

Reporting weekly for corporate risk, employee benefit and financial executives / \$2.00 a copy; \$75 a year

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Source: National Council on Compensation Insurance and state rating bureaus.

BI/John Smither

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Update

AmBase asks Manley to resign

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Meenaghan, The Home's president and CEO, was also named chairman of the insurance unit.

Mr. Manley remains an AmBase director.

Mr. Manley's \$1.8 million salary made him the second highest-paid insurance executive in 1988. A \$3 million interest-free loan from the company remains unpaid (BI, Aug. 28, 1989).

While an AmBase spokesman said that Mr. Manley's severance will be negotiated this week, AmBase's 1989 proxy statement says that certain AmBase officers—including Messrs. Manley, Scharffenberger and Meenaghan—would be entitled to a payment equal to approximately three times "their current or average annual compensation" if the officer is terminated, resigns for "good reason" or, in certain cases, if the company is acquired.

The decision to request Mr. Manley's resignation reflects an acknowledgment of his failure to make AmBase a financial conglomerate, the spokesman said.

Giving Mr. Scharffenberger control of the three insurance units reaffirms the board's decision to sell them, the spokesman said.

A source said Mr. Manley may form an investment group to buy AmBase Corp.; its securities brokerage unit, New York-based Gruntal Financial Corp.; or its savings and loan unit, Carteret Bancorp in Morristown, N.J. Mr. Manley is uninterested in the insurance units, the source said.

Allianz in East German venture

BONN, West Germany—Allianz A.G., West Germany's largest insurance company, is forming a joint venture with East Germany's sole, state-run life, liability and accident insurer, Staatliche Versicherung der DDR.

The new company—in which Allianz and Staatliche will be the sole insurer shareholders—will be named Deutsche Versicherungs A.G. and have its headquarters in West Germany, Allianz stated.

The agreement to form the joint venture follows the East German government's recent approval of a plan to privatize Staatliche. Allianz says it will support the East German insurer as it adapts to a free-market system.

Staatliche reported total premium income of 7.5 billion East German marks at year-end 1989, of which 3.9 billion marks came from life insurance. Assuming a one-to-one exchange rate with the West German deutsche mark, Staatliche's 1989 premium income was \$4.44 billion, of which \$2.31 billion came from life insurance.

Bendectin award overturned

WASHINGTON—A federal appeals court has overturned a \$20 million jury award against Merrell Dow Pharmaceuticals Inc., ruling that data did not show any "significant" connection between Dow's anti-nausea drug Bendectin and birth defects.

The court also upheld the district court judge's decision to throw out \$75 million in punitive damages.

In the suit, a 10-year-old boy's family claimed Bendectin caused his birth defects.

A spokesman for Cincinnati-based Merrell Dow, a unit of Dow Chemical Co. of Midland, Mich., said the company was not surprised by the appeals court decision because the safety of Bendectin has been reaffirmed many times.

Last year, the U.S. Supreme Court let stand a federal court ruling dismissing hundreds of bodily injury claims against the drug manufacturer (BI, Jan. 16, 1989).

Bendectin, once widely prescribed to pregnant women for morning sickness, was taken off the market in 1983.

Group seeks health care reform

WASHINGTON—More than 35 major corporations, labor organizations and consumer groups have formed a new coalition to press for reforms of the nation's health care delivery system.

The group—known as the National Leadership Coalition for Health Care—says it intends to develop a comprehensive health care plan to achieve universal access with emphasis on built-in cost control elements, a sound financing plan and administrative simplification.

"Only major structural and systematic reform is the answer. We must get business, labor, government providers, insurers and consumers working together in a coordinated effort for comprehensive change," the coalition said.

Members include: American Telephone & Telegraph Co., Ford Motor Co., Marriott Corp., Lockheed Corp., the Communications Workers of America and the United Steelworkers of America.

Former Iowa Gov. Robert D. Ray and former Rep. Paul Rogers, D-Fla., are chairmen.

PRMC award payment ordered

CHICAGO—A Chicago federal judge has ordered Harris Trust & Savings Bank to turn over to Pacific Reinsurance Management Corp. \$7.2 million held in trust for Ohio General Insurance Co. to satisfy a 1988 arbitration award.

Ohio General is a successor company to Ohio Reinsurance Corp., one of six reinsurers ordered to pay contested balances to PRMC, the defunct reinsurance pooling unit of Mission Insurance Co.

The Ohio Insurance Department, which placed Ohio General in rehabilitation last month, has not decided whether to appeal the order (BI, Feb. 26).

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Errors & omissions

• The types of services reviewed by Philadelphia-based TAO Inc. were incorrectly identified in the directory of utilization review providers in the Feb. 19 issue. TAO reviews only psychiatric and substance abuse services.

Bank investment contracts may retain FDIC coverage

By JUDY GREENWALD

WASHINGTON—In an apparent setback for the life insurance industry, the Federal Deposit Insurance Corp. is recommending that it continue to insure bank investment contracts, which are emerging as a major force in the \$150 billion guaranteed investment contract market.

The insurance industry, however, plans to continue its efforts to eliminate, or significantly reduce, federal coverage for the contracts.

BICs are bank deposits that, although technically different from guaranteed investment contracts underwritten by insurance companies, operate similarly.

An estimated 75% to 85% of funds invested by defined contribution pension plans are in GICs and BICs (BI, Oct. 16, 1989).

BICs make up only a small per-

centage of the overall defined contribution plan investment market, but observers estimate that they may account for as much as one-third of the new contracts being written.

At issue is whether the FDIC should insure BICs for up to \$100,000 per employee in a defined contribution plan that invests in BICs. This is known as "pass-through" coverage.

Insurance companies contend that banks' ability to promote FDIC coverage for BICs gives them an unfair competitive advantage over insurers, whose GICs are not federally insured. Insurers also assert that federal insurance on BICs represents an additional danger to a banking system already threatened by a shaky savings and loan industry.

Banks, for their part, say the danger is minimal. They also say

that FDIC coverage encourages competition on investment contracts, which enables defined contribution plan sponsors to obtain better rates.

In addition, security for plan participants is improved by FDIC coverage, which encourages plan sponsors to diversify investments beyond insurer GICs, banks contend.

The FDIC studied the issue of pass-through insurance coverage for BICs in compliance with the Financial Institutions Reform, Recovery and Enforcement Act of 1989 (BI, July 3, 1989, May 22, 1989).

Its study, submitted to Congress last month, points out that the FDIC provided pass-through coverage for bank deposits of most pension plans and other "trusteed" employee benefit plans for several decades.

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Texas work comp reform Bill's backers fear changes by trial lawyers

By MICHAEL BRADFORD

AUSTIN, Texas—An architect of the Texas workers compensation reform law and workers comp insurers vow to protect the reforms from any attempted amendments.

A legislator who led the state's workers comp reform movement as well as workers comp insurers fear that trial lawyers in particular might seek changes.

Insurers also took a few swipes at the state plaintiffs' bar during a one-day seminar sponsored by the Alliance of American Insurers late last month.

Trial lawyers, however, deny they are plotting to ambush insurers and the new legislation. Insurers, they say, will eventually learn for themselves that added costs imposed on insurers will make the law

unworkable.

Insurers also face much greater regulatory scrutiny under the new law, noted a state workers compensation regulator.

Gov. Bill Clements has called the workers comp reform bill passed last December "the most significant piece of legislation to come out of the Texas Legislature in 20 years" (BI, Dec. 18, 1989).

The reform law, which takes effect Jan. 1, 1991, scrapped most of the state's unusual trial de novo system, which has led to nearly all Industrial Accident Board decisions being challenged with an appeal for a jury trial; limits doctor shopping by workers; allows large employers to self-fund workers comp risks beginning in 1993; and requires the use of an impairment

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Business blasts government panel report

Parental leave endorsed

By MICHAEL SCHACHNER

WASHINGTON—Employers are criticizing a government panel's recommendation to require employers to offer one-year unpaid leaves with continued health care coverage and guaranteed job protection to parents with a newborn or newly adopted child.

The National Research Council last week also suggested that employers assume more responsibility

in assuring that their workers have access to high-quality child care. The panel suggested that employers assist employees in accessing child care resource and referral networks, provide full or partial vouchers for child care expenses and create pretax spending accounts for child care.

The NRC, an arm of the National Academy of Sciences, did not estimate what its proposals, if implemented, would cost employers.

"Child care must be viewed as an investment in the health and development of children in America," said John Palmer, panel chairman and dean of Syracuse University's Maxwell School of Citizenship and Public Affairs.

By the year 2000, the mothers of about 80% of school-age children and 70% of preschoolers will work or be looking for work outside the home, according to the NRC.

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Inside

✓ Risk managers in California must become more 'aggressive' in fighting insurance reform, says the new president of the Los Angeles Chapter of RIMS. **PAGE 7**

✓ The Pepper Commission's recommendations, while well-intentioned, would cause more problems than they would solve, says this week's editorial. **PAGE 8**

✓ A golf tournament sponsored by the Memphis Chapter of RIMS unexpectedly has turned into an extremely successful fund-raiser for insurance education. **PAGE 10**

✓ Employee benefit plans should be re-cast in light of major social and economic changes, a consultant says at a LOMA conference. **PAGE 12**

✓ The lack of a well-conceived plan of operation can lead to failure in structured settlements, says Michael J. Casey of Ringler Associates in Perspectives. **PAGE 24**

✓ France's largest insurer believes Europe will constitute the single most important insurance market after European Community trade barriers fall. **PAGE 29**

✓ Insurance brokers should benefit in 1990 from a year

of stable to rising premium rates, says analyst Leonard M. Wilson. **PAGE 39**

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Mounting health costs spur creativity

By JERRY GEISEL

Small firms must 'get involved and do more'

While small employers around the country are being squeezed by a tight market for group health insurance and clobbered by soaring premiums, about 3,000 small Rhode Island companies have access to secure and, in some cases, less costly coverage.

The firms can obtain health coverage on preferential terms from two Rhode Island-based health maintenance organizations by paying a \$75 first-year fee and a \$60 fee in succeeding years to The Good Neighbor Alliance Corp. The alliance, based in Cranston, R.I., is a small business service agency that contracts with the HMOs. The agency operates for profit.

Alliance members, which also include a couple hundred members in Connecticut and Massachusetts, can obtain coverage from the HMOs without meeting minimum employee counts, and the coverage is less expensive than the employers could obtain from commercial insurers and in some cases less costly

than coverage available from HMOs.

While the Alliance program illustrates how small employers can band together to obtain health insurance on more favorable terms, some small firms are independently taking action to try to stem the rising tide of health care costs.

For example:

- Panel Processing Inc., an Alpena, Mich., manufacturer of wood panel components with 176 employees, cut annual health care costs \$60,000 to \$70,000 by self-funding, establishing a flexible benefit program and instituting other cost management measures.

"We couldn't sit on our thumbs and do nothing with the way costs are rising. We had to take action, and now we are saving

substantial sums of money," said Phil Hitchcock, executive vp.

- Sandmeyer Steel Co., a stainless steel products manufacturer in Philadelphia with 160 employees, is saving between \$10,000 and \$20,000 a year in costs by self-funding its health care program.

"We would rather pay claims as they come in, rather than let an insurance company earn investment income on our premium," pointed out Ron Sandmeyer, vp-finance and administration of the 38-year-old family-owned business.

- Perrysburg, Ohio-based Master Chemical Corp., which blends fluids for metal cutting, has experienced only 5% average annual health care cost increases since 1983

because of cost-containment techniques like self-funding, adopting a flexible benefit plan and giving employees cash rewards for spotting hospital billing errors.

"You have to get involved and do more than say, 'Oh, no!' after a big rate increase," said Ron Sladky, vp-finance at the 125-employee firm.

These programs are among the initiatives nationwide identified by the Washington, D.C.-based National Assn. of Manufacturers that are being taken to control health care costs. A previous story profiled companies that have set up in-house medical clinics (BI, March 5), while future stories will report on other cost containment strategies.

Small employers' success in holding down health care costs has implications beyond their bottom lines.

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Genetic damage from DES alleged

By MARK A. HOFMANN

WASHINGTON—In the first case of its kind against a DES manufacturer, the son of a woman who ingested an anti-miscarriage drug made by Eli Lilly & Co. contends the drug genetically altered him, causing a rare cancer in his daughter.

While other suits have alleged that DES has injured grandchildren of women who ingested the drug, (BI, Sept. 29, 1986), "this is the first case" alleging the drug caused genetic mutation in a child and that this mutation caused a grandchild's injury, explained plaintiff's attorney Aaron M. Levine of Aaron M. Levine & Associates in Washington, D.C.

Defense attorney Jay Mayesh of Stroock & Stroock & Mayesh in New York, who has represented other DES manufacturers in suits filed by daughters of women who took the drug, also believes this is the first suit of its kind against a DES manufacturer.

Mr. Levine said no one has any idea of how widespread the problem might be. One case, though, is "by no means proof of an epidemic," acknowledged Mr. Levine, who filed the suit March 12 in U.S. District Court in the District of Columbia on behalf of an Olney, Md., Methodist minister.

The plaintiff, J. David Roberts, is seeking \$2 million in compensatory damages and \$2 million in punitive damages, contending Lilly caused him emotional distress by marketing a drug it knew was harmful and withholding adverse reports about the drug's safety.

However, product liability defense attorneys say medical evidence does not support the charge that DES causes mutation of children of women who ingested the drug and subsequent injuries to the women's grandchildren.

They also say that it is unlikely that Lilly or any of the 300 other DES manufacturers could have known 40 years ago that the drug would be harmful to the children and grandchildren of women who would ingest it.

A spokeswoman for Indianapolis-based Lilly said the company had not seen the suit as of late last week.

But, she said: "We believe that

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PCB cleanups lag as deadline nears

By MICHAEL BRADFORD

Some owners of high-voltage transformers will be racing to meet an Oct. 1 deadline for removing or dramatically lowering levels of PCBs in the units, despite years of widespread publicity about the federal regulation.

Some transformer owners that have not already begun removing polychlorinated biphenyls may miss the deadline, imposed by the U.S. Environmental Protection Agency in 1985, because the process of removing the toxic chemical can take several months to up to two years, experts say.

Compounding the problem for some companies and public entities is uncertainty over whether they or the local electric utility actually own a contaminated transformer.

The EPA, however, is not sympathetic toward transformer owners that are pushing to meet the deadline.

"There were five years to prepare, which we think is certainly adequate," said an EPA spokeswoman in Washington, D.C.

However, an EPA spokesman in Dallas said the agency is optimistic that transformer owners will meet the deadline.

"If they don't, there can be some pretty stiff fines," he said.

Violators face daily fines of up to \$25,000, and individuals convicted of violating the federal law could be sentenced to a year in prison.

The cost of treating transformers to remove the PCBs or replacing contaminated transformers ranges from \$20,000 to more than \$50,000 per transformer, and some companies have spent millions of dollars to comply.

But, many businesses and public entities are confused or are unaware of the regulation, according to Marla Jeane Motter, manager of market development for ENSR Operations in Canton, Ohio, a division of Acton, Mass.-based ENSR Corp. that treats PCB-contaminated transformers.

"We've talked to a huge number of commercial property owners and very few were aware of the PCB regulations," she said.

"There will probably be some problems in meeting the deadline," agreed Fred Potenza, executive vp of risk management consulting services at Gallagher Bassett Service Inc. of Rolling Meadows, Ill., a unit of Arthur J. Gallagher & Co.

Arnie Sugar, project manager for ECOVA Corp., a Dallas company that treats PCB-contaminated equipment, said that while most of his clients will meet

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Detoxification of PCB-contaminated high-voltage transformers is a complex job that can take up to two years to complete.

Photo courtesy of ENSR Operations

Airline reinsurers may force rates up

By STACY SHAPIRO

LONDON—Aviation insurance underwriters may be forced by their reinsurers to increase airline hull and liability insurance rates during the last quarter of this year when 75% of the world's airlines renew their coverage, says a London reinsurer.

But if aviation insurance rates do shoot up as they did in 1986, airlines will retain more of the coverage through captives, an airline risk manager promised.

"Reinsurers, I am convinced, are going to be making insurers aware that unless they start moving the premiums in the right direction, then the costs imposed upon them by their reinsurers will be totally unaffordable as the year continues" and especially next year, cautioned Tim Dumenil, aviation underwriting manager for Zurich Re (U.K.) Ltd.

Mr. Dumenil delivered his prediction to risk managers of major airlines and leading aviation brokers and underwriters at the Fifth Airline Insurance Conference, sponsored earlier this month in London by Insurance & Reinsurance Research Group Ltd.

Airlines "will be forced to retain more, forced to pay more, or be forced to retire to the sick bay," Mr. Dumenil said. "Reinsurers can no longer foot the bill at the rates and premiums in the world today. If no more money is going to be

paid, then there can only be a knock-on effect."

However, Ralf Oelssner, director of corporate insurance for Lufthansa German Airlines and president of Airline Mutual Insurance Ltd. in Bermuda, an airline industry-owned captive, warned that if rates skyrocket, airlines will take remedial action.

He cautioned underwriters that if they increase rates at the end of the year or the beginning of next year, "Don't overdo it."

Otherwise, "there will be high self-retentions kept by the airlines (and) increased use of captives," Mr. Oelssner said.

A Lloyd's of London aviation underwriter asked what Mr. Oelssner would consider "over-reaction in rating terms."

"Airlines want rates to be based on their merits," Mr. Oelssner replied, meaning that airlines should be charged a rate that is based on their individual loss history.

"I support this," said another airline insurance manager in the audience. "Where we feel some frustration is when underwriters overdo it downwards and upwards. Quite a bit of our frustration is lost when we know we are being rated on our merit."

But Peter Crawford, managing director of Aviation & General Insurance Co. Ltd. in London, said that underwriters could be forced to increase rates to cover escalating claims costs. Therefore, "it will be difficult to give individual

rating," he said.

Airline hull and liability insurance rates rose rapidly in 1986, when rates increased by as much as 300% for some airlines. The rate hikes pushed total world airline premiums to \$1.2 billion in 1986, while claims only totaled \$350 million, according to Mr. Crawford (BI, Feb. 2, 1987).

In sheer frustration, the International Air Transport Assn. in 1986 set up Airline Mutual Insurance in Bermuda, managed by Thomas R. Miller & Son (Bermuda) Ltd., to fight against the rate increases (BI, Nov. 17, 1986).

As of last week, 37 companies operating 75 airlines belonged to AMI, said a Thomas R. Miller spokeswoman.

However, airline insurance rates have been falling ever since 1986. According to IRRG, which sponsored the conference, net worldwide airline premium income in 1987 totaled \$950 million, while claims totaled \$1 billion; in 1988 premiums totaled \$650 million while claims totaled \$1.25 billion; and in 1989 estimated premiums totaled \$350 million while claims totaled \$1.1 billion.

"It is likely that premiums in 1989 will be exceeded by claims by 200% to 300%," said Mr. Crawford of Aviation & General. "Adequate premium will have to be paid for the cover," he added.

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Satellite loss not covered

By STACY SHAPIRO

LONDON—Insurers are not expected to pay any portion of last week's loss of a telecommunications satellite worth more than \$250 million, even though a co-owner of the satellite had purchased launch insurance.

The board of governors of the International Telecommunications Satellite Organization, a consortium of national communications companies that owned the satellite, had recommended that the partners not insure the satellite because satellite insurance rates were too high, insurance sources confirmed.

Satellite launch insurance rates, which have been as high as 30% of the value of a satellite, now range between 16.5% and 20% of a satellite's value (*BI*, March 5).

However, Communications Satellite Corp. in Washington D.C., a partner in Intelsat, decided to buy launch insurance, led at Lloyd's of London, for its 26% share in Intelsat's satellites, sources say.

Comsat's policy, though, covers the U.S. communications company for two satellite losses above a one-loss "deductible." Because last week's loss is the first loss under the program, insurers will not have to indemnify Comsat, sources confirm.

Comsat's portion of last week's loss is \$66 million.

Comsat's coverage was placed by Corroon & Black Inspace Inc. of Bethesda, Md., a unit of Corroon & Black Corp., and Lloyd's broker Crawley Warren & Co. Ltd. in London.

Sources did not know whether other Intelsat members had purchased coverage on the satellite, which failed to reach proper orbit after its March 14 launch from Cape Canaveral, Fla. The Intelsat satellite failed to separate on the final stage from a Titan 3 rocket owned and operated by Martin Marietta Corp. of Bethesda, Md.

The disaster followed the destruction late last month of two satellites when an Ariane rocket exploded. The probes were insured for about \$95 million each.

BI announces changes in Chicago, L.A. staff

Two *Business Insurance* staff members have been promoted and two new copy editors have been hired in the Chicago office, Associate Publisher and Editor Kathryn McIntyre has announced.

Joanne Wojcik, formerly copy desk chief in Chicago, has been named Los Angeles bureau chief, effective April 2. She replaces Donna DiBlase, who took an employee benefits consulting position with Hewitt Associates in Santa Ana, Calif.

Paul Winston, a copy editor who has been with *Business Insurance* since 1935, will succeed Ms. Wojcik as copy desk chief.

In addition, Colleen Johnson and Nancy Johnson have joined *BI* as copy editors.

Ms. Wojcik, who joined *Business*

Insurance as an assistant copy editor in 1985, was promoted to copy editor in 1986 and to copy desk chief in 1988.

She previously had been an assistant news editor at The Daily Sentinel in Grand Junction, Colo., and a reporter at the Delta County Independent, in Delta, Colo. Before moving to Colorado in 1981, Ms. Wojcik was an editorial production assistant at *BI*.

Ms. Wojcik, 32, received a bachelor of arts degree in English from the University of Illinois at Urbana in 1979. She can be reached at 213-651-3710.

Mr. Winston, 27, joined *Business Insurance* in 1985 as a proofreader and was promoted to assistant copy editor in 1986 and to copy editor in 1988. He previously was a columnist for Lerner Newspapers in Chicago and served as an editorial intern for Rolling Stone magazine in New York.

Mr. Winston received a bachelor of arts degree in English composition from DePauw University in Greencastle, Ind., in 1985. He can be reached at 312-649-5442.

Colleen Johnson, 26, joins *Business Insurance* from the Sarasota Herald-Tribune in Sarasota, Fla., where she was a metro copy editor and a city desk reporter covering the legal beat. She also has been a reporter at Florida Today in Melbourne, Fla., and an intern with the Detroit News and The Pittsburgh Press.

Ms. Johnson received a bachelor of science in journalism degree in 1985 from Northwestern University's Medill School of Journalism in Evanston, Ill. She can be reached at 312-649-5441.

Ms. Johnson replaces Karen Huelsman as a copy editor. Ms. Huelsman left *BI* in January to join the Chicago Sun-Times as a copy editor.

Nancy Johnson, 35, who is not related to Colleen Johnson, comes to *BI* from Practice Development Institute, a Chicago management and marketing consultant, where she wrote and edited newsletters covering employee benefits and other topics.

Before that, Ms. Johnson was an associate editor at Charles D. Spencer & Associates, publishers of Employee Benefit Plan Review and other periodicals. At Spencer, Ms. Johnson was responsible for a monthly publication focusing on international benefits topics. She also has taught journalism and literature at a North Dakota high school.

She received a bachelor of arts degree in English from North Dakota State University in Fargo in 1979 and a bachelor of science degree in English education from Minot State University in Minot, N.D., in 1984. She can be reached at 312-649-7784.

Ms. Johnson succeeds Mr. Winston as a *BI* copy editor.



Ms. Wojcik



Mr. Winston



Ms. C. Johnson



Ms. N. Johnson

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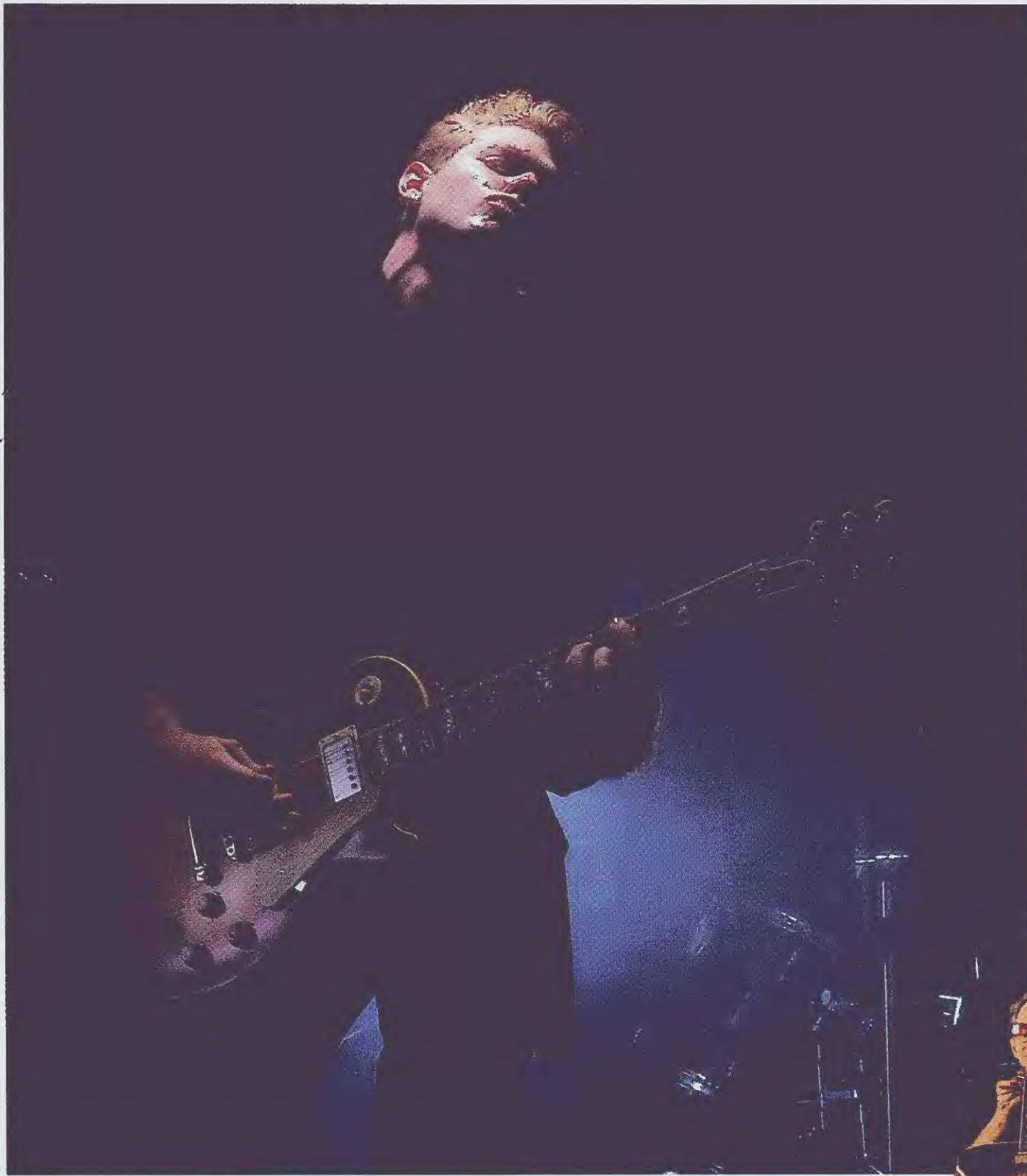
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For Gibson, that's been a sound decision.

With Wausau's help, Gibson has achieved Highly Protected Risk status.



WAUSAU INSURANCE

Lockheed pact includes higher deductibles

By MICHAEL SCHACHNER

Union members at Lockheed Corp. will see deductibles for health care coverage increase, although annual out-of-pocket expenses will be capped, under a new contract.

The 41-month contract, signed March 5 but retroactive to Oct. 1, 1989, covers 18,000 members of the International Assn. of Machinists & Aerospace Workers at four locations—Burbank, Palmdale and Sunnyvale, Calif., and Marietta, Ga.

The benefit changes take effect Aug. 1 and are expected to reduce the rate of increase in Lockheed's health care costs by 12%, said Lou Barnard, vp-human resources for Calabasas, Calif.-based Lockheed.

Mr. Barnard said Lockheed spent \$179 million on health care for its 81,000 union and non-union employees last year. Lockheed self-insures its medical plan.

Under the new contract, health care deductibles will double to \$200 for individual coverage and \$400 for family coverage. Employees will be required to pay 20% of costs above the deductible, unchanged from the expired contract.

However, the new contract will cap employees' annual out-of-pocket expenses for all medical services, whereas the 20% copayment previously was unlimited.

Employees using health care providers in a Lockheed preferred provider network now will only have to pay 20% of medical expenses up to \$1,000 in excess of the deductible for individual coverage and \$2,000 for family coverage.

Out-of-pocket maximums for non-network medical care are \$2,000 in excess of the deductible for individual coverage and \$4,000 for family coverage.

The contract would also:

- Caps annual and lifetime benefits for mental health and nervous disorders and substance abuse and chiropractic care, for which it now provides first-dollar coverage.

For example, mental health benefits will be capped at \$50,000 per year and \$100,000 per lifetime under the new contract. Substance abuse payments will be capped at \$10,000 per year and \$20,000 per lifetime. And chiropractic care benefits will be capped at \$750 annually. Those benefits were uncapped under the expired contract, according to Mr. Barnard.

- Ties health care coverage for employees who retire before age 65 to their years of service. Under this provision, Lockheed will pay 3% of an employee's medical expenses for each year of service up to 90%.

Under the expired contract, employees who retired before age 65 paid 20% of medical costs, plus \$10 per month for individual coverage and an additional \$10 per month for spouses.

- Creates a non-leveraged employee stock ownership plan.

The ESOP is to replace Lockheed's thrift savings plan July 1. Employees will be able to contribute up to \$40 per month, with Lockheed matching contributions at a 60% rate—or up to \$24 per month—in common stock.

Under the existing savings plan, company matching contributions were made in cash at 50%—or up to \$20 per month.

UHC ESOP

Employees of United HealthCare Corp. will soon begin receiving shares of common stock under a new non-leveraged employee stock ownership plan funded entirely by UHC profits.

The ESOP, created Feb. 16, will purchase company stock on the open market and allocate it period-

Benefit beat

ically to individual accounts.

Minneapolis-based UHC, a health care cost management firm, has contributed \$500,000 to the ESOP to use in buying stock.

ESOP shares will be distributed to employee accounts on the basis of employees' salaries. However, employees who earn more than \$75,000 annually will receive contributions based only on \$75,000 of yearly earnings.

Stock credited to employees' accounts will be vested over a seven-year graded schedule and distributed to the employee only upon leaving the company. UHC employees who have been with the company for longer than a year

before October 1989 will be vested based on their length of service with the company.

UHC stock was selling for \$9.63 per share on March 14.

Hospital charges

Petroleum industry workers generate the highest average inpatient hospital charges per employee among workers in six industries, according to an Employer Health Care Data Center survey.

Petroleum workers had average annual inpatient charges of \$612, compared with \$562 of inpatient hospital charges generated by chemical industry workers; \$535

for computer workers; \$500 for industrial machinery and food laborers; and \$487 for finance industry employees, according to the survey by EHCDC, a unit of Westport, Conn.-based Corporate Health Strategies.

The survey was based on the health care experience of 42 employers from the six industries. About 75% of the employers were self-insured and their claims were handled by New York-based Metropolitan Life Insurance Co. The remainder had health care plans insured by Met Life.

Overall, the plans covered more than 800,000 lives during 1988.

Petroleum industry workers also utilized inpatient health care services more than any other group on average. The industry's admission rate per 1,000 lives was 82.7, fol-

lowed by 75.6 in the finance industry; 72.6 for computer workers; 72.4 for food workers; 70.8 among chemical employees; and 69.9 for industrial machinery workers.

The survey also found that the average length of stay for inpatient treatment is longest in the chemical/pharmaceutical industry—7.5 days. Other average lengths of stay were 7.4 days for petroleum industry workers; 7 days for machinery industry workers; 6.9 days for computer industry workers; 6.5 days for finance industry workers; and 5.8 days for food industry workers.

"Industry Experience and the Nature of Norms: Some Pitfalls and Opportunities for Cost Management Strategy," is available for free from Employer Health Care Data Center, Corporate Health Strategies, 276 Post Road West, Westport, Conn. 06880. ■



What line of property/casualty insurance is hardest to buy?



Ralph F. Perry
Director-risk
management
DHL Airways
Inc.,
Redwood City,
Calif.

Observing things from a new job and without having gone through a renewal, I foresee directors and officers liability as the toughest type of insurance to buy because we are a privately held company. However, in terms of putting together a satisfactory insurance package, workers compensation coverage is difficult to purchase to our advantage.



Barry Glaser
Director-risk
management
Control Data
Corp.
Minneapolis

Given the soft, pliable marketplace today, the problems of purchasing coverage are few and far between. The biggest difficulty is in communicating your risk to underwriters.



Cheri J. Hawkins
Director-
insurance
Weyerhaeuser
Co.,
Tacoma, Wash.

Professional liability is the toughest line to buy, especially since we use both traditional markets and alternative financing facilities. Not only do annual renewals require voluminous complex applications and attachments, but the excess traditional markets refuse to follow form or drop down over alternative facilities, thus creating potential gaps in layering.



Richard A. Hundza
Risk manager
Southdown
Inc.,
Houston

I have no tough line of insurance to buy. One line is impossible to buy—pollution. And two lines, directors and officers liability and excess liability, are more expensive than I would prefer.

Compiled by Christine Woolsey

Risk exec warns of insurance reforms

By LOUISE KERTESZ

LOS ANGELES—Risk managers in California must become more "aggressive" in fighting insurance reform that could spell "the beginning of the end for the risk management community," asserts a new RIMS chapter president.

For example, risk managers in California have kept too low of a profile on Proposition 103 and on suggestions of requiring employers to offer health insurance to workers, says Ted Jones, new president of the Los Angeles chapter of the Risk & Insurance Management Society Inc.

In his inaugural address earlier this year, Mr. Jones noted that neither the California insurance commissioner nor the insurance industry sought risk managers' input "when Proposition 103 was bouncing about."

But, "neither the chapter nor RIMS national took any action to voice their opinions about all the propositions that were being put on the ballot," noted Mr. Jones, administration director at Sunkist Growers Inc. in Sherman Oaks, Calif.

"Let's make no mistake that with the passing of Proposition 103, California is now a state with legislated insurance. I'm also told that this year a proposition on health and benefit insurance will be put on the ballot. If that passes, which is very likely, we then will have legislated liability insurance, property insurance, auto insurance, benefits and health insurance."

And, while Gov. George Deukmejian will not endorse a report from two Cabinet secretaries that suggests mandated employer-provided health care, the state Legislature is expected to consider such legislation (BI, March 12).

"There is also a strong rumor of a proposition for making workers comp state-owned and run," Mr. Jones said.

"My concerns are that if all this insurance becomes legislated, what will we need risk managers for?" he asked.

"We've been overlooked too long, and it's especially important to get involved now that our industry is being chipped away," Mr. Jones said in an interview last week.

Mr. Jones also believes it is important to foster more cooperation among risk managers, brokers, insurers and consumer advocates, perhaps through "some kind of advisory council" consisting of representatives from each group.

And, such an advisory council "should be consulted by the insurance commissioner," on such issues as premium increases in an effort to modify the wild swings when the soft market hardens, he said.

If an advisory council takes shape in Los Angeles, Mr. Jones plans to seek involvement of other RIMS chapters in California.

Mr. Jones—who is disappointed that no risk manager is running for California's insurance commissioner—also believes risk managers must "become an important voice" in the November election.

The Los Angeles RIMS chapter consists of about 160 member corporations, making it the second-biggest chapter in the country, behind the New York chapter.

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Opinions

Pepper proposals misfire

REGRETTABLY, recommendations hammered out by a blue-ribbon commission to improve access to health care coverage are a major disappointment.

Earlier this month, the bipartisan Pepper Commission, after more than a year of study, recommended that all employers with more than 100 employees be required to offer a health care plan meeting federal standards or be subject to a new payroll tax.

In addition, this same mandate would apply to smaller firms unless, after a transition period, at least 80% of employees at small companies receive health care coverage from their employers.

The Pepper Commission also recommends the establishment of a massive long-term health care program, the cost largely paid by the federal government (*BI*, March 12).

The biggest disappointment is the commission's rigidity in how employers would have to meet this federal benefit mandate.

The commission says that an employer—to avoid paying the new payroll tax—would have to offer what it calls a "Specified Benefit Plan." Under such a plan, an employer would have to pay 80% of the premium for both individual and dependent coverage. In addition, annual deductibles could not exceed \$250 for individual coverage and \$500 for dependent coverage, while an employee's maximum annual out-of-pocket expense could not be greater than \$3,000.

These recommendations, while well-intentioned, would cause more problems than they would solve.

If employers must pay an arbitrarily set percentage of health insurance costs, they likely will cut back on other benefit programs to recover those added costs. For instance, a company unable to afford the Pepper Commission mandate could cut contributions to a 401(k) salary reduction plan or eliminate a planned cost-of-living adjustment in retirees' pension benefits.

Such cutbacks could hurt workers more than asking them to pay a greater share of health care costs.

The Pepper Commission's rigid formula on what constitutes a minimum benefit plan also fails to take into account the huge variety of employer-provided health care programs.

For example, employers with flexible benefit plans typically allow employees to use "flex dollars" to choose from a range of health care deductibles and coinsurance requirements.

Would a flex program giving employees the option to buy a health care plan with a \$1,000 deductible for a relatively small number of flex dollars be considered a "Specified Benefit Plan"? Obviously, the Pepper Commission did not consider such an arrangement in



making its recommendation.

And that's the point. No set of federal rules—as the debacle over Section 89 non-discrimination rules should have made clear—can take into account the variety of health care arrangements that companies now provide to meet employees' and the employers' own needs.

The Pepper Commission also is being criticized—justifiably—for failing to say how the federal government would pay the \$66 billion annual cost of the new long-term health care plan and a new public plan to provide acute care coverage to the uninsured.

We suspect the commission ducked the financing question—not because it thought the issue should be resolved by the congressional tax committees—but because it feared public support for the recommendations would cool once it was understood that taxpayers would have to foot the bill.

Indeed, support among the elderly for a relatively modest expansion of the Medicare program collapsed last year when retirees discovered they would have to fund the expansion through new taxes.

However, it is unfair to say that the Pepper Commission report is a complete failure.

Coming up with fair, sensible recommendations to improve access to health care coverage is indeed difficult. Through its recommendations, the Pepper Commission has helped ensure that debate will continue. That debate may one day produce the answers that are so badly needed.

Letters

Work comp cost sharing could stem abuse

To the editor: In reference to your Feb. 26 editorial on joint efforts to solve workers compensation problems, we have been grappling with work comp problems for some time and have yet to come up with a plan to provide workers compensation "at a reasonable rate."

Despite all the efforts, no state to my knowledge has directly involved all of the participants in the workers comp problem. Most workers comp beneficiaries have no input, nor do they feel any direct effect of an abused workers comp sys-

tem.

For some unknown reason, when workers compensation came into being, the cost was completely borne by the employer. If workers had to pay half the workers compensation premium—as they are required under the Social Security—you would have a much greater involvement by employees, hence a strong

enough political force to do something about the problem.

Until something is done to involve all participants, very little will be accomplished.

Camors C. Roth
President
Seymour & Roth Inc.
Monroe, La.

Congressmen should look who's talking

To the editor: Regarding the story "House Panel Blasts States for Regulatory Deficiencies" (*BI*, Feb. 26), I once again see that our Congress has the hubris to criticize the states for their regulatory deficiencies. Can you believe the people who gave us the Social (in)Security system and the savings and loan bailout are once again harping on the poor state insurance regulators.

What a joke! I cannot believe that these people have such a short memory as to make such blanket statements. As usual,

our Congress takes no responsibility for its actions. They must grant themselves total absolution once they blame someone else for their shortcomings.

Everyone agrees the state regulatory system is not perfect and has problems. But compared to the federal regulatory system, state systems appear better and better every day.

W. Meade Collinsworth
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Philanthropy on Memphis fairways

By MARK A. HOFMANN

Golf outing funds scholarships

MEMPHIS, Tenn.—A golf tournament that members of the Memphis Chapter of the Risk & Insurance Management Society initially intended as a small get-together unexpectedly has turned into an extremely successful fund-raiser for insurance education.

In fact, players have to be turned away from the annual Memphis RIMS golf tournament, the fourth installment of which is set for Sept. 13 at the Holiday Golf Club in Olive Branch, Miss. Previous competitions were in August, but the date was changed in hopes of avoiding rain and extreme heat.

Participants' fees and corporate donations to last year's tournament raised \$18,500 for Memphis State University's insurance program, said Fred J. Keeton, president of the RIMS chapter and senior corporate claims manager for Holiday Corp. in Memphis.

An endowment from tournament proceeds now funds a permanent annual scholarship of about \$2,500 and several smaller scholarships each year, he said. Tournament money has also been used to pay for a subscription to the RIMSNET computer information service for the university.

The tournament "enhances our profession by helping us qualify young people" for careers in risk management, said Mr. Keeton.

Terry L. Varner, corporate risk manager for Memphis-based Perkins Family Restaurants and the chapter's society director and legislative representative, said the group tries to "increase the exposure" of students to risk management careers through the scholarships.

The first scholarship, awarded in 1988, was

for \$1,000, said Mars Pertl, associate professor of insurance and chairman of MSU's department of finance, insurance and real estate. Two \$2,000 scholarships were awarded for the 1988-89 academic year and one \$2,500 and two \$750 scholarships were awarded for 1989-90, he said.

Mr. Pertl noted that MSU generally has 30 or fewer risk and insurance majors.

fore the tournament wondering if we were going to have 60 golfers," said Don Batchelor, vp of the chapter and risk manager at United Planters National Bank in Memphis.

But a last-minute surge of interest completed the field two days before tee-off, he said. Donations and fees raised \$8,500 for the school, he said.

The tournament raised \$18,000 the next

'I can remember meetings a few weeks before the tournament wondering if we were going to have 60 golfers,' says Don Batchelor of the Memphis RIMS tournament that now turns golfers away and has raised more than \$40,000 in three years for college risk management scholarships.

Mr. Varner said that the golf tournament was originally designed as a way to get chapter members together for a summer event. Even though none of the chapter officers were golfers, an August tournament seemed like a good idea, he said. If there was extra money after fees were paid, the money would go to education, he said.

Invitations went out to brokers and vendors as well as the chapter's 30 or so members, Mr. Varner said.

The response took the organizers by surprise, noted Mr. Keeton.

"I can remember meetings a few weeks be-

year and \$18,500 in 1989. Mr. Batchelor noted that the 1989 figure was reached despite the fact that sponsors who had donated \$5,000 the previous year were no longer associated with the chapter.

Course rules limit the field to 144 players, said Bob Wilson, a chapter member who has been involved with the tournament since its inception. Mr. Wilson, claim director for Methodist Health Systems Inc. in Memphis, said that this year's entry fee for employees of RIMS members and sponsoring organizations will be \$55. Fees for other players will be \$75. Non-golfers can register for

other activities for \$25. A reception is held on the eve of the event.

Mr. Wilson added that there are four levels of corporate sponsorship: platinum for contributors of at least \$4,000; gold, for contributors of \$2,500 to \$3,999; silver, for those giving \$1,500 to \$2,499; and bronze, for those contribute \$750 to \$1,499.

Two 1989 sponsors gave \$3,000 and six others gave \$1,500 or more. Fred S. James & Co. Inc.'s Memphis office and Atlanta-based GAB Business Services Inc. donated \$3,000 in 1989. Alexander & Alexander Inc.'s Dallas office donated \$2,500. Five businesses—Marsh & McLennan Inc.'s offices in Nashville and Memphis; Rolling Meadows, Ill.-based Gallagher Basset Services Inc.; Lloyd's of London broker NHM Financial Institutions Ltd.; Johnson & Higgins' Nashville office and Corroon & Black Corp.'s Nashville office—each donated \$1,500, Mr. Batchelor said. Twenty-five other groups also donated.

Mr. Varner noted other RIMS chapters have inquired about promoting insurance education through golf tournaments, though he did not know whether other chapters had followed suit. A RIMS spokeswoman in New York said she did not know whether other chapters had started tournaments.

Mr. Varner stressed that the Memphis effort was not meant to undercut the Robert S. Spencer Memorial Foundation Inc., which provides scholarships designed to encourage careers in risk management on a national basis. Mr. Varner said the Memphis chapter's activities were intended to encourage the same interest in risk management careers on a local level and to support the risk management and insurance program at MSU. ■

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Small companies

Continued from page 3

A congressional commission recently reported that 74% of the 14.2 million U.S. workers without employer-provided health insurance were employed by firms with fewer than 500 employees (BI, March 12).

Clearly, the high cost of health insurance deters many of those companies from offering coverage.

"We're concerned that small employers will stop offering coverage if health insurance costs continue to spiral," said Gerald A. Gleeson, senior vp with the Philadelphia Chamber of Commerce, which sponsors group health care plans for members.

Indeed, in a 1987 survey by the U.S. Small Business Administration, 62% of companies with fewer than 100 employees reported that high costs kept them from providing a health care plan (BI, May 11, 1987).

Small employers, like larger companies, have been hit with brutal increases in health insurance costs.

For example, health care costs for employers with fewer than 500 workers rose 61.6% to an average of \$2,646 per employee in 1989 from \$1,637 in 1984, according to a recent survey by benefit consultant A. Foster Higgins & Co. Inc. (BI, Jan. 29).

In 1989, health care costs for small employers jumped 17.3% from \$2,256 per employee on average in 1988.

While the increases were roughly in line with those incurred by larger firms, rising costs are an especially heavy burden for small companies.

"Health care can be a tremendous drain on small employers' cash," said

Tom Marshall, a Foster Higgins consultant in Washington, D.C.

In addition, only a small number of insurers—sometimes only a Blue Cross/Blue Shield plan—will write coverage for small employers, benefit experts say.

They "don't have a lot of choice," said Karen Pellegrini, a Wyatt Co. consultant in Wellesley Hills, Mass.

By contrast, the Good Neighbor Alliance program gives small companies "access to health insurance that they never have had, and small employers get service and follow-up that they never saw," said Alliance President Dorthie D. Maynard.

For Alliance members, the Ocean State Physicians Health Plan, an HMO in Warwick, R.I., and Rhode Island Group Health Assn. in Providence will waive their usual 10-employee minimum for obtaining coverage.

Without such a waiver, Alliance members—which have about five workers each on average—would face a rough time in the commercial insurance market.

For example, rates for an indemnity plan from Blue Cross/Blue Shield—one of the few insurers willing to write coverage for very small companies—are about 25% higher than HMO rates for Alliance members, Ms. Maynard said.

Small companies belonging to the Alliance also can have opportunities to purchase coverage at a lower-than-normal cost from the HMOs.

For example, Alliance members pay \$128 monthly for single coverage and \$308 for family coverage from the Rhode Island Group Health Assn.

Comparable community rates directly from the HMO would be \$155 a month for individual coverage and \$372 for family coverage, assuming the companies were large enough to obtain the coverage.

And, there is another advantage for Alliance members: The Alliance does most of the paperwork.

It processes enrollment forms, forwards premiums to the HMOs, handles address changes and explains the HMOs' benefits to member companies' workers.

"The small employer does not have the staff to handle all the paperwork," Ms. Maynard said.

"The program is a good service to the community," said an Ocean State Physicians Health Plan spokeswoman. "The Alliance does a very good job of managing the program. They act as benefit managers."

While the Alliance program illustrates strength in numbers for small employers, some small firms are fighting spiraling health care costs on their own.

For example, Panel Processing moved from a fully insured plan to a self-funded program in 1986, despite annual revenues of only about \$25 million.

"Being a small company, we couldn't get respect. We couldn't get claims information. We couldn't get answers on why our premiums kept going up," explained Panel Processing's Mr. Hitchcock.

Panel Processing purchases specific stop-loss coverage from by New York Life Insurance Co. that pays individual claims exceeding \$20,000. Aggregate stop-loss coverage, also

written by New York Life, kicks in if total claims exceed about \$385,000.

Panel Processing has taken other steps to rein in health care costs.

In 1986, the company added a hospital preadmission certification program in which employees or their physicians must notify a cost management firm before surgery to agree on necessity of the procedure and length of stay.

Two years later, it added a flexible benefit plan in which employees use "flex credits" to select different health plans with varying deductibles and out-of-pocket limits.

While Panel Processing's health care costs increased to \$350,000 in 1989 from more than \$230,000 in 1986, the company would be spending between \$60,000 and \$70,000 a year more—or 17% to 20%—on health care coverage if it had not reshaped its health care program, according to Mr. Hitchcock.

Sandmeyer Steel also believes self-funding is enabling the company to hold down health care costs. Annual savings from two years of self-funding are \$10,000 to \$20,000, or 2% to 4% of the company's total 1989 health care costs of more than \$500,000, Mr. Sandmeyer said.

"Self-funding has many advantages. We save on state premium taxes, and we think we have more control over our program" than if it was fully insured, he said.

Small employers are taking other steps to hold down health care costs in the long run.

An audit program at Master Chemical rewards employees who spot errors in their hospital bills by re-

turning 50% of the savings to the workers.

Employees have found such errors as bills for services not performed and charges for extra hospital days.

The program has saved several thousand dollars since its 1983 inception, Mr. Sladky estimates.

Some small employers are adopting wellness programs to contain rising health care costs.

For example, Walton Construction Co., a family-owned firm in Lenexa, Kan., with 130 employees, pays the initiation fee and half the monthly membership fee for employees at a local fitness center.

"In the long run, we should have healthier employees and fewer claims," said Vic Read, Walton's comptroller.

And, small companies are taking other new tactics in their battle with rising health care costs.

For example, the Philadelphia Chamber of Commerce, which for years offered members only an indemnity plan underwritten by a BC/BS plan, now lets members secure coverage through Keystone Health Plan East, an HMO subsidiary of Pennsylvania Blue Shield, whose rates are substantially lower than rates charged by the Blues' indemnity plan.

"We are beginning to see a gradual shift to the HMO," said Mr. Gleeson, the Chamber's senior vp.

And Panel Processing's Mr. Hitchcock said the company has become so comfortable with self-funding that is examining if it can go totally bare and save the cost of stop-loss premiums.

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Benefits require new thinking: Consultant

By KATHRYN J. MCINTYRE

FORT LAUDERDALE, Fla.—Employee benefit managers and those that sell them products and services should rethink their programs in light of major social and economic changes in the United States, advises a strategic planning consultant.

The increasing number of women in the workforce, the rapid pace of change in people's lives and the melding of workplace and home life are among important social changes that should be recognized by people shaping employee benefit programs, says Edith Weiner, president of Weiner, Edrich, Brown Inc., strategic planning consultants in New York.

Furthermore, economic changes, including the growth of entrepreneurs and the emergence of diverse economies in one country, call for

new employee benefit programs, she says.

Ms. Weiner made her remarks earlier this month during the 1990 Employee Benefits Symposium, "A New Decade: Facing the Challenge," sponsored in Fort Lauderdale, Fla., by Atlanta-based LOMA (Life Office Management Association), an association serving life and health insurers.

The growth of working women is different in the 1990s than it was previously, Ms. Weiner maintains, because many working women are facing increased financial burdens. Many women are responsible for families; others must take full financial responsibility for themselves if they are childless or unmarried.

"Independent financial security is going to become a major and overarching issue for women over the

next 10 years," she predicted.

A social phenomenon known as "transitioning" also is important, said Ms. Weiner, noting that "the majority of people always seem to be in a state of transition," including changing jobs and changing marital status.

LOMA

This uncertainty about the future "makes it difficult to plan for one's future," Ms. Weiner said.

As a result, "employee benefits are going to have to match that flexibility, step for step. People have to be able to experiment with what they need because they are not sure what they are going to need," she advised.

The melding of workplace and home life is another important social change, according to Ms. Weiner.

It does not mean that more people are working at home but that "more people are homing at work," she said.

"They are doing more of their personal business on work time because they have no choice," Ms. Weiner said, observing that work is increasingly intruding upon what had been workers' personal time.

"Certain things we don't consider employee benefits are very important in this kind of environment," she said, citing, for example, "open use of the telephone on company time."

"We've almost gone backward on that," she added. "When employers start to monitor telephone calls, they are not realizing what people have to do to juggle their lives today."

Among major economic changes is restructuring—mergers and acquisitions and growing technology, Ms.

Weiner said.

"Restructuring has caused a lot of people to feel insecure about where they are," she explained, leaving employees to feel either "entitled" to employee benefits or grateful that they have access to some benefits.

Entrepreneurism also is an important economic change because entrepreneurs are educated, experienced, talented people who once knew the value of employer-provided benefits.

Now, having to pay for benefits on their own, these small business leaders view the tax-free status of corporate employee benefits "bitterly," Ms. Weiner said. As a result, new taxes on these benefits will be demanded, she suggested.

Finally, the aging of the population is important to employee benefits because older peoples' savings rates will increase dramatically as they become more fiscally conservative.

They are concerned about retirement—their parents' and their own—and educating their children, she explained. They will want "safe and secure investments."

With these social and economic changes in mind, Ms. Weiner issued four challenges to those providing workers with employee benefits and four challenges to those who sell employee benefit products.

Ms. Weiner challenged employers to:

- Know your workforce before you design questionnaires.

"The questionnaires are always designed with the answers in mind so they wind up not telling you anything very different.

"You have to start reforming your view of the world before you give them questionnaires about the benefits they need. You will find yourself asking very different questions."

- Monitor satisfaction with benefits.

Employers have to know if they are spending their employee benefit dollars effectively.

- Know the value attached to privacy and be aware that privacy is becoming regarded as a benefit.

- Don't assume that one's position in the hierarchy of an organization has anything to do with one's financial situation or sense of security.

An executive secretary may feel much more financially secure than an executive who makes \$150,000 or more.

"You can't assume that benefits can be designed looking at the hierarchy."

To sellers of employee benefit products and services, Ms. Weiner said:

- Recognize the smaller entrepreneur market.

These entrepreneurs should be seen "not just as a niche market, but also that their needs, wants and activities will dictate the patterns of benefits available to the rest of the population as well."

- Re-research uncertainty and insecurity.

These concepts have not been well-researched in several decades. As a result, new products are not being developed.

For example, some people today want insurance against the loss of insurance or insurance against real estate tax increases during their retirement.

- Know the needs of a diverse market.

For example, preretirement women without children or a spouse face totally different financial challenges from men and married women whose needs are met by today's products.

- Get portable while remaining affordable.

More portability in benefits is needed, and benefits need to be more affordable. Too often, people can't afford to take advantage of existing portability in benefit plans. ■

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Work comp rates

Continued from previous page
individual company will pay may be tailored through the insurer's application of so-called rating programs, including experience rating, deviations, discounts and dividends.

The NCCI does not follow one rigid formula for calculating rates in every state, but uses a consistent set of procedures to examine the dynamics in a particular state, Mr. Fein said.

That includes projecting immature losses to their ultimate value, calculating projected benefit payments to reflect the benefit levels and mix of losses by injury type for a particular state and adding trend factors to reflect the impact of inflation.

Finally, in most states, the NCCI adds profit and expense factors to determine the final rate.

However, a minority of states require the NCCI to file only loss cost data and require insurers to individually compute their profit and expenses.

The NCCI's request and its extensive supporting documentation are reviewed by a state insurance regulator and members of the regulator's staff in a process that one pundit described as "dueling actuaries."

For example, regulators analyze the components of rate filings and whether the elements that make up the filing have been appropriately calculated.

Critics of NCCI filings point out that the NCCI tends to overestimate expense factors like general expenses, overhead expenses, loss adjustment expenses and assessments for guaranty funds and second-injury funds, said Martin M. Simons, chief casualty actuary of the South Carolina Department of Insurance.

For example, he and other actuaries contend that the NCCI relies too much on general expense data from stock companies, which incur higher costs because they use independent agents as a sales force.

Data from mutual companies, which primarily market their coverage directly to the policyholder, should be given more weight, these critics contend.

In response, the NCCI's Mr. Fein said those arguments oversimplify complex issues. He emphasized that the NCCI continuously reviews all ratemaking components to ensure their appropriateness and accuracy.

In addition, many insurers feel that NCCI rate filings are inappropriate because they do not properly reflect investment income.

The NCCI tailors its filings to achieve a 97.5% loss ratio, which would produce a 2.5% profit margin before investment income is taken into consideration.

"Virtually all states that consider investment income lower NCCI rates as a result," according to Alan Wickman, an actuary with the Nebraska Insurance Department.

For example, about one-third of the states base their final rate determination on combined ratios exceeding 105%, according to a compendium of regulatory viewpoints on workers compensation ratemaking released in December by the NAIC's Casualty Actuarial Task Force.

"I don't know of any (actuaries) who would say that there is unnecessary fat or an organized, concerted NCCI plan to put fat in" a rate filing, said R. Michael Lamb, a casualty actuary with the Oregon Department of Insurance and Finance who heads the NAIC's Casualty Actuarial Task Force. In fact, the NCCI is making an effort to present more reasonable filings each year, he said.

However, actuaries for regulators and ratemaking organizations

often have differences of opinion about what is an appropriate filing, he said.

"The data is what it is," emphasized Mr. Fein.

"These are the facts. We are not moderating our procedures to come up with palatable numbers," he said.

After hearing opinions from actuaries and comments from the public, a regulator evaluates the arguments and typically approves a rate lower than the NCCI originally proposed.

The NCCI usually responds by refiling an additional rate increase request and the pattern repeats itself.

While it's complex, some defend the current ratemaking process.

"The problems in workers compensation are not in the ratemaking," Mr. Fein said. "The real issue is controlling costs."

But some members of the National Assn. of Insurance Commissioners disagree and are exploring

whether to prohibit insurer rate-making organizations from filing fully developed rates.

The NAIC expects to launch an intensive study to determine the feasibility of a proposal by the NAIC's Workers' Compensation Advisory Organization Activities

Following research by another subgroup headed by Mr. McCartney, the NAIC had previously adopted proposals recommending a "loss cost" approach for organizations, like the Insurance Services Office Inc., that file advisory rates for other lines of property/casualty

likely to begin this spring, consists of an examination of NCCI operations in Maine, Florida, Utah and Nebraska. The other phase will involve an economic analysis of the workers comp marketplace to determine the probable impact of implementing a loss-cost system on as yet unspecified elements of the workers compensation system.

The recommendation that the NCCI file loss costs rather than fully developed workers compensation rates could be modified after that study, regulators emphasize.

Proponents of limiting rating organizations to calculating loss costs and forcing workers compensation insurers to file their individual expense and profit factors say the new system will increase competition among insurers.

And, increased competition should benefit insurance buyers—especially small employers—through lower premiums and bet-

Continued on next page

While actuaries often have differences of opinion about what is an appropriate filing, 'the data is what it is,' emphasizes the NCCI's Richard Fein. 'We are not moderating our procedures to come up with palatable numbers.'

Working Group, headed by Mr. McCartney, that would limit a rating organization to providing workers compensation insurers with only current and future loss cost data, instead of calculating fully developed rates (*BI*, Dec. 11, 1989).

insurance.

New York-based ISO, the largest advisory organization serving non-workers compensation insurers, voluntarily adopted that approach last year (*BI*, April 10, 1989).

One phase of the NAIC's workers compensation rate study, which is

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Continued from previous page
ter loss control services from insurers, they say.

In addition, proponents contend the loss-cost approach should increase the information available to insurers and regulators since an individual insurer will have to separately file its own profit and expense information.

"It's a small step in the right direction," said J. Robert Hunter, president of the National Insurance Consumer Organization in Alexandria, Va.

However, he recommends that the NAIC also require individual insurers to do their own analysis of future trends when determining rates, which is one step beyond what the NAIC subgroup has proposed.

"I think very significant savings could occur if the cartel stranglehold is broken," Mr. Hunter said.

However, Maine Insurance Superintendent Joseph Edwards said any impact the proposals would

have on rates "would be a modest impact."

He and other regulators—including representatives of the New York Insurance Department—oppose a recommendation that individual states move to a loss-cost approach at this time.

"We don't know enough about how breaking out loss cost will impact markets," Mr. Edwards said.

Opponents of such a change generally fear that many small insurers may withdraw from the market because of the increased cost of calculating their own expense and profit factors. In addition, opponents worry that insurers may cut, rather than enhance, loss control services to save money.

Finally, they say regulators in several small states will be overburdened with individual insurer filings, even if they each consist of only a single page of paper that refers to the NCCI rate filing for all but profit and expense factors.

However, "I just don't think it

will mean that much" extra work, said Nebraska's Mr. McCartney, who heads one of the smaller state insurance departments.

The Risk & Insurance Management Society Inc., which represents insurance buyers and self-insurers, is not particularly concerned whether work comp rating organizations like the NCCI are limited to presenting only loss costs as long as they are allowed to include trend factors for future loss developments in their rates.

"We at RIMS rarely hear our members, who foot the premiums for workers' compensation coverage, complain about advisory organization rates," according to a recent RIMS statement.

"RIMS members often have more than one rating option available to them, which they find useful. Besides schedule rating, there are rate deviations, experience rating, retrospective rating, consent to rate and dividends," the RIMS statement said. ■

Comp insurers see new need for rate hikes

By MEG FLETCHER

Workers compensation insurers' poor financial results are triggering another round of requests for double-digit rate increases nationwide.

Insurers reported an estimated 120.1% combined ratio after dividends for workers compensation business in 1989, compared with a 118.4% combined ratio in 1988, said Richard Fein, acting president of the New York-based National Council on Compensation Insurance, the nation's largest workers

comp ratemaking and statistical organization.

"It's pretty bad," he said. "We had hoped there would be an improvement."

Workers compensation in general "is deteriorating," observed Joseph Edwards, superintendent of the Maine Bureau of Insurance and chairman of the National Assn. of Insurance Commissioners' Workers Compensation Task Force.

The NCCI—and other ratemakers for work comp insurers in about 10 additional states—responded to poor results in both the voluntary workers comp market and in assigned risk plans designed to provide coverage by asking for higher rates in dozens of states. Assigned risk plans are for employers that cannot find coverage in the voluntary market.

Overall rates are about 15% low on average, Mr. Fein said.

Average increases ranging from 1.7% in Wisconsin to 36.7% in Florida took effect in 19 states earlier this year. Requests are pending for rate hikes in an additional 15 jurisdictions, with more to come. The requests range from 7.3% in the District of Columbia to an average 86.2% increase in Rhode Island (see story, page 1).

Workers comp cost increases primarily are caused by skyrocketing medical costs and an increased number of workers filing claims for higher-cost injuries, like permanent partial injuries, said John Lewis, a work comp expert in Miami who has been hired by several states to analyze work comp systems.

The medical component of work comp benefits is rising faster than overall inflation. Medical costs now comprise about 40% of work comp costs, up from about 33% a decade ago, the NCCI reports.

In addition, more claimants are receiving the higher benefits that are paid for more serious injuries, Mr. Lewis said.

Current rate increases stem in part from a 1972 report by a national commission on state workers comp laws that recommended significant changes to many state work comp systems, especially increased benefit levels, explained Steve Millikan, vp and director of workers compensation for the Alliance of American Insurers in Schaumburg, Ill.

Many states that implemented those changes faced an outcry several years later from employers upset about increased costs and employees, who feared that benefits would be cut.

Despite major work comp changes made by 15 states in the past five years, "there seems to be little impact and the costs of the systems and the rate levels requested by the insurance industry continue to rise," Mr. Millikan said.

About a dozen states moved from administered pricing, where regulators approve rates, to competitive rating, where intervention is scaled back and competition generally sets rates.

Companies have found, however, that competitive rating can produce more volatile rate changes, Mr. Lewis said.

Regulators trying to understand the underlying causes of cost increases say they are frustrated by the lack of data needed to answer questions like: How are claims and expenses allocated among health care providers, claimants and

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Work comp rates

Continued from previous page
others? What other cost factors are driving persistent increases in system costs? What are the effects of legislative changes affecting state work comp systems?

"The absence of data is a serious problem for nearly every state," said Mr. Lewis.

Data is primarily collected by the NCCI, state work comp administrators and the federal Department of Labor.

Regulators complain that much of the information is difficult to use because each group tailors its data collection to individual needs. Some regulators are also wary of NCCI data, fearing it may be slanted to support insurers' rate requests.

The National Assn. of Insurance Commissioners late last year tried to standardize data collection through a model data reporting law that would allow work comp regulators to collect more detailed claims information from rate-makers and others to better analyze the costs and operation of

each state system (BI, Dec. 11 1989).

The NAIC recommends states adopt the model, which would require work comp insurers, self-insurers and state data collectors to file detailed claims information with state authorities.

Last month, before most states even had a chance to adopt the model, the NCCI agreed to implement many of the data collection proposals starting in January 1991 in the three dozen or so states where it operates.

The organization believes collection of this data will help in controlling work comp costs and developing more accurate rates, Mr. Fein said.

Voluntary participation by the NCCI is "a major, major step" forward, said Maine's Mr. Edward.

The NAIC's model is "a fairly reasonable starting point for individual states," Mr. Lewis said, adding that it "certainly" will be helpful.

Insurers, he said, will likely try to pass the new costs for data collection on to policyholders, while self-insurers will likely absorb

them.

In addition, while the NCCI will probably become the work comp insurance industry's primary data source, many insurers still do not believe that a single, fully integrated data base is feasible for a

**The NAIC model is
'a fairly reasonable
starting point'
for states,
says John Lewis.**

variety of reasons, including maintenance costs, Mr. Millikan said.

That and other questions remain to be resolved. "It will be a real tough call how it will all play out," he said.

Yet, "data collection is the most important thing we've got going," Mr. Lewis said.

Other observers note that the move toward improved data collection is just one of several recent developments that could help con-

trol rising work comp costs:

- Comprehensive legislation approved last year in Texas. California and other states could significantly improve operation of work comp systems (BI, Dec. 18, 1989; Oct. 2, 1989).

It is too early to say what impact these changes will have on rates, but the most optimistic observers say that the changes should at least hold the line on rate increases in the near future.

- Work comp rates have actually declined in two states so far this year: 8.4% in Maryland; and 4.1% in Alaska.

Work comp reform measures, including setting up more objective criteria to evaluate permanent partial disabilities, may help explain rate reductions in both states, some observers say.

Maryland's rate decrease appears to be at least partially caused by benefit reforms, said JoAnn Porter, NCCI director of government, consumer and industry affairs for the state. Moving from a two-tiered to a three-tiered system for paying benefits to workers with permanent partial injuries is ex-

pected to reduce benefit payments to less seriously injured workers, she said.

Recent work comp amendments may explain the Alaska rate drop, said Eric Oxfield, counsel to the American Insurance Assn. in Washington, D.C.

One amendment adjusts payments to the cost of living where claimants reside, thus reducing the incentive for claimants injured in Alaska and receiving benefit payments based on its high cost of living from moving to a state with a lower cost of living, he said.

However, Len Traiman, NCCI director of government, consumer and industry affairs for Alaska, said: "It's too early to tell with the reform legislation whether that had an impact or not" on rates.

Other factors, like a slowdown in Alaska's economy, may have played a role, he said.

- For the first time in nearly two decades, representatives of key workers compensation constituencies—including employers, labor and insurers—are forging a national advisory group to seek reforms (BI, Feb. 26).

Comp rate changes implemented in 19 states

Workers compensation rate changes have been approved in 19 states this year, while requests for rate increases are pending in 15 other jurisdictions.

And rate increases are expected to be filed in several other states.

The New York-based National

Council on Compensation Insurance, the largest workers compensation statistical and ratemaking association, is seeking an average increase of about 15% nationally, according to Acting President Richard Fein.

Last year, workers comp rates nationwide rose 6.1% on average, but increased 10.1% on average in about three dozen states where the NCCI proposes rates for insurers for regulatory approval, he said.

This year's 19 rate changes range from 1.7% in Wisconsin to 36.7% in Florida, according to data from the NCCI and the independent ratemaking organizations in about 10 other states.

Rates actually were cut 8.4% in Maryland and 4.1% in Alaska.

The rate change percentages reported for individual states are typically averages that are weighted by premium volume to reflect the market shares held by both the voluntary market and assigned risk plans in states with residual markets.

In addition, most rate changes reflect fully developed rates, which include components for insurers' profits and expenses.

However, a few states require advisory rating organizations to limit the data filed to insurers' loss costs, requiring insurers to individually file profit and expense factors.

In addition, rates filed in states that have passed competitive workers compensation rating statutes, such as Illinois, are primarily advisory rates.

Following are rate changes enacted this year by rating organizations. The combined weighted average rate increase is stated first, followed by the percentage of change in the voluntary and assigned risk plans, if applicable and if they differ from the overall average:

- Alabama: 11% average weighted increase; 9% increase in the voluntary market; 17.9% increase in the assigned risk plan.
- Alaska: 4.1% decline.
- Arkansas: 3.5% increase.

- California: 5.9% increase.
- Connecticut: 21.7% average increase; 22.1% increase in the voluntary market rate based on loss costs only; 17.8% increase in the assigned risk plan.
- Florida: 36.7% average increase; 29% increase in the voluntary market; 63.6% increase in the

- Texas: 27.7% average increase; 22% increase in the voluntary market; 50.4% increase in the assigned risk plan.
- Utah: 12.5% average increase.
- Wisconsin: 1.7% increase.

Nearly all the increases took effect Jan. 1.

Ratemaking organizations are

The NCCI this year is seeking an average work comp rate increase of about 15% nationally. Last year, workers comp rates nationwide rose 6.1% on average, but increased 10.1% on average in about three dozen states where the NCCI proposes rates.

assigned risk plan.

- Idaho: 7.2% increase.
- Illinois: 10.1% average increase; 10% increase in the voluntary market; 10.7% increase in the assigned risk plan.
- Indiana: 23.3% increase.
- Maryland: 8.4% decrease.
- Massachusetts: 26.2% increase.
- New Jersey: 4% increase.
- North Carolina: 9% increase.
- Oregon: 7.6% average increase; 6.1% increase in the voluntary market's loss cost rate; 21.1% increase for the assigned risk plan.
- Pennsylvania: 7.49% increase.
- Tennessee: 12.5% increase.

also asking insurance regulators in 14 more states and the District of Columbia to approve rate increases ranging from 7.3% in the District of Columbia to 86.2% in Rhode Island:

- Colorado: 14.3%.
- Delaware: 16.2%.
- District of Columbia: 7.3%.
- Iowa: 16.3%.
- Louisiana: 53% average increase; 37.7% increase in the voluntary market's loss cost rate; 73.7% increase for the assigned risk plan.
- Maine: 26.5% average increase; 26% increase in the voluntary market; 26% increase in the assigned risk plan's safety pool; 32.3% increase in the assigned risk plan's accident prevention account for poorer risks.
- Missouri: 19.6%.
- Nebraska: 25.7%.
- New Hampshire: 27.1%.
- New Mexico: 51.2% average increase for voluntary market. An earlier increase for the assigned risk plan was denied.
- Oklahoma: 10.5%.
- Rhode Island: 86.2% average increase. The NCCI is seeking a 123.3% increase for insurers that write less than 1% of the voluntary market and for insurers writing assigned risk plan policies. It is seeking a 28.1% increase in loss cost rates for insurers that write at least 1% of the voluntary market.
- South Carolina: 13.5%.
- South Dakota: 23.6%.
- Vermont: 7.6%.

Effective dates for these pending rate increase requests range from Jan. 1 to July 1 of this year.

The NCCI also expects to file rate increases in more states this year, but details will not be available until the filings are made, Mr. Fein said.

—By Meg Fletcher

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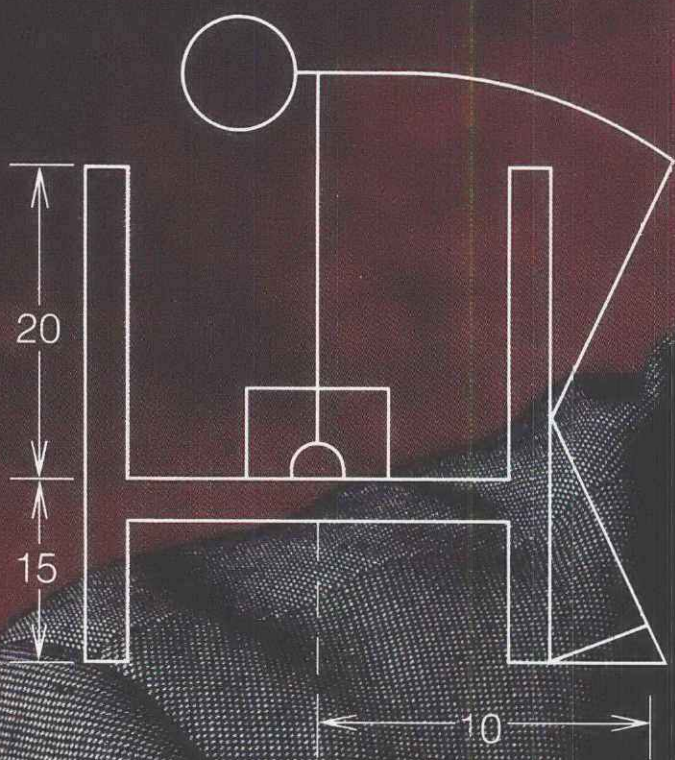
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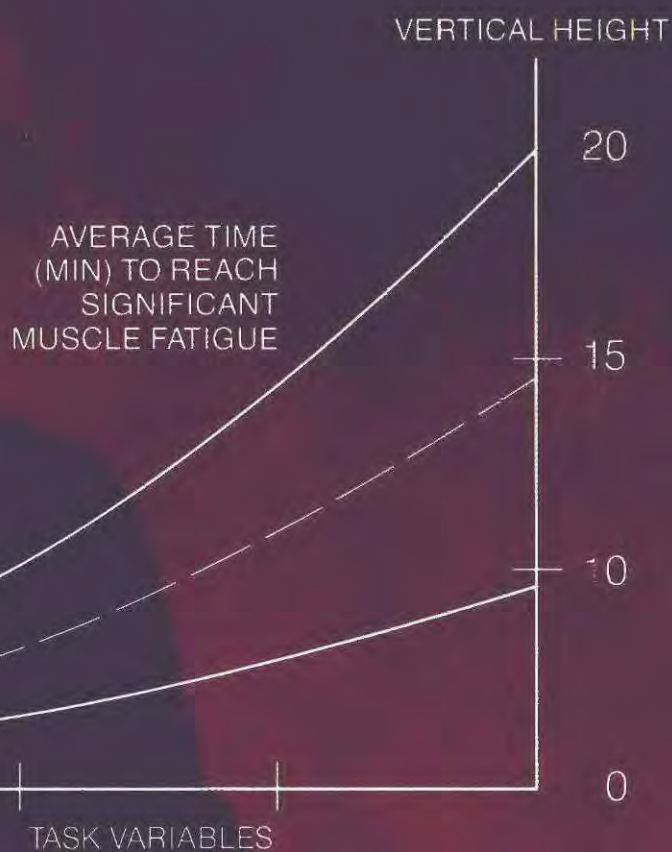
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Using structured settlements

By Michael J. Casey

OPERATING WITHOUT A PLAN is planning to fail!

That adage is especially appropriate when a self-insured company uses a structured settlement to resolving a personal injury claim. While the use of structured settlements can be a boon to self-insurers, the lack of a well-conceived plan of operation can lead to failure. Most major insurers have developed specific programs that set forth guidelines on when, where, how and with whom structured settlements should be negotiated. Self-insurers should do the same.

The ever-increasing number of companies that self-insure their liability risks should use structured settlements for several reasons. Most importantly, the use of structured settlements in the resolution of personal injury and wrongful death claims can save money and, thus, have a direct bearing on corporate profits. However, if a self-insured company does not use structured settlements properly, it is probably wasting money. If the company allows other parties to control the structured settlement process, it may allow them to take advantage of the inherent savings at the company's expense. In addition, it can result in additional continuing obligations after settlement, potential adverse tax consequences and a great deal of aggravation.

Therefore, it makes sense for self-insurers to establish guidelines for handling structured settlements. Programs can be tailored to meet the particular goals and needs of individual organizations. Also, this type of direction from management allows those making settlement decisions—both the company's own employees and its outside defense counsel—to know what is expected.

Several considerations must be taken into account when establishing your company's structured settlement guidelines. You should provide answers to the following questions:

- What broker should be selected?
- What life insurers should be used?
- What cases are candidates for the structured settlement approach?
- How will these cases be assigned to the broker?
- What are the guidelines for negotiations?
- How should the paperwork dealing with the settlement and with assignment of liability to another party be handled?
- How will the structured settlement program be evaluated?

Since the structured settlement broker is your link to the life insurance companies that provide structured settlement annuities, the annuity brokers that have the ability to access the entire market will be in the best position to insure that you can purchase an annuity at the most competitive cost through the strongest possible insurance company.

An individual agent of one life insurance company, or an independent agent that has access only to a few life insurers, may not be able to provide you with the best available quote.

How can you determine whether the broker you are considering has access to the annuity marketplace? You can ask for a list of the insurers the broker claims to represent and call those insurers to make sure the broker does indeed have a contact with them. Also, the major brokers that have been in the business for a number of years with a good track record will be known to others in the field, including insurers and defense counsel.

You should interview the brokers, ask for a list of their clients and check references, just as you would with any other vendor. If you face litigation over a wide geographic area, you might want to consider whether the broker has qualified staff members in those locations to provide on-the-spot services.

Other services you should expect from a structured settlement broker include:

- Experience in handling personal injury claims.

Self-insurers need guidelines for settling claims

- Ability to provide timely proposals in response to your needs.
- Creativity in responding to special circumstances.
- The ability to specifically serve self-insured companies.
- Attendance at settlement conferences.

Once a broker has been selected to handle your structured settlement business, you must work with the broker to establish guidelines. The first step is to determine what life insurance companies you will use to fund future obligations under your settlement agreements. Your broker can provide valuable input in this area. He can list the companies available, the financial strengths and ratings of those companies, the nature of the assignment of liability, which is essential to a self-insured company, and the quality of the insurers' service.

A self-insured's approved life insurance company list could name specific companies or it could

If a company allows other parties to control the structured settlement process, it may allow them to take advantage of the inherent savings at the company's expense.

simply name the A.M. Best Co. rating and size of company that is the minimum acceptable to the self-insured.

The next step deals with assignment of obligation. In a structured settlement agreement, a settling defendant or his insurance company must promise to make future payments as called for in the settlement program. Section 130 of the Internal Revenue Code provides that the settling party may assign this liability to a third party. A structured settlement release agreement provides that if such assignment is made, the plaintiff will look only to that third party for those future payments.

Third-party qualified assignments are becoming more prevalent due to the attractiveness of the ability to transfer an ongoing obligation to another entity. This can be an advantage to both the defendant and the plaintiff.

Structured settlement guidelines for self-insurers should include a direction to require the assignment of any obligation in a release agreement following any personal injury or wrongful death claim. Tax law clarifies the need for a self-insurer to end any continuing obligation for payments in a personal injury of wrongful death claim in order for the self-insurer to be in a position to deduct the cost of the settlement in the year the case was settled.

Thus, the self-insurer, if it wishes to take a deduction for the cost of the settlement in the year the case in settlement is made, must make a qualified assignment to a third-party assignee.

Section 130 of the Internal Revenue Code defines qualified assignment, and most of the life insurance companies writing annuities for structured settlements provide a facility to conform to Section 130. Although similar in many respects, assignment procedures do vary among different insurers. A structured settlement broker should review these assignment procedures with the self-insurers and together you should select the assignment procedures with which you are most comfortable.

Structured settlement guidelines also can

expedite claims handling. For instance, the guidelines should indicate the type of cases in which the structured settlement approach should be considered.

Cases in excess of \$25,000, for example, can be recommended as a candidate for structured settlements. And, cases involving catastrophic injuries, like brain damage and spinal cord cases, should always be considered.

The dollar level and the type of case you wish to consider as a candidate for structured settlements will vary from company to company, depending on the nature of the claims the company typically faces. Do not assume, however, that structured settlements can only be used in catastrophic cases. A 10% savings on a large volume of smaller cases could affect company profits.

The method by which cases are referred to the structured settlement broker should be outlined. You may wish to control all assignments through a central location to insure that the proper broker is used.

Early referral of the candidates for structured settlement also is recommended. This avoids a last-minute rush and allows for a well-thought-out plan of negotiation.

In order to maximize the savings from your use of structured settlements, the program should call for some hands-on training. The broker you select should be willing to provide training session for your employees. In addition, the broker should work closely on a case-by-case basis in the preparation of settlement offers and the presentation of those offers to plaintiffs.

Presentations on structured settlements to a self-insurer's risk management and claims staff are necessary and useful. However, working one-on-one with a broker on an actual settlement is the best training available.

One of the most important steps in a structured settlement process comes at the point when a settlement agreement is reached with the claimant. The release and assignment agreements play a very important role in the agreement. For the release itself, it is very important that the defense attorney is involved in preparing the release format. It is equally important that the structured settlement broker work closely with the defense counsel in developing the appropriate release.

As previously stated, virtually all self-insurers using structured settlements to resolve claims will want to assign their obligations to a third party under Section 130 of the Internal Revenue Code. This assignment document can be provided by the structured settlement broker, working closely with the defense attorney. However, misunderstandings and confusion can occur while the settlement paperwork is being completed. It is very important for a self-insurer that the guidelines for the structured settlement program insures the coordinated efforts of the broker, the defense attorney and the company's risk management staff.

Naturally, a self-insurer will want to monitor its structured settlement program to evaluate its effectiveness. Here again, the structured settlement broker is in the best position to provide you with data. The broker can track and measure the cases resolved through a structured settlement with those that were not. You can then measure claims activity against your expectations and develop a historical benchmark against which you can measure future cases.



Michael J. Casey is an associate in the Chicago office of Ringler Associates, a structured settlement broker.

ASK A BENEFIT MANAGER

Communication key to managed care

Q

Based on your experience of implementing a point-of-service managed health care program nationwide, can you provide any advice for companies considering a similar approach?

A

To adequately cover this subject in detail, I will answer this question in two parts. In this article, let's review what is driving employers to managed health care programs and the importance of an extensive communications effort.

Health care increases for corporations began another upward spiral in 1987, and the health insurance trends for fee-for-service indemnity plans have been around 20% or more since that time. Many large employers have seen their annual health care costs increase at rates of 10% to 40%, and many smaller employers have seen even higher annual increases. And, the projections for the future do not look any better.

This has frustrated employers, which have made

many health care plan changes since the early 1980s to control cost increases. In reviewing the alternatives available, several employers have determined that the traditional fee-for-service indemnity plans will not do the job. Employers must find a more affordable way to provide quality health care to their employees and dependents. Cost increases in health maintenance organization-type plans—staff, group or individual practice association models with a gatekeeper—have been running about one-half the cost increases for indemnity plans.

The forms of managed health care plans being adopted by employers varies considerably, based on the company's health care objectives and comfort level.

The movement by employers to point-of-service managed health care for their employees and dependents as a way to transfer employees and dependents to the more cost-effective managed health care system is gaining momentum. The adoption of this type of managed health care program requires more active employer involvement than fee-for-service indemnity plans, particularly with employee communications, network building, quality of care, data analysis, claims and other administration requirements.

Each managed health care arrangement offers certain challenges but, clearly, the one that is most difficult is the "single-plan, nationwide approach." Few companies have done this to date and the approach offers a significant management, human

resources and administration challenge. The acceptance of managed health care by providers and employees varies by region of the country. With the growing number of employers going to point-of-service managed care plans, we will see most of these regional differences disappear over time.

A company considering this approach must determine that the potential financial gain is worth taking on this nationwide challenge. If your corporate objective is to get your health care costs under control as quickly as possible, the nationwide approach should be considered.

One of the most critical components of a successful managed health care point-of-service program is a well-conceived communication strategy. You must develop a plan that not only describes the new program but also explains the reason for its adoption.

The best-negotiated managed health care arrangement will not succeed if employees do not understand it or, over time, recognize its advantages. It is important to educate employees and dependents about the realities of the U.S. health care system. Employees need to understand the seriousness of the issue and the economic impact it will have on them and the company if changes are not made. The adoption of a point-of-service managed health care plan is a major change for employees and their dependents. For some, it will be their first exposure to a managed health care plan.

Continued on page 26

Do homework before choosing RMIS

Overlook bells and whistles, focus on system needs

OCCASIONALLY I FIND myself providing advice to clients and prospects that I never thought I would say as a consultant. For example, last month I told a client: "A risk management information system is not the solution to your problem."

For one who has been saying the opposite in this column for the past few years, it seemed a contradiction. However, when taking things into perspective, it really is not.

We all are guilty of myopic thinking from time to time. For example, today's risk management professionals look at rising costs, deteriorating claims service performance, etc., and think that an RMIS will solve all their problems. In fact, one provider of claims services, previously a manual operation, believed that a new, state-of-the-art RMIS it was about to install would "do everything" and solve all its problems. The intimation is that the system *replaces* the decision-making, evaluative process. It doesn't. The system *enhances* the process.

This myopic thinking is dangerous, whether one is considering designing and installing a new risk management information system or redesigning an existing one. Wrong decisions, as I have said in past columns, are expensive.

Why do people continue to make poor systems decisions? I have thought about it and identified the base cause: They do not do their homework.

Here are three general principles that will help you to avoid this trap:

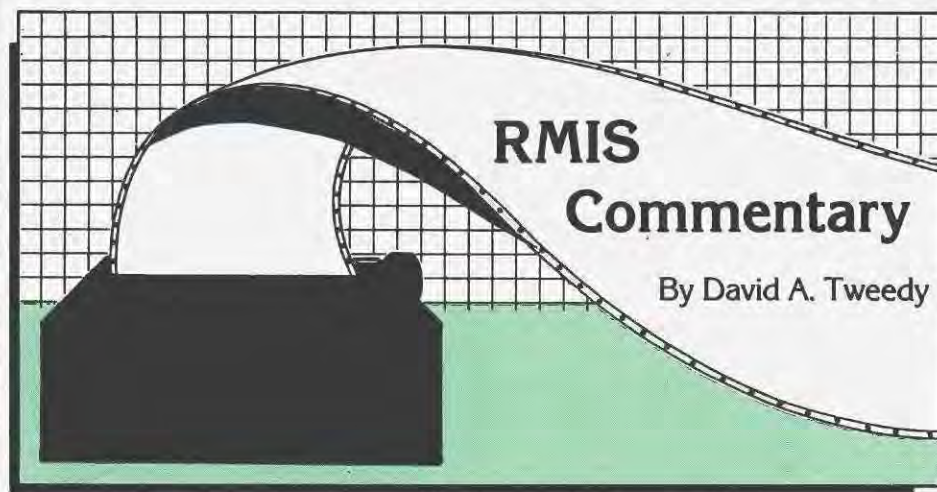
- ✓ Understand the difference

between information systems and operational systems.

Too often, people cannot "see the forest for the trees." The same is true with RMIS or any other management information system decisions. People focus on the system—meaning the assembly of hardware and software in telecommunications equipment

operational system that already exists.

A good example would be the automation of a third party claims administrator that used computers for certain things (recording payments, for example) but maintained paper files for everything else (investigation results, medical bills, etc.). Simply installing an automated claims system



designed to perform certain functions. They forget that within their organization there already exists a "system," best described as a complex interaction of people, departments and external agencies—all connected by telephone, paper linkups, computers and meetings. That system must be clearly understood first.

Making a decision on a RMIS without first evaluating the operational system within your organization is a formula for trouble. The RMIS may not function at all within the parameters of the

that has the ability to store, evaluate accuracy, pay and record information on indemnity and medical claims is worthless unless the company's operational system is modified. If management does not want to change this style, you have just spent a lot of money on an information system that has little benefit.

- ✓ Mesh your RMIS abilities with corporate objectives/mission.

Another myopic trap that some fall into is failing to match the RMIS with the organization's mission or corporate objectives. For example, if

the risk manager selects a system that is unable to grow within the organization's increasing acquisitions, the RMIS investment is a waste.

Part of a company's operational system should include a clear understanding of where management is heading with the company in the short and long term. I understand there are problems in estimating a company's direction or growth, but clearly some attempt must be made before planning any major information system changes. That means regularly communicating with senior management.

- ✓ Do not focus on "bells and whistles" but on the "meat" of an RMIS.

Another common failure is the tendency to be "wowed" by bells and whistles on an RMIS that look great but actually have no real application to the situation at your organization.

For example, I have had many people say they would like loss development and forecasting modules added to their RMIS to help them budget for future years' losses. When I asked them how many annual claims they have per year, the typical answer is less than a few hundred. Statistically speaking, that is an insignificant amount and will produce highly unreliable numbers.

Other functions, such as imaging, electronic mail and even cost-of-risk allocation also may not be appropriate for a given situation. One client I spoke with had an existing RMIS with a cost-of-risk allocation module. When

Continued on page 26

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Communicating managed care

Continued from page 24

A good communication program must anticipate employee concerns and address them upfront.

The program should include:

- Communication objectives.

The objectives of the communication program are to clarify the rationale for adopting the program and to explain the program's mechanics so that employees can make informed decisions about providers.

In addition, the program should review differences between the new program and the medical coverage available through either the indemnity plan or HMOs. Finally, the communications program should ensure a smooth transition to the new program.

- A letter from the chief executive officer discussing the impact of health care cost increases on the company and reasons why health care benefit changes need to be made.

- The above-mentioned letter should be followed by a more in-depth article in a company newspaper or magazine, which comments at length on the reasons for implementing the new managed health

care plan.

- Establish employee focus groups as they can serve a number of purposes. The sessions help pinpoint issues and concerns that need to be dealt with in print material and also can serve as a stage for a videotape about the new health care program. Based on comments from these focus groups, you can fine-tune your communication message.

- The culmination for your implementation is small group meetings. The meetings could open with a videotape, followed by leaders walking through the new benefit program in detail using slides or handouts. After a question-and-answer session, employees should receive information packets containing descriptive brochures, summary pamphlets, provider directories, rate sheets, enrollment forms and a feedback card.

This type of comprehensive communications program by itself will not guarantee that the employees will accept the program; however, without a well-planned and implemented communication program, your chance of success will be greatly reduced.

In my next article in May I will review other aspects of implementation, including employee reaction, network building and administration. ■

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

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



Mr. Duva

This month's column on employee benefits issues is written by Joseph W. Duva, director of employee benefits at Allied-Signal Inc. in Morristown, N.J. Susan M. Werner, director of risk management at Hardee's Food Systems Inc. in Rocky Mount, N.C., answers risk management questions. William J. Miner, an actuary with The Wyatt Co. in Chicago, answers actuarial questions on benefits issues. Richard E. Sherman, a principal with Coopers & Lybrand in San Francisco,

answers actuarial questions in the casualty field. Mr. Duva's and Ms. Werner's columns usually appear alternately on the second Monday of each month. Mr. Miner's and Mr. Sherman's columns appear alternately on the first Monday of each month. Mr. Duva's next column will appear in May.

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

Evaluating RMIS need

Continued from page 24

I asked how often it was used, he said once a year. After that, he performs a manual check on it to see if it was done right, which defeats the purpose of the RMIS module.

Now I am not saying these functions are not valid. What I am saying is that they should be obtained only if they will be used.

Conducting a thorough needs identification process will help eliminate these observed problems.

For one thing, you can sit down and draw a process flow chart to discover just how information flows through

the risk management or claims department (I know this doesn't sound exciting, but it really is helpful). Before you even go out and select a system, you can correct some of the process mistakes and bottlenecks that you discover.

The needs analysis also will help you cost justify the system that you are looking for. If you have identified problems, you are better able to quantify tangible savings that could be corrected through reduction of inefficiencies or focusing on problem claims areas that the system will help you identify.

In the final analysis, the RMIS is designed to help you do your job better. It is a tool that helps improve your efficiency to perform risk management or claims management decisions in a meaningful way.

I hope that this topic has not been discouraging to those anticipating a major project in the immediate future. In fact, it should be an incentive to do it right the first time.

As I have said in the past—and continue to say—a well-designed and responsive RMIS is an invaluable tool, well worth the time, effort and money. ■

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.

Workplace stress led to heart attack: Court

The Supreme Court of Oklahoma held that a myocardial infarction caused by mental stress and anxiety created within the work environment was compensable under the Worker's Compensation Act.

In 1981, Kenneth Docker was employed by Oklahoma State Technical University as a data processing instructor. From 1981 until March 1984, he had generally above-average job performance evaluations. In 1984, a new program manager was appointed. Shortly thereafter, she asked Mr. Docker to work overtime without compensation to help develop a new curriculum. When he refused, his relationship with the manager became strained, causing him to suffer from insomnia and anxiety.

He later received a below-average job evaluation. This upset him and he became worried about loss of his job. The director sent him a letter indicating he was a poor instructor and if he did not improve, he would be forced to resign. His anxiety and insomnia were aggravated and he sustained a myocardial infarction on April 30, 1984. He sought compensation but was denied. But, the Court of Appeals ruled in his favor.

The state Supreme Court was satisfied that Mr. Docker's heart attack was sustained in the course of his employment and the causal connection was linked to work-related stress and anxiety. *Docker vs. Oklahoma State University*, Supreme Court of Oklahoma, Dec. 21, 1988 (BI/05/Jan.-\$10).

Coverage denial valid, despite notice error

The Supreme Court of Florida ruled that a comprehensive general liability insurer was not prohibited from denying coverage, notwithstanding its non-compliance with notice requirements.

Block Marina Investment Inc. obtained a comprehensive general liability insurance policy from

Legal briefs

AIU Insurance Co. that contained an exclusion for damage to property in the care, custody and control of the policyholder. Although a marina operator's legal liability endorsement to the policy was written that would have provided coverage for the claim in question, this endorsement was eliminated from the policy prior to the act of negligence that gave rise to the claim against Block.

The insurer informed Block that, although the claim was not covered, it would provide a defense subject to reservation of its right to assert a coverage defense. Two weeks prior to trial, the insurer refused further defense, notifying Block that the claim was not covered. The trial court ruled against the insurer because it had failed to notify Block of its refusal to defend within 60 days after its reservation letter and within 30 days before trial as required by state law.

On appeal, the appellate court said that the effect of the trial court decision was to give insurance cover to Block for a loss, coverage of which had been eliminated from the policy, and the contract of insurance expressly excluded such losses from coverage.

The court said the Legislature did not intend to give a policyholder coverage excluded under a policy simply because an insurer fails to comply with the terms of the state notice law. *AIU Insurance Co. vs. Block Marina Investment Inc.*, Supreme Court of Florida, April 27, 1989; rehearing denied July 14, 1989 (BI/01/Jan.-\$10).

Insurer's refusal to cover job injury upheld

A clause in a group health insurance policy that excluded injuries "arising out of and in the course of any employment for wage and profit" has acquired a definite meaning that is generally recognized and is

the same meaning as in the Workers' Compensation Act, a Kansas appellate court ruled.

Thus, the court denied benefits to a worker injured on the job who filed a claim under his wife's group health insurance policy.

A.L. Leonard was hired to repair a company's roof. He, in turn, hired or contracted with Ronnie G. Crawford to help him at \$8 per hour. Mr. Crawford testified that he was working for Mr. Leonard and followed the latter's instructions. Mr. Leonard had no workers compensation insurance.

During construction, Mr. Crawford fell through the roof and sustained medical expenses of about \$8,400. He filed a claim under his wife's group health insurance policy issued by Prudential Insurance Co. of America. Prudential denied the claim. Mr. Crawford sued and won in the trial court.

The appellate court reversed, concluding the trial court erred in holding that a workers comp exclusion in the group health policy did not apply unless compensation benefits had been recovered or the injured party had a legal right to recover work comp benefits. According to the court, workers compensation law should be used to determine whether an injury arises out of and in the course of employment so as to trigger the exclusion. The court said that Mr. Crawford's injury fell under the exception. *Crawford vs. Prudential Insurance Co. of America*, Court of Appeals of Kansas, April 28, 1989; review granted June 6, 1989 (BI/03/Jan.-\$10). ■

These abstracts were prepared by Cases Unlimited Inc. Copies of these decisions are available by sending a \$10 check payable to Cases Unlimited to *Business Insurance*, 740 N. Rush St., Chicago, Ill. 60611-2590. List the number for each opinion.

Work comp reform

Continued from page 2

rating schedule instead of loss of wage-earning capacity to determine disability benefits.

Rep. Richard Smith, D-Bryan, an architect of the new legislation, and workers compensation insurers, which praise the reforms, call for continued vigilance in protecting the changes.

"I would caution anybody that has any notion that we have a bill that was compromised in the country that it has little impact, that you're wrong," Rep. Smith said.

"I don't think there's a better concept anywhere in the country among the states" that have attempted workers compensation reform," he said.

"It will work, but it will only work if we're vigilant," Mr. Smith said. "We've created a workers comp system on paper, and now our job is to try to keep the system."

"My biggest fear now is that the trial lawyers will continue to try to find ways to pervert this system as I think they did with the system we had before. There wasn't anything inherently evil about our previous law, but it had become perverted and manipulated," Mr. Smith said.

"The worst thing we could do as Texans and as people who are interested in fair and equitable reform of the system is to let our guard down and not be vigilant about changes both in the rule-making process and in the Legislature."

Dick Brown, legislative coordinator of the Texas Compensation Insurance Assn., an insurer group formed to lobby for changes in Texas workers comp law, shared Mr. Smith's concerns.

"Time is running out for the trial lawyers, since most of the reforms will take effect during the next few months. So perhaps (the Texas Trial Lawyers Assn.) will make one last run, even if it's a kamikaze effort, at undoing Senate Bill 1 before it's too late," Mr. Brown said.

But Tommy Jacks, president-elect of the Texas Trial Lawyers Assn., said his group has no plans to mount an attack against the legislation any time soon.

"It's a little premature to be thinking about that," Mr. Jacks said in an interview following the Alliance seminar.

Workers comp is not even on the agenda for the current special session of the state Legislature, he points out.

But, Mr. Jacks said, "that piece of legislation is so screwed up it will probably be the subject of review during every session for the next decade or so. As it stands now, it's an unworkable system."

And, he predicted, workers compensation insurers "will be seeking changes as soon as the trial lawyers, if not sooner."

The expense of conforming to the new law will have insurers crying for change, Mr. Jacks said.

For example, the new system of adjudicating claims will "go slower, cost more and be a hell of a lot more complicated," he said. "There's no way that cannot affect their claims dollars. I don't think that has sunk in yet."

Although trial lawyers believe the workers compensation reform law must be remedied through amendments, they have no immediate plans to propose such changes, he said.

He also predicts that insurers will seek changes in the increased regulatory demands they will face.

Under the new law, insurers' claims handling processes will be more closely scrutinized, said Joe Gagen, chairman of the Industrial Accident Board, which is being replaced by the Texas Workers Compensation Commission. The commission will determine workers comp awards, which will be subject to additional administrative appellate steps before they can

reach a jury trial.

In fact, workers compensation insurers "are going to become more and more an adjunct of the governmental agency responsible for administering the program."

For example, Mr. Gagen said, insurers currently have 30 to 40 days to start weekly benefit payments after notification of an injury. "Under the new law, you're going to have seven days. Seven days to investigate the claim and either deny it or start benefits. And then 60 days to make some determination about liability in the claim."

"The agency will have the ability to go into your claims offices and audit your workers compensation files," Mr. Gagen noted. If violations are found, the commission can levy fines and charge for the audit, he said.

Insurers also are subject to an increased number of penalties that can be levied in many cases "irrespective of fault, irrespective of intent, but penalties for failure to

perform up to a certain level," Mr. Gagen said.

"You're going to have to pay a lot of attention to how you handle claims, or you're going to have the agency very much involved in how you conduct your business," he warned insurers.

Legislators, Mr. Gagen explained, set the stricter claims handling standards for insurers because they felt improper claims handling caused increased attorney involvement in workers comp disputes.

"The only way that legislators knew to get that accountability into the system" and decrease attorney involvement was to give regulators greater authority over insurers, Mr. Gagen said.

Legislators included some measures—such as the provision that calls for basing benefits on an injured worker's impairment rather than on his or her loss of wage-earning capacity—designed to reduce the cost of the system, Mr.

Gagen said.

But, lawmakers also informed insurers that they are "going to expect a very high level of performance" in their day-to-day claims handling, he said.

"Legislators sent a message to insurers that they want insurers 'to promptly act and actively investigate claims and make a prompt decision. If benefits are due, start those benefits, and don't pay benefits if you have reason not to pay them. And then explain the reasons why not,'" Mr. Gagen said.

However, he suggested that as a trade-off for this closer scrutiny of workers comp insurers' claims handling, the new law is designed to control the costs of the workers compensation system.

For example, he pointed out that under the new law:

- Medical care in some cases must first be authorized by the commission or the insurer.

- Benefits will be determined according to an injured worker's

impairment rather than loss of wage earning capacity.

- There are more stringent fraud penalties for workers who try to obtain benefits by fraudulent means.

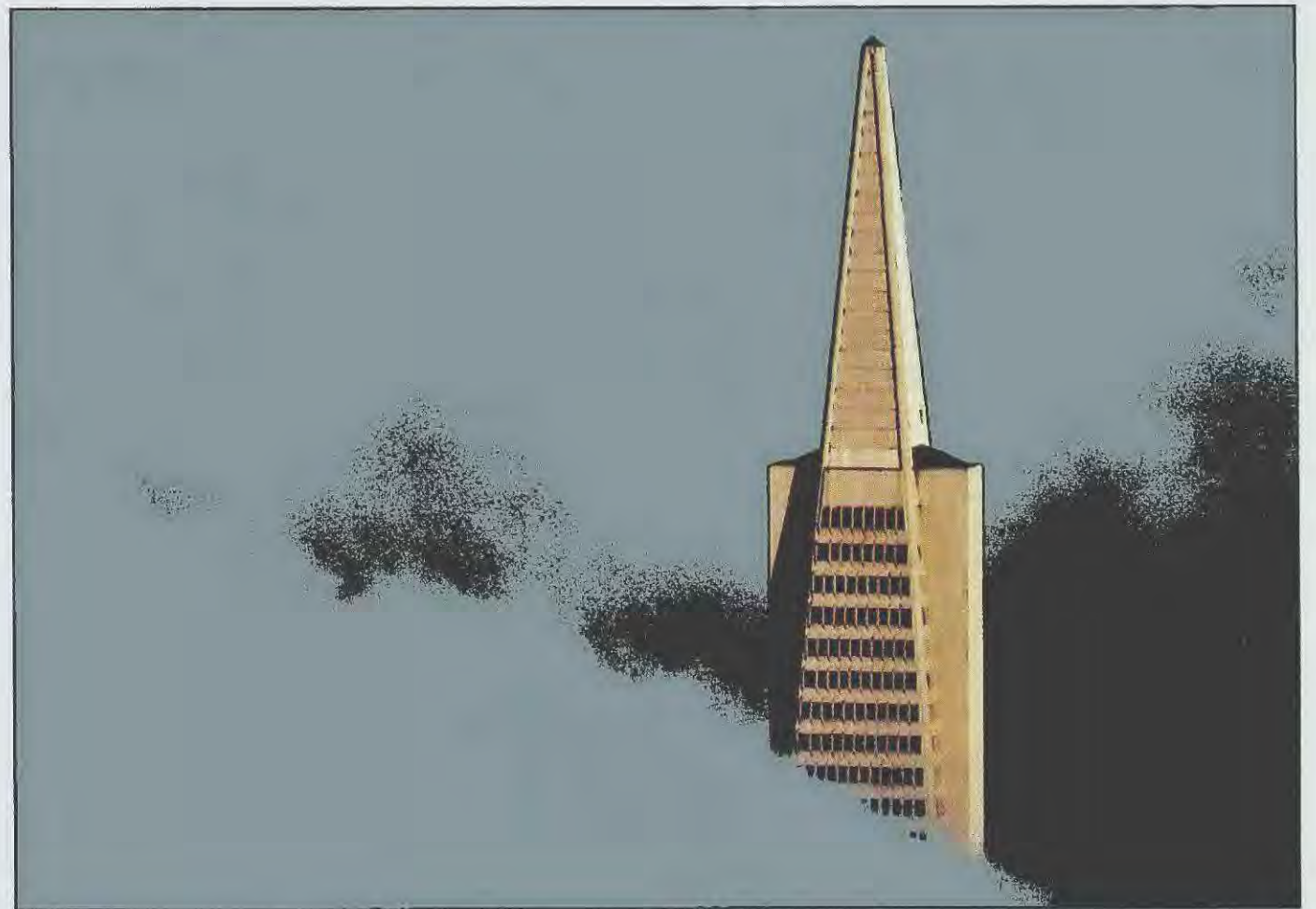
- There are stringent fee guidelines for medical providers as well as tough penalties for providers who overcharge.

Mr. Brown of the TCIA said that although the new law creates "some nuisances," such as new audit and reporting requirements, "few if any problems in our comp system" were not addressed by the sweeping legislation.

"Also, in many other states that have been through the workers compensation reform process, the legislatures more often than not have bashed the insurance industry as part of the process. This did not happen in Texas."

Mr. Brown summed up that "on balance, the insurance industry obviously paid a miniscule price for reform."

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Bank contracts

Continued from page 2

"Providing pass-through insurance coverage for BICs does not represent an expansion of the existing coverage. If a BIC meets the statutory definition of 'deposit,' then it is accorded the same insurance coverage that is provided for most other trustee employee benefit plan deposits," according to the study.

"However, in light of the unique risks associated with BICs, the FDIC believes that it would be prudent to monitor bank involvement in this market," the study adds.

The study disappointed, but did not surprise, the American Council of Life Insurance in Washington, D.C., said Gary Hughes, chief counsel-securities.

FDIC views on continuing the pass-through coverage for BICs were "myopic" and "legalistic," Mr. Hughes said.

Banks should only receive \$100,000 of FDIC coverage per contract—not per covered employee—regardless of the size of the contract, he maintains, adding that virtually all other bank deposits are insured this way. For instance, an individual depositor with a large bank account is only entitled to up to \$100,000 in FDIC coverage, he said.

He also advocates forcing banks to set up affiliates to issue BICs. The contracts then would not be considered federally insurable deposits.

Despite the FDIC recommendation, Mr. Hughes said he remains optimistic that federal coverage of BICs will be eliminated.

Insurers are encouraged by the Bush administration's budget message, which said the federal deposit insurance "systems needs to be reined in," but did not mention BICs, he said.

He also said that since BICs are a relatively new product—first offered in 1987—changing the insurance system now would not disrupt the market. Defined contribution plan sponsors could still buy BICs without FDIC coverage so long as they analyze the quality of banks offering them, he said.

The ACLI plans to press for legislation removing the FDIC coverage, he said. He does not have in mind adding such a provision to a current bill, but, he said, "it's still early in the year."

Meanwhile, James D. McLaughlin, director of agency relations-trust and securities for the Washington, D.C.-based American Bankers Assn., applauded the FDIC recommendations.

The current system, he said, "is not something that Congress has to fix."

"We're gratified that they reached that conclusion," said Mr. McLaughlin. "The insurance industry is trying to use the scare tactics of the (federal deposit) insurance fund to further their own competitive needs."

Insurers forget, he said, that for years they enjoyed a "virtual monopoly" on GICs. When banks entered the market, "they suddenly started to worry about competition," said Mr. McLaughlin.

"I think it's a clearly anti-competitive move on the part of the insurance industry," he said.

Outside observers are divided on FDIC coverage for BICs.

Kim McCarrel, a Portland, Ore.-based consultant with Wyatt Asset Services Inc., a Wyatt Co. subsidiary, said she was happy with the FDIC recommendation.

"I'm delighted. I think being able to diversify (investment contracts) across industries is very important" because it reduces the risk, Ms. McCarrel said.

Defined contribution plan sponsors would still be able to acquire BICs without FDIC coverage, acknowledged Ms. McCarrel, who said her clients look first at the underlying financial strength of an institution offering contracts. But, she added, BICs are easier to explain to plan participants when the full faith and credit of the FDIC is behind the contracts.

The FDIC coverage provides a "little added protection," she noted.

However, David Langer of David Langer Co. Inc., an actuarial consulting firm in New York, said: "I don't think the way it's currently structured banks should have the (FDIC) guarantee." He said he was concerned there were no safeguards to prevent a repetition of the savings and loan crisis in the banking industry.

Only banks following federal investment guidelines, he said, should be permitted to offer FDIC coverage for BICs. For instance, banks with junk bond holdings should pay a higher premium to the FDIC "for the privilege," Mr. Langer said.

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InsurerTopics

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to insurers and reinsurers



Hazards ahead

By MARK A. HOFMANN
and LAURA MAZZUCA

When the going gets tough, the tough get going, runs the football adage.

But when the going gets tough enough—when profit margins thin and legislators become more aggressive—even tough property/casualty insurance companies start looking elsewhere for business.

And that can mean tough times for the agents who represent these insurers.

Commission cuts, increased volume demands, cut-rate commercial insurance premiums and withdrawals from unprofitable markets have all shaken the relationship between insurers and their agents.

Insurers say they're not going out of their way to make agents' lives miserable. And, both sides agree that insurer-agent relations vary greatly according to whom you speak to and from where they're talking.

For instance, in states where consumer advocacy groups remain dormant and restrictions on insurers like Proposition 103 have not been proposed, producers and insurers can get along famously.

"Companies see Illinois as a good marketplace and are more than willing to write here," said Jack Payan, president of Payan-Stitt Corp., an agency in Palos Heights, Ill.

Payan-Stitt has maintained a contract with one insurer since Franklin D. Roosevelt's early years in the White House and with two others since the 1940s.

However, in some Sun Belt states, where lackluster economies exacerbate already-low property/casualty rates or where restrictions on insurers' rates have been enacted or are

Tough conditions strain insurers' ties with their agents

pending, many producers are cultivating surplus lines connections in case standard insurers desert their markets.

Such regional disparities, however, are overshadowed by industrywide problems—especially mounting pressure from consumer advocacy groups for reforms and preparation for an impending but elusive hard market (see story, page 28F).

"Anytime you have legislation that's perceived as being onerous, the potential for an impact in the relationship between companies and agents is there," said Don Scruggs, executive vp and chief operating officer of New York-based Continental Corp.'s agency group.

The insurer tries to avoid "acting precipitously": Despite Proposition 103's mandated 20% rate rollbacks, Continental, a minor player in the California personal lines market, neither cut commissions nor attempted to withdraw from the state, Mr. Scruggs said.

"We have tried to maintain the same kind of marketplace as before," he said.

General Accident Insurance Co. of America, which is represented by 175 agents in California, says it also tried to avoid hasty and drastic action in the wake of Proposition 103.

Upon learning the company would have to refund a portion of its premiums to California policyholders, executives decided very quickly not to require agents to return a portion of their commission, said Frank Coyne, executive vp for Philadelphia-based General Accident.

"We have no ambiguity about our dedication to the independent agency system," said Mr. Coyne. "With the complexity of the business today, the independent agent is more important than ever."

Other companies have reacted differently to the California law.

Hartford, Conn.-based Aetna Life & Casualty Co. cited Proposition 103's restrictions on rate increases last year when announcing a cut in personal lines automobile commissions from 15% to 10% beginning in April.

"You can imagine what the reaction was. Some agents were not real happy about it," said an Aetna spokesman. He added that the commission cuts were necessary to compete with direct writers.

The state's largest auto insurer—Bloomington, Ill.-based State Farm Mutual Automobile Insurance Co.—neither withdrew nor cut commissions. State Farm's 2,400 California agents, independent contractors who represent only State Farm, reacted favorably, said Don D. Rood, senior vp-agent.

"We've had a tightening of our relationship," said Mr. Rood. Agents in other states "feel good about what happened in California," he said.

Closer relations between SAFECO Insurance Co. of America and its agents may be due more to what SAFECO didn't do in response to the law than what it did do.

Continued on next page

Criteria

Continued from page 28B

Royal's Mr. Watt also emphasized the importance of perpetuation, explaining that his company considers the presence of "succession criteria" one earmark of professionalism.

Other important criteria, said Mr. Watt, include reputation, skills and, most importantly, the presence of a business plan to set goals for the agency and its insurers. Business plans are "relatively new phenomena" and many agencies have adopted formal business plans only in the past decade, he said.

Zurich-American also seeks a long-term business plan including an annual premium goal, a renewal goal, a loss ratio goal and a "hit ratio," said Mr. Dudek. The hit ratio attempts to predict how many

submissions will be needed to achieve the premium goal.

Professionalism, said Transamerica's Mr. King, is also a central consideration. "We're looking for someone who's in the property/casualty business for the long haul," he said. Continuing education, he added, is "the first indicator of professionalism of an agency."

Zurich-American also stresses education, looking for a "producer whose staff is involved in insurance education and who is constantly upgrading personnel knowledge," Mr. Dudek said. However, he added that education alone does not define professionalism or attractiveness. Agencies must be financially stable, he said, but committed to business expansion.

"We're looking for producers who want to grow," he said. ■

Insurers, agents try to avoid hard feelings in tight market

By MARK A. HOFMANN

Neither insurers nor agents want to see a future hard market cause the same sort of hard feelings that the mid-1980s hard market did.

When the property/casualty insurance market suddenly turned hard in 1984 after a prolonged soft market, agents found that they could not renew business they had placed with the same insurer for years for any price. Coverage simply wasn't there and agents were left to face angry customers alone. Agents were ill-prepared for what happened and agent/company re-

lations soured.

Insurers don't want that to happen again.

"We learned a lot," said Chuck Dudek, vp and director of marketing-standard lines for the Schaumburg, Ill.-based Zurich-American Insurance Group.

Consistency is another key to maintaining good agent/company relations. "It's not so much what you do at the time of the market change as it is what you've done consistently over time," said Greg Georgiess, senior vp and managing director of Chubb & Son Inc., a subsidiary of Warren, N.J.-based

Chubb Corp.

Mr. Georgiess said that his company seeks long-term relationships with agents. Top managers visit agencies for one-on-one discussions with producers and underwriters accompany agents on client calls, he said.

"We're in constant communications with our agents," said Bruce W. Herrick, president of American Reliance Insurance Co., a Lawrenceville, N.J.-based insurer active in five Mid-Atlantic states and Florida.

Mr. Herrick's company won national acclaim from agents in the mid-1980s for "EZ-One," a program in which senior company executives, including Mr. Herrick, spent time in agents' offices to learn how to ease friction between agents and the company (IT, Dec. 12, 1988). EZ-One helped attract national recognition for the insurer, notably the Alexandria, Va.-based National Assn. of Professional Insurance Agents' Company Award of Excellence in the regional company category in 1985 and 1986.

"We've never stopped that process," said Mr. Herrick. "It's just working and building relationships and understanding." He termed the effort "in the trenches work."

Mr. Herrick noted, however, that companies like his might have a slight advantage over some national companies when dealing with agents. "Our agents know we're fairly stable in our underwriting philosophy," he said.

American Reliance targets Main Street commercial accounts and small contractors that generate annual premiums below \$25,000, Mr. Herrick said. The prices for such accounts simply don't swing as violently as the prices charged very large commercial accounts, he said.

John King, national marketing manager—commercial insurance for Woodland Hills, Calif.-based Transamerica Insurance Co., also stressed pricing stability for keeping agent/company relations on even keel.

"We haven't been a player in the soft market, so the impact (of a harder market) won't be as significant on our agents," said Mr. King.

Still, even given the best efforts of insurers to avoid market dislocations, dislocations—including withdrawals from certain territories or lines of business—occur.

"It's very, very difficult to prepare your producers for these things," said Bill Watt, senior vp-field operations for Charlotte, N.C.-based Royal Insurance Group.

Insurers find they cannot get returns on certain lines of business in some areas, said Mr. Watt. If the returns aren't there, the insurer withdraws. "It's something we don't relish," said Mr. Watt. "There is not any formula," he added.

"The underlying principle is we value our agency relationships. The last thing we want is to be arbitrary," he said.

Zurich-American's Mr. Dudek said that when his company has found itself forced to retrench in writing workers compensation coverage in some states, it has attempted to enlist the help of agents in getting the laws changed.

"We work with agents to influence reform in the legislatures," and encourage letter writing to state representatives, Mr. Dudek said. "We're taking a very active role." ■

May

Advertising/Sales Promotion IMS Conference Report

What strategies are used by successful agencies to promote their firms? Returning from the recent Insurance Marketing Services Conference, BI will report on how agents can improve their marketing and advertising efforts to generate more business.

Issue: May 7
Ad Closing: April 24

June

Niche Marketing

Want to increase your business? You've got to find that niche that sets you apart from your competition. BI will look at how niche marketing works for agents and brokers, how they can specialize by type of coverage they offer as well as by targeting their clients demographically or by nature of business.

Issue: June 4
Ad Closing: May 22

July

NAIB Conference Report

What hot topics will be discussed at the National Assn. of Insurance Brokers conference...the volatile property/casualty market...insurer solvency...or, the industry's image? Joining executives from leading insurance brokerage firms at this meeting, BI editors will report on the state of the industry and issues vital to both brokers and agents.

Issue: July 2
Ad Closing: June 19

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Agent/Broker Topics

Insurer stability remains prime concern of agents

Ratings, market commitment cited

By LAURA MAZZUCA

Agents and brokers continue to focus on stability when looking for insurers to represent.

Most agents rank insurer stability—in the form of a solid A.M. Best Co. rating, dedication to a given market and commitment to long-term relationships—as among the top traits they expect insurers to provide.

And while insurers frequently tout support services like assistance with perpetuation planning and automation, agents and brokers do not assign a high priority to these functions.

Although market stability has not been a problem in the recent soft underwriting climate, producers hope that today's relationships with stable insurers will hold up when the market hardens (see story, page 28A).

"We've always sought companies with unique financial strength and a historical ability to stay in the marketplace," said Jack Payan, president of Payan-Stitt Corp., a family-owned agency in Palos Heights, Ill., with \$7 million in premium volume.

'Although we realize that there are problems that can arise in cycles that no insurer can avoid, we will not associate with companies that don't have long-standing financial and market stability,' says Jack Payan.

"Although we realize that there are problems that can arise in cycles that no insurer can avoid, we will not associate with companies that don't have long-standing financial and market stability," said Mr. Payan.

After company stability, producers looking for insurers cite their desire for competitive products and prices backed by efficient service from insurers, including quick response time, good claims service and consistent underwriting practices.

Quality products and services are particularly important at a time when consumers are growing increasingly critical of the insurance industry, said Richard Baker, chief executive officer of Myers Baker & Co. Inc., a Chicago agency with \$25 million in premium volume that represents about a dozen insurers.

Agents' desire for better service is noted in recent reports by the National Assn. of Professional Insurance Agents and the Independent Insurance Agents of America.

A survey of state IIAA chapters last August, for instance, found that agents across the country were primarily concerned with an insurance company's service, operations/products, unilateral actions, contracts, communications and its promotion of the independent agency system.

Desirable insurers identify target markets, define their philosophies and provide products geared toward these markets, said Robert Nicosia, president of Pilgrim Insurance Agency in Nutley, N.J., an agency with \$30 million in premium volume that represents eight major insurers and five regional companies.

Producers also expect quick response from insurers, and insurers—aware of pressure from consumers—have improved their response capabilities in the last year or so, especially for preferred agents, said Mr. Baker.

Good service from insurers includes a savvy underwriting department, promptly returned phone calls, a consistent understanding of the market, quick and accurate turnarounds on quotes, policy turnaround within 30 days and promptly processed endorsements, said Owen D. Pipal, president of Pipal-Anderson Inc., an agency in Boise, Idaho, with \$1.6 million in premium volume that represents six insurers.

"Responsiveness has always been our No. 1 priority. That's what makes an insurer attractive to us," said Conrad Foa, chief executive officer of Foa & Son Corp., a New York brokerage with \$40 million in premium volume. Only in the "hardest of hard" markets is delivery system quality superseded by the need for capacity, he added.

Even commissions and other financial considerations take a back seat to quality service, according

more aggressive in applying the same standards to their insurers that the companies in turn apply to them.

The IIAA report on agent-company relations also contained "An Independent Agent's Form for Company Evaluations," a standardized system through which agents could rate insurers on a scale of 1 for poor to 5 for excellent in areas like operations and product availability, communications, claims service, contractual relationships and promotion of independent agents.

And in a two-part project, "Evaluating Company-Agency Relationships" (A/BT, Nov. 13, 1989), the PIA and its advisory council of 78 insurance executives polled insurers on what they want from agents, and developed a similar agency rating form that allows agents to evaluate insurance companies.

It is especially important for agents to rank insurers on quantifiable criteria, just as insurers increasingly seek more information about agency loss ratios, financial performance and other data.

"If (insurers) want a detailed account of our perpetuation program, we have a right to know what their mission is, too," said Mr. Jones of Moore & Johnson.

In many cases, perpetuation agreements are now included in insurer contracts.

Although Chase & Lunt Inc. has always looked at service, products and capacity, it has frequently underestimated the importance of this contractual relationship, said Josiah H. Welch, president and treasurer of the agency in Newburyport, Mass., with \$8.5 million in premium volume.

"Twenty years ago, I would have been hard-pressed to put my hands on our contract, let alone be able to tell you what it contained," he said.

Producers today are more sophisticated about what a contract should contain. "It shouldn't take a back seat, but instead be considered vital on deciding on whether to take a company on board," Mr. Welch added.

Most producer-insurer contracts contain simple, basic provisions on termination, indemnification, arbitration and other elements to protect the producer; and a profit-sharing agreement, which spells out what remuneration the producer can expect from the insurer.

Too many agency contracts are unilateral, allowing insurers which become dissatisfied to cancel contracts, complained Mr. Welch. Contracts should instead allow both parties equal power, he said.

Producers also stressed the importance of working with insurers that demonstrate a spirit of cooperation and understand how the independent agency system operates.

"We're looking for a company that wants to know its agents, one that doesn't become a corporate monolith," said Mr. Tucker of Leick, Marshall in Dallas.

Other agencies look for "a willingness to work with an agent on different problems," such as in smoothing over a rocky relationship with a client, said William M. Houston, president of Insurance Services, a Denver agency with \$3 million in premium volume.

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Agents build ties with insurers in soft market

By LAURA MAZZUCA

While agents and brokers cannot accurately predict when the commercial property/casualty insurance market will turn, they agree that relationships developed over the years with top insurers will pay off when the market does tighten.

"If the market turns hard tomorrow, we've got the companies in here that could ride it through for us," said Jack Payan, president of the Payan-Stitt Corp. agency in Palos Heights, Ill.

Insurers and producers seem to have learned from problems in the last hard market and are doing their best to keep lines of communication open (see story, page 28A).

For instance, insurers are "spend-

ing more time with us and courting our good business," through regular office visits and keeping agents abreast of new products they offer, said Conrad Foa, president of Foa & Son Corp., a New York brokerage.

Many agents and brokers are trying to improve their standing with insurers by focusing on their insurers' niche marketing targets, submitting accurate and complete information, and training their staffs.

Others, however, say that it's just business as usual, whether or not a hard market arrives.

"I'm in a real wait-and-see mode" since the overall market remains soft in Idaho, said Owen D. Pipal, president of the Pipal-Anderson Inc. agency in Boise. "We're just maintaining our insurers rather than

jumping to the next hot market on the street."

Producers actively preparing for a hardening market stress communication with insurers.

"We have a responsibility to listen to companies and not just ignore them," said Clay Tucker, president of Leick, Marshall, Neal & Associates in Dallas. "Agents can be very insensitive to a company's problems, too."

Good relations, fostered by work on agency councils, will help Mr. Tucker's agency retain its markets when the cycle hardens, he says. "We're confident they'll stay, but it's because of the hard work we've done in the soft market."

Other agents prefer to deal with insurers individually rather than go

through councils or associations

"Right now we're just trying to maintain good contact with the management of the companies we deal with," said Richard Baker, chief executive officer of Myers Baker & Co. Inc., a Chicago agency.

His staff meets regularly with underwriters and service staff as well as insurer executives, with each producer keeping tabs on a particular insurer, said Mr. Baker. So far, he said, companies seem receptive to agency overtures.

"If there is a problem, we'll sit down, discuss and evaluate where the system is breaking down," said Robert Nicosia, president of Pilgrim Insurance Agency in Nutley, N.J.

Rather than winning and dining executives, he said, "talking business"

is the order of the day. "Agents are no longer afraid to speak their minds as long as it benefits both sides of the relationship," he said.

Such dialogue, say insurers and producers, can ensure that both sides focus on the same thing, such as specialized niche business.

For instance, Jerry T. Hargrove, president of North Side Insurance in Atlanta, recently invited his top insurers to discuss what lines they were interested in writing.

He found most of his underwriters wanted to write coverage for small commercial risks such as shopping centers, printers, large property risks and non-residential contractors. Very few, however, were interested in personal auto or monoline workers compensation in his area.

"We've broadened the base of what we write in commercial lines," said Daniel J. Blum, president of The Insurance House Inc. in Lafayette, La., which now places specialized property/casualty coverages for alligator, catfish and crawfish farmers.

Agents and brokers also emphasize that they must improve their own performance.

"The bottom line is loss ratios," and the best way to maintain good ones is to deal consistently with insurers, providing accurate information about risks, said Mr. Payan.

His agency concentrates on sending complete histories on applications, including losses; being on time with premium payments; submitting accurate, complete applications and underwriting information; and answering insurer questions within 24 hours, he said.

Mr. Payan also recommends that agency employees pursue continuing education. He sends representatives to seminars offered by preferred insurers, "not only to learn, but to make contacts."

"This is an area that's sometimes ignored by agents," he said.

Some producers are preparing for a market turn by either increasing or decreasing the number of insurers they represent.

Adding insurers, some believe, is a safe hedge against loss of capacity in a hard market.

L. Merritt Jones Jr., president of Moore & Johnson Agency Inc. in Raleigh, N.C., says he lacked confidence in several of his regular insurers. He added two last year to provide solid markets for preferred clients.

Other producers contend that solidifying and deepening relationships with a few companies will assure insurer fidelity in a hard market.

"We have cemented relations and placed our business with a lot fewer companies," said Mr. Foa, who has concentrated his brokerage's business with eight insurers today, compared with 15 in 1984.

"The people you're going to offer your capacity to are your major producers," so it doesn't make sense to keep too many around, he said.

Producers would do well to consolidate markets to emulate insurers, which have focused almost exclusively on their preferred agents and eliminated the unprofitable ones, said Mr. Payan. Although his agency recently added a fourth personal lines insurer, it was only because the other three were not performing up to par, he said.

Adding companies, with the attendant bookkeeping and processing, increases agency costs, he said.

While many agents agree that cutting back to one or two insurers in a tight market would be virtually impossible, they say they are more selective when choosing insurers.

Agents are "looking very hard at the companies for a product or a competitive edge," said Mr. Nicosia, whose agency just added another insurer because it offered a product that a client needed.

Loss Control & Catastrophe Planning

Hugo. The San Francisco quake. Insurers catastrophe planning was surely tested. This issue will look at how insurers dealt with the ravage of Hugo and the destruction in San Francisco following the earthquake. BI will also examine how insurers help their policy holders prepare to survive tomorrow's disasters.

Issue: April 16
Ad Closing: April 4

Automation: Underwriting/Policy Management

Which underwriting and policy management functions are ready for the age of automation? And what are the latest electronic marvels available to insurers for streamlining those functions? BI will talk to insurers, consultants and computer manufacturers to learn which systems work ... and which don't.

Issue: May 21
Ad Closing: May 9

Advertising/Marketing/Sales Promotion

When budgets are set, what can insurers do to stand out in their market and get the most for their advertising and sales promotion dollars? BI will look specifically at events sponsorship, and particularly at "second tier" events, as viable marketing investments. And, BI editors have invited advertising executives to review and critique insurance advertising in general.

Issue: June 18
Ad Closing: June 5

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EC changes boon to insurers: Report

By MARK A. HOFMANN

HARTFORD, Conn.—The property/casualty insurance industry will benefit from the coming economic integration of the European Community, says a securities firm report.

With the advent of a single market in Europe, demand for property/casualty insurance will increase "at a rate that is expected to be in excess of the EC's gross national product growth rate," concludes insurance industry analyst Conning & Co. of Hartford, Conn.

"As wages and savings rates increase, per capita demand for personal lines and life insurance products will increase," says the report, "Insurance Opportunities in the European Community of 1992."

"Because per capita spending on insurance is generally less in the EC than in the U.S. or Japan, market penetration opportunities exist and will be easier to realize in a stronger, more fluid economy," it continues.

By July 1, "buyers will be able to purchase the broadest coverage at the most competitive prices from any EC or non-EC insurer licensed anywhere in the EC. Insurers who can efficiently provide innovative products and services for both the multinational and larger national companies should prevail in this competitive environment," it said.

However, U.S. property/casualty insurers and brokers reflect "less of an international perspective" than their European counterparts, the authors say.

"In choosing to enter the market, the interwoven relationships of European insurers and banks and their perspectives and strategies for long-term profits rather than quarterly results should be understood. Regardless of the place of establishment in Europe, U.S. firms must have the ability to provide full services completely integrated into European business practices, reflecting both cultural familiarity and a client preference for custom-tailored, nationally oriented products," the report says.

Consolidation among European firms on the eve of a single market, presents significant opportunities for U.S. insurers, reinsurers and brokers that provide service to alternative risk financing facilities, the report points out.

Captive formation among European parents, Conning says, will be "enhanced" in 1992, and "these new captives, reflecting the general increase in sophistication in risk management and financing techniques, are likely to be more highly capitalized and will write more of the parent company's total risk exposures, including health care."

European demand for liability coverage, the report predicts, will gradually increase,

in part due to recent EC directives on product and pollution liability and "to the creeping exportation of American attitudes on litigation." But the lack of contingency fees and relatively low number of jury trials in Europe will hold that demand in check, Conning predicts.

The authors predict that price competition among insurers will be fierce in the short term, though the "market may stabilize by the mid-1990s."

Life insurers will feel the impact of economic integration more slowly than their property/casualty counterparts, says the report. EC member nations are reluctant to "surrender regulatory control over politically oriented issues like pensions," says the report. In addition, there is inconsistency in terms and pricing of life products from nation to nation.

Nevertheless, "As the climate improves, life insurers will benefit from a strong demand, a changing product line, and from enhanced distribution brought on by operating efficiencies and closer associations with the financial services community. As national differences in life insurance product lines gradually diminish, products will become easier to market across the EC and perhaps more sophisticated and interest-rate sensitive as Europe slowly becomes more exposed to the popular, but less profitable,

American and U.K. life products."

The report also notes that political and economic democratization that has shaken Eastern Europe in 1989 and 1990 will "have a fundamental influence on the environment" of Western Europe. But, the authors say, the impact of recent and continuing events in Eastern Europe is "highly complex" and the issue is "too unsettled to clearly determine longer-term patterns."

"Getting at Eastern European markets will be daunting," the report warns. "Each nation is burdened with underdeveloped state infrastructures manned by now discredited Communist party bureaucrats. Private enterprise is minimal. Turning around these systems should be undertaken as soon as possible to maximize chances for success."

The report also says that "the insurance market share trump card of the 1990s is clearly Eastern Europe with 3.63% of the world premium. The Eastern European nations (excluding the Soviet Union with its 285 million potential consumers) offer to the EC most importantly its pent-up demand for insurance products and services."

"Insurance Opportunities in the European Community of 1992" costs \$425. For further information, contact Jack Corroon, Conning & Co., 101 Pearl St., Hartford, Conn., 06103; 203-527-1131

College to open underwriting department

NEW YORK—Pace University's Lubin Schools of Business will open a Center for Education in Insurance Underwriting this fall.

John M. Cozzolino Jr., former director of research at the Insurance Services Office Inc. in New York, will direct the center.

Initially, the emphasis will be on property/casualty insurance underwriting. One long-term goal is the development of an underwriting curriculum for both graduate students and undergraduates at Pace and other schools.

He said an underwriting curriculum is necessary, even though Pace offers actuarial science courses. The new curriculum will be modeled after university finance programs.

"There is a contrast in the underwriting field. Actuaries are quantitatively trained and specialized, whereas underwriters aren't quantitatively trained and traditionally learn underwriting through on-the-job experience. I'd like to see a change in training and the development of a new generation of analytically trained underwriters," he said.

Initial funding for the center is a \$10,000 grant from the Philadelphia-based CIGNA Foundation, CIGNA Corp.'s philanthropic arm.

For more information, contact Mr. Cozzolino at 212-346-1915.

FAIR plans

BOSTON—The residual property insurance market recorded a \$17.7 million statutory underwriting loss during the first six months of 1989, down 18.8% from \$21.8 million during the comparable period of 1988, according to the Property Insurance Plans Services Office, a division of the National Committee on Property Insurance.

Operating losses sustained by Fair Access to Insurance Requirements—or FAIR—plans dropped 38% to \$6.2 million in the first six months of 1989 from \$10 million in the first six months of the previous year.

FAIR plans, which provide coverage to property owners normally considered uninsurable because of exposure to risks over which they have no control, totaled \$138.4 million in the first six months of

IT briefs

1989, down 8.3% from the first half of 1988.

Reinsurance text

MALVERN, Pa.—A new two-volume reinsurance text for use in a course required for the Insurance Institute of America's new Associate in Reinsurance designation will be available in July.

"Principles of Reinsurance" will be required reading in the class of the same name. Other courses required for the designation include the new Reinsurance Practices course and two courses required for the Chartered Property & Casualty Underwriter designation: CPCU 5, Insurance Company Operations; and CPCU 8, Accounting and Finance.

The cost of the textbook was underwritten in part by a \$30,000 donation from the Brokers & Reinsurance Markets Assn., a group of U.S. reinsurance brokers and underwriters based in Olympia Fields, Ill.

A text for Reinsurance Practices is due out in December.

Each volume of "Principles of Reinsurance" will cost \$24.

Fraud indictments

BROOKLYN, N.Y.—Three attorneys, a law office manager and four private investigators have been indicted on federal racketeering charges for allegedly bilking the city of New York and insurance companies out of \$9 million by filing fraudulent personal injury claims.

The indictment charges that defendants committed perjury, tampered with jurors, created fraudulent medical reports, back-dated documents and obstructed court proceedings.

As part of the scheme, the indictment charges, the defendants obtained false statements from prospective witnesses; falsified physical evidence; and created fraudulent medical reports, photographs and other documents.

Among the cases mentioned in the indictment were two auto acci-

dent cases in which a person was allegedly bribed to testify as an eyewitness, even though he did not see either accident and was in prison on forgery charges when one occurred.

The attorneys charged all were associated with the Manhattan law firm of Morris J. Eisen, P.C. The law firm itself is not a defendant, said Andrew J. Maloney, U.S. attorney for the Eastern District of New York.

The investigation was carried on by the U.S. attorney's office, New York County District Attorney Robert Morgenthau and Bronx District Attorney Robert Johnson.

Research papers

APPLETON, Wis.—The Society of Insurance Research plans to award two prizes for research papers on "Availability and Affordability of Personal Auto Insurance in a Competitive Environment."

A panel of insurance professionals and scholars will select the winners of a \$5,000 first prize and a \$2,500 second prize. The competition is open to academics, insurance company employees and consultants. The society's officers, board members and committee chairmen cannot participate, and research firms are not eligible.

The winning papers will be presented at the society's annual meeting in Columbus, Ohio, Nov. 14-16.

Papers must be no more than 5,000 words. Three copies of a double-spaced paper must be submitted by July 1 to: Research Competition, c/o Debbie Krueger, Administrative Director, Society of Insurance Research, P.O. Box 933, Appleton, Wis. 54912; 414-730-8858.

Tax manual

WASHINGTON—The American Insurance Assn. is making its State Taxation Manual available to non-members for the first time.

It contains information on property/casualty insurance industry

tax policies of the 50 states, the District of Columbia and Puerto Rico.

The manual describes the taxes, fees and assessments that must be paid. It also cites applicable tax rates, bases for taxes and credits against taxes. In addition, the book contains a calendar incorporating state deadlines for filing, paying and prepaying taxes.

The manual costs \$425. For further information, contact: State Taxation Manual, American Insurance Assn., 1130 Connecticut Ave N.W., Suite 1000, Washington, D.C.; 202-828-7197.

Joint venture

BOSTON—John Hancock Financial Services and The American

College in Bryn Mawr, Pa., are forming a joint venture to provide professional education to Hancock's field managers.

A spokesman for Boston-based Hancock Financial Services said about 250 managers will attend the 2½-day seminars at Gregg Conference Center at the American College, a school dealing exclusively with life insurance and related financial services subjects.

Topics include managing change, managing for profitability, ethics, leadership and planning.

The program, the only one of its kind offered jointly by the college and an insurer, is designed to help field managers prepare for work on the Chartered Life Underwriter and Chartered Financial Consultant designations. ■

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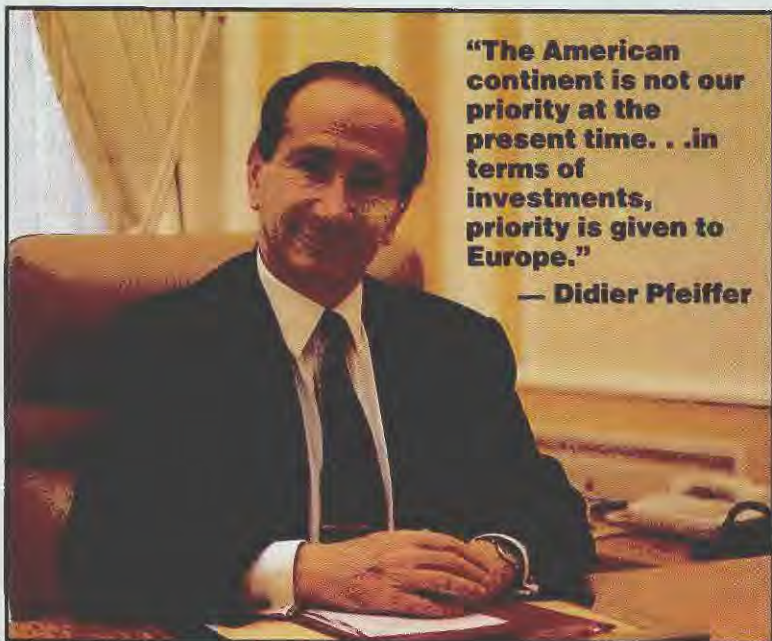
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Business Insurance

INTERNATIONAL

UAP chief maps growth strategy

French insurer to focus on EC



"The American continent is not our priority at the present time. . . in terms of investments, priority is given to Europe."

— Didier Pfeiffer

By ISABELLE BERGLAS

PARIS—Unlike many European insurers, which are planning to expand into the North American market, Union des Assurances de Paris S.A. is staying in its own backyard.

UAP, France's largest insurer, believes Europe will constitute the single most important insurance market after European Community trade barriers fall in 1992 and, as such, warrants its undivided attention.

"The American continent is not our priority at the present time. We know it represents 50% of the world market and we realize the importance of maintaining commercial links with it but, in terms of investments, priority is given to Europe," UAP Chief Executive Officer Didier Pfeiffer said in an interview in his Paris office last month.

"Our development strategy is based on a twofold concern," Mr. Pfeiffer said. "First, we wish to strengthen our leadership position in France because we have noticed that large, international insurance conglomerates always start from a position of strength

in their own country. Second, our international priority is Europe because we believe that after 1992 Europe will constitute a single market and it is important for us to be present in each country."

The company's latest major acquisition was the December 1989 purchase of a 34% stake in Groupe Victoire, a Paris-based insurer, for 14.3 billion French francs (\$2.47 billion).

UAP's interest stemmed from Victoire's European connections. "Since Victoire bought the German insurance group Colonia, it writes more premiums abroad than in France," said Mr. Pfeiffer, referring to the purchase of Colonia Versicherung A.G. by Victoire.

He hastened to add that UAP is not considering any more major acquisitions in France. "We are No. 1 and we believe it is complicated to take control of a company in a country where you are already very visible."

Over the last few years, UAP—whose major shareholder is the French government—has indeed developed its strategy of working together with national partners in each country, or as Mr. Pfeiffer puts

Continued on page 31

Risk managers urged to study East bloc plans

By STACY SHAPIRO

LONDON—Risk managers—along with corporate legal, tax and accounting staff—should be involved in planning Eastern European joint ventures "at an early stage," says a brokerage executive.

This way "risk management can be carried out correctly and the most appropriate method of insurance placement, most suitable to your needs, can be identified," said George Nixon, chief executive of Willis Wrightson Ltd., a Willis Faber P.L.C. unit.

Any new venture carries with it the risk of failure, but Western firms run an added risk of losing control of ventures with state-controlled companies, Mr. Nixon told those attending a seminar on Eastern Europe sponsored by Wrightson sponsored March 1.

He advised risk managers to

learn about countries where their companies plan to invest and to become involved in selecting joint venture partners to make sure objectives between Eastern and Western interests are compatible.

Contract wordings also "are going to be a major issue and some risks can be managed in the contract stage," said Mr. Nixon.

"I heard of a case recently where the joint venture contract ran to 10,000 pages—almost as big as an American casualty insurance policy!" he quipped. "Clearly, it is important to get this right and to deal with any appropriate risk management issues in it."

One issue that should be considered is environmental liability, said Nicholas Davenport, managing director of UNISON S.A. in Brussels, Belgium.

Cleaning up East German pollution, he said, could cost an esti-

mated 200 billion deutsche marks (\$116 billion). Foreign investors ought to have pollution audits done "so that it is not their 'deep pocket' that pays for the 'altlast,' the German concept meaning 'burden of the past,'" said Mr. Davenport.

Mr. Nixon warned against abdicating risk management responsibilities to a foreign partner.

"Eastern Europeans are much less sophisticated than us in this area, and it is important to you that your standards prevail," said Mr. Nixon.

He applied the same rule to securing coverage.

"Suitable insurance protection is considered essential by U.K. companies. It is considered less so in many Eastern European countries and the usual breadth of protection provided is much more restricted

Continued on next page

Businesses protest pollution proposal in West Germany

By DON L. KIRK

BONN, West Germany—West German businesses would face expanded pollution liability—and higher liability insurance costs—under draft legislation introduced last month by Chancellor Helmut Kohl's government, businesses and insurers contend.

The proposal seeks to limit pollution by proposing strict liability and stiffer penalties for companies that pollute the environment. Because environmental concerns are a leading issue in this election year, the measure is expected to be passed by the West German Parliament by the end of the year.

However, the draft has been blasted by West German business and insurance groups, which contend it would increase insurance costs and squeeze some smaller companies out of business.

The legislative proposal would make pollution liability coverage mandatory for certain "high risk" companies, though such companies are not defined. In addition, it would significantly expand companies' liability for pollution-related damage and injury, leading to higher insurance costs.

For example, under the measure:

- Companies would be held strictly liable for air and soil pollution.

Laws imposing strict liability for water pollution have been in force in West Germany for about 30 years.

- A company would be held liable for pollution caused by "normal operations."

Currently, a company can be held liable for accidental or intentional pollution of the environment.

- A company could be held liable if it is "likely" it caused pollution damage or injury.

As a result, a company would have to prove it did not cause pollution damage in order to escape liability.

Currently, the burden of proof is on a plaintiff, which must prove that a company caused pollution damage before the company can be held liable.

However, damage to the environment that is not caused by a single company but occurs collectively, like environmental damage caused by acid rain, is not addressed in the draft.

West German businesses contend that expanding liability for pollution caused during the course of "normal operations" would cost insurers billions of deutsche marks.

The draft has the potential to put a lot of small and mid-sized companies out of business, contends the Federation of German Industries (BDI).

"It's not just the high cost of insurance premiums" to insure the expanded exposure, says a spokesman for the BDI. "Risk management would be next to impossible. Companies will have to pay a lot more to guarantee pollution will not occur. That's something large corporations can afford, but not the smaller companies."

"Insurers would have to pay billions to clean up polluted areas" under the proposed law, says Ernst Wunderlich, a director of Allianz Versicherungs-A.G. in Munich. "While insurers want to cover risk, they must be able to calculate it—that means liability must be restricted to accidents and positive proof of wrongdoing."

Liability for pollution caused by normal operations is an "exaggerated risk which can't be kept under control," he argued.

Under the draft's proposals, companies would end up paying more than 17 billion deutsche marks (\$9.9 billion) to

Continued on next page

West Germany



Lloyd's to contemplate arbitration procedures

LONDON—Lloyd's of London is considering adopting a standard arbitration procedure to resolve a growing number of disputes in the market.

The Corporation of Lloyd's earlier this month issued a consultative document outlining proposals to establish a uniform arbitration procedure and conciliation procedures to settle disputes "within the family," said Chief Executive Alan Lord.

The proposed dispute resolution mechanisms would be used to resolve disputes between syndicates and between names and members' agencies, Lloyd's said.

The Lloyd's market recently has been hit with dozens of disputes between syndicates, many over the validity of runoff reinsurance contracts.

Concern has grown in recent years over procedural delays in arbitration proceedings; the lack of a standard arbitration procedure at Lloyd's; and the fact that arbitration decisions that may be important to others in the market usually are confidential and cannot be disclosed, Lloyd's pointed out.

"The Council (of Lloyd's) considers it appropriate

to examine the question of establishing a standard arbitration procedure, initially on a voluntary basis, for disputes arising out of insurance and reinsurance contracts between syndicates. . . . At the same time, the council considers that this exercise may also be useful in the settlement of disputes between their names and their agents," a statement from Lloyd's said.

"Such arbitrations would be conducted by experts drawn from a Lloyd's-appointed panel, the costs being recouped as part of any awards made," explained Lloyd's.

"The inclusion of conciliation or mediation procedures in the consultative document—and the question whether a conciliation service should be set up within Lloyd's—stems from the increasing popularity of conciliation to settle commercial disputes, particularly in the U.S.," said the statement.

Under conciliation, a neutral third party would try to find and emphasize common ground between parties at odds and negotiate a settlement.

Lloyd's noted that a conciliation process has been used successfully to settle disputes over runoff reinsurance contracts written by syndicate 317/661, managed by RHM Outhwaite (Underwriting Agencies) Ltd.

The Lloyd's proposal is being sent to the individual Lloyd's market associations as well as to the Assn. of Lloyd's Members. Lloyd's will accept comments and suggestions until the end of June.

—By Carolyn Aldred



Risk management not developed in Eastern Europe

LONDON—A lack of risk management experience and poor financial infrastructures in Eastern Europe make joint ventures there a risky business, according to a banking executive.

"Those who have attempted joint ventures in Eastern Europe will be aware of how little an understanding there is in the East of the concept of risk evaluation as well as risk taking," said Andrew Seton, director of investment bank Morgan Grenfell & Co. Ltd. in London.

By training tens of thousands of people in risk management and insurance, accounting and the law, Western companies could create a lot of good will and forge partnerships for the future, Mr. Seton told risk managers, brokers and underwriters at a one-day seminar on Eastern Europe sponsored by retail broker Willis Wrightson Ltd. of London.

In addition, most of the Eastern bloc suffers from unwieldy bureaucracy, foreign debt, and inconvertible currency, Mr. Seton said.

The countries also lack entrepreneurialism and private enterprise, and people are frustrated by shortages of goods, he said.

Some countries, however, are better off than others, he said.

Another potential problem for joint ventures is that some countries, like Poland and Hungary, are debt-ridden "despite being very advanced in terms of introducing institutional changes," Mr. Seton said.

"Even amongst the most intelligent of the Polish leadership, for example, there appears to be some subconscious expectation that their debts will be forgiven," he said.

Mr. Seton does not think Western banks will sweep those debts under the table.

"I do not think this is in the cards and, alas, this is not going to help them to benefit from an influx of Western financial services to the extent that is needed," he said.

However, Western companies can avoid some pitfalls by doing their homework on which countries could best support joint ventures, according to Mr. Seton.

—By Stacy Shapiro

Eastern Europe

Continued from previous page

than we are used to," said Mr. Nixon. "The overall message is manage the risk first and worry about insurance second, but nevertheless early," he added.

Added managers also will have to choose other advisers such as brokers to help plan the venture, delegates were told.

Until recently, brokers were not recognized in six of the seven Eastern European countries discussed at the seminar; only Poland allowed brokerages.

However, West German brokerage Jauch & Hubener is opening a Budapest, Hungary, office for the UNISON brokerage network, which includes Willis Faber P.L.C. and Johnson & Higgins, said Hans Hajek, general manager of Jauch & Hubener in Vienna and UNISON country manager in Austria. Set to open in a few weeks, the Budapest office will be the first Western brokerage office in Eastern Europe, he said.

Also, Marsh & McLennan Cos. Inc. announced recently that it will open a representative office in East Germany through its new German subsidiary, Gradmann & Holler.

Meanwhile, Alexander & Alexander Services Inc., Sedgwick Group P.L.C. and other brokerages have represented the Western partners in joint ventures.

And brokerages are beginning to train Eastern European insurance officials in Western methods.

"The challenge before us in the East is to build upon our long-term reinsurance friendships with monopoly insurance organizations in such a way as to help insurance markets develop," said Mr. Davenport. His company offers training facilities and technical assistance to make "that transition as easy as possible."

Meanwhile, the insurance availability in the countries where joint ventures may be located, experts point out.

"This is an incredibly complex topic," said Michael White, chairman of Willis Group Eastern Europe. But "there is a certain amount of uniformity."

Mr. White discussed six East European countries and the Soviet Union. His comments, he emphasized,

were as of March 1 but could rapidly become outdated.

The nations include:

- Bulgaria, where the Council of Ministers recently issued a decree on the freedom of services and industry. It "has not taken sufficient count of running government statutes and an amended version will be debated," said Mr. White.

Brokers are banned from doing business in Bulgaria.

The country has two state insurers: DZI, which writes national domestic business; and Bulstrad, or Bulgarian Foreign Insurance and Reinsurance Co. Ltd., which writes international and reinsurance business.

There are also "opportunities to make insurance arrangements outside the country, but only in hard currency (which) requires special circumstances at present," he said.

- Czechoslovakia "is thought to be very close to change," he said. For now, all insurance must be placed with the two state-owned insurers, Ceska Statni Pojistovna in the Czech regions; and Slovenska Statna Pojistovna in the Slovak areas.

Brokers are banned from placing insurance in the country.

- The German Democratic Republic, where the concept of insurance is highly developed and it is estimated that 90% of householders insure their property "with state-owned Staatliche Versicherung der DDR," said Mr. White.

The other state-owned insurer, The Auslands Und Ruckversicherungen AG der Deutschen Demokratischen Republik, which writes international and reinsurance business, "has developed a very good understanding of the international market over a number of years, which is reinforced by visits to London by key personnel on a regular basis," he said.

- Hungary "presents a difference" because it now has six insurance companies, some of them joint ventures with Western insurers.

The companies include AB Generali, which is 60% owned by Al-lami Biztosito, the state-owned insurer that gave up its monopoly in 1986; 20% by Assicurazioni Generali in Trieste, Italy; and 20% by German investor Erste Allgemeine.

Generali's contacts with Eastern Europe go back to 1831 when Trieste was part of the Austro-Hungarian

empire, said Benito Pagnanelli, a Generali director. However, Generali's network of East European insurance offices was lost after World War II, he added.

In the past few years, however, "we have started to regain the lost network," said Mr. Pagnanelli.

- Poland, which in 1985 permitted establishment of two non-state insurance companies—Westa and Polisa. The two state-owned insurers are PZU, the only insurer allowed to write compulsory classes of insurance and domestic insurance, and Warta, which writes international and reinsurance business.

- Romania, which only offers insurance through state-owned Administratia Asigurarilor de Stat (ADAS) at the moment.

"They are expecting a more open market and they would welcome this with their international experience, but at present they retain their solo position," said Mr. White.

- The Soviet Union, where two state-owned insurance companies currently dominate the market—Gosstrakh, which covers personal insurance, and Ingosstrakh, which writes international and reinsurance business (BI, Feb. 26).

Soviet officials are drawing up insurance laws, but will most likely not allow foreign insurers to set up offices in the country, Rudolf M. Shuravin, managing director of Ingosstrakh's London subsidiary, Black Sea & Baltic General Insurance Co. Ltd., said in an interview.

But Mr. Pagnanelli of Generali told delegates that the support of local insurers is important in overcoming language barriers and geographical, claims handling and currency problems. It is unclear, he said, whether foreign investors must now legally insure with Ingosstrakh rather than a foreign insurer.

"Is that important?" asked Mr. Shuravin. "It is difficult for joint ventures to insure (anywhere except within) the Soviet Union."

Mr. Shuravin said a Japanese executive in charge of risk management decided to see a site for himself and took two days to get there. But when he got to the site, the manager on the site said "who invited you here?" and wouldn't speak to him until Ingosstrakh representatives showed up, he said.

CONFEDERATION LIFE



Peter W. Lloyd



William A. Allison

Confederation Life announces the appointment of William A. Allison as Senior Vice-President, United States Operations, based in Atlanta, Georgia. Mr. Allison joined the Company in 1957, and was until recently Vice-President, Group Insurance for the United States Region. He succeeds Peter W. Lloyd, who retires after 42 years with the company.

The Confederation Life Group of Companies, headquartered in Toronto, operates in Canada, the United Kingdom and the United States. Confederation Life and its associated companies are leaders in individual and group insurance products and pension fund management, and offer an increasing variety of financial, banking, leasing and trust company services, including mutual funds.

German pollution proposal

Continued from previous page

retroactively clean up some 70,000 polluted areas under the new law, Mr. Wunderlich estimated.

Allianz, as a leading commercial insurer in West Germany, would be hard hit, he said.

HUK-Verband, an association of West German liability, accident and auto insurers, called the provision that would shift the burden of proof for pollution liability "guilt by suspicion."

West German companies should not be held liable for damage they only "likely" caused, said a spokesman for HUK-Verband.

"It turns the entire legal system upside down," he said. Under current law "a plaintiff has to prove injury was caused by a company," the spokesman noted. Under the draft proposal, "all you have to do now is say you're injured and a company is responsible. It is then up to the company to prove" it is not responsible, he said.

sponsible, he said.

In addition, the head of HUK-Verband took issue with the expansion of liability for pollution caused by normal operations.

West German industry should not be liable for damages that "are unavoidable because there was no negligence nor a fault in or the failure of the installation," said Walter Breining, head of HUK-Verband.

"In many cases damage occurs because the government has set emission levels which are just too low," he said. "There has to be some way to exclude a case like this said."

Dieter Grell, a HUK committee chairman, contends the government's proposal would force the West German insurance industry into the role of "environmental police."

However, he warned that the high liability insurance premiums that would result if the draft is enacted would not guarantee that companies will improve pollution control.

"The costs for pollution control are much higher than possible premium (increases). Even an increase in premiums of 400% would not force companies to invest in preventative control and competition among insurers would keep premiums down anyway," Mr. Grell said.

In addition, the rules would make companies "dependent on the insurer for their operational licenses," he said. Municipalities in West Germany would require proof of environmental liability insurance before allowing a business to operate, he predicted.

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INTERNATIONAL

UAP strategy

Continued from page 29

it, "developing a synergy in Europe." To that end, UAP now has stakes in several major insurance companies in Europe.

In 1987, it acquired 31% of Royale Belge S.A. for 4 billion French francs (\$752 million at year-end 1987 exchange rates). In October 1988, it acquired 10% of Sun Life Assurance Society P.L.C., a major British life insurance company.

Today, UAP owns 25% of Sun Life, at a total cost of 2 billion French francs (\$346 million), making UAP the second-largest shareholder in Sun Life.

Then, in January 1989, UAP bought 90% of Allsecures, an Italian insurance subsidiary of Toro Group, at a cost of 1 billion French francs (\$165 million at year-end 1988 exchange rates), thus gaining control of 2% of the Italian insurance market.

Most recently, on Feb. 13, UAP announced that it had agreed to acquire 91% of General Europa S.A. (Gesa), the Spanish assistance and emergency services company, which provides such services as medical for emergencies in remote areas, for 850 million French francs (\$147 million).

"UAP believes that the assistance sector constitutes a fundamental complementary element of the insurance business and is therefore likely to undergo great expansion," said Mr. Pfeiffer.

The merger of Gesa with UAP's already established assistance activities will make the operation the No. 2 emergency services company in Europe behind Europe Assistance, with 700 million French francs (\$121.1 million) in annual revenues.

UAP will be joined in the purchase of Gesa by Compagnie Generale des Eaux, a leading French water and services group, and eventually by other industrial or insurance companies. Initially, UAP will sell 20% of Gesa to Generale des Eaux, but UAP's final stake could fall to 45% to 60%. However, UAP would retain operating control of the Spanish company.

Further proof of UAP's European emphasis was given in January 1989 when UAP sold its 35% stake in Commassur, a Canadian portfolio company that controls two insurance companies: Commerce Group Insurance Co. and Belair Insurance Co.

The sale netted UAP 7 billion French francs (\$1.2 billion) which, according to Mr. Pfeiffer, will be used to finance the purchase of Allsecures.

UAP is the largest insurance company in France, based on 1989 premiums of 64 billion French francs (\$11.1 billion at year-end 1989 exchange rates), up 15.1% from 55.6 billion French francs (approximately \$9.2 billion at year-end 1988 exchange rates) the previous year.

UAP reported a 1988 net profit of 2.8 billion French francs in 1988 (\$462 million) and estimates 1989 profits at 3.3 billion to 3.4 billion French francs (between \$571 million and \$588 million).

Today UAP has 30,000 salaried workers and agents—45,000 if you include companies in which UAP has acquired a minority interest—in more than 60 countries.

Currently, just under two-thirds of UAP's premiums are written in France, though the company controls 67 insurance and reinsurance companies worldwide. UAP's business is about 55% property/casualty, 45% life and 5% reinsurance. Personal lines represented 47% of gross premiums in 1988.

UAP was among the 20 largest insurance groups in the world last year, Mr. Pfeiffer said, adding that

he expects that it will move up in 1990.

UAP's flexibility in expanding in Europe is enhanced by the current political climate for insurers in France.

Since 1988, the status of French insurers has been governed by French President Francois Mitterand's policy of neither "privatization nor nationalization." In the mid-1980s former Prime Minister Jacques Chirac attempted to privatize state-owned insurers like UAP (*BI*, April 11, 1988).

However, reforms of the French Insurance Code passed by Parliament at the end of its 1989 fall session, part of which went into effect Feb. 26, allow French insurance companies to broaden their base of shareholders.

"The 1973 law which set rules for the insurance business was very restrictive; shareholders other than the state had to be French individuals or French institutional investors. This new law has introduced clauses which enable any shareholder, French or foreign, an individual or a company, to acquire up to 25% of our capital," Mr. Pfeiffer said.

Within that framework, UAP on Feb. 26 made a stock offering to increase its capital by more than 10 billion French francs (\$1.73 billion at current exchange rates), with the state contributing about 50% of the increase.

This increase allows the creation of a 10% cross-shareholding between UAP and state-owned Banque Nationale de Paris, as announced in March 1989; the continuation of UAP's European development plans; and the partial financing of its 34% stake in Victoire.

Prior to UAP's share offering, the French government held a 85.3% stake in the group. But after the offering's March 15 close, the state expects to own 75.6% of the insurance group, including Banque Nationale shares.

As of late last week, shares totaling at least 2.2 billion French francs (\$380.6 million) were acquired by non-French investors, shares valued at 4.4 billion French francs (\$761.2 million) were bought by French investors, and the remainder were bought by the French government, UAP reported.

According to Mr. Pfeiffer, the purpose of the cross-shareholding agreement with Banque Nationale is "to solemnize our common belief in developing our activities side-by-side to satisfy the global needs of our customers, since the insurance and banking businesses complement one another."

Despite talk of privatization of French government-owned insurers during Mr. Chirac's term as prime minister, Mr. Pfeiffer evades the issue of privatization and how it would affect UAP.

"UAP has the means to ensure its development. We have enough work so that we don't need to think about hypothetical situations which, if they occur, will be dealt with (with) the same determination and enthusiasm we apply to current problems."

Mr. Pfeiffer came to UAP after acquiring a broad background in finance.

For several years, he was a member of the cabinet of two prominent French secretaries of the treasury, Maurice Couve de Murville and Valery Giscard d'Estaing, who became president in 1974.

Mr. Pfeiffer went on to Washington, D.C., first as financial attache to the French Embassy, then as deputy administrator for the World Bank.

He joined UAP in December 1972, became manager of financial affairs in 1973, chief executive officer in charge of investments in 1976 and finally chief executive officer in 1984. ■

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Spanish bank focuses on insurance growth

By MARIA KIELMAS

MADRID, Spain—Following a protracted battle for control of its operations, Spain's largest banking group, Banco Bilbao Vizcaya, is now devoting its attention to coordinating its multiple insurance interests.

Confusion about the state of the bank's insurance holdings has reigned since Banco de Bilbao and Banco de Vizcaya, both among Spain's seven largest banks in terms of deposits, proposed merging in January 1988 to form Banco Bilbao Vizcaya.

Bitter in-fighting between Banco Bilbao Vizcaya's Bilbao and Vizcaya factions came to a head after the death last December of Co-President Pedro Toledo, former head of Vizcaya.

However, his successor—Jose Angel Asiain, co-president of Banco Bilbao Vizcaya and former head of Bilbao—resigned one month later in an effort to end the dispute.

The furor subsided only after Emilio de Ybarra, a former Banco Bilbao Vizcaya vp, was named head of the bank group and received the endorsement of

Spain's central bank, Banco de Espana.

Banking is crucial to insurance matters because—like in many other European nations—Spanish banks control a large portion of the nation's insurance industry.

Spanish banks have increased their merger activity since Spain joined the European Community in 1986 in preparation for the single market in 1992 (*BI*, April 11, 1988).

When Banco de Bilbao and Banco de Vizcaya merged in 1988, their stated intention was to create the country's largest insurance group.

Bilbao's insurance holdings included 100% of Euroseguros and 40% of Corporacion General Aseguradora, a holding company for Spanish insurers Aurora Polar, Catalana Occidente and Pervision Nacional.

Bilbao also owned brokerage Gavial S.A.

Vizcaya brought insurer Plus Ultra de Seguros y Reaseguros to the table.

Following the merger, in September 1989, Banco Bilbao Vizcaya sold its share in the CGA group and acquired a 90% stake in Aurora Polar.

"We wanted to unite Aurora Polar with Plus Ultra to create a bigger insurance group. It was an easy exchange of shares and very convenient," explained Gerardo Aroztegui, deputy general manager of Banco Bilbao Vizcaya and chief executive of Plus Ultra.

Banco Bilbao Vizcaya also has acquired Spanish motor insurer Dapa.

"We wanted a specialist in motor cover," Mr. Aroztegui said.

"It is still probably too early to say what we will do in the future as everything is not clear, but we are working toward a final decision," Mr. Aroztegui said.

While Banco Bilbao Vizcaya's insurance units "have been in a process of coordination, it has not been decided yet if a merger between them will be necessary," Mr. Aroztegui said.

Plus Ultra is slightly larger than Aurora Polar, Mr. Aroztegui noted, but their portfolios are similar: about 45% commercial insurance; 20% life insurance; and the balance homeowners coverage.

Meanwhile, Banco Bilbao Vizcaya's insurance brokerage subsidiary, Gavial, joined with Morice Toza—Spain's largest reinsurance broker and a unit of Alexander & Alexander Services Inc.—in 1988 to form Gavial Alexander S.A. (see related story). The firm serves Banco Bilbao Vizcaya's industrial clients.

In addition, the bank created BBV Brokers S.A. after the merger. BBV Brokers only places coverage for the bank.

Gavial Alexander, which has given some technical assistance to BBV Brokers, will place coverage for all commercial insurance buyers.

Mr. Aroztegui noted, though, that BBV Brokers this year will offer new products, such as risk management services for small businesses.

Meanwhile, Osaka, Japan-based Nippon Life Insurance Co. last month acquired a 4.5% stake in Banco Bilbao Vizcaya. ■



A&A targets EC banks for brokerage partners

LONDON—European banks are more aggressive than ever in setting up brokerage and insurance company networks throughout the European Community, a brokerage executive contends.

That's why "we have deliberately courted the banks" when seeking new EC offices, says Michael Barrett, chief executive officer of broker Alexander Stenhouse Europe Ltd. in London. Alexander Stenhouse is the European retail insurance unit of Alexander & Alexander Services Inc. of New York.

"The banks have real European ambitions to offer services to their clients," he said.

For example, he noted that:

- A&A owns 49% of its Spanish correspondent broker Gavial Alexander S.A., while the remainder is owned by Banco Bilbao Vizcaya, Spain's largest banking group (see related story). Gavial Alexander has 100 employees in five offices in Spain.

- A&A owns a 45% stake in broker Fides Alexander A.G. of Zurich, Switzerland. The remaining 55% is owned by a subsidiary of banking group Credit Suisse.

- Alexander Stenhouse owns 20% of broker Jaspers Industrie Assekuranz GmbH in Cologne, West Germany. Another 20% is owned by West Germany's largest bank, Deutschebank, and the remainder by private investors.

- A&A owns 49.9% of Paris-based broker S.G.C.A. Sixteen percent of the broker is owned by banking group Credit du Nord of Paris; 6% by French insurer L'Union des Assurances de Paris; 17% by French insurer Assurances Generales de France; and the rest by S.G.C.A.'s 500 employees.

In addition to the above brokerage partnerships, A&A owns several other brokers in continental Europe, including:

- Bekouw Mendes Holdings B.V. in Amsterdam, The Netherlands, which is 100% owned by A&A.

- Alexander Stenhouse S.A./N.V. in Brussels, Belgium, which is 100% owned by A&A.

- Alexander & Alexander Italia Spa. in Milan, Italy, which is 51% owned by A&A. The remainder is owned by a consortium of individual investors.

- Alexander & Mata Ltda. in Lisbon, Portugal, which is 49% owned by A&A and 51% owned by the largest marine agency in the country, J. Mata.

- A&A Sigorta Musavirlik A.S. in Istanbul, Turkey, which is 49% owned by A&A and 51% owned by Patko, a local trading company.

Earlier this year A&A's European executives met in West Germany to discuss strategy in Eastern Europe, said Mr. Barrett.

A&A works as a reinsurance broker with most of the state-owned East bloc insurers, he noted.

"Our business relationships there are highly developed," Mr. Barrett said, adding that A&A expects to take advantage of those relationships to organize insurance programs for joint ventures in Eastern Europe.

"We know of 100 companies that are our clients that are considering joint ventures," he said. About a half-dozen clients have set up joint ventures, including McDonald's Corp., which opened a restaurant in Moscow earlier this year.

"We want our trade relations to grow as perestroika opens the East," Mr. Barrett said.

—By Stacy Shapiro

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Business Insurance

Reliance sells unit to Winterthur Swiss in \$630 million deal

Markets

Reliance Group Holdings Inc. is selling its General Casualty Cos. subsidiary to Winterthur Swiss Insurance Co. for \$630 million in cash.

Reliance will realize a pretax gain of \$380 million from the sale, which is expected to be completed during this year's second quarter. The sale is expected to boost the Reliance Group's policyholder surplus by about \$300 million, said a Reliance spokesman. Reliance reported \$668.4 million in surplus as of Dec. 31.

General Casualty wrote \$400 million in premiums in 1989, of which 57% was standard commercial lines business and the remaining 43% personal lines. Through independent agents, it writes business in 10 Midwestern states: Wisconsin, Illinois, Minnesota, Iowa, Indiana, Nebraska, Kansas, Missouri, South Dakota and North Dakota.

General Casualty's \$400 million in premiums in 1989 accounted for about 22% of the \$1.8 billion in total premiums written by Reliance, said the spokesman.

Sports specialist

K&K Insurance Group Inc., a wholly-owned subsidiary of Lincoln National Corp. in Fort Wayne, Ind., acquired a major interest in underwriting agent National Sports Underwriters of Overland Park, Kan.

The new company, which will operate as National Sports Underwriters Ltd., will develop and administer insurance for college and high school sports programs.

"After working with National Sports Underwriters on several programs, we were impressed with the whole team," said K&K President and Chief Executive Officer Greg C. Mosher.

National Sports Underwriters Ltd. pioneered such programs as the NCAA Lifetime Catastrophic Injury Insurance program, which provides benefits to college athletes that are crippled by athletic-related injuries.

Mergers/acquisitions

Minneapolis-based **United HealthCare Corp.** plans to acquire **PrimeCare Health Plan Inc.**, a Milwaukee-based health maintenance organization owned by Heritage Health Systems Inc. in King of Prussia, Pa. Under the agreement, United HealthCare will pay approximately \$11.25 million for PrimeCare, which includes the repayment of PrimeCare debt and the purchase of all common stock. The acquisition will increase United HealthCare's membership by 103,000, bringing total membership in the United HealthCare HMO network to 1.1 million. The HMO services Minnesota, Iowa, Nebraska, Missouri, Illinois, Wisconsin, Michigan and Indiana.

Pioneer Financial Services Inc., a Rockford, Ill.-based holding company for six life insurers, acquired **Manhattan National Life Insurance Co.** for \$27 million. Manhattan National Life will operate as a wholly owned subsidiary of Pioneer with executive and administrative offices to remain in Cincinnati.

Pioneer also recently acquired **National Health Services Inc.**, a medical utilization review firm in Milwaukee.

Richmond, Va.-based **Hilb, Rogal & Hamilton Co.**, the nation's 12th largest broker with 1988 revenues of \$49 million, recently completed a set of acquisitions: HRH's Mobile, Ala. subsidiary acquired the property/casualty agency business of **Altus Bank** in Mobile; HRH's Birmingham, Ala. office acquired the majority of assets of property/casualty insurance agency **Perry-Rosamond-Mellen Inc.** in Birmingham. In ad-

Continued on page 35

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The Massachusetts Bay Transportation Authority is soliciting for Consultant Services to provide a Claims Management Litigation Support Information System to support its: General Counsel Office's Claims Division, Labor Relations Directorate's Workman's Compensation Section, Treasurer Controller's Insurance Section and related Operations Directorate divisions. The system will assist the Authority to better administrate and monitor accidents involving both riders and employees. These accidents result in workman's compensation claims, patron and bystander claims, and insurance expenditures.

The project will require all services necessary to install a turnkey system to support these departments while permitting related management information to be shared. The system will interface with other Authority systems and use the Authority's mainframe hardware (IBM 3090 equivalent). All data will be entered, processed and analyzed by Authority personnel. Specific responsibilities in this project will span the preparation of project plans, system development and/or system adaptation efforts; the production of system specifications and documentation; the performance of implementation, testing, user and technical training and installation of system components; and the provision of a period of system maintenance and turnover to the MBTA.

Firms having the demonstrated capabilities to undertake this work content are invited to submit ten (10) copies of a letter of interest together with appropriate references to any enclosed materials which accompany the letter and demonstrate your firm's qualifications to:

Steven J. MacIsaac, Manager, Strategic Planning
Information Systems Services Directorate
Massachusetts Bay Transportation Authority
10 Park Plaza, 8th Floor
Boston, MA 02116

Firms responding to this invitation not later than 4:00 p.m., on April 13, 1990 will be considered for selection providing that as a minimum, the response includes:

- history/background and the most current annual report
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- MIS experience - citing specific projects, clients, type of work, scope/description of work, duration, cost performance, and proposer's specific role in the project
- application system requirements - type of hardware, system software, and communications environment(s) supported
- Client references - name, position, address, and telephone number of reference, and
- firm's Affirmative Action Plan and Employee Profile

Consideration for selection shall be based upon proposed staffing, organization, and specific task related experience, as demonstrated by the successful installation of large computerized claims management/litigation support system projects. Consideration shall also be given to each firm's Affirmative Action Plan, as well as its commitment to the utilization of disadvantaged businesses in joint venture or as subcontractants.

Following an initial evaluation of qualifications and performance data, three or more firms considered to be highly qualified to provide the required services will be selected for interviews and requested to submit formal proposals.
Thomas P. Glynn
General Manager

NOTICES

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

PEOPLE OF THE STATE OF ILLINOIS, ex rel.
Zack Stamp, Director of Insurance
of the State of ILLINOIS,
plaintiffs,
NO: 89 CH 11201

V.
INTERCONTINENTAL INSURANCE
COMPANY,
a Domestic Stock, Property and Casualty
Insurance Company,
Defendant.

NOTICE OF CLAIMS DATE AND PROCEDURES

PLEASE TAKE NOTICE, that on January 12, 1990 an Order of Liquidation With a Finding of Insolvency was entered against Intercontinental Insurance Company ("Intercontinental") by the Circuit Court of County, ILLINOIS, ("Liquidator") is the statutory and court affirmed Liquidator of Intercontinental.

TAKE FURTHER NOTICE, that on January 19, 1990, the Circuit Court of Cook County, Illinois, entered an Order Fixing the Time and Procedures of Filing of Claims ("Fixing Order"). Pursuant to the terms of the Fixing Order, all policies of insurance issued by Intercontinental is not licensed to do business and which do not have an applicable insurance guaranty association insureds of Intercontinental are cancelled as of 12:01 a.m. on January 12, 1990, unless the same had been cancelled or have expired prior to such date.

TAKE FURTHER NOTICE, that all rights and liabilities of Intercontinental, and its creditors, policyholders and stockholders, and all other persons interested in its assets, are fixed as of January 12, 1990, unless otherwise provided in a subsequent order of the Court.

TAKE FURTHER NOTICE, that all persons and entities, who have, or may have, claims, contingent or otherwise, against Intercontinental, or the property or assets of Intercontinental, shall have the right to present and file with the Liquidator, proper proofs of claim on or before 4:30 p.m., Central Daylight Time, on July 12, 1991, and all contingent claims filed by the insureds of Intercontinental, and persons having a cause of action against such insureds, must be fully liquidated on or before 4:30 p.m., Central Daylight Time, on July 13, 1992. Such contingent claims by insureds may be allowed if such claim is fully liquidated, and the insured presents evidence of the payment of such claim to the Liquidator, on or before such final date and such contingent claims by persons claiming against such insureds may be allowed if such persons demonstrate to the Liquidator that the proofs submitted to the Liquidator upon such claim satisfy the requirements of ILLINOIS Revised Statutes, 1987, Ch. 73, Para. 821 by such final date.

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

THE LAST DATES FOR THE FILING OF PROOFS OF CLAIM WITH THE LIQUIDATOR AND THE LIQUIDATION OF ALL CONTINGENT CLAIMS, IS SET FORTH ABOVE. NO PERSONS HAVING OR CLAIMING TO HAVE ANY CLAIMS AGAINST INTERCONTINENTAL INSURANCE COMPANY, OR ITS INSURED, SHALL PARTICIPATE IN ANY DISTRIBUTION OF THE ASSETS OF THE COMPANY, UNLESS SUCH CLAIMS ARE PROPERLY FILED, AND IN THE CASE OF CONTINGENT CLAIMS PROPERLY LIQUIDATED, WITH THE LIQUIDATOR ON OR BEFORE THE ABOVE RESPECTIVE DATES.

James W. Schacht, Special Deputy Liquidator

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Sub-total 24,021

Associations 554
Government, Unions and Educational Institutions 1,417
Commercial Consumers Sub-total 25,992

Insurance Agents and Brokers 10,515
Insurance Companies 7,673
Actuaries, Consultants, Attorneys, Adjusters, Appraisers and Third Party Administrators 3,800
Others Allied to the Field 2,771
TOTAL 50,751

* Source: Business/Occupational breakdown of qualified circulation, May 29, 1989 issue, as submitted to BPA for June 1989 BPA Publisher's Statement.

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Airline rates

Continued from page 3

By the beginning of this year, airlines were still receiving 50% rate reductions on their hull and liability insurance programs, said an airline insurance manager.

"Rates are now anything from 10% to 20% of their level in 1986," said Peter Butler, managing director of Lloyd's of London broker Nicholson Chamberlain Colls Aviation Ltd.

And until the last quarter of this year, rates are likely to remain soft, sources at the conference agreed.

However, "the world airline premium income is likely to be on the order of \$250 million in 1990 whilst losses in recent years average somewhere between \$800 million and \$850

million," Mr. Butler said. "That certainly does not sound like good business and, as a Lloyd's name, it worries me very much."

The continuing soft aviation insurance market is forcing aviation reinsurers to take a stand, however.

At the end of last year, major aviation reinsurers decided they would not back 18-month airline hull and liability insurance policies and forced aviation insurance underwriters to offer only 12-month policy periods (BI, Dec. 4, 1989).

But while aviation insurance underwriters also were willing to pay more for excess-of-loss reinsurance coverage at the end of last year, "they weren't asked to pay more. Why not?" said a member of the audience.

Mr. Dumenil of Zurich Re ex-

plained that there were "commercial pressures"—namely excessive capacity—that led reinsurers to decide not to raise rates at the end of last year for 1990 aviation reinsurance programs. Therefore, terms were renewed for 1990 at the same level as last year with "the hope that underwriters would go back to decent underwriting and would change their minds worldwide" about cutting prices, he said.

But the underwriters have not stopped cutting prices, so reinsurers will have to take action, "because we cannot afford the cash flow anymore. We have losses coming in" from years past as well as current policies, but "there's no more money coming in through the front door," Mr. Dumenil said.

Drop Warsaw liability limits: Lawyer

LONDON—U.S. airlines should lobby Congress to drop all liability limits for international flights before it approves another international agreement or a separate proposal that would uphold liability limits, urges a leading U.S. aviation attorney.

Currently, airlines' liability to passengers on international flights is limited by Article 22 of the Warsaw Convention of 1929 unless willful misconduct of the airline can be proven. Aircraft manufacturers are excluded from the limits.

Under amendments to the convention by the 1967 Montreal Agreement, airlines' liability for international flights making a stop in the United States is limited to \$75,000 per passenger.

But the U.S. Department of Transportation is seeking Senate ratification of the Montreal Protocols, another international agreement drafted in 1975 that would increase the per-passenger liability limit to 100,000 Special Drawing Rights (\$129,800 at current exchange rates).

In addition, early last year the Transportation Department proposed a supplemental compensation plan to provide unlimited recovery for economic damages only for U.S. citizens and residents on international flights, subject to a per-incident, per-aircraft limit of \$500 million (BI, March 27, 1989).

In November, at a "brief and sparsely attended" hearing, the Senate Foreign Relations Committee decided to extend the supplemental plan to encompass non-economic damages as well as economic damages, said George Tompkins, a partner with the New York law firm Condon & Forsyth.

"It appears from this hearing that the Bush administration vigorously supports ratification of the (Montreal) Protocols and adoption of the supplemental compensation plan," he said.

But Mr. Tompkins, a leading airline defense attorney, opposes the legislation. "I question the wisdom of adopting a 1970s concept on a 1929 treaty for the next century," he said.

Instead, he believes that Article 22 of the Warsaw Convention, which contains the liability limits, should be scrapped and replaced with unlimited liability.

"Litigation occurs because of limits of liability," he said, contending that most litigation stemming from international airline disasters in U.S. courts today focuses on ways of avoiding the Warsaw Convention liability limits.

At the Insurance & Reinsurance Research Group Ltd.'s Fifth International Airline Insurance Conference earlier this month, Mr. Tompkins questioned why the International Aviation Transport Assn. supports approval of the Montreal Protocols and the supplemental plan.

"Privately, I don't think it makes a lot of sense," commented Ralf Oelssner, director of corporate insurance for Lufthansa German Airlines. "Some think that you would open Pandora's box and all hell would break loose (if unlimited liability were adopted). I don't think that would happen."

Another airline insurance manager, who also supports unlimited liability, said, "Isn't it a compromised way to save the Warsaw Convention where the limit is just one feature? I'm not a defender of the liability limit, but maybe it is a good way to save the rest of Warsaw."

Hearing these positions, Mr. Tompkins told conference attendants: "These views are not expressed to the Senate and they should be. I'm not in favor of losing Warsaw either, just Article 22. But the airline industry (in Washington) is advocating that they need the liability limits to help their growth. The Senate needs to be told otherwise."

One aviation risk manager at the meeting questioned whether an unlimited liability system would increase airlines' insurance rates.

"Different awards would be made in different countries," answered Peter Crawford, managing director of Aviation & General Insurance Co. Ltd. "So the rates will depend on the number of domestic passengers on board and the number of international passengers."

Whether rates rise "depends on the time that (unlimited liability) comes to the market," added a Lloyd's aviation underwriter. "You can't say there won't be an extra cost because it will depend on the state of the market at the time. . . . But I would like to see the removal of limits."

"If the liability limit were removed, what impact would there be on airline manufacturers?" asked a Lloyd's broker.

"There would be a reduced amount of litigation against manufacturers," said Mr. Tompkins. "They get dragged into passenger cases where they don't belong because of the limit of liability" which doesn't apply to them.

—By Stacy Shapiro

Markets

Continued from previous page

dition, HRH acquired **Gainesville Insurance Agency Inc.** in Gainesville, Fla. Terms of the transactions were not disclosed.

Arnold Benefits Consultants, an independent employee benefits consulting firm in Phoenix, Ariz., merged into the benefits division of **Corroon & Black/Arizona** in Phoenix.

Poe & Associates of Texas Inc. in Houston acquired **Bynum, Beck & Drew**, a Houston-based property/casualty agency. Poe of Texas also acquired **Beck/William Schwartz Benefits Inc.**, a Houston agency specializing in life and employee benefits coverages.

In addition, Poe & Associates Inc., the nation's 15th-largest brokerage based on 1988 revenues of \$35.1 million, acquired **Browne & Browne Inc.**, a property/casualty insurance agency in Fort Lauderdale, Fla. Browne & Browne's staff will relocate to Poe's Fort Lauderdale office.

Surplus lines broker **Repath &**

Associates Inc. in Nashville, Tenn., acquired **Crump E&S Agency of Ohio**. The Columbus-based surplus lines agency now operates under the name **Repath E&S Agency of Ohio Inc.**

Maryland Benefit Services Inc., a Baltimore-based benefit consulting firm, acquired **Bernard Fish & Associates**, a benefit consulting and administration firm in Baltimore.

Motors Insurance Corp., a Detroit-based subsidiary of General Motors Acceptance Corp., acquired **Motors Re Management Corp.** of Burlington, N.J. The acquisition will result in the formation of a wholly owned MIC subsidiary, **MIC Re Corp.**, which will combine the current management and staff of both companies. The new company, which specializes in automobile physical damage insurance, will be located in Burlington, N.J.

Multi-line property/casualty agencies **Keifer Marshall Insurance Agency Inc.** in Temple, Texas and **Anco Insurance of**

Temple/Belton Inc. in Belton, Texas merged. The companies will maintain their present offices, with the Temple office operating under the name **Keifer Marshall/Anco Insurance**.

Chicago-based broker **Associated Agencies Inc.** acquired **American Builders & Contractors Insurance Agency** of Costa Mesa, Calif. ABC, which generates about \$5 million in premium volume per year, will move its offices and staff to Associated Agencies Inc. of California's location in Irvine, Calif.

Coventry Corp., a managed health care company in Nashville, Tenn., acquired **Group Health Plan Inc. of St. Louis**, a health maintenance organization with more than 107,000 enrollees representing 600 local employers.

Chicago-based **Aon Corp.** acquired **Martin Boyer Co. Inc.**, a workers compensation and general liability services company with offices in Chicago, Peoria, Ill. and St. Louis.

"We are certainly going to put our rates up and our retentions."

Mr. Dumenil backed up this decision by pointing out that aviation underwriters now keep a net retention of \$50,000 and \$100,000 per risk. "In some cases it is less than that."

That means that all aviation insurers participating on an airline's account are retaining only 0.75%—or between \$7.5 million and \$10 million—of total insured limits of more than \$1 billion, he said.

Meanwhile, it is taking insurers up to seven years to settle outstanding claims from airline disasters, he said. For example, insurers still must pay out \$991 million in outstanding claims stemming from major aviation disasters from 1983 to 1989, he said.

Mr. Dumenil also pointed out that aviation underwriters depend on the marine market and to a lesser extent the non-marine market to write aviation reinsurance.

But as a result of catastrophes such as Hurricane Hugo, the California earthquake, the Exxon Valdez oil spill in Alaska, the explosion of the Piper Alpha drilling platform and the "great storms that have ravaged Europe"—not to mention satellite and airline losses—"the non-marine market, for the most part, came out of writing aviation at the end of last year," he said.

"Many reinsurers may have difficulty surviving these losses," Mr. Crawford said.

And, those that do survive will want to "claw back" money and restrict coverage, he said. "Adequate premium has to be paid for the cover, (but) the lack of profitability is more likely to lead to a reduction in capacity and in the amount of coverage offered."

But Mr. Oelssner of Lufthansa warned that underwriters—who still are vigorously competing for airline

business—should not hike rates at the end of the year to the extent that rates were increased in 1986.

Airlines that can afford rate increases probably would be willing to pay if the new rate reflects the airlines' loss experience, Mr. Oelssner said. "But don't push us to other markets" by increasing rates to an exorbitant height, he warned.

And, while Mr. Oelssner said he is willing to consider suggestions from underwriters on changes to his airline's insurance program, he noted that it will be "carnival time" during the last quarter of the year when 75% of the world's airline insurance programs come up for renewal.

Then, underwriters will have two alternatives, he said.

The underwriters could maintain their market share and hope for improvement in rates next year, or "they could increase rates and be remembered," he said, meaning that the airlines will not forget that underwriters raised rates.

"My hunch is that they will do the first—maintain market share," he added.

But if there is an upswing in rates, underwriters should be aware that airlines will retain more risk and increasingly use captives such as AMI, Mr. Oelssner said.

"Is Ralf implying that airlines are ready to subsidize their insurance costs" by using captives? an underwriter asked.

"Captives arise when the price is not right and when the product is not right," Mr. Oelssner said. "It is a type of self-defense."

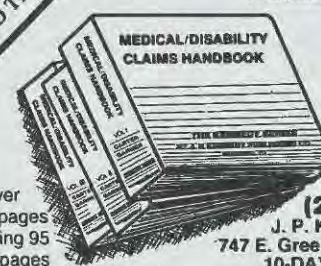
However, the underwriter said he believes that AMI and other airline captives can offer only a limited amount of capacity to airlines. "Underwriters shouldn't consider this to a great extent to put their own houses in order," he said.

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PCB regulation

Continued from page 3
the deadline, "it's hard to say about all of them."

Production of PCBs, which began in the 1920s, was halted in 1979 after the chemicals were found to be extremely toxic when burned. However, transformer owners were allowed to continue using the chemicals as coolants.

The EPA regulations apply to both network and radial transformers located in or within 99 feet of commercial buildings. Under the regulations:

- All high-voltage PCB network transformers—480 volts or greater—must be removed or retrofitted with non-PCB fluids, a procedure generally known as "reclassification," to reduce PCB contamination levels to 500 parts per million or less.

- All high-voltage PCB radial transformers located in or near commercial buildings must be re-

moved or reclassified, or fitted with electrical safety devices to protect against transformer ruptures caused by high-current faults or sustained low-current faults.

- Low-voltage network transformers not located in sidewalk vaults must be equipped with an electrical safety devices to protect against ruptures by high-current faults by Oct. 1 or removed or reclassified by Oct. 1, 1993.

- Low-voltage network transformers located in sidewalk vaults must be removed or reclassified by Oct. 1, 1993.

Federal authorities estimate that there are a total of 100,000 contaminated transformers in the country, but experts cannot say how many are in or near commercial buildings or would be covered by the EPA regulations.

While conceding that determining the location and ownership of each transformer will be nearly impossible, the EPA spokeswoman said "inspections will continue."

Most electric utilities, schools, hospitals, office buildings, shopping centers and municipal buildings use transformers covered by the EPA guidelines, according to Ms. Motter.

The cost of replacing or retrofitting a transformer can vary greatly.

Most transformers use either askarels—fluids that contain PCBs—or a mineral oil solution manufactured without PCBs that over the years becomes contaminated with askarels during maintenance, according to Ms. Motter.

Disposal and replacement of an askarel unit can cost up to \$50,000 per unit, and removal can take up to one year, she said.

Mr. Potenza of Gallagher Bassett Service also noted that some transformers are "designed and customized for specific purposes. Companies may need two years lead time to get delivery."

But, askarel transformers also can be reclassified through multi-

ple treatments with chemicals that destroy PCBs or by using a small processor that distills PCBs.

Reclassification of an askarel transformer generally costs \$20,000 to \$30,000, Ms. Motter said.

Disposal and replacement of mineral oil units can cost even more than replacing askarel units, Ms. Motter said.

Owners of mineral oil transformers instead usually opt for the more economical option of reclassifying the units, she said.

Reclassification costs for mineral oil units vary widely because transformers can hold between 500 and 20,000 gallons of fluid, Ms. Motter pointed out. Depending on the type of fluid used and the retrofit process, reclassification costs 90 cents to \$10 per gallon.

Ms. Motter said it can take from several months to longer than a year to treat PCB-laden transformers.

Transformer owners that have

not yet contracted for PCB cleanup will have their backs against the wall, Ms. Motter asserted.

Some employers, though, have been conscientious about meeting the EPA deadline for PCB cleanup.

For example, Texas Utilities Electric Co. spent more than \$35 million several years ago to either replace or clean up PCB-contaminated transformers to comply with the federal rules.

"We put a high priority on it and got it done," said Mike Williams, risk manager for the Dallas utility.

Shortly after the EPA issued the rules, Texas Utilities "changed or flushed" 350 high-voltage transformers as well as replaced 75,000 contaminated capacitors, Mr. Williams said.

A changeover of 10 transformers at Boston City Hospital, begun last fall, is nearly complete and will cost the hospital about \$270,000, said Bob Bradley, a project manager for the city.

"We'll make it on time," he predicted.

Two transformers "were useless," and eight others are being "retrofitted" to remove contaminants, Mr. Bradley said.

Tracking down transformers and determining ownership created a lot of confusion, according to Mr. Bradley.

"Once we do find a location, the biggest problem is determining who owns the transformer."

But, when the city found transformers that it was able to determine it did not own and contacted the owners, their reaction has been, "We know it's there, don't worry about it," he said.

"People have them out there and are looking the other way. They're hoping they will get bypassed or skipped over" by the EPA, he said.

Sluggish management was the biggest obstacle for engineers at Nashua Tape Products, which is removing or converting nine transformers, said Dave Keister, a company engineer.

"It took a lot of requests, but they finally realized that this was coming down the road and they had better do something," he said.

Of nine transformers at the Nashua Corp. unit's Watervliet, N.Y., plant, four have been replaced and three have been reclassified so far, according to Mr. Keister.

The company expects to complete the \$200,000 project by reclassifying the remaining two transformers by the Oct. 1 deadline, he said.

But replacement or reclassification costs pale next to the "tremendous" costs of cleaning up after either a fire involving fluids contaminated by PCBs—which are converted into deadly dioxins when burned—or a PCB leak, Ms. Motter pointed out.

For example, a 1981 fire in the 18-story state office building in Binghamton, N.Y., has cost \$100 million in cleanup and litigation costs, she said (BI, Sept. 24, 1984).

And, when less than two gallons of PCB fluid spilled from a transformer at a Midwest plastics company, the cleanup cost \$460,000, Ms. Motter said.

The company also lost 1,600 hours of production time because it had to replace part of the roof, perform hundreds of lab tests and incinerate rainwater that fell in the contaminated area.

"Their insurance company refused to pay the damages," Ms. Motter pointed out.

Thomas W. Jaeger, president of property loss control consultant Gage Babcock & Associates Inc. in Vienna, Va., agreed that cleanup following a fire involving PCBs can be lengthy and expensive.

For example, Mr. Jaeger noted that a museum recently inquired about the PCB exposure a fire could cause. He told museum officials that such an accident could shut down the facility for years and ruin its entire collection. ■

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

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Transit failure

Continued from page 1

gle between the Transit receiver and Weavers. Last summer, receivership officials refused to disavow press reports projecting Transit-related losses to the Weavers line slip at \$300 million (*BI*, July 10, 1989).

Mr. Wilson, who had asked the receivership to deny the reports, maintained that losses to the line slip will total no more than \$60 million.

In an interview last week, Mr. Arnold said he expects claims against the Weavers slip to total \$100 million to \$300 million, calling the \$60 million estimate "far, far off the mark."

Transit has just started putting together loss information it hopes to use to commute agreements with line slip reinsurers, said Mr. Arnold, adding he is "confident" the commutation will exceed \$100 million.

However, Mr. Wilson said in his statement that "nothing that the receiver has said or done gives us reason to revise existing reserves of approximately \$60 million in connection with Transit."

"To date, the receiver has largely failed to substantiate its demands for reinsurance recoveries. Those companies underwritten by H.S. Weavers comprise only a small portion of the reinsurers still waiting for the receivership to present claims to which the reinsurers can respond positively," Mr. Wilson said.

"Like the receiver, the directors and officers of Transit's reinsurers are fiduciaries and cannot simply give their companies' money away out of fear the receiver will do the sort of thing he has done in his statements to the subcommittee," he said.

Mr. Arnold, meanwhile, denied that he is trying to pressure Weavers reinsurers into settling Transit claims, and he said he hopes relations with Weavers are not damaged.

"I hope it does not exacerbate it," Mr. Arnold said. "I did not go to Washington to throw gasoline on the fires."

Mr. Wilson's statement added that "the receiver's decision to attack me, my fellow directors and our companies will not affect our reinsurance discussions with the receivership. We are professionals and our representatives will continue to act professionally. We will honor our legal obligations and expect the receivership to honor theirs."

Last week's subcommittee hearing was the first since the February release of the subcommittee's report on solvency regulation and the failures of Transit, Carlos I. Miro's Anglo-American Insurance Co. of Louisiana and other insurers (*BI*, Feb. 26).

In addition to Mr. Arnold's testimony, the subcommittee heard an official of the Louisiana Anglo-American receivership, who described the status of Anglo-American's liquidation and outlined several practices he described as common to fraudulently run insurers (see related story).

Anglo-American of Louisiana is not related to Anglo American Insurance Co. Ltd. in London, which participates on the Weavers line slip.

Transit, ordered into liquidation in December 1985, has entered records

collected from more than 330 U.S. agencies and other businesses into a computer system, which began producing bills to reinsurers last August, Mr. Arnold reported.

About 50% to 60% of the \$130 million Transit has already collected has been from reinsurance recoveries, with the balance from settlements of lawsuits and other funds, he said.

Most of this money was collected before the computer system became operational, Mr. Arnold said.

Since August, another \$200 million in bills have gone to Transit reinsurers, including the Weavers line slip, Munich Reinsurance Co. and the defunct Mentor Insurance Ltd.

Overall, the receivership is hoping to recover \$500 million to \$800 million in Transit assets, mainly in reinsurance recoverables, Mr. Arnold said.

Meanwhile, the estimated size of the Transit insolvency has ballooned to \$3 billion to \$4 billion from the \$2 billion estimated a year ago.

The increase followed a Coopers & Lybrand study of the NUA book of business completed last summer, which found gross losses from NUA's high-risk excess casualty book could hit \$2.4 billion, said Mr. Arnold.

Gross premiums written by NUA for Transit from 1978 to 1985 were \$205.6 million, of which Transit retained \$14.4 million and ceded \$191.2 million to reinsurers, he said.

Receivership officials devoted much of their earlier testimony to Mr. Miro, also a former Transit MGA, but losses from the Miro operation "pale in comparison" to those expected on the NUA book, Mr. Arnold told the subcommittee last week.

NUA, formed in 1978, was owned 37.5% by Transit, 37.5% by Weavers, 20% by Mr. Foss and 5% by NUA Secretary Barbara K. Marrs. NUA board members included Mr. Wilson, former LUI Chairman C. Ronnie Driver, former Transit President George P. Bowie, Mr. Foss and other company officials.

Mr. Foss and Ms. Marrs are now officers and own 25% of Chicago-based LUI Management Inc., an underwriting manager 75% owned by LUI.

Under its agency agreement, NUA had authority to bind Transit to excess liability business with limits of up to \$10 million per risk, with Transit retaining up to 10% and ceding 15% to reinsurers on the Weavers line slip and 75% to other reinsurers.

The agreement was amended to increase the binding authority to \$25 million per risk and to end the restriction on the amount of reinsurance placed through Weavers, according to Mr. Arnold's written testimony.

Mr. Arnold complained of NUA's failure to underwrite prudently, set adequate reserves and monitor unauthorized reinsurers to ensure that adequate letters of credit here posted securing reinsurance recoverables.

Those involved in forming NUA were less concerned with Transit's welfare than with boosting their own income through fees and commissions generated by the Transit business, Mr. Arnold charged.

"The very parties who created the

MGA company all had a 'parasitic' interest," he alleged, explaining that Transit's interest was to generate fronting fees and ceding commissions on "non-risk" business, while NUA, LUI and Weavers were primarily concerned with generating management fees and commissions.

Although LUI owned some reinsurers on the Weavers line slip—most notably Walbrook Insurance Co. Ltd.—these companies were in turn heavily reinsured, generating more ceding commissions and reducing risk on the Transit business, he said.

Meanwhile, Russell Re, which acted as a Transit MGA from 1978 to 1984, was structured in much the same way NUA was, with shares held at one time by Transit, Mr. Driver, Mr. Wilson and former LUI Director Harold S. Weavers, among others, Mr. Arnold testified.

Although the three LUI officials held a 66.7% interest in Russell Re from 1978, the holdings were not disclosed until last year, when LUI reported the shares had been transferred without payment to LUI (*BI*, May 22, 1989).

In his testimony, Mr. Arnold asked why this controlling interest in Russell Re had not been disclosed and attacked LUI officials for self-dealing.

"When you factor in Mr. Peter Wilson's and Mr. Ronnie Driver's stock ownership in LUI, it is evident that 'greed and money' actually motivated them to engineer the Russell Re and NUA... corporate entities," he said.

"These two producing agencies... fed millions of dollars of reinsurance transactions to Weavers, whose slip moved the ceded reinsurance to Walbrook and other Weavers slip companies. All of these transactions were designed to generate heavy commissions and overrides at several stages which 'fattened profits' for LUI," he testified. "Transit's underwriting profit and solvency were clearly secondary."

Mr. Arnold also complained that Transit's potential recoveries in a lawsuit against former Transit directors and officers will be limited because the insurer's D&O liability coverage, written by National Union Fire Insurance Co. of Pittsburgh, Pa., a unit of American International Group Inc., includes defense costs within the policy limit.

About 40% of the limits have been exhausted by defense costs, according to Mr. Arnold, who said discovery in the case has been stayed during settlement negotiations.

National Union provided D&O limits totaling \$15 million under two policies.

In his testimony, Mr. Arnold advocated new laws that would forbid insurance company D&O policies to include defense costs within policy limits.

Noting that part of Transit's insolvency stems from its inability to collect from some of its 1,400 reinsurers, he called for federal accreditation of alien reinsurers.

Standards should include a minimum of \$50 million in capital and surplus and the filing of audited financial statements similar to those required of U.S. insurers, he said. ■

Insolvency increases with scrutiny of deals

By DOUGLAS McLEOD

WASHINGTON—The insolvency of Carlos I. Miro's Anglo-American Insurance Co. has grown as new details of questionable transactions among the company and its affiliates emerge, says a liquidation official.

The size of the insolvency has grown to about \$23 million from the \$19 million estimated last year, said Fredrick R. Tulley, special counsel to the Louisiana Insurance Department.

So far, the liquidator has recovered about \$3.2 million but has been left with more than \$17 million in worthless receivables—including promissory notes and reinsurance balances—owed by Anglo-American affiliates in Dallas, London and Ireland, Mr. Tulley said.

The Louisiana department has sued the affiliated companies and Mr. Miro personally, charging that he used the affiliates to siphon money out of Anglo-American for his own benefit (*BI*, Sept. 11, 1989).

However, Mr. Miro has left the country, and the department has been unable to formally serve him with the complaint, testified Mr. Tulley of Taylor, Porter, Brooks & Phillips, a Baton Rouge law firm.

Anglo-American of Louisiana is not related to Anglo American Insurance Co. Ltd. in London, which participates on the line slip managed by H.S. Weavers (Underwriting) Agencies Ltd. (see story, page 1).

Based on new information discovered in the liquidation process, Mr. Tulley outlined a dizzyingly complex set of transactions in which Mr. Miro allegedly extracted \$2.8 million from Anglo-American.

Turning a normal reinsurance transaction on its head, Anglo-American posted a \$1.5 million letter of credit for the benefit of an Irish reinsurer Mr. Miro controlled, Mr. Tulley said.

The same day the LOC was delivered, the reinsurer used it to borrow \$1.3 million from Barclay's Bank in London. Then, the money was wired to Anglo-American's parent company, which used it to "repay" Anglo-American for insurance premiums the parent had previously misappropriated, Mr. Tulley said. This allowed Anglo-American to avoid taking a \$1.3 million write-off related to its parent's debt, he said.

Meanwhile, Anglo-American had posted a \$1.5 million certificate of deposit to obtain the LOC. However, this asset was lost when the Irish reinsurer drew down the LOC to repay its \$1.3 million loan from Barclay's Bank. The \$200,000 left from the drawdown was used to pay Mr. Miro's personal debts, Mr. Tulley testified.

Anglo-American did not hold onto the "repayment" from its parent company, he added. The \$1.3 million was wired back to London and replaced with a \$1 million note from Kamel Properties Ltd., secured by a mortgage on Mr. Miro's Dallas condominium. Regulators have not been able to find out who owns Kamel Properties, Mr. Tulley said.

J. Albert Kroemer, Mr. Miro's Dallas attorney and Kamel's president, said he is only a trustee for Melvin Stein, Mr. Miro's London lawyer. Mr. Stein is trustee for the undisclosed principal of Kamel. Mr. Kroemer refuses to identify this principal, citing attorney-client privilege and his Fifth Amendment right against self-incrimination, Mr. Tulley said.

The subcommittee earlier asked the U.S. Justice Department to investigate possible crimes by Mr. Miro, Mr. Kroemer and others.

Advocating new federal insurance fraud laws, Mr. Tulley outlined practices he described as "symptomatic" of corrupt companies:

- "Laundering" of assets, by transferring cash from the insurer out of state or overseas, then transferring the same money back to the company and counting it as additional surplus.

- In addition to Anglo-American, Mr. Tulley cited transactions in which the now-defunct New England International Surety of America Inc. secretly transferred \$1 million to its parent company's Swiss bank account, later receiving the same cash as a capital contribution intended to bolster the failing company (*BI*, May 1, 1989).

- Bogus or grossly overvalued assets. Mr. Tulley cited a defunct Louisiana insurer whose assets included a \$5 million mortgage on a \$6.2 million Texas property. This turned out to be a worthless fourth mortgage behind more than \$7.9 million in previous liens, he said. Mr. Tulley did not name the company, but he was referring to the defunct American Lloyd's of Metairie, La., which was ordered liquidated in June 1989 (*BI*, July 10, 1989).

- Assets of a now-insolvent Wyoming insurer also included a \$500,000 "Indian nation revenue bond," backed by equity in a gold mine that had not yet been developed, he said. Again, Mr. Tulley did not name the insurer, but he was referring to Commercial General Insurance Co. of Wyoming, which was ordered liquidated last September.

- Rollover of business from an insolvent insurer into successor companies. After American Lloyd's entered insolvency proceedings, Mr. Tulley noted, its owners rolled their business over into Oxford Indemnity Co., a Wyoming company they also controlled, which went under less than six months later. ■

DES claim

Continued from page 3

there is nothing in the medical literature to suggest this is a viable claim."

The spokeswoman would not comment on Lilly's insurance.

Company officials have said Lilly was insured until 1969 for DES claims by New York-based Home Insurance Co. and Lloyd's of London and that Lilly subsequently self-insured this risk (*BI*, June 16, 1980).

Home would not comment.

It has been estimated that drug companies carried no more than \$10 million in limits to cover DES claims (*BI*, April 10, 1989).

Since the synthetic estrogen diethylstilbestrol was first widely prescribed as an anti-miscarriage drug in the late 1940s, thousands of suits

have alleged DES caused uterine deformities, producing cancer and birth defects in daughters of women who took the drug.

Lilly now faces about 650 suits related to DES, which the Food and Drug Administration banned in 1971.

In the latest suit, Mr. Roberts charges he was "chromosomally and genetically injured as a result of his in-utero exposure" to DES, which his mother ingested while pregnant in 1949.

As a result of this alleged mutation, Mr. Roberts' 13-year-old daughter Amy contracted clear cell adenocarcinoma of the vagina, a rare cancer, and died June 4, 1989.

Mr. Roberts claims that Lilly should have recognized that bodily harm to others was likely by fail-

ing to warn about the drug's potential dangers and by overpromoting DES as safe and harmless.

His suit claims Lilly was negligent, through its "failure to test, failure to warn, overpromotion of DES and failure to report adverse studies regarding the safety and efficacy."

Lilly and other drug companies conspired to "market the drug despite its known dangers and thereby enrich themselves through the sale of diethylstilbestrol," the suit says.

DES's safety was misrepresented in "advertisements, labeling and literature," on which Mr. Roberts' mother and her physicians relied, the suit alleges.

The company also made "false, misleading and unfounded" implied and express warranties, the suit says. ■

As a result of the alleged negligence, the "plaintiff suffered permanent damage to his genes and resultant pain and suffering, incurred medical expenses for the care and treatment of his daughter in excess of \$250,000 and funeral expenses."

"Having marketed and promoted DES in its defective and unreasonably dangerous condition," Lilly is strictly liable, the suit contends.

However, Mr. Mayessh, the defense attorney, said while the cancer that killed Ms. Roberts is rare, it occurs regardless of whether the victim, the victim's parents or the victim's grandparents used DES.

"I'm aware of absolutely no support in the scientific community for that allegation," Mr. Mayessh said. Another defense attorney, Victor E.

Schwartz of Crowell & Moring in Washington, D.C., said: "The mere fact that one thing follows another does not mean it causes another."

Because DES and cancer are not directly connected, "you get into an area of very broad-scale speculation," he said.

Only a small portion of the women who ingested DES ever sued manufacturers, he said.

Mr. Schwartz also contends that it is unlikely DES manufacturers could have predicted this sort of problem 40 years ago.

"If we go back to 1948, when DES was first used, the idea that a man would have reason to know that a product would cause problems in a third generation seems at first blush inconceivable," he said. ■

Parental leaves

Continued from page 2

Some parents are now "forced to make choices they should not have to make," the NRC said.

In addition, the NRC recommended that local governments and the federal government follow the lead of some European nations in guaranteeing quality child care, but it did not suggest revenue sources.

For example, the NRC recommended substantially increasing government child-care subsidies for poor families.

Implementing all of the panel's recommendations would cost local

and state governments and the federal government \$5 billion to \$10 billion annually, the NRC said.

About \$16 billion a year is now spent on child care by public and private sources, including parents, according to the NRC.

But, the Washington, D.C.-based National Federation of Independent Business criticized the report as being one-sided.

"This report takes into account only the child and the family, not the business owner," an NFIB spokeswoman said. "It doesn't look at the real world where business exists, too."

While the NFIB has not estimated what one-year unpaid

leaves of absence would cost, "it would be very expensive for business owners," the spokeswoman said.

The amount would depend on how much a replacement employee was paid, she explained.

A 1987 General Accounting Office study estimated that providing 10-week leaves of absence with continued health benefits would cost U.S. firms with at least 35 employees at least \$102 million annually.

The NRC expects to make the full report, "Who Cares for America's Children? Child Care Policy for the 1990s," available to the public by late April. ■

Allied-Signal

Continued from page 1

For example, while Allied-Signal reported that its per-capita health care cost for employees enrolled in the program is \$2,450, employers with more than 40,000 employees reported that indemnity plan costs leaped 24.2% in 1989 to \$3,088 per employee, a recent survey by benefit consultant A. Foster Higgins & Co. Inc. found (BI, Jan. 29).

In addition, Allied-Signal executives said last week that the huge cost savings attributable to the managed care program largely have been achieved through paring back unnecessary hospital care.

For example, hospital stays for participants in the managed care program averaged 4.8 days, compared with an average length of stay of 7.3 days for employees and dependents covered under Allied-Signal's indemnity plan.

"We believe we have eliminated a lot of unnecessary care," Mr. Duva said.

He and CIGNA executives also said the program has improved the quality of care.

Mr. O'Brien explained that to be accepted in CIGNA's HMOs doctors have to meet detailed professional standards. That process is more likely to assure that physicians will be of the highest professional caliber than word-of-mouth communication and other methods that employees normally use to find physicians, he said.

Allied Signal's managed care program offers physicians and hospitals financial incentives to provide cost-efficient care.

Typically, primary physicians participating in the program are paid on a capitated basis—they receive a fixed fee for each Allied-Signal employee that selects them, CIGNA's Mr. O'Brien said. Specialists are paid according to a fee schedule, while hospital payments are made on a per-diem basis.

Mr. Hennessy, Allied-Signal's

chairman and CEO, said the company looked to chart a new course in paying for health care after its costs increased 39% in 1987.

That increase, Mr. Hennessy said, was "unacceptable. We recognized the need for a totally new approach."

According to company projections, unless Allied-Signal made dramatic changes in the way it offered and delivered health care to its employees, costs would continue to increase at nearly a 20% clip through 1990, which would bring health care costs to \$564 million. In 1987, Allied-Signal's health care costs were \$355 million.

Allied-Signal said it cannot compare its current overall health care expenditures to its earlier projections because the company now employs fewer workers.

The course Allied-Signal chose, Mr. Hennessy said, was to pick a single insurer to run a national managed care network and to guarantee that if cost increases exceeded an agreed-upon percentage, the insurer would have to swallow those costs.

Allied-Signal executives said in 1988 that CIGNA was selected because the insurer offered the best financial arrangement and it already had established HMO networks in many of the areas where Allied-Signal had employees.

Besides the risk contract in the managed care program, CIGNA also has agreed to pick up health care cost increases—above a stipulated percentage—for Allied-Signal employees who are not yet covered by the managed care network and are enrolled in an indemnity plan administered by CIGNA. Details of that arrangement were not disclosed.

CIGNA agreed to the risk sharing contract because Allied-Signal was willing to design a plan that would strongly encourage employ-

ees to use the managed care network, Mr. O'Brien said.

Under the plan, all employees enroll in the managed care portion of the plan and select a primary care physician—or gatekeeper—just as HMO enrollees do. To receive network benefits, employees must contact their network physician first about any health care problem. The primary care physician then will coordinate health care for that employee.

Employees still have the option to receive health care services from a non-network provider without first going through the gatekeeper, but their out-of-pocket expenses are much higher.

For example, employees who use network providers do not pay deductibles, while employees who use non-network providers must pay an annual deductible equal to 1% of annual base pay for individual coverage and 3% of annual base pay for family coverage.

In addition, employees who use network providers pay fixed-dollar copayments on some services, including \$10 for physician office visits and \$5 for prescription drugs, while employees who use non-network providers must pay a 20% copayment, up to an annual maximum of 12% of their annual base pay including the deductible.

Aside from lower out-of-pocket costs for using the network, employees using network providers also do not have to file claim forms.

Jerry Jasinowski, president of the National Assn. of Manufacturers, said at the press conference that Allied-Signal's success in controlling health care costs is a powerful example of employers using ingenuity to battle health care inflation (see story, page 3).

Mr. Duva said the Health Care Connection will be extended to 4,000 more Allied-Signal employees within six months. ■

Searle not liable in IUD suit

MIAMI—G.D. Searle & Co. is not liable for injuries to a woman who claimed she was rendered infertile by the company's CU-7 copper intrauterine device, a U.S. District Court jury has found.

A six-person jury ruled unanimously March 8 that the CU-7 was not responsible for any alleged injury to Holliday Adams, who

sought unspecified compensatory damages.

Skokie, Ill.-based Searle, a Monsanto Corp. unit, has lost only four of the 20 jury trials in CU-7-related cases since 1974, when the intrauterine device was first introduced.

Three of those cases were subsequently settled and one is on ap-

peal, according to a Searle spokeswoman.

Of an estimated 1,300 CU-7 suits filed in the past 16 years, 300 are still pending and the remainder were dropped, dismissed or settled, she said.

Searle voluntarily withdrew the IUD from the market in 1986.

—By Mark A. Hofmann

Pepperidge Farm faces fines

WASHINGTON—The Labor Department is proposing fines totaling \$638,500 against Pepperidge Farm Inc. for 133 alleged willful violations of record keeping and ergonomic standards at its Downers Grove, Ill., plant.

The proposed fines follow a six-month Occupational Safety and Health Administration investigation prompted by an employee complaint.

OSHA alleges that within the last two years, 20 employees of Pepperidge Farm, a subsidiary of Campbell Soup Co. in Camden, N.J., have been diagnosed with cumulative trauma disorders caused by repeated awkward or forceful hand and arm or body action.

At least 19 other employees have required surgery for CTD-related injuries, but Pepperidge Farm did

not properly record these injuries, according to OSHA.

In addition, the company attempted to discourage employees reporting CTD-related injuries from filing workers compensation claims by telling them that those injuries were not work-related, OSHA alleges.

In December 1988, OSHA proposed \$1.38 million in fines against Pepperidge Farm's Downingtown, Pa., plant for similar alleged violations. Pepperidge Farm still is contesting those proposed fines.

Campbell Soup considers the new charges "without merit" and will "vigorously" contest the proposed fines to the Occupational Safety and Health Review Commission, a spokesman said.

—By Adrienne Locke

Update

Reinsurer results deteriorate

WASHINGTON—The combined ratio for 68 U.S. reinsurers increased to 107.4% in 1989 from the 103% ratio posted by a similar group in 1988, according to a Reinsurance Assn. of America survey.

The 1989 combined ratio reflects a 77% loss ratio and a 30.4% expense ratio.

In addition, total net premiums written fell 3.6% to \$10.7 billion from \$11.1 billion a year ago, the survey found.

Sixty reinsurers also reported \$767 million in gross losses and \$228 million in net losses from Hurricane Hugo and \$67 million in gross losses and \$55 million in net losses from the San Francisco Bay area earthquake.

The reinsurers reported \$11.9 billion in policyholder surplus in 1989.

EPA delays coverage deadlines

WASHINGTON—Several groups of owners and operators of underground petroleum storage tanks will have an additional year to comply with Environmental Protection Agency financial responsibility requirements.

The EPA last week extended the compliance deadline to April 26, 1991, for petroleum marketers owning between 13 and 99 tanks at multiple sites. The old deadline had been April 26, 1990.

In addition, petroleum marketers owning fewer than 13 tanks at multiple sites or those having fewer than 100 tanks at one site, now have until Oct. 26, 1991, to meet the EPA requirements. The former deadline was Oct. 26, 1990.

Also, the deadline for non-marketers with less than \$20 million in net worth and for local governments has been extended one year to Oct. 26, 1991.

Owners and operators of more than 100 tanks were not granted deadline extensions.

Under EPA rules, owners of underground petroleum tanks with monthly throughputs exceeding 10,000 gallons must secure environmental impairment liability coverage with limits of \$1 million per claim. Owners of smaller tanks must maintain EIL limits of \$500,000 per claim and \$1 million aggregate.

EPA Administrator William K. Reilly said the reprieve was given because many gas station owners and petroleum marketers said they would experience undue hardships because of the earlier deadline.

However, insurers feel the one-year extension will further reduce capacity for underground storage tank coverage.

John Matelski, chairman of McLean, Va.-based Front Royal Group, which specializes in writing EIL coverage, called the compliance deadline extension a move that "falls out of good common sense. Owners can still have accidents that will damage their economic well-being."

Subway crash insured

PHILADELPHIA—The Southeastern Pennsylvania Transportation Authority has \$250 million in property insurance to cover damages from the derailment of a metropolitan subway train in which three people were killed and 160 others were hurt earlier this month.

SEPTA also has a \$2 million self-insured retention to cover liability claims that may arise from the accident. However, a 1978 state law caps SEPTA's liability at \$1 million per incident and \$250,000 per person, pointed out Connie Clayton, SEPTA's risk manager.

In the March 7 accident, a rush-hour train with more than 1,000 passengers smashed into a tunnel wall, causing support beams to crush one of its six cars.

Arkwright Insurance Co. of Waltham, Mass., a unit of Arkwright Mutual Insurance Co., wrote all of the property coverage for the transit authority above a \$50,000 deductible, Ms. Clayton said.

The extent of the damage was not known late last week but will exceed \$1 million, Ms. Clayton said.

The train's motorman tested positive for cocaine use after the accident, but National Transportation and Safety Board investigators have not determined the cause of the derailment.

Suit claims wrongful dismissal

CHARLESTON, S.C.—A supermarket chain has fired, as a matter of policy, an unspecified number of employees just as they were to become fully vested in a profit-sharing plan, one of the employees charges in a suit seeking class-action status.

Food Lion Inc. of Salisbury, N.C., is also charged in the suit with wrongful dismissal in the March 1988 firing of that employee for "gross misconduct" and with violating federal law by not offering him and other workers continued health care coverage as the Consolidated Omnibus Budget Reconciliation Act of 1985 requires.

An employer does not have to extend COBRA benefits to an employee who has been terminated for gross misconduct.

The suit—filed March 12 in U.S. District Court—seeks \$100 a day in damages for each employee not offered COBRA coverage.

Officials at Food Lion, which is owned by Delhaize Le Lion of Belgium, could not be reached for comment.

Briefly noted

A Pennsylvania Supreme Court judge has stayed an order dissolving the policyholders committee of **Mutual Fire, Marine & Inland Insurance Co.** pending the committee's appeal of the dissolution order. . . . A New York state judge has ordered the New York Insurance Department liquidation bureau to show cause why a court-appointed referee should not hear questions relating to the estate of defunct **Constellation Reinsurance Co.** and why a formal creditors' committee should not be organized. The liquidation bureau is pressing a plan to commute Constellation's contracts, while some creditors have expressed an interest in acquiring the reinsurer's assets and liabilities (BI, Jan. 22). A hearing is scheduled for tomorrow. . . . India's Supreme Court has approved an interim compensation plan under which the government will pay \$12 a month to each of the 500,000 people who lived near the site of the 1984 **Bhopal gas disaster** and \$44 a month to each of the 3,110 people disabled by the leak.

Stable to rising premiums should help brokers in 1990

By LEONARD M. WILSON

Special to Business Insurance

THE PUBLICLY OWNED insurance brokers finished 1989, the soft market's third year, in something less than a blaze of glory, notwithstanding growing optimism over the course of premium rates. Results for the fourth quarter were aided, to be sure, by an evident easing in competition. But operating comparisons continued to be burdened by market conditions that restrained revenue gains.



Mr. Wilson

The pace of growth in brokerage commissions improved in each successive quarter, and rate competition abated in intensity through the year. This trend has boosted hopes for a turn in pricing. In the figures below, we have incorporated estimated changes in domestic retail commissions and premium rates on a quarter-by-quarter basis:

- For the first quarter of 1989, public brokers' retail commissions were down an estimated 1% compared to the first quarter of 1988, while premium rates were down an estimated 14% from the year-earlier figures.
- Estimated second-quarter retail commissions showed no change compared with the second-quarter of 1988, while premium rates were estimated to be 13% lower.
- In the third quarter, retail commissions were up an estimated 3% compared with a year earlier, and premium rates were down by an estimated 10% over the third quarter of 1988.
- Fourth-quarter retail commissions showed an estimated 6% increase over the year-earlier period, while premium rates dropped an estimated 7% from the fourth-quarter of 1988.

Extrapolate the trend, and 1990 becomes a year of stable-to-rising premium rates. That's what the optimists hope. At this juncture, though, a stall in the march toward a firm market cannot be ruled out as an

equally plausible scenario.

The figures also indicate that brokerage commissions would advance markedly if premium rates, instead of exerting a drag, were to become only a neutral factor.

New business production did not falter in the fourth quarter. Gross new business for most brokers was up in the area of 15% over the prior year's book of business, while lost business remained around 5%. As a consequence, net new business amounted to 10%. The steadiness in new business production remains a bulwark of progress for all the brokers. It attests to the efficacy of broad geographical reach and comprehensive service capabilities.

Reinsurance brokerage was the proverbial mixed bag. Pricing was by all accounts fairly stable. But the hoped-for decline in primary retentions has not yet materialized. Catastrophic losses in the U.S. and recently in Europe have firmed some sectors of reinsurance, we gather. Nonetheless, liability coverages are still competitive.

Benefit consulting grew strongly again in the quarter, as it had for prior periods. Consulting has gained steadily in relative importance during the past three years as property and casualty commissions have stagnated. Marsh & McLennan Cos. Inc. illustrates the point. The company's consulting revenues stood at \$193.8 million, almost a third of total fourth-quarter revenues of \$592.1 million. Full-year consulting revenues were a staggering \$754 million. While profit margins tend to be skinnier than for most brokerage activities, consulting has the virtue of immunity to the property and casualty cycle, and, driven by the complexities of society, seems able to expand at a predictable 10% to 15% annual pace.

Overall, fourth quarter comparisons suffered from the anemic rise in revenues. Expenses have been kept in check by all the brokers, but they still advanced in most instances at a faster rate than revenues. Stable headcounts and relatively low general inflation account for good performance on the cost side. Implied in the restrained growth in staff is solid gains in productivity, which has accommodated the addition of new business.

M&M posted flat pretax earnings for the full year, but fourth quarter comparisons showed a clear acceleration with a 8% advance in pretax results. In an adverse property and casualty climate, the company enjoys a distinct advantage from a strong position in consulting, which grew 14% in 1989.

Earnings for Alexander & Alexander Services Inc. declined in both the fourth quarter and full year. The company could point to a successful cost-containment program in addition to brisk new business as the ingredients for pronounced gains in an environment of better pricing.

Fred S. James & Co. Inc., in line with the group, showed only narrow revenue progress. Notably, profits increased moderately with close attention to costs. James—now called Sedgwick James Ltd. (BI, Jan. 15)—might benefit as much as any of the public brokers from rising rates since the company comes close to being a pure U.S. insurance brokerage.

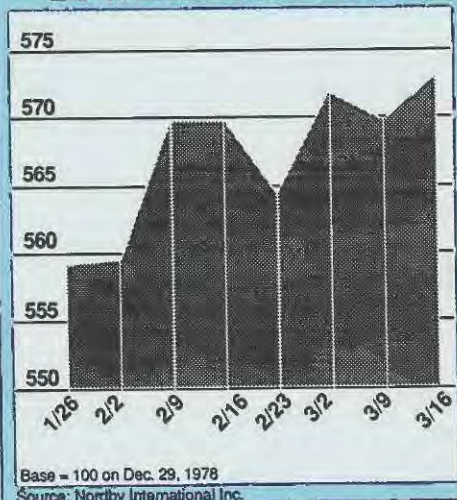
Corroon & Black Corp. recorded modestly lower results for the quarter and the full year. Reinsurance brokerage was a significant laggard. The industry's most active acquisition program also penalized operating performance, but appreciably enhanced participation in targeted lines and geographical markets.

Arthur J. Gallagher & Co. closed 1989 with a profit gain in the fourth quarter and was able to achieve a creditable rise in earnings for the full year. With revenue growth of 15% for the year as a whole, Gallagher demonstrated the momentum of its new business production and the steadying effect of its leading-edge self-insurance activities.

Quarterly reports provide a window for making judgments about upcoming operating performance. On the strength of the fourth quarter, the brokers should sustain new business in 1990, keep a tight rein on costs for the third consecutive year, and benefit from a less hostile rate environment.

What seems unclear is whether the property/casualty insurance market can make a complete shift from price competition to firmness in 1990.

BI Insurance Index



Insurance industry stocks crept upwards last week, as the *Business Insurance Index* rose 3.1 points to 573.0 on March 16, from 569.9 on March 9. Advancing issues were led by Lawrence Insurance Group, up 14.3%; Frank B. Hall & Co. Inc., up 12.5%; and U.S. Healthcare, up 11.4%. Decliners followed AmBase Corp., down 7.6% (see story, page 1); Tokio Marine & Fire Insurance Ltd., down 7.3%; and NAC Re Corp., down 6.8%. The most active issue during the period was Sears Roebuck & Co. (Allstate), 3.1 million. The BI Index gained 0.5%; the Dow Jones 30 Industrials were up 2.2%; the Standard & Poor's 500 grew by 1.2%; and the New York Stock Exchange Composite gained 0.9%.

British Issues

March 15 Companies	Price	P/E	Div. pence	Yield %	1 Week High-Low pence pence
Comml Union	466	21.5	28.7	6.2	468-463
Genl Accident	1040	15.9	66.7	6.4	1040-1010
Gdn Royal Exch	228	19.0	15.3	6.7	228-226
Royal	468	25.2	34.0	7.3	470-465
Sun Alliance	295	11.0	17.0	5.7	295-291
Brokers					
Bradstock	247	17.4	10.0	4.0	247-247
CE Heath	530	14.9	34.5	6.5	530-527
Hogg Robinson	149	10.4	9.7	6.4	154-148
Lloyd Thompson	268	17.9	9.3	3.5	268-268
PWS Holdings	60	9.4	3.3	5.6	61-59
Sedgwick Grp	263	19.8	16.0	6.1	263-258
Steel Brl Jones	288	18.0	15.3	5.3	288-288
Willis Faber	254	17.9	15.3	6.0	258-254

Source: Philip Olsen/Paul Hodges, Insurance Industry Specialists Kitcat & Aitken Stockbrokers, London

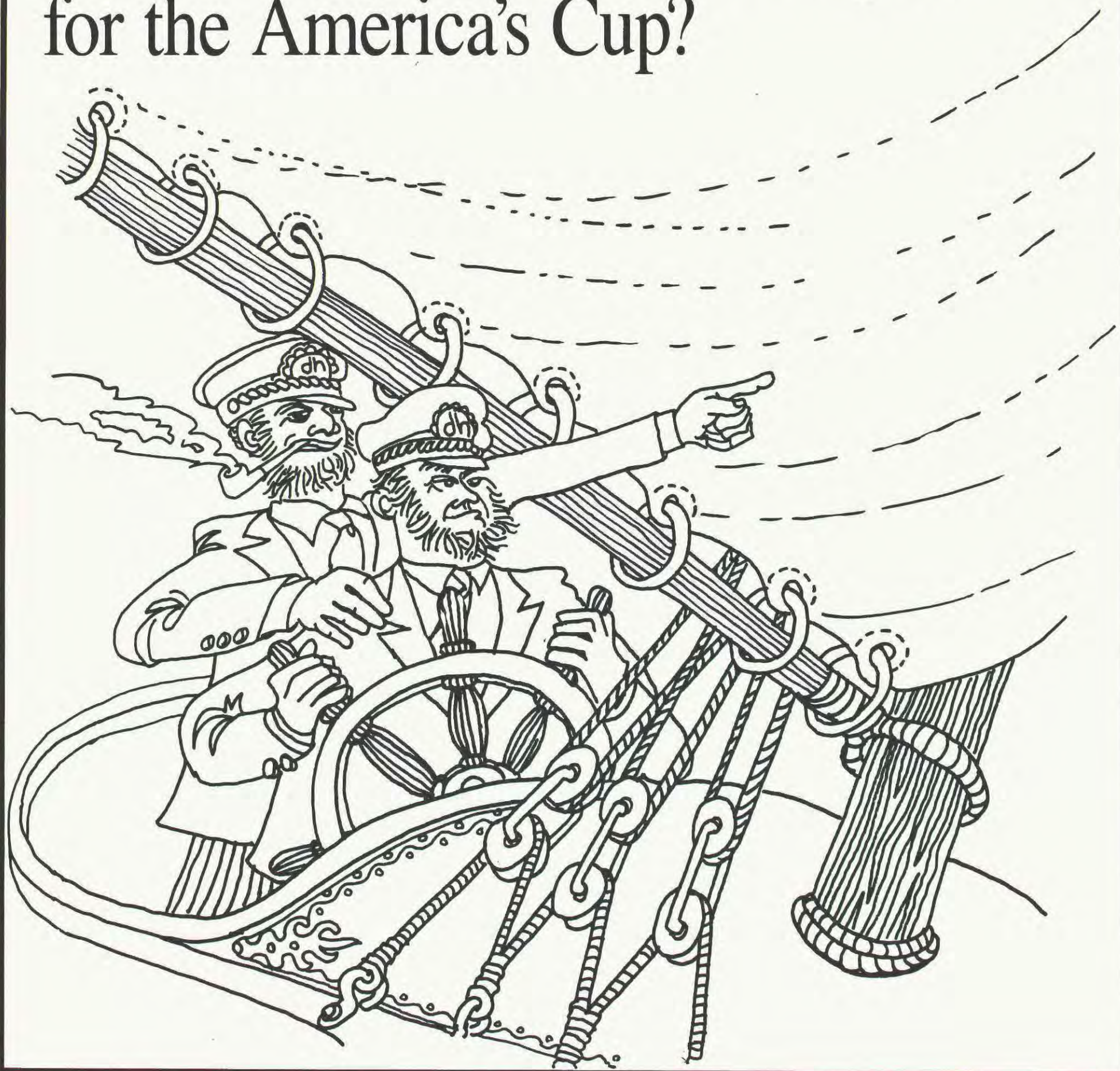
BI Industry Stock Report

MARCH 12, 1990 THROUGH MARCH 16, 1990

BROKERS													CONGLOMERATES & HOLDING COMPANIES													INSURERS/REINSURERS													HEALTH MAINTENANCE ORGANIZATIONS																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																											
		Price	Weekly % change	Year to Date % change	Annual High	Annual Low	Vol.(000)	\$ Div.	% Yield	P/E	Book value	Mkt/Bk. value			Price	Weekly % change	Year to Date % change	Annual High	Annual Low	Vol.(000)	\$ Div.	% Yield	P/E	Book value	Mkt/Bk. value			Price	Weekly % change	Year to Date % change	Annual High	Annual Low	Vol.(000)	\$ Div.	% Yield	P/E	Book value	Mkt/Bk. value																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																												
Alexander & Alexander	NYS	27.00	1.41	-14.29	34.00	24.00	270	1.00	2.70	19	9.18	2.94	Lawrence Insurance Group	ASE	8.00	14.29	12.28	8.00	6.50	5	0.28	3.50	15	3.29	2.43	Aetna Life & Casualty	NYS	50.63	1.25	-12.72	62.50	48.50	675	2.76	5.45	9	58.11	0.87	Torchmark Corp.	NYS	50.38	1.00	-12.01	58.75	32.00	429	1.40	2.78	13	13.23	3.81																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																															
Corroon & Black	NYS	33.88	1.12	-11.44	41.00	31.00	221	1.36	4.01	16	12.73	2.66	Liberty Corp.	NYS	47.63	2.42	12.06	47.75	32.50	25	0.92	1.93	18	31.82	1.50	Ambase Corp.	NYS	7.63	-7.58	-39.60	16.38	7.38	439	0.20	2.62	3	29.08	0.26	Transamerica	NYS	39.38	1.94	-11.76	48.00	33.00	405	1.92	4.88	9	34.63	1.14																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																															
Gallagher Arthur J. & Co.	NYS	24.63	2.07	-0.51	26.50	17.63	54	0.60	2.44	17	5.33	4.62	Lincoln National	NYS	55.00	2.09	-9.84	62.88	46.75	234	2.60	4.73	9	49.19	1.12	American General	NYS	31.50	3.70	-3.82	38.50	28.13	592	1.56	4.95	10	34.68	0.91	Travelers Corp.	NYS	34.38	0.73	-6.78	45.00	32.00	579	2.40	6.98	5	44.85	-																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																															
Frank B. Hall	NYS	3.38	12.50	12.50	4.50	2.50	153	0.00	0.00	-2	-2.80	-1.21	NAC Re Corp.	OTC	32.63	-6.79	-10.00	41.00	23.88	511	0.20	0.61	13	22.81	1.43	American Heritage	NYS	23.25	0.00	-18.42	24.63	19.50	1	0.92	3.96	12	22.60	1.03	Trenwick Group Inc.	OTC	20.38	-2.98	-16.41	26.88	13.75	125	0.36	1.77	15	16.91	1.20																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																															
Hib. Rogal & Hamilton	OTC	15.25	0.00	-18.12	20.63	11.00	51	0.28	1.84	20	4.60	3.32	Navigators Group	OTC	31.50	0.00	14.55	31.50	21.75	8	0.00	0.00	11	15.22	2.07	American Indemnity/Fint.	OTC	6.75	0.00	-15.63	13.00	6.75	3	0.56	3.30	-2	17.38	0.39	United Fire & Casualty	OTC	30.75	0.82	-6.82	34.50	29.00	1	1.20	3.90	10	22.56	1.36																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																															
Marsh & McLennan	NYS	70.13	-4.59	-10.10	89.75	58.63	1207	2.48	3.54	17	10.56	6.64	Nobel Insurance LTD	OTC	2.00	3.20	0.00	5.00	1.50	16	0.00	0.00	0	7.76	0.26	American International	NYS	95.25	-0.91	-9.72	112.00	76.25	1080	0.48	3.50	11	41.92	2.27	USF&G Corp.	NYS	30.00	2.13	1.27	34.00	26.88	1314	2.92	9.73	38	22.87	1.31																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																															
Poe & Associates	OTC	13.00	6.12	-1.89	13.00	8.00	1	0.40	3.08	16	1.89	6.88	NWNL Companies	OTC	31.00	-1.59	-21.52	44.13	26.50	547	1.20	3.87	6	37.50	0.83	Aon Corp.	NYS	36.75	0.00	-13.27	43.25	29.38	184	1.40	3.81	10	19.62	1.87	UNUM Corp.	NYS	45.75	-0.27	-4.19	51.38	29.25	194	0.60	1.31	10	31.20	1.47																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																															
BROKERS AVERAGE			2.7	-6.3					2.7	15			Ohio Casualty Corp.	OTC	49.50	2.06	3.66	52.50	34.75	951	2.32	4.69	10	33.30	1.49	Argonaut Group	OTC	69.75	-4.5	1.27	71.50	51.25	36	1.60	2.29	8	36.83	1.89	USLIFE Corp.	NYS	39.25	0.00	-13.26	48.13	38.25	153	1.48	3.77	5	54.34	0.72																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																															
													Old Republic Int'l	OTC	24.13	0.00	-5.85	30.38	22.50	130	0.72	2.98	5	30.70	0.79	AVEMCO Corp.	NYS	24.13	-0.52	-1.03	27.50	20.38	21	0.40	1.66	16	9.52	2.53	Washington National	NYS	24.13	0.52	-14.60	29.13	23.63	35	1.08	4.48	-	32.90	0.73																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																															
													Orion Capital Corp.	NYS	19.75	-1.25	-15.05	28.50	18.50	98	0.84	4.25	6	19.72	1.00	Baldwin & Lyons Inc.	OTC	20.75	0.00	-3.49	24.00	15.75	33	0.28	1.35	7	20.80	0.59	USLICO Corp.	NYS	22.50	0.56	-5.26	25.38	21.00	32	1.00	4.44	6	27.73	0.81																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																															
													Phoenix RE Corp.	OTC	11.50	-5.15	-11.54	15.50	8.75	19	0.20	1.74	88	12.99	0.89	Belvedere Corp.	ASE	4.75	-2.56	-13.64	6.38	4.25	7	0.04	0.84	-7	8.03	0.59	Zenith National Ins.	NYS	16.63	-0.75	-11.33	21.50	14.00	22	0.84	5.05	0	13.81	1.20																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																															
													Protective Life Corp.	OTC	14.25	7.55	0.00	16.25	10.88	79	0.68	4.77	9	14.54	0.98	Chandler Insurance	OTC	9.63	1.32	-18.09	13.25	7.00	851	0.00	0.00	5	9.53	1.01	Chubb Corp.	NYS	100.88	0.37	5.22	102.75	64.00	763	2.64	2.62	10	55.49	1.82	INSURERS/REINSURERS AVERAGE			0.4	-7.7				3.5	11.5																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																					
													Provident Life	OTC	23.13	-1.07	-10.63	30.13	20.25	307	0.80	3.46	7	23.24	1.00	ClGNA Corp.	NYS	51.50	0.24	-14.52	66.75	45.25	624	3.04	5.90	11	66.64	0.77	HMO America Inc.	OTC	6.13	-2.00	-20.97	10.63	1.38	247	0.00	0.00	-95	1.12	5.47	ALL COMPANIES AVERAGE			0.8	-8.0				3.0	10.4																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																					
													Re Capital Corp.	ASE	12.63	1.00	-12.93	15.25	9.75	9	0.00	0.00	11	12.60	1.00	CNA Financial Corp.	NYS	75.38	2.55	-24.63	108.75	58.50	146	0.00	0.00	8	54.87	1.37	Pacificare Health Sys.	OTC	21.75	4.82	-16.35	30.38	10.75	119	0.00	0.00	6	6.35	3.43																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																																															

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