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Update

Maryland insurer exec Bramson pleads guilty to federal charges

BALTIMORE—Maryland insurance executive Leonard Allen Bramson has pleaded guilty to federal money laundering, conspiracy and fraud charges related to a web of U.S. and offshore insurers he operated for roughly a decade.

Mr. Bramson pleaded guilty April 24 in federal court in Baltimore to laundering up to $10 million in profits from a string of Bramson family-run insurers, including International Bahamian Insurance Co., Professional Risk Insurers

Continued on next page

Five offshore insurers face investigation

California officials study insurer finances

By DOUGLAS McLEOD

SAN FRANCISCO—The California Insurance Department is investigating the finances of five offshore insurers before deciding whether to allow them to continue writing surplus lines business in the state.

The five companies include two barred from writing business in Illinois last year.

Financial statements circulated earlier this year for one of the five insurers—Pendleton Insurance Co. Ltd.—included a phony audit opinion from the Bermuda office of Coopers & Lybrand, which has since disavowed any relationship with the insurer.

Another of the five is Trelawney Insurances Ltd. of Ireland, identified during a U.S. Senate hearing last year as among a group of companies operated by Atlanta-based insurance consultant Alan Teale. Trelawney has taken over California business previously written by another of Mr. Teale's companies, United States & Continental Reinsurance Co., which was enjoined from operating in California last year.

The California department has not decided whether to file objections against any of the five insurers with the state Surplus Lines Assn. The five are among nearly 30 offshore insurers whose financial statements are under review, said Dennis Ward, chief of the enforcement division.

An objection letter from the department would alert surplus lines brokers to regulators' concerns. Brokers would not place business with an insurer that is the subject of an objection letter.

Separately, the California Office of Administrative Law last week rejected emergency regulations that would have tightened financial and reporting standards for offshore insurers (see story, page 39).

In addition to Pendleton and Trelawney, insurers under regulatory review include Tiberian Insurance Co. Ltd. of Anguilla, West Point Insurance Co. Ltd. of Antigua and West Atlantic Insurance Co. Ltd. of the Turks & Caicos Islands.

Pendleton—initially domiciled in the British Virgin Islands and more recently in Anguilla—has had a variety of problems with its audited financial statements over the last year and has run into problems with regulators in several jurisdictions.

It was formed in Tortola, British Virgin Islands, in January 1990 by Aurora Investment Trust Ltd., a Cayman Islands firm represented by New York insurance executive Vishwa P. Shah.

Previously, Mr. Shah had operated Universal Casualty & Surety Co. Ltd. of the Cayman Islands, which entered liquidation in 1984 and which liquidators later charged had reported non-existent assets in financial statements (*BI*, Dec. 17, 1990).

In a case unrelated to this investigation, Mr. Shah also pleaded no

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L.A. riot damage costliest in history

Losses to top $200 million; most damage likely insured

By JOANNE WOJCIK

LOS ANGELES—Property damage from arson and looting in Los Angeles County totaled more than $200 million late last week.

And damage was expected to increase from the estimate by the Los Angeles Fire Department on Friday as violence spread to wealthier areas like Westwood, Santa Monica and Long Beach, where 104 fires were reported Friday.

By Friday, at least 30 people were killed in riots touched off by the Rodney King verdict. More than 1,000 were injured.

"The situation is so fluid that anything I say now will be outdated in an hour," said a spokesman for Fireman's Fund Insurance Co. in Novato, Calif., who was trying to estimate the insurer's riot-related losses.

As of Friday, 34 claims had been filed with Fireman's Fund, including two for "well over $100,000" for fire and looting damage to a shopping center and a linen factory.

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AP/Wide World Photo

Los Angeles firefighters attempt to fight a fire in a commercial building, one of hundreds that raged in the city last week.

COBRA cover to continue even if insurer fails: Court

By CHRISTINE WOOLSEY

SAN FRANCISCO—An employer must provide COBRA benefits to former employees until the employer's legal obligation ends, even if the employer's health insurer fails, a federal judge ruled.

The ruling also suggests that employers that seemingly comply with proposed Internal Revenue Service regulations relating to continuation coverage may have to go further to ensure their former employees receive COBRA benefits.

"This case demonstrates the legal land mines out there for employers," commented Gerald L. Maatman Jr., an employee benefits attorney with Baker & McKenzie in Chicago. "Even if employers comply with the proposed IRS regulations, that's not a safe harbor."

The IRS regulations, proposed in 1987, require among other things that COBRA coverage be identical to the coverage provided under the plan to "similarly situated" beneficiaries.

But, in a bench ruling, U.S. District Court Judge Vaughn R. Walker in San Francisco said Congress intended a broader interpretation of the Consolidated Omnibus Budget Reconciliation

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Work comp system hurts California: Report

By JOANNE WOJCIK

SACRAMENTO, Calif.—A commission appointed by California's governor blames the workers compensation and legal system for many of the state's economic problems.

The California business community is applauding the commission's report, which backs some of business's pet workers comp and civil justice reform proposals.

Trial lawyers and consumer groups, though, dismiss the report, released April 23, as containing nothing new and serving only as a rubber stamp of Republican Gov. Pete Wilson's political agenda.

In its 107-page report, the Council on California Competitiveness, formed by Gov. Wilson in December and chaired by former Major League Baseball Commissioner Peter Ueberroth, asserts that jobs are leaving the state at a runaway pace that is threatening its economic future.

Employers, labor, insurers hail Minnesota comp reform. Page 4

Rising comp losses increase insurers' reform pleas. Page 12

Prompting this exodus, the panel said, are: the litigious and costly workers compensation system, which has become a "national embarrassment"; the state's complicated and counterproductive legal system; its complex regulatory system; and the poor education and training of youth and workers.

In the past 18 months, California lost more than a half-million jobs, while more than 600,000 people moved to the state, the report indicates.

"People are coming, but jobs are going," said Mr. Ueberroth in announcing the council's findings. "California has become a costly and difficult place to do business. Adopting our proposed measures will change that."

Mr. Ueberroth warned: "It's

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Update

Leonard Bramson pleads guilty

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Management Exclusive Co., Casualty Assurance Risk Insurance Brokerage Co. and Trans-Pacific Insurance Co. (F.S.M.) of Micronesia. The Maryland Insurance Department has appointed a receiver for these and 39 other firms formerly run by Mr. Bramson and his brother Martin, said Assistant U.S. Attorney Geoffrey R. Garinther.

Separately, Leonard Bramson pleaded guilty to fraud and other charges in federal court in Newark, N.J., last week, as did an associate, Kent E. Conshafter, stemming from their operation of Preferred Indemnity Insurance Co. of Old Bridge, N.J. The men admitted they ignored New Jersey Insurance Department demands that Preferred stop underwriting and continued to write high-risk liability business, creating fraudulent records to conceal its operation.

Leonard Bramson faces maximum sentences of 20 years on both the Maryland and New Jersey charges. Mr. Conshafter faces up to a 20-year sentence. No sentencing dates have been set.

Leonard Bramson also will help the Maryland receiver recover funds from the companies' more than 240 bank accounts worldwide. Up to $20 million may be recovered from those accounts, Mr. Garinther said.

The Bramson brothers and Mr. Conshafter were indicted in New Jersey last year, along with Warren H. Berkle Jr. Mr. Berkle pleaded guilty to conspiracy and fraud charges earlier this year and is still awaiting sentencing (*BI*, April 6).

Martin Bramson, who has a previous drug conviction, jumped bail last year and is being sought on New Jersey money laundering and fraud charges and Maryland weapons possession charges (*BI*, Nov. 4, 1991). Martin Bramson and his father, Norman, are believed to be operating two new medical malpractice insurers—National Medical Consultants and Grand Medical Insurance—through a post office box in Anguilla, British West Indies, Mr. Garinther said. Norman Bramson became a fugitive last year after pleading guilty to currency violation charges in Detroit.

C&F bad faith award

MARSHALL, Texas—A state court judge ordered Crum & Forster Inc. to pay Monsanto Corp. $71 million in bad faith damages for its actions in underlying pollution-related litigation.

That is only half what the judge could have awarded. A jury in March awarded Monsanto $50 million in punitive damages and three compensatory awards of $13.1 million, two of which could have been trebled, bringing the total to $142 million (*BI*, March 16).

But, after reviewing the jury's verdict, Judge Bonnie Leggat April 21 only trebled one $13.1 million award—plus $5.36 million in interest—for a violation of the Texas Deceptive Trade Practices Act. Monsanto also was awarded $15.5 million in attorneys fees.

The state court jury on March 5 ruled that Crum & Forster conspired with other parties to control "the prosecution of claims that were asserted against Monsanto." The jury also found that a Crum & Forster unit inappropriately denied Monsanto reimbursement of defense costs. Crum & Forster is appealing the ruling.

Insurer regulation study sought

WASHINGTON—A congressional panel is calling on the U.S. Treasury Department to determine what federal and state regulators should do to "anticipate and prevent severe financial difficulties in the insurance industry."

The House Banking, Finance and Urban Affairs' Subcommittee on Policy Research and Insurance unanimously approved H.R. 4731 Wednesday. The bill, sponsored by Rep. Ben Erdreich, D-Ala., orders a study and directs the Treasury "to determine any adverse effects that the solvency problems of (insurers) may have on the availability of credit in the U.S. economy."

Rep. Erdreich said the study would help determine whether state regulation would adequately protect policyholders.

Judgment in health cover scam

LOS ANGELES—A state court awarded $16.9 million to a broker and an association health plan that charged another broker with misrepresenting a purported London insurance placement.

Adams, Clay Insurance Brokerage Co. of Burbank and Transcare Assn. Inc. won the award April 24 against National Underwriters Insurance & Reinsurance Brokers of Boca Raton, Fla., and one of its employees, Gary I. Hoskie. Adams, Clay charged in a 1989 lawsuit that National Underwriters, Mr. Hoskie and others deceived it into paying $288,000 for non-existent health coverage purportedly placed with Arab Insurance Group of London (*BI*, Jan. 1, 1990).

About $1.3 million of the compensatory award will go to cover claims of trucking company members of Transcare, and the balance will go to Adams, Clay, said plaintiffs' attorney Walter Lack of Engstrom, Lipscomb & Lack in Los Angeles.

Utica Mutual Insurance Co. wrote errors and omissions coverage with limits of $1 million per claim/$3 million aggregate for National Underwriters and Mr. Hoskie, Mr. Lack said. But, Adams, Clay will argue Utica Mutual should pay the entire award because it turned down a $500,000 settlement offer, he said.

Lawyers appointed by Utica Mutual to defend National Un-

Continued on page 50

Errors & omissions

• Steve Brady is vp-professional liability for St. Paul Fire & Marine Insurance Co. in St. Paul, Minn. His company affiliation was incorrectly reported in the April 27 issue.

OSHA needs more funds, labor organization says

By JERRY GEISEL

WASHINGTON—Organized labor is charging that the federal government is spending less to enforce workplace safety rules than it does to protect fish and wildlife at a time when the worker injury rate is on the rise.

In "Death on the Job," a report issued last week, the AFL-CIO says that in 1990, the last year for which statistics are available, the workplace illness and injury rate hit its highest level in a decade.

In 1990, there were 8.8 injuries and illnesses per 100 workers, up from 8.6 in 1989 and the highest rate since 9.5 in 1979, the AFL-CIO says, citing Bureau of Labor Statistics.

The Occupational Safety and Health Administration, the 21-year-old federal agency charged with enforcing the nation's safety and health rules, has a budget of $300 million to promote workplace safety. States spend another $80 million on their OSHA-approved safety programs.

But that is still well short of the $1.1 billion that various federal agencies spend to protect fish and wildlife.

"The consequences of the lack of funding for OSHA are frightening when viewed in terms of the ability of the government to inspect workplaces for safety and health violations," the AFL-CIO report says.

OSHA and the state-approved safety programs have fewer than 2,000 inspectors to inspect nearly 6 million worksites. At the cur-

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Combining coverage holds promise, problems

'24-hour' cover explored

By MEG FLETCHER

CHICAGO—Employer, insurer and labor officials are willing to explore coordinating workers compensation plans with group health care benefits to put a lid on rising medical costs.

Although there are advantages to combining workers comp and group health care coverage into a single plan, many problems must be overcome before comprehensive "24-hour" coverage is a reality, a panel of executives agreed.

The panelists discussed the concept of 24-hour coverage at the seventh annual Harold H. Hines Jr. Memorial Symposium last week in Chicago.

About 330 people attended the April 29 symposium sponsored by the Chicago and Northeastern Illinois chapters of the Risk & Insurance Management Society Inc., the Insurance School of Chicago and *Business Insurance*.

The general concept of 24-hour coverage calls for combining group health and workers compensation benefits into a single program covering employees both on and off the job.

Several similarities between group health and workers comp programs could provide some basis for coordinating the two

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Employers alter retiree benefits in light of FAS 106

By CHRISTINE WOOLSEY

NEW YORK—Annual retiree health care expenses of employers that recognize their accumulated retiree health liabilities over an extended period under a new accounting rule are about six times higher than they would be under the pay-as-you-go approach, a new study says.

The higher expenses also mean a sharp cut in pretax earnings, it says.

Many companies are trying to combat this sting by altering their benefit plans to trim their retiree health care liabilities, reports the survey by TPF&C, the benefit consulting division of Towers, Perrin, Forster & Crosby Inc. in New York.

Large companies must adopt the Financial Accounting Standards Board's new retiree health care accounting rule, FAS 106, no later than 1993. It requires companies to accrue as an expense against earnings retiree health care obligations from the date employees are

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Mavis Walters is named 1992 APIW Insurance Woman of Year

By CHRISTINE WOOLSEY

NEW YORK—Mavis A. Walters, executive vp of the Insurance Services Office Inc., will receive the 1992 Insurance Woman of the Year award May 28 from the Assn. of Professional Insurance Women Inc.



Ms. Walters

The APIW is recognizing Ms. Walters for her "unique capacity to excel both as a skilled insurance technician and as a public interpreter of insurance issues," said Louise A. Ryan, APIW president and vp of St. Paul Reinsurance Management Corp. in New York.

The APIW introduced the Insurance Woman of the Year award in 1976.

Candidates for the award, who are nominated by

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Inside

✓ Minnesota's health care access law is a significant improvement over many other proposals, this week's editorial says. **PAGE 8**

✓ Workers comp insurers' 123% combined ratio for 1991 adds urgency to their plea for reform, the National Council on Compensation Insurance said at its annual issues conference. Coverage begins on **PAGE 12**

✓ A hardening London market presents "challenges and opportunities" for risk managers, said Lloyd's Chairman David Coleridge at the annual AIRMIC conference. Coverage begins on **PAGE 41**

✓ Britain's pollution problem and new environmental legislation could leave insurers with a hefty cleanup bill, says the Loss Prevention Council. **PAGE 45**

✓ Brokers are taking an optimistic view in their 1991 annual reports, analyst Leonard Wilson says. **PAGE 51**

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AP/Wide World Photo

Insurers' quake claims small

An earthquake and aftershocks last month caused less than $5 million in insured damage to downtown Ferndale and other areas in Northern California, according to the American Insurance Services Group Inc.'s Property Claim Services division. State authorities estimated total damage at $51 million—$30 million to homes and businesses and $21 million to state, county and municipal government property.

War on health costs shifts to drug plans

By MICHAEL SCHACHNER

In their battle against health care inflation, employers increasingly are finding that managing prescription drug benefits like other forms of health care can mean substantial savings.

Having realized that uncontrolled card-based prescription drug plans have driven utilization and costs to unprecedented heights, employers are now redesigning their drug benefit plans.

Employers are controlling drug costs by implementing mail-order drug plans, negotiating discounts with retail pharmacies, offering incentives to purchase generic rather than more costly name-brand prescription drugs, and implementing point-of-sale monitoring systems.

Some employers even are creating on-site, internally administered pharmacies (see story, page 24).

"Pharmaceutical benefits have come to the forefront of what employers can still control. There's clearly room for management both in terms of cost and utilization," said Beth Bird, a group benefits consultant with Hewitt Associates in Lincolnshire, Ill.

After years of paying little attention to drug costs and instead focusing on other areas of health care cost containment, employers just now are realizing that drug costs in most cases are equal to or exceed the amounts they are spending for mental health and substance abuse treatment.

Recent studies—like one by the Employee Benefits Research

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Flood waters subside, but questions remain

Insurers taking various stances when determining coverage issues

By SARA MARLEY

CHICAGO—While some insurers are making payments to owners of buildings hard-hit by last month's freak Chicago flood, other insurers have yet to make blanket determinations on how policies will be interpreted.

In addition, insurers do not have a firm estimate on insured losses, partly because business interruption claims have not yet been tallied.

Many insurers still are debating whether the breach in the tunnel beneath the Chicago River constitutes a "flood" or "water damage," though some have resolved that issue. For example, Protection Mutual Insurance Co. says the "Great Chicago Flood" was indeed a "flood."

And some aren't drawing a distinction.

"Due to the unique circumstances of the Chicago situation, Chubb has chosen to honor policyholders' claims. The flood exclusion in our commercial property policies does not apply," said a spokeswoman for Chubb Corp. in Warren, N.J.

While policyholders and others say that three weeks is too long to make coverage determinations, insurers defend the delay. Each manuscript policy in question, they say, may have a differ-

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Photo by Brooke Hummer

The Executive House has coverage for its flood-related losses.

Coverage confusion reigns for policyholders

By SARA MARLEY

CHICAGO—As waters subside from downtown Chicago basements, claims adjusters are wading through claims for property, business interruption and extra expense losses.

And as a few hours with a Continental Corp. adjuster shows, policy language can mean the difference between coverage and confusion.

The Executive House hotel, one of the buildings visited by Continental general adjuster Richard J. Kuzmanoff in the wake of the disaster, has a broad difference-in-conditions endorsement that provides coverage for virtually any peril.

No water seeped into the basement of the riverfront building, but the hotel lost electricity from April 13 to April 15 and was not fully operational until April 16, said Rahul Bhalla, director of finance at the hotel.

He estimates the hotel's business interruption and other losses at $60,000 to $70,000.

The hotel has a $100,000 deductible under the Continental policy, but it purchases insurance from Lloyd's of London syndicates that covers $85,000 of the deductible above a $15,000 retention. The Lloyd's policy follows the wording of the Continental policy.

A few blocks away, the Chicago Athletic Assn., which did take on a few inches of water, initially received a decidedly different message from Continental: "The reservation of rights letter is in the mail."

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Superfund study shows little money spent on cleanups

By STACY GORDON

SANTA MONICA, Calif.—A study showing that insurers and policyholders spend hundreds of millions of dollars on legal fees rather than on environmental cleanups may give ammunition to Superfund critics who want to dismantle the law's fault-based structure.

Insurers spend nearly a half-billion dollars annually on environmental claims, but precious few dollars actually go toward hazardous waste cleanup, according to a recent study by RAND's Institute for Civil Justice.

Instead, 88% of insurer money spent on environmental claims—or $410 million annually—is consumed by transaction costs like legal fees, leaving only $60 million to clean waste sites.

Specifically, insurers spend 42 cents of every dollar on coverage disputes, 37 cents to defend policyholders in environmental claims and 9 cents for internal transaction costs. Insurers spent only 12 cents on remedial expenditures.

Five Fortune 100 companies surveyed spent almost 21% of the money earmarked for pollution cleanup on transaction costs. However, the study does not estimate the total amount spent by all policyholders on transaction costs.

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No end in sight: Buffett

Berkshire ready to increase volume when market finally turns

By LORI BLOCK

OMAHA, Neb.—Warren E. Buffett says Berkshire Hathaway Inc. is ready to write more insurance and reinsurance business when the market turns.

The emphasis is on the "when."

Mr. Buffett, Berkshire's chief executive officer and widely acclaimed investment wizard, predicted a prolonged soft market years ago and is not ready to forecast a change any time soon.

With $8.7 billion in surplus supporting $856 million in net written premiums last year, Berkshire has the capacity to write a vast amount of additional business. But the company's insurance group holds firm in its resolve to not write business at what Mr. Buffett terms "ridiculously low prices."

"There will come a time when our volume will jump dramatically," Mr. Buffett said last week at the annual shareholders meeting, which resembles a religious revival more than a business gathering.

Mr. Buffett's comments, which echo those he made in the 1991 annual report, came in response to questions from at least 1,700 who packed the plush old Orpheum Theater in Omaha.

Each year, Mr. Buffett, sitting beside his sidekick and straight man, Vice Chairman Charles T. Munger, blitzes through the formalities of a shareholders meeting before fielding questions.

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Minnesota comp law gets favorable reaction

By SARA J. HARTY

ST. PAUL, MINN.—Employers, labor groups and insurers agree Minnesota's new workers compensation reform law is a step in the right direction, though each side points to some shortcomings.

A major provision in the new law, which Gov. Arne Carlson signed Tuesday, allows employers to require injured workers to seek treatment from managed health care networks and be subject to utilization review procedures.

The law also calls for a new relative value provider fee schedule that will cut current workers comp medical fees by 15% overall.

The law also limits lifetime benefits for minor injuries.

And, it requires insurers to allow employers to assume any size deductible in their workers compensation insurance programs.

Because of expected savings as a result of those provisions, the law mandates a 16% decrease in workers comp rates, effective Oct. 1.

The bill "is certainly a step in the right direction" and should "help shape the system in years to come," said Laurence Koll, counsel to the Minnesota Self Insurance Assn. in St. Paul.

While displeased with the benefit reductions that are contained within the law, the Minnesota AFL-CIO in St. Paul supported the bill and thinks "it will have significant cost savings attached," said President Bernard Brommer.

But, the AFL-CIO is "withholding judgment" on the managed care provisions in the bill, Mr. Brommer said. "We think there is a potential for employers to establish company doctors and essentially hold injured workers captive."

To a large extent the success of managed care will depend on how the Department of Labor and Industry regulates these managed care plans, he added.

"Allowing employers to supply medical treatment through a managed care organization" should result in significant cost savings, said John Ellefson, assistant to the Labor Department commissioner.

Managed care plans must meet several requirements, including that they are geographically convenient to employees and allow employees to change providers at least once during treatment for an injury or illness.

The state's Labor Department also will be responsible for developing the new medical fee schedule, which goes into effect Oct. 1, 1993. The schedule will be similar to the new Medicare physician fee schedule (*BI*, June 10, 1991).

"This is the first law that allows all three principal pieces of a comprehensive program to be developed all at once—managed care, utilization review" and a relative value fee schedule, said Fred McGarvey, vp of the Midwest region of the American Insurance Assn. in Skokie, Ill.

The major benefit reductions contained in the law affect workers with temporary partial disabilities.

Benefits for employees with temporary partial disabilities are now limited to 225 weeks. But, even if the benefits do not start immediately after an injury, benefits must cease 450 weeks after the date of the injury.

There was no limit under the previous law.

In addition, the new law cuts the minimum benefit for temporary total disability injuries to 20% of the statewide average weekly wage or the employee's actual weekly wage, whichever is less. Previously, the minimum was 50% of the state average or the employee's actual weekly wage, whichever was less.

However, the maximum benefit for temporary total disability was increased to 105% of the state average weekly wage from 100%.

Benefits for all types of injuries under the new law still will be adjusted for inflation, but the increase will be limited to 4% annually rather than 6%. And, the first adjustment is now deferred until the second anniversary of the injury, rather than on the first anniversary.

"We're not excited about the reductions of benefits contained in the legislation," the AFL-CIO's Mr. Brommer said.

The labor group had supported a measure that would have reduced the time workers can receive temporary benefits to 260 weeks.

While the law offers promise of significant savings, employers say the procedure through which benefits—especially permanent total disability benefits—are determined still must be changed.

In Minnesota, a permanent total disability rating can be assigned if an injury makes it impossible for a worker to perform any available job in the area where the worker lives.

The fact that some individuals in rural areas continue to receive lifetime benefits even though they could find work in other areas of the state is the "single most important unresolved factor" in workers compensation in Minnesota, Mr. Koll said.

Smaller employers may have the most to gain from the portion of the law that allows employers to choose any size deductible.

All workers comp insurers must provide employers with the deductible of the employer's choice and then reduce the premium accordingly.

"Allowing the use of deductibles is very positive for the small employer" since many of small companies with good loss histories cannot afford to self-insure their workers comp programs, said Tom Triplett, executive director of the Minnesota Business Partnership, a group of the 100 largest companies in Minnesota.

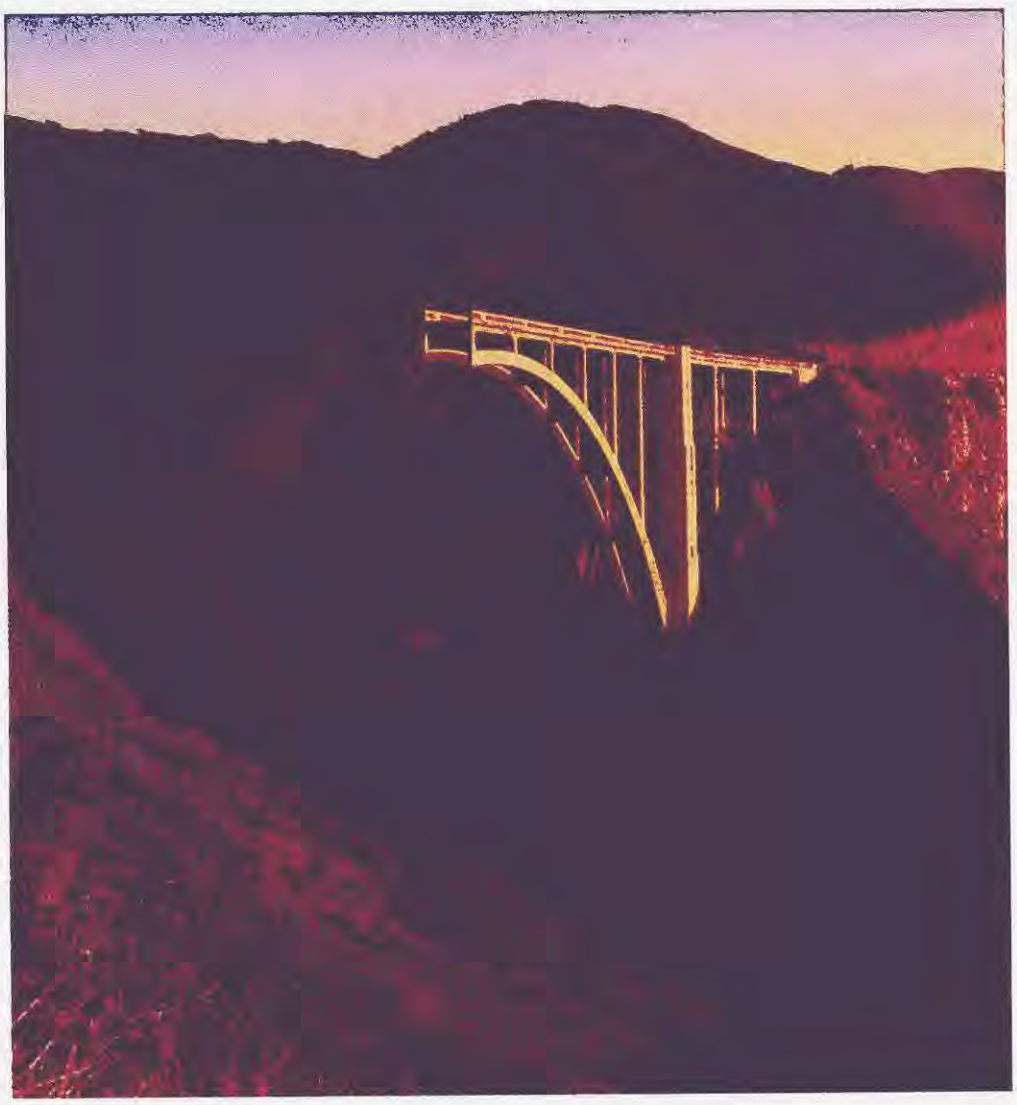
"In general, insurers are reacting to the substantial law changes as responsible changes—apart from the mandated (rate) reductions," said Bob Johnson, executive vp of the Insurance Federation of Minnesota, a St. Paul-based insurer trade group.

While he said "there is no way right now to speculate on market reactions," the consensus among insurers is that the changes included in the law do not justify the mandated 16% reduction in rates.

The bill initially contained other reforms that may have indeed resulted in a 16% savings, the MSIA's Mr. Koll said.

But some of those provisions were stripped from the final bill, he said, adding that he could understand if some insurers were concerned that the bill may mandate inadequate rates.

But, "over time, I anticipate" savings from "some provisions in the bill will exceed" the 16% mandated reduction, he predicted. ■



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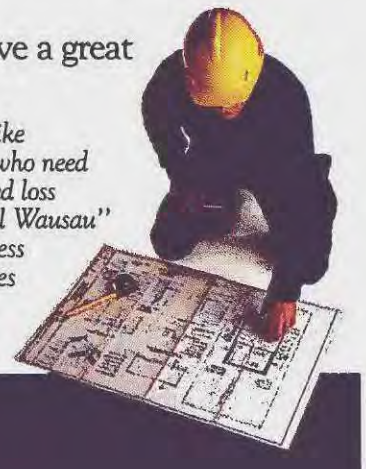
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Campbell adds managed mental health plan

Campbell Soup Co. is implementing a managed mental health and substance abuse program companywide, based on the success of a pilot program that reined in runaway treatment costs while improving employee satisfaction.

The pilot program aimed to cut mental health care and substance abuse costs by 20% while maintaining at least a 90% level of employee satisfaction.

Instead, costs were reduced by 36%, and the employee satisfaction level jumped to 98%, based on surveys and submissions to a benefit appeals process.

The program is scheduled to be implemented by year end at Campbell's approximately 40 plants for use by about 60,000 employees and dependents.

Benefit beat

The impetus for the pilot program came in 1988, after company officials' determined that psychiatric and substance abuse costs had increased about 20% annually since 1986, when the company introduced its employee assistance program.

"I was given a charter to reduce costs and to maintain employee relations," said Ed Stetzer, who was then corporate director of managed health care for Campbell in Camden, N.J.

Mr. Stetzer now is a Morristown, N.J.-based vp of North, Clawson & Bolt Ltd., an employee assistance and managed care consulting firm that is administering Campbell's new Quality Care Program.

Campbell decided to add a managed mental health component to its EAP.

Employees and dependents who seek treatment through the Quality Care Program receive greater mental health and substance abuse treatment benefits than are available under the company's self-insured indemnity plan.

Under the Quality Care Program, Campbell employees and dependents typically receive 100% coverage for the first 10 days of inpatient care and 80% coverage thereafter. All outpatient treatment obtained through the program is 80% covered.

Those who do not seek treatment through the Quality Care program generally are reimbursed for 50% of inpatient and 50% of outpatient charges under Campbell's indemnity plan.

"We have found that you need a 30% differential (to) create the appropriate incentives" for employees to use the EAP, said NCB President Ron North.

And, in fact, EAP utilization has increased 56%.

A wider array of counselors also is available through the Quality Care Program. Patients who obtain care outside of the program must see medical doctors rather than counselors to be covered, Mr. Stetzer said.

Mr. Stetzer explained that Campbell turned to managed mental health care because research showed that 75% of all patients admitted for psychiatric or substance abuse treatment are self-admitted. These are "uninformed consumers buying a product they know nothing about," he said.

But, Mr. North said, "We have always maintained the importance of providing employees with a degree of choice."

Campbell introduced its pilot program in 1990 at three major sites. About 10,000 employees and dependents were eligible to participate.

One site had union workers, who were "comfortable with the program" mainly because there were no reductions in benefits, Mr. Stetzer said.

Campbell has found that 70% of all mental health cases can be resolved through short-term counseling available through the EAP. Up to eight counseling sessions are available to employees at no charge.

If employees or dependents need more than those eight sessions, case managers refer them to appropriate inpatient or outpatient care.

EAP counselors and clinicians are on site at all Campbell locations, and phone access to the EAP is available 24 hours a day, seven days a week.

But, face-to-face evaluations can better enable the case manager to "get a much more complete picture of the nature of the problem and appropriate solution," Mr. North said.

Campbell contracts directly with case managers, but NCB is the EAP administrator. This arrangement avoids giving case managers incentives to either overtreat or withhold needed treatment, Mr. Stetzer said.

—By Sara J. Harty

Domestic partners

Only 35% of San Francisco Bay Area employers have considered extending health care benefits to their employees' domestic partners, but 53% said they will probably consider offering such benefits in the future, a recent survey found.

The cost of providing the benefit is the greatest obstacle employers site for not extending health care benefits to the domestic partners of employees, reports the study conducted by the San Francisco office of A. Foster Higgins & Co. Inc.

Ninety percent, or 45 of the the 50 companies surveyed, said cost was the barrier to offering coverage to domestic partners.

Eighty-five percent of the survey respondents cited the definition of domestic partners—typically considered a couple of the same or opposite sex who are not legally married but are living together in a permanent relationship—as an important issue in considering whether to offer domestic partners health benefits.

Survey respondents are questioning whether partners of the same sex would represent a high health risk.

Respondents also are unsure how to define a permanent relationship other than marriage.

And, whether to provide coverage for dependent children of a domestic partner struck 63% of respondents as being a very important issue to consider.

—By Michael Schachner



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Opinions

Big step in health reform

WHILE BY NO means perfect, Minnesota's new health care access law is a significant improvement over many other proposals pending in state legislatures and in Congress to increase access to the health care system.

The Minnesota statute, signed last month by Gov. Arne Carlson, will create a state pool to provide subsidized coverage to lower-income Minnesota residents not covered under employer-provided health care plans (*BI*, April 27.)

The pool will be funded by several sources, including new taxes on health care providers and health maintenance organizations, as well as a 5-cent increase in the state tax on a pack of cigarettes.

The Minnesota law is significant for what it does not do as well as what it does.

First of all, it does not interfere with the health care plans currently offered by Minnesota employers.

The law wisely recognizes that the design of employer-provided health care plans—the amount of cost sharing, the benefits offered—are best decided by individual employers and their employees. Employer health care plans should not be tampered with in an effort to extend coverage to the uninsured.

By contrast, several of the so-called "play-or-pay" proposals now under congressional consideration specify the level of benefits employers must offer, which constitutes an unwarranted attempt at benefit micro-management by the federal government.

At the same time, the Minnesota law does not pretend that it will ensure universal health care coverage. After it is phased in over the next several years, the new state pool will provide coverage only to about 160,000 of the 400,000 Minnesotans who now are uninsured. Participation in the pool is voluntary, is limited to Minnesota residents with incomes under a certain level and requires premium contributions from participants, with the amount individuals must pay increasing with their income.

Pool participation could be increased if, for example, individuals were asked to pay lower premiums and the state further subsidized coverage through higher taxes on providers or through some other source of revenue. But state legislators correctly recognized that individuals must share in the financial responsibility for financing health care coverage.

In enacting the law, Minnesota legislators understood that there are limits to the financial burden



the state can assume in providing any benefit program, including health care coverage for the uninsured.

By contrast, a 1988 Massachusetts law intended to ensure universal coverage for residents through a play-or-pay type of approach has run aground because Massachusetts legislators finally recognized that the state simply cannot keeping raising taxes—without driving business away—to provide health care coverage for all.

The Minnesota law also recognizes, unlike a number of proposals in Congress, that the best way to ensure that employers continue to offer health care plans is to try to do something about rising health care costs. Under the Minnesota law, a new state health care cost containment commission will be established to develop recommendations to hold down costs.

This is not to say we agree with everything in the Minnesota law. Slapping new taxes on hospitals and physicians would seem to invite higher charges by providers. A broad societal problem—providing coverage to the uninsured—would seem to demand a broader revenue source.

It is not likely that all states will follow the Minnesota approach as they seek to extend health care coverage to those without access to the health care system. But, as Gov. Carlson says, other states—as well as Congress—should keep an eye on the Minnesota experience as they develop their own proposals.

At issue

What was your most unusual workers compensation claim?



Eugene F. Berrodin
Director of Risk Management
Michigan Municipal League
Ann Arbor, Mich.

An elected councilman in a small community was struck and injured by a snowmobile while performing municipal functions. It turned out that citizens had previously complained about reckless and speeding snowmobiles. City Council members volunteered to watch for reckless operators and report license numbers to the police department.



Aden Hogan Jr.
Director of Risk Management
Mesa County,
Grand Junction, Colo.

My most unusual workers comp claim came when I was responsible for public safety in a western Kansas city. A Malaysian sun bear escaped from his cage at the zoo, and the police were dispatched to the scene. Our insurer found it interesting as I explained the injuries to the police officer's posterior, which occurred after he had roped the bear.



David Hartwig
Risk Manager
Marion County,
Salem, Ore.

When an employee's van broke down, another employee went to rescue the driver. The rescuer decided to look under the hood to see if he could fix the problem. Unfortunately, the hood fell down—and latched. The employee's head was stuck under the hood; his arms and legs were not. His injury required only 10 sutures to the forehead.

Compiled by Sara Harty

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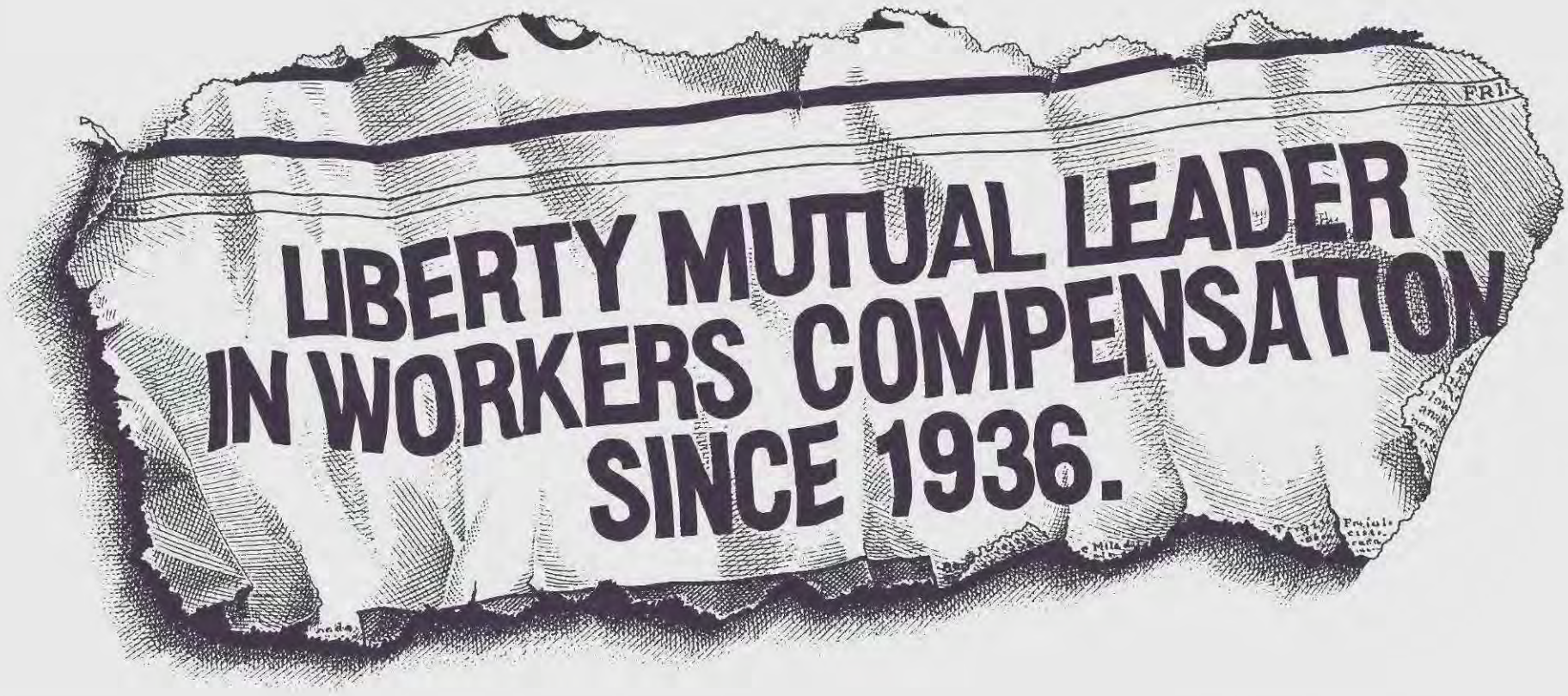
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Big reforms or big rate hikes, NCCI warns

By MEG FLETCHER

PALM BEACH, Fla.—Workers compensation insurers posted a "disastrous" 123% combined ratio for 1991, which adds urgency to their plea for major reform of the workers comp system as well as rate increases, says the National Council on Compensation Insurance.

Workers comp insurers' 1991 combined ratio is significantly worse than the 118% combined ratio that they have averaged over the past five years (see story, page 16).

Factoring in investment income produces a 110% operating ratio, but that still is worse than workers comp insurers' average 105% operating ratio over the past five years, the NCCI says.

Those who care about creating a better workers comp system for employers, workers and insurers should follow the NCCI's lead and "harness the forces of change," said NCCI President William Hager at the group's annual issues conference, held April 22-23 in Palm Beach, Fla.

"We are at a final juncture. We either implement massive reforms, or we get massive rate increases," he said.

In the past two years, "we at the NCCI have made a major corporate commitment to positive change," said Mr. Hager, whose address was accompanied by an audiovisual presentation that included rolls of thunder and flashing thunderbolts.

The changes are designed to enhance the organization's standing with some legislators and regulators, who complain that the NCCI misuses data to justify higher rates and that workers comp insurers operate inefficiently (*BI*, April 20).

Those changes include:

- Increasing the role of the NCCI's professional staff members and decreasing the role of insurer representatives in ratemaking.
- Devoting more money to enhancing data credibility.
- Instituting aggressive antifraud programs.
- Strengthening performance standards and economic incentives for servicing carriers that provide coverage to employers in states' residual markets.

Other residual market initiatives include efforts to make premiums more fairly reflect an employer's risk and to eventually make residual markets self-sufficient.

- Implementing cost containment and loss control programs.
- Adding public members to the NCCI board of directors and recommending that state insurance commissioners add public members to NCCI appeals committees.
- Funding additional educational publications for insurers and employers.

The credibility of the NCCI's rate filing requests received an added boost when a National Assn. of Insurance Commissioners study concluded that the NCCI accurately processes data and that its ratemaking procedures are reasonable, Mr. Hager said (*BI,* Dec. 23, 1991).

Participating in the commissioners' study cost the ratemaking group $3.5 million, he said. "The NCCI's operation is the only pricing unit in the United States to have ever been subject to this degree of regulatory scrutiny."

However, the NAIC also concluded that some areas need improvement, including integration of the processing systems.

But the NCCI is not alone in working to improve workers compensation, Mr. Hager said. He praised legislators from a handful of states—like Colorado, Louisiana, Oregon and Texas—who have passed reforms to help control costs.

Among the reforms are measures that have imposed tighter standards for compensable claims, required mediation rather than more costly litigation of contested claims, mandated that a panel of independent physicians determine medical issues and called for new safety programs in an effort to prevent workplace injuries.

Mr. Hager also praised state insurance regulators who have recently approved higher rates requested by the NCCI, including those in Alabama, Connecticut, Florida, Illinois, Louisiana, Nebraska and Vermont.

Problems persist, though, in too many other states, Mr. Hager said.

He urged insurance commissioners nationwide to join with the NCCI and require that residual market pools be made self-sufficient, so that collected premiums equal pool costs.

For the last five years, employers purchasing coverage in the residual market—which tend to have more dangerous workplaces—received $10 billion in "subsidies" from insurers and employers in the voluntary market, amounting to $2.2 billion last year, Mr. Hager said.

Those subsidies occur when insurers that cannot escape residual market assessments pass this burden to policyholders through residual market loadings and by raising rates for other types of insurance to offset workers comp losses.

"Working people and labor leaders everywhere ought to be outraged over the massive subsidies that risks in the residual market are currently enjoying as a result of the upside-down logic that subsidizes, instead of fully surcharging, pool risks," he said.

Mr. Hager also criticized "the unbelievable number of irresponsible professionals"—including lawyers, doctors, chiropractors, psychologists and rehabilitation professionals—"who would have us believe that the system is designed to serve them and not the workers."

He was especially critical of physician-owned auxiliary services like clinical labs. At least one study found that such cross-ownership increased utilization

Continued on page 16



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1991 comp results seen as worst ever

By MEG FLETCHER

PALM BEACH, Fla.—Cost trends in workers compensation that favor employers and injured employees at the expense of insurers are accelerating, insurers say.

Preliminary estimates indicate that workers comp insurers' combined ratio surged to a record 123% in 1991, well over the average 118% during the past five years.

The record-setting combined ratio should be "a strong message that prompt and swift corrections are necessary now," said Richard Fein, executive vp and chief operating officer of the National Council on Compensation Insurance. Mr. Fein spoke here last month at the group's annual issues symposium.

Workers comp insurers' ballooning combined ratio represents "the largest, longest and most pervasive financial disaster in the history of property/casualty insurance," said Mr. Fein.

Investment income, however, makes up for some of the losses. After factoring in investment income, workers comp losses and expenses still stood at 110% of revenue in 1991, worse than the 105% average over the previous five years.

Mr. Fein estimated that workers compensation insurers have lost $7 billion in surplus since 1984 and now need at least $15 billion in additional surplus to support current premium.

Since 1984, workers compen-

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Call for reform

Continued from page 12

and costs (*BI*, Feb. 17).

Challenges also come from Capitol Hill.

For example, McCarran-Ferguson reform proposals—like a bill sponsored by Rep. Jack Brooks, D-Texas (*BI*, Nov. 18, 1991)—threaten the NCCI's experience modification rating program, its "most powerful injury-prevention program," Mr. Hager said.

"The experience rating modification is a single universal index that applies to virtually every employer in the U.S. with a premium above $5,000. The modification provides a powerful barometer of an employer's commitment to workplace safety and injury prevention," he said.

"The language currently floating around Washington to amend the McCarran-Ferguson Act would inadvertently, but nonetheless in fact, end the right to gauge employers' safety in this area by ending the right to produce their experience rating modification," Mr. Hager said.

He urged lawmakers to amend the bill to include "safe harbors" that protect a uniform classification system, loss data trending, uniform experience rating, joint development of policy forms and participation in and ratemaking for the residual markets.

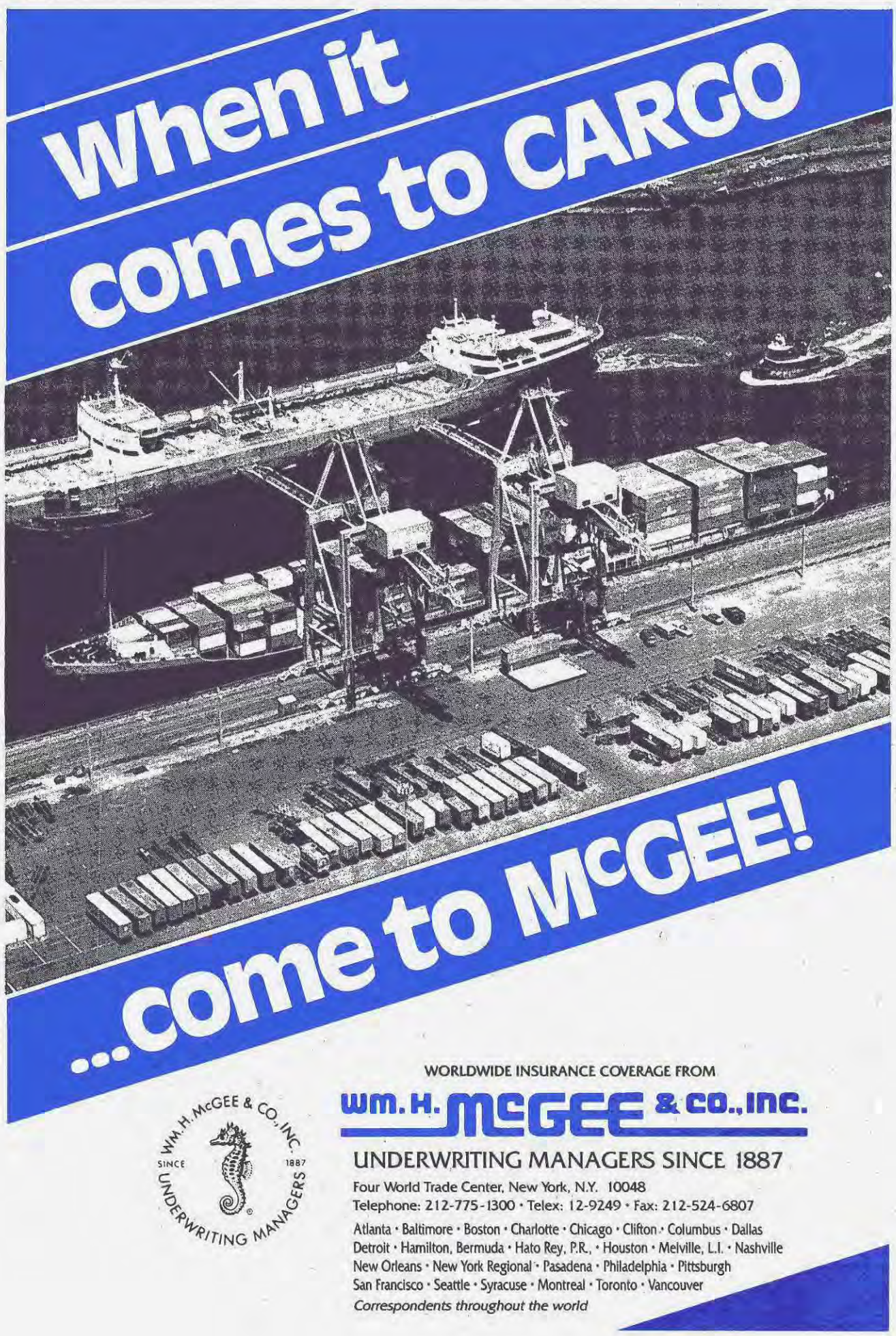
In other action at the meeting, the NCCI board of directors elected:

- J. John Wortman of Michigan Mutual Insurance Co. in Detroit as chairman of the NCCI board.
- Jon Shebel, president of the Associated Industries of Florida in Tallahassee, as the NCCI's second board member representing the public.

Mr. Shebel joins John Sarpy, an attorney and deputy director of the Occupational Safety and Health Administration in Washington, D.C.

A third public member will be elected next year.

- Virginia Surety Insurance Co. in Chicago, an Aon Corp. unit, as a board member. The company will be represented by Senior Vp John Washburn, a former director of insurance and deputy governor in Illinois and a former NAIC president. ■



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Cost trends

Continued from page 16

sation insurers have posted operating losses—after investment income—of $11.5 billion, Mr. Fein said.

More states are approving higher workers compensation insurance rates, though not at the pace needed to ensure "rate adequacy," he said.

And, these rate increases are counter-balanced by the fact that the overall rate level increased by less than 10% last year in states in which the NCCI represents insurers. It was the first time in eight years that rate levels did not increase by a double-digit percentage, according to Mr. Fein.

He attributed this primarily to caps on rate hikes in Florida and Texas, which account for about a quarter of the premium volume in NCCI states.

Meanwhile, "alarming trends" in medical costs and wage-loss compensation continue, he said.

Workers comp medical costs have been rising at a 14% average annual rate over the past decade, the NCCI reports. The average medical benefit per case rose to $6,611 in 1990, up 12.8% from $5,863 in 1989, according to the NCCI.

The increases are far in excess of the 8% increase in the medical component of the Consumer Price Index during the same period, he noted.

In addition, wage-loss compensation benefits for injured workers have been rising at 11% annually, which is well ahead of the rate of wage increases. The average claim was $12,833 in 1990, up 11.5% from $11,506 in 1989, the NCCI reports.

"The amount an insurance company can charge is always significantly below the price that should be charged," Mr. Fein said. "Only one party feels the pain of the true cost of the benefits paid to workers. The claimants continue to get the benefit payments and employers are shielded from the actual system costs," Mr. Fein said.

One manifestation of rate inadequacy is the growth of the residual market for workers compensation, he added. The residual market's share of workers compensation premium was 25%, up slightly from 24.1% in 1990, the NCCI estimates. That marked a slowdown in growth. The residual market accounted for 22% of the total in 1989, 19.6% in 1988, 19% in 1987, 16.3% in 1986, 9.7% in 1985 and 5.5% in 1984.

For the first nine months of 1991, the residual market had an average 16% underwriting burden, up slightly from about 15% for 1990, according to NCCI estimates. That means that in most states, an average insurer was assessed 16 cents for every premium dollar written in the voluntary market in order to support the residual market.

The combined ratio for all state residual market pools dropped slightly to 148% in the first nine months of 1991 from 149% in 1990, according to NCCI estimates.

"These cost trends will continue unless reform actions take place," Mr. Fein said. "Our message has been consistently confirmed by the results. We hope it results in significant actions to impact the marketplace and restore workers compensation to the financial health it deserves and that employers and workers deserve." ■

Employers face legal issues

By MEG FLETCHER

PALM BEACH, Fla.—Employers should be concerned about two high-profile, workers compensation-related legal issues.

Many employers face problems stemming from the Americans with Disabilities Act of 1990 and, separately, from workplace conditions that may lead to employees' reproductive injuries, said panelists at the annual National Council on Compensation Insurance issues conference last month in Palm Beach.

Employers should be concerned about the impact of the Americans with Disabilities Act because of its many implications, said Mary Adelman, an attorney with Seyfarth, Shaw, Fairweather & Geraldson in Washington, D.C.

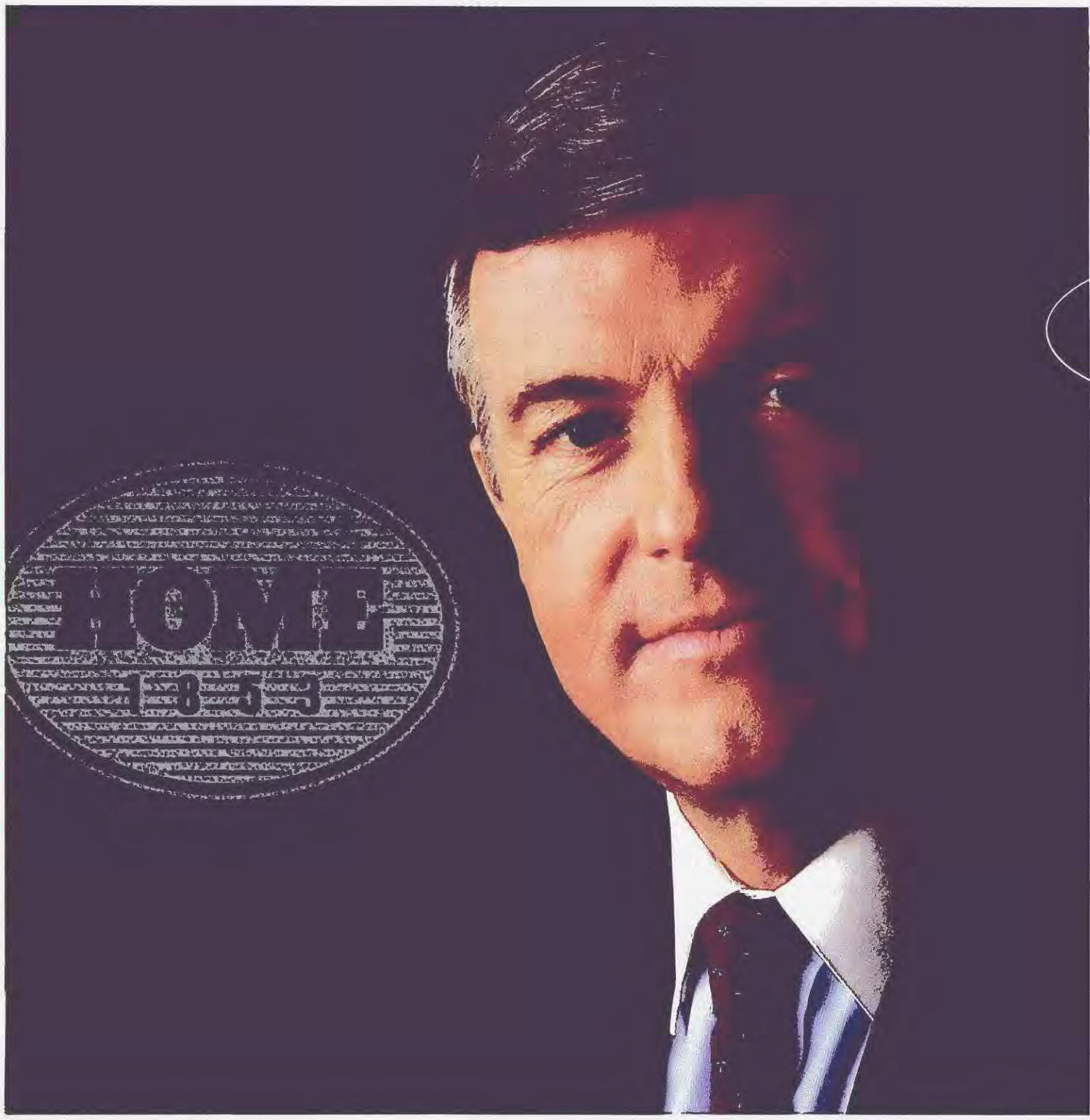
The act is designed to protect disabled people from discrimination in employment, hiring, transportation, access to public facilities and services, as well as communications.

The employment-related provisions of the Americans with Disabilities Act took effect for all state and local governments in January (*BI*, Jan. 27). Those provisions will not apply to nongovernmental employers, unions and employment agencies with 25 or more employees until July 26. Non-governmental employers with 15 to 24 employees must comply by July 26, 1994.

Because the act requires employers to make "reasonable accommodations" for qualified disabled people, it may increase operating costs. Health care and workers comp costs may also increase because the law requires those benefits to be extended to disabled people, whose condi-

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tions may be more likely to deteriorate, the panelists said.

But employers could also benefit from the act, they noted. The law could create an atmosphere in which injured employees can return to work faster, thereby trimming workers comp costs.

Employers could use several strategies to help trim costs under the ADA.

Employers should learn about the law and revise employment practices to comply with it, said Diane Stanton, an attorney with Jackson, Lewis, Schnitzler & Krupman in Orlando, Fla.

They should begin by evaluating whether an applicant is protected by the law, which is not always obvious. Examples of applicants who would not be considered disabled under the ADA would be an obese person or a pilot with imperfect vision who can still legally fly cargo planes but not passenger planes, Ms. Adelman said.

The law does not require an employer to make any accommodation for a disabled job applicant or employee that is "an undue hardship," or unduly expensive. But, some of the accommodations that the act requires, like hiring someone to assist an employee while traveling, would not be considered "reasonable" by most individual employers' standards, Ms. Adelman said.

It's 'really surprising' that companies use a large volume of chemicals that have not been tested for their reproductive impact, although some testing has begun of impacts other than cancer-related conditions, Mr. Schumacher says.

Though an employer can refuse to provide accommodation if it creates an "undue hardship," that defense should be considered only "a last resort," said Ms. Stanton.

Once employers offer employment to a qualified disabled person, they should carefully check his or her work and relevant medical history.

Employers may be able to legally withdraw an offer of employment if it can be proved that the applicant made a material misrepresentation on the application, has a recent history of denied workers comp claims or misreported a medical conditions, Ms. Adelman said.

But it is unclear whether an employer can legally require an injured employee to sign a workers comp claim settlement that waives his or her right to any future ADA claims, she added.

The act also may outlaw dollar-amount health benefit caps on specific illnesses, like acquired immune deficiency syndrome. It is also uncertain whether employers can achieve almost the same end by imposing treatment caps—like on the number of allowable injections of a life-saving drug—on such diseases, Ms. Adelman said.

Employers also should be concerned about potential reproductive injuries to workers, the panelists said.

The U.S. Supreme Court's decision in a case involving Johnson Controls Inc. created "a conundrum" for employers, said Randy Schumacher, an attorney and toxicologist with The Jefferson Group Inc. in Washington, D.C. In that decision, the justices ruled that a lead battery manufacturer could not prohibit all fertile women from holding jobs that pose a significant risk to the health of unborn children (*BI*, March 25, 1991).

However, it did not provide any protections for employers worried about being sued by the children of female workers for birth defects caused by exposure to hazardous chemicals in the workplace.

Given the uncertain legal climate, employers and insurers should take whatever steps they can to reduce liability, Mr. Schumacher said.

He recommended that employers establish appropriate employee training programs, protective clothing standards, monitoring programs, compliance audits and communication programs.

In addition, employers that buy hazardous products need to ask manufacturers what information, if any, is known about their health impact.

It's "really surprising" that companies use a large volume of chemicals that have not been tested for their reproductive impact on women or men, although some testing has begun of impacts other than cancer-related conditions, he said.

"Protection against reproductive and developmental toxicity afforded the public by current regulation is uncertain at best," the Government Accounting Office concluded last October in a report to Congress following a survey of how federal agencies regulated 30 widely recognized reproductive and developmental toxicants.

The Occupational Safety and Health Administration is developing standards on the use of glycol ethers, which are used to de-ice airplanes, among other substances, said John Sarpy, OSHA deputy director and a public member of the NCCI's board of directors.

Development of standards is frustrated by the fact that most of the research is focused on cancer risk to animals rather than the reproductive or developmental risk to humans, he said. ■

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A NEW TEAM

United they stand, but it's not easy

By MEG FLETCHER

PALM BEACH, Fla.—The best way to convince states to approve meaningful workers compensation reform is to build a coalition among key participants in the workers comp system to draft workable legislation and then lobby legislators.

But the path to developing a coalition is often rocky, because many players—like attorneys and medical professionals—want to tailor reforms to enhance their self-interests, several experts agree.

"Coalition building is essential," said Eric Oxfeld, assistant general counsel of the American Insurance Assn. in Washington, D.C.

A state-by-state approach to reforming the workers comp system may offer a better long run "payoff" than attempting a national approach, said Peter S. Barth, a professor of economics at the University of Connecticut in Storrs.

Messrs. Oxfeld and Barth participated in a panel discussion on coalition building at the annual National Council on Compensation Insurance issues conference last month in Palm Beach, Fla.

In addition, coalition building has a historic precedent: the efforts to get states to implement the 19 "essential" recommendations made in 1972 by the National Commission on State Workmen's Compensation Laws.

While efforts to achieve national reform faltered, some of the energy was transferred into state reform efforts, said John F. Burton Jr., a professor who directs the Institute of Management and Labor Relations at Rutgers University.

Thus far, states have adopted an average of 12.66 of the 19 recommendations, ranging from nearly all in New Hampshire to about seven in Mississippi, said Mr. Burton, who chaired the commission.

In recent years, panelists credited successful coalitions with securing major workers comp reforms in Colorado and Kentucky as well as some mixed gains in California.

Currently, the AIA has joined with the Alliance of American Insurers and the National Assn. of Independent Insurers to try to develop effective state coalitions.

In addition, efforts to build coalitions are expected to draw on the information and partial consensus emerging from similar efforts. One example is a National Conference of State Legislatures' subgroup and a labor-management group jointly discussing issues and drafting position papers.

But the path to developing a successful workers comp reform coalition is often rocky.

"Progress is very slow and frustrating," said James N. Ellenberger, assistant director of occupational safety and health for the AFL-CIO in Washington.

Workers comp issues are complicated for time-pressed legislators to understand and can be politically tough to tackle, Mr. Oxfeld said.

"Workers compensation issues are a tough vote for most legislators," said Alan Tebb, general manager of the California Workers' Compensation Institute. The key is for the coalition to make the work comp proposal "a safe vote," he said.

One of the most difficult problems coalitions face is deciding who should be involved, some panelists say.

Ideally, they should consist of employers and employees aided by insurers, regulators or legislators, most panelists say.

Views within those groups, though, are often divergent. The insurance industry, for example, is "a lot more heterogeneous than homogeneous," said Mr. Barth.

Involving self-insured employers can also be important. Their involvement demonstrates that reforms are important to the state's business climate and are not merely insurer-driven, Mr. Oxfeld said.

Allowing labor representatives to remain outside—as happened in Colorado—can be hazardous because they will subsequently seek to regain the ground they have lost, he said. That can include challenging laws in court or seeking to amend unfavorable laws.

Knowing which groups to keep out can also be important.

Doctors, injured workers and defense lawyers, for instance, should all be allowed to air their views but not to actively participate in the coalition, panelists advised.

Once formed, a coalition must develop reform proposals that balance competing interests. Then, members must agree to adhere to a reform proposal and lobby exhaustively for it, they said.

A workers comp coalition in Kentucky was built on "trust," but it took time, consistency and persistence to develop that, said Edward Holloway, president of the Associated Industries of Kentucky. The coalition also took the heat off legislators by giving them an organization to which they could refer constituents who are unhappy about the reform proposals.

The coalition in California also benefited by having the strong support of the governor and a willingness to include sunset provisions so that legislators will have to revisit measures that they had modified, Mr. Tebb said. ■

N.Y. high court rejects concert liability

ALBANY, N.Y.—A manufacturer whose product is used in concert with another company's product cannot be held liable if the other company's product is defective, New York's highest court has unanimously ruled.

In overturning an intermediate appellate court ruling, the New York Court of Appeals ruled 7-0 that Goodyear Tire & Rubber Co. is not liable for exploding tire rims manufactured by units of Bridgestone Corp. and K-H Corp.

The court also ruled that Goodyear should not have been required to warn consumers about the alleged dangers of the rims, since they were produced by other companies.

Goodyear was sued by the estate of John Wunderlich, a truck driver who was killed in 1984 when a multipiece tire rim on a General Motors truck exploded as he was inflating a Goodyear tire (*BI*, April 1, 1991).

"In terms of concert of action, this ruling firmly establishes that one company is not liable for a competitor's product. Secondly, it establishes that one company has no duty to warn about the potential dangers of another product," said Goodyear attorney Alan Kaplan of Gallagher, Gosseen & Saller in New York.

As a result of the ruling, Mr. Wunderlich's estate will drop its concerted action liability claim against The Budd Co., a multipiece rim maker also named in the Goodyear litigation.

But its product liability claim is still pending against General Motors Corp., Firestone Tire & Rubber Co. and K-H Corp. unit Kelsey-Hayes Co., which manufactured the rim that exploded and killed Mr. Wunderlich.

—By Michael Schachner

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Drug benefits

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Institute in Washington, D.C.—have shown that about 10% to 15% of an employer's overall health care expenditures are attributable to prescription drugs. For retirees, prescription drugs represent nearly 40% of overall health care costs for employers.

By comparison, about 10% to 12% of the average employer's overall health care costs are related to mental health and substance abuse treatment, said Michael Freeman, president of the Institute for Behavioral Healthcare, a San Francisco-based mental health research group.

An increasingly popular way of significantly slashing prescription drug costs is implementing a mail-order plan.

"While it may sound glib, costs can be saved simply by cutting pricing," said David Eilerman, regional vp in the Buffalo, N.Y., office of America's Pharmacies Inc., a mail-order drug company. And, a mail-order plan is one of a couple of methods that can "do the trick," he said.

"Mail-order definitely promises a pricing advantage and can promote the dispensing of generic drugs," agreed Jim Braun, a consultant in the Washington, D.C., office of The Wyatt Co.

Indeed, "mail-order plans are mostly used for maintenance drugs where generics are more available and often just as appropriate," he said.

Generic drugs can be substituted for name-brand drugs about 25% of the time under a mail-order program, said James Norton, a managing consultant with A. Higgins & Co. Inc. in Stamford, Conn.

Most major medical plans or card plans do not offer incentives that are significant enough to influence patients to obtain generics, he said.

Mail-order programs generally save employers about 20% compared to retail pharmacies, said Mike Darkoch, vp-claims administration and provider relations with managed care and health plan administrator Baxter Healthcare Corp. in Lincolnshire, Ill.

However, Henry Blissenbach, president of Diversified Pharmaceutical Services, the managed drug division of Minneapolis-based United Healthcare Corp., says the savings can be even more substantial if the mail-order plan dispenses a high level of generic drugs.

Generic drug prescriptions cost about $5 on average, compared with name-brand drugs, which average about $30 per prescription, Mr. Blissenbach said.

Mail-order plans also provide employers time "to intervene and possibly correct an inappropriate prescription," Mr. Darkoch pointed out. "With mail service, you have a couple of days to get in touch with the prescribing physician to see if an alternative or generic substitute could work as well."

"One can strictly monitor outgoing prescriptions to prevent duplicates, and expensive drugs often can often be replaced with less expensive generic drugs," Foster Higgins' Mr. Norton said.

But, mail-order programs can get employers in trouble when the benefit levels are too generous, according to Wyatt's Mr. Braun. "A lot of plans still provide for large supplies at low copayments. With this scenario, savings from the lower-priced drugs get swept away."

Rick Schatzberg, executive vp-marketing with Medco Containment Services Inc. of Montvale, N.J., observed that prescription drug savings are more the product of good plan design than the delivery system.

"A well-designed mail-order plan with copayments of $5 for generic drugs and $15 for name-brand drugs can save someone 20% off retail. Conversely, a mail service plan will lose its savings if it only requires a $2 copay for a three-month supply. Heck, a card with a $25 copayment is cost-effective.

"Plan design is everything. If you want to cover Tums, oral contraceptives and other over-the-counter drugs, savings will be hard to achieve regardless of whether you have a mail-service delivery system or you contract with pharmacies at 10% off average wholesale price," he said.

The State of Washington Uniform Medical Plan, which extends prescription drug benefits to about 50,000 of the state's 106,000 public employees under a self-insured major medical plan, recently raised copayments in its mail-order program.

Last year, about $7.4 million, or 6.9%, of the $108 million the state spent on health care was attributable to mail-order drugs.

The plan, which has taken several steps to control its prescription drug costs, now requires employees to pay $4 for a three-month supply of generic drugs and $13 for name brands.

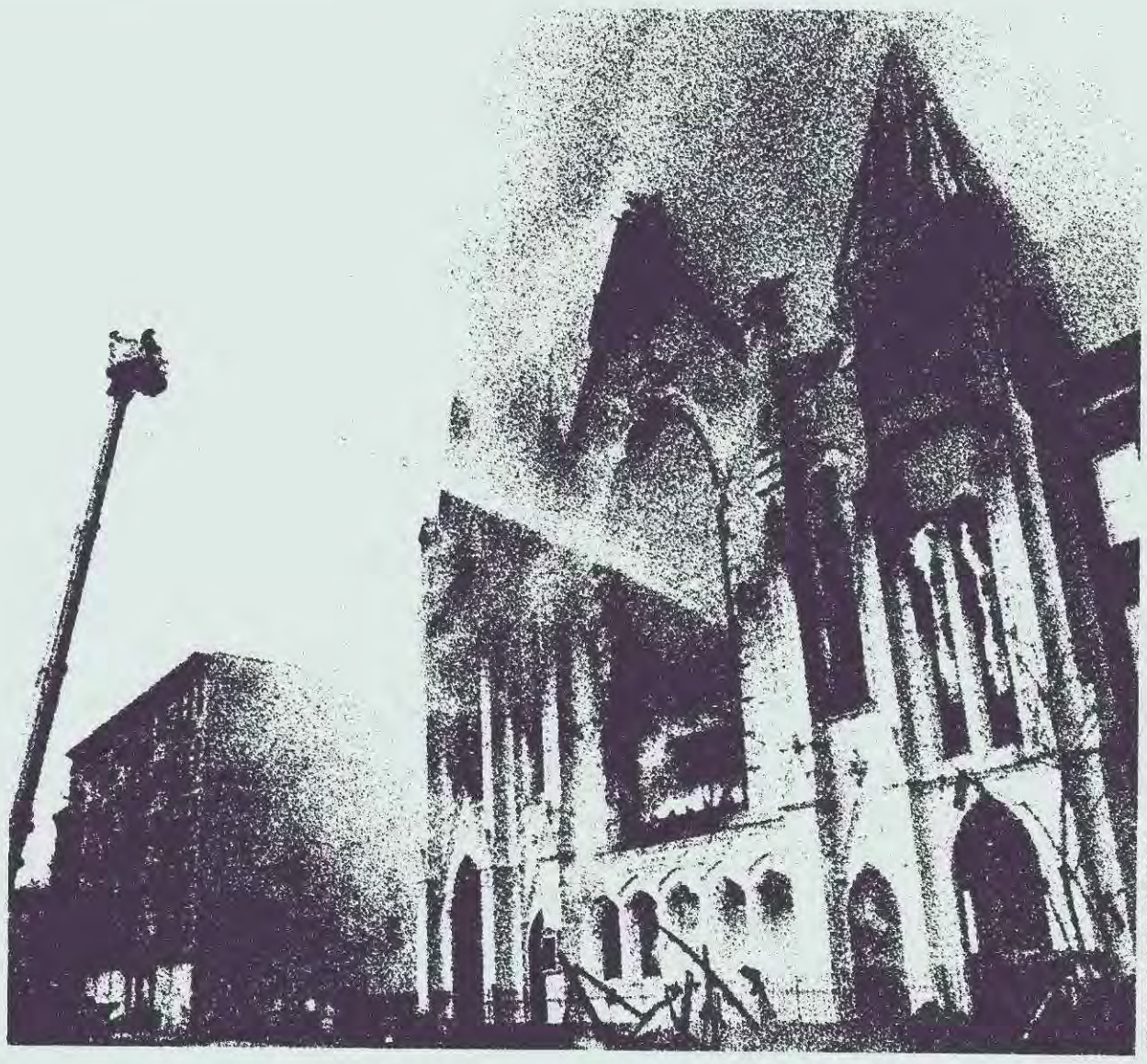
Prior to implementing this copayment requirement at the beginning of the year, the required copayment was $5 for a month's supply of generic or name-brand drugs.

The Spokane office of Medco Containment Services Inc. dispenses generic mail-order drugs at 20% off the average wholesale price, while name-brand prescriptions are provided at 13% off the average wholesale price.

"You have to level the playing field in terms of who bears the cost of inflation," said Margaret Stanley, health administrator for the state of Washington. "Before, any savings the mail-order plan was generating were being lost because of the low copayments."

Gerald Chalfin, senior vp with Cleveland-based INSURx Inc., suggests a somewhat different tactic. "What employers need to do is replace straight copay-

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AP/WIDE WORLD PHOTOS

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Drug benefits

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ments with percentage coinsurance and even deductibles. This will cut down on waste, which can sometimes be a problem with mail-order plans."

While mail service is becoming a more widespread method of dispensing prescription drugs, most employers still want to keep a retail option open to their employees, at least for short-term prescriptions.

Indeed, many drug experts advocate integrating mail service with a retail plan.

For example, benefit managers should consider a plan that allows plan participants to obtain short-term prescriptions and one refill at the retail level but requires them to obtain all subsequent prescriptions by mail service, according to prescription drug plan administrators.

"Coordinating mail service with retail whereby acute prescriptions are filled locally and maintenance drugs are provided by mail is a solid plan," Medco's Mr. Schatzberg said.

However, employers increasingly cannot afford to pay retail prices, consultants and drug experts say. As a result, employers are hiring prescription drug management firms to negotiate discounted prices with pharmacies.

"Costs are still high because 65% to 70% of all people still get prescriptions filled at a retail pharmacy that's not discounting its rates," said Elizabeth Dichter, a vp with PCS Inc., a Scottsdale, Ariz.-based drug management firm that has negotiated discounted rates with more than 90% of the nation's retail pharmacies.

While plan administrators like PCS and PAID Prescriptions Inc., a subsidiary of Medco, have built the largest networks of discounted pharmacies, other firms and employers themselves are beginning to construct smaller networks of retail pharmacies that charge rates even lower than those of the PCS and PAID networks, according to several consultants.

"It's common for a retail pharmacy to charge average wholesale price minus 10% on a contract basis. However, there are some deep discounters that will go as low as AWP minus 25% on certain drugs," said Hewitt's Ms. Bird.

"Contracting with a major drugstore chain can produce savings, but employers need to avoid reimbursing the pharmacy at AWP minus 10% when the pharmacy is charging the customer across the counter AWP minus 25%," she said.

"Contracting for price has become a wide open ball game," agreed Foster Higgins' Mr. Norton. "No longer is a simple discount off AWP enough for most employers. Benefit managers really have the green light to negotiate with pharmacies."

However, Medco's Mr. Schatzberg said employers shouldn't attempt to "draw blood from a stone."

"AWP minus 10% is normal for the large pharmacy networks. The smaller networks can be attracted to go even lower. But there isn't unlimited room at the pharmacy level to cut costs. Plan sponsors seem to want their cake and be able to eat it too. If AWP minus 20% becomes the norm, I think you'll see fewer pharmacies willing to join networks," Mr. Schatzberg said.

The state of Washington is one of several employers that have combined a mail-order program with a retail program under which it negotiates discounts with pharmacies.

Negotiated discounts with 80% of Washington's pharmacies is generating some significant savings for the state's Uniform Medical Plan, which hired INSURx Inc. last year to negotiate the discounts.

The new rates are expected to save the state about 12% compared with what it paid at the retail level prior to the establishment of the network.

Last year, before the discounting program was undertaken, $8.3 million, or 7.7%, of the state's $108 million of health care costs was attributable to retail pharmacy drug costs.

Chicago-based Continental Bank Corp., which also has combined a mail-order and a retail pharmacy program, took several steps last year to reduce its prescription drug costs. It has negotiated contracts with major retail chain pharmacies, increased the copayment requirement for the cost of name-brand drugs obtained at a retail outlet and raised copayments on its mail service program.

These changes last year have resulted in about a 22% savings compared with what Continental Bank was paying before for prescription drugs, said Dennis Nirtaut, employee benefits director.

The bank provides prescription drug benefits to about 4,800 employees, retirees and their dependents through a self-insured major medical plan.

Last July, Mr. Nirtaut began directly negotiating a discount retail plan with two units of American Drug Stores for the bank's workers in Chicago and California.

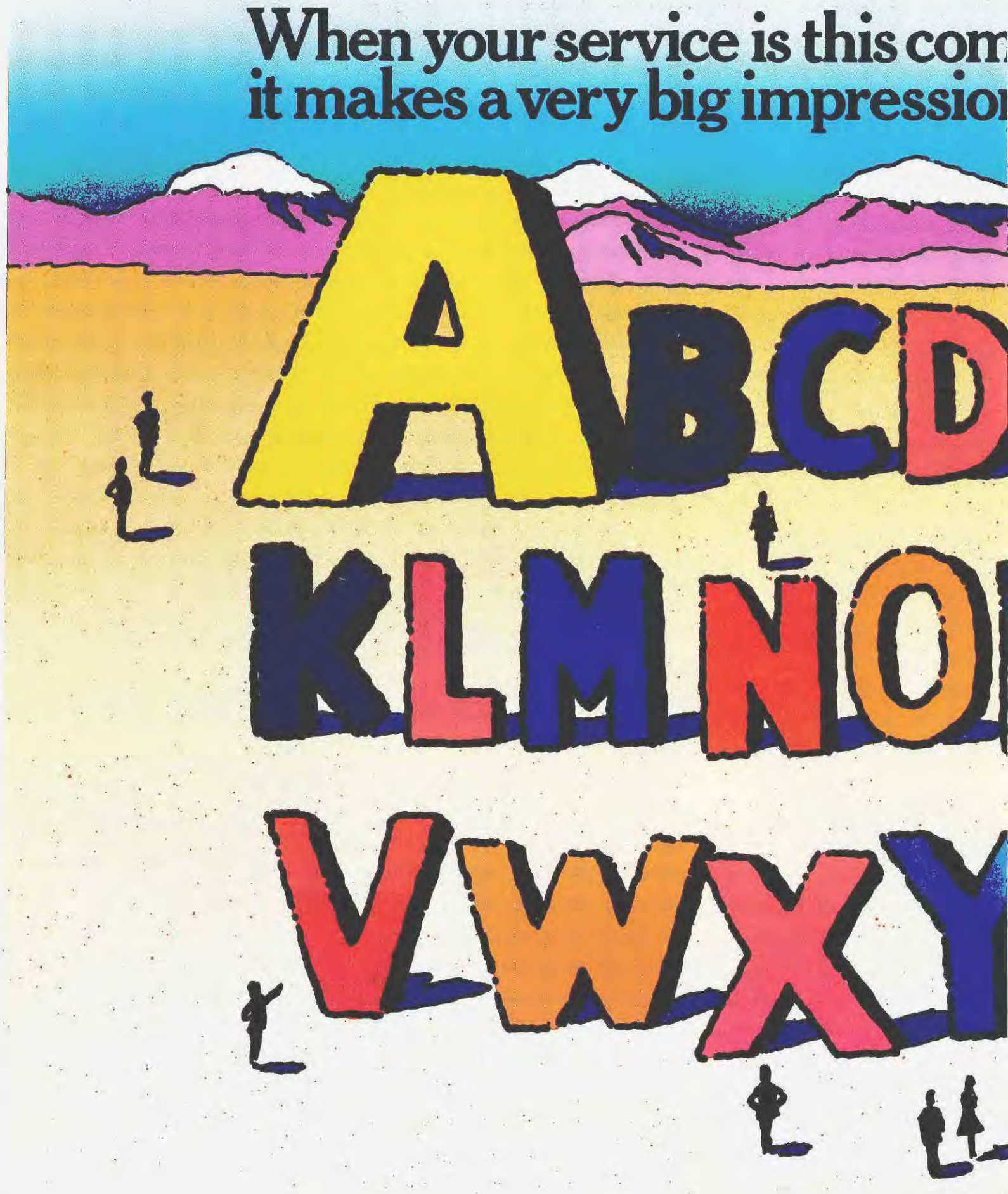
At the same time, its mail-order administrator arranged a similar agreement with retail chain outlets in other regions where the bank operates.

The bank's current retail plan provides for a 28-day prescription plus one refill. The plan requires employees to pay 20% coinsurance on generic drugs and 50% coinsurance for name-brand drugs.

Employees must obtain subsequent prescription and maintenance drugs through the bank's mail-order program.

Prior to the change, Continen-

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Continued from previous page
tal employees filled short-term prescriptions at any pharmacy at non-discounted retail rates. Employees paid deductibles outlined by the bank's major medical plan and were subject to a 20% copayment for either generic or prescription drugs.

"We were getting absolutely no discounts and our drug costs got to be three times what our mental health costs were. It was time to do something," Mr. Nirtaut said.

Since the retail plan copayments were increased, "we have seen mail-order usage increase 56%," Mr. Nirtaut said.

"They're not going to pay 50% of the cost of something that they can get for $10 through the mail-order plan even if American Drug Stores is giving us an excellent discount," he said.

Continental also increased the copayment on its mail service program to $10 from $5. The program is administered by Baxter HealthCare.

Another way employers save money on prescription drugs is to hire administrators to monitor all prescriptions at the point of sale for appropriateness.

For example, PCS's QUANTUM Alert system, which is on line at 54,000 pharmacies nationwide, reviews drug utilization at the point of sale to identify potential problems with prescribed therapy.

Since 1990, the system has denied 3.3% of the 289,000 prescriptions it identified for review because patients were obtaining a prescription refill before it was clinically appropriate.

The system also has recommended professional evaluation of about 6% of all prescription orders to reduce the chance of harmful and costly side effects.

Overall, the system has found that about 9% of all prescriptions need to be checked further before dispensing.

"A concurrent review system like this exposes excessive refills and risk to patients," said Don Johnson, director of clinical services with PCS. "Point-of-sale UR is the technology of the present and future."

Baxter's Mr. Darkoch agreed. "We look at every prescription at the time it's submitted to the pharmacy. We're still not sure about the amount of money it saves, but therapeutic substitution that prevents a negative reaction is valuable. Also, if there's a cheaper substitute for what has been prescribed, we'd like to at least give it a shot at getting that drug dispensed."

Ms. Stanley says the Washington Uniform Medical Plan will realize savings as a result of INSURx's utilization review system.

Under the UR system, before drugs are dispensed by the pharmacist, each prescription is reviewed electronically to make sure that the same prescription has not been filled elsewhere or that it is not a refill in excess of what is allowed.

"Their software is catching a lot of what we would have paid for in the past," she said.

The UR system plus the other steps Washington took to control its prescription drug costs should save the state an amount equal to about 11% of its overall drug costs, Ms. Stanley said.

The Maytag Co. of Newton, Iowa, has used a UR committee rather than a software system to influence physician prescription patterns.

"Our drug costs have been increasing by about 20% per year, which tells me there's need for some serious drug utilization review," said Bill Ward, employee benefits director. "The key to successful DUR is getting all parties—including physicians, pharmacists, management and the employees—together."

Maytag last year established a drug utilization review committee consisting of two doctors, two pharmacists, two labor representatives, two management representatives, a retiree representative and the administrator of Newton's only hospital.

The group meets monthly to review unusual prescriptions and discuss alternatives. When a doctor is identified as having an antiquated or abnormal prescription pattern, the committee sends that physician a nonthreatening letter that points out the flaw and makes corrective recommendations. "It's working great so far," Mr. Ward said.

During the first year of the program, the overall number of prescriptions obtained by Maytag employees and retirees fell by 5% and the generic fill rate increased to 28% from 23%.

Mr. Ward acknowledges that such a hands-on approach to influencing prescription behavior may work best in America's heartland where communities tend to be more intimate.

But he said the concept could work even in urban areas if the top echelons of physician and pharmacy associations buy into it. "I know it wouldn't be as easy to get such a program up and running in New York as it is in Iowa, but our results are great," he said.

Mr. Darkoch of Baxter Healthcare said software systems currently examine prescriptions after they have been issued by doctors. "But in the future, we'd like to intervene at the point the prescription is being written. We're in the process of modifying our system so that we as the plan administrator can converse with the doctor as the prescription is being written."

He said some doctors may oppose this type of intervention, while others may actually welcome guidance of this sort.

"To us, it seems valuable, considering many doctors haven't had a pharmacological course since medical school. Many doctors don't even know the drugs that are available," Mr. Darkoch asserted. ■



MAY CLOSINGS

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closing: May 5
editorial feature: Property Loss Control
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issue: May 25
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editorial feature: Conference Report: PRIMA
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Business Insurance
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Printer fights costs on home front

PEWAUKEE, Wis.—Quad-Graphics Corp. has eschewed outside prescription drug cost control vendors and has built its own on-site pharmacy and implemented a mail-order system.

The printing company hopes to reduce its bill for prescription drugs under its self-insured major medical plan by 25% annually, even after accounting for the cost of operating the pharmacy.

The pharmacy, which opened in December 1990, is part of the company's new on-site medical clinic.

"With 3,000 employees and 9,000 dependents (at headquarters), we have the demographics to make an on-site center and pharmacy work," said Dr. Robert Kessler, director of medical services.

The pharmacy is run by one full-time pharmacist, two part-time pharmacists and one technician.

Dr. Kessler would not reveal the cost of running the pharmacy. Salaries, he said, are commensurate with those elsewhere in Wisconsin.

Employees who get a prescription filled at Quad-Graphics' on-site pharmacy are subject to a 25% copayment.

For Wisconsin employees who cannot access the company's medical center, Quad-Graphics has contracted with Walgreens Co.

And for employees at its New York and Georgia facilities, Quad-Graphics also has negotiated discounted arrangements with local pharmacies.

At these outlets, employees pay 50% of the cost after meeting a $50 annual deductible.

Even employees who live far from Pewaukee can get prescriptions filled at 25% of the cost, Dr. Kessler explained.

"We send couriers out five times a day from our pharmacy to people in Wisconsin and we can get a script to someone overnight in New York and Georgia. Obviously, what we're trying to do is get employees to buy from our center," he said.

Before the on-site pharmacy was established, employees had to meet a 20% copayment on top of deductibles at retail pharmacies. This approach was costing the company big dollars, Dr. Kessler said.

"We were the type of company retail pharmacies cost-shifted against. Because we had no discounts, they charged us more to make up for the discounts they were offering to others," he said.

But now the company is on a cost saving track. "And, we can closely examine prescription patterns because we're storing valuable information from every prescription we fill," he said.

Quad-Graphics obtains this information from drug claims administrator Apollo Enterprises of Glendora, Calif.

—By Michael Schachner

Improper drug use can cost millions

Most approaches to prescription drug cost control focus on levels of benefits, cheaper dispensing methods and promoting cheaper substitutes whenever possible.

Yet when employees do not take prescription drugs properly, employers lose millions of dollars annually, said Dorothy Smith, president of the Consumer Health Information Corp. in McLean, Va.

Ms. Smith estimates that 10% of all hospital admissions and 23% of nursing home admissions are attributable to people not taking prescribed drugs properly.

According to Ms. Smith, 10% of all patients refuse to get their prescriptions filled, and nearly 50% of all patients take their drugs improperly. That includes taking too many pills at one time or taking pills at the wrong intervals.

Also, patients do not obtain prescribed refills about 30% of the time.

"Cost-control (is) more than just cutting the retail price of the drugs. It means getting employees to comply with how they should take their medication," she said.

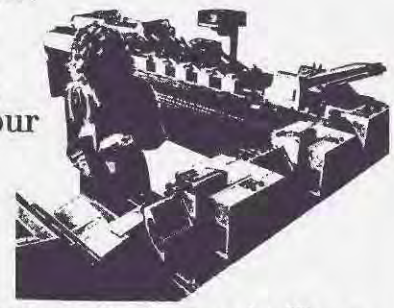
"Benefit managers need to get their workers counseling. They need to get the pharmacist to clearly explain how the drugs should be taken. Most pharmacists don't take the time to explain how to take what they dispense. If companies have to pay the pharmacists extra to explain, they should, because it will save them millions in the long run," Ms. Smith said.

—By Michael Schachner

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Focus on Latin America

Newly opened markets spur opportunities for investors

By Douglas N. Smith

International issues

A NEW ERA IS EMERGING for U.S. investment in Latin America as those countries move toward economic liberalization.

In my April 13 column, I noted how U.S. insurers are taking an interest in Latin America as they compete in an increasingly global market. And, as the Latin American countries reduce tariffs, privatize state entities and deregulate some state industries, U.S investment there will increase.

The privatization trend is expected to open up insurance purchasing and promote development of new products. Economic growth in Latin America is expected to continue for the short to medium term.

Following are insurance trends with a discussion of how the liberalization and deregulation process has affected some of the major Latin American countries.

• **Argentina.**

The liberalization of the insurance market in Argentina has had the most significant impact in the areas of reinsurance, tariffs and workers compensation. In the reinsurance market, insurers are no longer obliged to cede 60% of all reinsurance to the Instituto Nacional de Reaseguros, the national reinsurance organization that was terminated Jan. 1 due to its financial instability and consequent inability to pay claims. The demise of INDER should signify the beginning of a new era in Argentinian insurance as competition should lead to consolidation in the marketplace.

As competition in Argentina's reinsurance market has become more intense, European insurers pose a significant challenge to the U.S. insurance companies.

INDER's collapse has increased access to reinsurance markets, which, coupled with a greater willingness on the part of insurers to assume risk in Argentina, has softened the market. Free from compulsory cession, underwriters will be able to cede 100% to any reinsurer, whether local or foreign. As competition in the reinsurance market has become more intense, European insurers pose a significant challenge to the U.S. companies.

Another recent requirement is the elimination of tariff rating. However, the superintendency of insurance has to authorize the rates to be applied by the insurers in order to protect the financial stability of the companies.

• **Brazil.**

In Brazil, changes have led to the development of additional insurance coverages and an anticipated change in workers compensation. Some of the new insurance coverages are pollution liability, financial guaranty, surety for rental contracts, and condominium directors and officers liability.

Workers compensation is expected to be privatized in the future. But the movement toward privatization may be delayed because of recent problems discovered in the state Pension and Welfare Ministry, which may hinder progress toward a private system.

Brazil also has taken steps to allow non-admitted policies for operational risks that are similar to U.S. property insurance. For now, the insurance market remains somewhat soft, and changes in various tariff categories and tax laws are anticipated. Meanwhile, the Instituto de Resseguros do Brasil remains the last state insurance monolith in Latin America.

• **Colombia.**

The liberalization process in Colombia was initiated in July 1990 when the insurance market was deregulated. Recent legislation requires all non-admitted reinsurance brokers and companies to register with local insurance authorities. The mandatory retention of 60% of reinsurance within Colombia has been replaced by the freedom to place facultative and treaty reinsurance anywhere. The previous limit of 49% on foreign ownership of local companies has now been eliminated; both foreign brokers and insurers can now own 100% of local companies. In Colombia, it is now possible to issue any policy wording at any price: policies simply have to be filed with the insurance authorities.

In general, as the insurance industry adjusts to deregulation, capacity has been reduced, but rates continue to be soft. There is a general trend toward consolidation in the marketplace as competition, new products and increased professionalism will compel insurers to adjust to a new environment. As with Argentina and Brazil, U.S. insurers' interest here will be closely matched by European insurers.

For the long term, as Colombia's political situation improves and its economic program continues to grow at close to 4%, U.S. and foreign insurers' opportunity for development and growth should be high. U.S. corporations investing in Colombia that are concerned with terrorist coverage should be optimistic that increased economic activity and liberalization of insurance regulations may encourage innovative products or coverage to address this problem.

• **Peru.**

The present turmoil in Peru caused by President Alberto Fujimori's action to dissolve the Peruvian Congress will most probably have an adverse effect on recent deregulation trends in the Peruvian insurance industry.

Since June 1991, Peru has been operating as a free market. This is a radical change from 1970-1991, when the Reaseguradora Peruana S.A. enjoyed a monopoly over reinsurance and the Insurance Company Popular and Porvenir monopolized insurance for state-owned interests. During that period, few new products were developed, and there was little competition because of the power of the two monopolies.

Today, there are no restrictions regarding pricing and conditions, and no tariff is applicable. Deregulation has meant that insurance contracts can be written with unlicensed or non-resident insurers. However, such insurance is subject to the same tax rates applicable to locally issued policies. Competition is increasing and companies are being consolidated.

The present turmoil in Peru caused by Fujimori's action to dissolve the Congress will probably have an adverse effect on Peru's recent insurance deregulation trends.

Deregulation in Peru has not resulted in a rush of foreign insurers intent on entering the Peruvian market, and political events of the past few weeks will do nothing to change this situation. Severe political problems associated with the activities of the Shining Path, a revolutionary group, must be addressed before extensive foreign investment will be seen in insurance or other sectors.

Recent petroleum discoveries and the Peruvian governments's desire to increase exploration and production operations by both foreign and national operators may have been an early indication of future direction and growth, but all bets must be considered off given the present domestic strife. Already, it has been reported that up to $200 million in capital has fled the country. International businesses and investors that previously saw Peru as a long-term development project, especially in the natural resources extraction industries, most likely will put strategic investment plans on hold indefinitely. And without investment growth, insurance industry liberalization and accompanying modernization will most likely be stifled. A more serious issue to consider would be the removal of President Fujimori from power and a reversing of his administration's liberalization decrees by an angry Congress.

Ironically, prior to President Fujimori's action it was thought that the Reaseguradora might be sold to foreign investors as part of the government's privatization plan. This most certainly is no longer the case.

• **Venezuela.**

The liberalization that has taken root in most areas of the Venezuelan economy has not occurred in the insurance industry. Substantial debate concerning the opening of the market to foreign insurers has yielded no concrete advances so far.

Current proposals before the Legislature are not expected to be implemented until late 1992 or 1993. The most likely change will be the elimination of current tariffs for fire and group life policies. Pricing for property exposures would likely decrease, and all-risk forms should replace named peril forms.

However, if legislation is passed and the market does open up, it is believed that immediate 100% foreign-equity participation will not be allowed. Rather, it will be conducted on a sliding scale basis similar to participation in the banking sector. Percentage increases would be permitted over time by the investor until a majority position is achieved or 100% ownership reached.

If the expected opening of the market does occur next year, it is estimated that consolidation will eliminate some 60% to 70% of the insurers either by merger, acquisition or failure. This would have a positive impact for insurance purchasers in Venezuela, since broader coverage and advantageous terms would prevail. Increased competition would most likely result in higher professional standards and multiple insurance products available to the companies operating in Venezuela.

Economic liberalization in Latin America should continue in the short to medium term. Opportunity for U.S. investors will be enhanced by the process of deregulation and privatization.

The insurance industry in general, and those U.S. or foreign corporations that purchase insurance and risk management services for their operations, will only benefit by the movement to a free insurance market in Latin America. Increased competition from Europe and U.S. insurers, extra capacity and new markets will have a positive impact in the Latin American insurance market and for buyers of insurance. ■



Douglas N. Smith is senior vp and manager of the International Department of Johnson & Higgins in New York. His column appears the first Monday of every month.

ASK A CASUALTY ACTUARY

How IBNR reserves become claims reserves

Q **Can the information typically used in applying the Bornhuetter-Ferguson method also be used to estimate the rate at which IBNR reserves convert to claim reserves and the rate at which claim reserves convert to paid losses?**

A In my Jan. 13 column, we looked at how the Bornhuetter-Ferguson method differs from the incurred loss development method for calculating incurred-but-not-reported reserves. As noted in that column, the percentage of losses unreported is commonly used in applying the Bornhuetter-Ferguson method. These same percentages also can be easily and quickly used to estimate the rate at which reserves for incurred but not reported claims convert to claim reserves.

Table 1 provides a sample set of calculations for accomplishing this.

The starting point is the set of percentages of (ultimate) losses unreported as of several ages (year ends).

The differences between these percentages for successive year ends make up column B.

To obtain the percentage of incurred-but-not-reported claims converted to case reserves (column C), the percentages in column B are simply divided by percentages unreported for column A for the immediately preceding year end.

For example, the 29% in column C for age 24 means that between the ages of 12 months and 24 months, 29% of the incurred-but-not-reported reserves as of 12 months were converted into case reserves.

Obviously, during the course of the year, some of those case reserves also were converted into paid losses and so do not show up as case reserves as of 24 months.

Because the conversion percentages tend to follow stable patterns, they can also form the basis for various different reserving and forecasting techniques.

If we were talking about accident year 1988, for which ultimate losses are estimated to be $10 million, this would mean that incurred-but-not-reported reserves as of 12 months (year-end 1988) would be $7 million.

Since 20% of ultimate losses ($2 million) were reported during calendar year 1989, this means that 29% of the year-end 1988 incurred-but-not-reported reserves of $7 million were converted to case reserves.

In the strictest sense, this conversion ratio is not exactly correct.

To the degree that paid losses differ from the final case reserves, the conversion ratios estimated by this method will be inaccurate.

It is usually the case that, in the aggregate, paid losses will be somewhat less than the final case reserves, with the difference called "salvage" by claims managers.

In each of the tables, all of the percentages except the conversion percentages in the last column are relative to ultimate losses.

In order to be able to estimate similar percentages for the rate of case reserves being converted into paid losses, it is necessary to have a set of cumulative percentages of ultimate losses paid as of each annual accident year.

Table 2 provides a sample set of calculations for conversion of beginning case reserves to paid losses.

In order to estimate the percentage of ultimate losses that appear as case reserves as of each year end (column C), it is necessary to calculate the difference between the cumulative percentage reported (column B) and the cumulative percentage paid (column A).

The cumulative percentages reported in column B are merely the complements of the percentages unreported in column A of Table 1.

The set of percentages paid, listed in column D, are the differences between the successive cumulative percentages paid, which appear in column A.

The case-to-paid conversion percentages in column E are then the ratios of the percentages paid in column D to the case reserve percentages as of the previous year end from column C.

In a real sense, these case-to-paid conversion rates are not accurate because the rates do not include case reserves which were established during the calendar year.

Because of this, the conversion percentages in column E can exceed 100%.

This would be most likely to occur with coverages for which claims tend to be settled very quickly, like property insurance coverage.

In Table 3, we correct for this by including claims which were newly reported during the calendar year.

After we make this correction, the case-to-paid conversion percentages are significantly lower, and they will never exceed 100%.

In Table 3, we start in column A with a repeat of the percentages listed in column C of Table 2, only they are shifted 12 months.

We then include the percentages of newly reported losses during the year (column B), which are the successive differences between the percentages in column B of Table 2.

We add columns A and B to obtain the percentage of losses reserved at any time during the calendar year (column C).

By dividing the percentages paid (column D of Tables 2 and 3) by column C, we obtain the more correct case-to-paid conversion ratios in column E.

It is quite common for the IBNR-to-case conversion rates and the case-to-paid conversion rates to follow a stable pattern over successive development years.

By this, I mean that they will either stay fairly steady or will slowly progress upward or downward depending on the nature of the particular claims involved.

These conversion percentages can form the basis for some interesting models of the behavior of insurance and self-insurance programs.

Because the conversion percentages tend to follow stable patterns, they can also form the basis for various different reserving and forecasting techniques. ■

Table 1
Conversion of IBNR to case reserves

Age of accident year (months)	(A) Percentage unreported	(B) Percentage reported during year	(C) Percentage conversion of IBNR to case
60	10%	10%	50%
48	20	10	33
36	30	20	40
24	50	20	29
12	70	30	30
0	100		

GRAPHIC BY JOHN HALL

Table 2
Conversion of beginning case reserves to paid losses

Age of accident year (months)	(A) Cumulative percentage paid	(B) Cumulative percentage reported	(C) Case reserves as percentage of ultimate losses	(D) Percentage paid	(E) Portion of case reserves paid in next year
60	75%	90%	15%	15%	75%
48	60	80	20	20	67
36	40	70	30	15	60
24	25	50	25	15	75
12	10	30	20	10	

GRAPHIC BY JOHN HALL

Table 3
Conversion of reserved losses to paid losses

Age of accident year (months)	(A) Beginning case reserves as % of ultimate losses	(B) Newly reported losses during year	(C) Losses reserved anytime during year	(D) Percentage paid	(E) Portion of losses reserved anytime in year and paid in year
60	20%	10%	30%	15%	50%
48	30	10	40	20	50
36	25	20	45	15	33
24	20	20	40	15	38
12		30	30	10	33

GRAPHIC BY JOHN HALL

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

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


Mr. Sherman

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.

Ms. Werner's and Mr. Nirtaut's columns appear on the second Monday of alternate months. Mr. Miner's and Mr. Sherman's columns appear alternately on the first Monday of each month.

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



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Health costs are big worry for small business

By MARK A. HOFMANN

Washington

WASHINGTON—The rising cost of health insurance is the biggest worry of small-business owners, says a survey sponsored by the NFIB Foundation, an affiliate of the National Federation of Independent Business.

Sixty-one percent of those surveyed reported that the cost of health insurance was a "serious problem" while only 5% called it "no problem at all."

The 5,020 small-business owners who responded to the survey—financed by VISA U.S.A. Inc.—were asked to rank 75 potential business problems on a scale of 1 to 7, with 1 representing a "critical problem" and 7 representing "no problem at all." Health insurance costs received a mean ranking of 1.93.

The next biggest worry, federal taxation of business income, was cited as a critical problem by only 32% of the sample. It had an overall mean ranking of 2.86.

Two areas of risk management—workers compensation costs and the cost and availability of liability insurance—ranked in the top five concerns of small business owners.

Workers compensation costs came in fourth with a mean ranking of 2.98, with 40% of the respondents terming it a critical problem. Fifteen percent said it was no problem.

The survey notes, however, that workers comp costs "would have been the second-ranked problem were it not for the 9% of survey respondents who do not employ anyone. These self-employed people do not purchase workers compensation as do all but a few employers. The problem is, therefore, even more severe for small employers than it would first appear."

The cost and availability of liability insurance ranked fifth on the list of worries, being cited by 33% of the respondents as a critical problem and earning a mean ranking of 3.02. Twelve percent said that liability insurance posed no problem.

The study holds, however, that even though liability insurance is not as serious a concern for small businesses as it was a few years ago, "liability insurance historically has experienced seven-year cycles. If the cycle holds, small-business owners should be entering a more difficult period shortly and the problem already is ranked fifth."

Copies of "Small Business Problems and Priorities" are available for $15 and can be ordered by writing to The NFIB Foundation-Publications, 600 Maryland Ave. S.W., Suite 700, Washington, D.C. 20024

PBGC premium filings

Changes proposed by the Pension Benefit Guaranty Corp. to the deadlines for payment of termination insurance premiums will simplify premium filings for most employers, but will require faster payments for some others.

Currently, employers with fully or overfunded defined benefit plans pay an annual flat-rate premium of $19 per participant. Underfunded plans pay the $19 premium plus a variable-rate premium of up to $53 per participant, depending on by how much the plan is underfunded.

When these premium payments are due depends on the size of a pension plan.

Plans with fewer than 500 participants must pay the PBGC premium no later than 8½ months after the close of the prior plan year.

For example, a fully funded plan with 200 participants operating on a calendar-year basis would have to pay a $38,000 premium to the PBGC by Sept. 15.

Employers with plans with 500 or more participants make two premium filings. In the first, due two months after the close of the prior plan year, employers estimate what their flat-rate premium will be and pay that amount.

Then, 8½ months after the close of the prior year, employers pay any additional flat-rate premiums, plus interest on any shortfall. Additional amounts, known as a reconciliation payment, can be owed because an employer's final enrollment numbers may prove higher than its earlier estimate.

The second filing also includes the variable-rate portion of the PBGC premium.

The PBGC, though, now wants to amend this schedule.

Under the proposal published last month in the Federal Register, plans with fewer than 5,000 participants would pay the flat-rate and variable-rate portions of the premium no later than nine months after the end of the prior plan year.

For example, an employer with a calendar year plan would pay the PBGC by Sept. 30.

The PBGC estimates that this change would reduce to 1,000 from 8,000 the number of plans that would have to make two annual premium filings.

"For an intermediate-size employer, the change would reduce filings and improve cash flow," said Kyle Brown, an attorney with The Wyatt Co.'s Research and Information Center in Washington, D.C.

"This definitely will be a break for the large majority of plan sponsors who otherwise would have to pay premiums earlier in the year," agreed Scott Tucker, an associate in William M. Mercer Inc.'s Washington, D.C., office.

However, employers with very large pension plans—those with at least 5,000 participants—will have to speed up payment of premiums.

Under the PBGC proposal, payment of the estimated premium—both the flat-rate and variable-rate premiums—would be due 15 days after the close of the prior plan year. In addition, the reconciliation payment would be due nine months after the close of the prior plan year.

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Business Insurance

Agent/Broker Topics

A monthly editorial section sent exclusively to agents and brokers

Nothing biting in acquisitions



Agents bide time until market turn prompts buyers to take the bait

By LAURA MAZZUCA

Low commissions and skimpy profit sharing. Insurers demanding more volume. Increasingly hostile consumers. More and more rules and regulations.

Rotten market conditions are causing many agency principals to seriously consider hanging out a "Gone Fishin' " sign and selling out.

Tempting though it sounds, that move may be unwise. Experts warn that unless principals are facing a last-ditch scenario—say, approaching retirement age without a successor—they might be better off riding out the storm.

Buffeted by a hardy recession and facing poor growth potential, many agency principals are anxious to sell. But large brokers, facing many of the same problems themselves, are growing more conservative in their purchases.

Thus, says Carlton R. Copp, a vp with consultant and analyst Conning & Co., "We see this continuing to be a buyers' market."

The Hartford, Conn.-based firm recently reviewed 1990-1991 and year-to-date broker acquisitions. Its conclusion: There are fewer acquisitions, and the prices are lower (see chart, page 32B).

Consultants agree that while public brokers are still acquiring agencies, they are far more selective than during the mid-1980s mergers and acquisitions boom.

Also contributing to this buyers' market is the fact that marginal agencies with low growth potential are on the market, bringing down the overall values of agencies.

What's a principal to do? Hang in there, consultants say.

"If you have some staying power, you might want to stick it out for a while," said Carol A. Hammes, president of The Middleton Group, an agency consulting firm in Lisle, Ill. "Waiting right now would not be the worst thing you could do."

Conning & Co. predicts a "modest recovery of acquisitions in 1992" as the stock market improves and good agencies continue to be acquired by regional, national or even global brokers "looking to fill in weak spots and consolidate offices," Mr. Copp said.

Of course, there's no guarantee the market will turn while you're waiting and seeing. But things are bound to improve, at least a little, said Timothy J. Cunningham, senior consultant with Hales & Associates in Westchester, Ill.

By the same token, today's market might make it a good time to consider a merger or an acquisition of your own, some say.

"It's a real good time to buy, but only on your own terms," said Larry Marsh, president of Marsh, Berry & Co. Inc., a consulting firm in Mentor, Ohio. "Throw all the old formulas out the window."

Public brokers are still buying agencies, though today's low-key activity is a far cry from 10 years ago, when most alphabet houses were set on a course of steady geographic expansion.

Even five or six years ago, an agency with $1.5 million in gross revenues could easily sell out to a public broker, said Ms. Hammes.

And although a few regional brokers—most notably, Hilb, Rogal & Hamilton Co. of Glen Allen, Va.—are still charting a course of gung-ho acquisitions, most big brokers are far more cautious and selective today.

Supreme Court to hear tax case on intangible assets. Page 32J.

"Agents are always saying, 'I used to have them (brokers) knocking on my door, but they're not anymore,' " Ms. Hammes said.

Put simply, fewer agencies are being bought because there are fewer good agencies to buy. On top of that, fewer brokers are willing to pay premium prices, said Mr. Cunningham of Hales.

Brokers are making "select, strategic" purchases, rather than the generic acquisitions of a decade ago, said Fred Dopfel, executive vp and managing director of Russell Miller Inc., a consulting and investment banking firm in San Francisco.

Today's acquisitions are "reflecting the values of the 1990s—greater caution, new values, profitability, strategic fit and the quality of people they're acquiring," Mr. Dopfel said.

Agencies with specialty businesses, non-brokerage revenues from services like group benefits and consulting, high profitability and growth potential are attracting brokerages.

These brokers also are drawn to

Continued on next page

Sprucing up an agency to attract buyers

Still interested in selling your agency?

Consultants offered a few words of wisdom for principals who want to, as one put it, "make the bride ready for the altar."

Financial M&A Management

- Get a consultant to represent you.

It may sound self-serving, but consultants can smooth the path along the way to acquisition, said Fred Dopfel, executive vp and managing director of Russell Miller Inc.—a consulting firm, of course, based in San Francisco.

Not only will the consultant work with you to establish a fair selling price for your agency, but he or she also will play matchmaker and help you find an appropriate list of suitors, Mr. Dopfel said.

- Fine-tune agency finances.

Tighten up receivables, clamp down on expenses and eliminate unnecessary overhead, advised Carol A. Hammes, president of The Middleton Group in Lisle, Ill.

- Make sure your agency is well-run and staffed with young, competent producers and other staffers.

This means the purchasing company won't have to reorganize management when the deal is done.

"They're not just looking at a book of business," said Ms. Hammes. Instead, broker buyers seek "depth" in account servicing and staff. "They're looking for something that can effectively run itself."

If necessary, spend money to "make sure everything looks good organizationally" by hiring a manager or sweetening compensation for top producers, Ms. Hammes advised.

That sort of investment will encourage a sale more effectively than a last-ditch investment like an expensive computer system, which probably would be replaced by the purchasing broker's own system.

Even though brokers are looking for agencies with service-based revenues, she recommended against tacking on a financial services or other division in the eleventh hour. Getting such a specialty off the ground can take a long time, and buyers much prefer established operations, Ms. Hammes said.

- Do your homework.

Identify brokers that might be a good match for your agency, Ms. Hammes advised.

Is there one brokerage that always competes with your agency for certain types of new business? Or one that always bids against you on renewals? If it's a strong, profitable business, it might be a good idea to find out what it's looking for in an acquisition.

- Let buyers know you're willing to stick around.

By sticking around for at least a year or two after the sale, principals can help ease the transition, said Ms. Hammes.

- Don't just talk about your agency's desirability—prove it.

Too many sellers promise "change, prosperity and growth," but lip service alone won't clinch the deal, said Larry Marsh, president of Marsh, Berry & Co. Inc. of Mentor, Ohio. Instead, "bite the bullet" and cut costs by clamping down on expenses and phasing out unneeded employees.

And ironically, if you reduce expenses and tighten your belt well enough, you may find that you don't even want to sell after all, he added.

—By Laura Mazzuca

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Agents can benefit as buyers or as sellers

By LAURA MAZZUCA

When an agreement is made for the right reasons and the transaction is handled correctly, an agency can come out ahead either by being acquired or by acquiring agencies of its own.

Financial M&A Management

At opposite ends of this spectrum are Phillip J. Buchanan, president and chief executive officer of RBH/Curtis Day & Co. of San Francisco, which was acquired by Rollins Burdick Hunter Group Inc. last year; and Bob Wuttke, president of Western States Insurance Agencies of Missoula, Mont., which has been acquiring agencies in the state since its 1981 inception.

Both acquisitions and sales work—for different reasons, they say.

"I felt it was one of those things that was meant to be," Mr. Buchanan said of the agency's marriage with RBH. He and his partner, Julie Ferro, the agency's executive vp, were tired of battling the regulatory climate in California. "We felt that the challenges and opportunities in the state would be better handled by a larger firm," Mr. Buchanan said.

Additionally, the agency's unexpectedly strong growth over the past eight years made issues of management and ownership perplexing, he said.

"It came down to the environment we're in, and that it's not going to get any easier," he said.

On the other hand, Mr. Wuttke's agency benefits from big brokers in an entirely different way.

Starting out with a trucking niche, Western States Insurance Agency has grown steadily by acquisition in a state where many alphabet houses have pulled up stakes, citing Montana's sparse population and insufficient business volume.

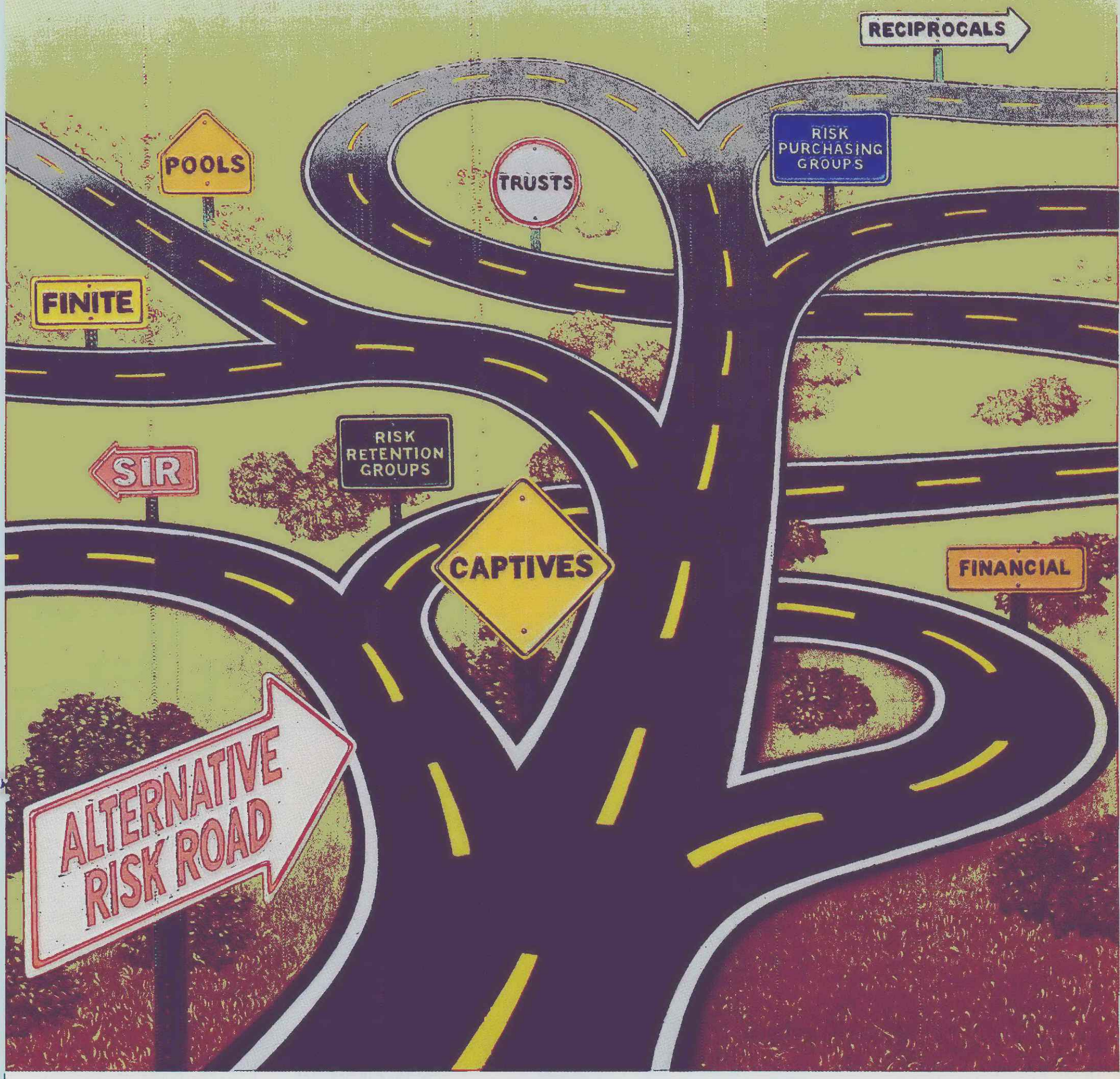
Ironically, their loss has been Mr. Wuttke's gain. In 1982, he acquired Marsh & McLennan Inc's Montana operation; in 1988, the Montana book of Fred S. James & Co. Inc.; and in 1989, Rollins Burdick Hunter Group's statewide book.

By combining business, Mr.

Continued on page 32F

GRAPHIC BY JOHN HALL

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Buyers and sellers

Continued from page 32D

Wuttke's agency achieves economies of scale unavailable to these individual operations.

In spite of their differing approaches, however, both Messrs. Buchanan and Wuttke, in their own ways, are working with big brokers to their own advantage.

Curtis Day & Co. has been a strong presence in Northern California since its beginning in 1966. Last year it was the nation's 70th largest broker (*BI*, July 1, 1991).

Much of Curtis Day's growth came after 1983, when Mr. Buchanan and Ms. Ferro purchased the agency from Mr. Day. At the time, the agency had about 18 employees and revenues of $1.25 million. Since then, it grew at a compound average rate of 30% per year. By 1990, its gross annual revenues topped $10 million.

RBH, which was focusing on regional agencies that were doing well, came calling in April 1991. At that time, Mr. Buchanan and Ms. Ferro were struggling with poor market conditions and the inevitable internal problems associated with a successful business. "My response was, 'I'm flattered; we'll give it some thought,' " he said.

So they did, giving special consideration to several issues.

Curtis Day—which specializes in construction, government agencies and transportation coverage—has a lot of revenue tied up in workers compensation, so "our income could easily fall pretty precipitously," Mr. Buchanan noted. A "Big Brother" like RBH would be better able to weather the short-term storm in this line in return for eventual profitability.

Internal issues also played a role in the decision. Before being approached by RBH, the company was considering starting an employee stock ownership plan; now, employees participate in a 401(k) plan through RBH, he said.

A personal issue was also contemplated. Mr. Buchanan and Ms. Ferro, both in their early 40s, "didn't want to devote our whole lives to the business," he said. While Mr. Buchanan originally wanted to pass the agency down to family members, the business grew too fast for him to do so.

Last but not least, RBH's business philosophy was a close match with Curtis Day's.

Several weeks later, the Curtis Day principals told RBH they were interested in the offer, but they wanted to retain a consultant to set an agency price and to explore other potential buyers.

Curtis Day signed an engagement agreement with Russell Miller Inc., which stipulated that if the agency elected to pursue the sale, it must do so through the consultant; if not, it must wait one year before selling.

Russell Miller determined the value of the agency by looking at net operating income, considering niches and specialties, and setting a fair market value, which Mr. Buchanan would not specify.

The consultant also came up with a list of more than 20 other potential buyers that seemed like a good fit with Curtis Day, eventually targeting about eight to do due diligence studies on, Mr. Buchanan said.

But most of the other "serious players"—including Sedgwick James North America and Willis Corroon P.L.C.—either had no office in the area, or already had one into which Curtis Day would be absorbed.

RBH, which already had offices in San Francisco and Oakland but "no strong management team," wanted Curtis Day to run its Northern California operations, meaning the brokerage would retain its autonomy, said Mr. Buchanan.

The Curtis Day principals signed a letter of intent with RBH in September—and the deal with RBH was closed Oct. 31. The swift completion was particularly "amazing," he said, because RBH was also closing its acquisition of Dutch broker Hudig-Langeveldt Group bv (*BI*, Aug. 19, 1991).

By the first of the year, the big task of putting all the Northern California operations together had begun. The Oakland RBH office moved in with the San Francisco branch before the purchase, while a third office in Palo Alto will also be brought in, he said.

By July 15, all four offices will operate out of the Curtis Day location, but it will probably be the end of the year "before the kinks are all ironed out," Mr. Buchanan said.

In the meantime, the branch is busy. Most of the new entity's management team is from Curtis Day, so "it's been a challenge," Mr. Buchanan said.

Morale, though, has suffered. On both sides of the fence, it has been merely "okay," Mr. Buchanan noted. "Both sets of employees feel somewhat betrayed"—Curtis Day employees because they had not been consulted about the sale and RBH employees because "they feel like Curtis Day bought RBH."

Like Curtis Day, Western States Insurance is a strong presence in its region. In fact, next to the First Bank Montana National Assn. in Billings, a subsidiary of FBS Insurance in Minneapolis, Western is the largest insurance agency in the state, Mr. Wuttke said. Its premium volume is about $30 million with 73% from commercial lines. The agency has 54 employees, seven insurance offices and a financial services subsidiary.

But unlike Curtis Day, which made only one minor acquisition before its purchase by RBH, a significant percentage of Western's growth came from acquisitions, Mr. Wuttke said.

Revenues from small agencies in the sparsely populated state typically don't meet the corporate needs of their big-broker parents, which initially came into Montana for its lucrative logging business. Now, though, the logging industry doesn't generate enough business to keep them there, Mr. Wuttke explained.

But acquiring these operations is an opportunity for his agency—not only to grow and expand its book of business, but also to land insurers and add skilled, brokerage-trained employees.

Expanding from an exclusively trucking book of business, Western used acquisitions to add specialities in municipalities, logging, lumber and timber businesses as well as Main Street coverages.

But Western doesn't just raid big brokerage orphans. When considering an acquisition, Mr. Wuttke looks for growth areas. The locations of his seven agencies "follow the interstate" for high-population tourist areas.

Although most of Western's business is in commercial lines, some of the offices in small towns split the business almost evenly with personal lines, he said. And personal lines are becoming more important in Montana because of the recent "tremendous influx of wealthy people," as the Big Sky State becomes a haven for "escapees from California."

Celebrities like rock star Huey Lewis and sports figures like golfer Miller Barber make their homes in Montana. And although the locals don't look on them as a "big deal around here," their expensive homes have created a growth business for high-priced real estate coverage, Mr. Wuttke said.

"We're probably never going to get rich, but we're making a living," he said. ■

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How to survive in the big time: Agents adopt financial controls

By LAURA MAZZUCA



IRVING, Texas—Insurance agencies must learn to operate like any other business to survive internal growth and external market conditions, experts say.

This means that agency chief financial officers will play a more important role, focusing on financial management to hold down costs.

At a recent workshop here, offered by the National Assn. of Casualty & Surety Agents, CFOs and agency principals discussed financial management strategies and pitfalls, focusing on areas like balance sheet analysis, receivables and payables, cost accounting and Internal Revenue Service audits.

"The book has never been written on financial management in an insurance agency, because the scope is too narrow. Instead, everybody is doing a lot of different things," said Robert A. Gleason Jr., president and chief executive officer of The Gleason Agency Inc. in Johnstown, Pa. Mr. Gleason is also chairman of NACSA's Agency Management/ Education Committee.

For that reason, the NACSA workshop's "exchange of ideas" was particularly helpful to agency CFOs, who rarely get together, he said.

"Business today is tough and less forgiving than it has been in the past. It's more demanding. As a result, there is a need for all firms to more effectively manage their operations," said Bobby Reagan, chief executive officer of Hales & Associates Inc., a consulting firm headquartered in Westchester, Ill. Mr. Reagan acted as the meeting's facilitator.

In the past, agencies were run "like candy stores, where the owner does everything," said Steven A. Warner, executive vp of Ulrich, Voorhees, Warner Associates, a brokerage based in Somerset, N.J. Mr. Warner spoke on a workshop panel.

But agency growth has overwhelmed this sort of management; many of the failures and sellouts that dot today's landscape are the result of businesses that simply became too complex to be managed in this way, Mr. Warner said.

Agencies must be managed "the way Ford does things," with levels of management and work delegation, he said.

And some of the same problems that face big corporations—including controlling finances; maintaining the business's physical plant; maintaining automation systems; and legal threats like hiring, firing and sexual harassment issues—can hurt agencies as well.

"This is the big time," Mr. Warner said. "All of these elements must be controlled."

Most important is financial management. As agency revenues must be squeezed and expenses better controlled, the CFO must take a more active role, Mr. Reagan said.

CFOs must not only focus on general financial issues, like double-checking payables, getting a fair price from vendors and turning over receivables faster, they must also attack insurance-specific issues.

Areas like contingent and bonus income—once simply a perk pocketed by the agency principals—must be considered by agency CFOs as a means of additional agency revenue, Mr. Reagan added.

Because of this, the CFO cannot simply be a number-cruncher but must have a solid background in basic insurance operations, Mr. Warner said.

CFOs and agency principals who want to manage their finances can start with these areas:

Payables and receivables

When dealing with receivables, client education is most important, he said. If you don't make exceptions for clients, receivables will be easier to manage.

For instance, one of Ulrich Voorhees' hospital clients paid a former broker four to five months after billing because the hospital was on a 90-day reimbursement schedule, he said.

When the account came to Ulrich, Mr. Warner said, the client was told upfront that the brokerage's collection policy was five days after billing—no exceptions. In spite of its own collections schedule, the hospital managed to work out an early-invoice system with the brokerage that enabled it to pay within five days.

Also, collections should be handled by the accounting department rather than producers, whose "selling" personalities are not equipped to handle it, he said.

At Ulrich, the producer has the last call when cancellation is pending; he can always front the money for the client. Naturally, this doesn't happen much, Mr. Warner added.

Ulrich requires payment before the coverage is effective. Specialty insurers demand it, so it is Ulrich's policy as well.

When it comes to payables, the agency should negotiate standardized payment terms with insurers—including surplus lines companies—which might include putting them all on a monthly payment schedule, he said. Paying bills is easier with all insurers on the same schedule.

Balance sheet analysis

CFOs and agency principals can get a good idea of the agency's financial health by a close study of its balance sheet, experts say.

Extremely important to the balance sheet is the liquidity-current ratio—or current assets divided by current liabilities. This refers to short-term working capital used to meet financial obligations. With today's poor market conditions and the threat of lost accounts, this line on the balance sheet has become increasingly important because it encompasses what a firm needs to operate prudently, Mr. Reagan said.

Liquidity is directly influenced by receivables, which on the balance sheet are broken down into a receivable-to-payable ratio and a percentage of receivables that are 60 days past due, Mr. Reagan said. This is a ticklish area, because sometimes receivables can be shown as an asset, even if the money is not collected. As a result, the receivables line can look good even when the money isn't there, he said.

The balance sheet's bottom line, tangible net worth as a percentage of net revenues, is the final indicator of what the agency is doing right or wrong. It refers to the difference between all agency assets and liabilities and represents tangible assets that are available for long-term obligations, like perpetuation plans, whereby an owner's interest in the agency will be bought out, he said.

Using industry statistics compiled from a 1991 agency peer analysis, Hales & Associates has developed guidelines on what a financially viable insurance agency's balance sheet should look like.

While the industry average for liquidity was a ratio of 1.07-to-1, Hales recommends a ratio of at least 1.1-to-1.

Industry averages were 64% for the receivable-to-payable ratio and 16% for the percentage of receivables due past 60

Continued on next page

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Financial controls

Continued from previous page
days. Here, Hales recommended 50% for the former, 10% for the latter, because receivables are an area that the agency can control.

And for tangible net worth as a percentage of net revenues, the industry average was 8.91%; Hales recommended at least 15%.

While the industry statistics seem to indicate that the average agency is performing poorly, Mr. Reagan noted that this appearance is "unavoidable" because acquisitions and perpetuations can negatively affect liquidity and tangible net worth figures.

Contingent management

With commissions continuing to shrink, contingents have taken on more importance in total agency revenues.

These estimates are important to an agency, because, as commissions shrink and expenses rise, many more agents and brokers are making profit-sharing an important part of the agency's income. In olden days, they'd simply pocket this. But not anymore. "You're looking for income from all different revenue streams," Mr. Gleason added.

According to Russell Miller, contingencies and profit-sharing now comprise about 6.7% of the average agency's gross revenues.

As a result, it's a lot more important to be able to estimate what these figures might be. A good start is to get insurers to cooperate by specifying in company contracts what the contingents will be, Mr. Gleason said.

Agents have access to some of the data that companies use to determine this—like premium and loss data—and can frequently estimate contingents by comparing the agency's figures with the insurer's. So Mr. Gleason advised asking the insurer for these figures compared with the year before so an agency can project what the profit-sharing picture will look like.

While the Gleason Agency currently uses an account executive to figure this, it is in the process of transferring the task to the agency controller, he said. "You just need the formula and the numbers," he added.

Cost accounting

Cost accounting is a method used to determine how much it costs to manage each account on the books, Mr. Gleason said. Many agents and brokers are starting to keep track of hours, phone calls and faxes, "just like lawyers and CPAs have been doing for years," he said.

Even though they're being paid on commissions, agents need to know if the agency is making money on a client, because it may not renew coverages that are not cost effective, he added.

IRS audits

They're not exactly a form of financial management, but they are one of the realities of doing business, said Karlista Patterson, assistant controller at Hibbs-Hallmark & Co., an agency with annual premium volume of $22 million in Tyler, Texas. Ms. Patterson spoke on a panel dealing with IRS audits at the NACSA meeting.

Just the word strikes fear in the hearts of business owners, even those with nothing to hide. "When you hear the word 'audit,' you just cringe in your shoes," Ms. Patterson said.

But other panelists noted that while agencies do get audited, they are not likely to be "targeted" by the IRS for more audits than other businesses, Ms. Patterson said.

Statistics show, however, that insurance companies *are* more likely than other businesses to be audited, probably because of the legislative spotlight that's focused on them, she added.

Hibbs-Hallmark was audited in early 1991 on its tax returns for 1988, 1989 and 1990, when a large bad debt writeoff "kicked us out of the system" and caught the IRS' eye, she said.

The agency first learned the bad news when it received an information documentation request in the mail from the IRS, listing all the paperwork that the IRS auditor would need.

In Hibbs-Hallmark's case, the request list was fairly "generic"—the IRS wanted to see the agency's general ledgers; receipts; bank deposits; copies of its employee stock ownership pension plan including documentation and IRS approval; auto logs and expense reports; and W2 statements, to differentiate between full-time employees and those who contracted with the agency, she said.

The IRS also wanted to know how the agency's receivables were divided—that is, what percentage of total income represented property/casualty, life and other sales.

Because the agency principal is a major stockholder, his personal taxes were also audited. If the business had been a partnership, the auditor would have looked at the individual tax returns of all partners, Ms. Patterson added.

Before the auditor was set to arrive, Ms. Patterson and the agency comptroller compiled the information requested by the IRS. They set up individual files, numbered one through 14, to correlate to each document requested on the audit statement, so when the auditor came in, "she didn't have to do anything but start," she said. "Always have complete documentation; make sure everything is neat and tidy." An auditor is more likely to find fault if he or she has to dig through a mess, which will arouse suspicion, she added.

When the auditor showed up, she had an initial meeting with the agency principal and the controller, who explained how the agency operated, because most IRS agents on a general audit "have no idea what your business is about," she said. The agency's own certified public accountant also is entitled to sit in on such proceedings, she said.

The auditor was there for 1½ days, or about eight hours. But other panelists observed that similar agency audits can run from two to three days, even six months to a year, Ms. Patterson said.

During the course of the audit, the auditor requested some additional documentation on expenses and ended up disallowing some tennis and swim club dues written off by the agency principal. "They can't go home empty-handed," Ms. Patterson added.

But in the long run, she felt that the auditor treated the agency fairly. "It's just the luck of the draw. If they walk in and don't like you, they can make your life miserable," she said. ■

JUNE — **Legislative Issues; NAIB Report**

Issue: June 1
Ad Closing: May 19

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

JULY — **Compensation & Incentives**

Issue: July 6
Ad Closing: June 24

Can employee compensation at independent agencies continue to increase faster than revenues during the current recession and soft market? *BI's Agent/Broker Topics* section will focus on this critical issue, reporting on how agencies can attract and keep qualified personnel without going overboard on compensation. What perks and benefits are being offered as an alternative to big raises?

AUGUST — **Marketing & Sales Promotion**

Issue: August 3
Ad Closing: July 22

The recession and the soft property/casualty insurance market are delivering a two-fisted punch to most agencies' budgets. Yet, now more than ever, agencies need to spread the word about their services. *BI's Agent/Broker Topics* section will look at how agents promote themselves considering the slimmer margins under which they're operating and will examine what types of sales promotion are the most cost-effective.

Agent/Broker Topics

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Around the world (and more) in a year



At a Lions-sponsored hospital in India

Searching out leads, a California agent tried the Lions Club. Thirty years later, he's glad he did.



with children near Thessaloniki, Greece

By LAURA MAZZUCA

AS A KID growing up in a small Michigan farming community, Donald E. Banker dreamed of visiting exotic ports of call, meeting the famous and traveling around the world in style.

Little did he know that the career path leading him to such adventures wouldn't be politics, acting or the circus—but the humble calling of the insurance agent.

Serving as president of the Lions Club International over the past year, Mr. Banker, 61, has visited many of the 171 countries where 40,000 Lions clubs are located. His travel itinerary has included Africa, China, Eastern and Western Europe, India, South America and Southwest Asia.

Mr. Banker figures he and his wife, Diane, have put on a quarter million miles in the past year.

He has met with Arab ambassadors, Masai tribesmen, Mother Teresa and the Pope.

None of it ever would have happened if he hadn't joined the West Torrance, Calif., Lions Club in 1963 to help drum up more commercial business for his insurance agency.

Being an insurance agent helped him make the transition from D.E. Banker & Associates, his $3.5 million annual premium volume agency in Lomita, Calif., to his role as the top representative of the world's largest service organization, representing more than 1.3 million business and professional people worldwide.

"Insurance people, because of the business we're in, must be able to adjust quickly and well in sales or claims situations," Mr. Banker said.

Such aplomb is indispensable when one day you're in a thatched hut caulked with cow dung in Kenya and the next day you're shaking hands with Pope John Paul II in the halls of the Vatican.

With 41 years in the business, Mr. Banker has those agent skills down pat.

Born and raised in Michigan, he moved to California to attend the University of California at Los Angeles, then started his own agency in 1964.

Over the years, Mr. Banker's agency has experienced the changes that he says are typical "of a community-oriented agency that doesn't become a national agency," such as acquisitions, mergers and growth fluctuations.

Mr. Banker joined the Lions almost 30 years ago because its "friendly, relaxed atmosphere" seemed like a good way to get involved in the community and to meet other business people who might need commercial coverage, Mr. Banker said.

Additional business was far from the only thing he got from the Lions.

His involvement in the organization gradually grew, and he served as club president, regional chairman and district governor. In 1981, he was elected to a two-year term on the international board of directors.

This progression was "just an evolvement—being asked to do certain things, then a little bit more," Mr. Banker said.

The responsibility culminated in 1984, when he began devoting more time to Lions obligations. "I made a decision that I wanted to do this," Mr. Banker said. "When you make a commitment that goes beyond the community, it takes a tremendous amount of time."

With this in mind, Mr. Banker arranged to buy out his share of the agency in 1983. As sole owner of his own agency, Mr. Banker now has five employees and generates $3.5 million in annual premium volume.

Being the Lions president requires a five-year commitment—the first three years as vp, the fourth as president and the fifth as chairman of the Lions Club International Foundation. But the crucial year is the fourth, when the president travels almost constantly. Mr. Banker arranged to take a year off from the business to devote himself to the Lions presidency.

His term began in June 1991, when Mr. Banker was named president at the Lions' annual convention in Brisbane, Australia.

To paraphrase a Chinese proverb, Mr. Banker was serving in "interesting times."

With the Berlin Wall toppled and the Soviet Union in pieces, the Lions' philosophy of "a democratic, free market system requiring autonomy and free choice" was hungrily received in Eastern Europe.

Mr. Banker visited Hungary, Czechoslovakia, Poland, East Germany and Romania, one of the region's poorest nations. "They're like little children in that they want to learn as much as they can," he said. "And they're going to be competitors with the rest of the world in time."

Lions Club chapters in Western Europe are working with their Eastern bloc counterparts on a peer group basis—lawyers to lawyers, for example—to teach them how to operate in a free market system, Mr. Banker said. For six months to a year, the Lions invite them into their homes and businesses to observe the free enterprise system in action.

In his visit to China, Mr. Banker met with businessmen in Beijing to discuss establishing Lions chapters there. He also met with five Arab ambassadors of the United Nations to establish Lions chapters in the Middle East.

But the Lions Club isn't just about business. Much of Mr. Banker's job as president was to promote the Lions' "SightFirst" program, a $100 million international initiative in developing countries to eliminate reversible and preventable blindness caused by cataracts, glaucoma and vitamin deficiencies in children.

The Lions, in conjunction with the World Health Organization, the United Nations and Third World governments, provide financing, technology and training to enable local doctors to perform field surgery and establish basic hygiene where blindness is common.

In Kenya, where a SightFirst project was launched last year, Mr. Banker visited a Masai village where 90% of the tribe's children will be blind by age 20 from traucoma, an eye disease carried by flies. Lions workers there are digging wells in the drought-ridden area and teaching basic hygiene habits to help prevent the disease with regular eye washing.

In Calcutta, India, Mr. Banker visited Mother Teresa's homes for the ill and the dying, where nuns bring in people from the crowded streets to wash them, care for them and "allow them to die gracefully."

Mr. Banker met Mother Teresa several years ago, when the Lions gave her a humanitarian award. And in Italy, after a private audience with the Pope, he and his wife were given the royal treatment, complete with a parade, in the small Sicilian village where her family came from, he said.

How will he adjust to everyday life after his presidency ends June 26?

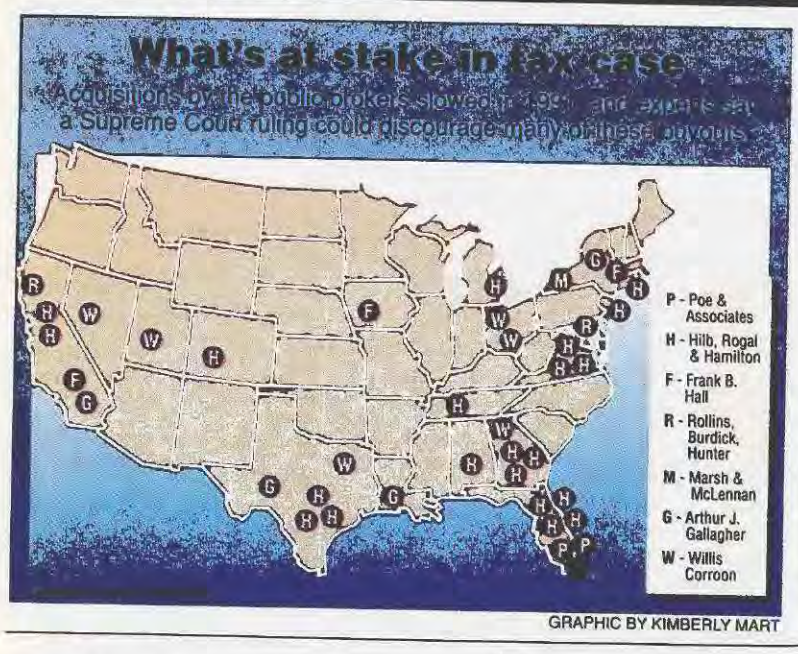
Mr. Banker quipped that since his office manager just won a local "agent of the year" award, "I may just come back and watch her work"—that is, when he's not golfing or playing with his four grandchildren.

But he adds that at 61, he is "too young to retire." So in a few weeks he'll be back to selling insurance in today's competitive Los Angeles marketplace.

He will not soon forget this year, though. "Something like this is worth anything you have to give up. It's a once-in-a-lifetime experience." ■



and meeting John Paul II in the Vatican



GRAPHIC BY KIMBERLY MART

Final word on intangibles?

Supreme Court will rule on amortization of customer lists

By MICHAEL SCHACHNER

WASHINGTON—An estimated 15% to 30% of an average agency's buyout value will hang in the balance until the Supreme Court decides whether businesses can continue to amortize the value of customer and subscriber lists from other firms they acquire.

Last month the high court agreed to rule on whether such intangible assets have a value that can be depreciated and written off over a period of time. No hearing dates have been set.

Right now, agencies and brokerages deduct an estimated $200 million to $1 billion annually in depreciation on their customer lists. A Supreme Court ruling disallowing those deductions would create a major disincentive to buying out other agencies or brokerages.

Major brokers say the court's ruling will determine whether they make acquisitions with cash or through stock transfers.

The Internal Revenue Service has permitted businesses to take annual tax deductions against the value of customer—or expiration—lists of acquired companies since 1974. The deductions range from seven to 10 years, reflecting the value of the lists at the time of purchase.

Under a 1989 IRS ruling, though, no intangible asset, including subscriber and customer lists, could be depreciated if it contained an element of goodwill. In an acquisition, goodwill represents the value of a company's good name and reputation.

As a result, many brokers and large agencies have backed away from cash-based acquisitions and have instead pursued stock-for-asset deals where tax deductions are irrelevant.

Other acquiring companies have continued to take deductions for the depreciating value of expiration lists in hopes that IRS auditors would not consider the lists part of goodwill.

But in hundreds of cases, the IRS has denied millions of dollars in depreciation deductions on the grounds that customer lists do comprise goodwill.

These denials have prompted various businesses to sue the IRS, but federal courts have split on whether or not customer lists contain elements of goodwill.

Now the Supreme Court has agreed to set a national precedent on this issue.

The case it will review involves Newark Morning Ledger Co., a unit of Advance Publishing Inc., which publishes the Newark Star Ledger.

The publishing company's predecessor for years claimed depreciation deductions on the value of a subscriber list that came with a Michigan newspaper it bought.

Those deductions were denied by the IRS, which asserted that a paid-subscriber list was part of the goodwill of the acquired newspaper and thus was not depreciable.

Morning Ledger sued in federal court to recoup denied deductions on the $67 million appraised value of the paid-subscriber list.

A trial court judge ruled that the subscriber list was depreciable because customers could be identified and the value of the list could be determined with a fair amount of accuracy.

But on appeal, a 3rd Circuit U.S. Court of Appeals panel ruled that the list was an asset that contributed to continual income, but was akin to non-depreciable goodwill.

Other federal courts have ruled the lists depreciable, a discrepancy which prompted the Justice Department to request a Supreme Court ruling on the issue.

Experts expect the impact of the ruling to extend well beyond newspaper publishing. Any business where customer and subscriber lists are elemental to a stream of income could be significantly affected.

For insurance agencies, purchase prices could fall as much as 30% if purchasers are not allowed to amortize the value of expiration lists, agents and brokers say.

Should the Supreme Court deny the amortizations, the hardest hit businesses in the insur-

Continued on next page

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Business Insurance
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Continued from previous page
ance industry could be the owners of small, independent agencies, agent trade groups say. These owners theoretically work for years to build the business, including the expiration list, with plans to sell the agency to a larger firm to finance retirement.

"This is probably the number one issue these days for agents," said Chris Larsen, a Washington representative with the Independent Insurance Agents of America. "The man on the street who's selling insurance to real people in the real world understands what's on the line here. We believe that taking the ability to amortize intangibles away from the purchaser will drive down an agency's value by about 30%."

Lynnea Olsen, director of federal affairs with the National Assn. of Professional Insurance Agents in Washington, D.C., argues that customer lists should not be considered goodwill.

"Agencies generally aren't purchased for their name. It's their customer list that fuels the sale. The IRS seems to believe that prohibiting this type of amortization will only affect large corporations, which is a total misconception," said Ms. Olsen.

Tax attorneys and insurance consultants who appraise the value of expiration lists also say the lists' values should be depreciable because they directly lead to revenue production and have an assessible lifespan.

"An expiration list for an insurance agency is much different than a paid-subscriber list for a newspaper," said Bob Chapman, a consultant with Russell Miller Inc., a San Francisco-based consulting and investment banking firm.

"The agency list includes coverages, expected revenues and customer rosters. It's the critical element in putting together a purchasing value. When we appraise an agency for a potential buyer, we usually attribute a large portion of the purchasing price to the value of the expiration list," said Mr. Chapman.

Sources agree that an expiration list normally accounts for 50% to 80% of an agency's purchasing price. It's the ability to amortize this portion of the price that often enables one agency to buy another, experts say.

Even observers who are keenly interested in a Supreme Court ruling are unsure which way the court will go.

Ken Kies, a lawyer who will file a brief on behalf of the Amortization of Intangibles Coalition, a collection of agent trade groups, declined to predict the outcome.

But, he said, it's, "basic if you can accept the premise that a list is an asset you buy that wears out over time, but produces a steady stream of income before it dies."

A major chunk of agents' retirement income is at stake, said Mr. Kies, who is with Baker & Hostetler in Washington, D.C. "If you devalue an agency by 20% by not allowing for the amortization of expiration lists, you're playing with an agent's retirement money. It's almost like taking 20% of an IRA's value away."

Larger brokers that have grown through agency acquisitions are also eagerly awaiting a Supreme Court decision.

"There's no question this ruling will affect the way we acquire companies. Right now, a lot of deals are dragging. All we want to know is what exactly we can do," said Robert H. Hilb, president of Hilb, Rogal & Hamilton Co. in Glen Allen, Va., the most acquisitive of the public brokers.

HRH and most others in the insurance industry supported an intangible-taxation measure attached to the congressional tax package President Bush vetoed in March.

That measure, based on an earlier proposal by Rep. Daniel Rostenkowski, D-Ill., would have allowed for fixed 14-year amortization of the entire purchasing price of an entity.

"Fourteen years may be a long time when we usually amortize a list over eight to 10 years," said Mr. Hilb. "But we still supported it because at least it was a clear solution to this problem."

Both the IIAA and PIA are currently lobbying House and Senate tax writers to again draft separate bills allowing for the depreciation of intangible assets. Observers say there is a good chance that Congress may pass a tax package, including an intangible measure, acceptable to President Bush.

"Without the ability to amortize intangibles, you're penalizing the entire service industry," said IIAA's Mr. Larsen. "It's hard for us to accept changing a law that has existed since 1974 in midstream. A new intangibles proposal similar to the Rostenkowski proposal would be welcomed."

Michael Cloherty, vp-finance with Arthur J. Gallagher & Co. Inc. in Itasca, Ill., said the impending Supreme Court ruling will clear up the structure of agency acquisitions.

"Right now, we're not doing many cash acquisitions because of the deductibility question. Almost all of our deals are stock-for-asset deals or some other non-cash deal. This way you don't get into the question of deductions. It's too big a risk to move forward on a cash basis when it's unknown whether you can write it off or not." ■

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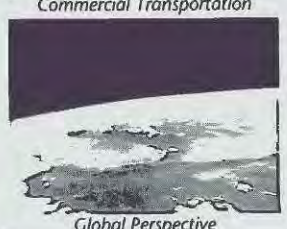
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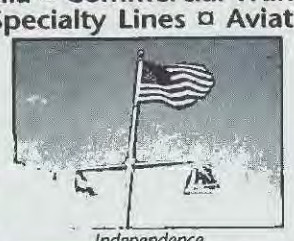
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Agent/Broker Topics

How to be a survivor, not victim, of the '90s

By STEPHEN C. ANDERSON

SELLING INSURANCE products in the '90s requires far more creativity than at any time in the industry's history.

The use of innovative marketing strategies, tactics and weapons is a must if you want to be a survivor rather than a victim of the changes that are rapidly transforming the way insurance products and services are sold.

When properly used, a carefully considered marketing program will increase new prospects and lower your cost per sale, resulting in higher agency profits.

But simple mistakes can creep into the most effective and innovative marketing programs and torpedo your success. Once you recognize which mistakes you are making, you can take steps to correct them and start realizing the maximum leverage of your programs.

- Determine the lifetime value of your customer.

Without knowing the lifetime value of a new customer, you have no way of knowing how much you can afford to spend to bring in each new customer.

With this knowledge, you may be able to spend two, three or four times what your competition is spending to acquire new customers. The competition may stop running an ad which seems to be losing money or stop mailing letters to prospects because that approach doesn't seem to be breaking even or making money.

ABT perspective

For example, if a new customer costs you $100 to acquire and you make $50 in commissions the first year, it would seem that you are losing $50 on that client. But when you realize that this new client will be with you for four years and you will make at least $200 in total commissions, clearing $100 in total income over the four years, this apparent loss turns into a gain.

Multiply this small increase by the total number of new clients you will gain, and you begin to build an income stream that grows larger each year.

- Use direct response advertising.

By far the most deadly marketing mistake is the use of image advertising instead of direct response advertising.

Many agencies spend hundreds of thousands of dollars on ads that are clever, funny, or "pretty." Those ads may build your agency's image, and they may even win awards. But they don't guarantee that the public is going to buy what you're selling.

The worst aspect of image advertising is that you rarely if ever really know how well your ads work. The result is wasted ad dollars, vague ideas of who saw the ad and, ultimately, frustration.

Direct response advertising directs people to take action. It tells them what to do and compels them to see the reasons behind it.

- Test your marketing methods.

Most agencies don't make it a regular habit to test and compare various marketing approaches. Rather, they make a subjective or arbitrary decision based on personal preference, hearsay or hunches. This is a costly mistake.

You do not have the right or the power to predetermine what your customers and prospects want or need. You *do* have the responsibility to ask them what approach they like best. You can do this by using very definitive, inexpensive and immediate tests.

If you want to know which approach is best, conservatively test one ad or letter against another with a small group of people. Then wait to see which format generates the most response from customers and prospects.

When you test and carefully track and analyze the results, one approach always substantially out-performs the others, sometimes by an enormous margin. This means higher sales or larger average orders for the same effort. This is real marketing leverage.

You can use this method to test sales concepts, prices, ad ideas, headlines, TV or radio commercials, Yellow Pages ads and other ways to sell products and services.

When you find winners, integrate them into your business. These winners become control. As long as they work, keep using them until you have tested something else that works better.

- Explain "why."

Whenever you ask for a sale, run an ad, make a presentation to a customer or prospect, deliver a renewal quote or offer a product or service for sale at a specific price, always tell the customer why you are doing it. For example, do you spend 25 hours doing a comprehensive risk analysis of their business before you come up with an insurance program? Describe the process you go through to develop a quote for them. Your customers will not take advantage of a value unless they understand it.

- Put yourself in their shoes.

Most agents never put themselves in their customers' position. Do your customers enjoy doing business with you? Or do you take them and their business for granted? An agency that is appealing, easy to do business with and looks organized tells your clients that you and your staff know what you're doing.

But you can't know whether your business is appealing or desirable by sitting behind a desk and asking others for the answers.

Go to one of your competitors and get a quote or purchase a policy. How were you treated? What can you learn that you can use in your agency?

- Offer a guarantee.

What is the first question you face when you are contemplating buying a product or service? Don't you wonder if you have made the right decision? What if another agent has a better deal? What if it is not the right policy for me? What if I am buying too much coverage?

Most agencies put all the risk of buying a new policy or changing to a new insurer on the prospect rather than on the agency, where it belongs. By offering a guarantee of satisfaction, you can eliminate every factor of intimidation or resistance that exists in the prospect's mind.

If you offer the client a guarantee, you may be the only agency in town that says, "I don't want you to buy from me unless this policy does what I say it will and you are completely, unconditionally satisfied."

Many agents have taken the subtlety of a guarantee and turned it into a primary premise of their unique business advantage.

- Use data base marketing.

Finding and keeping clients with easy-to-use software tools is your key to survival in bad times. The goal of your agency's computer database is to optimize your customers' value through conversion, retention and repeat sales. A data base allows you to create new marketing opportunities if you know how to utilize its power.

You need to collect data on who is, or should be, buying your products and services. This is not simply names and addresses, but includes buying history—what they bought, when they bought, how much they bought. It includes birthdays, anniversaries, marital status, number and age of children, likes and dislikes. It opens up new ways to market more products.

Additional information could include expiration dates of current policies, how long a person has been a client, their occupation and comments they made about investment choices. You can combine thousands of customer characteristics to develop a detailed marketing profile.

Advances in microchip technology have made this process easier and cheaper. In 1973, it cost $7.14 to access one customer's name and address. Today, the cost is about 2 cents.

Take advantage of this technology to build a comprehensive database, increase the number of qualified prospects and offer them what they want.

- Cross-sell current clients.

Identifying prospects and converting them to customers is a costly process. Yet what do most agencies do when they get a new customer? They ignore the customer entirely and put all their marketing efforts into getting more new customers.

Once a person buys from you, that person will most likely want to buy from you again—assuming, of course, you deliver what you promised. Compile a data base of all people who buy, or just inquire, and then try to sell them related products, services or upgrades.

The best prospect of all is your existing customer. Instead of concentrating only on front-end sales, an agency needs to devote a large part of its marketing efforts to re-selling and cross-selling to existing customers and prospects.

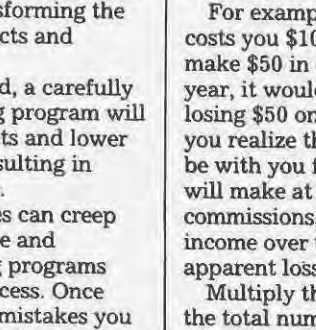
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Stephen C. Anderson is president of American Insurance Consultants, an agency management and marketing firm in Hurst, Texas.

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Business Insurance

APIW award

Continued from page 2

APIW members, are extensively interviewed on their professional and personal accomplishments.

"The process took several hours. I found it an interesting experience," Ms. Walters said. "Many of the questions I was asked I hadn't been asked before, and it gave me an opportunity to think about my career from a different perspective."

After graduating cum laude from Fordham University with a degree in mathematics, Ms. Walters began her career in New York as an actuarial trainee with the National Bureau of Casualty Underwriters, the predecessor to ISO.

"ISO was formed as a consolidation of six national associations in 1971," Ms. Walters explained. She began working for ISO as an assistant actuary that year.

In January 1972, Ms. Walters moved to Washington, D.C., to serve as a consultant to the Price Commission in the Executive Office of the President. The Price Commission was established to develop rules and regulations governing allowable price increases under then-President Nixon's Economic Stabilization Program, which froze wages and prices from January through November 1971.

The Price Commission eventually became the Cost of Living Council, and Ms. Walters served as director of its insurance division.

When her job with the federal government ended, Ms. Walters worked briefly for Legg Mason & Co., a regional brokerage and investment firm in Washington.

Meanwhile, ISO was making overtures to her to return.

Describing the interview process for the APIW award, 'Many of the questions I was asked I hadn't been asked before, and it gave me an opportunity to think about my career from a different perspective,' says Ms. Walters.

In 1975, Ms. Walters was named assistant vp at ISO and asked to head a new Washington office.

Establishing a Washington office for ISO "was interesting, but the pressure was nowhere near the pressure and excitement in connection with the job with the federal government," Ms. Walters said. "It was challenging, but it was easy compared to the job I had just come from."

In 1977, Ms. Walters was promoted to vp at ISO, and in January 1982 she became senior vp.

She assumed her current position as executive vp in 1988.

Ms. Walters now divides her time between ISO's New York and Washington offices. She is responsible for ISO activities on policy matters of national significance, including ISO's federal affairs operations. She works with both state and federal officials on issues affecting the property/casualty insurance industry.

Ms. Walters has testified before congressional committees and in state legislative forums, explaining, among other things, the technical factors underlying many insurance industry issues.

Ms. Walters also is a fellow of the Casualty Actuarial Society and a member of the American Academy of Actuaries, which she served as president in 1991. She also has been a board member for each group.

Fred R. Marcon, president and chief executive officer of ISO, will present Ms. Walters with the APIW award at a reception at the City Midday/Drug & Chemical Club in New York.

Ms. Walters said she has not received an honor like the APIW award before, but that "it reminds me of the warm feeling I had when my high school principal asked me to give the commencement address." ■

Washington

Continued from previous page

However, employers would be given a new safe harbor to use to avoid interest charges if they underestimated the amount of premiums they owed. Employers that in their first installment pay a premium equal to the total premium paid the previous year would not owe interest on the shortfall.

Reporting unfunded plans

Legislation approved by a House panel would require the Pension Benefit Guaranty Corp. to file an annual report with Congress listing employer pension plans with at least $25 million in unfunded benefits.

H.R. 3837, approved recently by the Ways and Means Committee, would require the PBGC to list pension plans with at least $5 million in unfunded benefits and that have obtained waivers from the Internal Revenue Service to delay required contributions of at least $1 million.

Currently, the PBGC publishes a list, known as the Top 50, of the sponsors of the 50 largest underfunded pension plans.

The PBGC supports the Ways and Means proposal, which was introduced by Rep. J.J. Pickle, D-Texas. "We are pleased with the proposal. It shows congressional interest in providing additional information on pension underfunding. We think an expanded list of companies with large underfunded pension plans would encourage better funding and thereby improve retirement security for millions of people," a PBGC spokeswoman said.

D.C. health cover mandate

The Supreme Court has agreed to review the legality of a 1990 District of Columbia law that requires employers to provide health insurance for up to 52 weeks to employees collecting workers compensation benefits.

During this period, the employer has to pay the entire premium, including any portion of the premium previously paid by the worker (*BI*, Nov. 12, 1990).

The Greater Washington Board of Trade had challenged the law, arguing that it is pre-empted by the Employee Retirement Income Security Act of 1974. Section 514 of ERISA pre-empts any state law that "relates" to employee benefit plans. The U.S. Court of Appeals for the District of Columbia previously ruled that ERISA pre-empted the District of Columbia law. ■

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Berkshire meeting

Continued from page 3

This year, the official meeting was dispensed with in less than 10 minutes, after which Messrs. Buffett and Munger answered a barrage of questions for nearly 2½ hours. Periodically, the two sipped soda produced by The Coca-Cola Co., 7% of whose stock was owned by Berkshire at year-end 1991.

After a short break, Mr. Buffett—accompanied by Mr. Munger—returned to answer more questions for more than an hour in what traditionally has been a more informal setting. Instead, at least a third of the shareholders returned to the theater to lob more questions—with the continued assistance of microphone-wielding moderators—and listen to the comments of the "Wizard of Omaha."

The interest in Mr. Buffett's thoughts aren't surprising: A single Berkshire common share traded at $9,000 last week, up from $8,125 a year ago. Berkshire is the highest-priced stock listed on the New York Stock Exchange, in part because the board refuses to split its shares.

Similarly, Berkshire refuses to follow the path set by others in the insurance industry and has sacrificed business during the lingering soft market—a soft market that, in 1988, Mr. Buffett predicted would last at least four years.

The fact that the market hasn't turned yet "just shows you we were not as pessimistic as was thought at the time," commented Michael A. Goldberg, a Berkshire vp who heads the insurance group.

While Mr. Buffett did not venture a guess on when the market would turn—and thus when Berkshire would rev up its underwriting—Mr. Goldberg said the market has to harden sometime because "you just can't go on indefinitely with these kinds of losses."

"Within the next few years, we expect some sort of upturn. Whenever it comes, it comes"—the company doesn't need to prepare for it, Mr. Goldberg said.

But, Berkshire doesn't "see any signs right now" that a turn is imminent, Mr. Goldberg said, though he cited some isolated hardening in professional liability and other lines.

Few Berkshire shareholders are insurance experts, so Messrs. Buffett and Munger answered with careful explanations any questions about the insurance group, the company's cautious approach to insurance and reinsurance, and its operating and regulatory environment.

For instance, Mr. Munger told one questioner that instead of viewing Berkshire's relatively low premium volume—as compared with its surplus—as "unrealized profits," he and other investors should view it "as unrealized losses."

Meanwhile, Mr. Buffett is critical of many insurers that are following a far less cautious underwriting approach. Like other observers, he believes that many insurers are underreserving, a move that "may obscure the picture for a time," he wrote in Berkshire's annual report.

"In the long run, of course, trouble awaits managements that paper over operating problems with accounting maneuvers," Mr. Buffet continued. "Eventually, managements of this kind achieve the same result as the seriously-ill patient who tells his doctor: 'I can't afford the operation, but would you accept a small payment to touch up the X-rays?' "

That isn't to say that Berkshire doesn't take risks. By the company's own account, it may be the largest writer of "super-cat" or super catastrophe retrocessional coverage.

To illustrate what kinds of events trigger super-cat coverage, Mr. Buffett noted that neither last's year's fire in Oakland, Calif., which caused $1.2 billion in insured damage, nor Hurricane Bob, which ravaged the New England coast and cost insurers $780 million, qualified as a "super cat."

Berkshire did not emerge from 1991 unscathed, however. Typhoons that hit Japan in September, causing an estimated $4 billion to $5 billion in insured damage, qualified as a super cat, likely triggering payments from about 25% of Berkshire's super-cat policies, Mr. Buffett said.

Despite the typhoon losses, Mr. Buffett estimates that super-cat business produced a 1991 underwriting profit of about $11 million.

Writing in the annual report, Mr. Buffet noted that the super-cat business is "enormously volatile," with annual premiums that can generate either a 100% profit or a 200% loss.

"We try to price (the super-cat policies) with a margin of safety," said Mr. Buffett. "But we can't be sure that it's been done adequately" because little actuarial data is available for such business.

"The variety of things that can cause super cats are wider than my imagination, or Charlie's," he added. However, as long as pricing remains "apparently adequate," Berkshire plans to remain in this niche, he said.

"In marketing this product, we enjoy a significant competitive advantage because of our premier financial strength," Mr. Buffett wrote. "Thinking insurers know that when 'the big one' comes, many reinsurers who found it easy to write policies will find it difficult to write checks."

In fact, Mr. Buffett alluded in the annual report to a well-known comedian by writing that "some insurers can say what Jackie Mason does: 'I'm fixed for life—as long as I don't buy anything.' "

More seriously, he continued, "Berkshire's ability to fulfill all its commitments under conditions of even extreme adversity is unquestioned."

A statistic with which Berkshire shareholders have become familiar is 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.

Berkshire's track record in this area has been impressive, with the cost of funds being lower than government bonds every year since 1967, the first year the company generated this statistic. Last year, the cost of funds was 6.31%, up from 1.63% in 1990 but still below the yield on long-term government bonds, which was 7.40% last year.

"We regard (the float) as a very significant asset," Mr. Buffett said.

In the last five years, the company's feeling about the insurance industry "is better than ever," despite the soft market, he

Continued on next page



Continued from previous page
said.

While many shareholders may not be familiar with the specific workings of the insurance industry, they have not missed the fact that insurers face tighter regulation in the future. One shareholder asked Mr. Buffett what he thought of some of these proposals, including a proposal that state regulators limit insurers' equity investments.

Mr. Buffett said that Berkshire does not object to such limitations and, indeed, approves of them in some instances.

"There have been significant abuses by some property/casualty companies. . .so this is not an improper subject for legislators and commissioners to address," Mr. Buffett said. Insurers that "don't have large amounts of capital should be regulated with a jaundiced eye."

Mr. Munger added that he would "be in favor of heavy investment limitations on people with thin capital."

"We basically like tough cops," Mr. Buffett said. "But we also want recognition that we have lots of capital." And, to Mr. Buffett, that recognition should translate into investment freedom.

The Berkshire insurance group is a key component of the Berkshire empire and consists of a dozen companies, led by Omaha-based National Indemnity Co.

The insurance group's earned premiums rose 31.2% last year to $776.4 million from $591.5 million in 1990. The gain came from a sizable increase in reinsurance business: direct insurance premiums earned continued to shrink, falling to $141 million from $154 million in 1990, while reinsurance assumed rose to $635.4 million from $437.5 million.

Net income attributable to the insurance group rose slightly last year to $281.7 million from $279.5 million in 1990.

At the same time, Berkshire's overall net income rose 14.6% to $439.9 million to $384 million.

Insurance group assets are invested in stocks in companies like The Coca-Cola Co., Capital Cities/ABC Inc., GEICO Corp., The Gillette Co., Guinness P.L.C., The Washington Post Co. and Wells Fargo & Co. Its bond holdings include: American Express Co., RJR Nabisco, Salomon Inc. and USAir.

Besides its insurance companies, Berkshire has a controlling interest in several other operations including: See's Candies, a California-based candy maker; Borsheim's, an Omaha jewelry store; the Nebraska Furniture Mart, a massive Omaha retailer; World Book, the encyclopedia publisher; Fechheimer, a uniform manufacturer and retailer; and The Buffalo News, a Buffalo, N.Y., newspaper.

Berkshire's latest acquisition, which was completed in July, is H.H. Brown Shoe Co., which is a Greenwich, Conn.-based manufacturer of work shoes and boots. ■

Buffett holds no plans for White House

OMAHA, Neb.—With one billionaire already unofficially running for president, at least one shareholder of Berkshire Hathaway Inc. wondered whether Warren E. Buffett would be interested in throwing his hat into the ring.

He shouldn't have wondered.

Berkshire's chairman and chief executive officer emphatically stated that H. Ross Perot's presidential ambitions "do not give me any ideas."

So much for the "Buffett in '92" bumper stickers.

During a four-hour session, Mr. Buffett fielded shareholders' questions on a variety of subjects (see story, page 3). Following are a few of the highlights:

• Foreign investment. Berkshire's youngest investor, 11-year-old Nicholas Kenner, opened the session by asking Mr. Buffett why he invested in Guinness P.L.C., the first significant Berkshire investment in a foreign company.

Nicholas seemed to take exception on two grounds: First, Guinness is not a U.S. company. Second, Nicholas is prevented by law from actively supporting the investment through personal purchases of Guinness products, though he can buy products made by See's Candy Shops Inc. and The Coca-Cola Co., other companies in which Berkshire has a major stake.

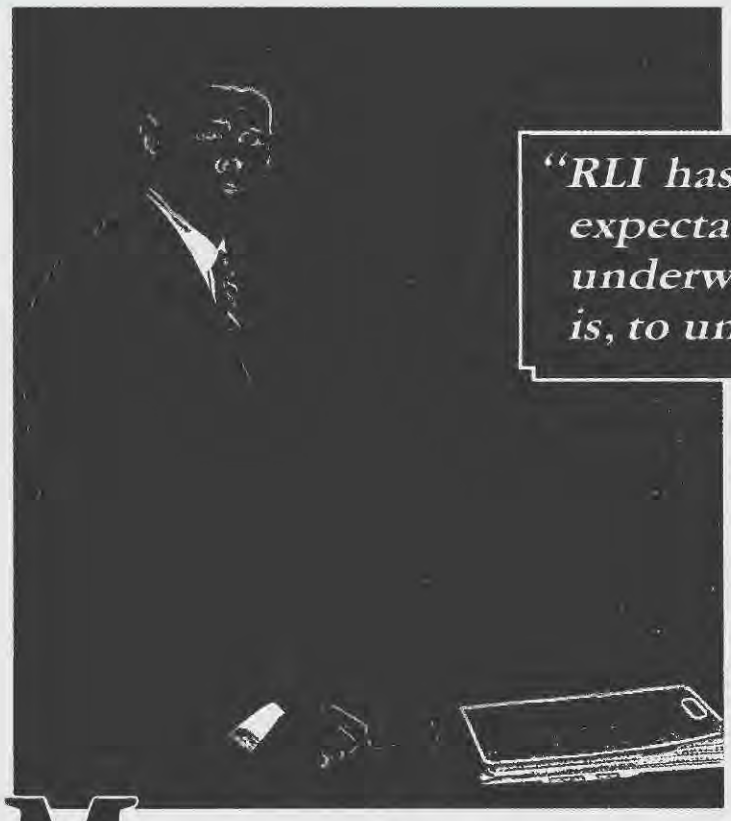
Mr. Buffett said, both at the meeting and in the company's annual report, that while Berkshire "still has a bias" toward U.S. companies, the U.K.-based beer maker earns its money "in much the same fashion" as Coca-Cola and The Gillette Co., two American firms "that garner most of their profits from international operations."

He added that Berkshire's primary investment requirements are that he and Vice Chairman Charles T. Munger like the management and understand the business.

Mr. Buffett did not respond to Nicholas' other complaint about the investment, thus sidestepping the possibility of encouraging the delinquency of a minor.

• Berkshire's investment in Salomon Inc. Mr. Buffett is currently acting as the interim chairman of the New York-based

Continued on next page



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Wizard of Omaha

Continued from previous page
investment house mired in ethics problems.

Mr. Buffett said he would make the investment again if market conditions were the same as they were in September 1987, when Berkshire invested $700 million in Salomon.

However, he conceded that he might have passed if he knew what a dramatic impact the deal would have on his personal life.

• Executive compensation.

Despite the widespread negative publicity over some huge executive paychecks, Mr. Buffett refused to condemn large salaries, even at companies in which Berkshire has a significant stake.

Messrs. Buffett and Munger each earn $100,000 in annual cash compensation.

However, the chairman holds 479,242 shares of Berkshire stock, valued at $9,000 a share or a total of $4.3 billion, while the vice chairman owns 21,607 shares with a value of $194.5 million.

"I don't object to very large sums being paid," said Mr. Buffett. "I just object to large sums being paid for poor performance."

That remark, as well as others, generated loud applause from the audience.

Apparently, the company's shareholders don't have any objections to the fact that Michael A. Goldberg, a Berkshire vp and the head of its insurance operations, was paid $1.8 million last year.

Mr. Goldberg also owns 470 shares of Berkshire stock valued at $4.2 million.

—By Lori Block

Safety study

Continued from page 2
rent rate of inspections, a worksite can expect to be inspected once every 84 years, the report says.

In addition, penalties paid to OSHA by employers that violated safety rules in situations where workers died or were seriously injured are low, the AFL-CIO says.

Between 1972 and 1990, the median penalty paid by an employer following an incident resulting in the death or serious injury of a worker was just $480. The average penalty was $1,130, according to AFL-CIO statistics.

"When the low rate of workplace inspections is viewed in combination with the paltry financial consequences of violating the law, the message to employers is clear: OSHA is an agency with a weak bark and an even weaker bite," the report says.

OSHA officials, while not disputing the accuracy of the AFL-CIO statistics, say certain comparisons are meaningless and conclusions drawn are incorrect.

Comparing OSHA budgets with those for fish and wildlife is "meaningless," an OSHA spokesman argued. He noted, among other things, that wildlife cannot form employer/worker safety teams and do not have experts from workers compensation insurers providing loss prevention services.

And, more significant than the average fine is the total of $56 million in fines OSHA imposed on employers, including a series of record penalties against individual firms, he said.

"This sends a tremendous message to employers that violations of worker safety and health rules will not be tolerated," the OSHA spokesman said. He added that legislation, which became effective in 1991, gave OSHA authority to impose sharply higher penalties.

The OSHA spokesman also dismisses as irrelevant the union's point that the agency's level of resources are such that a worksite can expect to be inspected once every 84 years.

"They are missing the point. There is no way we could get to every worksite, and OSHA should not get to every worksite. It is important to go to worksites where there are problems. We target our resources," the OSHA spokesman said.

Even if OSHA were to have hundreds of thousands of inspectors, it could not stop all accidents, said Tom O'Day, associate vp with the Alliance of American Insurers in Washington, D.C.

"Inspections alone will not prevent accidents. What makes a difference is when employers and workers realize it is in their best interests to develop a safe working environment," Mr. O'Day said.

The message is clear, the report says: 'OSHA is an agency with a weak bark and an even weaker bite.'

Management is more safety conscious than ever because of increased company awareness that an unsafe working environment means lost productivity, low employee morale, higher workers compensation insurance costs and negative publicity when accidents occur, Mr. O'Day added.

Workplace accidents have increased in recent years, the OSHA spokesman acknowledged.

But, workplace-related fatalities have declined. In 1990, there were 10,500 occupational deaths, down from 11,500 in 1985 and 13,700 in 1971, when OSHA was established.

For that, OSHA may deserve some credit. But demographic factors have played a more important role, said Peg Seminario, director of the AFL-CIO's Department of Occupational Safety and Health in Washington, D.C.

With employment rising in the service sector and declining in more hazardous areas like manufacturing, it is only natural than occupational fatalities would decline, she said.

Ms. Seminario said it is difficult to say exactly how much money would be enough to give OSHA adequate resources, but an increase is necessary.

"Obviously, there never can be enough. But there has to be an increase in resources to give the agency a greater presence" at worksites, she said.

At a minimum, OSHA's budget should be increased 10% annually—net of inflation—over the next five or six years, Ms. Seminario said.

•

Copies of "Death on the Job: The Toll of Neglect, A State-by-State profile of Worker Safety and Health in the United States" are available for $5 from the AFL-CIO, Department of Occupational Safety and Health, 815 16th St., N.W., Washington, D.C. 20006.

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Offshore insurers

Continued from page 1

contest in 1987 to federal charges that he used phony documents to defraud a Philadelphia bank on a $2.5 million loan (*BI*, July 6, 1987).

Mr. Shah confirmed in an interview that he helped form Pendleton, but said it wrote no business before Aurora sold it in 1991.

Pendleton Management Co. of Lakewood, Colo., became the insurer's majority owner in 1991, said Nigel Bailey, insurance supervisor for the British Virgin Islands.

Pendleton Management is headed by Neil E. Smith, Colorado incorporation records show.

Mr. Smith, a business associate of Mr. Shah, was among five people indicted earlier this year in an alleged health insurance fraud scheme involving another offshore insurer, Cabot Day Insurance Co. (*BI*, Feb. 17). Mr. Smith has pleaded not guilty to these charges, which are unrelated to Pendleton.

Pendleton's initial financial statement, as of June 1990, was audited by the Bermuda office of KPMG Peat Marwick. However, Peat Marwick notified the National Assn. of Insurance Commissioners in July 1991 that it had resigned as Pendleton's auditor.

Illinois regulators that month warned surplus lines brokers not to produce business for Pendleton, and the British Virgin Islands struck the insurer from its register of companies in August.

Since then, Pendleton has produced another financial statement as of July 31, 1991, audited by Rupert Folkard, an accountant in Mississauga, Ontario.

The statement shows total assets of $25.6 million, including a $25 million "collateralized corporate debenture" that is not described further in the statement and $14,073 in cash.

British Virgin Islands regulators, though, refused to restore Pendleton to the register on the basis of this financial statement, regulatory and other sources familiar with the company say.

Meanwhile, another July 31, 1991, Pendleton statement with a phony Coopers & Lybrand audit opinion surfaced earlier this year.

Coopers learned about the statement when a client asked for confirmation of the opinion, said George Holmes, a Coopers & Lybrand partner in Bermuda. The purported opinion was on the letterhead of the firm's Bermuda office and bore a facsimile of Mr. Holmes' signature, he said.

Mr. Holmes noted several problems with the purported opinion, though, including that it was signed by Mr. Holmes personally rather than by the firm and that the letter is dated July 31, 1991, for the year ending the same day.

"We're efficient, but we're not that efficient," said Mr. Holmes.

Coopers & Lybrand sent out letters in January stating that it has never audited Pendleton and disassociating itself from the alleged audit report. Copies of the letter went to insurance regulators in the United States, Canada, Bermuda and the British Virgin Islands, as well as to the Bermuda police and the U.S. Securities and Exchange Commission.

The accounting firm has never determined who produced and circulated the phony opinion.

In interviews, Mr. Shah and Mr. Smith denied any knowledge of the alleged audit.

A new Pendleton Insurance Co. was formed in Anguilla last December.

Mr. Smith said the plan was to move the old Pendleton's business into the new Anguilla company and name the new firm Greenbrooke International Assurance Ltd.

However, Anguilla regulators recently struck Pendleton from the island's register for failing to disclose that it had been de-registered in the British Virgin Islands, said John Swarbrick, Anguilla's insurance inspector.

Pendleton representatives were to meet with Mr. Swarbrick last week to discuss the action. Mr. Swarbrick said Pendleton representatives have told him the insurer has new ownership and capitalization but have provided no details.

Mr. Smith said the Anguilla company is not owned by Pendleton Management, but he and a lawyer for the insurer would not identify the new owners.

Pendleton is now being managed by DataLink Management Inc. of Lakewood, Colo., he said.

"We are trying to keep going in business and keep our nose clean, and all these things keep coming up," he complained.

During the first quarter of 1992, California brokers reported to the Surplus Lines Assn. that they had placed more than $1 million in business with Pendleton, says the California department's Mr. Ward.

Meanwhile, California regulators are also examining Tiberian Insurance Co., formerly known as Limerick International Re-Insurance Co. Ltd. and until February an inactive "shelf company" in Anguilla.

In a complex series of transactions, Tiberian was acquired in February by Pantheon Industries Inc., a publicly held company in Scottsdale, Ariz., whose stock is traded over the counter.

Last year, Pantheon also acquired Avalon Insurance Co. Ltd., a previously inactive Bermuda insurer, according to Pantheon's 10-K filing with the SEC.

A Nov. 30, 1991, Tiberian financial statement audited by Denton, Netherton & Co. of Englewood, Colo., reports total assets of $30.1 million. These include:

- Two $10 million promissory notes issued by Krung Thai Bank Ltd. of Bangkok, Thailand. Tiberian acquired the notes from an unrelated third party in exchange for 4 million shares of Tiberian preferred stock, according to Pantheon's 10-K.
- $4.2 million in debenture notes receivable from Chancery Lane Underwriting Managers Ltd. of Ireland.

Chancery Lane is owned by Kevin P. Chapman and Michael C. Cunningham, chairman and president, respectively, of Pantheon. Mr. Chapman and Mr. Cunningham are also directors and officers of Tiberian and Avalon, the 10-K says.

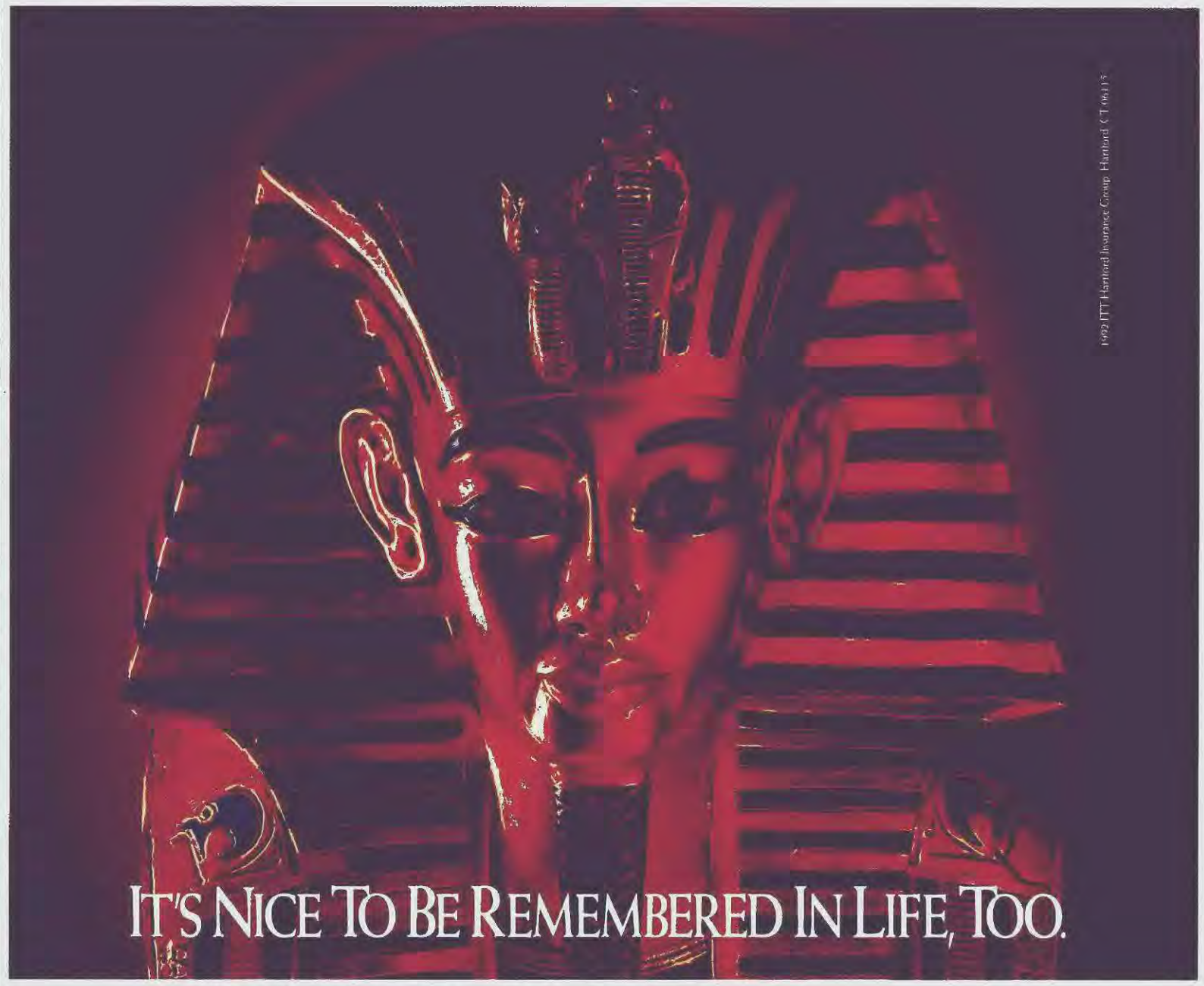
- $3.6 million in common shares of Polydyne Industries Inc., a publicly traded penny stock company 81% owned by Pantheon and its subsidiaries and headed by Mr. Cunningham.

Polydyne's only business operation as of last Nov. 30 was European International Re-Insurance Co. Ltd., an Irish reinsurance unit. However, European Re stopped writing new business last September because it lacked audited financial statements, the 10-K reports.

Tiberian's statement notes that Pantheon has experienced losses in each of its three previous fiscal years and may have to draw on its subsidiaries' reserves for operating capital, potentially jeopardizing Tiberian's ability to underwrite.

The statement and the 10-K also disclose that some of Pantheon's transactions are under review by

Continued on next page



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Offshore insurers

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the SEC.

The reports describe this as an "informal inquiry," but add that if a formal investigation follows, legal expenses and possible judgments, settlements or fines might require Pantheon to draw on its subsidiaries' reserves for operating capital.

Mr. Cunningham could not be reached for comment.

Robert W. Urbine, managing director of Tiberian and Avalon, also could not be reached.

Arthur W. Taylor, Pantheon's chief executive officer, said in an interview that Tiberian and Pantheon itself are in a "development stage," and that Pantheon hopes to improve Tiberian's liquidity with the proceeds of a private placement of Pantheon common stock in Europe. The bulk of the $10 million to $20 million Pantheon hopes to raise would be contributed to Tiberian, Mr. Taylor said.

"If you can solve (the liquidity problem), then everybody leaves you alone," he observed, adding that he was not aware the California department is reviewing Tiberian's financials.

The California Surplus Lines Assn. hadn't received any reports of business placed with Tiberian during the first quarter, according to Mr. Ward.

Mr. Taylor said Tiberian has written "very little" direct insurance business so far. But it has lined up several producers.

One of these is Werlhof Aviation Insurance Agency Inc. of Sacramento, Calif., which is planning to produce trucking, taxi and limousine business for Tiberian, according to Alan H. Gallaway, Werlhof's president.

The California department is currently trying to revoke the licenses of Werlhof and Mr. Gallaway on an unrelated complaint. The complaint charges them with improperly aiding Assn. Benefit Services Inc., an unlicensed managing general agency, in producing health insurance business for another offshore insurer.

Werlhof and Mr. Gallaway have denied the charges. A hearing is scheduled for this fall.

Another Tiberian producer is Evergreen Management Services Ltd., a St. Louis firm headed by Arthur A. Blumeyer III.

Mr. Blumeyer formerly headed Bel-Aire Insurance Co. of St. Louis, which the Missouri Insurance Department has been trying to place in receivership for more than a year (*BI*, Jan. 28, 1991).

Mr. Blumeyer said he plans to place taxi and limousine, amusement park, liquor liability and other risks with Tiberian through the American Assn. of Parents & Children of Naples, Fla.

AAPC brochures describe the organization as being "dedicated to the enrichment of the American family experience." The brochures offer a variety of member benefits, including insurance.

Mr. Blumeyer said that he will use Tiberian as a market for clients who become AAPC members.

He added that he has also considered producing business for Pendleton and may yet do so "if they come up with a good (financial) statement like Tiberian."

Offshore insurers under California department scrutiny are:

- Trelawney Insurances, incorporated in Ireland in 1990 by a representative of Corporate & Marketing Insurance Consultants Inc., an Atlanta firm headed by Mr. Teale.

Trelawney was one of several Teale-controlled companies that were the focus of a series of Senate Permanent Investigations Subcommittee hearings last year (*BI*, July 22, 1991; July 1, 1991).

A year-end 1990 financial statement audited by Allen Wagner, an accountant in Washington, D.C., reported that Trelawney had total assets of $9.6 million. These included $9 million in "marketable securities" that are not described in detail and $6,864 in cash.

Ownership of the company may change: Lawrence Hoehne, chairman of Orca Holdings Inc. of Bothell, Wash., said he has reached an agreement in principle to acquire Trelawney from its owners, whom he would identify only as "European investors." CMIC no longer owns the insurer, he said.

Orca International Services Inc., another company Mr. Hoehne heads, has acted as the U.S. manager for Trelawney and "it just made sense to acquire them," he explained.

Mr. Hoehne confirmed that Trelawney has taken over California business previously written by U.S. & Continental, another Teale-controlled offshore company that was enjoined from operating in the state last December.

Although U.S. & Continental wrote about $51 million in premiums in California during 1991, Mr. Hoehne said Trelawney has taken over only about $150,000 in premium volume. The state Surplus Lines Assn. received reports in the first quarter of $36,095 in premiums placed with Trelawney.

However, Trelawney is cancelling its California agency agreements, running off its current business—which includes commercial auto and lawyers professional liability risks—and withdrawing from the state, he said.

Anne Coleman-Dunne, executive officer with the insurance section of Ireland's Department of Industry and Commerce, said that Trelawney is authorized to act only as a reinsurance underwriter and broker. The company is not authorized to act as a direct insurer, she said.

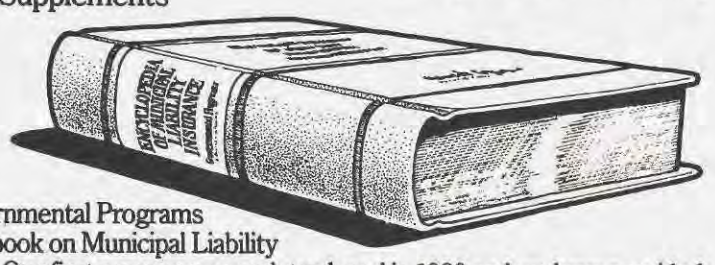
Asked about this, Mr. Hoehne said he believed that if the company's direct insurance underwriting "is acceptable to a jurisdiction like California, that's an

Continued on next page

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Continued from previous page
acceptable situation."

Mr. Hoehne added that Trelawney's direct writing is now a "moot point," since it is withdrawing from California and plans to focus on reinsurance underwriting in the future.

• West Point Insurance Co., incorporated in Antigua in June 1991.

During the first quarter of this year, California brokers reported placing business with West Point generating $2.1 million in premiums, according to the California department's Mr. Ward.

A statement of West Point's financial condition as of Feb. 29, audited by Charles J. Davitian, a New York accountant, reported total assets of $20.8 million.

These assets consisted of $539,976 in cash and $20.3 million in common stock of a company the statement identifies as "Anglo Resources & Technology Corp."

However, the statement incorrectly identifies the company, according to Mr. Davitian. The stock, he said, is actually that of African Resources P.L.C., a company he describes as a U.K.-based mining and timber conglomerate with operations in Luxembourg and the African nation of Sierra Leone. The stock is traded on exchanges in London and Amsterdam, he said.

Mr. Davitian said he believes Anglo Resources & Technology is related to African Resources, but he is not certain of the relationship. West Point is owned by James Charge, said Mr. Davitian.

Mr. Charge was identified in a Senate subcommittee hearing last year as one of two men who tried to obtain a license for Victoria Insurance Co. in Delaware in 1986 (*BI*, April 29, 1991).

Victoria—later licensed in Georgia and operated by Mr. Teale and others—was ordered liquidated in 1988.

Mr. Charge could not be reached for comment.

The Illinois department warned brokers last August not to place any business with West Point.

• West Atlantic Insurance Co., incorporated in the Turks & Caicos in 1983 and relicensed under the islands' new insurance law in May 1991.

During the first three months of this year, California brokers reported placing business generating $702,000 in premiums with West Atlantic, Mr. Ward said.

The company was initially owned by R. Michael Hick, a Houston insurance agent who was hit with a cease-and-desist order by Texas regulators in 1990.

The order, unrelated to West Atlantic, alleged that Mr. Hick illegally acted as an agent for American Trust Insurance Co. Ltd., a Turks & Caicos insurer formerly headed by Mr. Teale (*BI*, July 25, 1988). Mr. Hick settled the American Trust charges in April 1990.

He sold West Atlantic in 1990 to American Midwest Capital Corp. of Houston, which recapitalized the insurer, said a June 30, 1991, financial statement audited by Leroy P. Studer, an accountant in Newport Beach, Calif.

AMCC contributed $13.1 million in assets, the statement says, including a $5 million certificate of deposit not described further; a $5 million debenture collateralized with unidentified OTC stock; $1.5 million in Federal National Mortgage Assn. securities; a $1 million bond backed by AMCC and collateralized with FNMA securities; and 37 acres of land in Pulaski County, Ark., valued at $605,000.

AMCC was headed by Thomas J. Hannsz, a Houston lawyer, and Clint Cavin Jr., according to Texas incorporation records.

Mr. Hannsz died of a heart attack in January. Mr. Cavin could not be reached.

Mr. Hick, now a director of Program Managers Inc. in Houston, said West Atlantic stopped underwriting in March. Program Managers is handling the runoff of West Atlantic's business, he said. ■

OAL rejects rule on surplus lines

SACRAMENTO, Calif.—The California Office of Administrative Law last week rejected an emergency regulation proposed by the Insurance Department that would have set financial and reporting standards for non-admitted insurers.

The emergency regulation, proposed as Section 2174 of the insurance code, would have:

• Required surplus lines brokers to file more extensive financial and other information about a non-admitted insurer before placing any business with that insurer. That additional information would have included an annual statement on forms prescribed by regulators, an audit report and a copy of the insurer's trust agreement.

• Required a non-admitted insurer to have at least $15 million in capital and surplus unless the insurer qualified for an exemption. An exemption would be allowed for insurers depositing at least $5.4 million in a trust account for policyholders at a Federal Reserve bank.

• Set standards for the quality of assets, which may have included cash and readily marketable securities listed on U.S. exchanges, and required that an insurer be in business for at least three years prior to the filing.

While informing California regulators of its decision, the OAL last week had not yet submitted a written response detailing its objections, said Dennis Ward, chief of the Insurance Department's division of enforcement.

The grounds on which the OAL reviewed the proposed section included the necessity for and clarity of the regulations and the Insurance Department's authority under the law to impose them, he said.

Currently, the California department reviews non-admitted insurers on the basis of general requirements regarding their financial stability, integrity and reputation, he said.

Section 2174 regulations were originally proposed by the department last year (*BI*, March 23; July 8, 1991).

—By Douglas McLeod

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COBRA benefits

Continued from page 1
Act of 1985.

Relying on case law, Judge Walker noted that "Congress enacted COBRA because it was concerned about the fate of individuals who, after losing coverage under their employer's ERISA plan, had no group health coverage at all."

And, he said, employers must not be "unduly restrictive" by allowing former employees to fall through the cracks because they happen to live outside a health plan's service area and therefore cannot be covered by the same health plan as current employees or other COBRA beneficiaries.

At issue was whether Bonita House Inc., a non-profit mental health residential care program with facilities in Berkeley and Ukiah, Calif., had to secure health coverage for a former worker when a self-insured multiple employer welfare arrangement to which it subscribed became insolvent.

Bonita House provided two health care plans to its workers —a Kaiser Permanente Medical Care Program health maintenance organization covering workers employed in Berkeley or Ukiah—and the self-insured MEWA—the California Council of Community Mental Health Agencies Employee Health Benefit Trust—which covered workers in Ukiah only.

In October 1990, Bonita House closed its Ukiah facility and laid off all its Ukiah employees, including Isis Coble. Ms. Coble found another job, but her new employer's health plan would not provide coverage for pre-existing conditions during the first few months of employment.

'Employers are losing most of the cases regarding COBRA,' says Mercer's Chip Kerby.

As a result, Ms. Coble elected to receive COBRA benefits from Bonita House.

However, in April 1991, Ms. Coble's former health plan—CCCMHA—became insolvent. Bonita House decided not to replace the trust and to provide only the Kaiser HMO to its employees. "This change appeared reasonable to Bonita House, because, at the time, all of (its) remaining employees worked in Berkeley and resided in Kaiser's service area," Judge Walker wrote.

Two of the three former Bonita House employees who elected COBRA continuation coverage lived within the Kaiser service area, so only Ms. Coble lost health insurance due to the insolvency of the trust, he noted.

Ms. Coble lived more than 30 miles away from Kaiser's service area.

Bonita House sought to have Ms. Coble covered by Kaiser, but the HMO—citing Kaiser policy and California law—declined to extend coverage to her because she lived outside its service area.

Meanwhile, Ms. Coble incurred a large amount of non-reimbursed medical expenses to treat a pre-existing condition not covered by her new employer's plan. She subsequently sued Bonita House, claiming that by offering only the Kaiser HMO plan, Bonita House did not satisfy its obligation to provide continuation of coverage under the plan.

Bonita House argued that by offering the Kaiser HMO to Ms. Coble, it satisfied the plain language of the COBRA requirements by providing "coverage. . .identical to the coverage provided under the plan to similarly situated beneficiaries. . .," said defendant's attorney Dan Feinberg of Sigman & Lewis in Oakland, Calif.

Ms. Coble, on the other hand, argued that the mandate to provide continuation coverage means a COBRA beneficiary is entitled to "protection against the risk of individually bearing the cost of medical treatment. . ." and "if the employer's geographically restrictive HMO plan cannot reach the COBRA beneficiary, it is the employer's obligation. . .to provide identical coverage through some other means."

Judge Walker agreed in his March ruling.

"It seems as though the court in this case is saying that the former employee, through no fault of her own, lives outside the HMO service area and that the employer is responsible for providing her coverage," said Chip Kerby, a principal in the Washington, D.C., office of William M. Mercer Inc.

"I'm not surprised that the court ruled the way it did. Employers are losing most of the cases regarding COBRA," Mr. Kerby said. "Part of the problem is the law is not well-written. It's so imprecise that every month there seems to be a new COBRA case."

Judge Walker expressed a similar sentiment about the uncertainty in the law. "The statutory language is reasonably susceptible to either of the interpretations advanced by the parties and is therefore of little help in resolving the problem at hand," he wrote in his decision.

However, San Francisco-based plaintiff's attorney Richard Green, who represented Ms. Coble, disagreed. "I don't think the law is ambiguous," he said. "I think the intent of the law is to protect clients like mine from hanging out to dry."

Employers that amend their health care plans—particularly those who shift from an indemnity plan to an HMO—should be sure their new plan will cover COBRA beneficiaries, said Henry Saveth, a principal with A. Foster Higgins & Co. Inc. in New York.

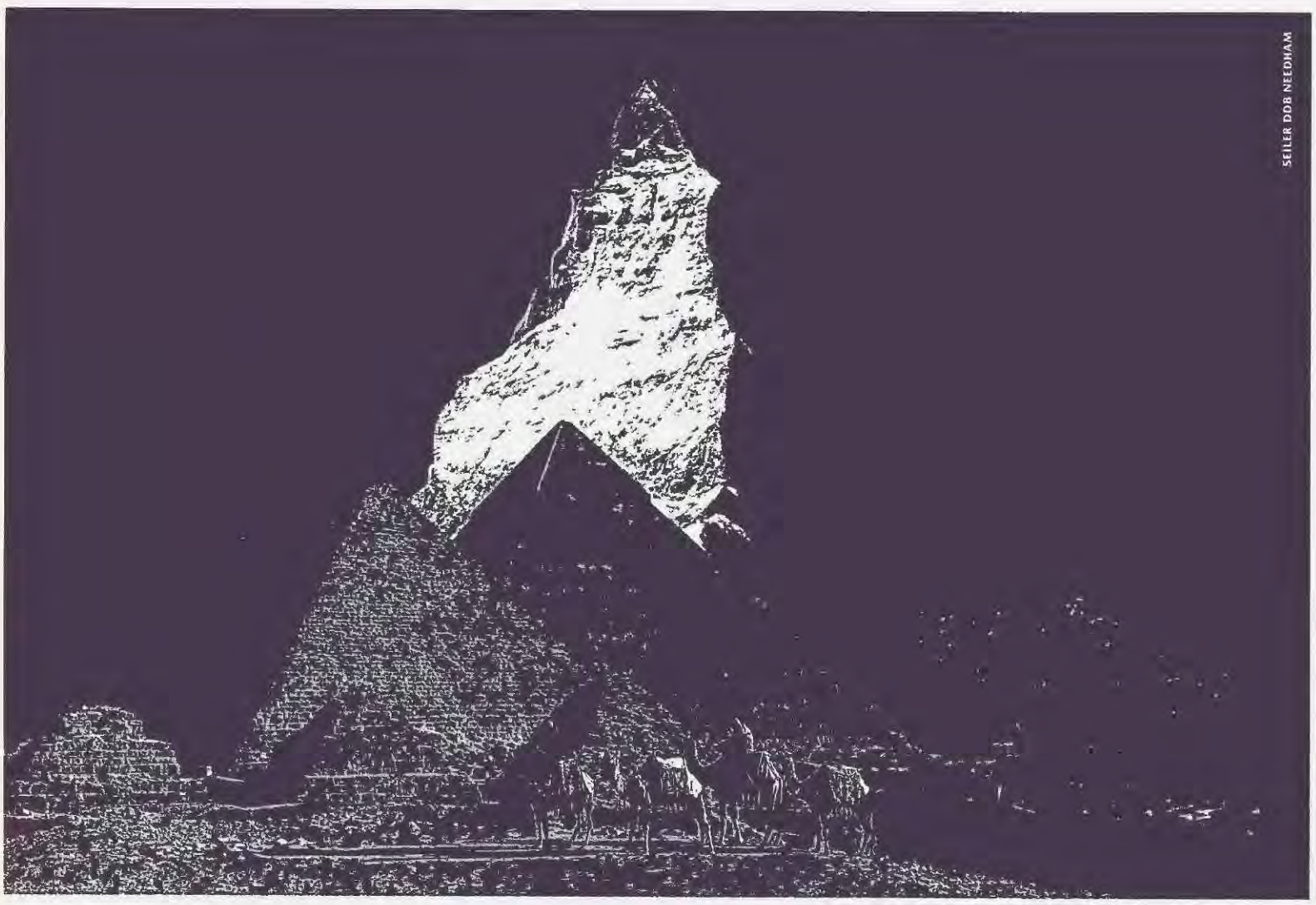
"An indemnity plan may terminate COBRA beneficiaries' coverage along with the group policy," he said. And, because insurers are not required to automatically pick up COBRA beneficiaries, employers will have to make arrangements for those not covered by the new plan.

"You could, if you are terminating a relationship with an insurer, negotiate with it to continue coverage for COBRA beneficiaries for 12 to 18 months," Mr. Kerby pointed out.

Bonita House is awaiting a final judgment regarding what damages are due to Ms. Coble, Mr. Feinberg said, noting that punitive damages are not allowed in ERISA cases. He could not say whether the company will appeal.

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Isis Coble vs. Bonita House Inc. U.S. District Court for the Northern District of California; No. C-91-3369-VRW.



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INTERNATIONAL

Maxwell pension fund halts payments

By GAVIN SOUTER

LONDON—About 240 former employees of companies once controlled by media magnate Robert Maxwell are no longer receiving pension benefits following revelations that their pension funds may be broke.

The problem stems from the alleged theft of 426 million pounds ($758.3 million at current exchange rates) from six Maxwell-controlled pension funds. The money allegedly was used to bolster the finances of the late publisher's languishing business empire (*BI*, Dec. 16, 1991).

The members of the Headington Pension Plan were informed of the decision to stop payments in a letter from Alan Fishman, a director of the independent trustees of the plan, Clay & Partners Pension Trustees Ltd. in London.

"It is with extreme regret that we have to inform you that we will be unable to make the pension payment due on 1 May and that pension payments will be suspended until further notice," the letter said.

Payments had to be suspended following the revelation that the assets that funded the payments may have run out, Mr. Fishman said.

Those assets were held by a Common Investment Fund for six Maxwell-controlled pension funds. That fund was administered by another Maxwell company, Bishopsgate Investment Management, which is now in liquidation and controlled by Robson Rhodes, an accounting firm.

The amount of assets in the CIF allocated to the individual pension funds had not been calculated since April 1990.

Robson Rhodes has now calculated the assets attributable to each fund using several different methods. Depending on the method of calculation, the value Headington Plan's assets ranged from a negative 660,000 pounds ($1.2 million) to a positive 1.2 million pounds ($2.1 million), Mr. Fishman said.

Previously, Clay & Partners had believed that the Headington Plan's assets in the CIF totaled 1 million pounds ($1.78 million), he said.

"All previous reporting by Robson Rhodes had indicated that this was the case. We were therefore shocked at this disclosure," Mr. Fishman said.

Lawyers have warned the plan trustees that they would be ill-advised to continue making pension payments when there is a possibility that the plan has no assets, according to Mr. Fishman.

The payments are unlikely to be resumed in the near future as the method of calculating the assets will likely have to be settled in court, Mr. Fishman pointed out.

None of the other five Maxwell pension plans is estimated to be out of assets, and all five of the plans are continuing to make benefit payments. ■

AIDS cover excluded from many overseas programs

By LORI BLOCK

NEW YORK—When conducting business overseas, smart U.S. companies should never assume that business conditions and insurance practices parallel those back home.

Such advice is particularly pertinent for health, life and disability coverage relating to AIDS, according to a recent study by William M. Mercer Inc.

Nearly a quarter of the 135 U.S. multinationals surveyed indicated that illnesses related to acquired immune deficiency syndrome are excluded from medical, disability or life insurance programs provided to overseas employees.

However, only 13% of the corporations surveyed said that their international benefit networks had informed them of the AIDS exclusions.

Therefore, according to Giles C. Archibald, a Mercer managing director, the actual number of policy exclusions may be higher.

"Because such exclusions are a common practice in some countries, some insurance coverage may contain provisions of which employers are unaware," he explained.

Many employers assume that because AIDS is covered in the United States, it is automatically covered everywhere else, Mr. Archibald said. "That isn't the case."

Instead, where laws do not prohibit them, AIDS coverage exclusions are emerging around the globe.

In addition to studying the experience of the multinational employers, Mercer examined practices at 11 major international benefit networks.

Mercer learned that only the network operated by American International Group Inc. of New York ac-

Continued on page 45

Combating risk management woes

Chaos theory may hold some clues

By STACY SHAPIRO

CAMBRIDGE, England—What do risk management and chaos theory have in common?

Not a lot at the moment.

But once mathematicians and scientists come to terms with chaos theory—which holds that order may be found in apparent disorder—risk managers may learn to use it as a tool to predict the unpredictable.

AIRMIC

And risk managers may come to find that current definitions of risk are totally wrong.

"What do we mean by chaos?" asked consultant Robert Brown at one of the most popular workshops at the Assn. of Insurance & Risk Managers in Industry & Commerce conference last month. The answers he received were nothing surprising: "unexpected," "disorder," "unpredictable," "out of control," "confusion," "panic."

Scientists, though, define chaos as "stochastic behavior occurring in a deterministic system," said Mr. Brown, principal consultant for KPMG Management Consulting and until recently a consultant for European Risk Management Ltd.

Translated, that means "random behavior controlled by laws and showing patterns."

One aspect of chaos theory was first considered by accident by Edward Lorenz, a meteorologist, in 1963. Trying to discern a long-term pattern in the weather, Mr. Lorenz put a series of rounded numbers into his computer and went off for a cup of coffee, Ms. Simmons said.

When he returned, the scientist found not the sequence he had wanted but no sequence at all.

Nothing was wrong with the computer. Instead, what Mr. Lorenz discovered is known as the butterfly effect—the ability of tiny changes in one spot, like a butterfly's wings flapping, to create huge changes, say hurricane winds, in another.

"This discovery obviously put the kibosh on long-term weather forecasting," Ms. Simmons added.

It also turned science on its head. Since the time of Isaac Newton, people thought that everything was predictable even if ideas or numbers were slightly wrong, said Ms. Simmons. But Mr. Lorenz showed that if you get something slightly out of kilter, it could have huge implications.

Mr. Lorenz found something that was "aperiodic," which shows a pattern that repeats but never quite identically, she said.

By using computers, scientists have been able to show patterns in chaotic situations that they couldn't calculate mathemati-

Continued on next page

Rate hikes provide challenge to firms

By STACY SHAPIRO

CAMBRIDGE, England—A hardening insurance market can bring out the best in a risk manager.

It is in each corporation's long-term interest to encourage and support a healthy insurance industry, says a British executive.

AIRMIC

The London market already "has seen some sizable increases in premiums and tightening of terms and conditions, and I anticipate this will continue," said David Coleridge, chairman of Lloyd's of London.

This hardening "presents both challenges and opportunities for the professional risk manager," said Mr. Coleridge at the Assn. of Insurance & Risk Managers in Industry & Commerce conference, held earlier this month in Cambridge.

"Good risk management will be increasingly significant in determining the price at which, and the terms upon which, firms can purchase their insurance," said Mr. Coleridge.

It is therefore pleasing, he said, that AIRMIC and Lloyd's continue to strengthen their connections during this time, with Lloyd's representatives attending the annual AIRMIC conference and an AIRMIC committee meeting with Lloyd's Non-Marine Underwriters' Assn.

"The successful management of risk should be a team effort," added George Paul, chief executive of U.K. conglomerate Harrisons & Crosfield P.L.C.

"A healthy and wide underwriting market is essential to this process, and it is therefore in a client's long-term interest that the current plight of underwriters, both members of Lloyd's and the insurance companies, be resolved as quickly as possible."

Current financial problems in the insurance industry are "certain to lead to higher premiums, greater deductibles and

Continued on next page

Oil monopoly blamed for sewer blast

By LOUISE KERTESZ

GUADALAJARA, Mexico—The Mexican attorney general is blaming oil monopoly Petroleos Mexicanos for the April 22 sewer line explosion.

Pemex, which earlier pointed the finger at another company, is conceding it may have been responsible and is contributing at least $30 million to the relief effort.

The disaster left 190 people dead and approximately 600 injured and leveled 20 city blocks, according to the press attache to the Mexican consul in Los Angeles. No official damage estimates have been released.

Four Pemex officials have been charged with criminal negligence and jailed in the wake of the disaster. One is Jose Adan Abalos, chief of operations at a Pemex facility in Guadalajara, the press attache confirmed.

Mexico's attorney general, Ignacio Morales Lechuga, charged that a Pemex oil pipeline leaked into the sewer, causing the explosion.

Charges also were filed against two local government officials, who were also jailed. The mayor of Guadalajara, who was also charged, was not arrested, the consul's office confirmed.

Pemex officials in Guadalajara shortly after the disaster had blamed the explosion on a cooking oil factory that was allegedly dumping a volatile substance into the sewers.

But last week the company

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AP/Wide World Photo

The sewer line explosions in Guadalajara, Mexico's second-largest city, caused massive amounts of property damage.

Risk managers

Continued from previous page
stricter underwriting," Mr. Paul said. "It is becoming more difficult and much more expensive for people to insure their own stupidity."

Stricter underwriting will entail larger deductibles, higher premiums for bad risks and lower premiums for good ones.

This hardening market "will increase the demand for risk managers and for training to widen their skills," said Mr. Paul.

Risk managers will work together with insurers to better understand and monitor risks and try to reduce them, Mr. Paul said.

And industry should recognize the importance of risk management, said Mr. Paul, who believes in this so much that one of his first decisions when he became chief executive of Harrisons in 1987 was to hire risk manager Elizabeth Taylor, deputy AIRMIC chairman and next year's chairman.

Despite "huge" total premiums, Mr. Paul found the company was "woefully underinsured" for its U.S. liability exposures. "(That) gave me sleepless nights," he said.

Now, the company's subsidiaries have higher deductibles to reduce its premium, but also purchase catastrophe coverage, he said.

Management of each of the subsidiaries also has been fully briefed on its own risks. "This has led to a welcome overall reduction in the total cost of risks and fewer sleepless nights," said Mr. Paul.

Harrisons has also invested in new loss prevention equipment to reduce risks, albeit after two costly fires, Mr. Paul pointed out.

Fail-safe equipment now shuts down a kiln before malt overheats and causes another 1.5 million pound ($2.6 million) loss, as occurred at one factory owned by Harrisons. The company also has installed new smoke detectors, sprinklers, hose reels, effective fire doors and roof venting in a warehouse that was damaged when an arsonist set a fire.

All other facilities are being examined to see if fire risks can be reduced, he said.

Risk managers must beware of some of the pitfalls of their trade if they are to be effective in their companies, said Geoff Saunders, risk management adviser to British mining company RTZ Corp. P.L.C.

He cautioned, for instance, against using too much obscure language.

"I don't know about you, but I am still constantly surprised at the frequency with which I get accused by people in RTZ of using too much jargon," said Mr. Saunders.

Risk managers will play different roles in different organizations, so they should explain again and again just what their roles are, said Mr. Saunders.

"Keep it simple, and never use words of more than one syllable; otherwise the board will have difficulty in understanding," said Mr. Saunders to an amused audience.

Mr. Saunders of RTZ Corp. advises risk managers to 'remember never to stray too far from the basic question, and you will always be credited with common sense if nothing else.' That question, he says, is 'What could go wrong?'

Risk managers also should remember that they are not setting out to be a "jack of all trades and master of none," said Mr. Saunders. They are not the company doctor, environmental scientist, fire brigade and works engineer all rolled into one, he said.

Mainly, risk managers should ask "What could go wrong?" said Mr. Saunders.

When the board of directors' investment committee introduces a new acquisition or plans for expansion, insurance costs will normally be calculated in the proposal to the board. Risk managers should then alert corporate decision makers to risks that cannot be insured, said Mr. Saunders.

The risk manager can tell the board of plans to mitigate the uninsured risks, or offer a contingency plan, but the board has the final say on whether to run with the risk, he noted.

A major part of risk management is using common sense, said Mr. Saunders.

"Remember never to stray too far from the basic question, and you will always be credited with common sense if nothing else: 'What could go wrong?' "

"Think of becoming a name at Lloyd's? What could go wrong? Think of writing a line on Piper Alpha or the London Underwriting Centre? What could go wrong? Thinking of having an affair? What could go wrong?" asked Mr. Saunders rhetorically.

Risk managers should remember that brokers can help in reducing risks, said Kenneth J. Davis, chief executive officer of Alexander Stenhouse U.K. Ltd.

"Whilst nobody knows your own organization as well as you do, the broker's cumulative knowledge of industry sectors, combined with a broad perspective on risk management has, over the years, often been a catalyst for innovation," Mr. Davis told AIRMIC members.

For example, Alexander Stenhouse has recently joined forces with accountants Touche Ross, U.K. law firm Denton Hall Burgin & Warrens and public relations company Ogilvy Adams & Rinehart to form Total Crisis Management, which is a combined resource to deal with all aspects of crisis management on a 24-hour basis.

Brokers also have the tools to help risk managers outline the most logical scenarios for the future to help harness the worldwide changes that are taking place, said Mr. Davis.

These changes include technological changes, world economic developments, environmental developments and social concerns that can alter attitudes toward risk and indemnification, Mr. Davis commented. ■

Chaos theory

Continued from previous page
cally, said Mr. Brown.

So what does this have to do with risk management?

In risk management "we're involved with dealing with chaotic systems," said Mr. Brown.

To illustrate order with seeming disorder, he asked AIRMIC members whether it was likely or unlikely that two people in the room would have the same birthdays. Five people who put their hands up to say it was likely were recognized for the correctly realizing that the probability was indeed high.

"It is important that we understand probability," said Mr. Brown. "When we get into chaotic systems, they may not be random. It may be that (the chaotic systems) have patterns."

By contrast, patterned systems can also produce chaos.

This was demonstrated by Mr. Lorenz, the meteorologist, whose experiments with water dripping showed that although there is a pattern of movement, if it continues ad infinitum, it produces a "chaotic" effect, said Ms. Simmons.

"You may think we are making this up as we go along," said Mr. Brown. However, it seems that in between stable conditions there can be a "sudden and rapid change which is a catastrophe" such as an earthquake. The site of the earthquake is going from one stable situation to another but in between there is a catastrophe.

"This is the precursor to the chaos theory," he said.

Ms. Simmons notes that a biologist, Robert May, showed how these theories apply to population growth. There will be an increase in the number of fish in a pond until the population overwhelms the food supply. Then the population tails off.

Later, the population drops to a stable level and oscillates between two different sizes in cycles. But eventually the size of the population becomes chaotic, creating "the principle of universality" where there is a constant in a chaotic pattern, said Ms. Simmons.

The workshop was designed to intrigue, said Mr. Brown. "If we're in risk management, we should look around and see what's going on. . .and see a science to chaos.

"There may be patterns to certain types of random situation," he said. "This art can be applied to risk management."

For example, risk managers should realize that meteorologists probably can't predict the weather accurately beyond four days because of the state of the art of computers, said Mr. Brown.

Someday, though, random situations might be devised on the computer so that "we could predict what's going on," he said.

He warned risk managers: "Your predictions are pretty damn awful." But knowing a little bit about chaos theory means that you're one step ahead of everyone else, he said. This theory and its application "will bring enormous change in our business."

Several recent popular books deal with chaos theory: "Chaos: Making a New Science," by James Gleick; "Does God Play Dice" by Ian Stewart; and "A Brief History of Time" by Stephen Hawking. ■

High earnings may hide shaky insurer solvency

By STACY SHAPIRO

AIRMIC

CAMBRIDGE, England—Just because an insurer reports higher earnings doesn't mean that it is inherently more profitable.

The insurer could be benefitting from a one-time boost from a financial reinsurance transaction. Or the insurer might have written more premium but not increased its reserves commensurately, which would inflate profits.

That's why it is vital to assess insurer solvency, risk managers were told at the annual Assn. of Insurance & Risk Managers in Industry & Commerce meeting last month.

John Ryan, vp of the Tillinghast division of Towers, Perrin, Forster & Crosby Inc. in London, gave some tips on how to assess the security of an insurer.

To begin with, a British risk manager should contact his or her broker's security committee, which should have complete data on the insurers with which the broker places clients' coverage. "This should be your first port of call," Mr. Ryan said.

Most brokers have security committees, though their quality can vary widely, he said.

If a risk manager's insurance program includes overseas companies, specialist services like Insurance Solvency International, a unit of Standard & Poor's Corp. in London, and A.M. Best Co. of Oldwick, N.J., are "essential" sources of information, though the financial data on which they base their judgments is sometimes out-of-date, Mr. Ryan warned.

"Market gossip, as there usually isn't smoke without fire," also shouldn't be forgotten, said Mr. Ryan. "London is a particularly good talking shop."

There are several things to look for when assessing insurer solvency.

One of the main items to check is reserve adequacy, said Mr. Ryan. However, "company management might tell you that one thing you can be sure about" is that the company is adequately reserved. I don't know an insurance company that doesn't say that about itself, even if it is declared insolvent the following day."

An insurer's rates also should be considered. Low rates may mean that the company is in trouble, said Mr. Ryan. Slow claims payment also can be a tip-off.

Market gossip about an insurer's solvency also shouldn't be forgotten, according to Mr. Ryan.

Risk managers also should check how much business a company cedes to reinsurers. "Companies heavily dependent on reinsurance" need to be considered more carefully, he said.

Mr. Ryan was particularly critical of financial reinsurance, since it "does not transfer much risk," though it can wipe liabilities from the balance sheet. "The effect is often cosmetic" and can distort the ratios that are being examined, he said.

Financial reinsurance can include time-and-distance reinsurance policies that Lloyd's syndicates buy because they are not allowed to discount their loss reserves, Mr. Ryan explained.

U.K. accountants are now cracking down on the reporting of financial reinsurance transactions, which will have a "major impact" on British underwriters' balance sheets, he said.

A member of the audience asked Mr. Ryan how much value to place on the returns that every licensed U.K. insurer must file annually with the Department of Trade and Industry.

Mr. Ryan replied that while the returns contain good information about some classes of business, like general liability, only a limited amount of information is provided about other classes.

Mr. Ryan said that insurance companies fail for various reasons, including:

- Dishonesty, fraud and/or incompetent management.
- Unintentional underreserving.
- Inadequate reinsurance.
- Inadequate rates.
- Inadequate capital, even though the company may have started off well-capitalized.

The responsibility to study the security of an insurer could be the broker's, though it is unlikely that the broker will take the full responsibility if an insurer fails, said Mr. Ryan.

Blame can be assigned to an insolvent insurer's auditors, though they are only judging the company by the accounts they are being shown, he said.

In the United Kingdom, the DTI also can be blamed for an insurer insolvency, but the department is unlikely to pay any compensation to aggrieved parties, said Mr. Ryan.

The Policyholder Protection Board is supposed to pay 90% of all claims to individual U.K. policyholders if a U.K. insurer goes into liquidation. However, the policyholder protection may be reduced following a recent court decision in the High Court, said Mr. Ryan.

The decision by Justice Webster, which is being appealed, holds that the PPB will only pay losses that are known at the time of the insurer's liquidation (*BI*, April 13).

Risk managers "ultimately have the responsibility for where insurance is placed," said Mr. Ryan. ■

INTERNATIONAL

Avoiding catastrophe

AIRMIC attendees put a light touch to serious subject

By STACY SHAPIRO

CAMBRIDGE, England—Humor and hyperbole can be powerful tools to convey a serious message.

AIRMIC

Insurance industry experts literally took the stage at the Assn. of Insurance & Risk Managers in Industry & Commerce conference last month to warn of the pitfalls that lead to catastrophic losses.

A sometimes humorous, sometimes serious skit about the hypothetical Megabyte Co. reminded risk managers that there's no substitute for foresight and careful consideration of the risks in any transaction. And just as bad as ignoring avoidable risks is the failure to develop a well-orchestrated plan to deal with those disasters that can't be avoided.

The production began with a hypothetical news flash:

A fire at a factory owned by Megabyte in Muckton, England, has killed 11 adults and 14 children attending a birthday party at a nearby housing development.

Wood preservative has contaminated the nearby River Muck. "The tragic incident was inevitable," says the broadcaster. "A resident suggested that the Health and Safety Executive has already expressed its concern about the safety of the factory. A spokesman for Megabyte declined to comment except to say that the discharge of wood preservative happened when the site was owned by another company.

"When asked to say why the production manager at the factory apparently admitted the company's responsibility for the tragedy, the spokesman said such a statement could not be made at this stage but a full inquiry would be held at Megabyte.

"As well as the children and the adults who died at the party, seven people at the factory and neighboring houses were killed and there were numerous injuries, some of them serious. . "

As the newsflash faded, five people representing the board of the hypothetical Megabyte appeared on stage.

"I'm sure you're all aware of why this extraordinary meeting of the executive board is meeting at this ungodly hour," says Megabyte's chairman, played by Roger Miller, director general of AIRMIC.

The chairman reiterates that there has been an explosion at the Muckton factory, which is part of a new division of Megabyte's wood products business.

As a result of the disaster, "our share price is down 25%, which has previously never happened to Megabyte," says the chairman.

A board member, Mr. Streetwise—played by Brian Street, director of operations at ECS Underwriting Ltd.—insists that the company discover how and why this tragedy occurred, and why "we bought this fiasco of a site."

The chairman explains that the site was acquired when Megabyte bought a division of "Maxworld P.L.C." This site was expected to be "the jewel in the crown" of the takeover, because Megabyte expected to sell the site to home builders to finance a large portion of the acquisition cost, he relates.

"The first thing to do is to find out what happened and what our legal position is," the chairman continues. That's why Megabyte has hired "Utmost, Good & Faith" to find out what went wrong.

The chairman was then asked why the company doesn't keep its current lawyers, "Sue, Grabbit and Run." The reply: That was the law firm involved in the acquisition of the site.

"Shall we keep our heads until someone else removes them?" says the chairman, to a bickering board and an amused audience.

In comes the lawyer from Utmost, Good & Faith, in real life Nick Hughes, partner in Barlow, Lyde & Gilbert of London. He insists that he will have to interview all the people involved and have access to all Megabyte's files, which the chairman allows. The executive board meeting adjourns, and Mr. Hughes retires to one podium on the stage, calling in individuals to be interviewed.

The first person to be interviewed is the finance director "Heinz Beancounter," played by David Bull, risk manager for Cheshire County Council.

During the interview, the AIRMIC audience discovers that the Megabyte acquisition of the Maxworld division, which included this disaster site, was completed in September, six weeks after Maxworld first approached Megabyte about the deal.

"The price was good," says Mr. Beancounter, but one of the conditions of the deal was that it be completed quickly.

Megabyte bought the division because it wanted to increase its market share in the wood products trade. "We felt the whole deal would be able to do that with low risk," he says.

"What do you mean by low risk?" asks Mr. Hughes.

"Low financial risk," says Mr. Beancounter. "We expected to get a third of the acquisition cost back by selling the Muckton site for housing."

When asked by Mr. Hughes why an environmental audit was not carried out on the site—which was leaking methane gas because it had once been a landfill—Mr. Beancounter says that it wasn't "the way" of Megabyte to seek audits in the United Kingdom. Environmental audits are carried out on U.S. acquired property, but only because the banks insist on them, he adds.

Besides, he says, "we didn't want to hold the deal up."

Mr. Beancounter does say that he asked Maxworld whether it had carried out an audit of the site, and the company said no. So, Mr. Beancounter negotiated a warranty in the acquisition deal so that Maxworld would be liable for any environmental loss.

"But the warranty isn't worth anything now, because they are going into liquidation," says Mr. Beancounter.

"Will you change your policy now in light of this tragedy" and carry out environmental audits of all sites during acquisitions, asks Mr. Hughes.

"Oh. . .yes," Mr. Beancounter hesitates, not sounding convincing.

"You seem kind of flippant, Heinz," says Mr. Hughes, "There are possible manslaughter charges here. The (public is) after blood."

"It's sabre-rattling, I think. I'm not really concerned," answers the finance director. "I don't think there are any grounds for a successful action against us."

Megabyte's stock price has tumbled and shareholders are concerned, adds Mr. Hughes.

"Maybe you are really a hasbean," Mr. Beancounter is told, to a round of laughter and applause at the pun. "What about your personal liability?"

Mr. Beancounter again doesn't seem too worried.

Next, Mr. Hughes interviews "Will Byit," Megabyte's acquisitions director. Mr. Byit—in real life Brian Bareham, group risk and insurance manager for Rank Hovis McDougall P.L.C.—walks in, looking disheveled and pompous.

Mr. Byit points out that Megabyte looked at buying the Maxworld site in 1988. But there was no need to carry out an environmental audit then, because Megabyte planned to dispose of the Muckton factory. Maxworld had already sold two-thirds of the site for a housing development, he says.

"Don't you think that if Maxworld could have sold this site for housing, they would have done so themselves?" asks Mr. Hughes.

"Never really thought about that," Mr. Byit replies.

When "you happy little elves" set off on the acquisition trail, was there an acquisitions manual specifying quality standards that should be met? asks Mr. Hughes.

Yes, there is an acquisitions manual, but there are no quality standards, Mr. Byit replies. "We rely on you lawyers for that. We give them a big fat fee."

Mr. Hughes asks whether the risk manager was involved at any time in the acquisition of the Maxworld division.

No, says Mr. Byit. An acquisition "is confidential. . .It involves as few people as possible."

Megabyte is involved in another acquisition now in Eastern Europe.

"Cher. . .Cher. . .something or other," said Mr. Byit, perhaps referring to Chernobyl. "It's a brownfield site."

Next, Mr. Hughes interviews Megabyte's risk manager, Ernestine Tryer, played by Sarah Laycock, risk management consultant at Johnson & Higgins Ltd.

She agrees that she wasn't involved in the acquisition and only heard about it the day before the press announcement in an internal memo to the employees.

She introduced herself to Will Byit only a few days before the acquisition, since she had just joined Megabyte.

Ms. Tryer wanted to explain to Mr. Byit the questionnaire that he should use to examine potential acquisitions, but he was too busy to listen, so she left it with him to consider carefully.

When Ms. Tryer heard about

Continued on next page

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AIRMIC skit

Continued from previous page
the acquisition, she contacted a risk management official at Maxworld, who said he had just renewed the global liability insurance policy.

Ms. Tryer asked if there had been any problems, and the Maxworld official pointed out that the Health and Safety Executive and the National Rivers Authority had issued reports in 1990 critical of the site in question that recommended Maxworld spend money to clean up the site.

Mr. Hughes interrupts and asks whether Ms. Tryer, at the time of the acquisition, did anything to stop the deal. She replies she tried to discuss the situation with her boss, Mr. Beancounter, but he said not to worry about the site because it was going to be sold anyway.

Nevertheless Ms. Tryer asked for all of Maxworld's wood products division accounts, including copies of the regulatory reports, but she didn't have time to look at them when they arrived. "I'm busy, too."

However, when she did finally read the files, she was "stunned" by the 1990 HSE fire safety report, which required immediate action on the site and noted "serious breaches of regulations."

She also discovered that one company decided not to bid for the Maxworld's unit because of an environmental audit that said the site had been a waste dump that was capped in 1955. Home builders didn't want to touch it, she discovered.

She called the managing director of Megabyte's wood products division about the report and insisted that there be immediate action on the site and a "no smoking" policy at the Muckton factory to stop a disaster. Although the managing director was "clearly concerned," Ms. Tryer says, he said he had other problems. Nothing was ever done.

Next, Mr. Hughes interviews "Emmanual Labor," the site production manager at the Muckton factory. Mr. Hughes discovers that Mr. Labor—played by David Kettley, a risk manager for Northern Telecom—was carrying out two jobs since the maintenance man on the site retired in 1990 and wasn't replaced. Mr. Labor knew nothing about maintenance, and said the propane gas tank that was next to wooden pallets on the site was not Muckton's responsibility, but the responsibility of the gas utility.

On the day of the disaster, Mr. Labor was home sick when he got a call and went over to the site. "No one from head office was around," says Mr. Labor. He tried calling executives, but couldn't find anyone home.

He couldn't find the emergency plan either.

"You seem to have admitted liability to the press," says Mr. Hughes. "Why?"

"This guy came up to me and I thought he was from one of the emergency services," says Mr. Labor.

It's just a shame that somebody had turned off the detection and alarm system (that lets) the factory know that too much methane and/or propane gas was leaking, says Mr. Labor. "Everybody keeps saying it's my fault, but it wasn't."

Chris Barber, group risk manager for Rugby Group P.L.C., also appeared in the production, which was written by Paul Maynard, a broker with Minet Insurance Brokers (U.K.) Ltd. ■

U.K. risk managers eye benefits

By STACY SHAPIRO

CAMBRIDGE, England—British risk managers are becoming more interested in employee benefits now that captives and self-insurance are playing a greater role in benefit financing.

AIRMIC

However, the average U.K. company—which does not offer a health care plan in light of Britain's national medical system—still is a long way away from offering the complete employee benefits package that a U.S. employer provides.

CIGNA Services U.K. Ltd., a British unit of CIGNA Corp., made four recent benefits-related presentations to risk managers, said John Gillman, national accounts director for employee benefits. He spoke at the Assn. of Insurance & Risk Managers in Industry & Commerce conference last month.

Risk managers are now more likely to take responsibility for benefit plans, instead of personnel or pensions managers, because of rising benefit costs among British companies, he said. When total benefits-related premiums rise above 1 million pounds ($1.78 million), the risk manager often steps in, he said.

Some risk managers are using captives to finance benefits-related costs, said Mr. Gillman. "Five years ago, you wouldn't think of using a captive" for benefits, he said.

Alternatively, U.K. firms may consider self-insuring some benefits and buying a stop-loss insurance policy to protect against catastrophic costs, he said.

Employee benefits in the United Kingdom differ fundamentally from those in the United States, where the major benefit cost is group health care coverage. Most medical care in the United Kingdom is provided through the government-funded National Health Service.

However, most middle and upper management employees at British companies now expect a benefits package that includes a corporate pension program, private medical and dental insurance to avoid the delay inherent in using NHS facilities and group life insurance. Long-term disability coverage also is often provided.

One workshop delegate asked whether flexible benefits can be imported from the United States as a way of reducing British companies' benefits costs.

While Mr. Gillman said it is possible, most British employees don't understand flexible benefits, since they are not widely used. Also, a plan in which employees have their choice of benefit options can be difficult to administer, he noted.

However, CIGNA is considering launching a flexible benefits program for its own employees in the United Kingdom later this year, particularly because British employers are saying, "Show me someone who's done it in the United Kingdom," said Mr. Gillman. "Flexible benefits are coming. . .(but) it's real uncharted territory."

One audience member wondered why firms provide benefits rather than simply paying workers higher wages. Some smaller British firms offer no benefits, unlike in the United States, where nearly all companies offer some type of benefit plan.

"Employers sometimes wonder why they offered benefits to begin with," said Mr. Gillman. But once benefits are offered, employees come to expect them, and the employer is perceived as a caring organization.

"I wouldn't go anywhere that didn't" offer benefits, said Mr. Gillman on a personal note.

He suggest that companies thinking of dropping benefits survey their employees to determine whether they prefer benefits or higher salaries. After taking the survey, however, companies should expect to take some sort of action, because employees will expect it, he said.

"You never know until you ask. Asking can be a danger, but it can also be worthwhile."

Mr. Gillman suggested considering another U.S. import—managed care programs—to reduce private medical benefits costs. Employees in a managed care program feel that they are still receiving better care than through the NHS, but employers' health care costs are reduced, he said.

Also speaking at the session were Chris Booth and Terry Sparkes, both of whom are CIGNA U.K. directors. ■

Sewer blast

Continued from page 41
conceded that it may be liable for the catastrophe. "Some Pemex officials appear to be responsible for negligent actions or omissions in relation to the tragedy," Pemex said in a statement.

The company said it will "continue to furnish all the data, information, documentation and technical help requested" to facilitate the judicial process.

Meanwhile, "independent of the final results of the judicial process" Pemex said it would contribute about $30 million to reconstruction and will continue "to channel equipment, resources and personnel necessary" to relief efforts.

Pemex also promised to "accelerate" its efforts to bring its maintenance and accident prevention programs "up to the highest levels of technology."

Pemex buys liability insurance from government-owned Aseguradora Mexicana, but has a significant self-insured retention, said J.D. Dawson, owner of broker Dawson y Correa, with offices in Mexico City and Las Colinas, Texas.

Jenner, Fenton & Slade Ltd. places excess coverage for Pemex in London.

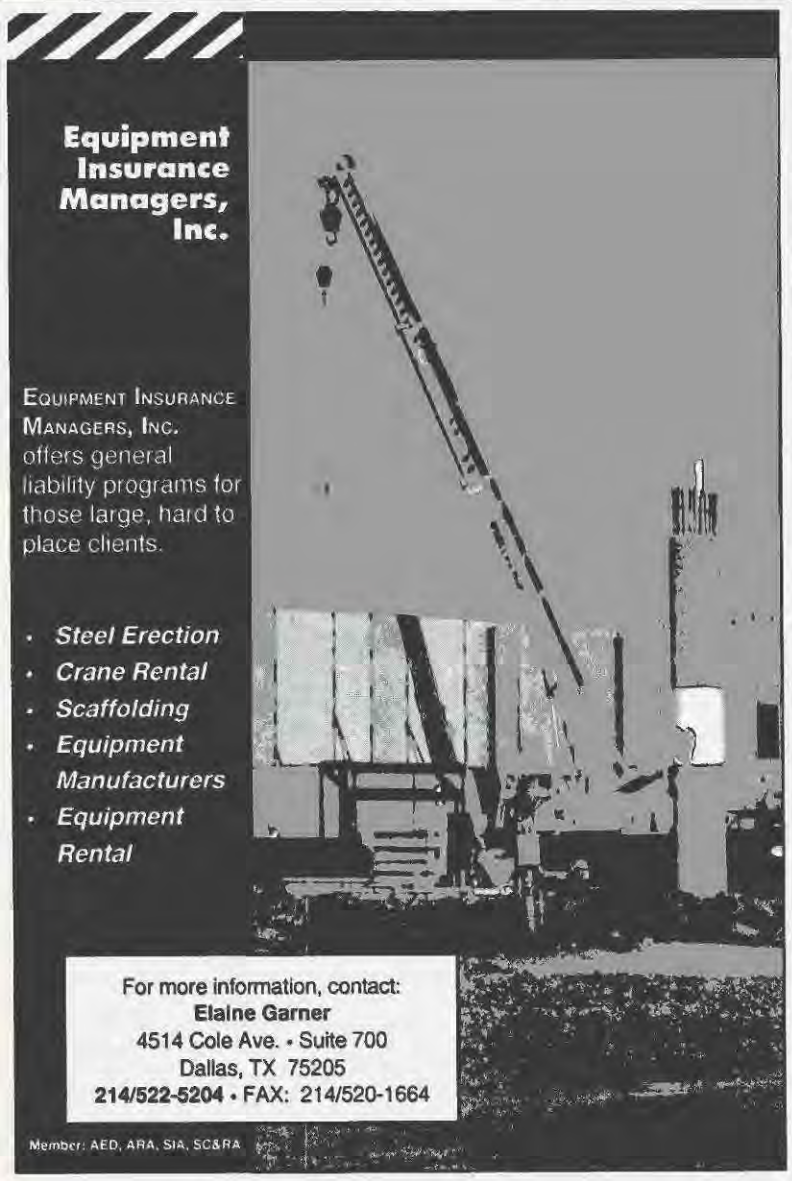
A Pemex spokesman said he could not provide data on the firm's retention or liability limits. Aseguradora spokesmen were unavailable for comment.

Pemex has liability coverage in excess of $100 million on one policy alone, according to a source in Mexico City.

Potential liability losses for Pemex will be limited by Mexican law, which ties court awards for bodily injury and death to a geographic area's minimum wages, sources report.

Insured property damage is not expected to be high, since many homes and businesses in the area of the explosion are not insured, sources said.

Insured damages as a result of the strong earthquake in Mexico City in 1985 were only approximately $65 million, points out Richard Atherton, partner and international director at Asesores Kennedy in Mexico City (*BI*, Sept. 30, 1985). ■



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INTERNATIONAL

Pollution laws could cost British insurers

By GAVIN SOUTER

LONDON—Insurers must pressure industry to clean up its act in the wake of the growing pollution problem in Britain and the plethora of environmental legislation expected to be heaped on industry by the European Commission, a British loss prevention organization warns.

The pollution problem and the new environmental legislation could leave insurers with a hefty bill for cleaning up the environment, says the Loss Prevention Council in its report, "Pollutant Industries."

The council, which is partially funded by the Assn. of British Insurers and Lloyd's of London, provides loss prevention services.

Industrial pollution is worsening despite the increased concern of government and environmental advocacy groups, the loss prevention organization says.

"The summers of 1989 and 1990 saw the worst photochemical smogs ever experienced in the U.K.," says the April 24 report.

Additionally, a 3.7% increase in water pollution occurred between 1989 and 1990, with 25,563 recorded cases of water pollution in England and Wales, the report says.

'The onus is on industry to improve its record or face prosecution, fines and even closure. Key words for the future must be recycle, recover, reuse or substitute,' the Loss Prevention Council's report says.

Much of the pollution could have been prevented, according to the Loss Prevention Council. "Poor housekeeping, responsible for many pollution incidents and spillages, could be minimized through an improvement in storage facilities."

The rise in pollution is being accompanied by a rise in the prosecution of polluters, the report also notes.

For example, Shell U.K. Recently was fined 1 million pounds ($1.77 million at current exchange rates) for discharging 150 tons of crude oil into a river, it says.

Additional prosecutions of companies under the Environmental Protection Act 1990 are inevitable, it says.

"The onus is on industry to improve its record or face prosecution, fines and even closure. Key words for the future must be recycle, recover, reuse or substitute," the report says.

The European Commission has been imposing directives to pressure industry to clean up its industrial processes and guard against spillages and leakages, according to the report.

"There have been about 280 directives so far in the environmental area, with about 90 still in the pipeline," the report says.

Pending legislation from the European Commission includes a directive on civil liability for waste damage. The report says the draft directive would require every company, which would have unlimited liability for its pollution risks, to:

- Obtain enough pollution liability insurance to cover its risks.
- Name its pollution liability insurer in its annual report.
- Develop a a 30-year "aftercare period" plan for a polluted site.

Insurers should encourage industries to introduce risk management programs that will minimize pollution risks, the report says.

A grading system should be developed to assess pollution risks posed by different industries, it says. The assessment should cover three major areas: the riskiness of a particular operation, the level of safety and the loss control measures implemented and the potential loss in the event of a pollution incident.

"The evaluation of risk could be reduced to a simple score or pollution rating for different industries," the report said.

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"Pollutant Industries" is available for 25 pounds ($44 at current exchange rates) from the Loss Prevention Council, 140 Aldersgate Street, London EC1A 4HY.

AIDS coverage

Continued from page 41

tually has come out with a policy statement relating to AIDS coverage in different countries. AIG mandates local AIDS exclusions for life and health coverage, except where prohibited by law. The other 10 networks, Mercer found, do not mandate exclusions, but exclusions are frequently applied locally.

Therefore, practically speaking, the differences among how the networks cover the deadly disease are narrow, Mr. Archibald explained.

"Only AIG has attacked it head-on, because AIG has coverage in a lot of lesser-developed countries," Mr. Archibald said. "It is hurt more by AIDS; therefore, it came out with a policy."

As a result of the networks' formal and informal policies, employers would be well-advised to inquire whether exclusions are in force in the countries in which they operate, Mr. Archibald said. The survey should send a message to employers that they may "have made promises to employees who may not be insured now, or may not be insured in the future," he said.

Although Mr. Archibald could not identify which countries have laws prohibiting exclusions and which do not, he said that the United Kingdom, Ireland and Australia may generate the most concern for U.S. multinationals, because U.S. multinationals have vast interests in these countries, where exclusions are prevalent.

For instance, Australia poses a vexing problem, particularly for newly hired employees, because exclusions are being applied to group life insurance policies for new member corporations and new employees, Mr. Archibald noted. AIDS exclusions also are being applied to some forms of disability coverages. There are no exclusions for medical coverage in Australia.

In the United Kingdom, life insurers typically are not excluding AIDS coverage. But insurers are applying exclusions for medical and disability coverage, according to the survey.

AIDS exclusions are in force for disability coverage in Ireland, but none are being applied to life insurance. And, because health insurance is only offered through a government-sponsored organization, employers need not be concerned about AIDS exclusions from medical coverage.

However, the survey also noted that most disability insurers operating in Ireland will include AIDS coverage for long-standing clients—if those clients are willing to pay extra premiums.

Mr. Archibald advises employers to negotiate on a local level in all countries in which they may be affected by exclusions to see if coverage can be obtained for an extra premium.

Employers also can agree on their own to pay any AIDS-related claims rejected by insurers, he added.

In fact, Mercer found that many employers are investigating how they can provide coverage to their employees in countries where exclusions are being applied.

Most of the surveyed corporations that knew of such exclusions were opposed to them, and 27 of the 31 affected companies have a policy of paying some AIDS-related claims not covered by insurers.

"Employers would be wise to develop a policy to deal with this issue after first reviewing their current insurance coverage to identify which, if any, (insurers) have such exclusions for AIDS," Mr. Archibald said.

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For a free copy of the AIDS survey, write to the Public Relations Department, William M. Mercer Inc., 1166 Avenue of the Americas, New York, N.Y., 10036.

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FAS 106 survey

Continued from page 2

hired until they become eligible for the benefits (*BI*, Dec. 17, 1990).

Employers now generally report these expenses as they are paid, like when an insured company pays a premium or a self-insured company pays a claim. In addition, when companies adopt FAS 106, they will have to recognize either at once or generally over a 20-year period so-called transition obligations, or accumulated retiree health care obligations.

TPF&C surveyed 150 Fortune 1000 companies, which on average had about 18,000 employees and 5,500 retirees.

The survey, "Facing FAS 106: Where Employers Stand," reports that these big companies face an average retiree health care expense equal to 7% of payroll when they recognize their retiree health care liabilities over an extended period rather than all at once.

This expense, which also includes current retirees' health care expenses, is about six times the typical pay-as-you-go cost on average, according to TPF&C.

The median annual cost per employee under FAS 106 will jump to $2,360 from $475, a fivefold increase, according to the survey.

Another 25% of respondents reported that this expense will equal 10% of payroll.

That expense has caused a 17% reduction in corporate pretax earnings on average for companies that account for their transition obligations over an extended period, the survey found.

Earnings reductions of at least 20% were reported by one-fourth of the surveyed companies.

The survey found that a company's net worth would drop an average of 13% if it recognizes its accumulated FAS 106 liabilities as a one-time charge.

Benefit levels at the surveyed companies are high, which means their FAS 106 liabilities will be significant, noted Richard Ostuw, a TPF&C vp in Cleveland.

For example, among 69% of the respondents, all employees are eligible for lifetime medical coverage, the survey reported. In addition, 64% offer lifetime life insurance benefits. And, nearly half—49%—offer one or more ancillary retiree health benefits, like dental plans, vision benefits, prescription drug cards and contributions toward the Medicare Part B premium.

On average, the surveyed companies pay just over 80% of the cost of medical coverage for all retirees. Among the companies that contribute toward the cost of lifetime retiree medical coverage, 42% pay the full amount.

Mr. Ostuw pointed out that the new survey confirms that FAS 106 costs vary widely from company to company.

For example, the FAS 106 liability will be lower for employers with a young workforce than those with an older workforce because fewer young workers will stay until retirement, Mr. Ostuw explained.

Many employers are now confronting their retiree health care costs and related reporting issues, reviewing and redesigning their retiree health care benefit programs, the survey found.

For example, about 73% of the surveyed companies already have increased the amounts current and/or future retirees are required to pay for coverage or are planning or considering increasing these contributions.

Among companies with 10,000 or more employees, 80% say they have or are considering increasing retiree contributions.

Most employers are focusing on health benefits because they account for most of the FAS 106 liability, Mr. Ostuw noted. Nevertheless, nearly 20% of the surveyed companies indicate they already have reduced or eliminated retiree life insurance benefits or plan to do so.

Other employers are tying retiree health benefits to age and length of service—much like the eligibility requirements for pension plan benefits, the survey found. For example, 23% have restricted retiree health plan eligibility with new age and length-of-service rules, and 37% are planning or considering such changes.

Only a few respondents—7%—have imposed specific caps on employer contributions for current retirees. However, more than twice as many—18%—have taken this approach to contributions for future retirees.

And, 29% are planning or considering a cap on employer contributions for future retirees, according to the survey.

Other employers are looking to managed care—even though developing networks for retirees can be problematic since retirees tend to move away from their employers' locations.

The survey found that 24% of the respondents have established preferred provider arrangements or some form of managed care for current retirees and that 25% more are planning or considering similar changes.

Thirteen percent of respondents are planning or considering implementing flexible benefit plans for retirees, the survey noted.

The survey also found that 80% of respondents completed an actuarial valuation of their retiree health care obligations during the past three years.

Mr. Ostuw noted, though, that this means a significant percentage of survey respondents—20%—have yet to measure their retiree health care obligations.

•

Free copies of the survey are available by calling TPF&C's publication hot line: 800-525-6741.

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The Health Care Commission of the State of Kansas intends to issue a request for proposal(s) (RFP) on May 15, 1992 for its insured indemnity medical and prescription drug plans and HMO plans. The deadline for receipt of the proposal(s) is June 26, 1992, 5:00 p.m., C.D.T.

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California report

Continued from page 1

clear that without new jobs, which will generate the taxes which will pay state government bills, the future of the state of California is in jeopardy.

"We need to remove impediments to businesses so they can grow and create new jobs."

The council recommends that the state provide business incentives to create and maintain quality jobs, as well as make the government a partner with business, rather than an antagonist.

Among the council's key recommendations to the governor and the Democratic and Republican leaders of the state Legislature is to revamp the state's inefficient and fraud-ridden workers compensation system. California workers comp costs have shot up to $10 billion in 1991 from less than $4 billion in 1981.

These cost increases are excessive considering that the workforce grew by only about 25% during the period and the incidence of disabling work injury per 1,000 workers actually decreased, the report said.

To remedy the situation, the council recommends the following:

- Workers compensation insurers should have to compete, giving them an incentive to hold down costs.

This proposal is similar to a recommendation submitted to the state Legislature last month by the Workers Compensation Rate Study Commission. The commission, a panel of academicians assembled to suggest ways to better formulate rates, suggested eliminating the state's minimum rate law and replacing it with a system of open competition (*BI*, March 23).

- Curtail stress claims by disallowing "cumulative trauma" claims, requiring that work-related conditions be at least 51% responsible for a stress-related illness and excluding benefits for stress-related claims stemming from good faith personnel actions.

An employer-supported bill introduced this session by Assemblyman Jim Brulte, R-Los Angeles, that also would tighten eligibility for stress claims was rejected by the state Assembly's Insurance Committee last week.

The bill, A.B. 3167, would have raised the standard of proof for stress claims to "clear and convincing evidence"; require that the predominant cause of the disorder be a "sudden and extraordinary" employment event; and specify that benefits be denied for claims linked to good faith, non-discriminatory personnel actions, like terminations, layoffs and demotions.

A measure that died in the Legislature last year would have required injured employees to prove that at least 50% of their stress is work-related (*BI*, May 20, 1991).

Currently, only 10% of a worker's stress-induced injuries must be work-related to be compensable.

- Allow employers to increasingly use managed care programs, like health maintenance organizations and preferred provider organizations, to stop runaway workers comp medical costs.
- Reduce litigation by eliminating testimony from medical experts, other than treating physicians, on the extent of injury and disability.
- Allow less-costly alternatives to vocational rehabilitation.

The council also makes several recommendations for reforming California's infamous legal system, which it asserts is "causing us to sue ourselves to death."

"More than 850,000 civil lawsuits were filed in 1991," the report stated. "Spiraling liability insurance, huge legal bills, large settlements (and) unpredictable jury verdicts all create a 'tort tax' on California residents."

The report also points out that while the state's population grew by 25% over the last 10 years, the number of lawyers swelled by 44%.

To combat legal system abuse, the council makes the following proposals:

- Encourage alternative dispute resolution through increased use of arbitration and mediation.
- End frivolous litigation by discouraging attorney advertising and by sanctioning lawyers who file frivolous suits.
- Limit punitive damages.
- Repeal the Corporate Criminal Liability Act that as of Jan. 1, 1991, created new criminal penalties for companies that fail to disclose serious concealed dangers in products or in the workplace. Manufacturers object to the law, which they say allow product liability cases to be shifted from civil to criminal courts.
- Protect privacy by preserving confidential settlements.

The council 'completely and totally failed to do' a serious analysis, says Will Glennon.

Support for the council's recommendations so far has followed party lines, despite Mr. Ueberroth's assertion that its proposals are non-partisan.

Business interests and Republicans are praising the council's findings, while consumer groups, trial lawyers and state Democratic officials dispute them.

The California Chamber of Commerce, which backed Assemblyman Brulte's workers comp reform legislation, views the report as "another testimony to the severe need for reform of the workers comp system," said Roxanne Gould, the Chamber's Sacramento-based director of insurance and employee relations.

"California employers are providing the safest workplaces in the nation and are being rewarded with spiraling costs," she said.

John Sullivan, president of the Assn. for California Tort Reform, a business-backed lobbying group, agreed: "They have aimed at some of the areas in greatest need of attention."

In particular, the tort reform group supports repeal of the Corporate Criminal Liability Act.

Even though so far only one company has been prosecuted under the act—Leslie Salt Co. of Alameda County agreed to pay a $100,000 fine in February after a worker at the company's Newark plant was crushed to death by two conveyor belts—"it has the potential of being an unfair standard," Mr. Sullivan said.

The California Manufacturers Assn., which has been lobbying to amend what it calls the "Be a Manager, Go to Jail" law, agrees that it is "a real deterrent for companies considering locating in California."

The Assn. of California Insurance Companies was particularly supportive of the council's recommendations for workers comp reform.

"Fighting fraud and controlling the endless expenses of stress, litigation, courtroom doctors, health care and vocational rehabilitation have been the top priorities of employers and insurers for several years," said Robert Gore, vp of the Sacramento-based trade group, whose members write more than 50% of private California workers comp insurance volume.

"ACIC members have, since Jan. 1, already filed more than 1,100 fraud complaints with the state Department of Insurance," he said.

"The council did an excellent job of identifying the areas for reform," said Mark Webb, Western regional counsel to the American Insurance Assn. in Sacramento. "The recommendations would go a long way toward reducing work comp costs if adopted."

Although popular with insurers and other business interests, the council's recommendations were less well received elsewhere.

"The report was a serious disappointment," said Will Glennon, legal analyst for the California Trial Lawyers Assn. in Sacramento.

"With Ueberroth heading it, the council had the opportunity to do a thorough, serious analysis of the problem, but they completely and totally failed to do that," he said.

In fact, the recommendations are so reflective of Gov. Wilson's political agenda that parts of it "probably were lifted from other documents," he suggested.

Mr. Glennon criticized many of the proposals as "old ideas."

For example, while the report targets product liability as a specific area of concern, "it's an infinitesimal amount of product costs," he asserted. And, "less than 1% of manufacturers are sued for product liability."

Conceding that the proposals may not be particularly new, Martyn Hopper, state director of the National Federation of Independent Business, said the council is "producing the leadership to push some of these reforms through the Legislature."

CMA President William Campbell agreed: "This document gives us a guide that will hold the Legislature accountable for its actions. This is not an employer document; it was created by an independent council consisting of representatives of many groups. For the Legislature to refuse to implement these recommendations would result in economic suicide for the state.

"Many pending bills in the Legislature would address several of the council's recommendations. Now, it is up to the Legislature to approve them. We will keep a close watch on the legislation, and let the people of California know how individual members are voting on these crucial issues."

And the Chamber's Ms. Gould pointed out, "Just because someone told you it was a problem before doesn't mean that if they repeat it in this report, it should be invalidated.

"Perhaps those people really are closing their eyes and ears to the reality that these problems do exist." ■

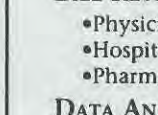
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Flood claims

Continued from page 3

Coverage for the private Michigan Avenue social club was not as broad as the hotel's. However, last week, or two weeks after the flooding began, Contintental determined that the club's claim would be covered because of "direct loss by water," Mr. Kuzmanoff said.

General Manager Gregg E. Salomone estimated the club's total loss at $50,000 to $60,000.

The club has $2.3 million of property coverage written by Continental. The coverage is subject to a 50% coinsurance requirement above a $25,000 deductible.

The hotel and the club are just two of the many Chicago Loop businesses forced to close for days last month when a portion of a wall in an underground freight tunnel system under the Chicago River collapsed. About 300 million gallons of Chicago River water flooded the tunnel, and the basements of many downtown buildings.

Even buildings that were not flooded had to shut down during a controlled blackout. With the power off, utility crews worked to reroute electric currents from submerged equipment.

Continental last week still had not made a blanket determination on whether it will classify the event as water damage. Instead, it is evaluating its 15 claims individually, said Adrian Tocklin, senior vp-claims with Continental in New York.

"We are not calling it a flood. Each claim is still judged on its own merits, but we won't use any ambiguous flood exclusion to try to avoid payment of loss," Mr. Kuzmanoff said.

"We are not trying to be evasive," Ms. Tocklin said. "It is just the nature of the loss and the individual business policies. Most of it is covered—there's no question."

The Executive House will be indemnified for loss of business, its expense in relocating guests to other hotels, overtime pay for security and maintenance workers, as well as the cost of spoiled food.

The hotel's comprehensive policy also contains a tail coverage for the lost business after reopening but before its operations are back to a normal level.

The hotel's broad DIC endorsement is not common. Usually only conglomerates or multinationals like the New York-based Taj International Hotels, which owns the Executive House, purchase this coverage, Mr. Kuzmanoff said.

Determining the hotel's lost business takes into account the number of reservations it had and its occupancy rates in previous weeks as well as for the same period a year ago.

The hotel also could not take reservations for three days, but it will be indemnified only for the lost revenue attributable to customers who did not call back.

"It's a challenge to convert lost calls to revenue," Mr. Kuzmanoff said.

Other insurable lost income includes revenue from parking, laundry and in-room movies.

Average food and beverage receipts, banquet bookings and the cost of spoiled food also will be covered.

But, the adjusting process quickly becomes more complicated. For example, the Executive House notes the weather on its daily records, because restaurant receipts increase during inclement weather.

From the information, Mr. Kuzmanoff will build a spreadsheet to predict what the hotel's revenues would have been during the affected time.

The Executive House also can recoup the costs of extra expenses caused by the flooding as well as the subsequent power outage.

For example, to evacuate guests safely, the hotel had to rent a generator and buy emergency lights, battery packs and candles.

In addition, the hotel's contract with its 170 unionized workers requires it to pay employees for four hours of work if they report for work but are turned away.

Because telephones were down Monday and Tuesday, employees could not reach the hotel for instructions on whether to report for work.

About four housekeeping and support staffers showed up for work April 14 and were turned away, but three engineering crew members worked many overtime hours during the first few days of the crisis.

Meanwhile, the Chicago Athletic Assn. had to wait two weeks for Continental to determine whether the damage and lost income it sustained were caused by water damage and covered under the its policy.

The club's major loss was lost income from its three restaurants, which were closed for four days, Mr. Salomone said.

The club also caters luncheons and meetings sponsored by members.

In addition, the club has athletic facilities and 55 hotel rooms. As many as 600 of its 1,700 members might use the facility in a day, Mr. Salomone said.

While Continental did not immediately concede it would cover the claim, it asked the club to begin compiling documents that would show expected revenues from its various businesses and the amount of food that spoiled while the insurer examined the club's policy.

The club can include in its claim the wages of salaried administrators for the time they spent managing the crisis and working to mitigate the loss, like mopping up a wet basement, rather than performing their normal duties. ■

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Chicago flood

Continued from page 3

ent definition of flood and water damage, which makes assessments difficult.

"Commercial policies are not homogeneous like homeowners or automobile policies. Every one is somewhat different," said Tim Householder, associate property claims manager at Kemper National Insurance Cos. Insurers' "response will be somewhat more measured. They want to think through what they do."

Insurers began acting on certain claims last week, but few made broad determinations of coverage.

For example, ITT/Hartford Group Inc. last week advanced $1 million to Lurie Co., owner of a 23-story downtown office building with tenants including LaSalle National Bank and Kemper Financial Services. The total damage to the building is not yet known, a Hartford spokeswoman said.

Ten feet of water poured into the building's lowest basement. While some employees returned to the building last week, they had no heat and only one elevator worked.

The building will be fully operational today, after the replacement of the electrical switch room, the telephone control room and the elevator control panel, said Lurie Executive Vp Mike Kurzman.

The building will be covered because it "suffered water damage in the basement," said a Hartford spokeswoman.

Despite covering Lurie's damage, Hartford has not determined whether it will cover the 34 other claims it faces, mostly for business interruption, according to the spokeswoman.

"We believe most of the policyholders will be covered, but we need to look at each claim individually before (deciding)," she said.

Payments have also been made by Kemper, which advanced $250,000 to the Chicago Merchandise Mart, and by Chubb, which paid $500,000 to the Chicago Board of Trade.

"It's a multimillion-dollar decision for many companies, depending on which way they go. They are considering the legal ramifications," said Sean Mooney, senior vp and economist with the Insurance Information Institute, an industry-funded public relations group.

Coverage "has not been decided," said a CNA Insurance Cos. spokesman. "I don't know when to expect" a decision.

"Decisions won't be made until the damage is known," said a Travelers Corp. spokesman. "We are not going to have a decision on coverage until we can get an adjuster in to look at the damage."

However, at least one Travelers policyholder has been told it is covered, according to Dan Pufunt, building manager for 11 S. LaSalle, an office building owned by LaSalle Partners. Damage to the building could reach $2 million, he said.

Consumer groups are criticizing insurers for their indecision.

"Clearly claimants have a right for a clear determination on what policy language means," said J. Robert Hunter, president of the National Insurance Consumer Organization in Alexandria, Va. "I'm surprised it hasn't been made yet.

"Not many more facts are going to come out about how (the disaster) happened," he said. "It seems fairly straightforward. It sure looks like a flood to me. Water is outside its normal boundaries."

As the former federal insurance administrator, Mr. Hunter headed the National Flood Insurance Program.

It doesn't look like flood to everyone, though. Jerry Bell, commercial lines specialist with the National Assn. of Independent Insurers in Des Plaines, Ill., argued, "It's not a flood by the dictionary definition or by the definition used by most courts."

Illinois courts have never decided whether floods caused by artificial means or human error trigger flood coverage, said Steven Merican, a partner with Rivkin, Radler & Kremer, a Chicago law firm that represents insurers.

Other industry observers are urging insurers to make coverage determinations quickly, but they also note the complexity of the catastrophe.

"This is an unusual situation," said Robert W. Esenberg, past president of the Risk & Insurance Management Society Inc. and risk manager for the city of Virginia Beach, Va. "Insurance companies have to move fairly quickly in advising clients if they do or don't have coverage."

He added that, "recognizing the complexity of what happened, it's not surprising that things are taking more time than a normal flood or natural catastrophe."

Agents and brokers also want insurers to make decisions quickly.

"We are sitting in limbo just like the insureds," said Nancy Solomon, an agent with Martini, Miller & Schloss, a Northbrook, Ill.-based agency. However, she noted that insurers are "up against something they have never had to face before."

Even when insurers have made coverage determinations, they haven't agreed on the cause of the loss.

The Merchandise Mart loss is being attributed to water damage, which carries a deductible one-fifth the size of the Mart's flood deductible, according to Bennet Harvey, general counsel for Merchandise Mart Properties Corp. Mr. Harvey said coverage was never in doubt, and Kemper informed Mart officials within a day or two of the event that the loss would be considered water damage.

Protection Mutual, which writes property coverage for Marshall Field & Co. and Filene's Basement, two hard-hit Loop retailers, is considering the disaster a flood. It will pay claims from policyholders that have flood coverage, a spokeswoman for the Park Ridge, Ill.-based insurer said.

Filene's Basement on State Street was closed for 11 days after water filled two subbasements and rose perilously close to the store's underground sales floor.

There was never any question whether the Wellesley, Mass.-based retailer's insurance would apply, because its policy specified coverage for both water damage and flood, said Risk Manager Doug Shapiro. In fact, Mr. Shapiro said, the question never came up in his discussions with Protection Mutual.

"We had full coverage. Aside from the deductible, we are not suffering any loss," he said. "We were fortunate. We had an excellent policy with an excellent company. You combine the two, and it makes a bad situation a lot easier to cope with."

Filene's Basement carries a sublimit for flood damage, but the same deductible as under its normal property coverage applies. Damage and business interruption losses will "not even come close" to exhausting the coverage limits, Mr. Shapiro said.

Carson Pirie Scott & Co., another State Street retailer that reopened only last week, will be covered for property and business interruption losses under its property policy underwritten by Kemper. The policy has a $50,000 deductible.

Kemper did not inform Carson's parent, P.A. Bergner & Co. of Milwaukee, whether the losses would be covered under "flood" or "water damage" portions of its policy, said said Darren Jackson, Bergner's treasurer. A $50,000 deductible applies to both types of coverage.

"Under no circumstances will we use up our limits," he said. Damage and business interruption estimates were not available.

Due to the uniqueness of this disaster, damage estimates have emerged more slowly than usual.

The Property Claim Service of the American Insurance Services Group Inc. hopes to have a damage estimate early this week, said Gary Kerney, director of catastrophe services.

But others say that initial estimates—some of which exceeded $1 billion—may have been overstated.

"I don't think this is going to be as big as originally thought in terms of recoverable insured dollars," said Michael Segal, president and chief executive officer of Near North Insurance Brokerage Inc. in Chicago.

Business interruption losses are proving more difficult to assess than property damage, he said.

"Most policies do require physical damage to tangible property" before a business interruption claim is paid, Mr. Merican said. Many businesses that were forced to shut down were tenants of flooded office buildings; the businesses themselves sustained no property damage.

However, Mayor Richard M. Daley's order to evacuate the Loop and shut off power to buildings could be considered an act of civil authority that could extend coverage under some business interruption policies.

Contingent business interruption policies could also provide coverage to those businesses that suffered no property damage, Mr. Merican said.

In any case, "by their nature, it takes much longer to discern" business interruption claims, said a spokesman for the American Insurance Assn. "It's not just obvious physical damage."

Business interruption claims will take a long time to calculate "because of the immensity of the incident and the fact the claims require lots of documentation to support," said Melvin Mussen, vp and national manager of Johnson & Higgins' disaster planning consulting services in St. Louis.

"People are careful about obtaining and assembling information," he said. "It just takes time." ■

24-hour coverage

Continued from page 2

plans, said Raymond B. Werntz, vp-benefits and compensation for Whitman Corp. in Rolling Meadows, Ill. Both plans involve sick or injured employees who often visit the same types of providers, he said.

Both plans also face cost increases driven by the same forces and focus on returning employees to productive work, he said.

The time is right to explore coordination of group health and workers comp programs, said Dennis H. Chookaszian, president and chief operating officer of CNA Insurance Cos. in Chicago.

Corporate officials who handle workers comp claims are increasingly interested in coordinating the benefits paid out under the two systems, he noted, adding that such coordination "is going to happen." A coordinated plan could reduce administration costs and eliminate duplicate claims, he said.

Under separate but coordinated plans, an employer may be able to reduce medical care costs for on-the-job injuries by encouraging employees—where allowed by law—to use managed care services like preferred provider organizations that offer discounts, he added.

Labor unions would be willing to negotiate 24-hour coverage issues, though they have several concerns about the concept, said Richard Walsh, president of the Illinois AFL-CIO in Springfield.

Combining the two programs could help labor by speeding medical benefit payments, he said. It also could eliminate "major" controversies that sometimes erupt when an employer's group health and workers comp insurers disagree about which insurer should pay an employee's medical claim.

That could save an employer the cost of litigating the compensability of a claim, said panel moderator Kathryn J. McIntyre, publisher/editorial director of *Business Insurance* in Chicago.

But, panelists noted many potential roadblocks to the development of a comprehensive 24-hour plan.

Many things separate group health and workers compensation plans, Mr. Werntz said. For example, workers comp is mandatory and regulated by state laws.

Workers comp is a "social insurance" program that provides employers with a "liability shield," he said. The program is intended to be the exclusive remedy for employees injured in the workplace. In exchange for this protection from liability suits from injured workers, employers are responsible for paying full medical and wage loss benefits promptly.

In contrast, group health plans are voluntarily offered by employers. And, the federal government, rather than the states, is the primary regulator of group health care benefits, he pointed out.

In addition, workers comp and group health plans differ in the extent to which managed care techniques, like limiting an employee's choice of physician, can be implemented, Mr. Werntz said.

Workers comp laws provide for first-dollar coverage and often let workers choose their own doctors while limiting the types of managed care techniques an employer can implement. Group health plans, though, often require employee copayments and deductibles and generally are not barred from adopting managed care techniques.



Photo by Michael A. Marcotte

Richard Walsh, left, Dennis H. Chookaszian, and Raymond B. Werntz discuss 24-hour coverage.

Furthermore, different corporate managers often administer workers comp and group health plans. Efforts to coordinate the two plans could create "turf" battles, Mr. Werntz said.

For insurers, the issue of 24-hour coverage is "quite complex" and full of problems as well as opportunities, Mr. Chookaszian said.

Most formidable among those problems could be persuading each state to approve a single combined workers comp/group health policy, he said. But, that may not be essential if insurers can develop programs to coordinate workers comp and group health care claims handling and apply managed care techniques to both types of coverage.

It also is difficult for any insurer seeking to coordinate group health and employee benefit coverages to develop an effective national network of managed care service firms, like disability management specialists, because it is tough to find the necessary services in some states, he said. "The problem is there are no firms that can provide these services" everywhere.

And, most insurers will likely have to obtain services from several different companies and have trouble coordinating them, he said. Fewer than 10 insurers have enough resources and expertise in both the group health and workers comp areas to do it themselves, he said.

"I think 24-hour coverage is unlikely," Mr. Chookaszian said.

Labor also has several misgivings about the concept. For example, Mr. Walsh is concerned that employees injured on the job would lose existing options to choose their own doctors and would have to pay part of the cost of treatment.

Labor representatives may be willing to negotiate contributions to the cost of care in exchange for larger wage-loss benefits, he said.

Mr. Walsh said labor also is concerned that a 24-hour program would reduce an employer's incentive to provide a safe workplace.

In addition, "there is very little evidence that there is employer demand for this product," he said.

But, one of the biggest problems standing in the way of 24-hour coverage is that many small employers offer no health plan. This emphasizes the need for a national health insurance program providing minimum benefits to all, he said.

The debate over 24-hour coverage should not overshadow the necessary link that must exist between an employer and its employees, Whitman's Mr. Werntz said. Employers and employees must realize that employees' lifestyle and use of medical services can drive health care costs as much as the behavior of health care providers, he said.

Employers must honestly explain the economic realities of health care to employees and help them become more independent and responsible health care consumers, he said.

The annual Hines Symposium is held in memory of Harold H. Hines, who at the time of his death in 1984 was president and chief operating officer of Rollins Burdick Hunter Co. in Chicago. Mr. Hines previously served as president of Ryan Insurance Group Inc., which later merged with RBH. He also was president of Marsh & McLennan Inc. ■

L.A. riots

Continued from page 1

Many business interruption claims also are expected.

Morris Davis Jr., owner of an Inglewood insurance agency and former president of the Inner City Brokers & Agents Assn. in Los Angeles, predicted that insured damage could surpass that in last year's Oakland Hills fire: $1.2 billion.

The Los Angeles riot already is the most costly in U.S. history.

Before last week, the 1965 Watts riot was the most costly civil disorder, the Insurance Information Institute reported. Insured property damage from that riot totaled about $44 million, which equals nearly $182.6 million in current dollars.

As of Friday morning, more than 1,500 fires had been reported in the Los Angeles area, including more than 500 to large structures. Thousands of merchants were looted. At least 3,000 people were arrested.

Particularly hard hit were strip malls and small businesses with little security.

A Fedco Inc. department store in West Los Angeles was heavily damaged by arson Thursday. Ironically, the day before, Fedco Risk Manager Nathaniel Lord said in an interview that Fedco workers are instructed in evacuation techniques rather than taught to set up fire brigades since most of its stores are near fire stations.

Among the areas in which the most serious destruction and violence occurred were:

- Hollywood, where the Frederick's of Hollywood lingerie store and other stores were looted and numerous fires broke out.
- Koreatown, where numerous small fires and looting was reported. Crowds were attracted to the area by a large arson-suspected fire that gutted an apartment building.
- The Crenshaw District, where a gas station and community center were torched while streams of people looted shops, including a Boys Market grocery store, a Thrifty drugstore and several other stores.

A spokeswoman for Boys Market said as many as 40 of its area stores were looted.

Among the stores looted were a Target discount store in Culver City; May Co. and I. Magnin department stores in the mid-Wilshire district and in downtown Los Angeles; several Kinney and Payless shoe stores; Radio Shack, Silo and Circuit City electronic stores; and several Thrifty and Sav-On drugstores.

Most fire damage and losses from looting should be covered by insurance, said Gary Kearney, director of catastrophe services at the Property Claim Services division of the American Insurance Services Group. "Riot and looting are covered perils."

The division declared the riots a catastrophe since damage is likely to exceed $5 million.

Most of that will be paid by commercial insurers, either directly or through FAIR plans that cover many of the businesses in South Central Los Angeles, said a spokesman for Transamerica Insurance Co. FAIR plans cover high-risk areas.

"Our biggest risk will be our share of the FAIR plan losses," which are based on market share, he said. Transamerica's share will be 2% to 3% of total FAIR plan losses.

By early Friday, Transamerica, which insures many small businesses in Southern California, received six claims totaling more than $1 million.

Adjusters were not sent into riot areas, so better estimates were not available, he said. Estimates also were hard to tally because the rioting "hopscotched around."

Among the businesses forced to close early on Thursday was Marsh & McLennan Cos. Inc. and subsidiary William M. Mercer Inc., which evacuated their mid-Wilshire offices after fire broke out in a nearby building under construction, said Daniel C. White, M&M's western region managing director.

Riot damage spread to other cities.

Looters smashed store windows in San Francisco, where a curfew was also imposed Thursday night. Fire damage was confined to garbage cans and store windows, said city fire officials.

A rally of several hundred in Atlanta led to violence when people began smashing windows in stores and cars. Windows were broken downtown and there was looting in the Underground Atlanta area.

A spokesman for the mayor's office estimated damage at less than $100,000 as of Friday. ■

Pollution study

Continued from page 3

To make matters worse, the study estimates that transaction costs for both insurers and policyholders will escalate in the future.

These enormous transaction costs account for the fact that only 5% of the 1,200 sites on the National Priorities List had been cleaned as of 1990.

"Insurer transaction costs alone would pay for 15 additional cleanups per year," the study says.

The RAND study was based on data from four very large insurers, which represent 15% of commercial premium volume, and five Fortune 100 businesses. None of the companies were identified. Figures from this group are representative of all insurers and Fortune 100 businesses, the authors said.

Of the five businesses, two self-insure their pollution liabilities, and one is engaged in a coverage dispute with its insurers. Two others have simply given notice to their insurers of pending claims.

Study co-author Lloyd Dixon says he was most surprised to learn the vast difference between the amount insurers and policyholders spend on transaction costs.

One reason for the differential—88% for insurers and 21% for policyholders—is that policyholders spend money on cleanups at the same time they are contesting coverage with insurers, thus lowering the ratio of transaction costs to cleanup costs, he explained.

Insurers, on the other hand, are making very few remedial payments because they staunchly deny that cleanup claims are covered by comprehensive general liability policies, he added.

However, Mr. Dixon cautioned: "We don't know the total transaction costs for all PRPs." The study fails to examine the amount spent on cleanup and transaction costs by small and medium-sized companies or by federal, state and local governments.

What is clear from the study is that 75% or more of the transaction costs for both insurers and policyholders goes toward legal fees, said Mr. Dixon, a RAND economist.

And those costs rise in cases with more than one potentially responsible party. "At multiparty PRP sites, the PRPs are forced to negotiate with each other and this drives up the transaction costs," Mr. Dixon explained. They negotiate how to allocate the liability, how to clean up the site and how to deal with the Environmental Protection Agency.

Insurers blamed the high transaction costs on the liability structure of Superfund.

"Superfund has created an extraordinarily inefficient system that fails to clean sites, while enriching lawyers," said David Aylward, president of National Strategies Corp. in Washington, D.C., which handles environmental work on behalf of Crum & Forster Inc., American International Group Inc. and Fireman's Fund Insurance Co.

Because Superfund imposes strict, joint and several liability, it engenders litigation, Mr. Aylward said.

"This study points out the enormous amount of money being spent on transaction costs, not cleanups," agreed John Arlington, senior counsel for the American Insurance Assn. in Washington, D.C. "This suggests that there is something fundamentally wrong with the Superfund system."

"It certainly suggests that the retroactive liability aspects of Superfund are problematical," said Mr. Arlington.

Joseph W. Brown Jr., chairman and chief executive officer of Crum & Forster in Basking Ridge, N.J., agreed: "Superfund transaction costs are spiraling out of control. . .If Congress doesn't do something soon to stanch the hemorrhaging of resources to non-productive, non-cleanup activity, both the economy and the environment will be the real losers."

While insurers blamed high transaction costs on the liability structure of Superfund, policyholders pointed their fingers at insurers for increasing transaction costs.

"It is a national tragedy that 42% of the money spent by insurance companies responding to environmental cleanup claims goes to fighting policyholders in court," said policyholder attorney Eugene Anderson of Anderson, Kill, Olick & Oshinsky in New York.

"Why do insurance companies do this?" asked Mr. Anderson. "Because there are gargantuan economic rewards for insurance companies that just say 'no' to policyholders."

Policyholder attorney Kirk Pasich agreed: "On a case-by-case basis it may be more cost-efficient for an insurer to litigate with its policyholder than pay the claim. This is especially true when insurers can share transaction costs."

Insurers may find it more profitable to litigate with policyholders rather than pay environmental claims because they can control funds during litigation, they can share litigation expenses with other insurers and most insurance disputes are settled for less than the full value of the claim, the policyholder attorneys say.

The coverage litigation is likely to become worse before it gets better, said Mr. Pasich of Hill, Wynne, Troop & Meisinger in Los Angeles.

As more and more state supreme courts resolve the legal issues involved in coverage disputes, like the meaning of the CGL pollution exclusion clause, more and more insurers will engage in fact-specific litigation in an attempt to prove policyholders expected or intended to pollute the environment, he said.

These fact-specific trials are far more expensive that trials over broad coverage issues, said Mr. Pasich.

"The insurance industry has sent a message to policyholders, he said: 'You want coverage for environmental claims, fine, pay $10 million to $20 million to prove it.' "

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Copies of the report, numbered R-4132-ICJ, are available for $7.50 from RAND, 1700 Main St., P.O. Box 2138, Santa Monica, Calif. 90407-2138; 310-393-0411, ext. 6686.

Update

Judgment in health cover scam

Continued from page 2

derwriters and Mr. Hoskie have filed motions for a new trial or reduction of the award, Mr. Lack said.

Mr. Hoskie and Arnold Skoller, another National Underwriters official, and their attorneys could not be reached.

EPA rule clarifies lender liability

WASHINGTON—Financial institutions generally will be able to foreclose on properties when loans are in default without becoming liable for environmental harm caused by the borrowers under a final U.S. Environmental Protection Agency rule.

A lender cannot be held liable for environmental damage by a borrower if the lender performed traditional lending activities, like advancing a loan or inspecting a facility prior to granting a loan. A lender also cannot be held liable for performing certain administrative functions, like acting the controller of a foreclosed facility.

But, if the lender performs "operations" functions, like acting as plant manager or chief executive officer, it could be held liable for the environmental damages of the borrower.

The rule was prompted by a 1990 11th U.S. Circuit Court of Appeals ruling that lenders could be held liable for "participating" in the financial management of a facility (*BI*, June 4, 1990).

Lead paint makers not liable

PHILADELPHIA—Manufacturers of lead paint pigment do not have to reimburse cities for the costs of removing and testing lead paint used in public housing facilities, a U.S. District judge in Philadelphia has ruled.

Judge James T. Giles dismissed the largest lawsuit in the nation against former manufacturers of lead paint pigment, a product banned in housing for nearly two decades.

Philadelphia, which sought class-action status on behalf of cities with populations exceeding 100,000, argued, among other things, that the manufacturers should be held liable based on their market share, since there is no way to identify which manufacturer's product was used in specific buildings. But Judge Giles ruled that the market share liability is not allowed under Pennsylvania law.

"Obviously lawyers are trying to apply the market share theory in lead paint cases" as they have in DES cases, said Paul M. Pohl, a lawyer with Jones Day Reavis & Pogue in Pittsburgh who represented Sherwin-Williams Co., one of the defendants. "But they have been totally unsuccessful," he said, noting that at least three judges have rejected market share liability in previous lead paint cases.

Both New York and California courts allow makers of the anti-miscarriage drug DES to be held liable based on their market share when the drug was prescribed (*BI*, April 10, 1989; Nov. 28, 1983).

Philadelphia has not decided whether to appeal.

N.C. safety plan in jeopardy

WASHINGTON—North Carolina may become the first state to have its workplace safety program taken over by the federal Occupational Safety and Health Administration.

OSHA Administrator Dorothy Strunk notified North Carolina Labor Commissioner John Brooks late last month that the state had 45 days to show why the federal government should not withdraw approval for the state's program, one of more than 20 state workplace safety programs operated independently of OSHA.

OSHA began a formal review of the North Carolina program in January in the wake of a September 1991 fire that killed 25 workers at a Hamlet, N.C., poultry processing plant (*BI*, Jan. 13; Oct. 7, 1991; Sept. 9, 1991). After the fire, investigators found the plant had never been inspected by state safety officials. OSHA in late October took over the state program's responsibility for investigating new workplace safety complaints (*BI*, Oct. 28, 1991).

In January, North Carolina was given 90 days to correct deficiencies in its program or face possible decertification. In her letter to Mr. Brooks, Ms. Strunk said that some deficiencies "have been addressed only by assurances," and in other cases, "you have declined to take any corrective action at all."

Mr. Brooks responded that OSHA is "using the safety and health of the North Carolina workforce as a political football."

Briefly noted

At least four potential buyers of **Frank B. Hall & Co. Inc.** have received confidential detailed financial data from Bear Stearns & Co., the investment bank Hall retained to find a buyer. Hall Chairman and Chief Executive Officer Donald R. Bell would only say that "more than a handful" of potential investors have expressed a "very high level of interest" in Hall (*BI*, March 30). . . .**American Feed Industry Insurance Co. Risk Retention Group**, an Iowa-domiciled company providing product liability and general liability coverage to animal feed manufacturers, says it is receiving an A− rating from A.M. Best Co. Best has given letter ratings to only a few risk retention groups. . . .Severe weather caused an estimated **$60 million of insured property damage** to portions of Alabama, Louisiana, Mississippi and Texas April 19-20, says the Property Claim Services division of the American Insurance Services Group. . . .Best downgraded **Mutual Life Insurance Co. of New York** and unit MONY Life Insurance Co. of America in Phoenix to A− from A, citing underperforming mortgage and real estate portfolios and significant junk bond holdings. . . .**General Re Corp.** shares fell $7.38 a share to $81 last Thursday on news that its first-quarter operating income fell 13.8% to $116.5 million. Net income rose 38.2% to $207.8 million.

Brokers bruised, but optimistic

By LEONARD M. WILSON

Special to Business Insurance

THERE IS A NAGGING irony in the soft commercial property/casaualty insurance market. Insurance brokerage profitability has never been under more pressure. Yet the complexity of client needs and the brokers' professional expertise rise ever higher. This conundrum is nowhere more apparent than in 1991's crop of annual reports.

Alexander & Alexander Services Inc., as one example, speaks of arranging health care coverage for an employee group of 5,000 spanning five countries. Imagine that happening 10 or 15 years ago when the skills needed for global transactions were rudimentary at best. Serving multinationals in a multiplicity of intricate coverages is a prideful highlight of this year's annuals.

The squeeze on profitability is evident in letters to shareholders, which underscore difficult operating conditions, the soft market, declining interest rates and the recession. Brokerage managements were not immobilized by these daunting challenges. Tight cost control and intensified new business generation were leitmotifs of 1991.

Notwithstanding the sober tinge, 1991 annual reports remain a vehicle for expression of managements' optimism. The public insurance brokers may be a bit wearied by the soft market, but they continue to manage aggressively though wide-ranging initiatives designed to cope with today's conditions and prepare for future growth.

Marsh & McLennan Cos. Inc. reorganized insurance brokerage operations into two separate business practices: insurance brokerage and risk management. This step is aimed at meeting the varied needs of a disparate client base.

The company also brought its ownership of French broker Faugere & Jutheau to 100%. Over the years, Marsh & McLennan has moved steadily in the direction of full integration of non-U.S. operating units. As the annual report puts it, the company now has in place a global organization with a single ownership and a single management.

Alexander & Alexander implemented a restructuring of retail insurance brokerage as one answer to the challenges of the soft market. The firm's restructuring is intended to achieve significant reductions in operating costs while creating greater focus on client requirements.

Operations were organized into three segments designated: the Global Network Segment, the Corporate Specialty Segment and the Small Commercial Business Segment. The change has the goal of aligning more efficiently insurance brokerage resources with servicing requirements of customers.

Sedgwick Group P.L.C. was able to claim for its North American subsidiary, Sedgwick James, a reduction in expenses of 3% for 1991. U.S. operations experienced a substantial advance in profits, a notable accomplishment under current conditions, we think. Sedgwick responded to warming trends in the geopolitical arena by opening offices in Budapest, Hungary, and Warsaw, Poland, to complement an existing office in Moscow.

Globalism in insurance brokerage transcends political dynamics.

Willis Corroon P.L.C.'s annual report characterized the firm as the "24-Hour Worldwide Group." Creating a common culture for the company was a major initiative of 1991, subsumed under the rubric of "one company, one culture."

The operational reorganization set in motion by 1990's merger was completed by the end of 1991. The company is now able to realize global benefits of the amalgamation through three strategic business units: direct brokerage, reinsurance brokerage and benefit consulting.

Frank B. Hall & Co. Inc. forged what it calls a hub and satellite structure for domestic insurance brokerage operations. Profit centers were combined so as to increase efficiency of staff and effectively share resources. Cost reduction and better profitability were clearly a major thrust for 1991.

Hall's directors couched their decision to seek an acquisition mate as an examination of strategic alternatives. Their determination to sustain operations with an unflagging commitment to high-quality service was strongly enunciated.

Rollins Burdick Hunter Group, an Aon Corp. subsidiary, acquired Hudig-Langeveldt Group bv in 1991. The acquisition has markedly enhanced the multinational capabilities of the company.

Arthur J. Gallagher & Co. was active on the acquisition trail in 1991. Houston, New York, Baton Rouge, La., and Los Angeles were four target cities in which acquisitions were closed in 1991. Acquisitions will be a central part of future growth plans, the company affirms.

Gallagher also established a new managed health care network. This service was developed through cooperative arrangements with existing medical providers. One important area for revenue generation is workers compensation medical cost containment.

Hilb, Rogal & Hamilton Co. sustained an active program of acquisitions with a tally of 18 during the year. The firm's network of offices now embraces 47 in 20 states.

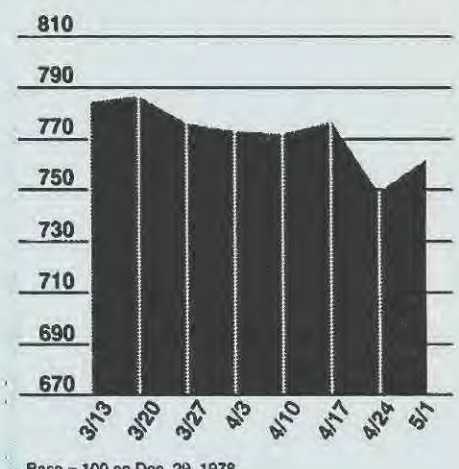
Without exception, 1991 annual reports couched expectations for 1992 in cautious terms. Beleaguered is probably too strong a characterization, but brokers are geared for another bruising year. Restructuring and cost control may again be important themes for this year. Management initiatives will continue to aim toward preserving current levels of profitability.

Investors should be encouraged by this display of management activism in dealing with the soft market. Leverage on the upside when rates improve will be so much the greater. ■



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BI Insurance Index



Base = 100 on Dec. 29, 1978
Source: Nordby International Inc.

Insurance industry stocks revived last week, as the *Business Insurance* Index rose 12.4 points to 761.1 on May 1 from 748.7 on April 24. Advancing issues were led by United Healthcare Corp., up 11.7%; HMO America Inc., up 10.3%; and Kemper Corp., up 10.1%. Declining issues followed General RE Corp., down 12.3%; American Indemnity/Financial, down 7.4%; and SCOR U.S. Corp., down 6.6%. The most active was Sears, Roebuck & Co. (Allstate), 5.1 million shares traded. The *BI* Index was up 1.7%; the NYSE Composite was up 0.9%; the Standard & Poor's 500 was up 0.9%; and the Dow Jones 30 Industrials rose 0.4%.

British Issues

April 30 Companies	Price pence	P/E	Div. pence	Yield %	1 Week High—Low pence	pence
Comml Union	470	N/M	31.5	6.7	470—463	
Genl Accident	468	N/M	35.7	7.6	468—463	
Gdn Royal Exch	141	N/M	10.0	7.1	147—141	
Royal	215	N/M	15.0	7.0	215—203	
Sun Alliance	293	N/M	19.0	6.5	294—286	
Brokers						
Bradstock	145	16.3	6.3	4.3	146—145	
CE Heath	392	26.0	34.5	8.8	392—388	
Hogg Group	170	11.3	10.9	6.4	171—170	
JIB Group	191	14.0	10.0	5.2	193—191	
Lloyd Thompson	228	22.8	6.0	2.6	228—225	
Lowndes Lmbrt	317	13.2	17.3	5.5	318—317	
PWS Holdings	54	5.9	5.3	9.8	54—54	
Sedgwick Grp	215	16.8	16.0	7.4	221—215	
Steel Brrl Jones	263	13.2	17.7	6.7	263—257	
Willis Corroon	268	17.0	17.6	6.6	270—268	

Source: Philip Olsen, Insurance Industry Analyst, London

BI Industry Stock Report

APRIL 25, 1992 THROUGH MAY 1, 1992

		Price	Weekly % change	Year to Date % change	Annual High	Annual Low	Vol.(000)	$ Div.	% Yield	P/E	Book value	Mkt/Bk. value
BROKERS												
Alexander & Alexander	NYS	19.00	0.66	-7.32	23.38	18.00	272	1.00	5.26	119	9.77	1.94
Gallagher Arthur J. & Co	NYS	23.00	8.24	2.79	25.25	19.00	58	0.64	2.78	18	5.88	3.91
Frank B Hall	NYS	4.00	6.67	-5.88	5.50	3.13	110	0.00	0.00	-3	-5.24	-0.76
Hilb, Rogal & Hamilton	OTC	11.75	0.00	-11.32	17.50	11.00	38	0.40	3.40	19	3.56	3.30
Marsh & McLennan	NYS	78.00	2.30	-4.15	83.75	70.00	198	2.60	3.33	18	14.77	5.28
Poe & Associates	OTC	14.63	-0.85	21.88	16.00	9.50	19	0.40	2.74	17	2.52	5.80
BROKERS	AVERAGE		2.8	-0.7					2.5	27		
CONGLOMERATES & HOLDING COMPANIES												
Berkley W.R. Corp.	OTC	31.25	-4.94	2.46	36.25	23.50	185	0.36	1.15	12	23.89	1.31
Berkshire Hathaway Inc.	NYS	9025.00	0.00	-0.28	9025.00	250.00	0	0.00	0.00	-33	4612.00	1.96
ITT (Hartford Group)	NYS	64.13	0.98	11.04	70.63	50.00	799	1.84	2.87	11	64.01	1.00
Sears (Allstate)	NYS	43.38	-1.70	14.52	48.00	32.50	5139	2.00	4.61	12	37.38	1.16
CONGLOMERATES	AVERAGE		-1.4	6.9					2.2	0		
INSURERS/REINSURERS												
AEGON N.V.	NYS	69.13	0.55	-1.25	71.75	54.75	37	2.30	3.33	7	N/A	N/A
Aetna Life & Casualty	NYS	41.63	-2.06	-5.40	47.00	31.88	1302	2.76	6.63	8	64.23	0.65
Allied Group Inc.	OTC	19.75	0.64	16.18	23.00	16.00	52	0.64	3.24	7	19.85	0.99
American General	NYS	45.50	2.25	2.25	45.50	36.38	558	2.08	4.57	10	37.14	1.23
American Heritage Life Ins	NYS	27.25	5.31	-11.02	30.00	19.88	5	1.00	3.67	14	N/A	N/A
American Indemnity/Fin'l	OTC	7.88	-7.35	65.79	9.25	4.50	13	0.08	1.02	6	12.93	0.61
American International	NYS	83.50	0.00	-15.12	99.38	78.63	1980	0.48	0.57	11	45.34	1.84
Aon Corp	NYS	43.25	-0.29	9.15	45.25	34.75	263	1.68	3.88	12	18.50	2.34
Argonaut Group	OTC	27.25	0.93	14.74	32.00	21.75	104	0.84	3.08	9	48.26	0.56
AVEMCO Corp	NYS	24.75	-1.98	-1.00	28.00	19.63	11	0.40	1.62	22	9.55	2.59
Baldwin & Lyons Inc.	OTC	27.00	-3.57	4.85	28.00	22.50	12	0.28	1.04	8	24.29	1.11
Belvedere Corp.	ASE	5.50	2.33	69.23	6.13	2.88	3	0.04	0.73	15	7.65	0.72
Chandler Insurance	OTC	5.63	-4.26	73.08	5.88	2.13	20	0.00	0.00	70	5.95	0.95
Chubb Corp	NYS	64.88	-1.33	-15.75	78.00	60.75	862	1.60	2.47	10	35.19	1.84
CIGNA Corp	NYS	51.00	-0.49	-16.56	61.75	41.25	288	3.04	5.96	11	73.15	0.70
CNA Financial Corp	NYS	85.75	-6.54	-12.50	104.50	75.50	153	0.00	0.00	9	70.23	1.22
Continental Corp.	NYS	26.00	1.46	-5.88	30.38	23.25	357	2.60	10.00	27	37.83	0.69
EXEL Ltd	NYS	34.00	0.00	-9.33	40.25	27.38	254	0.92	2.71	7	N/A	N/A
Fund American Corp	NYS	64.00	1.19	-8.41	70.25	62.00	321	0.68	1.06	21	36.11	1.77
Fremont General Corp	OTC	18.63	0.68	-23.59	26.00	18.00	485	0.88	4.72	5	19.13	0.97
Frontier Insurance Group	NYS	34.50	4.55	27.78	34.50	20.47	28	0.60	1.74	13	11.20	3.08
Gainsco Inc	ASE	13.63	0.93	-2.68	15.00	8.38	17	0.04	0.29	15	3.37	4.04
General RE Corp.	NYS	78.63	-12.27	-22.82	104.75	78.63	2085	1.80	2.29	11	37.50	2.10
Guaranty National Corp	NYS	14.25	1.79	-1.72	17.00	12.63	26	0.48	3.37	9	N/A	N/A
Hanover Insurance Co	OTC	37.00	4.96	3.50	42.75	27.13	88	0.44	1.19	16	37.44	0.99
Harleysville Group	OTC	18.50	1.37	-12.94	23.25	16.75	528	0.64	3.46	9	22.99	0.80
Hartford Steam Boiler	NYS	51.00	1.24	-11.30	62.38	45.13	68	2.00	3.92	15	17.05	2.99
Kemper Corp.	NYS	27.13	10.15	-28.85	46.13	24.00	1442	0.92	3.39	6	34.20	0.79
Lawrence Insurance Group	ASE	8.25	-2.94	-25.84	11.13	7.88	1	0.48	5.82	16	4.71	1.75
Liberty Corp	NYS	24.88	6.99	12.43	25.38	19.50	27	0.48	1.93	13	23.86	1.04
Lincoln National	NYS	52.50	3.96	-4.11	61.00	45.38	354	2.92	5.56	11	45.16	1.16
Markel Corp.	OTC	26.75	0.00	21.59	28.25	14.25	17	0.00	0.00	13	3.22	8.31
Mutual Risk Mgmt. Ltd.	NYS	30.00	0.84	-14.59	37.75	17.00	49	0.12	0.40	22	-	-
NAC Re Corp.	OTC	26.25	-4.98	-16.67	33.00	21.75	134	0.16	0.61	12	18.90	1.39
National Re Holdings Corp.	NYS	18.00	-2.04	N/A	23.63	17.00	102	0.12	0.67	9	N/A	N/A
Navigators Group	OTC	37.00	-4.82	-9.76	48.25	29.50	4	0.00	0.00	21	13.52	2.74
Nobel Insurance LTD.	OTC	4.88	2.63	21.88	6.00	3.38	14	0.00	0.00	4	7.76	0.63
NWNL Companies	NYS	36.75	4.63	18.07	38.50	18.63	205	1.48	4.03	10	42.73	0.86
Ohio Casualty Corp.	OTC	49.50	-1.49	0.00	58.25	43.50	354	2.68	5.41	8	36.38	1.36
Old Republic Int'l	NYS	19.75	0.00	11.27	21.13	13.75	203	0.72	3.65	4	33.09	0.60
Orion Capital Corp.	NYS	29.75	0.00	-5.93	34.25	27.00	40	0.92	3.09	5	20.42	1.46
Phoenix RE Corp.	OTC	9.25	-3.90	-11.90	11.75	8.50	69	0.20	2.16	37	13.30	0.70
Provident Life	OTC	22.00	4.14	-5.38	24.25	16.75	305	1.00	4.55	9	25.88	0.85
Re Capital Corp.	ASE	15.38	-0.81	6.96	18.63	13.13	37	0.24	1.56	12	15.05	1.02
Reliance Group Holdings	NYS	4.63	5.71	12.12	6.13	3.50	96	0.32	6.92	3	5.61	0.82
RLI Insurance Corp.	NYS	18.50	1.37	12.12	20.38	11.88	21	0.48	2.59	8	14.41	1.28
St. Paul Companies	NYS	69.38	1.09	-4.80	75.75	57.13	493	2.72	3.92	7	52.00	1.33
SAFECO Corp.	OTC	46.88	3.88	-3.85	50.00	35.50	632	1.48	3.16	12	31.50	1.49
SCOR U.S. Corp.	NYS	16.00	-6.57	4.07	18.88	11.63	3	0.28	1.75	9	11.19	1.43
Seibels Bruce Group	OTC	5.63	0.00	2.27	8.75	4.00	22	0.36	6.40	-3	7.35	0.77
Selective Ins. Group	OTC	19.38	1.97	15.67	19.75	13.75	167	1.04	5.37	9	18.91	1.02
Statesman Group Inc	OTC	5.88	-4.08	2.17	6.88	2.63	741	0.00	0.00	4	2.48	2.37
Tokio Marine & Fire	OTC	37.13	0.00	-27.91	55.25	32.25	2	0.00	0.00	-	70.93	0.52
Torchmark Corp.	NYS	56.25	-1.53	-2.81	61.50	46.50	3002	1.60	2.84	12	16.70	3.37
Transamerica	NYS	43.63	-5.16	9.40	46.75	31.25	560	2.00	4.58	29	36.56	1.19
Transatlantic Holdings	NYS	32.63	5.24	-16.08	39.63	29.00	104	0.24	0.74	11	18.38	1.78
Travelers Corp.	NYS	20.38	-1.81	-5.78	25.13	17.25	1492	1.60	7.85	7	41.44	0.49
Trenwick Group Inc.	OTC	27.50	6.80	-3.51	30.75	23.00	9	0.72	2.62	10	21.71	1.27
United Fire & Casualty	OTC	59.25	0.42	31.67	62.00	42.00	1	1.32	2.23	12	35.39	1.67
USF&G Corp	NYS	10.75	-1.15	48.28	11.63	5.63	1867	0.20	1.86	-5	11.96	0.90
UNUM Corp.	NYS	36.75	3.89	-9.26	40.63	28.81	562	0.64	1.74	11	37.25	0.99
USLIFE Corp	NYS	44.25	2.02	-7.57	47.88	38.25	120	1.64	3.71	9	60.34	0.73
Unitrin	OTC	34.50	3.76	-3.50	39.25	31.00	443	1.00	2.90	14	30.70	1.12
USLICO Corp.	NYS	18.25	0.00	-1.35	21.00	17.00	43	1.00	5.48	-19	29.44	0.62
Washington National	NYS	17.63	0.00	11.02	19.25	13.38	40	1.08	6.13	-8	26.86	0.66
Zenith National Ins.	NYS	16.38	1.55	-2.96	18.50	13.75	191	1.00	6.11	7	13.14	1.25
INSURERS/REINSURERS	AVERAGE		0.3	2.1					3.5	12.8		
HEALTH MAINTENANCE ORGANIZATIONS												
FHP International	OTC	13.50	2.86	-5.26	27.00	9.88	752	0.00	0.00	12	5.44	2.48
HMO America Inc.	OTC	16.00	10.34	-4.48	24.88	11.38	1515	0.00	0.00	18	0.61	26.23
Pacificare Health Sys	OTC	53.25	4.41	34.81	62.50	21.50	860	0.00	0.00	21	6.55	8.13
Safeguard Health Enter	OTC	12.75	2.00	36.00	14.75	5.13	128	0.00	0.00	22	3.53	3.61
Sierra Health Services	ASE	19.75	-3.07	6.76	27.50	12.38	45	0.00	0.00	10	1.78	11.10
United Healthcare Corp.	NYS	76.63	11.66	2.85	93.00	40.25	1036	0.03	0.04	32	3.76	20.38
United Medical Corp.	ASE	8.38	-4.29	19.64	10.88	5.88	8	0.20	2.39	32	8.79	0.95
U.S. Healthcare	OTC	49.25	9.14	18.67	57.75	21.25	4580	0.56	1.14	22	3.38	14.57
HMOs	AVERAGE		4.1	13.6					0.4	21		
ALL COMPANIES	AVERAGE		1.5	5.5					2.9	14		

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