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Update

Court deals Travelers a defeat in dispute with N.F.L. teams

NEW YORK—A state trial court has dismissed a suit by Travelers Insurance Co. against half the teams in the National Football League, its commissioner and its president.

Travelers acted as the fronting insurer for a workers compensation program for 14 N.F.L. teams that was reinsured by the league's Bermuda-domiciled captive, N.F.L. Insurance Ltd. The captive was ordered into liquidation last year (*BI*, Sept. 16, 1991).

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Asbestos fund proposed

Keene plan would bar tort suits, punitive damages

By MICHAEL SCHACHNER

NEW YORK—A major asbestos defendant wants Congress to enact a federally administered fund that would be the exclusive remedy for thousands of pending and future asbestos-related injury claims.

Keene Corp. last week unveiled the framework for what it believes is a workable system under which asbestos defendants and their insurers would initially contribute approximately $250 million per year to pay claims.

Under the proposal, the fund would compensate "deserving" claimants based on a percentage of the average value of previously resolved cases. Punitive damages would not be paid by the fund.

The fund would be managed by a claims board within the U.S. Department of Labor.

According to Keene's outline, the board would annually determine the amount to be maintained by the fund for the following year. That determination would be binding on asbestos defendants.

The legislation would permit defendants to enter into an agreement among themselves as to how much each asbestos producer would contribute. If no agreement is reached, the board would have the authority to determine contributions based on various criteria, including market share, the number of claims facing each defendant and the companies' current net worth.

Keene says this type of claims facility would not only aid defendants and claim-

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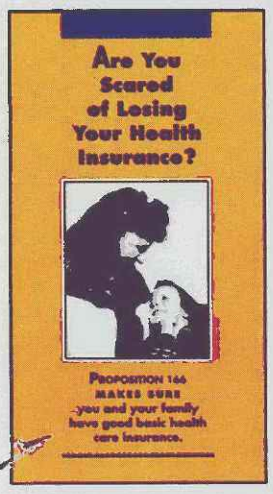
Health care initiative draws fire

By LOUISE KERTESZ

SACRAMENTO, Calif.—A coalition of strange bedfellows—business, labor, health insurers and Insurance Commissioner John Garamendi—are fighting a physician-backed ballot initiative that would require California employers to offer a basic health plan.

Both sides will blitz voters in the next few weeks through TV spots and other advertising to ram home their thoughts about the initiative, Proposition 166.



A Field poll last week showed 46% of voters in favor of Proposition 166. Only 26% were opposed.

The California Medical Assn., which is sponsoring the ballot initiative, won't say how much it will spend to rally support; opponents represented by the Consumer Health Insurance Coalition could spend up to $3.5 million to fight the proposal.

The coalition maintains that California—already in the midst of its worst economic downturn in decades—would suffer a net loss of 375,000 jobs if all employers had to offer a minimum health care plan.

Requiring all employers to offer a health care plan would be "like throwing ice water on an economy that is already in a deep freeze," said a coalition spokeswoman.

Opponents also say that Proposition 166 is flawed because it only recommends but does not establish cost controls.

The proposition is "bad medicine and bad law," said Alan Katz, president of the Reseda-based California Assn. of Health Underwriters, an agent/broker group. However, "There is a real danger it will pass."

The measure "would place an intolerable burden on too many California employers, especially medium-sized and small

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New retiree health strategy tested

By CHRISTINE WOOLSEY

ST. LOUIS—Companies that want to buy some time before deciding whether to eliminate retiree medical benefits can follow the lead of McDonnell Douglas Corp.

In a novel approach, the defense contractor is attempting to dodge the FAS 106 bullet by replacing its non-union retiree medical benefit plans with a four-year, retiree-pay-all health plan funded by surplus defined benefit pension plan assets.

Beginning this week, 20,000 non-union retirees will be offered a one-time pretax pension supplement of $18,000 that can be used only to prepay the cost of retiree health care coverage for the next four years. Those who choose not to buy health care from the company will get no payment and will lose their retiree health benefits. Retirees must make a choice before the Nov. 20 enrollment deadline.

Consultants say this strategy is ingenious for companies with a high proportion of retirees to active employees and that need to soften the blow of Financial

McDonnell Douglas taps surplus pension assets

Accounting Standard 106 to their financial statements.

But they point out that the strategy requires substantial pension plan surpluses. And the plan poses tax disadvantages for retirees, who will have to pay income taxes on the one-time pension supplement.

Moreover, after four years, the question of what to do about retiree health care benefits will come up again—as will the FAS 106 obligation.

"We felt four years was a solid length of time to give retirees assurance that their medical benefits would be paid for," a McDonnell Douglas spokeswoman said. During that time, the company will examine other alternatives to provide retiree health care benefits.

However, McDonnell Douglas officials may be counting on the federal government to set up some sort of universal health plan within the next four years. Even if no such plan materializes, McDonnell Douglas does not plan to restore the retirees' benefits, though. "We will not return to company-funded (retiree) health care after 1996," the spokeswoman said.

To account for its accumulated retiree health liabilities, McDonnell Douglas would have had to take a staggering one-time charge of $1.2 billion to $1.5 billion. Using the pension funds will trim that charge in half, to about $600 million or $700 million. The company, which self-insures its health care benefits, hopes to eliminate the FAS 106 charge altogether by persuading 20,000 more retirees from roughly seven unions to adopt a similar plan, the spokeswoman said.

Under the new plan, non-union retirees will be asked whether they want to continue receiving McDonnell Douglas health care coverage beginning Jan. 1, 1993. If they say yes, the company will transfer to them the one-time pension supplement of

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Tort costs grow faster than economy

By SARA J. HARTY

Costs associated with the U.S. tort system have grown almost four times faster than the U.S. economy over the past half-century, a new study finds.

Yet only a fraction of that money actually winds up in the pockets of tort victims, the study shows.

The U.S. tort system cost $132.2 billion in 1991, which includes insured and self-insured claims payments, administrative costs and attorneys' fees, according to Tillinghast, a Towers Perrin unit.

According to Tillinghast, tort costs have increased 385 times from 1933 to 1991, while the gross national product increased only one-hundred-fold over the same period.

Total 1991 tort costs break down as follows: Insured costs—excluding medical malpractice—were $102 billion; self-insured costs were $21.1 billion; and medical malpractice costs were $9.1 billion.

Medical malpractice costs are broken out because the distinction between insured and self-insured costs is blurred for these types of claims.

Of the total tort costs, consumers pay about $63 billion, of which roughly $60 billion, or 95%, is insured, Mr. Sturgis said. Businesses pay $69 billion, of which about $47 billion, or 68%, is insured, he said.

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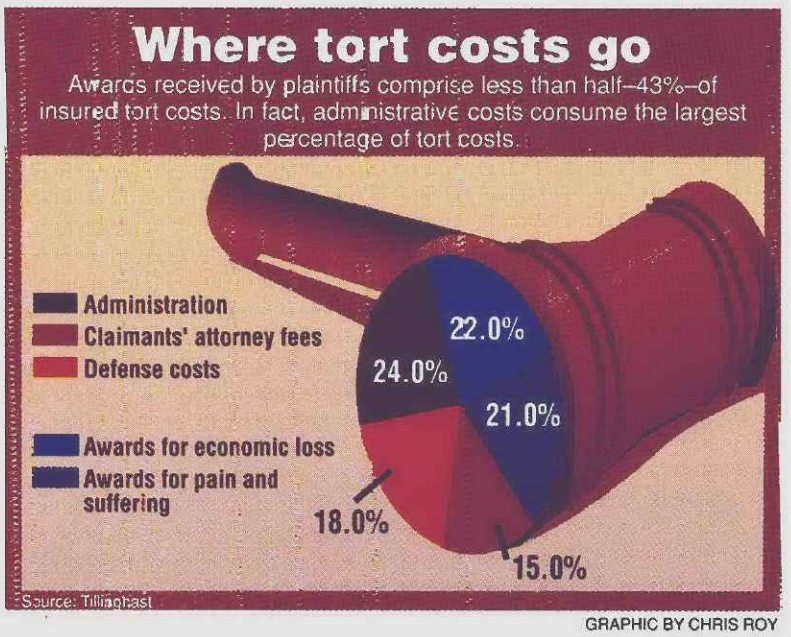

GRAPHIC BY CHRIS ROY

Update

NFL captive suit dismissed

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Travelers, which charged the defendants with breach of contract and tortious interference, sought to recover $3 million in unreimbursed claims. The insurer attempted to assert its breach of contract claim directly against the teams and the league by arguing that the court should pierce the captive's corporate veil to reach the defendants.

After ruling that Bermuda law would apply to the claim, the judge on Oct. 5 concluded that there was not sufficient grounds to pierce the corporate veil.

In dismissing the tortious interference claim, the judge ruled that Travelers failed to show that the defendants' interference—the refusal to allow Travelers to collect directly from the teams—was prompted by malice or other improper motives.

Travelers has not indicated whether it will appeal.

Skandia America chief resigns

NEW YORK—James F. Dowd, Skandia America Corp.'s chairman and chief executive officer, resigned abruptly last week just two weeks after the cancellation of an initial public offering.

No successor has been named as CEO, though Johannes Norrby, executive vp and controller of parent Skandia Group, has been temporarily named chairman.

According to Mr. Norrby, Mr. Dowd's resignation resulted from a disagreement with Skandia Group over his desire to expand Skandia America and increase its U.S. presence.

Skandia has no plans to revive the stock offering, Mr. Norrby said. Mr. Dowd said the offering had been oversubscribed at $18 per share (*BI*, Oct. 5). The common stock offering would have raised $162 million, while proceeds from the sale of $60 million in preferred stock would have been used to buy back common stock.

The sale would have reduced Skandia Group to a minority share of the company's voting stock. Mr. Dowd described the withdrawal as a "pure economic decision" and said Skandia was prepared to renew the IPO when the timing was right.

Mr. Dowd, who has spent 21 years at Skandia, will continue as a consultant, the company said.

GM to release documents

FORT WORTH, Texas—Consumer advocates last week won a fight to have General Motors Corp. release all documents related to a product liability lawsuit it settled in March.

Public Citizen, the Washington-based consumer group, filed an action after the settlement asking that the auto maker release documents from the case as required by a 1990 state law.

The lawsuit involved a 1989 crash in Arlington, Texas, that killed the driver of a 1987 Chevrolet pickup truck when it burst into flames. The suit charged the truck was installed with an unsafe fuel tank.

Public Citizen wants GM to recall trucks with similar fuel tank designs and asked a Texas District Court to order the company to release documents that it believes will show that GM fitted more than 9 million trucks with the allegedly unsafe tanks.

GM, which last week agreed to release the documents, said that it wanted to keep the documents secret because they contained proprietary information. It says the papers show it acted responsibly in making the trucks crash-worthy.

In a statement, GM said Public Citizen and a "small group of trial lawyers with vested financial interests in products liability litigation against General Motors" waged a battle to gain proprietary information.

Texaco tallies refinery damage

WILMINGTON, Calif.—A Texaco Inc. hydrocracking unit that was destroyed in the Oct. 8 explosion at a refinery near Los Angeles could cost more than $100 million to replace.

The complex device, which separates hydrogen from crude oil before the oil is converted into gasoline, was in a section of the refinery "decimated" by the explosion and subsequent fire, confirmed Daniel Grogan, assistant general manager-risk management for Texaco in White Plains, N.Y.

Precise damage estimates will not be available until this week.

Mr. Grogan has said that total losses from the explosion and fire could total "hundreds of millions of dollars" (*BI*, Oct. 12).

Researchers at the Factory Mutual System in Boston said that installing a new hydrocracker can cost anywhere from $10 million to $200 million, depending on its exact functions.

"They're all custom-made, and price depends on capacity, the type of crude oil they're processing and the chemical properties of that crude," said a Factory Mutual spokeswoman.

Hall agrees to sell Adjustco

WILTON, Conn.—Managed care company Preferred Health Care Ltd. has signed a letter of intent to acquire third-party administrator Adjustco Inc. from broker Frank B. Hall & Co. Inc. for $7.3 million.

Wilton, Conn.-based PHC will integrate Adjustco's workers com-

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Errors & omissions

• Travelers Corp. will not acquire 100% of Transport Life Insurance Co. as part of its agreement with Primerica Corp. (*BI*, Sept. 28). However, Travelers will acquire Transport Life's third-party administration unit and its preferred provider organization.

State Farm's $2.1 billion Andrew loss a record

By SALLY ROBERTS and MICHAEL BRADFORD

For the second consecutive week, an insurer's updated estimate of Hurricane Andrew losses is thought to be the largest gross loss ever reported by a U.S. insurer for a single event.

In addition, hurricane-related losses have forced two more small Florida property/casualty insurers into liquidation.

State Farm Group last week raised its estimate of losses stemming from Hurricane Andrew to $2.1 billion from $1.6 billion. State Farm's updated figure surpasses Allstate Insurance Group's gross loss estimate of $1.73 billion (*BI*, Oct. 12).

State Farm does not buy reinsurance.

A State Farm spokesman said its losses are higher than initially estimated because the insurer could not account for homes that did not meet building codes for wind resistance. In South Florida, many of "the houses didn't hold up" because they were not built strong enough, he said.

State Farm's loss estimate is based on nearly 150,000 claims in Florida and Louisiana.

State Farm earlier this month added $2 billion to the surplus of its State Farm Fire & Casualty Co. unit to cover losses stemming from Hurricane Andrew and Hurricane Iniki.

Allstate's losses have prompted A.M. Best Co. to place the insurer's consolidated A rat-

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Policyholder can direct claims to certain insurers

'Additional insured' ruling

By SARA J. HARTY

CHICAGO—Illinois policyholders named as additional insureds on liability policies may have more discretion in selecting which insurer should respond to a lawsuit following a recent state appeals court ruling.

By tendering a claim to another company's insurer rather than its own, a policyholder could help prevent loss experience from driving up premiums under its own policy.

The ruling is the first in Illinois to expressly allow additional insureds to select which policy should respond to a claim.

Few appeals courts in other states—and none in Illinois—had previously considered the issue because defendants usually notify all insurers that could possibly cover a claim, including both their own insurers and those that write policies that list the defendant as an additional insured.

Litigation over coverage for additional insureds typically involves disputes between general contractors and subcontractors. The Aug. 28 Illinois ruling involved such a dispute, though insurance lawyers say the ruling also could apply in some landlord-tenant or retailer-manufacturer contexts.

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Deadlines approach for two *BI* directories

The deadlines to return questionnaires for two *Business Insurance* directories are rapidly approaching.

BI will publish its annual directory of employee benefit consultants in the Dec. 21 issue, which will also contain a spotlight report forecasting trends in the employee benefit market in 1993. The deadline for returning completed questionnaires is Nov. 2.

In addition, questionnaires are still being accepted for the fifth annual Managed Care Market Report, which will be published in mid-December. The report will list health maintenance organizations and preferred provider organizations nationwide. The extended deadline for returning questionnaires is Oct. 28.

The directories are published as an editorial service; there is no charge to be included. Participants just need to fill out and return a questionnaire provided by *BI*.

If you would like an employee benefit consultant questionnaire, please call Kathy Welyki at 312-649-5279. HMOs that have not received a questionnaire should call Cindy Bloom at 312-280-3195. PPOs should contact Kerry Dziubek at 312-649-5398.

GATT negotiators try to break down persistent barriers

By LAURA MAZZUCA

As the clock ticks out the last weeks of 1992, negotiators participating in talks for the stalled Uruguay Round of the General Agreement on Tariffs and Trade are attempting to hammer out a last-minute consensus on issues that have held up the talks for two years.

Countries participating in the GATT talks are meeting this week in Geneva in a round of bilateral talks to address liberalizing insurance, banking, transportation and other service industries.

In an attempt to smooth over disputes about farm-trade reforms, trade representatives from the United States and the European Community met Oct. 10 in Brussels, Belgium. And, trade representatives from the United States, the European Community, Canada and Japan were meeting again last week in Canada to discuss trade and other issues.

The two-day Brussels talks ended in another stalemate, again primarily due to the failure of the United States and European Community nations to agree over agricultural issues like farm subsidies. This impasse, coupled with foreign negotiator skittishness over the outcome of the U.S. presidential election next month, may derail a final GATT agreement yet again, some negotiators say.

Others fear that unless an agreement on GATT is reached before year end, the failure will sound the death knell for

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✔ Senate candidates offer their views on health care reform and other industry issues. **PAGE 18**

✔ Insured losses from the Cairo earthquake are low, but the city's faulty construction courts disaster. **PAGE 31**

✔ The nations's workers comp system needs intensive care, participants said at a recent joint meeting of insurer and brokerage executives. **PAGE 34**

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East meets West at Singapore meeting

China opens door to new investment

By STACY SHAPIRO

SINGAPORE—China is once again a hot topic for foreign investors and risk managers.

While companies investigate the opportunities there, the Chinese government is considering new insurance legislation. And American International Group Inc.—which traces its roots to an insurance agency started in Shanghai in 1919—earlier this month became the first 100% foreign-owned insurer licensed to operate in the country in more than 40 years.

Many foreign investors steered clear of China after the 1989 massacre of students demonstrating for democracy in Tiananmen.

Earlier this year, however, China's 88-year old leader Deng Xiaoping toured burgeoning Southern China, which has had an open-door foreign investment policy for 10 years. This tour "represented the most senior endorsement of the open-door policy of economic reform and rapprochement with the international community since the 1989 Tiananmen incident," said John Williams, chief executive of the liaison office of Sedgwick Group P.L.C. in Beijing.

Last week's 14th congress of China's Communist Party in Beijing also was expected to "endorse the open-door policy of reform and even take steps to open the door wider to international contacts," said Mr. Williams.

As a result, he said, "Confidence is now running at an all-time high. New industries and companies are starting throughout China, and more freedoms are being allowed these new companies. The confidence has also spread overseas, and foreign funds are pouring into China."

China is not for the fainthearted, however, warned Kailin Tuan, professor of risk management, insurance and international business at Temple University in Philadelphia.

Oriental dragons danced at the Asia-Pacific Risk Management Conference in Singapore this month. Delegates later heard about China's new insurance regulations.

Asia Pacific Risk Management Conference

"Now is the best time to come to China," he told the 150 delegates at the third Asia-Pacific Risk Management Conference and Trade Exhibition, held Oct. 4-7 and hosted by the Risk & Insurance Management Society Inc. and the Risk & Insurance Management Assn. of Singapore.

However, foreign investors must expect further political disruptions like the student massacre in Tiananmen Square, said Mr. Tuan. "Tiananmen Square is only a blip in the large history of China. . .China always goes forward, then backward.

"If you're scared, don't go to China," Mr. Tuan added.

The first risk management rule for investing in China is to take a "long view"

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Globalization tests risk management

By JOANNE WOJCIK

SINGAPORE—Economic globalization has created the demand for a new breed of risk manager who can effectively meet a company's needs amid diverse cultures in international markets.

Organizations like the Risk & Insurance Management Society Inc. and the International Federation of Risk & Insurance Management Assns. must be instrumental in supporting and educating tomorrow's risk managers, risk management experts say.

And support service providers, like brokers, also can prove valuable to risk managers seeking to enhance their global expertise, they contend.

As the world moves toward a "global fit" based on increased interdependence among all producing and consuming nations, risk managers from Western countries are studying risk situations in the Pacific Rim, said Suzanne Crager, president of RIMS.

Meanwhile, their Asian counterparts are pursuing a better understanding of advanced risk management practices developed by Western companies, she added during a keynote address at the Third Asia-Pacific Risk Management Conference and Trade Exhibition held Oct. 4-7 in Singapore.

"Increasing numbers of risk managers in the United States and Canada are faced with the necessity of understanding risk conditions in various nations of the world," pointed out Ms. Crager, assistant vp-risk management and insurance for PNC Financial Corp. in Pittsburgh.

"Their companies may be exporting

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401(k) administration options

By SALLY ROBERTS

As benefit consultants and large mutual fund companies battle it out for a share of the 401(k) plan administration market, the ultimate winner could be the employer sponsoring the plan.

By absorbing some record-keeping costs within their investment management fees, mutual fund companies are providing 401(k) record-keeping services at a significant discount over the fees charged by benefit consultants.

Mutual fund firms also offer their package of investment options with daily account valuations, more frequent transactions and employee communication services.

This "one-stop-shop" has given the mutual fund companies an edge in the 401(k) administration market, according to Robert G. Wuelfing, president of Access Research Inc., a benefit research firm in Windsor, Conn.

Market competition benefits employers

But benefit consultants are putting up a fight. They contend that the investment options available to plan participants are often limited to those offered by the mutual fund company.

Some benefit consulting firms —which dominate the record-keeping market—are closing the gap in terms of fees. And, several have formed alliances with investment managers and trustees to offer employers virtually the same one-stop shopping as the large mutual fund firms, at competitive prices.

Either way, record-keeping costs are lower for employers, consultants say.

"The basic guiding forces for employers looking for a 401(k) plan administrator is trying to get the best investment services for the lowest cost," said Harry Gross, a partner with Kwasha Lipton in Fort Lee, N.J.

For the employer, choosing between a mutual fund company and a benefit consultant allied with an investment manager is a "best of both worlds-type scenario," because both are offering lower prices, said Jim Rushin, a consultant with Hewitt Associates in Lincolnshire, Ill.

Hewitt, for example, recently announced the details of a new 401(k) administration alliance with six money managers, including: American Funds; Dreyfus Group; Kemper Financial Services; Neuberger & Berman; The Putnam Cos.; and 20th Century Mutual Funds.

Also included in the alliance is The Northern Trust Co., which acts as the trustee; LaSalle National Trust and PRIMCO Capital Management Inc., which act as guaranteed investment contract managers; and Wells Fargo Nikko Investment Advisors, an index fund manager.

The alliances can "trade at the

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Comp costs rise despite fee caps

By LOUISE KERTESZ

SAN FRANCISCO—State caps on doctor and hospital fees have done little to hold down the cost of caring for injured workers in California, according to an insurer-funded report.

Workers compensation medical costs—which include physician fees and hospital payments—increased to 49.1% of claims costs in 1989 from 39.4% in 1971. In 1989 alone, workers comp medical costs in California increased by $210 million, according to data from the California Workers' Compensation Insurance Rating Bureau.

That information was included in the report on the state's official medical fee schedule by the California Workers Compensation Institute, an insurer group.

The official fee schedule does hold down the cost of individual medical procedures, the CWCI report said. But it "does nothing to control the cost of unregulated procedures or overall utilization."

Also, the fee schedule has not been updated since 1987, and it does not adequately reflect many procedures physicians now use to care for injured workers, the CWCI report said. This situation "encourages creativity" in physician billing, said Alan Tebb, CWCI general manager.

Pressed by restrictions on their fees, doctors apparently have been prescribing more services. "If you squeeze the balloon it's going to pop out somewhere else," Mr. Tebb said. "The message of the re-

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Supreme Court to define expert witness testimony

By MARK A. HOFMANN

WASHINGTON—The U.S. Supreme Court has agreed to decide how far federal judges may go in restricting expert testimony in civil cases.

The case before it involves whether federal judges overstepped their bounds by refusing to admit scientific testimony by witnesses whose work has not been subject to peer review or published in professional journals.

Courts are divided over whether unsubstantiated theories—popularly derided as "junk science"—can be admitted as evidence in civil cases.

"Some courts have let people testify only on the basis of their credentials" without taking into account whether any scientific evidence exists to support their views, said Victor Schwartz, a partner in the Washington law firm Crowell & Moring and a longtime advocate of reducing the liability burden on businesses.

Mr. Schwartz contends that "there is a substantial obligation on the court to review whether or not this person should be allowed to testify before the jury."

He added, though, that courts should be careful not to brand all testimony that lacks the majority support of the scientific community as inadmissible "junk science."

A Supreme Court decision in the case, *Daubert vs. Merrell Dow Pharmaceuticals*, is expected some time next year.

The suit involves two youths who blame their birth defects on Bendectin, an anti-nausea drug their mothers took during pregnancy. They are asking the Supreme Court to reinstate their cases against Cincinnati-based Merrell Dow, which manufactured Bendectin until it was removed from the market in 1983.

In 1990, a federal appeals court ruled that scientific research showed no "significant" connection between Bendectin and

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401(k) market

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end of the day just like mutual fund companies," making daily account valuations and transactions available to participants, said Stacy Schaus, a Hewitt consultant in the Lincolnshire office.

In the past, account valuations were generally available from consulting firms no more frequently than on a weekly, monthly or quarterly basis.

In addition, in an alliance, the employer "is focusing on one group, just like a single fund family," even though many companies are involved, Ms. Schaus said.

The "formal alliances are assimilating what the mutual funds are doing," explained Mr. Gross of Kwasha Lipton, which is negotiating with several investment managers and mutual funds to offer such a bundled product.

Noble Lowndes & Partners recently entered into an alliance, said Trisha Brambley, vp-retirement plan services at the Newtown, Pa.-based benefit consultant.

Noble Lowndes is allied with Wall Street Investor Services, which acts as the trustee and will make the following funds available to Noble Lowndes clients: American Funds; Alliance Funds; Mass Financial Funds; Oppenheimer Funds; and Putnam Funds.

In addition, A. Foster Higgins & Co. Inc. recently allied with The Franklin Institutional Services Corp. and is pursuing other alliances, said Doug Edwards, a Foster Higgins consultant in Princeton, N.J.

The Wyatt Co. is in the early stages of negotiations with mutual funds and trustees, said Lou Valentino, director of the defined contribution practice in New York.

"The alliances are a new phenomenon in the market," said James H. Gately, senior vp with The Vanguard Group Inc., a mutual fund organization in Valley Forge, Pa., that offers 401(k) administration services.

Mutual funds, by contrast, have been in the market for more than six years, observed Ted Lavelle, senior vp with Fidelity Investments in Boston, another mutual fund firm targeting 401(k) clients.

The creation of the alliances means "consulting firms have finally acknowledged that daily valuations and transactions are more effective," he said.

As competition increases, both the alliances and mutual fund companies are quick to blow their own horns.

One advantage in dealing with full-service mutual funds is the ease of communication with 401(k) plan participants, according to Vanguard's Mr. Gately.

Both employees and employers deal with only one company, rather than multiple investment organizations as in the new alliances, he said.

In addition, plan participants can call one number and a representative can help them with questions about any of the investment options offered.

Mutual funds also have an advantage with problem resolution, Mr. Gately said. If there is a problem or a needed adjustment, there is one point of reference, whereas alliances have outside trustees to handle transactions involving plan assets and a variety of money managers to deal with, he said. Mutual funds companies have trustees within their organizations.

Making their case, benefit consultants argue that employers relying on a single mutual fund company to administer their 401(k) plans could run into problems.

For example, if an employer that uses a single mutual fund organization becomes dissatisfied with the record keeping and wants to drop the company, it must overhaul the whole plan, according to Ms. Brambley of Noble Lowndes.

"It's an all-or-nothing proposition," she said.

Also, with a mutual fund, employees must invest all or a significant portion of their assets in one firm's products, Ms. Brambley added.

Employee often like to diversify their assets, especially because the large sums at stake today, she said.

The new alliances between consultants and investment firms are more flexible than mutual funds, Hewitt's Ms. Schaus said. This is "absolutely an advantage on an investment level."

Because employers may be limited to just one mutual fund family, they run the risk of not getting all the best funds available, she contends.

"No fund family is best in all assets," Ms. Brambly agreed.

The alliances offer employers the best fund options from a variety of mutual fund companies, added Hewitt's Mr. Rushin.

"It's kind of like getting the all-star team," he said.

But at least one mutual fund firm challenges the characterization of its services as restrictive or limited.

Employers that buy the full package of bundled services from Fidelity can still offer outside mutual funds and Fidelity will handle the record keeping, said Bob Reynolds, its president.

Another advantage consultants cite for their services is better communication and record keeping.

Mutual fund companies' primary interest is in money management, and they have just recently expanded into record keeping as a peripheral business, said Mr. Gross of Kwasha Lipton.

While Vanguard's Mr. Gately said he sees the benefit consultant's point in claiming years of record keeping experience, he points out that the consultants' experience is based on monthly and quarterly valuations, which "is irrelevant to the daily environment today," he said.

In addition, some mutual funds have hired benefit consulting experts, noted Mr. Reynolds.

Not all benefit consulting firms are responding the same way to competition from mutual fund firms.

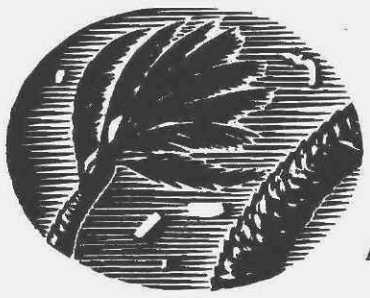
"Too many companies have tried to duplicate what mutual funds are doing," said Robert Aglira, managing director at William M. Mercer Inc. in Philadelphia.

Mercer is not formally affiliating with any specific mutual funds, he said.

Instead, the consultant is developing "preferred arrangements" with two large money managers to develop funds that will be valued daily and can be traded quickly, he said.

Employers can still pick any funds they want, but these two preferred arrangements can be among their options, Mr. Aglira said. ■

Another case for USF&G: Miami, FL. August, 1992



After Andrew, the Doyens were left with nothing. No house to live in. No cars to drive. No food. No clothing. And no furniture. So they got to a phone and called their independent agent, who contacted USF&G.

Our adjuster, Chuck Witt, was the first to make it to the Doyens' devastated neighborhood, check in hand.

But his arrival meant much more than the money. Chuck knew all about starting over. And not just the paperwork, but the process of rebuilding. How much it costs, how long it takes, and how to build it better next time. All of which enabled the Doyens to start putting their life, not just their home, back together again.

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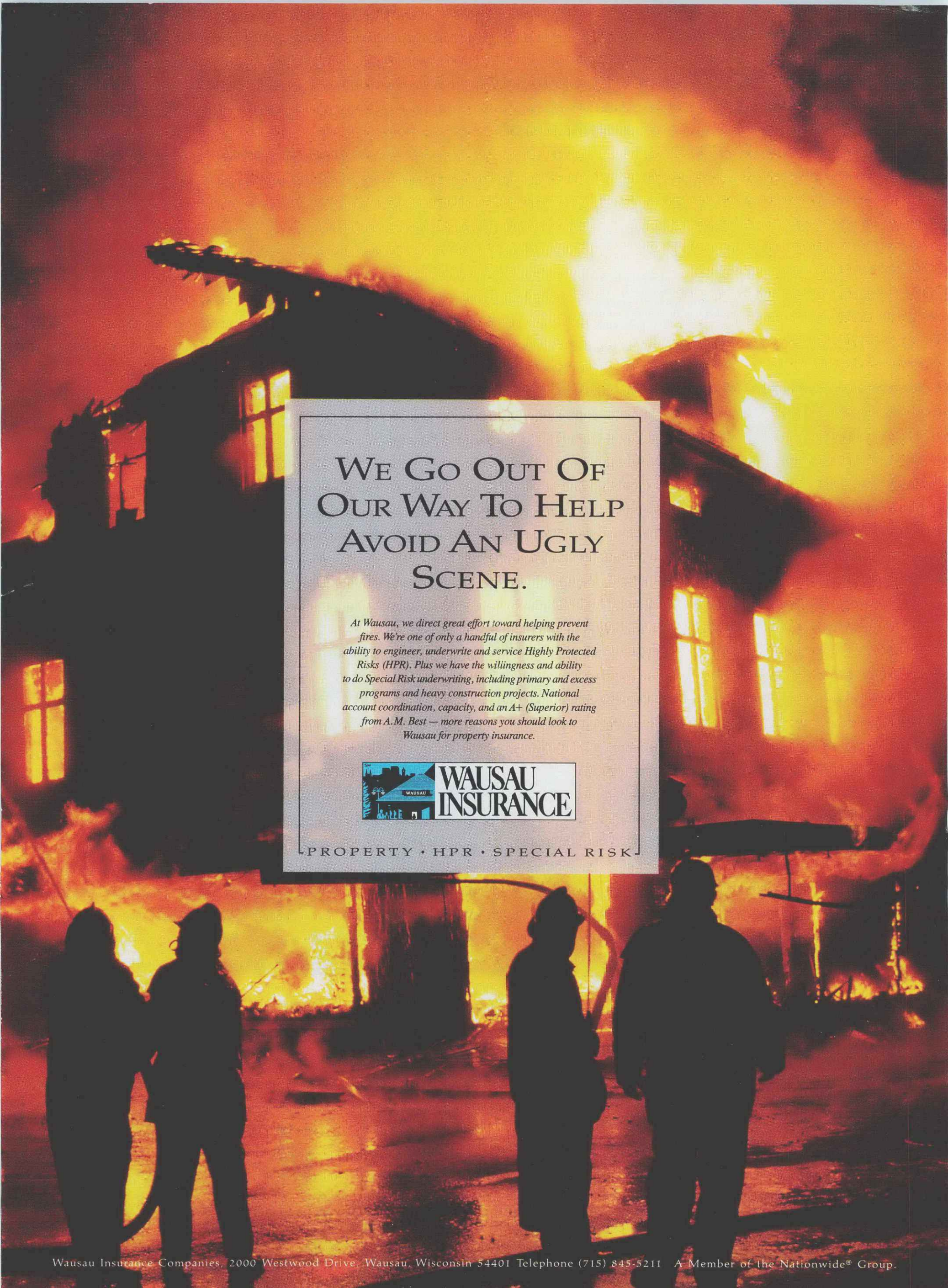

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Kodak early retirement plan draws 8,000

Benefit beat

More than 8,000 employees at Eastman Kodak Co. have taken advantage of an early retirement plan established to help cut the company's workforce.

Kodak had hoped to cut its workforce by at least 3,000 through the plan, allowing the photography and chemical concern to avoid forced layoffs.

But, about 8,300 of the 12,000 or so eligible employees signed up by the Sept. 30 deadline, the spokesman said.

"Three thousand employees was a floor. The program was left open and we were prepared to take all takers," a spokesman said.

Established last August, the plan targeted employees in the company's imaging business, corporate staff units, health sciences and chemical products divisions (*BI*, Aug. 26, 1991).

Kodak would not say how much the early retirement benefits would cost, but securities analysts have said that the company will take a third-quarter charge of $45 million to cover the cost.

Eligible employees who opt for early retirement will receive their full pension benefits, extended health, dental and life insurance benefits, severance pay and other incentives.

Employees with 75 years of combined age and service, as well as employees who are between the ages of 55 and 62 and have been with Kodak for at least 10 years, were eligible for full benefits under the program. Normally, employees must have 85 years of combined age and experience to retire with full pension benefits.

In addition to the pension and health care benefits, early retirees will receive a monthly Social Security bridge payment until they are eligible for Social Security benefits at age 62. These payments will equal $700 to $900 per month, depending on the retiree's earnings over the last three years.

—By Sara J. Harty

Manage care or else

As more large employers adopt managed care, midsized employers are paying the price for shying away from change.

Trying to recoup their losses on managed care discounts, health care providers have raised charges for people covered under traditional indemnity plans.

Those increases disproportionately affect mid-sized employers, which are less likely than their larger counterparts to use managed care, according to a recent Johnson & Higgins survey.

Among mid-sized employers—those with 1,000 or fewer workers—still offering traditional indemnity plans, the average per employee health cost rose 17.3% in 1991 to $3,571 from $3,044 in 1990.

Among large employers with indemnity plans, by contrast, the average increase was 9.6%—to $3,575 from $3,262—reports J&H Employee Benefit Services, which caters to midsized companies.

Some 29% of midsized employers still offer only traditional indemnity plans, while 62% offer at least one type of managed care plan.

Among the managed care plans offered, the survey found that 44% of midsized employers offer employees one or more health maintenance organization, 26% offer a preferred provider plan and 10% offer a point-of-service plan.

Why are midsized employers reluctant to move to managed care? Many have long maintained an indemnity plan, and there is a general "ignorance of the alternatives," said Michael Turpin, national practice leader of employee benefit services for J&H in Costa Mesa, Calif.

Mr. Turpin cautioned midsized employers not to wait for a change in the health care industry to be the impetus to switch over to managed care. "Now's the time to do it."

The J&H report is a special analysis of data collected by A. Foster Higgins & Co. Inc. The company surveyed 1,154 employers with fewer than 1,000 employees from private and public organizations for its annual health benefits survey.

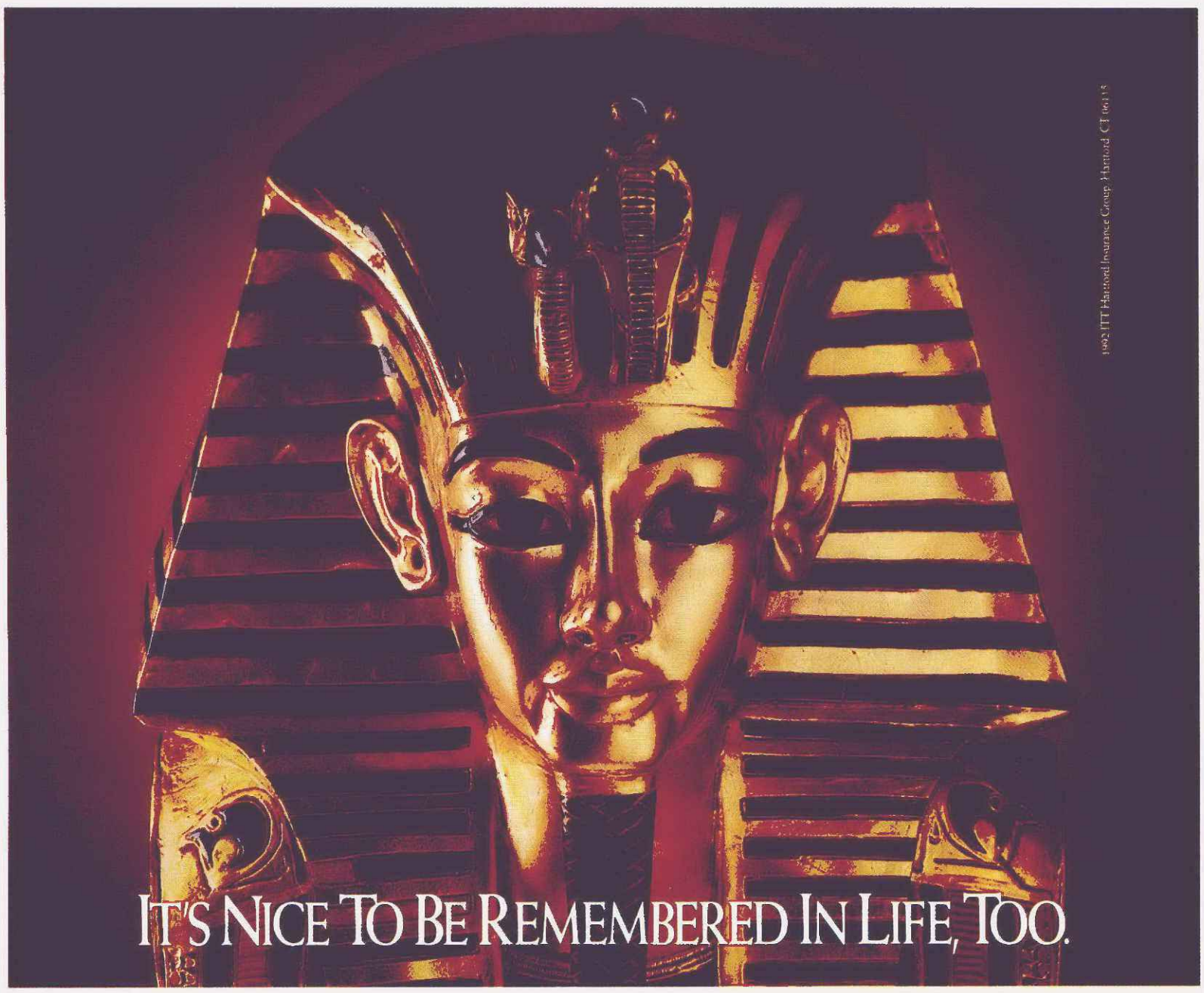
Other findings in the report include:

- The average total cost of providing employee health benefits for midsized employers was $3,546 per employee, up 15.2% from $3,079 in 1990. For large employers, however, the increase was only 9.7%, to $3,663.
- The median deductible for individual coverage at midsized employers remained at $150. For large employers, it jumped to $200 from $150 in 1990.
- The average family deductible, under which the family pays a specific amount regardless of the expense incurred per individual, is $397 for midsized employers and $431 for larger employers.
- In 68% of the plans, deductibles apply only to hospital benefits. Eleven percent of midsized employers require a separate hospital deductible, while 21% require no hospital deductible at all.
- Ninety-one percent of the employers require copayments for physician office visits.
- Seventy-one percent of the employers require employees to pay copayments for inpatient hospital services.
- Seventy-five percent of employers require copayments for inpatient surgery, while only 62% require copayments for outpatient surgery.

According to the survey, many plans either reduce or waive copayments to encourage outpatient surgery.

For a free copy of "Midsized Employer Health Plans," contact Annette Trujillo at Johnson & Higgins Employee Benefit Services, 695 Town Center Drive, Suite 700, Costa Mesa, Calif. 92626; 714-435-8489.

—By Sally Roberts



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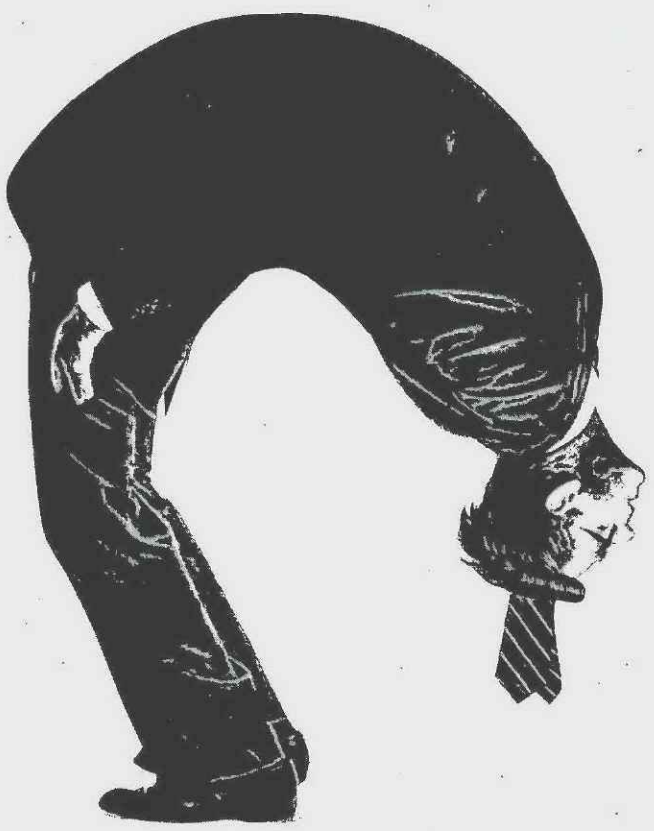

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Opinions

The antitrust dilemma

THE INSURANCE INDUSTRY won an important victory when the U.S. Supreme Court agreed to review the antitrust litigation filed by the state attorneys general (*BI*, Oct. 12).

We hope this is the last victory that the defendants must win in this litigation, not because we do not want them to prevail before the high court, but because we would prefer to see the case settled—now.

The defendants' victory is justified. The litigation never had much merit, and we strongly agreed with Judge William Schwarzer's 1989 dismissal of the litigation. The 1991 ruling by the 9th U.S. Circuit Court of Appeals that reinstated the case went overboard. We concluded at the time that, according to the 9th Circuit's opinion, any refusal by reinsurers to reinsure a particular type of risk would constitute a boycott subject to antitrust sanctions.

Now the ball is back in the industry's court, with some pointing out that the Supreme Court's decision to review the case is a sign that it will reverse the appellate ruling reinstating the case.

With that in mind, we must ask: What does the insurance industry stand to gain by letting the Supreme Court decide the case?

In the short term, plenty. A high court ruling that, in essence, vindicated insurers' behavior when rewriting the general liability policy form in the mid-1980s would indeed be a huge victory for the insurance industry. Of course, such a ruling will trigger new calls for repeal of the McCarran-Ferguson Act by the industry's critics.

A ruling against the industry by the Supreme Court would be a stunning defeat. And, the insurers have two ways to lose. To have the case dismissed, the industry must win on two points: whether domestic insurers forfeit their antitrust exemption under McCarran-Ferguson when dealing with foreign insurers, and whether agreements among insurers and reinsurers on matters like policy language and coverage terms can constitute a boycott that falls outside the McCarran exemption.

A settlement would not be unprecedented: A separate antitrust suit filed by the Texas attorney general in state court was settled last year for a total of $6.6 million and minor changes in the way insurers do business.

Of course, all of this is easier said than done. Any settlement offer likely will be rejected by the states simply because the attorneys general have nothing to lose—but time and taxpayers' money—by proceeding with the case. If the four years of litigation have proven anything, it is that attorneys in the public sector can waste money on frivolous litigation just as easily as private personal injury lawyers.

Besides ending the tremendous flow of money on both sides, a settlement would accomplish something else: It would again allow a free discussion of issues that affect the insurance industry.

For the past 4½ years, industry officials have been reluctant to speak in public about industry trends—especially pricing—because of fear that such talk could be regarded as an industry "conspiracy." In fact, organizers of some conferences specifically tell speakers what areas are considered forbidden turf.

While the attorneys general say they are acting in the best interest of policyholders, they also are hurting those they are trying to protect. An informed consumer is a wise consumer. The antitrust suit is blocking the flow of information from industry executives to the policyholders, something that may be almost as dangerous as any perceived boycott.

Letters

Greed and excess led to insurers' bad image

To the editor: Winston Churchill said, "The farther back you look, the farther forward you see."

In 1985, during the last hard market, insurers squeezed every penny they could as fast as they could from businesses until they screamed for help. But the ghosts of the excesses came back to haunt the insurance industry in more ways than anyone could ever have imagined. To wit:

- Proposition 103.
- Antitrust suits from state attorneys general.
- Firestorms in personal auto and workers compensation insurance.
- Agency terminations, commission cuts and contract revisions.
- Company withdrawals and market abandonments.
- Egregious agency-company relations.
- Horrendous consumer public relations resulting in bottom-of-the-barrel ratings.

Why is the industry's public relations so pitiful? Consider these actions:

- Eleven months after the disastrous Oakland, Calif., fires, 30% of the claims remain unsettled. This is an inexcusable and unacceptable service standard!
- The Chicago water damage. It was not a flood by standard definitions, but it certainly is creating a flood of litigation and poor public relations.
- The American International Group Inc. memo. "We have opportunities from (Hurricane Andrew) and everyone must probe with brokers and clients. This is an opportunity to get price increases now."

Considering the state of the economy, along with the most atrocious consumer relations the industry has ever experienced, no sensible insurance industry employee should ever think, let alone discuss, the merits of the "next hard market."

The industry must begin to care more about people and care more about public relations than just the almighty bottom line, or the excesses and results of the last hard market may truly cause the next hard market to be. . . .the last hard market.

For once, let us learn from our mistakes.

Dennis W. Jeff
President
Glenn E. Orndorf Inc.
Lancaster, Pa.

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NAIB represents buyers' interests

To the editor: As chairman of the National Assn. of Insurance Brokers, I must take issue with a reference in your Oct. 5 editorial on consumer rights. You identify the NAIB and the American Insurance Assn. as "organizations that represent the sellers of insurance products and services."

In fact, the members of the NAIB represent the interests of commercial insurance buyers in the insurance marketplace as well as providing risk management services to commercial insureds. However, we do consider ourselves an "industry group."

We concur with your editorial that RIMS represents insurance consumers.

Alan G. Page
Chairman and Chief Executive Officer
National Assn. of Insurance Brokers
Washington

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Chinese market

Continued from page 3

and make "a long-term commitment," said Mr. Tuan. Risk managers should "assume that the worst still could happen."

Since 1978, when Mr. Deng began his country's economic reform, China has received foreign loans totaling $52.5 billion from the World Bank, the Asian Development Bank, the United Nations Development Program and governments of about 20 countries, said Mr. Tuan.

By the end of 1991, more than 40,000 foreign-funded enterprises had been approved by the Chinese government, and total promised foreign investment had reached $50 billion, he said.

In the first five months of this year, another 8,926 foreign-funded enterprises were approved with total investments of $10.4 billion, more than twice the total at the same time last year.

In most cases, the foreign investor is only allowed to own 49% of a joint venture with a Chinese partner. "To achieve success, you must know your partner well," Mr. Tuan warned.

A major challenge facing foreign investors, according to Mr. Williams, is the fact that risk management "is a totally new concept to the Chinese."

However, 20 universities in China are now offering insurance and actuarial courses, said Mr. Tuan. This year, Mr. Tuan—who left Shanghai in 1949—also will start a graduate course on insurance and risk management in China.

He urged RIMS/RIMAS members and members of other risk management associations to support further risk and insurance management courses in China.

In the meantime, China's insurance market is still dominated by the state-owned People's Insurance Co. of China, which reopened in the 1970s after it stopped all domestic underwriting during China's Cultural Revolution.

During 1992, PICC reported a gross premium volume of 23.6 billion renminbi ($4 billion), compared with total claims of 12.6 billion renminbi ($2.1 billion).

Two other Chinese insurance companies also have been operating since 1988:

- The China Pacific Insurance Co., whose premium volume in 1991 totaled 255 million renminbi ($42.5 million), and claims totaled 81 million renminbi ($13.5 million).
- The Ping An Insurance Co., which had premium volume totaling 111 million renminbi ($18.5 million) in 1991, with claims totaling 45 million renminbi ($7.5 million).

These two insurers must cede 30% of all their business to the PICC, said Mr. Williams. If the PICC rejects the cedants' wordings or premiums, the insurers are effectively barred from writing the business, he said.

This practice is expected to change, however, with new insurance legislation that is being drafted by the country's insurance regulatory authority, the People's Bank of China. The legislation is expected to be approved next year, according to Mr. Williams.

Brokers are not allowed to operate in China under the present law. Sedgwick is the only international broker with an office in China devoted to insurance consultancy, he said.

The fourth insurer to establish itself in China recently is AIG, said Mr. Williams. Receiving approval to be the first wholly owned foreign insurer in China was for AIG "a great achievement and will bring much greater flexibility and choice to the Chinese market," Mr. Williams pointed out.

This recent approval "is going to be a test bed which, if successful, will encourage the People's Bank of China to take a closer look at the possibility of other international insurers coming into the Chinese market," he said. "First, however, we would expect one or two more Chinese insurance companies to be approved, and if the AIG experiment is successful, then we can expect another two to three years before the next foreign insurer is allowed to underwrite in China."

When asked whether AIG would cede 30% of its business to the PICC, Robert J. Thomas, regional president of Southeast Asia regional division for AIG (Hong Kong) Ltd., answered: "We will follow the rules of China."

Ross Bovill, regional development director of Sedgwick James Asia Pacific Ltd. in Singapore, moderated the session. ■

Bright future seen for Hong Kong economy

SINGAPORE—The Sino-British Joint Declaration of 1984 will allow Hong Kong to enjoy "a high degree of autonomy" when China assumes control in 1997, an insurer says.

Elections will be allowed and Hong Kong's existing economic system and lifestyle will be permitted to continue for 50 years.

"So what's the problem?" asked Robert J. Thomas, regional president of the South East Asia division of AIU (Hong Kong) Ltd. in Hong Kong.

"I would suggest that the nagging question of what's going to happen to Hong Kong after 1997 keeps reappearing because of the purely subjective factor of 'confidence' or lack thereof," he said at the Third Asia-Pacific Risk Management Conference.

"My informal poll suggests that more people feel confident and positive rather than negative on life after 1997. I myself see a future that is optimistic for the success of the 'one country, two systems' policy."

Many business leaders believe that economic reforms in China will continue, so that there will be "greater harmony" with Hong Kong after 1997, Mr. Thomas said.

"For the underwriter and risk manager in Hong Kong, perhaps the run up to 1997 is more unsettling than post-1997," he said. Social crime—fraud, corruption and violence—is expected to climb in the next four years. The exodus of talented people—or "brain drain"—continues despite increased salary and benefit packages.

However, by 1997, "I project that the wave of social crime will stabilize to 1990 levels," he said.

In the meantime, the Hong Kong insurance market is changing, though much as a result of global trends, Mr. Thomas said. Over the past two years, Hong Kong has tightened its insurance laws, giving more power to the insurance commissioner and introducing rigorous reporting rules for insurers.

Hong Kong has more than 200 insurance companies, and "we can project that post-1997 Hong Kong will have substantially fewer," he said. "The withdrawal of licensed carriers will be due to factors such as pressure internally from the more empowered Hong Kong insurance commissioner and externally from the expected shakeout in the worldwide insurance industry."

Chinese insurers will also increase their market share, he said.

—By Stacy Shapiro

Is someone else profiting from your loss experience?

Globalization

Continued from page 3

products, establishing production or distribution facilities, importing components, sub-assemblies and finished goods, or engaging in a variety of technology agreements and trading relationships."

Continuing education can increase risk managers' understanding of the implications of world and regional politics, suggests RIMAS President Jeanne Tan, also a keynote speaker. Ms. Tan is executive officer of group insurance for Jack Chia M.P.H. Ltd. in Singapore.

"Clearly this conference is an indication of an emerging interest in the practice of risk management in the region," Ms. Crager agreed.

The conference, the fourth risk management meeting in Singapore and the third co-sponsored by RIMS and the Risk & Insurance Management Assn. of Singapore, attracted about 170 people from about 18 countries.

Continuing risk management education "will prepare the risk manager to overcome cross-cultural differences brought about by a region with a multinational, multicultural, multireligious and multilingual environment" where behaviors differ greatly not only from Western ideology, but within the region itself, Ms. Tan said.

"A professor from East Asia once said this: 'Trying to describe Asian management is like staring into a kaleidoscope. . . One moment it seems familiar, conventional and the traditional management technology developed in and practiced by the West and taught in the best of schools. The next moment, the colors shift, the shades deepen. . . .

" 'In the blink of an eye, you have before you something inscrutably unfamiliar, a management technology shaped by precepts of the immortal Confucius, enlivened by prescriptions of the strategists Sun-tzu and the samurai, Musashi, and driven by values and age-old attitudes rooted deep in the Asian soul,' " Ms. Tan said.

"That will provide some challenges to educators in risk management and something to consider when training risk managers in East Asia," Ms. Tan commented.

Ms. Tan also called on IFRIMA, the organization founded in 1984 to represent risk management associations worldwide, to serve as a "United Nations Secretariat," bringing together all of the world's risk management associations.

Additionally, IFRIMA could provide risk management experts to countries where the discipline is in the developmental stage, Ms. Tan added.

That way, "IFRIMA could also act as a network and resource for risk managers, risk practitioners, academics and even risk management service providers who have to source worldwide insurance covers," she said. "It could be a benefit to trade partners across national boundaries.

"IFRIMA could—with contributions, resources and support from established associations like RIMS, with the help of the United Nations Council on Trade and Development, risk management associations around the world and others who have an interest in the promotion of risk management—rally together to form a 'United Risk Management Forum' for the global fit, and for the survival of the risk management discipline and the progress of the risk management profession."

Currently, IFRIMA, made up of 20 member associations representing 19 nations, has no paid staff of its own. The organization's primary focus has been to develop a core curriculum for risk management studies (*BI*, July 1, 1991).

RIMS' Ms. Crager agreed. "There's no doubt that strong local and national associations are key to achieving the best interests of the discipline."

Brokers, intermediaries and consultants also can help risk managers gain global expertise, suggests Terry J. Paradine, managing director heading Marsh & McLennan Inc.'s Asia-Pacific regional office. Mr. Paradine also spoke at the conference.

"While the risk manager takes center stage and coordinates resources to achieve an effective risk management program, it is the broker who provides many of these resources," he said.

Brokers can, for example, provide advice in ensuring occupational health and safety, property engineering and compliance with all regulatory requirements, in addition to helping identify environmental exposures.

"Clients have become more sophisticated insurance buyers, and they are looking to their brokers to meet their insurance needs in a complex business environment," he said.

As a result, "the very nature of major broking houses is changing to reflect the need to add value to the services of brokers as intermediaries, and allow them to work more effectively with risk managers," Mr. Paradine said.

Some brokerages are restructuring along functional, rather than geographic, lines. This way "clients are segmented into cohesive categories sharing common characteristics and needs," he explained. "This segmentation allows specialized needs, particularly for risk management, to be met more effectively." ■

Meeting attracts 170 participants

SINGAPORE—A total of 170 delegates and exhibitors from 18 countries attended the Third Annual Asia-Pacific Risk Management Conference Oct. 4-7 at the Westin Stamford and Westin Plaza hotels in downtown Singapore.

The biennial event was co-sponsored by the Risk & Insurance Management Society Inc. of New York and the Risk & Insurance Management Assn. of Singapore.

No date has been set yet for the 1994 Asia-Pacific conference, according to Candace Clark, international risk manager for Apple Computer Inc.

Ms. Clark served as co-chairwoman of the conference with RIMAS President Jeanne Tan, executive officer of group insurance and securities at Jack Chia-MPH Ltd.

For further information on other RIMS-sponsored conferences, contact Barbara Parker, Conference Director, RIMS, 205 E. 42nd St., New York, N.Y. 10017; 212-286-9292.

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Airline is ready when crisis occurs

Singapore carrier drafts detailed plan

By STACY SHAPIRO

SINGAPORE—Singapore Airlines Ltd. knows just what to do when a crisis strikes.

But a crisis doesn't happen every day, and employees react differently in different situations. Some may call their families before getting to their duties, others may entirely forget what to do in a crisis.

To stay on course, airline employees can turn to the pocket-sized, 59-page "Crisis Management Centre Aide Memoire," which spells out duties and lists relevant telephone numbers.

The pocket guide is just one facet of the airline's extensive crisis management system, which was described by a member of the airline's corporate affairs department at the Third Asia-Pacific Risk Management Conference in Singapore this month.

Interest ran high, particularly because the lecture and a tour of the airline's facilities at Changhi Airport came one day after an El Al Israel Airlines jet crashed in Amsterdam (*BI*, Oct. 12).

Singapore Airlines has one of the best loss records in the world. In its 40 years, it has had only one major incident—a 1991 hijacking.

The airline's 52-aircraft fleet, which includes 28 Boeing 747s, is one of the youngest in the world, with an average age of five years.

Risk management is "a very instinctive part" of management throughout the airline, according to Insurance Manager Angela Chua.

"We consciously take high deductibles" in all property/casualty and aviation hull and liability insurance policies, so that departments are accountable for the losses they incur, Ms. Chua said.

Though the airline has a risk management audit once every three to five years, risk reviews are "done every day," she said.

The insurance and risk management department reports to the director of corporate affairs and has been involved in the drafting of the airline's crisis management plan, according to Ms. Chua.

Asia Pacific Risk Management Conference

Staff are trained at the airline's Crisis Management Centre at Changhi Airport. Regional centers are being set up in London, Tokyo, Los Angeles and Sydney.

Disaster planning at Singapore Airlines goes well beyond training. The airline has developed and may start marketing its Kriscom system, a disaster management system that records inquiries about passengers and tracks the status of casualties.

Singapore Airlines also has collected data on other airline disasters to demonstrate how handling a crisis can affect an airline's public image and future profits.

For example, after one crash last year, photos were taken of rescue workers carrying a dead passenger hung on a pole like a dead pig. This shows "no respect for the dead and their relatives," said the spokesman for Singapore Airlines. It created "a poor image" for the airline.

It is critical to rush the dead passengers to a morgue on stretchers in body bags, he noted.

In another jetliner crash, a French television crew arrived on the scene before rescue workers. Some of the 140 lives were lost could have been saved if the rescue team had arrived earlier, he said.

By contrast, when a British Midland Airways jetliner crashed in Kegworth, England, a few years ago, the airline chairman arrived on the scene and spoke to the media, which demonstrated that the airline cared, according to the spokesman. As a result, British Midland increased its market share, he noted.

If a crisis were to hit Singapore Airlines, all 50 overseas and local managers would be contacted by telex and told to recall all relevant staff and activate local crisis plans. "As a guideline, we activate everybody," said the spokesman.

This is done "before CNN knocks on their door," he added.

Only when the airline's Crisis Management Centre knows the location of the crisis can some of the offices be told to stand down from an alert status, he said.

The head office will send a task force consisting of personnel from technical, customer relations and administration departments, including legal affairs and insurance representatives.

The crisis management team at the designated crisis station will be headed by a local senior vp, the general manager and the station manager. The highest ranking member of the team on hand at the time of the crisis will direct management of the crisis and handle media relations until these duties are assumed by a higher-ranking official.

Efforts will be made to isolate relatives of passengers on the ill-fated flight, putting them in local hotels at the airline's expense, if needed, or sending them to the hospital where the injured have been taken.

A private area should be set up where survivors of a crash can be reunited with family and escorted away from the media, the spokesman said.

The airline's phone staff will talk to next-of-kin, who will only be told if a relative was listed as a passenger on the flight and, if known, where he or she is located, said the spokesman. If the passenger is injured, the airline will not tell relatives about the extent of the injuries, only the location of the hospital where he or she is being treated.

Next-of-kin for passengers who die in a crash will be provided with a "buddy" from the airline to assist with any arrangements. U.S. airlines have done this for years, said the spokesman.

Media relations are another critical factor in a crisis. At Sin-

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Crisis planning

Continued from page 12

gapore Airlines, only the director of corporate affairs or the manager of public affairs can authorize the release of the passenger list to the media in full or in part. The full passenger list can only be released when the next-of-kin of all dead passengers have been notified.

When speaking to the media, Singapore Airlines tells its executives to:

- Be open and honest, disclosing only facts. "Half-truths can be discovered, resulting in loss of goodwill."
- Avoid responding with "no comment," as it may lead to more speculation.
- Answer queries quickly as delays can be mistaken for hiding information.
- Keep statements simple.
- Be calm and cool. ■

Vietnam rich with potential—and risks

By STACY SHAPIRO

Asia Pacific Risk Management Conference

SINGAPORE—Could Vietnam become the fifth "Asian Tiger"?

Maybe, but for now, at least, it's a "crouching tiger," observed Ross Bovill, regional development director of Sedgwick James Asia Pacific Ltd. in Singapore.

Vietnam is widely considered to have the business potential of Singapore, Hong Kong, Taiwan or South Korea.

"Vietnam is rife with business risks at the present time, and fortunes will be lost as well as made. These business risks are often outside of the investor's control, and he can only make the judgment: Is the risk worth the reward?" he said.

For some U.S. citizens at a session on business risks in Vietnam at the Third Asia-Pacific Risk Management Conference, the country's name conjured up images of the war-torn country U.S. troops vacated in 1975 after more than a decade of fighting.

The U.S. government still imposes a trade embargo on Vietnam. "Apart from denying investment and trade opportunities to U.S. corporations, this embargo has had a most significant effect of blocking World Bank, International Monetary Fund and Asian Development support for Vietnam's desperately needed infrastructure development," Mr. Bovill said.

He predicts this embargo will be lifted after the U.S. elections in November.

But, even with the embargo in place, things are changing in the country. Vietnam, which is heavily agricultural, is the world's third-largest exporter of rice, according to M. Rajaretnam, executive director of the Information & Research Centre Pte. Ltd. in Singapore.

Other exports include mulberry leaves for silkworm; soybean bean, coffee, cocoa, rubber, tea and sugar cane.

It is "naturally blessed" with rich soil, Mr. Rajaretnam said.

In addition, it is rich in other natural resources, like oil, hydroelectric potential, large forests and marine/aquatic resources, he said.

And, it has a large labor pool.

Since 1986, the communist-run government has been moving toward a market economy. But while a new constitution "gives the impression" that the party and the government are separate, "the party is still very much in control," Mr. Rajaretnam said.

Even though 90% of the national assembly are communists, it remains evenly balanced between reformists and conservatives. "Political stability remains a priority and economic reforms will continue, though at a gradual and acceptable pace," Mr. Rajaretnam said.

"The theory in this region is that you shouldn't sacrifice progress for politics."

Vietnam also recently became an "observer" to the Assn. of South East Asian Nations—a group of six nations with growing economies—and may become a full member. "Vietnam has made a strategic choice to be a part of Southeast Asia rather than China," Mr. Rajaretnam said.

Foreign investment was first allowed in 1987. Since then, $3.2 billion has poured into the country, mainly from Taiwan and Hong Kong.

Capital also has come from Australia, France, Japan, Korea, Singapore, Thailand and the United Kingdom.

Almost 40% of all foreign commitments are in the oil sector, though most projects that have been finished have been in the hotel sector, Mr. Rajaretnam said.

Vietnamese law allows foreign investors to operate under business cooperation contracts, to set up joint ventures or to establish fully owned subsidiaries. In practice, Mr. Bovill said, most use joint ventures.

Messrs. Bovill and Rajaretnam cited several possible constraints on economic growth in Vietnam:

- An inadequate infrastructure.
- A lack of foreign currency exchange.
- A lack of modern management and accounting skills.

Risk management will present major challenges for potential foreign investors, Mr. Bovill added. "There is no local risk management expertise in Vietnam. You will have to bring it with you and, more importantly, ensure that joint venture agreements permit you to exercise it."

All such agreements must include a statement about insurance. If joint venture partners are state-owned entities, coverage will probably have to be obtained from state-owned insurer BaoViet in Hanoi, he said.

Vietnam is not expected to enact its first law regulating insurance until next year. Until then, there are non-admitted insurers in the country. French and Japanese insurers have shown an interest and are reinsurers of BaoViet.

Mr. Bovill warned insurers that while global reinsurers can be used for joint ventures, "be prepared for quite handsome ceding commissions in return for this service."

Risk managers can use captives, but it is not advisable until the project is well-established and the risks are lowered.

There are no brokers authorized in Vietnam, but many foreign brokerages have "long established relationships with BaoViet," he said.

Vietnamese companies are not required to buy any insurance. But, foreign investors have to buy workers compensation insurance that covers a company for up to $8,000 per employee and automobile liability insurance with limits of up to $20,000 for property damage and $1,500 for bodily injury. ■

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Battling health cost increases in Singapore

Double-digit annual cost hikes make managed care a necessity: Doctor

By JOANNE WOJCIK

SINGAPORE—Employers in Singapore should develop a preferred provider network with a gatekeeper function to manage their employee health care costs, a medical professional recommends.

A PPO is a more viable approach than a health maintenance organization because it is "financially safer for providers and more acceptable to patients given Singapore's current fee-for-service system," said Dr. Alfred Loh Wee Tiong, senior partner at Raffles Medical Centre in Singapore.

"PPOs provide fewer incentives not to treat as do HMOs," because "physicians retain autonomy and do not carry risk," Dr. Loh said during a panel discussion on controlling health care costs at the Third Asia-Pacific Risk Management Conference, held Oct. 4-7.

Managed care is fast becoming a necessity in Singapore, which now has an annual medical cost inflation rate of 10% to 15%, according to Dr. Loh.

For example, the cost of an acute care hospital bed rose more than 133% over the last 10 years to $280 per day in 1992 from $120 in 1983.

And, lost time due to employee illness can be costly for employers in other ways, Dr. Loh pointed out.

In 1991, each Singapore worker took an average of seven days of medical leave, which translates to a loss of about 10.4 million man-days or the equivalent of a 70-year shutdown of a plant that employs 500 workers, he estimated.

But, employers will not have an easy time implementing medical cost containment in Singapore's market-driven economy since "the two key players in the health care delivery system will always pull in opposite directions," Dr. Loh said.

"Insurance companies make money by keeping people out of hospitals and reducing the amount of care required by medical providers. On the other hand, hospitals and doctors benefit by doing the opposite. Higher occupancy and greater intensity of care normally translate into greater profitability."

In addition, Singaporeans are used to having the freedom to select providers under the island nation's current MediSave program.

Under MediSave, employees contribute 15% of pretax wages, matched by an employer contribution of up to 25% of payroll, to an account earmarked for their personal health care expenses and housing costs, Dr. Loh explained.

The amount that employees and employers contribute has a lifetime cap of $15,000 Singapore ($9,315 at current exchange rates) per individual. Employees can use the funds to either pay for medical services or to purchase a health insurance plan or both, he said.

Dr. Loh feels that of all the forms of managed care that have emerged in the United States since the 1970s, the PPO model will work best in Singapore because of the population's preference for provider choice.

"While the HMO model has been lately presented as a possible approach to health care cost containment, I think the PPO model is more viable, financially safer and is a generally more acceptable approach for providers, patients and employers."

In addition, Dr. Loh recommends a gatekeeper-model PPO, as opposed to the early PPO models that provided only discounted fee-for-service care.

"The PPO model that Singapore can adopt should involve three levels, namely: the gatekeeper, the specialist panel and the hospital panel.

"The gatekeeper must, by function and definition, be the primary health care doctor, the general practitioner or the family physician," Dr. Loh said.

Asia Pacific Risk Management Conference

In addition to making referrals to the pool of specialist providers, the primary care physician would be responsible for implementing all cost containment measures, including utilization review and data collection and analysis.

The specialists in the PPO would accept the measures needed to ensure cost containment without jeopardizing the quality of care, he stressed.

"The participating hospitals provide the third-level role and are prepared to accept negotiated fee adjustments, utilization review and patient care evaluation."

A gatekeeper-model PPO offers numerous advantages, according to Dr. Loh. "Using the economy of scale in the purchasing of health care from providers, the PPO model would bargain for special adjusted fees from physicians and hospitals."

In addition, using the gatekeeper as the first point of contact in the chain of health care would ensure that medical staff understand the need for cost containment while ensuring uniform quality of care.

And, "using the data from utilization review, a whole host of information may be available."

Also speaking during the session were Gina Greenlee, senior account manager for Johnson & Johnson Health Management Inc., who described the company's wellness program, and Robert Sophia, regional manager for Johnson & Higgins Consulting (Far East) Ltd., who discussed other health care cost containment techniques.

Dr. Leow Yung Khee, resident doctor at Insurance Corp. of Singapore Ltd., moderated the panel. ■

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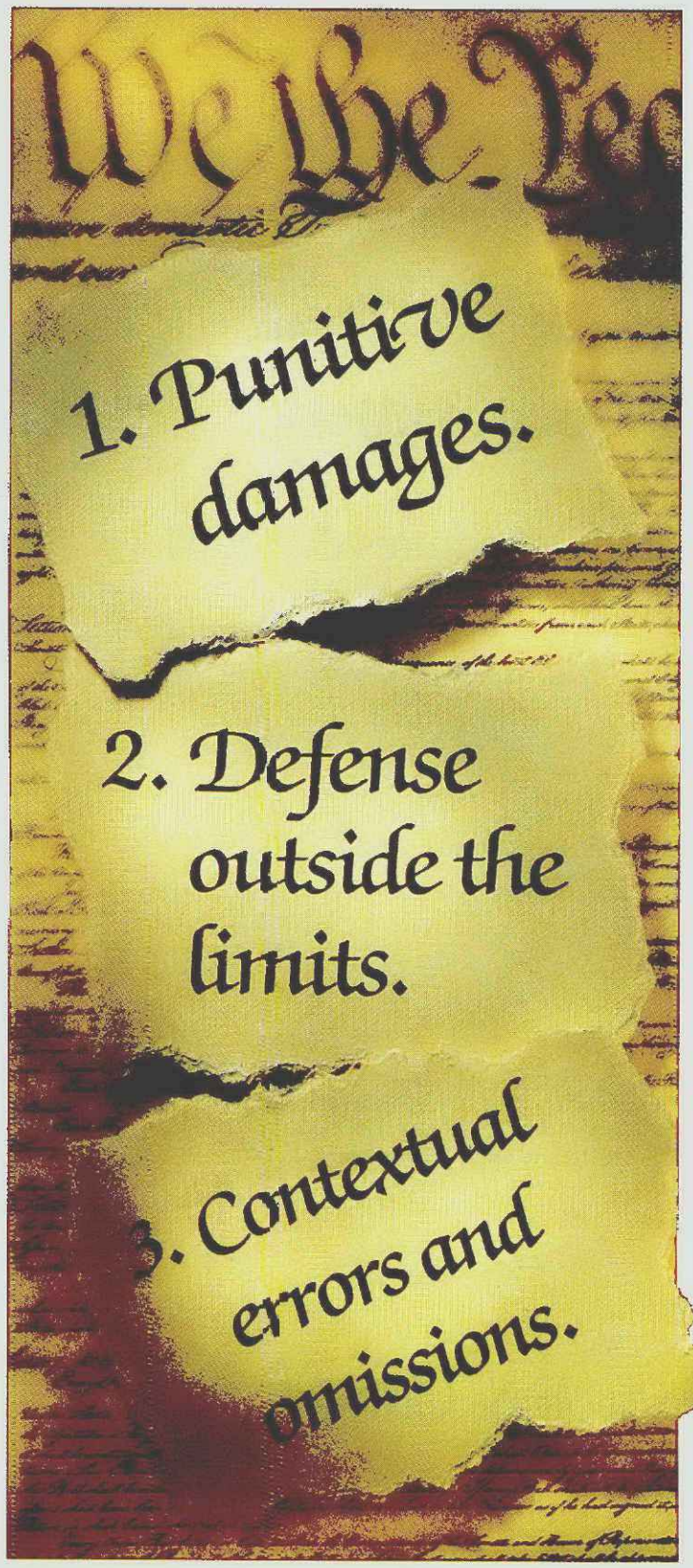

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U.S. oil spill law rocks the boat

Its financial, safety standards may be too hard on shippers, lawyer argues

By JOANNE WOJCIK

SINGAPORE—The financial responsibility and remediation requirements of the U.S. Oil Pollution Act of 1990 will be difficult, if not impossible, for the shipping industry to meet, oil spill liability experts say.

Eventually, the new U.S. environmental law will lead to replacement of the entire world fleet of oil tankers as well as implementation of tougher oil spill regulations in other countries, the experts added.

"Since its enactment, the U.S. Oil Pollution Act of 1990 has generated a considerable amount of controversy within the international oil and shipping communities," attorney Raymond J. Burke Jr. said at a session on U.S. pollution liability laws at the Third Annual Asia-Pacific Risk Management Conference earlier this month.

"OPA 90 imposed upon the owners and operators of vessels and shore facilities a scheme of virtually unlimited liability for marine oil pollution damages and required the publication of a series of detailed federal regulations implementing numerous statutory provisions intended to lessen the likelihood of maritime mishaps that could result in oil spills," asserted Mr. Burke, who is with Burke & Parsons in New York.

In purely monetary terms, the Coast Guard has estimated that compliance with the new rules will cost the shipping industry approximately $1.3 billion over the next 24 years, he said.

And industry estimates are even higher: $7 billion in the next 22 years, Mr. Burke pointed out.

Under OPA 90, the liability limit for tankers weighing more than 3,000 gross tons is $1,200 per gross ton, or $10 million, whichever is greater. That means the liability of a 50,000-gross-ton tanker would be limited to $60 million in case of an oil spill.

However, last year the U.S. Coast Guard proposed requiring vessel owners, operators and charterers to also meet the financial requirements of the Superfund law—formally known as the Comprehensive Environmental Response, Compensation and Liability Act. This would raise the limits to $1,500 per gross ton for tankers over 3,000 tons and $900 per gross ton for non-tankers.

The Coast Guard is the federal agency drafting the OPA 90 financial responsibility requirements, Mr. Burke explained.

"To put these figures in perspective, a 50,000-gross-ton tanker would have to provide evidence of financial responsibility in the amount of $75 million," he estimated.

Despite these limits, liability may be unlimited if the discharge is caused by gross negligence or willful misconduct or for a violation of a federal safety, construction or operating regulation, according to Mr. Burke.

"For example, if due to ordinary negligence, one of the Rules of the Road is violated, limitation of liability will be lost," he said.

Therefore, "a simple error of navigation, something that is common to any marine casualty, can easily spell financial ruin for a shipowner," he added.

Liability limits are similarly lost if the responsible party fails to report the oil spill, to cooperate in its removal or to comply with an authorized removal order.

To meet the maximum liability that could be imposed, OPA 90 requires shipowners and operators to establish financial responsibility through evidence of insurance, surety bond, guarantee, letter of credit, qualification as a self-insurer or any other methods found acceptable by the U.S. Coast Guard.

Even stricter than the statute is the proposed Coast Guard rule, which would permit use of only insurance, surety bonds, qualified self-insurance or guarantees to meet the requirement.

In addition, both the proposed rule and the original OPA 90 permit the direct assertion of claims against guarantors—including insurers—that provide the required evidence of financial responsibility.

"While the guarantor's liability may not exceed the amount of its guarantee, this provision has been one of the major sources of controversy to emerge from OPA 90," Mr. Burke said.

Protection and indemnity clubs, the traditional underwriters of marine oil pollution coverage for more than 95% of the world's oceangoing merchant fleet, oppose the financial responsibility provisions. P&I clubs, said Mr. Burke, maintain that they will not provide insurance under any law that alters their role as indemnity underwriters for their member shipowners.

"The direct action provision would have precisely this effect by casting the P&I clubs into the shipowners' shoes as guarantors for a multitude of potential claims of unprecedented size and scope," he pointed out.

Although the proposed regulations list several other methods for demonstrating financial responsibility, none is considered a viable alternative to P&I coverage, according to Mr. Burke.

"Surety bonds are an unrealistic option in terms of both their cost and limited availability," he said. In addition, "the amount of financial responsibility needed under the proposed regulations would make it difficult to find a guarantor for a shipowner's potential liability.

"Finally, the levels of working capital and net worth required to qualify as a self-insurer are virtually impossible to meet," he asserted.

A shortage is likely to develop in capacity for marine liability coverage as shipowners and operators try to amass the huge limits required by OPA 90, said John J. O'Connell, professor of international insurance at Thunderbird

Continued on next page

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McDonnell Douglas

Continued from page 1

$18,000 from its defined benefit plan, which had a $2.2 billion surplus at the end of last year.

The new plan will draw about $300 million from the pension surplus, an amount roughly equivalent to the payout McDonnell Douglas would have made for retiree health coverage under the old company-funded plan.

Retirees who choose to receive the pension supplement can direct that money to a company-run voluntary employee benefit account created to pay for retiree health care coverage. Or, retirees can receive the supplement as additional pension benefit payments over their lifetime or have it deposited into an individual retirement account.

Retirees who choose the additional pension payments or IRA deposit must still purchase four years of health benefits from the company. The coverage will be identical to that the retirees would have received under the company-funded plan.

However, retirees do not have to purchase medical coverage if they choose not to receive the pension supplement.

The spokeswoman for McDonnell Douglas pointed out that the $18,000 supplement is taxable income to the retirees and the company will withhold 20%, or about $855 annually. That leaves $14,400 to pay for four years of retiree health care benefits, which cost $15,255. Retirees can pay for the $855 shortfall directly or have it withdrawn monthly from their pension benefits.

The $15,255 cost also includes individual contributions—ranging from $10.40 to $34 per month—that retirees will continue to pay under the new health plan.

Workers that will retire within the next four years will be eligible to receive a pro-rated pension supplement. However, workers who stay on the job for more than four years are not now guaranteed retiree health care benefits.

Despite the tax disadvantages for retirees, most of them found the proposal "a sound alternative to eliminating retiree health care or shifting more of the cost burden to retirees," the spokeswoman said.

Summary plan documents typically allow employers to alter or eliminate benefits including health benefits at any time.

Federal law generally prohibits a company from withdrawing money from defined benefit plans without terminating the plans. But the McDonnell Douglas withdrawals would not violate the law because the withdrawals are classified as pension benefit improvements, according to Michael Lackey, a vp in the St. Louis office of Towers Perrin, which helped McDonnell Douglas design the plan.

"This is equivalent to an increase in the retirees' pension benefits," he said. "It's similar to an organization deciding to take money from surplus pension plans to increase retirees pension benefits to offset inflation. The only difference is that McDonnell Douglas is directing the increase to be used for retiree medical plan premiums over the next four years."

Mr. Lackey pointed out that McDonnell Douglas will benefit from increased cash flow because the retirees—and not the company—are now paying for their health care benefits over the next four years.

"Essentially the company is trading one benefit for another," said William Miner, an actuary with The Wyatt Co. in Chicago. "The essence from the employer's perspective is it is able to reduce its FAS 106 obligation by replacing its company-funded retiree health care plan with a retiree-pay-all health care plan. They also are softening the blow for retirees by giving them the money to pay for retiree health care for the first four years. That can be attractive, but the price employers are paying is they are giving up some of their pension assets."

"The approach they've taken can work well if you have a surplus in your pension funds and if you have enough left to pay for future pension benefits," said Jerry Wilson, a consultant with Hewitt Associates in St. Louis. But, "Not many employers have that size of surplus."

And, he noted, McDonnell Douglas' approach only takes care of the problem over the next four years. "It may be a brilliant stroke if something is legislated to take care of those retirees' health care costs within four years. But if not, the problem will come up again." ■

Oil spill law

Continued from previous page

American Graduate School of International Management in Glendale, Ariz.

Still, insurance transfer could be a mere stop-gap. Oil pollution losses, explained Mr. O'Connell, will probably exceed the OPA 90 financial responsibility requirements.

"Just as property values vary among geographic regions, so will the potential value of property damage," he said.

OPA 90 already has contributed to substantial premium increases for basic and excess P&I coverage purchased by tanker owners trading with the United States, according to Mr. Burke (*BI*, Feb. 10; Jan. 6).

Failing to meet the OPA 90 financial responsibility requirements carries an even higher price: A vessel may be denied entry to ports in the United States or its territorial waters, defined as 200 nautical miles from the continental U.S. shoreline, American Samoa, the Marianas, Guam, the U.S. Virgin Islands and Puerto Rico.

Non-complying vessels also may be detained or subject to civil penalties of $25,000 per day.

In addition to meeting the financial responsibility requirements for maximum liability, OPA 90 also requires that single-hulled oil tankers be converted to double-hulls or be phased out of service by 2010, and that all newly constructed tankers be equipped with double hulls.

"It has been estimated that double hulls add approximately 15% to 20% to the cost of new tanker construction," Mr. Burke added.

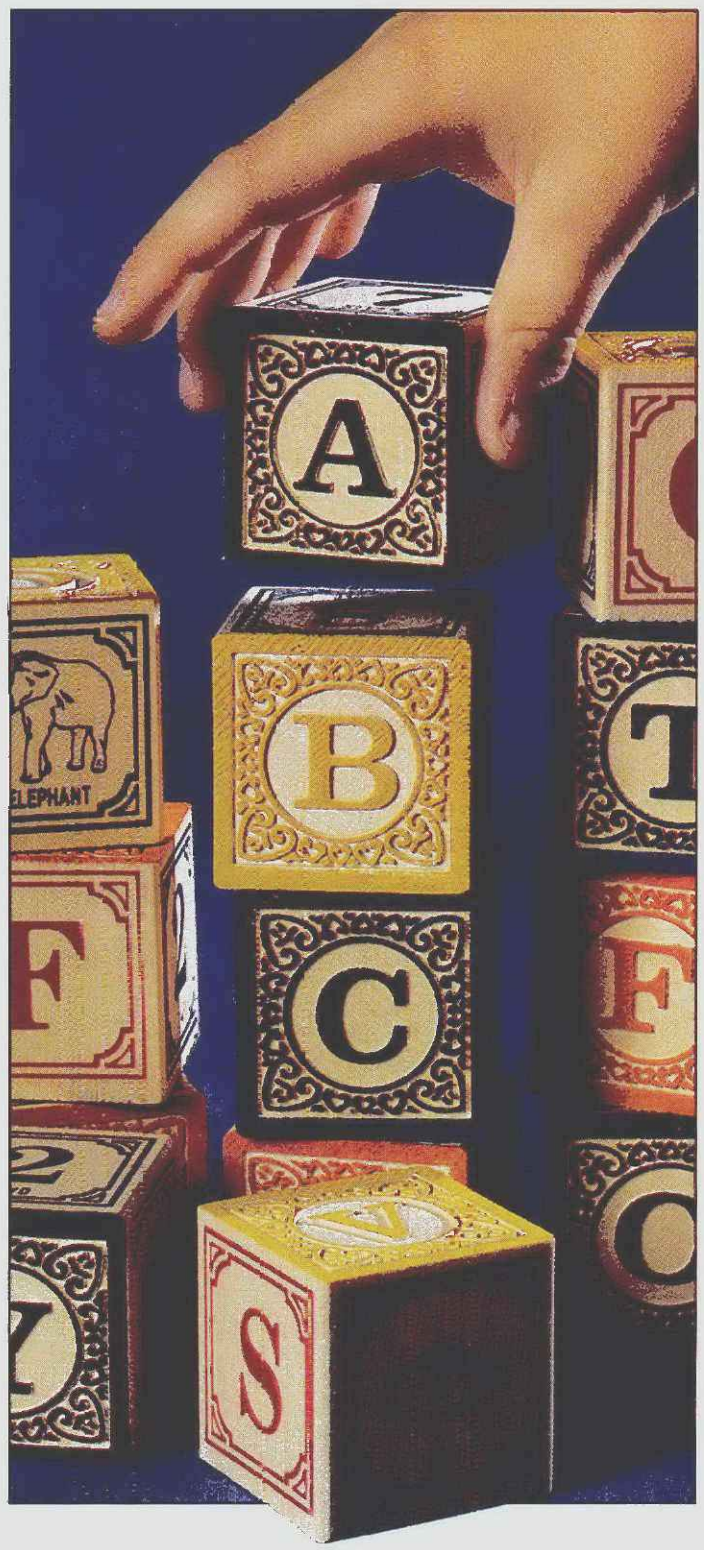
Although OPA 90 applies only to U.S. waters, it is unlikely that many shipbuilders will build tankers that cannot dock in American ports, he observed.

And, eventually, other countries are likely to beef up their environmental regulations so their ports are protected from substandard vessels, Mr. Burke predicted.

Indeed, other countries will only accept vessels that don't meet U.S. standards in their ports for a limited time as they eventually are led to believe that such tankers are unsafe, Mr. O'Connell agreed.

The discussion was moderated by Robert Crockett, corporate insurance manager for Apple Computer Inc. ■

The ABC of E&O



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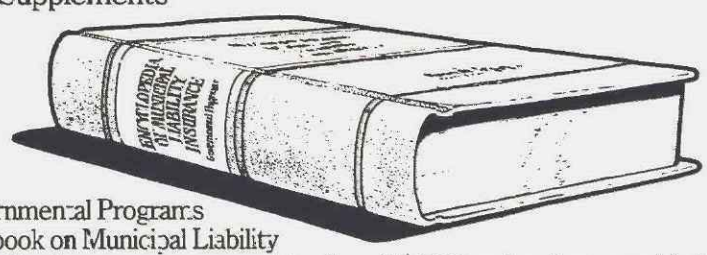

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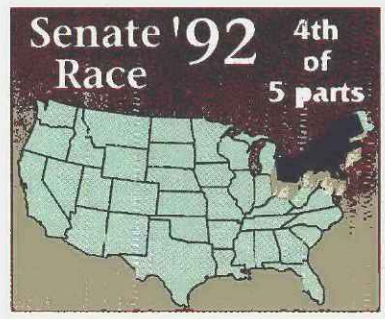
Eastern Senate races profiled



In the fourth installment of a series on U.S. Senate races, *Business Insurance* this week spotlights the major candidates in Connecticut, Maryland, New Hampshire, New York, Ohio and Pennsylvania.

Candidates were asked their opinions on the health care crisis, tort reform, reform of the McCarran-Ferguson Act and a possible federal role in insurance regulation.

Connecticut

Democratic incumbent **Christopher J. Dodd** supports reform of the health care system that would make quality health care coverage affordable. Sen. Dodd, 48, co-sponsored the Better Access to Affordable Health Care Act, S. 1872, which would help control health care costs without imposing major new mandates or taxes on small businesses.

Sen. Dodd

Sen. Dodd is also an advocate of preventive care programs like childhood nutrition and immunizations and prenatal care.

He wrote the Family and Medical Leave legislation, S. 5, that would have allowed working parents to take a leave for the birth or adoption of a child or to care for a sick family member without losing their job or health insurance. The bill was vetoed by President Bush earlier this month.

Republican challenger **Brook Johnson**, 46, chairman of C.S. Brooks Corp., did not reply to repeated requests for his views.

Maryland

Republican challenger **Alan Keyes**, 42, is the immediate past president of Citizens Against Government Waste and an interim president of Alabama A&M University in Huntsville.

Mr. Keyes says employers should be given tax incentives to expand managed health care programs. Echoing a proposal by the Bush administration (*BI*, Feb. 10), Mr. Keyes said individuals not covered by group plans should receive tax credits to help

Continued on page 20

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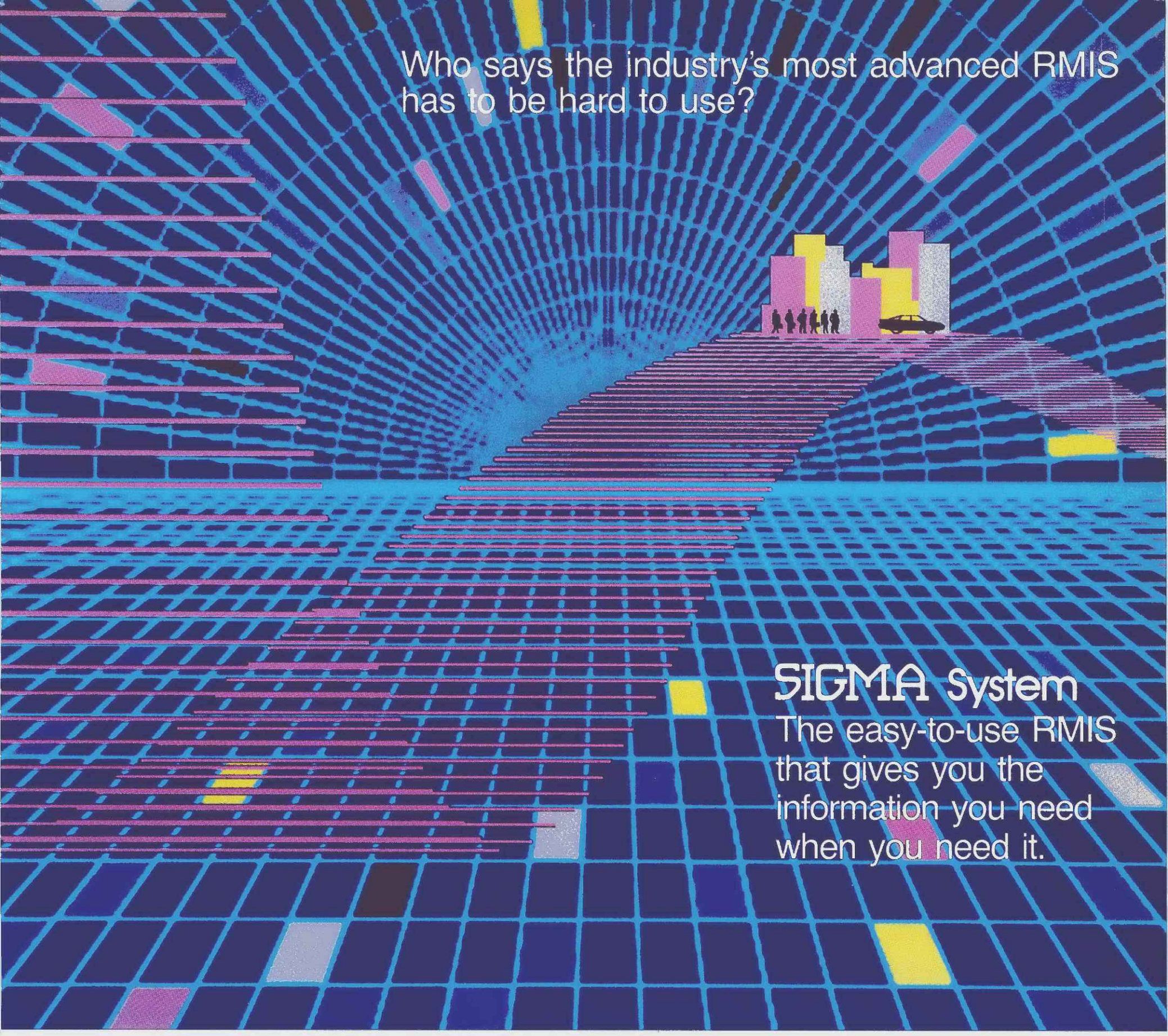

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BI

Senate races

Continued from page 18

cover the cost of insurance.

"This approach empowers individuals to make choices about the health plan which best suits their individual needs rather than funneling more money into government bureaucracies," Mr. Keyes said in a position paper.

Mr. Keyes

Mr. Keyes wants to make it easier for small employers to form risk pools to buy health insurance. He also favors increasing to 100% from 25% the tax deduction that the self-employed can take for health insurance premiums.

He says, "Socialized medicine's 'cure' is much worse than the ailment."

On civil justice, Mr. Keyes favors wider use of alternative dispute resolution and backs caps on both non-economic damages in medical malpractice suits and attorneys' fees.

Federal regulatory authority should only be expanded when absolutely essential, he said.

An opponent of antitrust reform, Mr. Keyes says that changing the McCarran-Ferguson Act —by, for instance, restricting insurers' ability to share information—would make it more difficult for a new, small insurer to enter the business.

Democratic incumbent **Barbara Mikulski,** 56, was elected to the U.S. Senate in 1986.

Sen. Mikulski did not formally respond to *Business Insurance*; however, an aide said she favors expanded access to health insurance, but is concerned that expanding access may hurt small business.

Sen. Mikulski was one of 38 senators who voted last month against cutting off debate on a bill, S. 640, that would have established a uniform federal product liability law. The failure to limit debate killed the bill.

Sen. Mikulski does not sit on any committees that have jurisdiction over proposals to reform the McCarran-Ferguson Act or to federally regulate insurance. Industry lobbyists say they know of no positions Sen. Mikulski has taken on those issues.

New Hampshire

Democrat **John Rauh**, a retired chief executive officer of manufacturer Clopay Corp., is vying for the seat being vacated by Republican Warren B. Rudman, who is retiring from the Senate.

Mr. Rauh, 60, favors creation of a national health care board—

Mr. Rauh

Sen. D'Amato

with representatives from health care providers, business, labor unions and consumers—that would control health care costs by setting maximum fees and creating practice guidelines. The board would also try to trim waste by eliminating redundant medical equipment and facilities.

And, the board would simplify claim procedures and claim forms to cut administrative confusion and expense.

Mr. Rauh would like to see the unemployed and self-employed covered under a new health care program that would include Medicare and Medicaid. Employers would have the option of providing coverage through this program or through private insurance.

Republican Gov. **Judd Gregg**, 45, did not respond to repeated requests for his views.

New York

Republican incumbent **Alfonse D'Amato,** 55, backs a federal health care program to provide "the broadest possible services in the most efficient manner for all Americans."

He supports President Bush's proposal to provide tax credits and refunds to low- and middle-income Americans who buy health insurance. He also advocates expanding Community Health Centers and the National Health Services Corps programs, which currently provide medical services to about 7.5 million people.

Sen. D'Amato took no specific position on antitrust reform, saying only that further hearings are needed.

Democratic challenger **Bob Abrams,** 54, "whole-heartedly" endorses a single-payer, national health insurance program.

Mr. Abrams

Mr. Abrams —who is New York attorney general—supports the universal, Canadian-style health care program sponsored by Rep. Martin Russo, D-Ill. It is expected to be reintroduced next year by Jim McDermott, D-Wash.

This program would entail raising corporate payroll and income taxes substantially, though Mr. Abrams does not favor funding the program through corporate taxes alone.

Instead, he favors a corporate payroll tax of 6.75%, and an individual income tax of 1.45%. Also, he favors putting 90% of current state Medicaid contributions toward the government program, and raising the maximum corporate tax rate to 38% from the current 34%.

Mr. Abrams would also raise excise taxes on liquor and cigarettes.

Mr. Abrams believes U.S. citizens should not have to pay coinsurance or deductibles for health insurance and should retain the right to choose their own doctors and hospitals.

"The symptoms of America's health care crisis are there for everyone to see," he said. "But so is the cure: the immediate implementation of a single-payer national health care system.

"What the president is proposing is a pathetic program that offers a paltry few hundred dollars of tax credits to help people pay for their medical insurance, leaving the serious health care crisis untouched," he said.

On civil justice, Mr. Abrams advocates protecting the rights of injured people to sue. As New York attorney general, he continuously urged New York's congressional delegation to defeat any product liability reform bill designed to insulate manufacturers and sellers from lawsuits by consumers.

Mr. Abrams was the principal proponent of the New York Toxic Torts Bill, passed in 1986, and he changed a rule that had generally made it impossible for people exposed to toxic substances to sue the companies responsible for the contamination.

He favors repeal of the McCarran-Ferguson Act, and has advocated the position in Senate testimony each year since 1986. He was one of the 19 attorneys general who brought the major insurance antitrust lawsuit in 1988 (*BI*, March 28, 1988).

Insurance regulation should remain with the states, he says. But, he added, states that permit "file and use" rating are not actively regulating insurance.

Ohio

Democratic incumbent **John Glenn**, 71, believes the health care system must be comprehensively reformed to control costs, streamline bureaucracy and ensure access to all Americans without sacrificing quality of care.

Sen. Glenn

Long a backer of tort reform, he says that "fear of indefinite liability has had a chilling effect on U.S. industrial de-

Continued on next page

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InsurerTopics

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Handling a storm of claims

Computers, faxes, mobile phones all but replace pencil and paper when adjusting disaster claims

By MICHAEL BRADFORD

Administering claims after a catastrophe just isn't what it used to be.

In the dark ages of the 1970s, insurers and adjusters relied on pencils and paper when gathering claims data. Today's adjuster is more apt to reach for a laptop computer or cellular phone than a pencil sharpener.

CLAIMS Handling & Automation

And after catastrophes like Hurricanes Andrew and Iniki, those who process claims data come to know how important technology has become. Computers and telecommunications have made their jobs a lot easier.

"I used to keep all the information on three-by-five cards and used accounting paper in the '70s," recalled Dennis Fox, national general adjuster for The Home Insurance Co. "When you needed to change something, you had to erase it. It became a nightmare."

Earlier this month, Mr. Fox sat in a Fort Lauderdale hotel room surrounded by the technology that has revolutionized the way he and other insurers handle catastrophe claims. He has a laptop computer, portable fax machine, photocopier, printer and cellular telephone at his fingertips.

Most critical may have been the cellular phone. "Without the cellular phones, we would have been dead in the water," said Mr. Fox. With telephone lines down, they allowed him to direct adjusters in the field and exchange claims data.

Mr. Fox's room is the central nervous system of The Home's claims activities in Florida. From there, he assigns adjusters to locations, then consolidates the data they bring to him.

Mr. Fox loads the data into a spreadsheet program he developed, prints a report and faxes it to The Home's headquarters in New York. Reports went out two to four times each day shortly after the hurricane, and have now slowed to one a day.

Among other things, the reports detail the insurer's total exposure, break down claims by line of exposure and can show each adjuster's case load.

Mr. Fox's remote connection through a laptop computer gives him the same access to data as if he were sitting at his desk in New York.

Automation, he said, "makes my job a lot easier." And, it allows for greater flexibility and productivity.

"When I send a report to New York, if they want it in a different format, I can do it easily," said Mr. Fox. "In the old days, they got what I sent."

Mr. Fox said he has learned that it is easier to establish a "beachhead," like his hotel location, than an actual office early after a catastrophe.

"I live and breathe this in the early days, working 18 hours a day. If I was in an office, it would be tougher to do that. But it's easy to spend that kind of time on it when you're in your room. There's nothing else to do."

Out in the field, some Home adjusters carry laptops loaded with programs that can help them estimate damages and negotiate settlements.

Like The Home, Kemper National Insurance Cos. gathers claims data in Florida and sends it to another location for processing.

Because all of Kemper's regional offices are tied together in the same computer network, claims can be processed from any of those offices, explained Tom Kaye, national catastrophe claims coordinator at Long Grove, Ill.-based Kemper.

Hurricane Andrew claims are processed through the insurer's Atlanta office. Kemper adjusters report to satellite offices in the south Florida area.

"Once we have claims reported, we can get policy information and the policy number from the local agent," said Mr. Kaye. "We fax the policy number to the Atlanta office. They put that into the system and the insured's profile comes up on the screen. That's how we establish a claim file."

Kemper has handled around 2,000 claims from Hurricane Andrew and most of the personal lines claims have been closed, said Mr. Kaye. "We've made contact with all the policyholders. Commercial losses are larger and don't close as fast," he noted.

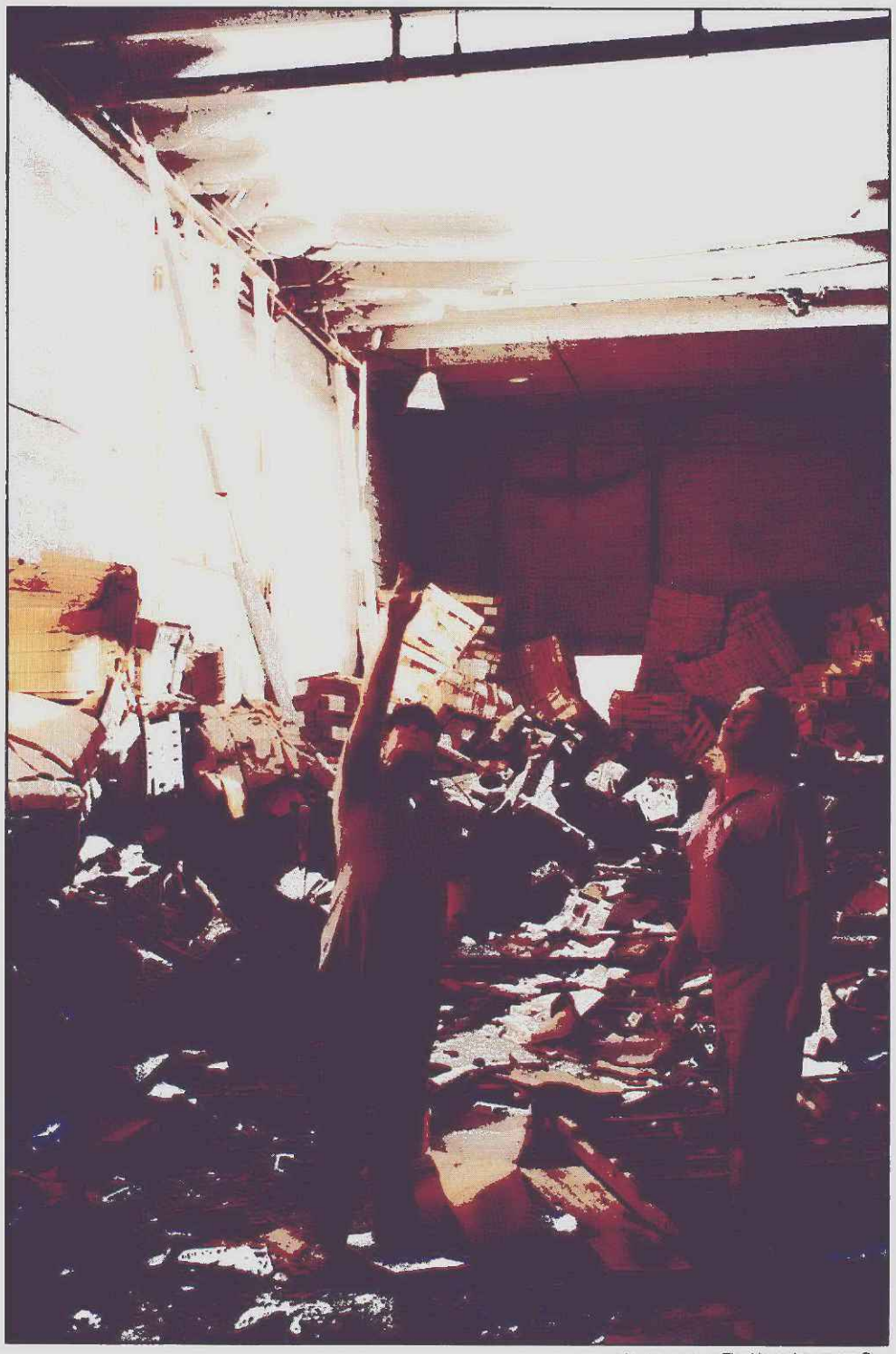

Photo courtesy The Home Insurance Co.

Floyd Kearson, of the Carrillo Agency in Miami (left), and Bill Atkinson, an adjuster for The Home Insurance Co., inspect what's left of a roof after Hurricane Andrew.

Although insurers have come to rely on their automated systems, they stress that during a catastrophe, the systems are merely machines that help get claims settled more quickly.

"In a catastrophe situation, the primary goal is to service the policyholder," said Mr. Kaye. "The automated system is kind of in the background. Most insureds don't know or care how their claims get processed."

"In a catastrophe involving homes and businesses, you still have to have personal contact," concurred a spokesman for State Farm Group of Bloomington, Ill. Automated systems provide efficiency, accuracy and service aspects that make the process smoother for the policyholder, he said.

State Farm, an insurer that considers much of the information regarding its claims system proprietary, established an office in north Miami shortly after the storm. It was equipped with 250 personal computers.

"When we run a catastrophe operation, we bring in people from outside the region to handle the claims," the spokesman said. A separate operation that can function like a State Farm regional office is set up in the area.

"The point of contact with us is the agent," he explained. However, policyholders unable to report claims to their agents were able to call a toll-free number and report damage after Hurricane Andrew.

When claims are received, State Farm dispatches an adjuster to the site. That adjuster returns to the office and feeds the claims information into the computer network that is tied into the insurer's central claims system.

"Aside from some of the logistical difficulties up front" the system has worked very well in Florida, he said.

One difficulty insurers encountered after Andrew and Iniki was power outages. And insurers know that when the power is out, the fanciest technology in the world can't make a claims handler's life any easier.

"One of the big problems on Kauai was that all the electricity was shut off," said Bruce Anderson, vp of marketing at Hawaiian Insurance Group in Honolulu. "There were literally thousands of telephone and power lines down.

"Our office was damaged, and there were no telephones or electricity and no commercial flights in or out."

So in the age of high-tech computer claims handling, "we were pen and pencil, catching rides as we could on private planes and with government relief efforts."

Before the hurricane struck, Hawaiian Insurance Group was working on expanding its automated claims handling system to the Kauai office. But the storm blew away those plans, damaging the insurer's office and reducing its claims handling to what employees could carry to Honolulu aboard their flights.

"We're expecting around 5,000 claims," said Mr. Anderson. The company has estimated its claims will total between $140 million and $150 million and will translate to a loss of $15 million to $18 million after reinsurance (*BI*, Sept. 28).

Continued on next page

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Insurer Topics

Catastrophe claims

Continued from previous page

Allstate Insurance Co.—whose gross loss from Hurricane Andrew may be the industry's highest ever at $1.73 billion (*BI*, Oct. 12)—relied on two key software packages to increase its efficiency in handling storm-related claims.

After establishing a catastrophe claims center in Miami, the insurer put to work an "estimating system" program to helps determine settlement amounts, a spokesman explained.

Allstate is using software developed by Certified Collateral Corp. for the first time as it processes Andrew claims, the spokesman said.

Damage information from adjusters is fed into the system, which estimates losses and repair costs.

"It's particularly helpful because of the huge volume of claims," the spokesman explained. "It doesn't change the process. . .it speeds it."

Allstate also relied on its "mechanized dispatch" software that was developed while claims were being settled during Hurricane Hugo, the spokesman said.

The system replaces manual record keeping that allows claims managers to audit the claims process. By accessing the system, managers can determine, among other things, how many claims have been adjusted or closed and which need further attention.

The system also allows claims handlers to quickly answer customer inquiries, the spokesman noted.

Meanwhile, state insurance regulators and consumer advocates seem to agree that automation is increasing claims-handling efficiency.

While it is too early to judge the entire industry's performance in reaction to the hurricanes, "overall, we think the companies have done a pretty good job to date," said a spokeswoman for the Florida Department of Insurance. However, she added, "There may be some areas where individual companies" haven't performed as they should.

There's no yardstick for measuring insurers' recent performances, she pointed out. "No one has ever been through a storm like Andrew."

Companies that have historically done well in settling catastrophe claims seem to have performed up to par after Hurricane Andrew, she said.

Automation has probably made insurers more efficient, the spokeswoman noted, just as it has helped the Insurance Department become more responsive to consumers.

"Our department has become more technology-oriented," she said, "from fax machines that can send out 800 letters a night unattended to an E-mail system we use to communicate with the Miami office instantly" via computer when consumer complaints are received regarding hurricane claims.

She agreed with insurers that technology "still doesn't replace the need for an adjuster to go to a home, find the person and negotiate a settlement amount."

"I would say the effort was good by most companies," said J. Robert Hunter, president of the Alexandria, Va.-based National Insurance Consumer Organization. The larger ones reacted well, he said.

"We got some calls" from policyholders who complained that they took time off from work to meet adjusters who never arrived, he said. "There's going to be some of that."

Mr. Hunter said insurers found themselves in a position similar to that of government authorities who initially underestimated the need for support in the hurricane-stricken area.

"They were a little overwhelmed at first. First they thought they needed 100 people, then it was 500." ■

After Hurricane Andrew hit, insurers found themselves in the same boat as federal relief officials, says consumer activist J. Robert Hunter. 'They were a little overwhelmed at first. First they thought they needed 100 people, then it was 500.'

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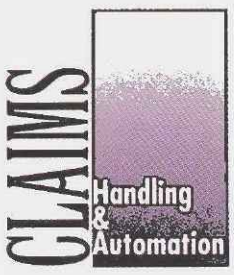
Upgrade pays dividends

Insurer's new imaging system works so well, it plans to sell it

By MARK A. HOFMANN

IRVINE, Calif.—What do you get besides increased efficiency when you install an image processing system?

The answer—if you happen to be the president of American Sterling Corp.—is not only a better way to process the flood of paper that inundates most insurance companies, but a new software subsidiary as well.



The company began upgrading its data processing about five years ago when its American Sterling Insurance Co. unit found itself "drowning in paper," recalls Michael Thompson, president of the Irvine, Calif.-based parent company.

Ironically, imaging—creating computer images to replace paper records—was not the original thrust of the upgrade. Instead, efforts were focused on developing expert systems, programs that replicate some of the expertise of a human operator in processing information.

American Sterling Insurance, which underwrites credit insurance for lenders, tracks the mortgage loans to make sure the borrower maintains property coverage. The property insurance documents must be matched to the loans. About 20,000 documents were pouring in daily from about 850 insurers.

The result was a "very, very labor-intensive" operation, said Mr. Thompson. Some 48 data entry operators tried to gather information from nearly 5,000 different formats. Each operator handled an average of about 500 documents a day.

Steadily, the barrage of paper took its toll on the operators. Turnover averaged 60% to 70% per year. Operators took about four weeks to train and generally about six months to reach average efficiency, so the situation was a heavy drag on the company's operation.

Operator burnout, plus the workload, resulted in an error rate of about 8%. With so many errors, the company had to handle even more paper.

American Sterling wanted a computerized expert system to help match data to data. Because no off-the-shelf product met the company's need, it set out to develop its own expert system, said Mr. Thompson.

The data match rate improved dramatically, but efficiency still lagged, he said. As a result, American Sterling began looking at imaging technology. Once again, it didn't find quite what it wanted and decided to build a customized system.

With the new system, mailroom workers sort and scan mail as it comes into the office. The scanner assigns each document batch and individual identification numbers and uses an optical character recognition system to record the image. Data entry operators then edit the data and kick out poor quality or handwritten documents for manual review, he said.

American Sterling wanted a computerized expert system to help match pieces of data. Because no off-the-shelf product met the company's need, it customized its own imaging system, explains Michael Thompson.

Mr. Thompson said that imaging provided the productivity spur the company wanted. Each operator now handles an average of 1,250 documents a day, with an error rate of less than 0.1%, he said. The work that formerly required 48 people is now handled by 12, he said. The other employees have been reassigned or their jobs permitted to fall from the payroll through attrition.

The shift to imaging has changed the profile of the employees hired to handle the data, Mr. Thompson said. Whereas quick keystroking was crucial in the pre-imaging days, the emphasis is now on employees' ability to read and comprehend information.

Developing the new system was not cheap. Putting together the initial expert system cost about $1.5 million. The imaging system cost an additional $2.5 million to develop and implement, said Mr. Thompson.

So impressed was American Sterling with its own handiwork, that the company decided to market it. In May, the company set up a subsidiary—4i Solutions Inc. in Lake Forest, Calif.—which now sells two imaging products: 4Front Data Capture System and 4Site Extended Processing System.

Mr. Thompson is unabashed in his enthusiasm for imaging's potential.

"I think imaging will be the technology of the '90s," he said. He added that prices for the technology itself, once prohibitively high for all but the largest corporations, have continued to fall since its introduction less than a decade ago.

"One of the reasons imaging hasn't taken off is that people have too many dollars invested in existing technology and existing software."

Mr. Thompson cautioned, however, that while imaging technology alone increases productivity, its greatest advantages are realized when it is seen as a tool for rethinking workplace processes and procedures.

"If you just look at it as a method of replacing so many square feet of filing cabinets, you're not going to get the benefit," he said. ■

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Insurer Topics

Photo courtesy Image Data Corp.

A body shop employee sends an image of a damaged vehicle to USAA.

Imaging applications grow to include auto repair claims

By LAURA MAZZUCA

CLAIMS Handling & Automation

CHICAGO—The use of computer imaging is gradually growing in the insurance industry, and in five years or so will be as prevalent as the facsimile machine, say users.

And, imaging—a process in which the electronic image of a documents can be stored in a computer and displayed on screens—will save insurers money, as well as third-parties, like auto repair shops.

Five years ago, the big business question was "Do you have a fax machine?" said John Warkenthein, business manager for CCC Information Services Inc. in Chicago, a provider of automated claims services to property/casualty insurers. Today, the question is simply, "What's your fax number?"

Similarly, electronic imaging will become more commonly accepted in the business world.

And the insurance industry particularly stands to gain from its use, especially in the claims area, said Mr. Warkenthein, who participated in a panel discussion on imaging at the annual CCC Information Services claims conference in Chicago early this month.

Imaging frequently functions as an "electronic camera," thus providing an alternative to sending actual photos.

For collision repair shops, it's a benefit because they don't have to wait for an insurance adjuster to check out the work. Instead, the repair shop can send the insurer an electronic image of the completed repairs.

Imaging can also enhance a repair shop's professional image, and can be used as a sales tool to graphically illustrate to customers "before" and "after" work, Mr. Warkenthein said.

Imaging also saves on postage for mailing claims and photos. And, it's a winning proposition for the customer, who gets his car back more quickly.

United Services Automobile Assn. has been using "photocapture" technology since it launched a pilot project in 1989 with seven collision repair shops in the San Antonio, Texas, area, said Keith Waldrop, chief production manager.

The technology was designed to be used as part of the San Antonio-based insurer's direct repair concept, to improve service to policyholders and third-party clients and "make the member a customer for life," Mr. Waldrop explained.

Before introducing the technology, USAA conducted focus groups at the repair shops, and found that employees were concerned that they would either end up with technology that would rapidly become obsolete or be too complicated to use.

USAA provided training for shop employees on leased imaging terminals, and "the confidence level increased a thousandfold," Mr. Waldrop said.

Today, 56 separate repair shops in 15 states are interfaced with USAA's formally adopted photocapture system, now known as STARS—Streamlined Automotive Repair Service—sending images to 16 separate USAA receiving photophones, Mr. Waldrop said.

Between January and August of this year, USAA received 40,000 images, and has processed 2,900 claims through the program.

Imaging improves the claims process by "closing the loop" and eliminating the typical three-day period for claims processing.

Because it only takes about 52 seconds to transmit an image, imaging eliminates "phone tag" between the insurance adjuster, the shop and the dispatcher, allowing them to "place the customer first" in the process, Mr. Waldrop said.

Continued on next page

Agent/Broker Topics

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Continued from previous page

It has also created a "psychological comfort zone" for repair shops and appraisers, who frequently clash over estimates, he said.

USAA's outlay for the pilot project included "a lot of manhours" and about $15,000 for the leased terminals. But photocapture technology has allowed the insurer to reduce its overall claims cost because of the accelerated process, he said.

For appraisers, who are "on the other side of the image," photocapture technology enhances claims service by improving turnaround time, said Dan Moreno, USAA staff appraiser.

Over a 90-day test period with seven shops in California, Mr. Moreno noted a decrease in mail from the shops of about 100 supplemental reports per month.

Imaging also eliminates the need for reinspection after the repair is completed, because the appraiser can approve the work the same day using a photo image rather than having to visit the shop in person.

Without imaging technology, a field appraiser on a typical day can only complete five claims and two reinspections, including a 30-minute drive time for each location.

With photocapture, however, the appraiser can complete seven claims and six to eight supplements per day, Mr. Moreno said.

Imaging also will be a boon to the collision repair industry. Gerber Glass & Auto Collision Centers in Skokie, Ill., added imaging only four months ago at three of its locations, but has already seen an improvement in service, said Edward Carpenter, vp of marketing and sales.

"Our objective is to provide the most convenient way to return a customer's car to its preaccident condition," he explained.

Gerber, a direct-repair facility for several insurers, has found that imaging gives the company an edge in performance and efficiency, Mr. Carpenter said.

USAA's photocapture technology "has been a major factor in our success," said Wayde Peet, body shop manager of Ken Batchelor Cadillac in San Antonio. The body shop and dealership began using USAA's photocapture technology in December 1990.

Imaging allowed the shop to improve its damage report time by 20% to 30% for USAA policyholders, allowing a one-day turnaround since supplemental reports are addressed as they occur inside the shop, Mr. Peet said. This has both improved customer service and reduced operating costs.

"Everyone wins: the vehicle owner, the repair facility and the insurer," he said.

Like Mr. Carpenter, Mr. Peet's shop uses imaging as a sales tool, storing repair images on a floppy disk and showing them to customers to illustrate the work they do.

Imaging is also an important documenting tool to use in a legal situation if a client complains about work, he added.

Most importantly, imaging gives shop owners a "level of trust" with their clients, eliminating "suspicion and marginal trust" because it provides them with "instant verification" of the work being done, and avoids delays in completing the work, said Dave March, owner of Fountain Valley Bodyworks in Fountain Valley, Calif.

Mr. March estimates that photo imaging allowed his shop to increase its production by 30%.

Imaging is not just used in the body shop area. Approximately 5,500 photo phones are installed in the United States and 26 other countries, said Richard Koon, vp-sales and marketing for Image Data Corp. in San Antonio. The first Image Data units were installed in 1985 and are still fully compatible with the newer models.

While about 150 of these are in claims offices or body shops, many other applications exist, such as in the medical industry, Mr. Koon said. ■

Auto repair specialists Dave March and Wayde Peet (left and center) join USAA's Dan Moreno in a panel discussion of the impact of imaging systems on automoble damage claims.

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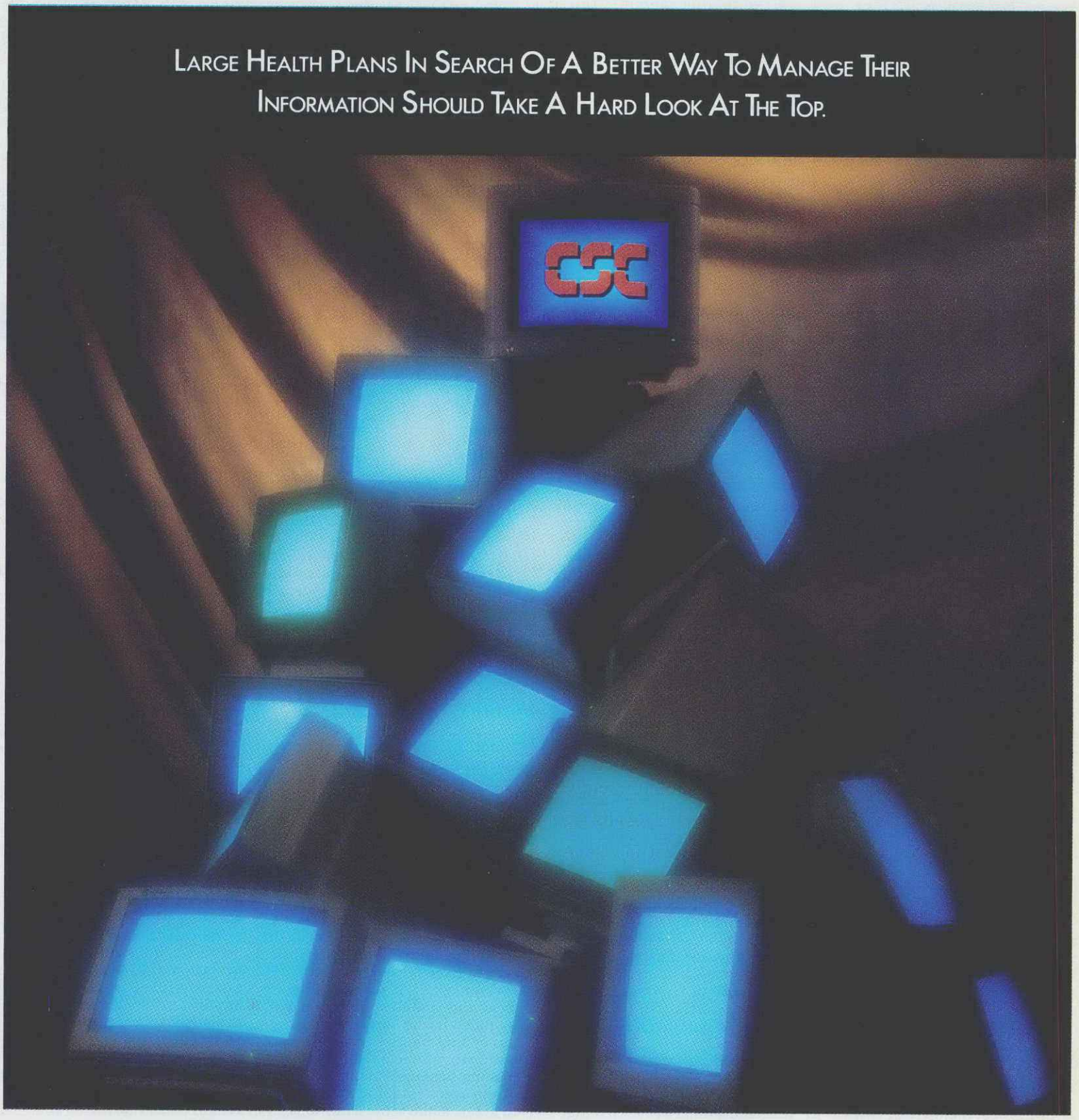

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Insurer Topics

Insurers praise the power of 're-engineering'

But survey shows they have a lot to learn about managing it

By MARK A. HOFMANN

Many insurers herald "re-engineering" as their salvation, yet they can't agree on what the concept means and are not adept at managing it, according to a survey.

There simply "is not a great deal of precision" in how insurance executives define re-engineering, says Ray Manganelli, president and chief executive officer of Gateway Information Services Inc., a Swiss Reinsurance Co. unit in New York.

CLAIMS Handling & Automation

Generally, re-engineering means fundamentally rethinking business processes to dramatically improve productivity.

What Gateway does is look at a client's business strategy and then define what employees do and how they do it to improve results. There is no presupposition about how the work ought to be restructured to achieve results, said Mr. Manganelli.

Gateway recently surveyed 20 senior insurance executives on their attitudes toward re-engineering. The executives, who represented both life and property/casualty companies, were part of a group of 121 senior managers that represented the manufacturing and utilities industries in addition to insurance, said Mr. Manganelli.

When asked to define re-engineering, their answers included:

- "Redesigning workflow."
- "New ways to accomplish tasks."
- "Reviewing procedures."
- "Retooling administrative systems."
- "Redesigning from the ground up."
- "Changing (automation) platforms."

"Our belief is that the insurance industry has seized on the idea because (the industry) has all of the characteristics of organizations that will have problems in the 1990s," Mr. Manganelli said.

One of these problems is a tendency to "underautomate," he said. He traces most systems insurers use to the earliest computer systems. And instead of making the maximum use of their systems, insurers are content to use automated systems basically as calculators.

Another problem is that despite automation, insurers remain labor-intensive, he said. The companies are also hierarchical, with armies of clerical workers carrying out the decisions made by a handful of managers.

Re-engineering means fundamentally rethinking business processes to improve productivity.

Mr. Manganelli said the survey indicates that insurers' main reason for re-engineering is increased competition. The second most common reason to embrace the concept is technological changes.

But, he noted, insurers don't adequately budget for re-engineering programs and therefore have a tendency to face greater budget constraints than their counterparts in other industries. Only 10% of the insurance executives surveyed had budgeted for their programs, compared with 35% of their counterparts.

A quarter of the insurance executives didn't know the results of re-engineering programs that have gotten under way between 1989 and this year, according to the survey.

Mr. Manganelli said insurance executives often fall into a trap he called "re-engineering orthodoxy." For example, they are willing to wait three to five years to get results. By that time, "your targets would be obsolete," he said.

Some programs can cost $1 million a month in consulting fees. So, the program should provide short-term payoffs that defray costs very quickly, Mr. Manganelli said.

Another mistake executives make is to think small, and allow re-engineering to affect just one department or function, he said. "What good is a program like re-engineering if it doesn't have a significant enterprise-wide impact?" asked Mr. Manganelli.

Gateway recently introduced its own re-engineering product, RapidRe, to improve the re-engineering process, he said.

The product involves five steps: using software to review current processes and procedures, comparing the results against benchmark data for similar operations or industry leaders, identifying areas that present high opportunities for improvement, implementing immediate and short-term improvement initiatives, and developing a plan to institute the longer-term initiatives.

Mr. Manganelli said this type of modular approach allows companies to use savings that result from short-term initiatives to pay for longer-term goals, so the program becomes self-funding.

The objective of re-engineering should be to rethink work processes and work smarter, not necessarily to trim operations, he said.

"You can't cut your way to profitability. You can't cut your way to competition in the 21st century." ■

Insurers can avoid their day in court

Expressly limiting agent/broker authority can minimize liability for misrepresentation

By Peter H. Kirwan

IT Perspective

IN TODAY'S LITIGIOUS climate, insurance companies are recognizing that their ability to avoid the spiraling web of litigation rests largely upon the conduct and status of their agents and brokers.

The principles applied in determining liability of an employer for the alleged conduct of its employee are analogous to the age-old Latin maxim *respondent superior*, which means "let the master answer."

Under most present circumstances, the insurer-agent or insurer-broker relationship is defined by contract. Most agency contracts incorporate a provision to expressly define the scope of authority under which an agent or broker may act on behalf of an insurer.

Although the actual authority of an agent or broker may be clearly defined in such contracts, the applicant or policyholder is generally not informed of the boundaries of a particular agent's actual authority.

Accordingly, the applicant or policyholder is usually entitled to rely upon the agent's apparent authority to make representations on behalf of the insurer regarding the coverages of a particular insurance policy.

In the vast majority of cases alleging agent misrepresentations, it is the agent's apparent authority to bind a policy that exposes the agent's insurer to liability. Although there are an overwhelming number of different factual and legal dimensions defining the scope of apparent authority, the general result is all too familiar for the insurance company; i.e., the agent acting within the scope of his actual or apparent authority has the power to bind his or her insurer. This authority often leads to unfavorable results for the insurer.

All too often, insurance companies find themselves pulled into litigation to defend the alleged conduct or representations made by their agents. Cases that allege agent misrepresentation often become credibility contests between that agent and the policy applicant.

In light of the prevailing climate toward insurers, it is not unreasonable to assume that the applicant stands a strong chance of prevailing in such cases.

An insurer can attempt to limit its liability and possibly avoid litigation for cases involving allegations of agent misconduct in a number of ways.

Although the focus here will be on other means to avoid liability for agent misconduct, the importance of a thorough and detailed training program for agents should not be minimized.

Such a program should instruct an insurer's agents to avoid making any representations about coverage or underwriting that are not expressly covered in the company's promotional materials.

With applicants' sophistication increasing, it is extremely difficult to anticipate each and every question that an agent may be asked. Accordingly, sometimes the most complete and thorough training sessions cannot preclude an agent from providing information not covered in the promotional materials.

Most jurisdictions follow the general rule that an applicant or policyholder cannot benefit from the representations and/or conduct of an agent that exceeds that agent's express authority if the application in question contains clear and unambiguous limitations on that authority.

Therefore, it is important that the language contained in such "limiting" provisions be clear and unambiguous. Examples of such provisions generally state that the agent does not have the authority to waive, alter or modify any provision of the application or policy for which the agent is applying.

Provisions limiting the scope of an agent's authority will not be upheld unless such provisions are brought to the attention of the policyholder, a federal court said in *Brown vs. Interocean Insurance Co.* As noted earlier, clear and unambiguous language included in the application or policy that limits the agent's authority protects the insurer by placing the applicant on notice of the agent's limited authority to act or make representations on behalf of the company.

However, including such limitations exclusively in the insurance policy is not sufficient. Notice of the limitations placed upon the agent should be included in marketing brochures, applications, conditional receipts and any other promotional material left with the applicant or policyholder.

Brown, a 1977 case tried in Georgia, involved a life insurance application that contained a provision stating, "No agent shall have the right to make, alter, modify or discharge any contract or policy issued on the basis of this application. . ." The court found this language to be clear and unambiguous and put the applicant on notice of the limitations placed upon the agent's authority. Accordingly, the court held that the agent's representations to the applicant that exceeded the agent's actual authority were not binding on the insurer.

A large percentage of misrepresentation cases involve an agent's alleged misrepresentation of the scope of coverage provided in the policy. As the promotional materials do not always clearly define the scope of the policy's coverage, the courts are more reluctant to enforce a limitation on the agent's authority.

In order to increase the "enforceability" of such a provision, the insurer should take careful steps to notify the applicant of the coverages provided. One way to do this is to attach a sample or specimen policy to the application.

A provision in the application requiring home office approval for coverage represents yet another preventive technique to effectively limit the scope of an agent's apparent authority. Such a provision generally provides that coverage does not take effect until the application is approved and accepted by the home office. This provision must be clear, unambiguous and conspicuous in order to withstand legal scrutiny.

In such cases, the courts will generally rule that no policy of insurance is in effect until the home office approves the application and accepts the first premium payment.

This additional safeguard should not be used as a substitute for the provision limiting the agent's authority. It should be utilized simultaneously to provide additional insulation to the company for its agents' conduct.

Most cases involving allegations of agent misrepresentation focus on the "reasonableness" of the plaintiff's alleged reliance on the representations. In determining whether an applicant's reliance was "reasonable" in order to support a claim for misrepresentation, the courts generally look to see whether such alleged representations are contrary to written materials in the plaintiff's possession. Accordingly, it is becoming more and more important to expressly limit the scope of an agent's authority so as to defeat this claim of "reasonable" reliance.

While an express limitation on the agent's authority can guarantee an insurer's protection from misrepresentation claims, it will reduce the overall exposure to such claims. ■

Peter H. Kirwan is an associate with the law firm Hoge, Fenton, Jones & Appel Inc. in San Jose, Calif. He specializes in insurance and bad faith litigation matters.

Insurer Topics

Insurers address overspecialization concerns of agents

By LAURA MAZZUCA

NEW ORLEANS—With direct writers becoming an increasing competitive threat in commercial lines, insurers must be careful to avoid crippling their distribution force through overspecialization, an insurance executive says.

James Cannon, president of SAFECO Insurance Cos., warned that there is a limit on how far insurers can go with specialization before they begin to weaken their distribution system by not providing enough markets for midmarket independent agents.

SAFECO, which maintains almost two-thirds of its business and $1 billion in premiums in personal lines, has long been concerned about competition from direct writers.

But now direct writers are also beginning to take an increasing interest in commercial lines. "If you think commercial business is competitive today, just wait," he warned during a panel discussion at the annual Independent Insurance Agents of America convention last month.

In fact, State Farm Group employs more Chartered Property & Casualty Underwriters than any other insurer, he noted.

Specialization, one of the industry's current fallback competitive strategies, will lead to subspecialization in the future, said Douglas W. Leatherdale, president and chief executive officer of The St. Paul Cos. Inc.

Insurers will see more niches they are willing to invest in, because "you simply can't be everything to everybody and do it well," said Mr. Leatherdale.

While "it's a certainty that our industry will continue its focus on what we do best," specialization will not just stop at product niches, said Fredric G. Marziano, vp of Continental Corp. and president of its agency and brokerage group. At Continental, specialization includes geographic regions and selectivity in producers.

Ten years ago the insurer had an agency force of 11,000. Now it gets most of it business—72%—from 1,100 "Circle" preferred agents. Continental, which is the second-largest commercial package writer after State Farm, will continue to focus on the preferred agents to reduce expenses and improve retentions, he said.

But pointing out the downside of specialization, Mr. Cannon said SAFECO must appoint six independent agents to get the volume that State Farm gets from one agent. This makes the case for diversification rather than specialization, he said.

Because "agents specialize in people in their community," many can't specialize in lines of insurance and must have contracts with insurers that can be all things to all people, added Eric G. Gustafson, chairman of Blake Insurance Agency Inc. in Portsmouth, N.H. Most of the IIAA's 280,000 members are small producers and need insurers to provide them with a wide range of products.

And while it's true that direct writers are making inroads into independent agents' market share, "It's not because the customers have left us, but we've left them" by not providing enough markets to place all of their business, said Mr. Gustafson, who is the new president of

Continued on next page

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Insurer Topics

Specialization

Continued from previous page
the IIAA.

In order to usurp the direct writers' market share, independent agents and insurers must cooperate to bring operating costs down, he said.

Maintaining the competitive edge was not the only survival issue the panelists discussed. Insurer chief executive officers speculated on how natural disasters like Hurricanes Andrew and Iniki—and man-made problems like insurer solvency legislation—would affect the industry.

While it's still too early to predict the magnitude of the effect of the hurricanes, "logic would suggest there has to be an impact, particularly on the property side," Mr. Marziano said.

The disasters will almost certainly affect reinsurance pricing and availability, beginning with January, April and July 1993 treaty renewals, he said. In fact, Continental Corp. announced late last month that it would stop writing reinsurance business and sell its Continental Reinsurance Corp. unit (*BI*, Sept. 28).

The St. Paul Cos., which has a presence in reinsurance underwriting, is having difficulty finding retrocessional coverage, especially for catastrophic treaties, said Mr. Leatherdale.

The biggest impact on the primary market will probably be "some diminution of capacity," he said.

SAFECO, which sustained about $125 million in losses from the Oakland, Calif., fires last year, is hoping not to be affected by the "precedent-setting string" of catastrophes, said Mr. Cannon.

However, insurance agents should pride themselves on the job they did in the wake of the hurricanes, commented Mr. Gustafson.

In fact, agents were on the scene in Florida even before the Federal Emergency Management Agency, he said. The insurance industry should "tell the public in a nice way what has been done," he added.

On legislative issues, the panelists agreed that the insurance industry must be more active in presenting its case to the public.

"The record shows that we understand what those key issues are, but we've failed miserably to get the insurance consumer to do something about it," said Mr. Cannon.

A "great object lesson" was the passage of Proposition 103 in California, when the insurance industry was not aggressive enough in mounting a campaign against the initiative.

Grass-roots efforts by the industry should communicate to the public that state legislatures are dominated by lawyers, whose own agenda is being promoted in the passage of legislation such as proposals involving rate rollbacks and freezes, said Robert L. Bailey, president and CEO of State Auto Insurance Co.

For example, the workers compensation system was originally devised as a no-fault program, "but it has deteriorated to a giveaway system," said Mr. Marziano of Continental, which writes about $1 billion in workers compensation coverage per year.

In the 1920s, experts identified 59 forms of stress. Today, the types of stress have grown to include 292 categories, which are compensable in some states for workers compensation.

But the insurance industry must address its concerns "to someone other than insurance insiders," noted Mr. Marziano of Continental.

While agent associations and others are doing a good job of lobbying Congress, a personal letter to a congressman is just as important, he said.

The insurance industry needs to become more sophisticated in using the media "the way everyone else does" to get its message across through sound bites, advertising and other forms of communication.

Agents' relationships with consumers puts them in a unique position to get the industry's message across.

"Money is not the key factor in this," Mr. Bailey said. "When you people get riled up about issues, things happen."

However, "no magic solution" exists for complex legislative issues, said St. Paul's Mr. Leatherdale.

The insurance industry should try to identify proposals that would reduce costs, "but not without seriously reducing access to the system," he said.

And while the push for federal regulation of insurer solvency is not as strong now as it was earlier in the year, "it's naive to assume that there won't be some form of federal regulation," Mr. Leatherdale said.

Although he said that the insurance regulation bill sponsored by Sen. John Dingell, D-Mich., is well-structured and "the best I've seen, addressing key issues in a rational fashion," the panelists agreed the legislation's fatal flaw is the separation of solvency and rate regulation (*BI*, April 20). ■

NAMIC names Johnson for 1993 chairmanship

BOSTON—The National Assn. of Mutual Insurance Cos. chose E. Alan Johnson as its 1992-1993 chairman during the group's annual business meeting late last month.

Mr. Johnson, president of Dayton, Iowa-based Scandinavian Mutual Insurance Assn., succeeded Robert L. Harrison, president of Indiana Lumbermens Mutual Insurance Co. of Indianapolis.

Lee Bondhus, president of the Reinsurance Assn. of Minnesota in Esko, Minn., was elected chairman-elect of NAMIC, an Indianapolis-based trade group which represents more than 1,240 mostly small to medium-sized mutual insurance companies.

Paul O. Stillman, president of Preferred Mutual Insurance Co. of New Berlin, N.Y., was elected vice-chairman.

The group also elected four directors-at-large: Gary Black, secretary/general manager of Farmers Mutual Insurance Co. of Grundy County in Trenton, Mo.; L. Gerald Roach, president of the Richmond, Va.-based Mutual Assurance Society of Virginia; Douglas C. Ryder, president of Holyoke Mutual Insurance Co. of Salem, Mass.; and James Taylor, president of Pennsylvania National Mutual Insurance Co. of Harrisburg, Pa.

Bruce Heaton, secretary/manager of the POINT Mutual Insurance Co. of Pontiac, Ill., retained his position as NAMIC's secretary/treasurer.

A call to fight fraud

BOSTON—The insurance industry must devote more attention to fighting insurance fraud, outgoing NAMIC Chairman Robert L. Harrison told the members of the association in his annual report to the group on Sept. 28.

"We must communicate to our insureds and the public that cheating the insurance company is cheating themselves—and most importantly—that cheating is not right," said Mr. Harrison, who is president of Indiana Lumbermens Mutual Insurance Co. in Indianapolis.

"Fraud is one of the most serious problems the industry faces today. We could slash auto insurance premiums by up to 25%, if it weren't for fraud. It's mind-boggling to realize that fraud costs the property/casualty industry $17 billion annually. To put that in perspective, that amounts to two Hurricane Andrews every year," said Mr. Harrison.

After praising the industry-supported National Insurance Crime Bureau in Palos Hills, Ill., for its work and promising that NAMIC and NICB would work closely in the future, Mr. Harrison called on his audience to "work for stricter laws and more state resources governing insurance fraud."

Only 11 states currently have insurance anti-fraud bureaus, he said.

"This all comes down to a matter of survival. We have already downsized our companies to reduce our overhead expenses and we are struggling to show a profit. To survive in the '90s, we must join together to fight this growing problem.

"Some companies might take the attitude of 'it's not going to happen to us,' but as more and more companies crack down on crime, the criminals will move to the easiest targets. If your company is not ready to fight fraud, you will pay dearly," he said.

Mr. Harrison also called upon NAMIC members to work to block Rep. John Dingell, D-Mich., in his attempts to enact H.R. 4900, which would allow insurers to choose state or federal solvency regulation. Mr. Harrison called the bill "bad news" that would result in more bureaucracy. He said that state regulation is the best choice.

He asked his listeners to continue to fight H.R. 9, which would remove several key insurance company exemptions from federal antitrust law.

Mr. Harrison said that the measure, which is sponsored by Rep. Jack Brooks, D-Texas, would ultimately result in changes that would be "costly and especially damaging to small and medium-sized insurers."

IT briefs

Disaster resistance

BOSTON—The keynote speaker at the National Committee on Property Insurance's annual forum will address how the public can be better prepared to resist natural disasters.

Gilbert White, interim director of the Natural Hazards Research and Applications Information Center at the University of Colorado at Boulder, questions the effectiveness of some structural solutions to natural exposures. For example, Mr. White's studies have demonstrated that flood-control structures such as levees and dams can actually increase the possibility of damage when people build houses and businesses on land they mistakenly believe is safe.

Mr. White favors using land-use restrictions and floodproofing to complement or replace more traditional approaches to the problem.

Speakers at the Dec. 16 forum in Boston will also examine how to measure the economic impact of catastrophic events and the nature of conflagrations.

NCPI is a Boston-based nonprofit advisory organization supported by the property/casualty insurance industry.

For more information on the annual forum, call Karen Gahagan at 617-423-4620.

Environmental laws

WASHINGTON—The American Insurance Assn. has published the 1992 edition of its "Environmental Liability Laws: A Summary of Selected State Environmental Liability Laws and Regulations."

The reference book features a state-by-state analysis of laws and regulations affecting hazardous petroleum products.

The analysis focuses on each state's enforcement powers, financial responsibility requirements, funds, and civil and criminal penalties. It also discusses liability provisions including: direct action, defenses and presumption, statute of limitations and citizen suits.

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The manual is available for $175.

Contact the AIA's Publications Department, 1130 Connecticut Ave. N.W., Washington, D.C. 20036; or call 202-828-7197.

Dutch consolidation

KEENE, N.H.—The Nationale-Nederlanden North American Property and Casualty Group and its five regional marketing companies have consolidated into a single corporate identity, the Netherlands Insurance Cos.

Peerless Insurance, Excelsior Insurance, First of Georgia Insurance and The Netherlands Insurance cover 17 East Coast states. Indiana Insurance covers the Midwest.

The group's annual premiums for 1991 were $653.5 million and year-end assets totaled $1.3 billion.

New CPCU brochure

MALVERN, Pa.—The Society of Chartered Property & Casualty Underwriters is offering a brochure describing job opportunities in the insurance industry.

Among the jobs covered in "There is a Career for You in Insurance" are: actuary, claims adjuster, loss control specialist, risk manager and underwriter. Copies are 50¢ each, with discounts for bulk orders. Contact Susan Schaefer, circulation assistant, The Society of CPCU, 215-251-2743. ■

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Insurer Topics

Issue of October 19

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Business Insurance

Continued from previous page
velopment, depriving consumers of needed products and limiting American job growth."

Believing that the health of the insurance industry is critical to the nation's economy, Sen. Glenn does not support repeal of the McCarran-Ferguson Act, "which has contributed to the building of this industry."

He also does not favor federal regulation of the insurance industry.

Republican challenger, **Mike Dewine**, 45, currently lieutenant governor of Ohio, did not respond to repeated requests for information.

Pennsylvania

Republican incumbent **Arlen Specter,** 62, helped draft legislation, S. 1936, that would provide incentives for small businesses that offer health care to employees. His position papers stress commitment to health care reform at almost all levels; however, he does not support a government-administered, single-payer insurance system.

Sen. Specter also had a hand in drafting S. 1668, which aimed to make long-term care insurance more available.

He believes the current tort system "works reasonably well in most areas." He voted to allow the Senate to consider the major product liability reform bill, S. 640.

He is "not about to involve the federal government in the business of regulating insurance." But he did say the insolvencies of Executive Life Insurance Co. and Mutual Benefit Life Insurance Co. raise questions about the states' ability to regulate.

"For now, I believe the most prudent course of action is for Congress to continue to monitor closely the health of the industry and to encourage the efforts of the industry and the states to assure the industry's continued financial stability," he said.

He opposed amending or repealing the McCarran-Ferguson Act.

Democratic challenger **Lynn Yeakel,** 51, is president of Women's Way, a national umbrella organization comprising about 30 nonprofit groups that raise funds for women's issues.

Ms. Yeakel's health care reform approach is based on the single-payer model, with states and the federal government acting as coinsurers of services. She supports elements of H.R. 1300, which would establish a Canadian-style plan.

"We should establish a national health care and budget board, which should be modeled on the independent Federal Reserve Board. This would remove petty politics from health care budget decisions," Ms. Yeakel said. "The health care budget should then be financed by a progressive and equitable system of taxation."

Ms. Yeakel

She favors a single financing mechanism for health care. "We need to replace payroll taxes for Medicare, employer-provided insurance benefits, premiums for the medical portion of car insurance and out-of-pocket costs paid by individuals and families," she said.

On civil justice, Ms. Yeakel opposes all current proposals to discourage lawsuits against business, arguing that the proposals are "unfair and would unnecessarily alter the face of tort law in all 50 states."

Any reform measure must preserve the incentives that contribute to a safe marketplace, she says. "Victims must have access to and effective remedies for injuries suffered due to defective products."

Specifically, Ms. Yeakel opposes a product liability reform measure, S. 640, because it "jeopardizes the the rights of victims to sue and recover for legitimate injuries."

The tort reform movement, she said, is "based on myths and questionable data." Actual experience, she insists, shows that the tort system does not reward undeserving plaintiffs and that punitive damages are not skyrocketing.

She cites statistics that only one in 10 injured people ever bring a product liability suit, and only half of them prevail in court. Also, she cites an American Bar Assn. study that found that punitive damage are applied sparingly and only in the most serious cases.

Vermont

Neither Democratic incumbent **Patrick Leahy**, 52, nor his Republican challenger, **Jim Douglas**, the 41-year-old Vermont secretary of state, responded to a *Business Insurance* questionnaire.

•

Jerry Geisel, Sara J. Harty, Sara Marley, Sally Roberts and Michael Schachner contributed to this report.

Wilson vetoes disclosure bill

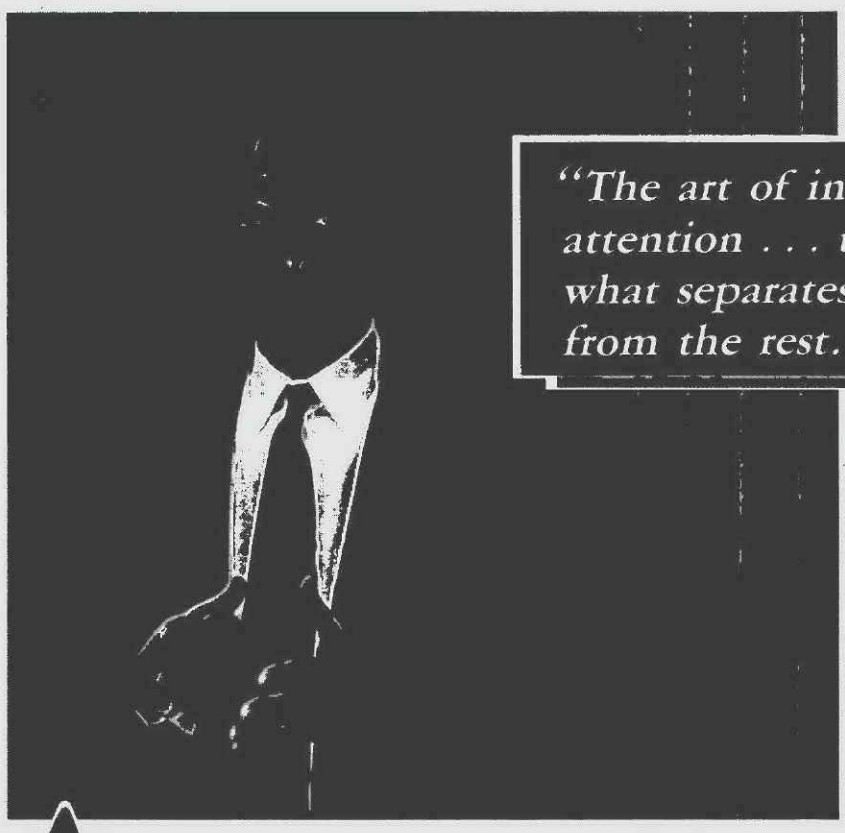
SACRAMENTO, Calif.—Gov. Pete Wilson vetoed legislation designed to increase public disclosure of defective products, environmental hazards and financial fraud.

Business groups opposed the bill, S.B. 711, claiming that it would lead to more litigation and make California businesses less competitive.

The bill would have curbed secrecy agreements in tort cases in which plaintiffs and defendants agreed to keep confidential information discovered during the litigation.

The bill would have barred from secrecy agreements evidence of product defects, environmental hazards or financial fraud, unless a court included such information in a final protective order.

—By Louise Kertesz



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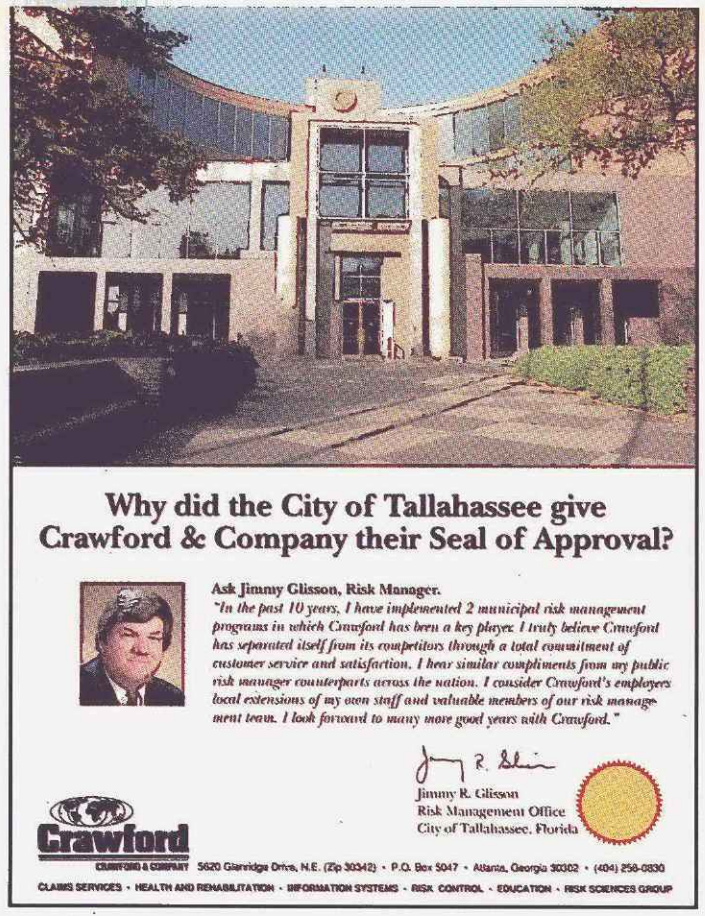

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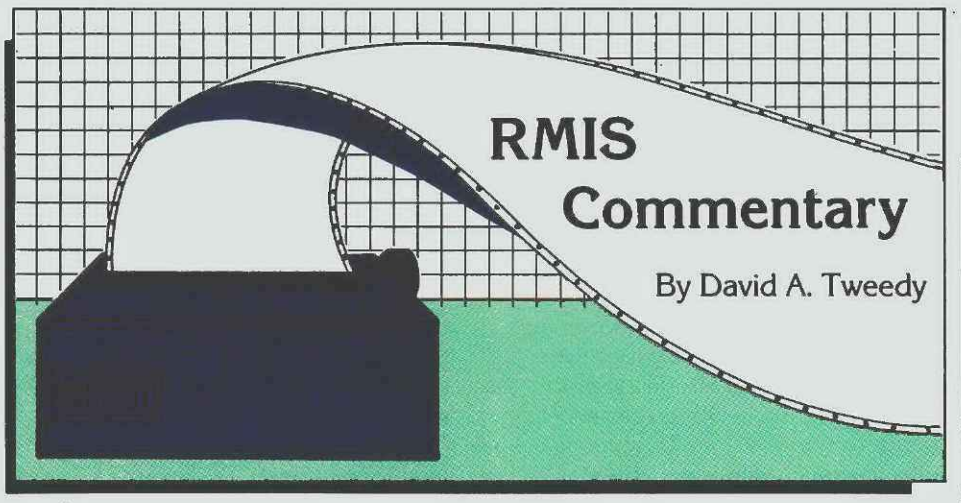
User friendly software

What to look for to actually measure the useability of an RMIS



USER FRIENDLINESS is a very often used—but infrequently defined—term that is important to any user of risk management information systems, or any computer system for that matter. Last month's column centered around the term's definition (*BI*, Sept. 21). Let's now examine how one *quantifies* a system's user friendliness. Rick Hoehne, president of Paradigm Infosystems in Bothell, Wash., will again offer his expertise on the topic.

How does one determine which system is easier to use than others?

With varying levels of computer literacy, people have different opinions on what is and what is not easy to use. In addition, the comprehensiveness of the system itself is a factor in how easy it is to use. Some systems deal only with one claim line while other systems are wider in scope, incorporating claims management, insurance management, underwriting and financial analysis. One module or function may be easier to use than others, or the relative skill of the person using the system may be stronger in one area than another.

While the matter is largely subjective, there are certain essential quantifiers to look for when judging an RMIS' user friendliness. Each represents major steps or events in using any system. These are:

✔ **Screen layout.**

Obviously, this is the first thing one notices when looking at a new system. If the system is menu-driven like most are, is it logical and obvious to the user, whether a seasoned veteran or a novice to the risk/claims profession?

The existence of icons to identify certain functions will greatly help, as I spoke of last month. An even friendlier screen would look like a paper form that is constantly being used internally by the department.

For example, many systems' screens, like Paradigm's Paradisk, are laid out exactly like a First Report of Injury for a particular state.

Also, are the screens presented in the same order that the user performs his/her job? If the process of entering a claim follows a specific format, the system ought to follow the same steps to avoid unnecessary screen changes and the need to look up data.

These features all rely on the system's vendor. The system should be designed for the user, not from the convenience standpoint of the programmer. I often see this problem when I review proprietary systems: The programmer found it more logical from a systems programming perspective to design the screen and data-entry process in a certain fashion even though it wasn't optimally efficient for the user.

Finally, does the screen layout help or assist the one monitoring or entering data? In other words, does the screen limit the input of data only to pertinent information, in order to prevent entering incorrect data? For example, if one is entering claims data on a workers compensation medical-only claim, the system should not accept data pertaining to indemnity claims. The other field should be temporarily disabled as a further prevention for incorrect data entry.

✔ **Data entry, monitoring and manipulation.**

The next area of importance is the ease of entering and accessing data. The system should reduce the need to rekey data in different screens and should provide quick exits from one screen to another when exceptions occur.

In other words, does the system have pop-up or pull-down menus or other simple navigation devices for moving into different areas of a program?

As a practical measure, the user should look at the six to 10 most common screens used in any system—like diary, claims entry, checkbook, reserves, provider list and report menu—and ask the vendor if it is possible to move from screen to screen with only one entry. Or, how many keystrokes are required to move from one screen to another?

In addition, how many keystrokes does it take to add a claim? How many screens are involved for this function? Are the screens jammed with information that is irrelevant or misleading?

When claims information is entered, is it automatically included through the entire system to avoid repetitive data entry? It is here that most errors in data integrity occur.

✔ **Reporting function.**

This may be the most obvious quantifier of all because it is here that risk managers and senior managers see the bottom line or result from the information system.

Again, the same questions apply: How many keystrokes does it take to provide a simple ad hoc report consisting of claim number, claimant name, date of loss, location, total paid, total incurred, subtotal by location, etc.?

More importantly, can the ad hoc report writer simply do it, or will the vendor answer with, "Oh, we have that as a canned report—no problem." This answer is not acceptable.

A true test of how easy a reporting function is to use is its ability to intuitively construct a report with a minimum of keystrokes and screens. The report should be accurate, logically laid out—i.e., no computer operating system garbage—and have readily accessible and easy-to-understand graphics support.

In fact, you may have several different report formats in mind as you review the system or have the vendor demonstrate how to construct the report.

Another crucial area is the ability of the reporting package to combine typical data base information, like lists of certain claim parameters, with word processing and analytical applications.

While the matter is largely subjective, there are certain essential quantifiers to look for when judging an RMIS' user friendliness.

Most systems with canned or developed report writers have difficulty seamlessly integrating those three functions. Special operating system codes must be written to perform these functions, according to Paradigm's Mr. Hoehne.

However, in the McIntosh environment or Microsoft Corp.'s proposed Windows NT program, the applications software—data base, spreadsheet, word processing, etc.—are embedded within the operating system and hardware to allow total flexibility.

Therefore, reports can contain summary lists, analytical fields and custom-typed letters as the need arises without leaving the application and going into an operating language like DOS.

✔ **Help screens.**

Help screens should be available from anyplace in the system. Mcintosh-related systems have balloon help boxes. Anyone familiar with the Windows environment knows that help screens are instantly accessible.

Once the key features have been identified, the next step is to quantify the user friendliness of a system.

The RMIS evaluation can be as simple or as complex as necessary. The end user could construct a matrix identifying each of the key features involved, assign them weighted values of importance and numerically assign values of 1 (poor) through 10 (excellent) on each of these features.

Or, one could simply tick off on a yes/no basis each of the key areas of greatest importance. The basic recommendation here is to perform the analysis up front to save headaches in the future.

It bears reminding, though, that user friendliness still is quite relative. To a computer software engineer, some of the above criteria are not as important as they are to the occasional PC user or neophyte system user.

The risk management professional must judge what degree of user friendliness is needed for the task at hand. For example, an insurer or a TPA about ready to commit to a very large system installation must consider the relative impact of user friendliness for the majority of those who will be working with the system: inexperienced clerical individuals. If the risk manager will be the only one using the system, only he or she can judge what's easy to use and what isn't.

Secondly, RMIS vendors are recognizing the importance of user friendliness in marketing the systems. Indeed, even some of the older, more established system vendors in the mainframe environment—such as Risk Sciences Group Inc. in Atlanta and Corporate Systems Ltd. of Amarillo, Texas—are providing user friendly front-end applications to make things easier for their clients. This was a good step in the right direction.

However, Mr. Hoehne says, "In the end, you and you alone will be the judge of user friendliness. In evaluating this, it is best to apply good, old-fashioned common sense."

Furthermore, "The system vendor must design for the rule, but plan for the exception," he added.

I heartily agree. By applying the methodology discussed in the last two columns, an RMIS user can reduce some of the subjectivity involved in judging user friendliness and deciding, indeed, what is best for him or her. ■

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

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

Communication gap

Book offers risk managers tips on working with TPAs

"Claims Management: How to Select, Manage, and Save Money on Adjusting Services"
By Kevin M. Quinley
Published by LRP Publications, 747 Dresher Road, P.O. Box 980, Horsham, Pa. 19044-0980; 215-784-0860
$50 (includes shipping)

By William E. Rogers

Books & Ideas

ARE CLAIMS ADJUSTERS from another planet?

From time to time, every risk manager asks that question. Risk managers often don't understand claims adjusters—and vice versa—but it's important for the two professions to understand each other if the joint goal of reducing claims costs is to be achieved.

Kevin Quinley's new book, "Claims Management: How to Select, Manage, and Save Money on Adjusting Services" will do a lot to increase that understanding. Think of it as a claims-to-risk management dictionary.

Mr. Quinley is a claims professional and an accomplished writer. Regular readers will recognize him as the individual who normally reviews books for *Business Insurance*. Let's turn the tables on him and see what his book has to offer.

"Claims Management" begins with a chapter on selecting the right adjusting company. This is the longest chapter in the book, and it comprehensively covers the topic.

Risk managers must make many decisions when choosing a third-party claims administrator, and this chapter gives the pros and cons of each of these choices—for instance, large or small? Generalist or specialist? One company or several? It also gives information on checking references, conducting interviews, comparing subrogation capabilities, and a number of other important issues that many risk managers normally may miss.

The next chapter presents a discussion of negotiating fees from the client's perspective. It reviews the common ways to compensate a TPA—case fees, time and expense, and annual retainer—and gives the advantages and disadvantages of each method.

The following chapter continues a discussion of fees by looking at 60 ways to reduce them. This chapter is packed with practical suggestions that will help TPA clients keep miscellaneous costs as low as possible.

Because of these three chapters, you might get the impression that this book is applicable only to unbundled or self-insured programs. True, it does lean in that direction, but much of the information in "Claims Management" will be useful in helping readers evaluate insurance company claims services. For instance, the next two chapters discuss quality control and computers in claims management, two issues that concern every policyholder.

The quality control chapter is itself an example of quality. Mr. Quinley discusses claims reviews and claims audits in a very knowledgeable way, and his discussion of reserving practices should interest every insurance buyer.

Likewise, the chapter on computers is useful in evaluating both insurance companies and independent adjusters.

Two other chapters are equally applicable to both TPAs and insurers. One of these introduces quantitative measurements of claims adjusting performance, and the other focuses on the qualitative aspects of monitoring and evaluating performance. The information in both chapters will help risk managers and insurance brokers judge how well claims are being managed.

"Claims Management" also talks about alternatives to adjusting companies, including lawyers, paralegals, rehabilitation specialists and in-house adjusting. A related chapter looks at public adjusters, and the book concludes with a chapter on how to remedy claims adjusting problems.

The discussions in Mr. Quinley's book are supplemented with eight appendices that contain sample agreements, claim assignment worksheets, checklists, plans, budgets and guidelines.

Criticisms? Only one: I wish this book had an alphabetical index. In Mr. Quinley's defense, the table of contents does contain a lot of detail; however, this book is full of useful information that deserves to be easier to find. But I'm nit-picking. This is a terrific book and it fills a real need because, as the author points out, few books exist on the subject of claims management.

Every insurance buyer who wants to take control of the way his or her claims are handled will find this book to be a valuable asset. ■

William E. Rogers is manager-risk management services for The Gleason Agency Inc. in Johnstown, Pa. He is the author of "How to Cut Workers Comp Costs: 115 Proven Ways" and was named to the Business Insurance Risk Management Honor Roll in 1986. Mr. Rogers holds the Chartered Property & Casualty Underwriter and Associate in Risk Management designations.

Beyond the same old two-step

"Dancing With Lawyers: How to Take Charge and Get Results"
By Nicholas Carroll
Published by Royce Baker Publishing, 953 Mountain View Drive, Lafayette, Calif. 94549; 510-284-7684
$19.95

By Kevin M. Quinley

Books & Ideas

REGARDING LAWYERS, SOME risk managers may feel, "Can't live with 'em—can't live without 'em." So, some books talk about "working with a lawyer."

Often, that is because they are written. . .by lawyers! One could have the proverbial fox author a guidebook for guarding hen houses, or ask cat burglars to lead a seminar on home security. "Dancing with Lawyers" is different from most of the "truth about lawyers" genre. It is written by a client, one who hires lawyers, pays them and—occasionally—fires them.

If a seasoned risk manager wrote a book about managing lawyers, it would turn out something like this.

Thus, the book is really about making lawyers dance to your tune, not theirs.

The text offers a blueprint and a buyer's guide to legal services, telling risk managers how and why they should:

- Shop hard.
- Find a lawyer with know-how.
- Extract a quote.
- Make a time-line of activity.
- Keep the lawyer's nose to the grindstone.

In blunt, direct language, "Dancing With Lawyers" offers two workable attitudes for dealing with attorneys: the "pure business" attitude and the "autocratic" attitude.

These approaches work for both risk managers and other types of clients because—as author Nicholas Carroll explains—there are big differences between clients, but there are few differences among lawyers.

Due to their training, lawyers cannot stop solving legal problems—even when there are no legal problems. When your only tool is a hammer, everything starts to look like a nail. This is the first and most critical realization, and the prime reason no client can afford to leave the central decisions to lawyers, Mr. Carroll argues.

"Dancing With Lawyers" tells risk managers how to differentiate between the decisions that attorneys are competent to make—and the decisions that are not suitable to be entrusted to them.

Mr. Carroll is a professional client. As a real estate investor and head of overseas operations for an import firm, he hires a wide spectrum of lawyers for tax, corporate, copyright, trademark and real estate work.

His advice is generic across-the-board wisdom, which can be brought to bear on any legal need that risk managers might have. While he is admittedly not a risk manager, Mr. Carroll's down-to-earth advice contains kernels of hard-earned insight which any risk manager can employ.

The author's irreverence, tinged with practicality, is a pinprick to burst the bubble of most any lawyer's pomposity.

One of the nice things about the book is that it is eminently readable, divided into bite-sized chunks. One can sample and graze without sitting down to read the whole book cover to cover. As is often said about eating Chinese food, though, readers might feel unfulfilled 30 minutes after finishing. The advice is occasionally so abbreviated that it borders on the supercilious.

If I were a lawyer, I would not want to have Mr. Carroll as a client. While he decries the consumer handbook approach to managing lawyers, his own advice often borders on micro-managing attorneys. Many risk managers—already with full plates—will question the time demands needed to give counsel the kind of close monitoring the advocated by the author. This may be more of a commentary on today's state of risk management than a weakness of the book.

In the book's third and largest section, "How to Get the Job Done," Mr. Carroll quickly reduces a complicated business to a simple list: what the customer wants, on time, within the client's budget—simultaneously forewarning of the myriad of expensive ways that lawyers frequently wander afield.

One of his central themes is that lawyers are better deal breakers than deal makers. Also, efficiency is not their strong suit: ask them what the time is, and often what you get is a dissertation on watch repair.

Cynical without overt malice, often funny and very practical, "Dancing With Lawyers" is the type of book that only a non-lawyer client could have written.

Perhaps in a former life, Mr. Carroll actually was a legal-bill-paying risk manager, but we will likely need Shirley MacLaine to confirm that theory. ■

Kevin M. Quinley is vp of risk services for MEDMARC Insurance Co. Inc. and subsidiary Hamilton Resources Corp., both of Fairfax, Va. Mr. Quinley holds the Chartered Property & Casualty Underwriter and Associate in Risk Management designations.

Proposition 166

Continued from page 1

businesses," said Mr. Garamendi. "Moreover, I find it lacking in any significant cost containment provisions."

Organized medicine counters that California voters are frustrated with the lack of affordable health insurance. Noting that the opposition group is primarily funded by insurers, the CMA charges that there is a "blatant attempt by the national insurance industry to block health care reform in California."

The CMA—which collected signatures to put the proposal on the ballot (*BI*, July 6)—calls its plan "Affordable Basic Care." It would require employers with 25 or more employees to provide a basic package of health benefits to employees working 17.5 hours per week or 70 hours per month and to their dependents, beginning Jan. 1, 1994.

Among the things covered would be hospital inpatient care for at least 45 days, emergency care, outpatient care, preventive care and mental health care (see story, page 29).

By 1997, the requirement would be phased in for all employers, unless 90% of California employers have voluntarily provided a specific basic medical plan by then.

About 4 million of the 7 million Californians without health insurance would be covered by employer-sponsored health plans if the initiative becomes law.

But, by Jan. 1, 1996, a state Health Care Coverage Commission would have to propose a way to provide coverage to all California employees, even those working fewer than 17.5 hours a week or 70 hours a month. That panel would oversee implementation of the initiative and monitor health plans. Its 12 members would be appointed by the governor and Legislature.

And by Jan. 1, 1997, the commission would have to file a proposal on how basic coverage should also be provided to Californians not eligible for employer coverage.

The basic plan would cost about $100 per month per covered person, the CMA estimates.

While this plan would force employers without health plans now to pay $2.2 billion in premiums in fiscal 1993-94, the proposal would save public plans and employers now providing coverage more than $4 billion, the CMA says.

Employers would be required to pay at least 75% of the cost of the plan. Employers that offer a basic plan plus other plans with richer benefits would have to pay at least 75% of the cost of the plan with the lowest premium.

Employee contributions would be capped at 25% of the premium of the lowest-priced plan or 2% of wages, whichever is less. Employees, though, still could be subject to deductibles.

To help small employers—those with fewer than 25 employees—pay for coverage, the initiative calls for a state corporate income tax credit that is equal to 25% of their annual premium costs.

Supporters of Proposition 166 expect that many employers would turn to health maintenance organizations and indemnity plans with preferred provider networks to provide the basic benefits and hold down their costs.

Indeed, the initiative says a basic plan may exclude coverage or charge a higher copayment for "services that an individual obtains without complying with any reasonable procedures established by the carrier. . .to ensure the efficient and appropriate utilization of non-emergency covered services" or for services not obtained from preferred providers.

The penalty for employers not complying with the ballot initiative would be "twice the health care costs incurred by an employee or that employee's dependent during the period in which the employer failed to provide coverage, and the employee's reasonable attorney's fees," the initiative says.

Before the proposal could be implemented, the state would need a waiver of the Employee Retirement Income Security Act.

Continued on page 26

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UPDATE: OCEAN MARINE LINES

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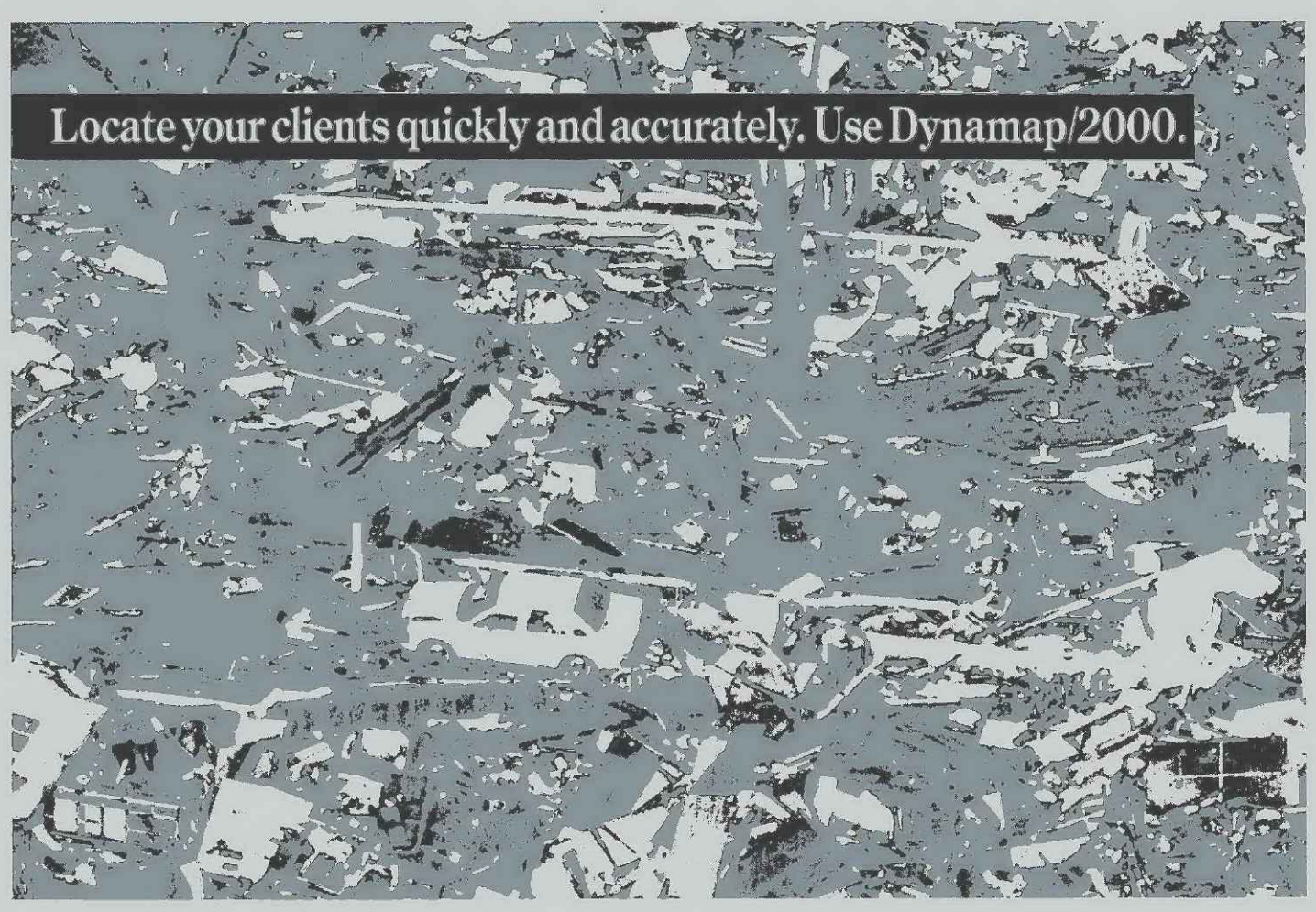

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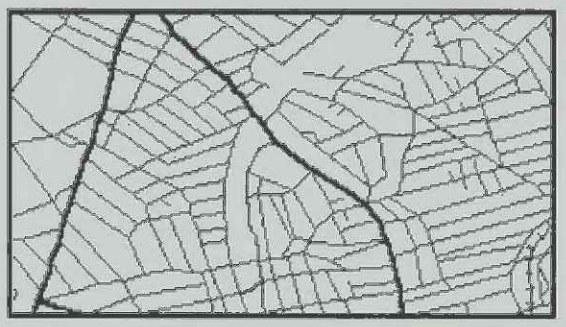

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Proposition 166

Continued from page 25

ERISA pre-empts state laws that relate to employee benefit plans.

Voter approval of Proposition 166 would send "a big message to Congress" to grant the waiver, said a spokeswoman for the Sacramento-based CMA.

"A couple of years ago, ERISA would have been an obstacle," she said. "But the political dynamics have changed." Now several states are proposing health reforms requiring similar waivers (*BI*, June 15).

"Given California's size, passage of the initiative would be a big boost for California and other states" that have requested waivers, the spokeswoman said.

'A couple of years ago, ERISA would have been an obstacle. But the political dynamics have changed,' a CMA spokeswoman said. Now several states are proposing health care reforms requiring similar waivers.

Recently Sens. Patrick Leahy, D-Vt., and David Pryor, D-Ark., introduced a bill that would create a federal commission to review, grant and oversee applications for ERISA waivers in states seeking to implement comprehensive health care reforms (*BI*, June 29).

Democratic presidential nominee Bill Clinton is "very supportive" of state health reform efforts, the CMA spokeswoman added. "And Proposition 166 is very close to what he is advocating nationally."

Gov. Clinton has proposed a modified "play-or-pay" approach that would require employers to either offer a health plan or pay pay a premium to a public fund to cover the uninsured (*BI*, Sept. 21; Aug. 10).

The CMA spent $800,000 "just to qualify the initiative for the ballot," but the association is not sure how much it will spend to campaign for the proposal.

"We will have some presence in the media in the final weeks," the spokeswoman said.

But for the most part, the CMA plans "a modest, grass-roots campaign" in which physicians will appear on TV talk shows, send letters to their patients and display promotional material in their waiting rooms, she said.

"The docs have a very good rap. They tell it well. And they have the money to get their message across," said Mr. Katz of the California Assn. of Health Underwriters.

Jobs and the economy are California voters' top concerns, according to the latest Field Poll. And labor and consumer groups will be trying to convince voters that voting for Proposition 166 could cost their jobs, said Jan Meisels, a lobbyist for the Health Insurance Assn. of America of Woodland Hills, Calif.

The HIAA is a member of the Consumer Health Insurance Coalition.

In TV ads, the coalition emphasizes its contention that Proposition 166 would cost thousands of jobs.

"Many employers are hanging on by their fingernails," said the coalition spokeswoman. Passage of the initiative would prompt many of those companies to close up or pull out of the state, she said.

As a result, the number of uninsured Californians would increase, she said.

Citing independent research, the CMA counters the job-loss argument. "Studies on employer health care mandates show that there would be little or no loss of employment," said the spokeswoman, citing studies by the Rand Corp. and Harvard University.

The net employment impact of Proposition 166 is "little to none," she said.

Continued on page 28

HINSHAW & CULBERTSON

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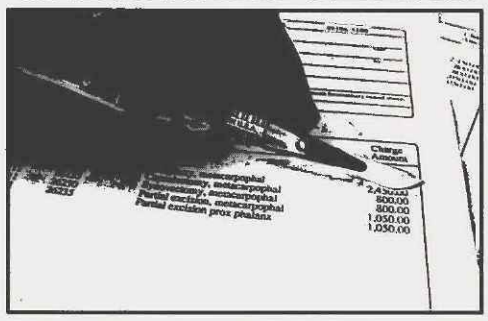

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Proposition 166

Continued from page 26

One complaint workers have about Proposition 166 is what they call a loophole that would let employers avoid providing coverage.

"Proposition 166 allows employers to cut hours below 17.5 a week and split full-time jobs to avoid the mandate to provide coverage," said Jack Henning, executive secretary-treasurer of the California Labor Federation, an AFL-CIO-affiliated group that is a coalition member.

Proposition 166 also lacks significant cost control measures, opponents complain.

"Because there is no cost control, employers will be pressured to cut other benefits and reduce wages —solely to the benefit of the doctors who wrote this initiative," said Mr. Henning.

"This is not an insurance crisis but a cost crisis," said Anne Eowan, a lobbyist for the Assn. of California Life Insurance Cos. "Though we support the concept of reforming the existing delivery system, without cost containment (the initiative) will be no solution to the cost spiral."

The Health Care Coverage Commission that would be created under the initiative would be charged with exploring cost-containment measures.

It would collect and analyze utilization data and then recommend medical practice patterns, provide comparative medical cost information to employers, develop a uniform claim form and set guidelines for the use of new medical technology. Included within the commission would be three panels, one to examine medical policy, one for cost containment, and one for technology.

The commission also would be charged with establishing six regional small-employer health insurance purchasing pools.

The initiative does call for some small-group reforms, but the consumer coalition points out that a law recently signed by Gov. Pete Wilson has resolved the problems of soaring premiums and pre-existing condition exclusions for small employers (*BI*, Oct. 5).

The coalition's TV advertising will continue through the election, said Richard Claussen of Goddard Claussen/First Tuesday in Sacramento, a communications firm retained by the coalition. The firm specializes in management of ballot issue campaigns.

The coalition also hopes to begin advertising in radio spots, but it does not plan to use any print media or billboard advertising, the coalition spokeswoman said.

Total spending by the coalition to defeat the initiative could reach $3.5 million, with insurers contributing $3 million, Mr. Claussen said.

Among the insurer groups in the coalition are the HIAA, the ACLIC and the American Council of Life Insurance. Business groups like the California Manufacturers Assn. and the California Chamber of Commerce have also joined.

"Coupled with historic shifts in manufacturing, defense and aerospace industries, this costly proposed mandate is coming at the worst possible time," said a spokesman for the manufacturers' association. ■

'Because there is no cost control, employers will be pressured to cut other benefits and reduce wages—solely to the benefit of the doctors who wrote this initiative,' says Jack Henning of the California Labor Federation.

Municipal liability limited

JACKSON, Miss.—A new state law gives most government entities in Mississippi broad immunity from civil lawsuits.

However, the liability of incorporated municipalities carrying out proprietary functions, like garbage collection, was limited to a lesser degree.

The law allows any government entity to buy liability insurance and limits any claim to the amount of coverage. The law does not specify how much coverage these entities should buy. Previously, most government entities needed legislative authority to buy liability coverage.

The law allows public entities in some cases to pay claims up to their deductible. Previously, public entities in some cases had to receive authority from the Legislature to pay these claims.

Also under the law, school districts may now buy workers compensation insurance.

—By Deborah Shalowitz

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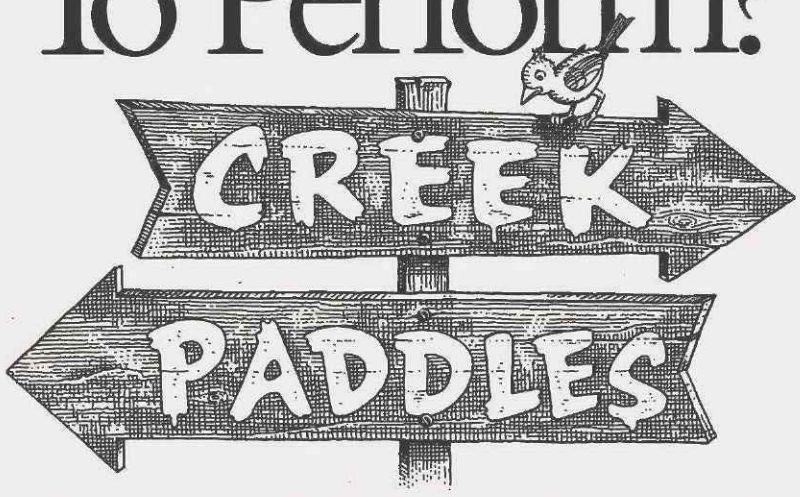

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CMA proposal outlines basic health coverage

SACRAMENTO, Calif.—The "Affordable Basic Care" plan called for under Proposition 166 in California would require employers to provide basic health insurance to all employees and their dependents after 60 days on the job.

But the initiative would not require new employers to provide basic health insurance until 27 months after they first receive an employer tax identification number from the state.

Employers would be exempt from the requirement if they already offer a health plan that meets standards spelled out in the initiative or if their workers are covered by collective bargaining agreements.

The basic health care package would cover:

- Hospital inpatient care for at least 45 days, including the cost of comprehensive services like surgery, drugs and respiratory and physical therapy following prior authorization.
- Outpatient medical and surgical services, including the cost of diagnostic services, hospital visits and at least 20 home or office visits, pap smears and mammograms under a specified schedule, and sterilization. Artificial insemination would not be covered.
- Emergency care.
- Comprehensive maternity and prenatal care.
- Mental health benefits, including inpatient or acute residential care for at least 15 days and at least 15 outpatient visits.
- Certain plastic and reconstructive surgery.
- Prescription drugs.
- Long-term care, including home care, skilled nursing care and hospice care, if a plan's insurer determines that these services are cheaper alternatives to covered inpatient care.
- Child preventive care, including routine physical examinations, proven preventive procedures, immunizations and screenings.
- At least 10 outpatient visits for speech, occupational and physical therapy.
- Durable medical equipment.

Not included is coverage for certain implants, eyeglasses and routine eye examinations, prescription drugs not provided as an inpatient hospital benefit, treatment of chemical dependency except for acute inpatient detoxification, and obesity treatment or weight loss programs.

Deductibles in the plans could not exceed $250 annually for an individual or $500 for a family, adjusted annually to the federal minimum wage.

No copayment could exceed 20% of the charge of a covered service.

Outpatient prescription drugs could carry a $200 deductible for an individual and a $400 deductible for a family, also adjusted annually to the minimum wage.

The lifetime policy limit of a basic package must be at least $500,000 per enrollee.

Employers must continue to provide coverage for employees who become ill and cease employment, and for their dependents, for three months or until the employee becomes eligible for other coverage—through, for example, COBRA, disability coverage or Medicaid.

The initiative also would allow employers to consolidate workers compensation and health insurance programs in a so-called 24-hour coverage plan. A new California law authorizes four 24-hour coverage pilot programs (*BI*, Oct. 5).

—By Louise Kertesz

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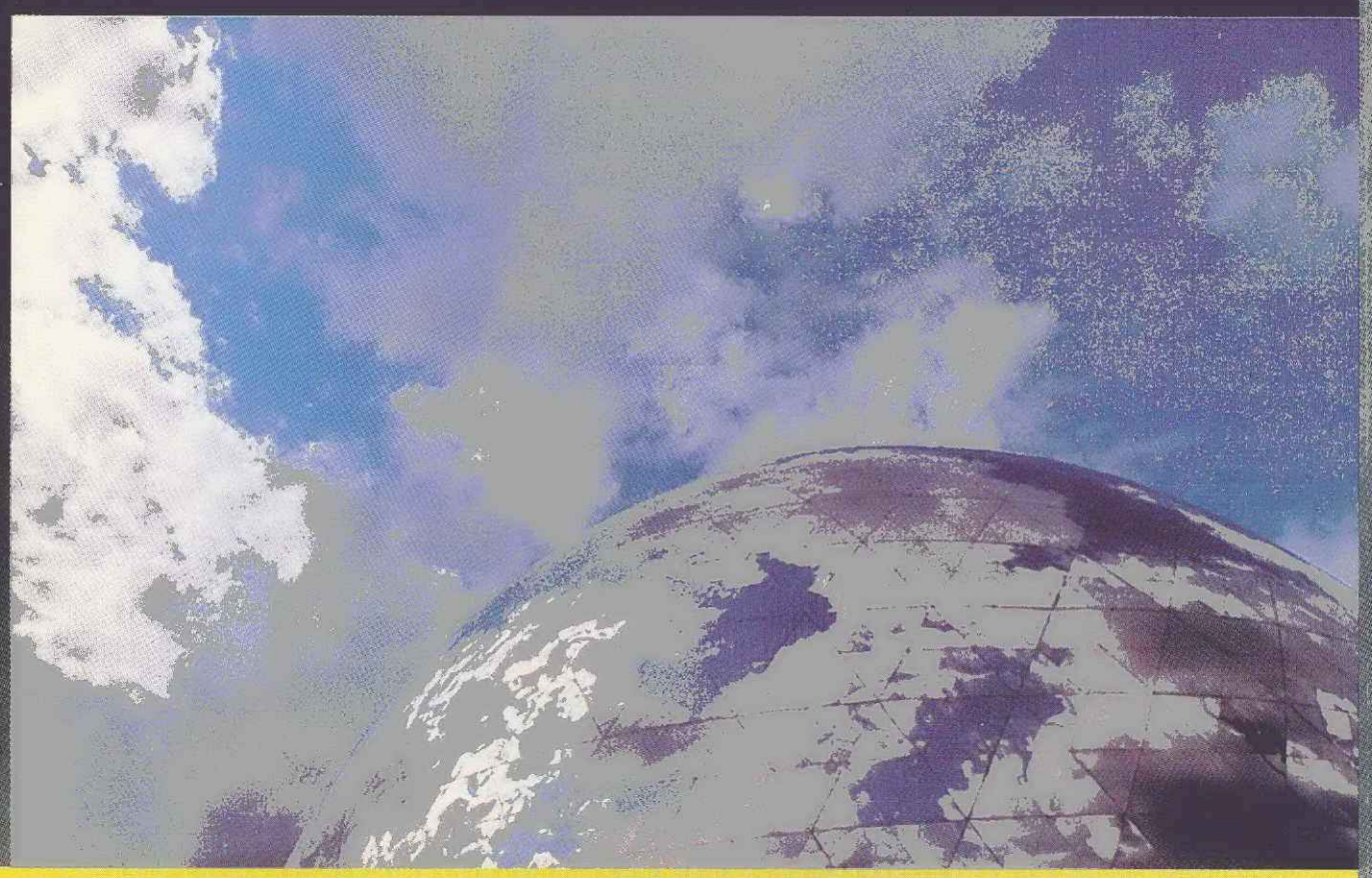

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INTERNATIONAL

INTERNATIONAL DIGEST

ING stock issue will help finance BBL buyout

AMSTERDAM, Netherlands—Internationale Nederlanden Groep shareholders last week approved a proposal from the Dutch insurer's executive board to double ING's capital through an expanded offering. Some of the proceeds will be used to finance ING's planned takeover of Banque Bruxelles Lambert, Belgium's second-largest Belgian bank.

Before the extraordinary meeting, the ING board was empowered to issue 300 million common shares and 300 million preferred shares that could be used by ING as protection from hostile takeovers, an ING spokesman explained. The board now has been given the authority to issue up to 350 million common shares, another 250 million preferred shares to generate financing, and another 600 million preferred shares as takeover protection.

The ING spokesman aid that this adds up to the possibility of increasing the company's capital to 3 billion Dutch guilders ($1.82 billion at current exchange rate) from 1.5 billion guilders ($912.2 million). ING stock was trading at about 47 guilders ($28.58) per share last week.

ING now is assembling a 40-person team to send to Brussels for about four weeks to conduct due diligence on BBL, said the spokesman. Once the audit is complete, ING will decide on a bidding price. BBL stock was trading at around 3,440 Belgian francs ($114.31) per share last week.

ING already holds 10% of BBL and has said it intends to acquire another 6.7% being offered by other shareholders. The financial services group has said it would be willing to spend a maximum of 3.2 billion Dutch guilders ($1.94 billion) for BBL's remaining outstanding shares (*BI*, Sept. 21).

German Cartel Office again supports 'allfinanz'

BONN, Germany—The German Federal Cartel Office said last month that it will not oppose Allianz A.G. Holding's acquisition of a 22.3% stake in Dresdner Bank, which is Germany's second-largest bank.

Both Dresdner and Allianz assured the Cartel Office that the insurer's minority holding will not affect the bank's independence. Dresdner has assets of more than $100 billion.

Meanwhile, the Cartel Office also has approved Deutsche Bank's acquisition of 56% of German insurance group Deutscher Herold Versicherungs Gruppe. It is the second time this year that Germany's largest private bank has procured major holdings in an insurance company.

Deutsche Bank hopes the acquisition will extend its private lines insurance operations, according to bank President Hilmar Kopper. The bank now sells its own life insurance policies through DB Life Insurance Co. In July, Deutsche acquired a 30% stake in Germany's largest industrial insurer, Gerling Konzern.

At Deutscher Herold's headquarters in Bonn, Mr. Kopper underlined the bank's "allfinanz" strategy: "We aren't interested in becoming an insurance corporation, but we're not going to be a holding company for insurance companies either."

"Deutscher Herold has a large network of field agents which makes it attractive," he said. In addition, Deutsche Bank also gains a major share of Germany's third-largest independent marketing company, Bonnfinanz, which markets life and property insurance.

As a result of the deal, Deutsche Bank's 6 million customers will be offered Deutscher Herold insurance policies at a number of the bank's branches. Mr. Kopper did not exclude a possible increase in Deutsche Bank's stake in the insurer.

Deutscher Herold, Germany's 15th-largest insurer, has more than 2 million policyholders. In 1991, Deutscher Herold's life insurance premium volume increased 11.6% to 1.28 billion deutsche marks ($844.9 million at year-end 1991 exchange rate) from 1.15 billion deutsche marks ($634.8 million) in 1990.

UNUM's Tokyo move furthers expansion strategy

TOKYO—UNUM Corp. announced last month that plans are under way to establish a Tokyo office. UNUM, a Portland, Maine-based provider of disability insurance in North America and the United Kingdom, said the office will further its goal to have significant positions in the European and Pacific Rim disability insurance markets by 1998.

The Tokyo office will by headed by David M. Tourangeau, senior vp of Pacific Rim development for UNUM.

AIG enters Czechoslovakian market

PRAGUE, Czechoslovakia—American International Group Inc. has received a license from Czechoslovakia's Ministry of Finance to conduct insurance operations in the Czech Republic beginning this month.

Called First American Czech Insurance Co. A.S., the Prague-based company will offer commercial insurance products to foreign-owned businesses and domestic, privatized companies, as well as a range of life insurance products for the domestic market. AIG already has composite life and non-life insurance companies in Poland and Hungary. AIG also participates in an insurer in Estonia.

—By Don Lewis Kirk and Maria Kielmas

Cairo earthquake won't rock insurers

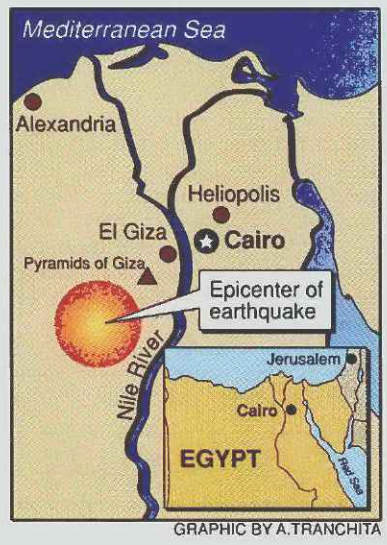
By MARIA KIELMAS

CAIRO, Egypt—Insurers are not expecting large losses as a result of the Oct. 12 earthquake centered about 20 miles southwest of the Egyptian capital.

Insured losses are low, insurers say, because insurance is not common in Egypt and most damage occurred in low- or middle-income residential areas.

The Egyptian government estimates that the temblor and numerous aftershocks caused an estimated 400 deaths, more than 3,000 injuries and the collapse of at least 200 buildings.

Seismological observatories in the United States and Europe calculated the earthquake's epicenter some 20 miles southwest of Cairo. The earthquake, whose magnitude was calculated at various observatories as between 5.5 and 5.8 on the Richter scale, struck at 3 p.m. local time, trapping people in their homes, schools or workplaces.



GRAPHIC BY A.TRANCHITA

Aftershocks continued to shake Cairo last week, causing more buildings to fall.

Brokerage executives who witnessed the initial earthquake thought the only area of impact from an insurance standpoint was a small number of apartment buildings that were damaged or destroyed, said a spokesman for Alexander Howden Reinsurance Brokers in London.

"Earthquake insurance is very rare and not included as a standard on property cover" in Egypt, he said.

Nooruddin A. Nooruddin, managing director of the Arab Insurance Group in Manama, Bahrain, also said that claims are not expected to be large. "No major commercial building or infrastructure seems to have been affected," he said.

ARIG is one of the major Egyptian reinsurers, participating in property treaties as well as facultative reinsurance on engineering, aviation and oil risks.

The gross annual premium volume for the Egyptian market is $400 million, implying a very

Continued on page 33

IRA bombing damage

British insurers seek government reimbursement of losses

BY STACY SHAPIRO and GAVIN SOUTER

LONDON

LONDON—Members of the Assn. of British Insurers "have not forgotten" that they would like the British government to pick up the bill for property/casualty losses on the mainland caused by Irish terrorist action, said a spokesman.

But neither the eight bomb blasts in London last week courtesy of the Irish Republican Army nor other IRA bombings in the British capital since April have caused insured losses large enough to warrant government aid, according to the ABI spokesman.

The ABI first called for British government indemnification for IRA bomb damage on the British mainland in April. That request was prompted by two terrorist bombings—one in the heart of London's insurance district—that caused the greatest property damage in London since World War II (*BI*, April 20).

The April blasts, killing three people and injuring more than 90 others, are expected to cost more than 1 billion pounds ($1.71 billion at current exchange rate).

The Commercial Union building, one of the hardest hit, reportedly will cost between 30 million and 35 million pounds to repair ($51.3 million and $59.9 million).

After the April explosions, "we said we couldn't cope with the losses of that size" from IRA terrorism, said the ABI spokesman last week. Since the British government pays for any claims arising from IRA blasts in Northern Ireland, the ABI requested that the government extend this policy to the British mainland. ABI members also threatened to exclude IRA terrorism from standard U.K. property policies.

Since April, however, "mercifully we haven't had any big losses. . .so for the time being it's status quo," and U.K. property policies still cover IRA at-

Continued on page 33

Deaths, insured loss are lowered for El Al crash in Amsterdam

GLOBAL BRIEFS

AMSTERDAM, Netherlands—Claims from the Oct. 4 crash of an El Al Boeing 747-200 cargo jet into two apartment buildings in an Amsterdam suburb are now expected to total about $100 million, only half what London underwriters had initially estimated.

Fifty-five deaths have been confirmed since the crash, well below the 250 deaths initially expected by Dutch authorities.

According to John Westcott, chairman of Lloyd's Aviation Underwriters Assn., no liability settlements have been agreed to date, though insurers have issued some cash advances to relatives of the people killed and to people who lost their homes.

"It looks like the crash is going to cost about $100 million," Mr. Westcott said. "It will be months before a report is issued on the cause of the accident and we will know who is responsible."

The crash, which destroyed two 10-story apartment buildings, appears to have been caused by a structural or mechanical failure, but it is not clear whether the fault was in the 14-year-old Boeing aircraft or in El Al's maintenance. Engine manufacturer Pratt & Whitney may also be vulnerable to third-party liability claims, underwriters said.

The claim on the airline's $62 million hull insurance policy was paid within three days of the crash, said an official at London broker Alexander Howden Ltd.

El Al's hull and liability insurance was underwritten by a pool of five Israeli companies. Much of the coverage was reinsured outside of Israel, with 40% of the cover placed in London (*BI*, Oct. 5).

—By Aline Sullivan

Australian names

BRISBANE, Australia—Government securities regulators have agreed to exempt Lloyd's of London from the national Corporations Law.

The 1991 law requires companies or organizations to send a complete prospectus and trust deed to individuals from whom it

Continued on page 32

INTERNATIONAL

Product lets insurer lock into third-event cat cover

By ROGER SCOTTON

HAMILTON, Bermuda—Financial reinsurer Commercial Risk Partners Ltd. is offering a new product that allows clients to secure the availability of third-event catastrophe reinsurance coverage at a fixed price before it's needed.

Known as the CAToption Program, the product is expected to particularly interest insurance and reinsurance companies that have been forced to buy catastrophe coverage reinstatements in the wake of Hurricanes Andrew and Iniki.

The product is intended "to respond to the current upheaval in the property catastrophe market," said Dan Marren, president and chief executive of Commercial Risk, which was formed in April.

"There is a significant lack of capacity for third-event covers and when quoted, they are priced over-expensively," Mr. Marren said.

The Commercial Risk approach is to "reserve" third-event capacity for a client in return for a comparatively "small option premium" which will vary depending on the layers of coverage involved. The option premium can then be used to offset the cost of the whole premium in the event of coverage being triggered.

"You don't usually buy third-event cover until you need it, so what we're offering is an option to buy that coverage at a certain fixed price," says Mr. Marren, whose company coined the term "shared risk" to describe its financial reinsurance underwriting philosophy (*BI*, Feb. 24).

"The options are automatically exercised with the second event. No underwriting is necessary. The second event triggers the third-event coverage.

"People don't want to overpay for coverage they might not need. But if it turns out you don't need the coverage, all you will have paid is the option price. Either way, it's far less expensive than paying the whole premium today or waiting for the second event to hit and then paying even more."

Coverages triggered under the options will be written on a multiyear, shared-risk basis. Under this underwriting technique, coverages that remain loss-free generate "significant" profit commissions for the cedants.

Mr. Marren, who runs Commercial Risk's Vermont unit, Commercial Risk Re-Insurance Co., said that to Commercial Risk's knowledge, it is the only company offering this type of program. But he says he does not expect to write many CAToption programs.

"It's a real gamble as to whether you feel you can get hit between now and your Dec. 31 renewal. We're not going to write an unlimited number of these options. I'd guess we'll write four or five this year and perhaps a few more than that early next year for the April 1 renewals."

'You don't usually buy third-event cover until you need it, so what we're offering is an option to buy that coverage at a certain fixed price,' says Mr. Marren. 'No underwriting is necessary. The second event triggers the third-event coverage.'

The company, which is 75% owned by the Societe Commerciale de Reassurance S.A. of Paris, says its CAToption program already has attracted an "encouraging level of interest among brokers."

In a separate announcement, Commercial Risk Partners says it is forming its own brokerage and marketing subsidiary, Commercial Risk Services Inc. in New Jersey. The new reinsurance intermediary will produce business for the Vermont unit.

The new company's aim is to complement existing business relationships, not replace them, according to the parent, so the parent will continue to work with unaffiliated intermediaries.

The new company will be run by William T. Harris Jr., who formerly was president of AMRISK Corp. and senior vp of American Risk Management Corp., which is part of the International Risk Management Group. ■

GLOBAL BRIEFS

Continued from page 31

is seeking to raise funds.

Without the exemption, all 650 or so Australian names would have been required to receive a prospectus from each syndicate in which they wished to participate.

This would have made it "impossible, in a practical sense," to have names in Australia, said Ian Hutchinson, general counsel in Australia for Lloyd's and a solicitor with Freehill, Hollingdale & Page of Sydney. "The compliance cost for 650 names did not make any sense."

The names last year were granted a one-year exemption from the requirement for 1992. The new exemption from the Australian Securities Commission is indefinite.

With its own bylaws and regulations, Lloyd's did not "fit" Australian law, and there was "a substantial overlap" in the Lloyd's regulations and the new Australian law, Mr. Hutchinson said.

"It is important for the market to have certainty, and that would be difficult if various countries were trying to overlay their own regulatory systems," he said. He said the ASC had considered the application for exemption in detail and was satisfied that the regulatory structure of Lloyd's would protect names.

The commission feels Lloyd's regulations are "broadly comparable" to the corporations law, said a spokeswoman for the ASC. "Participation in the Lloyd's market is distinguishable from passive investment in a collective investment scheme on the basis that names carry on business as sole traders with unlimited liability."

Feeling they would be prejudiced if unable to participate at Lloyd's, many names actually supported the exemption from Australian law, she said.

Lloyd's own security was another consideration for regulators. The security of Lloyd's policies could be undermined if names could have evaded liability on the basis of non-compliance with the Australian law, she said.

The spokeswoman did issue a note of caution for Australian names, noting that the Lloyd's market is controlled primarily by English law. All Lloyd's documents sent to Australian names will be required to state that the Australian regulations do not apply.

The spokeswoman said the ASC was "conscious of the publicity the Lloyd's market has received," and potential investors should "question the risk-return relationship. . .before committing themselves."

Meanwhile, an Australian Supreme Court judge who is deciding whether his court has jurisdiction to render a verdict in a member's lawsuit against Lloyd's has still not delivered a judgment (*BI*, Sept. 7).

The member, Dr. Emlyn Williams, contends that Lloyd's has breached the Australian Corporations Law by failing to provide him with a prospectus and that it has breached Australia's Trade Practices legislation.

—By Kate McIlwaine

Australian reinsurance

MELBOURNE, Australia—Reinsurers must become more flexible contract writers and provide alternative risk transfer services in order to maintain premium volume, a reinsurer says.

The need for reinsurance is decreasing as ceding insurers increase their retentions, and reinsurers therefore have to focus on alternatives like captives, risk-retention groups and self-insurance programs, said Tony Richardson, general manager of Australia & New Zealand for American Re-Insurance Co.

Mr. Richardson spoke last month at a property insurance seminar sponsored by the Insurance Institute of Victoria.

As the Australian insurance industry matures, fewer insurers with stronger balance sheets mean a move away from premium-intensive proportional contracts to lower-premium, excess-of-loss contracts.

"With some exceptions, the premium ceded as reinsurance over a longer period will continue to decrease as a percentage of total written premium," he predicted.

With fewer, larger insurers, tailor-made reinsurance services will be required, forcing reinsurers to be more flexible contract writers, he noted.

Owners of Australian captives are becoming more sophisticated, seeking true risk financing mechanisms. Reinsurers are "ideally placed" to work with captives, he said.

Colin Knox, principal consultant of risk management and insurance services with Melbourne-based CRA Ltd., a large mining and resource development company, agreed that the use of captives would increase, particularly with the current uncertainty in the market, increasing rates and the inability to place some risks.

American Re's Mr. Richardson said another important future source of activity for reinsurers is risk retention groups, such as councils and trade groups, which cooperate to manage their exposures.

And, he said, corporate Australia could accept larger deductibles or opt for self-insurance. "This is an obvious area where reinsurers can use their programming expertise," he said.

CRA's Mr. Knox said brokers and underwriters also need to meet the challenge of providing new risk financing methods. Buyers with globalized operations need insurance packages that are as consistent in coverage as possible, regardless of the location of the risk.

"To rely on a hotchpotch of different covers and insurers around the world for each offshore operation is a risk manager's nightmare," he said. He predicts greater liaison between buyer, broker and underwriter as risks become more complex.

Buyers are increasingly asking underwriters to visit sites, and since underwriters have a "wealth of often-untapped knowledge" in claims files, they should assist buyers to reduce exposures by providing them with loss data, he said.

Mr. Knox also called for more flexibility in contracts, saying buyers need tailor-made policies for some risks.

—By Kate McIlwaine

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SET YOUR DATES

issue:	October 19
closing:	**October 7**
demographic section:	Insurer Topics: Claims Handling/Claims Automation
issue:	October 26 — Reader Service — Bonus Distribution: NAII; Baden-Baden
closing:	**October 13**
editorial feature:	Reinsurance: Trends & Issues
	Directory: Reinsurance Brokers
issue:	November 2
closing:	**October 21**
demographic section:	Agent/Broker Topics: Relations With Direct Writers
issue:	November 9 — Ad Study — Bonus Distribution: PIA
closing:	**October 27**
editorial feature:	International Benefits & Risk Management
	Directory: International Insurers & Benefit Networks

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Business Insurance Coverage Guaranteed

INTERNATIONAL

LONDON

Continued from page 31
tacks on the British mainland, said the ABI spokesman. However, "the disquiet of insurers hasn't gone away," he added.

Estate protection plan

Lloyd's of London's wholly owned reinsurance company CentreWrite Ltd. has found a new use that has been approved by the Department of Trade and Industry.

Last week, Lloyd's broker Holman Wade Ltd. announced it is renewing its exclusive members' Estate Protection Plan with CentreWrite Ltd., covering 1993 and 1994 calendar years.

The Estate Protection Plan is the only way a Lloyd's member's estate can have automatic unlimited coverage against underwriting losses after the member's death. The coverage from CentreWrite also will cover losses from syndicates in run-off as well as to losses within the current three-year account. Premiums are tax-deductible.

A member pays a premium for the plan, ranging from 350 to 950 pounds ($599 to $1,625) depending on the member's age. The policy covers losses in excess of a certain amount of member's premium income.

Holman Wade approached CentreWrite when it became apparent that the market had contracted and underwriters couldn't commit themselves early enough to give members' promised coverage before year end. Members needed the protection before they committed themselves to writing premium income in 1993.

Losses on this coverage have been high, with underwriters paying out more than 33 million pounds ($56.4 million) this summer in claims against total annual premium of 10 million pounds ($17.1 million).

A Lloyd's task force had determined that "the proper use of CentreWrite was to help individual members with old year problems," and the plan "is the most major move forward" to address this, said Michael Wade, chairman of Holman Wade and member of the task force.

CentreWrite is writing the coverage and financial reinsurance has been arranged to back the plan. During November and December, Holman Wade will also seek quota-share reinsurance for the plan without being paid a brokerage commission, which could reduce the risk on CentreWrite by half, said Mr. Wade.

So far, CentreWrite has promised to write run-off reinsurance contracts for Lloyd's syndicates and members, but nothing of any significance has been written.

"It's got off to an extremely slow start, but this is a major contract which is offered to any member of Lloyd's who wants to buy it, and most do," said Mr. Wade.

Andrew toll rises

The London Insurance & Reinsurance Market Assn. said last week that its members have so far paid out $122 million in claims from Hurricane Andrew.

This total was settled through the Electronic Loss Advice and Settlement System, LIRMA's electronic claims system. LIRMA members have reserved $205 million for outstanding Andrew claims, meaning the total cost to LIRMA members from Andrew totals $327 million.

"This performance demonstrates the ability of London market companies to provide a fast and efficient service to the world," said Philip Evans, LIRMA's chairman.

Prudential sells units

General Accident P.L.C. plans to buy the direct Canadian general insurance business of rival British insurer Prudential Corp.

General Accident will pay up to $165 million Canadian ($132.6 million) for the business, depending on the amount of capital Canadian regulators allow Prudential to retain in its direct operations there.

Prudential's direct Canadian operation had assets of $181 million Canadian at the end of June ($151 million at June 30 exchange rates). The company wishes to retain $25 million Canadian ($20.1 million) as part of the deal. If the Canadian authorities allow Prudential to retain the capital, General Accident will pay only $140 million Canadian ($112.5 million) instead of $165 million Canadian ($132.6 million) for the assets, said Barrie Holder, general manager at General Accident.

General Accident is raising the money for the acquisition through the issue of 13.5 million new shares which will be placed with institutional investors at a share price of 488 pence (84 cents).

If the deal is not approved by the Canadian authorities, the extra capital will be used to pay some of General Accident's outstanding debts, Mr. Holder said.

Prudential's Canadian direct general operation wrote net premiums of $308 million Canadian in 1991 ($266.5 million at year-end 1991 exchange rates) and earned pretax profits of $19 million Canadian ($16.4 million).

In the six months ended June 1992, the business had an unaudited net premium income of $160 million Canadian ($133.4 million) and an unaudited pretax profit of $23 million Canadian ($19.18 million).

Most of the business is personal lines insurance, Mr. Holder said.

Zurich eyes MMI

Zurich Insurance Group is holding talks with Municipal Mutual Insurance Ltd. about acquiring the troubled British insurer.

If the deal goes through, Zurich could be the main insurer for British local governmental authorities by year end, said Dennis White, Zurich's chief executive in Britain.

"There are still a number of issues, but subject to these being resolved, we shall be able to offer insurance cover to local authorities on realistic terms before the year end," Mr. White said.

MMI is Britain's largest insurer of local authorities, but in recent years it has been hit by large liability claims including compensation payments to victims of the Hillsborough soccer stadium disaster and their families.

In 1991, the company lost 238.6 million pounds ($446.2 million at the year-end 1991 exchange rate) on net premiums of 784.9 million pounds ($1.47 billion).

Rescue plans for MMI involving a consortium of continental European insurers were dropped late last month. (*BI*, Oct. 5).

Zurich is not a major insurer of local authorities elsewhere in Europe, a spokesman said. However, the company has targeted Britain for expansion and sees the MMI business as an opportunity to fulfill its plans, the spokesman said.

Neither Zurich nor MMI would provide details of the proposed sale. Zurich did say that one issue being discussed is the responsibility for paying past liability claims.

Local authority associations have welcomed the announcement and put on hold tentative plans to set up a captive insurer or alternative mutual insurer to carry their risks.

The associations said in a joint statement: "The LAAs will need to be satisfied that existing contracts with MMI would be honored in full in any agreement between MMI and Zurich. Moreover, the LAAs would need to examine very carefully the treatment of claims arising under previous year's policies."

When the previous rescue plan collapsed, local authorities were forced to go to commercial insurers, which often charged more than MMI did.

Zurich would not comment on the premiums it would charge, but a spokesman stressed they would be "realistic".

New ERM manager

The European arm of International Risk Management Group has taken on a new managing director this month in a drive to expand its European business.

Gareth G. Bradburn was named managing director of European Risk Management Ltd. of Weybridge, England, effective Oct. 1.

The appointment comes nearly two years after the retirement of ERM's previous managing director, William Sennett.

Mr. Bradburn has spent the last 16 years with Swiss-South African Reinsurance Co. as a director and general manager. ■

Cairo earthquake

Continued from page 31
sparse coverage for a population of 60 million.

About half the volume comes from automobile insurance.

Direct insurers are obliged to cede 30% of their gross premium to the government-run Egyptian Reinsurance Co. Egypt Re then retrocedes about 50% to 60% of its premiums overseas.

According to Alexander Howden, the broker with the largest reinsurance book in Egypt, about 10% of this retrocession goes to the London market and the remainder is spread internationally. Howden believes that there will be very little earthquake exposure on any pro-rata or excess-of-loss treaties with the international market.

No foreign insurance companies are allowed to operate in Egypt, and neither are foreign brokers placing direct insurance.

Although insured losses appear low, the Alexander Howden spokesman noted that economic losses from the earthquake could increase because of government-ordered demolition of poorly constructed buildings that were damaged in the earthquake but remain standing.

Demolition costs are not expected to be covered under any insurance policies.

International press reports said that classical and religious buildings like older mosques generally withstood the earthquake well.

But for modern buildings and those up to a century old, it was a different matter, said one Egyptian executive who was abroad at the time of the earthquake.

"In Cairo, it only takes one gust of wind and buildings fall," he said.

It is a common practice to illegally add two or three extra floors to apartment buildings, usually after bribing local government officials, he said. Such buildings become dangerously unstable.

This view is upheld by Herbert Tiedeman, consulting engineer to the Swiss Reinsurance Co. in Zurich. Mr. Tiedeman has participated in two United Nations missions to Egypt concerned with emergency disaster planning.

Buildings in Cairo are very, very vulnerable, says Mr. Tiedeman. "The mortar is bad or not there, the reinforced concrete frames have a very low resistance to damage and it is all sitting on the very soft subsoil of the Nile Valley which amplifies the effects of an earthquake," Mr. Tiedeman said.

He recalled that on his last mission to Egypt, he told a conference, "be prepared for serious damage." Some of the property damage that may be identified as a result of this earthquake could have originated with previous quakes, Mr. Tiedeman said.

Egypt, particularly the Upper Nile Valley, has a 12,000-year-long documented history of destructive earthquakes.

Last week's earthquake was modest, said Mr. Tiedeman, but its effects were all the more marked since it was centered at a very shallow depth and close to poorly constructed buildings.

"The terrible thing in Egypt is that it has all its eggs in one basket," says Mr. Tiedeman. "Most of the population lives in and around Cairo and works in the Nile delta area.

"If there is an earthquake of magnitude 7.0 or higher, it could be devastating for the country." ■

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4C042

Comp system needs intensive care: Panel

By JAMES M. BURCKE

WHITE SULPHUR SPRINGS, W.Va.—It will take strong medicine to cure a workers compensation system that is in "critical condition," insurers and agents agree.

NACSA/NACSE CONFERENCE
The Greenbrier

And, "as the patient becomes more ill, the cure becomes more radical," says David A. Kocher, group executive for property/casualty operations at Aetna Life & Casualty Co. "I don't think there is any limit on what we should consider to fix it."

Complicating the healing process is the fact that the well-being of the workers compensation system varies from state to state, points out Gerald L. Maatman, chairman and chief executive officer of Kemper National Insurance Cos.

The deficits generated by the residual markets "in about a dozen states are causing the patient to hemorrhage," he says.

But there is hope, Mr. Maatman adds. Insurers and employers can work together to ensure significant reforms, he says, noting that "Texas is one state that has come back from the dead."

Messrs. Kocher and Maatman participated in a panel discussion on workers compensation at the annual joint meeting of the National Assn. of Casualty & Surety Agents and the National Assn. of Casualty & Surety Executives, held Oct. 4-7 at The Greenbrier resort.

Mr. Kocher explained that a key question that must be asked when assessing workers comp problems is "the question of limits."

"How much do we want to pay injured workers?" asked Mr. Kocher, explaining that society must weigh the compensation that will be paid to a worker with a partial disability against the economic loss that will be sustained if a business moves out of state—or out of the country.

The problems affecting the workers comp system are very much like other "national problems" like the federal budget deficit or the health care cost crisis, pointed out Joseph A. Edwards, former Maine superintendent of insurance and now a workers comp consultant to the American Insurance Assn.

In all three cases, everyone realizes that expenditures are exceeding the funds available, he explained.

However, no party wants to be the one to sacrifice their objectives to balance costs with resources, Mr. Edwards said.

"We're a generation that wants to have it all," he said.

In the workers compensation marketplace, "costs are going up faster than rates," he said. Among the factors driving the overall cost of the workers comp system, he said, are:

- Rising litigation costs.
- Rapidly escalating medical costs.
- The increased number of people seeking workers comp benefits.

"The definition of compensability has been expanded to allow for stress, back pain—all kinds of subjective injuries," Mr. Edwards said, adding that "without claimants, there is no payday for the special interests. There would be no doctors and lawyers," whose involvement in the system increases its costs.

But, reforming the system is not easy, the panelists noted.

"Carriers cannot lead the workers comp reform effort themselves," Mr. Edwards said. They need to enlist the support of local business groups and agent associations in each state, since these groups have a "presence in the state; insurers do not," he said.

"When local interests lead the effort, you get reform," he said.

However, powerful groups—most notably trial lawyers—will attempt to block most reform efforts, Mr. Edwards warned.

Kemper's Mr. Maatman agreed.

"We have to find a way to separate organized labor from the trial bar" when lobbying for workers compensation reform, he said. "We have not been able to do that effectively at the state level."

Keeping trial attorneys out of the negotiation process was critical to the approval of Florida's 1979 workers compensation reform law, said J. Hyatt Brown, president of Brown & Brown Inc., a brokerage in Daytona Beach, Fla. "The reform was not bastardized."

However, the trial bar still can derail workers comp reform efforts even after a reform law is enacted, Mr. Brown said, again citing the Florida law.

In most states, the trial bar has "a direct effect on the election of circuit court judges," he said, explaining that judges interpreted the Florida law far more broadly than lawmakers, insurers and employers ever intended.

Employee involvement in reform efforts at a local level can help nullify the efforts of trial lawyers to block reform, said J. Patrick Gallagher, president and chief executive officer of Arthur J. Gallagher & Co. in Itasca, Ill.

However, to be successful, employers must take their case directly to employees, he said.

"People understand numbers. When employees hear from the employer what is really going on, you can separate employees from trial lawyers," he explained.

Employers are leading the reform effort in some states, Mr. Gallagher pointed out.

He singled out the efforts of The Walt Disney Co., which has drafted a comprehensive California workers comp reform proposal (*BI*, July 20).

Mr. Gallagher, whose company specializes in providing services for self-insured employers, also said that self-insurers are out front in applying managed health care programs to workers comp claims. "Their cost savings have been dramatic."

However, Kemper National's Mr. Maatman asserted that "it's misleading to say that major workers comp carriers aren't on the ball" on the managed care issue. "You can't be competitive" as a workers comp insurer unless you offer comprehensive managed care programs, he said.

The discussion was moderated by Robert E. Vagley, president of the American Insurance Assn. in Washington. ■

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GATT discussions

Continued from page 2

multilateral trade agreements in general.

"We're at a real crossroads right now," said Stewart H. Steffey, a senior vp with CIGNA Worldwide Insurance Co., which is a member of the U.S. GATT team negotiating financial services issues. "If we can't have a strong GATT, will the process of multilateral trade work, or is it a failed approach?"

The passage of a GATT trade agreement would be "a major kick start" to address the worldwide recession, he said. But if GATT, which passed the seven-year mark of negotiations on Sept. 20, fails again, that failure may "irreparably harm" multilateral trade agreements, Mr. Steffey said. "One has to be sobered by the fact that we haven't made much progress on GATT in seven years," he added.

Rather than working through GATT, the United States seems to have had better luck with bilateral negotiation, the most recent result of which is the North American Free Trade Agreement between the United States, Canada and Mexico. NAFTA, in part, opens up the Mexican insurance market to foreign competition for the first time in 50 years (*BI*, Aug. 24).

The United States has also invoked Section 301 of the Trade Act to impose sanctions on countries—like India, South Korea and Taiwan—which practice restrictive trade policies, said Gordon Cloney, president of the International Insurance Council of the United States, a group of U.S. multinational insurers.

But while bilateral trade negotiations on a country-by-country basis seem to work, they are more time-consuming than multilateral agreements, Mr. Cloney said.

Agricultural wrangles have hogtied GATT progress since 1990, when service industry issues like insurance trade barriers were introduced to the talks (*BI*, Dec. 3, 1990).

The service rounds of the talks have progressed, but agricultural disagreements continue. U.S. insurers stand to gain free access to currently restricted markets worldwide if the more than 100 countries participating in GATT reach an agreement (*BI*, Dec. 9, 1991).

Although a framework is already in place for the General Agreement on Trade in Services—which establishes negotiating principles for service industries like insurance—the United States and participating GATT countries continue to disagree on perceived trade barriers, Mr. Cloney said. Some countries, most notably those in Latin America and Southeast Asia, are "the least forthcoming so far in insurance and services," preferring to wait and see what trade-off incentives they get in areas like agriculture and textiles, he said.

As a result, no matter how well the service talks progress, they cannot succeed until agricultural issues are resolved, said Henry G. Parker III, international consultant to Chubb Corp. and founding chairman of the International Insurance Council.

Service issues cannot be negotiated separately because countries like the United States, "a free and open market with little in insurance (restrictions) to trade off," need agriculture, textiles and other elements to use as "trading chips" to negotiate more favorable service-trading deals with restrictive countries, Mr. Parker said.

The upcoming U.S. presidential election also has foreign negotiators in a "high state of confusion," said Margaret S. Wigglesworth, execu-

Continued on next page

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GATT discussions

Continued from previous page
tive director of the Coalition of Service Industries Inc. in Washington, which represents multinational service companies.

Negotiators are concerned that if they strike a deal now with the Bush administration, the plan may not be approved by a new president, Ms. Wigglesworth said.

"The presidential elections are having a psychological impact on the GATT, the way they do on the stock market," she said.

Although the Democratic platform favors free and expanding trade, including the GATT talks, nominee Bill Clinton only recently endorsed NAFTA, and then with reservations about the potential loss of U.S. jobs.

Potential signatories to a GATT agreement are also worried about Ross Perot, said Mr. Parker, who also is chairman of the international committee of the American Insurance Assn. "If you think we're confused about all this, just imagine how (other countries) feel."

While the German elections of two years ago also chilled the GATT talks, Germany didn't have the "noose of fast-track hanging over its head," the way the United States does now, Ms. Wigglesworth said.

"Fast-track" refers to an agreement whereby Congress would hold yea-or-nay votes on GATT-generated trade bills without allowing them to be "Christmas-treed" with amendments.

While the fast-track provision technically expires on June 1, 1993, the president must notify Congress about impending legislation by March 1, 1993. This means that the necessary mandated private sector reports and recommendations on the legislation are due in December.

"Even if lightning struck and the administration completed GATT legislation in six weeks, it would still need to be submitted by December," Mr. Parker said.

If the agricultural talks in Geneva succeed—and some observers believe they will because President Bush, anxious to score points with voters, will pull out all stops to push for an accord—the services market access talks in Geneva will accelerate in order to nail down commitments before year end.

Although GATT can be extended if the talks break down, the United States will lose its authority to negotiate the round next spring, and a rare opportunity to multilaterally eliminate service trade barriers in other nations will slip past. ■

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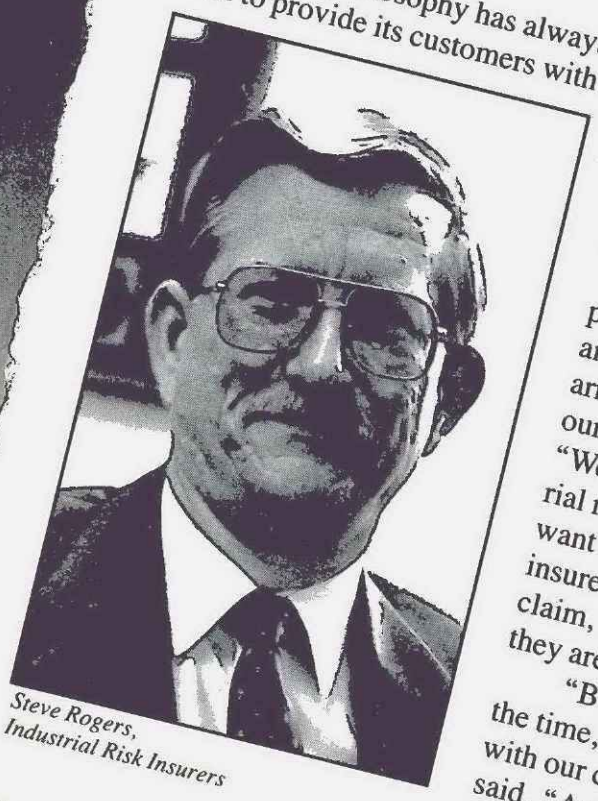

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Workers comp

Continued from page 3
search is that a cap on physician fees is not the way to control costs."

Internal data at Industrial Indemnity Co., one of the largest workers comp insurers in the state, tells a similar story. "With the frozen unit price we had in place since 1987, over time the utilization factor has grown quite noticeably," said Will Murphey, vp of medical management in the insurer's workers comp division in San Francisco.

"The fee schedule does only about 50% of what you need to do to control costs," agreed Gregory Johnson, a principal with William M. Mercer Inc. in San Francisco.

Controlling the amount and type of treatment for injured workers is also critical, he said. With little control, "the overall cost of the system has surged forward dramatically."

Insurers were able to control the unit price of procedures through the fee schedule. In 1991, insurers paid providers an average of 2.5% less than allowed by the schedule for regulated procedures. But despite that average, doctors last year attempted to bill 57% of all procedures at levels above the scheduled fee, "perhaps indicating physician frustration that the fee schedule has not been updated since 1987," the CWCI report said.

Even though insurers did not actually pay those higher charges, medical costs rose. "The other major determinant of total costs, changes in utilization of medical services, offers a better explanation of medical cost increases than changes in unit price," the report explains.

Take office visits, for instance. In 1987, about one-third of all new patient office visits involved "brief or limited services," the report said. By 1991, that share had fallen to just over a quarter, with "intermediate or comprehensive" exams increasing to nearly 75% of the visits.

"As the 'intensity' of the office visit increases from brief to comprehensive, so does the unit value for that procedure and, thus, the cost," the report says.

Increasing use of magnetic resonance imaging also contributed to rising costs. Average MRI payments to doctors jumped 37% from 1990 to 1991, an increase that "cannot be explained solely by greater demand for MRIs resulting from a surge in the number of serious injuries or by inflation," the CWCI report said. In fact, state researchers say that the number of disabling work injuries fell about 9% in that period.

Fee schedules do not control more frequent use of medical services, and without such control, the report concludes, "there is little hope of controlling medical costs."

The report outlines proposals that have been made to control medical utilization in work comp: mandatory utilization review by insurers; managed care; flat fees for medical treatment and physician financial incentives; and deductibles and coinsurance.

"We support virtually all these recommendations," said Industrial Indemnity's Mr. Murphey.

Many of those elements were included in a workers comp proposal Gov. Pete Wilson introduced recently in a special legislative session. That session adjourned without any action on workers compensation.

Under Gov. Wilson's proposal, the state could certify managed care organizations, which would be authorized to contract with insurers and self-insured employers to treat injured workers. Workers' choice would be restricted; they would have to use a doctor in the organization unless they predesignated a personal physician.

Continued on next page

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Business groups had backed the measure.

Industrial Indemnity and William M. Mercer also "have been considering the concept of prospective fees" for workers comp physician services, Mr. Murphey said. "We're working to build a data base to allow us to go forward with that."

Such flat fees would "begin to shift a lot of the responsibility to the physician for the outcome of the case," rather than giving the physician broad discretion to control the intensity and duration of treatment for injured workers, he said.

Meanwhile, the Division of Workers Compensation is working with 25 representatives of payers, providers and intermediaries to update the fee schedule.

The fee schedule has not been updated since 1987 because of "changes and turmoil" within the division as a result of workers comp reform efforts, Mr. Murphey noted.

The division hopes to hold hearings on the new schedule in December.

The schedule includes some ground rules, which are not strictly utilization review but are interpretive tools to help physicians in billing, the division says. The schedule will better serve providers in reflecting the services they provide to injured workers, the division said.

The division conceded that failing to update the fee schedule may have given doctors some incentive to provide more services and charge more for them. But annual updates of the fee schedule are now planned. ■

Keene proposal

Continued from page 1

ants, but would also benefit the nation's court system by transferring 150,000 current asbestos injury cases, and an estimated 200,000 future cases, from overcrowded court dockets to a non-adversarial resolution process.

Claimants' awards would be guaranteed, paid quickly and theoretically not be subject to attorney contingency fees of up to 50%, Keene asserted.

Speaking at a press conference Wednesday in New York, Keene Chairman Glenn W. Bailey insisted that the current asbestos-related claims resolution system is dysfunctional.

Specifically, Mr. Bailey said court awards are unpredictable, and the ongoing assessment of punitive damages against asbestos defendants is unfair. If the system is not changed dramatically and soon, the number of asbestos producers seeking bankruptcy protection will grow from the current count of 16 and claimants will never receive due compensation.

Keene proposes that the claims fund be established as the exclusive national remedy for all asbestos injury claims, similar to the existing mechanisms for black lung and harbor workers' claims, explained Stuart Rickerson, Keene's vp and general counsel.

"If all claims aren't resolved through the fund, then we won't be able to control what many people see as a national disaster. Voluntary participation would only expand the problem," he said.

At the heart of the asbestos litigation problem, according to Mr. Bailey, is that limited resources are not getting to injured parties. Of the $12 billion that has been spent to date on all facets of asbestos litigation, he said, plaintiffs have received only about $3 billion to $4 billion. The remainder has gone to defense lawyers, contingency fees for plaintiff's lawyers and administration costs (see story, page 1).

'If no action is taken, all the companies involved in asbestos litigation may eventually go bankrupt, and the government will then become the lone defendant. Something has to be done to put this crisis behind us,' Mr. Bailey says.

"This fund would provide truly injured people faster and more equitable recoveries" than the current system, Mr. Bailey said. "What is happening now amounts to legalized extortion for the lawyers. Somehow, we have to take the money out of the lawyers' hands and give it to the sick people. We firmly believe a fund like this would pay meritorious claims on a much faster basis, with injured claimants getting more of the limited resources that we still have available," he said.

Also included in the Keene proposal, which would cost the federal government about $8 million per year to administer, is a mandate for the creation of a "non-impaired, non-trial track registry." The registry would list people who have no immediate symptoms of asbestos-related injuries but fear that past exposure to the substance may eventually affect them. If those listed on the registry become sick, they would be eligible for payment through the fund.

The proposal's elimination of punitive damages is the element that could attract the attention of groups interested in tort reform, one observer said.

"Punitive damages in asbestos litigation are flat-out wrong," said Mr. Rickerson. "It's the punitive damages that have bankrupted 16 companies and are costing thousands of jobs. If punitive damages are intended to punish and deter, why impose them on an industry that hasn't made the product in more than 25 years?"

Martin Connor, president of the American Tort Reform Assn., shares that sentiment, describing as "farcical" the award of punitive damages in current asbestos litigation.

"Anyone who believes that the asbestos industry deserves further punishment is living on Mars. These companies have already paid out billions of dollars" and they're going to pay out more before all the claims are resolved.

While not spelling out exactly how, the Keene plan by its nature also appears to greatly reduce the amount of contingency fees that plaintiff's lawyers will be able to justify.

"We're trying to eliminate all the transaction costs," said Mr. Rickerson. "Payment for legitimate injuries will be prompt and assured. Logically, if all one has to do is submit a simple form to the board, there's no justification for a one-third or one-half contingency fee to be paid to a lawyer or accountant."

The proposal has already drawn criticism from the plaintiffs' bar.

The funding called for in the proposal is inadequate, according to Stan Levy, a partner with Levy, Phillips & Konigsberg in New York.

"$250 million is woefully short, even if you did cut out lawyers, which never would happen. There'd be arguments before the board and appeals of awards. These cases aren't as clear-cut as they're saying."

Mr. Rickerson said Keene came up with the $250 million initial figure by calculating its annual asbestos claim costs and estimating what other defendants are likely spending.

Mr. Levy also questioned whether asbestos defendants even have the money to contribute to the fund. "From the way Keene has been presenting its case, it doesn't have the money to put up."

He also said any government-administered claims fund eventually runs into administrative problems that delay payments.

"People simply don't get paid with these funds. If you look at the Longshoremen's and Harbor Workers' Act, the claims are now eight to 10 years behind."

Thomas Henderson, a plaintiffs' attorney with the Pittsburgh firm of Henderson & Goldberg, called the Keene proposal "contrived" and "designed to buy time."

"This is enlightened self-interest in the shabbiest form. It amounts to a shameless and cruel hoax on victims. Keene's only concern is staying in business and buying time to improve its floundering capital base. What they're really looking for here is some immunity from paying claims until the 22nd century," Mr. Henderson said.

However, Mr. Henderson admitted that high transaction costs in asbestos litigation are hurting plaintiffs.

"I'd accept anything that would get these claims out of the court system where defendants use delaying as a tactic for not paying. But I wouldn't accept this type of limited fund that provides defendants with partial immunity from facing their responsibilities to pay the full amount of claims."

Keene now is venturing on its own with this proposal, but it would welcome the help and support of other asbestos defendants in informing lawmakers about the need for the fund.

Keene and its insurers have paid more than $420 million in asbestos-related claims and attorneys' fees.

At this point, most observers—including officials of insurers and other asbestos defendants—are declining to comment on the proposal, but at least one group of asbestos defendants acknowledged that elements of Keene's proposal make sense and are worthy of further exploration.

Larry Fitzpatrick, president of the Center for Claims Resolution, a voluntary claims facility in which about 20 asbestos defendants participate, said his group would probably support elements of the Keene proposal.

"We have to eliminate the punitive damages. Few companies still have the resources to pay these windfall awards. They take away from a company's ability to pay compensatory damages to other legitimate claimants."

Mr. Fitzpatrick called the registry "a great idea."

"This would benefit all claimants, even those current plaintiffs with no outward signs of injury who often compromise their claims and then have no future recourse when they actually get sick," he said.

While not specifying which members of Congress Keene has spoken to about introducing legislation to create an asbestos claims fund, Mr. Bailey said that "several" congressmen have "expressed interest" in the proposal.

"We're committed to this," he said. "If no action is taken, all the companies involved in asbestos litigation may eventually go bankrupt, and the government will then become the lone defendant. Something has to be done to put this crisis behind us. We think this is the answer."

A possible bill sponsor is Rep. Pat Williams, D-Mont., who recently addressed the House of Representatives on asbestos compensation legislation. But he said he would not introduce a bill that would deny individuals access to the courts. ■

Illinois policy selection ruling

Continued from page 2

In the Illinois case, general contractor Great Lakes Towing Co., a Cleveland-based tugboat, towing and ship repair company, was named as an additional insured on a liability policy purchased by Thatcher Engineering Corp. Thatcher was hired to repair a dockwall on Great Lakes' Chicago premises.

A Thatcher employee was killed while working on Great Lakes' property. After it was sued by the employees' survivors, Great Lakes tendered a defense to member insurers of the Institute of London Underwriters, which wrote Thatcher's policy.

Great Lakes also informed its own liability insurer, Hartford Fire Insurance Co., of the incident, but told Hartford that the ILU policy should respond.

The ILU ultimately settled the claim for $75,000. It then asked Hartford to pay half that amount. Hartford refused—as Great Lakes had instructed.

The trial court found, and the appellate court confirmed, that when two policies potentially apply to a loss, the additional insured may "elect which of its insurers is to defend and indemnify the claim by tendering its defense to one insurer and not the other and thereby foreclosing the settling insurer from obtaining contribution from the non-settling insurer."

The ILU will not appeal.

For construction companies, the ruling is important because general contractors usually are named as additional insureds on a subcontractor's policy.

Subcontractor policies typically provide that if the general contractor is held responsible for an occurrence that arises out of the subcontractor's work, the general contractor will be covered as an additional insured under the policy, explained attorney Robert L. Kiesler of Kiesler & Berman in Chicago, which represented Hartford.

Although significant from a legal standpoint, the opinion will probably not have much practical effect, insurer attorneys say.

One reason is that policyholders almost always seek defense from their own insurers. "Normally an insured will just tender a claim (to its insurer)," said Hugh C. Griffin, a partner with Lord, Bissell & Brook in Chicago, which represented the ILU.

Another reason the ruling may have limited impact is that it involved a very small claim. "With a big claim, the insured puts both carriers on notice and says, 'Take care of me,' " he said.

When the policyholder knows that it is faced with a "policy limits-type situation, you definitely want to put all carriers on notice," agreed Mary Beth Denefe, a partner with Haskel & Perrin in Chicago, which specializes in representing insurers.

For cases that fall into the middle ground, however, the incentive to tap other policies is diminished, she observed.

Another extenuating circumstance in this case was that the ILU policy contained no "other insurance" clause, "so we didn't have that to fall back on," Mr. Griffin said.

An "other insurance" clause spells out how a policy will pay a claim when more than one policy covers the same risk.

The ILU had argued that the existence of the clause in the Hartford policy required Hartford to contribute. But the court ruled that "any liabilities arising under this clause are not triggered until the insurer becomes obligated to pay or defend." Since Great Lakes never tendered the claim to Hartford, it never had those obligations.

If the ILU policy had contained an "other insurance" clause, which is fairly typical in liability insurance policies, it may have changed the outcome of the case, said Mr. Griffin.

Attorneys point out that no Illinois courts previously had considered a policyholder's right to direct a claim to a policy on which it is an additional insured. Very few other states' courts have considered the issue, which may indicate that the question seldom arises, they say.

"The court had a clear slate and took the view, 'Why shouldn't an insured be able to protect its premium exposure?' " Mr. Griffin said.

One question the court did not consider is whether a policyholder can "untrigger" a claim made with an insurer.

"If the insured is able to tender a case to an insurer and later say, 'Hmmm, I'd rather tender this to another insurer,' " it becomes significant, said Mr. Kiesler, who represented Hartford. Unless a policyholder can untrigger a claim, its ability to choose insurers is not very important since most policyholders lack the foresight to file the claim with only certain insurers, he said.

"I'm not actually sure that you can do that, but this case doesn't address (the issue)," agreed Ms. Denefe.

The opinion also raises issues about the notice a policyholder must give an insurer, she said. Even if two to three years has passed since an accident, "Is the court going to say that an insured has the absolute right to tender to whoever it wants without respect to traditional notice?" Ms. Denefe asked.

Insurers have long tried to deny coverage to policyholders that do not give insurers timely notice of a claim, she said.

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Institute of London Underwriters vs. The Hartford Fire Insurance Co.; Appellate Court of Illinois, First District, No. 1-90-3510.

Tort costs

Continued From page 1

"The point I would make to you is that ultimately all of this is paid for by consumers," said study author Robert W. Sturgis, a vp with Tillinghast in Hartford, Conn.

"My opinion is that most consumer groups are in an awkward position. They are finding themselves on the wrong side of a consumer issue," he said, referring to general opposition to tort reform.

Tillinghast also found that in 1991, only 22% of tort costs went toward awards for economic losses.

"If you regard it as a system that compensates victims for their losses" it is "less than 25% efficient," Mr. Sturgis said.

Awards for pain and suffering comprise 21% of tort costs, which means that together, only 43% of total costs actually go to tort victims, he said.

The other components of 1991 tort costs are: administrative costs, 24%; defense costs, 18%; and claimants' legal costs, 15%.

"The only thing that surprises me about Tillinghast's work is that so many people aren't ready to accept the data," said Martin F. Connor, president of the American Tort Reform Assn. in Washington.

"The overhead costs of the system are scandalous," he observed. But, "there is no silver bullet. We have to keep plugging away state by state, year after year.

"I don't think anyone should expect a miracle cure. It's a slow process."

Tillinghast reports that tort costs escalated after 1950. From 1950 to 1991, tort costs grew by 11% per year on average, while the U.S. gross domestic product increased by only 7.5% per year on average. Gross domestic product is the measure of goods and services produced within U.S. borders, including goods produced with foreign capital and labor.

Since 1985, though, the annual rate of tort cost growth has moderated to about 8% on average, down from 16% annual growth earlier in the early 1980s.

It is too soon to tell if this trend will continue or is simply a "statistical pause," Mr. Sturgis said.

Over the entire 58-year period studied, tort costs have shown a "very steady 11% annual increase," he noted. "So the fact that in the last four years it seems to have leveled off—the numbers themselves suggest that it just a blip."

Some components of the tort system suggest that the leveling off will not last.

For instance, medical malpractice costs "took everyone by surprise" and began to decline in 1986, after 20 to 30 years of increases, Mr. Sturgis said.

However, he added, "It's quite clear to us that those costs started back up again in 1991."

Although medical malpractice costs are hardly a driving force in overall tort costs, it could be indicative of the overall picture, Mr. Sturgis said.

Tort costs are growing faster than either social programs or the economy, the study shows.

For example, from 1980 to 1991, tort costs grew 12% annually on average, the study says. Workers compensation costs grew 9% annually; Social Security expenditures grew at 8.2%; public welfare costs grew at 6.6%; and the GDP increased 7.4%.

Taking a longer perspective, though, presents a different picture. From 1950 to 1991, the growth rates for the other systems are more in line with tort costs.

Since 1950, tort costs grew 11% annually on average; workers compensation grew 10.5%; Social Security grew 12.4%; public welfare grew 10.6%; and GDP grew 7.5%.

The study also found that U.S. tort costs as a percentage of GDP far exceed the size of tort costs in other countries.

In 1991, U.S. tort costs were equal to 2.3% of GDP.

Tort costs in Denmark comprised a mere 0.4% of the GDP in 1991; Japan's tort costs were 0.7%, while Australia, Canada and France's costs were only 0.9%. Italy's costs as a percent of the GDP came closest to the United State's at 1.3%.

It doesn't appear that the tort problems in the United States are being exported to other countries, Mr. Sturgis observed.

And, by the year 2000, U.S. tort costs will soar to $300 billion, or 3.5% of the GDP, he predicted in what he called a "reasonably conservative, reliable projection."

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Copies of "Tort Cost Trends: An International Perspective" are available free from Darlene Rodgers of Tillinghast at 175 Powder Forest Drive, Weatogue, Conn., 06089-9658; 203-843-7049.

For the Record

Energy bill to fund coal miner benefits

WASHINGTON—A comprehensive energy bill that President Bush is expected to sign into law includes funding arrangements for health benefits for about 120,000 unionized coal industry retirees.

In July, senators from coal-producing states struck a deal on a new retiree health care fund to be financed by per-capita payments from all coal companies that were signatories to national wage agreements with the United Mine Workers of America since 1950 (*BI*, Aug. 3).

No payments will be required of companies that never employed union miners.

Further support for the fund, which will go into effect after the current national wage agreement expires Jan. 31, is to come from drawing about $70 million each year from overfunded UMWA pension plans.

Notably missing from the final deal is authorization for a tax on coal production. Sen. John D. Rockefeller IV, D-W.Va., and others had long favored such a tax to fund retiree care.

MBIA completes offering of shares

ARMONK, N.Y.—MBIA Inc., holding company of financial guarantee insurer Municipal Bond Investors Assurance Corp., will net $75.2 million from the sale of 1.43 million new shares at $54.875 each.

Credit Local de France also sold 370,000 of the MBIA shares it held as part of the offering, cutting its equity to 2.2% from 3.2%.

In addition, MBIA has sold $100 million worth of 30-year debentures.

The company said the funds will provide additional capital for future needs.

State says well owner liable for spill cleanup

BATON ROUGE, La.—The owner of a well that has spewed thousands of gallons of oil into the Gulf of Mexico is responsible for cleanup, the Louisiana governor's office says.

Greenhill Petroleum Corp. has recovered an undetermined portion of the more than 117,000 gallons of oil. Oil escaped for more than a week beginning Oct. 1, when a fire started as workers tried to reactivate the well. About half of the oil that spilled evaporated.

On Oct. 9, the fire was finally extinguished and the well capped. Greenhill was finishing cleanup efforts last week.

The Houston-based company would not provide details of insurance that might pay for the cleanup or oil loss. Based on oil futures prices, the lost oil was worth around $60,000.

The oil slick has reached Timbalier Island—home to pelicans and other birds—off the Louisiana coast, according to Tim Hebert, a deputy coordinator at the Office of Oil Spill Coordination in the Louisiana governor's office. Commercial and recreational fishing is done in the affected waters, he said.

IVANS, RINET launch joint membership plan

GREENWICH, Conn.—The insurance industry's electronic communications providers in the United States and Europe have launched a joint membership program.

The joint venture between Greenwich, Conn.-based Insurance Value Added Network Services and Brussels, Belgium-based Reinsurance & Insurance Network will provide an electronic link between business partners in the reinsurance industry, said IVANS President Robert Y. Barham.

The joint program also will allow reinsurers and brokers to avail themselves of the electronic communication benefits, products and services of both IVANS and RINET at significant savings over separate memberships, said Mr. Barham, who estimated the savings could be as much as 80%.

For example, a reinsurer with $500 million in premium volume would pay total initiation fees of $287,000 to join both IVANS and RINET, but only $56,000 under the new joint agreement. In addition, annual assessments in separate memberships that would total $80,300 would only costs $45,000 under the joint plan.

IVANS and RINET are nonprofit organizations that promote electronic communication in the insurance industry with the aim of improving efficiency.

Through a joint venture with the Brokers & Reinsurance Markets Assn., the Reinsurance Assn. of America and the London Insurance Market Network, RINET is developing electronic transaction standards for reinsures.

The IVANS/RINET program "is an important step in capitalizing on the efforts of the standards-development joint venture by focusing on the implementation and use of insurance (electronic data interchange) standards," said Jean Yvon Lacave, general manager of RINET. ■

Update

Hall agrees to sell Adjustco

Continued from page 2

pensation claims administration business with the medical monitoring program of PHC's workers comp division, CareSys.

Adjustco's current book of business is 58% claims administration, primarily workers comp; 25% rehabilitation case management; and 17% workers comp utilization review, disability management and some small specialty lines.

The acquisition is part of PHC's commitment to develop "a fully systems-integrated, managed care solution for workers compensation," said CareSys President Dickon Pownall-Gray.

Hall sold a 49% stake in Adjustco in 1987 to Leonard J. Russo Insurance Services for an undisclosed amount. But Hall regained that stake in 1989 after Russo failed to honor the terms of the agreement (*BI*, July 17, 1989; Oct. 27, 1987; March 23, 1987).

The sale of Hall to Aon Corp.'s Rollins Burdick Hunter Group Inc. unit is expected to be completed shortly.

Refund for work comp insurers

ST. PAUL, Minn.—The Workers Compensation Reinsurance Assn. will refund $100 million to insurers and self-insurers in Minnesota later this month, pro-rated based on their premiums.

The refund is the result of better than expected returns on investments for the years 1979-1986, said Michael D. Markman, WCRA chairman and senior vp of The St. Paul Cos. Inc. This is the first such premium refund by the association, which is a state-created independent provider of workers comp reinsurance. All insurers and self-insurers in the state are required to belong to the association.

Names view Feltrim report

LONDON—The efforts of 1,300 members of syndicates managed by Feltrim Underwriting Agencies Ltd. to seek damages from numerous defendants, including the Society of Lloyd's, may be strengthened by last week's publication of a damning report on Feltrim syndicate losses, the members' leader said.

Members face losses estimated at 650 million pounds ($1.11 billion at current exchange rate) from defunct Feltrim excess-of-loss reinsurance syndicates 540/542 and 847.

Members of the Feltrim Names' Assn. are suing 59 members agents, the Feltrim agency, underwriters Patrick Fagan and K.R. Gofton-Salmond, auditor Arthur Andersen & Co., actuaries Bacon & Woodrow, the Society of Lloyd's and several brokers including Walsham Brothers.

The names hope to recover their losses from the defendants' errors and omissions underwriters. Feltrim carried only 8 million pounds ($13.6 million) of E&O coverage, 2 million pounds ($3.4 million) of which was underwritten by the members on other syndicates, said association Chairman Colin Hook.

The long-awaited report by a committee investigating the Feltrim losses shows "sheer incompetence and negligence at an unbelievable level," Mr. Hook said. But the committee, headed by Sir Patrick Neill, found no evidence of "dishonest or fraudulent conduct or practices in the affairs of Feltrim or in the LMX market."

Montana fund rates to rise

HELENA, Mont.—Higher workers compensation insurance rates will be needed over the next several years to eliminate the $37 million deficit that Montana's State Compensation Mutual Insurance Fund has piled up in only two years of operation.

"It's my anticipation that Jan. 1 we will have some increase," said Pat Sweeney, president of the competitive state fund. Fund directors are scheduled to meet Nov. 5 to discuss rate hikes.

Rates will be raised over five to 10 years to make up the deficit gradually, Mr. Sweeney said.

Tillinghast, a Towers Perrin insurance consulting unit, recently concluded that the fund was undercapitalized at $12 million when it began writing policies on July 1, 1990. On that date, the fund assumed from the state's prior workers comp fund a book of business generating $95 million in premiums.

Briefly noted

A newspaper report last week said the U.S. solicitor general will urge the Supreme Court not to review the **H&H Music Co.** case. The estate of an employee who died due to complications from AIDS sued the employer after it reduced lifetime health care benefits for AIDS to $5,000 under a new self-funded plan from $1 million. The change was made after the employee began filing AIDS claims (*BI*, Oct. 12; Aug. 6, 1990). . . .A West Virginia circuit court judge signed a final order approving a settlement under which Blue Cross & Blue Shield Assn. will pay $8.6 million to creditors of the failed **Blue Cross & Blue Shield of West Virginia** (*BI*, March 16). . . . Peter Christie last week officially became the chairman of London-based broker **Minet Group P.L.C.**, replacing Ray Pettitt, who retires from the company at the end of this month. Mr. Christie, 45, has been with Minet for 24 years in various management positions and was named chief executive officer in June. Minet is a subsidiary of The St. Paul Cos. Inc. . . .The **National Council on Compensation Insurance** has filed for a 17.5% workers compensation rate increase in Alabama's assigned risk plan. The proposed increase is approximately the average between the recommended 24.8% increase in assigned risk rates and the 12.3% increase in loss cuts for the state. . . .Leading **excess-of-loss reinsurance underwriter** David King resigned last week amid reports from his agency, K.P.H. Underwriting Agencies Ltd., that Mr. King's syndicate 745 would produce a substantial loss in 1990. Deputy underwriter Andrew Elliott will replace Mr. King.

Expert witnesses

Continued from page 3

birth defects (*BI*, March 19, 1990). Merrell Dow—which is now a unit of Kansas City, Mo.-based Marion Merrell Dow—has won the overwhelming majority of Bendectin-related suits (*BI*, Oct. 14, 1991).

In the *Daubert* case, the plaintiffs want to call a witness to testify that his own studies show a link between the use of Bendectin and birth defects.

Lower courts, most recently the 9th U.S. Circuit Court of Appeals, dismissed the claims because the witness' work has not been published in scientific journals.

The validity of the evidence itself is not an issue before the Supreme Court. Instead, the justices will be deciding merely whether a federal judge can ban expert testimony on the basis of a 1923 federal court case that barred testimony not founded on "generally accepted" theories, procedures and methods. That case, *Frye vs. the United States*, set a standard used until the mid-1970s.

At that time, the newly codified Federal Rules of Evidence said that expert testimony not accepted by the majority of a scientific community could be allowed if "scientific, technical or other specialized knowledge will assist the trier of fact to understand the evidence or to determine a fact." The code did not mention the Frye decision.

The plaintiffs in the Bendectin case contend that the federal rules prohibit judges from banning experts from testifying solely because their conclusions are not generally accepted by scientists. They say that the appellate court's decision represents a "blatant abuse" of judicial power.

"I think probably the worst type of loss in a tort case is when your client is held liable and he didn't cause the accident," said Mr. Schwartz. "The problem with so-called junk science is that it brings about this most egregiously unfair result in civil law."

Mr. Schwartz stops well short of calling for a blanket ban on all evidence that does not enjoy the unanimous support of a particular scientific community.

"You have to tread very carefully," he said. Permissible evidence should not have to represent the majority opinion if it has "reasonable objective support" and is a "well-rounded minority view that's grounded in scientifically predicated research," he said. ■

Andrew loss estimates

Continued from page 2

ing under review with negative implications.

Standard & Poor's Corp. lowered its rating on Allstate Insurance Co. and its property/casualty subsidiaries' claims-paying ability to AA− from AA+.

S&P also lowered Allstate Life Insurance Co.'s and its subsidiaries ratings to AA+ from AAA. The life companies' ratings were lowered due to the reduced financial flexibility of Allstate due to Hurricane Andrew-related losses, S&P explained.

GEICO Corp. also raised its estimate of gross losses from Andrew to $135 million from $80 million. Like several other insurers, GEICO said the number of claims has not increased but the estimated cost per claim has grown.

USF&G Corp. also boosted its hurricane-related losses last week to approximately $80 million after taxes and reinsurance, from $45 million.

"The whole claims settlement is much more costly" than expected because the costs for relocation, removal and reconstruction are higher than first estimated, a USF&G spokeswoman said.

Other insurers also have recently raised their Hurricane Andrew loss estimates as the full extent of damages from the storm become better known (*BI*, Sept. 28).

The Property Claim Services division of the American Insurance Services Group initially estimated that insured losses in the United States stand at $7.8 billion.

However, insured losses not counted by PCS, like marine losses and losses in the Bahamas, could add about $800 million to that total. And, London sources have said that claims advices from the hurricane indicate that insured losses may total $10 billion to $12.5 billion.

PCS has not raised its estimate of insured Andrew losses since it was issued a week after the storm. But the agency expects to update the industrywide toll from Hurricane Andrew this week.

Meanwhile, two Florida insurers have consented to liquidation orders issued by a Florida state court judge. The Florida Insurance Department has not yet determined the amount by which each insurer is insolvent.

Great Republic Insurance Co. of Miami, which wrote commercial property/casualty, homeowners, auto liability and physical damage coverages, reported $2 million of surplus and $6.2 million of total assets as of June 30. Great Republic reported $2.9 million of net written premiums in 1991.

The Florida Insurance Guaranty Assn. will cover claims from Great Republic's 5,395 policyholders up to $300,000 per claim.

Miami-based Ocean Casualty Insurance Co., which writes mostly auto coverages, reported $2.3 million of surplus and $12.6 million in total assets as of June 30.

The insurer has paid more than $12 million in claims but has estimated it will incur more than $28 million in losses as a result of the hurricane, the Insurance Department says.

Claims filed by Ocean Casualty's 21,000 policyholders also will be paid by the guaranty association.

Florida Fire & Casualty Insurance Co. of Fort Lauderdale entered liquidation last month as a result of hurricane losses (*BI*, Sept. 28).

In a separate Florida catastrophe, the tornadoes that struck the state Oct. 3-4 caused an estimated $100 million of insured property damage, according to PCS.

The tornadoes, which packed winds of up to 150 mph, destroyed some commercial properties and hundreds of mobile homes in Pinellas County, which is just west of Tampa.

The storm system, assigned Catastrophe No. 31, moved northeastward from the Gulf of Mexico to the Atlantic. It caused extensive flooding in the Jacksonville area.

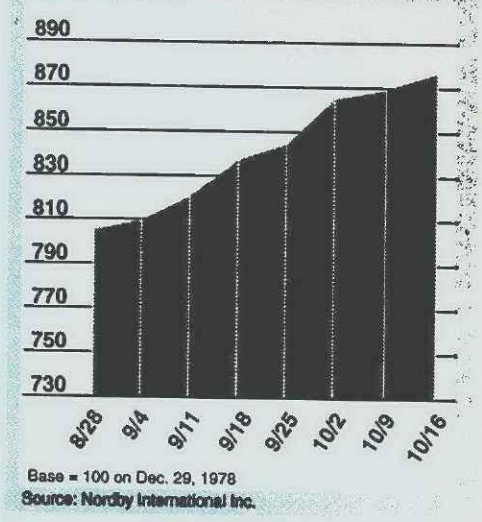
State Farm reported $22 million in property damage claims and $1 million in auto claims from the tornadoes.

Allstate expects $18 million in net pretax losses from the tornadoes. The insurer has received 2,800 tornado claims, of which half are already closed, a spokesman said.

Nationwide Mutual Insurance Co. estimates net losses from the tornadoes to be $9 million before taxes. ●

Mark A. Hofmann and Eileen P. Gunn contributed to this report.

BI Insurance Index



Base = 100 on Dec. 29, 1978
Source: Nordby International Inc.

Insurance industry stocks continued an upward trend last week, as the *Business Insurance* Index climbed 8.2 points to 876.2 on Oct. 16 from 868.0 on Oct. 9. Advancing issues for the week were led by Pacificare Health System, up 9.4%; American Indemnity/Financial, up 7.3%; and United Fire & Casualty, up 6.3%. Declining issues for the week followed Kemper Corp., down 7.9%; US Facilities Corp., down 7.1%; and FHP International, down 6.0%. The most active issue was U.S. Healthcare, 6.1 million shares traded. The *BI* Index was up 0.9%; the NYSE Composite was up 2.0%; the Standard & Poor's 500 was up 2.3%; and the Dow Jones 30 Industrials rose 1.2%.

British Issues

Oct. 15 Companies	Price pence	P/E	Div. pence	Yield %	1 Week High—Low pence	pence
Comml Union	519	N/M	31.5	6.1	530—	514
Genl Accident	503	N/M	35.7	7.1	510—	497
Gdn Royal Exch	146	N/M	10.0	6.8	157—	146
Royal	172	N/M	7.0*	4.1	186—	172
Sun Alliance	284	N/M	19.0	6.7	301—	284
Brokers						
Bradstock	115	12.9	6.3	5.5	116—	115
CE Heath	294	17.1	34.5	11.7	294—	291
Hogg Group	130	12.2	10.9	8.4	130—	128
JIB Group	136	10.0	10.0	7.3	137—	136
Lloyd Thompson	209	16.0	7.5	3.6	209—	209
Lowndes Lmbrt	257	10.0	16.8	6.5	258—	257
PWS Holdings	54	6.2	5.3	9.8	54—	54
Sedgwick Grp	133	10.5	8.0*	6.0	142—	133
Steel Brrl Jones	177	8.8	17.7	10.0	181—	177
Willis Corroon	191	12.0	17.6	9.2	205—	191

Source: Philip Olsen, London * Estimated

BI Industry Stock Report

OCTOBER 12, 1992 THROUGH OCTOBER 16, 1992

		Price	Weekly % change	Year to Date % change	Annual High	Annual Low	Vol.(000)	$ Div.	% Yield	P/E	Book value	Mkt/Bk. value
BROKERS												
Alexander & Alexander	NYS	25.75	1.98	25.61	27.38	18.00	149	1.00	3.88	107	13.10	1.97
Gallagher Arthur J. & Co	NYS	28.63	0.00	27.93	28.63	19.00	142	0.64	2.24	21	5.88	4.87
Frank B. Hall	NYS	3.00	0.00	-29.41	5.50	2.63	41	0.00	0.00	-3	1.95	1.54
Hilb, Rogal & Hamilton	NYS	13.75	-3.51	3.77	15.63	11.00	49	0.40	2.91	22	3.56	3.86
Marsh & McLennan	NYS	90.75	0.83	11.52	92.50	70.00	467	2.68	2.95	21	28.00	3.24
Poe & Associates	OTC	12.75	-3.77	6.25	16.00	11.25	1	0.40	3.14	16	2.82	4.52
BROKERS	AVERAGE		-0.7	7.6					2.2	26		
CONGLOMERATES & HOLDING COMPANIES												
Berkley W R. Corp.	OTC	41.88	-4.01	37.30	45.50	25.25	270	0.36	0.86	15	36.95	1.13
Berkshire Hathaway Inc	NYS	9300.00	-0.05	2.76	9300.00	254.69	0	0.00	0.00	31	7270.00	1.28
ITT (Hartford Group)	NYS	65.75	1.74	13.85	70.63	50.00	890	1.84	2.80	18	112.05	0.59
Sears (Allstate)	NYS	41.88	-0.30	10.56	48.00	32.50	2562	2.00	4.78	11	34.50	1.21
CONGLOMERATES	AVERAGE		-0.7	16.1					2.1	19		
INSURERS/REINSURERS												
AEGON N.V.	NYS	42.13	4.01	20.36	42.13	28.81	122	2.68	6.36	7	N/A	N/A
Aetna Life & Casualty	NYS	42.00	0.90	-4.55	47.00	36.50	504	2.76	6.57	14	87.60	0.48
Allied Group Inc.	OTC	29.00	1.75	70.59	29.25	16.25	9	0.64	2.21	9	19.85	1.46
American General	NYS	49.25	1.29	10.67	50.38	39.00	344	2.08	4.22	11	60.00	0.82
American Heritage Life Ins.	NYS	31.88	1.59	4.08	32.50	21.94	4	0.84	2.64	16	N/A	N/A
American Indemnity/Fin'l	OTC	5.50	7.32	15.79	9.25	4.50	6	0.08	1.45	8	12.93	0.43
American International	NYS	108.25	1.52	10.04	111.50	81.00	1921	0.56	0.52	14	99.30	1.09
Aon Corp.	NYS	49.25	2.87	24.29	50.25	35.38	178	1.68	3.41	13	39.70	1.24
Argonaut Group	OTC	28.50	-0.44	20.00	30.25	21.75	21	0.84	2.95	8	20.96	1.36
AVEMCO Corp.	NYS	25.38	-1.93	1.50	28.00	21.50	39	0.40	1.58	24	9.55	2.66
Baldwin & Lyons Inc.	OTC	30.00	-2.44	16.50	33.00	23.50	0	0.48	1.60	8	24.29	1.24
Chandler Insurance	OTC	4.63	0.00	42.31	7.63	2.38	2	0.00	0.00	42	5.95	0.78
Chubb Corp.	NYS	83.38	0.76	8.28	87.50	62.38	1082	1.60	1.92	13	42.67	1.95
CIGNA Corp.	NYS	52.25	0.97	-14.52	61.75	47.00	430	3.04	5.82	11	117.15	0.45
CNA Financial Corp.	NYS	95.00	1.88	-3.06	104.50	78.50	72	0.00	0.00	10	70.23	1.35
Continental Corp.	NYS	25.63	4.06	-7.24	34.75	20.00	595	2.60	10.15	18	40.00	0.64
EXEL Ltd.	NYS	40.38	-5.56	7.67	44.50	29.75	418	0.92	2.28	8	N/A	N/A
Fund American Corp.	NYS	70.50	0.36	0.89	71.25	62.50	108	0.68	0.96	18	36.11	1.95
Fremont General Corp.	OTC	25.25	-4.72	3.59	27.25	17.00	87	1.00	3.96	6	45.55	0.55
Frontier Insurance Group	NYS	34.38	3.00	27.31	40.50	21.91	45	0.60	1.75	13	26.65	1.29
Gainsco Inc.	ASE	14.00	5.66	50.00	14.00	7.28	128	0.04	0.29	21	3.37	4.15
General RE Corp.	NYS	106.63	-0.93	4.66	111.25	77.50	620	1.80	1.69	14	78.65	1.36
Guaranty National Corp.	NYS	19.50	0.00	34.48	20.38	12.63	24	0.48	2.46	13	N/A	N/A
Hanover Insurance Co.	OTC	45.00	-2.17	25.87	47.75	28.75	508	0.44	0.98	10	37.44	1.20
Harleysville Group	OTC	26.50	-1.85	24.71	27.75	16.75	57	0.64	2.42	11	22.99	1.15
Hartford Steam Boiler	NYS	56.75	-1.09	-1.30	59.25	45.13	103	2.12	3.74	17	35.50	1.60
Kemper Corp.	NYS	22.00	-7.85	-42.30	46.13	20.75	591	0.92	4.18	9	50.00	0.44
Lawrence Insurance Group	ASE	8.13	0.00	-26.97	11.13	7.00	2	0.48	5.91	18	4.71	1.73
Liberty Corp.	NYS	26.63	1.91	20.34	32.88	20.13	186	0.48	1.80	11	29.35	0.91
Lincoln National	NYS	65.25	2.15	19.18	67.50	49.38	148	2.92	4.48	12	81.00	0.81
Markel Corp.	OTC	28.75	0.00	30.68	29.00	17.75	171	0.00	0.00	7	15.59	1.84
Mutual Risk Mgmt. Ltd.	NYS	35.88	1.77	2.14	37.75	23.13	39	0.24	0.67	22	-	-
NAC Re Corp.	OTC	35.00	0.72	11.11	36.75	21.75	537	0.16	0.46	15	18.90	1.85
National Re Corp.	NYS	25.63	-5.53	N/A	27.63	17.00	494	0.12	0.47	13	N/A	N/A
Navigators Group	OTC	32.50	-1.52	-20.73	48.25	28.50	9	0.00	0.00	18	13.52	2.40
Nobel Insurance LTD	OTC	4.63	2.78	15.63	6.00	3.63	76	0.00	0.00	3	7.76	0.60
NWNL Companies	NYS	37.25	-1.32	19.68	43.75	26.00	1132	1.48	3.97	11	62.65	0.59
Ohio Casualty Corp.	OTC	62.75	-1.95	26.77	66.63	44.00	148	2.68	4.27	10	18.00	3.49
Old Republic Int'l	NYS	24.50	4.26	38.03	25.63	16.00	370	0.40	1.63	9	33.09	0.74
Orion Capital Corp.	NYS	39.00	-1.89	23.32	41.00	29.00	65	0.92	2.36	6	43.50	0.90
Phoenix RE Corp.	OTC	12.25	0.00	16.67	12.88	8.50	78	0.20	1.63	25	13.30	0.92
Provident Life	NYS	26.00	1.96	11.83	28.00	18.25	85	1.00	3.85	11	39.50	0.66
Re Capital Corp.	ASE	15.13	-0.82	5.22	16.38	12.25	40	0.24	1.59	18	16.07	0.94
Reliance Group Holdings	NYS	5.13	0.00	24.24	5.88	3.50	46	0.32	6.24	3	6.40	0.80
RLI Insurance Corp.	NYS	20.63	0.00	25.00	21.38	15.38	6	0.52	2.52	9	14.41	1.43
St. Paul Companies	NYS	72.50	-1.36	-0.51	80.75	59.00	438	2.72	3.75	7	86.60	0.84
SAFECO Corp.	OTC	52.25	-0.48	7.18	55.25	36.13	549	1.64	3.14	14	51.65	1.01
SCOR U.S. Corp.	NYS	16.38	-5.07	6.50	18.88	13.13	19	0.28	1.71	9	11.19	1.46
Seibels Bruce Group	OTC	2.50	-4.76	-54.55	6.75	2.13	94	0.36	14.40	-1	10.60	0.24
Selective Ins. Group	OTC	21.00	0.60	25.37	23.50	15.50	154	1.12	5.33	9	30.75	0.68
Statesman Group Inc.	OTC	7.25	0.00	26.09	8.13	5.00	97	0.00	0.00	4	2.48	2.92
Tokio Marine & Fire	OTC	46.75	2.47	-9.22	55.25	32.25	0	0.00	0.00	-	70.93	0.66
Torchmark Corp.	NYS	50.75	2.53	31.53	53.38	34.00	268	1.04	2.05	15	40.95	1.24
Transamerica	NYS	43.88	1.45	10.03	46.75	35.63	244	2.00	4.56	22	55.00	0.80
Transatlantic Holdings	NYS	45.00	-1.10	15.76	47.75	29.38	243	0.24	0.53	14	18.38	2.45
Travelers Corp.	NYS	22.25	-0.56	2.89	23.75	17.13	1748	1.60	7.19	9	59.00	0.38
Trenwick Group Inc.	OTC	37.00	-1.33	29.82	40.50	23.50	119	0.80	2.16	13	21.71	1.70
United Fire & Casualty	OTC	42.50	6.25	41.67	42.50	28.84	0	1.00	2.35	9	35.39	1.20
Unitrin	OTC	39.00	0.65	9.09	39.50	31.00	302	1.20	3.08	12	37.23	1.05
UNUM Corp.	NYS	44.50	0.00	9.88	45.00	32.00	807	0.64	1.44	13	37.70	1.18
US Facilities Corp.	OTC	8.13	-7.14	-45.38	19.00	7.00	287	0.00	0.00	6	9.58	0.85
USF&G Corp.	NYS	19.25	-1.20	41.38	15.00	5.63	1237	0.20	1.95	-12	12.30	0.83
USLICO Corp.	NYS	18.75	0.00	1.35	20.38	17.00	14	1.00	5.33	-20	33.15	0.57
USLIFE Corp.	NYS	44.25	-2.48	-7.57	52.50	39.00	63	1.72	3.89	9	84.55	0.52
Washington National	NYS	22.75	-0.55	43.31	23.63	14.00	64	1.08	4.75	-57	33.50	0.68
Zenith National Ins.	NYS	16.63	-0.75	-1.48	19.50	13.75	57	1.00	6.02	8	13.14	1.27
INSURERS/REINSURERS	AVERAGE		0.0	11.8					3.4	11.7		
HEALTH MAINTENANCE ORGANIZATIONS												
FHP International	OTC	19.50	-6.02	36.84	21.25	9.88	1409	0.00	0.00	20	15.50	1.26
Pacificare Health Sys.	OTC	43.75	9.38	10.76	43.75	10.75	178	0.00	0.00	26	28.25	1.55
Safeguard Health Enter.	OTC	7.63	0.00	-18.67	14.75	6.75	159	0.00	0.00	10	3.53	2.16
Sierra Health Services	ASE	33.38	4.30	260.81	34.00	13.38	90	0.00	0.00	17	1.78	18.75
United Healthcare Corp.	NYS	53.38	3.89	-28.36	53.88	29.06	1168	0.01	0.02	38	43.60	1.22
United Medical Corp.	ASE	7.00	0.00	0.00	8.75	5.88	1	0.20	2.86	39	8.79	0.80
U.S. Healthcare	OTC	49.75	5.85	79.82	49.75	19.16	6119	0.36	0.72	31	20.55	2.42
HMOs	AVERAGE		2.5	48.7					0.4	22		
ALL COMPANIES	AVERAGE		0.3	21.1					2.8	14		

System design: Nordby International Inc.

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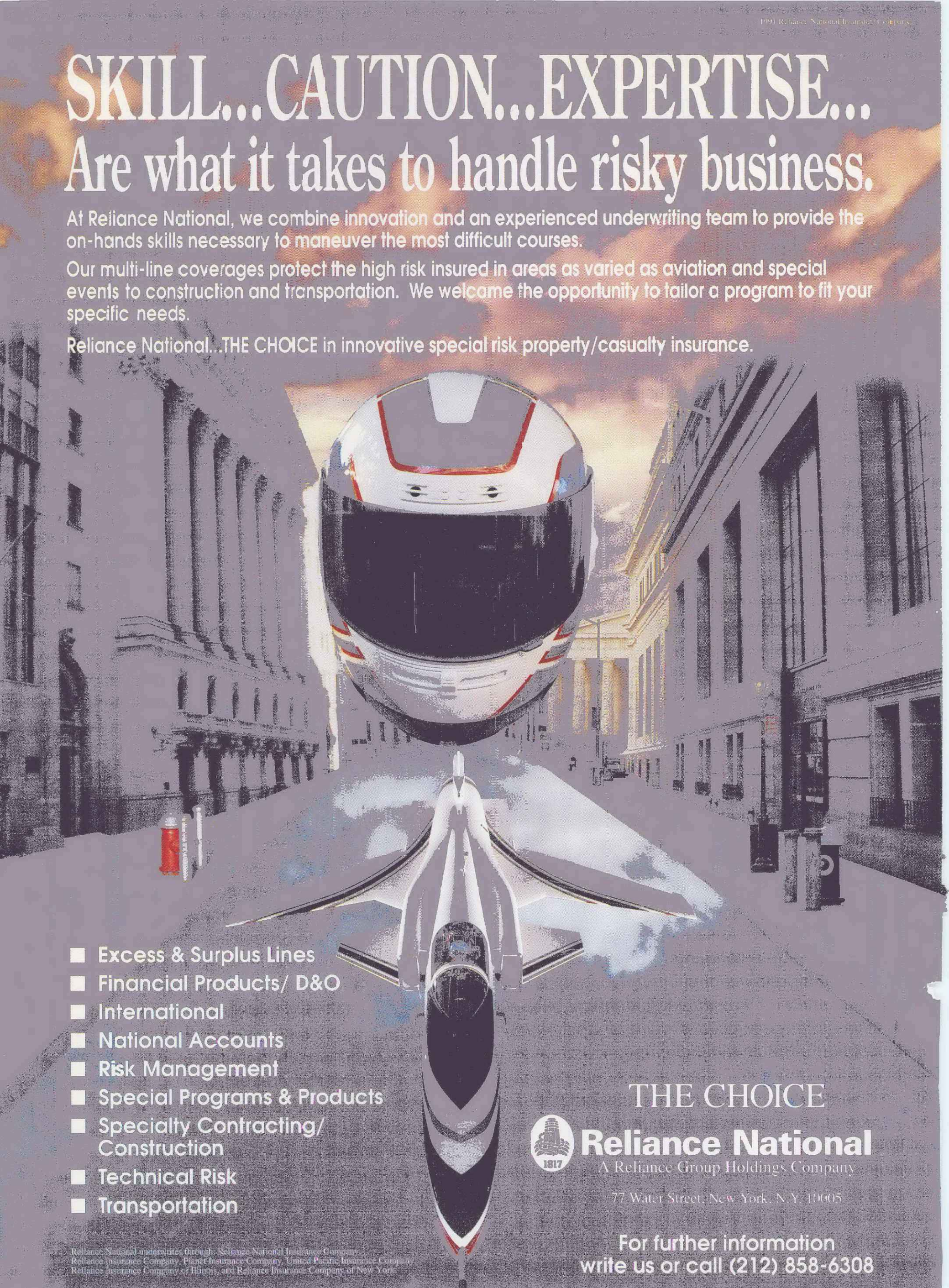

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