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LTV resumes fight in N.Y. court for termination of pension plan

NEW YORK—LTV Corp. is back in court arguing it should not assume responsibility for one of three pension plans despite a U.S. Supreme Court decision affirming the right of the Pension Benefit Guaranty Corp. to return the three plans with more than \$2 billion in unfunded liabilities to LTV.

In a brief filed with a U.S. District Court in New York, LTV says one of the plans no longer has assets and thus cannot be returned to the Dallas-based steel

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Public Citizen says report valid despite mistakes

By JERRY GEISEL

WASHINGTON—Public Citizen admits it erroneously concluded in a recent report that two of the 20 largest U.S. property/casualty insurers would be financially vulnerable and potentially at risk in a severe economic downturn.

Although still standing by the report's other findings, the consumer organization admitted late last week it erred in calculating the surpluses of Hartford Insurance Group and Aetna Life & Casualty Co. and should not have raised solvency concerns about the two insurers.

As a result of the corrections, Hartford and Aetna failed only three, rather than four, of the six solvency standards the group crafted to test insurers' financial wherewithal. Public Citizen, a consumer organization founded by Ralph Nader, had concluded that insurers failing four of the tests are potentially at risk in an economic downturn (BI, Oct. 22).

However, amid mounting criticism from insurers and insurance rating agencies, Public Citizen said that it still stands by the rest of the report, which concludes that three other large U.S. insurers are potentially at risk: American International Group Inc., Liberty Mutual Insurance Co. and USF&G Corp.

Late last week, AIG demanded that Public Citizen retract its findings about AIG, adding that failing to do so "would border on fraud."

The findings in "Insurance: The Next Industry in Crisis?" were based on tests of each insurer's surplus level, ratio of surplus to losses, swings in premium volume, leverage, liquidity and junk bond holdings.

Public Citizen said a combination of low premium volume, high claims and a weak return on investment "could spell financial trouble" for the five insurance companies.

However, Public Citizen has admitted it erred in calculating Hartford's and Aetna's surplus.

In its report, Public Citizen said Hartford's surplus fell 33% and

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COBRA cost hikes included in budget

By JERRY GEISEL

WASHINGTON—Budget legislation expected to receive final congressional approval over the weekend would shift hundreds of millions of dollars in annual health care costs for the nation's poor from federal and state governments to employers.

Provisions tucked in the legislation could force employers to provide health care coverage to certain current and former employees and their dependents, even if those individuals are also eligible for Medicaid.

Under those provisions, states would be required to determine if it would be cheaper to pay the employee share of the premium for regular group health care coverage than to cover Medicaid-eligible individuals and dependents in their Medicaid programs. States could also pay the COBRA premium, which is 102% of the group rate, for former employees who are eligible for Medicaid.

In addition, under a provision contained only in the House budget bill, states also could pay COBRA premiums for former employees not yet eligible for Medicaid if those individuals had incomes below the federal poverty level and relatively few assets. It wasn't

clear last week if this provision was included in the final budget agreement.

The budget agreement also raises pension insurance premiums, increases FICA taxes, boosts Medicare deductibles and hikes taxes on life and property/casualty insurers (see story, page 40).

The intent of the Medicaid provisions is clear: Legislators want to shift some of the cost of providing health care coverage from Medicaid, which is funded by both the federal and state governments, to employers.

These provisions would save the federal government more than \$1 billion in Medicaid costs over the next five years, according to congressional estimates. Since the federal government pays on average about 60% of Medicaid costs, the states also would save nearly \$1 billion.

If the federal and state governments can save money by taking people out of Medicaid and putting them into their employers' group health care plans, that will mean employers' health care costs automatically will increase, experts say.

"This is cost shifting from the government to the employer. If it is cost-effective for the state to take someone out of Medicaid and have

him covered by an employer plan, then it is going to be costly for the employer," said Bob Williams, a consultant with The Wyatt Co. in Washington, D.C.

"If you have hundreds of millions of dollars in savings for Medicaid, those savings are going to come out of employer plans," agreed Frank McArdle, a consultant in the Washington, D.C., office of Hewitt Associates.

Indeed, benefit experts say there would be many situations in which it would be cost-effective for a state to pay a COBRA premium for a Medicaid-eligible beneficiary, though it ultimately would be more costly for the employer.

Hewitt's Mr. McArdle, for example, noted that it would make good economic sense for a state to pay a monthly COBRA premium of \$200 or \$300 for a beneficiary with chronic health problems rather than have its Medicaid program be liable for what could be tens of thousands of dollars in medical bills.

Employer representatives point out that providing health care coverage to the nation's poor is a function of Medicaid, not COBRA.

"We have a system called Medicaid. It—not COBRA—is intended to provide coverage to the poor."

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West Virginia plan insolvent by \$37 million

BC/BS plan is liquidated

By CHRISTINE WOOLSEY

CHARLESTON, W.Va.—A Blue Cross/Blue Shield plan has been ordered liquidated for the first time.

Blue Cross & Blue Shield of West Virginia in Charleston, which is insolvent by more than \$37 million, was ordered into liquidation Wednesday and is now being managed by state Insurance Commissioner Hanley C. Clark.

A preliminary agreement worked out last week calls for health care providers in the state to swallow about \$30 million in outstanding liabilities. Under that agreement, individuals and employers covered by the plan would not be responsible for any portion of outstanding claims.

Also under the agreement—which was worked out by, among others, West Virginia Gov. Gaston Caperton, the Blue Cross &

Blue Shield Assn. in Chicago and the troubled Charleston plan—the 100,000 West Virginians insured by the Charleston plan will be covered by a new BC/BS plan that will combine the Charleston plan and the solvent Blue Cross & Blue Shield of West Central West Virginia in Parkersburg, the only other BC/BS plan operating in the state.

The new plan—Mountain State Blue Cross & Blue Shield—will be owned by a subsidiary of Blue Cross & Blue Shield Mutual of Northern Ohio in Cleveland.

The agreement stipulates that BC/BS of Northern Ohio will pay \$7 million for some of the Charleston plan's assets, including the plan's building and equipment. The \$7 million "will be taken control of by the insurance commissioner and he is expected to use that to pay off part of the \$37 million debt," said a spokesman for the Ohio plan.

An additional \$7 million from the Ohio

plan will be infused into the new plan's parent company, Mutual Management Co., but these funds will not be used to pay the insolvent plan's liabilities.

Top management from the Cleveland BC/BS plan will manage the new plan, along with officials from the Parkersburg plan. The senior management of the Charleston plan will not be retained, though many of its other 725 employees will be given jobs with the newly formed plan.

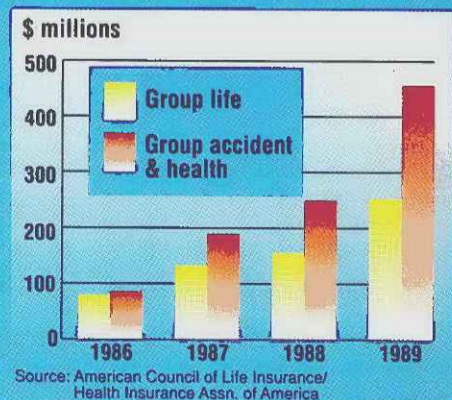
Officials at the national BC/BS Assn. could not be reached for comment late last week, though a spokeswoman in Chicago confirmed that the Charleston plan is the first of the nation's 73 Blue Cross or Blue Shield plans to be liquidated.

Gov. Caperton, who was chairman of broker McDonough Caperton Insurance Group before he was elected governor in 1988,

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Group insurers' AIDS claims soar

AIDS claims paid by group health insurers rose 83% in 1989, while AIDS claims paid by group life insurers increased 63%.



GRAPHIC BY JOHN SMITHER

Group health and accident insurers are paying the bulk of insured AIDS claims. See story, page 2.

Insurer rate of return is worse than other industries: ISO

Page 2

Pact with refinery neighbors to cost Mobil \$100 million

Page 3

Brokers fear next hard market will rival mid-1980s' crunch

Page 3

Update

LTV resumes pension plan fight

Continued from previous page and aerospace company.

The PBGC contends the plan does have assets. And, in any case, reconsideration of the agency's 1987 initial decision to return the plans to LTV is a decision the PBGC—not a court—should make, it says.

In 1987, the PBGC attempted to return to LTV the three previously terminated underfunded plans after LTV established a new low cost "follow-on" pension program. The high court in June upheld the agency's action (BI, June 25).

Judge clarifies bad-faith award

SANTA CLARA, Calif.—A group of 1,200 investors of now-insolvent investment and real estate firm Technical Equities Corp. are not entitled to any more punitive damages from the firm's general liability insurer than the \$43 million a jury awarded six investors in a test bad-faith case, a Superior Court judge has ruled.

But, in a separate clarification of a Sept. 26 ruling, Santa Clara County Superior Court Judge Conrad L. Rushing said the jury's decision in the test case to award economic damages to the six investors would be applied to all 1,200 investors.

The jury awarded a total of \$6 million of compensatory damages for economic losses and emotional distress.

The judge, though, did not determine the 1,200 investors' economic losses.

The jury in June awarded the \$49 million to the six investors in the test case against National Union Fire Insurance Co. of Pittsburgh, Pa. The jury found the American International Group Inc. unit, among other things, failed to inform the firm it had insurance to cover claims by investors against the firm (BI, July 30).

Judge Rushing last month applied that verdict to the 1,200 other investors, who are seeking \$107 million of damages to cover losses not covered by other settlements in the case (BI, Oct. 8).

National Union requested a clarification, and Judge Rushing ruled earlier this month that no further punitive damages would be awarded.

But, last week, Judge Rushing applied to the remaining 1,200 investors the economic damages portion of the jury award in the test case because of National Union's "breach of the duty of good faith and fair dealing... fraud... (and) negligent misrepresentation."

Last week's order "certainly will be appealed in some manner," said National Union attorney Wayne Jeffries, a partner with Pettit & Martin in San Francisco. National Union already is appealing the test verdict and decisions in underlying cases.

The 1,200 investors will seek a determination of their economic losses after the conclusion of a trial scheduled to begin this week in which they seek emotional distress damages, said plaintiffs' attorney Marie Seth Weiner of Cotchett & Illston of Burlingame, Calif.

Trustee fights cleanup liability

MADISON, Wis.—A federal bankruptcy court-appointed trustee is asking a Wisconsin appellate court to overturn a first-of-its-kind ruling by a lower court that the trustee is personally liable for the costs of cleaning up hazardous waste dumped by a firm he was liquidating.

If the ruling is upheld, independent attorney David J. Matyas of DePere, Wis., the administrator of the Chapter 7 liquidation of Better Brite Plating Inc., would be liable for between \$70,000 and \$400,000 in cleanup costs, as well as state fines of more than \$1 million.

A Brown County Circuit Court judge last December ruled in favor of the state, which claims that Mr. Matyas, as the DePere, Wis.-based company's administrator, did not obtain in a timely fashion a permit allowing the storage of hazardous waste on the company's property.

In Wisconsin, a company can store such wastes on its property for only 90 days without a permit.

Better Brite already had stored the hazardous wastes for more than 90 days before it went into liquidation, said Mr. Matyas, who is representing himself.

In oral arguments in the the appellate court last week, Mr. Matyas questioned whether his responsibilities as liquidator extended to resolving Better Brite's hazardous waste situation.

If the ruling is upheld—making trustees liable for pollution they did not create or had no knowledge of—the entire trustee system "will fall apart," argued John M. Van Lieshout, an environmental law attorney with Charne, Chancy & Taitelman in Milwaukee, who filed an amicus curiae brief on behalf of the Wisconsin Bar Assn.

Illinois seeks to liquidate HMO

CHICAGO—The Illinois Insurance Department is seeking the liquidation of a Joliet-based health maintenance organization that the department claims is insolvent by at least \$615,000.

In court papers filed last week in Cook County Circuit Court, the department claims Complete Health Care Corp. also has violated state insurance laws numerous times by, among other things, failing to maintain required reinsurance coverage, promptly responding to consumer complaints and keeping organized records, according to department attorney David Van Lieshout.

Complete Health provided medical services through its contracts with physicians and clinics to 772 enrollees as of Sept. 1. Its largest contracts were with the city of Chicago and an unspecified teachers' union, Mr. Van Lieshout said.

Complete Health, which was licensed in 1984, is obligated to honor its contracts with enrollees, providers and creditors until a final order of liquidation is entered, the department said in a statement. Following that, the Illinois Health Maintenance Guaranty Assn. would be responsible for the covered claims of Illinois residents, in accordance with statutory provisions.

The department filed the petition after it reviewed the HMO's March 31 financial statement and received more than 100 complaints, Mr. Van Lieshout said.

Complete Health has 10 days following notification to respond to the department's liquidation petition. An HMO spokesman was unavailable for comment.

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Insurers' returns below other industries': ISO

By COLLEEN JOHNSON

U.S. property/casualty insurers' rates of return, averaged over a 10-year period, fall below those of companies in other industries, according to a new study by the Insurance Services Office Inc.

In addition, insurers often faced more risk—defined as unpredictable variability in profitability—than companies in other industries, said the study, released late last month by the insurer-supported New York-based organization.

The finding that insurers have had a lower average rate of return from 1979 to 1988 is "in agreement

with data we've seen before," said Sean Mooney, senior vp and economist at the Insurance Information Institute in New York. "That's obviously a concern for the growth of the insurance industry because people are going to be concerned about the rate of return."

In conducting the study, titled "Long-Term Profitability: The Risk Return Tradeoff," ISO compared the results of the 10 largest insurers with the 10 largest companies in each of 49 other industries. In addition, it compared the performances of the 25 and 50 largest insurers with similar groups of companies in other industries.

In comparing the 10 largest insurers with the 10 largest companies in other industries, insurers' average rate of return from 1979 to 1988 was 11.5%, while companies in the 49 other industries posted an average rate of return of 12.1% during the same period. In ranking the industries with the highest rates of return, insurers came in 32nd out of 50.

The 25 largest insurers also were compared with the 25 largest companies in each of 34 other industries and were again found to have an average rate of return of 11.5%, ranking 21st out of the 35 groups

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Group health insurers pay bulk

AIDS claims hit \$1 billion

By CHRISTINE WOOLSEY

WASHINGTON—AIDS-related life and health claims paid by insurers reached an estimated \$1 billion in 1989, according to a new survey.

However, survey authors note that the new study may still understate the number and amount of AIDS-related claims because of insurance company misreporting and insufficient death certificate information, among other things.

And, consultants point out that the insurance industry's AIDS costs do not reflect employer costs associated with lost work time and decreased employee productivity.

The new AIDS survey, released by the Washington-based American Council of Life Insurance and the Health Insurance Assn. of America, reports that AIDS-related group health and accident claims paid by insurers soared to \$455 million in 1989, an alarming 83% increase from an estimated \$248.6 million in 1988.

By comparison, group health insurers' AIDS cost increased only 32% in 1988 from \$188 million in 1987.

Experts say the especially high increase in group health claim costs in 1989 may be attributable to the fact that the incidence of acquired immune deficiency syndrome is spreading to all areas of the United States.

"We're seeing AIDS now in all

parts of the country, so it is affecting all of our companies and employers in all parts of the country," noted Jude Payne, senior policy analyst with the HIAA.

Ms. Payne said the large increase may have occurred because more people with AIDS are entering the health care system earlier and filing health care claims sooner. And, insurers and employers may be identifying these claims as AIDS-related rather than classifying them as some other illness.

In addition, "extension of life may account for the jump in group health claim costs," according to Brenda Ballard Pflaum, an associate

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Retiree health obligations should be capped: Expert

By MICHAEL SCHACHNER

GARDEN CITY, N.Y.—Employers seeking ways to better estimate future retiree medical liabilities as called for under proposed Financial Accounting Standards Board rules should create postretirement medical plans that are immune from future inflation, says an employee benefit consultant.

In addition, the best way for employers to limit postretirement medical liabilities is to create a plan that is affordable and encourages treatment from providers that accept Medicare as payment in full, says John C. Hickey, a partner with Kwasha Lipton in Fort

Lee, N.J.

Mr. Hickey, who spoke earlier this month at the 44th annual conference of the Council on Employee Benefits in Garden City, N.Y., said

Council on Employee Benefits

Annual Conference
Garden City, N.Y.

employers should consider overhauling retiree medical plans that promise unlimited medical care.

In light of FASB's proposed accounting standards—which would

require employers to recognize retiree health care liabilities on their financial statements as they are accrued, rather than as they are paid—employers would be wise to replace current programs that guarantee unlimited benefits with a plan that promises a fixed amount of benefits.

Under the FASB proposal—which took another step closer to approval earlier this month (BI, Oct. 22)—employers with 500 or more employees and all publicly held companies would have to conform to the standard beginning in 1993. Employers with fewer than 500 participants have until

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✓ In Perspectives, attorney Peter D. Nesgos reviews how the insurance industry has met the needs of the commercial space launch industry, and attorney William D. Shernoff suggests buyers can maximize their insurance coverage to respond to an increasing array of 'exotic torts.' Perspectives begin on **PAGE 25**

✓ The Self-Insurance Institute of America criticizes varying state efforts to regulate multiple employer welfare arrangements and seeks federal oversight of the trusts. **PAGE 27**

✓ Aviation underwriters are imposing higher rates and an aggregate cap on hull war risk coverage in response to Persian Gulf tensions. **PAGE 33**

✓ Stock analyst Myron Picoult takes a whimsical look at some insurance industry 'games' that should give insurer executives a Halloween fright. **PAGE 41**

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Auditor blasts Texas regulation

By MICHAEL BRADFORD

AUSTIN, Texas—Only weeks after a state grand jury called fraud and insolvency rampant among Texas insurers, the state auditor is charging that the State Board of Insurance has inadequately regulated insurers. The State Board has no sufficient early-warning system in place to detect financially troubled insurers, the State Office of the Auditor charges in a report released earlier this month. Insurance company insolvencies will cost the state \$329.2 million in lost premium tax revenues by 1994, the state auditor's office report

estimates. According to the auditor, 283 of 2,388 licensed insurers doing business in Texas are "at risk" of future insolvency. Those companies write \$3.1 billion, or 11.1%, of the \$28 billion of annual premiums written in Texas. Companies "at risk" are defined as those the National Assn. of Insurance Commissioners has targeted for regulatory attention because of financial problems. The report also estimated that state guaranty funds will not cover \$108 million of the \$491 million of claims against insurers put in receivership from 1985 through 1989.

Calling the auditor's report "flawed," the State Board contends that it "reveals a lack of understanding of the insurance industry and insurance regulation." The auditor's assessment of insurers' financial health will "result in public ridicule" of the state auditor's office, the insurance board asserted. In a prepared response to the report, the insurance board claims the charge that taxes on \$3.1 billion in premiums are "at risk" is "highly misleading and an overstatement of risk. If a company goes insolvent, the premiums will flow to other companies." And, the board contends that

troubled companies would be at greater risk of insolvency if they were not receiving any regulatory attention. The board says it is "giving considerable attention to these companies, which is not acknowledged in the SAO report." A special grand jury report earlier this month concluded that insurer insolvencies and fraud could cost Texas taxpayers \$400 million. The grand jury's report compared Texas insurers to the state's critically ill savings and loan industry (BI, Oct. 8). The Travis County grand jury report was the result of a six-month investigation that produced several

indictments, most notably that of Robert Walker, president of failed National County Mutual Fire Insurance Co. (BI, June 25; Nov. 7, 1988). Soon after the National County insolvency, legislators criticized the State Board for failing to detect the insolvency earlier, leading to the resignation of all of the board's members. The State Board's current members have requested a special legislative investigation of the grand jury's conclusions. The auditor's report, released Oct. 9, recognizes that the State Board is committed to developing

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Mobil settlement leads to safety plan monitored by court

By JOANNE WOJCIK

TORRANCE, Calif.—Mobil Oil Corp. has settled a sweeping environmental lawsuit by agreeing to phase out use of a highly toxic chemical and by permitting a state court to oversee safety measures at its Torrance, Calif., refinery. The Oct. 18 agreement is expected to cost the Fairfax, Va.-based oil giant more than \$100 million. It settles a suit filed last year by the city of Torrance seeking California Superior Court jurisdiction over refinery operations. "It's much too early to know whether any of the settlement costs will be covered by insurance," said Michael McNerny, general manager-corporate insurance for Mobil. The settlement is believed to mark the first time a multinational corporation has agreed to permit court monitoring of a plant to improve safety. The suit, which was to have gone to trial Nov. 5, charged that accidents and safety problems at the refinery caused three deaths and more than a dozen serious injuries since March 1987, according to Torrance City Attorney Ken Nelson. Cited in the complaint were a 1979 explosion of butane gas from the refinery's tank farm that killed three people, including a passing motorist. Also cited was a November 1987 explosion and fire that injured 10 people when approximately 100 pounds of hydrofluoric acid were released. "We weren't seeking damage amounts," said Mr. Nelson, but rather to restrict the use of "hazardous or explosive materials that we felt constituted a public nuisance." Mr. McNerny says he is unaware of any claims against Mobil from injuries caused by the hydrofluoric acid explosion. A spokesman for Cal/OSHA said it did not track workplace safety at the time of the accident because the agency had been temporarily disbanded (BI, Feb. 23, 1987). Under the court-approved settlement, Mobil will phase out by Dec. 31, 1997, the use of hydrofluoric acid, a chemical used in the alkylation process that boosts the octane level of unleaded gasoline. However, Mobil has the option by Dec. 31, 1994, to convert to an alkylation process using the chemical if it can prove that it will not emit a vapor cloud upon release. Hydrofluoric acid and sulfuric acid are the only two chemicals currently used in alkylation, according to a spokesman for the American Petroleum Institute in Washington, D.C. About half of the 100 or so U.S. refineries that use the alkylation process use hydrofluoric acid, while the remainder use sulfuric acid, he said. Four of Mobil's five U.S. refineries use hydrofluoric acid, said a

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Market turn could rival mid-'80s' crisis: Broker

By MICHAEL BRADFORD

DALLAS—The next hard commercial property/casualty insurance market—whenever it finally arrives—could be as severe as the hard market of the mid-1980s, warns a top brokerage executive. Another brokerage executive agrees that market conditions could mirror the crisis atmosphere of the last hard market if rates do not begin to rise within a year. Insurers and brokers for years have said that, after the cataclysm of the mid-1980s, insurers would raise prices gradually and not curtail coverage en masse when the market tightens. Several leading executives retreated from that position at a seminar sponsored earlier this month by the Dallas-Fort Worth chapter of the Risk & Insurance Management Society Inc. Richard M. Miller, chief executive of Willis Corroon P.L.C. in New York, pointed out that the

brokerage—the product of the merger of Corroon & Black Corp. and Willis Faber P.L.C.—has changed its tune on a coming hard

said. "They felt that we had taken a knee-jerk approach to their risk management problems. And to some great degree, we had."



'Everything is set... for another hard turn in the market, whenever it comes.'
—Richard Miller

There is a fear, Mr. Miller said, that the insurance industry will be looked at by buyers "in the same light as we were before, as being totally non-professional" if another severe market turn occurs. Among the five executives, only Michael K. White, deputy chairman

of Alexander & Alexander Services Inc. in New York, predicted when the market would begin hardening. He agreed that the next hard market could be worse than predicted if rates don't begin rising within a year. "I think we will begin to see a market turn in the third quarter of 1991," said Mr. White, warning that if "it doesn't turn in 1991 and conditions continue, I'm afraid we will have another debacle similar to the 1985-1986 scenario."

Mr. Miller of Willis Corroon

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Largest P&I club sets 50% hike

Marine liability rates on the rise

By STACY SHAPIRO

LONDON—The world's largest protection and indemnity club, which insures more than a quarter of the world's shipping tonnage, will notify its members this week of a substantial increase in marine liability insurance premiums. The P&I club United Kingdom Mutual Steam Ship Assurance Assn. (Bermuda) Ltd., which is managed by Thomas R. Miller & Co. of London, is expected to notify its members of an overall 50% increase in marine

liability premiums for the next underwriting year, which begins Feb. 1. Meanwhile, U.K. Mutual shipowners will also be asked to pay a supplementary call for the year ending Feb. 1, 1990, equal to 65% of the original premium for that year to top up reserves. The members also will be told that they can expect an estimated supplementary call equal to 75% of the original premium for the year ending Feb. 1, 1991, although the final amount will not be decided until Oct.

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Proposal targets pre-existing conditions

By ADRIENNE C. LOCKE

WASHINGTON—The cost of employer-sponsored health care coverage would soar under federal legislation that would prohibit insured and self-insured plans from denying coverage for pre-existing medical conditions, benefits experts say. The House bill, H.R. 2649, would require the Health and Human Services Department to develop a minimum federal standard within 18 months for providing health insurance to new workers with pre-existing conditions. Insured and self-insured plans would face fines for violating the standard.

However, a health insurer group believes its proposal for health care insurance reform would both ensure coverage for individuals with pre-existing conditions and improve health insurance availability for the entire marketplace. While the bill, H.R. 2649, is expected to die in a House subcommittee this session, the bill's sponsor, Rep. Doug Walgren, D-Pa., will re-introduce the legislation next session, a spokeswoman for Rep. Walgren vows. The bill was introduced in June 1989 and was referred to the House Subcommittee on Commerce, Consumer Protection and Competitiveness, which has held one hearing on the measure.

However, "the bill will be re-introduced next year either as a free-standing bill or as part of a package, along with other legislation, as a result of the Pepper Commission proposals," she said. The Pepper Commission—a blue-ribbon panel that studied the U.S. health care system—last March recommended requiring employers to fund generous group health insurance plans or pay a new, hefty payroll tax (BI, March 12; March 5). The intent of the Walgren legislation is to make health care coverage for individuals with pre-existing conditions who change jobs more affordable. An employee who has a pre-existing condition that is excluded

under a new employer's health care plan until after a waiting period can obtain 18 months of health care continuation coverage from his or her previous employer under amendments to the Consolidated Omnibus Budget Reconciliation Act of 1985 contained in the sweeping 1989 budget bill (BI, Jan. 15). The waiting period for coverage of pre-existing conditions under many group health care plans elapse within 18 months, but the employee commonly must pay double premiums during that time: 102% of the true premium cost for the COBRA coverage from the former employer and any contributions required to pay for health

care coverage offered by the new employer. H.R. 2649 would: • Prohibit the sponsor of a health benefit plan from excluding, terminating or otherwise limiting any individual from coverage under the plan on the basis that the individual has a pre-existing condition. While the bill does not specifically refer to self-insured plans, "that was our intent—to include them in the law," the spokeswoman said. • Establish a standard for providing basic medical care at a "reasonable cost" based on "the most recent available medical and

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BC/BS failure

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directed members of the Charleston plan to disregard any health care bills incurred prior to Oct. 12 that were supposed to be covered by the insolvent Charleston plan. The governor has asked physicians and hospitals in the state not to pursue payment of those bills.

However, West Virginia hospital and physician associations noted that they were not involved in the bailout negotiations and are seeking other solutions to the crisis.

Health care expenses incurred after Oct. 12 will be covered by the newly formed BC/BS plan.

While West Virginia has a life/health insurance guaranty fund, policyholders of the insolvent Charleston BC/BS plan are not covered by the fund because it is chartered as a "health service corporation" under state law rather than an insurer.

Harry Don, an actuary for The Wyatt Co. in Cleveland, said he does

not expect employers to be hurt by the liquidation.

However, "if I were an employer, the thing I would be very, very vigilant about is making sure the providers don't come back to my employees" and request payment for outstanding claims, Mr. Don said. Providers have no legal right to reimbursement from employers who had paid their premiums to the plan, he said.

"We would advise employers to tell employees to wait to pay for any participating providers' claims," added Dan Holtz, a consultant with TPF&C, a unit of Towers, Perrin, Forster & Crosby Inc. in Cleveland.

However, self-insured employers that hired the Charleston BC/BS plan on an administrative-services-only basis would be responsible for paying the claims owed to providers, Mr. Don noted. "On an insured basis, the providers are up the creek, but ASO clients will have to pay the claims."

A solution to the Charleston plan's ongoing financial problems had been

a subject of discussion and negotiation for months. Earlier this year, officials of the Charleston plan approached BC/BS of Northern Ohio seeking help with its dire financial straits, said a spokesman for the Cleveland-based plan. "It became obvious early on that the plan didn't have enough money to pay its bills or sustain its book of business."

The state's efforts to locate a bailout partner began as early as February when Mr. Clark apparently considered merging the Charleston plan with a BC/BS program in Washington, D.C. However, the commissioner rejected that plan because he did not feel the Washington plan was financially strong enough to take over the foundering Charleston plan.

Earlier plans to merge the Charleston operations into the Parkersburg-based BC/BS plan also were abandoned because the Parkersburg plan's \$2 million surplus was not considered large enough to assume the Charleston plan's obligations.

The Parkersburg plan currently

has 75,000 members.

The last year that BC/BS of Charleston made a profit was in 1985, the spokesman said.

The Charleston plan reported premium volume of \$252.2 million in 1989 and reported a net loss of \$3.5 million. In 1988, the plan reported premiums of \$250.3 million and a loss of \$19 million, while the plan reported \$210.7 million in premiums in 1987 and a loss of \$23 million.

Of the 100,000 people insured by the plan, about 55,000 were enrolled in 2,100 group contracts.

The \$14 million the Ohio plan is providing to the insolvent plan and the new plan will come out of the Ohio plan's surplus, not claims reserves, the spokesman for the Ohio plan noted, adding that the Ohio Insurance Department has prohibited the plan from providing more than \$14 million to the West Virginia venture.

The Ohio plan reported premiums of \$923.1 million in 1989 with a surplus of \$102 million.

A spokesman for the Charleston plan said the plan failed because "we've simply had a health care system expand and grow beyond the ability for the state to pay for it."

The spokesman said the Public Employees Insurance Agency, the state-run agency that provides coverage for public employees like teachers and police, "fell behind in its payments to providers." As a result, providers increased their rates and shifted the burden to private payers, including the Charleston BC/BS plan, which was the state's largest private payer.

"We've had to increase our rates beyond what the market would pay and beyond what subscribers could afford," the spokesman said. A significant portion of subscribers took their business elsewhere, while those with the worst experience—who typically could only find coverage through Blue Cross—remained with the plan, he said.

Others, though, also are blaming the Health Care Cost Review Authority, the Charleston-based West Virginia state agency that sets hospital rates in the state, claiming the agency has done nothing to hold down provider cost increases.

Gov. Caperton and state legislators have agreed to try to remove rate-setting powers from the HCCRA. "This will permit insurers and providers to bargain freely to lower health care costs," a statement from the governor said.

John Burry Jr., chairman and chief executive officer of BC/BS of Northern Ohio, said reforms are needed to regulate the state's health care system. "The free market system must be given a chance to work for health care insurance in West Virginia, as elsewhere, and that means deregulating how provider rates are now set," he said.

Officials of health care provider groups, however, say that other problems in West Virginia, including the state's overall poor economic condition, contributed to the downfall of the BC/BS plan.

"We're concerned more about the terrible cost shifting going on in West Virginia and longer-term problems like Medicaid financing and the future of the Public Employee Insurance Agency program," said Steve Brenton, president of the West Virginia Hospital Assn. in Charleston.

Mr. Brenton said the hospital association and state medical association, which represents the state's physicians, have agreed for now to the governor's request that health care providers not bill individuals for claims not paid by BC/BS of Charleston.

The associations plan to meet with the governor to discuss other possible solutions, he said. "We're looking at other potential Blue Cross & Blue Shield assets that we may be able to tap through litigation."

The state's hospitals will be forced to swallow about \$16 million of the Charleston plan's debt, he said. "We have a relatively fragile hospital system and that's a big hit on top of the other problems plaguing us."

However, others point out that the hospitals and physicians are in the best position to absorb the \$30 million in debt owed by the insolvent plan.

There are 3,400 physicians and other health care providers who are owed about \$12.4 million of the debt, said the spokesman for the Ohio BC/BS plan.

"About half of those 3,400 are owed less than \$1,200 each and 77% are owed less than \$5,000," the spokesman said.

Late last week, Guy R. Bucci, a Charleston lawyer, filed a suit Oct. 23 in Kanawha County, W.Va., Circuit Court against the Charleston plan, as well as its chairman and president, and the national BC/BS Assn. The suit, filed on behalf of a plan beneficiary, contends that the groups defrauded policyholders who had been led to believe they were insured by a large, financially solvent company.

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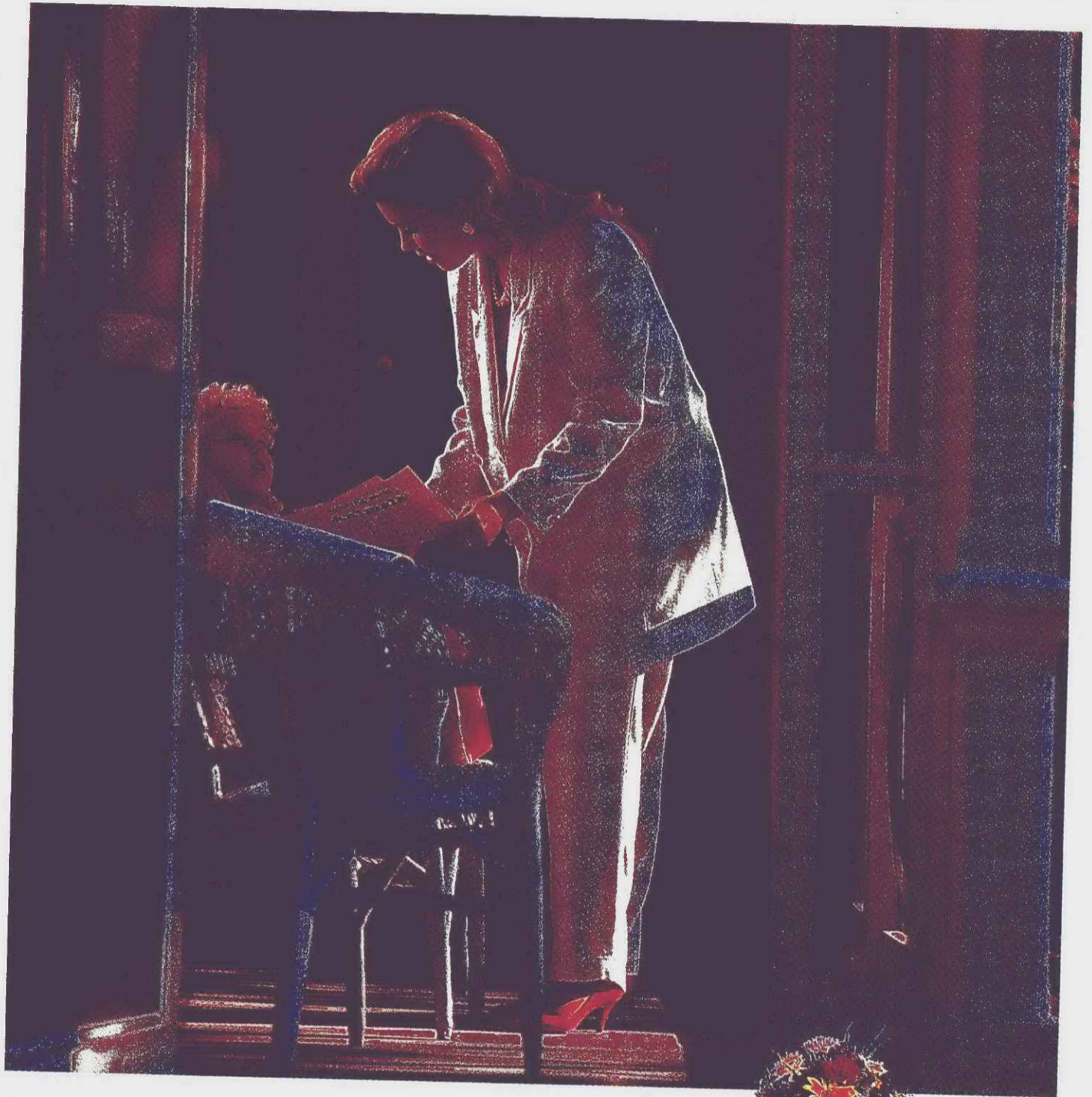
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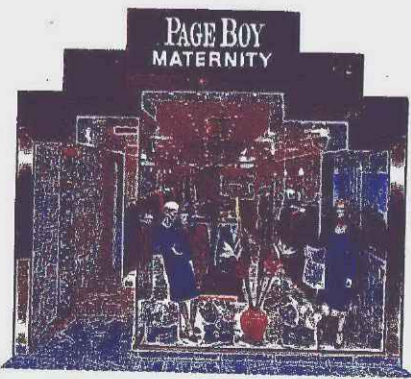
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GM blames its HMO cutbacks on rates

By MICHAEL SCHACHNER

General Motors Corp., balking at proposed health maintenance organization rates for 1991, is dropping five HMOs and is freezing new enrollment for salaried employees at 21 others across the country.

The giant Detroit-based automaker would not say by how much the move will reduce its costs.

Having spent \$2.9 billion on health care in 1989 for about 2 million active employees, retirees and dependents, GM is looking to shave costs wherever possible, a spokesman said.

GM said it will not renew the contracts of Empire Blue Cross & Blue Shield Healthnet of New York; Total Health Plus of Wilmington, Del.; The HMO of Dela-

ware Inc. in Newark, Del.; HMO Kentucky Inc. in Louisville; and CareChoices of Chattanooga, Tenn.

The spokesman would not identify the 21 of the company's remaining 114 HMOs whose enrollments have been frozen.

"These HMOs are either being dropped or frozen out because of their pricing structure, which didn't meet our criteria," said the spokesman, who could not say how many salaried employees were enrolled in the HMOs.

Employees previously covered by the five HMOs and workers who were preparing to enroll in one of the 21 HMOs with frozen enrollments will be required to participate in GM's self-insured traditional indemnity plan, the company spokesman said.

Salaried employees already en-

Benefit beat

rolled in the 21 HMOs will be allowed to remain in the HMO or switch to the fee-for-service plan.

Phone enrollment

In an effort to administer its self-insured flexible benefits plan with a much smaller staff, First Bank Systems Inc. is enrolling all employees by phone.

A computerized system eliminates much of the paperwork burden of benefits enrollment and lets the bank handle employee inquiries with a smaller staff, said Merle Flaata, vp-benefits.

The department's staff has dropped to 17 from 24 as part of

the nearly 20% reduction of the bank's workforce in six states to 9,000 during the last year.

"With the smaller benefits department workforce we had to become more automated. We really didn't have a choice," Mr. Flaata explained.

Using the Benefits Connection system, employees enroll in the flex plan and make changes using any push-button telephone.

Through Benefits Connection, employees can select one of three medical plans, determine how much to put into a health care spending account, set life insurance limits or select extra vacation days, among other things.

Employees also may check on claim status, inquire about spending account balances and receive such information as deductible

levels.

In addition, employees soon will be able to select 401(k) investment options by telephone, he said.

The system operates through a personal computer at the bank's Minneapolis headquarters. After entering a personal identification number, employees in Colorado, Minnesota, Montana, North Dakota, South Dakota and Wisconsin can handle most necessary transactions with the benefits department.

FBS introduced flexible benefits in 1984. Enrollments and inquiries were originally handled manually, "but the benefits department used to lose control of some things because there were too many people involved in enrollment," said Vicky Slomiany, a Wyatt Co. consultant in Minneapolis who helped design the new phone system.

"There was also tons of paper involved. This new system cuts down on those costs," she pointed out.

"We used to have too much manual labor on account balancing. A full flexible benefits plan like we have is highly paper-driven. We looked into the whole thing and decided we could really simplify the administrative process," Mr. Flaata said.

"We think this program will work out to be cost-justified," said Mr. Flaata, who would not disclose the cost of the system.

New employees and those who have altered their benefit plans during 1990 have used the system already.

Employees who will be using it for the first time when they enroll for 1991 received questionnaires and almost all respondents said they support the system, Mr. Flaata said.

Transplant coverage

Almost all employer-sponsored health care plans cover the cost of non-experimental organ transplants but only about 45% of the plans will pay a donor's expenses for such transplants, according to a recent survey by a health management company.

Sixteen percent of the 50 companies that responded to a Parkside Health Management Corp. survey on organ transplants said they review donor expenses on a case-by-case basis.

The remaining 39% do not cover donors' expenses.

In the area of organ procurement, 40% of the plans cover such expenses as location, registration and handling.

The survey also found that 20% of the plans pay for the covered life's transportation to and from the transplant site.

The survey, based on responses from companies in various industries, shows that "employers are progressing slowly on the transplant issue, and very few companies have established formal policies," said Jenifer Cline, president of the managed care services division at Parkside.

"Even as transplants become more common, employers seem to be evaluating each case individually. They don't have the experience yet to make definitive policies," she said.

Almost 13,000 organ transplants were performed in the United States in 1988, up 39.8% from about 9,300 in 1985, Parkside said, citing American Medical Assn. figures.

In response to what it perceives as "growing demand for transplants," Parkside is establishing a national network of organ transplant providers.

The network, to be called Parkside Preferred Transplant Centers, is scheduled to begin operating Jan. 1, according to Ms. Cline. ■

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Opinions

Good neighbor policy

A PORTION OF ANY good risk management program is being a good neighbor. Many companies—especially those that conduct hazardous operations—often forget this fact. We are glad that Mobil Corp. has not.

Mobil earlier this month settled a lawsuit filed by the city of Torrance, Calif., that sought court jurisdiction over Mobil's refinery operations in Torrance. The city alleged that accidents and safety problems at the refinery had caused three deaths and more than a dozen serious injuries in the last 3½ years (see story, page 3).

Mobil settled the litigation by agreeing to phase out the use of a highly toxic chemical at the plant at a potential cost of \$100 million and by agreeing to open its safety records and allow the court to appoint an independent safety adviser to oversee the refinery's operations.

We cannot comment on why Mobil agreed to settle the case rather than take it to trial, nor can we judge whether the city's allegations against Mobil are justified. But we do believe that the settlement reached by Mobil should be cited as an example of innovative corporate risk management practice.

While a risk manager can control only what goes on within his or her company, a corporation—and hence its risk manager—must bear responsibility for the impact of the company's actions and operations on the well-being of the neighboring community. It does not matter whether the company's plant was there before the town: All corporations must be good neighbors.

While obviously a company cannot tailor all of its operations to meet a community's wishes and objectives, a company with hazardous operations should involve the community in its safety preparations since the townspeople face a risk that they themselves cannot manage.



"WE HAVE A GOOD NEIGHBOR POLICY...THEY CONTROL THEIR WASTES, AND I KEEP THE STEREO DOWN!"

This lesson has been forgotten all too many times by companies that put their own well-being before that of their neighbors or the environment. Exxon Corp.'s unwillingness to fully restore the Alaskan coastline to its state prior to the 1989 Exxon Valdez oil spill—and its effort to shift the blame to other parties—comes to mind.

While the fact that Mobil's agreement with Torrance came about as a result of litigation does take some of the luster off the settlement, we still salute Mobil for its innovative agreement with the city. When it comes to protecting the lives of people—whether they are a company's own employees or its neighbors in the surrounding community—cooperation, not conflict, is always the best risk management policy.

Letters

FASB doesn't increase costs

To the editor: Christine Woolsey's Sept. 24 article, "FASB Rules to Hike Firms' Retiree Health Care Costs: Study," and the comments by Gary Laugham included in that article make it sound as though the FASB rules are somehow responsible for the impending financial crises of many employees.

On the contrary, the FASB rules will make employers recognize the cost of the commitments they are already making to retirees while there is still a chance they can survive the financial burden. Let us point the accusing finger where it belongs: improper funding or recognition of the cost of promises made to provide future health benefits.

If a portion of earnings from an employee's active years are not set aside to cover the cost of the health care benefits an employer promised to provide after the employee retires, where will the money come from? It has to be from the earnings of the remaining active employees. This works well if 100 active employees can support the health care benefit cost for one retired employee, but what happens when the ratio become 100 active to 50 retired employees,

or worse?

The pension funding issues were resolved many years ago. The time has come to deal with funding issues for retiree health benefits.

Dennis J. Hulet
Consulting Actuary
Milliman & Robertson Inc.
Seattle

To the editor: The Sept. 24 article "FASB Rules to Hike Firms' Retiree Care Costs: Study" contained a statement attributed to Gary Laugham of Hewitt Associates which seems to imply that retiree medical costs will rise because of proposed Financial Accounting Standards Board rules when, in fact, employer medical costs will be exactly the same whether accounted for by the current "pay-as-you-go" method or by the proposed FASB method.

Costs are always accounting entries, but accounting entries are not always costs. As I understand it, FASB is not attempting to change anything other than the method of currently recognizing the costs of a company's postretirement medical benefits.

I would certainly agree that FASB had made a mess of things by appearing to treat all postretirement benefits as a "promise" rather than by recognizing that some employers have carefully identified the distinction between an "intended" benefit and a "promised" one.

A number of plans continue medical benefits for qualified retirees but retain the legally protected right to terminate the entire plan and cancel coverage for active employees and retirees alike. In my view, such a plan should not be treated as if it were a postretirement medical plan that is truly a legal obligation of the company and which would survive any deci-

sion by the company to terminate the company's group medical plan.

Interestingly, the Internal Revenue Service won't even allow deductions for prefunding of postretirement medical benefits—whether "promised" or not. Yet, FASB is pressing accounting rules which will undoubtedly increase pressure for prefunding such benefits, and they are probably taking one more step toward converting currently manageable intentions into inescapable "promises" for many employers.

William T. Howard Jr.
Director-Risk Management
Arch Mineral Corp.
St. Louis

Punitive damages fuel unjust greed

To the editor: This letter is in response to the Oct. 8 editorial regarding the punitive damages "lottery."

Since punitive damages are that part of an award that is in excess of actual damages, their only justification is to serve as disciplinary punishment. The criminal counterpart—fines—goes into the public coffers except where bounties are paid.

There is no justification for the plaintiff to benefit by this component of justice. Why cannot our legal system be modified such that punitive damages in civil proceedings go into the treasury of the relevant government jurisdiction?

With no opportunity for undue enrichment of either the wronged party or his counsel, true justice would more nearly be served. Our present system is, instead, a reward for greed.

Charles C. King
Executive Vp
Hadley Peoples Manufacturing Co.
Siler City, N.C.

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At issue

Should government-mandated pollution cleanup costs be covered under CGL policies?



Kenneth Gerrity
Risk Manager
Genstar Stone
Products Co.,
Hunt Valley Md.

As a risk manager my answer should be yes, but in reality I do not feel the insurers contemplated this coverage or rated for it. Therefore, as insurers are being required to pay for these cleanups, employers with no exposure or minimal exposure will have to pay for it in higher insurance costs.



Jeffrey E. Brandon
Assistant Vp &
Risk Manager
Old Kent Fi-
nancial Corp.,
Grand Rapids,
Mich.

Yes, the CGL should have some form of sudden and accidental pollution coverage that includes those costs. The liberal interpretations of the courts have forced insurers to remove pollution coverage from the CGL. Businesses and governments are left to figure out a way to solve this problem, without meaningful and acceptable risk transfer taking place.



Emmett O'Brien Jr.
Risk Manager
Wake County,
Raleigh, N.C.

No. Policies specifically exclude that coverage and rates never contemplated that type of coverage. As a public risk manager, I'd love it. But long-term I would have to pay for other people's liability forever. Insurance is not a catch-all for the world's problems. I do not believe the courts should tamper with insurance contracts.



Kent M. Edwards
Vp-
Administration
Vallen Corp.,
Houston

Each of the policy forms is such that it has to be looked at with a magnifying glass. However, my initial response would be no, particularly if the question came after the fact. Whether it should be covered or not depends on where and how you want to pay for it. Do you want to pay for it as an insured or as a taxpayer?

Compiled by Christine Woolsey

Comings & goings: buyers

Vanagunas tapped as risk director

Audrey M. Vanagunas, 37, has been named corporate director-risk and insurance management at Ancilla Systems Inc. in Chicago. Ms. Vanagunas, who is responsible for managing property and casualty risks, replaces Lana Lenz, who left Ancilla. She reports to Peter Franklin, chief operating officer and chief financial officer. Before joining Ancilla—a health care system with seven facilities in Illinois and Indiana—Ms. Vanagunas was director of risk management services at Metropolitan Chicago Healthcare Council. Prior to that, she was project manager-education program development for the Joint Commission on Accreditation of Healthcare Organizations, also in Chicago. She holds a bachelor's degree in psychology and a master's degree in public health administration from the University of Illinois in Chicago. Ms. Vanagunas holds the Associate in Risk Management designation and is a member of the American Society for Healthcare Risk Management.

Edwin R. Hall, 42, has been named risk manager at Alexandria, Va.-based Perpetual Savings Bank. In this newly created position, he is responsible for corporate insurance policies, risk inventory and analysis, risk financing, claims administration, disaster recovery planning and internal systems and procedures. Mr. Hall reports to Meherji Madan, vp-internal audit division. Before joining Perpetual Savings Bank, Mr. Hall was production/marketing manager for Atlanta-based Alexander Howden North America in Washington, D.C. He holds a bachelor's degree in psychology from Oklahoma State University in Stillwater and a master's degree in business administration from Golden Gate University in San Francisco. Mr. Hall holds the Associate in Risk Management designation and is a deputy member of the Risk & Insurance Management Society Inc.

Ellis J. Wilkerson, 32, has been named risk manager at The Bank of Bermuda Ltd. in Hamilton, Bermuda. In this newly created position, he is responsible for developing, managing and administering the bank's risk management program. He reports to Edward H. Gomez, manager-corporate finance. Before joining The Bank of Bermuda, Mr. Wilkerson was senior insurance officer at Johnson & Higgins (Bermuda) Ltd. He holds a bachelor's degree in business administration in property and casualty insurance from The College of Insurance in New York. He holds the Associate in Risk Management designation as well as the Chartered Property & Casualty Underwriter designation. In addition, he is a member of both the New York Chapter of the Society of Chartered Property & Casualty Underwriters and the Bermuda Insurance Institute.

We'd like to report on staff changes in your company's risk management, safety and employee benefits departments. Just drop a note to Nancy Johnson, Copy Editor, Business Insurance, 740 N. Rush St., Chicago, Ill. 60611-2590, or call 312-649-7784. Please send a photograph, too.



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It's a system that, for 75 years, has been dedicated to getting injured workers their income benefits in a fast, no-fault, no-hassle way.

The Bad News

Unfortunately, there are problems with Workers Compensation in some states. Serious problems that are spreading to other states.

Unnecessary litigation and underfunded, understaffed, state-administered agencies are slowing down the entire process. On top of that, in some states minor injuries are over-compensated and major injuries are under-compensated.

The Good News

In some states, Workers Compensation works without a hitch. Workers are compensated quickly, and fairly.

But to bring that same quickness and fairness to the troubled states today, and to strengthen all systems for tomorrow, we have to promote change. A few examples:

Simpler procedures, better communication of rights and benefits, plus teamwork between doctors, employers and state regulatory agencies would do wonders for the individual systems.

So would agency-sponsored toll-free numbers for injured workers to inquire about their income benefits. And consumer brochures outlining specific workers' rights.

Ideally, alternative methods for resolving legitimate disputes should be adopted—short of going to court. This would allow for quicker resolution of those disputes and faster income benefits.

It's Up To All Of Us

To charge ahead and implement ideas like these, you can do one of two things to help.

One: Be aware. Find out what's happening in your state, how you're affected, and what you can do. Talk to your insurance company or business trade association.

Or two: Share your views by writing to Gary Countryman, President and CEO of Liberty Mutual, 175 Berkeley Street, Boston, MA 02117. We'll help you get in touch with people in your state who can help.

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Texas report

Continued from page 3

an early warning system for insurer insolvencies but questions the agency's ability to implement one.

"The State Board of Insurance is committed to implementing an early warning system, but the agency has not demonstrated a clear understanding of how this system should be developed and should function. This lack of understanding is reflected by the absence of comprehensive planning and an inadequate allocation of the resources needed to get the job done," the report said.

The report says an early warning system should "track the overall health of the industry and the relative health of individual companies. It should also provide assurance that all financially troubled companies are identified and that they receive appropriate regulatory attention."

In testimony before a state legislative panel on Oct. 11, State Board Chairman James E. Saxton Jr. said the agency is making progress in developing an early warning system.

In 1988, the State Board began to automate the job of compiling insurer financial data into "comprehensive information from which regulatory action can be taken," the State Board said in written testimony to the panel. During the past two years, computer workstations and a mainframe have been installed to help handle the workload.

And, a week after the state auditor's report was released, the State Board approved a policy statement on insurer examinations that is designed to strengthen the financial monitoring of insurers.

The policy emphasizes fraud detection and faster notification to the insurance commissioner of insurers suspected of having financial problems or being involved in

Texas State Board of Insurance Chairman James Saxton calls comparing the insurance industry's problems to the S&L debacle 'misleading.' While conceding that insurer failures are up, he says the industry in Texas 'is fundamentally sound.'

fraudulent activities.

Company examiners, for example, will be required to submit reports in draft form to regulators rather than waiting until final versions are completed. And, the statement stresses notifying regulators immediately if insurers interfere with an investigation by withholding records or delaying production of documents.

Texas Insurance Commissioner A.W. Pogue said the policy means the board will be "pro-active and aggressive in carrying out this function, which is vital to meeting our responsibility of monitoring

the solvency of insurance companies."

However, the State Board indicated in its written testimony to the legislative panel that an automated system to let regulators quickly spot troubled insurers will not be completed for at least seven years.

Sophisticated early warning systems cannot be developed with "cookie-cutter programs and off-the-shelf software," the board said in written testimony. "You have to start from scratch and take it one step at a time. We are on the frontier of innovation and expertise

nationwide. There are few insurance departments in the nation that can come close."

The magnitude of the State Board's task in tracking insurers is daunting and unprecedented, Mr. Saxton said in his testimony.

An insurer's annual statement could have "between 10,000 and 13,000 data elements, even without investment portfolio schedules," Mr. Saxton said in his testimony.

"When you realize that we receive about 4,500 financial statements," which includes annual statements and interim reports each year, "you will begin to understand the size of the job," he said.

However, referring to the grand jury report, Mr. Saxton called comparing the insurance industry's problems to the S&L debacle "misleading."

Conceding that insurer failures are increasing, Mr. Saxton argued that the industry in Texas "is fundamentally sound and in many ways less fragile than other parts of our economy."

At the national level, only 0.5% of the more than 6,000 insurers in the United States went insolvent in the last five years, Mr. Saxton said.

By comparison, approximately 800 thrifts, or about 27% of all thrifts in the United States, are insolvent or in serious financial trouble, he said.

Not only are there fewer insurer failures than thrift failures, but the financial impact of insurer insolvencies "fades by comparison to the savings and loan bailout," he said in testimony. "Texas insurance companies would have to fail at the same rate for the next 400 years for the losses due to insolvency to match" the amount spent through on bailouts of Texas savings and loans, Mr. Saxton said.

The federal government has spent approximately \$11 billion so far to bail out failed Texas thrifts, according to the Resolution Trust Corp., the federal agency that is taking over failed thrifts.

"In addition, the reasons for S&L failures just don't match conditions in the insurance industry," Mr. Saxton asserted.

"Experts agree that thrifts failed due to cash-flow problems, deregulation, changes in the way the federal government allowed reporting of net capital, changes in the tax laws and interest rates. Sure, mismanagement and fraud were present but there were other forces at work as well."

The State Board also testified that it took particular offense at the grand jury's statement that the agency has a tendency to overlook or "wink" at fraudulent financial filings by insurers.

"When found, this information is neither ignored nor swept under the rug," the board contended in its written testimony.

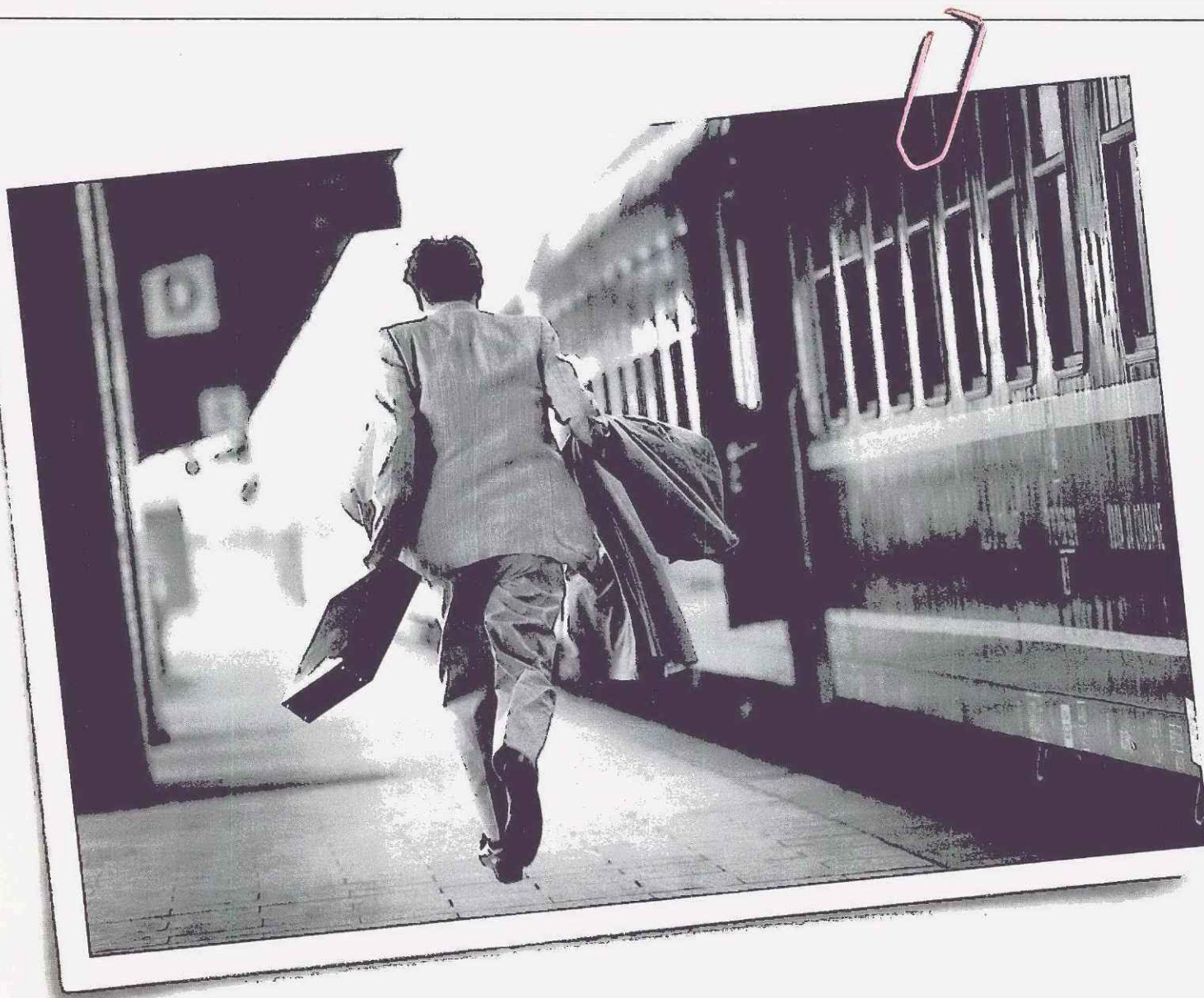
When falsified information is uncovered, the State Board begins an investigation or recommends supervision or other regulatory action to the insurance commissioner, according to the testimony.

Only a few of the more than 2,200 annual statements filed each year are found to contain "false information considered material to financial condition," according to the State Board's testimony.

Mr. Saxton also reminded the panel that the current three-member board replaced the State Board members who were in place at the time of National County Mutual failure.

"The present board took office with a strong mandate from both the Legislature and the governor to set a course for the agency that strengthened solvency surveillance and toughened enforcement of the insurance laws of Texas," he said.

"That is what we have been about for the past year and a half," Mr. Saxton said. "Our record is one to be proud of." ■



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FASB rule

Continued from page 2
1995 to begin annual accrual accounting.

"It's hard enough to estimate what health care costs will be next year, let alone five, 10, even 50 years down the line," Mr. Hickey said. But by designing a plan in which inflation isn't a factor you can at least remove that uncertainty, he said.

Mr. Hickey said new accounting standards could increase overall retiree health care plan expenses by 5% to 10% of payroll in many cases.

"This is a huge amount. In some cases it may be as much as half a company's profits," he said.

A recent survey by Hewitt Associates reported that employers think the average cost of future retirees' health care benefits under the FASB proposal would equal 6.25% of payroll, up from the current 1.1% (BI, Sept. 24).

Many employers now provide postretirement medical benefits in two parts, Mr. Hickey said. Under most plans, employees are eligible for retirement medical coverage when they reach age 55 and have 10 years' service. They usually receive regular medical coverage until age 65. After age 65, medical plans are coordinated with Medicare, with the employer paying costs above what Medicare pays.

"You're talking about providing medical coverage for 25 years in some cases. That's burdensome despite what the accountants are about to require," he said.

In order to reduce future costs, employers should create plans that encourage or even require retirees to seek care from doctors and hospitals that accept Medicare as payment in full, he said.

Medicare "pays almost the entire cost of hospitalization and 80% of doctor bills. Where it gets expensive for employers is when beneficiaries seek care through doctors who bill above the Medicare rate," he said.

"Employers don't have to cover these costs on the horns of the dilemma they're facing with FASB and health care costs. They may want to decide they cannot allow total freedom of choice," he said.

Mr. Hickey suggested that employers cap the amount they're willing to provide to retirees by terminating their current retiree health care plans and replacing them with fixed-dollar programs.

Mr. Hickey suggested other ways employers could continue to provide retiree medical coverage, reduce FASB liabilities and eliminate uncertainties:

- Create and contribute to an employee stock ownership plan for active employees. At retirement, employees could convert the stock value to cash and use it to pay for medical coverage.

- Increase pension plan benefits, which gives retirees more money to spend on health care. Because pension benefits are not subject to FASB rules, employers can boost pension contributions by an amount they believe would cover medical expenses for retirees, he said.

- Make bigger contributions to an employee savings plan, so the employee can use the balance at retirement to pay for medical expenses.

- Create and contribute defined amounts to retiree medical spending accounts.

"All these plans insulate a company from the unknown, and still allow companies to provide retirees with something," he said.

Another option is to require

active employees to contribute to the cost of their retiree health care benefits, Mr. Hickey said. This approach has become more prevalent as employers battle high health care costs and inflation, he said.

American Airlines Inc. last year began requiring more than half of its employees to contribute \$10 a month for the cost of retiree health care (BI, Dec. 4, 1989).

He said this type of plan can help reduce FASB liabilities by about 5% to 10%. "It's admittedly a modest reduction, but it does work," he said.

Requiring employees to help pre-fund their postretirement medical benefits also enhances employee security, Mr. Hickey said, because active employees who pay for retiree health care feel that the plan will be there when they need it.

The only problem with this approach is that it is not tax-effective, Mr. Hickey said, since the government does not allow employees to pre-fund retiree medical benefits with pretax dollars. ■

SET YOUR DATES

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closing: October 24
demographic section: Agent/Broker Topics: Automation: Interface with Insurers

issue: November 12 — Reader Service Bonus Distribution: PIA: NAII
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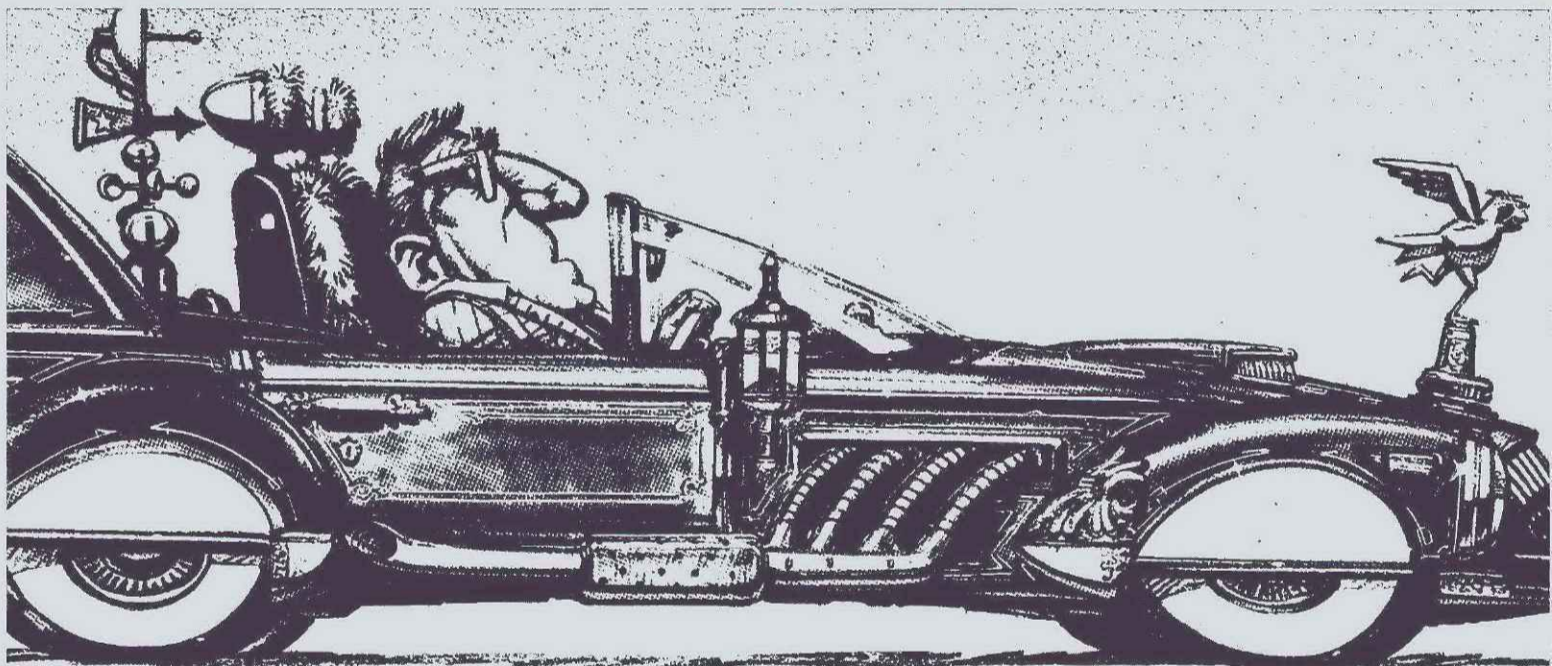
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Stalled talks on budget leave health care reform to states

By MICHAEL SCHACHNER

GARDEN CITY, N.Y.—Congress is unprepared to enact legislation to make health care more affordable and accessible, according to the top aide to a member of the U.S. House of Representatives.

Any meaningful health care reform, at least in the short-term, will

occur only at the state level, according to the director of an association representing state governors.

"Washington today can be characterized as a place of doom, gloom and angry finger-pointing," said Bonnie Brown, senior legislative assistant to Rep. Willis D. Gradison Jr., R-Ohio, the senior member of the House Ways and Means health sub-

committee.

"Congress is facing a \$105 billion decrease in spending if it cannot pass a budget bill, and they haven't come up with anything yet," said Ms. Brown earlier this month. "This is why the health care dilemma will not be solved in Washington."

John E. Luehrs, director of health programs with the National Governors Assn., agreed with Ms. Brown's assessment of the current situation in Washington.

"Health care's white knight will not be the federal government. It may not be the states either, but if there are to be changes, that is where they will have to occur," said Mr. Luehrs.

Both Ms. Brown and Mr. Luehrs spoke on potential health care reform at the 44th annual conference of the Council on Employee Benefits, held Oct. 11-12 in Garden City, N.Y.

According to Ms. Brown, one thing is certain: The federal government is not poised to improve the health care delivery system.

Many members of Congress would like to make major changes in the nation's health care system, in which more than 30 million Americans are without health insurance, she said. But the overwhelming budget deficit and a feeling that lack of access to health care has not yet reached a crisis level have halted reform efforts, she added.

"The budget deficit means that all policy coming out of Washington will be short-term. Health care reform is a long-term issue. And, our government is a crisis-acting government. Health care is not perceived as a crisis by most people," Ms. Brown said.

She contends, however, that the problems associated with health care have reached crisis proportions.

Council on Employee Benefits

Annual Conference
Garden City, N.Y.

"Health care costs are going up every year, and more than 31 million Americans lack health insurance. Furthermore, many others are inadequately insured and have no long-term care or catastrophic coverage at all," she said.

Ms. Brown said members of Congress acknowledge that there are two major gaps in the current health care system that need to be filled—the huge number of uninsured and the absence of widespread long-term care insurance—but that's as much as they can agree on at this point.

"It's a daunting mission to fill these gaps and not step on toes," Ms. Brown said. "That's why we are seeing so many of these health care commissions. 1990 has been termed the 'Year of the Commission.'"

The bottom line, Ms. Brown said, is that no national policy on health care is imminent.

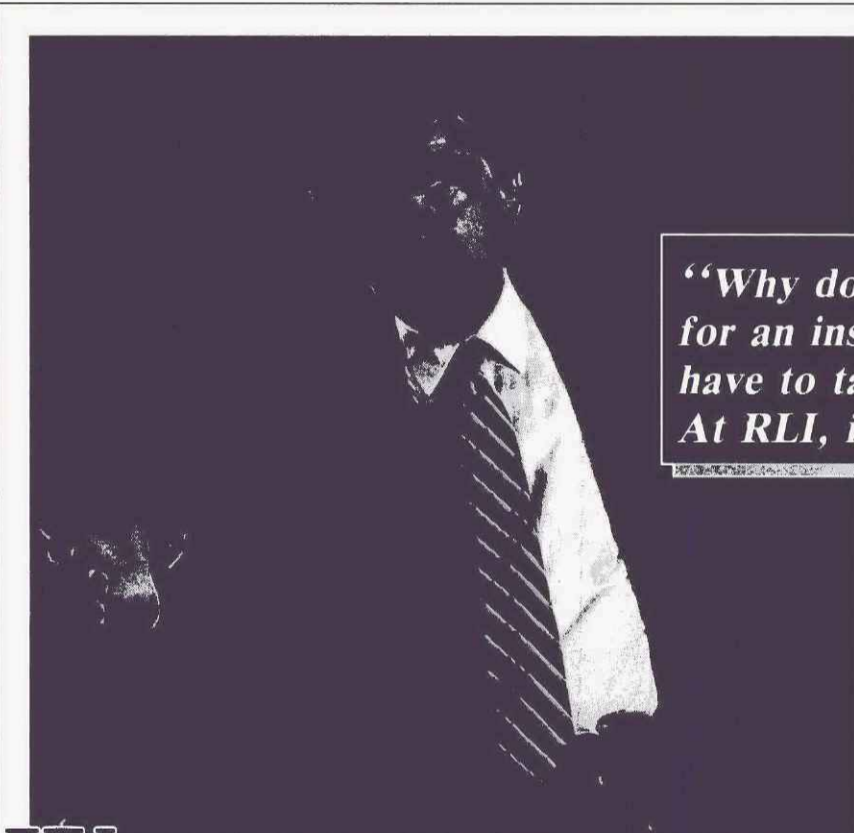
"All relevant health care changes were made 25 years ago. Since then, we have only seen basic tinkering. And there's not even adequate financing available for the programs already on the books. I just don't see much new happening," Ms. Brown said.

According to Ms. Brown, four major "barriers to health care reform" are too great to penetrate at this time:

- The budget deficit, which shortens the scope of all public policy.
- The lack of a perceived crisis regarding health care.

"Despite the fact that 31 million to 37 million Americans lack basic health protection, most of middle America is covered. Congress tends

Continued on next page



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Continued from previous page to drift from crisis to crisis, and with the deficit and the Middle East problems, health care doesn't get the attention it deserves," she said.

• American culture. Americans are too autonomous, and they value advanced technology too much to make the sacrifices necessary to ensure coverage for all residents, Ms. Brown said.

• No consensus exists on how to make health care more affordable and accessible.

Nevertheless, Ms. Brown said, improving access is vital because employers are providing fewer and fewer health care benefits every day.

"We're in a bad cycle right now," she said. "Health care costs are up, so employers are cutting back, which leaves even more people without coverage. Medicaid eligibility has been tightened, and dependent coverage is being dropped, because the exposure is too great.

"By the year 2030 we'll have 30 million people over the age of 65. Currently, 20% need long-term care of some sort and that number will triple by 2030. Something needs to happen," she said.

Even with national reforms unlikely anytime soon, the states may be ready to take the ball and run with it, according to Mr. Luehrs.

"I foresee some changes at the state level," Mr. Luehrs said. "Some may be comprehensive and others narrow, but there will be changes and more than one might expect."

"There's no doubt we are in the middle of a cost and access problem. We need cost containment, as well as universal access. The trouble is that, while most people want changes, they don't know what they want on the other end. Also, they're not willing to pay, so there's a lot of finger-pointing," Mr. Luehrs said.

Reform is more likely at the state level because "states tend to take more risks than the federal government, which waits until all numbers are in before" acting, he said.

"States have to balance their budgets each year," so they discontinue programs that aren't functioning properly and generally make changes at a faster pace, Mr. Luehrs said.

Another reason why reform is more likely at the state than federal level,

according to Mr. Luehrs, is that "governors like to see themselves as CEOs and problem-solvers, not politicians. They want to do their job and improve the quality of life."

While not specifying what individual states have on tap, Mr. Luehrs said most reform initiatives will occur in the area of public health care programs, since that is where money is dwindling.

Legislators will also consider regulating mandated benefits. However, Mr. Luehrs questioned whether states should focus much attention on this issue, "since in most states that have mandated benefits, those benefits are already offered through many group health plans.

Mr. Luehrs also suggested that pooling arrangements and reinsurance funds may become more widespread. He said states could require employers that did not offer health insurance to contribute to a state pool that would provide basic health services to the uninsured or underinsured.

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CEB meeting attracts 215

GARDEN CITY, N.Y.—The 44th annual conference of the Council on Employee Benefits, held Oct. 11-12 in Garden City, N.Y., drew 215 people, including benefit managers and other representatives from 136 companies.

The theme of this year's meeting was "Benefits Issues in the New Decade." Sessions centered around health care reform, postretirement benefits and managed health care.

Next year's conference is scheduled for Oct. 2-4 at the Westin Hotel in Chicago. CEB plans to hold its 1992 meeting in Boston.

The Council on Employee Benefits, founded in 1946, is composed of 191 Fortune 500 companies. Its purpose is to stimulate the development and improve the administration of its members' employee benefit plans.

For more information on CEB and future conferences, contact Charles Hunt, CEB President and Vp-Employee Benefits, Ralston Purina Co., Checkerboard Square, St. Louis, Mo. 63164, 314-982-1000; or Roger Groh, Corporate Director of Benefits, General Dynamics Corp., 7733 Forsyth Blvd., St. Louis, Mo. 63105, 314-889-8200.

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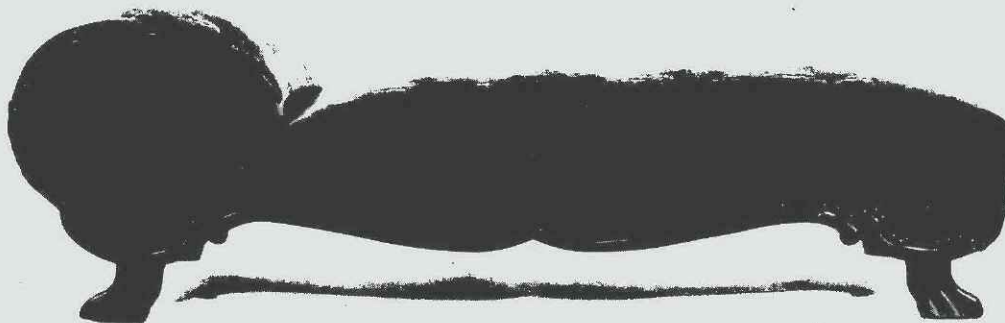
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Defined benefit plans to survive: Expert

By MICHAEL SCHACHNER

GARDEN CITY, N.Y.—Defined benefit pension plans will survive, despite talk that they are destined to be replaced by defined contribution plans, says an employee benefits consultant.

"Inertia and the fact that defined benefit plans make it easier for employers to target retirement income cost-effectively are the two primary reasons why defined benefit pension plans will survive," said Herbert Kosloff, vp in New York with TPF&C, the benefits consulting division of Towers, Perrin, Forster & Crosby Inc.

Furthermore, the plans "yield higher investment returns and the employer can dictate rewards," Mr. Kosloff said at the 44th annual conference of the Council on

Employee Benefits, held Oct. 11-12 in Garden City, N.Y.

Mr. Kosloff, who specializes in pension plan design, said that despite employees' difficulty in understanding benefit formulas, defined benefit plans will persist, simply because they are currently more prevalent than defined contribution plans and "it's easier for things that exist to remain in place than to change them."

Defined benefit plans, however, do pose problems for both employees and employers, he said.

"Defined benefit plans have some negatives. Mainly, employees find them very difficult to understand and younger employees, who move around from job to job much more often than the worker of old, don't appreciate the fact that benefits are based heavily on years of

service and final pay," Mr. Kosloff said.

In addition, employers that terminate defined benefit plans are subject to a 15% federal excise tax on any asset reversions they collect. And that tax could be raised

Council on Employee Benefits

Annual Conference
Garden City, N.Y.

to 50% under proposals pending in Congress early last week if the employer does not set up a replacement pension plan.

Meanwhile, Mr. Kosloff said the advantages of defined contribution plans are clear and sometimes per-

sue employers to drop their defined benefit plans.

"Defined contribution plans are easier to understand, they're appreciated more and they encourage employee contributions," said Mr. Kosloff. "On that front, they're perceived by employees to be better than defined benefit plans."

Defined contribution plans are also riskier. They sometimes tie employee account balances to volatile investments and financial market conditions, he said.

This format differs from traditional defined benefit plans, under which payment of retirement income is solely the responsibility of the employer.

Defined contribution plans are also much harder for companies to administer. Employers with defined contribution plans commonly

distribute quarterly updates on plan assets to all participants, which could require considerable administrative work at a large corporation with hundreds of individual participants, he said.

And, final benefits paid under defined contribution plans may not sufficiently reflect salary upon retirement, especially if a retiree started his career with a company at a low salary which increased significantly over the course of employment.

Creating cash balance plans—"a hybrid of the other two"—could solve some problems presented by the other plans, said Mr. Kosloff.

He said cash balance plans are legally considered defined benefit plans and are subject to employer-paid Pension Benefit Guaranty Corp. premiums. To employees, however, the plans resemble defined contribution plans because employers update them on the plan balance on an individual account basis (BI, Feb. 17, 1986).

Employees appreciate cash balance plans because, even though money is pooled like a defined benefit plan, individual employees can monitor their accounts, Mr. Kosloff said.

In addition, cash balance plans can easily be created from existing defined benefit plans without the employer having to terminate the plan and pay excise taxes on reversions, he said.

During his presentation, Mr. Kosloff identified a number of characteristics of the future workforce that will affect pension plan design.

He said the workforce in the upcoming century will live to be older, will retire earlier and will show less loyalty to employers. All these features would indicate that employers will be paying pension benefits for a longer period of time and that pension benefits will need to be portable, Mr. Kosloff suggested. ■

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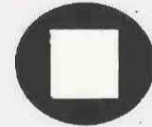
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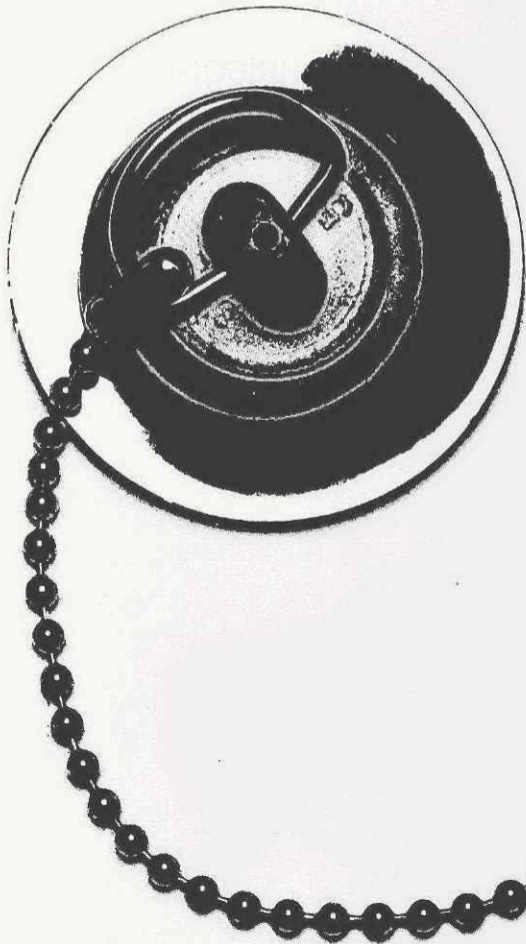
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Family benefits will be wave of future: Scholar

By MICHAEL SCHACHNER

GARDEN CITY, N.Y.—Employers in the 21st century will be called upon to provide more and more family-oriented benefits as older workers and women comprise the majority of the workforce, says a management professor.

One thing that will not change will be the need for employee benefits and human resource managers to involve top management in benefits design decisions and administration, he says.

The number of American workers between the ages of 45 and 54 will increase dramatically by the turn of the century and the percentage of working mothers with preschool-age children will increase to 67% from the current 25%, says Fred K. Foulkes, professor of management policy at Boston University. Mr. Foulkes spoke at a Council on Employee Benefits conference earlier this month in Garden City, N.Y.

"As the number of working mothers continues to increase, we'll see child care assistance programs going off the charts" in the year 2000, he said. "Family-oriented benefits will no doubt become the top human resource priority of the next century."

Despite the changing focus of benefit programs, upper management will still need to be included in decisions, he said. "Employers are going to have to tailor benefits to (employees). Companies will need a benefits philosophy that fits the business. Upper management must be involved from the start, or the chain of communication will be broken," he said.

The future workforce, according to Mr. Foulkes, also will be characterized by more part-time workers. "Part-time employment is up all over the world. People are more concerned about balancing work and family. It's

nearly as important as benefits for active employees as the average age in the United States rises.

- Technology allowing employees to work from home will be improved, with more emphasis on interactive equipment like personal computers and telephones.

- Employers will experiment more with benefits that are perceived to be of high value and low cost. These may include summer child care; programs that occupy school-age children during school holidays; and take-out meals employees can take home from the company cafeteria.

Cost will remain an important factor in benefit plan design in the coming years, Mr. Foulkes said. "Employers will always be cost-conscious." ■

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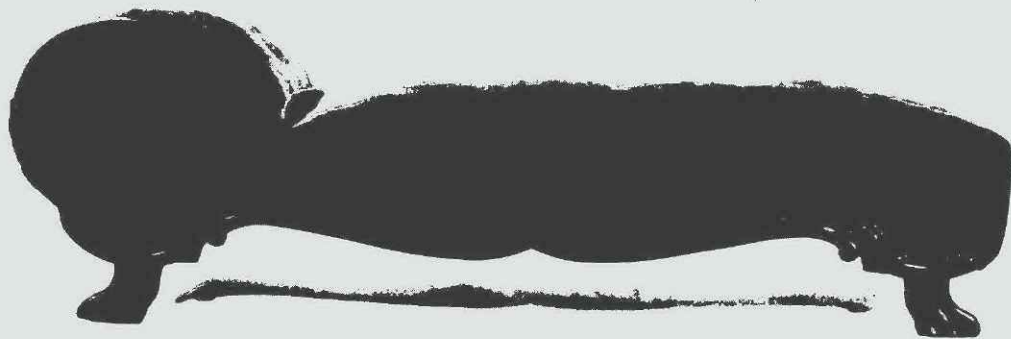
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possible that we could even see benefits that are equivalent to the amount of time an employee puts in," he said.

Unions by the year 2000 will have much less influence than they have had in past years, Mr. Foulkes said. By the next century, unions will represent only 4% to 5% of the working population. "Unions will not be human resource dictators in the future. Union membership is down worldwide with very few exceptions," he said.

A recent Boston University survey, he said, identified nine areas where changes in benefits will continue to occur or will begin to occur in the year 2000:

- The number of defined benefit retirement income plans will continue to decline as employees continue to show more appreciation for defined contribution plans (see story, page 18).

- The trend toward self-insured employee benefit programs will continue as employers find they can control their own costs more effectively than insurer premiums.

- Long-term health care plans will grow rapidly and employers will begin picking up at least some of the costs.

- Managed care will become more prevalent as employers grapple with constantly rising health care costs.

- Workers will pay more of the cost of their benefits as employers conclude that they can maintain benefit levels only by forcing workers to do so.

- Benefits communication will become more innovative and important.
- Retirement benefits will become



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Outpatient care costs increase rapidly as UR cuts inpatient expenses

By ADRIENNE C. LOCKE

ARLINGTON, Va.—Utilization review has reduced unnecessary or inappropriate inpatient medical care, but the increased use and cost of outpatient services have grown largely unchecked, experts agree.

"We did our job with inpatient review, and the result is that outpatient costs have blown up," said Marjorie Mook, a registered nurse and utilization manager at Ault-care, a UR company in Canton, Ohio.

In a kind of "shell game," medical providers have been very creative in shifting medical costs to outpatient services, said Robert S. Fry, vp of auditing services at Berwyn, Pa.-based Intracorp, CIGNA Corp.'s UR subsidiary.

"Some outpatient services are more expensive than inpatient services because of the way billing and reimbursement systems have been set up," he pointed out.

An effective outpatient UR program not only must determine how unnecessary costs are being added to a case, but it also must spot the practices and trends that need to be questioned further, Ms. Mook and Mr. Fry said at a session on outpatient UR during the Self-Insurance Institute of America's 10th annual conference Oct. 9-12 in Arlington, Va.

"When we see those types of programs develop, only then do we have the chance of breaking the cycle of cost-shifting and high outpatient costs," Mr. Fry said.

Ms. Mook said several factors have contributed to the rise in outpatient health care costs, the foremost of which is increased utilization.

With one of the goals of inpatient UR being to reduce the length and

expense of inpatient stays, increased utilization of less expensive outpatient services was a natural outcome, she said.

In addition, improvements in technology and medicine allow health care providers to perform an increasing number of services on an outpatient basis, Ms. Mook explained.

For example, a computerized axial tomography scan—a special X-ray that shows the size and shape of body organs layer by layer, which is especially useful for diagnosing injuries and diseases of the head—and a magnetic resonance imaging scan—a higher-quality process than the CAT scan that uses a magnetic field instead of radiation to diagnose the health of body tissue—are now commonly performed in outpatient settings, she said. In addition, many types of surgeries and some chemotherapy treatments are now performed on an outpatient basis, she said.

New services also have been developed to cater to the increased demand for outpatient care, such as outpatient clinics specializing in substance abuse, sports medicine, weight loss, private surgery, X-rays/MRIs and laboratory facilities, Ms. Mook said.

For example, in many cases, a reputable outpatient substance abuse clinic may do just as good a job as a more expensive and longer inpatient program, Ms. Mook allowed.

"We are trying to avoid the 28-day stay that has become standard (in substance abuse cases) by getting that treatment out of an inpatient setting and getting into an outpatient setting that in most cases is more appropriate," she said.

Continued on next page

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Continued from previous page

However, other specialized outpatient services are usually no different from what could be received from a physician in a normal office setting at a lesser price, she said.

Referring to the growth of outpatient services, she said: "Some of this is good, but some of it is profit-oriented."

Another source of higher outpatient costs is "creativity and fraud" in outpatient billing, Ms. Moock said.

One example of this is the practice of unbundling charges—in which a single medical procedure is broken down into the numerous individual procedures that make up the whole operation and then separately billed—which is becoming the most frequently used method of increasing charges, she said. Everything from outpatient surgery to emergency room services is being unbundled, she said. "There are seminars that providers can go to that show them how to unbundle charges," she said.

Another way physicians are increasing revenues is by upcoding, Ms. Moock said. For example, a regular office visit may be improperly identified as a more comprehensive visit that would have a different and more costly billing code. This means that an employer pays for an in-depth medical examination the employee never received, she said.

Other factors—such as an older general population, which needs more health care, and group health care plans designed to encourage employees to seek outpatient services—also have helped increase outpatient utilization, Ms. Moock said.

To be able to effectively hold down rising outpatient costs through utilization review, Intracorp's Mr. Fry said a review program must look at:

- **Setting.** This involves identifying where the outpatient service is being performed. For example, a lab at a doctor's private facility can be more expensive than using a commercial lab, Mr. Fry said.

- **Intensity of services.** For example, a UR program must review whether it is appropriate to use an X-ray or a more costly MRI scan for a particular diagnosis, he said.

- **Frequency.** This part of the review determines how often a patient is brought in for office visits and what occurs during each visit, he said.

- **Unit cost.** This aspect of the UR program, among other things, attempts to spot unbundled charges and investigates the possibility of setting up fixed-fee arrangements with doctors, labs and other medical service providers, Mr. Fry explained.

- **Access.** The UR program must ensure that controlling access to health care does not reduce the quality of care received, he said. "Any program that doesn't address all five of these criteria across the whole spectrum of its outpatient review just won't be effective in the 1990s," Mr. Fry said.

The UR process can be broken down into three parts, he said:

- **In the prospective phase,** the UR program should be able to quickly screen each case to determine if it qualifies for a more in-depth claims review, he said.

Ms. Moock said that a UR company's nurses and staff should be trained to know which cases to question and how to pick them out for further review.

If additional review is warranted, then that case can be moved on to someone who can contact the doctor involved and "thoroughly discuss the case," Mr. Fry said.

- **The concurrent stage** involves case management and following ongoing cases to ensure that appropriate treatment is provided, he said.

At this stage, a UR provider should be able to produce reports on cases that appear to involve over-utilization, Ms. Moock said.

- **The retrospective phase** involves looking back at all claims data to determine where more savings can be made and where the review process could be improved, Mr. Fry said.

Ms. Moock suggested a few questions an employer should ask when searching for a UR firm to handle outpatient review:

- **What is the number of office visits approved per 1,000 enrollees each year?** The national average is 2,600 per 1,000 enrollees, she said. A UR provider should either match that average or be below it, she said.

- **Does the UR provider have written criteria for reviewing outpatient visits and procedures?**

- **What outpatient claims does the firm review:** basic office visits or only more expensive cases?

- **What are the qualifications of the reviewers?**

- **Does the company have special UR programs, like a service to catch unbundled charges or upcoding?**

- **Is the UR service convenient to employer and enrollees?**

- **Is the service good? Are there adequate telephone lines, and are reviews done quickly?**

"The bottom line is quality," Ms. Moock said. ■

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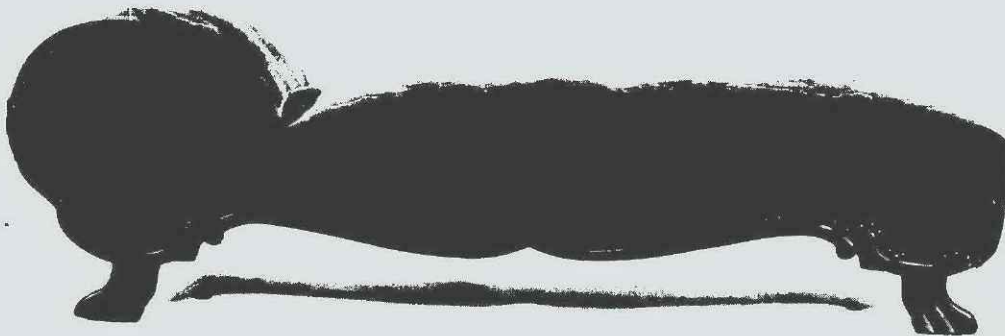
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Self-administration allows full control

By ADRIENNE C. LOCKE

ARLINGTON, Va.—Choosing to self-administer a self-funded health care plan can be very attractive to an employer that wants full control of its benefit costs, a benefits administrator says.

However, plan administrators must deal with many responsibilities and problems that go beyond deciding which claims should be paid, says Richard B. White, director of employee benefits at Watkins Associated Industries Inc., an Atlanta-based trucking company.

Mr. White, who spoke at the Self-Insurance Institute of America's 10th annual conference earlier this month in Arlington,



Va., said that self-administration allows a company to follow its health plan goals more closely and have complete control over how things are done, rather than trust that a TPA will understand and follow the company's vision.

"We are the masters of our own destiny," he said, adding that self-administrators are "on top of what corporate philosophies are and if they are changing. We have full control of all our data—when we want to see it and how we want to see it—and we have better control of the running of the plan, what the problems are and how to address them," he said.

Another advantage of self-administration is the ability to check medical bills with the employee for accuracy before they are paid, he said.

Mr. White said that when his department receives a medical bill, the employee is required to verify that all the billed procedures were actually performed. "Some doctors are adding charges, expecting that employers will never see it," he said.

Also, self-administration allows the employer more freedom in promoting cost-effective use of its health benefits, which Mr. White feels would be difficult to achieve with a TPA.

For example, Watkins saved \$70,000 in one year after establishing a preferred provider network for its employees. But to save even more, the employee benefits department added an incentive for preferred provider utilization.

The department included in each pay envelope a note stating that employees could receive a \$100 U.S. savings bond if they used a network provider in the event of hospitalization.

In the following year, the incentive saved the company an estimated \$400,000 in medical costs.

This successful plan was quickly and inexpensively implemented, and demonstrates the kind of flexibility and spontaneity that a company can have when it self-administers its self-insured plan, Mr. White said.

But employers should realize that self-administration is not as simple as they may think, Mr. White warns.

"If you don't want the problems and the headaches, then you don't want to go to self-administration," he said.

Top management must give total commitment for claims-payment funds and resources for developing a good claims management system, he said.

But while some companies be-

lieve it's an unnecessary expense to hire a third party administrator to handle the daily operations of a self-insured health plan, the knowledge, experience and resources of a TPA are difficult to match, says another benefits expert.

Employers can get a lot of value in the services of a TPA, says Thomas J. O'Neill, group vp in the Chicago office of Harrington Benefits Services Group, a Columbus, Ohio-based TPA.

Mr. O'Neill said that roughly 4%

Self-administrators are the masters of their own destiny, says Richard B. White of Watkins Associated Industries. He adds that self-administration allows full control of all data and better control of ways to deal with problems.

to 5% of each dollar spent on claims goes toward paying for a TPA, and that relatively small amount gives the employer a

choice of many services in addition to claims management.

He said that health insurance benefits have grown beyond claims

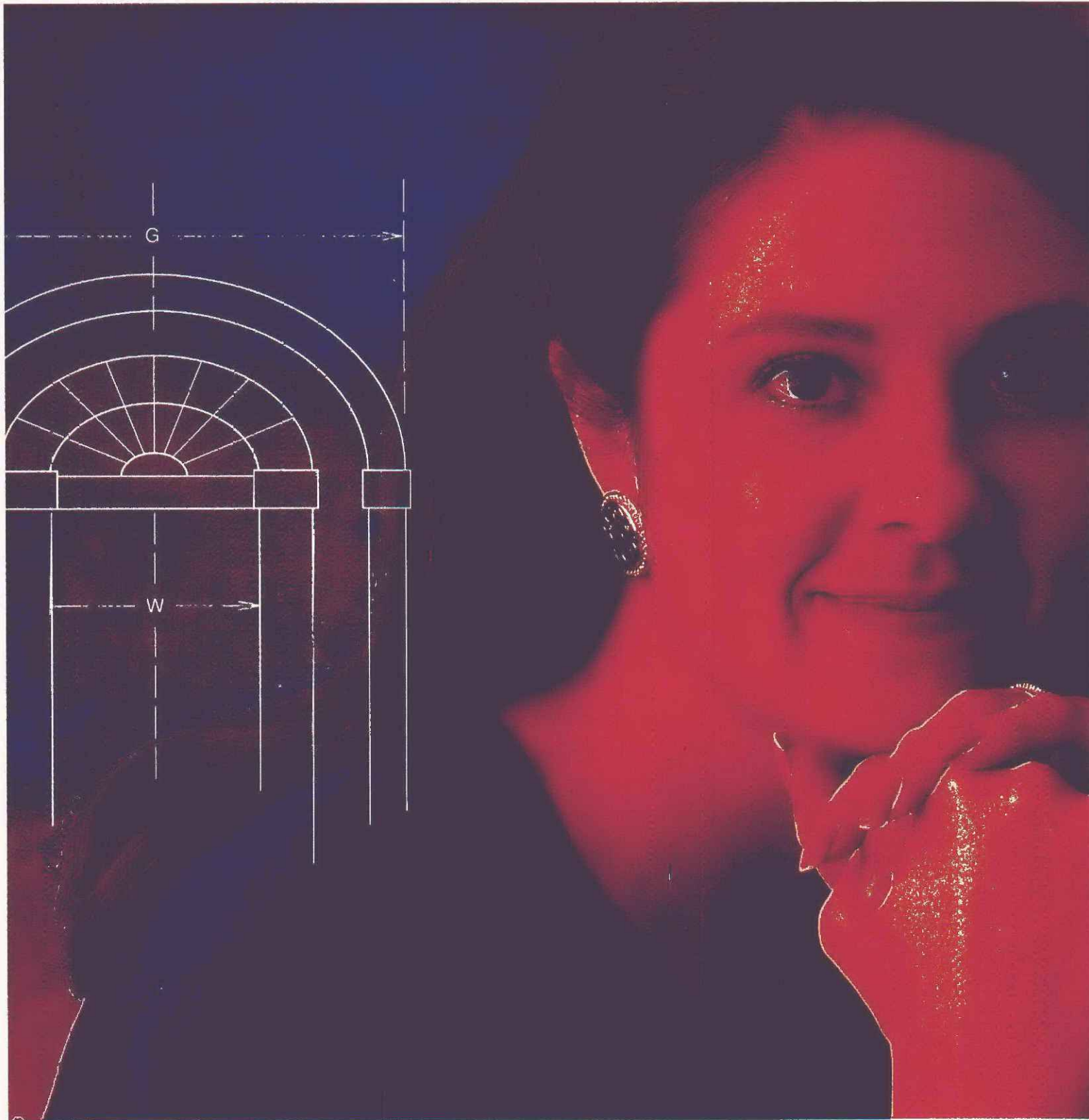
payment and have become very sophisticated over the years.

"A company is better off spending its time trying to manage that other 96% of its dollar than getting involved in the time-consuming, complicated process of claims administration," he said.

In addition, Mr. O'Neill said the do-it-yourself approach may be costing employers more than they think. Companies that choose to self-administer face problems such as finding employees who are

Continued on next page

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Continued from previous page knowledgeable enough to perform the services required for self-administration, he said.

Companies often wind up "reinventing the wheel" when trying to find better ways to do the job because they have no experience in self-administration, he said.

And, employers risk losing their in-house expertise if their administrative staff members leave the company, he said.

In contrast, a TPA can offer a single employer the accumulated knowledge and experience gained from working with other employers, Mr. O'Neill said.

He pointed out that TPAs offer services other than administration,

including: employee communication; case management; preferred provider arrangements; legislative updates; consultations; data base management; utilization review; and handling COBRA coverages.

Mr. O'Neill added that with a TPA, employee "confidentiality is not a problem."

Mr. White acknowledged that one of the biggest problems he currently has is that of employees obtaining access to medical records of other employees. Unless tight controls are implemented, a self-administered company will have problems with employees learning privileged health information about other employees, Mr. White warned.

He suggests precautions such as passwords for access into the data base and changing computer access so that it is difficult to pull single files.

Mr. White added that self-administration puts the employer in the "direct line of fire" when an employee is dissatisfied with how a claim was handled. "Before, you could blame the TPA if a claim is denied or was filed incorrectly, but now there is no out."

And, the company will be responsible for keeping up with all the regulatory and legislative changes that affect self-insured plans, he said.

Mr. White said that employers that are considering self-adminis-

tration should think about what type of computer system and software they may need and how much to spend on it; where the operations should be located; what amount of storage space is needed for files; and how and where the files will be maintained, Mr. White said.

He recommends that an employer planning to change from a TPA to self-administration should hire a consultant to help plan the new program. Using your outgoing TPA is one suggestion, he said.

"Most are willing to be a consultant for you. It will cost you money, but it is better than getting zonked for something that you didn't know about, he said. ■

SIAA elects Ridder as new president

ARLINGTON, Va.—Mary Ann Ridder, a consultant in the Indianapolis office of AHRC USA Inc., a Ronkonkoma, N.Y.-based firm that manages reinsurance pools, is the new president of the Self-Insurance Institute of America.

The elections were held during the SIAA's annual meeting, held Oct. 9-12 in Arlington, Va.

More than 1,100 people attended this year's conference.

Ms. Ridder succeeds Terry L. Kirch, chief operating officer of Resource Information Management Systems Inc. in Naperville, Ill., who will become SIAA's new chairman of the board.

In addition, William M. Bennett, president of BenefitAmerican Inc., a third party administrator in Columbia, S.C., was elected vp of operations, and Thomas D. Mather, senior vp of Creative Risk Management Corp., in Mount Clemens, Mich., was elected vp-national conference.

Other 1991 officers elected include:

- Bradford R. Olson, president of Casualty Financial Inc., a structured settlement company in Des Moines, Iowa, who was elected to the new position of vp-continuing education.

- Sam P. Cannon, chairman and chief executive officer of Management Services Inc., a Danville, Ill.-based TPA, who was elected vp-finance/chief financial officer.

- Lori Raffel, director of marketing at Sterling Investors Life Insurance Co., a stop-loss insurer in St. Petersburg, Fla., who was elected the SIAA's vp-publications.

- R. Harvey Nolen, president of Total Group Services Inc., a TPA in Grand Rapids, Mich., who was elected corporate secretary.

Also, three new members were elected to three-year terms on the SIAA's board of directors. They are: Douglas H. Hartman, senior manager at Ernst & Young in New York; Allen Bassuk, vp/risk manager of La Quinta Motor Inns Inc. in San Antonio; and David K. Steward, vp/employee benefits at B.G. Redmon & Associates, a Mesa, Ariz.-based benefits consulting firm.

The Self-Insurance Institute of America is a non-profit trade association for the self-insurance industry, with a membership that includes self-insured employers, reinsurers, third-party administrators and other vendors.

The SIAA seeks to improve the quality and efficiency of self-insured plans, encourage greater dialogue and cooperation, and enhance the public and business community's acceptance of this alternative to commercial insurance coverage.

Next year's annual meeting will be held in October in Orlando, Fla.

For more information, contact the SIAA, P.O. Box 15466, Santa Ana, Calif., 92705; 714-261-2556.

—By Adrienne C. Locke

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Satellite launch liability risks

By Peter D. Nesgos

IN DECEMBER 1986, the same year that the space shuttle Challenger catastrophe occurred, the president ordered that virtually all non-government satellites and other payloads be moved from the shuttle manifest and launched by private companies. The loss of the Challenger resulted in a strengthening of what was then a fledgling private launch industry by eliminating the National Aeronautics and Space Administration as the primary domestic launch agency.

Today, both established and entrepreneurial companies offer a host of launch services. These range from Martin Marietta Corp.'s commercial Titan and General Dynamics Corp.'s Atlas heavy

Products available as new industry gets off the ground

Insurers providing launch insurance—which covers the payload, replacement launch costs and lost revenue, from ignition through to initial satellite operations—suffered through a string of unfortunate losses that were particularly severe in 1985 and 1986. By the time of the Challenger catastrophe in January 1986 (which itself did not carry any insured payloads), insured losses for the

financial responsibility) in an amount responsive to the likely maximum probable loss arising from a failed launch. However, in no event would the required amount exceed the lesser of \$500 million or the amount available in the world insurance market at a reasonable cost. The insurance was to provide for any claims arising from the commercial launch activities licensed by the Office of Commercial Space Transportation, a newly established office of the Transportation Department.

An additional condition to obtaining a launch license was the requirement that the liability insurance also protect the various participants involved in the launch, including the United States, its agencies and personnel, the launch company's customers and their respective contractors and subcontractors.

The insurance industry has responded to the needs of launch companies by offering comprehensive launch liability insurance to pay claims for injury and damage to third parties arising out of licensed launch activities. New forms have been developed in London and in the United States.

Additional insurance requirements have been imposed regarding government property. As a condition for using government launch ranges, companies are required to purchase coverage (or demonstrate alternative financial responsibility) for loss or damage to government property in connection with launch activity. The amount of insurance required is the lesser of \$100 million or the maximum available in the world market at reasonable cost.

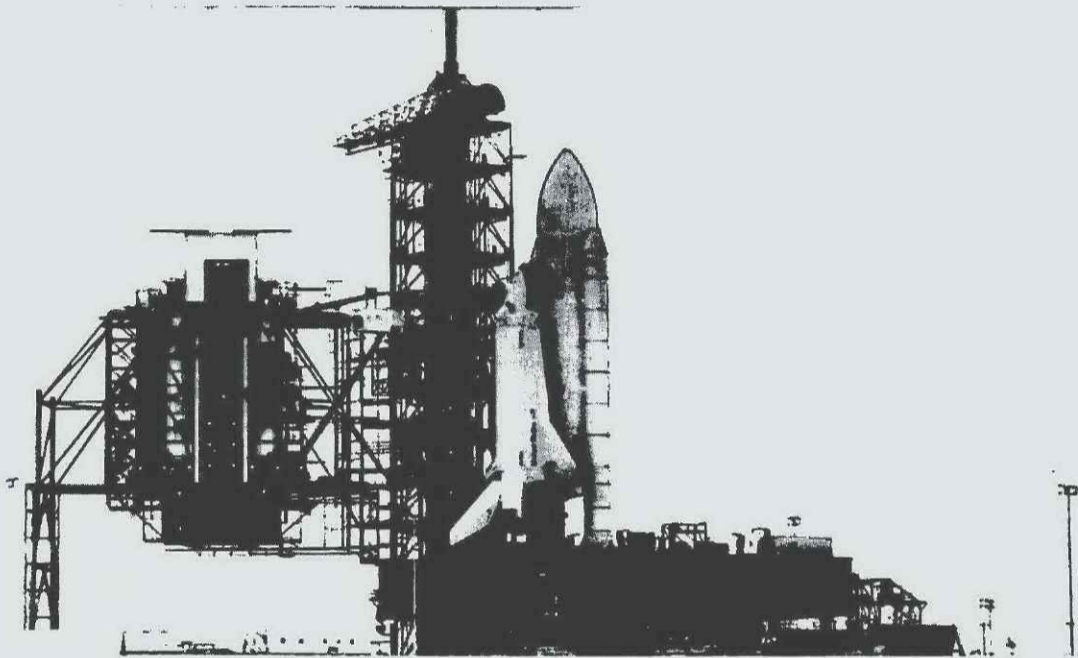
In connection with risks associated with launch activities, the government has come to the support of the private sector in two ways. It has agreed to indemnify the launch company for third-party losses exceeding the amount of liability insurance in place up to a maximum of \$1.5 billion. Second, it has assumed the loss to any of its property in excess of the insurance required.

The new launch liability insurance is gaining acceptance for United States launches. This policy responds to government requirements for comprehensive third-party liability insurance for loss or damage arising from licensed commercial launch activities in amounts prescribed by the Office of Commercial Space Transportation. Insured amounts required by the office have ranged from \$10 million to \$215 million depending on the launch vehicle and launch site. All participants in commercial launch activities benefit as insureds under this coverage, including the launch company, its customers, the government and the contractors and subcontractors of the foregoing.

An important additional component to this risk management scheme is the requirement that all launch participants agree not to make claims against each other that arise from commercial launch activities.

A combination of a single comprehensive launch liability insurance policy and claims waivers has proven to be a workable solution for the complicated risks and potential liabilities arising from commercial launches. Despite the ongoing clarifications and adjustments being required of launch companies and the government in approving proposed launch liability and government property insurance—for instance, agreeing on customary exclusions—the system is working. There have been about 20 launch licenses issued by the government to date and frequent dialogue between launch companies and the Office of Commercial Space Transportation has resulted in successful compliance with insurance requirements. The insurance industry has done its part and has met the challenge of supporting a new and vitally important industrial initiative. ■

Peter D. Nesgos is a partner in the law firm of Haight, Gardner, Poor & Havens, practicing in space finance and insurance law.



launch vehicles to the innovative Pegasus rocket, which Orbital Sciences Corp. recently launched from underneath the wing of an aircraft in flight.

Foreign competitors have also been active and successful in the commercial satellite launch market. Arianespace, the French launch company whose shareholders include the French space agency as well as European aerospace corporations and financial institutions, has managed to capture a large share of the world's commercial launch market. Currently, it has an order book of about 30 satellites to be launched, representing about \$2 billion in revenues.

The People's Republic of China recently announced its intention to launch the next Arabsat satellite and has an agreement in force with the United States that allows China over the next four years to launch a limited number of satellites that are either manufactured in the United States or contain U.S. components for international customers.

The Soviet Union has also been offering its services on its launch vehicles, which have a reliable track record. However, potential commercial users face considerable national security and technology transfer obstacles when exporting satellites with American-made components to the Soviet Union for launch.

Japan recently announced the creation of Rocket Systems Inc., supported by more than 50 large Japanese aerospace corporations, insurance companies and banks, which will begin offering commercial launch services on a new, domestically developed launch vehicle in 1993.

The Australians have announced the establishment of the Cape York Space Agency, which will offer launches on Soviet-made space vehicles from the launch center in northern Queensland.

The insurance industry has supported the commercial satellite launch business from its earliest days. The experience, though, has not always been a happy one.

previous year reached an all-time high approaching \$350 million. By the end of 1986, every major U.S. launch system, as well as the Arianespace program, had failed and was grounded.

Rate corrections and experience gained from losses as well as increased launch frequency since 1986 has helped get space insurers back on the road to recovery. Increased commercial involvement in launch operations has necessitated an expanded role for different types of insurance, both first-party and third-party coverages.

In the past, when a government agency such as NASA procured a launch vehicle from a manufacturer, it either provided indemnification or agreed to bear the cost of liability insurance for risks arising from the launch, or a mix of both. Now, with aerospace companies encouraged to offer launches commercially, new risks were faced for the first time arising from the use of launch facilities and the provision of launch services. Launch company contractors and subcontractors also were exposed to product liability risks that in the past had largely been taken care of by government indemnification.

Commercial launch companies in the United States experienced what they considered to be competitive disadvantages compared with the foreign launch programs, which were either state owned and able to offer unlimited indemnification for launch liability or private companies able to benefit directly from the state indemnity.

Legislation was introduced in the United States to provide some relief for a fledgling industry relying a great deal on commercially available insurance for its success.

The Commercial Space Launch Act was passed in 1984 in large part to encourage and facilitate commercial launch transportation. It empowered the U.S. Department of Transportation to issue launch licenses to private launch companies.

Amendments added in 1988 required that a launch company provide, as a condition to being granted a license, liability insurance (or alternative proof of

Insuring exotic tort litigation

By William M. Shernoff

THE WORLD OF commercial tort litigation is increasingly punctuated with lawsuits seeking substantial damages for a host of "exotic" commercial torts. These lawsuits usually parade out numerous and varied legal theories, such as unfair competition, breach of fiduciary duty, wrongful taking of trade secrets, trademark infringement, interference with contractual relations, idea misappropriation, conversion, misappropriation of confidential information, antitrust violations and other similar and related legal doctrines.

When a company is served with one of these lawsuits, it must defend and defend vigorously. Generally, such lawsuits strike at the heart of the company's business operations. The defense of such lawsuits is usually very expensive. Without exaggeration, millions of dollars of legal fees may be required to defend, not to mention paying an eventual judgment should the lawsuit be successful.

What about insurance coverage to defray these costs? To be sure, most companies have a fine collection of general liability policies, including excess policies and umbrella policies. The premiums paid probably rival the cost of the corporate art collection. But, more often than not, this fine collection sits in a drawer gathering dust while the company and its lawyers spend thousands—sometimes millions—of dollars waging legal war.

Some recent cases point out the fact that courts are finding that insurers may indeed be required to defend those lawsuits and could also be made to pay any resulting judgments. The *Technical Equities* litigation (*BI*, July 30) and *Keating vs. National Union Fire Insurance Co. of Pittsburgh, Pa.* (*BI*, June 11) involved underlying lawsuits claiming damages to investors for conduct involving a host of wrongful business conduct. The courts in both of these cases have upheld insurance policies' application despite the protestations of the insurers to the contrary.

In the *Keating* case, the court, in examining coverage for "unfair competition," noted such a term was undefined in the policy and therefore concluded it could encompass "any unlawful business conduct."

Similarly, in the recent *Jordache* case (*BI*, Aug. 6), the court ruled that the National Union umbrella policy "was activated" because the underlying

Analyze policies to get the most from coverage

lawsuit presented potential liability for "piracy" (a very exotic coverage found in most business umbrella policies). The court required "piracy" to be related to an "advertising activity" of the policyholder, but since both "piracy" and "advertising activity" were undefined in the policy, these terms were interpreted broadly enough to encompass charges, brought by a competitor against *Jordache*, of copying advertising ideas and concepts, among other charges.

Five very important rules have clearly emerged from a host of insurance cases that have struggled with questions of coverage. These rules are very important and should be ingrained in the minds of risk managers, corporate counsel and others concerned with insurance issues. They are:

- Ambiguities in an insurance policy will be interpreted in favor of the policyholder. This means that undefined terms or unclear language will probably be interpreted to mean what the policyholder believes rather than the insurer's interpretation.
- The duty to defend a lawsuit is much broader than the duty to indemnify. This means that if coverage is questionable, an insurer still has the obligation to defend the lawsuit so long as there is a "potential for liability" under any theory of law contained in the lawsuit.
- If there is a potential for liability under one cause of action in the lawsuit, generally speaking, an insurer must defend the entire action. This means that if a lawsuit is pleaded in 10 different causes of action, some of which are clearly not covered, a defense may still be owing if at least one cause of action provide a potential for liability under any coverage offered by the policy.
- "Exclusions" are generally given narrow interpretation. For example, the "intentional act or willful act" exclusions have been held to require a specific intent to harm, not a mere general intent to perform an act that may, by law, constitute an intentional tort.

• Lastly, don't blindly accept the insurance company's word for what may be covered or when a defense is owed. Get some good advice from counsel who understand insurance law and who will look out for your interests.

Unfortunately, most companies are not experts in insurance law and are unaware of the nuances that could bring insurance to the rescue. Often, insurers and their agents are quick to deny coverage so as to discourage the companies from pursuing the idea of insurance.

The consequences of these oversights can be dramatic. The *Jordache* case presents a staggering example. *Jordache* spent six years defending itself from various claims by its competitor. This was a bitter and costly corporate war spawning several different lawsuits in several jurisdictions. *Jordache* alone spent an amazing amount on attorneys' fees defending these lawsuits and related actions.

The final total was well over \$40 million before the case was finally settled in Los Angeles this spring. Yet it was a full three years into the battle before a light bulb went off in somebody's head that there may well be insurance that applies. When the insurer was finally notified, it claimed "late notice" as a defense, as well as other typical defenses to coverage. Luckily for *Jordache*, it was able to establish a potential for liability in the case and recover part of its legal expense in an out-of-court settlement. Certainly, earlier detection of insurance coverage would have brought even a better result.

It has always amazed me that so much time is spent by businesses buying just the right coverage. The analysis of corporate needs for insurance seems to have risen to a rare art form. Yet so little energy is devoted to analyzing and maximizing the benefits of these policies.

Perhaps a fresh perspective is needed to examine how to best maximize the use of these very expensive products call "insurance policies." ■

William M. Shernoff is a senior partner with Shernoff, Bidart & Darras in Claremont, Calif. He specializes in insurance cases on behalf of policyholders.



Company growth poses challenges

By The Insurance Institute of America

The following question and answer are drawn from the curriculum for the Associate in Risk Management designation awarded by the Insurance Institute of America. They represent the type of question asked—and the possible answers—in one of the three examinations for the A.R.M. designation.

This month's exercise, drawn from a recent national examination in ARM 54, *Essentials of the Risk Management Process*, deals with how an organization's growth often generates challenges in identifying potential losses and in forecasting and reporting actual losses.

Q: The risk management professional for a chain of automobile parts stores whose locations have grown to 150 from 15 over the past 10 years has determined that there is a 0.3% probability that, in any given store during any given month, a customer will fall and be injured.

- In a month when 400,000 customers visit the stores in this chain, how many customers should be expected to fall and be injured? Show your calculations.
- Briefly explain the significance of the following formula in projecting this chain's loss exposures:

$$g = \sqrt[n]{\frac{E}{B}} - 1$$

Where: n = number of periods
B = beginning value
E = ending value

- With reference to the growth of this chain in the past decade, describe three challenges such growth probably has posed for the proper management of each of the following aspects of this chain's risk management program: identifying the organization's loss exposures; and gathering appropriate data for estimating the frequency and/or severity of the organization's actual losses.

A: • If, on average, 0.3% of all customers fall and are injured, a month with 400,000 customers can be expected to generate 1,200 such falls and injuries (computed as 400,000 × 0.003).

• This formula gives the average compound rate of growth, g, in any variable over the n periods between the occurrence of the beginning value and the ending value. This rate can be used to forecast any given variable, such as annual numbers of losses or annual aggregate amounts of loss, for any future period, assuming that g remains constant.

• An organization's rapid growth is likely to have complicated both efforts to identify its loss exposures and gather data on its actual losses.

For identifying exposures, rapid growth is likely to bring:

- ✓ Many more locations whose exposures the organization's risk management professional must monitor.
- ✓ Much greater variety of hazards to which operations are exposed.

✓ And, the need to train many more people throughout the organization in recognizing and reporting loss exposures.

With respect to gathering data on actual losses, fast growth frequently implies complications from:

- ✓ The greater likelihood that different operating managers will report comparable losses in different ways.
- ✓ More chances that some loss reports will be unduly delayed or lost.
- ✓ And, greater variability in underlying conditions causing losses in different parts of the organization, jeopardizing the statistical validity of the organization's aggregated loss data. ■

The sample questions and answers used in this column are taken from the Associate in Risk Management designation curriculum of the IIA. For more information on the content of the A.R.M. program, write Dr. G.L. Head, Vp, Insurance Institute of America, P.O. Box 314, Malvern, Pa. 19355.

Federal control of MEWAs advised

By ADRIENNE C. LOCKE

ARLINGTON, Va.—Prompted by mismanagement and fraud, state regulators have increased their scrutiny of self-funded multiple employer welfare arrangements, experts say.

Their response in some states—shutting down all self-funded MEWAs, also known as multiple employer trusts or METs—has put regulators at odds with self-insurers, said James A. Kinder, executive vp of the Self-Insurance Institute of America of Santa Ana, Calif.

"The atmosphere out there now is 'let's not regulate them, just close them down,'" he warned at the trade group's 10th annual meeting, held Oct. 9-12 in Arlington, Va. SIIA members include self-insured employers, third party administrators and reinsurers.

To avoid varying state approaches to regulation, the trade group favors federal oversight.

"If there is going to be regulation of MEWAs, then we feel that it should be done on the federal level with federal enforcement, and with cooperation from the states in the policing effort," Mr. Kinder said.

Not all state insurance regulators, though, are calling for an end to self-funded MEWAs.

If self-funded MEWAs are "a way to get more people funding for insurance coverage, then this is something that we want to do," said Trevor G. Smith, assistant insurance commissioner of Florida, who also spoke at the meeting.

Self-funded MEWAs were designed to give small employers the advantages of group health insurance. Promoters, such as third-party administrators, established self-funded health care trusts, have marketed them to thousands of small firms, typically with fewer than 25 employees.

Organizers originally contended that the trusts were employee benefit plans and thus protected from state regulation by the Employee Retirement Income Security Act. But a 1982 federal law subjected nearly all MEWAs to the full scope of state regulation, though self-funded single-employer plans still are exempt.

A spate of MEWA abuse scandals has led the U.S. Justice Department and the U.S. Labor Department to initiate criminal investigations (BI, May 21; Jan. 29). Federal authorities said additional fraud investigations are under way in California, Florida, North Carolina, Pennsylvania, Texas and other states.

Florida, where many self-funded MEWAs are based, has had a difficult time with the trusts, acknowledged Mr. Smith.

Of the 28 self-funded MEWAs in Florida, six have terminated and 11 liquidated. Another three, he said, are in financial trouble but the state has not stepped in yet.

Two other MEWAs are working with the state to correct their financial difficulties, and the remaining six have moved from self-insured to fully insured status, he said. "That's not a very good track record," Mr. Smith said. "A lot of citizens have not had their benefits paid and will have to wait some time before they will."

The problems are not limited to Florida, Mr. Smith said. "Other states have had problems with MEWAs and there are some states that have said no more MEWAs."

It is the latter approach that the SIIA opposes, Mr. Kinder said.

The group abandoned its early support of state regulation and now calls for a law giving federal regulators authority over all MEWAs, he said. "We don't think that states can guarantee unifor-

mity. Whatever recommendations the NAIC would make will remain just that—recommendations to all the 50 states," he said, referring to recommendations of the National Assn. of Insurance Commissioners.

The NAIC is trying to more clearly outline the responsibilities of MEWA administrators as part of current efforts to update its 1977 model law for TPAs, according to Florida's Mr. Smith, head of the NAIC working group overseeing the project.

Proposed revisions to the model law would require sponsors of MEWAs to be licensed as a TPA by the states, he said.

That is similar to a proposal by the Labor Department, which is drafting legislation to require self-funded MEWAs to register with the Office of Pension & Welfare Ad-

ministration (BI, May 21).

The self-insurance group supports revising the model law, but says some of the proposed new def-



initions do not adequately differentiate between administrators of MEWAs and single-employer plans. As a result, the association contends, proposed rules designed to regulate MEWA administrators could restrict TPAs that administer self-funded single-employer

health care plans. Those firms still are exempt from state regulation under ERISA.

The insurance commissioners' model law, Mr. Kinder contends, could be improved by using clearer regulations recently adopted in Florida as a model.

Mr. Smith agreed. "We are willing to listen to them. We want a working model," he said in a later interview.

He added that the NAIC will take into account all recommendations from outside parties and hopes to have a final draft of the TPA model law ready for its December board meeting.

Until the responsibilities of MEWA administrators are clear in other states, Mr. Smith suggests that if a TPA finds itself administering a MEWA on the brink of

financial collapse, it should first try to explain the dire financial situation to the MEWA's leadership.

If action still isn't taken, "come to the state insurance regulator with the problem and let the regulator get in between the TPA and the trustees, and ask them if they understand their problem," he said. Many MEWAs think that good cash flow will solve their problems, but that isn't always so, he said.

Mr. Kinder says that the TPA will have to make a choice.

"At some point that you are advising your client and they won't take your advice, you must make a business decision whether it is worthwhile to continue to carry that business when they're not listening to you, because it will be you that goes down," he said.

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Restructuring For Opportunity

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For further details on the World Insurance Congress, the exhibition, or to register, contact:

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Conference Department
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Expert views pros, cons of self-insurance

By ADRIENNE C. LOCKE

ARLINGTON, Va.—Employers considering self-insuring their employee health care plans should first weigh the benefits of such a move against the risks and responsibilities, a benefit expert says.

Freedom from state benefit mandates and having complete control over plan design and policies are attractive reasons to self-insure, but employers must also recognize the great risk of self-insuring health care benefits, said Joyce A. Wans, vp at Group Management Services Inc. of Lynnwood, Wash.

"It's better that employers should hear this first than hear it later in bankruptcy court," she said at the Self-Insurance Institute of America's 10th annual conference, held Oct. 9-10 in Arlington, Va.

One of the main attractions of self-insurance for employers is being exempt from state benefit mandates and regulations, which allows employers to choose the design of their benefits plans, Ms. Wans said.

While states can mandate the types of benefits that insured health care plans offer, self-in-

sured health care plans are exempt from state regulation under the Employee Retirement Income Security Act of 1974.

"In truth, most (self-insured) employers do provide most of the benefits that are mandated by the state, but they want to modify them slightly," she said.

Self-insured employers also can control their own cash flow and reserves, Ms. Wans noted.

However, the disadvantages of self-funding should not be ignored, she pointed out.

Ms. Wans said that self-insuring health care benefits means the company's assets are completely at risk. "The employer is not just putting his reserves at risk, he is putting every dime on the line. That is a very significant disadvantage," she said.

The employer also is responsible for providing the services necessary to fulfill the plan's obligations, Ms. Wans pointed out.

If claims exceed reserves, the employer is still responsible for paying off these claims, even if that means tapping company profits or liquidating company assets, Ms. Wans said.

"A lot of employers go into self-

funding and don't realize that they are in a sense becoming an insurance company," she observed.

Most employee benefits—including medical, dental, vision, short-term disability or prescription drug benefits—are suitable for self-insurance because they produce a constant stream of relatively low-dollar claims that are



easy to predict, according to Ms. Wans.

However, other benefits, like life, death or accidental death and dismemberment benefits are not good choices for self-insuring because they produce claims that are both large and erratic, she said. An employer would never know when one of these types of claims would be filed or for how much, making it very difficult to predict exposure or the amount of reserves needed,

she said.

"These claims are like a flash flood: By the time you see how much water there is, you're already drowning in it," Ms. Wans said in a later interview.

In general, when an employer self-insures its employee health care plan, there are three sources of funds for paying benefits, according to Ms. Wans:

- Employer and employee contributions.
- Any investment income the employer receives on these funds.
- Stop-loss insurance, which covers losses beyond a self-insured plan's expected losses.

The three types of obligations under a self-insured plan are claims; expenses incurred in administering the plan; and payment of stop-loss premiums, she said.

There are two types of stop-loss coverage—specific and aggregate, both of which self-insured employers purchase, Ms. Wans explained.

Specific stop-loss insurance covers the portion of each claim that exceeds a specified dollar amount. Aggregate coverage does not respond until the total amount of self-insured losses in a given year reaches a pre-determined

amount, after which the aggregate stop-loss policy pays all remaining losses.

Specific claims are reimbursed on a monthly basis, while aggregate claims are not paid until the end of the contract year, Ms. Wans explained.

When estimating expected losses, self-insured employers must understand the so-called claims lag, Ms. Wans said. She explained that this is the time between when an employee received health care services and when the claim was paid or the check has cleared.

Unless the lag is taken into account, a self-insured employer could mistakenly believe it has caught up with its claims payments when it may still have claims that have not yet been paid, she pointed out. This could cause the company to underestimate losses, she said.

Ms. Wans said self-insured employers must be aware of and adjust their benefit plans according to market trends, like increases or decreases in medical costs, utilization patterns, changes in health insurance regulations, changing life spans and treatment of acquired immune deficiency syndrome cases. ■

Market conditions

Continued from page 3

wasn't as confident about when the market would begin to harden. "I wouldn't for a moment try to predict when the next market cycle will occur."

Some in the industry believe that "underwriting companies are coming to their senses and will begin making adjustments," but "we do not see that happening," said Mr. Miller.

He said, "We continue to see a deterioration of cash flow. Cash flow apparently is inadequate to totally cover claims for a number of companies."

As long as capacity remains abundant, "we might remain in a soft market," commented Donald Bell, chairman and chief executive officer of Frank B. Hall & Co. Inc. in New York. "However, offsetting this is a number of companies that are currently in negative cash-flow positions and the number is increasing."

Slumping insurer stock prices also are pressing the marketplace, Mr. Bell said. "Almost all the publicly traded companies are at or near their 52-week lows," he noted, asking rhetorically, "How long will it take for management to say, 'We will not play anymore even at the cost of market share?'"

Robert Clements, chairman of New York-based Marsh & McLennan Inc., said whenever the market turns, "we can all hope underwriters who have control of the market when it is hard recognize that the only effective way to ameliorate the cycle is (when it is) on the way up."

If insurers respond to a hardening by quickly pushing up rates to cover past losses as well as current claims, they will guarantee that "the cycle will repeat itself," said Mr. Clements.

Excessive rates "can't do anything but come down," he explained, while the industry builds excess capacity in the meantime.

Panelists said they worry that current low prices could help fuel a sudden market turn.

Some prices are "beginning to border on the irresponsible," said Mr. White of A&A. Some insurers "have already crossed over into negative cash flow" as claims outpace premiums, he noted.

Thomas R. Tizzio, vice chairman of domestic general insurance for New York-based American International Group Inc., said statistics show "too many" insurers "are accustomed to underwriting losses."

Since 1980, property/casualty insurers have racked up \$130 billion in

underwriting losses, he said. Losses of \$21 billion reported for 1989 alone were offset by about \$31 billion in investment income, he added.

"Projections for 1990 are about the same numbers, slightly down," said Mr. Tizzio.

Mr. Tizzio and other panelists agreed that environmental cleanup costs could significantly dampen future results.

Cleaning up the 1,200 hazardous waste sites identified by the federal Superfund program is expected to cost around \$12 billion, said Mr. Tizzio, adding that the system for channeling funds toward the cleanup effort is inefficient.

"Billions of dollars have already been spent and very few sites have been cleaned up," he noted. "We're troubled that half the funds go into the pockets of lawyers, not into the cleanup process."

And because some of the pollution occurred as long ago as 50 years, finding the polluters can be difficult, he said.

"For the insurance industry, there are important stakes in the hazardous waste debate," Mr. Tizzio remarked. "Insureds are seeking to recover under old policies... which did not anticipate such risks at the time they were written."

Mr. Tizzio pointed out that AIG Chairman Maurice R. Greenberg has proposed creating a National Environmental Trust Fund to finance cleanups through a surcharge on commercial property/casualty insurance premiums (BI, March 6, 1989).

"Our proposal has sparked a fair amount of debate," Mr. Tizzio said. AIG believes it is "the kind of solution regarding environmental cleanup that must be adopted."

Hall's Mr. Bell agreed that pollution "is one of the most important issues facing us in the decade ahead."

"The size of the potential liabilities coming from environmental pollution is enormous," he said, challenging the insurance industry to "take a collective stance in the development of products and creative solutions to handle the various and very serious life-threatening concerns that face us all."

Like Mr. Tizzio, Mr. Bell mentioned the need for a plan to spread cleanup costs. In addition, new risk management vehicles have to be developed to help policyholders minimize their financial and legal risks related to pollution, said Mr. Bell.

Risk managers and insurers have to support "a clear set of laws that

demonstrate what is acceptable and what is not acceptable for a safe environment," he said.

As the industry heads into a new decade, a core of global brokers is expected to emerge, Mr. White said.

"We will probably see around a half-dozen global brokers who will be able to meet the needs of buyers" with worldwide operations, he said.

Smaller "niche" brokers will remain, but there will be "a clear-cut division" among intermediaries who are expanding worldwide and those which are handling only domestic risks, said Mr. White.

Mr. Clements said coming years will bring "a process of consolidation, not only in the brokerage field, but also among insurance companies."

"Sad to say," he added, "that this is taking place at a time when the value of our currency is depressed and the resources of our insurance company markets are depleted."

Therefore, foreign companies will acquire U.S. insurers and their underwriting capacity, Mr. Clements predicted.

Mr. White said he expects Japanese firms to make a major move into the U.S. insurance market during the 1990s.

Japan "has a mountain of cash," he said. And with the exception of their willingness to write coverage for Japanese businesses based abroad, Japanese insurers have aggressively competed for foreign risks. "I think that's going to change," Mr. White said.

While Japanese firms may not acquire a major U.S. property/casualty insurer soon, they may attempt to purchase a life insurer, he remarked.

Michael G. Whelan, risk management officer of Enserch Corp. in Dallas, and W. Michael McDonald, group director of corporate risk management at Ryder System Inc. in Miami, moderated the discussion. ■

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Pre-existing

Continued from page 3
 financial data." The bill does not explain what this provision would exactly do.

- Prohibit the health plan sponsor from determining the amount of any premium, deductible, or coinsurance for an individual based on the number of claims submitted by that individual.

- Establish a standard for determining premiums, deductibles, and coinsurance under a health benefit plan based on "the most recent available medical and financial data." Again, the bill does not elaborate.

- Allow the use of eligibility requirements—such as waiting periods before becoming eligible for coverage and minimum and open enrollment periods—as long as they are applied uniformly and are applicable to all plan participants.

Any sponsor of a health care plan that does comply with the standard would face civil penalties assessed at the discretion of the Department of Health and Human Services of \$100 per individual enrolled in the plan for each day the plan is not in compliance.

The sponsor also would be liable to any employee or dependent covered under the plan for damages, including incurred health care costs, for failing to comply with the new standard.

Under the bill, federal officials would regulate self-insured plans, which are exempt from state regulation under the Employee Retirement Security Act of 1974.

The bill would direct states to develop standards for insured plans.

Within two years after enactment of the bill, states would have to submit evidence to HHS that they have adopted the new standard and have assumed responsibility for enforcing it within two years after enactment.

Six months after a state has submitted that proof, HHS would certify the state.

However, that certification could be withdrawn if the agency feels a state no longer meets the standard.

Specifics like enforcement and liability "need to be fleshed out" when the bill is re-introduced, Rep. Walgren's spokeswoman said.

According to a 1988 report on commercial insurers' underwriting practices by the Office of Technology Assessment—a congressional agency that analyzes technological and scientific issues—conditions excluded from group coverage include alcoholism, diabetes, uncontrolled high blood pressure, stroke, pregnancy, and severe obesity.

In addition, some plans exclude coverage for previous fractures, knee problems, hemorrhoids and migraine headaches.

Many benefits experts believe that H.R. 2649 would further fuel increases of health care costs for employers and self-insured employers.

Employers exclude pre-existing conditions from coverage under their health care plans for a fixed period of time to reduce exposure from employees who begin racking up medical expenses when they start a new job, said Dave Young, a consultant in the Washington, D.C., office of The Wyatt Co.

Prohibiting that practice will increase the cost to employers, Mr. Young said.

"If the legislation requires them to remove those pre-existing condition exclusion provisions, then, on balance, it will force them to increase their costs because they won't be allowed to limit or postpone those costs. Their costs will go up," he asserted.

If health care plans could not exclude coverage for pre-existing conditions for a certain period, health care costs would dramatically increase for everyone, agreed James A. Dorsch, Washington

counsel for the Health Insurance Assn. of America in Washington, D.C.

"If you could buy health insurance at any time, no matter what your health is, why buy health insurance until you get sick? The price for coverage would skyrocket because healthy people wouldn't buy health insurance," he said.

If an employer health care plan was not allowed to exclude pre-existing conditions, "that would drive up your claims costs, making you uncompetitive with those who are insuring healthy people," Mr. Dorsch said.

The cost of insured health care plans would rise for most employers under the Rep. Walgren's bill even if health insurers used community rating rather than experience rating when formulating rates for an employer's plan, he noted.

He explained that the cost of huge claims filed against even relatively few insured employer-sponsored plans in a community would lead to higher rates for all insured plans in the community.

And, as a result, efforts by many employers to improve the health of their employee population through, for example, wellness programs, would be virtually negated, he said.

While a person may not initially receive coverage for a pre-existing condition, he or she generally still would be able to receive coverage for other non-related illnesses during the waiting period, Mr. Dorsch said. After the waiting period, the pre-existing condition would be covered under most policies, he said.

"Very few plans would exclude a pre-existing condition over the life of an employee," agreed James Kinder, executive vp of the Self-Insurance Institute of America in Santa Ana, Calif.

Mr. Kinder said Rep. Walgren's bill also would discourage employers, especially small employers, from offering health care plans.

"There is only so much these small employers can bear and stay competitive. Any of these kinds of mandates will just continue to force costs up and encourage the greater discontinuation of benefits," he said.

Larger employers, however, "would respond by restructuring their employee plans and reducing benefits across the board," Mr. Kinder said.

However, "it is very difficult to quantify what the cost will be" to employers if the Walgren bill is enacted, said Kenneth Sperling, a consultant in the Rowayton, Conn., office of Hewitt Associates.

Because rates would still be affected by the severity of claims filed against a plan, an employer "might save one year but not save the next," he said.

Mr. Sperling also believes the legislation, if enacted, would affect insurers and self-insurers differently. "It may not necessarily make an employer drop its plan, but it might be the deciding point for an insurer who must decide whether or not to offer coverage to that employer. A self-insured plan might be able to bear the risk of taking on that pre-existing condition," he said.

The bill also would change the way employers look at hiring potential employees, according to Hewitt's Mr. Sperling.

"If someone comes to work for you and then goes on permanent disability in three months, you, as an employer, you have not been smart in hiring that person as an employee," he said.

Mr. Sperling said pre-employment physicals would become more prevalent.

For example, an employer would not want to hire an applicant with a history of high blood pressure for a stressful administrative position, he said.

However, employers would have

to require physicals for all potential employees and apply the same standards to be considered non-discriminatory, according to Mr. Sperling.

These physicals, though, "will only impact employees but will do nothing for the dependents," pointed out Wyatt's Mr. Young.

The HIAA's Mr. Dorsch said agrees with the goals of the Walgren bill, but feels H.R. 2649 "is not the way" to ensure affordable coverage for workers with pre-existing conditions.

Mr. Dorsch said the health insurance reform proposal the HIAA released shortly after the Pepper Commission's preliminary proposal is the best solution (BI, March 12).

The HIAA recommends, among other things, that:

- Employers with fewer than 25 employees that want to purchase group health insurance be guaranteed coverage even if one or more employees in the group are con-

sidered uninsurable or high risks. However, insurers still could impose waiting periods before covering pre-existing conditions.

- Once the group is insured, neither the group nor an individual in the group could be denied coverage because of claims experience.

- Employees that have met any pre-existing condition requirements would not have to meet them again if the employer changes insurers or if the employee changes jobs.

- No group would pay more than 150% of the average premium paid by similar groups for basic coverage.

- A privately funded reinsurance mechanism through which insurers could reinsure high-risk persons would be established. All insurers writing small group business would share in the pool's losses.


- Risk pools would be created by states for truly uninsurable individuals, such as those who are se-

verely obese, and would be financed by state revenues or other broad-based funding mechanisms, such as a special tax. If a state does not establish a pool, then the Health and Human Services Department would have the authority to set up a pool and finance it with federal dollars otherwise designated to be spent in that state.

Mr. Dorsch noted that state risk pools could provide adequate insurance for those who are "ready, willing and able to buy insurance."

"Yes, it would be more expensive than for people who are healthy, but it is a middle ground. What we are trying to do is find workable, practical solutions to help these people," he said.

However, Wyatt's Mr. Young questions the effectiveness of existing state insurance risk pools. "My impression is that, no, they are not beginning to be effective" in covering these high risks, he said.



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Six European companies form reinsurance venture

By DON LEWIS KIRK

COLOGNE, Germany—Five mid-sized European insurers will hold stakes in a Cologne Reinsurance Co. unit that is scheduled to offer reinsurance through intermediaries beginning Jan. 1.

The unit, Europa Reinsurance Co., will specialize in non-proportional liability, property, marine and energy reinsurance coverages. Europa will concentrate on the working layers rather than excess layers, said Rolf Tolle, executive director of Europa.

Europa has been capitalized at 54.4 million deutsche marks (\$35.8 million).

Each of the five European insurers has purchased 5% stakes of Europa for about 2.7 million deutsche marks (\$1.8 million). Cologne

Re, acquired last year by Groupe Victoire of France, will retain the remaining 75% interest in the Cologne, Germany-based unit.

The five insurers besides Cologne Re that hold stakes in Europa are:

- Iron Trades Employers Insurance Assn. of London.

- Central Beheer Reassurantie N.V. Herverzekeringmij of The Netherlands.

- French Teachers' Mutual Insurance of Niort, France.

- Westfälische Provinzial-Lebensversicherungsanstalt of Münster, Germany.

- Provinzial Feuererschicherungsanstalt der Rheinprovinz of Düsseldorf, Germany.

Cologne Re has dealt directly with ceding companies in the past, but the new venture will try to expand through reinsurance brokers,

Mr. Tolle noted.

"Cooperation will allow direct insurers to offer products they couldn't offer otherwise," Mr. Tolle said. "We see Europa as a means for the direct insurers to gain access to new business."

France, Germany, Italy and Spain are the most promising markets for the reinsurance network, he said.

Cologne Re says it plans to open an office in the London Underwriting Centre by 1992 and eventually reduce its stake in Europa to 51%.

Mr. Tolle described Iron Trades as "a reputable British underwriter of employers liability" insurance.

He describes Centraal Beheer as a large direct writer serving Dutch co-operatives.



Stacy Shapiro

Challenges and opportunities for U.S. insurers in Europe were discussed against the backdrop of the Seine River and the Eiffel Tower.

U.S. insurers lose ground globally: Chubb executive

By ISABELLE BERGLAS

PARIS—Despite the United States' prominent share of the world insurance market, too few U.S. insurers are active abroad, an insurance executive contends.

"Of the more than 5,000 insurance companies and groups in the U.S., only about 50 do anything outside of the country," said Henry G. Parker III, senior vp and managing director of Chubb & Son Inc., a unit of Chubb Corp. of Warren, N.J.

The United States is "the world's largest insurance market," but it is losing ground internationally, Mr. Parker said at a conference in Paris last month on "Challenges and Opportunities of U.S. Insurance in the '90s," sponsored by L'Argus.

"The U.S. is losing a significant market share of world premiums, with a drop from 43% to 37% during a two-year period ending in 1988," Mr. Parker said.

And, "currently, the U.S. is losing each year one percentage point or more of the (world) market," he said.

There are several reasons U.S. insurers should look overseas, according to Mr. Parker.

For example, the domestic market is overly competitive domestic market and new premium growth is slowing, he said.

"With U.S. property/casualty insurance premium growth last year at only 2.1%, compared to Asia growing 23% and Europe somewhat lower than that, the real growth potential for U.S. insurance companies is overseas," Mr. Parker said.

"Insurance is one of the greatest growth industries in the world," Mr. Parker said.

But, despite opportunities in foreign markets, U.S. insurers and brokers fail to pursue opportunities in 63% of the world's marketplace, he commented.

Mr. Parker said U.S. insurers and brokers are reluctant to expand overseas for several reasons, including a lack of "long-range vision," a failure to recognize the United States' shrinking share of the world market and pressure to improve quarterly earnings.

However, he also cited the "inventive army of protectionist devices that exist around the world to limit access to foreign markets."

Mr. Parker, who did not cite specific examples, said such measures include "a simple closing of the market to foreign insurers," "only limited access to markets" and requiring that "all or a portion of the ceded reinsurance be placed with a state-owned or controlled company."

In addition, Mr. Parker said that while "the European Community looks great, leading the way to a borderless insurance market," he expressed concerns about the introduction of a reciprocity standard in the draft of the E.C. Second Life Directive.

The draft would restrict authorization of companies based in non-E.C. countries to those countries that freely allow E.C.-based companies to trade within their own borders.

"The threat itself seems to have had a chilling effect on U.S. interest in European insurance markets," he said.

"The last and, indeed, best hope for globalization and free exchange of insurance markets around the world lies in the successful conclusion of the current round of GATT," Mr. Parker said.

The GATT talks are expected to result in an agreement in early 1991, called the General Agreement on Trade and Tariffs, that will regulate trading by insurers and banks around the world and prevent dominance of a market by one or two major financial services or insurance companies (BI, Nov. 13, 1989).

Giving the GATT negotiations a 50% chance of success, Mr. Parker said its failure would encourage the division of the world into regional trading blocs and the resumption of bilateral agreements.

Continued on page 35

E.C. pension ruling not as costly as feared

By DENISE CLAVELUX

BRUSSELS, Belgium—A European Court of Justice ruling that a company must provide equal pension benefits for men and women who retire at the same age is not costing European employers the billions of dollars originally anticipated, say industry analysts.

Observers had predicted the May 16 ruling would add substantial pension costs for companies located in six E.C. nations. Companies in the United Kingdom, where private pension plans are common, would fare the worst, losing billions of pounds, observers had predicted (BI, May 28).

Early cost estimates so far, though, are proving widely off the mark.

Andrew Davis, a consultant with Buck Consultants S.A. in Brussels, Belgium, said it is too early for the decision to have a big impact. In addition, the ruling applied "only in a very precise area where someone (was dismissed), although no doubt the principle" of equal pension benefits "applies more widely," he said.

According to a spokesman for the National Assn. of Pension Funds in London, the ruling merely accelerated an existing trend toward equalizing pension benefits in Britain.

"There was quite a trend in the United Kingdom anyway toward equality of pensions," he said. "This has certainly accelerated the trend and today virtually all companies operate identical rules for men and women."

Although the ruling set precedent for private pension plans in all E.C. nations, only six of the 12 member nations still permitted women to receive full benefits earlier than men at the time of the decision: Belgium, Greece, Italy, Portugal, the United Kingdom and Germany (BI, Oct. 9, 1989).

The ruling was regarded as a benchmark for the European Court of Justice, which had never before ruled in favor of a man in a sex discrimination case.

In the case before the European court, Douglas Barber sued his employer, Guardian Royal Exchange Assurance P.L.C. of London, alleging discrimination. Mr. Barber was forced to retire from the insurer at age 52. At the time, GRE did not allow male employees to receive their pension benefits until they reached age 62, although a woman retiring at his age could have immediately received a full pension.

Many analysts considered the ruling potentially costly for companies that had funded their pension plans on the assumption that men would be entitled to benefits later than women.

However, that thinking has changed, said the NAPF spokesman.

"It depends on how the companies decided to equalize. If they decide to retire females at 65 and not at 60, then it is in fact a savings and not a cost," he said.

Raising the retirement age could hurt current employees, the spokesman said. "Say a woman aged 59 wanted to retire at 60 and not work on until 65. If

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LONDON

Aviation war risk insurers hike rates, limit coverage

By STACY SHAPIRO and CAROLYN ALDRED

LONDON—London aviation hull war risk underwriters are imposing new restrictive annual aggregate limits and increased annual rates for airlines worldwide.

The new rate increases are on top of the additional hull war risk premiums being charged for airlines that fly to Persian Gulf nations.

Beginning this month, underwriters are insisting that an airline's hull war risk coverage

have an annual aggregate limit equal to the value of the three most expensive aircraft in the airline's fleet. This means that in any one year, the airline is insured only for a loss due to war that is equivalent to the values of its three most expensive aircraft.

Until now, aviation hull war risk underwriters had limited coverage only on a "per occurrence" basis.

For example, although the value of the aircraft owned by Kuwait Airways, which were confiscated by Iraq this summer, totals \$690 million, the coverage was limited

to \$300 million per occurrence.

The new aggregate limit is in addition to increases in annual hull war risk rates worldwide of between 40% and 50%, sources say.

The hardening of the aviation war risk market follows the \$300 million Kuwaiti claim that underwriters have agreed to pay. Sources say that the claim could wipe out some syndicates at Lloyd's of London—the largest single aviation hull war risk market—because underwriters have historically undercharged for the

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LONDON

London

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exposure.

Total annual aviation hull war risk premiums have averaged between \$30 million and \$40 million, they say.

The International Air Transport Assn. already has lobbied London aviation war risk underwriters to lower rates, saying airlines may have to pass higher insurance costs on to passengers (BI, Oct. 22).

Shortly after the IATA meeting, GPA Group P.L.C., the world's largest aviation leasing company, also met with aviation hull war risk underwriters in London to discuss how the changes could increase its uninsured exposures.

GPA leases about 250 aircraft in more than 40 countries. Its 80 customers range from international airlines to start-up tour operators.

Customers are responsible for

insuring the leased aircraft, though GPA would be liable for any losses that were not insured, according to Martin O'Brien, vp-insurances for GPA in Limerick, Ireland.

"I have met with some of the underwriters" to get an idea of what is going on in the aviation hull war risk market, Mr. O'Brien said.

He said he learned that:

- There is a "general intention" to impose an annual aggregate limit that is approximately equivalent to the three top aircraft values in each fleet.

- The underwriters are not being consistent in their approach: At least one airline has not had this new limit included in its renewal. However, the intention is to impose the new limit on most airlines.

- Airlines are being offered additional reinstatements or "top-ups" to the new limit, but only for an additional premium.

Leasing companies, Mr. O'Brien

admits, are concerned about the new exposure that the new limit imposes on them.

However, "everyone should look at this more calmly and not seek to impose instant solutions," he said.

"We are reviewing our portfolios to see what coverage we have from the lessees," Mr. O'Brien said.

GPA could ask its customers to buy more protection by way of additional reinstatements, he said.

Alternatively, GPA could consider buying catastrophe coverage to protect its fleet of aircraft in excess of the coverage bought by the lessees, he admitted.

However, Mr. O'Brien believes that the new aggregate limit may improve the security of the aviation hull war risk market, which is facing a substantial loss from Kuwait Airways.

"But what it means for capacity in the market, I don't know," he said. Total hull war risk capacity

probably ranges from \$400 million for aircraft traveling to the Persian Gulf region to more than \$700 million for aircraft traveling elsewhere in the world.

Punitive damages

A leading British plaintiff lawyer is calling for the introduction of punitive damages in Britain following the dismissal of what was only the second corporate manslaughter trial held this century in the United Kingdom.

With the difficulties of proving corporate manslaughter, expanding civil law to include uninsurable punitive damages against corporations is an option that should be examined, said Roger Pannone, senior partner of the Manchester-based law firm Pannone Napier.

The earlier manslaughter case also was not successfully prosecuted, according to lawyers.

In the most recent case, manslaughter charges were dropped this month against P&O European Ferries (Dover) Ltd. and seven of its former employees, accused of gross criminal negligence in connection with the capsizing of a ferry boat in the English channel in March 1987.

The charges were dropped against all of the defendants after the judge ruled part way through the trial that there was insufficient evidence against the company and five of the defendants to convict them.

The charges were dropped against the two remaining defendants for humanitarian reasons, according to prosecuting lawyers.

The ferry Herald of Free Enterprise capsized March 6, 1987, minutes after it left Zeebrugge Harbor in Belgium, causing the loss of 188 lives.

An inquest later ruled that the ferry drew water and capsized because the bow door not been closed before the vessel left port.

The judge ended the trial—which was expected to last several months—less than four weeks after it began.

Mr. Pannone, who first began advocating a system of punitive damages last year, has written to the Department of Transport proposing the introduction of punitive damages and has sent copies of the letter to other government departments, he said.

However, unlike in the United States, where the entire amount of punitive damages are awarded to plaintiffs, the U.K. system should require that part of punitive damage awards should "go into a fund to promote industrial safety," Mr. Pannone said.

Balise office moves

The Balise Insurance Co. Ltd. of Basle, Switzerland, is moving the management of its underwriting account from Lennox Underwriting Management Ltd. in London to English & American Underwriting Agency Ltd. in London.

Beginning Jan. 1, E&A will "provide underwriting and management support services from its established marine syndicate operation in London" on behalf of the Balise, according to E&A.

Doug Burgess will remain as marine underwriter for the Balise account in the Institute of London Underwriters, 49 Leadenhall Street, London.

IIL president's views

Technological changes sweeping through the financial services and insurance industry will have as great an impact as the steam engine had on the Industrial Revolution, contends a British insurance executive.

The Industrial Revolution of the 18th and 19th centuries "was not a single event, it was the convergence of many influences, but they erupted nevertheless under the catalytic effect of one new technology—that of steam power," said Roger Taylor, president of the Insurance Institute of London in an address to the institute earlier this month.

During that revolution, many industries were "altered or destroyed and many lives changed. Revolutions show little respect for individuals or, indeed, their institutions," he said.

"Today the introduction of another form of technology, the computer, is the catalyst of another revolution, a commercial revolution," Mr. Taylor said. "This time, where it will lead us is again uncertain."

One thing that is known about this new revolution, he said, is that it will produce "a large number of

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INTERNATIONAL

London

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casualties among both companies and individuals."

For example, "we have already witnessed the rapid transformation of a stock market which was centered on a lively trading hall with a wide range of participants: It now has become a marketplace where a limited number of big operators deal with each other via electronic networks from air-conditioned fortresses," he said.

"The trading hall stands empty, an early victim of the revolution but probably not the last," Mr. Taylor said.

This commercial revolution is a potential threat to London's role as the world's leading insurance market, he said.

London's success as an insurance center has been built from its location and from "writing a unique mix of heavily brokered insurance on a coinsurance basis through specialist companies, pools and syndicates," Mr. Taylor said.

However, "the commercial revolution will enable competitors, whether they are individual global companies or groups elsewhere, to target markets and deliver services in a manner that would have been impossible without the technology," he warned.

To combat that threat, "certain strategic issues need to be understood and tackled as a market" by London, he said.

Currently, the technological initiatives being made in London are "fragmented, and there are few if any common standards," Mr. Taylor said.

"In some ways they are like the early days of the railway boom when hundreds of new lines were being opened using different gauges, incompatible rolling stock and no planned national framework. The system was rationalized only after several decades and many business failures. History may well be repeating itself but, on this occasion, I do not believe that we will have the same luxury of time to put our house in order," he warned.

Pension ruling

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forced to continue working, she might be able to bring legal action."

However, women have brought no such actions in British courts, he added.

Other E.C. nations that did not require equal benefits for men and women in private pension plans will not face as drastic changes as British employers.

Italian companies, for instance, rarely offer private pension plans, although demand is growing among senior executives to have companies augment already-generous state pensions with private plans. And in Greece, only a limited number of subsidiaries of foreign companies offer private pension schemes.

A few Portuguese companies operate private pension plans informally, but these schemes can more easily accommodate a rule change.

The European Commission earlier this month began legal proceedings against Belgium for failing to provide equal pension and severance benefits to men and women.

The commission contends that Belgian law gives employers the right to limit full severance benefits to six months for women age 60, which is the statutory retirement age for women in Belgium, making them eligible for state retirement benefits.

However, men receive two years of full severance benefits even at age 65, which the statutory retirement age for men. ■

"We clearly need to establish some common framework for technology that not only addresses the problems of interfacing networks but the even more basic issues of the ways in which we accept and process work. It should also face up to the real challenge of developing electronic bridges to enable overseas customers and their brokers access to this market," said Mr. Taylor.

Comings & goings

Andrew N. Coppell will join Lloyd's of London on Nov. 1 as Group Head of Systems and Communications. Mr. Coppell replaces **Des Lee**, who has moved into product retailing. Mr. Coppell has been director of information services at London-based stock broker Kleinwort Benson Ltd. From 1972 to 1985, he held a similar position with Sedgwick Group

P.L.C., an international brokerage company based in London.

Russell Willmer has been appointed a director of Aldgate Consulting Group Ltd., the financial reinsurance and consulting arm of E.W. Payne Cos. Ltd., the reinsurance subsidiary of Sedgwick Group P.L.C.

George Boden, chief executive of Lloyd's of London broker Steel Burrill Jones Group P.L.C., has been appointed a deputy chairman of the company. **David Beresford Jones** continues as chairman and, **John Horwell** continues as deputy chairman.

Richard Fry has been appointed chief executive of the retail brokerage operations of Minet Holdings P.L.C. in the United Kingdom. These operations include Minet Insurance Brokers (UK) Ltd., Minet Consultancy Services, Minet Trans Risk Services and Cork Bays and Fisher. ■

U.S. insurers

Continued from page 33

"The world insurance and reinsurance markets are, by definition, already global," he said. "But the best reason to go overseas is the opportunity that an open insurance trading society gives to serve our clients' needs wherever they are, to export our loss control techniques and our products."

In a separate session, French executives expressed skepticism about U.S. insurers' desire for open markets.

The idea that U.S. insurers welcome foreign companies is "wishful thinking," said Bertrand Belinguier, general manager of GAN International, a unit of Groupe des Assurances Nationales of Paris.

"Even if 50 commissioners acted liberally, for any European insurer wanting to have a significant presence in the U.S., it will be like

going around an obstacle course, because it has to obtain authorizations from all 50 of them," he said.

Also, "about half of the states don't even want to consider insurers that are partially state-owned," Mr. Belinguier contended.

Entering the U.S. market by obtaining authorization to do business in a single state "is not sufficient to satisfy the needs of our clients throughout the U.S.," said Patrick Lucas, president of Paris-based Gras Savoye S.A., the world's 18th-largest brokerage.

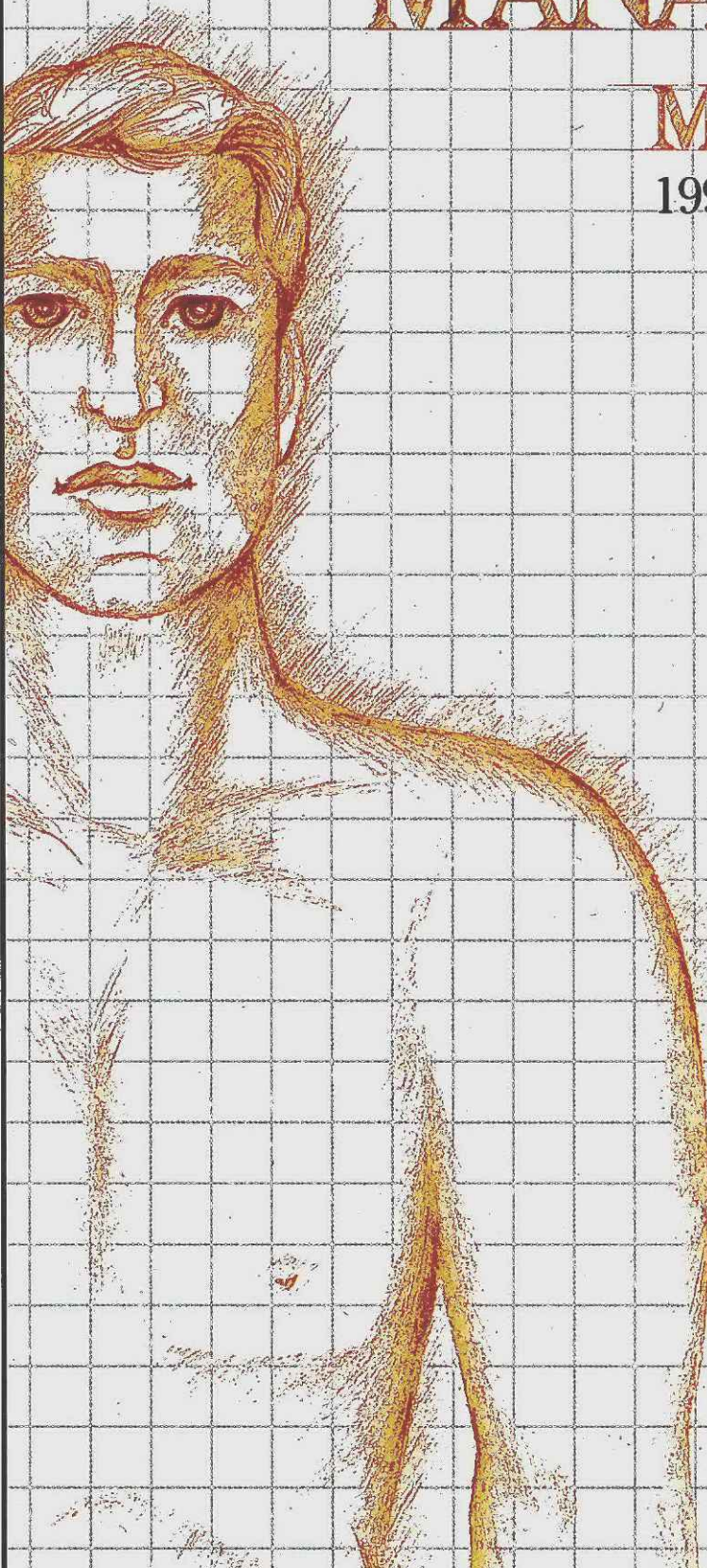
However, there are U.S. opportunities for reinsurers, said Patrick Peugeot, chairman of Paris-based reinsurer Societe Commerciale de Reassurance S.A., parent of SCOR U.S. Corp. of New York.

"In the U.S., there are no foreigners in the Top 20 insurance companies. But, if you look at the Top 20 U.S. reinsurers, about half are foreign owned," he observed. ■

MANAGED CARE

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Products & services

American Express Travel Related Services Co. Inc. is offering employers a new credit card-based group health benefit payment and information service.

Developed with Boston-based John Hancock Financial Services, American Express is offering the service, called Quattro, to Boston-area employers.

The first companies to distribute Quattro cards to their employees will be John Hancock and American Express, while the product is being introduced to other major corporations in the Boston area. American Express plans to eventually offer the service to self-insured employers and other health insurers nationwide.

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Employers that use Quattro can offer employees an optional line of revolving credit to extend payment of health care expenses. The credit would be strictly limited to health care purchases.

"The credit feature could be im-

portant as deductibles and co-payments increase," Mr. Caulfield pointed out. For example, if an employee is facing a \$500 deductible, he or she would be able to pay that amount over time.

B. Garland Cupp, executive vp of new product development at American Express, said "all participants—patients, employers, insurers, doctors and hospitals—will benefit."

Employers will pay American Express a per-employee fee for the Quattro service. In addition, American Express will keep a percentage of the payment it makes to providers, similar to how American Express charges its retail store customers.

For more information contact Terrence Arndt, Vp-Marketing and Sales, American Express Travel Related Services Co. Inc., 200 Vesey St., New York, N.Y. 10285; 212-640-4581.

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Sub-total 25,592

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TOTAL 51,386
* Source Business/Occupational breakdown of qualified circulation, May 28, 1990 issue, as submitted to BPA for June 1990 BPA Publisher's Statement.

ISO study

Continued from page 2

surveyed. The Top 25 companies in the other industry categories had a 12% average rate of return.

In comparing the 50 largest companies in 19 industry groups, insurers ranked ninth in terms of rate of return: Insurers' rate of return was 11.7%, while the other industries posted an average rate of return of 11.8%.

Looking at the study "from an investor's perspective, the insurance industry is not an industry they should be looking at for long-term profitability," said Joanne Morrissey, a principal with Firemark Consultants Inc. in Morristown, N.J.

"Investing has changed since 1987," she said. "Investors are interested in immediate returns."

But Ms. Morrissey said she is concerned that an investor looking at the study may forget that some insurance companies' performances exceed the industry's average and those companies are good investments.

She also said she thought the insurers' rates of return might ac-

tually have been lower than reported in the study, particularly considering the 11.2% maximum rate of return imposed in California under rules implementing Proposition 103.

"Insurance is a prophylactic against disaster," Ms. Morrissey observed. "The insurance industry really should be allowed to make a much higher rate of return than it is because of the risk."

Restricting rates of return is unfair because insurers will not reach their earnings potential in bad years and will be denied a high rate of return in good years, which should be the industry's reward for having borne risk, she said.

Using the 34 industry groups compared to insurers in the Top 25 cutoff, the ISO used a technique called "stochastic dominance analysis" to measure the industry's combined profitability and risk—or predictability of profits—from 1979 to 1988.

Taking the impact of all industry cycles into account in determining risk, ISO found that 12 industry groups—including "food and kindred products," "paper and allied products," and electronic and

Do not look to insurers for long-term profits, says Joanne Morrissey.

other electric equipment—were superior—that is bore less risk and were more profitable—to the insurance industry.

Nine industry groups—including depository institutions such as banks, metal mining and oil and gas extraction—were found to be inferior to insurance, meaning they were less profitable as well as more risky. The superiority or inferiority of 13 industries—including engineering and management services, furniture and fixtures, and electric, gas and sanitary services—could not be determined.

Insurers actually may face more risk than the study indicates, believes Joyce Culbert, vp of research at Firemark.

"Insofar as the report may be directed toward regulators and

politicians... it wasn't really as strong a statement as they wanted to make," she said.

The study also notes that "even more unpredictable than the property/casualty insurance industry's aggregate results are those of individual insurers."

The study ranked all insurers that reported consistently to A.M. Best Co. from 1979 to 1989 into four profitability quartiles for each year, with each accounting for 25% of total written premium.

"The movement of insurers from one quartile... to another over time shows that there was no consistent tendency for insurers to stay in their current quartile in the future," the study noted.

"Using each year from 1979 to 1988 as a starting point on average, 27% of the first-quartile insurers in each year... moved into the third or fourth quartile in the next year. This percentage of movement of first-quartile insurers into the third or fourth quartile in later years rises to 36% after two years, 43% after three years and 53% after four years," the study says.

Also, "30% of the bottom quartile moved to the top half one year

later and 48% of the bottom quartile moved to the top half three years after being in the bottom quartile," the study points out.

"Any random insurer has a 50% chance of being in either the upper or lower half of the industry" as ranked by premium volume, it says.

Other survey findings include:

- In six of the last 16 years, insurers' return on net worth was lower than the adjusted yield on long-term Treasury bonds.

- Insurers' return on net worth over the last 16 years averaged 10.8%, compared with 13.4% for the Fortune 500 industrial companies, 12.9% for companies in the Standard & Poor's 500 and 13.3% for the Dow Jones 30 Industrials.

- Since 1959, insurers' cumulative loss and loss adjustment expense growth has surpassed premium growth.

Copies of the survey, "Long-Term Profitability: The Risk Return Tradeoff," are available by writing Corporate Communications Department, Insurance Services Office Inc., 160 Water St., New York, N.Y. 10038.

Mobil settlement

Continued from page 3

spokesman. Only a refinery in Beaumont, Texas, uses sulfuric acid.

Refineries usually decide which chemical to use based on its proximity to the source and the disposal facilities needed, explained the petroleum trade group spokesman.

For example, hydrofluoric acid is used up during alkylation, while sulfuric acid produces a residue. In addition, about seven times as much sulfuric acid as hydrofluoric acid is needed to complete the octane-boosting process, the spokesman added.

Because sulfuric acid is less expensive, the operating costs end up about equal. But disposal makes sulfuric acid more expensive to use, he pointed out.

Other additional expenses include that of converting the process to sulfuric acid, which requires a different alkylation unit than that which uses hydrofluoric acid, according to the API spokesman.

Converting to sulfuric acid does not necessarily improve safety, according to the spokesman. "Both are products that require extreme care in using," he said.

Mobil already has spent \$25 million on research to develop a modified alkylation process or an alternative, according to a company statement.

According to its statement, the company is optimistic about the project and expects the research to be completed by the end of 1994, "allowing for a decision on a replacement process at that time."

Mobil projects total replacement costs to be "in the neighborhood of \$100 million," the statement said.

Also under the settlement, the court will appoint an independent safety adviser to oversee operation of the Torrance refinery. Both Mobil and the city will nominate and interview candidates, but the court will ultimately decide.

While the city will pay the safety adviser's fees and expenses, including professional liability insurance premiums, Mobil will reimburse the city for those amounts.

The court also will set the safety adviser's budget, which is not yet determined.

Among the powers that will be granted to the safety adviser are to study and make recommendations on the following:

- Installation of on-site and off-site detection equipment and warning systems to detect releases of hydrofluoric acid and other haz-

ardous materials.

- Installation of a closed-circuit television monitor for the city to view alkylation unit operations.

- The environmental and safety practices of contractors retained by Mobil for refinery work.

- Safety training for refinery employees and appropriate requirements for training by contractors of their employees.

- Safety programs for handling hazardous materials and substances.

- Traffic control systems on sensitive streets.

illustrates our determination to maintain the highest standards for continued safe operation."

Maintaining that hydrofluoric acid has been used safely at the plant for 45 years, despite the 1987 explosion, Mr. Maness said Mobil settled to "maintain good community relations."

The company agreed to the "unprecedented hydrofluoric acid phase-out in order to address the concerns of its neighbors and to resolve the dispute with the city," he said.

"That we were able to resolve

'That we were able to resolve our differences out of court is a clear indication of our intent to be good corporate citizens and good neighbors,' says Joel Maness, manager of the Mobil refinery sued over several chemical explosions.

- An emergency response plan.

Mobil is also required to give the safety adviser prompt access to the refinery. The adviser also is to be notified of any actual hazard or incident at the refinery that otherwise is required to be reported to any government agency.

The agreement expires on Dec. 31, 1997, unless the court decides to extend it.

It is not yet known how the court-appointed safety adviser will interact with the plant safety management staff, according to a Mobil spokesman.

However, Mr. McNerney, the insurance official at Mobil headquarters, suggested that the adviser may serve as an additional "cross-check" of the refinery safety program, much like the inspections the company's insurers now conduct.

"One purpose of the agreement is to make the public aware of the safety program" that Mobil already employs at the plant, he said. "We're an open book."

The settlement may be unusual because the Torrance refinery is in an urban area, according to Mr. McNerney.

The area in which the plant is located originally was sparsely populated, he explained, but California's burgeoning growth in recent years has increased the number of homes and businesses.

Joel Maness, manager of the Torrance refinery, said he considered the lawsuit settlement as fair given the unique situation. "We are fully committed to operating in a safe and environmentally sound manner. This agreement with the city

our differences out of court is a clear indication of our intent to be good corporate citizens and good neighbors who can resolve any problems with their community," he said.

The agreement will also ensure that the individual charged with overseeing plant safety is both qualified and objective, "not someone who has an ax to grind," Mr. McNerney said.

Mobil's corporatewide safety record is "excellent," according to both Mr. McNerney and a spokesman for the company in Torrance, who pointed out that all 12 of the company's domestic chemical plants are OSHA Star Program award winners.

Under the OSHA Star Program, companies that receive awards for safety are subject to less stringent oversight by the federal Occupational Safety and Health Administration.

In addition, during the 30 years Mobil has purchased property insurance from Industrial Risk Insurers of Hartford, Conn., the company has experienced a loss ratio of just 6%, according to Mr. McNerney.

"The best insurance program is loss prevention," he said.

Mobil's \$50 billion in worldwide assets are covered under a commercial property insurance program with "significant deductibles," according to Mr. McNerney, who declined to provide figures.

Mobil also purchases commercial liability coverage above a large self-insured retention.

In addition to purchasing property coverage from IRI, Mobil par-

ticipates in Oil Insurance Ltd., a Bermuda-based excess property and pollution liability insurance facility that provides limits up to \$150 million excess of at least \$5 million. Mobil does not purchase OIL's \$150 million excess of \$150 million layer, according to Mr. McNerney.

As part of its commercial liability insurance program, Mobil pur-

chases excess general liability coverage from Oil Casualty Insurance Ltd., a sister facility to OIL, which provides limits up to \$100 million excess of at least \$20 million.

Mobil also participates in A.C.E. Insurance Management Ltd., a Bermuda-based facility that provides excess liability limits up to \$200 million excess of at least \$100 million.

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AIDS claims

Continued from page 1
in the Chicago office of benefit consultant William M. Mercer Inc. As new drugs are created to prolong the lives of people with AIDS, health care costs related to AIDS escalate, she said.

The HIAA/ACLI study also reported that AIDS-related group life insurance claims increased to an estimated \$253 million in 1989, up 62.7% from an estimated \$155.5 million in 1988.

Total group life and health insurance claims related to AIDS in 1989 were \$708 million, up 75% from \$404.1 million in 1988.

AIDS-related claims involving individual accident and health policies in 1989 totaled an estimated \$79.4 million, up nearly 58% from \$50.3 million in 1988. AIDS-related claims involving individual whole life policies increased 63.6% to an estimated \$221.7 million in 1989, up from an estimated \$135.5 million in 1988.

These estimates are based on the reports of 301 life and health insurers that responded to the 1989 ACLI-HIAA survey and the 274 companies responding to a 1988 survey by the two trade groups. The 1989 respondents represent 65% of life and health insurers.

The HIAA and ACLI then extrapolated the reports from responding insurers to develop estimated results for the entire commercial life/health insurance industry.

The insurers that responded to the survey reported paying \$659.6 million in group and individual life/health AIDS-related claims in 1989, while the ACLI-HIAA study estimates that companies not included in the survey paid a total of \$349.5 million, bringing the industry total of 1989 AIDS-related claims to more than \$1 billion.

The industry estimates are based on the assumption that the reporting companies have the same share of AIDS-related claims as they have of total claims from all causes in various lines of business, according to William Carroll, an actuary for the ACLI and the study's principal researcher.

"These numbers are probably the most definitive, but the costs identified here are only a small portion of the total costs" associated with AIDS, asserted Lance Tane, a partner at Fort Lee, N.J.-based benefit consultant Kwasha Lipton.

"The study focuses on the insurance costs. The workplace costs are much greater," Mr. Tane said.

For example, insurance industry claims costs do not take into account the costs associated with lost work time because of AIDS, Mr. Tane said.

However, Mercer's Ms. Pflaum said the "employer community has not perceived a severe problem with AIDS so far." Employers have not expressed a great concern about costs associated with the disease because "AIDS has been somewhat slow" in having an impact on the employer community.

Part of the reason for the lag may be because "the initial AIDS population was not associated with the workforce. It may take longer for AIDS to reach into employer-sponsored health care costs," Ms. Pflaum said.

In a 1989 A. Foster Higgins & Co. survey, 40% of responding employers said they had an occurrence of AIDS among indemnity plan participants, compared with 34% in 1988.

However, Ms. Pflaum stressed that employers should be aware of the insurance industry's increasing costs.

"It behooves the employer community to stay ahead of the trends. Past experience with AIDS isn't a good way to plan for future experience," she said.

And, she said, the huge jump in AIDS-related group health care claims "is important to employers

because they should be aware that they may be pressured to get involved sooner in case management" or other cost containment strategies.

Given the surge in AIDS-related diagnoses and deaths in 1989 and 1988, a continued escalation in AIDS costs would not be surprising.

According to the Centers for Disease Control in Atlanta, 35,375 new AIDS cases were diagnosed in 1989, an 8.3% increase from 32,664 the previous year.

And, 24,179 people died from the disease last year, up 32.7% from 18,225 in 1988.

However, the CDC has indicated that the data reported to that agency may be understated by 20%, and many experts feel the ACLI/HIAA figures may be understated as well, pointed out Michael Cowell, vp and corporate actuary for UNUM Life Insurance Co. in Portland, Maine.

Underreporting is difficult to quantify, but some national insurers 'are reporting no AIDS claims,' says Michael Cowell of UNUM Life. 'I've got to ask how can they have that much business and no AIDS claims?'

"It's very difficult to say by how much the numbers are understated," Mr. Cowell said. Observers have indicated the figures could be understated by 10% to as much as 50%, he said. "But I like to deal with hard numbers, so I cannot substantiate" those estimates.

Mr. Carroll acknowledged that the ACLI/HIAA survey results "may significantly understate the number and amount of AIDS-related life and health insurance claims paid by the reporting companies."

"We know it's understated but I can't say by how much," said the HIAA's Ms. Payne. "It's probably more of a problem on the life side than the health side."

There are several reasons why the statistics may be understated.

"We know some companies do a very good job at identifying their AIDS-related claims," Mr. Cowell said. Unfortunately others do not, he noted.

"Some companies are reporting no AIDS claims," Mr. Cowell pointed out, noting that he questions large, national insurers that do not report any AIDS claims. "I've got to ask how can they have that much business and no AIDS claims?"

In addition, accounting for AIDS-related claims "becomes tricky with health insurance, because you start paying out claims for symptoms that you may not know are related to AIDS" until later. Insurers do not go back and reclassify those claims, he explained.

Diagnoses may be incorrectly stated or intentionally misstated, the ACLI's Mr. Carroll noted. And, he pointed out that "companies have had little immediate financial incentive to determine precise diagnoses for health insurance benefits, which are payable on the basis of general diagnosis or are payable regardless of diagnosis."

The life insurance statistics may be understated because death certificates may not show the cause of death as being AIDS-related. For example, in New York City, death certificates generally list the cause of death as "natural causes" or "external causes" rather than AIDS. Because of the high volume of AIDS cases reported to the CDC from the New York City area, this could significantly skew the study's findings, Mr. Carroll said.

The survey found that the average amount of an AIDS-related claim is steadily increasing for group life insurers. In 1989, the av-

erage size group life AIDS-related claim paid was \$34,200, a 5.5% increase from \$32,400 in 1988.

While group life and health insurance payments related to AIDS have risen dramatically, those payments represent a small percentage of total claims payments, the survey found. However, the ratio of AIDS-related claims to total claims rose significantly in 1989 for each major line of business.

The ratio of AIDS-related group accident and health claims equaled more than 1% of total claims paid for the first time in the four years since the insurance industry began collecting statistics on claims related to the disease.

Specifically, 1989 AIDS-related group accident and health claims represented 1.4% of total claims paid, up from 0.8% reported in 1988.

At the same time, the ratio of AIDS-related group life insurance claims represented 2.5% of total

group life claims, compared with 1.6% in 1988. The 2.5% marks the first time the ratio of AIDS-related group life claims has equaled more than 2% of total group life claims.

Even though these percentages are a small segment of total claims paid by life and health industry, it "proves (insurers) are still a major payer" of AIDS-related claims, Ms. Payne said.

And, she said the percentage is expected to continue to increase.

Based on a study conducted in 1987, "we had conservatively estimated that AIDS claims could reach 8% to 9% of total life insurance claims by the mid- to late 1990s," said UNUM's Mr. Cowell. "There are companies that have experienced numbers closer to 10%," particularly those that market AIDS coverage in areas of high incidence, Mr. Cowell said.

Mr. Cowell noted that since the 1987 study, he has "extended his analysis to health and disability insurance, and it looks as if the percentages are going to move in tandem."

Most observers do not expect AIDS to become a huge percentage of the nation's health care bill, but AIDS will probably account for more than 1% of those expenses, Ms. Payne said. In fact, the disease already accounts for up to 5% of health care costs in states with especially high incidence rates, she said.

"The numbers really go wild" when AIDS-related cases are figured as a percentage of total U.S. health care costs, Mr. Cowell said. "I've seen numbers range from 1% to 2% to several percentage points."

The nation currently spends about \$600 billion on health care annually. If AIDS were to account for 2% of total expenditures, the annual cost could reach \$6 billion to \$10 billion, Mr. Cowell said.

"I expect the current overall cost of care for AIDS will increase over time," Ms. Payne said. People with AIDS "will probably live longer, and new drugs to treat them will be more and more expensive."

Free single copies of the 1989 "ACLI/HIAA AIDS-Related Claims Survey" are available from either William Carroll, American Council of Life Insurance, 1001 Pennsylvania Ave. N.W., Washington, D.C. 20004; 202-624-2000; or Jude Payne, Health Insurance Assn. of America, 1025 Connecticut Ave. N.W., Washington, D.C. 20036; 202-223-7786.

NACSA to set up own office

WASHINGTON—The National Assn. of Casualty & Surety Agents and the National Assn. of Surety Bond Producers are establishing separate headquarters and staffs.

The two organizations have shared headquarters and staff for the last 30 years.

Ken A. Crerar, who has served as top-governmental affairs at NACSA for the last three years, is the new executive vp of the association. He succeeds J. Martin Huber, who will now devote his full time to NASBP.

"As time demands on NASBP have increased, our leadership felt

it was time for us to operate with a full-time headquarters staff," explained NASBP President Robert J. Hanna, who also is secretary-treasurer of Granger-Hanna Insurance Associates in Anaheim, Calif.

However, the two groups still will remain close, according to William T. Huntley III, president of NACSA and senior vp of Pritchard & Jerden Inc. in Atlanta.

"We are counting on a smooth and painless transition, which will be completed by July 1, 1991," Mr. Huntley said.

NACSA will be headquartered at its current government affairs of-

fice at 600 Pennsylvania Ave. S.E., Suite 211, Washington, D.C. 20003; 202-547-6616.

NASBP will remain at its current location: 6931 Arlington Road, Suite 308, Bethesda, Md. 20814; 301-986-4166.

NACSA represents 300 large insurance agencies and brokerages specializing in commercial insurance.

NASBP represents 650 agencies and brokerages that specialize in providing corporate surety bonding and insurance programs to construction contractors.

—By Kathryn J. McIntyre

Public Citizen report

Continued from page 1

Aetna's surplus fell 29% in constant dollars between 1972 and 1988. As a result, the two insurers failed a Public Citizen solvency test that measured whether an insurer's surplus deteriorated during the period.

But, after meeting with Hartford and Aetna officials following the report's release, Public Citizen acknowledged that Hartford's 1988 surplus actually was 6% higher and Aetna's 1988 surplus was 3% higher than their 1972 surpluses in constant dollars.

The mistake occurred because Public Citizen "double counted" the insurers' 1972 surplus by inadvertently adding the surpluses of individual Hartford and Aetna units to the surpluses of the groups' respective parent companies, which already included the individual companies' figures.

Then, those incorrectly inflated surplus figures for 1972 were compared with accurate 1988 surplus figures, leading Public Citizen to erroneously conclude that Hartford's and Aetna's surplus had deteriorated.

Hartford Chairman Donald Frahm said he was pleased that Public Citizen admitted its "blatant error."

However, Public Citizen's tests "have no proven ability to predict much of anything," Mr. Frahm added. "We regret that customers who depend on us for their financial security and peace of mind were needlessly harmed by these irresponsible allegations."

"It is a pretty obvious and amateurish mistake," said Hartford Controller Jim Westervelt. "They double counted."

If Public Citizen had taken the time and shown the courtesy to discuss its findings before the report was released, the double counting of surplus could have been spotted quickly, Mr. Westervelt said.

"We are outraged that Public Citizen would issue such an inaccurate report and unnecessarily alarm the very consumers it purports to serve," said John J. Martin, president of Aetna's personal financial security division.

"Public Citizen has been terribly irresponsible. The report on property/casualty insurers' financial strength was a concoction of arbitrary financial tests, incorrect information and sloppy analysis," Mr. Martin charged.

"This was not, by any stretch of the imagination, a genuine attempt by Public Citizen to aid insurers or consumers. Public Citizen never contacted Aetna for information or assistance prior to the release of its report. And state insurance regulators, whose job it is to oversee our industry, were not asked to participate in the report," Mr. Martin observed.

"This document was put together by people who are solely interested in pursuing a narrow political agenda," Mr. Martin asserted.

Despite the report's errors, Public Citizen is standing behind the

report.

"The insurance industry is vulnerable to a pattern of insolvencies and urgently requires stronger federal and state regulation to ensure that consumers are protected. Our report provides a reliable analysis of the standards for judging the potential financial vulnerability of property and casualty insurance companies in the event of a severe economic downturn," the organization asserted in a release late last week.

"The report's fundamental conclusion stands: Property and casualty companies should improve their business practices to avoid solvency problems in the future," wrote Public Citizen President Joan Claybrook in a letter to Mr. Frahm, apologizing for the group's error in calculating Hartford's surplus.

Report author Caroline Smith DeWaal, who earlier conducted a press briefing, was not available for calls last week. Press inquiries were referred to an organization spokesman, who said Public Citizen would evaluate all criticisms leveled against the report.

While Public Citizen regrets the incorrect calculation of surplus, that mistake does not invalidate the report's findings, the spokesman said.

However, AIG Chairman Maurice R. Greenberg last week demanded a retraction of Public Citizen's comments about AIG by "no later than the close of business on Friday, Oct. 26."

In an Oct. 25 letter to Ms. Claybrook, Mr. Greenberg charged that Public Citizen had made "false and misleading statements" about AIG's financial condition and said that its failure to correct those statements "would border on fraud."

In an interview, Mr. Greenberg threatened to sue Public Citizen if a retraction was not forthcoming by Friday.

Mr. Greenberg assailed the Public Citizen report in his letter to Ms. Claybrook and in the interview.

The report misused figures published by A.M. Best Co., the Oldwick, N.J.-based rating organization, to arrive at its estimates of AIG's surplus, according to Mr. Greenberg's letter, which contends that Public Citizen actually considered only about two-thirds of the surplus of AIG's property/casualty operations.

"Had you used the appropriate figures, AIG would have 'passed' even this meaningless test," he wrote, referring to the group's surplus-to-losses solvency test. An insurer "failed" that test if its surplus equaled less than 50% of its losses during three or more years between 1980 and 1988.

"We have an obligation to provide truthful information to the public and the people we do business with," Mr. Greenberg said in the interview. "Why shouldn't they be held to the same standard of truth we are?"

"This organization is irrespons-

ble. They don't know an insurance policy from baseball bats," he said, adding "I can understand ignorance of a subject, but I do not understand arrogant ignorance."

"You can't depend on amateurs to do an analysis that is very complex," said AIG Senior Vp and General Counsel Wayland Mead in New York.

The report has caused AIG a variety of problems, Mr. Greenberg complained: The company has received phone calls from worried policyholders, ministers of finance in countries in which AIG operates, overseas agents and some of its own overseas employees.

"Obviously, it didn't help in our business planning," Mr. Greenberg said.

Asked if the Public Citizen controversy would affect AIG's relations with consumer groups, Mr. Greenberg replied, "I would talk to any responsible consumer group, but this is not the way to get the dialogue going."

Liberty Mutual late last week also asked Public Citizen for a retraction, charging that it is inappropriate to include personal lines insurers along with long-tail commercial lines companies such as Liberty Mutual when comparing leverage ratios, liquidity ratios and premium volume changes.

"To use such an unsophisticated, broad-brush approach can only result in misleading results. Four of the six tests chosen by Public Citizen are biased against commercial lines companies in that their results are compared to those of a group which includes personal lines carriers," said Liberty Mutual Senior Vp, Chief Financial Officer and Treasurer Robert H. Gruhl in a letter to Ms. Claybrook.

Mr. Gruhl also noted that some of the Public Citizen tests like wide premium swings are "simply misguided and arbitrary," while the leverage test is only valid when comparing a company to its true peer group.

"Your report is flawed, not only in the tests selected, but in how Public Citizen chose to interpret the results," Mr. Gruhl said.

Meanwhile, United Services Automobile Assn. wants Public Citizen to retract its finding that the insurer had wide swings in written premium, even though the organization did not include USAA, which writes personal lines insurance, on the list of insurers that were found to be potentially at risk.

"A thorough researcher would have found that USAA has shown positive growth in every year from 1970 to 1989 and has had no swings," said Robert McDermott, chairman of San Antonio, Texas-based USAA.

However, unlike Hartford, Aetna, AIG, Liberty Mutual and USAA, USF&G said it would not dignify the Public Citizen report by seeking a retraction, even though the insurer says it should pass four of the six tests and should thus be eliminated from the list of potentially troubled com-

Update

Lawyers E&O slip formed

LONDON—A lawyers professional liability insurance facility set up Oct. 1 by a Marsh & McLennan Cos. Inc. unit has attracted five major New York law firms.

The facility offers up to \$50 million in coverage, confirmed Roger Gladwell, chairman and chief executive of M&M unit Bowring Financial & Professional Insurance Brokers Ltd.

Coverage is placed in London—led by Lloyd's of London underwriter Stephen Burnhope, whose syndicate is managed by Merrett Underwriting Agency Management Ltd.—and with U.S. insurers including National Union Fire Insurance Co. of Pittsburgh, Pa., an American International Group Inc. unit.

Limits above \$50 million can be placed on an individual basis, Mr. Gladwell added.

Five major New York firms switched their professional liability coverage to the new facility on Oct. 1 from an established line slip placed by Minet International Professional Indemnity Ltd., Mr. Gladwell confirmed.

The five firms are: Skadden, Arps, Slate, Meagher & Flom; Weil, Gotshal & Manges; Cahill, Gordon & Reindel; Kelley Drye & Warren; and Breed Abbott Morgan.

Briefly noted

A District of Columbia workers compensation reform package signed into law last week increases benefits for injured workers and will increase employers' workers comp costs by about 11%, experts say. But a provision of the new law requiring employers that provide health care coverage to pay 100% of the cost of that coverage for up to 52 weeks for injured employees receiving workers comp benefits will probably be challenged in court as illegal under the federal Employee Retirement Income Security Act of 1974, observers said. . . . Wind, hail, tornadoes and flooding caused an estimated \$50 million of insured property damage in portions of North Carolina, Virginia, Maryland, Pennsylvania, New York, New Jersey and Connecticut Oct. 18-19, reports the Property Claim Services division of the American Insurance Services Group. . . . David A. Olsen has been elected chief executive officer of Johnson & Higgins, succeeding Robert V. Hatcher Jr., who will remain chairman until he retires at the end of the year. Mr. Olsen, who was elected president and chief operating officer of the brokerage in 1987, will retain those titles.

panies.

Baltimore-based USF&G said asking Public Citizen to change its conclusions would give the report credibility it does not deserve.

"We weighed the advisability of petitioning Public Citizen to change their conclusions, but we strongly believe to do so would, in fact, give credibility to their report. We will not do that," said USF&G Senior Vp W. Minor Carter.

"Had Public Citizen involved a regulator, a certified public accountant, an actuary or a certified financial analyst in any of their 'tests,' their calculations or their analysis, we would take this report seriously. Since no one with a scintilla of experience or qualification took any part of this report or its conclusions, we refuse to ask ill-equipped amateurs to analyze any of our data," Mr. Carter said.

Other insurance industry executives say the entire premise of the report—that six quantitative tests drawn up by Public Citizen can measure whether an insurance company could be financially vulnerable in a severe economic downturn—is flawed.

"There is no evidence that these tests mean anything vis-a-vis solvency," said Aetna Vp and Corporate Actuary Walter J. Fitzgibbon Jr.

"It is frustrating. Our company's name has been damaged by an irresponsible report," said Hartford's Mr. Westervelt.

Insurer rating agencies also are blasting the Public Citizen report.

Best's Insurance Management Reports, a weekly newsletter published by A.M. Best Co., said the Public Citizen study is "irresponsible and without credibility."

In an editorial, Best said: "Consumers and the industry deserve independent and objective opinions of insurer financial strength. But they certainly do not need to be exposed to attention-getting scare tactics."

"Overall, it does underline the fact that there are real difficulties in this sort of statistical analysis," observed William O'Neill, vp with Standard & Poor's Corp. in New

York. "These folks were not as experienced as they should have been."

Statistical data should be a starting point for analysis of a company and not an end point, added Alan Levin, an S&P senior vp. If an insurer's statistics are out of line with industry norms, the statistics should serve as a starting point for discussion with the company about what is causing the aberration, he explained.

Noting that there is a need to identify troubled insurers, Mr. O'Neill said Public Citizen focused on the wrong companies.

"They were in the right church but the wrong pew," he said.

S&P has assigned a triple-A claims-payment rating—its highest—to Hartford, Aetna and AIG. It has assigned Liberty Mutual a double-A+ rating and USF&G a double-A rating.

However, Public Citizen rebutted the criticism, stating that "the insurance industry's vituperative attack on our report shows that it is painfully aware of its overall accuracy and credibility. Unfortunately as it is, the mathematical error. . . does not affect the validity of the entire report."

Meanwhile, the National Insurance Consumer Organization, an Alexandria, Va.-based group that also has received support from Mr. Nader, hopes the uproar over mathematical mistakes in the Public Citizen report does not divert attention from other findings in the report.

NICO President J. Robert Hunter said there should be no disagreement over a report conclusion that state guaranty funds would not be able to cope with the failures of large, multiline insurance companies.

However, Mr. Hunter, who acknowledged he had not read the final version of the Public Citizen report released Oct. 15, said he did not completely agree with the findings of an earlier version of that report he had read. Mr. Hunter declined to elaborate.

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New York Bureau Chief Douglas McLeod contributed to this report.

Budget pact hikes PBGC premiums

By JERRY GEISEL

WASHINGTON—Employers with defined benefit pension plans will pay higher insurance premiums to the Pension Benefit Guaranty Corp. next year.

The federal budget agreement, which was expected to receive final congressional approval last week, will boost the basic annual PBGC premium that is paid by employers with fully funded or overfunded defined benefit plans to \$19 per plan participant from \$16.

In addition, employers with underfunded plans would pay as much as \$72 per participant, up from the current \$50 maximum.

Negotiators also were near agreement late last week on provisions that would boost FICA taxes, Medicare deductibles and add restrictions and higher penalties on employers terminating overfunded pension plans.

"The pact means more benefit cost increases for employers. Employers definitely took a hit," said Frank McArdle, a consultant in the Washington, D.C. office of Hewitt Associates.

The new budget pact also would boost taxes on the nation's life and property/casualty insurers.

However, it wasn't clear late last week whether the budget pact would also include a provision—contained only in the Senate-passed version of the budget legislation—that would retroactively restore the tax-favored status of educational assistance benefits. House budget negotiators were resisting including the restoration of Section 127 of the Internal Revenue Code, which had allowed employers

to provide up to \$5,250 in tax-free tuition reimbursement.

The final pact was expected to include a provision that would increase the amount of wages subject to the 1.45% Medicare portion of the FICA tax to about \$125,000 from the current \$51,300 limit.

The final pact also was expected to include a provision that would require public employers to pay the entire 7.51% FICA tax—which covers both Social Security and Medicare—for workers who are not covered under state and local government's retirement programs, such as part-time workers.

However, negotiators were deadlocked last week on a provision—contained only in the Senate bill—that would extend the Medicare portion of the FICA tax to all state and local governments and their employees. Currently, the tax does not apply to workers hired before March 31, 1986, if the employer does not participate in the Social Security program. The House bill does not include such a provision.

Meanwhile, the final budget agreement also was expected to raise the Medicare Part B deductible next year to \$100, up from the current \$75 deductible. The final agreement, though, was not expected to include a provision—contained only in the Senate bill—that would impose a 20% coinsurance requirement on Medicare beneficiaries for laboratory tests.

Negotiators late last week also were trying to settle differences in the House and Senate passed bills that would impose major new taxes and restrictions on pension asset reversions.

Regardless of the version agreed upon, the restrictions

are likely to be so severe as to virtually eliminate the practice of companies terminating overfunded pension plans as a quick and inexpensive way to capture surplus pension plan assets, benefit lobbyists said.

Meanwhile, property/casualty insurers said final changes agreed upon by negotiators would reduce the tax bite of a provision that would require insurers to reduce tax deductions for loss reserves by the amount they expect to receive through subrogation and salvage. Currently, income from subrogation and salvage is taxable when received. This change will be implemented prospectively in a "fresh-start" approach rather than retrospectively, as had been originally proposed. As a result, the tax bite is expected to be in the \$500 million to \$700 million range over five years, rather than the \$1.1 billion previously expected.

"This is exceptionally good news for property/casualty insurers, particularly in light of the very confused nature of the budget and tax process," said Robert E. Vagley, president of the American Insurance Assn. in Washington, D.C.

Late last week, congressional negotiators also were trying to reach a final agreement on a provision—in slightly different forms in the Senate and House bills—that would boost taxes on life insurers by \$8 billion over the next five years by requiring them to amortize over 10 years certain policyholder acquisition costs. Currently, insurers can immediately deduct those costs.

Life insurers last week were conducting a major 11th-hour campaign to soften the impact of the provision.

COBRA

Continued from page 1

The government is trying to shirk its responsibility to provide coverage to these individuals," said Howard Weizmann, executive director of the Assn. of Private Pension & Welfare Plans in Washington, D.C.

Benefit experts are less concerned about provisions requiring states to pay premiums—if cost-effective—to employer health care plans for Medicaid eligible beneficiaries who are employed and their dependents.

Some low-wage workers opt for Medicaid coverage rather than for employer-provided coverage because they cannot afford to pay the required premium contribution for employer-provided family coverage.

However, consultants note that most employees who are eligible for a group health care plan would probably be earning too much money to be eligible for Medicaid.

"There aren't that many Medicaid-eligible people who also will have access to employer health care coverage," said Chip Kirby, a principal with William M. Mercer

Inc. in Washington, D.C.

Benefit experts also are angry at the way in which the COBRA/Medicaid provisions became part of the budget legislation.

Like the original COBRA statute, the latest provisions are buried in much broader legislation that is hundreds of pages in length.

No hearings were conducted on the provisions, preventing employers from making their views known.

"Where were the hearings? Where was the discussion? This was all done behind closed doors. It is very frustrating and disturbing," said the APPWP's Mr. Weizmann.

Aside from making employers victims of government health care cost shifting, the COBRA/Medicaid provisions will impose new administrative burdens on employers.

For example, rather than receiving COBRA premium checks directly from beneficiaries, employers will have to establish new administrative systems to handle premium payments made by the state agencies administering Medicaid.

"Employers will have another bureaucracy to deal with: the

states," said Mr. Weizmann.

At the same time, the legislation leaves many administrative questions unanswered, notes Linda Havlin, a Hewitt consultant in Lincolnshire, Ill.

For example, under Internal Revenue Service regulations, employers now can terminate COBRA coverage if a beneficiary is more than 30 days late in making a premium payment.

The budget legislation, though, doesn't make it clear if coverage can be terminated if a third party—the state—is late in making a COBRA payment.

At the same time, it isn't clear how the state will be able to collect health care-related information about an individual to determine if it would be cost-effective for the state to pay a COBRA premium rather than provide Medicaid coverage. Presumably, such information would be confidential.

There are other practical problems with the measure, as well. For example, a beneficiary generally has 60 days—after being notified of his or her right to opt for COBRA—to decide whether or not to sign up for coverage.

Some experts are skeptical

whether states could move quickly enough to decide within this 60-day period whether it was cost-effective to pay the COBRA premium in lieu of offering Medicaid coverage.

If the COBRA/Medicaid provisions become law, it will mark yet another expansion of COBRA.

Under the original COBRA statute—the Consolidated Omnibus Budget Reconciliation Act of 1985—employers had to offer up to 18 months of health care continuation coverage to employees who terminated employment, except those fired for gross misconduct.

In addition, up to 36 months of coverage had to be offered to employees' dependents who lost regular health care coverage because of the death of the employee, divorce or marital separation.

Employers were allowed to charge beneficiaries a premium of up to 102% of the group rate. However, because beneficiaries opting for COBRA coverage often are those who anticipate using health care services, the COBRA premium rarely covers employers' actual costs.

Expansion of COBRA since the statute was signed into law in 1986

includes a 1989 change that gave former employees the opportunity to obtain coverage for 29 months—rather than 18 months—if they are ineligible for Social Security disability benefits.

In addition, another change enacted last year allows individuals with pre-existing medical conditions to retain COBRA benefits even if the individual later becomes covered by another employer's health care plan (*BI*, Nov. 27, 1989).

"The government is nickeling and diming employers on COBRA. But these are becoming bigger nickels and dimes for employers," said Ellen Goldstein, the APPWP's director of health care policy.

There have been other efforts to expand COBRA. For example, the Women's Health Equity Act, introduced in the House of Representatives earlier this year, included a provision that would allow beneficiaries age 50 and older at the time of COBRA eligibility to purchase COBRA coverage for up to 15 years (*BI*, July 30).

That proposal, assailed by employers, was not expected to be acted on before the Congress adjourns. ■

P&I clubs

Continued from page 3
1, 1991.

A spokeswoman from Thomas Miller confirmed that the club's members would be notified this week about the increase in next year's premiums, as well as about the supplementary premiums. However, she would not comment on specific figures.

However, U.K. Mutual's move to increase marine liability premiums is in line with decisions made by other P&I clubs, observers say.

Like all P&I clubs, U.K. Mutual insures the third-party liability risks of merchant fleets. The club writes an unlimited amount of third-party liability coverage for

risks like cargo damage, collision, wreck removal and crew illness. Coverage for third-party oil pollution liability is capped at \$500 million per incident.

Also, like other clubs, U.K. Mutual funds the payment of losses by asking its shipowner members for an annual "initial call" or premium at the beginning of each underwriting year on Feb. 1, plus a "supplementary call" decided by directors to finance any unforeseen increase in claims.

In the past few years, P&I claims have been escalating, noted the Thomas Miller spokeswoman, and "the claims pattern is showing no signs of changing."

Total outstanding liabilities, including incurred-but-not-reported losses less reinsurance recoveries, for U.K. Mutual totaled \$210.7 million for the year ending Feb. 1, 1990, compared with \$157 million for the year ending Feb. 1, 1989, and \$103.5 million for the year ending Feb. 1, 1988, according to the club's annual report.

Total outstanding liabilities, including outstanding liabilities from previous years that the club still must pay, have reached \$666.2 million, the report says. Discounted at a rate of 8.5% annually, total outstanding liabilities still reach \$531.7 million, it says.

However, the reserves available

to meet the liabilities—excluding investment income—now only reach \$587.4 million, says the report.

The club is making additional calls on its members "to help meet outstanding liabilities and top up reserves," said the club's spokeswoman.

The increased level of losses faced by U.K. Mutual and other P&I clubs since 1987 is in part due to major marine losses, like the 1989 Exxon Valdez oil spill in Alaska, which cost P&I underwriters \$400 million in oil pollution cleanup costs alone, added the spokeswoman. However, claims also have risen for other reasons,

including the increasing age of insured vessels, she added.

To help stem the tide of P&I claims, U.K. Mutual has introduced a "ship vetting" program whereby four inspectors hired by the club examine the seaworthiness of vessels belonging to club members, said the spokeswoman. These inspectors have been hired in addition to inspectors from independent classification societies, who traditionally test the soundness of insured ships.

So far, U.K. Mutual inspectors have examined 110 of the 8,000 vessels of all sizes—from barges to supertankers—that are insured by the club. ■

Datebook

NOVEMBER

NOV. 6. Boiler & Machinery Basics seminar in Chicago, sponsored by the Society of Chartered Property & Casualty Underwriters Chicago Chapter; \$25. Deb Heiden, 708-696-1500.

NOV. 7. Introduction to Risk Management for Non-Insurance Man-

agers seminar in Atlanta, sponsored by The College of Insurance; \$195 for college sponsors; \$225 for others. Jane Wechsler, The College of Insurance, 101 Murray St., New York, N.Y. 10007; 212-815-9201.

NOV. 7-8. Preventing Loss and Damage seminar in Pueblo, Colo., sponsored by The Transportation Claims and Prevention Council Inc.; \$295. Transportation Claims & Prevention Council, Inc., 120 Main St., Box Z, Huntington, N.Y. 11743;

516-549-8984.

NOV. 7-8. Schedule P and Loss Reserving seminar in Winston-Salem, sponsored by Booke & Co.; \$795. Insurance Co. Services Division of Booke & Co.; 919-748-1120.

NOV. 7-9. Environmental Regulation Course in Seattle, sponsored by Executive Enterprises Inc.; \$1,045. **Also Dec. 10-12** in Albuquerque, N.M. Executive Enterprises Inc., 22 W. 21st St., New York, N.Y. 10010-

6904; 800-831-8333; 212-645-7880.

NOV. 7-9. Effective Management and Direction of Malpractice Insurers and Trusts seminar in Atlanta, sponsored by the Tillinghast division of Towers, Perrin, Forster & Crosby Inc.; \$750. Mary Tschopp, Tillinghast Seminars, 1 Atlanta Plaza, 950 E. Paces Ferry Road, Suite 1100, Atlanta, Ga. 30326-1119; 404-365-1712.

NOV. 8. Managing Serious Burn

Injuries—the Appropriate Use of Burn Centers seminar in Sherman Oaks, Calif., sponsored by the California Workers' Compensation Institute; \$75. **Also Nov. 14** in Orange, Calif. CWCI, 120 Montgomery St., San Francisco, Calif. 94104.

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