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Update

California court vacates rulings on claims-made notification

PASADENA, Calif.—The 9th U.S. Circuit Court of Appeals has withdrawn two conflicting decisions on provisions in claims-made policies that require policyholders to notify insurers of a claim within the policy period.

The court vacated a July decision that policyholders are not bound by claims-made policy provisions requiring them to notify insurers of a claim within the policy period unless the insurer's interests would be impaired (*BI*, Aug. 31).

Continued on next page

Ruling restricts defense recovery

By STEPHEN TARNOFF

CHICAGO—A policyholder facing an errors and omissions lawsuit is not entitled to immediate reimbursement of its defense costs from its E&O insurer, a federal court judge says.

A U.S. District Court judge ruled Oct. 5 that Evanston, Ill.-based Evanston Insurance Co. does not owe Security Assurance Co.—an Omaha, Neb.-based insurer that writes group accident and health insurance, among other coverages—the defense costs that SAC has incurred in defending an E&O claim.

However, Judge Bernard M. Decker also ruled that Evanston, a subsidiary of Evanston Services Inc., may ultimately be obligated to pay SAC's defense costs as they are incurred pending the resolution of additional coverage issues between Evanston and SAC, a subsidiary of The Central National Insurance Co. of Omaha.

The ruling in *Evanston Insurance Co. vs. Security Assurance Co.* is the latest decision in disputes between certain professional liability insurance policyholders and their insurers over whether the insurers must reimburse policyholders for defense costs as they are incurred or whether insurers can wait until underlying litigation against the policyholder is completed to determine whether they owe the policyholder coverage and, therefore, defense costs.

Courts have come to different conclusions on the issue, mostly in the context of directors and officers liability policies.

For example, the highest court to rule on the issue, the 9th U.S. Circuit Court of Appeals, found in *Okada vs. MGIC Indemnity Corp.* that a D&O insurer must pay defense costs as they are incurred (*BI*, Aug. 18, 1986).

However, under a majority of the approximately one dozen recent court rulings on the duty of insurers to defend D&O policyholders, insurers have no duty to pay defense costs as they are incurred, according to attorney Daniel Bailey, with the Columbus, Ohio, firm of Artor & Hadden, who represents insurers in D&O coverage litigation.

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Proposal would reduce cafeteria plans' appeal

By JERRY GEISEL

WASHINGTON—The latest congressional swipe at flexible benefit plans would blunt the plans' edge in controlling benefit costs as well as significantly reduce their appeal to employees.

Last week, the House Ways and Means Committee approved a proposal—to be attached to a budget reconciliation bill—that would place a $500 cap on the amount of pretax salary that employees in flexible benefit plans could contribute toward uncovered benefit expenses.

Acknowledging that there is some ambiguity, some experts say the proposal also would impose taxes on employees enrolled in flexible benefit, or cafeteria, plans that offer a choice of cash or tax-free benefits.

According to some interpretations, if such a choice of benefits were offered, employees would be taxed on the amount of cash they could have received over a $500 threshold, even if they rejected the cash and selected additional tax-free benefits.

Flexible benefit plans commonly offer such an arrangement. For example, an employee who may be eligible for benefits under a spouse's plan may opt for the minimum level of benefits offered by his or her employer and take unused benefit credits in the form of cash.

But there is no ambiguity about how the $500 cap on employees' pretax contributions toward benefit expenses would damage flexible benefit plans as a tool to control benefit costs and dampen their attractiveness to employees.

"This is a real bombshell," asserted Kevin Meehan, an attorney with The Wyatt Co. in Washington.

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Disease notification bill clears House

By DOUGLAS McLEOD

WASHINGTON—Supporters of an occupational disease notification bill are facing an uphill Congressional battle despite the bill's passage by the House last week.

In a 225-186 vote, the House last Thursday approved the High Risk Occupational Disease Notification and Prevention Act of 1987.

The bill, H.R. 162, requires notification of current and former employees who have been exposed to hazardous materials to seek medical testing to determine whether the exposure has resulted, or could result, in illness.

The House bill and companion Senate legislation—which opponents say could trigger a flood of liability lawsuits against employers—appeared to have broad congressional support when proposed earlier this year (*BI*, April 27).

Fearing quick congressional approval, several corporations and industry groups agreed to back the bills in return for amendments designed to limit some predicted negative effects on businesses.

However, House support for the disease notification bill gradually weakened and last week's vote was narrow enough so that the bill's backers may have trouble mustering the two-thirds majority needed to override a possible presidential veto, observers agree.

Several members of the Reagan Cabinet—including the secretaries of labor and health and human services—have said the president will veto the bill in the form passed by the House.

"I would say we are looking at a bill that's going to be vetoed, and we are looking at a veto that is going to be sustained," predicted Thomas A. O'Day, associate vp with the Alliance of American Insurers in Washington, which opposes the legislation.

'The goal would be to craft a bill that larger segments of the business community will find acceptable,' Mr. Cheek says.

The threat of a successful veto may doom the companion bill in the Senate or, more likely, force supporters of the legislation to accept further revisions in the Senate bill that would limit its impact on employers, added Leslie Cheek III, senior vp-federal affairs at Crum & Forster Inc., which earlier agreed to support the bills in return for revisions.

"The goal would clearly be to craft a bill that larger segments of the business community will find acceptable," Mr. Cheek said, noting that last week's House vote should encourage concessions by such strong supporters of the legislation as the AFL-CIO.

Such a revised bill would have to be approved by a House-Senate conference committee before being sent to the president.

The Senate bill, S. 79, was reported out of the Labor and Human Resources Committee this summer, though no date had been set as of last week for a vote by the full Senate.

The Senate may not address the bill at all during the current session, observers point out.

Although there are some differences between the House and Senate versions of the legislation, the bills generally would:

- Establish a federal Risk Assessment Board as part of the National Institute for Occupational Safety and Health.
- Require the government to individually notify current employees and former employees going back 30 years of exposure to substances the Risk Assessment Board identifies as hazardous. While employers would have the option to notify employees, they would not be required to do so.
- Require employers to pay for medical screenings and provide alternative employment for workers determined to be at risk of developing occupational diseases.
- Prohibit employers from discriminating against workers or job applicants found to be at risk.

Several amendments were added to H.R. 162 during debate on the House floor last week, including an exemption from the alternative employment provision for companies with fewer than 50 employees that make a "good faith effort" to deal with

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NEWSPAPER

Update

Claims-made rulings vacated

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Some insurers and attorneys contended that decision effectively turned claims-made policies in California into occurrence policies.

The court also vacated a lower court ruling that the language in claims-made policies limiting coverage was clear and therefore policyholders that fail to notify insurers within the policy period are not entitled to coverage.

Both decisions involved a lawsuit between New England Reinsurance Corp. of Hartford, Conn., and First State Insurance Co. of Wilmington, Del., both units of Hartford Insurance Co. managed by Cameron & Colby Co. Inc. of Boston, and National Union Fire Insurance Co. of Pittsburgh, a unit of American International Group Inc. in New York.

The insurers disputed who would pay approximately $1 million in defense and indemnification costs related to malpractice claims filed against 49 California lawyers. In 1983 New England Re and First State began insuring members of the Los Angeles Bar Assn., which had been insured since 1978 by National Union.

Following the 9th Circuit decision, New England and National Union settled their dispute and as part of the settlement agreed to petition the court to grant a rehearing and to vacate both the trial and appellate court decisions, said National Union attorney Lawrence Bistany, with the Los Angeles firm of Flahavan, Hudson & Francis.

The 9th Circuit opinion "is no longer an opinion," he said, adding that the decision has been withdrawn from publication. "The case is over and is in the process of being dismissed."

Mr. Bistany declined comment on the terms of the settlement with New England and First State.

A spokesman for Cameron & Colby declined comment on the 9th Circuit's actions.

House move protects benefits

WASHINGTON—The House of Representatives last week approved legislation that would prevent employers that have filed for Chapter 11 reorganization from unilaterally terminating or reducing retirees' health benefits.

Benefits could not be altered until either representatives of retirees agree to modifications or a court determines that the modification of benefits is necessary and fair to all parties.

The legislation, H.R. 2969, was prompted by last year's temporary cessation of retiree health coverage by LTV Corp. after it filed for bankruptcy.

A similar bill, S. 548, already has been passed by the Senate. Presidential approval is expected.

Hall finalizes Adjustco sale

BRIARCLIFF MANOR, N.Y.—Frank B. Hall & Co. Inc. has agreed to sell its Adjustco Inc. claims adjusting subsidiary to Emeryville, Calif.-based Leonard J. Russo Insurance Services Inc.

The projected closing date of the sale is Oct. 31., but terms of the transaction, which was sealed Oct. 9, have not been disclosed.

Hall decided earlier this year to sell Adjustco, which was losing money. Adjustco was classified as a discontinued operation in Hall's fourth-quarter 1986 results (*BI*, March 23).

The purchase "will take us from a regional operation to a national organization," a Russo spokesman said. "We're projecting our gross revenues for 1988 to be about $50 million—a fourfold increase."

Heavy storm batters London

LONDON—London insurers are expecting many millions of pounds of claims following severe storms that last week battered London and southeast England.

The London Weather Centre of Britain's Meteorological Office reported gusts of more than 90 mph as winds tore down buildings, trees and scaffoldings early Friday morning.

Lloyd's of London expects to pay out claims totaling "tens of millions of pounds" said a spokesman. A spokesman from the Assn. of British Insurers described the weather conditions as "extremely severe" but said it was too early to estimate damage.

In addition, many people in the London insurance market were unable to get to work on Friday as roads and railway lines were strewn with debris, the spokesmen said.

Fireman's sues Massachusetts

BOSTON—Fireman's Fund Insurance Cos. charges in a lawsuit filed against the Massachusetts Insurance Department late last week that the department's attempt to force the insurer to write insurance in the state is unconstitutional, as is the system for setting automobile insurance rates in the state's assigned risk auto insurance pool.

The lawsuit, filed in the Suffolk Superior Court, challenges a temporary restraining order the department obtained in July that forces Novato, Calif.-based Fireman's Fund to continue writing new policies in the state. The insurer attempted to withdraw from the Massachusetts insurance market in July (*BI*, July 6).

In 1986, Fireman's reported a net underwriting loss of $18 million in the auto liability line in the state and a $29.3 million assessment by Commonwealth Auto Reinsurance, the state's auto liability reinsurance pool, according to Joseph W. Brown Jr., the insurer's chief financial officer and vice chairman.

Fireman's Fund had been negotiating with the department on how to best leave the Massachusetts market. However, the talks broke down over the state's notice-of-withdrawal requirements and Fireman's Fund's financial obligations to CAR, said Richard J. Underwood, an attorney with Finnegan & Underwood in Boston, which is representing Fireman's Fund.

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Lloyd's of London settles litigation with Texas insurer

By MARK A. HOFMANN

AUSTIN, Texas—In a sealed settlement, Lloyd's of London has ended a dispute it initiated with a Dallas-based underwriter that uses the name "Lloyd's" in its identity.

In a lawsuit filed in January 1986, the London institution sought to stop Lloyd's U.S., a surplus lines insurer admitted solely in Texas, from using a name "confusingly similar" to Lloyd's of London (*BI*, Dec. 1, 1986).

Lloyd's U.S. countered that Texas law demands the name "Lloyd's" be used in the identity of all companies in which different underwriters share each risk.

'We anticipate no regulatory problems with the change in name' to Lloyd's United States, Mr. Davis says.

Lloyd's U.S. has said it will change its name to Lloyd's United States, but would not comment on whether the name change was mandated by the settlement.

Robert E. Davis, secretary of Lloyd's U.S., says: "We anticipate no regulatory problems with the change in name."

Lloyd's of London and Lloyd's U.S. have agreed not to disclose any details of the settlement and the U.S. District Court for the Western District of Texas in Austin has ordered that the settlement be sealed.

"All terms of the settlement agreement are sealed by mutual consent," Mr. Davis said.

George Graff, an attorney with Milgrim Thomajen & Lee in New York, one of the law firms that represented Lloyd's U.S., confirmed the name change, but would not say whether the name change was part of the settlement.

Mr. Graff declined to provide any further details of the settlement.

According to a Sept. 30 statement from LeBoeuf, Lamb, Leiby & MacRae, the New York law firm that represents Lloyd's of London in the United States, "All parties in the litigation between Lloyd's of London and Lloyd's U.S. have agreed to resolve their dispute pending in U.S. District Court for the Western District of Texas. The parties have agreed that the terms of the resolution shall remain confidential."

Texas law allows the establishment of "Lloyd's plan operations" in the state provided those operations use the word "Lloyd's" in their names. The state defines a Lloyd's plan operation as a company in which individual underwriters share risks and profits.

Unlike a Lloyd's of London syndicate, Lloyd's U.S. underwriters do not have unlimited liability—they are limited to their investment in the company.

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BI to publish HMO, PPO issue

In December, *Business Insurance* will publish a special issue containing directories of health maintenance organizations and preferred provider organizations, along with reports on the growing impact the managed care market is having on the health care delivery system.

This directory will be published as a special issue in addition to the regular weekly edition of *Business Insurance*. All subscribers to *Business Insurance* will receive the issue—the 53rd of the year published by *BI*—free of charge.

Besides listing names, addresses and phone numbers of HMOs across the country, the HMO directory will provide a wealth of information on individual HMOs, including:

- Federal and state qualification.
- Date operations began.
- Model type (group, staff model or individual practice association).
- Whether it is for-profit or non-profit.
- Its sponsor (physician group, hospital, insurer, etc.)
- Number of participating primary physicians.
- Number of specialists on staff and specialists available for referral.
- Number of administrative and marketing staff members.
- Service areas.
- Rating options.
- Types of benefits offered, like prescription drug programs and vision care.
- Number of employers contracting with the HMO and the number of employees covered.
- Gross revenues.
- Names and titles of top officers.

The PPO directory will contain similar information on each organization, including details on specialty services the PPO may offer, how it negotiates hospital charges and the utilization review services it provides to employer clients.

Along with the directories, the special issue will feature an in-depth report on the state of the managed health care market, including predictions and analysis of future market trends by industry experts.

The issue also will include a survey of *Business Insurance's* Employee Benefits Board on HMO and PPO issues, as well as an update on regulatory issues affecting managed care plans.

HMOs and PPOs throughout the United States are eligible to be included in the directories, which are published as an editorial service; there is no charge for companies to be included.

However, HMOs and PPOs that wish to be included must fill out and return a questionnaire provided by *Business Insurance*.

HMOs and PPOs that have not yet received a questionnaire should request one by writing to Marilou Jones, Directory Editor, *Business Insurance*, 740 N. Rush St., Chicago, Ill. 60611-2590; or by calling 312-649-5279 or 312-649-5460.

The deadline for alternative health care providers to return completed questionnaires to *Business Insurance* is Nov. 9.

Inside

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World horizons

AEAI/RIMS Risk Management Forum

Claims-made is a necessity: Weavers' Wilson

By KATHRYN J. McINTYRE

MONTE CARLO, Monaco—Underwriters need to use claims-made excess liability insurance policies to provide insurance buyers with continuity of coverage and to maintain their risk capacity, says a leading London underwriter.

Speaking before a gathering of international risk managers, Peter Wilson stated his case for the claims-made form for excess liability insurance.

"I predict that claims-made coverage will be maintained for the foreseeable future, particularly for the insured looking for true transfer of risk on an excess basis and for those wishing to establish much needed continuity with their insurers," said Mr. Wilson, managing director of H.S. Weavers (Underwriting) Agencies Ltd. in London. Mr. Weavers was the architect of the 1985 claims-made liability wording for excess business and offered the first claims-made policy for umbrella-type coverages in the United States.

"Many insurers' past track record has not demonstrated continuity of coverage or stability in pricing and this must partly be attributable to the vagaries and misinterpretation of the occurrence language," he said.

Mr. Wilson advocated use of the claims-made form at the Risk Management Forum held last week in Monte Carlo, jointly sponsored by the Risk & Insurance Management Society Inc. of New York and the Assn. Européenee des Assurés de l'Industrie of Brussels, Belgium.

RIMS is the largest organization of risk managers in the United States and AEAI is a federation of risk management associations in seven countries.

Also speaking at the seminar with Mr. Wilson was Thomas V. Hallett, senior vp of Frank B. Hall & Co. in Briarcliff Manor, N.Y. Mr. Hallett warned risk managers about the problems inherent in mixing claims-made and occurrence policy forms in structuring a liability insurance program (see story, page 52).

Mr. Wilson traced the development of the claims-made form for excess liability insurance to the fall of 1984 and early 1985 when the liability insurance crisis struck the United States.

Recalling the "severe lack of capacity and massive premium increases" when insurers realized their loss reserves were inadequate, Mr. Wilson said, there was a "need for an immediate solution to the problem and the claims-made concept emerged."

Mr. Wilson reminded the audience that the hard market erupted after four years of intense competition and was the culmination of disasterous underwriting results.

"Every major insurer of casualty business in North America was required to strengthen reserves due to past inadequacy and

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Photo: Kathryn J. McIntyre

Scenic buildings on a bluff overlook Monte Carlo, the venue for the AEAI/RIMS Risk Management Forum.

European tort system differs from U.S.

By CAROLYN ALDRED

MONTE CARLO, Monaco—European court verdicts in product liability cases will continue to be very different from those in the United States despite the introduction of strict liability in the European Community next year, risk managers say.

In a mock tort trial at the Risk Management Forum last week in Monte Carlo, participants, acting as jury members, produced a "very different verdict" from what probably would have been handed down in the United States, according to the trial's "judge."

And, at the end of the three-hour trial at the conference, sponsored by the Assn. Européenee des Assurés de l'Industrie and the Risk & Insurance Management Society, the mostly European audience criticized the U.S. legal system, particularly contingency fees.

The contingency fee system, although providing the opportunity for the poor to file suit, encourages litigation and increases court awards, the Europeans alleged.

Contingency fees are "almost unheard of" in Europe, said one risk manager.

However, the British Law Society has set up a working party to investigate the possible introduction of contingency fees in the United Kingdom, noted Hermann B. Hollmann, counsel for Ford of Europe in London.

Although most of the conference delegates recognized the merits of the contingency fee system, many said that fees should be capped to prevent excessive awards.

In addition, the lack of a contingency fee system in Europe "is one reason why product liability won't run away in Europe like people think it has in the U.S.," said Joel Pierce, a partner in the Boston law firm of Morrison, Mahoney & Miller.

Participants also criticized using juries in civil suits.

After summarizing the case, the judge that presided over the mock trial, Anthony Mercorella, a partner with

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Venice risk management conference

Photo: Holly E. Seguine

Gondolas parked along Venetian docks were a familiar sight to risk managers who attended the International Insurance & Risk Management Conference in Venice.

Self-insurance boom to continue: Kloman

By STACY SHAPIRO

VENICE, Italy—Self-insurance techniques will account for half of the total cost of risk financing by the year 1995, a U.S. risk management consultant predicts.

This year, more than $30 billion that would have been paid in premiums to commercial property/casualty insurers instead has been invested in self-insurance programs, says H. Felix Kloman, a principal and vp of the Tillinghast Division of Towers, Perrin, Forster & Crosby Inc. in Darien, Conn.

The recent hard market has produced numerous alternative risk financing methods, he pointed out, such as the use of capital bond markets, captives, municipal pools, stabilization plans, post-loss funding and large deductibles or self-insured retentions.

By the year 1995, "the alternatives may account for 50% of the total cost of risk financing," Mr. Kloman said.

"We see a strong move in the U.S. away from conventional insurance and a move to private funding. . .a move to self-insurance, which will comprise $30 billion in premiums in 1987," Mr. Kloman told more than 300 risk managers who attended the 17th annual International Insurance & Risk Management Conference Oct. 7-9 in Venice, Italy. The conference was sponsored by Management Centre Europe, an affiliate of the American Management Assn. that is based in Brussels, Belgium.

"Today, there are too many insurance companies to be efficient," Mr. Kloman maintains. In the United States alone, there are 3,500 insurance companies, which is "simply too many," Mr. Kloman said.

Also, the European and U.S. insurance industries are overregulated, depend too much on reinsurance and include more than 500 "severely underreserved" property/casualty insurers, Mr. Kloman said. "You will see more bankruptcies," he predicted.

In addition, the U.S. property/casualty industry's continued high expense ratio of about 30% is "the biggest albatross around our neck," he said.

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Flexible benefits

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"Should this ill-considered proposal be enacted, cafeteria plans would be so severely curtailed that they would be effectively eliminated," declared the Assn. of Private Pension & Welfare Plans in a letter to Ways and Means Committee Chairman Dan Rostenkowski, D-Ill.

When employers establish flexible benefit plans, they often also set up flexible spending accounts —also known as benefit banks or flex funds—into which employees can funnel pretax dollars through salary reduction. These spending accounts also can be freestanding and not offered as part of a complex cafeteria plan.

The employee is allowed to spend these pretax dollars on items like health care expenses—such as deductibles—that are not covered under the group health plan, vision and dental care, dependent care costs and legal expenses.

Because these spending arrangements allow the use of pretax dollars, employers can more easily shift more health care costs to employees in an effort to curb overutilization of health care services. Imposing high deductibles or making employees pay a greater share of premium costs has a less onerous bite if the employee pays the bills with pretax dollars funneled into a spending account.

When employees pay a greater share of medical bills, they become more careful consumers. And, that ultimately slows down health care inflation, experts say.

The arrangements are especially attractive for employees who have children, because pretax dollars can be used for day-care expenses.

But a $500 cap would be quickly reached by employees choosing health care plans with high deductibles and coinsurance.

"This will hurt health care cost containment. It will become much more difficult for employers to promote higher deductibles and coinsurance requirements," said Henry Saveth, a vp with Johnson & Higgins in New York.

A $500 ceiling also effectively would kill the use of a spending account for child care expenses, experts say.

"It takes all the air out of the balloon for child care. A $500 cap would pretty much destroy spending accounts for dependent care," said Tom Butterworth, a consultant in the Rowayton, Conn., office of Hewitt Associates.

While the Ways and Means committee has provided little explanation and justification for the proposed cap on flexible benefit plans, experts say there is only one explanation: the need for revenue.

"It is a hunt for revenue, and flexible benefit plans are the target," Mr. Butterworth said.

In fact, by curbing the tax advantages currently available through flexible benefit plans, the government could prevent a revenue loss of more than $4 billion over the next three years, according to an estimate by the Joint Committee on Taxation.

But some benefits consultants describe this estimate as bogus and say it was produced without any credible research.

"The revenue estimates are sheer speculation," said Lance Tane, manager of The Wyatt Co.'s flexible compensation team in Washington.

Benefit experts and lobbyists say the battle has just begun and that they are optimistic that employers —if they band together—can convince Congress to drop or modify the committee's proposal.

"There are many people who are going to be heard from," asserted Kevin O'Brien, a partner with the Washington law firm of Ivins, Phillips & Barker, which represents the Employers Council on Flexible Compensation.

"I can't believe in my heart that something that affects millions of people will be implemented into law without an understanding of the implications," Mr. Tane said.

Like many of the attacks legislators have launched on benefit arrangements in recent years, the proposed flexible benefits limits came with little warning. No hearings have ever been held on the proposal, and it was discussed behind closed doors.

In addition, as has been true with so many other Congressional benefit proposals, employers would have virtually no time to amend their plans and communicate the changes to their employees under the latest proposal.

As currently drafted, the flexible benefit proposal would go into effect on Jan. 1.

Some employers already have sent out 1988 enrollment forms for employees to make benefit choices and decisions on how much salary they want deferred to pay for benefits. If the proposal is passed, employers would face the costly and complicated task of sending out new enrollment forms.

"Employers would face a major administrative and communications challenge," Mr. Butterworth pointed out.

But it could be months before Congress decides what, if any, new limits should be imposed on flexible benefit plans.

That uncertainty not only would be nerve-wracking for employers and their employees covered by flexible benefit plans, but it also could force employers that are about to launch flex plans to hold off until the dust settles.

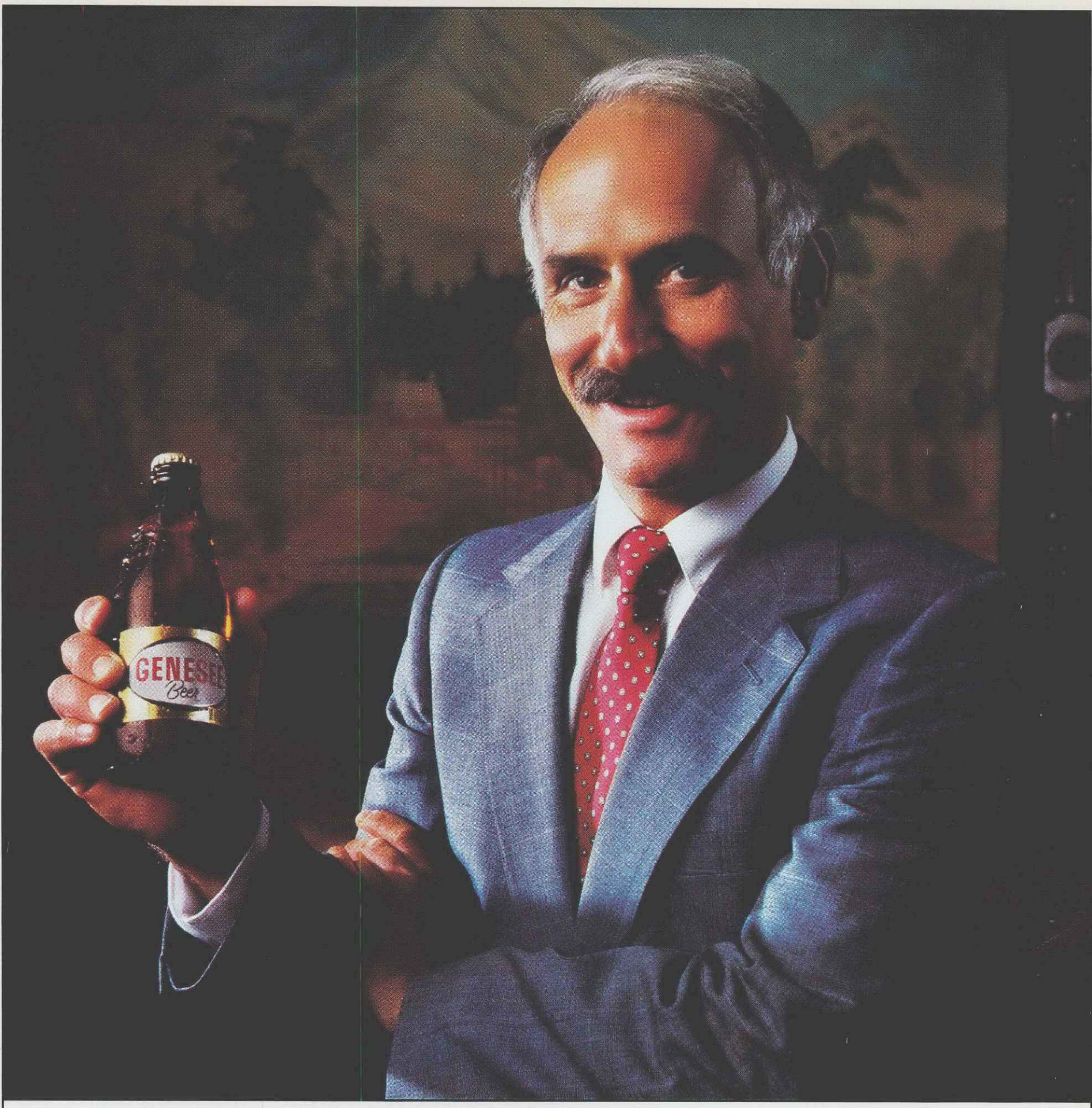
However, employers can take some comfort that they prevailed in their last battles with Congress over flexible benefit plans.

In 1983, employers were able to convince a congressional conference committee to delete a provision in legislation shoring up the Social Security program that would have slapped Social Security payroll taxes on the entire value of a flexible benefits plan if any cash or taxable benefits were offered as part of the plan (*BI*, March 14, 1983).

And, in 1984, employers convinced another conference committee considering a tax bill to add a provision to bar the Internal Revenue Service from retroactively enforcing rules that could have disqualified thousands of flexible benefit plans (*BI*, July 2, 1984).

But with Congress so hungry for revenues in an era of huge federal budget deficits, the battle will be a lot tougher this time around.

"Anything is possible because of the tremendous pressure for revenues," warned John Hickey, a partner with Kwasha Lipton in Fort Lee, N.J. ■



"Smooth."
A brewer's word for Wausau's claims service.

"The way Wausau handles claims and payment of claims is smooth," says Paul Killion, personnel director of Genesee Brewing Co., Rochester, New York.

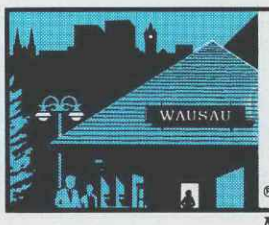
"If you have an employee whose check is late or the amount is wrong, that's a sore point. Wausau excels at timely and accurate payment of claims."

As for claims administration, Mr. Killion says, "Claims information comes in on time and it's accurate. If we have a question on how our claims are doing or on trends in accidents, we get the information and statistics.

"We've had a chance to compare Wausau with other carriers, and Wausau's better."

Thank you, Mr. Killion. That's a claim we're glad you made.

WAUSAU WORKS.℠



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Defense costs

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Although the Evanston decision dealt with an E&O policy covering an insurance company, attorneys say the principle the court addressed is similar to those cases involving D&O liability policies.

"This decision provides strong authority in the D&O context for finding there is no obligation to defend or to reimburse defense costs on an ongoing basis," said attorney Michael Marick, with the Chicago firm of Phelan, Pope & John, who represents Evanston.

However, SAC attorney Hugh McCombs, with the Chicago firm of Mayer, Brown & Platt, said that the particular language in the Evanston policy is not commonly used in either D&O or E&O policies, and thus the impact of the decision may be limited.

The case involved an insurance company and affiliate claims-made E&O policy purchased by SAC from Evanston, which ran from Oct. 1, 1982, to Oct. 1, 1985.

Policy limits were $15 million per claim, with a $100,000 deductible for each claim.

As of last November, SAC had paid more than $350,000 in defense costs and other fees for which it was seeking reimbursement, according to court papers.

The opinion said that in mid-1982, SAC negotiated with now-bankrupt American Benefits Trust, a multiemployer trust that provided medical benefits to trust participants, about the possibility of issuing to ABT a short-term medical and disability policy.

SAC apparently filed a master policy with the state insurance department but never formally issued a policy to ABT, the opinion said.

In late September 1982, ABT filed for bankruptcy, leaving numerous trust participants with outstanding claims.

In April 1984, the trust participants, along with ABT's trustees, sued SAC, contending SAC should cover the claims under the policy they contend SAC issued to ABT.

The State Superior Court in Los Angeles currently is hearing that suit, *Diamant vs. Security Assurance Co.*

SAC then sought from Evanston under SAC's E&O policy a defense to the Diamant suit and any indemnification costs that may arise. Evanston declined coverage and brought a declaratory judgment action against SAC in 1985.

Among Evanston's contentions in the suit are:

- It did not owe coverage because ABT allegedly first made the claim prior to Oct. 1, 1982, which is when the policy period began.
- SAC executives allegedly knew of the acts, errors or omissions giving rise to the underlying action, which negated coverage under the policy.

In a counterclaim, SAC claimed that Evanston breached the E&O policy by not paying its defense costs as they came due.

Both parties filed motions for summary judgment on the duty to defend issue, which is the only issue that Judge Decker has addressed so far.

At issue was policy language obligating Evanston to "pay on behalf of (SAC) the amount of loss. . .which (SAC) shall become legally obligated to pay resulting from claims first made against (SAC) during the policy period by reason of any act, error or omission by (SAC) in the performance of professional services."

In addition, the policy stipulated that the act, error or omission for which SAC would be insured must have occurred either during or prior to the policy period, "provided that on or prior to the effective date of. . .the policy no executive officer or director of (SAC) had knowledge of such act, error or omission. . . ."

The policy defined the term "loss" as "compensatory damages, punitive damages, settlements and claim expenses" that SAC incurs, the court said. Claims expenses included "costs of investigation and amounts incurred by the insured in the defense of legal actions, claims or proceedings and appeals therefrom," according to the court.

Also included in the policy was an "option to defend" clause, which provided that "it shall be (SAC's) duty to defend claims made against them, provided, however, that (Evanston) shall have the option, but not the duty to defend claims made against (SAC). . ." the court said.

"(Evanston) may also elect at its own expense to participate with (SAC) in the investigation, settlement and defense of any claim made against SAC for which insurance is provided by this part of the Policy," the policy said.

According to Judge Decker's opinion, SAC argued that the policy unambiguously obligated Evanston to pay SAC's defense costs as they became due.

SAC noted that the policy provided that Evanston would pay the defense costs "incurred by SAC" for which SAC "shall become legally obligated to pay" and pay those losses "on behalf of" SAC.

The words "on behalf of" imply that Evanston would directly pay SAC's defense counsel, and "incurred by" implies that Evanston would pay SAC's defense costs as they became due, SAC argued.

However, Judge Decker disagreed, pointing out that the policy must be read as a whole.

He noted that the portions of the policy cited by SAC also explicitly limited Evanston's duty to pay only to losses resulting from claims first made against SAC during the policy period. The policy also excluded claims based on an act, error or omission that SAC executives knew prior to the policy period, the judge said.

"Accordingly, unless and until it is determined that ABT first asserted its claims against SAC while the policy was in force, and that SAC executives did not. . .know of the act, error or omission which gave rise to the Diamant action, the policy does not obligate Evanston to pay SAC's defense costs," Judge Decker said.

Those issues still must be resolved during the ongoing coverage litigation in the district court.

The judge also rejected SAC's argument that it was owed defense costs under the "potential-for-coverage" precedent, which provides that once a claim is filed that is potentially covered, the insurer must defend the policyholder, unless it can prove the policy does not cover the claim.

Judge Decker said courts invoking the potential-for-coverage rule have interpreted conventional liability policies that contained an express duty to defend—not the "option to defend" included in SAC's E&O policy.

"To this court's knowledge no Illinois court has applied the potential-for-coverage rule to a policy which did not contain a duty to defend clause," Judge Decker said.

"Moreover, at least one court which faced a policy with an 'option to defend' clause decided the insurer could not be obligated to pay the insured's defense costs under such an agreement."

Judge Decker said that "under Illinois law, an insurance policy does not afford the insured the additional protection provided by the potential-for-coverage rule unless the insurer assumes the complete, present obligations associated with the traditional duty to defend."

The SAC E&O policy "only includes the aforementioned 'option to defend' clause. This clause not only does not require Evanston to defend SAC; it requires SAC to defend itself while giving Evanston the choice to participate in the defense," Judge Decker ruled. ■

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GM, UAW accord includes benefit upgrades

A tentative agreement between Detroit-based General Motors Corp. and the United Auto Workers Union on a new three-year contract includes improved health care, disability, pension and profit-sharing benefits.

The agreement, which closely parallels the pact that Ford Motor Co. employees approved earlier this month, is expected to be approved by GM workers before an Oct. 25 deadline.

UAW President Owen Bieber and Vp Donald F. Ephlin said the agreement "achieves all of our goals and will enable the corporation and our members to make real progress in the years ahead."

If the agreement is approved, it will go into effect for all workers at all GM plants on Jan. 1.

The GM and Ford agreements are virtually identical in most employee benefit-related areas, but a unique provision of the GM agreement establishes an early retirement option.

Under the Mutual Retirement Option, GM employees between the ages of 55 and 61 who have 10 or more years of service can elect early retirement and receive full retirement benefits. The plan provides the retiree full benefits for life after age 62 and one month and partial benefits until then.

Mr. Ephlin estimates that about 35,000 of GM's 335,000 active UAW members could qualify for the program.

Under both the GM and Ford agreements, the maximum amount of dental and mental health coverage was increased to $1,200 from $1,000 per year, a cost of living increase. Plus, 14 prescription drugs were added to the list of covered maintenance drugs at GM; 13 drugs were added to Ford's list.

GM and Ford's contribution to the monthly Medicare Part B premium—which covers physician expenses for retirees, surviving spouses and those on long-term disability—was increased to keep pace with anticipated changes in cost. The payment will be $25 as of Jan. 1, 1988; $27 as of Jan. 1, 1989; and $28 as of Jan. 1, 1990. But in no case will the contribution exceed the actual Part B premium.

GM and Ford employees now also have higher maximums limits for sickness and accident benefit and extended disability benefits.

The S&A weekly maximum benefit, which is based on 60% of an employee's weekly salary, was increased to $430 per week, depending on the employee's job and years of employment. The maximum under the old agreement was $390.

The extended disability benefit was increased to $1,560 per month from $1,405 for employees with less than 10 years of service and to $1,715 per month from $1,545 for employees with more than 10 years of service.

All GM and Ford workers also will receive increases in their basic life and extra accident insurance. The maximum life insurance benefit was increased to $41,000 from $37,500, and the maximum extra accident insurance was increased to $20,500 from $18,750.

In addition, beginning July 1, 1988, GM and Ford employees can purchase additional life insurance coverage ranging from $10,000 to $100,000.

And, under a new dependent life insurance program, GM and Ford employees can buy $5,000 to $20,000 in coverage for a spouse and $2,000 to $8,000 in coverage for each dependent child. The previous maximum coverage was $10,000 for a spouse and $4,000 for each child.

The new contracts also increase survivor benefits to $400 per month from $350 per month for those not eligible for full old age, survivors' or disability benefits under Social Security.

For those survivors eligible for Social Security benefits, the survivor benefit was increased to $225 per month from $200 per month.

GM and Ford autoworkers also gained increased profit-sharing benefits. Under a new formula, employees would receive a percentage of their employer's profits in any year profits exceed 1.8% of sales. The amount employees would receive ranges from 7.5% of those profits only in excess of 1.8% to 16% of the excess profits.

Previously, the most GM employees could receive was 10% above the excess while Ford employees received up to 15% of excess profits.

Pension benefits for employees were increased by $4.20 per month per year of service—or 19%—for employees retiring after Oct. 1.

Benefit beat

Hospital use

The average number of days patients spent in Indiana hospitals throughout 1986 dropped 5.2% to 6.1 days from 6.4 days in 1985, but the average length of each hospital stay remained at 6.3 days, according to a study by the Indiana Hospital Assn.

In addition, discharges at Indiana hospitals in 1986 dropped 5.6%.

"This trend reflects today's changing health care system," in which more patients are being treated on an outpatient basis, said Kenneth G. Stella, IHA president.

The number of outpatient visits reported by the 99 hospitals surveyed in 1986 increased 4.9% to more than 2.9 million per year, compared with the previous year's figures. Outpatient visits nationally also rose, jumping 8.3% in 1986 to 263.6 million.

Nationwide, the number of days patients stayed in hospitals in 1986 dropped 1.4%, according to the association. Discharges nationally slipped 2.1%, but the average length of stay rose to 6.6 days from 6.5 days.

Because Indiana hospitals traditionally have charged lower rates for hospital care than the national average, Indiana patients tended to spend more time in the hospital. As a result, hospitals in the state had to reduce utilization more than hospitals in many other states that charged more for their services to meet Medicare-imposed maximum utilization standards, according to a spokeswoman for the IHA.

●

Benefit beat keeps insurance and employee benefit managers informed on on what other companies are doing and of current developments in the employee benefit field. Have you made any benefit changes? Write Stacy Adler, assistant copy editor, Business Insurance, 740 N. Rush St., Chicago, Ill. 60611; 312-649-5262.

Bill discourages pension plans: ERIC

By JERRY GEISEL
and DEBORAH SHALOWITZ

Washington

WASHINGTON—Legislation passed by the House Education and Labor Committee would discourage employers from setting up defined benefit pension plans, a benefit lobbying group says.

The legislation—contrary to longstanding congressional policy—will "discourage the formation and expansion of defined benefit pension plans," according to the Washington based-ERISA Industry Committee.

In a letter to Committee Chairman Augustus F. Hawkins, D-Calif., ERIC criticized the proposal for failing to adequately strengthen ERISA's current minimum funding standards, imposing a "draconian" $200 per-participant exit fee on employers terminating pension plans and raising the current $8.50 PBGC termination insurance premium to $19 rather than adopting a variable-rate premium structure (*BI*, July 27).

In addition, ERIC faulted the proposal because it gives participants of terminated overfunded plans a right to a share of the excess assets.

"The proposals give participants a right to receive benefits that they have not been promised," ERIC said.

COBRA penalties

Congressional tax committee staffers are continuing to look for alternatives to the current severe penalties employers face if they violate COBRA's health care continuation provisions.

A House Ways and Means Committee staffer said the committee is discussing the concept of imposing monetary fines on employers that violate provisions of the Consolidated Omnibus Budget Reconciliation Act of 1985.

Those fines would replace the current COBRA non-compliance penalty: denial of the annual tax deduction for health care expenses.

The staffer, who says she is aware of suggestions for change from a Treasury Department official (*BI*, Oct. 12), said that new penalty provisions could be made part of a budget reconciliation bill that the Ways and Means Committee now is drafting.

Retiree health care

Because of budget constraints, Congress is not likely to restore tax incentives for employers to prefund retiree health care benefits, according to a congressional staff member.

"There is not the money to pay for" prefunding, says Phyllis Borzi, pension counsel for the House Labor-Management Relations Subcommittee and an aide to Subcommittee Chairman William Clay, D-Mo.

Speaking this month before a meeting of the National Employee Benefits Institute in Washington, D.C., Ms. Borzi said the only way Congress would approve tax incentives for prefunding of retiree health care benefits is if employers would be willing to have Congress cut tax breaks for other employee benefits.

Meanwhile, another staffer who also spoke at the NEBI meeting, defended the congressional decision—carried out in the Deficit Reduction Act of 1984—to eliminate tax breaks for retiree health care benefits.

Under DEFRA, investment income held by Voluntary Employee Beneficiary Assns. to prefund retiree health care benefits is immediately taxed.

Previously, investment income earned on VEBA reserves to pay for retiree health care benefits was not taxed.

Lawrence Atkins, an aide to Sen. John Heinz, R-Pa., said the use of VEBAs to prefund retiree health care benefits was an area "ripe for abuse."

Mr. Atkins noted that there were no participation or vesting standards for retiree health care benefits.

As a result, there was no assurance that money being set aside for these benefits would be used for that purpose.

Pension terminations

The Internal Revenue Service will not require employers that terminate overfunded pension plans to pay participants benefits they would have earned had they remained in the plans until retirement.

The IRS says the "benefit expectations" of employees in defined benefit pension plans do not have to be satisfied.

The IRS defines benefit expectations as "a level of benefit calculated as though participants had completed additional years of service for the purpose of benefit accrual from the date of plan termination to the participant's relevant retirement date," according to an agency document.

The IRS discussion of the matter followed the agency's decision to lift a hold on issuing determination letters to employers in eight states that wished to terminate their overfunded defined benefit plans (*BI*, Oct. 5).

The agency issued that hold following two appellate court decisions involving employer terminations of overfunded defined benefit plans.

In one case, the 11th Circuit Court of Appeals in Atlanta ruled in *George G. Blessitt and Willie Neal Jr. vs. Retirement Plan for Employees of Dixie Engine Co.*, that the company must use excess assets of a terminated pension plan to pay employees the value of unaccrued benefits (*BI*, Aug. 10).

In the other case, the 4th Circuit Court of Appeals in Richmond, Va., ruled in *B.E. Tilley, et al, vs. The Mead Corp.*, that the company must use the excess assets of a terminated pension plan to pay employees the value of early retirement supplements.

In a general counsel's memoranda issued after the IRS announced its decision to lift its hold on determination letters, the agency stated that Section 4044(a) of ERISA "should not be seen as increasing the term liabilities to include 'benefit expectations.' "

That section was intended to protect the PBGC from financial responsibility for guaranteed benefits when there were sufficient plan assets in the plan to pay these benefits, according to the Internal Revenue Service. ■

ISCEBS symposium

Proposed regulations give firms COBRA clues

By DEBORAH SHALOWITZ

PHILADELPHIA—Proposed regulations detailing how employers would have to comply with the health care continuation provision of COBRA are complicated, but close examination of them reveals some clues on how employers should proceed, an attorney says.

The proposed regulations regarding the Consolidated Omnibus Budget Reconciliation Act of 1985 "put a little bit of a spin" on how employers should operate, admitted Alan P. Cleveland, an attorney with the Manchester, N.H., law firm of Sheehan, Phinney, Bass & Green Professional Assn.

Mr. Cleveland made his remarks at the International Society of Certified Employee Benefit Specialists' sixth annual employee benefits symposium in Philadelphia last week.

Under COBRA provisions, employers must offer group health care benefits to former employees and employees' widowed, divorced or separated spouses. The penalty for non-compliance is loss of an employer's federal tax deduction for health care expenses for one year (*BI*, June 22).

Mr. Cleveland reviewed the proposed regulations, which were issued by the Internal Revenue Service and published in a question-and-answer format in the Federal Register on June 15, and pointed out several areas that might confuse benefit managers.

For example, Mr. Cleveland referred to the regulation that stipulates that all health care plans—except those sponsored by the government, a church or an employer with fewer than 20 employees—must comply with the proposed regulations.

He said that the exemption for government-sponsored health care plans includes only the federal government and the District of Columbia and that state and municipal-sponsored health care plans must comply with COBRA.

He also said that a covered employee under the regulations is any individual who is or was provided coverage under a group health plan. Mr. Cleveland noted that an individual merely eligible but not actually covered by an employer-sponsored group health plan is not considered a covered employee under the proposed regulations.

However, Mr. Cleveland said he found one aspect of the regulations relating to qualified beneficiaries "very disturbing."

This regulation states that the new spouse of an employee's ex-spouse would be able to elect group health care coverage through the employee's group health plan.

Although employers should plan on complying with that regulation, they should note on election forms that this coverage extends only until the final regulations are issued, Mr. Cleveland said.

That way, if the final regulations do not contain this provision, employers will not be locked into providing this coverage, he pointed out.

Employers can take other action to protect themselves from future complications that the proposed regulations may cause, Mr. Cleveland said.

Under the proposed regulations, termination of employment for any reasons except "gross misconduct" makes an employee eligible to elect continuation of his health care coverage. However, neither COBRA nor the proposed regulations define gross misconduct, Mr. Cleveland pointed out.

He advised employers to assume that the definition of gross misconduct is very strict—perhaps limited to criminal behavior.

In addition, an employer can insert into its benefit plan a definition of gross misconduct, Mr. Cleveland suggested. That way, if an employer chooses to deny health care coverage to a former employee on the grounds the employee was terminated because of gross misconduct, the employer has some evidence that it is not trying to elude COBRA regulations.

Katherine A. Hesse, a partner with Murphy, Hesse, Toomey & Lehane in Braintree, Mass., moderated the discussion. ■

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Flexible plans

Continued from previous page

55 in a flexible benefits plan that contained five ways to create flexible dollars and 11 ways to spend them. He pointed out that under that plan, there were 329,000 potential permutations of elections on the plan enrollment form.

Basically, he noted, flexible dollars can be created by any combination of mechanisms, including:

- Redirecting existing employer contributions.
- New employer contributions.
- Salary reduction.
- Sale of regular vacation.
- Election of a less comprehensive medical plan and giving all or part of the difference in the value between the new plan and the original plan back to the employee in the form of flexible dollars.
- Reducing benefits to a minimum core level and giving all or part of the difference between the new benefit levels and the original benefit package to the employee in flexible dollars.
- Sale of carryover vacation.

Anti-selection—when employees choose to buy the benefits in a flexible benefits plan that they are most likely to use—can be controlled thorough plan design, Mercer's Melvin Borleis points out.

Mr. Borleis noted that carryover vacation time is recorded as an expense for employers and increases in value as time passes and an employee's salary rises. He suggested that an employer consider freezing the dollar value of carryover vacation to mitigate this situation.

Ways to spend flexible dollars include:

- Medical, dental and/or vision care plans.
- Group term life insurance.
- Accidental death and dismemberment insurance.
- Short- and long-term disability insurance.
- 401(k) plans.
- Cash.
- Vacation or other time off.
- Spending accounts.
- Dependent care.

Flexible dollars cannot be spent on scholarships and fellowships, van pooling, educational assistance or meals and lodging, Mr. Borleis pointed out.

Both employers and employees can save money with flexible benefit plans if employees use pretax dollars to buy benefits.

An employee's take-home salary can remain the same, but more benefits can be purchased by using pretax dollars, he explained.

Similarly, an employer's costs can remain constant, but when benefits are purchased with pretax dollars, the employer's contribution increases in value because it has not been subject to Social Security payroll taxes.

And, the cost savings to some employers with flex plans exceeds the cost of setting up the plans, according to Mr. Borleis.

For example, the first-year expenditure to develop and implement a flexible benefit plan for a company with 1,000 employees would total approximately $170,000, he said.

This is based on assumptions of $35,000 for plan design, $30,000 for administration, $20,000 in enrollment costs and $85,000 in communication costs.

Meanwhile, the annual savings possible with a flexible benefit plan for the same company is approximately $195,000, he said.

This is based on assumptions of $64,000 in savings on Social Security taxes, $45,000 in medical plan savings when 300 employees elect a less comprehensive plan than the original, $56,000 in cost shifting from aftertax to pretax dollars of the medical plan for the 700 employees who elect to remain in the original plan, and $30,000 in elimination of carryover vacation.

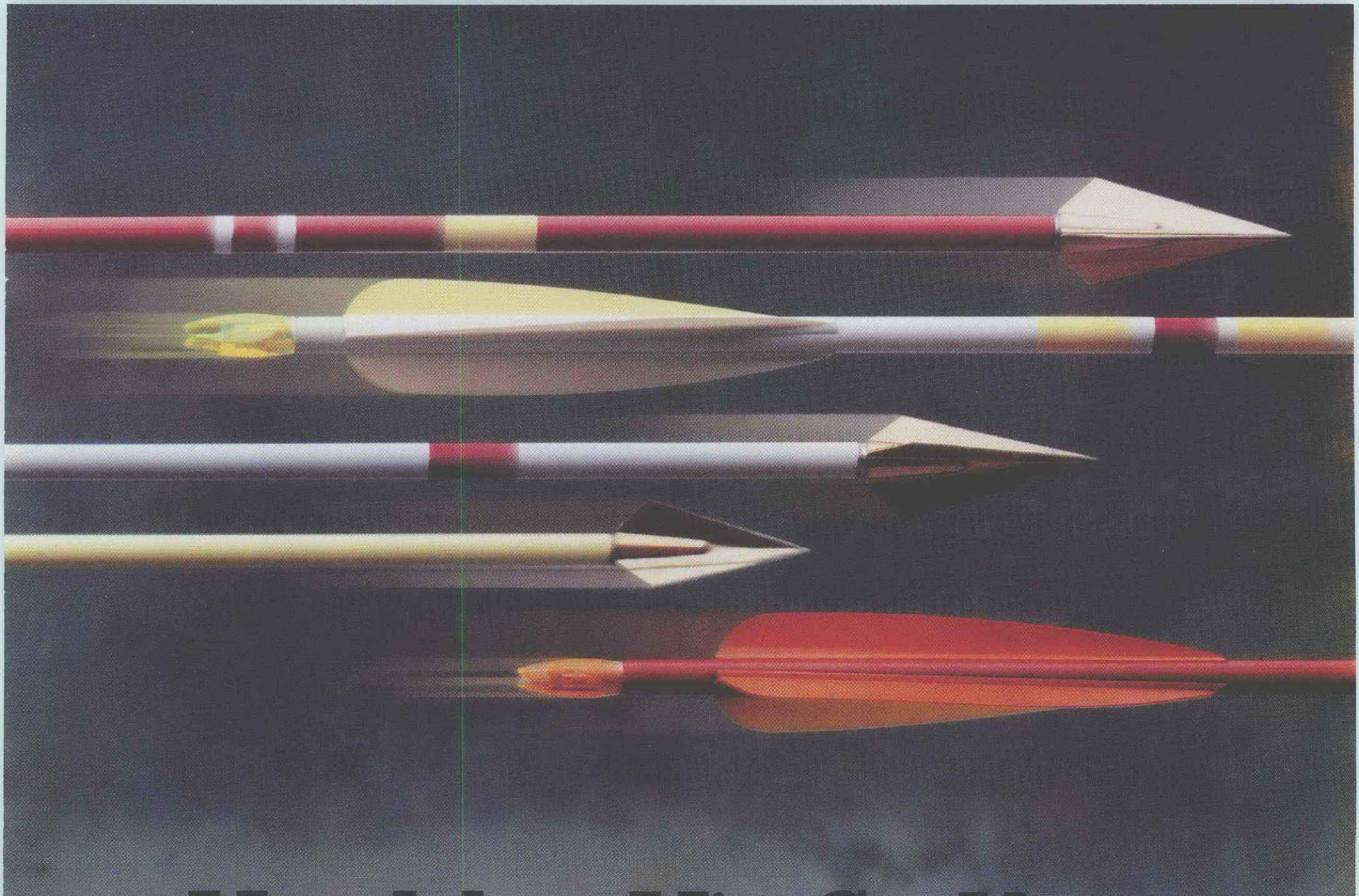
Generally, an employer can expect younger employees to buy time off, child care and long-term disability insurance with their flexible benefits dollars, while older employees generally sell time off and put money into 401(k) plans, Mr. Borleis said.

Anti-selection—when employees choose to buy the benefits they are most likely to use—can be controlled thorough plan design, Mr. Borleis noted.

He reminded the audience that employers can tailor to their plan features, prices and operation to meet their needs.

Employers can expect a 2% to 3% error rate on election forms, according to Mr. Borleis. "More than that, and your communication program wasn't sufficient," he said.

Richard Kleinert, a senior consultant in Meidinger's Cleveland office, moderated the discussion. ■



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New managed care options predicted

By DEBORAH SHALOWITZ

Many HMOs and PPOs will not survive an increasingly competitive health care market, Mr. Fox predicts. Others will be consumed by 'super-med' organizations that offer a range of unbundled managed care options, he says.

PHILADELPHIA—Alternative health care delivery systems present both opportunities and challenges for employers, says one expert in the field.

While employers can benefit from options such as health maintenance organizations and preferred provider organizations, they should be aware that increasing competition in these fields has significant implications, says Peter D. Fox, vp of Lewin & Associates Inc., a Washington, D.C.-based health care consultant.

Furthermore, trends in health maintenance organization and preferred provider organization growth have recently taken some new turns that employers should note, Mr. Fox said at the International Society of Certified Employee Benefit Specialists' Sixth Annual Employee Benefits Symposium in Philadelphia last week.

Mr. Fox

One emerging trend is the development of new managed care options that combine features of both HMOs and PPOs, according to Mr. Fox.

Traditionally, an HMO accepts risk through a capitation agreement with an employer and enrollees do not have a choice of which health care practitioner they use.

A PPO, on the other hand, maintains a traditional fee-for-service arrangement with an employer and employees may choose their own health care practitioner.

In most cases, health care providers associated with a PPO discount their fees to provide an incentive for health care consumers to choose them. Through this arrangement, PPO member providers seek to increase their volume of patients.

Mr. Fox noted that one area in which employers have been lax in instituting cost-control measures is outpatient care rates.

While many employers negotiate rates with hospitals, they limit their negotiations to in-hospital services, he explained, while the cost of ambulatory care is "absolutely exploding."

Employers could contain costs significantly by controlling these small-but-numerous outpatient care bills, he advised.

And the numbers of employees choosing HMO and PPO options are growing, Mr. Fox noted.

HMO enrollment has been growing by more than 20% a year since 1982, he said; and according to one recent estimate, more than 30 million people now have access to PPOs.

As they grow, competition among various managed care options has resulted in "price wars" between HMOs in local communities and, in some cases, a decrease in the quality of care offered by these organizations, cautioned Mr. Fox.

He noted one common complaint about HMOs is their lack of mental health care services. Another is their lack of services geared to the chronically ill.

Mr. Fox advised benefit managers to stop thinking of HMOs and PPOs as services and instead think of them as a products.

When buying a product, cost is only one of many factors considered in a purchasing decision, he reminded the audience.

Similarly, when selecting an HMO or a PPO, cost should not be the only factor weighed in the decision.

Many HMOs and PPOs will not survive an increasingly competitive health care market, he pointed out. Others will be consumed by "super-med" organizations that offer a range of managed care options, he added.

These super-meds eventually could offer a range of unbundled managed health care services, according to Mr. Fox, including:

- An HMO.
- A PPO.
- Utilization reviews.
- Assistance in developing employee wellness programs.
- Assistance in controlling absenteeism due to disability.
- Assistance in handling workers compensation cases.
- Assistance in promoting occupational safety and health.

Using the services of a super-med and contracting with an HMO on a nationwide basis are two completely different matters, Mr. Fox cautioned.

Although large employers might be tempted to contract on a national basis with one HMO that has numerous facilities across the country, that is just "an easy way out" and "basically a mistake." Local differences between competing HMOs can be great, he explained, depending on the local health care market.

In those areas in which organized alternative delivery systems do not exist, Mr. Fox noted, employers can still institute cost-containment measures.

These can include recruiting additional health care providers to the community; covering services provided by less costly health care professionals such as nurse-practitioners and physician's assistants; and teaching local health care providers cost-saving techniques.

Remember that in many of these situations, "you are probably the major employer in town, and that gives you some clout," Mr. Fox commented.

And "don't try for the same solution in every community," he advised.

Jerry S. Rosenbloom, academic director of the CEBS program and a professor of insurance at the Wharton School at the University of Pennsylvania in Philadelphia, moderated the discussion. ■

AIDS seminar

AIDS experts say education is best defense

By MEG FLETCHER

CHICAGO—Educating employees about AIDS is the first—but not the only—strategy that employers should adopt to cope with the national crisis, experts say.

"The single most important thing American business can do today is to help educate the public about AIDS," said Todd Swim, an associate actuary at the Allstate Research and Planning Center in Menlo Park, Calif.

'Education is the only way, short of a medical cure, to slow or stop the AIDS epidemic. It is also the most cost-effective way,' says Todd Swim, an associate actuary at the Allstate Research and Planning Center in Menlo Park, Calif.

"Education is the only way, short of a medical cure, to slow or stop the AIDS epidemic. It is also the most cost-effective way," Mr. Swim said at "AIDS: Corporate America Responds," a two-day seminar sponsored by Allstate Insurance Co. in Chicago last week.

"Education will help your employees and your customers deal with one another from a position of rational information and not irrational emotion," Mr. Swim said.

Dr. C. Everett Koop, surgeon general of the U.S. Public Health Service, said employers have the opportunity and perhaps the obligation to provide information on all aspects of acquired immune deficiency syndrome.

This should include an explanation of what constitutes high-risk behavior—like sexual or body-fluid contact with persons with AIDS and sharing syringes and needles typically used for intravenous drug use—and how to avoid those risks, he said.

But, employees must be made to understand that AIDS is not contracted through casual social contact in the worksite, he stressed.

"AIDS is not spread by working side by side with a person who has AIDS or who carries the virus in your plant or office setting. You don't get AIDS from shaking hands, sharing office machines or telephones, eating together or sharing the same locker. You don't get AIDS from toilet seats, towels, sneezing and coughing, drinking fountains or door knobs," Dr. Koop said.

AIDS in the workplace should be treated like any other chronic illness, he said, adding that imposing a stigma with the diagnosis leads to "irrational and unfair behavior," like ostracism.

"AIDS is usually contracted by behavior which most Americans do not practice and of which most Americans do not approve. That colors everything we see and hear in reference to AIDS."

However, many who carry the virus, like hemophiliacs, do so through no fault of their own. For example, the Ray children in Florida, hemophiliac boys who have AIDS, "are to be sincerely pitied, yet they were denied school, ostracized, denied access to stores, barber, church and eventually their home was destroyed by fire," Dr. Koop said.

"If your education program could prevent just one such incident from happening, it would be worthwhile," he said.

Such results are possible because educating an employee should provide spin-off benefits to the employee's family and social contacts, Dr. Koop pointed out. "We have to affirm that we are fighting a disease and not people."

"The ideal time to educate your employees about AIDS is before your corporation has its first AIDS case," he said.

In addition to implementing an education program, Dr. Koop said an AIDS policy should at least:

- Address AIDS within existing policies for other types of illness.
- Offer an employee with AIDS the opportunity to work as long as he or she reasonably can perform satisfactorily, bearing in mind the employee's capabilities, or offer work requiring less responsibility.
- Stress that managers and subordinates must respect employees with AIDS and encourage coworkers to be sensitive to the employee's needs.
- Refuse transfer requests made solely because there is an employee with AIDS at their worksite.
- Maintain the confidentiality of health records of persons who carry the virus but are not ill.

Employees in the health care industry face a special risk in dealing with AIDS patients because of the possibility of contact with infected bodily fluids like blood, emphasized John A. Pendergrass, assistant secretary of labor for the federal Occupational Safety and Health Administration.

He urged health care workers to use protective equipment like gowns, gloves and resuscitation bags when treating infectious and potentially infectious patients. In addition, they should treat blood and bodily fluids as if they are infected. And, they should properly dispose of equipment like needles and immediately clean spills.

"We have to educate people that they should take these precautions," because they are frequently ignored, Mr. Pendergrass said.

OSHA is launching an education program that includes targeted inspections of health care facilities to monitor behavior and promote adherence to existing guidelines. It is also considering whether additional guidelines are needed.

Once an employee has AIDS, employers may want to adopt a case management approach (*BI*, Sept. 7), suggested Dr. Paul Gertman, chief health care scientist with Caremark Inc. in Boston.

Customized arrangements including the use of alternative medical delivery systems like home health care can reduce the cost of treating an AIDS patient by one-half to two-thirds, he said. The treatment also can be both more humane and less risky for the patient, because he will be less exposed to infection than at a hospital, Dr. Gertman said. ■

Employers urged to draft AIDS guidelines

By MEG FLETCHER

CHICAGO—Employers must develop policy guidelines on how to best deal with employees that contract AIDS, health care and business leaders agree.

"We need you to set the example for being fair and objective and for not succumbing to groundless hysteria," said Dr. C. Everett Koop, surgeon general of the U.S. Public Health Service. "We need you to be informed about AIDS, to inform your employees about AIDS and to encourage your employees to exercise appropriate preventive measures."

Dr. Koop and 14 other speakers discussed AIDS-related topics at "AIDS: Corporate America Responds," a two-day conference in Chicago last week sponsored by Allstate Insurance Co. About 250 persons, including representatives from about 135 corporations, attended the conference.

Conference participants also helped draft policy papers on such topics as legal and human resource issues during closed working sessions.

Allstate plans for the participants to discuss drafts of those policy papers at a January meeting in Washington, D.C., and then make the drafts available to the White House, legislators and businesses.

In addition, Allstate will be involved in a detailed survey on AIDS in American business, which also will be presented at the January meeting.

Allstate called the conference because "the plain fact is, as a society, AIDS has us baffled," Herbert E. Lister, chairman of Allstate Life Insurance Co., said in prepared remarks. "We don't know who to believe, or who to blame. We are frustrated, and fearful and full of hope all at the same time."

Allstate itself does not have an overall policy to deal with employees with AIDS, and surveys show that fewer than one in three companies have corporate policies regarding AIDS-afflicted employees, Mr. Lister said.

According to an Allstate fact sheet, a recent Gallup poll showed that 33% of the public believes employers should be able to fire employees who have AIDS, although 43% believes those employees should not be fired.

"How do we deal with the fear in our workforces? How do we balance rights and responsibilities in a caring context?" Mr. Lister asked.

"Morally and materially, personally and professionally, we can afford to be silent no longer," he said.

"Daunting" statistics is one of the reasons that business cannot ignore the problem, said Todd Swim, associate actuary with Allstate Research and Planning Center in Menlo Park, Calif.

"Because it takes nine years from infection to diagnosis, the cases we see today are the tip of a very large iceberg," he said.

Projections based on a model developed by two State Mutual Life Assurance Co. employees for a joint project by the American Council of Life Insurers and the Health Insurance Assn. of America show that through mid-September there were 42,000 cumulative cases, more than half of which have resulted in death.

In addition, there are another 150,000 persons with AIDS Related Complex, a condition caused by the AIDS virus in which the patient tests positive for AIDS infection and has a specific set of clinical symptoms less severe than those with the classic AIDS disease.

There are about 1 million infected people altogether, many of whom have not been diagnosed, Mr. Swim said.

Projections also show there will be 425,000 AIDS cases, 800,000 ARC victims and roughly 2.3 million infected people by 1993.

"These frightening projections have a very good chance of becoming reality. Only an unforseeable medical breakthrough will reduce the projections significantly," Mr. Swim said.

"By 1993, the cumulative number of projected AIDS cases will exceed the total number of Americans killed in the Civil War, the Spanish-American War, World War I, World War II, the Korean conflict and the Vietnam conflict" combined, he said.

Growth in the number of cases will cause an increase in the total cost of treating those cases, other speakers at the conference pointed out.

Currently, the annual medical cost of treating someone with AIDS ranges from $25,000 to $150,000, depending on the type of care required, according to Allstate.

"In 1991, America will spend approximately $8.5 billion on direct personal medical care for AIDS victims and another $2.3 billion on other medical expenses, such as research and education," Mr. Lister said. And those sums do not include the indirect costs of lost time at work and lower productivity.

"Although few courts have squarely ruled on all of these issues, it appears that people with AIDS do fall within the definition of 'handicapped individuals' under federal and most state laws," Mr. Swim said. "Hence, they are afforded wide protection in the areas of employment and benefits," he said.

In separate interviews, spokesmen for life insurers emphasized that they especially want to be able to test prospective policyholders for AIDS.

"Otherwise, it is tantamount to wanting to insure a house that is

Continued on page 22

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Financial conglomerates a natural step: Execs

By STACY SHAPIRO

VENICE, Italy—Conglomerates composed of insurance, banking and manufacturing companies are not a frightening phenomenon but rather a normal evolution in business, say executives of two of Italy's most powerful companies.

Insurance companies and banks can invest in each other without any damage to society as long as they remain separate entities, said Enrico Randone, president and managing director of Assicurazioni Generali S.p.A. in Trieste, Italy's largest insurer.

Also, industrial companies can move into the financial services sector in an evolutionary fashion, which will benefit the companies and society in general, according to Umberto Agnelli, vice chairman of Fiat S.p.A. of Torino, Italy.

"You cannot create character and courage by frustrating the spirit of initiative," said Mr. Agnelli, quoting Abraham Lincoln.

"Just as the service sector is expanding in the economies of the advanced nations, so the more dynamic industrial companies and groups are intensifying their involvement," Mr. Agnelli said.

"In an increasingly global economy, companies are coming together in an infinite variety of agreements, a logical process that overflows the boundaries of individual manufacturing sectors. Indeed, it creates new frontiers, integrated groups whose existence is justified by the possibility of creating synergies."

Mr. Randone and Mr. Agnelli were the opening at the 17th annual International Insurance & Risk Management Conference earlier this month in Venice.

Generali, with more than $19 billion in assets, is believed to be the biggest company in Italy aside from the Italian government, which owns many companies.

Mr. Agnelli, also chairman of Fiat Auto S.p.A., served as an Italian senator.

In recent years, several industrial and financial companies, including banks, have been involved in acquiring or controlling stock in several insurance companies, Mr. Randone pointed out.

The growth of financial conglomerates should not be worrisome, although it should be properly managed and regulated, he said.

"We should not feel threatened by the fact that such institutions might wish to invest their resources in the insurance sector. On the contrary, those like myself who have labored for over 50 years in the profession to increase the visibility of a business sector which has remained hidden so long in the dark recesses of the shade should feel flattered at this desire to invest in our companies.

"However, it remains essential for the tasks, the functions, and indeed the modus operandi of these two business forces—investors and insurers—to be kept clearly distinct," Mr. Randone said.

Mr. Randone believes that financiers, businessmen and bankers should not be allowed to "superimpose" their investment directives on the management of an insurance company.

He said that investors must be aware that insurers have to meet totally different criteria than other

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Conglomerates

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companies. Therefore, there should be clear legislation stating the lines that must be drawn between insurers and their investors for the mergers to succeed and benefit consumers, he recommended.

"We should establish a precise and impassable line of demarcation between insurance companies and investors in respect to their respective tasks and duties. If possible, concise, clear legislation should also be passed in support of this demarcation," he said.

However, industrial companies have been involved in the service sector, particularly in banking, on and off for the last 200 years, Mr. Agnelli said. "So there is nothing new about it, though nowadays it is assuming different forms, which is why it so often comes up for discussion in Italy as in the rest of the advanced West."

In some ways, moving into financial services is an evolutionary process for Western industrial companies, which must finance and produce innovation to survive, he observed. Often it is a question of the search for a better balanced investment portfolio to spread business risk that moves manufacturers into the services sector, he said.

The trend of industrial companies moving into the service sector already has been established in the United States and in Japan in the tradition of the "Zaibatzu," the powerful conglomerates of pre-World War II Japan period that were dissolved following the war.

"There is nothing wrong in a big company that has always made refrigerators or TV sets suddenly deciding to buy a big food processing company," Mr. Agnelli said.

"Maybe the latter has a sales network that provides a new market outlet for refrigerators and TV sets. And there is even more chance of creating synergies between industry and finance, insurance and distribution," he said.

"In any event, entry into the service sector is one way industrial groups can prepare themselves for the future and deploy more and more diversified instruments to handle risk."

Fiat is a good example of an industrial company moving into financial services, Mr. Agnelli said. Fiat first moved into the service sector by creating a captive insurer to fund its own risks onshore in Italy.

Then, a few years ago, Fiat bought Italian insurance company Toro Assicurazioni S.p.A., of which Mr. Agnelli is chairman.

By 1994, 11% of Fiat's revenues will be derived from the financial services sector, he predicted.

"Some years ago we recognized the strategic value of entry into an efficient diversified tertiary business," he explained. "At the same time, the captive finance needs inside the group were growing by leaps and bounds and starting to make a decisive impact on the outside market as well," he said.

"A few months ago, we launched a rationalization process designed to eliminate every possible overlap in the financial area and to incorporate all the most successful financial operations into the group."

Mr. Agnelli pointed out that this linkup provides a more rounded company with the ability to use its best resource—people—to its advantage. "Since there is absolutely no reason why industrial companies should not grasp entrepreneurial opportunities in the service sector, it is rather odd that the phenomenon causes so much surprise and fear in political and economic circles, at least in Italy."

Meanwhile, European Community members are trying to implement the European Commission's freedom of insurance services directive, which, according to a European Court of Justice ruling, allows an insurer in one EC member country to serve as the lead underwriter for a multi-insurer program covering a risk located in another EC nation (*BI*, Dec. 15, 1986; Dec. 8, 1986).

But the Italian government reportedly opposes the directive and is trying to stall implementation.

An English delegate to the conference said he was sad that Italy, along with Greece and Belgium, should have a protective attitude to freedom of insurance services among EC nations.

However, Mr. Agnelli pointed out that many Italian insurers favor freedom of insurance services. The government is moving slowly to prepare the Italian insurance market, which is not as sophisticated as other EC markets, he said.

"The wise companies are moving (toward freedom of insurance) already," he said.

Generali is also in favor of freedom of insurance, but with some provisos. Mr. Randone pointed out.

"The Italian government has not adopted an Italian stance," he said. "But there are some discrepancies that need to be sorted out, which is no challenge to freedom of services."

For example, to do away with any distortion of competition between companies of different EC nations, countries must abolish with exchange controls, which Italy has but England has not; non-tariff barriers; and fiscal problems. "These are all areas where the Italian government is making efforts," Mr. Randone said. "But I hope there will be freedom of services." ■

Pollution risks a growing concern: Experts

By CAROLYN ALDRED

VENICE, Italy—Risk managers and insurers face increasing difficulties in spreading the risk of environmental and industrial hazards, according to experts.

"Before the end of the century, both industry and insurers will be faced with the problem of bringing back the dimensions of risk to a socially acceptable level," said Matthias Haller, director of the Insurance Institute of St. Gallen, Switzerland.

Although advances in safety and technology have reduced the frequency of major industrial accidents, the consequences of those accidents when they do occur are now far worse, he told the International Risk and Insurance Management conference, held Oct. 7-9 in Venice, Italy.

The conference was organized by Management Centre Europe, a Brussels, Belgium-based arm of the American Management Assn.

While the insurance system is responsible to society for spreading risks, it is up to industry itself to minimize risks, Mr. Haller said.

"The development of major industrial risks will reach the objective limits of the insurance system. Self-help measures can slow down the process, but not change the basic trend," he warned.

"How risk management operates in the world is close to losing equilibrium in terms of handling large risks," Mr. Haller said, adding that risk management must be fully integrated into economic and social management systems.

"One of the major safety functions now is not technical but one of (human) attitude," he said, adding that "insurance is not concerning itself sufficiently with society and behavioral problems."

So great is the political divergence between environmentalists and industrialists that training must be given in conflict management and behavioral characteristics, Mr. Haller said.

Since the beginning of 1986, he said, the world has witnessed three major catastrophes: the explosion of the space shuttle Challenger; the nuclear disaster at Chernobyl, Soviet Union; and the pollution of the Rhine River following a fire at a Swiss chemical manufacturer's warehouse.

"No large catastrophe that has happened has provided evidence to be used in the future to prevent it from ever happening again," he said.

The growing concern among people in Europe, particularly in West Germany, about environmental pollution is a major concern to insurers and risk managers, said Herbert Schilling, a director of Gerling Konzern Allgemeine Versicherungs A.G. in Cologne, West Germany.

"There are considerable daily occurrences of pollution, and people are becoming more aggressive," he said.

Mr. Schilling listed major environmental disasters in the recent decade, including: the dioxin poisoning in Servese, Italy, in 1976; oil pollution in the English Channel following the grounding of the Amoco-Cadiz supertanker in 1978; the poisonous gas leak in Bhopal, India, in 1984; and the polluting of the Rhine River in 1986.

In Europe today there are laws addressing pollution and the environment in West Germany, Switzerland, Spain and France, Mr. Shilling said.

However, there now is increasing political pressure to increase and broaden environmental liability in Europe, he said.

For example, he said, while liability for water pollution was introduced in West Germany in 1960, there now are moves in West Germany to expand water pollution liability laws to include pollution of the land and air.

Also, directives are expected to be introduced by the European Commission concerning liability for the transport of waste and the liability of waste dumps, he said.

The production of chemicals is bound to damage the environment to some extent, Mr. Schilling admitted. "However, we must be able to calculate the damage. For the legislator, damage is not quantifiable.

"Industry must be against unlimited liability as it could affect not only the future of the company but the whole economy," Mr. Schilling warned. Industry and insurers can successfully work together to deal with such problems as in the chemical spill that polluted the Rhine, he said.

In November 1986, firefighters

Continued on next page

Pollution risks

Continued from previous page

doused a fire at a warehouse in Basel, Switzerland, belonging to Swiss chemical manufacturer Sandoz A.G., causing toxic substances to wash into the Rhine (*BI*, Nov. 24).

In that situation, "the liability insurance worked properly. Most of the damages have been repaid and insurers believe everything is running smoothly and there is no need to change legislation," said Mr. Schilling, whose company led the primary layer of liability insurance for Sandoz, with limits of 1 million Swiss francs ($666,000).

In the past few years there has been a considerable increase in pollution liability losses, partly because of better monitoring techniques, he added. This has placed additional costs on industry, including:

- Expenditures in security and monitoring systems.
- Higher insurance premiums.
- Increased expenditure on documentation of plant emission.
- More expensive risk analysis.

In the extreme, these added costs could lead to the stoppage of production if risks cannot be quantified, Mr. Schilling said.

Pollution and other long-tail liability create an ever-increasing need for insurers and industry to work more closely together, said Christian Meyer, senior vp of Zurich Insurance Co. Ltd. in Zurich, Switzerland.

"Flexibility is essential in tackling industrial risks," he said, adding "it is nonsense to attempt to attract industrial clients with covers that are not crucial for their industrial activity. This only spoils the market and, in the long-term, will work against the industrialists' needs."

The insurance industry must contribute to the progress of general industry by acting as a partner to the risk transferring process, Mr. Meyer said.

"We have to take risks, but we want to control them. We want to minimize risks," he said. To do this, an insurer must "analyze the (policyholder's) attitude, activities, products, organization and staff."

"We have to work with the (policyholder) to find the most effective solution to implement safe procedures, safe work sites and safe products," said Mr. Meyer. "Industrialists, brokers, insurers and reinsurers must all contribute to a continuous dialogue. The silence of the past few years was wrong," he said.

Insurers have a moral responsibility to assist industry in its search for new markets and its daily entrepreneurial decisions and acts, Mr. Meyer said.

"We are not engaged in a price battle, but primarily are in the business of enhancing security. And this is an essential factor for the prosperity of our industries and our society," he said. ■

Automated Job Analysis Aids in Record Placements

From Minneapolis to Phoenix to Portland, Maine, Crawford & Company Health and Rehabilitation Services placed more than 4,000 disabled employees in jobs during 1986. Increased automation was a major contributing factor to Crawford's successful placements, which increased professional productivity and resulted in substantial return-to-work cost savings for several employers.

Operational in all Crawford & Company major Health and Rehabilitation locations, the Crawford Occupational System (COS) is an indispensable resource to the company's 700 medical services and vocational staff. Through COS, rehabilitation counselors can access a bank of over 12,300 job titles and skills descriptions from the U.S. Department of Labor's Dictionary of Occupational Titles (DOT). Its electronic skills transfer determination is a valuable tool for accurately placing disabled workers.

Since April 1985, the information provided by COS has also helped employers to modify an increasing number of jobs to accommodate disabled workers, according to Crawford Vice President G. Berk Lynch, Ph.D.

Crawford's rehabilitation counselors utilize COS through the company's entire Return-to-Work process. Through a series of screens and menus, COS aids the counselor to enter and store the worker's job history, including training, experience, education and nature of the disability.

COS then stores the job history files by DOT code, or by job title, establishing the basis for a match between the worker history and DOT files later on.

After creation of the client file, the rehabilitation counselor then searches the DOT file for job descriptions matching the client's abilities, experience and physical limitations. Through COS, counselors may impose restrictions on the search for appropriate occupations, such as isolating the highest *level* of an appropriate job (in terms of physical limitations or requirements) to which the worker can aspire.

"For instance, the exertional portion of a job description may require heavy lifting, but this job for someone with a back injury may allow a counselor to rule out any activities that require more than a specific [illegible]. Counselors may also choose the search at the highest level of academic or experience requirement," according to Dr. Lynch.

The system then produces a printout of the appropriate occupations, [illegible] time for the process is approximately 45 minutes. Specific job openings are identified.

COS condenses the time spent to determine the claimant's transferable skills and appropriate occupations. "Now counselors can devote more time to the ultimate goal of the rehabilitation counseling program—finding actual work for people that takes advantage of their skills and experience. Job placement [illegible] dramatically," Dr. Lynch. □

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G. Berk Lynch
Vice President
Health & Rehabilitation

Crawford Health & Rehab Opens In Canada, 155th Office In System

Crawford & Company offers disability/rehabilitation management and medical cost containment services through some 155 locations across the United States and, as of June 1987, in Canada.

Located in Toronto, services through Crawford's first Canadian Health and Rehabilitation office will focus on Long Term Disability and Automobile Liability cases. The company will provide disability case management services to facilitate the rehabilitation and Return-to-Work process.

Crawford expects to open at least two additional offices in Canada during 1987 to accommodate substantial growth in the LTD and auto liability markets. □

European risk managers devise own answers

By CAROLYN ALDRED

VENICE, Italy—European risk managers and insurers must continue to develop their own solutions to risk management problems, experts say.

"Let's not try and adopt unthinkingly what is handed down to us from the U.S.," said Matthias Haller, director of the Insurance Institute of St. Gallen, Switzerland.

The insurance market and liability system in the United States differs from that in Europe, Mr. Haller told risk managers and others attending the International Insurance and Risk Management Conference held earlier this month in Venice.

For example, the European insurance market has never been as cyclical as the U.S. market because continental European insurers do not rely on pricing to solve all their problems, said Wilhelm Zeller, a director of Cologne Reinsurance Co. in Cologne, West Germany.

"It is regrettable, but one has to recognize that American underwriters continue to see the problem of long-tail exposure as one of pricing rather than a fundamental problem," he explained.

'Some consideration is being given to sunset clauses or capping the tail,' Wilhelm Zeller says.

As a result, European, London and U.S. insurers continue to adopt different solutions to the current liability crisis, he said.

For instance, changes in policy wording concerning pollution coverage have been far more drastic in the United States than in continental Europe, Mr. Zeller said.

"At the beginning of 1980, more than a few American courts started to interpret" the 1973 Insurance Services Office comprehensive general liability "pollution exclusion clause against the intent of both the insurance market and the carriers as also including gradual pollution," he said.

As a result, the CGL policy adopted by ISO in 1986 has a far more comprehensive pollution exclusion that affects virtually all premises and operation hazards, he explained. Although ISO is working on new pollution coverage language, "it doesn't matter how long ISO is going to take because no market is prepared to underwrite pollution coverage in the U.S.," Mr. Zeller said.

The London market seems to follow the U.S. market very closely, he added. "Pollution coverage supported by meaningful amounts of capacity seems to be available (in London) for sudden and accidental occurrences," he said, adding that "previous EIL programs providing broader coverage on a claims-made basis appear to have fallen apart."

On the European continent, however, development of policy exclusions is much slower, Mr. Zeller said.

"This is, on the one hand, view to the fact that in some (European) countries new wordings are subject to lengthier approval procedures by the insurance authorities. On the other hand, it is usual in Europe to have continuous policies rather than renewal policies, which makes it more difficult to change existing policies," he explained.

However, there is now a clear trend emerging in Europe toward restricting coverage for sudden and accidental pollution occurrences. "Coverage for gradual pollution, for the most part, is only available through pools—for example, in France and the Netherlands—and it is on a claims-made basis," he said.

For long-tail exposures in general, "Everybody agrees that the existing system is inappropriate to handle the situation," Mr. Zeller said, adding, however, that there is no agreement on what is to be done.

Theoretically, claims-made appears the most appropriate solution, he said. "Although claims-made cannot eliminate the tails—we will continue to live with the fact that there will always be a time lag between causation and effect—it can reverse the existing after-tail into a pre-tail."

However, claims-made has two main problems, Mr. Zeller said. These are:

- If the retroactive date is advanced, either by an existing or a new insurer, a coverage gap can be created.
- If claims-made coverage is not continued at all, or is renewed on a different basis, a coverage gap can also result—unless an extended reporting period is granted.

As a result, the claims-made form frightens insurers and is unpopular with policyholders, he said.

"In some markets, therefore, consideration is being given to sunset clauses or capping the tail. This is being discussed in West Germany and is likely to be more widely accepted than the extremely unpopular claims-made" form, he added.

Although the ISO claims-made concept never really got off the ground on a broad scale in the United States, "the fact must not be overlooked that the Fortune 500 companies are to a large extent already on claims-made and that in 1985-86 hundreds, if not thousands, of U.S. policies were converted to claims-made," he said.

"The turmoil in the American market represented just another

Continued on next page

Continued from previous page
cycle during which the U.S. underwriters, unfortunately, have not learned that their problem is not simply pricing," Mr. Zeller explained.

"Given this situation, it is only a matter of waiting for the next crash in the American liability insurance market, which is as certain as the amen in church," he added.

One of the major reasons for the difference in the U.S. and European insurance markets lies with the U.S. legal system, explained Alexander Sloughter, a partner with the U.S. law firm of McGuire Woods Bottle & Boothe in Richmond, Va.

And the problems with the U.S. tort system are not improving, Mr. Sloughter warned.

"The entrenchment of the system is so deep that it might take a catastrophic event, such as a total recession or a total collapse of the U.S. trade balance, to persuade the ordinary citizen to change the system," he explained.

'Given this situation, it is only a matter of waiting for the next crash in the American liability insurance market, which is as certain as the amen in church,' says Wilhelm Zeller, a director of Cologne Reinsurance Co.

The liability insurance crisis has already had a notable effect on the American economy, he said. In particular, it has:

- Increased the price of U.S. products.
- Discouraged research into new products, particularly in the pharmaceutical field.
- Resulted in U.S. companies devoting enormous resources to coping with insurance problems.
- Cost manufacturers and insurers enormous legal fees.

Mr. Sloughter pointed out that the United States is a relatively new nation with few unifying institutions compared with European countries.

"What we do have is the law and, therefore, people go to court over matters that in more mature societies would be avoided by going to other institutions," he explained.

However, there are more immediate reasons underlying problems with the U.S. court system, he said. These include:

- The jury system, where private citizens render a verdict and determine the damages to be awarded.

"Trials involving products take a long time and the plaintiffs' bar found that by prolonging a case, it could infuse a great sense of importance to it," Mr. Sloughter said.

In addition, the length of time required to serve on a jury "has driven out of the process anyone with an important job," he said. Consequently, jury members often do not really understand the case and freely award other people's money, he noted.

- The contingency fee system, which has resulted in disproportionately high awards and large volumes of cases.

The plaintiffs' bar has overtaken unions as the chief antagonists of U.S. manufacturers, Mr. Sloughter said.

Despite these problems, European manufacturers continue to participate in the U.S. market and the United States continues to be the world's largest importer, he noted, adding that risk managers for European exporters have the responsibility to minimize the dangers of operating in the United States.

To do this, the risk manager must be independent of the departments whose activities he or she will affect and must have full support of the company's senior management, Mr. Sloughter said.

In particular, European risk managers must take special care with product literature accompanying exports to the United States. Translation of these instructions into English is one particular problem, he explained.

Mr. Sloughter pointed out that a warning notice must clearly indicate: a product's danger; the harm it may cause; and how users of the product can avoid the dangers.

Mr. Sloughter illustrated this by explaining that if Venice was to abide by U.S. custom, each bridge over the city's ancient canals would be adorned with an eye-catching notice that said: "Danger. Low bridge will knock your head off. Keep your head down." ■

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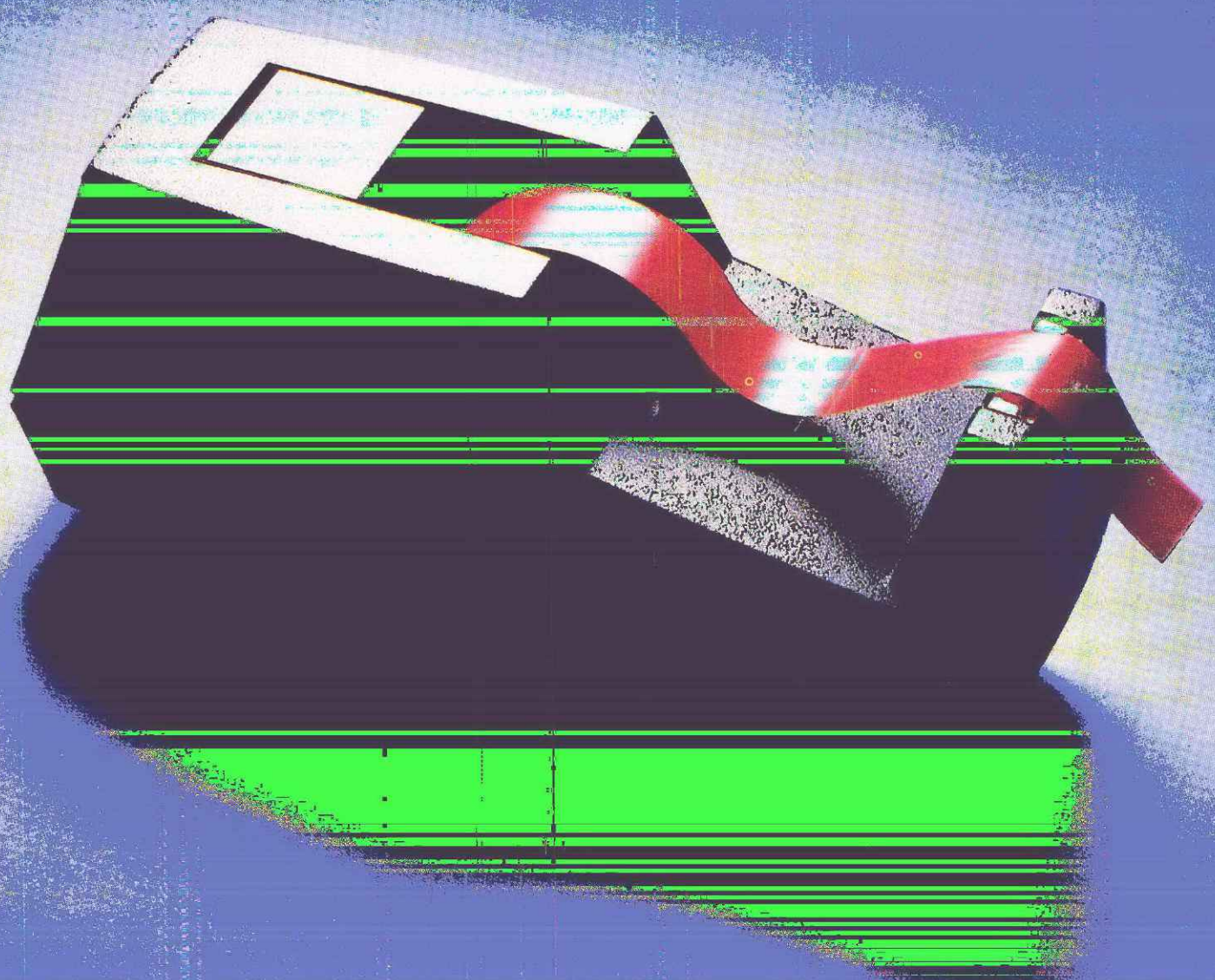

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HOW DO YOU MEASURE

HELPING EMPLOYEES

Guidelines for establishing an employee assistance program

By Daniel R. Thorne

EMPLOYEE ASSISTANCE PROGRAMS are receiving recognition as effective tools in detecting personal problems among employees. Around 50% of the Fortune 500 companies have either in-house or contracted EAP services. Approximately 10,000 EAPs exist in the United States, serving both small and large employee bases.

Research indicates that effective EAPs can lower physical and psychological health costs. One study of more than 200 companies in the Houston area found that those companies with EAPs had health insurance rate increases averaging 14%, while companies without EAPs had rate increases averaging 22%.

EAPs not only can reduce insurance premiums, but they substantially reduce a client's lost productivity and health care costs. Other studies document lower turnover, reduced disability cases, etc., with EAPs.

Because EAPs do affect insurance costs and premiums, the client's benefit personnel and compensation consultant must become aware of their advantages. However, risk management professionals also must be aware of the pitfalls that come with an EAP implementation.

In the beginning, some clients have unrealistic expectations of the job an EAP will do for them. For instance, Vendor A, an EAP, had two clients; one was ecstatic about its performance while the other was very disappointed. The situation usually occurs when the client does not understand the limitations of an EAP, expects more results and becomes disenchanted. Sufficient discussion and education about what EAPs can or cannot do would lead to more realistic objectives and results.

Here are some guidelines for forming an EAP:

✔ The motivation for implementing an EAP should be to save benefit dollars, help employees with personal problems, improve morale, etc. Many times, companies will not begin the development process until a crisis exists.

Company R initiated an EAP after one of its employees was found seriously ill in a hotel room with two large bags of illegal drugs by his side. This emotional response was the push needed to motivate the client to begin the search for an EAP, but health care or productivity cost problems should not be overlooked.

✔ In planning the creation of an EAP, the client's personnel must be cognizant of what are or are not an EAP's components. Bill Chiabotta of Southern Methodist University in Dallas, outlined criteria to use in choosing an EAP: office location, fee schedule, staff training, etc. Most compensation professionals are susceptible to the "psychobabble" and "therapese" proffered by EAP vendors. EAPs must be understood in laypersons' terms and the client has a right to expect simple explanations. Simplicity ensures employee understanding and successful utilization.

EAPs detect employees' personal and job performance problems and refer them for psychological treatment or to community resources.

All EAPs' common thread is that they detect employees' personal and job performance problems and refer them for psychological treatment or to community resources. A closed-system EAP hires its own counselors and has more control over cost and treatment outcomes; it assures more quality in return for higher fees. An open-system EAP uses fewer sessions and more uncontracted, albeit qualified, professionals, assuring lower operations costs but less responsibility for quality. Follow-through of treatment recommendations also is directly related to the number of sessions; more sessions increase rapport and trust between the employee and the counselor, thereby increasing motivation to receive treatment.

Most clients prefer a broad-brush approach to treatment, wherein psychological, legal and financial problems are handled as well as alcohol or drug abuse problems. In examining an EAP, it is best to look for a treatment staff that has a balance of chemical abuse and psychotherapeutic specialists. Since the treatment philosophies of these specialists can be diametrically opposed at times (e.g., alcoholism counselors disregarding psychotherapy while psychologists refuse to acknowledge alcoholism as a disease), the balance ensures appropriate handling of cases.

EAP costs can be deceptive and should be reviewed with care. For example, BR Corp. operates EAP services. BR is a for-profit company that also has many chemical abuse hospitals. Though BR does not charge for EAP sessions, an understanding exists that the client's employees should be referred to BR's units when in need of inpatient help. The higher costs of BR's inpatient programs clearly may not be offset by the "free" EAP services.

The client must recognize that EAPs will feel the pulse of the company and must be willing to listen to comments and suggestions.

✔ The actual operation of the EAP truly needs a balance of scrutiny and trust from the client's management. These factors, in addition to the appreciation of the EAP's limitations, will lead to an effective program.

Before the EAP is in its start-up mode, the client must decide if it wants the EAP to handle cases involving workers compensation, disability or drug screening matters. EAP involvement can lead to cost-effective case management in addition to quicker resolution of personal and company conflict over the cases. One disadvantage is that the EAP can be seen as "on the side of management" and lose its credibility with employees. Clients who use this option must have complete trust in the EAP's methods of treatment.

A hidden problem in EAPs is the handling of phone calls and referrals. Most EAPs use trained counselors or intake workers during business hours to help employees. However, during evening hours and weekends, answering services usually answer the calls. Answering services are notorious for hanging up on patients, placing calls on hold for as long as 15 minutes and miscommunicating messages. The client has the responsibility to check the EAP's phone intake system and encourage employees to register complaints with its personnel department or the EAP.

Low-visibility EAPs seem to defeat the purpose of helping employees to seek assistance. This occurs when the company wants an EAP, but rather than encouraging employees, it gives an impression that it is not serious about helping its employees. For example, Company N would not allow brochures or posters on its premises, except small notices in the lunch room and occasional lectures to employees. As a result, the company had a 3% utilization rate instead of the average 5%-8% that exists in its industry.

✔ Management training to help supervisors detect job performance problems are an integral part of EAPs. However, depending on the cooperation of both parties, they can be viewed as either beneficial or disastrous. Company U, for example, contracted five management training sessions. Even after a one-year period of the EAP's operation, the management "handcuffed" the EAP by refusing to allow it to conduct these sessions. If EAPs are chosen by the chairmen and presidents of companies, yet administered by personnel officers, then both sides must feel a part of the whole process, or else personnel departments feel threatened and may subtly sabotage the EAP's efforts.

Another difficulty with management training lies in the problem of educating employees about chemical dependency issues. Applying chemical abuse figures to business, approximately 10% of a client's supervisors have a drinking or drug problem, and 30%-40% of them have a family member with a chemical abuse problem. These supervisors therefore are not objective about dealing with these issues and refuse to cooperate.

In Company E, the client's EAP coordinator had difficulty in managing the EAP operation; it was later discovered that he was the husband of an alcoholic and himself had serious stress-related disorders. These attitudes must be overcome by the EAP to ensure success.

Managers also cannot wait too long to refer employees for help. In Company K, the supervisor of a troubled employee did not document customer complaints or poor job performance for five years, keeping the employee at work while losing money due to her problems. A system of follow-up training, not just one-time sessions, increases documentation and eventually the reduction of lost productivity costs.

✔ EAPs, even if designed according to the company's needs, are not a panacea for job performance troubles. Company R was encouraged by its EAP to increase drug testing and refer employees with positive test results; despite the increased testing, company accidents still increased. This case was a symptom of poor company management, not a poorly run EAP.

Employees, despite being given optimistic outcomes, do not always follow the path of reason. H.R., an employee with Company S, had a severe alcohol problem. A treatment plan was arranged whereby he could receive time off from work, with full pay, to go into an inpatient hospital program; the hospital agreed to write off the balance that the insurance plan did not cover; the employee's attorney told the employee that treatment would reduce the amount of jail time for two outstanding drunk driving charges. Despite all this, he refused treatment.

One side effect of EAPs is that they can uncover company flaws. In Company Y, for example, the EAP discovered that age and sex discrimination existed and potential lawsuits would be initiated. The client must recognize that EAPs will feel the pulse of the company and must be willing to listen to comments and suggestions to improve the quality of the working atmosphere.

✔ Despite the current abundance of EAPs, reliable evaluation measures of cost benefits and effectiveness are not well developed. The EAP and its self-evaluation methods are comparable to the "rabbits guarding the lettuce patch."

One approach to helping evaluate the need for an EAP is the utilization of employee attitude surveys. In pre-EAP planning, the client can use the survey to determine what employees think are personal or health problems, design an EAP system with these factors in mind and develop a valid operation for employees.

✔ In conclusion, EAPs do save benefit dollars

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Daniel R. Thorne is president of Daniel Thorne Associates in Orange, Calif. His firm designs and implements psychological health systems such as EAPs.

Providers are getting last laugh: Professor

By DONNA DiBLASE

DALLAS—At least one health care economist finds a different, less serious side to the U.S. health care system.

"The American health care system is a form of humor," declared Uwe E. Reinhardt, James Madison professor of political economy at Princeton University in Princeton, N.J., as he presented a picture of laughing doctors and other health care providers.

"The American health care system can best be explained in the cosmic equation: health care expenditures equal health care incomes. If you are on the right side of that equation, you're laughing. But, if you are on the left side of that equation, you're grimacing," he explained, meaning that health care providers are getting the last laugh at the expense of health care payers.

'The whole mentality of (cost control) approaches has been to stick it to the providers since they have stuck it to us for so long,' says Uwe E. Reinhardt, a professor of political economy at Princeton University in Princeton, N.J.

Mr. Reinhardt discussed the problems of the health care system and the possible future turns the system could take in "Employee Benefits at the Crossroads," a presentation delivered at the 41st Annual Fall Conference of the Council on Employee Benefits.

Some 223 benefits experts gathered at the meeting, which was held Oct. 8-9 in Dallas.

But, the price of health care does not necessarily have anything to do with the quality of health care, he cautioned.

Despite the huge amount of money Americans spend on a health care system that is touted as being the highest quality in the world, there are still many inefficiencies in the system, Mr. Reinhardt said.

For example, he pointed to an incident in which a woman with a bullet wound waited for 13 hours to receive care in a hospital emergency room. "This is a disgrace," he asserted.

Since the late 1970s, employers, insurers and other health care payers, including the federal government, have taken some steps to control health care expenditures, he said.

"Common approaches to controlling health care outlays have included controls on prices, such as Medicare DRGs, preferred provider organizations and health maintenance organizations."

There also have been controls on employees' utilization of health care, he explained.

"The whole mentality of these approaches has been to stick it to the providers since they have stuck it to us for so long," Mr. Reinhardt said.

"For example, in the 1970s, inpatient care was well-insured and outpatient care wasn't. So, doctors made more per hour for delivering care in the hospital than in their offices," he explained. This practice resulted in more hospital admissions and more people having their health care delivered in hospitals.

"But, now there is more covered outpatient care, so hospitals are being used for what they really were built for," Mr. Reinhardt added.

However, even with these health care cost controls, U.S. health care expenditures still are extremely high, he said.

"Are those who pay for health care fooled by a money illusion, that is, they fail to adjust money for inflation? Or, are they impotent in dealing with providers or are they merely indifferent to these expenditures?" Mr. Reinhardt wondered.

Health care payers may be ineffective in dealing with health care providers for several reasons, he said.

The main reason is what he called the "quality quandary," or the fact that payers are reluctant to strictly control health care costs and utilization for fear of sacrificing quality.

Another reason for ineffective cost control by payers is an impending shortage of skilled or professional labor, which will forces employers to offer very competitive benefits packages to attract the best employees, Mr. Reinhardt said.

"There's also just plain meekness all around. CEOs just don't have the stomach for health care cost control," he asserted.

With all of the cost, overutilization and quality problems in the American health care system, there are four different routes health care payers and the system itself could take, according to Mr. Reinhardt:

- "We could muddle through as usual."
- "We could move to universal national health insurance."
- "We could move toward mandated benefits."
- "We could have a two-tiered health insurance program," providing both affordable, minimum-level coverage and supplemental insurance at an additional cost.

"The advantage to muddling through as usual is that we really know how to do that. But, the disadvantage is that this is expensive and it's a disgrace," Mr. Reinhardt noted.

The force that would drive a move toward universal national health insurance—a program that would ensure the same government-provided coverage for all Americans—would be an impoverished baby boom, he said.

"The advantages to a system like this are that it favors equity and facilitates cost control," since everyone would have the same coverage so providers would not be able to shift the cost of uncompensated care to individuals with better coverage, he said.

"But, providers would be at a disadvantage under this type of system, and since all coverage and expenditures would be equal, this system is likely to inhibit innovation and motivation by providers," Mr. Reinhardt observed.

"The driving force behind mandated benefits is the deficit and the effectiveness of pseudo-taxation, which is what mandates are," he said.

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The CEB, founded in 1946, is composed of 188 companies. Its purpose is to stimulate and improve the development and administration of the employee benefit plans among its members.

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"An advantage to this approach is its political appeal," that is, that individual Americans would feel that the government is doing something to protect their interests, he said.

"A disadvantage is that this approach is dishonest taxation," he added.

And, while some businesses—mainly small businesses—are opposed to any attempt at mandated benefits, such as the legislation proposed by Sen. Edward Kennedy, D-Mass., large corporations are very much in favor of mandates.

This is because most large corporations have provided rich benefit plans for their employees for years and often feel that they are subsidizing the uninsured through higher insurance premiums and increased health care costs.

"In American business, when the going gets tough, the tough run to the government," Mr. Reinhardt observed.

Under a multitiered, tax-financed health insurance program, there would be a "tourist class, a business class and a first class," he explained, likening the program to classes of seating on commercial airlines.

"Under this program, every American would be insured by the tourist class. This would be publicly financed and care would be delivered through HMOs. This implies that care would be rationed," he said.

The second tier, consisting of the business and first class levels of insurance, would be supplemental and offered at an additional cost to those desiring more coverage, he said.

The advantages to this type of health insurance system are that it provides basic coverage for everyone, but also offers additional coverage only for those who want to buy it.

"This system also would keep us in the club of civilized nations," Mr. Reinhardt said, meaning that health care would be available to everyone.

In U.S. business, 'when the going gets tough, the tough run to the government,' Mr. Reinhardt says.

However, the obvious disadvantage is that the system would be two-tiered, with some Americans receiving only emergency or necessary care and some receiving more elective care.

While many Americans and American businesses are opposed to government involvement in health insurance and health care, "there are some programs that are properly government's tasks. You should encourage legislative initiative. It's time to get off the ideologic horse and have more faith in the government," Mr. Reinhardt urged. ■

Changing workforce requires new benefits

By DONNA DiBLASE

DALLAS—A dramatically changing workforce will require employers to offer more flexible and cost-controlled benefits, according to an economics and policy researcher.

The low birth rate in the 1960s and 1970s, combined with the middle-aging of America, will create a workforce "that will drive harder bargains. Benefit managers should move more toward cafeteria plans with capped dollar amounts and a choice of benefits so employees can have what is most important and valuable to them," suggested William D. Johnston, senior research fellow at the Hudson Institute, a research organization in Alexandria, Va.

These changes, along with a larger number of women in the workforce, "will require employers to address the needs of women workers and their families and reinvest in the current workforce. Employers also will have to promote greater worker mobility and flexibility by moving toward defined contribution pension plans and portability of vesting," he predicted.

"There will be significant new demands for time away from work, particularly for child care," he added.

Mr. Johnston discussed demographic trends, the changing economy and the labor and health care policy implications of these changes at the 41st Annual Fall Conference of the Council on Employee Benefits, held Oct. 8-9 in Dallas.

In his presentation, Mr. Johnston reported the research findings of the Hudson Institute's project for the U.S. Department of Labor, "Workforce 2000."

"There was a big spike in the 1960s and 1970s in the labor force, but there also was a decline in population. This slow growth in the population will result in slower economic growth and a shift in the economy toward income-sensitive products," he explained.

Along with slower population growth, "there has been a tremendous expansion in the number of employees in their middle years," Mr. Johnston pointed out.

This middle-aging of America will mean that:

- The workforce will be more experienced and dependable.
- Workers' economic dependency on employers and the government for retirement income and other assistance will decline.
- Workers' personal savings should rise.
- There will be fewer younger workers joining the labor force.
- The rigidity built into the economy will increase.

In addition to the changing age of the workforce, the Hudson Institute also predicts that the workforce of the future will be made up of mostly blacks, females and immigrants, he said.

All of these changes will mean more competition among employers for the best qualified employees, more investment in remedial training and education and renewed concerns over equal opportunity, he explained.

But, the aging of the workforce also could be affected by the spread of the Acquired Immune Deficiency Syndrome, he said.

"If the AIDS epidemic expands unchecked, this could throw calculations about the workforce off a bit. AIDS accelerates the statistics and trends because it's a disease that kills primarily young people," he said.

"We can see the potential for new demands in the area of health care, particularly in terms of AIDS. Even if we make very rapid progress, the number of deaths in the 1990s is likely to be about 200,000 annually. We predict efforts by everyone to duck the bills for this disease," he observed.

Along with the changes in America's workforce will be a change in the U.S. economy, he said. "There will be moderate economic growth and a further internationalization of markets. There also will be a continued shift to service employment, reduced inflation and lowered trade," he said.

And, "as the world economy becomes more integrated through the internationalization of trade, U.S. growth will depend on world growth," Mr. Johnston said.

In addition, he predicted that:

- Governments will lose control of currencies and interest rates.
- Human, financial and capital resources will become more mobile.
- Government protectionism will become too complicated and unpopular to implement.
- All new jobs will be in service industries as opposed to goods-producing industries.

"The impact of the shift to services will contribute to a slower growth in product manufacturing, smaller-sized worksites and less equally distributed incomes," he predicted.

The Hudson Institute also predicts that inflation will remain under control—in the 3% to 5% range between now and the year 2000—with excess capacity in the oil and energy industry, agriculture and manufacturing of automobiles, steel and semiconductors.

As a result of these many changes in the workforce and our economy, the institute predicts a continuing debate by the federal government over the issue of mandated benefits and that "these changes will lead to a whole period of government activism regarding benefits," Mr. Johnston said. ■

Mandated benefits proposal stirs debate

By DONNA DiBLASE

DALLAS—Both proponents and opponents of mandated employer-provided health insurance agree that many Americans are either uninsured or underinsured.

However, they disagree over the issue of who should pay to ensure that these individuals have access to health care.

S.B. 1265, the Minimum Health Benefits for All Employees Act, sponsored by Sen. Edward Kennedy, D-Mass., was the topic of lively discussion at the 41st Annual Fall Conference of the Council on Employee Benefits in Dallas (*BI*, May 25).

"This is great. The government designs the plan and you pay the bills," lamented Frederick J. Krebs, director of the Employee Relations Policy Center of the U.S. Chamber of Commerce in Washington.

'This is great. The government designs the plan and you pay the bills,' laments Frederick J. Krebs, director of the Employee Relations Policy Center of the U.S. Chamber of Commerce in Washington, of the Kennedy mandated health care proposal.

Basically, the bill would require employers to provide health insurance for all employees working 17 or more hours per week. The coverage would require employees to meet an annual maximum deductible of $250 for individual coverage and $500 for family coverage. Employees would pay a maximum 20% copayment up to a maximum out-of-pocket expense of $3,000 annually.

In addition, well-baby care and prenatal care would have to be fully covered by the employer health plan.

"Businesses that already insure their employees pay a built-in higher cost of uncompensated care. Through this legislation, we feel that health insurance could be left in the private sector and health care costs will go down for all businesses," countered Dr. Stephen Keith, a staff member of the Senate Committee on Labor and Human Resources, which Sen. Kennedy chairs.

Pointing out familiar statistics on the uninsured and underinsured population in the United States, Dr. Keith explained that there are more than 37 million uninsured Americans.

Another 53 million people are underinsured, meaning that their liability for catastrophic illness or injury is not capped by insurance, he added.

"Cost estimates of this bill range from $15 billion to $100 billion, but $25 billion would be the highest cost of the bill. We think there will be an estimated $4.8 billion reduction in uncompensated care," Dr. Keith said.

Mr. Krebs cautioned that "on the surface, this may look like you're doing something for nothing. But, there is a huge deficit and there is likely to be tremendous pressure to expand the benefit mandates in the future."

Mr. Krebs stressed that "you can't look at this legislation in a vacuum. You have to look at everything that is likely to have a significant impact on business and its costs and competitiveness."

In addition to increasing costs for employers, mandated group health insurance could have a significant negative effect on benefit plan design, Mr. Krebs also argued.

"Mandated benefits are the epitome of the feel-good government. This is the one-size-fits-all approach to employee benefits," asserted Mr. Krebs.

"Mandates reduce the options available to employers and their employees, along with increasing the fixed cost of labor.

"We're likely to end up stifling plan design flexibility because the safest thing for an employer to do will be to provide exactly what the bill says. Any structuring or tailoring of the plan to employees' needs will certainly be limited," he predicted.

"The government does do some things well, and we shouldn't have a knee-jerk reaction to criticize the government. But, this is not one of the things it does well," Mr. Krebs said.

But, Dr. Keith argued that "under the Kennedy plan, there would still be flexibility in terms of benefit design. This just sets a minimum level. It's not a Cadillac plan."

He added that the mandate would not increase most employers' labor expenditures.

"We estimate that 97% of businesses with 500 or more employees already provide health insurance for their employees. And, most smaller businesses with 100 employees or less also already provide health insurance," he said. By reducing the cost of uncompensated care, the bill would cause these employers' costs to decrease, he said.

But, "I would take these savings estimates with a grain of salt," Mr. Krebs pointed out.

"There's no question that there would be a major cost here, especially for small businesses. Health insurance costs run about $1,100 to $2,000 a year per employee," he continued.

He also said "you have to recognize that the small business community is a source of new jobs in our economy. With these increased costs, it will reduce employment or the rate of growth of the economy."

Dr. Keith said that "we hope we can positively impact not only the status of all uninsured and underinsured Americans, but also the health status of all Americans."

"There's no question that there's a problem with access to health care in this country. We can't just say no to this, we have to recognize that there is a problem," said Mr. Krebs.

"We agree with Sen. Kennedy on the goals he is trying to achieve. We should improve health care delivery and access for all Americans. But, this is a social problem and should be handled that way, not shifted to the business community," he contended.

Mr. Krebs warned employers that "we can't put our heads in the sand now. If we don't do something, we're likely to get more responses like this to similar problems." ■

CPCU meeting

Cycles inevitable, ISO president says

By LINDA J. COLLINS

SAN ANTONIO, Texas—The property/casualty insurance industry "will always have volatile earnings and underwriting cycles" since insurers do not have full knowledge of the underlying costs when they set their rates, according to the president of the Insurance Services Office Inc.

"An understanding of cycles and a commitment to managing cycles are therefore the primary challenges for our industry's leadership," said ISO President Daniel J. McNamara.


Mr. McNamara

Mr. McNamara and three other industry leaders discussed the effects of the last insurance cycle, what can be learned from it and how it may impact the insurance industry in the future at the 43rd annual meeting of the Society of Chartered Property & Casualty Underwriters last week in San Antonio, Texas.

While the property/casualty industry is now in its third year of financial recovery, the last cycle has left lasting scars, Mr. McNamara stressed.

"Our behavior in this recovery has resulted in trauma for some businesses and governmental entities, and that trauma has left our industry with deep wounds," he said.

When alternative markets were created to respond to capacity shortages during the hard market, it caused the traditional insurance market to shrink. As a result, alternative risk transfer mechanisms now represent 30% of the commercial property/casualty risk financing market, "a share worth nearly $50 billion of premiums annually," he said.

Mr. McNamara also predicted that a handful of "perils of uncertain magnitude" will continue to plague the insurance industry over the next few years. They include:

- Uncollectible reinsurance, which already totals $80 billion.
- Insurers' obligations to subsidize losses sustained by residual market mechanisms.
- Expense growth, which is outpacing premium growth.
- Higher tax bills and depleted service as a result of the 1986 Tax Reform Act.
- The perception of investors that the insurance industry is a poor investment. "We are not the present darlings of the capital market," Mr. McNamara quipped.
- Unstable relationships between some producers and insurers.
- Public hostility and distrust of the industry because of the abrupt

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price hikes and lack of availability as insurers attempted to recover from the last competitive phase in the cycle, which buyers now are voicing to government policymakers.

- Tighter regulatory controls.

The only way for the industry to regain customer loyalty is to establish a reputation for quality, according to Robert Clements, president of Marsh & McLennan Inc. in New York.


Mr. Clements

To do so, insurers must improve their attitude toward claims, commit themselves to bringing some stability to the market and exhibit "balance sheet management and discipline," Mr. Clements said.

The industry's "inability to manage insolvency and inability to manage cycles are its two greatest challenges in the future," according to Mr. Clements.

"In the area of balance sheet integrity, we're probably no better off today than we were 10 years ago, with all of the good professional work that's going on. It's very discouraging," said John J. Byrne, chairman and chief executive officer of Fireman's Fund Corp.


Mr. Byrne

Insurers' "responsibility, first and foremost, is for our loss reserves," Mr. Byrne said, adding that if insurance company managers thought more like owners of companies instead of like managers, things would be better.

Mr. Clements pointed out that the level of competency among insurers and producers is "higher than it ever has been, but so is the level of problems. Problems have grown at least as fast as the level of the qualifications."

Meanwhile, while it would do "nothing to improve affordability or availability" of insurance, the industry still faces the very real threat of congressional repeal of the McCarran-Ferguson Act, pointed out Edward J. Muhl, Maryland commissioner of insurance in Baltimore and president of the National Assn. of Insurance Commissioners.


Mr. Muhl

"Federal regulation of the marketplace of insurance would be a public disaster," Mr. Byrne added. However, he warned that unless the industry works to improve its current situation, it will be unable to avoid such regulation.

According to Mr. Muhl, state regulation is "a very unique and beneficial system for companies and policyholders" because states are "able to experiment" when a problem appears to be regional in nature "and apply solutions that are unique to a geographic area" rather than implementing an across-the-board remedy.

"State regulation is the best of both worlds,' Mr. Muhl stressed.

The NAIC is currently studying how it might be able to create more uniformity in state regulation without involving the federal government, he said. There "lies certain danger" with federal regulatory authority, he contended. "Where are you able to stop that regulation?" Mr. Muhl asked.

"I view federal involvement like filling a vacuum. Wherever they perceive that a vacuum exists, they will flow to fill that void," he commented.

'Federal regulation of the marketplace of insurance would be a public disaster,' John J. Byrne says.

"I share the view that state regulation of the property/casualty industry is best," Mr. McNamara said. He added, however, that "the NAIC is doing a great deal of work, but I think they're doing it after the fact in terms of setting up information systems in the central office."

Mr. McNamara also said he is not sure how useful such information is going to be in avoiding insurer insolvencies, because of the worldwide insurance marketplace and problems with reinsurance recoverables. ■

Panelists discuss industry's judgment

By LINDA J. COLLINS

SAN ANTONIO, Texas—The insurance industry always remembers the past and only anticipates the future after a crisis occurs, rather than during a crisis when it can take action, a consumer advocate says.

Commercial property/casualty insurers are now in the "recovery phase, or gouging phase, depending on who's calling it. . .and all the seeds are sown for another hard market in the mid-1990s," said J. Robert Hunter, president of the National Insurance Consumer Organization in Alexandria, Va.

"It's time to return to fundamentals, like fair price, excellent service and truth," Mr. Hunter said during a panel discussion on "Remembering the Past, Anticipating the Future" at the annual meeting of the Society of Chartered Property & Casualty Underwriters last week in San Antonio.

The property/casualty industry is likely to face major regulatory changes in the near future as a result of its behavior over the past several years, he said.

Congress is very likely to "remove the bureau rate from the marketplace" by repealing the limited antitrust exemption given to insurers in the McCarran-Ferguson Act, Mr. Hunter predicted. "The chances are better than 50-50" that Congress will amend the act, he stressed.

And while the industry is resisting federal regulatory control, its appeals to legislators are hindered by such inconsistencies as its arguments for stronger federal controls on banks' entry into the insurance business, he pointed out.

However, the industry's credibility with legislators is not its biggest problem, Mr. Hunter said, explaining that the industry lost public confidence during the recent hard market. The insurance industry is now tied with lawyers for "the bottom of the heap" in consumer trust, he added.

In the industry's defense, a decade ago the insurance industry was "pretty well defined. There were a few things called offshore captives, but they were pretty much a reaction to the last liability crisis in medical malpractice, product liability and a few other long-tail lines of specialty risks," said Lyndon L. Olson Jr., until recently chairman of the Texas State Board of Insurance and now president and chief executive officer of National Group Cos. in Waco, Texas.

"Ten years later, today, the insurance industry on the property/casualty side is radically changing. . . .I personally believe that the absolutely most serious problem facing the property/casualty industry today is the recoverability and the security and collectibility of reinsurance," said Mr. Olson.

Risk managers are moving their business out of traditional markets to "private insurance mechanisms, leaving poorer risks," he explained.

"I would submit that in the next five years or so, 30% to 45% of the commercial insurance in this country will be written through risk retention groups or risk purchasing groups" or self-insured programs, Mr. Olson said.

That could create even more serious solvency problems in the future, he pointed out. When risk managers set up alternative market mechanisms, they lose "150 years of fundamentalism," potentially to the detriment of consumers.

"We have to ask ourselves what happens when risk retention mechanisms fail, when captives fail, when self-insurance fails? Who pays the price?" Mr. Olson asked. "The regulated market pays the price."

He added that while he and others in the industry oppose federal regulation today, it is likely that in the future the industry will find it necessary to discuss this option.

Insurers also need to focus on their image in the eyes of consumers, an insurance company executive acknowledged.

Insurers have created their own image problem, escalated the public's concern unknowingly, lost sight of good business practices and overreacted to socioeconomic pressures, but insurance is still a good and useful business, said Roger W. Gilbert, president of Great American-West Inc. in Orange, Calif., and chairman of the Insurance Services Office Inc.

Insurers' image was damaged through "poor press, insensitivity to the public" and a tendency to talk among themselves rather than discussing problems with consumer groups or insurance buyers, Mr. Gilbert explained.

To change their image, insurers must become active in their communities and provide adequate explanations for rate increases and decreases.

"We tend to talk in terms of mathematics and the public probably doesn't understand or give a damn,' he added.

"We've done things and taken actions based on our own perceptions as opposed to what the public's perceptions might be. I've come to the conclusion that perception is more meaningful than fact," Mr. Gilbert added. "Every time we try to prove a point by fact, we lose.

In addition, primarily in response to stockholder earnings pressures, insurers have made a lot of short-term decisions without thinking about their long-term impact. For instance, insurers put pressure on branch offices for production increases that can only be accomplished through price cuts, thus driving the cycles, Mr. Gilbert explained.

Insurers have paid the price for undisciplined pricing through increased state regulation, he said. "And as time goes on, if we don't correct our problems, they are going to get even worse," he said.

Insurers need to correct this and to become more involved in the political process and support business coalitions that are attempting to deal with civil justice inequities, he said. They should build pricing models so that they know what the correct price is. And, they should also set a "walk-away price" for branch office underwriters, rather than constantly pushing them for premium growth, said Mr. Gilbert.

In the reinsurance arena, many problems arose from the fact that the number of reinsurers has doubled over the past 10 years and "their needs for people so diluted the then-existing pool of reinsurance professionals that almost no one had enough really talented people to do a quality job of underwriting, establishing claims reserves and managing the business being produced," said Edward B. Jobe, president and chief executive officer of American Re-Insurance Co. in New York.

Since most of the new companies did not have the necessary talent to run their businesses, "they gave their pens to others who could do this for them. . . .A catastrophe was being incurred, it wasn't being reported and its name was reinsurance underreserving," Mr. Jobe said.

Reinsurance cannot be bought and sold opportunistically, he stressed. "It must be structured to outlast the underwriting cycles. This means that the buyer doesn't leave the seller for a temporary price cut in a buyer's market and the seller doesn't reallocate surplus to temporary bigger profits in a seller's market," Mr. Jobe explained.

Fortunately, uncollectible reinsurance is causing many people to pay closer attention today to who their reinsurer is, Mr. Jobe said, which is "quite a change from a few years ago." Many insurers are building sophisticated monitoring systems to give them "a monthly handle on what their implementers are doing," he pointed out.

The panel discussion was moderated by Gerald A. Isom, president of Transamerica Insurance Co. in Los Angeles. ■

CPCU meeting draws 3,500

SAN ANTONIO, Texas—The 43rd annual Society of Chartered Property & Casualty Underwriters conference was the second-largest ever, drawing more than 3,500 members and guests to the Convention Center in San Antonio, Texas, Oct. 11-14.

Attendees included 1,560 new CPCUs who received their designations at a conference dinner held during the week.

During the program, speakers addressed such topics as: the future of the insurance industry from the perspectives of risk bearers, risk managers and producers; excess liability; the role of Lloyd's of London today and in the future; workers compensation; professional and directors and officers liability; tort reform; and the Risk Retention Act.

Other speakers addressed: personal automobile insurance; artificial intelligence; attracting and motivating people; insurance from a financial analyst's viewpoint; producers' errors and omissions coverage; and reinsurance capital infusion.

Entertainment during the meeting included an optional Texas-style rodeo and a final night fiesta party.

Risk managers respond to market swings, lawsuits

By LINDA J. COLLINS

SAN ANTONIO, Texas—Large fluctuations in the price and availability of property/casualty insurance and the increasing exposure to employee and consumer lawsuits is boosting the need for good risk managers in both large and small corporations.

In turn, risk managers are putting more pressure on the insurance industry to respond to their needs by creating their own markets when that response is not forthcoming, said a panel of risk managers and other industry representatives at the Society of Chartered Property & Casualty Underwriters' annual meeting last week in San Antonio.

Government regulatory agencies no longer exempt small employers from compliance with many requirements regarding their employees, said Garry M. Ritzky, personnel and risk manager for Turner Brothers Trucking Co. Inc. in Oklahoma City.

For example, "with the passage of the recent right-to-know legislation, small company risk managers are now in the training business," he said. And small employers are not immune to such things as hazardous waste cleanup or even age and sex discrimination suits, he added.

The difference between risk managers of large and small businesses is that risk managers of small companies usually handle multiple tasks within their organizations, Mr. Ritzky explained.

Because of the multiple demands on their time, they are more often interested in plan design than funding alternatives, or in "administering health insurance claims than in getting comparative quotes and organizing proposals," Mr. Ritzky said.

But the first requirement of any practical risk management program is "to protect the existence of the company," said Emmet F. Monaghan, vp of Johnson & Higgins of California and a former risk manager.

"By alternately supplying (catastrophic coverage protection) too cheaply and then removing it entirely from the marketplace, only to later reintroduce it in changed form at new pricing, the insurance industry has created the financial equivalent of the man who couldn't find comfort with one foot on the stove and the other in ice water," Mr. Monaghan stressed.

He is "firmly convinced" that the insurance industry can "effectively and profitably compete with risk retention groups, association captives, super-captives and the like that are in this business out of desperation, not interest or expertise."

However, to do so, the insurance industry will have to examine what its customers really want and then strive to deliver that product efficiently.

Insurers have to recognize that businesses cannot and will not go without catastrophic risk protection. Rather than waiting for the marketplace to respond, they will create their own coverage mechanisms, Mr. Monaghan stressed.

"Non-traditional vehicles such as captive insurers, self-insurers and risk retention groups should continue to apply pressure on the traditional markets" to lower rates and increase availability over the next couple of years, said Anton E. Pfaffle, vp and risk manager for Goldman, Sachs & Co. in New York.

But risk managers also should recognize that as an economic/financial tool, insurance is designed to be "distributive, not value-added. . .to spread risk around, not to get back $20 in claims by paying $10 in premiums," Mr. Monaghan pointed out. The cost of administration dictates that even $10 in claims "cannot in the long run be recaptured" for that premium, he added.

Company managers should recognize they are responsible for optimizing a business' earnings rather than maximizing them, and that ideally is best done through the purchase of insurance, he said.

But insurers also must provide their clients with continuity, even if they are forced to raise premiums dramatically, Mr. Monaghan added.

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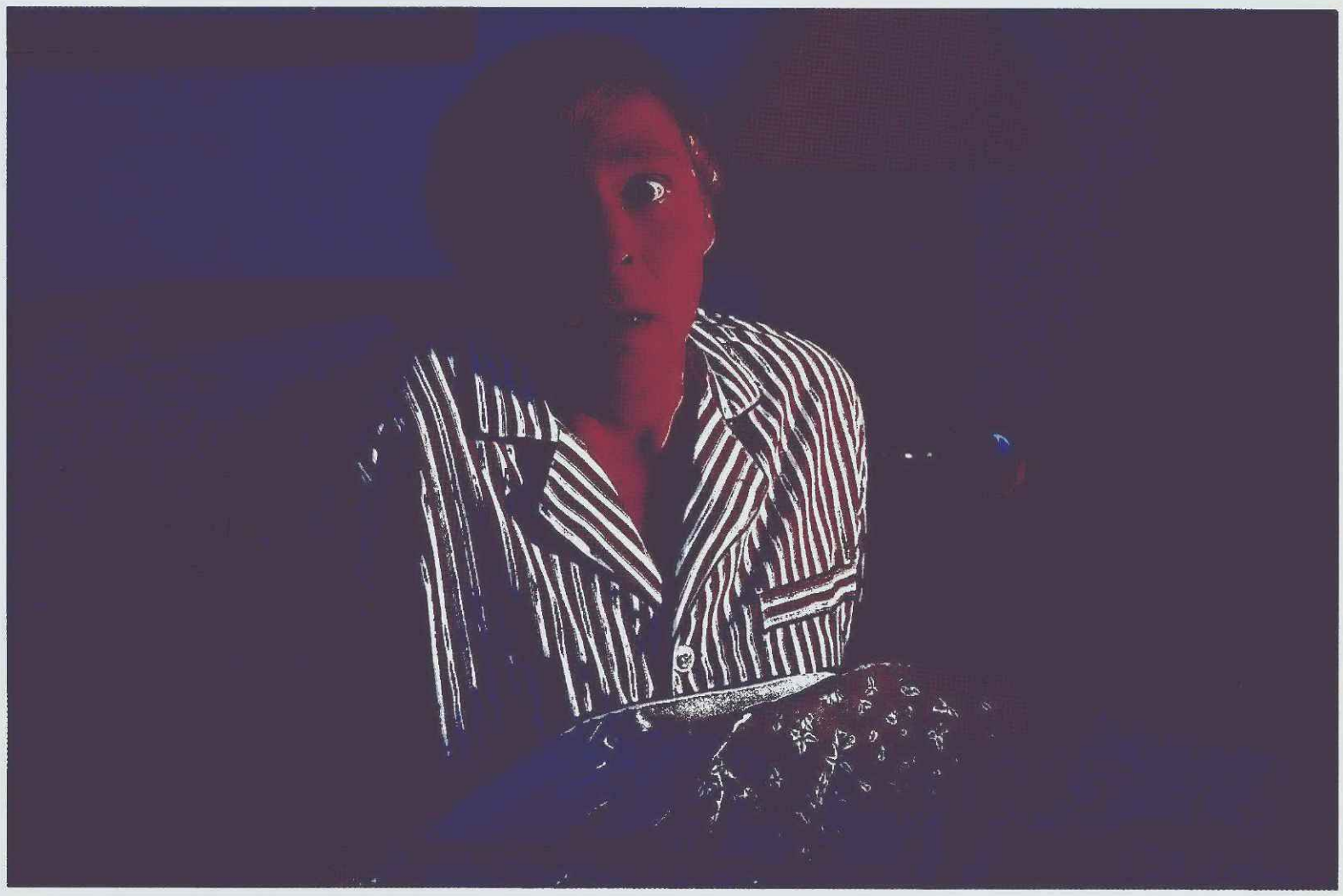

Risk managers

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"Long-term arrangements between insured and underwriter, whether formalized into such things as loss-stabilization contracts or informal agreements to work toward mutually profitable excess placements, can go a long way in stabilizing both cost and coverage," he stressed.

"Risk managers and underwriters alike should realize that an adversarial relationship, carried to extremes, weakens the industry to the detriment of both," added Mr. Monaghan.

Continued profit growth throughout 1987 should increase underwriters' confidence, said Mr. Pfaffle. "By 1988, even the difficult risks may begin to find coverage, and higher limits for all lines of insurance should become available."

But he urged "prudence this time on the part of insureds and insurers to avoid the dramatic pitfalls of the 1978-1983 period, which was followed by the radical limitation in coverages and extraordinary increase in premiums starting in 1984."

"Some experts predict that excesses will curtail the usual insurance cycle and lead to a restricted market by 1990," he added.

Also participating on the panel was Linda H. Lamel, president and chief executive officer of The College of Insurance in New York, who spoke on the increasing need for education in the field of risk management and the types of training employers are now seeking when hiring risk managers.

The panel was moderated by Maureen C. McLendon, senior research analyst of the International Risk Management Institute Inc. in Dallas. ■

Commitment key to safety: Expert

By MARK A. HOFMANN

CHICAGO—Management's commitment to safety is more critical than the scope of any program it may establish to achieve a safe workplace, according to a British expert.

"An honest policy that senior management believes in is better than an ingratiating policy that promises everything," Peter Ward, an official of the Accident Prevention Advisory Group of the British government's Health and Safety Executive, told attendees at the International Safety Rating Council meeting.

About 20 countries were represented at the meeting of the ISRC, an advisory group to Loganville, Ga.-based International Loss Control Institute. The ILCI is the for-profit organization that devised the International Safety Rating System in 1977.

The rating system is used to establish corporate safety programs where none exist and monitors and improves existing safety programs. It measures management performance by auditing how well an organization meets its stated safety goals in 20 areas.

Mr. Ward, who is with the British government's counterpart to the U.S. Occupational Safety and Health Administration, advised senior management to get involved in safety programs.

Of them several common failings in safety management, one of the most critical is the development of safety policies without senior management involvement, he said.

One of the problems with a lack of senior management input is that other levels of management do not know what is expected of them, Mr. Ward explained. There is no appraisal of management safety performance, because no one is certain of what is being appraised.

Without a safety auditing system, divisions in a company generally do not learn lessons from the mistakes made by other divisions, and mistakes are repeated, Mr. Ward continued.

And, the lack of a safety auditing system often leads to unplanned, scattered allocation of resources to safety efforts, he said.

In addition, without such a program, there is a tendency by management to treat communication about safety with employees as a trivial matter, he said. Some companies' discussions of safety matters are held on a level comparable to a chat over beers, Mr. Ward noted.

Measuring a company's safety performance by simply counting injuries is not enough, because listing numbers does not prevent accidents, Mr. Ward said.

To achieve better workplace safety results, management needs a system that identifies major areas of safety management and tests management goals against results, he said.

Corporate leaders must commit themselves to a safety policy, establish a formal framework for reports and see that management gets adequate training in safety matters, Mr. Ward stressed.

Plant managers should not wait for the government to inspect their facility and then ask nervously "How did we do?" Mr. Ward said. Instead, they should invite inspectors to meet with them to discuss the company's health and safety audit, safety program, objectives and plans.

"Good health and safety performance is good business," Mr. Ward said, adding that creating a good safety policy also can improve the quality of management.

Measuring the relationship—if any—between safety practices as measured by the ISRS and general management performance is the aim of an ongoing pilot research project described by another speaker at the meeting.

Larry D. Gaunt, professor of risk management and insurance at Georgia State University in Atlanta, said his study seeks to determine whether there is a correlation between management commitment to safety and other areas of managerial concern such as absenteeism, employee turnover rates and productivity rates.

"We're looking for a demonstrated relationship between quality efforts and economics," he said.

The study also seeks to ascertain whether a relationship exists between safety consciousness and a company's general financial performance.

Mr. Gaunt said that the project involves several companies in the United States and Canada. He said if the study proves successful, he hopes to expand it to other countries.

However, one of the problems with the project is the absence of a formal control group. Mr. Gaunt did not predict when the study might be completed.

Interest grows in ISRS

By MARK A. HOFMANN

Although insurers do not yet use the International Safety Rating System as a formal underwriting criterion, interest appears to be building in the safety promotion system.

At least two major enterprises in the United States and Canada have received premium reductions partly because they have used the ISRS, said Susan B. Arnold, executive director of the International Loss Control Institute in Loganville, Ga., which developed the ISRS.

Although Mrs. Arnold declined to identify the companies, she said that the size of the premium reductions "have been major."

Tony Perez, a director of First Insurance Group Inc. in Hato Rey, Puerto Rico, and a member of the International Safety Rating Council—an advisory group to the ILCI—says that in some cases use of the system has become a factor in negotiating coverage. And companies using the system have had an easier time finding some coverages than they did before they began using the ISRS, he added.

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ILCI developed the safety rating system in 1977 based on the idea that accident frequency rates and physical inspections by themselves are inadequate yardsticks of safety program effectiveness. Instead, the ISRS attempts to measure management's compliance with a safety program through the use of a comprehensive audit.

The ISRS measures and evaluates 20 elements of a safety program, including: management and employee training in safety matters; emergency preparedness; inspections; and methodology for investigating and analyzing accidents.

At least 1,200 companies use the ISRS to evaluate their safety programs, says Susan Arnold.

ISRS audits attempt to identify what needs to be done to develop an effective safety program and set standards through which a company or other entity can accomplish its safety goals. The ISRS can be used to either create a safety program from scratch or to bolster the weaknesses of an existing program.

At least 1,200 companies operating at roughly 2,000 locations in the United States and Canada currently use the ISRS to evaluate their safety programs, according to Mrs. Arnold. She estimates that the system is being used at a minimum of 1,000 additional locations throughout the world.

The ILCI was founded in 1974 under the sponsorship of Georgia State University's School of Business Administration. The ILCI is an independent, profit-making enterprise. ■

Lloyd's suit

Continued from page 2

In its suit, the Corporation of Lloyd's and underwriting members of Lloyd's of London sought an injunction to stop Lloyd's U.S. from using any "service mark confusingly similar" to Lloyd's of London.

Lloyd's of London specifically sought to stop Lloyd's U.S. from using "Lloyd's," "Lloyd's U.S.," "Corporation of Lloyd's," "Committee of Lloyd's" or any "colorable imitation thereof in connection with the promotion or provision of insurance underwriting services."

In addition, Lloyd's of London sought to have the Dallas insurer "deliver up for destruction" all policies or any other material bearing the contested words.

Lloyd's U.S. countered the trademark infringement charge by claiming that Lloyd's of London had filed a fraudulent application with the U.S. Patent and Trademark Office in 1979 to protect the Lloyd's name.

Lloyd's U.S. says the settlement ends all litigation between Lloyd's of London and Lloyd's U.S.

The Lloyds U.S. brief claimed that at least 10 states "have by statute (some for as long as 50 years) legislatively constituted Lloyd's as a generic term to describe the activity of insurance underwriting services offered by an unincorporated association of underwriters rather than by a single named corporate insurer."

Lloyd's U.S. also charged that Lloyd's of London, in its capacity as a non-admitted insurer in Texas, was accepting business that had not first been rejected by admitted insurers. In addition, the Texas company charged that Lloyd's of London "wrongfully coerced and intimidated insurance brokers, underwriters and others into discontinuing and refraining from engaging in business relations with (Lloyd's U.S.)"

A special master appointed by the federal district court to oversee the pre-trial phases of the lawsuit said in an order issued late this summer that there was evidence that Lloyd's of London had violated U.S. antitrust laws by persuading Lloyd's brokers not to do business with Lloyd's U.S. (*BI*, Sept. 14).

According to Lloyd's U.S., the settlement is comprehensive and ends all litigation—including antitrust charges—between Lloyd's of London and Lloyd's U.S. ■

AEAI/RIMS conference draws 617 registrants

By STACY SHAPIRO

MONTE CARLO, Monaco—There are many changes between early September and early October in Monte Carlo.

In September, more than 2,000 people descended on the principality of Monaco for the informal Rendezvous de Septembre (*BI*, Sept. 21). During a hot, dry and sunny week, casually-clad property/casualty insurers, reinsurers, brokers and lawyers met for 15-minute to one-hour meetings in the foyers of hotels, at the beach, at poolside or on yachts to informally discuss year-end renewals.

Only 250 attendees showed up for the formal conference meetings held in the Congress Center of the Lowes Hotel.

However, from Oct. 11-14, formality reigned in Monte Carlo as 617 registrants attended the AEAI/RIMS Risk Management Forum.

Suits and ties were donned for the formal conference sessions in the Congress Center. The conferences were held from 9 a.m. until 5:30 p.m., and few people sat by the pool the first day and a half, because the weather was rainy and cold.

The hotel lobbies also were quieter during the AEAI/RIMS conference, since the formal meetings took place in auditoriums or suites rented by brokers or underwriters.

The only area that registrants filled during coffee breaks or at lunchtime was near the Congress Center auditorium, where 15 booths lined the lobby to provide risk managers with information on brokerage firms, computer systems, loss prevention and engineering, risk management consulting and salvaging.

The stand with the most computers undoubtedly was CIGNA Corp., which hopes to soon market in Europe its risk information service computer system, known as CRIS. The system, which gives users instantaneous on-line access to premium and claims data, already is sold in the United States, said Hugh C. Roberts, president of ESIS International Inc., the CIGNA unit marketing CRIS. There already are 1,500 system users in the United States, 500 of which have personal computers in their offices that are connected to Corporate Systems in Amarillo, Texas, which developed CRIS with CIGNA, he said.

CRIS in not available yet in Europe, but CIGNA brought the system to the AEAI/RIMS conference "to get a feeling for how it will be received," Mr. Roberts said.

On the CIGNA stand was a quote that summarized the perceived need for CRIS: "There is only one thing worse than no information at all. Piles of information. By the time you get to the bottom of it, it's old information."

CIGNA received more than 60 inquiries about the system during the first day of the conference.

Across from the CIGNA booth on the main floor of the exhibition were two of the world's largest brokers: Sedgwick Group P.L.C., along with Fred S. James & Co. Inc., Sedgwick's U.S. unit; and Marsh & McLennan Cos. Inc.

Sixty people from Sedgwick were scattered around the AEAI/RIMS conference representing the 1,600 people in Sedgwick's continental European offices, according to David Patterson, director of personnel for Sedgwick in Paris.

The stand, which followed the theme of Sedgwick's 1986 annual report, had a glassed-in office area for Sedgwick employees to hold private meetings.

"We have a private place to live, which is essential," Mr. Patterson said.

Next door, M&M had a more open booth. In the company's traditional colors of white and blue-gray, registrants could pick up a deck of cards, a pen, information and a bag to carry other exhibition goodies.

A map of Europe showing M&M's European subsidiaries dominated the stand's backdrop.

The stand attracting one of the largest throngs of registrants, at least early in the conference was the Frank B. Hall & Co. Inc. stand, where registrants were given blue and white golf hats with the company's logo on the front.

Hall gave away 250 hats in the first 30 minutes of the conference, said Graham T. Lewis, senior vp of Hall's office in London.

Noting that there were more than 20 Hall employees at the conference, Mr. Lewis said: "We are here to show that we try. We are alive and kicking. . .We are firing on all cylinders. And, we have the finest European network of anyone."

Among the other companies at the exhibition were:

- Factory Mutual International, which showed three videos in English and one or two in French on, among other topics, the new early suppression, fast response sprinkler system that FMI is testing. FMI had information in six languages on the sprinkler at the booth.
- UNISON, the worldwide network of independent insurance brokers and benefit consultants that first began working together more than 20 years ago. In its big white display filled with fresh flowers, registrants found UNISON staffers including representatives from Willis Faber P.L.C. of London; Gras Savoye in France; and Johnson & Higgins of New York. Brokers in the UNISON network service more than 13,000 clients in 56 countries.
- Two Paris-based industrial appraisers—Roux S.A. and Galtier Expertises. Galtier is part of GLR Valuers International, founded two years ago to coordinate appraisals in other countries. GLR, headed by President Hubert Montus, includes U.K.-based Edward Ruston Son & Kenyon and Lloyd-Thomas Coats & Burchard Co. in the United States and Canada.
- The Tillinghast Division of Towers, Perrin, Forster & Crosby Inc., a Darien, Conn.-based risk management consultant. Tillinghast had 20 separate discussions with registrants on the first day of the conference, said Ulf Nordblad, managing partner for Tillinghast in Sweden.
- Alexander & Alexander Services Inc. and Anistics, A&A's risk management services arm, which hosted a cocktail party in the elegant Empire Room of the Hotel de Paris one evening during the conference.

A computer donned the long booth near the registration desk to show what the Anistics risk management information system can do.

This year, Luxembourg captive manager SINSER (Luxembourg) S.A.R.L., a unit of Scandinavian Insurance Services Ltd., bought one of Anistics' systems to develop a program for the 16 captives it manages. The system also has been sold to four companies in Sweden, and at least 10 SINSER members are expected to buy it within a year, according to Magnus Akerman, deputy managing director for A&A in Stockholm.

- Industrial Risk Insurers, which was promoting worldwide property insurance and loss prevention activities.
- Corocor S.A., based in France, which salvages equipment that is contaminated by chemicals. "We are doing well," said Bo Speerschneider, commercial director for Corocor. "We have had 200 cases so far."

Washing equipment in special solutions after it has been sprayed by chemicals can stop corrosion. For example, when gas leaked into a storeroom of one client during a fire and contaminated all of the computers there, Corocor was able to salvage the equipment for 2.9 million francs ($482,000 at current exchange rates) and thus saved the company 400 million francs ($66.5 million), Mr. Speerschneider said.

The only complaint by exhibition participants was the location of some of the booths downstairs from the auditorium near registration, where no one wandered after they had registered.

"It would have been nice to have had a bar or coffee area here, because as soon as registration is over, the action is gone," said one of the people staffing a booth in the area.

"The action is upstairs." ■

Europe needs risk managers: Experts

By CAROLYN ALDRED

MONTE CARLO, Monaco—More European companies, particularly those that export goods to the United States, should employ risk managers, according to a broker and an underwriter.

"European companies would be well-advised to create the position of risk manager in their firm. It is no longer sufficient today to be an insurance buyer," says Bruno Zingg, assistant vp-International Division of Zurich Insurance Co. in Zurich, Switzerland.

Mr. Zingg gave a joint presentation with John Newall, general manager of the Paris office of Lloyd's of London broker Sedgwick Group P.L.C., at the AEAI/RIMS Risk Management Forum last week.

"I believe that, by now, all European manufacturers know about the problems relating to exports to the (United States). But maybe some are still not taking this too seriously or still believe blindly in the quality of their product and the high standard of European technology and workmanship," said Mr. Zingg.

"Owing to the exorbitant demands by claimants in the U.S., manufacturers there are far removed from the arrogance that is unfortunately still encountered in some European industries," he added.

However, the implementation of the European Community's product liability directive in 1988 will confront Europe with similar litigation problems—"though not to the same extent as in the U.S.," he said.

While U.S. industry has been forced to "adopt extensive corrective measures in their (risk) management policy, Europeans may still be tempted to shrug off the situation with the excuse that the U.S. is always different," said Mr. Zingg.

The situation in the United States alone should convince European producers of the necessity for risk management, he said.

The European risk manager should be familiar with the legal problems of exporting goods to the United States and be directly accountable to top management, as is already the case within the largest European multinationals, he said.

A European exporter should choose an insurer and broker with experience in claims handling and claims settlement in the United States, he added.

However, insurers are not providing European risk managers with sufficient help, accused Mr. Newall.

"Over the past few years the commercial insurance market has abdicated from its responsibility to provide European exporters with the cover they require. It has not been a question of price. Regardless of price, proper cover has not been available," he said.

As a result, European companies have been driven out of the U.S. market and some U.S. firms have been driven out of business or into forming mutual insurers, he added.

During the early 1980s underwriters "seemed oblivious to the trend of ever-accelerating awards in the U.S. and then overreacted," he explained. The reinsurance market "clubbed together" to compel rates to rise and changed policy forms drastically. As a result, capacity was reduced by about 75% during 1985 and 1986.

"It was generally easier to buy U.S. products liability cover directly in the U.S. as opposed to on the European market."

Matters had reached a "pretty desperate point—and it took a pretty drastic reaction, most of all by reinsurers, to reverse the spiral," admitted Mr. Zingg.

But he denied that the insurance industry had overreacted. "The action it took was absolutely essential to turn the market around. . .a few years of steady losses, in fact, eroded the financial base of some of the major insurers. Reserving was insufficient in many cases," he stated.

Although the market has stabilized again, "it is clear to everyone that certain risks will remain virtually uninsurable—or at least un-reinsurable," said Mr. Zingg.

As a result, much of the business that has left the traditional insurance market and moved into captives, mutuals and pools will not soon return, he said.

"Some major industrial leaders feel that the insurance industry has had not just a capacity crisis, but a partnership crisis. They wonder if insurance can respond anymore to the manufacturers' needs," Mr. Zingg added.

For a European company that exports to the United States but has no manufacturing, marketing or servicing facilities there, "coverage always was and still is available," he said. However, "it must be pointed out that the client faces certain restrictions in coverage for the export portion of his risks."

And for European companies with manufacturing or other operating facilities in the United States, the situation became far more difficult, with "serious changes in the scope of cover and even an unwillingness (by insurers) to support industry in certain fields," he admitted.

However, for 1988 "some degree of relief can be expected," said Mr. Zingg.

Although the main restrictions introduced in 1986 are likely to remain, the widening of claims-made policy wordings, tail coverage or retroactive dates "should become at least discussable," he predicted.

"Denial or incapacity on the insurers' part would induce industry to slow down its own development or—I am convinced—to seek valid alternatives," he added.

Meanwhile, risk managers can take many practical actions to reduce a European exporter's U.S. exposure, Mr. Newall explained. These include:

- Efficient investigation of and preparation for any liability trial.
- Appointing a central custodian of internal and external company documents and memos and establishing a formal record retention system. This would include keeping all records associated with the development of a product.
- Using careful labeling, warning and instruction techniques for all products.
- Testing all products carefully during manufacture.
- Monitoring after-sale product performance.
- Requiring suppliers to assume responsibility for their products as far as possible.
- Ensuring goods are not damaged in transit.
- Ensuring adequate quality control throughout the process.

In addition, there are many legal defenses a producer can turn to when actually faced with a product liability claim in the United States, according to Mr. Newall. These possible defenses, although they are not available in all state jurisdictions, include:

- Contributory or comparative negligence.
- State of the art.
- Product modification after manufacture.
- Mishandling of the product.
- Misuse or abnormal use.
- Superior knowledge—if the customer is not an ordinary customer.
- Compliance with governmental regulations.
- Disclaimers or limitations on liability.

The most essential message for any exporter to the United States is "be careful," concluded Mr. Zingg.

"The U.S. is like a wild card in a deck and anything can happen. . .product law in most countries is clearly defined. You can learn the rules and play by them. In the U.S. you have less certainty because there are 50 different states and as much depends on what the individual jury may decide," he said. ■

Self-funding scarce overseas: Consultant

MONTE CARLO, Monaco—European companies generally self-fund less risk than U.S. corporations because they have a smaller economic incentive to self-insure, says a London-based consultant.

"Insurance has always been a less important expense item (in Europe) than in North America to the average corporation," said David A. Scott, chairman of Anistics Ltd. in London.

Also, European companies have fewer losses than U.S. companies, and thus their budgeted losses are smaller, he explained. Since self-funding generally saves the difference between the quoted premium and the budgeted losses, there are smaller savings for European companies that self-fund, he added.

Mr. Scott spoke at a seminar on risk financing methods at the AEAI/RIMS Risk Management Forum held last week in Monte Carlo.

Typical European deductibles for property insurance, according to Mr. Scott, are: in Britain, 1,000 to 50,000 pounds ($1,690 to $84,500); in West Germany, zero to 84,000 pounds ($141,960); in Italy, 3,000 to 6,000 pounds ($5,070 to $10,140); in Spain, 2,500 to 5,000 pounds ($4,225 to $8,450); and in Belgium, 500 to 1,500 pounds ($845 to $2,535). Property deductibles are not common in Austria and Most Netherland companies do not assume property deductibles.

When choosing a self-insurance limit, corporations should base the amount they self-insure on their own loss histories, not a standard formula, he advised.

"You cannot use ratios," such as retention to revenues, assets or profitability to determine the proper self-insured retention, according to Mr. Scott. The proper self-insured retention "depends on your risk profile and the risk attitude in your corporation."

A company's risk profile takes into account its anticipated losses and considers other factors. These include inherent risk—that more losses may occur than average—additional statistical risk due to outdated or incomplete loss data and a changing environment and factors for social inflation, the timing of settlements and investment income.

The high point for losses is then compared with anticipated losses and the premium discount offered by the insurer for the amount of the deductible. The discount offered should be at least equal to the budgeted losses.

Mr. Scott advised against using the often repeated self-insured retention formulas of 0.3% to 0.5% of gross revenues, 1% to 1.5% of equity or 5% to 15% of net profit.

These formulas are based on averages and "few companies are average," he pointed out.

—By Kathryn J. McIntyre

AIU uniting European operations

By STACY SHAPIRO

MONTE CARLO, Monaco—American International Underwriters Corp. is uniting its continental European operations under the banner of one Paris-based insurer.

Currently, AIU—a unit of American International Group Inc. that acts as a foreign manager for a number of AIG insurers—operates through several AIG insurance company units in different countries.

However, during the AEAI/RIMS Risk Management Forum in Monte Carlo last week, *Business Insurance* learned that within the next 12 months all AIU European subsidiaries will be named after French-licensed UNAT S.A.

UNAT's European headquarters will be Paris, where AIG's President of European Operations Steve Schleisman has relocated from AIU's previous New York base. Mr. Schleisman will become president of UNAT S.A., working with about 30 staff members in corporate management in Paris, while about 10 executives will be based in Brussels, Belgium.

All other AIU offices in Europe will become branch offices of UNAT, which has been licensed and approved in France and becomes operational Dec. 19.

All AIU companies in Europe will be re-licensed under the name UNAT in all relevant countries, he said. For example, the Dutch branch of AIG-owned New Hampshire Insurance Co. will become the Dutch branch of UNAT.

AIU in the United Kingdom and AIU companies in Eastern bloc countries will not be included in UNAT, however, and will continue to report directly to AIG in New York, said Mr. Schleisman.

UNAT will be capitalized at $50 million in Europe, Mr. Schleiseman said.

"UNAT will be (AIG's) sole property/casualty carrier on the continent in the European community and in non-EC countries on continental Europe. Clearly, we will be the servicing arm for the rest of AIG on the (European) continent," he explained.

The name UNAT—which Mr. Schleisman says doesn't stand for anything—was chosen because it is a European-sounding name that can be readily pronounced in all European languages, he said. Also, the name has been in the AIU stable for about 20 years, since some AIU executives thought it would be a good idea to unite all AIU operations in continental Europe under the name UNAT.

"The idea (to unite European operations) was originally born about 20 years ago," he explained. But, "cross-border barriers stopped this. It is sad that it took 20 years to happen."

"We are getting prepared for 1992" when the European Economic Community plans to complete its infrastructure for a united financial services market," said Mr. Schleisman.

"We think some of the borders are coming down in Europe. . .they will be coming down at least in the financial arena. So, we have totally restructured internally our European operations.

The move involves more than a superficial name switch, said Mr. Schleisman. Tagged internally as "Project Renaissance," the restructuring has placed 15 people—from the United States and Europe—in Paris where they have set up the "war room" to begin UNAT's push.

In addition, UNAT will preserve the AIU tradition of providing capacity in individual countries on individual risk areas. However, UNAT also will focus as a group on niches in which the company specializes, such as pharmaceutical, electrical and directors and officers liability risks, said Mr. Schleisman.

When the integration is completed, about 1,100 people will be employed by UNAT in Europe, 77 in France.

The advantage to European risk managers will be that all operations will be under one company. "We can speak with a single voice," he said.

Also, "we are bringing the decision making to Europe" with the corporate management based in Paris, added Peter O'Connor, who was director general of AIU New Hampshire Insurance Co. in Paris and will be general manager for UNAT in France.

Meanwhile, AIU has become the first foreign insurer since 1890 to be granted a license to write business in Finland, said Bengt Westergren, executive vp (Europe) of AIG. The license is under the New Hampshire name, but eventually will be changed to UNAT.

Also, AIG's European operations have found more buyers for its "exporters policy" that covers liability for products exported to the United States, said Mr. O'Connor.

Last year, AIG introduced an occurrence-based primary product liability policy with $5 million in limits to European businesses that export to the United States. The policy has a minimum deductible of between $10,000 to $25,000, and excess coverage can be arranged.

However, demand for the coverage was not strong in the first six months after the policy was introduced, (*BI*, Nov. 24, 1986).

In the last year, however, "there has been more action," said Mr. O'Connor. AIU in France put together four major exporter policy programs with premiums totaling more than $2 million, he said.

Also, three or four new programs were put together in the Scandinavian countries, said Mr. Westergren.

AIG's European operations also are putting together product liability policies for U.S. manufacturers' foreign subsidiaries, said Mr. O'Connor.

"There is a totally different attitude now from European risk managers who are tending to get more involved with their U.S. liability exposures," added Mr. Schleisman.

For example, Mr. Schleisman said he spoke to one European risk manager at the Risk Management Forum who wants to know more about covering liabilities for a major U.S. acquisition his company is targeting. "The responsibility is shifting to the European risk managers." ■

Tampering major concern of food and drink industry

By CAROLYN ALDRED

MONTE CARLO, Monaco—Product contamination and extortion are major concerns of food, drink and packaging companies, according to risk managers attending the AEAI/RIMS Risk Management Forum last week in Monte Carlo.

Product extortion and malicious tampering are worrisome problems both for food and drink manufacturers and retailers, agreed risk managers attending an industry working session for the food, drink and packaging industries.

"The complexity of retail outlets makes a product recall very costly," said Tony Benson, group risk manager of British brewing conglomerate Arthur Guinness & Sons P.L.C.

Also, animal rights organizations and other groups in the United Kingdom are increasingly choosing supermarket chains as tampering targets, one risk manager noted.

"If an attack, or even a hoax attack, is launched on a store, it can dramatically affect the whole network across the country if you are not given a location of the contaminated product," explained Anthony Lenz, chief accountant for Marks & Spencer P.L.C., a clothing and food retailer in London with operations worldwide.

In addition, because of the expense involved in a product recall, media coverage, reintroducing and repackaging the tampered products, the insurance capacity available from commercial insurers is "woefully inadequate" for the size of the exposure, the risk managers agreed.

In the 1970s, there was up to $200 million of product integrity insurance available, but then "Tylenol blew everyone out of the market," said Robert Demaria, a member of the risk management department at Mars Inc. in McLean, Va.

Since then, "the market has never developed sufficient capacity to cover the potential losses of major companies to product extortion," agreed Alex Chrzanowski, group insurance manager of Rowntree Mackintosh P.L.C., a confectioner based in York, England.

American International Underwriters, the international arm of American International Group Inc., is increasing its capacity for product contamination to $10 million per risk from $7.5 million on Jan. 1, 1988, said Gregory W. Bangs, regional manager of the crime and sensitive risk department of American International Underwriters (U.K.) Ltd.

However, "for a major company, this is not enough," he admitted.

Mr. Benson of Guinness suggested that major food and beverage companies explore the possibility of using a captive to write these risks, while Mr. Demaria suggested establishing an industry mutual insurer.

Alternative insurance capacity will be used more and more by the food and drink industry for other risks, too, if insurers do not provide the needed capacity, risk managers warned.

"The food industry is now being linked with the pharmaceutical industry as a long-term exposure risk, and we are seeing the same sort of responses from insurers as those given to pharmaceutical companies," said Mr. Chrzanowski of Rowntree Mackintosh.

Food manufacturers should not be treated by insurers in the same way as other manufacturers, particularly pharmaceutical companies, risk managers agreed.

"The market may be softening, but I want underwriters to get back to pure underwriting—to be critical and to separate the bad risk companies from the others," Mr. Demaria said.

"If insurers are not careful, the industry is going to move further and further away from insurers," Mr. Benson added. ■

Update

Fireman's sues Massachusetts

Continued from page 2

Mr. Underwood said the department rejected Fireman's Fund's offer to continue to write all lines of coverage except auto liability and pay CAR $75 million, an amount the insurer estimated the pool would assess the insurer over the next two to three years if the insurer continued to write auto risks in the state.

Insurance Commissioner Roger Singer could not be reached for comment.

Robins in contempt: Judge

RICHMOND, Va.—A federal court judge has found A.H. Robins Co. in criminal contempt and also fined its chief executive officer, E. Claiborne Robins Jr., $10,000.

U.S. District Court Judge Robert Merhige made his ruling in connection with the company's failing to recover money it paid to executives, creditors and others without court approval following its August 1985 reorganization filing.

Last year, Judge Merhige held Robins in civil contempt and ordered it to recover the funds, estimated at $8 million.

A Robins spokesman said more than one-half of the $8 million has been recovered and that the additional cost of recovery would exceed the $3.7 million outstanding. He added that all the funds paid senior executives had been paid back with interest.

The Robins spokesman said the company was "a bit puzzled and perplexed" by the findings, noting that an independent court-appointed examiner had indicated there was no basis for a contempt finding. The company is "strongly considering" an appeal, he said.

Robins, former manufacturer of the Dalkon Shield intrauterine device, filed for reorganization because of the overwhelming number of lawsuits against it, brought by women who used the IUD.

Florida insurers begin refunds

TALLAHASSEE, Fla.—Property/casualty insurers in Florida have begun refunding about $36 million to policyholders as mandated by the state's Tort Reform and Insurance Act of 1986.

The law requires insurers to give commercial liability insurance policyholders a one-time 40% refund on premiums for the months of October, November and December 1986, which amounts to a de facto 10% annual premium reduction.

The refund applies to policies written or renewed on or after July 1, 1986, the law's effective date. Policyholders can receive the refund in cash or as a credit to their renewal premium.

Insurers can be exempt from the law if they prove that the refund would produce an inadequate rate. To date, 39 insurers have sought a total of $31 million in relief, of which $20 million was granted by the state Insurance Department. A department spokeswoman says no further appeals are pending.

Insurers had challenged the law shortly after it was enacted on grounds that it violated the state constitution, but the Florida Supreme Court upheld most of the law in an April 23 decision. The high court, however, did let stand the lower court ruling that the refund apply only to those policies issued or renewed after July 1. The law had mandated refunds to all 1986 policyholders.

High court to rule on labor law

WASHINGTON—The U.S. Supreme Court will decide whether state laws clash with the intent of federal labor law when they bar companies from firing unionized employees in retaliation for filing workers compensation claims.

Many state laws give workers the right to sue employers who fire them for filing work comp claims, while federal law calls for arbitration of contract disputes.

If the laws are found to conflict, the high court may also decide which law should prevail.

The case stems from a complaint by Jonna R. Lingle, a former assembler with the Norge division of Magic Chef Inc., which is now part of Maytag Corp. of Newton, Iowa. The Herrin, Ill., resident alleges she was fired in 1984 in retaliation for seeking medical benefits for a neck injury that occurred on the job, according to her attorney Paul Alan Levy with the Washington, D.C.-based Public Citizen Litigation Group.

She sued claiming the company violated an Illinois law that bans retaliatory discharges. However, a federal district court in East St. Louis, Ill., decided that her claim was a labor contract dispute. That decision was upheld by a federal appeals court in Chicago.

Since the lawsuit was filed in July 1985, Ms. Lingle has received through arbitration some back pay and has returned to work, Mr. Levy said.

If allowed to sue under state law, she could seek more compensatory damages and punitive damages.

A Maytag spokesman declined to comment.

Briefly noted

NBC has agreed to change the name of the fictitious Ecumena hospital chain in its "St. Elsewhere" television series to settle a lawsuit filed by Louisville, Ky.-based **Humana Inc.** charging trademark infringement, unfair competition and violation of the right of publicity. The settlement does not release NBC from defamation claims that might arise should Ecumena be cast in a negative light in the episodes already filmed. . . .The Senate Finance Committee last week approved a **variable-rate premium structure** in which the annual premiums paid by employers to the Pension Benefit Guaranty Corp. would range from $14 per plan participant to as much as $70 in certain situations. . . .The Finance Committee also approved a proposal to make all of an employee's wages subject to the Medicare portion of the **Social Security payroll tax.** Currently, the 1.45% Medicare tax—included as part of the 7.15% FICA tax paid by both employers and employees—is imposed only on the first $43,800 of an employee's salary.

Ties with reinsurers essential: Broker

By KATHRYN J. McINTYRE

MONTE CARLO, Monaco—Risk managers should have close contacts with the reinsurance brokers and reinsurers handling their risks, according to a Lloyd's broker.

"It is essential for a risk manager to have a close relationship with his reinsurance broker. Furthermore, he should get to know his reinsurers through him," advises David Springbett, chairman of PWS Holdings P.L.C. in London.

Mr. Springbett, along with General Reinsurance Corp. Senior Vp Thomas Kellogg, discussed the reinsurance market's importance to risk managers at the AEAI/RIMS Risk Management Forum.

"Insurance managers needing a link to the reinsurance must know the broker and the reinsurer on an eyeball-to-eyeball basis," Mr. Springbett advised, because "reinsurance is a very personal business."

"Reinsurance is crucial to capacity," Mr. Springbett reminded the audience. When an insurer is underwriting a risk that demands international facultative reinsurance, "insurers want to see reinsurance in place before they quote—maybe not 100% but 75%," said Mr. Springbett.

In dealing with a reinsurance broker, the risk manager "must trust him, and vice versa. He should know what he is earning. He should not take advantage of him, and vice versa." Risk managers also "must know or try to know what is behind the primary policy," Mr. Springbett said.

In dealing with reinsurers, Mr. Springbett advised risk managers that "cheapest is not always best. Continuity is the best message. You should seek the right cover at the right price for both sides."

Risk managers can help market their risks to reinsurers with a good presentation of a risk. Mr. Springbett recalled that he was turned down at Lloyd's when he sought product liability insurance for an Indian truck tire manufacturer exporting to the United States. He requested that one of the tires be sent to him and he then rolled it through the Lloyd's underwriting room. Underwriters then wrote the risk.

"You should get access to the reinsurance market. Ask the broker or direct carrier for details of the reinsurance and insist on seeing them to be sure your risk is being properly presented," said Mr. Springbett.

"The size of the risk is not a problem," Mr. Springbett asserted. "If the rate is right, you can place it. Bad rates equal less capacity."

But while asserting "There is no capacity problem in the reinsurance market today," Mr. Springbett suggested that the reinsurance broker's task of selecting stable markets is difficult. "The motto used to be utmost good faith in our business and now it is caveat emptor—let the buyer beware.

"Our worry is will the reinsurer be able to pay," he said, citing concerns about solvency, exchange control freedoms and who the reinsurers of the reinsurer are.

While it is easy to assess the financial condition of U.S. companies because they file extensive financial reports with state insurance departments, assessing insurers in other countries is more difficult, Mr. Springbett said. There can be language problems, accounting inconsistencies, varying degrees of disclosure and poor auditing standards.

Reinsurance brokers formerly used all reinsurance companies available but today use very few, Mr. Springbett said. "There are billions of dollars today in outstanding premiums and claims due worldwide. We have an accounting mess."

Mr. Kellogg discussed how reinsurers will support alternative funding facilities: in the same way they support standard companies.

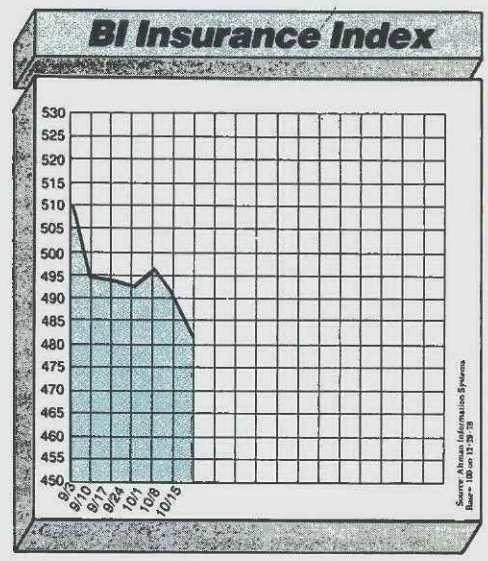
When considering whether to provide reinsurance to an alternative funding facility, the reinsurer will consider the facility's capital, backing and claims handling programs. Since reinsurers do not generally offer unbundled services such as claims handling, the reinsurer will want to know who will handle claims and what the claims handling philosophy will be, Mr. Kellogg said.

Mr. Kellogg noted that reinsurers are increasingly supporting self-insurers and alternative risk financing facilities. "If there is a legal entity, reinsurers are willing to work with it. Sometimes we work through established insurers and sometimes directly with the alternative facility."

Observing that the insurance market is becoming competitive again, session moderator P. Richard Hackenburg, executive vp of Corroon & Black of Massachusetts in Boston, asked what reinsurers are doing to prevent the primary insurers from committing wholesale suicide and how risk managers can access a more stable funding program.

Mr. Kellogg responded that he has "heard of large corporations canceling and rewriting programs with no concern for the security of the markets."

He added: "I do not believe the reinsurance market is contributing as much to the softness as in the late 1970s. Since 1984, many larger U.S. insurers have increased the size of their net retention to take advantage of the upturn in rates. At this juncture, I believe if they tried to cut back those nets, they would not be successful." ■



In the face of last week's market uncertainty, insurance industry stocks plummeted for a second week, as the *Business Insurance* stock index fell 8.9 points to 482.9 on Oct. 15 from 491.8 on Oct. 8. Advancing issues were led by: SCOR U.S. Corp., up 8.3%; SAFECO Corp., up 5.9%; The St. Paul Cos. Inc., up 5.3%; Tokio Marine & Fire Insurance Ltd., up 4.6%; and Travelers Corp., up 3.4%. Declining issues were led by: Frank B. Hall & Co. Inc., down 12.4%; American Indemnity Financial Corp., down 8.9%; USLIFE Corp., down 7.6%; Sears Roebuck & Co. (Allstate Insurance Co.), down 7.5%; and Washington National Corp., down 7.4%. Issues showing the most activity during the period were: Sears Roebuck & Co., 4.2 million shares traded; ITT Corp. (Hartford Insurance Group), 3.0 million shares traded; The St. Paul Cos. Inc., 2.5 million shares traded; and SAFECO Corp., 2.3 million shares traded. The *Business Insurance* index slipped 1.8% for the week, a fraction of the decline in the leading market indicators: The Dow Jones 30 Industrials lost 161.55 points, a 6.4% decline; the Standard & Poor's 500 dropped 16.09 points, a 5.1% decline; and the New York Stock Exchange composite fell 8.87 points for a 5.0% loss.

British Issues

Oct. 14 Companies	Price pence	P/E	Div. pence	Yield %	1 Week High—Low pence	pence
Comml Union	452	16.7	17.8	3.9	459—	441
Genl Accident	1133	11.6	38.3	3.4	1162—	1125
Gdn Royal Exch	1085	13.6	46.5	4.3	1100—	1085
Royal	572	9.7	21.2	3.7	588—	572
Sun Alliance	1213	13.3	32.2	2.7	1300—	1213
Brokers						
CE Heath	543	17.4	34.5	6.3	543—	523
Hogg Robinson	227	13.8	9.6	4.2	238—	225
JH Minet	394	14.4	12.9	3.3	400—	394
Sedg Grp	287	16.9	16.4	5.6	298—	287
Willis Faber	390	15.3	14.8	3.7	418—	390

Source: Philip Olsen/Alan Clifton, Insurance Industry Specialists Kitcat & Aitken Stockbrokers, London

Disease notification bill

Continued from page 1

workplace hazards.

The House also rejected a provision that would have barred medical malpractice suits against doctors who examine workers in connection with the bill's requirements.

Doctors fearing malpractice suits may recommend mass transfers of employees to less hazardous jobs, which may in turn prompt corporations to sue the doctors for resulting economic damages, noted Victor Schwartz, a partner in the Washington, D.C., law firm of Crowell & Moring and counsel for The Product Liability Alliance.

"The doctors are exposed like a rear end in the doctor's office," Mr. Schwartz observed.

While supporters maintain that the legislation is "tort neutral"—i.e., that it does not create any new tort liabilities—opponents fear it will trigger a tidal wave of employee lawsuits and workers compensation claims, as well as contribute to rising health care and personnel costs.

The bill would encourage three worrisome legal trends, Mr. Schwartz said: the rise of emotional distress claims, an increase in employee tort lawsuits against employers and weakening standards of causation in occupational disease claims.

"There's a little fire out there and this is liquid kerosene," he said of the legislation.

The legislation could create massive legal problems for employers despite an amendment to the House bill—obtained by corporations and industry groups in return for their support—barring a worker's use of an exposure notification as the basis for a tort claim or as evidence in court, opponents say.

Though the provision bars use of the notice itself, it does not block the use of other file materials that the Risk Assessment Board gathers to support its conclusion that an employee has been exposed, Mr. Schwartz noted. "The board has done 80% to 85% of the plaintiff's work for him," he observed.

Mr. Cheek pointed out several possible revisions, if the legislation is amended further in the Senate, including:

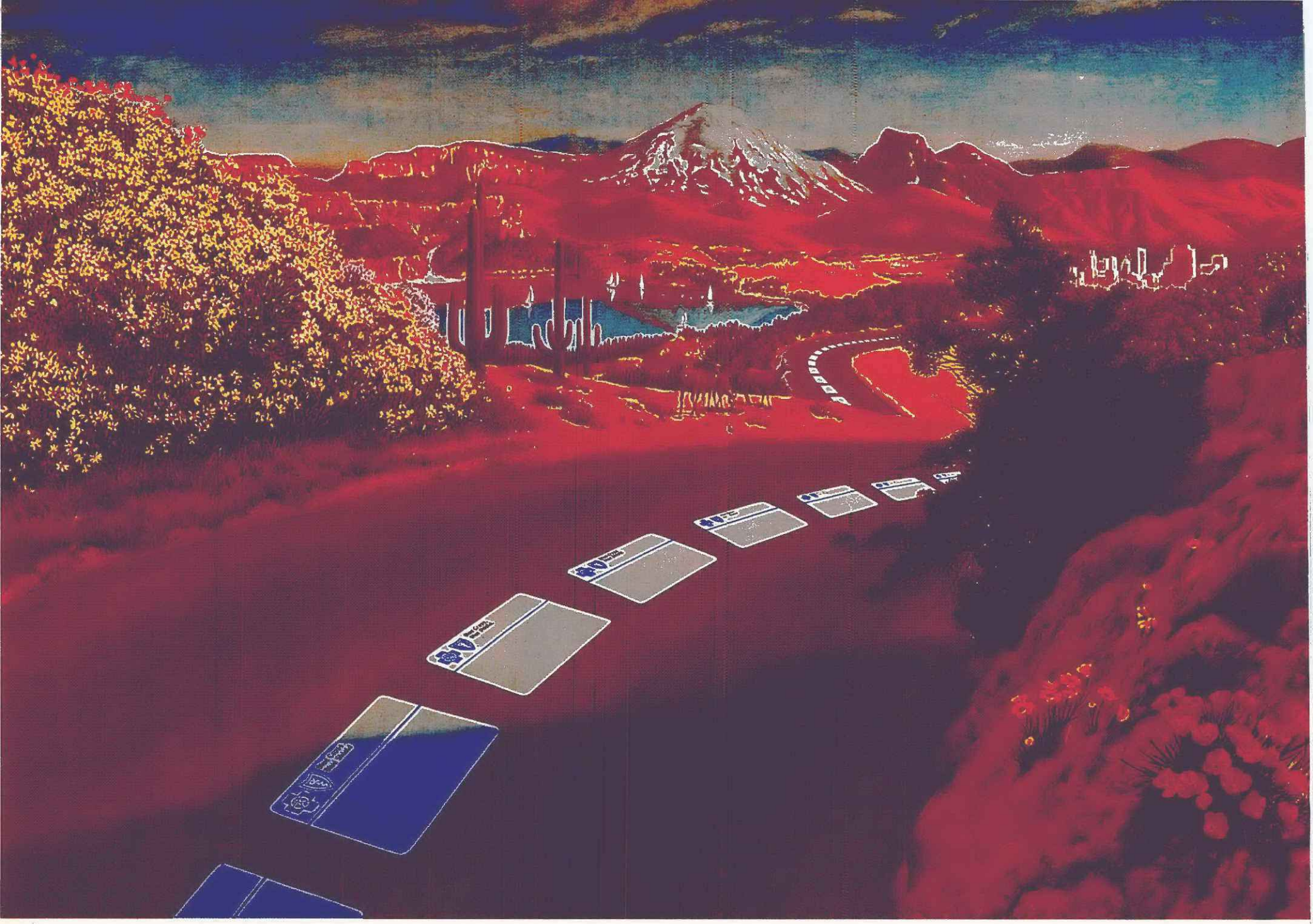
- A more extensive prohibition against the use of Risk Assessment Board materials in worker lawsuits against employers.
- Shortening the retroactive provision for notice to former employees from 30 years to perhaps 10 years.
- Holding Risk Assessment Board members accountable to political officials such as the secretary of Health and Human Services. ■

BI Industry Stock Report

OCT. 15, 1987 10/9/87 THRU 10/15/87

		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 Svcs	NYSE	26.50	-3.6	0.0	32.00	22.38	532	1.00	3.8	23.5	2.98	8.89
Baldwin & Lyons Inc.	OTC	16.00	0.0	-27.3	27.00	17.25	0	0.20	1.3	6.4	16.40	0.98
Corroon & Black Corp.	NYSE	33.00	1.5	1.1	37.50	26.63	768	0.84	2.5	15.3	6.31	5.23
Gallagher Arthur J. & Co.	OTC	19.25	-1.9	-26.7	31.00	19.00	22	0.40	2.1	14.5	4.81	4.00
Hall Frank B. & Co.	NYSE	7.88	-12.4	-45.7	19.00	7.63	88	0.00	0.0	14.5	0.00	N/A
Marsh & McLennan Cos. Inc.	NYSE	63.63	3.0	4.7	72.00	56.00	653	2.40	3.8	16.5	5.14	12.38
Poe & Assoc Inc.	OTC	10.00	0.0	-16.7	13.25	10.00	0	0.40	4.0	9.7	0.57	17.54
BROKERS	AVERAGE		-1.9	-15.8					2.5	14.3		
CONGLOMERATES & HOLDING COMPANIES												
Berkley W.R. Corp.	OTC	26.75	0.9	1.9	37.00	24.25	350	0.28	1.0	7.6	13.72	1.95
Berkshire Hathaway Inc.	OTC	4050.00	-0.5	43.6	-3792.00	2510.00	138	0.00	0.0	27.9	62.53	4.21
CIGNA Corp.	NYSE	65.50	-1.1	19.1	69.50	55.00	645	2.80	4.3	8.4	42.01	1.56
CNA Fin'l Corp.	NYSE	61.25	-1.0	14.0	66.50	47.25	367	0.00	0.0	12.4	42.71	1.43
General Re Corp.	NYSE	59.63	-1.2	7.4	68.88	47.63	1527	1.00	1.7	16.0	23.47	2.54
ITT (Hartford Group)	NYSE	61.88	-0.4	15.9	66.38	50.00	3031	1.00	1.6	13.7	44.08	1.40
Sears Roebuck & Co. (Allstate)	NYSE	45.00	-7.5	13.2	59.50	39.88	4219	2.00	4.4	10.9	32.94	1.37
Transamerica Corp.	NYSE	39.00	-5.2	19.5	51.38	31.50	905	1.84	4.7	7.4	26.94	1.45
CONGLOMERATES	AVERAGE		-2.0	16.8					2.2	13.0		
INSURERS												
Aetna Life & Cas Co.	NYSE	59.88	-0.4	5.7	68.13	55.75	1411	2.76	4.6	8.4	44.75	1.34
American General Corp.	NYSE	35.00	-4.1	-5.1	44.75	34.88	972	1.25	3.6	9.4	27.13	1.29
Amer Heritage Life Invt	NYSE	28.50	-0.9	11.0	34.00	25.75	0	0.96	3.4	14.0	20.37	1.40
Amer Indty Fin'l Corp.	OTC	12.75	-8.9	-29.2	19.00	12.75	23	0.56	4.4	14.0	20.40	0.63
American Int'l Group Inc.	NYSE	77.50	-0.3	26.8	83.75	60.00	1408	0.30	0.4	15.4	29.02	2.67
Aneco Reins Ltd.	OTC	3.63	0.0	70.4	4.38	2.13	66	0.00	0.0	15.4	1.93	1.88
Aon Corp.	NYSE	27.75	-0.9	5.2	29.88	23.25	343	1.20	4.3	9.6	15.23	1.82
Argonaut Group	OTC	45.50	-5.0	116.7	52.13	21.00	102	0.00	0.0	14.0	14.60	3.12
AVEMCO Corp.	NYSE	22.38	-2.7	-14.7	25.25	13.25	60	0.28	1.3	14.1	6.94	3.22
Belvedere Corp.	AMEX	5.50	-6.5	-36.3	9.13	4.75	1	0.01	0.2	14.1	6.71	0.82
Business Mens Assurn Co.	OTC	42.00	-7.2	62.3	48.25	25.25	235	1.10	2.6	14.1	22.15	1.90
Chubb Corp.	NYSE	68.00	1.9	14.8	73.50	53.75	757	1.88	2.8	9.6	39.52	1.72
Continental Corp.	NYSE	46.00	-1.1	2.8	54.88	40.38	754	2.60	5.7	9.1	41.62	1.11
Durham Corp.	OTC	27.75	-0.9	0.3	34.00	27.25	3	0.92	3.3	18.1	26.15	1.06
Farmers Group Inc.	OTC	48.50	-0.5	25.2	51.25	38.75	1294	1.20	2.5	14.7	19.95	2.43
Fireman's Fund Corp.	NYSE	36.13	-3.3	2.8	42.75	33.50	400	0.40	1.1	14.7	23.55	1.53
Fremont Gen Corp.	OTC	14.63	0.9	-9.3	20.50	14.25	96	0.60	4.1	14.7	16.75	0.87
Home Group Inc.	NYSE	16.50	-7.0	-21.4	24.88	17.38	422	0.20	1.2	3.6	16.30	1.01
Hanover Ins Co.	OTC	34.25	-0.7	7.9	37.25	29.50	51	0.36	1.1	7.8	20.91	1.64
Hartford Steam Boiler	OTC	27.75	-5.1	17.7	36.63	23.50	110	1.00	3.6	11.5	10.17	2.73
Kansas City Life	OTC	31.00	0.8	20.4	31.50	25.75	0	0.00	0.0	11.5	0.00	N/A
Kemper Corp.	OTC	30.00	-1.6	20.0	38.75	25.00	773	0.60	2.0	9.6	23.48	1.28
Liberty Corp. S.C.	NYSE	48.75	-3.0	32.7	53.00	36.50	12	0.80	1.6	18.9	19.96	2.44
Lincoln Nat'l Corp.	NYSE	48.88	-5.5	5.4	60.50	44.38	147	2.16	4.4	9.8	44.85	1.09
NAC Re Corp.	OTC	25.75	3.0	-1.9	32.25	22.50	97	0.00	0.0	33.0	18.12	1.42
Nobel Ins Ltd.	OTC	13.00	0.0	-20.0	18.50	10.75	9	0.00	0.0	33.0	9.04	1.44
Northwestern Nat'l Life	OTC	27.63	-4.3	-10.9	32.38	24.00	83	0.96	3.5	7.8	33.26	0.83
Ohio Cas Corp.	OTC	44.13	0.3	14.2	49.25	38.50	148	1.68	3.8	10.8	26.80	1.65
Old Rep Int'l Corp.	OTC	27.50	-0.9	0.4	33.63	23.63	45	0.74	2.7	9.2	19.80	1.39
Orion Cap Corp.	NYSE	20.88	-5.1	-23.0	31.00	20.00	28	0.76	3.6	9.2	9.39	2.22
Phoenix Re Corp.	OTC	10.00	0.0	-23.1	14.63	9.75	10	0.00	0.0	9.2	0.00	N/A
Protective Corp.	OTC	14.75	-4.8	-18.1	21.25	12.38	88	0.70	4.7	12.7	16.51	0.89
Provident Life & Acc Ins Co.	OTC	21.00	-4.0	-14.7	28.75	19.13	155	0.84	4.0	16.4	27.00	0.78
St. Paul Cos. Inc.	OTC	57.00	5.3	41.6	57.00	40.25	2522	1.76	3.1	10.6	29.89	1.91
SAFECO Corp.	OTC	35.75	5.9	33.6	38.00	24.38	2299	0.96	2.7	12.4	19.68	1.82
SCOR US Corp.	OTC	13.00	8.3	13.0	16.25	11.00	123	0.00	0.0	11.9	8.08	1.61
Seibels Bruce Group Inc.	OTC	15.25	-6.2	3.4	19.00	14.25	50	0.80	5.2	10.1	11.88	1.28
Selective Ins Group Inc.	OTC	24.75	0.0	13.8	27.50	21.00	77	1.08	4.4	7.9	16.02	1.54
Statesman Group Inc.	OTC	5.13	-4.6	8.0	7.06	3.88	70	0.05	1.0	7.9	5.19	0.99
Tokio Marine & Fire Ins	OTC	76.38	4.6	36.6	103.38	63.88	332	0.19	0.2	64.7	0.00	N/A
Torchmark Corp.	NYSE	31.75	3.3	22.1	36.75	23.75	874	1.00	3.1	11.4	13.01	2.44
Travelers Corp.	NYSE	46.00	3.4	3.1	52.63	41.50	851	2.28	5.0	9.5	45.03	1.02
Trenwick Group Inc.	OTC	12.75	-1.9	-22.7	19.13	11.50	2	0.00	0.0	15.7	13.83	0.92
United Fire & Cas Co.	OTC	29.50	-3.3	-10.6	33.00	26.50	2	0.96	3.3	8.7	18.32	1.61
United States Fid & Gty	NYSE	38.13	-4.4	-4.1	48.75	37.00	883	2.48	6.5	8.2	20.19	1.89
UNUM Corp.	NYSE	23.63	-0.5	-12.1	31.38	20.38	633	0.40	1.7	8.2	26.81	0.88
USLIFE Corp.	NYSE	36.25	-7.6	-16.7	47.63	34.75	140	1.12	3.1	9.3	43.09	0.84
Washington Nat'l Corp.	NYSE	33.00	-7.4	3.1	37.88	23.25	46	1.08	3.3	19.3	32.80	1.01
Zenith Nat'l Ins Corp.	NYSE	20.00	-7.0	-24.5	24.00	19.88	164	0.80	4.0	19.3	11.19	1.79
INSURERS	AVERAGE		-1.8	6.6					2.6	13.5		
ALL COMPANIES	AVERAGE		-1.9	5.4					2.5	13.5		

System design: MPACT Securities



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