

Business Insurance

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LUI insurers may be placed into creditor-arranged rehab

LONDON—The troubled insurance companies owned by London United Investments P.L.C. may be placed into a creditor-arranged rehabilitation plan under one of the options being examined by brokers and insurers that want to ensure an orderly runoff of business written on the U.S. casualty line slip managed by H.S. Weavers (Underwriting) Agencies Ltd.

Insurers and brokers—led by Sedgwick Group P.L.C. and Marsh & McLennan—
Continued on next page

Antitrust litigants debate influence of federal brief

By JUDY GREENWALD

SAN FRANCISCO—State attorneys general say two amicus curiae briefs will help them overturn the dismissal of their antitrust litigation against 31 insurance industry defendants.

One of the briefs was filed earlier this month by the U.S. Justice Department (*BI*, May 14), while the other was filed by 13 states not among the 19 states that already are plaintiffs in the litigation.

Both amicus briefs ask the appellate court to reverse U.S. District Court Judge William Schwarzer's decision to dismiss the case (*BI*, Sept. 25, 1989).

California antitrust guidelines anger insurance industry. Page 3

In addition, the 19 state attorneys general that filed the suit, along with private plaintiffs in the case, filed a 66-page appeal brief.

However, attorneys representing the insurance industry defendants minimize the briefs' importance, contending they are unlikely to have any significant impact on the 9th U.S. Circuit Court of Appeals, which is hearing the attorneys general's appeal.

In the original litigation, attorneys general from 19 states filed suit in U.S. District Court in San Francisco against property/casualty insurers, reinsurers, trade organizations, brokers and individuals, alleging the defendants conspired to manipulate the U.S. commercial liability insurance market (*BI*, June 27, 1988).

The 13 additional states that filed the amicus brief on May 11 were led by Texas, whose own antitrust suit against many of the

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Court won't hear asbestos lawsuit brought by states

By STACY ADLER

WASHINGTON—The U.S. Supreme Court last week refused to hear a lawsuit filed by 29 state attorneys general seeking to recover the cost of removing asbestos from state-owned buildings.

Without comment, the high court refused to hear arguments that 26 asbestos manufacturers should pay for removing asbestos from schools and other government buildings.

Removing asbestos from the nation's public and private buildings would cost an estimated \$51 billion to \$750 billion, according to the lawsuit. But removal from only public buildings in these 29 states would cost an estimated \$16 billion, said a spokeswoman for Ken Eikenberry, the Washington attorney general.

Mr. Eikenberry, who organized the suit, said he believed "the primary reason why the Supreme Court did not accept the states' claim was the complexity and burden presented by the consolidated case."

"The Supreme Court usually operates as an appellate court and would need special procedures to function as a trial court," he said.

The Supreme Court ruling does not prohibit states from suing asbestos manufacturers in state courts. Eight other states already have done so: Kentucky, Maryland, Minnesota, Mississippi, Pennsylvania, South Carolina, Virginia and West Virginia.

Washington "is going to pursue state action," said the spokeswoman.

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States implement new comp formula

Big firms with good records to suffer

By MEG FLETCHER

CHICAGO—Some large employers with good loss experience may face higher workers compensation premiums under a revised formula for calculating an individual employer's experience rating that is being introduced around the country.

The new formula also is likely to increase workers compensation premiums for small employers with poor workers compensation loss experience.

However, the new formula—proposed by the National Council on Compensation Insurance and already implemented in four states—is expected to decrease workers compensation premiums for small employers with good loss experience and for large employers with poor loss experience.

In essence, the revised formula means loss experience will be less of a rating factor for large employers and more of a rating factor for small employers than under the old formula.

The revised formula will encourage small employers to emphasize safety programs to reduce losses, supporters of the change say.

And, the formula may lead workers compensation insurers to insure more small employers with bad loss experience since they will be able to charge higher premiums, thus removing these employers from the residual market.

However, the prospect of increased work comp premiums could force some large employers with good loss experience to opt for self-insurance rather than continue to buy commercial insurance.

"It penalizes those large employ-

ers who do a good job and gives a break to those large employers who aren't doing as good a job," said Lucille Gallagher, vp-risk management for Monfort Inc., a meat processing company based in Greeley, Colo., and vp-governmental affairs for the Risk & Insurance Management Society Inc.

For large employers with bad experience, "It's going the wrong direction," she said.

The revised formula so far has been implemented in only four states: Nebraska, North Carolina, Georgia and Colorado.

However, 10 additional states will implement the changes between June 1 and Sept. 1: Mississippi, Connecticut, Indiana, Maryland, Minnesota, Tennessee, Wisconsin, Alaska, Alabama and Illinois.

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New IRS pension rules hurt and help employers

By JERRY GEISEL

WASHINGTON—Internal Revenue Service pension non-discrimination regulations published this month wipe out an earlier IRS rule that could have raised havoc for thousands of employers that offer special pension provisions to only a handful of participants.

But other provisions in the newly issued non-discrimination rules could cause problems for employers, benefit experts say.

In particular, one provision may make it difficult for companies to combine different pension plans to pass the non-discrimination tests.

Another provision—involving how compensation is computed—would snip pension benefits for high-paid executives.

The best news in the proposed regulations is the IRS's decision to withdraw a February 1989 regulation governing the minimum number of participants a pension plan must cover to be regarded as non-discriminatory.

That regulation was intended to implement a provision in the Tax Reform Act of 1986 that said a pension plan generally had to cover 50 participants, or 40% of a company's workforce, whichever was less.

'The IRS has got it right this time,' Buck's Mr. Rumack says of the minimum participation rule.

But the regulation proposed in 1989 by the IRS said this 50 employee/40% threshold had to be applied to each "current benefit structure" in its pension plan.

For example, if an employer with 10,000 participants in its defined benefit plan offered a slightly richer accrual formula to 30 participants, such as employees of an

acquired firm, the plan would have flunked the minimum participant regulation.

Embarrassed IRS officials, who earlier this month described their minimum participation regulation as "a symbol of complexity," now say that variations in benefit structures will be allowed as long as the overall plan meets the threshold as well as other general non-discrimination rules.

Benefit experts hail the IRS decision to withdraw the 1989 minimum participation rule.

"The IRS has got it right this time. The service is saying, 'We don't care about an individual benefit structure.' It wants to look at the plan as a whole as long as the plan covers 50 people," said Frederick Rumack, director of taxes and legal services at Buck Consultants Inc. in New York.

"The IRS heard the criticisms of its regulation and recognized that it went too far," added Frank Roque, a consultant with Hewitt

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Self-funded MEWAs pose increasing worries, panel told
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Chicago Board of Trade plans to introduce insurance futures
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Flexible benefit programs trim fat from health plans
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Update

LUI rehab discussed

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nan Cos. Inc.—continued discussions last week on how to prevent Walbrook Insurance Co. Ltd. and six other LUI companies from going into liquidation.

Most of the insurers involved in the discussions ceded business to Weavers, said David Robb, assistant vp of Hartford Insurance Group, one of the insurers involved in the negotiations.

"Well in excess of 100 million pounds (\$167 million)" is needed to "have a good prospect of conducting an orderly runoff of the various companies within the LUI group," John Garner, chairman of Lloyd's of London Insurance Brokers' Committee, wrote in a memo to brokers last week.

The working group has offers of at least 40 million pounds (\$66.8 million) to help fund an orderly runoff, *Business Insurance* learned.

One of the options now being considered is a "scheme of arrangement," confirmed Messrs. Garner and Robb.

A scheme of arrangement is a British court-approved rehabilitation plan that must be supported by a majority of creditors. It often is more advantageous than a liquidation because the administrator usually has more freedom than a receiver to administer a runoff using commutations and other methods to speed the process.

Also, the working party believes funds raised to support the runoff will be better protected under a scheme of arrangement.

Benefit cuts trigger Bell strike

CINCINNATI—More than 3,000 unionized employees of Cincinnati Bell remained on strike late last week, demanding continuation of fully paid, first-dollar health care coverage.

Under the contract that expired May 12, members of the Communications Workers Union of America employed by Cincinnati Bell paid nothing for health care obtained through various health maintenance organizations or through a network of preferred providers, said Dodie Ditmer, bargaining chairwoman for the union.

Employees using non-network providers paid 10% of costs above a \$100 individual deductible and a \$300 family deductible up to \$900 per year for individuals and \$2,700 per year for families.

Cincinnati Bell—an independent company that is not part of Ohio Bell, an Ameritech unit that settled a similar strike over health care benefits last year (*BI*, Aug. 21)—is seeking to implement a flexible benefits program for its union employees.

Under the flex plan, employees would pay weekly premiums of at least \$6 for family coverage. Individual coverage would not require employee contributions.

In addition, Cincinnati Bell has proposed that employees share in some health care cost increases over the term of the new contract.

Cincinnati Bell, which implemented flexible benefits for management last year, declined to comment.

The union also is seeking improved vision and dental benefits.

Skandia to buy Met Re

NEW YORK—New York-based Metropolitan Reinsurance Co. will be acquired by Skandia Insurance Co. Ltd. of Stockholm, Sweden, under a letter of intent signed by Skandia subsidiary Skandia International Insurance Corp. and Met Re.

Terms of the acquisition were not disclosed.

Met Re reported 1989 net reinsurance premiums of \$91.9 million, a 22% decrease from \$117.8 million written in 1988.

Skandia America Reinsurance Corp. in New York, another Skandia unit, is expected to assume most of Met Re's business, although some of Met Re's business will be assumed by other Skandia companies, according to a Skandia America spokesman.

Skandia America reported 1988 net reinsurance premiums written of \$234 million.

A spokeswoman for Met Re, a subsidiary of Metropolitan Life Insurance Co. in New York, said Metropolitan intends to focus on other lines of business.

Skandia is the world's sixth-largest reinsurer, according to a *BI* ranking, based on 1988 net reinsurance premiums of \$1.2 billion.

Insurers lose satellite suit

SANTA ANA, Calif.—Three insurers lost a four-year battle to recover almost \$5.6 million from component manufacturers of a \$75 million satellite that failed to reach proper orbit in 1984.

An Orange County Superior Court jury last week ruled that while the motor of the satellite's upper-stage rocket booster—known as the payload assist module—was faulty, manufacturers McDonnell Douglas Corp. of St. Louis, HITCO of Newport Beach, Calif., and Morton Thiokol Inc. of Chicago—now Thiokol Corp.—were not negligent.

However, the jury found that Morton Thiokol, which manufactured the faulty PAM motor, breached its warranty with McDonnell Douglas. But Morton Thiokol was responsible only for paying the insurers' portion of the cost of the \$485,000 motor, not the cost of the entire satellite, Judge James Alfino ruled.

The insurers, which underwrote 7.6% of the \$75 million in limits for the Palapa B2 satellite, should only receive their portion, or \$37,000, for the loss of the motor, said Larry Kaplan, partner of Adler, Kaplan and Begy in Chicago, which represented Morton Thiokol.

Plaintiffs Lexington Insurance Co., a unit of American International Group Inc.; Talbot, Bird & Co. Inc., a New York-based insurance management unit of London-based Guardian Royal Exchange P.L.C.; and Northbrook Excess & Surplus filed the suit in March 1986 (*BI*, March 10, 1986).

Plaintiffs' attorney Shaw, Pittman, Potts & Trowbridge in Washington, D.C., could not be reached to comment.

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Errors and omissions

• A legal decision reported in the March 26 Legal Briefs, *The Chainery Inc. vs. Fireman's Fund Insurance Co.*, was subsequently depublished by the California Supreme Court.

Fraudulent MEWAs pose growing worry

By JERRY GEISEL

WASHINGTON—Fast-buck artists linked with self-funded multiple employer welfare arrangements are leaving an increasing number of people with millions of dollars in unpaid health care claims, a Senate panel was told last week.

Self-funded "MEWAs are ticking time bombs for consumers," Jo Ann Howard, a member of the Texas State Board of Insurance, told the Senate Permanent Subcommittee on Investigations.

Con artists lure small employers, desperate to purchase affordable health insurance, to self-funded MEWAs by promising cut-rate premiums, regulators say.

"We are talking about fraud in big, bold letters. You are dealing with professional racketeers. They (the promoters) are professional thieves," said Raymond Maria,

deputy inspector general at the U.S. Department of Labor.

Many self-funded MEWAs—also known as multiple employer trusts or METs—often are no more than elaborate "Ponzi" or pyramid schemes, Ms. Howard said. Promoters, often with insurance sales backgrounds, expect from the beginning that the plans will become insolvent.

To gain the trust of unsuspecting firms, MEWAs initially pay small claims promptly from cash flow. But soon, premiums that should be set aside for reserves and to purchase stop-loss insurance are diverted to pay organizers fraudulent fees and administrative expenses.

Ms. Howard said unscrupulous MEWA promoters fight every effort by state regulators to shut them down as unauthorized insurance operations.

The organizers claim that pre-

emption provisions in the Employee Retirement Income Security Act of 1974 bar state regulation of self-funded MEWAs. While legal battles are being fought, promoters attract new clients and collect premiums.

"They want to slow us down because time is money," Ms. Howard said.

By the time a state can shut down a self-funded MEWA, it is too late. After it sets low prices, reserves inadequately and misappropriates premiums, the MEWA is broke and policyholders are stuck with unpaid medical bills, regulators say.

No one knows exactly how large the problem of collapsing self-funded MEWAs is.

"Neither we nor anyone else has any idea of the scope of the problem," acknowledged subcommittee Chairman Sam Nunn, D-Ga.

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Experts question plan's feasibility

Insurance futures proposed

By JUDY GREENWALD

CHICAGO—The Chicago Board of Trade is seeking federal approval to sell futures contracts for health and automobile insurance.

The contracts will be based on reinsurance, said Leslie Rosenthal, chairman of the CBOT committee that is designing the contracts.

He would provide few additional details, citing competition with rival commodity exchanges.

The exchange announced the plan—with little elaboration—on Wednesday after the Financial Times of London published a story

about the proposed contracts.

The futures contracts are expected to allow auto and health insurers to protect themselves from reinsurance premium swings, thus stabilizing the price of insurance sold to policyholders.

However, insurance industry experts have expressed both puzzlement and skepticism about the viability of insurance futures.

A futures contract is an agreement to buy or sell a commodity or financial instrument at a particular price on a stipulated date. The contracts are used to protect against price fluctuations by lock-

ing in a price.

A simplistic example would be a farmer who has hogs that will be ready to go to market in six months. He sells a futures contract, guaranteeing he will sell the hogs at a particular price.

If the price of the hogs rises during that period, the farmer then buys a contract for hog futures, effectively offsetting the earlier contract. He then sells the hogs in the open market at the higher price and comes away with a profit.

On the other hand, if the price falls during that same period,

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OGICO in rehabilitation in Ohio; sale possible within the month

By CAROLYN ALDRED

CONCORD, Mass.—The Oil & Gas Insurance Co. of Westerville, Ohio, must stop writing new business following a rehabilitation order obtained last week by the Ohio Department of Insurance.

However, OGICO can renew business and will continue to pay claims during the rehabilitation period, said Neil Rector, deputy director of the Ohio Department of

Insurance.

Meanwhile, the Oklahoma Department of Insurance is seeking a rehabilitation order for affiliate company Petrosurance Casualty Co. of Tulsa, Okla., said Mary Clark, the Oklahoma department's general counsel.

Petrosurance had been ordered to suspend underwriting by the Oklahoma Insurance Department on April 16 (*BI*, May 14).

Both companies are subsidiaries

of Concord, Mass.-based holding company The Group Inc.

The Group also owns Chicago-based Millers National Insurance Co., which the Illinois Insurance Department has been examining. Millers was substantially reinsured and managed by OGICO. Late last Friday, the department still was examining the financial status of Millers and had taken no further action.

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✓ Risk managers must renew an emphasis on claims management and risk control to trim work comp costs, says broker Steven H. Pahl in Perspectives. **PAGE 21**

✓ Colorado ski area operators will have their liability capped for many skiing and sledding accidents when a new law goes into effect July 1. **PAGE 24**

✓ The chairman of AXA Midi Assurances S.A. says the French insurer's chances of acquiring a U.S. insurer in the future have improved. **PAGE 27**

✓ British insurers are reporting severe first-quarter losses from windstorms that swept across Europe early this year. **PAGE 27**

✓ Brokers' first-quarter reports indicate a soft market and a continued challenge to maintain earnings, says analyst Leonard M. Wilson. **PAGE 35**

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Flex plans hold line on health costs

By MICHAEL SCHACHNER

Employers are increasingly controlling their health care costs by implementing comprehensive flexible benefit programs.

While the hundreds of flex plans introduced during the past decade have not actually cut employers' health care costs, employers are discovering that offering workers a choice of benefits does reduce the expense of offering unwanted or unused benefits and encourages employees to choose managed care programs.

Two companies—Master Chemical Corp. and Avery International Corp.—credit their flex plans with keeping health cost increases in the single-digit range in a time of double-digit health care inflation.

Avery, an office supply retailer in Pasadena, Calif., kept its annual health care costs below the national per-employee average in four of six years since implementing a self-insured flex plan in 1983.

"If we had done nothing but kept our old plan, we'd be paying at least 30% more each year for health care," said James Bochinski,

Unwanted benefits eliminated

Avery's director of compensation and benefits.

Master Chemical, which is based in Perrysburg, Ohio, introduced a self-insured plan for its 125 employees in 1984, and "we have put the same amount of money into our plan every year since 1984. Some years we even ran at a surplus, which we simply left in the plan for the following year," said Ronald Sladky, vp-finance.

Another company, Volvo North America Corp., says that while its flex plan is viewed primarily as an effective employee recruiting and retention tool, the plan also has generated some unforeseen savings.

Avery, Master Chemical and Volvo are

among companies identified by the National Assn. of Manufacturers as controlling costs through flex plans.

Other employers are fighting rising health care costs by: implementing case management programs (BI, May 7); analyzing claims data (BI, April 30); adopting comprehensive health management programs (BI, April 16); working with labor unions (BI, April 2); and operating in-house medical clinics (BI, March 7).

Even small employers have developed their own special cost management strategies (BI, March 19).

Companies across the nation report that flex plans are a useful health care cost containment tool.

For example, employers with flexible benefit programs reported per-capita total health care costs of \$2,635 in 1989, or 7% less than the \$2,831 reported by employers without flex plans, according to a survey released

earlier this year by A. Foster Higgins & Co. Inc. (BI, April 2).

And, based on 1988 data, health care benefit costs comprise 8.7% of payroll for employers with flex plans, compared with 9.7% of payroll for other companies, according to the survey.

Likewise, a recent survey by Hewitt Associates reports that per-capita health care costs rose 14.9% in 1988 for employers with flex plans, while costs rose 22% for employers without flex plans.

Today employers view flex plans—whose origin can be traced to the late 1970s—as a way to make increasing employee costs more palatable, benefits consultants agree.

"From a financial standpoint, cost hits (to employees) today are inevitable," says Kevin Meehan, a Wyatt Co. consultant in Washington, D.C. "Flex makes the hit to the employee more palatable. Many employers believe they could not get away with increasing employee costs without flex."

With flex plans, employers' costs are increasing 2% to 4% below the national average.

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Municipal E&O claims stabilizing: Study

By DEBORAH SHALOWITZ

The percentage of local governments and public officials reporting errors and omissions liability claims seems to be leveling off after a big increase in the early 1980s, a recent study says.

But E&O damage awards against government entities are rising, as is the number of claims for which no monetary damages are awarded, according to The Wyatt Co. survey.

And quite frequently when substantial monetary damages were sought from a government entity, the final settlement involved little or no monetary compensation, Wyatt found.

Meanwhile, more local governments are self-insuring their E&O liability risks than in the mid-1980s, according to the survey.

The survey, conducted in 1988 and 1989, covered 1983 through 1988. Respondents included 1,329 local governments in all 50 states. The survey was a joint project of Wyatt and the International Community Management Assn., a Washington, D.C.-based professional and educational association

of appointed administrators in cities, towns and counties.

The study focused on governments' and officials' exposure to errors and omissions liability, which typically does not involve accidental bodily injury or property damage. Such claims usually stem from alleged improper or inappropriate executive and managerial decisions or actions.

Approximately 26% of respondents reported E&O liability claims in the six years covered by the 1988 survey, compared with 25.2% in the six years covered by a similar 1985 survey. In 1982, only 16.4% reported such claims.

"We're observing a turning point" in the susceptibility of public officials and governments to errors and omissions claims, said Steven Math, an associate actuary with Wyatt in Boston. "The public has reached a level of knowledge and aggressiveness about filing claims that we think is going to stay for a while."

Local governments most susceptible to E&O liability claims were those serving populations of 50,000 to 250,000, about 34% of which re-

ported at least one E&O claim between 1983 and 1988.

Local governments serving populations of 10,000 to 25,000 reported the lowest claim activity: Only 20% reported being hit with an E&O claim.

Only 6.7% of those serving 500,000 to 1 million people reported E&O claims. But with only seven respondents in this category, no meaningful conclusions could be drawn, the study reports.

Claim activity varied by region. In the Southeast, 31% of government entities were hit with an E&O claim between 1983 and 1988, compared with only 19% in the Northeast.

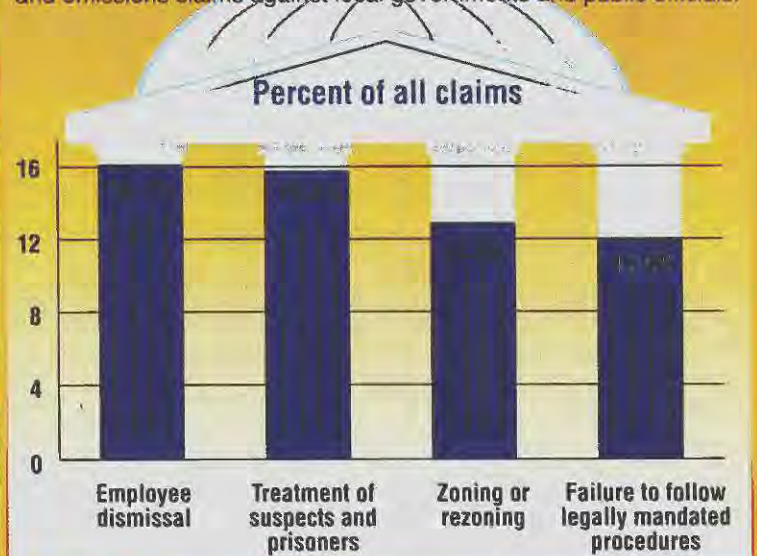
Private citizens filed 43% of all E&O claims against local governments and officials, while 29% were filed by employees or former employees, 13% by prisoners, and 8% by businesses. The remaining E&O claims were filed by labor unions, other government agencies and public action groups.

E&O claims most often were filed against local governments: 70% of them named the local govern-

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Top sources of public officials' E&O claims

Alleged improper dismissals of employees is the top source of errors and omissions claims against local governments and public officials.



Source: The Wyatt Co.

BJOHN SMITHER

Product liability bill will improve safety, proponent contends

By ADRIENNE C. LOCKE

WASHINGTON—Product liability reform legislation would help improve workplace safety by barring employers responsible for an employee's injuries from collecting a share of the tort award paid to the injured worker by the manufacturer of a product involved in the accident, a tort reform advocate said.

However, an opponent of this provision in the bill, S. 1400, testified before a Senate Consumer Subcommittee hearing that the provision steps beyond the boundaries of product liability reform and would make unwanted and unnecessary changes in workers compensation law.

Other supporters of the bill, introduced by Sen. Robert W. Kasten, R-Wis., called the legislation a "pro-consumer" bill because it would correct some of the problems in the current product liability system that translate into higher prices for consumers.

But, a consumer advocate contends that the bill would not benefit consumers if it encouraged manufacturers to bring unsafe products into the market.

The May 10 hearing at times broke down into volleys of insults and accusations about possible affiliations of some of the witnesses to plaintiffs' lawyers, which resulted in Sen. Kasten making an unusual call to place all witnesses under oath.

Sen. Kasten's request was denied by the subcommittee's chairman, Sen. Richard H. Bryan, D-Nev.

The raucous session was the subcommittee's final hearing in a series of three this spring on the Kasten proposal (BI, April 16; Continued on page 11

California antitrust rules anger insurance industry

By JOANNE WOJCIK

LOS ANGELES—Insurance trade groups, brokers and lawyers are boiling mad over final insurance industry antitrust guidelines released last month by California Attorney General John Van de Kamp.

They are particularly upset that the guidelines, which are the state Justice Department's interpretation of how state antitrust law will apply to the insurance industry, vary only slightly from draft proposals that observers said could severely restrict traditional industry practices (BI, July 31, 1989).

The final guidelines prohibit insurers from sharing prospective loss cost information to determine rates and suggest that use of standardized policy forms may constitute illegal price fixing.

The guidelines also question some common practices like using lead and following underwriters in reinsurance treaties; make surplus lines insurers subject to state antitrust law; and restrict communication between brokers and insurers.

In addition, the guidelines sug-

gest that insurers regularly consult antitrust lawyers before participating in trade group meetings or other joint activities that may be viewed as collusive.

"Very little is changed from the draft," said John J. Nangle, vp and assistant general counsel to the National Assn. of Independent Insurers in Des Plaines, Ill.

While his and other trade groups commenting on the draft "tried to be scholarly" in defending insurance industry operations, the attorney general apparently didn't pay attention, Mr. Nangle said.

At first glance, the final guidelines appear to be slightly more liberal than the draft, but "they still leave in question a lot of standard industry practices," said Barbara Haugen, director of federal affairs for the National Assn. of Insurance Brokers in Washington, D.C.

"If the guidelines are very strictly construed, they could have the opposite effect of what the attorney general is intending by reducing capacity rather than enhancing competition," said Jonathan F. Bank, an insurer at-

torney and partner with Buchalter, Nemer, Fields & Younger in Los Angeles.

Other insurance lawyers describe the guidelines as adversarial in nature.

"It threatens the industry with the prospect of having to defend against not only the law, but Van de Kamp's predilections of what the law should be," said Mr. Silberman of Sonnenschein, Nath & Rosenthal, a Chicago law firm.

California's antitrust law "is going to be subject to a lot of interpretation through litigation," the NAIB's Ms. Haugen predicted.

"Van de Kamp has laid down the gauntlet," said Tom Brunner of Wiley, Rein & Fielding, a Washington, D.C., firm representing insurers in antitrust and coverage cases. gauntlet," said Tom Brunner of Wiley, Rein & Fielding, a Washington, D.C., firm representing insurers in antitrust and coverage cases.

Unlike U.S. Justice Department guidelines that interpret certain federal laws, this document "says nothing about what are the legitimate business practices. It's an ad-

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Bush examines pension portability

By JERRY GEISEL

Plan would require lump-sum rollovers

WASHINGTON—The Bush administration is drafting legislation to make pension benefits more portable for the tens of millions of workers who change jobs before retirement, Secretary of Labor Elizabeth Dole said last week.

Many details are unresolved, but the proposal would require automatically rolling over an employee's lump-sum distribution from a defined contribution plan into his new employer's plan or into an Individual Retirement Account.

And if a defined benefit plan provided a pre-retirement lump-sum option, those distributions also would have to be rolled over into the new employer's defined contribution plan or into an

IRA.

Current law allows employees to take, with some tax penalties, lump-sum pre-retirement pension distributions in cash when they leave a company. Employees can, though they are not required to, roll the funds into an IRA. And new employers do not have to accept the distribution in their defined contribution plan.

The result, said Ms. Dole, is that 80% of these lump-sum distributions are spent rather than put back into a retirement plan.

"These savings have been granted tax-favored status on the condition that they be used for retirement income. Spending these

savings before retirement frustrates this objective," Ms. Dole said.

"Stated quite simply, portability, to the greatest extent possible, should ideally allow a worker to maintain a single retirement account for all of his or her savings," she added.

In an address last week to the Assn. of Private Pension & Welfare Plans, a benefits lobbying organization, Ms. Dole outlined other pension law changes the administration is considering. Those include:

- Requiring multiemployer plans to reduce the years of service required before an employee is

vested.

Such plans now may require 10 years of service before full vesting. Before the Tax Reform Act of 1986, single-employer plans also could use 10-year vesting, but that law generally required single-employer plans to adopt faster schedules by 1989.

Reducing that 10-year standard to five years for multiemployer plans—the limit typically used by single-employer defined benefit plans—would immediately vest an additional 1.1 million workers in multiemployer plans, Ms. Dole said.

That proposal would create a uniform vesting standard for

workers—regardless of whether they were covered by a single or a multiemployer pension plan. It would also boost costs for multiemployer plans.

- Increasing the attractiveness of special small employer pension programs, known as Simplified Employee Pension Plans, or SEPs.

The administration is considering raising to 50—from 25—the maximum number of employees a company can have for workers to make pre-tax contributions to the SEPs.

Under that change, "SEPs would allow an additional 5½ million workers to accumulate savings through pre-tax payroll deductibles," Ms. Dole said.

- Tougher enforcement rules.

The administration will soon send to Capitol Hill a legislative package that would increase the scope and quality of pension audits performed by outside certified public accountants.

That package also would increase penalties for employers that violate the Employee Retirement Income Security Act of 1974 and award attorney and expert witness fees to successful plaintiffs in private ERISA civil actions.

The administration also has requested enforcement staff increases—100 new positions in the

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For more information, call your CNA representative.

Most lump-sum distributions are spent rather than put back into a retirement plan, says Elizabeth Dole.

Pension and Welfare Benefits Administration and 33 in the department's Office of the Solicitor.

"We will strive to ensure that every participant receives the benefits to which he or she is entitled. I believe this can only be accomplished by renewed commitment through enforcement of our pension laws," she said.

Ms. Dole lashed out at a proposal by Rep. Peter Visclosky, D-Ind., to require employers to share control of defined benefit and defined contribution plan assets with employees.

She warned that the proposal, stripped last year from a broader budget bill, but now under renewed congressional consideration, would discourage companies from offering pension plans (BI, Jan. 22).

Under the Visclosky amendment, "Sponsors would have a strong disincentive to maintain their plans because they would bear the risk of plan investment performance without being able to determine investment strategies," she said.

The labor secretary also criticized proposals to bar companies from recovering surplus assets when they terminate overfunded pension plans.

Enacting such legislation would discourage employers from starting and fully funding pension plans.

That would result in less security and greater risk for millions of Americans, Ms. Dole said.

Ms. Dole pledged, to a warm round of applause, that she will fight to preserve the voluntary nature of the nation's pension system and to oppose government mandates.

"Our pension system has succeeded because it is driven by the market, and not government mandates. I am committed to doing all I can to ensure that it stays that way," she said.



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Opinions

Protecting beauty of reef

MARINE INSURERS ARE MISSING the boat by not requiring policyholders to use pilots aboard ships navigating between Australia and the Great Barrier Reef.

We only hope more underwriters get on board with this policy requirement before a devastating oil spill damages this unique and beautiful part of our world.

The Australian government, unfortunately, does not require the use of pilots on ships in the area.

As a result, marine insurers in Australia are trying desperately to get pilots on ships navigating these waters.

On one front, Australia's representative to the marine hull committee of the International Maritime Organization earlier this month argued that the IMO should adopt a requirement that ships navigating the waters between Australia and the Great Barrier Reef have a pilot familiar with the waters on board (see story, page 27).

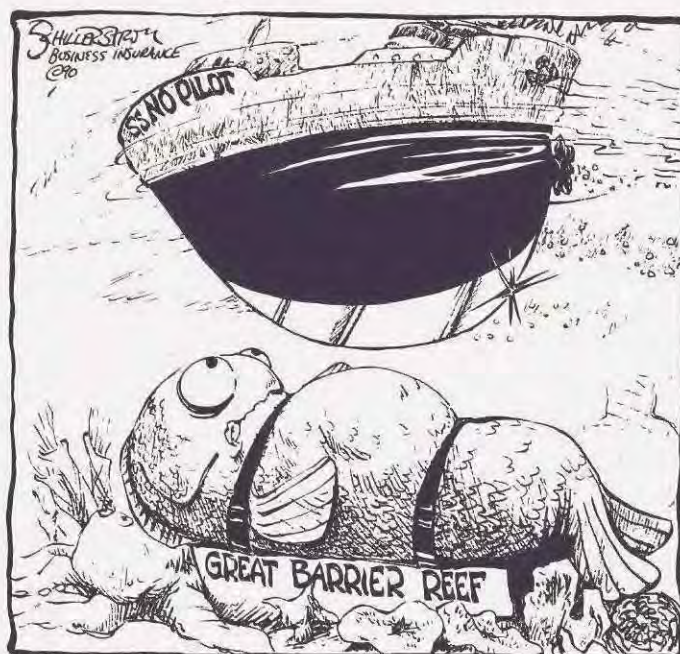
So far, the IMO—a United Nations agency that establishes standards for maritime safety and the prevention of pollution from ships—has only recommended that pilots be on board ships in this area. And too often the recommendation is ignored.

In addition, Australian marine underwriters are trying to convince their international colleagues to adopt this requirement in insurance policies. Australia's marine underwriters don't have the market share to do it alone.

The Great Barrier Reef is the world's largest collection of coral reefs—a 1,250 mile-long maze of islands, shoals and coral reefs along the Northeast coast of Australia.

The reef, most of which has been made a national park by Australia, could be severely damaged by an oil spill. It's estimated that tides would keep a 10 million-gallon spill, like the Exxon Valdez in Alaska's Prince William Sound last April, in the area for 10 years.

Ironically, as Australia's IMO representative was



•PIT AND PENDULUM.

arguing for this loss prevention measure, a cargo ship without a professional pilot ran aground on a reef off the north coast of Queensland.

No oil spilled—this time.

Confronted with the potential liability costs associated with damage to the environment and an Australian tourist economy reliant on the pristine Great Barrier Reef, marine insurers should adopt the pilot requirement to better protect themselves from large losses.

Of course, it will be extremely difficult to convince marine insurance underwriters everywhere in the world to adopt this requirement—especially those who do not appreciate the beauty of the Great Barrier Reef and the dangers of sailing through it.

But, until the Australian government adopts such a requirement, prudent underwriters will demand the use of pilots in the area as a condition of insurance.

Letters

A tip for RIMS: Drop an outdated speaker

To the editor: I am a deputy member of the Greater Kansas City chapter of the Risk & Insurance Management Society, and I attended the national RIMS conference in Boston. I have attended four other conferences in the last five years, and never was I so offended by a remark made by a luncheon speaker as I was by one made by Tip O'Neill.

In speaking of the comparison between the workforces of the United States and our foreign competitors, Mr. O'Neill stated that more than 60% of the U.S. workforce is female and that no one could convince him that women work because they want to.

While I do not believe it is polite to leave the hall when someone is speaking (and I never have before), I walked out after Mr. O'Neill's reference to working women. I wish all the women in the hall had had the same reaction I did. His statement was a slap in the face to the women risk managers in the room.

We have a female president of RIMS for the first time in its history. She has ac-

complished much in her career and deserves the recognition bestowed upon her. Many of us have enjoyed the intellectual stimulation of work for many years. We have gone into the workforce willingly to achieve personal satisfaction by contributing our talents to the business world.

It was personally offensive to me to have that achievement and contribution brushed aside by Mr. O'Neill in the context of the competitive world market. Ironically, Japanese women are now entering the business world in greater numbers than ever before.

With all due respect for Mr. O'Neill's accomplishments, he is hopelessly out-

dated in his thinking. There seems to be a movement in this country to put women again in the back seat whether they are working full-time at home or in business, and comments like Mr. O'Neill's add fuel to that movement.

I heard mixed messages at the convention—praise for women who are in risk management and a definite put-down of women from our Thursday luncheon speaker. I applaud RIMS for recognizing its women members; I boo RIMS for choosing speakers who do not.

Fran Romine

Insurance Administrator
Research Health Services System
Kansas City, Mo.

Why is UR 'little guy' ignored?

To the editor: With some frustration I read articles in your magazine that rely only on the "Big Boys" of the industry (Intracorp, Cost Care, etc.) as a source of reference on utilization review. If I'm not mistaken, *Business Insurance* should certainly remember printing an extremely comprehensive listing of such service providers.

Whatever happened to the little guy, blazing his own trail rather than simply following the utilization review boilerplate?

We have been, and will certainly continue to be, a leader in our field. Proportionately, as the little guy, we win our share of contracts, often offering our cli-

ents larger savings than the "Big 10" offers.

We'll guarantee it too!

Our little-guy approach has taken us nationwide and, as we quietly revolutionize the cost containment field, *Business Insurance* continues to call on the grandfathers of the business for their opinion.

Our small voice needs to be heard, our footsteps planted in the fresh soil of unique ideas, our clients applauding all the way to the bank.

Doug A. Sandler

Senior Account Representative
Medical Review Corp.
Morristown, N.J.

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Antitrust rules

Continued from page 3

versarial document," he said.

"There are a lot of customary insurance industry practices that will be challenged," Mr. Brunner added.

The guidelines will have a "chilling effect on what we believe is a lot of legitimate business activity," said Kenneth Nails, senior vp and general counsel for the Alliance of American Insurers in Schaumburg, Ill.

Deputy Attorney General Jesse Markham in San Francisco, who wrote the final guidelines, says they will test insurers. "The insurance industry represents that it's competitive. This will put them to the test," he said.

"Antitrust Guidelines for the Insurance Industry," is intended to provide a detailed analysis to insurers, brokers and others subjected to the Cartwright Act—California's antitrust law—by

Proposition 103.

The attorney general's office also published a summary of basic antitrust compliance rules intended for non-legal insurance industry personnel.

While the draft version was publicly circulated, the final guidelines have fallen into only a few hands. Among those with copies are insurance lawyers, publishers of antitrust resource materials and law libraries.

The final version of the guidelines include some corrections of inaccurate material contained in the draft version, as well as further clarification of certain ambiguous points, Mr. Markham explained.

The final guidelines also reflect developments since the draft was released last summer, such as the dismissal of the federal antitrust suit filed by state attorneys general, including Mr. Van De Kamp (see story, page 1).

In addition, the guidelines point out differences between California

and federal antitrust law.

"The guidelines take the point of view that California's antitrust law is more progressive and restrictive than federal laws," Mr. Markham explained. Joint trending or collective loss cost development are among the common industry prac-

On the other hand, "the sharing of strictly historical loss information is of no concern," he added.

Insurer attorneys criticize this application of antitrust law as impractical.

"The idea that insurers may not share price data simply ignores the

'What the industry needs to understand is that practices used to develop prices for next year's products based on last year's costs on a collaborative basis are illegal in California,' says Deputy Attorney General Jesse Markham.

tices that would be rendered illegal, he said.

"What the industry needs to understand is that practices used to develop prices for next year's products based on last year's costs on a collaborative basis are illegal in California," Mr. Markham said.

basic nature of the industry," said Royal Oakes, an attorney with Barger & Wolen in Los Angeles.

"If you sell steel, your price is based on your costs. If you sell insurance, you won't know your costs for years. The only way to price policies efficiently is for the

industry to exchange price data," he said.

"There has to be some way to reasonably put the information together to develop rates," asserted the Alliance's Mr. Nails. "Raw data means nothing. If it can't be combined, companies will not be able to estimate rates consistent with loss costs."

Setting rates without prospective data would be "more costly and especially difficult for small insurers," he added. "In the end, it could lead to the demise of smaller companies or their purchase by larger companies and eventually fewer companies competing in the market."

The Insurance Services Office Inc., which provides ratemaking data to insurers, declined to comment on the guidelines.

Use of standard policy forms is also challenged by the attorney general.

The summary to the guidelines states: "Any agreement among competing firms not to do business with certain customers or suppliers, not to do certain kinds of business or not to do business except under certain terms is considered an agreement to boycott and is illegal."

While the use of standardized products is not illegal per se, "when competitors get together to create a standardized product, antitrust restrictions apply," Mr. Markham said.

Mr. Nangle of the NAI asks: "How will consumers comparison shop if they all have different policies?"

And Wiley, Rein's Mr. Brunner said he was "startled" by the suggestion that "the development of standard exclusionary language could constitute a group boycott."

The document also shows a particular "hostility" toward the reinsurance industry, according to Mr. Brunner. "I clearly envision hostile scrutiny of certain practices and procedures."

Reinsurance treaties and facultative contracts underwritten jointly by two or more insurers "are not unlawful in and of themselves," say the guidelines. But they do have "significant anticompetitive potential," according to the guidelines.

"Indeed, a typical reinsurance treaty has some classic characteristics of a cartel, including enforceable conformance to prices and terms set by 'leaders,'" the guidelines assert.

That contention "ignores the fact that no cartel can exist in a competitive market, which reinsurance is," said Lawrence Trent, an insurer attorney and partner at Buchalter, Nemer in Los Angeles. Proposition 103, he adds, "specifically excludes reinsurance."

Criticism of the use of leading and following markets is directed at Lloyd's of London, according to other lawyers who represent insurers. "The attorney general is asserting his right to go after British and European reinsurers to the extent that they affect California business," Mr. Brunner observed.

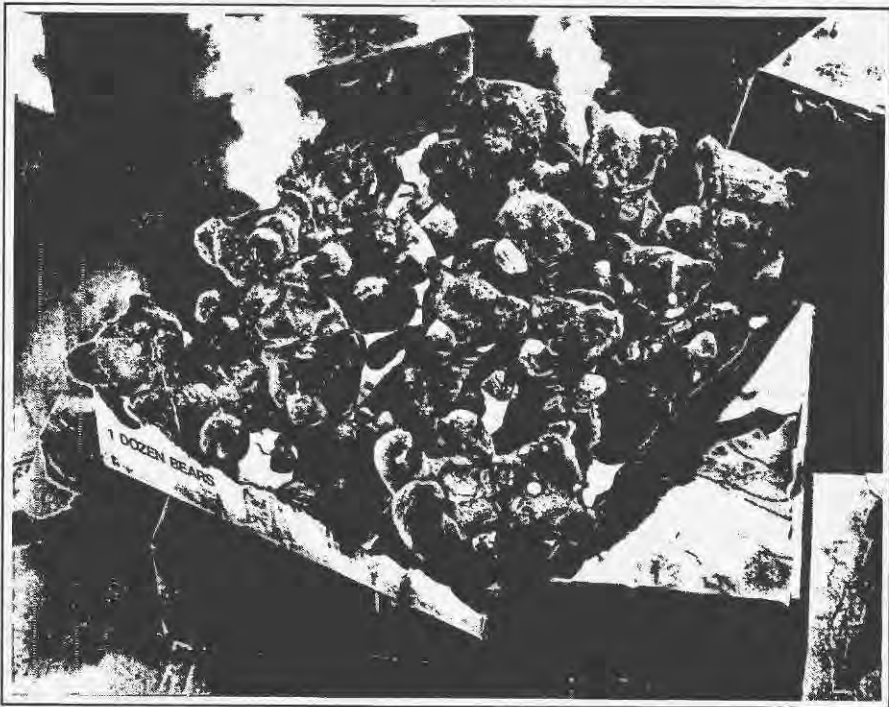
The guidelines also suggest that London underwriters and brokers attempting to influence coverage, such as by developing the pollution exclusion, could constitute a group boycott, Mr. Brunner pointed out.

The guideline summary states: "An agreement between a primary insurer and a reinsurer to reinsure a given risk is not prohibited by the antitrust laws. However, particularly in tight markets, decisions to exclude certain business from the reinsurance agreement have the potential unlawfully to effect a boycott of primary insurance customers."

The Reinsurance Assn. of America is still studying the guidelines and declined to comment.

Under the guidelines, surplus lines insurers would be subject to

Continued on next page



AUGUST 26, 1992

Continued from previous page
California antitrust law.

According to a footnote in the guidelines: "Reinsurance and excess insurance markets for specialized risks are likely to exhibit unusual barriers to entry in the form of limited supply of the necessary expertise and the lengthy period and limited opportunities to develop."

"The attorney general will examine closely any agreements among such firms that appear to take advantage of these barriers to new sources of competition."

The National Assn. of Professional Surplus Lines Offices Ltd. is still studying the document and declined to comment.

However, Richard Bouhan, executive director of Kansas City, Mo.-based NAPSLO, noted that Insurance Commissioner Roxani Gillespie has held that surplus lines are exempt from Proposition 103.

Industry trade groups say they are also concerned with the amount of communication that will be permitted between brokers and insurers placing layered coverage.

In the final guidelines the attorney general appears to acknowledge the need for some communication, but "he doesn't go far enough," said Ms. Haugen of the NAIB. He "reserved tremendous leeway to prosecute," she asserted.

For example, the sharing of rate information by agents and brokers with insurers could be a violation of antitrust law in some cases, according to Mr. Markham, the guidelines' author.

"Where there is a conspiracy among insurers to raise rates or boycott certain risks, and a broker facilitates this, it's illegal," he said.

Brokers "claim to need to relay from one insurer to another what each of the insurers in the market is doing," said Mr. Markham. "I'm not convinced that they need to."

The guideline summary also warns insurers to exercise caution when holding trade association meetings because such activities "bring people from competing firms together, creating opportunities for agreements that violate the law."

If, for example, industry representatives complain about low prices at an association meeting and several insurers subsequently raise rates, they could "support an inference of an unlawful agreement to raise prices," the summary states.

"Similarly, urgings that certain business is too risky to insure, followed by withdrawal of capacity, invite the same inference," according to the summary.

To avoid any appearance of impropriety, the guideline summary suggests that insurers consistently use written agendas for all meetings, excluding topics that competing firms should not agree on, such as prices, business plans, policy terms or exclusions.

In addition, the document suggests having lawyers at meetings where potential antitrust concerns may arise.

And the attorney general warns: "It does not matter where the meeting takes place. You cannot comply with California's antitrust laws by breaking them in another state or country. If the effects are felt in California, California law applies."

Numerous industry groups, brokers and insurers declined to comment on the guidelines pending further study.

Single copies of "Antitrust Guidelines for the Insurance Industry" are available for \$26.50, while the summary document, "Antitrust Compliance in the Insurance Industry," costs \$1. Send a check payable to the state of California to the Department of Justice, Public Inquiry Unit, P.O. Box 944255, Sacramento, Calif. 94244-2550.

Product liability

Continued from page 3
March 5).

Sen. Kasten introduced the legislation shortly after Rep. Thomas Luken, D-Ohio, introduced similar legislation in the House last year (BI, June 26, 1989).

Victor E. Schwartz, an attorney with Crowell & Moring in Washington, D.C., said S. 1400 closes a loophole in product liability law that allows an employer whose actions contributed to an employee's injuries to recoup what it has paid in workers compensation benefits through a subrogation lien on any recovery collected by that injured worker from a product manufacturer.

Under a provision in the Kasten bill, if the employer is in any way responsible for the injury, it cannot recoup its workers compensation payments, said Mr. Schwartz, who testified on behalf of the Product Liability Alliance, a coal-

ition that favors federal tort reform.

In most cases where this provision would arise, it is very clear that an employer's actions indeed contributed to an employee's injuries, he said.

The provision "places needed in-

centive on employers to keep their workplace safe. If the employer is at fault in creating a product-related accident, it loses its subrogation lien," Mr. Schwartz said.

But, Thomas D. Wilcox, executive director and general counsel for the National Assn. of Stevedores in Washington, D.C., an or-

tem."

The provision, if enacted, would deny to employers the traditional lien for injuries partially caused by third parties, he said.

Many employers depend on that reimbursement to keep their workers compensation programs afloat, especially self-insured employers that pay workers compensation benefits out of general operating revenues, Mr. Wilcox said.

Almost half of workers compensation benefits paid to workers employed by NAS members in 1988 was paid by self-insured employers, he said.

And, Mr. Wilcox said, there is nothing that indicates the current subrogation system needs to be altered.

"There is no evidence to date to justify a change in that policy," he said.

Meanwhile, another proponent of the Kasten legislation told the committee the nation's product li-

Continued on next page

A provision in the Kasten bill, 'places needed incentive on employers to keep their workplace safe. If the employer is at fault in creating a product-related accident, it loses its subrogation lien,' says Victor Schwartz of Crowell & Moring.

centive on employers to keep their workplace safe. If the employer is at fault in creating a product-related accident, it loses its subrogation lien," Mr. Schwartz said.

However, the bill also protects employers by barring a product manufacturer from subrogating

organization composed of privately owned marine terminal operators and stevedore companies, said this provision in S. 1400 would only add to the problems faced by a troubled workers compensation system, "without any significant benefit to the product liability sys-



AUGUST 26, 1992

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IT PAYS TO BE CAREFUL.

Product liability

Continued from previous page
bility system, if left unchanged, would continue to hurt consumers.

James Henderson, professor of law at the Cornell Law School in Ithaca, N.Y., called the existing system "anti-consumer" because it benefits only the trial lawyers, while driving up product costs charged by manufacturers.

In the end, "it is the consumer that pays the price of the current product liability system through higher prices and cost," Mr. Henderson said.

However, Linda Lipsen, legislative counsel at Consumers Union, a consumer advocacy group based in Washington, D.C., said the Kasten bill cannot help consumers if it provides an avenue for dangerous products to reach the marketplace.

Many of the "safe" products that supporters of product liability reform say are kept off the market by

fears of product liability legislation are, in fact, questionable from a safety standpoint, according to Ms. Lipsen.

As an example, she cited an asbestos substitute never marketed by Monsanto Co. that was touted in a March article by Vice President Dan Quayle as the "quintessential" example of how the existing product liability system keeps good products off the market.

However, the product caused cancer in laboratory rats during tests performed by Monsanto in 1986, according to a letter from the Environmental Protection Agency that same year, Ms. Lipsen testified.

The "secretary of commerce indicated in his testimony before this committee that if S. 1400 were approved, more of these types of products would be on the market," Ms. Lipsen said, referring to Commerce Secretary Robert A. Mosbacher.

However, "we don't need" more

unsafe products on the market, she added.

However, Sen. John C. Danforth, R-Mo., severely reprimanded Ms. Lipsen for not including this information in her written testimony, which is submitted days in advance of the hearing, and for using

However, Ms. Lipsen replied: "This is not something we do lightly." The subcommittee should know the truth about this product and other so-called safe products, she said.

Meanwhile, the senators attending the hearing also said they were

Senators say they were offended by a May 1 letter Ralph Nader sent to Sen. Kasten criticizing him for sponsoring 'another piece of cruel anti-consumer legislation' that would infringe on the rights of injured consumers to obtain fair compensation.

this information as part of a "sneak attack" on St. Louis-based Monsanto.

"I think you want to catch people off guard," he said, noting that she left no time for the subcommittee to investigate her allegation.

deeply offended by a May 1 letter written to Sen. Kasten by consumer advocate Ralph Nader that criticizes him for sponsoring "another piece of cruel anti-consumer legislation" that would infringe on the rights of injured consumers to obtain fair compensation.

The legislation would limit damage awards in some cases.

Mr. Nader suggested that Sen. Kasten and his colleagues would better spend their time dealing with the epidemic of white-collar crime and public scandals, like the collapse of savings and loan institutions, and the lack of affordable health care for the uninsured.

The senators took great offense at a portion of the letter in which Mr. Nader asked: "Why are you spending your time huddled in Washington with corporate lobbyists, many of whom finance your campaigns," while taking away long-existing rights of injured people?

Sen. John McCain, R-Ariz., labeled the remarks "repulsive" and "offensive," while Sen. John D. Rockefeller, D-W.Va., said the letter was typical of the kind of "knee-jerk" reaction for which groups associated with Mr. Nader are known.

In addition, Sen. Danforth insinuated that Washington, D.C.-based Public Citizen Research Group, a group affiliated with Mr. Nader, and Consumers Union accepted donations from the Assn. of American Trial Lawyers, a group composed mainly of plaintiffs' lawyers and a strong opponent of the product liability reform bill.

Sidney M. Wolfe, director of Public Citizen, and Ms. Lipsen angrily denied the allegations.

Sen. McCain later asked both groups to provide to the subcommittee records of all contributions the groups have accepted. Both witnesses agreed.

Among its other major provisions, the Kasten product liability reform bill would:

- Eliminate joint and several liability for non-economic damages in product liability cases.

- Permit punitive damages only if there is clear and convincing evidence of negligence by the manufacturer or product seller. A defendant could also request that the amount of punitive damages be determined separately at a second trial.

- Encourage attempts at settlement before the action reaches trial.

Either party would be able to make a settlement offer. If the defendant rejects an offer and the subsequent verdict is for an amount greater than the settlement offer, the defendant would also be required to pay the plaintiff's legal fees.

If the plaintiff rejects an offer and the subsequent verdict is for an amount less than the settlement offer, the defendant's legal fees would be subtracted from the award.

- Shield a manufacturer from liability if the claimant was under the influence of an intoxicating drug or alcohol and that condition was at least 50% responsible for the accident.

- Bar punitive damage awards for injuries involving drugs and medical devices that are approved by the Federal Drug Administration or aircraft that have been certified by the Federal Aviation Administration.

- Reduce the amount of the product liability award by the amount of workers compensation benefits received by the plaintiff.

- Generally restrict the filing of lawsuits to within two years of the discovery of the injury or its cause.

In addition, the legislation generally would bar product liability suits involving capital goods products that are more than 25 years old.

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Comings & goings: buyers

Allied appoints Yeaw group insurance chief

Gary P. Yeaw, 32, promoted to director of group insurance for Allied-Signal Inc. in Morristown, N.J. Mr. Yeaw has taken over the responsibilities formerly held by Joseph W. Duva, who left the company in April to become a partner at Ernst & Young in New York.

Mr. Yeaw, whose previous title was manager of employee benefits, is now responsible for planning, finance and policy development of welfare benefit plans for Allied-Signal's worldwide operations, including the company's managed health care programs. Mr. Yeaw reports to Ronald S. McGurn, vp-employee relations and benefits. Prior to joining Allied in 1982, Mr. Yeaw was an underwriter for Travelers Insurance Co. in Hartford, Conn. Mr. Yeaw holds bachelor's degrees in economics and finance from the University of South Florida in Tampa. He is a charter member of the International Society of Certified Employee Benefit Specialists. In addition, Mr. Yeaw serves as a trustee of the Regional Health Planning Council in Northern New Jersey and is a member of the board of directors of the National Assn. of Employers on Health Care Action.



Mr. Yeaw

Ms. Mitchell, who has been with Crowley Maritime for 17 years, most recently as manager of insurance accounting and systems, holds a bachelor's degree in business from the University of Oregon in Eugene.

We'd like to report on staff changes in your company's risk management, safety and employee benefits departments. Just drop a note to Nancy Johnson, Copy Editor, Business Insurance, 740 N. Rush St., Chicago, Ill. 60611-2590, or call 312-649-7784. Please send a photograph, too.

Charles F. Nalen, 43, named vp-risk management and environmental affairs at Crowley Maritime



Mr. Nalen



Ms. Mitchell

Corp.'s Pacific division in Seattle. In this new position, which Crowley created to give greater emphasis to environmental issues, Mr. Nalen is responsible for oil transportation safety, oil spill prevention, environmental compliance, contingency planning, insurance, occupational health and safety, and claims. Mr. Nalen, whose previous title was director of risk management for the Pacific division, has been with Crowley for 10 years. He reports to Brent Steinecker, president of Crowley's Pacific division. Prior to joining Crowley Marine, which provides marine transportation and related services, Mr. Nalen served as director of vocational education at Harry Lundberg School in Piney Point, Md., where he conducted tanker training courses. He also had been an engineer in the Merchant Marine. Mr. Nalen holds a bachelor's degree in adult education from the University of Maryland in College Park and has an engineering officers license from the Calhoun School of Engineering in Baltimore.

In a related appointment, Christine K. Mitchell has been named division risk manager for Crowley's Pacific division. Ms. Mitchell, who reports to Mr. Nalen, has taken over many of Mr. Nalen's duties in the areas of insurance and insurance accounting, claims management and contract review.

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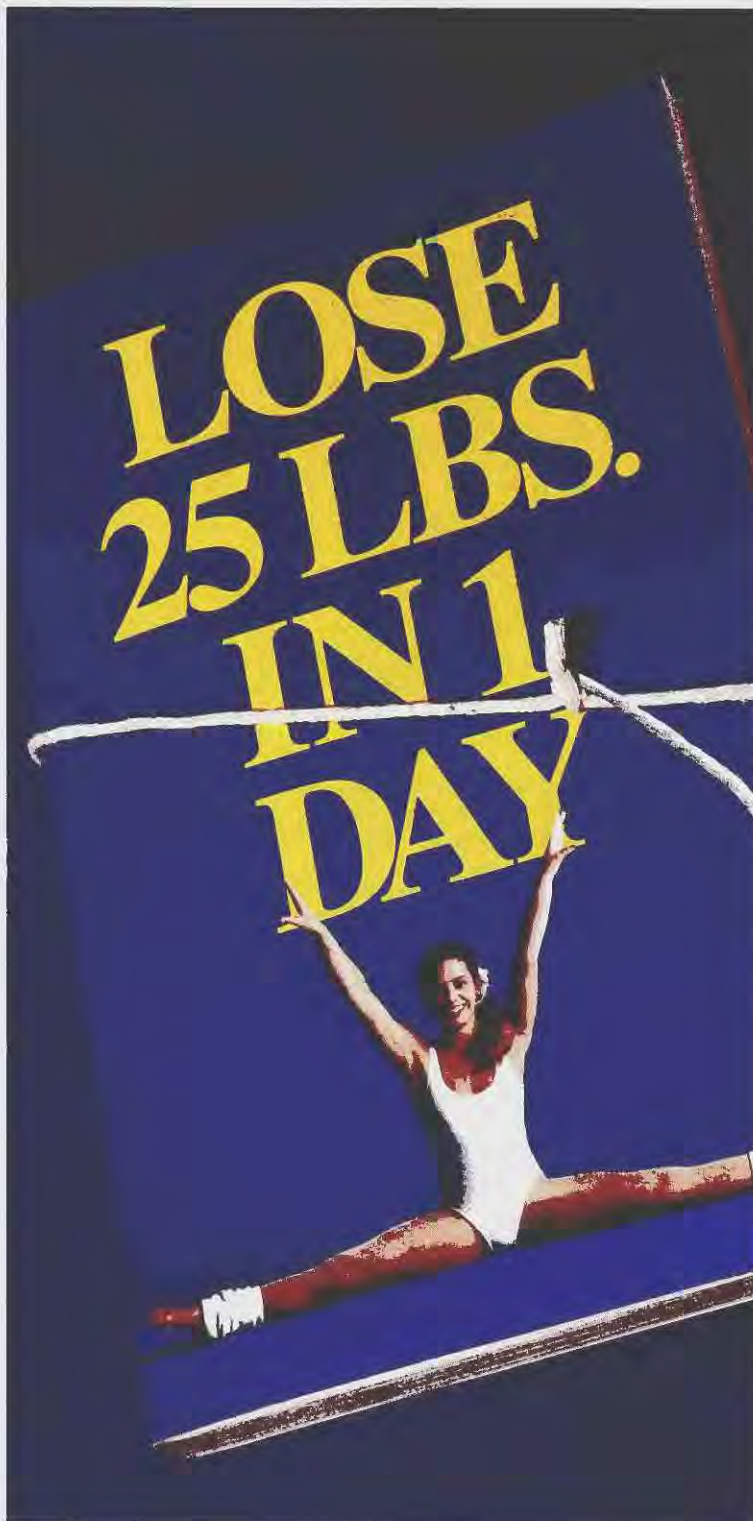
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AIA work comp reform plan includes increased regulation

By MEG FLETCHER

WASHINGTON—The American Insurance Assn. is proposing a slate of reforms—including increased regulation and the expanded use of preferred provider organizations—to combat workers compensation problems.

Workers compensation systems in many states face "unprecedented challenges," though workable solutions exist to solve them, the AIA notes.

The property/casualty insurance trade association outlined problems that are common to many states' work comp systems and proposes ways to remedy them in a recently released plan.

The AIA hopes that the 13-page

plan, entitled "An Agenda for Change," will become a blueprint for reform efforts in states with serious workers compensation problems, including Rhode Island, Florida, Massachusetts and Connecticut, said Eric Oxfeld, an AIA counsel.

"The workers compensation system is threatened by trends that are harmful to workers, employers and insurers," AIA President Robert Vagley said in a statement.

Those problems include soaring medical costs, unclear rules and procedures about benefit eligibility, needless litigation that delays benefit payments to workers, and legal challenges to the fundamental principle that workers compensation is an employee's exclusive remedy for workplace injuries.

In addition, "between 1984 and 1988, incurred claim costs increased 76%—from \$13.8 billion to \$24.3 billion," the AIA says, adding that "for the last 17 years, claim costs and expenses around the country have exceeded insurance premiums for workers compensation coverage."

"These are problems that cut across state lines," Mr. Oxfeld said.

Recommendations to correct general problems in troubled states include:

- Granting state administrative agencies the authority to adopt and enforce rules establishing appropriate behavior by all system participants, including injured workers, employers and their insurers.

These agencies should help avoid unnecessary litigation and provide prompt resolution of claims that are litigated.

In addition, they should review and approve for reasonableness all legal fees incurred by injured employees.

The agencies also can serve as information clearinghouses for workers and employers and provide forums for the resolution of all factual disputes.

- Implementing medical cost containment measures that ensure injured workers receive high-quality treatment at a reasonable price.

"Preferred provider organizations, which have become widely accepted under other payment systems, show promise for workers compensation in directing injured workers to high-quality, cost-efficient providers," the plan says.

The AIA also believes that a fee schedule specifying the maximum allowable payment for individual medical services can also be effective.

- Limiting vocational rehabilitation to voluntary programs rather than mandating them by law.

However, employers and insurers should see that all workers who can benefit from such programs are given an opportunity to participate, the AIA says.

- Improving safety and loss control by making insurers responsible for determining when loss control services are likely to be beneficial and for selecting appropriate services, rather than having the state mandate them.

- Applying reasonable limitations on occupational disease claims.

Arbitrary restrictions on occupational diseases, including statutory requirements that claims be made within an unreasonably restrictive time after last exposure, should be removed, the AIA said.

"AIA supports statutes of limitations that begin to run when the worker becomes disabled and knows or should have known of the disability and its relationship to employment," the AIA says.

In mental stress cases, the AIA supports restrictions including requiring that a licensed psychiatrist provide the diagnosis and limiting compensable cases to those that are caused by extraordinary workplace events.

The reform plan is part of the AIA's "intensive" effort to improve workers compensation programs throughout the nation, the group said.

The plan was produced by AIA staff members and reviewed by some of the AIA's 226 member insurers. AIA members write 38% of the workers compensation insurance nationwide, according to the organization.

The AIA is continuing its other activities to improve state workers compensation systems, including meeting with business, labor and other insurers. It also participates in a national work comp advocacy group organized by Gary L. Countrman, president and chief executive officer of Liberty Mutual Insurance Co. (BI, Feb. 26).

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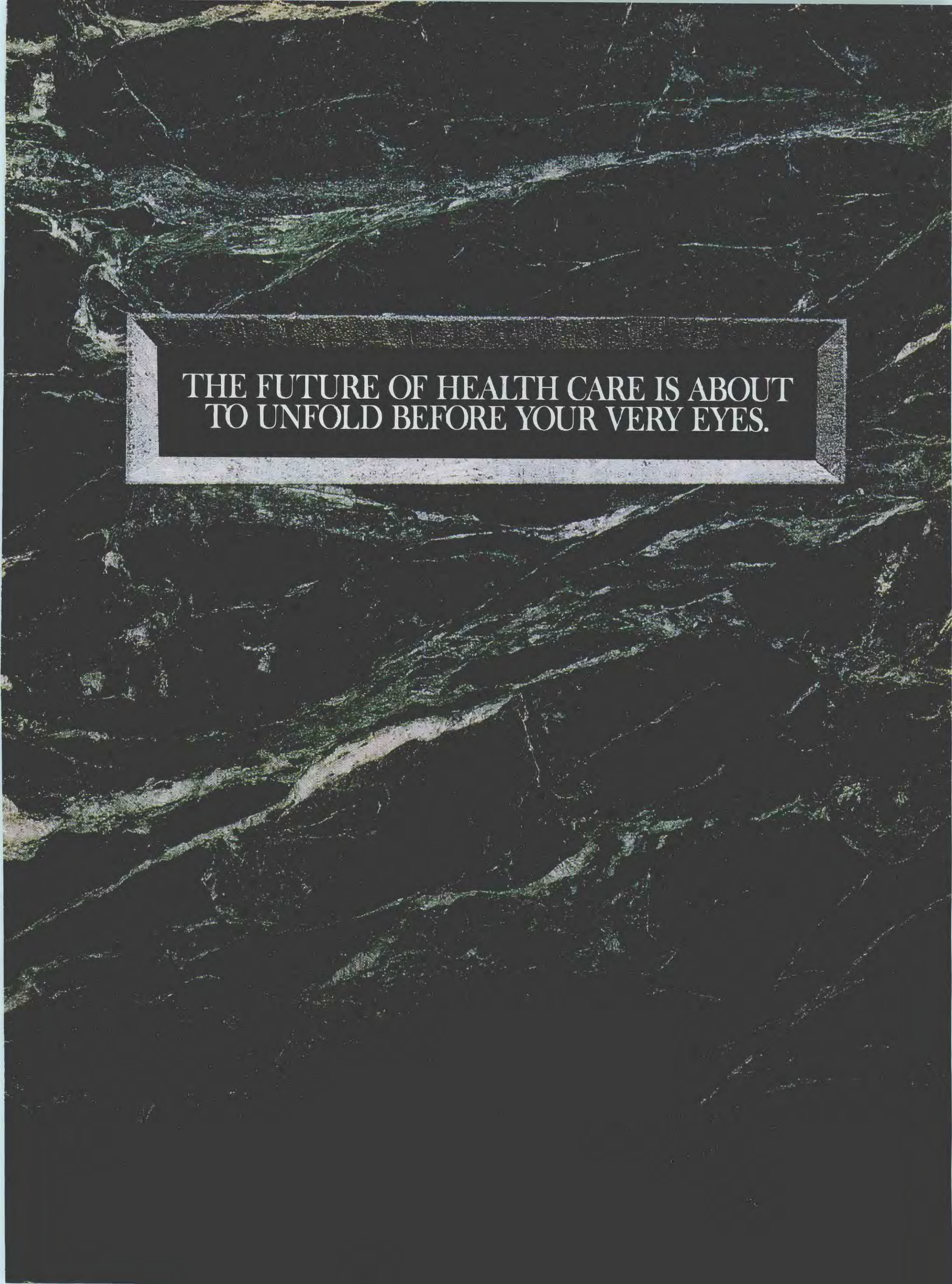
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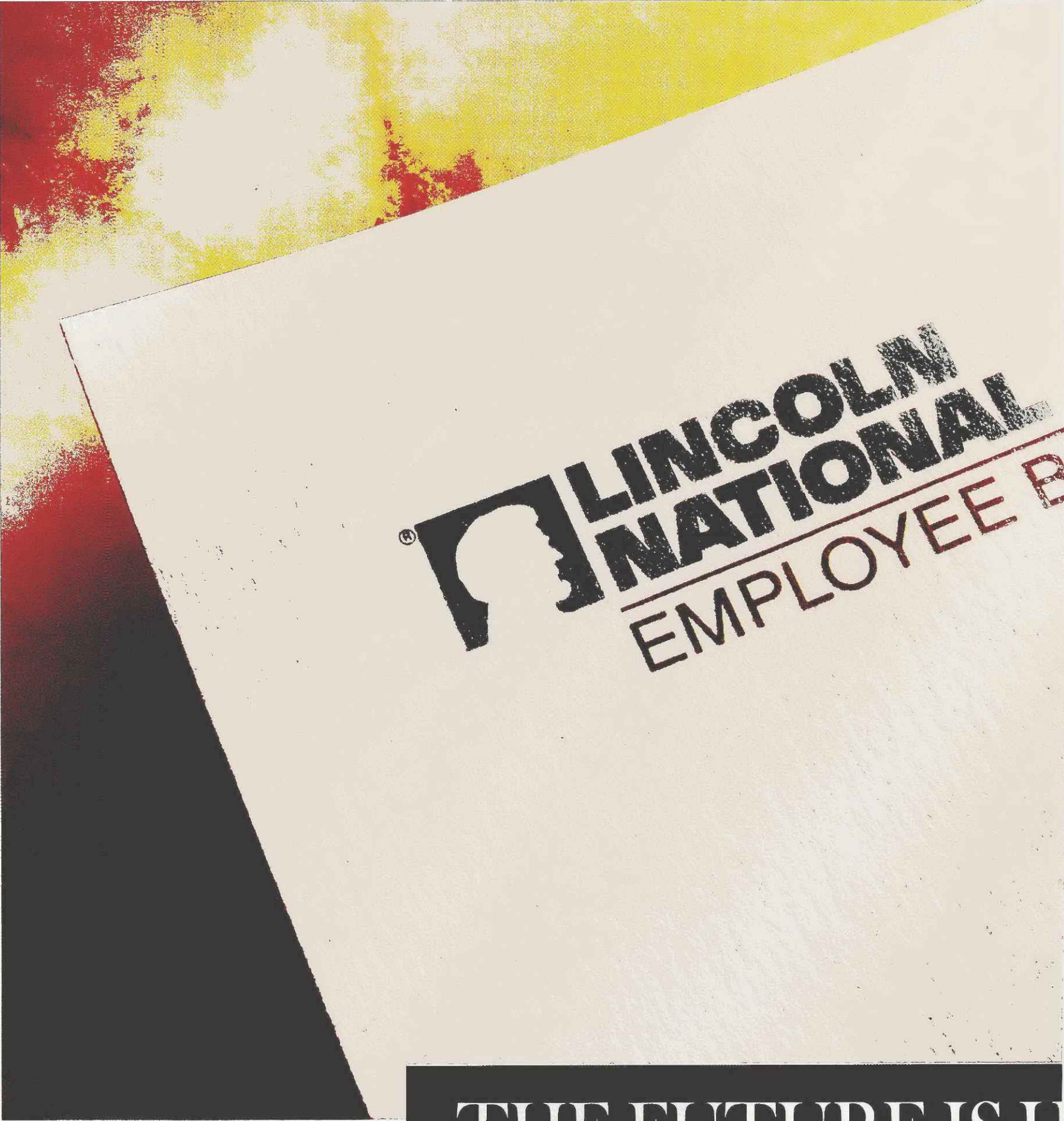
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The background of the entire image is a dark, heavily textured marbled pattern. The colors are predominantly black and dark green, with lighter green and white veins swirling and streaking across the surface. In the center of the image, there is a rectangular box with a dark, textured background. This box is framed by a thin, light-colored border that has a slightly irregular, hand-drawn appearance. Inside this central box, the text is written in a white, serif, all-caps font. The text is arranged in two lines, with the first line being slightly longer than the second.

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Work comp cost containment

By Steven H. Pahl

RISK MANAGERS, looking to hold down soaring workers compensation costs, must look beyond creative risk financing and renew an emphasis on claims management and risk control.

One of the dominant risk management strategies of the 1980s was the negotiation of increasingly aggressive cash-flow plans. Cash-flow plans can be defined as any traditional insurance arrangement that allows the policyholder to hold on to the premium payable beyond the inception of the policy. The amount of premium deferred and the length of the holding period define the "aggressiveness" of the plan.

Plans progressed from 16- to 18-month premium installments to very sophisticated unbundled, fronted, collateralized, insurers-cost-plus arrangements. The decade was marked by creative underwriting on the insurer side, and creative accounting/finance on the broker and buyer side of the equation.

Aided and abetted by cash-flow underwriting, one trend that emerged during this period was an increasing number of insurer insolvencies. Many state guaranty funds, expecting only the historical two or three failures per year, lurched into technical insolvency. State-run residual market mechanisms proved incapable of properly pricing the risks they assumed, piling up deficits in the billions of dollars.

At the same time, the indemnity and medical care components of workers compensation loss costs continued to race well ahead of the pace of inflation.

An ever-expanding definition of what constitutes a work-related injury made claims for stress, cumulative trauma and latent exposure injuries compensable. Many states legislated significant increases in benefit levels for employees while slashing requested rate increases from beleaguered workers compensation insurers.

The exclusive remedy doctrine, the cornerstone of

Belatedly, a virtual army of companies that traditionally sell managed care services to group health programs have turned their attention to the workers compensation arena.

workers compensation, has continued to erode as terms like "dual capacity" and "intentional harm" bring attention to the perennially ignored employers liability portion of the standard work comp policy. Many primary umbrella insurers began to require underlying limits of \$1 million for their coverage.

Workers comp medical benefits—which now comprise about 50 cents of every claim dollar spent—emerged as one of the last uncontested areas of growth for health care providers. Belatedly, a virtual army of companies that traditionally sell managed care services to group health programs have turned their attention to the workers compensation arena.

Many of the services these companies offer work well when dealing with a corporation's increasingly cost-sensitive employee population. However, the workers compensation claimant has in many states unfettered freedom of choice of medical care providers and, therefore, has no incentive to keep the cost of that care down.

As many policyholders are finding today, the first trend is having an impact on the cost of their carefully constructed cash flow plans. In the extreme, workers compensation assessments and residual market charges have become equal to or greater than the premium upon which these loads are based. More normally, it is not at all unusual to find these charges adding 25% to 30% to the premiums generated by a nationwide workers

Managers must look beyond risk financing

compensation plan. Obviously, such elements as the mix of states involved and any rating plan factors affecting the manual premium will also affect the amount of those charges.

Strategically, it makes little difference whether the current cash-flow plan is some variation of a guaranteed-cost approach or a purely fronted, fully collateralized arrangement. Every dollar of insurance included for premium reporting purposes will attract its proportionate share of taxes and assessments. Insurers simply pass through these charges in total to their customers. The alternative then is fairly obvious. . . buy less insurance.

Insurance buyers and risk managers must examine again the insured vs. self-insured calculation by state and, where reasonable, self-insure their company's work comp exposure. In the past, the comparative costs of these risk financing techniques may have been roughly equal to the prospect of dealing with a state regulatory mechanism tipping the decision over to an "insurance" alternative.

The fact that self-insurers did not pay state assessments, premium taxes or residual market charges for amounts they retain—although they do have other taxes to pay—simply was not a pivotal factor. It may certainly be so today.

Becoming a qualified self-insurer involves making formal application to the individual states for that privilege. While minimum levels of self-assumption depend upon a number of factors, \$175,000 may be the least amount a self-insurer would be responsible for and still attract a reasonably priced excess insurance program from a highly rated insurance company. Such insurance is readily and competitively available on both a specific (each loss) and aggregate (an accumulation of retained loss) excess basis.

Administratively, most large property/casualty third-party administrators maintain departments whose function is to manage the application process. They also calculate and pay on behalf of the customer those state charges associated with the privilege.

If, as expected, more companies avail themselves of the self-insurance option for workers compensation, the need for an effective loss control program will become greater than ever, but not for the obvious reasons.

The fact of the matter is that the incremental savings gained by switching from an insured cash-flow plan to a formal self-insurance approach, while not insignificant, is but a fraction of the savings available. The great potential benefit comes from forcing company management to deal directly, aggressively and creatively with the "loss" component of the cost-of-risk calculation.

As important as risk financing was to risk managers in the 1980s, I am convinced that the 1990s will find claims management and risk control elevated to star status. A renewed emphasis on these disciplines will require that corporations take the following steps:

- First and foremost, hire a risk manager.

For the self-insuring organization generating standard workers compensation costs of \$750,000 and greater, a full-time, skilled risk manager is a must. It is the individual who must purchase bonds and excess insurance, hire service providers, establish claims and safety protocol, establish and maintain a strong, in-house safety program, conduct periodic claim reviews and develop and manage a

useful risk management information system.

If a risk manager is already on staff, make certain that he or she has real authority over safety and claims matters. Often, such authority must supersede that of operations management in the interest of a safe working environment. Given recent legal developments, this authority is a valid risk management tool.

- Get serious about loss prevention and claims management.

Current opinion has it that safety begins with job and workplace design. Industry has become adroit in the use of time and motion studies, videotaping of jobs in progress and the resetting of job duties to minimize lifting, bending, stretching and actions involving repetitive motions.

As important as risk financing was to risk managers in the 1980s, I am convinced that the 1990s will find claims management and risk control elevated to star status.

Only recently has critical attention turned to the other, equally important factor in the workplace equation: The ability of the person hired to perform the job proficiently and in an accident-free manner.

Typically, an organization will require a pre-employment examination to assess an individual's overall physical condition. Depending on the nature of the situation, the applicant may undergo a battery of tests to determine his or her fitness for a particular job.

Seldom, if ever, are job criteria available that can screen out (in a non-discriminatory fashion) those not physically capable to perform a particular job at an acceptable level of productivity over time without an increasing likelihood of injury. So much more goes into "fitness" than just looking able, as any risk manager dealing with chronic back injuries will attest.

However, the tools exist today to scientifically establish such criteria. Applied to job classes with the greatest exposure to frequent and severe injuries, these techniques hold great promise for reducing loss costs through loss prevention.

In a self-insured environment, the risk manager has a real opportunity, if not a mandate, to control the ultimate cost of an accident/policy year. Central to this undertaking is a thorough understanding of the source and nature of the information needed to not only complete the requisite claim forms but to establish potential claim defenses. The promptness with which this data is collected often spells the difference between a claim you can successfully defend and one you've "bought." The best approach is to have your claims administrator conduct a managerial/supervisory training session that deals with accident investigation.

Once a claim has been made, depending on the nature of the claim, it often is then possible to utilize one of the myriad of services offered by managed care vendors. The most comprehensive of these reviews the information of every case involving lost time injuries and offers an independent estimate of the frequency and duration of treatment helping to set accurate medical reserves. It also provides evaluations regarding length of disability and identifies cases that may require a physician's review because of questionable treatment or questionable compensability.

Cases that fall outside of the guidelines established as a result of this scrutiny receive hands-on intervention from a medical professional who consults with the treating physician.

Many variations of the above theme exist through the utilization of preferred provider organizations

Continued on next page

Workers comp

Continued from previous page
or other medical care networks.

Again, employee freedom of choice as to treatment complicates the use of these cost-saving mechanisms.

Injuries involving hospitalization, potential physical or vocational rehabilitation and/or extended disability fit neatly into services sold and perfected in the group health setting.

One of the most overlooked aspects of injury cost containment is the manner in which the organization treats the injured worker in workers compensation cases.

While certainly not true in all cases, an employee who receives the same attention given to a disabled working relative is much less likely to unreasonably extend the length of disability or to make the ultimate disposition of the workers compensation claim difficult.

The risk manager has available all the tools needed to not only help prevent the most costly accidents through better hiring practices, but to also reduce greatly the cost of those accidents that inevitably take place.

Certainly the above suggestions could not be considered even a survey of what's available but, rather, those suggestions represent several relatively new services that can be utilized by risk managers to gain better control over

workers compensation costs.

The shift in emphasis from risk financing to claims management and risk control in workers compensation is not emerging—it is upon us right now.

Those who ignore the challenge will find that, while they may continue to enjoy the benefits of cash flow, the flow of cash they are most concerned with will have become a torrent.

Steven H. Pahl is an account executive with Arthur J. Gallagher & Co. in Schaumburg, Ill. Mr. Pahl holds the Chartered Property & Casualty Underwriter and Associate in Risk Management designations.

New cost control techniques emerge

Systems vendors' products grow in sophistication

By David A. Tweedy

MY WORK schedule during the Risk & Insurance Management Society conference in Boston this year allowed much less time than usual to give speeches, visit hospitality suites and spend the necessary time in the Exhibit Hall (which continues to get larger every year).

But despite the usual sensory overload and blurred images that occur after visiting the Exhibit Hall, I came away with some useful observations to report relating to risk management information systems:

- **Cost management/cost containment emphasis:** No question about it, much of the growth among vendors in the Exhibit Hall were among those touting strategies, systems or methods to analyze medical expenses, whether they be from a workers compensation or group health origin.

These vendors have been around awhile, but now they seem to be coming out of the woodwork because of the emphasis on managing medical costs.

It has been said that the 1990s will be the decade of controlling the workers compensation/group health cost spiral via cost management/cost containment techniques (utilization review, case management, preferred provider organizations, bill audits, etc.).

Risk management information system and employee benefit information system vendors are also recognizing this fact.

Two well-known vendors, Corporate Systems and California Interactive Computing Inc., are among several that have formed joint venture relationships with organizations specializing in medical cost management services or systems.

- **Integrated system solutions:** Every year, I comment on the level of sophistication of the risk management information system consumer. That trend toward increased sophistication has continued, and it is quite evident in a certain area: Clients are looking to purchase an RMIS/EBIS that integrates well into their corporate system's structure (finance/accounting, personnel, etc.).

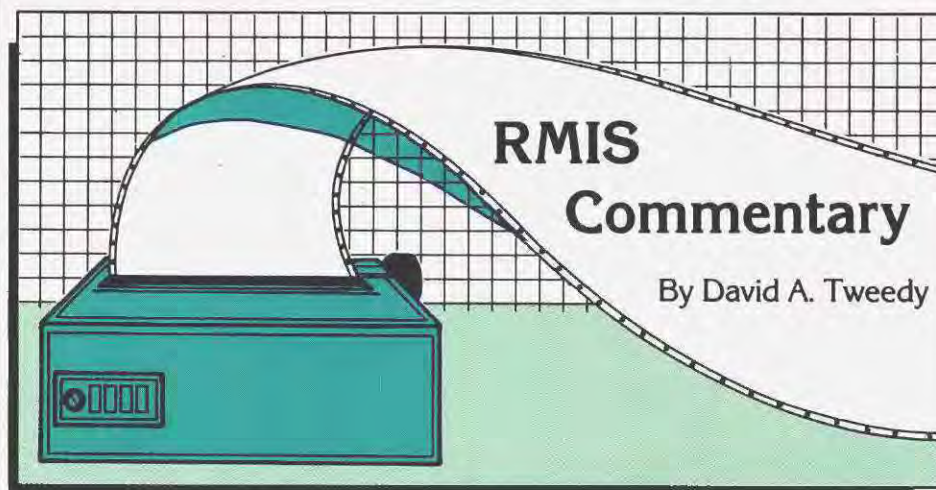
I have been a longtime advocate of

purchasing a system that can integrate with different existing systems within the organization for maximum efficiency.

Greater computer power, the proliferation of powerful microcomputers and advanced networking capabilities have augmented that process greatly.

I am personally excited about how I see my prophecy of the merger of EBIS

have learned it from reading this column or listening to their corporate director of management information systems, the message is getting through. Although I still talk with people from time to time who lament taking an initial plunge into a system solution without really studying the long-range implications, the majority of people I speak to now spend time preparing user and system



and RMIS taking place. I know of several organizations (clients included) who are pursuing a 24-hour coverage concept combining group health and workers compensation policies, or, at least, want universal reporting package that can track both group health and workers compensation claims, enabling the ease of checking for "double-dipping" or misallocation of claims (i.e., health claims erroneously submitted under workers compensation).

Potential customers are somewhat disappointed that they cannot go to a vendor and buy everything they need. Although vendors are not wholeheartedly jumping into providing joint EBIS/RMIS capabilities as well as policy issuance/tracking, statutory rating in accounting packages and agency automation packages, the advances in the hardware and software industry are making it easier to merge different hardware platforms cost-efficiently.

Another good sign is that consumers are recognizing they must perform the all-important needs identification/requirements documentation stage first before they go out and buy a system. Whether they

specifications, involving key departmental personnel with an interest in the ultimate comprehensive RMIS. Therefore, they are getting better results.

- **Back to the basics:** Vendors, more and more, are focusing on those system capabilities that made RMIS so popular initially—giving risk managers the ability to monitor and evaluate claims programs and, therefore, control costs.

There was not as much emphasis on the "bells and whistles" this year as there has been in the past. Rather, many of the vendors are focusing on their basic claims management package and providing more user-friendly cost management abilities. For example, many of the claims systems available really provide an ad hoc claims audit on the claim administrator in terms of reserve accuracy, contact of claimant, regulatory compliance, payment accuracy, settlement/negotiation reasonableness, subrogation pursuit, double-dipping and the all-important management reporting package.

To my thinking, this is key. A system should provide the diagnostic tools to a risk manager to evaluate the

effectiveness of the claims program he or she has, evaluate the accuracy of the medical bills being paid, and evaluate how well the legal aspects of the claim are being managed. This is a powerful capability, when used correctly, for the risk manager.

- **Less chaotic:** Perhaps I went to the Exhibit Hall at the right times, but I got the strong sense it was much less chaotic around the vendor booths this year. In fact, because people are better prepared than in the past, they are able to come in, make appointments with the vendors, see the demonstrations, pick up the descriptive material and leave without a lot of distraction. I am aware that many in the vendor community, over the years, have experienced "difficulties" in dealing with some of the sales strategies used by some larger exhibitors, but it seemed much more manageable and orderly this year.

One interesting note is that a lot of the vendors are passing out demonstration diskettes that prospects can take with no sales pressure, review at their leisure, and then set up a interview if they are interested. I think this is a great idea and probably saves some people their vocal cords.

In summary, I was impressed by the focus and intent of the vendors this year. Although I would like to see more integration between EBIS and RMIS (and I expect I will during the coming years), I expect that the emphasis on the basics and a total systems solution approach will well serve the risk management professional during this tumultuous decade.

David A. Tweedy is a senior consultant for Betterley Risk Consultants Inc. in Worcester, Mass. He is the editor of Betterley Risk Management Commentary and the author of RMIS Update, a yearly



publication analyzing major risk management information systems and vendors. Mr. Tweedy's column on risk management information systems appears the third Monday of the month.

Flex plan savings

Continued from page 3

age, says Marianne Brackey, a consultant with Hewitt Associates in Lincolnshire, Ill. "This is mostly because employers are passing off more of the costs" to employees.

Flex plans first grew in popularity in the early 1980s as employers tried to give workers more choices among medical plans, observers say. At that point employers were only permitted to offer cafeteria plans with non-taxable benefits. And all employee contributions were made on an after-tax basis.

But federal legislation passed in 1984 allowed employees to contribute pretax dollars to flexible benefit plans, which made the plans much more popular among employees, observers say.

"This legislation triggered the growth" of full-scale flex plans, said Ms. Brackey.

In addition, concern over rising health care costs prompted employers to establish flex plans to make cost shifting more palatable to employees.

The real explosion in popularity, though, did not occur for several years, said Mr. Meehan. By about 1987, corporate finance departments "began to realize that certain health care benefits like dependent coverage and first-dollar hospitalization could be taken away and replaced" with other, less expensive benefits.

Thirty-one percent of Fortune 500 companies now have flex plans, nearly double the 1988 total, said Ms. Brackey. And, the number of companies with flex plans still is rising 5% to 10% a year.

"With such a diverse workforce with varying needs, flex allows employers to stretch a limited pool of dollars over the greatest distance. It allows companies to spend only for benefits that will be used," she said.

"Among the Fortune 1,000, the rate at which flex plans were being implemented went up in the late 1980s, and the number of big companies putting them in is growing faster during the first part of 1990 than in 1989," Mr. Meehan said.

He cites three reasons for flex plan growth:

- Health care costs continue to climb.
 - Employers can offer work and family benefits inexpensively and these benefits are an excellent employee recruitment tool.
 - Employers simply are following their competitors' lead.
- "This is sad, but true," Mr. Meehan said.

Avery first began offering flexible benefits in 1983, when it established a plan that offered medical and dental plan options to a limited group of Avery employees.

The program subsequently was expanded and phased in on a group-by-group basis, explained Mr. Bochinski, noting that Avery now offers a comprehensive flex plan to 5,200 of its 11,600 employees.

Employees choose from one of four self-insured medical plans or can select coverage through vari-

ous health maintenance organizations. And, all four indemnity plans have built-in incentives for employees to use preferred providers: Employees using providers outside the company's network must pay an additional 10% of costs above their deductible.

Almost half the participants choose Avery's core medical plan, which requires employees with individual coverage to pay a \$100 annual deductible plus 20% of expenses beyond the deductible up to \$500 per year, he said. Core family coverage requires a deductible of \$300 with a separate out-of-pocket annual maximum of \$1,500.

Avery also offers high- and low-option plans, which carry deductibles of \$75/\$225 and \$300/\$900, respectively. The high-option plan requires a copayment of 10% up to \$250 per year for single employees and \$750 for those with family coverage. The low-option plan requires a copayment of 40%, up to a maximum of \$1,000 for individual coverage and \$3,000 for family coverage.

A fourth indemnity plan—purchased by more than 400 employees—is intended for married workers' spouses who are covered under their own employers' health care plans. This plan, which requires no deductible but covers only 25% of expenses, is intended to fill in gaps not covered by a spouse's plan.

Core medical coverage costs \$20.49 per month for single employees; \$44.81 for an employee with one dependent; and family coverage costs \$62.05 per month, said Mr. Bochinski. Higher contributions are required for the high-option plan, while some employees in the low-option plans receive a credit from Avery.

Monthly costs for HMOs—chosen by more than 40% of employees—range from nothing to \$110.

The Avery flex plan also offers three dental plan options, two levels of life insurance, two levels of long-term disability insurance, and health care and dependent care reimbursement accounts.

"The program has all the traditional cost-containment features," Mr. Bochinski pointed out. "We provide free annual physicals, case management for high-cost cases, mail order drugs and utilization review. We figure these things save about 18% per year."

He would not say how much Avery spent on health care in 1989, but said the annual cost per covered employee was \$2,772, about even with the national average expenditure of \$2,748 per employee in 1989 reported by Foster Higgins (BI, Jan. 29).

However, Avery's annual per-capita health care costs have been below the national average four times since Avery initiated flexible benefits in 1983.

In the two higher-cost years, including 1989, "we had a couple of premature babies delivered and that can really drive up costs," he said. "When you're self-insured you will have some spiked years."

The company, Mr. Bochinski says, has recovered and will again be able to hold costs below the na-

tional average in 1990.

Mr. Bochinski said Avery realized initial savings when it introduced flexible benefits because the flex plan replaced separate hospitalization and major medical plans with an all-inclusive comprehensive medical plan.

"That saved money from the start and it just carries over into the future," he explained. "Also, with many options available we don't experience adverse selection. People participate in the right areas and we don't spend money on wasted benefits."

Flex plans are most common among large employers concerned with trimming traditionally rich benefit plans, but one small employer—Master Chemical—used a flex plan to help it hold the line on employer and employee health care contributions from 1984 to 1988.

Only last year did Master Chemical require its 125 employees to contribute more toward benefits.

"Last year, monthly contributions went up by about 25%," said

'Flex allows employers to stretch a limited pool of dollars,' says Hewitt's Ms. Brackey.

Mr. Sladky, Master Chemical's vp-finance.

He cites two basic reasons for the success: flexible benefits, which have allowed the company to impose higher deductibles, and excellent loss experience.

"With such a small census, it's a bit dubious to attribute all of our success to flex. We have had good experience and we all know that with a small self-insurer like ourselves, one bad year can kill you," Mr. Sladky said.

Its worst year was 1989, when health care costs ballooned 46% to \$166,000.

Master Chemical employees choose one of five levels of deductibles for major medical coverage. The company fully covers hospitalization expenses.

Individual major medical deductibles range from \$100 to \$1,000 and family deductibles from \$200 to \$2,000. The plan also requires employees to pay a 20% copayment, which includes the deductible.

Annual out-of-pocket maximums range from \$500 for an individual with a \$100 deductible, to \$2,800 for an employee with family coverage and a \$2,000 deductible.

Coverage also is available through two local HMOs.

Employees may also select life insurance options ranging from one to four times salary and long-term disability coverage that provides 50%, 60% or 70% of salary. They also can convert credits into cash to be placed in dependent care or health care spending accounts.

Employees who opt out of all medical coverage receive a \$5 semi-monthly credit, while em-

ployees with individual coverage must contribute \$18.42 per pay-period for the more expensive of the two HMOs, the most costly plan option. An employee pays nothing toward his benefits if he selects individual coverage with a \$1,000 deductible.

Semi-monthly family contributions range from a credit of \$5 for opting out of all coverage to \$78.07 for the most expensive HMO.

Mr. Sladky said the flex program cost the company \$57,000 in its first year. "That's a low figure because of the conversion to flex. There's always a lag effect because you won't have any claims to pay on the first day."

Master Chemical subsequently spent \$118,000 on health care in 1985; \$104,000 in 1986; \$83,000 in 1987; and \$114,000 in 1988.

"The costs all the way through probably would have been closer to what we saw in 1989 without flex. Average cost increases in our region would indicate that our program would have cost more if we hadn't offered all the choices," Mr. Sladky said, explaining that part of the program's success results from employees opting for higher deductibles, which reduces the employer's cost.

The chemical company is "more committed now to flex than ever," though some changes are looming, he said.

"Some of our existing cost-containment features are antiquated," he said. "Second surgical opinions and precertification don't work by themselves and channeling people to outpatient facilities that don't require deductibles or copayments isn't working any more. These were innovative things in 1986, but we're thinking of dropping them now. We're looking into more modern cost-containment techniques like utilization review and managed care."

Meanwhile, Volvo North America Corp. of Rockleigh, N.J., eschews using its flex plan as an aggressive cost containment measure, and instead regards the program primarily as a recruiting tool.

"Volvo Options," begun in 1987, hasn't provided measurable savings because the company hasn't aggressively pursued cost control, said Keld Alstrup, director-compensation and benefits for the automaker's U.S. division.

"We have not gone after cost containment," he said. "When you do that, you risk creating a negative atmosphere. There were no Day 1 cost-containment features involved. We're not exactly satisfied that costs have risen 20% per year over the last three years, but we decided to spend the money."

The plan, which helps retain employees, "is discussed in all job interviews and is included in our recruiting advertisements," he said.

However, Volvo's health care costs—\$4.1 million last year for 1,175 employees—would have been even higher without the flex plan, Mr. Alstrup concedes.

"Without flex there would be nobody opting out of portions of the plan and we would certainly

have to pay more for additional life insurance benefits and core dental coverage," he explained.

Under the minimum premium plan, administered by Toronto-based Confederation Life Insurance Co., an employee begins the year with at least 870 "Flex-Bucks" to purchase core health care coverage, and basic life and long-term disability insurance. Employees receive an additional 15 Flex-Bucks for each year they are with the company, plus additional Flex-Bucks equal to 1% of salary.

"This allocation gives everyone enough to buy basic core benefits. If they then shop frugally and just buy what they need, the plan won't require any paycheck deductions," Mr. Alstrup explained. "If people want more than basic benefits, they pay for it on a pretax basis."

Core benefits are less generous than before the flex plan was set up, but Flex-Bucks permit employees to buy back what they had, enrich coverage or receive cash credits for unused Flex-Bucks, which can be converted into taxable dollars, placed in a 401(k) savings plan or exchanged for up to five vacation days a year, he said.

The plan requires employees to choose at a minimum the plan's core medical coverage, the cheapest option in terms of Flex-Bucks.

Core medical is a comprehensive medical plan that requires a deductible equal to 5% of salary, with a minimum deductible of \$750 for an employee with single coverage who earns less than \$20,000 per year and \$1,500 for an employee with family coverage who earns less than \$20,000.

Under core coverage, employees also pay 25% of charges up to \$1,500 per year.

Volvo also offers two medical options with lower deductibles, copayments and out-of-pocket maximums—one of which provides first-dollar hospital coverage.

The fourth medical option is an HMO.

Mr. Alstrup said the flex plan includes a dental plan option, which provides 90% coverage for basic services and 50% coverage for other services, up to a maximum of \$2,000 in benefits per year.

The plan also allows employees to select life insurance ranging from one to five times salary; accident insurance ranging from one to five times salary; short-term disability coverage that pays a maximum of \$200 per week or 67% of salary; long-term disability coverage with maximum payment options of \$600 per month, 50% of lost wages or 67% of lost wages; and additional vacation days.

Mr. Alstrup said that since all Volvos are built outside the United States, offering additional vacation time is not a real problem.

"Without a production line here we can afford to do this. The real cost would come in replacing line workers. It's a great recruiting tool. People starting new can come in with three weeks vacation and because we have priced this to be equal to their salary, it's a trade-off for us."

Municipal liability

Continued from page 3

ment as the defendant. About 30% included several officials or employees as defendants, while only 14% of claims were directed toward a single employee or official.

Alleged improper dismissal was the greatest source of claims, accounting for 16.1% of those filed.

Other leading reasons for claims included:

- Treatment of suspects and prisoners, 15.7%.
- Zoning or rezoning, 12.8%.
- Failure to follow legally mandated procedures, 11.9%.

Damage payments—awards and settlements—in public officials' E&O claims are rising consider-

ably, Wyatt found.

The largest settlement reported in the 1988 survey was \$5.2 million—up from \$1.1 million in the 1985 survey and \$230,000 in 1982.

"Should this trend continue, we may see claim settlements approaching \$25 million by 1991," the report added.

However, the great majority of claims still are for significantly less or no money, Wyatt found.

No monetary damages were paid in 63% of claims filed against local governments and another 23% required payment of less than \$20,000. Fewer than 1% of claims required payment of more than \$500,000.

"In many cases where substantial monetary damages were being claimed, the final settlement involved little or no monetary payment," the report noted.

"There are a lot of claimants that are kind of suit-happy," Mr. Math commented.

Many people file a claim against a local government "just to make a point," he said. "They're looking to set a precedent and control the government's behavior."

Defense costs and attorneys' fees are not included in these figures, the survey noted.

"Often legal fees and expenses equal or exceed the amount actually paid out in claim settle-

ments," the report added.

Governments reported spending \$16,477 per claim on average in the 1988 survey, up from the \$15,521 they reported in 1985.

Soaring premiums and severe restrictions on policy provisions have prompted many local governments to retain greater portions of their liability risks, the report noted.

In the most recent survey, 76% of local governments—down from 87% in 1985—reported purchasing primary public officials liability insurance, including coverage written by municipal risk-sharing pools.

"Instead of self-insuring as a last resort, (governments are) making a

conscious decision to self-insure because it's more cost-effective" when combined with a formal risk management program, Mr. Math noted.

Self-insurance tended to be more prevalent among local governments serving larger populations.

No local governments serving a population of 500,000 to 1 million reported buying primary E&O insurance. And 39% of governments serving populations of 250,000 to 500,000 reported buying primary liability insurance.

By contrast, 90% of governments serving populations of 10,000 to 25,000 bought primary E&O in-

Continued on next page

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**Business
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Municipalities

Continued from previous page
 surance and 79% of those serving populations of 25,000 to 50,000 bought primary liability insurance.

One million dollars was the most popular primary E&O limit, chosen by about 60% of the governments buying such coverage.

"One of the reasons for the popularity of this primary liability limit is that it is the minimum primary liability limit over which insurance companies will write excess public officials liability protection," the report noted.

The average primary coverage limit of those responding to the survey was \$1.45 million, down 22% from \$1.87 million in the 1985 survey.

The most popular deductible—chosen by 20% of local governments—was \$5,000. The most popular deductible among respondents to the 1985 survey was \$2,500.

The second most popular deductible among those entities participating in the 1988 survey was \$10,000, followed by \$2,500.

Of those governments that pur-

chased primary liability insurance, about half also bought excess liability insurance.

Premiums for local governments appear to have increased substantially since the 1985 survey, the report noted, but "it is difficult to construct meaningful statistical tabulations" because many variables affect premium charges. These include the size of the local government, the policy limit, the number of individuals insured, the deductible and retention arrangements, loss experience, the type of organization and coverage features.

However, "premiums shown in the current survey are often two to three times what they were in the 1985 survey for the same limits," the survey reports.

According to the 1988 survey, New York-based National Union Fire Insurance Co. of Pittsburgh, Pa., a unit of American International Group Inc., controlled about 20% of the municipal liability market, based on premium volume.

Next, with about 11%, was Scottsdale, Ariz.-based Scottsdale Insurance Co., a unit of Nationwide Mutual Insurance Co.

Other market leaders: Chicago-based International Surplus Lines Insurance Co., a unit of Crum & Forster Inc., 9%; Clarendon America Insurance Co. of Wilmington, Del., a subsidiary of Clarendon Insurance Group Inc., almost 9%; and National Casualty Co., a St. Louis-based unit of Nationwide, 8%.

The report, "Public Officials Liability Insurance: Understanding the Market," is available for \$75 from The Wyatt Co., 80 William St., Wellesley Hills, Mass. 02181; 617-237-3900.

Colorado law limits liability for ski resorts

DENVER—Ski area operators will have their liability capped for many skiing and sledding accidents when a new law goes into effect July 1.

A bill, S.B. 80, signed by Gov. Roy Romer earlier this month requires winter sport enthusiasts to assume the risk of injury or property damage resulting from the "inherent dangers and risks" of snow sports, including snow and weather conditions as well as natural and man-made surface conditions, like bare spots and water hydrants along ski trails.

The law also caps at \$1 million the damages a ski area operator may be required to pay in most accidents, including up to \$250,000 in non-economic damages. However, a court may raise that cap to compensate for a victim's lost earnings and health care expenses.

In addition, the law also shortens the statute of limitations for snow sport claims to two years from the current three years. The law also grants immunity from liability to volunteers rendering emergency medical assistance to an accident victim.

However, a ski area operator is still liable for injury caused by the use or operation of ski lifts. In addition, an operator is required to post warnings about hazardous conditions, and an operator must cover hard-to-see, man-made structures on slopes and trails in shock-absorbent materials.

The governor also signed two bills, H.B. 1065 and H.B. 1069, that limit liability in medical malpractice cases. The measures:

- Exempt from civil liability persons or health care institutions that render emergency assistance as long as any acts or omissions were not "grossly negligent or willful and wanton."

- Establish uniform standards for the imposition and distribution of punitive damages in medical malpractice cases against health care professionals.

For example, the law forbids mention of punitive damages in civil actions or arbitration proceedings until the plaintiff establishes there is—without a doubt—an issue to be tried.

In addition, it requires a showing of fraud, malice or willful or wanton conduct before punitive damages are imposed.

Also, the law bars punitive damages in cases in which a drug or product is used in accordance with standards established by approved state or federal regulatory agencies.

—By Meg Fletcher

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**Business
Insurance**

InsurerTopics

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Hungry for information

New demands yield improved data from insurance industry

By MEG FLETCHER

SCHAUMBURG, Ill.—The insurance industry is making progress in satisfying the ravenous government appetite for insurance data.

Government demand for data has forced insurers to realize the importance of the information they generate, said William Bolinder, president and chief executive officer of Zurich-American Insurance Group in Schaumburg, Ill.

While demands for data often have become "excessive" and "sometimes border on the ludicrous," the demands still must be considered and dealt with, Mr. Bolinder said during a seminar sponsored by the Insurance Data Management Assn. last month.

Historically, most requests for data come from state insurance regulators. Regulators seek financial information from insurers to determine whether they are operating prudently and will remain solvent.

Regulators also use data about pricing methods and losses from claims to evaluate the credibility of rate requests and ensure that rates are not "excessive, inadequate or unfairly discriminatory," which is the standard recommended by the National Assn. of Insurance Commissioners.

In the mid-1980s, though, the greatest demand for insurance company data came from state legislators and attorneys general, according to David Gates, a former Nevada insurance commissioner and NAIC president who now heads his own consulting company in Kansas City, Mo.

State legislators and attorneys general asked for a variety of information so they could respond to consumer complaints that first arose from the hard market of the mid-1980s.

Typically, these officials want to find out for themselves if insurers' requests for higher rates—or refusal to write certain lines of coverage—were justified, he said.

Some sweeping requests for information by state officials have proved troublesome for the insurance industry because the information was unavailable or not specific. Requests for data in a non-standard format also created burdens on insurers and the statistical agencies they finance.

In contrast, state insurance regulators' requests for information currently tend to be "more realistic in intent and utilization," Mr. Gates said.

One reason state regulators' requests are less onerous is that they typically use NAIC-approved reporting formats, which have been developed with input from insurance trade groups, he noted. While president of the NAIC, Mr. Gates was responsible for significantly enhancing data collection and processing capabilities.

The insurance industry generally has adopted a strategy of working with state regulators and the NAIC to help limit data requests to information that is both pertinent and feasible to collect, insurance industry spokesmen say.

The principal aim of that strategy is to make data collection and reporting requirements as uniform as possible from state to state, they say.

NAIC model laws on data reporting serve "as prototypical responses to reporting bills in states," said J. Michael O'Donohue, manager of government relations-national affairs for the Insurance Services Office Inc. in New York.

Insurers' strategy of working with the NAIC to help develop industrywide data reporting requests

is "sound," said Greg Heidrich, associate vp-research with the Alliance of American Insurers in Schaumburg.

But companies must lobby for uniform state reporting requirements if they wish to forestall federal regulation, he said.

Insurance industry spokesmen say they have recently worked with the NAIC to enhance data reporting in several areas, including:

• Workers compensation insurance claims.

Industry representatives are working to adopt by Jan. 1, 1991, many provisions contained in an NAIC model data reporting law, which the NAIC adopted last year (BI, March 19; Dec. 11, 1989).

The model law allows insurance regulators and state workers compensation administrators to obtain more detailed claims information from insurers so they can better analyze the costs and operation of state work comp systems.

Data managers for work comp insurers should begin now to develop a plan to obtain the information that will be requested, urged Thomas D. Steele, assistant vp-property and casualty data services for Wausau Insurance Cos. in Wausau, Wis. He distributed a draft copy of recommended data elements to the IDMA audience.

Insurers should gather data on three principal areas, he said:

• Accident information. This

would include: detailed biographical information on injured employees; general information about the employer; details of the accident and injury that led to a work comp claim; and general details, like the date the employer and insurer were notified of a claim.

• Benefit information. This data would include information about workers compensation benefits paid, including medical, vocational rehabilitation and post-rehabilitation benefits. Data on benefit offsets, such as Social Security benefits, unemployment compensation and employer pensions, should be included. Also, information on the recovery of some benefit amounts, be they from third parties or special funds, should be collected.

• Attorney involvement and litigation. This would include information on plaintiffs' attorney involvement in work comp claims and data on the level of litigation for contested claims.

• Auto and homeowners in-

surance claims.

The NAIC last December adopted a new model plan for collecting statistics on private passenger auto insurance issues that will give regulators more information about auto losses and where they occur geographically.

Industry representatives are working with state regulators to implement the model plan, said Stuart Yakes, assistant vp-independent statistical services for the National Assn. of Independent Insurers in Des Plaines, Ill.

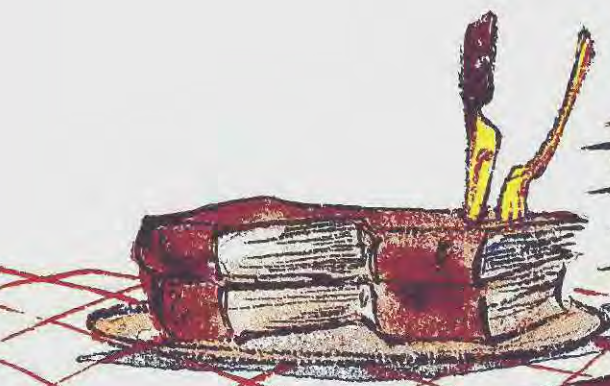
Similar changes in the reporting of homeowners insurance data are now being discussed by the NAIC, he said.

• Study of closed property/casualty claims.

Insurance industry representatives are participating in an NAIC study of closed property/casualty insurance claims, including a review of jury verdicts, said ISO's Mr. O'Donohue.

Industry representatives also are

Continued on next page



SCHILLERSTROM

Insurer Topics

Industry data

Continued from page 24B
problems, Mr. Inmon said.

The same system was used to support two activities: operational and management decision-making. Operational activities—like accounts receivable record keeping—require highly structured processing. On the other hand, data processing for management decision-making—which, for example, could be used to find out how many customers purchased at least \$100,000 of a certain product during the last calendar year—requires a highly unstructured approach.

But using a single data base created other problems, including increased transaction processing time, he said.

Ultimately, transaction processing and management support

activities were separated.

Most management support activities now are based on "extract processing," in which an analyst extracts a subset of needed data from the operational system.

However, extract processing by several analysts can cause problems. Inconsistencies in data extracted in different ways can cause questionable conclusions to be drawn, Mr. Inmon said.

Factors that could contribute to data inconsistencies include:

- Differences in the timing of the extracts.

An older extract would not contain recently added information.

- Differences in the subsets of data that analysts use.

For example, one analyst may look at records only for contracts valued at \$100,000 or more while another one may base his or her conclusions on all contracts, re-

gardless of their dollar value.

- Erosion of the data in the extract over time through the addition of information from a variety of external sources.

For example, an allowance for inflation could vary with the source providing it.

To reduce these problems, Mr. Inmon recommends that data managers consider "unified data architecture," which differs primarily by an added "atomic" level of data and letting analysts draw only from that level.

The atomic level consists of detailed snapshots of data from the operational system and serves as an archive for data taken at a particular time following explicit guidelines. Thus, it becomes a common reference point from which analysts can draw for future decision-support projects.

—By Meg Fletcher

Four years of teamwork credited in policy system

By MARK A. HOFMANN

CRANBURY, N.J.—If at first you don't succeed, the adage holds, try, try again.

But a series of false starts in connection with an automated policy-issuing system led Continental Corp. to conclude that maybe it was trying to do something the wrong way.

So rather than simply asking potential users what they wanted or telling the technical staff to build a system to perform certain tasks, Continental brought both groups together to work on what became the Total Commercial System.

That was four years ago. Now, the

teamwork concept responsible for that system will be extended to other areas of automation, says Bill Grier, Continental's vp-insurance automation planning and development in Cranbury, N.J.

Mr. Grier said the New York-based insurer decided to bring users and technical people together after suffering "three or four false starts" in the early 1980s.

For example, about 10 years ago an attempt to create a commercial policy writing and issuing system by relying only on user input "failed miserably," he said.

Users understood neither how automated systems worked nor their limitations, he said. And communication between users and technical experts proved difficult. "We were fighting each other," said Mr. Grier.

Another approach—working with an outside vendor on a rating system—was not a miserable failure, but it did leave the insurer "fully dependent" on the vendor for system changes, Mr. Grier said. That approach also proved very expensive.

So Continental decided to bring the two groups together throughout development, he said. Every two months the TCS Users Group—about 15 Continental underwriters, managers, raters and others—met with system developers in New Jersey.

Involving users early in software development represented a break with the past, according to Mr. Grier. Apart from one of the early-1980s false starts, users generally were not involved until much later.

Users reviewed plans and advised engineers of field office trends that could affect the system. Continental's aim was to design a system that wasn't outmoded even before it was up and running.

Communications problems between two teams of participants—one in Piscataway, N.J., sometimes as much as an hour's drive away from the other one in Neptune, N.J.—slowed things down. Offices were rented in Freehold, a town about midway between the two sites, and opened in early 1989.

Giving the project a home of its own helped create an "entrepreneurial spirit" that fostered development of the automation system, said Mr. Grier. "We began to create a team spirit."

Senior managers on a steering committee reviewed plans, set priorities and monitored progress, Mr. Grier said.

By the end of 1989, the system was up and running.

The result is a "full policy writing" system as opposed to the insurer's previous workstation system that performed only rating and quoting functions, Mr. Grier said.

The TCS follows policy issuance from initial quotes to printing. Laser-printed policies eliminate the need for separately typed declarations and endorsements, he said.

Continental learned insurance and systems experts can work together without becoming antagonists. The TCS development experiment also pointed to the possibility of cross-training people in both disciplines. For example, users are being encouraged to learn systems analysis and other data processing techniques, Mr. Grier said.

Systems experts are being encouraged to take insurance courses and, if they desire, to pursue professional designations such as Chartered Property and Casualty Underwriter, he said.

The experiment in cooperation will not stop here. "We plan to keep at least some of the teams together to work on the next logical step—a prelude to an expert system," he said. ■

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Issue: June 18
Ad Closing: June 5

Contracting for Services

What outside services do insurers rely on, and is the trend to keep work in-house or to contract out with consultants or other vendors? In answering these questions, BI editors will examine the types of outside services insurance companies need and use, and how to select the best vendors—from hiring part time office help to engaging actuaries or consultants.

Issue: July 16
Ad Closing: July 3

Employee Development & Education

BI editors will examine how insurers are using educational programs to keep their employees' job skills sharpened—are they developing their own programs or turning to outside sources. In addition this section will look at remedial programs—are they effective tools for helping employees who lack basic educational skills.

Issue: August 20
Ad Closing: August 8

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Automation lets Federated retrieve data

By MARK A. HOFMANN

OWATONNA, Minn.—Federated Mutual Insurance Co. had been relying on automated data bases for about 10 years when a mid-1980s burst of growth in commercial lines sent the insurer scrambling for a better way for field offices to gain access to data and to handle policies.

"We had developed a good foundation of data in commercial business," said Gary Tobiason, vp-information systems for Owatonna, Minn.-based Federated Mutual. The catch was that data was tied up in hard-to-access mainframe computer memory banks.

Mr. Tobiason said most of Federated Mutual's commercial business is "Main Street" accounts like small contractors, plumbers,

retail farm equipment dealers and automobile dealers. That business, generated by direct writing rather than through independent agents, is concentrated in the Midwest and Southeast, he said.

The insurer had automated its commercial accounts receivable in 1975, said Mr. Tobiason and subsequently wanted to automate as much of its policy production as possible. But with the insurer dependent on mainframe computers, "it soon became obvious" that further automation would be difficult with existing tools.

Meanwhile, it seemed that Federated Mutual was adding a mainframe computer every year—an expensive and time-consuming process, he said.

At the same time, Mr. Tobiason said Fe-

derated's automation professionals had always wanted to provide easier access to all of the data in the system. The insurer also wanted to cut down on paperwork and increase productivity.

Federated Mutual needed a way to link the mainframe with personal computers in agents' offices, he said.

Mr. Tobiason said that after examining the market, in 1986 he chose the Metaview cooperative processing software system developed by Metafile Information Systems Inc. of Rochester, Minn. The system linked personal computers to the mainframe and allowed laser printing of forms, said Mr. Tobiason.

The mainframe became a "large file server" to the personal computer-equipped

offices, he said.

Mr. Tobiason said savings from automation are difficult to determine because the system is still being phased in. The major application is currently commercial automobile liability insurance, for which the system provides rates and prints forms, he said. "All forms necessary to print a commercial auto policy are stored electronically," he said.

This application has saved roughly \$150,000 annually in forms alone, he said.

Greater savings should be realized as the system is extended to workers compensation and pollution liability insurance, both of which are currently automated for form printing but not for rating, Mr. Tobiason said.

Life/health firms invest in 'social' projects

By MARK A. HOFMANN

WASHINGTON—About a third of surveyed life/health insurers invest in socially desirable projects like low- and moderate-income housing, health facilities and neighborhood redevelopment, according to an insurance industry-sponsored study.

"Social investing is alive and well in the life and health insurance industry," says the report from the Center for Corporate Public Involvement, a joint committee of the American Council of Life Insurance and the Health Insurance Assn. of America, both based in Washington, D.C.

Just more than a third, or 55, of the 157 U.S. and Canadian insurers responding reported making at least one social investment in 1989. A social investment was defined as "those made specifically for socially desirable purposes that would not have been made otherwise under the company's customary lending standards."

Of 28 companies that gave reasons why they were not making social investments, 39% said the main reason for their decision was an anticipated low rate of return on the investment. The second most frequently cited reason, noted by 25% of those that did not make social investments, was the respondent's financial condition.

Other commonly cited factors for not making social investments were a perceived lack of a need for social investing in the company's geographical area, a preference to make direct contributions, a lack of interest within the company and a lack of opportunities to make social investments.

The survey's authors caution against projecting that level of social investing among the surveyed companies to the entire life/health insurance industry because only companies with at least \$140 million in assets were surveyed. The authors also concede that the survey results may be skewed because companies that have made social investments are more likely to respond than companies that have not.

Only companies belonging to either the HIAA or ACLI were surveyed.

Stanley G. Karson, director of the Center for Corporate Public
Continued on next page



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Insurer Topics

Continued from previous page
Involvement, said that while there has been no "scientific study" comparing how financial services industries stack in terms of their commitment to social investments, "my experience over the past 20 years is that the life/health industry is the leader in the field."

Life/health insurers have more money to commit to social investment than property/casualty insurers because they can generally make longer-term investments than property/casualty insurers, Mr. Karson explained.

Property/casualty insurers usually need more ready access to liquid capital than life insurers, he noted.

The amount that individual life/health insurers invested in social investment projects varied widely by insurer, according to the survey, but the most common social investment—cited by 27% of the insurers—was \$500,000 or below. The survey did not ask insurers what portion of their total portfolios was social investments.

Distribution of investments by project type also varied widely.

Of the 55 companies that made social investments, 42—or 76%—made an investment in housing projects or developments. Forty-one percent of all funds committed to social investments among the surveyed companies were invested in housing, with nine companies—or 16%—reporting making 80% or more of their social investments in housing.

The second most popular social investment was economic development and job creation, with 32 companies—or 58%—investing in this area. However, only 19% of the funds committed to social investments were invested in this area.

Other areas in which social investments were made include commercial revitalization, health facilities, educational projects and environmental projects.

All responding companies with assets exceeding \$15 billion reported making social investments. However,

only 18% of the life/health insurers surveyed with assets of \$350 million or less reported doing so.

A quarter of the companies making social investments were guided by a formal policy statement, a formal program or both. And 27 companies—nearly half of those that had made social investments—said those investments were made on an ad hoc basis.

The remaining companies either did not answer the question or reported having an "established procedure" that they follow when making decisions pertaining to social investments.

While there is considerable diversity among how insurers make social investments, "there is notable conformity on the issue of the source of funds used for social investments," the report said.

Three-quarters—or 41—of the companies said that the money came

from investment portfolios, while 16%—or nine—of the insurers said social investments came from funds earmarked for charities and other types of contributions. Four companies reported using both methods.

An overwhelming majority—94%—of the life/health insurers making social investments reported that they intended to continue doing so. Six percent reported they didn't know whether they would do so in the future.

Of the 47 companies projecting future social investment activity, 19% expected their social investment activities to increase, 11% projected a decrease and 64% said that activity would remain the same, with 6% not sure.

Mr. Karson said that the Center for Corporate Involvement has tracked social investments by life/health insurers since the early 1970s.

The total amount insurers invested

in social projects "has been pretty steady in the area of \$1.5 billion to \$2 billion" annually during the past few years, he said.

However, the 1989 study did not disclose the total amount that life/health insurers committed to social

investments.

Single copies of the survey are available free from the Center for Corporate Public Involvement, 1001 Pennsylvania Ave., N.W., Washington, D.C. 20004-2599



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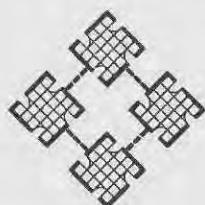


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Workplace issues to grow in prominence

Demographic changes to impact insurers: Panel

By JOANNE WOJCIK

PALM DESERT, Calif.—“Evolutionary” changes in the composition of the workplace will impact property/casualty insurers both in their role as workers compensation insurance underwriters and as employers themselves, asserts the outgoing chairman of an industry trade group.

“The expanding role of women in the workplace, the aging of the workforce and an intensifying labor shortage brought on by the ‘baby bust’ generation” are

“bringing dramatic change to the traditional employee-employer relationship,” E.L. Cox, outgoing chairman of the Alliance of American Insurers, told those attending the organization’s annual meeting last month in Palm Desert, Calif.

For example, changing demographics, such as an increase in the number of single-parent households, will force insurers to make changes in their employee benefit programs, he said.

And, as the workplace becomes more automated with less need for manual labor, the kinds of workers compensation claims and the types of employees who file them will change, said other speakers at the Alliance meeting, which focused on “the evolutionary workplace.”

“These are quality-of-life issues that demand answers to workplace questions regarding safety, health and medical care, the environment, child care, education and training,” said Mr. Cox. “These issues transcend employment and demand that we see the worker in a holistic way and not just between rush hours.”

Insurers have a twofold interest in the “evolutionary workplace,” he said.

“We have a pragmatic interest as employers. We also have a special

interest that exists because we are bearers of risk involved with insuring the workplace,” Mr. Cox said.

As employers, insurance companies must make changes in the way they conduct their business in response to changing demographics, several speakers at the Alliance meeting concurred.

“Home situations affect job performance and interrupt the flow of business,” said Peter A. Morrison, director of the Rand Corp.’s Population Research Center in Santa Monica, Calif.

The most prevalent change in home situations will be the loss of the full-time homemaker as more women enter and remain in the workforce, even after bearing children, he said.

“Most children will have working mothers,” Mr. Morrison predicted.

While only 30% of mothers worked in the 1970s, that percentage grew to 55% in the 1980s and is projected to reach two-thirds of mothers by the mid-1990s, he said.

“Employers will have to deal with this in terms of child care needs,” Mr. Morrison said.

Working mothers also will be less amenable to working long hours or undesirable shifts and will request more flexible work schedules, he said.

In addition, as the number of two-wage-earner couples increases, fewer employees will be willing to relocate, he added.

Employers also will be forced to beef up their benefit programs to attract and retain skilled employees as a shortage of entry-level workers develops, Mr. Morrison predicted.

Because it will be difficult to replace older, experienced workers, employers may find themselves offering incentives to persuade prospective retirees to remain on the payroll, if only on a part-time basis, he added.

“It also will be harder to replace

women on maternity leave, so you may as well keep their jobs open,” noted Susan Koralik, a partner with Hewitt Associates in Lincolnshire, Ill.

The workforce of the future also will be less educated, Ms. Koralik said.

“Employers will be competing for the hard-core unemployable,” she predicted.

However, few employers today are training workers in the areas where skill shortages are developing, she pointed out.

For example, while basic reading, writing and arithmetic skills

said Mr. Barth.

For example, injuries such as carpal tunnel syndrome that often are covered by employee health care insurance may increasingly be identified as work-related and be transferred into the workers compensation system, said Gerard F. Scannell, assistant secretary of the U.S. Department of Labor and director of the Occupational Safety & Health Administration.

“OSHA has found that ergonomic-related injuries or illnesses or cumulative trauma disorders such as carpal tunnel syndrome or tendonitis are not just confined to a

In addition, as technology improves, “many new hazardous substances will enter the workplace,” which could induce work-related illnesses and injuries, Mr. Scannell added.

“Another crucial and very sensitive issue of the 1990s could well prove to be drug abuse in the workplace,” he predicted.

“We’re seeing increased discussion of possible links between workplace accidents and substance abuse. There is not much data, but motor vehicle experience clearly demonstrates a strong relationship, as do some recent railroad, bus and other disasters,” Mr. Scannell said.

Substance abuse also could become more widespread among a workforce that is experienced in drug use, having grown out of the psychedelic ‘60s, suggested Mr. Barth of the University of Connecticut.

Indeed, “since 70% of all adult illegal drug users are employed, we must find innovative ways to fight drugs in the workplace,” Mr. Scannell asserted.

Other changes in work habits also could produce a different breed of work comp claims, Mr. Scannell and others at the Alliance meeting suggested.

For example, the definition of the workplace will change as more employees work from personal computers at home or use their cars to conduct business, they said.

Also speaking at the Alliance meeting were Mark I. Schickman, a partner in the San Francisco law firm of Fox & Grove; Dr. Sidney Shindell, professor and chairman emeritus of the Medical College of Wisconsin in Milwaukee; and George S. Odiorne, senior research associate at Eckerd College in St. Petersburg, Fla.

Franklin W. Nutter, president of the Schaumburg, Ill.-based Alliance of American Insurers, moderated the discussion. ■

‘These are quality-of-life issues that demand answers to workplace questions regarding safety, health and medical care, the environment, child care, education and training,’ says Mr. Cox.

‘These issues transcend employment.’

are at the bottom of the list for most companies’ worker training programs, they are high on the list of skill shortages, according to Ms. Koralik.

The changing workforce also is likely to affect insurers as underwriters of workers compensation insurance, according to Peter S. Barth, professor of economics at the University of Connecticut at Storrs.

For example, more stress claims are likely to develop as the workplace becomes more automated, he said.

Indeed, more and more employees working in fully automated offices and factories feel “rushed,” according to Mr. Morrison’s studies.

Workers compensation claims also could increase as employees become more aware of the health consequences of performing certain tasks or the risks of exposure to certain hazardous substances,

few industries such as meatpacking or poultry processing,” Mr. Scannell said.

These types of injuries “are widespread in almost every workplace,” he added.

Already more than 50% of work comp claims in several industries involve ergonomic-related disorders, primarily back injuries and upper extremity cumulative trauma disorders, according to Mr. Scannell.

And, almost one-half of the occupational illnesses in 1988 reported to the Bureau of Labor Statistics were cases of cumulative trauma disorders, he said.

Workers compensation insurance underwriters in the 1990s will be faced with insuring changing workplace exposures, such as the hazards of acquired immune deficiency syndrome, hepatitis B viruses and other blood-borne diseases, according to Mr. Scannell.

Alliance elects new officers

PALM DESERT, Calif.—Joel N. Tobey, president and chief executive officer of Amica Mutual Insurance Co., was elected chairman of the Alliance of American Insurers at the trade association’s annual meeting April 3-4.

Mr. Tobey, who has been president of the Providence, R.I.-based insurer since January 1985, was Alliance chairman-elect last year.

This year’s chairman-elect is W. Craig Heston, chairman and chief executive officer of Utica Mutual Insurance Co. of New Hartford, N.Y.

Named as Alliance vice chairmen for one-year terms were:

- Fred E. Bangs, president, chief executive officer and treasurer of Utica Fire Insurance Co. of Oneida County, N.Y.

- Stephen B. Otte, president and chief executive officer of Florists’ Mutual Insurance Co. of Edwardsville, Ill.

- Brian R. Wilkin, president of Hingham Mutual Fire Insurance Co. of Hingham, Mass.

Elected as directors for two-year terms were:

- C.I. Buxton II, chairman and chief executive officer of Federated Mutual Insurance Co. of Owatonna, Minn.

- Gary L. Countryman, president and chief executive officer of Liberty Mutual Insurance Co. of Boston.

- E.L. Cox, chairman and chief executive officer of Amerisure Insurance Co. of Detroit.

Entering the second year of their two-year term as directors are:

- A.E. DaSilva, executive vp and chief operating officer of Lumbermen’s Underwriting Alliance of Boca Raton, Fla.

- Robb B. Kelley, chairman and chief executive officer of Employers Mutual Casualty Co. of Des Moines.

- James L. Ketcherside, president and chief executive officer of Farmers Alliance Mutual Insurance Co. of McPherson, Kan.

- John L. Longnaker, president and chief executive officer of Pennsylvania National Mutual Casualty Insurance Co. of Harrisburg, Pa.

- Theodore J. Rupley, president and chief executive officer of Metropolitan Property and Liability Insurance Co. of Warwick, R.I.

- Leon J. Weinberger, president and chief executive officer of Employers Insurance of Wausau, Wis.

Spencer A. Broughton, chairman and president of Citizens Security Group of Red Wing, Minn., and George S. Milnor, president and chief executive officer of Millers Mutual Insurance Assn. of Illinois in Alton, were elected as directors for one-year terms.

Two hundred property/casualty insurance company executives attended the Alliance’s annual meeting, held April 3-4 at Marriott’s Desert Springs Resort and Spa in Palm Desert, Calif.

Next year’s meeting is scheduled for March 26-27 in Maui, Hawaii.

The Alliance of American Insurers is a national property/casualty insurance trade group with 170 member companies.

For information, contact Eleanor M. Ryan, Executive Services Manager, Alliance of American Insurers, 1501 Woodfield Road, Suite 400 W., Schaumburg, Ill. 60173-4980; 708-330-8518.

—By Joanne Wojcik

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Business Insurance

Antitrust suit

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same defendants is pending in a Texas state court (BI, Dec. 18, 1989).

In addition, the Justice Department's antitrust division filed a brief supporting the 19 state attorneys general (BI, May 14).

However, the Justice Department says in its brief that it is participating in the case because it is concerned that Judge Schwarzer's opinion may be misinterpreted and is not considering the "ultimate merits" of the case (see story, page 26).

Both the Justice Department brief and the brief filed by the 13 non-plaintiff states focus on Judge Schwarzer's opinion that the litigation should be dismissed because industry defendants did not violate the McCarran-Ferguson Act, which gives the insurance industry limited immunity from federal antitrust laws.

The Justice Department's brief also takes issue with Judge Schwarzer's dismissal of the case on the "state action" doctrine, which provides immunity from antitrust laws if anticompetitive restraint of trade reflects a state policy.

In addition, the Justice Department brief argues against the judge's decision to dismiss charges against foreign defendants on the basis of comity, which is a reciprocal respect for foreign law.

Michael Boudin, deputy assistant U.S. attorney general, said the decision by the Justice Department to file the brief arose from an ongoing program of identifying cases that have special significance "where we think our contribution may be of some help to the court, and the sound development of antitrust law."

These cases are carefully selected based on their merit and appropriateness, according to Mr. Boudin.

He said interpretation of the McCarran-Ferguson Act is "a matter of ongoing importance" because it affects an entire industry.

"We were concerned about how the district court's decision may be read" and of how the appellate court's statements on that issue could affect comparable cases, he said. The department subsequently concluded that the state action doctrine and comity issues were of concern as well, said Mr. Boudin.

Mr. Boudin said there is no guarantee the Justice Department brief will influence the cases' outcome. But, he said, it is "generally true" that government amicus briefs attract a court's attention because they represent expert advice from a party that does not have a direct stake in the outcome.

He also noted, however, that the Justice Department enforces antitrust laws "and the court takes that into account, too."

"I think it will be hard to overestimate its importance," said New York Assistant Attorney General Richard L. Schwartz, referring to the Justice Department's brief.

"I think they state very clearly the errors that Judge Schwarzer made, and the reasons why it's extremely important for the 9th Circuit to reverse them," said Mr. Schwartz.

California Deputy Attorney General Kathleen E. Foote said, "I think it should have some effect, hopefully, because... it underscores the public policy interest that the states are expressing."

"I think the focus on the public policy issues could well be an important aspect of the decision," she added.

The additional brief by the 13 states underscores the public policy issues as well, said Ms. Foote. Insurance market manipulation is very complicated and difficult to convey, she said. The state briefs will help stress the significance of the case to "ordinary people."

Laurel Price, assistant attorney general for New Jersey, said the Justice Department brief is significant because it is an "external litmus test," independent of the parties directly involved.

He said he believes the brief's argument on the comity issue is particularly significant because it "would seem to erode most of the theoretical underpinnings" of the defendants' position that comity should be an overriding issue in the case.

As for the 13 states' brief, Mr. Price said, "It can't hurt. It clearly shows there is a substantial amount of awareness and concern by governments at all levels" on the issue.

Robert C. Ward Jr., assistant attorney general for Michigan, added, "I think it's wonderful that the Justice Department has decided to file an amicus brief." Mr. Ward said his limited experience with briefs of this kind indicates it will attract the court's attention.

New briefs give the states' case 'a good deal of credibility,' says William M. Rubenstein.

As for the additional states' brief, Mr. Ward noted that some states were unable to participate in the original suit because they had neither the staff nor the financial resources available to take part in a major investigation.

Michigan, for example, was able to contribute financially to the litigation but was not able to contribute personnel because it has only a small antitrust division, according to Mr. Ward.

William M. Rubenstein, assistant attorney general for Connecticut, said the federal government and additional states' decision to file their briefs "adds a good deal of credibility" to the original 19 states' position.

The defendants' have contended, Mr. Rubenstein explained, that the litigation is politically motivated. These briefs lend credence to the validity of the states' legal opinions, he said.

Commenting on the brief filed by the additional states, a spokeswoman for the Texas attorney general's office said that "we do not think that the success or failure of the appeal in California will have a direct effect on our case in Texas whatsoever."

"Our involvement in the process is important to the state of Texas for antitrust enforcement generally, and we believe the lower court's decision should be reversed," she said.

Meanwhile, attorneys representing defendants in the case minimize the significance of both the briefs filed by the Justice Department and the additional states.

Alan H. Silberman, an attorney with Chicago-based Sonnenschein, Carlin, Nath & Rosenthal, who represents defendant Allstate Insurance Co. in the litigation, commented: "I think that in the end, the Department of Justice submission will not lead to the conclusion that Judge Schwarzer's opinion is in error."

Mr. Silberman said the brief states that Judge Schwarzer's opinion might be misinterpreted to indicate that it improperly expands the antitrust immunity provided by McCarran-Ferguson. The brief does not explicitly say, however, that it actually does so.

"We will establish the court applied the law correctly," said Mr. Silberman.

"The fact of the matter is the brief does not undercut the legal validity of (Judge Schwarzer's) opinion," though it may have

clarified some of the questions involved, he said.

Edmond Rondepierre, senior vp and general counsel at defendant General Reinsurance Corp., said that while the court will pay attention to all the briefs, "I don't think the outcome will be changed."

Mr. Rondepierre said the Justice Department brief's principal concern seems to be that Judge Schwarzer ruled too early in the proceedings and it does not rule out the fact that there could be a case for summary judgment in favor of the defendants, he said.

Summary judgment is often preceded by extensive discovery, but Judge Schwarzer ordered only limited discovery as to whether the defendants' alleged conspiracy was exempt from federal antitrust laws (BI, June 27, 1988).

Judge Schwarzer's approach, said Mr. Rondepierre, was that if there was any issue that could lead to the case's disposition, "let's rule on that one and save a lot of time and money" on discovery. This is what is now being questioned in the brief, he said.

"This doesn't change the nature of the issues in any way," said John G. Harkins Jr., an attorney with Philadelphia-based Pepper, Hamilton & Scheetz, who represents defendant Aetna Casualty & Surety Co. "I don't see it as adding any new dimension to the litigation," he said of the Justice Department's brief.

Mr. Harkins also said the additional states' brief is not significant. "Certainly that brief doesn't raise any new issues," he said.

"I don't think that there is any significance to that filing," said Aubin K. Barthold, an attorney with San Francisco-based Hancock, Rothert & Bunshoft, who represents defendant Edwards & Payne Ltd. in the litigation.

"I think that's an articulation of antitrust principles as seen through the eyes of the antitrust division, and I don't think it particularly meets the issues of the states' appeal."

"It's their wish list on their world view, but I don't think it bears any significance," Mr. Barthold said.

Referring to the additional states' brief, Mr. Barthold said that "theirs, obviously, is just a tag-along. They didn't participate in filing the complaint, so it's too little, too late."

Bartlett H. McGuire, an attorney with Washington, D.C.-based Davis, Polk & Wardell, which represents defendant Insurance Services Office Inc., said because of the way the federal brief qualifies its views, "It's a very, very narrow piece of paper." The brief "is not

going to be a matter of cosmic significance on the appeal," he said.

He also described the additional states' brief as a "complete non-event. I can't see why they did it. They don't add anything to what the other briefs say. It's just another piece of paper to read."

The next step in the judicial process is the filing of response briefs by the insurance industry defendants, which are due Aug. 6. Plaintiffs will respond to those briefs by Oct. 5.

Observers said oral arguments in the case are not expected to be held for another year. The three-judge appellate panel that will hear the case will be appointed shortly before that.

fore that.

If the appeal is successful and the case returned to district court, the case will no longer be handled by Judge Schwarzer, who has been named director of the Washington, D.C.-based Federal Judicial Center, the research and education arm of the judiciary in Washington.

Another U.S. District Court judge, Vaughn Walker, has been appointed to the case.

Besides Texas, the other states that filed the amicus brief are Delaware, Hawaii, Kentucky, Maine, Mississippi, North Carolina, North Dakota, Rhode Island, South Dakota, Utah and Wyoming. ■

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Justice Department unsure of merit of states' case

By JUDY GREENWALD

SAN FRANCISCO—An amicus curiae brief filed by the U.S. Justice Department concedes it is unsure whether the evidence state attorneys general could muster to support their antitrust allegations against insurance industry defendants "would persuade a jury."

The brief—which supports the states' appeal of a decision by U.S. District Judge William Schwarzer to dismiss the antitrust litigation—was filed because the department "has an interest in assuring that the federal antitrust laws and exemptions from them are construed in a manner that advances their objectives," the Justice Department's brief says.

The brief qualifies its support for the states' position, stating that "it is not our purpose to express a view on the ultimate merits of this case

which, if the case is remanded, will depend on the plaintiffs' ability to present evidence establishing the existence of an agreement among primary insurers and reinsurers to coerce competing insurers.

"Such a conspiracy is embraced by the broad allegations of the complaints, but we do not know whether the evidence plaintiffs can muster would persuade a jury," says the brief, which was filed with the 9th U.S. Circuit Court of Appeals, which is hearing the attorneys general's appeal of Judge Schwarzer's ruling.

The brief says it is not the department's "purpose to criticize the district court for its efforts to require the parties to focus their contentions and to resolve as many legal and factual issues as possible without trial."

"To the contrary, the United States strongly endorses judicial management techniques of the sort that we

understand were employed in this case to streamline antitrust litigation.

"If this case is remanded, we would not rule out the possibility of a summary judgment motion by defendants, based on proper construction of the law."

The brief adds, "We are concerned, however, that the district court's opinion may be read improperly to expand antitrust immunities."

"In our view, neither the McCarran-Ferguson Act, the state action doctrine, nor international comity considerations provide defendants with an absolute shield of immunity for the conduct alleged by the plaintiffs," the brief says, referring to the grounds on which Judge Schwarzer dismissed the litigation.

The Justice Department brief noted that the immunity provided to the insurance industry by the McCarran-Ferguson Act does not extend to any

agreement or acts of boycott, coercion or intimidation.

The attorneys general's suit, however, "fairly alleges" this conduct. "Therefore, the district court's ruling that the defendants were entitled to dismissal of all the federal counts on the basis of the McCarran-Ferguson Act was erroneous."

The Justice Department also maintains that Judge Schwarzer erred by dismissing the case on the basis of the state action doctrine, which provides immunity from antitrust laws if the anticompetitive restraint of trade reflects a state policy and if a state actively supervises any private anticompetitive conduct.

"In concluding that the challenged conduct reflected a clearly articulated and affirmatively expressed state policy, the district court acknowledged that the state statutes it relied upon as evidence of that policy

expressly prohibit coercion and boycotts," says the brief. "Unfortunately, its reasons for concluding that the challenged conduct nonetheless reflects state policy are unclear."

The brief states that Judge Schwarzer also was in error when he dismissed the foreign defendants from the case on the basis of comity—a reciprocal respect for foreign laws—on several grounds, including the difficulty of exercising jurisdiction over foreign defendants.

"The court failed to accord adequate weight to the fact that the competitive effects of the alleged conspiracy were felt primarily within the United States or to the resulting interest of the United States in enforcing its law," the Justice Department brief states.

Meanwhile, another 23-page amicus brief filed by 13 states that are not among the plaintiffs in the litigation focuses solely on the McCarran-Ferguson issue.

The brief maintains that the plaintiff states "have a substantial interest in ensuring that federal courts apply the antitrust laws in a manner consistent with underlying congressional policy, past decisions of the United States Supreme Court and this Circuit, and sound public policy."

Judge Schwarzer's decision, says the brief, "erroneously broadens the protection afforded to insurance companies under the McCarran-Ferguson Act and severely narrows the application of antitrust laws."

"The lower court's decision encourages insurance companies to disregard the antitrust laws, severely undermining the free enterprise system upon which the economic strength of this country rests."

An appellate brief filed by the 19 states and private plaintiffs in the litigation states that the defendants engaged in a boycott "well outside the scope of the protective cloak of the (McCarran-Ferguson) Act."

"Moreover, reinsurers are not sufficiently regulated by the states to qualify for McCarran protection. Finally, the deep involvement of unregulated reinsurers in this scheme should result in forfeiture of the McCarran Act exemption for all defendants," the plaintiff states' brief says.

The brief states also that the state action doctrine is not applicable in the antitrust litigation. "Neither the defendants' state action motion, nor the trial court's opinion, even suggests that the various agreements and their attendant boycotts were ever reviewed by any state regulator."

In arguing against the application of the comity principal, the brief states that the effects of the illegal actions by the insurance industry defendants were felt almost exclusively in the United States.

"Even the defendants cannot say that reinsurance for Lloyd's and the London company market has 'only a minuscule effect' on American casualty and property insurance markets," says the brief. "This factor thus weighs heavily in favor of asserting jurisdiction" against foreign defendants in U.S. courts.

The plaintiffs' brief also argues against dismissal of a claim that the defendants conspired—in violation of the Sherman Act, which also regulates antitrust activity—to limit the availability of property/casualty insurance products to consumers.

In addition to the brief submitted by the 19 states and private plaintiffs, the state of New York submitted its own brief, focusing on the foreign reinsurer defendants.

The brief argues that the immunity provided by McCarran-Ferguson Act is not applicable to foreign reinsurers because they are not regulated by New York law.

California Deputy Attorney General Kathleen E. Foote said other states did not join in New York's brief because it concerned New York law.

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INTERNATIONAL

AXA confident it will acquire a U.S. insurer in the future

By ISABELLE BERGLAS

PARIS—Only weeks after his bid for Farmers Group Inc. fell through, Claude Bebear is confident he eventually will acquire a U.S. insurer.

California regulators last month rejected the planned sale of Los Angeles-based Farmers to AXA Midi Assurances S.A., effectively scuttling that deal and the much larger purchase of B.A.T Industries P.L.C. of London by Sir James Goldsmith.

However, Mr. Bebear, AXA's chairman, said in an interview last week that the long, drawn out ordeal strengthened his hand.

"We were unknown in the United States. Now we are known as professional, competent and rich people," said Mr. Bebear.

California was only one of nine states whose regulators could have derailed the Farmers deal. That lesson is not lost on the aggressive Mr. Bebear.

"Next time, we will perhaps be more careful in our approach and take more into account the specificity of each state," said Mr. Bebear, who testified before regulators in several states.

And AXA's next U.S. acquisition attempt, he promises, will be a friendly bid, for which regulatory approval is much easier to secure.

Mr. Bebear says AXA has received many proposals since the Farmers acquisition fell through, but will not discuss specifics.

"We are in no hurry. We need to do something in the next several years. We are long-term minded," Mr. Bebear says.

If proposals submitted do not look promising, the chairman says the insurer's investment bankers will be instructed to find potential buyout targets in the \$1 billion to \$2 billion price range.

His goal for AXA, now France's second-largest insurer, is clear (BI, Oct. 16, 1989): We want "to become one of the biggest international groups. To achieve that, we need to be present in the United States to spread our risk around the world."

According to Mr. Bebear, two elements contributed to the failure of Sir James' bid for B.A.T and, thus, AXA's attempt to move into the United States.

First is the complexity of U.S. insurance regulation.

"If we had secured authorizations by the end of 1989, the bid would have been successful in London," he said. But even if California regulators had put aside their concerns about burdensome debt and approved the bid, "it was becoming obvious the takeover

Continued on next page



Mr. Bebear

2 syndicate cash calls follow runoff settlement

By CAROLYN ALDRED

LONDON—At least two Lloyd's of London syndicates are announcing cash calls from members following an out-of-court settlement earlier this month of a runoff reinsurance policy dispute.

Syndicate 544, managed by A.J. Archer Holdings P.L.C., and syndicate 421, managed by Merrett Underwriting Agency Management Ltd., are asking about 880 members for a total of more than 9 million pounds (\$15 million).

The two syndicates reached a confidential settlement, together with Lloyd's broker Winchester Bowring Ltd. and Merrett syndicate 417, midway through a London High Court trial over a runoff

reinsurance policy Merrett syndicates 421 and 417 wrote for syndicate 544 in 1982 (BI, May 14).

Lloyd's underwriter Stephen Merrett had voided the policy, claiming the Merrett syndicates were misled by incomplete information given to the underwriter who had accepted the policy. The policy provided 50% of unlimited runoff reinsurance for claims paid by syndicate 544 on or after Jan. 1, 1982 for years 1978 and prior, excess of \$9.2 million.

Derek Dolling-Baker, former underwriter for syndicate 544, sued Mr. Merrett to force payment of the policy. Mr. Dolling-Baker also sued Winchester Bowring, the broker that placed the policy, contending that the broker should pay

damages if information was judged to be incomplete and the risk was misrepresented.

The remaining 50% of the policy was written by syndicates 317/661, underwritten by R.H.M. Outhwaite (Underwriting Agencies) Ltd. Syndicates 317/661 settled with syndicate 544 following the Merrett settlement this month.

As part of the settlement, *Business Insurance* learned last week, the policy's attachment point has been raised from \$9.2 million to \$30 million. In addition, the policy has been capped at \$60 million excess of \$30 million.

However, the Merrett syndicates will pay current outstanding claims of \$2 million that are be-

Continued on page 29

British insurers report first-quarter losses

Windstorms wallop profits

By CAROLYN ALDRED

LONDON—British insurers are reporting severe first-quarter losses from windstorms that swept across Europe early this year.

General Accident Fire & Life Assurance Corp. P.L.C., the first major British insurer to report first-quarter results, announced a pretax loss of 80.9 million pounds (\$135.1 million), compared with a first-quarter profit of 54.9 million pounds (\$88.4 million) in 1989.

Results "were seriously affected by weather-related losses in the U.K. and Europe amounting to 90 million pounds (\$144.9 million) net, including internal reinsurance and reinstatement premiums," the company said in a statement May 10.

Worldwide weather losses in the first quarter were 110 million pounds (\$183.7 million) net of rein-

surance, and almost 200 million pounds (\$334 million) on a gross basis, said Nelson Robertson, General Accident's chief general manager.

The insurer's premium volume from commercial property/casualty and personal lines insurance for the first quarter totaled 782.9 million pounds (\$1.31 billion), up 8.9% from 718.6 million pounds (\$1.12 billion) for the same period in 1989. Premiums from life and investment policies totaled 102.4 million pounds (\$171 million), compared with 87.8 million pounds (\$141 million).

Commercial Union Assurance Co. Ltd. P.L.C. also reported a first-quarter loss of 25.6 million pounds (\$42.8 million), compared

LONDON

with a pretax profit of 45.1 million pounds (\$72.6 million) for the first three months of 1989.

The loss "reflected the two major storms which affected the United Kingdom and Continental Europe and which we now estimate have cost the group a total of 55 million pounds (\$91.9 million), including the cost of 22 million pounds (\$36.7 million) to reinstate our reinsurance protection," said Tony Brend, the chief executive.

Gross storm claims in the United Kingdom alone totaled an estimated 120 million pounds (\$200.4 million), said Commercial Union.

Meanwhile, in The Netherlands, where Commercial Union holds about 7% of the market, gross

Continued on next page

Australians seek pilots on ships navigating reef

By KATE McILWAINE

SYDNEY, Australia—Efforts to persuade the International Maritime Organization that ships navigating the waters between Australia and the Great Barrier Reef should be required to have a pilot familiar with the waters on board have met with little success, an Australian marine insurance underwriter says.

Australia's sole representative on the marine hull committee of the IMO unsuccessfully lobbied his colleagues to endorse the requirement earlier this month at a meeting in Casablanca, Morocco.

The IMO—a United Nations agency that establishes standards for maritime safety and the prevention of pollution from ships—already has recommended that pilots be used in the 2,500-kilometer stretch between the Queensland coast and the Great Barrier Reef.

But, shipowners and charterers have ignored the 1986 recommen-

dation, citing the cost of hiring a pilot, said Geoffrey G. Gauci, managing director of Marine & Aviation Management Services Ltd. in Sydney, an underwriting management subsidiary of Norwich Winterthur (Australia) Ltd.

Mr. Gauci, who is national underwriting manager for the Australian Hull Insurance Pool and the Australian Insurance Assn.'s Commercial Hull Syndicate, is Australia's first representative on the IMO international marine hull committee.

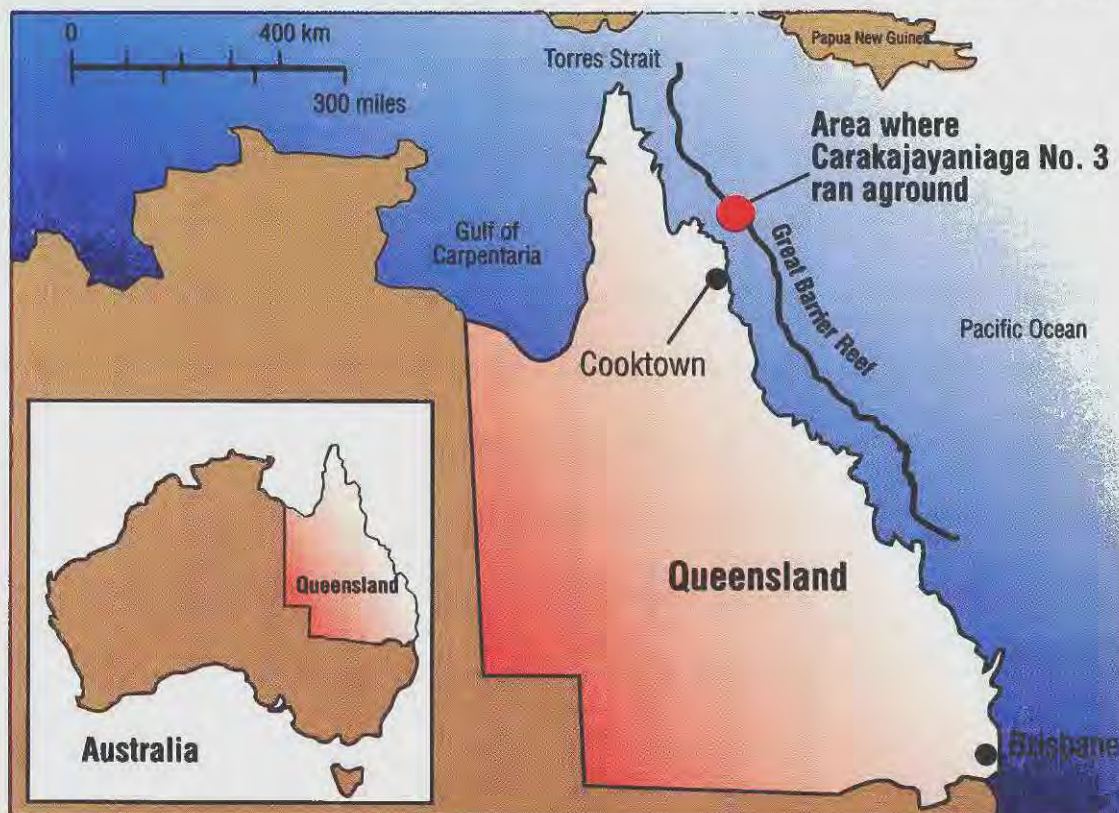
Brisbane solicitor Frank Turner, who represents several London-based protection and indemnity clubs in Queensland, said while the members of the clubs are encouraged to comply with IMO recommendations, they are not compelled to do so.

If IMO were to endorse a pilot requirement in the area, it would be up to Australia to pass a law enforcing the requirement.

Continued on page 29

Navigating the Great Barrier Reef

One of the most recent shipping accidents involved an Indonesian cargo ship that ran aground on a reef in early May.



Source: BI reports

INTERNATIONAL

Comment sought on proposal to discount Mentor's claims

By ROGER SCOTTON

BERMUDA

HAMILTON, Bermuda—Liquidators of failed Mentor Insurance Ltd. are seeking comments from creditors on a proposal to discount contingent claims against the Bermuda-based reinsurer.

Written submissions on discounting will be accepted until the end of the month and then will be placed before the Bermuda Supreme Court in June, when the liquidators will be seeking directions on how to proceed.

Mentor, a former captive of Ocean Drilling & Exploration Co. of New Orleans, was ordered liquidated by the Bermuda Supreme Court in 1985. The liquidation has been proceeding steadily despite an unsuccessful bid by dissident creditors in November 1989 to oust Charles Kempe and Michael Arnold as liquidators (*BI*, Nov. 6, 1989; Dec. 18, 1989).

Mentor is estimated to be insolvent by at least \$800 million.

In a letter to almost 3,000 creditors, the liquidators explained why they believe claims discounting is necessary and how they intend to

seek court approval for it.

Messrs. Kempe and Arnold, who are now preparing to pay Mentor's first interim cash dividend, possibly before the end of 1991, say they are empowered by the Bermuda court "to decide the question of whether to include an element for discounting" in their dividend calculations.

They argue that not to discount Mentor's contingent liabilities at all "would produce an injustice to those creditors whose claims were mature at the date of the winding-up or relatively shortly thereafter."

Messrs. Kempe and Arnold say in their letter that the application of a rate of discount "will reduce the quantum of Mentor's contingent and unliquidated claims, and possibly significantly reduce the claims of certain long-tail creditors."

And they say that discounting ultimately will boost dividends "in terms of cents in the dollar," including those payable to creditors whose

claims have been discounted.

The letter says that legal advisers have recommended that a market value of these claims be determined "at the date of the winding-up (court) order, namely June 21, 1985."

"To arrive at a market value of such claims, counsel have advised that discounting should almost certainly be applied, as an actuarial matter (and as one of a number of other factors) to arrive at that value."

"Subject to obtaining directions from the (Bermuda Supreme) court, the joint liquidators propose to discount Mentor's contingent liabilities to the date of the winding-up order. The decision to discount to the date of the winding-up, rather than the date of a dividend, is founded on the joint liquidators' belief that the former creates greater equity," according to the letter.

The liquidators estimate that between \$300 million and \$400 million of Mentor's claims were mature at the date of the winding-up and will not be subject to discounting. Approximately \$500 million or more in claims will be discounted—some over a period of just months, others over several years.

The annual rate of discount will be subject to the directions of Bermuda's Supreme Court but is likely to be between 5% and 7%, according to the liquidators' letter.

The case may establish precedent in Bermuda courts. ■

AXA plans

Continued from previous page
bid in London would fail."

He also blames a takeover wariness in the United States fueled by the collapse of Drexel Burnham Lambert Group Inc.—a major figure in the B.A.T. deal—and the long slump in the junk bond market created by Drexel's demise.

"All that put together made the acquisition far more difficult than it was a year ago. The timing was bad. The commissioners though it looked like a leveraged buy-out—and they didn't like it," he said.

He notes that the collapse of the B.A.T. takeover has yielded one paradoxical result: AXA stock is rising.

According to Mr. Bebear, "the analysts didn't exactly understand what we were trying to do with Farmers, so when they heard it didn't go through, they were very happy." ■

LONDON

Continued from previous page
claims from storm-related claims totaled 50 million pounds (\$83.5 million), estimated Director John Carter.

Commercial Union's first-quarter premium volume totaled 1.05 billion pounds (\$1.75 billion)—714.2 million pounds (\$1.2 billion) from property/casualty insurance and 336.7 million pounds (\$562.3 million) from life insurance.

The Assn. of British Insurers estimates total damage from the January and February storms and subsequent floods at 2 billion pounds (\$3.22 billion) in the United Kingdom alone.

More than 3.25 million claims were filed to British insurers, the ABI reports.

"Insurance companies can be justifiably proud of their record in dealing with the unprecedented number of claims that arose out of the storms. Almost three times the number of claims were received in January and February compared with the hurricane in 1987," said ABI Chief Executive Mike Jones, referring to the October 1987 windstorm that struck southern England and France.

"One in every eight households made a claim and the vast majority have been settled," Mr. Jones said.

According to the ABI, the first storm that hit the United Kingdom in January cost insurers 1.55 billion pounds (\$2.59 billion), while February storms cost insurers 530 million pounds (\$885.1 million).

Of the total number of claims, 3 million related to personal property, 240,000 related to commercial property and 55,000 related to auto losses, the ABI said.

Swiss Reinsurance Co. of Zurich, Switzerland, earlier this year estimated that the windstorms that swept through England, France, Belgium, The Netherlands, Denmark and Germany during the first three months of this year will cost world insurers \$8.8 billion (*BI*, April 30).

Lowndes Lambert stock

Lloyd's of London broker Lowndes Lambert Group Ltd. will seek a London Stock Exchange listing next year if stock market conditions are right, says Chairman Richard Shaw.

Lowndes Lambert was acquired by its management two years ago following the acquisition of its previous parent company, Hill Samuel Group Ltd., by TSB Group P.L.C. in 1987.

Since the management buyout, Lowndes Lambert has continued to expand through acquisitions and the growth of existing business.

Last year revenues from insurance brokering worldwide increased to more than 40 million pounds (\$64.4 million at year-end 1989), up 28% from 1988, said Mr. Shaw.

Pretax profit also increased to 5.15 million pounds (\$8.29 million) from 3.19 million pounds (\$5.77 million at year-end 1988).

Increased revenues during 1989 were generated by the acquisition of other brokerages and new accounts.

Lowndes Lambert is finalizing plans to acquire some U.K. commercial retail brokers, Mr. Shaw said, but he would not comment further.

Lloyd's rep resigns

Lloyd's of London's general representative in West Germany has resigned less than 18 months after becoming the market's first representative in West Germany.

Wolfram Kausche was appointed

to head a representative office in Frankfurt last year (*BI*, Feb. 20, 1989).

As an interim arrangement, Lloyd's is seeking approval from the Bundesaufsichtsamt fuer das Versicherungswesen, the German insurance regulatory authority, for Rainer Bohmer—Lloyd's Swiss representative—to act as a temporary representative until a successor is found. Meanwhile, Lloyd's Frankfurt office is under the day-to-day management of Stephan Schinnenburg.

Dealings expanded

Lloyd's of London underwriting agency Roberts & Hiscox Ltd. is the latest Lloyd's agency to announce plans to deal directly with non-Lloyd's brokers.

The agency has formed a new service company called Hiscox Insurance Agencies to write and service insurance policies, which will be underwritten 100% by Lloyd's syndicate 33, managed by Roberts & Hiscox Ltd. The service company will underwrite high-value privately owned assets such as fine art, antiques and classic cars through the service company.

Under the arrangement, HIS will be able to accept business from any broker—including non-Lloyd's brokers—throughout the country. The business will then be placed with syndicate 33 through a guaranteeing Lloyd's broker.

In recent years, many Lloyd's underwriters have complained that use of Lloyd's brokers for placing small risks is woefully inefficient. Brokers, for their part, have conceded the inefficiency but blamed inaccessible underwriters and the overly bureaucratic way of doing business at Lloyd's.

However, in recent months several initiatives have been started by brokers and underwriters to overcome the restrictions of the Lloyd's market and to better compete for less exotic business (*BI*, March 12).

SBJ expands

London broker Steel Burrill Jones Group P.L.C. is taking a controlling stake in a new brokering company specializing in fine arts, jewelry and specie risks.

The company—to be called SBJ Specialty Ltd.—was set up by Chairman and Managing Director Jim Clark, formerly managing director of Halford Shead & Co., a division of Alexander Howden Group Ltd., and Directors Chris Bailey West, Trevor Calver, David Codling, Peter Curtis and Clifford Lambdon.

SBJ's interest in the company "has been acquired for a nominal initial consideration. SBJ may be required to purchase the balance of the shares for a consideration, which has an upper limit and which is expected to be paid between 1994 and 1999, calculated by reference to the future earnings of the company and the price-earnings ratio of SBJ shares," according to a statement released by SBJ.

Castle acquires agent

Castle Underwriting Holdings Ltd. has acquired fellow Lloyd's of London underwriting agent Chiltern Underwriting Agents Ltd. for 800,000 pounds (\$1.34 million).

Castle Underwriting manages three Lloyd's non-marine syndicates with a total capacity of 117.9 million pounds (\$196.89 million). Chiltern Underwriting Agents is a Lloyd's members agency representing 136 members writing a premium income of 60 million pounds (\$100.2 million). ■

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INTERNATIONAL

Pilot proposal

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Separately, Mr. Gauci has tried to persuade underwriters that policies should be warranted to ensure a pilot was on board all ships negotiating the Torres Strait, which is above the northern tip of Australia, or any other areas of the Great Barrier Reef. But it's been "impossible" to convince them, he said.

The Great Barrier Reef—the world's largest collection of coral reefs—is a 1,250 mile-long maze of islands, shoals and reefs along the Northeast coast of Australia (see map, page 27). The Australian government has made most of the Great Barrier Reef a national park.

The Torres Strait, a thin stretch of water between Australia and Papua New Guinea, constitutes the shortest safe shipping route from the east coast of Australia to ports

in Asia and the Northern Hemisphere.

An estimated 2,000 oceangoing merchant ships cross the strait each year.

While Mr. Gauci attended the IMO meeting, a 3,000-metric-ton cargo ship without a professional pilot, the Carakajayaniaga No. 3, ran aground on a reef about 160 kilometers north of Cookstown, Queensland.

No oil spilled from the Indonesia-registered vessel and divers from the ship's agent reported no major hull damage after the ship was pulled clear of the reef by two tugs.

Mr. Gauci said the grounding of the Indonesian ship underscores the need for skilled local pilots who know the waters to be piloting ships through the reef waters.

Mr. Gauci said his efforts to get Australian underwriters to include a pilot warranty in marine policies

have met with little success because a "very minimal" amount of marine business is written in Australia.

"If we imposed the warranties we would need the support of the London underwriters and they are not prepared to do it," noted Warren Holmes, Queensland manager for Marine & Aviation Services in Brisbane. "No one wants to bite the bullet."

"If I was to tell shipping companies that they must have pilots or we will load their premium, they will go elsewhere and we will lose their business," Mr. Gauci acknowledged.

"The market is so soft and there is such an enormous amount of competition, no underwriter would run the risk of losing any business," he said.

As a result, some groups have taken the argument for a pilot requirement to foreign underwriters.

Chris D. Henri, marine manager for the Insurance Council of Australia in Sydney, said the ICA had asked the Institute of London Underwriters and syndicates at Lloyd's of London to consider requiring marine policyholders to warrant they will use pilots in the reef areas.

"I understand it will be discussed again in September at the annual meeting of the International Union of Marine Insurers in London," Mr. Henri said.

Unless pilots are used, there could be a serious accident on the Great Barrier Reef, Mr. Holmes said.

"Shipowners and masters must realize the dangers of risking ships, lives and pollution by proceeding in those waters without pilots," said Mr. Henri.

The 10-million gallon Exxon Valdez oil spill is a "timely reminder of what can happen when a

ship spills its guts in an environmentally sensitive area," he said (BI, April 3, 1989).

"It would take 10 years or more for a slick the size of that from the Exxon Valdez to move out of that area because of the tides," Mr. Gauci estimated.

According to Mr. Henri, though, the Exxon spill in Alaska's Prince William Sound has prompted more shipowners and masters to use pilots in dangerous reef areas.

"I think we are winning the campaign," he said.

Mr. Gauci, though, is less optimistic.

"In my opinion, the only way out is for government intervention. I regret that, because I am a true believer in free enterprise in the insurance market," he said.

Mr. Henri, though, said legislation should be a last resort, because enforcing it would be "a nightmare and expensive." ■

Runoff settlement

Continued from page 27

neath the new attachment point but would have been payable under the original policy terms, the Merrett agency explained in a letter sent to members' agents.

Above the new attachment point, the Merrett syndicates will pay a maximum of \$7 million prior to 1995 and up to a maximum of \$15.5 million prior to the year 2000, the letter explained.

Chris Burton, joint managing director of Archer, would not discuss the terms of the settlement and would not comment on whether Winchester Bowring is contributing to the settlement.

C.T. Bowring & Co. Ltd.—Winchester Bowring's parent and a unit of Marsh & McLennan Cos. Inc.—did not return repeated phone calls.

However, Mr. Burton confirmed that following the settlement, syndicate 544 "will be showing a loss for members on its 1986 account, although profits for the 1987 year

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**Profits in 1987
'should help mitigate'
some members'
1986 losses,
says Chris Burton.**

should help mitigate the loss" for members who invested in the syndicate both years.

Syndicate 544 is making a cash call of about 2.5 million pounds (\$4.18 million), about 20% of the syndicate's 1986 premium capacity of 12.7 million pounds (\$18.8 million at year-end 1986), to help cover a total loss for the year equal to 40% of capacity, said Mr. Burton.

The 1986 year will remain open for the near future, he said, adding that it was too soon to tell whether additional cash calls will be necessary in future years.

Syndicate 421 also has "produced a substantial loss on its open 1983 underwriting year," said Ken Randall, managing director of Merrett Holdings P.L.C.

As a result, the syndicate will be making a cash call this year of about 6.8 million pounds—200% of the syndicate's 1983 premium capacity of 3.4 million pounds (\$4.93 million at year-end 1983), he added.

The loss is due mainly to losses from several runoff reinsurance policies the syndicate wrote in the early 1980s, he noted.

Mr. Randall would not comment on the settlement.

Syndicate 417 has not yet reported its results. Syndicate 317/661 likely will report its results next week. ■

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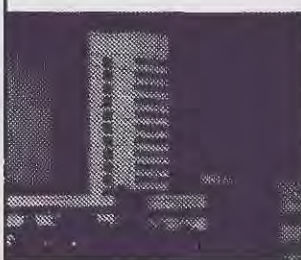
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MEWA hearings

Continued from page 2

But state regulators compare it to the national scandal caused by the collapse of self-funded MEWAs in the late 1970s and early 1980s. "This is a repeat of the late 1970s," said North Carolina Insurance Commissioner James E. Long. Precise figures on the number of people harmed by failed MEWAs are unavailable, but state regulators say the problem clearly has reached massive proportions. Ms. Howard testified that unpaid claims involving just six MEWAs that had covered Texas residents and are now bankrupt or otherwise defunct amount to tens of millions of dollars. "There are slick operators who will try to cheat the system. It is the individual. It is the family that suffers," said Sen. William Roth, R-Del. And the problem is likely to grow worse. "New schemes are multiplying like cancerous cells. Newly established

MEWAs surface on an almost weekly basis," Ms. Howard said. "Thieves are moving from MEWA to MEWA, from state to state," Mr. Maria said. In fact, the Labor Department and the Office of Inspector General are conducting more than 60 investigations of possible fraud, said Assistant Secretary of Labor David George Ball. Sen. Nunn said he intends to draft legislation designed to curb MEWA problems, though he did not offer specifics. Operation and regulation of self-funded MEWAs now "is an open-ended invitation for fraud," Sen. Nunn said. Some state regulators want complete regulatory authority. "The real solution is to eliminate duality," said Florida Insurance Commissioner and Treasurer Tom Gallagher. He noted that some MEWAs are subject to state law and others are covered by ERISA.

"The federal government should return control of health care arrangements and especially MEWAs to the individual states," he said. But Sen. Nunn said: "Victims want their medical bills paid. They are not interested in esoteric arguments on state vs. federal regulation." But the interplay of federal and state law is driving the MEWA problem today just as it did more than a decade ago. And the same force that drove small employers into the hands of crooked self-funded MEWAs in the 1970s—soaring premiums charged by commercial insurers—is back with a vengeance today. Self-funded MEWAs were designed to give small employers the advantages of group health insurance. Promoters established self-funded health care trusts and marketed these programs to thousands of small employers, typically firms with fewer than 25 employees. Many of the plans were based in California, Florida, Illinois and Texas.

Organizers contended that the trusts were employee benefit plans and thus protected from state regulation by ERISA's provisions that preempt states from regulating self-funded employee benefit programs. While state regulators said self-funded MEWAs were unauthorized insurers, MEWA promoters, then and now, vigorously resist regulators efforts to shut them down, citing ERISA's pre-emption provision. While the legal battles were being waged, the MEWAs continued to operate. By the time the Labor Department ruled on whether MEWAs were really benefit plans, many had gone bankrupt. In one well-documented case, the Idaho Insurance Department in 1977 tried to gain jurisdiction over the National Assn. of Independent Businesses, a Boise-based self-funded MEWA with more than 6,000 participants. The legal battle was going on three years later when the MEWA filed for bankruptcy, leaving hundreds of

thousands of dollars in unpaid bills (BI, Sept. 7, 1981). John Erlenborn, an Illinois congressman who called fraudulent MEWAs one of the country's most widespread white-collar crimes in the early 1980s, drafted legislation that Congress passed in 1982. Experts thought it would end the MEWA problem (BI, Dec. 27, 1982). Under the Erlenborn amendment, self-funded single employer health care plans still would be regulated by ERISA. However, with a few exceptions like self-funded plans developed in conjunction with labor unions and plans developed through rural electric cooperatives, group self-funded arrangements, like self-funded MEWAs, generally were made subject to the full scope of state regulation. In addition, fully insured MEWAs would continue to be regulated by the states as are commercial health insurers. But regulators say they still face all sorts of roadblocks when trying to assert authority over self-funded MEWAs.

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Ms. Howard said that delaying tactics impede state investigations. She outlined one case in which a state investigator asked an unidentified MEWA in November 1988 whether it was fully insured or whether it qualified for an ERISA exemption. A second request was sent a month later and a third in January 1989. Later that month, the MEWA said it had no participants in Texas. In February, the MEWA's attorney wanted to know the basis for Texas's request for information. "More than three months had passed and the state had obtained none of the basic information needed to determine whether this was a legally operating ERISA plan, exempt from state regulation, or a self-funded MEWA that was violating the insurance laws of Texas. Meanwhile, the MEWA continued to collect millions of dollars in contributions," Ms. Howard said. In other cases, MEWAs send state regulators on wild goose chases. One claimed to be fully insured and therefore bona fide under Texas law. However, several insurance companies denied providing coverage to the MEWA, Ms. Howard said in a written statement. She noted that MEWAs are prepared to fight it out when states demand documentation. "Money rightfully belonging to policyholders is plowed into attorney fees, expert witness fees, discovery fees, court costs, travel expenses and the like. The attraction of maintaining a continuing stream of contribution dollars during protracted litigation far exceeds the cost and nuisance of going to court," she testified. For instance, the regulator described another alleged agreement in which a MEWA agreed to pay attorneys a fixed percentage of premium contributions received. North Carolina's Mr. Long, in his testimony, described new ways that self-funded MEWA organizers escape state regulation. In one twist, unions agree to provide "associate union" membership to non-union members. The MEWA then claims exemption from state regulation as a collectively bargained plan, Mr. Long said. Mr. Ball, the assistant secretary of labor and chief of the Office of Pension and Welfare Benefits Administration, said the administration is drafting legislation that would require self-funded MEWAs to register with the department. Those failing to file statements would be subject to criminal sanctions, he said. The proposal, Mr. Ball said, will assist state regulators in policing MEWAs by providing a national registry of information about them and their promoters. That information, he said, should enable states to act quickly to prevent situations where contributions and reserves are inadequate to pay claims.

NCCI formula

Continued from page 1

In addition, adoption of the revised formula is pending in 14 additional states, and the NCCI expects to eventually introduce the proposal in the approximately 10 remaining states in which it acts as workers compensation insurers' ratemaking representative or consultant.

While the revised experience modification formula will change the work comp premiums paid by employers across the country, "most employers don't know that this is happening," pointed out Norman Goodman, president of Premium Review Associates, a Keene, N.H.-based consultant and software developer that specializes in workers compensation premium calculations.

The revised experience modification formula is designed to allocate premiums more equitably in both the voluntary and the residual workers compensation insurance markets, regulators say. Employers with bad loss records that are unable to meet insurers' underwriting guidelines can purchase coverage in the residual market, in which all work comp insurers in a state must participate.

"This plan is an improvement and something the NCCI should have done a long time ago," commented Alan Wickman, casualty actuary with the Nebraska Department of Insurance, which implemented the change in November. Nebraska was the first state to implement the revised formula.

"The old system was in place for 25 years and at that time was state-of-the-art. Since then, our ability to collect and analyze data has improved," said Rich Jaeger, senior vp and actuary with the NCCI, explaining the reason for the change.

"In the early to mid-1980s, the NCCI conducted a study which indicated that the predictive value of its basic experience rating formula could be improved," he said. This study showed that the experience modification factors for smaller employers typically did not fully reflect the employer's loss record, while larger employers tended to be given too many credits or debits for their loss history, he explained.

"This revision of the experience rating plan is also an effort to be responsive to the marketplace and to policyholders' comments," Mr. Jaeger said.

The new plan "will avoid the possibility of small employers with good experience and large employers with bad experience subsidizing other types of employers," he said, adding "there is some indication from policyholders that was the case in the past."

"In the past, the plan used to be more in favor of larger employers than smaller ones," said Larry White, property/casualty analyst with the Georgia Insurance Department, which implemented the change on Feb. 28.

Generally speaking, large employers are considered those with more than \$250,000 in expected workers compensation losses, while small employers are those with less than \$100,000 in expected losses, said the NCCI's Mr. Jaeger. However, these definitions may vary from state to state, he said.

The revised formula is not supposed to generate more premium revenue on either a state or national level. However, some observers say that while premiums for some employers are rising under the new formula, they have not seen any decreases in premiums.

Risk managers for some large companies and others complain the new formula is unfair.

"I feel the plan penalizes the larger insureds by not giving them full credit for safety programs and past experience," said James Crockett, manager of risk and employee benefits for the Denver Water Department. The department, which provides water service to the metropolitan Denver area, has 1,050

employees.

Application of the new formula in Colorado increased the Denver Water Department's minimum premium under its retrospectively rated workers comp insurance program by about 33%, said Mr. Crockett, who also is president of the Rocky Mountain Chapter of RIMS.

The Water Department had a 0.32 experience modification factor applied to its 1989 workers compensation premium, Mr. Crockett explained. The Water Department's broker calculated that increased losses would have caused the department's experience modification to climb to 0.48 this year under the old formula.

However, application of the new rating formula—which went into effect Jan. 1 in Colorado—has caused the Water Department's 1990 experience modification factor to jump to 0.61, Mr. Crockett said.

Workers compensation insurers essentially multiply an employer's experience modifier by the employer's manual work comp rate to determine an experienced-rated premium.

Under the new formula, the Water Department's minimum premium for 1990 is about \$130,000, compared with an estimated \$97,500 it would have paid this year under the old formula, Mr. Crockett said.

"In Nebraska, a few employers got zinged" by implementation of the new formula, even though their loss experience did not deteriorate, said Nebraska's Mr. Wickman.

One Nebraska broker said he knows of about a dozen medium-sized and large employers whose workers compensation premiums have increased this year primarily because of the new formula.

He questions whether the revised formula truly is "revenue neutral" because the only premium changes he has seen have been increases.

Mr. Wickman said that if such complaints continue, he may ask the NCCI for a statistical sample to test the revenue neutrality of the new formula.

Large employers with good loss experience may decide to self-insure their workers compensation risks rather than purchase commercial coverage if it becomes more expensive under the new formula.

"It certainly should induce more employers to go to self-insurance," said Monfort's Ms. Gallagher.

"Any time a company feels it is paying more than its fair share it looks at alternatives, including self-insurance," agreed Robin Obeiz, executive secretary of the Ohio Self-Insurers Assn. and an attorney with Vorys, Sater, Seymour & Pease in Columbus.

The NCCI's Mr. Jaeger says that a new shift by large employers with good loss history to self-insurance would "decrease the amount of premium volume written by insurance carriers. It is not expected to have any effect on the results or profitability of the remaining business."

In addition, he said that the defection from the commercial insurance market of large employers with good experience would cause the loss data from which manual rates are derived to deteriorate, which could mean increases in manual rates.

However, that doesn't mean that an employer's premium would then necessarily rise, he said.

"Even if the rate goes up because of the loss of better large insureds, other large insureds will have the opportunity to show up better" against the employers left in work comp insurance market, Mr. Jaeger said.

Unlike their larger counterparts, small employers with good loss history will receive more credit for their loss history under the new formula and thus be charged lower premiums.

"This will encourage small employers to come up with better safety programs to control their losses because a decrease in losses will be more accurately reflected in their premiums," said Georgia's Mr. White.

The prospect of lower premiums will provide not only the incentive for small companies to beef up their safety programs, but give them the funds to implement them, he said.

In the past, small employers complained that even if they tried to better control their losses, they did not see the effort reflected in their experience rating modification factor and their premium, Mr. White said.

However, Mr. Crockett of the Denver Water Department said a small employer's premium savings "might buy a few safety posters, but it isn't going to fund an extensive safety program."

The revised formula will also benefit large employers with bad loss experience, in that it will give them less of a debit and thereby lower their premiums for workers compensation insurance.

While this seemingly could discourage employers with bad loss experience from adding safety programs, "I don't think it creates a disincentive," the NCCI's Mr. Jaeger said. However, he did concede that "it does take away a little bit of the incentive which is there."

"I wouldn't want to take away any degree of incentive if that were the only consideration. The primary consideration is to get the right premium for each policyholder," he said.

Small employers with bad experience, though, will receive higher debits under the revised formula, increasing their work comp premiums.

"We've already received some calls about this," said Georgia's Mr. White.

A byproduct of higher debits for small employers with poor loss experience is that more insurers in the voluntary work comp market may be willing to underwrite these risks because the employers have to pay more, the NCCI's Mr. Jaeger said.

This could have a "marginally positive" impact on a state's residual market, Nebraska's Mr. Wickman said.

The workers compensation systems in many states are strained because too many employers are purchasing coverage in the residual market, leading to increasing residual market charges for insurers.

Meanwhile, many employers are unaware of the revision in the formula since "in virtually all states, no hearing is required because essentially it is a rating plan change as opposed to a rate change," Mr. Wickman said.

In Colorado, "a lot of people felt this was a back-door attempt by the NCCI to get a rate increase after the insurance commissioner denied a 28.3% requested increase" in December, said an Insurance Department spokesman. However, "that's simply not true," he said.

The NCCI refiled for a 14.3% rate increase, and a hearing on that is scheduled for May 24, he said.

Meanwhile, some employer representatives are downplaying the effects of the change.

"It's not a significant change, nor do we expect any significant results," said Virginia Morrison, manager of government affairs for the Greater Denver Chamber of Commerce.

"I can't say there is no concern, but it hasn't surfaced at this time," said Cynthia Cover, director of public affairs for the North Carolina Citizens for Business & Industry in Raleigh.

"It's been a non-issue," agreed Ronnie Chamberlain, deputy commissioner of the North Carolina Insurance Department's Fire and Casualty Division.

But, "all employers would like to know about the new calculation and whether they will benefit or lose by it," said Bonnie Stewart, staff attorney with the Connecticut Business & Industry Assn. in Hartford.

States in which the revised formula has been approved but will not go into effect until later this year are: Mississippi, June 1; Connecticut, Indiana, Maryland, Minnesota, Tennessee and Wisconsin, all July 1; Alaska, Alabama and Illinois, all Sept. 1. ■

Update

U.K. insurer plans runoff

LONDON—Officials of National Employers Mutual General Insurance Assn. Ltd. met with creditors in London late last week to discuss a proposed scheme of arrangement to run off its non-U.K. underwriting business.

The plan is expected to be filed in the British High Court in the next two months, said Joe Albon, consultant at NEMGIA's London offices. He would not say how much in losses the runoff entails.

The majority of the runoff will entail liabilities from workers compensation insurance written by Australian subsidiary NEM (Australia) Pty. Ltd. Those liabilities could amount to more than \$200 million Australian (\$152.6 million). NEMGIA has stopped paying those claims and "was instrumental" in having KPMG Peat Marwick, the Australian unit's provisional liquidator, appointed to run off the Australian business, Mr. Albon said.

By liquidating NEMGIA's Australian subsidiary, creditors can tap Australia's guaranty fund, he said.

NEMGIA in March sold more than 90% of its U.K. operations to AGF Holdings (U.K.) Ltd., the British subsidiary of Assurances Generales de France in Paris, for an undisclosed sum. NEM Insurance Co., which is what AGF named the operations, is not involved in the runoff of NEMGIA, said Mr. Albon.

NEMGIA, established in 1914, wrote 200 million pounds (\$362 million) in gross premiums and 99.7 million pounds (\$180.5 million) in net premiums in 1988, the latest figures available. Surplus stood at 32.6 million pounds (\$59 million) at year-end 1988, according to figures from A.M. Best Co.

Meanwhile, NEMGIA's Far East operations are not involved in the runoff and continue to operate, said Mr. Albon.

NEMGIA ceased underwriting and paying claims through an agency agreement with London-based Chancellor Insurance Co. earlier this year, said Mr. Albon. NEMGIA also stopped underwriting through the Victor Wright Underwriting Agency earlier this year, but Mr. Albon said that other participants on the Wright underwriting slip have "picked up" the NEMGIA business.

Pennsylvania auto insurance

HARRISBURG, Pa.—Insurers in Pennsylvania would be prohibited from writing all forms of new commercial and personal lines insurance if they stop writing personal auto insurance under legislation proposed last week by two state senators.

Auto insurers in Pennsylvania say the bill is unfair because it would force insurers to write personal auto coverage at a loss.

The bill was introduced after three insurers—Aetna Life & Casualty Co., Harleysville Mutual Insurance Co. and SAFECO Corp.—recently sent non-renewal notices to all 273,000 of their private passenger auto insurance policyholders in the state. The three insurers are among the 116 insurers that failed to file 10% rate reductions by May 1 as mandated under an auto insurance reform law signed by Gov. Robert P. Casey on Feb. 7, according to an Insurance Department spokeswoman.

The auto reform law calls for rates to be frozen from Dec. 1, 1989, to June 30, after which rates must be cut 10% if drivers make no coverage changes. In addition, drivers can obtain an additional 12% rate rollback if they select optional no-fault coverage (BI, Feb. 19).

Insurers adamantly oppose the proposed legislation.

"There is an element of unfairness involved. It would require companies to write the business at a loss," said an Aetna spokesman.

Leo Doyle, assistant vp and regional manager for the National Assn. of Independent Insurers, said the bill raises constitutional questions. "There's a simple question of due process. You can't force companies to write insurance in lines where they can't make money."

Also, Gov. Casey announced last week that the state had filed a suit in Commonwealth Court in Philadelphia against eight of the state's 10 largest auto insurers claiming the insurers acted in concert in ignoring the May 1 deadline for filing 10% rate reductions.

Briefly noted

Robert J. Vairo, president and chief executive officer of **Crum & Forster Inc.**, has also been named chairman. He succeeds Melvin Howard, who took early retirement. . . Richard H. Jenrette, chairman of **The Equitable Life Insurance Society of the United States**, has also been named president and chief executive officer. He succeeds John B. Carter, who retired. . . Due to a 10% increase in the frequency and severity of directors and officers liability insurance claims since its incorporation in 1986, **Corporate Officers & Directors Assurance Holding Ltd.** will apply a 5% surcharge to all renewals, policy extensions and new business effective June 1. It is the first rate increase by Bermuda-based CODA, a policyholder-owned facility. However, not-for-profit, closely held companies and Canadian- and U.K.-based companies will receive premium credits reflecting their reduced exposures. . . Citing losses related to the junk bond market, **AmBase Corp.**, parent of The Home Insurance Co., reported a \$42 million loss for the first quarter, compared with a \$26 million profit for the comparable period a year ago. AmBase's insurance operations posted a 108.4% combined ratio. . . Michael J. Mullen, an insurance and product liability lawyer most recently with Crowell & Moring in Washington, D.C., has been appointed executive director of the **National Assn. of Insurance Brokers**, effective today. A former counsel to the Senate Judiciary Committee and the Commerce Committee's Consumer Subcommittee, Mr. Mullen was the principal author of the Product Liability Risk Retention Act and its subsequent amendments. . . Workers in **flour mills** have shown a significantly greater incidence of cancer-related deaths than employees in the overall grain industry and the general population, says a study by the National Cancer Institute. While the reason for the increased cancer death rate for flour mill workers has not been determined, the NCI speculated that exposure to pesticides used to control insects in grain consumed by humans might be a possible cause. . . Milwaukee-based **Christiana Cos.** will appeal a California state court jury award of \$8.1 million to homeowners who charged in a 1985 suit that a unit of Christiana was responsible for faulty construction of a San Diego condominium project. About 84% of the award will be covered by insurance, said Christiana's chief financial officer. The remainder is not covered because one of its insurers went bankrupt.

OGICO

Continued from page 2

Ohio Superintendent of Insurance George Fabe took control of OGICO last week after the Court of Common Pleas, Franklin County, Ohio, appointed him as rehabilitator.

Three U.S. insurers have expressed an interest in buying OGICO and each is in discussions with the Ohio insurance department, Mr. Rector said.

"We should know within 30 or so days whether a sale will be forthcoming to protect policyholders," Mr. Rector said.

Mr. Rector would not comment on what will happen if a sale is not concluded.

OGICO, which writes property and casualty insurance for small oil and gas companies, "has a negative net worth of \$3.7 million on a statutory basis," said Mr. Rector.

OGICO wrote \$19.3 million in gross premiums on a direct basis and assumed \$14.2 million in reinsurance premiums in 1989. Its net premiums totaled \$22.8 million at year-end, with capital and surplus of \$7.5 million, according to The Group Inc. President Clive Becker-Jones.

Mr. Becker-Jones maintained last

week that OGICO's capital and surplus was at least Ohio's minimum of \$2.5 million. "The focus is on the quality of the assets," he said, explaining the difference of opinion over OGICO's solvency.

The Group Inc. failed in its effort to convince the department to delay the rehabilitation order so that the company could be sold.

The Group said previously that all its insurers were for sale, including Millers.

OGICO also underwrote reinsurance for captive insurance companies under an agency agreement with Aneco Reinsurance Underwriting Ltd. in Bermuda.

OGICO wrote 10 reinsurance policies for captives in 1989, which were reinsured 40% with Aneco and 40% with Forum Reinsurance Co. Ltd., both owned by Forum Re Group (Bermuda) Ltd.

Forum Re is related to The Group through common majority ownership of the two holding companies by Mark Hardy of Concord, Mass.

This year, "three or four" policies have been written by Aneco on behalf of OGICO, with 70% of the risk reinsured with Aneco, said Aneco Reinsurance Underwriting President Jonathan J. Crawley.

In the Franklin County Court Judge McGrath last week ruled that OGICO "is in such condition that its further transaction of business would be financially hazardous to its policyholders, creditors or the public."

Moreover, "without the appointment of a rehabilitator, (OGICO) is not in a condition to continue the insurance business and may cause harm to the interests of its policyholders, creditors or the public in general, and that unless restrained, (OGICO) will be forced to operate in a condition contrary to the best interests of (OGICO's) policyholders, creditors or the general public," the judge added.

And, "the assets of (OGICO) may become dissipated, causing irreparable and immediate injury of the policyholders, defendant creditors and the general public," he said.

Oklahoma's Insurance Department is seeking a rehabilitation order for Petrosurance partly because of the rehabilitation order placed on affiliate company OGICO, confirmed Ms. Clark.

Petrosurance's statutory deficiency as of December 31, 1989 is about \$1.5 million, said Ms. Clark. However, the company has not yet filed its first-quarter results, she noted. ■

Aneco directors resign to form new company

HAMILTON, Bermuda—The management of Aneco Reinsurance Underwriting Ltd., a specialist in reinsuring captive insurers, is raising money for a new reinsurance company to succeed Aneco.

As a result, Aneco Reinsurance Underwriting President Jonathan J. Crawley and three other members of the Aneco Reinsurance board have resigned "to avoid any resultant conflict of interest," according to a statement released last week by Forum Re Group (Bermuda) Ltd., which owns Aneco.

Forum Re Group (Bermuda) is affiliated with Concord, Mass.-based The Group Inc. through the common majority ownership of the two companies by Mark Hardy.

Mr. Crawley said last week that it is "totally coincidental" that the announcement of the formation of a new reinsurer by Aneco management was made the same week that the Ohio Insurance Department put Group Inc. subsidiary Oil & Gas Insurance Co. into rehabilitation (see story, page 2).

In addition to Mr. Crawley, resigning from the Aneco board were Aneco Vp of Underwriting Bruce M. Jones, Aneco Vp of Technical Services Eric J. Line and outside Director Robert W. Dressel.

"It is inappropriate for the board to remain composed of people who will be the board of the company that will negotiate with Aneco the details of the terms for the takeover of ongoing business," Mr. Crawley said in an interview.

The remaining Aneco Reinsurance board members are: David A. Thirkill, president of Forum Re Group unit Forum Reinsurance Co. Ltd., Ian A. Carswell, controller of Aneco Reinsurance; and Michael Jones of Cox & Wilkinson, the company's legal representative in Bermuda.

The new reinsurance company being formed, to be called Ascot Reinsurance Co. Ltd., will be capitalized with \$30 million, which Mr. Crawley expects to raise from a majority investor from the insurance or reinsurance industry, institutional investors, management and a bank.

Ascot will be capitalized "as soon as possible," Mr. Crawley said. "We expect to have confirmation of the makeup of the equity participants by June 30 or soon after," he said. "And after that, it's just a matter of lawyers for the equity participants and Firemark's lawyers doing the paperwork," he said, referring to Parsippany, N.J.-based Firemark Capital Corp., which is acting as Ascot's investment banker and has made a commitment to invest in Ascot.

When Ascot is capitalized, policies written by Aneco in 1990 will be assumed by Ascot, effective with the Aneco policy inception, with the permission of the policyholder.

In addition to reinsuring captive insurance companies, Aneco writes property catastrophe reinsurance for select London underwriters (BI, April 30).

Ascot also expects "to manage the runoff of the Aneco business under a management agreement," Mr. Crawley said, referring to captive reinsurance and property, aviation and marine reinsurance that has been underwritten in recent years by Aneco.

Ascot will not run off the business that Aneco refers to as discontinued lines, which includes casualty and multiperil reinsurance written before 1984. That runoff will be managed by an independent company that is handling business formerly managed by Group Inc. subsidiary Monument Square Associates Inc. of Concord, Mass.

Separately, Forum Re Group (Bermuda), which purchased Amberco Inc. from The Group Inc. earlier this month, put the reinsurance broker into runoff following the resignation of Amberco President William A. Wanklin and Senior Vp Julian Griffiths.

Amberco no longer will place renewal or new business, but Forum will ensure its old business and existing clients' files are managed in an orderly way, said Mr. Thirkill.

Meanwhile, Messrs. Griffiths and Wanklin have acquired Amberco's captive management company, Amberco Management Co.

Also, Forum Re's underwriter and Senior Vp Michael J. Welch resigned "several weeks" ago, said Mr. Thirkill, who could not comment on Mr. Welch's plans.

Asbestos lawsuit

Continued from page 1

woman in the attorney general's office.

A spokesman said last week that no decision has been made on what action Connecticut Attorney General Clarine Nardi Riddle will take following the Supreme Court's decision.

"I don't think anybody was really predicting how this thing would turn out," the spokesman said, referring to the court's refusal to hear the case.

Meanwhile, defense attorneys noted they said early this year that they did not expect the high court to hear the unusual suit, which sought to invoke the Supreme Court's original jurisdiction.

"I am not surprised," said Irene Warshauer of Anderson, Kill, Olick & Oshinsky in New York, who represented asbestos manufacturer Keene Corp. in the lawsuit. "This lawsuit was contrary to all prior procedures."

In their lawsuit, the attorneys general said going directly to the Supreme Court was appropriate because no other forum could hear a consolidated action against all the defendants.

However, Ms. Warshauer contended "these cases are being handled adequately by state trial courts."

Arlene Fickler of Hoyle, Morris & Kerr in Philadelphia said: "The state attorneys general had alternative forums."

"This was an inappropriate case

for the court to entertain its original jurisdiction," said Ms. Fickler, who represented U.S. Gypsum Co. in the litigation. "This usually leads the court to deny these petitions."

This particular case also would have required extensive discovery and a high degree of judicial administration, said Ms. Fickler.

"The Supreme Court is simply not in a position to handle this type of case," she said.

Chuck LaGrave, senior litigation counsel with Fibreboard Corp. in Concord, Calif., said the Supreme Court "showed appropriate judicial restraint" in denying the complaint.

"We never thought this was the appropriate avenue for this type of litigation," he said. "The states can sue in state and federal courts."

He concedes, however, that individual lawsuits may be "too costly" for the states.

The Supreme Court accepts original jurisdiction rarely, usually in disputes between states, like controversies involving borders or water rights, rather than disputes between states and private parties, according to legal scholars.

The attorneys general sued under a 1948 federal rule allowing the high court to share jurisdiction with other federal courts over lawsuits involving states and citizens of other states.

Asbestos manufacturers, the suit alleges, "knew or should have known, of the link between exposure to asbestos fibers and disease at the time

of the manufacture, distribution and marketing of their asbestos-containing products to the states."

Manufacturers also "breached their duty to provide safe products to the public" by failing to warn of asbestos' dangers, the suit alleges.

Other states joining the suit were: Alabama, Arizona, Arkansas, California, Connecticut, Delaware, Florida, Illinois, Indiana, Iowa, Louisiana, Maine, Missouri, Montana, Nebraska, New Hampshire, New York, North Carolina, North Dakota, Ohio, Oklahoma, Rhode Island, South Dakota, Tennessee, Texas, Utah, Vermont and Wyoming.

In its ruling last week, the high court denied New Jersey's request to join the suit.

Other defendants were: United States Gypsum Co., USG Corp., American Biltrite Inc., Armstrong World Industries Inc., Azrock Industries Inc., Basic Inc., Carey-Canada Inc., The Celotex Corp., Certainteed Corp., Crown Cork & Seal Co. Inc., Eagle-Picher Industries Inc. and The Flintkote Co.

Also, GAF Corp., Georgia-Pacific Corp., H.K. Porter Co. Inc., Kentile Floors Inc., Owens-Corning Fiberglas Corp., Owens-Illinois Inc., Pfizer Inc., Raymark Industries Inc., Sprayed Insulation Inc., and Turner & Newall P.L.C.

Alabama et al. vs. W.R. Grace et al., U.S. Supreme Court, No. 116 Original.

Affiliated FM challenges coinsurance ruling

By MICHAEL SCHACHNER

ST. LOUIS—Affiliated FM Insurance Co. says it will seek a new trial after a federal jury awarded Marsh & McLennan Cos. Inc. \$473,000 that the broker had paid toward a business interruption claim the insurer had refused to pay.

Affiliated FM contends that a Springfield, Mo., food processing firm is not entitled to coverage for its full \$550,000 business interruption claim from an April 1988 fire at a Georgia plant because the property had been underinsured.

American Dehydrated Foods Inc. "did not keep its insurance up to full value" as its contract required, said Jack Pomeroy, an Affiliated FM lawyer and vp in Johnston, R.I.

"ADF should have been insured to a higher value. There was a coinsurance provision in the contract stating if the insured does not keep insurance up to full value, we are only responsible for an appropriate

portion of the claim," he said.

A federal court in St. Louis rejected that argument. On April 25 the jury ruled that Affiliated FM—an Allendale Mutual Insurance Co. subsidiary—negligently misrepresented the coverage when it required ADF to carry insurance to full property value during the renewal of ADF's policy for the period of Oct. 31, 1986, to Oct. 31, 1987, and ordered the insurer to pay restitution to M&M.

If Judge William L. Hungate enters a judgment in accordance with the jury verdict, Affiliated FM will move to have the verdict overturned, Mr. Pomeroy said. The judge had not entered a judgment as of late last week.

He would not say whether Affiliated FM plans to appeal if its motion to overturn is denied.

New York-based Marsh & McLennan sued in June 1989, claiming Affiliated FM inserted a coinsurance penalty clause into ADF's policy during a 1986 renewal without informing M&M in writing of the change.

Henry Menghini, an attorney with the St. Louis law firm of Evans & Dixon, which represented M&M in litigation, said Affiliated FM had not required a coinsurance penalty clause in its original policy, which ran from May 1984 to October 1986, but in-

'The insurer had a duty at the time of renewal to inform us of all changes,' says Mr. Menghini.

serted the clause in the renewal policy without informing M&M in writing of the change in the policy.

"The broker never realized that there was a coinsurance penalty being included in the renewal," Mr. Menghini said. "Our argument was that the insurer had a duty at the

time of renewal to inform us of all changes. They omitted the most important change."

Affiliated FM contends that it telephoned the policyholder to discuss the inclusion of a coinsurance clause.

Affiliated FM had insured the food company for property damage and business interruption losses since May 1984.

ADF had insured its Georgia plant for \$600,000 but Affiliated FM determined that the value of the plant was \$4.3 million. Since the property was insured at only 13.8% of its value, the insurer said it only owed ADF 13.8% of its business interruption claim.

M&M paid the difference to American Dehydrated Foods because the company was "a good client," said Barry W. Furst, an M&M lawyer and vp. "We felt the insurance company was terribly wrong and we made a judgment to relieve the insured of litigation and assume the responsibility ourselves."

M&M had been the company's bro-

ker since 1984 when it acquired Lawton Byrne Bruner Insurance Agency Co. Inc. of St. Louis.

In its suit, M&M characterized Affiliated FM's refusal to provide coverage as "vexatious, malicious and without just cause or excuse."

"ADF paid substantial premiums for business interruption coverage as set out in renewal requests and agreed to by (Affiliated FM) and has met all conditions precedent under the applicable policy," M&M's suit alleged.

If M&M had known that a coinsurance clause was being inserted, the broker would have fought the clause, Mr. Menghini said.

Referring to Affiliated FM's contention that it had discussed the policy change with ADF, Mr. Menghini said: "Our expert testimony convinced the jury that insurers do not conduct business orally and that the scope of a renewal investigation is traditionally geared to focus on the terms that are subject to change." ■

Pension rules

Continued from page 1

Associates in Lincolnshire, Ill.

Had the IRS not changed course on the minimum participation rule, many employers, especially those involved in mergers and acquisitions, would have had problems.

"A typical Fortune 500 company had reason to be concerned if it was involved in a merger or acquisition," said Dennis Coleman, a partner at Kwasha Lipton in Fort Lee, N.J.

Rather than incur the expense of operating two pension plans, acquiring companies have continued to offer the new employees—through its own plan—the same, richer benefit formula that they previously had.

"The IRS didn't realize how common it was for large companies to have separate benefit structures," said John Woyke, a principal with TPF&C, a unit of Towers, Perrin, Forster & Crosby Inc. in Valhalla, N.Y.

It remains to be seen, though, whether any other good news is contained in the IRS pension regulations. The proposed regulations, which generally will take effect for plan years beginning on Jan. 1, were published in the May 14 issue of the Federal Register.

Despite their sheer bulk, consultants agree no comparison should be drawn between the pension non-discrimination rules and the late Section 89 non-discrimination rules for welfare plans (BI, Nov. 13, 1989).

"The IRS has made a good-faith effort to produce workable rules, though fine-tuning certainly will be needed," said Mr. Coleman.

In addition, the pension non-discrimination rules contain "safe harbors" that will greatly simplify compliance, benefit experts say.

Some employers, like companies that use a uniform contribution formula—such as the same percentage of salary as the basis for all contributions to a profit-sharing plan—will

qualify for a safe harbor and should face no additional compliance problems.

But some employers may run into problems unless the regulations are amended.

Benefit experts are concerned, for example, that an employer that offers a defined contribution plan to salaried employees, who tend to be more highly compensated, and a defined benefit plan to lower compensated hourly employees, could face problems.

As part of the new IRS rules, pension plans must cover a certain percentage of non-highly compensated employees—generally those making less than \$54,000 a year—to be considered non-discriminatory.

One method of testing, known as the ratio percentage test, would require the percentage of non-highly compensated employees covered by a plan to be 70% of the percentage of highly compensated employees covered by the same plan.

For example, if a plan covered 80% of a company's highly compensated employees, 56% of non-highly compensated employees would also have to be covered.

The IRS rules allow employers to aggregate different pension plans, like a defined benefit and a defined contribution plan, to pass this ratio percentage tests.

But in order to aggregate the plans, the IRS requires that the plans have comparable "core" features. Examples of a core feature would include the ability to take lump-sum distributions and make in-service withdrawal of contributions.

While defined contribution plans almost always offer lump-sum distributions, defined benefit plans often do not. And, while in-service withdrawal of contributions is common in defined contribution plans, defined benefit plans never—as part of receiving tax-qualified status—contain such a feature.

"This is a potentially serious problem," said

Gerald Uslander, a principal with William M. Mercer Inc. in Washington, D.C.

Employers would have to redesign their plans to create similar core features or perhaps open their plans to more lower-paid employees.

Other benefit experts, though, say the IRS may have made a drafting error and they want to get more information on the aggregating provision before commenting.

One thing that is clear in the regulations is that certain highly-paid executives will receive smaller pension benefits than they may have anticipated.

Under the Tax Reform Act of 1986, companies may use up to \$200,000—indexed annually after 1989 to the Consumer Price Index—of employee compensation in calculating the employee's pension benefit.

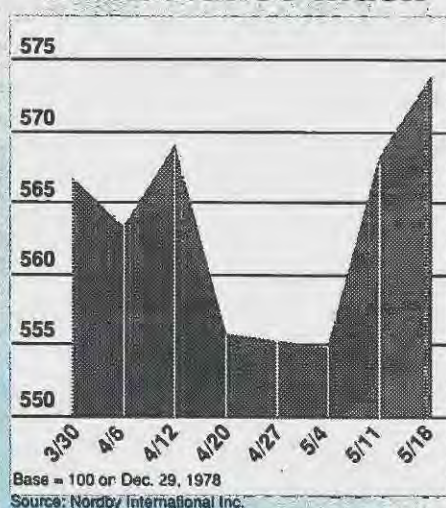
For example, a company's pension benefit formula may stipulate that an employee's pension benefit will be 2% of final average pay over a three-year period times the employee's years of service. The maximum amount of pay that could be recognized in 1989 would be \$200,000.

Indexed to the CPI, this limit rises to \$209,200 in 1990. And, based on current inflation, the 1991 limit is expected to be about \$220,000.

Benefit experts had expected the IRS to allow, in the case of plans whose benefit formulas are based on an average of several years of pay, that an employee could use the highest indexed limit in the year he or she is retiring as the basis for compensation.

However, the IRS says compensation must be based on an average of the limits in each of the years. For example, assume a plan bases benefits on three-year final pay and the eligible compensation limits are \$200,000 in 1989, \$209,200 this year and \$220,000 in 1991. For a very high-paid executive retiring next year, the maximum amount of compensation that could be recognized would be \$209,733, not \$220,000 as hoped for.

BI Insurance Index



Insurance industry stocks continued their ascent last week, as the *Business Insurance Index* rose 4.6 points to 573.8 on May 18, from 568.2 on May 11. Advancing issues were led by Nobel Insurance Ltd., up 16.0%; Frontier Insurance Group, up 11.4%; and Selective Insurance Group, up 10.8%. Declining issues followed Poe & Associates Inc., down 8.3%; Frank B. Hall & Co. Inc., down 6.7%; and Statesman Group Inc., down 5.7%. The most active issue during the week was Argonaut Group, 5.9 million shares traded. The *Business Insurance Index* gained 1.0% for the period, performing ahead of the leading market indexes: The Standard & Poor's 500 was up 0.8%; and both the Dow Jones 30 Industrials and the New York Stock Exchange Composite were unchanged.

British Issues

May 17 Companies	Price	P/E	Div.	Yield	1 Week High-Low
Comm Union	471	21.7	28.7	6.1	471-432
Genl Accident	1044	16.0	66.7	6.4	1044-1025
Gdn Royal Exch	233	20.4	15.3	6.6	233-222
Royal	463	24.9	34.0	7.3	463-433
Sun Alliance	314	11.5	16.7	5.3	314-302
Brokers					
Bradstock	235	16.5	10.0	4.3	235-235
CE Heath	528	14.9	34.5	6.5	530-528
Hogg Group	162	10.7	9.7	6.0	163-132
Lloyd Thompson	287	17.9	9.7	3.4	287-237
PWS Holdings	70	10.9	3.3	4.8	70-70
Sedgwick Grp	249	18.7	16.0	6.4	265-249
Steel Bri Jones	269	16.4	14.7	5.5	270-259
Willis Faber	276	17.4	16.0	5.8	276-274

Source: Philip Olsen/Paul Hodges, Insurance Industry Specialists Kilcat & Aitken Stockbrokers, London

Insurance futures

Continued from page 2

he delivers against the original contract, and profits from having sold the contract six months earlier at the higher price.

One of the questions raised about the viability of the CBOT's plan for insurance is how reinsurance is applicable to a futures contract.

One likely approach would be to set up a reinsurance index based on a "market basket" of prices, then allowing insurance companies to trade against it, said Michael Smith, an analyst with Shearson Lehman Hutton.

However, in order to establish price indexes so that futures contracts can be efficiently bought and sold, the underlying asset must be readily identifiable, like a specific volume of hogs or some stock market indexes.

Reinsurance contracts, which often are man-
uscripted, are not a commodity item nor are they easily indexed.

The concept may have been viable 20 years ago, when quota-share treaties were the norm, but that is no longer the case today, he said.

Under quota-share treaties, every risk accepted by the primary insurer within a particular class of business is shared by the reinsurer on a straight percentage basis.

Today, said Mr. Smith, more reinsurance is written on an excess-of-loss basis, with the reinsurer's responsibility beginning only when the loss exceeds the primary insurer's retention. Under this approach, reinsurance is much less of a commodity.

"Individual companies already have enough

trouble measuring the price" of their own renewals, so it would be difficult to establish an index on which the future contracts would be based, said Paul Ingrey, president of F&G Re in Morristown, N.J., a USF&G Corp. unit.

Mr. Smith also questioned how this concept would be greeted by state insurance regulators. Non-admitted reinsurance must be backed up by some security, such as a letter of credit, to guarantee the payment of reinsurance recoverables, he said.

Similarly, regulators are likely to demand additional security as well if an insurer buys a reinsurance futures contract, he said.

A spokesman for the National Assn. of Insurance Commissioners said that the NAIC had not seen the proposal and could not comment.

BI Industry Stock Report

MAY 14, 1990 THROUGH MAY 18, 1990

BROKERS																									
		Price	% change	Year to Date % change	Annual High	Low	Vol.(000)	\$ Div.	% Yield	P/E	Book value	Mkt/Bk. value			Price	% change	Year to Date % change	Annual High	Low	Vol.(000)	\$ Div.	% Yield	P/E	Book value	Mkt/Bk. value
Alexander & Alexander	NYS	24.00	0.00	-23.81	34.00	23.25	729	1.00	4.17	19	9.18	2.61	Lawrence Insurance Group	ASE	8.75	4.48	22.81	9.13	6.50	13	0.36	4.11	17	4.40	2.66
Corroon & Black	NYS	31.50	0.80	-17.65	41.00	28.50	304	1.36	4.32	17	12.73	2.47	Liberty Corp.	NYS	49.50	-0.75	16.47	49.75	32.50	13	0.92	1.86	16	31.32	1.56
Gallagher Arthur J. & Co.	NYS	21.63	1.17	-12.63	26.50	19.00	101	0.60	2.77	16	5.33	4.06	Lincoln National	NYS	54.38	-0.68	-10.86	62.88	47.50	225	2.60	4.78	10	49.19	1.11
Frank B. Hall	NYS	3.50	-6.67	16.67	4.50	2.50	62	0.00	0.00	-2	-2.80	-1.25	NAC Re Corp.	OTC	33.25	3.50	-8.28	41.00	24.38	170	0.20	0.60	15	22.31	.46
Hibb, Rogal & Hamilton	OTC	14.38	-0.86	-22.82	20.83	11.25	99	0.28	1.95	19	4.60	3.13	Navigators Group	OTC	31.25	1.63	13.64	31.75	23.75	40	0.00	0.00	11	15.22	2.05
Marsh & McLennan	NYS	73.13	3.54	-6.25	89.75	60.63	838	2.48	3.39	18	10.56	6.92	Nobel Insurance LTD.	OTC	3.63	16.00	81.25	3.63	1.50	179	0.00	0.00	-2	7.76	0.47
Poe & Associates	OTC	11.00	-8.33	-16.98	13.00	8.00	2	0.40	3.64	14	1.93	5.82	NWNL Companies	OTC	29.38	-1.67	-25.63	44.13	26.50	733	1.32	4.49	6	37.50	0.78
BROKERS AVERAGE			-1.5	-11.9					2.9	14			Ohio Casualty Corp.	OTC	43.50	2.96	-8.90	52.50	34.75	242	2.32	5.33	12	33.30	.31
CONGLOMERATES & HOLDING COMPANIES																									
Berkley W.R. Corp.	OTC	44.75	5.29	7.51	46.50	30.25	168	0.44	0.98	10	25.06	1.79	Old Republic Int'l	OTC	22.75	1.11	-11.22	29.00	21.13	132	0.72	3.16	5	30.70	0.74
Berkshire Hathaway Inc.	NYS	7115.00	-4.82	-17.51	8900.00	5675.00	0	0.00	0.00	-27	2869.00	2.48	Orion Capital Corp.	NYS	18.63	-0.67	-19.89	28.50	18.50	158	0.84	4.51	6	19.72	0.94
ITT (Hartford Group)	NYS	56.38	-1.10	-5.85	64.50	51.38	2350	1.60	2.84	8	56.33	1.00	Phoenix RE Corp.	OTC	9.88	2.60	-24.04	15.50	8.75	78	0.20	2.03	-14	12.99	0.76
Sears (Allstate)	NYS	37.00	-1.33	-4.52	48.13	34.75	4127	2.00	5.41	10	37.75	0.98	Protective Life Corp.	OTC	13.25	-0.93	-7.02	16.25	10.38	48	0.68	5.13	8	14.54	0.91
CONGLOMERATES AVERAGE			-0.5	-5.1					2.3	0			Provident Life	OTC	23.00	8.88	-11.11	30.13	19.30	436	0.80	3.48	7	23.24	0.99
INSURERS/REINSURERS																									
Aetna Life & Casualty	NYS	50.88	-1.69	-12.28	62.50	45.25	1652	2.76	5.43	9	58.11	0.88	Re Capital Corp.	ASE	13.88	0.00	-4.31	15.25	10.75	10	0.00	0.00	11	12.30	1.10
Amibase Corp.	NYS	6.38	2.00	-49.50	16.38	5.75	552	0.20	3.14	2	29.08	0.22	RLI Insurance Corp.	NYS	11.38	-1.09	28.17	12.38	6.38	25	0.40	3.52	6	12.42	0.92
American General	NYS	49.13	0.77	50.00	50.63	28.13	4313	3.20	6.51	14	34.68	1.42	St. Paul Companies	OTC	59.00	2.61	-1.67	63.50	48.53	1456	2.40	4.07	7	43.47	.36
American Heritage	NYS	22.25	1.14	-21.93	24.63	19.50	2	1.00	4.49	11	22.60	0.98	SAFECO Corp.	OTC	37.88	3.77	-4.72	42.38	27.75	738	1.36	3.59	9	24.37	.52
American Indemnity/Fin'l	OTC	6.00	-4.00	-25.00	13.00	4.25	25	0.08	1.33	-1	17.38	0.35	SCOR U.S. Corp.	NYS	10.75	-2.27	-24.56	14.50	8.25	35	0.20	1.86	14	10.31	1.01
American International	NYS	96.75	5.16	-8.29	112.00	81.25	2577	0.48	0.50	12	41.92	2.31	Seibels Bruce Group	OTC	10.75	-4.44	-1.15	13.63	8.75	335	0.80	7.44	-2	13.75	0.78
Aon Corp.	NYS	38.13	0.00	-10.03	43.25	32.50	286	1.52	3.99	11	19.62	1.94	Selective Ins. Group	OTC	18.00	10.77	-5.88	20.25	15.50	57	0.4	5.78	6	15.72	.15
Argonaut Group	OTC	74.50	2.76	8.17	74.50	54.25	5947	1.60	2.15	9	36.83	2.02	Statesman Group Inc.	OTC	2.05	-5.71	-24.98	3.63	1.38	186	0.16	7.76	4	4.19	0.49
AVEMCO Corp.	NYS	24.50	-4.85	0.51	27.50	20.38	36	0.40	1.63	17	9.52	2.57	Tokio Marine & Fire	OTC	51.88	-0.24	-31.18	78.13	40.38	37	0.0	1.93	-	70.93	0.73
Baldwin & Lyons Inc.	OTC	20.75	3.75	-3.49	24.00	17.00	5	0.28	1.35	7	20.80	1.00	Torchmark Corp.	NYS	46.00	-2.13	-19.65	58.75	37.38	552	4.0	3.04	11	13.23	3.48
Belvedere Corp.	ASE	4.25	-2.86	-22.73	5.63	4.13	1	0.04	0.94	-5	8.03	0.53	Transamerica	NYS	37.63	-0.66	-15.69	48.00	33.75	537	3.2	5.10	9	34.63	.09
Chandler Insurance	OTC	9.00	1.41	-23.40	13.25	7.63	39	0.00	0.00	5	9.53	0.94	Travelers Corp.	NYS	29.75	-1.65	-19.32	45.00	29.53	5507	2.40	8.07	6	44.35	.11
Chubb Corp.	NYS	93.38	4.04	-2.61	102.75	67.50	997	2.64	2.83	9	55.49	1.68	Trenwick Group Inc.	OTC	22.50	2.27	-7.69	26.88	16.30	56	0.36	1.60	15	16.91	.33
CIGNA Corp.	NYS	50.63	3.32	-15.98	66.75	45.25	775	3.04	6.00	11	66.64	0.76	United Fire & Casualty	OTC	31.75	3.25	-3.79	34.50	29.53	0	1.20	3.78	9	22.56	.41
CNA Financial Corp.	NYS	73.75	1.72	-26.25	108.75	68.25	396	0.00	0.00	9	54.87	1.34	USF&G Corp.	NYS	28.50	-1.30	-3.80	34.00	26.38	1307	2.92	10.25	36	22.37	.25
Continental Corp.	NYS	29.00	-0.43	-7.57	38.63	25.75	2956	2.60	8.97	11	41.36	0.70	UNUM Corp.	NYS	49.50	2.33	3.66	51.38	32.13	156	0.80	1.62	9	31.20	1.59
Durham Corp.	OTC	31.00	6.90	0.81	34.75	29.00	3	0.92	2.97	15	26.32	1.18	USLIFE Corp.	NYS	38.63	1.98	-14.64	48.13	34.75	334	1.48	3.83	4	54.34	0.71
Fireman's Fund	NYS	31.25	-3.85	-11.35	40.75	29.50	915	0.68	2.18	47	32.74	0.95	Washington National	NYS	19.88	0.63	-29.65	29.13	19.75	32	0.8	5.43	80	32.30	0.60
Fremont General Corp.	OTC	15.50	-4.62	-22.98	22.50	14.38	195	0.80	5.16	7	19.09	0.81	USLIC0 Corp.	NYS	21.63	-1.70	-8.95	25.38	21.30	38	0.0	4.62	6	27.73	0.78
Frontier Insurance Group	NYS	22.00	11.39	18.92	22.00	13.63	32	0.00	0.00	9	7.29	3.02	Zenith National Ins.	NYS	15.75	5.00	-16.00	21.50	13.50	112	0.84	5.33	0	13.31	1.14
General RE Corp.	NYS	84.75	2.73	-5.83	96.25	63.63	1384	1.52	1.79	13	29.04	2.92	INSURERS/REINSURERS AVERAGE			1.3	-7.8					3.6	10.6		
Hanover Insurance Co.	OTC	22.75	-1.09	-25.41	33.00	22.75	226	0.44	1.93	7	32.03	0.71	HEALTH MAINTENANCE ORGANIZATIONS												
Harleysville Group	OTC	23.00	2.22	-16.36	28.75	19.50	46	0.60	2.61	7	18.94	3.01	FHP International	OTC	16.25	3.17	-23.53	26.38	12.33	1627	0.00	0.00	4	3.34	4.59
Hartford Steam Boiler	OTC	57.00	0.00	-5.07	60.75	39.75	0	1.60	2.81	15	18.94	3.01	HMO America Inc.	OTC	5.00	-2.44	-35.48	10.63	4.38	221	0.00	0.00	24	1.12	4.46
Kansas City Life Ins.	OTC	35.75	0.00	-0.35	36.00	34.50	28	1.12	3.13	10	39.22	0.91	Pacificare Health Sys.	OTC	20.25	-4.71	-22.12	30.38	13.25	120	0.00	0.00	4	6.35	3.19
Kemper Corp.	NYS	38.13	2.35	-19.31	51.88	34.00	231	0.92	2.41	9	29.97	1.27	Safeguard Health Enter.	OTC	5.25	-8.70	-38.24	12.50	5.25	256	0.00	0.00	11	2.99	.76
													Sierra Health Services	ASE	6.88	3.77	-22.54	9.63	4.25	45	0.00	0.00	22	0.62	11.09
													United Healthcare Corp.	OTC	13.38	3.88	9.18	13.38	7.38	1299	0.00	0.00	11	0.34	39.34
													United Medical Corp.	ASE	8.75	2.94	45.83	9.13	5.38	14	0.20	2.29	28	5.70	1.54
													U.S. Healthcare	OTC	15.88	5.83	11.40	15.88	9.53	0	0.28	1.76	0	3.07	5.17
													HMOs	AVERAGE		0.5	-9.4					0.5	13		
													ALL COMPANIES	AVERAGE		0.9	-8.0					3.0	10		



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