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Update

Texas work comp reform law declared unconstitutional

EAGLE PASS, Texas—A state district court judge last week struck down Texas' new workers compensation law, ruling it unconstitutional because, among other things, it denies injured workers access to a traditional jury trial.

Judge Rey Perez said the law precludes disabled workers from obtaining benefits by applying "arbitrary and unreasonable" standards. And, he ruled the law improperly uses American Medi-

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AP/Wide World Photo

Cheese and butter melted by the fire bogs down firefighting efforts.

Food companies' fire losses covered

By MICHAEL BRADFORD and JOANNE WOJCIK

MADISON, Wis.—Food companies say they have adequate property insurance to cover tons of meat, butter and cheese valued at millions of dollars destroyed in a huge warehouse fire.

A four-alarm blaze on May 3 destroyed 50% to 60% of the Central Storage & Warehouse Co. complex in Madison, Wis., according to a Madison Fire Department spokesman.

The fire forced the temporary evacuation of about 3,000 nearby residents. No employees were reported injured, but several firefighters were treated for minor injuries sustained while battling the fire which was extinguished last Thursday.

Although firm damage estimates were unavailable late last week, a fire department spokesman said sources at the scene speculated that total losses—including the storage facility and its tenants' contents—could total between $50 million and $100 million.

The cause of the fire was still being investigated late last week.

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Employers seek to limit GIC losses

Executive Life fiasco may hit 401(k) plans

By JERRY GEISEL

WASHINGTON—Employers are attempting to minimize the impact of the Executive Life Insurance Co. debacle on employees whose 401(k) plan funds are invested in guaranteed investment contracts written by the insurer.

In what it describes as an unprecedented action, Holiday Inn Worldwide is promising that it—not employees—will bear any potential losses in principal connected to the purchase of Executive Life GICs by its 401(k) plan.

"Regardless of what state and federal regulators and the courts decide concerning the future of Executive Life, we believe that our employees deserve to know that their investments will be protected," according to Memphis, Tenn.-based Holiday Inn, a unit of British conglomerate Bass P.L.C.

Holiday Inn said it will make up any losses of principal on the $12.8 million in its so-called Stable Income Fund—one of three investment funds in its 401(k) plans—that is attributable to Executive Life GICs. Those contracts represent about 14% of the assets in the Stable Income Fund, which has about 7,000 participants.

Interest income, though, is not covered. Participants could still lose any interest that should have accrued on the funds that were invested in the GICs.

Georgia-Pacific Corp. took another approach. Anticipating problems with Executive Life, the Atlanta-based company earlier this year received permission from the U.S. Labor Department to purchase an Executive Life GIC held by a savings plan of a company Georgia-Pacific earlier acquired.

That action means that Georgia-Pacific, not the plan participants, now is an Executive Life creditor.

The Labor Department pledges fast action on similar requests by employers that want to purchase Executive Life GICs from their savings plans. A special exemption is required because such purchases are considered prohibited transac-

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Senators seeking criminal inquiry

By DOUGLAS McLEOD

WASHINGTON—A Senate committee is calling for a criminal investigation into the operations of two junk bond-laden First Executive Corp. life insurance units seized by state regulators last month.

The Senate Commerce, Science and Transportation Committee last week asked the Justice Department to investigate Executive Life Insurance Co. of California and Executive Life Insurance Co. of New York, along with the role played by the parent company in the insurers' failure.

"It has been alleged that (Executive Life of California) has been in a financially impaired condition since 1985," committee members said in a May 9

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RIMS gives big hand to retiring director

Risk managers helped Ron Judd, who is retiring this month after 24 years as executive director of the Risk & Insurance Management Society Inc. and its predecessor organization, go out in style at a special session at the 29th annual RIMS conference in New Orleans. Coverage of the conference's risk management sessions, including the program honoring Mr. Judd, begins on page 3.



U.S. government to assume liability in USAir disaster

By STACY SHAPIRO

LOS ANGELES—The U.S. government has agreed to accept the brunt of liability for the collision of a USAir Group Inc. Boeing 737 with a commuter plane at Los Angeles International Airport in February, which killed 34 people.

Under an agreement among the Federal Aviation Administration, USAir and commuter airline SkyWest Inc., "the U.S. government has accepted responsibility for between 85% and 95%" of the loss, according to one source.

"We can confirm that the Department of Justice (on behalf of the FAA) and the airlines have reached an agreement in regard to liability" for the USAir crash in Los Angeles, said a Justice Department spokesman.

"The U.S. (government) and the airlines have agreed to accept liability, and the department and the airlines will contact the families of the passengers shortly" in regard to this decision, he said.

However, the Justice Department spokesman would not comment on what percentage of liability the FAA will assume for the crash.

The exact percentage of liability

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National health fee schedule urged by corporate leaders
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Conflicting interests have hurt comp system: RIMS report
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Insurer executives believe federal regulation is likely
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NEWSPAPER

Update

Court overturns Texas reforms

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cal Assn. guidelines to assess workers' disability payments.

The Texas AFL-CIO, which filed the suit seeking to overturn the reform measure, hailed the decision. "The law was regressive, punitive and patently unfair to injured workers," said Joe D. Gunn, president of the Austin-based group.

The Texas Legislature overhauled the state's troubled workers comp system in December 1989 in an effort to cut system costs by as much as $380 million in 1991 (*BI*, Dec. 18, 1989). Among other things, the law, which became effective Jan. 1, 1991, scrapped the state's trial de novo system, which had led to almost all accident board decisions being appealed to a jury. Instead, the law created a commission to hear most workers comp appeals in administrative proceedings.

The Texas attorney general's office said it will appeal the ruling.

Despite the ruling, the law will continue to be in effect because the judge did not issue an injunction, a spokesman said.

Workers comp reform hailed

DENVER—Colorado businesses and insurers hail a major workers compensation reform bill approved last week by the state Legislature. The bill, which Governor Roy Romer has promised to sign, is expected to stabilize premiums in the state.

The National Council on Compensation Insurance expects to slash a proposed June 1 rate increase request to zero from 36% if S. 218 is enacted, said Barry Llewellyn, vp and actuary in the ratemaking organization's New York office.

As a result, Colorado's workers comp climate will improve and businesses will stop moving to other states, said George Dibble, president and chief executive officer of the Colorado Assn. of Commerce and Industry.

However, Colorado AFL-CIO President Eldon W. Cooper says the bill is "one of the worst pieces of legislation" passed in the last 40 years, because its restrictions and benefit cuts primarily affect workers without addressing unsafe employers and inefficient insurers.

Significant reforms in the 126-page bill include measures to:

- Unify and increase efficiency in the administrative agency that supervises the Colorado workers comp system.
- Restrict permanent total benefits to workers who can earn no income up to age 65, cap permanent partial disability awards and distribute such benefits more equitably.
- Increase the objectivity of impairment ratings using American Medical Assn. guidelines and giving independent medical examiners enhanced authority.
- Establish health care provider accreditation, restrict chiropractic care and put an 18-month freeze on providers' fees.

Financial reinsurance ban

LOS ANGELES—A new California Insurance Department rule will prohibit life insurers from using a form of financial reinsurance that regulators say artificially inflates an insurer's capital levels.

The rule, effective Dec. 31, 1991, prohibits the use of financing quota-share contracts, or surplus relief, under which the financial reinsurer assumes a fixed percentage of an entire book of business.

The rule was outlined in an April 15 letter to 640 life insurers licensed in the state from Insurance Commissioner John Garamendi.

Regulators made the accounting charge after discovering that $64 million of San Diego-based First Capital Life Insurance Co.'s $107 million in year-end capital came from such reinsurance agreements, industry sources say.

The department last Friday issued a cease-and-desist order against First Capital after deciding that it was in hazardous financial condition.

Roughly $165 million of the $474 million in capital at First Executive Life Insurance Co. also came from these reinsurance transactions, say sources familiar with the company. First Executive was put into conservatorship on April 11 (*BI*, April 22).

N.Y. considers comp rate hike

NEW YORK—The New York Insurance Department will hold a hearing May 30 on a proposal to raise workers compensation rates 25.1% on average as of July 1.

The proposed increase would cost New York employers an estimated $700 million over the next year, said Monte Almer, president of the New York Compensation Insurance Rating Board, which is the New York workers comp advisory rate service that submitted the proposed rate hike.

Workers comp rates in New York were increased an average of 29.4% in July 1990, primarily because of 1990 legislation that mandated higher workers comp benefits (*BI*, Aug. 13, 1990).

Exxon withdraws settlement

ANCHORAGE, Alaska—Exxon Corp. has terminated the $1 billion civil agreement reached in March that would have settled Alaska's civil suit stemming from the 1989 Exxon Valdez oil spill.

Exxon's action came shortly after U.S. District Court Judge H. Russel Holland rejected its plea bargain to criminal charges and set a May 24 deadline for Exxon to either enter a new plea or try to negotiate a new criminal fine.

Exxon, federal and Alaska officials are still trying to settle the civil and criminal charges, an Exxon spokesman said.

Under the settlement Exxon reached in March with Alaska Gov. Walter J. Hickel and the U.S. Justice Department, the oil company

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Errors and omissions

- The 1987 explosion at the Hoechst Celanese Corp. plant in Pampa, Texas, caused a loss estimated by Hoechst Celanese of $599 million. A story in the April 29 issue mistakenly attributed the estimate to Hopewell International Insurance Ltd., which provided property coverage for the plant.

Business leaders seek provider fee schedules

By ADRIENNE C. LOCKE

WASHINGTON—The federal government should develop national health care practice guidelines and a provider fee schedule, executives of major corporations told a House panel.

National practice guidelines would provide all employers a tool to check overutilization of health care services and better gauge the quality of care, the executives told the House Ways and Means Health Subcommittee last week.

However, a Chrysler Corp. official said that the federal government needed to take more drastic action to handle the health care crisis, including possibly establishing a national single-payer health care system.

In calling for a national provider fee schedule, corporate executives blamed the federal government for a large share of employers' growing health care costs. Physicians, paid too little for care delivered under entitlement programs like Medicare, are shifting costs to employer-sponsored health care plans, they said.

The executives testified last week before the subcommittee at a hearing on the health insurance costs of large companies and those companies' ideas for solving the problem.

Michael R. Peevey, president of Southern California Edison Co. in Rosemead, Calif., citing Health Care Financing Administration figures, noted that employers shouldered 28.8% of the nation's health care costs in 1988, the last year for which figures are available, up from 18.6% in 1967.

This rise has created a burden on business that "cannot be sustained," he said.

Mr. Peevey told the subcommittee that implementing national physician practice guidelines to standardize effective medical procedures would help health care payers gauge the appropriateness of care given by providers.

"To become knowledgeable purchasers (of health care) at the local level or the federal level, as individual payers or as part of a all-payer system, we will have the same need for information" about the appropriateness of care, Mr. Peevey said.

"We need to be assured that we are getting a dollar's worth of care for a dollar's worth of cost," he said.

John D. Evans, vp-human resources at the Eaton Corp., a truck parts manufacturer in Cleveland, agreed.

By implementing national guidelines, "we can enhance quality, control costs and possibly afford to improve access to quality health care for millions of Americans," Mr. Evans said.

The health care system "has the wrong incentives for paying doctors and hospitals for the health care services they provide," Mr.

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Later deadline for mental care, EAP directory

Business Insurance has extended the deadline for its first directory of employee assistance programs/managed mental health networks to May 20.

The directory will appear in the June 24 issue, which will also contain a Spotlight Report on these programs. The listings are published as an editorial service; there is no charge to be included. However, organizations must complete a questionnaire provided by *Business Insurance*.

If your organization provides EAP or managed mental health services on a stand-alone basis and you would like to receive a questionnaire, contact Karen Armaganian, Editorial Assistant, *Business Insurance*, 740 N. Rush St., Chicago, Ill. 60611-2590; 312-280-3195.

Report draws heated response

Risk managers hit comp factions

By MEG FLETCHER

The workers compensation system has been derailed by so many competing interests that it will be difficult to get the system back on track, says a panel of risk managers.

Workers comp now is "one of the greatest social problems of modern history," sums up the eight-page analysis by the Risk & Insurance Management Society Inc.'s workers compensation team.

The business community has been "asleep" for too long because it viewed the cost of workers comp merely as an "uncontrollable overhead expense" rather than as a risk that needed to be managed, says the analysis.

The workers compensation team, which was drawn from members of the RIMS Risk Management Roundtable, summarized its research and opinions in the May issue of the society's Risk Management magazine.

The analysis criticizes the actions of all players in the workers compensation system, including employers, insurers, employees and organized labor, physicians, attorneys, state administrative agencies and legislators.

However, representatives of some of these groups, in turn, are attacking the RIMS analysis as short-sighted, among other things.

"Our goal is not to incite a riot but to make each individual person think about his or her role in the process," said Mark T. Carter, leader of the RIMS workers comp team, author of the analysis and director-corporate risk management for LTV Corp. in Dallas.

But, "I haven't read anything in a while that has set me off as much," said James Ellenberger, assistant director for the AFL-CIO's department of occupational safety and health in Washington, D.C.

"It's pretty disgusting" and portions are written in a "condescending tone," he said. "I hope it is not indicative of the attitude of most risk managers. If it is, then business is in a lot of trouble."

Alan Tebb, general manager of the California Workers Compensation Institute, which represents workers comp insurers, observed that the analysis emphasizes a "pet theory" that reform is difficult because "whatever you try to do runs into opposition because someone's ox is being gored."

But, he noted that most claims people say the number of outright cheats among claimants is "pretty minimal," although both employees and employers can manipulate the system.

Florida state Rep. Bruce McEwan, R-Orlando, who chairs the National Council of State Leg-

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Inside

- Implicit in recent criticism of managed care programs is an assumption that all medical care recommended by doctors is appropriate, a notion that this week's editorial rejects. **PAGE 8**
- Legislation unanimously passed by a House Judiciary subcommittee would make bringing civil charges under the Racketeer Influenced and Corrupt Organizations act more difficult. **PAGE 77**
- The families of 107 passengers killed when a Korean Air Lines flight was shot down by Soviet fighter jets may seek more than $75,000 each in damages from the airline, a federal court says. However, the court ruled they cannot seek punitive damages. **PAGE 78**
- Many Texas employers will be paying more for retrospectively rated workers comp insurance policies because of new regulations. **PAGE 78**
- Mutual Risk Management Ltd., parent of the Insurance Profit Centre, a Bermuda rent-a-captive, is seeking a listing on the New York Stock Exchange. **PAGE 79**
- As congressional scrutiny of insurance company insolvencies rises, insurance industry executives increasingly believe federal regulation is likely, a recent survey concludes. **PAGE 86**

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Spotlight report

RIMS 1991

Several sources needed to evaluate insurer strength

By JUDY GREENWALD

NEW ORLEANS—Risk managers can and should do more to evaluate the insurer solvency than just considering their size and checking their rating from A.M. Best Co., industry experts advise.

When talking about evaluating an insurance company, "we're really talking about security and insolvency," said Bryan D. Murphy, president of Cayman Islands-based International Risk Management (Cayman) Ltd.

"Access to a rating agency such as Best is, to me, an essential ingredient of the tools of the trade" when evaluating insurers, Mr. Murphy said. However, the task is more complicated than simply checking a rating, he said during a session called "Rating Your Insurer—Can You Do Better Than Best's?" at the 29th annual Risk & Insurance Management Society conference held April 28-May 2 in New Orleans.

C. Richard Peterson, executive vp of broker Sedgwick James Inc. in New York, agreed: "There's some number crunching that really has to take place by the risk managers."

Mr. Murphy noted a risk manager "obviously must be concerned with the quality of the insurance that you're buying," Mr. Murphy said, though he conceded there are situations where price may be the determining factor.

He cited a survey he conducted in which risk managers were asked what are the most important factors in their selection of an insurer. Security was cited by 39%, scope of coverage was cited by 35%, price was cited by 23%, and 3% cited other reasons.

The survey also asked risk managers what sources they rely on to determine the financial security of their insurers.

Mr. Murphy said three factors each were cited by 100% of the respondents: a rating agency, a broker/captive manager and the insurer's reputation. In addition, 90% cited published financial statements, while 35% cited their own systems and 12% cited government regulators.

Mr. Murphy said he was surprised to see that only 35% of the respondents had some internal system for determining insurer security and that only 12% relied on state regulators to any extent.

The risk manager's task of ensuring the security of the insurers he or she uses is "a very, very difficult one," Mr. Murphy said. But this investigation cannot be subcontracted to any other party, he said.

The importance of this task is "greatly magnified when you are dealing with long-term exposures," he said. And, he said he strongly believes that risk managers should do more than look at the size and financial strength of insurers and their Best's rating.

There are several myths risk managers believe in regarding insurer security, Mr. Murphy said.

The first myth is that risk managers can rely on regulators to ensure insurer solvency, he said. Unfortunately, "regulation in and of itself is no guarantee" of solvency, and the quality of regulation can vary among states, he said.

Nevertheless, risk managers should improve their relationships with regulators, Mr. Murphy advised. If a risk manager has good contacts with regulators, he or she may gain access to unpublished information "which can be very useful to you," he said.

A second myth is that risk mangers can solely rely on a reputable rating agency to evaluate an insurer, he said. But, as important as a rating agency is, "you have to have access to other sources of information."

A third myth is that the failures that gripped the U.S. savings and loan industry and are now occurring in the banking industry will never occur in the insurance industry, Mr. Murphy said.

Insolvencies will not occur in the insurance industry "maybe to the same extent, but the insurance industry has enough problems of its own that suggests there's no room for complacency," he warned.

Those problems include underreserving, continued adverse development of pre-1985 casualty business and investments in junk bonds, he said.

U.S. banks hold an estimated $65 billion in junk bonds, while insurers—including life insurers—hold $66 billion, Mr. Murphy said.

"There were tremendously good investment decisions made by both industries," he said sarcastically.

A fourth myth is that risk managers can rely on an insurer's published surplus and solvency margins as accurate, he said.

The prevailing attitude is that after all the relevant information about an insurer has been published, "I've got nothing else to worry about," Mr. Murphy said.

But, in fact, factors like an insurer's reserving policy and the strength and quality of its reserves are not necessarily reflected in published data, he cautioned.

He also suggested the solvency ratio used by the insurance industry—a ratio of premium volume to surplus—is misleading.

In 1990, with $215 billion in net premiums and $135 billion in surplus, the industry's

Continued on next page



Sharing tips on how to assess insurance company solvency were, top, Bryan Murphy and John Snyder and, bottom, Martin Morris, Richard Peterson, Jospeh Petrelli and Ira Malis.

Farewell to Ron Judd

Tears, jeers mark RIMS leader's retirement

By MICHAEL BRADFORD

I've searched high and low
for virtues to cite,
but nothing commendable
has come into sight.

A shy guy is Ron Judd,
like a Patriot exploding a Scud.
Nor is modesty a reason
for his praises to shout,
for no one has less
to be modest about.

A great delegator
he's reputed to be.
The ladies work hard
while he is scot-free.

This is the man
for this morning's salute.
Is he really retiring
or did they give him the boot?

His achievements may be many,
but we can't recall any.
Except winning a goal
to which we have all aspired:
Ron has retired
before he expired.

—Eugene Anderson
Anderson, Kill, Olick & Oshinsky

With bad poetry, pointed barbs and a procession of teary-eyed speakers the Risk & Insurance Management Society Inc. bade farewell to Ron Judd, executive director and driving force behind RIMS.

Mr. Judd, who will retire later this month, was roasted and toasted May 1 at the annual RIMS conference in New Orleans during a ceremony that celebrated his achievements in shaping the organization.

In a surprise announcement, Mr. Judd was presented with the Dorothy and Harry Goodell Award, the highest honor bestowed by RIMS. The award, established in 1978 by Harry Goodell, a RIMS founder and its first president, recognizes outstanding achievements in furthering the goals of risk management.

Quoting Harry Goodell in an emotional good-bye, Mr. Judd told the audience that "we are a family. We have made a family out of this business. We've become a better industry because everyone is out there helping."

While the award is one of the fond memories Mr. Judd will cherish from his 24-year career at RIMS, known prior to 1975 as the American Society of Insurance Management, others were dredged up during the special ceremony that he probably would like to forget.

A slide show detailed some of the highlights in the life of Granville E. "Ron" Judd and featured some memorable poses of Mr. Judd in harmony with "wildlife."

In one shot, he stood aside a Playboy bunny, while in another he sat atop an elephant.

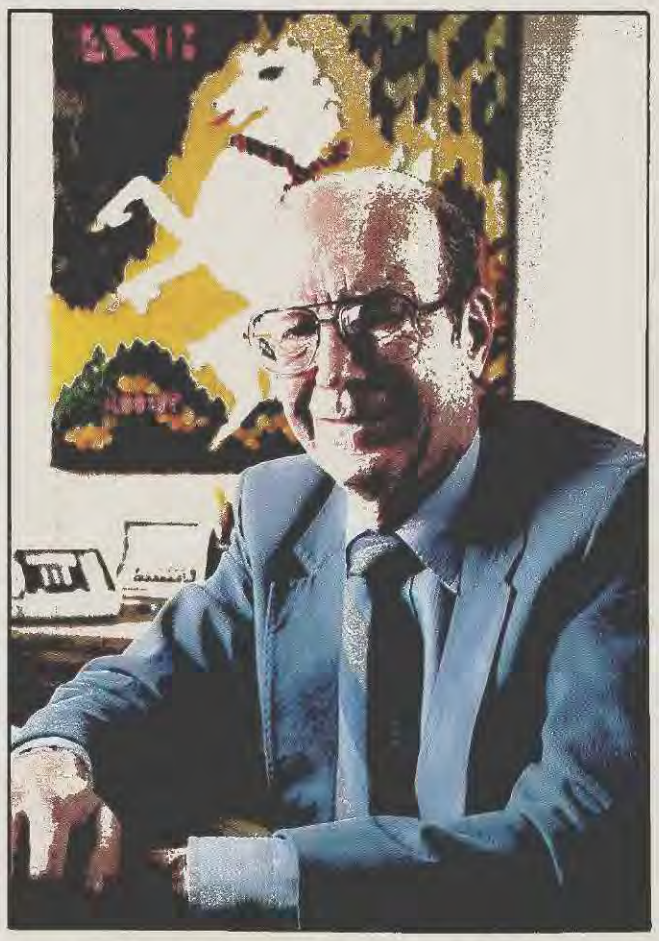
Speakers, including Mr. Anderson with his stream of verse, lined both sides of the stage at the New Orleans Convention Center and one-by-one delivered 90-second tributes to Mr. Judd.

Some laughed and some cried.

Outgoing RIMS President Cheri Hawkins made it through the opening of the tribute in good shape emotionally, telling the audience that Mr. Judd brought "energy, enthusiasm and curiosity" to the job. It was in closing the program that she let the tears flow.

Upon arriving at RIMS, Mr. Judd "saw potential," said Ms. Hawkins. "He saw a challenge, a chance to build something and he seized the

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Ron Judd survived poetry and barbs in a special tribute.

Insurer rating

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published solvency ratio was 1.59-to-1, or 63%, he said.

But the solvency ratio deteriorates to just 37% when an estimated $30 billion undervaluation of claims reserves and the estimated $25 billion invested in troubled instruments like junk bonds and real estate are taken into account, according to Mr. Murphy.

"I believe that the true result is closer to 37% than it will be to 63%," he said.

The fifth and final myth is that the risk manager's company will never be damaged by an insurer's insolvency, Mr. Murphy said. "Of course not," he said sarcastically.

"You must develop your own system of security," Mr. Murphy advised risk managers. Collect all published data on a company "and use it on a year-to-year basis for comparative purposes," he said, adding it is amazing what can be derived by such an analysis.

In time, a risk manager using such a system will develop his or her own "watch list," he said.

Develop informal information sources as well, he suggested. "Know what's going on in the street. That is where you'll get real information on a current basis that may not be published for years.

"You have to develop a system that gives you access to several different sources of information," Mr. Murphy maintained.

Focusing specifically on the adequacy of insurer loss reserves, Mr. Murphy said the risk manager must ask questions like whether reserve levels are subject to review by independent actuaries as opposed to internal sources.

Turning to investment strategy, Mr. Murphy said risk managers should focus on financial and investment issues, including insurers' junk bond and real estate holdings. Among other factors to examine are the insurer's non-insurance subsidiaries, including whether the parent understands the unrelated business and the insurer's cash flow, he advised.

While there is no magical or simple solution to evaluating insurers, "I believe very strongly that a combination of common sense and a good nose for trouble will stand you to very good stead," he said.

Sedgwick James' Mr. Peterson also recommended that risk managers do their own "number crunching" and compare their results with their broker's.

Pointing to Mr. Murphy's finding that many risk managers rely on their broker to assess insurer solvency, Mr. Peterson quipped, "That's a little scary."

But, "I believe the brokers do take this subject very seriously. Brokers see the solvency issue as very, very important in our business," he said.

There are obvious reasons to be concerned about insurer solvency, he said, pointing to the property/casualty insurance industry's rising combined ratio and declining interest rates, which means that insurers cannot use investment income to offset underwriting losses.

Junk bonds and shaky real estate investments are a concern as well, he said. "You've got a tremendously big exposure."

Mr. Peterson described how Sedgwick James monitors the solvency of insurers, noting he believes his company's procedures are typical among brokers.

Various committees normally meet monthly, or at least on a quarterly basis, to consider the security behind the insurers with which Sedgwick James places business, Mr. Peterson said.

"Very senior people" serve on these committees, he said. "We take this very seriously."

But Mr. Peterson also issued a word of caution to risk managers. "We are not security analysts," he said, noting that some very well-respected insurance people cannot read a balance sheet. "We really cannot draw any conclusions about insurance companies with any degree of certainty."

The problem brokers face is they "just cannot get access" to reliable data. Brokers must rely on the data filed with state regulators—regardless of how good the information is, he said.

Mr. Peterson said most of the data Sedgwick James examines is derived from the National Assn. of Insurance Commissioner's Insurance Regulatory Information System. For example, the broker looks for a net premiums written-to-surplus ratio of less than 2.5-to-1 and a 50% ratio of net premiums-to-gross premiums written.

Other factors that Mr. Peterson said Sedgwick James considers when judging an insurer's solvency include:

- Management experience and reputation.
- New lines of business or a new business venture the insurer has entered.
- The liquidity of assets and letters of credit held by the insurer.
- Its Best's rating.
- The state of domicile and whether that state has a good regulatory climate.
- The insurer's spread of risk.
- Loss ratios that exceed the industry average.
- Whether the business being written by the insurer is predominantly long-term or short-term.
- The insurer's ownership.
- Relationships with affiliates, including any loss portfolio transfers.
- Staff turnover.
- Premium growth without adequate surplus growth.
- Management contracts, including golden parachutes.
- Overly broad contract wordings.

Sedgwick James also considers several other rating services in addition to Best, Mr. Peterson said.

"What causes insurance companies to become insolvent?" Mr. Peterson asked.

Sedgwick James looks at a plethora of potential factors, like an insurer's expansion outside of its field of specialty, whether in terms of lines of insurance or geographically, he said.

Another factor to consider is whether the insurer is seeking market share at the height of a competitive market, he said.

Yet another clue to look for is whether an insurer assigns authority to managing general agents or buys excessive amounts of reinsurance, Mr. Peterson noted.

Other factors that he said lead to insolvency could include inadequate financial management, which could involve agency collection problems; overdue reinsurance recoverables; improper reserving; improper audit facilities; and fraud and greed.

Mr. Peterson said he has heard insurance brokers claim they know when a particular insurer is going

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BI graphics chief wins design prize

A *Business Insurance* staff member won a first-place award in a recent competition sponsored by the Chicago Chapter of the American Society of Business Press Editors.

Assistant Managing Editor/Graphics Jeanne M. Bartels captured the top prize in the tabloid front-page category for her design of page 1 of the Aug. 6, 1990, edition of *Business Insurance.*

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Rating insurers

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to become insolvent, but he advised risk managers to "don't always believe it." Conclusions based on "market feel," for instance, "can be very misleading."

Ira H. Malis, vp of Alex. Brown & Sons Inc. in Baltimore, examined how to assess an insurer from a financial analyst's perspective.

"As a securities expert, my job is to become an 'expert' on an industry and tell people to buy stocks," including whether they should invest and, if they should, which stocks they should buy, he said.

But, the approach taken by the securities analyst to evaluate a company can be used by others, including insurance buyers.

Among the sources of information Mr. Malis uses are an insurer's annual report, 10K statement, annual convention statement, proxy material and its Best's evaluation. Each of these sources has its advantages, he said.

For instance, the chairman's message in the annual report "gives you an indication of what the chairman's thinking," Mr. Malis said.

Most annual reports also include a five or 10-year history of the company, "which I find valuable," he said.

In addition, the annual report can provide information on whether dividends have been issued—which is a good sign—as well as data on earnings, growth in book value, return on equity and the relationship of debt to total capital. And, footnotes to the financial statement included in the annual report can provide information on an insurer's contingent liabilities, Mr. Malis said.

He advised risk managers to also look for information in the footnotes on any ongoing litigation.

IRIS was developed for one purpose, Mr. Morris says: to assist state insurance departments in assessing insurers' financial condition and to help regulators select companies that 'deserve the highest priority' in terms of regulatory attention.

Mr. Malis said the main value of a 10-K statement, filed with the Securities and Exchange Commission, is the reconciliation between beginning-of-the-year and end-of-the-year reserve levels, which is reported in the 10-K on the basis of generally accepted accounting principles.

In the insurer's annual convention statement filed with state regulators, information on asset quality can be derived from Schedule D, he said. In addition, Schedule F provides information on reinsurance recoverables, while Schedules O and P provide information on the development of loss reserves. The five-year historical data chart in the convention statement also is valuable, he said.

In addition, the convention statement provides information on the difference between gross and net premiums, any change in mix of business and the insurer's combined ratio, Mr. Malis pointed out.

The proxy material an insurer sends to its shareholders tells a securities analyst—and a savvy risk manager—whether there has been a change in auditors, he noted. There is usually a good reason for such a change, like a disagreement over loss reserves, he said. And, he said, it is always interesting to examine the compensation of the company's top executives.

Despite relying on these other sources of information, Mr. Malis noted that "we certainly do use" the analysis provided by Best.

Best is the most widely used insurance rating agency in the investment community, Mr. Malis said. It has become a "good indication of stock performance."

I. Martin Morris, a research economist with the Illinois Insurance Department in Springfield, Ill., discussed the use of IRIS data in investigating insurer solvency.

"I think it's important to explain the purpose of the IRIS program" because it is quite different from rating organizations like Best, Mr. Morris explained.

IRIS was developed for one purpose, Mr. Morris said: to assist state insurance departments in assessing insurers' financial condition and to help regulators select companies that "deserve the highest priority" in terms of regulatory attention.

The use of IRIS involves two phases, according Mr. Morris: the statistical phase and the analytical phase. The statistical phase involves calculating financial ratios from an insurer's annual convention statement. The analytical phase involves interpreting this data to determine which insurers should be targeted by regulators.

Risk managers and others that use the IRIS statistical data released by the NAIC should bear in mind that the primary purpose of IRIS is to prioritize regulators' work, he said.

It is also important to realize that the ratios are used simply as a means of pointing out areas that need more review.

"They are not an end in themselves," Mr. Morris. said. Regulators still need "to dig in and find out where the problems are."

Mr. Morris also noted that the statutory accounting principles used by state regulators are "considerably more conservative" than generally accepted accounting principles, which are used to report financial information to corporate shareholders.

At first, health maintenance organizations were not required to report their data on a statutory basis in Illinois, Mr. Morris pointed out. But, he said, before regulators began requiring HMOs to make their reports on a statutory basis, he grew tired of looking at an HMO's GAAP statements and seeing goodwill and "the CEO's wife's antiques" listed as assets.

He said that statutory accounting gives a better idea of one of the insurance buyer's chief concerns: "Are they going to pay their claims?"

Mr. Morris also advised risk managers to look at the number of insolvencies in perspective, pointing out that only about 1% of the nation's insurers were declared insolvent last year.

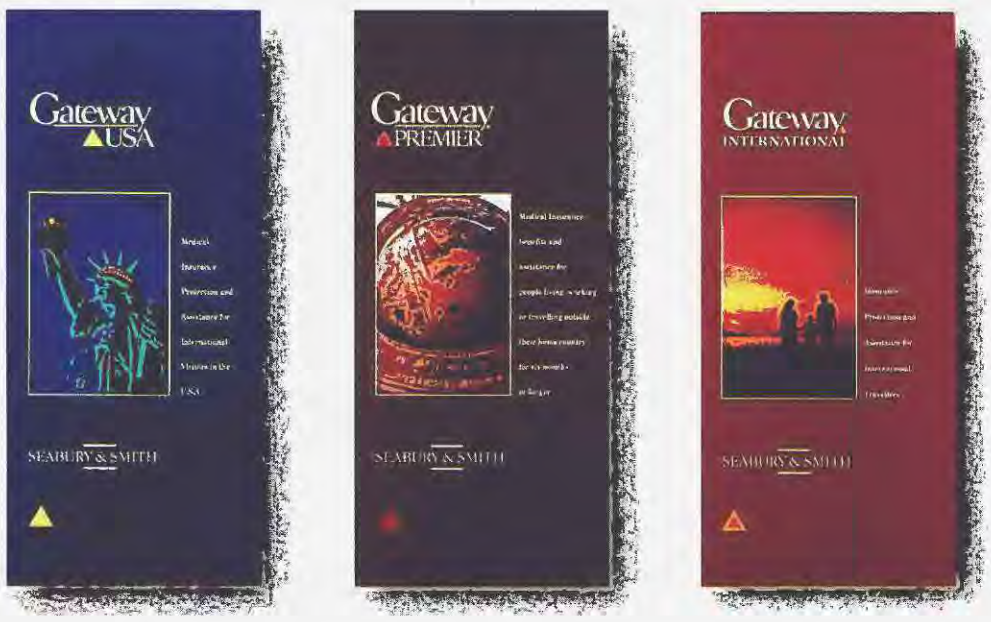
Mr. Morris emphasized that he is not trying to minimize the problem. "As far as I'm concerned, one insolvency is too many."

But, he added: "I don't think a Chicken Little approach is necessary here. I think we all need to step back and look at all this in perspective. The sky is not falling. It never will."

Also speaking at the session was Best Vp John H. Snyder and Joseph L. Petrelli, president of Columbus, Ohio-based Demotech, Inc.

Thomas A. Duffield, vp-insurance and risk management, for Archer Daniels Midland Co. in Decatur, Ill., moderated the session. Kathryn A. Westover, vp of American Risk Management Corp. in Burlington, Vt., coordinated the session. ■

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Opinions

The managed care gauntlet

EMPLOYERS AND INSURERS must meet head-on the challenge laid down by the medical community to prove that managed care and utilization review result in cost-effective and quality medical treatment.

At the recent Risk & Insurance Management Society conference, Dr. Donald K. Crandall, a member of the American Medical Assn.'s Council on Medical Services, openly challenged the effectiveness of managed care (*BI,* May 6).

Dr. Crandall argued that managed care and utilization review may simply delay employees' use of needed health care services. Those delays could lead to higher health care bills as small medical problems mushroom into more costly complications, he suggested. As a result, short-term savings from managed care may be illusory.

Lowering utilization of health care services through managed care programs does not make sense in the absence of a consensus on what is the appropriate level of care, Dr. Crandall maintains.

We agree, in part.

Certainly savings from managed care must be measured over several years. And, the medical community must develop a consensus on what is the appropriate level of care for various ailments, which Dr. Crandall said the AMA is promoting.

If managed care is really counterproductive, employers and insurers will want to reject it.

But, until years of experience on managed care programs have been analyzed, we must disagree in part with Dr. Crandall's remarks.

Implicit in his remarks is an assumption, which we reject, that all recommended medical care is appropriate.

A wave of studies have shown enormous variations in the rates at which certain medical procedures are performed by region of country. And, employers know that the rate at which doctors perform some procedures, like hysterectomies, vary in different parts of the country.

There is no rational explanation for such variations in treatment except that in some areas of the country doctors are performing certain procedures too often and in other parts of the country not often enough.

Also implicit in Dr. Crandall's remarks is that managed care and utilization review seek to deny necessary services. We disagree. We have talked with too many providers of managed care and utilization review to believe this. Rather than brag about care denied, they boast of helping employees and their families through difficult illnesses and long recoveries by finding the most qualified providers of care.



"WE NEED TO MONITOR FOR ANY ATRIAL FIBRILLATION"

And, the cold reality is that providers of managed care and utilization review are strongly discouraged from broadly denying care by the high likelihood that they would lose the ensuing lawsuits filed by those inappropriately denied care.

Physicians are not above review, and the sentinel effect of review only can lead to better medical care. Unnecessary care is the most expensive care for employees and employers.

Fortunately, employers and insurers that are investing in managed care and utilization review in an effort to control rising medical costs will meet Dr. Crandall's challenge. In addition to employers that are carefully monitoring the costs of their managed care programs, the Health Insurance Assn. of America has launched a multi-year study on the effectiveness of managed care.

We are confident that the results will prove that managed care does mean more cost-effective and better health care.

Letters

Publishing UR criteria would create more hassles

To the editor: The American Medical Assn. research study indicating that private utilization review vendors should publish their criteria (*BI,* April 1) falls far short of the mark in solving the UR dilemma for the physician community.

Physicians' current complaints regarding the UR "hassle factor" would only be exacerbated by the need to reference one of 300 to 400 varying private UR medical criteria prior to each individual review.

If, as the AMA's Dr. Kellie suggested, the release of this proprietary criteria would "result in improved medical care and fewer inappropriate procedures," the medical community should make it a top-most priority to develop its own uniform and public guidelines that would achieve this desperately needed goal.

In lieu of such an effort, private UR companies at significant expense have not only developed their own but are working in concert with the Utilization Review Accreditation Commission to make their review efforts more uniform, while submitting their criteria to the scrutiny of qualified designees of URAC for a credibility check.

In the end, if quality, cost-effective care is the issue, the variability of the UR industry's medical guidelines is not the problem. The problem is the wide-ranging variability of physician practice patterns, and we should all be working together in a concerted effort to make it better.

Vicki Merrill
President
Pacific Review Services
Cypress, Calif.

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Data on World Re called faulty

To the editor: Unhappily, the Georgia Insurance Commissioner has been given inadequate information concerning the reinsurers that participate in certain reinsurance programs arranged by World Re Inc. (*BI,* April 29).

To the current time, the reinsurers that participate in the reinsurance arrangements for World Life & Health Insurance Co. of Pennsylvania have performed well:

- In 1990, premiums of $6.16 million were remitted by World Life & Health to reinsurers.
- Claims of $5.85 million have been paid out of such funds by the same reinsurers.
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M.D. Bonar
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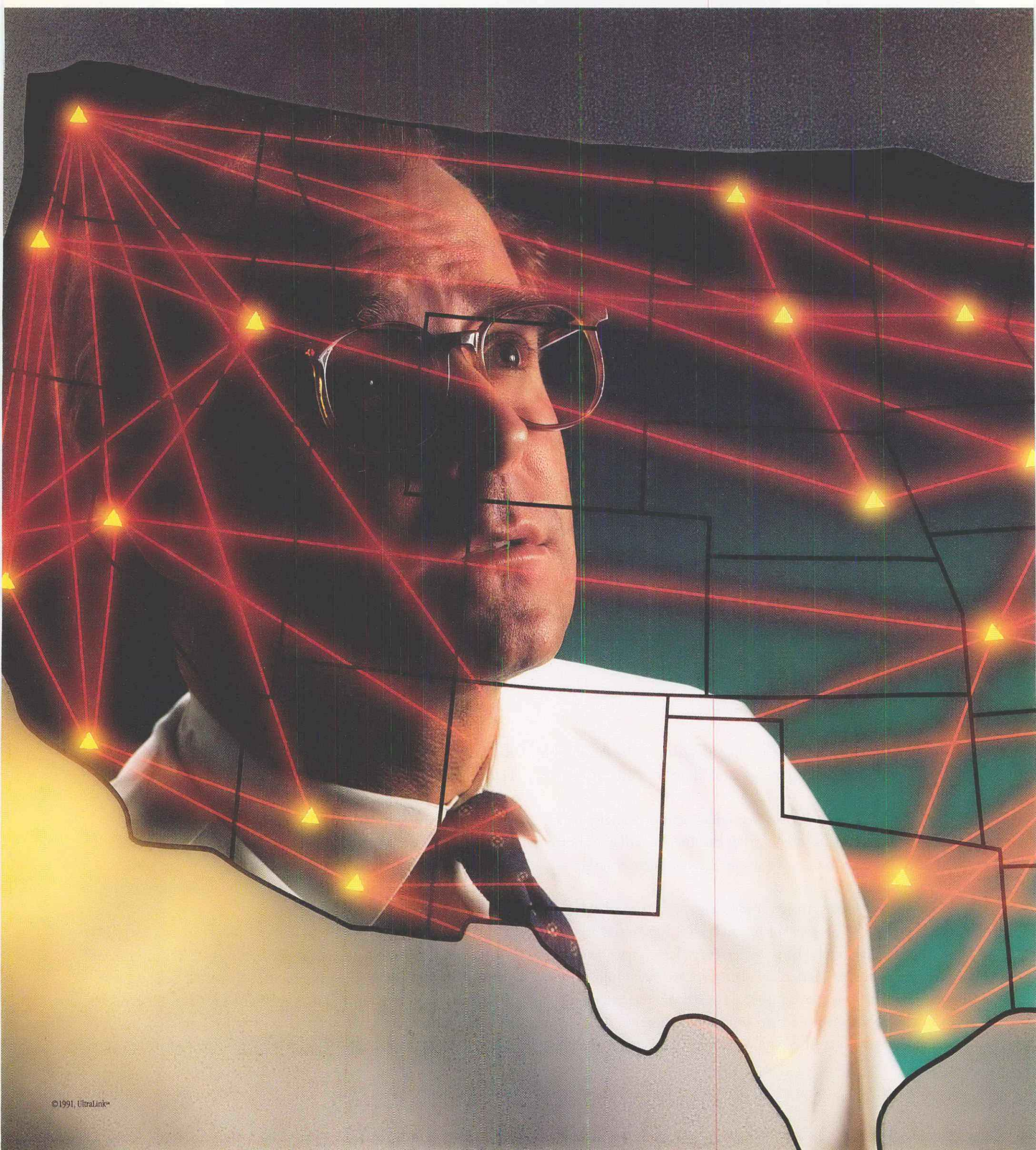
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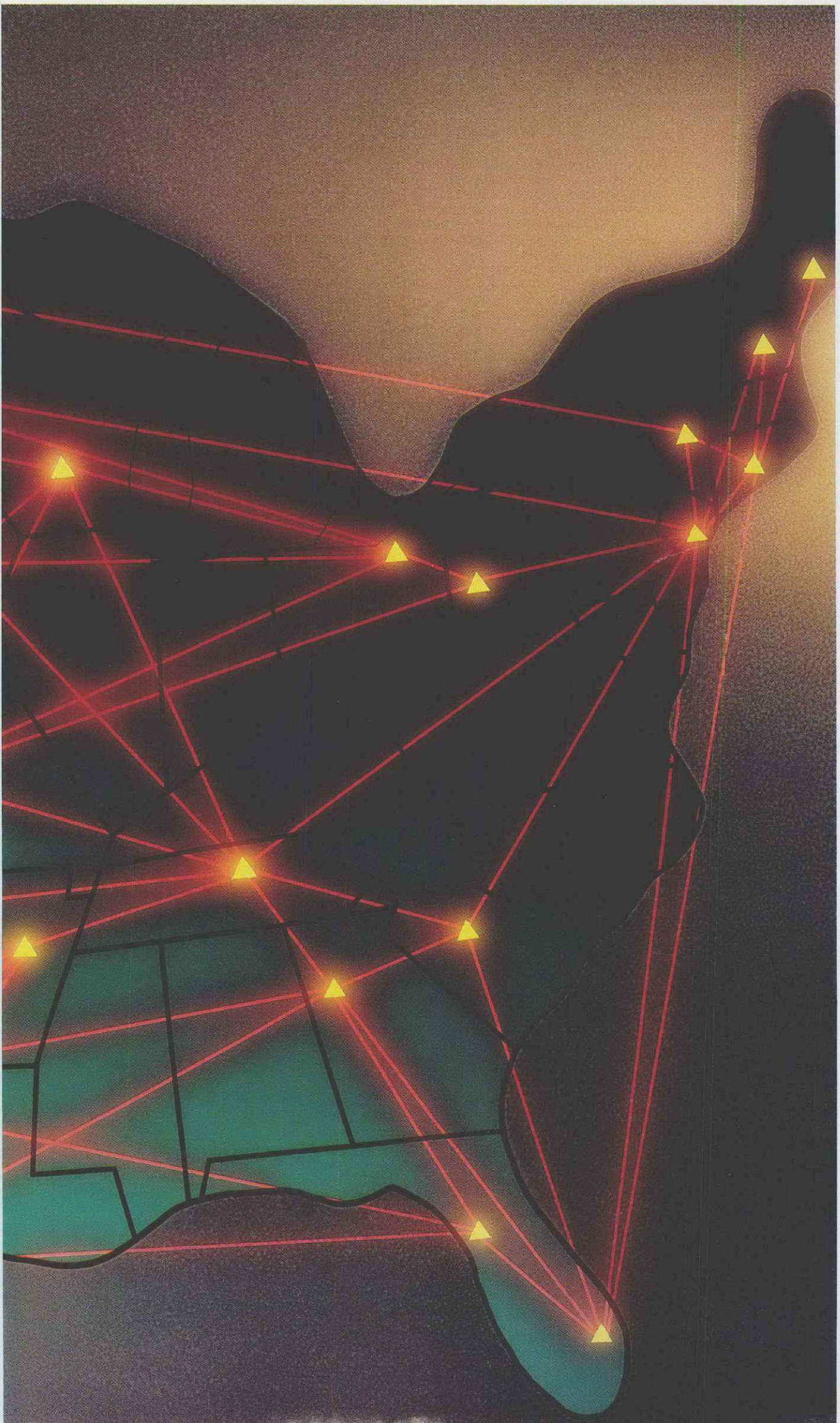
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D&O claims called inevitable

Only loss prevention can help, panel says

By MARK A. HOFMANN

NEW ORLEANS—For corporate directors and officers, a third certainty has been added to death and taxes—an increasing risk of D&O liability claims and litigation.

But risk managers can counter this fact of life by bringing loss prevention techniques to the boardroom, agreed a panel of authorities at the 29th annual Risk & Insurance Management Society conference in New Orleans.

As Dan K. Bailey, a partner in the Columbus, Ohio law firm Arter & Hadden, put it: "90% of loss prevention is nothing more than applying common sense to whatever the issue."

One of the biggest problems affecting corporate boards is that directors are chosen for the wrong reasons, Mr. Bailey said.

Visibility in the community or nation and personal ties to incumbent directors and officers are the typical determining factors, rather than ability, according to Mr. Bailey.

What boards need are members who bring an outlook somewhat different than that of current members, said Mr. Bailey, who is co-author of the fourth edition of "Liability of Corporate Officers and Directors."

Effective board members have both the time and interest to pursue their duties, Mr. Bailey said. Directors on more than three or four boards are probably spreading themselves too thin.

Board members also need to demonstrate "quality independence" by not fearing to challenge senior managers, he said.

Kenneth S. Wollner, a consultant with The Wyatt Co. in Chicago and author of Wyatt's annual D&O liability survey, also stressed the importance of independence.

Mr. Wollner, who also coordinated the session, pointed out that Wyatt surveys have shown that corporations with a high percentage of independent directors tend to have the same frequency of D&O claims as corporations dominated by directors drawn from management.

But claims against corporations with a large number of independent directors tended to be disposed of more quickly and at less expense than those brought against management-dominated boards, he said.

This indicates that boards with a greater proportion of independent directors can defend themselves against D&O claims more effectively than management-dominated boards.

Mr. Bailey said that promoting D&O loss prevention can be dangerous to the risk manager's job because it involves the egos of senior management and directors. He suggested that the risk manager try to recruit one or two senior officials into the effort and, if possible, just talk over lunch with a key person about the relevance of loss control to directors and officers.

Written D&O loss control guidelines can provide practical information for risk managers and directors. Among these are guidelines put out by Chubb Corp. and the audit committee self-assessment guide from Audit Committee Support Network Inc. in Plainview, N.Y.

Those guides advise basic steps like avoiding conflicts of interest, delegating responsibility prudently, protecting confidential corporate information and responding correctly to takeover bids.

Although quickly saying that he did not intend his remarks as a pitch for business, Mr. Bailey said frequent contact with the "right" lawyers is one of a board's most valuable assets. Corporations should not rely on the lawyers that handle most of their business when dealing with D&O liability questions, he said.

"What we're trying to do is tell directors and officers how to walk through this minefield without getting blown up," he said.

The extent of the minefield was amply illustrated by Stanley D. Halper, who had compared the inevitably of D&O litigation to death and taxes. Mr. Halper, who is president of the Audit Committee Support Network, a consultant to audit committees of corporate boards, noted that the number of claims against directors and officers is rising about 10% a year.

Citing Wyatt's 1990 figures, Mr. Halper added that the average cost of a claim brought in 1989 was projected to reach nearly $3.5 million (*BI*, Jan. 14).

"Among the largest dollar amounts of such claims are those relating to financial reporting matters. A properly functioning audit committee can be a positive influence in reducing the frequency and severity of such claims," Mr. Halper said.

Audit committees oversee a company's financial reporting and internal controls, Mr. Halper said. Companies whose shares are listed on the New York Stock Exchange, the American Stock Exchange and the National Assn. of Securities Dealers Automated Quotations system must have audit committees composed of a majority of independent directors.

"A properly functioning audit committee composed of a majority of independent directors represents a significant loss prevention factor," he said. But Mr. Halper quickly added that the mere existence of an audit committee is no guarantee that it will function properly.

"An audit committee whose activities are limited, or that does not receive appropriate information or support to properly perform its mission, is giving false comfort to shareholders and others," Mr. Halper said.

Risk managers could do a better job if they learned more about the responsibilities of the board, its audit committee, the chief financial officer, and internal and external auditors, Mr. Halper said.

"When was the last time you met with the internal auditors and independent public accountants to give them your assessment of risk to the company in areas such as control, environment and other issues?" Mr. Halper asked.

"Have you described to them the effect of the loss control programs that you have initiated on these risks? This has an important impact on the scope of work they perform, which is approved by the audit committee. When was the last time you met with general counsel to obtain their views and discuss with them the actions they are taking to lessen the frequency and severity of claims?" he asked.

Employee-generated actions are yet another area of increasing D&O claims. "There's been a spurt of employee claims since the 1970s," said Mr. Wollner.

According to the 1990 Wyatt survey, only shareholders—who accounted for half of all D&O claims—brought more D&O suits against for-profit companies than employees, who accounted for 23% of the total.

Half of the employee claims were for wrongful termination, said Mr. Wollner. Another 16% involved discrimination, 14% breach of contract and the remaining 20% involved other reasons.

He suggested a "performance management system" to decrease the possibility of claims stemming from wrongful discharge.

Under the system, employee performance is managed from the beginning, Mr. Wollner explained. Employees should participate in and agree to performance expectations. Their performance should then be reviewed regularly with coaching given to correct shortcomings. When necessary, corrective action should be initiated and, as a final precaution, every step of the process should be documented, Mr. Wollner said.

Moderating the session was Richard E. Hinds, general manager-risk management for FPL Group Inc., a diversified electric power holding company in North Palm Beach, Fla. ■

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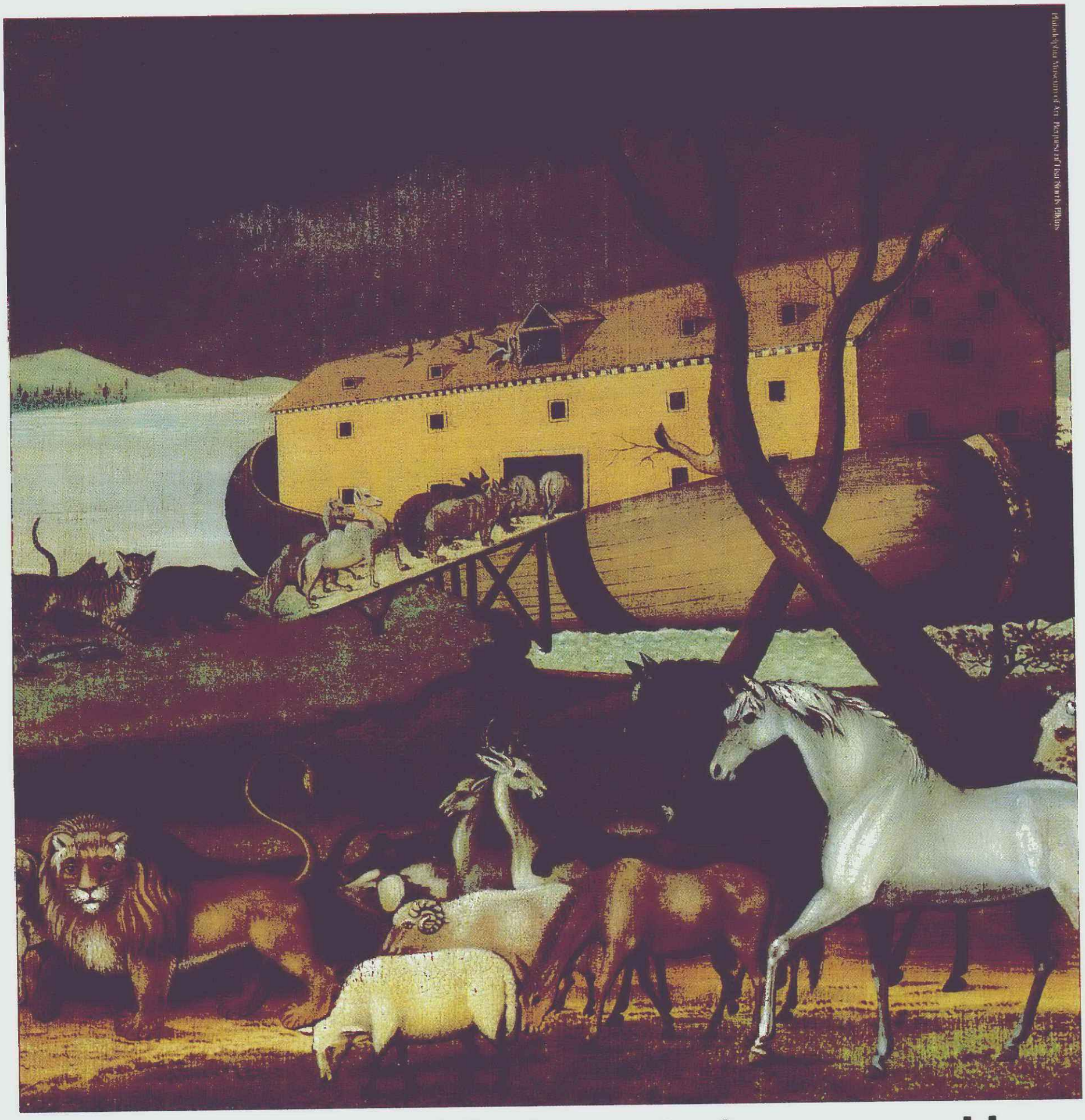
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Speak loudly and carry a periodic evaluation

Communication can lead to peace in battles with brokers

By GAVIN SOUTER

NEW ORLEANS—Poor communication is the most common cause of hostility between a broker and risk manager, and the first casualty of the conflict is the client company's risk management program, risk managers and a broker agree.

But if a client is not getting the results he or she wants, even when lines of communication are not blocked, he or she should remember that the broker is supposed to work for the client, a consultant added.

And to help maintain a smooth and effective relationship, periodic broker evaluations are invaluable, risk managers agree.

"A lot of brokers always feel that they are under pressure from their buyers and that risk managers do not define what it is that they want," said John Roskopf, vp at Rollins Burdick Hunter Co. in Chicago.

To obtain good results from brokers, risk managers must first decide what they expect from the relationship, Mr. Roskopf said at a session during the 29th annual Risk & Insurance Management Society conference in New Orleans.

"A lot of risk managers simply say, 'I am the client and I want service,' but if the broker is to perform, you as a risk manager must tell him what you want," he said.

The first move is for the risk manager to establish long- and short-term goals, determine who will be the account executive on the broker's staff, and decide how to communicate with and measure the performance of the broker, he said.

Meanwhile, the broker should ensure that the account executive dealing with a particular client has the proper background for that account and that there is an experienced second-in-command in place who can take over for any reason, he said.

Making sure that the broker has the right person on the account also is the responsibility of the risk manager, Mr. Roskopf said.

"You must find out who you want to deal with from the broker and you must then say who you want to deal with," he contended.

Once the lines of communication are in place, risk managers can legitimately complain about poor service, Mr. Roskopf said.

Common broker mistakes, according to Mr. Roskopf, include:

- Failure to communicate.
- Failure to listen.
- Not being creative.
- Overcommitment of resources to an account.
- Failure to define their duties.
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- Inability to anticipate clients' needs.
- Recommending what they think the client wants to hear.

Failure to listen is a common problem among brokers, said Charles Armstrong, manager of risk management for Xerox Corp. in Stamford, Conn.

"Usually, in order to get brokers to listen, I have to hit the desk and say, 'Listen, I'm the client.' I sometimes wonder whether we understand who the customers are and maybe we would get better performance if we did," Mr. Armstrong said. The ultimate customers of a brokerage include a company's shareholders, its operating companies and its employees, he said.

"We should sort out our own customers' requirements before we go to our broker," Mr. Armstrong said.

However, rather than a risk manager simply stating what he needs, he should negotiate and discuss the company's needs with the broker, he said.

"Maybe the broker cannot deliver what you want and you should give him a chance to tell you this," he added.

Client/broker relationships are personal relationships, noted Helen Bosley, a principal with Corporate Financial Management Inc., a consulting firm in Yardley, Pa.

"You need to develop a rapport with another individual, but you as the client are the driving force in the relationship," she said.

And to justify his or her position, a broker must bring some value to the relationship in terms of addressing the goals of the risk manager, Ms. Bosley said.

But risk managers need to assert their influence, especially if they are new to a company and find it hard to deal with the company's existing broker, she said.

"Don't be afraid to step up and indicate that the relationship is not working. If you don't develop a rapport with the person you are dealing with at the brokerage, get him to bring other people along with him," Ms. Bosley advised.

If the risk manager still does not get the desired results, he or she should go to the top and speak to the account executive's superior, she said. "You have to assert yourself. You have to say that your company wants you to deal with its insurance needs now, regardless of the relationships that went on before," she said.

A risk manager must also discover what motivates the company's broker and must be careful if the broker is revenue-driven, since this can lead to the broker taking a position that is diametrically opposed to the policyholder's needs, Ms. Bosley said.

"A good broker realizes that part of the value you have as a client is that if he does a good job, you will recommend him to others," she said.

Smaller companies should be exceptionally careful in choosing a broker. They may need more of the broker's services because their risk management departments may not have sufficient resources, she said.

In such a case, a company should retain a broker who is prepared to work in the client's office for one or two days a month, she advised.

Clients should never underestimate the threat of competition, Ms. Bosley said. If a risk manager is not satisfied with a broker, he or she should put the account out to bid, she suggested, explaining that if another broker is not selected, the service offered by the existing broker should improve.

"It takes five times as long and five times as much money for a broker to attract a new client than it does for him to service an old client. However, it costs you as

Continued on next page

HOW HOBBS MINIMIZE YOUR COST OF RISK.

Continued from previous page
well, so work at getting along with your broker," she said.

If a risk manager is selecting a new broker and does not know where to start, the best move is to join the local RIMS chapter and talk to colleagues to learn which are the best brokers, Ms. Bosley advised during a question-and-answer session.

Selecting a broker requires a lot of homework, said Thomas Lewison, corporate director of risk management at Hartz Group Inc. in Secaucus, N.J.

"We prepared what we wanted and they were not negotiable. Then we listened to the brokers and prepared our final objectives. It is very important to plan," he said of Hartz's selection process.

Although the planning required before broker selection can take a long time, it will save the risk manager both time and money in the end, Mr. Lewison said.

In dealing with a broker, the brokerage staff should meet with company officials outside the client's risk management department to better quantify the company's risks, he suggested. "We took time for the broker to meet the operating people and for them to get to know them."

Once the broker has been selected, an evaluation system should be set up to assess performance every six months, he said.

"We look at what was meant to have been established and what has been established. We put this down in writing and then we give them a report card and they give us a report card," he said.

Generally, any problems can be sorted out at these periodic evaluations, but if a broker ever lies to a client, the broker should be dismissed, Mr. Lewison warned.

"For example, a broker will lose the account if he says that the client has coverage for something but, when the client examines the coverage, he sees that it just is not there," he said.

However, a risk manager should not fire a broker just because he finds out that the broker has gone over his head, Mr. Lewison said.

"Brokers do this because they want a relationship throughout the company and, if this becomes a problem for you, you had better look at the relationship you have with your boss," he said.

Another speaker—Terry Reiff, director of corporate risk management and insurance for Dayton, Ohio-based Mead Corp.—noted that the company last year decided to review its casualty broker after a 14-year relationship.

"When selecting which brokers we wanted to bid for the account, we chose the incumbent broker and those others who we knew and who had the skills we required," he explained.

Five brokers ended up bidding for the account, Mr. Reiff said.

The next step was to tell the brokers about Mead, answer their questions and then visit the brokers in their offices, he said.

"Visiting their offices is an intangible benefit, but for me it was very important because you see how they work," Mr. Reiff said.

After this discussion process, Mead dropped two of the five brokers for the competition, he said.

Mead then received oral presentations from the three remaining brokers and spent five hours discussing which to choose, Mr. Reiff reported.

The criteria used to judge the brokers included their ability to respond to Mead's specific needs, their management ability, their service ability and, finally, their cost, he said.

The result was that Mead hired a new broker, which Mr. Reiff would not identify.

During the selection process, an ethical risk manager will ensure that all of the competing brokers have equal access to information and are told exactly how they will be evaluated, Mr. Reiff said.

Also, you should "tell the losers where they did not measure up and tell them face-to-face," Mr. Reiff said.

Brokers should be given bonuses for doing a good job, Mr. Lewison said during the question-and-answer period.

Mead has other ways of awarding good brokers, said Mr. Reiff.

"We don't believe in financial bonuses, but if your broker has done an exceptional job, it does wonders to write a letter to his boss," he said.

Mr. Armstrong was the only panelist who did not require confidentiality agreements from brokers.

The key quality sought from a broker is honesty, the panelists agreed. Other desirable qualities include a willingness to work as part of a team, openness and a realistic view of the challenge involved in handling the account, the panelists said.

The session was coordinated by Mr. Roskopf and moderated by Stephen Wilder, director of corporate risk management at The Walt Disney Co. in Burbank, Calif. ■

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RIMS speaker handicaps '92 election

NEW ORLEANS—The country's economic condition a year from now may determine whether Vice President Dan Quayle remains President Bush's running mate in 1992, said a conservative pundit during a luncheon speech at the 29th annual Risk & Insurance Management Society conference.

William Safire, a political columnist for The New York Times and a speechwriter in the Nixon administration, said that if the recession lingers, pressure will mount on the president to replace his No. 2.

Mr. Safire offered three choices:

- Jack Kemp, an unsuccessful candidate in 1988 and current Housing and Urban Development secretary.
- Secretary of State James Baker, the president's close friend.

Mr. Safire said that Mr. Baker would be able to get around the constitutional prohibition on electors voting for a president and vice president from the same state by switching his residence from Texas to Wyoming, where he owns a ranch.

- Gen. Colin Powell, chairman of the Joint Chiefs of Staff.

"It would be a good thing for the Republicans to be the first party to have a black on the ticket," Mr. Safire said.

The Bush and "Whomever" ticket will probably face a Democratic ticket headed by New York Gov. Mario Cuomo, Mr. Safire said. Another possibility is Tennessee Sen. Albert Gore, who gained a lot of political capital by being only one of two Democratic senators to support military action against Iraq.

Other possibilities include Virginia Sen. Chuck Robb and Gen. H. Norman Schwarzkopf, who Mr. Safire predicted will be the target of a draft movement among Democrats.

But if the economy turns around and President Bush looks invincible, the Democrats could attempt to "lose gracefully" without endangering their control of the Senate by nominating Texas Sen. Lloyd Bentsen, who was Michael Dukakis' running mate in 1988, Mr. Safire said.

—By Mark A. Hofmann

Question: What is educational and entertaining?

By JOANNE WOJCIK

NEW ORLEANS—Risk managers have not been keeping up with the Jones Act, Risk Management Jeopardy contestants demonstrated at the Risk & Insurance Management Society conference.

The first stumbler for nearly everyone—including the audience—during a conference session featuring the risk management version of the popular TV game show concerned "the type of coverage that applies to masters and members of the crew of a vessel."

The correct Jeopardy question was: "What is the Jones Act?" But when contestants argued that the Jones Act was not a type of coverage, it was decided that no credit would be given for that question.

Later, when the panel was again stumped by an easier answer, the audience shouted out: "What is the market cycle?" in response to the answer: "The two-word term usually used to describe the ups and downs of insurance price and availability."

Three teams of four—two risk managers and two students—participated in the game, which was held on the last day of the 29th annual RIMS conference in New Orleans.

The students were added to the teams to make the game work, according to Richard Hackenburg, executive vp at Corroon & Black of Massachusetts Inc. in Boston, who moderated—or more aptly "hosted"—the game show session.

While Mr. Hackenburg said the risk managers playing the game were "people brave enough and bold enough. . .to put their credibility on the line," he said the students were "the real brains behind the operation."

The game was developed by Norma Nielson, professor of insurance and risk management at Oregon State University, to prepare her students before their final exams.

However, it is unlikely that Ms. Nielson will try to "get rich quick" by marketing the game, because she received permission from the original Jeopardy producer, Merv Griffin Enterprises, to use the game only one time.

Developing the game was easy, according to Ms. Nielson, who used a generic software program called "Tool Box" to reproduce the Jeopardy game board.

It was more difficult to come up with Jeopardy-style questions and answers that would be challenging enough for the participants, she said.

Risk Management Jeopardy followed the playing format of the original Jeopardy game with one variation: Instead of a single contestant participating in each stage of the game, teams of two individuals played Single and Double Jeopardy, and all four members of each team congregated to answer the Final Jeopardy question.

Using a personal computer loaded with the modified Tool Box software and an overhead projector, Ms. Nielson operated the game from the front of the conference room, transforming the screen projecting the dark blue Jeopardy board with its six columns of numbers into a single panel with the printed answer.

Back and forth, the game ensued through Single Jeopardy and Double Jeopardy, until it culminated with the Final Jeopardy question.

Rather than buzzers, the contestants raised pieces of colored paper to indicate their desire to respond to a particular question. The judges—several other students from various universities—watched to see which team flashed its colors first.

Players appeared to have little trouble answering the first few sets of questions in the Single Jeopardy subject categories, which included "Captives," "Workers Compensation," "International Risk Management," "Welfare Benefits," "Insurance Markets" and "B'eware of Risk"—in which all of the questions contained the letter "B."

At first it appeared that Team 1 would run away with the game as it maintained the lead throughout Single Jeopardy.

But Team 3 finally made the scoreboard during Double Jeopardy with the question, "What is RIMS?" that correctly responded to the answer: "A professional association of risk managers with 88 chapters."

The categories in Double Jeopardy included: "Retirement Benefits," "Acronyms," "Forecasting," "Professional Liability," "Insurance Solvency" and "Potpourri."

Some contestants injected editorial comments into their responses.

For example, in giving the question that matched the answer: "An assessment made by insurers to replenish the funding level of a pool having inadequate rates and unfavorable experience," Shelly Roth, assistant treasurer-risk management at Contel Corp. in Atlanta, quipped: "What is a very expensive residual market load?"

Team 2 almost caught up with Team 1 when it correctly responded to the Final Jeopardy answer: "According to this model, stockholders with widely diversified portfolios in a perfect capital market face little or no uncertainty with respect to pure loss exposures."

But when all of the contestants came up with the correct Final Jeopardy question—"What is the capital asset pricing model?"—it was no contest: Team 1 wrapped it up with a score of $6,500, followed by Team 2 with $6,200 and Team 3 with $1,600.

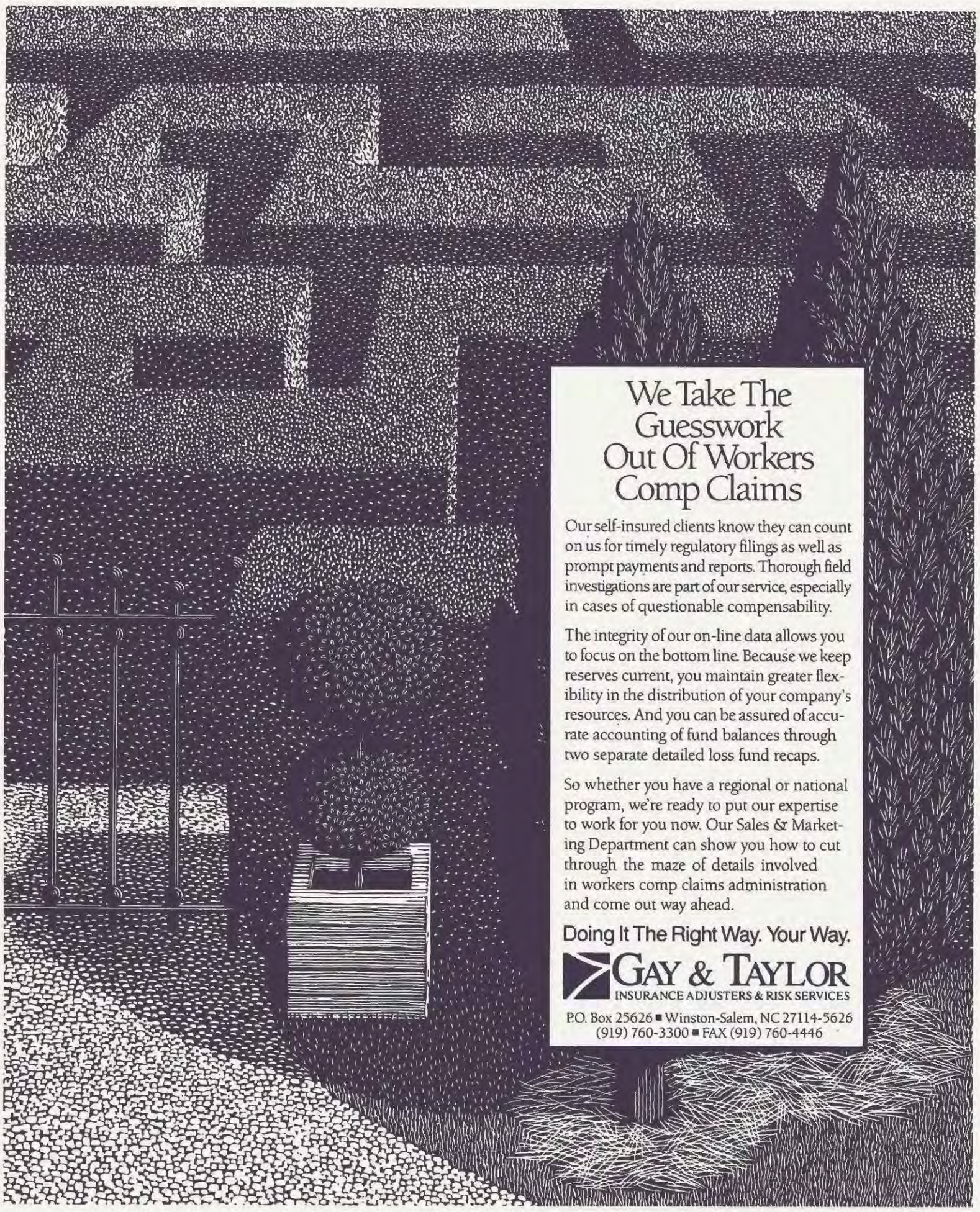
While the teams were not actually awarded their winnings, as on the television version of Jeopardy, all of the contestants were awarded parting gifts of pocket-sized desk sets.

Members of Team 1 were: Mr. Roth; Tom Regan, risk manager for North American Philips Corp. in New York; Rebecca McGowan, a senior majoring in risk management/insurance and finance at Temple University in Philadelphia; and Debbie McGonigal, a senior at Memphis State University in Memphis, Tenn., majoring in risk management and insurance.

Members of Team 2 were: Stanley R. Tarr, president of Educational & Institutional Insurance Administration Inc. in Chicago, a consortium of 100 Methodist and Lutheran colleges and universities; Vicki Gerken, corporate risk manager for Adams Communication Corp. in Minneapolis; Joey Van Ness, a junior at La Salle University in Philadelphia majoring in finance; and Donald Houston, a senior at Howard University in Washington, D.C., majoring in insurance.

Members of Team 3 were: Richard Welch, risk manager for the city of Los Angeles; Doug Haughton, manager of insurance and general credit at Westinghouse Canada Inc. in Hamilton, Ontario; Dave Cole, a senior at Indiana State University in Terre Haute majoring in risk management and insurance; and Andy Patton, a senior at Appalachian State University in Boone, N.C., majoring in risk management and insurance.

The session was coordinated by Mary Reiner, director of risk management at Columbia University in New York. ■



DEAR SUSAN,



WELL, I DID IT!! RIGHT IN THE MIDDLE OF A CROWDED NEW ORLEANS RESTAURANT, I DID IT! I **SUCKED CRAWFISH...** AND <u>LIKED</u> IT!!!

(IT HELPED WHEN I TRIED IT WITHOUT THE STRAW.)



RIMS 1991 KEPT ME PRETTY BUSY. I TOOK SOME TIME TO PLAY A COMPUTERIZED RISK MANAGEMENT SIMULATION GAME AT THE BECHER+CARLSON EXHIBIT. I SCORED BETTER THAN EITHER OF MY EDITORS. I SUSPECT IT WAS A COMBINATION OF LUCK AND NOT HAVING SUCKED AS MANY CRAWFISH AS THEY DID THE NIGHT BEFORE.

BEN COHEN, OF BEN & JERRY'S ICE CREAM, WAS THERE TO SPEAK ABOUT CORPORATE STEWARDSHIP. UNFORTUNATELY, HE DIDN'T BRING ANY SAMPLES.



STEVE ALLEN ALSO SPOKE. APPARENTLY, HE THOUGHT MORE ABOUT HIS 'PERKS' THAN HE DID ABOUT HIS SPEECH!

I WALKED OVER TO JACKSON SQUARE TO HEAR THE STREET MUSICIANS. THEY WERE PLAYING SOME GREAT NEW ORLEANS JAZZ. I ALSO MANAGED TO SPEND ONE EVENING (HONEST) ON BOURBON STREET. RESTAURANTS, BARS AND WROUGHT IRON BALCONIES LINED THE STREET. OH, YEAH, AND BURLESQUE JOINTS... LOTS OF BURLESQUE JOINTS. THERE WAS ALSO A HEALTHY HELPING OF LOCAL CHARACTERS....



YOU'D LOVE THE FOOD IN NEW ORLEANS. I DIDN'T HAVE A BITE OF RED MEAT ALL WEEK— JUST SEA FOOD SERVED IN AN ENDLESS NUMBER OF WAYS. I UNDERSTAND THE LOCAL HOBBY IS GOING OUT TO EAT... I KNOW WHY!

I'LL BE FOLLOWING THE 'BIG MUDDY' UP RIVER AND WILL BE HOME SOON!!!

YOUR LOVING HUSBAND,

Roger



Risk execs, lawyers told to forge alliance

By CHRISTINE WOOLSEY

NEW ORLEANS—Corporate risk management and legal departments should be natural allies because they share the goal of protecting their company, advise experts in both fields.

However, "in many cases that's just not the case, and they often seem to be going in opposite directions," said Thomas D. Lewison, corporate director of risk management for The Hartz Group Inc. of Secaucus, N.J.

Mr. Lewison coordinated and moderated a panel discussion during the 29th annual Risk & Insurance Management Society conference in New Orleans.

Panelists conceded that ego is one of the major forces preventing cooperation between risk managers and lawyers within a corporation.

"Very, very few lawyers appreciate the fact that graduation from law school is not a coronation," joked Eugene R. Anderson of Anderson, Kill, Olick & Oshinsky in New York, a firm that often represents policyholders in insurance coverage disputes. "It takes a lot of thought on the part of risk managers to put up with the legal aristocracy and to make it work.

"You have to set your mind to the fact that here is someone who thinks he is smarter than you are and who wants to protect his turf," Mr. Anderson advised risk managers.

"It's hard to deal with attorneys, because they do tend to think they have the answers to all the questions," Mr. Lewison agreed. However, he added, "it's also important for risk managers to consider their own psychological makeup. What turf are you trying to protect?"

Because lawyers and risk managers are in the business of assessing risks and both want to protect their corporation from a hostile outside environment, they are natural allies, Mr. Anderson said.

But, he said, they often do not have common resources available to them. "The attention a corporation gives to insurance is quite different from that accorded to, say, taxes," he noted.

Legal departments frequently have access to a "cadre of sophisticated tax lawyers," he said, while a risk manager with a $10 million insurance problem may be assigned the company's least-experienced lawyer, Mr. Anderson said.

"Few corporate law departments are involved in insurance matters, and even fewer corporations have in-house lawyers who are experts in insurance practices and law," he said.

There are ways to enhance relations between legal and risk management departments, said Mark C. Zylkin, manager of insurance for ICI Americas Inc., a chemical manufacturer in Wilmington, Del.

"We created a triad within our company with one person representing insurance, one representing risk management and one representing law," he said.

In addition, ICI holds periodic meetings, distributes written reports and conducts outside audits of its law department to be sure it is handling cases with a risk management perspective in mind, Mr. Zylkin pointed out.

"In my view, the law department should litigate claims, and the insurance manager should control the insurance contract," Mr. Zylkin said. Both parties "should agree to an approved methodology of dealing with claims as they occur, not after they occur," he said.

For example, it should be clear who has settlement authority—the claims administrator or the legal department, he said.

In addition, Mr. Zylkin said he asks his legal department to review contracts to be sure they actually say what he meant them to say.

Hartz's Mr. Lewison pointed out the risk management and legal departments can also discuss the legal implications of acquisitions and divestitures, product line discontinuance, loss control and regulatory compliance. And, legal departments can give risk managers information on legal developments that will affect risk management or insurance, he said.

Corporate cultures often determine whether or not risk managers and company lawyers will have a cooperative relationship, pointed out Richard M. Ornitz, an attorney with Stroock, Stroock & Lavan in New York.

"Cooperation comes from the structure of your organization," he said. For example, risk managers may report to the finance, regulatory or legal departments or directly to the chief executive officer.

But "each of those departments is part of a team," Mr. Ornitz pointed out. "And the legal and insurance departments have to understand that the other side has a component to add."

For example, "in drafting insurance policies, the technical aspects come from the risk management view and the risk manager says this is what we need coverage for," he explained. "The legal department understands how contracts are read" so it can provide language that will ultimately define whether or not the corporation is covered.

Risk analysis and loss prevention are two very important duties of risk managers, Mr. Ornitz said. However, in the event of a loss, the risk manager also has the duty to notify the insurer and the legal department as soon as possible.

And, he said, risk managers should verify whether they can officially notify their insurer of a claim with a phone call or whether a letter is necessary.

Mr. Anderson also sang the praises of early notification. "Late notice is not like wine—it does not get better with age," he said.

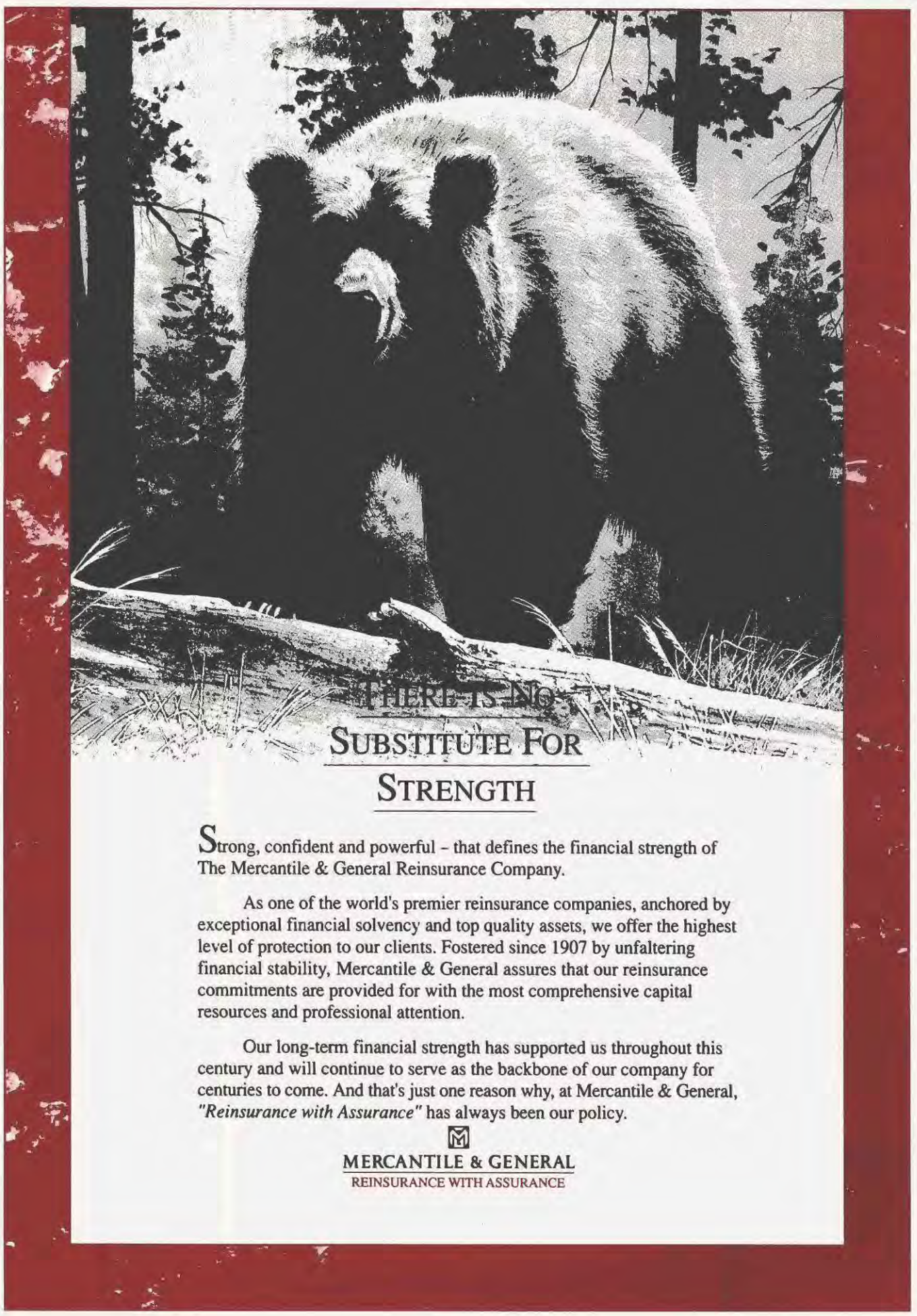
"There has been a custom in your trade for hundreds of years that it's OK to delay giving notice" of a loss. "The lawyers will tell you to give prompt notice, and you better listen to them," he said.

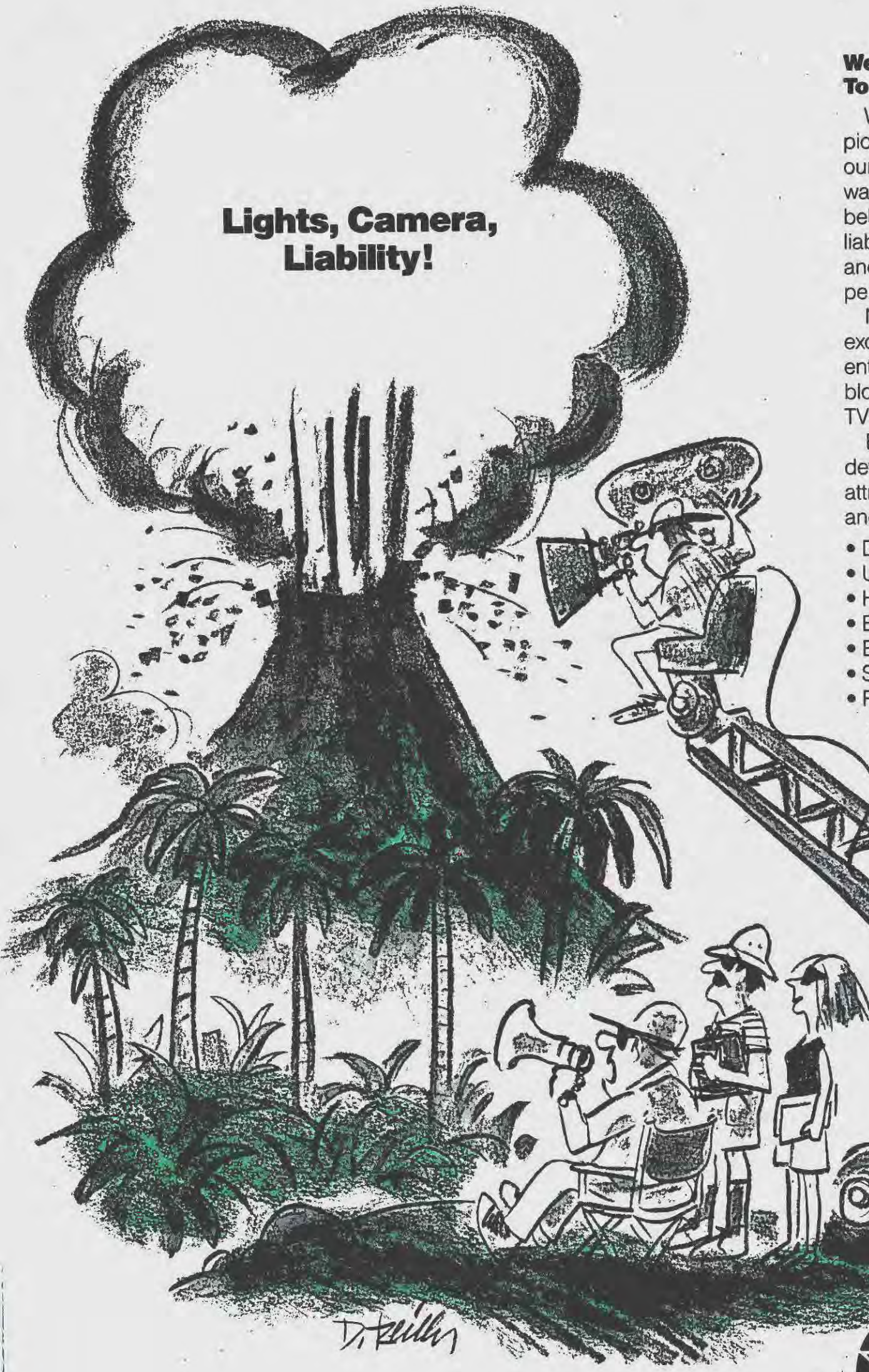
Mr. Ornitz said risk managers should also verify whether there is a clause within the policy that enables the policyholder to select its own counsel in the event of a coverage dispute.

"You may not always have the final say, but you can have input," he said. "It is vital to have a selection process that involves the legal department," he added.

Among the variables risk managers should consider when selecting an attorney are insurance expertise and legal judgment, quality, practicality, cost efficiency, chemistry and commitment, Mr. Ornitz said.

Debra E. Klugman, vp and senior associate general counsel for domestic companies at American International Group Inc. in New York, also spoke during the session. ■





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A world of differences

Cultural faux pas can hobble overseas risk programs

By GAVIN SOUTER

NEW ORLEANS—The cultural differences between foreign-owned companies operating in the United States and their overseas parents extend to their insurance programs, a risk manager says.

Consequently, non-U.S. companies operating in the United States should tread carefully and assess all of the different risk financing methods available to them rather than opt for insurance programs they know from their own markets, a broker advised. Tax and premium savings can total millions of dollars if the right U.S. program is chosen, he said.

The difference in cultures can cause ostensibly minor misunderstandings which, nevertheless, cause the overseas parents to hit the panic button, said Robert Muir, risk manager for Tarmac America Inc. in Herndon, Va., a subsidiary of Tarmac P.L.C. of Wolverhampton, England.

"Despite the fact that we speak the same language, working for a British parent can lead to confusion over terminology," Mr. Muir said during a session on "U.S. Risk Financing for Non-U.S. Corporations" at the 29th annual Risk & Insurance Management Society conference in New Orleans.

"For example," he continued, "I sent a fax to England saying that I had taken out cover from 9/1/86, and I quickly got a fax back demanding to know why I had organized cover from Jan. 9 instead of Sept. 1."

Also, if a U.S. risk manager mentions an umbrella liability policy to an official of an overseas parent, that official probably will not know what the risk manager is talking about, Mr. Muir said.

"If you do not sort these differences out, you can run into huge difficulties," he added.

Differences in compensatory awards in the United States also could shock a British parent, Mr. Muir said.

For example, some claimants from the Herald of Free Enterprise ferry disaster off the coast of Belgium in 1987 were only awarded 3,500 pounds ($5,600 at appropriate exchange rates). If the disaster had occurred in the United States, the awards would have been substantially more, he contended (*BI*, March 16, 1987, March 30, 1987).

"For example, in 1989 a 20-year-old Korean was awarded $58 million after he fell onto a subway rail he was looking down at and had both of his legs amputated. He was earning $100 a week in a laundry," Mr. Muir said.

Risk financing methods differ widely in the United States compared with other nations, remarked Lucien Laborde, president of Corroon & Black Corp.'s Research and Development Division in Nashville, Tenn.

The seven major risk financing methods in the United States, according to Mr. Laborde, are:

- A guaranteed-cost plan. This is a standard insurance package, Mr. Laborde said.

Its advantages include its defined cost, but a disadvantage is that the policyholder must pay the entire premium upfront, which can have an adverse effect on cash flow, he added.

- An incurred-loss retrospectively rated program.

Under such a plan, not all of the premium is paid upfront, and adjustments in the overall cost of the insurance are made based on the policyholder's loss experience, Mr. Laborde explained. "The advantage of this method is that it allows you to benefit if you apply good risk management techniques, and it gives you substantial encouragement to keep your losses down," he said.

However, the disadvantages are that the premiums are loss-sensitive and that the portion of the premium paid upfront still reduces cash flow, Mr. Laborde said.

- A depressed pay-in retro.

This is similar to an incurred-loss retro, but the initial premium is lower.

- A paid-loss retro.

The initial premium is kept to a minimum, but a trust account is established from which claims are paid. "This is beneficial to your cash flow, but you have to provide the insurer with some form of security in a paper of credit," Mr. Laborde explained.

- Large deductible plan.

"This is probably the hottest thing in risk financing currently in the United States," he said.

Under the plan, the company takes a $100,000 to $5 million deductible or retention and essentially purchases excess coverage. Any losses that are paid within the deductible or retention are not considered an insurance premium and consequently are not subject to premium taxes, he explained.

The main drawback of this type of program is that it can be used for workers compensation risks in only 28 states and not all insurers will write this type of program, Mr. Laborde said.

- A qualified self-insurance plan.

"Because you are eliminating insurance, this should be the least expensive over the long term," Mr. Laborde said.

However, the company is saddled with additional administrative burdens, the availability of aggregate excess coverage is poor and the approval process for workers compensation risks can be lengthy, he added.

- A single-parent captive insurer.

A captive gives a multinational company the potential to consolidate global coverage, gives the company greater control over claims and increases senior management's awareness of risk management. However, Mr. Laborde noted that the company must bear the cost of fronting programs when necessary, as well as administrative fees; the captive may require additional capital if loss experience is adverse; and increased management involvement is required.

"By making sure that you have the right program, you can save millions of dollars and, in one case, we managed to save a company over $10 million," he concluded.

Pearson P.L.C., a London conglomerate, uses a paid-loss retro program to insure all of its U.S. exposures, said Peter Rosier, manager-risk management and insurance. "We pay premiums in monthly installments, and this gives us a cash-flow advantage," he said. The company is considering using its captive to cover its U.S. program, he added.

Also speaking at the session was William Bradley, a partner with Sutherland, Asbill & Brennan in Atlanta, who traced the history of captive taxation. The session was moderated by Mr. Muir and coordinated by Claude Gallello, executive vp of Corroon & Black International in New York. ■



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Judd tribute

Continued from page 3
opportunity. He took the job."

In 1968, Mr. Judd attended his first ASIM conference and found "a debacle complete with dancing girls in every suite," Ms. Hawkins said. "So he went back and sat down and did some strategic planning. His goal was to build a respected profession."

One of Mr. Judd's first moves was to change the name of the ASIM's magazine to Risk Management from National Insurance Buyer. In addition, he began cleaning up the group's image and banned the word "convention" as a description of the group's annual conference.

"He began to build what is today the major event for the commercial insurance world," Ms. Hawkins said. Mr. Judd, she noted, was responsible for assembling a growing RIMS staff and establishing departments in research and education, government affairs and public relations.

"Ron's special gift is bringing people together to work for a common cause and picking the right people to get the job done right," said Ms. Hawkins.

Mr. Judd's efforts to bring respectability to risk management worked, according to John G. Johnston, vp of American International Group Inc. in New York.

"You convinced our underwriters that the risk manager walked on water," said Mr. Johnston. "The stature of the risk manager today is the result of all the work that you've done and the ingenuity that you brought to RIMS" in developing it into a formidable organization, he added.

Mr. Judd also fostered the overseas ties that led to the AEAI/RIMS International Risk Management Forum, held every other year in Monte Carlo.

Edith F. Lichota, a former risk manager, the 1990 winner of the Goodell Award and president of consultant Lichota & Associates Inc. in Norwalk, Conn., remembered spending time with Mr. Judd at the first Monte Carlo conference in 1981. His dedication meant he was always working, despite the distractions, she recalled.

On a "beautiful evening in southern France," with a giant moon over the Mediterranean "and the sea turning to silver, what were we doing? We stole a table from the adjoining deck. We ordered club sandwiches and we were planning the next bigger and better Monte Carlo conference," she recalled.

In a letter read by Ms. Hawkins during the tribute, Marsh & McLennan Inc. Chairman Robert Clements called Mr. Judd the "Frank Lloyd Wright of the risk management field, a master builder. You have been a primary force in shaping and developing an organization whose reach is now worldwide and whose stature looms large not only in all facets of the insurance business but in all areas of commerce and industry."

Alfred Malecki, publisher of *Business Insurance,* called 1967 a "very important year" because Mr. Judd joined the organization that became RIMS and *BI* began publishing.

Mr. Judd became skilled at "collecting money for good causes," said Mr. Malecki, particularly for the Spencer Educational Foundation Inc., which provides scholarships to risk management students.

Some say Mr. Judd's tight-fistedness was a hallmark of his career at RIMS.

Jon Harkavy, former director of governmental affairs and general counsel at RIMS and now vp and general counsel with Vermont Insurance Management Inc. in Montpelier, Vt., remembered his former boss as a man who was not particularly loose with the purse strings.

"I accused him of throwing nickels around like they were manhole covers and he claimed to have given me an unlimited budget and I overspent it," Mr. Harkavy said.

While budgets may have been a source of contention at RIMS, Mr. Harkavy testified that "the one thing the staff always agreed on were his old polyester suits. We once speculated that a moth died of chemical poisoning in his closet."

Still, he thanked Mr. Judd because "you always gave me enough rope to hang myself but never left me twisting in the wind."

Norman A. Baglini, president and chief executive officer of the Insurance Institute of America in Malvern, Pa., said that during lean times at RIMS, Mr. Judd "always returned my calls at lunch. This necessitated my calling him back at my expense. And even staggering my lunch hours didn't work."

Giving credit where credit is due, Mr. Baglini added that Mr. Judd "has repeatedly taken me aside, grabbed me by the elbow and said, 'When can we talk?' The topics are always far-sighted and frequently deal with the internationalization of risk management ideas, concepts and techniques. His persuasiveness and persistence are among the reasons RIMS has such an international stature today."

Richard Hackenburg, a former risk manager and RIMS president who now is an executive vp with Corroon & Black of Massachusetts Inc. in Boston, gave Mr. Judd credit for developing 12 rules of life in business. He listed those rules as:

- RIMS always makes the rules.
- The rules are subject to change at any time without prior notification.
- No insurance company, broker, agent or consultant can possibly know all the rules.
- If RIMS suspects that any insurance company, broker, agent or consultant knows all the rules, Ron Judd must immediately change some or all of the rules.
- RIMS is never wrong.
- If RIMS is wrong, it is because of a flagrant misunderstanding that is the result of some broker mess-up.
- If Rule No. 6 applies, the broker must apologize immediately for causing the misunderstanding.
- RIMS may change its mind at any time.
- The insurance industry must never change its mind without the expressed written consent of RIMS.
- RIMS, however, is permitted to be angry or upset at any time.
- The industry is never permitted to be angry or upset, unless of course RIMS wants the industry to be angry or upset.
- Any attempt to break any of the rules will result in the offender's incarceration in a room with a thoroughly mad and vicious unicorn.

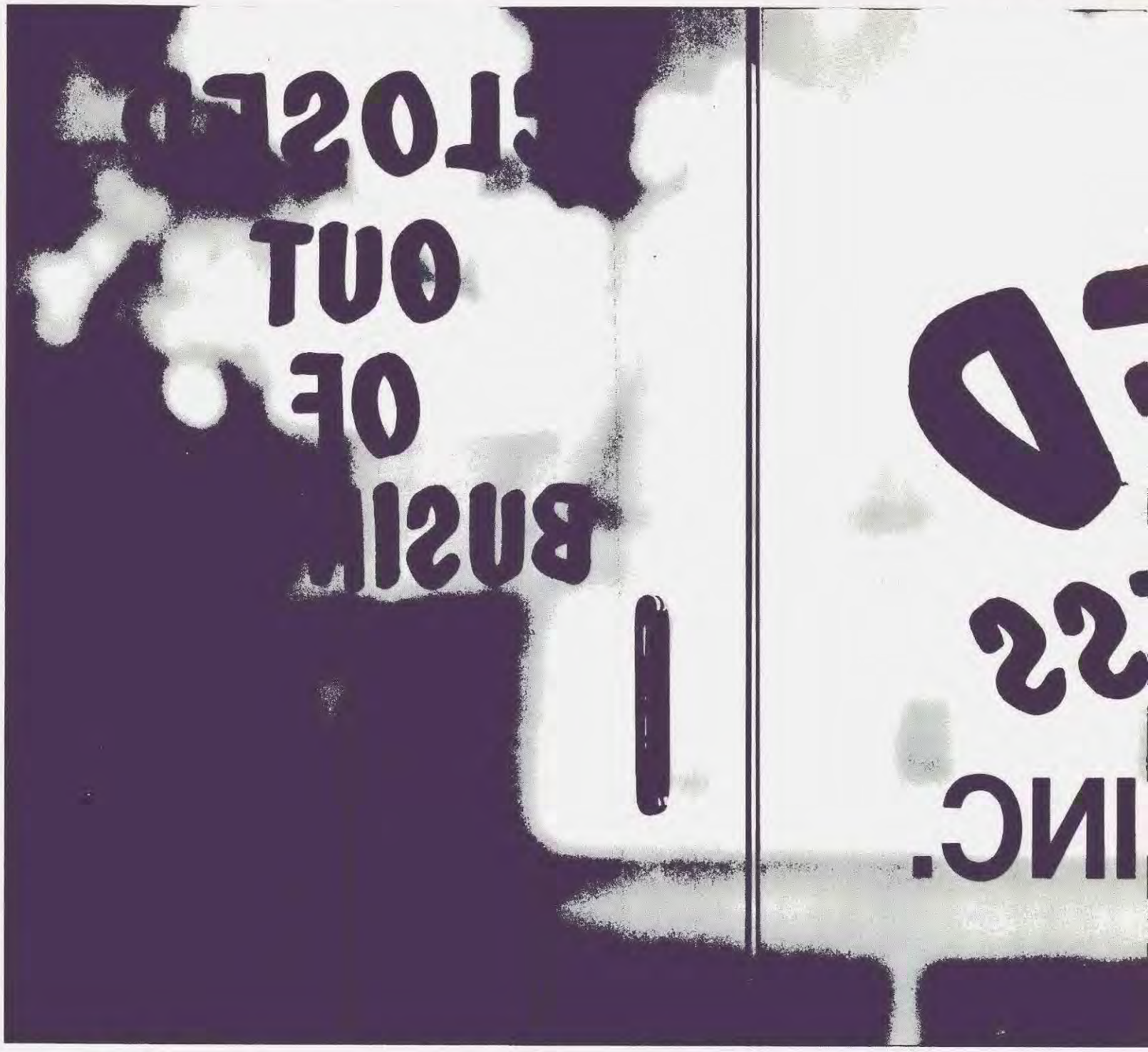
Mr. Hackenburg said, "Ron Judd is a man who had a dream. All of us in this room here today have played a part in that dream."

Rita Epstein, director of communications at RIMS, said "there are probably 8 million Ron Judd stories. You've heard just a few and, I assure you, they are all true."

She described Mr. Judd as a man who "loves to win and hates to lose. Most of us do. But with Ron, it's a credo, almost religious in nature. And he never gets mad, but he always gets even.

"Imagine working for this guy," said Ms. Epstein. "He doesn't do 9 to 5, he doesn't do vacations. He does a job and you better, too."

Mr. Judd "has given us all the greatest gift—he has given us himself. He has given us his heart and his soul. He has nurtured us, he has protected us, he has taught us so much," Ms. Epstein said. ■



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Ice cream maven urges business aid for disadvantaged

By MICAHEL BRADFORD

NEW ORLEANS—Companies have a responsibility to look beyond the bottom line and become stewards of their communities and the disadvantaged, says one of the partners in a unique ice cream business.

Ben Cohen—college dropout, former janitor, McDonald's cashier and holder of various other not-so-high-level positions—developed his philosophy of corporate stewardship while building one of the country's "hottest" businesses.

Mr. Cohen is chairman of Burlington, Vt.-based Ben & Jerry's Homemade Inc., where corporate decisions often are made not only with financial considerations in mind, but also with an eye toward helping others.

And that's the philosophy Mr. Cohen is preaching to other business leaders.

Mr. Cohen, speaking during a special session at the 29th annual Risk & Insurance Management Society conference in New Orleans, asked: "If we as individuals have a responsibility to help others, should we not retain the same values when we are organized as a business?"

It is "precisely when we are at our most powerful, when we are organized as a business, that we are told to leave our values at the door," he said.

Businesses are a powerful force for social change, Mr. Cohen stressed, but many corporate decisions are "based solely on bottom-line profit and loss."

It's up to businesses to take the lead in helping the poor and disadvantaged because legislators aren't doing the job and non-profit organizations lack the proper funding, Mr. Cohen told the audience.

"Business is the most powerful force in society. Government is the second most powerful source and the non-profits" are third, he said.

"Why should business care about the needs of children in inner cities? Because it is business alone, by virtue of its enormous power, that is in a position to help," he asserted.

By following the lead of companies like Ben & Jerry's, businesses can use their clout and resources to help the disadvantaged and promote other causes, Mr. Cohen remarked.

Ben & Jerry's discovered that "the proper course for us was to choose actions that have a positive effect on the community and our profits," Mr. Cohen explained. "We instructed our managers to integrate the concerns of the community in as many day-to-day decisions as possible."

The philosophy was first implemented when Ben & Jerry's introduced a chocolate-covered ice cream bar. While discussing packaging, the company decided to place a social message on the product's wrapper.

"We ended up calling those ice cream pops 'Peace Pops' and using the packaging" to rally support for a proposal to redirect 1% of the money spent on the U.S. military budget to peaceful activities, Mr. Cohen said.

The ice cream wrappers urge purchasers to support a non-profit organization called 1% For Peace, which uses its funds for projects like feeding and housing the homeless and teaching democracy in Eastern Europe.

Reaction from customers was positive, Mr. Cohen recalled, despite the naysayers who claimed stores wouldn't accept the product and buyers with different viewpoints wouldn't buy it.

The controversy over Peace Pops led to a realization that "business is a very, very political animal," said Mr. Cohen.

"Most of the lobbyists are paid for by business. But the difference here is that we were taking an overt political stand which was not in our own self-interest, whereas the norm is for business to take covert political stands. . .in their best interests."

Since that initial stand, Ben & Jerry's has backed other social causes, Mr. Cohen said.

The company's packaging has opposed the use of a bovine growth hormone, which stimulates growth in cattle but could lead to questionable health effects, he said.

Ben & Jerry's also makes an ef-

Continued on next page



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Ben & Jerry's

Continued from previous page
fort to produce ice cream flavors that have "a positive effect on disadvantaged segments of society," he said.

For example, blueberries used in Ben & Jerry's "Wild Maine Blueberry" ice cream are harvested by native American Indians in Maine (*BI,* April 22). A brownie used in "Chocolate Fudge Brownie" ice cream is produced by a bakery in New York that is run by a group that hires the homeless and uses its profits to house the homeless.

And Ben & Jerry's deals with service providers that also hold to socially responsible business tenets.

"In the area of (health) insurance, we switched our policies to Consumers United (Insurance Co.), a small company in Washington, D.C., because it invests the premiums we pay in low-income housing and other socially responsible investments," Mr. Cohen remarked.

He said the insurer "covers alternative practitioners for our workers and it employs a very high proportion of women and minorities. It also uses a very compressed salary ratio whereby the highest-paid person in the company is paid three times what the lowest-paid person gets."

Ben & Jerry's also uses South Shore Bank in Chicago, which was set up in a decaying part of the city to draw investments into the community.

"Our corporate charge card is the Working Assets MasterCard," said Mr. Cohen. Five cents of every transaction made with the card goes into a pool that funds non-profit groups.

Ben & Jerry's participates in a number of other socially and environmentally responsible projects, from paper recycling to registering voters at the company's Burlington ice cream shop.

On the legislative side, Ben & Jerry's has joined with 10 other companies in an organization called Act Now. The group's activities center on using the companies' combined clout to influence legislation.

The group has taken a stand on automobile fuel efficiency. "We're urging Congress to pass a law to increase fuel efficiency to 40 miles per gallon by the year 2000," he said. "The technology currently exists."

Such a move would reduce the greenhouse effect, decrease dependence on foreign oil and cut consumers' gas bills, Mr. Cohen explained, while adding only $500 to the cost of a car.

Mr. Cohen warned RIMS conference attendees that corporations that exist only to maximize profits "become disconnected from their souls, the spiritual interconnectiveness of humanity."

Like individuals, he added, "businesses can conduct themselves with the knowledge that the heart and soul and spirit of all people are interconnected. So as we help others, we cannot help but to help ourselves." ■

Risk managers urged to use self-promotion

By COLLEEN JOHNSON

NEW ORLEANS—To improve their status within their own companies, risk managers should make sure other managers and employees understand the importance of risk management and work to help other departments reach their goals.

Risk managers may find that "like Rodney Dangerfield, they get no respect," observed Eberhard E. Scheuing, director of the Business Research Institute and the Continuing Management Education Program in the Colleges of Business Administration at St. John's University in Jamaica, N.Y.

Many risk managers have said that they spend about 80% of their time placing and administering insurance and only 20% on managing risks, added Wolfgang F. Friedel, vp-international operations at Arkwright Mutual Insurance Co. in Shelton, Conn.

But if a company expects its risk manager primarily to be an insurance manager, he or she must still perform risk management functions, Mr. Friedel said.

Mr. Friedel and Mr. Scheuing spoke at a session of the 29th annual Risk & Insurance Management Society conference.

Mr. Friedel said there are several questions a risk manager should consider in determining whether he or she needs to educate others in the company about the importance of risk management:

- Does the risk manager report to a sufficiently high level within the organization, such as to the chief executive officer or chief financial officer?
- Does the organization have a risk management philosophy statement signed by a high-level senior executive?
- Does the risk manager's view of risk management coincide with that of top management?
- Does the risk manager participate in important strategic decision making?
- Is the risk manager recognized as the leader of loss control, and is loss control an integral part of the organization's philosophy?
- Is the risk manager encouraged to be pro-active in doing his or her job?
- Are organizational managers required to include risk management-related items in their budgets, and must the risk manager approve them?
- Do others in the company understand that the risk manager is involved in more than just insurance?
- Do others understand and support risk management?

If a risk manager answers any of these questions with a "no" or an "I don't know," the risk manager can't do his or her job effectively and should market the importance of risk management to the rest of the company, Mr. Friedel advised.

To market the risk management department, a risk manager should show how the department can help other managers meet their objectives, quantify the organization's risk and conduct cost-benefit analyses to show why risk management techniques should be adopted, he said.

Similarly, to gain respect and influence, Mr. Scheuing said, risk managers should:

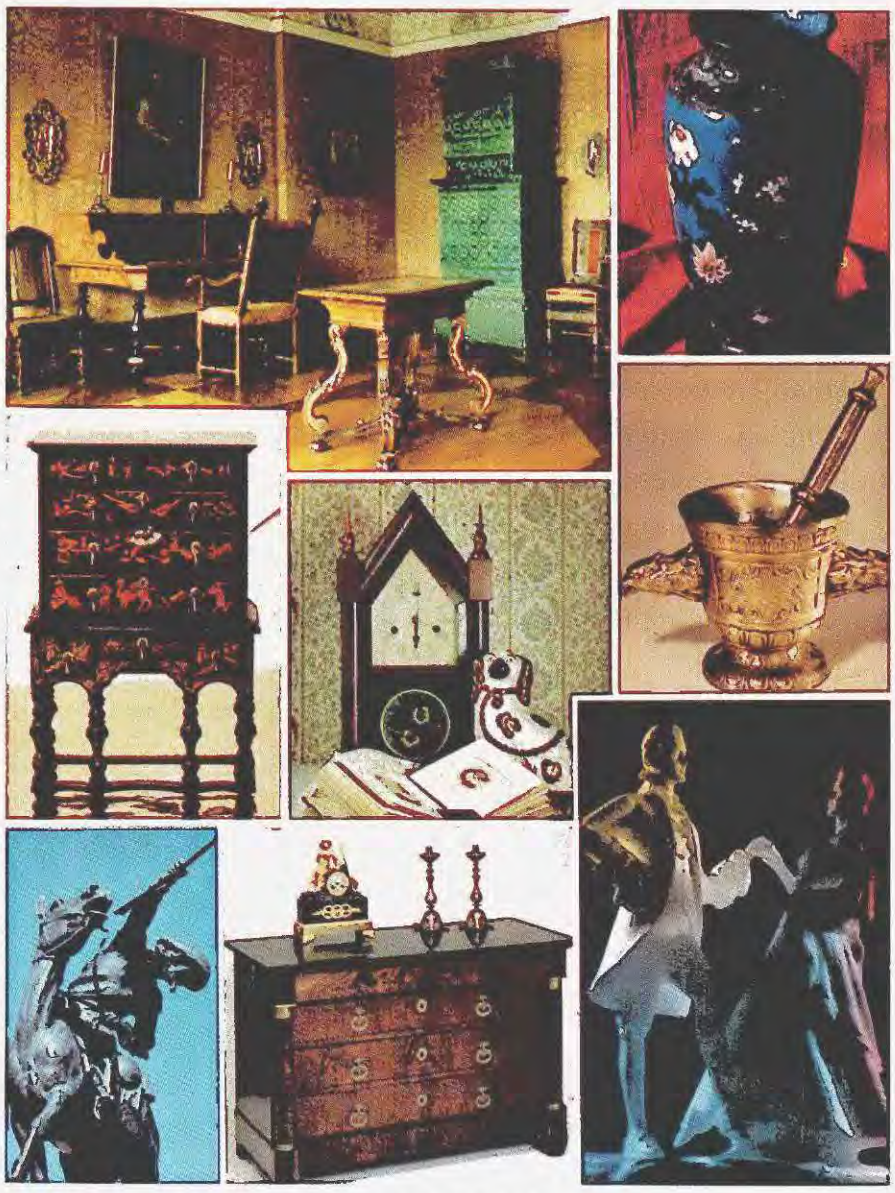
- Understand the needs of other people in the company.
- Launch a "consciousness-raising effort" to educate them about the importance of the risk management function.
- Demonstrate strong professionalism.
- Be a team player.

To determine the needs of others in the company, risk managers can hold focus group sessions or distribute surveys, he recommended.

After determining the needs of others in the company and selecting projects to help them fulfill those needs, the risk manager should use strong communication skills to ensure continued good relations, said George Cirasuolo, risk manager for Southern New England Telecommunications Corp. in New Haven, Conn.

Also speaking was Edward G. Perkins, senior vp of Johnson & Higgins of Connecticut Inc. in Hartford. Mr. Cirasuolo coordinated and moderated the session. ■

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Brokers, risk managers must scrutinize insurers

By JOANNE WOJCIK

NEW ORLEANS—Risk managers can avoid purchasing insurance from a shaky insurer by conducting their own investigation of a company's finances, an insurance broker says.

At the same time, brokers should be practicing due diligence and prudence in selecting a stable insurer for clients, according to William D. Pringle, executive vp and director of Frank B. Hall & Co. of New York Inc.

While a broker cannot guarantee that an insurer with which he or she has placed a client's business will remain solvent, "the broker has a greater responsibility than just being a deal maker," Mr. Pringle said at a session during the 29th annual Risk & Insurance Management Society conference in New Orleans.

Insurer solvency is becoming a major concern of risk managers as the number and size of insurers becoming insolvent increase, according to Mr. Pringle.

While only 1.25% of the nation's 4,500 insurers have become insolvent during the last 20 years, the speed with which insolvencies occur has accelerated, he said.

And while most of the insolvencies during the 1970s involved small personal lines companies, in the 1980s it was large commercial insurance companies—like Mission Insurance Co., Integrity Insurance Co. and Transit Casualty Co.—that have become insolvent, Mr. Pringle said.

One way insurance buyers can protect themselves from a possible insurance insolvency is to become educated consumers, he said.

"Do your own investigation and keep up with what's being written in the trades," he suggested.

Risk managers also should ask their brokers whether they are comfortable with the solvency of a particular insurer and why it was selected, Mr. Pringle added.

"You will learn more by asking more questions," he said.

In addition, price should not be the sole criterion for selecting an insurer, according to Mr. Pringle.

"Look at your insurance carrier in terms of its long-range stability," he advised.

Risk managers should use their common sense when screening insurers, said John B. Chesson, counsel for the Subcommittee on Oversight and Investigations of the House Committee on Energy and Commerce. Mr. Chesson is the principal author of the report on insurer solvency spearheaded by Rep. John Dingell, D-Mich. (*BI*, Feb. 26, 1990).

One area to which Mr. Chesson suggested risk managers pay particular attention is an insurer's accounting practices—how they value their assets and liabilities.

A good source of information that both risk managers and brokers can access for information is A.M. Best Co. of Oldwick, N.J., all speakers at the session agreed.

Best, which publishes both annual and quarterly reports on property/casualty and life/health insurers, studies some 3.5 tons of annual statements each spring to develop its insurer ratings, according to Paul E. Wish, a vp of the rating company.

"But we don't look only at the annual statement when rating a company," he said. "This is only a starting point."

After crunching the numbers contained in an insurer's most recent annual statement, Best compares that information with five years of data to spot inconsistencies or negative trends, Mr. Wish explained.

"We do take these numbers (the insurer-provided annual statements) as honest, but we don't take them at face value," he said.

In addition, Best separately calculates loss reserves, adding any excess to the insurer's surplus or any deficiency to the insurer's liabilities, Mr. Wish added.

Other information Best uses to develop ratings are all filings insurers make with the Securities and Exchange Commission, reports to stockholders and policyholders, and a questionnaire that inquires about the lines of coverage an insurer writes, the nature of its reinsurance contracts, loss reserve methodology used, policy count, organization changes, etc.

And, a final source of information used by Best is so-called "whistle-blowers," according to Mr. Wish.

For example, Best often receives letters from agents, consumers and sometimes other insurers, pointing out potentially troubled firms.

"When the information accumulates, we investigate it," he said.

But while Best's reports are considered by many to be the foremost guide to insurer financial information, they "are far from fail-safe," Mr. Wish cautioned.

Like Mr. Pringle, Mr. Wish also recommended that insurance buyers bone up on all sources of information available.

Another good source of insurer financial information is the Insurance Regulatory Information System developed by the National Assn. of Insurance Commissioners to isolate companies that might be having financial difficulty.

IRIS information was recently made available to the public, according to Nebraska Insurance Commissioner William McCartney.

"The NAIC maintains the largest insurer data base of any statistical gathering organization in the country," he said at the session.

And the organization also is improving the information received from insurers, he added.

For example, all state insurance departments now require insurers to file audit reports conducted by independent certified public accountants, as well as actuarial certification of loss reserves, he said.

And, beginning with 1990 annual statements, insurers must state whether their holdings are investment grade or non-investment grade, Mr. McCartney added.

An NAIC working group also is meeting next month to discuss the possibility of standardizing insurer investment provisions, he said.

This, he said, hopefully will prevent insurers from loading up their investment portfolios with too many junk bonds, as did First Executive Corp. units in California and New York, which were seized last month by state regulators (*BI*, April 22).

The session was moderated by Bettina B. Browne, vp-human resources at International Service System Inc. in New York.

Coletta I. Kemper, director of public affairs for the National Assn. of Insurance Brokers in Washington, D.C., coordinated the session. ■



Capital top priority in forming a facility

By JUDY GREENWALD

NEW ORLEANS—Risk managers considering forming risk retention groups should first be sure the groups will attract adequate capital before embarking on extensive—and expensive—planning.

Ruth Crystal, risk manager for the The Equitable Life Assurance Society of the United States in New York, described her company's experience with both an aborted and a successfully launched risk retention group at a session at the 29th annual Risk & Insurance Management Society conference in New Orleans.

Ms. Crystal noted that Equitable's attempt to form a risk retention group to insure environmental liability risks for real estate owners never got off the ground.

However, Equitable—which has extensive property holdings—became involved with a successful risk retention group that provides asbestos liability coverage.

Equitable attempted to create a risk retention group to provide environmental impairment liability coverage to real estate owners because there was a large enough base of potential participants to make a risk retention group viable.

"Every owner of real estate knows you can be hit" with environmental claims, Ms. Crystal said.

In addition, the project attracted good underwriting people and a back office operation was lined up, she reported.

The problem was obtaining enough capital from the policyholders, she said. Equitable did not want to start the risk retention group with just $500,000 to $1 million in capital, she said.

"Admittedly, our timing could not have been worse," said Ms. Crystal, noting the project was ready to go ahead just as the real estate market nose-dived. A shortage of capital is a "fact of life" in the real estate business, she said.

The project has been relegated to the "permanent pending file," she noted.

Ms. Crystal strongly urged those considering establishing an alternative risk mechanism to raise the required capital "before you spend a tremendous amount of money in start-up costs."

However, Equitable was more successful in finding an alternative risk financing facility to write asbestos liability insurance, said Ms. Crystal, noting that the company also is a policyholder of offshore excess liability insurers ACE Ltd. and X.L. Insurance Co. Ltd.

Ms. Crystal said Equitable first became sensitive to what she described as environmental issues after a 1983 fire at an Equitable building resulted in the release of polychlorinated biphenyls, or PCBs. This was enough to convince the company that it could be caught "flat-footed," she said.

The Equitable first educated itself about asbestos, Ms. Crystal said. It also set out to determine how much asbestos was in buildings it owned and where the asbestos was located in those buildings.

She noted that the company worked closely with government agencies and industry trade groups in a process that "took years and a great deal of money."

Equitable's intent was to control the risk and to assure as much as reasonably possible that non-friable asbestos remained that way, she said.

However, the insurer found that the asbestos abatement contractors it hired had inadequate liability insurance and that Equitable itself could not obtain better coverage, Ms. Crystal said. This led the insurer to seek coverage outside the traditional market.

Equitable eventually decided to join ERIC Group Inc., an Englewood, Colo.-based risk retention group with technical expertise.

Ms. Crystal suggested that a risk manager considering doing business with an already-existing alternative facility should first lay a strong foundation with his or her own senior management. Many senior corporate managers still distrust any insurance company that does not advertise or is not an institutional investor, she said.

The risk manager considering an established alternative facility must examine its financial statement, its history, its growth and its management, Ms. Crystal said. Insist on face-to-face meetings with the facility's senior management and underwriters, she said.

But, some risk managers can become so enamored with the idea of using an alternative facility that "one loses sight of why one is there in the first place," she noted.

Before joining the facility, a risk manager should think of the worst possible interpretation of the facility's policy language and test what it means, Ms. Crystal suggested.

In addition, she recommended testing the alternative facility for flexibility. Will the facility be able to respond to changes at the risk manager's company? she asked.

For example, the alternative facility should be able to quickly respond if the policyholder opens a new location or introduces a new product or type of operation, Ms. Crystal said.

The risk manager also must determine whether the facility has access to expertise on loss control, she said.

The risk manager also should know enough about the exposures insured by the facility to have some sense of whether the rates charged by the facility are adequate, Ms. Crystal said.

She advised risk managers to look for "a sense this is not a one-size-fits-all market" and that the staff understands the exposure and works from a base of knowledge.

In addition, the risk manager should examine how capable the facility is of sustaining losses as well as its claims-handling ability and staffing.

Ms. Crystal advised risk managers to "check your references" and ask contacts about the facility and its management. She recommended talking to current policyholders as well as those who either chose not to join the facility or that did join and subsequently dropped out.

The risk manager also must examine how desperate his or her company is for coverage. If coverage is necessary for the company's continued operations, it may have to settle for an alternative market with some shortcomings, but it should do so based on a full awareness of the alternative's operations, Ms. Crystal said.

Risk managers should bear in mind that when all of these steps are accomplished, the job is not even half completed, Ms. Crystal said. Risk managers must continue to monitor and oversee the alternative's activities.

Also speaking at the session was John Kezer, special counsel to Denver-based Wood, Ris, & Hames, and a former Colorado insurance commissioner, and Paul K. Freeman, ERIC's chief executive officer.

Ms. Crystal moderated the session, and Mr. Freeman coordinated the session.





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Reining in the litigation monster

Settle early and often, legal experts advise corporations

By MICHAEL SCHACHNER

NEW ORLEANS—While all lawsuits deserve an aggressive defense, risk managers and corporate counsel can control litigation costs by settling cases as early as possible.

"We are all capable of settling a case once a jury has been picked, but what we really must try to do is settle the case about one-third of the way through," said Jay Mayesh, a partner with the New York law firm of Stroock & Stroock & Levan.

Litigation costs often comprise the greatest part of claims expenses, so companies have a real incentive to settle cases as soon as is appropriate, said Mr. Mayesh at a session of the 29th annual Risk & Insurance Management Society conference in New Orleans.

Another defense lawyer also emphasized controlling litigation.

"Litigation costs are having a negative impact on the U.S. economy as a whole, so it's very important for every company to have a gatekeeper, whether it be an in-house counsel or a risk manager, who can say no," said Stewart E. Niles, Jr., senior partner at Jones, Walker, Waechter, Poitevent, Carrere & Denegre, a New Orleans firm. "There must be someone to control the litigation process."

Almost all claims are ready to be settled from the start, according to Judge Charles Schwartz Jr. of the U.S. District Court in New Orleans.

"Only 6.6% of all cases reach the trial stage," he said. "This shows that most cases do settle, so you might as well do it early."

Settlements are even more likely in personal injury suits. According to Paul McMenaman, president of Lititech Inc., a litigation consulting firm in Denver, 98% of all these suits are settled before trial, the only question being when.

"I know some cases have to be tried, but there's a huge load of cases that can be dumped. If, as an employer, you're self-insured or carry a self-insured retention below an insurance policy, you have money at stake. You may as well resolve the case before defense costs build up," Mr. McMenaman said.

Assessing when a claim is ready for settlement entails several steps, according to Mr. Mayesh.

Even before contacting a defense lawyer, a company should hire a private investigator, he said. "Investigators by nature are better diggers than lawyers, and they're a lot cheaper by the hour, too."

Any claim involving a medical injury should be reviewed in detail by a nurse paralegal, Mr. Mayesh insisted. "Nurse paralegals must scour medical reports paying close attention to the plaintiff's health history. It may show a condition that existed before the lawsuit."

After that background check, he advised companies to examine jury verdict reports from similar cases to get an idea of what a particular suit's chances are in court.

Expert witnesses play an important role in Mr. Mayesh's strategy. Bring experts in early on and make them members of the defense team, he advised. "They will provide you with a broad scope of knowledge that can help you depose a witness and make key decisions like upping a settlement offer or retracting an offer."

When settling, defense should view the plaintiffs' attorney as a businessman looking to move his or her inventory, he said.

"Plaintiffs' lawyers are almost always undercapitalized and in need of cash. Sometimes they'll offer a rock-bottom settlement, which you should jump at," according to Mr. Mayesh.

At certain times of the year, he added, plaintiffs' lawyers may actually be more willing to settle. "It seems as though every Christmas their hands are out," he said. "They have bonuses to pay."

Tax time and the summer slowdown are "good times to entice a lawyer to take a low settlement," he said.

Once a lawsuit is filed, it is imperative that risk managers immediately set a budget for the claim, said Mr. Niles.

"You never want to hear your outside defense attorney say something like, 'I have no idea what this is going to cost.' There are too many of us out there today for you to accept a 'don't know' or a 'not sure,' " Mr. Niles said.

Defendants should develop and stick to a litigation plan—including methodology and research—that outlines the desired result, he said.

Another area in which companies can cut back on unnecessary litigation costs is by using competent, competitive court reporters, Mr. Niles said. "Good court reporting services can be one-third cheaper than the bad ones."

Risk managers and corporate counsel can also control the litigation process by following a set of written policies and procedures, he noted.

Some key policies and procedures he mentioned include:

- Making sure that the risk management office coordinates all talks with the plaintiff.

"Sometimes outside counsel triggers alarm in the plaintiff, which can lead to a stall in the settlement process," Mr. Niles said.

- Making certain that all documents filed in a case have an objective. "Pleadings should only be a vehicle to getting something done," he emphasized.
- Requiring approval of all depositions. "I don't believe in trial by ambush. Statements and video tapes are often far less expensive than depositions," he said.

Judge Schwartz warned risk managers to take a close look at the time sheets their lawyers are filling out.

"When I'm asked to determine attorney's fees, that's what I look at. Also, make sure paralegal fees and copying fees aren't above and beyond what you are expecting. A lawyer is entitled to a reasonable fee, not an excessive one," he said.

Thomas D. Lewison, corporate director of risk management with The Hartz Group Inc. in Newark, N.J., coordinated and moderated the session. ■

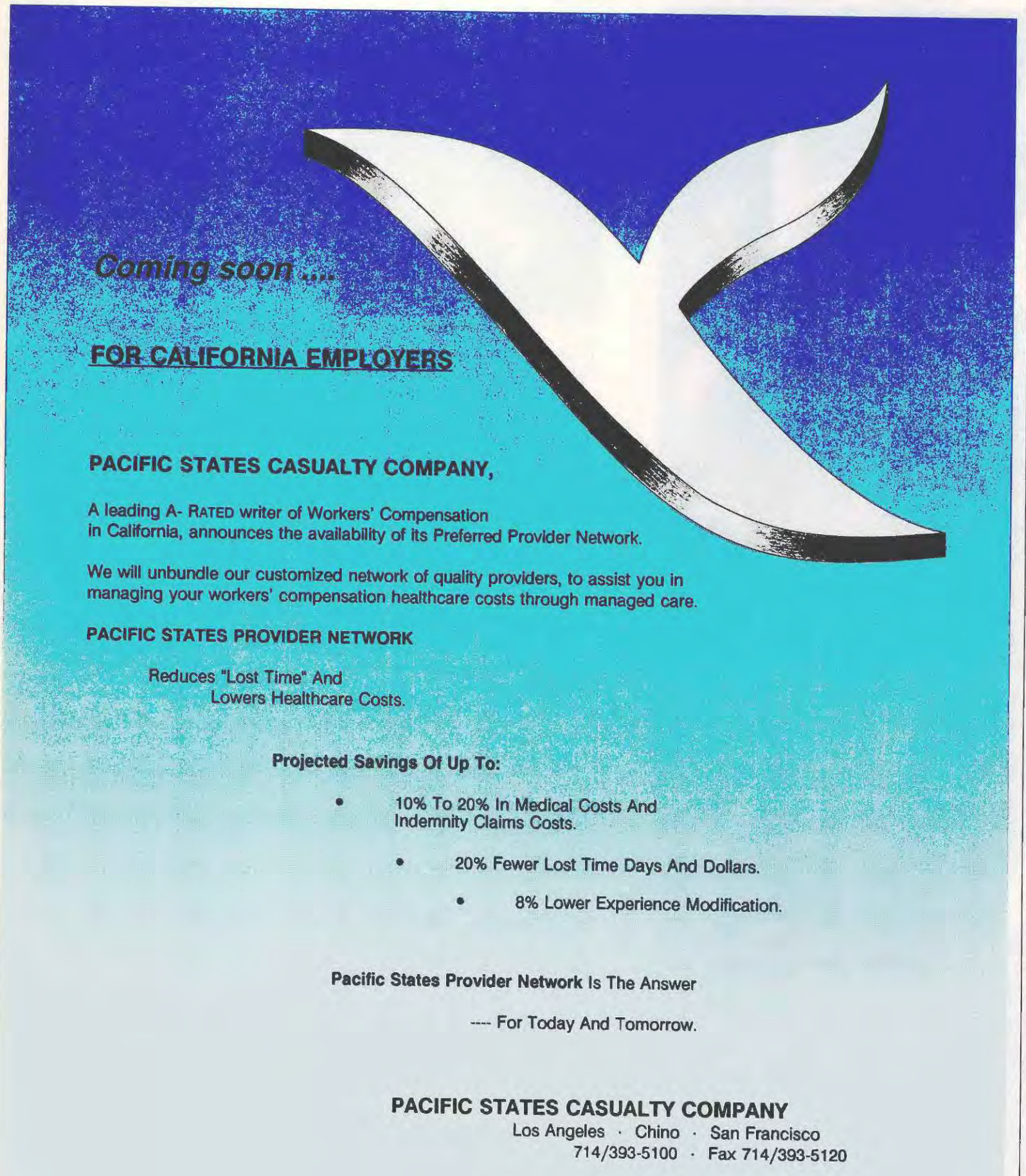




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Flex plans meet needs of changing workforce

By MICHAEL SCHACHNER

NEW ORLEANS—Flexible employee benefit plans will become more prominent in the 1990s as companies are challenged to meet the needs of an increasingly diverse workforce, says a benefits consultant.

As more disadvantaged women and minorities join an already aging U.S. workforce, employers will be required to become more flexible and innovative with their benefit plans, said Perry D. Brandorff, a consultant in the Irving, Texas, office of Hewitt Associates.

"Although we have been saying that benefits must meet the needs of a changing workforce for years, these changes are finally going to come. Employers can no longer deal with the changing workforce with current benefit structures," Mr. Brandorff asserted during a session at the 29th annual Risk & Insurance Management Society conference in New Orleans.

Mr. Brandorff said that overall, the U.S. labor force is growing at only about 1% annually—the slowest rate in history. However, he added, poorly educated workers, women and minority workers are making up the bulk of the labor force's new entrants.

As a result, employers must now become more creative in order to meet the needs of such a diverse group of new employees, he said.

"Because of these factors, employers have to become more creative. Simply offering a few choices of medical plans and a health care spending account is not enough. Work and family benefits, retiree health care and education and training are more important than ever," Mr. Brandorff said.

The best way for employers to accommodate workers with diverse needs is to set up a flexible benefit plan, he said. "Employees like choice, and flex plans permit employers to control costs better with greater employee acceptance," he said.

"Also, as competitive pressures continue to rise, employers that do not embrace flexible benefits will fall behind their counterparts."

A typical flex plan in the 1990s will consist primarily of several core benefits, including various levels of health care as well as dental and vision care, Mr. Brandorff said. In addition, most plans will offer employees a choice of dependent and health care spending accounts, vacation benefits, retirement income, long-term care and education and lifestyle benefits, among other choices, he said.

"Because of the changing workforce and skill level needs, education benefits will become more important, while convenience benefits designed to help an employee manage work and family responsibilities will also become vital," Mr. Brandorff said. "Employers have to help employees find more than 24 hours in one day."

He added that long-term care is quickly becoming "one of the hottest topics of the 1990s" and will be explored as a flex plan option by more and more companies in the near future.

Mr. Brandorff also said including wellness benefits as an option is important to workers and employers because they help employees avoid injuries and illnesses.

"Wellness plans lead to the early detection of those time bomb illnesses like cancer, heart disease and stroke. These sicknesses are the most devastating for the employee and the most expensive for the employer," he said.

Future flexible benefit programs will also offer "convenience" benefits like prepaid legal and financial planning services, personal errand services and group automobile and homeowners insurance, Mr. Brandorff predicted. However, such convenience benefits are "in the embryonic stage and will likely never become big ticket items," he added.

While flexible benefit programs provide workers with a menu of choices, they also permit employers to save on benefit costs.

"When employees choose their benefits, they become very aware of what they are getting and they tend to become better benefit consumers," said Mr. Brandorff, adding that most firms with flex plans have seen their rate of health care cost inflation decline.

Employers that do not adopt flex plans 'will fall behind their counterparts,' says Mr. Brandorff.

"Flex plans reduce the pressure to add new employer-paid benefits while at the same time they shift a greater share of costs to employees," he said.

"Flex plans seem to give employers the best bang for the buck," Mr. Brandorff said. "To manage costs you really have to get the three major players involved. You need to get the providers, the users and the payers participating. Flex appears to do what no other plan does; it draws in the employee."

Monsanto Co. last year launched a flexible benefits plan for more than 15,000 of its non-union and salaried employees in three of its corporate divisions (*BI*, Nov. 27, 1989) and has since expanded the program to include all of its 41,000 employees.

"The program has been very successful and has left us better positioned for future flexibility, both from the employee and company perspective," said Robert Lahr, manager-employee benefits with the St. Louis-based chemical manufacturer.

Mr. Lahr, who spoke at the session, said a "one-size-fits-all" approach to employee benefits is no longer practical. "Flexible benefits is the best way to impact costs and still meet employee needs."

He pointed out that a recent survey completed by Monsanto's flex plan enrollees showed that 85% prefer the flexible benefits program to the company's prior comprehensive benefits plan.

"People have various needs and are willing to pay more to maintain good programs," said Mr. Lahr.

Charles Stark, a regional vp in the St. Louis office of Metropolitan Life Insurance Co., also spoke at the session.

Warren Perkins, benefits manager with Boh Corp., a New Orleans-based construction company, moderated the session.

Mr. Brandorff coordinated the session. ■

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RIMS exhibitors take festive tone to attract clients

By JOANNE WOJCIK

NEW ORLEANS—Fun and games—along with serious business—reigned in the Exhibit Hall at the 29th annual Risk & Insurance Management Society conference as risk managers tried their hand at baseball trivia, miniature golf and even a video version of their 9-to-5 jobs.

Many of the souvenirs distributed by risk management vendors in the Exhibit Hall were sports-related, and risk managers filled their RIMS tote bags with fanny packs, baseball caps, golf tees and miniature footballs.

But even though the atmosphere was festive, many risk managers who visited the Exhibit Hall actually got down to business.

For example, several risk managers who stopped by Allendale Mutual Insurance Co.'s booth asked whether the Johnston, R.I.-based insurer underwrites global property insurance programs.

And those who visited the Frank B. Hall & Co. Inc. exhibit inquired about the company's brokerage and consulting services.

"We got some very good leads this year," said Mary E. Kenney, communications coordinator for Hall in the broker's Briarcliff Manor, N.Y., office. "The people who did stop were genuinely interested."

However, the Exhibit Hall did offer a significant number of diversions and gimmicks.

For example, in addition to distributing information on the company's brokerage services, Ms. Kenney and other Frank B. Hall employees made plastic keys as thin as a credit card that could be stored in a wallet in case of an emergency. Hall also handed out pocket-sized scissors, pins and medical kits.

Two thousand "Bermuda Bags" were handed out by Tuesday at the booth touting Bermuda as a captive domicile, as were an equal number of Bermuda flag lapel pins, said Robin Spencer-Arscott, chairman and chief executive officer of Rollins Burdick Hunter (Bermuda) Ltd.

Some 40 people from all facets of Bermuda's captive industry staffed the booth, which was designed to resemble the front porch of a Bermuda cottage with changing island scenes projected through the white-paned widows.

Not surprisingly, most of the risk managers who stopped at the booth

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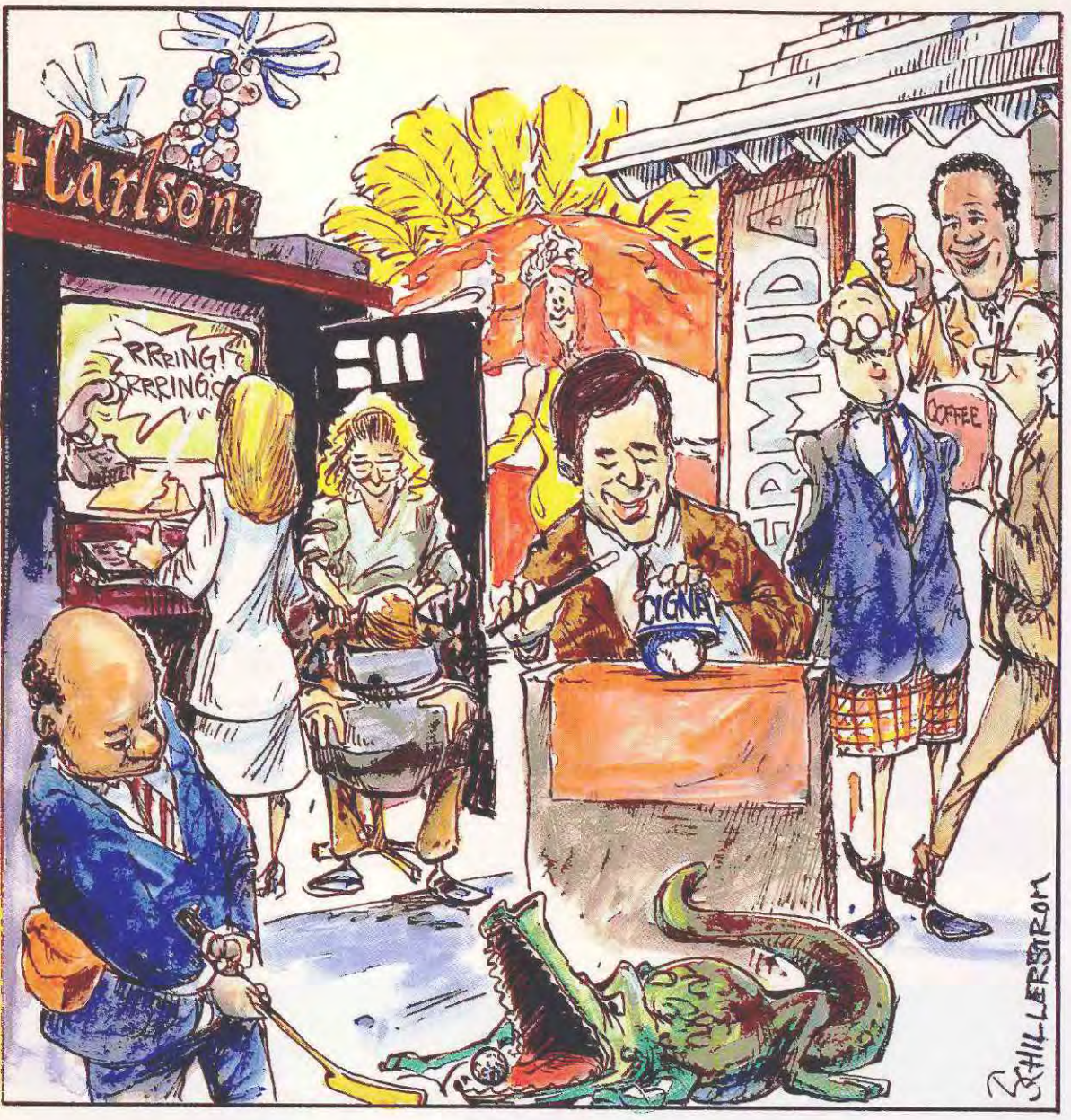


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Exhibits

Continued from previous page

were unaware that Bermuda is the largest offshore insurance center, he said.

"Maybe the rain helped us," remarked Florine Caron, assistant vp for Allendale, as she gave away souvenir coffee mugs filled with peppermint candy to passersby.

The weather that welcomed RIMS-goers to New Orleans included stifling heat, humidity and thunderstorms.

Nearby, Protection Mutual Insurance Co. of Park Ridge, Ill., gave away some 3,500 pounds of chicory-flavored coffee supplied by one of its longtime policyholders, American Coffee Co. of New Orleans.

"We ran out half an hour ago" after sending for reinforcements several times, said Don A. Moos, vp and regional manager in the insurer's Westlake, Ohio, office, shortly before the Exhibit Hall closed on Thursday.

One very popular exhibit—which only handed out a red-and-gray embroidered fabric badge in the shape of a blimp with a banner that boasted, "I played. . . 'the game,' "—attracted risk managers eager to test their skills at a video version of their daily jobs.

Developed by Becher & Carlson Risk Management Inc.'s systems department, the five-minute computer game simulates a series of risk management situations the player must resolve to protect the fictitious "Cajun Crawdad Co." from disastrous losses.

The animated game begins with the player being welcomed to the company by Cajun Crawdad President Phineas Cashfleaux, who explains that the company needs to reduce its overhead, including insurance costs, during recessionary times.

Although the object of the game is to achieve the lowest cost of risk through savvy risk management decision making, many risk managers attempted to see how fast they could bankrupt the company.

And others bemoaned the fact that their spouses, who had no background in either insurance or risk management, scored better than they did.

Like all games of chance, many of the situations the players faced were randomly selected by the computer, explained Sharon P. Heard, business development marketing manager for the Woodland Hills, Calif.-based brokerage and consultant.

"That's the way life—and risk management—is," she said. No matter how well risk managers prepared for possible adverse outcomes, some still found themselves without coverage when "Rock Solid Property & Casualty Co." ended up in receivership.

Becher & Carlson developed the game to be both educational and fun, Ms. Heard said.

While she could not estimate how many of those who cruised the Exhibit Hall tried their hand at the game, the blimp-shaped decals attached to conference badges seemed to be as ubiquitous as the bulging sacks of goodies that RIMS attendees carried from the convention center.

While some booths promised recreation, others provided relaxation.

There usually was a line for the three-minute neck massage provided by Shand Morahan & Co. Inc. to demonstrate the Evanston, Ill.-based underwriting manager's "creative touch in underwriting."

Two certified massage therapists from the Louisiana chapter of the American Massage Therapy Assn. were busy kneading tension out of

Continued on next page

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Continued from previous page
the shoulders of visitors and fellow exhibitors alike.

After the massage, visitors to the booth were handed telephone directories that mapped out the company's numerous insurance, reinsurance, legal, accounting and actuarial departments.

CIGNA Corp. entertained risk managers with a magic show performed by Bob Greenberg of Stamford, Conn., who always managed to slip into his act a word or two from his sponsor.

For example, while shuffling a deck of plastic-coated baseball cards used in a card trick, Mr. Greenberg pointed out one relief pitcher's record.

"This pitcher must be a Cy Young Award winner because he has so many saves," he said. "In fact, he must pitch for CIGNA. Do you know why? Because last year CIGNA saved one client $32 million."

In keeping with the baseball theme of the booth, CIGNA also sponsored a computerized baseball trivia game that pitted risk managers against brokers, insurers, benefits managers and "others."

In order to score, those playing the game responded to a series of baseball trivia questions with varying degrees of difficulty. For example, the questions were harder for players seeking to score a home run than for those who only wanted a single.

Another game that captured risk managers' attention was a putting green—complete with "hazards" like a plastic alligator—set up by General Rehabilitation Services Inc.

The point of the game was to attract the attention of risk managers interested in cost-effective medical and rehabilitation services for workers injured on the job, explained Peter Madeja, vp of the Berwyn, Pa.-based firm.

After playing a round, risk managers were given a cap and a brochure and invited to General Rehabilitation's hospitality suite, dubbed "the 19th hole," where two more putting greens were set up, according to Pat Wright, marketing coordinator.

The golf motif was picked up again by General Care Review Co., a General Rehabilitation workers comp cost containment affiliate based in Morristown, N.J., that distributed visors and golf tees from a booth nearby.

The Exhibit Hall's sports theme was also demonstrated by HCM Claim Management Corp.'s invitation to enjoy a glass of fresh-squeezed "OJ" with football star O.J. Simpson, the Hall of Fame running back who was nicknamed "the Juice" during his tenure with the Buffalo Bills and other teams.

"Have juice with The Juice!" invited HCM, a subsidiary of the Hertz Corp., which also served up information on the Park Ridge, N.J.-based third-party administrator's claims handling ideas.

In addition to a Wednesday morning exhibit hall appearance, Mr. Simpson also served as the guest of honor at a Tuesday night riverboat ride aboard the Creole Queen.

And M.F. Bank Cos., a salvage and restoration firm based in Minneapolis, also followed the football motif by handing out 1,500 miniature blue-and-white plastic footballs.

"Occupational athletes" attending RIMS were invited by Ergodyne Corp. of St. Paul, Minn., to try out a plastic-coated foam-rubber wrist rest designed to reduce keyboard strain that can lead to carpal tunnel syndrome.

Exhibitors dressed in trusses over gray sweatsuits offered risk managers spongy souvenir Pro Flex "grippers" to help them strengthen their hand muscles.

They also offered information on Ergodyne's numerous other tools for implementing workplace injury prevention programs.

Risk managers interested in other ways to prevent repetitive motion disorders and other work-related injuries could receive a fitness evaluation from Loredan Biomedical Inc. of Davis, Calif.

Jill Cleek, territory manager, demonstrated and invited others to use the LIDO Lift, a machine that simulates lifting and other work-related activities.

Peanuts and popcorn—but, unfortunately, no Cracker Jack—greeted risk managers who peeked into the exhibit hall movie theater built by The Hartford Steam Boiler Inspection & Insurance Co. of Hartford, Conn.

The presentation began with a showing of black-and-white clips from old movies complemented with humorous insurance- and risk management-related captions and ragtime player-piano music. It was followed by a 12-minute video that highlighted Hartford Steam Boiler's various insurance and loss control products.

In one of the clips, a caption commenting, "Now there's a business interruption gap" appeared below a tightrope walker balanced between two mountain ranges.

Risk managers leaving the exhibit hall couldn't help but notice the Mardi Gras queen waving from a booth staffed with representatives from White Plains, N.Y.-based Adjustco Inc., which was touting its claims management services. ■

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Workers comp woes

24-hour coverage gains support as way to stem litigation

By COLLEEN JOHNSON

NEW ORLEANS—The pros and cons of "24-hour coverage" and the problem of substance abuse in the workplace are among the concerns of workers compensation authorities.

Twenty-four hour coverage would allow for coordination of workers comp and group health insurance claims and eliminate the legal distinctions between the two, said Richard A. Victor, executive director of the Workers Compensation Research Institute in Cambridge, Mass. Mr. Victor was among the participants in a workers comp roundtable discussion at the 29th annual Risk & Insurance Management Society conference in New Orleans.

"This has kind of sprung up like mushrooms in the past 12 months," Mr. Victor said of the 24-hour coverage concept (*BI,* March 18).

Supporters of 24-hour coverage note that employers could save money in legal fees now spent in disputes over whether a claim is work-related and thus covered by the workers compensation system, Mr. Victor said.

Escalating medical costs for injured workers is another factor in the consideration of 24-hour coverage, Mr. Victor said. Growth in workers comp-related medical costs is about 50% higher than growth in non-workers comp-related medical costs, he noted.

Mr. Victor said after the session that those figures are from a Workers Compensation Research Institute publication that indicated medical costs within workers compensation increased 14.7% between 1980 and 1985, while non-workers comp medical costs rose 9.8%.

However, the 24-hour coverage concept has its share of flaws, session participants noted. For example, some members of the audience noted that if workers compensation benefits are not separated from health benefits, then workers injured on the job would have no incentive to return to work.

While several states are studying the 24-hour coverage concept, Florida in 1990 adopted a law permitting employers to offer the coverage, speakers said. The Florida law set up separate systems for medical and income benefits, Mr. Victor noted.

Another issue tackled by the roundtable participants was the impact of employee substance abuse on workers comp claims.

In only four states—Louisiana, Florida, Utah and Missouri—can an employer deny a workers compensation claim if substance abuse was involved in the incident, observed Susan L. Drake, assistant vp of workers compensation at Continental Insurance Co., a Continental Corp. unit in Cranbury, N.J.

And, drug use by employees appears to be increasing, she said.

The 1990 National Household Survey by the National Institute on Drug Abuse estimated that 76% of illegal drug users are employed either full- or part-time, Ms. Drake said. The 1988 version of the survey found only 70% of illegal drug users were employed, she said.

The 1988 survey also estimated that one in every five workers aged 18 to 25 and one in every eight workers aged 26 to 34 uses drugs on the job, Ms. Drake said.

An employer concerned about challenges to a drug testing program can adopt an eye-hand coordination test to be performed by employees before beginning work each day, Ms. Drake said.

The roundtable participants also debated whether the workers compensation system should be federalized.

"The workers compensation system is in worse shape than ever," said W. Michael McDonald, group director-corporate risk management at Ryder System Inc. in Miami and coordinator and moderator of the roundtable discussion. "It might be time to consider something that might add some consistency and stability to the system."

Various options include a complete federal takeover of the workers comp system, a federal workers compensation law that would be administered by states or minimum federal standards for workers compensation, Mr. McDonald said.

But, Ms. Drake said, "I don't see it happening at all."

"I also think federalization is very unlikely," agreed Frederick O. Kist, principal in casualty actuarial risk management consulting at Coopers & Lybrand in Atlanta.

If the system were federalized, it probably would be done at the highest benefit levels currently offered by individual states, Mr. Kist said. And, some employers would lobby against federalization, he said.

Mr. McDonald, seeing he wasn't getting much support from the roundtable participants, said: "I don't really believe it's going to be federalized, but I do think we could see some type of minimum standards."

Other workers comp issues discussed included:

- AIDS. Employees working with persons suffering from acquired immune deficiency syndrome might become stressed and be unable to work, Ms. Drake said.
- The increased number of employees working from their homes. This could create a workers comp problem for employers because they will have no control over the safety of the work environment, and it will be difficult to determine if an employee's injury at home was truly work-related, Ms. Drake said.
- Sick building syndrome. An estimated 10% of office buildings constructed in the past 15 years are sources of sick building syndrome, Ms. Drake said. The syndrome usually hits about 20% of workers in an affected location, although sometimes only one employee becomes ill, she said.
- Fraud. "I would submit it's almost impossible to prove someone was not injured on the job," said Mark T. Carter, director-corporate risk management at The LTV Corp. in Dallas.

Possible ways of avoiding workers comp fraud include pre-employment screening of applicants with a history of workers comp claims, elimination of lump-sum settlements for minor cases, and a requirement that recovering employees return to the job with a lighter workload, Mr. Carter said.

Other options, he said, include surveillance of employees who claim they have been hurt and can't work, incentives for employees to turn in co-workers who are lying about their injuries, paying injured workers not to hire attorneys, and paying a worker who has filed a claim to go to an employer-selected doctor.

But some members of the audience said that employers should work on improving relationships with employees and reducing antagonism. ■



Training required to convey work hazards

By MICHAEL SCHACHNER

NEW ORLEANS—The key element of an effective workplace hazard communications program is a thorough training and education course for employees who handle hazardous materials, says a corporate environmental manager.

Occupational illnesses have increased more than 30% in the past three years. Therefore, now more than ever, employers need effective hazard communications programs, said William S. Brewer, director of environmental management at NCR Corp. in Dayton, Ohio.

To ensure that employees understand the hazards of the materials with which they routinely work, risk managers must put together a communications program that clearly identifies and trains personnel in handling hazardous workplace substances, he said.

Federal safety rules require most employers to ensure workers have access to information about and understand workplace hazards, Mr. Brewer pointed out during a session at the 29th annual Risk & Insurance Management Society conference in New Orleans.

Employers that violate Occupational Safety and Health Administration communication standards could face fines and lawsuits, he added.

"Almost everyone in business today needs a hazard communications program. What employees don't know can and will hurt you," said Mr. Brewer. An effective communications program, he said,

"What it boils down to is document, document, document!' Mr. Houston says.

needs six elements:

- The identification of hazardous substances. A hazardous substance, he said, is defined as any chemical for which there is clinical evidence that acute health defects may occur if someone is exposed to it.

Anything that is flammable, explosive, corrosive, irritating, toxic or carcinogenic is considered hazardous under OSHA standards, Mr. Brewer said. Tobacco, food and drug products are exempt.

"It is important to note that the primary responsibility for evaluating the hazards of any substance has been placed upon the substance manufacturer or importer and not the downstream user. However, once you have accepted the substance into your place of business, it is your responsibility to ensure that, if it's hazardous, your employees are informed of the fact," he explained.

- Developing and maintaining an inventory of all hazardous chemicals in the workplace.

"While this not only makes sense, it's required," said Mr. Brewer. "But you'd be surprised how often this standard is overlooked," he added.

- Obtaining and maintaining material safety data sheets on all hazardous substances.

This is how manufacturers warn users of a product's hazards. The MSDS will typically provide information about hazardous ingredients, fire and explosion data, reactivity data and health hazard data, among other things.

- Properly labeling and marking containers used to hold or transport hazardous substances.

"The only exception here is a portable container into which hazardous chemicals may be transferred from labeled containers when the chemical is going to be used immediately by the employee performing the transfer," Mr. Brewer said. Stationary containers, he added, can be equipped with a simple sign or placard instead of formal labeling if the hazard is clearly conveyed.

- Training employees on the hazards of chemicals that they work with and teaching workers how to take the appropriate steps to protect themselves from exposure.

"This is by far the key element in a successful program. Any employee who may be exposed to hazardous substances during routine work must be trained at the time of initial assignment and at any time a new hazard is introduced into the workplace," said Mr. Brewer.

- Developing a written program that outlines all of the above steps.

"Not having a written hazard communications program is the most frequent OSHA violation. It's not that companies ignore this completely, but they tend to try to slide by and you just can't do that," said Daniel W. Houston, a vp with Marsh & McLennan Inc. in Atlanta.

Mr. Houston explained that the OSHA hazard communications rule requires each employer to develop a written hazard communications program that must be available at all times to regulatory authorities, employees and their representatives, like unions and professional associations.

A written program should consist of a list of all hazardous workplace substances, MSDSs, container labeling and hazard warnings, employee training records and procedures for non-routine tasks, Mr. Houston said.

"What it boils down to is document, document, document!" he exclaimed.

When listing hazardous substances, the employer must complete an inventory for each work area, according to Mr. Houston. The listing should also include an explanation of how substance mixtures were evaluated, as well as an explanation of how material safety data sheets are used.

Employers should also keep records explaining how material safety data sheets were obtained if not from the supplier, the means for having MSDSs available to employees during work and when requested, and the methods for maintaining and updating these files.

Mr. Houston urged employers to document their in-plant hazard labeling systems and describe how hazard warning information will be conveyed for material stored in stationary containers.

And, a company's employee training program should be documented so that it explains the program's objectives, methods and sessions.

Mr. Houston coordinated the session. It was moderated by Louis Frost, insurance and loss control specialist with Louisiana Power & Light Co. in New Orleans. ■



States seek middle ground on fronting

By MICHAEL BRADFORD

NEW ORLEANS—Insurance regulators claim they aren't trying to stamp out all fronting arrangements; they're just trying to flush out the bad guys.

There are some problems with fronting arrangements that need to be cleared up, regulators said during a panel discussion at the 29th annual Risk & Insurance Management Society conference.

Fronting is commonly used by corporations that own captive insurers and want or need to buy coverage from a licensed U.S. insurer. The licensed insurer, in turn, reinsures the risk with the corporation's captive.

Fronting is "illegal, immoral and, at least in this city, very fattening," said Jim Long, who, as president of the National Assn. of Insurance Commissioners, is known for prefacing his serious remarks with not-so-serious musings.

Research has identified fronting as the original sin, he gibed: The devil appeared as a serpent before Eve in the Garden of Eden and confronted her with a fronting proposal.

On a more serious note, he acknowledged that fronting has its legitimate uses. But regulators are "trying to weed out the thieves in the business and not severely impact the legitimate operations," said Mr. Long, who is also North Carolina's insurance commissioner.

He told risk managers that the NAIC "is not trying to totally eliminate your use of fronting," but is trying to protect policyholders from unscrupulous operators.

A proposed model law would prohibit many fronting arrangements, exempting some programs reinsured to captives owned by large companies (*BI*, April 8).

Robin K. Campaniano, the Hawaii commissioner, traces the controversy to insurers' reactions to NAIC concerns over fronting.

He explained that last year "the (NAIC) committee in charge of the fronting issue raised the question with the members of the industry: 'We think there are small problems with abuses out there. Can you help us and tell us what they are and how to address them?' "

The industry's response, Mr. Campaniano recalled, was to "stonewall. . .by indicating there was no problem. Everything was hunky dory."

That reaction, he added, "was an open invitation, quite candidly, for the people involved in that committee to institute the most onerous form of regulation possible in an attempt to flesh out some of the issues."

Not only did NAIC proposals generate "ire and venom," but they also sparked "some of the good discussions that we thought necessary," said Mr. Campaniano.

"As a result, we are probably back to square one and a half. That is, (both sides) have agreed to look at it the way it should have been looked at from the very beginning."

Mr. Campaniano said the NAIC is concerned with determining "whether or not we can set reasonable standards to address the fraud, the corruption, the abuse and to leave alone the honest fronting activities that go on."

North Carolina's Mr. Long also mentioned NAIC concerns about fraud in connection with other insurance arrangements.

Citing some "very serious abuses" of risk retention groups and purchasing groups, he said, "there is a group of very ingenious people playing in the fringes of the insurance business.

"If you give them one tiny little crack in the regulatory scheme, they'll drive a Brinks armored truck through there with your money it."

Regarding troubled Executive Life Insurance Co. of California, which was placed into conservatorship by California regulators (*BI*, April 22), panelists said no NAIC model law or state regulation was in place that could have prevented the problems with the insurer's junk bond holdings.

"The NAIC will come up, I would hope, within the next six months with standards of what is an appropriate limitation on junk bond holdings," said Bruce Smith, deputy commissioner of insurance in Colorado.

Junk bonds were once "all the rage," he pointed out. "Neither you nor I nor any of these so-called investment advisers would have said at that time that this is a bad deal. It's still not a bad idea if they don't default."

But companies trying to liquidate and sell them "are dead in the water," he said.

The NAIC is continuing to sharpen its focus on solvency and insurance fraud, Mr. Long pointed out.

"The NAIC in the past year and a half or so has more intensely focused on solvency and accomplished more than in the past 20 years combined," he declared.

Recently, Mr. Long noted, the NAIC promulgated a model bill dealing with insurance fraud because there is no federal legislation that addresses that type of crime.

"You can get federal time for stealing from banks, savings and loans and a lot of financial institutions, but not from insurance companies," he noted.

The model legislation, which has reached a Senate committee, would make it a federal offense to file false statements with insurance regulators, falsify insurance company records, obstruct the proceedings of the department of insurance and steal an insurance company's money, Mr. Long explained.

Convictions would carry fines up to $1 million and/or 30 years in prison. Those convicted would no longer be able to participate in the insurance business.

"Our basic premise on this is: You commit insurance fraud, you go to jail," said Mr. Long.

On another topic, Mr. Long said the NAIC last year achieved a "real leap forward" in improving financial regulation. Reinsurance oversight has been bolstered and the group has improved its ability to analyze solvency and is developing risk-based capital requirements.

Mr. Long said the NAIC continues to work on solvency-related efforts that include improved computer audit techniques.

Rejecting claims of a solvency crisis, Mr. Long said there were far fewer failures among insurers than among other financial institutions. Since 1986, 184 insurers have failed, compared with more than 1,000 commercial banks and around 880 savings and loans, he said.

Still, Mr. Long acknowledged, while they haven't reached the magnitude of other financial institutions, insurer insolvencies are a "very severe problem" to policyholders, claimants, insurance company employees and others.

The session was moderated by Samuel Y. Fisher Jr., insurance manager at Hamilton Brothers Oil Co. in Denver. It was coordinated by Freida L. Jackson, president of risk management consultant ARM Group Inc. in Charlotte, N.C. ■

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The Lockwood Companies

Beware of hidden merger liabilities

Fully investigate target company's past

By MICHAEL BRADFORD

NEW ORLEANS—Risk managcan prevent the cost of mergers and acquisitions from growing by uncovering hidden liabilities before closing a deal, according to a panel of experts.

Uncovering all liabilities before a sale protects buyers, sellers, bankers and lenders involved in the transaction, Harold F. Huff, vp at Johnson & Higgins Ltd. in Toronto, said during a discussion at the 29th annual Risk & Insurance Management Society conference.

Uncovering those liabilities requires risk managers to become involved early on, according to Mr. Huff.

The most important step before acquisition papers are signed is investigating and analyzing the selling company's insurance programs, loss history and other risk-related areas, he said. "It is very important to trace the firm's corporate history back to its beginning, using as many sources of information available in identifying its risk and exposure to loss."

Mr. Huff cited a J&H client that acquired a company a few years ago with the understanding that only assets, and not liabilities, were being bought.

"Consequently, when a claim was presented from the old firm's operation, our client refused to pay. A court ruled that under the principle of successor liability, the acquirer was liable for injuries arising out of the products" the acquired company had produced.

"To make matters worse," Mr. Huff said, "the products in question were aircraft parts, which the acquiring company did not realize had been manufactured by the target company some years before. While our client had adequate liability insurance, it did not have liability insurance for aircraft products, because there had been no apparent exposure."

An asset-only sale should clearly define which party is liable for claims that arise after the sale but are related to products or environmental exposures prior to the acquisition, said William Gillett, a senior associate with the New York law firm Shearman & Sterling.

Arrangements can be worked out before an acquisition that call for the seller to indemnify the acquiring company for claims that arise after the purchase, said Mr. Gillett. Or, the possibility of such claims can be considered when setting a purchase price, he added.

However, Mr. Gillett added, such agreements should be accompanied by a condition in the acquisition terms that will allow the acquirer access to all of the seller's insurance records and require the seller to provide assistance in settling any claims that may arise.

An evaluation of a selling firm's coverage must include a "thorough review of policy terms, conditions and exclusions," J&H's Mr. Huff said. And, he warned, "watch out for inadequate liability limits for prior years or substantial underfunded exposures contained in earlier self-insured retention programs."

Financial obligations of the company being acquired also hold the potential for hidden liabilities, said Mr. Huff. "Risk management programs for many firms often carry sizable financial obligations through use of deductibles or self-insured retentions."

He advised risk managers to quantify any additional premiums the company might owe. "Under two recent acquisitions, we found up to $2 million in hidden liabilities" through premium audits, he said.

Mr. Huff stressed that risk managers must "review all operations conducted in the target firm's business," and gather data on raw materials used, waste generation processes, physical plant operations and equipment, and types of products manufactured and their end use.

Gathering such information "will allow you to develop a roster of the significant exposures which could result from prior activities" of the company being acquired, Mr. Huff said. Some "notable exposures" include asbestosis, catastrophic risks from fires or explosions and environmental liabilities, he pointed out.

Mr. Gillett added that product liability exposures also pose particular challenges for acquiring companies.

Those exposures, he said, "have become some of the major considerations in determining the attractiveness, if not the wisdom, of the acquisition of a manufacturing company."

And it's not always clear-cut as to what types of companies face potential environmental and product liability exposures, Mr. Gillett pointed out.

He noted that "any company with considerable real property among its assets and certain service companies, including certain financial services companies, may face environmental liabilities."

And, Mr. Gillett said the area of expanding and changing product liability laws makes it nearly impossible to tell who faces that exposure.

For example, he referred to a

Continued on next page



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Spotlight report

Bringing them all into the loop

Input of many departments needed to ensure success of managed care

By CHRISTINE WOOLSEY

NEW ORLEANS—A successful managed care program must be built on strong communications with employees and all department heads, benefit consultants say.

When considering whether to implement a managed care program, employee benefit managers should be sure to involve other departments, said Herbert Leinberger, principal of benefit consultant Godwins Inc. in Coral Gables, Fla.

"Internal consulting" should occur whenever an employer considers drastically changing its benefit plans, Mr. Leinberger advised during a session at the 29th annual Risk & Insurance Management Society conference.

The human resources, risk management, administration and finance departments should all be brought into the loop, he said.

"You will find some surprises when you involve these other departments. You need to know what the hidden agendas of some of those departments are because they can make the managed care plan blow up or succeed," Mr. Leinberger said.

Different perspectives will often emerge. For example, the finance department may stress the importance of controlling costs, while the benefits department might stress the importance of offering employees a choice between a managed care plan and a higher-cost indemnity plan.

Mr. Leinberger also pointed out employee benefits managers often initially encounter resistance to a managed care plan at the management and non-management levels.

"People resist change, so when you want a whole corporation to move to managed care you've got to create some momentum," he said. "Don't say it's going to take two years to roll out this program" or people will tune you out.

Instead, benefit managers should seek input from other departments and make them feel like they are contributing to the success of the plan.

Creating a team spirit can help speed up the process, he added.

For example, benefit managers can ask the payroll department to compile demographic data on employees and their dependents, he said.

It is important to study employee demographics—like age, sex and location—and investigate what types of networks exist and where they are located, he said.

"One of the biggest stumbling blocks we have is going into a human resource department and asking for demographic data," Mr. Leinberger noted. At many small companies, the human resource and payroll departments have different information, he said.

After an employer commits to implementing a managed care plan, employee benefit managers must assess the cost and size of their current plans, he said. "Talk to finance people and establish baseline costs so that whatever you do you can compare" cost data from previous years, Mr. Leinberger suggested.

Benefit managers also should "find out from your company whether you are required to reduce health care costs or maintain them.

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Merger liabilities

Continued from previous page

case in which a tire manufacturer was held responsible for damages in a lawsuit brought by a motorist injured by an exploding tire rim, even though the tire manufacturer had no connection with the company that actually produced the rim.

In a separate case earlier this year, a New York court refused to dismiss two tire rim manufacturers from a $25 million product liability suit, even though neither firm manufactured the rim that exploded and killed the plaintiff's husband (*BI*, April 1).

There are also hidden liabilities connected with employee benefits and directors and officers liabilities, other speakers at the session pointed out.

Some lawyers have made a 'profit center' out of suing officers and directors, says Ralph Jones III.

Brian McDermott, a principal with benefit consultant A. Foster Higgins & Co. Inc. in New York, noted that an acquiring company also needs to carefully consider pension and medical benefits for retirees.

New financial accounting rules require companies starting in 1993 to fund post-retirement benefits for workers before the employees leave their jobs, he said (*BI*, May 6).

While the new rules create a "major, major balance sheet liability," not all companies have that liability, he added.

While retiree benefits are a major concern for acquiring companies, pension plans generally are not, according to Mr. McDermott. Most companies' pension plans are fully funded because of large investment income gains in the 1980s, he explained.

Ralph Jones III, managing director of Chubb & Son Inc. in New York, urged caution in examining the directors and officers liability coverage of companies being acquired.

There are plaintiffs' attorneys who have created a "profit center" of bringing cases against directors and officers with charges like breach of fiduciary duty, wrongful termination and antitrust violations, he noted.

The session was moderated by Maurice J. Smith, director of risk management and corporate real estate for CCL Industries in Willowdale, Ontario.

Mr. Huff coordinated the session. ■

After Answering 679 Our Fee Came To



Continued from previous page
Everyone wants to control them, but if you have a specific order to reduce them, that will affect" the type of managed care plan put in place, Mr. Leinberger explained.

However, even after those steps, "managed care will only work if you get your employees to buy into what you offer," he said. Attitude surveys and focus groups can help discover employee needs, he said.

One typical employee concern is discontinuing an existing relationship with their physician, Mr. Leinberger noted.

"Many times when a managed care plan is put together, the communicator isn't given much time" to explain the changes and the rules to employees, pointed out D. Mark Schumann, a principal with William M. Mercer Inc. in Dallas.

While most employees will have some trouble accepting the change, "there has been a dramatic shift in employee attitudes about managed care" since it first came on the scene in the early 1980s, Mr. Schumann pointed out. Employees are much more receptive to the idea today than they were 10 years ago, he said.

"Managed care is received with the most favorable reaction when an employee moves from town to town and doesn't want to have to find another physician on his own," he explained.

Communication, he said, remains a key factor in the success of any managed care plan.

"Many times, what a communicator provides in a process like this is oversimplified because if we do our jobs correctly we make it look very simple," Mr. Schumann said.

Successful communication efforts share some basic features.

"You should think about communication in terms of face-to-face meetings, not just booklets and videos, because that is key to success," Mr. Schumann said.

One common misperception among workers is that it is not their money or the employer's money they are spending when they seek medical treatment, Mr. Schumann says. 'They think, "It's the insurance company's money. It doesn't affect me." '

"Explaining the benefits inside and outside the network is the easy part. The tough part is explaining the reasons why this is a step the organization has to take," he pointed out.

A recent effort Mr. Schumann described included 42 focus group meetings to help assess employee attitudes about managed care and health care in general.

One common misperception among those workers was that it is not their money or the employer's money they are spending when they seek medical treatment, Mr. Schumann explained.

"They think, 'It's the insurance company's money. It doesn't affect me.' But, you'll find the light bulb goes on quicker if we show them that their use of health care does affect them," he said.

One way to make managed care more palatable is to explain that if health care spending is not controlled, less money will be available for other benefits and salaries.

Another option is to tie benefit costs to an organization's success. For example, he said, a company that owes its success to providing high-quality, low-cost products or services might suffer if it continues to pay top dollar for health care.

Mr. Schumann noted that employees in the focus groups also equated high costs with high-quality care. "They think, 'If I go to the high-end clinic or physician, I'll receive higher quality care and I'm entitled to that,' " Mr. Schumann said.

Quality, however, is not how employees ultimately judge medical services. They are far more likely to reflect upon it in terms of the provider's demeanor, he noted.

For example, instead of measuring the status of his health after getting medical care, the employee will focus on whether the physicians and nurses were pleasant or rude, Mr. Schumann said.

In addition, "employees tell us that any effort to manage health care is an intrusion on their entitlement to get the health care they need," he said.

And employees are "immune to the traditional explanations" about why establishing a managed health care plan is necessary, Mr. Schumann said. "They don't believe statements that health care costs are skyrocketing out of control and we have to do something."

Part of the reason this message isn't getting through is because "we haven't tried to teach people 'Benefits 101.' We haven't told them why costs are going up, what costs are going up and what trends we are concerned with," Mr. Schumann said.

"If you have 10 minutes to communicate to employees about managed care and you spend nine of them on why this is needed in your business, they'll be more likely to accept the change," he said.

Mr. Schumann also warned benefit managers that "when communicating changes in benefits, it's not the time to pour out the glitz and make things flashy and dashy." Rather, communication efforts should just explain the facts, he said.

Among the critical components a communication program should contain are details about how much the company spends in relation to similar companies and what medical services cost the company the most money, he said.

In addition, all communications efforts should include a real commitment to employees that they will be involved in setting up the managed care plan. Employers should make clear that they will listen to employees and will consider their concerns in designing the new plan, he said.

It is also important to predict how employees will react after they hear the details, he added. Employers cannot assume that employees will, for example, obtain care through a newly established preferred provider network after viewing a video on the company's managed care program.

"Research shows that the first perceptions and statements lock in. You need to know enough about your audience to know how they'll react after the communication," he said. "Then think of every reason under the sun why they won't react the way you want. Figure out what the barriers are."

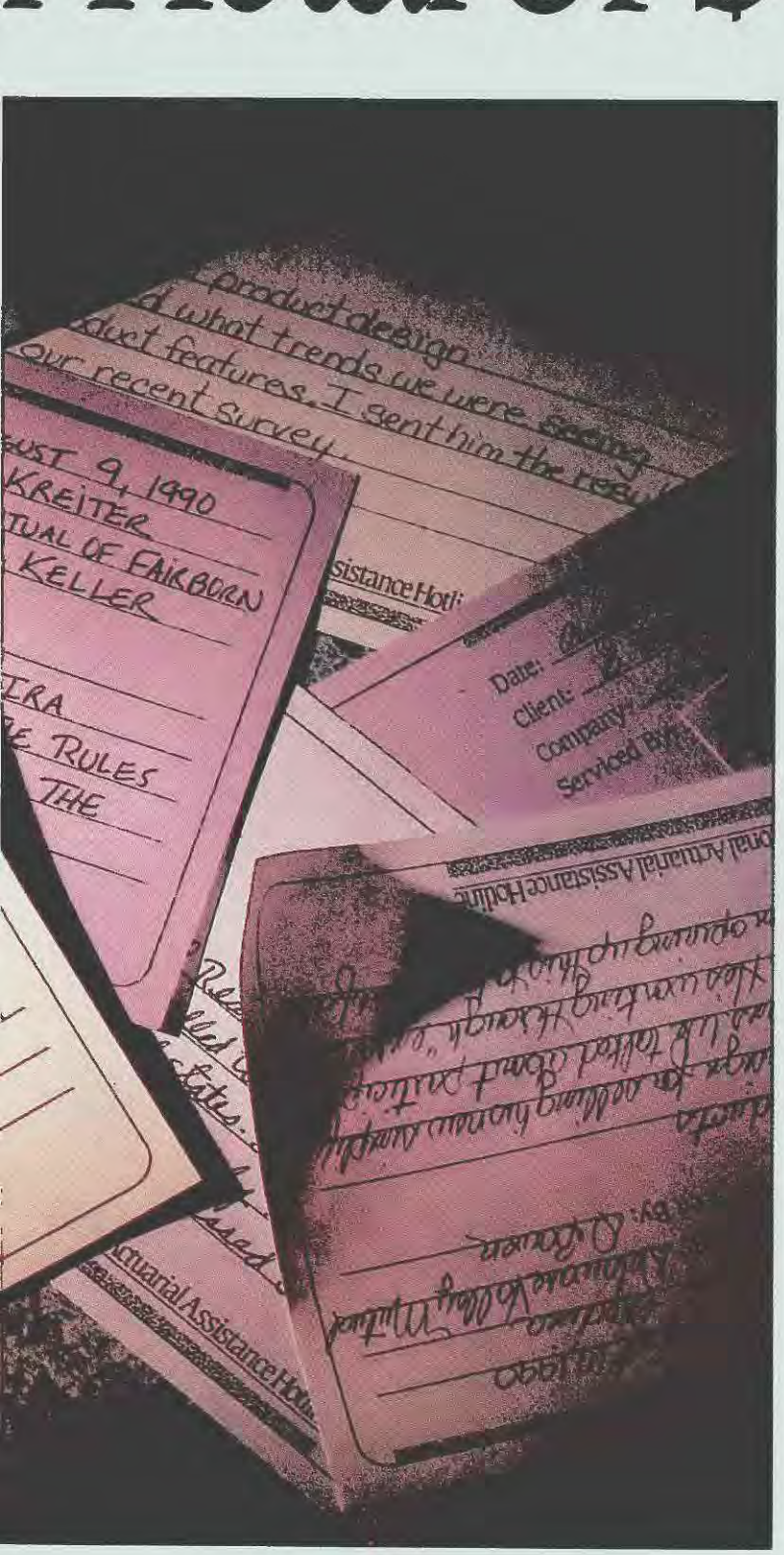
Top management involvement also is critical, Mr. Schumann said. Both the chief executive and the benefits director of a company should take part, he said.

"There is nothing that can duplicate the face-to-face interaction" between management and employees, he said.

Patricia A. Hemingway, vp of Aetna Health Plans in Dallas, also spoke during the session.

Anne B. Chervony, vp of risk management for BankAtlantic in Fort Lauderdale, Fla., also spoke as well as moderated and coordinated the session. ■

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Global programs for property cover can reduce costs for multinationals

By GAVIN SOUTER

NEW ORLEANS—Purchasing property insurance on a global basis—rather than buying coverage individually in each country—can substantially reduce premium costs for major multinational corporations, leading risk managers say.

Global property programs can cut premiums more than 30%, and the coverage obtained is invariably broader, they say.

And, they contend that the extra work needed to set up the program is worth it, since a single program is invariably better than the product of individual efforts by local and subsidiary managers.

Global programs, though, are strictly for big companies; others should stick to their local arrangements, a broker added.

"It is not for every organization. You must have operations in the U.S. plus two or more in foreign territories" for a global program to pay off, said David Peck, senior vp at Johnson & Higgins of Connecticut Inc. in Hartford.

Companies considering a global property insurance program also should have assets exceeding $100 million, Mr. Peck said during a seminar at the annual Risk & Insurance Management Society conference in New Orleans.

For companies that are large enough, a global program offers a wealth of advantages, including the opportunity to standardize loss prevention philosophy throughout all operations, he said.

Market clout is another advantage. "This is not just a buzz word; it really works. You are dealing with a lot of premium and this makes a difference in your overall ability to negotiate the program," said Mr. Peck.

A global program should combine insurers and take advantage of their individual strengths, Mr. Peck advised. And it should be planned to achieve set risk management goals, he added.

The principal insurer should have the financial strength and stability to be able to accept a global spread of risk and to balance a program's more and less profitable operations, said Peter Flint, global manager for Zurich-American Insurance Group in Schaumburg, Ill.

That insurer should be able to provide strong local service in each covered country, he added.

"Customer orientation will be high on the list of your carriers' strategic objectives. They will have a reputation for product innovation and program structure flexibility," Mr. Flint asserted.

Few insurers, however, have all the criteria required to be a major global property insurer, he said.

Once a suitable insurer is found and the global program is in place, it "can create overall cost efficiencies, improvements in coverage and can aid the implementation of a corporate risk management and risk financing strategy," Mr. Flint said.

Boston-based Gillette Co. took advantage of the soft market of 1988 to establish its global property insurance program, said William Mather, Gillette's director of risk management.

The goals of that program were:

- To obtain sufficient long-term underwriting capacity for the company's largest property exposures.
- To obtain the broadest policies.
- To eliminate any gaps and overlaps in property coverage.
- To obtain top-level loss control services.
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Continued from previous page

ker and Allendale Mutual Insurance Co. as the primary insurer, he said.

Astonishing is how Mr. Mather describes the savings. "We have achieved a significant reduction in our annual costs, which we estimate at about 30% or $1 million. This reduction, incidentally, was roughly twice the amount we had anticipated in our forecasts," he said.

Yet, despite the savings, the global program is providing Gillette with broader coverage, he explained.

For example, technological developments have meant that Gillette must purchase machine breakdown coverage, which was included in the global program without affecting the cost savings, Mr. Mather said.

"Overall, the reaction to this significant change in our program has been positive. The benefits of the new program outweigh the negatives, which included uprooting long-established relationships with both brokers and underwriters," he concluded.

When Blacker & Decker Corp. in Towson, Md., decided to set up its global property program, it asked two brokers to bid for the business, said Clayton Roop, director of corporate risk management.

"We furnished both brokers with details on locations, values, loss history, engineering reports, and we set up all the site visits they requested," Mr. Roop said.

Throughout the process, Black & Decker maintained an active involvement with the brokers and kept the competition clean and fair by making sure that both received the same information, he said.

The winning broker—which Mr. Roop would not name—establsihed a program led by Zurich Insurance Co. and with units of Kemper National Insurance Cos. insuring the top layers of the program.

The results, he said, have been delightful. "We had a single master worldwide policy; significant premium reductions, which I was amazed by when I saw them; broader terms and conditions; consistent loss control practices through Kemper; and we obtained ease of administration."

Management of foreign property risks has made a significant contribution to the success of Detroit-based General Motors Corp., said Bill Wiebrecht, manager-property risks.

One of the world's largest corporations, GM has assets of $180 billion, operations in 40 countries and property worth more than $124 billion, he said.

Its global property program was established in the late 1970s, Mr. Wiebrecht explained. "An all-risk property insurance policy was negotiated with (Industrial Risk Insurers), which has always been GM's principal primary property insurer, to replace five separate policies."

The global program only excluded boiler and machinery risks "beyond broad-form explosion and ocean marine risks," said Mr. Wiebrecht.

However, since IRI is not a licensed insurer overseas, GM used a fronting international insurer with affiliates or subsidiaries in each of the 40 countries in which local policies were required, he said.

"Generally, the fronting insurer retained a small portion of the risk and ceded the remainder to the IRI. These local policies mirrored the master policy where legally possible except for limits, deductibles and premiums," he added.

Again, the benefits of the program include: one master policy with global coverage, the elimination of coverage gaps and the establishment of local administration that coordinates with GM's needs Mr. Wiebrecht said.

The program has evolved throughout the 1980s, he said. In 1982, GM. subsidiary General International Ltd. began reinsuring the foreign primary fronting insurers and, in turn, ceded this business to IRI.

In 1988, GM consolidated the brokers servicing the program into one brokerage. And in 1989, the foreign primary insurer was changed.

According to Mr. Wiebrecht, the global program works because it embodies three basic concepts: stability, flexibility and teamwork. "The structure of an insurance program and the cost benefits derived is nurtured from a stable environment built around people working together effectively over a long period of time," contended Mr. Wiebrecht.

The session was moderated by Mr. Mather and coordinated by Mr. Peck. ■

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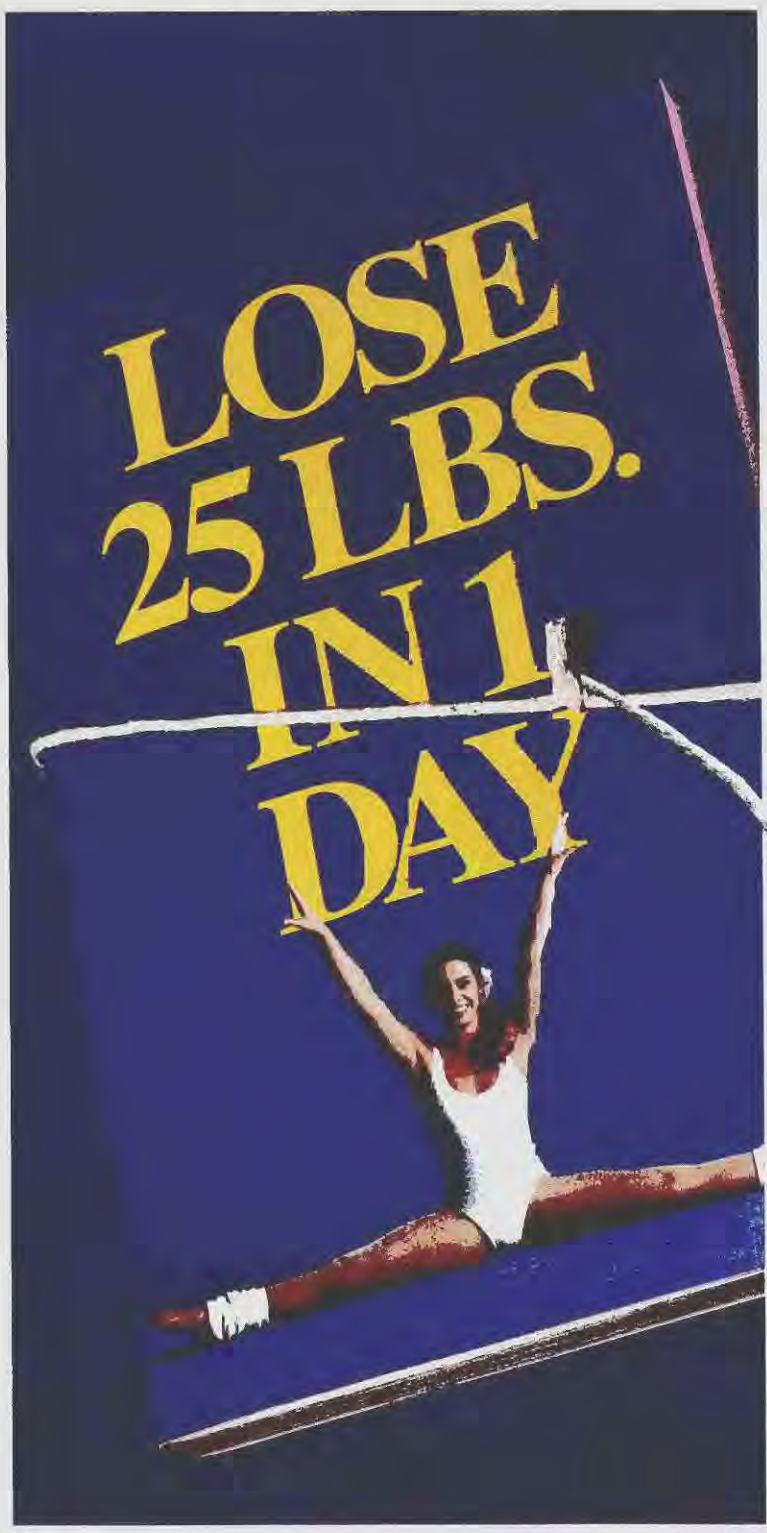
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ADR techniques are proper in many types of litigation

By COLLEEN JOHNSON

NEW ORLEANS—Before beginning a potentially costly trial against a third party or an insurer, risk managers should recommend that their management consider alternative dispute resolution, experts suggest.

The expense of taking a suit to trial can increase the total cost of litigation to five times greater than the amount of settling the case, said Robert L. Manning Jr., risk manager at Somers, N.Y.-based Pepsi-Cola Co., a unit of PepsiCo Inc., during a session at the 29th annual Risk & Insurance Management Society conference.

Alternative dispute resolution techniques are flexible and can be adapted to fit specific situations, said Scott P. Moser, a partner with Day, Berry & Howard in Hartford, Conn.

Alternative dispute resolution techniques include mediation, arbitration and summary jury trials —in which a mock jury gives an advisory verdict after hearing summaries of both sides' cases.

"ADR is literally whatever you want," he said.

For example, if either party to a lawsuit is concerned that a settlement reached through an ADR process like mediation could be excessively high or low, maximum and minimum settlement amounts can be set in advance so that the final finding is somewhere between those two benchmarks, Mr. Moser explained.

Another advantage of ADR is that the parties can bring in a third "neutral" party, like an arbitrator or mediator, whom both sides respect, rather than risking a judgment from an unfamiliar judge or jury, Mr. Moser said.

"The question is, 'Can we get someone we can listen to if they say something we don't want to hear?' " he asked.

ADR also can be used for resolving disputes among defendants in a single case, or even convincing a defeated trial opponent not to appeal, Mr. Moser said.

After winning a case at trial, Mr. Moser's firm once hired a neutral party to talk to jurors about why they reached their verdict to persuade the other side not to appeal, he said.

ADR can be used in cases of all sizes, Mr. Moser noted.

Companies interested in trying ADR should not be deterred even if their attorneys do not seem interested, Mr. Moser said. "If you all want ADR, your lawyers will do it. If they won't, get other ones."

But, an insurer involved in coverage dispute litigation may be reluctant to go through ADR to reach a settlement, noted Harold Levy, assistant general counsel at Hartford Group Inc. of Hartford, Conn. Insurers generally try to be consistent in their positions on the meaning of language in their policies, and an ADR finding could conflict with their stance, he said.

However, insurers generally are willing to try ADR techniques when handling their policyholders' defense because of the potential savings in legal fees and processing costs, Mr. Levy said.

And, some insurers will offer discounts to policyholders that use ADR techniques, he said.

There are some cases in which ADR is not appropriate, according to a handout provided by Mr. Moser. These include:

- When a party has a vested interest in delaying the litigation, seeking publicity or vengeance or causing high expenses for the other party.
- When a party wants to establish a judicial precedent.
- When a judicial resolution is "politically necessary," like in a case in which a public utility does not want regulators to question the wisdom of a settlement.
- When it is less expensive to litigate, like when a defendant believes it has a legal defense that will quickly end the case.
- When "the enmity of the parties cannot be overcome."
- When the parties need discovery from third parties who may not participate in the ADR process.
- When the case involves a public interest issue in which a compromise is unacceptable.

Parties looking for a neutral party can find one through lawyers' referrals, the court system or possibly a state mediation agency, said Eric Green, senior vp at Endispute Inc., an ADR firm in Cambridge, Mass.

"It's not much more difficult than finding the name of a good doctor or lawyer," Mr. Green observed.

Also speaking at the session was Jon E. Kent, executive director of ADR Resources Inc. in Bridgeport, Conn. Mr. Manning moderated the session, and Mr. Moser coordinated the session. ■

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'Clean' industries still need strong pollution policy

By JUDY GREENWALD

NEW ORLEANS—Even a so-called "clean" company with no obvious pollution problems can have potentially serious environmental liabilities that should be addressed in a company policy, says an official for a telecommunications company.

James R. Jowett, manager of corporate environmental, health and safety programs for MCI Telecommunications Corp. in Washington, D.C., discussed his corporation's environmental policy at a session during the 29th annual Risk & Insurance Management Society conference in New Orleans.

Mr. Jowett said MCI approaches its environmental policy with the attitude that if there is anything it can do to reduce its potential liability, "we're going to do it."

Mr. Jowett said he frequently hears that telecommunications is a "clean industry" with little pollution exposure. Relative to other industries, this is true, he said, but even a telecommunications firm has potential environmental liabilities.

There are a number of areas in the company's operations that are environmentally sensitive, said Mr. Jowett. For instance, MCI buys a lot of property and purchases other companies fairly frequently, he said. "There's liability associated with that," he noted, adding that it is easy to buy into other people's environmental problems.

MCI conducts an environmental assessment before all mergers and real estate transactions, even though New Jersey is the only state that requires it, Mr. Jowett said.

In addition, for every 25 to 30 miles of cable, MCI has a facility with lead acid batteries that must be properly disposed of after their useful life is over, he said.

Possible leakage from MCI's underground storage tanks is a potential problem as well, said Mr. Jowett, noting that the Environmental Protection Agency estimates that at any given time 40% of all underground tanks are leaking.

In addition, MCI has some phone cables that are made of lead and copper, which are environmentally sensitive, he noted.

Other of MCI's environmental concerns include the disposal of halon used in its fire extinguishing system, which can affect both employee health and the ozone layer, he said.

Asbestos is also a potential problem, according to Mr. Jowett. "I'm sure there's not a business in the books that's not dealing with asbestos exposure," he said. Because MCI frequently buys and renovates buildings, it must be concerned about this issue, Mr. Jowett explained. Some of its structures could become a liability if they are not appropriately managed, he said.

As a starting point in developing a corporate environmental program, MCI conducted an environmental analysis of its entire operations and presented it to senior management to "sensitize" them to this issue, said Mr. Jowett.

Factors discussed in the report included a discussion of federal, state and local environmental laws; the cost of compliance with those laws; the potential exposures faced by MCI; and the potential financial liability of the company and of its directors and officers in the event of environmental impairment.

MCI next set up a committee to develop and oversee its environmental program. MCI made certain that the right segments of the company were represented on the committee and that the right people served on it, according to Mr. Jowett.

Areas of the company represented on the committee, he said, included: risk management; environmental health and safety;

Continued on page 50



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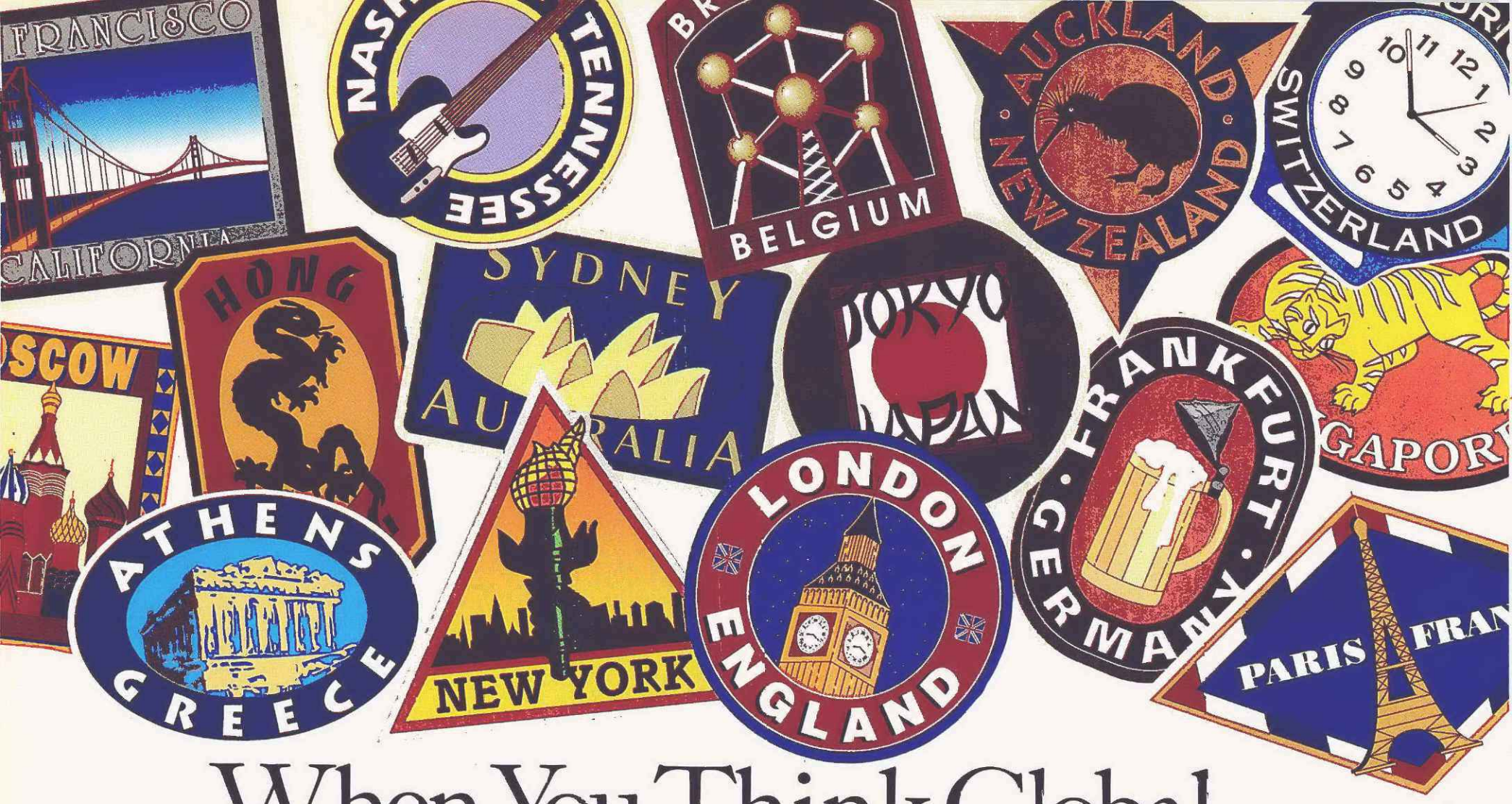
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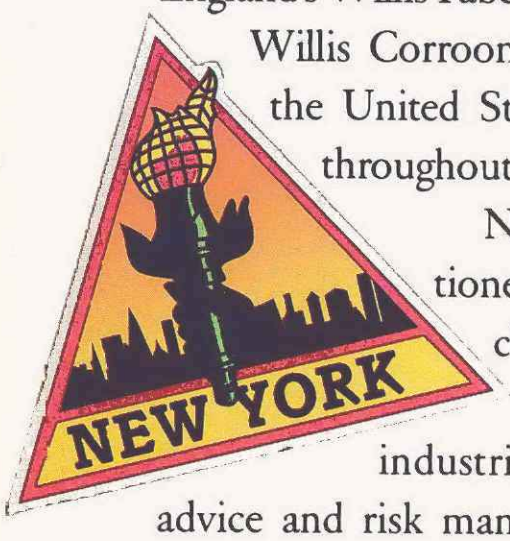
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A There has been a lot of discussion today regarding health care costs. We hear a lot of statistics on a global basis; however, on an individual company basis, many employee benefit managers lack the information they need in the area of health care data.

Our challenge today is obtaining organized data. We could, in many cases, go to our insurers or third-party administrators (like you did), and they can provide us with reports. However, the major shortcoming in this area is the lack of truly organized data.

We benefit managers are faced with large health care expenditures that are increasing at a significant rate. As they continue to increase, the problem will be compounded by the new FASB accounting standard, which will result in substantial liabilities on the balance sheet and even further increases in medical accounting expenses. As a result, we are going to see increased pressure and accountability placed on benefit professionals. We need to determine where and how our health care dollars are being spent. However, as you may know, this isn't so easy.

Data analysis can become very complex, and you can quickly become overwhelmed. The best approach is to start with very basic and simple analysis. Once you have completed the initial analysis, a more detailed analysis will logically flow.

The basis of data analysis consists of essentially two elements, the first of which is price. Some obvious examples of price are hospital charges, physician charges and cost of prescription drugs. The second element is utilization or quantity of services rendered. Some examples of utilization include the average length of a hospital stay, the number of hospital admissions per 1,000 covered lives and the number of hospital days per 1,000 lives. Therefore, your guide or formula for health care data analysis is simply:

Price × Utilization = Cost.

You might find that the prices charged by hospitals and physicians are good, but your overall costs are high. The opposite situation may also be true (i.e. high price, low utilization).

Your task is to organize your data so that it can be analyzed. This generally means breaking the data down into smaller elements. For example, let's take a look at hospital costs. Some elements include: hospital costs per day; hospital costs per admission; medical/surgical costs; mental health/substance abuse costs; and maternity costs. It's also important to identify the most commonly used hospitals.

Physician costs also need to be determined. These elements include inpatient surgical, outpatient surgical and outpatient office visits.

Utilization analysis tells us the quantity or frequency of services rendered. The basic utilization statistics are those mentioned above—average length of hospital stay, the number of hospital admissions per 1,000 covered lives and the number of hospital days per 1,000 lives. The next step is to calculate the above items by diagnostic category.

If we are fortunate enough to obtain the data, what do we do with it once we have it? For example, if you find that your inpatient cost per employee is $1,500 or your inpatient cost per day is $1,200, we need to ask if this is competitive. Data needs to be compared with norms. First, look at norms on as small a geographic basis as possible. For example, if your employees live and receive their health care in Chicago, the most meaningful norm will be Chicago-specific. There is usually a substantial cost and utilization variance from one geographic area to another.

Another breakdown within norms of data is the type of employees that you have. Generally, there are different utilization levels between salaried and hourly individuals.

Two very important adjustments that can be made to your health care data is to adjust for age/sex and to adjust for the case mix. For example, with the age/sex adjustment, you may want to look at your admission rate and adjust that for age/sex mix. If your group is young, your admission rate, and possibly your payment per capita by diagnostic category, should be lower than normal. The second adjustment is a case mix to reflect the severity of cases. Two examples of adjusting for the case mix would be to look at your average length of stay or your cost per case. Case mix adjusting is useful, because your average length of stay may be longer than others, but the reason for the longer stay is that you may have more serious cases than others.

Probably the best way to discuss data analysis is through example. At Continental Bank, we determined fairly early on that our insurer was not the answer to meet our data needs. Like many others, our insurer would sent us reams of reports, but they were cumbersome to work with and generally incomplete. We finally found a data management organization that would meet our specific needs.

It's not difficult to set up such a data analysis system. First, the insurer must provide a data tape quarterly to the data management organization, which then cleans up the data and formats it. Then, the benefit manager can access the data on-line. This type of system can issue standard reports that offer in-depth analysis once you develop your skills in this area.

One thing we learned from this process is that you have to be committed to data management. The first commitment that you have to make is financial. If your organization is not accustomed to spending many dollars on data management as it relates to the health plan, the expenditure will be substantial. However, when you view this as a percentage of health care expenditures, the cost is generally nominal. As a basis of comparison, determine how much your organization is spending on your human resource system. You will probably find that a health care data system is significantly less expensive.

The other commitment you need to make is to staff time. Data analysis involves staff training as well as time spent working with the system in order to be able to perform proper analysis.

Some of the activities we are able to do are fairly easy, and you may not even need a data system to do some of them. However, you may have to dig through the stacks of reports your insurer gave you.

We found our utilization to be very good, but we were being charged a very high rate for the services rendered to our employees. For example, our inpatient per-employee cost was 25% below the norm, but our charge per day was approximately 33% above the norm. Our response to this was to implement a preferred provider organization last year. Now we use the data analysis system to monitor our PPO price effectiveness and also to monitor utilization.

Another fairly easy analysis is to list your payments by major diagnostic categories. We found pregnancy to be the most common diagnosis for our employees and the area where we spent the most money. We decided to start a maternity education program and to step up communicating the need for our utilization review program, encouraging early contact to ensure that the hospitalization required for the actual delivery was kept at an appropriate level.

Catastrophic cases also represent great potential for cost savings. Defining catastrophic cases as those costing $30,000 or more, we found we had 22 such cases during that year. Catastrophic cases accounted for only 3.7% of inpatient cases, but they amounted to 26% of the inpatient payments. It is a good practice to review the criteria that your large case manager—if you have one—uses for reviewing a case and how quickly the large case manager gets involved.

Another analysis we did was simply to identify the 10 hospitals most utilized by our employees. We found that those hospitals represented 39% of the cases and about 38% of hospital payments. Knowing your top hospitals is useful in the selection of a PPO. When we went through the review process seeking a new insurer, we matched up our top 10 hospitals to ensure that these hospitals were in the PPO that we selected. If you are already part of a PPO, you can recommend that hospitals from your top 10 list be added to the PPO.

One area that benefit professionals do not discuss very often is the need to obtain data from health maintenance organizations. If you have tried to obtain data from HMOs, you have probably heard the same responses I have:

- "Our system isn't operational yet."
- "Our system can only generate a few basic reports."
- "If you want data, we can work with our programmers, but it will be very expensive."
- You have too few employees in our HMO; therefore, we aren't able to provide you with data."

You may be asking yourself why you should bother trying to obtain data from HMOs. If your organization is like most companies, on average, the rates charged by the HMOs are probably not much different than the cost of your medical plan. But if you take a closer look at the employees in the HMO and the indemnity plan, you will probably find that the employees in the HMO are younger than those in your indemnity plan. This means that the experience in the HMOs should be better—much better, actually, because it's a fully managed environment. We've been allowing HMOs to shadow price the medical plan for years and have not pushed them to provide data in order to substantiate their rates.

We are currently working with an employee benefit information system company, MEDSTAT Systems Inc., to obtain meaningful data from HMOs. We now can analyze that data on-line as we can with our medical claims.

We risk managers need to obtain meaningful information in order to do our jobs better. If we are going to make substantial changes to our employee benefit programs, we must find where we are spending our health care dollars, and we must have the means to measure the effectiveness of any changes we make. ■

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Mr. Nirtaut

This month's column on employee benefit management issues is written by Dennis J. Nirtaut, manager of employee benefits at Continental Bank Corp. in Chicago. Susan M. Werner, director of risk management at Hardee's Food Systems Inc. in Rocky Mount, N.C., answers questions on risk management issues. William J. Miner, an actuary with The Wyatt Co. in Chicago, answers actuarial questions on benefits issues. And, Richard E. Sherman, a principal with Coopers & Lybrand in San Francisco, answers actuarial questions in the casualty field.

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

Mr. Nirtaut's next column will appear in July.

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Environment

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legal counsel; network implementation, which is involved with the design, construction and monitoring of MCI's phone network; the international group, which would address problems in the 50 other countries in which MCI has operations; human resources; procurement; regional operations, with a representative from each MCI region; real estate; and sales and marketing.

The next step was development of an environmental and safety procedures manual, Mr. Jowett said. Among topics covered in the manual, he said, were: emergency response procedures; handling/disposal of lead acid batteries; underground and above-ground storage tanks; halon fire protection systems; asbestos; PCB management; and hazardous chemicals and their disposal.

The safety manual doesn't 'just sit on the shelf,' Mr. Jowett says of MCI's staff training program.

MCI then introduced training procedures so that the manual would "not just sit on the shelf," said Mr. Jowett. It trained its employees, using both the manual and material produced by MCI's internal TV and video production department.

As part of its environmental program, MCI conducts environmental assessments whenever it decides to acquire any property.

The company has a three-step program that includes looking at existing information, obtaining new information and making plans for corrective action, Mr. Jowett said.

For instance, when MCI considered acquiring a 70-acre site in Colorado Springs, Colo., it first conducted a thorough environmental assessment inside a building on the property, including looking at all electrical equipment and making sure polychlorinated biphenyls were not present. Outside, it tested the soil and water for any contamination.

If there had been any problem it would have been reflected in negotiations, Mr. Jowett said. So far, however, the environmental assessment process has not killed any deals, he said.

MCI also conducts an environmental assessment whenever it sells property, Mr. Jowett said. This process takes a "good snapshot" of the property, so that if environmental pollution subsequently becomes an issue, the company can say there was no problem when it was sold, he explained.

Other programs in the works at MCI, Mr. Jowett said, include an underground storage tank upgrade program and facility audits.

Also speaking at the session was Anthony M. Diecidue, chief of the compliance section of the Environmental Protection Agency, who oversees enforcement of the Comprehensive Environmental Response Compensation & Liability —or Superfund—Act's enforcement in three regions.

Among the challenges facing the EPA in the '90s is to improve the timeliness of its enforcement activities, Mr. Diecidue said. Part of the problem, he said, is that sometimes dozens of firms are involved in the cleanup of a single site, and they must all be dealt with.

Another challenge facing the agency is negotiating early settlements with companies that were only involved in pollution to a small degree, Mr. Diecidue said.

There is some risk of releasing these firms from liability in case it is later learned that they were more heavily involved in the pollution of a site, he said. But, the EPA wants to be fair, he added. "I think it makes good political sense, as well," said Mr. Diecidue.

Meanwhile, David J. Dybdahl, managing director-environmental risk management services at Willis Corroon P.L.C. in Nashville, Tenn., predicted several trends in insuring environmental liabilities, including:

- More packaging of coverages.
- Simplification of administration.
- Higher liability limits.

Mr. Dybdahl also offered some advice on obtaining EIL insurance:

- Plan for the hard market by using good insurers.
- Avoid "bargains" in insurance.
- Develop a relationship with your insurer.
- Find a broker "that understands your business."

The session was moderated by Mark F. Johnson, director of environmental risk management for PRC Environmental Management Inc. of McLean, Va.

The session's coordinator was Kenneth E. Anderson, risk management and insurance analyst for PRC. ■



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Spotlight report

Certificates of insurance offer few promises

By MARK A. HOFMANN

NEW ORLEANS—A certificate of insurance issued by a subcontractor can't always be taken at face value.

Wise risk managers look into the financial stability of both the party issuing the certificate and of all insurers listed on the certificate before accepting it, they add.

In a contract between two companies, one company may require the other to produce a certificate of insurance to indicate it will assume the financial consequences of any losses. The certificate is not a contract itself, but merely indicates which policies and coverages are in place at the time it's issued.

"An insurance contract is really, in my opinion, a credit contract. A certificate of insurance is really representative of that particular contract," said Gary J. Bausom, senior vp with Alexander & Alexander of California Inc. in San Francisco, at a panel discussion during the 29th annual Risk & Insurance Management Society conference in New Orleans.

A certificate of insurance "is one method by which a party ensures it is financially able of assuming a risk that's been transferred under a contract," explained Stephanie G. Sparks, senior vp with Sedgwick James of California Inc. in San Francisco.

"Certificates of confusion" might be a better name for the documents, quipped Chris Anderson, insurance and risk manager for the Worldwide Church of God in Pasadena, Calif. However, he added, whenever there is confusion, there is a potential for abuse.

Mr. Anderson said that Mr. Bausom "probably spoke to the most critical issue" in bringing up the question of creditworthiness of the parties involved in certificates of insurance.

"It's great to have a representation that there's coverage in place," Mr. Bausom said of the certificates. But, collecting that insurance might be a different story, he said.

He advised the audience to not only check insurer rating services —like A.M. Best Co. in Oldwick, N.J., Standard & Poor's Corp. in New York and Moody's Investors Service Inc. in New York—but to have their own internal credit departments assess the creditworthiness of any vendors or contractors presenting certificates of insurance.

In some cases, certificates may be unnecessary, according to Mr. Bausom. He cited the case of a client that handled more than 120,000 certificates of insurance a year. Closer examination showed that in some cases the contractor presenting the certificate was more financially sound than the insurer listed.

Thomas Seligman, president of Seligman Information Systems in Roslyn Heights, N.Y., noted that perhaps 10 million certificates of insurance are issued each year. If, for example, a risk manager receives 250 a year, each listing four policies, and each policy with a separate expiration date that needs to be verified, it could require numerous phone calls to verify the information in each certificate, Mr. Seligman said.

"It's a paperwork nightmare," said Mr. Seligman, whose firm provides automated certificate tracking software.

And he said that using an automated system helps keeping track of the quality of certificates easier. Every time you have thousands of certificates, "there's a chance some insurer listed on the certificate is going to run into financial problems," he said. By having all of the information a keystroke or two away, a risk manager can quickly inform senior management of potential problems so that they don't blossom into full-fledged liabilities, he added.

The Worldwide Church of God's Mr. Anderson listed several potential problems with certificates of insurance that can leave the company accepting a certificate with unexpected liabilities. He stressed that certificates "are intended to provide mostly general information," like the name of the insurers, the policy numbers, policy limits and deductibles.

But it's up to the risk manager holding the certificate to make sure the information is accurate, Mr. Anderson said. For example, in addition to determining whether the insurer named on the certificate can actually deliver in the event of a loss, there's a question as to whether the policy limits listed are accurate and current.

The risk manager needs to determine whether those limits are nearly exhausted and, if so, by how much, Mr. Anderson said.

There's also no guarantee that the holder of the certificate will be notified by insurers if there are significant changes in the policies, Mr. Anderson pointed out. In fact, the holder of a certificate may not even be notified if the policy is canceled, he said.

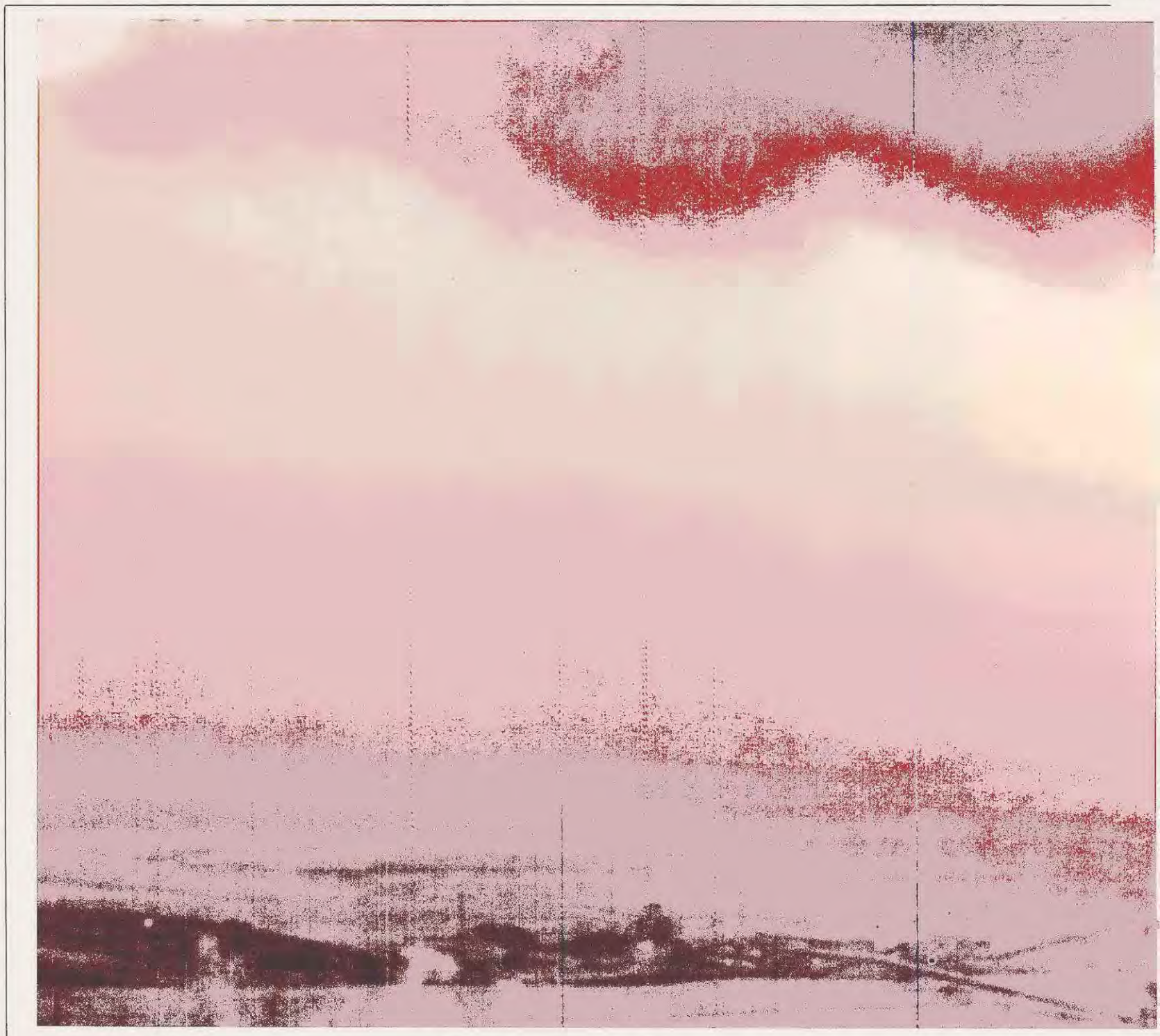
The certificate of insurance only tells the holder what's in force at the time the certificate was issued, not what will be in force the next day, said Sedgwick James' Ms. Sparks.

In an interview after the session, Ms. Sparks stressed the need to monitor the financial soundness of both the issuer of a certificate of insurance and the insurers listed on the certificate. She warned risk managers against simply consulting rating services. Instead, the risk manager needs to "do some legwork" and keep abreast of market conditions through informal networks with other risk managers and brokers, Ms. Sparks said.

Richard J. Welch, risk manager for the City of Los Angeles and moderator of the session, noted that responsibility for spelling out accepted and transferred liabilities in a contract cuts both ways. The risk manager receiving a certificate must make sure that it certificate covers all potential liabilities, he said, while the risk manager issuing a certificate should make certain that he is not accepting responsibility for something not required by the contract.

Mr. Welch also addressed the question of how long a certificate should be maintained on file after the contract is fulfilled. Occurrence-based policies should probably be maintained for decades because potential liabilities may arise long after the contract is fulfilled, he said.

The session was coordinated by Valerie Oberpriller, assistant vp-loss stabilization for Industrial Underwriters Inc., a San Francisco-based unit of Crum & Forster Inc. ■



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How to traverse the Superfund minefield

By GAVIN SOUTER

NEW ORLEANS—Pollution liability laws have made buying and selling U.S. real estate a hazardous business.

Two experts warn that detailed audits are needed to avoid being held liable either for someone else's pollution when buying property or for your own years after selling.

Although the audits can be expensive, the severity of U.S. pollution laws makes them worthwhile, said a lawyer and a pollution expert in a session for non-U.S. companies at the Risk & Insurance Management Society conference in New Orleans.

Foremost among the U.S. pollution laws is the Comprehensive Environmental Response, Compensation & Liability—or Superfund—Act.

That 1980 law has two basic components, explained Arthur Howson, partner with Gibbes & Clarkson, a Greenville, S.C., law firm.

First, "a large fund of money (allows the) government to clean up hazardous substances that threaten human health or the environment and then recover costs from potentially responsible parties," Mr. Howson said. Or, the "U.S. Environmental Protection Agency can issue orders requiring parties to clean up the property," he added.

Second is the law's "far-reaching liability scheme." Superfund liability is strict or no-fault, joint and several, retroactive and perpetual, Mr. Howson said.

Those in the firing line when the government goes looking for a deep pocket to pay for cleaning up a site include the current owner or operator, the owner or operator when the land was polluted, the generator of the hazardous waste or the one who transported it, he said.

"These last two are a particular problem if you are getting rid of a leaky underground storage tank, because if you take it out and take it to a scrap dealer, but he then goes and sells it to a guy down the road, you could be liable for cleanup when it leaks again," Mr. Howson said.

In cases like these, he recommended getting a certificate of destruction from the scrap dealer.

Often, though, buyers are held liable for cleanup costs whether or not they polluted a site, he said.

Liability includes:

- All costs of removal or remedial action incurred.
- Damages for injury to, destruction of, or loss of natural resources.
- The cost of any health assessment or health effects study done.

And interest is charged on all of these costs, Mr. Howson said.

Defenses in these cases are limited to claiming that the pollution was caused by an act of God or an act of war, or was the fault of a third party. And even if it is the fault of a third party, Mr. Howson cautioned, a defendant is only excused if the company exercised due care and attention to the hazardous substance or took precautions against foreseeable acts or omissions of the third party.

Precautions include making sure that the land was not already polluted, he added.

"The defendant must have undertaken at the time of acquisition all appropriate inquiry into the previous ownership and uses of the property consistent with good commercial or customary practice in an effort to minimize liability," Mr. Howson said.

Real estate buyers that fail to conduct environmental audits could be heading for a legal and financial nightmare, said John Dwyer, a vp at Kemron Environmental Services Inc. of Washington, D.C.

"There are basically three parties involved in real estate transactions: the buyer, the seller, and the lender. All of them want to cover liabilities," he said. Buyers must do an appropriate study, but the law gives them no concrete rules to follow, Mr. Dwyer said.

"There is no definition of an appropriate inquiry; it has just grown up with use, and at the end of the day, it is left up to the courts to decide," he said. To cover all the angles, Mr. Dwyer advised buyers to call on an expert to do a three-phase environmental audit:

- Phase one is a reconnaissance of the property, looking at its history and then visiting the site to "kick the bricks," he said.

The basic tools are a site map and any aerial photographs, he said.

The second move should be to look at the service drainage, he said. "Then you can see what is coming off the property, what is wrong with it and where it is coming from," Mr. Dwyer said.

Buyers next should look at where rain falls, gathers and runs off property to ensure that no hazardous substances wash onto other property.

After this you should look at air emissions, discharges, underground storage tanks, electrical transformers, ponds and lagoons, how the owners handle materials, how they get rid of hazardous waste and what is being produced by neighboring plants that might leak onto land being audited.

Look out for a careless attitude, he advised. "If you see sacks of hazardous chemicals just lying around open. . .that might just be the tip of the iceberg," Mr. Dwyer said.

- Next comes a more detailed look using soil samples and other more scientific techniques.

This second phase starts with surface sampling. "This is an excellent indication of what has been spilled on the ground and what is coming out of underground storage tanks," Mr. Dwyer said.

One step better is to dig a test pit with a mechanical digger. "Not many people will let you do this because of the damage it causes, but if you can do it, it gives one of the best snapshots of the whole history of the land," he advised.

A more sophisticated technique is to use soil borings down to the groundwater level. "Anything that has ever occurred in the way of spills will show up," he said.

Samples should also be taken from any ponds or lagoons just to find out what is in them, Mr. Dwyer said.

- Phase three is the quantification of the cleanup costs.

Costs can vary hugely. "For example, an agricultural chemical company found out that they had buried bags of pesticides, and when we looked we found over 300 bags and drums of pesticides, and it took $150,000 to get them out," Mr. Dwyer said.

And, at a recycling plant with 50 to 60 solvents spilled on the ground, extracting the chemicals cost more than than $5 million, he said.

The costs for each phase depend largely on the level of pollution. "Phase one can cost between $2,000 and $5,000, and more complex plants can cost over $10,000. Phase two can cost over $20,000, and there is no way you can put a standard number on phase three," Mr. Dwyer said.

The session was moderated by Richard Barry, assistant vp-environmental for CSX Transportation of Jacksonville, Fla., and was coordinated by J. Wesly Sexton, vp-loss control at Hewitt, Coleman & Associates Inc. in Greenville, S.C. ■



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E.C. liability rules may cause U.S.-style legal mess in Europe

By GAVIN SOUTER

NEW ORLEANS—European Community bureaucrats have ignored the lessons of history and have put in place a product liability framework that will mirror the legal nightmare that haunts the United States, a broker says.

When the product liability directive is added to the mountain of red tape churned out by E.C. legislators, companies operating in Europe will face a plethora of potentially disastrous risk management problems, a risk manager added.

However, a new realism concerning pollution risks and an increased interest in risk management techniques could help companies survive the E.C. legal obstacle course, risk managers said.

"In its approach to product liability, the E.C. has made a terrible blunder, and if you can obtain insurance for product liability (risks), you should buy it now," said Dennis Connolly, senior vp at Johnson & Higgins in New York.

The E.C. product liability directive—which implements a system of strict liability throughout the European Community—mimics mistakes made in the United States and is sowing the seeds for a European liability system that will be similar to the U.S. system, Mr. Connolly said during a session at the 29th annual Risk & Insurance Management Society conference in New Orleans.

The E.C. product liability directive "was intended to provide a uniform product liability law throughout Europe," Mr. Connolly said. "But what will happen is that as one country becomes richer and awards higher levels of damages, other countries will demand the same levels of compensation and you will have an escalating problem."

The directive at first sight seems clear enough—plaintiffs must prove damage, defect and causation to successfully sue a manufacturer—but on closer examination huge problems emerge, he contends.

For example, when lawyers determine causation, they will have to deal with a wide variety of gray areas, Mr. Connolly said.

"The problems we will have to wrestle with are not simple. For example, what if a product has a 20% chance of causing cancer? Is it deemed to have caused cancer or not? The directive does not deal with this problem," Mr. Connolly asserted.

The "defect" clause of the directive is equally problematical, he said. There is no definition of a "defect" under the statute. It only refers to the "expectations of the consumer," Mr. Connolly said.

"We rejected that system in the U.S. about 15 years ago. It is truly astounding that the directive could have missed this precedent," he added.

Proof of damage also is too vague under the directive, Mr. Connolly said.

For example, in many cases the products under question are destroyed by fire or explosions and in these cases the courts will have only the plaintiff's word that the product was actually being used, he said.

On a slightly brighter side, the directive does contain two key defenses for product manufacturers, Mr. Connolly said.

The first is a 10-year statute of repose, he said.

Under the second defense, a manufacturer cannot be held liable if a product has been made to government specifications, he said.

The general legal environment in Europe also is a plus for companies operating in the European Community, despite the product liability directive, Mr. Connolly said.

"In Europe, pre-trial discovery is not generally allowed, unlike in the U.S., where it is an accepted part of the legal process," he said.

There also are very few jury trials for product liability suits in Europe, so there is more consis-

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tency in the size of the compensatory awards, Mr. Connolly said.

Another benefit is that there is no contingency fee system, he added.

"European countries have a fee-based system" of compensating attorneys, he said.

However, Mr. Connolly warned that many "are beginning to think that this is not fair on poor people because they cannot afford to go to law. Consequently, the system is not set in stone, and they may move to a contingency fee system. And, this would increase the level of litigation in the E.C."

Other speakers noted the differences in occupational health and safety programs between E.C. nations and the United States.

"Many of the differences are only a matter of degree, but they can have important financial consequences," said William Mottel, director of safety and occupational health at E.I. du Pont de Nemours & Co. Inc. of Wilmington, Del.

Mr. Mottel noted seven major differences between Europe and the United States that affect safety programs. In Europe, there is:

- Greater tolerance of bureaucracy.
- Greater reliance on directives.
- A more conspicuous role for academics.
- A greater faith in elaborate protocols.
- A higher profile for union leaders.
- Greater support from government for private businesses.
- A greater tolerance for intercompany relationships, including cartels.

In the United States, by contrast, companies distrust bureaucracy, there are attempts to curb the avalanche of paper, academics are sought only for counsel or technical expertise, the government is less willing to help U.S. companies in international markets and "antitrust is still a bogeyman," Mr. Mottel said.

"U.S. businesses with operations in Europe must, of course, abide by the rules and protocols of host countries. This has required intense and constant effort to keep abreast not only of the rules in any one country, but also the differences in the rules within the E.C. and the political and social developments that may produce changes down the road," Mr. Mottel asserted.

The European Community is committed to eliminating differences in health and safety standards between member nations by Dec. 31, 1992, he said.

"On the plus side, the prospect is for some decrease in bureaucracies to be dealt with. There is also a hope for a more level playing field for industries within the European market," he said.

However, there is still a year and a half to go before everything is in place, so companies cannot yet predict what standards they will have to measure up to, Mr. Mottel added.

The template for any new directives, though, probably will be the "directive on the major accident hazards of certain industrial activities" released by the E.C. Council in June 1982, Mr. Mottel said.

"The 20 principal articles of this directive were comprehensive, ranging from integrity of industrial processes, safety procedures in operations and training to emergency response to incidents and ongoing disclosures of all potential hazards to all interested parties, including local communities," he added.

This directive resulted in new legislation throughout the European Communities, though not all E.C. member nations have fully developed the emergency plans required by the directive, Mr. Mottel said.

One of the negative aspects of the new uniform E.C. safety laws is the mountain of paper that they will produce, he said.

Also, "in leveling the playing field, regulators may be leveling up rather than leveling down. That is, the most restrictive protocols in each individual country may become the norm for all of them. If this happens, risk managers will find their challenges raised to a new high level of difficulty," he contended.

However, U.S. companies should not be put off from operating in the European Community, Mr. Mottel said.

Instead, they should simply do their homework, he advised.

U.S. companies also have a history of coping with cultural differences in the United States itself to fall back on, he said. "The South, in a good-natured way, still resents the carpetbaggers from the North, and the ranchers in the West continue to be leery of buttoned-down Ivy Leaguers."

To cope with the changes in the European Community, risk managers should make sure that all of the company's staff is properly trained in health and safety and show the surrounding communities how they are dealing with the risks posed by their companies' operations, he suggested.

"Plant communities need to be informed about the nature of local industrial processes and the precautions taken to minimize risks," he advised.

Attitudes toward pollution also are changing in Europe, said Phil Hughes, head of safety services at Courtaulds P.L.C., a conglomerate in Coventry, England.

"We are getting to the point in Europe where we realize that having dirty, filthy industries is pretty dumb," Mr. Hughes said.

Environmental protection is now a concern for most major industrial concerns in the European Community, though the concern has yet to reach the industries of Eastern Europe, he added.

With E.C. companies still in the early stages of environmental protection, some problems still exist, Mr. Hughes said, including:

- Absence of commitment to pollution control from some managers.
- Compliance with only the minimum standards. Some companies only do what they are compelled to do by law instead of taking all means to protect the environment.
- Reactive concern. Instead of stopping pollution problems before they occur, some companies only attempt to manage a problem once it has happened.
- Lack of commitment in establishing risk control systems.

Changes in corporate attitudes toward environmental health and safety issues will be accelerated by E.C. directives, Mr. Hughes said.

"The most important directive for workplace safety and loss control is the Framework Directive, under which there are five individual directives setting minimum requirements for the workplace; use of work equipment; use of personal protective equipment; use of display screen equipment; and manual handling of loads," he said.

Other E.C. directives include the Workplace Directive, which deals with safety standards, and the Machinery Safety Directive, which sets out essential safety standards for machinery, Mr. Hughes said.

Also speaking at the session was Tamar Posner, executive director-product and regulatory affairs at the Chemical Industries Assn. in London, who discussed E.C. proposals for mandating environmental audits.

The session was coordinated by John Kanouse, assistant vp at Johnson & Higgins in New York. ■

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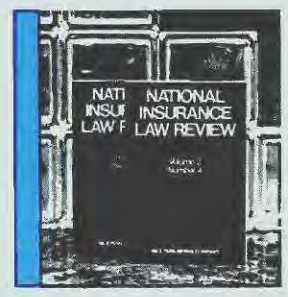


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Spotlight report

Surplus lines insurers long for hard market

By CHRISTINE WOOLSEY

NEW ORLEANS—Risk managers who are considering placing coverage in the surplus lines marketplace should be sure their broker has in-depth knowledge about the types of risks individual surplus lines insurers want to cover, says a leading surplus lines broker.

"One of the most important things for a surplus lines broker is to be knowledgeable about which insurance company wants what," said Robert B. Angle, vp of national marketing for Montgomery & Collins Inc. in East Hartford, Conn. "Insurance companies are like individuals—they all have personalities. If they got burned by a coverage once, they'll avoid it."

As a result, surplus lines brokers that seek coverage through surplus lines insurers must "make sure coverage submissions match up to insurance company appetites," Mr. Angle said during a session at the 29th annual Risk & Insurance Management Society conference in New Orleans.

Surplus lines brokers and insurers' appetites now are ravenous due to the soft market, Mr. Angle said. "When the Aetnas and the Travelers of the world are feasting, we are dying," he said.

"Surplus lines generally accounts for between 5% and 6% of the total insurance market. Today it's about half of that," he said.

The surplus lines market is counter-cyclical to the standard market. During a soft market, when rates are reasonable and coverages abundant in the traditional insurance market, surplus lines insurers and brokers suffer.

'Insurance companies are like individuals—they all have personalities,' says Robert B. Angle, vp of national marketing for Montgomery & Collins Inc. in East Hartford, Conn. 'If they got burned by a coverage once, they'll avoid it.'

"Stock companies get very bullish and expansive during the good times—they start to write coverages they used to shun," like directors and officers liability and errors and omissions, he said.

However, as the market hardens and admitted insurers become more selective about what they will underwrite, buyers turn to the surplus lines market for capacity, according to Mr. Angle.

"Surplus lines offerings are pretty much the same from year to year. But, we aren't taking coverages away from the admitted market. We write what they won't write."

For example, he said, "we do the big-ticket items," like liability coverages for hazardous chemical or airplane parts manufacturers. And, surplus lines insurers often write new types of risks that the admitted market does not want because it cannot look back on previous experience to judge how to write such a risk.

"It is to the buyer's advantage to engage a retail broker into a dialogue about his coverage and whether it can flow through the excess and surplus market," Mr. Angle said. Risk managers should discuss what rates and coverages are available in the surplus lines market and whether they would be an improvement over rates in the standard market, he said.

"Most risk managers get a little squirrelly about placing business with a non-admitted company because they are worried about not having guaranty fund coverage," Mr. Angle pointed out. But, he said, "some stock companies aren't as financially sound as excess and surplus companies."

Risk managers can look to A.M. Best's Co. to verify the financial condition of a surplus lines insurer, pointed out Kathryn I. Scott, vp of marketing for St. Paul Specialty Underwriting Inc. in St. Paul, Minn. Risk managers can also check the information surplus lines companies are required to file with state regulators, she said.

Richard M. Bouhan, executive director of the National Assn. of Professional Surplus Lines Offices Ltd. in Kansas City, Mo., discussed the history behind the surplus lines market and how it operates.

Joseph D. Timmons, president of Midwestern General Agency Inc., a wholesale broker in Kansas City, discussed the managing general agent's role in the surplus lines market. Mr. Timmons also is president of NAPSLO, which co-sponsored the session.

Vicki Gerken, corporate risk manager for Adams Communications Corp. in Wayzata, Minn., moderated the discussion. It was coordinated by Mr. Bouhan. ■

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Ethics painted in shades of gray

Unethical practices hard to avoid, harder to live down

By MARK A. HOFMANN

NEW ORLEANS—Although unethical behavior might appear to give a risk manager or other insurance professional a short-term advantage in some circumstances, good ethics means good business in the long run.

Despite the size of the insurance marketplace, "it can get awfully small when something goes wrong," said John W. Robson, director-corporate risk management and insurance at Anheuser-Busch Cos. Inc. in St. Louis.

Unethical behavior can tarnish a professional's good reputation quickly, he said.

Mr. Robson moderated a session on ethics in insurance and risk management at the 29th annual Risk & Insurance Management Society conference in New Orleans.

Following the spirit of the law is as essential as following the letter of the law, Mr. Robson said. But, too often insurance industry representatives are guided by three principles: market share, earnings per share and "What's my share?" Mr. Robson said.

But, "business as well as government now understands there is no right way to do the wrong thing," he added.

Timothy J. Mahoney, an executive vp with Marsh & McLennan Inc. in New York, said that 91% of the world lies regularly at work and at home, but everyone believes that he or she is a member of the other 9%.

"We all try hard to be ethical," he said.

"What to do, what not to do—that is the question," he said.

Ethics does not, strictly speaking, involve legality, said James S. Kemper III, senior vp-underwriting for Kemper National Insurance Cos. in Long Grove, Ill. Ethics is what society expects, and people expect to be treated fairly, he added. As such, ethics is an evolutionary process, he said.

"I think ethics is crucial to the long-term success of most businesses," Mr. Kemper said. Employees and customers will ultimately leave a business that acts in an unethical manner, he said.

Mr. Kemper said he believes most businesspeople are ethical. Ethics provide a good code for behavior, he said, explaining that ethics encourage consistency and discipline.

However, ethical standards are not always absolute, he said, noting that "ethical standards will differ by individuals."

For example, common business practices overseas may not conform to an American's definition of ethical behavior, he said.

Corporate codes of ethics can serve as guides to acceptable behavior, Mr. Kemper said. "Self-policing is necessary. Freedom requires self-discipline," he said.

"Obviously to us, ethical behavior is very important," said Mr. Kemper of his company, adding that he believes most insurance companies try to meet public expectations of ethical behavior.

The exercise of self-discipline came under examination when Mr. Robson asked the panel and audience to deal with a problem that can arise in the relationship between risk managers and brokers, insurers and other vendors. How should a risk manager respond to "frequent" offers of lavish entertainment and gifts? he asked.

Lavish gifts "shouldn't be necessary" to promote a good business relationship, said Judith J. Morgan, a principal in the Atlanta office of Tillinghast, a risk management consulting unit of Towers, Perrin, Forster & Crosby Inc.

"In extreme cases," lavish gifts and entertainment can be manipulative and lead to an even stronger ethical dilemma, she said. Each person involved in the transaction has the responsibility to elevate the situation to a different plane, she said.

There's nothing wrong with saying, 'We don't do business this way,' says Ms. Gallagher.

A risk manager may decline such offers, but should do so in a polite way, Ms. Morgan said, adding "let's put some of this energy" into creating a better business relationship.

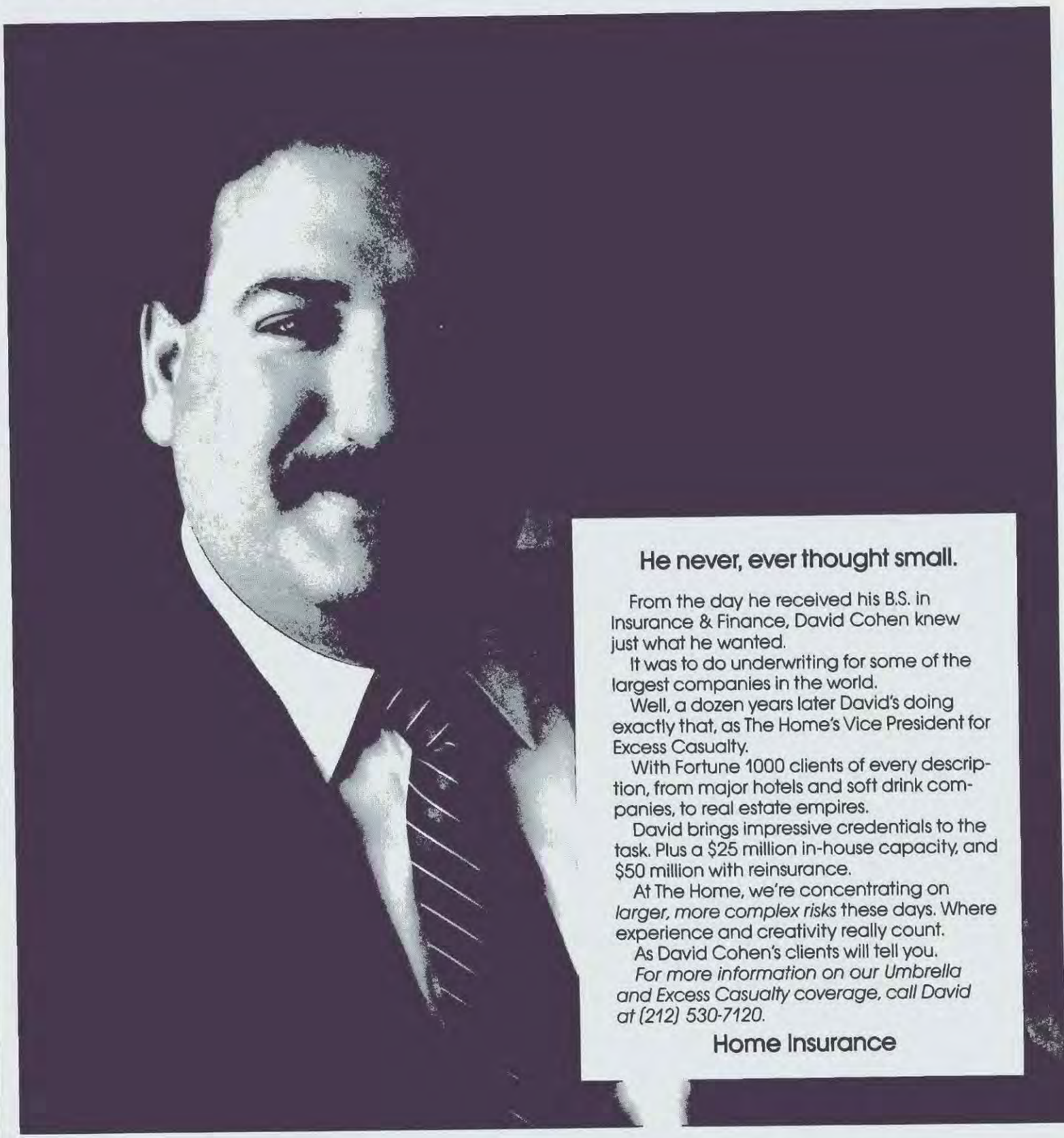
M&M's Mr. Mahoney once again urged, "stick with full disclosure."

"I agree there's probably a lot of unethical opportunities," said Lucille A. Gallagher, vp-risk management for Greeley, Colo.-based Monfort Co. and vp-government affairs for RIMS. "There's nothing wrong with saying, 'We don't do business this way.' "

Ms. Gallagher noted that ethics

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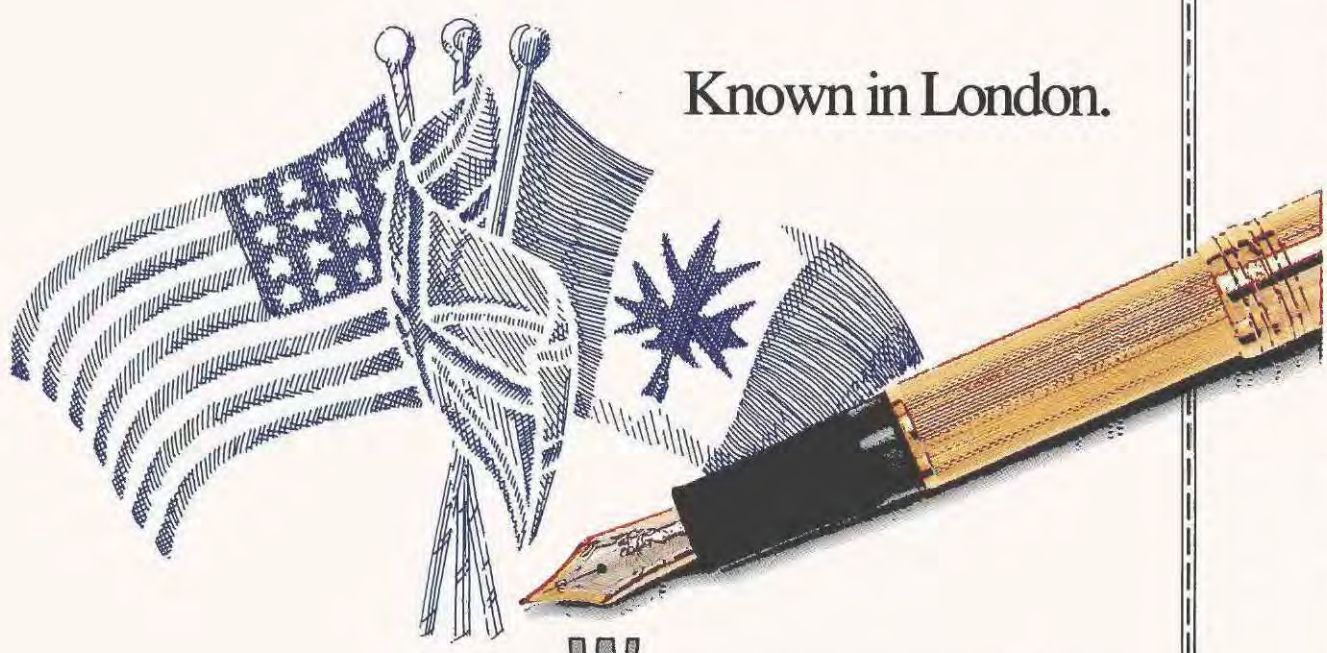
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Discussing ethics and risk management were, from left, George L. Head, Judith J. Morgan, Timothy J. Mahoney, James S. Kemper III, Lucille A. Gallagher and John W. Robson.



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Ethical dilemmas

Continued from previous page
within RIMS itself has undergone change, with lavish hospitality suites featuring "dancing girls" no longer regarded as acceptable at the annual RIMS conference.

Risk managers' primary responsibility is to promote safety and loss control, said George L. Head, vp of the American Institute for Property and Liability Underwriters, the Insurance Institute of America and Insurance Testing Institute, all of which are located in Malvern, Pa.

"You should not base this on gifts," said Mr. Head. Entertainment is not a decision-making criterion, he added.

However, Mr. Robson defended a certain amount of socializing among risk managers and their vendors. "You just don't get into the minds of people unless you get them in a business and social" situation, Mr. Robson said.

A question from the audience turned the tables, asking what a vendor would do if asked for lavish entertainment by a client.

Mr. Head says risk managers' primary responsibility is to promote safety and loss control.

M&M's Mr. Mahoney said that when such a situation arises, the brokerage always tries to take the situation out of the hands of the person directly approached and have another manager explain to the client why providing the lavish entertainment requested by the client is not in that client's own best interests.

"We try to say gently and politely 'no' and 'here are the reasons why," said Mr. Mahoney, adding that refusing such requests by clients can result in lost business for the vendor.

"Ethical questions are difficult questions, ' said Mr. Head. He suggested that risk managers should ask themselves, "To whom do I owe a duty?" and "What duty do I owe them?" when confronted with an ethical dilemma.

In general, everyone who is affected by the risk manager's actions is owed a duty, Mr. Head said.

The risk manager should rank those affected—be they employer, client or the insurance industry as a whole. And, "you owe a duty to yourself" as well, according to Mr. Head.

Julie K. Doepel, corporate manager-risk management for Southwestern Bell Corp. in St. Louis, coordinated the session. ■

Panel blasts pollution liability system

By MICHAEL SCHACHNER

NEW ORLEANS—One answer to the confounding question of how to finance environmental cleanups is to assess every potentially responsible party a share of liability based on their comparative fault, according to a risk manager.

This method would eliminate much of the litigation that is bogging down cleanup efforts and would provide a basis for prompt settlements, said Robert W. Teets, director of risk management & environmental affairs with Cooper Industries Inc. in Houston.

The current Comprehensive Environmental Response, Compensation and Liability Act, also known as the Superfund law, is massively flawed because corporations are spending much more money on attorneys and consultants than for actual cleanups, a four-person panel asserted at the 29th annual Risk & Insurance Management Society conference in New Orleans.

"The present environmental liability cleanup system is asinine," said Eugene A. Anderson, a partner in the New York law firm of Anderson, Kill, Olick & Oshinsky.

"Corporations are spending 70% of direct cleanup costs on lawyers and consultants—mostly lawyers. Lawyers generate controversy, they don't clean up hazardous waste," said Mr. Anderson.

"Too much time is being spent on litigation and raising money for cleanup rather than actual cleaning," agreed Jan Edelstein, special assistant to American International Group Inc. Chairman Maurice R. Greenberg, who has proposed assessing all commercial property/casualty insurance policyholders a flat fee to finance cleanups (*BI*, March 6, 1989).

"Too much is going to the three-piece suits and not to the moon suits," Ms. Edelstein said.

The fourth panelist, William A. Mahoney, senior vp with Marsh & McLennan Inc. in Tampa, Fla., said potentially responsible parties and their insurers have to work harder to settle environmental claims and clean up polluted areas.

"You have to get those claims closed so you can move on to the business you're supposed to be in. The way to do this is through structured settlements and finite funds. Insureds must kick in if insurers show they're willing to pay," said Mr. Mahoney.

But Mr. Anderson said this scenario will not occur unless there are meaningful changes to the current Superfund system. He insisted that insurers will never willingly pay their fair share.

"Risk managers always forget that the purpose of insurance is to insure. Now, middlemen are getting the money and they're getting it big," Mr. Anderson said.

"Insurers in 1966 said the (comprehensive general liability) policy would respond to future claims," but they are now denying coverage, he said. "Then, (insurers) added the pollution exclusion clause in 1970, but that has had little impact" in clarifying the debate.

The current cleanup system was designed to make the polluter pay, Mr. Teets said. But, it has been unofficially changed to a system in which the party most able to pay is attacked from all sides, he said.

"The system makes every potentially responsible party spend money to defend itself whether they were at fault or not. This has to change. We must keep and enforce the polluter-pays principle by making it clearer who a polluter is," Mr. Teets said.

Ms. Edelstein gave an example of how the system has gone astray. She told of a three-acre site on Long Island, N.Y., which the potential owner knew was contaminated. The site was bought anyway and later targeted by the Environmental Protection Agency for cleanup.

"There are now 257 potentially responsible parties, 140 law firms involved and 442 insurance companies listed as defendants. Superfund is very damaging, especially to small companies that may have been required to dump waste in certain areas and are now being required to clean it up," Ms. Edelstein said.

Ms. Edelstein urged risk managers to push for Superfund reform and said the system would improve if innocence became a defense.

"Today, you're liable if you own the property. Banks are worried about purchasing property or taking land as collateral. Under Superfund, you're liable if you own the land or if you're a transporter. We have to educate Congress and tell them that they have to make a change," she said.

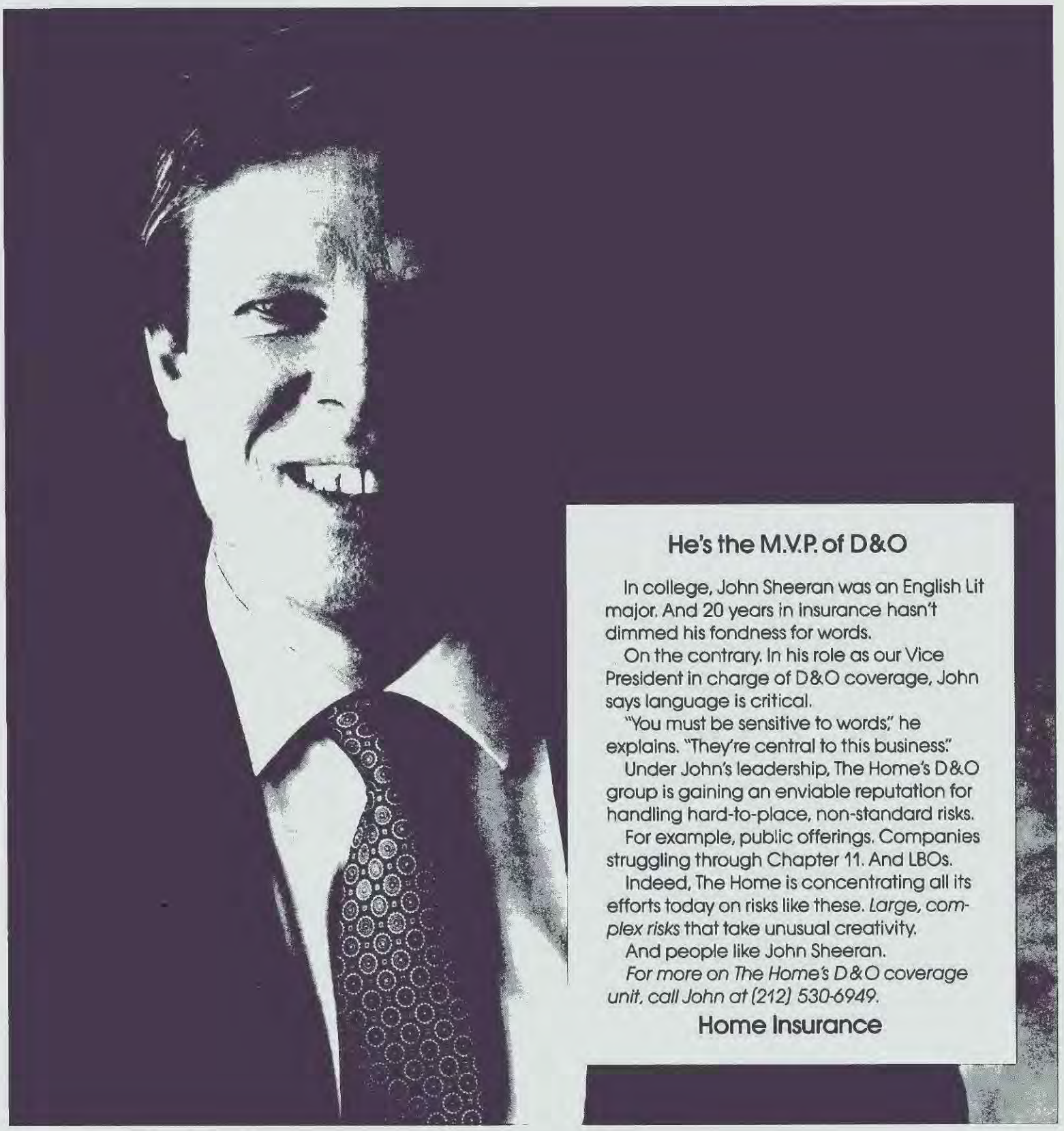
Risk managers can also make changes within their own companies to protect themselves from potential environmental claims, said Mr. Teets.

"We need to be pro-active and become more enlightened. Positive changes can lead to a real return on invested time," he said. "Any organization not doing intensive studies on waste production and disposal is only delaying an inevitable loss."

He also recommended that risk managers set up adequate reserves if liabilities have been identified, in addition to conducting an insurance coverage assessment that includes past and present policies.

Incoming RIMS President Robert W. Esenberg, risk management administrator with the city of Virginia Beach, Va., coordinated the session. Richard C. Heydinger, director of risk management services with Hallmark Cards Inc. in Kansas City, Mo., moderated. ■

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OLD PROS ON A NEW TEAM

Spotlight report

'Mega-insurers' may dominate Europe

By GAVIN SOUTER

NEW ORLEANS—International insurance markets are undergoing revolutionary changes that will alter the face of the insurance industry worldwide, insurance executives say.

In Western Europe, 10 to 15 insurance companies will come to dominate the market; in Eastern and Central Europe, there are long-term opportunities for patient insurers; and in Latin America, the pace of change is allowing foreign insurers to enter once-restrictive markets, industry observers said at a panel discussion during the 29th annual Risk & Insurance Management Society conference.

Western European insurers—like Allianz A.G. Holding of Munich, Germany; AXA-Midi Assurances of Paris; and Zurich Insurance Co. of Zurich, Switzerland—have invested heavily in the United States, but U.S. companies have not done the same in Europe, said Steve Schleisman, senior vp with AI Global, a unit of American International Group Inc. in New York.

"U.S. insurers have not invested directly in Europe. Instead, we are exporting some of the worst parts of our liability problems in product liability, legal liability and environmental liability," he said.

There will be eight major trends in insurance in Western Europe in the near future, Mr. Schleisman said:

• First, there will be increased concentration in the market.

"Most European insurers of any consequence have already decided that it is in vogue to be pan-European. Exactly what their strategies are is a subject of debate but it is taking place," Mr. Schleisman said.

There are currently 4,600 insurers in the European Community and, of those, 3,200 are exclusively property/casualty insurers, he said.

However, underlying these figures there are already concentrated markets, Mr. Schleisman contended.

For example, according to a survey conducted by Arthur Andersen & Co., 42 insurers in Italy have 80% of the insurance market there, Mr. Schleisman said. The survey predicts that by 1995 that group of insurers will shrink to 31, he said. In Spain, the survey noted there are 77 insurers with 80% of the market, which will drop to 41 companies in 1995, he reported.

When this trend is taken with the emergence of gigantic insurers and the growth of broker networks, the European marketplace will be dominated by a few mega-insurers, he predicted.

"It all adds up to the fact that we will see 10 to 15 insurance companies dominating Europe," Mr. Schleisman said.

• Second, the 1992 date for deregulation of trade in Europe will not cause the transformation of the insurance market.

The scale of the transformation that deregulation will bring is too large to bring about an immediate revolution in the market and true changes will not be seen until about 1995, Mr. Schleisman contended.

"And then French and German companies will emerge as the dominant insurers in Europe," he said.

• Third, a much stronger insurance cycle, similar to the U.S. cycle, will emerge in Europe.

"As the big get bigger and the smaller companies disappear, we will see a much stronger cycle. We will not have a 10-year soft market without somebody blowing the whistle," Mr. Schleisman said.

• Fourth, Lloyd's of London will remain a force in the United Kingdom and the United States, but will not penetrate the continental European market to any significant degree.

Lloyd's currently is facing several problems, like catastrophic losses from 1988 on, U.S. asbestosis claims and members fleeing the market. Those problems will prevent it from concentrating on enlarging its tiny European market share, Mr. Schleisman predicted.

• Fifth, the U.K. multiline insurers do not have the financial strength to be big players in the continental market.

"The U.K. composites are much more likely to be takeover targets rather than players. It is more than likely that they will be bought by German and French companies," Mr. Schleisman said.

• Sixth, banks will take a much larger role in the distribution of insurance in Europe.

"Many people say that distribution channels is the Achilles heel of the insurance industry," he said.

Brokers are only highly developed in Britain and the Netherlands, while in other countries exclusive agents dominate, Mr. Schleisman said.

Banks are already acting as agents in the life insurance field and they are looking at entering the property/casualty market, Mr. Schleisman said.

• Seventh, insurers are unwilling to write pollution liability insurance and industrial companies will find alternative ways of financing these risks.

"The insurance industry will be a minor player in the environmental issue," Mr. Schleisman said.

• Finally, risk managers will become much more influential within their companies.

"You will see greater growth of risk management as a profession in Europe over the next 10 years. We have already seen it with captive growth and higher levels of self-insurance," Mr. Schleisman said.

Consequently, risk managers will be able to do what they should already be doing—that is, looking at a range of ways of dealing with

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Continued from previous page
risks instead of just relying on insurance, he said.

Eastern and Central European insurance markets are changing even more rapidly than those in Western Europe, said Hugh Warren, executive vp and chief operating officer of Corroon & Black International in New York, a unit of Willis Corroon P.L.C.

"There is a lot of activity going on trying to change the countries' economies from command economies to market economies," he said.

There are also a lot of differences between the former Eastern bloc countries themselves, said Mr. Warren, although he added there also are some common traits.

Among the commonalities are a lack of infrastructure, poor telecommunications, the lack of a mobile workforce and wholesale markets that are organized by bureaucrats, he said.

"We looked at the possibility of setting up an office in Budapest, but we could not get the local staff. However, we are still thinking about the possibility," Mr. Warren said later in an interview.

Despite the difficulties, however, the fact that there are 420 million people in Eastern and Central Europe means that there are long-term opportunities for insurers in the former Eastern bloc countries and now is the time to get in on the ground floor, he said during the session.

Looking at individual countries, Mr. Warren said the Soviet Union currently is undergoing huge economic and political problems that have forced prospective insurance legislation into the background.

"The legal framework was supposed to be put in front of the Supreme Soviet by the end of last year, but because of problems in other parts of the country it didn't make it," he said.

In Poland, new legislation based on a British model should be in place by September, Mr. Warren reported.

"Because it is based on the U.K., it should be quite a liberal market and brokers are allowed. However, it is still very underdeveloped," he said.

Hungary led many of the other former Eastern bloc countries in general economic liberalization and the reform of its insurance market goes back to 1986, Mr. Warren said.

Consequently, most major Western insurers that are interested in operating in Eastern and Central Europe have already set up joint ventures in Hungary, he said.

In Czechoslovakia there are two distinct markets—the Czech and the Slovak, Mr. Warren said.

In both parts of the country, insurance mechanisms are being modeled on Swiss and German markets, so they will not be as liberal as Poland's U.K.-inspired system, he said.

Bulgaria and Romania are the least changed among the emerging Eastern economies and, consequently, Western insurers will have to wait longer to benefit from insurance developments there, Mr. Warren said.

The old East German insurance market is already being catered to by the 300 German insurers that automatically became licensed in the eastern provinces after the unification last year, he said.

Insurance companies also have witnessed a lot of changes in Latin America, according to Jack Perez, senior vp-Latin American/Caribbean region for broker Alexander & Alexander Services Inc. in New York.

"The changes are, for the most part, advantageous for the insurance buyer," he said.

Thirty years ago, state-run insurance industries and mandatory tariff rating were well-established throughout Latin America, Mr. Perez said.

"This worked against a creative approach to risk management problems but, in spite of this, there was still room to maneuver. For example, there was the view that any two brokers would produce the same tariff rates, but in practice this was not true," he said.

Instead the insurance authorities in some of the countries would turn a blind eye to some variance in the rates, Mr. Perez said.

"But still the sentiment was that nothing could be done to vary insurance rates in this part of the world," he said.

Now, however, change is moving ahead as dictatorships are replaced with democratic governments, Mr. Perez said.

Despite the difficulties, the fact that there are 420 million people in Eastern and Central Europe means that there are long-term opportunities for insurers in the former Eastern bloc countries and now is the time to get in on the ground floor, Mr. Warren says.

"This is the day of the entrepreneur. There is a movement towards economic pragmatism," he said.

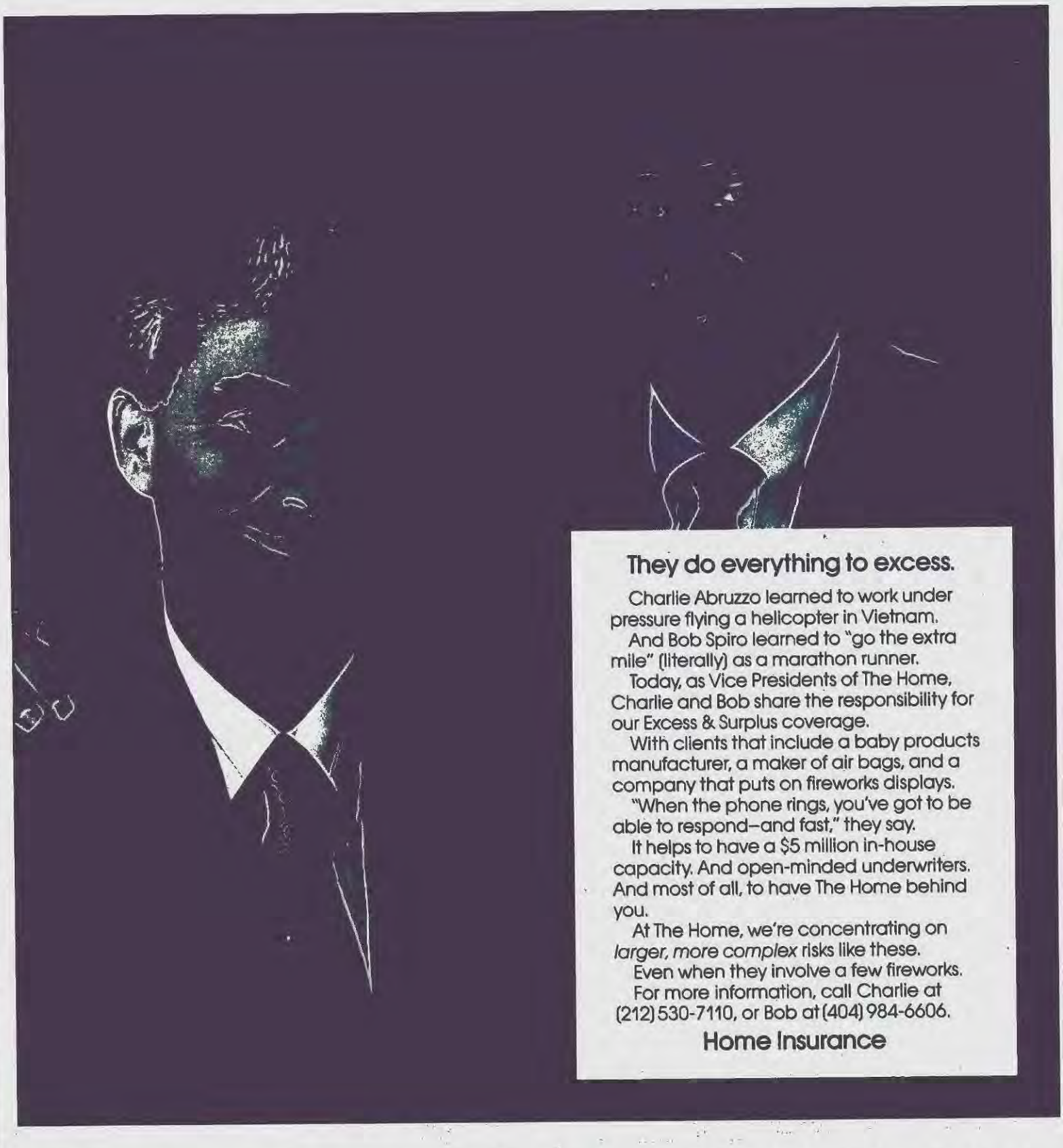
In Chile, Mexico, Colombia, Peru and Argentina, new laws are introducing competition among domestic insurers and, in some countries, foreign insurers, too, Mr. Perez.

And although Brazil and Venezuela are lagging behind other large Latin American countries in the liberalization of their insurance markets, they also are seeking ways of creating a more market-driven insurance system, he said.

"However, we must never forget that the tariff systems protected insurance companies and the new systems are based on solvency, so companies could go under and we must tread very carefully," he warned.

The session was moderated by Louis Drapeau, manager-insurance and risk management for The Budd Co. of Troy, Mich. It was coordinated by Cynthia Ziegler, vp of continuing education for the Society of Chartered Property & Casualty Underwriters in Malvern, Pa. ■

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OLD PROS ON A NEW TEAM

Spotlight report

PPO networks can trim work comp medical bill

By JERRY GEISEL

NEW ORLEANS—Just as employers have turned to preferred provider networks to try to hold the line on health care cost increases, companies should tap special provider networks to better control workers compensation medical costs, a panel of experts agrees.

"Preferred provider networks are essential to reduce costs," said Dr. Stephen D. Deutsch, medical director of the Occupational Orthopedic Center of Pawtucket, R.I., which specializes in treating work-related injuries.

Dr. Deutsch said traditional medical practice has failed—from both employer and employee perspectives—to provide medical care and facilitate injured workers' return to work.

"Traditional care can cost you and the employee dearly," Dr. Deutsch said at a session during the 29th annual Risk & Insurance Management Society conference in New Orleans.

In a workers comp PPO, the physicians specialize in the treatment of work-related injuries, Dr. Deutsch said. "They provide urgent care, specialized care, rehabilitation and case management. They are committed to quality of care and are accountable for their services."

In addition, physicians in a workers comp PPO are knowledgeable about workers compensation and include specialists in such areas as physical and occupational therapy, he said.

Physicians, Dr. Deutsch said, "can be your best friend or worst enemy. The physician needs to be interested in getting the employee back on the job as soon as medically possible."

One of the biggest differences between a physician who practices in a preferred provider setting and one who practices traditional medicine is attitudes toward pain, according to Dr. Deutsch.

Traditional care equates pain with physical disability and inability to work, he said. "You don't necessarily equate pain with physical disability. Pain can be the result of emotional distress," Dr. Deutsch explained. In fact, the longer injured employees stay away from work, the worse their perceived pain may be, he said.

And perceived pain can be devastating to the injured worker. More than half of those injured who say they have chronic pain later encounter substance abuse or marital problems, he noted.

It is up to the employer and the PPO to develop a light structured work schedule, he said.

"The employer must tell the (network) of an injured worker's job requirements" so a modified work schedule can be developed, he said.

Dr. Deutsch noted that because medical care in a PPO may initially be frequent and intense, medical costs—in the beginning—actually may be higher than in a non-network setting.

That is no cause for alarm, he said. "The driving force should be reduction in overall costs, which can be best accomplished by getting the worker to return to work as soon as possible."

Travelers Insurance Co. now offers a workers compensation PPO in about 30 locations, said Patrick J. Kinney, assistant director for property/casualty lines-special accounts marketing for the Hartford, Conn.-based insurer.

In recruiting physicians for the workers comp network, Travelers is not especially interested in discount arrangements, he said at the session.

"We don't want 40% discounts and then end up with physicians who provide twice as many services as are necessary," Mr. Kinney said.

Instead of just relying on discounts, workers compensation medical costs can be controlled most effectively through physicians in a network who agree to utilization review of services, Mr. Kinney said. "Ultimately, we are not trying to create an adversarial relationship. We want physicians who will agree upon a pattern of treatment," he said.

Unlike traditional health care PPOs, employers cannot give employees incentives, like enriched benefits, for going to specific physicians for treatment of work-related injuries. State laws require full medical coverage for work-related injuries.

In view of the freedom of choice given injured workers by those state laws, "You can't make an injured employee do what he doesn't want to do. Employees do gravitate to family doctors," said Thomas Turbyne, director of human resources for the Eastern regional zone at Avis Inc. in Garden City, N.Y.

A workers compensation PPO has to provide medical care that employees will use because they believe they will receive the best treatment, he said.

"The employee has to want to use the (network) because of access and quality of care—not through coercion," agreed Peter F. Rousmaniere, a vp with Lynch, Ryan & Associates Inc., a Westborough, Mass.-based management consulting firm.

But, "95% of employees will stay (in a PPO) if the care is right and appropriate. We don't lose them," said Thomas C. Lynch, the president of Lynch, Ryan & Associates and coordinator of the RIMS session.

A key way to assure that injured employees will go to a PPO is to assure them that they will have quick access to providers, Dr. Deutsch said.

"Access is critical," Mr. Rousmaniere agreed.

To be sure that employees are aware of a workers comp PPO, as well how workers compensation benefits work, employers need to spend more time on communications, Travelers' Mr. Kinney.

"Employers spend hours discussing their employee benefits program, but often there is no discussion of workers compensation," he said. Indeed, many employees say they never would have contacted a workers compensation attorney if their employers had contacted them soon after an accident, he said.

The session was moderated by Linda Ruthardt, director of risk and insurance with the Girl Scouts of the USA in New York. ■

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Shifting nature of political risks detailed

By MARK A. HOFMANN

NEW ORLEANS—Risk managers or chief financial officers who think they can predict where the next political flash points will be are playing a dangerous game of global Russian roulette, warns a political risk broker.

One recent loser in that high-stakes game made his fateful move about four years ago, recalled Jack Willyard, senior vp in the financial products division of Sedgwick James of New York Inc.

This U.S. businessman decided to reduce his political risk premiums by dropping coverage for a particular country.

Explaining his decision, he noted that the country in question used the U.S. dollar as its currency and was home to thousands of U.S. military personnel. Such a country had to be stable, he reasoned.

The country, so inviting four years ago, was Panama.

Panama and other hot political spots were the topics of a discussion at the 29th annual Risk & Insurance Management Society conference in New Orleans.

"Political risk insurance seems to favor summer with uncharacteristic regularity," said Mr. Willyard. He pointed out that the Tiananmen Square massacre, which was accompanied by a chill in U.S.-Chinese trade relations, took place in June 1989 (*BI*, June 12, 1989). And, Iraq invaded Kuwait during the summer (*BI*, Aug. 13, 1990).

But despite the exposures associated with dealing with foreign regimes regardless of the temperature, "many minor and major corporations continue to aggressively invest and trade overseas," he said.

"So many do so without any insurance protection against the catastrophic financial losses that can affect foreign investors and traders alike," Mr. Willyard said. These companies do so "at least as long as they don't have first-hand experiences with such losses," he said.

"By then, they're either out of business—as some companies have been dragged down by government actions or some political risk 'event'—or they're believers," he said. Sometimes believers are those who have heard of large losses in foreign lands from fellow risk managers or company officials who neglected to buy political risk coverage, he added.

Several types of lesser-known political risk coverages will be of interest to companies doing business overseas.

For example, the trade disruption or contingent business interruption form would cover losses in the event local authorities cannot maintain law and order, as happened in the Philippines last summer, he said.

An off-site terrorism endorsement would cover business interruption stemming from an event such as a terrorist attack on a power plant, Mr. Willyard said. Even though the policyholder's own facility would have sustained no physical damage, a power cutoff could hamper operations.

And a key operators endangerment endorsement would come into play if critical people were either evacuated from a plant by order of the local or U.S. governments, he said.

For risk managers with foreign exposures, worrying only about the actions or inactions of the host government will not suffice, said Mr. Willyard.

A federal agency, the Overseas Private Investment Corp., provides political risk coverage for U.S. investors, but will not pay claims if the proximate cause of loss is an action of the U.S. government, such as an embargo, he said. A wise risk manager might consider adding a contingent deprivation or embargo endorsement, he said.

Another speaker also offered cautionary words about dealing with what he called "government schemes" that offer political risk coverage like OPIC and the U.S. Export-Import Bank.

Dealing with a government agency may provide the overseas investor with a long-term commitment unavailable on the private market and "may support a hopeless risk," said Mark Drummond Brady, director of the London wholesale broker Lloyd Thompson Ltd. But national interest, he warned, is "the Achilles' heel of government schemes."

Complexity can be another problem. "The average private market wording is half the length of the government scheme wording," said Mr. Brady.

The private market has sustained some notable losses, he noted. For example, the overthrow of President Samuel K. Doe in Liberia last fall and years of expropriations in Iran cost private insurers money, he said. But some countries—particularly Latin America nations like Chile, Argentina and Mexico—have recently become better risks, he said.

Another speaker cautioned about the inability to quantify and predict the degree of political risk in a given country.

The nature of a political risk is that one's perspective can change overnight, said Mark Brockbank, director of Alston-Brockbank Agencies Ltd. in London and underwriter for Lloyd's of London syndicate 861.

Mr. Brockbank said he's currently being "inundated" with request for political risk insurance for the Soviet Union.

He noted that the March 17 national referendum on the country's future was boycotted by six of the 15 republics, and proved to be inconclusive, with support for President Mikhail Gorbachev and Boris Yeltsin, president of the Russian republic's parliament, about evenly split.

"The political future of the Soviet Union is far from clear," he said.

The session's moderator was Bryan T. Keogh, assistant treasurer with Phibro Energy Inc. of Greenwich, Conn. Mr. Willyard was the coordinator. ■



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How do terrorists look? Very familiar

By MARK A. HOFMANN

NEW ORLEANS—Risk managers who think of terrorism solely as the work of foreign agents should look much closer to home.

"The possibility of a foreign terrorist coming in with a ski mask and a pipe bomb is pretty remote," said Bruce T. Blythe, president and chief executive officer of Crisis Management International Inc., a consulting firm based in Atlanta.

In fact, the terrorist that American corporations should fear is most likely to be an American male over the age of 40, Mr. Blythe said during a session at the 29th annual Risk & Insurance Management Society conference in New Orleans.

Colleagues would describe the man who fits this terrorist profile as a loner who draws much of his self-esteem from his job, he said. When such a man loses his job, he can lose control and lash out at his former employer, with often tragic results.

"By far, the most common corporate disaster is murder," Mr. Blythe said. In fact, murder is now the most common cause of on-the-job deaths among women, he said, noting that "in the United States, the workplace is becoming more and more violent."

Dealing with an increasingly violent workplace requires applying the risk management process to catastrophe planning, said Steven M. Sachs, vp-risk management services division at Hobbs Group, the Columbia, Md.-based brokerage arm of Arkwright Mutual Insurance Co.

Risk managers need to begin by identifying the types of catastrophes that may overtake their company. These would include natural disasters, terrorism or extortion, and third-party criminal acts, such as a disgruntled former employee who picks up a high-powered firearm and begins shooting, he said.

Discussing the second possibility, terrorism or extortion, Mr. Sachs pointed out that a risk manager has to assess a variety of factors in determining the extent of the exposure: Does the company have a high profile? Is it mentioned frequently in the press? Do corporate executives travel a lot, making themselves convenient targets?

Once the exposures have been determined, the risk manager needs to decide which loss prevention techniques to apply to the problem, Mr. Sachs said.

An emergency catastrophe plan should be developed, documented and subjected to regular audits and reviews, he explained. Having a plan that doesn't work when an emergency occurs is one of the worst things that can happen to a corporation, he said.

As part of its plan, a corporation should have some system of providing psychological support for affected employees, Mr. Sachs said.

Mr. Blythe, who provides such services, said that a serious post-catastrophe problem stems from the inability of employees caught up in a disaster to understand that extreme traumatic reaction is normal.

Too often, said Mr. Blythe, management simply sends employees home for a day or so in the wake of a tragedy. This simply heightens feelings of isolation.

Employee assistance meetings following a catastrophe are often voluntary, he said. But this allows the most severely traumatized to avoid attendance; and others, feeling macho, will stay away as well.

The cost of inaction can be great for both individual employees and the corporation, Mr. Blythe said. Traumatic responses include increased neuroses among the already neurotic, the development of psychosis, and drug and alcohol abuse.

For the corporation, untreated psychological trauma means higher absenteeism, lower productivity, increased workers compensation costs and possibly litigation, he said.

Corporations should pre-arrange counseling services so that they can be offered as soon as possible after a tragedy, Mr. Blythe recommended. "You need to find people who are specialists in disaster psychology" and available for rapid deployment, he said.

"This is an emerging standard of care," Mr. Blythe said, adding that plaintiffs' attorneys are only too willing to bring up the lack of counseling when representing employees who have survived a corporate disaster.

In addition to arranging psychological services, the corporation should advise employees on how to handle press inquiries, he said. "I've yet to handle a corporate disaster where employees didn't feel assaulted by the media."

Planning for potential disasters should include coordination with local and federal law enforcement agencies, said Herbert D. Clough Jr., executive vp and director-international operations for Paul Chamberlain International, a Beverly Hills, Calif.-based security consultant.

"When you need assistance, it will pay handsome dividends," said Mr. Clough, a former Federal Bureau of Investigation agent. Establishing such cooperation should be part of the corporate crisis management plan, he said.

Mr. Clough also said that senior management needs to actively support and participate in the crisis management plan and other employees need to be aware of the plan.

Having a plan itself is not enough, he pointed out.

Like Mr. Sachs, Mr. Clough urged that plans be reviewed and updated regularly. A simulated emergency should be held every six months to test the plan, he said.

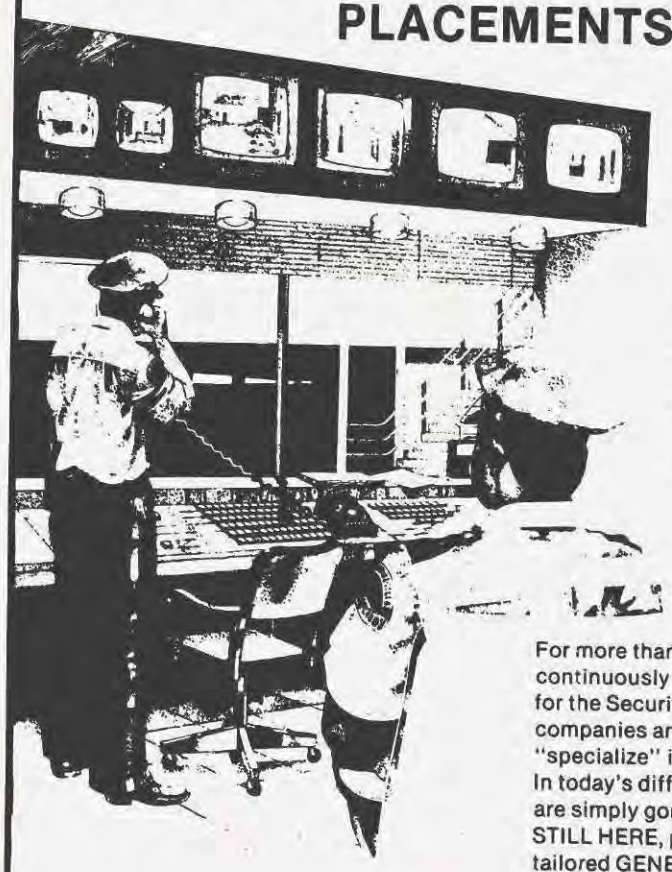
Mr. Clough pointed to kidnapping for profit as one of the major domestic exposures that need to be addressed in a crisis plan. Unlike their Latin American counterparts, U.S. kidnappers are far from professional, he said.

"Kidnapping in the United States is the dumbest crime in the book," he said. Its perpetrators tend to be "losers" of above-average intelligence and below-average achievement. Because they are amateurs, they are particularly dangerous, he said.

Mr. Clough said that one of his clients boiled down the essence of a crisis management plan to the point where it would fit on a laminated wallet card. When the man's daughter was kidnapped, he was able to follow the instructions and, ultimately, his daughter was freed, Mr. Clough said.

David C. Adler, risk manager for Portman Cos., an Atlanta-based real estate development firm, moderated and coordinated the session. ■

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Esenberg leads slate of new RIMS officers

NEW ORLEANS—The Risk & Insurance Management Society's Executive Council for 1991-92 took office on May 1 during the society's annual conference here.

As previously announced, the new president is Robert W. Esenberg, risk management administrator for the city of Virginia Beach, Va.

Mr. Esenberg delivered his inaugural address on April 29 at the annual membership breakfast at the conference (*BI*, May 6).

Most recently first vp of RIMS, Mr. Esenberg was first elected to the Executive Council in 1986 and has served as vp-member affairs/secretary, vp-conference and vp-governmental affairs.

Mr. Esenberg succeeds Cheri Hawkins, director of insurance for Weyerhaeuser Co. in Tacoma, Wash. Ms. Hawkins is the first woman to be elected president of RIMS.

She will probably not be the last. Waiting in the wings to assume the presidency is Suzanne H. Crager, assistant vp at PNC Financial Corp. in Philadelphia. She is the society's new first vp, an office that traditionally serves as a stepping stone to the president's post.

Ms. Crager was first elected to the Executive Council in 1989. She has served as vp-finance/treasurer and most recently was vp-conference.

Members of the Executive Council who were re-elected for the 1991-92 term are:

- J.A. "Tony" Bridger, vp-business and industry liaison. Mr. Bridger, risk manager for Bank of Montreal in Toronto, was first elected to the Executive Council in 1987. He has served as vp-member affairs/secretary and vp-conference. He also was vp-business and industry liaison in 1990-91.
- J.A. Yvon Menard, vp-conference. Mr. Menard, manager-risk and insurance for Marathon Realty Co. Ltd. in Toronto, was first elected to the Executive Council in 1989. He has served as vp-research for two years.
- Gerald L. Belfiglio, vp-finance/treasurer. Mr. Belfiglio, pensions and insurance manager for Ford New Holland Inc. in New Holland, Pa., was first elected to the Executive Council in 1989. He has served as vp-member affairs/secretary and served as vp-finance/treasurer last year.
- Lucille A. Gallagher, vp-governmental affairs. Ms. Gallagher, vp-risk management for Monfort Inc. in Greeley, Colo., was first elected to the Executive Council last year, when she also served as vp-governmental affairs.
- Gerald J. Ciardelli, vp-member affairs/secretary. Mr. Ciardelli, corporate risk manager for Jostens Inc. in Minneapolis, was first elected to the Executive Council in 1990 and served last year as vp-education. He has received the Chartered Property & Casualty Underwriter designation.

Three new members were elected to this year's Executive Council. They are:

- Marge P. Layne, vp-communications. Ms. Layne is corporate risk manager for Core-Mark International Inc. in South San Francisco, Calif. Ms. Layne also served on the Executive Council in 1988, when she was vp-education.
- Louis J. Drapeau, vp-education. Mr. Drapeau is manager-insurance and risk management for The Budd Co. in Troy, Mich.
- David R. Haight, vp-research. Mr. Haight is director of risk management for CF Industries Inc. in Long Grove, Ill.

RIMS also announced the winners of three awards at its annual conference.

Ron Judd, who will retire this month as executive director of RIMS, received the Dorothy and Harry Goodell Award, the highest honor the group can bestow (see story, page 3).

Steve Taylor, safety administrator for Home Depot USA Inc. in Atlanta, won the RIMS Research Award, which recognizes research conducted by deputy members of RIMS. Mr. Taylor was honored for his paper, "Reduction of Workers Compensation Costs Through the Use of a Formal Early Return to Work Program."

And the Cristy Award, which is given to the risk manager with the highest cumulative average for the three examinations leading to the Associate in Risk Management designation, went to Dellanie P. Fragnoli, analyst in the insurance department at Southern California Edison Co. in Rosemead, Calif. ■

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Increase in D&O claims not shrinking capacity

By CHRISTINE WOOLSEY

NEW ORLEANS—While the number of directors and officers liability claims has increased dramatically over the last 20 years, the D&O insurance marketplace is not on the verge of collapse, a broker says.

"All of the major D&O markets anticipate having the same limits five years from now that they have now," noted Corbette S. Doyle, senior vp of Willis Corroon Corp.'s Advanced Risk Management Services division in Nashville, Tenn. "This says to me that we don't have an apocalypse now, nor will we have one—at least in capacity—in the near future."

Ms. Doyle was the coordinator and a speaker at a panel discussion on the future of the D&O market at the 29th annual Risk & Insurance Management Society conference.

"In the last six months, I can cite to you no fewer than 20 lawsuits filed against the insurance market for" non-payment of D&O claims, said Jerold Oshinsky, an attorney in Washington, D.C., with Anderson, Kill, Olick & Oshinsky, a firm known for representing policyholders in coverage disputes.

At the heart of many coverage disputes is the ambiguous wording of policies, Mr. Oshinsky said.

"As risk managers, put on your commercial general liability hat when you deal with D&O," he said, suggesting that both types of policies should be carefully scrutinized and fully understood to avoid confusion that may result in a lawsuit.

Risk managers should recognize that "a D&O policy covers directors and officers, not the corporation," Mr. Oshinsky said. "However, you should be aware that there is a wide body of case law that provides companion coverage to the corporation."

He noted that D&O policies that have two sections—one covering directors and officers and one covering the corporation—should be viewed separately. "Don't let the D&O exclusions apply to the corporate reimbursement side."

In addition, risk managers should not "confuse 'defense' with payment of defense costs. Insurers have no obligation to defend you. The duty to defend and the duty to pay are two different things," he explained.

Mr. Oshinsky also pointed out the importance of understanding policy limits. Some D&O policies have no annual limits or per loss limit, but those policies are rare, he said.

Mr. Oshinsky said risk managers should not be misled about D&O exclusions. For example, he noted that D&O policies that exclude coverage for dishonesty often only exclude the coverage if the claim is adjudicated. As a result, companies that settle a D&O claim without going to trial may receive coverage for losses stemming from dishonesty.

Risk management should prevent the kinds of problems that arise in D&O coverage disputes and litigation, said William J. Kelly, senior vp of Morgan Guaranty Trust Co. of New York and the session's moderator.

However, he said, "until recently, it seemed as though the risk manager could do little to deal with the increasing frequency of D&O lawsuits." But, "based on the knowledge gained from the difficult experiences of the last five years, risk management strategies are beginning to emerge," he noted.

"While some strategies characterize themselves as loss prevention, they often appear more like preclaim preparation," Mr. Kelly said.

He stressed the importance of the risk managers having a respected role within a corporation. "Realistically, unless the risk manager has credibility within his firm and most especially at the corporate office level, he will not be in a position to exert any meaningful influence," he said.

"It's an old story, but it is especially true with respect to D&O: If the risk manager is perceived, and perhaps correctly so, as having no thorough understanding of his employer's business or any particular expertise in the area of D&O liability, he will not be in a position to make a difference."

"The risk manager is the key to loss prevention awareness," agreed George T. Van Gilder, executive vp for Chubb & Son Inc. in Warren, N.J. "Get yourself placed in the right communication circles so you can be aware of things. And, you should be placed in your organization so you are able to make decisions," he said.

One of the most fertile areas of D&O litigation is securities law—suits alleging misrepresentation or inadequate disclosure after stock prices fall, Mr. Kelly said.

However, risk managers can practice some lawsuit loss control, Mr. Kelly said.

They should, for instance, understand the expectations of a publicly traded company and what the corporation wants to achieve with its investors, he suggested. Then they should disclose that information in accordance with various regulations.

"The New York Stock Exchange requires that a listed company quickly disclose to the public any news or information which 'might be expected to materially affect the market for its securities,' " Mr. Kelly explained.

An aggressive approach to disclosure can sometimes protect a company from securities law litigation. Mr. Kelly explained that a rule of thumb in investor relations is that "the more you tell about the company, and the quicker you tell it to the widest possible audience, the less likely you are to run afoul of the securities laws."

In addition, Mr. Kelly said risk managers should attend conferences and read up on D&O. "Clearly the risk manager should be thoroughly familiar with all that is being written by responsible sources on loss prevention and work to see that his organization is, as far as possible, in compliance," he said.

Some insurers that write D&O and crime insurance for small commercial banks have basic education materials for directors as well as control recommendations.

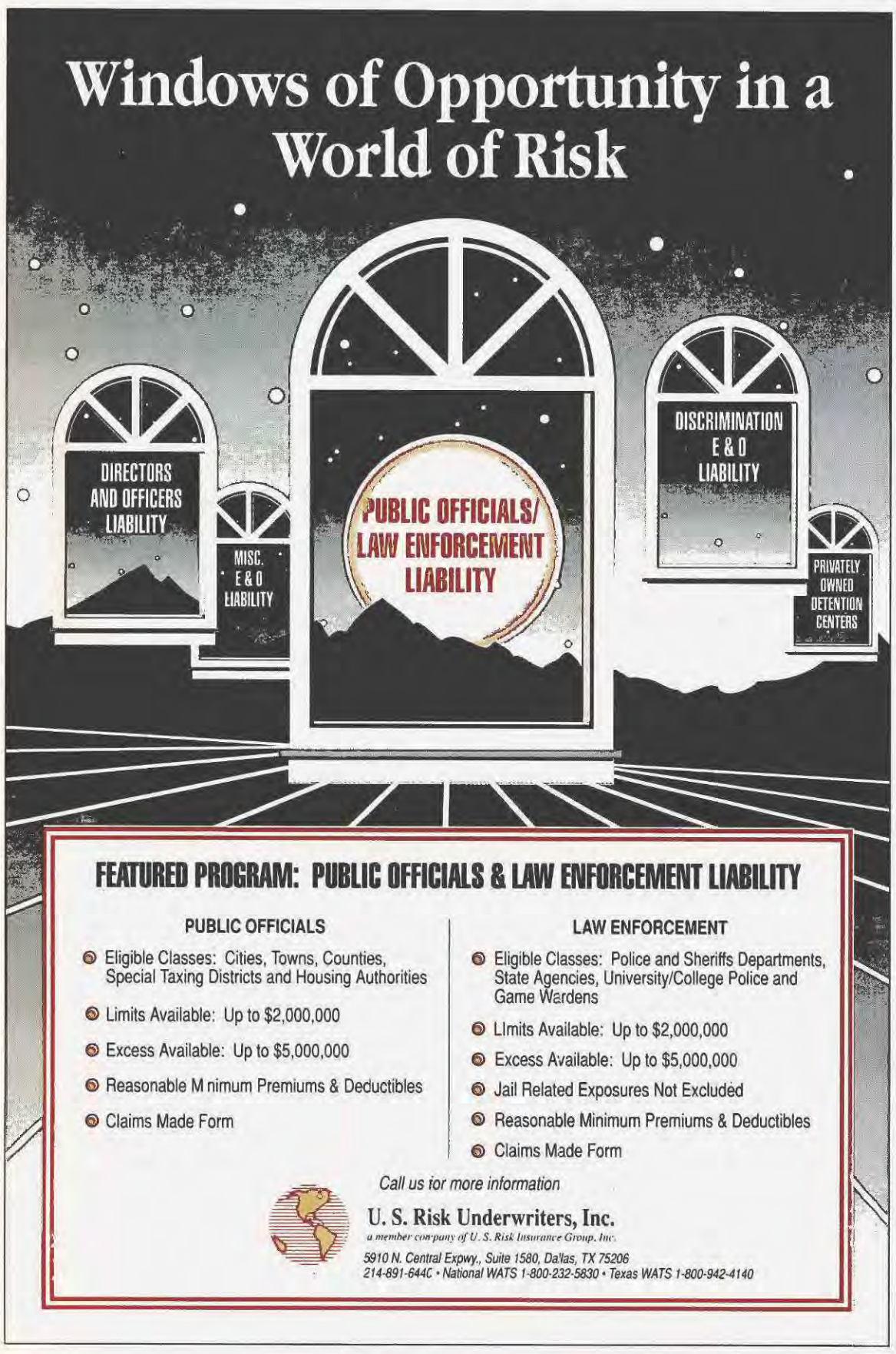
And, companies should keep in mind lessons learned from others' experience.

Among other things, "don't be intimidated by the size of the initial demand," Mr. Kelly said. "These demands are grossly inflated and designed to intimidate."

In addition, when a D&O claim results in a trial, "don't become overly bogged down in accounting and documentation issues." These issues are largely cosmetic, he said. The real issue is not whether every accounting entry was correct but whether there was a fraud related to disclosure.

And, Mr. Kelly, said, "a defendant should never be so self-critical as to accept the plaintiff's allegations as even plausible."

For example, "in cases where the directors are the largest shareholders in the firm, it is unreasonable to assert that they are about to defraud themselves," he said. ■



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Risk managers need hard data, soft touch

By COLLEEN JOHNSON

NEW ORLEANS—A risk manager must be aware of market conditions and work well with brokers and underwriters to develop an effective insurance program.

There are six steps a risk manager should follow when developing an insurance program, according to George B. Netherton, senior vp at Becher & Carlson Risk Management Inc. in Marietta, Ga.

A risk manager first should look at key issues like loss experience, market conditions, losses in the industry and any change in the incumbent insurer's underwriting philosophy, Mr. Netherton said during a session at the 29th annual Risk & Insurance Management Society conference in New Orleans.

The risk manager then should establish "aggressive"—but realistic—goals on the types of coverages the company needs, limits, retentions, pricing and services, said Mr. Netherton, former director of risk management for The Coca-Cola Co. in Atlanta.

Priorities must be set, and a risk manager may have to make concessions in a lower priority area to get what is needed in a higher priority area, he said.

The broker should be aware of the risk manager's priorities, he added.

Third, the risk manager should decide when insurance programs will be marketed, Mr. Netherton said.

Generally, programs should not be marketed every year, because underwriters "tend to lose their motivation to work on accounts they see year after year," he explained. However, risk managers may want to consider marketing excess programs more frequently, because excess market conditions tend to change more rapidly than primary market conditions, he suggested.

Insurers 'tend to lose their motivation. . .on accounts they see year after year,' says George B. Netherton.

The risk manager then should develop a list of acceptable insurers, considering factors like security, industry expertise, insurer resources, quality of services and underwriting staff and flexibility.

Then, an information list on the insurers being considered should be drawn up, he said. This list is usually developed by the broker.

Finally, the risk manager is ready to go to market, he said.

The risk manager must provide all essential information to the broker and be involved in selecting the insurer, Mr. Netherton said.

"It's very important for the risk manager to take a pro-active role, to be involved in that process," he said.

The risk manager also should meet with underwriters and prepare for those visits by talking with the broker and with other staff in the risk manager's company who could provide information the insurer may request, Mr. Netherton said.

Janel Clausen, assistant treasurer-risk management at Columbia Pictures Entertainment Inc. in Burbank, Calif., recommended that the risk manager "provide a great underwriting submission."

"If it's a bad job, it's going to reflect badly on you and your company," she noted.

"An informed underwriter is a happy underwriter," Ms. Clausen said.

Michael Cohen, vp and branch manager of the Washington, D.C., office of American International Group Inc., pointed out that the content of an underwriting submission is more important than its appearance.

"Even a very nice-looking submission can say nothing," he said. "You see a lot of that today."

After quotes are obtained, the risk manager should analyze them and recommend an insurer to his or her company, Mr. Netherton said.

Risk managers have the right to expect the underwriter they choose to understand their corporate philosophy and to communicate market conditions and other information, Mr. Cohen said.

The underwriter is the risk manager's link to developments in the reinsurance market and should keep the risk manager well-informed on those issues, he said.

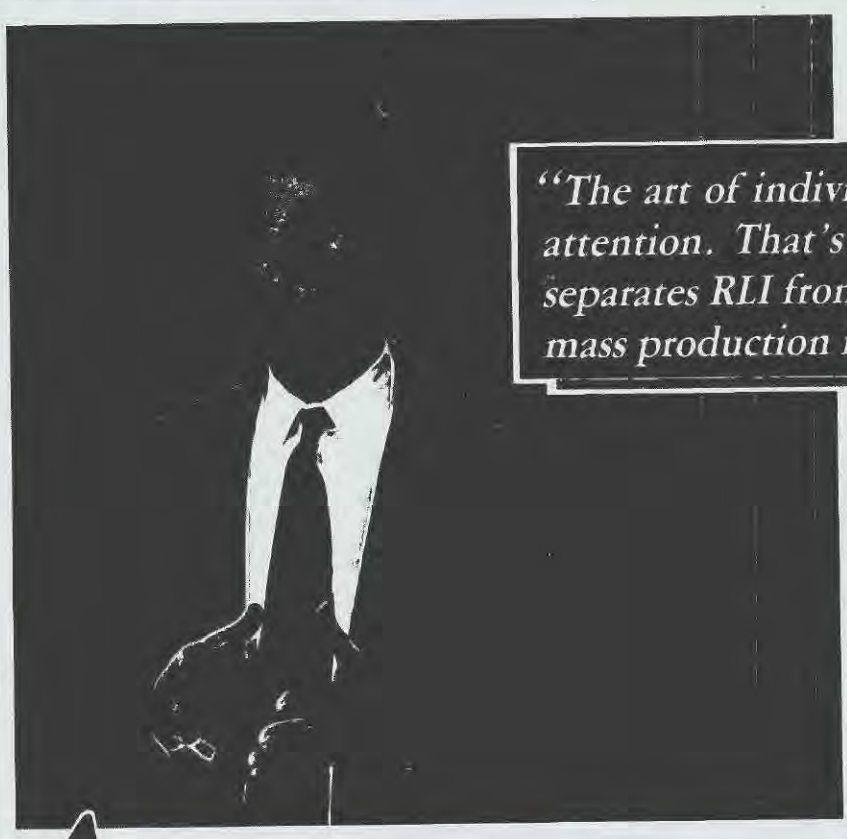
The insurer should communicate clearly, particularly when it comes to numbers, and should be sure to keep the broker apprised of all essential information, Mr. Cohen said.

"The underwriter's role today, I believe, is as a total educator," Mr. Cohen said.

When the selection process is finished, the risk manager should review what he or she has learned and remember those lessons for future renewals, Mr. Netherton said.

Also speaking was Peter J. Greene, regional vp of Genesis Underwriting Management Co. in San Francisco.

Ms. Clausen moderated the session, and Mr. Netherton was the session's coordinator. ■



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Imagining risk manager of the future

Adaptability to change will be necessary attribute, Lichota predicts

By JUDY GREENWALD

NEW ORLEANS—The highly successful risk manager of the future will be skilled at adapting to change in a volatile environment, says a prominent former risk manager.

"The highly successful risk manager will have a major in the art of adapting to change," predicted Edith Lichota, president of consultant Lichota & Associates Inc. in Norwalk, Conn.

Women who juggle home and career, she added, "have already recognized it's a very volatile environment."

As a new profession, risk management has the advantage of putting down roots in a casebook environment. This means recognizing that most questions have more than one correct answer, Ms. Lichota said at the 29th annual Risk & Insurance Management Society conference in New Orleans.

Ms. Lichota last year won the Dorothy and Harry Goodell Award, the highest honor bestowed by RIMS. And, she was named *Business Insurance* Risk Manager of the Year in 1987, when she was senior vp with Irving Trust Co. of New York.

Success at risk management will require recognizing which solution is the most appropriate and the "orchestration of the multilateral implementation that will achieve the defined objective."

Most risk managers of her generation "backed into" the field, she said. Ms. Lichota, for instance, is an attorney who became involved in risk management when her company needed product liability coverage.

As a result, these risk managers brought their own individual and personal orientations to the job. Methods and conclusions were not the same, because they were approached by different routes. Personal attitudes and skills also affected the roles played, said Ms. Lichota.

Today, however, young people can move purposely toward a career in risk management, she said. More than 70 colleges and universities now offer programs in risk management and insurance, including 33 that offer majors.

This, however, represents only a small portion of the nation's schools. For years, risk managers have been encouraging business colleges to include their field as part of the required curriculum, she said.

A position paper from the American Risk & Insurance Assn., which represents university professors, advocated that some form of risk management education be incorporated into the curricula of all accredited business programs. However, the proposal was rejected.

In the schools where these courses already exist, as well as in the ARIA position paper, there seems to be a clear recognition that "risk management is a managerial process" that requires planning and organizing, among other skills, said Ms. Lichota.

She quoted risk management consultant H. Felix Kloman as stating that a new definition of risk management is needed because of all the unprecedented levels of uncertainty that confront businesses today.

Mr. Kloman contends, according to Ms. Lichota, that the next decade's challenge will be in managing organizations so that risk can become an acceptable stimulus rather than an unacceptable threat.

"How do we prepare to deal with the broad spectrum of possible future adversity?" she asked. "Clearly, one measure of excellence will be communication skills.

"Another ingredient will be the ability, the capacity, the willingness and the basic understanding to interface effectively with all of the other corporate disciplines and to recognize both the risk exposures inherent in each and the contribution each can make to the solution of sophisticated exposures to loss," she said.

"Recall that we noted that my generation has tended to achieve success where it was involved in the broad decision-making management functions of our companies without being restricted to a narrow definition of insurance buying and routine funding programs," said Ms. Lichota.

"Personal experience suggests that plain old-fashioned networking will have a major role to play here," said Ms. Lichota. Risk managers should establish their own networks within their firms to keep on top of what is going on, she said.

"The risks of any entity will range across operations, legal, financial and political categories of exposure, and no one person can be experienced in all of them or have immediate personal knowledge of the current activity levels that are going on within the given organization," Ms. Lichota said.

The successful risk manager will have to know more, rather than less, about the maximum number of categories with which an entity is involved, as well as look at risk broadly as it affects the organization, said Ms. Lichota.

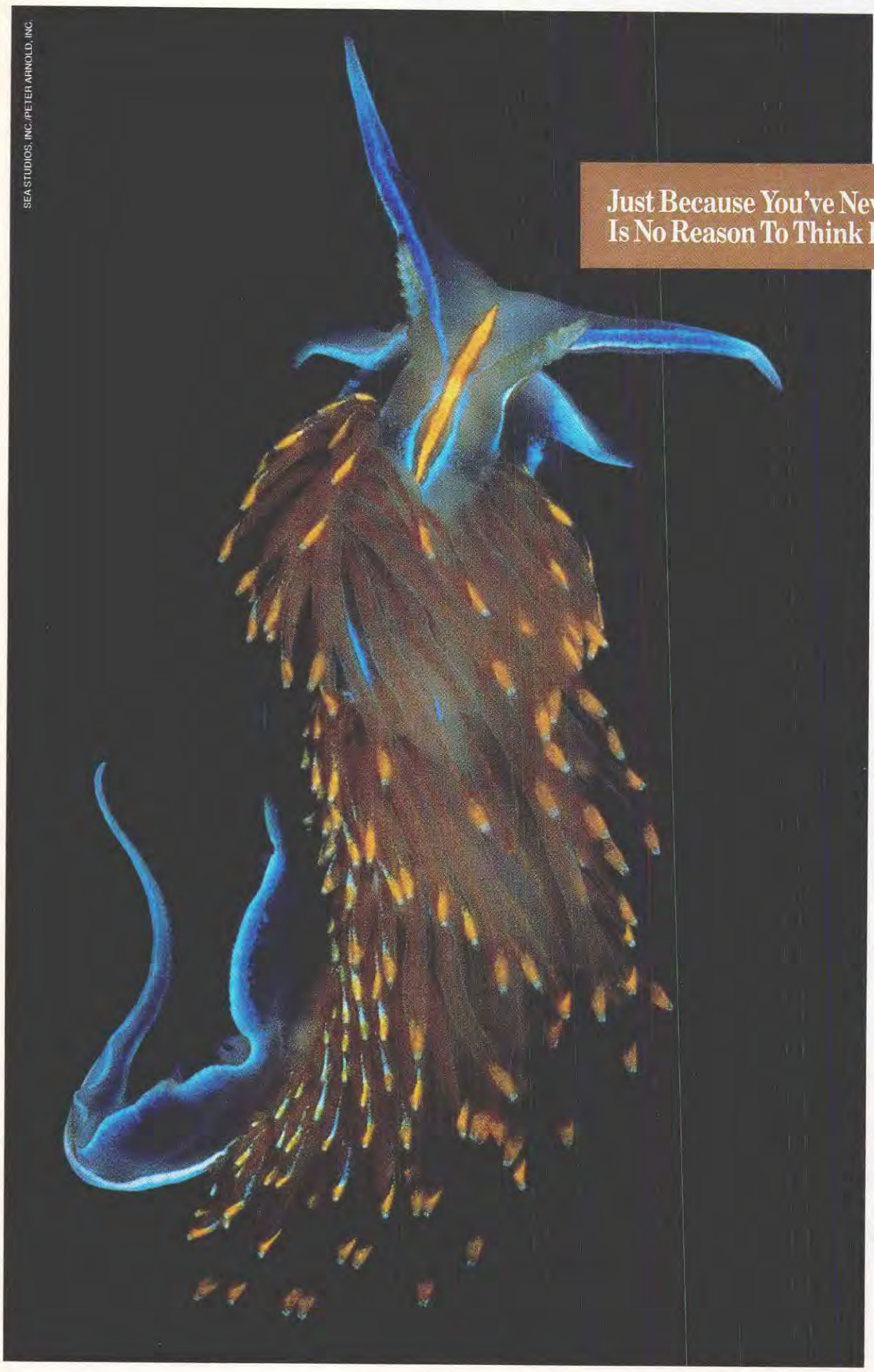
"An essential ingredient of risk management excellence is, and will be, the ability to pull together the various other disciplines which will be necessary to implement a multilateral response to a given problem," Ms. Lichota said.

"The risk manager has to become a little bit of an expert in everything," Ms. Lichota said, combining the expertise of a lawyer, engineer and production line supervisor.

Each problem is likely to require a different team, and the risk manager will have to establish his or her contacts to develop the team before the problem has crystallized sufficiently to know exactly which players will be needed, she said.

"When the successful risk manager has cobbled the pieces and the people together from within and outside of his or her organization to deliver a satisfactory result, the risk management solution will be a

Continued on next page



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Continued from previous page
whole that is greater than the sum of the parts," she said.

"The highly successful risk manager of the coming era will be the one who will have developed the knowledge and relationships to put all the pieces together," said Ms. Lichota.

Also speaking at the session was Thomas V. Irvin, vp-marketing and special risk facilities for CIGNA Property & Casualty Co. of New York.

CIGNA, which coordinated the seminar, distributed to attendees a tape of "A Passion for Excellence, The Leadership Difference," by Tom Peters and Nancy Austin.

Mr. Irvin noted that in some ways, risk management is emerging from the finance department just as accounting emerged from the legal profession.

As an emerging profession, he said, risk management is established in some ways but in others it is not yet fully recognized.

"Risk managers need both specialized knowledge as well as a network of key contacts," said Mr. Irvin, paraphrasing Andrew Carnegie.

A third speaker, Bill Perry, president of Logic Associates Inc., a New York-based personnel recruiting and placement firm, noted that the average middle management executive will change his or her job every 2.8 to 4 years.

In fact, he told the audience, a risk manager will change jobs more frequently than a company changes insurance brokers.

Mr. Perry suggested that to find the right opportunities, risk managers should "figure out what industry groups will be hot."

This will include firms specializing in the environment, the infrastructure and pharmaceuticals, Mr. Perry said.

"Go for the hot industry group," he said. He also recommended that risk managers seek jobs with firms that have international operations and are growth oriented.

Go to work for a company where you will be involved in business operations, he said. "Be a catalyst to make things happen," and find a job where there is the potential to move beyond risk management.

"Don't seek a position in a company where risk management is a distant second cousin," said Mr. Perry.

You don't want to work for a company that only wants a risk manager during a hard market, and not in a soft one, he said.

Seek a position where you can be involved as a catalyst for business operations, where you can make use of your management skills and where there is upward potential, he said.

Develop a franchise, suggested Mr. Perry, recommending that the risk manager become an expert in a particular type of company or business.

Develop your personality, he urged. Mr. Perry said he could send six equally qualified people to interview for a particular position, but the one who gets the job is the one whose personality fits best.

'An essential ingredient of risk management excellence is, and will be, the ability to pull together the various other disciplines which will be necessary to implement a multilateral response to a given problem,' says Edith Lichota.

Client companies that retain Logic's services are looking for leadership, Mr. Perry noted. "You have to want to be be a leader."

Communication skills are important as well, he said. He noted that clients tell him they want good communication skills, both verbal and written.

Mr. Perry also advised risk managers to "accentuate the positive" in communications. If you write well, communicate in writing. If you speak well, hold meetings. And read self-help books to improve yourself.

Salesmanship is necessary, he said. "It's the ability to accomplish what you want accomplished."

Risk managers should also be task oriented, said Mr. Perry. And never forget who is asking you to perform a particular task, he said. If it is the president of the company asking, then just go ahead and do it, he advised.

Effort is important as well, said Mr. Perry. He noted that one job called for hours of 7 a.m. to 7 p.m. Monday through Friday and 9 a.m. to 3 p.m. on Saturdays. "Now isn't that effort?" he asked rhetorically.

In fact, he said, "effort is never confusing time expended with results, and never confuse results with quantifiable results."

And risk managers should see problem delegation as an important task, said Mr. Perry. By delegating, you develop trust and loyalty in your subordinates, said Mr. Perry.

But he cautioned against delegating the superficial. "Delegate the meaningful." And once you delegate a task, do not interfere unless called upon. Delegate the toughest task to your best people "and don't forget to give credit where credit is due."

The session was moderated by Douglas A. Barlow, now retired, who was RIMS president in 1971-1972 and was inducted into the Insurance Hall of Fame last year. ■

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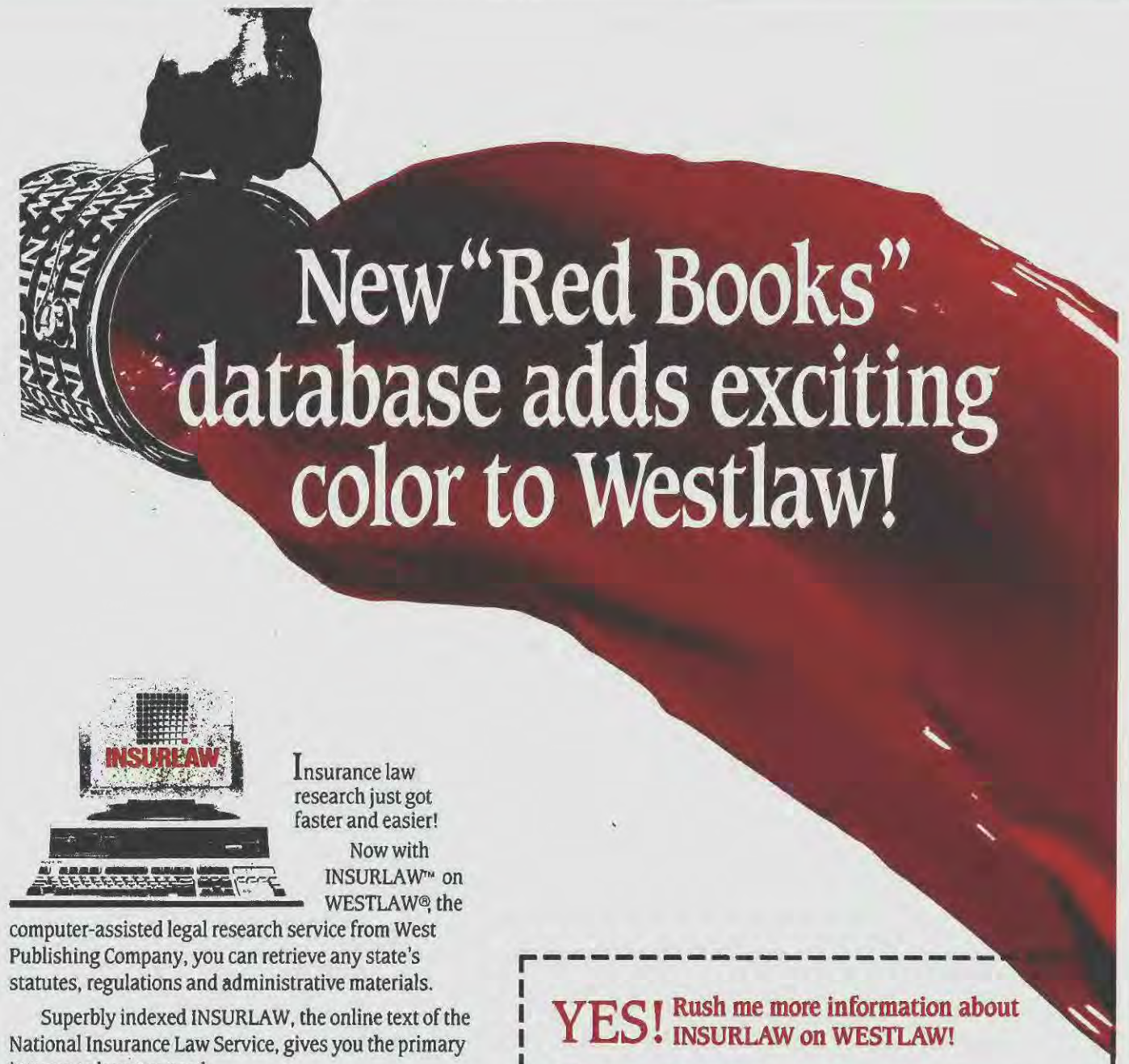
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Federal role inevitable in insurance regulation, says NAIB staff member

By COLLEEN JOHNSON

NEW ORLEANS—Insurer solvency and increased—or at least improved—regulation of the industry are crucial issues now facing legislators, lobbyists and others say.

"Change is in the air" in the insurance industry, noted Barbara S. Haugen, director of federal affairs for the National Assn. of Insurance Brokers in Washington, D.C.

Ms. Haugen was one of several speakers delivering "A 1991 Report on the Government and Insurance" at the 29th annual Risk & Insurance Management Society conference in New Orleans.

Some type of federal insurance regulation appears inevitable and may be in place as early as fall 1992, Ms. Haugen said. Rep. John Dingell, D-Mich., continues to push hard for some type of federal role, she said, noting the powerful congressman's staff recently released a "concept outline" for federal regulation (*BI*, March 25).

The basic premise of the concept outline is that a federal authority would directly regulate the insurance industry "where necessary," Ms. Haugen said, noting that the language of the draft is vague.

One agency being considered as an insurer regulator is the Securities and Exchange Commission, which has experience reviewing financial data on corporations and already is under the oversight of Rep. Dingell as chairman of the House Energy and Commerce Committee, observed Ms. Haugen.

The concept outline also suggests federal regulation and solvency certification of all reinsurers and surplus lines insurers covering risks in the United States, a difficult task, Ms. Haugen said. "I would not be at all surprised to see this initial concept scaled back some," she added.

The issue of whether a sophisticated, commercial buyer might need capacity available only from an unregulated surplus lines insurer should be looked at, Ms. Haugen said.

The paper indicates that insurers could be regulated directly by a federal agency, or through a self-regulatory organization overseen by the federal government, Ms. Haugen said.

And, the paper calls for federal minimum solvency standards for all domestically licensed insurers engaged in interstate commerce, she added.

Noting that the House is farther along than the Senate in its examination of insurance regulation, Ms. Haugen said that congressional interest in the industry is bipartisan.

"I don't think those who oppose federal regulation can stop it," Ms. Haugen said.

Meanwhile, the National Assn. of Insurance Commissioners is pushing states to adopt its model laws on solvency, Ms. Haugen noted. "Virtually everybody in the insurance industry supports efforts by the NAIC to improve solvency regulation."

Recognizing that the "future of state regulation is at stake," state legislators will move quickly to adopt the model laws, Ms. Haugen predicted. But, she added, it's unclear whether they can "move fast enough to satisfy the John Dingells of the world."

Ms. Haugen said she believes states will continue to have a role in regulating insurers, but that their efforts eventually will be overseen by the federal government.

Virginia Insurance Commissioner Steven Foster, who also spoke at the session, noted that "the NAIC has taken a critical look at itself, frankly, in the last four years" in an effort to improve regulation.

"1991 saw an unbelievable amount of action in the state legislatures," he said. At least 40 state legislatures this year have either adopted or are considering insurer solvency legislation.

In addition, the NAIC is making or considering several recommendations that would increase federal involvement in insurer regulation, Mr. Foster noted.

In April, Mr. Foster said, the NAIC proposed that federal criminal penalties be imposed for certain types of insurance fraud, including:

- Knowingly filing fraudulent financial statements with a state insurance regulator.
- Embezzling or stealing insurer funds, premiums or credits.
- Falsifying company records with the intent to defraud the insurer or its policyholders and creditors.
- Criminal obstruction of proceedings before state insurance regulators.

This proposal also would generally prohibit insurance industry involvement by a person convicted of a crime involving dishonesty, breach of trust or any of the offenses described in the proposed law (*BI*, April 22).

The NAIC also is considering recommending to Congress legislation on non-U.S. insurers and reinsurers, Mr. Foster said. Under this proposal, regulators would not grant credit for reinsurance placed with non-U.S. underwriters unless the underwriter was on an NAIC-approved list, he explained.

Also, the NAIC may eventually make a recommendation on whether a federal guaranty fund should be established, Mr. Foster said.

Congress also will continue to look at reforming the McCarran-Ferguson Act, Ms. Haugen predicted. Some trade associations, like the American Insurance Assn. and the American Council of Life Insurance, have indicated they are willing to negotiate on modifying McCarran-Ferguson, she said.

To the trade groups, McCarran-Ferguson is not worth the "public relations nightmare" of the image of an "industry free to collude," Ms. Haugen said. Since reform may be inevitable, members of these groups would like to be involved in the process, she pointed out.

In particular, property/casualty insurers want to retain the ability to collect and share historical loss data, to develop trending and standard policy forms and to participate in pools, Ms. Haugen noted.

Also speaking at the session were Peter A. Lefkin, vp-government and industry affairs in Washington, D.C., for Fireman's Fund Insurance Cos.; and Laurie Londoner, vp-government and industry affairs for Alexander & Alexander Inc. in Washington, D.C.

The session was coordinated by W. Lee Carter III, director of research and development for A&A in Dallas.

The moderator was Myriam Fontaine, director of risk management for The Gap Inc. in San Bruno, Calif. ■

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Heart-smart firms observe Fitness Day

By STACY ADLER

More than 3,000 companies nationwide will celebrate National Employee Health and Fitness Day on Wednesday by holding fitness awareness events for their employees or co-sponsoring events with other employers.

The annual event—sponsored by Allstate Life Insurance Co. and organized by the Assn. for Fitness in Business and the National Assn. of Governors' Councils on Physical Fitness and Sports—is designed to promote exercise and fitness in the workplace.

"Rising health care costs are forcing employers to look at prevention," explained Jim Liston, executive director of the Governors' Councils in Indianapolis.

In fact, the Health Care Financing Administration projects that per capita health care costs will more than double in the United States during the 1990s, making prevention even more important, he said.

Research shows that fitness programs can help prevent illness, which can reduce employers' health care costs and at the same time lower absenteeism and turnover for a company, he said.

Last year, 1,407 companies encouraged their employees to "walk off the job"—or take a lunchtime walk—in recognition of National Employee Health and Fitness Day, which originated in Illinois in 1982.

In addition, many companies offered some unusual fitness activities:

- Motorola Inc. in Chandler, Ariz., held a Fitness Olympics which included three holes of Frisbee golf, a health and fitness quiz, and a golf putting competition.
- U.S. Sprint in Reston, Va., held a "Poker Walk" in which employees were handed a playing card at four checkpoints along a two-mile walking course. The fifth card was dealt as they crossed the finish line. A prize was awarded to the employee with the best poker hand.
- Texaco Chemical Co. in Austin, Texas, held a basketball toss for its employees.

This year, many employers are not only sponsoring health and fitness events at their offices but also are taking a leadership role in hosting communitywide health and fitness activities.

For example, S.C. Johnson & Son Inc. in Racine, Wis., is inviting all companies in Southeastern Wisconsin to participate in a fitness celebration at Racine's Lake Festival Park on May 15.

"This year we decided to take a leadership role and involve the entire community in National Employee Health and Fitness Day," said Cindy Herrbold, fitness program coordinator for Johnson Wax. More than 35 companies are co-sponsoring the event.

Beginning at 4 p.m., there will be a one- to two-mile non-competitive walk/run that will be led by Bill Rodgers, four-time winner of both the New York and Boston marathons.

Later, Mr. Rodgers will conduct fitness clinics during which he will discuss fitness training and how to avoid injuries, changing trends in fitness training and the importance of nutrition.

More than 30 fitness vendors will be on-site to demonstrate fitness equipment and aerobics exercises.

In addition, the sponsoring companies' employees can have their blood pressure tested, their spinal cord checked for alignment or their body fat composition analyzed.

And, there will be live music and "heart healthy" food, Ms. Herrbold said.

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National Employee Health & Fitness Day

Between 3,000 and 4,000 employees are expected to attend the event. "We hope this event will serve as a model for future community-wide events," Ms. Herrbold said.

Another company taking a leadership role in its community is the Lifetime Fitness Center in Pittsburg.

The Fitness Center and the Pittsburgh Community Health Challenge are co-hosting a giant game of aerobic musical chairs on May 15.

Between 16 and 25 local companies and nearly 500 employees are expected to participate in the game, which is being held at noon at the PPG Plaza in downtown Pittsburgh.

"We hope this event alerts companies to the importance of exercise," said Diane E. Barryman, director of the Lifetime Fitness Center.

"This event can get even the most sedentary person active," she said, noting that the mayor of Pittsburgh has recognized May 15 as National Employee Health and Fitness Day.

Northbrook, Ill.-based Allstate also is conducting a wide array of fitness events. More than 1,000 employees are expected to participate in the day-long events.

As Allstate employees arrive for work on May 15, they will receive an apple—Allstate's corporate symbol.

During the morning break, employees can attend a walking clinic at which experts from Rockport Shoe Co. will discuss the benefits of walking.

There also will be fitness stations where employees can check their blood pressure and weight.

And, Sears, Roebuck & Co. of Chicago, Allstate's parent company, will display exercise equipment that employees can try out.

At lunchtime, Rockport will host a one-mile fitness walking test. After employees complete the inside walking course, their pulse and heart rate, among other things, will be measured. These findings, in conjunction with their course completion times, will help determine their fitness levels.

Employees also can take a walk on the one-mile outdoor Fitness Trail. Along the way, there will be a fitness station where employees can check their heart rates.

There will be a healthy meal in the cafeteria or employees can grab a "trail" bag lunch and head outside.

After work, all employees will be invited to participate in a fun run and low-impact aerobic classes.

Allstate also made fitness information available to all of its employees nationwide and all of its agents, a spokeswoman said.

"This year we want the whole company involved in National Employee Health and Fitness Day," she said. ■

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Workers comp

Continued from page 2

islators' Workers Compensation Committee, said that "the article was pretty much on base on a lot of issues, although it was a little unfair on some," particularly plaintiffs' attorneys.

Competing interests have changed the workers comp system from its original intent, the analysis states: a compromise under which "the injured worker agrees not to seek full compensation for lost wages in return for medical and living expenses. The employer overlooks considerations of fault in return for limited liability. Supposedly, a complicated and expensive legal battle is eliminated, creating a no-fault exclusive remedy."

The process was intended to primarily involve the employer and the injured worker, with oversight by a state workers comp board, the analysis notes. But, the no-fault process has become adversarial, in part because of disputes about an employee's degree of impairment and the use of attorneys and doctors on both sides, the analysis says.

And, soaring medical costs have compounded the problem, the analysis maintains.

As a result, employers' workers compensation costs are soaring, while some insurers complain that rising premiums still have not kept pace with costs. Some have even withdrawn from the market for that reason.

Among the competing interests the RIMS team identified and criticized are:

• Employers.

"Until recently, there has been a widespread lack of appreciation for the direct and indirect costs of workers compensation and their impact on productivity and competitiveness," the analysis says.

"Even when a risk manager or safety engineer did manage to show a little interest, operating budgets had no room for safety hardware or training which appeared to get in the way of production goals," the analysis says.

Employers also are faulted for inadequately following up with an employee after an injury, inadequately communicating employee workers comp rights and not supervising claims handlers closely enough.

• Insurers.

Insurers too often want to settle cases to reduce future exposure for medical benefits. Claims also are settled "prematurely and expensively due to threats of bad faith, gross negligence and unfair claims practices," the analysis says.

"All these actions serve to overpay small, questionable claims, underpay serious claims and compound system inequities," it says.

Ideally, insurers should be leaders in loss prevention, the analysis notes. They also should be concerned about cost containment, dispute resolution and claims adjusting while contesting frivolous claims and making only equitable settlements.

• Employees.

The workers comp system can become a "bonanza" for nominally injured workers who may file claims for many unjustified reasons, like revenge, and who take an unnecessarily long time to recuperate.

However, "the seriously injured, relatively well-paid worker does have some legitimate gripes" about trying to exist on benefits that may be only one-half of his former income, the analysis says.

The team recommended a change in attitude on the part of workers and rewriting laws to make benefit delivery more equitable.

The RIMS team also criticized labor unions for too often seeing employers as "the enemy," which encourages injured workers to seek out an attorney.

The analysis says employers and labor unions should share several goals including: improving loss prevention and safety, informing employees of their rights, discouraging fraud and malingering, resolving disputes within the system and encouraging rehabilitation.

"Organized labor does not necessarily view employers as enemies," Mr. Ellenberger said. However, the article "appears to be looking to assess blame rather than seeking constructive solutions."

Mr. Ellenberger emphasized that about 75% of all workers comp claims do not entail disputes and that state workers comp systems function as designed.

Cases that do involve litigation "do not exist in a vacuum" and may stem in part from employers challenging valid claims or delaying paying benefits to force a worker to settle a claim for less than its actual value, he said.

• Doctors.

"Statutory requirements for full coverage of all medical expenses generate little incentive to control costs," which can result in unnecessary or prolonged treatment, the RIMS analysis says.

This problem is compounded by the fact that many providers tend to shift a disproportionate amount of their overhead costs to workers comp cases, which typically are not subject to cost-control measures used in employers' group health care plans, the analysis says.

However, "most disputes arise over differing medical opinions from the supposedly objective employer's doctor and claimant's doctor," the analysis notes.

The medical community "needs to learn more about occupational injuries and their prevention and to work more closely with insurers and employers to overcome their inherent mutual mistrust," the RIMS team urges.

• Attorneys.

The analysis blames attorneys for encouraging worker compensation claim disputes and pitting labor against management.

In addition, lawyers are faulted for enhancing settlement values by threatening bad-faith claims and using political clout to develop laws more favorable to themselves.

As a remedy, the team suggests that legal assistance should be available to a person requesting it, but that person should have to pay for it and the action should not lead to further causes of action or inflated benefits.

Rep. McEwan of Florida, who is a workers comp attorney, criticized the analysis for its strong negative comments about plaintiffs' attorneys without acknowledging problems created by defense attorneys. Workers sometimes need an attorney's help because some employers and insurers "can literally starve claimants into cheap settlements," he said.

• State administrative agencies.

The individual state agencies that administer workers comp programs often suffer from inadequate funding, "bureaucratic impediments and inefficiencies" as well as political meddling, the analysis says. Many also suffer from the fact that administrative decisions are appealable to the courts.

The section of the analysis on state administrators was "a little weak" and could benefit from input from state administrators, said Allyn Tatum, commissioner with the Arkansas Workers Compensation Commission and president-elect of the International Assn. of Industrial Accidents Boards & Commissions.

The IAIABC has approached RIMS about establishing a liaison relationship to help develop workable solutions to such problems, he said. The problem of developing solutions is compounded by inadequate data, but the IAIABC plans to hire a full-time staff person to work on improving state data collection efforts, he said.

• State legislatures.

"The tendency in reform efforts is to attack symptoms, such as escalating premiums, rather than well-documented underlying causes," the analysis charges. That approach may stem from the fact that many legislators have only a cursory understanding of the issues, the analysis says.

While legislators do seek outside help, the presence of too many competing interest groups and constituents bogs down efforts to achieve a balance among them and often results in reforms that exacerbate problems, the analysis says. And, even when reforms do work, "the workers compensation beast is always evolving" and what worked yesterday may not help today, it adds.

Mr. Carter said he is pessimistic about solving workers comp system problems soon but that he is optimistic long-range solutions will be found because the problem has generated much support for developing workable solutions.

Other members of the RIMS workers compensation team are: Woodrow B. Anderson, director-risk management for KPMG Peat Marwick in Montvale, N.J.; Thomas A. Duffield, vp-risk management and insurance at Archer Daniels Midland Co. in Decatur, Ill.; Clark A. Fenn, director of risk management at Holyoke Hospital Inc. in Holyoke, Mass.; Stanley S. Henslee, vp-risk management at Ryan-Walsh Inc. in Mobile, Ala.; A. Herbert Johnson, director of risk management at Michigan Consolidated Gas Co. in Detroit; W. Michael McDonald, director of risk management at Ryder System Inc. in Miami; Fred B. Molineux, director of corporate insurance at Johnson & Johnson in New Brunswick, N.J.; and Carl Seaholm, risk finance manager at J.C. Penney Co. in Pittsburgh. ■

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Rockefeller calls for reform based on Pepper panel recommendation

By ADRIENNE C. LOCKE

WASHINGTON—Congress must reform—not replace—the U.S. health care system because uninsured Americans cannot afford to wait for Congress and the president to hammer out a national single-payer system, says Sen. John D. Rockefeller IV, D-W.Va.

"We have a president who will veto national health care. We cannot wait for Congress and the White House to come to a meeting of the minds over a national health system" while millions of uninsured Americans are held hostage to the problems of the existing system, said Sen. Rockefeller, who headed the Pepper Commission until it was disbanded last year.

"We are still arguing over the shape that health care reforms should take," he said. "I don't want to wait" any longer than we have to, he testified during House Ways and Means Committee hearings last month.

Other members of Congress who favor a national single-payer health care system criticized Sen. Rockefeller's approach during the hearings.

Sen. Rockefeller says the proposals advanced by the Pepper Commission are 'doable.'

The three-day hearings focused on the pros and cons of several reform bills pending in Congress and reform proposals developed by independent groups designed to improve health care access and affordability for the 31 million to 35 million uninsured Americans—many of whom are employed.

Sen. Rockefeller described as "doable" proposals made last year by the U.S. Bipartisan Commission on Comprehensive Health Care—known as the Pepper Commission.

Under those proposals, employers with more than 100 employees would be required to provide a federally-specified minimum health care benefits package or pay a new payroll tax to fund a public program to provide coverage to the uninsured.

Employers with 100 or fewer employees would have up to five years to provide this coverage to their workers (*BI*, March 12, 1990; March 5, 1990).

The commission rejected a federally funded single-payer system—even though such a system was favored by several members—because it was considered "neither fiscally sound nor politically pragmatic," he said.

"Our commission concluded that to achieve universal health care coverage in anything like the immediate future, we can neither patch nor replace current coverage. Rather, we must secure and extend the combination of job-based and public coverage we now have," he said.

"We think that putting together private and public coverage will be difficult, but I think it can be done," he said.

And, if the recommendations of the Pepper Commission are enacted, "no one single man, woman or child in the country" would be without health care coverage, Sen. Rockefeller said.

Rep. Henry A. Waxman, D-Calif., a member of the Pepper Commission, said he also favors this approach because it offers the least amount of disruption to the

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Health care reform

Continued from previous page
existing health care system.

"It maintains the system under which most employed people and their dependents are now covered, preserves a role for private insurance and requires less direct public expenditures," he said.

Rep. Waxman said that insurance reforms alone, like those proposed by the Health Insurance Assn. of America and the Blue Cross/Blue Shield Assn., will not resolve the problems within the health care system.

The HIAA and BC/BS have proposed, among other things, guaranteeing that small employer groups could not be denied health insurance due to bad claims experience. But they do not propose requiring all employers to provide health care coverage to their workers (*BI*, March 11).

"Let's not kid ourselves. If we eliminate medical underwriting in private insurance and require community rating of policies, and we do not set standards for basic benefits or require employers to provide coverage, the result—I fear—will be more uninsured persons," Rep. Waxman said.

He also told the committee that he will be introducing this month his own health care reform bill that will include many of the Pepper Commission's recommendations.

Rep. Don J. Pease, D-Ohio, said that while he believes the nation will move toward a national, single-payer system by the end of the decade, Congress should not wait eight or nine years for that system to come about.

"The Pepper Commission proposal is a reasonable solution in the meantime," he said.

Rep. Sam M. Gibbons, D-Fla., expressed his concern about how small employers would survive under the Pepper Commission proposal. It's "one of the things that worries me about the proposal," he said.

Rep. Jim McDermott, D-Wash., pointed out that small employers that do not now offer health plans would be required to do so under the Pepper Commission proposal. "I think that there are legitimately some businesses that can't afford this," he said. "It's going to cost jobs."

Sen. Rockefeller disagreed. "We will bend over backwards to make this affordable for small employers," he said. And reforms proposed by the commission would help hold down the cost of health insurance.

He added that the commission plan would give employers five years to offer health insurance plans.

"If you had a bill that says 'pay or play' right now, it would cost jobs, but the the Pepper Commission proposal doesn't say that," Sen. Rockefeller said.

In contrast, under a national single-payer system, small employers would be "loaded up" with taxes to help cover the cost of national health insurance, he said.

Rep. Bill Archer, R-Texas, asked Sen. Rockefeller which taxes he would raise to help finance the proposals recommend by the Pepper Commission, but Sen. Rockefeller said he would leave that matter to the Ways and Means Committee. He did note, however, that the commission offered six revenue-raising options.

In addition, he said any new or increased taxes should be "spread across the board and progressive so that you don't have to keep coming back for more."

Pepper Commission proposals were also criticized by those who thought they didn't go far enough.

Rep. Martin A. Russo, D-Ill.—who favors a national single-payer system—said that only a national system can provide quality health care to all Americans without increasing the amount spent nationally on health care.

Incremental reforms, like those the commission favors, cost money, he argued. And the longer it takes to make changes to the system, the harder it will be to enact truly needed reforms, he said.

Pepper Commission member Rep. Fortney (Pete) Stark, D-Calif., also supports a national single-payer system. "Unfortunately, other approaches—including the employment-based approach recommended by the Pepper Commission—would not be truly comprehensive," he said.

Rep. Martin A. Russo, D-Ill., admits he has little faith in commercial health insurers. 'I would like to believe that the private system can do it, and they have had all these years to do it, and that's why we are in the soup that we're in.'

Both Reps. Russo and Stark introduced legislation earlier this year that would establish a national single-payer health care system (*BI*, March 18, Feb. 4).

"I'm tired of hearing how a national single-payer system is the best system but it can't be done," Rep. Russo said.

Thomas J. Downey, D-N.Y., who is a co-sponsor of the Russo bill, acknowledged that while slow change may not be preferable for some legislators, there may be no other path to health care reform.

There must be a "far better approach to dealing with the problem than an incremental approach, although the political climate might require it," he said.

But, Rep. Nancy L. Johnson, R-Conn., criticized the Russo bill for proposing a system that would cost more money than the federal government has to spend, while creating no disincentives for over-utilization of health care.

Advocating a single-payer health care system assumes that the federal government is better at providing and managing health care than private insurers, she said.

Rep. Russo countered that he admits he has little faith in commercial insurers. "I would like to believe that the private system can do it, and they have had all these years to do it, and that's why we are in the soup that we're in," Rep. Russo said.

Despite the lack of agreement on how to reform the health care system, legislators say they recognize that the reform process must begin as quickly as possible.

"I think this is our last shot to reform health insurance at an affordable cost. And if that doesn't work, then we will have national health insurance," Sen. Rockefeller said.

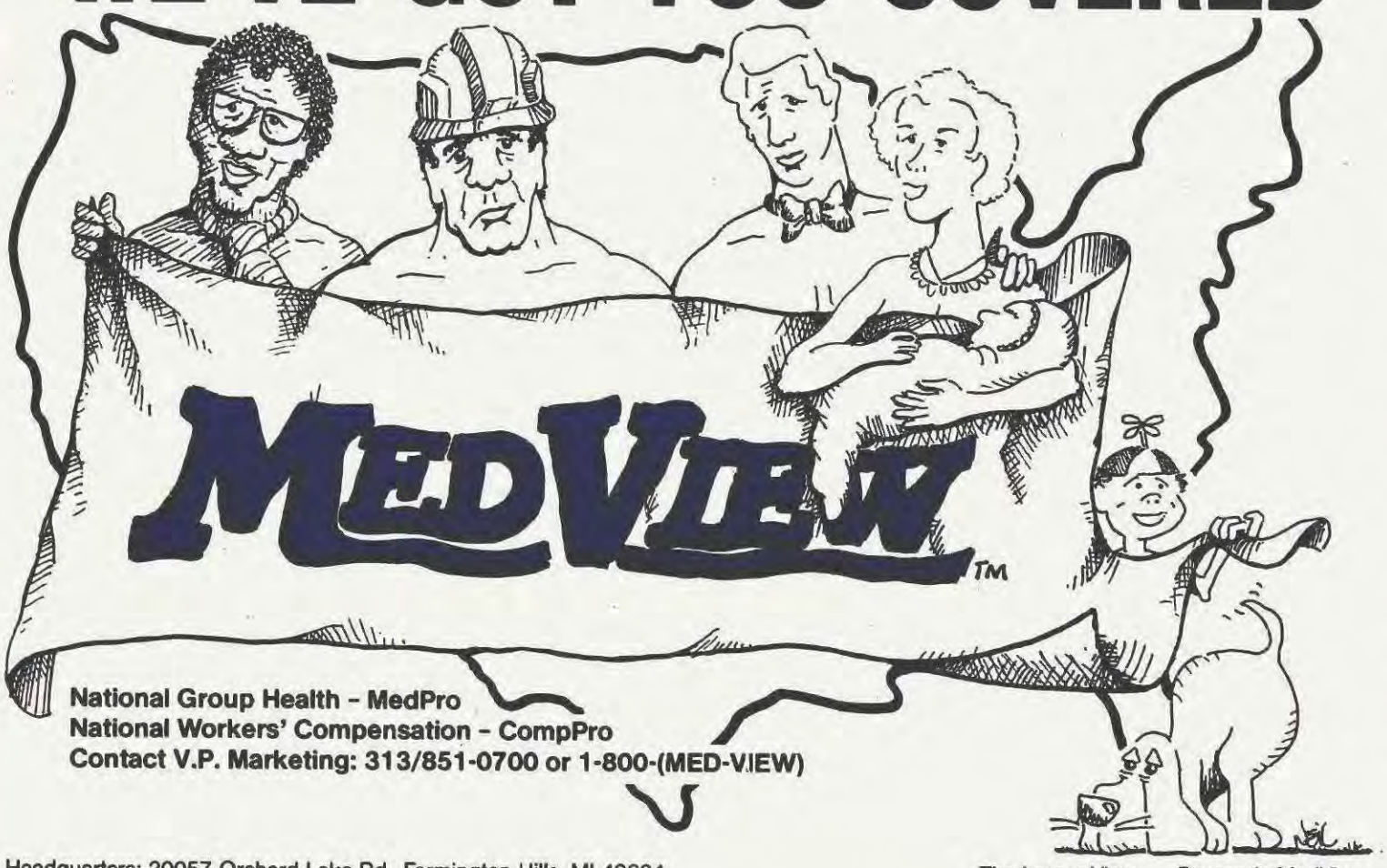
"We must begin the process to develop a clear consensus on strategies for reform," said Rep. Mary Rose Oakar, D-Ohio.

"We need to act now. We cannot in good conscience allow a single year to pass without putting in place those things we know will honestly reduce cost and increase access," Rep. Johnson said. "If we don't control costs, it doesn't matter what we do about access, no one will be able to afford health insurance."

"Despite the strengths of our system, we have been unable to assure that all Americans have timely or affordable access to the benefits of our health delivery system," Rep. Waxman said.

"For these Americans, access to health care means postponing routine care for themselves and their children and, in the end, seeking out urgent care in the crowded and expensive hospital emergency rooms," he said. ■

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'Quick fixes' opposed

Labor seeks comprehensive health reform

By ADRIENNE C. LOCKE

WASHINGTON—The so-called "incremental steps" that employers and health care insurers are asking Congress to take to reform the nation's health care system are too little and too late, charges a prominent labor leader.

"We are long past the stage of quick fixes. Nothing short of comprehensive reform will solve this problem," testified Lane Kirkland, president of the AFL-CIO, during House Ways and Means Committee hearings last month on long-term strategies for health care.

Ultimately, the AFL-CIO wants a national health care system patterned after Canada's. But the group is willing to support changes in the employment-based health care system that immediately address the issues of accessibility and affordability for the uninsured.

Urging Congress to put health care reform on the "fast track," Mr. Kirkland said, "There is not an issue that is more urgent or pressing in our society."

The AFL-CIO announced its own proposal for health care reform earlier this year (*BI*, Feb. 25).

Under this plan, employers would be required to offer a minimum benefits package equivalent to the benefits provided under Medicare Part A. Catastrophic coverage also should be provided, he said.

Any other benefits that employees might seek could then be negotiated during collective bargaining, he said.

In addition, the plan calls for:

- A cap on national health care spending.
- Guaranteed access to health care by establishing a national health insurance program for the currently uninsured.

Workers, unemployed people and others not in the labor force would be included and the program would incorporate Medicare and Medicaid.

- Reducing the Medicare eligibility age to 60 from age 65.

Mr. Kirkland compared the need for such radical change in the health care system to the underlying reasons for creating Social Security in the 1930s.

With Social Security, "we were lucky that we were able to translate human cost into monetary cost. And, it did not destroy society—it enhanced it," he said.

"That's what I think must be done today" in the area of health care, he said.

Rep. Bryon L. Dorgan, D-N.D., said the government needs time to resolve a complicated and costly issue like health care reform.

"The answer is not simple, it's not obvious and it is expensive. And we are being asked to answer that question at a time when the country cannot afford to," Rep. Dorgan said.

Fiscal constraints should not be a deterrent, argued Mr. Kirkland. Past administrations, he said, have not let enormous costs stand in the way of programs to benefit the nation as a whole.

"When (President) Kennedy said he wanted to put a man on the moon, he did not say, 'I want to put a man on the moon provided that it is budget neutral,' " Mr. Kirkland said. "This is a far more urgent matter than putting a man on the moon, and the failure to do anything about it is contributing to the problem."

Incremental change did have its defenders. Business groups testified that drastic changes are unnecessary until other alternatives aimed at providing affordable health care coverage can be tried and tested.

"From our standpoint, an incremental approach is far more acceptable," said John J. Motley, vp-federal government relations at the National Federation of Independent Business in Washington, D.C.

Referring to the factors leading to unaffordable health care, Mr. Motley said: "These changes didn't happen overnight. They will take time to resolve."

"We urge you to stay with the multipayer system to find your solutions," said Robert E. Patricelli, vp of utilization review firm Value Health Inc. in Avon, Conn., who testified on behalf of the U.S. Chamber of Commerce.

The "success story" of the employment-based health care system has begun to sour because the cost of health care benefits is quickly rising, Powell Woods, vp of human resources at Nestle U.S.A. Inc. of Glendale, Calif., testified on behalf of the National Assn. of Manufacturers.

With Social Security, 'we were lucky that we were able to translate human cost into monetary cost. And, it did not destroy society—it enhanced it,' Mr. Kirkland says. 'That's what I think must be done today' in the area of health care.

Mr. Woods said that the driving force behind spiraling health care costs "is a perverse reimbursement system that rewards (health care providers) for waste and punishes for good management."

"Those who are rewarded by this system are those who provide the most services," he said.

Several things can be done to improve the current health care system without scrapping it, he said. Those include:

- Eliminating state requirements that insured health care plans provide a minimum level of benefits.
- Enacting medical malpractice liability reforms.
- Expanding Medicaid to all adults and children living at or below the federal poverty level.

Congress must begin reforming the health care system now but "carefully and cautiously" with "measured steps," said John H. Church, chairman of the National Assn. of Wholesaler-Distributors in Washington, D.C.

"Any attempts to change health care in America as we know it in one fell swoop may put at risk the very best that our system has to offer," Mr. Church said.

Mr. Patricelli, speaking on behalf of the Chamber of Commerce, agreed.

The multifaceted problems the health care system faces, "as well as the political and budgetary dynamics of the debate, suggest an incremental approach" to reform, he said.

"Let's become aggressive incrementalists before jumping into the chilly waters of federal regulations whose depths we can only suspect," Mr. Patricelli said.

Bernard R. Tresnowski, president of the Blue Cross & Blue Shield Assn. in Chicago, urged the committee not to consider the problem of uninsured "an indictment" of the private system of health care financing.

That system "is meeting the health care financing need of the overwhelming majority of Americans," he said.

The private insurance industry is also working to develop programs to ease the problem of the uninsured, he said.

Mr. Tresnowski said BC/BS is ready and willing to work with the federal government in developing "well-planned and coordinated steps" that will help to ensure access to health care while controlling increases in health care costs.

"Developing a proposal that would meet the needs of the market while at the same time making it possible for traditional providers of coverage to continue to participate in that market was difficult—but not impossible," said Carl J. Schramm, president at Health Insurance Assn. of America in Washington, D.C.

However, only through a combination of efforts between the public and private sectors can health care costs be stabilized now and access improved in the future, he said.

Earlier this year, BC/BS and the HIAA released similar proposals to reform the small employer group insurance market (*BI*, March 11).

These plans call for:

- Guaranteeing that health insurance not be denied to small employers based on the group's experience.
- Guaranteeing that once the coverage is written, an insurer could not cancel it because of poor claims experience.
- Barring denial of coverage or imposing coverage restrictions for pre-existing conditions on a small employer that changes coverage or on an individual who changes jobs.
- Limiting how much insurers can increase premiums on renewal.

Both employers and insurers agree that managed care is an important part of bringing health care costs under control.

However, Rep. Sam M. Gibbons, D-Fla., expressed concerns that managed care techniques serve, in reality, to ration health care.

Mr. Woods of NAM disagreed. Managed care enhances quality by trying to eliminate unnecessary procedures, he said.

Managed care is a cost containment strategy that is still relatively new, he noted. "All of us need to bring this new technique to fruition," he said.

Before judgment is passed, managed care deserves a thorough test in the public and private sectors, he said.

"I believe that we ought to let this work, and it will work. I don't know if it will take five years, but I do know that it will take more than one," he said.

Mr. Patricelli also said managed care must be given time to work.

If after four or five more years incremental changes—like reforming the small employer group health insurance market and implementing managed care programs—do little to control health care costs and assure access, "then we might have to move to more draconian measures," Mr. Patricelli said.

"But, I'm not prepared to say at this time that these things won't work," he said. ■

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Democrats criticize Bush administration on health care stance

By ADRIENNE C. LOCKE

WASHINGTON—Democratic congressmen are criticizing the Bush administration for failing to take a leadership role in reforming the nation's health care system.

But, the administration is waiting until it has developed a workable proposal before announcing it, an administration official contends.

Democratic leaders told the House Ways and Means Committee during hearings last month that no health care reform bill will be approved by the Congress without the president's support.

"I've been on this committee too long to know that Congress can't do it alone," said Ways and Means Committee Chairman Dan Rostenkowski, D-Ill.

Rep. Rostenkowski said he was "a little disappointed" that the president had not developed a health care reform proposal.

And, while not proposing a plan of his own, President Bush has criticized many other plans that have been proposed, Rep. Rostenkowski charged.

The administration "has told us what they are against—we hope that they will soon tell us what they are for," he said.

"With the president threatening to veto any program that (increases) revenues, he can subvert us and keep us from having a plan put forth," said Rep. Fortney (Pete) Stark, D-Calif.

Rep. Stark earlier this year introduced legislation, H.R. 65, that would require employers to pay a payroll tax of up to $800 per worker to fund a universal health care plan (*BI*, Feb. 4).

The basic benefits called for in Rep. Stark's bill would be similar to those provided by Medicare. But, employers that currently offer more than the minimum benefits outlined in the bill would be required to continue to offer those benefits.

Sen. John D. Rockefeller IV, D-W.Va., said that President Bush "made every effort possible to undermine" the Pepper Commission and its attempts to gain support for its proposal.

Under the Pepper Commission proposal, employers with more than 100 employees would be required to provide workers with a federally-specified minimum health benefits package or be subject to a new payroll tax to fund a public program to provide coverage to the uninsured.

Employers with 100 or fewer employees would have up to five years to provide coverage to their workers (*BI*, March 12, 1990; March 5, 1990).

Sen. Rockefeller believes the administration did not want to debate the issue of health care reform until after last November's election.

However, "the elections are over, and I pray that the president gets on board," he said.

Health care reform will be the issue of the 1990s "and the next 10 years after," he said.

But, other Democrats are challenging the Democratic majority in the House and Senate to approve a health care reform proposal—with or without the president's backing.

"I think that the Democrats are making a big mistake in saying that we can't do national health care because the president is not a willing participant," said Rep. Marty Russo, D-Ill. "How do we know if we won't try?"

Rep. Russo has introduced legislation, H.R. 1300, that calls for imposing a payroll tax and increasing corporate and personal income taxes to finance a national, single-payer health care system much like Canada's that would be jointly administered be the federal government and the states (*BI*, March 18).

Rep. Russo welcomed a showdown on health care reform and urged Congress to approve a national, single-payer system.

If the president vetos such legislation, then "let him explain why he's not for quality, national health care," Rep. Russo said.

However, Sen. Rockefeller—who believes Congress will not approve a single-payer system—said a "political" battle over health care reform would waste time that the nation's uninsured population cannot afford to waste.

A Bush administration official, though, told the committee that the president is not delaying giving his support to a health care reform proposal, but only wants to have a workable proposal formulated before announcing it.

"We want to develop a program that will suit the needs of our people and that will be around for a long time," said Health and Human Services Secretary Dr. Louis W. Sullivan.

Dr. Sullivan rebutted charges of a lack of leadership from the Health and Human Services Department in the health care reform debate.

"While many reform schemes have been offered, I am convinced that there are currently no comprehensive reform plans that represent a clear improvement over the current system," he said.

"We share with you your sense of urgency. But we need to develop answers that make programmatic sense and would enjoy bipartisan support," he said.

The Bush administration did not want to be premature in proposing a plan that was not well-thought-out and, thus, end up with another unworkable plan, like the Medicare Catastrophic Act, plan, Dr. Sullivan said.

Congress in late 1989 quelled a political firestorm by repealing the 1988 expansion of the Medicare system, which imposed a highly unpopular surtax on middle- and upper-income retirees to help finance increased catastrophic health care benefits (*BI*, Nov. 27, 1989).

But, while the Bush administration may not be ready to announce a health care reform plan, it is looking into some initiatives for improving health care access and affordability, he said.

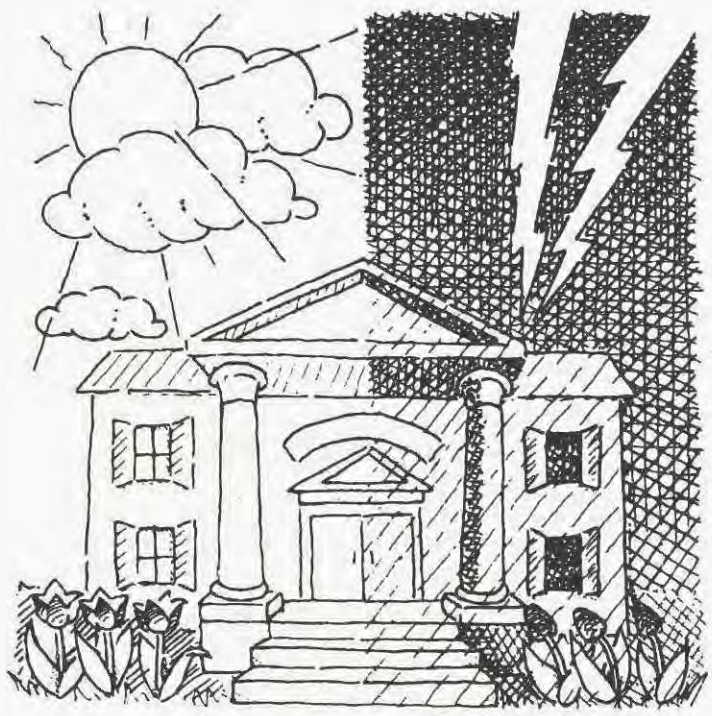
For example, the administration is considering limiting the amount of tax-free coverage that employers could provide to workers. The resulting increased tax revenues then could be used to provide tax credits to the uninsured, he said.

Dr. Sullivan also said that individuals have to take more responsibility for their own well-being and live healthier lifestyles.

It is often forgotten that "personal behavior is inextricably linked to the prevention of illness and disability," he said.

"Government cannot snatch the wine glass out of the hand of the pregnant woman; government cannot fasten your seat belt; and government cannot push you off the couch and out to exercise," he said.

But, Rep. Stark said that President Bush at some point will have to show leadership on the issue of health care reform. ■



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House panel approves bill that would curb RICO use

By ADRIENNE C. LOCKE

Washington

WASHINGTON—Legislation passed by a House Judiciary subcommittee earlier this month would make bringing civil charges under the Racketeer Influenced and Corrupt Organizations act more difficult.

The bill, H.R. 1717, introduced by Rep. William J. Hughes, D-N.J., was unanimously approved by the Intellectual Property and Judicial Administration Subcommittee.

The bill would tighten the "patterns of racketeering" standards for determining whether a suit can be heard under RICO. Federal judges would act as "gatekeepers," deciding which cases meet the more stringent standards.

In addition, the bill would heighten the standard of proof that a successful plaintiff must present during trial to "clear and convincing proof" from "a preponderance of evidence."

And under the Hughes bill, which would apply only to new cases, RICO suits could be brought only in federal court. Plaintiffs would still be able to seek treble damages.

"By tightening up the essential elements of civil RICO, we can preserve it as an effective law enforcement tool without the unwanted excess baggage of ever-increasing commercial litigation," Rep. Hughes said when he introduced the bill last month.

The proposal is almost identical to legislation Rep. Hughes introduced last session. That measure was approved by the full Judiciary Committee in September but never reached the House floor (*BI*, Sept. 24, 1990).

Rep. Hughes said the law must be reformed in light of U.S. Supreme Court rulings questioning the constitutionality of suing under RICO for actions not traditionally considered racketeering.

"We are well-advised to heed the Supreme Court's warnings and reform this law before we risk losing it entirely," he said.

The National Assn. of Insurance Commissioners disagrees.

A provision of the Hughes bill that any RICO action must "clearly serve the public interest and provide appropriate deterrence against the repetition of egregious criminal conduct" is too vague for consistent application in court, James Long, the group's president, said at a subcommittee hearing on the legislation last month.

Interpreting this provision "will require years of litigation and enormous legal costs, imposing practical barriers to the bringing of civil RICO suits," said Mr. Long, who is also North Carolina commissioner.

In addition, requiring gatekeepers to limit RICO actions to "major" participants in the criminal conduct that were responsible for the plaintiff's injury would create battles over who are major and minor participants in the alleged crime, he said.

And, raising the current standard of proof from "a preponderance of evidence" to a level "just shy" of the standards for criminal cases would only deter state insurance regulators from bringing meritorious claims, he said.

H.R. 1717 is now available for a vote by the full Judiciary Committee.

Model pension plan

The Department of Labor is proposing a program to encourage small employers to establish pension plans.

The Pension Opportunities for Workers' Expanded Retirement package would establish a model simplified pension program for employers that do not now have a plan and that have 100 or fewer workers, the department said.

Participating employers would be exempt from non-discrimination testing if they contribute at least 2% of pay to the plan for all employees. Employees would be able to contribute up to $4,200 on a pretax basis to the plan, while the employer could make a matching contribution of up to 50%.

To encourage rollovers of lump sum distributions, the model plan would give employees in defined contribution and defined benefit plans the option of having those distributions transferred directly into an individual retirement account or to a new employer's pension plan, if the new company accepts the distribution.

The POWER proposal also would: discourage preretirement distribution by eliminating the favorable tax treatment of five- and 10-year forward averaging for lump sum distributions; shorten to five from 10 years the vesting schedule for multiemployer plans, which cover about 8 million workers; and allow tax-exempt organizations and state and local governments to establish 401(k) plans.

BIC pass-through cover

The Bush administration's banking reform plan would eliminate "pass-through" Federal Deposit Insurance Corp. coverage only for certain types of bank investment contracts purchased by pension plans, says a Treasury Department official.

Each BIC beneficiary now has up to $100,000 of federal deposit insurance. BICs, which often are offered as an investment option in 401(k) plans, can cover many beneficiaries.

Under the administration's plan, the coverage would be eliminated for "window" contracts—which allow contributions over a certain time period, said Assistant Treasury Secretary Jerome H. Powell in testimony before the House Education and Labor Committee.

But there would be pass-through coverage for "bullet" contracts, which require contributions by a specific date, Mr. Powell said.

Life insurers, whose guaranteed investment contracts compete with the bank contracts, criticized the proposed definition of "bullet" BICs as too narrow. Unless it is "strengthened" to exclude more contracts, the proposal would "have a negligible effect on reducing Federal Deposit Insurance Corp. liability," charged Gary Hughes, a general counsel at the American Council of Life Insurance in Washington, D.C.

Since the administration's bank reform plan was announced in February, there had been some confusion about whether all BICs would lose the federal coverage (*BI*, March 25; Feb. 25).

UST violations alleged

The Justice Department and the Environmental Protection Agency have filed the first civil suit for violations under the underground storage tank provision of the Resource Conservation and Recovery Act.

Ownbey Enterprises Inc. of Dalton, Ga., was charged last month with failure to take corrective actions to address groundwater and soil contamination resulting from leaking underground storage tanks.

The EPA sought to pursue court action with Ownbey because the "case could not be resolved by other means available to us," said an EPA spokeswoman in Atlanta.

According the the suit, which was filed in U.S. District Court in Georgia, Ownbey failed to comply with an EPA administrative consent order agreed to by the company on Feb. 15. 1989. Under that order, Ownbey had agreed to provide a permanent water supply to users of a drinking water well that had been contaminated by petroleum leaking from the company's underground tanks.

In addition, the suit alleges that Ownbey did not carry out its own plan to clean up the groundwater contamination, which was also part of the administrative consent order.

The EPA and the Justice Department are asking the court to force Ownbey to comply with the consent order and to impose civil penalties against the company for failure to comply with the order of up to $25,000 a day for each day of violation after July 20, 1990. ■

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Chicago Board of Trade

Warsaw Pact cap nullified in KAL crash

Court rules airline guilty of willful misconduct in '83 disaster

By JUDY GREENWALD

WASHINGTON—The families of 107 passengers killed when a Korean Air Lines flight was shot down by Soviet fighter jets may seek more than $75,000 each in damages from the airline, a federal appellate court panel has ruled.

But the District of Columbia Circuit Court overturned a jury verdict that Korean Air Lines must pay $50 million of punitive damages, (*BI*, Aug. 7, 1989; Nov. 21, 1988).

KAL attorney George N. Tompkins Jr. of Condon & Forsyth in New York said the airline plans to appeal the ruling.

However, it has not decided whether to first seek a rehearing before the full appellate panel, or to seek review directly from the U.S. Supreme Court, Mr. Tompkins said.

The 137 plaintiffs also may decide to ask the Supreme Court to review the appellate panel's decision to overturn the $50 million punitive damages award, said plaintiffs' attorney Milton G. Sincoff of Kreindler & Kreindler in New York.

The litigation centers on the loss of KAL Flight 007, which Soviet fighter jets shot down in 1983 after the aircraft strayed into Soviet air space. All 269 passengers were killed. The airline already has settled with the families of 162 passengers.

The appellate court panel last week affirmed a jury's finding that KAL was guilty of willful misconduct in connection with the incident. As a result, the court ruled, the families can seek more than $75,000 in compensatory damages under the Warsaw Convention as amended by the Montreal Agreement.

'The whole thing is a disgrace,' Mr. Tompkins asserts, criticizing the ruling that the ICAO report is admissible. 'This was a political report' written in an attempt to cool tensions between the United States and the Soviet Union, he charges.

The convention limits airlines' compensatory liability for accidents on international flights to $75,000 per passenger, unless willful misconduct can be proven. Damages are not capped in cases of willful misconduct.

The court ruled 3-0 that a reasonable jury could find evidence of willful misconduct.

"Admittedly, plaintiffs' case at trial did not include any 'smoking guns,' but that is because no one knows exactly what happened," the court said.

However, the court adds: "There was sufficient evidence here from which to decipher a pattern of conduct giving rise to liability."

There is, "albeit not uncontroverted," evidence that the plane's computer may have been incorrectly programmed, causing the plane to go off course into Soviet air space, the court said.

The court refused KAL's request that evidence presented to the jury be ruled inadmissible.

The court said that although KAL "raised some valid concerns about the quality of the evidence submitted to the jury," that evidence was nonetheless appropriately admitted.

The evidence included a report by the International Civil Aviation Organization that tentatively concluded the crash was caused by a programming error.

The ICAO report included an official Soviet version of the incident as an appendage.

"Standing alone, we doubt that the Soviet report would have been admissible," the court said. But, its inclusion as an appendix to the ICAO report does not make that report inadmissible, the court explained.

"The whole thing is a disgrace," Mr. Tompkins asserted. He criticized the appellate court's ruling that the ICAO report is admissible, as well as the testimony of two experts who ruled on the report's findings.

"This was a political report" written in an attempt to cool tensions between the United States and the Soviet Union, not an investigative report, he charged.

In addition, the Soviet report is not just appended to the report but rather is an integral part of the entire report and is untrustworthy, Mr. Tompkins said.

"This is a bum rap, and the evidence should never have gone in," he said.

In ruling 2-1 to overturn the punitive damages award, the court referred to a similar ruling by a three-judge panel of the 2nd U.S. Circuit Court of Appeals. That ruling was in connection with the December 1988 explosion of a Pan American World Airways Boeing 747 over Lockerbie, Scotland, which killed 270 people (*BI*, April 1).

While the plaintiffs were pleased with the finding of willful misconduct, they were "naturally disappointed" that the punitive damages award was overturned, Mr. Sincoff said.

If the appellate panel's ruling that the plaintiffs may seek more than $75,000 each is upheld, compensatory damages would be determined by a federal district court, Mr. Sincoff said. ■

Work comp rule will hike costs for many Texas firms

By MICHAEL BRADFORD

AUSTIN, Texas—Many Texas employers will be paying more for retrospectively rated workers compensation policies because of new regulations that allow insurers to help defray their state assigned risk pool assessments.

Under an emergency rule that took effect May 1, employers that pay $350,000 or less annually for a retrospectively rated workers comp insurance program written or renewed after May 1 may have to pay a premium surcharge to help insurers offset their assessments to the Texas Workers' Compensation Insurance Facility.

The State Board of Insurance will set the mandatory "residual market factor" that insurers will apply to premiums to determine surcharges.

However, the emergency rule allows employers that pay more than $350,000 annually for retrospectively rated coverage to negotiate the surcharge with their workers compensation insurers.

The State Board has scheduled a June 7 hearing to discuss making the rule permanent.

Workers comp insurers in Texas pay assessments to the assigned risk pool based on their share of the voluntary market.

The pool's deficit reached $550 million in 1989, and the pool is expected to report a similar shortfall for 1990 when final figures are calculated.

Under a retrospectively rated plan, a policyholder's final premium is not determined until losses are paid.

In Texas, only employers that pay annual premiums of $15,000 or more are eligible for retrospective rating. However, insurers generally offer the plans only to employers that generate more than $75,000 in premiums, according to the State Board.

The emergency regulation is a "major step forward in assisting (insurance) companies in what is a real residual market burden," said Steve Millikan, vp-workers compensation for the Alliance of American Insurers in Schaumburg, Ill.

Alliance members that write workers comp coverage in Texas "see this as a very positive step by the board," Mr. Millikan said. "It will help recoup some of the cost of doing business in Texas."

The new rule is a "step in the right direction," agreed Roy Wood, director of government, consumer and industry affairs at the National Council on Compensation Insurance in Boca Raton, Fla.

However, Mr. Wood added that the regulation may not provide workers comp insurers the relief they need.

For example, for employers that pay less than $350,000 in premiums annually for a retrospectively rated plan, the factor used to determine the amount of the surcharge cannot push the employer's total cost past the maximum premium called for under the retro plan, Mr. Wood pointed out.

"I don't think that's the way they intended it," Mr. Wood said of the State Board's action. "They meant for the assessment to be passed completely through."

Insurers that write retro coverage for employers that pay more than $350,000 annually will likely be able to pass through the entire assessment amount because of the ability to negotiate the charge, Mr. Wood said.

In the past, some Texas workers compensation insurers have added unauthorized charges to premiums in an attempt to help defray their assigned risk pool assessments, according to the State Board.

Commissioner Phil Barnes issued a directive in April that disallowed any charges except those approved by the State Board.

The unavailability of coverage in the voluntary workers compensation insurance market in Texas was exacerbated earlier this year when American International Group Inc. and USF&G Corp. announced they would generally stop writing workers comp coverage in the state (*BI*, April 15; March 18).

AIG ceased writing new workers comp policies and only will "selectively renew" others because of problems in the state system.

USF&G stopped writing most commercial coverages in Texas, including workers comp, because of large losses in the state. ■

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INTERNATIONAL

Mutual Risk seeks public stock offering

By ROGER SCOTTON

HAMILTON, Bermuda—Mutual Risk Management Ltd., a Bermuda-based holding company that describes its Insurance Profit Centre as the largest independent rent-a-captive facility, is seeking a listing on the New York Stock Exchange.

Mutual Risk Chairman and Chief Executive Officer Robert A. Mulderig said that an application and prospectus were filed with the Securities and Exchange Commission on April 25 and that, if approved, the company could complete its NYSE listing by the end of June.

The common stock offering is being jointly underwritten by Morgan Stanley & Co. Inc. and Dean Witter Reynolds Inc.

Although the total number of shares to be offered to the public and the share price have yet to be disclosed, the offering is expected to raise approximately $25 million.

About half will go to a group of the company's existing owners—individuals who are yet to be named but are described in the prospectus as "selling shareholders."

The rest of the proceeds will be used by Mutual Risk mostly "to provide additional capital for its wholly owned insurance subsidiary, Legion Insurance Co.," a Philadelphia-based insurer that provides policy issuance and other fronting services to IPC clients.

The capital injection is needed to support the increased premium volume written by Legion in what the prospectus says is a steadily growing "alternative" risk financing market—a market that Mutual Risk estimates is worth approximately $47 billion in annual premiums.

The IPC rent-a-captive program, which allows policyholders to retain a significant portion of their loss exposures without the administrative costs and capital commitment of establishing their own captives, is Mutual Risk's main product (*BI*, April 29).

About 70% of Mutual Risk's fee income is derived from workers compensation coverage for companies or associations that are typically generating $750,000 or more in annual premiums.

Legion, which is licensed in 47 states and the District of Columbia, is a key part of the IPC program.

According to the prospectus, the rent-a-captive program works with Legion and its clients determining the level of exposure the clients wish to retain before transferring specific excess risk and aggregate excess risk to unrelated treaty reinsurers. Legion then issues policies and reinsures the liability either to a client's captive insurer or to one of the three companies that comprise the IPC: Mutual Indemnity Ltd., Mutual Indemnity (Barbados) Ltd. and Mutual Indemnity (U.S.) Ltd. A fourth IPC company, Mutual Indemnity (Dublin) Ltd. is in the process of seeking regulatory approval to open in Ireland for "certain clients located in Europe."

Legion generally retains "only a small portion of the risk on each program for its own account," the SEC filing says.

The filing reveals, however, that among changes planned for 1991, "Legion will attempt to revise the structure of certain of the IPC programs on an aggregate stop-loss basis where the IPC company will assume only the losses in excess of an aggregate retention in order to leave Legion with a more significant amount of net retained premium."

The prospectus goes on to say

Continued on next page

Reinsurer shoots down market forecasts

European changes a myth?

By GAVIN SOUTER

EASTBOURNE, England—Anyone who thinks that the future European market will see a huge increase in cross-border insurance sales, domination by mega-insurers and an opportunity to make a quick killing in Eastern Europe, should think again, says a leading German reinsurer.

London Insurance & Reinsurance Market Assn.

One by one, Achim Kann, chairman of Munich-based Frankona Reinsurance A.G., dispelled these notions. Consumers have a built-in resistance to buying insurance from foreign companies; the theory that the insurance market is becoming more concentrated does not stand up to analysis; and the East European economies will need to advance substantially before any insurance profits can be realized, he said.

Consequently, there will still be a place for medium-sized and small companies in the future, Mr. Kann said at a reinsurance seminar here last month organized by the London Insurance & Reinsurance Market Assn.

According to a recent survey, 91% of Germans would only buy a policy from a German insurer, he said. Only a tiny 3% would even compare the products of German insurers with those of foreign companies.

So companies that consider forming foreign subsidiaries in their own names "might as well forget it," he said.

"The majority of your potential customers will not accept you. You will only be used by some clever clients, or by even more clever agents as the price cutter, but your efforts to achieve a reasonable market share will be in vain," Mr. Kann warned.

People will still wish to buy insurance from an identifiable national company, although they will not be concerned if that company has a foreign parent, Mr. Kann added.

After 1992, Europe will be a single market with 340 million consumers and 4,600 insurance companies. But the consumers, he warned, will speak at least 10 different languages and there will be at least as many variations in economic behavior.

Competition will increase among commercial insurers and especially among brokers, he added later.

He cited recent research indicating that direct brokers in Germany will be able to increase their market share to 30% from 18%. "Brokers will be active and they will use the capacity of foreign insurers," Mr. Kann said.

The future concentration of insurance companies is also often exaggerated, he said.

Consideration of the single market has shaped insurer strategies for five years, yet the market share of each country's large insurers has

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Peruvian insurance law allows foreign investors

By MARIA KIELMAS

LIMA, Peru—Radical changes in Peruvian insurance law that will open up the industry to foreign investors are now effective.

The long-awaited law, published April 26, marks the biggest shakeup in the country's financial sector for more than half a century, insurers say.

Despite the liberalization, though, the insurance industry will not prosper until Peru's general economic malaise is cured, one insurer warns.

Publication of the law had been expected sooner but was delayed by political turmoil.

In late February, Prime Minister and Economy Minister Carlos Hurtado Miller resigned after the National Congress refused to support his shock economic stabilization program that aimed to cut inflation.

His replacement, Carlos Bolona, immediately announced plans to abolish import duties, suspend labor laws, privatize state companies and open up the insurance and banking sectors to foreign investors.

The following day, March 12, the official government newspaper, El Peruano, published Supreme Decree No. 038-91EF outlining some of the basic points of the law, which was finally published in full on April 26.



The main points in the measure affecting insurers, which will be outlined and regulated by the Superintendency of Banks and Insurance, are:

- Insurance companies can place reinsurance freely with reinsurers inside or outside the country.
- All individuals or corporations, public or private, can freely place insurance with either national or foreign companies or both.
- Public entities and state-owned companies can buy insurance from private insurers. Formerly they had to buy all of their insurance from the state-owned insurer, Cia. de Seguros Popular y Porvenir.
- Compulsory rates are abolished and insurance companies can set terms, conditions and premiums according to market conditions.

The SBI rules and solvency requirements should be published within three months, said Manuel Portugal, general manager of the Peruvian Insurers Assn. in Lima.

Insurers will also have to fulfill higher capitalization requirements, but these will be brought in over a transitional period, Mr. Portugal added.

The transformation of the market will lead to an influx of foreign insurers and brokers, said Caridad de la Puente Wiese, operations manager of Cia. de Seguros Condor in Lima.

"They came here to visit and now they want to participate. Peru is like a new market," Ms. de la Puente said.

Yet many problems could remain despite the new law, Mr. Portugal warned.

The liberalization of the market will only lead to real foreign in-

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Insurers expect minimal claims from last month's quake in Costa Rica, which measured 7.4 on the Richter scale.

Costa Rican quake yields few claims due to building code

By MARIA KIELMAS

PUERTO LIMON, Costa Rica—Insurance claims from last month's earthquake in Costa Rica will be minimal, even though around $100 million of damage was caused, an earthquake engineer says.

Most of the damage caused by the quake was to bridges, highways and water pipelines rather than commercial buildings, which have to comply with a stringent seismic construction code, said Franz Sauter, president of Franz Sauter Asociados S.A., an earthquake engineering firm in San Jose, Costa Rica.

However, earthquake coverage is included in all Costa Rican fire insurance policies and claims will be made for any damage to insured buildings.

The earthquake, which struck on April 22, measured 7.4 on the Richter scale, and its epicenter was about 15½ miles southwest of the Atlantic port of Puerto Limon.

The temblor's magnitude is comparable to the Iranian earthquake in June 1989 that struck the southern coast of the Caspian Sea and killed more than 50,000 people, Mr. Sauter said.

The Costa Rican quake killed 75, injured 1,000 and, in destroying 600 homes, left 15,000 people homeless, he said.

A spokesman for the state-owned insurance and reinsurance monopoly, Instituto Nacional de Seguros, said it is too early to estimate insured losses.

Earthquake cover is a standard feature in Costa Rican fire insurance policies, he added.

Gross premium income from fire insurance in Costa Rica totals about 10 billion colones ($84 million at current exchange rates), the spokesman said.

The INS reinsures more than 95% of its business overseas, the spokesman said.

The chief cause of the damage was local soil liquification at sites of soft alluvial deposits, Mr. Sauter said.

The soil conditions caused the collapse of a three-story hotel in Puerto Limon and the partial collapse of another, Mr. Sauter pointed out.

Some modern reinforced concrete buildings with brick infill walls also suffered severe damage, he added.

The Atlantic sea bed along the coast rose 6.6 feet, and authorities

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Mutual Risk offer

Continued from previous page

that "these programs, if implemented, will significantly increase (Mutual Risk's) premiums earned without significantly affecting the economies of the IPC program for the company or the client."

Last year, Legion's policy-issuing fee revenues rose 70% to $7.3 million at year-end 1990 while the number of Legion programs reached 56, up from 31 in 1989.

Policy issuance produced the biggest single source of fee income for Mutual Risk, which last year earned $17.7 million in total risk management fees, of which just more than $6 million came from IPC program fees.

Premiums earned by Legion accounted for another $17.5 million, bringing Mutual Risk's total revenues for 1990 to $39.1 million. Net income last year was $5.8 million, compared with $3.9 million in 1989.

Mutual Risk's prospectus says that under its operating plan for Legion, its ratio of gross premiums written to policyholder surplus should not exceed 4-to-1. With policyholders surplus of $30.6 million at year-end 1990, and gross premiums of $111.2 million last year, Legion is writing at close to full capacity.

Mutual Risk "anticipates that further capital contributions will be necessary during 1991 to facilitate Legion's gross premium growth. . .primarily by using the proceeds of a 1990 private placement of common shares and this offering," the prospectus says.

The 1990 placement involved the sale in December of 563,200 common shares to existing shareholders at $10 a share. The $5.6 million placement along with Mutual Risk's 1990 net income raised shareholders equity 42% to $34 million at year-end.

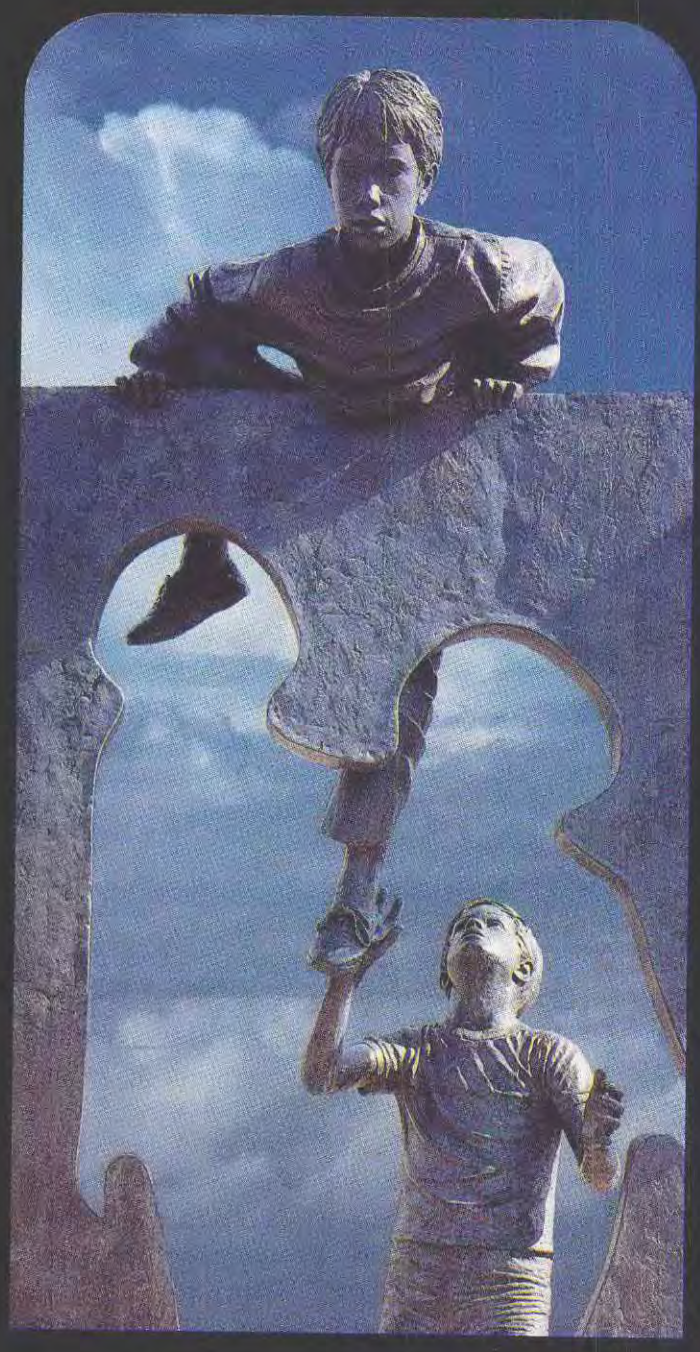
The prospectus also reveals that Legion has agreed to purchase a dormant Connecticut-domiciled insurance company, plus the acquired company's policyholder surplus consisting of cash and government securities, together estimated to be worth about $5 million. The dormant company was not named.

Mutual Risk's "selling shareholders," who stand to receive between $12 million and $13 million of the offering's proceeds, are expected to be named by the end of the month. By then, the opening price range of the Mutual Risk stock will have been determined, though in view of existing preferred share conversion rights, its common stock is unlikely to be offered at less than $13 per share.

Selling shareholders could include three venture capital companies that helped Mutual Risk to acquire Legion in November 1987 for $18 million: Conning & Co. of Hartford, Conn., which owns 12.2% of Mutual Risk's shares, and two Boston-based firms, Summit Ventures and TA Associates, which own 9.5% and 8.7%, respectively.

Other sellers could include some of IPC clients, which jointly hold 16.5% of Mutual Risk stock through Mutual Indemnity Ltd.

What is more certain, however, is that Mr. Mulderig, who owns a 7.7% stake, and 15 directors and officers holding 23.6% will not be among the sellers. ■



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INTERNATIONAL

Dispelling myths

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remained stable, Mr. Kann said.

In the 1980s, market share for the five largest insurers did not increase significantly in Germany, Italy, Britain, Spain or the Netherlands, according to Mr. Kann. Only France saw a significant rise—to 41% from 31%.

The figure rose to 45% from 41% in Spain, to 18% from 14% in the Netherlands and to 32% from 30% in Italy. And market share for the five largest insurers actually decreased over that period in Germany, where it fell to 33% from 39%, and in Britain, down to 55% from 56%.

Expanding the inquiry to the 10 largest insurers in each country accentuates the inherent stability, he said.

In France the 10 largest's market share increased to 68% from 58%, in Italy it increased to 65% from 59%, in Spain it increased to 38% from 33%, in the Netherlands it increased to 46% from 43%, in Germany it decreased to 48% from 53% and in Britain it decreased to 72% from 76%, said Mr. Kann.

"If we look a bit closer at the details in the market, it seems that the higher degree of concentration observed in some markets is mainly due to mergers and, secondly, that in nearly all markets those companies which led the group of the bigger players lost ground to the medium-sized ones," he observed.

Even if the competition is long-lasting and increasing, medium-sized companies should not be squeezed out of the market, Mr. Kann said.

In Germany, for example, the shareholders of strong medium-sized companies are not interested in selling out to foreign insurers so incoming companies tend to buy the weaker insurers, he contended.

"The challenge for the future for the direct insurance companies will consist of a landscape where a limited number of big players will compete all over the single European market, with a still tremendous number of medium or small-sized companies which in many cases might be strongly positioned in their local or regional markets," said Mr. Kann.

Eastern Europe offers two challenges to international insurers, he said:

- The transition of communist economies to free market systems.
- The destruction of the old insurance systems and the building of competitive insurance markets.

Dramatic change is under way throughout the region and all the nations will have to "go through a period of catharsis to rid themselves of all kinds of economic and social ills," Mr. Kann said.

Unemployment and inflation will remain high during the transition, he warned.

The insurance systems have already profoundly changed and there are now 45 insurance companies in Eastern Europe, compared with 11 in 1985, and there are another 150 mutual insurance schemes in the Soviet Union, Mr. Kann said.

Insurers have three major tasks in reviving a healthy insurance market in Eastern Europe he said:

- Transferring knowledge and experience.
- Establishing sales organizations.
- Training underwriters in a particularly difficult risk environment left by an economic system that exploited man and nature without any reasonable limits.

Later, answering questions, Mr. Kann noted that companies in what had been East Germany have been fully integrated into the Western system. Foreign insurers have little room to expand in the eastern provinces of the country because German companies are already pressing hard. ■

Japanese market restrictions relax

By GAVIN SOUTER

EASTBOURNE, England—The stable and restrictive Japanese non-life insurance industry could soon face radical changes that will ease tariff controls and allow more competition among local insurers, says a leading insurer.

London Insurance & Reinsurance Market Assn.

And Japanese insurers may also step up their activities overseas as the industry becomes increasingly global, said Isao Kuzuhara, managing director of Dai-Tokyo Fire & Marine Insurance Co. Ltd. in Tokyo.

As the Japanese expand outside their own borders, they could take with them coverages peculiar to Japan, such as non-life investment policies, Mr. Kuzuhara said at the 10th International Reinsurance Seminar, organized by the London Insurance & Reinsurance Market Assn.

There are 23 primary non-life insurers in Japan and two domestic professional reinsurers—Toa Fire & Marine Reinsurance Co. Ltd. and Japan Earthquake Re, Mr. Kuzuhara said. Another 33 foreign insurers and reinsurers are licensed to write non-life business in Japan.

The small number of insurers in Japan, compared with the United States and Britain, can be attributed to the government's restrictive attitude toward newcomers, he said.

"We consider that to raise the number of insurance companies without substantial capital and surplus would cause a bankruptcy. . .and would threaten the interest of the policyholders," he said.

But its recent admission of foreigners like Allstate Insurance Co. and Allianz Insurance Co. shows that the Finance Ministry is beginning

Continued on next page

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Japanese market

Continued from previous page

to open the doors a little wider, Mr. Kuzuhara said.

In 1989, non-life insurers in Japan wrote 9,591 billion yen ($66.7 billion at appropriate exchange rates) in gross premiums, of which 41% was automobile, 27% was personal accident, 19% was fire, 4% was marine and 9% was miscellaneous insurance, he said.

This premium makes Japan the third-largest non-life market in the world—after the United States and Germany—with 8% of worldwide business, Mr. Kuzuhara said.

"However, it is only 20% of the total premium volume of the Japanese life insurance industry, which is the second largest in the world. In this sense, we trust that there are still extensive possibilities to increase our non-life insurance market in the future," he said.

In 1989, more than 30% of the total premium income of the Japanese non-life market came from savings-type insurance policies which offer a return on the invested premium upon maturity of the policy, Mr. Kuzuhara said.

Eighty-nine percent of the 3,000 billion yen ($20.9 billion) taken in premiums from savings-type insurance will be returned to policyholders with dividends on maturity, he said.

Japanese insurers have offered the policies since 1968. Now, U.S., European and other Southeast Asian insurers are showing an interest and making inquiries as to how to underwrite these risks and manage the investments, Mr. Kuzuhara said.

"When the insurance commissioner for the state of New York visited Japan last year, he said that he is looking at a proposal from a company that wants to sell this type of policy," he added.

The Japanese distribution system is based on 585,000 agents, since there are no brokers, Mr. Kuzuhara said.

Major banking and manufacturing companies have set up their own agents to place their insurance with the aim of retaining the premium commission, he said.

The largest of these agents handles 24 billion yen ($172.7 million at current exchange rates) in premium volume a year, he added.

The Japanese reinsurance market was historically based largely on reciprocal agreements that used Toa Re as an administrative organization, Mr. Kuzuhara said.

Under the fire reciprocal exchange scheme, for example, 20 insurers exchange their key fire treaties with each other, and the total premium handled should be around 68 billion yen ($489.2 million) in 1991, he said.

These schemes were very popular until the early 1970s. Though they remain important, Japanese insurers now directly use the international reinsurance markets more frequently, he said.

However, in common with other markets, Japanese insurers are increasing their retentions, he said.

Recent changes in the Japanese market include the deregulation of the tariff system, Mr. Kuzuhara said.

Tariff rates are set by the Insurance Rating Assn., which bases its calculations on the industry's loss ratio, expense ratio and profit margin, he said.

However, some insurers argued that the premium rate for each insurer should be based on that company's individual ratio, and in February 1990 a range of rates were introduced, Mr. Kuzuhara said.

"Insurance companies could choose a premium rate within the scope of this range of tariff rates, although almost all companies had, in fact, chosen the lowest rate. Anyway, this was the first attempt at deregulation," he said.

Future changes include discretionary dividends on savings-type insurance policies, Mr. Kuzuhara said.

Currently, uniform dividends are paid, but the first discretionary dividend policies will be introduced this year, he said.

An even more important change that may come through is the dropping of the barrier between life and non-life insurers, Mr. Kuzuhara said.

In Japan, a company is not permitted to underwrite both life and non-life policies; however, there have been some gray areas, like personal accident and medical expense coverages, which have been written by both sides of the industry for years, he explained.

A Ministry of Finance study of possibly removing the barriers between life and non-life insurance will be published shortly. It is expected to recommend that life and non-life companies be allowed to operate in each other's areas through subsidiary companies, he said.

However, as the Japanese life companies are so much larger than the non-life companies, it is feared that the large life companies could soon dominate the non-life market, Mr. Kuzuhara warned.

Outside of their home country, Japanese insurers are following their domestic policyholders' own international expansion, Mr. Kuzuhara said.

"Most of the Japanese insurers' internationalization is done to support Japanese industries overseas. Sixty to 70% of their overseas business comes from Japanese industries operating overseas," he said.

Although there is still plenty of room for expansion in the domestic Japanese market, the internationalization of other areas of Japanese industry, like technology, has made the Japanese insurance industry more global, he said. ■

Pace of automation seen accelerating

By GAVIN SOUTER

EASTBOURNE, England—The London insurance market is going through technological evolution, not a revolution, say insurance information technology managers.

London Insurance & Reinsurance Market Assn.

The speed of change is increasing, however, and by 1992 all claims will be processed electronically, said speakers at a seminar last month organized by the London Insurance & Reinsurance Market Assn.

By making better use of technology and setting up compatible international data exchange systems, the industry will improve service and become more profitable and efficient, they said.

"My bias is toward seeking more intensive use of information technology on the grounds that it offers substantial value added, and if we in the London market do not grasp the nettle, we will lose our preeminent position in world reinsurance business," said Brian Clayton, manager and chief underwriter at Royal Reinsurance Co. Ltd.

New technology can improve service and boost profits, but the London market should not forget that its past success was based on face-to-face trading in several vibrant marketplaces, Mr. Clayton added.

The London market has developed into a strong and distinctive insurance community, he said. Its distinctive features include:

- The experienced and aggressive market-making force of brokers.
- The product development and risk-structuring skill of brokers.
- The relatively large number of sharply focused and lean underwriting teams.
- A healthy diversity of risk selection, pricing and marketing.
- Interplay between brokers and underwriters, which produces a "melting pot of experience."
- Face-to-face negotiations and the concept of lead and follow underwriters.

"The result is a market which is perfectly suited to absorb large and complex risks and to handle the claims speedily; a wide diversity which ensures entrepreneurial spirit; formidable capacity; first-class security; and technical expertise," Mr. Clayton said.

The diversity of the market makes it expensive to operate in, but the joint market initiative to establish a pilot scheme for electronic trading—between Lloyd's, the Institute of London Underwriters, LIRMA and the Lloyd's Insurance Brokers Committee—will cut costs, he said.

The initiative will also: improve accuracy; eliminate duplication of data; speed up processes; focus time where it is needed, that is, on larger risks; bring a common approach to data standards; capture risk data electronically; and "remove the photocopier logjam," Mr. Clayton said.

Claims settlement has been enhanced by the Electronic Loss Advice and Settlement System that was launched in 1988, he said.

That system provided better service to customers but left underwriters short of cash, Mr. Clayton said.

"I was less impressed with the cash flow implications of not being able to make (reinsurance) recoveries using the same quick and efficient facility. In short, I was paying out within two weeks or so of notification and waiting an average of 10 to 12 weeks for the recovery. This, to my mind, clearly demonstrates the need for market commitment and implementation," he asserted.

Brokers have benefited in several ways from ELASS, said Joan Martin, managing director in the information systems division at Willis Corroon P.L.C.

First, the average time for claims settlement has shrunk to one week from three weeks, she said.

"We have notified and settled catastrophe claims such as Hurricane Hugo, Piper Alpha and Exxon Valdez with impressive speed, making us and the insurers far more responsive to the client," Mrs. Martin said.

Second, brokers have been able to cut costs by reducing the number of people in their claims departments, she said.

"The days are rapidly coming to an end when the sole qualification of a young claims broker was the length of his arms—the longer they were, the more files he could carry," Mrs. Martin said.

Increased use of technology has also improved the quality of work done and cut the time wasted standing in line to see underwriters to settle a claim, she added.

Third, errors have been reduced as consistent and standardized data is transferred to all parties in the market, Mrs. Martin said.

Finally, information has become easier to control and payments are easier to confirm, she said.

The worldwide insurance industry should form closer technological links, Mrs. Martin said.

"I believe we in London should be working far more closely with the Broker & Reinsurer Market Assn. and the Reinsurance Assn. of America in the United States in agreeing to data and messaging standards," she asserted.

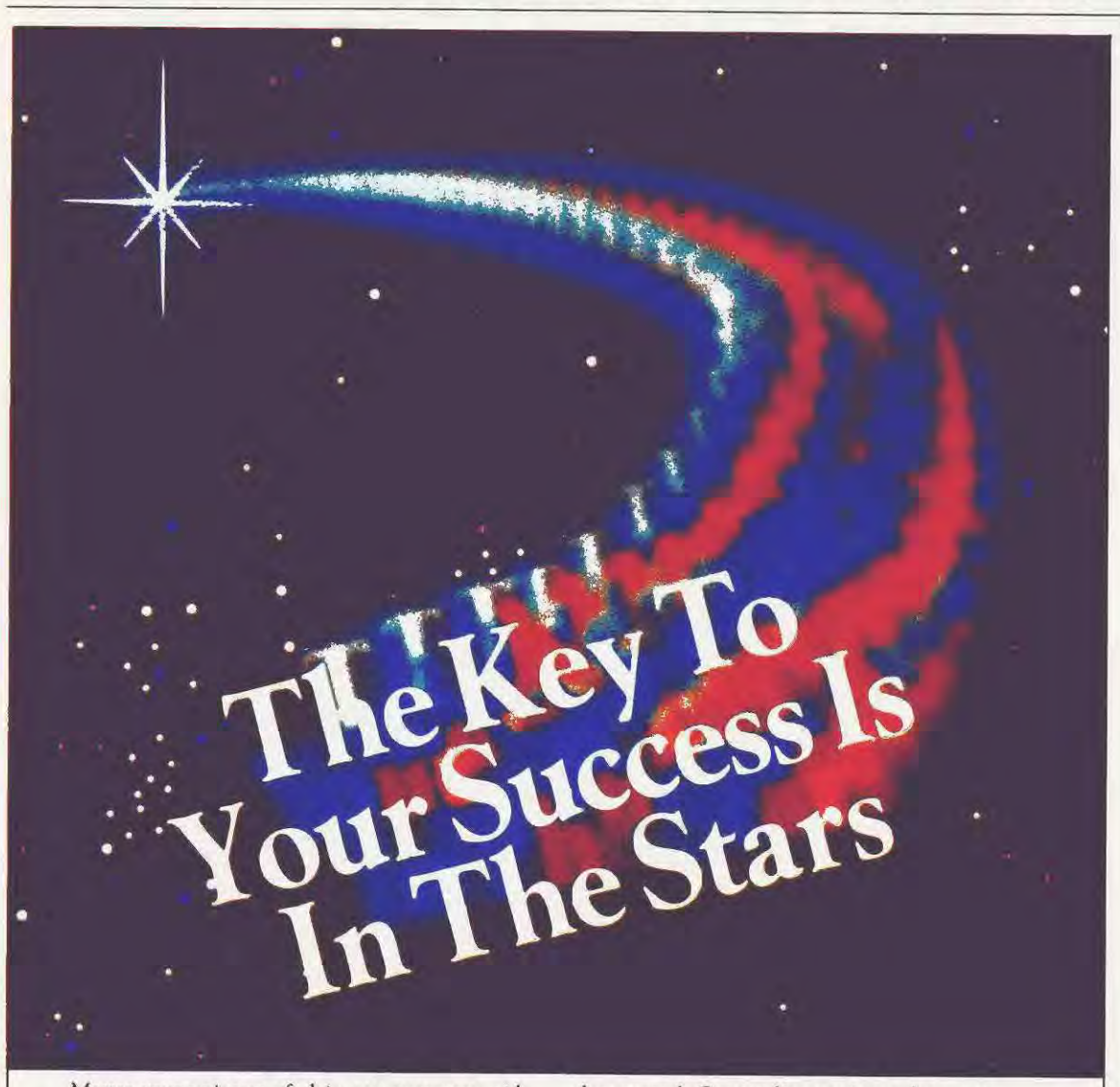
Also, the insurance industry should remember that their customers are developing their own information technology systems and the flow of electronic data will change all industries, Mrs. Martin concluded.

Currently, 40% of LIRMA claims are processed electronically and this will rise to 100% in 1992, said Mike Seddon, director of information technology at LIRMA.

Other areas of technological development are not proceeding so quickly, Mr. Seddon said.

"LIMNET has tried to work together with RINET to agree common standards for the treaty account and claims messages with some success in the treaty account area. Progress has, however, been somewhat hampered by RINET's desire

Continued on next page



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INTERNATIONAL

Automation

Continued from previous page
that LIMNET brokers and companies should join RINET to share the costs of the RINET standards work," Mr. Seddon said, referring to the London market's information system and the Reinsurance Network, a pan-European information system.

If LIMNET is to advance, London insurers should strive to develop international standards for messages coming into London, he said.

The London company market has not achieved the technological aims it agreed to in 1989, which included: the full utilization of the ELASS system; the introduction of an electronic pilot placement program; electronic processing of excess-of-loss adjustments and reinstatements; a LIRMA scheme for outwards reinsurance processing; and handling of proportional treaty statements, he said.

For 1991 LIRMA plans:

- The extension of ELASS to 100% volume across all brokers by early 1992.
- The development of an electronic slip support system to the joint LIMNET standard by early 1992.
- The agreement of a system for outward reinsurance processing, which will provide a vehicle for seven-day central settlement of reinsurance payments expected to be sufficiently similar to the Lloyd's proposals to attract significant broker support in early 1992.

"Planning remains on a highly cautious basis at present with claims completion top priority, outwards facilities second if they can be achieved speedily, and support for the first joint LIMNET project, electronic placing support, a close third," Mr. Seddon said. ■

Peruvian law

Continued from page 79
vestment if the country's foreign debt problem is solved, he said.

Peru's foreign debt totals $20 billion and the government is in arrears in payments to commercial banks as well as to multilateral agencies like the World Bank, the International Monetary Fund and the Inter-American Development Bank.

At the IMF and World Bank annual meeting in Washington, D.C., late last month, the United States and Japan said they would lead a group of industrialized countries that would help Peru to pay off arrears to the multilateral agencies leaving the way open for talks to resume with commercial creditors.

Peru's total arrears amount to some $3.5 billion, of which $2.1 billion is to the international institutions, Mr. Portugal said.

Meanwhile, the cholera epidemic currently plaguing Peru will not affect business or foreign insurer interest, he said.

The epidemic has affected tourism but is otherwise restricted to the poorer sectors of society, and "insurance company offices are working as normal," he added. ■

Costa Rican quake

Continued from page 79
feared that the Puerto Limon port would be shut down indefinitely, Mr. Sauter said.

However, the port facilities were back in operation on April 28, and direct communications with the capital, San Jose, were re-established the same day, he said. The speed of re-establishment was due to Costa Rica's national emergency plan—Plan Nacional de Emergencia, he said.

Communications with the South are still broken. In those areas, the main economic loss could be incurred by Standard Fruit Co., which has been unable to transport produce from its Estrella valley plantation by main highways, he said.

The relatively small human loss, given the size of the quake, is due to Costa Rica's seismic construction code, which was introduced in 1974 and revised in 1987, Mr. Sauter said.

The code enforces special design requirements for pre-stressed and post-stressed concrete, as well as post-tension buildings, that exceed those of California, he said.

Costa Rica's ban on adobe and "bahareque style" construction also helped save lives, Mr. Sauter added.

Adobe construction uses dried mud bricks that are up to three feet thick but lack any supporting frame. Consequently, during an earthquake, the construction is pulverized, and people inside often suffocate.

Bahareque construction is a Latin American adaptation of adobe construction, which incorporates a wooden frame surrounded by two surfaces of woven reeds that form the shell of the building. The space between the reed surfaces is filled with mud and pieces of brick that are plastered over. Heavy tiled roofs are constructed on top of bahareque buildings, but these often collapse during an earthquake and crush the people inside.

Costa Rica banned both styles of construction after an earthquake in 1910 destroyed the country's former capitol, Cartago. It is the only Latin American country to ban the buildings, Mr. Sauter said.

Poor bahareque construction in Managua was the chief cause of 10,000 deaths during the Nicaraguan earthquake in 1972, Mr. Sauter noted. Most construction in Costa Rica is now reinforced masonry, Mr. Sauter said.

Public utility and emergency services buildings have been reinforced against earthquake damage over the past five years, he added.

This process proved its worth in December 1990 when the country suffered another earthquake that measured 5.7 on the Richter scale, Mr. Sauter said. The quake centered on the town of Alajuela about 15 miles northwest of San Jose, causing severe damage to the capital. No telephone or electricity links were damaged during that quake thanks to the reinforcement program, he said.

The December quake caused a $40 million economic loss and a $9.6 million insured loss, he added.

However, this insured loss should not be used as a yardstick for losses from the latest quake, because the April quake occurred much further away from San Jose and caused little damage there, Mr. Sauter said.

The main damage in the most recent quake was to a ruptured petroleum storage tank that caught fire at Cost Rica's only oil refinery, the state-owned Refinadoria Costaricense de Petroleo. Another small tank exploded and killed three employees.

Venezuela has offered to supply Costa Rica with gasoline until the refinery is repaired, government sources say. ■

Market changed for good, broker says

By GAVIN SOUTER

EASTBOURNE, England—The U.S. property/casualty insurance market has changed dramatically over the past 20 years, and insurers are unlikely to see former underwriting profits return, a U.S. reinsurance broker says.

London Insurance & Reinsurance Market Assn.

The industry traditionally focused on expanding market share, but prior to the 1980s this was based on a stable marketplace, not the varying and more disciplined market of today, said Richard H. Blum, chairman of Guy Carpenter & Co. Inc. of New York.

Consequently, in the 1990s U.S. insurers will no longer be able to be all things to all people and will use more sophisticated financial techniques, he said at a London Insurance and Reinsurance Market Assn. seminar.

In 1990, the U.S. property/casualty insurance industry produced a pretax operating income of $11.5 billion, up 11% from 1989; surplus rose by 3.5% to $140 billion; and the combined ratio was slightly higher at 109.4%, Mr. Blum said.

"On the surface, it doesn't look like too bad a business. However, the annual rate of return on equity for the decade of the 1980s averaged 10%, while for the same period banks, utilities and the Fortune 500 companies averaged 13%—a significant difference which cannot persist indefinitely without withdrawal of capital from the business," he said.

Over the past 20 years, the U.S. industry has changed markedly. Once stable and profitable, it is now an aggressively competitive, highly volatile, high-risk/high-reward industry, Mr. Blum said.

One reason is that insurance company assets rose sharply in the 1980s, from less than $200 billion to more than $525 billion. That surge let insurers invest in the U.S. financial services revolution, he said.

The competitive market has resulted in a trimmer industry in which more emphasis is put on healthy balance sheets and return on equity, he said.

During the 1970s, the U.S. property/casualty industry produced underwriting profits in five of the 10 years. But in the 1980s there were no underwriting profits, and experts say property/casualty insurers will not see them again, Mr. Blum said.

However, in 1990 insurers earned $33 billion in investment income, he said. If there also had been an underwriting profit, it would have produced a 25% return on capital, which would have led to rate cuts, he said.

Also, insurers' results vary widely today, unlike during the 1970s when they stayed close to the industry average, Mr. Blum said.

"In response, insurers are more disciplined than in the past; no longer are they prepared to use their profitable lines to subsidize unprofitable ones," he added.

These changes have also blurred the public's understanding of the market, while performance expectations and return to investors are difficult to evaluate, he said.

U.S. commercial banks and savings and loans tended to make far riskier investments than insurers, but there are similarities between insolvencies in these industries and those in insurance, Mr. Blum said.

"These include excessive growth, significant expansion into new and different business areas, poor management information control systems and operating procedures, under-reserving and over-leveraging, not to mention ineffectively executed regulatory control and even fraud in a few cases," he contended.

Those similarities, however, apply only to mismanaged insurers, and the problems are not industrywide, Mr. Blum said.

One of the challenges now facing insurers is alternative risk mechanisms, which now account for about 30% of the commercial premiums in the United States, Mr. Blum said.

Other concerns for property and casualty underwriters include: politically driven solutions to environmental damage; the spread of state rate rollbacks; and the increase in the frequency and severity of catastrophic losses, he said. ■



Executive Life

Continued from page 1

tions under the Employee Retirement Income Security Act of 1974.

Meanwhile, several other major employers—including Honeywell Inc., Marathon Oil Co., Unisys Corp. and Xerox Corp., as well as Holiday Inn—are "freezing" savings plans assets that were invested in GICs issued by Executive Life.

Under a freeze, employers calculate what portion of a fixed income or GIC fund is invested in contracts from Executive Life. Employees cannot withdraw or transfer these assets. However, they continue to have access to all assets not invested in Executive Life GICs.

In most cases, a large percentage of employees' contributions are invested in instruments other than Executive Life GICs, allowing them continued access to the bulk of their funds.

These developments came as California regulators warned at a congressional hearing last week that it is unlikely that Executive Life will be able to fully honor its GIC contracts.

"Our goal is the protection of all policyholders to the maximum extent possible. But this company is in deep trouble. It is unlikely that the full contract value of GICs" will be met, John Garamendi, the California insurance commissioner, told the Senate Commerce Committee.

At the same hearing, several senators, while critical of state regulation of Executive Life, said they were not yet ready to endorse federal regulation of the insurance industry (see story, page 85).

The Senate hearing follows the takeover last month by California and New York regulators of the two insurance units of junk-bond laden First Executive Corp. of Los Angeles.

The California insurer—Executive Life Insurance Co.—was placed in conservatorship on April 11. The following week, the New York unit—Executive Life Insurance Co. of New York—was placed in rehabilitation (*BI*, April 29; April 22).

New York regulators believe the New York unit should have sufficient assets to meet policyholder obligations, barring uncontrollable events, like a collapse in the value of the insurer's junk bond portfolio.

But from the start, California regulators have been much less sanguine about the ability of Executive Life Insurance Co. to meet policyholder commitments.

Mr. Garamendi has warned, for example, that even if liquidation of Executive Life can be avoided and a buyer found, Executive Life's policyholder liabilities may have to be restructured.

Currently, Executive Life is paying only 70% of the monthly annuity payments it owes, while policy surrenders—in which a policy is canceled for its cash value—are frozen. And, no interest is being credited on the roughly 300 guaranteed investment contracts issued by Executive Life.

Those contracts, many of which were purchased by 401(k) plans between 1987 and early 1988 when Executive Life was an aggressive player in the GIC market, are valued at more than $3 billion.

'Our goal is the protection of all policyholders to the maximum extent possible. But this company is in deep trouble. It is unlikely that the full contract value of GICs' will be met, Mr. Garamendi testified before the Senate Commerce Committee.

If employers, like Holiday Inn, shield employees in 401(k) plans from potential Executive Life-connected losses, it would put employers on a new course in assuming defined contribution plan obligations.

In defined benefit plans, in which participants are promised a specific benefit, employers must make up any shortfalls caused by investment losses.

But in 401(k) plans and other defined contribution plans members bear the investment risk. An employer's obligation is limited to making a specific contribution, not guaranteeing a certain benefit, which has been a factor in the tremendous growth of 401(k) plans over the last decade.

Shielding defined contribution plan participants from investment losses "is an unprecedented step. It is not legally required," said Gerry Bell, a partner with Kwasha Lipton in Fort Lee, N.J.

Though under no legal duty to compensate defined contribution plan participants for investment losses, employers may believe that doing so would ease potential employee relations problems.

"Some employers would like to avoid morale problems by helping out employees," said Henry Saveth, a principal with A. Foster Higgins & Co. Inc. in New York.

"Employers are cognizant of the visibility of these plans and the importance of these plans to employees' retirement income needs," said Kwasha Lipton's Mr. Bell.

Other experts note that there may be a pragmatic reason for employers to make 401(k) plans whole for any Executive Life-connected GIC losses: Employers want to reduce the risk of litigation.

"If the plan sponsor doesn't make participants whole and there are losses, the employer faces the risk of being sued by participants for making an allegedly imprudent investment," according to Kim McCarrel, a consultant with Wyatt Asset Services Inc. in Portland, Ore.

The likelihood that employers may want to protect employees from Executive Life-related losses also could depend on how they explained GIC investment options to those in 401(k) plans, experts say.

"It is possible that plan documents were so loosely worded that employees could have been led to believe that the employer was backing up the GIC contracts," Ms. McCarrel said.

Employers, though, face considerable legal obstacles if they want to shield 401(k) plan participants from Executive-Life connected losses, benefit experts say.

The largest obstacles involve making additional contributions directly to a 401(k) plan to compensate for losses linked to Executive Life GICs.

For example, additional employer contributions could run afoul of Internal Revenue Service rules that limit annual contributions to 401(k) and other defined contribution plans.

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Continued on next page

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NOTICES

NOTICE

The Health Care Commission of the State of Kansas intends to issue a request for proposals (RFP) on May 15, 1991 for its insured indemnity & HMO plans which now covers 37,029 active State employees and 7,680 retired State employees. The 1992 premium for this plan is expected to exceed $145,000,000. The deadline for receipt of proposal(s) is June 28, 1991, 5:00 p.m., C.D.T.

The plan has been substantially strengthened over the last three years by lessening the adverse selection caused by HMOs and by including over 21,000 of the indemnity plan participants in a managed care program. As a result, the claims experience has become much more predictable. The estimated claims loss ratio for 1990 was 81.4%.

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Continued from previous page
both employer and employee contributions—may not exceed $30,000 per participant or 25% of an employee's compensation, whichever is less. In addition, aggregate tax-deductible annual employer contributions may not exceed 15% of plan participants' compensation.

At the same time, additional employer contributions could cause a 401(k) plan to fail the IRS non-discrimination tests that compare contributions on behalf of highly paid employees to rank-and-file employees.

"What would seem to be the simple act of topping up raises a whole host of technical questions," said Allen Steinberg, a consultant with Hewitt Associates in Lincolnshire, Ill.

Employers could reimburse 401(k) plan participants in cash for Executive Life GIC losses. However, such payments would be considered immediate taxable income to employees, benefit consultants say.

Holiday Inn, the first employer to publicly promise to guarantee the principal amount of each employee's investment in Executive Life GICs, hasn't decided which mechanism it will use to protect the investments, a spokeswoman said.

A smoother, less question-filled strategy to protect employees' investments, benefit consultants say, is for employers to purchase—as Georgia-Pacific did earlier this year—Executive Life-issued GICs held by their 401(k) plans. The 401(k) plan could then use the proceeds of the sale to make new, more secure investments.

"This lets employees know their money is continuing to work for them. It is quick, fair and generous," Kwasha's Mr. Bell said.

But before such sales, an employer would first have to obtain special permission—known as an exemption letter—from the Labor Department.

ERISA rules bar certain financial dealings between parties-in-interest, like a plan sponsor and the plan itself.

The Labor Department says it would move quickly on individual employer requests for exemptions to purchase GICs from their 401(k) plans.

"We are prepared to be helpful," said Ivan Strasfeld, director of exemption determinations at the Labor Department's Office of Pension and Welfare Benefits Administration.

Benefit experts note, however, that the cost of purchasing GICs from 401(k) plans could be too high for some employers, especially for companies with cash-flow problems.

"Some employers may not be in the financial position to do this," said Foster Higgins' Mr. Saveth.

"It is costly, but is it as costly as a breach of fiduciary responsibility lawsuit and the terrible publicity that would go along with such a suit?" asked Dallas Salisbury, president of the Employee Benefit Research Institute in Washington, D.C.

In addition, it isn't clear if the creditor status of an employer holding an Executive Life-issued GIC would be the same in the insurer's receivership as if its 401(k) plan owned the GIC, benefit experts say. The status of Executive Life-issued GICs held by 401(k) plans itself has not been resolved.

"Where a company comes in when standing in line is an open question," said Roger Bransford, national director of asset consulting in Atlanta with TPF&C, a unit of Towers, Perrin, Forster & Crosby Inc.

For now, the preferred course of action by employers amid the uncertainty about Executive Life is to freeze portions of their savings plans that invested in GICs issued by Executive Life.

Under a freeze, employers calculate the amount of money in their plans' fixed-income or GIC funds that is attributable to GIC contracts issued by Executive Life.

For example, assume a 401(k) plan has $100 million in GIC contracts, of which 10%, or $10 million, is in GICs issued by Executive Life. Through such a freeze approach, an employee that invested, for example, $10,000 in the GIC fund, would still be able to transfer or withdraw $9,000.

Stamford, Conn.-based Xerox, for example, says about $65 million, or 7.5% of the $885 million in its so-called guaranteed fund, is attributable to Executive Life GICs purchased between 1987 and early 1988. At Minneapolis-based Honeywell, 16%, or $72 million, of its fixed income fund is invested in Executive Life contracts.

A freeze assures equal treatment for plan participants, said Robert R. Evans, assistant treasurer at Xerox.

"Honeywell believes that the decision to freeze this 16% portion of the fund was the fairest option for all plan participants," the company said in a statement.

"A freeze is a good way to put things in a holding pattern until the Executive Life situation is settled," remarked Hewitt's Mr. Steinberg. ■

Garamendi doubts Executive Life will make full payments on GICs

WASHINGTON—California regulators are pessimistic that Executive Life Insurance Co. will be able to fully honor the more than $3 billion in guaranteed investment contracts it has issued.

Many of those contracts were sold to 401(k) plans between 1987 and early 1988 when Executive Life offered aggressive rates and received the highest ratings from A.M. Best Co. and Standard & Poor's Corp.

John Garamendi, the California commissioner, told the Senate Commerce Committee last week that Executive Life's financial problems will make full payments on the contracts unlikely.

Holders of GICs also stand to be behind other policyholders in line for Executive Life receivership. Mr. Garamendi, though, was not specific, saying only that a "substantial legal question" remains about what priority to give holders of the contracts.

Meanwhile, Mr. Garamendi renewed his criticism of an Internal Revenue Service demand for $643 million for back taxes and penalties from Executive Life. The IRS announced the demand shortly after California regulators seized the company last month (*BI*, April 29).

"Just why it has taken the Service a decade to assert its claim, whatever its merits, is unclear to me," he said.

Mr. Garamendi warned that if the IRS succeeds with its claim, it would "kill any effort" by his department to rehabilitate Executive Life.

A successful IRS claim means 'this game is over," he said. "It is an endgame."

Last week's hearings also gave several senators the chance to raise serious questions about the effectiveness of state insurance regulation.

"Events like the failure of Executive Life raise concerns as to the adequacy and effectiveness of state regulation. This case clearly raises doubts that existing state regulation offers the needed protection to policyholders and taxpayers," said Sen. Richard Bryan, D-Nev.

"State regulation is not working," argued Sen. Howard Metzenbaum, D-Ohio.

Sen. James Exon, D-Neb., said regulators, particularly the National Assn. of Insurance Commissioners, did not exercise sufficient initiative in dealing with Executive Life.

The senators for now, though, ruled out federal regulation as a response to the debacle.

"I still have reservations about the federal government taking over regulation," Sen. Exon said, noting that the savings and loan disaster occurred despite federal regulation of that industry. "The case has not been made for federal regulation."

Sen. Exon said one possible course of action could be the adoption of federal standards that state regulators would have to meet (see story, page 70).

—By Jerry Geisel

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Federal regulation likely: Insurer execs

By DOUGLAS McLEOD

WAYNE, Pa.—As congressional scrutiny of insurer insolvencies rises, insurance industry executives increasingly believe federal regulation is likely, a survey concludes.

Most insurer executives, though, are unhappy about the idea of either federal or dual federal/state oversight, according to a survey by SEI Insurance Asset Services, an insurance asset management firm in Wayne, Pa.

Insurance officials also expect a rising number of insurer insolvencies and view repeal of the industry's McCarran-Ferguson Act antitrust exemptions as a distinct possibility.

Despite major insurance company failures, though—the most recent being the collapse of junk bond-laden units of First Executive Corp. (*BI*, April 22)—the industry is generally careful in its investment practices, SEI found.

"I don't think we're looking at another savings and loan (situation)," observed Dan Gattis, senior vp with SEI. "This is a very conservative, well-run, formalized industry."

The survey was sent last December to 764 property/casualty and life/health insurers with assets of more than $100 million. Of these, 348, or 46%, responded.

The bulk of the survey's questions dealt with the insurers' investment policies and practices. However, SEI also asked the insurers about their expectations for the economy, the industry's performance, regulation and other issues facing insurance managements.

Companies were asked to respond to questions on a scale of one to five—with one being "extremely positive" and five being "extremely negative." SEI tabulated the mean score of all respondents to each question.

Asked about the overall solvency of the insurance industry, for example, the respondents registered a mean score of 2.5, and were therefore generally positive about solvency, SEI reported.

Insurers were also generally positive about future growth of industry premium volume, registering a 2.86 score, but were less confident about the general economy and about growth in the gross national product, registering scores of 3.18 and 3.24, respectively.

Insurers' perceptions of how consumers view the industry were also less than sanguine: On a question about consumer confidence in the industry, the mean score was 3.77.

Meanwhile, little that was positive emerged from questions about regulation, according to the survey.

Insurers responded with a slightly negative score of 3.37 when asked about their confidence in state regulation. However, when asked how they felt about the possibility of federal regulation, responses were a more negative 3.71; asked how they felt about possible dual federal/state regulation, responses were a more adamantly negative 4.25.

Despite their misgivings about a federal role in regulation, insurance executives appear resigned to the idea, the survey found.

In a similarly tabulated section of the survey—ranked on a one to five scale with one representing "highly unlikely" and five representing "highly likely"—insurers regarded the prospect of federal regulation as a somewhat likely 3.2, the survey found.

"With the scrutiny of First Executive, it's just a sense of inevitability now," Mr. Gattis said.

Meanwhile, insurer officials see the prospect of McCarran-Ferguson repeal as a moderately likely 3.14 and the possibility of increased federal taxation of insurers as a very likely 3.75.

The prospect that insurers will be required to mark investments to market value in statutory financial statements was seen as a moderately likely 3.38, the survey found.

The bulk of the survey dealt with insurer investment policies and practices. Among other things, SEI found that:

- Insurers continue to favor fixed income investments, with government, agency and corporate investment-grade bond issues used by 94% or more of the surveyed insurers.

Interest in junk bonds is falling off slightly, though. While 41% of the respondents reported owning high-risk, high-yield bonds, only 38% said they would consider such investments in the future.

- Insurers are becoming more international in their investment choices: While 21% of those surveyed own stock in international companies, 47% say they would consider those investments in the future.

Meanwhile, cash and short-term deposits with foreign financial institutions are held by only 13% and 17% of those surveyed, respectively, while 29% and 33% would consider such investments in the future.

- The nature of insurers' own operations is the strongest influence in setting investment policy, while cash flow needs and asset/liability management rank second and third. Capital market opportunities were the weakest influence on investment decisions, the survey found.
- Although asset/liability management was rated as an important influence on investment decisions, 58% of those surveyed do not measure investment performance against changes in the company's liabilities.
- Only 32% of those surveyed were "extremely confident" in actuarial forecasts of liabilities,

Continued on next page

The IRI Difference:

Our Account Teams Are Ready to Serve Your Property Insurance Needs

"IRI account teams combine both loss prevention and underwriting people," said Stan Couvillon, IRI Vice President—Loss Prevention. "In this way, our customers get the best of both disciplines when a recommendation is made. This is a key aspect of The IRI Difference.

"The training of our account teams is a painstaking process which involves weeks of basic classroom studies, months of advanced coursework and years of hands-on experience," he said. "Our customers tell us that our people are very thorough. That's understandable. Since 1890, we have been training our staff to take nothing for granted.

"During our first century, IRI employees helped conduct over five million inspections of facilities in more than 70 countries. This effort helped conserve billions of dollars worth of property and save thousands of jobs.

"Some of the other services our account teams provide are loss prevention advice in the blueprint stage, and the development of programs for pre-emergency planning and proper handling of impaired loss protection equipment," Mr. Couvillon said.

"In addition, IRI teams have emergency action plans ready in more than 30 IRI servicing offices worldwide in case a blizzard, arctic freeze, hurricane, cyclone or flood threatens the properties of our customers. In the past, these plans have helped to mitigate the results of natural catastrophes and other disasters," he stated.

"Recently, we've introduced a new loss prevention idea. It's called IRInformation, a subscription service for our customers and their insurance agent or broker. IRInformation is a two-volume, loose-leaf technical manual that answers many loss prevention questions. It's one more example of The IRI Difference."



Stan Couvillon, Industrial Risk Insurers

IRI℠

can make a difference

Industrial Risk Insurers, Hartford, Connecticut

Senate panel

Continued from page 1
letter to Attorney General Richard Thornburgh.

"It has also been suggested, however, that the company officials continued to promote the company as a viable and healthy business and were, perhaps, assisted by their rating and auditing firms in presenting this image," the letter says. "As a result, the company's 300,000 policy and annuity holders are now at great risk of losing their lifelong investments, including death and medical benefits."

The letter—signed by committee Chairman Ernest F. Hollings, D-S.C., Consumer Subcommittee Chairman Richard Bryan, D-Nev., and Slade Gorton, R-Wash., the ranking Republican member of the subcommittee—asks the Justice Department to investigate "whether the company or those acting on its behalf engaged in fraudulent or other criminal activity."

The Justice Department was asked to report its findings within 90 days.

Meanwhile, a former Minnesota regulator charged last week that the California Insurance Department "became uncooperative" with other regulators as the Executive Life crisis developed last year.

Thomas H. Borman, former Minnesota commerce commissioner, said California regulators withheld information on Executive Life of California's condition when Minnesota officials sought the information in early 1990.

At the time, the California department was headed by Roxani Gillespie, who left office earlier this year following the election of John Garamendi as the state's first elected insurance commissioner.

Mr. Borman also suggested that the California department delayed regulatory action against Executive Life because a takeover of the insurer last year—before the Jan. 1, 1991, creation of a guaranty fund to protect California life policyholders—would have proven politically embarrassing.

California department officials could not be reached for comment. Ms. Gillespie was traveling last week and also could not be reached.

Mr. Borman was among several regulators, Executive Life policyholder representatives and insurance industry officials to testify Thursday at a Consumer Subcommittee hearing. It was the second of two hearings last week on the Executive Life failure.

Minnesota regulators became concerned about the insurer in January 1990, when First Executive announced a $515 million charge for bond losses and Executive Life of California reported an $835 million net loss for the fourth quarter of 1989, said Mr. Borman, who is now a partner with the Minneapolis law firm of Maslon, Edelman, Borman & Brand.

Mr. Borman—who regulated banking and insurance as commerce commissioner—said he tried to obtain current information on Executive Life's condition but found that data "was either unavailable or seriously dated."

Minnesota had not yet received the latest California department exam of Executive Life—which was for year-end 1987—and the most recent A.M. Best Co. rating, for year-end 1989, was A+, he noted.

Mr. Borman testified that the California department failed to respond to "repeated requests" for current information about Executive Life's financial condition, including the exposure of Minnesota policyholders.

He also noted that he disagreed with California regulators' decision that neither a full-scale examination nor a more limited target exam of Executive Life was warranted.

"We were virtually without any current measure to monitor the company's deteriorating liquidity," Mr. Borman testified.

As the junk bond market continued to decline, Minnesota regulators conducted their own exam of Executive Life in February 1990, and obtained from the company a copy of the California department's 1987 exam, Mr. Borman said.

Following their own exam, Minnesota regulators required Executive Life to report its liquidity position and policy surrenders every other day during the first quarter of 1990, he said.

'Clearly, there were compelling political incentives to keep the company afloat,' Mr. Borman charges.

With help from the National Assn. of Insurance Commissioners, an arrangement was later reached under which Minnesota agreed not to take action against the insurer—letting California take the lead in monitoring its operations—as long as Executive Life met reporting and other requirements, he testified.

Mr. Borman noted that the California department became uncooperative as the crisis at Executive Life's parent company developed in early 1990, withholding information on the insurer's condition.

"It became clear to me that when a crisis develops in a state-domiciled insurer, the interests of the local state regulator quickly diverge from those interests of the other states," he observed.

Speculating on the reasons for the lack of cooperation, Mr. Borman noted that California was one of only six states that did not have a life insurance guaranty fund in 1990 and that its life insurance guaranty fund legislation went into effect Jan. 1, 1991.

"No doubt the absence of a guaranty fund would have been embarrassing politically to the then-current administration and legislators," Mr. Borman said in written testimony. "Clearly, there were compelling political incentives to keep the company afloat during 1990."

Asserting that insurance solvency monitoring should more closely resemble bank regulation, Mr. Borman recommended six changes to insurance regulatory standards:

- Troubled companies should be examined more frequently than once every three years, the current standard, and troubled companies should get more attention than well-managed companies.
- The results of triennial examinations should be completed and forwarded to other states promptly.
- Insurance examiners should scrutinize the value of real estate, loans and other insurer investments more carefully than they do now.
- Insurance companies should adopt a "risk rating system" to evaluate the quality of real estate and other loans.
- Statutory accounting should require insurers to report the market value of distressed real estate investments and loans, rather than the book value.
- Regulators should impose risk-based capital requirements on insurers, evaluating the adequacy of their surplus in light of risks in their investment portfolios, the adequacy of their reserves and the degree to which their assets and liabilities are properly matched.

Mr. Borman also suggested that the House and Senate form a task force of insurance industry officials, regulators and consumer representatives that would be given four to six months to recommend a uniform set of minimum standards for insurer solvency monitoring.

The Consumer Subcommittee also heard testimony from Alfred H. Sigman, a lawyer with the Oakland, Calif., firm of Sigman & Lewis, which represents employees of Pacific Lumber Co. in a lawsuit against their employer.

Los Angeles-based Maxxam Inc. acquired Pacific Lumber in 1986 though a leveraged buyout financed by junk bonds, many of which were bought by First Executive. Maxxam then terminated Pacific Lumber's overfunded pension plan and guaranteed participants benefits with an Executive Life annuity (*BI*, April 22).

Mr. Sigman offered several suggestions for preventing a repeat of Pacific Lumber employees' possibly disastrous experience with Executive Life:

- Prohibit employers from collecting asset reversions when overfunded defined benefit pension plans are terminated.
- Amend the Employee Retirement Income Security Act to require appointment of an independent fiduciary to choose an insurer to provide any annuity following a plan termination.
- Give the Pension Benefit Guaranty Corp. power to determine which insurers are eligible to provide annuities for pension plan participants.
- Extend the PBGC insurance program to include annuities purchased following plan terminations.
- Require mandatory disclosure of details of the annuity insurer selection process to plan participants.

Members of the National Organization of Life & Health Insurance Guaranty Assns. have formed a task force to work with the California department and develop a plan to address guaranty fund coverage of Executive Life obligations, said Eden Sarfaty, the group's president.

Initial indications are that individual policyholders' losses are likely to be small, according to Mr. Sarfaty.

However, holders of "unallocated funding obligations"—including guaranteed investment contracts—may suffer larger losses that are not covered by guaranty funds, he said (see story, page 1).

State guaranty fund laws typically put a $5 million limit on payouts to any one GIC contractholder, regardless of how many contracts are held or how many employees are covered by the contracts, he testified.

In a testy exchange, Sen. Bryan pressed Mr. Sarfaty about whether state guaranty fund boards—typically composed of insurance industry officials—include any public members.

"You mean somebody who doesn't know anything about insurance?" Mr. Sarfaty asked.

"I mean somebody who will protect the public," Sen. Bryan replied.

Mr. Sarfaty acknowledged that most boards do not include public members and that board meetings—at which decisions are made about coverage issues—are generally not open to the public. ■

SEI survey

Continued from previous page
while 63% were "moderately confident" and 5% were not confident at all.

- Allocation of assets among various investments is a highly formal process for most companies; 56% of the respondents said such allocation is subject to formal guidelines with infrequent deviations. Rigid guidelines are more common among smaller companies, with the larger insurers more often operating with only informal guidelines, the survey found.
- Insurers typically review their investment policies once or twice a year, though more frequent reviews may be triggered by changes in the tax structure or regulatory environment, changes in capital markets and changes in the insurers' product offerings or management.
- Fifty-one percent of the surveyed insurers use external money managers to handle investments, while 49% perform the function internally.

Of those who hire outside money managers, 51% employ only one, 46% employ between two and five managers and 3% employ more than five.

Expertise in handling specific types of investments and performance were cited as "extremely important" reasons for hiring an outside manager.

The respondents represented a wide range of companies: Property/casualty insurers made up 41% of the group, while life/health insurers represented 37% and companies writing a combination of the two made up the remaining 22%.

Most respondents—61%—were purely direct insurers, while 7% were pure reinsurers and 32% write both direct insurance and reinsurance.

Ranking the respondents by total admitted assets, 13% had more than $5 billion in assets, 22% had between $1 billion and $5 billion, 16% had between $500 million and $1 billion, 21% had between $250 million and $500 million and 28% had less than $250 million. ■

Warehouse fire

Continued from page 1
Central Storage is a storage site for food products owned by several companies, as well as for surplus butter and cheese owned by the federal government.

"What we've got here is a big grease fire," observed another fire department spokesman, noting that melted butter and lard was nearly two feet deep in places.

City crews were called out to build dikes to keep the slithering goo from running into a nearby lake, the spokesman said.

The warehouse owner has at least $8 million of primary property insurance and $1 million of primary occurrence-based legal liability coverage written by Bermuda-based captive IARW Insurance Co. Ltd., said Colin C. James, senior vp at Atlantic Security Ltd. in Bermuda, which manages IARW. The captive is owned by members of the International Assn. of Refrigerated Warehousemen.

There is no deductible for the coverage, Mr. James said.

The captive has an aggregate retention of $150,000 for both the property and liability coverage and reinsures the remainder of the risk with American Re-Insurance Co., a subsidiary of Aetna Life & Casualty Co. of Hartford, Conn.; Employers Reinsurance Corp. of Overland Park, Kan.; and Prudential Reinsurance Co., a subsidiary of The Prudential Insurance Co. of America of Newark, N.J.

Central Storage officials could not be reached.

Individual tenants generally purchase their own property insurance to cover the value of the goods that they store in a warehouse like the Central Storage facility, insurance industry sources concur.

And, warehousemen's liability coverage generally responds after the tenants' own property coverage, insurance adjusters say.

'I don't know of any cold-storage outfit with insurance that would cover an entire loss,' says Mr. Winburn of Oscar Mayer Foods Corp., which lost in the fire 4.2 million pounds of meat—mostly wieners—valued at around $6 million.

Most warehouse owners do not provide primary property insurance for their tenants' inventory because of the periodic turnover in inventory, explained a spokeswoman at meatpacker Monfort Inc. of Greeley, Colo.

"I don't know of any cold-storage outfit with insurance that would cover an entire loss," said Ray Winburn, senior vp-materials management at Madison-based Oscar Mayer Foods Corp.

Oscar Mayer lost in the fire 4.2 million pounds of meat—mostly wieners—valued at around $6 million, he said.

"The 4.2 million-pound loss is significant, but it doesn't affect our ability to service our customers," an Oscar Mayer spokesman said.

While Oscar Mayer's business peaks during the months between Memorial Day and Labor Day and inventories had been boosted to meet the demand, the company's inventory in other warehouses throughout the country can fill customers' needs, he explained.

"We don't expect a business interruption loss," Mr. Winburn said.

Oscar Mayer's inventory is insured under a manufacturer's output difference in conditions policy purchased by its parent company, Philip Morris Cos. Inc. of New York, according to Jerry Luttrel, director of risk management at Philip Morris.

The policy, which has a $1 million deductible, is written by Wm. H. McGee & Co. Inc., a New York-based underwriting manager, he said, declining to provide further details.

Kraft General Foods Inc. of Glenview, Ill., another Philip Morris subsidiary, is handling the Oscar Mayer claim.

Ocean Spray Cranberries Inc. of Middleboro, Mass., stored 5 million pounds of cranberries at the site, a spokesman said. The company had not determined late last week how much of its product was destroyed in the fire.

The spokesman could not provide a value for the cranberries. But, he said the company has adequate coverage, though he would not provide details.

Ron Krantz, an owner of meatpacker U.W. Provisions Co. in Madison, said the $2 million of meat products his company stored at the warehouse is insured, but it was not known how much of the meat was destroyed. Mr. Krantz could not provide insurance details.

The U.S. Department of Agriculture stored about 20 million pounds of butter and about 125,000 pounds of cheese valued at about $20 million at the warehouse.

A spokeswoman said it is not known how much of the butter and cheese was lost in the fire. The government did not purchase insurance, she said. ■

USAir crash

Continued from page 1

the government will assume has not yet been decided because compensation issues are still being negotiated, said another source. The issues include the loss of the aircraft and the apportionment of liability claims among USAir, SkyWest and the FAA.

Although the USAir's jetliner was only insured for $16 million, the hull claim will be based on the market value of the aircraft, which could be as much as $25 million.

The Boeing 737 jetliner previously was insured for $33 million per aircraft, but USAir renewed its hull and liability insurance program 18 hours before the crash with only $16 million in hull limits. The airline has $850 million of liability insurance (*BI*, Feb. 11).

USAir's broker, Frank B. Hall & Co. Inc. of New York, did not return calls. U.S. Aircraft Insurance Group in New York, which leads USAir's coverage, would not comment.

A USAir spokeswoman said airline authorities were en route from four days of National Transportation Safety Board hearings held last week on the crash in Los Angeles and could not be reached.

St. George, Utah-based SkyWest insured its aircraft for around $3.1 million and carries $250 million of liability insurance, brokers and underwriters say.

A liability reserve for the loss was originally established at about $36.7 million, underwriters say, though the reserve has since increased by an unknown amount. The FAA's portion of the original liability reserve could be between $31.2 million and $34.9 million.

"We are very surprised at the speed (with which) Uncle Sam has agreed to pay the loss," said the source. But, the source noted that the speed with which the government has acted may be linked to evidence indicating that an air traffic controller guided the USAir jetliner to land on the same runway where she had instructed the SkyWest commuter aircraft to wait for takeoff.

USAir Flight 1493, carrying 83 passengers and six crew members, collided into SkyWest Metro 3 on Feb. 1 as the USAir jetliner was landing at Los Angeles International Airport. The SkyWest airliner, which was preparing to take off at the time, carried 10 passengers and two crew members.

Thirty-four people died in the accident, including all those on board the SkyWest aircraft. Twenty-six people were injured, 11 seriously.

"The USAir 737 was cleared to land (by the local controller) after a SkyWest Metroliner was cleared into position on hold on the same runway," William Hendricks, director of the FAA's Office of Investigation, explained at the Aviation Insurance Assn. conference in Savannah, Ga., last week.

USAir landed at 6:06 p.m. and collided with the Skywest metroliner that was on the runway and "dragged" it across the air field, coming to a stop in an old firehouse building where it caught fire.

At first, firefighters did not realize that two aircraft were involved in the crash until they saw landing gear and wreckage from the smaller commuter aircraft, said Mr. Hendricks.

The air traffic controller, Robin L. Wascher, who cleared both airlines to their respective positions, told FAA investigators that at first she thought that there had been a bomb explosion on board the USAir flight and did not realize that there had been a collision.

In addition, she testified at the NTSB hearing last week that she did not see the Skywest plane on the runway when she cleared the USAir jetliner to land.

Other activity was going on at the airport at the time, Mr. Hendricks said. In particular, another jetliner had just landed on the same runway complex, he noted.

"Somehow this flight (did not maintain) communications from the tower and ground control" and was waiting to cross the runway where the crash occurred moments later, he said.

"This is an accident that never should have happened," Mr. Hendricks contended. "There were some distractions, but it was the opinion of the air traffic controllers who reviewed this that this was not considered a very busy time at the airport. So you basically have a human performance accident with many factors that still have to be examined."

However, the practice of "position and hold," in which aircraft hold their position on the runway —instead of a taxiway—until they receive clearance for takeoff, "has been discontinued during nighttime and poor visibility conditions," Mr. Hendricks said. "In my opinion, it should be discontinued entirely."

Mr. Hendricks said he was not aware that the FAA had agreed to accept most of the liability for the accident and referred questions to the Justice Department.

A former aviation lawyer for the Justice Department, however, said he was certain that the FAA would have to assume substantial responsibility for the loss.

USAir, too, will have some responsibility for the loss, because under federal aviation regulations, the USAir captain—who was killed in the crash—may have been negligent for failing to observe an aircraft on the runway before the aircraft landed, said Roy Krieger, a partner with Kroll & Tract in Washington, D.C., and former trial attorney with the Justice Department's aviation litigation section.

The co-pilot of the USAir flight said at the NTSB hearing last week that he had not seen the SkyWest plane until seconds before the crash.

However, "the government is going to buy the vast majority of this accident," said Mr. Krieger. "From what I know now, the government should pay in excess of 80% on this one."

Plaintiffs who sue the Federal Aviation Administration for compensation, however, will be confronted by restrictions, noted George N. Tompkins Jr., partner with Condon & Forsyth in New York.

Plaintiffs' lawyers cannot receive more than 25% of any award in contingency fees if they seek compensation from a government agency, he said. Also, a government agency cannot be sued for punitive damages, he said. ■

Northwest liable for crash: Jury

DETROIT—The crew of a Northwest Airlines MD-82 jetliner that crashed near Detroit in 1987 was guilty of willful misconduct and was fully responsible for the accident, which killed 156 people, a federal jury has found.

After an 18-month trial, the U.S. District Court jury concluded that McDonnell Douglas Corp., which built the jet, was not partly liable for the crash, which is considered one of the worst in aviation history (*BI*, Aug. 24, 1987).

The jury's willful misconduct finding means that the families of nine foreign travelers each can seek more than $75,000 in damages, said John Hennelly, senior partner of aviation at Bryan Cave in Los Angeles, who represented McDonnell Douglas. The Warsaw Convention, as amended by the Montreal Agreement, limits airlines' compensatory liability for accidents on international flights to $75,000 per passenger, unless willful misconduct can be proven.

In addition, the families of three travelers who had Northwest employee passes can seek more than the liability limitations stated on the passes, Mr. Hennelly.

The jury said after the trial that they believed the crew did not properly administer the pre-flight checklist and somehow had disabled the warning system, he said.

A spokesman for Minneapolis-based Northwest said the airline's insurer, Associated Aviation Underwriters, would decide whether to appeal. Executives at AAU were unavailable for comment.

Underwriting sources say that liability losses from the crash amounted to more than $232 million as of March, but neither Mr. Hennelly nor Northwest would comment.

—By Stacy Shapiro

Oregon stays AIG suspensions

SALEM, Ore.—The Oregon Insurance Department has agreed to stay a one-year suspension order that prevented five American International Group Inc. units from writing new workers compensation insurance in the state.

In addition, the department is rescinding its suspension order against a sixth AIG unit, New Hampshire Insurance Co., because the infractions occurred years ago.

The department in October 1989 proposed 18-month suspensions against six AIG units: New Hampshire, American Home Assurance Co., Birmingham Fire Insurance Co. of Pennsylvania, Commerce & Industry Insurance Co., Insurance Co. of the State of Pennsylvania and National Union Fire Insurance Co. of Pittsburgh, Pa. (*BI*, Oct. 23, 1989).

However, the suspensions were stayed pending appeal.

Under the agreement, the suspensions will be permanently lifted if the five insurers comply with the department's record-keeping requirements and other standards for two years.

The insurers' performance will be reviewed annually. If at the end of the first year, the companies are found not to be in compliance, the suspension order will go into effect and the insurers will have no right to appeal, an Insurance Department spokesman explained.

And if the insurers still do not comply at the end of the suspension, they will be prohibited from writing new workers comp insurance for three years, he said.

According to the department, the insurers failed to make timely benefits payments to injured workers and their beneficiaries; maintain records within Oregon of guaranty contracts, policy cancellations and endorsements; promptly file, record and maintain notices of employers' workers comp coverage with the state; resolve information errors in guaranty contracts; and maintain records required by law, including premiums due and collected, employer assessments and employee contributions.

—By Joanne Wojcik

Update

Exxon withdraws settlement

Continued from page 2

agreed to pay $1 billion over 10 years to restore Prince William Sound. Exxon also agreed to pay a $100 million criminal fine and plead guilty to four misdemeanors (*BI*, March 18). But, Judge Holland has rejected the criminal fine as inadequate (*BI*, April 29).

Storm claims hit $483 million

RAHWAY, N.J.—Three storm systems that hit wide areas of the Midwest and South over nearly two weeks in April caused about $483 million of insured property damage, according to the Property Claim Services division of the American Insurance Services Group.

The Rahway, N.J.-based claim services group reports that wind, hail, tornados and flooding caused an estimated $350 million of insured property damage to portions of Alabama, Arkansas, Georgia, Iowa, Kansas, Louisiana, Mississippi, Missouri, Nebraska, Oklahoma and Texas April 26-29. The loss, assigned Catastrophe No. 72, includes the devastation caused by a tornado that struck the town of Andover, Kan.

A series of the same perils, assigned Catastrophe No. 71, caused about $33 million of insured property damage to parts of Florida, Louisiana and Texas April 24-25.

A similar storm system caused about $100 million of insured property damage—assigned Catastrophe No. 70—to parts of Alabama, Arkansas, Florida, Georgia, Louisiana, Mississippi and Texas April 18-20.

The division says total insured property damage in the first quarter was $705 million—the largest first-quarter loss in about a decade.

USAIG to pay crash settlement

KEY WEST, Fla.—Southern Co. Services Inc. has adequate insurance to cover a $1 million settlement of a wrongful death suit filed by the widow of an executive killed when a company jet crashed in 1988.

Southern accepted a recommendation by its insurer, United States Aircraft Insurance Group of New York, to settle the case the day after a federal court trial in the case had begun, although it believed the executive deliberately caused the plane to crash, a Southern spokesman said. The settlement was in Southern's financial "best interest," he said.

Southern was sued by the widow of Jacob F. Horton, a senior vp at the company's Pensacola, Fla.-based Gulf Power Co. unit. Mr. Horton and two Southern pilots were killed in an attempt to land the plane shortly after takeoff because of an onboard fire.

The plaintiff claimed that improper maintenance caused the fire, said plaintiff's attorney Bill Wagner of Wagner, Cunningham, Vaughan & McLaughlin in Tampa, Fla.

However, Southern believed it had strong evidence—including tapes from the plane's in-flight recorder—showing Mr. Horton started the fire in an attempt to commit suicide after learning Southern's board had recommended his dismissal, the Southern spokesman said.

Southern also agreed to pay Mrs. Horton full workers compensation benefits, which the company disputed because of questions surrounding Mr. Horton's death, Mr. Wagner said.

Suits in state court soar: Study

WILLIAMSBURG, Va.—A new study estimates the number of tort lawsuits filed in state courts in 1989 grew by 7.6% compared with 1988—the greatest percentage increase in four years.

The estimate is based on the tort law filings in 20 sample states, according to "State Court Caseload Statistics: Annual Report 1989," a joint effort of the Conference of State Court Administrators, the State Justice Institute and the National Center for State Courts.

The study says 98 million lawsuits were filed in all state courts in 1989. The greatest percentage—68%—were for traffic and other ordinance violations, but 18% were civil lawsuits, 13% were criminal cases, and 1% involved juveniles, the study found.

The study—noting that only 337,000 cases were filed in federal courts in 1989—also shows that state courts are the workhorse of the civil justice system, survey authors say.

"The data simply says we are a litigious society and becoming more litigious," said Martin Connor, president of the American Tort Reform Assn. in Washington, D.C.

Nutter to head reinsurer group

WASHINGTON—After seven years as head of the Alliance of American Insurers, Franklin W. Nutter resigned last week to once again become president of the Reinsurance Assn. of America.

Mr. Nutter is expected to rejoin the RAA in early June.

Mr. Nutter had been president of the Washington, D.C.-based reinsurance trade group for three years before moving to the Alliance.

Mr. Nutter will help give the RAA "higher visibility" in Washington, said RAA Chairman Paul D. Hawksworth, president of Mercantile & General Reinsurance Co. of America in Morristown, N.J. "We're absolutely thrilled to have Frank back."

The executive committee of the Schaumburg, Ill.-based Alliance was scheduled to discuss Mr. Nutter's resignation last Friday.

Briefly noted

California Gov. Pete Wilson's proposals to reduce employers' **workers compensation costs** have been added to legislation, S.B. 581, introduced last month by Sen. Ed Royce, R-Fullerton. The proposals would tighten eligibility standards for job stress claims and allow employers to deduct from injured workers' permanent disability benefits the amount of temporary benefits paid to them while they were in vocational rehabilitation. . . .The District of Columbia city council repealed its controversial **gun liability law**. Under the law, manufacturers, importers and dealers of certain "assault weapons" could have been held strictly liable for any injuries or deaths caused by their use (*BI*, Jan. 7). . . .Three men charged in an **insurance fraud scheme** to bomb a Norfork chemical storage facility and make the incident look like a terrorist act pleaded guilty last week in U.S. District Court (*BI*, Feb. 18). The three men face prison sentences ranging from five to 15 years.

Health care reforms

Continued from page 2

Evans asserted. "We pay for quantity of care delivered, not the quality."

Neither the patient nor the employer has very much information to determine whether quality health care is being delivered, he said.

"Put bluntly, we are passive payers of health care charges, not pro-active buyers of health care services," he said.

Bruce Carswell, vp-human resources and administration at GTE Corp. in Stamford, Conn., concurred.

"Most people are ill-prepared to question their physicians as consumers rather than patients," he said.

"Quality can only be attained through contracting for a defined medically necessary and appropriate product in which availability is restricted to physician (networks) who hold themselves" to practice standards, commented Dr. John M. Burns, vp-health management at Honeywell Inc. in Minneapolis.

Dr. Burns said that managed care techniques—like utilization review and preferred provider networks—are some of the tools that allow employers to establish the highest level of quality medical care possible in a benefit plan.

Southern California Edison's Mr. Peevey agreed that implementing managed care techniques into health care benefit plans has helped employers reduce overutilization of medical services and thereby cut increases in health care costs.

In fact, the implementation of managed care programs at Southern California Edison slowed the company's annual health care cost increase to about 10% to 12% annually from an average of 23% a year during the 1980s, he said.

But, even with managed care, Edison's health care costs still are rising at a double-digit clip, he stressed.

The executives also said the federal government must take steps to prevent physicians from shifting the costs of public entitlement programs to private payers by developing a national health care provider fee schedule.

That would ensure medical fees paid by both private and public health care payers are equitable, they said.

The federal government "through its entitlement programs—Medicare and Medicaid—and the reimbursement systems for these programs has caused significant cost shifting to the private sector," according to Dr. Burns.

He also pointed out that what providers charge for a service often depends on how providers are reimbursed—for example, through fee-for-service plans or managed care networks—and the region of the the country in which the care is provided.

Mr. Peevey agreed.

Underfunding of public programs, the growth in uncompensated care and employer-negotiated health care discounts "are forcing providers to dramatically increase charges to other third-party payers," Mr. Peevey said.

A national provider fee schedule would reverse the pattern of cost-shifting to employers that has developed since the enactment of Medicare, he said.

This "approach is at least one way to ensure that no one payer can control its cost merely by dumping its expenses in other payers' laps," Mr. Peevey said.

"As long as our fragmented system of paying for health care continues, the other factors contributing to rising health care costs will continue to be beyond any single corporation's control," he told the subcommittee.

'Quality can only be attained through contracting for a defined medically necessary and appropriate product in which availability is restricted to physician (networks) who hold themselves' to practice standards, says Honeywell's Dr. Burns.

Walter B. Maher, director-federal relations in the Washington, D.C., office of Chrysler Corp., called for an even broader role for the government: He told the subcommittee that the ultimate solution to the health care crisis is either a public/private partnership for providing health care or a publicly funded and administered single-payer system.

"We do not see any other solutions at this time which hold promise for success," he said.

Whichever alternative the federal government chooses, it should adopt and implement measures designed to control cost and ensure quality health care, he said.

To accomplish these goals through a public/private partnership, he recommended that the government, among other things:

- Set limits on national health care expenditures.
- Develop a process for determining fair provider fees that are used by all payers.
- Require all employers to sponsor employee health care plans or pay a tax no greater than the cost of an applicable community-rated health care premium to finance the cost of coverage for its employees.

Chrysler Corp. several years ago endorsed a proposal by Sen. Edward M. Kennedy, D-Mass., that would generally require employers to offer group health care coverage (*BI*, June 29, 1987).

Mr. Maher said at last week's hearing that 75% of businesses employ fewer than 10 people, yet the majority of them do not offer health care coverage.

"They represent an obstacle to universal access if employment-based coverage is to be the chosen financial vehicle" for providing health care, he said.

However, if small employers' concerns about the cost of providing health care coverage cannot be allayed, the health care reform needed by employers currently offering coverage is stalemated, he said.

In this situation, "we believe that it would be appropriate to reconsider the tie to employment and move to a fully publicly financed system," Mr. Maher said.

In any case, employers need the federal government to take a greater role in the nation's health care crisis, Southern California Edison's Mr. Peevey said.

Rep. Willis D. Gradison Jr., R-Ohio, asked Mr. Peevey why he sought a federal solution to these issues, instead of addressing them on a local level.

Referring to Mr. Peevey's home state, Rep. Gradison asked: "What's involved here that California can't deal with? Or if they aren't willing deal with it, why should we?"

Mr. Peevey responded: "I don't think that this is a state-by-state matter. It's too fundamental for that."

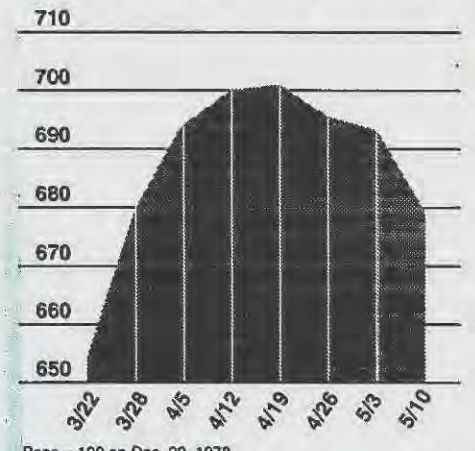
GTE's Mr. Carswell agreed.

"The time is long past when we can simply look within and get the job done," he said.

Rep. Nancy L. Johnson, R-Conn., asked whether businesses shouldn't be somewhat wary about asking Congress for assistance with health care issues.

"When you ask for help from the federal government, you are taking into account our record with Medicare and Medicaid," she said. ■

BI Insurance Index



Base = 100 on Dec. 29, 1978
Source: Nordby International Inc.

Insurance industry stocks halted their downward slide last week, as the *Business Insurance* Index fell 13.3 points to 679.5 on May 10, from 692.8 on May 3. Advancing issues were led by Pacificare Health Systems, up 23.8%; Frank B. Hall & Co. Inc., up 10.7%; and Sierra Health Services, up 10.3%. Declining issues followed Provident Life & Accident Insurance Co., down 12.8%; Alexander & Alexander Services Inc., down 12.4%; and Statesman Group Inc., down 9.1%. The most active issue during the period was U.S. Healthcare, 5.1 million shares traded. The *BI* Index lost 1.9% for the week; The Standard & Poor's 500 fell 1.3%; the New York Stock Exchange Composite lost 1.2%; and the Dow Jones 30 Industrials dropped 0.6%.

British Issues

May 9 Companies	Price pence	P/E	Div. pence	Yield %	1 Week High—Low pence pence
Comml Union	510	N/M	30.7	6.0	514—508
Genl Accident	535	N/M	35.7	6.7	541—535
Gdn Royal Exch	205	N/M	15.9	7.8	211—205
Royal	450	N/M	34.7	7.7	456—450
Sun Alliance	391	N/M	18.7	4.8	391—389
Brokers					
Bradstock	151	17.2	6.0	4.0	151—151
CE Heath	491	14.5	34.5	7.0	492—491
Hogg Group	200	12.1	10.7	5.4	200—200
Lloyd Thompson	367	24.4	10.0	2.7	367—367
PWS Holdings	95	11.6	4.7	4.9	95—95
Sedgwick Grp	248	23.8	16.0	6.5	249—247
Steel Burrl Jones	295	15.8	16.3	5.5	295—295
Willis Corroon	310	16.4	17.6	5.7	310—305

Source: Philip Olsen, Insurance Industry Analyst London

BI Industry Stock Report

MAY 6, 1991 THROUGH MAY 10, 1991

		Price	Weekly % change	Year to Date % change	Annual High	Annual Low	Vol.(000)	$ Div.	% Yield	P/E	Book value	Mkt/Bk. value
BROKERS												
Alexander & Alexander	NYS	21 88	0 57	-5 41	28 00	16 13	698	1 00	4 57	17	9 77	2 24
Gallagher Arthur J & Co	NYS	23 50	-6 00	1 08	28 38	19 75	178	0 64	2 72	18	5 88	4 00
Frank B Hall	NYS	3 38	-3 57	-6 90	4 13	2 00	150	0 00	0 00	-7	-5 24	-0 64
Hilb, Rogal & Hamilton	OTC	17 00	4 62	15 25	17 25	11 25	228	0 36	2 12	25	3 56	4 78
Marsh & McLennan	NYS	80 00	-0 31	2 56	87 25	59 75	377	2 60	3 25	19	14 77	5 42
Poe & Associates	OTC	12 75	4 08	59 38	12 50	7 75	40	0 40	3 14	12	12 50	1 02
BROKERS	AVERAGE		-0 1	9 4					2 3	12		
CONGLOMERATES & HOLDING COMPANIES												
Berkley W R Corp	OTC	30 00	0 00	-20 00	32 25	19 00	283	0 32	1 07	16	23 89	1 26
Berkshire Hathaway Inc	NYS	8075 00										
			0 94	20 97	8900 00	5675 00	0	0 00	0 00	-26	4612 00	1 75
ITT (Hartford Group)	NYS	58 25	-2 31	21 35	60 88	40 25	1028	1 72	2 95	7	64 01	0 91
Sears (Allstate)	NYS	37 50	-0 66	47 78	39 88	22 00	3560	2 00	5 33	13	37 38	1 00
CONGLOMERATES	AVERAGE		-0 5	17 5					2 3	3		
INSURERS/REINSURERS												
Aetna Life & Casualty	NYS	43 00	-0 29	10 26	54 38	29 00	1004	2 76	6 42	8	64 23	0 67
American General	NYS	38 13	-2 87	23 98	49 88	23 50	325	2 00	5 25	8	37 14	1 03
American Heritage	NYS	27 00	-1 82	28 57	27 88	19 63	14	1 04	3 85	12	19 25	1 40
American Indemnity/Fin'l	OTC	6 50	1 96	100 00	7 50	2 75	1	0 08	1 23	12	12 93	0 50
American International	NYS	87 63	-0 43	13 98	102 00	57 00	1789	0 44	0 50	13	45 34	1 93
Aon Corp	NYS	39 00	3 65	12 23	41 38	26 75	127	1 60	4 10	11	18 50	2 11
Argonaut Group	OTC	94 00	-0 79	46 88	99 88	53 00	46	2 04	2 17	9	48 26	1 95
AVEMCO Corp	NYS	31 88	-1 16	26 24	34 25	21 13	37	0 40	1 25	17	9 55	3 34
Baldwin & Lyons Inc	OTC	23 00	1 10	22 67	25 25	17 00	60	0 28	1 22	8	24 29	0 95
Belvedere Corp.	ASE	3 00	4 35	20 00	4 38	1 75	9	0 04	1 33	21	7 65	0 39
Chandler Insurance	OTC	3 88	-11 43	-43 64	9 25	2 75	47	0 00	0 00	-3	5 95	0 65
Chubb Corp	NYS	67 13	1 13	23 73	75 25	34 63	1113	1 48	2 20	11	35 19	1 91
CIGNA Corp	NYS	48 75	-2 50	19 27	56 75	33 25	918	3 04	6 24	11	73 15	0 67
CNA Financial Corp	NYS	81 50	-3 41	18 76	92 50	49 50	136	0 00	0 00	13	70 23	1 16
Continental Corp	NYS	29 50	4 89	18 59	31 38	15 75	1002	2 60	8 81	12	37 83	0 78
Durham Corp	OTC	32 38	-0 38	15 63	33 00	23 00	52	0 92	2 84	16	28 04	1 15
Fund American Corp	NYS	63 75	0 99	22 89	65 25	31 00	235	0 68	1 07	14	36 11	1 77
Fremont General Corp	OTC	18 50	-7 50	27 59	22 13	10 13	437	0 80	4 32	6	19 13	0 97
Frontier Insurance Group	NYS	22 75	-0 55	19 74	33 00	15 38	11	0 00	0 00	9	11 20	2 03
General RE Corp	NYS	90 25	1 55	-2 96	102 50	69 00	1098	1 68	1 86	13	37 50	2 41
Hanover Insurance Co	OTC	30 25	0 00	14 15	30 75	21 00	18	0 44	1 45	10	37 44	0 81
Harleysville Group	OTC	30 50	-0 41	33 33	31 50	13 50	11	0 64	2 10	9	22 99	1 33
Hartford Steam Boiler	NYS	59 63	-3 05	22 31	63 75	43 50	131	1 80	3 02	16	17 05	3 50
Kansas City Life Ins	OTC	35 00	1 45	13 36	36 50	30 00	12	1 20	3 43	9	39 22	0 89
Kemper Corp	NYS	37 75	-2 89	58 95	43 13	17 13	218	0 92	2 44	69	34 20	1 10
Lawrence Insurance Group	ASE	7 88	-4 55	12 50	9 00	6 38	2	0 48	6 10	12	4 71	1 67
Liberty Corp	NYS	40 38	-3 87	-1 82	50 25	39 00	33	0 92	2 28	13	23 86	1 69
Lincoln National	NYS	48 75	-2 50	13 37	56 50	30 75	355	2 72	5 58	11	45 16	1 08
NAC Re Corp	OTC	40 13	-2 13	21 59	42 50	25 50	184	0 20	0 50	15	18 90	2 12
Navigators Group (s)	OTC	33 00	1 54	51 15	34 00	16 50	203	0 00	0 00	18	13 52	2 44
Nobel Insurance LTD	OTC	4 00	0 00	33 33	4 38	2 38	35	0 00	0 00	-	7 76	0 52
NWNL Companies	NYS	28 63	8 53	69 63	34 50	11 75	220	1 40	4 89	6	42 73	0 67
Ohio Casualty Corp.	OTC	46 75	3 31	14 02	47 38	26 75	148	2 48	5 30	10	36 38	1 29
Old Republic Int'l	NYS	29 88	0 00	30 60	30 00	17 38	48	0 68	2 28	7	33 09	0 90
Orion Capital Corp.	NYS	28 00	-1 32	60 00	28 88	13 00	191	0 92	3 29	9	20 42	1 37
Phoenix RE Corp.	OTC	9 50	0 00	22 58	11 25	5 00	168	0 20	2 11	12	13 30	0 71
Protective Life Corp.	OTC	19 50	1 30	31 09	20 75	10 25	94	0 84	4 31	9	16 29	1 20
Provident Life	OTC	21 75	-2 25	24 29	26 25	12 00	32	0 92	4 23	6	25 88	0 84
Re Capital Corp	ASE	18 13	5 07	40 78	18 63	11 75	16	0 00	0 00	13	15 05	1 20
RLI Insurance Corp.	NYS	14 38	-4 17	-0 86	16 38	9 63	20	0 44	3 06	7	13 64	1 05
St Paul Companies	OTC	67 75	-2 52	7 97	74 25	47 00	1135	2 60	3 84	8	52 00	1 30
SAFECO Corp.	OTC	39 75	0 00	20 91	44 75	25 13	1276	1 48	3 72	9	31 50	1 26
SCOR U S. Corp	NYS	13 75	-5 17	11 11	15 25	8 38	29	0 24	1 75	10	11 19	1 23
Seibels Bruce Group	OTC	7 63	-1 61	79 41	11 63	4 25	41	0 36	4 72	-16	7 35	1 04
Selective Ins. Group	OTC	16 00	-1 54	20 75	18 25	12 50	129	1 04	6 50	6	18 91	0 85
Statesman Group Inc.	OTC	2 75	-4 35	75 94	3 00	1 25	137	0 00	0 00	-28	2 48	1 11
Tokio Marine & Fire	OTC	49 00	-2 24	3 70	56 50	34 50	0	0 26	0 53	-	70 93	0 69
Torchmark Corp	NYS	52 00	-2 58	6 39	58 50	38 00	362	1 60	3 08	12	16 70	3 11
Transamerica	NYS	32 13	-2 28	-1 53	41 00	23 25	722	1 96	6 10	10	36 56	0 88
Travelers Corp	NYS	22 75	-5 21	36 84	32 38	11 50	509	1 60	7 03	-12	41 44	0 55
Trenwick Group Inc.	OTC	27 75	-2 63	20 00	30 00	16 25	58	0 60	2 16	11	21 71	1 28
United Fire & Casualty	OTC	50 00	-3 85	42 35	58 00	28 75	3	1 32	2 64	8	35 39	1 41
USF&G Corp	NYS	11 38	-1 09	51 67	29 00	7 00	931	0 20	1 76	-2	11 96	0 95
UNUM Corp	NYS	62 75	-5 10	34 58	69 00	32 13	128	1 04	1 66	11	37 25	1 68
USLIFE Corp.	NYS	39 88	-1 54	42 41	41 75	23 25	96	1 64	4 11	9	60 34	0 66
Unitrin	OTC	38 00	0 33	23 58	41 50	24 50	145	0 80	2 11	14	30 70	1 24
Washington National	NYS	15 00	0 00	37 93	21 88	9 38	10	1 08	7 20	-8	26 86	0 56
USLICO Corp.	NYS	18 38	-2 00	15 75	22 38	14 75	107	1 00	5 44	8	29 44	0 62
Zenith National Ins.	NYS	17 50	3 70	28 44	18 25	9 88	364	1 00	5 71	-73	13 14	1 33
INSURERS/REINSURERS	AVERAGE		-1 0	27 1					3 2	8 1		
HEALTH MAINTENANCE ORGANIZATIONS												
FHP International	OTC	22 25	-4 30	45 90	29 75	8 88	945	0 00	0 00	19	5 44	4 09
HMO America Inc	OTC	14 25	-4 20	119 23	17 13	4 25	614	0 00	0 00	18	0 61	23 36
Pacificare Health Sys.	OTC	29 00	-7 20	78 46	34 00	12 00	703	0 00	0 00	17	6 55	4 43
Safeguard Health Enter	OTC	5 88	-2 08	23 68	7 63	4 00	6	0 00	0 00	20	3 53	1 66
Sierra Health Services	ASE	24 50	-9 68	78 18	29 50	5 50	178	0 00	0 00	42	1 78	13 76
United Healthcare Corp	OTC	44 00	5 71	89 25	45 63	12 25	5220	0 06	0 14	35	3 76	11 70
United Medical Corp	ASE	10 00	2 56	25 00	11 38	6 63	5	0 20	2 00	13	8 79	1 14
U S Healthcare	OTC	45 00	-6 74	53 19	54 25	14 00	4344	0 48	1 07	22	3 38	13 31
HMOs	AVERAGE		-3 2	64 1					0 4	23		
ALL COMPANIES	AVERAGE		-1 1	28 2					2 7	9		

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