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Update

Resignations from Lloyd's exceed last year's record pace

LONDON—Some 3,245 members have resigned from Lloyd's of London already this year, compared with 1,894 resignations at the same point in 1990, Lloyd's announced last week.

If the current rate continues, nearly 4,000 members could resign by year end, by far a record. A record 2,349 resignations in 1990 left the market with 26,558 members at the beginning of 1991.

The resignations will cause Lloyd's capacity to be cut by about 10% in the

Continued on next page

Health care leaders seek uniform billing

By JERRY GEISEL

WASHINGTON—Last week's Washington "summit" on reducing health care administrative costs could be the first step toward a paperless, electronic claims filing system that could save billions of dollars.

Health insurance executives, health care providers and Bush administration officials agreed at the meeting to work toward slashing administrative costs by developing a uniform health care billing system and reducing paperwork.

"Our goal is clear: to slash the red tape Americans face in obtaining health care," said Dr. Louis W. Sullivan, secretary of health and human services.

But that meeting may have been overshadowed by a come-from-behind political upset in Pennsylvania. Political activist Harris Wofford resoundingly defeated Richard Thornburgh, the former Bush administration attorney general, for the U.S. Senate seat formerly held by Republican John Heinz, who died in a aircraft accident earlier this year.

The victory by Sen. Wofford, who was appointed interim senator by Democratic Gov. Robert Casey following Sen. Heinz's death, is commanding attention from benefit observers. A key Wofford campaign theme was his endorsement of a single-payer Canadian-style national health insurance system. While Mr. Thornburgh took no strong positions on health care issues, he did criticize Sen. Wofford's proposal.

Sen. Wofford's victory could force national politicians, especially Republicans, to develop positions on health care reform before the 1992 elections (see Update, page 2).

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Lower Medicare age would cut FASB bill

Eligibility at 60 could be boon for companies

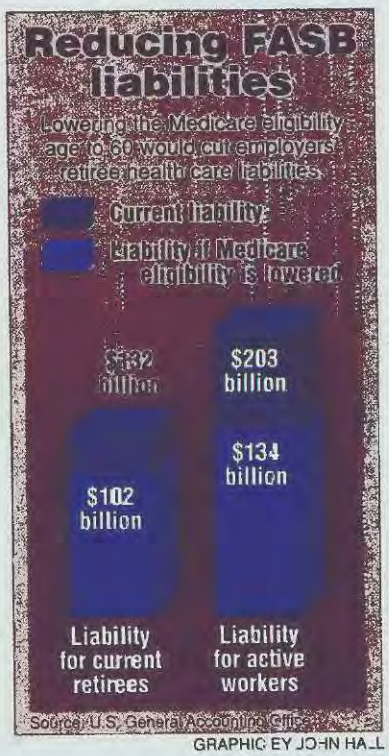
By JERRY GEISEL

WASHINGTON—Lowering the Medicare eligibility age to 60 from the current 65 would slice employers' retiree health care liabilities by nearly one-third, or $100 billion, the U.S. General Accounting Office says.

Employers have run up a whopping $335 billion in retiree health care liabilities, including $203 billion in promised but unfunded benefits for active employees and $132 billion in liabilities for employees who already are retired, according to the GAO.

Expanding Medicare to cover retirees between age 60 and 64—a key provision in health care reform legislation proposed by House Ways and Means Committee Chairman Daniel Rostenkowski, D-Ill. (*BI*, Aug. 19)—would cut Corporate America's retiree health obligations by $99 billion, or 30%, to $226 billion, the GAO says.

The lower Medicare eligibility age would slash employers' accrued retiree health care liabilities for active workers to $134 billion from $203 billion, a 34% decrease, while liabilities for current retirees would decline 23% to $102 billion from $132 billion.



GRAPHIC BY JOHN HALL

Aside from reducing retiree health care liabilities, which must be recognized starting in 1993 on large corporations' financial statements under a Financial Accounting Standards Board rule, lowering the Medicare eligibility age would slash employers' cash outlays to pay for their retirees' health care costs.

Employers this year are expected to spend $11.4 billion on health care for retired workers and spouses between 60 and 64. Lowering the Medicare eligibility age to 60 would cut that payout by 35% to $7 billion, according to the GAO.

"These reductions are dramatic," said Assistant Comptroller General Lawrence H. Thompson, who presented the estimates last week before the House Ways and Means Health Subcommittee.

These estimates—the first to

Continued on page 4

Asbestos compensation program proposed

By STACY ADLER GORDON

WASHINGTON—A federal agency is floating a radical new proposal to remove all asbestos personal injury claims from the court system and pay claimants through an administrative agency.

The Administrative Conference of the United States, an independent federal agency, commissioned a law professor to draft the administrative alternative to compensating asbestos personal injury claimants through tort litigation.

The Administrative Conference sought out an administrative alternative after the U.S. Judicial Conference in March released a report suggesting such an alternative because the volume of asbestos cases has reached "critical dimensions (and) is becoming a disaster of major proportion. . .which the courts are ill-equipped to meet effectively" (*BI*, March 18).

More than 100,000 asbestos bodily injury claimants now are litigating with asbestos producers in state and federal courts nationwide.

The 27-judge group urged Congress to consider creating a national system of compensating present and future victims of illness caused by exposure to asbestos.

While calling for legislation, the judges did not offer any proposals. Therefore, the Administrative Conference took the initiative of seeking out an administrative proposal.

Authored by Professor Lester Brickman of Cardozo Law School at Yeshiva University in New York, the administrative proposal calls for the creation of a trust fund—financed by the manufacturers of asbestos-containing products and their insurers—that would pay asbestos bodily injury claimants wages they lose due to asbestos injury. Medical and death benefits also would be paid.

While the producers of asbestos

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'How do we take a mass societal problem and still give the individual victim the sense that his grievance has been heard? These problems are not ones that can be readily solved.'

—U.S. District Judge Jack B. Weinstein

53% of days spent in hospital are unnecessary, study says
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Flight attendants seek billions for second-hand smoke illness
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Garamendi rejects latest bid by NOLHGA for Executive Life
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Update

Lloyd's member resignations

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1992 underwriting year, predicts Lloyd's Chief Executive Alan Lord.

The average capacity of the members who have resigned this year is 301,000 pounds ($580,930 at appropriate exchange rates), compared with the market average of 429,000 pounds ($827,970), he noted.

The market's capacity this year is 11.4 billion pounds ($22 billion) and should not fall below 10 billion pounds ($17.8 billion at current exchange rates) in 1992, he said. Lloyd's has received 171 applications from prospective members, while about 6,000 members have indicated that they wish to increase their capacity, he said.

"The 1992 capacity will meet all of the requirements of our long-established international clients," he said.

PBGC liabilities may change

WASHINGTON—The Pension Benefit Guaranty Corp. last week won a reprieve from taking control of a massively underfunded LTV Corp. pension plan, but faces legislation that would make it responsible for terminations that occurred before it was created.

U.S. Bankruptcy Court Judge Burton Lifland in New York last week ordered Dallas-based LTV to make an immediate cash payment of $39 million—enough to pay three months of benefits—to its Jones & Laughlin Hourly Pension Plan.

The plan, which is nearly broke, has about $1.5 billion in unfunded liabilities. Judge Lifland's action forestalls the immediate threat of termination. Under law, the PBGC must terminate pension plans that run out of assets.

In another LTV-related development, the PBGC and the LTV Steel Creditors Committee have agreed to a deal in which LTV would, upon bankruptcy reorganization, contribute about $1.5 billion to its three pension plans. More contributions would be made over 30 years.

In a separate development, the Senate this week is expected to vote on legislation that could increase the PBGC's obligations by $500 million.

The bill, S. 243, would require the pension agency to pay benefits to workers and retirees covered by underfunded pension plans that were terminated before the agency was established in 1974.

Aside from the cost, which could lead to higher premiums, the proposal could increase administrative burdens. The agency would have to track down people who may have retired many years ago, officials say.

Meanwhile, a House subcommittee report says that sloppy bookkeeping has left the agency unable to determine whether it has collected termination insurance premiums from employers.

The House Ways and Means Oversight Subcommittee contends the PBGC will have to write off nearly all delinquent premiums for 1988 because of computer malfunctions that year.

An agency spokesman said internal accounting controls have been strengthened and a "Big Six" accounting firm retained.

Republican health care plan

WASHINGTON—Employers that launch new managed health care plans would receive federal tax credits to help defray their costs under a health care reform proposal unveiled last week by a Senate Republican task force.

Employers that begin offering a managed care plan, which is not defined in the proposal, would receive a 25% tax credit on their costs for the plan, with that percentage declining five points each succeeding year until the credit expired after five years. A similar tax credit would be available for small employers offering a health care plan for the first time, while health insurance premiums paid by employees would be fully tax-deductible.

The plan does not say how lost tax revenues would be recovered.

State laws regulating managed care would be pre-empted under the measure. In addition, federal aid would be given to states that establish a new program to provide basic health insurance for poor people who do not qualify for Medicaid.

Other provisions in the measure, which is not yet in legislative form, would revamp medical malpractice laws, including eliminating joint and several liability for non-economic damages, capping non-economic damages at $350,000 and requiring periodic payments for awards exceeding $100,000.

The total cost of the proposal is estimated at $150 billion over five years.

Maxwell group accident policy

LONDON—Maxwell Communications Corp. P.L.C.'s group personal accident insurance policy may not pay any claim if it is found that its late chairman, Robert Maxwell, died of natural causes.

Spanish authorities investigating Mr. Maxwell's sudden death last week said he died of a heart attack, not drowning. His naked body was discovered in water near the Canary Islands.

Further autopsy investigations will try to determine whether he died from heart failure before or after falling off his yacht. If it is determined that Mr. Maxwell died from heart failure after falling overboard, then the group accident policy would pay. The policy specifically excludes death by suicide or natural causes.

The 20 million pound ($35.5 million) accident policy, placed by Willis Wrightson Ltd., is led in Lloyd's of London by syndicate 782, managed by Oxford Syndicate Management Ltd., and in the London company market by the Continental Assurance Co. of London P.L.C.

The media company did not insure any of the group accident risk

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Errors and omissions

• Due to a production error, the full listings for G.J. Sullivan Co. and Sullivan Payne Co. were omitted from the directory of reinsurance intermediaries published in the Nov. 4 issue. The full listings are reprinted on page 37.

• An incorrect premium volume was reported by Delaney Offices Inc. in the directory of reinsurance intermediaries. The company's correct volume is $20 million.

Needless hospitalization is rampant, survey finds

By LOUISE KERTESZ

SEATTLE—More than half of the days patients under age 65 spend in hospitals are medically unnecessary, according to a recent nationwide study based on reviews of thousands of medical charts.

Figures vary by region, but nationally 53% of the days spent in the hospital are unnecessary—either unwarranted admissions or needlessly extended stays—reports Milliman & Robertson Inc., a consulting firm based here.

Patients in New York and Chicago spend the most unnecessary days in the hospital—65% and 62% of the total, respectively. At the other end of the spectrum were Seattle, with 39%, Los Angeles, 41%, and Minneapolis, 44%.

In addition, the study found that 24% of all hospital admissions nationwide are unwarranted and 15% of office visits are medically unnecessary.

Milliman & Robertson concludes that while "the public's outcry about the cost of the (health care) system is valid. . .more must be done to eliminate the system's waste."

"The solution that effectively eliminates this waste, while maintaining high-quality care, will increase the quality of life for everyone and perhaps fund coverage for those who cannot afford or obtain some form of health insurance," the study says.

While some observers point to the M&R study as a significant development in the fight against unnecessary utilization, others question the methodology used and call the findings exaggerated.

The M&R study is based on data from thousands of medical chart reviews compared with the company's own utilization and length-of-stay guidelines—"Health Cost Guidelines and Healthcare Management Guidelines"—which are used by utilization review firms, health maintenance organizations and insurance companies.

"We have developed physician-created treatment plans to cover nearly 90% of all hospital admissions," said Dr. Richard Doyle, one of the study's three authors.

"More than 1,700 hospitals, insurers and other health care organizations currently subscribe to

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Unlicensed surety insurer

Kentucky files suit to bar firm that claims it is a captive

By DOUGLAS McLEOD

FRANKFORT, Ky.—The Kentucky Insurance Department is trying to enjoin the operations of an unlicensed surety underwriter it also charges with deceptive trade practices.

Kentucky regulators have filed suit in Franklin County Circuit Court against Contractors Surety & Fidelity Co. Ltd., an Atlanta-based company that has claimed to be a construction industry captive insurer.

Also named in the complaint is Leonard E. Smith, Contractors Surety's president.

The lawsuit charges Contractors Surety and Mr. Smith with illegally writing several construction performance and bid bonds in Kentucky without a license and failing to pay state premium taxes.

The suit seeks an injunction barring the company from writing business without a license and ordering Contractors Surety and Mr. Smith to pay any claims on bonds already issued.

In an answer filed last month, the company denied the allegations and charged that the Kentucky insurance code violates the U.S. Constitution.

Neither Mr. Smith nor a Frankfort lawyer representing Contractors Surety could be reached.

Regulators know relatively little about Contractors Surety's operations, though Cynthia K. Maynard, Kentucky special assistant attorney general, said she believes the company has written bonds in several states.

Contractors Surety was incorporated in Nevada in April 1989, but is not licensed as an insurer in the state and has operated from offices in Atlanta, according to records from Kentucky and other states.

Nevada regulators issued a cease and desist order against the company in August after learning it was writing business in other states, according to Teresa Rankin, Nevada's insurance commissioner.

The Georgia Insurance Depart-

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S&P's new solvency review finds most firms healthy

Industry in 'good' shape

By DOUGLAS McLEOD

NEW YORK—The insurance industry is generally in good financial shape, though a number of insurers writing a relatively small portion of industry premiums are financially weak, concludes a new report by Standard & Poor's Insurance Rating Services.

"This industry is in strong financial condition," observed Steven Dreyer, vp and head of S&P's solvency ratings project. "But our research shows there are a number of companies that do not appear to be strong."

S&P last week released the revised version of its Insurer Solvency Review, which includes ratings of nearly 2,600 life/health and property/casualty insurers based on year-end 1990 financial data. The two-volume review follows a similar report released earlier this year that was based on 1989 data (*BI*, April 22).

The review rates the claims-paying ability of 600 large U.S. insurers and includes "qualified solvency ratings" on another 1,975 companies. Unlike the voluntary claims-paying ratings—for which insurers pay a fee—the qualified solvency ratings are assigned after an analysis of insurer financial data filed with state regulators.

Overall, insurers S&P judged "adequate or better"—those with claims-paying ratings of AAA to BBB or a qualified solvency rating of BBBq—accounted for 87% of the $457 billion in property/casualty and life/health insurance premi-

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Inside

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NOLHGA bid rejected

Guaranty fund association not giving up fight

By JOANNE WOJCIK

LOS ANGELES—The National Organization of Life & Health Guaranty Assns. will ask a California judge to approve its takeover plan for Executive Life Insurance Co. even though Insurance Commissioner John Garamendi rejected the plan last week.

Mr. Garamendi on Wednesday rejected NOLHGA's improved, life insurance industry-backed proposal for the rehabilitation of Executive Life because it "falls short of guaranteeing policyholders the rock-solid protection they deserve."

Earlier last week, NOLHGA had bolstered its bid to take over the failed insurer with $1 billion in financial guarantees from 20 large life insurers.

The insurers said they would kick in up to 3% of their capital and surplus if state guaranty funds were unable or unwilling to pay policyholder claims, said James Jackson, vp of Transamerica Occidental Life Insurance Co. of Los Angeles, one of the 20 insurers agreeing to participate in the plan.

In addition, Morgan Guaranty Trust Co. of New York agreed to provide NOLHGA with a $100 million line of credit.

The guarantees were included in NOLHGA's response to nine financial and legal concerns outlined by Mr. Garamendi when he conditionally accepted the organization's buyout proposal late last month (*BI*, Oct. 28).

At the time, Mr. Garamendi said that the NOLHGA offer, which would pay policyholders 89 cents on the dollar for amounts not covered by guaranty funds, would guarantee a higher return for policyholders than any of the other eight bids submitted.

However, the commissioner last week said "NOLHGA was unable to eliminate the many risks and uncertainties inherent in this experimental venture.

"While I appreciate the life insurance industry's unprecedented cooperative campaign to salvage Executive Life, their proposal falls short of guaranteeing policyholders the rock-solid protection they deserve," Mr. Garamendi said during a press conference last Wednesday in Los Angeles.

The commissioner added that the nine conditions that he outlined on Oct. 24 were intended to ensure that NOLHGA's bid met two fundamental objectives:

- That it not impair in any way the ability of its member guaranty funds to meet their responsibilities to policyholders under the Executive Life "policyholder enhancement agreement" that the funds already have signed.

California regulators and the guaranty fund group agreed last summer that Executive Life poli-

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London insurers to stick with asbestos center

By CAROLYN ALDRED
and STACY ADLER GORDON

LONDON—The Center for Claims Resolution is changing its claims sharing formula as a result of a controversial British court ruling that reinsurers can refuse payment for asbestos claims settled by ceding underwriters under the Wellington Agreement.

As a result of the change, most London underwriters will remain members of the CCR—the successor to the Asbestos Claims Facility formed under the Wellington Agreement—despite fears that the July court ruling would prompt many London insurers to withdraw.

About 60% of London underwriters so far have agreed to remain CCR participants, according to Phil Frost, manager of the asbestos department at London Market Claims Services Ltd. The LMCS provides asbestos claims information to most London underwriters.

The LMCS is asking the remaining 40% whether they will continue to participate, Mr. Frost said.

"We are changing our sharing formula for a number of reasons," including the British court decision, said CCR President Lawrence Fitzpatrick.

Formerly, each producer member and its insurers and reinsurers paid a fixed percentage of all claims paid by the center, he explained. Under the changes, producers will only pay for settlements of claims in which they are actually named. As a result, reinsurers would only pay for claims that name producers insured by their ceding companies, he said.

London underwriters have questioned whether they could remain members of the CCR following a High Court ruling earlier this year in a dispute between Lloyd's of London underwriters Richard Outhwaite and Robert Hiscox.

In that dispute, the court ruled that a reinsurer could refuse to pay all claims settled through the now-defunct Asbestos Claims Facility if a ceding underwriter had not obtained the consent of the reinsurer before joining the facility (*BI*, July 22).

In addition, the court ruled that reinsurers have the right to refuse claims by ceding underwriters when the cedant had no legal obligation to make the underlying payment, despite the "follow-the-settlement" clause in the reinsurance contract.

Although Lloyd's syndicate 33, managed by Roberts & Hiscox Ltd., had advised its reinsurer, syndicate 317/661, managed by R.H.M. Outhwaite (Underwriting Agencies Ltd.), of its intention to join the Asbestos Claims Facility, Justice Evans in the July decision ruled that the Outhwaite syndicate did not have to reimburse syndicate 33 for payments made on behalf of asbestos producers that

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Storm toll is $60 million

Commercial lines exposures escape brunt of damage from Oct. 31 storm

By MICHAEL SCHACHNER

NEW YORK—The powerful Halloween storm that battered portions of the East Coast took much less of a toll on commercial and marine insurers than Hurricane Bob.

Personal lines insurers, however, weren't so fortunate. Beachfront homes, autos and other personal property were hit hard by the Oct. 31 storm, though overall insured losses were much smaller than those caused by the August hurricane that clobbered New England.

The Rahway, N.J.-based Property Claims Services division of the American Insurance Services Group estimates that the storm, which it designated Catastrophe No. 90, caused approximately $60 million in insured damage.

The original estimate for insured damage caused by Hurricane Bob was reduced to $620 million from $780 million by the Property Claims Services division following a second survey of insurers (*BI*, Sept. 2; Aug. 26).

Losses to residential property and personal automobiles from the Oct. 31 storm account for more than 75% of total insured losses, according to insurers and brokers in the hardest-hit areas: the shorelines of Massachusetts, Maine and Long Island, N.Y.

But losses could have been far worse for personal lines insurers if flood damage, which comprised much of the property damage, was insured. Flood damage is usually either uninsured or covered by the federally underwritten National Flood Insurance Program.

Insurers gave several reasons why they avoided the large-scale marine losses that accompanied Hurricane Bob. Almost all pleasure craft had already been placed in storage for the season, and com-

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AP/Wide World Photo

Richard Gallagher of Scituate, Mass., carries his daughter's doll house from what remains of his home after the New England storm.

Agency bans curb on non-admitted foreign insurers

California regulator to seek new rule

By MEG FLETCHER

SACRAMENTO, Calif.—A state oversight agency has thrown out a California Insurance Department emergency rule that set financial and reporting standards for non-admitted insurers outside the United States.

The Insurance Department vows to seek reinstatement of the rules through other channels.

Representatives of surplus lines insurers and brokers say they generally support stricter financial standards, designed to weed out insolvent or bogus non-admitted insurers (*BI*, Oct. 14).

And, many predict that California will eventually adopt some type of regulation to protect buyers from doing business with shaky non-admitted insurers.

The current version of the Insurance Department's controversial regulation—Section 2174—had been in effect since July 1 on an emergency basis.

However, the state Office of Administrative Law, which reviews rules drafted by California state agencies, on Oct. 28 refused to allow the Insurance Department to readopt the regulation on an emergency basis for another 120 days.

The regulation required surplus lines brokers to place business only with those non-admitted insurers outside the United States that had a minimum of $5.4 million in combined capital and surplus, as well as $5.4 million in a separate U.S. trust fund composed of highly liquid assets, excluding letters of credit.

The regulation also required a non-admitted non-U.S. insurer to file with California regulators information about its operations, including annual reports, audits and examinations conducted by regulators in its home country.

Previously, there were no state-established minimum financial standards in California for non-admitted insurers based outside the United States. The security committee of the Surplus Lines Assn. of California, a self-regulatory group, would screen these insurers to assess their financial security.

The OAL denied the Insurance Department's request to extend the emergency regulation because the

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Second-hand smoke suit filed

By CHRISTINE WOOLSEY

MIAMI—Seven flight attendants seeking $5 billion in punitive damages from tobacco companies for failing to warn them of the dangers of second-hand smoke face an uphill battle, attorneys say.

The plaintiffs, whose suit seeks class-action status on behalf of 60,000 flight attendants, will have difficulty proving that exposure to second-hand smoke from passengers' cigarettes is the primary cause of any ailments, some attorneys say.

And, the suit may not legally constitute a class action, they add.

The plaintiffs claim they are suffering from lung cancer and other diseases as a result of their exposure to smoke during years of working for airlines before Congress outlawed smoking on flights in the 48 contiguous states in 1989.

The suit, filed Oct. 31 in Dade County 11th Judicial Circuit Court in Miami, seeks unspecified compensatory damages and $5 billion of punitive damages.

Defendants named in the suit include Philip Morris Inc. of New York; RJR Nabisco Inc. of New York, the parent of R.J. Reynolds Tobacco Co.; Loews Corp., the New York-based parent of Lorillard Tobacco Co.; American Brands Inc. of Greenwich, Conn., which owns American Tobacco Co.; Brooke Group Ltd. of Durham, N.C., which owns Liggett Group Inc.; and Dosal Tobacco Corp. of Miami.

This is the first suit charging tobacco companies with responsibility for health problems from second-hand smoke, said Richard Daynard, chairman of the Washington, D.C.-based Tobacco Products Liability Project, a non-profit organization that encourages lawsuits against tobacco companies.

"Cigarettes should be illegal," asserts plaintiff's attorney Stanley M. Rosenblatt, of Stanley M. Rosenblatt P.A. in Miami, who represents the flight

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Medicare eligibility

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measure how a lower Medicare eligibility age would affect employers' health care expenditures—come as companies are trying to reduce their retiree health care obligations in light of the new FASB rule (see story, page 6).

That rule, officially known as Financial Accounting Standard 106, will, among other things, require employers to recognize accrued retiree health care liabilities on their income statements. Liabilities that have accrued at the time the rule takes effect can be reported immediately or amortized over 20 years.

For many companies, those liabilities are enormous and threaten to clobber equity and earnings.

One example is General Electric Co. which earlier this year took a $1.8 billion charge against first-quarter earnings to recognize accumulated retiree health liabilities. That move, made in response to the FASB rule, turned what would have been a $999 million profit in the quarter into an $801 million loss (*BI*, Sept. 23).

Some employers with generous retiree health care plans contend that reducing the Medicare eligibility age would more equitably spread retiree health care costs among all taxpayers.

"We would support expanding the Medicare program. It is a burden that should be more evenly distributed," said Walter B. Maher, director of federal relations for Chrysler Corp. in Washington, D.C.

Lowering the eligibility age is "a better way for the economy to finance health care," Mr. Maher said.

But benefit lobbying organizations aren't ready to endorse the move.

They warn that an expanded Medicare program could mean more cost-shifting by medical providers to employer-sponsored health care plans that cover active employees. Benefit lobbyists also worry about the additional cost—in the form of higher payroll taxes on both employers and employees—that would be needed to support an expanded program.

Lowering the Medicare eligibility age to 60 would cost the Medicare program $9 billion during the first year, with future costs depending on the rate of health care inflation, estimates the Employee Benefit Research Institute, a Washington, D.C.-based benefits think tank.

Rep. Rostenkowski in his legislation, H.R. 3205, would finance the reduction in the Medicare eligibility age through gradual increases in the Medicare portion of the Social Security payroll tax. That tax —which is paid by both employers and employees—would increase to 1.65% of the first $200,000 of wages from the current 1.45% of the first $125,000 of wages.

Rep. Rostenkowski also proposes a slew of other new taxes to finance a new public program for the uninsured.

His proposal to reduce the Medicare eligibility age puts businesses and their benefits lobbying organizations in a difficult position, Washington observers point out.

Some businesses—those with generous retiree health plans and big FASB liabilities—would be clearly helped by the Rostenkowski proposal. But others—those that offer no retiree health care benefits or have few retirees—would end up paying higher Medicare taxes while reaping few direct benefits.

"It is not surprising that a reform proposal like this one receives mixed views. Employer positions are determined by their own situations," noted EBRI Research Director Bill Custer.

"Companies with retiree health plans and big costs would have one view. Employers with a young workforce or no retiree plan would have another view," he explained.

"Employers are very mixed on the issue. Where you stand depends on where you sit. If you have an older workforce, the relief would be very favorable. If you don't have a plan, you end up paying a big tax," said Howard Weizmann, executive director of the Assn. of Private Pension & Welfare Plans in Washington, D.C.

Some fear that lowering the Medicare eligibility age would exacerbate the shifting by hospitals and physicians of costs not covered by Medicare to employer health plans that cover active employees.

Cost shifting occurs, employers and insurers contend, because Medicare does not reimburse the actual cost of medical services. As a result, hospitals and physicians inflate charges for patients covered under employer-sponsored plans, business groups argue.

Cost shifting would increase if Medicare were expanded and millions of beneficiaries were added. EBRI estimates that lowering the eligibility age to 60 would add about 5 million people to the 33 million retirees and disabled individuals now covered by Medicare.

"There is a concern about hospitals and physicians shifting costs" to employers' plans, said Rick Smith, director of public policy at the Washington Business Group on Health.

"The costs won't go away. There is no such thing as a free lunch," said Mark Ugoretz, president of the ERISA Industry Committee, a Washington, D.C.-based benefits lobbying group representing large employers.

Others worry that if the Medicare program were expanded, employers could be hit twice: once through higher payroll taxes and a second time if Congress decided to require employers, whose retiree health care liabilities were cut by the lowering of the eligibility age, to give additional benefits or cash to retirees.

There is a precedent for such a step. The Medicare Catastrophic Coverage Act passed by Congress in 1988, which expanded Medicare benefits, included a maintenance of effort provision.

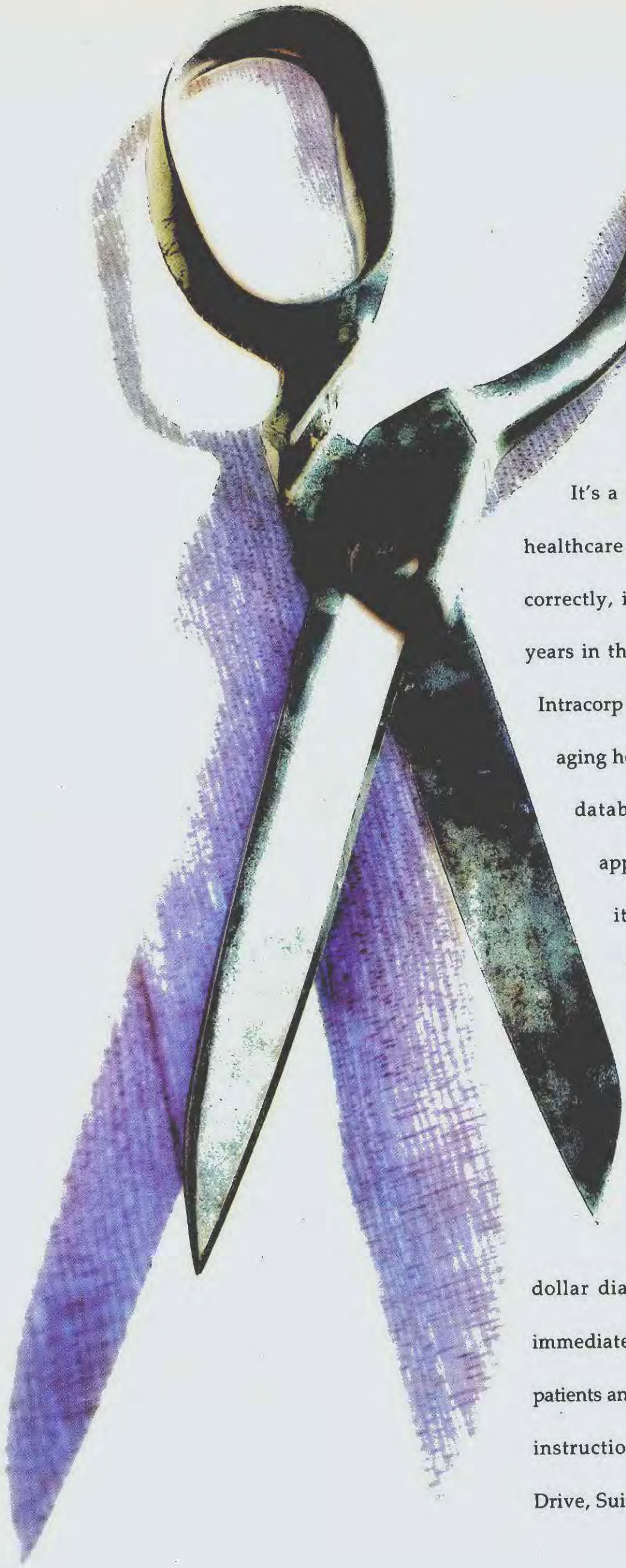
This provision required employers to give retirees additional health care benefits or their equivalent in cash for savings employers racked up in 1988 and 1989 after they eliminated retiree health care benefits that were duplicated by an expanded Medicare program.

The maintenance of effort provision ultimately lasted one year because Congress in 1989 repealed the entire Medicare Catastrophic Act after intense lobbying by middle- and upper-income retirees who didn't want to pay the higher taxes needed to finance expanded Medicare benefits.

The Rostenkowski bill currently does not include a similar maintenance of effort provision. But that's little comfort, benefit lobbyists say, noting that the 1988 provision was tacked on to the Medicare Catastrophic Act following lobbying by labor groups.

At last week's congressional hearing, labor organizations strongly endorsed lowering the Medicare eligibility age. A lower eligibility age would give greater health care protection to all retirees and spread out costs more equitably among employers, they testified.

The lower eligibility age "would represent a significant step toward assuring access to adequate health care services for all retirees. In addition, these provisions would help to reduce the competitive inequities being experienced by older companies with large retiree health care costs," said David Hirschland, assistant director of the United Auto Workers union's Social Security Department in testimony submitted to the subcommittee. ■



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INTRACORP

Westinghouse alters retiree health benefits

Westinghouse Electric Corp. is capping health care benefits for future retirees and dependents not eligible for Medicare who do not agree to help fund these costs.

However, Westinghouse will continue to offer full retiree health care benefits for future retirees who contribute to a special fund.

The strategy will help reduce the Pittsburgh-based manufacturer's obligations under the Financial Accounting Standards Board's Statement 106, according to Edwin Goff, Westinghouse's director of total compensation management.

Under FAS 106, which takes effect in 1993 for larger employers like Westinghouse, companies will have to accrue as an expense against earnings their retiree health care liabilities from the date the employee is hired until the employee is eligible for benefits. Differences between accrued and actual expenses also will have to be recognized on balance sheets.

Benefit beat

Under the plan, which will begin Jan. 1, Westinghouse will cap the maximum annual amount of health care benefits for individual future retirees not eligible for Medicare at $5,300. The maximum benefit for a pre-Medicare retiree with one dependent will be $7,600 per year, while the benefit for a retiree with two or more dependents will be capped at $9,600 per year.

Medical benefits for current retirees and those who retire before the end of the year are not affected by the caps. And the caps will not affect future retirees eligible for Medicare.

About 70,000 active Westinghouse employees will be able to limit their liability for costs exceeding these maximums by contributing to a personalized Retirement Health Care Security Fund until they retire.

The fund—which is set up as a 501(c)(9) trust, or voluntary employee beneficiary association—can be used by retirees not yet eligible for Medicare to pay any uncovered medical expenses, like deductibles. And for those employees who reach age 65, unused contributions to the fund can be used to pay for Medicare Part B premiums.

However, Westinghouse has agreed to accept the amount accumulated in an individual's fund as full payment for all expenses exceeding the new caps, even if that expense exceeds the amount held in the fund.

If a retiree's expenses exceed the cap but do not exceed the amount in the fund, the retiree can use the leftover funds for other medical expenses. If the retiree dies before the fund is depleted, the money is paid as a lump sum to his or her survivors. Employees who contribute to the fund and then leave the company receive their contributions to the fund as a lump-sum severance payment.

Employees that decide to contribute to the fund during a special November enrollment period will have to pay $15 per month until retirement. Contributions will be much higher for those who join later.

For example, a 50-year-old employee who joins the prefunding program after the special offer has expired could pay as much as $100 per month, depending on actuarial assessments, Mr. Goff said.

While the caps will allow Westinghouse to control future liabilities under FASB, they also offer employees an incentive to keep medical costs down so they can retain the money in their accounts, said Mr. Goff.

"FASB forced us to recognize the reality that we have committed to providing future benefits at a significant cost. For that, FASB is good," said Mr. Goff.

"But what we really hope to accomplish through this is controlling costs. The caps, which will only come into play after the year 2000 if inflation is kept below 10%, are designed as an incentive for everyone to manage costs. It's a way to control expenses without sticking it entirely to the employees," he explained.

Westinghouse's pre-65 retiree medical costs increased 21.6% to $62 million in 1990 from $51 million in 1989.

Currently, Westinghouse spends an average of $2,250 per year on health care costs for a single retiree who is not yet eligible for Medicare.

One of the first companies to implement a retiree medical pre-funding plan was American Airlines Inc. (*BI*, Dec. 4, 1989).

Other companies also are attempting to cap their FASB liabilities. For example, Media General Inc. and General Electric Co. have announced they will begin capping the amount they contribute to retiree medical plans (*BI*, Sept. 23).

Separately, Westinghouse said it will reduce its basic post-retirement life insurance benefit for all new employees to a flat benefit of $7,500 from 66% of salary.

All current retirees and active employees are unaffected by the life insurance change.

—By Michael Schachner

Flexible benefits

Fewer than one-third of small businesses offer flexible benefit programs, a new survey shows.

However, the 31% of the companies responding to the survey that offered flex plans are more likely than other companies to offer dental coverage, health maintenance organizations, preferred provider organizations and wellness programs than small businesses without flex plans.

The survey by Grant Thornton, the New York-based accounting and consulting firm, is based on the responses of 1,825 companies with fewer than 500 employees.

Nearly 85% of the small companies surveyed offered major medical coverage to their employees and 82% offered hospitalization coverage, whether or not they offered a flex plan.

Dental coverage was offered by 74% of the companies with flexible benefit plans, but by only 57% of the companies without flex plans.

HMOs were offered by just more than half—52%—of the companies with flexible benefits, but only 27% of companies without flex plans. Likewise, while PPOs were offered by 41% of the companies with flex plans, only one-fourth of the companies without flex plans offered PPOs.

One-fifth of the companies with flex plans offered wellness programs, compared with only 8% of those without flex plans.

Vision and hearing programs were offered by one-fourth of companies with flex plans but by only 18% of those without them.

While companies with flex plans offer more benefit options, small businesses with flex plans spend a slightly smaller percentage of total payroll costs on employee health care programs than employers without flex plans. Health care costs for employers with flex plans comprised 7.5% of payroll, compared with 7.9% for those without.

For a free copy of the survey, write to Liz DeIuliis, Grant Thornton Public Relations, 605 Third Ave., New York, N.Y. 10158.

—By Sara J. Harty

Whose Head Is It Anyway?

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Opinions

Pennsylvania wake-up call

LAST WEEK, THE BUSH administration took a big step by calling health insurer executives and health care provider representatives to Washington, D.C., for a health care "summit."

During the meeting, the participants agreed that health insurers and providers should attempt to reduce health care costs through the development of an electronic claims filing system (see story, page 1). Health and Human Services Secretary Dr. Louis Sullivan said a "paperless" health care claims systems could cut administrative costs by at least $20 billion a year.

Yes, it was a big step. But was it big enough, especially in the eyes of the 34 million Americans without health insurance?

The answer, unfortunately, is no.

An electronic health care claims system would be a great step forward for the employers that pay a huge chunk of the nation's medical bills. But it's time for all, especially the Bush administration, to concede that such relatively small fixes will not bring skyrocketing health care costs under control or extend coverage to the nation's uninsured.

Four and a half years ago, Sen. Edward M. Kennedy, D-Mass., introduced what was then considered a radical proposal that would require employers to offer health care benefits to their workers.

Since then, other members of Congress—mostly Democrats but also some Republicans—have introduced other proposals that would improve access to the health care system. The proposals include employer mandates or "play or pay" proposals, like legislation now backed by the Democratic Senate leadership; proposals that would give small businesses incentives to purchase affordable, basic health care coverage; and, of course, proposals that would establish a single-payer health care system modeled after the Canadian program.

In fact, more than two dozen proposals to expand health care access to some or all of those 34 million Americans are pending in Congress. Hardly a week goes by without some congressional committee or subcommittee holding a hearing on one of those proposals.

However, the outlook for major changes in the health care system, despite all of this interest, still is bleak.

As House Ways and Means Committee Chairman Daniel Rostenkowski, D-Ill., who has introduced two health care reform proposals this year, said during a recent speech in Chicago: Congress will take no action on health care reform "until the man at 1600 Pennsylvania Ave." comes up with a proposal.

We couldn't have said it better. With a wide spectrum of health care access proposals on the table, there can be no consensus until the White House acts.

And while the health care summit last week was

a sign that the Bush administration may be beginning to stir from its nearly three-year slumber when it comes to health care reform, targeting administrative savings or reforming the medical malpractice system—while good ideas—will not get the job done.

While the need for reform has not spurred the administration to action, political realities might.

The victory of Democrat Harris Wofford over heavily favored Richard Thornburgh, the former Bush administration attorney general, in last week's Pennsylvania Senate race likely will send the message that so far has fallen on deaf ears at the White House: Americans want to see changes in their health care system.

Sen. Wofford, who was appointed to the Senate earlier this year following the death of Sen. John Heinz, is an unabashed supporter of a Canadian-style single-payer health care system. Mr. Thornburgh did not have a health care agenda, though he did call Sen. Wofford's ideas "communistic."

Republican political strategists last week conceded that the party and the administration may be overlooking the importance of health care reform. We agree.

No major action likely will be taken on health care reform in Congress in the next year. Election years are not the time for such major decisions. However, election years are the time for politicians—including presidents—to take a stand on difficult issues.

Thirty-four million Americans have not been able to attract President Bush's attention to the problems in the health care system over the past three years. Maybe the nearly 2 million Pennsylvanians who voted for Sen. Wofford last week will be more successful.

At issue

Do you have a modified duty program for workers injured on the job?

William T. Knickerbocker
Director of Risk Management and Employee Benefits
School District of Kansas City,
Kansas City, Mo.

No, but not because I don't want one. The programs are almost necessary in today's market to keep workers comp costs down. One obstacle I have faced is unions that want workers to get full salary for doing what may be half their usual work. The programs can also create a morale problem among other employees who think, 'John is just sweeping floors while we do his work.'

Richard Gasowski
Risk Manager
City of Caspar,
Caspar, Wyo.

We do not have a light-duty program, but we do utilize a work-hardening program. These programs combine physical and occupational therapy over a period of four to six weeks to help the injured workers tone up, build strength and improve their diets. The therapists also perform functional capacity evaluations that add an objective measure to injured workers' complaints.

Patrick T. Cabulagan
Risk Manager
Jackson County,
Medford, Ore.

Because of relatively few time-loss claims, we have not had much opportunity to use our early return-to-work program, but I am convinced that an effective return-to-work program is a means to reduce workers comp costs. By getting injured workers back to work, money is saved that would have been spent on time-loss payments, training costs and extra-help costs.

Compiled by Sara Hardy

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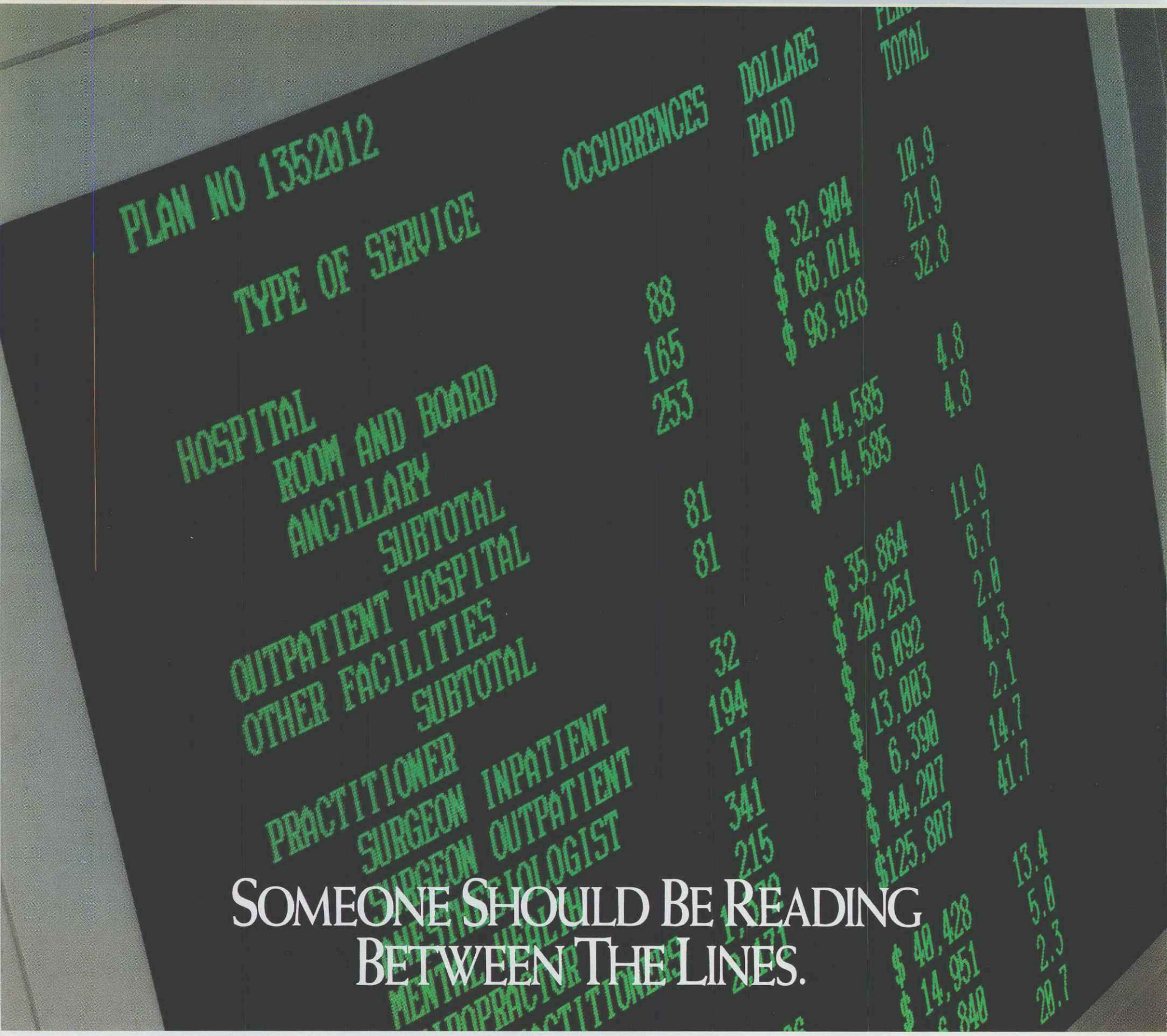

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Curbing rising workers comp costs

Use case management techniques: Expert

By CHRISTINE WOOLSEY

TORONTO—Applying case management techniques to workers compensation claims can produce a bundle of savings for employers faced with dizzying workers comp cost increases, says a disability manager for a large employer.

In addition, periodic audits of workers comp claims administrators can reap significant savings, she adds.

"Our goal is to return employees to work as soon as it is medically appropriate, whether they have a work-related or non-work-related illness or injury," said Elizabeth M. Solem, manager of disability programs and unemployment compensation at Minnesota Mining & Manufacturing Co. in St. Paul, Minn.

3M has taken a number of steps to better manage its workers compensation claims, Ms. Solem explained during a session at the 10th annual International Society of Certified Employee Benefit Specialists symposium held last month in Toronto. "Our mission in the disability group is to ensure employees receive proper benefits under whichever program they are injured," she said.

In the early 1980s, 3M decided that the employee benefits department—rather than the risk management department—should oversee workers comp cases because benefits were not being processed efficiently enough, Ms. Solem said.

"Workers compensation cost the company about $25 million in 1990," she pointed out. In addition, the company spends about $27 million for short-term and $3.5 million for long-term disability benefits annually, she said, noting that the short- and long-term disability costs do not include offsets for Social Security or workers compensation.

Because of the huge costs involved, "we wanted to case manage workers comp and disability claims," Ms. Solem said. Claims processing and case management steps should be the same for all injuries and illnesses, whether or not they are work-related, she explained.

In fact, the similarity between workers compensation and group medical claims lends credence to managing both types of claims within the employee benefits department, she said.

Both involve employee illness and injury and both require medical documentation of diagnosis, treatment and prognosis, she pointed out. And, the duration of an absence from the job should be the same for a workers compensation claimant with a particular malady as it is for a group health care claimant with the same condition.

3M's benefits department includes in-house case managers with workers comp and rehabilitation expertise, Ms. Solem said. The case managers cover four geographic territories in which 3M employees are located and help injured and ill employees receive the most appropriate and cost-effective health care in their area.

In addition, the company uses in-house attorneys with workers comp expertise to help negotiate settlements between the company and injured employees and to oversee any outside legal work, she said. The in-house attorneys also help 3M keep abreast of hazardous exposure issues, since some of the company's workers are exposed to chemicals at work.

Attorneys and rehabilitation supervisors also work closely with plant supervisors regarding any changes that may need to be made to the plant or its equipment in light of the Americans with Disabilities Act, a comprehensive antidiscrimination law that becomes effective for many employers next July.

"We have to be cognizant of different state disability laws, as well as the ADA," Ms. Solem pointed out. However, she said, "our message is (that) we should not fear the ADA. We have some good practices in place, and we should use them consistently" from plant to plant.

Ms. Solem said 3M has also seen a recent increase in stress-related workers comp claims.

"We have cases of people being off work for weeks at a time. Psychiatric reviewers, who retrospectively review these cases, tell us that, unfortunately, their colleagues don't consider returning to work a treatment goal," she said.

But returning to work is the goal of 3M's disability management process.

The benefits department—with the help of the employee's physician—makes decisions about when the employee will return to work, regardless of whether the injury is covered by workers comp or the group medical plan, Ms. Solem explained.

"Supervisors do not have this authority and they have to learn that they don't," she said, adding that supervisor training is a big part of the company's disability management program.

The 3M program emphasizes five basic steps:

- Maintaining regular contact and communication with disabled employees, including listening to them and demonstrating concern for them. Daily contact is recommended.
- Knowing and understanding the nature of the employee's disabling condition and how long it is likely to last.
- Knowing the physical requirements of the employee's job and documenting those demands. This helps 3M communicate job requirements to an injured employee's treating physician and modify job requirements to fit a worker's physical capabilities and limitations.
- Knowing the employee's current physical capabilities and limitations and how long any limitations are likely to last. The program attempts to provide productive work to meet disabled employees' physical capabilities, including light-duty job assignments.
- Communicating and cooperating with the disabled employee's health care provider. This involves explaining to the employee's physician 3M's objective of returning the disabled employee to work early and safely. It also entails communicating benefits to the em-

Continued on next page

Continued from previous page
ployee.

"This is not brain surgery," Ms. Solem said. "But because of the ADA, these steps are really important."

3M hopes to create a data base that will link group health and workers comp claims—as well as safety department data—for detailed analysis. "We want an integrated data base with work-related and non-work-related illnesses or injuries so our medical department can do epidemiological studies" on the causes behind such illnesses, she explained.

In addition, "management wants to know how much we are paying for car accidents or employee accidents related to alcohol," which also could be culled from such a data base, she said.

A computer system that links group health and workers comp data to the safety department could help the company set up preventive health and safety programs, she added.

3M also wants to create a state-of-the-art workers comp/disability claims administration system that incorporates cost management strategies used by group health claims administrators, Ms. Solem said.

Currently, the company uses a number of different TPAs to administer workers comp claims and is demanding that specific services be provided by them.

Among other things, 3M wants "to make sure the claims administrator does not pay a nickel more for workers comp claims in states with fee schedules," Ms. Solem explained. "Not all TPAs make sure this happens."

In addition, workers comp claims administrators should provide utilization review services—or let the employer choose its own UR vendor. Back injury cases, in particular, can benefit from UR, she said. Utilization reviewers should be sure any recommended procedure is medically appropriate; should verify whether an inpatient stay is necessary; should be sure office visits are included in surgical procedure fees; should monitor the complexity and number of outpatient visits; and should make sure providers are not unbundling services to make more money, Ms. Solem advised.

"If you are visiting a TPA and have not seen how a denied claim is handled, ask to see one," she recommended. TPAs that do not handle claims denials fairly are setting up employers for a problem with adversarial claims, she noted. "The terse messages that some TPAs send to employees make it sound like the employer and the TPA have no intention of giving an employee any benefits. Communication is a big issue."

Employers also should examine the speed with which their TPAs handle claims, Ms. Solem said. "If they are shooting them out really fast, they may not be looking at them closely enough. On the other hand, if they are too slow, you may hear complaints from doctors and employees."

And, she said, employers should request detailed reports from their TPAs about utilization and costs. "Don't let them give you data in three buckets: medical, indemnity and other," for example, Ms. Solem said.

"We found that the 'other' category contained legal fees, rehabilitation and other charges that we would have liked to see broken out," she said.

"We aren't looking for the TPA with the lowest price," Ms. Solem stressed. On the contrary, 3M is willing to fairly compensate TPAs that provide the services the company is looking for.

"The best vendor is the one that listens" to the company's requirements, she said.

Richard W. Flynn, practice leader at The Wyatt Co. in Philadelphia, moderated the session. ■

Optimize existing controls on costs: Consultant

By CHRISTINE WOOLSEY

TORONTO—It's often easier for a person to buy new clothes than lose weight.

Employers face a similar temptation when it comes to adding new health care cost control programs, says an employee benefit consultant.

"Adding new cost containment programs is easier than trying to make existing programs more effective," said Helen Darling, principal and senior consultant in the health care practice of William M. Mercer Inc. in Stamford, Conn.

But, she said, since so many employers are already paying for cost containment programs, it makes sense to make sure that existing programs are running as efficiently as possible before adding a new one.

Ms. Darling spoke during a session of the International Society of Certified Employee Benefit Specialists symposium last month in Toronto.

"There is a tendency to want to try a new program because it is being touted in the mass media," she warned. For example, chief executives were eager to try on-site fitness centers after CEO heart attack trends were identified.

But such new programs may not be suitable to a particular workforce, said Ms. Darling. "You have to look at your own experience and utilization data to see how such a program would benefit your company. Look at such a program's effects over the long haul: Will it be cost-effective over the long term or is it just a passing fad?"

Employers have taken many steps to control costs, including plan design changes that give employees financial incentives to purchase health care wisely, managed care networks and utilization review. Despite these efforts, corporate health care costs have continued to head skyward.

Employers should not give up on these programs, however, Ms. Darling said. Rather, they should try to get more value out of what they spend on health benefits and make sure they are getting the best bang for their buck from cost containment vendors.

"Pursue all possible administrative economies," Ms. Darling advised.

As an example, she said employers should conduct claims audits and medical management audits of their utilization review programs. "I have a client who pays $2 million per year on utilization review. We did an audit and found that the program was below average," she explained. "It would have been easier to get another program, but since they are already paying, we wanted to try to make that UR program more effective."

Among other things, employers should make sure their UR program requires mandatory precertification of outpatient procedures, she said.

Ms. Darling advised employers to concentrate their UR efforts on surgical operations and expensive diagnostic procedures like computerized axial tomography tests—

Continued on next page

Cost containment

Continued from previous page

CAT scans—and magnetic resonance imaging tests—MRIs.

"You may end up paying thousands to investigate whether a series of headaches is a problem," she said. "Outpatient precertification can make sure these tests are necessary."

Employers also should closely monitor the results of their utilization review programs, she said. "If something doesn't work, take it out." Some employers, she noted, are dropping mandatory second surgical opinions because they haven't saved much money.

However, not all programs that don't produce big savings should be dropped.

"You may find a program isn't cost-effective, but you may want to keep it anyway," said Ms. Darling. For example, banks—which typically employ many women of child-bearing age—may want to put in a high-risk pregnancy program even though there are no perceived problems. Such a program may cost the employer money, but it is great for employee relations, she said.

The bottom line is that health care should be managed like any other major purchase, says Helen Darling of William M. Mercer Inc. 'You've got to counteract the blank check mentality in every possible way,' she says.

Case management programs also should be examined to be sure they are achieving maximum savings, Ms. Darling said. "Case management does save money—from as little as $2 per $1 invested to as high as $14 per $1 invested. And, it also offers a real benefit" by making sure individuals receive the most cost-effective and appropriate care.

Employers should make sure the criteria a case must meet in order to be managed are not so narrow that cases that should be managed are rejected, Ms. Darling explained. Conversely, case management criteria must not be so loose that every case is managed, she said.

In addition, she said, employers should not be concerned with just controlling medical costs for individuals with catastrophic conditions.

As an example she cited the case of a teen-ager with a brain injury who incurred treatment costs of $600,000. That figure included medical treatments, rehabilitation and education. "His parents didn't check into this, but in that state the school system had an obligation to pay for the educational component of his care," Ms. Darling explained.

Companies with managed mental health programs and employee assistance programs should try to tie those programs together to increase efficiency, Ms. Darling said. And, she noted, "the old EAP is not the new EAP. Your program may not be as effective a cost manager as you'd like, even though it's doing wonderful things."

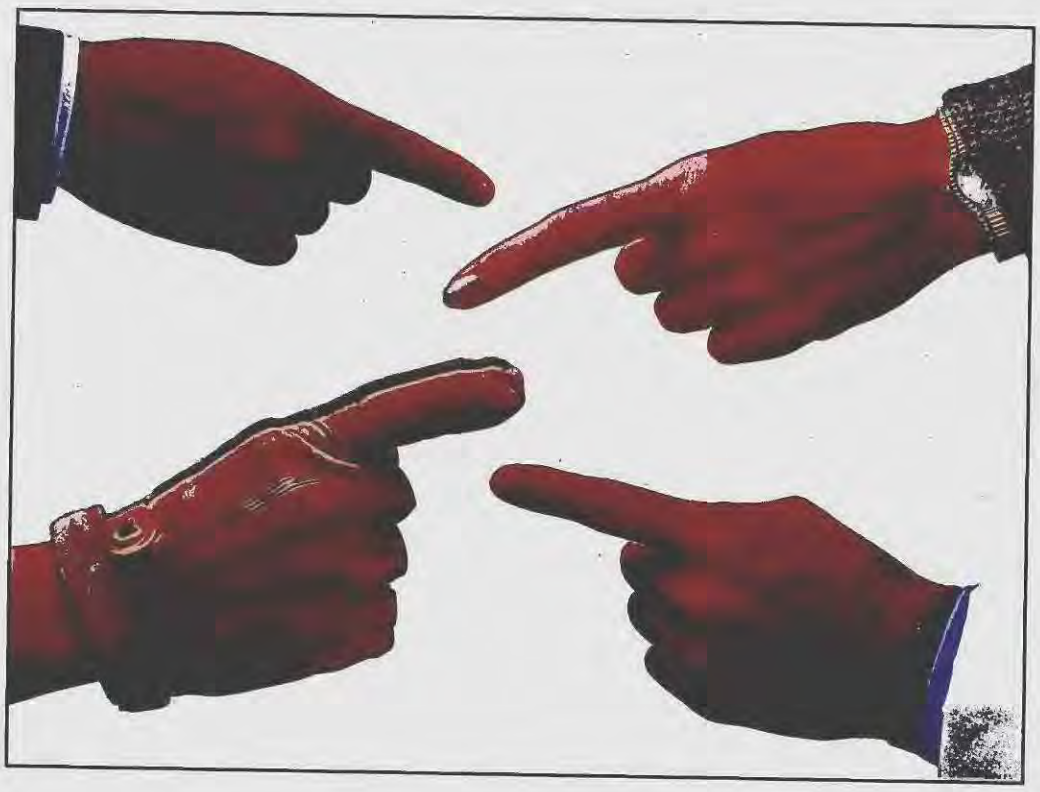
To maximize EAP efficiency, make sure counselors deal with problems that are becoming serious in individual employees' communities. Problems with stress, for example, became prevalent in one community facing large layoffs. But employees were seeking help from costly psychiatrists because their EAP did not address employee stress due to layoffs or job insecurity.

The bottom line is that health care should be managed like any other major purchase, Ms. Darling said. "You've got to counteract the blank check mentality in every possible way."

And, employers should be choosy when selecting cost containment vendors, like UR firms. "Quality and efficiency will be high variables, so select and monitor these firms carefully," she said.

"Think of case management and cost containment as something akin to trench warfare in World War I—you have to do an awful lot to gain an inch," Ms. Darling concluded.

Moderating the session was H. Kurt Howeler, group manager at the Bellevue, Wash., office of New York Life Insurance Co. ■



Everyone knows exactly who's responsible for the health care crisis.

What may be even worse than the skyrocketing cost of health benefits is all the finger pointing that goes with it.

It sometimes seems as though many people believe that fixing blame will somehow fix the problem. Meanwhile health care costs continue their upward spiral.

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Containing mental health benefit costs

By CHRISTINE WOOLSEY

TORONTO—Employers should review the design of their mental health and substance abuse benefits to ensure the plans do not encourage employees and dependents to seek the most costly care, says a benefit consultant.

Employers also should examine the outcomes of mental health and substance abuse treatments to make sure that providers are treating patients safely and effectively, she adds.

These precautions are necessary because mental health and substance abuse benefits have become a more costly component of employers' overall group health care costs, said Suzanne Gelber, a consultant with TPF&C, the benefit consulting division of Towers, Perrin, Forster & Crosby Inc. of New York.

"The health care trend of 20% to 25% premium increases we are seeing each year contains an increase in the use of mental health and substance abuse benefits by employees and dependents," Ms. Gelber said during a session at the 10th annual International Society of Certified Employee Benefit Specialists symposium held last month in Toronto.

Several years ago, "cost increases were about 3% to 5% for mental health and substance abuse benefits. Now we are seeing increases of 10% to 20%, and those benefits are consuming from 10% to 20% of all the health care dollars spent by employers," she explained.

Ms. Gelber said traditional benefit designs tend to reimburse mental health services like any other group health benefit—often contributing more for inpatient than outpatient care.

"Providers and patients very quickly figured out they could get more benefits" for inpatient services, and that has helped fuel the current cost crisis in mental health and substance abuse care, she said.

In some cases, "up to 50% of all inpatient treatment costs" are associated with mental health and substance abuse treatment, said Ms. Gelber, noting that the average cost of an inpatient stay could reach $8,000 to $12,000.

However, she pointed out, a very small group is responsible for racking up those costs. "Only about 5% to 6% of employees ever access this benefit over their lifetimes, so the problem of increased costs obviously has to do with" factors like the lengths of stays in treatment centers, she said.

According to Ms. Gelber, adolescent care should be of particular concern to employers trying to corral rising mental health and substance abuse costs.

Admissions for dependents are increasing mental health costs as a whole, and utilization trends show that adolescent care is far and away the leading element pushing up employers' costs, she said.

"It's typical for admission rates for adolescents to be at least twice the rate for adults," she said. "The cost of each stay in a mental health or substance abuse facility is high—usually twice the cost of the average medical care stay, especially in the case of adolescents. If you don't have a report for your claims administrator that breaks out adolescent utilization, you can pretty much predict that admissions, costs and length of stays for adolescents will be twice as high as for adults," she said.

There are a number of reasons why adolescent care is more expensive, Ms. Gelber said. "It's not necessarily that providers are greedy it's that treating children is difficult," she noted.

In addition, more substance abuse treatment is occurring in specialized treatment centers that have "gone out of their way to attract patients—especially adolescents—through advertising on television and in the Yellow Pages," she said.

State benefit mandates requiring fully insured employers to provide drug and alcohol abuse treatment to employees and dependents also have increased costs. Twenty-three states now require employers to provide drug abuse treatment for employees and dependents covered under fully insured employee benefit plans, while 40 states require insured employers to provide alcoholism treatment, according to Ms. Gelber.

Admission rates for adolescents can be 'at least twice the rate for adults,' Ms. Gelber says.

Self-insured employers are immune from state benefit mandates, because the Employee Retirement Income Security Act of 1974 preempts state law. However, they have seen costs associated with mental health and substance abuse treatment increase, too, since most provide some mental health and drug treatment benefits, she explained.

Another factor making cost management difficult is a lack of incentives for employees and dependents to be cost-efficient consumers of mental health and substance abuse services, Ms. Gelber said.

Employees and providers have come to view benefits as an entitlement, she said. "Employees misunderstand benefit plans. They think that because they have a 60-day maximum of inpatient bene-

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fits, they should stay in a facility for 60 days," she said.

In addition, poor plan design not only rewards high-cost care; it also rewards poor-quality care, Ms. Gelber said. Because of poor utilization management, employers end up paying for inappropriate inpatient care.

And poor-quality providers are often the cause of increased expenses, she pointed out. "Two out of three mental health benefit users select providers from the Yellow Pages, and they tend to make poor choices," she said. The problem is exacerbated by the high volume of providers that have sprung up in this lucrative and competitive marketplace.

Managed mental health care has not made much of a dent in costs or lengths of stays, Ms. Gelber said. The often ambiguous nature of mental health and substance abuse problems make them hard to manage, she explained.

For example, while diagnoses have become more scientific over the last three to five years, there is still no agreement on standards of treatment for mental health and substance abuse problems, she pointed out.

That disagreement "leads to great variance in the lengths of stays in different areas of the country," she said.

Managed mental health care providers are proliferating, so employers looking at this option should carefully choose an organization, Ms. Gelber said. These organizations typically help health maintenance organizations, insurers and employers manage their mental health and substance abuse utilization costs, she explained.

Poor-quality providers are often the cause of increased expenses, Ms. Gelber says. 'Two out of three mental health benefit users select providers from the Yellow Pages, and they tend to make poor choices,' she notes.

They offer specialized utilization review, provider networks, claims review and claims-paying services.

Ms. Gelber suggested that employers make sure that any managed care company they contract with:

- Uses a gatekeeper physician to make initial treatment assessments and referrals to specialists.
- Has psychiatric nurses or accredited clinicians conduct utilization review.
- Bases treatment protocols on specific mental health diagnoses listed in the DSM III R—a statistical manual of psychiatric illnesses and treatments.
- Has a high rate—at least 15% to 30%—of referrals made by physician advisers rather than non-medical staff.
- Guarantees an impact on admissions and lengths of stay and provides discharge planning.
- Checks out providers' credentials before contracting with them and updates credentialing annually.
- Has access to a full range of licensed mental health and substance abuse clinicians and programs.

Employers that incorporate this advice into their managed mental health and substance abuse benefit plans have seen encouraging results, Ms. Gelber said.

"With utilization review and case management, you can save 20% to 30% of projected costs. And, with effective use of managed care, you can save 30% to 40% of projected costs," she said.

Most Fortune 1,000 employers use employee assistance programs to help identify social and psychological problems in the workplace, Ms. Gelber noted. However, those programs haven't resulted in significant savings, she said.

Employers that have locations in multiple cities often use more than one EAP, which can lead to increased costs, she said.

"One employer had 90 EAP programs," Ms. Gelber said. "You should know, if you have more than one EAP, who each one is, what it does, how it charges, who sponsors it and how it measures treatment outcomes," she advised.

Susan R. Jenson, a consultant with Coopers & Lybrand-Actuarial, Benefits & Compensation Group in Stamford, Conn., moderated the session. ■

ISCEBS draws more than 380 to symposium

TORONTO—More than 380 people attended the 10th annual International Society of Certified Employee Benefit Specialists symposium, held here Oct. 20-23.

Forty sessions dealt with topics like national health care reform, workers compensation, legislative and legal changes, insurer solvency and managed care.

The ISCEBS is a non-profit association incorporated in 1981. The society's primary objective is to provide continuing education opportunities for those who hold the CEBS designation. Its membership represents all sectors of the employee benefits field: benefit managers, consultants, insurers, trust officers, administrators, attorneys, investment specialists and government regulators.

Future symposia are planned for Nov. 15-18, 1992, in Anaheim, Calif.; Sept. 12-15, 1993, in Washington, D.C.; Sept. 25-28, 1994, in Denver; and Oct. 8-11, 1995, in San Francisco.

For more information, contact the International Society of Certified Employee Benefit Specialists, 18700 W. Bluemound Road, P.O. Box 209, Brookfield, Wis. 53008-0209; 414-786-8771.

—By Christine Woolsey

Oregon health plan could be a model for nation: Expert

By CHRISTINE WOOLSEY

TORONTO—Any debate about adopting a universal health care system in the United States must include a discussion about what basic health benefits will be available, says a professor of public health and preventive medicine.

Oregon's experiment with providing access to basic health care for the state's low-income uninsured offers an example of what health benefits might be guaranteed to U.S. citizens in a universal health care system, he says.

"There is a lot of interest in the Oregon plan," says Michael J. Garland, associate professor of public health and preventive medicine and associate director of the Center for Ethics in Health Care at Oregon Health Sciences University in Portland.

"We want universal third-party coverage for everyone—not necessarily national health care," said Mr. Garland, who is active in the state's health care reform efforts.

A trio of 1989 laws seeks to provide every Oregonian with health insurance (*BI*, March 18).

Medicaid coverage reform, new employer incentives to buy health insurance and a high-risk pool coordinated by the state are the plan's three main ingredients, Mr. Garland said during a session at the International Society of Certified Employee Benefit Specialists symposium last month in Toronto.

"The Oregon effort is trying to coordinate different parts of the health care system so we can eliminate the uninsured without destroying private health insurance," he explained.

Under the plan, the state would eventually require employers to provide certain minimum benefits, but give them the option of offering more, Mr. Garland said.

"The idea that benefit packages should be built on health service priorities is the cornerstone of the plan," he said.

The Oregon plan created an 11-member Health Services Commission, which is composed of five physicians, three consumer representatives, one public health nurse and one social worker. That panel identified 17 categories of health care services and then ranked them in order of importance. The list will be used by the Oregon Legislature to provide an adequate level of health care to the uninsured within budgetary constraints.

Surveys, public hearings and community meetings were all used to find out what values were relevant in setting priorities for allocating health care resources, Mr. Garland said.

"Face-to-face dialogue in community meetings with one's companions is a characteristic feature of the Oregon experience that can be replicated in any effort to define health service limits," he noted.

The HSC also consulted with health care providers in the state to "develop data and expert opinion about probable outcomes of specific health services given specific conditions."

More important than the content of Oregon universal health care plan "is the process by which it was produced," Mr. Garland said.

"It actively called upon the democratic process."

The commission established and ranked broad categories of health services based on its findings. The entire list consists of 709 line items—each line made up of a health condition with an associated treatment. The HSC then organized the items into 17 categories to establish basic priorities in the list—with category one being the highest-priority group of services.

"The categories may be viewed as disease-oriented or health-oriented," Mr. Garland explained, noting that the 17 categories are divided into three sections: cate-

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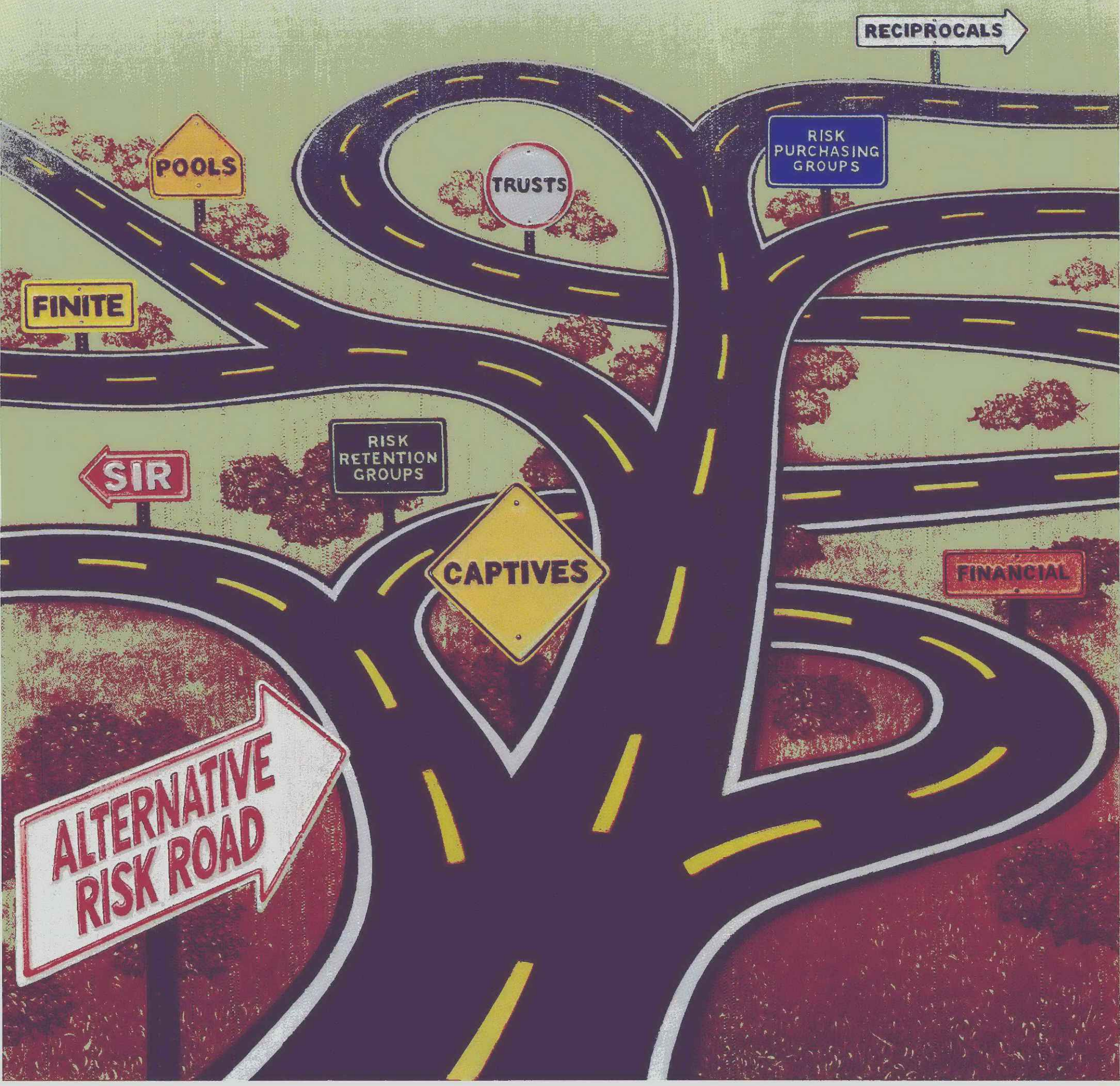

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Oregon system

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gories one through nine are "essential"; 10 through 13 are "very important;" and 14 through 17 are "important to individuals."

For example, category one includes "fatal conditions where treatment prevents death and there is full recovery." Category two is "maternity care" and category three is maternity care with "residual problems." Category four is "preventive care for children." Category five is defined as "treatment that does not prevent death but extends life or improves the quality of life."

The sixth essential category includes "reproductive services" like ultrasound tests; category seven includes "comfort care" like drugs to control pain and suffering; category eight includes preventive dental care; and category nine includes preventive health care for adults, like cholesterol screenings and mammograms.

Non-fatal conditions make up the "very important" section, including treatments that provide a full cure for acute non-fatal conditions and treatments that improve the quality of life for chronic conditions, Mr. Garland explained.

The "important to individuals" section is made up of treatments that may speed recovery for individuals but probably won't improve the health status of the population. Treatments that may provide minimal or no improvement in the length or quality of life for fatal or non-fatal conditions are ranked 17th.

"Adequate health care is not an objective standard written in stone," Mr. Garland said. "It's a function of an ongoing commitment of the community to stand together in a mutual commitment" to provide fair health care to all citizens.

The health care priorities list was submitted by the HSC to the Oregon Legislature in May. The Legislature set a funding level in June that secured funding for 98% of the "essential" section, 82% of the "very important section and only 7% of the "valuable to individuals section," Mr. Garland said.

General tax revenues will be used to fund the plan, he said. "We have an income tax in Oregon, but no sales or property taxes," he explained, noting that new taxes could be instituted in the future.

Employers will be asked to continue to provide coverage for their employees and dependents, Mr. Garland predicted. Companies that already provide benefits—whether they are insured or self-insured—will have to provide a package at least as comprehensive as the state's universal health benefits package.

Small employers that do not currently provide benefits will be given tax incentives to encourage them to offer a benefit plan equal to the state's package. Employees also will be required to contribute to the cost through deductibles and copayments, he added.

Public agencies will be created to plan for and administer the delivery of the services within the constraints set by the legislative budget, Mr. Garland said.

The state has asked that the federal Health Care Financing Administration waive Oregon's Medicaid rules so the state can take responsibility for providing health care to individuals under the poverty level.

A response to the waiver is expected by next January, Mr. Garland said.

The state will also have to seek a waiver of the Employee Retirement Income Security Act so it can mandate that self-insured employers in the state offer a minimum benefits package.

Richard Flynn, practice leader with The Wyatt Co. in Philadelphia, moderated the session. ■

Simple steps cut comp costs: Doctor

By MEG FLETCHER

CHICAGO—Employers can take several steps to reduce the cost of workplace injuries, says an occupational health physician and consultant.

But first they must believe that workplace injury costs are controllable and not just "a built-in line item cost of doing business," said Dr. Richard D. Rehm, chairman of INTEL-LIMED Inc. of Dallas, a consulting firm that advises employers on how to cut workers compensation costs. Dr. Rehm also operates Occupational Health Care Center clinics in Texas and Tennessee, which treat workers comp claimants.

"Workers compensation programs were originally set up to be a health care safety net, not an entitlement program," which they have become, Dr. Rehm said at Alexander & Alexander Inc.'s fifth annual seminar last month in Chicago.

"To a large extent, correcting that requires an attitude adjustment by the employer and the employee," he said.

Education plays "a major role" in changing the attitude, according to Dr. Rehm.

An employer must educate itself and its employees about how the state workers compensation system operates as well as how the employer handles claims.

Employee incentive or bonus plans can be useful in reducing injuries, but only after an employer has laid the proper foundation for controlling workers comp claim costs, he said.

"Control requires a pro-active approach, not just a reactive one," Dr. Rehm said.

He advised employers to take advantage of laws in some states that allow employers to determine who will treat injured workers. Choose the physician or group of physicians carefully, because the physician controls "the vast majority" of the process and can help contain an employer's claim costs, he said.

Doctors should not be chosen just because they offer low rates or have offices near the plant site, according to Dr. Rehm.

An employer should select a competent primary care physician or a group of physicians who understand the workers comp system and the employer's business operations, he said.

These physicians also must be willing to promptly communicate with the employer as needed about the status of an injured worker's case.

When possible, the company should refer injured employees to the physician and avoid hospital treatment except in emergencies.

But, company referrals are not always feasible because some states allow injured employees to choose their own physicians.

Even in free-choice states, though, employers may be able to wield some influence.

One way is through a so-called salary continuation program, he said. Under such a program, an employer makes up any lost wages between state-mandated workers compensation benefits and an employee's normal wage as long as the employee is treated by company-selected doctors and follows their directions.

Employers also must take steps to ensure they obtain adequate information about injured employees' conditions so the case can be managed properly.

Whenever possible, a supervisor should accompany an injured employee to the physician's office for initial treatment, Dr. Rehm advised.

And, as soon as possible after an injury, an employer should have each injured employees sign a release giving the company access to their medical reports.

This is important so an employer can work with the injured worker's physician in deciding when an injured employee is well enough to go back to work, he said.

Otherwise, the physician may be restricted by state law to giving medical information about the worker only to state workers comp officials or to the employer's workers comp insurer, not to the employer itself, Dr. Rehm said.

Although about 90% of all injured employees return to work within one or two days, Dr. Rehm advised employers to establish a limited-duty return-to-work program so more seriously injured workers can return to work in some capacity as soon as possible.

Many injured workers can return to work even if they are still experiencing some pain, unless going to work would worsen it, he said.

"An injured employee with a medical limitation may return to regular work, alternate work, modified work or no work," he said.

As an example of alternate work, an employee who is not able to perform a specific manual task at a plant could attend classes to improve his knowledge of company operations or his reading ability, Dr. Rehm said.

Employers benefit from limited duty programs because they send the proper message to employees, help maintain productivity and return injured employees to work faster.

In addition, such programs help reduce lost work days and litigation as well as help contain workers comp premium increases, he said. ■

On insurers' horizon: shakeout, scrutiny

By MEG FLETCHER

CHICAGO—Problems plaguing the property/casualty insurance industry will cause weak insurers to fail, leaving opportunities for strong companies, an insurer executive says.

Insurance buyers should be aware of this trend and choose only strong insurers, said James J. Meenaghan, chairman, president and chief executive officer of The Home Insurance Co. in New York.

"Things aren't very good in the insurance industry," Mr. Meenaghan told about 140 people attending Alexander & Alexander Inc.'s fifth annual seminar last month in Chicago.

Property/casualty insurers face several problems, he said. Rates have fallen since 1988, leaving insurers "at the bottom" of the cycle with no change in sight through 1992, barring a catastrophe large enough to turn the market, he said.

With rates low, many insurers are losing money. This has prompted some to stop writing coverages, like workers compensation and personal auto, in unprofitable markets, he noted.

Compounding that problem is shrinking investment income, Mr. Meenaghan said.

Meanwhile, property/casualty insurers also face increased scrutiny from brokers, regulators and others following several huge life insurer failures earlier this year.

This "tremendous" sensitivity to insurers' balance sheets is causing "a movement toward quality" companies and investments, he said.

Premiums will eventually rise, though competition will remain intense among the surviving international insurers, Mr. Meenaghan said.

"Even when prices go up, the game will be played hard," he said.

"Clearly, the strong will get stronger and the weak will get weaker, and disappear," he said, predicting more consolidation among insurers. "It's amazing to me that more consolidation hasn't already occurred already."

Mr. Meenaghan suggested that risk managers choose an insurer that:

- Has sufficient financial strength to survive in the future.
- Controls its expenses.
- Focuses on doing only those things that it can do well.
- Emphasizes having technically trained staff available.

Mr. Meenaghan said The Home is positioned itself to to meet commercial buyers' needs.

The Home plans to stop writing new personal lines policies as of Feb. 1, except in states that make it impossible to do so, and concentrate on writing commercial coverages for medium and large commercial risks, especially multinational risks.

The acquisition of a majority interest in The Home's parent earlier this year by Trygg-Hansa SPP Holding A.B. is expected to help The Home achieve its international ambitions, Mr. Meenaghan noted, adding that Trygg-Hansa last month invested another $621 million in The Home, (*BI*, Oct. 21; Feb. 18).

For risk managers looking for a strong global insurer and broker, the key is finding companies with "a significant presence" in North America, Europe and the Pacific-Asian area, said Patrick Thomas, vp and director of global business development with Alexander & Alexander International Inc. in New York.

About 90% of all world trade involves those markets, he said.

But for risk managers, brokers and insurers alike, operating in different areas means getting used to varying cultural and business practices, including a less developed approach to risk management than is typical in the United States, he added.

For example, Southeast Asians generally are not very concerned about insurance, he said.

Also, Eastern Europeans lack the infrastructure needed to make a property protection program work, he said. "Before sprinklers, you need water."

Even Western Europeans differ with U.S. firms over how best to protect computers, he said. Western Europeans are now considering halon after years of using carbon dioxide. Meanwhile, U.S. companies are moving away from halon because the gas harms the environment, he said.

Other issues that international risk managers must consider are whether to buy a single master policy or individual policies in different nations, Mr. Thomas said. ■

Asbestos fund

Continued from page 1

would be forced to participate in the administrative system, it would be the sole remedy for present and future asbestos personal injury victims.

Punitive damages could not be awarded under the proposed system. Also, attorneys' contingency fees would be eliminated.

The proposal generated heated debate during an Oct. 31 conference on the subject in Washington, D.C., sponsored by the Administrative Conference. Plaintiffs staunchly opposed the proposal, defendants strongly favored it and other observers—including a federal judge who advocates the consolidation of asbestos lawsuits—saw both advantages and disadvantages.

Mr. Brickman says that a system like the one he has proposed is needed now.

"There is an asbestos litigation crisis," he said. "There is a need for (federal) legislation.

"I believe I am the Sir Galahad of the asbestos claims crisis," boasted Mr. Brickman, saying his proposal would achieve the goals of:

- Relieving the burden on state and federal courts caused by the ever-increasing number of asbestos personal injury cases.
- Moderating the "hugely varying" results among courts in asbestos personal injury cases.
- Eliminating punitive damages.
- Reducing transactional costs, including legal fees.
- Ending the depletion of assets that is forcing—or has forced—many asbestos producers into bankruptcy.

To date, 12 asbestos producers have filed for protection from personal injury claims under Chapter 11 of the U.S. Bankruptcy Act.

Mr. Brickman's proposal calls for the manufacturers of products containing asbestos to contribute to the trust fund in proportion to their share of the market between 1940 and 1970. Asbestos producers that have completed bankruptcy reorganization, like Denver-based Manville Corp., would also contribute the amounts they have set aside to pay asbestos claimants. These contributions would cap manufacturers' liability for asbestos personal injury claims.

In determining the amount that each manufacturer must pay, the trustee would consider the amount of insurance each manufacturer has available and the manufacturer's cash flow so that the manufacturer is not financially impaired.

The manufacturers' insurers would contribute to the trust fund, "up to policy limits, amounts that they would have had to pay" in court judgments or settlements. In addition, insurers would be forced to contribute the amounts they would have expended in defense costs.

The critical difference between this proposal and an earlier agreement between asbestos producers and their insurers to create a fund to pay claimants—known as the Wellington Agreement—is that Mr. Brickman's trust fund would be mandatory.

Asbestos producers and insurers that signed the Wellington Agreement became part of a voluntary claims-handling organization known as the Asbestos Claims Facility. Each asbestos producer agreed to pay a specified percentage of all asbestos injury claims settled through the facility.

Disagreements over how claims were being handled eventually led to the demise of the Asbestos Claims Facility. But a smaller facility, known as the Center for Claims Resolution, was formed to replace it and still is operating today (see story, page 3).

While the federal government was responsible for a great many asbestos-related injuries to shipyard workers during World War II, Mr. Brickman's proposal does not require any government contribution.

"This is not fair or equitable," he said. "But it is politically viable." Any proposal that requires the federal government to contribute money would be "DOA, or dead on arrival," in Congress, he explained.

Mr. Brickman's proposal also calls for claimants to receive lost wages, plus medical expenses and death benefits equal to an unspecified number of months of wage-loss benefits. Under this system, claimants with severe illnesses, who usually die the earliest, will receive the least money. However, benefits can be paid retroactively to the date of disease if the claimant can prove he or she was disabled before filing a claim.

"The least sick do get the most because they live longer," conceded Mr. Brickman, though he also noted that under the proposal sicker claimants could receive higher monthly payments than those who are less sick.

'I believe I am the Sir Galahad of the asbestos claims crisis,' says Mr. Brickman.

To recover under Mr. Brickman's proposal, an asbestos claimant must be impaired and disabled. This means that only claimants whose disease has progressed to a certain diagnosable stage would be eligible for benefits.

Many asbestos claimants sue manufacturers even though they are not yet disabled, pointing to higher-than-average mortality rates among asbestos workers and the likelihood they will develop an asbestos-related disease.

Plaintiff's attorney Ronald Motley launched an all-out attack against Mr. Brickman's proposal during the Oct. 31 debate.

"For 62 years, the asbestos industry has been bashing lawyers, polluting the medical literature and fighting claimants with all of their resources," said Mr. Motley of Ness Motley Loadholt Richardon & Poole in Charleston, S.C.

He said asbestos victims staunchly oppose any administrative proposal that would take away their right to have claims heard by a jury.

In drafting his proposal, Mr. Brickman is acting not like Sir Galahad, but like "Robin Hood in reverse: taking from the asbestos victims to give to the asbestos manufacturers," Mr. Motley quipped.

Particularly troubling to Mr. Motley were the provisions in the proposal that eliminate the rights of claimants who are not sufficiently impaired to recover compensation.

"I have never met an unimpaired asbestos victim," he said. "They cannot get life insurance. They are short of breath. They suffer from higher mortality rates."

However, defense attorney Andrew Berry of McCarter & English in Newark, N.J., supported many parts of the Brickman proposal.

According to Mr. Berry, something must be done to eliminate the vast inconsistencies that can result from jury trials in asbestos litigation.

He told of one case where a panel of 12 jurors was selected: six regular jurors and six alternates. While the six alternates were eventually dismissed, they wanted to reach a verdict anyway.

The official jury and the alternate jury deliberated simultaneously. The official jury rendered an award of $1.3 million, while the

Continued on next page

Class-action settlement approved

BEAUMONT, Texas—A $185 million asbestos class-action settlement has been approved by a federal judge.

Ruling from the bench last month, U.S. District Judge Richard A. Schell approved the massive settlement of 2,300 claims against Concord, Calif.-based Fibreboard Corp. (*BI*, July 15).

He said the settlement was "fair, adequate and reasonable and negotiated in good faith."

The judge also concluded that the class-action settlement was in the plaintiffs' best interest because Fibreboard, which had net worth of $140 million at year-end 1990 according to its latest annual report, could not afford to pay the claimants individually.

The report estimated that 75,000 asbestos lawsuits are pending against Fibreboard.

Under the settlement, Fibreboard assigned its rights to $185 million of liability insurance to 2,300 oil industry workers to settle their asbestos bodily injury claims.

The settlement provides that the workers will seek payment solely from Fibreboard's comprehensive general liability insurer, Continental Casualty Co. of Chicago.

However, the injured workers will be able to seek payments directly from Fibreboard if a court ruling that grants Fibreboard broad coverage for asbestos injury claims is reversed on appeal.

Continental Casualty, a unit of CNA Financial Corp., wrote primary liability insurance for Fibreboard from May 1957 to March 1959.

Fibreboard believes the plaintiffs will be able to recover the full $185 million from Continental Casualty because the insurer's policies contain no aggregate limits.

California Superior Court Judge Ira A. Brown Jr. held in 1988 that each asbestos bodily injury claim filed against Fibreboard constitutes an occurrence. As a result, Continental Casualty policies cover an infinite number of claims if the claimants were exposed to asbestos prior to 1959 (*BI*, Sept. 12, 1988; Sept. 5, 1988).

Continental is appealing that decision.

—By Stacy Adler Gordon

Continued from previous page

alternate jury awarded the plaintiff only $20,000 to $30,000, Mr. Berry said.

"The lack of uniformity is too much," said Mr. Berry. While the jury system is a good way to decide certain disputes, jury trials have failed to produce any discernible pattern in asbestos injury cases, he said.

U.S. District Court Judge Jack B. Weinstein of Brooklyn, however, said that Mr. Berry overplayed the extent of inconsistencies in the jury system.

Ninety percent of all cases are settled, he said, explaining that the parties are able to settle because they know certain cases are worth a certain amount of money. "This is based on predictability," said Judge Weinstein.

And, Deborah Hensler, senior social scientist at The Rand Corp. in Santa Monica, Calif., questioned why asbestos litigants are so concerned with the right to a jury trial when fewer than 1% of all asbestos cases are actually resolved by juries.

The real concern, Ms. Hensler hypothesized, is over the mass consolidations of asbestos cases.

"Common-issue trials are a burning issue," plaintiffs' attorney Mr. Motley agreed. "The defenses (raised by manufacturers) are the same from Hawaii to Florida to Maine. Think of the waste of judicial time and energy," Mr. Motley said.

But Mr. Berry, the defense attorney, doesn't think judges who create mass consolidations are motivated solely by such altruistic goals.

"If a judge lumps 9,000 cases together, it is not just to move cases along; it is to create a situation in which a defendant cannot afford to try the case and is forced to settle," criticized Mr. Berry.

While Judge Weinstein has been an ardent supporter of mass consolidations of asbestos lawsuits, he said he was "suspicious" of an administrative alternative to tort litigation.

An administrative program "with great promise at first can deteriorate," he said. Furthermore, "there can be grave injustices and inequalities" for both manufacturers and claimants when lawsuits are consolidated.

Manufacturers that have already paid out great sums to claimants may feel it is unfair to treat them the same as manufacturers that have paid little, according to the judge.

And, many plaintiffs may feel they have been deprived of their right to a jury trial, Judge Weinstein said.

"How do we take a mass societal problem and still give the individual victim the sense that his grievance has been heard?" Judge Weinstein asked. "These problems are not ones that can be readily solved."

One possible solution is to compensate victims according to a schedule of benefits, according to Judge Weinstein. Under that type of system, victims would be paid according to the severity of their injury.

"But, again, this won't give many plaintiffs a sense that they are being fairly treated," the judge said, noting that "every system has its own advantages and disadvantages."

The tort system is very expensive and time-consuming, but "it may well be with asbestos claims we are left resolving these cases through the court system with certain modifications," according to Judge Weinstein.

"The cost of the system is just too great, but it can be modified," he said.

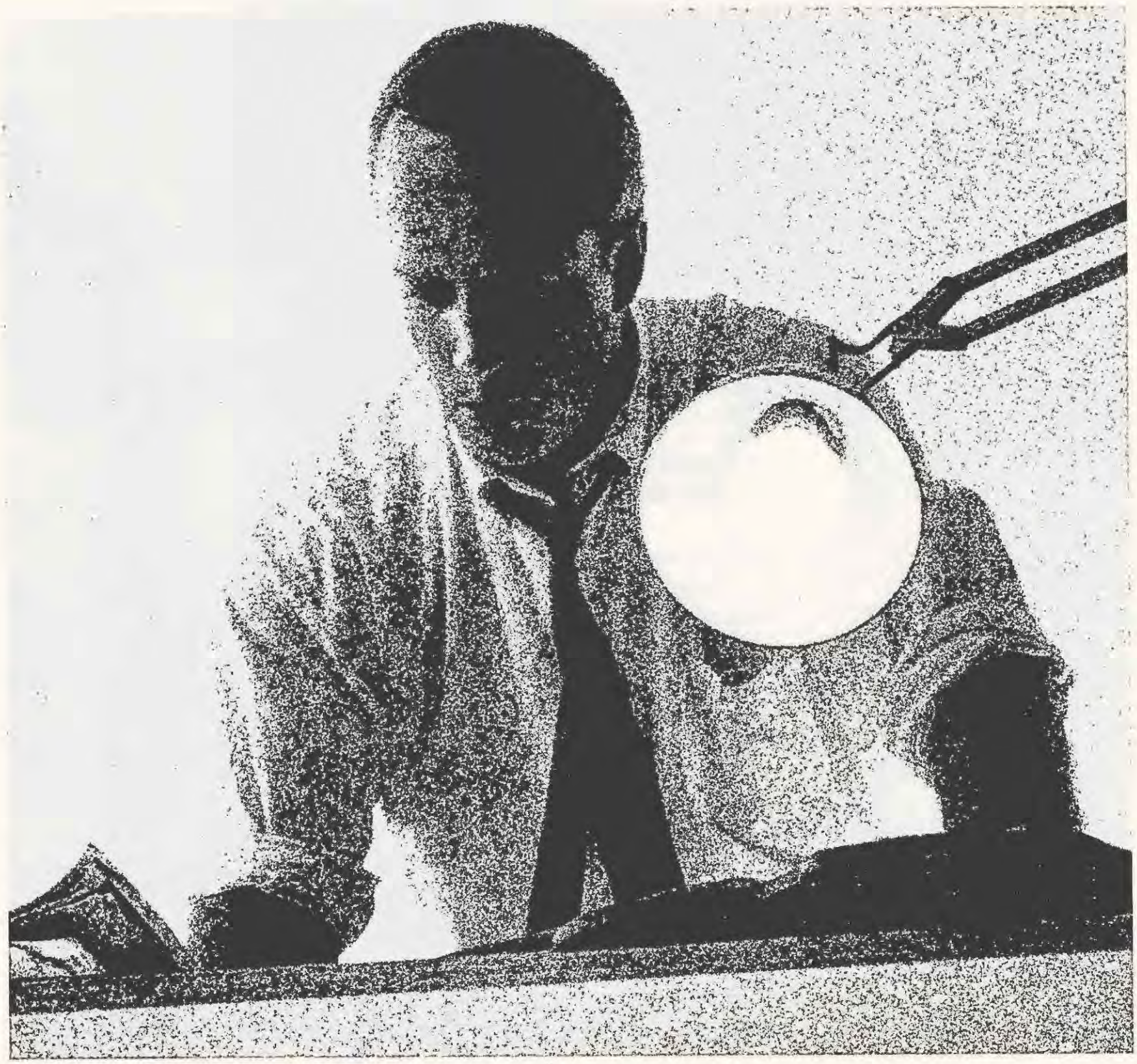
Whether Mr. Brickman's proposal or a modification of it is the solution "is very much an open question," said Ms. Hensler of Rand Corp.

"A national resolution of asbestos litigation would be preferable to the current state of affairs," Ms. Hensler said. "But an administrative solution should not be viewed as a magic silver bullet that will make the asbestos problem go away."

She urged "public and private decision makers to examine, critique, modify, improve upon or perhaps throw out altogether" Mr. Brickman's administrative proposal.

But, Ms. Hensler said, "policymakers must continue to give serious consideration to devising a resolution" to the "asbestos litigation crisis."

Also speaking on the panel was Howard Samuel, president of Industrial Union Department, an organized labor organization. The panel was moderated by Marshall J. Breger, chairman of the Administrative Conference of the United States. ■



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ASK A BENEFITS MANAGER

Changes in plan design to contain rising costs

Q **As year end approaches, I see that my company's health care costs will again exceed original projections with a trend of about 20%. How can I better control costs next year?**

A I sense some frustration in your question. If it makes you feel any better, you're not alone—many employee benefit professionals continue to be frustrated in their attempts to control health care costs.

You shouldn't feel too bad, though, with a 20% trend rate. According to recent figures provided by Metropolitan Life Insurance Co. of New York, the current trend rate for indemnity medical plans is 22%. The trend rate for plans with a preferred provider organization is 20%, while plans with a "gatekeeper" PPO is 17%. HMO costs are trending at 14%.

The amount the United States spends on health care is staggering, and the rapid growth in that amount, as indicated by the trend numbers, is alarming.

Last year, the nation spent more than $600 billion on health care, which is 12% of the gross national product. Over the past 10 years, the health care component of the GNP has increased 163%.

There are various elements you can consider in making benefit plan design changes, as well as administrative issues. However, before you consider plan design changes, you need to review your plan's health care data in order to determine how your health care dollars are being spent.

In an Ask a Benefit Manager column earlier this year (*BI*, May 13), the issue of health care data was discussed. I urge you to review that column in conjunction with this one.

This month I'll discuss two areas of health care management: cost containment and cost shifting in plan design. In January, I'll discuss alternative delivery and administrative issues. Following are cost containment strategies:

- **Preadmission certification and concurrent review.**

The majority of health plans today include a requirement for preadmission certification and provide concurrent review of the hospital stay. According to the 1990 A. Foster Higgins & Co. Inc. Health Care Benefits survey, 81% of respondents had preadmission certification programs and 65% had concurrent review.

With preadmission certification, employees are required to dial a number prior to hospitalization—or, in the case of an emergency, generally within 48 hours after hospitalization—to certify their stay at the hospital. The precertification health care professional, usually a registered nurse, will confirm the necessity for the hospital stay, as well as the number of days that will be covered by the plan. Having a preadmission certification program should affect your plan's utilization and reduce the average length of stay in a hospital.

You need to keep in mind that precertification vendors vary in terms of how strict they are with preadmission certification. This tougher stance will be good for controlling hospital stays, but may have a negative impact on employee relations. You need to assess how your organization would respond to a tougher stance on precertification.

Another item to look at when assessing a vendor is the number and type of personnel answering the telephone for precertification. You should ensure that the telephone line is adequately staffed and that there is an adequate number of doctors to assist with the calls.

- **Large case management.**

Large case management is one technique which, if used effectively, can result in substantial dollar savings for a very small investment. Considering the 80-20 rule—which states that 20% of a plan's cases will account for about 80% of its expenses—you can see how large case management can pay off. This can be further broken down with 7% of the 20% being catastrophic cases that absorb about 40% of plan expenses. Catastrophic cases are generally head or spinal injuries and premature babies. The remaining 13% of the 20% are chronic cases and also will absorb 40% of your expenses.

The key in large case management is how the large case manager gets involved with a case and how soon. Large case managers have certain protocols they follow in terms of which cases they will automatically review. It is generally helpful to have the large case manager and the precertification program with one organization, since cases can be identified for large case management through the precertification process. In this way, the large case manager can get involved in the case as soon as possible to ensure that the most efficient means of health care is provided to the employee.

For example, you have missed an opportunity if the large case manager gets involved only after 20 or 30 days' hospitalization of a head or spinal injury. Early involvement can get the injured individual out of the hospital sooner and into a more appropriate and cost-efficient care setting.

Who can know better about care that has been received than the patient? Many plans provide incentives to their employees to carefully check hospital bills for errors.

Sixty-five percent of respondents in the Foster Higgins survey reported use large case management.

- **Preadmission testing.**

Most plans today require preadmission testing, in which an individual receives most of the standard testing required for a particular condition before being hospitalized, rather than during the first day of a hospital stay. Typically, these preadmission tests are covered at 100%. In today's environment, it is most cost-effective to have these items performed prior to the actual hospitalization.

- **Second surgical opinion.**

Many plans provide a mandatory second surgical opinion for selected procedures, while in other plans the second opinion is voluntary. There has been much discussion regarding the overall dollar effectiveness of second surgical opinions. Because second surgical opinions are generally covered at 100% and, in many cases, the original opinion is not overturned by the second opinion, the plan has merely incurred additional expense without a change in the result. Benefit managers should look closely at how their second surgical opinion programs have been operating and whether they have been cost-efficient.

Although there is no consensus as to why second surgical opinion programs are not as effective as they were designed to be, there are some general reasons. First, doctors are uneasy about contradicting each other. If a doctor gains a reputation for disagreeing with other doctors' opinions, referrals to the doctor for treatment will diminish. Secondly, if a physician overturns a decision for surgery and complications develop in the patient, the doctor could face a malpractice lawsuit. Finally, in many cases, the second opinion is requested from a surgeon and, because surgeons are trained to perform surgery, they will most likely recommend that course of treatment.

One approach I like, which is taken by Metropolitan Life, is to have the covered individual contact the insurer when surgery is recommended. The nurse who handles these calls will ask specific questions regarding the procedure to be performed and will make a decision as to whether a second opinion is necessary. This eliminates much of the unnecessary expense of some second surgical opinions, while also maintaining a review of potential surgeries.

According to the Foster Higgins survey, there was a 1% decrease in the number of plans with second surgical opinions during the last year. Fifty-five percent of respondents mandate second surgical opinions—at least for specific procedures. Another 33% have voluntary programs.

- **Weekend admission restrictions.**

Except for emergency circumstances, plans should not allow weekend admissions to a hospital. Hospitals, like many organizations, provide skeleton crews on the weekend, and little else is done for the patient except standard maintenance.

- **Hospital bill audits.**

It is no secret that there are many errors in hospital bills. Who can know better about care that has been received than the patient? Many plans provide incentives to their employees to carefully check hospital bills for errors. Some plans, like the plan at Continental Bank Corp., allow employees to keep a portion of any error that results in their favor.

Many third-party administrators and insurers automatically audit hospital bills. There is generally a dollar threshold, like $10,000, above which bills are routinely audited.

The items discussed above should reduce the overall cost of health care, reducing the cost for both your employees and your health care plan. The following items will reduce your plan's costs, but also will shift costs to employees covered under the plan:

- **Eliminating first-dollar coverage.**

Some plans provide full coverage for certain items like outpatient surgery. During the 1970s and 1980s, many plans provided full coverage for outpatient surgery due to the high cost of inpatient surgery. Hospitals and doctors responded by shifting more cases to an outpatient setting and increasing their charges for outpatient services. Today, there are many cases in which outpatient surgery is not much less—and in some cases more—expensive than inpatient care.

From a plan perspective, it is best to have outpatient surgery reimbursed at the same copayment rate rather than at 100%. In reviewing your health care statistics, look closely at outpatient care and focus on the utilization and expense of such care.

Another area in which plans have provided 100% coverage was in emergency room care. This type of care is in most cases inappropriate and in the vast majority of cases, more expensive than care that can be received elsewhere. Elimination of first-dollar coverage for emergency care also should be seriously considered.

- **Deductibles.**

It still amazes me to see many plans with annual deductibles of $100 per individual and $200 per family. This is one area that should be reviewed very closely.

It would make sense to have the deductible increase automatically each year as the cost of health care continues to increase. However, very few plans index their plan deductibles.

There is certainly a trend toward increasing plan deductibles. Individual deductibles of $200, $300 and $400 are no longer uncommon. According to the

Continued on next page

Benefit plan design changes

Continued from previous page
plans released by The Wyatt Co. in September, the average individual deductible is $196 and the average family deductible is $437. The most common individual deductible throughout the 1980s—$100—applies to only 17% of plans in 1991.

Another approach is to have the amount of the deductible based on the annual earnings of the covered individual or as a percentage of one's annual earnings up to a maximum amount. Although this may sound difficult to administer, generally there are few administrative problems. Before taking this approach, check with your claims administrator.

- **Maximum out-of-pocket expenses.**

This is another area in which we've seen a fair amount of increases. As with the plan deductible, it would make sense to adjust the maximum out-of-pocket with inflation.

- **Copayments.**

The norm for copayments still remains 80%/20%. However, as more managed care programs are being implemented, we are seeing changes in this structure.

- **Stricter reasonable and customary limits.**

The norm in most plans today is to reimburse reasonable and customary expenses. Reasonable and customary is generally defined as those expenses of doctors and providers for a specified medical procedure within a specified ZIP code, generally at the 90th percentile.

For example, if a bill for gallbladder surgery is submitted for reimbursement, your claims administrator will compare the submitted charge to those charges by other physicians for the same procedure within the same ZIP code. The charge will be reimbursed based on the 90th percentile of those charges. Some plans have moved from reimbursement at the 90th percentile to the 75th or 80th percentile. This is clearly one way to shift the cost to the employee. However, be aware that employees may respond very negatively when particular fees are not reimbursed under the plan.

- **Employee contributions.**

It is surprising how many plans do not require employee contributions for coverage. Many plans that do not require employee contributions are associated with unions, which do not easily "buy in" to employee contributions.

Requiring employees to contribute for their health care coverage shifts expenses for the company. Having employees share a specified amount of their health care costs is a constant reminder that there is a cost associated with the health care plan. The recommended approach is to have employees pay for at least a specified percentage of the plan cost. Therefore, as plan costs increase each year, so do employee contributions.

According to the Foster Higgins survey, the percentage of employers that require a contribution for individual coverage is 57%, while 80% require contributions for family coverage.

There are a number of ways in which employee contributions can be structured. Some companies provide the health care benefit free to the individual employee while specified contributions are required for dependent coverage. However, this may become quite burdensome from an administrative standpoint.

One approach being used, although not very widely, is to base the employee's contribution on risk factors. Some organizations have lowered the employee contributions for those who meet specified requirements, like maintaining a certain weight, not smoking, exercising regularly and using a seat belt regularly.

Basing employee contributions on health risk factors clearly communicates that those who will more likely use the coverage will be paying more, while also providing another opportunity to communicate the importance of good health. It also may lead employees to change their behavior.

Still another reason to require employee contributions is to avoid covering additional individuals under your plan. Approximately 50% of all families have two wage earners, most of whom are eligible for medical coverage from their employer. If your company requires little or no employee contributions for medical coverage, the spouses and children of your employees will be covered under your plan. As required employee contributions increase at other companies, it is likely that your employees' spouses will drop their own coverage, resulting in your employees' spouses and children being covered under your plan.

If you are planning any cost-shifting arrangement, consider that the negative employee reaction to such changes may be partially offset by a flexible spending account plan. If you currently have an FSA, remind employees that they can partially offset their increased expenses by paying for them on a pretax basis through the FSA. If you currently do not have an FSA, consider implementing one in conjunction with cost shifting plan design changes in order to minimize the negative impact on employees. If designed properly, an FSA can be implemented for little or no cost.

For more details on FSAs, see the Sept. 9 Ask a Benefits Manager column. ■

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

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

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


Mr. Nirtaut

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

Mr. Nirtaut's next column will appear in January.

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.

Breach of contract not an 'occurrence': Court

An Illinois appellate court decided that a breach of contract claim was not a covered "occurrence" under a comprehensive general liability insurance policy.

In February 1987, Travelers Insurance Cos. contracted to provide comprehensive general liability insurance to P.C. Quote Inc., a company conveying stock market quotes by personal computer. The policy covered bodily injury or property damage "caused by an occurrence."

In February 1988, Quote was sued by Compumat Inc., alleging that an employee of Quote ordered 10 computers worth nearly $50,000 and that Quote failed to pay for them. Apparently the employee had no authority to order the goods and then diverted them to his own use before they were received by Quote.

Quote requested Travelers to defend it in the Compumat suit. Travelers refused but did file this suit seeking a declaration that it had no duty to defend.

However, the trial court ruled against Travelers.

On appeal, Quote argued that the loss of computers was property damage. But the appellate court said that there is a difference between damage to property and loss of property.

"If P.C. Quote must pay for computers it ordered but did not receive them, someone committed theft against the company and damages sustained by the company are not property damages," the court said.

Furthermore, the appellate court believed that Compumat's complaint against Quote did not allege an "occurrence."

According to the appellate court, the occurrence must be accidental. An accident occurs when something unexpected, unintended and unusual happens, the court said. Whether expected or not, it said, the ordering of computers and the subsequent failure to pay for the computers cannot be considered an "accident."

The trial court decision was reversed.

Travelers Insurance Cos. vs. P.C. Quote Inc., Appellate Court of Illinois, March 22, 1991 (*BI*/04/D.-$10)

Legal briefs

Group insurance cancellation

The District of Columbia Court of Appeals held that a group health insurer was required to directly notify subscribers of cancellation of the policy and that the employers' notice to an employee of cancellation was ineffective.

Janice L. Mueller enrolled as a subscriber in Healthplus Inc.'s group insurance policy in January 1988 offered through her employer. Thereafter, she was diagnosed with a gynecological infection that was recurrent and required treatment through September 1988.

In February 1988, Healthplus advised the employer that it would not submit a renewal proposal.

The employer then issued a memorandum to those employees enrolled in Healthplus stating that effective April 1, 1988, Healthplus would no longer provide medical services for the employer's employees.

Ms. Mueller attended seminars conducted by her employer regarding alternative health care options. She selected Prudential Insurance Co. of America in the belief that the latter would allow her to keep her own doctor.

Thereafter, Prudential rejected reimbursement requests after April 1, 1988, on the ground that the condition was pre-existing.

Ms. Mueller requested Healthplus to reimburse the claim but was denied. She sued Healthplus but lost in the trial court.

On appeal, Ms. Mueller argued that the Healthplus plan required notice of termination to be written directly to her. Thus, because she never received such notice, Ms. Mueller asserted that she was entitled to recover her medical expenses incurred after April 1, 1988.

The appellate court agreed, pointing out that the Healthplus plan expressly required notice of cancellation to be given by the terminating party to the subscriber.

Thus, the court concluded that despite Ms. Mueller's actual notice of cancellation, Healthplus failed to give effective notice as required by the plan.

Ms. Mueller was held to be entitled to receive benefits until the expiration date of the policy.

Mueller vs. Healthplus Inc., District of Columbia Court of Appeals, April 23, 1991 (*BI*/05/D.-$10). ■

These abstracts were prepared by Mayo H. Stiegler. Copies of these decisions are available by sending a $10 check payable to Mayo H. Stiegler to Business Insurance, *740 N. Rush St., Chicago, Ill. 60611-2590. List the number for each opinion.*

International movement

Multinationals hit stride as trade barriers open up

By Douglas N. Smith

MULTINATIONAL COMPANIES HAVE been meeting the global challenge for decades. In the beginning, the international movement was intended to take advantage of labor cost differentials or to gain efficiencies by locating manufacturing operations closer to an international customer base.

With the trend toward eliminating trade barriers, the opening of the former East Bloc countries and the creation of the single European market, meeting local trade regulations will have a lesser impact on planning the location of overseas facilities. There likely will be a tendency to consolidate operations in order to maximize the efficiency derived through larger facilities. However, with this trend will be a growing risk management problem.

Interdependency exposure is one such problem.

Interdependency is a business interruption exposure to an owned facility that relies on another subsidiary or other corporate family company for raw materials or intermediate components essential to the finished output of the operation. Any interruption in the flow of these materials or components could result in the slowdown or cessation of production and thus decreased sales and lost revenues.

Because of the bottleneck nature of interdependency exposures, the loss scenario may be much more severe than any business interruption worksheet may imply. Examples may be found in virtually any manufacturing operation:

- Manufacturers of solid state circuitry may have one facility that grows wafer material (the basic semiconductor material) that will be etched into final circuits by a number of other facilities. These circuits may be destined for any number of final products assembled in a number of different locations.
- Manufacturers of cosmetics may depend on one facility to supply a basic ingredient or color element.
- Pharmaceutical products generally require a number of intermediate processing steps (at an equal number of facilities) before an end product is completed.

The interdependency exposure can be compounded by the creation of sales organizations within a corporation whose sole function is to market the end product. Thus, loss settlements can be complicated.

Take, for example, a component that is manufactured in England for final assembly in Italy. The sales company is located in Germany. When a loss occurs to the goods in a warehouse in Italy, which entity suffers the interdependency loss?

The final answer to such loss scenarios usually lies in the paper trail that determines which entity has title to the goods at the time and place of loss.

Coverage for interdependency is found in specific policy conditions. Typically, property policies covering foreign locations account for interdependency loss scenarios for foreign-to-foreign locations and foreign-to-United States locations. United States-to-foreign interdependency exposures are usually covered under domestic property policies. Therefore, it is important to understand whether Canada and Puerto Rico are covered under the domestic or foreign property policies.

The reason for this usual interface is that each insurer (foreign and domestic) has the underwriting data necessary to evaluate the risk of physical loss or damage at their respective covered locations. Regardless of this convention, there are always exceptions, and risk managers should carefully review the interface between domestic and foreign property policies to ensure that each interdependency loss scenario has been properly accounted for.

Some foreign master policies (which can be thought of as blanket policies in the domestic vernacular) can act in lieu of individual policies admitted in each country. Such policies may not require specific interdependency provisions because any time element loss will be a component of the single loss settlement.

International issues

A master policy may be admitted in local jurisdictions and will provide difference-in-condition coverage to those local policies that vary with the master policy's terms and conditions because of local regulations, requirements, practice or expediency.

The loss settlement may, therefore, result in a mix of local reimbursement and settlement under the master policy to the corporate parent. The tax implications of such a structure should be carefully evaluated so that final settlements are as anticipated. In such placements where domestic exposures are placed separately from foreign exposures, there is still a need to account for domestic-to-foreign interdependency interface.

Global policies, on the other hand, do not have any interface problem with regard to interdependency loss because all locations are covered under one policy placed with a single insurer. This will also facilitate claims payment should there be any question as to whether an interdependency loss should be paid under domestic or foreign property programs.

In many cases, the interdependency exposure is either not well understood, not appreciated or perhaps considered too complicated to quantify. The result is that in far too many instances the interdependency limit (or sublimit) is determined by insurance company restraints and underwriting philosophy rather than actual analysis of coverage requirements.

In order to quantify interdependency exposures, companies are required to place a value on component parts or intermediate processes of final products. Accountants refer to such component costs as the contribution margin. The contribution margin may be a cost arrived at arbitrarily and may not truly reflect market value of a particular component or process. It also may be difficult to place a cost value on proprietary processes or unique components that are not available through outside suppliers. The true impact of an interdependency loss may be even more difficult to evaluate.

Recognizing the difficulty in grasping the exposure, the following steps can be a start to evaluating interdependencies:

- **Review operational plans.** As operational and strategic planners formulate recommendations for future organizational moves, proper consideration should be given to risk management principles.
- **Use product flow charts.** Interdependency exposures are easier to identify by use of flow charts that illustrate where bottlenecks occur.
- **Conduct site visits.** Discussions about flow of supply materials and components as well as finished product routes to the final customer are better understood by managers in the field who are attuned to operational changes and requirements on a local level.
- **Review sales documentation.** Title and risk of loss should be clearly defined between intercompany organizations and between the company and customer.
- **Evaluate loss scenarios.** The evaluation should not only account for potential perils that can cause physical damage to plant facilities but also to their impact on production capability. The evaluation should include the period of interruption that may result when supplies and machinery critical to production need repair or replacement following a loss.

The potential impact on outside services by catastrophic losses should be evaluated as well. For example, if disaster strikes the region, when will transportation, communication and electrical services be restored? Depending on the infrastructure of any particular country, these factors may have more impact on the down time than replacement of machinery and equipment. The contractor and subcontractor resources available may also be problematic when catastrophes occur and recovery and repair requirements place a strain on available resources.

- **Determine seasonal variations.** Interdependency exposures may fluctuate depending on the selling profile. Companies manufacturing consumer goods may be more affected near the year-end holiday season when sales are expected to peak.
- **Consider alternate supply resources.** Although one plant may be affected, another plant may be able to increase production in order to account for the lack of overall output. For certain components or supplies, it also may be possible to substitute products from non-owned companies. In these cases, the result may be an extra expense exposure rather than interdependency.

A related exposure is contingent business interruption. In this case, it is the time element loss that may occur if outside suppliers, vendors or customers cannot fulfill their obligations because of physical loss or damage at their facilities.

A similar analysis process can be used to determine an appropriate sublimit of insurance. It may seem that alternatives to outside suppliers may be relatively easy to find. However, should a company's product rely on proprietary processes or unique components that are either internally supplied or purchased from sole supply sources, there may still be bottlenecks in the supply chain. The more high tech a company is, the more likely there will be such choke points.

The interdependency loss (as for any time elemental loss) begins when the interruption of supplies or services is manifest in lost production and consequential revenues. Thus, it is not when the supply chain is interrupted that matters, but the point in time when the on-hand supplies have been exhausted and production is slowed or stopped.

Companies operating with minimum inventories will, therefore, experience interdependency losses sooner than a company whose inventories are maintained at a higher level. Master policy or global policy provisions should also clearly define the exchange rates (which may fluctuate over the period of loss) that will be used to the satisfaction of all parties.

Future trends indicate that interdependency exposures will increase as the global economy grows. Companies should carefully evaluate interdependency exposures when planning operational facilities. A balance of production efficiency and risk management planning will lessen the adverse impact that losses at one facility will have on the corporate bottom line. ■

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

Surety suit

Continued from page 2

ment also issued a cease and desist order against Contractors Surety and Mr. Smith in October 1990, citing performance and payment bonds the company wrote without a license on four Georgia construction projects.

Demanding a hearing on the order, Contractors Surety denied it had offices or employees in Georgia and maintained that it did not transact any insurance business in the state.

In the application for a hearing, a lawyer for Contractors Surety described the company as a subsidiary of Security Trust Inc., another surety company based in the Turks & Caicos Islands.

The application also said Contractors Surety is a captive insurer servicing a construction industry trade group, Contractors Surety & Fidelity Assn. Ltd.

Members of the trade group, according to the application, sign a "letter of acknowledgment" stating:

"I understand that (Contractors Surety), a Nevada corporation, represented by an attorney-in-fact in Atlanta, Ga., is a subsidiary of Security Trust Inc., a surety licensed in the Turks & Caicos Islands."

The application also states: "(Contractors Surety) is not licensed as an insurance carrier in any state, but as an insurance 'captive' (to) provide surety bonds on behalf of the members of our association who meet certain financial qualifications and underwriting standards."

The company was granted a December 1990 hearing on the Georgia cease and desist order, but two days before the hearing it signed a consent order with Georgia regulators.

Under the Dec. 18, 1990, consent order, Mr. Smith agreed that Contractors Surety would not transact insurance business in the state and would pay claims and premium taxes on bonds the company had already issued.

Kentucky regulators filed suit Aug. 15, charging Contractors Surety with issuing bonds without a valid certificate of authority and charging Mr. Smith with acting as an insurance agent without a license.

Two days before the hearing, Contractors Surety signed a consent order with Georgia regulators.

Although the complaint cites two performance and payment bonds and one bid bond issued on Kentucky construction projects, Ms. Maynard said she knows of roughly 10 Contractors Surety bonds issued in the state.

Several of these were bid bonds issued in 1991 and presented by contractors seeking work from Kentucky state agencies, Ms. Maynard said.

The agencies rejected the bonds because Contractors Surety is not licensed in the state, Ms. Maynard said.

In addition to violations of the insurance law, the complaint charges the company with violating the state consumer protection act by making "unfair, false, misleading or deceptive" representations.

The lawsuit also argues that Mr. Smith, who signed the bonds, should be held personally liable for the company's violations.

Kentucky regulators are seeking an injunction barring Contractors Surety from further business in the state and are seeking an order requiring the company and Mr. Smith to pay claims and make restitution to anyone injured by the company's allegedly deceptive practices.

In an answer last month, Contractors Surety confirmed that it has "permitted certain members of Contractors Surety & Fidelity Assn. to secure from it performance and payment bonds" on the Kentucky projects cited in the Insurance Department's complaint.

The answer also concedes that neither Contractors Surety nor Mr. Smith is licensed in the state and that Contractors Surety has never paid state premium taxes.

However, the company and Mr. Smith both deny having violated Kentucky laws.

In addition, the company and Mr. Smith argue that the Kentucky insurance code violates their constitutional due process and equal protection rights.

They also argue that the code is unconstitutionally broad and vague. ■

INTERNATIONAL

AP/Wide World Photo

British and French workers on the Eurotunnel project exchanged flags after their tunnels were linked on Dec. 1, 1990.

Cover ensures tunnel project remains airtight

Insurance package covers all phases

By GAVIN SOUTER

MONTE CARLO, Monaco—The construction project to link England and France by a rail line underneath the English Channel is covered by an extensive insurance plan, which covered the project for risks long before the first sod of earth was shifted.

The numerous liability risks associated with such a major project demanded cross-channel insurance and brokerage links as well as industrial and governmental cooperation.

A fixed link between England and France was first proposed by a Frenchman in 1750, said Jonathan Blackmore, group insurance manager for Eurotunnel Ltd. of London, the Anglo-French company that is building and will operate the tunnel.

Since then, several other proposals have been made to link Calais and Dover. But all fell by the wayside for political and financial reasons until 1985, when the English and French governments agreed that a private company should build a tunnel, he said.

The link will consist of two train tunnels and a service tunnel, each 31 miles long, Mr. Blackmore explained at the Risk Management Forum, which was co-sponsored by the European Assn. of Risk Managers and the Risk & Insurance Management Society Inc. in Monte Carlos last month.

"As soon as the Anglo-French treaty was signed and the concession awarded in early 1986, money had to be spent by Eurotunnel to prepare for construction," explained Philippe Fallet, commercial director of broker Gras Savoye S.A. in Paris, which serves as a broker for the project.

"The treaty, however, still had to be ratified by the parliaments of both countries before the concession came into force," he said.

This took more than a year, so Eurotunnel bought 40 million pounds ($22.5 million at current exchange rates) of coverage against non-ratification by either parliament, Mr. Fallet said.

The net premium for this cover-

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Some Lloyd's members decry wave of litigation

By GAVIN SOUTER and STACY SHAPIRO

LONDON

LONDON—A Lloyd's of London member who decided not to sue his members agency for the losses he faces warns that Lloyd's could be severely harmed if members litigating their losses in London's High Court win their case.

The member, who is on the open 1982 year of syndicate 317/662, managed by R.H.M. Outhwaite (Underwriting Agencies) Ltd., explained in a letter to The Times of London why he is one of the 629 members of the Outhwaite syndicate for 1982 who do not support the legal action currently being tried (see related story).

"Despite having voluntarily joined a commercial operation for gain, knowing that profit equates to risk, (the litigating members) are in effect attempting to severely, if not fatally, damage the very society of which they are members," wrote R.B. Gristwood of Sunderland, England.

If the action is successful, then "one of the fundamental principles of the whole Lloyd's system," the unlimited liability of members, could be abandoned, thus damaging the market, he implied. A verdict in favor of the members also would open the doors for another six or seven actions that members are bringing against members agencies in connection with losses from other syndicates, he noted.

The members also are suing the agents "to obtain the maximum recovery possible from errors and omissions insurance policies" that are written by other Lloyd's syndicates, Mr. Gristwood said. "Presumably, the members of the E&O syndicates will then sue their agents for not anticipating such developments and accumulation, not having the benefit of hindsight, leading to further actions, appeals and additional legal costs—an ever widening circle from the original stone," he wrote.

"It would appear to me that the only people to gain from this whole problem will be the insurance competition around the world, who must be delighted at the publicity given to these self-inflicted wounds, plus the legal profession," he said.

Mr. Gristwood concluded that he has resisted joining the Outhwaite members' legal actions "as I believe that basic principles are more important than money."

Meanwhile, Lloyd's member P.R.W. Pemberton of Cambridge, England, also wrote to The Times to explain why he, too, is not taking part in litigation against members agencies.

Mr. Pemberton wrote that he decided to join the "gravy train" known as Lloyd's because "greed got the better of me" when he realized that a lot of his friends were making money in the market.

Mr. Pemberton said he spoke to five members agents before joining Lloyd's and they all said "that if I joined Lloyd's, everything I owned was at risk. Despite my doubts about their inabilities, and the clear statement of my unlimited

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End to Outhwaite case not expected until 1992

By STACY SHAPIRO

LONDON—The continuing verbal battle between Lloyd's of London underwriter Richard Outhwaite and the plaintiffs' attorney representing disgruntled members of the Outhwaite syndicate's open 1982 account will likely push the trial into the New Year.

The trial of the suit, brought by 987 members against 81 members agencies led by R.H.M. Outhwaite (Underwriting Agencies) Ltd., was expected to be completed by the end of the year (*BI*, Nov. 4, Oct. 14).

However, cross-examination of Mr. Outhwaite by plaintiffs' lawyer Anthony Boswood has run more than two weeks and is expected to continue this week. This is expected to push the end of the trial into February.

Following Mr. Outhwaite's testimony, the two sides will present expert witnesses. First will come the plaintiffs' star witness, Uli von Eichen, former managing director of the London office of Munich Reinsurance Co. Lloyd's underwriter Chris Rome is expected to be one of Mr. Outhwaite's expert witnesses.

Closing arguments are expected to be heard in January and High Court Justice Saville at the earliest should give his decision at the beginning of February.

Observers expect the case to run its full course, rather than be settled, in light of its importance to the Lloyd's market.

If the members prove that Mr. Outhwaite was negligent in writing 32 runoff reinsurance contracts that have cost them hundreds of millions of dollars, it will set precedent for the thousands of other members who have filed suit over similar losses at other syndicates. Should the members lose, though, the other cases could probably be abandoned (*BI*, Sept. 2).

Over the past two weeks, Mr. Outhwaite and Mr. Boswood have verbally sparred over the underwriting of the runoff contracts.

For example, the plaintiffs' lawyer last week referred to a note detailing a conversation between Mr. Outhwaite and another members agency defendant. The note claimed that Mr. Outhwaite admitted to writing a few "pups"—meaning runoff reinsurance con-

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AXA chief sees changes from globalization

By GAVIN SOUTER

PARIS—Big insurers will prosper and small ones falter as the insurance market grows more international, a leading French insurer says.

As firms expand across borders, insurers and brokers that serve them will have to be equally international in their approach and infrastructure, he said.

Most insurers and brokers already realize this, and the growing number of takeovers, mergers and new insurance networks will not slacken, he said.

The internationalization of world insurance markets is happening at a breathtaking pace, said Claude Bebear, president of AXA Midi Assurances S.A. of Paris.

Takeovers in Europe are producing ever larger insurance groups, which are then buying into the U.S. market, Mr. Bebear said during the 21st International Insurance and Risk Management Conference sponsored by Management Centre Europe in Paris last month.

Japanese insurers also are threatening to expand outside their borders. "They are not setting up shop in Europe much yet, but they are on their way," Mr. Bebear said.

And when the Japanese do move into Europe, they will not stay on the fringes, but will make very substantial investments, he said.

U.S. insurers also seek expansion abroad.

This all means, said Mr. Bebear, that some major international insurers will dominate the world market, inevitably leading to widespread changes in the business.

In the intermediary market, this change is already well under way. "Brokers are setting up networks, and other brokers are merging as the smaller brokers realize that if they are to survive they have to reach a certain size," he said.

But even those changes may not

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Risk manager, broker advocate partnerships to improve market

By GAVIN SOUTER

PARIS—The relationship between risk managers and commercial property/casualty insurers must be radically changed for insurers to survive and for risk managers to obtain the coverage they want, a risk manager and broker agree.

When policyholders and brokers have confrontational negotiations with insurers in the process of obtaining coverage, the result can only be inadequate coverage and short-term price benefits instead of comprehensive coverage and stable pricing, they said.

Risk managers and insurers instead should form commercial relationships based on mutual understanding so that both parties can benefit from the relationship, the risk manager and broker said during the 21st International Insurance and Risk Management Conference sponsored by Management Centre Europe in Paris last month.

The commercial insurance environment is caught up in a depressing spiral of failure, according to Anthony Benson, head of group risk management at Guinness P.L.C. in London.

Instead of insurers and risk managers entering into close relationships that are profitable for all parties, brokers lead risk managers into battle with insurers in search of cheap but short-term coverage, he said.

"This will lead to the death of insurers," Mr. Benson predicted. "The objective of brokers should be to bring the client and the insurer together, and good and ill fortune must be shared by both parties."

If this type of partnership can be forged, then the insurer will be able to lead all of the policyholder's risks, and both parties will achieve the stability they are seeking, he said.

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INTERNATIONAL

Insurer size

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suffice. Mr. Bebear warns that policyholders increasingly are demanding to have direct access to insurers rather than dealing through an intermediary. "In the United States, both risk managers and individuals want to know who they are dealing with, because they are concerned about solvency," he said.

Concern about size already has hit reinsurers, Mr. Bebear said.

Reinsurers with capitalization of less than $100 million are now considered too small by insurers. Ten years ago, he noted, "you could be a reinsurer with a capitalization of $10 million."

And for risks that have the potential to produce large losses, like financial risks, policyholders are particularly wary of weak insurers, Mr. Bebear said.

"The financial world is not interested in small insurers," he said.

Consequently, small insurers only will be offered the risks that large insurers do not want, Mr Bebear said.

And the larger insurers will become technically better because, unlike smaller insurers, they have the resources to pay large salaries to experts, he said.

Large insurers also are able to secure discounts for services like loss adjusting because they provide service companies with so much business, Mr. Bebear said

Size also counts in the continuing computerization of the insurance industry, he said. Both large and small companies are gradually accepting the fact that large companies have the resources to build more sophisticated automation systems. "You have people who say small is beautiful, but while they are saying that, they are setting up cooperation agreements with other companies and are trying to become big through the back door," he said.

Size alone will not allow an insurer to thrive; an insurer must also have an international presence, the AXA president said.

"Even small companies are exporting their services and are working in other countries," Mr. Bebear said. And these industrial and commercial companies need advice from insurers that understand their risks and have the ability to settle international claims, he said.

This leaves small insurers at a disadvantage, he said. To settle claims in other countries, they must set up a network with foreign insurers. But because they can never fully control the other companies, the small insurer cannot serve clients with the same efficiency as an international insurer with foreign subsidiaries, Mr. Bebear said.

Also, international insurers' better spread of business and markets provides them with a more stable base to work from, he said.

"If I base everything in one country and the market in that country is sick, and I am only working in that market, then I will get sick too," Mr. Bebear said.

Working in many markets also leads to cross-fertilization of ideas between business cultures that make up the whole company, he said.

"You can set up international teams with people from different countries who will bring with them new ways of thinking and new working habits," Mr. Bebear said.

Some insurers that wish to remain domestic companies are realizing they need to change to spread their own risks and are moving into banking, he said.

"Combining insurance and banking is something which might work in the management of savings, but as soon as you move into the area of risk, you are talking about entirely different risks," Mr. Bebear said.

Also, some claims, like financial risk claims, could lead to a conflict of interest within an insurer/bank, he said. "It is better to stick to your own line of business, become European and then gradually internationalize and operate worldwide," Mr. Bebear said.

As a result of all this change, by the end of the century, 20 to 25 insurers will dominate the world market, he predicted. Those companies may divide themselves into groups or divisions, but they will still reap all of the benefits of size and international spread, Mr. Bebear said. ■

Meeting draws 243 to Paris

PARIS—The 21st International Insurance & Risk Management Conference, held Oct. 9-11 at the Hotel Meridian Montparnasse in Paris, attracted 243 participants.

The conference was organized by Management Centre Europe, which is the European affiliate of the American Management Assn.

All of the plenary sessions were co-chaired by Alain Neveu, risk manager for Pechiney S.A. of Paris, and Bernhard Fink, a board director at Gerling-Konzern A.G. in Cologne, Germany.

The 22nd International Insurance & Risk Management Conference will be held Oct. 14-16, 1992, in Vienna, Austria.

Insurer-client relations

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"In this way, the insurer has an exposure to all of the client's risks. And if, for example, he has a bad year on property, it is likely that he will have a good year on casualty or transit or vice versa," Mr. Benson said.

Insurers in these cases also would be able to provide some limited coverage for risks for which capacity is scarce or non-existent, like some financial, political, product contamination and pollution risks, he said.

In return for providing insurers with a spread of risks, policyholders will want long-term contracts of between three and five years, he said.

To ensure that insurers obtain the right price for the long-term coverage, premiums could be renegotiated at different stages during the coverage term, Mr. Benson suggested.

And, if primary insurers and policyholders are completely open about the details of the risks, then following insurers could adopt the same approach as the lead underwriter, he said. "Think of the benefits if this approach were adopted by 100 buyers of insurance and 30 to 40 leading insurers," he said.

Brokers would not be shut out under this kind of approach to buying insurance, he said. "The broker is an infinitely adaptable animal. He can become the confidant and aid to both parties."

Captive insurers also would be less of a threat to insurers, because they would be providing mutual protection both for the policyholder, if writing direct risks, and for the insurer, if writing reinsurance, he said.

Insurers currently are failing to provide some of the simplest needs of their policyholders, agreed Hugh Governey, managing director-corporate brokerage for Coyle Hamilton Group in Dublin, Ireland.

"Clients see insurance as a single commodity with a single purpose: that is, to protect their own company. But, the majority of insurers and reinsurers see their role as a provider of standard, off-the-shelf contracts," he said.

So the clients have to buy multiple policies to protect what they see as simple risks, Mr. Governey said.

This problem can be overcome if insurers are prepared to spend time studying the business of their large policyholders and cover all of their policyholders' risks, he said.

However, if insurers write broader coverage, risk managers should not buy insurance for risks that they can comfortably retain or are insignificant, Mr. Governey said. "It is uneconomical to insure risks that are totally protectable."

But, risk managers also should not underestimate their need for insurance for certain exposures, Mr. Governey said. "Many clients take an over-optimistic view of their exposures. There is too much emphasis on achieving short-term savings and not enough emphasis on long-term protection."

If policyholders emphasize loss control, then insurers should provide capacity—even for pollution risks—to meet demand, Mr. Governey said.

In addition, it is unacceptable for insurers to insert pollution exclusions into liability policies at renewal that leave policyholders with large uninsured exposures, he said.

Insurers will lose out in the long term if they continue to do this, he said. "Clients will look for alternative risk financing methods to cover these risks, and when they find coverage, they may use these methods to cover their insurable risks as well."

Insurers also should provide longer periods of coverage, he said.

"Twelve months is too short a period to determine whether a risk is good or bad. For some types of risk, it should be possible to provide five-year policies," Mr. Governey said.

Without long-term contracts, policyholders and insurers will never develop stable relationships, he said.

When risk managers are seeking insurers that can meet all of their demands, they should look for companies with several qualities:

- The financial capacity to underwrite all of a risk manager's exposures on a so-called composite basis.
- Experience in underwriting programs on a composite basis.
- Recognition as a leader in the market, to ensure support from following insurers and reinsurers.
- Technical resources in risk identification, advice and claims management.

Once a lead insurer is selected, the risk managers and the insurer must agree on a loss adjuster, Mr. Governey said.

But, he said, composite insurance programs will work only if:

- All participants are committed to the concept.
- All participants have a clear understanding of its objectives.
- Communication channels are efficient.
- The program is constantly monitored. ■

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Business Insurance

INTERNATIONAL

Rate undercutting for market share to endure: Analyst

By GAVIN SOUTER

PARIS—European risk managers can look forward to low property/casualty insurance rates for some time as insurers continue to undercut each other in their battle for market share, a financial analyst said.

With the old insurance cartels being broken up, the new European market could end up mirroring the market in the United States, where rates have fallen through much of the past decade, he said.

And even if European insurers resolve to raise their rates, U.S. and Japanese insurers are waiting on the sidelines, ready to plunge into the European market with cheaper capacity, he warned.

"The insurance industry is seeing unprecedented change, and it is change that will benefit the customer," said Christopher Pountain, executive director at Morgan Stanley International in London.

Traditionally, the major European insurance markets operated like cartels dominated by a few indigenous companies, he said at the 21st International Insurance and Risk Management Conference sponsored by Management Centre Europe last month in Paris.

"There was no cutthroat competition, and this heightened security. But, it produced little incentive to introduce new policies; too many people were employed, and they were paid so much, that expenses were 25% to 30% of premium income," he said.

But this scenario is being washed away by the elimination of trade barriers within the European Community, Mr. Pountain said.

Now, insurers are aggressively expanding across Europe, and the newcomers are ignoring local competitive—or non-competitive—arrangements, he said.

Allianz A.G. Holdings, for example, now owns companies in Italy, France and Britain, he said. "And in Britain, through its subsidiary, Cornhill (Insurance P.L.C.), it even sponsors that most English of games: cricket," he added.

The expansion is happening because insurers are realizing that a pan-European market is developing and that an insurer cannot limit its operations to one country, he said.

"They have to go out and win a meaningful market share, and to do that they tend to cut the price of their product," Mr. Pountain said.

Consumers fuel this price war because they base their purchasing decisions on price, regardless of the supplier, he said. "People say it doesn't matter who supplies it as long as it's cheap."

The internationalization of the industry also is leading to the internationalization of brokers, he said, noting that large brokers can provide the easiest routes for commercial clients to access new markets.

However, despite the willingness of insurers to join the global market, "all this competition for business is clearly having an adverse effect on insurers' profit margins," he said.

Insurers are becoming increasingly dependent on investment income rather than underwriting profits to stay in the black, Mr. Pountain said.

Despite the squeeze on profits, however, excess capital remains in the market. "For example, Allianz raised over $1 billion from two share issues in 1990."

Insurers will use the extra capital to pursue market share, which will cause large insurers to become even larger, Mr. Pountain said. "The widely held theory is that the big companies will be the winners, and the small to medium-sized insurers will simply fade away or be gobbled up."

Yet the economies of scale achieved by expansion are limited, Mr. Pountain said.

"We may come to the point where being big means being less profitable," he said. The larger companies may lose money when they spend in areas where they lack experience, he reasoned.

"The most suitable model for predicting the future of the European insurance industry is probably the United States. This is a market with no internal barriers between states and no restrictions on competition or commercial lines," he said.

Several insurers operate throughout the U.S. market, but there are indications that these companies are trying to become more regional. For example, they are withdrawing from personal auto insurance where the business is less profitable, Mr. Pountain said.

The most profitable property/casualty insurers in the United States are those that work in niches which they know well, he said.

However, the lack of profitability on the U.S. market, which is often attributed to market cycles, should make Europeans wary, Mr. Pountain said.

"Over the past 13 years, the U.S. industry has suffered a deterioration in results 10 times, and 1991 and 1992 look like further years of downturn. That doesn't sound very cyclical to me; that sounds like a bad industry," he said.

The U.S. market also is very competitive, with very few barriers to entry. Consequently, more insurers fail in the United States than in Europe, Mr. Pountain said.

"This is the downside of a free competitive market where the lack of any cartel means there is nothing to prop up the profits of weaker companies," he said.

If Europe follows the U.S. model, risk managers can expect a soft market for some time, Mr. Pountain said.

"Insurers may moan about the premium rates they are charging, but such is the excess of supply of insurance over demand for the product that prices will stay low," he said.

Prices will not start rising until insurers become so worried about the drain on their capital that they begin to look for profits rather than market share, Mr. Pountain said.

There also could be a potential problem for insurance buyers if the removal of barriers in Europe leads to fewer and bigger insurers. These companies may then establish a new cartel, he said.

However, if this does happen, it will not occur for several years, and the European insurers still will have to be wary of Japanese and U.S. insurers stepping into the market, Mr. Pountain said.

International brokers that can access many different markets will also ensure that competitive pressures in the European insurance market do not slacken, he said. ■

INTERNATIONAL

Reinsurer exec calls for candid talks with buyers

By GAVIN SOUTER

PARIS—Reinsurers and risk managers are forging closer relationships as corporations seek more direct control of their insurance programs, a reinsurer executive says.

This is evidenced by a large number of captive insurance company formations, which, with the support of reinsurers, allow risk managers to become more involved in constructing their insurance coverage and help to increase capacity, he says.

But if the partnership of reinsurers and risk managers is to develop further, they must form a more candid relationship, says Patrick Peugeot, chairman and chief executive officer of Paris-based SCOR S.A.

Reinsurers then will be able to provide more stable capacity and allow captive insurers to cover a wider range of risks, he said during the 21st International Insurance and Risk Management Conference organized by Management Centre Europe in Paris last month.

Reinsurers also can provide risk managers with expert advice to help them effectively utilize captives, Mr. Peugeot said.

By using a captive, risk managers gain more control over their insurance programs, he said.

Captives also allow a risk manager to obtain "auxiliary financial capacity," Mr. Peugeot said.

"By cashing in the premiums quickly and keeping close control over settlement, he can create a cash flow, which enables him to measure the actual quality of the risks he is transferring. Then, if he has adopted a proper pricing policy, he can accumulate reserves which enable him to handle specific hazards," Mr. Peugeot said.

To help policyholders get the most out of captive insurance, many reinsurers have set up departments to supply technical expertise to corporations on captive management and provide services to the captives, Mr. Peugeot said (*BI*, Nov. 4).

And the more information that reinsurers are given about a risk manager's corporation, the easier it will be for them to provide substantial reinsurance coverage at a reasonable cost, he said.

"This is the advantage of developing good relationships between captives and reinsurers," he said.

If a longer-term partnership develops between risk managers and reinsurers, then limits of coverage and costs can be projected over several years, he said. This provides stability of coverage and price, which is beneficial for both the reinsurer and the client.

"To establish the rules which ensure proper stability in these relationships, one formula seems to me to be fruitful: that of the 'right to the right price,' " Mr. Peugeot said.

And reinsurers are more likely to meet this requirement than insurers, he said.

If the risk taker is to guarantee the right price for the coverage provided, it must have a balanced portfolio, according to Mr. Peugeot. A reinsurer is more likely to have this balance than an insurer, due to the international spread of its risks, he said.

However, the relationship between risk managers and reinsurers is still in its infancy, Mr. Peugeot said.

Wider acceptance of such partnerships is curtailed by companies that simply look for the cheapest possible coverage, Mr. Peugeot said.

Instead, risk managers should seek to "cultivate" capacity through long-term relationships with reinsurers, he said.

"Those who have understood this

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INTERNATIONAL

U.S., European insurers grow more alike

By GAVIN SOUTER

PARIS—The differences between insurance markets in the United States and Europe are growing fewer as insurers on both sides of the ocean change to meet the needs of multinational companies, two risk managers agree.

The pace of change will not slacken and both U.S. and European markets will learn from each other's strengths and weaknesses, they predicted.

And although the changes already have led insurers and brokers to increasingly offer risk management consulting services, they should not forget that their primary task is to supply insurance, said the risk managers who spoke at the 21st International Insurance and Risk Management Conference last month, sponsored by Management Centre Europe in Paris.

The sheer size of the U.S. insurance market ensures its influence on the world market, said Pierre Sonigo, director of risks and insurance at Compagnie de Saint Gobain, a manufacturer based in Paris.

"With 35% of the world's premiums, compared with 24% in the E.C., the American insurance market is the largest market in the world. It is natural, therefore, to find the biggest brokers, the largest insurance companies as well as the best risk managers," he said.

And although the U.S. market has many strengths, it also has weak points, Mr. Sonigo said.

One of its strengths is its diversity, he said.

In addition to traditional stock insurance companies, the U.S. market consists of mutual insurers —like the members of the Factory Mutual System—which play a large role in the property insurance market; workers compensation pools; risk retention groups; specialized policyholder-owned insurers like ACE Ltd. and X.L. Insurance Co. Ltd.; and many captive insurers, Mr. Sonigo said.

Also, the U.S. market boasts strong, innovative and professional brokers, he said.

"They contribute to setting up large international programs, to developing new capacities in crisis situations and are constantly offering new services to their clients," Mr. Sonigo said.

The strength of the risk managers using the market and their organization, the Risk & Insurance Management Society Inc., also adds to the sophistication of the market, he said.

But despite its many strengths, the market has several weaknesses, he said.

The system of state regulation greatly complicates the process of drawing up insurance contracts, establishing new companies and keeping abreast of insurance legislation, Mr. Sonigo said.

Also, U.S. insurance contracts are far less flexible than European contracts, which are often drawn up by the clients, he said.

"Our American colleagues must generally use standard printed policies with countless numbered additional clauses, which are often absurdly complex for European buyers," Mr. Sonigo said.

The U.S. market also is far more unstable than the European markets, he said.

"The facility with which American insurers cancel contracts—even profitable ones—due to changes in strategy, and even the potential collapse of certain markets, is enough to frighten more than one European risk manager," Mr. Sonigo said.

Given these strengths and weaknesses, three distinct changes in the U.S. market are likely, he said.

First, insurers will prefer to provide risk management consulting services rather than write coverage, Mr. Sonigo said.

As an example, he cited workers compensation. Employers will be faced with higher medical costs, increased court awards and higher premiums, but the insurance market is not supplying insurance solutions to these problems, he said.

For example, Mr. Sonigo said that a major U.S. broker recommends that companies should self-insure their workers comp exposures in states where the costs are too high; use computer systems to help control costs; improve claims management; set up systems to help reduce medical costs; and improve loss control systems.

"Insurance is hardly mentioned," he said. "The set of solutions will require services of all kinds of experts that the risk manager will try to find via his broker, his insurer or independent sources."

This trend will spread from the workers comp field to other risks, Mr. Sonigo predicted.

Already, it is difficult to buy general liability coverage for a production process without accepting a high deductible, he said.

Also, the insurance market is providing little coverage for environmental risks, Mr. Sonigo said.

"It is true that selling specialized services can be more lucrative and less risky than insurance itself, but are we still in the same trade?" he asked.

A second trend concerns the structure of the U.S. insurance market, Mr. Sonigo said.

By giving regulatory powers to the states, the McCarran-Ferguson Act has led to a plethora of different laws with which insurers must comply, he said.

But, the web of legislation may be untangled if the United States follows the European Community's example, Mr. Sonigo said, predicting that there will be a U.S. equivalent to the E.C. freedom of services directive by the end of the 1990s.

"What we have been able to accomplish in the context of the liberty to provide services will be an example to our American friends," he said.

The third change will be an osmosis between the U.S. and European industrial risk markets, he said.

This will be inevitable as industrial companies establish facilities on both sides of the Atlantic, Mr. Sonigo said.

"The risk managers of those groups. . .will be contributing to economic agents involved in these markets their vision, their concepts and soon their insurers, adapted to meet local circumstances," he said.

Another aspect of the trend toward globalization is that U.S. companies are already looking at the European market for coverage, said Anton Pfaffle, risk manager at investment bank Goldman, Sachs & Co. of New York.

The current major attractions in the European market for U.S. companies are property and marine coverage, he added.

"I hope the large United Kingdom, French, German, Swiss and Scandinavian insurers will provide property insurance capacity on a blanket all-risk worldwide basis with little or no sub-limits or named peril restrictions," Mr. Pfaffle said.

However, later in the 1990s, all companies will be looking more for liability coverage as exposures increase for product, pollution and professional liability, he said.

The U.S. companies will access the European market through multinational insurance brokers, Mr. Pfaffle predicted.

In addition, the U.S. risk managers will look to the brokers and European insurers for services, including: risk inspections, loss analysis, advice on legal matters and E.C. legislation and advice on alternative risk financing, he said.

To help provide these services, some European brokers will have to change their business styles, Mr. Pfaffle said.

"I look for the European brokers to become more client-oriented and not insurer-prone, which is the case in some E.C. countries today," Mr. Pfaffle said. ■

Reinsurer-risk manager links

Continued from previous page

first seek to evaluate the minimum return sought by the reinsurers. . .then they commit themselves to building up a partnership," Mr. Peugeot said.

However, building a strong partnership is only part of the solution to a company's insurance problems, he pointed out.

The reinsurer should be reliable and the corporate buyer's exposures should be "transparent," he said.

"This reliability is expected from reinsurers to an increasing extent as the amounts at stake are increasing rapidly, far outstripping the automatic capacities of insurance companies," he said.

For example, due to new legislation, German insurers now have to provide up to 320 million deutsche marks ($97.8 million) of environmental liability coverage (*BI*, Oct. 21; Oct. 7), Mr. Peugeot said.

But, if reinsurers are to be reliable, policyholders must be candid with the details of risks, he said.

If they are not, costly legal actions will follow, Mr. Peugeot said.

"May I suggest to any risk manager who is tempted to conceal the real size of a risk. . .to think again, and consider the attitude of the risk-taker when asked to settle a loss," he said.

Closer and more understanding relationships between risk managers and reinsurers will become even more important because the demand for coverage will be greater, Mr. Peugeot predicted.

Demand will increase as regulatory and environmental constraints on companies become more strict, he said. Because the preventative technology to meet these requirements is not yet available, companies will increasingly look to the insurance industry to cover their risks, he said.

Coverage against product recalls, computer fraud and pollution will be in greater demand, although insurers currently do not provide adequate coverage for these risks, Mr. Peugeot said.

"Confronted with this situation, risk managers scrape together all the available capacities, and if there is still a shortfall, they try to constitute contingency funds, fed by fictional premiums or organized on the basis of financial reinsurance," he said.

Clearly, the combined use of a captive insurer and a reinsurer could help fill the coverage gaps, Mr. Peugeot said. ■

Risk manager attests to value of captives

By GAVIN SOUTER

PARIS—The advantages of using a captive insurer to directly underwrite a company's risks instead of turning to the traditional market far outweigh any disadvantages, a risk manager says.

A direct captive also can cut risk financing costs, improve loss control and plug gaps in insurance programs that a captive used to reinsure risks cannot, said Peter Flensburg, director of risk management at LM Ericsson A.B., a telecommunications concern based in Stockholm, Sweden.

Mr. Flensburg spoke during a session at the 21st International Insurance and Risk Management Conference sponsored by Management Centre Europe in Paris last month.

When Ericsson launched a direct captive in 1989, it already had a reinsurance captive, Ericsson Reinsurance S.A., which was set up in Luxembourg in 1985.

"The reasons to set up the original (reinsurance) captive were the usual: a large worldwide premium volume, a good loss record, the willingness to find a new solution for such a traditional business as insurance and a feasibility study that showed an overall profitability in a captive," Mr. Flensburg said.

The main advantages of the reinsurance captive, he said, are: control over the insurance system, the ability to put pressure on local rates, the building up of internal reserves for future losses, better control of loss records, wider coverage and reduced administration.

Despite these advantages, there were also factors in the captive reinsurer program that could be improved, Mr. Flensburg said.

These included: cash flow to the captive, services offered by local insurers and brokers, the flow of information from subsidiaries to the captive, and the overall quality of the insurance program, he said.

Most of those problems could be overcome by setting up a direct captive, according to Mr. Flensburg.

Consequently, Ericsson in 1989 formed a direct captive, Electra Insurance Ltd., in Dublin, Ireland.

"Many times I have been asked the question why we chose Dublin as our domicile. There are a number of reasons but the main ones are: the ability to operate within the European Community, Ericsson has long been connected with Ireland. . .and the fiscal and regulatory environment," Mr. Flensburg said.

There are seven main advantages in setting up a direct captive, he said. They are that:

- It is cost-efficient.

"With just a handful of people (some of them only partly involved in the operation), strict operating instructions and procedures, a few powerful personal computers and an efficient telecom system, we swiftly run the operation at a very low administrative cost," he said.

- It is profitable.

The fundamental financial advantage of a direct captive is that you retain a further 5% to 20% of the insurance risk and accept the premium for the risk while eliminating fronting commissions, he said.

- Broader insurance policy wording becomes available.

"Our experience in the market is that even if a local insurance company offers our subsidiary an all-risk wording for property damage, it will never be even close to the broad wording we would be able to issue from our direct captive," he said.

- Policies are always issued on time.
- Cash flow is swift.

If the captive is carefully organized, the risks can be transferred to the captive without any money leaving the group for a single day, Mr. Flensburg said.

- The company learns more about the mechanism of insurance.

"By dealing with insurance issues every day, we learn something from it," he said.

- Property loss control is improved.

Owning a captive puts more pressure on a company to improve its loss control system, Mr. Flensburg said.

However, there are a few disadvantages in owning a direct captive that need to be carefully monitored, he said. "There is a risk involved in setting up an insurance operation of your own. If you are not professional enough, you may risk losing money," he explained.

Also, owning a direct captive consumes management time, because directors who have little knowledge of insurance have to understand how the new subsidiary works, he said.

These two problems combine to present a third problem of security, he said. "By doing it all on your own, you certainly assume a greater liability as a director and officer. It is now more important than ever to scrutinize the security of your reinsurers," Mr. Flensburg said.

Companies have to reach a certain size before setting up a captive becomes worthwhile, he added. The size depends on the type of business the company is involved in, but premiums and costs should always be assessed to make sure that a captive is worthwhile, he said.

"For most larger international industrial groups, I think captives are here to stay in the long-term perspective. If they have the critical mass, I think they can make an insurance captive profitable," he said.

If a company later decides to return to the traditional market, a well-structured captive makes such a transition easy, he said.

"If the captive business is organized in a good way. . .a number of traditional insurers would immediately accept taking over the captive's portfolio," he said. ■

Outhwaite trial

Continued from page 27

tracts—that shouldn't have been written.

"Did you make that admission?" asked Mr. Boswood.

"I don't recall," said Mr. Outhwaite. "But I wouldn't use that language," he said, referring to the word "pups."

Mr. Boswood then asked Mr. Outhwaite whether he admitted that he had written "bad contracts which shouldn't have been written."

Mr. Outhwaite replied that any underwriter could make that claim, since all underwriters have written insurance policies that have produced losses. "Every single underwriter would admit in retrospect that there are contracts he shouldn't have written."

"But you continue to say that the underwriting of these (runoff reinsurance) contracts can't be criticized at all," Mr. Boswood charged.

"I never said that," said Mr. Outhwaite. He added that when he wrote these contracts, he believed that they were "reasonable" risks to underwrite and would "benefit my names."

Mr. Boswood also asked Mr. Outhwaite last week whether he had a list of questions that he used to evaluate each of the runoff reinsurance contracts, to which Mr. Outhwaite answered that he did not. With each runoff contract, brokers started negotiations fresh because each was unique, he said.

After much discussion over this point, Mr. Boswood asked in frustration, "can't this question be answered straightforward?"

"I am not prepared now to create a proposal form for you, Mr. Boswood," Mr. Outhwaite replied.

In the last few weeks, Mr. Outhwaite also has answered a sizable number of questions from High Court Justice Saville, who has intervened a number of times in the cross-examination seeking clarification.

For example, Mr. Boswood last week was questioning Mr. Outhwaite about the runoff reinsurance contract he wrote for Lloyd's underwriter Michael Cockell's syndicate, which later ended up in arbitration (*BI*, Dec. 18, 1989). Although Mr. Outhwaite was provided with figures for the overall outstanding reserves for the Cockell syndicate, he did not break out the size of asbestos loss reserves, although he admitted that he verbally asked questions about those losses.

"Any such reserve would not appear (on documents) based on what you asked?" asked Justice Saville.

Mr. Outhwaite told the judge that there would have been a "predictive element" of asbestos claims in the overall outstanding reserves, even though they were not broken out. "The arbitration confirms that the assumption I made was perfectly correct," he said.

Mr. Boswood also asked whether Mr. Outhwaite had reached any conclusion at the time the contract was written whether the Cockell syndicate's projections for future asbestos claims were adequate.

Mr. Outhwaite said he didn't because there was no reason to assume at the time it was written in 1982 that the "asbestos losses when they were paid should be paid any quicker. . .than any other claim."

Underwriters often project losses into the future, particularly when closing their underwriting year using time-and-distance reinsurance policies, said Mr. Outhwaite.

He noted that Lloyd's syndicates are not allowed to discount outstanding loss reserves. But, he added, they can pay a premium of 500,000 pounds, say, for a time-and-distance policy that will pay 1 million pounds in 10 years' time.

"So time-and-distance policies are a way of getting around Lloyd's refusal to allow discounting?" asked Justice Saville.

Precisely, said Mr. Outhwaite, "and that is why they are so popular."

A few times Mr. Boswood's questioning appeared to catch Mr. Outhwaite off guard. In particular, Mr. Boswood asked Mr. Outhwaite about his acquaintance with Mr. von Eichen, who has been sitting in court with the plaintiffs' attorneys.

Mr. Outhwaite said that though he'd had a few lunches and possibly a dinner with Mr. von Eichen, he'd never seen a line slip with Mr. von Eichen's initials on it. He also said he did not know Mr. von Eichen as Munich Re's excess-of-loss underwriter but as the head of the London office.

Mr. Boswood then asked whether Mr. Outhwaite had recently flown to Munich with his defense attorneys to meet with a Munich Re executive. Mr. Outhwaite was silent—apparently surprised that this was known—and then said yes, he had gone to Munich, but couldn't recall precisely what was discussed. He recalled, however, that the executive explained "why Munich Re hates to get involved in any litigation." ■

Members contemplate lawsuit against Merrett

By ELIZABETH WILCOX

LONDON—Members of Lloyd's of London's largest syndicate are seeking counsel on whether to sue over losses stemming from runoff reinsurance contracts the syndicate wrote.

The members of marine syndicate 418, managed by Merrett Underwriting Agency Management Ltd., contend that the syndicate should have kept open its 1982 underwriting account, in which it wrote 11 runoff reinsurance contracts that later produced sizable losses for the 1985 account (*BI*, Nov. 4).

By not acknowledging the size of the 1982 losses, the members allege, Merrett unfairly recruited names from 1983 to 1985.

Led by retired Canadian accountant Kenneth Lavery, the members gathered in London last week to discuss charges he had outlined in an Oct. 14 letter to a Lloyd's investigative committee.

Approximately 200 of the 300 members at the meeting voted with raised hands to appoint a steering committee and seek legal counsel on the feasibility of suing syndicate

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Eurotunnel coverage

Continued from page 27

age, which ran from May 19, 1986, to Dec. 31, 1987, was 2.24 million pounds ($4 million).

The coverage was written by an alliance of insurers including Commercial Union P.L.C., Union des Assurances de Paris, Assurances Generales de France, Allianz A.G. Holding and Lloyd's of London syndicates.

The coverage was placed by Gras Savoye and Faugere & Jutheau in Paris and Sedgwick Group P.L.C. in London.

The French Parliament approved the tunnel project in May 1987, and the British Parliament approved it two months later.

"However, it was a real risk because there was a general election in Britain in 1986, and a change of government may have affected the plans," Mr. Fallet said.

The construction policy for the project—written by the same group of insurers from Dec. 1, 1987, to June 15, 1993—covers third-party liability and construction risks. The policy also covered startup delays.

The policy, co-led by UAP and Commercial Union, generated 60 million pounds ($106.6 million) of total premium, said Mr. Fallet.

"The policies are totally bi-national, written in two languages, subject to the laws of both the United Kingdom and France and subscribed by U.K. and French markets in roughly equal proportions in two currencies," Mr. Fallet said.

The third-party liability coverage is written in layers up to a limit of 100 million pounds ($177.6 million) with the first quarter placed in the construction insurance market and the remainder in the marine market, according to Mr. Fallet.

The single-loss deductible is 2,500 pounds ($4,441), he said.

Limits for the all-risk construction coverage are 500 million pounds ($888.3 million) for any one loss. The policy covers the tunnels as well as heavy equipment and other "plant" risks.

"This is considerably more than the estimated maximum possible loss: 100 million pounds ($177.6 million)," Mr. Fallet said.

The deductibles are: 25,000 pounds ($44,412) for onshore risks; 100,000 pounds ($177,650) for offshore and tunnelling risks; and 250,000 pounds ($444,125) for third party claims specifically arising from faulty design and workmanship.

The deductible for equipment losses is 2,500 pounds ($4,441), except for tunnelling equipment, which carries a 100,000 pound ($177,650) deductible, Mr. Fallet said.

The startup delay coverage was the hardest coverage to design and calculate, he said, noting that the project's a daily costs were in 1987 were 1 million pounds ($1.88 million at 1987 year-end exchange rates).

Eurotunnel purchased 250 million pounds ($470 million at appropriate exchange rates) in startup delay limits, with a 14-day delay deductible, Mr. Fallet said.

So far, several hundred claims—mostly claims stemming from damage to plant and equipment—already have been filed.

"This is not unexpected considering the huge size of the project, employing 15,000 people at the peak of construction," Mr. Fallet said. He also noted that construction crews are using 182 miles of track to cart construction material throughout the tunnel project.

Ninety-five percent of the claims stem from damage to plant and equipment, but these generally have been for small amounts, he said.

European windstorms in 1987 and 1990 caused larger losses, as did a Feb. 23 fire at the Eurotunnel exhibition center in Calais, which produced losses of 1 million pounds ($1.8 million at current exchange rate)

Commercial Union and UAP have been given full authority by the following insurers to handle claims, and the co-leaders have to communicate with each other only on claims exceeding 500,000 pounds ($888,250), according to Mr. Fallet.

The claims breakdown shows:

- 65 third-party liability claims in England totaling 3.5 million pounds ($6.2 million at current exchange rates), and 11 claims in France totaling 120,000 French Francs ($21,468).
- 10 work in progress claims in England totaling 14.3 million pounds ($25.4 million), and 19 claims in France totaling 16.8 million French Francs ($3 million).
- 145 plant claims in England totaling 55.8 million pounds ($99.1 million), and 372 claims in France totaling 88.2 million French Francs ($15.8 million).

The insurance risks relating to the Channel Tunnel and Eurotunnel will change once it opens for business in 1993, Mr. Blackmore pointed out.

"In 1992, we shall be testing our first railway locomotive, and in mid-1993 Eurotunnel will be an operating railway," he said.

The company will own enough passenger cars to comprise 17 trains each more than half a mile long, 38 locomotives and 500 carrier cars to transport automobiles through the tunnels, he said.

"By 1994, we hope to be carrying 30 million passengers and 15 million tons of freight annually, and receiving revenues of 2 million pounds ($3.6 million) a day," Mr. Blackmore explained.

Eurotunnel will need to insure the three tunnels, two terminals and the rolling stock. Eurotunnel will be seeking property, business interruption and third-party liability coverage, he said. ■

INTERNATIONAL

Continued from previous page
management.

Many of those members face large losses from their participation on syndicate 418's still-open 1985 underwriting year. Losses on that account year averaged about 16,800 pounds ($29,854 at current exchange rates) per member, while the average amount written per member was 43,000 pounds ($76,411). So far, 1985 account losses are estimated at 67 million pounds ($119.1 million).

In Mr. Lavery's letter, he alleges that Merrett should not have closed its 1982 account because it was impossible to determine its asbestos liability on 11 runoff policies.

Although Merrett has said that it only learned of the scope of those losses in 1985, causing it to keep that account open, Mr. Lavery points out in the letter that syndicate 317/661, managed by R.H.M. Outhwaite (Underwriting Agencies) Ltd., kept its 1982 account open out of concern over "similar" runoff policies.

The losses resulting from the runoff policies written by Outhwaite are now the subject of legal action in London's High Court between syndicate members and the Outhwaite members agency (see story, page 27).

Mr. Lavery also alleged in the letter that the 2,089 names syndicate 418 recruited from 1983 to 1985 were "deceived" by underwriter Stephen Merrett, who said in his 1982 syndicate report that "we have determined an appropriate level of reserve."

Mr. Lavery contends in his letter that "these new deceived names are now expected, without a murmur, to help the 1982 names still remaining on the 1985 open year."

He later told *Business Insurance* that the 1982 losses "should have been borne" by the 1,959 names in the syndicate that year.

Mr. Merrett dismissed Mr. Lavery's allegations as "unfounded."

"As far as I know, there is no substance to any of the allegations that I have seen," he said.

Regarding Mr. Lavery's claim that the closure of the 1982 account was a misjudgment, Mr. Merrett said, "I have no idea on what basis he is making that claim."

Comparing Merrett's decision to close syndicate 418, while Outhwaite syndicate 317 remained open is not fair, he said. "It isn't a parallel." Syndicate 317 wrote far more contracts than syndicate 418, which affected the Outhwaite syndicate at a far faster and more significant rate, others contend.

Some names at the meeting expressed concern about Mr. Lavery's failure to invite a Merrett representative.

"Before proceeding any further, I'd like to invite the Robson brothers (directors of the Merrett Group) and Stephen Merrett to address the group," said Timothy Royle, a syndicate 418 member for more than 30 years. Mr. Royle also said: "Let us go slowly and not put too much money into the hands of the lawyers."

Later, Mr. Lavery said it was not proper to invite Mr. Merrett to the members' first meeting. However, he said that one steering committee objective is to explore a possible settlement and that Mr. Merrett may be invited to its next meeting Dec. 2.

Meanwhile, a report on whether members should take legal action is due within six months, said solicitor David Tiplady of D.J. Freeman, who was at the meeting. ■

LONDON

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liability, greed still held the upper hand."

Mr. Pemberton resigned as a Lloyd's member after only two years —1989 and 1990—because he was unhappy with "the way I found matters conducted."

Feltrim report delayed

An independent review into the loss-riddled Feltrim Underwriting Agencies Ltd. has been delayed, bogged down by the large volume of material that it must consider.

The review body was due to report to the Council of Lloyd's by the end of September, but does not expect to report until next year.

The report is expected to supply Lloyd's and the 4,000 members of Feltrim syndicates 540/542 and 847 with an explanation of the circumstances surrounding the syndicates' 1987 to 1990 underwriting losses.

The huge volume of material on the syndicates and the non-availability of some witnesses made the Sept. 30 deadline impossible, Lloyd's said.

The Feltrim syndicates, which primarily wrote excess-of-loss reinsurance, face a worst-case estimate of 380 million pounds ($675.3 million at current exchange rates) in losses, says the Feltrim Names Assn. ■

Utilization

Continued from page 2

the M&R guidelines. Properly implemented, these guidelines have not only reduced costs but improved the quality of health care delivered to the patient," Dr. Doyle said.

"We've developed our own criteria, which are very stringent," added David V. Axene, a consulting actuary with M&R and another of the study's authors.

M&R considers the criteria "a gold standard," he added. "We believe we have identified the least amount of health care resources to handle high-quality health care for a series of patients."

Consultants and insurers say M&R's findings and the methodology it used shine a new light on the problem of needless utilization.

The M&R study is "an exciting blending of actuarial and medical science," said Philip Turner, director and actuary at Blue Cross of California in Woodland Hills.

Mr. Turner observed that Mr. Axene "has been in the forefront of bringing together the two professions, and this study is an exciting first result of that match. He's actually been able to quantify some of these things that actuaries suspect and doctors know.

"The message here to various consumers of health care—employers and the general public—is that employers should be more and more demanding of explanations of where their health care dollars are going," Mr. Turner asserted.

"And we as citizens. . .need to question our doctors more as to what our doctors are prescribing for us," he said.

The M&R guidelines are "extremely detailed, good criteria," noted Dr. Thomas Mayer, a principal with William M. Mercer Inc. in Los Angeles.

"Given that they have used very aggressive criteria, what you're seeing is probably a true measurement of what could be obtained" in reducing unnecessary hospital days, Dr. Mayer asserted.

Mercer has "done over 300 different audits" in various geographical areas and found that between 31% and 51% of hospital days were unnecessary, Dr. Mayer added in support of M&R's findings.

The new study is useful in an area where there has been "a lot of speculation," said a spokesman for the Health Insurance Assn. of America in Washington.

"There's not a lot of numbers out there; that's what makes the M&R survey a real contribution," the spokesman asserted.

"M&R has also looked at outpatient care as well and tried to make a judgment on that more difficult area," the spokesman added.

Other experts, though, say the conclusions may be overstated.

"We've done a lot of work in this area. For some procedures we have found high rates of inappropriate use," said Dr. Robert Brook, vice chairman of medicine at the University of California-Los Angeles and director of the RAND Corp. Health Sciences Program in Santa Monica, Calif.

"We've been arguing that a quarter (of hospital days) could be done away with. Saying half could be done away with is a lot," he said.

That 24% of hospital admissions are unwarranted "has been supported by other studies," points out Douglas Cave, a consultant with Hewitt Associates in Santa Ana, Calif.

And the prevalence of managed care on the West Coast and in the Twin Cities as compared with New York and Chicago explains why patients in Los Angeles, Seattle and Minneapolis spend less unwarranted days in the hospital, he added.

"But 60% seems high to me," he asserted, referring to the figures for unnecessary hospital days in New York and Chicago.

Mr. Cave also questioned whether it was valid for M&R to impose the same strict utilization standards nationwide, since they can't be realistically applied uniformly in all geographic areas.

"Chicago might not have the same number of outpatient surgical facilities as Southern California," Mr. Cave explained. A patient in Chicago might therefore have to remain in the hospital longer than a patient in Los Angeles, he said.

"Or suppose an employer does not offer home health care," Mr. Cave added. Employees would not have the option of receiving certain treatments at home rather than in a hospital, he said.

According to the M&R study, amounts of unnecessary care vary significantly by region.

Nationwide, 24% of hospital admissions were unnecessary. But in Atlanta and Chicago, the figure was 32%, compared with only 14% in Los Angeles.

Other cities and the percentage of unnecessary admissions include: New York, 31%; Dallas, 30%; Miami, 28%; Kansas City and Boston, both 24%; Minneapolis, 23%; Phoenix, 20%; and Seattle and Washington, D.C., both 19%.

Likewise, while M&R concluded that 15% of all office visits nationwide were unnecessary, 36% of those in Los Angeles were considered to be unnecessary, compared with 0% of those in Chicago.

Thus, while Los Angeles has the lowest number of unnecessary admissions, it has the highest number of unnecessary office visits. In Chicago the situation is reversed.

The survey explains this by noting that "as inpatient services are more efficiently delivered, there is a tendency to move services to the outpatient setting."

Other cities and the percentage of unnecessary office visits include: Phoenix, 32%; Kansas City, 27%; Miami, 22%; Seattle, 18%; Dallas, 17%; Boston, 16%; Washington, D.C., 15%; New York and Atlanta, both 11%; and Minneapolis, 2%.

The study notes that while Los Angeles, Minneapolis and Seattle have the most efficient systems for inpatient hospitalization, "only Minneapolis appears to also be controlling the ambulatory consumption patterns."

In addition, the study notes these three cities "are significant centers for managed care development."

Besides New York, Chicago, Seattle and Los Angeles, the percentage of unnecessary hospital days in other cities include: Miami, 61%; Boston, 58%; Dallas 57%; Washington, D.C., 54%; Kansas City, 53%; Atlanta 52%; Phoenix, 45%; and Minneapolis 44%.

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For a free copy of the study, contact David V. Axene, Milliman & Robertson Inc., 1301 Fifth Ave., Suite 3800, Seattle, Wash. 98101-2605; 206-624-7940.

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Asbestos claims

Continued from page 3

were not policyholders of syndicate 33.

As syndicate 33 was not legally obligated to make these payments, the Outhwaite syndicate can refuse to pay them under the runoff reinsurance contract that it wrote for syndicate 33, the judge said.

The ruling sent shock waves through the London market.

"Over the summer everybody has been reviewing their position as a result of the judgment. If many opt out (of the CCR) as a result, it will be a very serious situation," one London lawyer said.

"The sharing formula changes will affect everyone," said the CCR's Mr. Fitzpatrick. "However, the practical affect of the changes in the sharing formula will be limited."

The total amount that each producer member will contribute to the center will not change, but individual contributions will only be allocated to claims that actually name a certain producer, he explained.

While the Outhwaite decision was one factor in the center's decision to implement the changes in its sharing formula, there were other reasons, said Mr. Fitzpatrick.

"Some U.S. reinsurers and non-signatory reinsurers have tried to use the center's sharing formula as a basis for refusing to pay," he explained. "Adoption of this named-only sharing formula should make it easier to collect from non-signatory insurers and reinsurers for amounts we pay in settlements."

In addition, the change could make it easier for the center to attract new members, Mr. Fitzpatrick said.

"We have had a number of discussions with new members and the pay-on-all-claims sharing formula has proved to be barrier," he said. "Modifying the formula to a named-only sharing formula should increase our prospects for reaching agreements with new members."

Mr. Fitzpatrick emphasized that the changes in the sharing formula will not affect the center's claims settlement practices. "It is purely an operational change," he said.

As a result of these changes, most London underwriters seem likely to remain members of the center, despite their reservations about Justice Evans' ruling.

The Asbestos Working Party in London, headed by former Lloyd's underwriter Robin Jackson, and the LMCS wrote to London underwriters, seeking their decision whether to remain CCR members by Nov. 1.

As of the beginning of last week, the LMCS had "responses from 60% of members," Mr. Frost said, adding that the remaining London members would be contacted within seven to 10 days.

"So far we have had no members wishing to opt out," he said. "I think we will get sufficient support to carry on."

If individual insurer members opt to withdraw while most of the other insurers remain CCR members, they would still be billed for membership through the LMCS, or they would have to on their own gather claims information and provide the claims services now supplied by the LMCS, Mr. Frost said.

Mr. Jackson was traveling and could not be reached.

"Most people will remain in the CCR. I don't see a mass defection, agreed John Wetherell, chairman of Lloyd's Non-Marine Underwriters Assn. "I think there is concern (about Justice Evans' ruling). However, a lot of people were perplexed by the judgment and I don't think it will affect membership of the CCR."

Leading Lloyd's underwriter Stephen Merrett also believes most London underwriters "are intending to remain with the CCR while it is still a viable entity in the U.S."

Meanwhile, underwriters still are waiting to see if reinsurers will use Justice Evans' ruling to void claims settled so far under the Wellington Agreement by both the Asbestos Claims Facility and the CCR.

"It seems to be a mixed reaction so far from reinsurers. Many are waiting to see what support the judgment gets," Mr. Frost commented.

"It's still very early" to establish whether reinsurers will use the ruling in an attempt to void claims," agreed Mr. Wetherell. "I am not sure that it would really help reinsurers if they adopted a very hostile stance. There would be a whole host of lawsuits" between insurers and reinsurers if the reinsurers attempt to void claims settled under the Wellington agreement, he commented.

"It would be very bad indeed for the market if reinsurers stopped payments in light of the judgment. Payments throughout the market would just grind to a halt," said Nigel Brook, a partner at London law firm Clyde & Co.

Mr. Merrett also believes that reinsurers will not radically alter their claims payment position with ceding underwriters that belong to the facilities as a result of the ruling.

Asbestos claims are being presented to reinsurers in a clearer and more specific fashion and there is a "more specific data base now as to amounts that are paid (through the CCR) where there is no clear liability attached" to individual underwriters, Mr. Merrett said.

Theoretically, "reinsurers can argue that they can avoid some claims as a result of the judgment" but many will continue to abide by the spirit of the facility and the fact that it was established to save insurers and reinsurers money, he said.

As a result, Merrett Underwriting Agency Management Ltd., whose syndicates also wrote runoff reinsurance policies similar to those underwritten by the Outhwaite syndicate, "have not changed our stance" and will continue paying such claims, he said.

"We are reviewing the position because we have a duty to our (Lloyd's) members. But, at the present time, we have not adopted a different position with our clients" following the judgment, Mr. Merrett said, though he added that the agency has "asked for some clarification (of claims paid) in some cases."

Other portions of Justice Evans' rulings also are causing problems for ceding insurers.

Although syndicate 33 was able to inform the Outhwaite syndicate, its only reinsurer, of its intention to settle claims under the Wellington Agreement as prescribed by the ruling, other insurers would find it an enormous task to inform all of their reinsurers over a 30- to 40-year period of their intention to join the Wellington Agreement, Mr. Brook noted.

Moreover, if permission was sought from all reinsurers, there is a strong chance that some would agree and some would not, he said.

Meanwhile, Roberts & Hiscox last week sought leave from Justice Evans to appeal his decision, said Mark Klimt, a partner with the London law form Fishburn Boxer, which represents the agency.

Permission to appeal the decision is being sought due to the "far-reaching and wide-ranging" implications of the judgment, Mr. Klimt said. ■

Second-hand smoke

Continued from page 3

attendants.

Cigarettes are a defective product, he said. "It's the only product which when used as intended will kill most people or make them seriously ill."

The suit does not name any airlines. While Mr. Rosenblatt said part of the blame rests with the airlines, the plaintiffs did not want to "muddy the waters."

"The airlines will be involved—they deserve blame, too—but I place about 90% blame on the tobacco companies and 10% blame on the airlines," said Mr. Rosenblatt, declining to say whether the plaintiffs will file separate litigation or workers compensation actions against the airlines.

The complaint contends the plaintiffs "never regularly smoked cigarettes" and "were unaware of the dangers to which they were exposed" while working as flight attendants.

However, plaintiff Norma R. Broin, who has worked for American Airlines since 1976, contracted lung cancer in 1989, when she was 32 years old, the complaint alleges. Ms. Broin had "never smoked cigarettes (and) no member of her immediate family smokes cigarettes," the complaint says, noting that Ms. Broin belonged to the Mormon Church, which forbids use of tobacco, among other substances.

The complaint lists 23 maladies from which the plaintiffs are suffering, including chronic bronchitis, emphysema, cardiovascular disease, infertility and peptic ulcer disease.

The defendants "know and have known for many years that cigarettes guarantee death, cancer, heart disease, pain, agony, anguish and grief to millions of Americans," the complaint alleges. "These defendants failed to place any warnings on their cigarettes or in their advertising so as to advise members of the public, including the plaintiffs herein, that constant and repeated exposure to cigarette smoke in the workplace" can cause serious health risks to nonsmokers.

"Defendants have conspired so as to deprive the plaintiffs of the medical and scientific data reflecting the dangers associated with passive smoking," despite having information on the "scientific fact that involuntary or passive smoking is a cause of major diseases, including lung cancer, in healthy non-smokers," the complaint alleges.

"Reports from the Surgeon General of the United States and the National Academy of Sciences have documented this fact," the complaint says.

In addition, "second-hand smoke exacerbates the health problems of people who suffer from chronic lung disease, heart disease, emphysema, asthma, allergies and diabetes. The National Academy of Sciences has reported that flight attendants breathe in the same amount of second-hand smoke as a person who lives with a pack-a-day smoker," the suit says.

The lawsuit contends that scientific studies documented the dangers of second-hand smoke as early as 1974.

The tobacco industry certainly became aware of the dangers of second-hand smoke after scientific literature in 1980 reported health problems from second-hand smoke, according to Mr. Daynard of the TPLP.

A spokesman for Philip Morris said the company will "vigorously defend against this suit."

"We believe the suit is trying to capitalize on the recent publicity surrounding environmental tobacco smoke. We don't believe the scientific claims regarding environmental tobacco smoke will stand judicial scrutiny. We claim the dangers of passive smoke have not been established," he said.

The other defendants would not comment on the suit, nor would the Washington, D.C.-based Tobacco Institute.

Some attorneys say that while the suit poses a new legal threat for tobacco companies, the plaintiffs face many obstacles.

"There will be a real difficult road ahead for these plaintiffs to demonstrate that exposure to second-hand smoke was the cause of their alleged individual maladies," said Arvin Maskin, a partner with Weil, Gotschal & Manges in New York specializing in mass tort litigation.

Showing causation "is likely to be an insurmountable burden" for the plaintiffs, he said.

"I don't think the flight attendants can prove" that passive smoke caused them harm, said Victor Schwartz, a defense attorney and product liability expert with Crowell & Moring in Washington, D.C.

"There is much more smoke in the airport than on an airplane," he said, noting that airplane cabins are equipped with state-of-the-art air filtration systems.

Mr. Schwartz also pointed out that the plaintiffs made a conscious choice to work as flight attendants despite their exposure to second-hand smoke.

"When you work for an airline, you can easily choose to go to a ground job from a sky job without loss of pay. These people continued to work in the sky. They chose to be in an environment that partially contains smoke," he said.

Tobacco companies could argue that they are not liable because airlines are "heavily regulated" by the Federal Aviation Administration, which "controls all aspects of airline safety," said Mr. Maskin, the mass tort specialist.

Another hurdle for the plaintiffs is obtaining class-action status, attorneys say.

"This is not a class action," Mr. Schwartz said. "There is not enough in common among the attendants: They all worked for different airlines, for different periods of time" and are suffering from a plethora of different ailments.

"I question the use of the class action device in this context," Mr. Maskin agreed. "It will be interesting to see if it's allowed."

"The suit hasn't proved a class exists," according to the Philip Morris spokesman. "We don't believe court rules permit this as a class action."

However, some attorneys think the flight attendants have a chance of recovering damages because, unlike smokers' claims against tobacco companies, the flight attendants did not choose to smoke.

"In non-smoker cases, because the plaintiffs didn't assume any risk by smoking, the issues brought up in smoker cases are swept away," said John F. Banzhaf III, executive director of Action on Smoking & Health, an anti-smoking group in Washington, D.C.

"This is not a case where it's possible for the jury to blame the victims," said Mr. Daynard of the TPLP. "In that sense, this case creates a different type of threat to the tobacco industry."

About 100 cigarette liability lawsuits are pending nationwide, most alleging that tobacco companies failed to warn consumers of the dangers of smoking and misrepresented that smoking was safe.

The U.S. Supreme Court will decide whether the Federal Cigarette Labeling and Advertising Act preempts suits filed under state laws charging tobacco companies with failure to warn or with misrepresentation (*BI*, Oct. 14).

Some attorneys say the high court's decision in that case may not influence courts presiding over cases alleging harm from second-hand smoke because the issues are different.

"I don't think the issues are the same" in the two cases, according to Kenneth Geller, an attorney with Mayer, Brown & Platt in Chicago.

"The case before the Supreme Court involves failure-to-warn claims and does not involve claims that the product was defectively manufactured or claims of strict liability," both of which are contained in the flight attendants' case, Mr. Geller said.

"Label warnings were never really directed to non-smokers, so I'm not sure the events in the Supreme Court case will be controlling," Mr. Maskin said.

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Norma R. Broin et al. vs. Philip Morris Cos. Inc. et al., 11th Judicial Circuit Court for Dade County, Fla.; No. 91-49788.

Health summit

Continued from page 1

"No Republican should run for election or re-election without a position on health care. It clearly turns up the heat to do something," said Dallas Salisbury, president of the Employee Benefit Research Institute in Washington, D.C.

It was a political issue—whether a single-payer national health care system can deliver benefits at much lower administrative costs than the current system—that triggered last week's summit.

Benefit observers say a catalyst for the summit called by the Bush administration was the release of several reports earlier this year, including one by the General Accounting Office, that found a single-payer system would save billions of dollars in administrative expenses.

In fact, the GAO reported that the annual $67 billion in administrative savings from a Canadian-style program would offset the cost of extending first-dollar health insurance to all Americans (*BI*, June 10).

Shortly after the GAO report was released, Dr. Sullivan, the HHS chief, warned at the American Medical Assn.'s annual meeting that a "critical mass" would rise up demanding a total government takeover of the health care delivery system unless ways were found to curb health care costs.

Now, "Secretary Sullivan is trying to take the wind out of the sails" of those who say "that the administrative costs of the current system are a reason to change to a single-payer system," said Stuart J. Brahs, vp-federal government relations in the Washington, D.C., office of The Principal Financial Group, a diversified financial services company.

One non-controversial way to curb health care costs would be to develop a uniform, nationwide health insurance billing system, Dr. Sullivan said.

As envisioned by Dr. Sullivan, everyone with health insurance would receive a computer card similar to those now used in automatic teller machines.

Consumers would present these cards to physicians and hospitals when obtaining health care services. Health care providers, in turn, would electronically file claims with the patients' insurers.

Such an electronic, paperless system ultimately could cut annual administrative costs at least $20 billion, Dr. Sullivan said.

Before that could happen, though, insurers and health care providers would have to agree on, among other things, the information that would be needed to design and process a uniform, electronic claims form.

"Before we move toward a paperless, computerized system, we need to standardize the entire claims process from data collection and billing to coverage and utilization review," said Richard Davidson, president of the American Hospital Assn. in Chicago.

Some observers—like Bernard Tresnowski, president and chief executive officer of the Blue Cross & Blue Shield Assn. of Chicago—believe that such a system could be in place by the end of the 1990s.

"There are enormous opportunities" to control administrative costs, said Joseph Brophy, president of The Travelers Insurance Co. of Hartford, Conn.

"I came away extremely positive from the meeting. Dr. Sullivan understands the issue. He understands the potential of technology to reduce administrative costs," Mr. Brophy said.

Some insurer executives who attended the summit applauded Dr. Sullivan for his efforts to curb administrative costs. They say his approach is pragmatic.

"Dr. Sullivan is saying let's take one piece at a time," said Robert O'Brien, president of CIGNA Corp.'s employee benefit units.

"That is a more much practical approach" than a total revamp of the system, Mr. O'Brien said.

But the public, if the Pennsylvania Senate race was any indication, may want more.

In that race, Sen. Wofford made his call for a national health insurance program a key campaign theme.

"Pennsylvania voters said they are no longer willing to wait years and years to solve a problem which is immediate for them": providing access to the health care system and controlling costs, said Frank McArdle, a consultant with Hewitt Associates in Washington, D.C.

Others contend that the voters' preference for Mr. Wofford, a one-time aide to President Kennedy and a co-founder of the Peace Corps, may be less of an endorsement of national health insurance and more of a call for politicians to address the cost and availability problems associated with health care coverage.

"People were not necessarily voting for national health insurance," said Howard Weizmann, executive director of the Assn. of Private Pension & Welfare Plans in Washington, D.C. "They were voting that health care is an important issue for them. They fear losing coverage. They fear rising costs.

"Dick Thornburgh was a victim because he sat down to the meal without the utensils. He didn't have a health care program," observed Mr. Weizmann, the former benefits manager at Sun Co. Inc. in Radnor, Pa.

As a result of Mr. Thornburgh's defeat, Washington observers expect Republicans—for political survival—to take a more active role in the health insurance debate.

"The message from Pennsylvania voters demonstrates it is no longer safe for politicians who say they don't have a solution for the health care crisis perceived by the public," Mr. McArdle said.

"If a politician doesn't have a serious health care proposal, he risks losing his or her job," Mr. McArdle said.

President Bush, who has strongly opposed national health insurance and has not developed a program to improve access to health care for the 34 million uninsured Americans, acknowledged last week that Sen. Wofford struck a chord—though not just on health care.

Voters are "concerned about their livelihood," President Bush said. Sen. Wofford "got a big hand for saying he wants to help those whose benefits have run out. . . . Sen. Wofford did a superior job of communicating his concerns to the people of Pennsylvania." ■

Executive Life

Continued from page 3

cyholders covered by guaranty funds will receive 100% of their benefits up to the limits set by the states in which they reside, even though the insurer will not be liquidated. These caps average $100,000 on cash values and $300,000 for death benefits.

• That the responsibility undertaken by the insurance industry to capitalize a new insurance company to succeed Executive Life and to provide financial guarantees for Executive Life's massive junk bond portfolio be financed with substantial additional resources, not those already committed to the policyholder enhancement agreement.

Insurance Department advisers had suggested several ways NOLHGA could address the concerns, including various reinsurance transactions, said Mr. Garamendi.

But the revised proposal "did not provide safeguards in the event the value of the bond portfolio declined and/or other financial reversals occurred," he said.

In addition, the 20 insurers that would back the NOLHGA bid "maintained a right to reimbursement from the guaranty funds that would place them ahead of the funds' commitments to make policyholders whole," Mr. Garamendi added.

Even though he rejected the NOLHGA offer, Mr. Garamendi congratulated the insurers and the guaranty fund organization's members "for proving to policyholders throughout the country that the life insurance industry is committed to their financial safety. Their efforts and continued involvement in the rehabilitation of Executive Life demonstrate good faith leadership in this time of crisis."

After rejecting the NOLHGA offer, the commissioner encouraged the next two highest bidders—a French investor group led by Altus Finance and Mutuelle Assurance Artisanale de France and a group led by San Francisco-based investment bank Hellman & Freidman—to enhance their offers by a deadline of today.

He also asked the two bidders to disclose their contemplated management structure for the successor to Executive Life and the identities of all investors in their bids.

While the Hellman & Friedman group did not say whether it would enhance its proposal before re-submitting it, a spokesman for the MAAF/Altus group said it was considering ways it could improve benefits to policyholders.

Mr. Garamendi will announce his final recommendation to the court on Thursday. A hearing to consider the bids is scheduled to begin Nov. 18 in Los Angeles Superior Court.

NOLHGA, though, is not taking the rejection of its offer as the final word, since Judge Kurt Lewin, who is overseeing the Executive Life conservatorship, has the ultimate say.

"While we are disappointed in the commissioner's decision, we are confident that the court will ultimately agree with us and we will continue to work to demonstrate to the court that the NOLHGA solution provides the greatest value and greatest long-term security for policyholders," Eden Sarfaty, the group's president, said in a statement.

And, in the meantime, the organization will continue to negotiate with Mr. Garamendi, said Robert Ewald, executive director of the Illinois Life & Health Insurance Guaranty Assn. in Chicago and co-chairman of NOLHGA's Executive Life task force.

But "if we cannot reach an accommodation with Mr. Garamendi, we will approach the court," he said.

"We and our advisers (at J.P. Morgan & Co. Inc.) believe that the commissioner's nine points were completely met," said Arthur Dummer, who co-chairs the task force with Mr. Ewald. Mr. Dummer heads the Utah Life & Health Insurance Guaranty Assn. in Salt Lake City.

"The assertion of double-counting of the $1 billion facility (from the 20 life insurers) is incorrect. Under NOLHGA's plan, policyholders would actually benefit from twice the protection because of the credit facilities," he said.

"The credit of the guaranty association system alone is of the highest quality, and that is what attracted the granting of credit by J.P. Morgan," Mr. Dummer said. "Even without that, this portfolio of assets, coupled with $300 million of capital and the carefully structured $1 billion credit facility, is of investment-grade quality."

Mr. Dummer also asserted that the commissioner's suggestion that the security of NOLHGA's enhancement agreement would be impaired is "grossly exaggerated."

"We find it amazing that (the department) is quite willing to accept the ability of the guaranty associations to meet over $1 billion of obligations for enhancement of other plans, yet is unwilling to do so for a unitary plan which costs much less," he said.

"The unused and uncommitted assessment capacity of the guaranty association system over the period of 1991-1996 is $9.5 billion, which is 10 times any reasonable assessment of need for (Executive Life) policyholders," Mr. Dummer said.

Illinois' Mr. Ewald said he was "astounded" that Mr. Garamendi would reject the organization's offer and instead accept an offer that provides lower benefits to policyholders.

"Our plan has the support of virtually every policyholder group," he said. And, "if you polled the insurance commissioners in each state, a vast majority would support our proposal."

NOLHGA's decision to pursue court acceptance of its takeover plan will not interfere with its agreement to serve as the ultimate safety net for policyholders if another offer is approved, according to Mr. Dummer.

Some insurance industry observers questioned Mr. Garamendi's motives in rejecting the NOLHGA offer.

"It makes it look like he's playing politics," said John B. Kleiman, vp at Conning & Co. in Hartford, Conn. He suggested rejecting the NOLHGA offer may be a ploy by Mr. Garamendi to up the ante in the bidding war.

In a statement, the American Council of Life Insurance said it "still believes that the NOLHGA bid offers greater guarantees and benefits to policyholders than the other bids presented to the commissioner."

As could be expected, the two bidders whose offers received new life when the NOLHGA bid was rejected welcomed the move.

"Commissioner Garamendi deserves praise for creating a competitive bidding process and for correctly identifying flaws in the NOLHGA bid," said F. Warren Hellman, president of Hellman & Friedman.

Hellman & Friedman's plan calls for creating a new insurer with Executive Life's assets, including its extensive junk bond portfolio, plus injecting $1 billion in new capital.

"We continue to believe that our bid to rebuild the company as the Sierra National Life Insurance Co. offers the greatest security and opportunity for policyholders," Mr. Hellman said.

"Rather than selling the bonds in a one-shot deal at a price far below their market value, we would enable policyholders to receive the full value of the bonds by liquidating them over time, taking full advantage of market conditions."

Industry analysts have suggested that the Altus/MAAF offer of $3 billion to buy Executive Life's junk bond portfolio is lower than the actual value of the bonds, especially since the junk bond market has improved recently.

"Furthermore," Mr. Hellman said, "we are the only bidder to offer an experienced management team, led by Jack Byrne (president of Fund American Corp., former parent company of Fireman's Fund Insurance Co.), to build the company as a viable, long-term California-based insurance provider to the benefit of policyholders."

Indeed, some industry observers have suggested that Mr. Garamendi may have rejected the NOLHGA offer partly because the new company formed by NOLHGA to pay Executive Life's policyholder obligations would have, in effect, been a runoff facility that would not generate new business.

During its annual meeting in Washington, D.C., last week, the National Assn. of Independent Life Brokerage Agencies criticized the NOLHGA proposal for its failure to create an ongoing concern.

"NOLHGA would have no motivation to create an ongoing insurance company," states a resolution the organization was considering. "It would liquidate the company and policyholders would have their policies assumed by another company with questionable financial strength and policyholder integrity.

"These beleaguered Executive Life policyholders deserve continuity, which will not be possible with the NOLHGA plan," the resolution states.

However, Illinois' Mr. Ewald said today's competitive life insurance market does not have room for another player.

In addition, once a company has been tainted, resurrecting it is difficult, said Conning's Mr. Kleiman.

"Our objective is to effect an orderly liquidation," Mr. Ewald said.

The Altus/MAAF-led investor group said that Mr. Garamendi's rejection of the NOLHGA bid was an affirmation that "only a bid which removes the junk bonds from the portfolio and replaces them with cash can provide the security, value and liquidity that policyholders require."

"Conditional guarantees and junk bond promises can't provide that," said John F. Hartigan, director of transition planning for Altus/MAAF and a senior partner in the Los Angeles office of Morgan, Lewis & Bockius.

"Only under the MAAF-led plan can policyholders be sure that their policies will never again be subjected to the volatile and unpredictable swings of the junk bond market."

Mr. Hartigan also criticized the Hellman & Friedman proposal to build a new company from the ashes of Executive Life.

"To recreate the old Executive Life —junk bonds and all—would be a tragedy," he said. "Promises of great returns and a brighter tomorrow based on junk bonds were the fatal attraction that brought about Executive Life's failure in the first place.

"Acceptance of a 'junk bonds-in' bid would make the policyholders once again unwilling captive investors in a vulture fund with little access to their own money. 'Conditional' guarantees cannot disguise this," Mr. Hartigan asserted.

Indeed, the bidding now is likely to center on whether policyholders would fare better in a bonds-in or bonds-out deal, Mr. Kleiman said.

While the MAAF/Altus proposal appears to dump the bonds at fire sale prices, it would be better than Executive Life's successor losing a substantial chunk of its capitalization if the junk bonds are retained and the market again sours, he said.

"The junk bond market has been slowly coming up over the year," he said. "Unfortunately, Executive Life has a lot of private bonds that can't be priced."

While Mr. Garamendi did not state a preference for either a bonds-in or bonds-out offer, he did say "the risk of the portfolio has to be dealt with."

He suggested that it is possible to "remove the risk of the bond portfolio with an enhancement or guarantee." ■

Ruling due soon in muni-GIC trial

LOS ANGELES—A ruling is expected early this week in a lawsuit to determine whether municipalities that invested bond issue proceeds in Executive Life Insurance Co. guaranteed investment contracts are "policyholders" or merely general creditors.

Last week both the municipalities and regulators rejected Los Angeles Superior Court Judge Kurt Lewin's 11th-hour suggestion that they submit to arbitration.

Denying the muni-GIC holders policyholder status would mean they could recover little or none of their $1.85 billion investment.

And giving them policyholder status would lower recoveries for all other policyholders in any Executive Life takeover plan, said California Insurance Commissioner John Garamendi.

He favors treating muni-GIC holders as general creditors, which have a lower priority in the rehabilitation than policyholders, including pension plans that purchased GICs.

"We expect to win the muni-GIC trial," Mr. Garamendi said. "If not, it would diminish the payout downward proportionate to the added liabilities."

If muni-GIC holders are "policyholders," the payouts—after guaranty fund recoveries—of 86 cents on the dollar under the Altus/MAAF rehabilitation proposal or 85 cents on the dollar under the Hellman & Friedman proposal would drop to "the low 70s," he estimated.

—By Joanne Wojcik

Inquiries on sex, religion are barred in pre-employment tests, court rules

SAN FRANCISCO—California employers cannot inquire about sexual orientation or religious beliefs in pre-employment psychological screening tests, an appeals court ruled last month.

In a 1989 suit seeking class-action status, three people who had applied for security guard jobs at Target Stores charged that the discount chain's owner, Dayton-Hudson Corp. of Minneapolis, violated their rights to privacy by asking questions not related to the jobs.

Only a "compelling interest" could justify invading applicants' privacy rights, the 1st Appellate District Court ruled Oct. 25 in a 3-0 decision.

"While Target unquestionably has an interest in employing emotionally stable persons (as security guards), testing applicants about their religious beliefs and sexual orientation does not further this interest," Justice Timothy Reardon wrote for the court.

A trial court had earlier denied the request—by one worker who was hired and two others who were not—for an injunction halting the use of Target's "PsychScreen" test.

In ruling that the test violate the applicants' right to privacy, the appeals court disagreed with a 1989 state appeals court decision that had been followed by the trial court.

The 1989 decision, upholding an employer's use of urine tests to screen for job applicants' drug use, ruled that job applicants have a more limited right to privacy than do employees. That court applied a "reasonableness" standard, allowing employers certain limited intrusions.

Justice Reardon remanded the matter to the trial court for further proceedings on class certification. Target plans to appeal the decision.

—By Louise Kertesz

Full listings for two reinsurance brokers

Due to a production error, the full listings for the following companies were omitted from the directory of reinsurance intermediaries published in the Nov. 4 issue. The full listings appear below:

G.J. Sullivan Co.

800 W. Sixth St., Los Angeles, Calif. 90017; 213-626-1000; fax: 213-622-5921

	1990	1989
Premium volume	$188 million	$130 million
% Treaty	100%	100%
Gross revenues	$9.5 million	$6.1 million
Total employees	40	35
Treaty	40	35

Founded: 1980.

Parent company: Gerald J. Sullivan & Associates Inc.

Branch offices: Birmingham, Ala.; Columbia, S.C.; New York; Seattle; Toronto.

Acquisitions: Kininmonth Lambert & Co. Ltd., Toronto.

Specialties: Surety, professional liability.

Licensed reinsurance intermediary in: New York and Texas.

Conducts business: Nationwide and in Canada.

Principal officers: Gerald J. Sullivan, chairman; J.F. Sullivan Jr., president; Sue Allaway, Julius Friedman and Paul G. Wayne, senior vps.

Contact: J.F. Sullivan Jr. or Louise M. Sullivan, assistant vp, 206-340-9255.

Sullivan Payne Co.

1501 Fourth Ave., Suite 1400, Seattle, Wash. 98101; 206-223-1200; fax: 206-625-6926

	1990	1989
Premium volume	NA	NA
% Treaty	90%	90%
% Facultative	10%	10%
Gross revenues	$52,000,000*	$50,000,000*
Total employees	390	410
Treaty	325	340
Facultative	65	70

* *BI estimate.*

Founded: 1928.

Parent company: Sedgwick Group P.L.C.

Branch offices: Chicago; Dallas; Los Angeles; New York; Philadelphia; Toronto; Vancouver, British Columbia.

Licensed reinsurance intermediary in: New York.

Conducts business: Nationwide.

Principal officers: Roger Espe, president/chief executive officer; Bob Holmes, executive vp/president (SPCo of Canada); Michael Wybar, W. Brian Smith and Thomas Hopkinson, executive vps; Lewis Hale, senior vp/chief operating officer; Rick Richman, senior vp/chief financial officer; Lennart Barkinge, Barbara Bufkin, Anthony Provenzale, Jeffrey Sirr, Bruce Catherwood, Daniel V. Malloy, Daniel V. Malloy III, Craig Ott, Guy Patterson, Jed Rhoads, Tom Rogers, Michael Bechtol, Taylor Collings, James Grieser, John Jolly, Samuel B. Walton and Victor Arneill, senior vps.

Contact: Roger Espe, 1 Liberty Place, Suite 3000, 1650 Market St., Philadelphia, Pa. 19103; 215-564-6060.

Membership: Brokers & Reinsurance Markets Assn. ■

Update

Maxwell group accident policy

Continued from page 2

through its Guernsey captive, Oxford Insurance Co. Ltd.

Meanwhile, sources in the London market were not aware of any key man life insurance policies taken out on Mr. Maxwell, either by his companies or his lenders, who are reportedly owed 2.2 billion pounds ($3.91 billion). Details of any individual life policies were not available.

Bill would allow IRA payments

WASHINGTON—Employees participating in 401(k) plans would again be able to make tax-deductible contributions to an Individual Retirement Account under a bill introduced last week by Sen. Lloyd Bentsen, D-Texas.

The measure, S. 1921, which restores tax-deductible contributions to IRAs for all taxpayers, also would allow employees to make withdrawals from 401(k) plans to purchase a first home or to pay for certain educational expenses without incurring hefty tax penalties.

Under the Bentsen bill, employees could make tax-deductible IRA contributions of up to $2,000, provided the combination of IRA and 401(k) contributions does not exceed the current maximum deferral of $8,475. For example, if an employee contributed $1,000 to an IRA, he or she could contribute up to $7,475 to a 401(k) plan.

Employers could encourage highly paid employees to exercise the IRA option to help employers pass Internal Revenue Service non-discrimination tests, said Henry Saveth, a principal with A. Foster Higgins & Co. Inc. in New York.

The Tax Reform Act of 1986 barred certain taxpayers from making tax-deductible contributions to IRAs if they were covered by a qualified pension plan (*BI*, Aug. 25, 1986).

The Bentsen bill also would allow first-time home buyers to make early withdrawals from 401(k) plans without owing the current 10% federal excise tax on preretirement distributions. It also would permit penalty-free withdrawals for qualified higher education expenses.

Guaranty National to go public

ENGLEWOOD, Colo.—Guaranty National Insurance Co. expects its stock to begin public trading on the New York Stock Exchange tomorrow following the sale of more than 50% of its stock by parent Orion Capital Corp.

Farmington, Conn.-based Orion is expected to sell 6.25 million shares of the stock at an estimated $16 to $18 per share, earning a total of $100 million to $112.5 million. Depending on the sale of an overallotment by underwriter Shearson Lehman Bros. Inc., Orion will own 42% to 48% of the insurer following the sale, said Roger B. Ware, Guaranty National's president and chief executive officer.

Orion took a majority stake in Guaranty National in 1984, then purchased the remaining stock in 1988. Previously, it had been a publicly traded company, Mr. Ware said.

Guaranty National expects to write $250 million in gross premiums this year. The insurer reported a 98.7% combined ratio and $9.4 million in net income in the first half and had $89.6 million in policyholder surplus.

Bill would repeal D.C. gun law

WASHINGTON—Two congressmen have introduced a bill to overturn a District of Columbia law that holds manufacturers of assault firearms liable for injuries or deaths caused by the weapons.

By an overwhelming margin, district voters in a Nov. 5 referendum supported the Assault Weapon Manufacturing Strict Liability Act of 1990 (*BI*, Jan. 7). But even before the polls closed, Reps. Dana Rohrabacher, R-Calif., and Larry Combest, R-Texas, introduced a bill to repeal the measure.

The law was originally signed on Dec. 17, 1990, but repealed a few months later when District Mayor Sharon Pratt Dixon persuaded the city council that the law would jeopardize congressional approval of $100 million in emergency aid to the city.

This summer, a group of clergymen began circulating petitions in favor of reviving the strict liability statute. The Nov. 5 ballot question asked voters if they wanted to "preserve the 'Strict Liability Act' as originally passed." Seventy-seven percent of voters supported "preserving" the law.

The law allows victims and families of victims of assault weapon-related crimes to sue manufacturers or dealers for damages. Weapons issued to law enforcement officers are exempt.

Briefly noted

Mississippi Insurance Commissioner George Dale received 70% of the vote last week in defeating Republican challenger David L. Anderson, an insurance agent from Tupelo. Mr. Dale, the nation's longest-serving insurance commissioner, was first elected in 1975. . . .The **Michigan Municipal Risk Management Authority** has terminated Governmental Risk Managers Inc. of Livonia, Mich., as the pool's underwriting and risk control manager. MMRMA's in-house staff will assume these duties. The move follows GRM Chairman Wade Waterman's indictment on charges of illegally borrowing $5 million from American Commercial Liability Insurance Co., a Michigan insurer he controlled (*BI*, Oct. 21). . . .**Workers comp insurers in Massachusetts** have asked the state Insurance Department for an overall 45.6% rate increase. . . .**South Dakota Insurance Director Mary Jane Cleary** resigned last week to become director of government, consumer and industry affairs in the National Council on Compensation Insurance's Denver office, which oversees Colorado, Montana and New Mexico. Deputy Director Darla Lyon is serving as acting director. . . .A London court last week banned **John Wallrock**, the former chairman of Minet Holdings P.L.C., from holding a directorship in a British company for the next five years for his alleged role in the PCW scandal at Lloyd's of London (*BI*, Sept. 10, 1990). . . .A stripped-down version of a controversial **banking reform bill** approved by the House Banking Committee does not contain provisions in an earlier bill that would restrict banks' already limited ability to sell insurance.

East Coast storm

Continued from page 3

mercial fishing fleets had secured almost all boats and barges in port in anticipation of the storm.

Brokers in the Boston area said that a large amount of personal property on the shoreline north of Boston and on Cape Cod was devastated by pounding waves and high winds.

And on Long Island, where a persistent high surf flooded homes and cars, property damage is "heavy," according to a broker.

"Personal property damage in the Boston area is much worse than Hurricane Bob. Homes were heavily flooded and many experienced severe structural damage," said Brian Whelton, a marine department vp with Sedgwick James North America in Boston.

Mr. Whelton said ocean swells reached 20 feet at Broad Sound just north of Boston. "It was mind-boggling. This storm never let up from the moment it hit. Boulders were thrown up on the causeway."

"This storm was pretty severe in the areas it hit," agreed M. Renwick Severance, vp-specialty services with Republic Hogg Robinson Inc. in Boston. "I think the commercial losses were pretty much confined to the lobster industry, where fishermen lost their traps and line, but the damage done to homes and beaches by the waves was bad enough that Massachusetts is eligible for some federal disaster relief."

"In terms of residential damage, this storm was worse than Hurricane Bob," said Edward Buchwald, a Johnson & Higgins director in charge of the company's Boston office. "My fear is that a lot of the household damage (due to flooding) may go uninsured unless people purchased coverage through the government flood program. The losses from water and flooding far outnumbered those from wind."

On Long Island, the damage to beachfront homes in the affluent communities along the southeastern coast and on Fire Island was "pretty heavy," according to Pat Plansker, an assistant vp with Alexander & Alexander of New York Inc. in Melville.

"Our clients were quite fortunate, but I don't think that's indicative of the whole island. Fire Island was hit very hard," Ms. Plansker said.

She said almost all losses were personal lines losses, the majority of which were flood-related, and should be covered under the government-sponsored National Flood Insurance Program. "There were no wind losses to my knowledge. Everything was due to the high waters."

A spokeswoman for Boston-based Liberty Mutual Insurance Co. said the 150 flood claims that the company had received as of late last week were all covered under the federal flood insurance program.

She estimated that flood claims will total about $1.15 million and will be paid entirely by the flood insurance program.

Otherwise, she said, insured losses from the storm were "not major." Other than flood claims, Liberty Mutual fielded about 85 personal auto claims totaling about $365,000, about 100 windstorm claims totaling about $100,000 and a few private boat claims.

A spokesman for Hartford, Conn.-based Travelers Corp. projected that the insurer would receive about 440 personal lines claims totaling about $365,000 and another 95 commercial claims totaling about $165,000.

"Most of our claims are stemming from flooded automobiles, where the dollar amount per claim is relatively low," he said. "The majority of damage was done on the north shore of Boston and Cape Cod. We're expecting smaller numbers from New Jersey, New York, Connecticut and Rhode Island."

Columbus, Ohio-based Nationwide Mutual Insurance Co. reduced its loss projection to about $1 million from the $2.5 million it estimated right after the storm.

A spokesman said that Nationwide has little personal lines or commercial exposure in Massachusetts and New Jersey. "We have had about 50 claims so far, although New York hasn't reported. About 75% were personal lines claims, 15% were commercial and the rest flood."

Two other major personal lines companies—Allstate Insurance Co. and State Farm Mutual Automobile Insurance Co.—said that early damage reports were minor enough that they didn't have to initiate any catastrophe procedures.

"We haven't even opened up a catastrophe file," said a spokesman for Bloomington, Ill.-based State Farm. "Much of the damage occurred in Massachusetts and on Long Island where we have a very small exposure."

Ocean marine insurers say the timing of the storm saved them from potentially devastating losses.

Mike Taylor, director of ocean marine with Royal Insurance Co. of America in Charlotte, N.C., said only three or four claims had been filed as of late last week.

"We were expecting the floodgates to open, and nothing really came in. We write a significant book of marine business in New England, and fortunately it seems as though all the boats had been laid up. With Hurricane Bob, our losses were nearly $3 million, but in this case our biggest loss is going to be about $40,000," said Mr. Taylor.

"On the marine side, this storm was clearly not as bad as Bob," said Sedgwick James' Mr. Whelton. "Most of the commercial fishermen had ample warning to get their equipment secured. But with Bob, the south shore of Cape Cod got pounded, and during August there's a heavy concentration of pleasure boats." ■

California surplus lines rule

Continued from page 3

department "did not pursue in a timely manner the rulemaking process required to formally adopt the regulations" as required by state law, according to an OAL memo.

For example, the Insurance Department failed to elicit public comment on the measure, although a hearing was held on the rules last week, said Craig Tarpenning, the OAL's senior staff counsel.

"We are not going to short-circuit the process again," said OAL Director Marz Garcia.

The OAL earlier this year blocked emergency regulations sought by Insurance Commissioner John Garamendi to implement rate rollbacks under Proposition 103, contending no emergency existed. However, Gov. Pete Wilson later overruled the agency's decision and the rules took effect last month (*BI*, Oct. 21; Oct. 14).

Mr. Garcia also said there are "substantial questions" about the legality of the regulation governing non-admitted insurers.

OAL officials declined to elaborate until a final version of the regulation is presented to them for review.

In response, the Insurance Department intends to launch a three-pronged attack to reinstate the tougher financial eligibility and reporting requirements. It will comprise:

- Appealing the OAL's refusal to extend the emergency rule to Gov. Wilson.

The Insurance Department already is appealing the OAL's rejection of another emergency order, Section 2173, that would have prevented surplus lines brokers from placing automobile bodily injury, property damage liability or medical claims insurance with non-admitted insurers unless the business had first been rejected by the California Automobile Assigned Risk Program (*BI*, Sept. 16; Feb. 11).

- Developing a final—instead of emergency—regulation to submit to the OAL for approval.

The hearing held by the Insurance Department last week covered the development of a final measure.

- Pursuing introduction and adoption of a similar bill by the state Legislature.

The legislative approach would circumvent the need for OAL approval of the regulation, an Insurance Department spokeswoman explained.

Tougher financial eligibility and reporting requirements are needed "to provide adequate policing" of non-admitted, non-U.S. insurers that are selected by surplus lines brokers, the Insurance Department said.

Several insurance industry spokesmen support the concept of tighter financial eligibility requirements for non-U.S. insurers.

The Kansas City, Mo.-based National Assn. of Professional Surplus Lines Offices Ltd., which represents more than 500 surplus lines brokers and agents, said in a statement it generally supports the requirements contained in the California regulation.

"We think Garamendi is on the right track. There are perhaps some insurers participating in the market that should not be there," said Peter Demmerle, an attorney with LeBoeuf, Lamb, Leiby & MacRae in New York, which represents Lloyd's of London underwriters and several other non-U.S. insurers.

Kenneth Merin, an attorney with Kroll & Tract in New York, which represents more than 30 non-admitted insurers based in Europe, said the insurers "heartily endorse" the Insurance Department's crackdown on shaky non-admitted insurers, "particularly offshore carriers in the Caribbean, which too often have not had the financial stability to meet their obligations to policyholders."

However, the attorneys say their clients would prefer if California followed the lead of the National Assn. of Insurance Commissioners, which proposes requiring $15 million in capital and surplus, which is $9.6 million more than the minimum sought by California, but only $2.5 million in a U.S. trust fund, which is $2.9 million less than required in the California emergency regulation.

In addition, the surplus lines industry would like to see the Insurance Department lift its prohibition against letters of credit used to satisfy the trust fund requirement, both the attorneys and NAPSLO say.

"If a letter of credit is irrevocable, 'clean' and is confirmed by a bank that is a member of the Federal Reserve System, then such a letter of credit should be accepted for trust fund purposes," NAPSLO said in its statement.

However, if California continues its prohibition against LOCs, the department should provide "for a gradual phase-out" of LOCs rather than an abrupt ban, said Mr. Merin.

Officials at the Surplus Lines Assn. of California did not return phone calls.

"Commercial surplus lines companies are being caught in the backlash of regulations that were put in place because several offshore non-admitted insurers were taking in premium dollars" without following through on claims, said Donald Craft, risk manager with Superior Fireplace Co. in Fullerton, Calif., who is president of the Orange Empire Chapter of the Risk & Insurance Management Society. ■

S&P evaluations

Continued from page 2

ums written by S&P-rated companies in 1990.

Those judged "adequate"—with claims-paying ratings of BB or qualified solvency ratings of BBq—accounted for another 10% of total premium writings.

However, S&P rated 559 insurers as "vulnerable" with claims-paying ratings of B or lower or a qualified solvency rating of Bq. These companies accounted for 3%, or about $12.3 billion, of total industry volume.

Among the 746 life/health companies assigned qualified solvency ratings, 126 received the top BBBq rating, 375 were rated BBq and 245 were rated "vulnerable" with a Bq rating. Companies in the three categories generated premium volume of $25.5 billion, $30.4 billion and $7.1 billion, respectively.

By contrast, 201 life/health insurers that received claims-paying ratings generated $203.1 billion in premiums. All but three were rated BBB or higher.

Among 1,229 property/casualty insurers assigned qualified solvency ratings, 299 were rated BBBq, 619 were rated BBq and 311 were rated Bq. Insurers in these groups wrote $48.9 billion, $16.5 billion and $3.6 billion in 1990 premiums, respectively.

The 406 property/casualty companies with claims-paying ratings wrote a total of $120.7 billion in premiums; all were rated BBB or better.

Some widely-known companies receiving S&P's Bq, or "vulnerable," rating include: AIG Life Insurance Co., American International Insurance Co. and Landmark Insurance Co., which are units of American International Group Inc.; Commercial Union Insurance Co.; Evanston Insurance Co.; John Hancock Property & Casualty Insurance Co., a unit of John Hancock Mutual Life Insurance Co.; and Maryland Casualty Co., a unit of Zurich-American Insurance Cos.

All of these companies are subsidiaries or affiliates of insurers that carry higher qualified solvency or claims-paying ability ratings from S&P.

An AIG spokesman declined to comment on the Bq ratings, noting only that several other AIG units that are members of the group's intercompany pool carry an AAA claims-paying ability rating.

Elizabeth L. Goldstein, vp and treasurer for Evanston, said she disagrees with "the whole concept" of the solvency rating, calling the rating process—based purely on statutory financial data—"very mechanical."

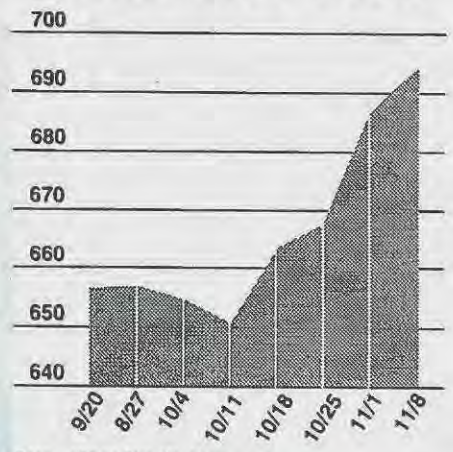
"I don't have a lot of respect for the solvency rating," she said, adding that she does respect the more in-depth analysis behind the claims-paying ability ratings.

Evanston has not suffered in the marketplace because of the Bq rating it received based on 1989 data, she added, which leads her to believe that few people are giving the rating much weight.

An Hancock spokesman said John Hancock Mutual Life Insurance Co., which received a AAA claims-paying ability rating, stands behind all of its subsidiaries.

Officials of Commercial Union and Zurich-American could not be reached. ■

BI Insurance Index



Base = 100 on Dec. 29, 1978
Source: Nordby International Inc.

Insurance industry stocks inched ahead last week as the *Business Insurance* Index rose 3.9 points to 693.6 on Nov. 8, from 689.7 on Nov. 1. Advancing issues for the week were led by Nobel Insurance Ltd., up 24.1%; Mutual Risk Management Ltd., up 22.7%; and Safeguard Health Enterprises, up 20.7%. Declining issues for the week followed Argonaut Group, down 9.3%; AVEMCO Corp., down 7.4%; and Statesman Group Inc., down 7.3%. The most active issue for the week was U.S. Healthcare, with 6.1 million shares traded. The *BI* Index was up 0.6%; the Standard & Poor's 500 climbed 0.4%; the Dow Jones 30 Industrials were down 0.4%; and the New York Stock Exchange Composite increased 0.4%.

Willis Corroon unit names officers

John N.W. Wooderson has been named chairman and **Frank F. White** president and chief executive officer of Willis Corroon Americas, a new direct risk management and brokerage unit of Willis Corroon P.L.C. of London. Both appointments are effective Jan. 1.

Mr. Wooderson is now deputy chairman of Willis Faber & Dumas Ltd., and Mr. White is now president and CEO of Willis Corroon's benefits and specialty sales group.

Other agent/broker changes:

Johnson & Higgins announced these changes: **Sheldon I. Ausman**, a retired managing partner with Arthur Andersen & Co., joined the brokerage as senior vp and adviser in Los Angeles; **W. Robert Medling Jr.** named senior vp and head of the brokerage services division in Nashville, Tenn.; **Frank L. Shoppe** named senior vp in the Atlanta office, where he has worked for 23 years; and **David J. Undis** named senior vp and head of account management and sales in Nashville, Tenn.

J&H also announced the election of nine other senior vps in its New York office: **Charles H. Bechtold Jr., James J. Delaney, Arthur G. Koritzinsky, Richard P. Lasko, Karen R. Logue, Robert K. Meyers, Douglas N. Smith, Karen A. Stein-Townsend,** and **Thomas F. Vietor III.**

Comings & goings: industry

At Frank B. Hall & Co. of Minnesota Inc., **Michael Prins** named president and will remain chief operating officer. He succeeds **Alan R. Diamond** who has been named chairman and will remain chief executive officer. Also, **Thomas L. Weigand** promoted to executive vp and **Alan J. Anderson** named vp and director of loss control.

Frank B. Hall & Co. of Missouri Inc. announced that two officers had left Alexander & Alexander Inc. to join its Kansas City office. **Erwin Schrag**, who had been a senior vp with A&A, will take the same title with Hall; and **David F. Brenner** will be a vp with Hall.

And at Frank B. Hall & Co. of Louisiana Inc., **Gilbert J. Sevier** named vp for new business development.

John Sacia, former president of the Rollins Burdick Hunter Co. office in Seattle, named chairman and CEO of RBH of Illinois in Chicago. **John Pacholick**, who had been chairman and CEO, will remain a regional manager and senior vp with the parent.

RBH also announced four additions to its Irvine, Calif., office: **Michael J. Bernay** named executive vp and will be responsible for forming a new production unit; and **Storm Bartling**, **Tom Thomason** and **Judi T. Wexler** were all named vps.

Arthur P. Wells Jr. promoted to vp in Irvine for Sedgwick James of California Inc.

Jessica Christensen promoted to executive vp from senior vp at Jardine Risk Management Inc. in Los Angeles.

Excess/surplus

James Barnes named chairman and chief executive officer and **David Hartoch** president and chief operating officer at Sherwood Insurance Services, following the retirement of **Donald K. Sherwood**, who founded the San Francisco-based wholesaler. Previously, Mr. Barnes headed the company's northern division and Mr. Hartoch the southern division.

David L. Hadler, formerly executive vp, elected president of Crump E&S of Illinois in Chicago, replacing **Kelly Sorem** who has been elected president of two other Crump E&S Inc. units, Midwest General Underwriters Group and Crump E&S of Wisconsin. ■

British Issues

Nov. 7 Companies	Price pence	P/E	Div. pence	Yield %	1 Week High—Low pence	pence
Comml Union	477	N/M	30.7	6.4	487—	477
Genl Accident	490	N/M	35.7	7.3	491—	484
Gdn Royal Exch	155	N/M	15.9	10.2	159—	155
Royal	287	N/M	34.7	12.1	287—	283
Sun Alliance	327	N/M	18.7	5.7	330—	322
Brokers						
Bradstock	167	19.0	6.0	3.6	167—	167
CE Heath	504	17.5	34.5	6.8	504—	501
Hogg Group	203	12.1	10.7	5.3	203—	203
Lloyd Thompson	465	23.4	12.0	2.6	465—	464
Lowndes Lmbrt	354	17.6	15.3	4.3	354—	352
PWS Holdings	84	9.8	4.7	5.6	84—	84
Sedgwick Grp	238	22.6	16.0	6.7	243—	238
Steel Brrl Jones	331	17.4	16.3	4.9	331—	320
Willis Corroon	287	15.1	17.6	6.1	294—	287

Source: Philip Olsen, Insurance Industry Analyst, London

BI Industry Stock Report

NOVEMBER 4, 1991 THROUGH NOVEMBER 8, 1991

		Price	Weekly % change	Year to Date % change	Annual High	Annual Low	Vol.(000)	$ Div.	% Yield	P/E	Book value	Mkt/Bk. value
BROKERS												
Alexander & Alexander	NYS	20.63	6.45	-10.81	27.63	18.88	748	1.00	4.85	17	9.77	2.11
Gallagher Arthur J. & Co.	NYS	22.63	7.74	-2.69	28.38	19.00	77	0.64	2.83	18	5.88	3.85
Frank B. Hall	NYS	3.38	0.00	-6.90	4.38	2.00	38	0.00	0.00	-7	-5.24	-0.64
Hilb, Rogal & Hamilton	OTC	13.50	5.88	-8.47	17.50	11.25	233	0.36	2.67	23	3.56	3.79
Marsh & McLennan	NYS	74.88	-0.33	-4.01	87.25	69.13	413	2.60	3.47	18	14.77	5.07
Poe & Associates	OTC	11.50	-2.13	79.69	12.50	6.50	4	0.32	2.78	13	2.52	4.56
BROKERS	AVERAGE		2.5	6.7					2.4	12		
CONGLOMERATES & HOLDING COMPANIES												
Berkley W.R. Corp.	OTC	25.50	-7.27	-32.00	32.25	21.50	97	0.32	1.25	14	23.89	1.07
Berkshire Hathaway Inc.	NYS	8500.00	0.00	27.34	8500.00	183.59	0	0.00	0.00	-31	4612.00	1.84
ITT (Hartford Group)	NYS	55.25	-1.12	15.10	63.00	44.50	1111	1.72	3.11	9	64.01	0.86
Sears (Allstate)	NYS	37.63	2.38	48.28	43.50	24.38	2523	2.00	5.32	13	37.38	1.01
CONGLOMERATES	AVERAGE		-1.5	14.7					2.4	1		
INSURERS/REINSURERS												
Aetna Life & Casualty	NYS	40.38	3.19	3.53	49.13	31.88	1896	2.76	6.84	8	64.23	0.63
American General	NYS	42.63	0.29	38.62	43.50	26.50	568	2.00	4.69	11	37.14	1.15
American Heritage	NYS	29.63	-1.25	41.07	32.25	19.63	1	1.08	3.65	12	19.25	1.54
American Indemnity/Fin'l	OTC	4.88	0.00	50.00	7.75	2.75	8	0.08	1.64	15	12.93	0.38
American International	NYS	88.63	2.01	15.28	102.00	67.88	2694	0.48	0.54	12	45.34	1.95
Aon Corp.	NYS	38.63	-0.64	11.15	41.75	29.75	308	1.60	4.14	11	18.50	2.09
Argonaut Group	OTC	26.75	-9.32	25.39	33.38	18.75	28	0.68	2.54	8	48.26	0.55
AVEMCO Corp.	NYS	23.50	-7.39	39.60	27.25	14.13	19	0.40	1.70	17	9.55	2.46
Baldwin & Lyons Inc.	OTC	26.50	0.00	41.33	27.50	17.00	6	0.28	1.06	8	24.29	1.09
Belvedere Corp.	ASE	3.25	-3.70	30.00	3.75	1.75	0	0.04	1.23	13	7.65	0.42
Chandler Insurance	OTC	3.25	-3.70	-52.73	7.25	2.13	113	0.00	0.00	-2	5.95	0.55
Chubb Corp.	NYS	69.50	-0.89	28.11	75.25	44.00	2051	1.48	2.13	11	35.19	1.97
CIGNA Corp.	NYS	53.50	-0.23	30.89	56.75	35.50	1153	3.04	5.68	11	73.15	0.73
CNA Financial Corp.	NYS	92.50	1.09	34.79	93.00	53.00	110	0.00	0.00	13	70.23	1.32
Continental Corp.	NYS	24.25	-3.96	-2.51	30.63	19.00	1012	2.60	10.72	8	37.83	0.64
Durham Corp.	OTC	37.00	5.71	32.14	37.00	24.50	73	1.00	2.70	21	28.04	1.32
Fund American Corp.	NYS	66.50	1.14	28.19	67.13	45.00	128	0.68	1.02	11	36.11	1.84
Fremont General Corp.	OTC	24.75	8.79	70.69	25.25	11.63	568	0.88	3.56	7	19.13	1.29
Frontier Insurance Group	NYS	24.25	1.04	27.63	25.88	15.69	31	0.00	0.00	10	11.20	2.17
Gainsco Inc.	ASE	11.75	0.00	54.10	12.88	4.50	29	0.04	0.34	15	3.37	3.49
General RE Corp.	NYS	92.00	-0.27	-1.08	102.50	80.00	868	1.68	1.83	13	37.50	2.45
Hanover Insurance Co.	OTC	37.00	1.37	39.62	38.75	21.25	42	0.44	1.19	16	37.44	0.99
Harleysville Group	OTC	18.50	-2.63	21.31	21.33	10.50	13	0.64	3.46	6	22.99	0.80
Hartford Steam Boiler	NYS	53.50	0.94	9.74	63.75	43.63	164	2.00	3.74	14	17.05	3.14
Kansas City Life Ins.	OTC	33.50	5.10	8.50	36.00	30.25	16	1.20	3.58	8	39.22	0.85
Kemper Corp.	NYS	39.38	4.30	65.79	39.38	17.63	603	0.92	2.34	9	34.20	1.15
Lawrence Insurance Group	ASE	9.50	-1.30	35.71	9.50	6.38	11	0.48	5.05	15	4.71	2.02
Liberty Corp.	NYS	43.88	2.63	6.69	48.00	39.00	5	0.92	2.10	14	23.86	1.84
Lincoln National	NYS	52.88	1.44	22.97	55.25	33.00	537	2.72	5.14	9	45.16	1.17
Markel Corp.	OTC	19.50	6.85	65.96	19.50	10.25	49	0.00	0.00	10	3.22	6.06
Mutual Risk Mgmt. Ltd.	NYS	30.38	22.73	-	30.38	17.00	232	0.20	0.66	31	-	-
NAC Re Corp.	OTC	25.63	3.54	-22.35	28.34	19.34	186	0.16	0.62	13	18.90	1.36
Navigators Group	OTC	31.50	1.61	44.27	35.00	16.50	18	0.00	0.00	18	13.52	2.33
Nobel Insurance LTD.	OTC	4.50	24.14	50.00	4.50	2.50	277	0.00	0.00	6	7.76	0.58
NWNL Companies	NYS	34.50	-0.36	104.44	37.25	13.25	586	1.40	4.06	9	42.73	0.81
Ohio Casualty Corp.	OTC	46.50	5.08	13.41	50.25	32.75	520	2.48	5.33	9	36.38	1.28
Old Republic Int'l	NYS	34.50	3.76	50.82	34.50	18.63	70	0.72	2.09	8	33.09	1.04
Orion Capital Corp.	NYS	31.50	-1.56	80.00	32.38	13.50	102	0.92	2.92	10	20.42	1.54
Phoenix RE Corp.	OTC	8.88	-1.39	14.52	10.25	6.25	53	0.20	2.25	10	13.30	0.67
Protective Life Corp.	OTC	20.75	-3.49	39.50	23.00	12.50	81	0.84	4.05	8	16.29	1.27
Provident Life	OTC	20.13	3.87	15.00	24.50	14.25	365	1.00	4.97	6	25.88	0.78
Re Capital Corp.	ASE	14.38	0.88	11.65	18.63	11.75	20	0.20	1.39	11	15.05	0.96
Reliance Group Holdings	NYS	4.75	0.00	2.70	7.50	4.25	69	0.32	6.74	3	5.61	0.85
RLI Insurance Corp.	NYS	16.00	0.00	10.34	16.38	10.50	27	0.48	3.00	8	14.41	1.11
St. Paul Companies	OTC	68.00	3.82	8.37	74.25	54.50	1563	2.60	3.82	8	52.00	1.31
SAFECO Corp.	OTC	40.00	2.89	21.67	44.75	27.75	935	1.48	3.70	9	31.50	1.27
SCOR U.S. Corp.	NYS	16.00	2.40	29.29	16.50	8.50	18	0.24	1.50	10	11.19	1.43
Seibels Bruce Group	OTC	6.38	6.25	50.00	8.88	4.25	44	0.36	5.65	128	7.35	0.87
Selective Ins. Group	OTC	17.00	1.49	28.30	18.00	12.50	131	1.04	6.12	9	18.91	0.90
Statesman Group Inc.	OTC	5.56	-7.28	255.92	6.38	1.25	912	0.00	0.00	17	2.48	2.24
Tokio Marine & Fire	OTC	50.00	-2.91	5.82	56.50	40.50	156	0.00	0.00	-	70.93	0.70
Torchmark Corp.	NYS	54.25	2.60	11.00	58.50	38.00	227	1.60	2.95	13	16.70	3.25
Transamerica	NYS	38.88	7.61	19.16	38.88	28.13	745	2.00	5.14	15	36.56	1.06
Transatlantic Holdings	NYS	35.25	2.55	28.77	39.38	22.63	149	0.20	0.57	12	18.38	1.92
Travelers Corp.	NYS	20.00	0.00	20.30	25.38	12.50	3076	1.60	8.00	6	41.44	0.48
Trenwick Group Inc.	OTC	27.00	6.93	16.76	30.00	19.25	91	0.72	2.67	10	21.71	1.24
United Fire & Casualty	OTC	44.00	1.73	25.27	58.00	32.00	0	1.32	3.00	11	35.39	1.24
USF&G Corp.	NYS	7.00	-1.75	-6.67	13.63	6.13	1470	0.20	2.86	-1	11.96	0.59
UNUM Corp.	NYS	74.50	8.17	59.79	74.50	39.00	582	1.04	1.40	12	37.25	2.00
USLIFE Corp.	NYS	45.13	2.27	61.16	45.13	25.63	125	1.64	3.63	10	60.34	0.75
Unitrin	OTC	33.63	-1.10	9.35	41.50	27.75	274	1.00	2.97	13	30.70	1.10
Washington National	NYS	15.38	-3.15	41.38	16.00	9.38	22	1.08	7.02	-7	26.86	0.57
USLICO Corp.	NYS	18.00	-1.37	13.39	21.00	14.75	84	1.00	5.56	-86	29.44	0.61
Zenith National Ins.	NYS	16.50	-0.75	21.10	18.50	10.13	65	1.00	6.06	138	13.14	1.26
INSURERS/REINSURERS	AVERAGE		1.8	34.3					3.4	14.2		
HEALTH MAINTENANCE ORGANIZATIONS												
FHP International	OTC	12.00	15.66	-21.31	29.75	9.88	2471	0.00	0.00	10	5.44	2.21
HMO America Inc.	OTC	13.63	-2.68	109.62	17.13	5.00	3014	0.00	0.00	15	0.61	22.34
Pacificare Health Sys.	OTC	25.50	13.33	56.92	42.50	12.50	348	0.00	0.00	13	6.55	3.89
Safeguard Health Enter.	OTC	8.75	20.69	84.21	8.75	4.00	198	0.00	0.00	20	3.53	2.48
Sierra Health Services	ASE	13.88	-0.89	0.91	29.50	8.63	181	0.00	0.00	7	1.78	7.79
United Healthcare Corp.	NYS	61.25	-3.92	163.44	64.75	17.00	1001	0.06	0.10	34	3.76	16.29
United Medical Corp.	ASE	7.00	7.69	-12.50	10.88	5.88	9	0.20	2.86	11	8.79	0.80
U.S. Healthcare	OTC	34.75	9.45	18.30	38.00	14.50	6111	0.44	1.27	18	3.38	10.28
HMOs	AVERAGE		7.4	49.9					0.5	16		
ALL COMPANIES	AVERAGE		2.2	31.6					2.9	13		

System design: Nordby International Inc.

Performance Without Consistency Isn't Enough.

Any group insurance company can promise fast claims service, but we guarantee it. ◆ We're confident enough about the quality of our claims service to put our high standards in writing, guaranteeing to meet our promised

turnaround time. We're comfortable offering this guarantee because we routinely exceed industry standards in turnaround time of claims processing. Our resources include an advanced cost-management technology in processing systems -- a Personalized Claims Administration system which provides flexible, adaptable administration of any benefits program. ◆ Clients who depend on your advice want to know what group insurance companies promise. Now you can tell them what we *guarantee*. For more information, call Patrick Moeschler at 1-800-877-1052.

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