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Update

Former Louisiana commissioner pleads guilty to insurer extortion

NEW ORLEANS—Former Louisiana Insurance Commissioner Sherman A. Bernard pleaded guilty last week to charges of extorting thousands of dollars in campaign contributions from insurers seeking licenses or other regulatory favors.

Mr. Bernard, commissioner from 1972 until his defeat by Douglas D. Green in 1988, was indicted last year on charges of shaking down officials of five insurers for a total of $80,000 in 1987 and 1988 (*BI*, Nov. 30, 1992).

Continued on next page

Lloyd's maps its future

Business plan includes radical reforms to reverse losses

By ALINE SULLIVAN

LONDON—Lloyd's of London is proposing radical reforms to strengthen the market as a river of red ink continues to flow through the 305-year-old institution.

Lloyd's unveiled its first-ever business plan Thursday, calling for dramatic restructuring to cap members' past liabilities, deep cost cuts and limited liability corporate membership starting in January 1994.

In releasing the plan, Lloyd's also forecast a record loss of 2.5 billion to 2.8 billion pounds ($3.79 billion to $4.24 billion at appropriate exchange rate) for the 1990 underwriting year, the results of which will not be officially announced until June. That will be followed by a loss of about 1 billion pounds ($1.57 billion at current exchange rate) for 1991 and a "small profit" for 1992, Lloyd's says.

Highlights of Lloyd's new business plan

- **Open years** Reinsure pre-1986 liabilities into a new company, 1986-1993 liabilities into 1994 account, and the remainder into CentreWrite.
- **Corporate capital** Limited liability companies would be allowed as members for the first time in 1994.
- **Cost cuts** Trim the payroll to 9,500 from 12,000. Lower operarting expenses by nearly $300 million.
- **Dispute resolution** Actively pursue negotiated settlements of outstanding legal disputes.

GRAPHIC BY CHRIS ROY

With this business plan, Lloyd's hopes to attract capacity of between 10 billion pounds and 12 billion pounds by 1997. Capacity dropped to 8.5 billion pounds this year from a high of 11.3 billion pounds in 1991.

Lloyd's lost a record 2.06 billion pounds in 1989 ($3.86 billion at appropriate exchange rate).

Underwriters and brokers at Lloyd's welcomed the 70-page business plan. Members' action groups also voiced support for the plan despite the absence of specific proposals to forestall litigation between Lloyd's, members agents, managing agents, and loss-saddled names.

"We shall continue to do our utmost to promote a negotiated settlement of names' disputes with agents," said Lloyd's Chairman David Rowland in the foreword to the plan. "However, it would be wrong to build expectations that substantial cen-

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Employer's direct pact cuts health costs 10%

By CHRISTINE WOOLSEY

PORTLAND, Ore.—Officials at Precision Castparts Corp. aren't holding their breath in anticipation that national health care reform will heal their ailing health care budget.

Instead, the aerospace component manufacturer is writing its own prescription for relief from the pains of rising health care costs.

Its formula: a heavy dose of health improvement among Precision's 10,000 employees and dependents; a 10% reduction in per employee health care costs through a contract with a local hospital system, coupled with a three-year price freeze; and access to patient outcome data.

If all goes well, the self-insured employer will save $10 million over the next three years —the equivalent of one year of free health care, says Roy Marvin, vp of administration for Precision Castparts.

Three health plans expired March 31 and were replaced with a direct contract deal with Legacy Health System, a Portland-based hospital chain. Precision Castparts employees are now restricted to Legacy providers; care from other doctors or hospitals won't be covered.

"We determined that we could not afford, based on competition in our industry worldwide, to continue to suffer increases in medical care costs for our employees and dependents," Mr. Marvin said. "So we developed

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Bomb claims may top $630 million

Losses may deplete terrorism pool

By ALINE SULLIVAN

LONDON—Insured losses from the April 24 terrorist bombing in London's financial district will be less than those from a 1992 blast.

Initial estimates of insured damage totaling 1 billion pounds ($1.57 billion) were revised downward shortly after the blast to between 300 million and 400 million pounds ($472.2 million and $629.6 million).

Insured losses from the recent bombing are expected to be lower due to a terrorism insurance pool backed by the U.K. government. The April 1992 bombing produced insured losses of approximately $700 million (*BI*, April 19; April 20, 1992).

However, the explosion has sparked concern about whether the pool, which was set up by the British insurance industry, will be able to absorb losses from this bombing and still meet future losses from terrorist attacks.

The bombing also prompted the Assn. of Insurance & Risk Managers in Industry & Commerce to renew its call for a compulsory terrorism levy on all property insurance policies.

Several buildings were destroyed, many others were damaged. One death and about 40 injuries were attributed to the bombing, for which the Irish Republican Army claimed responsibility.

Most of the businesses that had offices damaged by the blast were able to relocate staff and continue operations early last week. About 20,000 workers have been temporarily displaced from offices in the blast area.

Even at the lower insured damage estimates, claims from the blast are expected to exceed the funds held by Pool Re. Insurers and loss adjusters projected last week that claims from the blast will exceed Pool Re's reserves by more than about 200 million pounds ($314.8 million).



AP/Wide World Photo

The Hong Kong & Shanghai Bank building, at right, is among the most severely damaged by the bombing in London's financial district.

The pool was set up late last year to provide coverage after insurers introduced a terrorism

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NAIC chief blasts dual regulation

GOP members of House panel express doubts

By MARK A. HOFMANN

WASHINGTON—Dual federal and state insurance regulation would hurt rather than help consumers, the president of the National Assn. of Insurance Commissioners told a congressional panel last week.

Many of NAIC President Steven T. Foster's concerns were shared by Republican members of the House Commerce, Consumer Protection and Competitiveness Subcommittee.

Rep. Cliff Stearns, R-Fla.—the ranking minority member of the subcommittee—said H.R. 1290, the Federal Insurance Solvency Act of 1993, could stifle competition and innovation by giving an advantage to large established insurers at the expense of "smaller, entrepreneurial companies."

H.R. 1290, sponsored by House Energy and Commerce Committee Chairman John D. Dingell, D-Mich., would allow insurers to choose between state and federal solvency regulation (*BI*, March 15).

The bill calls for a new federal commission to set solvency standards that would have to be met by insurers engaged in interstate business.

The bill also contains a so-called "carve-out" provision under which federally certified commercial insurers with more than $50 million in capital and surplus would be allowed to sell coverage to "sophisticated" policyholders—those with more than $10 million in net worth—without state rate and form regulation.

Mr. Foster, who is Virginia's insurance commissioner, said H.R. 1290 would create a "confusing jumble of dual regulation." He said insurers would be able to choose whatever form of regulation served their self-interest, while creating a new federal insurance regulatory body

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RIMS coverage begins on Page 3

Update

Former regulator convicted

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The five insurers—Alliance Casualty & Reinsurance Co., American Surety & Fidelity Insurance Co., Anglo-American Insurance Co., Dixie Lloyd's and Sovereign Fire & Casualty Insurance Co.—later collapsed, leaving millions of dollars of unpaid claims.

Mr. Bernard could face 40 years in prison and $500,000 in fines. No sentencing date had been set last week.

Mr. Green was convicted of federal and state fraud charges in 1991 and is serving a 25-year prison term (*BI*, July 1, 1991).

Separately, three former officials of Carlos I. Miro's Anglo-American Insurance Group were indicted last month on fraud charges.

William Jackson, former managing vp of defunct Anglo-American Insurance Co., and Melvyn Stein, Mr. Miro's London-based lawyer, face 40 years in prison if convicted on mail fraud, conspiracy and money laundering charges.

The third defendant, former Anglo-American President David Vaughn, pleaded guilty last week to three mail fraud charges and faces 15 years in prison.

Task force malpractice plan

WASHINGTON—In the latest trial balloon floated by the Clinton administration's health care task force, physicians and hospitals could not be sued for medical malpractice.

Instead, liability would be limited to insurers, health maintenance organizations and other providers of health care plans. It isn't clear, benefit lobbyists say, if suits also could be filed against individual employers that self-fund their medical plans.

Backers of the proposal say it would cut down litigation expenses by reducing the number of parties that could be sued. It would also encourage insurers to scrutinize doctors more closely.

Meanwhile, benefit lobbyists who have recently met with members of the Task Force on National Health Care Reform say the group has yet to make many key decisions, including how universal coverage will be financed.

Executive Life annuity fight

LOS ANGELES—Battle lines are being drawn over policyholder status for some $500 million in annuities written by Executive Life Insurance Co. after a 1989 change in the California Insurance Code that made such funding arrangements "non-insurance."

COCARE, a group of companies that bought Executive Life annuities to fund pension benefits, last week announced its support for a revised rehabilitation plan for the failed insurer.

On the other side are holders of guaranteed investment contracts used to back municipal bond issues. They are asking a Los Angeles Superior Court judge to stay the rehabilitation plan while the court considers whether it complies with a 1992 state appeals court ruling that denied policyholder status to the muni-GICs issued after the 1989 change in the state law.

The court granted policyholder status to the pre-1989 muni-GICs, but said that more recent contracts "with the characteristics of muni-GICs are non-insurance funding agreements rather than insurance annuities." The court also found that GICs used to fund pensions were "substantially identical" to muni-GICs.

In an April 13 motion, the holders of the muni-GICs argue that under the 1989 decision—*Texas Commerce Bank vs. Garamendi*—all pension-GICs, muni-GICs and other similar annuity contracts issued after Jan. 1, 1989, should be denied policyholder status.

Ex-agents suing Nationwide

SAN FRANCISCO—Nationwide Mutual Insurance Co. wants to move to federal court a breach-of-contract lawsuit filed by former exclusive agents who charge they were effectively forced to quit under a revamped distribution system.

The suit, which seeks class-action status for about 2,000 former exclusive agents, was filed March 29 in California Superior Court in San Francisco. Nationwide filed its request last week.

If approved as a class action, the suit will seek tens of millions of dollars in compensation for the agents, said plaintiffs' attorney Edward P. Heartney, a partner with Lieff, Cabraser & Heimann in San Francisco. The plaintiffs are reviewing Nationwide's motion.

The suit charges the insurer breached its contract with all exclusive Nationwide agents west of the Mississippi River by requiring them to submit their largest new and renewal commercial business to Nationwide affiliate Employers Insurance of Wausau for pricing and first right of refusal. The change, which became effective this year, applies to business generating $250,000 or more in annual premiums.

As a result, exclusive agents are effectively blocked from competing for accounts that have obtained quotes from Wausau account representatives or appointed independent agents, the lawsuit says. The exclusive agents also say they lost their right to use the much lower pricing system they had used while producing business for Nationwide. That system was their main tool to attract new accounts and retain business, the suit says.

These changes effectively forced the plaintiffs to leave Nationwide, says the suit, which also seeks unspecified punitive damages.

Updates continued on page 46

Errors & omissions

• The Cedar Trust, owner of Financial Services Insurance Ltd., a Bermuda insurer allegedly capitalized with phony assets (*BI*, April 19), is unrelated to Cedar Trust Co. Ltd., a company controlled by partners and senior staff of Richards, Francis & Francis, a Bermuda law firm.

Court issues split decision in appeal of asbestos claims

By DOUGLAS McLEOD

TRENTON, N.J.—A split decision by a New Jersey appeals court has created new hurdles for Owens-Illinois Inc. in its effort to tap $960 million in insurance coverage for asbestos claims.

The Appellate Division of the New Jersey Superior Court last week affirmed a lower court ruling in Owens-Illinois' favor on several coverage issues.

Among other things, the three-judge appeals panel affirmed a continuous trigger of coverage, making the company's insurers from 1977 to 1985 jointly and severally liable for asbestos claims.

However, the court also ordered a trial of the insurers' claims that Owens-Illinois fraudulently concealed its asbestos exposures and that coverage is barred because the losses were expected and intended.

This part of the ruling reversed the lower court, which had rejected the insurers' claims.

Lawyers for both Owens-Illinois and the insurers expressed satisfaction with the parts of the ruling that went their clients' way and disappointment with those that didn't.

Both sides are considering whether to ask the New Jersey Supreme Court to review the ruling or wait until after trial of the fraud and "expected or intended loss" claims before appealing all issues together.

Toledo, Ohio-based Owens-Illinois, which produced asbestos insulation products from 1948 to 1958, faced roughly 54,000 asbestos bodily injury claims as of March 31, according to the company's 10-Q report filed with the Securities and Exchange Commission.

The manufacturer was also named in 18 pending asbestos property damage claims and lawsuits.

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IRS stance may let high-paid workers contribute more

New 401(k) testing option

By JERRY GEISEL

WASHINGTON—The Internal Revenue Service is giving employers that extend their 401(k) plans to young or new employees not normally allowed to participate another way of running the basic 401(k) non-discrimination test.

The new testing procedure, which involves splitting a 401(k) plan—for non-discrimination testing purposes only—into two plans, could enable high-paid employees to increase their contributions to 401(k) plans.

The new testing procedure also could encourage more employers to reduce 401(k) eligibility requirements.

However, some believe the new testing procedure will enable high-paid employees to contribute only slightly more money to their 401(k) plans, while a handful of high-paid employees could face drastic cutbacks in the amount they could contribute.

"I don't know if you do any big favors if some highly compensated employees are helped by an infinitesimal amount, while a few employees are noticeably hurt," commented Rhonda Davis, a consultant with Hewitt Associates in Boston.

Proponents of the new testing procedure acknowledge that it is not a big breakthrough, but, they add, it still is an option that can be considered.

"This may only be a small bone, but it still is a bone," said

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Riding out a stormy '92

Berkshire Hathaway unhurt by catastrophes, chairman says

By DEBORAH SHALOWITZ

OMAHA, Neb.—The more things change, the more things stay the same, the old saying goes.

It seems Warren E. Buffett, chairman and chief executive officer of Berkshire Hathaway Inc., follows this maxim.

Despite Hurricane Andrew, which generated the largest insured loss ever, "there's really been no significant change in the overall insurance business," Mr. Buffett told about 2,200 people last week at the annual shareholders meeting.

Aside from some insurers pulling out of the Florida property market, any market changes have been "unnoticeable," he said. "Everyone feels they still have lots of capital," Mr. Buffett told the crowd, which packed the main floor, the gilt-covered box seats and even the balcony of ornate Orpheum Theater.

With $10.43 billion in surplus supporting $740 million in net written premiums last year, Berkshire falls solidly into that category.

Shareholders from all over the United States and several Euro-

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Deadline near for directory of agents, brokers

Business Insurance will publish its 22nd annual directory of agents and brokers in the July 5 issue.

That issue will also contain a Spotlight Report on the commercial retail insurance brokerage business and profiles of the 20 largest brokerages worldwide.

The directory is published as an editorial service; there is no charge to be listed.

However, brokers must complete and return a *BI* questionnaire by the May 10 deadline.

If your company generated at least $500,000 of its 1992 gross revenues from commercial retail brokerage and you have not yet received a questionnaire, please request one.

To obtain a questionnaire or for more information, call Assistant Directory Editor Cindy Bloom at 312-280-3195.

Inside

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- Both chambers of California's Legislature have separately passed workers comp reform bills. **PAGE 41**
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Identifying goals is the first step to analyzing health claims

Collecting health plan data can lead to slower cost hikes and more focused benefits

By CHRISTINE WOOLSEY

ORLANDO—Analyzing health claims data can help control costs, as long as employers know what data to collect and examine, a benefit manager and consultant agree.

"The message is simple: By looking at your health care plan data, you can identify targets and opportunities for improvement that will substantially impact costs," said James A. Daddona, manager of benefit plans and programs for Mobil Chemical Co. in Pittsford, N.Y.

Claims analysis helped Mobil slow the rate of cost increase in its self-insured health plans, including employer and employee contributions, to an estimated 3.1% for 1993, Mr. Daddona said during a session on health care data at the 31st annual Risk & Insurance Management Society conference, held Aug. 25-30 in Orlando. Nationwide, group health costs rose an estimated 10.1% in 1992.

Employers need to use data "in a business context," Mr. Daddona said. "As we get into manipulating data it's very basic—but very important—to explain to management what is happening in our health plans based on our own plan data, not just national trends."

He advised companies to ask two questions: Why are they spending the money? What did they buy?

Overall company strategies should be kept in mind when collecting and analyzing health data. Those strategies might influence benefit plan design and human resources staffing.

Compensation and benefit goals should also be kept in mind. For example, a company that wants to hire only the best people may want to offer a richer benefit plan to entice recruits. A company that wants to produce a product for the lowest possible cost may want to keep internal costs to a minimum by offering scaled-down benefits.

Medical program goals also must be kept in mind, added Mr. Daddona. Employers must decide whether their aim is to control utilization by cutting benefits or assure the highest quality outcomes for high-tech medical procedures by establishing a centers of excellence program. Both strategies can determine what type of health plan data is collected and studied.

When determining what data to look at, "the emphasis is to look for value, not just lower costs," Mr. Daddona stressed. "If you simply want to cut expenses you can, but you really should try to optimize quality."

Rand Corp. studies, he pointed out, conclude that 20% to 30% of medical care is unnecessary or unproductive. "That is the first target. Look at specifics, understand who is using your plan and what percentage of health care dollars are spent by actives, dependents and retirees. Then look at what the money is being spent on."

Mobil currently is assessing whether to increase employee deductibles in some of its health plans, Mr. Daddona said. "If you have evidence of overutilization of certain benefits, that is an argument for increasing employee or dependent deductibles. Data gives you a way to make less subjective decisions."

Once data is collected, employers can compare it to other sources, including other health plans within the corporation, health plans in other locations and health plans of similar companies in the same industry.

"You must compare the data to meaningful benchmarks, though. None of us know intuitively whether 6.8 days in the hospital (for a certain diagnosis) is good news, bad news or indifferent," Mr. Daddona pointed out.

Comparative data allows employers not only to judge how their claims experience stacks up against

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Michelle Patton, Gregory K. Meyers and Hugh M. Cone say the pick of the managed care crop can be used on workers comp medical costs.

Managed care techniques also work on comp costs

Bill audits yield savings, experts say

By JOANNE WOJCIK

ORLANDO—Many of the managed care techniques designed to curb employee health benefit costs can transfer easily into the workers compensation arena, cost control experts say.

Medical bill audits can also be used to root out overcharges, fraud and duplication that further inflate employers' tabs for occupational illness and injury, the experts agree.

RIMS REPORT

While state workers comp fee schedules—similar to negotiated provider discounts in preferred provider arrangements—can reduce the unit cost of medical treatment, it does little to control utilization, the experts agree.

"If you control price, but you don't control volume, you can quickly lose what you're saving on price," observed Hugh M. Cone, principal at Corporate Health Concepts in Whittier, Calif., during a seminar at the 31st annual Risk & Insurance Management Society Inc. conference, held April 25-30 in Orlando.

Risk managers involved in administering workers compensation benefits should look into such cost controls as utilization management, preferred provider networks, direct contracting, even health maintenance organizations, suggested Gregory K. Myers, senior vp at Woodland Hills, Calif.-based Becher & Carlson.

And requiring employees to contribute to the cost of their workers comp medical treatment, as is currently permitted in Florida, can help reduce costs since studies have shown that employees are more likely to seek repeated treatment if its cost is negligible, he added.

Florida's experimental 24-hour program permits employers to charge employees a $100 deductible and 10% copayment for medical services rendered under the workers comp system.

But managed care techniques that limit provider choice are only feasible in those states where an employer can dictate which doctor an injured worker should see, Mr. Myers pointed out.

Currently, about 40% of states allow some employer choice in selecting providers that employees see for work-related illness and injuries, he estimated.

For example, in Alabama, the employer makes the initial physician choice, while the employee can select a second physician from a panel selected by the employer.

However, even in states where employers cannot select providers, they can offer employees non-financial incentives to use certain providers, such as information showing that the PPO network they have contracted with for treatment of occupational illness and injury offers high-quality care and is easily accessible, Mr. Myers suggested.

Provider bill review is one tool employed extensively in group health that can transfer easily into workers compensation since it does not limit provider choice or access to care, according to Mr. Cone of Corporate Health Concepts.

Employers should look at workers comp medical bills "not only as a source of saving money but also as a way to begin to develop information to build networks and to bridge into 24-hour care," he suggested.

Medical bill reviews, which make sure a bill is consistent with the injury sustained and that doctors' fees are consistent with what the state allows, helped Hilton Hotel Corp. reduce its workers compensation medical payments in Nevada by more than 30%, according to Mr. Cone.

The hotelier shaved $1.8 million off its $5.9 million in workers comp medical payments between April 1, 1990, and April 1, 1993, he said.

While that may seem high, "these savings are very realistic in states like California, Nevada, perhaps even Florida," Mr. Cone said.

But, adjusting the medical bill to conform to the medical fee schedule is not enough.

"If you do that. . .you can expect savings of 10% to 15% to maybe 20% from a fee checking system," he said.

Going a step further and also comparing the amount charged with the particular service provided can yield even more savings, according to Mr. Cone.

For example, if a provider submits a bill coded for an extended office visit but only saw the injured worker for a few minutes, "you can increase the savings to as much as 30%," or the difference in the reimbursement level between the two types of office visits, he estimated.

To further ensure savings, employers should make sure their claims administrator is making these reductions when paying workers comp medical bills, Mr. Cone added.

"If you're dealing with a third-party administrator, set up an audit mechanism where you can periodically on a random basis review medical payments and make certain if you're using bill review that in fact the claims department is paying the reduced amount."

"You might be surprised. Oftentimes a knowledgeable physician with a quick phone call can convince a clerk that his bills aren't reviewed" because he has a special relationship with the employer, Mr. Cone said.

Auditing TPAs also can help an

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Encouraging workers to care for themselves

Health promotion programs curb costs

By CHRISTINE WOOLSEY

RIMS REPORT

ORLANDO—Employers that have not designed some sort of health promotion program for employees, families and retirees better do so before it's too late, a benefit manager warns.

Encouraging employees to take more responsibility for their health can help companies curb the rising health plan costs that now jeopardize their profits, he said.

Businesses should form a partnership with employees, said Larry Muzzy, benefits manager of Dow-Corning Corp. in Midland, Mich. "At Dow we feel strongly about partnering with our employees—in the programs we design, in the responsibility for good health and in controlling health care costs."

He spoke last week at a session at the 1993 Risk & Insurance Management Society Inc. conference in Orlando.

Employers need to get their workforces to lead healthier lifestyles, said Edna Nelson, product director for Intracorp in Berwyn, Pa. Employer health education and promotions offer one of the most effective and least costly ways to do that, she said.

To demonstrate the need for health promotion, Intracorp appraised the health risks of 35 people at the session and found that, based on their modifiable health risks, the 35 generate an estimated $67,500 annually in avoidable costs.

The five most prevalent health risks among the 35 people were stress, bad eating habits, lack of exercise, the potential for mental health problems and the lack of self-care, Ms. Nelson said.

Americans generally are at risk for many preventable health problems, she noted. For example, 26% are overweight, only 22% of adults say they engage in moderate physical activity and less than 10% exercise more vigorously. In addition, 40% to 50% of people who have had medical exams recently still do not know their blood pressure or cholesterol.

Unhealthy habits can mean high health costs for employers. Ms. Nelson advised, "Make a healthy workforce a priority."

Dow-Corning has done just that, Mr. Muzzy said.

Over the last decade, health costs for the self-insured manufacturer have risen 12.8% annually, he noted. "That's not bad when you hear the rest of the country is seeing even higher increases, but our trend continued to go up. We recognized we had to do something and do it quickly."

The company created a health care task force "to provide management with a short-term and long-term approach to get our health care cost trends down to single digits." Employee wellness is something the task force has focused in on to manage costs.

"Our primary responsibility is to develop and direct a wellness effort that can enable Dow-Corning employees, families and retirees to move from a reactive/problem mode of health care to a more proactive/preventive mode," Mr. Muzzy said. The company, which has 8,600 active employees and about 15,000 retirees, hopes to reduce health care costs, injuries, turnover and absenteeism, and to improve job performance and morale.

One approach Dow-Corning uses is employee-driven personal health management activities. Health and safety magazines are sent to retirees each quarter and to employees bi-monthly. Other periodicals are sent as well and Dow-Corning has set up display cases, bulletin boards and posters detailing health promotion and illness prevention.

Dow-Corning also offers smoking cessation classes, women's issues programs, nutrition and stress management programs, fitness and recreation programs.

High blood pressure screening and coronary risk screening are provided on site. And the company also encourages women to have mammograms and regular pelvic exams. Dietary counseling also is available.

In the self-help category, Dow-Corning provides employees with interactive computers that contain health information and also has a library where employees and retirees can check out books on health care.

One of Dow-Corning's most successful programs has been its prenatal care program, Mr. Muzzy said.

Expectant mothers are encouraged to have regular medical exams. For example, Dow-Corning will give a free infant car seat to all mothers who visit their physician within the first trimester. "We pay only $45 to $50 for a high quality car seat, but we can save $200,000 to $400,000 by preventing a premature birth," Mr. Muzzy said.

Another successful program Dow-Corning has implemented, through a recently introduced flexible benefits plan, is Personal Health Care Management Accounts for employees. Employees are offered a choice of three different levels of benefits, and contributions to the health care management account are based on which level the employee selects.

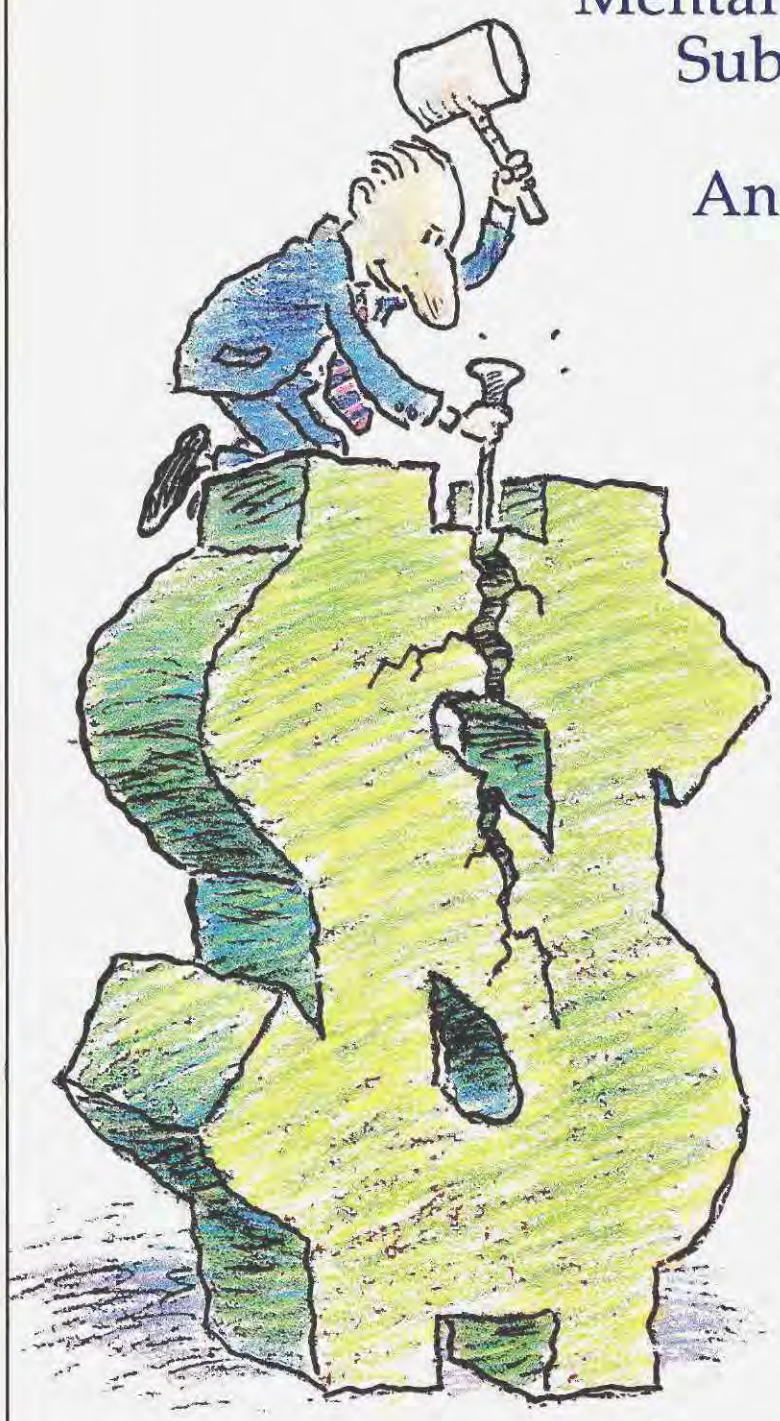
For example, an employee covered under the 90/10 plan receives $100; employees with 80/20 coverage get $200 and employees with 70/30 coverage will get $300. The employees can use the money to pay for certain health care-related expenses not covered under the health plans.

Dow-Corning is using its precertification program, which requires employees to get prior approval for medical services like surgery, to provide employees with information related to their specific health problem, Mr. Muzzy added.

The company, with the help of Intracorp, identified five diagnostic categories where Dow-Corning employees were above national norms. When employees call in for precertification and one of the targeted diagnoses shows up, they are asked additional questions and provided more information about their illness, he explained.

Martin Brown, corporate manager of employee benefits for The Clorox Co. in Oakland, Calif., moderated the session. Susan Fazo, director of corporate communications for Intracorp in Berwyn, Pa., was the coordinator. BI

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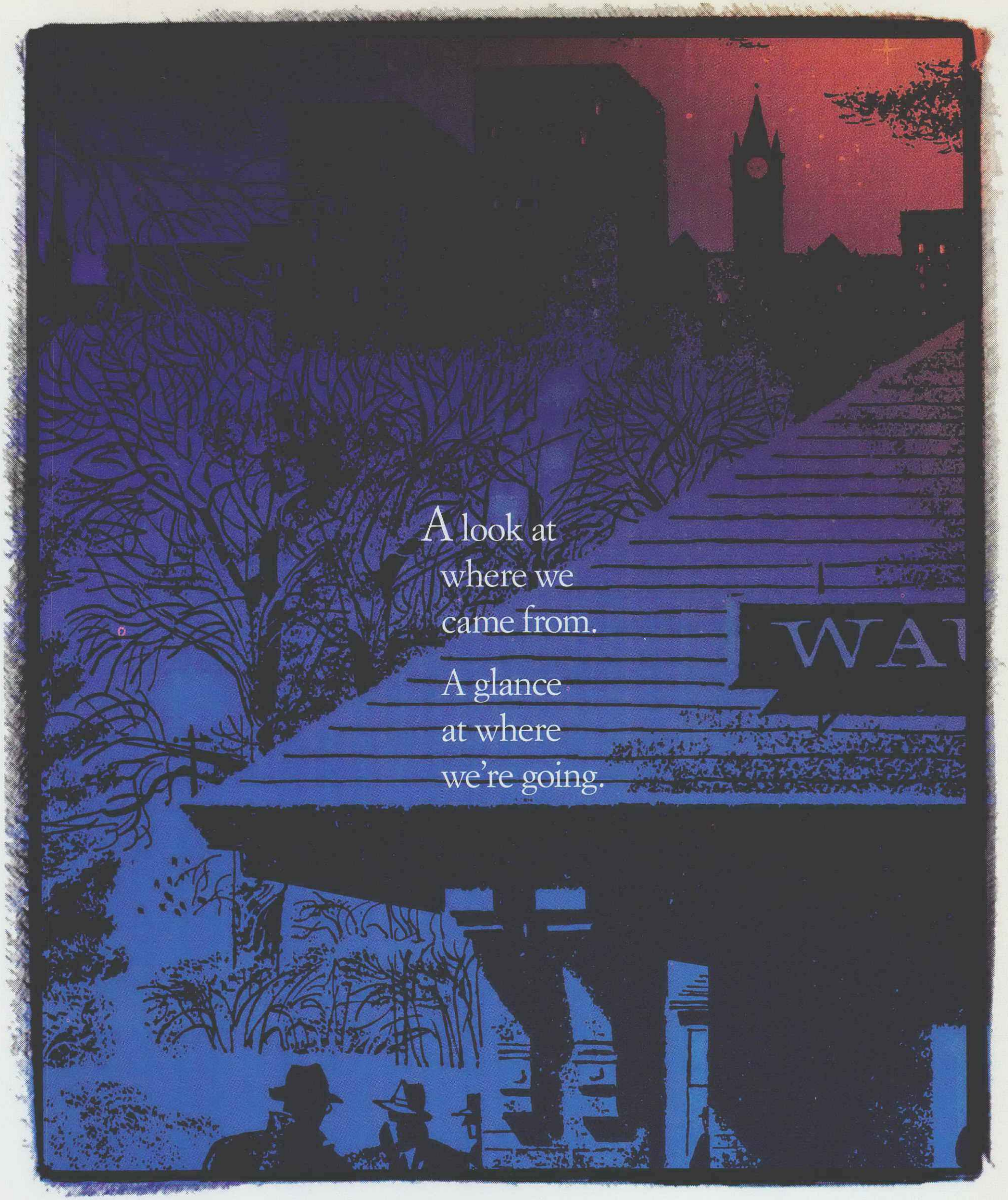
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Self-insurance still evolving

Multinational benefit pools save by reinsuring with captives

By JOANNE WOJCIK

ORLANDO—Multinational employers that insure their non-U.S. employee benefits through pooling arrangements can save money and improve their cash flow by using their captive as a reinsurer.

RIMS REPORT

While such arrangements work best when they are limited to "insured" benefit coverages, such as group life, they eventually may be the answer for U.S.-based multinationals that must prefund their retiree health care liabilities.

Using a captive to reinsure multinational pools is simply the next step in the evolution of self-insurance, explained F. Michael Ponicall, vp and principal of Towers, Perrin in Saddle Brook, N.J.

Although multinational pooling provided significant savings to employers when the technique was introduced in the late 1960s, negotiated arrangements in the early 1980s created additional cost control, he said during a session at the 1993 Risk & Insurance Management Society Inc. conference last week in Orlando.

But the self-insurance movement that began in the mid-1980s in the United States has not yet taken hold throughout the world, he said. And even in countries where self-insurance was permitted, "there were fiscal problems. If I tried to do self-insurance in Switzerland, for example, I couldn't get a tax deduction on the premium I paid," he noted.

"So people began looking at the fourth alternative, which is direct reinsurance. In other words, find a fronting company and directly reinsure it to a captive," Mr. Ponicall said.

"Now as long as you believe you can earn more money than an insurance company will credit you" through year-end dividends, "that's a good deal," Mr. Ponicall observed. "You've got local laws all satisfied, you've got local insurers."

The problem is, such arrangements are only feasible if an employer has a substantial workforce in one country.

So using a captive to reinsure a multinational pool—which gives employers the advantages of buying benefits locally while the coverage is experience-rated across their entire non-U.S. workforce—was the next logical step for employers whose workforces are spread throughout the world, Mr. Ponicall said.

"Why not negotiate a reinsurance agreement between the multinational pooler and the captive?" he suggested.

"This is the simplest way to do it, and it's a way to get basically to self-insurance, using their captive as a vehicle to do it," Mr. Ponicall said.

Such arrangements also provide additional cash flow for multinational employers because they keep most of the premium they pay for pool coverage in their captive, observed Donald J. Kinloch, director of marketing-international pensions for American International Group Inc.'s group management division in New York, who also spoke at the session.

Reserves established for non-U.S. benefit exposures, such as life, can be substantial, Mr. Kinloch observed.

For example, while "the average employee benefit for death in the United States is two times salary, the average in Australia is somewhere between six and eight times salary. Now if you've got 500 people in Australia and the average salary is $50,000 Australian ($35,725), the volumes you're talking about are very, very high," Mr. Kinloch explained.

Other types of coverage that are best for these arrangements are spouse and orphans' pensions and disability pensions, according to Mr. Ponicall.

For example, insurers establish substantial reserves for claims filed for spouse and orphans' pensions, he said.

"If I die at 35 years old, my spouse will get 50% of what I would have gotten had I made it to 65 and she gets that for the rest of her life even if she remarries," he explained.

But, using captives to reinsure multinational benefit networks "is not for everybody," asserts Mr. Ponicall, whose company has conducted 80 feasibility studies for multinational companies considering such arrangements.

He recommends that only companies with more than $3 million in annual benefit premiums and a paid-loss ratio of less than 50% over the past three to five years consider such a self-insurance arrangement.

Employers also should not use captives this way if they have many employees in countries where the benefit market is very competitive, such as the United Kingdom and Australia.

"Why would you want (these employees) in the pool, let alone the captive?" Mr. Ponicall queried.

Furthermore, not all coverages should be handled this way.

"Reinsuring an insured pension into a captive can cause some difficulties" depending on how the pension is being financed.

Today, most employers have flexible financing vehicles with banks and insurers for their retirement benefits "that really don't involve insurance guarantees," Mr. Ponicall said.

"And, second, it's really an employee relations problem. Do you want your pension fund in Switzerland funded in a Bermuda captive?"

Eventually, captive reinsurance may be the answer for U.S. companies struggling with ways to fund their retiree health care liabilities, according to Mr. Kinloch.

In addition, such arrangements may make it easier for companies to meet the requirements of the Internal Revenue Service, which permits companies to deduct premiums paid to wholly owned captives if the insurers write "a substantial amount" of unrelated business, Mr. Ponicall noted.

Unfortunately, few multinational networks are currently offering employers the option to use their captives as reinsurers, according to Mr. Kinloch.

"Other networks are willing to discuss it," but they usually will only permit captive reinsurance of the dividend, not the actual premium, he explained.

The session was moderated by Jerry Heinz, manager of the risk management department at Dow Chemical Co. in Midland, Mich. Mr. Kinloch coordinated the session. BI



Group benefits services
can't always be programmed.

Small firms can learn lessons from others' FAS 106 encounters

By MICHAEL SCHACHNER

ORLANDO—Smaller companies do have certain advantages over their larger counterparts.

RIMS REPORT

Take accounting for retiree medical benefits, for instance. Not only do small companies have longer to comply with Financial Accounting Standard 106—which is already in effect for bigger companies—but they also have been able to observe the pitfalls that large companies have encountered.

Smaller companies that have not yet decided how to comply with the rule must decide whether to make plan design changes that reduce the liabilities or to comply with the rule by taking a one-time hit or amortizing the accumulated liabilities over a period of time, suggested Christopher Hulla, actuarial manager in the Denver office of Buck Consultants Inc.

FAS 106 requires companies to account for retiree medical benefit liabilities on an accrual, rather than a pay-as-you-go basis. Big companies must comply by fiscal 1993.

For large companies, the impact of the rule can be enormous. Some have chosen to take one-time hits of more than $1 billion rather than spread their accumulated liabilities over as many as 20 years.

Privately held companies with 500 or fewer participants have until fiscal year 1995 to comply.

FAS 106 is causing reported post-retirement health care liabilities to grow astronomically, explained Mr. Hulla and Stephen Metz, a senior consultant with Coopers & Lybrand in Tampa, Fla. They spoke at a session during the 1993 Risk & Insurance Management Society Inc. conference last week in Orlando.

Plan expenses have increased many times over in the first year of FAS 106, depending on how many retirees a company has and how long its medical plans have been in effect.

What this underscores is that without creative accounting or serious benefit cuts, first-year FAS 106 liabilities will sharply reduce the net worth of many companies, said Mr. Metz.

"There's between $400 billion and $2 trillion in current national liabilities for retiree medical benefits, but there are things employers can do to reduce their future liabilities," said Mr. Metz.

Restrictions on eligibility are one option. "Now many companies provide the benefit if the retiree is age 55 and posted 10 years of service. That's a lot of company-paid benefits considering Medicare doesn't come in to help until age 65. Companies may want to restrict eligibility," Mr. Metz said.

Some companies are also cutting spousal coverages. "Some companies may find it better to eliminate spousal coverage," he said. "Let the company that the spouse worked for pay that bill."

Other ways to cut liabilities include requiring retirees to pay deductibles and coinsurance and capping lifetime or annual benefits. For companies without cost-shifting features, Mr. Metz suggested implementing a $200 individual deductible and 20% coinsurance for medical care as well as a $50 annual deductible for dental care.

Contributing only a fixed amount to retiree health care can also save money, but a company considering such a capped plan must be aware that once it's in place, it may force seriously ill retirees to pay a very large portion of costs.

"Cost-sharing through deductibles, coinsurance and reduced-cost medical networks is your best chance to lower this growing liability," said Mr. Metz.

Cost-shifting, however, is not the only option.

Mr. Hulla said offering retirees a set amount of cash in exchange for unlimited health care benefits is another way of controlling costs. "If you give retirees a set amount of money in exchange for (giving up) benefits, your liability is just that amount and no more," Mr. Hulla said.

Another option is creating a retiree flexible benefit plan that offers high-end options along with cheaper alternatives.

"Theoretically, under this type of program you can direct retirees to the plans based on what they can afford," Mr. Hulla said.

Companies that offer rich pension plans might consider dropping retiree medical benefits entirely, suggested Mr. Hulla.

"If you're providing retirees with a great pension, they can probably afford medical services themselves. This is a bold move that would have to be based on corporate philosophy," he said.

Pre-funding retiree health care expenses is another option that some companies have explored, but funding in advance has its own drawbacks, Mr. Hulla said.

"The tax advantages are limited and may be gone if Congress has its way. Pre-funding also strengthens the implied promise that current employees are vested in a retiree medical plan even though they're not," he said.

Mr. Metz said the final option is simply spreading the accumulated retiree health liability over the standard time allowed by FAS 106—20 years.

"Analysts and the financial markets prefer a one-time hit, but companies must consider the magnitude of the hit and what effect it will have on stockholder equity. Most companies are taking the hit now because future years' earnings will be better and five to 10 years from now, nobody will remember the hit you took. But, amortization may be preferable to negative plan amendments," he explained.

If a company does decide to amortize over time, it must make a projection of future liabilities and then adjust upward or downward depending on actual costs, he said.

"There is still some room for maneuvering within the rules. You can set your projection high and come down or set it low and account upward in future years. There is flexibility under 106. You can manage the monster," Mr. Metz said.

The session was moderated by David Beacom, risk manager for the Regional Transportation District in Denver. James Crockett, manager of risk and benefits for the Denver Water Authority, coordinated the session. BI



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Opinions

PBGC woes unlike S&L mess

EXAGGERATING A PROBLEM may capture attention in the short run, but it can destroy the chance of building the consensus needed to fix the problem.

The shortcomings of this strategy were demonstrated by the Bush administration's repeated efforts to compare the financial problems of the Pension Benefit Guaranty Corp.'s insurance program with the nation's savings and loan debacle.

Former Secretary of Labor Lynn Martin, for example, said, "One would have to be an ostrich with its head in the sand to ignore the S&L analogy." Some members of Congress also said the PBGC could face S&L-type problems.

Looking back, it was absurd to suggest that the problems of the PBGC and the S&Ls had something in common.

The S&L industry was racked by massive fraud and corruption, which brought on the collapse of many of those institutions. There is no evidence that fraud was a factor in the failure of pension plans taken over by the PBGC.

In sheer magnitude, the S&L fiasco fortunately has no equal. The cost to taxpayers of bailing out depositors who held accounts at federally insured S&Ls could be in the $300 billion to $500 billion range.

By contrast, the PBGC has a $2.4 billion deficit. Even under the PBGC's most pessimistic scenario—annual losses over the next decade that are about four times higher than the agency's historical average—the PBGC's deficit 10 years from now would range from $15.7 billion to $27.8 billion.

That deficit projection is disturbingly high, but it's not in the S&L league.

For all these reasons, comparing PBGC problems with those of the S&L industry was sheer hyperbole. It's no surprise that legislators, after concluding that the agency's problems were exaggerated, have been inclined to do nothing.

And that is why we welcome the more honest assessment by the agency's new executive director. Make no mistake, says Martin Slate, the PBGC has serious problems. Its deficit is rising and must be addressed.



But don't compare the PBGC's problems to the S&L situation, he says. The agency has billions of dollars of assets and annual premium income of hundreds of millions of dollars, he says. That means the agency can pay benefits it has guaranteed to participants for—as Mr. Slate puts it—"as far as the eye can see."

Certainly, the agency and its insurance program that protects benefits of 32 million participants in employer plans need attention.

Rules must be stiffened so employers with underfunded plans will have to speed up contributions to those plans.

And the agency's standing as a creditor in bankruptcy proceedings must be improved. If prospective lenders know that payment of pension claims has a high priority in bankruptcy, they will put pressure on employers to better fund their pension plans.

One comparison to the S&L situation is apt. The sooner the PBGC's problems are addressed, the smaller and less painful the cost will be.

Letters

Actuary not responsible for incorrect information

To the editor: In "A-rated Insurer Fails" (*BI*, April 12), remarks attributed to John H. Snyder of A.M. Best Co. about Demotech Inc. were incorrect.

Schedule P of Casualty Indemnity Exchange's 1992 annual statement stated data for years prior to 1992 that included numerous errors and erroneous information. Demotech was the consulting actuary to CIE for 1990 and 1991. During our tenure, Demotech received Schedule P data that CIE did not admit until Dec. 31, 1992, contained numerous errors.

Mr. Snyder's remarks would lead your readers to believe that Demotech should have discovered the erroneous information presented by CIE. His improper use of the words "review" and "certification" imply that actuaries are supposed to function as accountants and auditors. Please permit me to present the correct information.

Actuarial Standard of Practice No. 9 provides for "reliance on another," which means using that person's work without assuming responsibility therefore so long as the actuary's opinion defines the extent of any such reliance. Demotech's 1990 and 1991 actuarial opinions fully and accurately disclosed my reliance upon data underlying loss and loss adjustment expense reserves prepared by the responsible officers of CIE, including Schedule P.

The recommended actuarial standard of practice did not require the examination of records underlying the data supplied by company management. In 1990 and 1991 it was not the actuary's responsibility to discover erroneous information in data underlying loss and loss adjustment expense reserves. The recommended standard was to disclose reliance, and Demotech did so, fully and clearly.

Joseph L. Petrelli
President
Demotech Inc.
Columbus, Ohio

■ *Mr. Snyder replies:*

I would like to clarify several statements attributed to me in the article.

Casualty Indemnity Exchange had dramatically understated its loss reserves, particularly in regard to incurred-but-not-reported losses for several recent accident years.

It would appear that Demotech, the consulting actuary, was as much a victim of this erroneous information as A.M. Best Co.

The article quotes me as saying, "We will scrutinize, to a greater degree, smaller companies' reserves certified by Demotech."

A more complete statement of our position would be:

"We will continue to recognize and accept Demotech's loss reserve certifications. However, we reserve the right to scrutinize any company's loss reserves, regardless of the independent actuary involved."

Business Insurance welcomes letters from its readers. Please keep your comments as brief as possible. We reserve the right to edit letters for clarity or space. We will not publish unsigned letters. Send your comments to Letters to the Editor, Business Insurance, 740 N. Rush St., Chicago, Ill., 60611-2590.

Open market can solve health care crisis

To the editor: The experts quoted in your special issue on "Solving the Health Care Crisis" (*BI*, March 26) have overlooked a simple solution.

This is America, which has a free enterprise system.

Thus eliminate all health insurance, HMOs, PPOs, etc., and put doctors and the medical industry on the same footing as all other businesses—the open market.

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George A. Hatzes Jr.
President
The Alexandria Corp.
Alexandria, Va.

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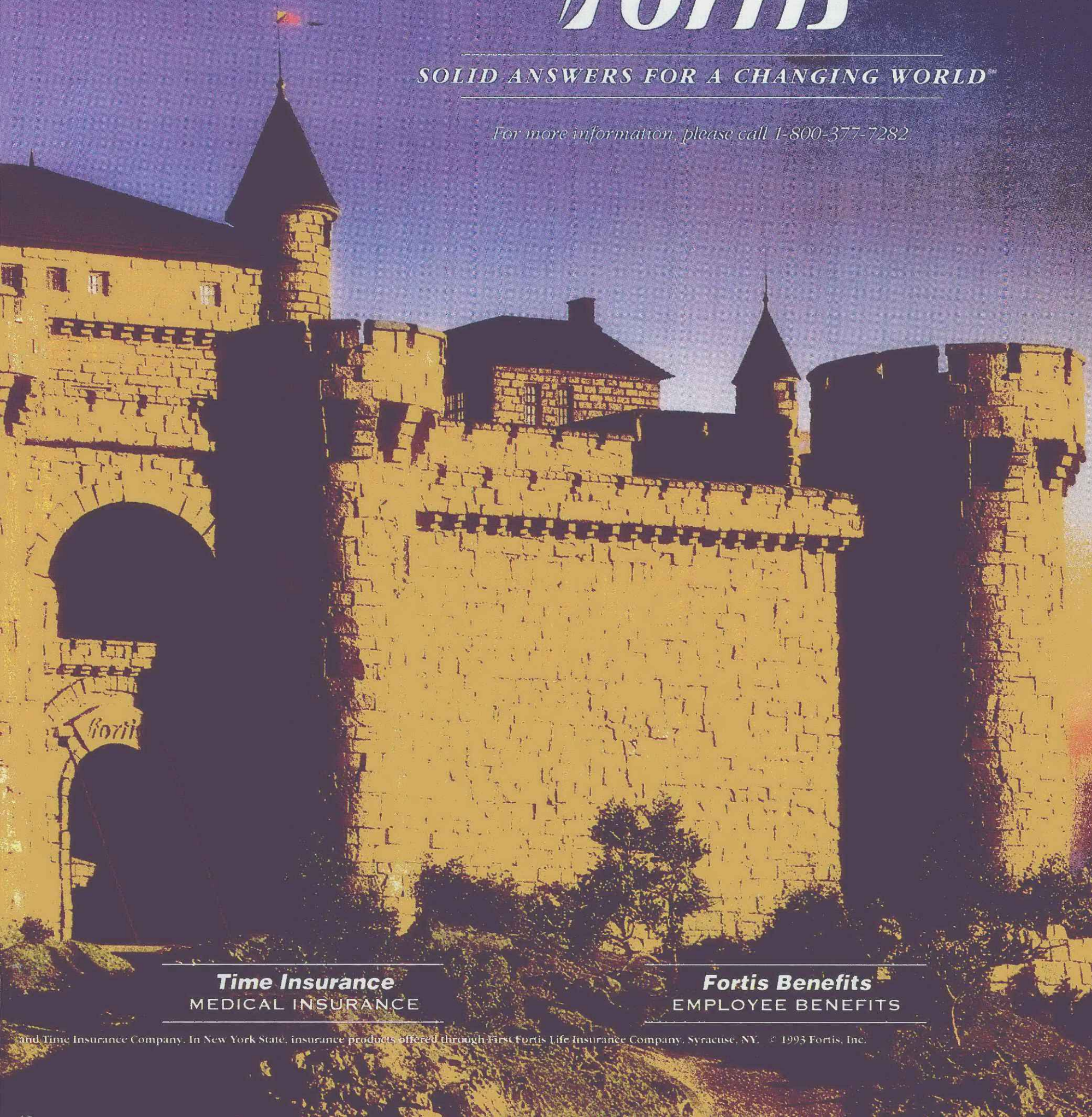
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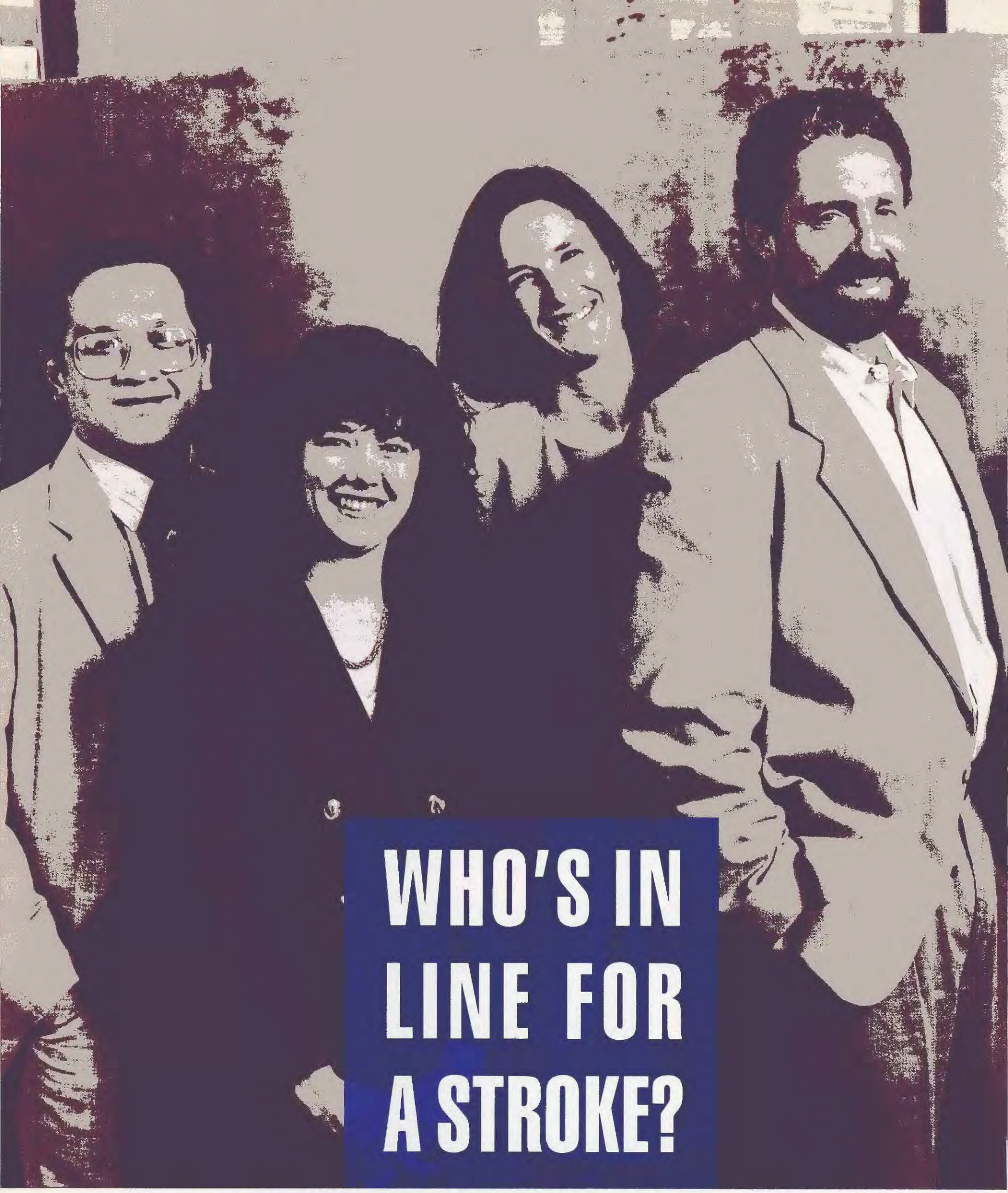
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INTRACORP THE HEALTH **CARE** MANAGEMENT COMPANY.

Benefit exhibits

Continued from page 12

gram."

Under the program, Intracorp coordinates a company's disability, health care management and cost control initiatives. This means data analysis and administration is coordinated as well.

Intracorp added a new wrinkle to its health care management program with an expert system program, which was available for demonstrations at the booth. The computer program allows Intracorp's utilization review nurses to determine appropriate treatment by keying in a patient's diagnosis.

The nurse is then able to compare the computer program's suggested course of treatment with the treatment the patient is actually receiving from the physician.

"The program shows a day-by-day description of an optimal treatment plan," said Frances Atkinson, vp-marketing.

Two exhibitors demonstrated how technology can be used to enhance benefit communication.

A life-size, robot-like statue with flashing red "eyes" greeted those who stopped by Information Access Technology Inc.'s booth.

The statue held a video monitor that displayed the company's interactive computer program about benefit plans. The program, called "SmartTalk," allows access via touch-tone telephone 24 hours a day. The program logs every call and provides a record of answers to each inquiry.

Callers who don't want to listen to the entire voice response menu can request a facsimile copy of the information by entering their fax number, said a representative for the Salt Lake City-based company.

Benefit consultant Godwins International Holdings Inc. believes that benefits should be communicated—in any language.

To demonstrate that benefit communication should be "no problemo" to the intended audience, the Rollins Hudig Hall unit's booth featured a video explaining a pension plan in Spanish.

It isn't easy to grab attention with a brochure and note pad, but one company did just that.

Handout-hunters did a double take when they saw the giveaways at Cost Care Inc.'s exhibit booth.

To make a point that "health care is un-square," the health care cost management firm's handouts were in the shape of a parallelogram. The type slopes at a 45-degree angle to match the sides of the brochure, the format of which makes page-turning somewhat more challenging than usual.

"You have to look at individual employee needs and tailor your plans around that," said Scott Schilling, national account executive for Cost Care, which was bought by John Hancock in 1990. "With 100% physician review, we can maintain quality care."

The Huntington Beach, Calif.-based company stresses patient and client customization in all its programs, which include medical review services, point-of-service fee negotiation and managed referral, which tightly controls all referrals to specialists.

Several medical service companies made their exhibit hall debuts this year.

Nurse's House Call offered shiny red apples, as representatives explained its home health care services for adults and children. The care includes nursing, physical and occupational therapy, and is a covered benefit through most HMOs, PPOs, workers compensation plans and case management companies, said Karen Christopher, community liaison.

The Basking Ridge, N.J.-based company has just introduced a new program, "Tomorrow's Child," which offers day care for children with special medical needs.

One "Tomorrow's Child" center is open in Brookline, Mass., with one more site in Massachusetts and two in Ohio slated to open later this year.

Another first-timer was Future Diagnostics Inc., a 4-year old cost containment firm that specializes in determining the necessity of radiology tests. The Los Angeles-based company has 120 imaging facilities in California that provide CAT scans and magnetic resonance imaging tests at rates considerably below customary charges. The company plans to expand nationwide in the next two years, said Vp Bill Wood.

You're only as young as you feel, the saying goes, and Risk Assessment Systems Inc. agrees. The Memphis, Tenn.-based company offers a "Personal Wellness Assessment," which measures chronological age against "wellness age" based on lifestyle factors including fitness, stress and cardiovascular health.

Risk Assessment Systems provides a printed report to the applicant, giving his or her rating in each of 14 risk factors. The report recommends ways to reduce poor ratings, like reducing sodium intake or quitting smoking. The test is used by HMOs, PPOs and employers. The company also provides insurance applicant testing and pre-placement screening services for employers.

Risk Assessment Systems distinguishes itself from other wellness programs by using results from its in-house clinical testing lab, not only from questionnaires.

Another newcomer to the exhibit hall was Lancer Compliance Services, a specialist in drug-testing compliance. The Long Beach, N.Y.-based company assists employers in developing drug-testing policies and procedures, and also administers record keeping, data collection and data reporting services to the appropriate federal agency.

About half the company's clients are transportation companies, which for the past five years have been required by federal law to test interstate drivers for drug use. But, within the next year, mandatory drug testing will be extended to all intrastate commercial drivers, including school bus drivers, and municipal sanitation and road maintenance vehicles, said Vp Robert A. Crescenzo.

The Precertification Center also made its debut at the RIMS exhibit hall this year. The company applies precertification procedures to short- and long-term disability claims under medical programs or workers comp. The Precertification Center in Camp Hill, Pa., was founded in 1984 and is staffed with registered nurses.

The program will save money for any size employer, said Peggy Belfonti, manager-disability programs. BI

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Expect more benefits legislation ahead

Measures focusing on 'technical issues' expected to follow family leave law

By CHRISTINE WOOLSEY

ORLANDO—With Democrats controlling the White House and Congress, employers can expect more employee benefits-related legislation than under the preceding 12 years of Republican administrations, a consultant says.

RIMS REPORT

The Family and Medical Leave Act, signed by President Bill Clinton in February, is only the beginning, said Charles E. Ginsberg, managing director of research and training services at Alexander & Alexander Consulting Group Inc. in Newburyport, Mass.

Speaking at a benefit legislation update at the 1993 Risk & Insurance Management Society Inc. conference last week in Orlando, Mr. Ginsberg said much legislative action will focus on technical issues. Those include pension simplification and changes to reduce the federal Pension Benefit Guaranty Corp.'s exposure to big losses.

However, even with a greater potential to avoid political gridlock, so much attention is being paid to national health care reform that some legislation won't make it through the House and Senate, according to Mr. Ginsberg.

Meanwhile, employers must be aware of the policy issues they face now that the Family Leave Act is passed, he said.

Under the act, generally effective Aug. 5 for employers with 50 or more employees, a worker is eligible for leave only if employed for at least 12 months with the employer, and for at least 1,250 hours of service during the 12 months before the leave.

An employee is entitled to 12 weeks of unpaid leave during any 12-month period to care for: a newborn child; an adopted child; the employee's spouse, child or parent with a serious illness; or an employee's illness that prevents performance of his or her job functions (*BI*, March 29).

The law provides employers the option to integrate their paid leave with their unpaid leave under the act.

"But if you don't integrate the two, you may be subjected to so-called leave-stacking by some workers," Mr. Ginsberg warned.

"Employees, especially second wage earners, could get paid leave with benefits continued, and then add 12 weeks' unpaid leave and keep the medical coverage meter ticking."

Employers must also address whether to develop a system for collecting employee medical plan contributions made during their unpaid leave.

Employers also must decide what benefits to restore when an employee returns from a leave, he said. For example, many employers say they plan to continue group life insurance benefits, but questions remain about whether they will continue to allow the employee to accrue pension benefits.

How to integrate the federal leave law with state family leave laws, which can be more liberal, is another decision for employers. The federal act "does not supersede more liberal state laws," so it's important to integrate the two, Mr. Ginsberg added.

A slew of other benefits-related legislation is pending:

- The Veteran's Reemployment Rights Act of 1993 (H.R. 995). This legislation would protect pension and other benefits of veterans, National Guard members and military reservists, regardless of category of military training or duty, Mr. Ginsberg said.

  It also adds new employee benefit rights for re-employed veterans and their family.

  The employee benefit provisions of the bill would bar health plans from applying pre-existing condition exclusions to re-employed military personnel and their families, Mr. Ginsberg explained.

  Mr. Ginsberg said the House is expected to take action on this in late April and there is no opposition in the Senate.

- A resolution that Congress passed April 1 will lead to a budget bill with "significant new tax legislation, including higher tax rates and employee benefit changes," he said.

- Legislation is pending that would limit to $150,000 the annual compensation that can be taken into account in calculating benefits under qualified retirement plans. The limit would apply to plan years beginning after 1993 and would be adjusted annually for inflation.

  The current limit is $235,840, adjusted from $200,000 in 1989.

- Health insurance deductions for the self-employed, pension simplification and PBGC reform are all under discussion. "Although the president has proposed neither pension simplification nor technical corrections, the budget bill is likely to include those that were in the two tax bills vetoed last year," Mr. Ginsberg said.

- A bill that would prohibit employers from reducing health care coverage for an employee's condition that was previously covered and treated under the employer's medical plan is likely to pass this year, he said.

  The bill—which would overturn the controversial decision in the H&H Music case in which an employee's health benefits were cut when he told his employer he had AIDS—also would prohibit discrimination among lifetime benefit levels in a group health plan based on specific conditions, like AIDS, he said (*BI*, Nov. 16, 1992).

John Biebel, president of St. Joseph's Hospital in Tampa, Fla., also spoke during the session. Chris Armstrong, director of risk management and insurance for The Williams Cos. Inc. in Tulsa, Okla., moderated the session. BI

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Voice response systems aid benefit departments

By MICHAEL BRADFORD

ORLANDO—Voice response systems are becoming a popular way to streamline benefit plan enrollment.

RIMS REPORT

Employees who are used to getting information over the phone accept the systems readily, said David A. Link, senior systems consultant with The Wyatt Co. in Washington.

Shifting to these automated systems is making employees "more self-sufficient and less dependent on the staff," which is good for both sides, Mr. Link said last week at the 1993 Risk & Insurance Management Society Inc. conference in Orlando.

Voice response systems streamline administration but do not make benefit staff cuts necessary, he said. Most benefit departments are properly staffed but bogged down with mundane work the systems can eliminate.

Enrollment errors, for instance, are quickly corrected with the telephone systems. "When you hand people a pencil and paper, they make errors," said Mr. Link. "Voice enrollment can do all your error checking for you" and let employees know if they are ineligible for a choice they made.

Voice response systems can also boost participation in benefit programs. Some, for instance, let employees see how various benefit options would affect their pay. That information lets employees do some modeling before making final choices.

Voice response systems also have applications beyond enrollment. They are well-suited for administering flexible spending accounts, estimating retirement calculations, taking employee surveys and posting jobs, said Mr. Link.

Benefit departments usually have three ways to set up and maintain a voice response system:

- An "interactive systems adviser," or someone with the expertise to develop a system for a company that already has the technology available.
- A service center, which allows an employer to turn over the entire design of the system and its operation. "All the phones and equipment are at the service center and all the printing and production of documents is done there," he said.
- An in-house center maintained by the employer or consultant. This is most useful for employers that need help with the design of the system but don't want to turn over its operation to a third party.

Or, employers may want to take the same approach as Florida Hospital, the Orlando-based hospital chain that set up a voice response enrollment program entirely on its own.

"We put the whole system together in four months," said Donald G. Jones, benefit manager at Florida Hospital.

Although the hospital decided not to use consultants, Mr. Jones acknowledged that doing so would have saved him "a lot of sleepless nights."

The system, which was built with $30,000 in hardware, was structured for 7,000 employees at four hospitals and 21 other locations in the Orlando area.

The system, which has been in place for two years, allows employees to use the telephone during open enrollment periods to make changes in their flexible benefit plans. It produces a written confirmation that is mailed to workers and handles communication with the hospitals' insurers.

"We're working on incorporating new hires into the process," to let them sign up at their convenience, he said.

Mr. Jones also coordinated and moderated the session. BI

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Flexibility key to work and family benefits

Employers also reap rewards from meeting workers' needs

By CHRISTINE WOOLSEY

ORLANDO—Employers can do much more to address work and family issues than simply establish flexible spending accounts or provide referral services.

RIMS REPORT

The real key to helping employees manage their work and family responsibilities is having a flexible mindset, say two benefit consultants.

"We hear repeatedly that work/family programs cost too much or that there is no return on the employer's investment or they don't have the support staff to set them up," said Randall Abbott, managing director for Alexander & Alexander Consulting Group Inc. in Boston.

"But the most important thing to remember is it is not flexible scheduling or flex time or flexible spending accounts that are necessary to deal with work/family issues. It's a flexible mindset—and the challenge of human resources in the 1990s and beyond is to have a flexible mindset; the rest will follow."

Speaking during a session on work and family issues at the 1993 Risk & Insurance Management Society Inc. conference last week in Orlando, Mr. Abbott outlined some specific programs employers have set up. William DeMarco, senior vp and North American managing director of organizational effectiveness for Alexander & Alexander Consulting in Lyndhurst, N.J., discussed the need for such programs.

"Balancing work and family responsibilities is not just a male or female issue; we are all in this together," Mr. DeMarco stressed. Employers will also reap benefits from providing such programs, he said.

Looking back in U.S. history, one can see that work and family issues were important. In the pre-industrial age when much of society was based on agriculture, the family unit often worked together. Farmers and their children spent time together—both as a family and as a working unit, he said.

However, "the business history of the 20th century is one where the interests of the workplace have taken pre-eminence over the interests of the family," Mr. DeMarco said. "The work/family trends of the 1990s have been an attempt to recalibrate the balance."

Employers are faced with deciding whether work/family issues are benefits issues, cost issues or just good business, he explained.

"In my opinion, work/family issues are survival issues. The issue is not an issue of legality or what I as an employer should allow because it's competitive with other companies," he said. "It's a more fundamental issue in a bigger context."

'In my opinion, work/family issues are survival issues,' says Mr. DeMarco of Alexander Consulting.

Changing workforce demographics are bringing work/family issues to the fore. According to a survey, 60% of all school-age children have mothers in the workforce, up from 39% in 1970. "Latchkey kids are not a new phenomenon anymore," said Mr. DeMarco.

The problem for working mothers isn't so much what to do with preschool-age kids, but what to do with children who get out of school at 3 p.m., he said.

"Working parents could hire a babysitter from 3:30 to 5:00, but because we are all doing more work, what are the chances of parents making it home at 5:00 anyway?"

Corporate America has been slow to respond, Mr. DeMarco said. A 1992 survey of more than 1,000 U.S. companies found that, excluding spending accounts, only 41% offer some kind of childcare assistance—predominantly resource and referral services. Only 30% offer some kind of elder care, again mostly resource and referral services.

Among the most common work/family programs now offered are dependent care flexible spending account programs, Mr. DeMarco said. Child care resources and referral services are the second most common program, but an Alexander & Alexander Consulting survey found that 47% of employers are not considering such programs.

Only 28% of 450 or so employers surveyed said they offer paternity leave and 55% said they are not considering such a program. Twenty-three percent said they offer sick child care leave, while 61% said they are not considering it. And only 5% said they subsidize employee child care, while 79% had not considered it.

Employers can implement more creative work/family programs than these, said Mr. Abbott.

The need for new programs is driven by employees' wishes, he noted.

"We find through surveys that an increasing number of people are more willing to trade pay for flexibility. They are also willing to buy extra time off in order to balance family needs," Mr. Abbott explained.

In addition, "There is more of a willingness among employees to say 'Take this job and. . .' You all know the song. More and more people are saying, 'Is this really worth it?' " he said.

To attract and retain the most talented workers, employers are going to have to take new initiatives, Mr. Abbott said. Vacation trading is one of them.

With vacation trading, employees, through a Section 125 plan—or flexible benefits plan—can buy or sell vacation days. Employees that sell days can redirect the pay for those days to other benefit areas, like health care deductibles, he explained. Or, they can receive cash payments, though such payments would be taxed unless the money is redirected to other flexible benefit choices.

One issue employers interested in this approach must address is how to value a day, Mr. Abbott said. One financial institution that implemented vacation trading valued a day by multiplying eight hours times the employee's actual rate of pay. The employer capped the value of a day at $150, however, so high-paid employees would not take huge amounts of money out of the flexible benefits plan.

This strategy won't work for every company, he cautioned. "Employers have to determine who will buy days and how many they will buy and who will sell days. Both factors will influence the employer's productivity levels. Among the questions to ask are: Will an employee have to be replaced if he takes more vacation days? If so, will his replacement cost more money?"

There are advantages of vacation trading, Mr. Abbott noted. For example, it avoids employees feeling they lost out on a benefit if they don't use all their vacation days, and it enhances employees' vacation flexibility. Also, if employees sell vacation days, it creates a pool of money they can use for other benefits.

"There are also some significant disadvantages to this approach," Mr. Abbott added. Administrative difficulties and scheduling problems could arise.

Another innovative strategy to help employees deal with family responsibilities is paid time off, also known as block plans. This strategy does away with traditional definitions of time off, like vacation, sick days and personal days and lumps all allowable days into one category.

"Lots of employees who are out of vacation days call in sick, but they don't like doing it," Mr. Abbott said. With block plans, employees are not required to give the reason for taking time off, as long as it is allowed.

However, this strategy can create new utilization patterns, Mr. Abbott said. Employees who are given 15 vacation days and five sick days may only use the 15 vacation days. However, if they are given 20 unallocated days, those same employees will most likely take all 20 days, he explained.

Above all, employers should listen to workers and their dependents before implementing a work/family program, Mr. DeMarco said.

"There is nothing worse than going to McDonald's with a little kid and having a menu with no burgers and fries on it. And, there is nothing worse than going to a fine French restaurant and finding a menu with burgers and fries and little else," he said.

Barry Mangels, director of risk management for Adventist Health System in Orlando, moderated the session. W. Lee Carter III, director of research and development for Alexander & Alexander Inc. in Dallas, was the coordinator. BI

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Rethinking compensability of some work comp claims

By JOANNE WOJCIK

ORLANDO—The solution to the workers compensation crisis may be to stop paying claims that really aren't work-related.

RIMS REPORT

Many state workers compensation laws now define compensable injuries so broadly that employers are paying for problems stemming from the natural aging process and the stresses of daily living.

"All this working at the margin of the problem, screwing around with the percentages of savings on the money you've spent" creates a kind of "shoppers mentality," said Stanton Long, president of American International Group Inc.'s cost containment division in New York.

However, while employers may be paying less for some health care services provided under workers comp, they are still buying many services that they shouldn't, Mr. Long said during "Worried Sick: The Psychological Frontier of Risk Control" at the 1993 Risk & Insurance Management Society Inc. conference last week in Orlando.

For example, 28% of workers compensation claims are for back injuries, "but it is a fact that if you're over 25 . . .your back is beginning to deteriorate. Does that entitle me to compensation from workplace funds because I'm getting older? Well, apparently it does," Mr. Long said.

Even the sunburn Mr. Long sustained from the Florida sun is compensable under the current workers comp system because it occurred while he was traveling on business and attending a work-related function—the RIMS conference, he quipped.

But, he added, it shouldn't be.

Because of the expanding definition of the type of illnesses and injuries that are covered by workers comp, the average annual number of lost-time days rose to 84 per 100 workers in 1990, from just 47 days 20 years earlier, according to Mr. Long.

Furthermore, the percentage of workers comp claims that are for permanent partial disability more than doubled between 1980 and 1990 to 13% from 6%.

As a result of the increasing frequency of these and other claims, workers comp costs as a percentage of payroll have doubled to almost 3% today from 1.5% in 1972.

Even if workers comp costs rose in proportion to the growing labor force and medical inflation rate, they should still be the same percentage of payroll as they were 20 years ago, Mr. Long said.

"Are all those employers in America that much more unsafe and careless and less sensitive to employees?" he asked. "Or have the standards and definitions for what's compensable been stretched to the point where you don't know what's in or out of the system?"

"What we're dealing with in contemporary workers compensation is a fundamentally new and different problem," concurred Ted Jean, risk manager for SAIF Corp. in Portland, Ore., which is Oregon's competitive state workers comp fund.

"It arises from new and different causes that we have to arrive at a better understanding of, and it will only respond to a new and different approach for prevention and control," added Mr. Jean, who coordinated and moderated the session.

In 1916, when the state workers comp system was launched, workers were primarily compensated for accidental traumas, such as cuts, bruises and broken bones. While sprains and strains were also covered, they represented just 12% of total workers comp costs, according to Mr. Jean.

"Nowadays we've totally turned around and tipped the scale in the opposite direction. Fully two-thirds of workers compensation claims come out of the class of illness and injuries that I call stress and strain problems," while accidental traumas have fallen to just a third of all claims, he said.

The power of suggestion is also contributing to the growth of stress and strain claims, according to Mr. Jean. Media reports that bombard the public with newly discovered health menaces have created a heightened sense of health anxiety, he said.

As a result, "we invent illness," he added.

For example, even though the theory that repeated motion can lead to cumulative trauma disorders is still unproven, compensation for cumulative trauma disorders under the workers comp system has increased nearly tenfold since 1983, said Mr. Jean, citing figures from the Bureau of Labor Statistics.

"Across the country, people's perceptions tell us that the problem is even greater," he said. "The National Center for Health Statistics in 1988 polled a sample of American workers and then extrapolated that to the total population and found that nearly 2 million Americans are convinced by some kind of process of self-diagnosis that they suffer carpal tunnel syndrome.

"My prediction is this huge phenomenon of carpal tunnel syndrome, while it peaks somewhere in the 21st century, is at some time going to burn out and return to relative obscurity," Mr. Jean suggested.

In the meantime, employers should root out psychological factors that can lead to workers comp claims, such as boredom, problems at home, job dissatisfaction—even personality conflicts in the workplace.

If workers believe their workplace is hurting them, it will, said Dr. Dorothy E. Dugger, vp and national medical director for Intracorp in Berwyn, Pa.

"It is well known that psychosocial stress can lead to injury," she said. According to a study by the National Institute of Occupational Safety & Health, workers' inability to cope with stress was a major factor in 80% of work-related accidents in 1982.

"In addition, psychosomatic problems contribute to over 60% of long-term disability cases. stress-related headaches are a leading cause of lost work time and heart disease alone accounts for about 135 million lost days per year," Dr. Dugger added.

The psychological influence is most apparent in back injury cases, she said.

History of back pain, job dissatisfaction and stress in life were the three primary factors found to contribute to the incidence of back pain in a late 1980s study of Boeing Corp. workers, Dr. Dugger said.

According to the study, "those with high stress were twice as likely to file a workers comp claim; those with job dissatisfaction as well as general life stress were 2.5 times as likely to file a claim; and, if you've actually had back problems, you are 3.3 times more likely to file a back claim," she said.

"When someone has an accident, it focuses the attention on physical symptoms, which are a lot more acceptable in our society. It often gets people out of unpleasant job or home responsibilities. And, furthermore, we're reinforcing this behavior by paying them for it," said Dr. Dugger. BI

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Polishing risk management's image urged by Bridger

By SARA MARLEY

RIMS REPORT

ORLANDO—Risk managers' jobs are on the line, the new president of the Risk & Insurance Management Society Inc. told delegates at the 31st annual conference.

"Our expertise as individuals in our respective organizations will determine whether risk management expands to its rightful role as a key senior management position, or whether it remains mired in middle management," said J.A. "Tony" Bridger, risk manager-corporate risk and insurance at the Bank of Montreal in Toronto.

"I realize these are tough words, but I am convinced that these are the stakes we face at present time," he said.

In the current economic climate, risk managers must not only be concerned with the stature of their role, but with the security of their position as well.

One way RIMS has responded to the economic crisis is by instituting a membership category for unemployed risk managers (*BI*, April 19).

RIMS should be available for networking for out-of-work risk managers and should aim to reduce the number of risk managers laid off by promoting the importance of risk managers, said Suzanne H. Crager in her final address as RIMS president last week in Orlando.

"If we had a better image among senior management we would have few, if any, unemployed risk managers," she said.

Despite the depressed job market, interest in risk management among college students continues to rise.

"The good news is that our image appears to be improving on college campuses," Ms. Crager said. As a result, RIMS has also proposed a new membership category for students, which Ms. Crager hopes will ultimately lead to student chapters on campuses.

Ms. Crager noted that the evolution from insurance buyer to risk manager happened just two decades ago.

"We celebrated that emancipation mightily, but 20 years later I wonder if we have substantially fulfilled the promise of risk management," she said. "Or if we have largely consolidated titles, while adding little if any incremental value to our organizations.

"I have the feeling that our stature, overall, has declined in terms of recognition as a key function by senior management."

Because corporate downsizing is a fact of life, risk managers must make an impact on their employers' bottom lines, Ms. Crager added.

"We have no choice but to educate ourselves and to learn to apply that education with ingenuity," she said. "And we can't confine our education to our narrow discipline. We're going to have to do a much better job of understanding the global context in which our organizations function."

RIMS as an organization has responded to economic conditions through "a focus on the budgeting process by forcing proposed expenditures through several screens to assure that they are in harmony with our strategic priorities," Ms. Crager said.

One of those priorities will continue to be communication, Mr. Bridger said.

RIMS and risk managers have improved communication internally, but "we've barely begun to get our message out to top management," he said.

Participation by RIMS deputy members is the key to spreading the word, Mr. Bridger said.

"The interests of RIMS, its chapters and individual risk managers are collectively linked," he said. "My vision is that RIMS can be the framework through which each of us can use reason and judgment to become leaders, and through this enhance our value to our respective organizations."

Communication and participation were important elements in drafting RIMS' new strategic plan, which Ms. Crager cites as "the landmark achievement of the year."

"It creates a rational and professional framework for policy development and decision-making," she said. "But as vital as the plan is to the future of our organization, it may, in fact, be overshadowed by the process through which it arose."

The plan establishes a framework "that welcomes the input of every chapter and every individual in this organization," Ms. Crager said.

The planning process exemplified the teamwork Mr. Bridger intends to make the hallmark of his year as RIMS president.

"I see my role as team leader to provide continuity and follow-through to existing programs and to continue the process established by governance," Mr. Bridger said.

Continuity is vital, Ms. Crager agreed. "Overwhelmingly, our activities and achievements were outgrowths of seeds sown earlier."

Mr. Bridger will look to RIMS' executive council for more chapter and public outreach. He credited Ms. Crager for preparing him to be president by making him part of the strategic planning process.

He in turn will help new First Vp Lucille A. Gallagher, vp-risk management for Monfort Inc. and the Red Meat Cos. Division of ConAgra in Greeley, Colo., to take the reins next year by having the Research Roundtable report to her. BI

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Hard times, benefit changes spark increase in lawsuits

By SARA MARLEY

ORLANDO—Employees are filing more lawsuits against their employers regarding benefits, but few are succeeding in court.

RIMS REPORT

The recession and fast-changing benefit plans are primarily to blame for the increasing number of lawsuits, a consultant said at the 1993 Risk & Insurance Management Society Inc. conference last week.

Most courts, though, have held that for an employer to be found liable for miscommunicating the coverage afforded by a benefit plan, the error must be made in writing and employees must prove they relied on those errors, an attorney said.

"As the recession hit and people were laid off and asked to retire early, they scrutinized all employee benefits more closely than in the past," said William L. Granahan, chief operating officer and senior consultant of Betterley Risk Consultants Inc. in Worcester, Mass. "Employee benefits have been reduced. Any time you go from an indemnity plan to a deductible plan in health insurance, (employees) are going to look at it more carefully."

Another reason for the surge in lawsuits is that the changing nature of benefits may make employers more likely to make a mistake when communicating the plan to employees, said Robert C. Macaulay Jr., a partner with Ropes & Gray in Boston who represents employers.

"Plans are changing so fast and becoming more complicated, so it's easier to make a mistake," Mr. Macaulay said. "We've seen more (lawsuits) in the last two years than in the prior 10."

A new accounting rule—Financial Accounting Standard 106—that requires companies to recognize their future retiree health care liability also is a factor in the rising number of lawsuits, he said.

"The impact of FAS 106 and the general cost (of health care) has caused companies to dramatically alter their retiree health benefits," Mr. Macaulay said.

In fact, suits filed over cutbacks in retiree health care benefits have accounted for most of the increase in benefits litigation over the past year, he said.

While some employers have terminated post-retirement health benefit programs, companies more commonly have changed or eliminated benefits for existing employees or have started requiring contributions from retirees.

Courts' response to lawsuits over retiree health benefits have differed for union and non-union retirees.

Many collective bargaining agreements did not specify whether retiree benefits continue after the agreement expired, or whether they, too, were subject to renegotiation. Courts are divided in interpreting those contracts, Mr. Macaulay said.

For non-union employees, however, most courts have found that employers have the right to modify benefit terms after retirement, he said. Even personal letters or notes that appear to guarantee health care coverage do not stand up in court if the employer also has reserved the right to change or terminate the plan in writing, he noted.

Despite a more adversarial climate, courts are upholding tough standards of proof for employees to advance benefit coverage claims.

The Employee Retirement Income Security Act of 1974 requires that both a plan and a summary plan description be in writing. Therefore, most courts have not allowed suits alleging oral misrepresentation to advance, Mr. Macaulay said.

Even in cases in which an error was written into the summary plan document, "the majority of courts said even a mistake in the summary plan description does not allow a plaintiff to recover unless he proves he relied on the mistake," Mr. Macaulay said.

But, disclaimers added by employers to summary plan descriptions stating that the plan document controls in cases of conflict have not been upheld by courts, he noted. ERISA requires that the summary be accurate, he said.

Employers are paying more attention to their responsibilities and liabilities regarding employee benefits in the current legal climate, observed Mr. Granahan of Betterley.

"Five years ago, we were never asked to do due diligence on companies like Travelers, Aetna, CNA and Chubb," he said "Now there are companies that are doing it every quarter."

Many employers who think they are covered by an employee benefits liability endorsement to their general liability policy may not be, Mr. Granahan said. That endorsement typically excludes any claim arising from ERISA, he noted.

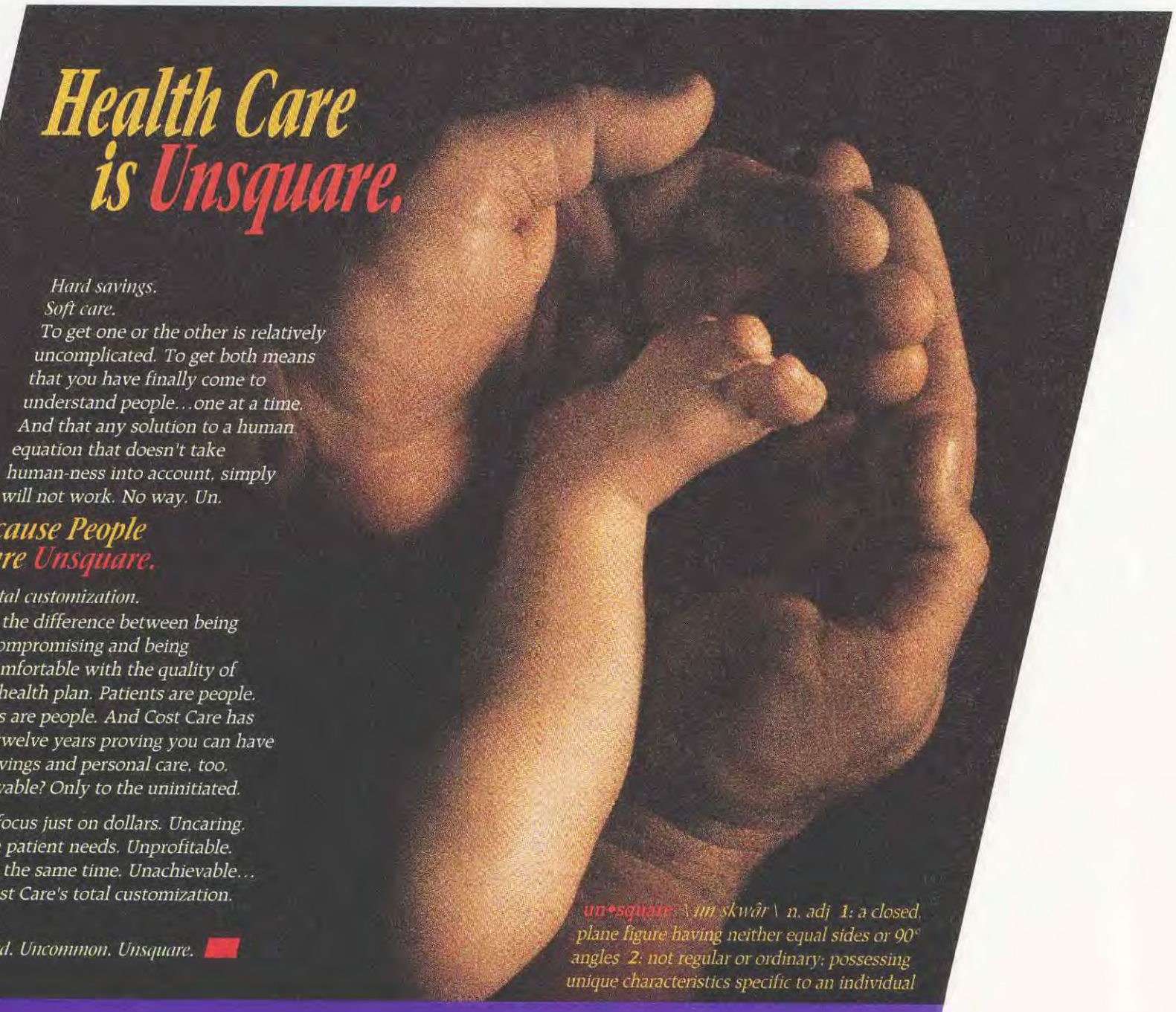
Instead, he said, employers should protect themselves through fiduciary bonds. In addition, employees who administer benefits should be bonded for at least 10% of the assets they have access to, he said.

An ERISA endorsement to a crime policy can also be purchased, Mr. Granahan noted. However, errors and omissions cannot be covered under a crime policy. Employers should look at their exposures to determine which method of risk transfer is appropriate.

Another safeguard is to hire third parties to prepare employee communications and summary plan descriptions, transferring the risk of error to their professional liability coverage, Mr. Granahan said.

Employers' exposure to liability for employee benefits is on the rise, he said. "The subject matter is more complicated and difficult to administer. Pay attention to risk management and risk transfer," he advised.

Mr. Granahan served as the session's coordinator and moderator. BI



Agent/Broker Topics

A monthly editorial section sent exclusively to agents and brokers



Internships often dispel industry stereotypes

Brokerage training programs draw top prospects

By LOUISE KERTESZ

To get the best and the brightest out of the nation's colleges, brokerages and agencies are finding they can't wait until graduation.

College internships and training programs have proved to be a successful draw in recruiting young people to build careers in insurance.

Through the programs, students "find that insurance is really not what they thought it was. Very few members of the public know what a large-risk commercial broker does," said George A. McWeeney, vp-operational support at Arthur J. Gallagher & Co. in Itasca, Ill.

"We're a hidden industry. The insurance industry has not done a good job of making this a glamorous career, yet almost to a person, (interns and trainees) come to love it," he said.

Internships and training programs are necessary because it isn't enough to just recruit college graduates into a brokerage and expect them to stick around. Many college graduates don't remain at their first jobs because they don't know enough to make an informed career choice right out of school.

Internship programs bring undergraduates into the agency or brokerage for a few summers and give them a "feel" for the industry and a particular company. By the time they graduate, they can make an informed choice of employer.

And, training programs for college graduates—also called "associate" programs—give entry-level employees a sense that they can enjoy future growth at a company.

"We hire the best and brightest graduates across the country," said Debra J. Willard, assistant vp and director of the risk management associate program at Alexander & Alexander Inc. in Dallas.

A&A allows associate program participants to try all areas of the firm to determine where their strengths are. "We try to fit the position and the person together. The student has a lot of say as to where they are going to end up."

That kind of flexibility and movement is essential for today's graduates.

Without "a formalized training and development program, you may attract (the top graduates), but you won't keep them," asserted Christopher Bulger, Sedgwick Group P.L.C.'s regional director for Northern California in San Francisco.

"These young people expect rapid upward movement and continuous growth in their levels of responsibility, and they expect to be measured consistently and accurately and compensated appropriately. If you don't have some formalized process, you'll lose them quite rapidly," he said.

Sedgwick started recruiting graduates for its associate training program about eight years ago. Then, about four years ago, "we determined that in order to attract some of the best graduates, we needed to give them some exposure to our organization. Many of them from the East knew nothing about California," Mr. Bulger said.

So Sedgwick's San Francisco office began offering about eight summer internships to college juniors. "We put them through as much of an orientation or mini-training as we can in two and a half months, so they can get the feel of the brokerage business," he said.

The brokerage pays interns about $1,200 a month—which seems the average for internships at brokerages—helps them arrange housing and often pays a small stipend for travel to San Francisco.

The experience of interning and training has sold students on Sedgwick's San Francisco office. The brokerage hires "a very high percentage" of its interns. And, it boasts an "extremely high" retention rate for the college graduates it has recruited: Of 70 hires since the college graduate training began, only six have left the company, Mr. Bulger said.



Many of the college hires at Sedgwick now "are playing significant roles. . . even in global accounts," and several are vps, he said.

Noelle Rodier, who graduated last year from the University of California at Berkeley with a degree in English, interned at Sedgwick in San Francisco in the summer of 1991. After graduation, she joined Sedgwick full-time.

The internship, she said, was a chance to get to know the brokerage business "in an unstressful situation."

Now Ms. Rodier—whose title is technical assistant—works at servicing accounts and organizing clients' insurance programs. "I'm on the phone all day long, talking to clients, their subsidiaries and underwriters," she said.

Perhaps the most ambitious and longest-running internship program among brokers is found at Arthur J. Gallagher & Co.

Gallagher's first intern, Warren G. Van der Voort Jr., came aboard 28 years ago and is now vp in charge of mergers and acquisitions. About 130 interns have since gone through Gallagher's summer program, recently at the rate of about 30 to 35 each year, said Mr. McWeeney.

About 70% of Gallagher's interns over nearly three decades were hired full-time after graduation and are still employed at the brokerage, several as managers, he said.

With the exception of mergers, the intern program is Gallagher's single largest source of supply for new brokers. This has persuaded the broker to recruit students only through its internship program rather than through direct campus recruiting.

The internship is "not simply to give college students a business experience but to recruit future company managers, hopefully officers," he said.

Gallagher interns typically work at the brokerage two summers, beginning after their sophomore year.

After a week in the classroom, learning such things as basic business concepts and the fundamentals of sales, interns rotate throughout the company.

"They go on calls with the broker, go to business meetings, visit our clients and insurance markets. At the end of each week, the student writes an evaluation of the experience and is evaluated" by Gallagher staff, Mr. McWeeney explained.

There's also a social part that allows for the building of "real firm friendships." Activities include events such as Cubs games and an afternoon barbecue at the vice chairman's home. "It's not the administration but the culture (of the brokerage) that drives it," Mr. McWeeney said.

Over the years, Marsh & McLennan Inc.'s active trainee program for recent college graduates has been the mainstay of its development program. "But in recent years we have especially concentrated our efforts on internship-type arrangements focused on the minority community," said Edward Pazicky, director of human resources in New York.

"We have restricted our proactive recruiting to minority efforts because we're so well-known, we have so many self-referrals, and we do need good minority candidates," he said. "Insurance brokerage is not something that minorities have been attracted to over the years. . .but we're certainly trying to do a better job."

One minority internship program M&M began participating in five years ago, titled "Inroads," now includes eight offices.

Each student has a mentor and special training programs. "They're brought in to learn the business," not to work on any isolated project, Mr. Pazicky said. And M&M makes a point of organizing social activities for the interns.

M&M has also made a priority of sponsoring juniors and seniors from mostly Southern colleges to

Continued on next page

Agent/Broker Topics

Agents fight insurance sales by banks

Arguments before high court pivot on 1918 changes to bank law

By SALLY ROBERTS
and MARK A. HOFMANN

WASHINGTON—Who would have thought that the Supreme Court would be hearing arguments over a pair of quotation marks?

Earlier this month, however, lawyers for the insurance and banking industries argued over punctuation in a case that challenges whether banks are legally selling insurance in small towns.

At issue is whether Section 92 of the National Bank Act—a 1916 provision granting banks operating in towns with fewer than 5,000 people the right to sell insurance—actually exists.

The Supreme Court is hearing an appeal of a ruling by the U.S. Court of Appeals for the District of Columbia that found Section 92 was repealed by Congress in 1918, even though legislation and court decisions since then have been based on the provision (*BI*, Feb. 17, 1992).

For more than 75 years, neither banks nor the insurance industry questioned the existence of Section 92, and national banks with branches in towns with fewer than 5,000 people have sold insurance in these small towns.

In 1986, though, the U.S. Comptroller of the Currency issued a ruling that interpreted Section 92 to permit national banks or their branches operating under the small-town exemption to also sell insurance outside a small town. That ruling essentially allowed the U.S. Bank of Oregon to expand insurance sales nationwide.

The Independent Insurance Agents of America filed suit against the comptroller, raising the question of Section 92's existence and pointing to the placement of the quotation marks.

The agents contend that Congress in 1918 called for sections of the banking act that appeared within quotation marks—including Section 92—to be repealed.

The government argued that the quotation marks around the small-town exemption were unintentional, and that congress did not mean to repeal that section of the law.

While it seems like an "esoteric argument, the practical implications for banks and independent agents are tremendous," noted Paul Equale, senior vp for government affairs for the IIAA in Washington.

If the IIAA wins, banks that are selling insurance in towns of 5,000 are doing so illegally and therefore "must divest," he said.

On the other hand, if the banking industry prevails in its appeal, agents could have tough new competition with banks selling insurance nationwide.

Both sides are optimistic about the outcome after battling it out in front of the Supreme Court April 19. A decision is expected some time this summer.

Christopher J. Wright, assistant to the U.S. solicitor general representing the Office of the Comptroller of the Currency argued that regardless of whether the elusive Section 92 was enclosed in quotation marks, the justices should pay attention to the words of Congress rather than punctuation.

Congress intended to include the small-town bank exemption in the Federal Reserve Act rather than within revisions to the National Bank Act, which were struck in 1918, he said.

"Congress did not intend to repeal Section 92," he argued.

He noted the 1926, 1934, 1940 and 1946 editions of the U.S. Code all contained Section 92.

Justice Byron White asked if it were not true that Section 92 had vanished from the 1952 edition and all subsequent editions of the code. Mr. Wright acknowledged the section had indeed vanished from the code.

Justice Sandra Day O'Connor noted that the bill signed by President Woodrow Wilson in 1916 contained the quotation marks.

"So I think we have to accept that, don't we?" she said.

Ann M. Kappler, a partner with Jenner & Block in Washington who represented the insurance agents, argued that quotation marks or no quotation marks, Congress clearly intended the disputed section to be part of the 1916 law, and clearly intended it to be repealed in 1918.

To bolster her argument, she noted that in the late 1950s, the question of Section 92's existence emerged again.

In her brief, Ms. Kappler noted that Rep. Wright Patman, a Texas Democrat who later became chairman of the House Banking Committee "argued forcefully that Section 92 had been repealed." He was backed in this contention by Rep. Emanuel Celler, D-N.Y., who served as chairman of the House Judiciary Committee at the time.

"An unambiguous enactment is the law. The United States Code is prima facie evidence of what the law is. The various contentions that have been made, to the effect that (Section 92) was never repealed, all run afoul of these unassailable principles. More than mere doubt and conjecture are required to overcome the force of law, or to overcome the official prima facie statement of it," wrote the late Rep. Celler.

"The only way Congress can revive Section 92" is to pass legislation doing so and have the president sign it, said Ms. Kappler.

"Congress cannot amend a non-existent law," she said. BI

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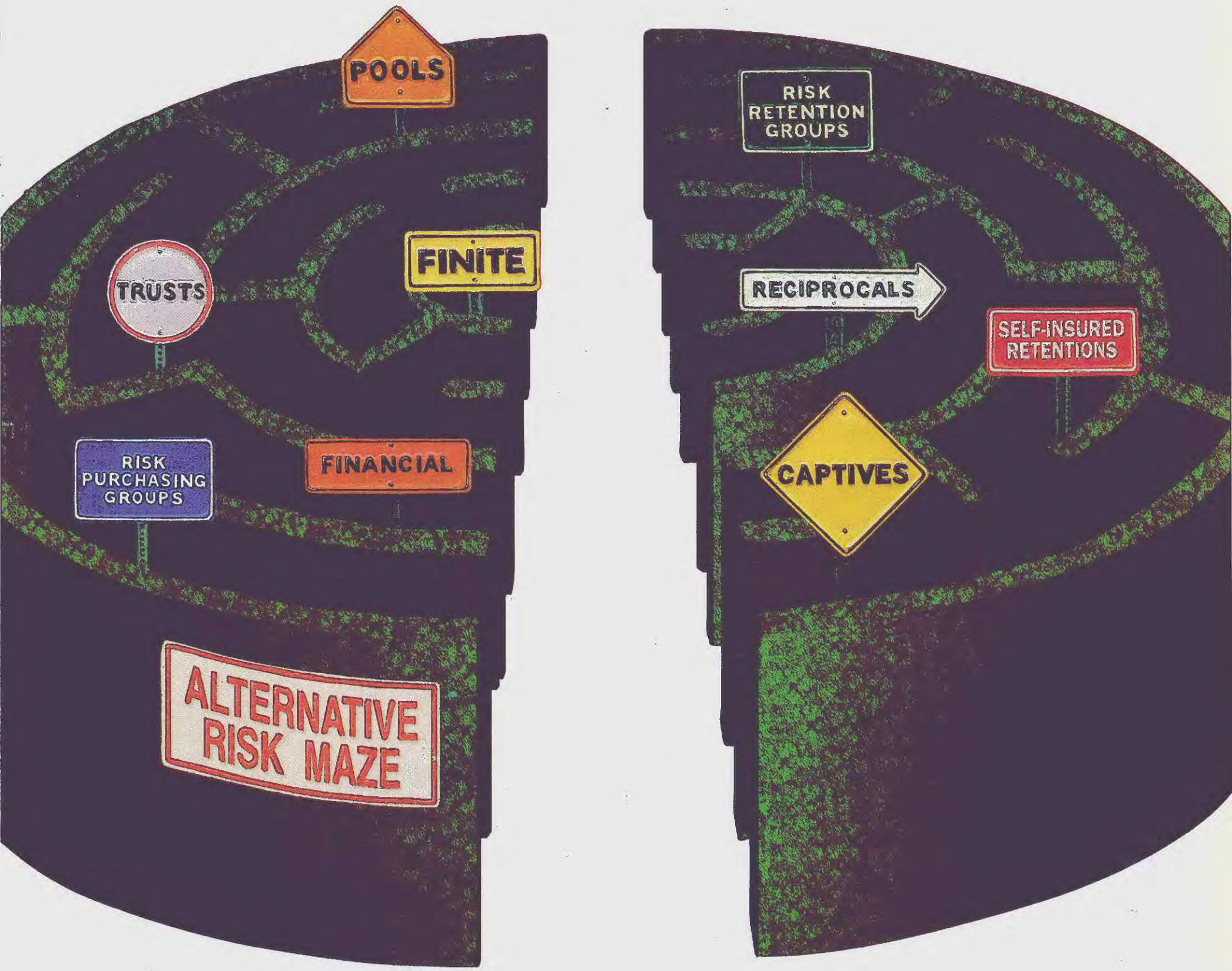
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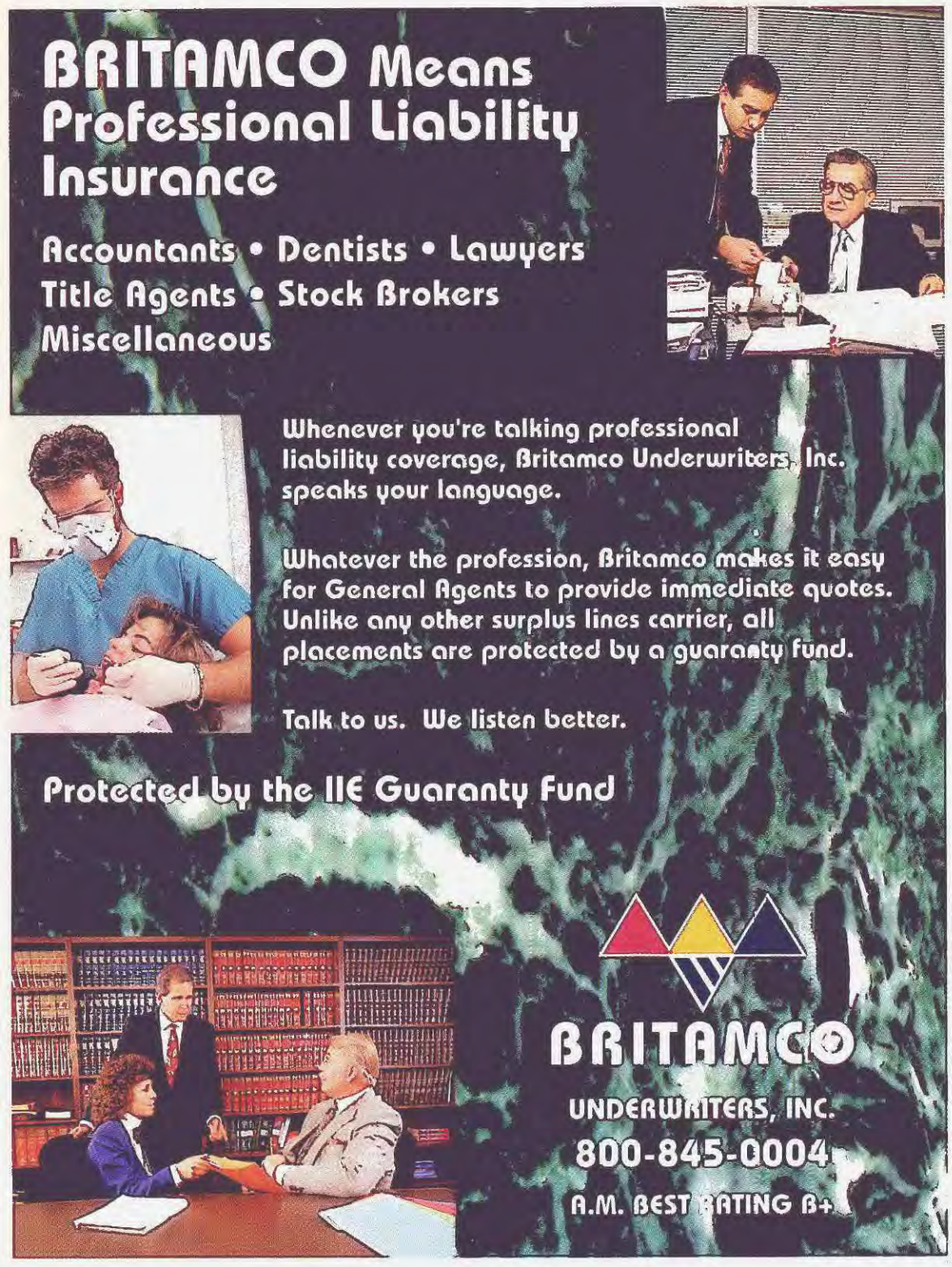


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Agent/Broker Topics

Ruling on intangible assets expected to aid Rosty bill

By SALLY ROBERTS

WASHINGTON—In a narrow victory, agents and brokers won the right to depreciate the value of customer lists from companies they acquire if they can prove the intangible asset has a useful life and a dollar value.

In a 5-4 decision, the Supreme Court ruled that a subscriber list acquired by the Newark Morning Ledger Co., a unit of Advance Publishing Inc. that publishes the Newark, N.J., Star-Ledger, "is an asset found to have a limited useful life and an ascertainable value which may be determined with reasonable accuracy," Justice Harry A. Blackmun wrote.

While the high court's decision was a big victory for agents, the Internal Revenue Service could still contest tax deductions on other areas, agency representatives warn.

The decision has clarified the law that intangible assets are amortizable, but it "still leaves the door open for the IRS to challenge the valuation and useful life," said Chris Larsen, senior Washington representative for the Independent Insurance Agents of America.

Agents are looking for legislation that could simplify the tax issue even further, said Lynnea Olsen, director of federal affairs for the National Assn. of Professional Insurance Agents in Washington. For example, H.R. 13 could accomplish this, she said.

House Ways & Means Committee Chairman Dan Rostenkowski, D-Ill., reintroduced H.R. 13—his omnibus tax legislation—earlier this year, which calls for a uniform, 14-year recovery for all intangible assets acquired after July 15, 1992.

Agency representatives say the recent Supreme Court decision will help as they urge support for the measure on Capitol Hill.

The decision definitely "puts Rostenkowski's plan in better light," Mr. Larsen said.

It makes lobbying the case "a heck of a lot easier," Ms. Olsen said.

For agents and brokers, these deductions on acquired customer lists are a major incentive when buying other agencies or brokerages. Agencies and brokerages deduct an estimated $200 million to $1 billion annually in depreciation on their customer lists (*A/BT*, April 5).

Previously, a panel of the 3rd U.S. Circuit Court of Appeals ruled the list was an asset that contributed to continual income but was akin to non-depreciable good will. BI

HIPC design to dictate independent agents' role

CLINTON AGENDA

By MARK A. HOFMANN

The design of the "health insurance purchasing cooperatives" that appear to lie at the center of Clinton health reform proposals will play a key role in determining if independent insurance agents will have a place in a revamped health care system, says a new report.

"Many of the HIPC's functions are already performed by independent insurance agents," Sophie M. Korczuk, of the consulting firm Analytical Services, wrote in a study conducted for the Independent Insurance Agents of America.

Continued on next page

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"Agents already assess client needs and the relative value of available insurance products in meeting those needs. Agents or coalitions of agents could thus participate in managed competition under some design options," said the report.

But there is no consensus on precisely what shape HIPCs will take. They could be government agencies, quasi-governmental agencies or private institutions. Whether or not they would be monopolistic has not been determined. Whether they would be organized along political boundaries or market segments isn't clear yet. The final shape of HIPCs will determine the agents' role in them, says the report.

"Independent insurance agents could participate in managed competition more easily if HIPCs were allowed to compete with each other and with independent insurance agents within market areas; if at least some small and medium-size employers could buy coverage outside an HIPC; if HIPCs were not structured as government agencies; and if HIPCs did not perform regulatory and/or community health planning functions in addition to their role as purchasing agents for individuals," says the report.

On the other hand, agents' opportunities would be greatly limited if HIPCs were granted geographic monopolies and were set up as government, rather than private, institutions.

The report also concludes that folding the medical portions of personal automobile and workers compensation insurance into a national health plan would hit agents hard in the wallet. Those two lines accounted for 58% of net property/casualty insurance premiums written in 1990.

"Integrating the medical component of automobile insurance with a universal (health care) system would particularly hurt independent insurance agents if the design of the new system foreclosed their participation. As with workers compensation, however, agents' experience in this coverage line would also create a powerful argument for their continued participation in this market," said the report.

•

Copies of "The Consumer Insurance Market in a Managed Competition System: Options and Opportunities" are available free by contacting Brenda Scott, Independent Insurance Agents of America, 412 First St. S.E., Suite 300, Washington D.C. 20003; 202-863-7000.

A/BT Briefs

Carolina agent groups fail to complete merger

RALEIGH, N.C.—The Independent Insurance Agents of North Carolina and the Carolina Assn. of Professional Insurance Agents have stopped merger discussions. They will, however, still hold a joint convention next month.

David Scull, secretary/treasurer of John Hackney Agency Inc. in Wilson, N.C., and president of the IIANC, said two years of studying the matter showed that dues for the combined group would be more than members of either of the existing organizations currently pay.

He said that the talks' end has not affected the groups' joint activities, such as working together on legislative issues. "We want to keep communications open," Mr. Scull said. He said he thought the groups would indeed merge at a later date.

"We're positive about the future. I'm hopeful that it will happen some time in the future," said Bob Broome, principal with Broome Associated Insurance in Hickory, N.C., and president of the Carolina PIA.

—By Mark A. Hofmann

Ky. insurance agency seeks to keep license

FRANKFORT, Ky.—Kentucky insurance regulators may take steps to strip the license of a financially troubled agency that says it needs to retain its license while completing a plan to pay all of its insurer creditors in full.

The action centers on $570,000 of overdue premiums that Burnett & Associates of Lexington owes Kentucky Central Life Insurance Co., which was placed in rehabilitation in February (*BI*, Feb. 22).

Kentucky regulators also want to recover the value of assets—estimated at several million dollars—that the insurer and its subsidiaries lost after the agency defaulted on loans secured by the assets. B&A also owes at least $660,000 in premiums to other insurers.

Under B&A's Chapter 11 reorganization plan, the agency would be sold to two of its agents, and the new firm—Insurance Agency of Kentucky Inc.—would pay its in-

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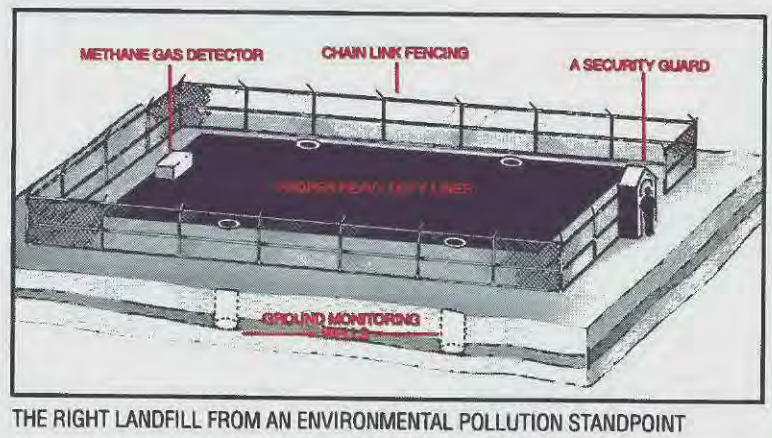
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A/BT Briefs

Continued from previous page
surer creditors in full over six years.

Bankruptcy attorney Thomas Bunch says B&A has to retain its license so it can legally authorize IAK to manage its business for 16 insurers while transferring the business to IAK. The transfer should be completed by early June, and B&A would surrender its license then, said Mr. Bunch of Bunch & Brock in Lexington.

But, Insurance Department General Counsel Patrick Watts does not "see any merit to what they're saying" because of B&A's "severe violation" of the regulations governing agencies' fiduciary duty to insurers.

While department hearings on the revocation of B&A's license may not be completed by early June, the department still may continue its action against the agency.

Mr. Watts said the department will "wait and see what the situation is" in June.

Agency owner Bruce Burnett will surrender his own agent's license, as the department requested.

—By Dave Lenckus

Brokers must think on global scale: AA exec

By JOANNE WOJCIK

SAN FRANCISCO—Insurance brokers must start thinking globally if they want to keep up with their customers, a leading brokerage executive advises.

Because many brokers already are managing or administering global insurance programs on behalf of their multinational clients, it makes sense for these brokers to restructure their own operations to enhance their service capabilities, suggests Ron Forrest, chairman and chief executive officer of Alexander & Alexander Inc. in New York.

Furthermore, with the U.S. insurance market growing more slowly than other world markets, it's necessary for brokers to look to other countries to increase their revenues, he said.

"Clients themselves are acting in a global manner. They're running their businesses differently. And all of this is driven by technology. The fact of the matter is the world is shrinking," Mr. Forrest told a group of insurance industry executives attending the recent National Insurance Symposium Leadership Conference in San Francisco sponsored by Russell Miller Inc.

"You take a fax machine, the 747 airplane that can fly halfway around the world non-stop, and you're looking at a totally different way of doing business," he said.

Going global offers some obvious advantages to brokers, according to Mr. Forrest, such as providing seamless service to clients, creating economies of scale and opening up new markets in which to sell existing products and services.

Besides the obvious ones, there are also some less obvious reasons for brokers to globalize their operations, Mr. Forrest said.

"A decade ago, the U.S. insurance market represented 55% of the world insurance market. Well, that's down to 42%," he explained. "So from the U.S. perspective, going global means looking outside the United States."

Another reason brokers need to think globally is to gain better control over insurance supplies, according to Mr. Forrest.

"This is more of a reactive than a proactive response" to the fact that many insurance buyers have turned to alternate markets to satisfy their insurance needs.

Globalization also may provide a chance for brokers to recapture some of the business lost to foreign markets, such as London, he said.

Finally, globalization provides a means for international brokers to diversify, he said.

Although many large international insurance brokers call themselves "global" brokers, they really aren't, according to Mr. Forrest.

Only four U.S. brokers can label themselves as global in today's insurance market: Alexander & Alexander; Marsh & McLennan Inc.; Sedgwick James Inc.; and Willis Corroon Corp., Mr. Forrest suggested.

However, there are at least five "emerging dragons," he said. Among them are: Rollins Hudig Hall Co.; JIB Group P.L.C.; Arthur J. Gallagher & Co.; Hilb, Rogal & Hamilton Co.; and Johnson & Higgins' UNISON network of correspondents.

To explain why so few brokers can really call themselves global, Mr. Forrest offered the following definitions:

- Domestic brokers deal only with business in the same country.
- International brokers are based in one country, but trade with other countries.
- Multinational brokers conduct the same type of business in a number of different countries, but the business is not usually linked.
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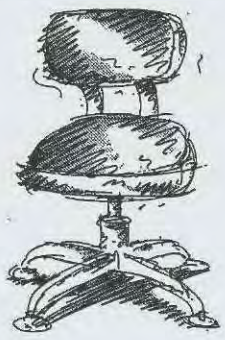
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ASK A CASUALTY ACTUARY

Steady demand seen for casualty actuaries in coming years: Survey

Q **Have the employment prospects for casualty actuaries changed in recent years?**

A To answer your question, I sent a brief survey to the 20 largest employers of casualty actuaries. The eight employers who responded were composed of three insurance companies: Allstate Insurance Co., ITT/Hartford Insurance Group and Reliance Insurance Co.; the two largest rating bureaus: the Insurance Services Office Inc. and the National Council on Compensation Insurance; and three consulting firms: Coopers & Lybrand, Milliman & Robertson Inc. and The Wyatt Co.

The questionnaire asked the respondents to estimate the average annual percentage change in the number of Casualty Actuarial Society members they have employed during the 1980s and during the past two years. It also asked for a forecast of the annual percentage change in the number of society members they expect to employ during the next two years. The same estimates were also made for actuarial trainees.

The results show that the overall annual growth in employed, experienced society members was 9% during the 1980s and 7% since 1991. The overall annual percentage growth in employed, experienced society members predicted for 1993 to 1995 is 8%.

The overall annual growth in employed trainees was 12% in the 1980's and 2% since 1991. The overall annual percentage growth predicted for 1993 to 1995 in employed society members who are trainees is 6%.

'The use of personal computers has decreased the need for beginning number crunchers and increased the need for analyses by experienced people,' says one source from a rating bureau.

These results suggest that the demand for CAS members has grown at a relatively steady rate and is expected to grow at a similar rate in the near future.

For each period, the responses varied widely. During the 1980s, the annual growth rates ranged from 0% to 25%. During the past two years, the range of responses was much smaller, varying from 0% to 10%. Forecasts for the next two years ranged from 0% to 15% growth per year.

Several respondents cited the growing complexity of the insurance industry, created in part by expanding regulatory requirements, as a key factor in fueling the need for highly experienced actuaries. Although some of the respondents felt the recession had somewhat dampened the demand for experienced actuaries, most also foresaw a rebound in demand during the next few years.

Others believe there has been a fundamental shift in the demand for experienced actuaries, but that this shift has most noticeably affected consultants. This clearly shows up in the membership statistics of the CAS. From 1982 to 1989, the number of society members employed by consulting firms grew at an average rate of 18% per year. Over the past three years, the growth rate has dropped to an average of 6% per year.

Meanwhile, the growth rate in the total membership of the society has remained relatively constant. It has ranged from 5% to 8% during the past 13 years.

A source from one of the major consulting firms said, "There was a large unsatisfied demand for casualty actuaries that developed since the mid-1970s. (Now) the supply of FCASs and students is much closer to matching the demand in 1993 than any time earlier."

"The supply of actuaries is probably closer to demand than it has ever been. The variety of suppliers, large national firms, Big Six and small one- or two-person practices has resulted in significant competition. In many cases, the new client is switching actuaries rather than selecting an actuary for the first time," agreed Frederick Kist, a managing partner with Coopers & Lybrand.

The overall annual percentage growth in actuarial trainees (defined as those with less than two years' experience) was 12% during the 1980s and only 2% since 1991. The overall annual percentage growth in employed actuarial trainees predicted for 1993-1995 by the respondents is 6%. These results suggest the demand for actuarial trainees has dropped dramatically since the late 1980s.

Again, for each period of time, the responses varied widely. Respondents reported the annual growth rate ranged from 0% to 25% during the 1980s. The range of responses for growth over the past two years was much smaller, varying from a 5% drop to a 10% gain.

For 1993 to 1995, the respondents' forecasts ranged from 0% to 16% growth per year.

A shift in the supply and demand for actuaries was a common reason among the respondents for the recent decline in the growth rate of employed trainees.

Eldon J. Klaasen, an actuary with The Wyatt Co., pointed out that "increased mechanization has diminished—temporarily—the utilization of trainee-level personnel."

Organizations are presently more in need of the professional analysis accomplished by CAS members than they are of the data preparation and basic analysis performed by trainees.

Also, one source from a rating bureau said, "The use of personal computers has decreased the need for beginning number crunchers and increased the need for analyses by experienced people."

In 1988, The Jobs Rated Almanac concluded that the actuarial profession was the occupation rated tops overall among the 250 vocations it reviewed. When asked if they believe this assessment was accurate in 1988, 75% of the respondents said yes and 25% answered no. When asked if they feel this assessment is currently accurate, only 37.5% answered yes, while 62.5% said no.

Those respondents who said the assessment was originally inaccurate disagreed mainly due to the rating for the "stress factor" related with the profession.

The Jobs Related Almanac rated the actuarial occupation as low-stress and some respondents disagreed with this conclusion.

In my Sept. 30, 1991, column I also disagreed with the Almanac's stress rating for actuaries. Those who differed with the Almanac's assessment also believed the study was biased in favor of inside office jobs.

Mr. Kist of Coopers & Lybrand stated, "I believe their assessment was based on a staff actuary at an insurance company that significantly underestimated the stress component associated with consulting. I believe (actuarial science) is a top occupation, but wonder where it would have placed with a different value associated with the stress component."

The majority of the respondents did not believe the assessment was accurate today. Several reasons were cited, including: increased competition; less job security; more frequent litigation; the recession; regulatory complexities; more pressure for performance; and a slow down in salary increases. All of these changes would argue for an increase in the stress level experienced by those in the profession.

One negative result of the Jobs Rated Almanac's top rating of the actuarial profession was the effect on students and career counselors. This produced a surge of students desiring to pursue a career in actuarial science.

Although some of the respondents feel the recession has somewhat dampened the demand for experienced actuaries, most also foresee a rebound in demand during the next few years.

Unfortunately, the demand for actuarial trainees leveled off just as those students were looking for jobs.

This fact is strongly supported by the survey results. Seven of the eight respondent's organizations had a significant drop in the job growth rate for actuarial trainees during the past two years compared with the 1980s. The one exception showed no growth during either of the two periods.

Fortunately for students currently looking toward a career in actuarial science, half the respondents claimed their organizations are expecting an increase in the number of trainees they expect to employ during the next two years. And, only one respondent expected a further reduction in the rate of growth in trainee positions.

Such growth in job openings, however, is small in comparison to the large number of students sitting for actuarial exams and hoping to obtain a trainee position. At present, there is a glut of students seeking to fill entry-level positions. BI

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This month's column on actuarial issues in the casualty field is written by Richard E. Sherman, president of Pacific Actuarial Resources (PAR) Excellence in Ashland, Ore. William J. Miner, an actuary with The Wyatt Co. in Chicago, answers actuarial questions in the benefits field. Susan M. Werner, director of risk management at Hardee's Food Systems Inc. in Rocky Mount, N.C., answers risk management questions. And Dennis J. Nirtaut, manager of employee benefits at Continental Bank Corp. in Chicago, answers questions on employee benefit plans.



Mr. Sherman

Mr. Sherman's next column will appear in August.

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

Health care benefits in the year 2000

Communicate now to help workers adapt to future change

By SALLY ROBERTS

ORLANDO—One of an employer's most important roles now is to begin communication and education efforts that will help employees understand the health benefit landscape in the year 2000, contends a risk manager.

RIMS REPORT

Communication and education are "absolutely essential," especially with respect to health care reform, said Millicent W. Workman, director of corporate risk management for Belz Enterprises in Memphis, Tenn. And employers must take "an active role now because there is no way in which communication will magically happen when health care reform occurs," she said.

Ms. Workman addressed the role of employers that plan to offer a benefit package in the year 2000 at the 1993 Risk & Insurance Management Society Inc. conference last week in Orlando.

"Employers need to change the way employees think about health care," she said.

For example, many employees seem to equate receiving more care with better care, she said. This perception must be addressed so employees understand that less care can be appropriate care. Managed care programs can help control health costs and utilization for employers and ensure that employees receive quality medical care, she noted.

Communication and education will also bring employers and employees to the same understanding of quality, she said. Employees see quality as easy access and short waiting lines, but employers are more concerned about cost containment and credentials, Ms. Workman said.

Employers must also educate their employees on preventive medicine, she said. "With all the advances in medical technology, we think we can live any way we want to and physicians fix us when we break. We must change this way of thinking." Employers "must make employees responsible and accountable for their own health."

For example, approximately 100,000 deaths occur each year from the abuse of alcohol, she said. An additional 400,000 Americans die each year as a result of their failure to use life-saving devices like seat belts, smoke detectors and disease-screening tests. Some of these deaths can be prevented if employers educate workers about good health habits, she said.

While questions remain about national health care reform, Ms. Workman predicted there will be universal health care with an employer mandate to provide some type of standard benefit package for employees.

Under a universal plan, all Americans will be guaranteed coverage, she said. To accomplish this, among other things, pre-existing medical condition exclusions will be eliminated and part-time employees may have to be covered, she said.

Under the standard package, employers will be required to provide the standard benefits or pay premiums to health insurance purchasing cooperatives that will in turn provide the standard benefits to the employees, Ms. Workman said.

An advantage to standard benefit packages is the positive effect on administrative costs, she said. Today, "20% of the health care budget is eaten up" by administrative costs. But while the standard benefit package will help decrease these costs, smaller employers that currently don't offer coverage will feel the bite of paying health care premiums for the first time, even if they have a tax subsidy, she said.

Coverage under the standard package will not be "cradle to grave," she predicted.

And employers that want to provide benefits most likely found outside the standard package, like dental, vision or chiropractic, will be able to do so, she said. Benefits provided outside the standard benefit package could be offered in a flexible benefit approach, which Ms. Workman said more employers will offer in the future.

She also said that these other benefits would address more child care needs in and out of the workplace.

Ms. Workman predicts that managed competition will be enacted as a health care reform measure.

Under managed competition, the concept of "centers of excellence" will become more prevalent among health plans, and health care outcomes will improve, she predicted. Centers of excellence programs typically involve contracts with premier hospitals that perform highly technical medical procedures at the highest level of quality.

In the year 2000, employers will have outcome data "on not only what saves lives, but what improves day-to-day life," Ms. Workman said. Employers will then be able to select providers based on performances because employers will get "a report card" every year, grading providers on price, quality and satisfaction, she said.

In the future, employers can also expect to continue paying the majority of the cost of employee health care coverage, Ms. Workman said. Employees will continue to contribute, but employers can expect to pay about 70%, she said.

Ms. Workman noted that even if health care reform were enacted tomorrow, it would be phased in over many years. "Reality doesn't happen that fast."

Robert L. Griffin, vp-group marketing for the southern group operations at The Prudential Insurance Co. of America in Atlanta also spoke at the session.

Joan E. Jacobson, vp of Johnson & Higgins of California in San Francisco, coordinated the session, and Jeffrey W. Pettegrew, director of risk management and insurance for Western Temporary Services in Walnut Creek, Calif., moderated the session. BI

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Trying to find hard data to chart wellness savings

Plans' impact can be shown: Experts

By NANCY P. JOHNSON

ORLANDO—Wellness programs are a great idea, but can they really save employers money on health costs?

RIMS REPORT

Yes and no, two wellness plan experts said at the 1993 Risk & Insurance Management Society Inc. conference last week.

Although formal studies on true cost savings due solely to wellness plans are rare, companies can use their own claims data to set wellness targets and to verify cost savings, the experts agree.

Cost data is easily determined if companies focus on specific diagnoses, they add.

Many benefit managers—as well as a company's top management—are skeptical of wellness programs' ability to trim health care costs, said Dr. Jeffrey S. Harris, principal and Western regional practice leader of the health strategies group at Alexander & Alexander Consulting Group Inc. in San Francisco.

This skepticism is due in part to the scarcity of formal studies using strict controls on the long-term savings of wellness programs, he said. While top management generally wants hard figures on projected savings before giving the go-ahead to new programs, most wellness studies are inconclusive about savings.

In fact, 41% of employers said they were "not sure" their health promotion activities are effective in improving employee health or containing costs, according to a 1992 survey conducted by Hewitt Associates (*BI*, Feb. 17, 1992).

According to Dr. Harris, making cost comparisons in wellness programs is difficult because:

- Wellness plans generally are not set up to accurately record employee utilization.
- Over time, participants' behaviors may also be affected by other aspects of society.
- Wellness studies tend to be short-term—five years or less in duration—while about 10 years is needed to accurately measure behavioral changes.

However, said Dr. Harris, a reduction in total costs can be seen over time if specific diagnoses are targeted. For example, if smoking cessation is targeted in an employee population, this should have an immediate impact on smoking-related conditions like premature births.

Several legal pitfalls should be avoided when collecting and analyzing employee health data.

Medical data should be coded so that specific medical conditions cannot be traced to individual employees, he warned. "You don't want to know who has certain conditions, like HIV or cancer." Once it is proved that an employer had the knowledge, that company is open for discrimination suits, he said.

Some employers are concerned that adopting a wellness plan with penalties for certain health risks—like weight problems or smoking habits—may open the door to even more discrimination suits under the Americans with Disabilities Act, said Dr. Harris.

Exposure to such suits generally can be avoided if physical examinations and health questionnaires are voluntary, he said.

Sometimes employees or employee groups raise questions of a wellness plan's fairness.

"For example, is it right for smokers to pay double the health premiums of non-smokers," if smokers' actual health costs don't reach that proportion, asked Dr. Harris.

This is sometimes brought up as an ADA discrimination concern, but if employers can prove

Continued on next page

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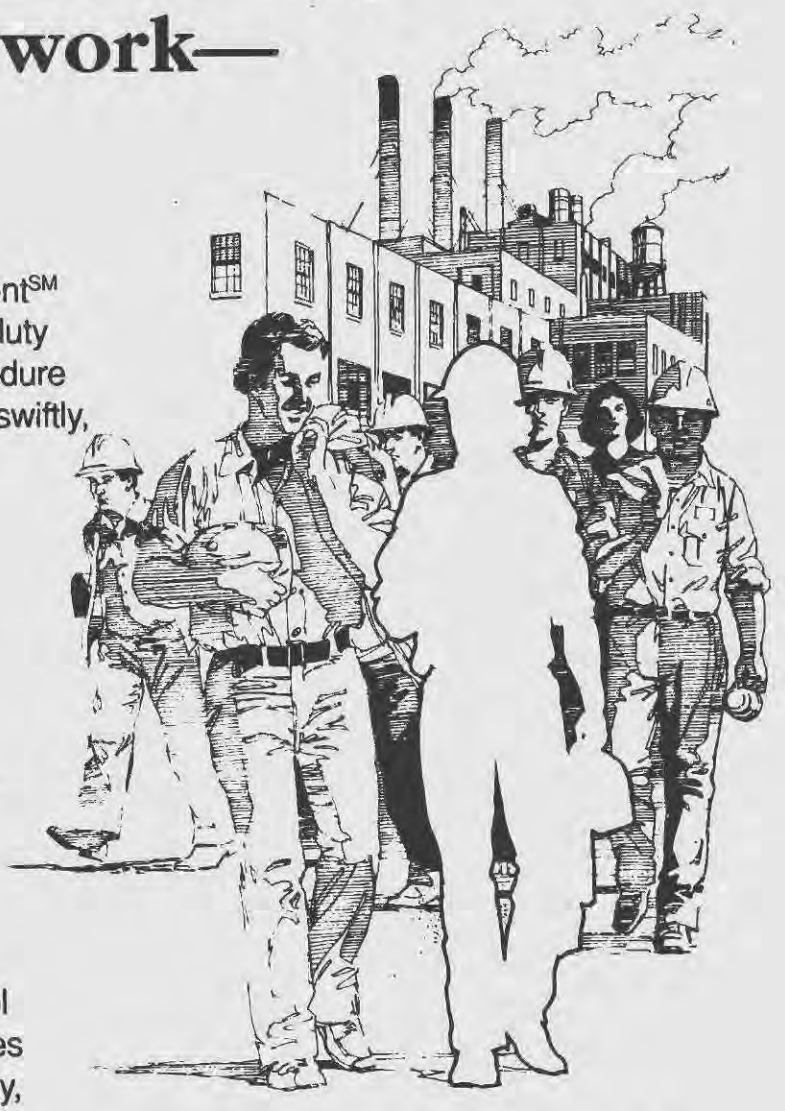
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Wellness plans

Continued from previous page

a certain group costs the plan that much more, the employers are protected, he said.

Costs also become an issue when wellness plan designers try to determine how much of a financial incentive is needed to modify employee behavior.

Modest financial incentives don't do the trick, said Dr. Harris. For example, studies show that employers need to offer at least a 25% discount in health care costs to make people change their behavior, he said.

But, incentives aren't the whole plan, said Lynn Gilfillan, community wellness coordinator for Adolph Coors Co.

Financial incentives are only one way to stress the importance of healthy living, she asserted.

The Golden, Colo.-based brewer has taken a personal interest in employee health since the turn of the century, when it began sponsoring company picnics, softball games and ice skating outings.

But, today Coors is well-known for its comprehensive wellness program, which began with an on-site exercise facility in 1981 (*BI*, Feb. 17, 1992).

Coors' wellness program includes classes in improving self-esteem, stress management, smoking cessation and nutrition. Cafeterias offer healthy food choices, and an on-site medical facility provides medical and dental services for little or no cost. The medical facility serves 5,500 employees, using four full-time medical professionals and 50 contracted professionals, on a budget of about $900,000 per year, she said.

To counter arguments that wellness costs can't be measured, Ms. Gilfillan came armed with actual cost savings from several in-house programs:

- Coors' cardiac rehabilitation plan, which involves job-site analysis, exercise and a phased return-to-work program for employees who have heart problems, costs $619 per person. The same rehabilitation program performed by an outside vendor would cost $2,076, she said.

Disabled employees used to take about seven months to return to work, primarily because of Coors' leave policy—six months with full pay, she said. But, under the cardiac rehab program, return-to-work time is reduced to about five weeks, with no evidence that outcomes are negatively affected, she said.

- A work conditioning program, which uses exercise to gradually prepare injured laborers for return to work, costs $560 per person. The same treatment performed outside the company would cost $2,150, she said.
- Under a voluntary mammogram program, early detection of breast cancer results in medical treatment costing about $7,000 per patient, compared with $140,000 per patient if detection of cancer is late, she said.

Responding to questions from the audience, Ms. Gilfillan noted that not all aspects of wellness programs are easily measurable.

Any connection between Coors' wellness program and improved morale is slim, she said. Although she has anecdotal evidence of improved morale—such as one woman who reported a much-improved life after she sought counseling to handle her teen-agers—attendance at exercise facilities dropped noticeably just after an employee cutback that had caused morale to plummet, she said.

Likewise, it is difficult to measure the success of efforts to reduce absenteeism, much of which may be caused by sick children rather than employees, she said.

And, absenteeism is strongly affected by corporate culture, said Dr. Harris, who added that one organization he worked with allowed employees 10 sick days per year. Employees tended to take them all until a stricter standard was imposed. Average sick days then dropped to fewer than three per employee per year, he said.

The session was coordinated by W. Lee Carter III, director-research and development at Alexander & Alexander Inc. in Dallas. The moderator was Donald MacMeekin, corporate risk manager-Cinemark USA Inc. in Dallas. BI

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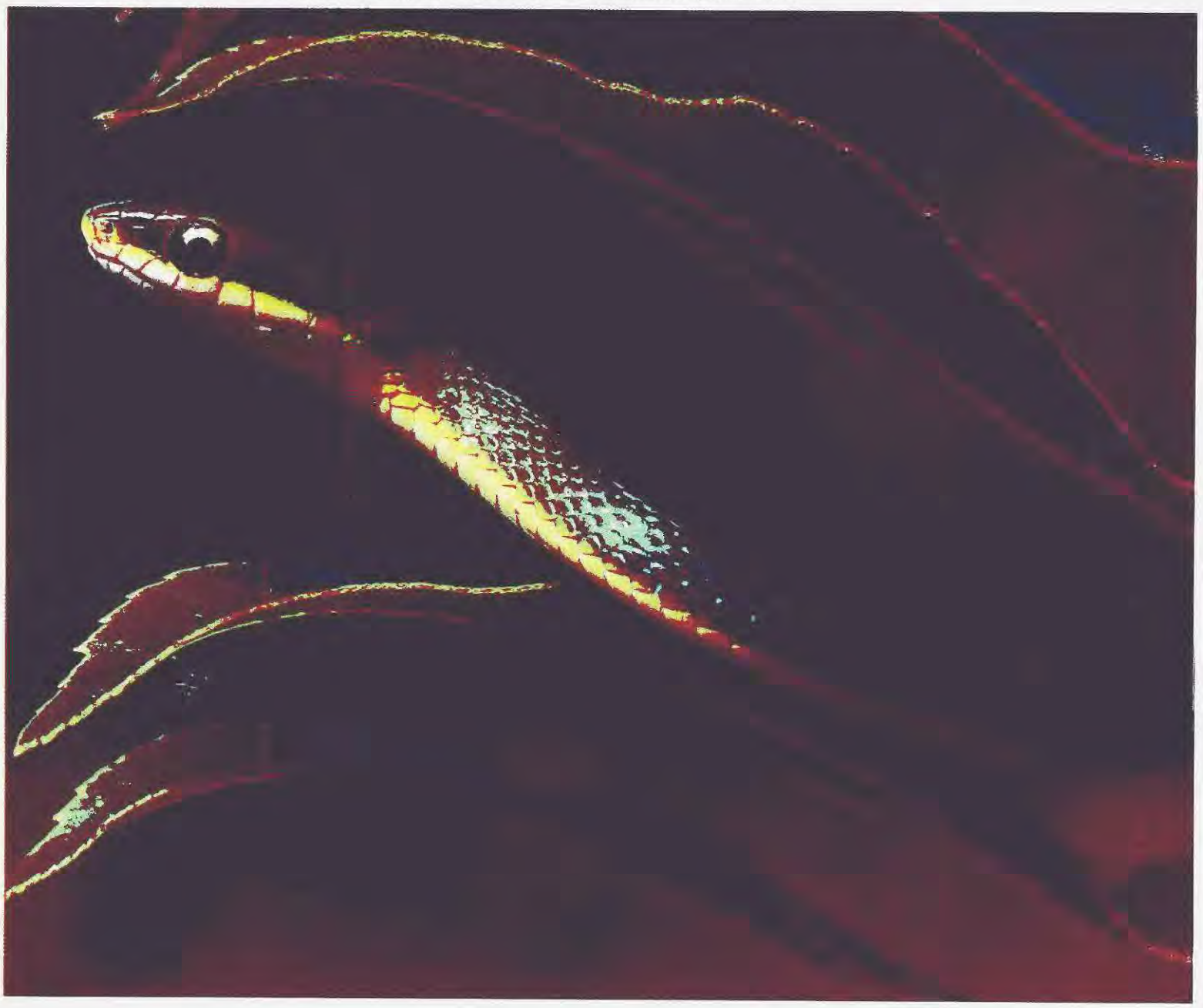
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By NANCY P. JOHNSON

RIMS REPORT

ORLANDO—Point-of-service plans are more than a successful way to ease employees into managed care—the programs also deliver measurable health cost savings, according to a corporate personnel director.

A point-of-service plan implemented in January 1992 has reduced Kaiser Aluminum & Chemical Corp.'s medical costs for covered employees by 15%, said Jim McKnight, corporate personnel director for the Oakland, Calif.-based company.

Speaking at the 1993 Risk & Insurance Management Society Inc. conference last week in Orlando, Mr. McKnight described his company's adoption of a point-of-service plan in a health care program centered around insured indemnity plans.

It was a harrowing time for Mr. McKnight, who said that six months before the Jan. 1, 1992, deadline for the switch, he changed benefit consultants and his group insurance manager quit.

"Talk about feeling alone," he said, to sympathetic chuckles from the audience.

Mr. McKnight's challenges didn't end there.

He had to deal with steelworker unions that resisted changes to Kaiser's traditional fully paid indemnity plan. "Employees expected that they could take rich benefits for granted," he said.

And, the company's workforce had been reduced in recent years to 6,000 from 27,000 in the mid-1980s, he said.

Meanwhile, Kaiser retirees numbered 12,000—two retirees per active employee. The average at most companies is one retiree for two or three active employees, according to Mr. McKnight.

Kaiser began considering a change in health care benefits about four years ago, mostly because of concern about national medical cost trends, rather than big increases in Kaiser's own medical costs, he said.

The company settled on a POS plan, in which employees are enrolled in networks similar to health maintenance organizations but can opt to receive services from non-network providers at reduced benefit levels. Claims for services rendered by network providers and non-network providers are administered by a single source, usually a health insurer. This system allows employees to choose a network provider or a non-network provider at the point the service is needed.

Kaiser employees have a 20% copayment under its indemnity plans. Under the new point-of-service plan, the copayment is halved to 10% when using network services, but rises to 30% for non-network expenses.

Now, after a year of POS experience, Kaiser is evaluating the plan, which is provided by Metropolitan Life Insurance Co.

While Kaiser had hoped most employees would be in the POS plan, the figure was 27% after one year, said Mr. McKnight. The remaining employees are in HMOs and indemnity plans.

But the financial results are better than expected, he said. For example, Kaiser had hoped that costs under the POS plan would be between 8% and 10% less than projected 1992 costs if the POS plan had not been implemented.

But, the POS plan costs were actually 15% less, he said.

And, while the company had

Continued on next page

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Continued from previous page
no specific targets for a lower medical trend, the vendor guaranteed a limit on cost increases of 15% per year for two years.

The point-of-service plan reduced Kaiser's medical costs by 15% for active and retired employees under age 65, he said.

It took a lot of work to research and implement the POS plan, said Mr. McKnight.

First, he had to determine the company's health care goals for its considerable number of retirees and union workers.

Communicating a change in benefits, especially to these two groups, was a nightmare, he said. "We found that due to our union contract and different obligations to various retiree groups, we had 32 versions of the new medical program," he said.

"Try to get the union involved up front," he advised. "They must understand the problem of health care costs and understand that managed care is not a threat to their benefits." Kaiser used the approach that the point-of-service plan was not a change in benefits, but rather a change in the delivery system, he said.

It was helpful to communicate early and frequently with union groups, he said. And, "you can't do too much communicating" with retirees, because the company has no face-to-face contact with them.

Mr. McKnight decided to switch benefit consultants in midstream because in his opinion the firm did not have sufficient experience in POS plans, he said.

After performing implementation studies, the employer should make a careful choice of vendors, said Eileen Raney, partner and West Coast director of integrated health benefits at Deloitte & Touche in Los Angeles. Deloitte & Touche is currently working with Kaiser on the aluminum producer's point-of-service plan.

A POS vendor should cost 15% less than a preferred provider organization, and cost inflation should be 8% to 12% less than that of a PPO, said Ms. Raney, who also coordinated the session.

Almost all the big insurers and HMOs say they have POS plans, but "I don't think they all meet the key characteristics," she said. The most effective POS plans reimburse providers on a capitated—not fee for service—basis, she said.

Companies should also avoid vendors that lease providers from other networks, she advised. This leads to blurred areas of responsibility and reduced quality control, she said.

Ms. Raney advised the following steps in selecting a point-of-service plan vendor:

- Pre-screen available organizations based on your performance goals.
- Limit the number of proposals you will consider.
- Develop qualitative selection criteria.
- Design bid specifications that can be quantitatively evaluated. Kaiser evaluated its bids with the help of Deloitte & Touche and a union representative, she said.
- Conduct comparative analyses of responses.
- Hold prebid meetings and bidders' conferences so that vendors can get to know your goals.
- Make on-site visits to vendors. "A vendor can say anything—on paper," she noted, adding that Deloitte & Touche asks to analyze 40 claims before a vendor is selected. "Reject offers to show claims (administration) demonstrations," she advised.

Make reference checks only to vendors that were let go by employers. "I get a lot of useful information that way," said Ms. Raney, who added that reference checks from current clients are "useless."

- Forbid vendors to bring salespeople to bid meetings, and limit the sales presentation to 10 minutes, she advised.
- Most importantly, negotiate all critical issues before awarding the contract, she said, adding that Kaiser negotiated three-year trend and rate guarantees with its vendor, Met Life.

The union must 'understand the problem of health care costs,' says Jim McKnight.

For example, Kaiser required patient-satisfaction surveys, outcome measurement and a study of provider practice patterns, she said.

Kaiser also negotiated standards for the provider network, like availability of doctor appointments, limits on distance to providers and provider selection and credentialing standards. "These areas have a lot to do with what employees think of the network," said Mr. McKnight.

Also, it is important to agree with the vendor on claims processing procedures and standards. For example, "claims accuracy" may mean one thing to your vendor and another thing to your company, Ms. Raney said.

It's important to find out how employees feel about the new plan, said Mr. McKnight. Kaiser employees were surveyed by an independent company one year after the POS program began, and the study showed that most employees are generally satisfied with the plan's doctors and hospitals.

But, they are generally unhappy with customer service.

"It's difficult to measure how much discontent is really due to customer service" and how much is due to the upset over the change from total freedom of choice to managed care, he said. "This is an area we plan to work on," he said. BI



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Health claims data

Continued from page 3

those of other organizations, but also how to predict potential claims experience. However, it doesn't necessarily prepare employers for single-incidence catastrophic events, like neonatal claims, transplant claims or severe mental health claims, he pointed out.

Being alert to employee needs can help mitigate some catastrophic claims, especially mental health claims. Employers should be aware, for example, how many employees and dependents are or have been in a state of crisis during the last year, Mr. Daddona suggested. "If you don't know about it, you can't design a plan to address it."

Employers also should try to assess what causes employee absences and how much of the mental health budget goes for dependents.

Through data analysis, Mobil determined prescription drug costs were rising faster than its costs in any other area. So the company decided to put in a managed mail order prescription drug program. "It's important to us because the number of retirees is increasing rapidly and their use of maintenance drugs is heavy."

Mobil also instituted a retail discount pharmacy program. Drug utilization has been monitored since the programs were established in 1987 so Mobil can understand and measure the impact of the programs.

The company also established a center of excellence program for organ transplants after analyzing its claims data. "Transplants are no longer considered experimental and we have to cover them, so we need to manage them. We put in the network and employees realize if they use it the odds of their surviving a transplant will increase. It's not a cost containment tool," he said.

Mobil also implemented an employee assistance program after analyzing its mental health claims data. He credits the program with cutting inpatient psychiatric admissions and lengths of stay.

Mobil also has identified problems that are primarily lifestyle-driven in certain geographic locations. "That has serious implications for prevention and health promotion programs. The data is hard evidence that will persuade management to put in these types of programs," he said.

Health claims data has uses beyond benefit plan design. It can also can help employers explain to management and rank-and-file employees the reason behind cost increases.

"We are constantly asking employees for more money to pay for health care, but doing so implies increased ownership of the plan," he said. "So you have to report what's going on to the owners. Now we usually explain plan changes in terms of health claims data."

Employers also should share health plan data analysis with consultants, administrators and managed care companies. "We are all involved in managed care operations, but if they don't have the benefit of seeing your data, you can't tell them the impact of their services," Mr. Daddona said.

Health plan data can also help companies control utilization.

"Utilization management is the starting point for cost management," said Kenneth LaPensee, director of health strategies data services for Alexander & Alexander Consulting Group Inc. in Lyndhurst, N.J.

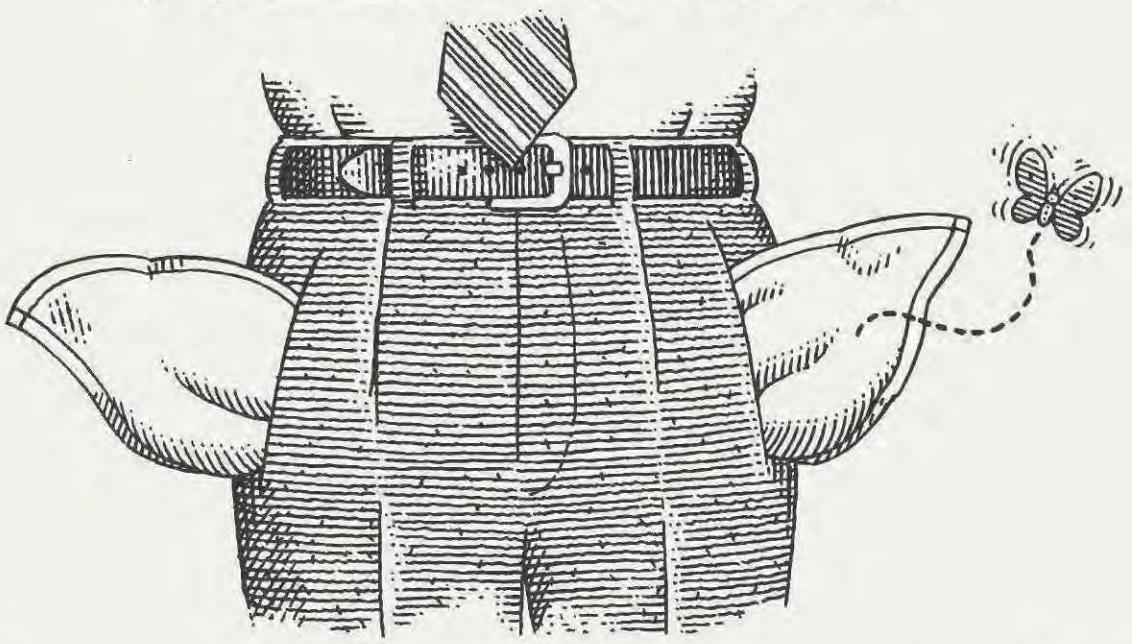
Employers should attempt to curb utilization over time if they want to control costs, he advised. As new medical services become available, utilization will increase initially, he said. "But once people are familiar with those services and the novelty wears off, the pressure for utilization should fade or stabilize at new level," he said.

Also, utilization of medical services that have been replaced by newer, more technologically advanced services should logically decrease when the new procedures are introduced, Mr. LaPensee said. "But unfortunately it never does," he noted.

Medical technology assessment in the United States needs to improve, he said. Although utilization management is important, it is also expensive, he added.

Thomas Seuntjens, director of corporate risk management and group insurance for Honeywell Inc. in Minneapolis moderated the session. W. Lee Carter III, director of research and development for Alexander & Alexander Inc. in Dallas was the coordinator. BI

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ADA's first year no boon for disabled

Discharged workers filed most claims

By MICHAEL SCHACHNER

ORLANDO-When the Americans with Disabilities Act went into effect more than a year ago, Congress intended for it to bring disabled persons into the mainstream of employment.

RIMS REPORT

However, except for a few companies modifying entryways to their buildings or changing the wording of their job applications, the ADA for all its good intentions has not accomplished what its authors had hoped, according to a risk and benefits manager.

"The ADA was Congress' mandate for employers to immediately absorb the disabled into the mainstream of employment. But so far, it hasn't worked," said James E. Crockett, manager of risk and benefits with the Denver Water Authority in Denver.

While acknowledging that the ADA is an aggressive document that employers must adhere to or risk facing legal repercussions from the Equal Employment Opportunity Commission, Mr. Crockett labeled the ADA a "boondoggle so far."

"What was intended as a law to protect disabled job applicants from discrimination has been used predominantly by angry discharged employees who had already been hired," he said.

Speaking at a session at the 1993 Risk & Insurance Management Society Inc. conference last week, Mr. Crockett said that during the first year of the ADA, 3,358 specific complaints were filed with the EEOC citing ADA violations by employers. But more than 50% of those complaints were submitted by discharged workers.

While the majority of ADA complaints have stemmed from discharged employees, approximately 20% of complaints filed in 1992 alleged that employers failed to reasonably accommodate disabled workers, which is a key requirement of the ADA.

In addition, hiring violations were the basis of about 15% of ADA-related complaints last year, while harassment was cited in 9% of complaints and unwarranted discipline was alleged in 7% of the more than 3,000 complaints filed in 1992.

Also contributing to Mr. Crockett's assessment that the ADA is off to a slow start is the fact that fewer than 10% of the complaints filed last year were investigated by the EEOC.

"The biggest problem for employers is that if an ADA case goes to court, it will be heard by a jury, and we all know that juries in these cases are not overly sympathetic to employers," said Mr. Crockett.

Indeed, of the 308 ADA cases acted upon by the EEOC last year, 50% were decided in favor of the employee filing the complaint. In comparison, in only 17% of these cases did the employer's argument hold up.

Other cases were either dropped or settled.

Thus, while Mr. Crockett predicted that it may take another three to five years before the United States fully feels the impact of the ADA, employers must still make an honest effort to comply with the law.

Specifically, employers must make a reasonable effort to accommodate disabled employees.

"As employers, we are now required to manage employee disabilities. There are many questions of interpretation surrounding the ADA, but the one thing that is clear is that employers have to ensure that reasonable accommodations are made. By 'reasonable' I mean whether the company can afford it," he said.

Examples of reasonable accommodations include:

- Restructuring facilities so they are accessible to the disabled.
- Allowing disabled personnel to move to another job in the company at equal pay.
- Modifying equipment so it can be handled by a disabled person.
- Offering a part-time or modified work schedule so that an employee can leave for physical or mental therapy.

"You have to accommodate if it doesn't impose an undue hardship. For employers, hardship is all dollars and cents. A $100 million company will have a more difficult time trying to prove that accommodating someone was financially unreasonable than would a small company. Undue hardship is a gray area," said Mr. Crockett.

John G. Carlson, president of RHM Systems Inc., a consulting firm in Marlboro, Mass., also spoke at the session and emphasized that even though the ADA stumbled out of the starting blocks, it is now a pillar of U.S. employment standards.

"Probably 10% to 15% of U.S. workers are functionally disabled today but are still doing their jobs. In addition, 30% of all working Americans will be disabled for at least 90 days sometime in their life.

"Combine that with the fact that advanced medical technology is helping people survive what had been deadly conditions like cancer, brain injuries and heart disease, and the ADA is coming at us from all directions," Mr. Carlson said.

To improve working conditions for the growing number of disabled workers, employers need to change their attitudes about the changes they implement.

"If you change an employee's job or location to comply with the ADA, don't look at it as accommodation, which implies a negative, but look at it as support, which connotes something positive," he said.

Mr. Carlson advised employers concerned with ADA compliance to focus on recruitment practices, building accessibility, improving work stations, enhancing hiring practices and training line supervisors and upper management.

"ADA training has to be worked into supervisory training, and it should be done at a level greater than just posting fliers," he said.

Mr. Crockett coordinated and moderated the session. BI

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Flexible communications key to flex plans

Corporate culture decides best approach

By MICHAEL BRADFORD

ORLANDO—Tailor-made communications programs will give flexible benefit plans the best chances for success.

Not all companies will try to sell employees on flex plans the same way, according to Marcy Rubenstein Lehman, an associate with William M. Mercer Inc. in Seattle.

"There's really no magical or universal approach to putting in flex communications. What may be appropriate for one organization probably won't work for another organization," Ms. Lehman said during a session at the 1993 Risk & Insurance Management Society Inc. conference last week in Orlando.

"There really isn't one boilerplate that works for a company," agreed Karen Feltes, benefits planning manager at Microsoft Corp. in Redmond, Wash. "We were fascinated to find out that Microsoft is really off the scale as far as what works for other companies."

Microsoft is putting the final touches on a flex plan for its U.S. employees.

"The key to a successful flex campaign is that it's tailor-made, that it meets the needs of the workforce," said Ms. Lehman.

Developing a program to convince employees that a flex plan is in their best interest involves several strategic moves, according to Ms. Lehman:

- Identify the objectives of a communications campaign "up front so you can meet those objectives throughout the campaign."
- Identify internal and external audiences and the types of messages they need to hear.
- Determine what types of media are needed to deliver the communications to the workforce and what resources are available to deliver the messages. "Does your organization have a corporate communications department that could help? . . .Do you have people that could help put together interactive technologies?" Ms. Lehman asked.
- Develop a timeline that includes "realistic target dates for all the components that will bring together a very successful campaign." Ms. Lehman said, "For example, put together a timeline that will indicate when all the copy has to be written, when the graphics designers have to be done with the art."

Microsoft Corp. identified the objectives it wanted to accomplish with a flex plan and then effectively communicated those goals to its employees.

Rapidly rising medical costs and a workforce that was growing older and more diverse were reasons Microsoft decided to implement a flex plan, according to Ms. Feltes.

In its research, Microsoft started with an employee survey regarding benefit offerings, Ms. Feltes pointed out. Employees were asked what they liked and disliked about their current plan and what they would like to see changed.

Microsoft ran concurrent focus group sessions that allowed employees to comment on their benefit plan likes and dislikes, she said.

Top managers' views were also solicited.

"We found that employees really liked the idea of flexibility and choice," Ms. Feltes remarked. "They were very excited about that because they wanted to trade some benefits for others that were more important to them."

An example, she noted, was that Microsoft found only about 30% of its workforce was taking advantage of the use of a health club the company offered as a benefit.

The other 70% of the workforce felt that the club was not a useful benefit, Ms. Feltes noted, "and they really liked the idea of being able to trade" the value of that benefit for another.

Ms. Feltes stressed that no matter how good a plan is, "if you do not communicate it well, people are not going to know what is offered to them."

Interestingly, Microsoft's computer literate workforce preferred hard copy communications, at least initially, according to Ms. Feltes.

"They particularly like hard copy when they are learning information," she noted. Employees indicated that they would like to be able to access benefit plan information through their computers after they became familiar with changes that were planned.

"They also liked the idea of small group meetings, where they could get their questions answered" Ms. Feltes said.

Microsoft employees also made it clear that they didn't want a lot of money spent on communications.

"The one thing we heard over and over," Ms. Feltes said, was " 'We don't want a flashy package. Please don't put a lot of money into building this communication package.' They wanted something that was simple, yet intelligent and smart."

Ms. Feltes said one of the fundamentals for a successful flexible benefit plan is to provide a core level of benefits that employees must accept.

In Microsoft's case, employees were given a basic benefit package and could then pick and choose among other offerings.

The core package of benefits was required because there was a concern that employees would opt for cash instead of medical coverage and be left without benefits in the event of an illness or injury, Ms. Feltes said.

"They can go down to a base level," she noted, but workers can't leave themselves without benefits.

Microsoft employees also asked for a "leave-me-alone button," Ms. Feltes said.

That option gave workers the ability to postpone their decisions regarding a flex plan.

While many employees said it would allow them time to make up their minds about benefit offerings, "the real reason for this leave—me-alone button was suspicion," said Ms. Feltes. "The employee population was very suspicious that if you're changing benefits, especially if you're putting in a flex program, that you're really going to start shifting costs over to them."

However, Ms. Feltes said, Microsoft is not shifting costs and will continue through its flex program to pay 100% of employees' health care premiums.

Thomas K. Sundell, principal with William M. Mercer in Deerfield, Ill., also participated in the panel discussion.

The panel moderator was Leslie Peterson, benefits administrator at Microsoft. The coordinator was Thomas C. Pursley, a principal with William M. Mercer. BI

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Workers comp costs

Continued from page 3

employer determine which workers compensation cases are potentially catastrophic and therefore good candidates for referral to specialist care and/or case management, pointed out Michelle Patton, risk management director for Mervyn's, a division of Dayton Hudson Corp., in Hayward, Calif.

"It is our feeling at Mervyn's that if the employee needs a specialist, we should get them there right away," she said. After three weeks, Mervyn's looks at the treatment and evaluates the worker's need for a specialist.

Employee participation in the medical bill audit process can further reduce costs by making injured workers feel that their employer cares they are getting the best quality treatment, she added.

But the savings achieved through medical bill review "is not the heart of the matter," Mr. Cone cautioned. "The heart of the matter is the information that comes from the bill review process."

Bill review can also be used to pre-screen the providers that an employer wants to include in a workers comp preferred provider network.

'The heart of the matter is the information that comes from the bill review process,' says Mr. Cone.

And, after the network is up and running, medical bill review serves as a check on those providers' performance, Mr. Cone added.

"You want to make certain that they are billing consistent with whatever the arrangement is, whether it's a fee schedule for industrial work or a contracted rate for group health," he said. "You can use bill review as a mechanism for managing the network."

For example, the provider who bills employers for 30 office visits to treat chronic back pain would likely be eliminated from a network if the average was 15 visits.

Indeed, Ms. Patton said that she has used medical bill review on occasion to eliminate providers found to be consistently overmedicating.

Additional savings can be reaped by automating bill payment and review systems, Mr. Cone said.

And using the same claims administrator and bill review firm to audit both group health and workers comp medical claims can eliminate duplication, he added.

Up to 5% of workers comp medical payments may be duplicated on the group health side, either through fraudulent double-dipping or clerical errors, Mr. Cone said.

It also allows the employer to determine which providers are providing mostly group health services vs. workers comp services and vice-versa, as well as "how much that physician is getting from you on a monthly basis," he said.

The session was coordinated by Becher & Carlson's Mr. Myers and moderated by Mervyn's Ms. Patton. BI

Oregon employer

Continued from page 1

our own program."

While more employers are striking deals on their own, it's too early to call such action a "trend," said Larry Craven, a principal with William M. Mercer Inc. in Portland who helped Precision Castparts craft its deal. But, "there is a growing awareness among employers because a lot of them are skeptical that Clinton's plan will save money."

"By the time they get around to doing all the things they are talking about, our three-year contract will probably be up," Mr. Marvin said. "We don't hold high hopes for federal government reform, which is why when (the managed competition) proposal came out, we didn't say 'Let's wait and see.' We did what we felt would be good for us."

The new agreement between Precision Castparts and Legacy calls for a 10% decrease in the per capita amount the company spent on employee health care in 1992. Mr. Marvin would not disclose the costs.

In addition, the hospital system agreed not to increase the per-capita fee during the three-year contract term.

To guard against under-treating patients, Precision Castparts required Legacy to establish a joint dispute resolution program for patients who feel they have been short-changed, Mr. Marvin said.

Legacy also agreed to implement an outcomes measurement system approved by Precision Castparts, so both parties can measure how effectively employees and dependents are being treated.

"We are trying to make Legacy treat health care as something other than a revenue source," Mr. Craven explained. "We don't want them to monitor their success with patients based on conventional pricing, but on how patients' health improves.

"The intent is to measure employees' health status somewhat scientifically through a physician-administered questionnaire," he said. "We want to get a rating of patients' health status early in the contract term and then monitor their improvement."

Mr. Craven stressed that all parties have to be partners in the health assessment and outcomes measurement effort. "The employer has to foster health improvement, the provider has to make services available and employees have to participate."

Precision Castparts will distribute information on health improvement and design incentives to get employees into programs like smoking cessation and weight management classes, Mr. Marvin said.

"Our feeling is that if patient outcomes are satisfactory and we get employees to participate in wellness programs, our health care costs will go down," he said. Attendance might also improve, which would save more money, he noted.

The agreement also calls for joint sharing of all data, except patient medical records. Access to the data will enable company officials to track the cost of procedures and physician treatment patterns so they can identify expensive physicians or those that frequently refer patients to costly specialists.

Under the company's new health care benefit plan, effective April 1, all employees and their dependents must choose a primary care physician. That doctor is responsible for providing all care to the patients and for referring them to specialists when needed.

The company will pay only for services from that primary physician or a doctor approved by the primary physician.

Single employees are not required to contribute to the new plan. Employees with one dependent pay a monthly fee of $25, while employees with two dependents or more pay $50 per month. All employees pay $10 per physician office visit and a modest amount for prescription drugs: $10 per prescription at local pharmacies and $5 per prescription through a mail-order program.

Legacy encouraged Precision Castparts to establish modest employee copayments, Mr. Marvin said.

"It's important for the employee to have an economic interest in going to the doctor. For those that budget closely, that $10 will be meaningful to them," he explained.

Telling employees their choice of doctors was limited was not easy, Mr. Marvin acknowledged. Last time the company made a significant benefit plan change—dropping a health maintenance organization—it ran into some problems.

"We didn't really consult our workforce about it and that nearly resulted in a revolt," Mr. Marvin recalled.

To avoid that reaction, Precision Castparts formed an Employee Benefit Involvement Team, he said. The EBIT—made up of employee representatives—meets periodically and receives training on benefit issues from the company's benefit consultants, attorneys and human resource staff.

The team was very involved in the creation of the new benefit plan and it was responsible for carrying information about the plan to the general workforce, Mr. Marvin said.

"There was some initial resistance because the change did require a fair number of employees to change primary care physicians," he noted. "But what made it easier was our CEO and I both had to change primary care physicians, too. So we weren't asking the workforce to do something management didn't have to do."

Employees aren't the only ones with an economic interest in the program, though. Because Legacy is providing care to employees for a fixed fee, it is on the hook if the cost of that care surpasses the per capita amount established by the two parties.

To help it control utilization and improve cost-effectiveness, Legacy will provide a 24-hour, toll-free telephone "consumer health care information service."

Employees can call the Personal Health Advisor line seven days a week to discuss their symptoms with registered nurses. The nurses cannot provide diagnoses, but they can help employees and dependents decide whether it is necessary to see a physician. The phone service also will provide general health education information.

The phone line will help improve consumer decision-making and "appropriately manage demand for health care services," said Robert Pallari, senior vp for Access Health Marketing Inc., the company supplying the phone service.

The phone service was one reason Precision Castparts chose to contract with Legacy rather than two other local hospital systems that also bid for the company's business.

Local market conditions helped Precision Castparts strike such a lucrative deal, Mr. Craven said.

"There are certain situations that make it easier, like a concentration of employees in an area where there is a competitive health care market."

But other employers can achieve similar arrangements.

"The significant thing to do is to bring the providers and employers together and not have everything filter through third parties," he said. "An empathetic provider system is very helpful," Mr. Marvin said. BI

Con Ed charges insurer failed to pay settlement

By DOUGLAS McLEOD

NEW YORK—Consolidated Edison Co. of New York Inc. is pressing a bad faith lawsuit against Commercial Union Insurance Co., charging that the insurer breached a settlement agreement covering asbestos defense cost claims.

Con Ed filed the suit in U.S. District Court in New York last month, nearly a year after it settled litigation with Boston-based Commercial Union over coverage of defense costs and expenses incurred in asbestos personal injury cases.

Commercial Union agreed to pay a portion of Con Ed's defense costs, but the insurer has since refused to reimburse Con Ed, delaying payment with repeated demands for documentation, the suit charges.

The lawsuit also goes beyond Con Ed's own claims, charging that Commercial Union's behavior toward the utility is part of a pattern of bad faith in asbestos coverage litigation that dates back to the 1970s.

In addition to $642,864 in compensatory damages, Con Ed seeks an unspecified amount of punitive damages for Commercial Union's alleged bad faith breach of the agreement.

Commercial Union has not yet filed an answer to the complaint, and Commercial Union officials declined to comment on the suit.

Employers Liability Assurance Corp. Ltd., a Commercial Union affiliate, wrote comprehensive general liability policies covering construction of Con Ed's Indian Point No. 2 and No. 3 generating plants between 1966 and 1976, according to the suit.

Starting in 1987, Con Ed was named as a defendant in more than 1,900 asbestos personal injury and wrongful death suits arising from alleged exposure to asbestos at sites owned or operated by the utility, court papers say.

Con Ed spent "considerable sums" settling asbestos cases and incurred heavy defense costs, the complaint says.

From 1988 until January 1991, Con Ed's defense costs were divided under an interim cost-sharing agreement. David Elkind, of Anderson, Kill, Olick & Oshinsky in Washington, who is representing Con Ed, declined to divulge details of the cost-sharing agreement.

After the agreement expired in January 1991, the utility filed a declaratory judgment action against Commercial Union, seeking a ruling that the insurer owed a duty to defend and indemnify it.

While the coverage case was pending, Con Ed paid its own defense costs and kept Commercial Union informed about the status of the asbestos cases, the suit says.

Con Ed and the insurer settled the coverage dispute in June 1992, with Commercial Union agreeing to cover a portion of the utility's defense and indemnity costs.

As of June 30, 1992, Con Ed had spent $2.3 million settling 348 asbestos cases filed in New York state court and had been dismissed as a defendant in joint federal asbestos litigation in the Eastern and Southern districts of New York, court papers say.

The coverage agreement called for Commercial Union to pay 20% of the $2.3 million in state court settlements and 20% of "verifiable, reasonable and necessary" defense costs from expiration of the cost-sharing agreement until June 30, 1992.

Defense cost reimbursements were to be made within 45 days after Commercial Union received Con Ed's invoices and supporting documentation. Con Ed sent a bill for $642,864 for 1991 defense costs to the insurer last July, along with 3,000 pages of supporting documents. It still has not been paid, the utility's latest complaint charges.

Instead, Commercial Union last August wrote to Con Ed seeking further documentation, much of which Con Ed says it had already provided.

Con Ed forwarded the information again in November, including an hourly analysis of time spent by the utility's outside lawyers, the suit says.

The next month, Commercial Union again refused the reimbursement request and asked to review all of Con Ed's files on the asbestos cases, including expense records, pleadings, legal briefs and correspondence, the suit says.

The two sides exchanged letters once more, with Commercial Union in February repeating its demand to review the entire file.

The lawsuit charges that the insurer has breached the settlement agreement and engaged in unfair claims settlement practices by refusing to cover the legal bills.

In accusing Commercial Union of bad faith, Con Ed also argues that the insurer's actions fit a pattern of unjustified delays and denials of coverage that stretch back through unrelated asbestos cases over two decades.

In the 1970s, Commercial Union frequently argued that coverage in asbestos cases was triggered only if a claimant was exposed to asbestos during the policy period, the suit says.

Since about 1980, though, the insurer has switched to an argument that coverage is triggered only by manifestation of an asbestos-related disease during the policy period.

This shift in Commercial Union's strategy was based "not on its standard-form policy language, nor on basic principles of insurance coverage, but instead on economic considerations," the complaint charges.

The suit cites a March 1980 internal report in which Commercial Union officials calculated that the cost of settling asbestos claims using a manifestation trigger would be about $6 million, while settling on an exposure basis could cost the insurer nearly $80 million.

Commercial Union continues to argue that manifestation is the sole trigger of coverage despite the fact that it has litigated and lost on the issue in at least seven unrelated cases, the suit says.

"Commercial Union's unjustified breach of its settlement agreement with Con Edison is a continuation of Commercial Union's deceptive acts and practices. . .which are designed to delay or avoid payment for asbestos-related claims without regard to the merits of the claims," the complaint charges.

The suit seeks to treble Con Ed's $642,864 in damages under a New York law dealing with unfair claims settlement practices.

It also seeks an unspecified amount of punitive damages for bad faith. BI

Market turn may be only a subtle shift

By GAVIN SOUTER

NEW YORK—Don't bet on a rerun of the mid-1980s casualty market turn.

Financially hard-pressed and more sophisticated clients will not allow for a sharp change in rates, several experts agree.

Any change in prices will be gradual, and when it does come, insurance buyers should assess their options before they arrange coverage, experts say.

The market could turn any time between now or next year and beyond, the experts say.

"A lot of people are kidding themselves if they think that there is going to be change in the market that will bail out insurers," said Richard Napier, senior vp at General Reinsurance Corp. in Stamford, Conn.

Many casualty insurers were in fact bailed out by the sudden turn in 1985, but that is unlikely to happen again, he said at a conference called "Will 1993 See the Next Hard Market in Casualty Insurance" at the College of Insurance in New York.

"That happened once, but I don't think that we will get a second shot at it," Mr. Napier said.

Market conditions now are different from the early 1980s, and that too will mean that any change in the market will be different, said John Schumacher, senior vp at American Home Assurance Co. in New York.

"Things had gotten much worse in the early 1980s than they have in the early 1990s. The reversal in 1985 was so overdue that it became a rush," he said.

To some extent, the market is already hard and casualty insurers that cannot make a profit now should not be in the market, said Robert A. Kerekes, senior vp at Johnson & Higgins in New York.

Rate increases for specific risks and several senior management changes at insurance companies indicate that the market has already changed, he said.

"Rather than make price changes, companies are making changes at the top because they cannot allow their loss ratios to continue as they are," Mr. Kerekes said.

Today's risk managers have a deeper insight into how insurers work and they are making greater demands on insurers. Rather than compete on price, insurers will compete more on services, Mr. Kerekes said.

"Clients want carriers and brokers to manage their losses, and that is how the market is hardening," he said, adding that more clients are looking seriously at what services the insurers and brokers offer.

Clients are also limited in how much more they can pay for insurance by the constraints on their budgets, said John F. Gross, managing director of Marsh & McLennan Inc. in New York.

"Right now, I don't think that clients have much room to pay increases," he said.

The advertising industry in particular is going through a tough time at the moment, said James M. McGuire, director of risk management at Omnicom Group Inc. in New York.

"My particular industry is risk-averse and we have been going through a bad time for the past several years," he said.

Many advertising agencies would not be able to afford a large increase in insurance prices, Mr. McGuire said.

If prices do increase substantially, some smaller companies may have to bear more of their risks themselves, Mr. Gross said.

"Alternatives to insurance cost money, and smaller companies do not have that. That's why a lot went bare in the 1980s. Everybody from doctors to cab drivers," he said.

Risk managers should face up to the fact that higher casualty rates are inevitable, said Merritt W. Fabel, director in the corporate risk and insurance department at American International Group Inc.

"The more that risk managers realize that it is a numbers game and rates have to go up, and the more they can get their financial people to realize that, the better it will be for the company when rates change," Mr. Fabel said.

Risk managers should also seek to establish long-term relationships to avoid any sudden increases in rates, he said.

The timing of the turn in the market will depend on varying factors, the executives said.

The market is still waiting for an event to trigger a swing in the market, said Mr. Schumacher of American Home. "We are still waiting for an event or diminution in capacity," he said.

It could be a physical event like the Bhopal, India, disaster in the 1980s or it could be a regulation or accounting change, but it is yet to happen.

For the market to change significantly a large insurer will have to go bust, said Mr. Kerekes of J&H. "If we have major, major insolvency that affects a lot of clients, then that will create the swing," he said. BI

Major fallout in P/C market, insurance exec forecasts

By GAVIN SOUTER

NEW YORK—Half the property/casualty insurers now operating in the United States will disappear by the end of the century, an insurance executive predicts.

Current conditions in the market should eventually lead to firmer rates, but too many financially weak companies are in need of a sharp increase in prices that won't materialize, he says.

Survivors will come from all sectors of the market, but companies that remain will be well-reserved and have a clear vision of their place in the marketplace, he adds.

"By the end of the 1990s, half of the property/casualty insurers in the U.S. will be merged or broke," said Jeffrey W. Greenberg, executive vp at American International Group Inc. in New York.

In 1992, about 3,900 companies wrote property/casualty business in the United States, according to the New York-based Insurance Information Institute.

Poorly reserved companies will find that they are unable to continue to underwrite and will be "forced into the arms of large insurers," he predicted.

However, insurers can expect some respite from soft rates as the conditions in the market are ripe for a change in pricing, Mr. Greenberg said at a conference last month organized by The College of Insurance in New York.

Recent large catastrophe losses, low interest rates, rock-bottom commercial insurance rates, the current expansion of some surplus lines markets and higher catastrophe reinsurance rates all set the scene for a turn in the commercial property/casualty insurance market, he said.

But the next turn in the market will not mirror the last hard market of 1986, when liability insurance prices shot up and capacity became scarce for some risks.

"It seems clear that in the wake of the catastrophe losses last year, the property market is leading any hardening in the market," Mr. Greenberg said.

"But few people are predicting that a hardening in 1993 will be like the turn in 1986," he added.

After the market turned in the mid-'80s, many insurers took advantage of the situation and imposed much higher rates, which they thought they would be able to maintain permanently, Mr. Greenberg said.

However, commercial buyers fought back by turning to alternative risk financing arrangements, he said. "There were a lot of bruised people that came out of that cycle."

Insurers that are counting on the next turn in the cycle to bail them out of troubled financial situations will be disappointed, Mr. Greenberg said.

"Any turn in the market today will not be enough to make up the deficiencies some companies have had for many years," he said.

The weakness of some insurance companies became evident last year when 10 U.S. insurers were seized by regulators and several more required injections of capital to continue, Mr. Greenberg said.

Also, "$18 billion in insured losses just from hurricanes drained the industry of a lot of financial strength," he said. And the run of catastrophes has continued from 1992 into the first quarter of 1993, he observed.

"(Insurance) is not a healthy business right now for many people," he said.

The companies that do make it through to the next century will come from all sectors of the commercial insurance market, Mr. Greenberg predicted.

"All of the players will not have to be global," he said.

There will be enough room in the market for local insurers, niche insurers and smaller insurers, as well.

But these survivors will offer clients stability and more added services, like advice on loss control, he said.

"Buyers don't object to paying higher prices; what they object to is instability," Mr. Greenberg said.

Buyers increasingly will also put added emphasis on well-financed insurers, he said.

"If you are in the hands of a second-tier insurer you are taking a risk in addition to your deductible," Mr. Greenberg said.

The biggest issue for buyers in a changing market will be whether the company with which they insure has the reserves and the reinsurance support to pay claims, he said.

And buyers will partially base their judgment on the commitment that insurers show to their chosen sector, Mr. Greenberg said. Insurers that chase high rates and enter and leave market sectors quickly will not be supported by buyers, he said. BI

401(k) non-discrimination test

Continued from page 2

Marjorie Martin, director of technical services at Noble Lowndes & Partners in Roseland, N.J.

The new testing procedure actually has its roots in a batch of non-discrimination and coverage regulations the IRS issued between 1989 and 1991. Those regulations allowed an employer offering pension and savings plans to employees it did not have to legally cover —those under 21 years of age or with less than a year of service—to split plans in two for running a certain non-discrimination test.

Specifically, that test, known as the 410(b) ratio test, could be run on one "plan" covering the so-called "otherwise excludable" workers—those under 21 years old or with less than a year of service. The test could then be run separately on all other employees.

Under the ratio test, the percentage of low-paid employees covered by a plan must be at least 70% of the percentage of high-paid employees covered.

But only recently have IRS officials made clear that this splitting technique can also be used when running the basic 401(k) non-discrimination test for plans that cover workers who could have been legally excluded.

"We have no problem with this method," an IRS attorney said.

Under this technique, a 401(k) plan would be split—for testing purposes only—into two components: one component would cover the "excludable" employees or those under age 21 and/or with less than one year of service; the other component would cover all other eligible employees.

An employer then would separately run the basic 401(k) non-discrimination test—known as the actual deferral percentage test—on the two plans. The ADP test is used to compare salary deferrals of high- and low-paid employees. Deferrals of high-paid employees cannot exceed those of the low-paid by more than legally prescribed amounts.

Lumping young and short-service employees—who are more likely to have low salaries and make smaller contributions to 401(k) plans than older, longer-service workers—into one group has a key advantage: Because their contributions are tested separately, they won't reduce the maximum contributions of high-paid employees who are in the other plan for testing purposes.

For example, even if new, young workers in the separate plan contributed an average of just 1% of pay to the plan, it would have no effect on how much high-paid workers could contribute to the 401(k) plan.

On the other hand, if all employees were tested as if they were in one plan, the low deferral rate of the young, short-service employees could bring down the amount that highly paid employees could contribute without the plan failing the non-discrimination test.

Through this splitting technique, Ms. Martin said, highly paid employees of a Noble Lowndes client —a New Jersey contracting firm— were able to contribute $250,000 more as a group than they otherwise could have.

This splitting technique also could encourage more employers to drop their age or service requirements and give them a recruiting edge over competitors, Ms. Martin said.

"There may be other reasons to have age and service requirements" but because of the splitting technique, concern about passing the non-discrimination test will not be as much of an issue, she said.

A 1991 Hewitt Associates survey found that just 17% of employers with 401(k) plans did not require employees to meet age and/or service requirements.

But some benefit consultants question if this splitting technique will let high-paid employees contribute much more to 401(k) plans.

If a large company only hired a few employees annually, the aggregate contributions of those employees would be so small that it would not significantly change 401(k) non-discrimination testing results, said Michael Sternklar, a principal with Kwasha Lipton in Fort Lee, N.J.

And in some cases, this splitting technique could sharply restrict the ability of newly hired, high-paid employees to make big contributions.

If a company hires just one or two high-paid employees during a year and they are tested with the other short-service or young employees, most of whom may make only very small contributions, the high-paid employees would be sharply limited in what they could contribute.

Through splitting, "You may help a lot of (high-paid) employees a little, while you could hurt a few a lot," said Paul Strella, a principal with William M. Mercer Inc. in Washington.

In reality, few new hires are considered high-paid for testing purposes. Generally only those are among the top 100 paid at their firms are considered high-paid. For longer-service employees, the definition is much broader.

Other consultants doubt that the splitting technique, by itself, would encourage many employers to drop age or service requirements.

If such requirements were dropped, employers' administrative costs would increase because, among other things, 401(k) plan documents and enrollment forms would have to be given to more employees, many of whom might only stay a few months, noted Doug Edwards, a managing consultant with A. Foster Higgins & Co. Inc. in Princeton, N.J.

"You don't want to do all that paperwork for someone who may leave in a few months," said Hewitt's Ms. Davis.

Since the splitting technique is voluntary, it should be considered by employers without age or service requirements in their 401(k) plans, consultants agree.

"You can compare results by splitting or not splitting and see which method produces the best result," said Mr. Strella. BI

INTERNATIONAL

Gerling regroups to seize potential in diverse markets

By DON LEWIS KIRK

COLOGNE, Germany—A change in the insurance climate is forcing Germany's Gerling Group to restructure its operations.

In the wake of poor underwriting results in fiscal 1991-92 and a tightening reinsurance market, the insurance group is seeking to reposition itself and diversify its book of business.

Large commercial fire and marine claims coupled with low industrial insurance rates wreaked havoc on Gerling's results for the fiscal year ending June 30, 1992.

The company posted underwriting losses of 571 million deutsche marks ($374.6 million) at June 30, 1992, compared with underwriting losses of 381 million ($210.3 million) at June 30, 1991.

Profits dropped to 14.9 million deutsche marks ($9.8 million) in fiscal 1991-92, from 169.7 million deutsche marks ($93.7 million) in 1990-91.

Anton Weiler—a member of the board of directors and former chief of Gerling's non-life insurance flagship, Gerling Konzern Allgemeine Versicherungs A.G.—placed the non-life insurer's gross loss ratio at 90% of premium volume.

The losses were caused in part by competition among industrial and commercial insurers in Germany.

A rate war in recent years among German insurers Allianz A.G. Holding, Haftpflichtverband der Deutschen Industrie VaG, Colonia Versicherungen Konzern and Gerling, among others, created the lowest industrial fire insurance rates in Europe.

To acquire greater market share in Germany, and more recently to position themselves for the single European market, the insurers consistently lowered rates in recent years.

Last year, pressure from reinsurers finally reversed that trend.

"It reached a stage in which reinsurers lost every interest in the business," said Bernhard Fink, Gerling's sales and marketing director. "In my opinion, reinsurers went along with the game too long. For years, they compensated poor German results in industrial reinsurance with foreign industrial reinsurance or non-life reinsurance. But then there was Hugo and Andrew—and suddenly they woke up."

As a result, Gerling can count on a hardening market in which to launch its new rating structure. The rate increases will not be across the board, but will be tailored to individual clients' needs.

But raising rates is only part of the solution, according to Mr. Fink. "It also takes strict control of expenses and efficiency in all aspects of transacting business," he said.

Ironically, Gerling is a victim of the corporate strategy that also

Continued on next page

Different health systems, similar hikes in spending

Increased use driving up costs worldwide

By ALINE SULLIVAN

ZURICH—Rising health care costs are straining insurers and governments worldwide, regardless of national health care systems, according to a recently released study by Swiss Reinsurance Co.

The study—which examined health care in Canada, France, Germany, Italy, Spain, Switzerland, the United Kingdom and the United States—found that all of the countries had similar growth rates of health care spending despite significant differences in their health care systems.

"There is no apparent connection between the organization of health care and the growth rate of health care expenditure," the study report said.

In all of the countries studied, except for the United States, health care is primarily financed by general taxes or social security contributions.

Private health insurance accounted for less than 10% of total health care financing in all countries except the United States, where private health insurance accounted for more than 30% of total financing.

However, private insurance in 1990 accounted for a substantial proportion of total health and accident insurance premiums in many of the countries studied: 13.6% in Canada and 18.5% in Germany. In the United States, private health and accident insurance constitutes 13.1% of total premium volume.

In the United Kingdom, private health and accident insurance in 1990 represented less than 4% of total premium volume, though the U.K. growth rate for this class of business is one of the highest in the world.

During the past 20 years, the average annual growth rate of private health insurance in the United Kingdom was 11% and in Italy it was 21%, according to the study.

Both the U.K. and Italian governments, as part of efforts to reduce the cost of state-supported health care, have encouraged citizens to purchase private health care coverage. Strong growth is expected to continue in these countries, the study added.

Internationally, private insurance plays a minor role in financing health care spending.

From 1970 to 1990, the rise in health care spending was greatest in Spain, where real costs rose 6.3% annually. The United States recorded a 5.5% annual rise in expenditures. France, Italy and Canada each recorded a 5.0% rise and Germany a 4.0% rise. Switzerland and the United Kingdom recorded the smallest annual increases over the 20-year period, with 3.5% and 3.8% respectively.

Increased utilization of health care services accounted for much of the recent growth in expenditure, the report said. Price increases in excess of general inflation were negligible.

The United States spent the greatest amount on health care in 1990 at $2,566 per capita, according to Swiss Re.

Switzerland, which also plans to reform its national health care system, was second with $2,488 per capita. Spain spent the least at $831 per capita.

Health care systems in the countries studied were classified into three groups, although elements of other systems were found in all the countries. Outside the United States, private insurance contributions play a minor role in financing health care spending. However, private health care insurance is available in all of the countries.

National health services, like that in the United Kingdom, provide the entire population with free access to publicly controlled medical institutions that are funded by general tax revenues.

Social insurance systems finance health care mostly through compulsory payroll taxes shared equally by employer and employee. Ambulatory treatment and the hospital systems are partly private. France, Germany and Switzerland operate this type of system.

In the United States, "the status of the private insurance industry depends on the forthcoming reform of health care," according to Swiss Re. "If the current private financing of health expenditure is replaced by a system financed by taxation or by social insurance contributions, the significance of private insurers will suffer."

Continued on next page

Canadian insurers shore up guaranty fund

TORONTO—Canada's life insurance guaranty fund has secured a $190 million Canadian ($151.1 million) credit line to bolster its ability to make payments to policyholders of defunct insurers.

The extra funds will be provided by the 214 Canadian life insurers that are members of the industry-sponsored guaranty fund—called the Canadian Life & Health Insurance Compensation Corp., or CompCorp.

Under the loan agreement, CompCorp can borrow as needed against the $190 million fund in addition to the $95 million Canadian ($75.5 million) it can raise annually through a levy on its members.

CompCorp was set up in 1988 to administer the Canadian life and health insurance industry's Consumer Protection Plan. CompCorp's membership includes about 99% of Canada's life and health insurers.

CompCorp is funded by annual membership fees and it can assess members up to 0.5% of annual premiums if funds are inadequate to cover the obligations of insurers that go into liquidation.

CompCorp covers both individual and group insurance. It pays out up to $200,000 Canadian ($159,000) for death benefits; $60,000 Canadian ($47,700) for non-registered investment products; $60,000 Canadian for registered retirement savings plans and registered retirement income funds; and $2,000 Canadian ($1,590) for disability and retirement income benefits.

Because most corporations renew their group life insurance plans annually, CompCorp puts a time limit on its protection. Payments would be made on group life plans written by defunct insurers until the plan renewal date or up to six months after the liquidation date, whichever comes first.

The extra line of credit is based on twice the maximum annual levy. The loans provided by the member companies will be paid back with interest over an undetermined period.

The possible need for extra funds was caused by two recent life insurer liquidations in Canada: Cooperants Mutual Life Insurance Society of Montreal, and Sovereign Life Insurance Co. of Calgary.

—By Gavin Souter

GLOBAL BRIEFS

Brokers lobby Japan

WASHINGTON—Major U.S. brokers are urging the Japanese Ministry of Finance to permit them to openly service Japan's $75 billion property/casualty insurance industry, and Japan's top regulator recently agreed to consider this recommendation.

Although global brokers may still have to wait two or more years before they have open access to the world's second-largest property/casualty market, a nine-member team representing the National Assn. of Insurance Brokers appears to have made some progress. The team met April 15 in Tokyo with Norifusa Kagami, director of the Insurance Department in the Banking Bureau of the Japanese Ministry of Finance.

During the meeting, the NAIB team presented Mr. Kagami with a paper that recommended gradual deregulation of medium-sized and large insurance transactions. The paper called for the Japanese to give foreign brokers more opportunities to provide brokerage, risk management and other services to Japanese companies.

Mr. Kagami said he would examine the position paper in detail along with a similar proposal made last year by a governmental subcommittee of the Insurance Advisory Council to Japan's Ministry of Finance, said Christopher Collins, a managing director with Marsh & McLennan Inc. in New York and a member of the NAIB team.

"The meeting was certainly cordial and Mr. Kagami seemed very interested in the possibility of opening the doors to outside brokers. He wants more information on the subject both from us and his people in Japan. It is our hope that sometime this year a draft of a law allowing open access may be prepared," Mr. Collins said.

Currently, foreign brokers can only service the local Japanese operations of foreign multinational corporations. Japanese law prohibits international brokers from competing for the business of Japanese companies.

Brokers are allowed to affiliate themselves with Japan's 23 non-life insurance companies, but can do so only as agents of the company and must follow the instructions of the company they represent.

"While we are free to do business with any company on an agent basis, we're not really tapping into Japan's market at all," said Mr. Collins. "We feel the Insurance Advisory Council's proposal is a good one and it would be ideal if they admit brokers and restructure their insurance industry sooner than later."

—By Michael Schachner

Indian aircraft insured

LONDON—The Indian Airlines Boeing 737 that crashed near the Western Indian town of Aurangabad last week was reinsured in the London market for a hull value of $15 million.

The reinsurance was placed mainly in the London market by broker Willis Corroon P.L.C. and is led by the Ariel Syndicate at Lloyd's of London, insurance sources say.

The reinsurance was written for the General Insurance Corp. of India, the state-owned insurer and reinsurer.

The aircraft crashed shortly after takeoff when it tried to avoid a truck that had wandered onto the runway. The aircraft broke into three parts, killing at least 52 of the 118 people on board. The four crew members were among 45 persons who have been rescued.

—By Maria Kielmas

Gerling regroups

Continued from previous page
made it Germany's largest industrial insurer.

"In the past, our sales force worked under the directive 'increase volume,' " Mr. Fink said. "Too little was done to differentiate between profitable and less profitable segments. A lot of business was written which should have been reconsidered.

"Company policy separated our salespeople from the insurance company, which meant they didn't have the responsibility for the insurance side. That's what we want to change."

Although profits decreased, Gerling's premium volume increased a healthy 15.7% to 9.6 billion deutsche marks ($6.3 billion) in fiscal 1991-1992 from 8.3 billion ($4.6 billion) a year earlier. Gerling expects premiums to grow about 14% in fiscal 1992-1993.

"The problem is not sales," Mr. Fink said. "It's profit."

As a result, Gerling is bringing its sales network under direct control of the insurer and setting up regional "profit centers" that will have flexibility but also greater responsibility for the business they write, he said.

Gerling also formed an alliance last July with Deutsche Bank A.G., which acquired a 30% stake in the industrial and commercial insurer. With the bank's financial and marketing support, Gerling hopes to enter new markets and offer new products (*BI*, Aug. 17, 1992).

For example, Gerling has teamed up with Deutsche Bank and Deutscher Herold Lebensversicherungs A.G., a personal lines insurer, to form a new company called Globale Krankenversicherungs A.G. The joint venture will offer supplemental health insurance coverage, travel-related health coverage and retirement consulting services.

Gerling is also counting on increased interest from German industry for risk management consulting services.

Five years ago, Gerling was among the pioneers of industrial risk management consulting in Germany through subsidiary Gerling Consulting A.G. Today, it is one of the company's most profitable enterprises.

"There is great demand for consulting in environment, quality control and work-safety management. Unfortunately, most companies still don't realize how dangerous it is to go without risk management," Mr. Fink said.

The demand for risk management advice is fueled partly by new environmental protection laws, he said. "If the environment is damaged, a company owner is held directly responsible—not the worker who caused the accident. In the eyes of the law, it's the manager who failed to uphold safety standards. When it comes down to it, companies must prove they have the best safety management available. Many companies still have a long way to go to catch up."

Mr. Fink blames low insurance rates for German companies' late awakening to risk management. "It's grotesque, but many companies did nothing about risk management simply because they got insurance at such low rates," he said.

While underlining its strength as a large industrial insurer, Gerling is moving toward insurance for small to medium-size businesses and committing itself to writing more group life insurance and personal lines business.

"Gerling will remain the leading industrial insurer. No question," Mr. Fink said. "But we're using our expertise for middle-size companies in other areas, including property/casualty, business interruption, even legal insurance and environment liability."

Gerling's focus on small and mid-size companies is central to its new image. Gerling intends to provide these smaller firms with various risk management services that previously were primarily offered to larger companies, he said.

Mr. Fink says Gerling will also expand operations to professionals, including lawyers, tax consultants and auditors. Last year, Gerling used its ties to the Deutsche Bank to develop new products, such as a pension fund management venture in Vienna with the Deutsche Bank and an Austrian partner.

In accord with its commitment to group life insurance and pension plans, Gerling is also seeking to strengthen its ties to the growing number of "captive brokers"—which are insurance brokerage subsidiaries of German companies.

The groundwork for Gerling's new approach was laid in October 1992, when Gerling Chief Executive Adolf Kracht told management it was time for a new corporate structure and launched a major overhaul of Gerling leadership.

Juergen Zech, who had steered Cologne Reinsurance Co. to exceptional profitability, moved in as chief of Gerling Allgemeine Versicherungs A.G. effective Jan. 1, replacing Mr. Weiler. Mr. Zech is a natural counterpart to Mr. Kracht, who is a banker by trade.

Mr. Zech will play a major role in Gerling's future. His reputation as "the best insurance man on the market" stems from his expertise in areas like financial reinsurance, said Mr. Fink. It is likely he will craft an insurance strategy for corporate clients seeking special solutions to financing risk.

Among other moves, the group has merged national and international sales and marketing departments.

"Gerling invested a lot to become Europe's industrial insurance specialist," he said. "Starting from scratch, we've built up operations in all European countries. We can use this network for large, middle-size and small companies, and that is what we plan to do." BI

Swiss Re study

Continued from previous page
However, there is a possibility that the U.S. private insurance system may simply become more regulated, the report said. "This would also open up new opportunities to private insurers as the primary aim of the reform would be to make health insurance cover available to those hitherto uninsured," the report stated.

"Increases in health care expenditure represent just as much a challenge to private insurers as to social insurers," the report said. Reforms should focus on containing costs, forms of remuneration, limitation of insurance benefits and efficient utilization of resources, said the report.

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For a copy of the report write the Swiss Reinsurance Co., Economic Studies section, P.O. Box 8022, Zurich, or call Yvonne O'Dell at Swiss Reinsurance Co. (U.K.) Ltd., 071-623-3456

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CONFERENCE AGENDA

SUNDAY, MAY 16

6:00 – 7:30 p.m. EARLY REGISTRATION & COCKTAIL RECEPTION
Hosted by The Upjohn Company

MONDAY, MAY 17

7:45 a.m. *Continental Breakfast & Registration*

9:00 a.m. OPENING REMARKS BY CONFERENCE CO-CHAIR
Kathryn J. McIntyre
Publisher & Editorial Director
Business Insurance

9:15 a.m. NEW INITIATIVES IN MANAGED CARE
Panel Moderator:
James M. Burcke, Editor
Business Insurance
Joseph W. Duva, Chairman and CEO
Preferred Solutions Inc.
Larry Goelman, President and CEO
Cost Care, Inc.
Harry Neer, Vice Chairman
USA Healthnet, Inc.

10:30 a.m. MID-MORNING REFRESHMENTS & TABLE-TOP EXHIBITS
Hosted by Clinical Pharmacy Advantage

11:00 a.m. MULTI-EMPLOYER COALITIONS: A GRASSROOTS APPROACH
J. Bryan Bushick, M.D., Consultant
Towers Perrin
Lawrence J. Frye, President
Iameter, Inc.
Dee Kemnitz, Vice President, Employee Benefits
Carlson Companies, Inc.

12:15 p.m. LUNCHEON FOR SPEAKERS AND ATTENDEES
Hosted by John Hancock Financial Services

1:00 p.m. KEYNOTE LUNCHEON SPEAKER
Sean Sullivan, President & CEO
National Business Coalition Forum on Health

1:45 p.m. *Break*

2:00 p.m. *Concurrent Session A:*
STRUCTURING AND MANAGING AN ON-SITE MEDICAL FACILITY
Panel Moderator:
Kathryn J. McIntyre
Publisher & Editorial Director
Business Insurance
Jerry Appelbaum, M.D., Corporate Medical Director
The Gates Clinic, Inc.
Deborah T. Carroll, Director of Benefits
Barnett Banks, Inc.

Insurers take stand on reform plan

Comp and health benefits don't mix: AIA

WASHINGTON—The American Insurance Assn. wants the Clinton administration to adopt a "coordinated" approach to integrating workers compensation insurance with national health reform.

In an April 26 letter to Hillary Rodham Clinton, AIA President Robert E. Vagley said that splitting the current workers comp system into medical and wage-loss components and then merging the medical part into the new national health system will not work.

"The resulting diffusion of responsibility will increase both medical and wage replacement costs," Mr. Vagley wrote.

Separately, an association of workers comp system administrators also urged the task force to not include the medical component of workers comp in any health care reforms.

The idea of putting the workers comp medical component into the national system is apparently being offered to small businesses in return for their support of health care reform, said Mr. Vagley. Such a move would force safe employers to subsidize unsafe ones because all would pay the same health care premiums despite their safety records, he said.

In addition, employees would be required to contribute toward treatment of workplace injuries because no differentiation would be made between work-related and non-work-related injuries.

Instead, the AIA has suggested to the Task Force on Health Care Reform, which Mrs. Clinton heads, that workers comp benefits be coordinated with national health care.

"Under the coordinated approach, employers would continue to purchase workers compensation insurance. . . .That insurance would continue to provide wage replacement and medical benefits" with experience rating remaining intact, he wrote.

However, self-insured employers and workers comp insurers would be permitted to enter into agreements with "authorized health plans" to provide some or all of the medical treatment required for workplace injuries, he wrote. This would permit cost containment measures available under a new system to be applied to workers comp, according to Mr. Vagley.

"These agreements would include financing arrangements for reimbursement of the (authorized health plan) by the insurer on a capitation basis or some other mutually agreeable basis," wrote Mr. Vagley. He added that the agreements could also involve the selection of treatment and rehabilitation providers.

Mr. Vagley wrote that the coordinated system would reimburse the health care plan for treatment stemming from workplace injuries without penalizing safety-minded employers or shifting the cost to employees.

Meanwhile, state workers comp system administrators also urge national health care reformers to exclude workers comp medical coverage at this time and to appoint a separate committee to study the issue.

"A National Health Care Plan simply should not absorb workers' compensation health care programs at this time without carefully implemented strategies for addressing the unique set of linked goals from medical care to medical stabilization to productive employment," Evelyn Scott Ferris, president of the International Assn. of Industrial Accident Boards & Commissions, wrote in an April 13 letter to the task force.

If such issues are not carefully considered, she warned that costs will increase instead of decrease, state workers comp laws would be "in total disarray and confusion," litigation would "flourish," and the progress of state managed care programs would be "retarded or lost."

—By Mark A. Hofmann and Meg Fletcher

Concurrent Session B:
HOW TO ENROLL RETIREES IN MANAGED CARE PLANS

William J. Boyle, Director, Benefits and HRIS
Western Union

Marcia Inch, Principal
William M. Mercer, Inc.

Charles A. Newman
Program Manager, Health Care Management
GE Power Systems

3:15 p.m. **MID-AFTERNOON REFRESHMENTS & TABLE-TOP EXHIBITS**
Hosted by Clinical Pharmacy Advantage

3:45 p.m. **WORKERS COMPENSATION: INTEGRATING MANAGED CARE TO CONTROL WORKERS COMPENSATION COSTS**

Edwin E. Freedman
Managing Director, AlexComp Consulting Plus
The Alexander Consulting Group Inc.

Bill Murphy, Director of Risk Management
Sky Chefs

Robert L. Buckley
Manager of Special Investigations
Kemper Risk Management Services

5:00 p.m. **COCKTAIL RECEPTION**
Hosted by USA Healthnet, Inc.

TUESDAY, MAY 18

7:45 a.m. *Continental Breakfast & Table-Top Exhibits*

9:00 a.m. **REMARKS FROM THE CHAIR**

9:15 a.m. **KEYNOTE ADDRESS**

John Polk, Executive Director
Council of Smaller Enterprises

9:45 a.m. **HEALTH CARE REFORM: WHAT ARE THE OPTIONS?**

Panel Moderator:
Jerry Geisel, Editor-at-Large
Business Insurance

Ellen Goldstein, Director of Health Care Policy and Communications
Association of Private Pension & Welfare Plans

Doug Leland, Vice President
Intracorp

Thomas R. Reardon, M.D.
Member, Board of Trustees
American Medical Association

Michael A. Zarcone, Government Relations Counsel
MetLife Insurance Co.

11:00 a.m. *Mid-Morning Refreshments & Table-Top Exhibits*

11:30 a.m. **RECEIVING THE MOST VALUE FROM YOUR PHARMACEUTICAL BENEFIT PLAN**

James W. Heenan, Director, Corporate Account Sales
The Upjohn Company

Jim Miller, Vice President – Marketing
PreferredOne

Norrie Thomas, President & COO
Clinical Pharmacy Advantage

12:30 p.m. **LUNCHEON FOR SPEAKERS AND ATTENDEES**
Hosted by The Alexander Consulting Group Inc.

1:15 p.m. **KEYNOTE LUNCHEON SPEAKER**

The Honorable Robert G. Torricelli
House of Representatives, New Jersey, Democrat

1:45 p.m. *Break*

2:00 p.m. **CASE STUDIES OF SELECTED WINNERS FROM THE *BUSINESS INSURANCE* EMPLOYEE BENEFITS COMMUNICATION AWARDS**

Concurrent Session A:
Charlotte Jerace, Manager
KPMG Peat Marwick

Concurrent Session B:
Richard D. Quinn, III
Director, Corporate Benefits Planning
Public Service Electric & Gas Co.

Lee Saviola
District Manager, Managed Care Administration & Employee Education
AT&T

Pamela G. Stout
Communications Team Leader – New York Region
The Wyatt Company

Concurrent Session C:
Vicki Dungan, Principal
Dungan Communications Resources

Lorna Mackey, Manager, Benefits Communication
PepsiCo Inc.

3:15 p.m. *Mid-Afternoon Refreshments*

3:30 p.m. **SHOULD THE PRIVATE SECTOR ADOPT RESOURCE-BASED RELATIVE VALUE SCALE (RBRVS) PHYSICIAN FEE SCHEDULES?**

Panel Moderator:
Christine Woolsey, Associate Editor
Business Insurance

Zachary Dyckman, Ph.D., Executive Vice President
Center for Health Policy Studies

Thomas R. Reardon, M.D.
Member, Board of Trustees
American Medical Association

4:30 p.m. **CONFERENCE ADJOURNS**

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California lawmakers acting on work comp

SACRAMENTO—The California Senate and Assembly each overwhelmingly passed similar comprehensive workers compensation reform bills last month.

S.B. 30, sponsored by Sen. Patrick Johnston, D-Stockton, and A.B. 110, sponsored by Assemblyman Steve Peace, D-Chula Vista, target reforms in the areas of medical-legal evaluations, stress claims and vocational rehabilitation.

A third bill, A.B. 1300, sponsored by Assembly Speaker Willie Brown Jr., D-San Francisco, is designed to help law enforcement officials fight workers comp fraud.

S.B. 30 would reduce employers' workers compensation premiums by $891 million, according to an estimate by the Workers Compensation Insurance Rating Bureau.

The bill would require injured workers to receive treatment from a certified managed care organization under most circumstances. In addition, it would limit the number of medical-legal evaluations to no more than two, one from the employer's physician and one from the employee's physician.

It would limit vocational rehabilitation services to $10,000 per injured worker and make other substantive changes to the program, including prohibiting referrals by providers to facilities in which they have a financial interest.

In the case of stress claims, the injured worker would be required to prove "by a preponderance of evidence that employment was the predominant cause of the injury," according to a legislative summary.

In addition, the bill would eliminate "compensation for lawful, good faith personnel

Continued on next page

California bills

Continued from previous page

actions, terminations or layoffs" and place other limits on post-termination claims.

S.B. 30 would also require workers comp insurance rates to be based solely on employers' prospective loss costs and increase the insurance commissioner's oversight and administration of rate setting.

The bill, which has gone to the Assembly, stipulates that half of the savings created from the enactment of S.B. 30 and other reform bills in 1993-1994 shall be used to increase indemnity benefits to injured workers.

A.B. 110, which has gone to the Senate, would mandate reforms similar to those in S.B. 30 for medical-legal evaluations, physician self-referrals, managed care for injured workers, stress claims, vocational rehab and other areas.

In addition, it would restructure the Industrial Medical Council, which oversees the medical treatment of injured workers and establish higher standards for qualified medical examiners.

According to Assemblyman Peace's estimate, this bill will result in annual savings of about $1 billion.

A.B. 1300, which has also gone to the Senate, would increase penalties for anyone who deliberately files or helps file a false claim.

The bill would also give district attorneys the power to seize fees and profits gained fraudulently, as they do with drug dealers.

Earlier this spring, Gov. Pete Wilson signed S.B. 31, sponsored by Sen. Johnston, which will dramatically reduce the cost of medical-legal evaluations by requiring a new method for the state to set specialists' fees.

Currently, fees for the evaluations are based on fees the specialists charged the previous year.

—By Louise Kertesz

Profiling the 'typical' risk manager

Financial expertise, MBA degrees grow more important: Logic survey

By NANCY P. JOHNSON

The profile of the typical risk manager hasn't changed much from last year.

The average risk manager for a company with $2 billion to $4 billion in annual sales is male. He holds an Associate in Risk Management designation and a bachelor's degree, with a master's degree in business administration half completed.

Counting himself, he has a three-person staff, and he reports to either the vp-finance or the treasurer, a 1992 risk management survey by Logic Associates Inc. of New York indicates.

"We see a slight increase in MBAs, which will be more in demand" for risk management positions, said Barry Citron, vp of Logic Associates, which is an executive search firm specializing in risk management.

"The demand for risk managers to be financially oriented is much greater," said Bill Perry, president of Logic. "The old-line 'insurance buyer' is out of vogue."

At smaller companies—those with between $201 million and $500 million in annual sales—94% of risk managers hold at least a bachelor's degree and 25% also hold an MBA.

At middle-size companies—those with between $2 billion and $4 billion in sales—those numbers are 98% and 38% respectively. And at the largest companies surveyed—those with more than $7 billion in annual sales—those numbers are 100% and 43% respectively, with 3% of respondents holding a law degree.

The educational background figures are nearly unchanged from Logic's 1991 survey.

At the smaller companies, 13% of risk managers hold the Chartered Property & Casualty Underwriter designation, while 30% hold the Associate in Risk Management designation; at mid-size companies, 30% hold the CPCU designation, and 37% hold the ARM designation; and, at the largest companies, 26% hold the CPCU designation and 38% hold the ARM designation.

These figures are about even with the 1991 survey findings.

Automated risk information systems increasingly are standard in risk managers' offices, the Logic survey found.

Nearly all—97%—of the respondents from the largest companies have a computerized risk management information system, compared with 87% of risk managers at mid-size companies and 58% at smaller companies. The prevalence of RMIS is up slightly from 1991 levels.

Women are still making inroads as risk managers at the smaller companies, but nearly all risk managers at the largest companies are men.

There are more female risk managers at the smaller companies—33%, up from 31% in 1991. At mid-size companies, the percentage of female risk managers was up slightly to 15% from 14%. But, at the largest companies, the total actually declined to 2% from 3%.

"Overall, there are more female risk managers than last year," said Mr. Perry. The study did not break down the 1,346 total respondents by sex.

Risk management clerical staffs were trimmed slightly at the smaller and mid-size companies last year, according to Logic.

At smaller companies, the number of clerical staff members in 1992 fell to slightly more than one on average from slightly less than two in 1991.

At mid-size companies, staffs fell to slightly less than three on average last year, from slightly less than 3½ in 1991. But at the largest companies, clerical staffs grew to slightly less than four on average from slightly less than 3½ a year earlier.

Risk managers' areas of responsibility vary considerably according to company size, according to the Logic survey.

For example, risk managers at small companies are more likely than those at the largest companies to have hands-on responsibility for pension or benefit administration.

At companies with less than $200 million in annual sales, 52.2% of risk managers had direct, hands-on responsibility for benefits administration and 22.3% had the same responsibility for pension or profit-sharing plan administration.

In contrast, at companies with more than $7 billion in annual sales, only 18.8% of risk managers had direct responsibility for benefit administration and 14.5% had responsibility for pension or profit-sharing plan administration.

At the smallest companies, risk managers generally are directly responsible for claims handling, safety/fire engineering, and negotiating placement of property/casualty coverage. But at the largest companies, risk managers generally have supervisory or advisory roles for those areas (see chart).

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Copies of the "1992 Risk Management Compensation Survey" are available for $65 each from Logic Associates Inc., 170 Broadway, Suite 814, New York, N.Y. 10038; 212-227-8000.

Risk managers' areas of responsibility

By company sales in millions of dollars

Legend: **Direct, hands-on responsibility** / Supervisory/advisory responsibility

	$0-200	$201-500	$501-1,000	$1,001-2,000	$2,001-4,000	$4,001-7,000	More than $7,000
Risk financing	52% 32%	74% 20%	57% 26%	93% 6%	63% 17%	37% 22%	27% 46%
Negotiation of coverage placement	58 32	59 25	55 32	78 13	80 14	56 41	31 44
Claims handling	46 42	60 23	66 30	47 48	41 57	32 51	23 52
Safety/fire loss engineering	56 36	67 23	41 28	36 38	28 58	29 46	35 46
Data security	53 33	21 33	16 32	6 40	9 45	31 54	27 48
Benefits administration	52 29	43 28	18 29	12 24	17 25	15 59	19 48
Pension/profit-sharing administration	22 37	33 38	13 24	15 12	1 13	17 46	15 71

Source: Logic Associates

GRAPHIC BY CYNTHIA WATSON

The Professional Marketplace

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Sub-total	**28,114**
Associations	392
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Sub-total	**29,626**
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Others Allied to the Field	968
Single Copies	-
TOTAL	**52,785**

* Source Business/Occupational breakdown of qualified circulation, November 30, 1992 issue, as submitted to BPA for December 1992 BPA Publisher's Statement

For the Record

Illinois insurer tax ruled unconstitutional

SPRINGFIELD, Ill.—The Illinois Insurance Department is asking a state judge to reconsider a ruling that a 2% premium tax on out-of-state insurers is unconstitutional.

Sangamon County Associate Circuit Judge Stuart H. Shiffman ruled that the tax on non-Illinois insurers doing business in the state is discriminatory and violates the equal protection clause of the U.S. Constitution.

The ruling came in a lawsuit filed by the Missouri Insurance Department as liquidator of Transit Casualty Co. The liquidator sought to recover $973,017 in premium taxes Transit paid to Illinois between 1980 and 1985. Transit was declared insolvent and ordered liquidated in 1985.

While finding that the tax on so-called "foreign" corporations is unconstitutional, Judge Shiffman ordered further hearings to decide whether the Transit estate is owed a refund and how much the refund should be.

Robert Enoex, chief counsel of the Illinois department, said the department has asked the judge to reconsider his ruling. If reconsideration is denied, the Insurance Department will appeal, he said.

Illinois currently collects about $180 million to $190 million a year in premium taxes from non-Illinois insurers, Mr. Enoex said.

Energy industry captive raising liability limits

TAMPA, Fla.—Energy Insurance Mutual Ltd., the excess liability insurance captive for 121 electric and gas utilities, plans to increase its general liability limits to up to $100 million excess of $25 million beginning June 1.

EIM currently offers up to $75 million of excess general liability limits.

EIM also will increase its combination of general liability and directors and officers liability limits to $125 million from $100 million on June 1.

The captive will continue to offer up to $50 million of directors and officers liability limits excess of $25 million.

Insurers balk at paying settlement of Texas suit

MIDLAND, Texas—Insurers are balking at covering the $115 million that two Texas-based energy companies tentatively agreed last week to pay to settle a 1989 lawsuit.

Baker Hughes Inc. and Dresser Industries Inc. each agreed to pay $57.5 million to Parker & Parsley Petroleum Development Inc. The Midland-based oil and gas producer sued a Baker Hughes-Dresser joint venture, charging negligence and breach of contract in connection with providing materials for oil and gas production.

In 1990, a federal court awarded Parker & Parsley $185 million. That award was later overturned for lack of federal jurisdiction, and a Parker & Parsley suit was pending in state court when the tentative deal was announced last week.

Dresser is suing in state court in Houston, seeking coverage under excess general liability policies written in the 1980s by syndicates at Lloyd's of London and other London insurers.

Its $200 million in excess liability insurance was led by Lloyd's syndicates underwritten by Richard Youell and managed by Janson Green Ltd., said Linda Nabors, risk manager at Dresser.

Dresser's excess layers are exposed because underlying coverage has been nearly exhausted by payment of unrelated past claims, said Scott Nickson, vp and general counsel at Dresser.

Baker Hughes would not discuss its coverage, saying only it was in talks with insurers. Asked whether coverage for the award was the subject of litigation, a spokesman said, "Not yet."

Risk Sciences Group to acquire Paradigm

ATLANTA—Risk Sciences Group, a risk management information system subsidiary of Crawford & Co., has acquired Paradigm Infosystems Inc. of Bothell, Wash.

Paradigm is one of the few RMIS vendors to offer systems designed for the Apple Macintosh environment. Its programs also can be run on PCs using a Microsoft Windows-style graphical user interface.

"RSG has been criticized for a lack of PC-orientation in software," which is what Paradigm specializes in, said RSG President Richard F. Denning. "We want to be the biggest in the field," he said, adding that RSG is also exploring acquisitions in Europe.

Formed in 1987 as the software division of Emerald City Insurance Consultants, Paradigm was incorporated as a separate company in 1991.

Paradigm's officers and staff will remain the same and Chief Executive Officer Richard Hoehne will report to Mr. Denning.

Diet supplement maker ordered to pay $1 million

SAN DIEGO—Japanese chemical company Showa Denko K.K. would not say whether it has insurance to cover $1 million in damages it was ordered to pay to a woman made ill by dietary supplement L-tryptophan.

Robert Greig, an attorney with the New York firm Cleary, Gottlieb, Steen and Hamilton, which represents the company, said Tokyo-based Showa Denko is considering an appeal.

The $1 million awarded by a state Superior Court jury last week is less than the company had offered to pay to settle the case. "I can confirm that an offer was made and the plaintiff's counsel was very disappointed," said Mr. Greig.

Elizabeth DiRosa originally sought $10 million in compensatory damages after suffering symptoms including damage to internal organs and skin problems beginning in 1990. Her attorney asked for $134 million in punitive damages in his summation to the jury.

The jury awarded no punitive damages, finding Ms. DiRosa partially responsible for her injuries because she kept taking the supplement after news accounts detailed the dangers it posed. BI

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Berkshire meeting

Continued from page 2

pean nations were treated to a command performance at the Omaha theater. For almost four hours, Mr. Buffett, Vice Chairman Charles T. Munger and their enlarged images projected on a screen fielded a wide variety of questions on Berkshire's vast holdings.

The tone of the annual meeting was both light and serious. Official business such as electing directors took five minutes. "You can tell I don't get paid by the hour," Mr. Buffett quipped.

Questions ran the gamut from whether the company hedges against currency fluctuations for its British Guinness P.L.C. subsidiary —"The answer is we don't"—to whether it will ever change its name —"You don't have to worry about us changing anything at Berkshire."

As in previous years, Mr. Buffett reiterated his interest and confidence in super-catastrophe retrocessional coverage, in which Berkshire is a worldwide leader.

Such coverage has a dual trigger, requiring both the ceding reinsurer's and the total industry's losses to exceed defined levels in a given catastrophe.

Berkshire's net worth gives it "the capacity to assume risk on a scale that interests virtually no other company," Mr. Buffett wrote in the annual report. "We have the appetite as well: As Berkshire's net worth and earnings grow, our willingness to write business increases also."

Overall net income fell 7.4% in 1992 to to $407.3 million from $439.9 million in 1991. Net worth rose 16.9% to $8.5 billion from $7.27 billion in 1991.

Berkshire will have a big super-cat loss someday, Mr. Buffett said. "We're prepared for it happening. Berkshire has the ability to sustain huge losses."

Although "it's very hard to know until 10 or 20 years go by whether you've been charging the right premiums," he said, "we think we've charged rates that if we stay in (for) the long term will be remunerative."

Berkshire's loss on Hurricane Andrew—about $125 million—was approximately equal to the company's 1992 super-catastrophe premium income. Although other super-cat losses were "negligible," this line produced an overall loss of about $2 million in 1992, Mr. Buffett said in the annual report.

Mr. Buffett also noted in the report that GEICO Corp., the personal lines insurer in which Berkshire holds a 48% stake, "suffered a net loss from Andrew, after reinsurance recoveries and tax savings, of about $50 million, of which our share is roughly $25 million."

While many of Mr. Buffett's comments at the meeting and in the annual report echoed those made in previous years, some things are changing within the Berkshire family.

The title of youngest Berkshire investor was usurped by 2-month-old Riley Timothy Guerin, of Beverly Hills, Calif., from 12-year-old Nicholas Kenner. Mr. Guerin owns two shares of Berkshire, which last week was selling at $12,455 per share, up from $9,000 a year earlier.

Another change brewing: In March, Berkshire requested permission from Nebraska insurance regulators to set up a life insurance company.



Warren E. Buffett

"We're going to set up a life company very soon through Central States Indemnity," Mr. Buffett told shareholders, referring to the Omaha-based credit insurer Berkshire bought six months ago. The new unit would write structured settlements, which Berkshire has written through its property/casualty subsidiaries.

"There ought to be a place for Berkshire to be bigger in this field," added Mr. Munger.

Vp Michael A. Goldberg later added that the company's principal reason for setting up the life unit is to "improve the marketability of our structured settlement business."

However, he added, there is "certainly a possibility" of using the life insurer for other purposes, which he would not identify.

Nearly a third of the 60-page annual report is a letter from Mr. Buffett that quotes philosopher George Santayana, Alice in Wonderland and Abraham Lincoln. The chairman's advice on reading the report: "Start at the front and read to the back."

The report contains a statistic with which Berkshire shareholders have become familiar—the company's "cost of float," a compendium of numbers designed to show whether the company's cost of funds for the insurance operations is less than the year-end yield on long-term government bonds.

The "float" is the amount of money available for investment, defined as the total of: loss reserves, loss adjustment expense reserves, and unearned premium reserves minus agents' balances, prepaid acquisition costs and deferred charges applicable to assumed reinsurance.

Last year, the cost of funds was 4.76%, down from 6.31% the previous year and considerably lower than the yield on long-term government bonds, which was 7.39% last year.

The bulk of the insurance group's float comes from large transactions developed by Ajit Jain, president of the reinsurance division of Berkshire Hathaway in Stamford, Conn.

"His efforts are likely to produce a further growth in float during 1993," Mr. Buffett said in the annual report.

The insurance group is a key component of the Berkshire empire and consists of 13 companies, led by Omaha-based National Indemnity Co.

The companies "underwrite multiple lines of principally casualty coverages for primarily commercial accounts, providing, for example, liability coverages for truck and bus operators, and casualty coverages for especially large or unusual risks," the annual report explains.

The insurance group's earned premiums dropped 14.4% last year to $664.3 million from $776.4 million. Direct premiums earned increased 8.4% to $152.8 million in 1992 from $141 million, while reinsurance assumed dropped 19.5% to $511.5 million from $635.4 million in 1991.

Net income attributable to the insurance group declined 3.9% to $270.8 million from $281.7 million.

"Charlie and I continue to like the insurance business, which we expect to be our main source of earnings for decades to come," Mr. Buffett wrote in the annual report. "We will look for ways to expand our participation in the business, either indirectly as we have done through GEICO or directly as we did by acquiring Central States Indemnity."

Insurance group assets are invested in stocks including: Capital Cities/ABC, Inc.; The Coca-Cola Co.; The Federal Home Loan Mortgage Corp.; GEICO Corp.; General Dynamics Corp.; The Gillette Co.; Guinness P.L.C., The Washington Post Co.; and Wells Fargo & Co. Its bond holdings include: American Express Co.; Salomon Inc.; and USAir.

In addition to its insurance companies, Berkshire has a controlling interest in a diverse array of other operations. BI

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BI to hold forum on health cost management

NEW YORK—Registration is still open for the second annual *Business Insurance* Health Care Management & Cost Containment Conference.

The conference, co-sponsored by *Business Insurance* and The International Business Forum, will be held May 16-18 at the Sheraton New York Hotel in New York City.

Conference speakers represent the points of view of employers, health care providers, health insurers, managed care companies and consultants. They will address the latest outlook for health care reform proposals, developments in managed care, how multiemployer coalitions are controlling health care costs and how to communicate changing benefit plans to employees.

"The conference will be particularly timely, as President Clinton is expected to release his health care reform plan this month," said Kathryn McIntyre, publisher/editorial director of *Business Insurance*, and co-chairman of the conference.

The conference fee is $795, which includes lunches, refreshments, receptions and the conference workbook.

For more information or to register, contact The International Business Forum Inc., 50 Charles Lindbergh Blvd., Suite 400, Uniondale, N.Y. 11553-3619; 516-229-2375; fax: 516-229-2386.

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Lloyd's plan

Continued from page 1

tral funds will be available to recompense those who have suffered. We would only contemplate a modest contribution if it was demonstrably to the net benefit of the society as a whole."

Lloyd's proposes handling the problem of the hundreds of accounting years left open by loss-plagued syndicates in two stages. Ultimately the plan will cover the liabilities of individual members for all policies written up to and including 1985. The liabilities will be reinsured into a new reinsurance company, "NewCo," which will have reserves of between 4 billion and 5 billion pounds ($6.3 billion and $7.87 billion). The reserves will be transferred from the syndicates' existing reserves for pre-1986 liabilities into the new company.

Under the first stage of this process, a managing director will be appointed to supervise the process, and central administration will be established to manage these liabilities. The existing Lloyd's runoff company, Syndicate Underwriting Management, will be strengthened to manage the long-tail liabilities of both ongoing syndicates and syndicates in runoff.

In the second stage, liabilities for policies written in 1985 and prior years will be reinsured by NewCo. Members may be subject to further cash calls to finance losses incurred in these years if existing reserves are not sufficient. Lloyd's hopes to have all members' pre-1986 liabilities capped by the end of 1995, allowing names on open years who have previously been unable to leave the market place to resign.

The plan's architects chose 1985 as the cut-off date because that was the year that the claims-made commercial general liability policy form was introduced in the United States. That policy form reduced insurers' liability for the long-tail pollution and asbestos claims which have plagued Lloyd's.

Under the plan, CentreWrite Ltd., Lloyd's existing runoff reinsurer, will reinsure post-1985 liabilities of syndicates with open years of account, again to enable members to leave the market.

"With this restructuring the market will have put in place the strongest practical 'ring fence' against the impact of old-year liabilities," the report said. "Current names will be protected from further deterioration on the old years, once they have made the necessary payments to NewCo. Future providers of capital, both individual and incorporated, will be protected from the risk of assuming liability for claims on (pre-1986) policies."

Critics of the plan suggested that NewCo could exhaust its reserves and the investment income those reserves generate, leaving it dependent on the Lloyd's Central Fund. This might force a levy on members, like the one imposed last year to replenish money earmarked in the Central Fund to cover claims.

Deputy Chairman Robert Hiscox, however, said that Lloyd's could issue bonds or other financial instruments to raise the needed funds, rather than use the Central Fund.

Six pages of the plan were devoted to the expected impact of the 1990 loss and the problems posed by disputes between loss-making members and their agents.

Proposals to mitigate the impact of cash calls on names included allowing names to take about 5% of their 1993 premium trust funds as credit against this year's solvency test, allowing calls for closed-year losses to be partially delayed if the syndicate does not require cash immediately. Members whose net worth drops below the minimum 250,000 pounds ($393,500) but continues to exceed 100,000 pounds ($157,400) will be allowed to underwrite for one more year.

Lloyd's officials rejected calls to help offset member losses through a large loan or bond issue, saying it lacked the needed assets.

"There is no financial institution that is going to lend Lloyd's the equivalent of building the Channel Tunnel on the basis of this building and the building across the street," said Chief Executive Peter Middleton.

Disputes between names and their agents over errors and omissions coverage for major losses also were reviewed in the plan. No solutions were proposed, however.

The Lloyd's E&O panel in March proposed a framework for settlement of the claims without litigation, recommending that Lloyd's use money from its central resources to cap members' liabilities.

According to the new business plan, the proposals present two major challenges: bringing the parties to a negotiated resolution and providing the resources necessary to fund the central contribution that may require. The Council of Lloyd's does not have the power to impose a resolution on the disputing parties, said the report. No decision has been made concerning a central contribution.

"Lloyd's must have regard to the interests of all members, not seeking to advantage one group over another," said the report. "This means taking into account the fact that many of the claims are competing for the same finite amount of E&O cover. It also means taking into account the interests of names who are on the loss-making syndicates but are not members of the action groups."

Neil Shaw, chairman of the Assn. of Lloyd's Members and head of the E&O panel, said more work must be done immediately to address the litigation problem.

However, Mr. Shaw welcomed most of the proposals and called on names to support them. "The society has suffered over 5 billion pounds ($7.87 billion) of losses in three years and under the effective leadership of the chairman and chief executive in the space of four to five months, the first business plan in Lloyd's history has been produced," Mr. Shaw said. "That is a mammoth feat and should be recognized."

Robin Warrender, chairman of underwriting agency London Wall Holdings Ltd., said he was impressed by most aspects of the plan but disappointed that more was not done to help loss-burdened members and to tackle the threat of litigation.

'We aren't going to (sit back and admire the plan). This plan starts Tuesday,' vows Peter Middleton.

By contrast, Tom Benyon, director of the Society of Names, said the business plan was not the place to address these problems. "Lloyd's management is to be congratulated for producing a workmanlike, imaginative plan in such a short time," he said. "They have done exactly what I would have done in their place."

And Alan M. Levin, director of insurance rating service at Standard & Poor's Corp., which rates Lloyd's syndicates, said the plan "has the ingredients to (return) Lloyd's to its former stature."

Lloyd's had two reasons for combining all pre-1986 liabilities into one runoff plan. First, it will enable existing members who want out of the market to determine their liabilities and buy their way out. Second, it should reassure new names that they will not end up paying for the problems of the past.

The new members that Lloyd's officials are particularly keen to attract are limited liability companies that would trade at Lloyd's as "corporate names" alongside the existing private investors. Mr. Middleton said that financial institutions have shown great interest in becoming "corporate names."

Corporate investors are interested in Lloyd's, said Mr. Hiscox, but only on three conditions: they don't want to pay for losses of the past; they want Lloyd's to be strongly managed; and they want the minimum amount that can be invested at Lloyd's increased in the future.

When Lloyd's is on its feet again and people are interested in joining, "we will up the ante," he said.

But the institutions that have approached Lloyd's are also concerned that an influx of corporate capital into the market may send underwriting capacity soaring and rates tumbling.

To prevent this, the business plan proposes that Lloyd's should for the first time seek to manage its capital. In the middle of each year, Lloyd's officials will consult with the market's active underwriters concerning the level of underwriting capacity they see as desirable for the following year. A maximum capital limit will then be set and the market will have to stick with it.

Existing names will be given the first opportunity to increase their capital and therefore their underwriting limits. Then new names, both private and corporate, will be invited to make up the difference.

Lloyd's will undertake what Mr. Middleton termed a "bookbuilding exercise," supervised by a merchant or investment bank, to raise underwriting capacity to the desired level. Companies will bid for the chance to join as corporate names.

Lloyd's estimates that the bids, which will be officially termed "entrance fees" and will be paid into the Central Fund, will vary between 0.5% and 2.5% of premium limits. When the full target capacity has been reached, the book will be closed.

Corporate names will not enjoy the same gearing advantages as individual names whose liabilities remain unlimited. Corporate names will have to deposit funds at Lloyd's equal to at least 50% of their overall premium income limits. Under new rules in the business plan, individual names will only have to deposit 20% to 25% of their overall premium income limits.

The business plan envisages corporate capital being admitted next year. No changes to British law will be required for this to occur, but changes to U.S. state insurance laws may be needed.

Rising costs come under intensive scrutiny in the business plan, which proposes slashing costs 30% over the next two years. That includes eliminating 2,500 of the 12,000 jobs now in the market.

"Lloyd's costs are too high and are not falling fast enough to reach the levels required to achieve our target profitability," said the report. That target is a very ambitious 33% annual return on members' funds and a 20% return on corporate capital.

To help achieve this, managing agents' fees will be restricted to a maximum 0.5% of capacity in 1994 and 0.4% in 1995. This will result in an annual savings to names of about 15 million pounds ($23.6 million), the report said. Projected syndicate expenses will be subject to stringent external review by a panel of independent members agents.

James MacDonald, finance director of Sturge Holdings P.L.C., said the change in fees will not pose a problem to Sturge-owned agencies. "We are already at that level anyway because we reduced our fees to 0.5% last year," he said.

Other agencies may not fare as well. The plan calls for more extensive intervention by the new Market Board and Regulatory Board to "identify and take action on managing agents that appear to be no longer economically viable."

Members agencies have also been targeted for a major restructuring. The plan proposes to establish a single service company, the Central Services Unit, to provide administrative services to all members agents. Beginning next year, that unit should enable agencies to cut costs and lower fees to members.

The business plan proposes new classes of membership: "high-liquidity" names who have liquid assets of at least 500,000 pounds ($787,000) and names who belong only to members agents pooling arrangements, which would be similar to mutual funds.

The high-liquidity names will be allowed to deposit funds at Lloyd's equal to only 20% of their premium income limit, subject to a minimum deposit of 200,000 pounds ($314,800). MAPA-only names will be allowed to participate on the basis of lower solvency ratios.

Other changes proposed in the business plan include expanding Lloyd's membership in non-English speaking countries, building positions in new markets and accelerating the move to electronic processing of claims.

Several outside observers praised the plan last week.

For the first time, Lloyd's is mandating changes rather than suggesting that changes are the best market practice, observed Michael Butt, director of Phoenix Securities Ltd. in London and future vice-chairman of Mid-Ocean Reinsurance Co.

There will be a lot of squealing in the marketplace and among members about some of the changes, but these should be ignored, he said.

"The change of style is dramatic for the Lloyd's community," he added.

Lloyd's officials warned last week that the market may have no future if the plan is not is not supported by market professionals and members. Implementation of the plan will start immediately after the May 3 bank holiday in Britain, they said.

"The danger of producing a plan like this is that you then sit back and admire it," Mr. Middleton said. "We aren't going to do that. This plan starts Tuesday." BI

Dual regulation

Continued from page 1

would cost $1.8 billion during its first six years.

"This bill would require states still to spend money to regulate those insurers that chose not to be federally certified while the federal government spent additional billions. By any calculation or measure, it is clear that H.R. 1290 would cost the American taxpayer a mint while not saving one penny," he said.

Mr. Foster said state regulation can be bolstered without adding a federal layer of bureaucracy. He cited the NAIC's financial regulation standards and accreditation program as an example of how this could be achieved.

Rep. Dingell asked how many state insurance departments had earned accreditation, and Mr. Foster replied that though 19 had once been accredited, there were now only 18.

"Do you mean the number's going down?" asked Rep. Dingell.

Mr. Foster said that the revocation of New York's accreditation earlier this year because it didn't meet the NAIC's standards showed how well the accreditation process is working (*BI*, March 19).

Rep. Dingell did not seem impressed with the argument and continued to question Mr. Foster on the effectiveness of state insurance regulation.

Subcommittee Chairwoman Cardiss Collins, D-Ill., also seemed less than dazzled by the states' regulatory performance, saying regulators have been "rather lax" in carrying out their oversight duties.

Rep. Dingell said that his committee's Oversight and Investigations Subcommittee will look further into the matter of state oversight.

The Republican members of the Commerce, Consumer Protection and Competitiveness Subcommittee were considerably more sympathetic to Mr. Foster's arguments and uniformly critical of creating a federal regulatory system before exhausting all state approaches.

Rep. Stearns was particularly critical of the large insurer carve-out in Rep. Dingell's bill.

"I have reservations about dual-track regulation when based solely on the size of the company. If we further segment the market based on the size of the insurer, I am afraid we'll stifle innovation in the marketplace," he said.

"As with most markets, the real innovators in the insurance industry are often the smaller, entrepreneurial companies. If through regulatory laws which give a greater pricing advantage to large companies, we effectively eliminate the ability of these companies to compete, then we will have done consumers of all sizes a great disservice," Rep. Stearns said.

Later in the more than five-hour-long hearing, Robert E. Vagley, president of the Washington-based American Insurance Assn., said in response to a question from Rep. Collins that he hoped Congress would consider ways to make the commercial insurance market available to more buyers and sellers.

Mr. Vagley, who supports federal solvency regulation, suggested that Congress consider factors other than arbitrary capital requirements to define "sophisticated" purchasers of insurance. One factor he recommended is whether the purchaser employed a risk manager.

The Risk & Insurance Management Society Inc. last year expressed support for federal solvency regulation of property/casualty insurers writing coverage for large commercial policyholders (*BI*, April 6, 1992).

RIMS also last month advocated the creation of a national guaranty fund. "RIMS believes that a national, prefunded guaranty fund, with uniform rules and administrative practices, will promote greater fairness and efficiency for insureds and will create greater financial security," the trade group said in a position paper.

The paper does not specifically endorse H.R. 1290. BI

London bombing

Continued from page 1

exclusion in most commercial property polices for losses in mainland Britain. Terrorism losses in British-occupied Northern Ireland are covered under a separate government compensation fund.

Pool Re's total current reserves are unknown because individual insurers are holding the reserves in trust until the pool is signed into law, said a spokesman for the Assn. of British Insurers.

The British Parliament is scheduled to consider by mid-May the legislation to establish Pool Re—which will be reinsured by the government. The government has indicated that it will respond to Pool Re claims as though the legislation was already in place.

Under Pool Re's arrangements, insurance companies and participating Lloyd's syndicates will pay 10% of claims above the pool's reserves. The remaining 90% will be paid by the British government.

If the pool's reserves are depleted, the brunt of damage from any subsequent terrorist attacks will have to be paid by the government until Pool Re receives fresh funds as policies are purchased, said a spokesman for the British Department of Trade and Industry. The pool is funded by an extra premium on property policies written by participating insurers.

Pool Re's viability in the event of future bomb blasts has been called into question by some.

The ABI estimates that annual premium income from the terrorism levy will total about 250 million pounds ($393.5 million). But insurers and loss adjusters said this amount may be inadequate to meet the cost of any future explosions.

Losses in excess of the pool's reserves will be expensive both for insurers, which may be forced to raise rates, and taxpayers, who will have to foot a substantial portion of claims paid by the government.

The Department of Trade and Industry will meet with the ABI this week to discuss future arrangements for Pool Re, an ABI spokesman said. The government may pressure Pool Re to increase premium rates, which would be passed on to policyholders, he said. About 220 insurance companies and Lloyd's syndicates participate in the pool.

Pool Re's rates for properties in major cities, like London, range from 0.09% of insured values for property worth up to 5 million pounds ($7.9 million) to 0.023% for property valued at more than 500 million pounds ($787 million). Properties believed to be terrorist targets may be charged an additional 50% of their premium.

Pool Re rates have not changed since the explosion, the spokeswoman said.

AIRMIC Chairwoman Liz Taylor

Continued on next page



AP/Wide World Photo

$25 million in tornado damage

TULSA, Okla.—Insured property damage from a tornado that swept the Tulsa, Okla., area April 25 is expected to exceed $25 million.

Jerry Johns, president of the Southwestern Insurance Information Service in Austin, Texas, said estimates of insured property damage from the tornado, which killed seven people, were between $25 million and $28 million late last week.

The tornado damaged or destroyed homes, businesses and churches in Tulsa and Rogers counties. In the town of Catoosa, about 15 miles east of Tulsa, it destroyed at least 75 mobile homes and approximately 25 houses. Several truck stops in the area, like the one pictured above, were also damaged by the twister.

Mr. Johns stressed that the estimates were preliminary because claims were being submitted slowly. "It could conceivably go quite a bit higher," he said.

A spokesman for Bloomington, Ill.-based State Farm Group, one of the largest insurers in Oklahoma, said last Friday that it had received about 3,400 property claims totaling about $6.8 million, and about 2,000 auto claims worth about $2.6 million.

The Property Claim Services division of the American Insurance Services Group expects to issue an estimate of insured property damage later this week.

—By Mark A. Hofmann

Asbestos coverage appeal

Continued from page 2

From Sept. 1, 1977, until Sept. 1, 1985, Owens-Illinois bought primary liability coverage with limits of $750,000 excess of a $250,000 per occurrence self-insured retention from United Insurance Co., a Cayman Islands-based group captive managed by International Risk Management (Cayman) Ltd.

Owens Insurance Ltd., the company's Bermuda captive, provided umbrella coverage with limits ranging initially from $50 million excess of $1 million to a high of $150 million excess of $1 million in 1985.

Owens Insurance, managed by an IRM affiliate, then reinsured 100% of its risk with United Insurance; General Reinsurance Corp. of Stamford, Conn.; CIGNA Reinsurance Co. of Philadelphia; and Allstate Insurance Co. of Northbrook, Ill.

The manufacturer filed suit in New Jersey Superior Court in 1984, seeking a ruling that its insurers and its captive reinsurers must defend and indemnify it for asbestos bodily injury and property damage claims.

A state judge handed Owens-Illinois a broad victory in 1990, finding in its favor and allowing it to tap the $960 million in aggregate limits of its liability policies from 1977 to 1985 (*BI*, April 16, 1990).

The three-judge appellate division panel affirmed part of that ruling last week, but reversed another.

Among other things, the appeals panel affirmed the lower court's application of the continuous trigger, also known as the triple trigger. Under this approach, insurers are liable for bodily injury claims if they are on a risk any time between a claimant's exposure to asbestos and manifestation of an asbestos-related disease.

The panel also ruled that once an insurer's policy is triggered, it is liable to the full extent of its limits, subject only to "other insurance" clauses. The court rejected insurers' arguments that their shares of the loss should be pro-rated based on the duration of claimants' exposure during their policy periods.

The panel also rejected the insurers' argument that each asbestos claim should be subject to a separate $250,000 self-insured retention, ruling that Owens-Illinois should absorb only one retention per policy period for those claims. "The insurers' position would completely nullify (Owens-Illinois') coverage—both primary and excess—for all but those few individual personal injury and property damage claims which exceed the $250,000 (retention)," the court found.

The insurers lost arguments that coverage should be barred by a number of exclusions and endorsements.

Among these was a product liability exclusion in the United policy that the court concluded was mistakenly inserted following the form of a pre-1977 policy. The exclusion was inconsistent with the rest of the United policy, which was clearly intended to cover product liability risks and for which Owens-Illinois paid "substantial premiums," the panel found.

The court criticized United for trying to use the exclusion, observing that "United has adopted the unholy mantra, 'we collect premiums; we do not pay claims.' "

Owens-Illinois suffered setbacks to these challenges in the appellate division: The panel ordered a trial on whether Owens-Illinois concealed its asbestos exposure from the insurers.

The appeals court noted that laboratory studies the company commissioned in the 1940s found that the company's insulating material, Kaylo, was hazardous and appeared to cause asbestosis. Only 25 asbestos claims were pending against Owens-Illinois in 1977, but the company reported these to its previous insurer, Aetna Casualty & Surety Co., and did not disclose them to United, the opinion says.

The company did not formally notify its insurers of its exposure until 1980, by which time about 2,000 claims had been filed, the opinion said.

Insurers had argued that Owens-Illinois sold Kaylo knowing of its dangers, and that coverage should be barred because the resulting claims were expected or intended by the manufacturer.

The insurers also charged that Owens-Illinois fraudulently concealed its asbestos exposure.

The panel reversed the lower court's dismissal of these claims, finding enough factual questions in the charges to require a trial.

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Owens Illinois Inc. vs. United Insurance Co. et al., Superior Court of New Jersey, Appellate Division, A-4411-89T2.

Update

Bill exempts large self-insureds

OLYMPIA, Wash.—Large self-insured companies would be exempt from a new requirement that employers offer a "certified health plan" under the final version of a universal coverage bill now awaiting Gov. Mike Lowry's signature.

Instead, companies with more than 7,000 employees could offer their own plans if they meet all the bill's requirements. That exemption was added by a conference committee last month.

However, smaller employers—including self-insurers—would be required to offer a uniform benefit package at or below the maximum premium set by a new five-member board to be appointed by the governor and confirmed by the senate (*BI*, April 12).

Beginning July 1, 1995, employers would be required to offer a certified plan to employees working more than 80 hours per month and their dependents, and to pay no less than 50% and no more than 95% of the premium of the lowest-cost plan within their region.

The state has not yet sought a waiver of the Employee Retirement Income Security Act and Medicaid law that would be required to implement provisions of the law.

Gov. Lowry is expected to sign the bill this month, and provisions to phase in universal coverage by 1998 would start in July.

New discovery rules criticized

WASHINGTON—Defense lawyers are objecting to a proposal by the U.S. Supreme Court to change the way pretrial information is exchanged in civil lawsuits.

Last month the court proposed altering the Federal Rules of Civil Procedure to require parties in federal court to disclose upfront certain core information—including insurance limits. The change would take effect Dec. 1 unless Congress intervenes.

Defense lawyers argue that the new rule would make information —like insurance details—too readily accessible to plaintiffs.

Legal reform groups and some academics support the changes in the discovery rules as a way to curb litigation costs.

Trustee Superfund liability rule

PHOENIX—Trustees could face Superfund liability for full cleanup costs if they had the power to control the use of contaminated land and knowingly allowed hazardous waste disposal, a federal judge has ruled.

U.S. District Judge Samuel Conti established the two-pronged test in response to a pretrial motion in the case of an Arizona bank acting as trustee of a dump site. The trial court can use the test in June to determine how much the bank should pay to help clean up the property, which subsequently was purchased by the city of Phoenix.

Earlier this year the judge ruled the bank could be held liable, but did not indicate the extent of its liability.

The judge rejected arguments by Valley National Bank—now Bank One, Arizona—to limit its potential liability to total trust assets. Instead, the bank, which leased the site to Garbage Services Co., could be liable for total cleanup costs now estimated at $60 million.

This ruling will make trustees more wary of the condition of the land they hold and the way they manage it, said Thomas Greco, associate general counsel at the American Bankers Assn.

Briefly noted

A Johnson & Higgins official denied reports that J&H would buy the 70% stake of **International Risk Management Group Ltd.** held by Swiss Reinsurance Co. . . .The U.S. Supreme Court let stand an appellate court ruling that **Trans World Airlines Inc.** was not guilty of willful misconduct for failing to prevent a terrorist from planting a bomb on one of its jets in 1986 (*BI*, Sept. 7, 1992). The family of a man killed in that explosion charged that TWA's security had been lax and that they should therefore be allowed to seek damages in excess of the $75,000 per person limit set by the Warsaw Convention. . . .Approximately 100 small business owners in Los Angeles are suing 50 defendants—including alien, non-admitted insurers, surplus lines brokers, retail agents and adjusters—over unpaid claims related to the **Los Angeles riots**. . . .Hearings are expected later this spring before the House Energy & Commerce Committee on a new **federal product liability bill**. H.R. 1910 is similar to a Senate bill introduced earlier this spring (*BI*, April 5). . . .Florida Gov. Lawton Chiles last week signed the **Health Care and Insurance Reform Act of 1993**, the first such state law based on managed competition. Small firms say several provisions in the act could kill its chance for success (*BI*, April 12). . . Vermont Gov. Howard Dean is expected to soon sign legislation that would allow **captives** domiciled in the state to directly write group life and health coverages. Meanwhile, a conference committee was meeting over the weekend to try to resolve differences in a broad economic package approved by the House and Senate that would substantially reduce premium tax rates for Vermont captives (*BI*, April 26). . . .**Wind, hail and tornadoes** caused an estimated $60 million in insured property damage to parts of Missouri and Texas on April 19, reports the Property Claim Services division of the American Insurance Services Group. . . .A Texas judge has ordered **Western Lloyds Insurance Co.** into temporary receivership after regulators found it insolvent by $9.2 million. The insurer wrote property, general liability, inland marine and crop insurance and automobile reinsurance. . . .Sphere Drake Underwriting Management (Bermuda) Ltd. is the new lead underwriter for the **Risk Exchange Assn.**, which has written no business since Skandia America Reinsurance Corp. left as lead underwriter. . . .Lloyd's of London underwriting agency **Sturge Holdings P.L.C.** is expected to announce this week that it will cease underwriting policies for its marine syndicate 206, insurers said. Sturge would not comment. Sturge last week said it would leave eight syndicates open for the 1990 underwriting year.

London bombing

Continued from previous page

recently contended that Pool Re is underfunded and will not work (*BI*, April 12).

Last week, at the Risk & Insurance Management Society Inc. conference in Orlando, she reiterated AIRMIC's call for a compulsory levy on all commercial and personal property policies to cover terrorism losses. The government could then reinsure the fund generated by the levy, which could total 300 million pounds ($472.2 million) per year, she said.

"We are very concerned that the government is going to have to pick up too much of this loss," said Ms. Taylor, group risk manager for Harrisons & Crosfield P.L.C. in Ipswich. "This returns us to our original proposition for a compulsory levy so that everybody contributes toward this risk."

Critics of the AIRMIC plan say that a compulsory levy would benefit only businesses in London—which is the country's main financial center and a key target of terrorists—and not the rest of the country.

"But the City of London is there for the benefit of the nation as a whole, and I think it's a bit of a cop-out for people not in London to say that they won't participate—because they do benefit," said Ms. Taylor.

She also said a compulsory levy might deter the IRA from thinking that it is hitting the government's pocketbook with every bombing.

Many other British executives at the RIMS conference were affected by the blast, particularly executives of Willis Corroon Group P.L.C., Alexander & Alexander Services Inc. and others whose offices were damaged.

The April 24th explosion came almost exactly one year after a nearby bombing badly damaged the Baltic Exchange building and Commercial Union P.L.C.'s headquarters (*BI*, April 20, 1992). Insured damages have been placed at $700 million. The IRA also claimed responsibility for that attack.

The ABI said last week that early damage estimates of 1 billion pounds ($1.57 billion) from last month's explosion are likely to prove "wildly inaccurate." Total damage is more likely to reach about 300 million pounds ($472 million), the insurer group said.

Many businesses damaged by the blast still have terrorism coverage under their property policies, the ABI noted. Policies that have not yet been renewed this year do not contain the new terrorism exclusion. Some businesses that have renewed their coverage may have decided not to pay extra for terrorism coverage.

Most major British insurers expect lower losses from the April 24th blast than from last year's bombing.

A notable exception is Commercial Union P.L.C., which had not made any changes to its terrorism reinsurance arrangements this year prior to the explosion. That means the company will have to pay claims of up to 100,000 pounds ($157,400) under its standard commercial property polices.

Commercial Union estimates it will incur losses of about 25 million pounds ($39.4 million) net of reinsurance. "We have since purchased terrorism reinsurance from Pool Re to protect against future attacks," a spokesman said. Commercial Union paid out 15 million pounds ($23.6 million) in claims from last year's bomb.

Sun Alliance & London Insurance P.L.C. expects claims of about 15 million pounds ($23.6 million), of which 5 million pounds ($7.9 million) will be covered by reinsurance. Sun Alliance bought terrorism reinsurance "on the open market" earlier this year, a spokeswoman said. Sun Alliance paid 39 million pounds ($61.4 million) in net losses in last year's bombing.

General Accident Fire & Life Assurance Corp. P.L.C. expects about 7 million pounds ($11 million) in claims from the explosion, roughly in line with last year's losses, a spokesman said.

Royal Insurance P.L.C. and Guardian Royal Exchange P.L.C. each forecast net losses of less than 5 million pounds ($7.9 million). Both bought terrorism reinsurance earlier this year from Pool Re to protect against losses under expiring property policies.

GRE incurred 10 million pounds ($1.6 million) in losses from last year's explosion and Royal paid 15 million pounds ($23.6 million) in net losses.

The ABI said last week that businesses affected by the bombing "are likely to have carefully worked out contingency plans which should minimize the disruption and keep down business interruption claims." London's weak real estate market has also left office space open for relocating companies.

Press reports following the attack said that most firms displaced by bomb damage had found alternative space.

Three of the most important buildings in the City—Lloyd's of London, the Stock Exchange and the Bank of England—were not damaged..

Among the hardest hit was The Hong Kong & Shanghai Bank, which was the main tenant in the 99 Bishopsgate building.

The bank's offices will probably have to be demolished, said David Rowland, U.K. marketing director of Thomas Howell International, the bank's loss adjusters. He said the bank is covered for terrorism by its captive insurer and several insurers led by Sun Alliance. The coverage was renewed on March 1 and the risk is reinsured with Pool Re.

The Hong Kong & Shanghai Bank's London headquarters is in a different part of London and most of its staff will be moved to that and other sites in the city, a bank spokesman said.

National Westminster Bank's headquarters, the NatWest Tower, was badly damaged. A spokesman would not comment other than to say the bank is "fully insured." Insurance for the building is spread throughout the London market and may be covered for terrorism losses under policies that had not yet renewed since Pool Re's formation.

A Pool Re spokesman said some of the insured terrorism claims from the NatWest tower may be reinsured by the pool. With little commercial reinsurance available for terrorism risks, some insurers have purchased reinsurance with Pool Re to cover losses in excess of the 100,000 pound ($157,400) automatic terrorism cover that is included in expiring insurance policies.

National Westminster's approximately 1,300 staff members who work in the tower have been been moved to other locations, said the bank spokesman. Last year's blast blew out about 100 windows at the NatWest Tower.

Willis Corroon relocated the 500 people who worked in its Camomile Street office to other offices. It is too early to say what the cost will be to Willis and its insurers for business interruption and office damage, said a spokesman.

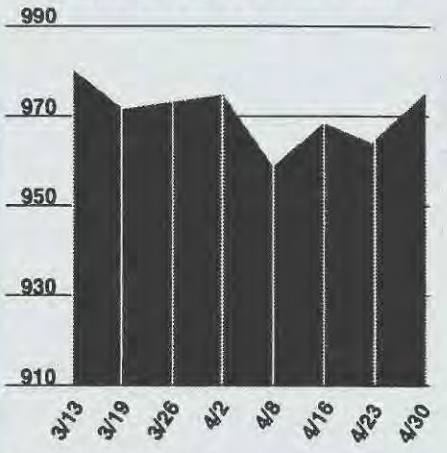
Lloyd's broker Macey Williams Ltd.'s offices in St. Helen's Place were also damaged.

Three other British banks, Barclays Bank P.L.C., Lloyds Bank P.L.C. and The Bank of Scotland P.L.C., also lost office space in the blast.

Other affected firms include: stockbroker Baring Securities; the National Bank of Abu Dhabi and the Abu Dhabi Investment Authority; Saudi International Bank; Tokai Bank; Long Term Credit Bank of Japan; U.S. law firm Simpson Thatcher & Bartlett; Mitsubishi Corp. Finance; and Korean securities firms Daewoo Securities and Coryo International.

Also, several London churches were badly damaged. Although most are insured for building damage and contents, they opted not to buy additional terrorism coverage. BI

BI Insurance Index



Base = 100 on Dec. 29, 1978
Source: Nordby International Inc.

Insurance industry stocks rose last week, as the *Business Insurance* Index climbed 11.4 points to 975.1 April 30 from 963.7 on April 23. Advancing issues for the week were led by: American Indemnity/Financial, up 23.4%; FHP International, up 16.5%; and U.S. Healthcare, up 12.7%. Declining issues for the week followed: SAFECO Corp., down 10.6%; Allied Group Inc., down 7.7%; and Frontier Insurance Group, down 7.4%. The most active issue was U.S. Healthcare, 11.3 million shares traded. The *BI* Index was up 1.2%; the NYSE Composite was up 0.7%; the Standard & Poor's 500 was up 0.7%; and the Dow Jones 30 Industrials rose 0.4%.

British Issues

April 29 Companies	Price pence	P/E	Div. pence	Yield %	1 Week High—Low pence	pence
Commi Union	586	N/M	32.5	5.5	608	586
Genl Accident	560	N/M	35.7	6.4	566	560
Gdn Royal Exch	185	N/M	9.3	5.0	185	179
Royal	319	N/M	6.7	2.1	326	319
Sun Alliance	327	N/M	19.0	5.8	329	325
Brokers						
Bradstock	125	14.6	6.8	5.4	126	125
CE Heath	313	18.1	21.3*	6.8	313	310
Hogg Group	190	16.7	10.9	5.7	190	190
JIB Group	191	18.9	10.0	5.2	194	191
Lloyd Thompson	279	22.5	7.5	2.7	279	279
Lowndes Lmbrt	349	13.9	16.8	4.8	350	349
PWS Holdings	59	8.7	5.3	9.0	59	59
Sedgwick Grp	166	20.4	8.0	4.8	170	165
Steel Brrl Jones	218	12.8	17.7	8.1	219	216
Willis Corroon	174	16.3	8.8	5.0	177	174

Source: Philip Olsen, London * Estimated

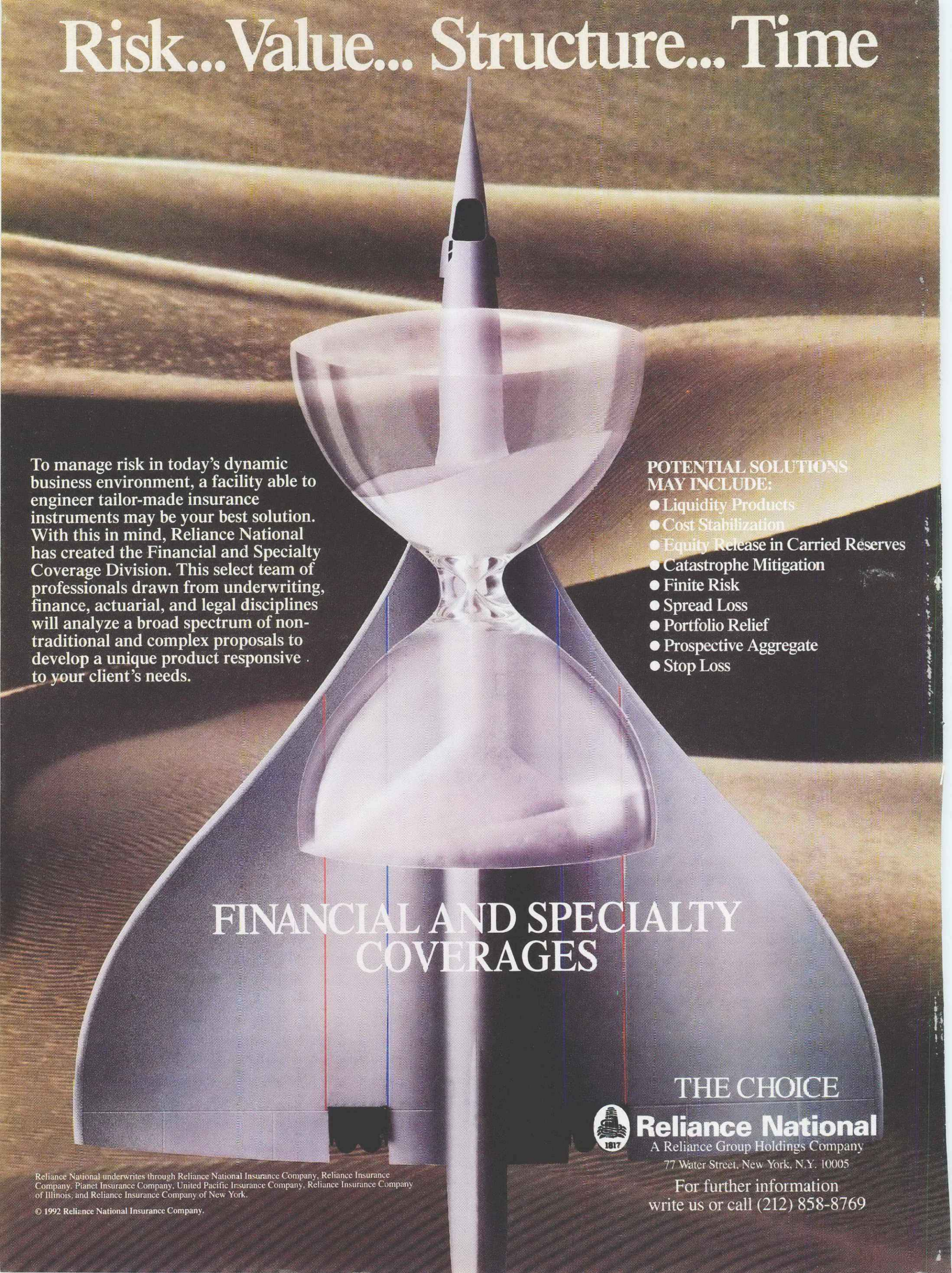
BI Industry Stock Report

APRIL 26, 1993 THROUGH APRIL 30, 1993

BROKERS		Price	Weekly % change	Year to Date % change	Annual High	Annual Low	Vol.(000)	$ Div.	% Yield	P/E	Book value	Mkt/Bk. value
Acordia Inc.	NYS	20.88	0.00	-2.91	24.75	15.13	23	0.36	1.72	13	7.01	2.98
Alexander & Alexander	NYS	25.88	5.08	-2.36	28.88	19.00	590	1.00	3.86	22	10.00	2.59
Gallagher Arthur J. & Co.	NYS	33.50	0.37	18.58	35.63	21.00	170	0.72	2.15	21	6.35	5.28
Hilb, Rogal & Hamilton	NYS	15.50	-3.88	-0.80	16.88	11.00	102	0.44	2.84	21	3.11	4.98
Marsh & McLennan	NYS	89.50	-3.24	-2.05	97.63	73.50	526	2.68	2.99	21	14.40	6.22
Poe & Associates	OTC	20.13	0.63	20.15	21.25	11.25	16	0.40	1.99	77	2.64	7.62
BROKERS	AVERAGE		-0.2	5.1					2.2	25		
CONGLOMERATES & HOLDING COMPANIES												
Berkley W.R. Corp.	OTC	43.00	-0.58	0.00	50.50	31.25	469	0.40	0.93	16	23.51	1.83
Berkshire Hathaway Inc.	NYS	12650.0	0.80	7.66	12650.0	277.34	1	0.00	0.00	-42	6437.3	1.97
ITT (Hartford Group)	NYS	82.00	2.66	13.89	84.25	62.50	1109	1.96	2.39	-35	68.23	1.20
Sears (Allstate)	NYS	52.38	-2.10	15.11	55.75	37.75	4858	1.60	3.05	-9	40.18	1.30
CONGLOMERATES	AVERAGE		0.2	9.2					1.6	-18		
INSURERS/REINSURERS												
ACE Ltd.	NYS	28.63	0.88	-	29.63	27.50	1341	0.00	0.00	-	34.06	0.84
AEGON N.V.	NYS	45.13	-4.24	8.41	49.38	33.00	36	0.68	1.51	8	34.06	1.32
Aetna Life & Casualty	NYS	52.88	3.17	13.71	53.75	38.00	1500	2.76	5.22	96	67.08	0.79
Allied Group Inc.	OTC	38.75	-7.74	22.05	45.50	18.75	241	0.72	1.86	9	11.29	3.43
Allmerica Prop. & Casualty	NYS	55.00	-3.51	8.91	60.38	34.75	74	0.44	0.80	5	40.44	1.36
American General	NYS	29.75	0.00	-47.81	33.25	21.56	1793	1.08	3.63	12	39.89	0.75
American Heritage Life Ins.	NYS	35.00	6.87	15.70	35.00	27.13	13	0.84	2.40	16	16.51	2.12
American Indemnity/Fin'l	OTC	9.88	23.44	64.58	9.88	4.75	82	0.08	0.81	5	14.43	0.68
American International	NYS	126.63	1.71	9.16	131.88	83.00	2589	0.56	0.44	16	54.21	2.34
American Re Corp.	NYS	38.50	1.65	4.05	41.75	34.25	483	0.00	0.00	39	N/A	N/A
Aon Corp.	NYS	51.25	-3.98	-5.09	56.75	41.25	270	1.80	3.51	17	27.17	1.89
Argonaut Group	OTC	33.25	-4.32	9.02	35.25	25.50	91	0.84	2.53	10	21.70	1.53
AVEMCO Corp.	NYS	21.25	0.00	-9.09	28.00	21.00	5	0.40	1.88	25	7.33	2.90
Baldwin & Lyons Inc.	OTC	33.50	-1.47	-8.22	36.50	27.00	1	0.48	1.43	8	30.85	1.09
Chandler Insurance	OTC	4.13	10.00	-13.16	7.63	3.50	1	0.00	0.00	17	8.63	0.48
Chubb Corp.	NYS	89.38	-0.69	0.56	96.38	64.63	1614	1.72	1.92	13	40.67	2.20
CIGNA Corp.	NYS	60.88	-1.02	3.84	68.00	47.13	635	3.04	4.99	11	81.73	0.74
CNA Financial Corp.	NYS	96.25	-1.66	-1.79	102.88	81.50	116	0.00	0.00	-9	80.24	1.20
Continental Corp.	NYS	27.38	2.82	1.86	34.75	20.00	477	1.00	3.65	13	38.32	0.71
EXEL Ltd.	NYS	50.50	-0.74	6.88	51.88	32.38	499	1.00	1.98	9	N/A	N/A
Fund American Corp.	NYS	82.00	2.34	13.89	84.00	64.00	20	0.00	0.00	14	81.85	1.00
Fremont General Corp.	OTC	41.38	0.00	19.93	41.50	41.38	0	0.00	0.00	-	25.62	1.61
Frontier Insurance Group	NYS	45.38	-7.40	4.31	49.00	30.25	80	0.60	1.32	16	13.97	3.25
Gainsco Inc.	ASE	15.38	0.82	8.85	18.56	8.00	196	0.04	0.26	19	2.65	5.80
General RE Corp.	NYS	115.50	-1.49	-0.22	130.50	79.00	1268	1.88	1.63	17	46.07	2.51
Guaranty National Corp.	NYS	20.88	-5.11	5.70	24.00	14.00	26	0.00	0.00	13	9.12	2.29
Harleysville Group	OTC	29.00	-1.69	2.65	32.75	18.00	74	0.64	2.21	18	16.77	1.73
Hartford Steam Boiler	NYS	56.00	-0.67	-3.03	59.88	50.88	124	2.12	3.79	21	19.74	2.84
HCC Insurance Holdings	OTC	21.50	-4.44	6.17	23.50	12.25	171	0.00	0.00	22	19.74	1.09
Kemper Corp.	NYS	38.38	1.66	29.54	43.00	20.75	743	0.92	2.40	-11	37.66	1.02
Lawrence Insurance Group	ASE	6.38	10.87	-26.09	10.25	5.50	3	0.12	1.88	106	4.66	1.37
Liberty Corp.	NYS	32.13	-3.02	13.72	33.88	24.88	63	0.56	1.74	13	18.43	1.74
Lincoln National	NYS	80.13	0.00	9.57	83.63	53.50	399	3.04	3.79	10	58.92	1.36
Markel Corp.	OTC	32.63	-4.74	4.40	36.50	23.00	227	0.00	0.00	7	15.44	2.11
Mutual Risk Mgmt. Ltd.	NYS	39.50	11.27	-2.47	46.00	25.75	44	0.28	0.71	23	7.51	5.26
NAC Re Corp.	OTC	39.63	-5.93	-2.16	44.75	21.75	529	0.16	0.40	70	13.60	2.91
National Re Corp.	NYS	39.50	0.64	33.33	39.63	17.63	388	0.12	0.30	15	N/A	N/A
Navigators Group	OTC	32.75	0.00	0.77	38.00	28.50	2	0.00	0.00	25	15.69	2.09
Nobel Insurance LTD.	OTC	6.69	1.90	13.84	8.25	4.25	162	0.00	0.00	2	3.91	1.71
NWNL Companies	NYS	59.00	6.07	15.97	64.88	34.50	390	1.60	2.71	14	46.21	1.28
Ohio Casualty Corp.	OTC	62.75	-3.83	-0.59	68.75	49.50	258	2.84	4.53	12	43.08	1.46
Old Republic Int'l	NYS	23.63	1.61	-5.03	27.38	19.50	419	0.40	1.69	8	18.63	1.27
Orion Capital Corp.	NYS	43.00	-5.75	21.55	46.38	23.69	170	0.80	1.86	9	28.62	1.50
Phoenix RE Corp.	OTC	30.50	3.83	93.65	30.50	9.00	671	0.20	0.66	-47	13.32	2.29
Provident Life	NYS	29.13	-0.43	2.19	31.50	20.75	65	1.04	3.57	11	30.38	0.96
Re Capital Corp.	ASE	15.00	0.84	-9.09	16.63	12.25	40	0.28	1.87	71	16.88	0.89
Reliance Group Holdings	NYS	6.63	-3.64	8.16	8.50	4.25	1249	0.32	4.83	3	2.94	2.25
RLI Corp.	NYS	25.25	-2.42	2.02	28.63	18.13	23	0.52	2.06	11	17.92	1.41
St. Paul Companies	NYS	79.50	-0.16	3.25	83.25	67.88	340	2.80	3.52	12	59.79	1.33
SAFECO Corp.	OTC	57.88	-9.57	1.98	66.75	47.00	2798	1.64	2.83	15	35.37	1.64
SCOR U.S. Corp.	NYS	18.88	-1.95	7.86	20.75	13.13	74	0.32	1.70	79	14.39	1.31
Seibels Bruce Group	OTC	0.94	-6.20	-49.97	6.13	0.38	128	0.00	0.00	-0	6.22	0.15
Selective Ins. Group	OTC	24.25	0.00	10.23	25.75	18.38	55	1.12	4.62	12	20.22	1.20
Statesman Group Inc.	OTC	13.00	-1.89	8.33	16.50	5.00	775	0.20	1.54	7	6.71	1.94
Tokio Marine & Fire	OTC	62.75	4.80	30.73	62.75	36.75	15	0.00	0.00	-	70.93	0.88
Torchmark Corp.	NYS	54.63	-0.68	-3.74	64.75	37.00	371	1.04	1.90	15	14.87	3.67
Transamerica	NYS	49.38	0.25	2.86	56.13	40.00	816	2.00	4.05	11	35.86	1.38
Transatlantic Holdings	NYS	49.63	-2.46	-11.58	56.75	29.38	140	0.28	0.56	16	21.85	2.27
Traveler's Corp.	NYS	27.50	-4.35	0.92	30.75	17.13	2321	1.60	5.82	-4	43.85	0.63
Trenwick Group Inc.	OTC	46.75	-2.60	14.72	49.75	25.75	153	0.80	1.71	17	23.87	1.96
United Fire & Casualty	OTC	37.50	7.14	-9.64	43.00	35.00	0	1.00	2.67	107	28.47	1.32
Unitrin	OTC	43.50	-2.79	1.75	46.75	32.75	440	1.20	2.76	14	36.51	1.19
UNUM Corp.	NYS	54.88	3.05	3.54	58.38	35.75	1038	0.80	1.46	15	21.83	2.51
US Facilities Corp.	OTC	10.50	-3.45	5.00	13.75	6.50	196	0.00	0.00	14	9.64	1.09
USF&G Corp.	NYS	17.00	-5.56	37.37	19.63	9.88	1471	0.20	1.18	-100	10.29	1.65
USLICO Corp.	NYS	17.13	-1.44	-4.86	20.00	15.00	53	0.24	1.40	-5	29.80	0.57
USLIFE Corp.	NYS	37.50	-0.66	3.45	42.63	29.25	579	1.20	3.20	12	64.90	0.58
Washington National	NYS	25.25	-1.94	9.78	28.00	17.63	69	1.08	4.28	15	30.27	0.83
Zenith National Ins.	NYS	26.38	-1.40	33.54	29.25	16.38	101	1.00	3.79	28	14.81	1.78
INSURERS/REINSURERS	AVERAGE		-0.3	6.5					2.3	18.8		
HEALTH MAINTENANCE ORGANIZATIONS												
FHP International	OTC	24.75	16.47	23.75	29.00	13.25	1223	0.00	0.00	23	9.61	2.58
Pacificare Health Sys.	OTC	37.00	5.71	-27.45	57.50	25.50	535	0.00	0.00	20	3.90	9.49
Safeguard Health Enter.	OTC	8.25	-2.94	-15.38	12.75	7.00	8	0.00	0.00	10	4.03	2.05
Sierra Health Services	ASE	14.25	-2.56	-34.10	21.69	8.06	137	0.00	0.00	12	2.01	7.09
TakeCare Inc.	OTC	39.63	1.60	-10.96	50.25	25.75	441	0.00	0.00	16	2.01	19.71
United Healthcare Corp.	NYS	54.00	9.64	-5.05	68.00	36.25	1625	0.03	0.06	33	4.68	11.54
United Medical Corp.	ASE	9.50	1.33	49.02	9.75	6.13	5	0.20	2.11	17	10.30	0.92
U.S. Healthcare	OTC	46.50	12.73	4.20	59.75	29.34	11343	0.52	1.12	23	3.60	12.92
HMOs	AVERAGE		5.2	-2.0					0.4	19		
ALL COMPANIES	AVERAGE		1.2	4.7					2.0	17		

System design: Nordby International Inc.

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- Portfolio Relief
- Prospective Aggregate
- Stop Loss

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