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Update

USF&G no longer will write voluntary comp risks in 7 states

BALTIMORE—United States Fidelity & Guaranty Co. is pulling out of the voluntary workers compensation insurance market in seven states.

USF&G already has stopped writing new policies and will not renew expiring policies in Arkansas, New Hampshire, New Mexico, South Carolina, Tennessee, Vermont and Virginia.

The insurer says its share of workers comp markets in those states ranges from a high of 4.4% in Arkansas to a low of 1.1%

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Court holds U.S. liable for Superfund cleanup

By MARK A. HOFMANN

WASHINGTON—The federal government can be held partially liable for the cleanup of a hazardous waste site under the Superfund Act, a landmark U.S. District Court ruling says.

The court held that if the government controls or operates a facility during the time pollutants are released, it can be held jointly and severally liable for cleanup costs as the "owner or operator" of the facility.

"This is the first time the government has ever been held liable in a case like this, where it's not a solely owned government facility," said Carol L. Press, an attorney with the Philadelphia law firm Hangley Connolly Epstein Chicco Foxman & Ewing, which represented FMC Corp. in the litigation.

Chicago-based FMC sued the government to contribute to the cleanup of a Superfund site in Virginia.

While it's not known how many waste sites could be affected by the ruling, which involved a former rayon manufacturing plant the government controlled during World War II, the decision could have a major impact on Superfund cases.

Given the federal government's control over much of the nation's industrial complex during World War II and in earlier national crises, the number of waste sites for which the government may have to contribute to cleanup costs is potentially quite large, said John Arlington, senior counsel for the American Insurance Assn. in Washington, D.C.

The AIA has made reform of Superfund—officially the Comprehensive Environmental Response, Compensation and Liability Act of 1980—one of its legislative priorities for the 1990s.

The ruling "has the potential to be of significant impact in as much as the government has tended to be involved in many projects, and these projects tend to be large in scale," agreed Myles D. Berman, a partner in the Chicago law firm Altheimer & Gray who specializes in environmental law.

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'Michelangelo' virus could infect some computer systems

By MICHAEL BRADFORD

A computer virus coded to spring to life on the birthdate of a famous Renaissance painter could leave some system operators staring at the ceiling.

Most risk management information systems and other corporate computer systems consider themselves well-protected against viruses. And a lot of the reaction to the threat of a virus is overblown, they say.

Even so, the virus, which is called "Michelangelo" and written to activate on March 6, could do some harm.

Computer viruses are time bombs spread through electronic bulletin boards, infected disks or contaminated computers.

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Oregon defends health plan

Federal study criticizing universal health program is faulty, state official says

By LOUISE KERTESZ

SALEM, Ore.—A federal study critical of Oregon's proposed universal health care program—which hinges on a system of rationing Medicaid health care services—is based on insufficient data and a misconception of the plan, a state Medicaid official charges.

A confidential draft report by the Congressional Office of Technology Assessment charges, among other things, that the state underestimates the plan's costs, confirmed Lynn Read, project director for the Medicaid portion of the Oregon Health Plan at the Office of Medical Assistance Programs.

The report also faults the state's method of setting priorities and rationing health care for Medicaid recipients for being subjective, she said.

But Ms. Read argues that the OTA researchers came to erroneous conclusions because they focused and reported mainly on the Medicaid portion of the proposed state plan, rather than considering the plan as a whole.

Ms. Read added that she does not expect the report to hurt the state's chances of winning federal approval for its five-year pilot program.

"We have a large health policy objective which I believe is being lost in some of the reporting (on the Oregon health plan) and in some of the OTA analysis," she said. "We are looking at extending health coverage to all Oregonians."

Under the plan, which was established by the Oregon Basic Health Services Act of 1989, Medicaid coverage would be extended to all citizens at or below the federal poverty level (*BI*, March 18, 1991).

Currently, about 120,000 state residents with incomes beneath the federal poverty level are ineligible for Medicaid because they do not meet certain other qualifications, according to state figures.

Those qualifying factors include being pregnant

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Two employers drop out of MIG project

By CHRISTINE WOOLSEY

Two employers are not going forward with a project that would have allowed them to provide Medicare benefits to their retired workers.

Citing higher than expected costs and administrative difficulties, Highland Park, Mich.-based Chrysler Corp. and Southern California Edison Co. of Rosemead, Calif., chose not to proceed beyond the feasibility analysis stage of the Medicare demonstration project.

However, their exit does not mean that other employers won't continue with the program.

In fact, a third employer—Deere & Co. of Moline, Ill.—recently completed the feasibility analysis phase and indicated that it wants to proceed with the development phase.

And another organization—Amalgamated Life Insurance Co. in New York—is currently in the development phase of the project (*BI*, May 22, 1989; Nov. 9, 1987). ALICO administers more than 40 Taft-Hartley plans providing benefits to hundreds of thousands of union retirees and employees.

And, The Medical Center Inc., a Beaver, Pa.-based hospital, is trying to pool a group of employers before it enters the feasibility stage.

Under the "Medicare Insured Group"—or MIG—project, self-insured employers or unions will administer Medicare benefits to their retirees under a unified program in conjunction with the employers' own retiree health care benefits.

In return, employers or unions that sign contracts with the Health Care Financing Administration, the federal agency that administers Medicare, would receive 95% of what HCFA estimates it would cost to provide Medicare benefits for those employers' retirees.

The 5% cut in Medicare expenditures could save the federal government billions of dollars, assuming that a large number of employers with large numbers of retirees participate in the voluntary program.

Under the plan, an employer will keep any difference between the amount received from the government and the amount the employer pays in Medicare benefits. However, the employer also is liable if benefit costs exceed the government payment.

Theoretically, employers should be able to administer re-

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Update

USF&G plans comp pullout

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in New Hampshire.

USF&G wrote $14.5 million in voluntary workers comp premiums, or 3.6% of Tennessee's market in 1991; $14.4 million, or 2.8%, in Virginia; $6.5 million, or 4.4%, in Arkansas; $6.4 million, or 2.6%, in South Carolina; $3 million, or 1.9% in New Mexico; $1.5 million, or 1.1%, in New Hampshire; and $1.1 million, or 1.8%, in Vermont.

"In these states, the underlying costs of the product have been severely impacted by spiraling medical and legal costs, assigned risk pool assessments that are increasing and rate inadequacy," USF&G said. "The cessation of voluntary workers compensation in (these) states follows other profit-enhancing actions taken regarding this line of insurance."

USF&G, though, still wants to remain a servicing carrier for the residual market, a spokeswoman said.

But whether it can do so is up to the National Council on Compensation Insurance.

Pollution exclusion rejected

NEW YORK—In one of the first decisions of its kind, a New York state appellate court says the pollution exclusion clause does not bar coverage for asbestos bodily injury claims.

The pollution exclusion bars coverage for the "release" of "irritants, contaminants or pollutants" into "the atmosphere."

In a novel argument, Continental Casualty Co. argued that the release of asbestos fibers into the air is a discharge of an irritant, contaminant or pollutant and therefore falls within the terms of the exclusion.

The New York Appellate Division did not agree. In a unanimous decision overturning a lower court ruling, the appellate court held: "The underlying complaints before us do not allege environmental pollution of land, a water course or the atmosphere, but simply bodily injury sustained by an ultimate user of a product." As a result, the CNA Financial Corp. unit had a duty to defend the policyholder against asbestos bodily injury claims, the court ruled.

In another unique finding, the court adopted an injury-in-fact trigger of coverage—or the period of time when a plaintiff is suffering from an asbestos-related illness—for asbestos bodily injury claims.

"These are both very significant decisions for policyholders in New York," said Martin Schwartz of Rubin, Baum, Levin, Constant & Friedman in New York, who represented policyholder Rapid-American Corp.

Policyholder attorney Robert Carter agreed: "If the lower court's decision had not been reversed, it would have wiped out defense coverage for policyholders facing asbestos lawsuits." Mr. Carter is with Anderson, Kill, Olick & Oshinsky in Washington, D.C., which filed an amicus curiae brief in the case.

Continental Casualty, which wrote four primary general liability policies for Rapid-American from 1971 to 1979, probably will appeal, an attorney said.

Rapid-American faces more than 200 claims for asbestos bodily injury from former employees of Philip Carey Manufacturing Corp., an insulation manufacturer it acquired in 1967.

Hall reports 1991 net loss

NEW YORK—Frank B. Hall & Co. Inc. reported a net loss of $25.6 million for 1991, compared with a net gain of $4.2 million in 1990. Revenues for the year rose 4.2% to $461.6 million from $443.1 million in 1990.

During the fourth quarter, the brokerage reported a loss of $19.4 million, compared with a net gain of $2.5 million in the fourth quarter of 1990. Revenues fell 5.2% to $117.6 million from $124 million in the final quarter in 1990.

Part of the loss is attributed to a $15.4 million charge taken in the fourth quarter as a result of the "downsizing" of some of the broker's operations.

Poor performances on the part of startup operations contributed $10.1 million more of losses, Hall reported.

The charge is a matter of "giving more critical mass" to certain key areas and cutting expenses in other areas, said Donald R. Bell, chairman and chief executive officer.

While Hall would have been profitable without these charges, the broker "continues to be in a restructuring mode," said Michael A. Smith, an analyst and vp with Lehman Brothers in New York. Hall "has had continuing difficulties getting back on track after their disasters in the '80s," he said.

But, Mr. Bell said: "We feel that we're in great shape. Once the market turns, there's no question there will be a leveraged effect on our results."

LTV bankruptcy ruling stands

WASHINGTON—The U.S. Supreme Court last week declined to review a ruling allowing companies in bankruptcy protection to terminate retiree health care benefits in certain situations.

At issue in the case—involving three coal mining units of LTV Steel Co.—is the scope of a 1988 federal law designed to protect workers when their employers are in Chapter 11.

The Bankruptcy Protection Act generally allows companies in bankruptcy to alter or eliminate retiree health care benefits if the retired workers agree or if a bankruptcy court finds that the action is needed to protect the company (*BI*, June 6, 1988).

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Policyholders may pay for Prop. 103 logjam

By LOUISE KERTESZ

LOS ANGELES—With the implementation of the Proposition 103 rate rollback still clouded in confusion, there's plenty of blame to go around.

However, insurance policyholders—virtually the only group not blamed at a California Senate hearing last week for the turmoil surrounding Proposition 103—may end up paying part of the price.

Insurers, Gov. Pete Wilson, the state Office of Administrative Law, former Insurance Commissioner Roxani Gillespie and even some members of the trade press all took their share of criticism at the hearing.

State Sen. Art Torres, D-Los Angeles, called the hearing because "the public deserves to know why" most policyholders have seen no rebates since the initiative was approved in 1988.

However, Insurance Commissioner John Garamendi noted at the hearing that "unfortunately" insurers likely will be able to pass on to consumers the $100 million that they have spent fighting Proposition 103 in court. Insurers can be barred from passing along the costs only if those challenges are determined by Mr. Garamendi to be in "bad faith."

And, in response to repeated questions from Sen. Torres, chairman of the Senate Committee on Insurance, Claims and Corporations, Mr. Garamendi said that he had no "bad faith" standard against which to judge the insurance companies' court challenges. Each case will have to be evaluated individually, he said.

After the hearing, Sen. Torres told reporters that only a comprehensive program could hope to break the insurance reform logjam in California.

He also said he would sponsor a bill based on the commissioner's recent proposal for 24-hour universal health care coverage, which includes care for auto accident injuries (*BI*, Feb. 24).

Also after the hearing, Thomas F. Conneely, president of the Assn. of California Insurance Cos., a property/casualty in-

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'Loss-in-progress' doctrine bars CGL recovery

Cleanup firm loses ruling

By MEG FLETCHER

DETROIT—A federal court ruling may make it more difficult for Michigan policyholders to recover pollution cleanup costs from their general liability insurers.

The court ruled that a pollution cleanup firm cannot recover from its comprehensive general liability insurer the cost of cleaning up groundwater contamination caused by a toxic chemical spill that happened before the company purchased coverage.

Interpreting Michigan law, the U.S. District Court in Detroit found that once hazardous chemicals are spilled, groundwater contamination is a "loss in progress," regardless of when the groundwater actually was contaminated.

This is the first time that a federal court interpreting Michigan law "has both recognized and favorably applied the 'loss-in-progress' doctrine in insurance litigation" of this type, an insurer attorney said.

The cleanup firm has requested judicial reconsideration and probably will appeal if reconsideration is denied.

Policyholder attorneys, concerned about the decision's erosion of policyholder rights, are decrying the ruling.

"It's basically another example of insurance companies' efforts to confuse the courts and undermine the integrity of the judicial process," said Bruce Brown, an attorney with Anderson, Kill, Olick & Oshinsky in New York.

"Rather than prove that the policyholder expected or intended that the damage would occur—as would be required under an occurrence definition in the policy—they have misapplied concepts which are really only relevant in first-party property cases," he said.

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Managed care conference

Deadline for early bird registration approaches

NEW YORK—The deadline to obtain a reduced, early bird registration fee for the First Annual Health Care Management and Cost Containment Conference to be held April 27-28 in New York is less than two weeks away.

The cutting edge of managed health care plans is the focus of the conference, which will feature more than two dozen experts from the managed care, group health insurance and benefit consulting fields.

The conference fee for those who register before March 13 is $695. After March 13, the registration fee will be $795.

The meeting, co-sponsored by *Business Insurance* and The International Business Forum Inc., will be held at the Grand Hyatt Hotel in midtown Manhattan.

With the theme "Managed Care, a Changing Industry," the First Annual Health Care Management and Cost Containment Conference will feature speakers representing employers, health care providers and managed care companies and employee benefit consultants.

The speakers will address the problem of skyrocketing health care costs and offer ways to help control expenses. The latest innovations in managed care also will be discussed.

"Managed care plans—when properly designed, executed and monitored—can be an im-

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- Banks should prepare for the financial institution bond market to harden by the end of 1993, a consultant says at the American Bankers Assn.'s National Security and Risk Management Conference. **PAGE 10**
- Four insolvent insurers owned by London United Investments P.L.C. are being put into provisional liquidation in London nearly two years after they stopped paying claims. **PAGE 23**

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Good news/bad news on benefits

House-approved tax bill would ease administration

By JERRY GEISEL

WASHINGTON—For the first time in years, a federal tax bill may actually simplify employee benefit plan administration.

Tax legislation enacted by Congress in recent years has made benefit plan administration far more complex or added to employers' benefit plan costs.

But the tax bill approved by the House last week in a 221-209 vote is a refreshing break from the past, benefits experts say.

Most notably, the measure would give employers a new and simpler way of running the Internal Revenue Service nondiscrimination tests for 401(k) salary reduction plans (*BI*, Feb. 24). It also would create two new safe harbors that employers could use to avoid running the nondiscrimination tests.

Other provisions in the legislation, some of which have not been reported previously, would:

- Simplify the definition of who is considered a highly compensated employee for pension non-discrimination testing purposes.
- Require the IRS to round to the nearest $100 and $1,000 the annual inflation adjustments in the maximum employee deferral to a 401(k) plan and the maximum benefit that can be funded through a defined benefit plan.

In addition, the IRS would have to give employers more advance notice on the amount of these inflation-related adjustments.

- Permanently extend the tax-favored status of employer-provided educational assistance benefits under Section 127 of the Internal Revenue Code.

Some other provisions, though, would boost employers' costs and increase employees' taxes.

For example, the legislation would require multiemployer pension plans to speed up vesting schedules, which would increase employers' costs, while another provision will require employers in certain situations to transfer terminating employees' pension distributions to a new employer's pension plan.

The legislation also would hurt employees by boosting taxes on pension distributions. In addition, employees participating in company stock programs would face increased taxes.

Other provisions in the legislation—very narrow in scope—would help certain airlines pass IRS pension non-discrimination tests and give coal companies a new way to fund retiree health care liabilities.

Benefit experts note that the benefit provisions in the legislation pale in comparison to the benefit changes in other tax bills Congress has considered and passed

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New law increases banks' COBRA burdens

By MARK A. HOFMANN

WASHINGTON—Some banks will feel a more painful COBRA bite because of a provision buried in a banking reform law.

Under the Federal Deposit Insurance Corp. Improvement Act of 1991, banks that take over failed institutions must offer those facilities' former workers health care continuation benefits as prescribed under the Consolidated Omnibus Budget Reconciliation Act of 1985.

However, benefits experts are interpreting the provision to mean that banks are required to offer only the level of health care benefits they offer, not the benefits the failed bank offered.

The banking reform law defines banks that take over the assets and liabilities of failed financial institutions as "employers" of the employees of the failed institution.

The law, which President Bush signed on Dec. 19, states that the Federal Deposit Insurance Corp. "shall require that any successor. . .provide a group health plan with respect to former employees of such institution in the same manner as the failed depository institution would have been required to provide but for its failure."

A provision in H.R. 4210, which was approved on a 221-209 vote by the House of Representatives last week, reiterates the COBRA requirement and would add it to the Internal Revenue Code.

"It could be a nasty surprise" for banks that buy up failed institutions, said Henry Saveth, a principal with A. Foster Higgins & Co. Inc. in New York.

"If you have a bank, and you're in the takeover business, this is a big deal," he said. "Nobody wants additional COBRA liabilities."

"We are concerned," commented Cathy Wooster, benefits planning manager at Barnett Banks Inc. of Jacksonville, Fla.

"We believe there will be a cost impact on Barnett and other healthy institutions" that acquire failed banks, she said.

Ms. Wooster said she is surprised by the provision. Federal authorities should want to make failed institutions "more attractive" to would-be buyers rather than discouraging their acquisition by loading them with extra costs, like COBRA costs, she said.

However, a spokeswoman for the

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Rating firms, others sued in ELIC collapse

By MEG FLETCHER
and MICHAEL SCHACHNER

LOS ANGELES—California Insurance Commissioner John Garamendi is seeking hundreds of millions of dollars in damages from three insurance rating agencies, an accounting firm and others in the collapse of Executive Life Insurance Co.

The suit, filed Thursday, names former ELIC executives as well as Drexel Burnham Lambert's junk bond executives for "fraud and deceit, negligent misrepresentation, breach of fiduciary duty," and other actions.

The complaint details excessive and sometimes questionable junk bond investments that were the primary reason ELIC was placed into conservatorship in April of last year (*BI*, April 22, 1991; April 15, 1991).

The suit names Deloitte & Touche, ELIC's former auditor, as well as three insurance rating agencies: A.M. Best Co., Moody's Investor Service Inc. and Standard & Poor's Corp.

The 69-page suit alleges Deloitte & Touche and the rating firms contributed to ELIC's failure through "fraud and deceit" and "negligent misrepresentation," among other things.

While the suit seeks unspecified compensatory and punitive damages, the Insurance Department says the damages could ultimately run into the hundreds of millions of dollars.

The suit 'cites the deeds of those who we believe looted' ELIC, says Mr. Garamendi.

Los Angeles Superior Court Judge Kurt Lewin last month gave final approval for Altus Finance and Mutuelle Assurances des Artisanale de France to purchase ELIC. Altus is guaranteeing 72% of ELIC's obligations, while life/health guaranty funds will make up the difference, up to the maximum policy limits covered by individual funds. The deal will cost the guaranty funds at least $1 billion.

The lawsuit, filed in Superior Court in Los Angeles, is part of the state's legal effort to recover funds from parties allegedly responsible for ELIC's failure.

The "suit names the names and cites the deeds of those who we believe looted this company, and allowed it to be looted, at the expense of policyholders," said Mr. Garamendi, who filed suit in his role as ELIC's conservator.

Specifically, the complaint names Fred Carr, chairman and until recently president of First Executive Corp., a holding company whose principal subsidiary was ELIC. It also names former ELIC officials Merle Horst, Douglas Macian, George Rosenthal and William Sanders.

The state alleges that under the direction of Mr. Carr and the other named ELIC officials, the insurer filed false reports, used improper and bogus surplus relief arrangements and other "accounting tricks" to repeatedly inflate its net worth.

The officials also engaged in a deceptive advertising, endorsement and promotional campaign to misrepresent the security and liquidity of the company's junk bond investments to gain state approval, the suit says.

First Executive declined to

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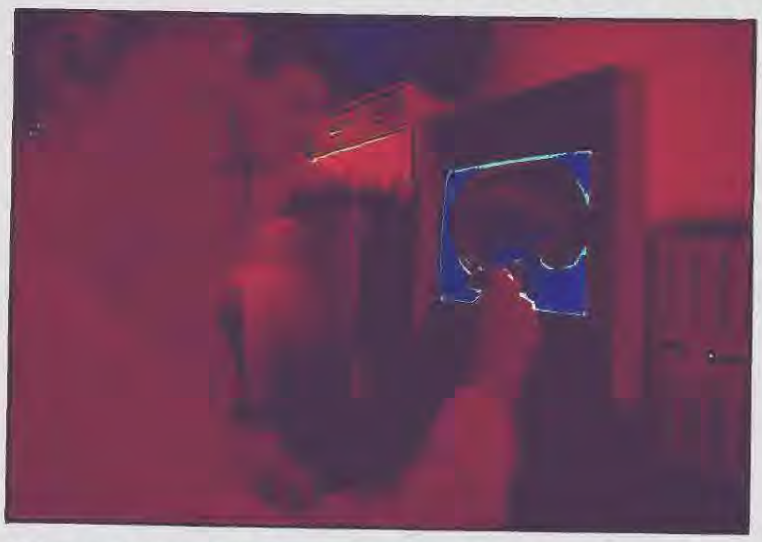
Maine battles 'defensive medicine'

Pilot malpractice program aimed at cutting health costs



Maine aims to limit "defensive medicine," like using costly diagnostic imaging devices not warranted by treatment guidelines.

By LAURA MAZZUCA

AUGUSTA, Maine—Physicians and legislators in Maine are hoping that a new experimental medical practice program will lower treatment costs and eventually reduce malpractice claims and premiums.

Doctors who volunteer for the program agree to limit their use of "defensive medicine" in exchange for being able to cite practice parameters when defending against malpractice claims.

The Medical Liability Demonstration Project, which went into effect Jan. 1, sets practice parameters and risk management protocols for specialists in obstetrics and gynecology, emergency medicine, anesthesia and radiology, all areas where malpractice claims are frequently filed.

Doctors who can show they followed the practice criteria will have an affirmative defense against medical malpractice claims for services provided from 1992 through 1996.

In turn, doctors participating in the program agree to limit their use of so-called defensive medicine—basing medical decisions primarily on avoiding legal liability.

Part of a 1990 tort reform law, the program is the first of its kind in the country and has generated interest on both state and federal levels, said Gordon Smith, general counsel for the Maine Medical Assn. in Augusta.

Several bills that would link treatment practice guidelines and physician liability have been introduced in Congress. One bill introduced by Sen. William Cohen, R-Maine, is based directly on the Maine program.

And a January 1992 report from the General Accounting Office titled "Medical Malpractice: Alternatives to Litigation" cites the Maine program as a "unique approach for resolving malpractice claims."

For the most part, medical malpractice insurers support the

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Louisiana guaranty fund faces big deficit

By MICHAEL BRADFORD

BATON ROUGE, La.—A recent spate of insurer insolvencies in Louisiana may create a shortfall in the Louisiana Insurance Guaranty Assn. that could grow wider if other insurance companies fail.

The recent failures of four insurers already threaten to create a deficit of about $84 million in the state's guaranty fund, and that deficit could grow to as much as $200 million if insurance companies now being monitored by Louisiana regulators fail, said Insurance Commissioner Jim Brown.

"That's the worst-case scenario," Mr. Brown said, referring to the potential $200 million shortfall.

Two insurance companies that wrote mostly personal automobile coverage in the state—Colonial Lloyd's of Metairie, La., and Presidential Fire & Casualty Co. of Gretna, La.—have failed this year. Two others—Arist National Insurance Group and Alliance Casualty & Reinsurance Co., both of New Orleans—now are in rehabilitation.

These four insurers could cost the fund about $84 million if it is forced to pay their claims, Mr. Brown said.

"All of a sudden, we're approaching $84 million that can't be funded now," according to Mr. Brown.

'All of a sudden, we're approaching $84 million that can't be funded now,' says Mr. Brown. And if the 10 to 12 insurers currently being watched by Louisiana regulators fail, it could raise the guaranty fund's deficit to as much as $200 million.

In addition, the commissioner said that if the 10 to 12 insurance companies currently being watched by Louisiana regulators fail, it could raise the guaranty fund's deficit to as much as $200 million.

The guaranty association currently has enough money to meet obligations incurred before the recent spate of insolvencies, Mr. Brown pointed out.

The annual assessment of 2% of net written premiums against admitted property/casualty insurers in the state pumps about $63 million per year into the fund to pay the claims of failed insurance companies, Mr. Brown explained.

"We've got to be creative" in finding ways to make up the fund's potential shortfall, Mr. Brown said.

Increasing the assessment to 3% is unlikely, according to Mr. Brown. "I think there would be a backlash to paying more than 2%. I would rather consider a bond issue and extend it over several years."

No state currently assesses insurers more than 2% of premium to finance its guaranty fund, Mr. Brown said.

There's no doubt that the LIGA will survive; there is just the question of where it will find its financing, said Joel Ory, executive director of the guaranty association.

Mr. Ory also mentioned a bond issue as a way of funding the association. And, he pointed out that the Legislature could extend the annual 2% assessment beyond 1994, when it is due to return to 1%.

The assessment was doubled from 1% to its current level in 1990, in the wake of the Champion Insurance Co. insolvency (*BI*, June 12, 1989).

The failure of Baton Rouge-based Champion is expected to cost the LIGA about $150 million, Mr. Ory said.

If the LIGA does not receive additional funds, it may be forced to pay only a percentage of claims, according to Mr. Ory.

Mr. Brown said that while regulators look for healthy insurers to take over the policies written by insurers with financial problems, it is unlikely that buyers will be found for the Louisiana insurers.

The companies wrote automobile insurance at minimum limits, business that "the majors don't want to fool with," Mr. Brown said. ■

David Olsen, Chairman and CEO of Johnson & Higgins, on responsiveness:

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Stevens joins *BI* sales staff in Los Angeles

LOS ANGELES—Marta Hill Stevens joins *Business Insurance* this month as Western sales manager in Los Angeles, Advertising Director Martin J. Ross announced.

Ms. Stevens joins *BI* after two years as Western sales manager of two other Crain Communications Inc. publications: Pensions & Investments and City & State. She previously held other sales and marketing positions.

Ms. Stevens

"With 10 years of sales experience, Marta will bring new ideas and creative sales approaches to *Business Insurance's* Los Angeles sales office," said Mr. Ross.

Ms. Stevens, 34, is a 1979 graduate of Bennington College in Bennington, Vt., where she received a bachelor of arts in drama and literature.

She succeeds Michael Sharpe, who left the company.

Ms. Stevens can be reached at 6500 Wilshire Blvd., Suite 2300, Los Angeles, Calif. 90048; 213-651-3710, extension 107. ■

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Prescription drug plan touts generics

The State Teachers Retirement System of Ohio is counting on a new prescription drug plan to control costs by shifting more costs to retirees who do not obtain generic prescriptions through a network of discount pharmacies or a mail-order program.

By carving out a stand-alone retail drug plan with a mail-order option from its major medical plan, the STRSO should be able to significantly trim the amount it spends on prescription drugs, which reached $50 million in its fiscal year that ended June 30, said Lynne Hokanson, assistant director-health care services.

In addition, by carving out the prescription drug program from its major medical plan, the system will be better able to obtain valuable data on drug utilization, Ms. Hokanson said.

"Under major medical, it's very difficult to control prescription drug costs. We get no specific data from our administrator, so there's no room for utilization review or quality control," she said.

Prescription drugs accounted for 28% of the STRSO's total health care costs last year. The Columbus-based state-run agency provides benefits to 92,000 retired teachers and their dependents.

Under the new prescription drug plan, which took effect Sunday, retirees will be able to obtain prescription drugs at discounts off average wholesale prices through a network of pharmacies and a mail-order program.

"For the first time, we'll be getting a discount at the retail level, and we're changing copayments to promote the usage of less expensive generic substitutes at both the mail-order and retail level," she said.

Ms. Hokanson said Hartford, Conn.-based Aetna Life & Casualty Co., which administers the agency's self-insured major medical plan, arranged a pharmacy network for the system that will consist of about 50% of Ohio's retail pharmacies.

Retirees who obtain prescriptions filled at a network pharmacy will pay no deductibles. Retirees who purchase generic prescriptions will be subject to a $4.50 copayment, while those who purchase name-brand prescriptions will be subject to a maximum $9 copayment.

Retirees who obtain prescription drugs from a pharmacy that is not part of the network will have to meet a deductible of $75 to $200, depending on their deductible under the STRSO major medical plan, and a 40% copayment.

Previously, retail prescription drug costs were covered under the system's major medical plan, subject to deductibles of $75 to $200 and a 20% copayment requirement.

The new drug plan also will significantly increase copayments on name-brand drugs obtained by mail but will lower the copayment for generic substitutes.

The mail-order plan, which is administered by Medco Containment Services Inc., now requires a $2 copayment for generic drugs and a $10 copayment for name-brand prescriptions. Previously, the plan required a $3 copayment for any prescription.

Benefit beat

"Because we're a retiree group, about 75% of our prescriptions are filled by mail order. Naturally, we'd like to increase the generic dispensement rate," Ms. Hokanson said.

Generic drugs generally cost less than half of what name-brand drugs cost, according to benefits experts.

—By Michael Schachner

Family benefits

Employers should offer workers "family-friendly" benefits, like unpaid leaves of absence for those with newborns or newly adopted children, as part of a national effort to help children start school ready to learn, says a new report by an educational think tank.

"During the past decade, America's business leaders have been vigorously involved in school reform, continually reminding us just how directly education is linked to economics and how our ability to compete in world markets is closely tied to the quality of our schools," says the report by Princeton, N.J.-based think tank Carnegie Foundation for the Advancement of Teaching.

"But special attention also must be given to families, and most especially to the care of children," it says.

"For all children to be well prepared for school, a responsive workplace is absolutely crucial," the report adds.

Specifically, parents of newborn or adopted children should be allowed at least 12 weeks of unpaid leave, the think tank recommends in its 162-page report, "Ready to Learn—A Mandate for the Nation," which is filled with statistics, quotes and anecdotes.

Citing statistics gathered by the U.S. Labor Department's Bureau of Labor Statistics, the report noted that nearly 60% of all

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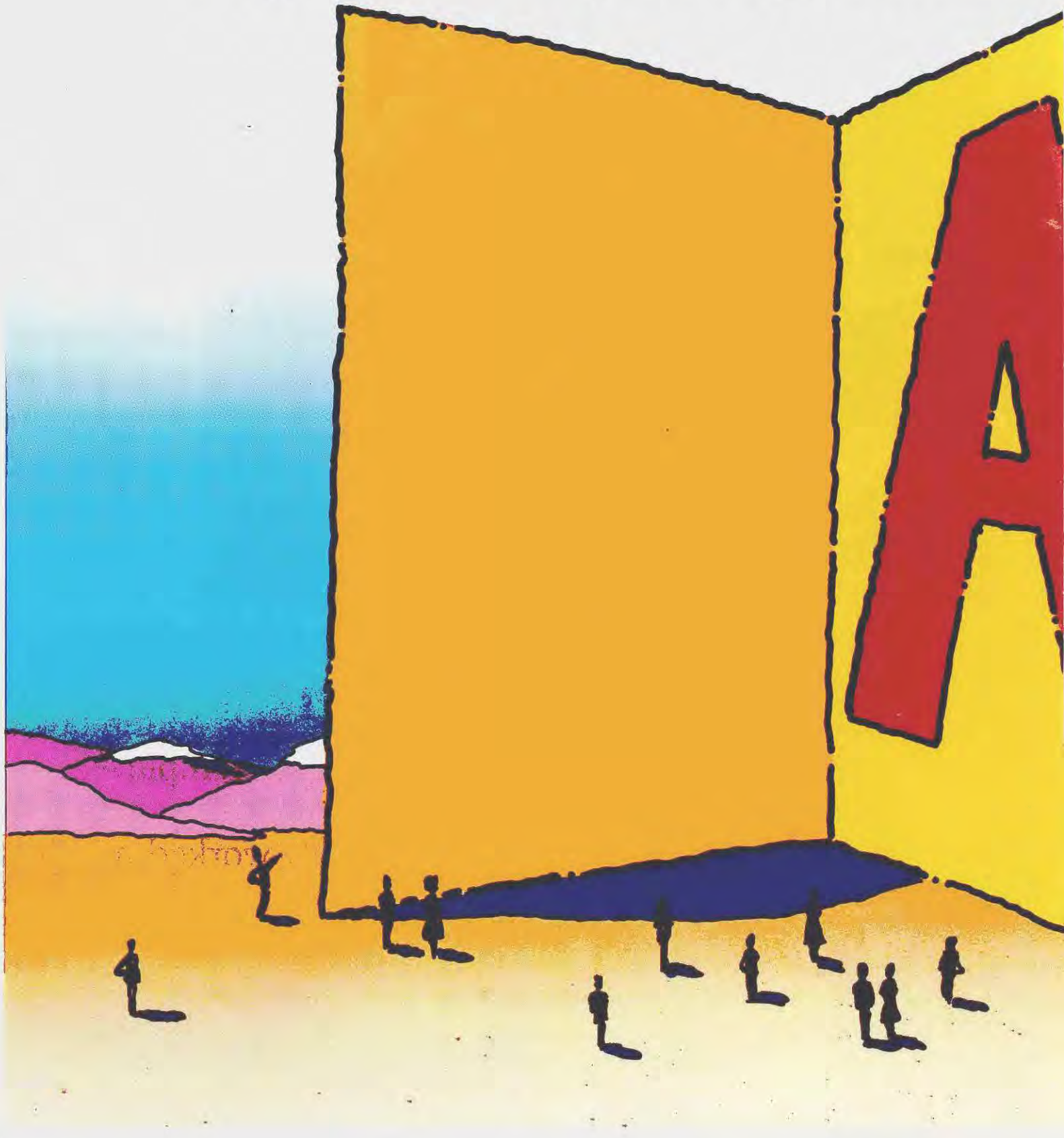

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mothers with preschool children and approximately half of those with children younger than 1 year old were in the workforce in 1990.

"The United States is, in fact, the only industrialized country that does not have a national policy guaranteeing maternity and infant-care leave," the report notes.

Parental leave is "a policy that would strengthen the child's emotional and social well-being and promote learning," the report said.

Employers also should allow flexible scheduling and job-sharing so that employees can better balance work and family obligations, the report recommends.

The think tank suggests that employers give parents of preschool children at least two paid "parenting days" to visit their children in daycare and preschool programs and to consult with teachers.

The report also recommends that employers help workers locate high-quality child-care services.

"We believe all companies should help their employees locate, evaluate and, if possible, pay for quality child-care and preschool services either on site or at local centers," the report states.

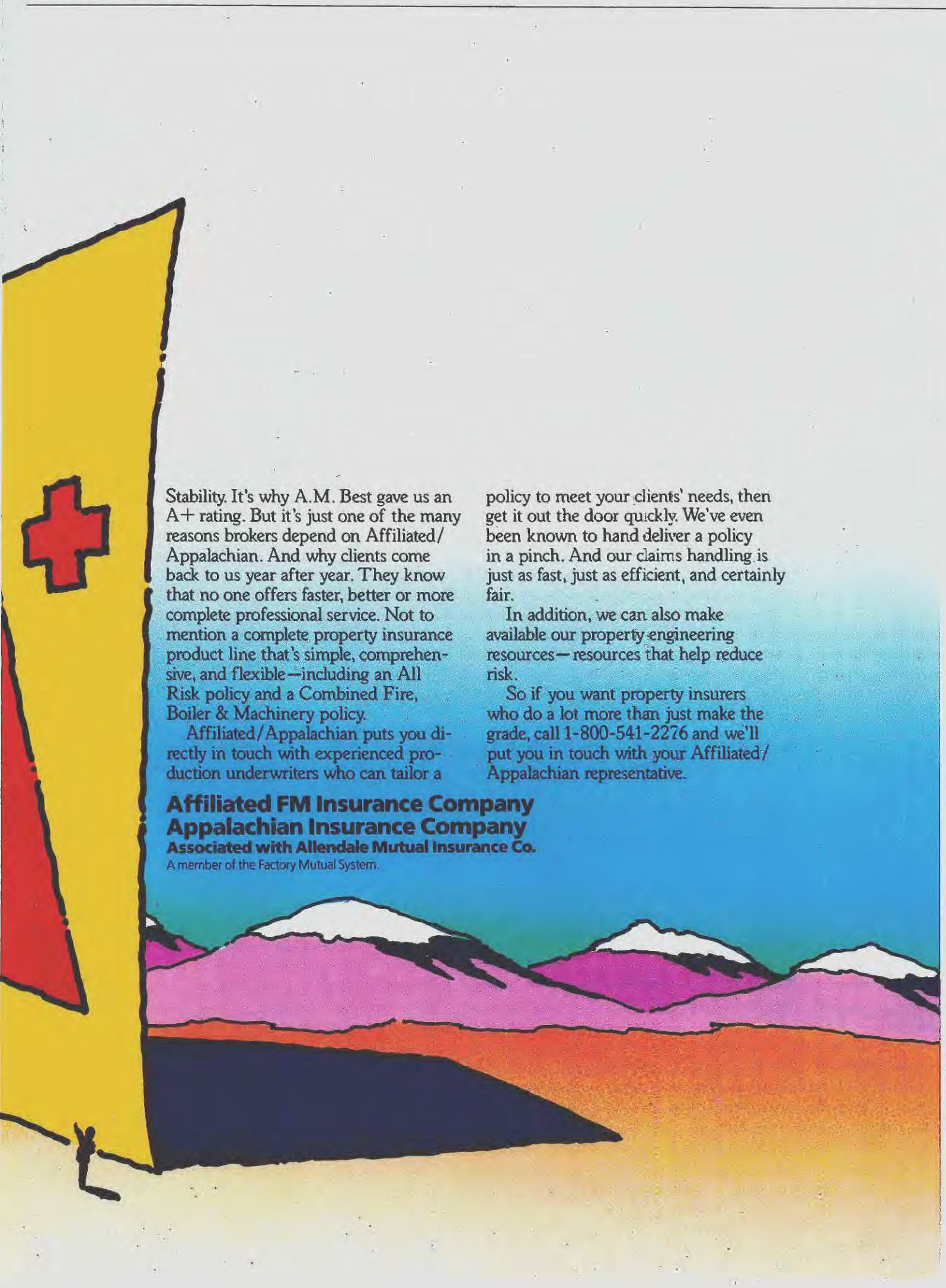
This can be accomplished either by offering an on-site daycare center, establishing a collaborative daycare center with other companies, subsidizing the cost of care for workers' children at a community daycare center or providing a child-care referral service.

Another suggestion offered by the think tank is to establish a national clearinghouse to help employers develop family-friendly policies, gather data on the full range of programs being offered and give special recognition to companies with creative programs.

The report recommends additional goals to foster children's learning readiness, like a secure home environment and the establishment of high-quality preschool programs. The development of indoor and outdoor parks also was on the list of objectives to benefit children.

Copies of the report, "Ready to Learn-A Mandate for the Nation," can be purchased for $8 each from Princeton University Press, 3175 Princeton Pike, Lawrenceville, N.J. 08648; 609-896-1344.

—By Deborah Shalowitz



Comings & goings: industry

Search for new ABI chief begins

American Financial Corp. is looking for a new president and chief executive officer for its American Business Insurance Inc. subsidiary, following the resignation last month of Bernard H. Mizel.

Meanwhile, J. Terry Griffith, senior vp of ABI, will serve as acting head of operations until a new president and CEO is named, according to a spokesman for the San Francisco-based brokerage.

Mr. Mizel's decision to leave ABI was based on his desire to reduce his travel commitments and to pursue other interests, the spokesman said. Mr. Mizel, 58, also sold his 10% stock interest in ABI to American Financial, which owns 90% of the brokerage.

The value of his ABI shareholding was not available because the company is not publicly traded.

Since ABI purchased McDonough-Caperton Insurance Group of Charleston, W.Va., last year, the brokerage has grown substantially both in terms of revenues and geography (*BI*, June 10, 1991).

The merged companies would have placed No. 10 in *Business Insurance*'s ranking of the largest U.S. brokerages based on their 1990 gross revenues (*BI*, July 1, 1991).

ABI estimates 1991 revenues of $80 million and projects 1992 revenues of $125 million, according to the spokesman.

In comparison, ABI reported 1990 revenues of $68 million, while McDonough-Caperton produced 1990 revenues of $37.2 million.

Mr. Mizel, who will stay on as a consultant to ABI through year-end, could not be reached for comment.

Insurers

Gary C. Dunton named vp and head of the standard commercial accounts unit at Aetna Life & Casualty Co. in Hartford, Conn.

Ramon L. Humke named chairman of Meridian Insurance Group Inc. in Indianapolis, where the Indianapolis Light & Power Co. executive had been an outside director. He replaces **Harold C. McCarthy**, who is resigning.

Other suppliers

Joanne R. Wiggins named executive director in Virginia for United Behavioral Systems Inc. The United HealthCare Corp. unit manages a mental health and substance abuse treatment network in Virginia. ■

Opinions

Creative cost shifting

SHIFTING COSTS to employees can obviously reduce an employer's health care expenditures. However, care must be taken to ensure that employers, overburdened with rising health care costs, do not pile costs too heavily on employees.

Employers that are thinking about shifting health costs to employees must remember the first principle of cost shifting: It does little to reduce underlying costs. Paying 70% of costs rather than 80% will save money in the short term. However, as the cost of health care continues to rise unchecked, the company's 70% share will very soon be as costly as the 80% share it formerly paid. The company has accomplished little, except for possibly alienating its workforce.

However, employee cost shifting can have another benefit: By paying a larger share of their health care costs, employees should learn more about the true cost of health care.

One positive way to shift costs to employees is to encourage healthy lifestyles. There are two ways employers can accomplish this: the carrot or the stick. Employees can give "bonuses"—commonly extra credits under a flexible benefit plan—to employees who do not smoke, are not overweight, exercise regularly, etc. Or, they can simply force employees who are perceived to practice unhealthy lifestyles—like smoking—to pay higher premium contributions.

We prefer the first approach: encouraging healthy behavior. While some may point out that giving bonuses is the opposite of cost shifting, it really is not. The employer can factor in the approximate cost of the bonuses when setting premium contribution levels and adjust the employee contributions accordingly, so that smokers and others are really penalized.

By using this method, employers get away from negativism—like "if you smoke, it will cost you"—that too often is the cornerstone of employee benefit communications.

There is another way—and we think a much better way—of shifting health care costs to employees: Eliminate coverage or boost premium contributions for working spouses that have access to their own employers' health care programs.

"WAS THAT DONE A BIT TOO ENTHUSIASTICALLY?"

As employers shift more costs onto employees, a new type of "adverse selection" is taking place. Employees facing huge out-of-pocket costs find it cheaper to buy dependent coverage through their spouses' employers than to pay for individual coverage from their own companies. Often, employees flocking to their spouses' health care plans are those who are likely to rack up huge health care claims during a year but do not want to pay the stiff deductibles and copayments required by their own employers.

Employers have for years groused about cost shifting from government health care programs. Now, they must do something about cost shifting from other employers.

However, employers that are thinking about denying coverage—or at least increasing contributions—for spouses with access to health care coverage from their own employers should make sure to give employees or their spouses time to plot their strategy, especially in light of coverage restrictions for pre-existing conditions. In short, do not give the spouses only two weeks to re-enroll in their own employers' plans.

Respecting employee privacy

WHILE EMPLOYERS have the right to make employees who lead unhealthy lifestyles pay more for their health care coverage, employers do not have the right to tell employees what they can or cannot do on their own time.

For example, employers absolutely should encourage workers to stop smoking. And, they can tell workers that they cannot smoke in the workplace. However, we have a hard time distinguishing between an employer who will not hire a smoker and an employer who will not hire a person because of his or her religion or political beliefs.

Make employees pay for their behavior, but do not limit their right to choose the type of lifestyle they want to lead.

Letters

Medical malpractice 'problem' misrepresented

To the editor: I want to congratulate you on two recent articles: "Jury Out on Data Bank" (*BI,* Feb. 10) and "Medical Malpractice: Hospital Coverage Competitively Priced, Plentiful" (*BI,* Dec. 2, 1991). I have forwarded them to Thomas Croft of the U.S. Health Resources and Services Administration, which administers the National Practitioner Data Bank.

The whole issue of tort reform for medical malpractice is being totally misrepresented by health care providers. Various surveys indicate that 70% to 80% of employers blame the high cost of health care on medical malpractice insurance premiums. Apparently, the public is not aware that medical malpractice premiums comprise only 4.2% of a physician's gross revenues and only 1.2% of a hospital's gross revenues.

Considering that the United States has a hospital occupancy rate averaging 55% to 60% and has 50% more physicians per capita than Canada, it appears that we may be able to solve our health care problems by better utilizing surplus capacity than focusing on a small cost item for doctors and the entire health care system.

David H. Ellig
President
Med Ed
Tempe, Ariz.

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Bankers bond hardening predicted

Alternative markets will play a bigger role

By MICHAEL BRADFORD

SAN DIEGO—Banks should prepare for the financial institution bond market to harden by the end of 1993, a consultant advises.

Signs of an approaching market hardening include declining premiums and rising loss ratios among bond underwriters, according to Edgar W. Armstrong Jr., consultant and manager-risk management services with The Wyatt Co. in Washington.

While he stopped short of predicting exactly when a tightening will occur, "I do doubt that we will go too many more months before there is some kind of turn," Mr. Armstrong told those attending a session at the recent American Bankers Assn.'s National Security and Risk Management Conference in San Diego.

Financial institution bonds—also known as bankers blanket bonds—cover risks including employee dishonesty, robbery, burglary, misplacement, loss in transit and forgery.

Mr. Armstrong referred to a report by the Surety Assn. of America that showed domestic financial bond underwriters saw premium volume shrink 6% in 1990 to $560 million. At the same time, insurers' loss ratios on the business jumped 11 points to 48% from 37%, he said.

He pointed out that expense ratios for the business have "historically been high, pushing 50%." That means "we're getting dangerously close to that 100% combined ratio," the consultant said.

Underwriting results in 1990 were a lot worse than in 1989, he said. And, although figures aren't yet available, Mr. Armstrong said he has heard "that '91 was a lot worse" than 1990.

The Surety Assn. of America predicts red ink for domestic bond underwriting results this year, Mr. Armstrong noted. "I'm not here to say they're wrong. The numbers point to that kind of thing happening. The market is going to change.

"Be prepared for another hard bond market cycle—maybe not during the next 12 months" but at least by the end of 1993.

While domestic insurers see deteriorating results, Mr. Armstrong pointed out that some alternative markets for financial institution bonds have done well.

For example, he said, the ABA's Bermuda-based captive, American Bankers' Professional & Fidelity Insurance Co. Ltd., posted a 1990 combined ratio of 84.4%.

Another banking industry captive, Bermuda-domiciled Bankers Insurance Co. Ltd., recorded a 96.65% combined ratio in 1990, he added.

"I'm not sure how they did in '91, but if they're like most insurance carriers, that experience got just a little bit worse," Mr. Armstrong said of the captives.

"Alternative markets continue to grow," he said. "They're going to be a bigger and bigger part of the bond industry. Maybe that's what's prolonged the soft market, who can tell?"

Capacity for financial institution bonds also is available in London.

Lloyd's of London syndicates will continue to write financial institution bonds and other classes of business for banks, despite the losses that market has incurred in other areas and fears about Lloyd's financial fitness, according to Stephen Burnhope, director of Merrett Underwriting Holdings Ltd.

Mr. Burnhope said "misleading media comments" regarding Lloyd's have led some to believe that because the marketplace is self-regulated, "somehow that means it's unregulated. That's absolutely wrong."

Lloyd's has to demonstrate to United Kingdom insurance regulators each year that it has "sufficient reserves to cover liabilities," Mr. Burnhope noted. "We've always been able to exceed the minimum requirements by several times."

Mr. Burnhope stressed that he has written coverage for financial institutions for 15 years and plans to continue with "as much capacity this year as we committed last year."

The financial institutions bond market has long been characterized by extremes, commented John P. Cavoores, managing director of the department of financial institutions at Chubb & Son Inc. in Warren, N.J.

Those "on both sides of the transaction base their philosophy on the old adage, 'Get it while you can,' " Mr. Cavoores pointed out. "When pricing is high, capacity and coverage is limited and underwriters get it while they can. When prices are depressed, coverage and capacity are abundant and insureds get it while they can."

Presently, the market is at a midpoint, and there is an abundance of coverage and capacity, according to Mr. Cavoores. Insurance buyers generally are able to meet their pricing goals, even though there has been a leveling of price reductions in recent years, he added.

"The bottom line is: The market is in a perfect position to strike a balance," Mr. Cavoores said. However, there are several issues that will make such a balance difficult, he noted.

"Given the solvency of both of our industries, the emerging role of regulators, the out-of-control legal system, the health crisis, future toxic liabilities and the final tally of the bank crisis, it won't be long till underwriters start arbitrarily raising prices and restricting capacity in this class to help build up reserves and prop up capital," Mr. Cavoores said.

There are ways bank risk managers and insurers can work together to smooth the market cycles, he suggested.

One way is for the industry to agree on what the phrase "long-term relationship" means, he said. "It should mean more than a 60-day pre-renewal meeting and a celebration lunch after the deal is done."

Risk managers have to decide what types of relationships they want, Mr. Cavoores said. If they choose the "uninformed" capacity of new underwriters in the market, risk managers will get "uninformed claims settlements that have no bearing on your coverage," he noted.

"If you want knowledgeable risk takers, you'll get knowledgeable claims settlements that use your contract and your relationship as a framework for that settlement," according to Mr. Cavoores.

"Let's develop and keep an open dialogue throughout the year," he urged. "As underwriters and brokers, we need to broaden our knowledge base of the banking industry's needs so we can provide some new products."

Although the domestic market for financial institution bonds appears to be on the verge of some turbulence, the professionalism of those in the market is a reason for optimism that conditions won't become too bad, according to Harry H. Haacke, senior vp with Johnson & Higgins in New York.

"This is the most professional time for any of us in this business," he declared. In the early days of his career, in the 1960s, Mr. Haacke said, "we could never find risk managers, let alone risk managers as capable as all of you."

Underwriters, too, have become more professional as market cycles have buffeted the industry in recent decades, Mr. Haacke said.

And, he pointed out, the coverage that is available to banks today is based on "honest capacity."

A bank will find that $25 million in capacity today is not "false capacity. It's not built on reinsurance" like some offerings of the past have been, Mr. Haacke noted.

"Yes, there is reinsurance. In a catastrophe business you have to have it," he said. But when an underwriter today offers limits of $25 million, "you have to believe he will have it for you tomorrow and the next day.

Mr. Haacke said he believes "we've got a good market now. If prices are competitive here and there, so be it. There are accounts that are good and frankly will get better deals here and there; and there are accounts that have losses and will have to pay more."

Michael R. Becker, vp of insurance and risk management at First Chicago Corp. in Chicago, moderated the session. ■

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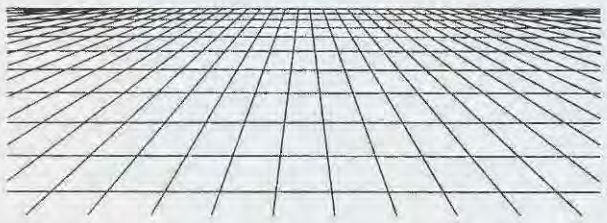

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Banks told to be ready to handle a power loss

By MICHAEL BRADFORD

SAN DIEGO—Financial institutions need backup power, a plan for relocating and a system for filing insurance claims in the event of a blackout like the one that struck Manhattan in 1990, a panel of bankers say.

The panel, in a presentation to members of the American Bankers Assn. during the group's National Security and Risk Management conference in San Diego, agreed that a business continuity plan should be in place to cope with difficulties like those that arose when a fire knocked out electricity in a large area of Manhattan's financial district (*BI*, Aug. 20, 1990).

The fire at a Consolidated Edison Co. of New York Inc. substation left some financial institutions without power for several days.

"Power really is critical in our business," said Douglas G. Hoffman, senior vp for corporate risk and insurance services at Bankers Trust New York Corp. "It's extremely difficult to measure the ultimate loss to companies affected by the outage," he said of the blackout. But effective business continuity plans and "sheer luck in many cases" helped stem those losses.

There is an enormous disparity between the insurable loss for financial institutions and their "ultimate loss," which involves losses not covered by insurance, Mr. Hoffman said.

The ABA panelists, all members of the New York Clearing House Assn.'s risk and insurance management and business continuity committees, pointed out that financial institution members of that association reported insurable losses of about $5 million as a result of the power failure, while exact figures for ultimate losses were expected to be much more than that.

The relatively small losses from the 1990 blackout indicate that "either the emergency wasn't very serious or banks were prepared for the situation," said Richard D. Wilder, vp of corporate insurance at Morgan Guaranty Trust Co. of New York. "I believe the latter."

Risk management and business continuity planning "are the keys" in a situation like the power failure, Mr. Hoffman remarked. Banks and financial institutions most affected by the blackout were those that had no backup arrangements for processing data, or found that their generators failed or had contaminated fuel, he said.

Many financial institutions that were among the hardest hit committed "management missteps" like "insufficient communication, plans, decisions and so on," he added.

For example, Mr. Hoffman mentioned a financial institution

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Is vault half full or half empty?

FDIC reports suing in 'only' half the failures

By MICHAEL BRADFORD

SAN DIEGO—Directors and officers of failed financial institutions have about a 50-50 chance of being sued by the Federal Deposit Insurance Corp., a broker warns.

The FDIC gave "great solace and relief" to bank risk managers in a recent report to Congress that indicated the agency "only" sues directors and officers of failed institutions "in about half the cases," H. Don Akin, senior vp at Rollins Financial Brokers Inc. in Tulsa, Okla., said sarcastically.

At a seminar at the American Bankers Assn.'s National Security and Risk Management Conference in San Diego, Mr. Akin quipped that the FDIC's revelation should make directors and officers "feel a lot better right off the bat," only having "half a chance of being sued."

"The concern we all have about increased litigation is not theoretical," agreed Lena Mkhitarian, senior vp of New York-based National Union Fire Insurance Co. of Pittsburgh, Pa., a unit of American International Group Inc. "Litigation against directors and officers and others involved in failed institutions is on the upswing."

She said the trend is evidenced by numbers from the FDIC that show the agency in 1989 recovered $2.9 million on average in cases against officials of failed institutions.

The FDIC requires certain criteria to be present before it will pursue a case against a director or officer of a failed institution, according to Rollins' Mr. Akin.

Before suing, "the FDIC must believe that they have a good, strong, solid case," he said. "Second, it must be cost-effective to bring the suit."

Cost-effectiveness, Mr. Akin explained, is determined after the FDIC looks at the personal assets of the director or officer and assesses whether there is "enough there to get."

The FDIC also considers whether there is a directors and officers liability insurance policy covering a bank's officials and, if so, what exclusions the policy contains, said Mr. Akin.

If one or both of the criteria are met, "there's a pretty good chance if you're a director or officer you'll be sued," he said.

Waving his billfold at the audience, Mr. Akin said: "If you're a bank director or officer, it's your wallet we're talking about. It's your personal assets we're talking about."

One way the FDIC and the Resolution Trust Corp.—a federal agency managing the thrift bailout—are seeking to make litigation cost-effective is by researching past D&O policies held by failed institutions to see if more money can be recovered, said Mark I. Rosen, vp with Executive Risk Management Associates, a Simsbury, Conn., unit of Aetna Life & Casualty Co.

When an institution fails there may be no coverage, or a policy in place with low limits or a clause that excludes coverage of claims by regulators, he said.

In such a case, the FDIC may decide to "look back into prior policy years where maybe the limits were greater or the restrictions on the policy were less severe" and attempt to collect on those policies, said Mr. Rosen. However, he noted, regulators have had little success in such attempts.

Apart from the specter of going after old D&O policies, banks also worry about a threat to two important exclusions contained in D&O policies, Mr. Akin pointed out.

He explained that the FDIC is asking Congress to "remove the 'regulatory' exclusion and the 'insured vs. insured' exclusion" that is in most policies.

The regulatory exclusion bars coverage for claims brought against a director or officer by regulatory agencies like the FDIC and RTC.

The insured vs. insured exclusion bars coverage for claims against a director or officer by another director or officer of the same corporation, or by the corporation itself.

Mr. Akin said he surveyed 16 underwriters of D&O liability insurance and found that while many were willing to remove the regulatory exclusion from policies, "tampering with the insured vs. insured exclusion was another matter."

If Congress makes the insured vs. insured exclusion illegal, underwriters indicated the move could "severely restrict the marketplace," according to Mr. Akin. Coverage would be available at a reasonable price only to banks considered the best risks, he said.

There is a greater question than whether the D&O policy's exclusions will be retained, National Union's Ms. Mkhitarian contends. "The question is, what qualified director is going to agree to sit on the board" with their personal assets on the line? she asked.

While insurers are not arguing with the government's right to prosecute directors and officers who have engaged in illegal activities, Ms. Mkhitarian said that "very little attempt is made to distinguish between those institutions which have failed because of economic circumstances and those which have failed because of insider abuse."

She said theories of liability advanced by the FDIC and the RTC in lawsuits against failed financial institutions are "so loose that directors and officers who have acted properly, in accordance with the industry standards and their understanding of the regulatory requirements at the time," cannot be assured that they can successfully defend themselves.

Meanwhile, Mr. Akin said his survey of domestic D&O underwriters found most would not say whether the cost of coverage will increase for financial institutions.

He said there was a "reluctance on the part of underwriters to admit openly" that they would be raising D&O prices when informed that the survey results would be shared with risk managers at the ABA conference. "And I can't blame them for that," he said.

However, Mr. Akin said most underwriters indicated they would like to get a minimum 10% increase in premiums for D&O coverage.

On the other hand, a few underwriters indicated they would be lowering premiums. "I didn't have the heart to ask, 'Does that mean you've been overpriced in the past?' " he said.

The survey identified total D&O capacity of around $175 million among domestic insurers, with individual insurers offering limits ranging from $2 million to $25 million.

A recent Wyatt Co. survey found that respondents—which included banks with assets ranging from $100 million to more than $1 billion—had aggregate D&O policy limits from $250,000 to $210 million (*BI*, Feb. 24).

In addition to U.S. markets, brokers accessing London markets can put together D&O limits of around $25 million, said Viken P. Gudenian, director of Bowring Financial & Professional Insurance Brokers Ltd. in London.

The session was moderated by Cynthia L. Hupp, vp and risk manager at Seattle-First National Bank in Seattle. ■

Blackout procedures

Continued from page 10

that incurred an insurable loss of about $600,000 after a generator exploded.

And, a bank forced to relocate its staff for more than a week because of the outage turned in claims totaling more than $1 million, he said.

Mr. Hofmann pointed out that several lessons were learned as a result of the blackout. The importance of backup power was one of the most valuable.

Mr. Hofmann warned, however, that "no backup generator is without risk," noting that periodic testing is crucial to ensure that the systems don't lack fuel, that fuel is clean and that the generator will perform when needed.

Banks also should consider which systems to power with the backup generators, Mr. Hoffman advised. While most city codes require that certain lights, elevators and other functions be served by backup power, financial institutions also should consider whether items like security systems and communication centers should be tied in to the generator.

"You've got to pick what is critical and make sure it's hooked up," he observed.

In addition, when implementing a continuity plan, "there has to be some emergency chain of command" in place to handle a crisis, Mr. Hoffman said. Those in the chain should be aware of the emergency procedures and when to implement them, he noted.

During the New York blackout, there was confusion at some financial institutions concerning when to begin implementing emergency plans, Mr. Hoffman said.

Small details like resources and supplies have to be considered as well, he said. "It's no surprise that flashlights came in very handy" during the outage.

One positive outcome of the power failure was that it provided a "live test," Mr. Hoffman said. "Some might argue about that; those that were out for the longest will certainly argue. But when you really consider it, it was not life-threatening for most people and not survival-threatening for most firms. It really provided a pretty good test for planning."

Part of a company's disaster planning should include a system for preparing and filing claims, according to Stephen J. Krol, vp in the risk management and insurance department at Chemical Banking Corp. in New York.

"A good claims administration program should be constructed on a strong foundation consisting of a plan, elements of investigation and the ability to manage the costs of the claim with objectivity, patience and understanding," said Mr. Krol.

He said some of the features of a good claims administration system are:

- Established lines of communication among all internal personnel involved in the claim, including medical and legal personnel, as well as personnel in other areas.
- Prepared forms and internal reporting procedures that can be used to gather information.
- A separate general ledger account that itemizes expenses applicable to the loss.
- Coordination among personnel assigned to handle security, physical operations and disaster recovery in order to "preserve the property from further damage" after an emergency and make necessary repairs.
- An agreement on how an outside loss adjuster will be selected. Mr. Krol said he thinks the decision should be made by the corporate insurance department or risk manager. "Often, a claim can be unduly complicated because of mistakes made by somebody unfamiliar with insurance."

Mr. Wilder of Morgan Guaranty said problems in claims adjusting crop up because of the length of time it takes to handle claims like those from the New York blackout. The average time to settle claims related to the outage was more than a year, he noted.

Communication with an insurer during such a long period is sometimes via an adjuster and an accountant employed by an adjuster, Mr. Wilder said.

Problems arise when the adjuster and accountant aren't qualified to properly handle claims involving loss of bank revenue like that from interest income and trading, he added.

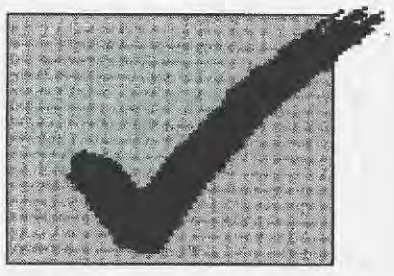
"I therefore feel it's very important that these losses be thoroughly explained by a person with a strong background in some of these businesses," Mr. Wilder emphasized. "If the loss is not fully explained when submitted, questions will develop which can prolong the adjustment process."

The best way to expedite the settlement process is by making sure that the information that will be contained in the claim is "clear, concise and well organized," he told the group.

He also encouraged bankers to communicate with their insurers during the claims adjustment process to make sure the insurer is "aware of the manner in which the claim is proceeding."

The session was moderated by Kristin W. Davis, vp at National Westminster Bancorp Inc. in New York. ■

Checking References?



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Banks aim to limit liability for pollution

By MICHAEL BRADFORD

SAN DIEGO—Financial institutions increasingly will be called on to pay to clean up pollution, despite federal assurances that few are being called on to do so, a broker says.

Banks and other creditors can sometimes be found liable for environmental damage caused by debtors, said Vincent E. McGeehan, president and chief executive officer of Rollins Financial Brokers Inc. in New York. "I think that's the tenet that really has caused concern in the industry."

Lenders have a decidedly different perspective on the implications of that tenet than does the Environmental Protection Agency, said Mr. McGeehan.

According to the EPA, he said, the agency has collected only about $1.5 million from eight financial institutions for cleanup costs and has named only 44 institutions as potentially responsible parties in pending cases.

"But that's only the tip of the iceberg, I feel, because that's only the EPA issue," said Mr. McGeehan. "That doesn't necessarily deal with the various state and municipality acts, which in some cases can be more stringent than the EPA."

Mr. McGeehan participated in a recent panel discussion at the American Bankers Assn. National Security and Risk Management Conference in San Diego.

Lenders and others also are concerned with federal legislation that could narrow the secured lenders exemption from environmental liability, the brokerage executive said.

Currently, unless a secured creditor participates in management of a business that has polluted or eventually does pollute, it is exempt from liability under the Comprehensive Environmental Response Compensation & Liability Act, better known as the Superfund law.

Under the proposed bill, S.B. 651, Mr. McGeehan said, a creditor would be considered to be participating in management if it "exercises decision-making control over the borrower's environmental compliance to the extent that it takes responsibility for the borrower's waste disposal or handling practices which result in the release or threatened release."

A creditor also would be participating in management if it "exercises control at management level by assuming responsibility for establishing and implementing policies and procedures for environmental compliance," according to Mr. McGeehan.

Lenders still would be permitted to "police the loan," foreclose on the business' property and prepare it for sale without losing the secured creditor exemption, he noted.

"It allows you to do all these things and doesn't require that you monitor the environmental exposure, but suggests that it's a good idea," he said.

Both S.B. 651, sponsored by Sen. Jake Garn, R-Utah, and a similar measure, H.R. 1450, sponsored by Rep. John J. LaFalce, D-N.Y., are now pending before committees.

Aside from not participating in management, lenders have other ways to minimize their chances of being held liable for pollution damage, said another panelist.

One is to carefully analyze non-real estate loans to assess the environmental risks, said Susan Horsfall, risk management officer at First Michigan Bank Corp. in Holland, Mich.

She referred to a case in which a creditor of a paint and chemical company was held liable for cleanup costs after it was found to have participated in management by making loans so that the company could buy inventory.

To avoid liability, Ms. Horsfall said, lenders should:

- Include clauses in loan contracts that address environmental issues.
- Develop policies and procedures in lending and trust departments for addressing environmental concerns.
- Assess current loans for potential exposure.
- Require loan applicants to provide environmental audits of properties.

The EPA has collected only about $1.5 million from eight financial institutions, Mr. McGeehan says.

- Monitor vacant land to ensure that there is no dumping on the property.
- Make sure lending documents authorize the bank to monitor, review and inspect properties.

Ms. Horsfall cited a 1991 American Bankers Assn. survey showing that financial institutions are aware of the environmental risks associated with lending practices.

Of the 7,000 survey respondents, 64% said they had rejected loan applications for fear of environmental liability, the survey said.

And, 88% said they had changed lending procedures in order to avoid environmental liability, while 220 reported incurring cleanup costs related to property held as collateral.

Environmental remediation insurance for lenders is relatively new, and coverage conditions vary among underwriters, Mr. McGeehan said.

"We encourage you, if you do have an interest in these types of coverage, to do just what you would do with any other type of insurance you purchase," he said. "And that's to consider what's best for you and your institution and attempt to negotiate the coverage enhancements that are important to you."

The session was moderated by Michael R. Becker, vp at First Chicago Corp. in Chicago. ■

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Thieves sting banks with high-tech forgeries

By MICHAEL BRADFORD

SAN DIEGO—High-technology thieves are reaching into bank vaults through a new kind of fraud.

Using state-of-the-art computers, image scanning devices and laser printers, forgers can create or alter checks that have a good chance of making it through a bank's processing system, according to Joseph T. Woodall, bank fraud supervisor for the Federal Bureau of Investigation in Los Angeles.

The technology also allows crooks to generate phony insurance claims, stocks and bonds, letters of credit, expense account receipts, business licenses and other documents, Mr. Woodall pointed out.

And losses aren't penny-ante, he noted. One Midwestern bank with a corporate client in Los Angeles was stung for $700,000 after forgers managed to pull off an elaborate scheme that started with a counterfeit check drawn on the business's account.

Speaking at the American Bankers Assn. National Security and Risk Management Conference in San Diego, Mr. Woodall pointed out that such computer forgery is relatively inexpensive. Less than $20,000 is all that's needed to put the crooks in business.

Equipment that is very "user-friendly," Mr. Woodall emphasized, makes it even easier for the crooks. "Someone with just a little computer background can utilize this equipment in counterfeiting and forging of documents."

He explained that once a check or document is scanned into a personal computer's memory, it can be recalled and altered. Image scanners currently on the market can scan colors and are "good enough to scan currency," he said.

Likewise, laser printers will print in color and at high resolution, Mr. Woodall pointed out.

All a crook needs, he said, "is a little skill and a lot of perseverance" to become a desktop publisher and computer forger.

In fact, "as these crooks go through the penitentiary, a lot of them are being educated," said Mr. Woodall. "A lot of them are learning how to use the computer while they're in the penitentiary."

After picking up basic computer know-how in prison, "once they get out, they can hone it in a little bit and perfect it."

High-tech crooks are producing forgeries that are much harder to detect than the criminal profession's old handiwork, Mr. Woodall noted.

While it may have been difficult to distinguish a hand-altered check with the naked eye, a lab analysis would easily spot it, he explained. And in the old days, crooks didn't have the knowledge or technical skills to print counterfeit checks and had to rely on someone else for the finished product, he said.

"Now, with a little bit of computer knowledge. . .they can go in there and play with these things and take as long as they want to finally get the thing perfect," Mr. Woodall said of check forgery.

Today, there are no tell-tale signs that a computer crook has produced a check, Mr. Woodall said. While forgeries done the old-fashioned way might have been marked by typewriter impressions that could have been traced to a certain machine, laser printers leave no such signature.

The only thing a lab analysis can reveal from a computer forgery is fingerprints and the fact that it was produced on a laser printer, he said.

Although it is easier to forge corporate checks, travelers checks and cashiers checks, bogus currency is not yet a major concern, Mr. Woodall noted.

While existing technology will allow currency to be scanned and reproduced, he pointed out that forgers have a difficult time acquiring the special paper used for printing U.S. currency.

As crooks become more sophisticated, they are becoming more difficult to deter, he said. Even so, there are a few ways banks and corporate clients can lower the odds of being hit by a computer forger.

Although image scanners are capable of reading colors, using color does make it more difficult to forge checks and documents, Mr. Woodall said, particularly if the background is one color and the type is another.

Banks and corporations should put controls on the availability of the paper used to print checks, he added, so that the public doesn't have easy access to it.

Bank accounts with high balances and a lot of activity are favorites of counterfeiters because it is easier to slip checks through those accounts, Mr. Woodall noted. Lowering account balances would at least ensure that a crook didn't "get away with that much money," he said.

"If you get a check in that looks suspicious, make a phone call on it," he said. That simple bit of risk management has resulted in several counterfeiters being nabbed, Mr. Woodall said.

The session was moderated by Thomas W. Begg Jr., vp and head of the corporate investigations and fraud unit at First Chicago Corp. ■

Bankers conference draws 600

SAN DIEGO—Bankers gathered on the Southern California waterfront recently to discuss insurance market conditions, risk management and security issues.

Risk managers, security officers, underwriters, brokers and other banking industry professionals were in San Diego for the American Bankers Assn.'s National Security and Risk Management Conference, held Jan. 26-29 at the Sheraton Harbor Island Hotel.

Approximately 600 conference registrants heard market updates on coverages like financial institution bonds, environmental liability and directors and officers liability.

Sessions also centered on topics like disaster planning, banks' legal liability and a new kind of fraud perpetrated by desktop publishers.

Next year's conference is slated for Feb. 7-10 at The Peabody Hotel in Orlando, Fla. Information is available from the ABA at 1120 Connecticut Ave. N.W., Washington, D.C. 20036; 202-663-5221.

Proposition 103

Continued from page 2

surance trade group, urged Mr. Garamendi "to put a stop to this procedural shell game" and work with insurers to obtain an expedited court ruling on the validity of the implementation regulations.

Mr. Conneely echoed the sentiments of Gov. Wilson, who said: "What is needed is clear guidance from the courts on the validity of (the implementation regulations). It is past time to end the grandstanding and epic foot dragging. Enough is enough."

Gov. Wilson recently issued an order overruling the Office of Administrative Law's rejection of Mr. Garamendi's regulations that would implement Proposition 103 rate rollbacks. The governor said he issued the order not because the OAL ruling was flawed, but to end "the disillusioning spectacle of government going 'round in circles."

While Gov. Wilson's order gives Mr. Garamendi the go-ahead to proceed with hearings to determine the size of individual insurers' rate rollbacks, all agree that the final outcome of the debate over implementation of the rollbacks will be determined in court.

Under Proposition 103, most property/casualty insurance "charges" in effect between November 1988 and November 1989 were to be rolled back to 20% below their November 1987 levels.

In upholding that rollback in 1989, the California Supreme Court ruled that insurers were entitled to a fair rate of return, which it did not specify.

After taking office in January 1991 as the state's first elected commissioner, Mr. Garamendi dropped the 11.2% benchmark rate of return developed by his predecessor, Ms. Gillespie. Mr. Garamendi's implementation regulations, issued on an emergency basis, set a 10% benchmark (*BI,* Oct. 21, 1991).

In his order overturning the OAL decision, Gov. Wilson noted that the Insurance Department submitted implementation regulations on an emergency basis nine times. Twice the OAL has rejected sets of regulations, and twice it was overruled by the governor.

In a heated exchange with OAL Director Marz Garcia at the hearing, Sen. Torres declared, "What's holding up the rebates is your analysis (of the regulations)."

But Mr. Garcia insisted that he was just following the law. If there is no emergency, he said, regulations should be submitted through the regular process, which allows for a longer public comment period than the emergency process.

That was not the end of the criticism of the executive branch at the hearing.

Although Gov. Wilson said in his order that insurers had abused the implementation process, his order "included gratuitous rhetoric repeating arguments he had been spoon-fed by insurance companies," Mr. Garamendi charged.

"We don't need a fifth column undermining consumer interests within state government," the commissioner said.

Proposition 103 supporters outside the government also had their say.

"Though (the initiative) has managed to survive everything the multitrillion-dollar insurance industry could throw at it, the insurance companies' three-year counterattack against 103 has exposed incompetence and bias in the executive branch and undermined the integrity of the judiciary and threatened to politicize it," charged Harvey Rosenfield, head of consumers' group Voter Revolt and author of the initiative.

Mr. Rosenfield added that "a few pseudo-journalists in the trade press" were joining insurance industry efforts to "undermine" the authority of Steven Miller, head of the Insurance Department's rate regulation bureau.

"We now expect the battle for Proposition 103 to continue for at least another two years," he said.

However, insurers say that asking them to roll back auto insurance rates is akin to squeezing blood from a turnip.

A State Farm Mutual Automobile Insurance Co. attorney testified that the company lost $50 million on its California business in 1989, the year for which it has been ordered to pay a refund of $243.6 million. State Farm and more than 100 other insurers have filed suit to challenge Mr. Garamendi's emergency regulations.

Although he stopped short of declaring victory following Gov. Wilson's order last month, Mr. Garamendi left little doubt about how he thought the campaign was proceeding.

"In the battle over Proposition 103, it is the people of California who are winning," the commissioner said. "We have delivered over $170 million in (rebates) to consumers so far."

One insurer executive, though, contended that Proposition 103 did not deserve the credit for those refunds.

Interinsurance Exchange of the Automobile Club of Southern California, a direct-writing insurer based in Los Angeles, has refunded $80 million on its own, said Lawrence C. Baker Jr., vp and general manager.

Those refunds were facilitated not by Proposition 103, Mr. Baker said at the hearing, but by changes in the assigned risk plan and a California Supreme Court decision that eliminated third-party bad faith actions.

"The issue of one-time rebates is distracting and keeps public and legislative focus off the real issue of auto insurance reform. Nothing in Proposition 103 will lower, over the long term, rates that are already beyond the ability of many Californians to pay," Mr. Baker said.

"To get relief, we need to reform California's auto insurance system," he said. ■

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Texas Insurance Department cuts staff

AUSTIN, Texas—The Texas Department of Insurance is operating with a leaner staff after cutting 92 positions, bringing its number of employees to 1,092.

"These staff reductions are based on functions that are either non-essential or functions that can be combined," said Insurance Commissioner Georgia Flint. "We have taken a hard and thoughtful look at how this agency can function best in a leaner, more efficient manner, and we reached the decision that a reduction in force had to take place."

While she recognized the cuts as "painful for this agency and for the managers who had to make the decisions, we have no choice if we are to fulfill our duties to make the Texas Department of Insurance a more effective organization."

Gov. Ann Richards used "lean government" as a theme in her 1990 campaign and criticized the insurance department specifically for being mismanaged.

The department provided outplacement services with the help of several state agencies, including the Texas Employment Commission and the Employee Assistance Center of Texas.

"We are sensitive to the fact that we are causing changes in the lives of both individuals and families," said Ms. Flint. "We understand that these are difficult times. I intend to use every effort—and pledge the very best efforts of my staff"—to help laid-off workers find jobs, she added.

—By Michael Bradford

Workplace warnings

NEWARK, Calif.—A unit of Minneapolis-based Cargill Inc. has been fined $100,000 in what is believed to be the first charge brought under California's new Corporate Criminal Liability Act.

Cargill Salt Co. entered a no-contest plea on Jan. 24 to a misdemeanor charge under the law, which requires employers to warn employees and regulatory entities in writing of "serious concealed dangers" in the workplace within 15 days of their discovery (*BI*, Sept. 10, 1990).

Company owners and managers that violate the law can be fined up to $1 million and imprisoned for up to three years.

Alameda County Deputy District Attorney Blair Thomas initially brought the charge in January 1991 against Newark, Calif.-based Leslie Salt Co., which has since merged with Cargill Inc. and been renamed Cargill Salt Co. The charges were filed after a worker was killed by a bag-flattening machine in a Newark salt-packing plant.

The prosecution charged that Leslie Salt did not notify its employees or the California Occupational Safety and Health agency of the hazards of operating the machine.

Cargill Salt entered its plea after weighing the costs and "the very high emotional strain" of litigation on its employees, a spokeswoman said.

"We still believe we were innocent," because the company was not aware of the concealed hazard that caused the employee's death, she said. "That was the first time we had a life-threatening injury since the refinery was built in the 1940s."

—By Louise Kertesz

Around the states

Work comp reform

MONTGOMERY, Ala.—Workers compensation reform measures supported by Alabama Gov. Guy Hunt and business interests in the state were reintroduced into the Legislature earlier this month.

The reforms, which are contained in S.B. 25 and S.B. 26, are similar to proposals in H.B. 1, which died Feb. 3 after the Senate failed to approve the House-passed measure during a recent special session.

If enacted, key proposals in the bills would:

- Establish a system of administrative law judges to replace state courts as adjudicators of workers comp cases.
- Introduce a medical fee schedule.
- Change the definition of a compensable injury, which would have the effect of limiting payments for some cumulative trauma claims.
- Change the method of calculating permanent partial injury benefits, which would lower payments.

"There is a reasonable possibility that there will be some legislation passed in the '92 regular session," said Robert Maxwell, Atlanta-based director of government, consumer and industry affairs for the National Council on Compensation Insurance.

—By Meg Fletcher

Texas fraud squad

AUSTIN, Texas—Texas insurance regulators have seen the enemy—and it is fraud.

"We have declared war against fraud and do not intend to retreat or lose," said Claire Korioth, chairwoman of the Texas State Board of Insurance.

Insurance fraud is costing Texas insurers and taxpayers "between $3 billion and $4 billion" per year, she said. "That's all kinds of fraud—property, casualty, health, life, accident, agent, surplus lines and insider fraud."

Ms. Korioth said the Texas Insurance Department estimates that "at the very minimum, 10% of all claims paid are fraudulent. That's not nickels and dimes, that's billions."

Ms. Korioth made her comments during the introduction of the department's newly created Insurance Fraud Unit and its director, Caroline Scott.

Ms. Scott, a former assistant attorney general who won judgments of $19.2 million in six insurance fraud or misconduct cases, will direct a staff of 37.

The unit was authorized by a 1991 insurance reform law that made insurance fraud a felony in Texas (*BI*, June 3, 1991). The unit—staffed by auditors, white-collar crime experts and professionals with backgrounds in medical, financial and computer operations—is expected to be functioning next month.

Ms. Korioth said the Insurance Fraud Unit aims not only to deter the crime, but expects to help lower insurance rates as fraud is reduced.

—By Michael Bradford

California safety

SACRAMENTO, Calif.—About one-third of employers examined by the California Occupational Safety and Health agency last year were cited for failing to comply with regulations implementing a law requiring workplace injury and illness prevention programs, Cal/OSHA reports.

Citations were issued to 32%, or 1,420, of 4,446 employers that underwent safety inspections between July 1, 1991, when the law became effective, and Nov. 30, 1991, according to a Cal/OSHA spokesman.

Of the 2,606 inspections conducted following employee complaints, 36%, or 950, resulted in a citation.

Of the 654 inspections triggered by a workplace accident, about 29%, or 192, resulted in a citation.

Although the citations are considered "regulatory" and do not carry any monetary penalty, employers can eventually be fined as much as $70,000 for repeated or willful non-compliance under new regulations to be promulgated this year, the spokesman said.

—By Joanne Wojcik

Earthquake fund

SACRAMENTO, Calif.—Insurance Commissioner John Garamendi and insurers are supporting an emergency bill introduced earlier this month that would repeal the 1990 state law creating the California Residential Earthquake Recovery Fund.

The law, which took effect Jan. 1, requires insurers to collect additional assessments on homeowners policies for a fund to cover the first $15,000 in earthquake damage to owner-occupied dwellings. The impetus for the fund was that earthquake riders on homeowners coverage usually have deductibles amounting to 10% of policy limits.

Mr. Garamendi, who as insurance commissioner heads the program, has publicly criticized it for lacking adequate financing and an enforcement mechanism.

"Unless we repeal this program right now, the real disaster is that a major earthquake won't be limited to damaged homes, but will extend to the millions of taxpayers who will foot the bill to cover the shortfall in the fund," the commissioner said in announcing his support of the repeal bill.

If a major earthquake were to strike this year, the fund would incur a $71.1 million deficit, regulators estimate. And the deficit would continue to grow because premiums are inadequate and reinsurance not readily available, they say.

Insurers support repeal at least in part because complying with the law may cost them business.

"Some of our members who have already billed the CRERF surcharge to new or renewal policyholders have some pretty good indications they're losing business to companies that have not yet done their billings," said Thomas F. Conneely, president of the Assn. of California Insurance Cos.in Sacramento.

The repeal bill, A.B. 2049, was introduced by Assemblyman Phillip Isenberg, D-Sacramento.

—By Joanne Wojcik

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COVERAGE MAY NOT BE AVAILABLE IN ALL STATES

Oregon plan

Continued from page 1
or enrolled in the federal Aid to Dependent Children program.

In addition to increasing the number of individuals eligible for Medicaid, the state would eliminate Medicaid coverage for certain costly, high-risk services and other medical services that do not "improve the quality of life." That would free up money to extend basic health insurance to all of the state's uninsured, low-income individuals.

The state's Health Services Commission, established under the 1989 law, put 709 health care services into 17 categories of care, which then were classified as essential, very important or valuable to only certain individuals.

The Legislature has determined there are enough state and federal Medicaid funds to cover the top 587 of these services in a standard Medicaid health plan, according to a Department of Insurance and Finance report.

Oregon is asking the Health Care Financing Administration for a five-year waiver of federal Medicaid rules, which govern what services must be provided under the program, to implement this portion of its plan.

Another component of Oregon's universal health care plan is a small-business insurance program currently under development. This program would allow businesses employing 25 or fewer workers to buy a health plan that would be somewhat less comprehensive than the Medicaid plan.

The Oregon plan also stipulates that if an additional 150,000 Oregonians are not covered by health insurance between 1989 and 1995, employers that do not offer health coverage to employees working 17.5 hours or more per week will have to pay a payroll tax. The state would use those tax proceeds to purchase coverage for uninsured employees.

Employers would have to offer a plan at least as broad as the basic benefit package available to Medicaid recipients.

Another component of the plan is a high-risk pool created in 1987 to cover individuals considered uninsurable. The plan is funded partially by the state and partially by assessments on insurers and policyholders.

The state estimates the Medicaid expansion will cost $204.6 million over five years, with the federal government picking up $109.6 million and the state paying $95 million.

The OTA, though, contends the state has underestimated the cost, Ms. Read confirmed. This could result in further significant reductions in benefits to Medicaid recipients in the future as the cost of the program increases.

But, Ms. Read contends the OTA's charge is based on a faulty analysis of the plan.

"I don't believe OTA has done an analysis that allows them to make that conclusion. The report is definitely based on some misunderstanding of what Oregon did do," she said.

"We think we have done a good job of pricing it, given the unknowns. We utilized outside experts," like Coopers & Lybrand in San Francisco and Lewin/ICS, a Washington, D.C., firm that has been involved in pricing analyses for many national health care proposals, Ms. Read said.

'The report is definitely based on some misunderstanding,' says Lynn Read.

State officials say they have heard the OTA's criticism of the Oregon Health Plan before. "It reflects what we heard in the congressional hearing" on the plan in September, the Insurance Department spokesman said.

A number of the federal agency's assumptions are based on testimony at the hearing chaired by Rep. Henry Waxman, D-Calif., Ms. Read agreed.

"The OTA didn't interact with us directly and didn't conduct a level of analysis that would support their conclusions in the report," she declared.

Ms. Read also complained that the agency did not provide the data on which its conclusions were based.

"And when they speculate, they focus almost entirely on the potentially negative" aspects of the Oregon plan.

Ms. Read conceded that Oregon expects plan costs to rise annually the first three years the plan is in effect as the 120,000 new Medicare recipients obtain health care coverage.

But in the fourth year of the plan, the employer play-or-pay plan would kick in, so costs to the state would begin to decrease as employer plans or tax proceeds would begin covering a portion of the Medicaid recipients, Ms. Read said.

In addition, the effects of managed care will be felt at that point, "so by year five, the federal cost is just sitting there at $2.9 million."

If the program is renewed and continues for two years beyond the original five-year pilot period, the state's Medicaid program would be cheaper to run than it is today, and more Oregonians would have health insurance, she said.

Ms. Read also criticized the OTA for faulting the method of setting health health care priorities as subjective.

Although the rankings of health care treatments contain "objective and quantitative analysis, by making them somewhat subjective they are less formulaic and more responsive to larger concerns," she said.

In May 1990, the state obtained a computer-generated priority list based on a cost-benefit analysis.

"But, we felt it to be too rigid, too quantitative," Ms. Read said. She noted that adding a subjective element causes one category of services—"comfort care," which is defined as "pain management and hospice care for the end stages of diseases such as AIDS and cancer"—to rank higher on the list.

In addition, Medicaid funds may cover more than the 587 services through some provider groups, she said. And, health care providers probably will continue to offer low-income patients some services at no cost.

Neither Ms. Read nor the Insurance Department expect the report to hinder state efforts to win federal approval for the plan.

Indeed, "that could happen any time now," the department spokesman said.

"We don't expect the report to make the process of obtaining a waiver any more difficult," Ms. Read said.

Besides, she said, "the final report will look different based on input from the reviewers," including state officials and an OTA technical advisory panel.

Several senators requested the OTA report when it was thought that Oregon would seek congressional approval for its plan rather than go the administrative route, she said.

A separate analysis of the plan is being done by the Department of Health and Human Services, Ms. Read said. HHS officials "have not questioned our cost estimates and have not asked us to reprice" services. ■

First U.S. insurer office allowed in Prague

Markets

American International Group Inc. has received permission from the Czechoslovakian government to open the first U.S. insurance trade representative office in the country.

New York-based AIG plans to establish a licensed insurance company in Prague as soon as Czech legislation permits.

"We are proud to be the first U.S. insurance organization to be granted a trade representative office permission in the Czech republic," said Mark Hansen, AIG's representative in Prague.

"It is a strategically important step for gaining knowledge of market conditions in this rapidly changing environment," said Mr. Hansen.

"We view this as an important extension of our continued involvement in the insurance industry" of the former Soviet bloc countries, added Bengt Westergren, AIG's senior representative and president for Central and Eastern Europe.

AIG's international subsidiary, American International Underwriters, is licensed in Estonia, Hungary, Romania and Yugoslavia. And AIG is marketing personal lines coverage in Russia through a joint venture with a Russian bank and a Finnish insurer (*BI*, Oct. 7, 1991).

Insurer for non-profits

The Nonprofits' Mutual Risk Retention Group has been formed in Vermont to insure non-profit health and human services organizations with 501c(3) status.

The risk retention group for nonprofits will provide general liability, auto, directors and officers liability, professional liability and improper sexual contact coverage.

The limits for all lines except improper sexual contact are $1 million per occurrence/aggregate, with limits up to $5 million available. Limits for improper sexual contact are $250,000 per occurrence/aggregate.

The group has initial capital of less than $700,000, according to a spokesman for USA Risk Group, which was involved in the group's formation. Participating members contributed 10% of their initial liability premiums up to $1 million toward the capital.

The risk retention group will be "substantially" reinsured by Sphere Drake Insurance P.L.C. of London, said Jon Harkavy, vp and general counsel of USA Risk Group.

NMRRG is writing coverages nationally except in California, where a program for non-profits already exists.

USA Risk Group subsidiaries Vermont Insurance Management and Risk Retention Management will provide captive management, marketing and administrative services.

Mergers/acquisitions

Evangelical Health Systems of Oak Brook, Ill., has purchased half of **Parkside Health Management Corp.** from Lutheran General Health Care System of Park Ridge, Ill. Parkside, a for-profit managed care company, operates the PATH PPO, one of the Chicago area's largest PPO with 35 hospitals and 2,800 physicians.

Gay & Taylor/Ward-THK, a Winston-Salem, N.C.-based claims administration and loss control firm, has merged with **Thomas Howell Group** of London.

Travelers Corp. has acquired **Lynch, Ryan & Associates Inc.**, a workers compensation cost control consultant in Westborough, Mass.

Minneapolis-based **United HealthCare Corp.** has purchased the **Physicians Health Plan Corp.**, which owns the 154,000-member Physicians Health Plan of Ohio Inc. UHC paid $73 million cash for the Columbus, Ohio-based health maintenance organization.

Tampa, Fla.-based **Poe & Associates Inc.** has acquired **Deyo-Fawcett Insurance Services Inc.** The Houston-based agency specializes in life, health, employee benefits and property and casualty insurance. Principals Terry Deyo, Darryl Fawcett and Bruce Lindsay, as well as their 20 agents, will remain with the company. The office will be under the direction of Robert Pryor, the managing vp of Poe & Associates of Texas.

Willis Corroon Group P.L.C. has acquired the **River Oaks Insurance Services Inc.** of Houston. River Oaks is a retail property and casualty brokerage specializing in energy-related accounts. River Oaks principal Michael Gilbert has been named senior vp of the Willis Corroon Marine & Energy operation in Houston, while principal James Donnelly Jr. has been named marketing manager for Willis Corroon Corp. of Texas Inc.

New offices

The London Agency Inc., an underwriter for specialty umbrella and property lines, has moved its headquarters to 6 Concourse Parkway, Atlanta, Ga., 30328-5346; 404-393-9955.

The Environmental Risk Division of **Frank B. Hall Insurance Brokers Inc.** has moved to 490 L'Enfant Plaza East, S.W. Suite 7200, Washington, D.C., 20024; 202-479-4400; fax 202-479-2293.

Chubb Corp. has opened a branch office at 225 Asylum St., Hartford, Conn. 06103; 203-493-2900.

GRE Insurance Group has opened an underwriting office at 8300 Norman Center Drive, Suite 1160, Bloomington, Minn., 55437; 612-897-5900. The New York-based property and casualty underwriter is a subsidiary of Guardian Royal Exchange Assurance P.L.C. of London. ■

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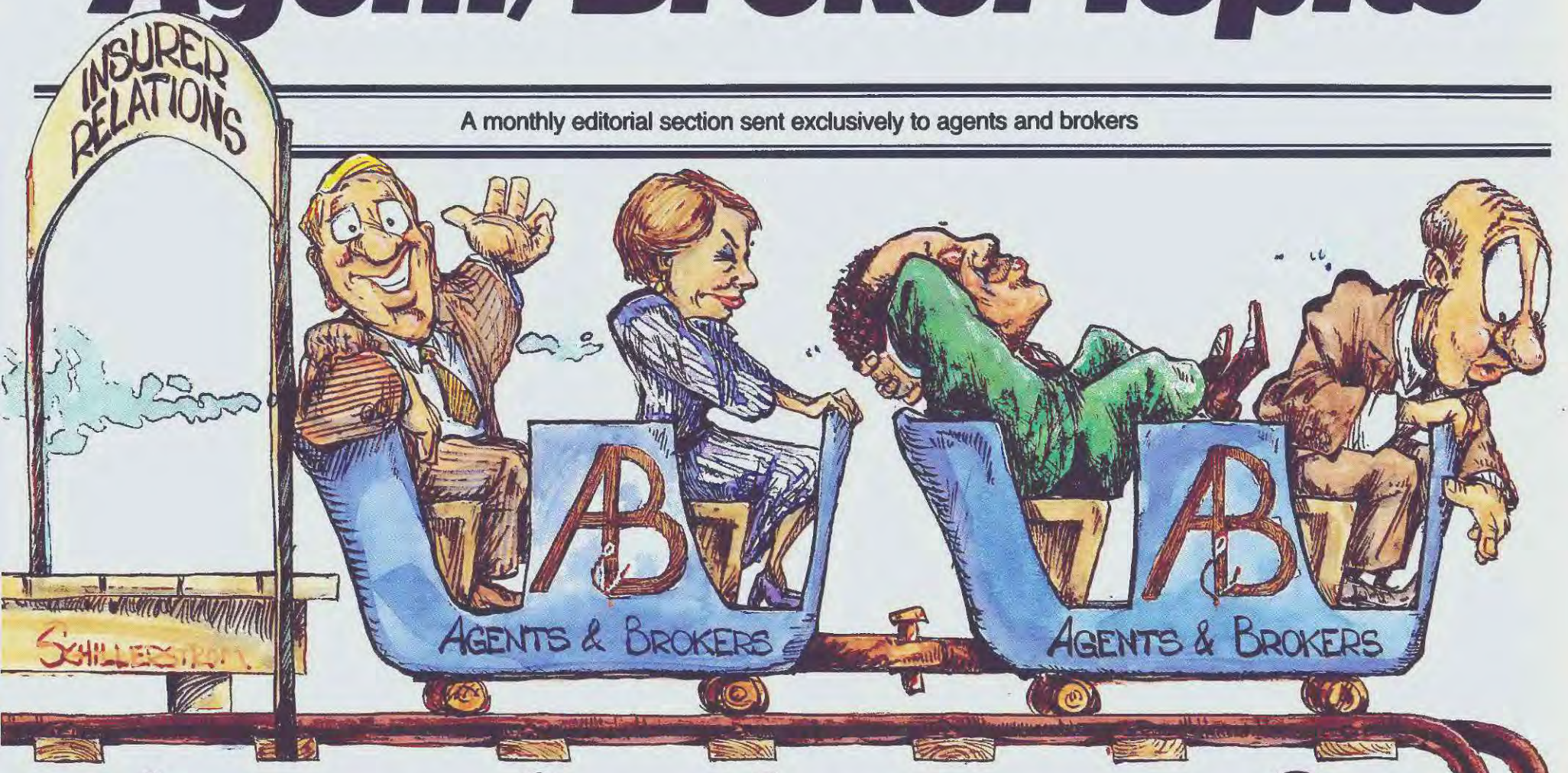


A turn for the worse?

By LAURA MAZZUCA

Just when you thought relations with your insurers had nowhere to go but up. . .

RELATIONS

When *Agent/Broker Topics* first surveyed agents and brokers last year concerning relations with insurers, some agents believed things couldn't get any worse.

They may have been wrong.

Twenty-five percent of the agents and brokers contacted this year say they are satisfied with how insurers treat them. But that is down sharply from the 58% who reported satisfaction with their insurers in a similar survey last year (*A/BT*, March 4, 1991).

In fact, the largest segment of 52 agents responding to this year's survey—40%—were completely dissatisfied with the relationship, while 35% were both happy and unhappy, depending on the insurer.

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

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

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

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

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

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

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

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

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

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

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

An ugly situation

By any measure, it's been a rough year for agent-insurer relations.

The past year saw many insurers pulling out of regions and lines of business (see story, page 16D). Add to that the pressures of expense control in a recession, insurance industry battles with lawmakers and the ongoing soft market. In short, agents say the relationship can be ugly.

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

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

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

Many agents squarely place the blame for deteriorating relations at the feet of insurers. "The changes are not due to the market, but (due to) the leaders of the companies," wrote a vp of a Michigan agency with $26 million in annual premium volume. "They are moving away from the agency system and using the soft market as an excuse."

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

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

"I do not feel the persons underwriting our business have an understanding of the individual risk that we as the agents on the 'firing line' do, yet they do not take our word for anything like they used to," wrote the president of an agency in Fargo, N.D.

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

Insurers "are constantly changing direction; (they are) unable to maintain stable commitment to product availability; (they) state they want to write on an account basis, but will not write some lines like commercial auto and workers compensation," said a Massachusetts agent.

"Relationships are erratic; sometimes markets seem like the proverbial 'pea on a hot griddle,' " wrote James S. Hebb III, senior vp of Jardine

Continued on next page

Agency gripes

Continued from previous page
Group Services Corp., a unit of Jardine Insurance Brokers Inc. in Washington, D.C.

Just how inconsistent these relationships are is reflected in the contracts between agents and insurers.

Fifty-eight percent of the agents and brokers surveyed said at least one insurer they represent had changed contract terms or requirements in the past year, compared with 51% that had a contract changed a year earlier. Respondents cited reductions in commission structures as the most common change, followed by: changes in contingent commissions; increased life insurance production requirements; higher volume requirements; and requiring sales of other lines of business.

Naming names

Some respondents noted very specific contract changes and, as in last year's survey, were no shrinking violets when it came to naming names.

"Chubb reduced personal lines commission until you hit a certain minimum volume," wrote the president of an Illinois agency with annual premium volume of $5 million.

A vp of a New York agency with annual premium volume of $12 million reported that Kemper National Insurance Cos. changed its contingent commission agreements, while Chubb Corp. reduced commissions.

A California agent noted that Aetna Casualty & Surety Co. reduced its auto insurance commissions, while ITT Hartford Group Inc. "demands life sales."

A vp of a New York agency with $13 million in annual premium volume said that CIGNA Corp. reduced its commissions 2.5% on package policies, and Utica National Insurance Co. decreased commissions 3% on workers compensation coverage.

One respondent—an Ohio agency with $9 million in annual premium volume—has been offered higher commissions for surpassing growth goals. The agency, though, declined to say which insurer made the offer.

A Kemper spokesman said any contract changes were related to an agency's inability to meet volume requirements.

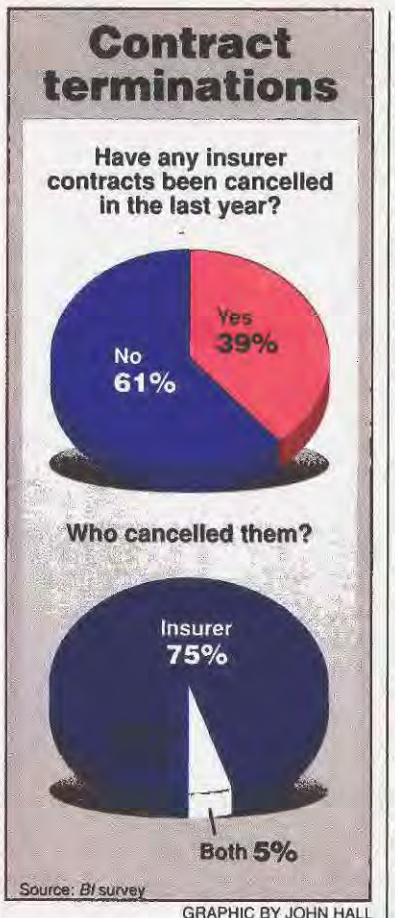
Aetna said changes were tied to loss ratios on business produced by an agency.

Spokesmen for Chubb, CIGNA and Hartford each said contract changes were made on a case-by-case basis and did not reflect any overall policy change.

A spokesman for Utica National said it only reduced commissions in one line of workers comp coverage.

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

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



GRAPHIC BY JOHN HALL

Refusing to take all the blame

No doubt about it, insurers know that all is not well in their relations with independent producers.

But they're not taking all the blame. Insurers point to direct writers eroding their markets, continuing pressure on insurers to reduce expenses and a more critical consumer.

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

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

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

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

'Company bashing'

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

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

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

Instead of bad-mouthing insurers, agents should get together with companies to address public policy issues—like no-fault insurance and the high cost of medical care—on a local level. This would improve relationships in the long run, said Mr. Lawson of the Alliance.

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

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

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

"These are particularly trying times and it takes a great deal of patience and understanding on both sides of the fence," commented the president of a Kentucky agency with $6.5 million in annual premium volume. "It seems many times we as agents find ourselves at totally different views (with) companies (and are) unable to continue a stable course. We have no choice but to attempt to solve our problems and differences. If we fail, then the independent agency system as we know it will pass." ■

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Underwriting is common complaint

Lack of skills, experience and authority are all mentioned by disgruntled agents

By LAURA MAZZUCA

INSURER RELATIONS

A good underwriter is hard to find.

Nearly a third of the 52 agents and brokers responding to this year's *Agent/Broker Topics* agency-insurer relations survey cited underwriting problems as a major concern.

"The most important reason for dissatisfaction is the near-virtual total void in authority of most underwriters; everything is a 'management' decision," wrote the president of an Illinois agency with $5 million in annual premium volume.

"And there is a near total lack of an ethic in honoring commitments made by underwriters. Everyone wants to weasel out of a deal if they can," the agent said.

Insurance companies, of course, see things differently. They defend the work of their underwriters and point to improvements like specialized training programs and automated underwriting programs.

Inexperience was a recurrent complaint by agents about underwriters.

The president of a Virginia agency with $14.3 million in annual premium volume blamed the inability to build a relationship with underwriters as well as insurers' underwriting problems on rapid turnover and a shortage of trained personnel.

Another problem cited by agents: Most underwriters don't understand how an agency operates.

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

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

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

Surveyed agents and brokers also griped about what they called the excesses of "class underwriting," in which an insurer may overlook a good risk because it has decided an entire class of risks is unprofitable.

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

Another common complaint concerns "tunnel vision" underwriting: focusing on very narrow markets, said Jeffrey M. Yates, executive vp and general counsel for the Independent Insurance Agents of America in Alexandria, Va.

Agent groups also report hearing many complaints from members about high turnover among underwriting personnel, underwriters being too far away from localities and related issues.

But insurers rallied to the defense of underwriters, citing enhanced training programs and even automation as recent advances.

Agents and brokers who complain about unskilled underwriters may just be upset that business has declined, contends Rodger S. Lawson, president of the Alliance of American Insurers in Schaumburg, Ill. "Toughness can be construed as a lack of skill."

At Aetna Casualty & Surety Co., "We have seen no dropoff in the people or the training," said Terry Toohey, director of agency relations with the Hartford, Conn.-based insurer.

Last fall, Aetna introduced a specialization program, in addition to its usual underwriter training program, which stresses areas like contractors and residential risks.

Novice underwriters at most insurance companies go through a training program both at the home office and in the field. Typically lasting six months to a year, these programs introduce the basics of the business as well as human relations, a combination of "ethics and pure underwriting technical skills," said Wallace Gardiner, national sales manager for Chubb Corp. in Warren, N.J.

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

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

Other insurers have implemented automation to increase the efficiency of their underwriting systems.

Six years ago Kemper National Insurance Cos. began developing an automated system. And in the last two years it has been using automation in personal lines auto and homeowners coverage, said Peter T. Standbridge, executive vp-personal lines group for the Long Grove, Ill.-based insurer.

Right now, about half its business in these areas is underwritten through the system and Kemper hopes to increase this by 10% within the year. "It's been a little disappointing, but it's a cultural change," Mr. Standbridge added.

Kemper producers, who are electronically linked with the insurer, enter basic policy information, which is assigned a numerical

Continued on next page

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Agent/Broker Topics

Withdrawals cause worry

Agents asking for more help when insurers leave a market

By LAURA MAZZUCA

One of the most obvious strains on agency-insurer relations is the increasing number of insurers pulling out of certain states or lines of business.

In the last few years, several national insurers have pulled out of major markets.

Crum & Forster Inc., for instance, totally withdrew from personal lines in 1990; Aetna Casualty & Surety Co. has dropped personal auto coverage in 27 states over the past 2½ years; and ITT Hartford Group Inc., USF&G Corp. and Travelers Corp. have stopped writing personal lines business in some states in recent years.

In cases like those, insurers often cite similar reasons for their moves: poor loss ratios; harsh state laws or regulations; or changes in marketing plans.

Some of those companies, though, do a more humane job than others in preparing their agents for the worst.

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

"It has been a real source of concern," he said.

When insurers pull out of a particular line or a state, they are required to comply with state rules—on matters like notification—that are designed to make the departure orderly.

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

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

Although Aetna tries to help agents place coverage with other insurers, sometimes it simply complies with the state's notification rules.

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

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

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

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

Most chose to move their policies when they renewed, said the spokesman.

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

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

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

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

— Jeffrey M. Yates
IIAA

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

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

Not all insurers go that extra mile, though.

Although he and other sources declined to name names, Mr. Yates noted that some insurers abandoning a particular line or state don't give agents enough time to regroup.

Worse yet, some terminate agent contracts, then write the business directly, bypassing the agent who originally drummed up the business.

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

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

That sort of behavior not only alienates agents, it creates a bad public image for an industry that already suffers from a black eye in many circles, he said.

And, Mr. Yates said, it drives policyholders to direct writers. "This creates a difficult situation for companies remaining in the market."

An insurance company can avert most market withdrawal problems by simply giving agents sufficient notice of its decision to leave.

The IIAA recommends that insurers leaving a state warn agents at least six months in advance and offer to renew existing business for at least one year after the withdrawal, Mr. Yates said.

One state that has been particularly hard hit with market withdrawals is Louisiana.

"The companies were not interested in how this really affected us," complained James J. Cooke Jr., a partner in Engelhardt/Cooke & Associates in Metairie, La. "But as an agent it has impacted me very severely."

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

Although all the withdrawing insurers gave agents due notice, a few went beyond the minimum requirements, according to Mr. Cooke.

USF&G and Aetna, for instance, allowed his agency to renew business for another year, despite their intent to withdraw, according to Mr. Cooke. "I think they did as much as they could for us."

After the smoke cleared and the insurance companies were gone, Mr. Cooke's agency had to replace almost 20% of its book of predominantly commercial business.

While the agency had little trouble placing commercial business, there were "inherent problems" in the changeover, including problems finding new underwriters for some personal auto policies, Mr. Cooke said.

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

Although they offered to share loss experience data with him, none of the departing insurance companies helped Mr. Cooke place the business with other insurers, he said.

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

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

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Underwriting

Continued from previous page

value, Mr. Standbridge explained.

"Alarm signals" go off if the score is too low to qualify for automatic underwriting, he said. An auto insurance application that indicated a high performance sports car or a drunk driving conviction, for instance, would have to be reviewed by underwriters.

If the point total meets Kemper standards, the policy is issued, and "it is never seen by a human being," he noted.

This is an improvement over the traditional process because much of the paper shuffling and wasted time is eliminated.

There are drawbacks, however.

While such "template underwriting" can be used for small commercial coverages like business owners policies, most commercial coverages are too complex to automate, Mr. Standbridge said.

Also, agents must be sure to submit complete information, or the system simply doesn't work. Automation forces both agency and insurer to "get it right the first time," he added.

Even when underwriting is conducted more traditionally, it's essential for the agent to do his part.

Agents must classify the business properly in order to avoid underwriting problems in the first place, stressed Mr. Yates of IIAA.

Direct writers like State Farm Mutual Automobile Insurance Co. expect their agents to know the market intimately, which minimizes underwriting problems, he pointed out. ■

Once a preacher, then an agent, Dan Burton still spreads the word

But now marching orders come from voters

By LAURA MAZZUCA

INDIANAPOLIS—As a young Protestant preacher in southern Ohio and Indiana, Dan Burton learned through experience the best way to preach the word of the Lord.

Later, as an independent insurance agent, he discovered "the beauty of the free enterprise system," and brought the same zeal to pitching policies and running his own agency.

Today, that energy is put to work in a slightly larger arena: the U.S. House of Representatives.

"When you look in the Bible, they talk about not hiding your light under a basket," says the five-term Republican from his office in his hometown of Indianapolis. "If I see something wrong, I try to point it out and make it right."

And Dan Burton sees plenty wrong in government today. In more than 10 years as head of his own insurance agency, he learned first-hand the plight of the small-business man struggling with government red tape.

"The federal government is literally strangling the free enterprise system," Rep. Burton said. Regulations on workplace safety, employee benefits and other areas are killing small businesses, he said.

While legislation like the recently enacted Americans with Disabilities Act—as well as parental leave and clean-air bills—seems like a good idea, it ultimately costs the taxpayer dearly, he said. "We go overboard with regulations and demands on business."

He's not afraid to speak his mind on other issues, either. When Soviet President Mikhail Gorbachev addressed Congress in 1987, the outspoken ex-preacher said it was "analogous to having Adolf Hitler come before the British Parliament."

Rep. Burton has warned against cutting military budgets during the Cold War, vehemently opposes abortion and supports the death penalty.

Spreading the word

And he's equally committed to proselytizing the word of the insurance industry on Capitol Hill.

An ultimately unsuccessful push for a banking reform bill last year gave him a chance to do just that.

Several proposed bills in the House and Senate would have taken away some of the exemptions from antitrust law that insurers now enjoy under the McCarran-Ferguson Act and would have broadened the authority of banks to sell insurance.

This did not sit well with Rep. Burton, to put it mildly. He says he "fought that hammer and tongs," because as an agent, he had seen first-hand how mortgage lenders could pressure insurance buyers.

When banking interests argue that safeguards exist to prevent conflicts of interest, Mr. Burton gets personal. He recounts how he lost several clients in the 1970s when the banks they applied to for loans hinted that the loans would be easier to secure if the clients transferred their insurance coverage to the bank.

"I go to the floor and tell them what happens, give specific cases that happened to me," Mr. Burton said. "I try to inform congressmen of the problems raised by such legislation."

As chairman of a caucus of members with insurance backgrounds, he is tapped by fellow legislators for his expertise during debates on insurance-related bills. The caucus also stays close to proposed legislation and other insurance-related issues by working with trade associations.

Insurance industry lobbyists do a good job of educating members in how the business really works, he said. But because many in Congress don't understand the esoteric business of insurance, the atmosphere on the Hill is "mixed" on insurance issues, he said.

Although he retains his broker's license, House ethics rules prevent Mr. Burton from having any direct dealing with the insurance agency he established in Indianapolis in 1968. His wife, Barbara, still runs the bond division of The Burton Agency; another local agency handles the casualty and life business for a commission split.

Mr. Burton is not the only erstwhile agent in the halls of Congress. There's also Sen. Jake Garn, R-Utah, the ranking Republican on the Senate Banking, Housing and Urban Affairs Committee.

In the House, former agents include Rep. John Tanner, D-Tenn.; Rep. Gerald Solomon, R-N.Y., the ranking Republican on the House Rules Committee; and freshman Rep. Bill Barrett, R-Neb.

But it is Rep. Burton's outspokenness that has given him a relatively high profile in Congress.

From his seat on the very visible House Foreign Affairs Committee, he has championed—with varying degrees of success—issues dear to the hearts of those on the right. For years, he backed aid to the Contra rebels in Nicaragua, opposed sanctions against South Africa and urged active opposition to Soviet expansion.

He's also known for his golfing prowess, having taken a few congressional championships from Rep. Marty Russo, D-Ill., the Democrats' best.

And he's a crowd pleaser in suburban Indianapolis. Rep. Burton has been re-elected three times by comfortable margins: He won 63% of the vote in 1990.

Working his way up

In both insurance and politics, Rep. Burton worked his way up from the bottom.

While in high school, he landed a job as a file clerk at State Automobile Mutual Insurance Co. in Indianapolis. After a year at Indiana University, then working as a preacher and serving a year in the Army, he went to work for Continental Casualty Co. in Cincinnati as an underwriter.

He later worked as a special agent for Phoenix Mutual Life Insurance Co. and in the same capacity for New Amsterdam Insurance Co. in Indianapolis.

Mr. Burton went on to work four years as a junior partner with Cleveland Smith Agency in Indianapolis before leaving to start his own agency in 1968.

For years, his dual careers in insurance and politics overlapped.

In the early days of his agency, his wife, Barbara, worked days as a secretary, then at night handled the agency's billing and paperwork that Rep. Burton's couldn't accomplish because of his political schedule as an Indiana legislator. She later received her agent's license and started to work full-time for the agency.

Political training ground

"A hearty, bluff backslapper, he made his way up selling insurance," The Almanac of American Politics has written of Rep. Burton.

In fact, those years spent selling insurance and real estate were the perfect training ground for politics, he said.

"I had to go out and sell individual policies," Mr. Burton recalled. "The more I worked, the more I sold. So (an insurance agent) is the perfect example of how the free enterprise system works."

For Rep. Burton, as for others of his political stripe, 1964 proved a watershed.

That was the year he saw Norman Thomas, former head of the American Socialist Party, on television. Americans would never accept socialism from the Socialist Party, but they would support the same ideologies under the guise of liberalism, said Mr. Thomas, who went on to predict a "socialist victory" by 1970.

"I was an independent thinker at the time," recalls Rep. Burton, "and I thought, my gosh, if that guy's right, I don't want anything to do with it."

Poring over the Congressional Record at his local library convinced him that the United States was, in fact, headed toward a social-welfare state. "I became concerned with government intrusion in the private sector," especially on issues like taxes, insurance regulation and other government mandates, he said. "I wanted to get involved to change things."

Thus galvanized, he joined the Young Republicans and worked for Barry Goldwater's presidential campaign in 1964. Two years later, he was running his own campaign for state legislator.

He ran for the Indiana House of Representatives and won, serving from 1967-1968, and then the Indiana Senate, from 1969-1970. In both 1970 and 1972, he unsuccessfully sought the U.S. House seat he now holds.

Rep. Burton finally won a U.S. House seat on his third try in 1982, and has been re-elected ever since.

It's been an eventful 10 years. During that time, the Berlin Wall fell and the Soviet Union, Ronald Reagan's one-time "Evil Empire," crumbled into a collection of states struggling for democracy.

Rep. Burton feels he played a small part in such world events. "Those of us who were outspoken on the floor played a role, too," he said. "You don't win battles by being a wallflower."

Some of his positions have provoked charges of extremism. Rep. Burton, for instance, is on record as supporting mandatory, universal AIDS testing.

Even his opponents, however, give him high marks for integrity. He's never taken a position that he didn't personally believe in, said Rep. Andrew Jacobs Jr., the Indiana Democrat whose congressional district abuts Rep. Burton's. "When he says something, he really means it."

Their relationship got off to an inauspicious start: Rep. Jacobs defeated Rep. Burton in the 1970 race. But today they're friends. "We're the kind of friends who can disagree very strongly on things, but go the other way by kidding each other about it," said Rep. Jacobs.

Rep. Burton faces re-election this year. Although the strong Republican alliances in his district seem to indicate that he's a shoo-in, he's still gearing up for a hard race. "In politics, you never take anything for granted," he said.

If he does lose his seat in Congress, Rep. Burton probably will go back to being an insurance agent. But he'll continue to stay active in government "because I feel so strongly that government is out of control." ■

Agent/Broker Topics

Agency accepted illegal payments: Regulators

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

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

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

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

According to the suit, the illegal payments to the agency include:

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

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

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

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

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

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

Calls seeking comment from Mayer & Meyer were not returned.

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

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

The investigation should be completed sometime this month.

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

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

—By Sara J. Harty

APRIL — **Consulting Services**

Issue: April 6
Ad Closing: March 24

In a competitive market agents are forced to look beyond the typical placement of insurance for their revenue. *BI's Agent/Broker Topics* section will look at the alternative fee based services agents are turning to. What services are agents providing for their clients? How do agents search out these non-traditional markets? How receptive are their clients? Are agents successfully increasing their revenues by offering consulting services?

MAY — **Mergers/Acquisitions/Divestitures**

Issue: May 4
Ad Closing: April 22

Reality: there are fewer agencies today than 5 years ago; smaller agencies had trouble surviving as larger competitors gobbled them up, and in the throws of recession the numbers are dwindling still. *BI's Agent/Broker Topics* section will look at what small to medium-sized agencies can do to hang on ... merge with similar sized agencies, buy books of business handled by smaller firms, groom themselves for acquisition by a bigger operation. Editors will examine how agencies can improve their financial management in a sluggish market.

JUNE — **Legislative Issues; NAIB Report**

Issue: June 1
Ad Closing: May 19

The role of lobbyists and political action committees take on new importance during an election year. *BI's Agent/Broker Topics* section will look at the role insurance lobbyists and PACs will be playing in this year's campaign. Are legislators shunning insurance PAC money for fear of being branded as a tool of big business? In addition, editors will report on developments from the National Association of Insurance Brokers meeting in Pebble Beach, California.

Agent/Broker Topics

Agent/Broker Topics is a monthly demographic section published within the pages of *Business Insurance*, and sent exclusively to *BI*'s agent/broker subscribers. Advertisers in *Agent/Broker Topics* are positioned within an unparalleled editorial environment and reach an undiluted audience representing a wealth of purchasing power for insurance products and services. With an average premium volume of $14.91* million, 94%* of these influential readers take action as a direct result of the articles or advertisements they read in *Business Insurance*.

* An Audience Profile of the Business Insurance 'Agent/Broker' Subscriber, 1990.

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Robert P. Ashlock, Assurex president, is dead at age 55

By LAURA MAZZUCA

COLUMBUS, Ohio—Robert P. Ashlock, president and chief executive officer of Assurex International Corp., died Jan. 27 after a three-year battle with cancer. He was 55.

Mr. Ashlock created a number of innovative programs during his tenure as the head of Assurex, an insurance and financial services organization owned by 64 independent agencies and based in Columbus, Ohio. His initiatives included an offshore captive for agent and brokers errors and omissions coverage and assistance with perpetuation plans (*A/BT*, July 3, 1989).

Mr. Ashlock

His most recent concept, the Assurex Marketing Group, develops and markets national coverages for environmental and other hard-to-place risks.

Mr. Ashlock joined Assurex International in 1977 as executive vp and became president in 1984.

Before joining Assurex, he was a vp of R.E. Harrington Inc., a firm that specializes in claims administration for companies that self-insure workers compensation as well as accident and health exposures. Earlier, he worked in strategic planning and business development for Xerox Corp.

"Bob really constantly demonstrated the entrepreneurial spirit that was needed in the last 10 or 15 years to sustain the growth of our national organization," said Keith A. Pierce, president of The McElroy-Minister Co., an agency in Columbus, Ohio, and an Assurex partner. "He never stopped coming up with ideas."

Mr. Pierce, who is also Assurex's chairman of the board for 1992 and who had worked closely with Mr. Ashlock for more than 10 years, lauded his dedication to Assurex. Under Mr. Ashlock's leadership, Assurex grew from "a trade association to a worldwide marketing source" with partners in 37 states as well as Canada and seven other countries.

An Assurex spokeswoman said a search is now under way for a replacement, and a new CEO probably would be named by June.

Mr. Ashlock is survived by his wife and two daughters. ■

Lobbyists oppose taxing earnings from annuities, loans against COLIs

By LAURA MAZZUCA

Independent agent and life insurer trade groups are opposing a Bush administration proposal to eliminate favorable tax treatment of annuities and loans against corporate-owned life insurance policies.

Lobbyists for life insurance companies claim that the provision would severely strain insurers and independent agents, which have relied on the sale of annuities to bolster their business during the soft market.

Currently, the earnings on annuities are tax-deferred. When annuities mature, investors can choose from several payout options.

Because annuities provide this tax benefit, the administration contends some people buy them for "tax avoidance." The administration proposes eliminating the tax deferral on earnings on annuities sold to most individual investors.

The administration also proposes ending the favorable tax treatment of corporate-owned life insurance policies.

COLIs are life insurance policies bought by employers—and payable to the employer—as corporate investments. Companies can borrow against the cash value of these policies to fund benefit programs and can deduct the interest paid on those loans.

The Treasury Department, though, favors barring these deductions.

One group actively lobbying against this proposal is the powerful National Assn. of Life Underwriters.

The group contends that removing the tax incentives to owning annuities would undermine long-term savings, unfairly burden life insurers and weaken the insurance industry, resulting in job losses and shrinking capital when the country can least afford it.

In addition, Treasury's COLI proposal would be retroactive—taxing both new and old insurance policies—which transgresses "basic principles of fairness," NALU contends.

For almost 15 years, the Treasury Department has discussed taxing annuities as a way to raise revenue, commented Robert A. Rusbuldt, director of federal affairs for the Independent Insurance Agents of America. But increasing pressures to trim the budget deficit are what probably spurred the current proposal, he added.

Annuities have become a big moneymaker for independent agents in recent years.

"Annuities are a very popular product," Mr. Rusbuldt said. "Independent insurance agents have been getting into the life business more and more over the last 10 years; the increase is being driven by marketplace changes."

Many agents are aware that the tax benefits could be revoked, he said. While he doesn't know if the threat has made a difference in the actual sales of annuities, "I'm sure there are some agents who are using this for a selling advantage—and they should," Mr. Rusbuldt added.

Despite the tax proposal's effectiveness as a short-term sales pitch, insurance agent trade groups uniformly oppose it. The IIAA has actively lobbied against the proposal, while the National Assn. of Professional Insurance Agents says it supports the life underwriters trade group in its opposition to the proposal.

That pressure is already starting to pay off, say some insurance lobbyists. They note that the Treasury Department pushed back the Feb. 1 effective date of its proposal, stating that the provision would instead apply to all new annuity contracts entered into after the proposal becomes law.

Insurance lobbyists predict that the tax proposal will not stand.

Both the revised Republican and Democrat versions of the House tax bill have eliminated the annuities taxation proposal. And, while "anything can happen" in Congress, lobbyists hope that settles the issue, said Gary Hughes, chief counsel of securities and banking for the American Council of Life Insurance in Washington, D.C.

No bill has emerged yet in the Senate, but "we're working very hard to make sure" that the annuity tax proposal is not included in the final version, said a NALU spokesman. ■

Electronic work comp records offered

A/BT products & services

More than 6 million workers compensation records in 15 states are available through an electronic data base offered by the National Assn. of Professional Insurance Agents and DAC Services Inc.

The data base gives agents access to detailed medical and claim records from 15 state workers compensation bureaus. By using the data base, agents can assist policyholders by cross-checking an job applicant's claims history. Using such information can help agents improve their own loss ratios and save their clients money in workers comp premiums.

Agents can help employers make accurate insuring and hiring decisions if the screening reveals previous workers comp claims, the PIA says. The DAC data base also helps agents detect fraud by uncovering patterns of illicit claims.

DAC, which is based in Tulsa, Okla., has been offering this data base to commercial transportation companies and other firms since 1989 (*BI*, Sept. 11, 1989).

Reports are available for Arkansas, Colorado, Florida, Illinois, Indiana, Iowa, Kansas, Maine, Maryland, Michigan, North Dakota, Nebraska, New Mexico, Ohio and Oregon.

Reports cost $4 per computer search and $5 per phone report. DAC provides free software to use the data base.

The workers comp service is one of four new underwriting information programs the PIA offers its members through DAC. The other services allow agents to uncover multiple licenses for commercial drivers; track down unpaid bills by locating missing policyholders; and run credit checks on clients.

The multiple license data base for commercial drivers enables agents to discover if a driver has hidden violations by obtaining licenses from several states. The cost of the service is $3 per extra license found.

And, agents can verify credit records using a DAC data base that accesses financial and public records of more than 170 million consumers. Reports cost $3

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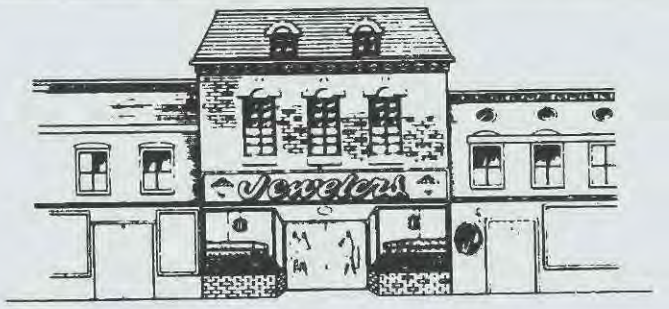

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For more information, contact DAC Services, 4110 S. 100th East Ave., Suite 200, Tulsa, Okla. 74146; 1-800-331-9175. PIA members also can call PIA services at 1-800-742-6900.

Agency management

"Keys to Profitability: Successful Agency Management" is a collection of articles compiled by consultant Russell Miller Inc. that cover most aspects of managing agency operations.

Topics include marketing, managing sales and producer performance, producer compensation, perpetuation, managing client service and administration and accounting.

The compilation is available for $25 per copy. Send payment with complete mailing information to: "Successful Agency Management," Russell Miller Inc., 300 Montgomery St., San Francisco, Calif. 94104, or call the marketing department at 415-956-7474.

Homeowners program

Aetna Life & Casualty has introduced a new compensation program for homeowners policies produced by independent agents.

The program features a 20% commission for all agencies; guaranteed quarterly bonuses based on quarterly gross written premiums for Aetna's homeowners, valuable items, dwelling fire and pleasure boat categories; an annual year-end bonus based on the agency's homeowners net policy growth; and an additional 1% annual bonus for agencies that process 60% of their homeowners transactions through computer interface with Aetna.

For more information, contact Mary DiLeo of Aetna at 203-273-7973.

New CU info system

Commercial Union Insurance Cos. of Boston recently introduced an automated phone system for its agents that gives them immediate access to billing information for personal lines customers.

By entering information with the telephone keypad through a menu of options, agents can have immediate access to specifics like a client's last payment credited, the outstanding balance and the next amount due.

In a preliminary test of the system, CU agents in New England made more than 3,000 calls to the system, known as Telematic. More than 90% of these inquiries were handled by automation; less than 10% required a service representative.

Although Tele-matic is currently available only for personal lines accounts, the insurer is planning to offer it for commercial lines accounts in the near future.

For information, contact Stephen Kyle at 617-725-6364.

High-value yacht cover

CIGNA Corp. last month announced a new "Executive Yacht Program," designed exclusively for yachts valued in excess of $2 million and more than 65 feet long.

The program broadens the standard limits of yacht policies to reflect the insurance needs of larger vessels.

In addition to the hull limits purchased, the policy includes $10,000 in medical payments coverage; $100,000 in personal property coverage; $10,000 in towing limits; captain and crew liability coverage with the same limit as liability coverage (for example, if the policyholder chose liabilities of $1 million, captain and crew liability would be $1 million); uninsured boaters coverage, with limits of up to $1 million.

For more information on the new yacht program, contact your local CIGNA yacht agent or James M. Beattie at CIGNA at 215-761-4745.

Agents IRA program

Independent insurance agencies and their employees can earn a guaranteed minimum interest rate of 7.85% by investing in the Independent Insurance Agents of America's individual retirement account program.

Participants may invest up to $2,000 per year, either in a lump sum or in minimum deposits of $100. All contributions are invested in intermediate- to long-range fixed-income securities.

There are no startup costs, loads, commissions, fees or service charges, and no surrender fees if participants terminate or transfer the account.

The program is administered by the Assn. of Insurance Administrators Inc., and contributions and interest are guaranteed against loss by Connecticut General Life Insurance Co., a subsidiary of CIGNA Corp.

For more information on the IIAA's IRA program, contact Laura Conway at 800-221-7917.

Tips on life sales

A new book from the Life Insurance Marketing & Research Assn. is designed to help insurance agents generate new business leads.

"New Prospects! 50 Ways to Find and Approach Them" was written in response to a recent LIMRA study indicating that poor prospecting skills are a prime reason for the failure of terminated agents.

Consumer studies have found that the proportion of life insurance buyers has changed dramatically, with a significant drop in the number of first-time buyers. Among the ideas presented in the book are tips for identifying prospects among small business owners; ways to enhance telephone prospecting; pointers for prospecting by mail; and ways to prepare for the prospect interview.

Copies of the book are available from LIMRA for $7 each. Contact LIMRA's Customer Service Unit at 800-235-4672; Connecticut residents and callers outside the contiguous United States should call 203-677-0033. ■

House to consider customer list amortization

WASHINGTON—The House Ways and Means Committee is now considering a measure that would allow agencies to continue amortizing customer lists when they acquire other agencies.

The measure, part of a much broader tax package, comes in direct response to recent Internal Revenue Service denials of agent deductions for customer lists, say insurance lobbyists.

Insurance agent and broker groups have been lobbying Rep. Daniel Rostenkowski, D.-Ill., the Ways and Means chairman, to include a depreciation measure in a tax package.

The measure now being considered would set a uniform 14-year depreciation schedule for all intangible assets, and allow good will, which cannot ordinarily be depreciated, to be included in agency valuations.

At 14 years, the schedule is twice as long as the one used now. But the measure is valuable because it would guarantee the deductions and let agents include good will in the calculations, said Daniel J. Blum, president of the National Assn. of Professional Insurance Agents in Alexandria, Va.

A House vote on the proposed plan is expected shortly.

New IIAA program

ALEXANDRIA, Va.—After seeing its membership shrink by about 2% in 1991, the Independent Insurance Agents of America has launched a member-retention program.

The program, dubbed "Rich in Tradition, Right for Today," provides new members with quarterly information materials, including a history of the IIAA, a catalog of products and services, a membership survey and information on conventions and meetings.

New ACORD system

WHITE PLAINS, N.Y.—A new program from ACORD Corp., the insurance industry automation standards organization, has changed the way its claims forms are distributed to agencies.

Agents and brokers now must subscribe to one of two ACORD programs to obtain ACORD forms from the Insurance Services Organization Inc. The program, implemented Jan. 1, will not affect ISO products and services forms.

A forms-only subscription is $50 per year, including a reference guide to the forms. The ACORD Agency Subscriber Program is $75 per year.

In addition to the forms and reference guide, subscribers to the latter program will receive discounts on software including the 1992 Benchmark Calculator software, which enables agents to track financial and productivity performance against that of other agencies.

And subscribers also will receive "More Mail for Your Money," a postal efficiency guide; the "IN ACORD" newsletter; and updates on downloading and new technology.

For more information about the program, contact ACCORD Executive Vp Gregory A. Maciag at 800-444-3341, ext. 400. ■

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Business Insurance

Managed care

Continued from page 2

portant tool for corporate America to control rising health care costs," said Kathryn J. McIntyre, publisher/editorial director of *Business Insurance* and conference chairwoman.

"We are co-sponsoring this conference to help employers and those who provide managed care services to capitalize on the cost savings that these programs can offer," she said.

Panel discussions will get under way Monday morning when three experts will discuss current models of managed care, trends that are changing managed care and the next generation of managed care. The panelists will be Dr. Roger S. Taylor, national leader of health care at The Wyatt Co. in Washington, D.C.; Charles Jacobs, president of InterQual Inc., a medical consulting firm in Marlboro, Mass.; and Warren L. Moser, president of Advanced Benefit Concepts, a consulting firm in Pasadena, Md.

New approaches to containing health care costs will be addressed by John. J. Hague, corporate director of benefits for Campbell Soup Co. of Camden, N.J., and Jim Norton, a managing consultant with A. Foster Higgins & Co. Inc. of New York.

The final Monday morning session will offer advice on direct contracting with health care providers, including customizing plan design and leasing existing managed care networks. Speakers include Leesa J. Key, a partner with Coopers & Lybrand in Chicago, and Paul McAuliffe, director of compensation and benefits for Becton, Dickinson & Co., a health care products firm in Franklin Lakes, N.J.

William E. Caulfield, senior vp-group benefit operations for John Hancock Mutual Life Insurance Co. in Boston, will speak at the Monday lunch.

Preventive care will be the focus of the first panel discussion on Monday afternoon, with a discussion of financial incentives to promote healthy behavior, successful wellness programs and effective employee communications. The speakers are Lynn Gilfillan, community wellness development coordinator for Coors Brewing Co. in Golden, Colo.; John Moses, a consultant with Hewitt Associates in Lincolnshire, Ill.; and Sonia Muchnick-Baku, director of the National Resource Center on Worksite Health Promotion for the Washington Business Group on Health, an employer coalition in Washington, D.C.

Two concurrent sessions are offered later Monday afternoon. "The Top Risk Management Issue of the 1990s: Workers Compensation" will examine how to apply managed care techniques to containing workers comp costs. Speakers include David Figurelli, treasurer for Estar Inc., a holding company in New Haven, Conn.; and Douglas Rinaldi, risk manager for the city of Waterbury, Conn.

"Flexible Benefits: Have They Proven Effective in Containing Health Care Costs?" is the subject of the other concurrent session. John Hickey, a partner with consultant Kwasha Lipton of Fort Lee, N.J., and Andrea L. Schutz, vp and director of human resources for Educational Testing Services of Princeton, N.J., will address this topic.

The final session of the day will offer advice on managing mental health and substance abuse benefits while improving quality and containing costs. Donald Longnecker, manager of finance and planning-health care group insurance at Chrysler Corp. in Highland Park, Mich., will discuss how Chrysler succeeded in integrating its managed mental health program with its employee assistance program. David McDonnell, president and chief executive officer of Preferred Health Care, a managed care company in Wilton, Conn., also will speak. Sara Bilik, vp of marketing for Preferred Health Care, will moderate the session.

Registrants may attend a cocktail reception Monday evening.

At the top of Tuesday's schedule is a working breakfast that will offer employers advice for cost-effective mental health and substance abuse plan design as well as vendor selection, management and evaluation. Ms. Bilik of Preferred Health Care and David Stone, corporate vp of marketing for Preferred Health Care, will address the topics, followed by remarks from the conference chairwoman, Ms. McIntyre.

Kicking off the day's sessions is a panel entitled "Health Care Reform: What Is on the Horizon?" moderated by Jerry Geisel, *BI*'s editor-at-large in Washington. Panel members include Dr. William Custer, research director for the Employee Benefit Research Institute in Washington; Ellen Goldstein, director of health policy and communications for the Assn. for Private Pension & Welfare Plans in Washington; and Frank McArdle, partner and research consultant with Hewitt Associates in Washington.

Techniques for monitoring a provider's quality of care and other topics will be discussed in the next session by John George, executive vp of InterGroup Services Corp., a PPO based in Pittsburgh, and Donna Lynne, first deputy commissioner for the city of New York's Office of Labor Relations. Joseph Metz, director of governmental legal services for Buck Consultants Inc. of New York, will moderate.

An update on developments in health maintenance and preferred provider organizations, including information on exclusive provider organizations and open-ended HMOs, will be offered by Art Drechsler, vp at Martin E. Segal Co. of New York, and Larry Goelman, president and CEO of Cost Care Inc., a Huntington Beach, Calif.-based unit of John Hancock.

The Tuesday luncheon speaker will be Gerry Goodrich, deputy commissioner of health for the state of New Jersey.

Two concurrent sessions are offered Tuesday afternoon.

"Efficient and Cost-Effective Uses of Technology in Managing Health Care Costs" will provide advice on evaluating the claims process and monitoring physician costs. Jack Romeo, director of health care systems for Bethlehem Steel Corp. of Bethlehem, Pa., and Dr. David Rullo, medical director for Health Payment Review, a claims administration firm in Boston, are scheduled to speak.

"Understanding and Implementing FAS 106" is the subject of the second concurrent session, which features Lee Launer, partner with Coopers & Lybrand in New York, and Neela K. Ranade, vp-welfare benefits consulting for Actuarial Sciences Associates, a subsidiary of American Telephone & Telegraph Co. in Piscataway, N.J.

The conference will conclude with a session concerning health care coalitions and how employers have banded together to reach common goals. Debra Hubers, director of marketing for The Alliance, a health care purchasing coalition in Denver, and Dorothee Maynard, president of the Good Neighbor Alliance in Cranston, R.I., are the scheduled speakers.

The conference will include a table-top exhibit area where publications will be displayed and software will be demonstrated.

Registrants can enclose payment along with completed registration forms, choosé to be billed or pay with the American Express card.

For registration information, including group registration, contact Theresa Amenta, The International Business Forum Inc., 50 Charles Lindbergh Blvd., Suite 400, Uniondale, Long Island, N.Y. 11553; 516-229-2375; fax: 516-229-2386.

For exhibit space reservations, contact Kim Mascolo of IBF at the same number. ■

Events slated for conference

NEW YORK—Several organizations are sponsoring events at the First Annual Health Care Management and Cost Containment Conference.

Coopers & Lybrand will sponsor a cocktail reception on Monday from 5:15 p.m. to 6:30 p.m.

John Hancock Financial Services is sponsoring Monday's luncheon featuring William E. Caulfield, senior vp-group benefit operations for John Hancock Mutual Life Insurance Co. of Boston.

Preferred Health Care of Wilton, Conn., is sponsoring a working continental breakfast Tuesday from 7:30 a.m. to 8:45 a.m.

COBRA provision

Continued from page 3

American Bankers Assn. in Washington, D.C., said that the bank trade association had not taken any position on the provision.

And, "in terms of the world at large, it's very focused," said Frank McArdle, a consultant in the Washington, D.C., office of Hewitt Associates.

The impact of the provision will be felt by relatively few employers, he said.

But, for banks like Barnett that expand through acquisition of failed banks, the COBRA provision definitely imposes new cost burdens that could affect the decision on whether to make an acquisition, Ms. Wooster said.

And, since Barnett self-funds its health care plan, "we can't pass the cost on to an insurance company," she added.

"We believe we'll have to calculate the cost impact and factor that into the bid" that Barnett makes to acquire any failed bank, Ms. Wooster said.

Like other employers, a major problem for banks is that the COBRA provision allowing employers to charge COBRA beneficiaries a premium of up to 102% of the employer's group rate is insufficient.

A survey of large Chicago-area employers last year indicated how large an additional financial burden COBRA imposes upon businesses, said Dennis J. Nirtaut, manager of employee benefits at Continental Bank Corp. in Chicago, which is not pursuing a strategy of growth through acquisition of failed institutions.

The Chicago-area employers reported that COBRA premiums covered only 47% of their claims cost, Mr. Nirtaut said.

And, that is not taking administrative costs into account, he said.

Regional bank holding company Wachovia Corp. in Winston-Salem, N.C., has not had to confront the new COBRA requirements yet, but experience indicates that they could prove to be "quite onerous," said Dennis Lee, manager-compensation and benefits.

Mr. Lee said that Wachovia "would have to charge 172% of the true premium to cover the liability" of COBRA beneficiaries in 1990.

However, benefits experts agreed that the successor bank does not necessarily have to offer the same benefits to COBRA beneficiaries that the failed bank offered.

"It need not offer the same plan unless it continues to offer it to active employees" of the acquired institution, said Foster Higgins' Mr. Saveth.

In many cases, offering the same plan would be impossible because the plan contracts signed by the failed bank would have already lapsed, Mr. Saveth explained.

"Obviously, it would not be in our best interests to interpret the legislation to imply that we would offer the same benefits" as the failed institution had offered, said Barnett Banks' Ms. Wooster. "Our preference would be to offer what we offer current employees." ■

Health conference names advisory board

NEW YORK—Members of the advisory board for the First Annual Health Care Management and Cost Containment Conference include:

- Kathryn J. McIntyre, publisher and editorial director of *Business Insurance* in Chicago, and conference chairwoman.
- Jacqueline C. Berkelhamer, executive director of the American Assn. of Preferred Provider Organizations in Chicago.
- William E. Caulfield, senior vp-group benefit operations for John Hancock Mutual Life Insurance Co. in Boston.
- William Custer, director of research for the Employee Benefit Research Institute in Washington, D.C.
- John Hickey, partner with benefit consultant Kwasha Lipton in Fort Lee, N.J.
- Dr. Anthony Masso, director of managed care and insurance products for the Health Insurance Assn. of America in Washington, D.C.
- Joseph Metz, director of governmental legal services at Buck Consultants Inc. in New York.
- Sonia Muchnick-Baku, director of the National Resource Center on Worksite Health Promotion for the Washington Business Group on Health in Washington, D.C.
- Louise Probst, president of The Alliance, a health care purchasing coalition in Denver.
- Glenn Shively, chairman-health care industry for Coopers & Lybrand in Philadelphia.
- Kenneth Sperling, consultant with Hewitt Associates in Rowayton, Conn.
- Dr. Roger S. Taylor, national leader-health care for The Wyatt Co. in Washington, D.C.
- Howard Weizmann, executive director of the Assn. of Private Pension & Welfare Plans in Washington, D.C. ■

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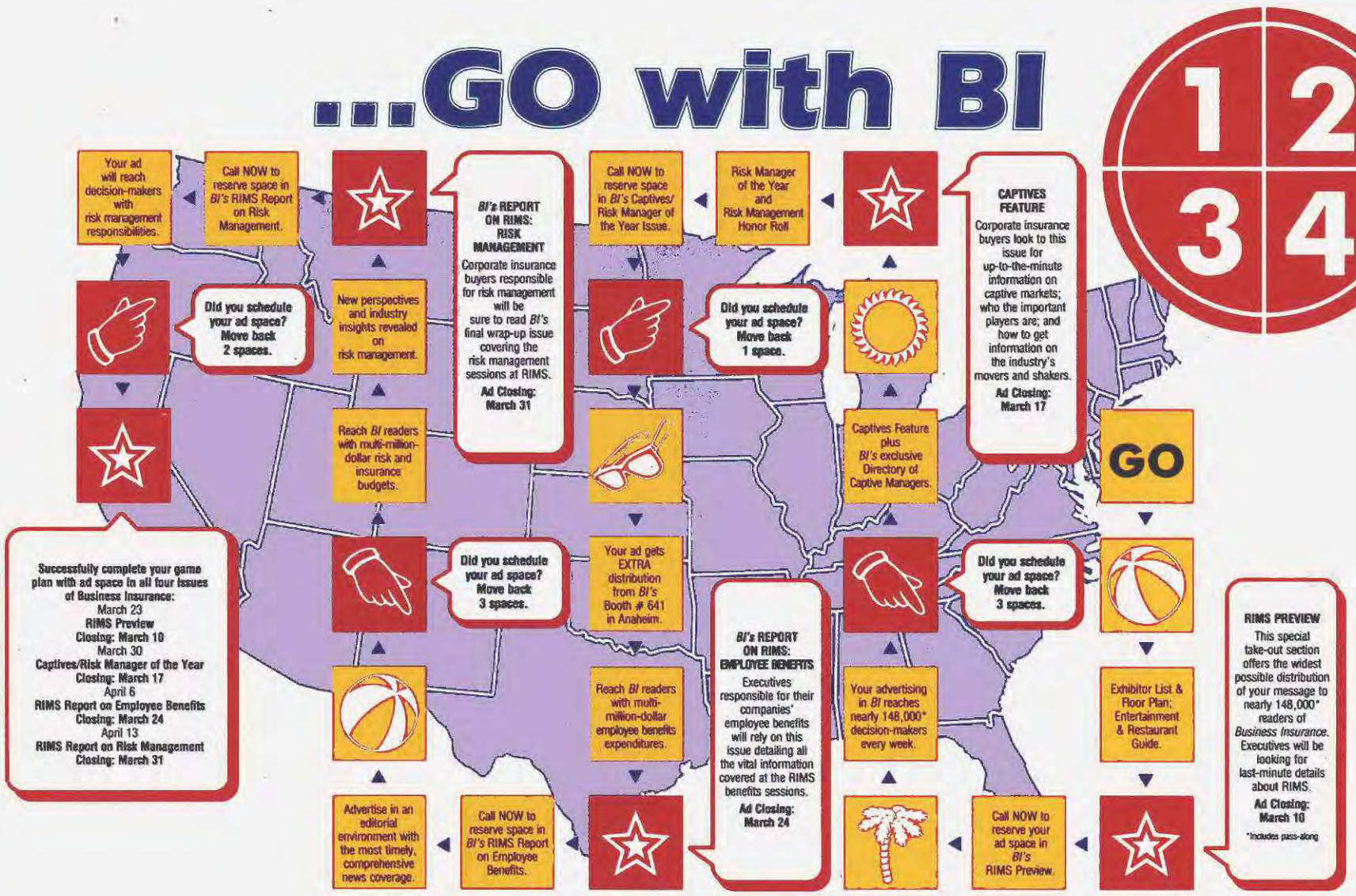

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Business Insurance
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Judicial reform on hold

Supreme Court changes stance on restrictions for punitive awards

By Richards D. Barger
and Royal F. Oakes

FOR A FEW YEARS the hopes of American businesses generally, and insurers particularly, were high. Between 1986 and 1990, the U.S. Supreme Court dropped several tantalizing hints suggesting that, if presented with the right case, the justices might restrict the availability of punitive damages on one or more constitutional grounds.

There was speculation that the high court would decide that a defendant is denied due process where a jury is given virtually unbridled discretion in awarding punitive damages that bear little resemblance to a plaintiff's actual damages. Later, the court said it would welcome the opportunity to decide whether punitive damages amount to "excessive fines" under the Constitution.

When the case of *Pacific Mutual Life Insurance Co. vs. Haslip* was accepted for hearing by the court, the insurance industry in America thought a shining moment of judicial rationality in America was at hand. The insurance industry was wrong.

Amazingly, in light of its several hints, the high court's March 1991 ruling in *Haslip* generally upheld not only the constitutionality, but the rationality of punitive damage awards, defending the state law safeguards that supposedly prevent jury excesses (*BI*, March 11, 1991). Only Justice Sandra Day O'Connor, in a blistering dissent, disagreed with the majority. Justice David Souter did not participate in the decision, since he did not join the high court until after oral arguments had been heard in the case.

In examining the background, nature and effect of the *Haslip* decision, it is interesting to direct our attention to the North, where a $60 million punitive damage award issued by an Alaska jury underscores the opportunity the insurance industry lost in letting *Haslip* slip away. That award also underscores what insurers face now that the high court has reduced the anti-punitives campaign from an attempt at a knockout punch to a whittling away at punitive damages statutes across the 50 states. As a result of this required shift in gears, the next decade may see little or no real progress in curbing the virtually unfettered use of punitive damages by civil juries in America.

The road culminating in *Haslip* was a long and bumpy one for insurers. Throughout the 1970s and 1980s, angry juries increasingly made headlines with multimillion-dollar punitive damage awards. It was a frenzy that fed on itself, as citizens who read more and more accounts of despicable corporate conduct being punished in a big way suddenly found themselves on juries, with the ability to fill out verdict forms that amounted to blank checks.

The trend toward sizable awards naturally led to calls by business and insurance groups for judicial reform, but each advance on these fronts was met with well-financed and carefully orchestrated counterattacks by trial lawyer groups and purported "consumer" organizations. These groups were unsympathetic to evidence that punitive damages have never been demonstrated to have a significant deterrent effect on irresponsible corporate conduct, whereas the price increases payable by all consumers as a result of increased legal costs and punitive damages are easily documented.

When Pacific Mutual's petition for certiorari was accepted by the Supreme Court in the *Haslip* case, it seemed almost too good to be true. A quick check of the law books told insurers that in *Aetna vs. Lavoie*, a 1986 case, the Supreme Court had noted the due process issue, raising the possibility that a punitive damage award against an insurance company would be struck down because it bore no rational relationship to the insured party's actual damages. The high court refused to tackle the issue, however, instead disposing of the case on the grounds that a state court judge had improperly failed to disqualify himself from the matter.

Two years later, in *Bankers Life & Casualty vs. Crenshaw*, the Supreme Court again had the opportunity to address the due process issue, but refused to do so on the ground that the insurance company had failed to properly raise the argument in lower courts.

Finally, in the 1989 case of *Browning-Ferris Industries of Vermont Inc. vs. Kelco Disposal Inc.*, the court—in spite of its rejection of the argument that punitive damages violate the "excessive fines" clause of the Eighth Amendment—unanimously expressed concern regarding the question of whether punitive damages violate the Constitution's due process clause (*BI*, July 3, 1989). Apparently, something happened over the next two years to alleviate that concern, because the court overwhelmingly joined in Justice Blackmun's opinion in *Haslip* that seemed to convey that *Aetna*, *Bankers Life*, and *Browning-Ferris Industries* had been the careless work product of a justice of the peace, not a long-running expression of concern at the highest judicial level over punitive damages.

When *Haslip* was accepted for hearing by the Supreme Court, the insurance industry thought a shining moment of judicial rationality was at hand. The insurance industry was wrong.

What was it about the *Haslip* case that mesmerized the high court into doing an apparent about-face on punitive damages?

By way of background, the case involved a group health insurance policy issued to a city by Pacific Mutual. After the company learned that one of its agents had pocketed the premiums paid by the city, Pacific Mutual canceled the policy.

One city employee, Cleopatra Haslip, was then denied coverage when she was hospitalized for kidney treatment, so she filed an action in the Alabama state court for breach of the implied covenant of good faith and fair dealing, better known as "bad faith." During the trial the jury was instructed that punitive damages could be awarded in an amount necessary to "punish" Pacific Mutual. The jury returned a verdict of approximately $1.1 million. Although the jury did not state what portion of the award represented punitive damages, as opposed to compensatory damages, for purposes of appeal all parties appeared to assume that the great majority of the award represented punitive damages.

Pacific Mutual appealed the verdict, the Alabama Supreme Court affirmed the award, and the U.S. Supreme Court agreed to hear the case.

During oral arguments, the justices gave the insurance industry one last reason for false hope. Justice O'Connor asked Ms. Haslip's attorney whether due process was satisfied "when a jury is told punitive damages are wholly within their discretion." Hearing the lawyer's affirmative response, Justice O'Connor pointedly remarked, "That's a very strange notion of what due process means."

Justice Antonin Scalia asked Ms. Haslip's lawyer, "Do you really think it's fair to call this a standard—telling a jury to make sure the punishment fits the crime?" Courtroom observers said Justice Scalia appeared unsatisfied with the lawyer's answer.

Regardless of body language and sharp words from the bench, five months later the Supreme Court rejected the challenges to punitive damages. The court's opinion focused on the safeguards provided by the jury instructions given to the Alabama jury, and by the appellate process in the state. For example, the court noted that the trial and appellate courts are free to alter a jury's award in light of several guiding principles, including:

- Whether a reasonable relationship exists between the punitive damages award and the harm likely to result from the defendant's conduct.
- The reprehensibility of the defendant's conduct, and the existence and frequency of similar past conduct.
- The profitability to the defendant of the wrongful conduct.
- The financial position of the defendant.

In a concurring opinion, Justice Scalia shied away from endorsing the notion that appropriate safeguards exist, and instead examined the issue from a historical viewpoint. Because "jury-assessed punitive damages are part of our living tradition that dates back prior to 1868," Justice Scalia argued, "I would end the suspense and categorically affirm their validity."

Justice O'Connor, in dissent, was impressed by neither the majority opinion nor Justice Scalia's concurring views. Discussing the jury instruction given by the trial court judge, she wrote:

"This instruction is as vague as any I can imagine. It speaks of discretion, but suggests *no* criteria on which to base the exercise of this discretion. Instead of reminding a jury that its decision must rest on a factual or legal predicate, the instruction suggested that the jury may do whatever it 'feels' like. It thus invites individual jurors to rely upon emotion, bias, and personal predilections of every sort."

Justice O'Connor also pointed out that the Alabama trial court judge told jurors in *Haslip* that "imposition of punitive damages is entirely discretionary with the jury."

In her dissent, Justice O'Connor went on to propose reforms that could minimize the harmful effects of punitive damages:

"For example, state legislatures could establish fixed monetary limits for awards of punitive damages for particular kinds of conduct. So long as the legislatively determined ranges are sufficiently narrow, they could function as meaningful constraints on jury discretion, while at the same time, permitting juries to render individualized verdicts. Another possibility. . .is that states could bifurcate trials into liability and punitive damage states."

Following its issuance of the *Haslip* opinion, the U.S. Supreme Court has directed that several cases pending on appeal be disposed of in light of the principles announced in *Haslip*. In addition, the court refused to hear two cases decided by the Alabama Supreme Court in 1989 involving insurance fraud claims: *Land & Associates Inc. vs. Simmons* and *Massachusetts Mutual Life Insurance Company vs. Collins*.

Haslip was not the only 1991 headline to spoil the day of the insurance industry. A state court jury in Anchorage, Alaska, issued the largest bad faith verdict against an insurance company in history, awarding $60 million to a restaurant owner who had been unable to collect on a fire insurance policy.

The Narrows vs. Lloyd's of London is a case involving a restaurant called "The Narrows" owned by Jeanne Lindley and her son Carson Lindley.

Continued on next page

What have we learned?

Managed care experience can be model for health care reform

By Mark H. Tabak

THE ISSUE of health care has become one of spiraling costs and dizzying figures. But rather than stare at the numbers, let's look instead at some valuable lessons drawn from the front lines of managed care.

In fact, these lessons may be applied in considering reforms of our national health care system. These lessons are the tools of the trade that have made a very real difference in the way health care is delivered to between 20% and 30% of Americans, depending on which measures are used. They form the foundation of a system of health care delivery that enables employers at private firms, as well as public institutions and labor unions, to restrain the rate of increase in the annual cost of providing health care coverage for their employees.

The lessons center on three critical issues: How do we limit health care cost increases? How do we ensure the delivery of quality care? And, how do we make it possible for all Americans to have access to care?

Managed care, by its very nature, provides a number of tools that facilitate the control of health care costs. Many of these tools can be readily applied to a national health care delivery system.

Managed care is defined as a process that organizes the efficient delivery of medical and medical support services to the patient on a planned basis. The key is that managed care provides a planned and, therefore, controllable approach, unlike the fee-for-service approach, which largely leaves the factors of cost and quality to chance.

At the foundation of managed care is a simple mathematical formula: Health care costs = cost per unit × total number of units. In our existing health care system, which is largely characterized by fee for service, every procedure is treated as one unit, and payment is made on a per-unit basis. By contrast, in managed care, both factors—cost per unit and the total number of units—are dealt with at the same time.

Therefore, lesson No. 1 is: Deal with the cost per unit and the total number of units together in order to better control health care costs. This approach enables the managed care provider to leverage volume and negotiate rates with physicians and hospitals.

There's little doubt in anyone's mind that our current system is out of control. Costs are escalating for a number of reasons, but one stands out above all others. Our current reward system is upside-down. The traditional fee-for-service system rewards physicians, hospitals, laboratories, right on down the line of health care providers, for performing the greatest number of services at the highest possible cost. In managed care, this lesson is applied: Reward physicians and hospitals for providing the most appropriate level of care that results in the desired outcome.

Mathematical formulas and reward systems make sense on paper and in practice when it comes to controlling costs. But there's a softer side to managed care that is essential to any health maintenance organization's ability to control costs—the management of relationships between payor and payee.

Managed care means managing relationships effectively with the best-quality providers. This isn't easy; it truly taxes the skills within the individual managed care organization. But the lesson here for national health care reform is that unless we treat health care as an entire process and forge effective working relationships with everyone who plays a role in the process, we cannot expect to control costs for the long haul. On a national basis, this may mean finding a way to bring the players closer together. Any solid health care system should be based on greater interdependence between those who provide the services and those who pay for them.

Closely interwoven with cost control measures is the issue of health care quality. By taking a close look first at the definition of quality health care, we can identify a number of tools that have contributed meaningfully to the delivery of quality health services in the managed care arena. When applied to national health care reform, the same quality control tools also can help to limit cost increases.

Quality in managed care can be defined as doing the right thing for the patient at precisely the right time—the first time around. What lessons have we learned in managed care that bring the most appropriate and timely service to the patient in the most efficient and effective manner? Seek out and contract with the best providers by specialty, then initiate an on-site assessment program using internal staff—not external consultants. Close monitoring of providers, as well as the system of rewarding those who provide accurate, efficient and effective treatment, is essential both to controlling health care costs and ensuring quality care.

If managed first for quality, costs will fall into line. How do we reform our national health care system to be certain that we have the best providers? Consider establishing provider networks on a market-by-market basis and monitor adherence to quality standards on a local level. "Quality," as defined earlier, is equal to "appropriateness."

An important issue at play here—namely technology—relates to both quality and cost. The advancement of medical technology has had a substantial impact on the quality of health care in our society—but at a price. In recent years, we've seen dramatic increases in the areas of cardiac testing, imaging methods and many other procedures and programs. However, the lesson we keep coming back to is this: More is not always better. Use technology when it makes sense, but avoid high-tech procedures when they have no proven value.

The technological developments in health care are, without question, phenomenal, and the treatments are a blessing for families and individuals who benefit from them. But somewhere down the road to our national health care reform, we must become more judicious in our use of high-tech procedures.

Utilization review is one method that is being used more and more to ensure the delivery of quality health care. Once a set of specific treatment methods and patterns of care is established, each case is reviewed to determine discernible outcomes. The process also includes pre-certification for hospital admission, a careful review at the conclusion of each stay and retrospective analysis.

In delivering quality care, a lesson

Continued on next page

Punitive damages

Continued from previous page

After the eatery burned down on May 28, 1989, Jeanne Lindley claimed, the insurance company representatives failed to investigate and pay her claim in good faith. The restaurant had been insured for $280,000, with a policy issued in 1988. Half of the risk was underwritten by Gotham Insurance Co., the other half by 25 Lloyd's underwriters, led by John Wetherell.

The Lindleys then sued Gotham and Lloyd's of London. After the trial court judge determined that the defendants were not complying with discovery responsibilities in good faith, he took the remarkable step of entering the defendants' default judgment, ordering payment of the full amount of the policy. He also convened a jury to decide the *size* of an appropriate punitive damages award—not whether such an award is appropriate, but its magnitude.

The jury felt that $60 million sounded about right, as that was the income *all* Lloyd's syndicates received, in the aggregate, on the average day. Never mind that basing an award on the annual income of all Lloyd's syndicates is a little like putting General Motors Corp. on trial and then basing an award against the company on the income of every company on the New York Stock Exchange. The Alaska trial court judge saw nothing out of line in this astounding display of muscle-flexing by a jury.

Something about the cold Alaska air may lead to excessive verdicts, as the Lloyd's case is not unique. Recently an Alaska woman recovered $18,000 in compensatory damages and $1.2 million in punitive damages when an insurance company denied her $10,000 claim. In *Weiford vs. State Farm Mutual Insurance Co.*, Linda Weiford submitted a claim to her insurer after an automobile crash. She demanded $10,000 in compensation for lost wages and medical expenses, but the insurer would pay only $5,000.

At her subsequent bad faith trial, her attorneys introduced evidence that State Farm's negotiation tactics in her case reflected a companywide "get tough" policy to reduce the size of claims paid. After mulling it over, the jury decided that a punitive damage award of $1.2 million was appropriate, as that was the sum State Farm allegedly expected to save as a result of its "get tough" policy.

The insurance industry seems doomed, at least for the remainder of the millenium, to fighting the punitive damages battle on a case-by-case, legislature-by-legislature basis, as opposed to obtaining some sort of overall relief from the U.S. Supreme Court. One observer has a fascinating theory as to why the high court refuses to bite the bullet on issues that seem to cry out for simple, fair solutions.

In a recent issue of the University of Pittsburgh Law Review, the late Paul Bator—in an article entitled "What Is Wrong With The Supreme Court?"—argued that members of the court "seem to be in love with the promulgation of complex and open-ended formulas, formulas equipped with a multiplicity of three-part tests and five-pronged inquiries." He argued that the Supreme Court decisions often result in the fact that "instability, uncertainty and confusion are not alleviated, but rather reinforced." He wrote, "The more uncertainty and contradiction there are in the law, the greater the incentive to litigate, and the more new cases there will be."

The *Haslip* decision falls prey to this syndrome. In embracing multiple checklists, warnings given to juries, and multifaceted post-trial tests for ferreting out abuses of the jury's discretion, the high court has subjected insurers to a continued nightmare of expensive uncertainty and irrational jury awards.

In failing to score its knockout punch against punitive damages, the insurance industry has for the time being lost the battle over whether the power of the jury to "punish" vests too much discretion in jurors. ■

Richards D. Barger is senior partner of the Los Angeles law firm of Barger & Wolen. He has served as California insurance commissioner and as president of the National Assn. of Insurance Commissioners. Royal F. Oakes is a partner at Barger & Wolen. Both specialize in insurance matters.

A capital-raising solution

Surety bonds emerge as tool for raising cash

By Michael L. Stoll

AVAILABLE FUNDS ARE NOT easy to come by these days. Instead of increasing to meet demand, loans to U.S. businesses by banks dropped $25 billion in 1991. Banks and conventional financial institutions are under such tight restraints that they cannot lend cash to capital-starved companies, even those with good credit ratings. Companies are cash poor, and the lack of lending sources is increasing.

But, what does this lack of funding have to do with risk managers? Superficially, raising necessary capital seems more like a problem for chief financial officers.

The answer is simple. At their fingertips, risk managers have a traditional insurance mechanism that can ease the company's pain of dwindling cash flow. It is the conventional surety bond—a financial obligation with payment guaranteed by a third party—and it's taking an unconventional twist. By using corporate assets as collateral for surety bonds, businesses can secure funding for necessary endeavors like expansion and renovation, and capital investments like plant and construction equipment.

To do this, a business forms a Special Purpose Company (SPC) to which the collateral is assigned. Surety companies then sell the SPC's collateral in the form of commercial paper—negotiable instruments by which businesses obtain cash. Because the issuance of commercial paper includes a payment guarantee by the surety company, the commercial paper is rated AAA and is therefore easily marketable.

Not all companies, however, fit the bill for this type of venture. Those that benefit most from obtaining financing through surety bonds are businesses that have highly marketable assets of at least $50 million. Among the list of most common assets middle-market companies use for collateral are consumer and trade receivables, certain unsecured obligations or prime income-producing properties.

The benefits of using surety bonds for financing, however, extend far beyond that of obtaining additional capital. Another—possibly more important—benefit today is the ability to borrow at rates substantially less than the prime lending rate.

Commercial banks have high overhead costs, which are passed on to the borrower in the form of higher interest rates. Because surety financing is not managed through the conventional commercial lending institutions, heavy administrative overhead costs are substantially reduced. More efficient use of resources translates into the borrower paying only a base rate plus the actual costs associated with the transaction, like the credit enhancement fee, the service fee, the bank liquidity fee and any intermediary fees.

But, how much is the interest rate reduced by going through an alternative lender? Based on the size of the loan, the savings can be quite significant. The interest on most loans is calculated using basis points, a method that fractionalizes interest points, thereby increasing accuracy. Most companies borrow from banks at 150 to 250 basis points over prime. Financing through securitization reduces this to as little as 100 to 150 basis points *below* prime. Considering that one basis point equals 0.01%, a loan for $100 million with a 100 basis-point difference can equal a $1 million reduction in financing costs.

Although financing through surety bonds need not be a difficult transaction, an intermediary experienced in using surety bonds for financing should be consulted at the outset. The borrower and the specialist then need to work together to determine which of the business's assets would be eligible for securitization. Usually, accounts receivable are the most desirable, because they are the highest grade of collateral among a business's assets and are a collateral common to almost every business. Additionally, there is an established, identified market for this type of commercial paper.

To protect investors from any possible misfortunes of the borrower, an SPC is formed and collateral from the borrower is sold to the SPC at cost. Because all dealings are with a trust that governs the SPC, investors are isolated from the balance sheet of the borrower. This protects the transaction from adverse financial results of the borrower and increases marketability of the commercial paper.

The underwriting process then determines the amount of debt that can be created using the company's accounts receivable as collateral. To determine the value, an underwriter evaluates the investment caliber, including the financial stability of the customers represented on the list. The historical write-off—or the percentage of uncollectible debt over the past five to 10 years—is determined at a worst-case scenario.

For instance, Company A's accounts receivable are worth $100 million. To properly assess the advance value, an underwriter assigns a worst-case scenario write-off of 10%. This then translates into a 90% advance value, or $90 million worth of funding proceeds for the borrower.

Once the underwriter's valuation has been assigned, $90 million of commercial paper may then be issued, collateralized by $100 million of Company A's accounts receivable. The obligation is guaranteed 100% by the specialized surety company—which specializes in providing surety bonds—allowing for easy marketability at the best rates.

The following example shows how the specialized surety companies work and how a transaction like this is carried out for a middle-market company:

A furniture retailer needed additional capital to finance a leveraged buyout. With about $300 million in debt, supported by only $10 million in equity, the firm already was highly leveraged. The company needed to reduce its cost of funds to stay viable.

A specialized surety company estimated the value of the furniture retailer's trade receivables to be approximately $100 million, making this asset a key component in the deal. To ensure easy marketability of the commercial paper, a Special Purpose Subsidiary was formed. The furniture retailer then systematically sold its receivables to the subsidiary.

The special purpose subsidiary then issued commercial paper backed by the newly purchased receivables. Because the specialized surety company guaranteed payment through the bond, the commercial paper was top-rated and it sold quickly. Without the guarantee, the paper could have been rated speculative grade, virtually eliminating the possibility of a market. When the deal closed, the company's financing cost was 200 basis points below comparable financing. The deal was conceived, structured and completed within 90 days.

Not all surety bonds, however, are collateralized by receivables. Another company chose to use existing and future loan notes, similar to mortgages, as collateral. A real estate management firm wanted to continue to lend money to a co-op corporation it managed, but without the personal credit obligations of signature loans. Instead of tying up its banking relationships and exposing its families' assets, the borrowers opted to obtain money from a third party, a surety underwriter.

The real estate management company transferred existing and future loan notes from the co-op corporation to an SPC, which used the notes as collateral to issue commercial paper.

Because the commercial paper was guaranteed by the surety company, it was rated AAA. The third-party loan not only relieved the borrower from personal credit obligations, but also reduced the financing rate and enabled it to expand the loan program.

Some other programs involving surety bond financing are the issuance of Eurodollar bonds secured by a pool of international commercial mortgages and the issuance of fixed-rate bonds secured by residential and commercial mortgages in Australia and Britain. These, however, are only a few examples of how surety bonds can be applied to fund capital for middle-market companies.

With the economic environment becoming even more market-driven, the uses for this type of financing are increasing rapidly. The growing demand for capital, and its prohibitive cost—coupled with restricted capacity—makes this insurance mechanism one of the most applicable today. ■

Michael L. Stoll is manager-special risk services for Hobbs Group, Inc., a wholly owned subsidiary of Arkwright Mutual Insurance Co. in Waltham, Mass.

Managed care solutions

Continued from previous page

learned from utilization review is: Information is power. When charges vary for a particular procedure with no discernible difference in outcome, ask questions. On a national basis, we should encourage the establishment of a clearinghouse to conduct a similar kind of review.

Effective information systems allow us to establish patterns of medical care and pick up discernible differences in outcomes. By utilizing similar information systems on a universal basis, we may be in a better position to manage limited resources.

When 35.7 million Americans are denied access to health care because they lack insurance, something is clearly wrong with the system.

But just as cost is a factor in quality, it also is the key factor in the access issue. While we ought to be able to say that access to certain types of health care is a fundamental right, we cannot consider a blank check for an unlimited amount of health care as a basic right. The economic pie is only so big, and an increase in one slice can only be made to the detriment of another slice.

Managed care deals with finite resources. On a daily basis, we remind ourselves of this lesson: Use limited resources to do the most good. Accept this reality and develop a system that maximizes existing resources by instituting more preventive health care programs.

Perhaps the most compelling lesson from managed care that will result in greater access to health care is the need to focus on preventive care. Over the years, we've learned that so many illnesses and a commensurate amount of health care services are lifestyle-related issues. On a national basis, we must look at heart disease, diabetes and so on from an early diagnosis point-of-view and intervene appropriately.

Consideration of each of these managed care lessons is vital to effective reform of our national health care system. But the greatest problem we face in health care reform today is the lack of consensus as to what we're trying to achieve. And there's no way we can measure our progress if we don't know where we're trying to go.

Therefore, we must set realistic and consensus-driven goals for health care reform before embarking on a program for change. All those in the health care arena and members of Congress should first consider what it is that we want to achieve when it comes to financing, paying and providing health care to Americans. Only then can we begin applying these lessons to the critical task of reforming our nation's health care system. ■

Mark H. Tabak is president and chief executive officer of Group Health Plan, a St. Louis-based health maintenance organization.

Datebook

MARCH

MARCH 9-10. Documenting Your Environmental Program: Preparing for and Surviving a Regulatory Inspection conference in Washington, D.C., sponsored by Executive Enterprises Inc.; $1,090. **Also April 6-7** in Los Angeles. Executive Enterprises Inc., 22 W. 21st St., New York, N.Y. 10010-6904; 800-831-8333; 212-645-7880.

MARCH 9-11. Accident Investigation seminar in Washington, D.C., sponsored by Loss Control Management Services; $855 for members; $950 for non-members. **Also April 7-9** in Cleveland. LCMS, 4546 Atlanta Highway, P.O. Box 1898, Loganville, Ga. 30249; 404-466-2208.

MARCH 9-11. Environmental Regulation Course in Philadelphia and Washington, D.C., sponsored by Executive Enterprises Inc.; $1,045. **Also March 16-18** in Las Vegas; **March 23-25** in Atlanta; **March 30-April 1** in Chicago; **April 6-8** in Virginia Beach, Va.; **April 7-9** in Detroit; **April 13-15** in Boston; **April 27-29** in St. Louis; Minneapolis; and Anchorage, Alaska. Executive Enterprises Inc., 22 W. 21st St., New York, N.Y. 10010-6904; 800-831-8333; 212-645-7880.

MARCH 9-13. Modern Safety Management seminar in Denver, sponsored by Loss Control Management Services; $990 for members; $1,100 for non-members. **Also March 23-27** in Los Angeles and Atlanta. LCMS, 4546 Atlanta Highway, P.O. Box 1898, Loganville, Ga. 30249; 404-466-2208.

MARCH 9-13. Risk Management seminar in Atlanta, sponsored by Loss Control Management Services; $1,080 for members; $1,200 for non-members. LCMS, 4546 Atlanta Highway, P.O. Box 1898, Loganville, Ga. 30249; 404-466-2208.

MARCH 10. Pay for Performance seminar in Nashville, Tenn., sponsored by the Society of Chartered Property & Casualty Underwriters and Agency Administration Section; $125 for section members; $145 for society members; $165 for non-members. Mari Stambaugh, Continuing Education Coordinator, The Society of CPCU, 720 Providence Road, P.O. Box 3009, Malvern, Pa. 19355; 215-251-2775.

MARCH 10. Human Resource Management System seminar in New York City, sponsored by Genesys Software Systems Inc.; no charge. **Also March 12** in Hartford, Conn.; **March 18** in Dallas; **March 19** in New Orleans. Jayna Smith, 508-685-5400, ext. 3080.

MARCH 10. Americans with Disabilities Act seminar in Anaheim, Calif., sponsored by the California Workers Compensation Institute; $195. **Also March 11** in Los Angeles; **March 16** in Millbrae, Calif.; **March 20** in Sacramento, Calif. CWCI, 120 Montgomery St., Suite 1300, San Francisco, Calif. 94104; 415-981-2107.

MARCH 10. Executive Briefing seminar in New York City, sponsored by Genesys Software Systems Inc.; no charge. **Also March 12** in Hartford, Conn.; **March 18** in Dallas; **March 19** in New Orleans. Jayna Smith, 508-685-5400, ext. 3080.

MARCH 10-11. Reasoning Reinsurance seminar in Dallas, sponsored by University of Dallas' Graduate School of Management; $675. Professor Bruce Evans, Executive Director, University of Dallas, Reinsurance Management Institute, Irving, Texas 75062; 214-721-5360; or Carla Aslakson, seminar coordinator, 214-721-5299.

MARCH 10-13. The 16th Annual Bermuda Insurance and Reinsurance Forum in Hamilton, Bermuda, sponsored by the Tillinghast division of Towers, Perrin, Forster & Crosby Inc.; $900; $800 for additional registrants from the same company. Eileen Callahan, Conference Director, Towers Perrin, 100 Summit Lake Drive, Valhalla, N.Y. 10595; 914-745-4611.

MARCH 11. Americans with Disabilities Act: Understanding it and Complying with its Intent seminar in Los Angeles, sponsored by NATLSCO; $100. **Also March 13** in San Francisco. NATLSCO, Michele Arger, 1 Kemper Drive, Long Grove, Ill. 60049; 800-323-9585.

MARCH 11. How to Evaluate and Improve an Employer's Workers Compensation Program seminar in Livonia, Mich., sponsored by Michigan State University; $265. **Also March 24** in Boca Raton, Fla.; **April 8** in Peabody, Mass.; **May 7** in Kalamazoo, Mich. Edward E. Anderson, Personnel Management Program Service, School of Labor and Industrial Relations, MSU, 422 S. Kedzie Hall, East Lansing, Mich. 48824-1032; 517-355-9591.

MARCH 11-13. Techniques of Risk Management seminar in Atlanta, sponsored by The Risk & Insurance Management Society, Inc.; $700 for RIMS members; $800 for non-members. **Also June 10-12** in Montreal. RIMS Education Department, 205 E. 42nd St., Suite 1504, New York, N.Y. 10017.

MARCH 11-13 Claims Management seminar in Atlanta, sponsored by The Risk & Insurance Management Society, Inc.; $700 for RIMS members; $800 for non-members. **Also June 10-12** in Seattle. RIMS Education Department, 205 E. 42nd St., Suite 1504, New York, N.Y. 10017.

MARCH 12. Small Business Solutions Workshop in Chicago, sponsored by the Illinois State Chamber of Commerce; $135 for members; $195 for non-members. The Illinois Chamber, 20 N. Wacker Drive, Suite 1960, Chicago, Ill. 60606-3083; 800-621-4220; 312-372-7373.

MARCH 12-13. Winning Workers Compensation Cases—For the Defense seminar in San Francisco, sponsored by SEAK Inc.; $375; group discounts are available. Geoffrey J. Shapiro, SEAK Inc., P.O. Box 3849, Berkeley, Calif. 94703; 510-547-3834.

MARCH 12-13. Annual Ratemaking Seminar in Dallas, sponsored by the Casualty Actuarial Society; $350 for CAS members; $450 for non-members. Kathy Spicer, CAS, 516-352-8453.

MARCH 12-13. Liability Claims Managers Conference in Atlanta, sponsored by the Liability Insurance Research Bureau; $150. Lisa Smith, LIRB, 1501 Woodfield Road, Suite 400 W, Schaumburg, Ill. 60173-4978; 708-330-8651.

MARCH 16-17. Managing the Workers Compensation Crisis: Effective Cost Reduction Strategies seminar in Chicago, sponsored by the American Management Assn.; $1,200 for members; $1,380 for non-members. **Also April 21-22** in Los Angeles; **May 28-29** in New York; **June 15-16** in Atlanta; **Sept. 14-15** in New York; **Sept. 21-22** in Los Angeles; **Oct. 29-30** in Chicago; **Nov. 16-17** in New York. AMA, P.O. Box 319, Saranac Lake, N.Y. 12983; 518-891-0065.

MARCH 17-18. Illinois Environmental Regulation seminar in Cleveland, sponsored by the Institute of Business Law at California State University; $795; some discounts available. **Also April 7-8** in Parsippany, N.J.; **May 13-14** in New York; **June 23-24** in Dallas. Department L-CH, Institute of Business Law, California State University, Los Angeles, P.O. Box 3488, Santa Monica, Calif. 90408; 213-450-0500.

MARCH 17-19. The Second International Emergency Management Exposition and Conference in San Francisco, sponsored by The Interface Group; $275 for full conference; $100 for single day attendance; $25 for exhibits only. The Interface Group, 300 First Ave., Needham, Mass. 02194-2722; 617-449-6600.

MARCH 18. Pollution Liability: The Law and Available Insurance seminar in South Portland, Maine, sponsored by the Society of Chartered Property & Casualty Underwriters and the Buffalo chapter; $60 for society members; $70 for non-members. Tricia Hogan, The Society of CPCU, 720 Providence Road, P.O. Box 3009, Malvern, Pa. 19355; 215-251-2773.

MARCH 18. Update on Capitol Hill—What's Hot—What's Not dinner in Hartford, Conn., sponsored by the Southern New England Chapter of the International Society of Certified Employee Benefit Specialists; $20 for members; $30 for non-members. **Also March 19** in Norwalk, Conn.; breakfast is $15 for members; $25 for non-members. Southern New England Chapter of the ISCEBS, Karen Semrow, 203-36-5420.

MARCH 18. Workers Compensation—The Legal View Workshop in Springfield, sponsored by the Illinois Chamber of Commerce; $135 for members; $195 for non-members. **Also March 25** in Chicago. The Illinois Chamber, 20 N. Wacker Drive, Suite 1960, Chicago, Ill. 60606-3083; 800-621-4220; 312-372-7373.

MARCH 18-19. Financial Reinsurance: The 1992 Update conference in New York City, sponsored by Executive Enterprises Inc.; $1,090. Executive Enterprises Inc., 22 W. 21st St., New York, N.Y. 10010-6904; 800-831-8333; 212-645-7880.

MARCH 18-20. Enrolled Actuaries Meeting in Washington, D.C., sponsored by the American Academy of Actuaries; $575. Convention Department, Enrolled Actuaries Meeting, 1720 I St. N.E., Seventh Floor, Washington, D.C. 20006; 202-223-8196.

MARCH 19. Leaking Underground Storage Tanks Seminar in Chicago, sponsored by the Chicago Chapter of the Chartered Property & Casualty Underwriters; $25. Chicago Chapter CPCU, Deb Heiden, Protection Mutual Insurance Co., 300 S. Northwest Highway, Park Ridge, Ill. 60068; 708-692-9710, ext. 212.

MARCH 22-25. Life Agency Management Program in Orlando, Fla., sponsored by the General Agents & Managers Assn.; $365 for GAMA members; $430 for non-members; $100 for guests. GAMA, LAMP conference, 1922 F St. N.W., Washington, D.C. 20006; 202-331-6088.

MARCH 23. The Fundamentals of Workers Compensation seminar in Boca Raton, Fla., sponsored by Michigan State University; $265. **Also April 7** in Peabody, Mass. Edward E. Anderson, Personnel Management Program Service, School of Labor and Industrial Relations, MSU, 422 S. Kedzie Hall, East Lansing, Mich. 48824-1032; 517-355-9591.

APRIL

APRIL 27-28. First Annual Health Care Management & Cost Containment Conference in New York City, sponsored by *Business Insurance* and International Business Forum Conferences; $795; $695 if registered prior to March 13; group discounts are available. IBF Conferences, 50 Charles Lindbergh Blvd., Suite 400, Uniondale, N.Y. 11553-3619; 516-229-2375.

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issue:	March 23
closing:	**March 10**
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issue:	March 30 — Bonus Distribution: RIMS; NMCC
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editorial feature:	Captives/Risk Manager of the Year
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editorial feature:	RIMS Report: Employee Benefits
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Business Insurance

INTERNATIONAL

'Insider's report for insiders'?

Posgate faults Lloyd's task force

By GAVIN SOUTER

LONDON—The recent report by a Lloyd's of London task force that calls for major reforms at Lloyd's was "an insider's report for insiders," according to controversial former underwriter Ian Posgate.

Mr. Posgate contends that the report neither advocates the fundamental changes needed at Lloyd's nor draws up a strong route forward for the market to follow.

And the much lauded marketwide stop-loss scheme recommended by the task force will not help members cope with the huge losses the market could face in the future, he said.

Task force members were all subject to conflicts of interest, Mr. Posgate asserted at a conference held last week in London by the Society of Names, a group representing Lloyd's members.

"David Rowland is a very able man, but he is chairman of the biggest broker at Lloyd's," Mr. Posgate said. Mr. Rowland, the chairman of Sedgwick Group P.L.C., chaired the task force.

And the task force member who represented the interests of external members, Anthony Haynes, joined a Lloyd's managing agency soon after the report was published, Mr. Posgate said.

"Within a month of the publication of the Rowland report, it is announced that he is to become chairman of Wellington Underwriting Agencies Ltd., one of the largest managing agencies," said Mr. Posgate. "It seems a conflict of interest to me."

The individuals who served on the task force instead should have functioned as expert advisers to an independent task force,

Continued on next page

KELM insurers placed in provisional liquidation

By STACY SHAPIRO

LONDON—Four insolvent insurers owned by London United Investments P.L.C. are being put into provisional liquidation nearly two years after they stopped paying claims.

Meanwhile, hundreds of North American lawyers, doctors and accountants are trying to determine in a test case in London's High Court whether a British guaranty fund administered by the Policyholders Protection Board will pay a portion of their professional liability claims not paid by the four insurers.

Last week, lawyers for the liquidators of Transit Casualty Co. and the directors of the LUI insurers agreed that the directors would appoint provisional liquidators to take over the insolvent insurers. The decision was approved by the PPB.

The agreement follows Transit's threat to withdraw support for proposed schemes of arrangement and insist that the four insurers be liquidated (*BI*, Feb. 10).

The four "KELM" companies —all of which participated on the defunct U.S. casualty line slip underwritten by H.S. Weavers (Underwriting) Agencies Ltd. —are Kingscroft Insurance Co. Ltd., El Paso Insurance Co. Ltd., Lime Street Insurance Co. Ltd. and Mutual Reinsurance Co. Ltd. The companies together have total gross liabilities of between $2 billion and $2.3 billion.

As of August 1990, the companies had total assets of 281.9 million pounds ($532.8 million at year-end 1990 exchange rates) and total liabilities net of reinsurance of 351.1 million pounds ($663.6 million).

The four insurers stopped paying claims in March 1990, when sister company Walbrook Insurance Co. Ltd. ceased underwriting and LUI was put into administration (*BI*, April 2, 1990).

Last week, the throng of lawyers from Transit, KELM, the PPB and other creditors met in the court building for several hours to hammer out the terms of the agreement, just as applications to liquidate the companies were scheduled to be heard in a nearby courtroom.

When the applications—which have been delayed since they were first filed in August 1990—were finally heard,

Continued on next page

A new rival for London?

Despite strides, many in French market still skeptical

By WILLIAM PITT

PARIS—Can the French insurance market profit from the London market's current problems and develop as a rival wholesale and reinsurance market?

That question dominated conversation at Assure Expo, the French insurance market's annual convention, which was held last month at La Defense, a business district outside Paris.

Just before the convention, Marsh & McLennan Cos. Inc. acquired Faugere & Jutheau, France's largest brokerage and the target of M&M's advances for years (*BI*, Feb. 10).

Robert Husson, Faugere & Jutheau's chairman, said after the deal was completed that an important factor behind his decision to sell was the potential for new international business to be funneled into Paris via his brokerage.

"The operation we have just undertaken may encourage Paris to become a placing (wholesale) market like London," Mr. Husson said.

In a separate interview with *Business Insurance*, Claude Bebear, chairman of giant French insurer AXA S.A., said that the prospects for Paris as a wholesale insurance market depend heavily on brokers.

"Can the Paris market rival the London market? I think it will take some time," he said.

"What makes an insurance market is largely

Continued on page 26

P.A.R.I.S. executive eyes U.S. venture

By WILLIAM PITT

PARIS—A leading political risk insurance executive plans a major assault on the U.S. market.

Speaking from his Paris office concurrent with last month's Assure Expo, Louis Habib-Deloncle, founder and chairman of Pool des Assurances des Risques Internationaux et Speciaux, better known as the P.A.R.I.S. Pool, said he is "meeting with a number of U.S. insurers" to encourage them to commit capacity to a similar venture in the United States.

Fourteen European insurance companies currently participate in the P.A.R.I.S. Pool, which was founded in 1985.

Mr. Habib-Deloncle already does some business in the United States through Unistrat Corp. of America, the U.S. subsidiary of Unistrat Holding bv, the Netherlands-based company that controls P.A.R.I.S. (*BI*, Feb. 3).

The current $4 million per risk capacity available through Unistrat Corp. of America is provided by United Fire & General Insurance Co., which is controlled by France's lar-

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More litigation may rise from Lloyd's turmoil

By GAVIN SOUTER

LONDON—Lloyd's of London continues to fend off verbal and legal attacks.

While Lloyd's has put up a vigorous defense against allegations of malpractice circulated by members of Parliament in February, the threat of legal action against individual managing agents by hundreds of disaffected members is mounting.

Also, some members of Richard Outhwaite's syndicate who were not included in last month's settlement of litigation filed against their members agencies have banded together to demand some form of compensation.

Lloyd's Chairman David Coleridge strongly denied charges of "insider dealing" and malpractice in the market at a Tuesday meeting with MPs and representatives of members' action groups.

In a detailed written response to allegations made by Paul Marland, a Conservative MP and a member of Lloyd's facing losses, Mr. Coleridge said that working members were not placed on profitable syndicates at the expense of external members who were placed on loss-making syndicates.

"It is not the policy of the Council of Lloyd's that working members should have preferential access to syndicates. Members agents have a duty to act in the best interests of all their names," he said.

Also, Mr. Coleridge noted that the 10 highly profitable "insider" syndicates cited by Mr. Marland did not derive more than 60% of their capacity from working members (*BI*, Feb. 17). Between 54% and 91% of the 10

Continued on next page

Benefits abroad a vexing problem in U.S.

By LORI BLOCK

Economic globalization is increasingly challenging employers to provide benefits to three different categories of employees in posts worldwide.

While some employers have made strides in determining the best approach to provide benefits to key employees working overseas, some still have complex issues to resolve, a recent survey indicates.

The survey, "Benefit Policies for Third Country Nationals, U.S. Expatriates and Key Local Nationals," details the benefit options adopted by 56 Fortune 500 multinationals and the problems presented by those options.

"If you're expanding internationally, you're going to find (you have) more and more of these employees. And the problems associated with providing benefits to them are going to increase," said Rick Cornwell, a partner with Kwasha Lipton, the Fort Lee, N.J.-based benefits consulting firm that conducted the survey.

The first step in determining how to provide benefits to key overseas employees is identifying the category in which they belong. Then companies must determine what benefits should, can and cannot be provided to members of each category and how—or whether—these benefits should be funded.

Often a company's first concern lies with its expatriates, individuals typically described as U.S. citizens working overseas for an extended assignment. Nearly half of the surveyed companies require that the employee be dispatched overseas for a minimum duration (usually one or two years), and 39% require that the assignment be of an indefinite duration if the employee is to be granted expatriate status, which can confer other compensation advantages.

In addition to the time factor, 39% designate expatriates by some "discretionary means," judging the individual's importance to the organization, the survey found.

The other two classes are key local nationals, which the survey defined as "management or other key employees who are working in their country of citizenship for an overseas branch or subsidi-

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INTERNATIONAL

KELM insurers

Continued from previous page
KELM's trial lawyer asked for a seven-day adjournment to allow the directors to file an application for a provisional liquidator to be appointed.

Chris Hughes, a partner with Cork Gully, a London unit of Coopers & Lybrand, will be appointed as one of the provisional liquidators, sources say.

Under provisional liquidation, the power of the KELM directors is suspended and transferred to the provisional liquidator, who will examine proposed schemes of arrangement to decide whether they are in the best interests of the creditors, including Transit. The schemes, which have been discussed for some time, allow for an orderly system of dividend payments to creditors.

If the provisional liquidator determines that the schemes are viable, they would be submitted to the court and, if approved, the companies would be removed from provisional liquidation. If the schemes are not viable, the companies will be put into court-ordered liquidation.

A decision concerning the schemes could be made by autumn of this year.

"The (KELM) directors have concluded that (provisional liquidation) provides the best prospect of finalization of the schemes of arrangement, which the companies, in consultation with the creditors committee and the Policyholders Protection Board, have been striving to promote," the KELM directors announced.

However, creditors of the insurers may not see any dividends for some time if a dispute continues between Weavers and the approximately 20 insurers, including the KELM companies, that participated on the Weavers line slip. That disagreement centers on who should control at least $100 million that Weavers holds in trust for the companies. Weavers claims it is entitled to some of the money (*BI*, Jan. 13).

The High Court was asked last week to hear the dispute between Weavers and the KELM companies as soon as possible to avoid a lengthy wait for creditors.

"Pending resolution of that dispute, the directors believe that the appointment of provisional liquidators will best serve the interests of the creditors," the KELM directors stated.

Meanwhile, the PPB indicated that the appointment of provisional liquidators would enable the board "to consider, as a matter of priority, making interim payment to protected policyholders," the directors said.

However, a trial started last week in the High Court to determine whether claims owed to North American professionals by the KELM companies are eligible for payment by a guaranty fund under the Policyholder Protection Act of 1975.

The Policyholder Protection Act says that "private policyholders" that bought "U.K. policies" written by an authorized insurer are entitled to be paid 90% of their claims if the insurer is liquidated.

The amount paid to the policyholders would be financed through a 1% levy on net British property/casualty premium volume written by authorized insurers in the United Kingdom. The total cost to the PPB from the KELM companies could be more than $300 million.

Justice Webster now must decide whether the KELM companies issued "U.K. policies" as defined under the act and whether the North American plaintiffs are "private policyholders."

The act defines a U.K. policy as a policy of insurance "at any time when the performance by the insurer of any of his obligations under the contract evidenced by the policy would constitute the carrying on by the insurer of insurance business of any class in the United Kingdom."

The group of North American professionals that is seeking the ruling contends that the act applies to them because the KELM companies performed all the obligations of the professional liability policies in London through Weavers, including underwriting, claims functions and administration. The KELM companies were authorized U.K. insurers "carrying on business" in the United Kingdom, regardless of the fact that the coverage pertained to North American risks, the plaintiffs say.

"The purpose of the act is to protect any person (wherever the person might be) from defaults of members of the British insurance industry. . .so the British insurance industry doesn't let them down," Jonathon Sumption, trial lawyer for some of the plaintiffs, told the court last week.

The North American professionals also contend they are "private policyholders" entitled to coverage as defined by the act, even though they may belong to professional partnerships, or may have formed professional corporations.

The plaintiffs include the 234 partners of the former accounting firm Clarkson Gordon, now part of Ernst & Young, in Canada; 123 partners of law firm Fried, Frank, Harris, Shriver & Jacobson in New York; and three New York doctors who represent the Federation of Jewish Philanthropists and the Combined Coordination Council in New York, which together buy professional liability insurance for 4,700 doctors.

The KELM companies wrote a portion of the professional liability policies via the Weavers line slip through London brokers.

However, the defendants—which include the PPB and London insurers—argue that the act is meant to impose a "territorial limitation," so that coverage is provided only to persons domiciled in the United Kingdom insuring risks based in the United Kingdom with a U.K.-authorized insurer.

"The legislature might have defined United Kingdom policy in the act as any contract of insurance effected in the United Kingdom," said the PPB. "It did not do so, presumably because this would have spread the net far too wide. Instead, it defined a United Kingdom policy in terms of the carrying out by the insurance company of the contract of insurance. The territorial limit is fixed in relation not to the entering into of the contract but the performance of the contract."

One must ask where the "performance of the policy" takes place, the PPB says. "If under the policy it is to take place outside the United Kingdom, it would not constitute the carrying on of the relevant class of business in the United Kingdom," the board said.

Also included as defendants in the action are Royal Insurance (U.K.) Ltd., representing the Assn. of British Insurers, and New Hampshire Insurance Co. Ltd., representing U.S. insurers' London units. The insurer defendants would be forced to pay the levy to the PPB if the plaintiffs win their case. ■

Lloyd's troubles

Continued from previous page
syndicates' capacity was supplied by external members, he said.

In fact, he pointed out that "some syndicates, which in the past have incurred large losses, have had a higher than usual participation by working members."

Meanwhile, a group of members who are seeking court injunctions to prevent members agencies from drawing down on their Lloyd's funds have had to change tactics, said Michael Freeman, senior partner at London law firm Michael Freeman & Co., who represents many of the members.

Mr. Freeman originally planned to issue writs on behalf of eight members—who were representative of the entire group—against their members agents to prevent them from drawing down the funds.

The members are facing cash calls for losses on syndicates primarily managed by four managing agents: Devonshire Underwriting Agencies Ltd., Feltrim Underwriting Agencies Ltd., Gooda Walker Ltd. and Rose Thomson Young (Underwriting) Ltd.

Last week, in fact, Lloyd's appointed an independent loss review into the 1989 account of syndicate 216, managed by Devonshire. Similar reviews are already underway into Gooda Walker and Feltrim losses.

However, Mr. Freeman's plan to proceed with just the eight plaintiffs and set a precedent for the other members was derailed last week when Lloyd's itself succeeded in joining the action as a defendant.

When Lloyd's joined the action, all parties agreed that the members agents would not draw down on the funds of litigating members until the trial is concluded.

As a result, each member wishing to seek an injunction to prevent a drawdown will have to file a writ now instead of waiting for the outcome of the eight original requests for injunctions.

Mr. Freeman said that now he will file about 600 writs on behalf of members.

Lloyd's is anxious to be represented in the case, as it believes that the proposed injunctions threaten a crucial aspect of how the market operates, a Lloyd's spokeswoman said.

Meanwhile, another lawyer representing Lloyd's members has written to all of its clients who are Lloyd's members advising them not to join the action organized by Mr. Freeman.

David Tiplady, partner at London law firm D.J. Freeman & Co., wrote to hundreds of clients to point out that he agreed with a statement by Mr. Coleridge that the members should not join the action seeking injunctions.

In another development, about 100 members of syndicate 317/661, managed by R.H.M. Outhwaite (Underwriting Agencies) Ltd., who were not party to last month's 116 million pound ($201.6 million at current exchange rates) settlement, have formed an action group to seek compensation.

Syndicate members who were not party to the original litigation —which was brought by members of the syndicate's open 1982 underwriting year—cannot now file suit against their members agencies because the statute of limitations has expired (*BI*, Feb. 17).

The group is chaired by Richard Fielding, chairman of C.E. Heath & Co. (Insurance Broking) Ltd.

A group of 250 Outhwaite members have approached Mr. Tiplady of D.J. Freeman seeking to pursue compensation through the courts.

Some of the members may be able to argue that they are not time-barred from taking litigation, Mr. Tiplady said.

For example, if the members can prove that they did not realize the full extent of their losses for several years after 1982 because of Lloyd's three-year accounting system they may qualify for an extension, he explained.

Also some working members were encouraged by their employers not to litigate on the understanding that their employers would compensate them for their losses. If the members have not received the promised compensation they may be able to sue their employers, Mr. Tiplady said. ■

Posgate's perspective

Continued from previous page
Mr. Posgate said.

The task force members' conflicts of interest, he charged, left the interests of members not working in the market largely ignored.

The task force "simply said: 'If the outside names do not come up to scratch and allow us to earn large amounts of money, we will ditch them and allow corporate membership,' " Mr. Posgate said, referring to the recommendation to eventually allow corporations to become members.

Before the task force report was released, Mr. Posgate had said he hoped it would include six recommendations: an end to unlimited liability; a more efficient cost structure; a one-year accounting system; retention of the broker market; prohibitions against Lloyd's syndicates writing excess-of-loss reinsurance for other syndicates; and the appointment of an independent chairman of Lloyd's.

Only one of those recommendations was actually included: the retention of the broker market (*BI*, Jan. 20).

The task force recommended retaining unlimited liability because it is the most distinctive feature of Lloyd's, Mr. Posgate said. "Ninety-nine percent of the world insurance market is with companies that are quoted or mutual. It's difficult to be distinctive if you are only 1% of the whole."

Allowing corporate membership, he said, would create an anomaly: Corporations could benefit by limited liability, but individual members would not.

The task force made no specific recommendations to help Lloyd's syndicates reduce their costs, Mr. Posgate said. And unless costs are cut, syndicates will lose business to the more efficient corporate market, he said.

Lloyd's three-year accounting system benefits only Lloyd's professionals, Mr. Posgate said. "I'm sure that outside names would prefer one-year accounting, but insiders want to tie names into the market with the three-year accounting."

Also, the task force did nothing to address the problem of the spiral in London market excess-of-loss—or LMX—reinsurance, Mr. Posgate said.

"The spiral is the City's version of pyramid selling and has clear advantages to agents and brokers, whilst outside names get hurt," he said.

Brokers and agents both receive larger commissions for placing so-called spiral business than for other risks, he said. But the spiral serves no useful insurance function and consequently would be easy to outlaw, Mr. Posgate said.

Many outside members have suffered from large losses on syndicates that specialize in LMX business while working members avoided those syndicates, he charged.

"Insiders do not necessarily choose the best syndicates for themselves, but they know the syndicates not to choose," Mr. Posgate said.

Mr. Posgate himself says he suffered only a small loss in 1988, compared to the large losses suffered by other members, because he knew the syndicates to avoid.

And Mr. Posgate criticized as insufficient two internal investigations into the huge losses on LMX reinsurance. He said an independent actuary should be heading the probe, not Sir David Walker, who is head of the U.K. Securities and Investments Board and a Council of Lloyd's member (*BI*, Feb. 24).

The task force went halfway to appointing an independent chairman of Lloyd's by recommending that the regulatory and marketing activities of the council be separated, he said. And the idea of having a market board to oversee the governance of Lloyd's is probably better than having an independent chairman, Mr. Posgate added.

The introduction of the market-wide stop-loss program to cap members' losses once they have reached 100% of their overall premium limit in an underwriting year does not go far enough, he said.

"For me, the risk at Lloyd's is not the spiral. I avoid those syndicates with my insider knowledge. The real risk is the possibility of having three large catastrophes in one year," Mr. Posgate said.

This could produce losses in excess of 20 billion pounds ($34.9 billion at current exchange rates), which would far exceed the size of the stop-loss fund, he said.

Although working members would be the primary beneficiaries of the task force plan, it did have some features that external members should welcome, Mr. Posgate said.

These include the extension of CentreWrite Ltd., Lloyd's reinsurance facility, to cover members' runoff accounts and the recommendation for the introduction of members' agents pooling arrangements, which would help spread risks more evenly among the membership, he said.

Meanwhile, former Lloyd's chief executive Ian Hay Davison has warned that unless Lloyd's makes fundamental changes it "may not survive the end of the century."

Lloyd's needs to take four steps to ensure it survival, Mr. Hay Davison said in a letter to the London Times.

These are: a clearer recognition by Lloyd's that its principal duty is to serve its policyholders and its members; the separation of the Council's regulatory and commercial function; a resolution of the open year problem; and commercial changes in the market including better underwriting; quicker claims processing; and improved training. ■

Expat benefits

Continued from page 23

ary" of a U.S. company; and third-country nationals, defined as "non-U.S. citizens working overseas outside their country of citizenship." However, some companies regard certain expatriates or key local nationals as third-country nationals.

But regardless of definitions and requirements, Mr. Cornwell said that companies typically share two concerns regarding expatriates: continuity of coverage and the maintenance of benefits that are at least as generous as those offered under the plan in the host country.

Quite often, though, the standard of comparison is the U.S. plan, which may partially explain why an overwhelming majority of the surveyed companies choose to provide their U.S. expatriates the same benefits as typical U.S. employees. For instance, if a company's medical plan includes indemnity coverage for people living outside the network, the expatriate receiving treatment in a foreign country would be covered under the indemnity option.

"I don't think that's a hardship for most companies," Mr. Cornwell said. "It's just a natural extension of their existing plan."

Robert Braddick, a principal with A. Foster Higgins & Co. Inc. in New York, concurs. Keeping expatriates in the U.S. plan "is far and away the most common practice for expatriates," he said. Because the expatriate is posted to a foreign country temporarily, "offering a free-standing program is just not time- or cost-effective."

However, serving expatriates long distance under the U.S. plan could pose an administrative burden, particularly in situations where the employee has children who need regular medical attention, the survey found.

In addition, Mr. Braddick said, such an approach is hampered by the currency fluctuations that take place between the time the expense is incurred and the time it's paid. At issue is which party takes the hit, the company or the employee.

There are other alternatives to the home-plan approach. One approach, adopted by 5% of the companies, is to place expatriates in a local medical plan. In some cases this arrangement is accompanied by an agreement to evacuate them for a medical emergency when necessary, which can alleviate some concerns regarding the quality of care in the host country.

Death and disability benefits for expatriates were kept in the U.S. plan in 98% and 95% of the companies, respectively.

And, while 87% of the companies with defined benefit pension plans keep their expatriates in that plan, only 56% of the companies with defined contribution plans reported that they keep their expatriates in the plan.

Kwasha Lipton theorizes that this dramatic departure from an otherwise cohesive policy of keeping expatriates in the home plan possibly is because the pretax savings on contributions might not have much meaning for expatriates. Some host countries may not allow deductions for contributions and expatriate employees have significant tax exclusions for U.S. purposes, so deductions may be less important.

Providing benefits for expatriates isn't always this straightforward, particularly in instances where the expatriate does not have a direct relationship with the U.S. parent company, says Mr. Cornwell. Tax laws can differ if the employee is working for a foreign subsidiary of a U.S. company, he said.

Among the surveyed companies with roughly 20,000 or more employees, the average number of expatriates was approximately 125, or 0.6%. Still, expatriates generate much concern because they typically are individuals in whom the company has a vested interest and wants to retain.

Similarly, key local nationals, the second category of employees discussed in the survey, "are key people who are very important to the organization," explained Mr. Cornwell.

Most of the companies determine who is a key local national through discretionary means, though 12% said they have a specific minimum pay requirement.

While more than 80% of the surveyed companies have employees in this category and acknowledge the problems associated with providing them adequate benefits, few have taken steps like including them in the U.S. plan or establishing a separate plan to solve these problems, the survey indicates.

According to Mr. Cornwell, this problem is most acute in developing countries where the local social security programs "might be adequate for the rank-and-file (workers) but not for these people." As a result, a gap occurs between what the key local national should be receiving, based on his position in the company, and what he is receiving through local coverage.

"Even one person not being adequately compensated can be a problem," Mr. Cornwell said.

Likewise, there is a growing awareness among key local nationals of what their U.S. counterparts receive, and what their peers at other local companies receive. Thus, they are more likely to compare their compensation against these benchmarks than against the local social security benchmark.

This problem is exacerbated when a "cadre of expatriates and third-country nationals" arrives and the key local national sees firsthand what kind of benefits they have, Mr. Braddick said.

Mr. Cornwell suggests that companies "try to determine (whether the key local national is) comparable in stature to the U.S. managers and other foreign managers in their organization and other organizations." Then, he said, assess the benefits the key local nationals are receiving in light of their stature.

"There will be a tendency for benefits to ratchet up as this process of comparison and maintaining competitiveness evolves," Mr. Cornwell said.

Yet Mr. Braddick doesn't foresee a stampede of companies rushing to boost the level of benefits provided to key local nationals. Instead, he believes it's more likely that companies gradually will be pushed into a corner by these employees who realize that the philosophy of compensating them based on local conditions provides them with benefits beneath others in the corporate hierarchy.

But, for now, the survey shows that companies overwhelmingly rely on local plans to compensate these employees. For instance, 86% of the companies place their key local nationals in a local defined benefit plan, while only 4% put them in a U.S. plan. According to the survey, key local nationals are eligible for inclusion in U.S. plans, but such participation could give rise to local tax liabilities.

The remaining 10% place key local nationals in a plan alongside so-called third-country nationals, the final class of employees examined in the survey.

Similarly, the survey found that very few companies provide defined contribution plans outside a local plan for key local nationals.

This pattern carries over into death, disability and medical benefits, for which at least 90% of the companies cover their key local nationals through a local plan, even though the survey respondents deemed local benefits to be inadequate for this class of employees.

'Even one person not being adequately compensated can be a problem,' says Mr. Cornwell.

Mr. Cornwell explained that to exceed local benefits, companies must decide what to provide, how to provide it and how to fund it. For instance, in the area of retirement benefits, a company could establish an offshore trust, which may generate tax-exempt earnings on the funds invested, but may not allow tax-exempt contributions.

But, he added, if a company determines that there is a need to boost the retirement benefits of its key local nationals by a significant amount, funding the plan may be beneficial. Otherwise, he recommends establishing a plan on a "pay-as-you-go" basis.

Among the surveyed companies with at least 20,000 employees, key local nationals represent approximately 0.9% of the workforce.

Furthermore, their proportion to a company's total workforce could increase at the expense of third-country nationals and expatriates. Mr. Braddick noted that U.S. companies are pulling back the number of overseas appointments, partly in response to the recession. But, he added, companies are also concluding that local operations are best run by local people. While Mr. Braddick predicts that the use of expatriates will rise again, key local nationals are likely to play a larger role in the operations of many companies.

Benefit planning is perhaps the most complicated for the third and smallest category of employees, third-country nationals. At the surveyed companies with at least 20,000 employees, 0.4% of the employees are third-country nationals.

Mr. Cornwell said these are people who either "have skills that are worth applying in other places" or people "the company wants to get exposure to as much of the business as possible."

When it's time to design benefits for them, no mold seems to fit. "They're not direct employees of the U.S. companies like expatriates, so it's not natural to include them in the U.S. program. On the other hand, it's not natural to include them in the program of the host country because they're not citizens of that country either," Mr. Cornwell explained.

Add to that the fact that third-country nationals tend to move frequently, and it's easy to see why companies are struggling to determine the best way to provide for these employees.

According to the survey, 62% of the companies provide defined benefit coverage for these employees in a special third-country national plan. But the remaining 38% opt for a variety of methods: 3% put third-country nationals in the U.S. plan, 14% put them in the plan that exists in the employees' country of citizenship, 9% put them in the local plan, 5% provide no coverage and 7% do something else.

This lack of a consensus is even more dramatic for defined contribution plan. The most popular option, chosen by 27% of the companies, is to provide nothing, while 18% fell into the "other" category.

But, despite the lack of consensus, Mr. Cornwell said some inferences could be drawn from the survey.

For instance, the larger the company, the more likely it is to have a separate retirement plan for third-country nationals. Mr. Cornwell said these formal arrangements usually evolved from informal one-on-one agreements.

"Hand-in-hand with this evolution went an increasing desire to at least consider funding these (plans)," Mr. Cornwell said.

About 41% of the third-country national defined benefit plans are funded. But the decision to fund these plans generally wasn't made for economic reasons. The survey indicates that 62% of the companies chose to fund the plan primarily to enhance employee security and relations, 39% cited the "perceived tax advantages" of funding, 15% said funding facilitated cost allocation and 14% said funding fit into the company's philosophy.

To Cornwell, companies' reasons for funding their programs indicate a lack of in-depth analysis. "I wonder if the companies simply don't know whether funding offshore is better than funding internally. I just don't know if companies have analyzed it."

Mr. Cornwell said Kwasha Lipton has done some of these analyses and has found that there is no pat answer: For some companies, offshore funding makes economic sense; for others, internal funding is the answer.

Messrs. Cornwell and Braddick say that companies should determine a target benefit level for third-country nationals. Companies should then provide the difference between the target level and the level of benefits the employee is eligible for from the countries in which he has worked and resided.

"In theory, (this approach) is terrific," said Mr. Cornwell. But offsetting those government retiree benefits may present administrative difficulties, the consultants said. Yet, because it's an export of the U.S. approach, it's the one that appeals to U.S. companies.

However, Mr. Cornwell suggested that a radical departure from the U.S. approach might suit third-country nationals better. Eliminate the concept of offsets and, instead, determine an appropriate percentage of annual earnings that should be accumulated for each individual every year and credit that amount to them.

●

Copies of "Benefit Policies for Third Country Nationals, U.S. Expatriates and Key Local Nationals," are available without charge from Rick Cornwell, Kwasha Lipton, 2100 N. Central Road, P.O. Box 1400, Fort Lee, N.J. 07024-1400; 201-592-1300.

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INTERNATIONAL

E.C. directive may be OK'd by August

By CAROLYN ALDRED

BRUSSELS, Belgium—The European Community's Third Non-Life Insurance Directive could be in place by August, following action on the measure last week.

The European Council of Ministers, which is composed of the ministers of financial or economic affairs from the E.C. member states, last week reached a "common position" on the directive.

The Third Non-Life Directive is designed to allow the cross-border placement of all property/casualty insurance, not just large commercial coverages, which were covered in the Second Non-Life Directive (*BI*, July 9, 1990; July 2, 1990).

In addition, the council recently adopted a recommendation to harmonize the regulation of intermediaries throughout the European Community.

Although the council has reached agreement on the Third Non-Life Directive, the measure must still be approved by the European Parliament before member states could adopt it.

The Parliament must hold a hearing within four months of the council reaching common agreement on a proposal, according to an E.C. spokesman in Brussels. And, if the Parliament approves the directive, it must be in place within member states in another four months, he said.

The Council of Ministers' intermediaries recommendation "seeks to set up guidelines for member states on how they should regulate insurance intermediaries," said Patrick Pearson, administrator for the E.C. insurance division in Brussels.

The recommendation would apply to all agents, brokers or other distributors of insurance products. It will include banks, post offices, and savings and loan-type companies called building societies, which are increasing their insurance sales in E.C. countries, he said.

The European Community "is seeking the introduction of minimum professional qualifications for all intermediaries," said Mr. Pearson.

According to the recommendation, intermediaries "should disclose to (their national) authorities the spread of their business to different insurers for the previous trading year," Mr. Pearson said.

In addition, intermediaries selling insurance "will be under obligation to disclose to clients any financial or legal arrangement with any insurer," he noted.

Another objective of the recommendation will be compulsory registration of all intermediaries in their home state, Mr. Pearson said.

The proposed intermediary regulation has been adopted as a recommendation rather than as compulsory legislation because under another piece of legislation—the E.C.'s Second Life Insurance Directive, adopted in 1990—member states have until May 1996 to introduce broker regulations.

However, under the recommendation, member states would have to report back to the Council on Dec. 18, 1994, regarding the progress they have made toward fulfilling the recommendation, Mr. Pearson noted.

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Associate Editor Gavin Souter in London contributed to this report.

French insurance market

Continued from page 23

the capacity of the brokers. And from that point of view, the London market is a very important market and it will remain so," Mr. Bebear said.

He argued that while French insurers are better positioned in the continental European market than their British counterparts, "French broking is not on the same scale as English broking."

Only two French brokerages—Faugere & Jutheau and Gras Savoye S.A.—are large enough to compete with brokers based in London, Mr. Bebear said.

And, he expressed skepticism over British and U.S. brokerages' willingness to pour major resources into Paris. "I'm not sure that today they are prepared to support at once a strong presence in London and a strong presence in Paris," he said.

Representatives of France's leading brokerages debated this and other issues at Assure Expo. They agreed that insufficient capital is their greatest weakness.

The point was made most forcefully by Claude Chouraqui, chairman of Societe Intercontinentale d'Assurances pour le Commerce et l'Industrie S.A., a French broker in which U.K. broker Jardine Insurance Brokers Group Ltd. last October acquired a 27% stake.

"You have to measure (brokerages') capacity to invest," he argued. "French broking has a major capital weakness."

Mr. Chouraqui recalled the days when the main motivation for forging links with a big Anglo-Saxon brokerage house was to gain access to the London market. That motivation has declined, he said, as the capacity of the French insurance market to write coverage for industrial risks increasingly has developed.

"Today, the essential motivation is to provide an international service for our clients—and also the possibility of bringing foreign risks into France," he said.

This is not a possibility that French brokerages have exploited very actively. The largest French brokerages, Faugere & Jutheau and Gras Savoye, have both concentrated on building their retail brokering operations and have paid little attention to the wholesale opportunities posed by the development of the French insurance market.

However, Gras Savoye Chairman Patrick Lucas did allude to the remarkable growth of French insurance companies in recent years, growth that may in turn boost the standing of Paris as a wholesale insurance market.

"It is not unthinkable that in five years' time there will be six major actors in European insurance, of which four will be French," he said.

French insurance companies already have a worldwide reputation as underwriters of space and aviation risks.

Jean-Francois Bouly, chairman of another family-owned

Continued on next page

The Professional Marketplace

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NOTICES

IN THE SUPREME COURT OF BERMUDA
NO. 259 of 1991
IN THE MATTER OF ANECO REINSURANCE UNDERWRITING LIMITED
and
IN THE MATTER OF THE COMPANIES ACT 1981

(Under the Order for Winding-Up the above-named Company, dated 12th day of December 1991)

NOTICE IS HEREBY GIVEN that the First Meeting of Creditors in the above matter will be held at The Bermuda Chamber of Commerce, Front Street, Hamilton, Bermuda on Friday 26th day of March 1992, at 10:00 a.m.

To entitle you to vote thereat, your Proof must be lodged with me not later than 5:00 PM, on Monday the 23rd of March 1992.

Dated this 21st day of February, 1992

Malcolm L. Butterfield
Provisional Liquidator
C/O Dorchester House
P.O. Box HM 1171
HAMILTON
Bermuda HM EX

(The statement of the Company's affairs has not been lodged)

NOTE

At the First Meetings of the Creditors and Contributories they may amongst other things:

1) By resolution determine whether or not an application is to be made to the Court to appoint a Liquidator in place of the Official Receiver.
2) By resolution determine whether or not an application shall be made to the Court for the appointment of a Committee of inspection to act with the Liquidator, and who are to be the members of the Committee if appointed.

NOTE: If a Liquidator is not appointed by the Court the Official Receiver will be the Liquidator.

Business Insurance
Circulation Breakdown*

Commercial Consumers

Administrative:
CEO's Presidents, and Owners . 2,500
Vice-Presidents, General Managers and Other Administrative Personnel 4,263

Financial:
Chief Financial Officers and Vice-presidents of Finance 2,972
Secretaries, Treasurers, contollers and other Financial Personnel 4,406

Risk/Employee Benefits:
Vice-presidents, directors, managers, and other related department personnel of: insurance, risk, employee benefits, personnel, compensation, pension, safety, security, industrial relations, human resources and employee/labor relations 10,976
Sub-total 25,117

Associations 458
Government, Unions and Educational Institutions 1,234
Commercial Consumers
Sub-total 26,809

Insurance Agents and Brokers . . 9,430
Insurance Companies 8,045
Accountants, Actuaries, Attorneys & Consultants 3,405
Adjusters, Appraisers, TPA's, Captive Managers & Health Care Providers 1,392
Others Allied to the Field 1,518
TOTAL 50,599

* Source Business/Occupational breakdown of qualified circulation, May 27, 1991 issue, as submitted to BPA for June 1991 BPA Publisher's Statement.

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INTERNATIONAL

French market

Continued from previous page
French broker, Compagnie Europeenne de Courtage d'Assurances et de Reassurances, also acknowledged the "remarkable development of the French market" in recent years, but reasserted the continuing unique position held by London.

"The big French insurers say that world insurance is an inverted pyramid resting on a point, and that point is the London market," he said.

Nevertheless, AXA's Mr. Bebear expressed confidence that the Paris market would grow. "French insurers are strong and have an international outlook. There are some brokerages in France that are becoming more international, too."

And he sounded a warning to London: "The Paris market cannot grow except to the detriment of London." ■

Big insurers boycott Expo

By WILLIAM PITT

PARIS—The organizers of Assure Expo hope to next year avoid the controversy that erupted when France's biggest insurers last month boycotted the meeting that bills itself as the "principal insurance exhibition in Europe."

Notwithstanding the absence of major French insurers like Union des Assurance de Paris and AXA S.A., attendance was up slightly this year, said Henri de Clairval, an executive with Vidal S.A., which organizes Assure Expo.

The eighth annual event was held Feb. 4-7 at La Defense, a business district just outside Paris.

AXA prefers to make individual presentations, says its chairman, Claude Bebear.

Some 27,498 people—up from 27,154 last year (*BI*, Feb. 25, 1991)—visited the conference center to view the products and services available from the French market and a number of foreign companies.

The big insurers presented various reasons for their absence. Claude Bebear, chairman of AXA, said that the company saw little point in advertising its wares to the direct agents of other insurance companies or to its own intermediaries. AXA prefers to make individual presentations, he said.

Conference organizers say they have been holding talks with the major French insurers and their trade group, the Federation Francaises des Societes d'Assurances, in an effort to persuade them to attend next year.

According to the French trade press, another reason some companies did not show up was the cost of renting space in the huge exhibition hall.

Mr. de Clairval said that a standard exhibit space of roughly 30 square feet cost 32,670 francs ($5,794) before taxes. Nevertheless, some foreign insurers, like representatives of Lloyd's of London, booked far more than the standard space.

Assure Expo is part conference, part exhibition, and is increasingly being mimicked throughout Europe, although a version of Assure Expo has yet to take off in the United Kingdom.

Mr. de Clairval said there are Assure Expo-lookalikes now being staged in Belgium and Spain, and wondered why the British insurance industry was not following suit.

Next year a bigger effort will be made to lure foreign brokers to the event, said Mr. de Clairval. Multilingual translation facilities will be available so that seminars and debates will no longer be confined to French-speaking attendees.

Next year's Assure Expo will be held Feb. 2-5 in Paris. For more information, contact Vidal S.A., 29 Rue Druout, 75009 Paris, France; 1-482-47601. ■

Political risk insurance

Continued from page 23
gest reinsurer, SCOR S.A.

Mr. Habib-Deloncle plans to increase this capacity to $7.5 million per risk by bringing other insurers on board the U.S. venture.

In Europe, by contrast, the P.A.R.I.S. Pool can provide coverage of up to 11.5 million European Currency Units ($14.2 million) per risk.

The U.S. market is ripe for development, he said. Although he acknowledged the existence of a number of political risk insurers in the U.S. market, like American International Group Inc. and Citicorp International Trade Indemnity Inc., he maintained these are "not sufficient to make a proper market."

Mr. Habib-Deloncle also argued that current U.S. debate over the appropriate role of government in providing export credit and political risk coverage for private U.S. exporters might work to the benefit of private-sector insurers.

"The idea of the U.S. government is to get out (of providing coverage) as much as possible," he said.

Another target of Mr. Habib-Deloncle's energies is the community of exporters that have not fully awakened—in his view—to the benefits of political risk insurance. He suggested that U.S. companies that export goods to Third World countries are often "more fixed in their attitudes" than their European counterparts. "Either they assume the risk themselves, or they don't do the business," he said.

Mr. Habib-Deloncle argued that a stronger marketing effort is needed from U.S. insurers and brokers in order to "make American exporters more aware of the risks" and how to cover them. ■

Sedgwick Group profits increase 18.9% in 1991

By GAVIN SOUTER

LONDON—Sedgwick Group P.L.C.'s 1991 profits jumped 18.9% to 82.4 million pounds ($154 million at year-end 1991 exchange rates) compared with the previous year's 69.3 million pounds ($133.7 million at year-end 1990 exchange rates).

However, if an exceptional charge of 21.4 millions pounds ($41.3 million) in 1990 for the closing of unprofitable offices is excluded, the broker's 1991 earnings would have been 8.3 million pounds ($15.5 million)—or 12%—lower than the previous year.

Sedgwick's gross revenues fell by less than 1% to 685.1 million pounds in 1991 ($1.28 billion) from 691 million pounds ($1.33 billion) in 1990.

The lower underlying profits largely resulted from a 7.2 million pound ($13.5 million) drop in investment income due to lower interest rates in the United States and Britain, said Stuart Tarrant, Sedgwick's group finance director.

Pretax profits from U.S. business increased 23.2% to 31.3 million pounds ($58.5 million) in 1991 from 25.4 million pounds ($49 million) in 1990.

Gross revenues from U.S. business, however, fell slightly to 283.3 million pounds ($529.6 million) in 1991 from 285.9 million pounds ($551.8 million) the previous year.

Most U.S. rates continue to fall with little prospect of short-term increases, said Sedgwick Chairman David Rowland.

However, some rates are increasing in the London market, he said.

"Change is now apparent in sections of the London market, such as reinsurance, marine hull, energy and aviation," Mr. Rowland said.

However, it is too early to predict any other London market rate increases, he said.

LONDON

Broker in receivership

Lloyd's of London has appointed receivers for Lloyd's broker Durham Hadley Cannon, a subsidiary of D.G. Durham & Co. Ltd., freezing the assets of the company in order to pay insurance creditors.

It is only the second time that Lloyd's has enforced this power given to it under a 1988 broker bylaw. The receivers are partners Chris Hughes and Ian Bond of Cork Gully.

The move follows D.G. Durham's announcement last December that it had decided to withdraw from the Lloyd's brokering market, said a Durham spokeswoman. In January, parts of Durham Hadley, which employed around 150 people, were sold to Richard Longstaff Insurance Holdings Ltd. and Alfred Blackmore U.K. Ltd., she said.

Sun Alliance downgrade

Standard & Poor's Corp. has downgraded the claims-paying ability of Sun Alliance & London Insurance P.L.C. in the wake of the company's poor 1991 underwriting results.

S&P has cut its claims-paying rating of Sun Alliance to AA from AA+. It has also lowered the commercial paper rating on Sun Alliance Group P.L.C., the insurer's holding company, to A-1 from A-1+.

The downgradings reflect Sun Alliance's greater than anticipated operating losses in 1990 and 1991 and the expectation of continued poor short-term results, S&P said.

Sun Alliance is expected to report more than 450 million pounds ($841.1 million at year-end exchange rates) in underwriting losses for 1991, largely due to a flood of claims from its mortgage indemnity guarantee policies, S&P said. That would follow underwriting losses of 181 million pounds ($343.5 million at year-end 1990 exchange rates) in 1990.

And, in 1992, the company may incur a loss in excess of 100 million pounds ($180 million at current exchange rates) before returning to profitability in 1993, S&P added.

"As a result, Sun Alliance's surplus strength has eroded from historically superior levels. . .it may be several years before capital strength is restored to recent past levels through consistent, good quality earnings," S&P said.

Still, Sun Alliance remains well-capitalized and has a leading share of the U.K. homeowners insurance market and a strong position in the commercial property market, S&P said.

Minet restructuring

A change in the corporate structure of Minet Holdings P.L.C. means that two senior executives retiring from its Lloyd's of London brokerage arm will not be replaced.

The reorganization is the first step in a five-year strategic plan for Minet, said Peter Christie, chief operating officer of the London-based broker.

Jack Gore, chairman of J.H. Minet & Co. Ltd., and Peter Foster, deputy chairman of the unit, both retired at year-end 1991. However, because of a new operating structure at Minet, neither executive will be replaced, Mr. Christie said.

Under the change in structure, Minet's four major operating groups are now: international; Americas; reinsurance; and multinational professional services, which includes professional liability business.

Each group will be headed by an executive vp who will report to Mr. Christie. ■

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Computer virus

Continued from page 1

The Michelangelo virus—which first popped up a year ago in Sweden—targets IBM and IBM-compatible personal computers. It could cause some users to lose all data stored on internal hard disks, computer experts point out.

There are indications that some banks could have problems this Friday, a payday for many workers and a busy day for financial institutions.

In preparing its latest quarterly ratings of financial institutions last month, VERIBANC Inc. scanned 681 disks received from banks. The Wakefield, Mass., firm found eight disks—a little more than 1%—were infected with viruses.

Three of the disks contained the Michelangelo virus and five others were planted with a bug called Stoned, a virus that turns a computer's data into gibberish and flashes a message calling for the legalization of marijuana.

"If you imagine 1% of the banks in the country have infected computers, that would be about 120 banks," speculated Warren Heller, research director at VERIBANC.

He also pointed out that in the previous quarterly rating, only one disk was found with a virus. "It was the multifold increase that caught our attention," he said.

"It will be interesting to see if banks have trouble cashing checks on Friday," Mr. Heller added.

Whether a virus is able to creep into a computer system depends on the safeguards used to protect machines from viruses or other security breaches.

"It depends on the system and how sensitive the information is," said Thomas F. Ellis, Southwest region director-computer risk management services for Arthur Andersen & Co. in Dallas. Companies with sensitive information or data that is hard to replace will go to greater lengths to protect it, he explained.

The most vulnerable systems are "networks" of computers that are connected to each other and swap potentially infected programs, he said.

That means companies that use local area networks—called LANs—have a greater risk of infection. "Many are vulnerable; it's just a question of whether lightning strikes," said Mr. Ellis.

Observers agree that virus detection procedures have become routine at many companies.

Virus detection equipment is scanning Knight-Ridder Inc.'s computers across the nation.

"It looks like we're in pretty good shape," said James H. Matthews Jr., director-risk management at the Miami-based communications company. "We've found others, but not that one," he said of Michelangelo.

Mr. Matthews said Knight-Ridder, which operates 27 newspapers, is installing virus detection devices throughout its system and will have it in place at all locations before Michelangelo is set to strike.

Knight-Ridder's hunt for viruses isn't related to the Michelangelo threat, he said.

While there is cause for concern for operators of some risk management information systems because of their LAN design, there is less reason for employee benefit managers to worry.

"It is a severe problem in a LAN environment, particularly as programs travel back and forth." said Jerry C. Buckley, president of California Interactive Computing Inc. in Northridge, Calif.

Benefit administration systems, however, are less susceptible to viruses. Their closed architecture means that communications generally don't travel through open networks. Instead, said Mr. Buckley, they are linked to vendors' mainframes where viruses don't operate.

Some computer experts who contend that the virus threat is overblown cite the relatively small amount of data lost to the bugs.

While a "fair amount of people have lost a lot of time" restoring data that succumbed to viruses, the amount of data actually lost has been fairly low, said, Phillip Chapnick, director of the Computer Security Institute in San Francisco.

He acknowledged, however, that some users could suffer a severe impact from the Michelangelo virus. "If Michelangelo is as widely dispersed as they say it is, March 6 could be a bad day," he said.

"It's causing a lot of unwarranted concern," said Pamela S. Kane, president of Panda Systems in Wilmington, Del. "It's been a while since we've had a big scare, so we're ripe for it."

Ms. Kane pointed out that a similar virus threat took place in 1990, when a data-chomping bug was supposed to appear on Columbus Day. Instead, it was "dead quiet," she said.

Insurers who provide coverage for computer systems are calm but guarded as March 6 approaches.

"I don't think it will be an enormous problem, quite frankly," said Thomas Cornwell, vp-electronics industry group at Chubb & Son Inc. in Warren, N.J. Still, he added, "if it really is nasty, it could be expensive for a bunch of folks, including us."

Chubb's insurance written for data processing systems includes coverage against damage from a virus, Mr. Cornwell explained.

The coverage is written in a variety of ways, according to the client's needs, he said. Depending on the policy, coverage may pay for lost income and extra expenses related to replacing data that was destroyed by a virus.

Mr. Cornwell said Chubb has paid claims for data lost because of viruses. All the claims have exceeded $100,000, he confirmed.

Damage related to a virus is considered vandalism and also is covered under all-risk data processing policies written by Atlantic Mutual Cos. in Madison, N.J., according to Ben Hedrick, commercial inland marine manager.

Like Chubb, Mr. Hedrick says Atlantic Mutual isn't "looking for anything to bust loose" when March 6 rolls around. "If it does, it means we haven't done our job going in."

He explained that Atlantic Mutual's coverage for systems, which is written on an inland marine policy form, is carefully underwritten. "We look for people who are using safe computing practices" and are aware of the threat of viruses.

Atlantic Mutual, which writes the coverage for systems ranging from one personal computer to multimillion-dollar systems, has seen few virus-related problems from its policyholders.

Mr. Hedrick pointed out that some companies won't report damage from viruses because of the negative publicity. "It's a breach of security," he said.

Although most companies are using safeguards to protect against viruses, experts point out that there are ways to guard against Michelangelo for those who have yet to take steps.

Most importantly, make sure data is backed up and alternate systems are in place in case a virus renders systems unusable.

However, backed-up data will have to be checked, warned Mr. Ellis of Arthur Andersen. "If you do a good job of backing up, you may also be backing up the virus. Then you have a chance of reloading it."

Because the Michelangelo virus is set to activate on a particular date, there is the opportunity for a stopgap risk management measure, sources said. Changing the computer's internal clock past March 6 will prevent it from activating.

But Ms. Kane of Panda Systems pointed out that moving the computer's clock doesn't get rid of the virus and the threat remains if the clock eventually does register March 6.

Other anti-virus measures that computer experts recommend include:

- Using software that will scan a system, detect viruses and delete them.
- Limiting access to systems so that infected disks from outside sources can't be used.
- Restricting the use of electronic bulletin boards. Often, infected programs are downloaded by employees. ■

Medicare Insured Groups

Continued from page 1

tirees' claims at a lower cost than the federal government has by implementing cost containment measures like utilization review and managed care networks.

Currently, many retirees receive health care benefits from both Medicare and employer-provided supplemental plans.

"The theory is potentially appealing," said Frank McArdle, a consultant in the Washington, D.C., office of Hewitt Associates. But, questions remain about what kind of payment method will be used for health care providers and how HCFA's initial payment rates to employers will be adjusted to reflect actual utilization and experience, he said.

"Once the MIG is in operation, HCFA won't be receiving (Medicare beneficiaries') claims data, so it would be hard to get the government to readjust rates to accurately reflect increasing costs," Mr. McArdle said.

"The Medicare program has not been meeting most of the health care cost needs of retirees and, given the pressure on Medicare because of its grave financial situation, it's hard to envision Medicare keeping up with health care cost increases," he added.

Employers in the program would have to assume the financial risk for those cost increases under the MIG system, he said.

A third status report on the MIG program released last month by the General Accounting Office also voiced concern about how Medicare payment rates will be updated.

"At the time of our June 1989 report, HCFA planned to update MIGs' initial experience-based payment rates by using some index of cost growth, such as overall Medicare cost changes," the report stated. Noting that "HCFA would no longer obtain cost data for MIG enrollees because it would not receive claims from them," the GAO pointed out that "as time passed, it might become increasingly difficult to measure objectively whether underpayments or overpayments to MIGs were occurring."

The GAO concluded that "the MIG rate-setting methodology should be thoroughly tested before general legislation authorizing MIG contracts on a non-demonstration basis was granted."

The report noted that as of November 1991, HCFA had not decided how to update the initial experience-based payment rates as the MIG programs advanced. But, it pointed out, "HCFA officials said that they are waiting for a prospective MIG to present a payment updating method for the agency to evaluate."

Chrysler decided not to continue the MIG project "because the only reason we were interested in the project was to demonstrate that we could reduce health care costs for Medicare-eligible retirees. I couldn't assure my management that we could save money," said Walter B. Maher, director of federal relations for Chrysler in Washington, D.C.

"The government was an assured winner and we were not. I couldn't ask my management to enter into something that would exacerbate Chrysler's health care cost problems," Mr. Maher said.

Questions also arose concerning who would pay for administrative costs associated with the project. "Applying managed care techniques usually involves additional administration, and it was not made clear whether the employer or Medicare would pick up the tab for administrative costs," Mr. Maher said.

Administrative costs were the primary reason Southern California Edison chose not to go ahead with a MIG, said Dr. Jacque J. Sokolov, vp and medical director for the utility.

Southern California Edison has 55,000 people enrolled in its health plan, of which 10,000 are retirees and their dependents. Of that 10,000, about half are eligible for Medicare benefits.

When the utility entered into the MIG feasibility stage, it looked at setting up an exclusive provider organization for its 5,000 Medicare-eligible retirees, Dr. Sokolov said. That idea evolved into plans to develop a "third-generation managed care" program that will: better coordinate its managed care networks, quantify qualitative measures and create patient management teams, he said.

However, the utility discovered that "it would be much more costly to make a (benefits plan) change for only 5,000 people than it would be to make a change for all 55,000 people," he said.

"The MIG feasibility evaluation demonstrated that there could be some innovative things we could do as a corporation. But, we found that doing them for a 5,000 population wasn't as advantageous as doing them for all our employees. We want to develop a program to impact both active employees and retirees," he explained.

Southern California Edison may revisit the MIG project later this decade. "Even though we chose not to move forward, I still think the MIG program is very valuable," Dr. Sokolov said.

Chrysler's Mr. Maher agreed that the project was valuable despite the company's decision to drop out. "It was a positive matter to pursue. From the research we conducted, we learned more about the utilization patterns of our employees, which will help us with our own cost management activities."

Max Fine, an independent benefit consultant to ALICO, said that administrative costs were not an issue in its MIG.

"Amalgamated administers 41 Taft-Hartley trusts for active employees, so administrative costs would be negligible," he commented.

Richard J. Van Bell, president of John Deere Health Care Inc., a managed care subsidiary of the manufacturer, commented: "We've been studying the feasibility of developing a MIG for over a year, and at this point, we plan to continue the analysis in 1992. If conclusions of the feasibility study are confirmed, we will probably implement a MIG sometime in 1993."

Hewitt's Mr. McArdle noted that a MIG makes more sense for Deere than for some other employers, because the company already is involved in health care delivery through subsidiaries. Deere's Heritage National Healthplan unit operates a health maintenance organization and administers fee-for-service health care for employees and retirees. ■

HMO fined $30,000 for late payment

WOODLAND HILLS, Calif.—A large fine levied against California's second-largest health maintenance organization for late payment of a claim will serve as an example to health insurers, says Insurance Commissioner John Garamendi.

The commissioner fined Woodland Hills, Calif-based Health Net $30,000 last week for mishandling a $192 claim in 1990.

"Although the amount of this claim was small, Health Net handled it egregiously," Mr. Garamendi said. The commissioner said he hopes the "penalty sends a message to insurers that no matter how minor the misdeed, this kind of irresponsible behavior will not be tolerated."

The California Insurance Department charges that Health Net took more than 130 days to pay a member's bills for emergency treatment from a non-network provider, violating the state's Unfair Claims Practices Act.

In addition, Health Net repeatedly misrepresented to the member that his bill had been paid when it had not been, according to Mr. Garamendi.

Normally the department would not have jurisdiction over HMOs because they are regulated by the state's Department of Corporations.

Health Net, though, had been licensed as an insurer in the state until 1991, since its founder, Blue Cross of California, is an insurer, explained a spokesman for the HMO.

Health Net recently received approval to convert to for-profit status (*BI*, Feb. 24).

The HMO had no direct comment on the fine. It did say that its consumer complaint record was among the best in 1991 rankings by the Insurance Department.

—By Joanne Wojcik

Government liable

Continued from page 1

"The federal government has been. . .somewhat lackadaisical" about potential environmental hazards from its projects, he said. "If the federal government is going to be recognized as a potentially responsible party in these matters, it makes available a solvent, findable defendant whose pocket is likely to be deep," Mr. Berman added.

The case, heard in the U.S. District Court for the Eastern District of Pennsylvania in Philadelphia, pitted FMC against the U.S. Commerce Department, as successor agency to the War Production Board. The case involved responsibility for cleaning up a one-time rayon manufacturing plant that the War Production Board had controlled during World War II.

"The production of high-tenacity rayon yarn at the facility during the war generated large amounts of hazardous substances requiring disposal," observed U.S. District Judge Clarence C. Newcomer in his Feb. 20 decision.

Although the plant was owned during the war years by American Viscose Corp., it was considered a "war plant" and, thus, "subject to maximum control by the government," he said.

FMC Corp. purchased the Front Royal, Va., site from American Viscose in 1963 and sold it in 1976 to Avtex Fibers-Front Royal Inc.

The plant was placed on Superfund's priorities list in 1986.

Avtex Fibers closed the plant in late 1989, and subsequently filed for federal bankruptcy protection.

The Environmental Protection Agency informed FMC that it expected it to clean up the site.

FMC acknowledged it bore some responsibility for the site, but sued the Commerce Department to force the government to contribute to the cost of the cleanup.

FMC argued that the federal government, through the War Production Board, was an "owner, operator and/or arranger" of the site under Superfund, and therefore potentially liable for cleanup costs.

Judge Newcomer agreed, ruling that the government actually owned facilities and equipment at the site and participated in the management and operation of the facility from 1942 to 1945.

In addition, "the government knew or should have known that the disposal of hazardous substances was inherent in the manufacture of high-tenacity yarn," the judge wrote.

High-tenacity rayon yarn was used as a rubber substitute in manufacturing tires during the war. A substitute was needed because U.S. access to 90% of its prewar rubber supply in Southeast Asia was cut off by Japan.

The judge held the government "jointly and severally liable for the costs that FMC has already incurred and will in the future incur in responding to such release or threatened release of hazardous substances."

Ms. Press, the FMC attorney, said that the federal government's liability would be determined at a future allocation trial. No date has been set for the proceeding.

The ultimate cost of cleaning up the site could run into the tens of millions of dollars, said Neil Epstein, FMC's lead counsel and a partner with Hangley Connolly Epstein Chicco Foxman & Ewing.

FMC in November 1990 won a sweeping victory in separate litigation against its insurers over coverage for cleanup costs (*BI*, Nov. 26, 1990).

The California Supreme Court ruled that the cost of cleaning up polluted property constitute "damages" as the word is used in comprehensive general liability policies. The court also ruled that FMC should be granted coverage whenever policy language is ambiguous.

Dozens of insurance companies wrote FMC's liability overage.

Ms. Press' law firm has received several inquiries about the case from other attorneys whose clients may be in a similar position.

She cautioned, however, that the FMC case was "very fact-specific" and might not impact a large number of the approximately 1,250 other sites on the Superfund priorities list.

However, the ruling "is significant in that it shows that courts are willing to address the role that the War Production Board played," commented Thomas Truitt, an attorney in the Washington, D.C., office of Piper & Marbury, a Baltimore law firm.

Mr. Truitt represents Los Angeles-based Occidental Petroleum Corp., which contends that the federal government bears some responsibility for cleaning up the notorious Love Canal site near Niagara Falls, N.Y.

The government arranged for some toxic substances to be dumped at the Love Canal site.

If the FMC argument is successful in the Love Canal case, the government could be held responsible for cleaning up approximately 15% of the hazardous waste at the infamous dump site, Mr. Truitt estimated.

However, "the extent to which the case has bite nationally, I don't know," he added.

In fact, there is no reliable estimate of how many sites might be affected by Judge Newcomer's decision.

The Commerce Department referred all questions about the case to the Justice Department.

A spokeswoman for the Justice Department said that the government had no comment on the case and declined to "speculate" whether it would appeal.

The AIA's Mr. Arlington said the decision has a potentially wide-ranging impact depending on how far back in time courts apply Judge Newcomer's standards.

During both world wars, the federal government took de facto ownership of thousands of manufacturing and transportation facilities, he said.

For example, one of the key sectors run by the government during World War I was the railroads, Mr. Arlington said.

Because some Superfund sites have ties to the railroad industry, it is not inconceivable that FMC's argument could be repeated in the case of railroads that are named as potentially responsible parties for polluted sites.

"I think we'll have a bunch of lawyers who suddenly become experts on War Production Board activities," said Mr. Arlington with a laugh.

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FMC Corp. vs. United States Department of Commerce, et al., United States District Court for the Eastern District of Philadelphia, No. 90-1761.

Executive Life

Continued from page 3

comment. None of the ELIC officials could be reached.

The complaint also alleges that Michael Milken, his brother Lowell, and Drexel Burnham Lambert official Ray Johnson engaged in fraud, negligent misrepresentation and intentional and negligent breach of fiduciary duty, among other things.

The suit alleges Mr. Milken operated a vast financial network consisting of ELIC and numerous other entities that provided him a market for billions of dollars of junk securities.

Mr. Milken, who is serving a 10-year prison sentence for securities violations, has offered to pay $500 million to settle suits filed against him and other Drexel officials (*BI*, Feb. 24).

Mr. Garamendi also is suing the rating agencies.

"While Executive Life was purchasing junk bonds at an imprudent rate, and far in excess of any other insurance company, (these agencies) gave Executive Life high ratings," the suit says.

In fact, until January 1990, Best and S&P gave ELIC their highest ratings, the suit points out. "It wasn't until Executive Life announced a massive write-off of its junk bond holdings in January 1990 that they lowered their ratings."

The complaint alleges that the rating agencies had access to "confidential and inside information" that "belied" the ratings they gave to ELIC.

The suit is not the first against the rating agencies stemming from ELIC's collapse. The agencies are named in more than 20 suits filed by angry ELIC policyholders (*BI*, Aug. 5, 1991).

John Grillos, general counsel for Oldwick, N.J.-based Best, said Mr. Garamendi's suit is without merit, though he had not seen it.

Mr. Grillos said that the California department conducted an on-site audit of ELIC in 1990. And, on Dec. 28, 1990, "almost a full year after we began downgrading these companies, (the department) said, 'In our expert opinion, the Executive Life Insurance Co. is in no imminent danger.' Less than four months later, they took it over. So who's at fault here?"

Mr. Grillos said Best has no professional liability insurance to respond to the lawsuit. "Why would we insure for the risk of liability when what we print is opinion? Opinion is protected by the First Amendment."

New York-based Standard & Poor's also had not seen the lawsuit, but a spokeswoman called it "groundless."

She said S&P, a unit of McGraw-Hill Inc., is covered under its parent's insurance.

Chester Murray, associate director of Moody's, said the agency gave ELIC a non-investment grade rating 15 months before it was seized. "We never gave it a rating that entered a AA category."

Moody's has no liability insurance that would respond to fraud and negligence allegations, said Matthew Mole, general counsel.

The suit also alleges Deloitte & Touche, ELIC's accounting firm, either knew of, or recklessly or negligently disregarded, evidence revealing adverse facts about ELIC's finances and inappropriately certified the company's financial statements.

Deloitte & Touche said ELIC's problems have "nothing to do with its accounting policies or our audits." The suit appears to be a "search for deep pockets," it said.

Major accounting firms generally have self-insured retentions of $6 million to $10 million per claim for professional liability risks with an aggregate retention of $20 million to $30 million (*BI*, Oct. 8, 1990). ■

Maine project

Continued from page 3

demonstration project.

"We are optimistic as are most other parties, and are supportive of their efforts," said Timothy Morse, vp of the medical services division of The St. Paul Cos. Inc. of St. Paul, Minn., the major medical malpractice insurer in Maine.

Some 300 St. Paul policyholders are enrolled in the project.

Other insurers, though, share the constitutional concerns of plaintiffs' lawyers: the law may violate the constitutional guarantees of equal protection of the law.

"It creates an unfair and, in fact, impossible judicial standard" and leads doctors to believe "they are on the threshold of immunity," said Robert J. Stolt, legislative chairman of the Maine Trial Lawyers Assn. in Augusta. The association lobbied against the legislation and tried to discourage doctors from enrolling in the program.

Among the insurers that share this concern is Medical Mutual Insurance Co. of Maine, another large writer of medical malpractice coverage in the state.

"We never really liked the bill," said Theodore T. Briggs, executive director of Medical Mutual, which is based in Portland.

The insurers' lawyers fear that if an affirmative defense is deemed unconstitutional, the company may be held liable for claims from care provided by program participants. These claims may never have arisen had the doctor practiced defensive medicine.

Ultimately, the Maine Supreme Court may have to decide the issue, cautions Mr. Smith of the Maine Medical Assn.

This uncertainty, however, has not discouraged Maine's specialized physicians from signing up for the program. Patients do not have to be notified that their doctors are participating.

The American Medical Assn., which supports practice parameters in general, encouraged doctors to participate.

"We have been strongly supportive of the efforts (in Maine)," said Dr. John T. Kelly, director of the Office of Quality Assurance for the Chicago-based AMA. "Our intent is to monitor what happens there very closely."

At least 50% of the licensed physicians in all four specialty areas had to agree to participate before the program could get off the ground, Mr. Smith said.

Before the Nov. 1 cutoff date, 375 doctors volunteered: 59, or 53% of the state's anesthesiologists; 106, or 68% of emergency medicine specialists; 58, or 60% of radiologists; and 152, or 57% of obstetricians and gynecologists.

In fact, the program is proving so popular with physicians that recently introduced legislation to establish open enrollment in the program stands a good chance of passage this year, observers say.

Aiming to hold down health care costs, a coalition of business, labor, insurance and health care interests developed the concept behind the demonstration project.

Pricing and availability of medical malpractice insurance were less of an issue, because rates in Maine are on par with the national average, said Mr. Briggs of Medical Mutual.

There has been no "market crunch" in medical malpractice coverage in Maine. In fact, rates have stabilized over the past 18 months, said Frank Ferland, vp of commercial lines for Morse, Payson & Noyes, a Portland broker.

No estimates are available for savings in malpractice premiums or health care costs. Officials in Maine are seeking federal funding to develop a study to measure the program's effects.

The real impetus for the program is to contain the amount of defensive medicine practiced.

Based on medical literature and earlier research, the coalition identified defensive medicine as a major factor in rising health care costs.

Maine ranks slightly below the national average in per-family health care costs, but costs there have been rising more rapidly than in many states (*BI*, Dec. 23, 1991).

"The underlying drive for people to get involved is the cost of medicine," said Dr. Richard Flowerdew, chairman of the anesthesia section of the practice parameters committee and a project participant. "I don't think anyone has joined just because they see it as a legal protection. . . .We pay health insurance premiums ourselves."

Defensive medicine drives up consumer health costs by about $15 billion annually nationwide, the AMA estimates.

Under a system that encourages defensive medicine, an emergency room physician treating 10 patients with head trauma might prescribe CAT scans and magnetic resonance imaging for each of the patients simply to protect against malpractice claims, said Brian Atchinson, staff attorney for the Maine Department of Professional and Financial Regulations in Augusta.

Doctors in the Maine program instead would administer such tests only as indicated by their specialty's practice parameters, which are basically an expansion of the "treatment tree" methods taught in medical school, Mr. Atchinson said.

Panels of specialists in each practice area developed the criteria based on parameters established by each specialty's professional association, Dr. Flowerdew added.

The main expense for the project will be administration, which will be handled by the state Department of Professional and Financial Regulation. Funding will come from physicians licensing fees paid to the Board of Registration, part of the state Medical and Insurance Department.

Insurers will be required to annually track the experience of policyholders enrolled in the project and compare them with other physician policyholders, said Mr. Morse of St. Paul.

The legislation requires that full a full report on the program be presented to state lawmakers by Dec. 1, 1997.

While project supporters are optimistic, they remain cautious about pending federal legislation that would mandate use of practice parameters nationwide.

"The effort in Maine will provide us with useful information on how such guidelines work," said Dr. Kelly of the AMA. "But it is our view that federal proposals to require the use of parameters are premature until we see the results in Maine."

"Because it is so innovative, we don't know all the ramifications yet," Mr. Smith acknowledged. "It's not something that should be quickly replicated in this country. Wait and see what our experience is in two or three years."

Other elements of Maine's medical liability tort reform package, however, have already proven their effectiveness.

For example, Maine estimates that a modification of the collateral-source rule that took effect in July 1990 in malpractice cases will cut medical malpractice premiums by 2%. ■

House tax bill

Continued from page 3

in recent years.

Still, they say, benefit managers must be aware of the changes to administer their companies' benefit programs.

"The House tax bill is not landmark pension legislation. But there are a lot of details that benefit managers will have to master to administer their companies' programs," said Henry Saveth, a principal with A. Foster Higgins & Co. Inc. in New York.

And, while the legislation may not be of earthshaking importance, the simplification provisions are a welcome change in direction from earlier tax laws like the Tax Reform Act of 1986, benefit experts say. That law most notably gave rise to Section 89, the infamous provision—later repealed—that set up enormously complicated non-discrimination rules for health care plans.

"The House bill is a departure from past bills. Unlike previous tax bills, this measure seeks to simplify employee benefit law. It is a change in direction, if only a modest one," said Frank McArdle, a consultant with Hewitt Associates in Washington, D.C.

"Many of the simplification changes are small, but they will be welcomed," said Gerald Uslander, a principal with William M. Mercer Inc. in Washington, D.C.

"It is a modest beginning toward simplification, but at least it is a beginning," observed Howard Weizmann, executive director of the Washington, D.C.-based Assn. of Private Pension & Welfare Plans.

Under one proposed change that would help employers with 401(k) plans, employers would be allowed to compare salary deferrals made by lower-paid employees during the previous year with the contributions made by high-paid employees in the current year.

By contrast, IRS regulations now require employers to compare the current-year contributions of the two groups when running non-discrimination tests.

By using lower-paid employees' prior year contributions, employers could know at the start of a plan year how much high-paid employees could contribute to the plan without failing the non-discrimination tests.

The package also includes a provision—first proposed in 1990—that would establish two new safe harbors for 401(k) plans. Plans qualifying for either of the safe harbors would not be subject to non-discrimination tests.

However, to qualify for the safe harbors, a typical employer would have to significantly increase its contributions to its 401(k) plans.

As a result, "for only a small percentage of employers will the safe harbors be helpful," said Karen Frost, a Hewitt consultant in Lincolnshire, Ill.

Another provision would allow non-governmental tax-exempt employers, like trade associations, to set up 401(k) plans. The 1986 tax law barred tax-exempt employers from setting up 401(k) plans, though it allowed plans that already had been established to remain in place.

"This will be of great relief to certain tax-exempt employers who have not been eligible to establish other types of defined contribution plans that allow salary reduction," said Foster Higgins' Mr. Saveth.

The legislation also would simplify the definition of who is a highly compensated employee for pension non-discrimination testing purposes.

Under this measure, highly compensated employees would be those who own at least 5% of a company or earn at least $62,345 per year, an amount that would be increased annually with inflation and rounded to the nearest $1,000.

By contrast, current law sets numerous definitions.

Another simplification provision would require the IRS to round to the nearest $1,000 or $100, respectively, annual cost-of-living adjustments to the maximum amount of benefits that could be funded through a defined benefit pension plan or deferred to a 401(k) plan.

"Rounding will make benefit threshold amounts, like the 401(k) maximum deferral, easier to remember for both employers and employees. In a small way, it will reduce complexity," Mr. Saveth said.

Safe harbors will help 'only a small percentage of employers,' says Karen Frost.

In addition, the IRS would have to give employers more advance notice on what the annual cost of living adjustment increase will be for pension and 401(k) plans.

Under this change, the IRS would publish the new maximum benefit and deferral limits long before the end of the year. As a result, an employee would know before the start of a new year how much could be deferred to a 401(k) plan.

Currently, the IRS does not publish the adjustments to maximum benefits and deferral limits until mid-January, often after employees determine their contribution levels for the year.

Still other provisions in the law would make life easier for benefits managers and employees in other ways.

For example, the legislation would permanently extend the tax-favored status of employer-provided educational assistance benefits. That would end the uncertainty employers have endured for years over whether and when Congress would continue Section 127, which is now set to expire June 30.

Some provisions in the House-approved tax bill, like the tax packages of the past, would add to employer costs and increase employees' taxes.

For example, the legislation would:

- Require multiemployer pension plans to adopt new, more rapid vesting schedules.

The plans could adopt a schedule in which employees were first and fully vested after five years or adopt another schedule whereby they were 20% vested after three years with vesting continuing at the rate of 20% annually until an employee was fully vested after seven years of service.

Although single-employer plans now typically use five-year cliff and seven-year graded vesting, multiemployer plan have been allowed—through a special exemption in the 1986 tax law—to use 10-year cliff vesting.

- In certain situations require employers to directly transfer an employee's pension and savings plan distributions to an employee's Individual Retirement Account or to a new employer's defined contribution plan.

However, the new employer still would be allowed to refuse to accept such a transfer to its defined contribution plan. Such transfers also would not be required if the new employer did not offer a defined contribution plan.

This provision, while modestly increasing employers' administrative burdens, is not nearly as burdensome as other proposals circulating on Capitol Hill that would force the new employer to accept a rollover from the old employer's plan.

- Increase employees' taxes by eliminating favorable tax treatment—known as five-year averaging—of lump-sum pension distributions.

- Tax employees receiving pension plan distributions composed of company stock on any unrealized appreciation of the stock since it was purchased by the employee.

Such appreciation now is taxed only when an employee actually sells the stock, not when the stock is distributed from the plan.

Certain other provisions of the legislation are aimed at helping specific industries or companies with their benefit provisions. For example, the legislation also would help certain airlines employing non-union pilots.

The legislation would exempt airline pension plans covering non-union pilots from taking into consideration other airline employees when determining whether the pension plan covers a sufficient percentage of non-highly compensated workers to satisfy IRS non-discrimination tests.

Airlines often have separate and more generous pension plans for pilots, who tend to be highly compensated. The separate plans reflect the fact that pilots need to accrue benefits more rapidly than other workers because of federal rules requiring retirement before age 60.

Without the exemption in the legislation, a pilots' pension plan could fail IRS non-discrimination tests because it would not cover a sufficient percentage of non-highly compensated employees, said Kyle Brown, an attorney with The Wyatt Co. in Washington, D.C.

The tax measure also would allow coal companies to use surplus assets in special black lung disability trusts to pay for retiree health benefits without being taxed on the funds (*BI*, Feb. 10).

After the surplus assets are removed, however, the trusts still would be required to have assets of at least 110% of black lung liabilities.

While the House has completed action on the tax package, the Senate Finance Committee is scheduled to start work on its own tax bill this week. It's not know which benefit provisions contained in the House bill will be incorporated in the Senate legislation.

Meanwhile, the Bush administration has warned that it would veto the House bill in its current form if sent to the president. The administration opposes some of the non-benefits provisions in the House bill. ■

Update

LTV bankruptcy ruling stands

Continued from page 2

In 1990, though, the 2nd U.S. Circuit Court of Appeals ruled that the law does not apply in all situations.

The appellate court said the law did not apply in this case because the mine workers' collective bargaining agreement promising the benefits had expired.

Trial rejected in Lloyd's dispute

LONDON—A preliminary hearing, rather than a full trial, will determine whether Lloyd's of London owes a duty of care to members, the British House of Lords has ruled.

Ruling on a dispute between Lloyd's and members of loss-riddled syndicates formerly managed by Oakeley Vaughan Underwriting Ltd., the House of Lords agreed with Lloyd's that settling the issue at a preliminary hearing would save time and money.

In June, Justice Gatehouse ruled that the duty of care question should be settled in a preliminary hearing. But, members won a reversal on appeal (*BI*, Sept. 23, 1991). Members want a full trial so they could cross-examine former Lloyd's chairmen.

The case will go to trial only if the preliminary hearing rules that Lloyd's does owe a duty of care, said members' lawyer Michael Freeman, a senior partner at Michael Freeman & Co. in London. The trial would determine, among other things, whether Lloyd's did act in its members' best interests.

No date has been set for the preliminary hearing.

NFL owners lose pension ruling

WASHINGTON—National Football League owners will have to make back payments of as much as $38.7 million to a players' defined benefit pension plan after the Supreme Court last week let stand an appeals court ruling.

The 4th U.S. Circuit Court of Appeals last year rejected the owners' claim in a 1987 action that they could defer contributions under the terms of a 1982 bargaining agreement because the plan was overfunded and therefore contributions would not be tax-deductible.

But, in upholding a lower court ruling, the 4th Circuit last August ruled that the owners must make the full payment because the Internal Revenue Code allows clubs to carry forward any contributions not deductible in the year they are paid (*BI*, Sept. 9, 1991).

Only about half the award is for contributions to the Bert Bell National Football League Retirement Plan, said a lawyer for the players, Joseph A. Yablonski of Yablonski, Both & Edelman in Washington, D.C.

The remaining half represents interest and legal fees, he said, noting that the owners dispute the amount of interest owed.

The Supreme Court has left "a number of difficult issues to be resolved. . .including the amount of interest to be paid," the NFL said.

The plan, a Taft-Hartley plan established in 1969, covered about 5,000 players active through the 1988 season.

RJR settles shareholder suit

NEW YORK—RJR Nabisco Inc. agreed last week to pay $72.5 million to former shareholders and employees holding stock options to settle charges that the company failed to disclose material information before RJR's 1988 leveraged buyout.

The shareholders charged in a class-action lawsuit that RJR failed to disclose the possibility of a takeover before Kohlberg Kravis Roberts & Co. of New York bought the company for $25 billion. RJR shares had been trading at $40 to $54 a share until the deal was announced in October. But after the announcement, the stock price soared to $109.

Shareholders who sold their shares after March 30, 1988, but before the deal was announced, will recover under the settlement. The settlement, though, is subject to approval by U.S. District Judge Michael B. Mukasey.

An RJR spokesman would not confirm how much of the settlement will be covered by insurance.

Briefly noted

A federal district judge had no authority to change the **Manville Personal Injury Trust Fund** so that the most seriously ill victims are paid first and attorneys' fees are capped at 25% of those payments, plaintiffs' attorneys and asbestos manufacturers appealing the massive restructuring argued in federal appeals court last week (*BI*, Nov. 26, 1990; Sept. 10, 1990). The asbestos manufacturers, which still face asbestos claims, contend they would have to pay more money to settle those claims if the restructured Manville fund survives legal challenges. . . .Wind, hail and tornadoes caused an estimated **$10 million of insured property damage** to a wide area of south-central Texas Feb. 22-23, reports the Property Claim Services division of the American Insurance Services Group. The severe weather was assigned Catastrophe No. 94. . . .**Mutual Benefit Life Insurance Co.** policyholders may have their account values paid in full, but their recoveries depend on how well the insurer can minimize real estate investment losses and resolve certain tax issues, says a report by the insurer's supervisor. . . .The Italian government has passed a law that sets up a fund to compensate **victims of the Mafia** by imposing a 1% tax on some insurance policies. Insurers opposed the decree when it was announced last November (*BI*, Nov. 25, 1991). The tax will apply retroactively to all policies issued since Jan. 3, 1992.

Inland pollution ruling

Continued from page 2

Although Mr. Brown commented that the decision possibly could be broadly applied to anyone with liability for a pollution exposure, he added, "It's hard to believe that it will be a standing precedent for long." The decision is "so poorly reasoned" it will likely be overturned, he said.

Insurer attorney Thomas Brunner of Wiley, Rein & Fielding in Washington, D.C., agrees that the decision "would apply to about any pollution case, as well as a variety of long-term problems."

For example, it could apply to a case involving a manufacturer that spilled toxic chemicals at its plant or the owner of an apartment with lead-based paint on its walls, he said.

Essentially, the decision says that if a policyholder purchased insurance from different insurers during two policy periods and the problem became known during the first policy period, there would be coverage only under the first policy, he said.

In the case, Stricker Paint Products Inc. hired Inland Waters Pollution Control Inc. of Detroit in January 1981 to remove and dispose of several hundred drums containing "waste paint materials" xylene and toluene from its property in Novi.

But, while Inland was crushing the drums at the Stricker site, liquids leaked out.

Inland then transported the crushed drums and a few inches of frozen soil containing the leaked waste liquid to a disposal facility, court papers said.

Inland also spread lime on the property to soak up any remaining contaminated liquid. This soil also was subsequently transported to a landfill.

Several months later, Inland purchased general liability coverage from National Union Fire Insurance Co. of Pittsburgh, Pa.

The policy provided $1 million of occurrence/aggregate limits for bodily injury or property damage. Inland subsequently renewed this coverage.

More than six years after the 1981 cleanup, a Stricker environmental consultant reported that the site's soil and groundwater contained a "significant" amount of solvent contamination.

Stricker sued Inland in June 1987 to recover the costs of a second cleanup.

New York-based National Union, a subsidiary of American International Group Inc., refused to defend Inland or pay any of the $105,000 settlement Inland paid Stricker.

Inland then sued National Union, seeking indemnification, defense costs and interest.

Inland did not seek coverage from previous insurers because it "couldn't prove the existence of prior coverage, due to possible lost policies," explained Inland attorney Mark S. Demorest of The Robert Ufer Partnership in Bloomfield Hills, Mich.

The U.S. District Court ruled for National Union.

Inland appealed, but the 6th U.S. Court of Appeals in Cincinnati affirmed the portion of the lower court decision denying coverage to clean up the contaminated soil.

The court ruled the soil was contaminated before the National Union policy went into effect.

But, the 6th Circuit reversed the portion of the lower court ruling denying coverage for the cost of cleaning the contaminated groundwater because it was not clear when the groundwater became contaminated.

The 6th Circuit sent the case back to the federal court in Detroit to determine the facts of this issue.

National Union asserted before the lower court in Detroit that because the groundwater contamination process began prior to the effective policy date, the injury was a "loss in progress" and therefore not covered.

The insurer also argued that the Inland lawsuit should be barred because the cleanup firm knew before it obtained the coverage that contamination had occurred or was likely.

Inland argued that it did not have certain knowledge of the groundwater contamination because many other factors could have contributed to the contamination.

But, Judge Gadola granted National Union summary judgment based on the "loss-in-progress" doctrine.

In explaining his decision, Judge Gadola said: "Plaintiff spilled the contaminants on the ground. Despite its efforts at mitigating the damage, the water table became contaminated as a result of the spill. The damage may have taken years to manifest itself, but it is a direct result of the spill caused by plaintiff" before purchasing coverage from National Union.

Judge Gadola did not rule on National Union's "known-risk" argument because of a lack of evidence that the cleanup firm knew about the pollution and the risk to the groundwater.

"I think it is a significant decision," said Randall E. Phillips, an insurer attorney with Provizer, Lichtenstein & Phillips in Southfield, Mich., who previously served as National Union's local counsel in this case.

The decision is consistent with Michigan law, though it is one of the few to extended these doctrines to pollution cases, he said.

National Union attorney Sheldon Karasik of Sheft & Sheft in New York declined to comment on the decision, citing company policy.

However, Inland disagrees with the ruling on many points.

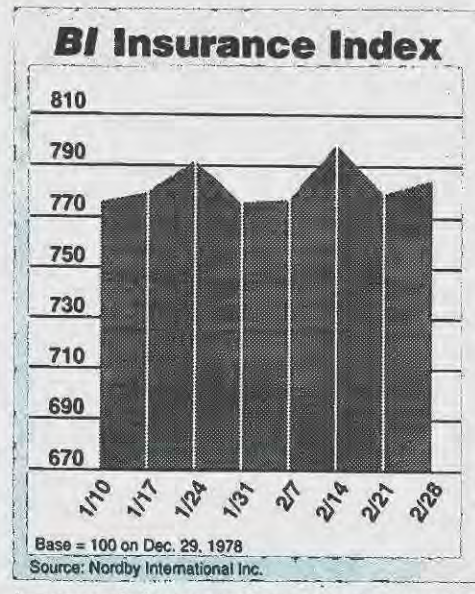
In asking the lower court to reconsider its ruling, Inland argued the decision was inappropriate because, among other things, it does not recognize soil and groundwater contamination as two distinct types of damages. This is inconsistent with the 6th Circuit's decision, Inland argues.

In addition, the loss-in-progress doctrine, as formulated by the court, is "inconsistent" with the express language of insurance policies, Inland contends. Inland's policy defines occurrence as "an accident, including continuous or repeated exposure to conditions, which results in bodily injury or property damage neither expected nor intended from the standpoint of the insured," Mr. Demorest said in his request for a rehearing.

Applying the "illusory" loss in progress and known risk doctrines is "basically circumventing the occurrence standard and trying to create a lesser standard," said Mr. Brown of Anderson, Kill.

Those doctrines are usually found in first-party liability cases, according to Mr. Brown.

However, insurer attorney Mr. Brunner, of Wiley, Rein & Fielding, said he knows of a dozen or so environmental liability cases in which the doctrines have been applied. ■



Insurance industry stocks reversed course last week, as the *Business Insurance* Index rose 3.2 points to 784.0 on Feb. 28 from 780.8 on Feb. 21. Advancing issues for the week were led by Frank B. Hall & Co. Inc., up 13.8%; NAC Re Corp., up 13.2%; and Sierra Health Services, up 12.6%. Declining issues for the week followed AVEMCO Corp., down 10.1%; Phoenix Re Corp., down 8.5%; and Kemper Corp., down 6.3%. The most active issue for the period was Sears, Roebuck & Co. (Allstate), 4.5 million shares traded. The *BI* Index was up 0.4%; the New York Stock Exchange Composite was up 0.33%; the Standard & Poor's 500 was up 0.31; and the Dow Jones 30 Industrials fell 0.4%.

British Issues

Feb. 27 Companies	Price pence	P/E	Div. pence	Yield %	1 Week High—Low pence	pence
Comml Union	458	N/M	31.5	6.9	466—456	
Genl Accident	426	N/M	35.7	8.4	436—426	
Gdn Royal Exch	110	N/M	15.9	14.5	120—110	
Royal	190	N/M	15.0	7.9	226—190	
Sun Alliance	271	N/M	18.7	6.9	284—271	
Brokers						
Bradstock	161	18.1	6.3	3.9	161—161	
CE Heath	444	15.5	34.5	7.8	447—443	
Hogg Group	175	10.4	10.7	6.1	176—175	
JIB Group	192	15.9	10.0	5.2	192—189	
Lloyd Thompson	238	23.9	6.0	2.5	238—238	
Lowndes Lmbrt	350	17.3	15.3	4.4	353—350	
PWS Holdings	65	7.1	5.3	8.1	65—65	
Sedgwick Grp	213	16.6	16.0	7.5	215—209	
Steel Brri Jones	299	15.9	16.3	5.5	299—298	
Willis Corroon	242	12.8	17.6	7.3	243—240	

Source: Philip Olsen, Insurance Industry Analyst, London

BI Industry Stock Report

FEBRUARY 24, 1992 THROUGH FEBRUARY 28, 1992

		Price	Weekly % change	Year to Date % change	Annual High	Annual Low	Vol.(000)	$ Div.	% Yield	P/E	Book value	Mkt/Bk. value
BROKERS												
Alexander & Alexander	NYS	21.00	1.20	2.44	27.50	18.00	550	1.00	4.76	-84	9.77	2.15
Gallagher Arthur J. & Co.	NYS	24.13	0.52	7.82	28.38	19.00	43	0.64	2.65	18	5.88	4.10
Frank B. Hall	NYS	4.13	13.79	-2.94	5.50	3.13	331	0.00	0.00	-6	-5.24	-0.79
Hilb, Rogal & Hamilton	OTC	13.00	-0.95	-1.89	17.50	11.25	30	0.40	3.08	21	3.56	3.65
Marsh & McLennan	NYS	74.88	-0.17	-7.99	87.25	70.00	428	2.60	3.47	18	14.77	5.07
Poe & Associates	OTC	14.25	-1.72	18.75	14.50	6.88	24	0.40	2.81	16	2.52	5.65
BROKERS	AVERAGE		2.1	2.7					2.4	-2		
CONGLOMERATES & HOLDING COMPANIES												
Berkley W.R. Corp.	OTC	34.00	-4.90	11.48	36.25	23.50	193	0.32	0.94	14	23.89	1.42
Berkshire Hathaway Inc.	NYS	8725.00										
			0.29	-3.59	8725.00	242.50	0	0.00	0.00	-37	4612.00	1.89
ITT (Hartford Group)	NYS	64.25	4.68	11.26	64.25	50.00	4252	1.84	2.86	10	64.01	1.00
Sears (Allstate)	NYS	43.38	0.00	14.52	45.13	30.50	4483	2.00	4.61	13	37.38	1.16
CONGLOMERATES	AVERAGE		0.0	8.4					2.1	0		
INSURERS/REINSURERS												
AEGON N.V.	NYS	69.00	0.91	-1.43	71.75	54.75	2	2.30	3.33	7	N/A	N/A
Aetna Life & Casualty	NYS	45.63	1.96	3.69	49.13	31.88	1184	2.76	6.05	10	64.23	0.71
Allied Group Inc.	OTC	21.50	6.17	26.47	21.50	13.50	302	0.56	2.60	8	11.50	1.87
American General	NYS	40.75	-0.61	-8.43	44.75	36.13	1030	2.08	5.10	10	37.14	1.10
American Indemnity/Fin'l	OTC	6.63	0.00	39.47	9.25	4.50	4	0.08	1.21	6	12.93	0.51
American International	NYS	87.50	-0.28	-11.05	102.00	78.63	1694	0.48	0.55	12	45.34	1.93
Aon Corp.	NYS	42.75	-2.84	7.89	45.25	34.38	302	1.60	3.74	11	18.50	2.31
Argonaut Group	OTC	26.00	0.00	9.47	33.38	21.75	60	0.68	2.62	8	48.26	0.54
AVEMCO Corp.	NYS	24.50	-10.09	-2.00	28.00	18.63	32	0.40	1.63	18	9.55	2.57
Baldwin & Lyons Inc.	OTC	26.50	0.47	2.91	27.50	21.50	0	0.28	1.06	7	24.29	1.09
Belvedere Corp.	ASE	4.25	-5.56	30.77	5.38	2.63	16	0.04	0.94	12	7.65	0.56
Chandler Insurance	OTC	4.13	6.45	26.92	4.75	2.13	148	0.00	0.00	52	5.95	0.69
Chubb Corp.	NYS	67.88	-0.37	-11.85	78.00	60.75	2102	1.48	2.18	11	35.19	1.93
CIGNA Corp.	NYS	54.88	-2.01	-10.22	61.75	41.25	817	3.04	5.54	11	73.15	0.75
CNA Financial Corp.	NYS	81.00	0.93	-17.35	104.50	75.50	84	0.00	0.00	8	70.23	1.15
Continental Corp.	NYS	28.63	6.51	3.62	30.38	23.25	622	2.60	9.08	29	37.83	0.76
EXEL Ltd.	NYS	36.25	6.62	-3.33	40.25	27.38	234	0.90	2.48	7	N/A	N/A
Fund American Corp.	NYS	66.25	-1.12	-5.19	70.25	59.38	105	0.68	1.03	18	36.11	1.83
Fremont General Corp.	OTC	23.50	1.08	-3.59	26.00	15.63	291	0.88	3.74	6	19.13	1.23
Frontier Insurance Group	NYS	30.25	2.11	12.04	30.50	18.28	36	0.00	0.00	11	11.20	2.70
Gainsco Inc.	ASE	14.50	-0.85	3.57	15.00	5.88	2	0.04	0.28	18	3.37	4.30
General RE Corp.	NYS	94.63	3.13	-7.12	104.75	85.00	414	1.80	1.90	13	37.50	2.52
Guaranty National Corp.	NYS	15.75	5.00	8.62	17.00	12.63	108	0.48	3.05	11	N/A	N/A
Hanover Insurance Co.	OTC	37.75	0.00	5.59	42.75	27.13	57	0.44	1.17	16	37.44	1.01
Harleysville Group	OTC	21.50	3.61	1.18	23.25	16.75	6	0.64	2.98	10	22.99	0.94
Hartford Steam Boiler	NYS	46.38	-3.89	-19.35	63.75	46.38	166	2.00	4.31	13	17.05	2.72
Kemper Corp.	NYS	31.38	-6.34	-17.70	46.13	28.88	1089	0.92	2.93	7	34.20	0.92
Lawrence Insurance Group	ASE	9.88	-1.25	-11.24	11.13	6.88	0	0.48	4.86	16	4.71	2.10
Liberty Corp.	NYS	23.25	5.68	5.08	23.75	19.50	130	0.48	2.06	12	23.86	0.97
Lincoln National	NYS	56.25	0.67	2.74	61.00	45.38	323	2.92	5.19	12	45.16	1.25
Markel Corp.	OTC	26.25	0.48	19.32	28.00	13.75	27	0.00	0.00	12	3.22	8.15
Mutual Risk Mgmt. Ltd.	NYS	36.00	-3.03	2.49	37.75	17.00	143	0.12	0.33	27	-	-
NAC Re Corp.	OTC	30.00	13.21	-4.76	33.00	21.75	111	0.16	0.53	14	18.90	1.59
Navigators Group	OTC	46.00	0.00	12.20	48.25	26.00	4	0.00	0.00	25	13.52	3.40
Nobel Insurance LTD.	OTC	4.38	0.00	9.38	5.25	3.00	41	0.00	0.00	6	7.76	0.56
NWNL Companies	NYS	32.50	8.79	4.42	38.50	18.63	320	1.40	4.31	9	42.73	0.76
Ohio Casualty Corp.	OTC	55.75	0.00	12.63	58.25	40.00	69	2.68	4.81	9	36.38	1.53
Old Republic Int'l	NYS	38.50	-2.22	8.45	40.50	24.38	137	0.72	1.87	8	33.09	1.16
Orion Capital Corp.	NYS	32.75	1.16	3.56	34.00	18.75	48	0.92	2.81	9	20.42	1.60
Phoenix RE Corp.	OTC	9.38	-8.54	-10.71	11.75	8.50	187	0.20	2.13	38	13.30	0.70
Provident Life	OTC	22.25	4.71	-4.30	24.50	16.75	192	1.00	4.49	9	25.88	0.86
Re Capital Corp.	ASE	13.50	0.00	-6.09	18.63	13.13	5	0.20	1.48	11	15.05	0.90
Reliance Group Holdings	NYS	4.63	-2.63	12.12	7.13	3.50	36	0.32	6.92	3	5.61	0.82
RLI Insurance Corp.	NYS	20.13	2.55	21.97	20.13	11.88	33	0.48	2.39	9	14.41	1.40
St. Paul Companies	NYS	72.25	0.35	-0.86	75.75	57.13	163	2.72	3.76	8	52.00	1.39
SAFECO Corp.	OTC	49.38	3.40	1.28	50.00	35.50	969	1.48	3.00	12	31.50	1.57
SCOR U.S. Corp.	NYS	18.13	1.40	17.89	18.88	11.63	6	0.24	1.32	11	11.19	1.62
Seibels Bruce Group	OTC	4.38	-2.78	-20.45	8.88	4.00	64	0.36	8.23	-2	7.35	0.60
Selective Ins. Group	OTC	19.25	1.32	14.93	19.75	13.75	77	1.04	5.40	9	18.91	1.02
Statesman Group Inc.	OTC	6.00	2.13	4.35	6.88	2.13	393	0.00	0.00	4	2.48	2.42
Tokio Marine & Fire	OTC	41.13	-2.95	-20.15	55.25	40.38	21	0.00	0.00	-	70.93	0.58
Torchmark Corp.	NYS	57.75	1.76	-0.22	61.50	46.50	164	1.60	2.77	12	16.70	3.46
Transamerica	NYS	41.88	4.69	5.02	42.88	31.25	638	2.00	4.78	36	36.56	1.15
Transatlantic Holdings	NYS	37.13	-0.67	-4.50	39.63	29.00	17	0.24	0.65	12	18.38	2.02
Traveler's Corp.	NYS	21.00	-1.18	-2.89	25.38	17.25	1438	1.60	7.62	7	41.44	0.51
Trenwick Group Inc.	OTC	29.50	-3.28	3.51	30.75	23.00	133	0.72	2.44	11	21.71	1.36
United Fire & Casualty	OTC	51.50	4.30	14.44	58.00	40.50	6	1.32	2.56	10	35.39	1.46
USF&G Corp.	NYS	9.38	0.00	29.31	12.50	5.63	1291	0.20	2.13	-4	11.96	0.78
UNUM Corp.	NYS	73.00	-1.18	-9.88	81.25	57.13	566	1.04	1.42	12	37.25	1.96
USLIFE Corp.	NYS	43.88	3.24	-8.36	47.88	34.25	263	1.64	3.74	9	60.34	0.73
Unitrin	OTC	34.00	0.37	-4.90	41.50	31.00	308	1.00	2.94	13	30.70	1.11
USLICO Corp.	NYS	18.75	1.35	1.35	21.00	17.00	31	1.00	5.33	-89	29.44	0.64
Washington National	NYS	17.25	-2.13	8.66	19.25	13.25	43	1.08	6.26	-52	26.86	0.64
Zenith National Ins.	NYS	16.25	8.33	-3.70	18.50	13.75	990	1.00	6.15	7	13.14	1.24
INSURERS/REINSURERS	AVERAGE		0.8	2.6					3.2	10.6		
HEALTH MAINTENANCE ORGANIZATIONS												
FHP International	OTC	15.50	1.64	8.77	29.75	9.88	1010	0.00	0.00	14	5.44	2.85
HMO America Inc.	OTC	23.50	11.90	40.30	24.88	8.50	1461	0.00	0.00	25	0.61	38.52
Pacificare Health Sys.	OTC	54.25	-0.46	37.34	62.50	21.50	925	0.00	0.00	21	6.55	8.28
Safeguard Health Enter.	OTC	11.75	-5.05	25.33	12.38	4.63	126	0.00	0.00	20	3.53	3.33
Sierra Health Services	ASE	26.75	12.63	44.59	29.50	12.38	222	0.00	0.00	15	1.78	15.03
United Healthcare Corp.	NYS	80.00	1.11	7.38	93.00	29.63	2387	0.06	0.08	34	3.76	21.28
United Medical Corp.	ASE	7.50	3.45	7.14	10.88	5.88	3	0.20	2.67	23	8.79	0.85
U.S. Healthcare	OTC	50.00	1.01	20.48	57.75	21.25	4147	0.56	1.12	24	3.38	14.79
HMOs	AVERAGE		3.3	23.9					0.5	22		
ALL COMPANIES	AVERAGE		1.5	9.4					2.7	10		

System design: Nordby International Inc.

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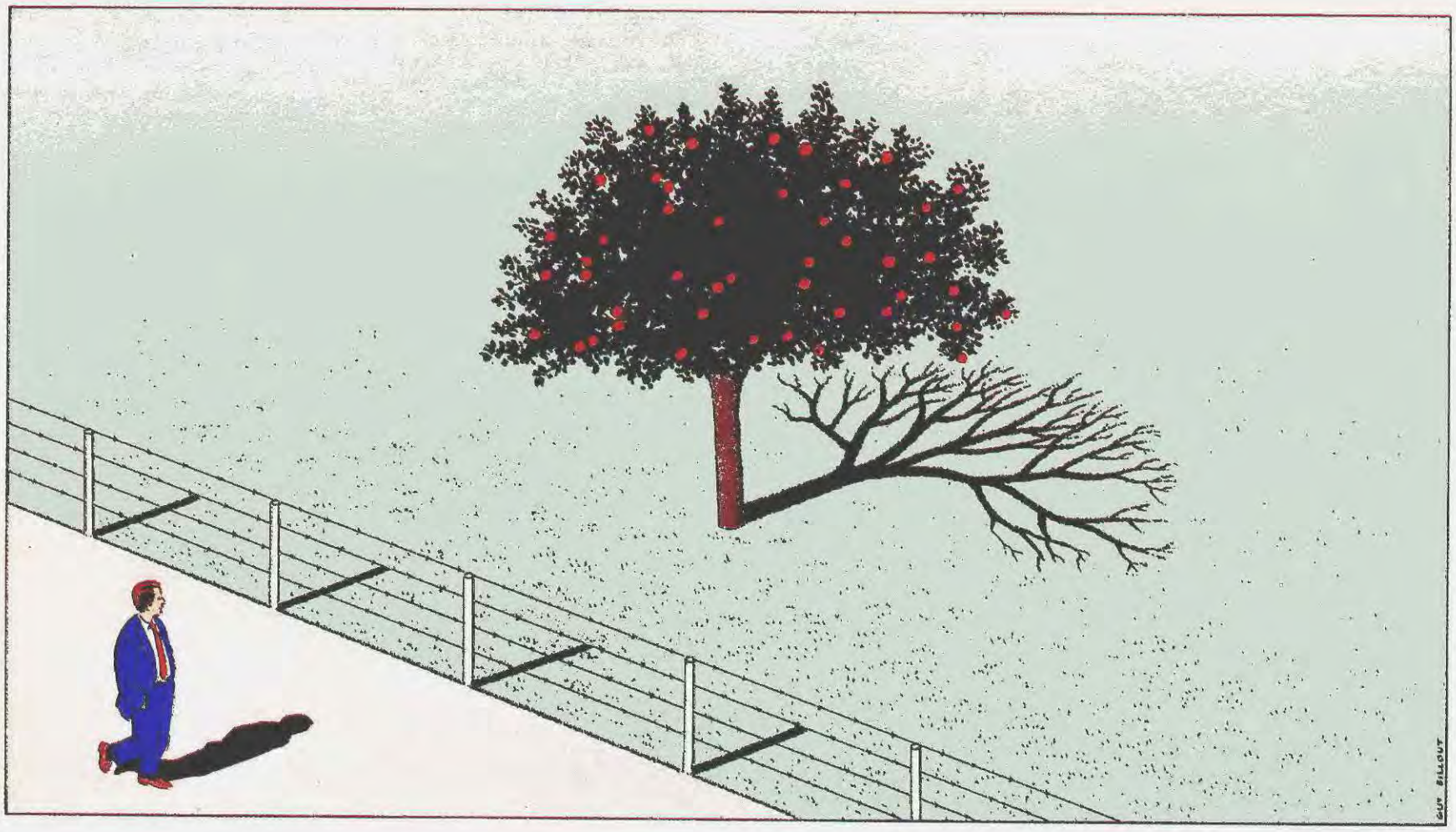
Every group insurance company promises the fruits of its knowledge and resources. But we put our knowledge and resources to work on practical ideas for employers and employees. ◆ For example, we identified early one of the great



emerging issues in employee benefits -- the provision of practical, economical group long-term care coverage -- and moved to implement it. Today, those we serve have this coverage available to them -- because our experience and the resources we command made it possible early. ◆ Clients who depend on your advice want to know how well group insurance companies know the industry. Now you can tell them how we make our experience and expertise work for them. For more information, call Patrick Moeschler, Director of National Accounts, at 1-800-877-1052.

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