregnancy during the study period and were considered under the same job stress levels.

"This study is very powerful and important and will ease the concerns of pregnant women who want to know if using a VDT will harm them," said Barbara A. Grajewski, senior epidemiologist at NIOSH. ■

Citicorp to sell its insurance broker unit

LONDON—Citicorp is selling its worldwide insurance brokerage to a group of investors led by the broker's management in London.

The sale is expected to be completed during the second quarter.

The New York-based bank says the sale reflects its decision to concentrate on its core activities.

The bank will maintain "a significant minority stake" in the broker, said David Woodward, chief executive of London-based Citicorp Insurance Brokers.

"Citicorp saw that the insurance business was poised for good times, but it wanted to concentrate on its banking activities," he said.

Mr. Woodward is leading the team of 12 brokerage directors and several London financial institutions financing the buyout.

Projected brokerage revenues are 39 million pounds ($72.2 million at current exchange rates) this year, compared with 34 million pounds ($65.6 million at year-end exchange rates) in 1990.

CIB's main operations include professional liability, marine and aviation brokerage. It has 750 employees in 19 nations.

Formed in 1984 from the insurance division of a Citicorp affiliate, Grindlays Bank, the brokerage doubled in size in 1989 when it bought broker Nelson Hurst & Marsh (Holdings) Ltd.

—By Gavin Souter

Update

Exxon settles in Valdez case

Continued from page 2
week. But Judge Stanley Sporkin later lifted his order.

Exxon, which pleaded guilty to four misdemeanors, must pay $190 million immediately. That includes the $100 million fine, half of which the U.S. Justice Department will distribute to Alaska as restitution. Further payments of $150 million in 1992 and $100 million in 1993 will go toward restoring Prince William Sound.

In addition, Exxon will pay $660 million over 10 years to restore the Sound.

The settlement also permits state and federal officials to seek another $100 million of damages if new harm is discovered later.

Exxon says it has spent more than $2.2 billion to clean up Prince William Sound after its tanker spilled more than 11 million gallons of crude oil, the nation's largest oil spill ever (*BI,* April 3, 1989).

And, $240 million has been paid to more than 14,000 claimants in separate litigation, a company spokesman said.

Exxon had $400 million in coverage to respond to liability claims.

Cargo plane insured for crash

NEW YORK—Air Transport International Inc. of Little Rock, Ark., has hull, cargo and general liability insurance to cover the crash of its DC-8 cargo plane at a New York airport last week.

The plane, which was carrying cargo for DHL Airways Inc. and the U.S. Postal Service, went down shortly after takeoff from John F. Kennedy International Airport.

The ensuing crash and fire destroyed the plane and its cargo and shut down the airport for more than two hours. Three crew members and two passengers were treated for minor injuries and smoke inhalation.

United States Aircraft Insurance Group in New York is the primary hull underwriter, said an Air Transport spokesman. He would not detail the company's cargo liability and general liability coverages.

London insurers say a DC-8 generally would not valued at more than $3 million.

USF&G dropping lines in Texas

BALTIMORE—After turning a profit in Texas only once in the last 10 years, USF&G Corp. will stop writing most lines of coverages there next year.

A spokesman attributes the decision to stop underwriting all types of insurance except life, fidelity and surety lines to a $300 million statutory loss in Texas over the past 10 years.

Policies that expire this year are being renewed for one year but will not be renewed in 1992, said the Baltimore-based company.

USF&G, which opened its first Texas office in 1918, says it will remain in the state as an admitted reinsurer for all lines.

In a letter to employees and agents, the company said its decision was based on "historical loss data and projections for future profitability." After USF&G posted a $569 million net loss for 1990 and slashed its dividend for the second time in four months, the company's credit ratings were lowered earlier this month. Standard & Poor's Corp. now rates USF&G debt as below investment grade (*BI,* March 4).

Briefly noted

Standard & Poor's Corp. lowered the claims-paying ratings of the **Aetna Casualty & Surety Intercompany Pool** and Aetna Life Insurance Co. to AA+ from AAA as a result of Aetna's $163 million increase in reserves and writedowns for problem mortgages in 1990. S&P said the downgrade of Aetna's intercompany pool also reflects below-average property/casualty earnings and personal auto and workers compensation concerns. S&P also lowered the debt rating of Aetna Life & Casualty Co. to AA+ from AAA. . . .Local governments and law enforcement agencies can be held liable for **failing to train police officers** on the legal limits on the use of force, the 9th U.S. Circuit Court of Appeals ruled. The decision, which upheld jury verdicts totaling $582,000 against Mason County, Wash., could influence litigation related to the March 3 beating of a motorist by Los Angeles police officers, attorneys say. . . .The 9th U.S. Circuit Court of Appeals Friday heard oral arguments in the appeal of a federal judge's decision to dismiss the massive **antitrust litigation** filed against insurance industry defendants. . . .A Colorado state court ordered **McDonald's Corp.** to pay $210,000 to a woman and her 3-year-old son, who was molested by a worker hired as part of the company's "McJobs" program for mentally and physically disabled individuals. Though the state was not a named defendant, the jury found it 55% at fault because the employee was cleared by a state social services worker who did not disclose a previous child molestation conviction. . . .Wind, hail, tornadoes, flooding, ice and freezing temperatures caused an estimated **$120 million of insured property damage** to portions of eight southern and Eastern seaboard states March 1-4, reports the the American Insurance Services Group. Bad weather also caused an estimated $65 million of insured property damage to portions of California and Arizona Feb. 27-28. . . .A Florida judge last week placed commercial **auto insurers** American Risk Assurance Co. and affiliate National United Insurance Co., both of Miami, into rehabilitation. The judge also ordered the liquidation of International Bankers Insurance Co., a Miami-based personal auto insurer that is insolvent by $4 million and claims $8 million of reinsurance recoverable from syndicates on the defunct Insurance Exchange of the Americas. . . .Voter Revolt, the group that sponsored **Proposition 103,** has asked the California insurance commissioner and the state attorney general to investigate complaints that insurers are firing agents who cut commissions to sell coverage at competitive prices. Proposition 103 repealed a law prohibiting such competition among agents and brokers. . . .A Superior Court judge last week ordered National Union Fire Insurance Co. of Pittsburgh, Pa., to pay $127 million in economic and physical and emotional distress damages to 1,200 investors of now-insolvent investment and real estate firm **Technical Equities Corp.** (*BI,* July 30, 1990). . . **U.S. reinsurers** reported a 106.1% combined ratio in 1990, an improvement from the 107.4% reported last year, according to a Reinsurance Assn. of America survey. Total net premiums written by the 64 companies surveyed rose 9.1% to $10.71 billion last year from $9.82 billion in 1989.

Product liability

Continued from page 2

at the National Assn. of Wholesaler-Distributors in Washington, D.C., agreed. Mr. Anderson also is executive secretary of the Product Liability Alliance in Washington.

Supporters of this bill in Congress have "no interest in sitting around re-creating the wheel and making changes that are not necessary," he said.

And, if there are hearings, they should be kept short, according to Sen. Kasten. Last year's hearings were "too long" and did not leave much time for a Senate debate, he said.

Sen. John D. Rockefeller IV, D-W.Va., one of the co-sponsors, says there is broad support for the bill in the Senate, reflected by the passage last year of S. 1400 by the Senate Commerce Committee (*BI*, May 28, 1990).

"We have never been in a situation where we have passed a bill out of the Senate Commerce Committee by a 13-7 vote and had all the same members back" the following year, he said.

The bill also was reported out of the Senate Judiciary Committee without recommendation last year (*BI*, Sept. 3, 1990; Aug. 20, 1990).

Sen. Rockefeller said a key reason that the Senate did not vote on product liability reform last year was that the measure was sent to the floor late in the year, when the Senate was focusing on the budget.

However, the senator said he is "absolutely convinced" that S. 640 has both the Republican and Democratic votes to pass this session.

However, Sen. Rockefeller said he does not believe that lawmakers will be influenced by the U.S. Supreme Court's recent ruling that punitive damage do not violate defendants' constitutional rights to due process and suggestions by several justices that Congress and state legislatures reform the current system of awarding punitive damage.

Sen. John Danforth, R-Mo., another co-sponsor, also predicts that this session "may be the charm" for product liability reform legislation.

However, "the chance of this legislation passing is directly proportional to the public's sense of outrage over the unfairness of the current system," he said.

Some insurer representatives, though, believe there is only a slim chance product liability reform legislation will be enacted this session.

Thomas O'Day, associate vp-federal affairs at the Alliance of American Insurers in Washington, D.C., said, "The bill has a long hard road ahead of it."

There still is strong opposition to product liability reform in the Senate, he said. But, the bill is passable if the majority leadership allows it to reach the floor, he said.

"You've got to have the chance to prove that you have the votes," Mr. O'Day said.

Peter Lefkin, vp-government affairs in the Washington, D.C. office of Fireman's Fund Insurance Co., said he does not see enough interest in Congress for product liability reform.

"I don't see any indication that it is a priority in Congress, which is unfortunate because there is a strong need for this bill," he said. "It should have been addressed by Congress for 12 years, but representatives won't vote for something that could come back and hurt them later."

Among other things, the Kasten bill would:

- Eliminate joint and several liability for non-economic damages.
- Shield a manufacturer from liability if the plaintiff was under the influence of an intoxicating drug or alcohol and that condition was at least 50% responsible for the accident.
- Make product distributors responsible for only the harm caused by their own negligences. They would be responsible for a manufacturer's negligence only if the manufacturer could not be brought to trial or did not have the funds to pay an award.
- Allow punitive damages only if there is clear and convincing evidence of negligence by the product distributor or manufacturer.

And, if grounds for punitive damages are found, the defendant could request a second trial to determine the amount of those damages.

- Prohibit punitive damage awards for injuries involving drugs and medical devices approved by the Federal Drug Administration or aircraft that has been certified by the Federal Aviation Administration.
- Encourage attempts at settlement before product liability litigation reaches trial.

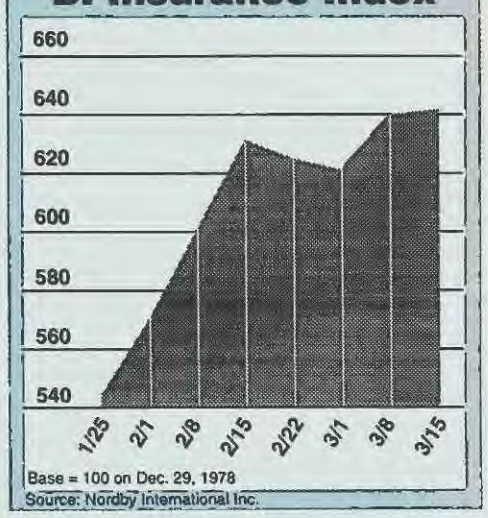
If a defendant rejects a plaintiff's offer and the subsequent verdict results in an award greater than the settlement offer, the defendant would be required to pay the plaintiff's legal fees.

If the plaintiff rejects a settlement offer and the resulting award is less than the settlement offer, the defendant's legal fees would be subtracted from the award.

- Allow any voluntary alternative dispute resolution mechanisms allowed by a state to be used as a means of resolving a suit. A party that refuses to use alternative dispute resolution and loses the case would be required to pay all legal fees.
- Reduce the amount of any product liability award by the amount of workers compensation benefits the plaintiff receives.
- Generally limit the time during which a product liability suit must be filed to within two years of discovering an injury or its cause.

The bill also would generally prohibit lawsuits involving capital goods products that are more than 25 years old. ■

BI Insurance Index



Insurance industry stocks rose last week as the *Business Insurance* stock index rose 1.2 points to 640.1 on March 15 from 638.9 on March 8. Advancing issues were led by Chandler Insurance Co., up 34.8%; Statesman Group Inc., up 11.1%; and Lawrence Insurance Group Inc., up 10.7%. Declining issues followed Safeguard Health Enterprises, down 9.3%; USLICO Corp., down 8.8%; and Frank B. Hall & Co. Inc., down 7.14%. The most active issue during the week was United Healthcare Corp. with 5.3 million shares traded. The *BI* index gained 0.3% for the week, while the Standard & Poor's 500 fell 0.4%; the Dow Jones 30 Industrials dropped 0.2%; and the New York Stock Exchange Composite lost 0.4%.

British Issues

March 14 Companies	Price pence	P/E	Div. pence	Yield %	1 Week High—Low pence pence
Comml Union	537	N/M	30.7	5.7	537—515
Genl Accident	563	N/M	35.7	6.3	572—559
Gdn Royal Exch	228	N/M	15.9	7.0	229—225
Royal	471	N/M	34.7	7.4	471—458
Sun Alliance	396	N/M	18.7	4.7	396—381
Brokers					
Bradstock	148	16.8	6.0	4.0	148—147
CE Heath	518	15.3	34.5	6.7	518—512
Hogg Group	192	12.8	10.6	5.5	192—190
Lloyd Thompson	347	23.1	10.0	2.9	347—340
PWS Holdings	94	11.4	4.7	5.0	95—94
Sedgwick Grp	257	24.7	16.0	6.2	257—248
Steel Brri Jones	305	16.9	16.0	5.2	305—295
Willis Corroon	308	16.2	17.6	5.7	308—303

Source: Philip Olsen, Insurance Industry Analyst London

EPA discovers simple, cheap way to eliminate PCBs

CINCINNATI—U.S. Environmental Protection Agency officials say they are optimistic that they have stumbled upon an inexpensive and simple way to eliminate highly toxic PCBs.

Researchers in Cincinnati are running tests to determine whether quicklime, a caustic material used to make cement and steel, could ultimately replace incineration as the most common way to destroy polychlorinated biphenyls, said Tim Oppelt, director of the EPA risk reduction engineering laboratory in Cincinnati.

Incineration, which has been criticized for releasing toxins into the air, costs at least $500 per cubic yard of PCBs. But, by mixing quicklime with PCB sludge, the toxins can be destroyed for $50 to $100 per cubic yard, researchers believe.

Since it was discovered by accident in 1987, the method has passed several preliminary tests, Mr. Oppelt said. Results are expected in several months from tests designed to determine whether the process is easily controlled.

The potential for using quicklime for eliminating PCBs was discovered at an Indiana oil refinery. Workers there had used quicklime routinely to thicken PCB-contaminated sludge to makes the sludge easier to burn, an EPA spokeswoman in Chicago said. But, as part of an experiment on treating the sludge with a different process to reduce PCB contamination, EPA officials for the first time measured PCB levels in the sludge months after the quicklime was added and discovered that the PCBs were gone, the spokeswoman said.

—By Laura Mazzuca

BI Industry Stock Report

MARCH 11, 1991 THROUGH MARCH 15, 1991

		Price	Weekly % change	Year to Date % change	Annual High	Annual Low	Vol.(000)	$ Div.	% Yield	P/E	Book value	Mkt/Bk. value
BROKERS												
Alexander & Alexander	NYS	26.50	1.92	14.59	28.88	16.13	208	1.00	3.77	20	9.18	2.89
Gallagher Arthur J. & Co	NYS	28.00	0.00	20.43	28.38	19.75	29	0.64	2.29	20	5.33	5.25
Frank B. Hall	NYS	3.25	-7.14	-10.34	4.25	2.00	103	0.00	0.00	-7	-2.80	-1.16
Hilb, Rogal & Hamilton	OTC	14.75	-0.84	0.00	16.50	11.25	185	0.36	2.44	20	4.60	3.21
Marsh & McLennan	NYS	79.38	0.16	1.76	82.00	59.75	829	2.60	3.28	19	10.56	7.52
Poe & Associates	OTC	10.00	0.00	25.00	13.00	7.75	0	0.40	4.00	10	2.40	4.17
BROKERS	AVERAGE		-0.3	7.3					2.3	12		
CONGLOMERATES & HOLDING COMPANIES												
Berkley W R. Corp	OTC	44.00	-4.86	17.33	46.50	28.50	176	0.44	1.00	14	25.06	1.76
Berkshire Hathaway Inc.	NYS	7950.00	0.63	19.10	8900.00	5675.00	0	0.00	0.00	25	2869.00	2.77
ITT (Hartford Group)	NYS	55.25	-2.86	15.10	60.88	40.25	1254	1.72	3.11	8	56.33	0.98
Sears (Allstate)	NYS	32.00	0.00	26.11	41.75	22.00	3832	2.00	6.25	12	37.75	0.85
CONGLOMERATES	AVERAGE		-1.6	19.4					2.6	15		
INSURERS/REINSURERS												
Aetna Life & Casualty	NYS	45.00	-1.10	15.38	54.38	29.00	1097	2.76	6.13	8	58.11	0.77
American Genera	NYS	37.50	-2.60	21.95	50.63	23.50	921	2.00	5.33	8	34.68	1.08
American Heritage	NYS	24.25	1.57	15.48	24.13	19.63	5	1.00	4.12	11	22.60	1.07
American Indemnity/Fin'l	OTC	6.50	-3.70	100.00	7.25	2.75	1	0.08	1.23	-20	17.38	0.37
American International	NYS	90.63	-3.33	17.89	96.25	57.00	1713	0.44	0.49	13	41.92	2.16
Aon Corp	NYS	35.38	-4.71	1.80	41.38	26.75	239	1.52	4.30	10	19.62	1.80
Argonaut Group	OTC	79.00	3.95	23.44	78.00	53.00	7	1.60	2.03	9	36.83	2.14
AVEMCO Corp	NYS	29.13	-0.85	15.35	30.13	21.13	16	0.44	1.51	18	9.52	3.06
Baldwin & Lyons Inc.	OTC	24.00	3.23	28.00	24.25	17.00	4	0.28	1.17	8	20.80	1.15
Belvedere Corp.	ASE	2.75	0.00	10.00	4.63	1.75	2	0.04	1.45	69	8.03	0.34
Chandler Insurance	OTC	3.88	34.78	-43.64	9.88	2.75	205	0.00	0.00	-5	9.53	0.41
Chubb Corp.	NYS	67.50	-2.70	24.42	70.25	34.63	1047	1.48	2.19	11	55.49	1.22
CIGNA Corp.	NYS	46.00	-5.40	12.54	55.50	33.25	1981	3.04	6.61	11	66.64	0.69
CNA Financial Corp.	NYS	84.00	0.00	22.40	92.50	49.50	183	0.00	0.00	15	54.87	1.53
Continental Corp.	NYS	27.38	-2.23	10.05	31.38	15.75	285	2.60	9.50	11	41.36	0.66
Durham Corp.	OTC	28.50	1.79	1.79	34.00	23.00	5	0.92	3.23	14	26.32	1.08
Fund American Corp.	NYS	59.88	-2.64	15.42	61.75	29.50	1097	0.68	1.14	24	32.74	1.83
Fremont General Corp.	OTC	17.50	-4.11	20.69	21.00	10.13	266	0.80	4.57	6	19.09	0.92
Frontier Insurance Group	NYS	22.50	1.12	18.42	33.00	15.38	21	0.00	0.00	9	7.29	3.09
General RE Corp.	NYS	95.38	-1.55	2.55	99.88	69.00	881	1.68	1.76	14	29.04	3.28
Hanover Insurance Co.	OTC	27.75	-3.48	4.72	30.25	21.00	918	0.44	1.59	11	32.03	0.87
Harleysville Group	OTC	28.00	-1.75	22.40	30.00	13.50	50	0.64	2.29	9	18.94	1.48
Hartford Steam Boiler	NYS	55.63	-0.89	14.10	62.13	43.50	179	0.00	0.00	-	18.94	2.94
Kansas City Life Ins.	OTC	33.50	0.00	8.50	36.50	30.00	8	1.20	3.58	9	39.22	0.85
Kemper Corp.	NYS	32.75	1.55	37.89	43.13	17.13	226	0.92	2.81	126	29.97	1.09
Lawrence Insurance Group	ASE	7.75	10.71	10.71	9.13	6.38	5	0.36	4.65	12	4.40	1.76
Liberty Corp.	NYS	41.00	-4.09	-0.30	50.25	39.00	25	0.92	2.24	13	31.82	1.29
Lincoln National	NYS	50.00	0.50	16.28	56.50	30.75	209	2.72	5.44	12	49.19	1.02
NAC Re Corp.	OTC	38.25	0.00	15.91	39.00	25.50	79	0.20	0.52	16	22.81	1.68
Navigators Group	OTC	41.00	3.14	25.19	41.00	24.75	3	0.00	0.00	16	15.22	2.69
Nobel Insurance LTD.	OTC	3.19	2.02	6.27	3.75	2.00	75	0.00	0.00	-	7.76	0.41
NWNL Companies	NYS	28.00	0.45	65.93	34.50	11.75	395	1.32	4.71	6	37.50	0.75
Ohio Casualty Corp.	OTC	40.88	-1.51	-0.30	50.00	26.75	358	2.48	6.07	9	33.30	1.23
Old Republic Int'l	NYS	28.00	0.00	22.40	29.00	19.00	64	0.76	2.71	6	30.70	0.91
Orion Capital Corp.	NYS	22.38	-0.56	27.86	23.00	13.00	99	0.92	4.11	8	19.72	1.13
Phoenix RE Corp.	OTC	9.63	6.94	24.19	11.75	5.00	24	0.20	2.08	120	12.99	0.74
Protective Life Corp.	OTC	17.25	-1.43	15.97	18.00	10.25	159	0.76	4.41	8	14.54	1.19
Provident Life	OTC	22.25	1.14	27.14	26.25	12.00	458	0.92	4.13	6	23.24	0.96
Re Capital Corp.	ASE	16.00	-1.54	24.27	17.00	11.75	31	0.00	0.00	11	14.43	1.11
RLI Insurance Corp.	NYS	16.25	0.00	12.07	16.38	9.50	32	0.44	2.71	8	12.42	1.31
St. Paul Companies	OTC	68.25	2.25	8.76	70.25	47.00	788	2.60	3.81	8	43.47	1.57
SAFECO Corp.	OTC	38.63	-1.59	17.49	40.50	25.13	895	1.36	3.52	9	24.87	1.55
SCOR U.S. Corp.	NYS	14.00	-2.61	13.13	15.25	8.38	19	0.20	1.43	10	10.61	1.32
Seibels Bruce Group	OTC	6.75	3.85	58.82	11.75	4.25	19	0.36	5.33	21	13.75	0.49
Selective Ins. Group	OTC	16.75	1.52	26.42	18.50	12.50	38	1.04	6.21	7	15.72	1.07
Statesman Group Inc.	OTC	2.50	11.11	59.95	3.00	1.25	162	0.00	0.00	-15	4.19	0.60
Tokio Marine & Fire	OTC	51.00	4.08	7.94	56.50	34.50	96	0.26	0.51	30	70.93	0.72
Torchmark Corp.	NYS	55.75	0.22	14.07	56.13	38.00	238	1.40	2.51	13	13.23	4.21
Transamerica	NYS	38.13	4.45	16.86	41.00	23.25	914	1.96	5.14	12	34.63	1.10
Travelers Corp.	NYS	23.50	3.87	41.35	34.38	11.50	1704	1.60	6.81	-13	44.85	0.52
Trenwick Group Inc.	OTC	25.00	-5.66	8.11	27.50	16.25	97	0.60	2.40	10	16.91	1.48
United Fire & Casualty	OTC	42.75	0.00	21.71	43.00	28.75	2	1.32	3.09	7	22.56	1.89
USF&G Corp.	NYS	10.25	6.49	36.67	29.50	7.00	3137	0.20	1.95	-2	22.87	0.45
UNUM Corp.	NYS	59.00	0.43	26.54	63.00	32.13	210	0.80	1.36	11	31.20	1.89
USLIFE Corp.	NYS	36.00	3.60	28.57	41.75	23.25	148	1.48	4.11	8	54.34	0.66
Unitrin	OTC	37.75	-1.95	22.76	40.25	24.50	331	0.80	2.12	16	33.99	1.11
Washington National	NYS	13.38	-0.93	22.99	24.13	9.38	22	1.08	8.07	-15	32.90	0.41
USLICO Corp.	NYS	18.25	-8.75	14.96	23.00	14.75	14	1.00	5.48	8	27.73	0.66
Zenith National Ins.	NYS	17.00	-2.86	24.77	18.25	9.88	66	1.00	5.88	-33	13.81	1.23
INSURERS/REINSURERS	AVERAGE		1.2	25.4					3.2	13.0		
HEALTH MAINTENANCE ORGANIZATIONS												
FHP International	OTC	22.25	0.00	45.90	23.25	9.75	1061	0.00	0.00	18	3.54	6.29
HMO America Inc.	OTC	9.25	2.78	42.31	9.38	4.25	610	0.00	0.00	13	1.12	8.26
Pacificare Health Sys.	OTC	23.75	8.57	46.15	26.00	12.00	339	0.00	0.00	16	6.35	3.74
Safeguard Health Enter.	OTC	4.88	-9.30	2.63	7.63	4.00	4	0.00	0.00	15	2.99	1.63
Sierra Health Services	ASE	21.63	-4.42	57.27	22.88	5.50	180	0.00	0.00	64	0.62	34.88
United Healthcare Corp.	OTC	32.63	4.40	40.32	33.88	9.13	5347	0.06	0.18	26	0.34	95.96
United Medical Corp.	ASE	9.38	-1.32	17.19	11.38	6.63	4	0.20	2.13	12	5.70	1.64
U.S. Healthcare	OTC	44.50	9.20	51.49	43.25	11.13	3127	0.48	1.08	27	3.07	14.50
HMOs	AVERAGE		1.2	37.9					0.4	24		
ALL COMPANIES	AVERAGE		0.8	24.1					2.7	14		

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