OCTOBER 30,1997

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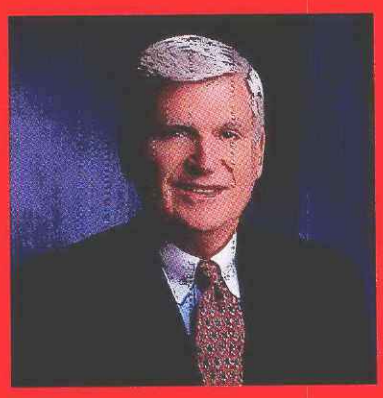

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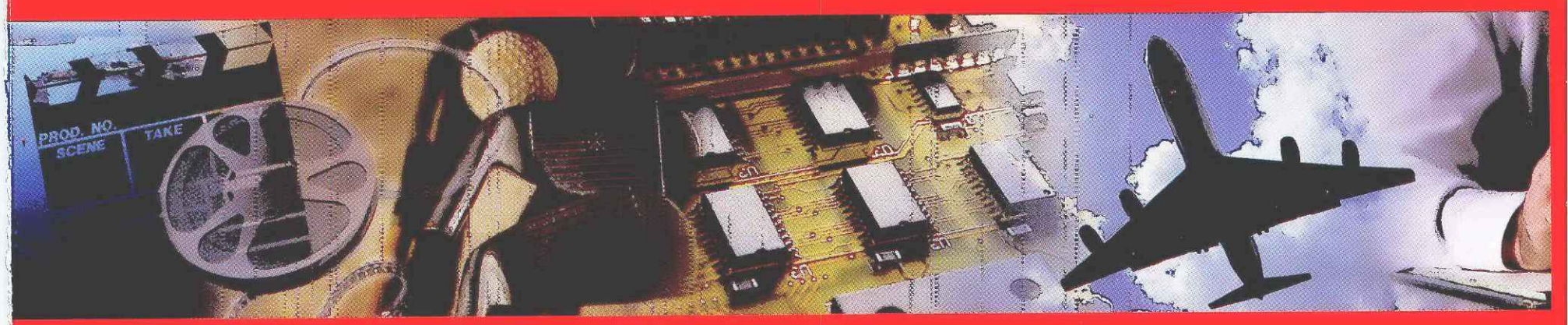

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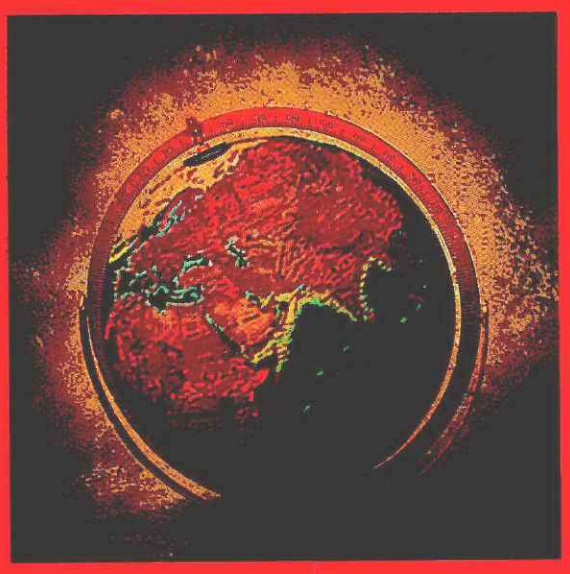

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OCTOBER 30, 1997

Business Insurance

Reporting Weekly on Corporate Risk, Employee Benefit and Managed Health Care News / $30

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30 years of B...surance

CHICAGO—Building on our commitment to excellence in journalism, *Business Insurance* celebrates its 30th anniversary and looks forward to covering the risk management, employee benefits and aged care co... during the ...
"Fre... goal has been to provid... the buyer of comm... insurance with... source ... about ...

McKenna Denise Reuther Bannon

Smiles and goodwill abound as the principals in the United Auto Workers and Ford Motor Co. contract talks shake hands after having agreed to a three-year pact. It still must be ratified by union members. Chief negotiators include Sidney F. McKenna, director of labor affairs at Ford; Malcolm L. Denise, Ford vice president for labor relations; Walter P. Reuther, UAW president; and Ken Bannon, UAW director of the Ford department.

Maxwell thinks Keeton scheme may be 'solution' to auto problem

PHILADELPHIA—A constitutional amendment may be required if this state were to adopt an automobile compensation system similar to the Keeton-O'Connell plan, said David O. Maxwell, state insurance commissioner.

Mr. Maxwell told the annual conference of the Delaware Valley Chapter of the American Society of Insurance Management, "The present state constitution prohibits any limitations on recoveries for personal injury or damage except in workmen's compensation cases." Limitations under the Keeton-O'Connell proposal would be $10,000.

"I would not say I favor the proposal in all its manifestations, but we have this matter under serious consideration because there is ... for a solution to existi... mobile liability pro... nsurance com...

...on-O'Con... fects, as ... facing ... and

Currently before the Pennsylvania Senate insurance committee, Mr. Maxwell said, is a bill to control cancellation and non-renewal of automobile insurance policies.

He said his department recently sent out questionnaires to companies and brokers in Philadelphia and Pittsburgh to evaluate the position of property insurance for riot-vulnerable areas. The target date for returning the questionaires is Nov. 15.

ONE SOLUTION to the problem, he said, could be the Boston

(Continued on page 7)

NAIC approves reserve fund

ATLANTA—The executive committee of the National Assn. of Insurance Commissioners voted unanimously to endorse a proposed amendment to the Internal Revenue code that would provide tax deferrments for reserve funds set aside to pay riot and other catastrophic losses.

James L. Bentley, president of the NAIC, and over 30 state insurance commissioners, who attended the special meeting on Oct. 20, moved that the proposal be sent to the insurance advisory panel of the President's Commission on Civil Disorders, headed by Gov. Hughes of New Jersey.

This was the first time direct action was taken on the proposal, which Mr. Bentley had outlined in earlier speeches (see story on page 22).

Specifically, the fund will allow insurance companies to take money from gross income and deposit it in a fund on a tax-free basis, provided it is used to cover catastrophic losses, such as riots.

A spokesman for Mr. Bentley said he expected the proposal would reach Congress before January, although the status of the tax inventive plan now rests with the insurance advisory panel of the President's Commission on Civil Disorders.

35¢ a copy; $8 a year — October 30, 1967

New Ford pact includes prescription drug and national medical plans

DETROIT—Increased life and health insurance benefits, fattened pension payments and the first national prescription drug insurance plan are included in the benefits package of a new three-year contract agreed upon by negotiators for Ford Motor Co. and the United Auto Workers.

For the first time, Ford workers will enjoy uniform hospital and medical benefits under a national account plan controlled by Michigan Blue Cross-Blue Shield.

For 160,000 hourly Ford workers, those benefits are the sweet frosting on a contract cake considered the most costly in auto industry history.

On top of wage increases, pegged at about 6% annually for a three-year period, Ford granted improvements in layoff benefits that give a worker with seven years' seniority a full year's income at 92% of his normal take-home pay.

ANALYSTS SAY the settlement, reached in the 46th day of a strike costly for both Ford and the union, is weighted toward wage hikes eagerly sought by the UAW rank-and-file. The gain is large enough, some observers say, that it will push up the level of wage gains in contracts yet to be concluded.

It also poses some major bargaining challenges for General Motors Corp., Chrysler Corp. and American Motors Corp., all lined up to renew UAW contracts.

Both the hefty wage gains and the richer layoff benefits, which UAW President Walter Reuther labels "guaranteed annual income," may prove snags to bargaining yet to come in the industry. In GM's case, such non-economic issues as the number of representatives accorded the union are reported to be potentially troublesome subjects of the upcoming talks.

BENEFIT EXPERTS for the auto companies guess, though, that for such matters as insurance and pensions, the Ford settlement has set a pattern for all the auto industry contracts. Said an official of one of the companies yet to bargain, "I don't expect benefits to be a stumbling block in any other negotiations."

Of the benefits embodied in the Ford-UAW pact, only prescription drug insurance is entirely new.

The drug plan, shuffled by bargainers to the third year of the pact, won't go into effect until October, 1969, but at that time it will become an important benefit for workers with high prescription bills.

It provides that all active UAW members and their immediate family members may buy prescribed drugs from pharmacies participating with the program for $2 for each prescription. The balance of the cost will be covered by payments to the pharmacist from Blue Cross in many areas and from John Hancock Mutual Life Insurance Co., Ford's life insurance carrier, in a smaller number of states. The present plan excludes re-

(Continued on page 7)

Sunken ship had no U.S. insurance

NEW YORK—The Panoceanic Faith, an American freighter which sank in heavy seas 870 miles south of Kodiak, Alaska, this month, was not covered by insurance in the U.S. market, Business Insurance learned.

"The American market is not too enthusiastic about old ships," said a marine insurance source, explaining that this was probably why domestic coverage could not be arranged. The ship was built in 1944.

It was understood that coverage for the Panoceanic Faith, valued at $1,000,000, was provided by Lloyd's and other British insurance companies.

Bound for Yokahama, Japan, from San Francisco, the vessel was loaded with a cargo consisting of 10,200 tons of fertilizer. "This type of cargo is generally not insured," the source continued.

Business Insurance

Reporting weekly on corporate risk, employee benefit and managed health care news

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Three decades of changes for *BI*

A look back at some of the milestones in our maturation

By KATHRYN J. McINTYRE

How long have you been a reader of *Business Insurance*?

Do you remember our first issue, dated Oct. 30, 1967, when many in the insurance business said a publication covering risk management and employee benefits was not needed?

Do you remember our first ranking of the largest U.S. insurance brokers, and executives of Johnson & Higgins refused to give us the firm's revenues, so we estimated them? That was 1972. And we estimated J&H's revenues every year until 1994, when the firm finally released its 1993 and 1992 revenues.

Do you remember our first Employee Benefit Communications Awards, to recognize employers' excellence in explaining what were then known as "fringe" benefits? That was 1973, before even the passage of ERISA.

Do you remember our editorial, "Sue the Bastards," in which we urged reform of the legal system before "liability is no longer insurable"? That was 1976.

Do you remember our announcement that we would present a "Risk Manager of the Year," and the furor that created among those who protested that no one person could be singled out for accomplishments? That was 1977.

Do you remember our first weekly issue on Jan. 7, 1980? Yes, we once published only every other Monday.

Do you remember the opening of our London bureau in 1981? We now have three people reporting from our London office and several correspondents elsewhere around the world.

Do you remember our Jan. 5, 1987, report on the San Juan Dupont Plaza hotel fire? That was the first time we went to press on a Friday night instead of a Thursday night, allowing us to get all the late-breaking news into the coming Monday's edition.

Do you remember the first time you saw a capitalized B and I in *Business Insurance*, replacing what I called our e.e. cummings logo? The capital letters first appeared in our Oct. 26, 1987, issue celebrating our 20th anniversary.

Do you remember the debut of our weekly International news page, reflecting both the growth of risk management around the world and the globalization of the insurance business? That was March 5, 1990.

Do you remember the first *Business Insurance* Workers Compensation Conference, where topics included integrating group health and workers comp programs? That was October 1993.

Do you remember the first production of RIMS-TV at the annual Risk & Insurance Management Society Inc.? That was April 1995.

Do you remember the launch of our home page on the Internet and the posting over the weekend of our late-breaking news reports from our "Updates" column? That was August 1996.

If you answered yes correctly to even one of these, you are a veteran reader who pays attention, and you have my sincere gratitude. If you answered yes to any of these but got the dates wrong, you still have my gratitude. And don't worry about your memory. I've been here almost 21 years, and there are a couple dates even I had to look up.

If you are a more recent reader of *Business Insurance*, you may be surprised by the dates of some of these milestones in our 30-year history, some sooner than you may have expected and some later.

On the occasion of our 30th anniversary, I wanted to recall a few of these innovations at *Business Insurance* because you won't find mention of them elsewhere in this anniversary issue.

In publishing this special commemorative issue, we wanted to chronicle and celebrate our shared experiences over the past 30 years, focusing on people, events and trends that have brought risk management, employee benefits management, insurance and reinsurance to where they are today.

We hope you find this special edition as informative and entertaining to read as we did researching, reporting, editing and compiling it.

And please read it carefully.

You never know when I will pop another unannounced quiz.

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from Wausau, Wisconsin, begins

offering innovative products along with

small-town doses of friendliness and personal

service. Their way of doing business catches on with

companies across the country. And their reputation grows.

They become the business insurance experts, from Wausau.

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People make the difference

Publication's knowledge a result of experienced leaders

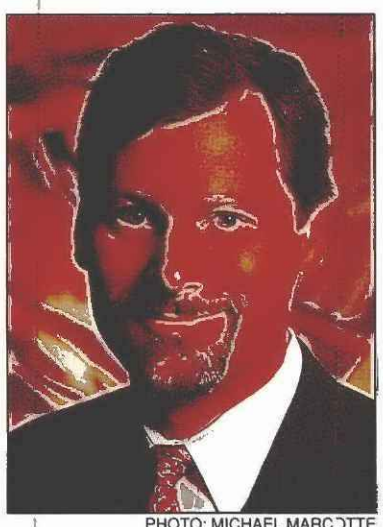


PHOTO: MICHAEL MARCOTTE

By PAUL D. WINSTON

This special anniversary issue celebrates the movers and shakers, history, trends, and future possibilities in the industries we cover: risk management, employee benefits and commercial insurance and reinsurance.

We hope this collection of interviews and features is informative and thought-provoking whether you've been in risk management or benefits for three years or 30 years.

In reviewing the first 30 years of *Business Insurance*, I am grateful to all the people whose contributions brought this magazine to where it is today.

As in any business, what makes us successful is our people. We are fortunate to have had over the years many staff members whose knowledge and ability are second to none.

We are even more fortunate to have many staff members who have been with *Business Insurance* for more than a decade, in several cases two decades.

I joined the magazine in 1985 and yet am a relative newcomer compared with some members of our staff.

Among *BI*'s current editorial, sales and promotion staff, five people have been with our magazine for more than 20 years; two have been with *BI* for more than 15 years; and 12 have at least 10 years of tenure.

Two members of the *Business Insurance* staff to whom I am especially indebted are:

• Kathryn J. McIntyre, publisher and editorial director, who more than anyone else is responsible for guiding BI to where it is today.

Kathryn joined BI in 1977 as a reporter and quickly moved up the magazine's management ranks, culminating in being named editor in 1980 at age 28. She remained editor until 1992, when she was named to her current position as publisher and editorial director of the magazine.

As not only a journalist but also a woman trying to get a foot in the door of the male-dominated world of insurance, her job was no small challenge. But she rose to that challenge and in doing so has won the respect of the insurance industry for her tenacity, integrity and journalistic acumen.

A lot of doors are open to our staffers today because of Kathryn's efforts.

• Editor-at-Large Jerry Geisel, who has covered Washington for BI since 1977. Jerry not only has covered hundreds of legislative and regulatory developments affecting employers, but uncannily recalls the page number and issue in which we reported on many of them.

His knowledge of benefits issues gives readers invaluable insights and has helped establish the credibility of the magazine with sources in Washington and elsewhere.

Jerry's experience also has been integral in guiding other staff members and assisting with many special projects.

Many of you also know our two senior editors who have been with the magazine for 15 of its 30 years: Douglas McLeod and Stacy Shapiro.

Of course, there are many other people on whom I depend to put out the magazine each week.

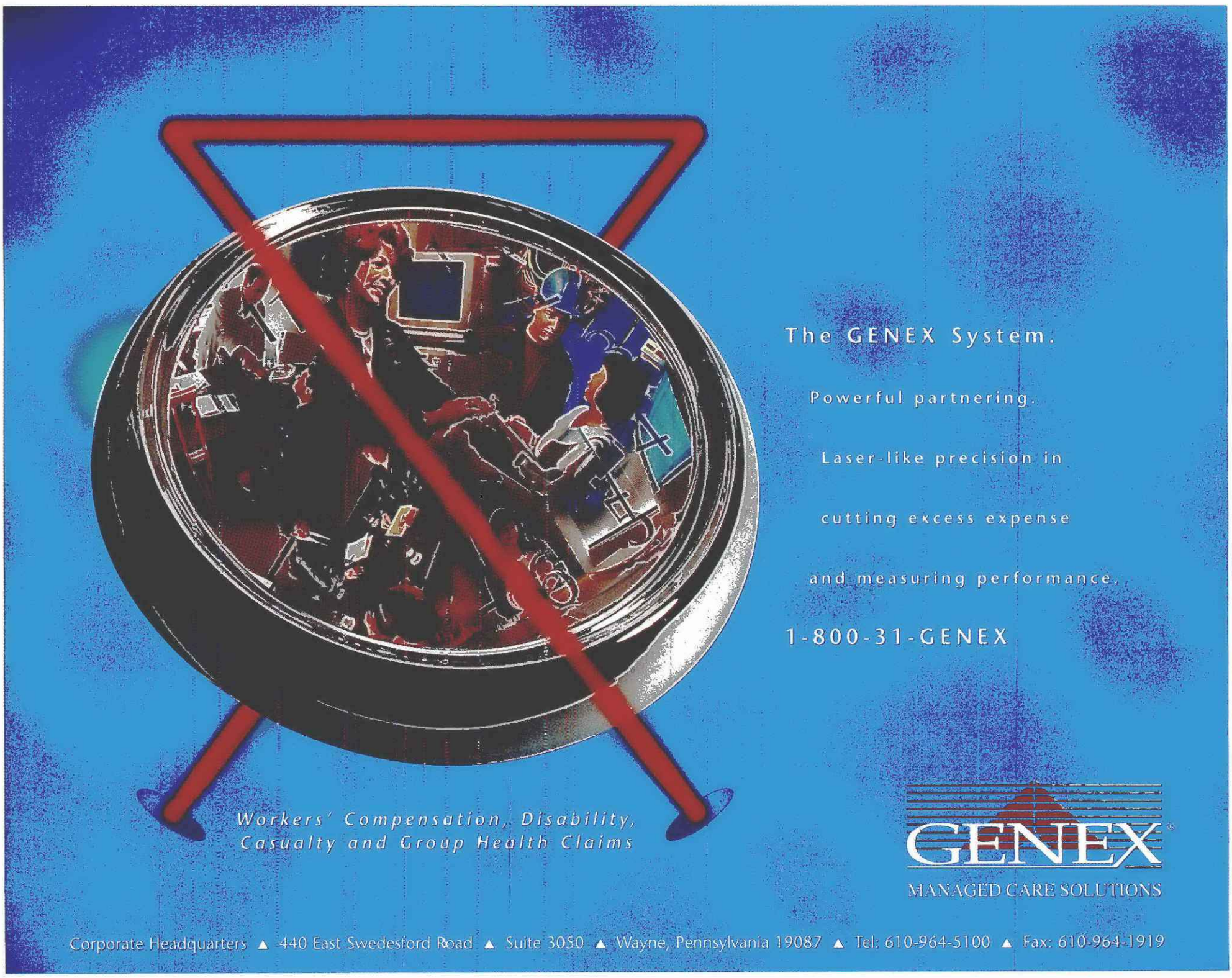
Our reporters are our public face. They develop relationships within the industry and with our readers, do the legwork and reporting on the news and trends that our readers depend on to make informed business decisions.

Less visible, but no less integral, is our copy editing staff. They strive to keep our prose polished, our facts straight and to make our headlines zing.

Other critical members of the team include our senior managers, graphics staff, directory editors, salespeople, promotion staff, circulation, production and administrative staff.

Now that you know who's really behind this magazine each week, we thought you might like to see what they look like. Photographs of the staff appear on page 128.

As we celebrate our 30th anniversary, I raise my glass to toast all the people within *Business Insurance* past and present who have made it possible. 30



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1987 *10th* 1997

Our reach is truly global, with a London branch office and a Lloyd's syndicate. We have expanded into Latin America with operations being coordinated out of our office in Miami. TIG Re is rated "A" (Excellent) by A.M. Best Company and has $661 million of GAAP equity.

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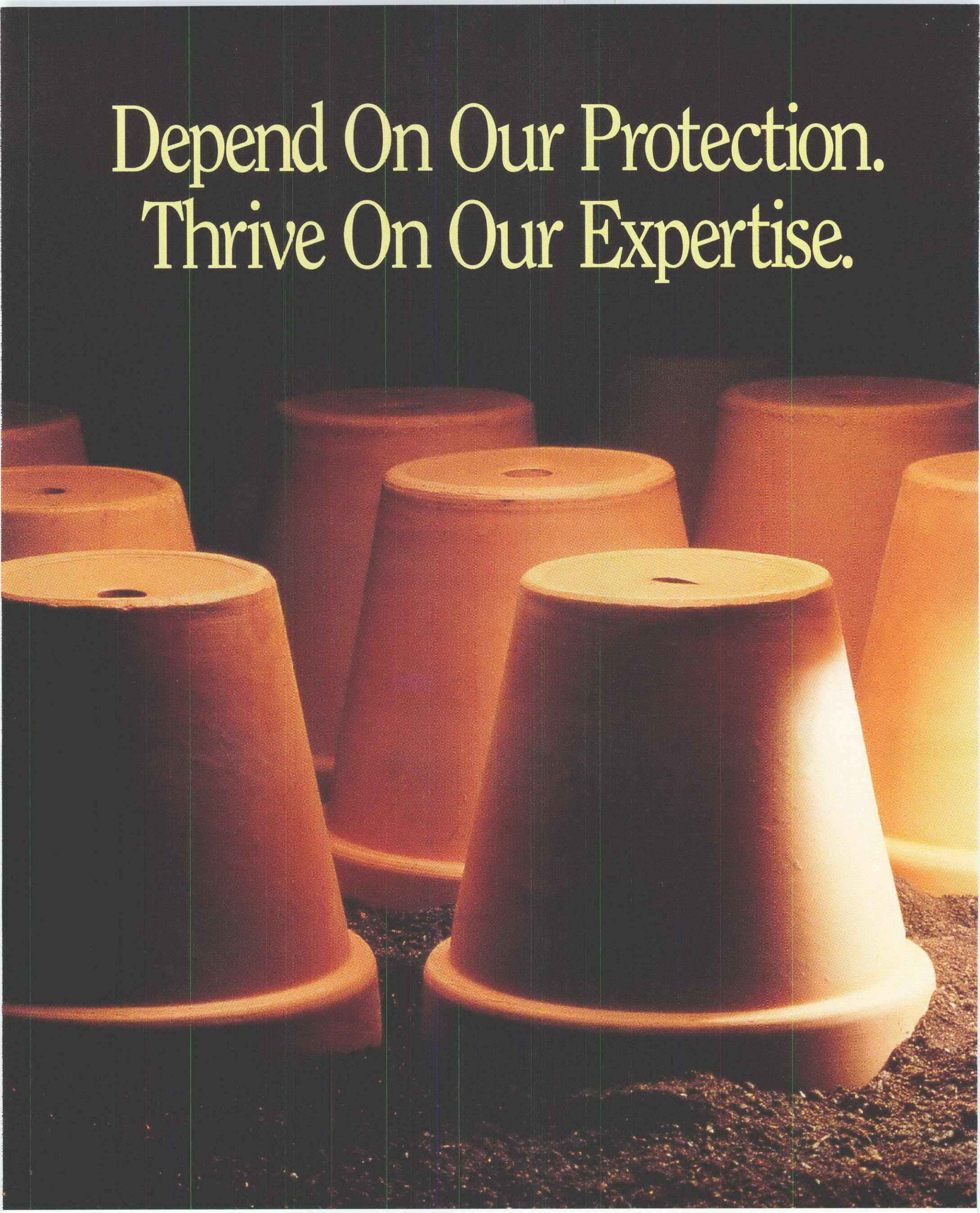

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30

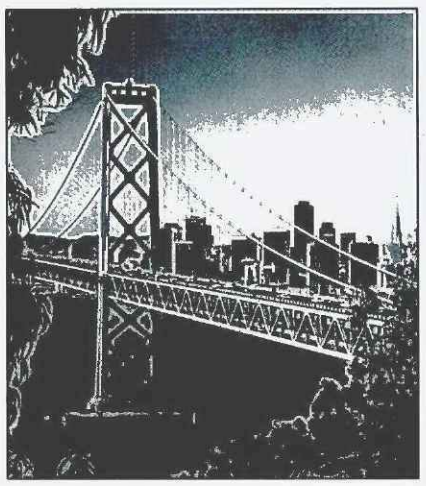
A LOOK BACK

1967 • 1971

—1967—

● Racial trouble in Milwaukee prompts the city to seek catastrophe insurance that would include coverage for race riots. However, the city receives no bids on the coverage after sending letters to 47 insurance companies and associations. The city says it plans to try again.

● In its inaugural editorial, *Business Insurance* writes in part: "In this issue, we've focused on this summer's riots as tangible evidence of the tightening insurance—and reinsurance—markets, but we recognize that the riots are by no means the cause of the capacity problem. A series of natural catastrophes, such as Hurricane Betsy, which caused more than $600 million worth of damage, the McCormick Place fire (in Chicago) and various other floods and hurricanes, have all contributed to the shrinking market."



● The directors of the Golden Gate Bridge in San Francisco "regretfully" accept a three-year multiperil insurance contract that covers the bridge for $46 million, less than a third of its total value and almost $10 million less than the amount for which the bridge had formerly been insured. The San Andreas earthquake fault is a reason cited for the reduced coverage. Meanwhile, *Business Insurance* learns that New York's George Washington Bridge is covered for the maximum amount.

● Sinclair Oil Corp. and its broker, Marsh & McLennan, put together an all-risk liability policy that covers automobile and public liability, workers compensation and employer's liability and protection and indemnity insurance.

● The new comprehensive general liability policy draws criticism from buyers, insurers and agents at an American Management Assn. conference.

● Proposals to develop a formula for federal drug reimbursements and to include drugs in Medicare are defeated in the Senate's version of the Social Security legislation. In light of a Ford Motor Co. contract that agrees to provide prescription drug benefits to the automaker's workers, benefit managers are predicting that such benefits will become standard.

● Dr. Joseph W. Ehrenreich, director of the University of California's research institute for business and economics, tells a group that buyers must unite their efforts and use bargaining power to reduce health care costs.

—1968—

● A capacity shortage at Lloyd's of London prompts the market for the first time in its history to ask for investment from outside the United Kingdom in an effort to get new capital into syndicates.

● About 615,000 railroad workers—more than 95% of unionized rail employees—agree to a health and welfare plan that is the largest U.S. private benefit plan, with annual premiums of $220 million.

● Sixty-two children born malformed after their mothers took the drug thalidomide will be paid settlements that could total $6 million for the insurers of the company, Distillers Co. Ltd., that made and marketed the drug. As part of the settlement, the families are withdrawing allegations of negligence against the company.

● In the wake of the assassination of Sen. Robert F. Kennedy, the American Risk & Insurance Assn. will set up a commission to probe the social responsibility of the insurance industry in a complex, sophisticated society. In the same issue, *BI* runs an editorial that takes up half the front page and bears the headline, "Guns must go!"

● Hurricane Betsy will cause Lloyd's to post the first loss in its 280-year history when 1965 operating figures are released. However, Chairman Ralph Hiscox expects "marked improvement" in 1966 and 1967.

● P. Lorillard Co. assigns group life insurance coverage for one division's 235 employees to the North Carolina Mutual Life Insurance Co. The deal, involving a $2.2 million policy, is believed to be the first of its kind in the United States between a large corporation and a black-owned company.

● Baseball's Satchel Paige joins the Atlanta Braves as a player and pitching coach to get in the 158 days of service he needs to meet a five-year qualification for pension benefits. Mr. Paige's minor league years were no credited.

● Blue Cross of Oregon looks at home health care as a way to cut the high cost of hospitalization.

● Colonial Stores President Ernest F. Boyce proposes cafeteria benefits and suggests employees be allowed every five years to choose their benefits.

● American Telephone & Telegraph Co., the world's largest private employer, will pick up the cost of the company's group life and basic medical programs, beginning in 1970.

● Medigap policies are one of the new benefits offered by the American Assn. of Retired Persons and the National Retired Teachers Assn.

—1969—

● Lloyd's of London names the first seven U.S. members of what had been an all-British underwriting society.

● Coverage for treatment of drug and alcohol addiction is extended to most of the nation's 2.5 million civil service employees as part of regular medical benefits.

● Lloyd's of London decides for the first time to admit women in January 1970. Women must be British and permanent residents, and they will do business through agents rather than conduct business personally in the market.

● Student unrest causes headaches for campus insurance managers. "God knows what will happen in the future," says a lawyer involved in the insurance program at Brandeis University in Massachusetts.

● More than 40 U.S. citizens are among as many as 160 killed—about half were on the ground—when a DC-9 bound for Miami crashes in Venezuela in the worst disaster in aviation history. U.S. Aviation Insurance Group is the sole reinsurer for hull and liability in the crash. The plane is insured for its full value of an estimated $4 million.

● Malpractice insurance is canceled for Dr. Denton Cooley, who performed the first heart transplant using an artificial heart, after he performed the operation. Dr. Cooley and other surgeons on his team get coverage reinstated with another company.

● Alexander & Alexander prepares to go public with an offering of 290,000 shares to the public and 10,000 to employees, making it the third-largest U.S. broker the third to go public.

● The 5th U.S. Circuit Court of Appeals issues an 8-3 decision to overturn an earlier ruling that found American Tobacco Co. "absolutely liable" in the death of a lung cancer victim.

● An insurer advises doctors prescribing birth control pills to get patients to sign statements acknowledging "awareness of the serious risks involved."

● *Business Insurance*, through an investigation, learns of a manuscript insurance policy to cover the $1.4 million contract of Lew Alcindor, who signs with the Milwaukee Bucks. It is the largest player contract in sports history. Policy limits are rumored to be in excess of $600,000.

● No special insurance is in place to cover samples of the moon in transit or in possession of scientists or universities. "There's no way to insure something that's irreplaceable," a spokesman said.

● The Bahamas' Insurance Act of 1969, which calls for registration with the government, minimum capital reserves and reporting of financial statements, among other things, prompts U.S. captives to leave for locations such as Bermuda. Some leave upon introduction of the legislation, and others plan to leave after its enactment.

● Hurricane Camille is called the most violent storm in U.S. history, but losses are not expected to reach the $700 million level of insured damages Hurricane Betsy caused in 1965.

● Clothing workers in the Baltimore area pay 2% of their gross pay to finance a day care center for the children of working mothers. The center, which will accommodate 325 children, results from a collective bargaining agreement between area clothing companies and the Baltimore regional joint board of the Clothing Workers union.

● Companies increasingly turn to computer printouts to communicate benefit plans to their employees.

● Broker Frank B. Hall & Co. announces it intends to go public.

—1970—

● The cake for the wedding of Tiny Tim and Miss Vicki is insured for $1,000.

● A survey by the Assn. of Insurance Managers in Industry & Commerce in the United Kingdom shows risk management is growing in stature there as a profession.

● A Securities and Exchange Commission study that notes the "striking" change in pension fund asset distribution says private pension plans invested more than half their assets in common stocks in 1969.

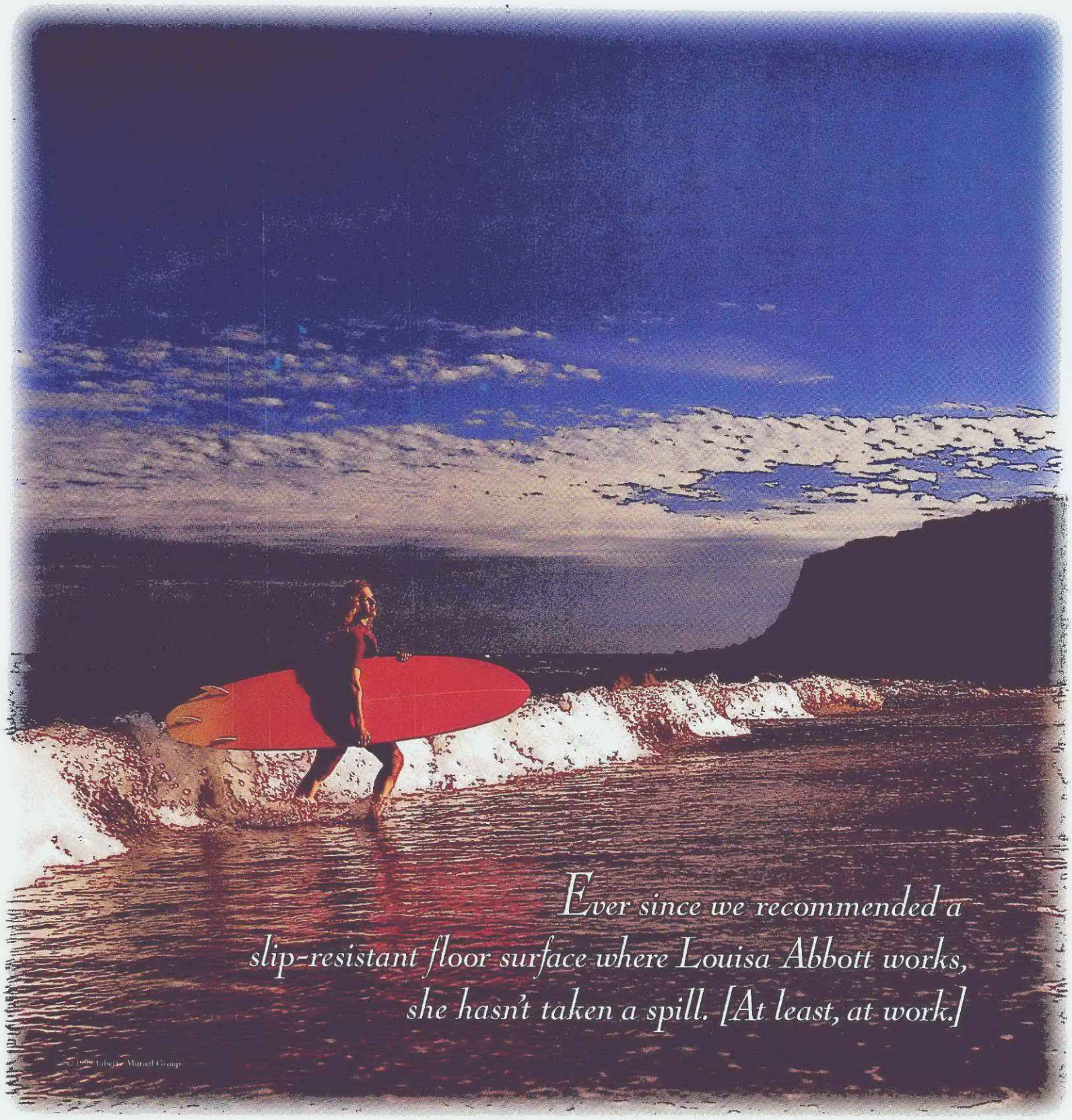
● The Continental Can Co. and American Can Co. institute a dental plan covering about 6,000 employees in what is believed to be the first uniform, nationwide, non-contributory dental program in U.S. industry.

● Health insurers generally agree that group and individual policies will cover abortions in the event a New York state bill legalizing all voluntary abortions—the most liberal in the country—becomes law. The bill later becomes law in New York.

● U.S. companies are not panicking over India's expected takeover of general insurance companies in the country and think that India will welcome them back in a few years.

Continued on page 12

WITH OUR POLICYHOLDERS WE ARE ENGAGED IN A GREAT MUTUAL ENTERPRISE. IT IS GREAT BECAUSE IT SEEKS TO PREVENT CRIPPLING INJURIES AND DEATH BY REMOVING THE CAUSES OF HOME, HIGHWAY AND WORK ACCIDENTS. IT IS GREAT BECAUSE IT DEALS IN THE RELIEF OF PAIN AND SORROW AND FEAR AND LOSS. IT IS GREAT BECAUSE IT WORKS TO PRESERVE AND PROTECT THE THINGS PEOPLE EARN AND BUILD AND OWN AND CHERISH. ITS TRUE GREATNESS WILL BE MEASURED BY OUR POWER TO HELP PEOPLE LIVE SAFER, MORE SECURE LIVES.



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Continued from page 10

● A jury in Miami awards a 21-year-old man $2.25 million in damages in what is described as the largest judgment ever returned in an individual personal injury suit in the United States. The victim was crippled from the waist down in an automobile accident.

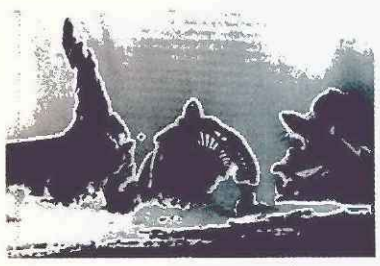
● *Business Insurance* learns that the insurance industry soon will exclude pollution coverage from policies on U.S. companies that knowingly pollute. Lloyd's has made a similar move, but members of its syndicates may or may not adhere to it.

● Because of Ohio's sovereign immunity, Kent State University does not carry liability coverage for the deaths of four students and the injuries of six others shot by Ohio National Guardsmen in protests over the U.S. incursion into Cambodia. Any payments of any claims would come from state funds, an official in the state's attorney general's office says.

● The Insurance Co. of North America is setting up the nation's first privately owned and operated rehabilitation company. The company will operate independently of INA.

● A comprehensive plan for national health insurance is released, with the major thrust being "to use the mechanism of financing to bring about a rational reorganization of health care and its means of delivery in the United States." Perhaps the most controversial part of the plan is that the entire private health insurance industry would be excluded.

● The acquisition of Great American Reserve Corp. by J.C. Penney Co. is compared with the move Sears, Roebuck & Co. made years earlier in entering insurance with Allstate Insurance Co.



● Palestinian commandos blow up a Pan American 747 in Cairo, Egypt, resulting in the largest claim filed to date for a single aircraft. It was worth $24.5 million. The 155 passengers were evacuated before the explosion.

● As of January 1971, the University of Pittsburgh's Blue Cross & Blue Shield policies will provide maternity benefits to the unwed daughters of subscribers, and single women will be allowed to sign up for family plan policies that will cover therapeutic abortions.

● Firemen's Insurance Co. of Washington, following in the steps of many peers, cancels 5,500 homeowner and business policies in Washington, D.C., because of social unrest.

● Gulf & Western Industries disbands its 24-person insurance department in favor of a risk management company. The move is expected to trim G & W's insurance management overhead by 50%, with savings coming primarily from the elimination of duplicate efforts of its broker and the company insurance department.

● In a major victory, the United Auto Workers succeed in winning a "30-and-out" principle into a new three-year contract with General Motors, meaning length of service rather than age will determine when an employee can retire with a full pension.

● A fire at the Columbia Pictures ranch in California causes between $1 million and $3 million in damage, destroying Western street scenery with false-front buildings that were used as sets for movies such as "High Noon" and "Cat Ballou." Columbia says the losses are covered by a $12 million property policy.

● Even though employees at Theodore Hamm Brewing Co. in St. Paul, Minn., can choose between a beer break and a coffee break, the company has an excellent safety record. Hamm's record averages three to six lost-time injuries per million staff-hours worked, which is much better than the brewing industry's average of 17.68 lost-time injuries per million.

● Testifying before a Senate Labor subcommittee, labor representatives charge that employers inaccurately and deceptively report workplace accidents. Labor leaders allege that the 1969 workplace injury and death toll actually was twice the number reported by employers. A group of steelworkers from New Jersey tells the subcommittee, "You have guys with crutches or with their arms in slings being brought to work so that your lost-time report is not a true picture of the accident rate."

● The National Council on Compensation Insurance estimates that workers compensation premiums rose 11% in the previous year, to $3.5 billion. The NCCI also launches a new facility, the National Workmen's Compensation Reinsurance Pool, to provide reinsurance to insurers that cover assigned risks.

● A research committee supported by several large insurance companies suggests that an American version of Lloyd's of London may help ease the U.S. capacity crunch. The committee's report stresses that underwriting methods used by such a a centralized facility would be compatible with current underwriting methods and that the facility would be an additional source of capacity for U.S. commercial risks.

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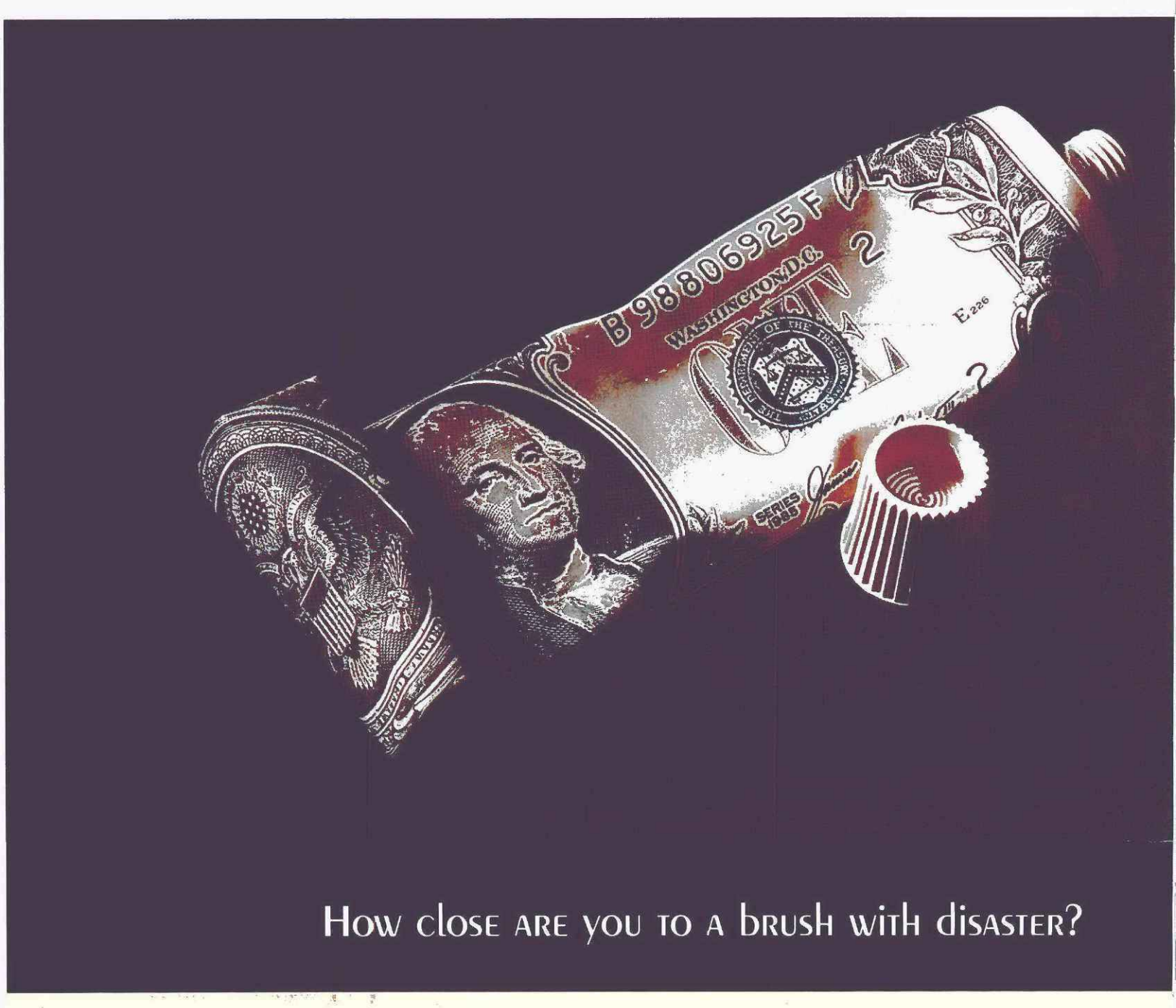

How close are you to a brush with disaster?

Alternative Markets Division, Florham Park, New Jersey
Facultative ReSources, Inc.,
Stamford, Connecticut; Atlanta, Georgia; Schaumburg, Illinois
Fidelity & Surety Division, Schaumburg, Illinois
Latin American & Caribbean Division, Coral Gables, Florida
Property & Casualty Treaty Division, Florham Park, New Jersey

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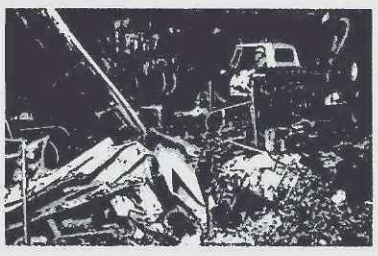
—1971—



● A new McCormick Place opens in Chicago almost exactly four years after an electrical fire destroyed the previous convention center. The new complex boasts $3 million in fire prevention systems.

● Lloyd's sues Penn Central Co. in an effort to nullify a $10 million directors and officers liability policy the company took out for its executives in 1968. Lloyd's essentially accuses the company of lying on its application.

● Twenty-five U.S. insurers, under the shell of the American Institute for Marine Underwriters, have formed the Water Quality Insurance Syndicate and in May will begin insuring water pollution cleanup costs in amounts up to $14 million per occurrence. The move comes a month after full implementation of the Water Quality Improvement Act of 1970.

● Bon Vivant Soups Inc. is voluntarily recalling thousands of cans of its soups, sauces and other canned foods after a can of vichyssoise turned out to be responsible for the botulism-poisoning death of an upstate New York man. Insurers say the company has no recall coverage.

● Illinois Gov. Richard B. Ogilvie, in the wake of 29 insurer failures since 1959, signs legislation establishing a state insurance guaranty fund.

● President Nixon's wage/price freeze leads to questions for insurers and corporate customers, although it does appear that increases on fringe benefits are frozen.

● More than 50 companies have been penalized for violations since the Occupational Safety and Health Act of 1970 took effect in April 1971, says a spokesman for Insurance Engineering & Inspection Co.

● Risk managers are angry about a plan of the Insurance Consultants' Society to publish standards for risk management programs, with a spokesman for the American Society of Insurance Management noting that even recognized scholars in the field cannot accurately define the broad concept.

● The U.S. Justice Department issues subpoenas for the financial records of several U.S. corporations that own captive insurers in Bermuda. The Justice Department orders at least eight companies to provide information on their Bermuda captives to a federal grand jury. Although the Justice Department declines to comment on its action, some sources suggest the government is looking into whether the increasingly popular offshore companies are violating any laws.

● Bermuda regulators announce they will undertake the first official count of captive insurance companies based in the domicile. A previous headcount was unavailable because Bermuda registers all companies under one category. Estimates of the number of captive insurers on the island range between 80 and 150.

● An appellate court upholds what some observers believe is the largest wrongful death judgment in the United States, a $1.8 million award to the parents of a 15-year-old boy who died when a foreign transport plane crashed into the building where he was working. The boy's 17-year-old brother also died when a Dominicana Airlines DC-4 crashed into the Miami auto paint shop owned by the boys' father. A lawsuit is pending in the older son's death. Coverage for the Dominicana Airlines plane is underwritten at Lloyd's.

● A three-day workweek becomes a reality for 180 computer operators at Manufacturers Hanover Trust Co. in New York. The new plan, intended to reduce the amount of overtime the bank pays, calls for employees to work shifts of 12 hours and 25 minutes, with a 45-minute lunch break and two 20-minute coffee breaks. Under the plan, employees at Manufacturers Hanover will work either Monday through Wednesday or Thursday through Saturday, with each period having one day and one night shift.

● No risk managers are named to President Nixon's 15-member National Commission on State Workmen's Compensation Laws, despite urging by *Business Insurance* that appointing a risk manager would give input on how changes in the law would affect employers' exposures. The American Society of Insurance Management also had nominated one of its members to serve on the commission.

● Bahamanian officials complete a crackdown on fraudulent insurers, screening license applications detail by detail to ensure the companies meet solvency requirements.

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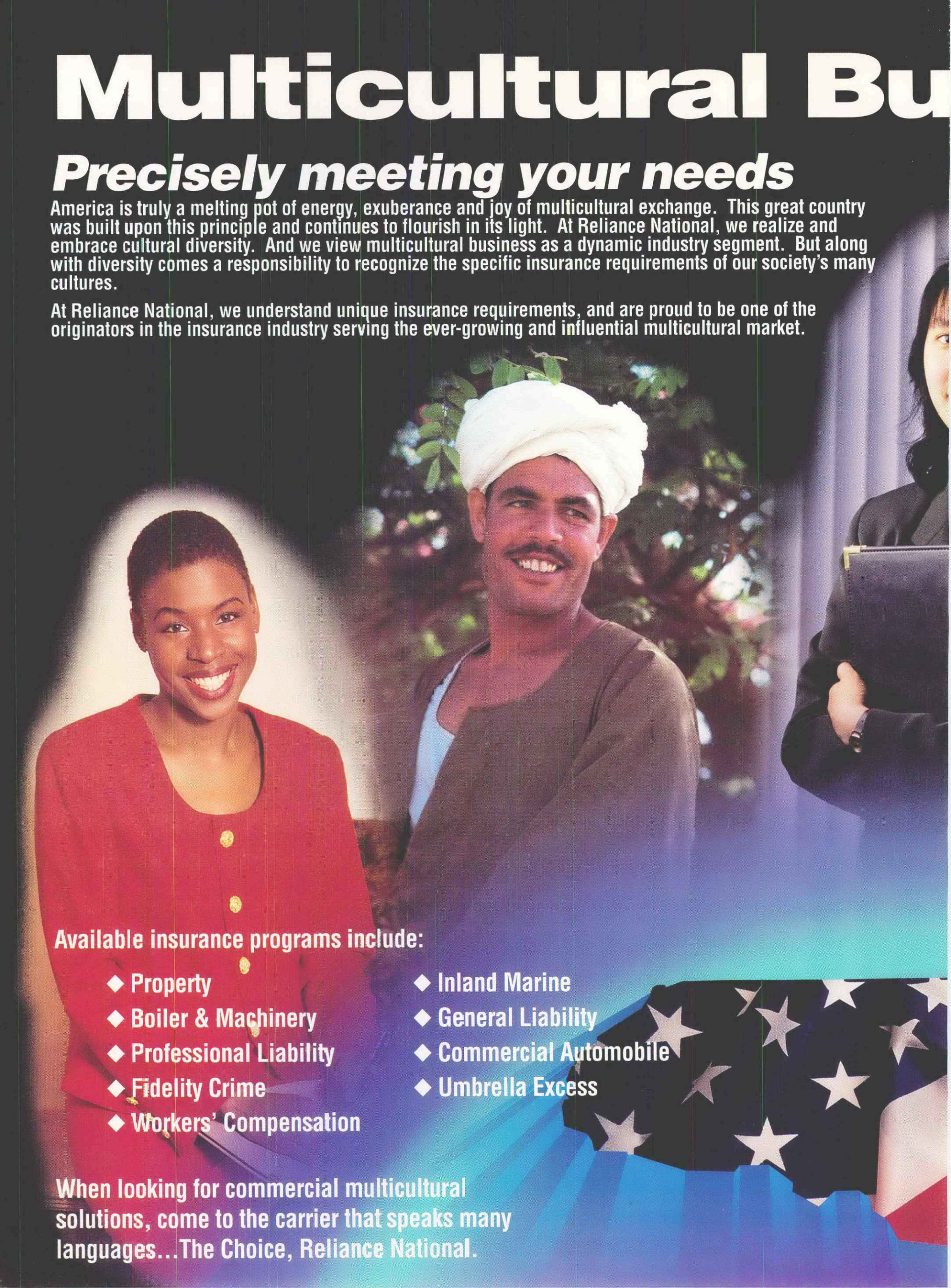

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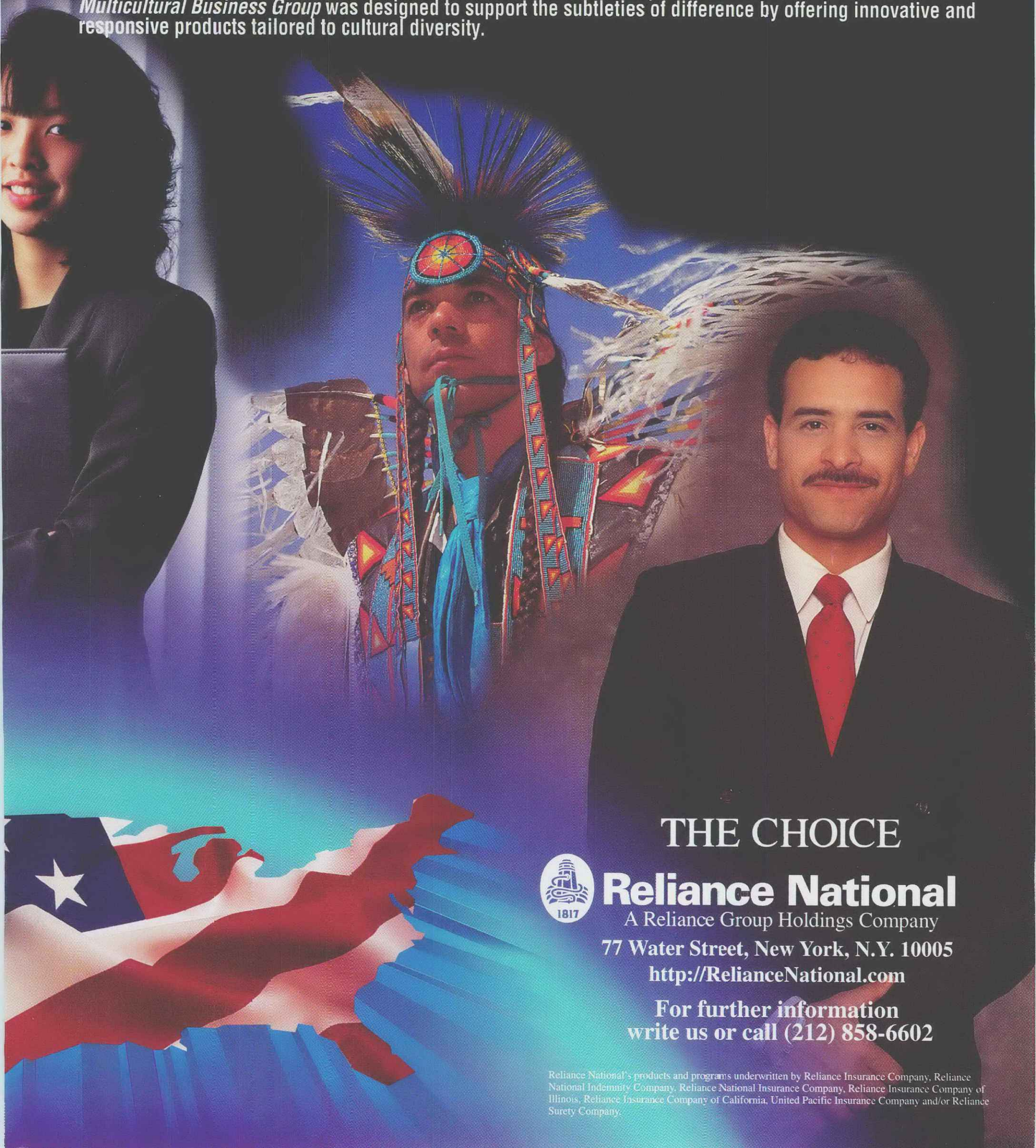

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30 VIEWS

Leslie Cheek

Former insurance lobbyist assesses challenges, past and future

What is a lobbyist's most important job? Providing reliable information, says Leslie Cheek.

Mr. Cheek should know. For 25 years, he was a lobbyist, first for the American Insurance Assn. and later for Crum & Forster Group. During that time, he was respected as one of the insurance industry's most skilled and hard-working lobbyists in Washington.

Mr. Cheek also knew the fine art of bridging differences. Behind the scenes, he developed the compromise that led to the enactment of the Risk Retention Act in 1981. Mr. Cheek convinced congressional staffers that there was no need for federal chartering of the groups, as had first been proposed.

During his tenure in Washington, Mr. Cheek has seen—in some ways for better and other ways for worse—how lobbying has changed.

Now retired, Mr. Cheek, 56, lives on a 38-acre horse farm in the Virginia countryside and occasionally consults on insurance issues.

He discussed his career as a lobbyist and other issues with Editor-at-Large Jerry Geisel.

Q: What did you like about being a lobbyist?

A: I liked the give and take, the opportunity to deal with intelligent, highly motivated people both in the private and public sector as well as deal with intellectually stimulating issues and the chance to find some common ground where there were divisions between the public and private sectors.

What did you dislike about lobbying?

The main thing I disliked was—at the end—the political fund-raising situation that kind of forced both members and the private sector to do kind of a dance that had more form that substance to it.

What do you mean?

There was a time when issues were decided more on the merits than on who had the political power through fund-raising and the like. The process became more politicized as time went by.

The other thing I disliked was the post Watergate-reforms. Even though one could make a strong case for government in the sunshine, what the lack of a closed mark-up does to a member is to force him or her to offer bad amendments for the sake of a local interest group that, were the local interest group's representatives not sitting in the room, he or she would be able to dish off and say: "I know this is a lousy amendment. I don't particularly want to push it. But if my folks ask you, please tell them that I fought hard for it and that it went down only after a strong fight."

As a result, now there is much more posturing, much more grandstanding, too much of what I would call soundbite media, where the issues truly get lost.

Are the problems caused by so much money in the system and the openness?

There is that—the money and government in the sunshine. The other thing is that, like it or not, issues are becoming more complicated. When I think back to the mid-60s, where the issue was: Are we or are we not to make sure insurance is available in our central cities? The simple answer is yes, we are, and here is a simple way to do it: state pools to whom members can be sold riot reinsurance. Very straightforward.

Contrast that with the Clinton health care proposal, which was well over a 1,000 pages. So, you can't blame process entirely for what is dislikable about politics now. You also have to consider substance.

How has lobbying changed?

Dramatically. When I worked on the Hill in the mid-1960s, the total staffing was around 7,000. As recently as the last Republican takeover, it was well over 20,000.

Proliferation of subcommittees, a great deal more process for every bill to go through. The other major change is that before, the game on Capitol Hill was very much a Washington game. Everyone had their representatives here. Everyone knew who they were. Most of the lobbying took place in Washington.

Now, with the explosion of grassroots organizations, the development of highly motivated interest groups—like the Christian Right—and single-interest lobbying groups, the process has become far more diffuse.

What are the implications of that?

The outcomes are far less predictable. It takes far longer to enact any of the initiatives. Look at product liability as an example. It still hasn't happened.

The Product Liability Alliance was organized in 1981 and here it is 1997 and we still have not enacted a broad product liability law.

Maybe that is because it is a tough issue.

It is a tough issue. It illustrates how diffuse things have become. In the early years of the product liability reform effort, the coalition existed primarily so each member of that coalition could count on the support of others for its particular fix.

For example, the tool and die makers wanted a statute of repose because their equipment lasted forever. Same with the general aviation manufacturers.

Automobile manufacturers wanted an end to joint and several liability.

There was not a core consensus as to what the important aspects of product liability reform were. But, as we've seen, the number of issues that the bill deals with dwindles each year.

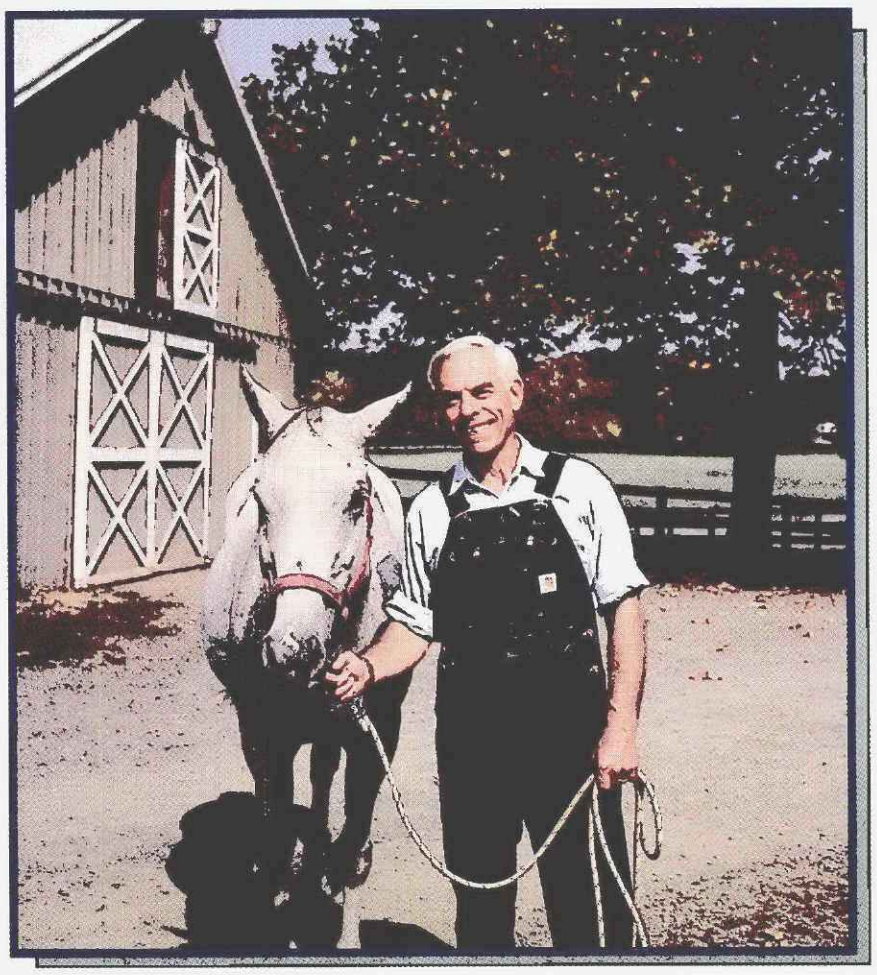

PHOTO:DAVID HITTLE

What are the most important functions a lobbyist performs?

The most important function is providing information, especially when issues are complex. It is important for members to have as much information from the various interest groups as possible in order to reach a rational and sensible position.

The second most important function is to build a bridge between the interest he or she represents and the public interest. Sometimes, it is easy to find a way to build that bridge. At other times, it has proven extremely difficult to do.

For example, we were able to do that with a fair degree of ease in the Risk Retention Act. But in product liability reform, it has been extremely difficult to get that bridge built.

What makes for a poor lobbyist?

One who is too insistent on getting everything he or she wants. It is important to understand, as the song goes, when to hold 'em and when to fold 'em. Those who don't when to fold them make ultimately lousy lobbyists.

What is your opinion of insurance industry lobbyists?

The insurance community has grown progressively more sophisticated in its lobbying efforts. I remember, when I was a Hill staffer, one lobbyist came in and presented me with his organization's demands, all of which, he informed me, were non-negotiable. I think now the industry is far more sophisticated in its substantive approach to the issues and in its willingness to recognize that the rules of the game have changed.

The industry has been swift, as in health care, to adapt to the new grassroots aspect of lobbying. It has mobilized its economic power through the political campaign contribution process. It has learned how to diffuse difficult issues. It understands the power of indirection, the power of the irrelevant to derail a change it does not want.

Can you give me an example?

The one that comes to mind most easily are the "Harry and Louise" ads that the Health Insurance Assn. of America put together. By focusing attention on a handful of minor provisions in a 1,400-page bill, the HIAA was able to mobilize public opinion against the entire Clinton health care package.

Are lobbyists from individual insurers more effective than those working for the trade associations?

I think there was a time when the answer to that would have been yes. But now the trade associations have staffed up to the point where by themselves they are formidable forces. What is more important, there was a time when

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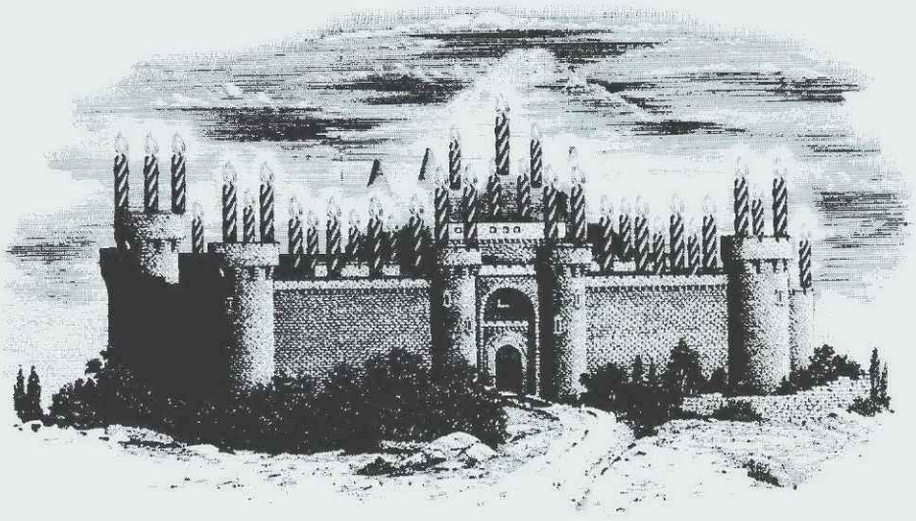

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HAPPY BIRTHDAY TO YOU
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HAPPY BIRTHDAY TO YOU.

(REPEAT 30 TIMES FOR FULL EFFECT.)

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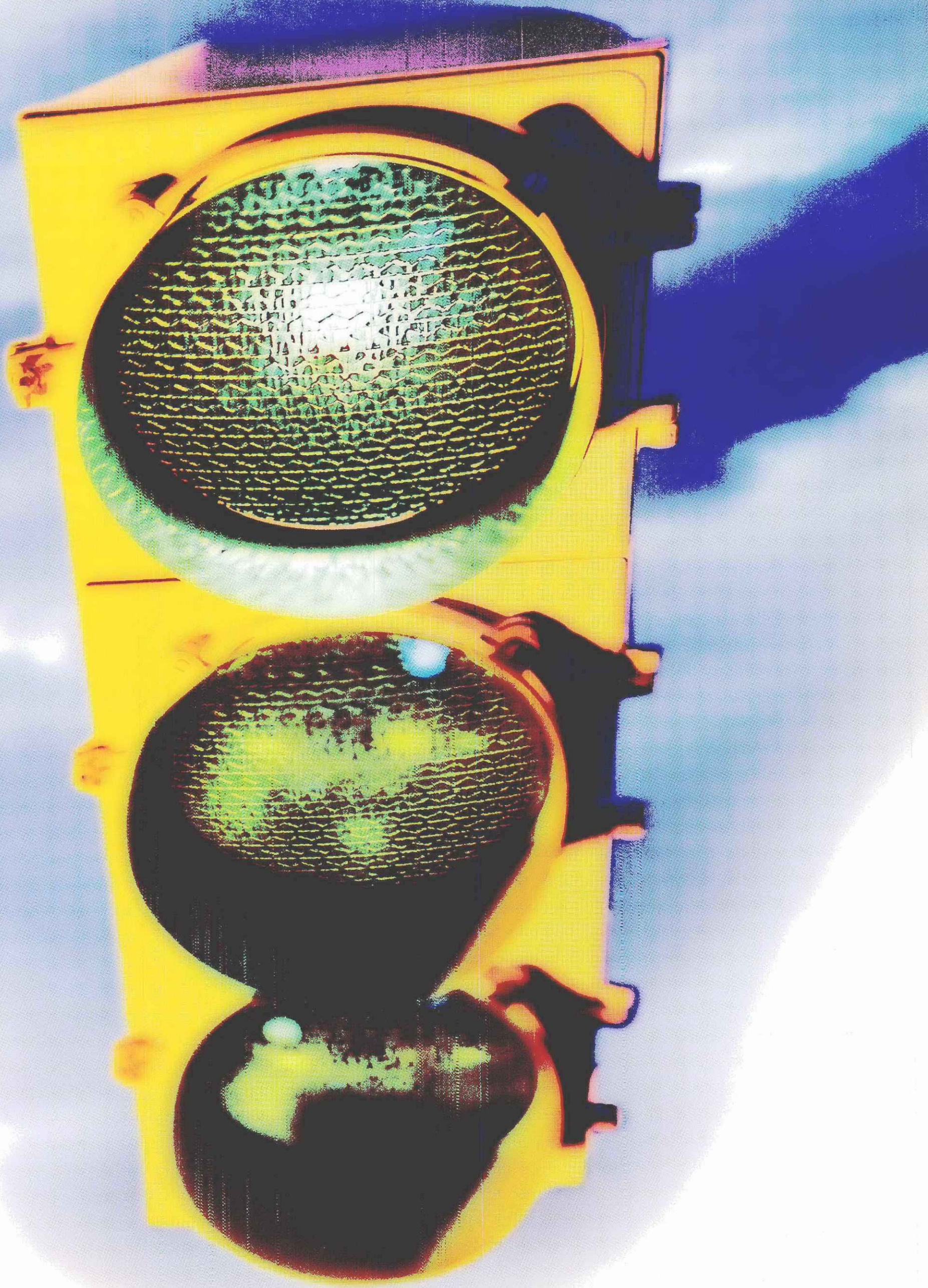

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Cheek

Continued from page 16

the trade associations viewed individual company lobbyists as a threat to their own individual viability.

Over the years, they have come to understand that the individual companies give them more muscle. There is a great deal of congeniality. Virtually all of the trade associations have the equivalent of the AIA's federal affairs subcommittee. They meet frequently and they divide up responsibilities. Now, you essentially have one well-oiled machine.

The other thing that has changed is the willingness of the trade associations to try to develop industry-wide consensus. The industry has discovered whenever it is divided, it fails. But whenever it is united, it more often than not succeeds.

What were some of the issues in which the industry failed because of divisions?

The most extreme would be the no-fault auto issue. You had a powerful, substantive reform that virtually the entire industry was behind. But the industry divided along traditional state/federal lines.

The example where it succeeded was ultimately the Risk Retention Act amendments, where the industry recognized that the original Risk Retention Act was a good idea but it needed some fine-tuning.

You played a key reform in the original Risk Retention Act. Why did you get involved?

The reason I got involved was that my company—Crum & Forster Group—was very active in the excess and surplus lines and reinsurance business. We were used to dealing with umbrella coverages and large excess limits.

Therefore, we did not see the idea of permitting business to band together to cover some level of their own exposures as a threat to our interests. In fact, we welcomed the opportunity to manage risk retention groups, to sell them whatever excess or umbrella coverages they needed.

We also recognized that insurance is much more efficient when it is utilized to cover catastrophic losses than when it is intended to cover losses from the first dollar. Administratively it is much simpler.

You sort of viewed employers as getting together and taking care of this primary layer of coverage, with insurers providing reinsurance or catastrophic coverage?

Exactly.

The risk retention legislation was highly controversial. The insurance trade groups were greatly opposed. How did you fashion a compromise?

I looked at the positions that both the congressional staffers and federal officials had taken on one hand and the industry's on the other to see if there wasn't some way of accommodating both of those interests. I felt that the industry had a good point at being concerned about the creation of a chartering entity in Washington. I think it would not have taken much imagination to see that becoming a federal solvency regulator with the power of life and death or insurers.

On the other hand, it made perfect sense to me that particularly big business or lots and lots of small business had a perfect and legitimate argument in saying they ought to be permitted—far more than state law at that point allowed—to take on some of their own exposure.

If you had your own dollars at stake, you probably were going to care a lot more about loss prevention than if you knew your insurer would pay from the first dollar.

In short, I saw some public policy benefits in the positions of the advocates of risk retention were taking.

How did you derive the concept of "Let's have the states do it, but once a risk retention group meets the requirements of one state it could operate throughout the country?"

It was an idea that Mike Mullen, then counsel to the Senate Commerce Committee, and I arrived at. Mike and I had these long discussions in which I said that our companies basically felt that risk retention was an acceptable concept. But I also told him we agreed with the industry view that having this done by an industry czar, if you will, was unacceptable.

I said to Mike, "What was the problem that people who wanted to form risk retention groups are encountering?" He rattled off a list of things like countersignature laws, limits on the ability to self-insure. In short, all kinds of statutory state wrinkles that had the effect of hamstringing the ability of a company with far-flung divisions and the like to deal with an insurance problem in a unified way. I said if those are the problems, why don't you selectively eliminate those problems and just say if you as a risk retention group meet the regulatory standards in a licensing state you can then use that licensing authority in that one state as a shield against any law in any other state that would prevent the law of your chartering state from being applicable to your operations.

Did you get heat when you brokered this compromise? What were others in the industry telling you?

It divided along predictable lines. Producers, almost uniformly, were hostile because it meant an agent in a chartering state could write business for the entire group. The agents had a much larger stake in things like countersignature laws and the like than companies did.

In the company ranks, the divisions also tended to be along equally predictable lines. Those who wrote generally primary coverages opposed it, while those like us, AIG and Chubb, who were comfortable in the excess limits and umbrella business, did not see this as particularly onerous.

Sixteen years later, what has been the legacy of the act?

It has proven to be less significant than it appeared to be at the time. But, particularly because of the Risk Retention Act, states have become far more sophisticated in their approach to self-insuring entities.

Do you means developments like captive laws?

Exactly right. I've seen it happen many times. For example, just the fact that Congress was seriously considering federal standards for state no-fault automobile insurance laws spurred 16 states to enact their own no-fault laws because they recognized no-fault was a good idea, and secondly, because they saw their own action as heading off perhaps something far worse from their point of view at the federal level.

I think the same thing has happened in the whole area of captive chartering and self-insuring. The states have taken a far more pragmatic approach to insurance regulation in part because they saw that Congress was willing to act and eliminate through pre-emption laws Congress thought were economically damaging.

What has been an issue where the industry was dead wrong, a position that still makes you cringe?

The issue I would pick would be the earliest stages of product liability reform, where the insurance industry was willing to embrace as its own cause every single business' beef with state product liability law. The early bills were crammed with changes, many of which would have made absolutely no difference in the predictability of a product liability risk, which should have been our only focus.

The insurance industry would have been far better off—indeed, product liability reform might have become law—had the industry said: "We're having a problem with product liability. What are the four or five key issues that make it difficult for us to predict liability risk?" I still think they boil down to a very small number: the collateral source rule; a statute of limitations; a state of repose; joint and several liability.

So the bills became a lightning rod for the opposition?

Yes, because there was everything, including the kitchen sink, thrown in those early bills. It became very easy for the trial bar to focus on the irrelevant as a means of defeating the relevant.

Product liability was an example where the industry was just dead wrong in embracing all of business' beefs instead of focusing in on its own self-interest, which was the ability to better predict product liability risk. 30

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30 VIEWS

Stanley M. Chesley

Plaintiffs' attorney perfects class-action strategy

Stanley M. Chesley was a little-known trial attorney in 1977, when he took a case that other lawyers rejected because the payoff didn't seem worth the trouble.

The case centered on a Memorial Day 1977 fire that killed 165 people at the Beverly Hills Supper Club in Southgate, Ky. Mr. Chesley, undeterred by criticism that the insurance payoff would be paltry because coverage limits were low, embarked on a bold strategy to sue multiple defendants that he contended were partly responsible for the fire.

The last of the defendants settled eight years later, bringing the total payout by all defendants to around $50 million.

It was no small victory. Mr. Chesley's tactics changed not only the direction of his career, but also how mass tort cases would be handled.

Since the Beverly Hills Supper Club case, it has become common for plaintiffs lawyers to sue multiple defendants in an attempt to find culpable parties in class-action lawsuits. They rely on the tactic and theories used by Mr. Chesley in the Kentucky case and in subsequent lawsuits such as those related to the MGM Grand Hotel fire in Las Vegas in 1980 and the 1987 Dupont Plaza fire in San Juan, Puerto Rico.

Mr. Chesley, 61, continues to pursue mass tort cases and has represented plaintiffs in dozens of prominent personal injury and product liability cases. He also is a negotiator with the Castano Litigation Group, one of the groups involved in the proposed $368.5 billion global settlement with tobacco companies.

From his Cincinnati office at Waite, Schneider, Bayless & Chesley, Mr. Chesley recently discussed the 1977 case and the future of tort law with Associate Editor Michael Bradford.

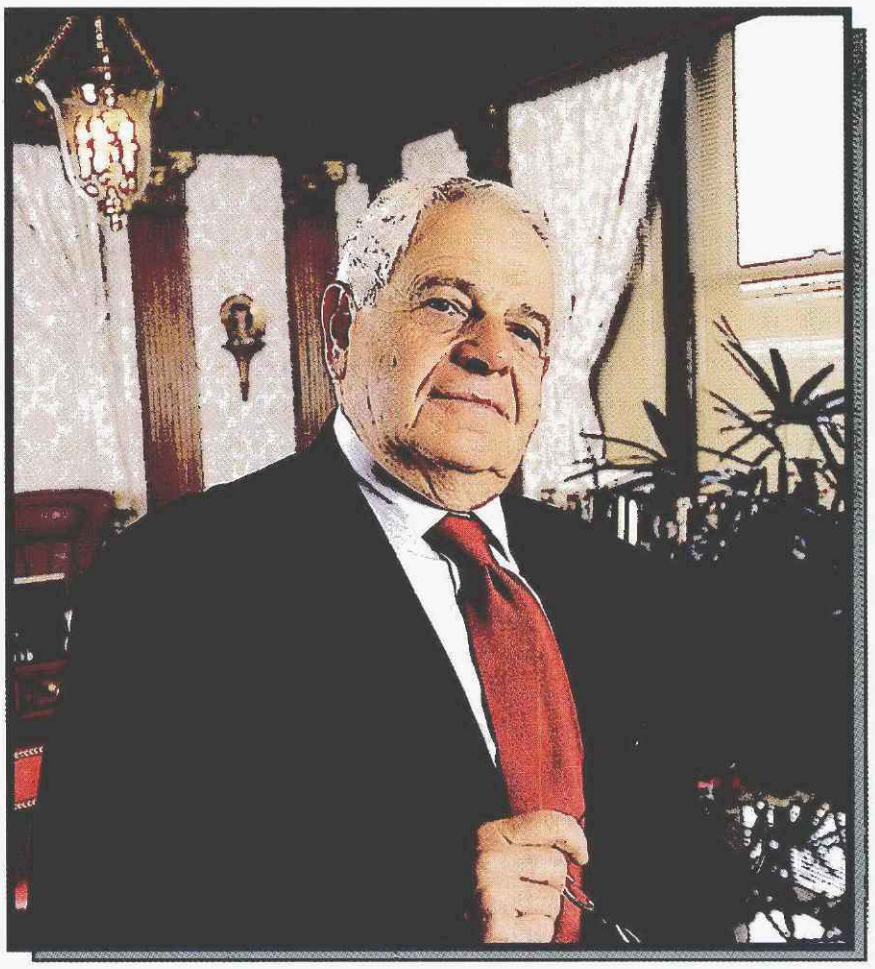


PHOTO: MICHAEL MARCOTTE

Q: Why did you take the Beverly Hills Supper Club case?

A: That was 20 years ago, I was 41 years old and had some good success in the courtroom. And there weren't a lot of people who wanted to get involved in this case because the owners only had $1.3 million worth of insurance. So I conceived the idea of suing a lot of different culpable defendants under the theory that they contributed to and were a proximate cause of the fire.

What lessons came from that case?

All fires are localized unless it's an explosion, and the question is, what causes them to spread? We learned a lot in that fire. We learned that what really spreads is the smoke and what really kills is the smoke, not the flames.

Back in those days, 20 years ago, they were talking about dying from carbon monoxide. Nobody had ever looked at toxic smoke, which is the hydrogen chloride and cyanide. We got into that and found a whole group of culpable defendants. Aluminum wire was a causative factor, the furnishings, the draperies, the carpet, upholstered goods. All of which was beyond belief. I'll give you an example.

(Mr. Chesley pulled a tiny bit of foam from an envelope marked "Beverly Hills" and touched it with the flame from a disposable lighter. The foam, the type found in the chairs at the supper club, burned for several seconds with a thick black smoke.)

That's cyanide. They didn't have the nerve to go in front of jury on this.

Was that the toughest case you've handled?

I think Beverly Hills was the toughest. I had limited resources at the time. I was groping with areas I was not familiar with, products that I had little or no familiarity with.

That was probably one of the most exciting cases because I wanted to make a difference. And instead of getting a million dollars, we got over 50 million, which back then was a lot of money.

We had a lot of interesting theories. We had enterprise liability and concert of action against the aluminum industry. And we copycatted a lot of things in the MGM Grand and Dupont Plaza fires litigation.

You have to understand, I live in Cincinnati, Ohio. I don't live in New York or even Texas or California. It's very exciting being a River City boy to be able to get involved in some of these things. And I think I've really been able to be on the cutting edge of litigation in the last 25 years.

Courts are taking a hard look at class-action settlements. Are we going to continue to see them? Will there be changes in the way they are handled?

I think the reality is the insurance industry is going to have to rethink how they handle mass tort.

What the insurance industry likes is time, diversion, delays, putting it in 50 jurisdictions with court delays, legal maneuvering. And the class action takes away the legal maneuvering because it's in one place, one trial. The reality is that most defendants, particularly insurance companies, do not want one trial. I realized that back in '77 and that's what I've been using as the pressure point.

They don't want the class action because they're assuming that it's so costly for the average person, who's afraid to go to a lawyer and who doesn't know what lawyer to go to. So they go to the advertising lawyer who's got a legal clinic or is in the yellow pages and doesn't know a darn thing about the case.

In some of these cases, I think the bad reckoning has come for earlier settlements because of the transaction costs of the litigation. There used to be a belief that a defendant could outspend the plaintiff, out-expert and outmaneuver them. That day is over.

And for every Stan Chesley, there's an army right behind me. Us old war horses, we've got a lot of trainees who are in the trenches ready to roll.

How will the Supreme Court's decision to deny class-action settlement of asbestos claims in the *Amchem* case influence future cases?

I think we're starting to see some impact. Some courts are starting to write about it. But I think it remains to be seen; it's fresh.

Part of the problem with *Amchem*, which I call *Georgine*, is how to deal with futures. The unknown future claimants are a problem. If you've got to protect them, how do you notice them? How do they fit into it? They must be dealt with fairly and that's a problem.

I think settlement classes with known claimants have a better result.

Another problem with class settlements is the issue of allowing some claimants to opt out. How should opt outs be handled?

I like the opt-out. Opt outs give everybody a right. You don't like the settlement, you don't like the deal, you don't like going forward as a class? Then opt out. But bear in mind you if you opt out you've got to file suit and go forward.

What is the likelihood that the tobacco industry's settlement proposal with state attorneys general will be approved by Congress?

I think it will.

We're working on some amendments, a tightening of the Food and Drug Administration piece.

It's a question of, when you've got anything new, what does that mean? Where does it go? Who's going to be looking at it? On this one, it's got to be approved by Congress.

People want to know why tobacco settled. I was at the negotiating table. It's very simple. You have 47 million smokers. If they were to lose 10% of their cases and win 90% every cigarette company would be bankrupt because of the volume of cases. It's the same with breast implants. Even if they win a vast majority of the cases, they can't survive.

And the other thing is, they can't put together as many good trial teams on the defense side as we can on the plaintiffs side. We have more bodies, we have more people that are in tune with it, we have more people that are knowledgeable about it.

Will the tobacco settlement remain unique or will there be others structured the same way that will need the approval of Congress?

I think it's too early to tell. It's intriguing. I think the law is ever, ever evolving.

This is very interesting because there are no insurance companies involved.

Continued on next page

Continued from previous page

This is a non-insurance case. In most litigation you have the plaintiff, the defendant and the insurance company.

As things go forward and the plaintiff starts to do better, there becomes a civil war between the insurer and the insured. And then you have a third wave of litigation which is the reservation of rights, failure to pay, the bad faith claims, refusal to participate in the settlement.

Every major case that I've been involved in over the last 18 years has involved these ongoing tangential pieces of litigation: the defendant suing the insurance companies for declaratory judgment. And asking for our help.

For example, in the MGM fire, we testified by deposition for MGM against an insurance carrier. The insurance carrier thought that when we got to about $250 million, it was punitive. We testified that our position was it wasn't punitive, that this was fair compensation and their evaluation of the case was just plumb stupid.

How do you respond to the criticism aimed at attorneys' fees that are paid in class action cases?

My answer to the attorneys' fee issue is that it's a red herring that the insurance industry likes to talk about. When I tell you that the tobacco industry spent $600 million in attorneys fees last year, that doesn't seem to bother anybody. They say, "Well, they have a lot of things going on, they have a lot of lawyers."

But if plaintiffs lawyers get $600 million, there's a hue and cry. And that's the spin the insurance industry has put on it. They would like all plaintiffs to have $50-an-hour lawyers and the insurance industry to be able to hire $300 lawyers. It would be like one baseball team having all $50-an-hour players and the other team having $300 players. Who's going to win?

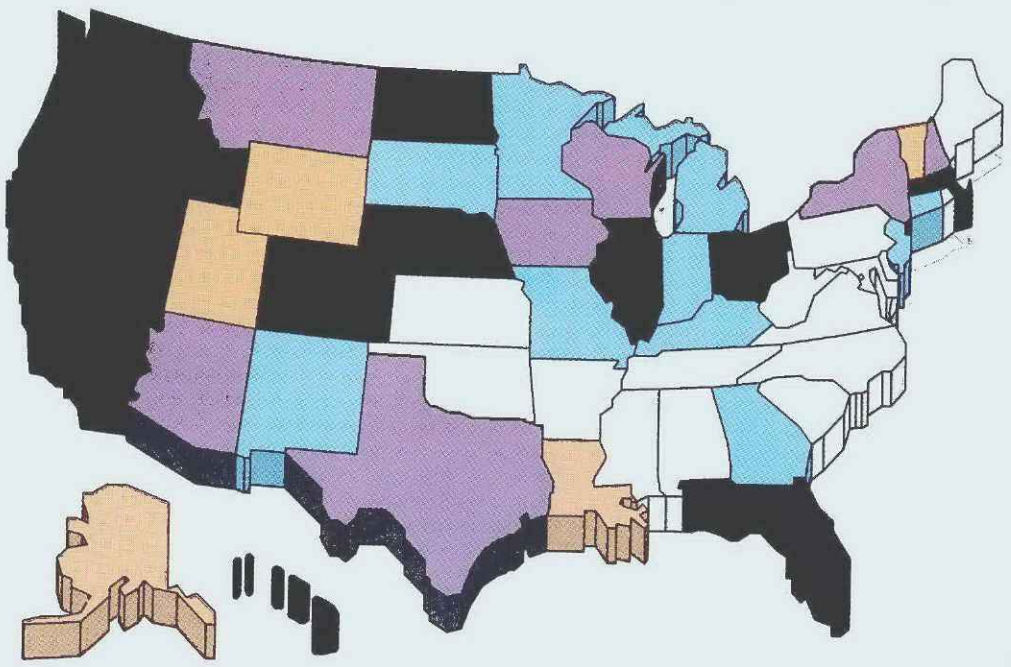
The bottom line is, they don't like an even-handed playing field. So they attack the contingency fee because they would like to have less of a caliber of lawyer against them.

It always boggles my mind to see this criticism. The person who got his leg cut off or is dying from cancer from cigarettes, the last thing he's able to do is take his unemployment compensation or workers compensation check and send a lawyer an hourly fee.

I believe the insurance industry doesn't want to be in the courtroom. They would much rather have a legislative solution: Capping of damages, getting rid of punitive damages, trying to do something on contingency fees. All the things that have nothing to do with the system of justice but all ways to lobby around what they don't want to have. They don't want to be at the mercy of the judicial system. 30

Tort reform in the states

While repeal of joint and several liability is still an issue at the federal level, 36 states have modified their joint and several liability rules since 1986. (As of October 1996)



Note: New York also abolished joint and several liability, with exceptions for various cases.
Source: insurance Information Institute, American Tort Reform Assn.

GRAPHIC BY JOHN HALL

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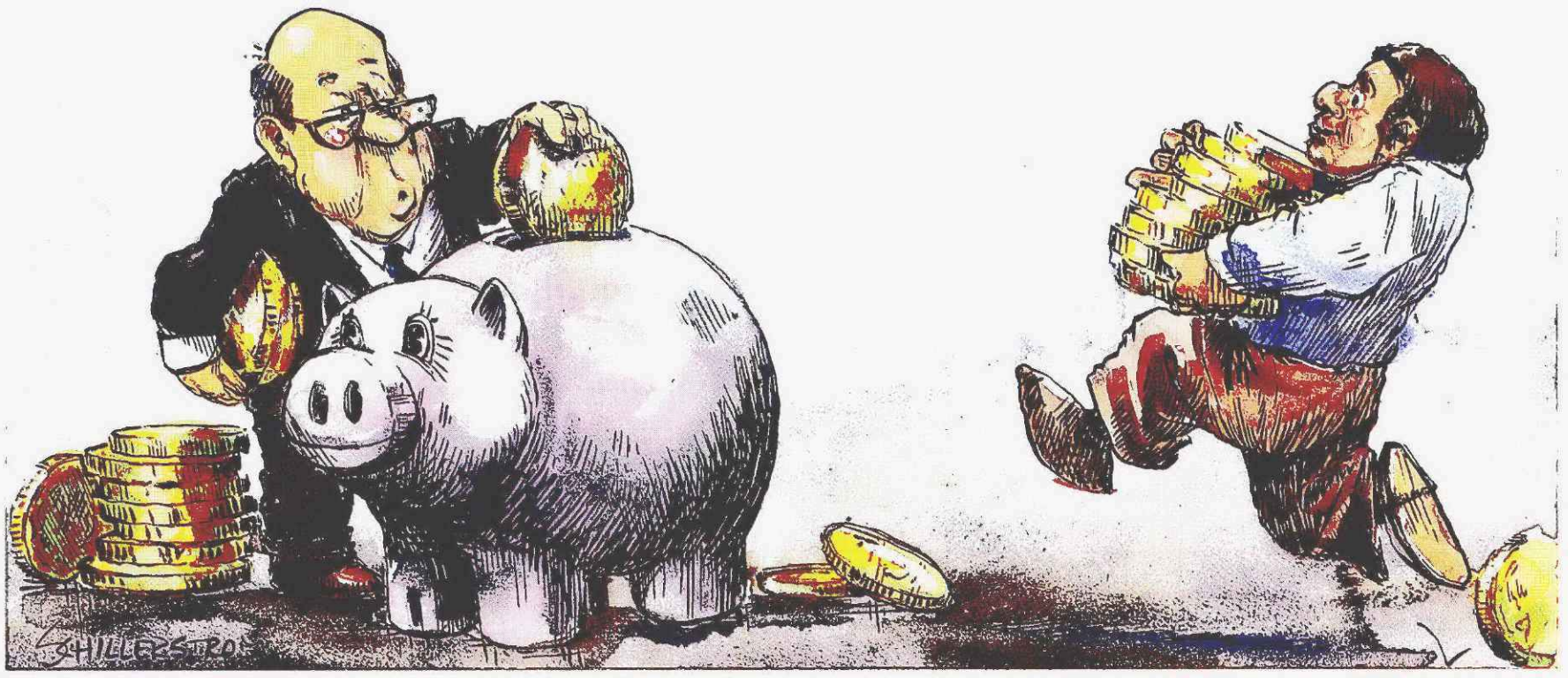

It's not your father's pension plan

Hybrids offer best of defined contribution, in a defined benefit plan

By JERRY GEISEL

TRENDS & ISSUES

An employer drive to make pension plans more visible and meaningful to an ever more mobile workforce is transforming the defined benefit plan landscape.

Amid demographic changes and a growing recognition that employees didn't understand or appreciate their defined benefit pension plans, hundreds of large employers since the mid-1980s have converted their old-line final average pay plans into a new generation of pension hybrids.

The hybrids, which include cash balance, pension equity and lifecycle plans, are named for their unique designs, which are intended to combine the best features of defined contribution and defined benefit plans.

From defined contribution plans—especially 401(k) plans—the hybrids borrow the account balance feature in which benefits are expressed as a lump sum. That allows employees to know instantly the cash value of their benefits rather than try to figure out a complicated formula with several unknowns, such as future salary.

Like 401(k) plans, many of the hybrids feature benefit portability, allowing employees who quit their jobs to take their account balances as a lump sum. That gives employees the flexibility to receive cash or roll the money into individual retirement accounts or their new employers' pension plans.

That flexibility is a major difference from traditional plans in which employees—regardless of their ages when they stop working—must wait until they reach normal retirement age to receive a benefit in the form of a monthly annuity.

In addition, through their design, the hybrids give much richer benefits for an employee's first few years of employment compared with traditional final average pay plans. That is a big attraction to a workforce that has become conditioned to short tenures and multiple employers.

While having defined contribution plan features—individual account statements and usually benefit portability—hybrids still are defined benefit plans. They promise employees a specific benefit. If the employer makes poor investment decisions and the plan assets are insufficient to pay promised benefits, the employer will have to make additional contributions to the plan.

That is a fundamental difference from defined contribution plans, such as 401(k) plans, in which employers agree to make a specific contribution to the plan. But if the value of employees' accounts declines because of employees' investment decisions, the employer does not have to make additional contributions.

By merging the best features of defined contribution and defined benefit plans, hybrid plans, especially cash balance plans, have become the new star performer in the defined benefit plan universe.

In a cash balance plan, employees receive credits based on a percentage of pay, such as 7% of pay. This amount is expressed as an account balance, which is increased by a predetermined interest rate, such as the one-year U.S. Treasury bill rate plus 1%.

In a pension equity plan, employees earn credits, expressed as percentages, for each year they work. The percentages typically increase with age. The percentages are added up to come up with a percentage, such as 150%, that is multiplied by final average pay. For example, someone with 150% and a final average salary of $50,000 would get a $75,000 benefit, resulting from the final average pay multiplied by 150%.

In a lifecycle plan, an employee's years of service are multiplied by final average pay. The sum is then multiplied by a percentage based on the addition of employee's age and service. This amount is divided by a so-called conversion factor. The conversion factor is based on the employee's age when benefits begin to be paid. The result is the employee's benefit.

Assume a woman retires at 65 after 30 years of service and final average pay of $35,000 a year. The example assumes the percentage based on age and service is 9% and the conversion factor, based on the age at which benefits begin, is 9. In this example, the 30 years of service would be multiplied by $35,000, with that sum multiplied by 9%. That amount, $1,050,000 in this example, would be multiplied by the percentage—9% in this case, based on age and service—resulting in a figure of $94,500. That amount would be divided by the conversion factor of 9, resulting in an annual benefit of $10,500, or $875 a month.

Roughly 300 employers have established hybrid plans since the mid-1980s.

Employers switching to hybrid plans are a virtual "Who's Who in Corporate America," including Ameritech Corp., Bell Atlantic Corp., Georgia-Pacific Corp., International Business Machines Corp., RJR Nabisco Inc., and UNUM Corp.

On Jan. 1, AT&T Corp. will convert its traditional plan for management employees to a cash balance plan. With 58,000 active participants and $10.4 billion in plan assets, AT&T will become the largest employer to adopt a hybrid plan.

Making pension plans more visible and understandable was a key motive in adopting hybrid plans, employers say.

"It is real. It is visible. It is tangible. Employees can see its value grow," said Jean LaVecchia, senior vp-organization development at New Haven, Conn.-based Southern New England Telephone Corp., which set up a cash balance plan in 1996.

"Each quarter, employees see their account balances increase based on pay credits and interest credits. And the benefit always is expressed as a lump sum. The reaction has been very positive," said J. Richard Brophy, corporate retirement programs manager at Maynard, Mass.-based Digital Equipment Corp., which adopted a cash balance plan last year.

A growing recognition that employees no longer expect to spend their careers at one company also has driven the growth of hybrid plans. Those plans, especially cash balance plans, give much greater benefits to employees' first years of service compared with traditional final average pay plans, whose design is sharply skewed in favor of long-service employees.

"Our plan is a positive for recruitment. It will attract people because they don't have to stay here before earning a meaningful benefit," said Mary Beth Clifton, acting manager of benefits and workers compensation at Juno Beach, Fla.-based Florida Power & Light Co., which has a cash balance plan.

Other employers say the appeal of hybrid plans has been the smoother accrual of benefits throughout a worker's employment so that certain events, such as turning 55 or completing 30 years of service, wouldn't drive employee decisions on when to leave.

"We wanted to smooth the (benefit) curve so the design of the plan wouldn't motivate employee behavior to retire or not. Instead, personal career decisions and business decisions would become more of a driver," said Robert Cornett, vp-human resources at Portland, Maine-based insurer UNUM Corp., which has a lifecycle plan.

Even with hundreds of employers moving to hybrid plans, the plans still constitute only a small proportion—less than 1% of all corporate-sponsored defined benefit plans. But given the size of many hybrid plan sponsors, perhaps as many as 10% of defined benefit plan participants are in hybrid plans.

That percentage could grow substantially in the years ahead.

"Many, many of our clients are considering installing cash balance plans or a variant. If an employer is considering a design change, the probability is high that it will move to a cash balance" or other type of hybrid plan, said Michael Gulotta, president of benefit consultant ASA Inc. in Somerset, N.J.

"If you look at the Fortune 1,000, by 2020 perhaps only 20% will have a traditional final average pay plan," said Robert Byrne, managing principal of The Kwasha Lipton Group of Fort Lee, N.J., which designed the first cash balance plan.

"Gradually, (traditional) plans will become extinct. I have 36 years of service. Younger people are not likely to stay that long," and pension plans have to change to accommodate that more mobile workforce, said Richard Quinn, director of performance and rewards for Public Service Enterprise Group, a Newark, N.J.-based utility, which put in a cash balance plan last year.

Others aren't so sure.

William Miner, a consultant and principal with Watson Wyatt Worldwide in Chicago, said there always will be a role for traditional final average pay plans at companies that want to encourage long service through plan design.

But no longer will plan design be a case of "one size fits all," Mr. Miner said.

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A love affair with 401(k) plans

Retirement plans' appeal remains constant among employers, employees

By JERRY GEISEL

Employers' and employees' long-time love affair with 401(k) plans is stronger than ever.

Added in 1978 to the U.S. Tax Code by federal legislation and sanctified in 1981 by Internal Revenue Service regulations, 401(k) plans are growing at a rate unprecedented in pension plan history.

Last year, 248,000 employers sponsored a 401(k) plan, double the number 10 years before. By 1999, 401(k) plan sponsorship could top 300,000, assuming a modest 6.5% annual growth rate, according to Access Research Inc., a unit of SpectremGroup, a San Francisco-based consulting and research firm.

Among employers with more than 5,000 employees, 95% sponsor 401(k) plans, while 80% of those with 1,000 to 5,000 employees sponsor a 401(k) plan.

As the number of 401(k) plans has grown, so have the number of participants, which last year totaled just under 24 million compared with nearly 11 million in 1986.

According to Windsor, Conn.-based Access Research, assets held by the plans between 1986 and 1996 grew at a compound rate of 18%, rising to $810 billion from $155 billion—thanks to bigger employee contributions and a booming stock market.

"You have a lot more plans, with more eligible employees, who participate at a higher rate. The result is a lot more money in the plans," said David Wray, president of the Chicago-based Profit-Sharing/401(k) Council of America, a trade group that represents plan sponsors.

So ubiquitous have 401(k) plans become that it now is virtually unheard of for a large employer not to have one, said Michael Sternklar, a principal at The Kwasha Lipton Group in Fort Lee, N.J.

Even the smallest of companies now have 401(k) plans.

"We are trying to recruit top talent and we hope this benefit will help us in our objective," said Stacey Paradise, accounting manager at Abtex Corp., a 12-employee abrasive disk manufacturer in Dresden, N.Y., which began to offer a 401(k) plan in January.

Why 401(k) plans have achieved such popularity among both employers and employees is no mystery.

For employees, the plans give them tax breaks that no other pension program can match. Their contributions are made with pre-tax dollars and earn tax-deferred interest.

"You don't have to be a rocket scientist to conclude" that the tax breaks would be a powerful draw, said Ted Benna, president of The 401(k) Assn. in Cross Fork, Pa.

The visibility of a growing account balance also has made the plans a hit with employees, especially compared with traditional defined benefit plans under which benefits are determined by often arcane formulas.

"It is a much more tangible benefit" compared with many defined benefit plans, which can seem like a "black box" to employees, said Robert Cornett, vp-human resources at UNUM Corp. in Portland, Maine.

And perhaps the greatest appeal to employees—at a time when many think they will only stay a few years at one company before moving on—is that 401(k) plans represent the ultimate in benefit portability.

When employees leave, they can take the money, roll it into an individual retirement account, transfer it to their new employer's 401(k) plan or keep it in their former employer's plan.

"Younger employees today no longer think of spending 30 years with one company. They want to be able to take something when going from one employer to another without losing something. They want something portable," said George Dascoulias, project manager-retirement savings plan at Eastman Kodak Co. in Rochester, N.Y.

For employers, 401(k) plans also are something akin to dream plans. The cost is predictable and typically much lower than a defined benefit plan and the administrative hassles—compared with defined benefit plans—are usually much less.

"This is a very easy plan to administer. For the most part, our administrator (The Principal Financial Group) handles everything," said Ms. Paradise of Abtex Corp.

An added bonus for employers: employees love and appreciate the plans. At Kodak, for example, its 401(k) plan is so popular that it is "part of our culture," said Mr. Dascoulias.

However, some companies with generous profit-sharing plans have not con-

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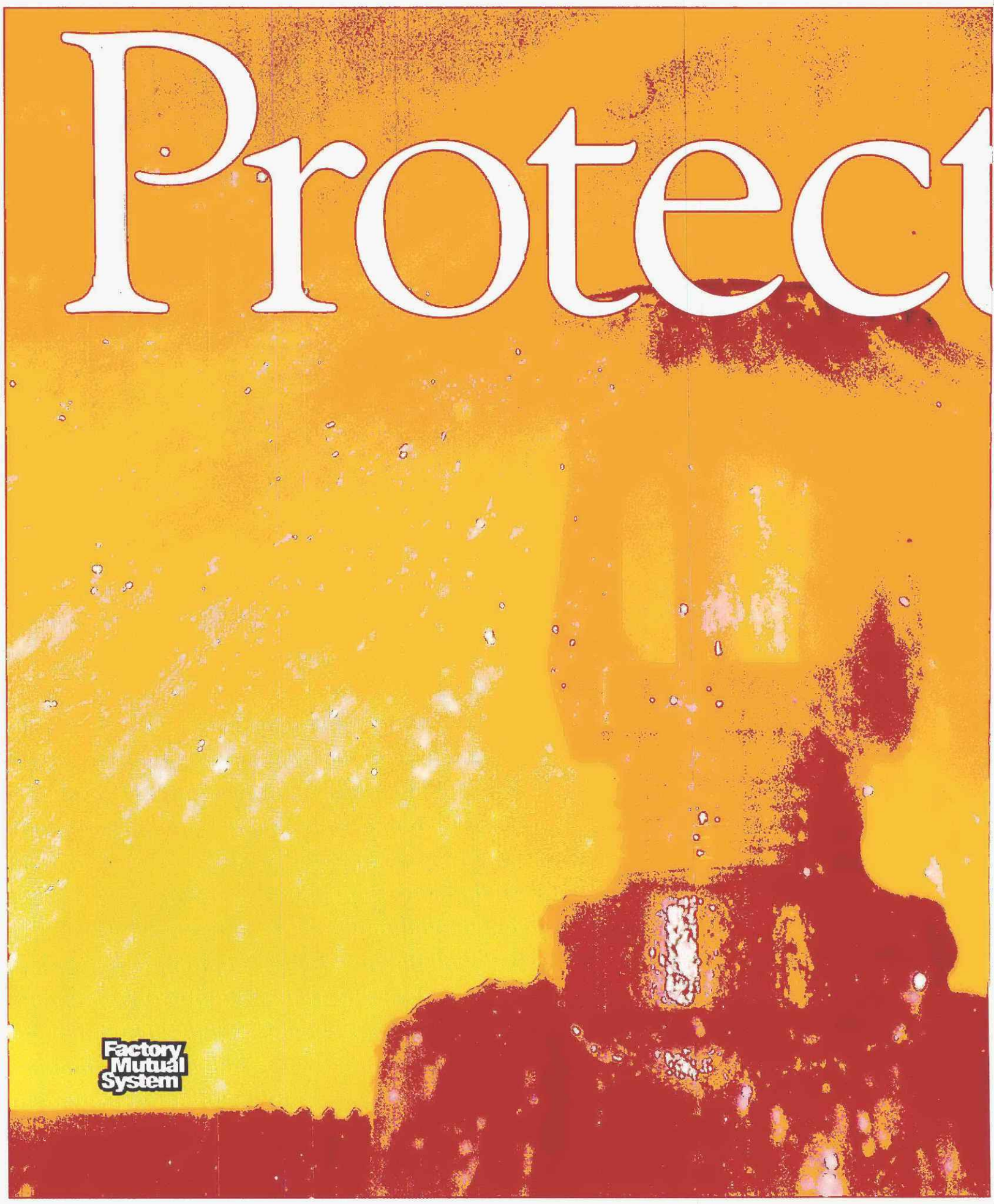

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verted them to 401(k) plans. They reason that most lower-paid employees would never be able to save enough to generate a company match equal to what the company contributes to the profit-sharing plan.

Despite 401(k) plans' popularity, there are some misgivings about the plans' growth, which has paralleled a steady decline in the number of defined benefit plans.

From 1986 to 1996, the number of defined benefit plans fell to 48,000 from 112,000.

One of the biggest concerns with 401(k) plans is whether employees will turn against the plans—and perhaps the employers that sponsor them—if the stock market plunges and employees' 401(k) plan account balances fall with the market.

"What if there is a bear market? A lot of retirement hopes and dreams could be dashed. There could be considerable backlash," said Raymond Sharp, a principal and consulting actuary with Buck Consultants Inc. in Secaucus, N.J.

While that remains to be seen, pension experts say even if employees' account balances are clipped by a fall in the market, many employees still will be far better off than if their employers had not set up a 401(k) plan.

"Millions of employees are saving money for retirement that would not in all probability have been saved," said Dallas Salisbury, president of the Employee Benefit Research Institute in Washington.

Many small employers, without the 401(k) plan option, might not offer any savings plan. At The Principal Financial Group, the largest administrator of 401(k) plans, about half of the new 401(k) plans set up each year are for small employers that did not previously offer a savings plan, said Dick Prey, a senior vp with the Des Moines, Iowa-based company.

One of the consequences of the growth of 401(k) plans and telling employees how much money is in their account balances is that it has focused employees on the need to save for retirement.

"This is not like a traditional plan where benefits are calculated at the end of a career. In a 401(k) plan you watch your money grow. It is a good thing to recognize the connection between saving now and having something later," said Mary Ann Arlt, vp and consulting attorney with ASA Inc. in Somerset, N.J.

Unlike defined benefit plans, in which employees often are passive and indifferent participants because they have no role in investing contributions, 401(k) plans have forced employees to be active participants.

Employees must choose the level of their contributions and to which investment options the contributions will go.

"This has made employees partners in the retirement planning process. They have to decide how much to save and what kind of investments they want to make," said Donald Smith, director of human resources at AT&T Alascom in Anchorage, Alaska.

While perhaps unintended, the hand of Congress also has increased the expansion of 401(k) plans.

By tightening certain non-discrimination tests in 1986, legislators forced employers to do a better job of getting lower-paid employees to participate in order for the plans to allow higher-paid employees to make generous contributions to the plans.

"Employers realized they had to do something (to boost participation) and what they did was education, education, education," said Gary Blank, a retirement plan consultant in San Francisco.

Employers' efforts to teach employees the mechanics of 401(k) plans and the importance of contributing to the plans have worked. Participation rates among employees have soared, climbing to an average of 78% last year, up from 71% in 1990 and just 62% in 1984.

"There has been a real focus on getting employees to participate, and that is paying off," said Scott Peterson, a consultant with Hewitt Associates L.L.C. in Lincolnshire, Ill.

Technology also has boosted the appeal of 401(k) plans. Technological advances, for example, have enabled employers to offer literally dozens of investment options in the plans while giving employees the opportunity to change their investment choices—in some cases daily. That many options was unimaginable only a few years ago.

"Who would have thought we would offer 36 investment options?" asked Kodak's Mr. Dascoulias. "But the way technology is going, what's pie in the sky today could become commonplace in the future." 30

Since the late 1870s, the automatic sprinkler has provided basic fire protection support for industry. Although the fundamental design of the automatic sprinkler is simple, the facilities it protects have become increasingly complex.

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Dennis H. Chookaszian

Insurance company CEO eager to explore new horizons

Dennis H. Chookaszian is one CEO who manages to keep his insurance company on a profitable course, while always watching the horizon for new challenges and opportunities.

Mr. Chookaszian, chairman and chief executive officer of CNA Insurance Cos. in Chicago, is often sought as a speaker on forward-looking topics, from securitization of insurance, to the Internet, to financial services integration. But he has done much more than just talk: CNA is at the forefront of taking such ideas and turning them into a reality.

Mr. Chookaszian, 54, has served in his current executive position since 1992. Since that time, he has led CNA to become the largest commercial insurer in the United States. In addition to the 1994 acquisition of Continental Corp., which boosted its stature significantly, CNA has since made smaller acquisitions in targeted specialty areas.

From 1990 to 1992, Mr. Chookaszian was president and chief operating officer, and from 1976 to 1990, he served as chief financial officer. Before he joined CNA, Mr. Chookaszian was a management consultant with Touche Ross & Co. in Chicago for eight years.

He holds a bachelor's degree in chemical engineering from Northwestern University in Evanston, Ill., a master of business administration degree from the University of Chicago and a master of science degree in economics from the London School of Economics.

Mr. Chookaszian recently spoke with Editor Paul Winston about CNA's current course and his views on future trends in the commercial insurance industry.

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Q: You are often seen as a futurist for the insurance industry. Why is that?

A: I think that the role of the CEO is to be a futurist. I think the CEO of any company has to be able to envision the future and get his company there. Andy Grove, the Intel CEO, said it real well in his book, when he talks about transformational change, and why he's effective in his company by being able to identify transformational change before it occurs.

In the insurance industry today, look at all the change that's going on, all of the consolidation, distribution ideas coming up, and technology is playing such an important role.

Not all companies in the insurance industry, however, appear to be following that philosophy.

I see a number of people who are futurists and leaders in our industry. People like Ron Ferguson of Gen Re is clearly a thought leader who has driven the industry. Somebody like Norm Blake of USF&G, who follows a different approach than we are, but is someone who's got his eyes focused on the future and understands where he's got to take that organization. Even in a smaller company, Cary Blair over at Westfield is a person who has a company rooted in tradition, something that's very well established, but he knows where he wants that company to be five and 10 years in the future.

I would agree there are some who may not be as focused as they should be, but there are some really good people out there. Their companies I think will be leaders, winners of the future.

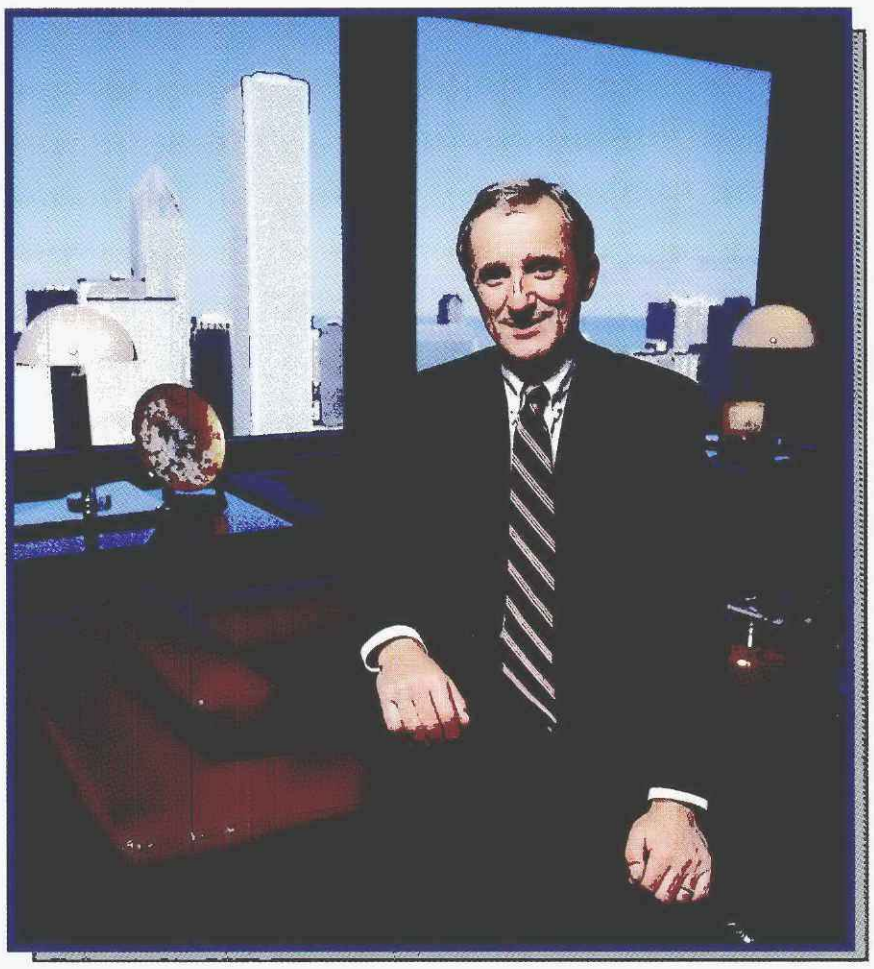

PHOTO: MICHAEL MARCOTTE

You are following a multiline strategy at CNA, while many others are deciding specializing is the way to go. Why did you choose this strategy?

We're certainly following the road less traveled. When we started on this road, back about 20 years ago, it was the road most traveled. Along the way, people have reversed direction or got on a different road. We're about the only company left with a real broad-based strategy.

What has driven the strategy of these other companies has largely been the shareholder value movement. What you've seen is companies attempting to try to boost their short-term stock price by selling off at a high multiple part of the business, which is what Aetna did. It can have very significant short-term gains.

I believe that long-term, a company that can manage multiple businesses is going be better off remaining a multiline franchise. The challenge to us is how to do that. If we're going to be successful at what we do, we've got to manage these businesses as well as a specialty company. And we've got to compete with them. Nobody competes with us as a multiline; they compete with us in commercial, in workers comp, in directors and officers.

We've got to do each of the pieces as well as they do. And that's not easy to do, which is one of the reasons other companies have stopped doing it.

Do you face the same shareholder pressures as other companies, or does the ownership of a large portion of CNA by Loews Corp. give it some relief from that?

We don't face the same shareholder pressures, no question about it. Our shareholder is interested in building long-term value. They've made that very clear. So our dominant shareholder has said, "Build the greatest value of the company five to 10 years out." And you don't build the greatest value by selling off pieces that are your best pieces.

That's not a good way to do that because when you get the cash, what do you do with the cash? If you go out and try to buy something else with it, you can buy something that costs you as much as what you sold or more. There's no advantage to doing that if you're trying to buy long-term value.

One of the areas you've expanded into is securitization of insurance, via Hedge Financial. How is that working?

As we've done some strategic thinking about the future, we've identified five transformational ideas. They are: banks in the insurance business, the Internet, securitization, business process outsourcing and employee leasing or PEOs. In all five instances, we have initiatives under way to try to expand them; Hedge Financial is one of them.

Because they are transformational ideas, they won't happen this year. It's not like we'll wake up and say, "Omigosh, look how big this is." But over the next five to 10 years, we think those ideas potentially are very powerful.

In Hedge Financial's case, we laid out a two-year plan to have Hedge basically go and visit our 30 different business units and see if they can put together a few transactions, with the idea that it's not going to be very big. It's a small organization, with only 20 people. We'll see where we are in two, three, four, five years. It's a long-term building process.

So you're using the CNA units as a sort of lab for testing securitized products?

Exactly. I've said what we're doing is making CNA a product laboratory for securitization products and will see what work. Because there isn't anyone that has a broader range of products than we do, so there isn't a better product laboratory than CNA.

We also have scale, and in at least two-thirds of our businesses we're the dominant player or close to the dominant player. As a result, much like mortgage-backed securities, you are able to group together the products in ways so that if securitization can work, it will work for us easier than it would work for someone who's got 10 policies.

You also mentioned professional employer organizations, or employee leasing, as one of the five areas you have identified. How does that fit with an insurance company?

It's an idea that's not new—it's been around about 10 years—but it's a business that has grown out of relatively small operations. Some of them previously were doing things that maybe were not even appropriate in terms of the benefits they tried to eke out or the advantages they tried to gain by often trying to skirt regulations, hoping they'd get bigger.

Eventually they got to the point where they were doing a very legitimate thing, which was bundling together services that are necessary to provide the administrative side of employment for an employer.

The goal is to give an employer two things: one is a set of services that reduces costs and, second, take away all the hassle of administration.

Now, every time a PEO would win an account, we were losing the work comp, the health insurance, the life insurance. We were losing premiums, because the PEO got them. So we said this is a real problem, especially for our agents who were losing the account. So what we did to try and combat that is decide to form

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a PEO and try to do it on our scale. So we'll try to do it a whole lot bigger and a whole lot more professionally than it's been done. Whether that will work or not remains to be seen.

When you say you were losing business to PEOs, how did that happen? Because they self-insured their clients' exposures or were aligned with other insurers?

Some of it was self-insured, some was aligned. We write PEOs, as well, so we would take insurance from a PEO back in which would undoubtedly include some of our customers on the front end, but a lot who were not our customers. So we continue to write PEOs. We like that business and are happy to write it. But we don't like losing customers up front.

Are there areas where advances of information technology will be used more widely in commercial lines?

I think it will help from the processing point of view, and in information gathering and providing better information to your insured. It happens today and will happen more effectively in the future. What it won't do is eliminate the distribution mechanism. It won't get rid of the agent. On the personal side, it will be different and the agent may be the person setting up the web site.

How will agents and brokers adapt to the greater efficiencies posed by Internet marketing?

I think what will happen is that the independent agent will adapt fine to the commercial lines side of it, the greater efficiency, but there won't be dramatic changes.

On the personal insurance side, some will become Internet marketers—they will actually build linkages—but others will fail, and will be unable to do it.

What we'll do eventually, is that if you come in to our web site, for example, and get a quote, then we'd like to set it up so that if you want information it will steer you directly to an agent in your community, one of our agents. So the agency gets a referral out of it.

Do you think that state-based regulation of commercial lines eventually will become a thing of the past, with states focusing more on personal lines?

One of the fears is of a form of dual regulation, meaning solvency regulation at the federal level and rate regulation by the states. That's the worst possible thing that could happen.

There's been a lot of discussion of dual systems of commercial and personal, with the idea that the sophisticated commercial buyer doesn't need solvency regulation and the protection of the guaranty fund. I would generally favor that, if it were to happen, but the problem is that it's more likely what you'll get is some kind of federal regulation with state interference, which you really don't want to see happen. So I think that that's an idea that is not politically popular yet, but over time it should happen, but in the short term it will not.

Is there anything in particular you'd like to see to make state insurance regulation more efficient?

There's a major problem in that you've got insurance commissioners who, by and large, don't stay there very long.

If you had a person in my job for two, three, four years, something like that, they're barely getting started, barely getting a culture established and finding a way to bring about change in their organization, and you don't want to take them out of that. But in the electoral process, that's what happens.

Do you see consolidation shifting back to the insurance side, from the brokerage and reinsurance side of recent years?

The one impediment is that among the top 20 companies over the next five years maybe there will be a couple mergers but not much more than that because the management doesn't want it to happen.

When you come right down to it, in our merger with Continental we had 15 people in our senior management and they had 15 people in their senior management and when we merged what happened is senior management lost their jobs. That will prevent most mergers.

So will mergers among insurers take the shape of buying a company to obtain expertise in an area, such as buying a specialty company?

American States is a good example of that. As long as you're willing to pay the price, which SAFECO was. They paid $2.8 billion to obtain $1.8 billion of premium. It's a big number. As long as somebody is willing to do that, that's the way it will take place. It's also what we did to boost our surety operation.

In your view, will the hard-soft market cycles return?

"This is the market that will be" is a statement you hear some people make. The same people made that statement back in 1990 and they were dead wrong and they'll be dead wrong this time, too. It's a cyclical market and it always will be. There's nothing that will change the cycle. The insurance cycle is shorter, longer, but there's a cycle.

So there will be a hard market at some point. Maybe not for a long time, maybe not a real long time, who knows? But it is not going to remain unchanged.

What's likely to be the result of a long soft market?

If you look at the top 20 firms, they write half the insurance premiums. There will be one to three consolidations. If you look at the little, tiny firms, they're going to try to make it as niche players, in a very specialized way. The medium-sized players have a problem. These are third-quartile companies with $600 million to $800 million in premium.

If you're not real profitable, you're going to get swallowed up by somebody who can use the volume. If you're doing it as part of another company, they will sell it off, which is what Allstate did.

Allstate had $600 million of commercial insurance, of which, maybe after runoff, they had $400 million left. It wasn't big enough for us to get real excited about, but they sold it to St. Paul.

What recommendations do you have for risk managers in terms of the skills they'll require in the future?

I'd say special training is very important, such as the Chartered Property & Casualty Underwriter, and technical skills are very important.

Probably most important will be the ability to sell your ideas to management. There is so much changing that it requires them to come to management with a new set of ideas.

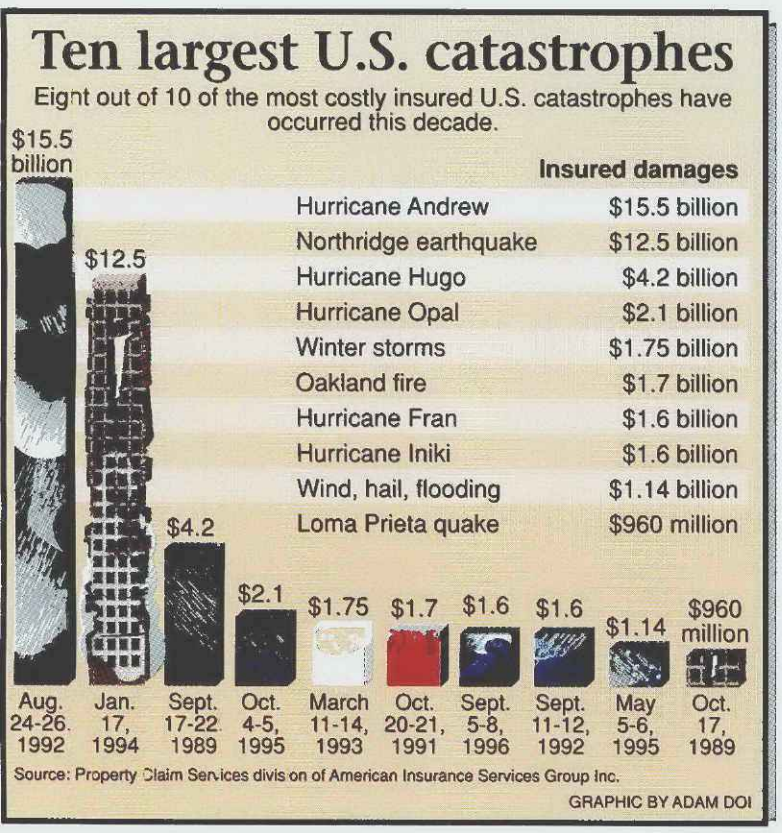
Do you agree with the view that risk managers should look beyond their traditional insurance roles to help manage other aspects of risk within their organizations?

I think it makes sense for them to expand into other balance sheet issues. I think you have to look at your risks on a broad basis. Whenever I meet with risk managers I encourage them to try and do that and try to manage a much broader spectrum of risk.

How has your role as a CEO of a major insurer changed?

It requires more leadership, no question about it. There's an awful lot of change going on.

The role has actually changed in several ways: one is more vision is required. Second, cultural leadership is more important. By that I mean developing a culture by design, not by default. And making sure your culture fits your business objective, and making it a more collaborative organization, more a partnership. . . . I also have to rely on less sleep!



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VIEWS

Ronald Compton

CEO bets future success on being a specialist, not a generalist

Ronald Compton says he believes in bold moves. His actions back up his words.

Within four months between late 1995 and early 1996, Mr. Compton, the chairman and CEO of Aetna Inc., transformed what had been Aetna Life & Casualty Co. from a multiline insurer into a managed health care giant. First, he sold Aetna's property/casualty business for $4 billion to his Hartford, Conn., neighbor, Travelers Corp., in December 1995.

Four months later, Mr. Compton snapped up U.S. Healthcare, the second half of his one-two punch for restructuring the company and making Aetna the nation's second-largest managed health care company.

The dual moves mark the culmination of Mr. Compton's tenure as head of the venerable Hartford-based insurer, where he has been chairman and CEO since 1991, stepping up after three years as president.

Mr. Compton, 64, has announced his retirement from Aetna, effective March 1, 1998, ending a career at Aetna that started in 1954.

He discussed the present and future of managed care and Aetna's place in it with Associate Editor Michael Prince.

Q: What was the main impetus for restructuring Aetna away from the property/casualty business and towards managed health care?

A: I guess several things. First, Wall Street wasn't giving us any credit for being a multiline company.

Second, having solved a lot of management problems in the past that I had to confront when I came into this job, we were now in a position to move the company forward and I'm a believer in bold moves. We had a ninth-place property/casualty company and a second or third-place health company. While we had enough money to do anything we wanted to do, the fact is to invest heavily in both of those businesses would have not been, in my judgment, the best use of the shareholder's money. So, we had to make a decision on what business we wanted to be in and the health care business and its allied businesses came out a clear winner.

I came out of the P/C business myself. I knew what it would take to reposition Aetna back to where it had been in its glory days in the P/C industry of the 1950s and '60s. And that would have caused us to have a lack of focus, I think, in the other businesses.

So I came to the conclusion that it was better to divest the P/C business in some way that would benefit it and then focus our energies and capital and human resources on health and financial services.

Did you see anything in managed care that swayed your thinking towards the move?

Yes. "Demographics is destiny," a friend of mine once said. And we demonstrated that managed care can improve quality and constrain costs. And that's something that society needs badly and we know we can do it because we've done it and the demographics are there.

about patients' dissatisfaction with managed care. In addition, many measures have been passed regulating the managed care industry, such as those that mandate minimum coverage for hospital stays for certain procedures or those that regulate the HMO-provider relationship.

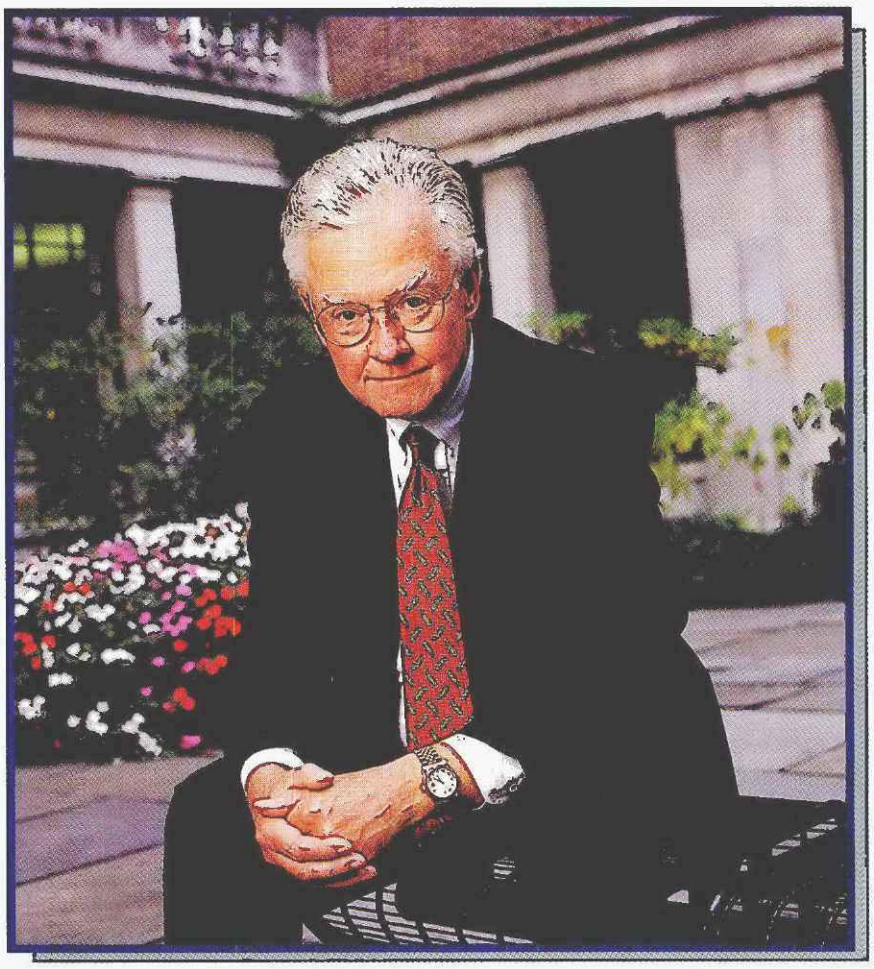

PHOTO: DAVID LUBARSKY

So we believed that we could provide a large number of people with very high quality medical care at an affordable cost.

Was there any one incident or fact that tipped your thinking in favor of managed care?

No. I don't believe in making decisions on sort of one anecdotal thing. The evidence has piled up over a couple of decades. Managed care has snowballed. It's still picking up speed. Ultimately 80% to 90% of people in this country will be in some form of managed care. It's just the business to be in if you can do it well.

So is that how you see managed care evolving in the future, growing more and more?

Oh sure. I mean over the near- or mid-term people will continue to move from fee-for-service plans to managed care because the quality is better, the cost is better. In addition, you have this whole Medicare population out there.

So the future—particularly the near- and mid-term future—for managed care is terrific.

There have been many stories

Are these laws necessary?

Absolutely not. There is a large group of people out there that would like to see managed care done away with. And they keep trying all the time. There are thousands of bills in the state legislatures every year, such as any-willing-provider bills and others, meant simply to do away with managed care. It's nuts.

The government should not be interfering between us and a provider. Notwithstanding what anybody attempts to do, the public wants managed care. A lot of people out there are kicking up a lot of stuff about dissatisfied people.

The reason you and everybody else hear about it is because of the fax machine. They fax this stuff to the media and to Capitol Hill and all over the place. But for every one of those, I've got five or 10 or 100 people who are very, very happy. Our patient surveys show very high satisfaction with managed care, higher in some cases than with fee-for-service.

I'll put it this way. I've moved six times in business. Every time I move I have to find a new doctor. Who do you think is better at vetting doctors, your next-door neighbor or us? You move and you're in our plan, we give you a list as big as a phone book full of doctors. All have been vetted, all experienced with us. So naturally, satisfaction is going to be higher.

Are there things that are going to go wrong? Sure. There are things that go wrong with everything. But we fix them. We try to keep incidents of that down to an irreducible minimum.

I get letters from people that would tear your heart out. A lady from New Jersey sent me a picture of two little girls and a little boy. And she wrote me this letter about how without us these two little girls would not have this brother who had to have open heart surgery at some god-awful early age, like 18 months, and how his whole family was certain they would lose their home because of the enormous expense of the surgery. And they couldn't believe it when they found out it was costing them zip. Nothing. I've got a pile full of that stuff.

Why aren't those stories talked about by politicians and reported by the press?

Come on, when was the last time a politician ever told you something positive? It doesn't happen. There are a lot of people in political life that I admire and I like. But the fact is they get along by finding things wrong and fixing them. Whether they're wrong or not or whether they need fixing or not, that's what they do.

I'll give you an illustration of what we do that you can't do outside of managed care. We know every diabetic in our HMOs. We also know everybody who has had an eye exam. And as you may know, you can go blind from being diabetic, except if it's caught in the early stages of incipiency. Then, there's a laser surgery that can prevent you from going blind.

So we simply match up all the diabetics, and there are tens of thousands of them, and match them up with all the people who've had eye exams in the last year. And if someone is diabetic and has not had an eye exam, we contact them and their physician to make sure that one happens. And the last statistics I saw, we had something like 300 people who had not done that and 47 of them had this laser surgery and did not go blind. I tell these stories all over Washington and state legislatures and they never get to the press because it's not news. Being against something is a much better vote getter than being for something.

What role, if any, do you see government playing in health care?

Several roles. I'm not one of those people that says the government has no role anywhere. That's silly. First, it is the government's job to punish abusers, whether they are serial killers or ripping off Medicare, and I know there is a big difference morally, but it's the government's job to outlaw things that are wrong.

In addition, it's the government's job

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to take care of people who can't take care of themselves. Government should also be educating people about how to stay well.

I think where there are abuses in the system, drive-through deliveries, drive-through mastectomies, then someone has to level the playing field and say, "Wait. Industry shouldn't be doing it." But if that occurs, then sometimes we'd need government assistance to level that playing field and make sure everyone is playing by the same rules.

What influence will purchasing coalitions have on health care. In Minnesota, for example, the Buyers Health Care Action Group has been an influential player and now purchases health care directly for its members. Do you see other employer coalitions developing and then directly purchasing health care from providers and squeezing out the HMOs or other intermediaries?

First, purchasing cooperatives. I think there will be lots of experiments, lots of different ways to go about buying health care and I think purchasing cooperatives for certain kinds of businesses are very good.

Second, is how about buying directly from the providers. My view is they can't do it as well as we can. And I think over time I'll be either proven right or wrong. But right now the evidence is they're not going to squeeze out HMOs.

They're not going to be able to keep up with us. Quality in medicine is a direct function of turning data into information.

Take my eye exam and diabetes thing. We have identified 30 of those, including congestive heart failure and asthma. Well, it takes big to be able to do that. So while they might have a really fine group of physicians offering their services, I doubt if they can in any conceivable way make the capital investment in those kind of data systems. We have one very expensive system that goes all the way across the country and is therefore optimized in terms of its usage and costs.

So we'll compete with them. I love to compete. I'm a competitive guy and let's see who does the better job.

You mentioned the advantage of size. By purchasing U.S. Healthcare, Aetna became one of the largest managed health care companies in the country. Is size important to success in managed care, or can smaller, regional companies continue to play major roles?

I think the regionals are going to provide a tremendous level of quality service. There are some exceptionally well-run, very caring, very high-quality regional HMOs. And they are top competition. They can't do some of the things we can do easily, such as countrywide service. If you work for one of our big Fortune 500 clients and you moved from here to there, you're still with us, whereas if you're with a regional you have to make a shift. But, they're tough competition, which is good, because it keeps us on our toes and makes us think all the time about the customer.

Do you see other large insurers making the move Aetna did away from the property/casualty business and towards managed care?

I think it's not so much a getting away from property/casualty as it is focusing. Now, my friend Sandy Weill at Travelers went towards property/casualty and focused that way. I don't think there's anyone running away from the P/C business.

I think it's a matter of focus and the reason it worked so well between Travelers and us was because for each of us it was a win-win thing. Each of us got the opportunity to focus on what we wanted to focus on. I mean he was number 11 and we were number nine and you put them together and they are number three in the commercial business. Hey, wait a minute, that's good for everybody.

The past few years have seen impressive reductions in health care inflation and in some cases a lowering of costs to businesses. But many people are saying those days are over and costs are starting to head up as it's not possible to squeeze further savings out of medical providers. How can managed health care companies continue to control costs without cutting quality of care?

Well that's simple. Let me answer your first question first, though. Yes, prices are going to rise again. But bear in mind where they've been. They've been at zero increase, zero increase and 3%. That's a three-year average of 1%. Now we're looking at 3% or 4% which is a touch above the consumer price index. But I can remember the late '80s when we were having back-to-back 20% years in the fee-for-service business.

Second, cost has nothing to do with quality, nothing. Let's take my eye exam/diabetes example. That's quality. That's somebody not going blind. But it's cheaper than someone who goes blind. They used to say in ancient China you paid your doctor when you were well and when you got sick you shut him off. That's a big incentive for the doctor to keep you healthy. 30

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VIEWS

Betty Cordial

Consultant helps regulators stamp out insurance scams

Betty Cordial, president of Vista Consulting Group Inc. of Glenview, Ill., is a leading expert on insurance insolvency and fraud issues. She provides receivership advice to state regulators and acts as a special deputy receiver overseeing rehabilitations and liquidations. Since 1985, she also has been a consultant for the National Assn. of Insurance Commissioners, representing the NAIC with state, federal and international law enforcement agencies.

She has conducted insurance fraud training seminars for the FBI and in 1996 traveled to Poland on behalf of the U.S. State Department and FBI to help train Polish law enforcement officials in fighting international white-collar swindlers.

Ms. Cordial, 52, got started in this line of work by "cleaning up after these guys" as an official of the California Insurance Department's conservation and liquidation division, where she handled 38 insolvencies between 1971 and 1982.

She recently discussed insolvency and fraud issues with Senior Editor Douglas McLeod.

Q: What was the toughest case you've worked on?

A: Probably one of the longest-running was the Bramson family case. It's been going on 18 years.

They were originally from Chicago. The father, Norman, appeared to be a small-time swindler. He had previous convictions for running gambling operations and other types of swindles. He also worked as a building inspector. He was charged with soliciting bribes on inspections.

His son Martin was actually a police officer in the City of Chicago. He was only on the police department a couple of months, and then they found out that the day before he'd been sworn in, he'd been convicted of having sex with a minor. Marty was fired by the police department. Later, he ran a whole string of drugstores in the D.C. area and was arrested and convicted there on what D.C. police described at the time as one of the biggest illegal drug distribution schemes in the District.

Another son, Leonard, was actually an attorney in the (Cook County District Attorney's) office here.

The family first set up a Bahamas company called International Bahamian Insurance Co., and they started marketing through newspaper ads offering podiatrists' coverage throughout the country. From the Bahamas, they went to a number of different domiciles, adding to the number of companies they had.

It was a horrible case. There were people who were really injured. I remember one claimant in particular: A doctor had made a mistake during some surgery, and she had to have her feet amputated as a result of it. The doctor ended up declaring bankruptcy. She never got any money. There are a lot of horror stories out there.

This continued to escalate until some time in 1989. At that point, I received a call from the New Jersey Insurance Department. They wanted to know if we had any information on some people who had supposedly taken over an insurance company in New Jersey without getting proper approval. The department got the names of these people and wondered whether we had any information. The names that they gave were known aliases of the Bramson family: Marty Martin, Hans Martin—Martin Bramson used all kinds of names.

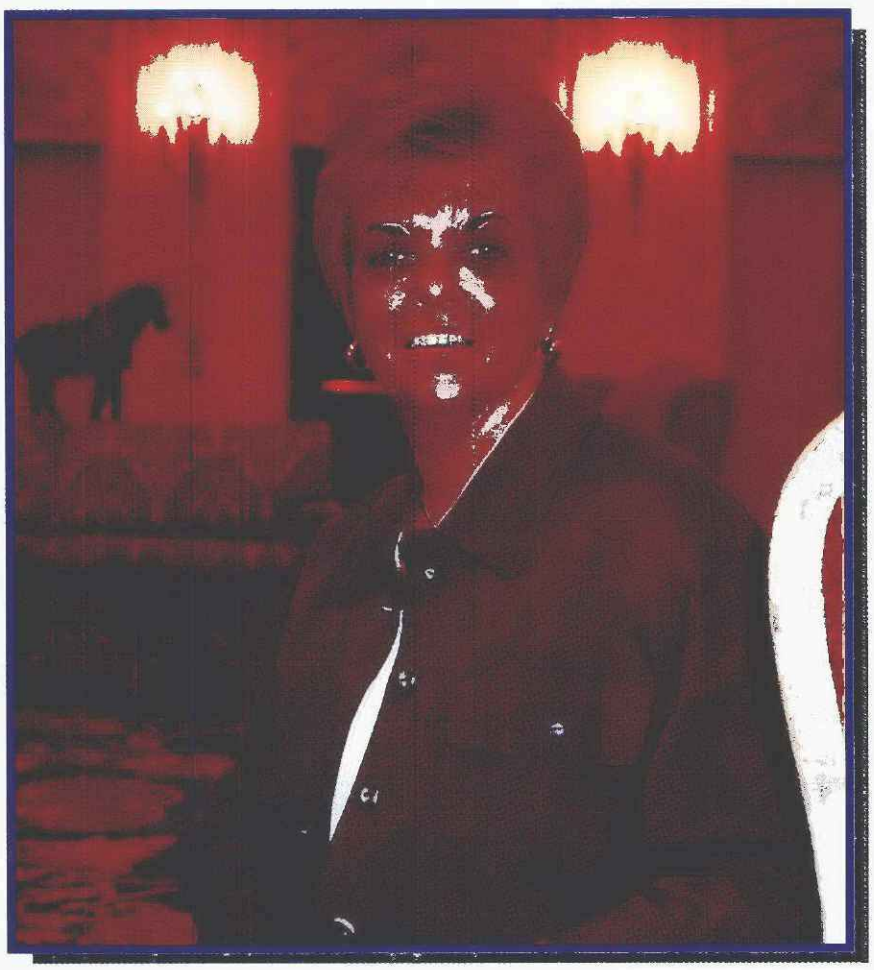

PHOTO: MICHAEL MARCOTTE

It just so happened that by being in New Jersey, they were in a jurisdiction where we had the most experienced FBI agent on insurance fraud in the country.

Bad luck for them.

So I called that agent and said, "Remember that case I've been talking about for almost 10 years?" And he said, "Oh yeah, I sure do."

"OK, you owe me on this one. It's now in your jurisdiction."

We worked extensively with the Bureau helping them develop the case. I think probably one of the most gratifying days of my life was when we arrested and served the search warrants on them.

How big a problem are fraudulent insurance companies like the Bramsons', compared with the widespread problem of fraudulent claims?

Overall, it's a smaller dollar problem, but in my opinion it causes catastrophic losses.

Certainly I don't mean to diminish the claims fraud issue. The cost of claims fraud is recouped through rate increases, so it certainly impacts every insurance buyer in the United States. But the internal fraud, the unauthorized insurer fraud, causes huger catastrophic losses to the policyholders and victims.

There were hundreds of millions of dollars of unpaid claims during the Los Angeles riots (because of fraudulent offshore insurers).

How good are regulators and law enforcement people at fighting these frauds?

I think regulators addressed the issue as soon as they became aware of it. Unfortunately, a con man doesn't pay much attention to a cease-and-desist order or an injunction. They're not operating in compliance with state laws, so why would they pay any attention to an order that's issued by an insurance commissioner? They generally just ignore them.

Why aren't they in jail? Why do the same swindlers surface over and over again with new companies?

They move between states so quickly that by the time states find out about them, issue the orders or close them up, they're already gone. They've moved across the border to another state. As a result of that, these types of fraud issues are more appropriately addressed by federal law enforcement. It's an interstate and an international problem.

It's also very difficult to get these cases prosecuted on a state or local basis. For instance, in many states, attorneys general don't even have authority under the state law to prosecute cases. They act as the civil attorney for the state; they do not have authority to prosecute (criminal cases).

These are complex cases. Unless you've got a lot of victims concentrated in one particular county, the local district attorney or prosecutor isn't going to be interested.

Then you get into the issue of priorities and what's important. What is the focus of the U.S. Attorney's offices across the country? What crimes have been targeted as the crimes they're going to work on?

Generally, insurance fraud cases take quite some time to put together and get ready for a trial. And if you have an assistant U.S. attorney that can do a quick bank robbery or drug case compared to spending six months or a year putting a white-collar crime case together. . .that's just what happens.

We just do not have, in my opinion, enough federal prosecutors that are interested in pursuing these types of cases.

Have you had cases that died in the prosecutor's office?

Yes. I can even think of one case where a person had agreed to enter a plea bargain and prosecutors just never got around to drawing up the agreement.

I'm looking forward to Section 1033 (the 1994 federal insurance fraud statute) being actively used by law enforcement and by prosecutors.

Traditionally, all of these cases have been prosecuted generally under mail and wire fraud charges, and this provides for a federal prosecution for—among other things—submitting false information to regulators. But it also prohibits anyone who has ever been convicted of a felony involving dishonesty or breach of trust from ever again being involved in the business of insurance.

Do state regulators and federal agencies cooperate with each other?

Absolutely. And I think that's increasing. At the NAIC, we have a federal/state coordinating working group—we meet quarterly—and I think that's one vehicle we've used to create cooperation between the states and the federal law enforcement agencies. We always have federal law enforcement representation at every one of these

Continued on next page

Continued from previous page

meetings, and multiple agencies—the U.S. Postal Inspection Service is always there, the FBI is always there, labor racketeering is almost always there, IRS has just started to come. But we actually get together and discuss cases of mutual interest, give them specific cases that we think are especially egregious.

In addition to that, there are also regional task forces that were started three or four years ago, and I think those have been very successful.

Can state insurance regulators do anything to prevent insolvencies of U.S.-licensed companies caused by insider fraud? How much of that is visible to regulators in the normal course, and how much can be stopped?

I certainly think administrative supervision is a very valuable vehicle used by regulators, whether a state actually has the administrative supervision model law or whether it's contained in some other provision of their code. If the commissioner finds that there is wrongdoing occurring at a company, certainly administrative supervision is a valuable tool to address that.

Why is it valuable?

Because it gives the commissioner the ability to actually oversee what is going on at the company. They can place their own representative at the company to oversee management.

There are different levels of administrative supervision: The commissioner's representative could actually sit there and approve every check that goes out and sign off on every single transaction the company gets involved in, or could just generally oversee the company and watch the bottom line.

You have this problem: You can put a company in rehabilitation, but realistically, when that becomes public, it's going to be the death knell for the company. Very few companies placed in rehabilitation are actually able to come out, because when it becomes public, the agents take their business somewhere else.

Some failed U.S. insurers have collapsed despite having clean audit or actuarial opinions from outside accounting firms. Are professionals held sufficiently accountable for these failures, and has this changed?

The services provided by professionals are integral to the regulatory scheme. Regulators rely on the opinions offered by professional firms. Every year, there are proposals being presented to limit liability (of professionals). But take a look at who's presenting those: the self-interested professional groups. If they are offering services that are relied upon by regulators, then they should have to answer for those opinions.

I certainly think, at this stage, that professionals (are held responsible). I can go back to the early receiverships I worked on, in the early 1970s in California, when the liability of outside professionals or other third parties was just sort of ignored. We never aggressively pursued the negligence or errors—or in the case of some third parties, wrongdoing—of outside parties. When a company was placed in receivership, it was a much simpler process.

You just change the locks on the doors, collect all the money you've got, distribute it to the policyholders and that was it.

But that changed when you saw the number and effect of the insolvencies that occurred over the past 10 years, and also how much it's cost the industry for guaranty fund assessments. There's a more vigorous and aggressive effort to pursue parties that contributed to the insolvencies.

Swindlers are very creative people. Do see them developing any new scams?

Certainly they always become involved with any hard-to-place risk. You go back to the early 1990s and you saw traditional property/casualty con men all of a sudden going into the health care business. Another area where you always see them is where there are mandatory coverages or where certification is required in order for a company to operate.

Certainly we are seeing a lot more problems with bonds: It's a booming market out there, and the con men see small contractors that need bid bonds and performance bonds—need proof of coverage—and they're right on the spot.

Every time you have a program set up by Congress that involves insurance, it's usually immediately targeted.

It goes back to the whole ERISA/multiple employer welfare arrangement issue; that has progressed now, and there are enough controls in place after 20 years for regulators to address MEWAs. So now the new spin is the union health care plans and the phony unions.

Also, I've had two calls in the past month on known con men that are setting up medical savings account businesses: They're going to provide the coverage, and they're also providing the vehicle where the MSA (funds) will be deposited. 30

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30

Sharpen those No. 2s

Risk managers and benefit managers must build an extensive base of knowledge to meet their daily professional challenges. How much information have you amassed in your tenure? We've culled some need-to-know information, newsy nuggets and professional history from 30 years of issues. So test yourself by completing the appropriate quiz. The answers are at the bottom of page 127.

WHAT DO YOU KNOW?

1. What is the only casualty coverage that risk retention groups cannot write?

- ○ a) Workers compensation
- ○ b) Directors and officers liability
- ○ c) Surety coverage
- ○ d) Medical malpractice

2. Which U.S. catastrophe caused the second-highest amount of insured damage?

- ○ a) Hurricane Hugo
- ○ b) Hurricane Andrew
- ○ c) Northridge earthquake
- ○ d) Los Angeles riots in 1992

3. Who established the National Insurance Consumer Organization?

- ○ a) Edward Kennedy
- ○ b) Joan Claybrook
- ○ c) J. Robert Hunter
- ○ d) John Dingell

4. Which U.S. state passed the first legislation authorizing captive insurance companies in 1972?

- ○ a) Hawaii ○ b) Tennessee
- ○ c) Vermont ○ d) Colorado

5. Which broker set a record for an insurance brokerage acquisition in 1979 when it paid $54 million to buy R.B. Jones Corp., the ninth-largest U.S. insurance broker based on 1977 revenues of $26 million?

- ○ a) Marsh & McLennan Inc.
- ○ b) Alexander & Alexander Services Inc.
- ○ c) Johnson & Higgins
- ○ d) Fred S. James

6. Which company purchased retroactive or backdated liability insurance coverage after a disastrous fire at one of its locations in 1980?

- ○ a) Beverly Hills Supper Club
- ○ b) K-Mart Corp.
- ○ c) MGM Grand Hotels
- ○ d) Sears, Roebuck & Co.

7. Who was the first winner in the *Business Insurance* Risk Manager of the Year award?

- ○ a) Thomas Hallett
- ○ b) Howard Weber
- ○ c) Spencer Traver
- ○ d) Robert Spencer

8. When did the Internal Revenue Service issue its first formal ruling that premiums paid to a wholly owned captive insurance company are not tax-deductible as a business expense?

- ○ a) 1967
- ○ b) 1972
- ○ c) 1977
- ○ d) 1987

9. Who was the first elected insurance regulator in California?

- ○ a) Roxani Gillespie
- ○ b) Linda Kaiser
- ○ c) John Garamendi
- ○ d) Charles Quackenbush

10. Which was the first U.S. state to implement an open rating law for workers compensation risks?:

- ○ a) Florida ○ b) Oregon
- ○ c) New York ○ d) New Jersey

11. What was the predecessor organization of the Risk & Insurance Management Society Inc.?

- ○ a) American Assn. of Insurance Management
- ○ b) American Society of Insurance Management
- ○ c) Public Risk & Insurance Management Assn.
- ○ d) National Insurance & Risk Assn.

12. Which U.S. president vetoed a federal product liability reform measure?

- ○ a) George Bush ○ b) Lyndon Johnson
- ○ c) Bill Clinton ○ d) Jimmy Carter

13. EMLICO, a long-time General Electric Co. insurer, moved to which captive domicile after redomesticating from Massachusetts?

- ○ a) Bermuda ○ b) Barbados
- ○ c) Cayman Islands ○ d) Bahamas

14. *BMW North America Inc. vs. Gore* was a decision handed down by the Supreme Court that involved:

- ○ a) Whether punitive damage awards can be so excessive as to be unconstitutional
- ○ b) How much outside business a captive must write in order for its parent to be able to deduct premiums paid to the subsidiary
- ○ c) The percentage of damages that plaintiffs attorneys can take in a case
- ○ d) The liability of asbestos producers

15. What manufacturer of insulation products offered a $10,000 reward in 1980 for certificates of insurance proving that the company had insurance to cover asbestos claims?

- ○ a) Fibreboard ○ b) Johns-Manville
- ○ c) Keene Corp. ○ d) Owens-Corning

16. When did ACE Insurance Co., formed by 34 member companies in 1985 to provide $100 million in insurance limits excess of $100 million, pay its first claim?

- ○ a) 1985 ○ b) 1987 ○ c) 1990
- ○ d) It has yet to pay a claim

17. Which U.S. broker was the first to purchase an interest in a Lloyd's of London broker in 1980?

- ○ a) Alexander & Alexander Services Inc.
- ○ b) Fred S. James & Co. Inc.
- ○ c) Corroon & Black Corp.
- ○ d) Marsh & McLennan Cos. Inc.

18. When was a settlement agreement announced in the antitrust litigation brought in 1988 by state attorneys general against insurance industry trade groups and several insurers?

- ○ a) 1992 ○ b) 1993
- ○ c) 1994 ○ d) 1995

19. When did the Factory Mutual System announce that it would abandon its 140-year-old premium deposit plan, which required buyers to pay up to five times their annual premium cost in advance for a three-year policy?

- ○ a) 1977 ○ b) 1980
- ○ c) 1983 ○ d) 1987

20. Which U.S. congressman championed the cause of gutting the McCarran-Ferguson Act?

- ○ a) Jack Brooks ○ b) Fortney Stark
- ○ c) Henry Waxman
- ○ d) Daniel Rostenkowski

1. Which company's disability benefits policy led to the passage of the Pregnancy Discrimination Act of 1978?

- ○ a) General Electric Co.
- ○ b) Ford Motor Co.
- ○ c) International Business Machines Corp.
- ○ d) None of the above

2. What is the basic annual per participant premium the Pension Benefit Guaranty Corp. charges employers with fully funded pension plans?

- ○ a) $20 ○ b) $16
- ○ c) $19 ○ d) $100

3. Which White House aide directed the Clinton administration's ill-fated health care reform drive?

- ○ a) Leon Panetta ○ b) Ira Magaziner
- ○ c) Gene Sperling ○ d) Michael McCurry

4. What did Section 89 do before it was repealed?

- ○ a) Set non-discrimination rules for health care plans
- ○ b) Set non-discrimination rules for pension plans
- ○ c) Expand COBRA penalties
- ○ d) Set new rules for federally qualified health maintenance organizations

5. What is the one medical condition that allows an individual to qualify for Medicare before age 65?

- ○ a) Epilepsy
- ○ b) Acquired Immune Deficiency Syndrome
- ○ c) End Stage Renal Disease
- ○ d) Cancer

6. About how many people under age 65 are uninsured for health care expenses?

- ○ a) 20 million ○ b) 40 million
- ○ c) 50 million ○ d) 60 million

7. What is the most common vesting schedule defined benefit pension plans use?

- ○ a) Five-year cliff
- ○ b) Seven-year cliff
- ○ c) Seven-year graded
- ○ d) Five-year graded

8. Which benefit consulting firm did Mellon Bank Corp. acquire?

- ○ a) Kwasha Lipton
- ○ b) A. Foster Higgins & Co. Inc.
- ○ c) Buck Consultants Inc.
- ○ d) Coopers & Lybrand

9. Which country spends the most per capita on health care?

- ○ a) Canada
- ○ b) United States
- ○ c) Germany
- ○ d) France

10. Which Secretary of Treasury at one time proposed abolishing 401(k) plans?

- ○ a) Robert Rubin
- ○ b) Lloyd Bentsen
- ○ c) Donald Regan
- ○ d) James Baker

11. What did the Multiemployer Pension Plan Amendments Act of 1980 do?

- ○ a) Imposed withdrawal liability on employers leaving underfunded multiemployer pension plans
- ○ b) Allowed small unions to establish their own pension plans
- ○ c) Allowed unions to establish cash balance pension plans
- ○ d) Exempted multiemployer pension plans from PBGC insurance premiums

12. How many tax-favored medical savings accounts can be established under federal legislation passed last year:

- ○ a) 100,000 ○ b) 500,000
- ○ c) 750,000 ○ d) no limit

13. A 1996 law limits the period of time an employer can deny coverage for a new employee's pre-existing medical condition. What is that period?

- ○ a) 12 months ○ b) 6 months
- ○ c) 3 months ○ 4) 1 month

14. Which employer tried but failed to win Labor Department approval to reinsure its group term life insurance program through its Vermont captive?

- ○ a) Carnation Co. ○ b) CSX Corp.
- ○ c) Exxon Corp. ○ d) Microsoft Corp.

15. Which U.S. senator led the drive to impose stiff excise taxes on pension plan reversions?

- ○ a) Edward Kennedy
- ○ b) Howard Metzenbaum
- ○ c) James Jeffords
- ○ d) Barbara Boxer

16. Which employer established so-called follow-on pension plans after its massively underfunded plans were terminated?

- ○ a) LTV Corp.
- ○ b) Inland Steel Co.
- ○ c) General Motors Corp.
- ○ d) Chrysler Corp.

17. What does dual choice refer to:

- ○ a) Giving employees a choice of defined benefit and defined contribution plans
- ○ b) A requirement—no longer in effect—that said employers in certain situations had to offer HMO coverage to employees
- ○ c) Giving employees at least two investment options in their 401(k) plans
- ○ d) Giving employees in HMOs a point-of-service option

18. Beginning next year, what is the minimum inpatient coverage health care plans must offer after a normal vaginal delivery?

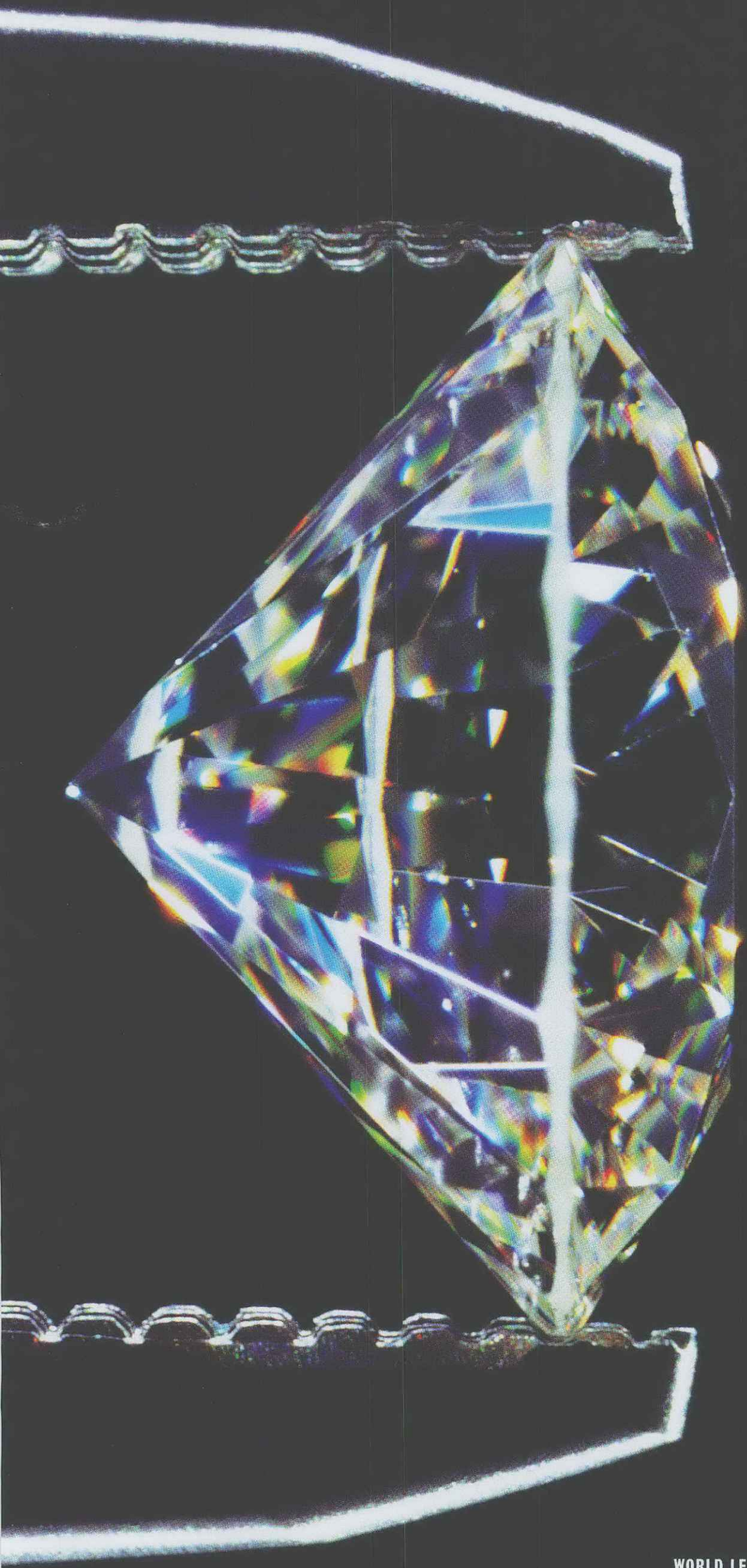
- ○ a) 24 hours ○ b) 36 hours
- ○ c) 48 hours ○ d) 96 hours

19. When did Congress pass the Family and Medical Leave Act?

- ○ a) 1990 ○ b) 1991
- ○ c) 1992 ○ d) 1993

20. How much federal withholding tax is imposed on employees' lump-sum pension distributions unless those payouts are directly rolled over into an IRA or a new employer's pension plan?

- ○ a) 5% ○ b) 10%
- ○ c) 15% ○ d) 20%



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—1972—

● Lloyd's of London and other British insurers are prepared for a claim of close to $8 million in the wake of the sinking of the once-stately Queen Elizabeth luxury liner. Lloyd's portion of the loss is expected to be about $3 million.

● Almost three-fourths of the insurers—255 companies—registered in the Bahamas prior to 1970 are eliminated in a government crackdown on suspect Bahamas-based insurance operations.

● Colorado becomes the first state to enact legislation encouraging the formation of captives that may underwrite corporate risks on domestic exposures.

● Widespread changes in state labor laws, Social Security and government hiring, promotional and retirement policies may come if 38 states ratify the Equal Rights Amendment passed by the U.S. Senate.

● Labor Department insiders say staffers are working hard on a system of self-inspection to help reduce on-the-job injuries and accidents. The plan would appeal to the budget-conscious Nixon Administration in fostering compliance without hiring thousands of inspectors.

● Company officials say the 20% increase in Social Security payments President Nixon signed into law will have varying effects on employers.

● More than a million California union workers have coverage that is completely employer-paid to help with hospital, surgical and other medical costs for the workers and their families.

● The Food and Drug Administration raises eyebrows with its announcement that the "National Electronic Surveillance System" has been put into service, connecting 119 hospital emergency rooms in 30 states with a computer in Washington. The system will provide "a daily nationwide summary of household accidents."

● The National Assn. for Female Executives is working with CNA to design group insurance plans tailored to the lifestyle and independent financial status of women executives.

The move is a response to income protection insurance policies that generally will provide a woman executive only half the coverage a man gets even if she makes more money than him and life insurance that covers her with a spouse add-on clause to her husband's policy rather than offering her a high-limit policy for herself.

—1973—

● International Business Machines Corp. adds an adoption assistance plan to its employee benefit program. It is believed to be the first of its kind by a major U.S. employer. The plan will pay 80% of eligible expenses up to a total of $800 for each adoption. The benefit enhancement was made because "it just seemed like a good, equitable thing to do," said an IBM spokesman.

● Monty Hall, television host of game show "Let's Make A Deal," has been insured for $1 million. Mr. Hall's safety has been in question at times as frenzied prize winners, garbed in bizarre costumes, beat him from the sheer ecstasy of landing a great American windfall. Hatos-Hall Productions Inc., which produces the program, has obtained a Lloyd's of London policy on Mr. Hall. The policy covers disabling injury or death incurred during the show.

● Coverage in excess of $6 million is put together in London and spread among a number of large insurers to cover Secretariat, the horse favored to win the Kentucky Derby. The policy covers all risk of mortality from disease or accident and against possible sterility of the horse when it reaches siring age. Johnson & Higgins engineered the policy.

● Fearful of product liability lawsuits, General Motors equips its 100,000 1974 cars containing optional air bag safety equipment with electronic recording devices capable of providing information about the new system's performance during a collision. The devices are designed to help refute claims by owners of air bag-equipped cars that the system malfunctioned in some way.

● Blue Cross of New York will offer its first prepaid group health plan ever at the Long Island Jewish Hillside Medical Center. A full range of clinic and hospital services will be available under the new plan for a single monthly premium. Tentative rates have been set at $23 for a single person, $46 for two, and $70 for more than two.

● Betty Grable's death on July 2 brings to an end an insurance legend: the girl with the million-dollar legs. The 20th Century-Fox film studio claimed in the 1940s it insured Miss Grable's famous "gams" for $1 million with Lloyd's of London. Whether the policy was ever actually written remains a mystery. No written record of it exists at Lloyd's or the studio.

● The national energy crisis is not a major worry for corporate risk managers, they tell *BI* in an informal survey. Most of the risk managers said their companies had experienced no problems due to the energy crisis and that they did not expect any in the future.

● A bill that would limit private expenditures for medical care in the case of catastrophic illness is introduced in the Senate. The bill, introduced by Sens. Abraham Ribicoff, D.-Conn., and Russell Long, D.-La., would limit individuals' expenses to $2,000 and the first 60 days of hospitalization. It also would make available a "certified private insurance policy at a reasonable cost" to cover those expenses. And, low-income people would have all health expenses paid by a federal program.

—1974—

● President Nixon signs into law only two days before the end of 1973 a bill requiring all employers with more than 25 employees to offer optional enrollment in an HMO if one is available in the area.

● The Health Maintenance Organization Act of 1973 authorizes $375 million over the next five years for evaluation and organization of HMOs around the country. There are an estimated 115 such group practices currently in operation.

● B.F. Goodrich discloses that it has traced four worker deaths to a rare cancer caused by vinyl chloride, making it a major new occupational hazard.

● The Nixon administration proposes a national health insurance plan that would require employers to offer a group health insurance plan that includes elements of "basic coverage," including unlimited hospital and physician services, payment for out-of-hospital prescription drugs, prenatal and maternity services, limited mental health care and well-child care. Administration officials estimate the plan will cost employers between $310 and $415 per full-time worker.

● George Foreman, the boxing heavyweight champion, is protected by an American International Underwriters Corp. 24-hour, all-risk accident policy until he steps into the ring in Caracas, Venezuela, March 26 to defend his title against Ken Norton. Purchased by Video Techniques Inc., the $350,000 policy covers the company's interests in Mr. Foreman should he be unable to fight because of an accident prior to the bout.

● The worst air crash in history occurs when a Turkish Airlines DC-10 jumbo jet goes down outside Paris, killing 346. Lloyd's of London and the London market have the majority of the $20 million hull coverage. Passenger liability claims are expected to add an additional $10 million to $20 million in losses. In addition, the possibility exists of liability suits against the plane's manufacturer, McDonnell-Douglas Corp., because the crash occurred when the plane lost its cargo door.

● A federal district judge rules that General Electric Co. was guilty of sex discrimination because it denied disability benefits to its pregnant employees. The judge found GE's policy to be in violation of the Civil Rights Act of 1964. GE is expected to appeal the decision.

● By his resignation, President Nixon preserves his employee benefits, which include an annual $60,000 pension for life. Mr. Nixon probably would have lost his benefits had he been impeached. He still could lose his benefits if he is indicted and prosecuted for his role in the Watergate cover-up.

● Pension reform fallout is expected as soon as President Ford signs the Employee Retirement Income Security Act of 1974, a move expected on Labor Day. A "suicide" loophole is expected to trigger an unknown number of plan terminations, which may hit the Pension Benefit Guaranty Corp., a federal agency created under ERISA.

● Motorcycle stuntman Evel Knievel's Snake River Canyon jump spectacular on Sept. 8 requires him to provide more than $1 million in liability insurance to protect his audience and the grounds they use while watching his jump. Mr. Knievel attempts to ride a rocket-powered motorcycle across the canyon, which is 1,600 feet wide and 540 feet deep, but the ride is cut short when his drogue parachute opens prematurely. He opens his main chute in time to land safely on the canyon bottom.

Continued on next page

A LOOK BACK

1972 ● 1976

30

Continued from previous page

● A flurry of litigation is initiated in the wake of a growing controversy over the effectiveness and safety of the Dalkon shield.

● Railroad property and liability underwriters are moving out of the market so fast it's hard to say who is writing the business anymore. Recent government publicity describing as potential bombs railroads that transport dangerous materials, coupled with publicity about the extremely poor maintenance of roadbeds by the railroads, has forced insurance rates skyward while deductibles have doubled.

out will mean a loss of $1 million in premium income for OIL.

● Five lawsuits against Mattel Inc. are settled out of court for $30 million, by far the largest directors and officers settlement in history. The settlements involve class-action lawsuits filed in 1973 and 1974 charging securities law violations. Three groups of Mattel's D&O underwriters—Lloyd's of London and the London market, International Surplus Lines Insurance Co. and Unigard Insurance Group—will pay a total of $13.8 million of the settlement.

● In five years, property/casualty self-insurance will increase by 50% due to corporate economizing, Time Inc. predicts. Employee benefits self-insurance is likely "to double" in this period. Time's marketing department found in a survey of more than 500 corporations.

● A U.S. Tax Court ruling in a petition filed by Ford Motor Co. is expected to have a major impact on the future of captive insurance companies. The case, generally considered a landmark for captives, involved a petition filed by Ford as the result of a $6.6 million assessment by the Internal Revenue Service on premiums paid by Ford's foreign subsidiaries into its Bermuda-based captive, Transcom Insurance Co. Ltd. The IRS claims "payments from foreign subsidiaries (to captives) are receipts of dividends to the domestic corporation advanced to the offshore company," because by insuring risk in a wholly owned captive, the economic loss remains in the corporate family.

● The first of what is expected to be a multimillion dollar series of lawsuits filed by relatives of the crew of the Edmund Fitzgerald, an ore boat that sank in Lake Superior last month, are filed in district court. Relatives of two of the 29 crew members, all of whom died when the ship sank during a severe storm on the lake, file a $2 million lawsuit. The suit charges negligence in the way the vessel was loaded.

● The recent growth in medical malpractice lawsuits and awards adds significantly to the cost of insurance for physicians and hospitals this year and will add to health care costs for everyone, according to the Health Insurance Assn. of America. The HIAA said malpractice insurance costs to physicians and hospitals in 1975 was $1.5 billion, a 25-fold increase from $60 million in 1960.

Continued on next page

—1975—

● The Ford administration will not submit a national health insurance proposal to Congress in 1975, and President Ford is "almost certain" to veto any national health insurance measure passed by Congress this year. The decision is based on the state of the economy and President Ford's one-year moratorium on all new federal spending programs.

● More companies are using self-insured employee benefit programs, according to a Fortune Market Research study of the top 1,000 U.S. industrial corporations.

● Burmah Oil & Gas Co. completes a record-size placement of an offshore oil drilling risk into five layers with coverage written jointly by more than 100 insurers. The complex structure of the placement will save Burmah significant premium dollars.

● The U.S. Supreme Court overturns a long-standing maritime liability law, establishing in its place a comparative negligence rule for assessing ship collision damages. Previously, financial responsibility was split evenly between parties involved regardless of fault.

● A bipartisan effort is under way to amend the Health Maintenance Organization Act of 1973. Identical bills have been introduced in the Senate and House to change the act to reduct the burdens it places on employers and to cut the cost of the benefit programs HMOs must offer.

● Gulf Oil Co., one of the founders of Oil Insurance Ltd., the petroleum industry's mutual insurance company launched in 1971, is withdrawing from OIL effective Jan. 1, 1976. The mutual's largest member, Gulf's pull-

In 1906, CNA was one of the first companies to insure working women against accidents and illnesses, occurring on the job or away.

1897 1997
A Century of Commitment

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Continued from previous page

—1976—

● Three property insurers share the brunt of the coverage for a bombing of LaGuardia Airport on Dec. 29, 1975, during the height of the Christmas rush. Kemper Insurance Cos., Federal Insurance Co. and Arkwright-Boston Insurance Co. all have policies that will be triggered as a result of the bombing, which ripped through a locker area, killing 11.

● The Supreme Court in March refuses to expand the 1934 Securities-Exchange Act to include negligence as a basis for civil suit by victims of fraud. The court said Ernst & Ernst, one of the "Big Eight" accounting firms, could not be sued for failing to uncover a securities swindle carried out by a firm it audited. The decision should ensure that accountants' liability insurance remains available, though rates are not likely to drop soon.

● Acting Federal Insurance Administrator J. Robert Hunter has warned the insurance industry to clean up its own act quickly or face federal action. Mr. Hunter told the Independent Insurance Agents of Wisconsin that though insurers' financial situation is improving, he fears they may be implementing excessive rate increases.

● In an effort to control health care costs, the major automakers, the United Auto Workers and Michigan Blue Cross-Blue Shield set up a voluntary pilot program providing coverage for second opinions in elective surgery cases.

● Reforming the McCarran-Ferguson Act, which for more than 30 years exempted the insurance industry from antitrust laws, would bring about the benefits of more competition and less regulation for industry and consumers alike, suggests a top Justice Department official.

● A majority of U.S. employers offer dental benefit plans, according to the first-ever *Business Insurance* Employee Benefit Board survey. The survey of 90 benefit managers shows that more than 60% have dental plans, covering a total of 1.5 million workers, and other companies intend to iomplement the plans soon.

● The unexpected August resignation of James D. Hutchinson, administrator of ERISA for the Labor Department, is a dramatic sign that crucial administrative problems still exist after two years of hammering out the meaning and workings of the complex pension reform law.

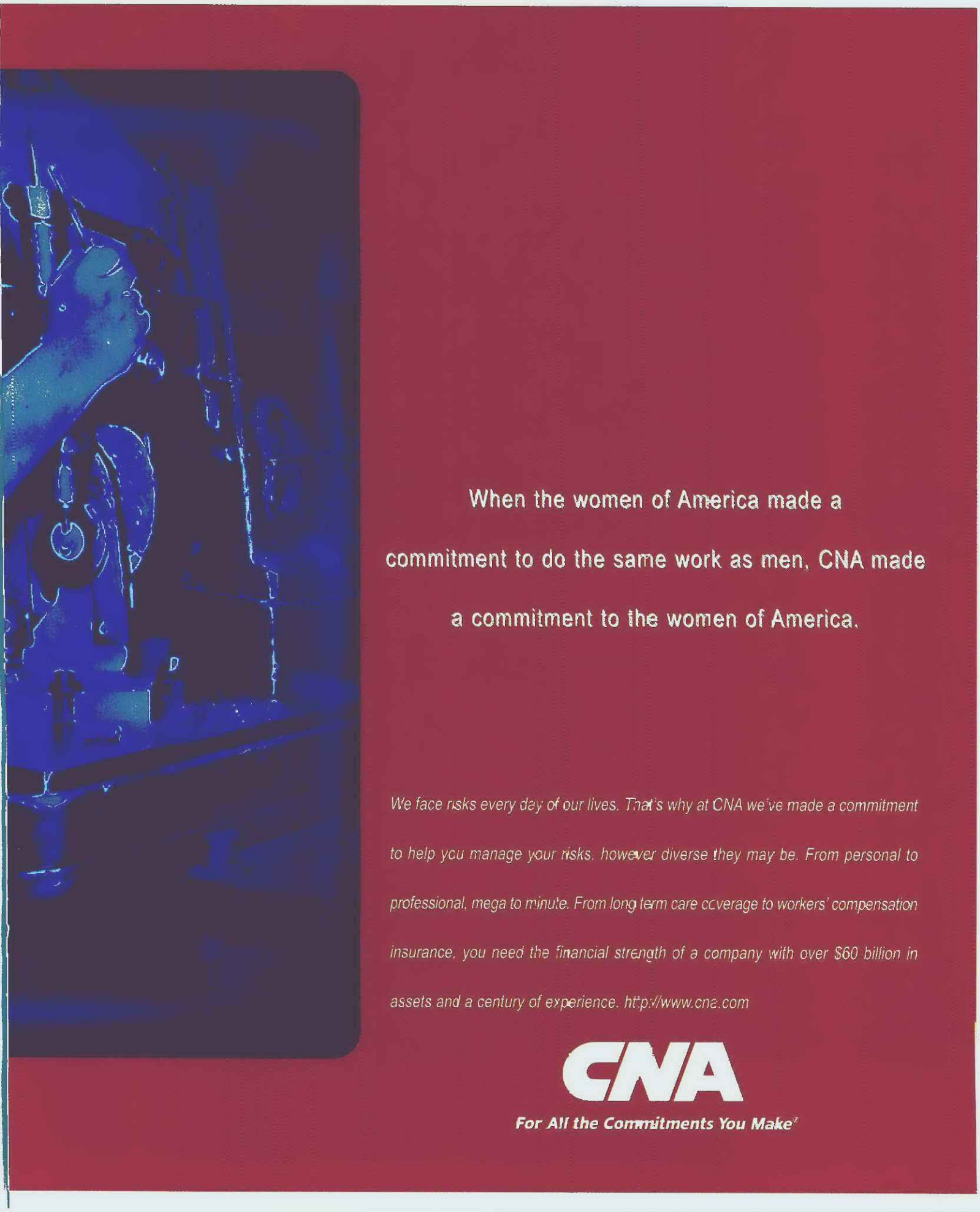
● Private sector U.S. companies paid an average of $3,984 per worker for employee benefits in 1975, a 23% increase over costs only two years ago.

● Despite good loss experience this year, especially in the liability area, the overwhelming majority of insurance managers on *BI*'s Editorial Advisory Panel expect premiums to continue to climb though the end of this year. All of the panelists who have already gone through renewals report that rates increased across the board from 10% to as much as 450%.

● The Supreme Court rules that excluding pregnancy from disability insurance is not discriminatory, reversing rulings by six courts of appeal, including the ruling in the General Electric Co. case before the court. Legislators immediately begin considering amending Title VII of the Civil Rights Act to circumvent the decision.

● Even as they struggle under huge premium increases for group health insurance during 1976, employee benefit managers say they expect more of the same next year. As a result, the benefit managers on *Business Insurance*'s Employee Benefit Board say they are seriously considering internal funding programs for employee benefits, either through tax-sheltered trusts or other types of self-insurance.

● A 25% increase in the membership of Lloyd's of London assures greater capacity for Lloyd's during 1977. More than 2,400 new names will be joining Lloyd's syndicates during the next year, bringing the total number of names to more than 10,000 and providing additional capacity. However, many at Lloyd's note that much of the added capacity will be eaten up by inflation. Because of inflation, experts estimate the actual gain in capacity at Lloyd's from the 25% increase in membership will be only 12% to 15%.



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VIEWS

Joseph P. DeAlessandro

Versatile career includes creation of indispensable coverages

"I like building," says Joseph P. DeAlessandro, and in his long career in the insurance industry he has done his fair share of building new coverages for policyholders in the United States.

Most of the innovations he was involved in were developed in the 20 years he spent at American International Group Inc. In that time, he and his team at the AIG subsidiary National Union Fire Insurance Co. of Pittsburgh, Pa., where he became president, helped nurture directors and officers liability coverage from a fledgling product to indispensable insurance protection for corporations; created Employee Retirement Income Security Act fiduciary liability coverage; developed kidnap and ransom insurance for bankers; and developed private political risk insurance in the United States.

After he retired from AIG in the mid-1980s, Mr. DeAlessandro helped Sanford Weill build Commercial Credit into the Travelers Group through a series of audacious takeovers.

After retiring again he then took on his present job in the early 1990s as a partner in American European Group, which specializes in taking over and turning around insurance companies, including Kentucky National Insurance Co. and Rutgers Casualty Insurance Co. Mr. DeAlessandro, 67, is president and CEO of both companies.

Mr. DeAlessandro recently spoke with New York Bureau Chief Gavin Souter.

Q: What would you say was the most significant thing you were involved with in your time in the insurance industry?

A: I think the most significant was the formation and development of directors and officers liability insurance when I was with Hank Greenberg. Hank is phenomenal at being able to assess the ability of a person and let them run with it—and as long as they do well he never interferes. So I had the opportunity to go in there and develop a product which I thought was a good one.

At the time that I started getting involved in D&O there was a major question as to whether or not it was a legal coverage, whether or not a corporation could pay the premium on behalf of its directors and officers.

We formed a group to influence the legislators to suggest to them that they make it possible for corporations to buy it, because in essence D&O protects the shareholders' interests. And we were very influential in getting the Delaware statute to be approved in 1967, allowing corporations to buy D&O insurance and also to put provisions in their bylaws to enable the company to indemnify the directors and officers for certain acts that would not be considered criminal or self-dealing.

So we made a very strong mark on the market. Then it was a question of selling the insurance to people we felt needed it but didn't know they needed it. I decided that we had to get a major national account to really show that somebody was standing up and listening and I honed in on Coca Cola.

It was the kind of account we wanted. It was squeaky clean, well-managed and extraordinarily accepted by the people. So I made a couple of visits down to Atlanta and after a long discussion about why they needed it vs. why they didn't they bought the policy and that was really the beginning.

PHOTO: DAVID LUBARSKY

What was the reason behind the product?

First of all, the people who serve as directors of a company are putting their fortunes on the line without D&O insurance. If there is any litigation against the company, it's against the directors and officers.

But it was unclear as to whether a corporation was able to help them. So with the blessing of the state of Delaware we were able to determine that there was an indemnity that could be available to the directors via corporate reimbursements, so now the corporation had a liability. So you have now created a liability and you have a policy to protect that liability.

From the directors' point of view, they were fine with being indemnified by the corporation and the corporation being reimbursed by an insurance company. But there were certain instances where the corporation was unable to protect them by statute because of either some criminal wrongdoing or something they had done individually where the corporation could not pay for hurting itself.

So you have a policy that does two things. One was corporate reimbursement, which protected the corporation for indemnities it could make on behalf of the directors, and the second piece, for directors and officers directly, where they couldn't be reimbursed by the corporation. So we gave them a rounded package.

At first people were dubious about it but it is now a household item.

How important was D&O in the overall development of the commercial insurance market?

It became a very important production tool. By the 1970s, if you wrote the D&O you could demand the balance of the account. It was a hook and worked very successfully.

You could count the number of companies that wrote D&O on the fingers of one hand and have two fingers left over. So we could say we would be happy to write your D&O and we would like to have the opportunity to write the balance of your business, and we did.

How else did the coverage expand in the first few years?

Well, a few years later, in 1969 or 1970, I started a new program for bank directors and officers. No one wanted to insure banks. The theory went that the bank directors are only rubber stamps, they don't know what they are doing, they have no knowledge and some nefarious guy comes in and runs the bank.

I said "Bullfeathers, that isn't true anymore." So I launched a program for small banks which became very successful.

Then we wrote for larger banks, less successfully than for the smaller banks.

Around the same time that we did the banking program, I came out with my BEPI program—Bankers Executive Protection Insurance. In the 1970s we had a rash of kidnappings in the country and they were focussing on banks.

The modus operandi was they would call the president of the bank and say we have your wife and we want $25,000 in a brown paper bag and we'll collect it at McDonalds in an hour. Now, the kidnappers knew at that time a bank executive was able, under his own recognizance, to take $25,000 out of the bank. This went on and on and on.

We wrote the coverage for the kidnappings and it became very successful.

It was interesting, because when the banker took the funds from the bank and conveyed them to a third party he was actually in default, because he took funds that were not intended for the purpose of paying off the kidnappers. Therefore there was a serious question about the ability to cover the presidents of the banks.

So I said, look, when you buy my coverage under the BEPI program you will assume that we have on deposit in your bank the limit of the liability of the coverage you purchased so that if the situation should develop where the president needs to take the money to pay off the kidnapper, he will not be defaulting, he will be using monies that are there for that purpose. It was a big change.

How did you become involved in the ERISA coverage?

I had researched with my people the effect of the ERISA law that was coming through Congress in 1974 and the need for it. The intent of ERISA was basically to provide fiduciary liability for those who have an involvement with employees or employee trusts.

We researched it and determined a format for the coverage. President Ford signed the bill on Sept. 26th, I had a policy on the street on the 27th, and we became the lead market in ERISA.

As a marketing tool we also decided to put both D&O and ERISA coverage under the one policy, because eventually there were insurers that wrote ERISA but not the D&O and there were D&O carriers who didn't write ERISA and since we wrote both we developed the package policy.

Why did you want to get into political risk coverage?

The concept of AIG was we wanted to be as much of an insurance supermarket as we could be. We didn't want somebody to walk into our office with a program and then have to walk into another company to finish it off.

At AIG we had an awful lot of interna-

See **DeAlessandro** *on page 44*

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VIEWS

Rep. John D. Dingell

Leader in federal solvency reform critiques insurance regulation

U.S. Rep. John D. Dingell, D-Mich., rocked the insurance industry in 1990 when the House Oversight and Investigations subcommittee that he chaired released its report "Failed Promises." The report, which blasted the quality of state insurance regulation, rekindled the debate over what role, if any, the federal government should play in insurance regulation, which has traditionally been a province of the states.

Rep. Dingell, 71, who was first elected to fill his late father's congressional seat in 1955, later introduced a bill to provide federal insurance solvency regulation, but it was never enacted. His 1994 follow-up report, "Wishful Thinking," was no more complimentary to state regulation of insurance than his initial report. By then, significant portions of the insurance industry had endorsed the idea of federal solvency oversight for multistate insurers. But any chance of federal insurance regulation seemed to vanish when voters gave Congress its first Republican majority in 40 years in the 1994 elections.

Rep. Dingell, whose 14 years as chairman of the House Energy and Commerce Committee made him one of the most powerful people in Washington, recently discussed the quality of insurance regulation, the outlook for product liability and Superfund reform and one of his longtime legislative goals—radical reform of the nation's health care system—with Washington Editor Mark A. Hofmann.

Q: As a proponent of federal regulation of insurance solvency, do you think the issue is ever likely to re-emerge? Do you see any appetite for it now with the Republican majority?

A: Are you speaking about me personally, or are you speaking about the issue in the abstract?

First of all, I continue to have an interest in insurance solvency. And I do that because I'm convinced it is going to be an ongoing problem that is going to afflict business, which is going to afflict the insurance industry generally—particularly the honest and responsible insurers—and it is going to affect the insured, because they're going to confront on a continuing basis questions associated with solvency. It's also going to cause significant problems for state and local government units and federal government, which is not infrequently going to be called upon to pony up money to deal with insurance collapse. It's going to be a major problem with regard to fraudulent behaviors on the part of overseas insurers, the inability of state insurance regulators to reach across state lines outside the boundaries of the United States to address either incompetence, inadequate reserves, insolvency or—quite honestly—outright fraud and criminality.

It also is going to be a very major problem insofar as reinsurance, and the fact that foreign nations are becoming the havens of scoundrels who will take advantage of American companies, American individuals and businesses by selling inadequate insurance.

I remember at one point British insurance regulators talking about how they were going to take care of British insureds (of insolvent insurers), and then the question was what they were going to do about American insureds. They said that is an American problem.

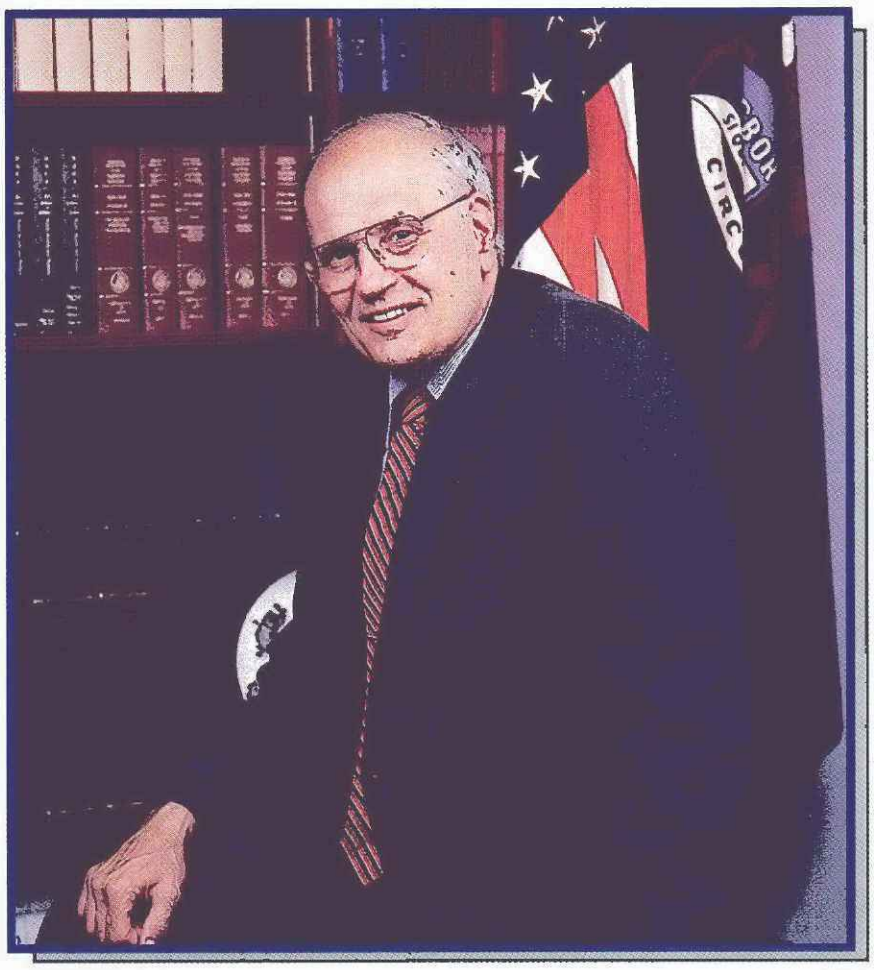


PHOTO: DAVID HITTLE

Is there any appetite in this Congress to revisit that question?

No.

Do you see anything on the horizon that might change that?

A Democratic Congress.

A major insolvency?

A major insolvency would be helpful.

What led you to become involved in the solvency question to begin with?

A wave of insurance company collapses, massive frauds, misbehavior across state lines that state regulators were incapable of reaching, misbehavior outside of this country taking advantage of U.S. insurance companies and U.S. insureds. Also, significant problems in terms of state regulators being able to reach wrongdoers who had run outside the country or across state lines to do business to the detriment of American business, individuals and insureds of different kinds and categories. And a succession of massive insurance failures that had to be made up by honest people in the insurance companies, by the stockholders, the insureds and quite honestly by the policyholders of the mutual companies who were compelled to pony up to deal with the problems of other insurance companies.

And also the rampant incompetence and incapacity of state regulators to address these problems.

Speaking of state regulators, what's your opinion of the National Assn. of Insurance Commissioners' accreditation program to improve state oversight?

We had a number of interesting hearings on that. We had them in to discuss those matters and I found that in many of the meetings where they discussed the question of accreditation they were more interested in the menu and the solicitation of funds to provide adequate entertainment for the state regulators than they were ever in addressing the question in a real and vigorous fashion.

Do you think there's been any improvement in the quality of state regulation since you began looking into it?

No. As a matter of fact, if you look you will find that there was a very significant problem about one company that moved overseas to escape U.S. regulation and U.S. controls. They went into bankruptcy.

Are you referring to EMLICO?

Yes.

In "Wishful Thinking," you singled out Bermuda as a domicile with lax regulation....

Let's see, I could mention Bermuda, the Cayman Islands, Turks & Caicos, and a number of other impecunious offshore islands where they're less interested in American insureds than they are in getting the necessary filing fees, and becoming offshore banking centers for things like money laundering and other things of equal interest to the United States government.

Switching gears a little bit, you've been a longtime supporter of federal product liability reform. What aspect of reform do you feel is the most important and what kind of changes are necessary in order to get the president to go along with reform? Or is that an impossible question?

First of all, getting meaningful reform is the important purpose, and getting it in early and getting something that the president could sign is important. To go beyond that I think would be unwise for me at this particular time because I have negotiations going on with the White House and with my colleagues on both sides of the aisle to try to come up with a piece of legislation that the president can sign.

The parameters were the bill that was sent to the president and the veto message. We'll try to see what we can get that will enable us to get something that will pass the House and Senate, and be supported by the leadership in both the House and Senate and ultimately be signed by the president. That's my purpose.

Having said that, there's not a whole lot I can go into in specific details because, quite honestly, I don't want to occlude my prospects by defining specific goals.

I'm sure you're aware of the fact that our product liability compensation system is one which drips unfairness to everybody. It inhibits our competitiveness. It creates a situation where innocent sufferers are oftentimes not treated justly, are not compensated fairly, and wind up being victimized by a system that is supposed to help them.

In a similar situation, oftentimes, innocent manufacturers and innocent providers of important services wind up being highly victimized to no particular benefit on the part of anyone.

Regarding Superfund reform, do you think risk managers and insurers ought to drop their efforts to repeal retroactive liability?

Well, remember, I am a pragmatist. What I want to do is make progress in

Continued on next page

Continued from previous page

the public interest and not spend my time in vast theological arguments about what ought to be done or what ought not be done.

There are easily identifiable questions that we need to address, and within a realm of reason we can deal with those in an intelligent fashion.

Having said that, we have a fine beginning in the proposal which we put out of the committee under my leadership when I was chairman in 1994 by a vote of 44 to nothing. In an unfortunate burst of partisanship, my Republican colleagues decided they did not want that piece of legislation enacted (*BI* May 23, 1994).

So, in '94 they took over and in another burst of partisanship they decided they were going to write a most curious piece of legislation which would essentially have the taxpayers and the public pay the polluters, which was a piece of assininity that I've rarely seen exceeded in this place.

Having said that, I think if we were to take as a beginning point what we did in '93 and proceed forward we could achieve some meaningful relief for industry and could have something which was supported by industry, by the environmentalists and by government.

And perhaps it would be possible to achieve some additional changes in the law that could again help industry and might expedite the entire process, eliminate a lot of litigation and a lot of the huge and costly wastes of time, money and effort that are now a regular component of the Superfund problem.

You've been an advocate of comprehensive health reform for a long time, including a single-payer system. President Clinton's effort didn't go anywhere. Do you think the time is going to come when a single-payer system or other broad changes in the health-care system are going to be possible?

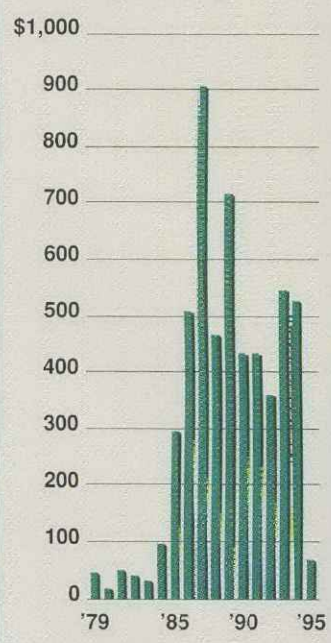
Well, again, I am a pragmatist. I have my ideas of what perfection would be. I happen to think that the country needs an intelligent single-payer system. I can establish that it costs less, entails less fraud and misbehavior, is more efficient in terms of delivery of services and the basis of cost and the needs of employers and ordinary citizens as well as doctors and other health-care professionals.

I will tell you that the current system pleases no one. It costs too much. It's riddled with waste, fraud and abuse. It leads to numbers of people being uncovered, without any health care whatsoever. It results in people paying costs that they should not pay, people paying for the costs of services provided for others. It disregards oft times the needs of the patient. It intrudes into doctor-patient relationships in a most curious and extraordinary and vicious fashion and it leads to a situation where the doctors are losing faith in the system because they're finding that no longer do they relate to their patient but rather to some faceless bureaucrat in some kind of private entity that is not even responsive to government.

So, we are going to have to do something about it and as soon as people realize it costs too bloody much and affords too little in the way of what people want from a decent health care system, we'll get on to doing something. 30

Bailing out insolvent insurers

Total guaranty fund net assessments by year*
($ millions)



*Does not include New York, which operates on a prefunded assessment basis
Source: National Conference of Insurance Guaranty Funds

GRAPHIC BY JOHN HALL

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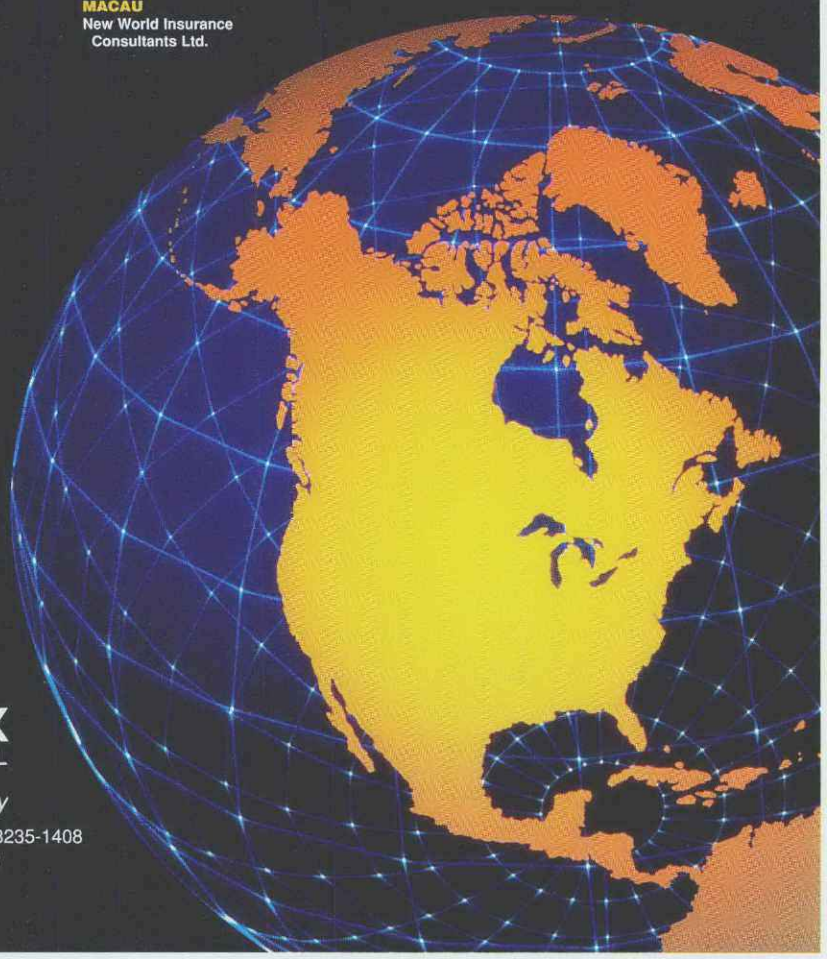

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Opening doors in industry

Women find success, though insurance still male-dominated field

By JOANNE WOJCIK

A woman who wants to succeed in the insurance business has to get up pretty early in the morning.

She'll probably have to work a lot of nights and weekends, too

And when she finally wins that coveted key to the executive washroom, she probably won't have a lot of other women to share it with.

In fact, the much talked-about layoffs in middle management at companies and organizations during the 1990s severely depleted the ranks of women waiting for their chance to grab the proverbial brass ring.

But while most of the women who've made it to the top acknowledge a glass ceiling still exists, in many cases it's moved up a bit higher. In some places, it may even be cracking.

"There's still a sort of 'old boys' network," observed Ellen Thrower, president of The College of Insurance in New York.

"It's still pretty much a male-dominated corporate world," agreed Sheila Small, director of risk management at Bell Atlantic Corp. in Philadelphia.

When Cheri Hawkins was elected the first woman president of the Risk & Insurance Management Society Inc. in 1990, 30% of the key risk management jobs were held by women, Ms. Hawkins recalled.

Ms. Hawkins

"I don't know how many women are risk managers today, but I expect it's a lot more," she said.

Even though she retired last year as risk manager for Tacoma, Wash.-based Weyerhauser Co., Ms. Hawkins still is working in the field. As president of her own firm, Risk Management by Referral, Ms. Hawkins is working as a free-lance risk manager for a temporary employment company from her home in Auburn, Wash.

While more women have moved into risk management over the past 10 years, "it's hard to find good positions after the corporate restructuring" that occurred in the past few years, according to Noreen Klink, risk manager of the Helene Curtis business unit of Unilever Home & Personal Care USA in Chicago.

In most companies, risk management is "a middle-management function, and those were cut back the most in the last recession," she explained.

"There's definitely a glass ceiling, but it's moved up a lot higher," said a more optimistic risk management executive who did not want to be identified.

She recounted an anecdote from the mid-1970s when she was awarded her first "office" after a promotion to risk analyst.

"My boss told me not to call it an office. He said to call it an 'alcove' instead," she recalled.

Later, when the director of purchasing was looking for a desk for a newly hired auditor, he asked her: "Do you really need this manager's desk? Wouldn't you rather have a secretary's desk?"

But that newly promoted woman risk analyst didn't back down.

"No, I like this desk. I think I'll keep it," she said.

Assertiveness like that is one of the traits most women find necessary to succeed in the traditionally male-dominated insurance world.

Women need to call more attention to themselves to make their colleagues and upper management aware of their worth, said Paula Gould, senior vp of J&H Marsh & McLennan Inc. in New York.

While younger women are better at blowing their own horns, many older women feel uncomfortable doing that, she observed.

Besides being assertive, women also must see themselves as equals to men in the business world, according to Eileen Jo Brayman, vp of marketing and vp of risk management for Sander A. Kessler & Associates Inc., a retail insurance broker in Santa Monica, Calif.

Ms. Brayman

"Be yourself. There's nothing wrong with being feminine," she said. "But women also must have a comfort level in associating with a man, woman—anyone—without an attitude. See yourself as an equal in the business world."

She gave as an example the time she was to take a couple of Hispanic clients out to lunch. "Because of their culture, they had a problem with my picking up the check for dinner," she explained.

But she eventually won them over when they realized she wasn't a "woman," per se, but their insurance broker, which, in effect, is a genderless role.

Career-oriented women also should continue their education, women executives agree.

"Merit is the thing that's going to carry the day," observed Heidi Hutter, chief executive officer of Swiss Re America Corp. in New York.

"Pursue a professional designation. It's a mark of individual achievement," she advised.

Ms. Hutter also encourages women to "get involved in professional organizations. Write an article, give a speech. There are so many ways to get involved."

Indeed, "The women that I know all have a tremendous appetite for knowledge, professionalism and a desire to complete things," said Linda Brooke, executive vp of the Connecticut Interlocal Risk Management Agency, an intergovernmental insurance pool based in New Haven.

"There also is a growing tenaciousness and competitiveness," traits that not only will enable women to further their own careers, but which also are necessary for risk managers to sell their own programs to upper management, she explained.

Ms. Brooke

"In the past, women were much less aggressive," Ms. Brooke recalls.

"What makes the risk management professional truly successful in most organizations today is a combination of communication skills and the ability to build and work in cross-functional teams," observed Dickie Brooks, director of risk management for E. & J. Gallo Winery in Modesto, Calif.

"This is good news for women who are typically rewarded and reinforced throughout our social and educational systems for communicating effectively and for working in groups," she said.

The new client-focused approach many insurance and risk management organizations have adopted in recent years also is giving women—who by nature and socialization often act as caregivers—a chance to shine, points out Ms. Gould.

Risk management is a natural occupation for women who historically have had to handle more than one task at a time, observed Ms. Small of Bell Atlantic.

Ms. Small

"You need to have a high energy level, be highly organized and be able to handle a lot of balls in the air at once," she said.

Besides her demanding career with its

See **Women** *on next page*

TRENDS & ISSUES

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30 VIEWS

William Gradison

Insights into the past and future of health care policy-making

Remember Harry and Louise?

They were the middle-class couple that worried so much on television commercials about how the Clinton administration's health care reform package would destroy the health care system.

The couple was fictional, but their anxieties about the Clinton proposal in an advertising campaign paid for by the Health Insurance Assn. of America, an industry trade group, had much to do with increased public skepticism of the package and the eventual collapse of the plan.

A professional advertising agency created the Harry and Louise campaign after HIAA President Bill Gradison came up with the idea of a couple sitting down at a kitchen table, the place where families often talk through issues.

Reflecting three years after the demise of the Clinton plan, Mr. Gradison, 68, attributes the plan's failure to many administration mistakes, not the least of which was the administration's secrecy and its overreaching.

Mr. Gradison has considerable experience and success in developing a consensus.

Before joining the HIAA in 1993, he served 18 years as a Republican member of Congress, including as ranking minority member of the House Ways and Means Health Subcommittee. Widely respected for his moderation and political good judgment, Mr. Gradison helped develop and win passage of a wide variety of health care legislation, including COBRA's health care continuation provision.

Mr. Gradison discussed his views on a variety of health care issues with Editor-at-Large Jerry Geisel.

Q: The year is 1992. Bill Clinton has been elected president. Were you hopeful or fearful of what the new administration would propose in the health care reform package that it said it would develop?

A: I didn't have any idea of what they would come up with. Health care reform was an issue—responding to what was thought was public concern—that the administration gave a high priority to.

But the process they set up to develop their plan made it very difficult from the outside to get a sense of what it might actually be.

Did you think you could work with the Clinton administration?

Absolutely.

All my Washington experience suggested that reasonable people can sit down and work things out. We attempted to do that. But in the end, it proved impossible because the administration decided it needed some villains in order to sell its plan.

Insurers were to be among the selected few. Saying that was not paranoia. It was reality. It was reflected in statements that came from the First Lady, among others.

When did you get a sense that the administration was not interested in working with the health insurance industry?

I had three meetings with Ira Magaziner, which were totally pleasant. He started the first meeting by saying something like, "Pollsters at the White House tell us that it will help us to sell our plan if we identify as enemies (of the plan), health insurers, the pharmaceutical manufacturers, and the physicians." The physicians later were dropped.

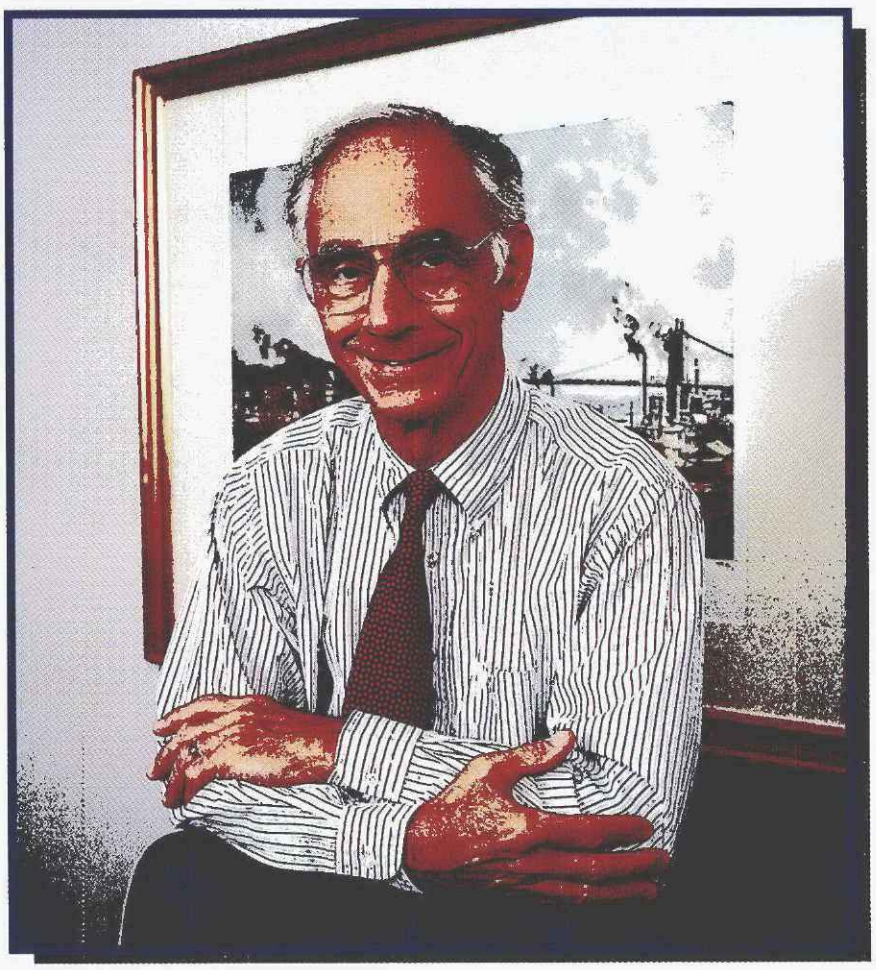


PHOTO: DAVID HITTLE

When did you decide that you had to take, if you will, a more aggressive, a more adversarial approach?

When the August 1993 recess of Congress came along, there was a paper developed for Democratic incumbents for when they went back to their districts. It was chock-full of inaccuracies and criticisms of our industry.

Our chairman then—David Hurd of The Principal Financial Group—went through and marked up a copy. I believe he identified 40 or 50 inaccuracies or unfairnesses in there. From then on, my counsel of "let's try to work with them" didn't carry much weight.

David took the lead in pressing us to develop a more aggressive stance, and also a fund-raising effort among members to finance an aggressive campaign.

It was a voluntary fund-raising campaign but an extraordinary success. I think that was partly a result of the industry reacting to unfair criticism and a reaction to Dave Hurd's leadership.

Harry and Louise—that middle-class couple that had so many anxieties about the Clinton health care reform plan—who came up with that?

The writing and selection of scripts was done by (advertising agency) Goddard-Claussen. The idea of a couple sitting down at a kitchen table talking about health insurance goes back to some speeches I gave before I ever thought of leaving the Congress.

What I said briefly was that health insurance was the only issue I knew of in the 30-odd years I held elective office that directly impacts on every American family.

Therefore, I concluded, it would not be decided by advertising or speeches, but to quote myself, over the kitchen tables of Americans as they sat down and asked what this meant to them and their families.

Mrs. Clinton made no secret of her distaste for the advertising campaign. Did that surprise you?

Yes, it did, because of the way it helped to get our message across.

I have been in politics a long time. One of the things I have learned is not to give attention to your critics.

We didn't buy any time from the three major networks. After her explicit criticisms made our ads news, the networks, in their newscasts, showed our commercials and her criticism of them together.

We ended up getting an enormous amount of free exposure to our ads in network news.

From a standpoint of Politics 101, her criticisms of the ads were puzzling to me and, frankly, they still are.

In short, she gave you priceless publicity?

We didn't have the money to buy it.

Why did the public respond so favorably to the ads?

People could relate to them (Harry and Louise) as individuals.

Why did the Clinton health care reform plan die? What were some of the factors?

The main thing is that while the public then and now is not satisfied with the health care system, they want changes to be done in a step-by-step way.

One of the realities of health insurance that makes it so difficult to bring about a change is its very success. About 85% of Americans have health insurance of one kind or another. That is not good enough. But it means that a lot of people are cautious about swapping the known for the unknown. The Clinton plan really didn't leave alone those who are covered and are satisfied.

This is a country that moves gradually when dealing with problems.

Does that explain why the limited health care portability legislation passed last year even though comprehensive reform legislation died in 1994?

Yes, and that is why in 1997 there was further progress made in coverage through the children's health care initiative in particular. A step-by-step approach may prove a quicker way of getting there.

What effect will the health care portability measure have on increasing access to coverage?

I think it will increase accessibility and decrease affordability.

When there is a trade-off—both at the federal and state levels—between access and cost, there is a tendency to go for access. But I don't think in the group market that the Kassebaum-Kennedy legislation will have much effect one way or another on costs. The hazards are in the much smaller and fragile indi-

Continued on next page

Continued from previous page
vidual market.

This whole question of access vs. affordability is reflected in the discussion of benefit mandates as well at both the state and federal levels.

The key is understanding there are some costs involved. What is so difficult from a public policy point of view is that we have a voluntary system. If the price of health insurance seems too high to businesses or individuals, then they don't buy it.

Is that where we are going—legislation, so to speak, by body part? We've seen mental health care benefits parity, mandated minimum inpatient coverage for mothers and newborns after delivery? What's next?

It is too early to tell. Certainly, the initial steps that were taken as far as maternity stays and the modest step taken with regard to mental health stays were very hard to vote against. I think there have been some second thoughts.

Once the idea of a mandate is accepted, it is very hard to say there should be a mandate for maternity but there shouldn't be for mastectomies or other benefit coverages.

Has partisanship changed in Congress?

You worked with Rep. Pete Stark, D-Calif., to get COBRA's health care continuation provisions enacted in the mid-1980s. Is it more partisan today, or does Congress act in a more bipartisan way compared with the 1994 period?

Things do seem more partisan overall. But within the Ways and Means Health Subcommittee, I can't tell you how excited I am by the bipartisanship that has developed there.

Pete Stark and Rep. Bill Thomas, R-Calif., are working in the same way that Pete Stark and Bill Gradison worked when the tables were turned, when Pete was the chairman of the subcommittee. That bipartisanship was reflected in the wide range of health care issues that came to the committee earlier this year.

To what do you attribute that unanimity after so much dissension?

I expect these two fellows and their staffs came together and tried to work together much as we used to come together and work things out.

You know you can't really spring things on people and expect them to participate enthusiastically.

One of the greatest critics of the process that led to the collapse of the Clinton health care reform plan was Pete Stark. He felt very much frozen out of the process and he was chairman of one of the subcommittees that had to move the legislation at that time.

It is not the way to get a buy-in when you are trying to move legislation.

What are your concerns about the future?

The key to successful incremental change is to put money on the table; i.e., to recognize the desirable goal of greater coverage cannot be accomplished by shifting costs to those who already are covered.

That is not just a political comment. It also is an economic comment. Pushing up costs of insurance for the currently covered as a means of paying for the uncovered runs the risks of people dropping out entirely.

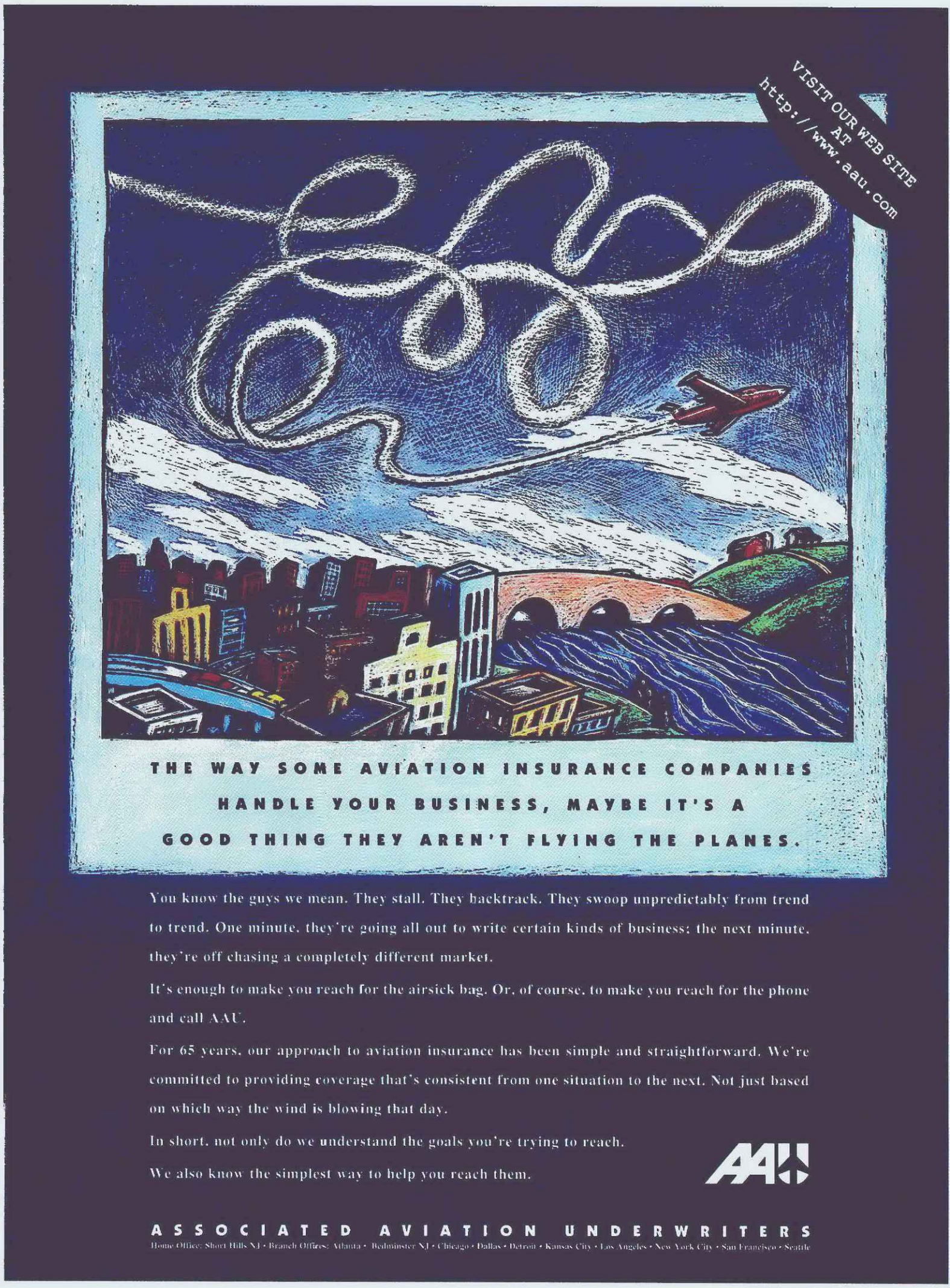
Your last thought?

The greatest challenges facing insurers and health plans are not a result of regulatory or legislative changes at the state or federal levels in most cases.

In fact, the really dramatic changes are in the marketplace. They are accelerating. I think it is virtually impossible to tell what these plans are going to look like in just three to five years.

It wasn't so long ago that some people thought health maintenance organizations would carry the field. We now are finding that traditional HMOs with limited networks are not where growth is. It is plans with greater choice.

Regrettably, greater choice involves greater cost. How that trade-off is resolved will have a lot to do with determining what options are available in the private insurance markets. 30



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VIEWS

Arnold Hiatt

Pioneer of onsite day care addresses corporate responsibility

Over 25 years ago, at Arnold Hiatt's urging, The Stride Rite Corp. became the first employer to offer onsite child care facilities.

Since then, the company has expanded its facility to provide intergenerational care for the dependents of its employees.

Mr. Hiatt, 70, became president of the Lexington, Mass.-based shoe manufacturer in 1968. Three years later, the company opened a day-care center at company headquarters, initially for nearby residents.

"I thought it would be an investment in the community," he said from his present office overlooking Boston Harbor. More than just a place where children could spend their day, the center offered medical services and teaching to prepare the children for school.

Within six months, the company expanded the center to include children of employees. Thus, the first onsite day-care center in the United States was born.

Company employees paid the cost on a sliding scale depending on their salary, with top executives paying the full amount and lower-paid workers paying nothing.

In 1990, Mr. Hiatt once again struck out into the unknown by creating the country's first onsite intergenerational day-care center at Stride Rite. The new center brought together both the children and parents of employees, as well as seniors and children from the community.

Following his retirement from Stride Rite in 1992, Mr. Hiatt became chairman of The Stride Rite Foundation. Also, he helped found Business for Social Responsibility, a Washington-based organization that develops policies that maintain corporate profits while being socially responsible.

Mr. Hiatt spoke recently with Associate Editor Michael Prince about dependent care services and corporate responsibility for certain benefits.

Q: Why, as an employer, did you open the first onsite day-care center for employees?

A: About six months after the day-care center started I was stopped by the president of the union in the hallway at Stride Rite. The head of the union said to me, "If you can spend so much money on the day-care center, why can't we get a raise?" And I said, "That's a separate issue, but if you're interested in having children of employees come to the day-care center, that's another matter."

As a result of that discussion, we decided to expand the day-care center and to make it half employees and half community children. And eventually we had over 60 children in that center at any given time, generally 30 from the community and 30 from the employees.

So, while I'm being given credit for opening the first onsite employee day-care center in the country, I really opened it for the community, if the truth be known.

Did you have a vision on how the day-care center would work?

I'd like to tell you that I was omniscient and I knew exactly what was going to happen, but I didn't. I was interested only in providing space and support for children who seemed to need it. And I didn't think of all of the things that happened subsequently.

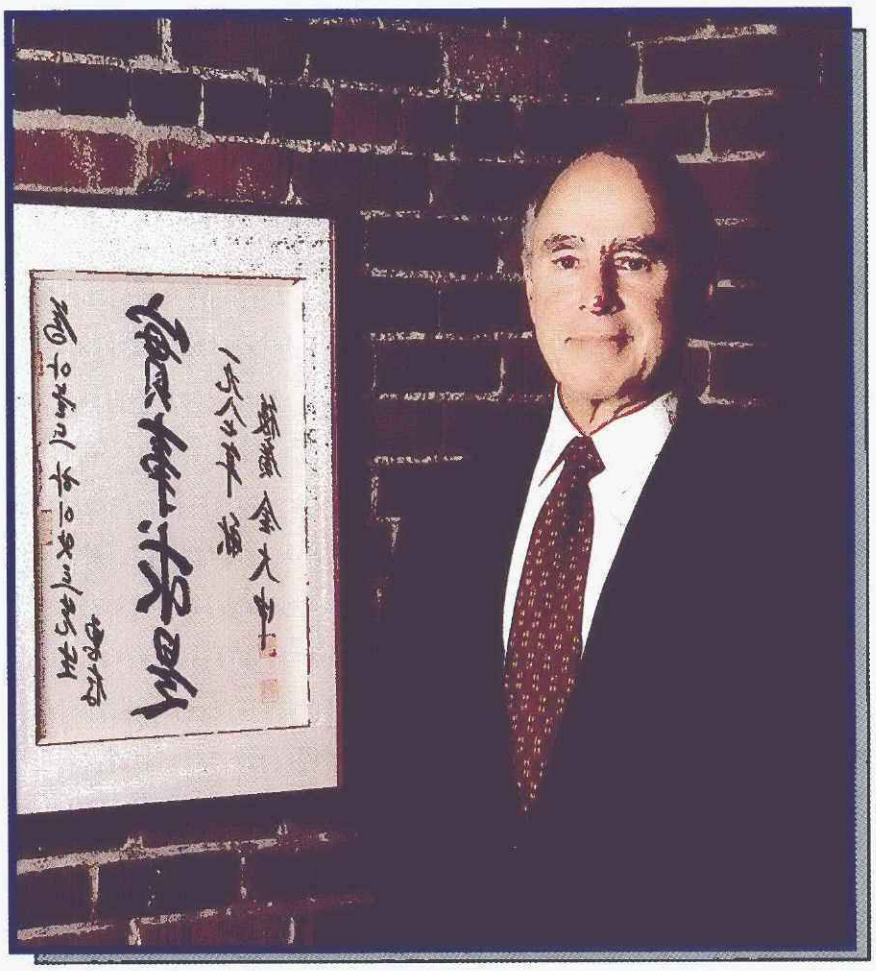

PHOTO: KERRY BRETT

As I look back, if I were perhaps a visionary I would have said at that time, "If we invest in a day-care center for our employees, Stride Rite will become a rather unique company, would be able to attract more people and better people, will be able to reduce our turnover, will save money on training costs, people will feel that Stride Rite is the company that cares." None of that was conscious at the time, even though I wish you'd give me credit for it.

Did the center have the benefits you described?

It did have all those benefits, but they were not planned or calculated. We didn't say, "Let's make an investment and we're going to get a lot of return." That was not my motive.

It happened that we can attract much better people and it also happened that we never had to spend what is estimated to be $21,000 to advertise for a new employee, to train the new employee and to bring that new employee up to a level of productivity of the departed employee. These benefits accrued to Stride Rite.

After a year or two went by, we held bi-monthly seminars where we would invite heads of other companies both in Massachusetts and nationally after we became known for this. And the purpose of the seminar was to demystify the process because CEOs generally wouldn't consider opening a day-care center. They didn't think it was their responsibility, it was irrelevant, and it would increase their costs with a particular concern about their insurance premiums going up.

So by having these bi-monthly seminars we could say, "It is something you can do, it's much simpler than running a complicated company and it is a small investment with a very large return." And then we said our insurance premiums have not gone up.

We did not have many takers. I think in the course of the first 10 years we did this, we caused about 50 day-care centers to open up around the country.

Was part of your goal to spread the word about the center?

Very much so. Because I thought it was good for business, the community and employees.

You seem to emphasize that corporations possess a certain degree of social responsibility. Do you feel companies should participate in this type of corporate responsibility or is this a benefit that enhances the company's profits?

The answer is both.

I did feel that business is in a position to do something for their communities and their employees. And I also felt it was good business. My feeling is that businessmen and women generally had not recognized the extent of their influence and power to go beyond the narrow definition of a bottom line.

For example, Stride Rite had a family leave program 10 years before President Bush vetoed the legislation. President Bush, who knew more perhaps about being president than he knew about business, said it would make business less competitive in the global marketplace. He was saying this while companies like Stride Rite had a family leave program and Stride Rite had been and continued to be in the last six years of my tenure in the 99th percentile of financial performance on the New York Stock Exchange.

My feeling was that part of the success of our company was that we had employees who were our partners and not our adversaries and Stride Rite was in the business of high quality and high levels of service. You can't supervise thousands of people and maintain high standards on a consistent basis unless that supervision comes from within the employees themselves.

And people really cared about the product and the company. Part of it was people liked the idea of coming to work in the morning. They felt this was kind of an extended family and they liked that feeling—even people who were not beneficiaries of child care or elder care or never used family leave.

What was the employees' response to the day-care center?

I think they loved the idea. They loved the idea of seeing kids in the hallway. They loved the idea of kids coming around during holidays, whether it's Christmas or New Year's, and serenading them. They were coming to work in the morning and they had their little kids on their hand and they knew their kids were in a safe place and their kids were not just getting custodial care but learning how to read, being looked after medically. They say you don't have to be more than a half-inch taller than a pygmy to be a giant. And we looked very good.

What changes were made to the program over the years?

My assistant Ellen adopted a child who was two months old. We did not have an infant care center. I believe that infants should be with their mother; so we took children from 2 years on. But Ellen needed to work. She said, "Why are you imposing your will on new mothers?" I realized ideally Ellen should be at home with her child, but practically she couldn't afford to be.

So, we expanded the range from infants through children who were ready to go to school. We did some informal tracking and it confirmed what we had read.

There were a number of studies that were done in a much more methodical and scientific way that said children who are given a head start tend to have less teenage pregnancy, there's less drug addiction, there's less alcoholism, they tend to finish school more than kids who don't have a decent head start. In terms of society, and it's proven at Stride Rite that the

See **Hiatt** *on page 56*

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Hiatt

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investment in child care is a very small one compared to the return.

It seems that the company's day-care center was benefiting society and in many ways the company was doing what in other countries the government does. What role should government play in these activities?

Well, don't forget by 1980 we had a president in the White House who was trying to downsize government, get government off our backs, who wanted the private sector to pick up a lot of the slack.

As a matter of fact, President Reagan established a new office of deputy to the president in charge of volunteerism.

Someone told President Reagan that there was a man by the name of de Tocqueville who came to this country in the 19th century from Europe and he was admiring the spirit of neighbor helping neighbor and I guess Reagan thought that was not only a good "B movie," it was also something his administration should adopt.

You seem to be saying the government has sort of abdicated its responsibility in this area?

I would say that's sort of true

So is the only alternative for Corporate America to step into this void and take on this role?

Either that or Corporate America should say to the administration, Democrat or Republican, "Why don't you guys wake up? We're willing to make the commitment to public education when mothers weren't working and you started at age 5. And you said every child has to go to school and you never asked Corporate America to pick up the tab."

But America is no longer an agricultural economy, it's an economy in which both parents work and now it's time to extend downward the responsibility of government. What's the difference between paying for a 6-year old in the first grade or a 2-year old in preschool?

Do you see a day when the majority of companies will have on-site day-care centers?

Well, I think you see in the 1980s and 1990s a lot more day-care activity and companies are recognizing the importance of it. But there are no standards. One company might maintain a day-care center like Stride Rite did, where we didn't spare any expense. Another company might say we can only afford one staff person for 10 children instead of every five children, which is the recommended ratio.

So why not have uniformity and consistency and universality? Can you imagine what the fifth grades of this country would look like if government said we're not going to assume responsibility anymore for the fifth grade?

If we want Corporate America to take care of the fifth grade, some kids would go to fifth grade and some kids wouldn't go. And some would go to schools with a good fifth grade teacher and some with a lousy fifth grade teacher. Why should we penalize 4-year-olds or 3-year-olds?

In 1990, Stride Rite's day-care center became a multigenerational one. What was this in response to?

The day-care center I've been talking about did not change. That was the original day-care center in Roxbury and that continued to be a children's center. We then moved the corporate offices from Roxbury to Cambridge and we knew that parents were being squeezed, not just from below, but from above.

Parents were living longer and oftentimes the employee had to provide care for that parent as well as the child. That's called the "sandwich generation."

I had heard about a nursing home in Arizona that had done some controlled experiments in that a group of residents were given a responsibility for maintaining flowers in flower pots. After two years the mortality rate of the residents that had a responsibility started to drop compared to the normal mortality rates in the same residential home.

I also knew that in families grandparents were separated from children and many children of single parents did not have extended families.

I grew up in an extended family and that's what an intergenerational center is.

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Judith C. Hanratty

Executive prompted oil giant to reassess tolerance for risk retention

Judith C. Hanratty has given The British Petroleum Co. P.L.C. a better understanding of its risks, while showing other risk managers on a grand scale new possibilities for self-insurance.

Rather than spread its considerable risks among insurance companies, most of which had fewer resources than BP, the oil company under Ms. Hanratty's guidance chose to spread them even more broadly—to its shareholders.

Ms. Hanratty, 54, a barrister specializing in constitutional and administrative law in her native New Zealand, moved to London in 1986 to assist in the privatization of what is now The British Petroleum Co.

She had planned to stay 18 months as a member of the BP share sale team. During that time, however, the scope of the work of the share sale team changed to include the purchase of Standard Oil of Ohio and Brit Oil. Ms. Hanratty decided to extend her stay when she was asked to run Tanker Insurance Co., BP's captive insurance company and insurance adviser.

She now is company secretary of BP.

Among many official posts in the United Kingdom, Ms. Hanratty sits on the Insurance Brokers Registration Council, the Monopolies and Mergers Commission and is a governor of the College of Law in London.

Ms. Hanratty recently spoke with London Bureau Chief Sarah Goddard about her experiences at BP and TIC.

Q: Why did you decide to remain with BP after the privatization?

A: The remit was to try to bring the philosophies relating to insurance from Standard, Brit Oil and BP into some cohesion. At the time, there were differences among the three because the organizations approached problems in different ways. I had to decide then whether I stayed or went back to New Zealand. It was tempting to do something really with a lot of scope, and I was interested in the financial and economic sides.

I came into this with a completely fresh mind, which I guess is not a tradition of the insurance industry. At the TIC, all the staff had joined virtually as cadets and been in the same organization all their lives. I think that's probably true of much of the industry at that time.

What were the problems you faced as you took over TIC?

BP was running a variety of insurance activities across its empire. I think partly because of the organization of the company, it was heavily based on country autonomy, so there was quite a lot of doing their own thing in separate countries. There were two strands to the whole thing; one had to try to amalgamate in an administrative sense and to get people working in a team.

Insurance was a bit of a mystery to the rest of the organization. People thought they knew all about it because they bought their own car insurance, but then when it got bigger and it was refineries, they left it to the professionals.

There was a regime that sopped up all the larger things into the Tanker Insurance Co. Most of the insurance-related arguments we had with managers in the different countries were over price, and TIC swept all the problems away. So it was a residual insurance risk-bearer. It was run as an insurance company.

There it was, happily trotting along, and

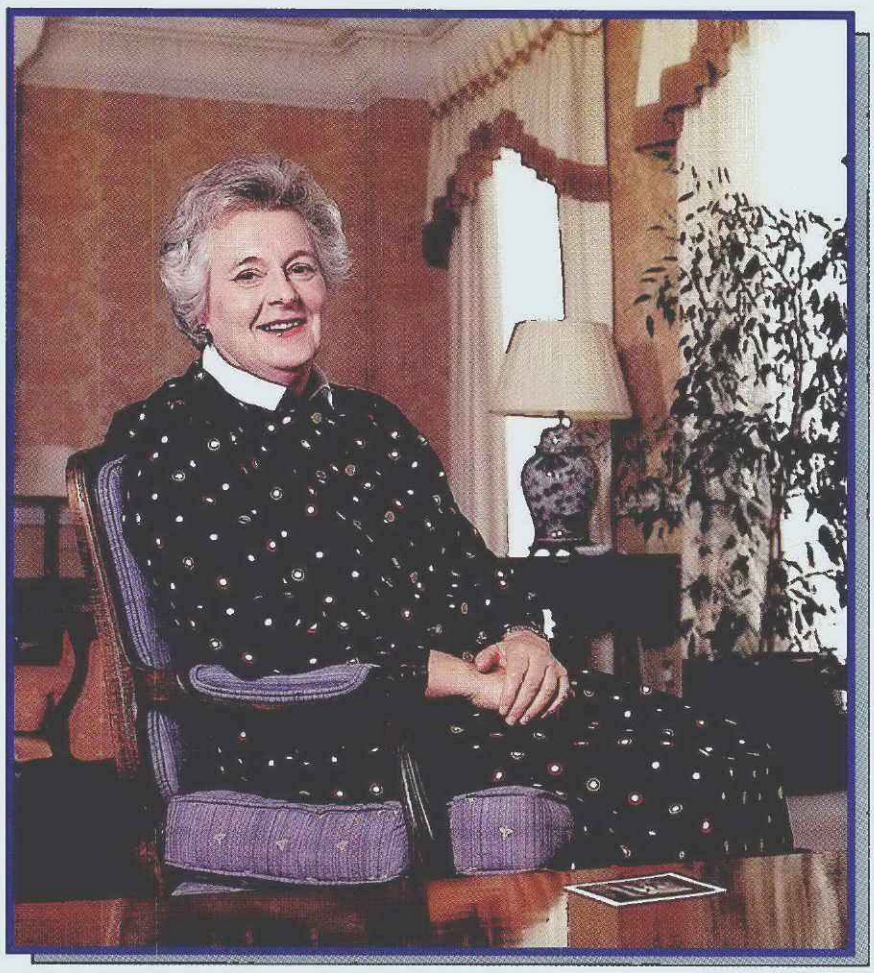

PHOTO: MARC SCHLOSSMAN

I think people were content to see the evening out of cash flows in various businesses, and it reinsured out very substantially. But there were some structural reasons why it could only participate to a partial extent in underwriting large platforms in the North Sea, for example. Those were going out for a much more substantial placement in the market.

So there was a fair amount of premium actually going into the insurance market, albeit managed by TIC, and so my attention was drawn to that money. Payment was being provided in such a way that if one was to look at the efficiency of the organization, what it was doing, who was doing it, whether it really was answering the demands of its customers, if you like, it was not as efficient as it could have been.

How did you tackle the international aspects of BP's risk exposures?

In some places, such as America and Australia, there were local mandatory insurances, so we had funded systems and so on. What we have done is systematically used the best practice in one place to enforce higher standards elsewhere, and what you find is though things are different in another place, you try and match it with its own funny, quirky requirements. I engaged the local office of a global broker—but not always the same one—in each place and told them what I wanted, for what I call the domestic side.

We created a competitive environment from the start and put an enormous amount of work and imagination into it. There was a certain amount of mutual learning, and we kept on testing them against each other. We've now gone miles further in what I call partnerships with suppliers. At that stage, in 1991 and 1992, we were probably pretty much at the leading edge in asking people to be partners with our insurance. And it took a long time to understand what that meant: that we would measure their performance, pay them according to whether they achieved certain preset targets. This was even different from a fee; this was saying that is your basic expectation.

I think we rowed the boat out further than anyone else at that stage. For example, we took all of the people dealing with our domestic U.K. insurance within BP and required the broker to hire them to handle BP's business from inside the broker's office.

Basically, we were buying a service and the people, and there was really no way that in BP you could grow that sort of person.

In what ways did you tackle and bring together the attitudes toward insurance brought to the table by the three organizations: BP, Standard and Brit Oil?

Standard Oil had purchased quite substantial insurance for its upstream operations. Really, I wondered why that should be, because it was a very, very large organization, with $35 billion capitalization, and I couldn't really understand why insurance was special and different from the way they looked at any other financial activity.

Myself and a colleague tried to rationalize the purchase of insurance. Then it transpired from thinking that way that really there was no value to the shareholder. This comes into focus because BP had transformed themselves over 1988, 1989.

When we came in in 1990, we analyzed this on the basis of what benefit there would be paying this amount of money to shareholders. BP already was well diversified and was paying to reduce volatility in cash flows, but in fact we could well absorb it ourselves. To some extent, insurance appeared to give a solution to managers—it was a psychological device. Because we're insured, it doesn't matter—we've passed the problem somewhere else. So you had to think, well, there is a downside to all this as well, apart from the financial one.

As became obvious with the distressing events of the Exxon Valdez, there is the point of managing crises, giving people the confidence that management understand the risks, and putting them right. And because of the technical and specialized nature of the oil industry, that is a very substantial part of investor confidence. Reputation is absolutely vital, and an insurance policy cannot save your reputation.

We did an analysis on what our expectation of loss would be at various levels: Less than $10 million, between $10 million and $500 million and above $500 million. We tried to match the analysis to some rule of thumb-type feeling against the insurance industry.

The analysis showed a relatively infrequent one-in-30-year possibility of a loss more than $1 billion. The average annual loss in the category of $10 million to $500 million was about $70 million a year. That is a number that could be easily eaten by the general finances of the group. It was very easy for it to eat those up as they occurred, simply allowing them to happen. And in that context we accepted that individual managers would not be blamed or penalized by the financial effects of these, if they did not arise from culpable misdemeanor by them. The emphasis moved off the purely financial side; they really had to understand all the risks of the organization as a whole.

BP is now self-insured for the vast majority of its program. What made you decide to pull your coverage from the traditional insurance market?

We realized that effectively insuring is not much different from other financial transactions—you borrow the money before you know whether you are going to need it—and with the changes in technology, you very well may not need to do it.

And you were paying something in

See **Hanratty** *on next page*

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Hanratty

Continued from previous page

the order of 30% in interest and transaction costs. I think the reason was the poor old insurance industry was swallowing these things as best it could at that time in the late 1980s, and we were saying these people were just handing these things on, and the premium dollar was ending up substantially less when it gets to the ultimate risk-bearer. You only had to look at the major slips to realize that this was a massively complex process.

Very shortly after I took the job, they were still trying to solve a claim that was on the liability account. The claim went into three markets and it made me realize then that when you get to very large claims, there is a value to the insurers in delaying. These large lumps of money are very hard to manage for any organization. I think the industry at that stage really wasn't well equipped; it certainly wasn't able to efficiently deal with the large claims. The efficiency has improved enormously; the bigger players are looking all the time at ways in which they can diversify out into the capital markets.

BP came to a clear conclusion that its insurable risks were of a nature that it would be more economically efficient for the shareholders to diversify that risk into the capital markets. Ninety-seven percent are diversified funds. The reality is the point at which there would be a real impact has only one or two possible scenarios—where the immediate impact would be more than $2 billion.

The TIC sits as a small instrument that can be used by the corporation when it's appropriate, for example when it needs to buy insurance for a joint venture. It doesn't buy reinsurance and is capitalized to $500 million.

Are you considering using the capital markets for BP's catastrophic coverage?

We have been looking at that. They just need time to develop, but that doesn't mean to say that they aren't doing interesting things. I don't think we are in a position to really be a vanguard, but we have a very active watching brief on what is going on.

What impact has your approach to the insurance program had on BP?

We split risk apart, really. We put a lot of heavy responsibility onto others. The other thing is that we said this insurance was just simply a swapping shop, the TIC became an institution. Since the privatization, BP has atomized into 80 business units, and the managers have the responsibility of understanding risks. They have all the processes necessary to deal with the risks themselves with due guidance from the corporation as a whole.

It has driven a better understanding of risks. There is a better-managed process to analyze, understand and price risks, and the continual evaluation of what might be happening in the outside world that might be of value to the shareholder.

We have continued to add up what we have saved. We are banking the stream of money that would have come back if the risk had happened, and that which would have been lost in transaction costs. It is a very substantial amount of money over a period of time.

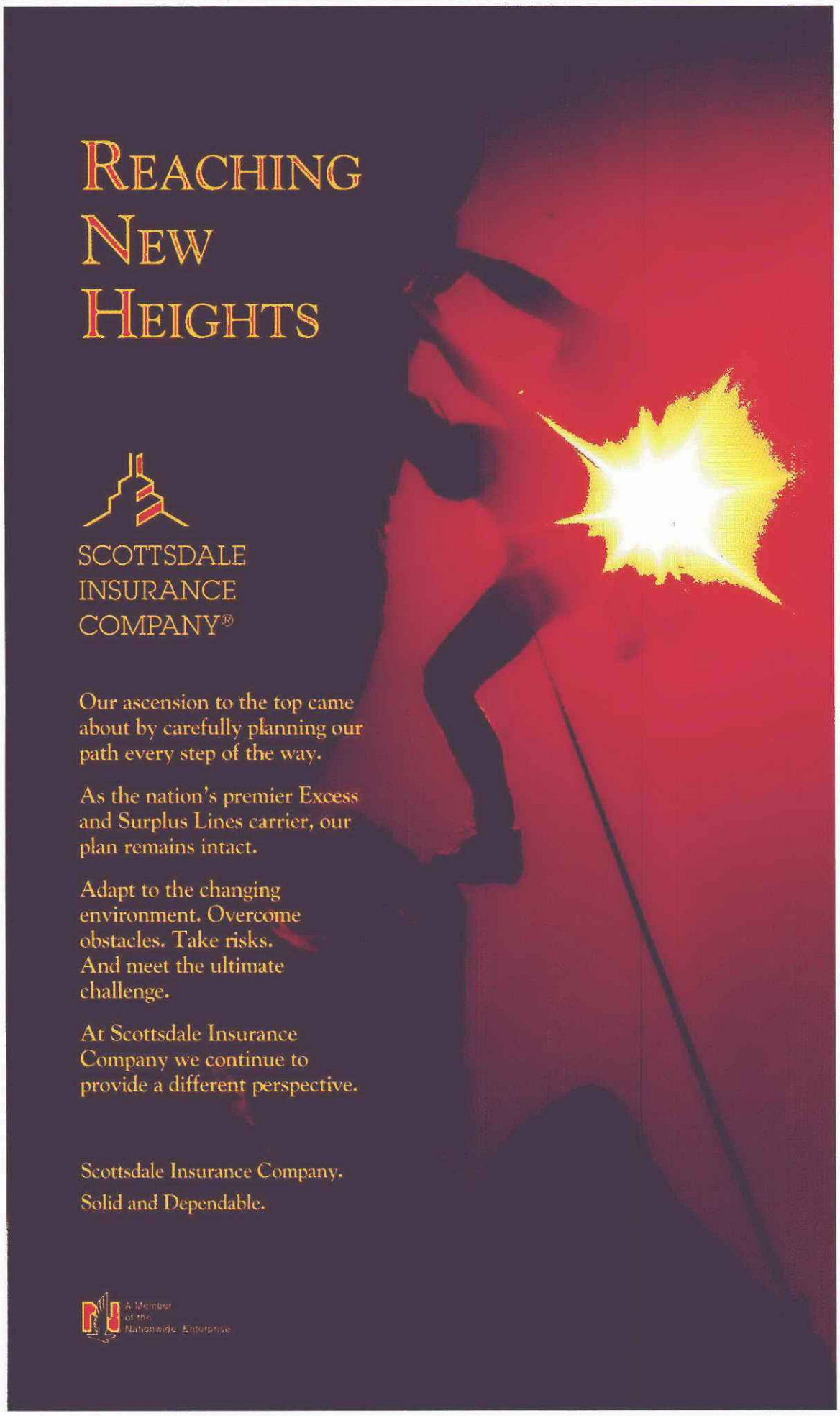
Since we did this, the corporation has become more diversified. It has a bigger spread of activities across the globe, and each time we add a different and uncorrelated risk to the corporation's portfolio, we are constantly carrying out an internal diversification process.

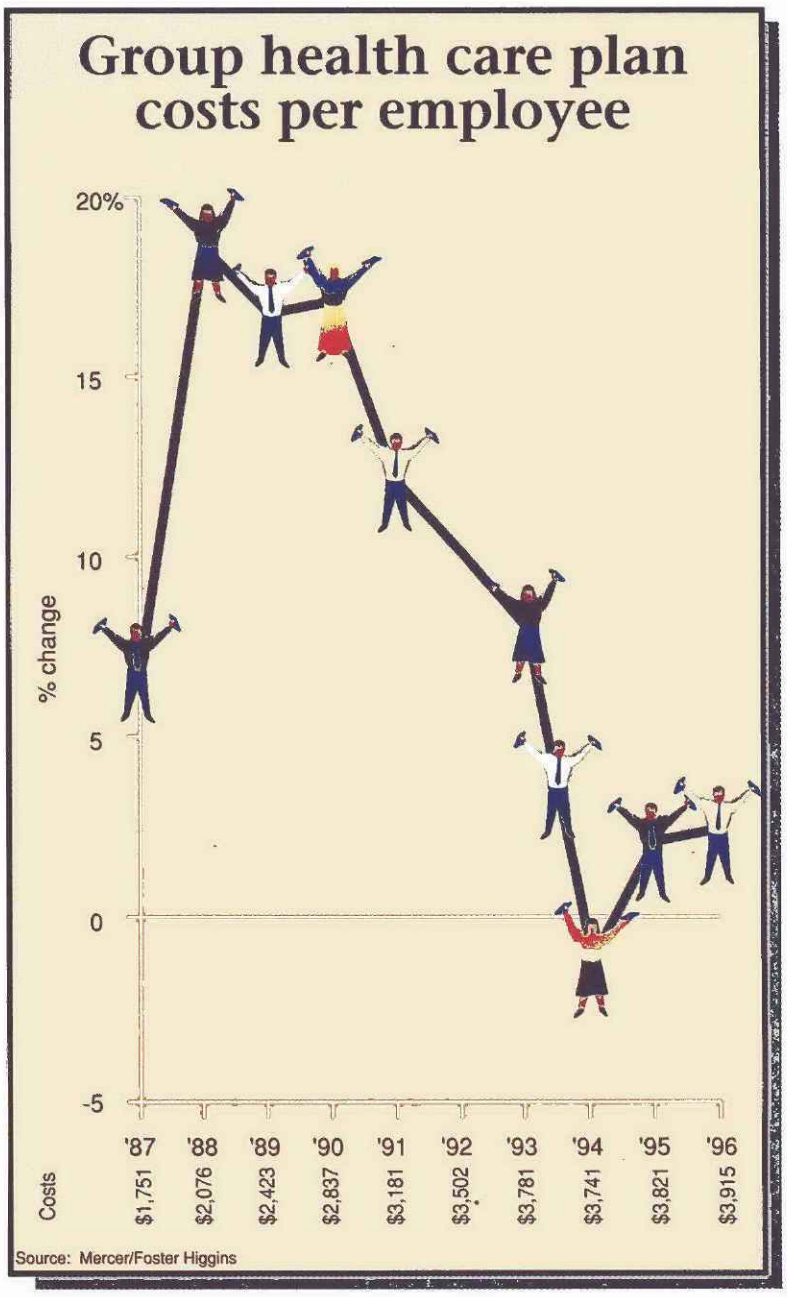
What changes do you see happening in the insurance and risk management world?

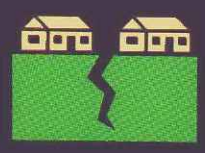
There is a never-ending science of understanding risk and quantifying it, deciding the best balance of risk the individual organization can bear and how to get rid of risk that it feels is unwise to bear. People will go on inventing better instruments and put pressure on producers. I don't think we will ever cut out brokers as a profession, but they are not necessarily always going to act as an intermediary.

There will be certain products where a risk manager will feel confident as a buyer to buy them because they know them or trust the brand. But sometimes they need professional advice before they go and buy the brand.

It can be hard for people to go out and get the best product for themselves. The intermediary must provide it at the point it can really add value and is truly acting as a professional. 30







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A LOOK BACK 1977 • 1981

—1977—

● Pension consultants say there is no large-scale movement among big corporations to replace their defined benefit pension plans with defined contribution plans as a result of the Employee Retirement Income Security Act of 1974.

● Three national health insurance bills are introduced in Congress, despite the Carter administration's warnings that it will not support such legislation this year.

● The Chicago Transit Authority, operator of the antiquated elevated train system that suffered a tragic accident, leaving 11 dead and about 210 injured, is self-insured for the first $2.5 million. Above that retention, the CTA has $20 million in catastrophe insurance to cover losses from any one incident. Losses from this accident, the worst in CTA history, have not yet been determined.

● One of the largest aviation losses in history is expected to result from the March 27 collision of Two Boeing 747s at an airport in the Canary Islands. Almost 600 people died. Both airlines, KLM Royal Dutch Airways and Pan American World Airways, have hull insurance totaling $63 million on the planes. It will be the largest hull loss insurers ever have had to pay for a single crash. That amount is likely to pale in comparison with liability claims, which observers predict could exceed $400 million.

● The first round of what promises to be a long legal battle has gone in favor of 16 drug companies that marketed DES, a drug once prescribed for pregnant women to prevent miscarriages that now is being blamed for the health problems of the women's daughters. The suit was brought in Wayne County, Mich., by 144 daughters of women who had taken diethylstilbestrol during pregnancy. Because the majority of the daughters could not identify the manufacturers of the drug their mothers took, they sued the 16 companies they claim had dominated the market. A county court rejected the theory of industry-wide liability.

● The looting is over, the fires are out, the lights are back on. But New York is still in the dark about ultimately who will be liable for the worst power blackout in the city's history. The blackout is investigated by federal, state and city officials. Consolidated Edison, which is largely self-insured, says it is not liable for an estimated $1 billion in damages caused by the July 13-14 power failure.

● The Internal Revenue Service formally rules that a U.S. company cannot deduct as business expenses premiums paid to an offshore insurance company wholly owned by the parent.

● The Pension Benefit Guaranty Corp. officially asks Congress to raise the annual termination insurance premium to $2.25 per participant from $1. The hike is needed because pension plans have been terminating at a much higher rate than had been expected, and the PBGC's deficit already has hit $61 million, says Matthew M. Lind, acting executive director.

● The Insurance Services Office Inc. files nationwide for exclusion of punitive damages in all liability coverages. Although the majority of ISO members vote in favor of the exclusion, some insurers say they will continue to offer the coverage. ISO acknowledges that some state insurance departments may balk at the exclusion.

● State insurance regulators become alarmed by the rapid growth of employee benefit trusts operating under the Employee Retirement Income Security Act of 1974. Regulators' fears intensify following the bankruptcy of a large self-funded trust based in California, the National Multiple Employers Foundation. State insurance officials worry that more trusts will become insolvent, leaving thousands of employees with unpaid claims.

—1978—

● The Supreme Court rules in late January that it is unlawful to require women to contribute a larger proportion of their salaries to pension plans than men. However, the court said the ruling would not be retroactive because of the "devastating liability" that would involve.

● Employees at American Can Co. in New York are testing a new flexible benefits plan. The pilot program was designed by Hewitt Associates and is being underwritten by Metropolitan Life Insurance Co. The program, considered the most flexible offered by any major corporation, consists of required core benefits and optional benefits.

● The Supreme Court lets stand a lower court ruling that airlines can require flight attendants to stop flying as soon as they become pregnant. The previous summer, the 4th U.S. Circuit Court of Appeals ruled that United Airlines' forced-leave policy was justifiable because pregnancy "could incapacitate a stewardess in ways that might threaten the safe operation of aircraft."

● A California Superior Court judge reduces a record $125 million punitive damage award against Ford Motor Co. to $3.5 million in a case involving the crash and explosion of a 1972 Pinto. The judge said the jury award was "excessive as a matter of law." He also awarded $2.5 million to the then-13-year-old victim of the crash, making the total award $6 million. The plaintiffs in the personal injury and wrongful death case charge that Ford placed the gas tank in the 1972 Pinto where the automobile manufacturer knew from its own studies that it would be apt to rupture upon light impact.

● Congress gives final approval to a bill that would require employers to treat pregnancy as any other disability, and President Carter is expected to sign the bill into law.

● Many employers are finding that day care is a benefit for them as well as for their employees. Employers that have implemented the benefit often say it helps them recruit workers and improve morale while reducing absenteeism and turnover.

● All parties are denying liability for claims involving leakage near New York state's Love Canal, an incident that may evolve into one of the most complicated liability cases ever. Damages may eventually total $2.65 billion after the leakage of toxic industrial chemicals from an old landfill in the Love Canal section of Niagara Falls.

● A class-action suit filed in Los Angeles seeks $1 billion in damages from 15 major U.S. producers of asbestos, claiming that the companies conspired to conceal and distort information on the hazards of asbestos. The suit, filed on behalf of 5,000 shipyard workers in Southern California, seeks "restitution profits," claiming that the asbestos producers were "unjustly enriched" by the profits of their continued production of asbestos.

—1979—

● A class-action lawsuit filed on behalf of Vietnam veterans who claim that they were injured by the herbicide Agent Orange could result in huge product liability for the manufacturers of the chemical. The suit claims the herbicide, which contains dioxin and was used as a defoliant to kill trees and clear ground cover in Vietnam, causes cancer. A plaintiff's lawyer says that if the herbicide is found to cause cancer, three chemical companies named in the suit—Dow Chemical Co., Hercules Inc. and Northwest Industries Inc.—could face liabilities "far in excess of their net worth combined."

● Despite lawsuits challenging the practice, Blue Cross & Blue Shield plans say they will expand their move to deny claims for procedures they deem medically unnecessary. The Blues are urging member plans to curtail payments for the "admissions battery" of routine tests done before hospital admissions, which Blue Cross & Blue Shield says often are unnecessary.

● Drafts of guidelines for a new law that treats pregnancy as any other disability indicate that if employers provide dependent medical coverage, they will have to cover the pregnancy-related expenses of employees' wives. In its guidelines, the Equal Employment Opportunity Commission says that because the new law requires employers to cover their employees' pregnancy as any other disability, they must extend such coverage to dependents.

● The accident at Three Mile Island nuclear plant near Harrisburg, Pa., will be the worst commercial nuclear accident in history. American Nuclear Insurers paid out more than $600,000 in emergency claims in the first several days after the accident at the plant; that amount is almost as much as the total liability payments for the country's 73 nuclear plants over the past 22 years. Experts say the $600,000 will be dwarfed by the liability and property damage claims that ultimately will be filed.

● A provision in a 1979 bill that would amend the Employee Retirement Income Security Act of 1974 would allow states to require employers to offer certain health care benefits. The Senate Labor and Human Resources Committee has approved the ERISA overhaul legislation, including the controversial provision that would overturn a series of federal district court decisions that a section of ERISA pre-empts states from imposing benefit requirements on employers.

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● A complex maze of liability litigation is likely after the crash of an American Airlines DC-10 in Chicago that killed 274 passengers and two bystanders, making it the worst U.S. aviation disaster. Involved in the possible dispute over liability, which experts say could reach $200 million, are the airline, the manufacturer of the aircraft and suppliers of components. These parties may be involved because the crash occurred when some malfunction—caused perhaps by faulty design, manufacture or maintenance, or simply wear and tear—caused the engine to fall off the left wing during takeoff.

● The possible bankruptcy of Chrysler Corp. could trigger a sharp increase in the premiums that other companies pay for federal pension termination insurance. The Pension Benefit Guaranty Corp. could be left holding the bag for Chrysler's enormous pension obligations if the automaker were to fold. Even though the PBGC would have a lien on Chrysler's pension assets and a right to 30% of its net worth, the federal agency could still need more funds from other employers.

● Both Illinois and Florida are considering forming insurance exchanges similar to Lloyd's of London and the recently created New York Insurance Exchange. In Illinois, a bill to create such an exchange unanimously passes the state

Continued on page 62

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Continued from page 60

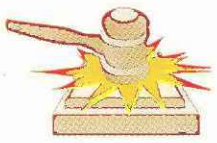
Senate, which supports the idea as a way to bring money and jobs into the state. However, insurance companies in Illinois are more wary and would like to first see if New York makes a success of its insurance exchange. The Florida Legislature also has passed a bill calling for the formation of an insurance exchange, but only after the insurance commissioner establishes its economic feasibility.

● Insurers say they may stop writing liability coverage for general admission rock concerts after 11 people are trampled to death before a concert by The Who in Cincinnati. The fans were killed when 7,000 general admission ticketholders stormed the glass doors outside Riverside Coliseum. Fireman's Fund Insurance Co. underwrote two spectators liability policies for the concert.

—1980—

● Lloyd's of London has called in Scotland Yard to help investigate the $84 million loss of the oil tanker Salem. Lloyd's believes the tanker's $60 million oil cargo was sold secretly to South African interests before it sank off the Senegal coast Jan. 17. Lloyd's suspects the tanker was scuttled to hide the theft. The tanker's cargo was 100% insured in the London market, with Lloyd's taking about 60% of the risk.

● Newport News Shipbuilding & Dry Dock Co. of Newport News, Va., is challenging federal guidelines requiring employers to cover the pregnancy-related expenses of employees' wives if the employers offer dependent health care coverage. The suits seeks to overturn Equal Employment Opportunity Commission guidelines issued in March 1979.



● The U.S. Supreme Court has ruled that workers cannot be fired or reprimanded for refusing to accept dangerous tasks, though employers do not have to pay them for time not worked. The court upheld a regulation by the Occupational Safety and Health Administration that allows employees to refuse to perform a task when they perceive a "real danger" of death or serious injury and there is not time to go through normal complaint channels.

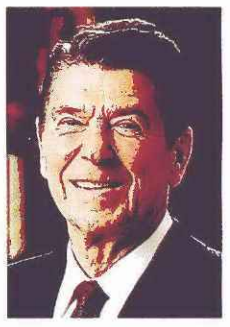
● A California Supreme Court ruling that women can sue DES manufacturers as a group has opened the door to the theory of industry-wide liability. In the case, women are suing all manufacturers of diethylstilbestrol, a drug given to pregnant women to prevent miscarriage but alleged to have caused cancer in some of their adult daughters. Most of the daughters cannot identify the specific manufacturer of the drug their mothers took. The decision says that when a specific manufacturer cannot be established, all manufacturers must divide the liability based on their market share.

● Insurance companies and state officials are trying to untangle the web of coverage questions surrounding the eruptions of the Mount St. Helens volcano in Washington. Total property claims from the disaster are expected to top $1 billion. The insurance commissioner of Washington has instructed insurance companies to adopt liberal guidelines in determining coverage for the disaster, though insurers are still debating what is covered.

● The Internal Revenue Service will not impose the tougher pension vesting standards it had planned, but it intends to stop automatically approving some pension plans. The IRS action is part of its crackdown on plans that discriminate in favor of highly paid employees.

● Employers are in the midst of an epidemic of wellness programs. Companies are using a variety of ideas, ranging from corporate spas to fitness seminars, to cut their health care costs by keeping their employees from getting sick in the first place.

● Attorneys predict an avalanche of toxic shock syndrome lawsuits against manufacturers of tampons. At least 14 suits alleging tampon involvement in toxic shock syndrome, a potentially fatal illness, already have been filed against Procter & Gamble, maker of Rely tampons. Other tampon makers are named in other suits.



● Experts agree that when President-elect Ronald Reagan and the conservatives who were elected to Congress

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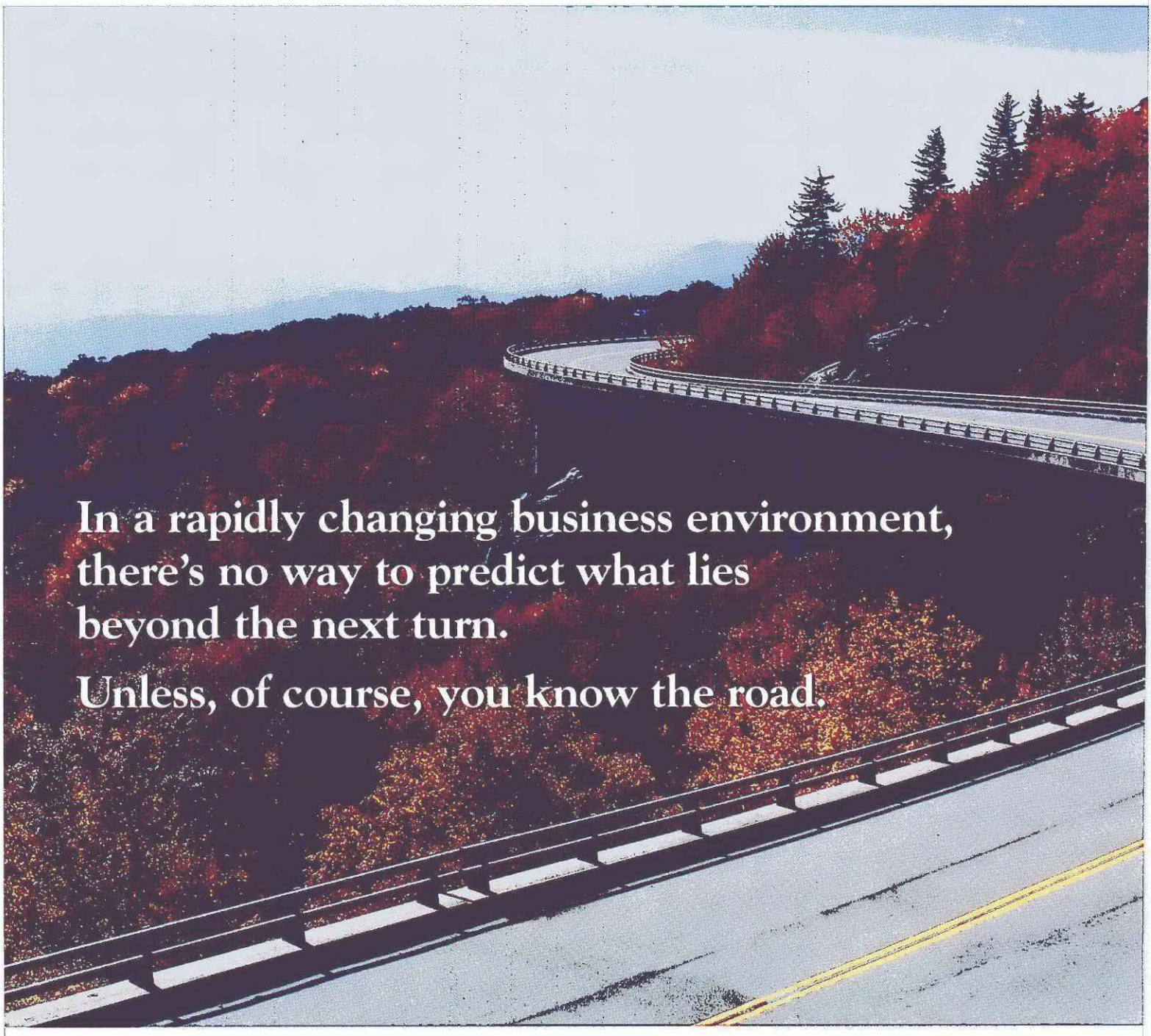

ATLANTA BOSTON CHICAGO COLUMBUS DALLAS

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—1981—

Continued from previous page
take over in January, business will have a powerful new ally. Among other things, they say, the changing of the White House guard will be the death sentence for a national health insurance plan, long pushed by liberal Democrats.

● Liability coverage of $30 million may not be enough to cover claims resulting from the fire at the MGM Grand Hotel in Las Vegas that killed 84 people. The first class-action negligence lawsuit filed after the disaster seeks $175 million in damages on behalf of about 375 Mexicans staying at the hotel.

● Major health insurers say group medical insurance rates are up an average of 30% over the last year, and some rate increases may be as high as 60%. The insurers attributed the hikes to inflation and increased utilization.

● The 52 American hostages freed from Iran are coming home to a bundle of tax-free benefits. The Hostage Relief Act of 1980 provides tax-free salaries and hazardous-duty pay, medical expenses and education benefits for dependents for up to two years for any hostages hospitalized for illness or injuries resulting from their captivity.

● The major recommendation of the President's Commission on Pension Policy is that every U.S. employer should be required to offer a pension plan that immediately vests 3% of each worker's annual wage. The panel said that unless private pensions are made mandatory, a two-tiered system will develop. Those employees covered by private plans will prosper, but those with only Social Security benefits will face poverty in old age.

● The Equal Employment Opportunity Commission will appeal a federal court ruling that employers do not have to offer equitable pregnancy benefits to spouses of male employees. In a landmark case, U.S. District Court Judge J. Calvitt Clarke Jr. overturns a 1979 EEOC guideline that says if an employer's health insurance plan covers the medical expenses of female employees' spouses, it must equally cover maternity expenses of male employees' wives.

● The nation's air traffic controllers, threatening a nationwide strike for June 22, are demanding a 25% increase in retirement benefits. The 15,000-member Professional Air Traffic Controllers Organization says that PATCO's members need an increase in retirement benefits because so many suffer job burnout.

● Under Vermont's new captive law, companies are allowed to form the kind of pools for product liability coverage that would be allowed under the long-delayed federal Risk Retention Act. The Vermont law is the first to create the domestic captive insurer category of industrial insured, which would allow pooling.

HYATT

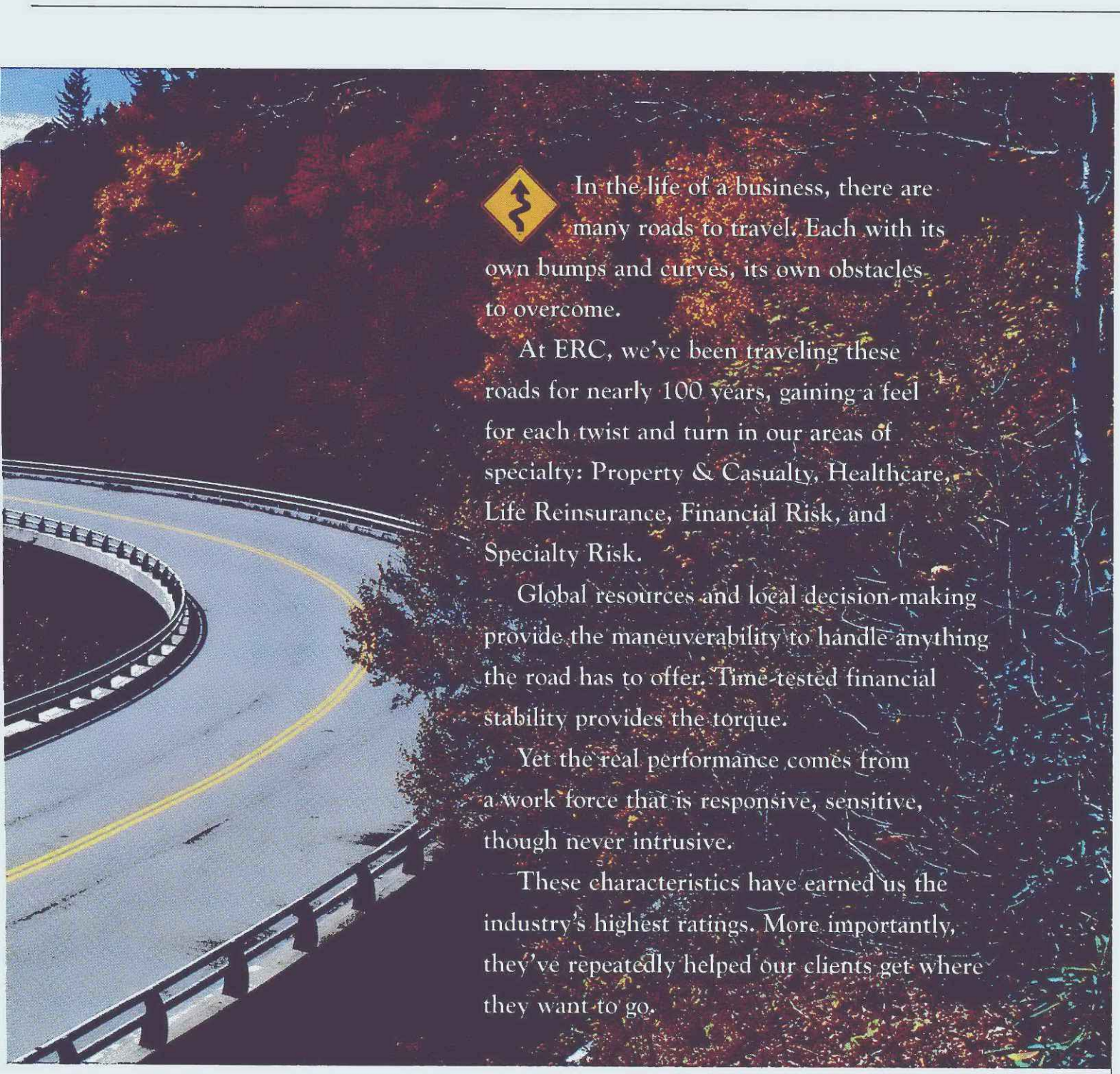
● Only the owner and the operator of the Hyatt Regency hotel in Kansas City, Mo., appear to have anywhere near the liability coverage that will be needed to pay claims resulting from the July 17 collapse of skywalks at the hotel. Even if investigators ultimately find that the designers or builders are responsible for the tragedy, which killed at least 111 people and injured approximately 200, their coverage will not come close to the estimated $100 million in claims that is expected to result.

● Although the Major League Baseball strike has ended, the dispute over strike insurance is heading into extra innings. Underwriters still are considering whether to reimburse baseball owners for their losses for the seven days of games that were canceled between the July 31 strike settlement and the end of the first week of August, when the insurance would have run out. Although a pact was reached July 31 in the 50-day-long strike, the professional baseball players had not ratified the deal before the end of the policy period.

● The Illinois Insurance Exchange is off and running. Its three underwriting syndicates have a total of $9 million in initial capitalization.

● The cost of providing employee benefits has risen 763% since 1951, according to the U.S. Chamber of Commerce. The annual cost of benefits provided to the average worker rose to $5,560 in 1979 from $644 in 1951. During the same period, the Consumer Price Index increased only 190%.

● Employers are finding that wellness plans can save them money. Companies are discovering that they can save millions of dollars on absence and treatment costs by helping their employees stay healthy.



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30 VIEWS

Jon Harkavy

Lobbyist committed to development of alternative risk market

Jon Harkavy has been one of the primary voices for commercial insurance buyers before Congress and state insurance regulators for nearly two decades.

Mr. Harkavy currently is vp and general counsel of USA Risk Services Inc., an Arlington, Va.-based company that offers administrative and management services for group captives and self-insurance pools.

Mr. Harkavy also is president of the Coalition of Alternative Risk Funding Mechanisms, an organization representing state, national and international captive organizations on legislative and regulatory matters. Mr. Harkavy is a former director of the National Risk Retention Assn. and currently serves as chairman of the governmental and industry committee of the group.

From 1981 through 1989, Mr. Harkavy was the director of governmental affairs and general counsel of the Risk & Insurance Management Society Inc. During this time, Mr. Harkavy was instrumental in the passage of the Federal Liability Risk Retention Act Amendments of 1986.

While at RIMS, Mr. Harkavy lobbied on behalf of insurance buyers on numerous legislative and regulatory issues.

Mr. Harkavy, 45, has a law degree from Temple University and a bachelor's degree from Pennsylvania State University.

Mr. Harkavy discussed alternative risk financing, regulation and lobbying efforts with Associate Editor Deborah Shalowitz Cowans.

Q: You, as much as anyone, have been a proponent of the alternative risk financing market. Why?

A: I have to put on a couple of hats. Putting on my old RIMS cap, when I was at RIMS I think the most formative lesson I learned was the 1986-1987 hard market.

It may never be replicated, but at that point risk managers were searching desperately for affordable coverage that wasn't there. What we saw then, as we see now, was that the mere existence of a viable alternative market gives the insurance consumer an escape hatch, or greater control of the traditional market.

I think that the prolonged existence of the soft market has a lot to do with the continued viability of the alternative risk market.

Switching hats a little, when I came into the business end of the business of insurance, I saw associations that truly had control of the business. The alternative market has provided associations a much better way of giving a better insurance product to their members and making more revenue off of it.

For agents, the alternative market offers some exciting potential solutions. Much like associations, many brokers and agents control their own books of business. Agents can set up agents captives, and we're seeing more of this now.

People talk about the alternative market sometimes as if there's some kind of a sinister, outside, third-party force coming in and taking over the marketplace. Really, it's just a restructuring of all the fiscal players.

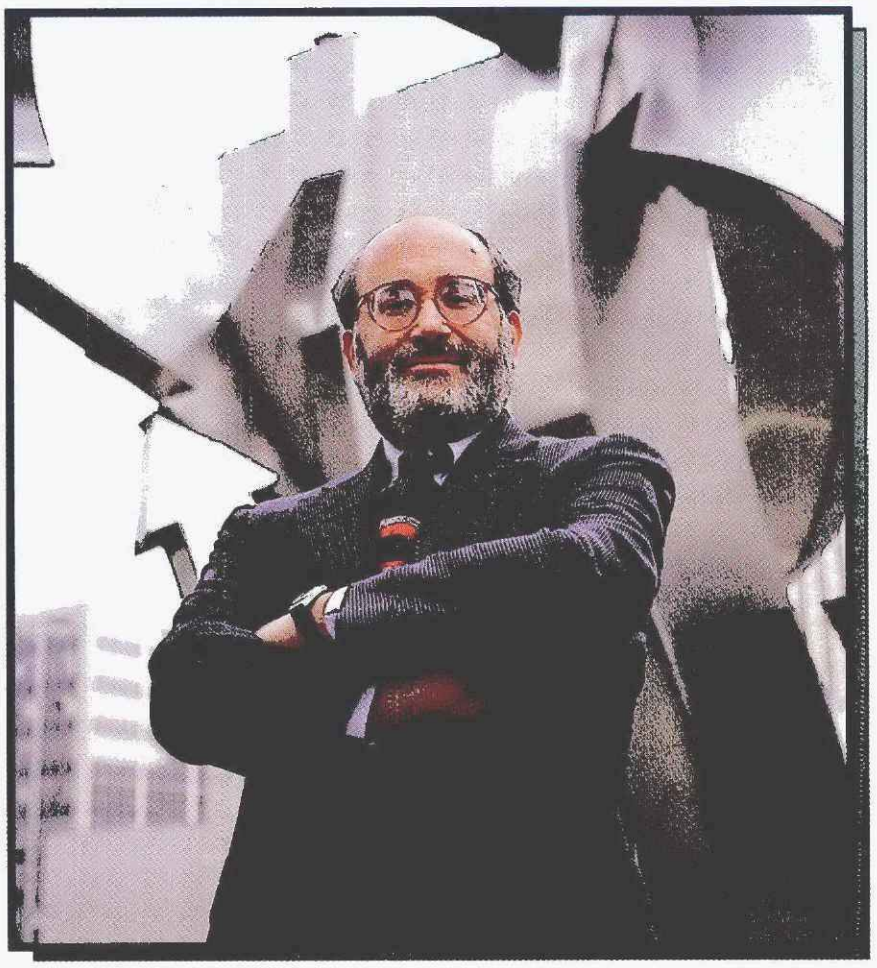

PHOTO: DAVID HITTLE

Are alternative risk financing mechanisms still needed, seeing as the commercial insurance market is so competitive?

Yes. One of the reasons I feel the commercial market is so competitive is the existence of a viable alternative market. Probably even more important is the alternative market allows for an unbundling of services, which the policyholder and the marketplace wants. That would be very, very difficult if the alternative market didn't exist.

What is the future of alternative risk financing?

You have a situation where you're talking about 40% 45% of the market. Is it truly alternative anymore? Many of the startups I see now are not in the area of affordability or availability of coverage. It's a matter of control—both of the future and of the revenue stream. I see a lot more hybrids—of pools, captives, alternative market types and products put out by the traditional insurance industry.

Do you view the insurance industry as the enemy, a friend, a partner?

Everybody seems to have, for better or for worse, a more or less shared stake in outcomes now. In the vast majority of times, the pain that the alternative market feels is quickly felt by the rest of the industry. So in most cases I regard them as friends or partners with a particular interest.

The era of a confrontation between the alternative market and the traditional market is not over, but I would say that very close to 80% of the things that I see at the NAIC or the federal government are working in a cooperative as opposed to an adversarial position with the traditional insurance industry.

Insurers devote enormous resources to lobbying. Do risk managers devote enough?

Coming from the governmental affairs background that I do, my answer is probably not enough. But let's face it, given the concerns of specific industries, insurance lobbying is going to take a back seat.

And, risk managers are best served by a large degree of laissez faire market, so most of their problems are defeating something, as opposed to changing something radically.

During your tenure as a lobbyist for RIMS, what frustrated you about employer involvement in commercial insurance issues? What pleased you?

The problem that I saw at RIMS was that while captives and perhaps tort reform were very, very important to me, they just were not number one areas for corporate governmental affairs involvement. Very few risk managers saw lobbying as part of their role as risk managers. And I can't say I blame them. They're not paid as lobbyists, and they're not paid for changing the landscape.

But when you had an area that risk managers could really get their teeth into and understand, when they truly felt that their own interest was at stake and that they were being treated unfairly, the rallying cry and the enthusiasm and the support was wonderful. The ISO claims-made form is an example. This was an issue where every risk manager got involved. We got calls and letters from membership and we managed to force the NAIC to take action where clearly they weren't going to.

You helped get the Risk Retention Act of 1986 passed. Why did RIMS devote so much time to that?

The Risk Retention Act provided a means, other than going offshore, for policyholders to form in one state and operate nationwide free of form and rate regulation. It's just a structure, like a limited liability corporation or an "S" corporation. I just thought that an escape valve needed to be written that the NAIC or the individual state could not tread upon.

Why did the buyer succeed in that effort and not in others?

Congress was not going to pass tort reform; they were not going to change insurance regulation very much. But they wanted to show they were doing something. So you take what you can get.

The insurance company was lower than whale dung at the time. We managed to humanize insurance to the maximum extent possible with very, very sympathetic witnesses such as non-profit hospitals, nurse-midwives and municipalities.

It was not the large corporate risk manager that got this passed; it was the service providers that saw the opportunity and the mid- to smaller-sized commercial insureds.

What changes, if any, are needed to the Risk Retention Act?

Quite a few—some tinkering, some major changes. Among risk retention groups, the biggest problem is that we need a mechanism that's simpler than having to go to federal court to adjudicate differences between risk retention groups and a state. Now, the burden is very much on the policyholder if a state wants to cause problems. A state can take all sorts of actions that we strongly feel are preempted by the Risk Retention Act, and if you're a risk retention

See **Harkavy** *on page 68*

"General Re's actions went far beyond the contract."

Robert Caldwell, left, with John Seibert, General Re

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Robert Caldwell, President,
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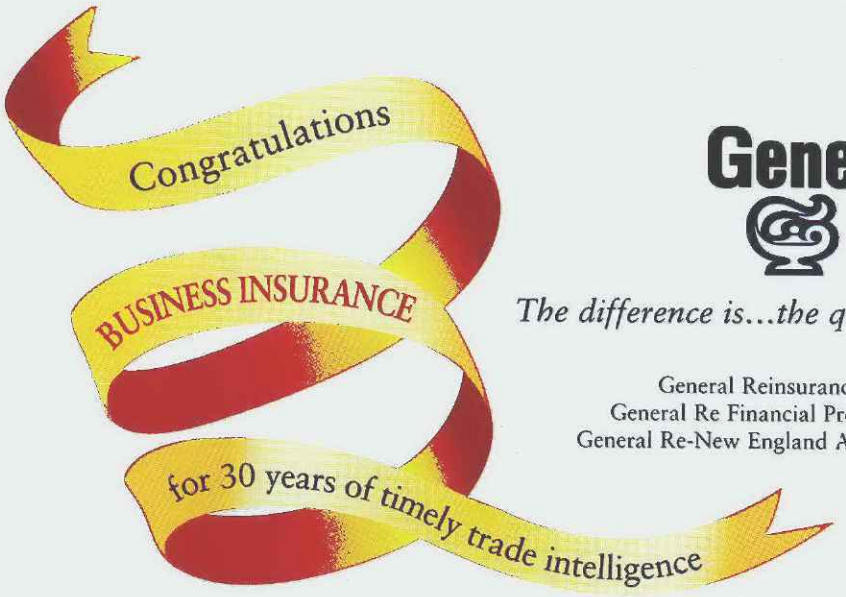

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Harkavy

Continued from page 66

group, you're in a constant quandary whether to roll over and play dead or sue them. That s one problem.

The second is the restrictions on what you can write. Right now it's liability only. But not everybody wants to bifurcate their insurance coverages. For example, a nor-profit wanting auto insurance can get auto liability from a risk retention group, but what about property damage to your own auto?

Third, I think the purchasing group mechanism needs to be made easier so that an insurance company doesn't necessarily have to be licensed in every single state in which it operates and can operate with one form and rate.

Today only 68 risk retention groups operate. Does that mean the law was a failure?

No. We go back to the circular argument. If the Risk Retention Act didn't exist and the alternative market didn't exist, would the market be as soft as it is today? I really feel that risk retention groups and pools are nothing more than structures that you pull off the shelf when needed. It's valuable when you need it. I wouldn't look at the 68 groups and say failure. I'd say it's a soft market and the need has not been hugely present.

Louisiana in 1995 enacted legislation that would have imposed new regulations on risk retention groups. Do you see Louisiana as an example of regulator hostility to risk retention groups? If so, what is the NRRA doing to combat this?

Yes, although it was interesting how that developed. The impetus behind the passing of the bill was a spurned state property/casualty association that thought they were operating on an unlevel playing field.

Now, did regulators mind that they did that? No, because regulators by their nature don't like risk retention groups.

What the NRRA is doing about this is we point out the law, point out the problem. We'd like to think that if there's some good faith, we can hammer out the problems. In most cases, while there is some animus towards risk retention groups and purchasing groups, I like to believe that state officials do what the federal law requires them to do.

Why are regulators so hostile to risk retention groups?

A couple of reasons. If you're a regulator, you have a group that is operating, in your fiefdom, your franchise, without appropriate supervision by the state or the say-so of a regulator who in their mind has no real stake in the action. And there has been some degree of insolvencies. So if you combine both of those, yes, you're going to have some resentment.

Do you think this is going to change?

I think this is what you should expect for a while. What I'm hoping for is reluctant compliance with federal pre-emptions. And will regulators ever like risk retention groups? No, in my opinion.

More than 80%of domestic captives are licensed in Vermont. Why, then, is there a need for other domestic domiciles?

A couple of reasons. Whenever I have a fight with the NAIC, whenever I have a problem on the federal level, it's nice to have more than one insurance commissioner, more than a small congressional delegation to draw upon for support. Plus, as we all know, competition augurs well for consumers. The more choices that policyholders get, the better off they are.

Why should captives have special tax status?

I am not looking for captives to have a special tax status. What I'm looking for is for them to be treated like everyone else—parity. You want to control your own destiny, you want to do a business function, which is to control risk, as cheaply or as efficiently as possible. You should have the benefits of deductions. You're just taking care of a business expense in the most efficient way.

Do you envision the day when so much business is handled by captives that future administrations will increase taxation of captives?

Yes. You can't have estimates of 40% or more of the commercial market being an alternative market without some people either trying to level the playing field or governments looking at it as a potential revenue source.

What do you feel has been your greatest success?

Helping pass the Risk Retention Act was very important, as was managing to coalesce the support of the risk managers against the ISO CGL policy.

More recently, what I see gradually happening and I'm very pleased with is a growing sense of solidarity among different domiciles and captive associations. Before, there was occasional interaction between them, but basically everybody was looking at things parochially. Now, they're working collectively for the greater good of the alternative market. 30

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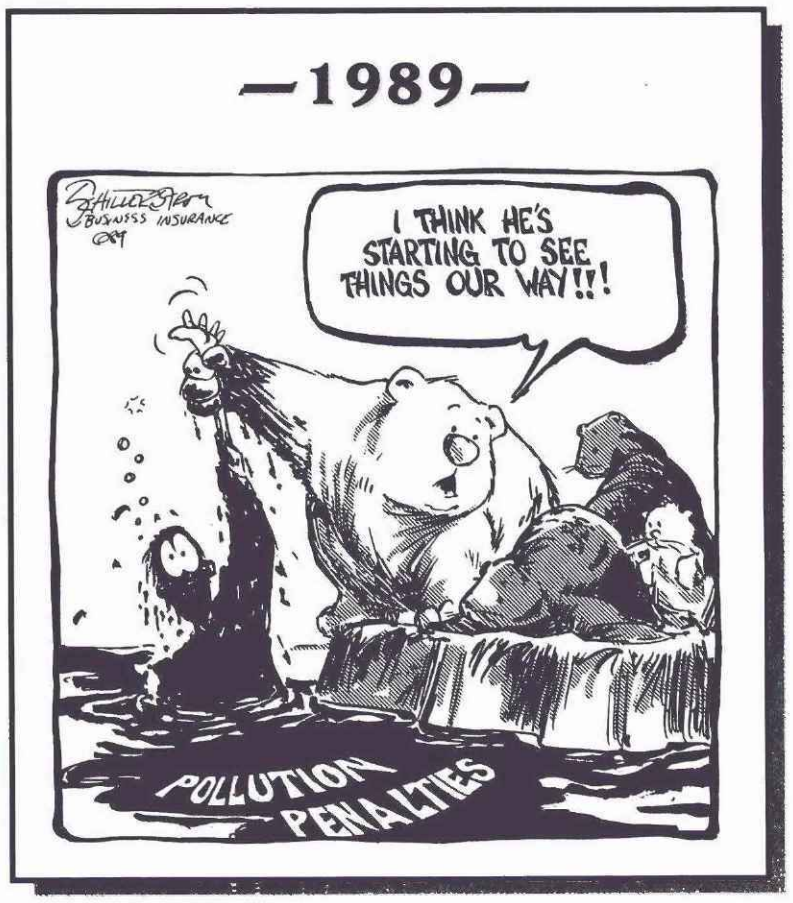

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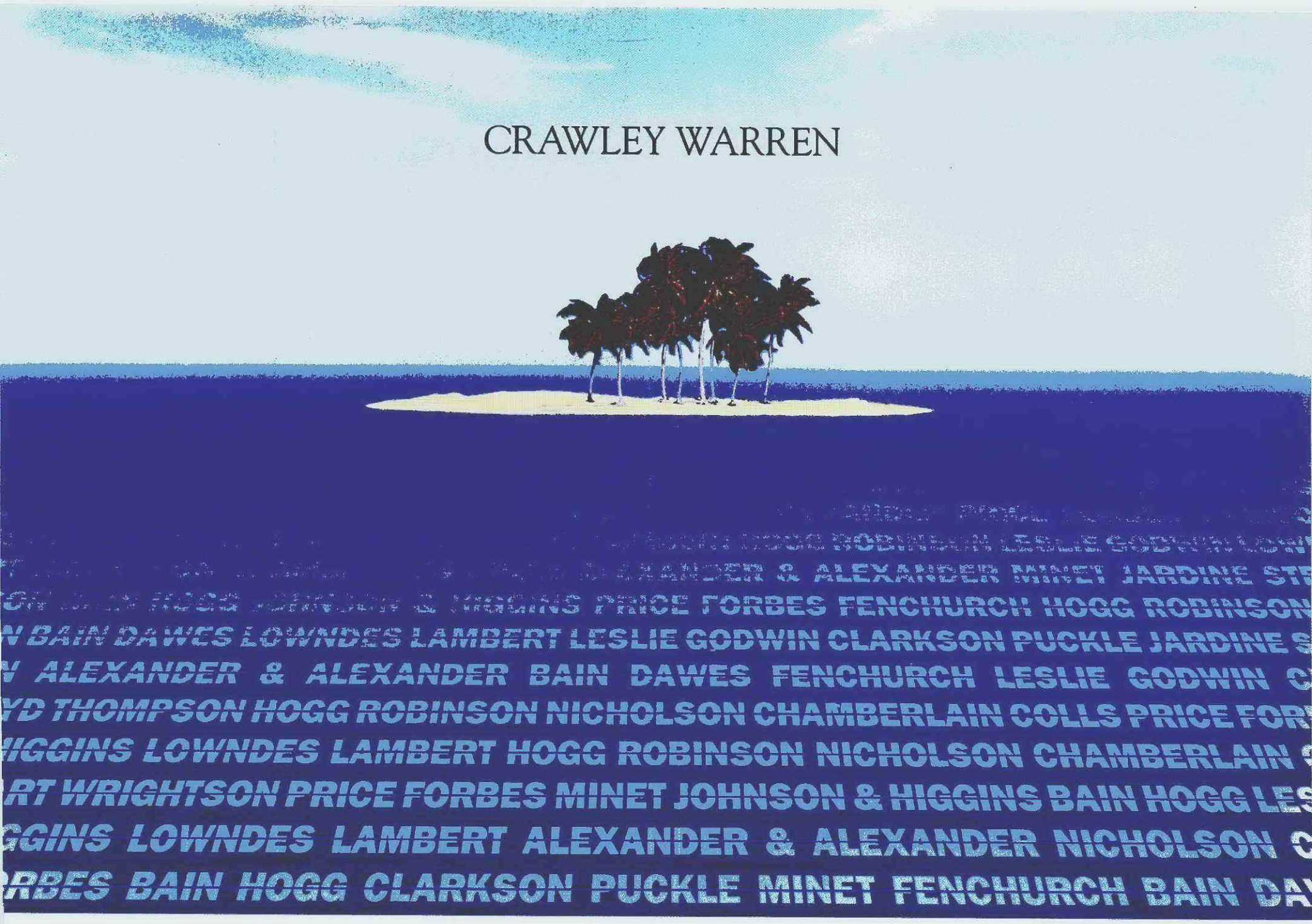

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VIEWS

Carol Harrington

Manager putting technology to work for risk management

Carol Harrington, director of risk management at Palo Alto, Calif.-based Sun Microsystems Inc., is credited with in 1996 helping develop an innovative site on the World Wide Web that allowed information to flow among Sun, its broker Sedgwick Group P.L.C. and insurer Chubb Corp.

She also is credited with encouraging the development earlier this year of a multiyear, multiline insurance program for the $8.6 billion-a-year maker of powerful server computers and software.

Prior to joining Sun nine years ago, Ms. Harrington held risk management positions at Raychem Corp. and Rolm Corp. and had been a risk analyst for Varian Associates. She also has been an agent for Fireman's Fund Insurance Co.

Ms. Harrington, 57, is a graduate of San Jose State University, with a B.S. in Business/Finance. She is a past president of the Northern California chapter of the Risk & Insurance Management Society Inc., an instructor for the Insurance Educational Assn. and holds both the Chartered Property & Casualty Underwriter and Associate in Risk Management designations.

With her computer periodically beeping with e-mail notices in the background, Ms. Harrington talked with Senior Editor Judy Greenwald.

Q: How did you get involved in using the Internet to communicate with your broker and insurer?

A: Working for a technology company, I definitely have the advantage. As you can see, I have the tools available to me.

I felt that we should stretch and we should involve the brokerage firm as well as insurance companies. So I contacted Sedgwick and asked if they would be interested in networking with Sun Microsystems electronically so that we could transfer information.

We started with the small step of actually electronically trading e-mails, and then we extended from that to sending information via attachments and things of that sort.

As we grew, then, we moved in and selected Chubb Insurance Co. as the third point of the triangle. (Along with two consultants), we worked on a team basis.

We met periodically and talked about all the steps that we wanted to do to expand the opportunity to communicate more on an electronic basis, in other words to make our lives simpler and to get information to communicate more prospectively and more timely, too.

We started with one goal, which was to communicate the certificates of insurance, and then we traded information like local offices and loss control procedures and contacts and things of that sort.

More information could be gained by any Sun personnel worldwide just by going onto our Web page and clicking on and filling out templates, giving information that would automatically go both to the broker and also to the insurance companies.

Are you still working on this with Chubb and Sedgwick?

PHOTO: MAX RAMIREZ

We will continue to communicate with our business partners electronically and will add new partners as we change and expand the insurance program.

We all used this almost as a learning base and then we took it on from there, expanded the concept of communicating electronically.

What are some of the other ways that you've been using technology as a risk manager?

One way that we use it internally is we have a risk management Web page so that all of our information is out there. All the Sun offices can see the information, such as frequently asked questions about their insurance coverages, templates for losses and things of that sort.

We've gotten very involved in a local Santa Clara Northern California RIMS group. We communicate electronically with these local companies.

If there's any information that we want shared, we just send it out. It goes out to all of our peers and counterparts, and we can all assist each other and help each other.

How quickly do you feel others in the risk management profession will move along the same lines?

How far ahead of the pack are you because you work for Sun?

I think I definitely have an advantage because within the Sun organization, in all countries, we all use systems and we all communicate electronically; it's just paperless. We don't send memos from one to the other, so that's definitely been an advantage.

But I think if you look around, we're in the world of computers now. I think everyone has computers on their desks, their laptop, all kinds of computers.

I think the risk managers, as far as I know, are all somewhere along that curve of setting up Web pages, trying to figure out how they can communicate electronically, and looking for their suppliers, their brokers, their insurance companies, their consultants to provide them with information online.

I see all of that at various levels of stages, but all going toward the same goal of being able to communicate electronically.

What are some of the new ways that you envision technology and risk management developing in the future?

I think we're going to see a lot of our traditional work being done electronically, not only just on a communications level, but also in the processing of information.

I envision that in the future we will take information that's needed by insurance companies and pull that from various databases within our organization and transmit that information online directly to insurance companies, which in turn will be able to take that information and make it part of their policy contracts.

There won't be a lot of redundancies and passing of this information to a broker, who in turn will copy it into some format application and send that onto an insurance company. As you copy and re-send it, there's a higher level of chance for error. I think this will prevent that, so there won't be a lot of corrections, endorsements and changes to forms.

I envision insurers of the future going to companies' home pages where we have annual reports and new product introduction information. They can gain at any point in time during the policy period information on the company just by virtue of looking at their Web site.

Ideally, I'd like to pay their invoices online, too. Why have an invoice that's typed up by an insurance company, that's sent to a broker, who types up an invoice on brokerage paper, who sends the invoice in the mail to Sun Microsystems, who transmits the invoice to Sedgwick, and then on to the insurance company?

Ultimately we should be able to somehow transmit those funds electronically, directly to the insurance company, and that would prevent redundancy in the system.

I think another thing is, insurance companies are going to be able to offer products online. I think some of the direct writer insurance companies, life insurance companies, are doing that.

I think you see that moving more into larger clients, Fortune 100, or Fortune 500 companies, maybe they are too complex for that online quote, but I think we'll be moving toward that in the future.

Would you discuss the development of your multiyear, multiline insurance program?

I think we're seeing some amazing trends in the insurance industry now. I think products over a number of years haven't changed that much, and insurance companies have always provided products to the insured off the shelf, products designed by the insurance company in traditional lines of coverage.

I think what we're seeing now is that insurance companies are listening more to the customers, and they're developing products that specifically respond to customer needs, and that trend is continuing.

There's a lot of capacity out there and we've taken advantage of the situation by virtue of putting together a response to Sun Microsystems' risk management needs.

We've tried to build a product that's more simplistic from an administrative standpoint, multiline coverage, multiyears, thereby preventing us from having to go annually to the market for 40 to 50 insurance contracts that renew

Continued on next page

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every single year.

As soon as we finished that old renewal process, and the policies were completed and forwarded in, we went through the process again and back out, reviewing and renewing policies.

Now that we have a multiyear program that is designed specifically for Sun, we can focus on the things that we need to be focusing on, which is defining what our risks and exposures are, going out and—they call it risk mapping or risk profiling—determining what exposures you need to address, focusing on contingency planning.

What if something happens, if you lose major manufacturing or a sole source supplier? What's your plan for the future?

It frees up a lot of time to do more of the strategic things that should be done rather than the traditional renewal and administrative processing things.

We're also able to set up a base of coverage that can be expanded as we find we have more needs for more creative types of coverages, non-traditional-type coverages such as political risk coverage.

It allows us to take a look at some of the commercial exposures, the financial risk, the financial exchange rate risks, credit risks, things of that sort, and also expand traditional insurance coverage, to infringement-type coverages or employment practices coverage, things that are available out there and can be just rolled into that blended program.

The new program is a three-year, multiline property and casualty insurance program. The catastrophic insurance limits have been provided by X.L., CIGNA and Swiss Re.

We have $300 million per-occurrence limits and $600 million in the aggregate. Allendale provides an excess property insurance program to blanket limits.

The new catastrophic program is excess of our captive insurance company retentions.

What are some of the other particular challenges facing you at Sun as risk manager?

I think a lot of us are trying to really focus on what really makes sense for the corporation as a whole and to redefine what risk is within our organization, so we're involved a lot more with top management and working with exposures other than traditional insurance exposures.

This involves thinking out of the box, and going out to suppliers, asking them if, in fact, they have any solutions that can address our specific needs, and always focusing on what makes sense from a strategic standpoint for the corporation, the shareholders, the stake holders, to protect the balance sheet, the bottom line for the corporation, for all the risks that are involved, not just property and casualty insurance risks.

Sun is a relatively new company. Do you think that gives you an important advantage in using these new approaches that perhaps other companies might not have?

That's a good question.

I think companies have to be financially strong, with a really good balance sheet, to involve programs where you have a high level of retention.

You have to be a company that is willing to open your mind toward taking on your own traditional exposures and claims and funding for those that are at a high excess level.

Also, the ones that are open and innovative that are, like I say, able to make change happen within the organization, those are the type of companies that will moving forward into these new models.

What are some of the other problems and challenges you see facing the risk management profession in the future?

The traditional administrative tasks will be outsourced so a broker or an insurance company will be doing those transaction-type exercises, such as getting certificates, filing certificates, issuing claims forms.

Any kind of repetitive transaction will be outsourced to various suppliers.

I see the risk management function in the future involving more of a strategic, high-level partnership with the organization, working at the vp level and working with management.

The others in the risk management organization, the staffs that will support that, won't necessarily be insurance technologists—if there is such a term—with insurance expertise.

Rather than just traditional insurance people, they will be individuals that will have financial expertise or even operational expertise within their own organizations.

They will be familiar with the operations, the manufacturing, the logistics, and will be able to use that information, along with their understanding of financial concepts, to come up with new ways of handling risks and exposures. 30

The world's 20 most costly insured losses

Natural catastrophes dominate the 20 largest insured losses.

Date	Catastrophe	Location	Insured damages*
August 1992	Hurricane Andrew	U.S.	$17.95 billion
January 1994	Northridge earthquake	U.S.	$13.28 billion
September 1991	Typhoon Mireille	Japan	$6.42 billion
January 1990	Winter storms	Europe	$5.53 billion
September 1989	Hurricane Hugo	U.S.	$5.33 billion
October 1987	Autumn windstorm	Europe	$4.15 billion
February 1990	Winter storm	Europe	$3.84 billion
July 1988	Piper Alpha explosion	U.K.	$2.66 billion
January 1995	Hanshin earthquake	Japan	$2.55 billion
October 1995	Hurricane Opal	U.S.	$2.17 billion
March 1993	Winter storm	U.S.	$1.91 billion
September 1992	Hurricane Iniki	U.S.	$1.80 billion
October 1989	Phillips explosion	U.S.	$1.68 billion
September 1979	Hurricane Frederic	U.S.	$1.63 billion
September 1996	Hurricane Fran	U.S.	$1.60 billion
September 1974	Hurricane Fifi	Honduras	$1.60 billion
September 1988	Hurricane Gilbert	Jamaica	$1.48 billion
December 1983	Winter storms	U.S.	$1.39 billion
October 1991	Oakland fires	U.S.	$1.39 billion
April 1974	Tornadoes	U.S.	$1.37 billion

* Losses in 1996 dollars

Source: Swiss Re, sigma No. 3/1997

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J. Robert Hunter

Consumer advocate challenges conventional wisdom in insurance

30 VIEWS

Few people have proved to be such a thorn in the insurance industry's side as J. Robert Hunter.

What particularly annoys some insurers is that Mr. Hunter had himself once been an insurance professional before joining the Federal Insurance Administration as an actuary and ultimately ending as acting federal insurance administrator in the mid-1970s.

But it was as head of the National Insurance Consumer Organization, which he founded in 1980, that Mr. Hunter made waves. He criticized industry practices and at one time blasted the industry as being so unattractive to college students that it could fill its management ranks only with "dregs."

When Texas Gov. Ann Richards named Mr. Hunter state insurance director in 1993, some insurers feared the worst, but many later said that Mr. Hunter proved to be unexpectedly even-handed.

Mr. Hunter, 60, now director of insurance for the Consumer Federation of America, explained why he has taken the positions that he has in an interview with Washington Editor Mark A. Hofmann.

Q: How did someone who started out professionally in the insurance industry end up so critical of the insurance industry?

A: It's a combination of things. I grew up in an insurance home. My father was a marine insurance adjuster. During the war, he would tell me these stories about how it was a business based on good faith and how people would take each other's word and claims would be paid in advance, just on the word of somebody to keep the war effort going so ships could be repaired. It just sounded terrific.

When I took the job at the federal government as chief actuary in 1971, I actually viewed it as a stepping stone, good for my resume, so I could come back into the insurance industry, and hopefully become an executive of some sort.

When I got my first paycheck and I took the paycheck into the bank to cash it and I'm looking at the paycheck, and it was from the people of the United States. And I said, "Gee, you know, just like my other checks all came from the insurance companies and I gave them my allegiance, I really owe my allegiance to the people." I really started looking at insurance from their perspective.

I still gave weight to the industry viewpoints, but was just aware that there was another viewpoint.

Over the years, some of your critics say you have been more interested in making sensational charges than in being fair and balanced in your criticism. Why do you think you have aroused such strong passions in the insurance industry?

I don't know why I arouse strong passions because I don't think I try to be sensational. They were surprised when I went to Texas and was balanced. I said, "Gee, my job when I was at NICO wasn't to be balanced. My job when I was at NICO was to raise issues."

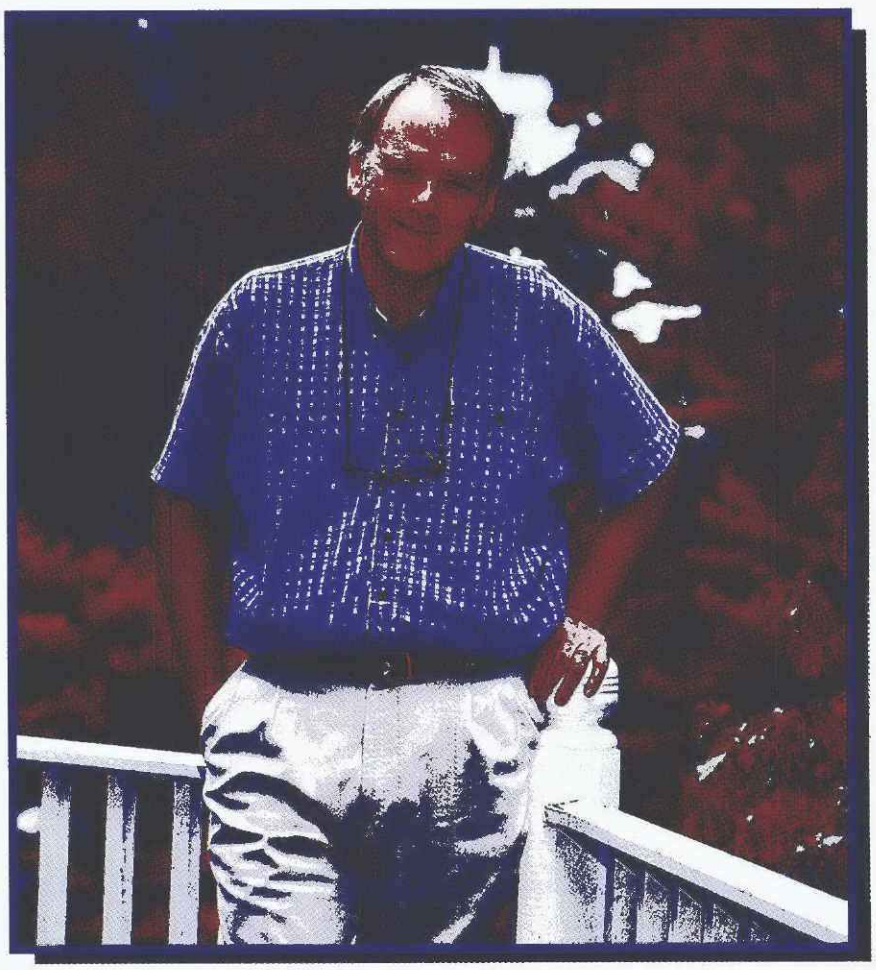

PHOTO: DAVID HITT_E

A consumer group's job is to raise issues they think are being handled inappropriately.

Early on, insurers employed several different strategies. But they had never faced a consumer advocate before. First they ignored me. Then they attacked me as totally out of the mainstream, wacky, off the wall.

The first issue I raised was we ought to factor investment income into rate making, total-return rate-making methodology. That was the first report from NICO and I said it would save $5 billion if it was fully implemented in auto insurance alone. They all said this is crazy. Now they accept that as an adequate way to make rates.

I've never been really radical in terms of what I was saying. They just didn't like anybody disagreeing with the industry.

I may have overstated things on occasion, like when I used the word "dregs." Obviously, I apologized immediately on that.

I was saying that the insurance industry falls so far short of its promise that when I go to universities and ask how many people would like to work in the insurance industry, no hands go up. And that's bad because you'd assume if the insurance industry was really doing its job right, it would attract the young, idealistic people. That's why I used the phrase, why I said instead of getting the best out of these classes, they're getting the dregs. Well, that was obviously the wrong choice of words.

But I think in the main, I've been careful because the industry is always ready to pounce on a bad study like the Public Citizen solvency study. And they haven't been able to pounce on me much.

In 1980, after leaving the Federal Insurance Administration, you founded the National Insurance Consumer Organization to help consumers better understand insurance. Did NICO accomplish that?

The goals are pretty much the same. Partly it's consumer education, and obviously we haven't achieved it. I think they're better than when we started, but there's still a shortfall.

Consumer education was one of the prime goals. But one of my goals was always to get other people involved on our side because it was never anywhere near to being a close fight. When I started, I was it. There was nobody else.

There's also public policy analysis, research, media work.

How did becoming head of the Texas State Board of Insurance change—if at all—your attitudes about insurers?

I knew I would be even-handed, they just didn't believe it until I actually did it, because I understood the difference between being a regulator and being an advocate.

So I was able to be much more balanced and judicial in looking for solutions. I always respected most insurance executives; I didn't respect them all, but that would be true of any industry, I guess.

There are two kinds of issues I try to raise. Some are going after particular bad practices by insurance companies. Quite frequently, I think I'm going after a bad guy.

Then there are the general issues, like the investment income question where I think the whole industry is off base. Not because they are bad, but because they are getting away with it.

Maybe they just need to be thinking differently. A lot of us never thought much about investment income until the interest rates went to double-digits.

Sometimes when I raise an issue, I don't think they are all bad guys. I just think it's an institutionalized across-the-board kind of change that needs to be done.

Do you think insurers and their trade groups have at times intentionally mislead the public?

I think the property/casualty industry intentionally tried to mislead the public on the insurance cycle in the mid-1980s, trying to blame it on the lawyers. The crisis was not manufactured. The crisis was caused by this cycle and they suddenly were way, way short on reserves. Some companies got very frightened.

Where I consider they misled the public was they turned around and said "Oh, those lawyers did it." They said, "We're good managers and we had nothing to do with it. We just got surprised by these huge lawsuits." That's nonsense.

You may have other arguments to make for tort reform, but this is not one of them. The problem here was an insurance industry out of control and it didn't manage itself properly, and I proved it with numbers. Their attempt to blame it on the legal system was just fraudulent.

Do you think the crisis of the mid-1980s was manufactured by insurers to win tort reform legislation?

The crisis was not manufactured, the excuse was manufactured.

Why has the commercial insurance marketplace been soft for so long?

The market is soft because it's overcapitalized. And the outstanding stock and bond market makes and keeps it well overcapitalized. I don't see any immediate kind of potential for any immediate kind of crisis.

Could it happen? Sure it could happen. Greed is infamous.

See **Hunter** *on page 74*

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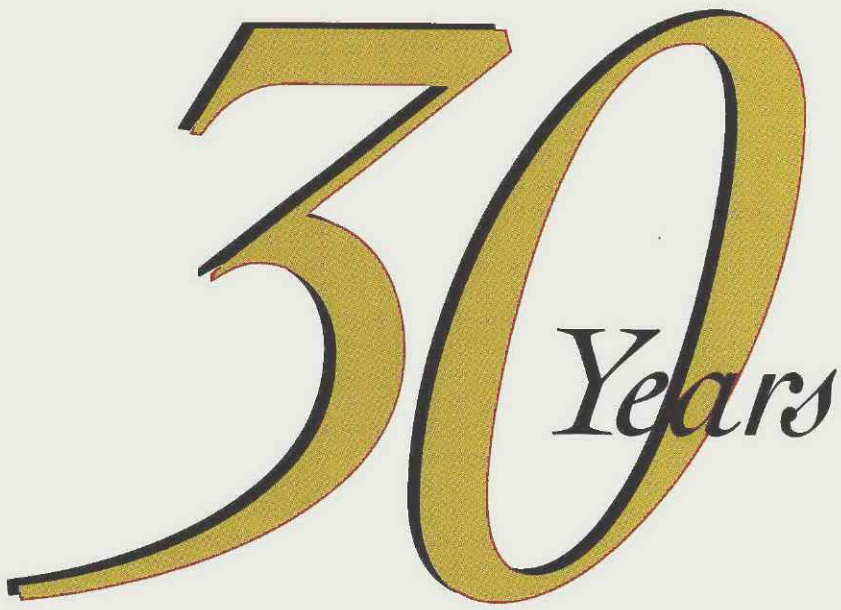

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Hunter

Continued from page 72

Companies will overcompete at the end of a cycle. If you continue to have overcompetition at a time when the market turns sharply downward—which is always possible when you get to a market like this—you could obviously have some kind of crisis.

In the last three or four years, there have been very few, if any, failures of major property/casualty insurance companies. What do you attribute that to?

You'd have to be pretty dumb to fail in this market. I mean the stock market just keeps going up and up and up and the bond market's strong. It's pretty hard to fail.

How would you rate the quality of state regulation?

Some states are almost not there in terms of regulation; some states have very high quality departments, some have excellent leadership. So, it's really spotty.

What changes do you recommend to improve the regulation of commercial insurance companies?

You have to split it between large commercial accounts and smaller commercial accounts. Smaller commercial accounts are sort of like individuals and need some of the same kinds of protection.

Having said that, I think large commercial accounts don't need all those kinds of protections. I've talked to (American Insurance Assn. President) Bob Vagley and others over the years about the possibility of easing regulation on these larger accounts and having more freedoms.

I'm for that generally. The only area I can think of where I differ is they want to get the large commercial accounts out of the guaranty funds.

Which is better equipped, the states or the federal government, to regulate insurers, given the entry of banks into insurance?

The feds are better probably to regulate banks, the states are better equipped to regulate insurance companies. It seems to me what we need in the federal-state question is mature thought about it, forgetting about turf but looking at who could do what best.

It's clear to me that there are certain things the feds can do better.

Suppose Lloyd's of London had gone under, for example. It seems to me the feds could be better dealing with Britain than others about what happens in the wake of that. I don't see how a state could enter into a treaty with London to try to solve it. It would be unconstitutional.

There are a lot of reasons the federal role needs to be reconsidered. Banks' entry is only one of them. There's also the merger mania, and the multinational nature of insurance. It's very important that we have a national approach.

National is a key word, here. To the extent that the NAIC can do something like the accreditation program, it has at least a national minimum, so some of these national approaches could be done by the states.

What do you think about the National Assn. of Insurance Commissioners' efforts as a group?

They spend a lot of time—too much—trying to protect their turf and not trying to do what's best. Of course, the NAIC makes some difference. It seems to me that with the accreditation program, if it really works and stays in place and doesn't get watered down too much, the NAIC can make a very significant difference.

If it just becomes a model-bill-producing group and no states pay any attention to them, which happens quite frequently, then it doesn't meet its potential.

The NAIC has its ups and downs and I think it's in a down cycle right now. I think it's weakening the accreditation program. I think it's totally focused on the federal-state issues and sort of paranoid about the potential of federal involvement.

Why have there been so few people, like yourself, willing to publicly challenge the insurance industry?

When I started at NICO, I was it. Ralph Nader was a little involved in helping me get started. But now you have quite a few people working on insurance from a consumer perspective. I consider that one of our successes. There are probably about 20 groups working on it. I consider that a really important change.

I'm not necessarily critical anymore in terms of there being a presence on the other side. That makes me feel good.

How have your views of the insurance industry changed in the last decade?

I think they've made some improvements. I think the fallout from the cycle really shook them up. And the Prop. 103 thing shook them up.

They've reached out to consumer groups. They've started working on the question of their just being a passthrough; they're working on safety with us; they're working on antifraud measures.

It's been quite a breakthrough in working on some of these things.

I still think the industry falls way short of its promise. It still doesn't attract those bright, idealistic people out of college, but I think it's had a breakthrough.

I think a lot of it has to do with the cycle, with the fact that we were able to organize commercial interests to work with us on McCarran. Commercial interests joined us to say. "You guys need to be taught a lesson."

Ultimately, even AIA came over (to support reform of the McCarran-Ferguson Act). That was a shot across the bow and Prop. 103 was a shot across the bow.

Ten years ago, it was sort of a war all of the time. No matter what we said, the reaction was negative, particularly leading up to Prop 103. Lately, they're much more careful about reacting to what we say.

So, I think they've had to make some changes for the better, I think they have a long way to go.

What do you see on the horizon?

I think a review of whether there should be a greater federal role is inevitable. When is a very interesting question.

I can think of several things that could trigger it. Obviously a new batch of insolvencies, which could occur if you had a return of the cycle, which I think could happen. Not in the immediate future, but could. Democrats could come back.

You've got Dingell, who must be insulted about what happened with accreditation. I think they promised him stuff that they didn't deliver. 30

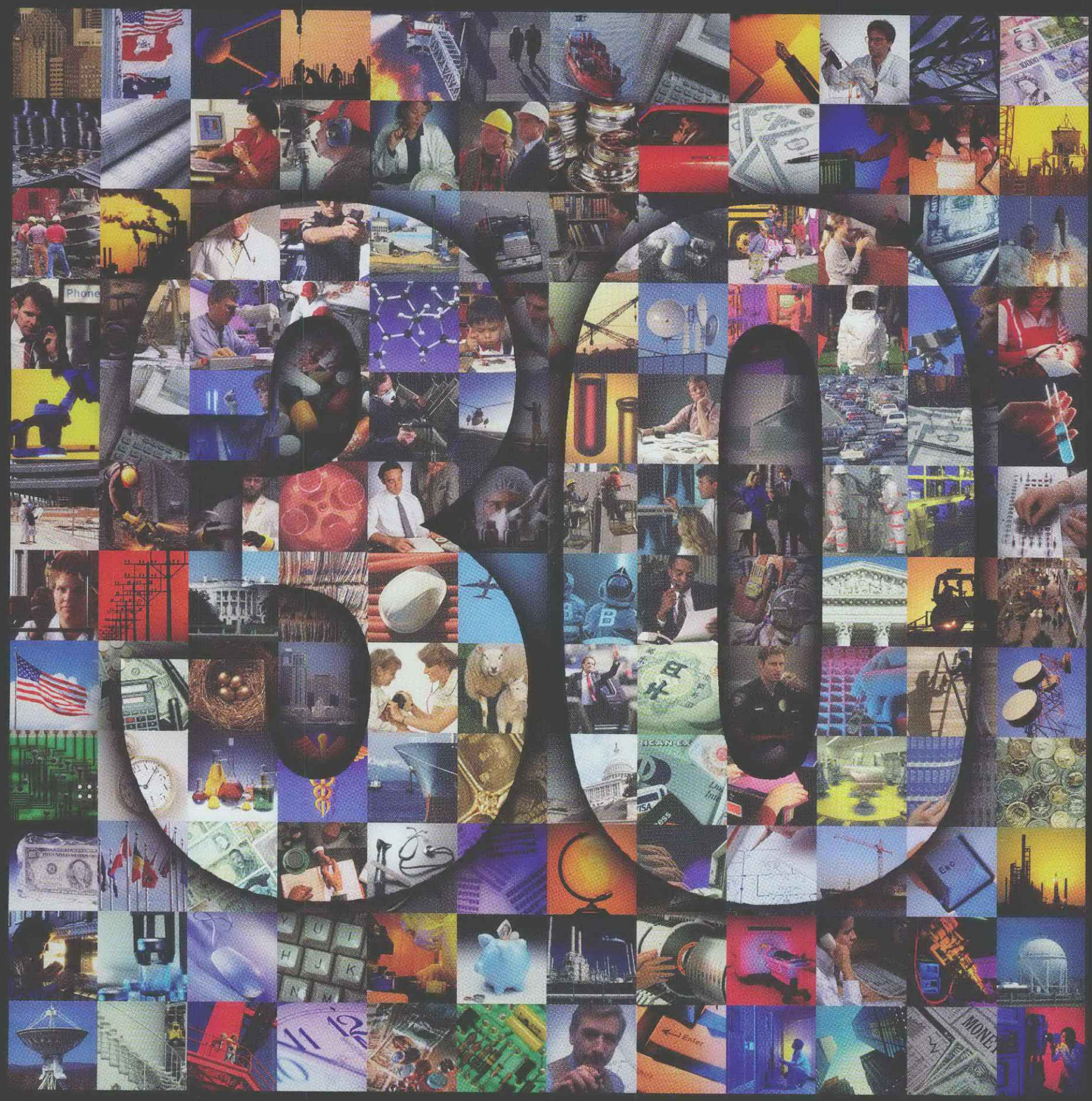
—1995—

"HOW ABOUT IF YOUR RECOMMENDATION JUST SAYS THAT YOU'RE "ONE HELLUVA GUY"?

—1996—

—1997—

"DON'T EVEN THINK ABOUT IT."



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VIEWS

Heidi E. Hutter

CEO blends the new with the traditional in reinsurance

Heidi E. Hutter is bridging the gap between the old and the new in reinsurance.

When she joined Swiss Reinsurance Co. straight from college in 1979, she entered the traditional world of reinsurance in the traditional role of actuarial assistant.

Since that time, Ms. Hutter, 40, has come to represent the untraditional. In the 1980s, she joined the then-pioneering world of financial reinsurance at Swiss Re subsidiary Atrium Corp. From 1993 to the end of 1995, she took on the highly unusual task of creating a reinsurer to help solve the long-tail liability problems of Lloyd's of London.

After overseeing the establishment of Lloyd's runoff reinsurer, Equitas Ltd., Ms. Hutter returned in early 1996 to Swiss Re in New York, where again she was in the limelight as a woman not yet 40 who was chairman, president and chief executive officer of Swiss Reinsurance America Corp.

Recently, she spoke to New York Bureau Chief Gavin Souter about change and the future of the reinsurance industry.

Q: In your time in reinsurance, how would you say the industry has changed?

A: I think several things have gone on. For one thing, in the reinsurance business we have a far deeper understanding for what the basis of reinsurance is all about, and that underlies a lot of the other trends.

For example, look at globalization, the development of financial and finite-type reinsurance alternatives. A lot of the things that we've seen as developments, I see more and more as symptoms of an underlying issue, which is the pressure on companies for performance and the need to look at risk and return so that one brings those together as return on risk-adjusted capital.

What is the understanding of what reinsurance is all about?

When I joined the industry, I remember some of the things that I was told early on, and the impression I had was that companies bought reinsurance because they always did. There was a very large element of tradition, and some of the early things I learned about reinsurance were the time-honored traditions, the uberrimae fidei, the long term, the pay-back concepts that one didn't just have a business relationship but that one had a long-term relationship with a reinsurer.

Many of the best parts of those things still exist, but I think the feeling I had when I joined was that insurance companies did this because they had to, and one could hardly think of an insurance company that didn't have reinsurance, so it was just part of the nature of being an insurance company. You had these nice people called reinsurers who took over the big risks because the insurance company didn't have experience with that, and there was a whole different aura around the reinsurance environment in those days.

Now, more and more we can see it's not that those things were wrong, but the reason companies buy reinsurance is actually grounded in economics and finance, and a lot of good behavior is actually grounded in logic.

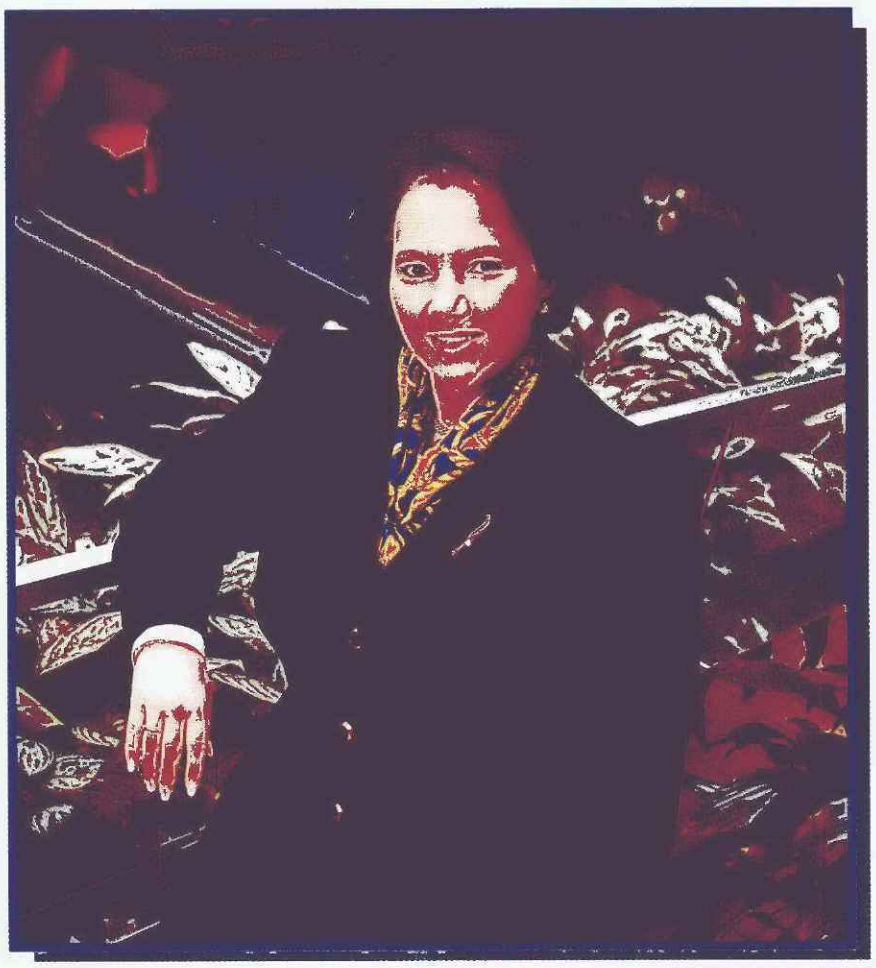

PHOTO: DAVID LUBARSKY

So is it that companies have a better idea about why they buy reinsurance?

I think different companies are at different points in their cycle. In general, there's a better understanding of why people buy reinsurance and, as a consequence, more and more companies are looking at why they buy it and if they should continue to.

Of course, there is also pressure to find more optimal ways to buy reinsurance or in some cases not to buy reinsurance and use alternatives and other mechanisms instead.

What impact would you say that financial reinsurance has had on the market?

I think the impact that it has mainly had is that it changed the way people looked at reinsurance. The early financial contracts were solutions for particular problems, where reinsurance became the vehicle for the solution, and those early products were the beginning of the wave of the solution-driven mentality that we and others are proponents of. It's a mentality that says the reinsurer is not exclusively a company or a group of people that sells reinsurance products but rather functions as not only a risk-taker and risk-sharer but also a solutions provider.

In the past couple of years we've seen a lot of consolidation. Is that just part of the cyclical nature of reinsurance and we'll soon see other reinsurers sprouting up, or have things changed forever so that you've got to be big to compete?

First off, I think the consolidation has been a good and necessary thing in the United States. I think during my career we have had time periods when we've had too many reinsurers, in the sense that there is more capital chasing too little expertise, and expertise is a thing that we are still in short supply of, and unfortunately we still do some foolish things in our industry as a consequence of that.

I'm delighted that the number has concentrated down, because it is what I view as the winnowing out of the amateurs. There is certain critical mass that one has to have as a reinsurer to have the kind of rating tools and techniques, to have the cat modeling, to have the understanding just to be on top of the technology alone in terms of products developments, and what's on the horizon in terms of legal issues.

So I think one has to have a certain level of expertise and the related size that comes with that. So from that standpoint, I think it's been a necessary trend.

Some people then go on and take any trend and extrapolate. If you look at some people's forecasts, one almost has a sense that they would get to the point where you have a negative number of reinsurers in the world.

I think as with any other marketplace, there always are opportunities for new entrants. It's not a one-directional trend; I'm convinced that there will be some new companies along the way, but on the whole, it's a consolidation trend.

Why was Lloyd's of London not left to market forces and allowed to disappear? Why was a special effort made to keep it going?

I'd not agree with the way you phrased the question. I think it was left to market forces. There was not a government bailout, and Lloyd's did have to deal with its own problems.

I think that outside the industry, many people didn't understand that those within the industry did not want to see Lloyd's fail and that there's a recognition that a major failure reflects badly on the entire industry.

In terms of Lloyd's and reconstruction and renewal, of course you are right in calling it a special effort. One would hope that it's a special effort that never again gets repeated in Lloyd's history. I hope that is a once in a 300-plus years event for everybody's sake.

From your standpoint now, though, it would be a competitor out of the way, wouldn't it? What is special about Lloyd's? Why does Lloyd's have to continue?

I, for one, never had the sense that Lloyd's needed to be saved or in fact that it was saved because it was special. I think it comes back to market forces. I think the reason it all came together was that many people saw and believed that there was an ongoing viable business, and so corporate capital came into marketplace. If there was no ongoing profitable business, I think the entire organization would have been put into runoff. But it was market forces in 1993 that felt that there was value that caused people to make the investment.

In the longer horizon, would I be happier if there were one less competitor? In a small way one could answer, "Yes," but to a large extent, my organization doesn't really compete head-on with Lloyd's, and they do provide reinsurance and insurance in a lot of areas.

We'd all love to see a tightening of the market, but it will only happen when enough people get fed up with the current conditions, and who'll lead the way remains to be seen.

You know all the figures. Do you think Lloyd's policyholders will have their claims paid in full?

Continued on next page

Continued from previous page

In terms of knowing all the figures, one thing I realized is how quickly one's information becomes dated. So I will not try to argue it from a numerical standpoint, but rather I will come back to the fundamental principles.

I think the rationale for creating Equitas was sound and remains sound. The fundamental rationale of bringing together the expertise and managing it in a coherent and cohesive way is as sound now as it was then.

In terms of the actual numbers, obviously we all face uncertainties surrounding things like asbestos and environmental. There was a period in time when the estimates just seemed to be spinning wildly higher and higher.

Most recently, industry estimates seem to have come to a much lower level, and those were the levels on which Equitas was based, so I think there is a pretty good shot at all of it, but it will be decades before any of us knows if we have gotten this right.

In what ways do you think the reinsurance industry will change in the future, and in what ways do you think it should change in the future?

The thing I feel most comfortable predicting is the evolution of the whole financial services industry and the continuation of this process, which we saw the beginnings of in the financial reinsurance world with the blending of some of the more financial techniques and combining that with what had been traditional reinsurance. That I feel quite sure will continue.

I think some people had early hopes that the derivative-type securitization market would take off like a skyrocket, and I think we've seen that there are a number of things that have been created successfully, but it certainly hasn't taken off the way some of the early proponents had hoped it would.

That doesn't bother me, though, because what we see now is that transactions are taking place and that people are finding ways to bridge the traditional and the financial worlds, and so these early transactions are the precursor of more that will follow.

In terms of what should happen, well, I suppose we have lots of people moaning and groaning about the underwriting cycle and hoping we have a correction in the marketplace.

Whether one thinks it should happen or not, I don't think it will, and maybe that's a bit of a cautious reaction, because if I never plan on it happening and if it happens, I'll be pleasantly surprised.

Also, I think the whole industry itself is not as well-positioned in terms of its future. I think insurance just doesn't have the image I wish it did externally, and I wish the image would catch up with reality.

The reality is that we have a fascinating business; we touch every part of economic and social interaction in the world. Yet the image is still of a dusty door-to-door insurance salesman, and I think that is just so out of sync with reality. So I wish the image will catch up with reality, but I don't think that is going to happen anytime soon.

On the subject of insurance derivatives, will reinsurers be able to stand their ground, or will investment bankers come in an take over?

I absolutely believe reinsurers will not only stand their ground but actually enhance it.

I don't see investment bankers coming in and taking the field, because the deals require expertise from both areas. Without an understanding of the risk dynamics, the structuring of a new product doesn't get past ground zero.

Will reinsurers have to become aligned with investment banks?

If a reinsurer becomes aligned to a single investment bank, it actually would lose positioning and advantages. Our great virtue is diversification, and the way we achieve that is through trading with many, many enterprises around the world. And our customers, we believe, would not take too kindly to it if we were too closely affiliated with one firm. Likewise, harnessing to one distribution channel would not be a sensible route.

What about your own position within the industry? You are a young person at the head of a major reinsurer and you are a woman as well, and again that is unusual for someone in your position. Do you think you reflect a change in the whole industry?

My view on women coming through the business and the changing of the guard is it is part of what's happening in the industry. There are simply more women in the insurance industry workforce, and I think my generation has benefited from some women who have pioneered before us, but I think we continue to lead the way and pioneer for the next generation.

I really believe that 20 years from now, no one will even think twice about this.

In the 20 years that I've been in the business, it has changed quite dramatically. I think 20 years from now it shouldn't be an issue for anyone at all. 30

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Risk management's finest

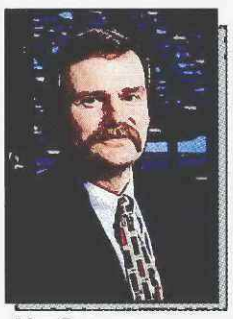
For 20 years of the publication's 30-year history, Business Insurance has had the privilege of bestowing our Risk Manager of the Year Award on an individual whose achievements and innovation have elevated risk management standards and advanced the profession.

Here is the list of those 20 individuals and where they are now. Some are with the same company, others have moved to new jobs or started their own businesses, others are enjoying retirement and sadly, a few have passed away. We also list those individuals that we have named to our Risk Management Honor Roll, which debuted in 1981.

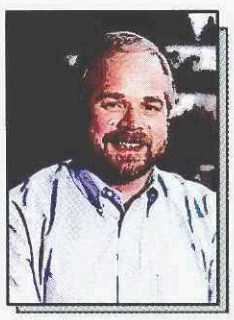
WHERE ARE THEY NOW

Ms. Lindenmayer

1997: The most recent Risk Manager of the Year is **Judy M. Lindenmayer**, vp- Fidelity insurance and risk management for FMR Corp. in Boston.


Mr. Casey

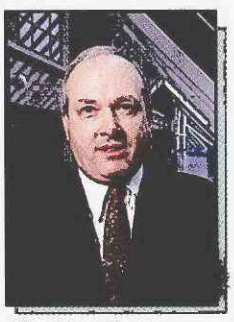
1996: **Brian D. Casey** is director of risk management and loss prevention for Corning Inc. in Corning N.Y., the same position he held when he won the award.


Mr. Lange

1995: **Scott K. Lange** is the director of risk management for Redmond, Wash.-based Microsoft Corp., the same position he held when he was Risk Manager of the Year.

Ms. Gallagher

1994: **Lucille A. Gallagher** was vp of risk management for ConAgra Red Meat Cos. in Greeley, Colo., when she was honored. In December 1996, Ms. Gallagher started her own firm, Human Resource Risk Management L.L.C. in Greeley, where she is CEO and managing partner.


Mr. Heydinger

1993: **Richard C. Heydinger** is the director of risk management services for Hallmark Cards Inc. in Kansas City, Mo., the same position he held when he won the award.

Ms. Workman

1992: **Millicent W. Workman** was the director of corporate risk management for Belz Enterprises in Memphis when she was selected as Risk Manager of the Year.

She currently is the corporate risk manager for Mueller Industries Inc. in Nashville, Tenn.

Mr. Davenport

1991: **Arnold L. Davenport** is vp of risk management for Marriott International in Bethesda, Md., the same position he held when he was honored.

Mr. Wilder

1990: **Stephen M. Wilder** was director-corporate risk management for The Walt Disney Co. in Burbank, Calif., when he was named Risk Manager of the Year.

He was named vp-risk management in 1993.

Mr. Pettegrew

1989: When he won the award, **Jeffrey W. Pettegrew** was risk manager and chief administrative officer of the Contra Costa County Municipal Risk Management Insurance Authority in California. In October 1991, he joined Western Staff Services in Walnut Creek, Calif., as director of insurance and risk management, and now is vp-insurance and risk management.

Mr. Mather

1988: **William L. Mather** was administrator-risk management for The Gillette Co. in Boston when he was voted Risk Manager of the Year.

He was named director of risk management later that year and retired to Needham, Mass., in June 1996.

Ms. Lichota

1987: **Edith F. Lichota** received the honor when she was senior vp for the Irving Trust Co. in New York. Ms. Lichota spearheaded the development of Bankers Insurance Co. Ltd., where she was vp-administration. In 1989, she became an independent consultant but maintained her ties to BICL. At age 65, Ms. Lichota died of a sudden heart attack on Nov. 21, 1994.

Mr. Nelson

1986: **Donald Nelson** was director-risk management for ARA Services Inc. when he won the award. In October 1989, he went to Alexsis Inc./Alexander & Alexander Inc. in Philadelphia, where he was a vp and risk management consultant. Mr. Nelson retired in November 1995 and currently lives in Wilmington, Del.

Since his retirement, he has worked as a risk management consultant on an as-needed basis for Hibbard Brothers Inc. in Media, Pa.

Mr. Lang

1985: **Harold C. Lang** was named Risk Manager of the Year when he was director of insurance and risk management for Leaseway Transportation Corp.

In February 1987, he went to Kohler Co., a plumbing products company based in Kohler, Wis., where he was director-insurance and risk management. Mr. Lang retired in 1995 and is living in Kohler, Wis.

Mr. Inserra

1984: **Richard M. Inserra** was director of insurance and risk management for American Can Co. when he was named Risk Manager of the Year.

He then became managing director-risk management and corporate real estate. Mr. Inserra worked for Triangle Industries

Continued on next page

Risk Management Honor Rolls

John J. Carney
National Freight Industries Inc.
Betsy Kutska
Park District Risk Management Agency
Russell Opferkuch
Bankers Trust Co.
William R. Powell
Salt River Project
Jeannie Sedwick
Wake Medical Center

Craig S. Macdonald
Bi-State Development Agency
Michael Tawney
Loomis Armored Inc.

Lee D. Holland
Tennessee Municipal League Risk Management Pool
K.C. Kidder
Norwest Corp.
Judith Payne
South Dakota
Bruce Zaccanti
Jupiter Mechanical Industries Inc.

Sal M. Bianchi
Intergovernmental Risk Management Agency
Judith Moses McDonald
Comerica Inc.
Ronald J. Guilfoile
City of St. Paul, Minn.
Thomas J. Hickey
Malcolm Pirnie Inc.

David G. Adler
The Portman Cos.
Thomas E. Bell Sr.
Middle Cities Risk Management Trust
June Dickinson
SunTrust Banks Inc.
C. David White
State of Oregon

Marc Darby
Bombardier Inc.
Jerry Newsom
State of Georgia
Judith Tornese
Transamerica Corp.

Donald D. Batchelor
Union Planters Corp.
Mary L. DeCampli-Stewart
Metropolitan Washington Airports Authority
Rod Umscheid
University of California

Josephine Goode Johnson
University of Maryland Medical Service System
Roger D. Oaks
Tennessee Farmers Cooperative
M. Michael Zuckerman
Thomas Jefferson University

John A. Lindquist
Browning-Ferris Industries Inc.
J. Douglas Higley
State of Louisiana

Gregory L. Daniels
American National Red Cross
Timothy G. Galarnyk
Lunda Construction Co./Phoenix Steel Inc.
Stephen A. Finley
City of Lakewood, Colo.
Edward G. Weiss
First of America Bank Corp.

Susan M. Werner
Hardee's Food Systems Inc.
Mark F. Wilson
First Mississippi Corp.

Delmer Ison
Washington Metropolitan Area Transit Authority
William E. Rogers
Conemaugh Valley Memorial Hospital

Susan N. Weiner
Dade County Public Schools
Eva F. Goodrich
Cincinnati Electronics Corp.

Sidney D. Blatt
Holloway Cos.
Gene Snyder
State of Oregon

Jerri Nelson MacMillian
Aetna Life & Casualty Cos.'
Real Estate Investment Department
Robert Sinclair
Metropolitan Government of Nashville and Davidson County

Spencer J. Traver
BF Goodrich Co.
Runner-up
Paul B. Harvey
Ponderosa Homes
Gene M. Marsh
General Conference of Seventh-Day Adventists
George N. Pierce
Orange County, Fla.

Robert Bieber
Westchester County, N.Y.
William Ryan
University of Michigan

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Continued from previous page

Inc. in New York and left there as vp-risk management and business development.

Beginning in 1989, Mr. Inserra was president and principal of his own firm, Insurance Strategies Ltd. in Ridgefield, Conn. In 1991, he joined Union Carbide Corp. as director of insurance and risk management.

In 1992, he became assistant treasurer-risk management and insurance, a position he holds today for the Danbury, Conn.-based company.

Mr. O'Connell

1983: **John A. O'Connell** was executive director/risk manager for Holy Cross Shared Services Inc. when he won the award.

Mr. O'Connell later was appointed president of Holy Cross Shared Services and president of the Havican Insurance Co., a Holy Cross-owned captive in Colorado.

In addition, Mr. O'Connell was one of the founding members of Consolidated Catholic Risk Retention Group, a Vermont-domiciled RRG owned by Catholic health care systems.

Now retired, Mr. O'Connell serves on the boards of two not-for-profit organizations, Notre Dame Federal Credit Union in South Bend, Ind., and the St. Vincent de Paul Society for the South Bend area.

Mr. Russell

1982: **Eckart Russell** was named Risk Manager of the Year while serving as risk and insurance manager for Alcan Aluminum Ltd. in Montreal.

At Alcan, he later became a manager responsible not only for risk management but also for foreign exchange risk, financial planning and futures markets activities.

In 1986, Mr. Russell joined Johnson & Higgins as a vp in Montreal. He later became senior vp/director of J&H Canada.

Mr. Russell will remain in Montreal as a senior executive with J&H Marsh & McLennan.

1981: **Duane E. Allen** earned the honor while working as assistant treasurer for Hanna Mining Co. in Cleveland, now known as The M.A. Hanna Co.

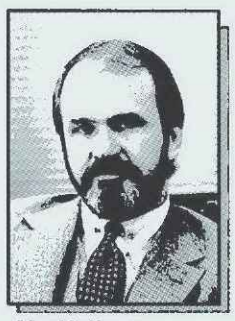
He worked there until 1984 as assistant treasurer-director of risk management.

Mr. Allen

Mr. Allen then was a principal with Applied Risk Funding Services in Laguna Hills, Calif.

From 1987 to 1996, he was president and owner of Applied Risk Insurance Services in Pasadena, Calif.

Today, Mr. Allen is president and part owner of MacAfee & Edwards Inc.-Mexican Insurance Specialist in Pasadena and also works as an independent broker.


Mr. Hallett

1980: **Thomas V. Hallett** was risk manager for General Motors Corp. when he was named Risk Manager of the Year.

Mr. Hallett, a leader in the field of risk management, died suddenly of a heart attack in 1993 after a career that included positions as executive vp at Frank B. Hall & Co. Inc. and senior vp at Alexander & Alexander Services Inc.

Mr. Erickson

1979: **Edward L. Erickson** was director of insurance for American Broadcasting Cos. when he won the award. He retired in January and is living in New York.

Mr. Weber

1978: **Howard T. Weber** was director of insurance at Minnesota Mining & Manufacturing Co. when he won the honor of becoming *BI*'s first Risk Manager of the Year. He served in the same position with 3M when he died in 1988.

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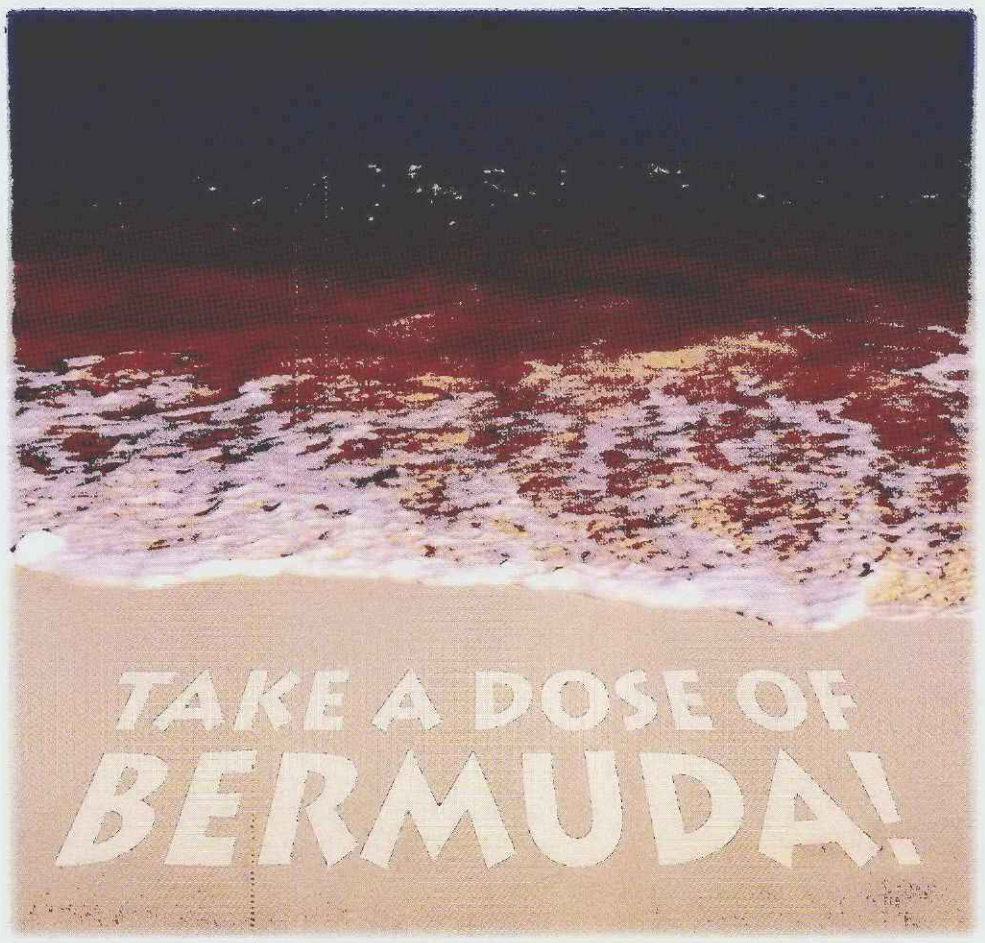

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Linda S. Kaiser

Former regulator looks back at liability-based restructurings

Linda S. Kaiser, Pennsylvania's insurance commissioner from January 1995 until June 1997, approved one of the most contentious insurance company restructurings in recent years.

Under CIGNA Corp.'s liability-based restructuring, the company split its Insurance Co. of North America subsidiary in two and assigned most of INA's liabilities to the portion of the company that was merged into a separately capitalized runoff facility. The other half of INA continues to operate unencumbered by those liabilities. As a result, it has earned a higher rating from A.M. Best Co.

CIGNA's restructuring, which continues to face legal challenges, and other recent LBRs have created an industry stir over the rights of insurers, policyholders and others affected by those transactions.

A white paper that a National Assn. of Insurance Commissioners' panel released this summer suggested that regulators should approve LBRs only if the transactions protect policyholders' rights.

Ms. Kaiser participated on the NAIC task force that authored the paper. But, before the paper was completed, Ms. Kaiser, 41, resigned as Pennsylvania's commissioner to rejoin Reliance Insurance Co. in Philadelphia as a senior vp, secretary and general counsel.

In a recent interview with Senior Editor Dave Lenckus, Ms. Kaiser shared her perspective on LBRs in general and some events surrounding CIGNA's restructuring.

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VIEWS

Q: How should regulators balance the interests of various groups affected by an LBR, especially when some groups' interests may be at odds with others'?

A: By statute in Pennsylvania, the insurance commissioner is charged with considering the interests of policyholders, creditors and other members of the public community, like shareholders, producers and others who might have an interest in the transaction.

So the interests being looked at are very broad, under Pennsylvania law.

Can a regulator's decision equally balance all of those interests, or does one group always emerge with what looks like a better deal?

I don't think a regulator can favor one group. It was the role of my department (in CIGNA's reorganization) to balance all of the interests in that transaction.

This balancing of opposing interests was no different than our review of insurer mergers and other transactions that I ruled on.

In fact, that balancing applies not only to other kinds of insurer transactions but the regulatory process in general. For example, if policyholder interests were always paramount, insurers would never receive a rate increase.

How strong a voice should policyholders have in proposed LBRs?

How much say policyholders should get is a matter of public policy. The question then should be, "Who is setting the public policy?" Is it the state's regulators, legislature or judiciary?

A state could have a statutory requirement, for example, delineating how much say policyholders should have. Or, case law could set forth how much say policyholders should have.

Those requirements are the floor. Then, of course, a regulator could go beyond those minimum requirements

PHOTO: SAL DIMARCO JR.

What kinds of documents do you think policyholders should be allowed to review so they can assess how they would fare in an LBR?

The philosophy the department followed while I was commissioner was to encourage public access to publicly available documents. However, there are provisions in Pennsylvania law that make certain documents unavailable to the public—for example, documents arising out of the financial examination of insurers. Those provisions do not leave the commissioner the discretion to decide to release those documents. To release them would have been in violation of the statute.

That confidentiality requirement was established in the model holding company law. Forty-nine of the 50 states are required to hold examination papers confidential and not hold them out for public dissemination or examination.

Are there any other documents that policyholders affected by an LBR should be entitled to review?

There is a right-to-know law in Pennsylvania. Policyholders, creditors and other interested persons should have access to material that is defined to be public by the law.

Wouldn't a national standard on the level of involvement that regulators should grant policyholders during an LBR regulatory review help protect the interests of all parties in such transactions?

It seems to me that it would be difficult to establish a national mandatory standard for policyholder involvement in an LBR. It would be difficult to get 55 jurisdictions to agree to a consistent standard.

And, that's not how insurance historically has been regulated.

Do you support the findings of the NAIC's white paper on LBRs?

I haven't read the final white paper. I was no longer a member of the NAIC when the white paper was voted out of committee and sent to the parent committee.

To the extent you were familiar with the paper, do you think regulators who assess LBRs in the future should follow the paper's guidelines?

The working paper was never designed to be a blueprint for regulators to follow. It was originally thought the white paper would be useful to assist regulators who have never been through a transaction of this type. They would receive the benefit of thoughts from regulators who'd been through the process.

But, given the controversy LBRs have generated, wouldn't a blueprint be helpful to protect the interests of all parties affected by an LBR?

During the time I sat on the task force, there was no consensus by the regulators that that would be a prudent line of action.

Part of this reluctance was that the LBRs to date have been so dissimilar that it would be difficult drafting a model law that could address all the variable ways of doing an LBR.

It wasn't deemed to be an appropriate use of NAIC resources.

Will the industry likely see many more LBRs like CIGNA's?

I don't know of any other state that has a provision that permits a division like the one in the CIGNA transaction. However, there are many other ways to structure an LBR that don't require a corporate division. For example, a company could set up a whole new unit.

Wouldn't that kind of transaction be a novation requiring prior policyholder consent, a situation that many restructuring insurers would want to avoid?

Some types of LBRs may very well require policyholder consent, depending on state law. However, you should keep in mind that many insurance company transactions—mergers of stock companies, for example—do not require policyholder consent.

The National Conference on Insurance Guaranty Funds has created some concerns about LBRs in general with its declaration that, since INA is still active, state guaranty funds would not respond if CIGNA's runoff facility were to fail.

What is your reaction to the NCIGF's decision?

I'm unaware of anything in current law that would support the allegation by the fund that they don't have to pay their policyholder obligations in accordance with current statutory schemes. I'm unaware of any state where there is a defense to paying claims.

So, unless something exists in a state's statutory language that allows it not to pay claims, the fund would have the obligation to pay in accordance with the state statutes.

In evaluating a proposed LBR, can a regulator ever be sure that a restructured insurer's proposed runoff facility will not fail?

With as much assurance as a regulator can have in evaluating an ongoing company, a regulator can evaluate a runoff company and make an informed decision about the viability of the company.

Were you surprised by the level of opposition to CIGNA's LBR?

I wouldn't say that I or the department was surprised by the level of opposition. The parties expressed their interest very early in the process.

Knowing the level of interest led the department to hold the hearings it did.

Is Reliance considering or would it consider restructuring in the same manner CIGNA did?

No. Reliance is very comfortable with its reserve position and therefore has no need to consider any restructuring.

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If I have seen further, it is because I have stood on the shoulders of giants.

—Sir Isaac Newton

THOSE WHO HAVE GONE

The past three decades have witnessed many notable achievements in insurance, risk management, employee benefits. Although many professionals who brought innovations have passed away, their contributions remain influential.

Among those remembered for their legacies are leaders from the Risk & Insurance Management Society Inc.

Robert S. Spencer, president of the RIMS in 1977-1978, died of a heart attack in February 1979 at age 53. Mr. Spencer, vp-insurance at Fuqua Industries Inc. in Atlanta, was an outspoken advocate of risk management and the risk manager's role in corporate affairs. He founded Fuqua's insurance department in 1967, a year after joining the company. Mr. Spencer also established a self-insured workers compensation program in 1972 and a Bermuda-based captive in 1976. During his tenure as RIMS president, membership in the society grew by 20% and RIMS launched a research service for members. After his death, the Atlanta RIMS chapter established a memorial scholarship fund that supports students in risk management and insurance. The Spencer Educational Foundation Inc., now administered by RIMS in New York, has awarded 183 scholarships.

Anita Benedetti, deputy executive director of RIMS and president of the Spencer Educational Foundation Inc., died in August 1996 at age 47 after a battle with cancer. During an 18-year career with RIMS, Ms. Benedetti directed research, education and international activities and served as an industry liaison. During her tenure as president of the Spencer Educational Foundation, the foundation's assets grew to nearly $1.9 million from $103,000. In 1995, RIMS gave special recognition to her contributions when it presented her with the society's highest honor, the Dorothy and Harry Goodell Award. In addition, The Spencer Foundation board voted this fall to award a $10,000 Anita Benedetti scholarship to an outstanding woman.

Among the leaders in risk management were three named *Business Insurance*'s Risk Manager of the Year (see story, page 78).

Howard T. Weber, *Business Insurance*'s first Risk Manager of the Year, died in July 1988 at age 61. He received *BI*'s inaugural Risk Manager of the Year Award in 1978 in recognition of his development of risk management as director of insurance at Minnesota Mining & Manufacturing Co. in St. Paul, Minn. That same year, he helped launch Corporate Insurance & Reinsurance Co. Ltd., a Bermuda-based captive reinsurer.

Thomas V. Hallett, *BI*'s Risk Manager of the Year in 1980, died of a heart attack in March 1993. Mr. Hallett, 52 when he died, was a senior vp at broker Alexander & Alexander Inc. He was named Risk Manager of the Year for carrying out a major reorganization as director of risk management at General Motors Corp. While at GM, he consolidated the automaker's property and liability insurance programs and negotiated large cost reductions. After leaving GM in 1980, Mr. Hallett joined the brokerage industry, serving lastly as a principal business strategist and risk management liaison at A&A.

One of the first women to reach the top of the risk management profession was **Edith F. Lichota**, who died in November 1994 at age 65. At the time of her death, she was vp-administration at Bankers Insurance Co. Ltd. and an independent risk management consultant. As vp-risk management and later senior vp at Irving Trust Co., Ms. Lichota spearheaded the development of BICL, the first captive insurer for the commercial banking industry. She was named *Business Insurance*'s Risk Manager of the Year in 1987, becoming the first woman and first financial institution risk manager to receive the honor.

During the past three decades, the brokerage industry has lost respected members.

Among them was **Harold H. Hines Jr.**, who was president and chief executive officer of Rollins Burdick Hunter, a Chicago-based broker that became Aon Group Inc. He died in June 1984 at age 59 after a heart attack. Mr. Hines was known throughout the commercial insurance industry for his speeches and writings on the industry's development. The Harold H. Hines Jr. Memorial Symposium, presented annually since 1985, continues Mr. Hines' legacy of examining insurance and risk management issues.

James Stewart, former chairman and chief executive officer of New York's Frank B. Hall & Co., which is now a part of Aon Group Inc., died in September 1991 at age 78. Under Mr. Stewart's chairmanship in the 1960s and '70s, Hall became a publicly traded broker and until its merger with Rollins Burdick Hunter and Hudig Langeveldt in 1991, was itself among the world's largest brokers. Mr. Stewart's father, Cecil Parker Stewart, had been Hall's CEO in the 1930s.

Robert F. Corroon, former chairman of Corroon & Black Corp., died in January 1994 at age 71. His career spanned a time of tremendous growth and consolidation among brokers. Before retiring in 1989, Mr. Corroon built Corroon & Black into a company with hundreds of millions in revenues and 5,000 employees. In 1990, Corroon & Black merged with Willis Faber Group P.L.C., becoming Willis Corroon Group P.L.C., which today is the world's fourth-largest broker.

Richard Shaw, chairman and chief executive of Lowndes Lambert Group P.L.C., now known as Lambert Fenchurch Group P.L.C., died of a heart attack in November 1995 at age 59. Mr. Shaw led Lowndes Lambert as it became a publicly held company and climbed the ranks of the world's largest brokers. At the time of his death, Lowndes Lambert was the 15th-largest. Today, Lambert Fenchurch Group is among the world's 10 largest insurance brokers.

John P. Gallagher, vice chairman of broker Arthur J. Gallagher & Co., died in February 1996 at age 68 after suffering a stroke. Mr. Gallagher was instrumental in building the Itasca, Ill.-based brokerage, now the world's fifth-largest. He was a founder and developer of Gallagher Bassett Services Inc., Arthur J. Gallagher's third-party claims administration and risk management information unit. Mr. Gallagher also was one of the first to convince public entities to self-insure.

Aon Corp. lost one of its top executives in late 1996 when **Arthur F. Quern** died in a plane crash. Mr. Quern, 54, was chairman and chief executive officer of Aon's insurance brokerage and risk management services unit, Aon Risk Services Co. In addition, Mr. Quern was senior vp and corporate secretary of Aon Corp. He joined the Chicago-based company in 1983 after 15 years of government service. Mr. Quern held various positions in the administrations of President Gerald Ford, New York Gov. Nelson D. Rockefeller and Illinois Gov. James Thompson. In 1984, Mr. Quern was named president of Aon brokerage unit Rollins Burdick Hunter after the death of Harold H. Hines Jr.

Bermuda has lost several men who were responsible for building the island's reputation as a premier domicile for alternative risk financing and insurance.

Sidney R. Pine, an expert in captive insurance tax law, died of cancer in September 1989 at age 79. Mr. Pine, of counsel at LeBoeuf Lamb Leiby & MacRae in New York, was known for his role in developing offshore single-owner and group captives as early as the 1960s. As an attorney, he represented captives, their owners and management companies for more than 25 years.

Angus Robinson, who died of cancer in April 1990 at age 43, was an innovator in alternative risk financing. he was a founder of Trenwick Group Inc. in Hamilton, Bermuda. At the time of his death, he was president and chief executive officer of Chartwell Reinsurance Co. After his death, his friends and business colleagues formed The Angus Robinson Jr. Memorial Foundation to award scholarships to students of insurance and reinsurance. The foundation has granted scholarships totaling more than $125,000.

Frederic M. Reiss, who founded Bermuda's captive insurance industry in the 1960s, died in November 1993. He founded the Reiss Organization, which became International Risk Management Ltd. in 1988 after its acquisition by Swiss Reinsurance Co. IRM remains one of Bermuda's largest captive management companies.

Michael J. Kevany, the former chairman, president and chief executive officer of X.L. Insurance Co. Ltd., died in May 1995 at age 69. He had joined X.L. in 1988 after seven years at CIGNA Corp. and 20 years at Royal Insurance Co. Before stepping down as X.L.'s president and CEO in 1994, Mr. Kevany led the excess insurer through a period of growth in which X.L. moved its headquarters to Bermuda from Barbados, expanded its product offerings and launched a European subsidiary, X.L. Europe.

Corporate Insurance & Reinsurance Co. Ltd., a Bermuda-based captive reinsurer, lost Chairman **William F. Schwoebel** in August 1981. Mr. Schwoebel, who was 69, died of an aneurysm. He became CIRCL's first chairman in 1978 after retiring as senior vp-finance at National Steel Co. in Pittsburgh.

Numerous executives are remembered for their key roles at insurers around the world.

Melvin B. Bradshaw, former chief executive officer of Boston-based Liberty Mutual Insurance Group, died of cancer in January 1991 at age 68. From 1974 until his retirement in 1987, Liberty Mutual grew exponentially, becoming one of the nation's largest property/casualty insurers. In 1971, Mr. Bradshaw was a member of President Richard M. Nixon's National Commission on State Workmen's Compensation Laws.

Longtime insurance executive **John C. Morrison** died in April 1996 at age 70. Before retiring in 1991 as president of CIGNA Corp.'s Advanced Products division, Mr. Morrison was an underwriting executive at Insurance Co. of North America, which became CIGNA Corp. following the 1982 merger of INA and Connecticut General Group. Mr. Morrison was best known for innovations in underwriting insurance for large international corporate risks. He also held various posts at American International Reinsurance Co. Inc. and American International Group Inc.

Sir Peter Green, chairman of Lloyd's of London from 1980 to 1982, died of cancer in July 1996. While at Lloyd's' helm, Britain's Parliament passed the Lloyd's Act 1982, which provided for the market's self-regulation and prohibits members from suing the market. Ironically, Sir Peter was disciplined in October 1992 for "discreditable conduct" as an underwriter. Long before that, however, he made a point of visiting the United States as Lloyd's chairman and meeting with risk management and insurance executives, something few Lloyd's chairmen had done.

Leslie Dew, a former deputy chairman of Lloyd's of London in the 1970s, died in July 1997. While at Lloyd's, he was a longtime non-marine underwriter on several syndicates and chairman of Merrett Holdings P.L.C. He left Lloyd's in 1976 and moved to Bermuda, where he became an underwriter for Gulf Oil Corp. captive insurer Insco Ltd.

Robert Kiln, an innovative underwriter at Lloyd's, died in August 1997 at age 77. Mr. Kiln founded one of Lloyd's largest managing agencies, R.J. Kiln & Co. Ltd. He also was an underwriter on syndicate 510, which R.J. Kiln managed, and served on the Council of Lloyd's from 1971 to 1981.

The surplus lines industry lost a steadfast promoter in April 1981, when **Joseph H. Blades** died of a heart attack at age 55. Mr. Blades, chairman of the Blades Group of Cos. in Houston, built wholesaler J.H. Blades & Co. Inc. from a one-man agency into a company with a premium volume of tens of millions of dollars before selling it in 1978 to Crum & Forster Insurance Cos.

Another influential figure in the surplus lines industry was **Louis W. Biegler**, who died in February 1995 at age 80. Mr. Biegler founded L.W. Biegler Inc., which later became Crum & Forster Managers Corp., and International Surplus Lines Co. He promoted specialty lines of insurance and, as chairman of the Illinois Insurance Exchange, helped make the IIE a leading surplus lines market.

The employee benefits profession also said goodbye to influential leaders.

William Harrison Givens Jr., senior vp of pension operations at the New York-based Equitable Life Assurance Society of the U.S., died of cancer in July 1985. Mr. Givens, 58, was a descendant of two U.S. presidents, William Henry Harrison and Benjamin Harrison. In addition to a 38-year career at Equitable, Mr. Givens was one of the forces behind the formation of the ERISA Industry Committee, a lobbying organization representing large employers on pension issues.

Sen. Jacob K. Javits, who died in March 1986 at age 81, was a principal architect of pension reform legislation in the 1970s that ultimately became the Employee Retirement Income Security Act of 1974. Among ERISA's provisions are vesting and funding requirements for pension plans and the creation of the federal Pension Benefit Guaranty Corp., which guarantees employees' and retirees' benefits if their employers' pension plans fail. The liberal Republican senator from New York served in Washington from 1957 through 1980, when he lost a bid for a fifth term. The fruit of his labor, ERISA, is his legacy to employee benefits.

Martin Slate, executive director of the PBGC, died in February 1997 at age 51 after a heart attack. Appointed to head the PBGC in 1993, Mr. Slate joined the PBGC when the agency's financial condition was so precarious that some feared it would need a taxpayer bailout. Reform legislation that Mr. Slate helped shepherd through Congress closed loopholes in federal law and put the PBGC—and the pension insurance system—on a sounder financial footing.

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A LOOK BACK

1982 ● 1986

—1982—

● The Reagan administration unveils legislation that would shift to employers most of the burden for paying the health care costs of older workers. Under the legislation, most medical and hospital costs would move to employer plans from the Medicare program for active workers age 65 and older.

● The Insurance Services Office Inc. releases a new comprehensive general liability policy form, the first CGL revision since 1973. The new form requires all risks to be written on a claims-made or claims-discovered basis with a definite aggregate limit, helping insurers reduce potential long-term losses from still-undiscovered risks.

● Rising costs and a slow economy may lead employers to reduce health care benefits for the first time in years. Recession-battered companies are asking their employees to accept benefit concessions, particularly in negotiations with labor unions.

● Employers may face thousands of dollars in added benefit costs following a federal court ruling that mandates equitable pregnancy benefits for employees' wives. The court upholds an Equal Employment Opportunity Commission argument that companies must extend the same level of pregnancy benefits to workers' spouses as to pregnant employees.

● For the first time since 1977, no state passed comprehensive product liability reform legislation, partly due to the easing of the insurance market for product liability coverage.

● A federal court judge in Pennsylvania becomes the first judge to uphold a 1980 federal law that gives multiemployer pension funds the power to demand huge payments from companies that withdraw from the funds.

● A New York bankruptcy court will establish several precedents for resolving mass health injury litigation as part of Manville Corp.'s reorganization. Manville, seeking bankruptcy protection from mounting asbestos injury suits, faces 16,500 claims and expects 32,000 more. The bankruptcy proceeding will address several complex issues, including how much to award a person who contracts a disabling disease from asbestos.

● Broker Alexander & Alexander Services Inc. sues former directors of Alexander Howden Group P.L.C., alleging they diverted $56 million in Howden funds for personal gain. A&A, which completed its acquisition of Howden in early 1982, offered to settle the matter quietly for a French villa, several valuable paintings, a Panamanian company and shares in a petroleum company. After learning the directors had overstated the value of these assets, however, A&A sues for full recovery of the funds.

—1983—

● A federal court ruling, later affirmed by an appellate court, lets companies that self-insure their workers compensation risks to deduct certain reserves from their taxes. The rulings, which permit Kaiser Steel Corp. to deduct more than $425,000 in reserves for uncontested workers comp claims, reject government arguments that employers must determine the accuracy of their liabilities on a case-by-case basis.

● Equal pension benefits for men and women is at issue in a U.S. Supreme Court ruling. The high court holds that insurers cannot pay lesser benefits to women who contribute the same amount to pension funds as do men. Insurers defend the practice by arguing that women outlive men and therefore collect benefits over a longer period. Equal benefits must be offered for contributions made to plans after Aug. 1, 1983, the court rules.

● One of Bermuda's largest captives, Insco Ltd., formed by Gulf Oil Corp., ceases underwriting unrelated marine business and reinsurance for Gulf's marine risks. Insco cites poor profit potential as the reason.

● Standard & Poor's Corp. begins issuing claims-paying ability ratings on insurance companies. The move gives risk managers a source other than A.M. Best Co. for information on insurers' financial health.

● The breakup of American Telephone & Telegraph Co. spurs a pension dispute. A labor union, the Communications Workers of America, asks a federal court handling AT&T's breakup not to divide some of the pension assets among the seven regional Baby Bells. Each regional company is to form its own pension plan, which would prevent AT&T workers who switch companies from carrying over their pension credits.

● Dow Chemical Co. stops producing Bendectin, an anti-nausea drug prescribed for pregnant women. Dow Chemical claims bad publicity, legal expenses and rising insurance premiums force its hand, but critics argue the company intends to reduce its liability.

● More employers take steps to contain health care costs. Hit with double-digit cost increases throughout the 1980s, employers resolve to hold the line on further increases. A wide-ranging study finds that changing benefit plan design and administration can generate considerable savings.

● A South Dakota law permits state-chartered banks to sell insurance. New York-based Citicorp acquires a controlling interest in a state-chartered South Dakota bank and signals its intent to enter the insurance market.

—1984—

● Years of fierce competition among insurers lead to a long-predicted hard market. Tightening commences early in the year as reinsurers begin canceling treaties. The domino effect spreads to all property/casualty lines by the end of year, prompting sharp increases in rates.

● As a result of pressure from reinsurers to cap liability under the commercial general liability policy form, the Insurance Services Office Inc. agrees to exclude both sudden and non-sudden pollution from its proposed new general liability forms. Policyholders fear that the decision could leave them high and dry, especially amid the tightening environmental impairment liability market.

● In a move seen as a potential blow to self-insurance, Congress passes legislation removing tax deductions for self-insured loss reserves. Under the law, companies that establish self-insured reserves for property/casualty losses may deduct losses only as they are paid, not losses that are known but payable in a future year. The Deficit Reduction Act of 1984 also increases taxes due on the income of offshore captive insurers.

● Major defendants in asbestos litigation and their insurers agree to the formation of a facility to handle asbestos claims more fairly and efficiently. Named after Harry H. Wellington, the Yale Law School Dean who chaired the negotiations, the Wellington Agreement provides extensive coverage to policyholders while ending all punitive damage claims the asbestos producers brought against their insurers.

● Federally mandated warnings on cigarette packages do not shield tobacco companies from lawsuits by smokers, a U.S. District Court judge rules. The decision opens the way for a lawsuit to be heard against cigarette makers Liggett Group Inc., Philip Morris Inc. and Loews Corp.

● The Internal Revenue Service declares many types of flexible spending accounts invalid, in effect wiping out a tool that many employers use to help contain health care costs. In the spring, the IRS unveils rules under which an FSA would be valid. Under those rules, participants must forfeit unused benefits in an FSA at the end of each year and employees must make irrevocable benefit selections before beginning the plan year. Employers claim the "use it or lose it" requirement will remove FSAs' effectiveness as a cost-containment tool.

● The re-election of President Ronald Reagan in 1984 is expected to threaten the tax-favored status of employee benefit plans. The Reagan administration, which promises not to raise basic taxes, may tap benefits as a potentially huge source of tax revenue.

● To help employees be better workers and parents, a growing number of employers are crossing the long-observed line that has kept employees' family problems out of the workplace. Corporate giants such as Time Inc., Digital Equipment Corp. and Philip Morris Cos. Inc. are sponsoring "work and family" seminars to help working parents cope with their dual roles.

● A new law aims to give women a better chance of earning pension and survivors' benefits. The Retirement Equity Act of 1984 will require employers to overhaul retirement plans to lower the minimum participation age and ease eligibility rules for survivors' benefits. Most of these changes are expected to lead to slight benefit cost increases.

● The tightening of the property/casualty market begun earlier in the year worsens, leading to the worst capacity crunch in history. Rates on some classes of business rise 1,000% while capacity dwindles. Many larger companies turn to alternative markets to obtain coverage. In addition, several prominent insurers pull out of the environmental impairment liability market, leaving capacity for EIL risks almost non-existent.

—1985—

● A.M. Best Co. issues poor ratings to many large commercial insurers. Best also changes its evaluation criteria, no longer giving credit for reinsurance ceded to non-U.S. companies and secured with a letter of credit. Of the 1,775 property/casualty companies that Best rates in 1985, 331 receive lower ratings, while 118 get omitted ratings. Twenty-five companies received a higher Best rating, one-fourth the number that did in 1984.

● In a disheartening end to insurers' four-year battle for product liability reform, the Senate Commerce Committee declines to advance comprehensive reform legislation.

● The alternative market gains another insurer with the formation of ACE Insurance Co. Ltd. in the Cayman Islands. ACE begins issuing policies after raising about $260 million in capital from more than 20 corporate sponsors and non-sponsor policyholders.

● In an early merger of large brokers, Sedgwick Group P.L.C., the largest Lloyd's of London broker, joins forces with Fred S. James & Co. Inc., the fifth-largest U.S. broker. The acquisition gives Sedgwick the U.S. presence it has long sought and give James, currently a subsidiary of San Francisco-based Transamerica Corp., the vast overseas network it lacks.

● A judge rules retirees have a contractual right to promised post-retirement health care benefits. In his decision, U.S. District Court Judge Thomas Wiseman Jr. in Nashville, Tenn., rules employers cannot unilaterally change those benefits after retirement, even if plan documents expressly say the employer has the right to alter or terminate plans.

● A far-reaching federal legislative proposal gives Congress a hand in shaping benefit plans. Included in a legislative package is a provision that would deny employers their tax deduction for health care expenditures if they did not cover employees' spouses and dependents after an employee dies, separates from his or her spouse or divorces.

● Employers lose a battle over ERISA preemption as the U.S. Supreme Court rules that states can require employers to offer certain benefits under group health insurance plans. The ruling gives employers an incentive to self-insure, however, because the court says self-insured plans cannot be required to offer specific benefits.

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● Wheeling-Pittsburgh Steel Corp.'s termination of its severely underfunded pension plans would give the Pension Benefit Guaranty Corp. the largest claim in its 10-year history. Wheeling-Pittsburgh claims could hit $200 million to $300 million in unfunded liabilities, much higher than the PBGC's previous record claim of $63.3 million. More big plan terminations may be on the horizon.

—1986—

● The crisis in the availability of liability insurance forces states to consider passing tort reform measures, which 34 legislatures do. Of those states, however, only nine pass significant reforms. The other states' reform measures are more limited.

● Property/casualty insurance rates rise while capacity continues to shrink. Risk managers had been stung in 1984 and 1985 with high rate increases and many were unable to find adequate liability limits, prompting some companies to go without coverage.

● Congress expands the federal Risk Retention Act to make it easier for businesses to band together to self-insure liability risks and buy liability insurance on a group basis. Amendments to the Risk Retention Act permit the formation of special, group owned captives—called risk retention groups—to provide all casualty coverages except workers compensation.

● The Insurance Services Office Inc.'s revised claims-made commercial general liability policy form is adopted by more than two-thirds of the states, though a dozen bar or restrict its use. Hotly debated, the claims-made CGL form gains support after ISO accedes to regulators' demands that the form reinstate aggregate policy limits when extended reporting period coverage is purchased. Insurers use the form for primary coverage mainly on the most hazardous and largest businesses.

● New excess liability insurance facilities take form offshore in response to U.S. businesses' coverage needs. ACE Insurance Co. Ltd., organized in late 1985 by broker Marsh & McLennan Cos. Inc. and investment bank Morgan Guaranty Trust Co., writes $200 million in gross premiums in its first year. M&M and Morgan Guaranty subsequently help form a new Bermuda-domiciled insurer, X.L. Insurance Co. Ltd., to offer lower-layer excess general liability coverage. X.L. writes limits of $75 million excess of at least $25 million in underlying coverage.

● Health care continuation provisions in the Consolidated Omnibus Budget Reconciliation Act anger employers. COBRA requires employers with at least 20 full-time workers to extend their group health care programs to former employees and widowed, divorced or separated spouses of employees. Although companies may charge spouses and former employees a premium of 102% of the group rate, the law adds substantial numbers of people to employers' health care plans and raises their administrative costs.

● The Tax Reform Act of 1986 makes numerous changes to employee benefit plans, including lowering the maximum annual salary deferral level for401(k) plans to $7,000 from $30,000 and requiring employers to adopt more rapid pension vesting schedules.

● Health care costs surge as the medical component of the Consumer Price Index rises at average rate of 7.7%, the highest since the early 1980s. Several factors are blamed for the rise, including that employers squeezed all the savings they could out of health care cost control measures and that providers raised prices to offset lower utilization of services.

● Congress considers but ultimately rejects a proposal to require employers to subsidize state health insurance pools for high-risk individuals. Employers battled to stop the proposal, which, if adopted, would have significantly raised their costs.

● A federal appeals court says companies can terminate health care benefits for retirees. Overturning a ruling against White Farm Equipment Co., the court says the Employee Retirement Income Security Act of 1974 does not permit a federal judge to fashion common law to mandate vesting of retiree health benefits. 30

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had tried working at a

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VIEWS

Josephine Musser

Regulator finds use for health care, business expertise

Wisconsin Insurance Commissioner Jo Musser credits an aptitude for math and science, a fondness for computers and wonderful mentors in helping her climb the career ladder two steps at a time.

During the past two decades, the former nurse ran an outpatient cardiac rehabilitation center before becoming a leading health care business executive overseeing an employer purchasing cooperative in the Madison, Wis., area.

The cooperative's success catapulted her to prominence and led Gov. Tommy Thompson to solicit her in 1993 to accept an open-ended appointment as the state's top insurance regulator.

Ms. Musser, 46, recently indicated that she will resign her state post Jan. 2, 1998. Wisconsin state law prevents her from discussing her plans while serving as commissioner, though published reports indicate she intends to run for a congressional seat in 1998.

While taking her career steps, Ms. Musser bolstered her bachelor's degree in nursing with two master's degrees, including a master of business administration degree from the University of Chicago. She earned it through the university's executive program while working full-time in Madison.

At the National Assn. of Insurance Commissioners, Ms. Musser also heads committees on health insurance and legislative policy, internal administration, financial condition as well as liaisons groups with industry representatives and consumers.

In Wisconsin, she also serves on several insurance-related state boards and councils and participates in some women-focused groups. Ms. Musser reflected on her career recently in an interview with Senior Editor Meg Fletcher.

Q: What have you learned about the health care marketplace during your transition from nurse to business executive and then to state insurance regulator?

A: It occurred to me that, plainly speaking, health care providers didn't know enough or a great deal about business and the business community did not know enough about health care delivery systems.

So, I decided to be the bridge between the health care community and the business community to try to help each side view the other a little differently.

After obtaining my graduate degree in business, I worked as a consultant for a variety of companies, including heading the Madison-Area Employers' Coalition on a part-time basis and drafting its health care business plan.

In 1989, I was one of three women to establish the Employer Alliance Healthcare Cooperative in Madison. The business group, which developed a large database system, pooled its purchasing power to successfully negotiate contracts with health care providers. That meant dealing with a "mature health maintenance organization market" of vertically integrated health care systems.

Throughout, I was intrigued—and still am—by the economics of health care delivery systems, employment and benefits.

What do you like best about being insurance commissioner?

PHOTO: MICHAEL MARCOTTE

The learning. I love what I learn. I like sitting down at the table and talking with people about Codification Issue Paper 46 or various other things. I just love it.

The corollary to that is I can't stand not knowing what I'm talking about. I'm very uncomfortable if I don't (know), so I put as much time as I can into learning the issues before I open my mouth.

I've learned so much about politics, people, the technical side of these things. I've learned a great deal about just wonderful people, my colleagues, the insurance commissioners across the country. I value their counsel and their friendships and their support. They are such good, dedicated, committed people—they are amazing.

Have individual consumers been helped or hurt by the transition from fee-for-service to prepaid capitation, an increased emphasis on cost-efficient care, and health care provider consolidation?

Consumers have been predominantly helped and the delivery system has been predominantly enhanced, but the potential for harm is there.

When you talk about fee-for-service to prepaid, obviously you have to balance the patient interest and the economic interest, and to the extent that the care that they receive is good care, the help has more potential than the harm. To the extent that the economic interests of some groups may outweigh the patients' interest on any given day, that is a great potential for lower quality and harm. I generally believe, certainly in this community, that the consumers have gained tremendously.

I think that the quality of care and access to care in this community and this state is very high and it has remained high in the face of cost pressures, aided by near-full employment. Costs have gone down, relative to national costs, more so than in nearly every state.

In a state like Wisconsin, which has very little unemployment, health care providers' emphasis on cost-efficiency doesn't impact quality and access because the competing companies want to provide good benefits. It is to everybody's benefit.

In general, consolidation is good. There are lots of economies of scale, especially in data systems and benchmarking and best practices that small, independent physician groups really can't achieve. However, when consolidation reaches the point of establishing monopolies, obviously that hurts the patient and price competition goes down. Our motto here is to have a healthy competitive environment, which stops short of major consolidation but includes mature and sophisticated health care services.There is more than enough confusion and chaos to go around. I think that consumers and legislators are hurt by a lack of clarity.

For example, a point-of-service plan in Kansas City, Mo., is almost the opposite of a POS in Wisconsin, in terms of restrictions on the networks and the incentives. And it's amazing when I talk to people and I'm assuming they are talking POS the way I know POS, and it's not. You can hardly even communicate, even with congressmen during hearings. To some, a PSO (physician service organization) in their state is an HMO in Wisconsin; 18 of our 26 HMOs are owned by physicians.

The way out of this alphabet soup is functional regulation, which is the basis for Wisconsin's regulation.

What can employers do to improve the way their employees are treated?

It's a lot easier for large employers than small employers because large employers have the resources and sophistication to manage operations' costs. Small employers lack resources and sophistication but can overcome some of that by coming together in groups like business coalitions and sharing data management services, reports and expertise. The agent community and the health manager community are really invaluable.

Businesses in general can greatly improve the environment for employees just by paying attention. It's almost like the old Hawthorne effect, where just by having the CEOs sit at the table or having the large employers and small employers get together and ask a few questions generates an amazing accountability that is brought to bear on the situation.

Employers' questions should start with costs because quality is still a very elusive concept. Consumers, physicians, legislators each have their own definition of what that term means.

Maslow's concept of a pyramid-shaped hierarchy of needs serves as a useful analogy to health care needs and people's perception of quality.

Just as a person's most basic need is food and shelter, a health care consumer would probably say his basic need is for simple, straightforward things like claims being paid and access. However, a lot of insurance people, including me, think that the basic level is solvency because if there is no one there to pay the claim, it doesn't matter what's on top of the pyramid.

As health care consumers have their needs met, you move up into more sophisticated levels. People move up to asking about how diabetes is managed or what are typical heart surgery morbidity and mortality rates.

Please discuss some of the NAIC's significant internal issues, including the voluntary nature of its funding source, program budgeting and working with an industry liaison committee.

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The extent to which the voluntary nature of the NAIC's funding source is a concern is inversely correlated with the amount of federal pressure to federalize insurance regulation.

The commissioners most concerned about it are involved with major NAIC projects such as codification or the financial database reengineering or IRIN (Insurance Regulatory Information Network), which require spending $1 to make $5 for the insurance community and to advance regulation.

To the extent that the boycott on database fees was used as a way to exert control over regulators, I think the lasting effects hurt the industry a great deal more than it hurt the NAIC, in terms of the impact on trust and accountability.

The NAIC is such an extraordinary bargain for the industry, when compared with the cost of an insolvency or the bad public relations caused by the churning of life insurance policies. They know that and we know that.

Program budgeting per se is a term of art, not a term of science. I don't think it was primarily driven by industry critics, but rather by our own need.

The liaison committee provides a forum where insurers are being heard. The largest point of contention between the industry and myself was to have member companies at the table instead of just trade associations. I can't underscore enough how pleased and satisfied I am at having the member companies at the table and see firsthand the NAIC process and meet the commissioners personally. A lot of information was getting lost in translation between associations and their member companies.

Now, with this group and consumer board, there is a much higher level of trust, understanding and support for NAIC involvement in broader issues such as encouraging state input into insurance-related issues on Capitol Hill.

What are the important external issues the NAIC is facing, including federal efforts by doctors, multiple employer welfare associations and banks to avoid state regulation.

For most of those groups, federal regulation means less regulation and that, in fact, is what they are seeking. Physicians entered the market late and are now looking for special regulatory treatment and have not yet learned that harms everyone eventually. There will be bankruptcies, there will be insolvencies and consumers will be left unprotected.

Overall, if I have been struck by anything, going to the Hill, it is how narrowly they interpret our existence, our technology, our financial databases. They do not understand the sophistication and expertise of the state insurance departments.

What does the move toward closer links between banks and insurance through financial modernization mean for the NAIC?

The NAIC's future doesn't include membership by regulators of broader financial services. It is true that the regulatory framework of insurance regulation doesn't align itself neatly with banking and securities oversight and there are conflicting and competing regulatory goals. I am not certain where it will lead, except I don't think that anyone will have the shortsightedness to get rid of state regulation of insurance. It has to be built upon rather than gotten rid of.

Federal regulatory oversight is not the answer because we will lose too much in consumer protection. But it is becoming a global marketplace and the state framework does not neatly align itself with the international forces.

Yet, the European Union's effort to open borders could learn a lot from the NAIC's accreditation program, which helped break down barriers among states. A lot of people try to frame it as a turf battle and it's not; it's about consumer protection and regulatory sophistication and the support that the NAIC members provide to each other.

We are the world's largest insurance marketplace. We cannot afford to have other countries make the rules. We must be represented.

Are there any other trends you have observed in state regulation of insurance?

A lot of resources need to go toward educating people about what we do, which is primarily consumer protection. There is also an increased sharing of resources by state insurance regulators through the NAIC.

What has been your contribution to the health care marketplace and state regulation, especially for today's market.

What I have been able to contribute is a respect for the uniqueness of every state and its individual condition, although I know Wisconsin has more sophisticated systems than most states. At the same time, I know that one-size-fits-all regulation would be unwieldy.

However, I am still frustrated by a general lack of progress in determining quality of care. Our data systems have improved, but we still don't know what consumers need and want to know to make an effective market. 30

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30 VIEWS

Patricia Nazemetz

Helping employees navigate the managed care revolution

In 1988, Xerox Corp. realized changes had to be made to its health care plans, or the rising costs would devastate the company. By the end of that year a system was designed, partly based on the results of a companywide survey, and in 1989, the revamped system was in place. Instead of fee-for-service health plans, Xerox placed its fortunes with managed care. At the forefront of Xerox's charge into this new frontier was Patricia Nazemetz, now the company's director of total pay, who at the time was director of benefits.

"We knew by 1988 that we had to make some changes, that fee for service would eventually put the company out of business," she said from her office at Xerox's campus-like headquarters in Stamford, Conn.

At the outset, Xerox contracted with more than 150 health care providers managed by six network managers. Since then the number of plans has grown to 230, encompassing the vast majority of Xerox employees. The company's bold venture and success in moving its employees into managed care has served as a model for other employers.

Ms. Nazemetz, 48, joined Xerox in 1979 as benefits operations manager and was the company's director of benefits from 1988 to 1995. From 1995 to 1997 she was director-human resources policy and practice before assuming her present position.

In addition to her work at Xerox, Ms. Nazemetz, is active in managed care as chairwoman of the board of directors for the National Committee for Quality Assurance and is a member of the boards of the Washington Business Group on Health and Kaiser Health Plan of New York.

Ms. Nazemetz discussed the managed health care revolution at Xerox and her hopes for future system changes with Associate Editor Michael Prince.

Q: Why did Xerox decide to aggressively move into managed care at a time when few companies were doing it?

A: The first impetus to move in that direction was costs. Our costs were moving on the fee-for-service side at a pretty rapid pace. We made some design changes in the early 1980s that encouraged many of our people to move to managed care because of higher costs to employees to stay in fee-for-service plans. And so we decided to build on that platform and thought we would be able to influence it in terms of how care was delivered; we could focus on quality, and manage the costs without sacrificing quality.

Was there any one particular event or one particular anecdote that occurred that made you finally decide to make the decision?

No. I think it's always dangerous to manage on the basis of some particular event or crisis. The corporate drive for quality at Xerox through the 1980s was to figure out what your customers want. And we viewed the employees as customers. We went out and spent a lot of time in both focus groups and then conducted a companywide survey of all our U.S. employees, asking them what they were looking for in health care benefits. The results of that survey reinforced the managed care direction.

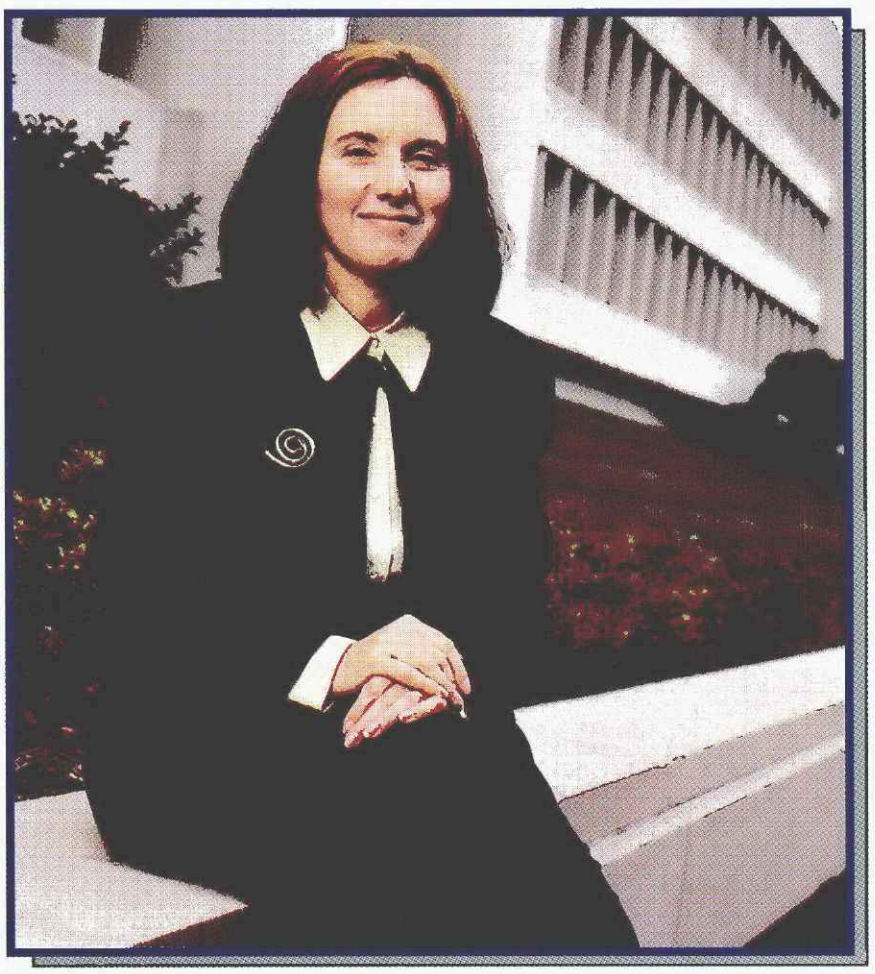

PHOTO: DAVID LUBARSKY

What were some of the concerns you had when you started the change?

We were concerned with not being disruptive with our employees. We were trying to allocate the dollars we had for health care in a way that met most of our employees' needs. Like with any benefit change or in any pay program change, it's never desirable to alienate the population or to make them unhappy. So, one of the considerations was to make it an evolutionary change, not a revolutionary one, and to allow people to choose managed care on a voluntary basis. We kept the fee-for-service plans even though they were very expensive.

A great deal of the success comes from the response by Xerox employees who chose the managed care options over the fee-for-service options. What incentives were provided by the company for employees to make that choice?

Well, there have been several. Initially, we simply said we will peg our contribution to the most cost-effective health care option in a given community or environment, and we knew from our experience that was typically HMOs, even though the HMOs were providing a significantly higher level of benefits. It said you get first-dollar coverage, which was a big deal for our employees. And the premium contribution from the employee is either non-existent or is minimal. Or we can have the fee-for-service plan, which is going to cost you more out of pocket in terms of co-pays and deductibles and more out of your paycheck in terms of premium contributions. The employees made those choices. Since then we've added things such as report cards on the plans. We now also require NCQA accreditation for the plans. Now employees have what we think is maybe not adequate information, but certainly significantly more information than they had six or seven years ago about how to choose a health care option.

How important is gathering and disseminating information about health plans to the future of managed care?

I think that gathering information is critical, and being able to provide information to consumers, in this case to our employees and their families, is critical if you're going to have truly informed choice about plans. If the marketplace is going to work—and we do believe in the marketplace—it can only work if people know what they are buying and can do value comparisons.

If everything looks equal, you'll wind up picking the cheapest-priced program until you have a bad experience. We're not looking to abandon our employees to a chaotic system, so we think that true information that is valuable at the consumer level is what has to happen if the health system is going to survive in any affordable state.

What are you doing now to provide that?

There are three key pieces of measurement or information that we have been pursuing since the beginning in 1989.

The first is NCQA accreditation. We were the first company to require NCQA accreditation for our plans because that addresses the structure and process of the plan itself that will ultimately deliver a good outcome.

The second is now called HEDIS data. When we started out, we helped to invent the original HEDIS information set. And we worked very aggressively with NCQA, which owns the HEDIS management responsibility, to make sure those measurements continue to be refined.

And the third piece of information is what we called consumer value survey information. We survey our employees, and work with other employers who survey their employees, to find out how people feel about these plans. We think all those are valuable to employees.

I think the next level of information has to be down at the individual provider level.

While people will select a plan, the reality is they pick their relationship with their doctors, not a relationship with the health plan. So one of the things that we continue to work on through NCQA and surveys is to try to figure out how to get usable provider-level information and whether that can exist, because that information is ultimately where the consumers will make the decisions.

You mentioned that you have a number of HMO options for employees. Early on, Xerox decided to go with a large number of provider options rather than a few providers. Why was that decision made, and how has it worked out?

One of the things our employees told us was that they wanted choice. The ultimate choice I guess is an unfettered, unmanaged, fee-for-service plan, which we had in place and which was fast becoming unaffordable both to the company and our employees. They also told us affordability was a major factor. So, one way of getting choice is to provide multiple health plan options at a particular level and to really allow people to make the choice and to allow the health plans to compete for the business of the individual consumers.

We though it would do a number of things. First, it would meet our employees' requirement for more choice. Second, it would create some price competition. And most importantly, it would

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create quality improvement competition. I won't say it's a total success, but it's worked pretty well, and we have moved 85% of our people into managed care on a voluntary basis.

How have the company's employees responded to the changes?

I think they've responded pretty well. We sort of downplayed it. We didn't say this was some revolutionary change. It was fundamental, but it was not viewed by employees as a major change.

One of the things that I viewed as a sign of success was several of the comments we got from our human resources staff the first year was that people aren't even noticing it's there. It's sort of invisible to them. To me that was a sign of success, because we were not looking to create a big ripple that said we're changing your health care.

What problems have you encountered along the way?

There weren't any major obstacles or difficulties. I would say now, 1997, the issues or the concerns and maybe the disappointment is that the plans still don't have what I would view as a truly patient-centric health system. They're still organized around the health plan, costs, managing costs and figuring out how to keep costs under control, but not necessarily how to delight the patient.

And that's the next frontier where we will be focusing our interest in the future. To me there's got to be a next plateau, and I don't think we've determined what that is yet, and my goal is to try to get the health industry to start thinking about that.

What do you think the next frontier will be?

A patient-centered system that focuses on getting the needs of the patient or customer met. Such a plan would keep people in the system well, identify problems early on, take care of their problems from start to finish when they occur and help to manage the overall quality of life. Basically, thinking with the patient at the center.

A colleague of mine calls it putting the patient in the center, not in the middle.

I think what we do with managed care is to put the patient in the middle and have them try to make sense of the system. We need a system that really revolves around them at their core.

I think it means the whole system of providers, individual doctors, hospitals, pharmaceuticals and all the ancillary provider communities have to work as a team with a common focus of helping the patient. And I don't think they're organized in quite that way.

The plans that are out there that figure this out first will ultimately be the market leaders.

How can you or other employers help to bring this about?

I think it's a matter of putting our focus there, just like we put our focus on managed care in the employer community 10 years ago. I think it's putting our focus on patient-centered care, identifying measures that will help to ferret out those types of plans and provide a continuous improvement road map for those plans. Also we have to communicate that information to our employees and help to distinguish the kind of leaders in that field from the others. I think patients will ultimately make that choice.

Whether you're going to a supermarket, or a car dealer, or most importantly for your health care, you want to be considered as the customer, you want to be treated fairly well and you want good results. And most plans that focus on that and are willing to measure it, willing to step in front and commit to that and stand for that, I think won't have a problem getting customers.

How have employees' attitudes toward health care changed over the past 10 years?

There has been lots of focus on the health system. One thing that the Clinton debates in the early 1990s did was to focus Americans on what's right and what's wrong, what's good and what's bad about the health system. I don't think we came to any conclusions, but everybody certainly became pretty aware of health care.

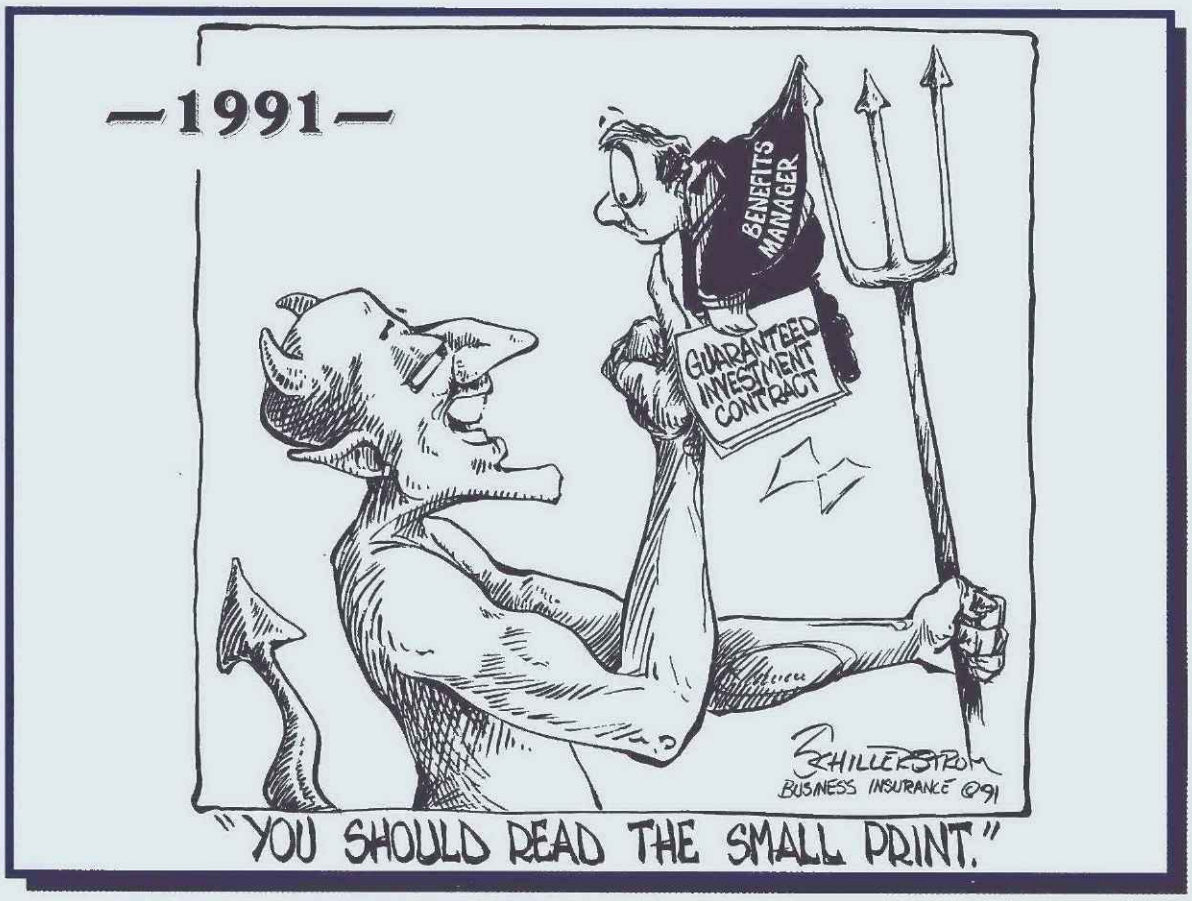
I think people are probably a little bit cynical about the health system. There is a concern that their employers or those who are purchasing health care for them, including insurance companies, are focused only on costs, and I think that's a perception we have to help to change. I think they also feel at times that providers are not interested in their well-being but are interested in continuing to preserve income levels and practice in the way they used to practice.

How will health care benefits at Xerox change in the future?

That's the crystal ball question. I think we will continue to have more choice and more flexibility to really push the envelope a little on letting employees make more decisions, and to try to get better information to help employees to make even better decisions.

Ultimately I think our goal would be to just provide employees with a totally open-ended system, where they could take the dollars that Xerox has available for health care and really apply whatever they felt was appropriate to purchase the health care.

I view our role as evolving to one of providing people with what I would call marketplace intelligence; what's out there, what to look for, how to shop for a health plan or health system. And we provide a significant part of the financing to allow people to purchase their health benefits, but with less control and with less choice-making on the part of the company than today. 30



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Brian M. O'Hara

X.L. leader eyes early days, future of a Bermuda success story

Brian M. O'Hara is part of one of the great risk management and Bermuda success stories.

As chairman and chief executive officer of X.L. Insurance Co. Ltd., he presides over an insurer that started out as a kind of policyholder self-help group but has become one of the world's major insurance and reinsurance companies and one of the principal jewels in the Bermuda business crown.

X.L. grew out of the liability crunch in the mid-1980s, when Marsh & McLennan Cos. Inc. and J.P. Morgan & Co. put together the then-policyholder-owned facility to offer the excess liability coverage traditional insurers had shunned.

After writing $206.6 million in gross premiums in 1986, its first year of operations, X.L. grew to gross premiums of $729.4 million at year-end 1996.

Along the way, Mr. O'Hara has helped take the company public and lead it into other lines of insurance. Today, X.L. will cover not only its core excess liability and directors and officers liability risks but also property, employment practices liability, single aggregate and multiyear coverages, reinsurance and even currency risks.

Mr. O'Hara first became interested in Bermuda as a child through family connections with the island. Then in 1976, while working for General Reinsurance Corp. in San Francisco, the personal interest began to include his business interest when he read an article on the offshore insurance market and captives. The article "struck a chord," he recalled.

In 1978, he assumed responsibility for the newly developing department for captive reinsurance underwriting at General Re.

He later left General Re and helped found Trenwick Group and opened its Bermuda office in 1979.

In 1986, he joined X.L. as president and chief operating officer. He has been there ever since.

He also is president and CEO of EXEL Ltd., the holding company for X.L. and other subsidiaries.

Mr. O'Hara, 49, discussed developments in the excess liability and Bermuda insurance market with New York Bureau Chief Gavin Souter.

Q: As you look back on the liability insurance market, what would you say has changed the most? What have been the fundamental changes?

A: Bermuda has seen a big change on the whole liability landscape. Back in the early 1980s, reinsurance was a big driver of underwriting capacity, and there was a proliferation of MGAs who would get an issuing paper, set up a treaty and then buy lots of facultative reinsurance, and that is how the whole system kind of worked. That all collapsed in 1984-1985, and that's where the Bermuda big net line underwriting came into play.

But now we see change back the other way, where you see new entrants into casualty underwriting backed by both treaty and facultative reinsurance. It's not that Bermuda is going away, but that other part had gone away. It had vanished for five or six years, but now some of the practices that were pronounced dead are re-emerging.

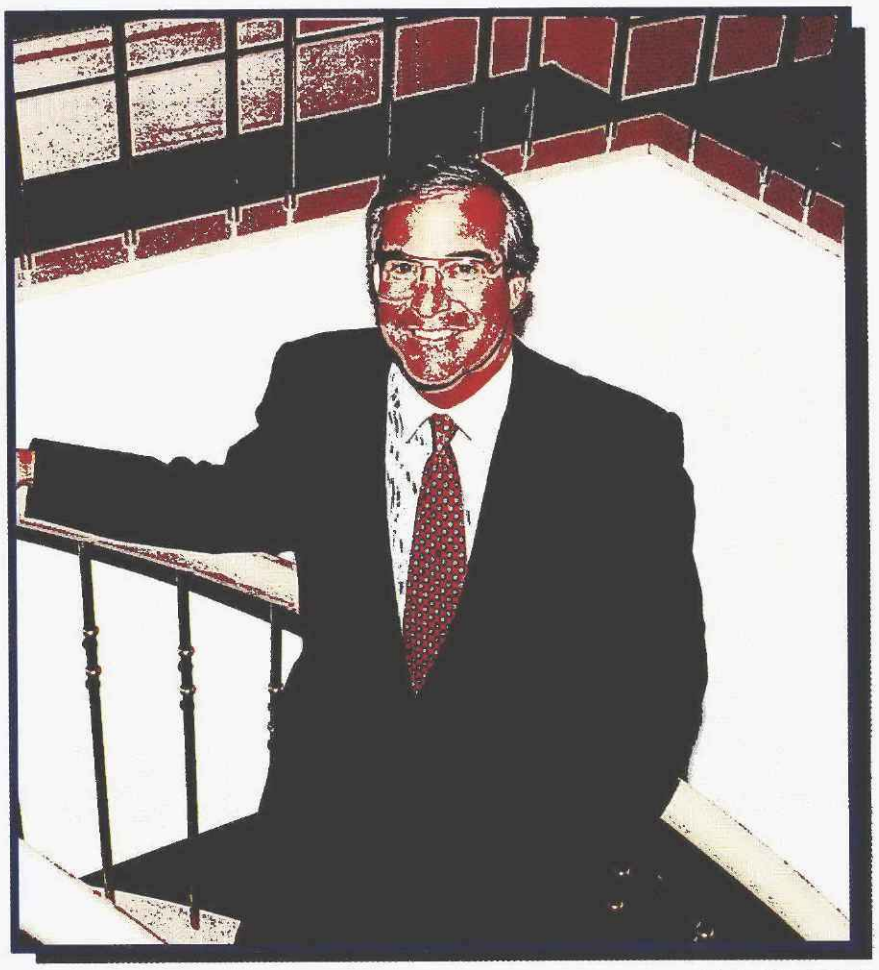

PHOTO: ARTHUR BEAN

Is it headed for the same result?

Inevitably. There is not enough accountability in that system, and not enough strength in the structure, because the decision for the capacity to persist is an annual decision, and as bad results come in, those decisions will be negative. There will be changes and some will depart. It's part of the cyclicality.

So not a lot has changed then?

As we know the world today, it hasn't, except that the existence of large net line capacity is here and is here to stay.

Large net line capacity this time was put in the hands of professionals, and the capital was provided by very serious-minded people.

In the early '80s, they thought it was a cash cow that couldn't go wrong. A lot of the captives were successfully underwriting the business they controlled, but they did not realize that underwriting someone else's business that they didn't control is a different kettle of fish.

They thought that it was so automatic that they didn't need to hire true professionals. They hired total amateurs, who all departed from the scene long ago.

In that business, the top line can look really good for a while until the results come in, and I suspect that we are going through a similar period now.

What difference do the large net line insurers make in terms of insurers' relationships with their clients?

We hope and expect to continue long-term relationships with our customers, which we have enjoyed since the beginning.

We'll lose more and more of those who are driven by price and availability and who probably don't care about the fact that it won't necessarily be consistent, because they feel there is so much capacity that they can go back to the net line providers when the reinsurance-backed providers go away. And that remains to be seen, whether they will be able to or not, because I can't predict what our behavior will be in that regard two or three years down the road.

What would stop you from taking them back?

Maybe we'll be fully preoccupied by existing customers.

X.L. has been one of the success stories of Bermuda, but looking back with the benefit of hindsight, what do you think could have been done to have made the company even more successful?

I suppose we could have diversified sooner than we did. I guess that is a difficult question for me to answer without sounding self-serving. In the beginning, we not only did a lot of things right, but we were real lucky, too—and it's always nice to be lucky.

In what way were you lucky?

Early experience was marked by an absence of catastrophes.

We didn't have any losses for the first three years, so we were able to build up reserves and capital, and that got us beyond the critical mass we needed.

We could have done all the right things, and then if silicone implant litigation had hit in year two, it would have been a different story today.

Looking back, I forget just how frightening it was taking on Fortune 100 companies at a $25 million attachment point and putting out $75 million. Having done it now for 11 years we have become a little blase about it, but it was downright scary, and we held our breaths for the first two or three years.

We were fortunate that when we did get hit with a wide, sweeping catastrophe, like silicone, we had matured financially, so we were able to ride it out without any real hiccup.

Again, we were lucky that we didn't get hit with another big loss. If EMFs had turned out to be another huge financial catastrophe on the heels of silicone, it would be a different story. So I guess you always hope for a little luck in the business, but if you count on it, you are in trouble.

What was the thought process behind your diversification?

Diversification gives us a broader reach and a broader relationship with our core customers, which is part of what our multiline "Risk Solutions" effort is all about.

The Risk Solutions approach is where we are not only managing the traditional risks but adding things like currency risk management and other business risk elements.

Did you feel you had to diversify? Could you have continued to have been a successful company by just focusing on excess liability and D&O?

In order to grow, we had to add our new lines, because the core GL business had reached something of a saturation point, and at the same time, more and more new capacity was entering into the business that was going to take business away from us. In order to utilize our capital base, we had to grow, but we didn't want to grow in areas we didn't know or understand or where we wouldn't meet our customers' need.

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30 VIEWS

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Do you think investors are any more demanding now?

I've always found them demanding.

Our original investors were our policyholders, and they had an entirely different mind-set. They were driven by having stable capacity not so much as return on investment, and some of them didn't think they'd ever get a return back.

There was a minority that invested for a return, but for most of them it was very pragmatic—it was the only way for them the buy casualty catastrophe insurance.

The transition from those shareholders to the public shareholders was a trying experience. Our investment banker, Goldman Sachs, did not think it was possible. They did not think that the capital markets would be receptive to what we did for a living.

At the same time, a large portion of our policyholder shareholders did not think going public was a good idea. They thought that we would lose our focus and, in trying to satisfy investor demands, we would give up our promise to maintain a stable market for these large, difficult risks.

I think so far that we've shown that we can do both. That those interests are not opposed, that it can be a win-win situation.

Would you say the customers and risk managers have changed much over the years?

Certainly, the actual people have changed.

The sophistication and understanding of the business is much greater. We wonder whether the recent experience of fewer large losses isn't necessarily correlated to better risk management practices and greater awareness at the top of organizations as to the value in better risk management.

What future changes do you see in the insurance industry?

The industry has to deliver more value over time.

It's probably true in all industries that costs are being squeezed out, and levels of costs being eliminated.

In the large-risk area, the larger corporations are becoming more sophisticated and more demanding, and people are thinking in more untraditional ways, so they are going to do business with people who can give them more for less cost. It's that simple.

Currently the market is meeting the demands for less cost, but the question is, is that sustainable? Is it due to structural changes, or is the industry just underpricing the product again?

It's easy to do that in our industry for a period of time, because the costs don't come in for a while, and admittedly the costs are hard to know in our industry as opposed to manufacturing industries and other service providers.

We provide a promise, and no one is quite sure what the cost of that promise is from time to time.

We are trying to come up with ways that are less expensive, because they are fundamentally more efficient.

In Bermuda there are some fundamental cost advantages with the regulatory and tax structures being what they are, and that can be passed on to the customer.

What we are now trying to do is broaden the array of risk transfer services that the core customers want so that they can concentrate on whatever their core business is.

They don't want to spend a lot of time and effort on worrying about the unknown or unforeseeable; that is what we think our job in life is.

As you try to do that job, are you going to venture even further outside the traditional realms of insurance?

The product will become more diverse, I think.

We still will call it insurance, but we shall be doing things differently from the way they were done in the past, perhaps.

In what way?

The length of time over which the products function; investment income may become part of the equation on a direct basis, not just on a computed notional basis; and our vision is that there will be a blending of the traditional lines with non-traditionally insured business risks that have been managed through other means, whether they be banks or derivatives, hedging or the way they've conducted business fundamentally.

I can't say what all those things are, but I believe that the demands of the customers and the pressures they put on us will force the winners to come up with mechanisms and means to deliver those broader protections.

What about Bermuda? Can Bermuda grow much more?

There are physical limitations, but it can grow more in terms of the sophistication of the product it delivers.

It'll grow more, probably as something of a headquarters attached to a more global presence. So where labor-intensive things may be done in a London or a New York, or a Singapore for that matter, there could be expansion from Bermuda back and out. 30

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30 VIEWS

Margaret E. O'Kane

NCQA strives to boost plan quality with better information

Margaret E. O'Kane sees the drive for health care quality as a rigorous and demanding, yet extremely worthwhile journey.

As president of the Washington-based National Committee for Quality Assurance, she is passionate about the NCQA's mission to build a quality health care delivery system. Ms. Kane blends that passion with the realization that the organization doesn't have all of the answers and cannot act alone.

The NCQA traces its roots to an HMO trade association—the Group Health Assn. of America, which later became the American Assn. of Health Plans. Ms. O'Kane joined the GHAA in 1986 to work on quality issues and realized that a major quality initiative could not be conducted in the context of an industry trade association. She told GHAA leaders, "If we do it effectively, it will alienate the members, and if we don't do it effectively, we won't have any credibility." Looking back, she said, "Even if we did do it effectively, there was still going to be a credibility issue because we were under the organization."

The NCQA received a grant from the Robert Wood Johnson Foundation, enabling it to become independent in 1989. Ms. O'Kane became its president in 1990.

The private non-profit organization is dedicated to assessing and reporting on the quality of managed care plans through numerous programs, including its HMO accreditation program, its advancement of the Health Plan Employer Data and Information Set standardized performance measures and its Quality Compass database that compiles HEDIS data and accreditation information. More than half of the HMOs in the nation are currently involved in the NCQA accreditation process. The organization recently released its first annual "State of Managed Care Quality Report."

Ms. O'Kane, 50, has an extensive health care background that includes working as a hospital respiratory therapist and serving as director of quality management for a large HMO.

She shared her perspective on health care quality with Managing Editor Roseanne White.

Q: What has the NCQA learned about health care data collection over the past five years?

A: It's very complicated. The quality of the data is an issue, and we have an audit product that we're launching now to address quality issues. It's very difficult for plans to gather the data.

It's truly amazing that a system that spends $1 trillion a year hasn't been made to show how it's doing or what it's doing. So it's difficult, but it's also extremely compelling and what we're learning from it is very important.

We believe that performance-driven evaluation is the future of health care accreditation. So, we will be working on a project to integrate HEDIS into our accreditation program. More and more in the future, performance will be driving accreditation. That's going to be a very long-term project, but we're starting on it this year. We think it's going to change the model for accreditation—and it should.

So how will accreditation be integrated with the performance data?

At this point, accreditation is a very meaningful review of systems, how the health plan operates and so forth. We get a richness of information that we don't get through HEDIS data. But on the other hand, the performance information that we get is also extremely valuable and it does speak more directly to the concerns of many in the purchasing community about how the plan is doing.

So we think that putting these things together, which has always been our ultimate purpose, will make for a much stronger evaluation process that will really drive improved health care in this country.

PHOTO: DAVID HITTLE

Have health care buyers become savvier about using the data?

We're all learning what the data means. For example, we're all learning that there are geographic variations in performance, so that where you wind up in performance on a particular measure is a function not only of how effectively you're performing as a health plan but also how the underlying medical care system in the community is working. So I think that adds a dimension to this. It's a little more complicated than what we were saying.

If the performance numbers were randomly distributed around the country and there weren't geographic variations, we could say, "OK, this is acceptable and this is unacceptable." It looks like we're going to have to do some geographic adjustments in order to make it a fair comparison.

Without standardized performance evaluation, we just don't know where we are. The employers that have the technical competence and the dedicated staff to really work with these numbers are learning as we all are how to use them more effectively. But our concern really is that so much of the market consists of small employers that really don't have the time or the resources to use these numbers effectively, and they can't go out and hire an expensive consulting firm. So that's one of the compelling arguments for making this a user-friendly product. And it won't just be an accreditation system, but it will be more information on how the plan does in particular areas.

What are the pitfalls for buyers and providers of having too many different sources of data collection and evaluation?

I think that the pitfalls are terrible. The reason HEDIS actually got off the ground is because people understood that if you didn't get everybody on the same page what you had was a Tower of Babel effect. If you have too many measures, first of all the plans can't report all the measures so they will start to pick and choose, and it'll fragment the market. When you fragment the market, you don't have enough plans reporting on any particular measure to know what the norms are and what they ought to be.

It's not as though we feel HEDIS is the be all or end all of performance measurement. It's clearly in its early stages. We are trying to work with the Foundation for Accountability and others that are going to try to advance the state of the art. Unless we have a standardized core set of measures, I think we'll be back where we were pre-1993, before people were using HEDIS, where it was kind of all over the place and where you don't know what the numbers mean.

So will there be a HEDIS update in 1998? What can we expect from that?

Incremental change, really not dramatic change. There was, of course, a big jump between HEDIS 2.5 and HEDIS 3.0. It takes a while for the plans to be able to establish the systems and collect the data effectively. The cost burden of collecting HEDIS 3.0 is about double that of collecting HEDIS 2.5, because there's more of a need to go to medical records. We weren't able to really say much about how the client did when the people got sick, and now we're starting to move into that area.

What is your response to HMO executives who have said that the need to offer the services necessary to win accreditation is a factor in rate increases?

We believe very strongly in the quality-enhancing effects of our standards and being quality driven. I can't say it doesn't cost more. And I think we should all be very concerned that we've developed an accountability system for HMOs that's pretty good—it's not perfect and it's going to be evolving—but we have many other types of health plans out there, including plans that are called managed care, that aren't being held accountable. So we worry that having one segment of the market accountable puts them at an unfair disadvantage if it does drive up their costs for maintaining these systems and having a quality-driven managed care product. We think that the policy world ought to be thinking hard about how to hold all health plans accountable for quality.

As president of a group whose mission is to foster ongoing quality improvement in health care, what is your reaction to what some observers call a managed care backlash?

Well, I think it's not surprising that there's a backlash because of the enormity of the changes that have gone on. When you try to rein in an industry that has never been accountable and that spends $1 trillion a year in a very unorganized way, it causes a lot of changes.

Patients are suspicious I think, of a lot of what managed care plans have done. Some physicians are losing income. There are plenty of legitimate gripes that physicians have with managed care organizations, as well.

I think that in some ways the industry needs to woo patients more effectively. I think there's been a general feeling that the purchaser is the customer and the consumer is not. I think everybody is understanding now that that's no longer an acceptable strategy. If you can't ultimately convince the consumers, the patients, of the value of what you're doing, then you've got a problem.

I think managed care needs to show its quality-enhancing face to its patients. I think that's happening in some plans, where people get a card when they need a mammo-

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gram or a child needs his or her shots.

A lot of what people experience in managed care is "No, you can't have that service" or "If you need this service you have to come in here and get this form." There have been a lot of perceived barriers created by managed care without adequate explanation of why the barriers are necessary; sometimes the barriers frankly aren't.

Anytime you're just fundamentally changing the relationships the way managed care has done you can expect a backlash—especially in something as personal as health care. I think it's the Marcus Welby paradigm people have in their heads about health care, even though I don't think it ever existed. And, there's a sort of general anti-corporate sentiment in the country. I think a lot of people feel that they're losing control over many aspects of their lives. So this sort of plays into that general feeling of powerlessness and frustration as well.

What about your relationship with the American Assn. of Health Plans?

We have a cordial relationship. They, of course, are very helpful in getting comments on the various changes we make. We don't always agree. Their job is different from our job. We feel our constituency is the public, and they see their constituency as health plans. So it's really appropriate that we aren't in lock step.

Give us an update on some of the NCQA's other efforts.

We've done a lot of work to try to understand how consumers want information—what's the best way to present it to them. We've done a bunch of projects, including one in Colorado working with a business coalition that's getting performance information, and several report card projects with other groups.

We formed measurement advisory panels, trying to bring more of the research clinical community into the process of developing measures both to improve the quality of the measures and to generate more support for them. It's important to get clinical leaders who are publishing state of the art articles to help us.

We have a program with the American Diabetes Assn. that involves a list of quality measures for diabetes care that the physician evaluates his or her performance against, and if they pass they get a provider recognition certificate.

Subsequent to that, we've been working with the Health Care Financing Administration, FAACT and the ADA on the Diabetes Quality Improvement Project, to develop some other performance and outcome measures for diabetes care.

What have been the NCQA's major 1997 accomplishments?

One thing is we've really made some great progress with our turnaround times in our accreditation reports. We basically rewrote our standards and we have scoring guidelines. As a result, it's much easier for our surveyors to write the reports, and we've cut the turnaround time to 106 days. So that's been a big breakthrough.

Because of the complexity of our process, our reports used to be about 80 pages long with a lot of written prose, and you can imagine it would be very difficult to write that. Not only that, but the writers have been synthesizing huge amounts of documentation from health plans. What we've done is we've standardized the scoring and made the rules very specific, and we also have developed tools where the surveyors can just fill in the information and they don't have to write volumes. That's really had a good impact on the speed with which the reports are produced.

The plans tell us, "We got everybody really excited about meeting the NCQA standards and then we wait six months for the report and everybody loses their momentum." It's been an issue we've been struggling with for three years, and this is the coming to fruition of about two years of hard work by the accreditation staff and a scoring task force.

What will top the NCQA's 1998 priority list?

Integration as well developing a more flexible evaluation process that we can use for PPOs, PSOs and other forms of managed care that are becoming so prominent in the marketplace.

How do you define value in health care?

Value is the amount of improved health that you get for a given expenditure of dollars.

That contains within it the seeds of a complete transformation of the paradigm of health care—from one that is sickness-driven and that is absent in the wellness phases of a person's life and just sort of jumps into the breach when care is needed; and even then doesn't provide it in any kind of reliable way.

What we are seeking to move toward is a system that keeps people well, that finds disease early, that manages disease effectively and that minimizes the bad impact of disease and hopefully that also makes the end of life a more benign process.

What else would you like buyers to know?

My message to buyers is that they are the linchpin in this whole agenda, and if they are not buying on value, the whole thing falls apart. I think there's a general sense in the health plan community that many buyers are still buying on price, and as long as that's happening it's very frightening to go into a completely price-driven managed care world. I am optimistic that if we can make the information more user friendly then consumers will demand more quality, so it will be harder to buy on price. 30

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30 VIEWS

Wolfram Rohde-Liebenau

Risk manager beats the German property insurance cartels

To some he is a gentleman rebel, to others a rogue.

For the history books, Wolfram Rohde-Liebenau is the risk manager who brought down Germany's property insurance cartel—the konsortialkommission, or KOKO.

In his modest way, Mr. Rohde-Liebenau will tell you he did nothing of the kind. He merely helped his company, Siemens A.G., buy a large portion of its property insurance outside the domestic German market. But in so doing, Siemens broke the choke-hold of the KOKO cartel and changed forever the way commercial insurance is bought and sold in Germany.

It's not surprising that it was Mr. Rohde-Liebenau who catalyzed a shift in the market. During his career he has been a front-line defender of buyers' rights, a pioneer of risk management in his own country and a champion of insurance deregulation in Europe.

Mr. Rohde-Liebenau, 66, began his career in 1958 as a lawyer, became a banker and credit analyst for Dresdner Bank and later worked for Germany's largest insurer, Allianz A.G., and reinsurer Munich Re A.G. In 1975, he became head of Siemens insurance division.

Significantly, he was never really happy with the "golden age" of his early insurance years. When he discovered he had no effect on decision making, he rebelled and went to Siemens, where he has been making his ideas count with insurers ever since.

Germany's highly regulated, protected market made him uneasy. Mr. Rohde-Liebenau was one of the first in Germany to apply the principles of risk management and set up a captive. He also helped the captive brokers of industrial companies become a respected, powerful entity in Germany.

He retired in 1996 as risk manager and head of Siemens' insurance division and from the executive board of Siemens' German captive, Risiko A.G.

He recently spoke with Correspondent Don Lewis Kirk about changes in risk management in Germany and Europe.

Q: What do you consider the most important changes during the last 30 years in insurance and risk management?

A: In Germany it has been a shift from insurance management to risk management. Freedom of services in the European market brought an end to national cartels, which gave us more freedom, but also more responsibility. As a result of deregulation, risk managers must closely scrutinize insurance conditions.

It's all been a slow process. Remember, European insurance deregulation started in 1958. For almost 30 years, German insurers were able to stall deregulation, which is a major reason why Allianz, for example, become as big and powerful as it is. German industry was always at odds with insurers over freedom of services, and it's a great accomplishment that deregulation has occurred.

As a member of national and international committees, you promoted the interests of German commercial insurance buyers. Why have you been so active in the politics of insurance?

As Siemens' risk manager, I had an effect on insurance conditions, but I wanted more. I wanted to have a formal influence on policy. If we leave the direction of the market to those whose commercial interests are opposed to ours, we're to blame for getting off course.

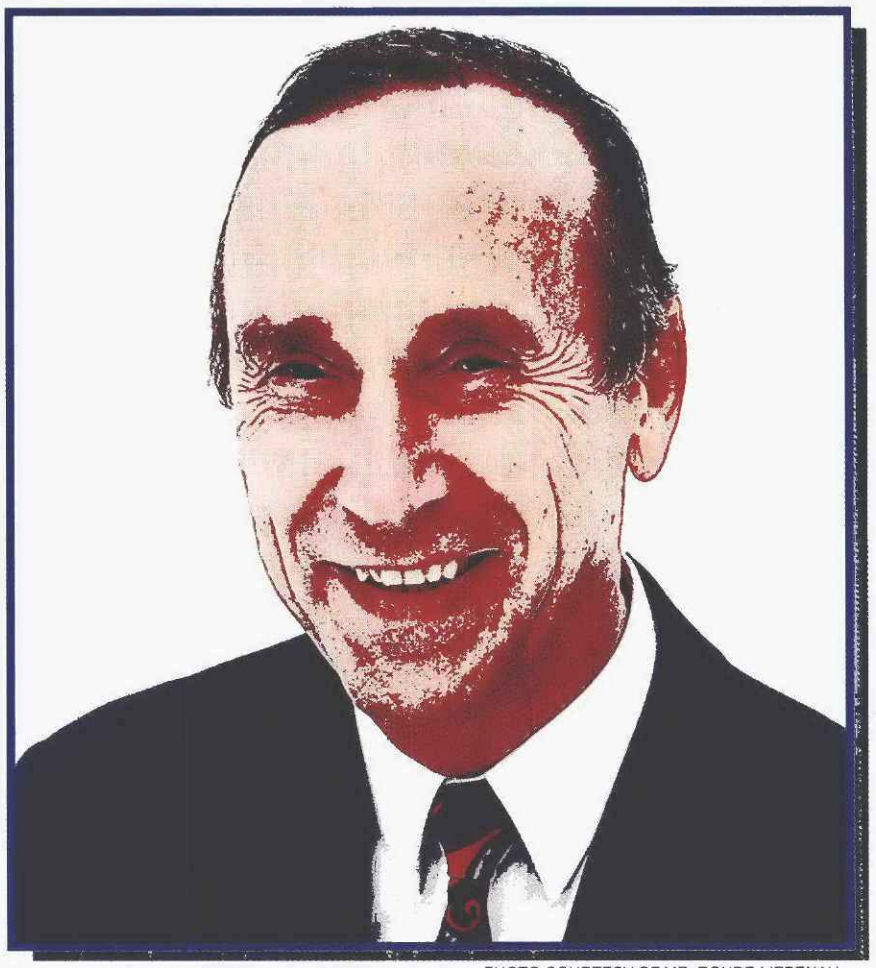

PHOTO COURTESY OF MR. ROHDE-LIEBENAU

Insurers have an interest in minimum protection at maximum cost, and we want maximum protection at minimum cost.

What are the incentives for risk management and alternatives to insurance in Germany?

Foremost, is premium tax pressure. The German government has imposed a 15% tax on insurance, which means that non-insurance solutions to reducing risks cost 15% less than insurance solutions. That doesn't include brokers' commissions and fees.

Relatively few German companies have risk managers. Is that a conducive environment to change?

When I began my job at Siemens in 1974, I was told to forget risk management. My boss believed a wrong commercial or technical decision would cost the company more than foreseeable claims.

But luckily, I had support from the head of corporate planning, who told me to keep at it and not to expect changes overnight.

The environment did change. BMW took the first step in 1980, when it formed its own captive. We followed, and today risk management is an essential tool with insurance buying at a second level. It should be the second level.

What was the significance of Siemens buying property insurance from insurers outside of Germany?

When we dared to leave the German market in 1994, it brought the whole system down, which I personally did not intend to do. I thought German insurers would continue with their old patterns. I thought they would reproach me for taking a risk outside the German market. So when they decided to dissolve the KOKO, it came as a real surprise to me.

But wasn't it a good thing? At a time when German companies were already burdened by a recession, the KOKO began raising rates for very large risks, including yours, by up to 300%. Didn't that upset you?

The problem wasn't the premium, it was the inequity. The best risks were paying the highest rates. So we began to look around for alternatives. We needed a billion deutsche marks PML capacity and that was only possible as an HPR risk. I told our German insurers we'd qualify, but they did not grasp the significance of what I was saying. They thought we would fall on our faces.

Instead, the industrial property insurance market and the KOKO cartel collapsed?

German insurers began to underwrite any property risk at any price foreign insurers were willing to offer. No premium was too low. German insurers vowed no foreign insurers would take another risk from the market in our lifetime.

It reminds of the talk of wanting to defend the fortress Europe. Do German insurers see their market as a fortress to defend?

German insurers wanted to retain their totality. The German KOKO was an accepted legal instrument. Any risk seeking over 1 billion deutsche marks in insurance had go through the cartel. The KOKO remained as long as German buyers had no alternative.

The German insurance industry blamed me for bringing down the principles of solid insurance underwriting. I was the enemy, but I acted under different presumptions. I felt misunderstood. I found their view narrow and national.

In retrospect, it's hard to believe the KOKO stood up for so long, especially at a time when the European Community and Germany were deregulating their insurance markets. Why did it?

Believe me, the KOKO could have kept on. If Siemens hadn't taken the step, it's likely no one else would have, and we'd have fallen back into a cartel situation.

Unthinkable! What is the point of the European single market if we were not able to do what we had the right to do? Had we failed it would have been either through our own stupidly or the absolute power of the other side of the market. My company decided to go its own way.

As a result, the German property market has become quite soft. Is the job done?

Not at all. Don't believe I favor unsound underwriting. The market has gone overboard. Good risks and bad risks are getting the same low premium. That's insane.

But I do want to be able to call a spade a spade. The issue was not premium but inequity. German insurers like Allianz and Gerling accept risks outside Germany at international rates. We couldn't get those rates. Even though we're a Fortune 500 company, we were excluded from conducting business like any other international company.

You've often said the real issue is communication.

If the insurance industry believes it alone can tell us what we need, problems won't get solved. I remember when the International Chamber of Commerce in Paris was in the process of setting up an insurance committee and we had trouble getting in because the insurance industry wanted us out. I became a member anyway.

What do you consider the big issues for today's German market?

We still have to establish the principles

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of risk management in Germany. I see so many risk managers restricted in their freedom of movement. When the layout for a new factory is known, a risk manager should be called in. He or she should say, "No, we can't put the computer center near the production hall where it is exposed to a fire, because it would bring the whole process to a standstill." Factory plans should change as a result.

It's also a question of complete financial risk management control at the executive level. Risk management isn't just about safety and product liability issues; it is about financial risks. Very few companies—not even Siemens—have allowed this kind of competence. But it is where risk management must go. We need to be able to report not just to some second-level person, but to the top. Risk management isn't successful without that freedom.

German companies should form risk management departments with real responsibility for questions of risk at the highest level. This is what state-of-the-art standard international companies need to remain competitive.

Doesn't Germany's changing economic and social environment make CEOs hesitant to give you that kind of power.

Cost pressures and changes in social security are all the more reason to rely on risk management.

Just consider the cost of risk. Insurance costs alone account for up to 2% of company costs. If we include workers compensation, health insurance and pension problems, the cost of risk management may easily jump to 25% of total labor costs.

We have a strange mixture of public and private insurance in Germany. Much is antiquated and requires good risk management skills to bring it up to date.

German companies confront a number of difficult insurance issues, including problems with buying coverage for environmental liability risks. Doesn't that make you want to jump back in the ring?

It makes me question if insurers want to take risks at all.

Look at the EMF (electronic magnetic field) issue. I'm on a joint committee of industry, insurers and risk managers, looking at the problem. In a very blunt manner, we were told insurers will take EMF risks from product liability and shift it to environment risk, where coverage is very limited.

Do you see a greater need for captives and alternative solutions in a case this?

Yes. This is the point at which group captives might make good sense. If exclusions in standard policies take away the necessary cover, then the response should be that industry takes care of it without insurance.

Captive insurers have been utilized by a very small minority of German industry. They will be needed to a larger extent in the future, as an instrument for risk management and alternative risk transfer. But I'm afraid we are still far away from realizing that. German insurers are very jealous of German industry captives.

But aren't tax issues distancing you even more from conventional insurance solutions?

The government made this stupid change and increased the tax on insurance premiums to 15%. It's almost insane. It has forced German industry to invest in risk management. Every penny we swap with insurers is burdened with a 15% insurance premium tax. As a result, anything we can pay for ourselves should be paid for by ourselves.

What do see for the future?

For German risk managers and corporate insurance managers, there are two possibilities: Either we have support of insurers to solve our liability problems or we must take on these risks ourselves. Support would benefit both industry and insurance companies. But if insurers are fearful of risks, then industry must find alternatives.

We must be willing to fight. Quality is determined not by those who sell, but by those who buy.

How do you see globalization changing risk management in the future?

Globalization has a strong influence on risk management decisions. Production methods have changed radically. Today we produce with fewer parts, less factory space and a minimum of employees, and yet we produce a higher quality product and get it to the market in about one-third of the time it used to take.

Siemens has focused on simplification and acceleration of processes to get faster results at lower cost with competition being the dominant force. We have had to learn to compete in different volumes, using different technologies. We have had to learn new tricks and unlearn others.

As a result, one of the major change-related activities of our risk management department is to advise on the design and start-up of new facilities. This makes our risk managers real movers and shakers in our organization. One of the company's risk managers is assigned to every new factory project, venture or joint venture.

Our knowledge of global markets also has been an important factor in getting adequate protection and coverage. Information was one of the forces that drove us to foreign markets. Certainly the German cartel and its premium increases were pushing from behind, but we were also very attracted by new ideas and ways to contain risk. 30

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WILLIS CORROON

30 VIEWS

J. Patrick Rooney

Promoting MSAs to give employees greater choice in health care

Is managed care the only way to control health care costs and ensure quality? No, says J. Patrick Rooney.

Mr. Rooney, who led Golden Rule Insurance Co. for nearly two decades before becoming chairman emeritus last year, has another idea: medical savings accounts linked to high-deductible health insurance policies.

Since the early 1990s, Mr. Rooney has been pushing MSAs, one of the few new ideas to emerge on financing health care since the advent of managed health care.

The concept of MSAs is straightforward: set a very high deductible. Then, the employer contributes some of the premium savings to a special account. Employees can withdraw money from the account to pay uncovered health expenses or keep the funds for their own use.

With that financial incentive, employees are more likely to use health care services carefully, while still retaining the ability to choose their own health providers, Mr. Rooney said. With such a system, employees will be happier and more productive, he adds.

For Mr. Rooney, MSAs are more than a theoretical concept. Golden Rule, which was founded in Lawrenceville, Ill., by Mr. Rooney's father and today has its major operations in Indianapolis, adopted MSAs for its own employees in 1993. And the company lobbied Congress to gain tax-favored status for MSAs, which paid off in 1996 when Congress passed legislation giving MSAs established by small employers new tax breaks under a pilot program.

Mr. Rooney, 69, today has started a new insurance company, Medical Savings Insurance in Long Beach, Calif., which sells MSAs. He recently discussed MSAs and other health care issues with Editor-at-Large Jerry Geisel.

Q: You have been one of the most ardent supporters of medical savings accounts. How and when did your interest in MSAs begin?

A: I was in Washington and heard a speech at a program given by the National Federation of Independent Business Foundation. There was a professor there who discussed a rudimentary idea. It didn't have a name. At that time it was not called medical savings accounts. But he said: "Why don't employers buy insurance for the big bills of employees and give them the savings, which could go into an account for employees and could accumulate?" You cut out the insurance company entirely on these small bills. That would give employees a financial interest—at least in the small bills—because if they spent more wisely there would be money that would accumulate in their own account.

When was that?

That was in November 1990. I had the advantage that I had resource people that could work on the idea. We went back and developed it in the spring of 1991.

What was the reaction of the market when you unveiled it?

It wasn't unveiled at first to perspective customers. I went to Rep. Andy Jacobs (D-Ind.), with the idea. I said to him that the problem with this idea is that if people buy insurance, it is tax-deductible. The money they put into the savings account under tax law would have to be taxable income to the employees.

I said to Rep. Jacobs that we ought to change the tax code so that the decision would be neutral from a tax standpoint. He immediately said that is a wonderful idea.

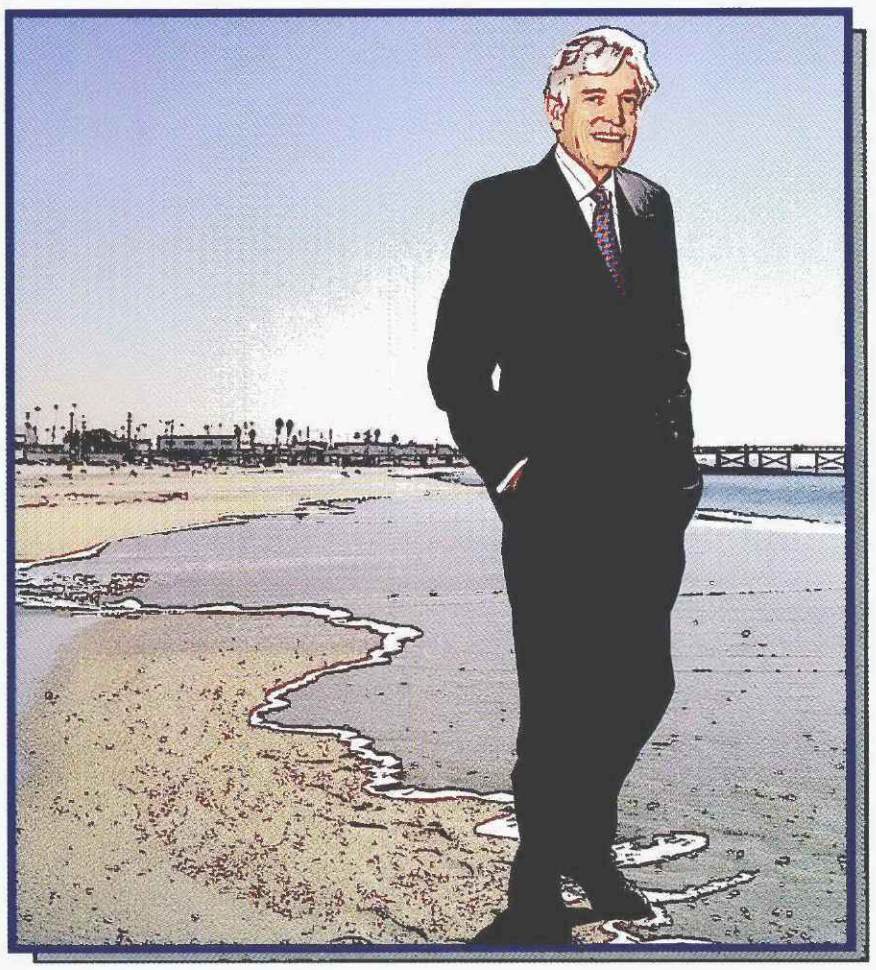

PHOTO: CYNTHIA MOORE

The first place we offered it to was employees of Golden Rule. I said if it is such a wonderful idea, why don't we offer it to ourselves. And we did. We took a lot of precautions to make sure no one felt strong-armed.

We had a lower level management person hold meetings to explain the idea. Employees were each given pads in which they could personally calculate their medical care costs and whether or not it was going to be advantageous to them.

We gave them a choice. We proposed to them giving them a catastrophic plan that would begin after $3,000. After that, it would pay at the rate of 100%. We would put $2,000 into the savings account. We explained to employees that there was a drawback.

We told them that we would have to go to the payroll department and tell them we are putting this money into your account and they will withhold from your paycheck the taxes on the $2,000 we are putting in.

More than 80% of employees chose to do it right off the bat. It is up to 93% today.

How do you measure the performance of the plan compared with what you had before?

We don't have any good measure of the performance except in terms of employee satisfaction. There is no question that employee satisfaction is much higher. I never have had a situation before in my life that employees have stopped me and told me how much they liked our health plan. Since we put this in—at least in the beginning—I've had employees who stopped me in the hallway or elevator to tell me how much they liked it.

For employees, there are at least two obvious advantages. The medical savings plan provides first-dollar benefits. If you are an employee who doesn't manage your money well and you have a sick child, you don't have to worry about a deductible. If you take your child to the doctor, you have first-dollar benefits.

In addition, employees can use the account for other kinds of medical care that the insurance does not normally cover. For example, our employee plan never has covered dental and vision care. If you discover your daughter needs orthodontia, you can pay for it out of your medical savings plan. The employees like that very much.

We have had several separate surveys of employees. Those surveys have shown high employee satisfaction connected with the fact that I can get my eyeglasses paid for and I can get my dental work paid for, and if there is money left over, it is my money.

The underlying theory of an MSA is that I will have an incentive to use medical care services more carefully because I get the money in the account and because I have a big deductible.

But does the individual really have the knowledge and the clout to deal with providers to get the best deal?

Two answers to that. Yes. I believe they do.

Secondly, there is a learning effect. Today, I being the consumer—I being illustrative only—don't have the knowledge or I am timid and don't want to ask ahead of time, the doctor might bark at me. There is a learning effect. You learn from your co-workers.

Some critics of MSAs say they are great for young, healthy people, but that the older, less well employees will—if there is a choice—stay in the traditional indemnity plan or the HMO. The net effect would be that the employer's health care costs really haven't changed very much.

It may. It doesn't have to. My argument is that an enlightened employer will want employees happy and satisfied with the health care plan. If employees are happier and more satisfied, that has utility to me as the employer. The first issue is, do the employees like it better? Incidentally, it may save money.

So, saving money is incidental? What is paramount is that employees have choice and can save money if they use services carefully?

Yes.

If MSAs are appealing to employees, why haven't more large employers established them?

My opinion is that the people making the decisions within the corporations believe that the employee is not capable of making the decisions. There is a lack of intellectual confidence in the employees. They think the way to control things is to create financial incentives so that the doctors that run the HMOs or whoever is answering the telephone will exercise better oversight of the employees. I'm positive on the ability of human beings to learn either immediately or to learn eventually.

It seems smaller firms are more receptive to MSAs. Why?

You have more of the entrepreneurial personality (at smaller firms). "Oh, I understand." That is kind of the classic response. Or, "It makes sense to me." I'm talking about a boss or owner, very likely someone who built the business.

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Golden Rule was very aggressive, i.e., lobbying and advertising, to get Congress to change the tax law—and ultimately it has—albeit in a limited way, as it applies to MSAs. Why were you so passionate about this?

I think that is reflective of Pat Rooney's personality. I am a missionary. My fundamental statement on this subject is that we have to do something that is more rational to control health care costs. I do not believe that our society can afford the continuing escalation of health care costs. But rather than denying people medical care, let us create options for the public.

My company offers a PPO. When I go to a PPO doctor, the price is set and it usually is much lower than the doctor's normal charge. Doesn't that seem to be a more effective way to control costs rather than have individuals try to negotiate prices?

I would change the word more. I'm not sure it is the only effective way. I have asked what I would want for my family. I would want protection for my family for big medical bills. But I would want to throw the insurance company out of the small bills.

Last year, Congress gave MSAs tax-effective status, but limited the number of accounts that could be established to 750,000. After four years, Congress will decide whether or not to continue the program. Is that long enough or big enough to prove how well MSAs do or do not work?

I don't think that had much to do with the decision. I think it was a political decision between the Democrats and the Republicans. But granted the current state of the public knowledge and the public understanding of medical savings accounts, it may well take a couple of years before the 750,000 cap is reached.

Let me give you an example. I met with a very prominent Republican from Orange County, Calif. He is devoting his career to managing politics for the Republicans. He leaned back and said he was sorry that he had to admit this, but he said, 'You are going to have to tell me what medical savings accounts are.' Business writers ask me the same thing. The problem with medical savings accounts is that the public doesn't know about them or understand them. Indeed, Dr. Paul Ellwood told me the same was true for HMOs in the beginning.

Do you see that 750,000 cap being lifted one day, and if so, why?

Sure. Any idea like this that gets this much conversation is going to happen.

Does it grate you that you promoted it, yet your own company employees—because of Golden Rule's size—can't offer tax-favored MSAs to employees?

I would like it better if I could say to employees: "Now you have the tax savings." But, it is an imperfect world. I'm mature enough about politics to know there is going to be some give and some take.

Are there some companies that shouldn't have MSAs?

I don't know of any reason why any firm should not have them. I would give it to employees as an option. I would not ram it down their throats.

The program has to be designed very carefully. If the employer puts too much in the MSA, the employer can end up spending more than before. Isn't that so?

I'd suggest that the benchmark for the expenditure is the amount of money that now is being spent on the existing health plan.

Some employers, when they go to the medical savings plan, cut back on the expenditure. They put in less money in the account than I would have them do.

My opinion is that if you create increased employee satisfaction, that already is a big deal. Employers are not so benevolent that they would provide this if it wasn't a matter of employee satisfaction. There are employers who, when they go to the medical savings plan, cut back on the expenditure. I think that is a mistake.

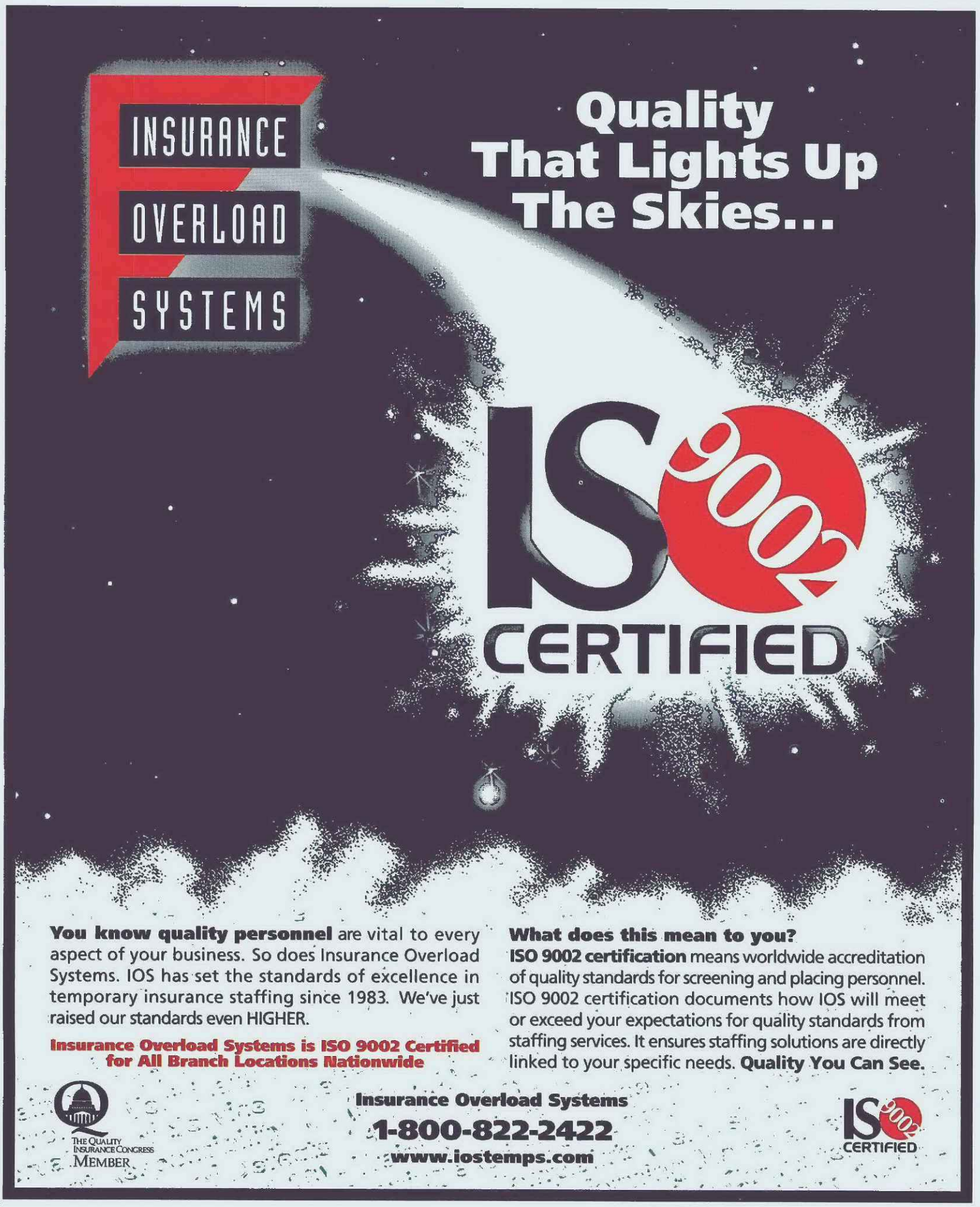
I would choose to put the same money into the medical savings plan and the high-deductible plan—the two would add up together to be the money that is already being spent. If I put more money in the savings account than I thought was really necessary, then I'd say, 'Oh, that is a gain in employee satisfaction.'

So, what should motivate the employer to set up MSAs?

It should be happier employees. I'll treat employees as adults. Let them make decisions for themselves. Out of this, Mr. Employer, the employees will know you treated them with dignity and they will have the opportunity to pay you back.

What do you see as the future of medical savings accounts?

They will be seen as a rational alternative. Rational, well-informed people will prefer to have this as an option. They will have a much more significant share of the market. 30



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TRENDS & ISSUES

Policies on cheating have few limits

Crooks constantly creating new schemes to swindle buyers

By DOUGLAS McLEOD

The more insurance fraud changes, the more it stays the same.

For 30 years, hard-working and creative swindlers have been cooking up new schemes to bilk policyholders using new corporate structures, new domiciles, new ways of exploiting—and getting around—government insurance regulators.

In the property/casualty business, scams have ranged from crooked agency operations to fraudulent U.S.-domiciled insurance companies to fleets of bogus offshore insurers and reinsurers serviced by equally suspect management firms.

Some of these swindlers more recently saw solid gold opportunities in the health care field and seized on loopholes in federal employee benefit law to set up phony multiple employer welfare arrangements and fraudulent union health plans.

Through all these schemes' mutations, though, one thing hasn't changed: The scams always involve taking your money now for a promise to perform later.

Insurance is, and always has been, tailor-made for thieves.

The insurance-buying public got its wake-up call on the extent of the fraud problem in 1982 with the collapse of Illinois-domiciled Kenilworth Insurance Co.

Picking up the pieces of shattered Kenilworth, regulators discovered that the same loose-knit band of agents, brokers and reinsurance intermediaries had looted a series of U.S. insurance companies in schemes dating back to 1971.

The Kenilworth case, the latest in the series, was a classic of the genre: In 1981, a group of men led by convicted felon John V. Goepfert secretly took control of Kenilworth, then a struggling auto insurer with a few million dollars in surplus (*BI*, Dec. 6, 1982).

Mr. Goepfert had talked his way into the company with the promise of a huge influx of new business, and he was true to his word: Almost instantly, Kenilworth was tapped into by a network of producers who swamped the tiny company with tens of millions of dollars of high-risk surplus lines and London market reinsurance business.

Kenilworth was fleeced on this business in a dizzying variety of ways, Illinois regulators later found.

For example, agents employed the "Christmas tree" scam, using master policies to issue multiple insurance certificates on unrelated risks that were never reported to Kenilworth.

The swindlers also stripped off excessive commissions and billed phony inspection fees and additional premiums that never found their way to the company.

Kenilworth's own reinsurance, meanwhile, was directed to companies such as Universal Casualty & Surety Co. Ltd. of the Cayman Islands, operated by a man—Vishwa P. Shah—later convicted of wire fraud in an unrelated case. Universal Casualty itself collapsed in 1984 (*BI*, Dec. 17, 1990; July 6, 1987).

When it was all over, Kenilworth faced more than $30 million in claims it couldn't pay; state guaranty funds covered only about a third of these.

Mr. Goepfert and several others, including Kenilworth's former president, were eventually convicted on a variety of federal fraud charges stemming from Kenilworth's collapse (*BI*, Dec. 8, 1986; May 12, 1986).

Agency frauds may have reached their apogee with the near-destruction of Omaha Indemnity Co. by one of its managing general agents, Royal American Managers Inc.

Looking to expand its property/casualty business, Omaha Indemnity, a unit of Mutual of Omaha Insurance Co., entered into MGA agreements in the early 1980s with Kansas City, Mo.-based RAM and a predecessor MGA, World American Underwriters Inc.

Under the RAM agreement, the MGA had authority to bind Omaha Indemnity to surplus lines and assumed reinsurance risks, arrange Omaha Indemnity's own reinsurance and handle claims.

By 1985, the insurer realized what a catastrophic mistake it had made, but it was too late: RAM had processed $196 million in premiums, reporting only $61 million to Omaha Indemnity and actually remitting only $7 million.

Much of the unreported premium was funneled to RAM-affiliated reinsurers in the Turks & Caicos Islands and at the now-defunct Insurance Exchange of the Americas in Miami; these reinsurers had nowhere near the financial capacity to handle the business and, in fact, already were insolvent by year-end 1985, Omaha Indemnity later charged (*BI*, April 28, 1986).

RAM diverted millions more in unreported premiums into a "loss fund," only a small portion of which was ever used for its purported purpose of paying claims, the insurer alleged.

Meanwhile, RAM principals James R. Wining and Willie A. Schonacher Jr. were living well: Both men collected salaries of up to $600,000 a year, maintained Mercedes Benz, Jaguar, Porsche and BMW company cars and bought themselves beachfront homes in the Turks & Caicos, Omaha Indemnity lawyers charged.

It didn't last, though. In 1989, Omaha Indemnity won a $225 million arbitration award against RAM; it was believed at the time to be the largest such award in history. RAM and its affiliates have since folded (*BI*, June 12, 1989).

In 1992, Mr. Wining and Mr. Schonacher pleaded guilty to federal conspiracy charges; Mr. Schonacher was sentenced to two years in prison, but Mr. Wining got only five years probation (*BI*, May 23, 1992).

In all, Omaha Indemnity absorbed more than $200 million in net losses and would have gone under without massive support from its parent.

"If (insurers) really believe that an MGA's first thought is for the company, that's really a study in futility," Mr. Goepfert himself once observed of agency fraud. Allowing MGAs to handle claims, he added, is "the kiss of death." (*BI*, Nov. 6, 1989).

Messrs. Wining and Schonacher were not the only swindlers at the Insurance Exchange of the Americas. For a while, it also was the home of a man who would build a network of fraudulent companies still unmatched in its scale and breadth: Alan Teale.

Mr. Teale—by many accounts an arrogant and high-handed man—sported a resume already marked with insurance company casualties and damaged policyholders when he began organizing an offshore empire in the mid-1980s.

From relatively humble beginnings as a British broker, he served as president of the IEA until 1984. He went on to become a top officer and MGA for Atlanta-based Victoria Insurance Co., which was found after its 1988 collapse to have had no real capital and surplus (*BI*, April 29, 1991).

As Victoria neared the brink, Mr. Teale and several cohorts turned their attention to the International Underwriting Assn., a group of about a dozen offshore insurers, several based in the Turks & Caicos, that began writing direct surplus lines business in the United States (*BI*, July 25, 1988).

Over the next several years, this network expanded to comprise, at various times, more than two dozen insurers and reinsurers based from the Caribbean to Ireland to Belgium, along with a mind-boggling maze of affiliated management firms, reinsurance inter-

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mediaries, claims adjusters and consultants.

The network wrote everything from auto insurance to coverage for Fortune 500 property risks to group health reinsurance. The business came from a vast array of agents and brokers; Mr. Teale and his wife, Charlotte C. Rentz, even formed purchasing groups under the federal Risk Retention Act to serve as funnels for small commercial liability risks (*BI*, May 1, 1989).

In a 1991 report, U.S. Senate investigators found that tens of millions of dollars in premiums disappeared into this network. At least 13 insurance-related companies operated from Mr. Teale's Atlanta headquarters—one of them alone representing 19 alien insurers—and the same bookkeeper managed 86 bank accounts for those companies, moving money in so many directions that tracing premiums became impossible.

The foundation of Mr. Teale's operation was the network of offshore insurers, some of which he formed himself but many of which were set up by other swindlers and merely managed by Mr. Teale.

The insurers were invariably in places where regulation was slight to non-existent—Belgium and Ireland, for example, do not regulate reinsurers—and where corporate secrecy laws forestalled curious regulators and disgruntled claimants.

(For real convenience, though, nothing beats having your own domicile: Several insurance swindlers, not including Mr. Teale, made use of the Dominion of Melchizedek, a fictional province dreamed up by convicted felon Mark L. Pedley. At least one con man based his purported insurance and banking empire there, while another capitalized his companies with Melchizedek "government bonds" (*BI*, Jan. 6, 1997; March 29, 1993). Depending on which swindler you asked, the dominion was in Antarctica, the South Pacific or an island off the coast of Colombia.)

To attract business, these companies also had to present an illusion of financial strength, and that meant producing audited financial statements showing millions of dollars in assets.

Mr. Teale and others in his network did this with varying degrees of credibility: Some balance sheets appeared plausible enough, while others barely withstood the light of day.

Two of the network's members, for example—Helensburgh Ltd. of Dublin and Euroam-Re Reinsurance Co. of the Netherlands—claimed to be capitalized with "treasury bills" issued by the Sovereign Cherokee Nation Tejas, a purported Indian nation created by a retired U.S. Air Force colonel in the 1970s on a sand bar in the Rio Grande River.

Dallas Bessant, a British citizen who said he was adopted by the group and given the name "Wise Otter," owned both insurers and is scheduled for trial on federal fraud charges in January 1998.

Several other Teale-managed companies were capitalized with virtually worthless over-the-counter stock that had been "rented" from securities swindlers and placed on the insurers' balance sheets at grossly inflated values.

One group of Teale companies, for example, secured its reinsurance obligations with valueless OTC stocks they claimed were worth $6 million. These included shares in a company that sold sports trading cards from a private home and the stock of a shell company associated with convicted insurance con man Arthur A. Blumeyer III.

Other bogus assets were tougher to spot: Mr. Teale, for example, helped a now-defunct Florida MEWA forestall its insolvency by lining up an infusion of Government National Mortgage Assn. securities. While the Ginnie Maes later proved phony, Senate investigators found it is virtually impossible to confirm the actual ownership of Ginnie Maes because of the way they are traded and held (*BI*, Oct. 21, 1991).

For all his hard work, Mr. Teale finally attracted too much attention: In January 1993, 18 months after they invoked their Fifth Amendment right against self-incrimination at a Senate hearing, Mr. Teale and his wife were indicted on federal fraud charges. They pleaded guilty; Mr. Teale died in prison in 1994, and Ms. Rentz still is serving a 13-year sentence in federal prison.

Others in the network, including insurance company operators, agents and securities vendors, have since been convicted of participating in the fraud.

Toward the end, a growing part of Mr. Teale's business was health insurance fraud, particularly MEWA scams. He was not alone: It has been big business for many swindlers for more than two decades.

Under the pre-emption provision of The Employee Retirement Income Security Act of 1974, small employers could band together to insure worker accident and health risks, either by buying insurance on a group basis or by setting up a self-funded trust.

Con artists seized on self-funded plans, setting up their own trusts and raking in millions of dollars of contributions by offering cut-rate coverage to small businesses desperate to save money. The trust operators would typically pay a few claims early on but would set aside little or no money for reserves; buy no reinsurance, or reinsure with other fraudulent companies; and siphon off huge percentages of the trusts' funds in fees and expenses.

A wave of these bogus trusts collapsed in the late 1970s and early 1980s, their operators insisting to the end that ERISA's pre-emption provisions barred state insurance regulators from interfering with their business.

Congress amended ERISA in 1983 to make clear that self-funded MEWAs are subject to state insurance regulation. The change didn't do much immediate good, though, as MEWA swindlers engaged in stalling campaigns, suing insurance departments and launching other delaying tactics that could tie up regulatory action for months. By the time these tangles were resolved, bogus MEWAs might already have gone under or moved on to other states (*BI*, May 21, 1990).

Life was getting harder for MEWA crooks, though, as regulators and law enforcement officials took a tougher line—and as court after court affirmed state regulatory authority.

Thus, in the early 1990s, the swindlers shifted gears again, taking advantage of another ERISA loophole: union benefit plans.

Even with its MEWA amendment, ERISA continued to exempt union-sponsored health plans from state control. Seeing another good thing, the swindlers set up their own phony unions and convinced small employers to have their workers join, making them eligible for coverage under self-funded "union" welfare plans.

Employers didn't mind, because the coverage was cheap and the "unions" agreed to do nothing inconvenient, such as engage in real collective bargaining on wages and working conditions. The crooks were happy, too, because the union offered new conduits for siphoning away money through "dues" and other union-related fees and expenses.

Perhaps the biggest and most audacious of these frauds was the National Council of Allied Employees, a bogus union set up in Glen Head, N.Y., by William Loeb, then a five-time convicted felon (*BI*, May 18, 1992).

Falsely claiming an affiliation with the AFL-CIO, Mr. Loeb ran the NCAE as a franchise operation, selling charters for NCAE "local" unions to other swindlers across the country and collecting a cut of their revenues.

At least five of these locals operated more or less independently in the early 1990s, collecting millions of dollars of premium and triggering injunctive lawsuits or cease-and-desist orders from regulators in half a dozen states. One of them, Local 555 in Encino, Calif., took over a block of former MEWA business and reinsured it with companies in Anguilla and Ireland that later failed to pay claims. Another, Local 615 in Tempe, Ariz., was run by a former Loeb associate who falsely claimed the health plan was insured by a licensed Kentucky insurer. Both plans later collapsed, leaving millions of dollars of unpaid claims.

For his part, Mr. Loeb ignored the regulatory actions and filed his own federal lawsuit against seven state insurance departments, charging them with violating NCAE's constitutional rights.

He was indicted in 1992 for embezzling nearly $500,000 from Consolidated Local Union 867, another phony labor group he operated before forming the NCAE. Captured in Arizona after he jumped bail, Mr. Loeb was convicted and sentenced to 71 months in jail (*BI*, Dec. 13, 1993).

Several other operators of NCAE plans also were convicted of criminal charges or reached settlements with the U.S. Department of Labor barring them from acting on behalf of benefit plans.

The Labor Department later developed new rules to address the problem of phony unions (*BI*, Aug. 7, 1995).

Whenever Congress changes federal benefit laws, though, it seems to open new avenues for con men. Legislation passed in 1996, for instance, allows the formation of tax-advantaged medical savings accounts, and state regulators are now eyeing former MEWA swindlers who are reportedly developing MSA plans.

Trying to combat illegal property/casualty and health insurance schemes, regulators in the past decade have developed new anti-fraud laws and have become more aggressive in pursuing wrongdoers. Most agree, though, that nothing short of jail time slows down a committed swindler for very long.

One might conclude in looking at the most egregious cases that the perpetrators usually go to prison. This isn't so, though: For every swindler caught and convicted, a dozen or more may escape to engineer another scam.

Law enforcement and regulatory officials hope 1994 federal crime legislation—which for the first time made insurance fraud a federal crime—will lead to more prosecutions. It remains to be seen, though, how effectively this law is enforced.

Meanwhile, the oldest advice is still the best: "Let the buyer beware." 30

JEFFERSON INSURANCE GROUP

Newport Tower
525 Washington Boulevard
Jersey City, New Jersey 07310

Tel: (800) 207-9847
(201) 222-8666
Fax: (201) 222-9161

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30 VIEWS

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Sir David Rowland

Master communicator spearheads reconstruction of Lloyd's

Lloyd's of London Chairman Sir David Rowland is one of the great statesmen of the insurance business.

As one of the best communicators in the industry, he led Lloyd's from the brink of disaster to one of the biggest financial reconstructions ever. Had he failed in his mission, Lloyd's could have collapsed, leaving the vast majority of the insurance industry worldwide in chaos.

When Sir David became Lloyd's first full-time chairman in 1993, the market was wracked by catastrophic losses and thousands of angry, litigating names who refused to pay claims.

More than three years, several court decisions and a lot of tears later, Sir David had cajoled regulators and convinced the vast majority of Lloyd's membership to sign last year's Reconstruction & Renewal Plan. The R&R plan reinsures about 740 pre-1993 syndicate years into run-off reinsurer Equitas Ltd. and leaves the current Lloyd's market with almost a clean slate to continue underwriting.

Along the way to R&R, there were some serious bumps. Court decisions went in members' favor; Lloyd's Chief Executive Peter Middleton resigned; the first settlement offer was vetoed; and a U.S. court decision would have killed the deal on the eve of signing the second R&R proposal if it had not been overturned.

Mr. Rowland landed at the top of Lloyd's after an exemplary career in the insurance industry.

After receiving a master of arts degree in natural sciences at Trinity College, Cambridge University, Sir David started his Lloyd's career in 1956 as a trainee broker in the marine division of Matthews Wrightson. After setting up its credit insurance division, he became a board director in 1964; managing director of successor Stewart Wrightson in 1972; and chairman of Stewart Wrightson Holdings P.L.C. in 1981.

Sir David helped build Stewart Wrightson until it was sold in 1987 to Willis Faber P.L.C. As deputy chairman of Willis Wrightson, Sir David was targeted to be the next chairman. But after a difficult merger in which hundreds left the group, he resigned to become chief executive of Sedgwick Group P.L.C. in 1988 and chairman in 1989.

Sir David was named The College of Insurance's 1996 Leader of the Year; and was knighted by Queen Elizabeth II earlier this year for his achievements during his stellar London market career.

He retires at the end of this year, at age 64, to be succeeded by Max Taylor, executive director of Willis Corroon Group P.L.C.

Sir David spoke with Senior Editor-International Stacy Shapiro at his 12th floor office atop Lloyd's.

Q: What lessons in your earlier career do you think helped you as chairman of Lloyd's?

A: The early lessons were that everybody's bound to make mistakes and it's a good thing to admit them and it's remarkable how much help you're given by people when things go wrong.

And there was a realization that however arrogant one becomes about one's own ability, you must work together with other people as a team. Also, I was very lucky to have one or two older people who took an interest in me. Their experience and advice and interest and guidance at times helped me in my career. They had no particular interest in me other than through a relationship which developed in business.

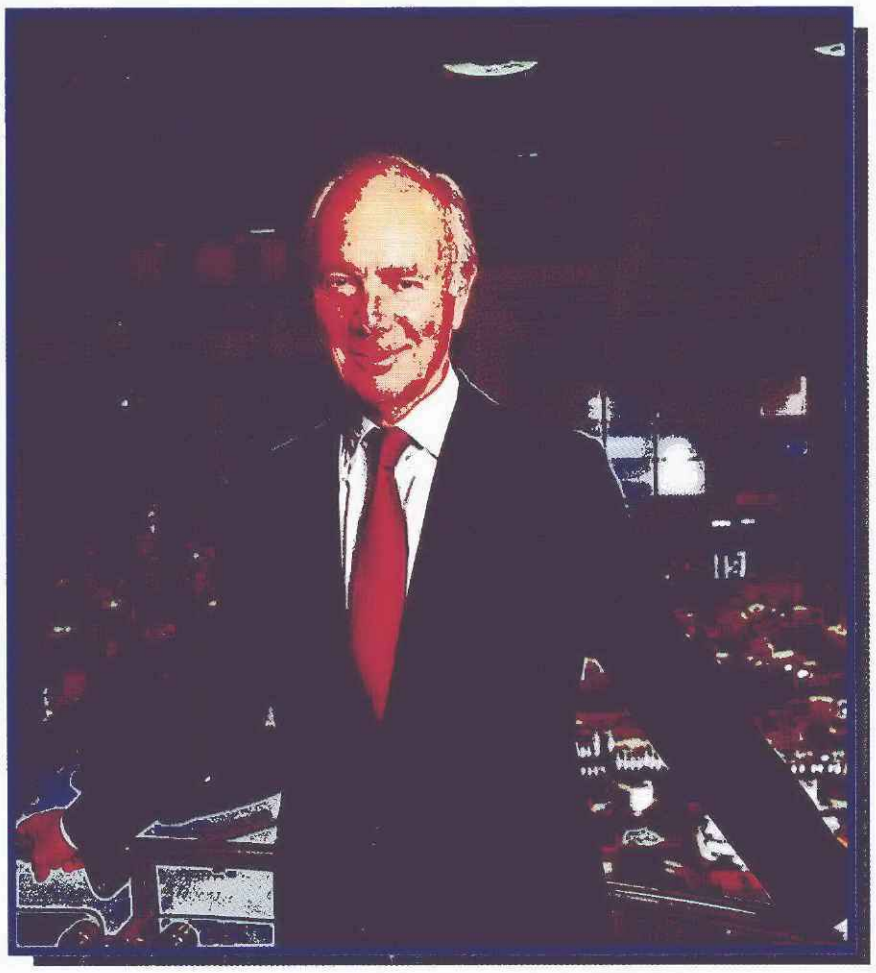

PHOTO: MARC SCHLOSSMAN

So I feel that it is very, very important to do as much as one can to help younger, very able people.

The year before you were selected chairman of Lloyd's, you said, "Anybody sane wouldn't want the job." So why did you agree to become chairman of Lloyd's?

The quote must have gone on It wouldn't have been me if I hadn't added something like "but I'm passionate about Lloyd's." But there wasn't an alternative.I became the person that most people wanted for the job. I couldn't run away.

And I actually do feel passionate about Lloyd's and always have. To have let Lloyd's collapse without trying to restore it would have been a disgrace. I had a faith that we could find a route through.

Once you became chairman, were you surprised by the depth of the problem that you found?

As chairman of a Lloyd's task force in 1991, I was lucky in that I was much more knowledgeable than I would have been otherwise. But of course I was surprised, particularly by the depth of feeling among the members and the anger and the suffering; and by the huge complexity of the problems we faced.

But because the task was so enormous, in the most extraordinary sense the job was relaxing because all you could do was the best that you could do. It would have been impossible to finish the job unless you could do the best that you could do. So you got into a different sort of mind set.

Did you make any mistakes?

Certainly I misjudged a very fundamental thing, and that was time. Although we all knew in 1993 it would take time to reconstruct Lloyd's, I didn't think it would take so long.

Everyone had to work through a period of anger before they could come to a degree of give and take, before a solution could be produced and we could establish a consensus to get things fixed.

I believe the first offer to the membership, whatever it was like, was destined to fail because we hadn't yet reached that stage. Looking back, I would say that the failure of the first offer was absolutely why the second offer was successful.

But three years and eight months is a very long time span. I had been asked to serve for three years as chairman and I thought within the three-year period it would be possible to complete the job.

Were there any setbacks along the way?

Each setback was a building block for the next thing.

The verdicts that were coming through on members' litigation in one sense were setbacks, but in another sense they were not because they established the definition of liability and produced a degree of clarity. They set ground rules for where fault lay from which you could build an offer.

So in one sense the headline "Gooda Walker Members Awarded $500 Million" could have been considered a setback. But on the other hand, if that hadn't happened you wouldn't have been able to work so closely with (Gooda Walker Action Group Chairman) Michael Deeny and produce a settlement that actually worked.

So setbacks can be building blocks. Peter Middleton and I worked closely together and he was a considerable contributor to reaching out to names.

Though his departure was a setback at the time, Ron Sandler became chief executive with the qualities of a good manager and an excellent executor. So what I once considered to be a setback turned into a very great advantage.

What do you think were your personal qualities that allowed you to lead Lloyd's through this troubled time?

The only qualities that I would claim to have is that no one believed that I'd back away from the task. I was either going to be the last chairman of Lloyd's or we would solve it.

As time went on, we did cope with the problems and we built a record that people believed. So during those last difficult days with the court cases in America that seemed impossible, we were able to assure people that we would get it fixed. That was extremely important.

Louisiana Insurance Commissioner Jim Brown said one of your great qualities was that you were a great salesman.

Oh yes, to my colleagues, to names, to regulators, to everybody. One quality which I'm lucky to be able to do is talk. As a leader and a chairman you have to be able to stand up to any group and talk to them truthfully. We could only say that we intended to solve the problem, but we could make no promises because we didn't know if we could get there. So the question the whole time was whether they actually believed you or not.

Who was your most difficult audience?

It was the early meetings with members—not just the floodlit meetings in places like the Albert Hall where

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you needed to control the proceedings—but the smaller meetings where people were seriously angry and some faced destitution. They were daunting and there wasn't an immediate solution.

What are the most important changes in the market now?

The attitude of the market and blowing the Lloyd's doors open for the first time. There is now a real understanding that we are here to serve the customer.

The capital structure has changed. It may have evolved anyway (toward corporate capital), but in 1993 we faced two years of catastrophic losses and a period of bad publicity and anger. But serious investors were willing even then to invest money into us, about £900 million in the first year, which showed customers that serious people were willing to invest in us, which was important. If something like that hadn't happened, it is unlikely that there would have been an evolution at Lloyd's.

Opening the doors to the new form of capital helped us to accelerate change at Lloyd's.

What do you think will be the major issues for the market in the future?

I hope under Max Taylor, whom I am pleased will be the next chairman, that the market devotes itself to the needs of the customer, and that there will be less arguments about the different sorts of capital providers. The market rather should spend more time on the problems of distribution and how to adapt to the changes in risk transfer.

What has been your priority in this, your last year as chairman?

The key reason I am here at all is because I believe that you shouldn't leave a job until you have appointed a good successor.

I didn't choose Max Taylor at all. He was chosen by a committee led by Sir Jeremy Morse, who considered a number of people related to the market. The Council agreed that Max was the best choice.

As chairman, you have to care about Lloyd's. There are easier ways of earning a living. There are still pressures in this job that are different from those that you find when you are running a company. On good days it is fascinating; on bad days it's bloody difficult. But what carries you through is that you care about it. We were very fortunate that there was such a good range of people who are related to the market to choose from.

Meanwhile, there is a very good team in place. Ron is an excellent chief executive. He offers a range of talents and characteristics that you don't want to duplicate. Max and Ron will be a very good team together.

What will you be doing in your retirement?

Until I have finished this job, I will not comment. 30

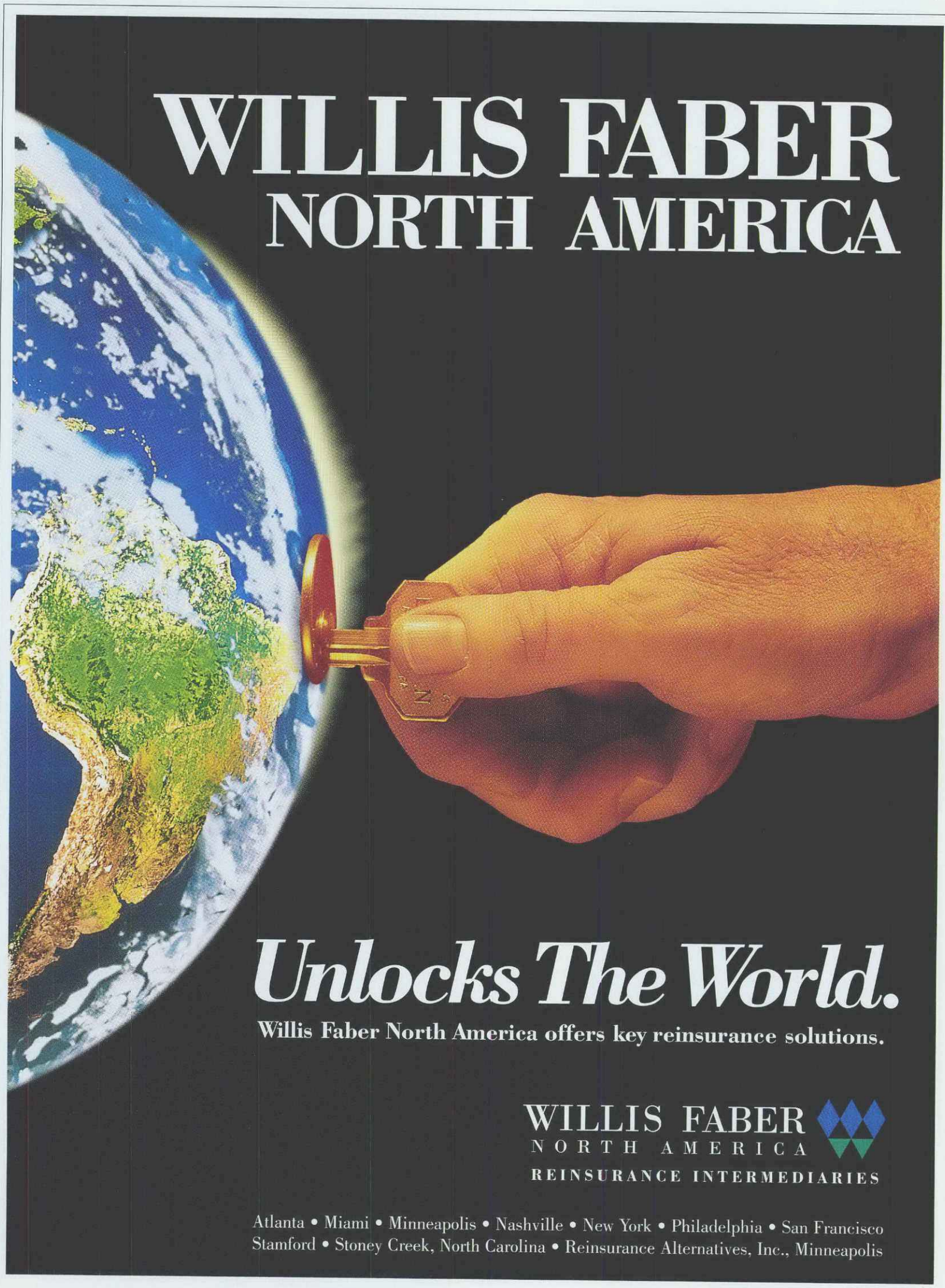
Membership in Lloyd's

1967	6,080
1968	6,059
1969	6,042
1970	6,001
1971	6,020
1972	6,299
1973	7,140
1974	7,589
1975	7,710
1976	8,565
1977	10,662
1978	14,134
1979	17,279
1980	18,552
1981	19,137
1982	20,145
1983	21,601
1984	23,436
1985	26,050
1986	28,949
1987	31,484
1988	32,722
1989	31,329
1990	28,770
1991	26,568
1992	22,259
1993	19,537
1994	17,529
1995	14,804
1996	12,798
1997	9,959
1998*	8,000

* *BI* estimate

Note: years 1988-1999 do not include non-underwriting names seeking to resign from market.

Source: Lloyd's Membership Department, *Business Insurance*



30 VIEWS

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Patrick G. Ryan

Aon founder has an appetite for acquisition, and he's still hungry

Not many executives can claim they have stirred up a multibillion-dollar industry quite the way Patrick G. Ryan has over the past year.

The chairman and chief executive officer of Chicago-based Aon Group Inc. is the mastermind behind the purchase and integration of five of the world's 20 largest insurance brokers since last October.

His deal-making not only has touched off widespread consolidation within the industry, but it also has created a global brokerage giant grossing nearly $4 billion in revenues in 1996.

What is now known as Aon Group is really an outgrowth of Ryan Insurance Group, a small managing general underwriting agency that Mr. Ryan created in 1964 at the age of 26.

For 14 years, Ryan Insurance Group distributed specialty credit life insurance products to automobile dealers. Then in 1978, Mr. Ryan acquired four agencies that had been operating under the financial service division of Esmark, a Chicago-based conglomerate, and Mr. Ryan's dream to build a large insurance brokerage distribution began to take shape.

That acquisition, which included Scarborough & Co., propelled Ryan Insurance Agency Group for the first time into Business Insurance's rankings of the largest U.S. brokers, debuting in the No. 19 spot based on a mere $11.6 million in revenues.

Three years later, Ryan Insurance Agency broke into the Top 10 with its acquisition of James S. Kemper & Co., which at the time was the 20th-largest broker.

But it was not until the 1982 deal that Mr. Ryan made with W. Clement Stone, who was president and chief executive officer of Combined International Corp., that Mr. Ryan finally assembled the necessary resources to become a national player in the insurance brokerage industry.

Just months after the merger with Combined was secured, Mr. Ryan, who was named president and CEO of Combined, bought Rollins Burdick Hunter Co. for $109 million, propelling the broker to the No. 7 spot in the rankings, with $118.4 million in revenues.

Mr. Ryan's only other major brokerage acquisition during the 1980s was of Bayly, Martin & Fay International Inc. in 1989. He now looks back and says that he wishes he had been more aggressive in building the brokerage during that time.

He more than made up for lost time during the 1990s, however, with the purchase of several household names in the brokerage industry. Among them were: Hudig-Langeveldt Group B.V.; Frank B. Hall & Co. Inc.; Bain Hogg Group P.L.C.; Alexander & Alexander Services Inc.; Minet Group; Sodarcan Inc.; and most recently, Jauch & Huebener KGaA.

Mr. Ryan, 60, sat down with Associate Editor Sally Roberts recently in his downtown Chicago office to reflect on his career.

Q: How did you come up with the idea to create Ryan Insurance?

A: I always wanted to be an entrepreneur. I went into the insurance business out of college.

I wanted to have my own company, so I tied knowledge of the retail automotive industry that I gained through my father's business growing up into the insurance experience that I had.

The goal then was to really be a consultant/broker/service provider to the retail automotive industry.

We focused exclusively on servicing the automotive industry from '64 to '78. Then the idea was to take that same concept, of specialization and brokerage distribution, into other industries.

So the second industry we focused on was banking, which came through Scarborough. The goal was to then build the brokerage service distribution.

I don't think many people realize Aon Corp. has brokerage roots.

People miss that part because they focus on the fact that we had underwriting companies. They miss the continuity that we started as a brokerage and stayed with it. But because we merged in '82 with Combined, that threw people off.

The strategy behind Combined was that we saw it as the vehicle to fund our dream.

It had a $500 million shareholder equity and no debt and $100 million in cash flow.

You've completed so many acquisitions in your career, what was the most strategic deal behind Aon's current position?

There are three deals that I would highlight as critical to our present position. The first one was, as soon as we merged with Combined—a month later because we now had the money—we bought Rollins Burdick Hunter, and that took us from a local, relatively small broker to one with national presence. The next was in '91 with Hudig-Langeveldt, because that was the decision we made to globalize the brokerage business and to make the total commitment to move forward in a very aggressive way. That acquisition launched us in Europe and in the Far East. And then the next year, the acquisition of Frank B. Hall. That deal gave us the presence in the U.S. and in Europe to become a major player.

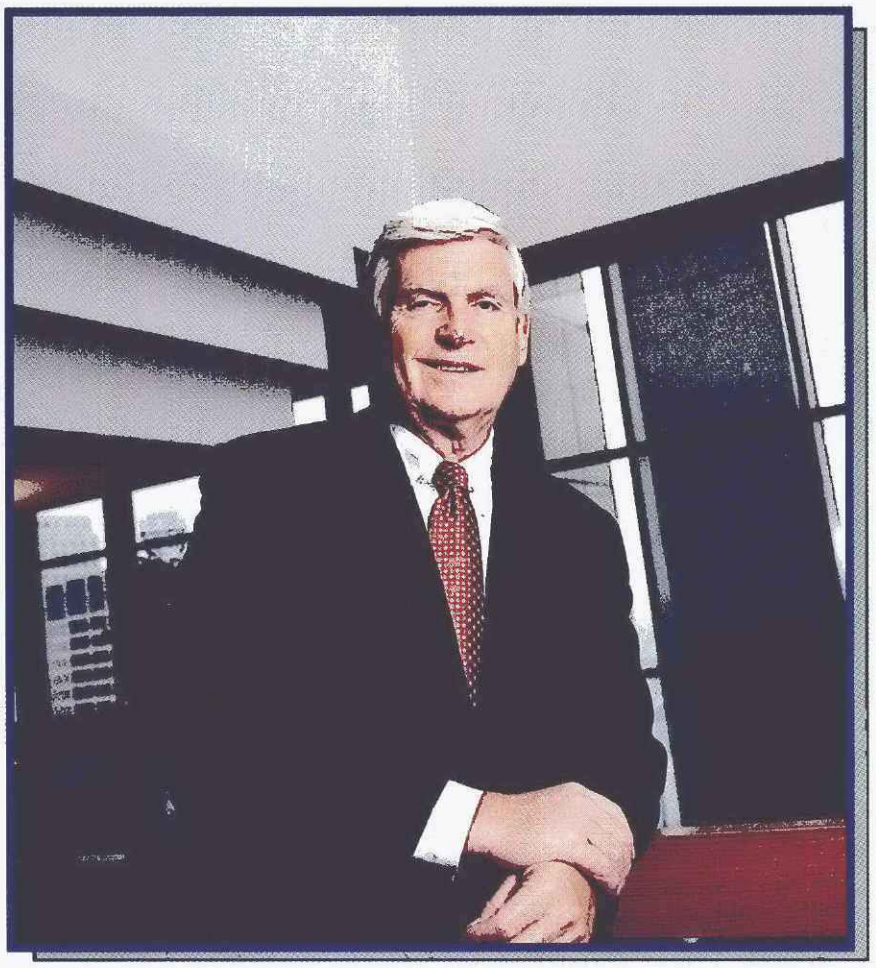

PHOTO: MICHAEL MARCOTTE

Was there one deal that was most exciting for you personally?

In different ways, I think the Hudig-Langeveldt was the most exciting because it got us into all these different cultures and then proved to me that we were capable of building a global business. Up until then, we were basically adding to a domestic business. Frankly, in six years, we went from doing business in one country to doing business in over 100 countries. Hudig-Langeveldt was the platform behind that.

Are you sorry you couldn't buy Corroon & Black?

Sure. People always say I'm too stubborn to admit that, but Corroon & Black was a very good fit for us. Together, we would have been a huge mid-market player. I felt Corroon & Black and what was then RBH fit together very, very well, culturally and strategically. It's the only deal we missed out on.

Are you done buying?

No (laugh).

You have quite a bit of experience in taking on several large acquisitions at one time. What are the keys to making multiple acquisitions?

The first one is respect for cultural differences—the cultural differences within the company or companies and the cultural differences due to nationalities. I think we have had the ability to respect those cultural issues and bring them together to make them work.

Another key is a belief and respect that each company has its strength and to identify those strengths and bring them together as decisively as possible. Indecision and uncertainty is very difficult for the human quotient to deal with.

Thirdly, and very importantly, is to deal with the weaknesses that you've got. Either decide to eliminate them or invest very quickly.

Does brokerage size really matter in today's market?

Size gives you scale, which translates into efficiency; size often gives you resources; size often gives you geographical reach. So size does matter. But is it really relevant if you're No. 1, 2 or 3? Probably not. But do I believe it matters if you're second-tier size? Personally I do believe it matters, and I know people who are of that size that would argue like hell to say that it's not a relevant issue. I would disagree.

Has Aon reached the critical mass you think a broker needs in order to thrive in today's market?

Oh, sure. But that doesn't mean we don't want to be larger. We don't have to get larger for the sake of gaining efficiencies, but there are parts of the company that are not large enough.

Such as?

Latin America, parts of Europe and parts of the Far East.

Is there anything that you would do differently since forming Ryan Insurance?

Oh, I think I would have accelerated the growth of the brokerage more in the mid-'80s. We bought Life of Virginia in the mid-'80s. Although that was a good investment for us, I was trying to re-

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ward our shareholders by giving them balance with brokerage, accident and health, and life. So I was proud of the balance we had with the three distinct businesses. Although financially (Life of Virginia) worked out for us, because we bought it and made a lot of money selling it, probably, if I had the chance to do that all over again, I would not have made that move and would have moved more aggressively earlier into the brokerage business.

It was a different market then. Do you think you could have been as aggressive as you have been since the market turned soft?

In retrospect, at the time it probably wouldn't have been as easy to do. Maybe that's why I didn't do it. The brokerage industry was very good in the mid- and late '80s coming off of the big price increases in '86. So it's easy for me to say I should have. When I think back, though, we couldn't do a lot of those deals. We couldn't have done Hall then; we couldn't have done A&A; I tried to get Corroon in '90 and couldn't get it done. So maybe I'm being a little too harsh in that retrospective.

If you were not in the insurance business, what would you be doing?

My sort of fantasy was always being a trial lawyer. . .matching wits with some other guy. But I really think I would be in business. I almost went into the real estate business.

What stopped you?

It was right before I started Ryan Insurance and went off to visit friends in California. Real estate was booming in Southern California, and I thought, "God, I could do that." So I interviewed for a job out there and got it. When I came back to get my things, I called a friend of mine, and he said: "Don't make a move. I've got this great idea." He and I and some other people were going to start a life insurance company. Well, I went to my first meeting with these guys and they couldn't even agree on where they would have the second meeting. But, by this time I'd given up the job, and I was back here and Southern California didn't seem as appealing.

Who has been the most influential person in your career?

My wife and my family. I love what I do, and in doing that, it takes a lot of time and a lot of focus. Therefore, you need people to understand and do more than accept it. . .they need to encourage it because they know that it is part of you, rather than fight it. I've been a beneficiary of that. That's been very important. If I didn't have that, it would be very difficult.

For people who do not know you, what would they find most surprising about you personally?

That I'm not as aggressive as I seem. People always think that I'm so aggressive. I appear to be impulsive because I do things quickly, but I think things through very carefully before I do anything.

Do you personally enjoy the limelight that has come with Aon's growth?

I think I'm used to it. I honestly don't seek it out. But I guess I'm accustomed to it because running a large public company gives you certain exposure, and then being a meaningful participant in the insurance industry gives you identity. I've always been active in different external affairs, so that gets you exposure, too. So after a while you take it as it comes. I think, frankly, to a certain degree I have a responsibility for Aon, its shareholders, its employees and its clients to have the company recognized, but for personal sense of gratification, I don't seek it out.

Do you have any mentors?

Very early I had two mentors: One was John Swearingen (retired chairman of Standard Oil Co.). He is just a guy if you had a situation, you could explain it to him and he'd give you very sound advice. In the early days, there was a guy named Jim Rutherford, who was 45 years older than I was, so he was close to being able to be my grandfather.

He was head of Prudential Mid-America and a well-known Chicago businessman. He sort of mentored me in the early days. He was from Arkansas. . .one of those wise men who you just go to with a question or a problem.

I've had very good friends who are not so much mentors as much as they are confidants and advisers. And I seek people's advice.

What's the biggest accomplishment in your career?

Aon, because I am a builder. What drives me is the creation of a company with great value to its clients, great importance to its employees and great importance to its shareholders and to its community.

What are you doing when you're not working?

I spend a lot of time with my family. We travel. We have a home up in Wisconsin which we go to. I like to read and snow ski. I like water sports. 30

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30 VIEWS

Richard L. Sandor

Father of financial futures secures a place in the insurance market

Known as the "Father of Financial Futures," Richard L. Sandor is chairman of Hedge Financial Products Inc., a CNA Financial Corp. subsidiary specializing in the securitization of insurance risks.

CNA acquired Hedge Financial, formerly Centre Financial Products Ltd., earlier this year. Hedge Financial's charge is to find ways to transfer traditionally insured risks to the capital markets, using such techniques as derivative instruments and structured financial products.

In addition to his Hedge Financial role, Mr. Sandor is vice chairman of the Chicago Board of Trade. It was during a 1970s stint as vp and chief economist at the CBOT that he earned his reputation as the principal architect of interest rate future markets.

Mr. Sandor, who received his bachelor's degree from the City University of New York, Brooklyn College, and his doctorate in economics from the University of Minnesota, began his professional career as an academic and continues to work in that arena.

He has held faculty positions at the School of Business Administration of the University of California at Berkeley and at Stanford University and has taught as a visiting professor at Northwestern University's J.L. Kellogg Graduate School of Management. He recently was appointed distinguished adjunct professor at the Columbia University Graduate School of Business.

In 1973, Mr. Sandor authored an article published in a British academic journal suggesting insurance risk could be traded as futures and options. Two decades later, he was instrumental in making that concept a reality as the Chicago Board of Trade introduced its catastrophe insurance futures and options contracts.

Mr. Sandor, 56, spoke about the cat contracts' progress, the securitization of risk and the future of risk transfer with Associate Editor Rodd Zolkos.

Q: After hundreds of years of the insurance and reinsurance industries doing business in the "traditional" way, why the interest in recent years in securitizing risk and taking advantage of the capital markets?

A: Here is the fundamental premise: We have a $7 trillion economy. There's $250 billion of capital in the insurance business. The numbers don't compute.

The second thing is that the buildup of coastal property values has been enormous. Cities like Miami exploded. Needless to say, Los Angeles, San Francisco, Tampa, the Texas area, all of these high-risk areas had enormous growth in property values. And as that was occurring we began to get a number of disasters: Hurricane Hugo in '89, Loma Prieta, Andrew, Iniki.

We're just witnessing a confluence of weather events striking high-risk, high-property value areas. So it seems that with $250 billion in capital, a $7 trillion economy, all of the liabilities associated with that: E&O, medical liability, tobacco, etc., that the property and casualty risks are now larger than they ever have been in the history of the planet. And in spite of the fact that rates on line are low, there is still unsatisfied capacity in high-risk zones at reasonable prices.

And I think the growth of the economy coupled with the recent catastrophic events has really focused the insurance industry and the capital markets on opportunities to provide risk transfer mechanisms.

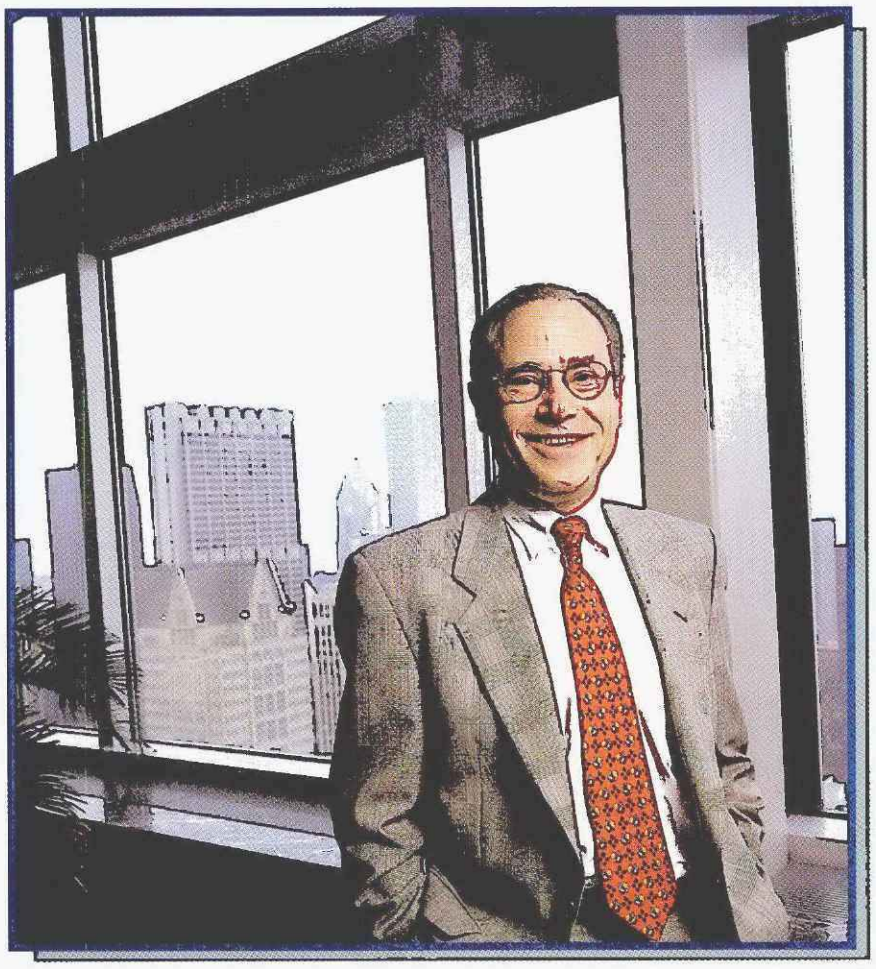

PHOTO: MICHAEL MARCOTTE

It would seem that CNA's establishment of Hedge Financial is a good example of a traditional insurance company recognizing those opportunities and moving to get involved in them.

I think what you're seeing in CNA's formation of Hedge Financial is a perfect example, recognizing that we need to bridge the gap between the insurance markets and the capital markets. The recent venture between AXA and Paribas is yet another example. The recent efforts by Aon to deal in the derivative area, the efforts of AIG, Phoenix Re, the buildup of Goldman Sachs' specialty unit, everywhere you look you see that this industry is well on its way to becoming a critical element.

The interesting thing is you couldn't have imagined a better scenario in which to do it, but it's one that's typically available.

The first thing that happens is you get a lot of risk that becomes apparent or new—volatility. You search for standardization, ways to standardize the product. Once you standardize the product, you're capable of developing organized futures and options markets as well as morphing risk into the capital markets.

This timing was perfect, because prior to the real beginning in December '92—following Andrew, when the Board of Trade launched its futures—rates had gone up because of all of the recent catastrophes. So the rates of return to people who became synthetic insurers were very, very attractive. Fortunately over the next five, six years, anybody who had taken insurance risk made money as the markets again became quiet.

If you take financial futures, you had your first kind of introduction of risk and high rates in '73 at the oil embargo; you started interest rate futures in '75; in '79 you had the second embargo and the Jimmy Carter inflation and, boom, the market took off.

So typically what happens is markets demonstrably show that there are attractive risks to be undertaken in the capital markets, that they have the depth and capacity with $20 trillion to $30 trillion in capital.

The economic environment responds after one introduction of volatility, and perceptions about risk become realized, markets start to form, and the next scenario is another big catastrophe and some young man or woman in an insurance department gets written up on the front page of the Wall Street Journal having hedged the company's catastrophes and then, all of a sudden, you get the market maturing.

In some quarters you hear the talk that the catastrophe futures contract hasn't taken off, that it's been slow to take off or whatnot, but I gather from what you're suggesting that this is sort of a normal maturation process.

Yes, very much of a normal maturation.

The problem is that gestation periods of organized markets and over-the-counter markets are a lot longer than people would suggest. The communication that we now have focuses a lot of attention and looks for immediate gratification, but most industrial inventions and most financial innovations. . .it took 15 years to get the mortgage-backed market into futures. It took 10, 15 years to get financial futures off the ground.

As a matter of fact, it took close to 20 years to get junk bonds to be an accepted medium—right?—and finally do it. Power steering was invented in the 1930s and didn't get into use until the '50s; Xerox took 20 years to get to photocopying.

Then what's happening here isn't just consistent with what's happened with financial innovation, but technological innovation?

As well, as well.

While I taught around at a bunch of different universities, I actually didn't get trained in finance. My Ph.D. dissertation and my early writings were indeed more on the economics of science and invention.

So I kind of look at this all as a process and take a great deal of comfort that any student of inventive activity is going to really take comfort from the fact that in any industry in which there is change, it takes a significant amount of time.

So, we have to recognize that we're taking change, looking for it to occur instantaneously, but even the most successful inventions, like the personal computer, the Web, you know you could be asking the same questions five or six years ago about the Web, even today, and it won't be in full force for 20 years. We know it'll take that much longer.

Thus far most of the securitization of risk has occurred has been in the catastrophe area. You mentioned the possibility of transferring other sorts of what are now insured risks to the capital markets. Any reason why it's focused on catastrophe so far?

Capacity and the biggest fear—I mean everybody recognized you could have a $100 billion event, you know, $100 billion in Florida, California, Kobe. The cat represented the largest concen-

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tration, and it was not diversified away, and so I think the numbers are so humongous that it became the obvious.

It's the same way the securitization of assets such as mortgages preceded credit cards, because it's the same technology. Now you wouldn't think about not securitizing a receivable. I think the natural sequence was, "What's the biggest market that lends itself to it?" and then once you crack that, you'll figure out a way or the inventors will figure out a way to securitize longer-tail liabilities.

At least, with a cat within 12, 18 months, you know the damage. You do a liability, it may take five years. But, there's no reason why you shouldn't securitize the claims on liabilities. I mean, how's that for a novel idea? Why not securitize potential lawsuits and the claims arising therefrom and put them into the capital market?

I happen to think that not only would you liquefy the insurance companies, but you'd probably get the lawsuits settled quickly because, if you have a personal claim where people are not emotionally tied to something, you can get to a business. Once you commoditize it, the ability to settle it, I think, increases.

So I think there's enormous opportunity from the securitization of liabilities, which will have direct benefits to the insurance companies and social benefits in that it will reduce litigation. I know that sounds a little way-out, but you start putting values on these—markets clear a lot more quickly than the U.S. judicial system.

Once the investor gets hold of it, he's got a real clarity with regard to "This is a financial instrument," that it has nothing to do with personal pain, suffering, things that are going to get in the way, lawyers, you know. With putting a value on it, markets are color-blind and emotionless in their best sense, and they're the best way for conflict resolution. So I see an enormous opportunity in that and one that would have very big implications in the whole legal structure and claim settlement for the insurance business.

I consider that the major challenge.

So beyond bringing prices down and making insurance more available, securitization of risk might have greater social value by reducing litigation, for example?

Sure. You would have all the standard benefits of lower premiums, wider availability for liability insurance.

And, by the way, we've looked at it, and it could extend to things like medical care. I mean, capitation is a security.

Any form of disability, disease management, which everybody is concerned about, this can all be securitized. As a matter of fact, the Board of Trade looked at medical insurance futures, and we may bring that back at some time.

Do you think it's possible that as these markets develop, some of the larger corporations—and maybe even some smaller ones—might be able to begin transferring some of what are now their insured risks directly into the capital markets, without the involvement of the insurance companies?

It's possible but unlikely. It's not at all clear that we won't see enormous changes with corporates.

We have to ask what the role of captives will be in the future. And we also have to ask finally about the melding of financial risks and insurance risks. Because the end game as a chess player is really earnings per share.

And the day an insurance company can take enough of these separable financial, property and casualty risks and combine them into a policy, which in effect guarantees earnings per share, you will have reached the maturity of the market, because you really want to protect earnings and the balance sheet.

You mentioned the coming together of the insurance industry and the banking industry, the convergence of the financial services industry. Any other sorts of speculation on possible changes of the structure of the insurance industry and even within some policyholders themselves?

I think we're going to see financial risk management and traditional insurance melded in the corporate environment. You know, separately the person would buy insurance and whatnot, but you could easily see airlines buying combined hull coverage and jet fuel caps in one policy.

And that becomes maybe cost-effective, provides degrees of comfort where you deliver a financial guarantee within an insurance policy, get rid of rogue trader type of problems; it all becomes one coherent risk management department and it doesn't matter what those risks are.

The second thing I see as a possibility is that self-insurance now can be changed.

There's an enormous amount of risk out there now; you know a quake that strikes Intel's plants or shuts down Microsoft's office, that's self-insured, right? And that's just because of the cost of it.

Suppose you were to shut down Microsoft's Washington operations for three months because of a major quake in Seattle; you can't even imagine the billions of dollars. Well, there's no real effective way to transfer that risk, and I'm sure they'd like to. It doesn't compute. So I do think a lot of the self-insured risks today, if there was an efficient mechanism, would be absorbed.

And ultimately you might see big connects like Chilean earthquake risk and copper. There are natural relationships between listed markets and insurance markets, all of which might lead to outside products where a professional risk manager could say to a large Chilean copper producer, "You know you perhaps are self-insuring now, but you might go directly into the market."

Is there any way to predict any kind of dollar amount or percentage of what is now insured risk that might be transferred into the capital markets in 10 years?

Tens of billions to hundreds of billions, I think. The numbers will, as I say, accelerate as we solve these problems bit by bit. And, again as in all research, it's always a refinement of the technology.

The numbers are so enormous, and we know as students of economics that there's one thing that human beings consistently do: They're willing to pay money to avoid risk. This is a characteristic of any economic system. And the amount of these risks is in the trillions.

Is there anything that could prevent the development of a market for transferring these kinds of risks into the capital markets?

I think it's an inevitable trend. It's Victor Hugo, "Nothing is as powerful as an idea whose time has come," and this has come. In a prior time I would have said regulation or non-market forces could have stopped it. But with the whole globalization of markets, Bermuda, you know, we no longer live in a closed economy, and if anything, the trend is toward deregulation, which I think will accelerate the amount of financial innovation as we go to deregulated or re-regulated markets.

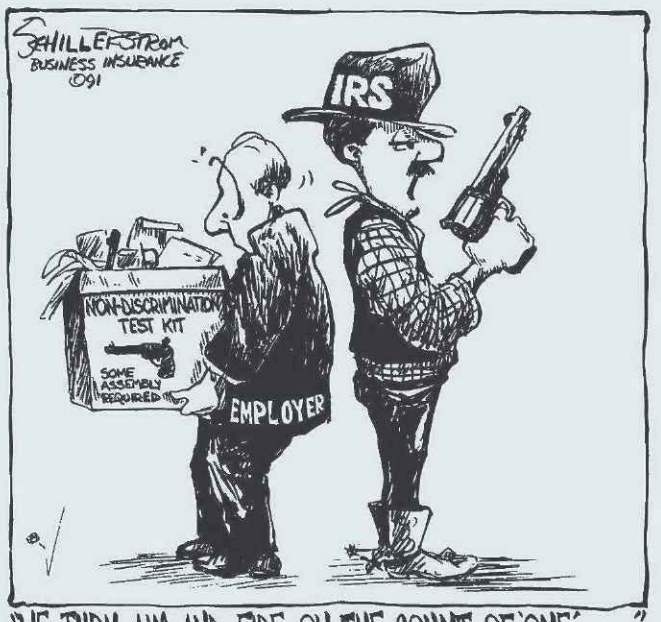
I'd like you to assess the way you see your role. You've been an educator, an economist, you're involved with the Board of Trade, here at Hedge Financial. Do you see yourself as a financial trader? An insurance executive? A visionary? All of the above?

A professional inventor.

More than anything I enjoy problem-solving. Sometimes the solutions are not so good. (Laughs.) And, you know, I've been privileged to be involved in three areas: one is financial futures and the invention side, another is insurance derivatives, and I'm currently working on environmental derivatives. We're advising the U.N. on global warming and market-based solutions to environmental problems and trading sulfur dioxide entitlements.

I think there's a segue and a bridge between the insurance industry and environmental, and I'm most intrigued with some of those areas as well as the insurance. I just like a problem. So I'm a businessman and a professional inventor and an academic. 30

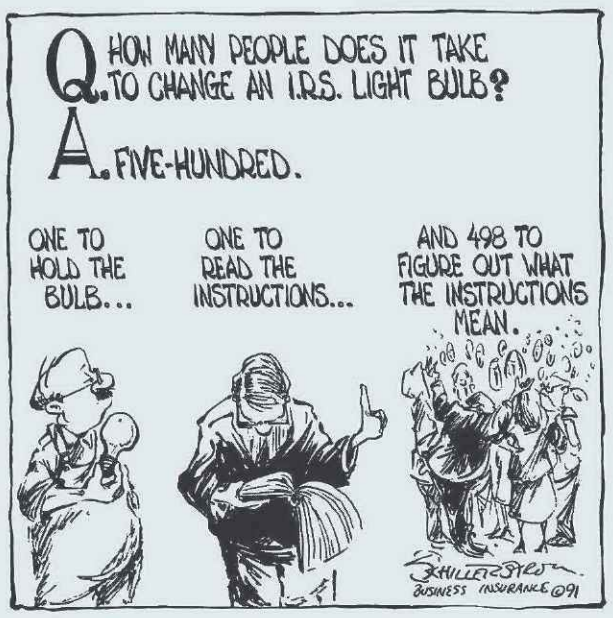
—1991—



"WE TURN, AIM AND FIRE ON THE COUNT OF 'ONE'...."

—1986—

—1991—



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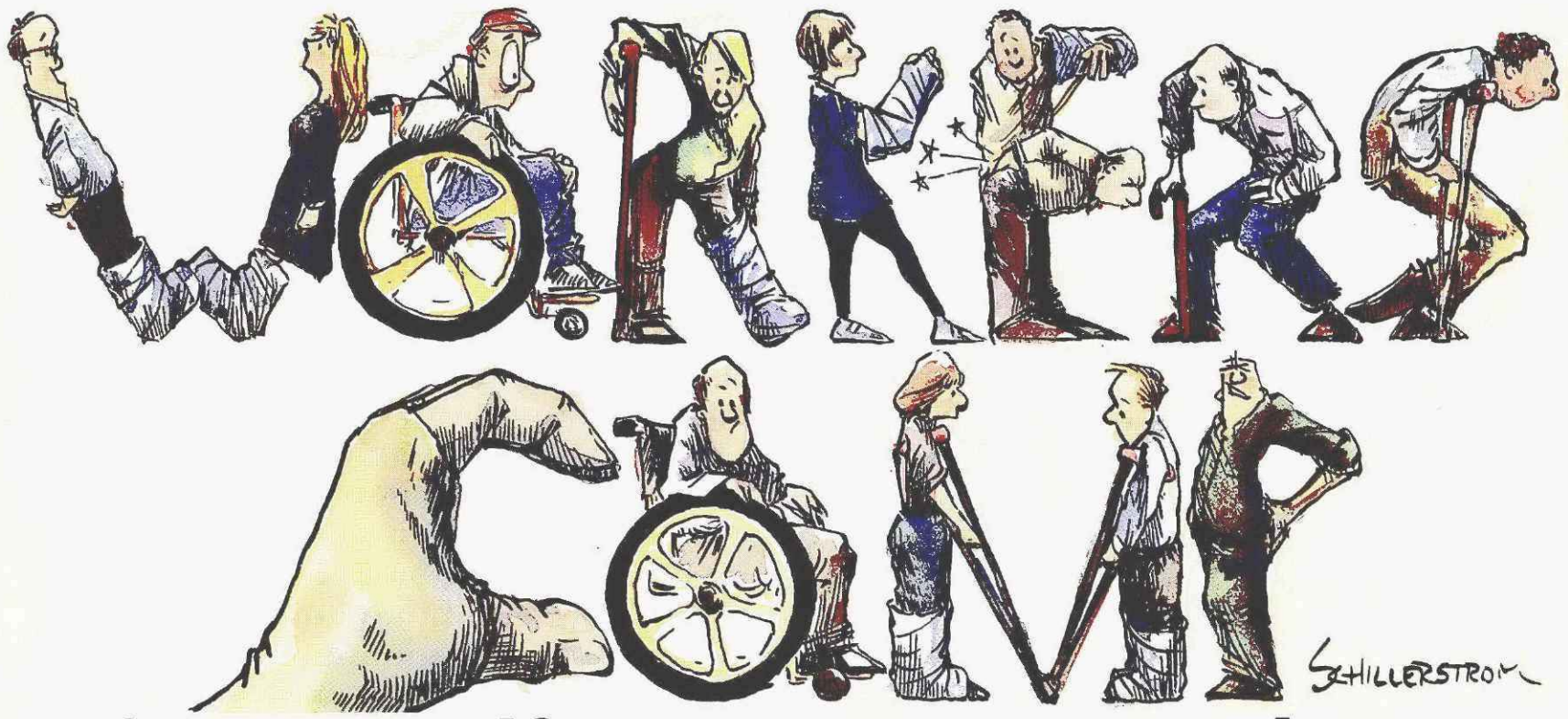

Reforms, self-insurance ease the pain

Employer moves draw accusations of going too far

By MEG FLETCHER

TRENDS & ISSUES

Employers in the 1980s struggled under the burden of an expensive and unresponsive workers compensation insurance market, but by the early 1990s they had solved many of their problems through legislative reforms, loss-control programs and increased use of self-insurance.

Rates that employers deemed unaffordable and capacity that was sometimes scarce because workers comp insurers were suffering poor underwriting results encouraged employers to change the system.

The turnaround is evident in data from the National Council on Compensation Insurance. Between 1992 and 1994, workers comp insurers' combined ratio improved to 100% from 122%.

Improved results have continued since then, with 1995's ratio at 97% and 1996 at 101%, according to the Boca Raton, Fla.-based statistical and rate-making agency.

Whether those improvements will continue, however, depends upon employers' willingness to use claims data to improve their programs and to monitor legislative activities, some experts say.

And a few observers warn that pro-employer reforms have gone too far and that a backlash by workers and labor union may be brewing.

Understanding how the turnaround occurred requires scrutinizing the root causes of the affordability and availability problems of 1984-1992:

- Residual market burdens became unwieldy in many states.
- State workers comp regulators were reluctant to raise rates, so insurers could not pass the higher costs on to employers.
- Several insurers withdrew from troubled markets.
- A recession hurt economies on both coasts.

"The (workers compensation) insurance crisis was a product of the claims cost crisis," said Eric Oxfeld, president of Washington-based UWC Strategic Services on Unemployment and Workers Compensation, formerly known as UBA Inc.

Higher claims costs stemmed from significant improvements in benefit payments following a 1972 report by the National Commission on State Workmen's Compensation Laws. That commission was established as part of the Occupational Safety and Health Act of 1970.

There was general agreement in the workers compensation community that benefits needed to be improved, especially to avoid the explicit threat of federal standards for state-based workers comp programs. However, legislation to improve benefits failed to include adequate controls to ensure that benefits remained affordable for employers, Mr. Oxfeld said.

The Commission found that disability benefits were inadequate and developed 19 essential recommendations to improve state workers compensation systems.

A key labor spokesman has a different perspective, though.

Benefits were "pretty pathetic" before the commission's report, said James Ellenberger, assistant director of occupational safety and health for the AFL-CIO in Washington. After the 1972 report, "there was a period of improvement, but that period fell far short of what the commission itself had recommended and what we thought was necessary," he said.

It took risk managers' skills to bring down the rising wage loss costs that helped cause the hard market.

From a risk manager's perspective, "the hard market was the best thing that could have happened to workers comp," said Billie Fae Fuschi, assistant director of workers compensation for Memphis, Tenn.-based Methodist Health Systems Inc.

"It forced employers to come up to the table, put their cards on the table, and revamp their systems," she said. That often required the services of a risk manager who could understand and cope with the complex issues, she added.

As a result, "I think there has been more of an emphasis on loss control."

For example, Tennessee's broad 1992 reforms require employers with poor workers comp experience modification factors to establish safety committees, she said.

In fact, workers comp costs seem to have steadily declined as risk managers' involvement in workers comp increased, said Anne Allen, assistant director for government affairs at the Risk & Insurance Management Society Inc. in New York. Her conclusion was based on comparisons between the organization's 1990 and 1996 "Cost of Risk" surveys.

In addition, employers were forced into self-insurance during the hard market, and many of them continued to favor that approach even after market conditions improved, Ms. Fuschi said.

"There was a tremendous growth in self-insurance as insurance companies' premiums increased so vastly," said Douglas Stevenson, a Chicago attorney and executive director of the National Council of Self-Insurers.

The percentage of self-insuring employers grew from about 20% in 1980 to about 34% by 1995, he said. Nationally, most of the increase was in individual companies self-insuring, though self-insurance groups were particularly popular in a few states like Florida, he said.

However, failures of national trucking companies in the 1980s heightened regulators' concerns about individual self-insurers' solvency and made them impose increasingly strict requirements on self-insurers.

The NCSI responded by encouraging the establishment of guaranty funds for self-insurers of workers compensation, which has increased to 29 currently from seven funds in 1985, Mr. Stevenson said.

Republican victories in state legislative races in the early 1990s also helped set the stage for major pro-employer changes. Those changes included making residual markets more financially self-sufficient, streamlining systems to reduce claims-related litigation and distributing benefits more equitably.

"Temporary total benefits became better distributed," said Richard A. Victor, executive director of the Workers Compensation Research Institute in Cambridge, Mass. As a result, workers at either end of the pay scale received more equitable compensation, rather than higher-paid workers getting too much and lower-paid workers getting too little, he explained.

However, having several states enact caps or shorten the duration of TTD benefits created still-unanswered questions about whether they helped or hurt workers comp systems, Mr. Victor said.

Permanent partial disability benefits are still "a mystery" because measuring the adequacy and equity of these benefits is still "an exceptionally difficult analytical problem," Mr. Victor said.

One of the key elements to properly calculating PPD benefits is reducing subjectivity, Mr. Oxfeld said. That desire has driven some states to adopt rules requiring that the American Medical Assn.'s guidelines be used to determine an injured worker's impairment rating and directly translated into his or her disability rating.

However, Florida, New Mexico, Oregon and Texas have adopted a "cutting edge" approach to PPD determinations by allowing consideration of other factors—like age and occupation—or longer benefit durations.

Meanwhile, new laws in several states have helped by streamlining administrative operations, reducing subjectivity in benefit awards and eliminating fraud, which has led to a reduction in litigation, experts say.

Two other general trends also have improved workers comp market conditions.

The incidence of non-fatal worker-related injuries and illnesses fell to 8.1 for every 100 equivalent full-time workers in 1995, the lowest rate in nearly a decade, according to a survey of private industry by the U.S. Department of Labor's Bureau of Labor Statistics released earlier this year.

In addition, workers comp costs were lowered by medical cost management, Mr. Victor said. For example, Medicare created incentives to reduce hospital stays and health care providers increasingly provided services on an outpatient basis.

"All of these efforts at controlling costs have even resulted in rate decreases in many states as cost trends have leveled

Continued on next page

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off," according to the NCCI.

The convergence of these developments in the past few years allowed workers comp to go from problem child to positive role model.

"I think we are in the best of times for seeing change. . .for the better," said Ms. Fuschi of Methodist Health Systems.

Employers are taking a more hands-on approach to dealing with problems and seeking solutions rather than blaming workers, she said.

For example, several businesses voluntarily adopted ergonomics programs that have been successful in reducing musculoskeletal disorders, according to the U.S. General Accounting Office (*BI*, Sept. 15). Such disorders may be responsible for as much as one-third of the $60 billion that private sector employers spend annually for workers' injuries and illnesses, according to the Department of Labor's Occupational Safety and Health Administration.

The federal government may help employers, too.

While Congress has banned OSHA from issuing a controversial ergonomics standard, OSHA is allowed to continue developing one. In addition, Congress is considering a proposal to let employers who want safe workplaces to obtain compliance evaluations from qualified third-party auditors (*BI*, Oct. 6). That proposal, part of the Safety Advancement for Employees Act, was voted out of the Senate Labor and Human Resources Oct. 22.

The improved climate is also seen in workers comp insurers' financial results.

The operating performance of workers comp insurers outpaced the rest of the property/casualty industry in 1995 and generated an underwriting profit for the first time in more than 10 years, according to the latest data available from A.M. Best Co. in Oldwick, N.J. The $733 million underwriting gain was an improvement of about $1.25 billion from 1994's $521 million underwriting loss.

While the combined ratio increased from 1995 to 1996, that was "largely due to heavy competition, rate reductions and a reduced level of reserve take downs from earlier accident years," according to the NCCI.

"Not only is there no widespread talk of crisis, but workers comp is becoming innovative," said the WCRI's Mr. Victor. "I think workers comp is increasingly being looked at by the non-workers comp disability management community for lessons about how to manage disability to facilitate prompt return to work and get good outcomes."

While both types of programs have a long way to go to manage outcomes, "the seeds are being planted," he said.

Future progress depends upon that because "I think we have picked the low-hanging fruit, and the next level of cost containment will be much more difficult to achieve. We'll have to measure outcomes to achieve it, to avoid reducing quality," he said.

This is also a time of great change for those involved with workers comp data and research using that data, he said.

Two new WCRI programs are designed to help shift the way state workers comp systems typically improve themselves from the historic cycle of crisis-reform-crisis to more continuous improvement, Mr. Victor said.

The institute's "CompScope" program is designed to measure the performance annually of state workers comp systems in meeting their goals. The WCRI has developed special statistical methods that will allow for meaningful interstate comparisons so the WCRI can benchmark states' performance in their searches for best practices. The first states to participate are California, Massachusetts, Minnesota and Pennsylvania, and more will be added later.

In addition, the WCRI's Disability Management and Benefit Integration program will emphasize finding "what works" by standardizing the measurement of outcomes and quantifying savings.

Better data generally will help large employers and workers comp insurers who represent medium and smaller-sized employers, to continue to control costs, said UWC's Mr. Oxfeld. He recommends doing that by hiring only qualified applicants, maintaining good labor relations, using sound claimant practices and monitoring legislative and regulatory activities.

He also encourages increased use of managed care in workers comp, which can benefit both employers and workers, if it provides better results for workers at lower cost.

However, one of the challenges facing the system is the new but growing sentiment that pro-employer system reforms have gone too far.

"I do believe that we are in an era where there has been a great willingness on the part of employers and insurers to exploit their power and either cut benefits or trim eligibility standards, in some cases unreasonably," said John F. Burton Jr., dean of the School of Management and Labor Relations at Rutgers University in New Brunswick, N.J. "It's a myopic strategy."

For example, total benefits—cash plus medical—paid to injured workers nationally declined 9.3% in the 1993-94 period, which was the third consecutive annual decrease, according to a new study he helped research. It was summarized in the July/August issue of *John Burton's Workers' Compensation Monitor*, just before he ceased being affiliated with that publication.

Current workers comp reforms that decrease workers benefits now seem to be totally out of touch with the modern human resource strategy of showing workers respect by empowering them in their jobs, said Mr. Burton, who chaired the 1972 national commission.

Indeed, business groups and labor are squaring off in Ohio in a statewide referendum in November over recent workers comp reforms sought by employers (*BI*, Sept. 8).

Overall, "we continue to be concerned about a couple of trends that seem to be part of the grand designs, mostly driven by insurers and some employer groups," said the AFL-CIO's Mr. Ellenberger.

He said those trends include restricting claims related to certain illnesses, injuries and workplace stress; lowering benefits by altering formulas for calculating them; introducing managed care restrictions on medical care and adoption of the American Medical Assn. impairment guidelines.

In addition, "there is a big difference between loss control and loss prevention," said Mr. Ellenberger. Some employers and insurers have been pursuing loss control to keep claim costs down rather than loss prevention, which prevents injuries or illnesses in the first place.

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A LOOK BACK

1987 • 1991

—1987—

● A California court is giving permission to the California Insurance Department to liquidate Mission Insurance Co. and four of its subsidiaries. The liquidation order ends more than a year of frenzied efforts to keep Mission alive. The Mission insolvency currently totals $520 million and may become the largest insurance company insolvency ever.

● New York Insurance Department Superintendent James P. Corcoran is suing Frank B. Hall & Co. and auditor Touche Ross & Co. for $140 million, charging they are responsible for the insolvency of Union Indemnity Insurance Co. of New York, a former Hall unit. The suit accuses Hall of "neglecting and abusing" Union Indemnity, which was ordered liquidated by a New York court in 1985, and accuses Touche Ross of knowingly approving false financial statements for Union Indemnity.

● Legislation being drafted by Rep. Rod Chandler, R-Wash., would give employers a new tax-effective way to fund their retiree health care liabilities. The legislation would allow an employer to make annual tax-deductible contributions of $2,000 per employee to a special retiree health care trust. The funds would earn tax-free interest. Business groups say their members would welcome a tax-attractive vehicle to fund the tens of billions of dollars in promised but unfunded retiree health benefits.

● Insurers say they will fight legislation introduced by Sen. Howard Metzenbaum, D-Ohio, that would gut the McCarran-Ferguson Act. Among other things, the legislation would bar the Insurance Services Office Inc. from analyzing claims information and publishing advisory rates.

● In one of the largest suits of its kind, Westinghouse Electric Corp. is suing all of its property and liability insurers since 1948 for the defense and indemnification of pollution claims against the company. The suits seeks coverage for the cost of cleaning up 74 separate hazardous waste sites nationwide and for responding to the hundreds of bodily injury claims filed by Westinghouse customers claiming they were exposed to toxic substances contained in the company's products.

● Competition in the property/casualty insurance market is accelerating. Brokers report that property rates are falling at least 25% while rates for most types of liability insurance are dropping 10% to 15%.

● Police in Britain and France have arrested five former officials of Alexander Howden Group P.L.C. on various charges of fraud or theft. The officials, including flamboyant former Lloyd's underwriter Ian R. Posgate, were arrested in connection with the siphoning of "millions of pounds" from Howden and its subsidiaries prior to 1982.

● The Pension Benefit Guaranty Corp. is returning three previously terminated pension plans, which have more than $2 billion in unfunded liabilities, to LTV Corp. The PBGC took its action after Dallas-based LTV, which earlier said it couldn't afford to contribute to its pension plans, set up a new low-cost pension program.

● The stock market crash is unlikely to cause the commercial property/casualty insurance market to tighten, even though the crash reduced insurers' surplus by about 10%. The record one-day 508-point drop in the Dow Jones 30 Industrials may restrain competition somewhat, but many experts believe lower rates are inevitable because the industry enjoys a glut of capital.

● The New York Insurance Exchange is closing its doors to new and renewal business following membership approval of an underwriting suspension. Syndicates stopped binding business Nov. 23 and agreed not to issue policies with effective dates subsequent to Dec. 31.

—1988—

● Some 59% of employers with more than 10,000 workers say at least one of their employees has AIDS. The Alexander & Alexander Consulting Group survey found that 10.1% of employers nationwide have at least one employee with acquired immune deficiency syndrome. Large employers were more likely to have employees with AIDS than smaller firms.

● As many as 50% of employers with 401(k) plans have had to cut back on salary deferrals to the plans by higher-paid employees in order for the plans to pass the tough non-discrimination tests laid down by the Tax Reform Act of 1986. In addition, employers say they are adding loan provisions to boost participation by lower-paid employees.

● Insurers, reinsurers and other industry officials conspired to manipulate the U.S. commercial liability insurance market, seven state attorneys general have charged in anti-trust litigation. As a result of the conspiracy, the Insurance Services Offices Inc. was forced to rewrite its new commercial general liability insurance policy forms to exclude all coverage for pollution and include a retroactive date in the claims-made CGL policy, the suit says. The suit names four primary U.S. insurers, ISO, the Reinsurance Assn. of America, six U.S. reinsurers, eight Lloyd's of London managing agencies, six British reinsurers and three reinsurance brokers.

● J.C. Penney Co. Inc.'s health care plan, under which an employee only can obtain coverage for a spouse who earns less than the employee is legal, a federal appeals court says. The 6th U.S. Circuit Court of Appeals said the plan did not discriminate against women because Penney had a "legitimate business reason" for offering the plan. Benefit experts note that as the number of two-wage earner families increase, more employers may try to limit coverage for an employee's spouse.

● Massachusetts Gov. Michael Dukakis signs legislation establishing an innovative "play or pay" approach to expanding health care coverage in the Bay State. Under the law, which is scheduled to go into effect in 1992, employers that have at least six employees would be have to pay a new $1,680 tax per employee to fund health care for the uninsured. The per employee tax can be offset for each dollar an employer spends on health care.

● Competition continues to heat up in the commercial property/casualty insurance market. Buyers renewing their coverages this spring are seeing rates fall by between 10% and 40% while also receiving better terms and conditions. Unlike the soft market of the late 1970s and early '80s, competition is now being driven by insurers rather than reinsurers.

● Employers are paying out far more in COBRA claims than they are taking in premiums from COBRA beneficiaries. Some employers responding to a *BI* survey say they are paying $2 in COBRA claims for each dollar of premium paid by former workers and spouses who purchase coverage under the Consolidated Omnibus Budget Reconciliation Act of 1985.

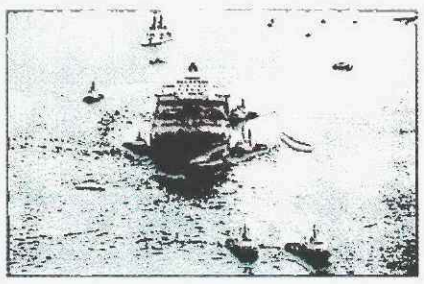
● The explosion of the Piper Alpha oil platform in the North Sea could produce a $1 billion loss, the largest man-made disaster in history. Some 164 people were either killed or missing. The 12-year-old platform, which was operated by Occidental Petroleum Corp., was insured for $790 million, while liability losses could exceed $100 million.

● The explosion of a Pan American World Airways jumbo jet over the Scottish town of Lockerbie could produce one of the biggest aviation losses ever. Underwriters are reserving $250 million to $300 million to cover claims arising from the crash of the Boeing 747, which killed all 243 passengers and about 15 people on the ground.

—1989—

● The Internal Revenue Service is preparing a new rule that could require employers with flexible spending accounts to cover employee health care expenditures they never intended to pay. Under the rule, employers would have to reimburse employees for health care expenses even if there was not enough money in the FSA to cover the expense. Employers would be out of luck if an employee quit before making new contributions to the FSA.

● Many benefit managers say they will continue to offer their employees coverage from Maxicare Health Plans Inc., despite the bankruptcy filing by what had once been one of the nation's largest health maintenance organizations. Employers say they will closely monitor service provided by Maxicare and hold special open enrollment periods if necessary.



● Exxon Corp. has at least $600 million of commercial insurance to pay for pollution cleanup and liability claims resulting from a massive oil spill in Alaska's ecologically rich Prince William Sound. About 10.1 million gallons of crude oil spilled from the Exxon Valdez tanker after it hit a rocky reef.

● Alexander & Alexander is questioning the ability of H.S. Weavers (Underwriting) Agencies to pay future claims. A&A says it is unable to determine Walbrook Insurance Co. Ltd.'s potential to meet future obligations. Walbrook writes most of the Weavers line slip. A&A, a major producer of business for Weavers, is instructing its brokers to obtain alternative quotes, leaving it to clients to decide if they want to buy coverage from Weavers.

● The Pension Benefit Guaranty Corp. cannot return to LTV Corp. three previously terminated pension plans and their $2 billion in unfunded liabilities, an appeals court says. The 2nd U.S. Circuit Court of Appeals in New York dismissed the argument by the federal pension agency that the Employee Retirement Income Security Act of 1974 gives the agency the power to return previously terminated plans after a company, like LTV, sets up new pension plans.

● Frank B. Hall & Co. will pay $48 million to the New York Insurance Department to settle charges that it was responsible for the collapse of former subsidiary Union Indemnity Insurance Co. of New York. The agreement, which calls for Hall to make an initial $19 million payment followed by installments over a 10-year period, settles a $140 million suit against Hall by New York insurance regulators.

● Insurance industry defendants in a massive antitrust suit win a big victory when a federal judge dismisses the 1988 suit by 19 state attorneys general. U.S. District Judge William Schwarzer in San Francisco essentially ruled that the states failed to show that the defendants engaged in a boycott, which would be a violation of the McCarran-Ferguson Act. The states are expected to appeal.

● Insured property damages from Hurricane Hugo, which ravaged North and South Carolina, Puerto Rico and the Virgin Islands, will be at least $4 billion, making it the costliest storm on record. The brunt of the damage was in South Carolina, where insured losses are put at $2.55 billion. In the Charleston area alone, more than 300,000 buildings were damaged. The flood of claims, though, is not expected to douse property/casualty rate cutting.

● An employer can prohibit fertile women from holding jobs that pose a significant risk to the health of their fetuses, a federal appeals court says. The 7th U.S. Circuit Court of Appeals says the "fetal protection policy" of Johnson Controls Inc., a Milwaukee-based manufacturer of lead-filled batteries, did not unfairly discriminate against fertile female employees.

● At least $1 billion in property damage claims are expected from a powerful earthquake that shook the San Francisco-Oakland area. The quake, which registered 7.1 on the Richter scale, resulted in the collapse of a mile-long section of the Nimitz Freeway in Oakland and the deaths of several dozen motorists.

● Section 89 is no more. The House and Senate vote to repeal the controversial part of the Internal Revenue Code that set massive and, according to employers, hopelessly complex non-discrimination rules for welfare plans.

—1990—

● The Washington Supreme Court rules that the costs of a government-ordered pollution cleanup are insurable. The Jan. 4 ruling marks the first time a state supreme court has interpreted standard language in the comprehensive general liability policy that states the insurer "will pay on behalf of the insured all sums which the insured shall become legally obligated to pay as damages."

● AlliedSignal Inc.'s trailblazing national managed health care program could save the industri-

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al giant $200 million in health care costs over three years based on the program's results during its first 18 months. AlliedSignal says the per-capita health care costs for the 43,000 employees enrolled in the program, initiated in 1988, now is about $2,450. That is 23% less than the $3,200 the company projected had the employees and the 70,000 dependents remained in a traditional indemnity plan.

● Despite pro-policyholder rulings by state supreme courts in Washington and North Carolina, the Maine Supreme Judicial Court says the costs of government-ordered pollution cleanups are not covered "damages" under comprehensive general liability insurance policies.

● The Internal Revenue Service proposes long-awaited pension non-discrimination rules, which interpret the pension provisions of the Tax Reform Act of 1986. The regulations, which are detailed in more than 300 pages, cover areas such as minimum participation requirements for pension plans, Social Security integration and non-discrimination tests relating to benefits and employer contributions.

● The merger of Corroon & Black Corp. and Willis Faber P.L.C. is expected to be a perfect fit that will create the truly global broker each had long sought to become. The combination will create the fourth-largest insurance broker in the world.

● State insurance regulators can require a risk purchasing group insurer domiciled in another state to be licensed in their states before the purchasing group can do business, the 11th U.S. Circuit Court of Appeals has ruled. Employers for now can continue to "restructure" their 401(k) plans to make it easier to pass non-discrimination tests, but the Internal Revenue Service may ban the new technique. Restructuring a 401(k) plan for testing purposes could mean the difference between passing and failing the non-discrimination tests, benefit experts say.

● Legitimate concern about insurers' real estate portfolios and unreasonable investor panic are fueling a dive in insurer stock prices, analysts say. A sharp downturn is sparked by the Oct. 5 announcement by Travelers Corp. that it is adding $650 million to real estate and mortgage loan reserves.

● A woman who contracted AIDS from her dentist is suing a dental preferred provider organization for its role in directing her to that now-deceased provider. If Kimberly Bergalis' suit against CIGNA Dental Health Plan is successful, it could increase managed care organizations' liability.

● Bloodstock insurers are facing their largest-ever claim after the death of Alydar, one of the most successful breeding stallions in thoroughbred history. Alydar may have been insured for more than $35 million.

—1991—

● Rep. Jack Brooks, D-Texas, introduces legislation—identical to a measure that died during the last congressional session—that would overhaul the McCarran-Ferguson Act and strip insurers of their key exemptions from federal antitrust law.

● The Persian Gulf War is creating chaos for risk managers, insurers and brokers worldwide. Because of the fighting, buyers and brokers are uncertain whether policies will cover terrorist acts prompted by the war; insurers have canceled terrorism coverage for energy-related risks so the coverage can be rewritten at a higher price; and aviation and marine war risk rates are rising.

● The U.S. Supreme Court rules 7-1 that the due process clause of the 14th Amendment does not mandate restrictions on punitive damages awarded by juries. The court rejects the arguments of business organizations that had asked the court to limit punitive awards. Instead, the court concludes that trial judges must properly instruct jurors on the purpose of punitive damages and calls for sufficient judicial review of punitive awards.

● A U.S. Supreme Court ruling that employers may not prohibit all fertile women from holding jobs that pose a significant risk to the health of their unborn children could increase liability and other costs for employers. The ruling is a defeat for Johnson Controls Inc., which had enforced a policy of prohibiting fertile women from working with lead, a known toxin.

● Concerned about the declining value of Executive Life Insurance Co.'s extensive junk bond holdings, California Insurance Commissioner John Garamendi has seized control of the insurer. Of Executive Life's $10.1 billion in assets, about $6.4 billion is invested in junk bonds, Mr. Garamendi said.

● Insured damages from a fire storm that roared through an affluent area of Oakland, Calif., could reach $1.2 million, according to insurance industry estimates. Although the loss is another blow to the catastrophe reinsurance market, it is not expected to force up prices in the commercial property/casualty market.

● Officials of a California county say a hold-harmless agreement will shield the county from liability in the death of a woman who was struck by a giant umbrella constructed on county land as part of a project by the artist Christo. The 20-foot umbrellas, each weighing almost 500 pounds, were deployed along California's Tejon Pass.

● Lloyd's of London members are resigning from the market at a record pace. Some 3,245 members have resigned from Lloyd's already this year, compared with 1,894 resignations at this time in 1990. The resignations will cause capacity at Lloyd's to be cut by 10% for 1992, officials predict.

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30 VIEWS

Thomas L. Schmitz

Insider on benefits outsourcing directs employers to new frontier

Thomas L. Schmitz is Hewitt Associates L.L.C.'s guru on outsourcing employee benefit plan administration.

Mr. Schmitz has led Hewitt's foray into benefit outsourcing since 1989, when he developed technology that integrated previously separate recordkeeping systems for 401(k) plans, flexible benefit plans and defined benefit plans.

Mr. Schmitz in 1990 took outsourcing another step, when Hewitt staffers dealt directly with participants in a 401(k) plan sponsored by General Dynamics Corp. During the next several years, Hewitt expanded its business of offering employers integrated data systems and direct handling of participants' 401(k) inquiries.

In 1993, Hewitt took what Mr. Schmitz calls "the next logical step" and began working with GTE Corp. to administer more than its 401(k) plan.

Lincolnshire, Ill.-based Hewitt now has 110 benefit administration outsourcing clients whose plans cover approximately 9 million employees and dependents.

Mr. Schmitz, 49, joined Hewitt in 1972. He has a bachelor's degree in business administration from Drake University and is a Fellow of the Society of Actuaries. He worked for a small insurance company in Ohio for a year and a half before joining Hewitt's Cincinnati office.

Mr. Schmitz, who holds the title of consultant, discussed the growth of outsourcing employee benefit plan administration with Associate Editor Deborah Shalowitz Cowans.

Q: Benefit outsourcing can mean many different things to different people. How do you define it?

A: Outsourcing technically can be defined as anything we do that employers could do for themselves. In the benefits outsourcing business, it's been defined a little bit differently than that. Even though we do software and recordkeeping for a client and they could do those things themselves, that was never really referred to as outsourcing.

What's referred to as outsourcing is the participant interaction portion of this. The benefits industry got into the business of outsourcing when we started to talk to participants directly and take phone calls. That was the dawning of the day of the age of outsourcing to this business.

For decades, employers have outsourced administration of their defined contribution and flexible benefit plans. What is so different about the benefit outsourcing that is occurring today?

Right now clients are asking us to administer any type of benefit plan. A lot more defined benefit administration work has been outsourced.

Another key change has been that whereas the administration that was done outside was primarily around flex enrollments or running a flex plan, now it's broadly around health care and all the other elements of group benefits.

The other piece that's been outsourced is all the interaction among all the third parties involved, particularly in the health care area. We would be heavily involved in the interaction from an eligibility and a billing standpoint, for example. And then the other piece, of course, is participant interaction.

PHOTO: MICHAEL MARCOTTE

Benefits outsourcing is growing rapidly. Is there some way to quantify the growth in both the field as a whole as well as your own growth?

Overall industry growth is pretty difficult to quantify. There's been quite a bit of fallout in the business as various competitors have really struggled to make the investment. I've never seen a number (quantifying) benefit outsourcing, but I read a number about HR outsourcing. The number was $30 billion.

Our revenue growth in our outsourcing business has been in excess of 50% each of the last two years. For our fiscal year ending on Sept. 30, 1997, our outsourcing business revenue was in excess of $350 million—(approximately) 50% of the revenues of Hewitt Associates. We're expecting another very high growth year.

What is driving the growth of outsourcing?

The early '90s, when outsourcing started to take off, was a time of focus on restructuring and cost reduction. Outsourcing seemed a means to do that, particularly with regard to staff functions.

I think it's moved beyond that. There's a decision made by an organization to outsource and it's a mix of factors. Clearly cost is part of that. Another factor is the way that the organization views the HR function. If delivery of benefits to their employees is not considered core to improving that organization's results, they've been pushing this stuff out the door.

The third major component is technology. As there's been much more choice in benefit plans, systems that were in place before just couldn't handle it. So clients had to make decisions about reinvestment.

Many clients are deciding that it doesn't make any sense for them to reinvest (in new technology) when they can go to an organization that spent that money and spread it over an entire book of business.

What types of employers are most likely to outsource?

I don't think there's a type. Our clients are very large to medium size to smaller organizations. Probably the growth in the next few years is going to be in the 5,000 to 20,000-employee range.

It's probably a multi-location employer that likely has had benefits activities spread around several locations and there's some efficiency by centralizing them. That probably rules out the single location hospital or bank unless they've got a technology need that's different.

A number of our clients are looking at restructuring, spinning off things, buying new things and they are much more nimble when they can turn to us.

What are the advantages of outsourcing from an employer's point of view?

Outsourcing allows the client's HR function to focus on more strategic, value-added activities. I would say that's the number one value that we bring. Also, there's a consistency of answers, a consistency of customer service and quality. And compliance clearly is part of why we're hired.

The next big thing is the access to newer technology. The next new benefit trend or direction—we're ready to do it.

How do corporate benefit managers' jobs change when they outsource benefit administration functions? What happens to corporate benefit managers' departments?

Its going to vary by the employer. The operational tasks are certainly the first to be outsourced, and that's where you're going to see some redeployment of those people or some reduction of staff. There may have been dozens of people doing clerical tasks and that's gone.

However, for the benefit managers themselves, and usually for a few other key staff members, it's likely that they get a chance to refocus time and energy on being strategic. And there's still the need to work with the service providers.

What types of benefit functions can be outsourced?

Benefit outsourcing today includes 401(k) plans, all types of defined contribution plans, defined benefit pension plans, flex plans, and broadly health care and group benefit plans.

We keep doing more for the client than we were originally hired to do. So now we're doing employment verification for mortgages, charitable contributions, new hire processing, policies and procedures. Those are all types of emerging things that a client might ask us to do.

What type of performance standards should an employer expect from its outsourcing vendor?

There should be a core set of performance standards that are measured for all clients so these standards can be benchmarked against the entire provider data base. Those would be operational, customer service type of standards. So the client should know how well it's being served compared with that provider's group of clients.

The second area would be a willingness to measure key areas specific to the client's needs or concerns.

The third would be an openness to financial risk as a result of meeting, exceeding or not achieving performance standards. If a client wants to put some fee to financial risk, there ought to be an upside for exceeding performance and there ought to be a downside when you don't make it.

A fourth area would be implementa

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tion. Is that organization willing to guarantee that they're going to meet the dates the client hired them to meet?

Stay focused on the key measurements. Probably something in the area of five to 10 measurements of performance standards at the start is adequate and just agree that you're going to build them over time. The right ones are going to emerge from the discussions you've been having on an ongoing basis with the client.

Is the outsourcing business profitable?

There is a rap on the business itself that nobody's making money. Hewitt Associates is profitable in its outsourcing business. It's funding the investments that we need and being profitable at the same time.

With that said, the outsourcing business has proven to be difficult for lots of people to make money in. There are investments in real estate, technology, people and training those people. The implementations are an investment in themselves. The market doesn't pay fully for the cost of implementation.

Have technological advances promoted outsourcing benefits administration?

I think to a certain extent the advances in technology have driven outsourcing. Clients just didn't want to keep making the investment necessary to add all the features necessary to offer their employees that competitive benefit package, that next plan design, or take advantage of the next technology tools. That's one twist.

The other twist is that the technology is clearly an enabler. If we had to answer every phone call, do every transaction just with people, we couldn't build the buildings fast enough. Voice response and the Internet are enablers of outsourcing. The integrated data bases that we've been able to create are enablers of outsourcing. So the technology's both a driver and an enabler of the outsourcing trend.

Consultants and others have made enormous financial investments in benefit outsourcing centers. If employees can get their questions about their benefit plans answered via the Internet, why would employers need consultants to run call centers?

The Internet is only a small part of what we're doing in the outsourcing relationship. The Internet is an access into employee information much like voice response is an access. It's got some opportunities to be a tool that you can use more effectively in some ways than voice response. For example, for things like modeling of a flex election or modeling financial security, its got much more capability than what you can do through the phone.

But the Internet does not deal with all the other things that are needed to support the outsourcing relationship or to provide benefits to the employee. It doesn't do all the kind of back room things that are necessary to create a loan from a 401(k) plan or write checks. It's not the recordkeeping system.

The Internet actually could increase the volume of interaction on benefits, not decrease it.

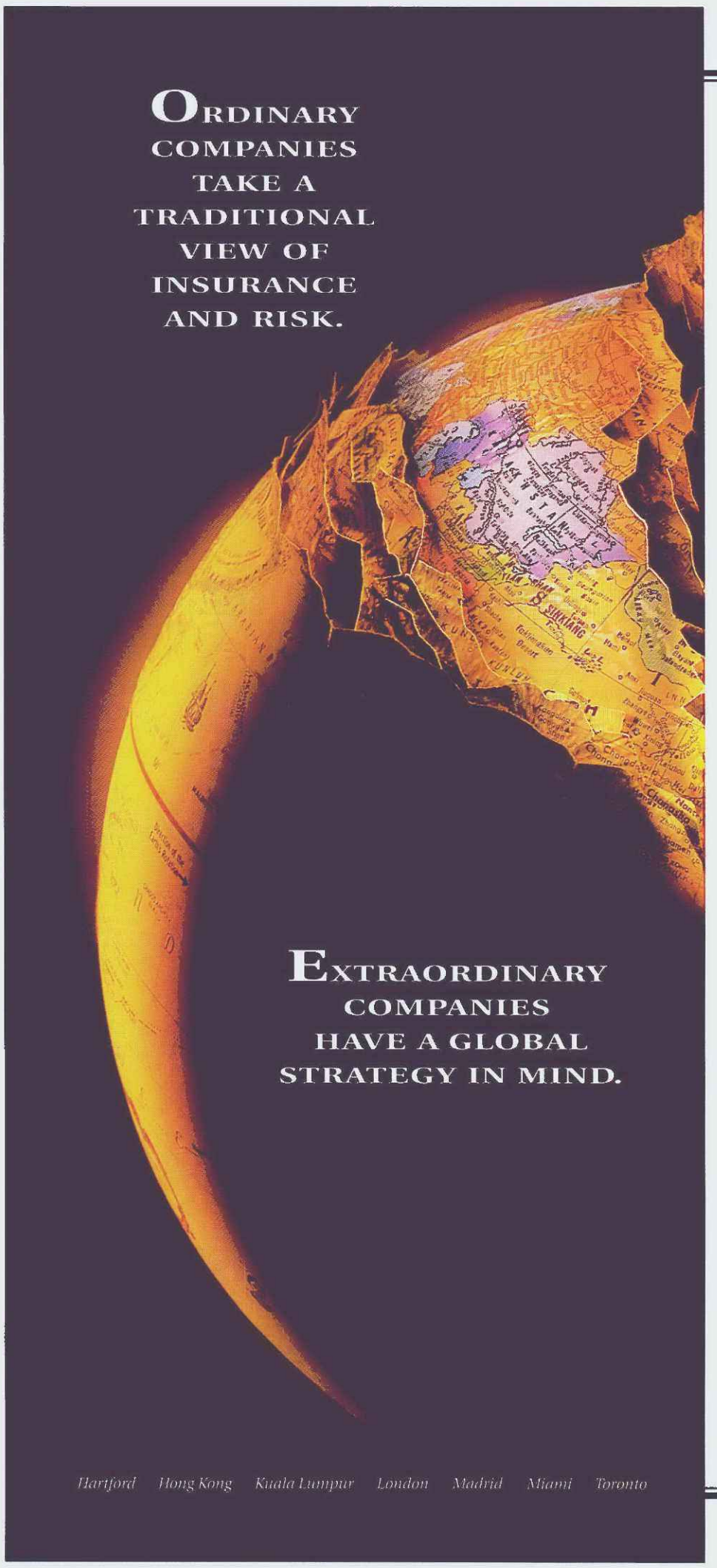
There are a couple of parallels you could draw to other emerging technology.

What did ATMs do to the banking industry? ATMs did not decrease the number of tellers; ATMs increased the overall access and transactional banking that went on. What happened with cellular phones? They didn't really decrease what we were doing at home; they just made us have more phone conversations. It's possible that's the way the Internet might take us.

Are we going to have fewer people answering questions from employees directly? So far, we haven't seen that and we don't think that's the direction.

Right now we're taking over 100,000 phone calls a day at Hewitt Associates for those 110 clients. About two-thirds of those are going into voice response. Those could be inquiries about 401(k) balances, moving money, doing flex enrollments or other kinds of transactional type things. One third of those calls actually end up with a benefits center associate on the phone.

I think the Internet is going to expand the total amount of interaction on benefits and only somewhat affect the redistribution of how these calls come in. I suspect the Internet is going to have more of an impact on the voice response piece than on the live portion. 30



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30 VIEWS

Victor E. Schwartz

General counsel discusses the past and future of product liability reform

The words "product liability reform" and the name Victor E. Schwartz are almost synonymous.

Mr. Schwartz, general counsel of the Product Liability Coordinating Committee, has been advocating reform since his days as chairman of the U.S. Commerce Department's Task Force on Product Liability and Accident Compensation during the Carter administration.

He also is a former law professor at the University of Cincinnati and currently a partner in the Washington law firm Crowell & Moring.

Mr. Schwartz, 57, recently discussed the past, present and future of the product liability reform effort with Washington Editor Mark A. Hofmann.

Q: Are we any closer to the enactment of reform legislation than we were when the reform movement began nearly 20 years ago?

A: I think we're closer for several basic reasons. First, President Clinton has indicated that he would sign reasonable reform.

Maybe more importantly this time is that the Congress has taken a cooperative view, and it's striking. Last time, a bill was introduced in the House and people who wanted more reforms wanted a stronger bill and moved the bill to make it stronger and better, but it was moving it away from where a Democratic president was and (away from) his constituency. This time, a bill was introduced in the Senate. When it was marked up, a number of changes were made to accommodate the president's veto. The members read the veto message and made changes.

The business community, which is never going to be one—it can't be, (business interests) vary like the colors of the rainbow—is more in harmony with itself than it was in the last Congress. Among the things the trial lawyers do to kill bills, one that the business community is directly responsible for, is divide and conquer. The fact that the business community is closer together helps.

In sum, you have the president say, "Yes, I will sign a reasonable bill." I accept that he's speaking in good faith; he did sign the General Aviation Recovery Act of 1994. This may be another reason. The fact is that GARA bill of 1994 was successful. And President Clinton, and all politicians, like success.

Here you have a laboratory animal, so to speak, in the crucible of federal product liability law—and it worked.

All that will make this a little bit different year. I'm not suggesting here it is, we finally are there. I am hopeful we are there.

Why has reform failed so many times?

The stars have not been aligned right. When you had Reagan and Bush, you had Republican presidents who would sign the bill and Democratic Congresses where the leadership would not let the bill fly.

I think all of us in the business community are fooled, just the way sometimes Charlie Brown is fooled again and again when Lucy picks up the football at the last minute, by the trial lawyers' No. 1 weapon, which is delay is denial. If somebody simply says we want you to delay something, it's easy to resist that. But delay often comes in very attractive clothing. One year we got bogged down for two months because we were told the consumer groups wanted to make a deal.

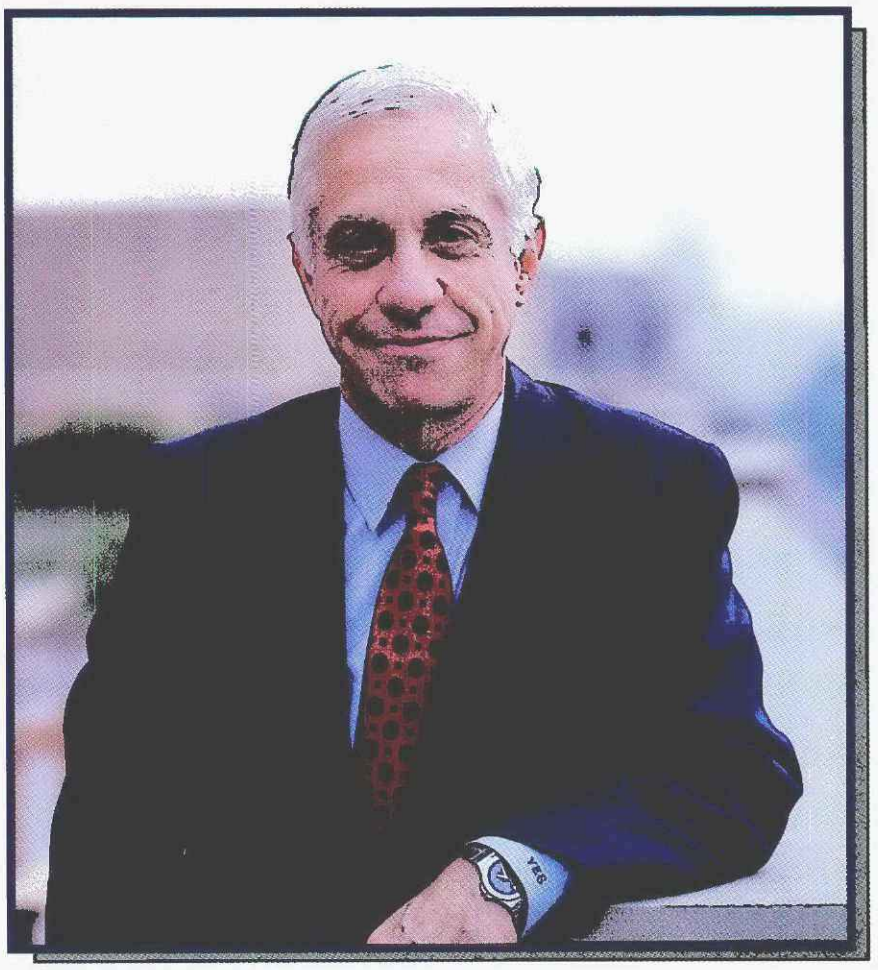

PHOTO: DAVID HITTLE

The consumer groups then met with Rep. (Henry) Waxman, D-Calif. He told them it was a mistake to have an agreement, and the whole thing fell apart. Whether that was planned from the beginning, I don't know But this I do know—delay is denial

Even now, I am hopeful that the White House initiative is real. Rep. John Dingell, D-Mich., and Sen. John D. Rockefeller IV, D-W.Va., helped place this in motion. My fear is this is another delay-is-denial thing, so that we spin our wheels, we get into 1998 and things plummet.

Finally, when you have legislation that has as much change as this legislation does, it is naive to think it will be done in a year or even five years.

From the time we had a republic, tort law—product liability being part of it—was made up by judges. The power to make tort law was delegated by the state legislatures to the courts. The state legislatures retrieved lawmaking in virtually every other area. But the law of torts stayed with the courts.

All of the sudden, in 1981, we come along and say there should be a federal product liability law.

So your argument is why should any legislature—state or federal—get into this area? So you have to make the argument as to why a legislature should do this. I believe one reason is when there are things that affect what we eat, what medicines we take, how much we pay for stuff, it's a public policy issue as much as taxes.

That's Step A. Step B is why should the federal government get involved? The last time before enacting the General Aviation Act in 1994 that Congress got involved in making tort law in any significant way was with the Federal Employers Liability Act of 1909. So you then have to justify, if a legislature is to do it all, why the federal government is to do it. Then, and only then, you get to the issue that's discussed in the press, which is content.

In this 20 years, we've had three mountains to climb. Should a legislature do it at all? Should it be the federal legislature? And only then, content. Most federal legislation only has one mountain—content.

Why has the trial bar been so successful in blocking reform? Can businesses learn anything from the trial bar?

I think they can. I think the trial bar has been absolutely unified even though (its members) have differences. On a public front, they've shown absolute unanimity.

Second, when the clarion call goes out, they act like they're 2 million people. There's only 58,000 members of ATLA. I've been told back in July that there were bushels of letters in the White House, telling the president to oppose this bill.

Do you ever see Congress passing product liability legislation? What changes have reform proponents made in their positions over the past 20 years? Is watering down the proposal acceptable?

I don't think watering down is acceptable. I think what is acceptable is to have whatever's in the bill to improve things for the public at large.

It's interesting what we took out and what we put in. When this effort began, the emphasis was on standards of liability for manufacturers: Liability for design, failure to warn or mismanufactured products. In 1990, those things were taken out of the bill because the courts, I think, heard the message from the federal government. A lot of legal literature was produced by this effort. The core of the early Kasten bills (product liability reforms introduced annually since 1981 by Sen. Robert Kasten, R-Wis.) in a sense became law by courts.

Two areas that were added and changed were, first, addressing joint liability. Joint liability was not in the bills until about seven or eight years ago. Politically, it does concern people to have somebody whom a jury thinks is 2% at fault or 10% at fault or 20% at fault bear everything.

Second, to try to put some limits on the amount of punitive damages. That was not in the bill until the last Congress.

Was there a moment when product liability legislation could have been enacted but the opportunity was squandered?

There has been more than one moment. I think that when the Republicans controlled the Senate in 1986 and you had a Republican president, the bill should have become law. But there was delay and delay and delay, people hoping more could be put in the bill.

1986 was the most important golden moment that I know about. If the bill had come out of the Senate, we could have mustered a majority in the House, we probably could have pulled the bill out of the Judiciary Committee. We would have had the momentum because you had the president of the United States and the Senate with a message. But delay squandered the opportunity.

The other opportunity was the one I spoke about earlier, when there was agreement between the business community and the consumer community, but I don't know if there is anything we could have done about it because Rep.

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Waxman and the consumer groups decided to reverse positions.

Which president was most sympathetic to the cause of federal product liability reform?

George Herbert Walker Bush. George Bush actually had an interest in the topic. When he would go out on the campaign trail he would throw that in and he would always get good applause.

The second most sympathetic administration is going to surprise you, in terms of importance, and it was Jimmy Carter. We wouldn't be here if it wasn't for President Carter—absolutely not. President Carter first allowed the federal product liability task force, which begun under Ford, to continue its work. President Carter approved of the Uniform Product Liability Act, which was model legislation for the states. But when it was put out, the Carter administration said: We'll try to do this at the state level, but if it can't be done at the state level—which was shown to be correct, because each state went its own way and treated UPLA like some shopping list—President Carter and his consumer people and his secretaries of commerce were the ones who were instrumental in seeing this was a public policy issue.

Has there been any change in the makeup of the pro-reform forces over the past 20 years?

In the beginning, you had just a few groups. It was trade association-oriented.

Now you have a very major entry by small business. In the past two years, the National Federation of Independent Business has gotten much more interested in this bill. The addition of NFIB and its 600,000 members is the most important thing politically on our side.

Secondly, you had a new group evolve called the Civil Justice Reform Group. These are larger businesses, and they've taken an interest in it.

Finally, I think the creation of the Product Liability Coordinating Committee is very important because it brought under one roof a lot of people who were separate. There's still pantheism in the world of product liability. But you went closer to monotheism with the development of the PLCC.

If a uniform product liability code is enacted, what is the next legal area businesses should tackle?

I think trying to find some standards across the board for punitive damages. I do think the punitive damage system desperately needs reform, way beyond the products area. Many of the awards are in areas other than in product liability and I do think it has an impact on all of us.

You need punitive damages. I don't think you have to destroy them—they have their place. But right now they don't separate the dolphins from the tuna.

One of the most egregious things is multiple imposition of punitive damages for the same conduct. Punishing somebody again and again and again for the same wrong, driving a company out of business before people have compensatory damages.

Do you think it is a mistake that juries and not judges decide product liability cases?

Absolutely not—I believe in the jury system. The problem has been that jurors have not received good guidelines. Jurors can only be as good as the instructions they are given.

It probably isn't well known that the genesis of the Risk Retention Act was a report you produced in the late 1970s recommending that buyers have a new alternative—risk retention groups—to the commercial insurance market. Today, only about 70 RRGs are doing business. Why are there so few? Does the small number indicate that the Risk Retention Act is a failure?

I don't think the Risk Retention Act was a failure. I think the Risk Retention Act accomplished what it was supposed to, and that was to make the commercial market competitive. Our idea was to have the industry be competitive.

Let's go back to 1978 when we drafted it. Ralph Nader and some of the consumer groups urged me to have federal regulation of insurance. I thought that was not a good idea. I thought it was politically impossible. Some in the insurance industry said to me, "It's all the tort system; you should know that. How can we set rates when no one knows what the rules are?"

But rates had been set without a database. So I thought, and people I worked with at the Department of Commerce thought, putting another competitive facilitator in the system would result in fair pricing.

The success of the Risk Retention Act has been that the commercial insurers have been fairer and used more market reality in their pricing.

I'll tell you one thing that surprised me, where I thought there would be more use of the risk retention groups and I was wrong. There's a second part of the Risk Retention Act that does not involve small businesses having to put capital in risk retention groups. It's called the purchasing group section, and that allows businesses to group together just like they would for health care insurance and buy liability insurance.

Where do you see yourself in 10 years?

In 10 years, I probably see myself in Florida some of the time. I want to always continue to work to the extent that God enables me to do so on public policy in the area of torts. The No. 1 thing I'm working on today is not federal product liability as public policy. It is to deal with the issue of legislatures vs. courts at the state level. I think there has been an invasion of the balance of powers between state courts and state legislatures.

As long as I'm alive, I'd like to work on issues that have a public policy benefit and help formulate reasonable public policy in this area. 30

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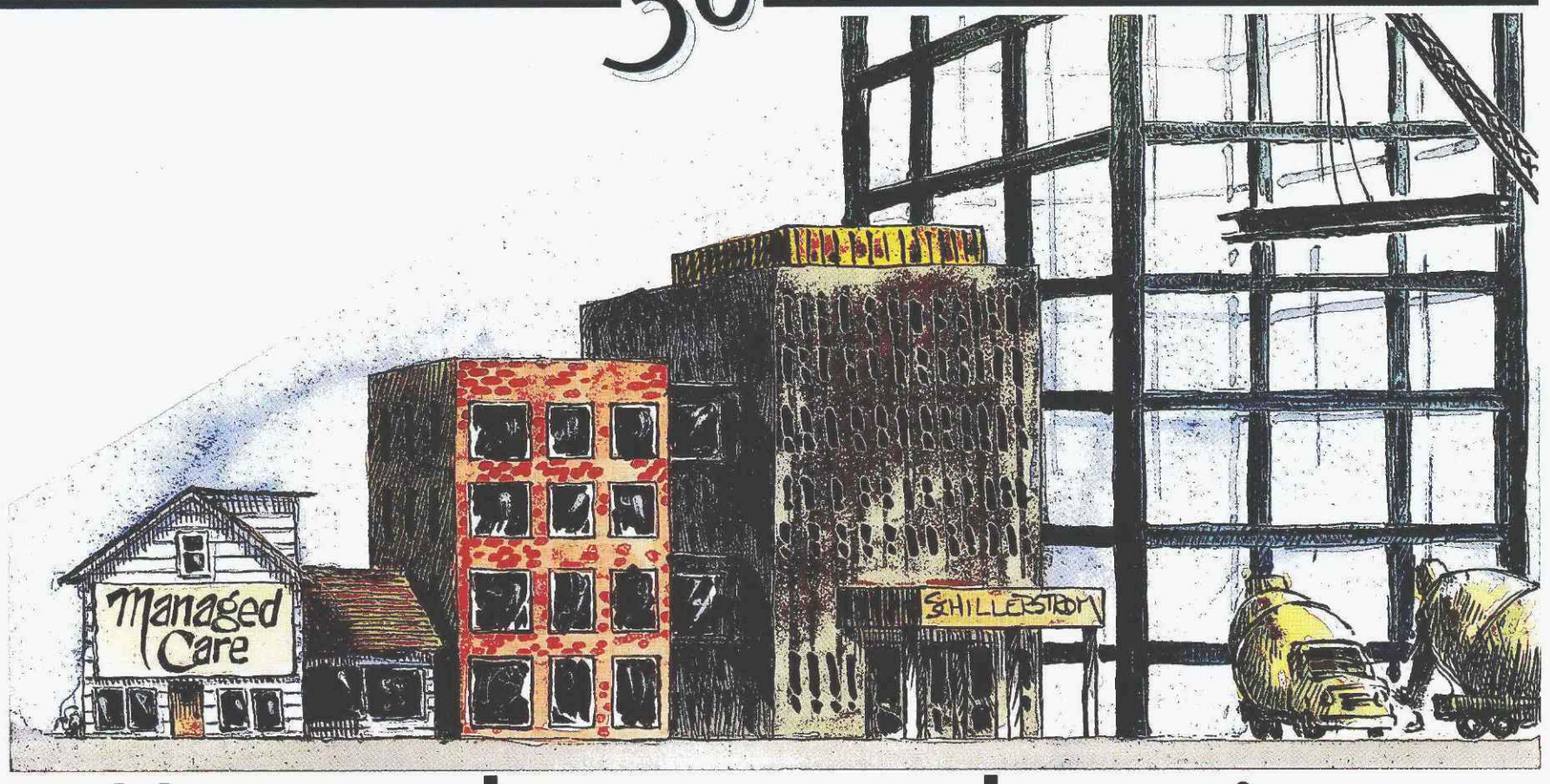

Managed care growth continues

HMOs, PPOs and POS plans redefine 'traditional' health care

By ROBERT KAZEL

The story of the nation's health care system today is the story of managed care, and the story of managed care can be summed up in one word: growth.

Managed health care has taken the nation by storm, particularly in the past five years, and by now is the norm for virtually all large plan sponsors coast to coast.

Traditional fee-for-service medicine still exists, but it is becoming a shrinking sliver of the health care pie.

Total HMO enrollment as of Jan. 1 was 66.8 million, according to the Minneapolis research firm InterStudy. Of those, 7.5 million were enrolled in point-of-service plans sponsored by HMOs.

That's a huge increase from just five years ago, when 36.5 million were enrolled in HMOs, with 1.5 million in POS programs. These statistics, compiled by InterStudy, also show that 10 years ago only 28.5 million people were in HMOs, or roughly 40% of today's enrollment.

Nearly 20 years ago, at the beginning of the HMO movement, there were only 132 HMOs serving 6.3 million people.

These figures do not include other types of managed care, such as preferred provider organizations, and indemnity plans with managed care features, such as gatekeeper access to specialists.

The rate of growth, as measured by the number of enrollees, has accelerated year by year. In 1993, the rate of growth for HMOs was 8.5% according to InterStudy. In 1997, it will be an estimated 13.0%, said Richard Hamer, InterStudy director.

According to consultant William M. Mercer Inc., the percentage of large employers offering a traditional indemnity plan declined to 52% in 1996 from 68% in 1993. During the same period, the percent of employers offering HMOs increased to 57% from 46%.

Managed care has been embraced by benefit managers because it has proven cost-effective and "created the potential for better quality health care," said Robert Dankmyer, vp of corporate benefits at Marriott International Inc. in Bethesda, Md. Fee-for-service medicine offered no such potential, he said.

"A lot more attention can be paid to outcomes and a lot more attention can be paid to best practices," said Mr. Dankmyer. Eighty-five percent of Marriott's employees are enrolled in 160 HMOs and 7% are in POS programs, he said.

Certainly, employers have moved in a big way to managed care plans because they are the clear leader in holding down costs. Last year, for example, HMOs cost an average of $3,185 per employee, $554 less per employee than the traditional indemnity plan cost of $3,739. Large employers can and have saved millions of dollars a year as employees have moved out of high-cost traditional indemnity plans into more cost-efficient HMOs and other managed care plans.

Benefit managers also say—in explaining HMO growth—that employees are very satisfied with the care they receive in HMOs.

For example, at Marriott, HMOs always are the most popular with employees on satisfaction surveys, according to Mr. Dankmyer. The company in 1990 introduced a POS option in 32 cities, but it still views its HMOs as "the plan of choice," he said.

Similarly, since starting its managed care program five years ago, Hershey Foods Corp. in Hershey, Pa., has achieved an 80% enrollment rate in managed care with high employee satisfaction, said Richard Dreyfuss, director of compensation and international benefits.

In California, where managed care gained its early foothold, 42.6% of the state population was enrolled in HMOs last year, according to InterStudy. A heavy concentration of the population in managed care, though, no longer is just a West Coast phenomenon: 47.1% of Maryland's residents were in HMOs last year, and in New York, which was slow to embrace managed care but now is a hotbed of HMO competition, nearly 31% of residents last year were enrolled in HMOs.

"It's moved from a fringe part of the employee benefit program to the main part," said Richard Ostuw, chief actuary of Towers Perrin in Stamford, Conn.

Managed care also has branched out to meet employees' varying needs and desires. Through PPOs and POS plans, choice has become the main selling point of many plans.

"Managed care used to equal 'HMO,' " said Pam Hastie, a principal at Buck Consultants Inc. in Chicago. She defines managed care as any system that exerts a measure of control over the patient receiving health care.

To deal with the increased choice, plan sponsors and employees both have grown smarter.

"I think the speed at which it's changed in the past couple of years is faster than in the past five years," Ms. Hastie said.

"Employees are much more aware than they have ever been. There is definitely more education in areas such as prescription drugs."

But the growth of managed care has not been without its share of problems and anti-HMO sentiment.

Beginning last year, public anger erupted amid reports that HMOs on occasion were denying care to the very sick or needy.

While these "horror stories" have been dismissed as anomalies by HMO executives, the industry acknowledges its practices from time to time have earned it a black eye.

"We need to do a much better job" of reassuring the public, said Kathy Swenson, senior vp of Oakland, Calif.-based Kaiser Permanente. Kaiser, which recently issued a patient bill of rights, believes managed care in general gets low marks in opinion polls for the same reason school systems or politicians generally get low marks—even though people give high marks to their own schools or public officials. People tend to feel alienated from social forces from which they feel removed.

With 8.7 million members, Kaiser is convinced its members are by and large happy, because few have voted with their feet, Ms. Swenson said. "Ninety-six to 97% of our members still choose the (traditional) HMO product," she said.

Health care plans need to react in positive ways to the negative media attention that has developed recently, said Richard J. Sinni, New York practice leader of Watson Wyatt Worldwide. The plans were extremely popular in the early 1990s but have come under attack recently by providers, the media and Congress. All these adversaries reinforce one another.

"They have to be aggressive and responsive," Mr. Sinni said of HMOs. "I think they have to be a little more proactive than they are."

Enrollment growth and a managed care backlash, though, aren't the only trends shaping the industry. Within the past few years, a wave of megamergers and acquisitions has swept managed care.

Large transactions have included the 1996 purchase by Aetna Life & Casualty, now Aetna Inc., of U.S. Healthcare Inc. for $8.9 billion; the 1994 creation of MetraHealth Cos., a joint venture of Metropolitan Life Insurance Co. and Travelers Corp.; and the subsequent 1995 purchase of MetraHealth by United HealthCare Inc. for $1.65 billion. Earlier this year, CIGNA Corp. bought Healthsource Inc. for $1.7 billion.

Investor-owned consolidations also included the 1996 acquisition of Fountain Valley, Calif.-based FHP International Corp. by PacifiCare Health Systems of Cypress, Calif., for $2.1 billion, and the purchase of Woodland Hills,

Continued on next page

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Calif.-based Health Systems International by Foundation Health Systems of Rancho Cordova, Calif., for $3 billion.

Experts attribute the frequency of mergers and acquisitions in the past five years to the failure of HMOs to maintain adequate profits in hotly competitive markets where the drive for market share has put pressure on rates.

For the top 25% of HMOs—based on profitability—profit margins hit 8.2% in 1994 but fell to 2.1% in 1996. The least successful HMOs in the industry in 1994 had a profit margin of 0.8%, but in 1996, their expenses exceeded revenues by 9.2%.

Because of their losses or paper-thin margins, HMOs warned they could no longer maintain the low rates plan sponsors had come to expect.

"I think the easy gains have been made," said Tom Billet, a vp in the Stamford, Conn., office of The MEDSTAT Group, a health care consulting firm.

A clear trend of the past five years is the tendency of employers to band together, hesitantly at first but then with increased confidence, to give themselves more leverage in negotiating with HMOs.

Purchasing coalitions have sprung up in every part of the nation with varying roles and degrees of success, with the ultimate goals of keeping costs down and ensuring quality.

The work of coalitions has led to a much broader network of physicians to choose from in the case of most HMOs, said Larry Boress, vp of the Chicago-based Midwest Business Group on Health.

Purchasing coalitions have been instrumental in helping compel HMOs to compete not only on price but overall value or performance, Mr. Boress said.

In some cases, such as the San Francisco-based Pacific Business Group on Health, this has led to detailed report cards intended for consumer use and readily available on the Internet or via toll-free telephone calls.

"Customer service has really moved up to the forefront," Mr. Boress said.

Purchasing coalitions that have stayed together and worked with managed care networks have been successful, he said, while those that have tried "bashing (health) plans" have failed, he said.

Many coalitions have done much to educate employers during the past five years, but like the MBGH and the New York Business Group on Health, many don't actually purchase health care on behalf of member employers.

"I have very large employers, and they feel alone they have leverage," said Laurel Pickering, managing director of the New York group. "They feel they have more power."

"I think (the coalitions) don't have the clout that's going to be necessary," said Ms. Hastie of Buck Consultants. "I think they're trying to do an awful lot on their own with some very good goals, but when they took on the responsibility of contracting and staying together to buy group insurance, there can be differences of opinion, and it can become political."

Still, purchasing coalitions recently have been instrumental in creating report cards to aid employees in their selection of health plans.

"Part of the philosophy of managed competition is that we need an accountable health care system," said Mr. Hamer of InterStudy.

"The ideal is that health plans eventually compete on the basis of price and quality. HMOs in most cases are quite happy to have their quality scrutinized," he said.

Such report cards, unheard of five years ago, now are seen as a key motivator for positive change among HMOs.

The inspection and measurement of HMO value can be considered a trend in itself. Whereas five years ago virtually all employers pointed to price as the sole criteria driving HMO selection, many large employers now are pointing to value—the ability to achieve stated goals and demonstrate that employees' health is being improved—as a criterion.

Some HMOs say they don't mind the scrutiny.

"Our relationship with (coalitions) is outstanding," said Jon R. Wampler, consultant to PacifiCare, which has 3 million commercial members in 14 states. PacifiCare maintains good relations with coalitions in order to improve itself, he said.

"Consumers for the first time will be able to dead reckon instead of putting their finger in the air and guessing which way the wind is blowing," he said.

"Now the employee is much more responsible," said Ms. Hastie. "I can't tell you what responsibility the employer should ultimately have. The onus is really going to be on the employee. They're going to have to make an educated decision."

The task of measuring HMO quality has fallen also in the past five years to a variety of organizations, including Washington-based National Committee for Quality Assurance, a broad-based independent group that accredits HMOs and reports performance data collected under its Health Plan Employer Data and Information Set; the Portland, Ore.-based Foundation for Accountability, a group founded by managed care expert Paul Ellwood and employers; and a host of benefit consulting firms with proprietary measurement tools.

"They're still concerned about cost, but they're absolutely concerned about value now," said Mr. Sinni.

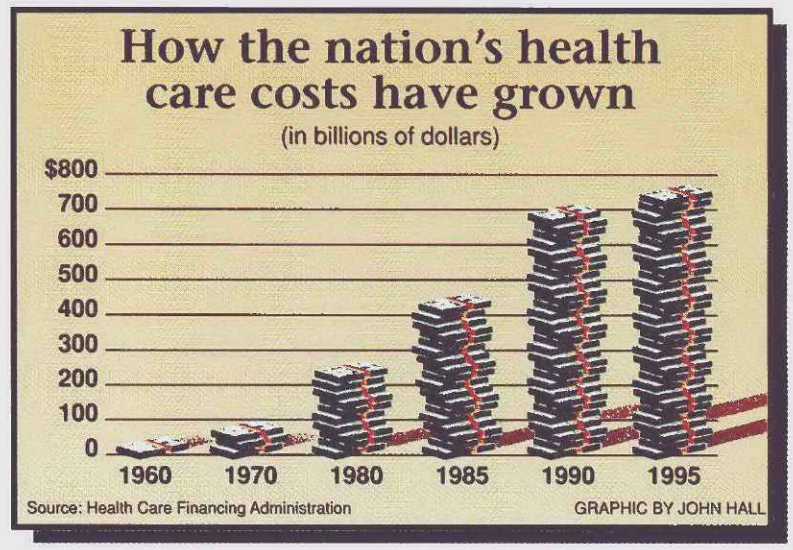
Another clear trend of the past five years, and one that has tended to mitigate the loss of profits in other areas, has been growth of Medicare risk HMOs.

By offering seniors benefit-rich packages in exchange for little or no copayments, and often by including outpatient prescription drug benefits, which Medicare does not provide, some HMOs have found a vast well to tap. In 1992 the product was barely known to seniors, said Kevin Counihan, senior vp of Waltham, Mass.-based Tufts Health Plan.

Today the company has 68,000 retirees in its two Medicare risk plans.

Mr. Wampler said PacifiCare has more than 1 million people in its risk HMOs, including 400,000 alone in California.

"It's a phenomenal growth story," he said, referring to its Medicare risk HMO. 30



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Ellen Thrower

Addressing challenges to strengthen The College of Insurance

Reviewing a decade of gains at The College of Insurance, President Ellen Thrower gives much of the credit to the College's board of trustees, board leaders and industry supporters.

Still, Ms. Thrower has presided over a remarkable renaissance at the College since joining it in 1988, a renaissance that has seen the school bring a huge debt burden under control, attract new corporate support, increase enrollment and expand academic programs.

Getting her to take the job wasn't easy: Then a professor and director of the Insurance Center at Drake University in Des Moines, Iowa, Ms. Thrower says she had no interest in becoming a college president and no desire to move to New York City.

A search committee of insurance brokers finally convinced her otherwise—"In some ways, I think I got broked," she says—and Ms. Thrower, 50, has never looked back.

She discussed some of the hurdles the College of about 730 students has overcome and some of the challenges it still faces in an interview with Senior Editor Douglas McLeod.

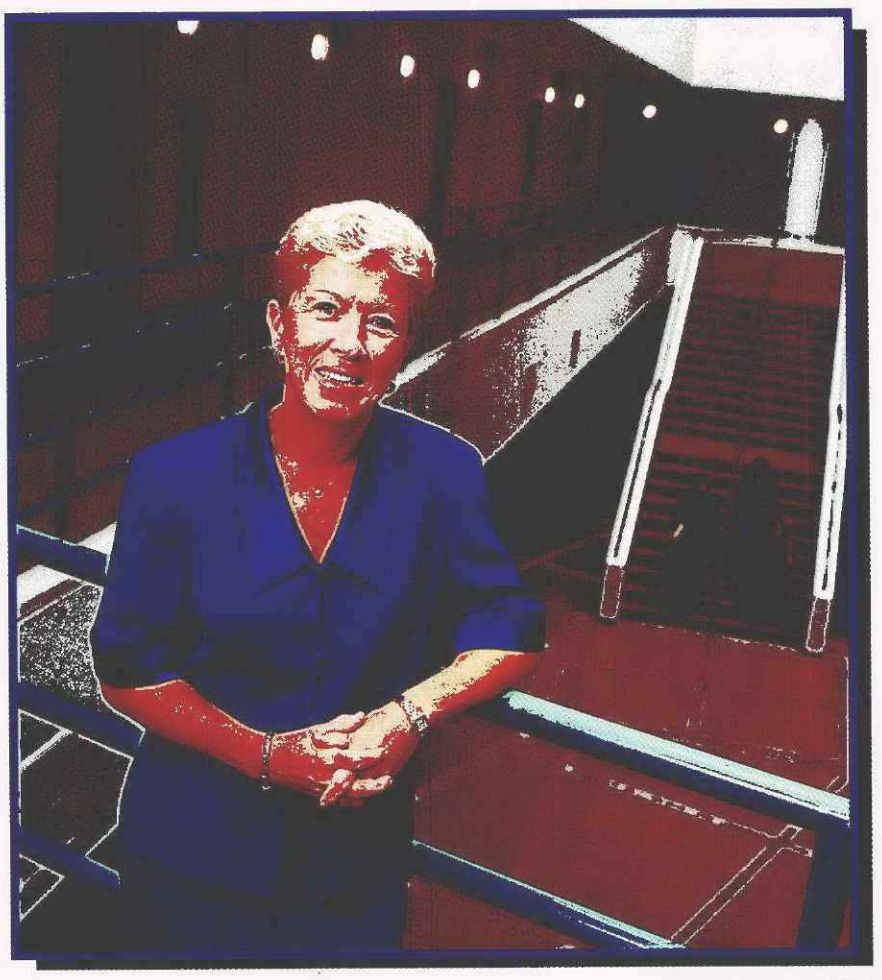

PHOTO: DAVID LUBARSKY

30 VIEWS

Q: Why was the College of Insurance formed? Why was it necessary, and what impact has it had?

A: The College was formed almost 100 years ago, in 1901, as a learned society. It was founded by insurance leaders who really came to passionately believe that there was a need for a good source of insurance education.

Over the years, the Insurance Society of New York evolved into a school of insurance, and then in 1962 we became a fully accredited college. So we are very close to our centennial, and we have been a fully accredited college for 35 years, offering an undergraduate baccalaureate degree that is firmly grounded in liberal arts as well as graduate level programs—an MBA and very soon a master of science in risk management.

What does the College offer in insurance education that differs from what other liberal arts colleges have to offer?

We're similar in our strong grounding in liberal arts. But our students select majors that are either in insurance or risk management or actuarial science or finance. Our students also have an extensive range of opportunities to blend theory and practice, such as through their cooperative work experience, where they learn things in the classroom and then apply them in their internships.

Our undergraduate and graduate students have terrific opportunities to meet today's industry leaders. They also have multiple job offers. Ninety-five percent of our students have jobs within 30 days of graduation. There are more job opportunities now than we have students graduating.

One of the things we've done is develop a partnership with nearby Pace University to give our students access to their liberal arts courses. By doing that we have significantly increased the richness of their liberal arts opportunities and at the same time have been able to focus significant resources on our area of core competency and what differentiates us, which is risk management, insurance and actuarial science.

We now have 10 full-time risk management, insurance and actuarial faculty. We'll be hiring two more full-time faculty next year, and we still have three endowed chairs, two $1.5 million chairs and a $1 million chair, that we expect to fill in the next 18 to 24 months. I believe at that time we would have one of the largest and finest risk management and insurance faculties anywhere.

We also, because of the significant enrichment of our faculty, have been able to do some very exciting things in the curriculum area. We have developed over the past year a new M.S., the master's of science in risk management and insurance, that I think is very cutting edge in many ways. There will be courses in alternative risk finance, financial risk management, derivatives, securitization—an awful lot of them current and emerging issues.

Have any companies told you how their College of Insurance graduates have performed vs. those from other schools?

We have heard from a number of companies that the students they hired with insurance majors from The College of Insurance generally advance faster and the retention is significantly better. The reason for advancing higher is I think they are better prepared. When they graduate, they don't really need the same level of education and skills-building that students who don't know anything about the industry do.

The retention of students with that background, we are told by companies, is far greater. They may lose some of these students that they hire, but if they do, it's typically to competitors vs. to a manufacturing group or something else.

Is it a good thing that they're losing them to competitors instead of to other industries?

You know, it's an interesting thing. While they hate to lose good young people that they have hired, they really believe that ultimately the industry is better off because these people are in the industry. As we have fewer amateurs and more professionals, the industry overall is better.

What kind of impact have College of Insurance students had in the industry?

It's tough to answer. First of all, if you look at our 97-year history, we have really provided education to literally tens of thousands of individuals. Many leaders of today have taken certificate programs, courses, special seminars at The College of Insurance and even earlier at the School of Insurance. And if you look at the leaders today who have studied at the College in a variety of areas, it is significant.

In addition, we've always had a special emphasis on opportunities for students at the economic margin. And so I think it's also providing a lot of educational opportunities to first-generation college students, sons and daughters of immigrants, students from all over the world. A third of our students now are minorities, and so I think we have played an important role in attracting a lot of very bright young people who would otherwise either not have come to this industry or would not have had the opportunity for a college degree and a good professional career.

There's another area where I believe we've had an impact: Through a significant range of professional education courses and programs, we have been accessible to a lot of employees working full time who would like to become better or improve knowledge and skills. We have been a good source of what everyone is referring to now as lifelong learning.

One last area: Our library has the oldest and most extensive insurance collection in the world. It was also formed at the turn of the century and is endowed by Kathryn and Shelby Cullom Davis. Our library is a repository of historical and current information about insurance and financial services that I believe is second to none.

In getting to where the College is now, what are the toughest hurdles it has had to overcome?

We have a beautiful campus; it's one of our greatest assets. When I arrived in 1988, it was one of our greatest liabilities.

There was a significant amount of outstanding debt that was taking so much time and attention, it really did not enable the College to pay attention to an awful lot of areas that it needed to. So probably the most pressing issue was finding ways to begin resolving a terrific debt problem. I can say with the help of the C.V. Starr Foundation and Hank Greenberg, who's been a trustee of our College for 25 years, a challenge gift program was established, designed to pay off the debt. And we are at a point where we're very close.

Has the College faced other challenges?

Developing relationships and partnerships with insurance companies, insurance groups, realizing—and I think we did this early on—that they are customers of ours, just like our students and their parents. They make investments in this institution and they hire our students, and we need to meet their needs.

Also, to really reach out to our alums. The president of the alumni association now is automatically a member of our board of trustees. When I arrived here 10 years ago, we didn't know who our alums were. And they're some of the strongest evidence of the value of our education.

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And I think the last challenge when I arrived 10 years ago was to deal with a fragmented board of trustees and begin building and developing and enriching the board. I think today the board of trustees is one of our finest, most important resources.

What was fragmenting the board of trustees?

I think there was a lot of attention on the building debt. I think we had a number of trustees who were on the board because they were told to be, because it was an assignment by their company, so they didn't really understand the College. I think today if you look at our board of trustees, they're here because they care about the College, they really are investing in our vision of becoming a world leader in insurance and risk management education.

Is the College where you would like it to be today, or do you see other problems or challenges you need to work on?

I think the College is progressing, but we have a ways to go. We need to continue to enrich our intellectual resources. We need to be far more influential in the research area in terms of identifying research issues that are really important, whether they involve company policy issues in the insurance industry or problems and challenges that companies and various industry groups are facing or will face. Our faculty intends to be a major player in this area.

One of my biggest challenges I think is to work with the board to identify ways to increase our endowment and to really generate long-term investments in the College by the industry.

It's rare to see a private, non-profit college or university operate well without a reasonably significant endowment. The nature of colleges and universities is such that tuition doesn't provide 100% of the costs. It never does. And through annual support—which is really the lifeblood of any institution—and significant endowments, we are able to provide scholarships, additional faculty support, which could be through chairs, distinguished lectureships. And increasingly the big need is in the information technology area. This is a universal challenge right now: There's very little extra money or venture capital to invest in the technology that we really have to be invested in.

Have you seen a change in that? Have more companies been willing to support the College?

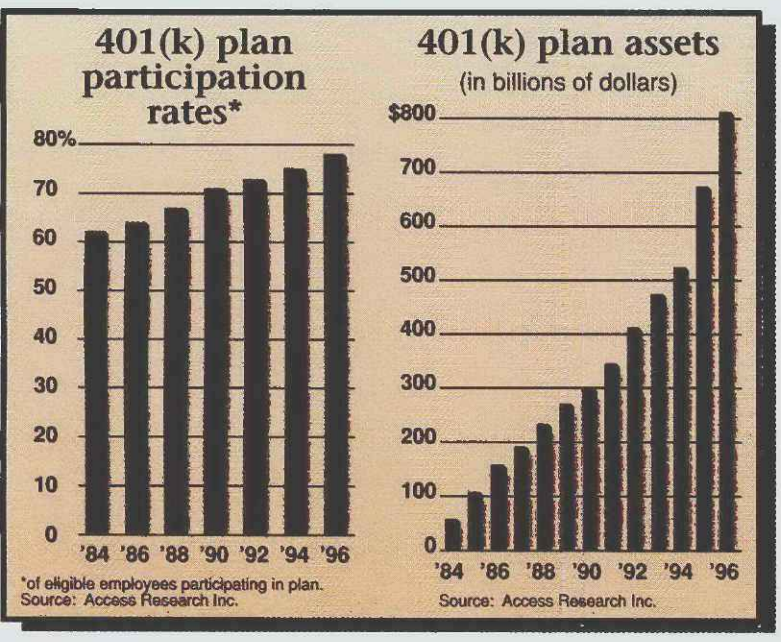
It's significantly increased. I can't guess the magnitude. . .it's well above 1988, when there were fewer than 50 companies that were providing financial support to the College. In our last campaign, we had more than 300. We now provide educational programs not only in New York but through a variety of partnerships with groups. We offer programs in the Midwest, on the West Coast and in a number of countries. We have several programs that are under way throughout the year in Bermuda. As we expand our ability to really be a resource to the industry, not only throughout North America but beyond, we will continue to see companies hopefully interested in investing in our college.

Another challenge—and it sort of ties in with the endowment—is that we see this incredible wave of mergers and acquisitions.

So often, mergers involve companies that are supporting the College. When we see mergers and acquisitions, inevitably there are fewer employees that are going to be taking courses, and there is an impact on the financial investments and support of individual companies. That has really added pressure to our need to establish a permanent, reliable source of support for scholarships, for growth with this institution.

Do you see the College playing any significantly different role in the future than it has up until now?

While our focus is always going to be on insurance, we are far more focused in terms of our curriculum and our educational focus on risk management, risk financing and what we see as the changing world of insurance and financial services. 30



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Terry Van Gilder

Former underwriter bets future on catastrophe modeling's success

Terry Van Gilder's insurance career began in 1971 as an underwriter for Chubb's Department of Financial Institutions. Mr. Van Gilder eventually rose to the position of executive vp of Chubb & Son Inc. and chief underwriting officer of Chubb Group in Warren, N.J.

He left Chubb in 1995 to become chairman of Menlo Park, Calif.-based Risk Management Solutions Inc. RMS is widely known for its computer catastrophe models that are now used throughout the insurance industry and have, in some cases, replaced traditional actuarial methods.

Before leaving Chubb for RMS, Mr. Van Gilder helped spur a research and development relationship between Chubb and RMS. Chubb became an investor in RMS through Morgan Stanley's Merchant Banking Group. Mr. Van Gilder also encouraged Chubb to become a shareholder in Bermuda-based Cat Ltd. The idea to form Cat Ltd. was born at RMS, in part as a vehicle for testing the underwriting capabilities of RMS' software.

Mr. Van Gilder, 53, recently purchased a historic restaurant and inn that dates back to 1755 and is located on the eastern shore of Maryland. He is overseeing its restoration and business development. He also is a board member for RMS, which continues developing new systems that could shape insurer and risk management operations.

Mr. Van Gilder recently spoke with Associate Editor Roberto Ceniceros about catastrophe modeling and RMS' role in the evolving relationship between insurers and reinsurers.

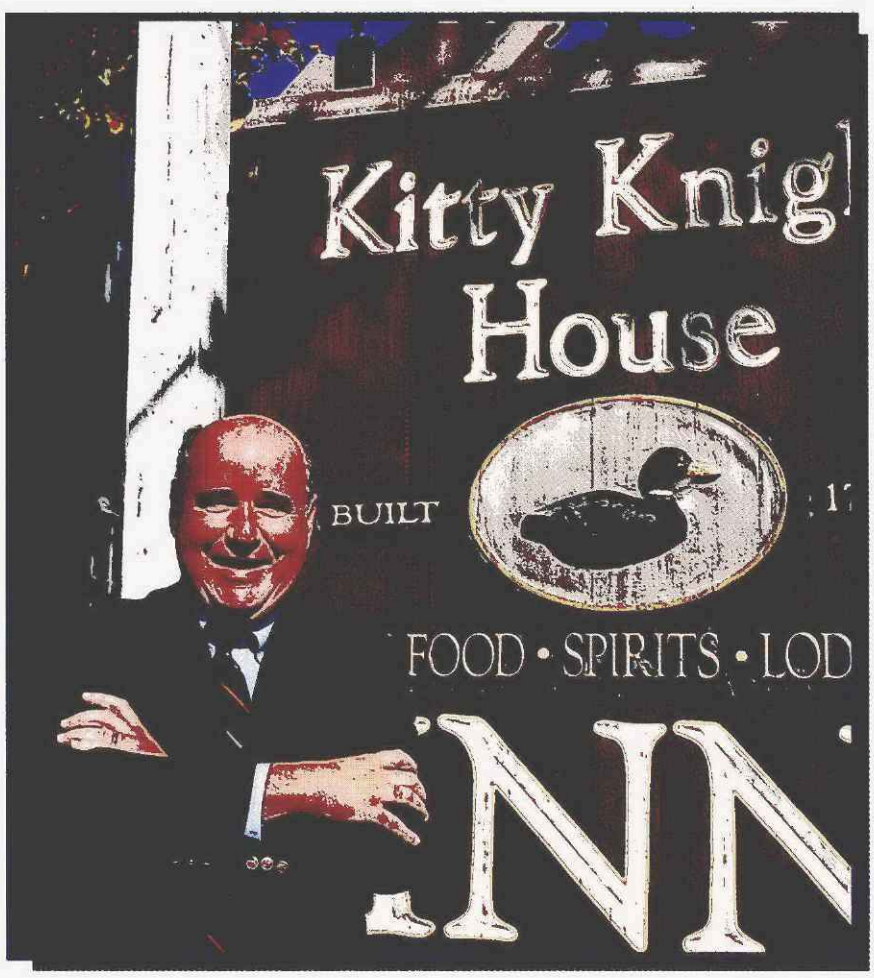

PHOTO: DAVID HITTLE

Q: What drew you to catastrophe modeling?

A: As senior underwriting officer and then as chief underwriting officer at Chubb, one of the issues I was trying to deal with—and the whole industry was trying to deal with, although it was just in its very early stages in the late 1980s—was this whole issue of managing catastrophe exposures.

Most insurance companies, even today, have not equipped themselves very well to deal with catastrophe exposures. They have a very difficult time understanding their accumulations.

I just felt the tools available to us and the techniques that we were using, although tried and true from a traditional perspective, were not adequate for the task.

So how did you get involved with RMS?

I was looking for people or companies who could help me manage catastrophe risk better. It was a concerted effort. Then we bumped into some RMS people at an industry conference.

By comparison to what RMS does today, it was a real little program then. At that time, they were not even sure if the insurance industry would be a significant customer base. They were mostly technical and engineer oriented.

What I did that was beneficial to Chubb and RMS is I entered into a research and development relationship. They were helping me figure out how to deal with the set of issues that I had and I was helping them figure out how to deal with insurance companies, how the product should be developed, how they should explain it and why it would be useful.

How many clients does RMS now have?

We have about 370 clients. Virtually every significant insurer and reinsurer in the world is a client of RMS.

So has RMS data played a role in the evolving relationship between insurers and reinsurers?

Oh yes. In many cases, reinsurers are much more knowledgeable today and involved in the affairs of the primary companies they insure. That is usually on a cooperative basis, not on the basis of imposing themselves.

And they are using the software that we create for them and the methodology around it to not just understand what primary companies are doing, which was the original purpose of most reinsurers.

They also manage their capital more directly and we have a whole set of tools that pertain to that.

How long has that been happening?

I would say since the early '90s.

Have reinsurers been assuming even greater influence in the business of primary insurers?

The greater involvement and the insistence on the part of reinsurers that they understand what the primary companies are doing—and by understanding it, then seeking to alter their behavior in some respects—grew out of a couple of issues, including the explosion of tort liability. That caused people to view casualty reinsurance very differently, and caused capacity constraints and differences in terms and conditions, many of which were imposed by reinsurers.

How has your involvement with RMS shaped your view of the industry?

That is how I came to believe—and I still believe—that the future of the industry very much lies in becoming more sophisticated in the use of automation. Companies have traditionally equipped themselves with systems that are really oriented toward reducing the cost of transactions and keeping statistical records.

Still, it is rare to see on an underwriter's desk a very sophisticated piece of equipment that pulls in information from a variety of sources and allows better decisions to be made that relate to the rest of the organization, such as its entire financial situation. RMS today is working with a number of clients on building workstations that do that.

In many respects, the insurance industry as a whole has been very conservative and slow in utilizing more sophisticated means to understand its business.

It has to adopt better analytical tools that help determine which way to take a company. They're either going to find ways to utilize methods and tools appropriate for the industry or they are going to suffer rather badly in competition or in comparison to other financial institutions. If they don't get a better grip, they are either going to fall by the wayside or become part of something else.

What are the shortcomings of the traditional underwriting methods, such as evaluating a risk's probable maximum loss?

The problem I see with much of the industry is that what they are doing is very static. It is the dynamic part of the book of business that is interesting.

That is what is wrong with looking at individual risk PMLs. They look at a static deterministic event, at one thing. But the range of possible events, the probability associated with them, and the magnitudes of all those things have a lot to do with it. That risk is part of a book of business. It doesn't exist by itself and you can make thousands or hundreds of thousands of decisions in an accumulated book of business and it will kill you because you are not managing the dynamic quality of it. You are not managing the total of it. You are managing individual risk decisions.

The concept I tried to get infused into RMS is optimization. You are not just randomly presented with risk and selecting risk. If you are alert, you are purposely going about business in a particular way, so as to attract certain kinds of business and take it into your company in a particular way at a particular price level and under certain terms and conditions because it makes sense in the total context of what you are managing.

There have been optimization theories applied to portfolio management in other kinds of financial institutions for years. This is not new, but it is real new in the insurance industry. The idea is that you conscientiously go about constructing a portfolio of a particular type.

Where does that lead an insurer?

Strategic capital allocation. It's a concept I was working on at Chubb several years back and some companies have a sense of it, some do not. It's basically about a pool of capital you are trying to employ and produce a return on.

There are an infinite number of ways you can deploy that capital: You can underwrite risk, you can invest in bonds, you can invest in other things. It really gets into the question of the possibilities you have available to you. Are you employing your capital in the most logical way to produce the best return?

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Most insurance companies until very recently didn't.

So what we are trying to do today is work with insurers and reinsurers more on the concept of strategic capital allocation. You have this list of things you can do.

Do they produce an ultimate book of business that you look at and you say, "This makes sense. This is who we want to be. This is who we are. This is what we have the expertise to do and this produces a meaningful return in the context of whatever we say to our shareholders we are going to achieve."

It's very difficult for companies to do that.

There has not been a lot of expertise focused on that issue in the industry overall, although you will hear a lot of lip service. It's about developing a model of the business which takes into account, much like we do in the catastrophe area, various contingencies that are likely to occur, how likely are they to occur, what trends look like.

Some of it is based on traditional actuarial methods and some of it is based on our own expertise in terms of analyzing a series of events and the probabilities associated with them and things that can randomly skew results, much like hurricanes do.

We are applying those same skills of catastrophe modeling to the issue of managing an overall portfolio of disparate things and then trying to pull that all together into some body of material that can be communicated effectively, not just to management but throughout the company.

This is what we do in the catastrophe arena every day for companies.

So, you are helping insurers lay out goals and over time change their risk mix?

Sure. And become in the process much more successful entities that can survive in a hostile environment and have a much better grip on what they are doing. Those are really the issues. That is a very unique new thought process, the ability to lay out a sophisticated model.

Are you doing anything similar for risk managers?

For corporate clients—who are working on a broader sense of risk management and working on managing the overall risk of a corporation, but have traditionally looked at the downside of risk—we are trying to apply the analytical skills that we have to the issues of quantifying, mitigating and managing risks, whether or not it has anything to do with natural hazards.

We are taking RMS people who have backgrounds in software development, engineering, statistics and actuarial areas and applying those skills to broad corporate issues of managing risks in a very different and more intelligent way.

The idea is there are upsides and downsides to risks. There is also the question of maximizing the upside, and can you figure out over time what things are more likely to lead to a positive result and lessen your focus on cutting off the downside risk?

The question is, can you figure out which things are more likely to be more productive or lucrative for the company to do? It's very much in the research and development stage. 30

10 largest U.S. fire losses

(in millions)

Year	location	estimated loss	in 1995 dollars
1906	San Francisco earthquake/fire	$350	$5,915
1871	Great Chicago Fire	168	2,129
1991	Oakland, Calif., fire	1,500	1,678
1872	Great Boston Fire	75	951
1989	Pasadena, Texas, chemical plant	750	923
1904	Baltimore fire	50	545
1992	Los Angeles riots	567	616
1993	Orange County, Calif., wildfire	528	557
1995	Massachusetts textile mills	500	500
1942	U.S.S. Lafayette	53	496

Note: Loss estimates from 1984 Fire Almanac for fires occurring before 1984. Adjustment for '95 dollars based on Consumer Price Index.
Source: National Fire Protection Assn.

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Stephen Wiggins

Managed care innovator bemoans demonization of industry

The customer is always right. That philosophy is tailor-made for a retail store, but can it also serve as the credo of a health maintenance organization?

Stephen Wiggins, chairman and founder of Norwalk, Conn.-based Oxford Health Plans, has built the nation's fastest- growing managed health care plan by listening to members' needs and responding with innovative, sometimes risky, products.

Mr. Wiggins, 41, started his company in 1986 with a modest amount of venture capital. The HMO's revenues exceeded $4 billion with 1.9 million members as of 1996. It is one of the fastest-growing companies in the nation, in spite of suffering a major downturn in the stock market last week after reporting it would post a quarterly loss.

Before founding Oxford, he created Accessible Space Inc., a non-profit health care company that develops long-term care facilities for severely handicapped people. He spearheaded that venture after his best friend was paralyzed in a diving accident.

Among Mr. Wiggins' many innovations at Oxford has been the recent approval of coverage for treatment by alternative medicine specialists, such as acupuncturists and massage therapists.

Oxford also recently announced it would allow physician specialists to take cases directly from patients instead of demanding that members go through gatekeepers.

Mr. Wiggins recently talked to Associate Editor Robert Kazel about how Oxford fits into the managed care world.

30 VIEWS

Q: It appears consistently in polls and surveys that people like their personal HMOs, but that they dislike HMOs as a group. What are the implications of that for the industry?

A: That's consistent with the most vocal critics being always outside the industry. They've always been non-members. The press has clearly demonized our industry. It's easier to write a sensational news story and anecdotes rather than systemic fact, which seldom gets reported.

For HMOs, systemic facts are very positive and do a good job on almost all fronts. But perception is reality, and we must respond and give consumers greater assurance.

In this battle of anecdotes, how can managed care companies fight back and how has Oxford fought back?

I think it's most important to fight back against this perception through the behavior and integrity of the company by delivering quality service, by delivering health services responsibly. At the same time, I think the industry will have to accept regulation and perhaps a new framework for governance to assure that transgressions that might occur are less likely.

Can you explain what you mean by that?

President Clinton's health care commission has been formed to address quality and will soon release a proposed patient bill of rights. Many of the rights being considered pose new obligations on HMOs.

In some cases, they require complete changes of the HMO or internal review by a third party of medical necessity determination after an internal review has taken place. Health plans will have to accept more micromanagement by government in the future.

How much management by federal and state governments are you willing to accept and do you deem it good or bad for the industry as a whole?

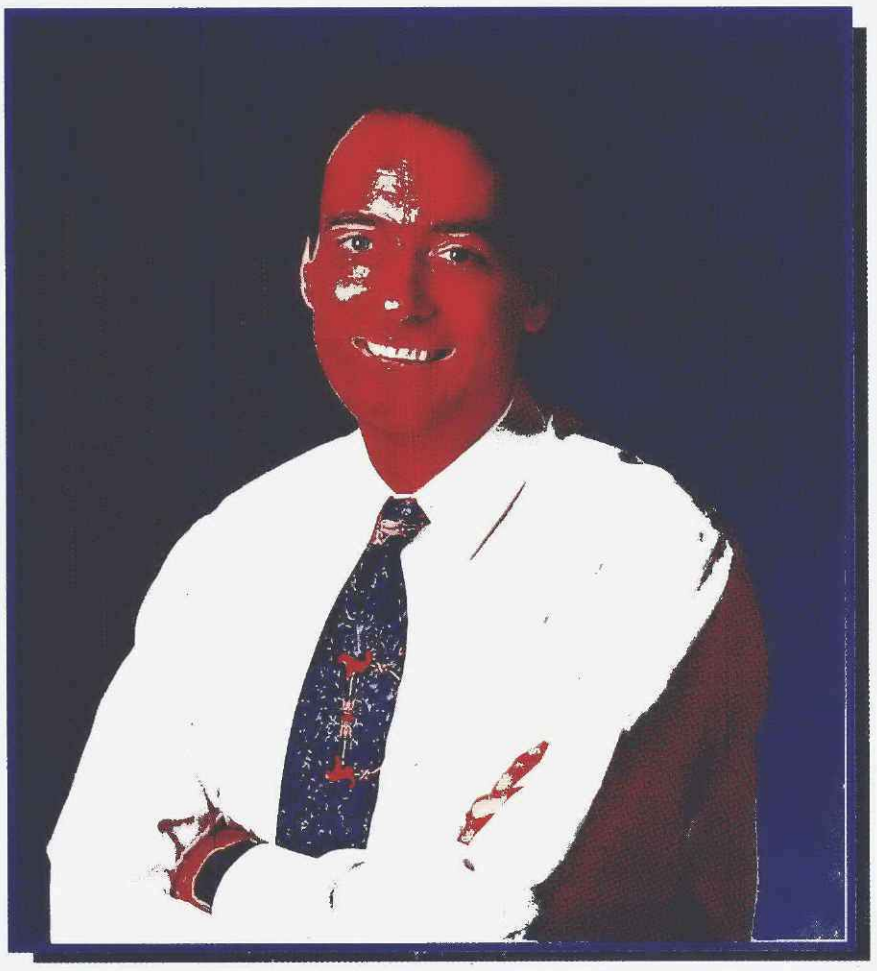


PHOTO COURTESY OF OXFORD HEALTH PLANS

Management is bad. Markets based on promoting innovation by containing the cost of health benefits have been very successful at reducing health care costs and encouraging a high range of innovations that might not be possible in a more regulated environment.

What do you think about the future structure of managed care programs, specifically preferred provider organizations vs. point of service plans vs. HMOs? Which will predominate?

The structure of health plans of the future will depend on consumer demand and how responsive the industry is to those demands. Choice will continue and is the most important consideration of buyers of benefits. Less restrictive plan types are popular because they deliver the fewest restrictions.

I believe we're headed for even greater choice as all plans find more creative ways to manage choice, perhaps using less control and more of a management model, consequently developing products that may take us back to the old scheduled plan of the indemnity world. These would be the first health plans to deliver HMO-level costs with indemnity-level freedoms.

Are we in for an upward trend in the long term for prices?

The upward trend we are experiencing right now is primarily driven by underpricing historically. Health care costs go up. HMOs have succeeded in moderating the cost increase.

Any insurers that have to win market share price their products below their cost and are now having to catch up. But overall, I'm certain we've had health inflation levels at half historic indemnity levels.

What would you say to benefit managers about the long-term rates during the next five years?

For purposes of setting budgets, I would tell them to expect a 3% to 5% cost increase.

Would that be true in areas where purchasing coalitions are active? In general, what effect do you think coalitions have on the industry?

They gang up on health plans and not providers. If the purchasing coalitions expect to put their buying powers on providers, we would see inflation down. Purchasing coalitions will not change the underlying cost. They may change it temporarily if the purchasing coalitions pay for their own insurance, but that would be a short-term phenomenon.

I believe it's a myth that large employers get a bargain.

In many respects the large employers are more exposed to true health insurance inflation trends because they predominantly self-fund their benefits. The purchase of insurance and the competitive market for health insurance make it so that smaller companies can move from carrier to carrier and shield themselves from inflation effects longer than a self-funded employer can achieve.

Do you believe that managed care groups need to have a mission beyond making money, and how does this relate to managed care's need to do research for the industry?

Any health plan that has as its mission solely making money soon will be out of business and out of money. Any organization of any type must have a mission that focuses on its customers first. In the health plan industry, I would focus on the health of our members and improving optimal healing for those members who are in the middle of a disease.

Most health plans are full of very high-integrity people that believe health plans offer a platform for good while doing well. What I mean is, it is rewarding personally while responding to a greater social mission.

Health plans are uniquely positioned to affect people's lives, and every health plan has many employees who every day do their jobs with a higher mission in mind or a higher calling in mind.

As regards research, many health plans are out front on the issue of research. Oxford started the largest initiative to fund outcomes-based research. We spend $2 million a year on outcomes-based research.

Health plans have no responsibility for funding medical research. Car companies and sewing machine manufacturers and insurance underwriters did not create a social obligation to fund research. The organizations funding research, and there are many, are doing so out of their own sense of mission.

I invite you to find a car company or a clothing manufacturer doing the same.

So where does the perception come from, and you hear it all the time, that HMOs are not doing research?

It's just a perception. It's just Part Two of the continuing saga of the demonization of HMOs, seldom based on fact and always based on conjecture.

Looking at the recent past, what were the most significant changes for managed care in general and for Oxford in particular?

Well, there are a number of significant changes. The past five years have seen an almost total collapse of the private indemnity market for health insurance. Most of the biggest names in insurance are exiting the business or experiencing dire financial results.

I think a second profound change has been the heightened consumerism in health care—the fact that more people have more information about health services they seek than ever before. That is creating new demands on health plans to be responsive to what customers want.

Continued on next page

Continued from previous page

We also see health plans offering unique benefits such as alternative medicine, changing their policies to accommodate alternative lifestyles, eliminating friction such as gatekeeper requirements.

What were the biggest changes at Oxford during the past five years?

Well, we've gone from a small company to a Fortune 300 company. I'd say that's a big change.

How was that possible?

In 1996 we were the fifth-fastest growing company in America of any type. We were the fastest growing health plan by far. That created a complete transformation of our organization, principally due to scale.

To what do you attribute your success?

Excellence in running health plans comes from doing lots of little things well. It's not possible to point to a single strategy or action that uniquely drives long-term success. Success is complicated in this business.

We're in a period now in which HMOs face increasing scrutiny. Do you think HMO report cards and other evaluations of this type are good for the industry?

All external appraisals will serve to improve the quality of our industry. I welcome them. I wish there weren't so many. The cost to health plans for NCQA accreditation requires far too significant a resource, an expenditure, to maintain accreditation than is appropriate. NCQA needs to develop better ways to measure the quality of health plans. We're forced to collect information just for them that serves no other purpose.

What would you rather see happening?

I would rather all these review organizations come up with a single, consistent method for assessing health plans and the overall governance of our industry so that we are no longer dependent on independent agencies. We should instead create a framework much like the securities industry has achieved where the disclosure of information allows consumers to see information that is important to them on each health plan and compare for themselves.

Are you in favor of information being presented in the form of a report card?

As long as the report card is specific to the consumer's choice. If it's a report card on a doctor, it should be related to how that physician performed for the specific service they are seeking. If it a report card on a health plan, it should relate to the specific product they buy; it shouldn't relate to the entire health plan.

Are you in favor of physician groups as well as individual doctors being evaluated in report cards?

Absolutely. But you measure medical groups for different th ngs. Individual physicians in medical groups need to be measured because a medical group doesn't perform bypass surgery. We need more information on the quality of that individual.

In evaluations, how much emphasis should be placed on outcomes instead of the processes of health care?

Let me turn the question to you: Would you or any patient care about the process or the outcome? What's most important to you will always be the outcome. I believe outcomes are more equally measured and lend themselves more easily to measurement more than processes.

Also watching HMOs more closely in the next few years will be the federal and state governments. How likely is it that HMOs will come under increasing regulation in the next few years and how will the industry respond to it?

You will continue to see body part by body part initiatives that create more mandates that further standardize benefits for those employers seeking fully insured coverage. Larger employers that are self-funded will largely be immune from the regulations, which are predominantly being enacted at the state level, because of their ERISA protection. The alternate result will be to discourage innovation and raise premium costs.

Do you see increased lobbying by managed care plans or more lobbying by an association that will combine the efforts of many managed care companies?

We are at a very unfortunate point in our political evolution right now. Anecdote is winning the political debate. The industry really tries to be a reasonable voice in the debate. Unfortunately, interest group politics are too irresistible for most politicians. The road for them is to buy into the conjecture and anecdote.

The much harder job is to defend market-based reform and free market principles. Over the three years, the free market is getting shut out. We're losing the game on regulation.

What opportunities do Medicare and Medicaid risk HMOs pose for the industry and for Oxford?

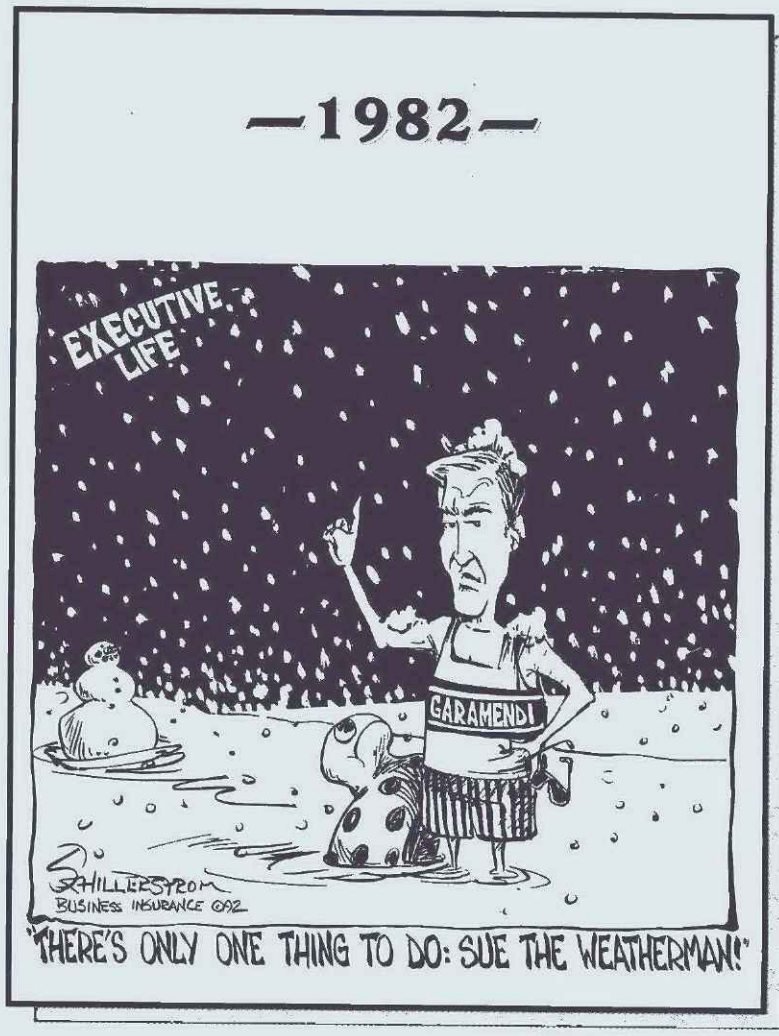
Medicaid has proven to be a very dangerous program to commit to, principally because state governments cannot be trusted to maintain adequate funding levels. Politicians seem to think that cutting Medicaid reimbursement rates is something they do to HMOs but not individual subscribers.

In one state, Medicaid reimbursement to HMOs was cut from $190 to $117 a month in just two years—after they added a prescription drug program, which would actually make the reduction even greater.

These cuts have had a profound negative impact on the choice and ultimately the quality of service available. No health plan in their right mind wants to be a party to administering the government's aimless budgetary maneuvers.

Medicare is a completely different animal. There's still hope that a public-private partnership can be achieved in serving seniors.

It will be interesting to watch what Medicare does to reimbursements, because many federal government officials are starting to sound like state officials in their belief that premium cuts are made to health plans and not beneficiaries. I hope they don't follow the same foolish path that has led to a mass exodus from state Medicaid programs from high quality HMOs and has led to massive benefit reductions for consumers. 30



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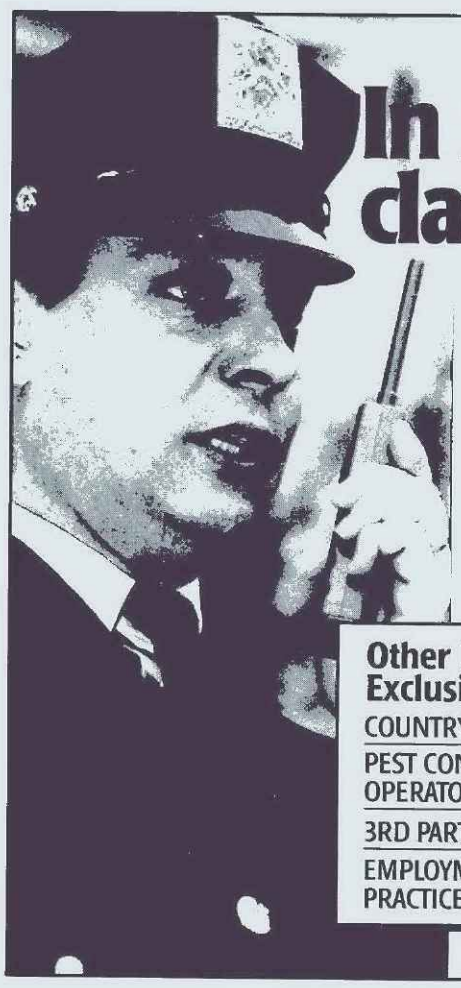

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30 VIEWS

Björn Wolrath

Former CEO of Skandia questions rationale for mergers

Björn Wolrath's career has come full circle.

After 16 years as CEO of Stockholm, Sweden-based Skandia Insurance Co. Ltd.—he retired in December 1996—the 54-year old Mr. Wolrath is going back to school.

The Swedish government has appointed him as a member of the board of the University of Stockholm. Not only is this Mr. Wolrath's alma mater but also was his first employer after graduating in 1968. He was assistant to the Stockholm University president for two years, joining Skandia in 1970.

Through his new consulting company, Momentum A.B., located just a block away from his old Skandia offices, Mr. Wolrath will pursue a long-standing personal ambition of promoting greater linkages between academic institutions and industry. As partners, the two should work together to address new needs in education and social welfare, which governments no longer can afford to fund, he says.

Skandia and its Norwegian subsidiary, Vesta Insurance Co. Ltd., will be in the forefront of this drive, he hopes.

Meanwhile, Mr. Wolrath continues to represent Skandia within the Swedish Insurance Federation, and has been elected chairman of the Swedish Insurance Society.

Skandia provides insurance and financial services throughout Scandinavia and approximately 26 countries worldwide, with more than half of its total employees outside Sweden.

In addition to its operations in Sweden, Norway and Denmark, Skandia has a cooperation agreement with and minority shareholding in Finland's Pohjola Insurance Co. Ltd.

Skandia in September sold most of its reinsurance operations worldwide to Hannover Re, focusing its core operations on life insurance, pensions and annuities and direct non-life insurance.

Mr. Wolrath recently spoke with Correspondent Maria Kielmas about the global insurance market.

Q: How have you seen the global insurance business change over the past 30 years?

A: Thirty years ago, you only had local insurance companies taking care of their home market. Either you were a big player with a lot of contracts or a small player, but you still kept your territory. You had customer loyalty. Once you were a Skandia customer, you kept on being a Skandia customer. There was an ambition to merge with other companies, but it would be a domestic company. Buy a competitor.

From a world perspective, you have to remember that in those days there were many nationalizations. It was not a question of increasing private ownership of insurance but the other way around. Governments were taking over the whole industry. It was probably related to national pride; colonies became new countries and insurance was seen as part of the welfare system. Brokers were not important.

So the shift has been with the freedom of trade. Freedom of services comes as the next step. The World Trade Organization has still not succeeded in bringing about freedom of insurance services. It will come, but I think it will take some time. I think that currency devaluation problems in a number of countries in Southeast Asia recently will delay freedom of services. They will be none too keen on letting in outside operators.

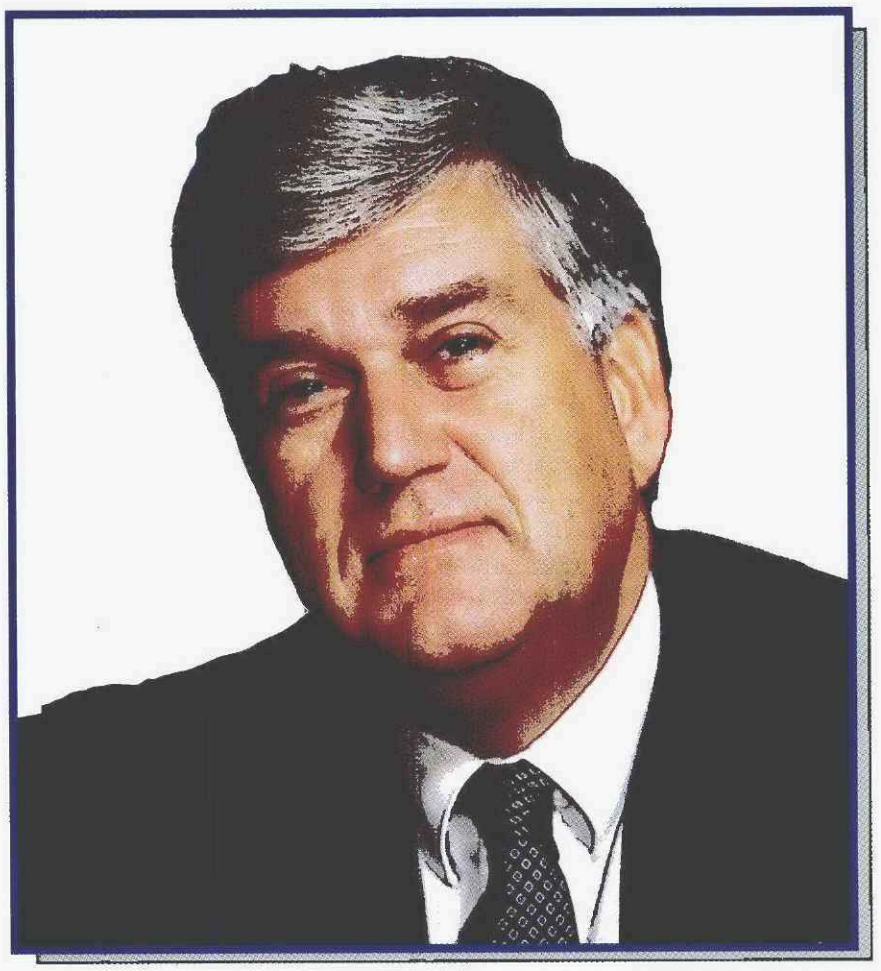

PHOTO: COURTSEY OF SKANDIA INSURANCE CO. LTD.

Do you think the trend toward mergers between banks and insurance companies will continue?

If you merge two companies, it normally leads to just one thing: You are cutting down on staff. Then you have cut costs and try to live happily ever after. The question is, are you achieving anything? Are you providing a better service or becoming a creative group? I think it's easy to overlook the fact you need to focus on internal growth. How do we create new products and services in order to grow?

When the bank Kreditkassan and Storebrand Insurance Co. tried to merge in Norway, there was a survey that asked the public, "Do you think that the merged company will provide a better service?" The answer was no. "Do you think the products will be sold at a lower price?" The answer was no. "Do you think that the products will be better quality?" The answer was no. The fourth question was, "Do you think this company will be better placed to compete on a worldwide basis?" The answer was yes.

Isn't the fourth question the justification for mergers that management typically uses?

I think the management said this merger will make us more competitive, and they were able to sell that message to the public. But when the public thought, "What's in it for me?" They didn't think they were getting anything. If they had thought about how they answered the three questions, they would not have answered the fourth as they did.

Do you think the notion that a merger will make a company bigger and therefore better able to compete globally is just nonsense?

Yes, if the only thing you are doing by merging is cutting costs. You should not just sit there and say, "We are the biggest organization." You should look for new products and new business. That's what most companies are forgetting.

If we look at the Scandinavian region, there is no bank and no insurance company, with the exception of Skandia, which has any important presence internationally. They are all domestic. Even if a bank has an office in Hong Kong or the United States, they are only servicing Nordic clients. They are not selling anything to the public in Hong Kong or the United States. I think that's dangerous, because only those companies that have the ability to invest in new products, new services, do it another way and do it internationally will be able to survive.

So why did Skandia try to buy the Swedish state-owned bank Staatshypothek?

Staatshypothek was mortgage finance. It was a shrinking operation that we would have been able to buy at a good price, have a good return and at the same time free resources as the business was shrinking. The capital could have been used in our case to expand our life and pensions business. In the meantime, we would have had a good return on business that was on the books.

It was like doing a rights issue. Unfortunately, the government decided to merge it with another bank. The outcome of the deal was they lost 4 billion Swedish kronor ($523.6 million).

So where are the new products and services? Where are the new markets?

Take insurance. Companies are buying bits and pieces from specialists. You have product liability, currency risks. You can collateralize, securitize, and put it on the capital market. This is being done slowly.

On the other hand, you have pensions. Governments say the pay-as-you-go system will support you in the future, we think, but we don't know. So you are moving from pay-as-you-go into funding. What this will lead to, you don't know, but it is moving more money into financial institutions. These funds will look for a home. They can be put into bonds of a different flavor; some will be insurance-linked.

You will see creative finance houses organizing the financing and insurance of risks and linking them to other things. If you have an investment banker that is creating the financial products and a company that is writing the insurance risks, then you will find new insurance products and new ways of covering risk. This will be big competition for the traditional insurer of multinational corporations.

Skandia recently sold its reinsurance operations. What will happen to the reinsurance market?

It's quite clear there will be only a few players on the world market. The problem for Skandia and the others is that in reinsurance you need much more money to do things that are interesting to insurers and brokers.

For Skandia, the basic Scandinavian business and worldwide life and pensions business is big enough and profitable enough. So it was a simple matter to quit reinsurance. It should be one way or the other. I think reinsurance companies will have very tough competition from other financial institutions. The big investment banks will be organizing coverage, such as options, for risks. They are very creative, like bespoke tailors.

The reinsurance industry is very traditional, very conservative, while for the banks, everything is a new situation. They are getting more money from savings, so they are very keen to increase their output of services.

Do you foresee a time when insurance is just another division of banking and reinsurance does not exist?

No, I don't think so, but it depends. A lot of reinsurance business is related to technical matters, and there will always be a need for specialists to go out and look at a risk. You have to know your trade. What reinsurers

Continued on next page

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Continued from previous page
have realized is that they have to add on a new style of doing business to complement what they already have.

Will the European market be a microcosm of this world?

No.

I think Europe is a very conservative part of the world where brand names matter. It will take time before a Spanish farmer buys his farm insurance from a German insurance company.

There will be a number of mergers, but among insurers. We will see boutiques appear to cover a specialist part of insurance.

Will any interesting new players come into the market from the former communist countries of eastern and central Europe?

No. They have a full job organizing their own markets; I don't see how they can provide anything that is not already provided today.

It's interesting to look at the Japanese. They have a very regulated home market with no competition. Ten years ago most Japanese insurers were in Europe or had plans to come to Europe. Today they are hardly here.

Why?

Because they don't offer anything that doesn't exist in Europe already.

What about U.S. companies?

The U.S. insurance industry is much more competitive because of its competitive situation at home. I'm a little amazed that while U.S. manufacturers have been around Europe since the war, there are not so many players from the U.S. financial institutions here, especially in the insurance fields. It's difficult to get a U.S. insurance policy in Europe.

Why is that?

U.S. insurers have been too involved trying to cope with their domestic problems; many have been hurt by high liability claims. More claims, less capital. But I think they are moving now, and you will see more U.S. companies here in the future.

How will the European Monetary Union affect insurance?

It will increase the competition in Europe because there will not be a currency risk. It is clear that there is more competition and companies will be more Europeanized and there is more international thinking. You will be able to insure a German risk from Sweden, if Sweden is in the EMU, which I doubt.

So will that Spanish farmer then buy a German insurance policy?

It will be easier. He will be offered something from a German company that will be in euros (the future European single currency) and will be recognized and compared directly with what is offered by Spanish insurers Mapfre or Fenix. It will pave the road, but he still needs to know the company and trust the company.

What are the origins of Skandia's captive management business?

Skandia held an internal study on whether to start up a captive operation. It was a matter of some concern, because we were big insurance providers for Swedish multinationals. If you start up a captive for them, then a part of the business disappears. It may go through your books, but it's like a sieve, and the holes are quite big.

After discussions and quarrels, we decided that if the customer really wants a captive, we could not stand against his wishes. So why don't we organize ourselves to be a good captive administrator? That was 20 years ago, and now Sinser is the second-biggest in the world and the biggest in Europe. In the meantime, we kept our relationship with the Swedish multinationals. Efficiency in risk management in Swedish manufacturing has been immense.

When did you start providing risk management services to clients?

In 1973, I was asked by top management to join a committee about risk management. I had come from the investment side; I was in charge of stocks and bonds. I thought that was what risk management was all about. We had the expertise because we were dealing with money. After a couple of meetings I realized that this was something new.

It has evolved into a situation today where it's a question of balance sheet coverage. In the old days it was more profit and loss. Then the only risk Swedish companies carried was $100, which is crazy. Now we are talking billions.

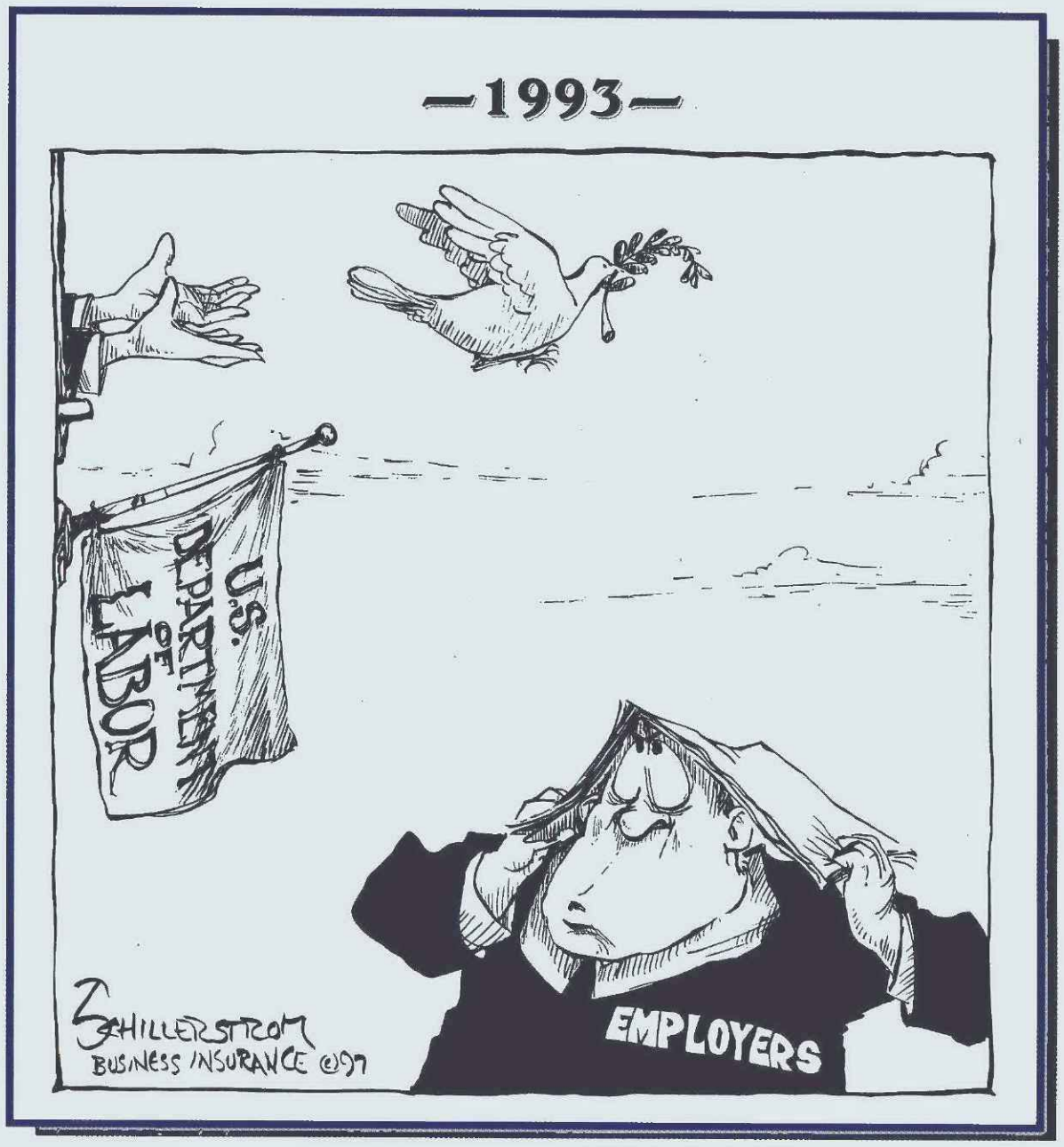
Where is Skandia going now?

We are following the big Swedish multinationals wherever they go. Whether we do it on our own or with Pohjola. We are keeping our strong card in the market. You will probably see more captives in company pension schemes; organized accident and insurance schemes.

What can the insurance industry do to help multinationals counter massive inherited liabilities as a result of the actions of environmental or political pressure groups?

I think it is necessary for the companies themselves to be ahead of the pressure groups. There is also a limit to insurance. You have to have people who are smart enough to think around corners. Let people with a more broader outlook be in on the discussion. People who will sit back and say that will not work.

Computer specialists and underwriters should be able to explain to all sorts of people how they see the insurance policy, the coverage and everything it relates to. With major risks you need people to look and say that there are other risks to be taken into account. These additional risks could be related to the effects of pressure groups (on a company's operations and its potential liabilities) and to the aggregation of various different risks in the case of catastrophes. 30



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A LOOK BACK

1992 • 1996

—1992—

● Workers compensation losses continue to rise. The National Council on Compensation Insurance reports that workers comp insurers' aggregate combined ratio hit a record 123% in 1991, compared with an average of 118% over the previous five years.

● While health care costs continue to rise several times faster than inflation, increases are smaller compared with previous years. The 1991 increase, 12.1%, was the lowest in four years.

● Included in a new law expanding unemployment compensation benefits to the jobless are provisions that require employers, at a terminated employee's request, to directly transfer pension distributions to the employee's individual retirement account or to a defined contribution plan offered by the individual's new employer.

● During his presidential campaign, Bill Clinton promises to unveil a plan to cure the major ills of the health care delivery system within 100 days of taking office.

● In August, Hurricane Andrew devastates southern Florida and rakes parts of the Louisiana coast, leaving insurers with losses A.M. Best Co. projects at $16.5 billion, making Andrew the most expensive catastrophe the insurance industry has ever faced.

● The Florida Supreme Court joins the highest courts of Colorado, Georgia and Wisconsin in ruling that a standard pollution exclusion clause in many CGL policies does not preclude coverage for gradual pollution that was neither intended nor expected by the policyholder.

● For the first time ever, more employees are enrolled in managed care plans than in traditional plans, a KPMG Peat Marwick study shows. More than 55% of employees covered by employer-sponsored health plans are enrolled in health maintenance organizations, preferred provider organizations or point-of-service plans, according to the study.

● Employers face an end-of-the-year deadline to comply with Financial Accounting Standards Board rules in recognizing retiree health care plan obligations. As the mid-December deadline for FAS 106 approached, many employers recognize their accumulated retiree health care obligations under the new rules in one-time charges. Others, though, decide to amortize the liabilities over the permitted 20-year period.

● Many employers face problems stemming from the Americans with Disabilities Act of 1990. While public and private employers generally support the law, many are concerned about its vague wording, which may be destined for clarification through the courts.

● The flow of red ink continues at Lloyd's of London, despite the market's decision to implement radical changes, such as establishing a system to help cap members' liabilities, changes in the governing structure and considering the possibility that corporate capital be allowed in the market for the first time.

—1993—

● President Clinton names First Lady Hillary Rodham Clinton to spearhead the administration's effort to overhaul the nation's health care system. The administration unveils a reform package that promises universal coverage. The package calls for state-established health care cooperatives, which would negotiate rates with insurers and offer employees many different plans. But employers blast the proposal as unworkable and for giving government too much control over the health care system.

● On Feb. 5, President Clinton signs into law the Family and Medical Leave Act and ends a long deadlock on the issue of federally mandated family-leave benefits. The FMLA, which allows employees to take job-protected unpaid leaves for the birth or adoption of a child, for their own illness, or to care for an ill family member, became the first major piece of legislation signed by the new president.

● Having caused an estimated $510 million in insured losses, the Feb. 26 bombing of New York's World Trade Center ranks as the largest U.S. man-made insurance loss of the year and the second-largest of all time. Only the 1992 Los Angeles riots, which caused an estimated $775 million in insured property losses, were bigger.

● After several years of staggering underwriting losses—most recently a $4.2 billion loss for the 1990 underwriting year—Lloyd's of London produces a business plan that contains radical reforms, including introducing corporate capital.

● A provision tucked into a tax bill reduces to $150,000 from $235,840—beginning in 1994—the maximum amount of an employee's wages that employers can use in computing pension benefits and contributions. Benefits provided through defined benefit plans to employees considered "highly compensated" under the tax code could be reduced by more than 40%.

● Reform efforts aim at containing spiraling workers compensation costs. In California, for example, comprehensive legislation passed in July is designed to cut $1.5 billion from an $11 billion system while increasing benefits to injured workers.

● A potentially expensive new benefit mandate would require employers that offer group health care plans to file information, like employees' and dependents' Social Security numbers, with the Health Care Financing Administration. HCFA would transfer the information to a new data bank intended to help HCFA make sure the Medicare program isn't paying the medical bills of people covered by private plans.

● The final changes to the "Fronting Disclosure and Regulation Act," made in a closed executive session during the National Assn. of Insurance Commissioners' winter meeting, broadens the exemption for single-parent captives to include those located in non-accredited U.S. jurisdictions, not just accredited ones.

● The six-year-long soft market is not expected to change anytime soon. Although brokers and risk managers reported higher property rates at year-end 1992, as catastrophe reinsurance prices climbed dramatically after Hurricane Andrew, casualty rates remained flat, or even a little lower, during the same renewal period.

—1994—

● A massive earthquake tears through Los Angeles on Jan. 17. The Northridge earthquake leads to the collapse of thousands of buildings, kills at least 55 people and injures about 7,000. people. Insured losses from the Northridge quake, the second-costliest catastrophe in U.S. history, are expected to exceed $10 billion.

● The U.S. Labor Department denies CSX Corp.'s bid to reinsure its group term life insurance program through its Vermont-domiciled captive. The CSX case attracts widespread attention in employee benefit and risk management circles because of potential tax implications.

● A federal judge approves potentially the largest product liability settlement in history, the $4.75 billion global settlement proposed by the three leading manufacturers of silicone breast implants. Dow Corning Corp., Bristol-Myers Squibb Co. and Baxter Healthcare Corp. are still wrestling with their insurers for coverage to pay for the deal.

● One of the longest-running legal battles comes to an end in October, when a massive antitrust lawsuit that pitted state attorneys general against nearly three dozen insurance industry defendants is settled. Under terms of the settlement, the defendants agree to relinquish control of the Insurance Services Office Inc.

● Despite an unprecedented presidential and congressional effort, health care reform legislation goes down in flames. One business group after another denounces the Clinton package. In the wake of the debacle, President Clinton, who once said he would settle for nothing less than universal coverage, says he will pursue a more gradual approach to expanding coverage.

● The Republican electoral sweep on Nov. 8 sends the congressional risk management and insurance agenda spinning. Perhaps the most dramatic change is the defeat of House Judiciary Chairman Jack Brooks, D-Texas, who repeatedly introduced legislation that would have greatly circumscribed the protections granted to insurance companies under the McCarran-Ferguson Act.

● Unlike two previous drug company buyouts of pharmaceutical benefit management firms, Eli Lilly & Co.'s move to buy PCS Health Systems Inc. for $4 billion is scrutinized by the Federal Trade Commission, which looks for potential anti-competitive practices that could be spawned by the alliance. In November, the FTC and Indianapolis-based Lilly finally reach a consent agreement that PCS will accept all discounts and rebates offered by other drug manufacturers.

● The consolidation of the property/casualty insurance industry continues with CNA Financial Corp.'s proposed $1.1 billion buyout of Continental Corp. The acquisition would make CNA the nation's third-largest property/casualty insurance company and the largest commercial property/casualty insurer.

● President Clinton signs a legislative package that includes the most significant changes in pension funding rules since ERISA was enacted 20 years ago. Key provisions of the legislation, known as the Retirement Protection Act of 1994, include tighter funding requirements, higher annual premiums that employers with underfunded plans pay the PBGC and more conservative mortality and interest rate assumptions in calculating plan liabilities. Federal regulators say the law could wipe out the PBGC's deficit in a decade.

● HMO consolidation reaches new heights in 1994 when FHP International Corp. announces it will purchase TakeCare Inc., while Travelers Corp. and Metropolitan Life Insurance Co. agree to convert their predominantly indemnity-based business into a single managed care plan.

—1995—

● Benefit plan sponsors dodge a judicial bullet that could have killed all benefit plan changes made in recent years when the U.S. Supreme Court overturns two lower court decisions against Curtiss-Wright Corp. The court rules that Curtiss-Wright's reservation of its right to modify its health plan satisfied the plan amendment requirements in the Employee Retirement Income Security Act of 1974.

● The U.S. Supreme Court narrows the focus of the ERISA's pre-emption of state laws and increases the cost of some benefits in April when it upholds New York's ability to impose a state surcharge on hospital bills paid by commercial insurers and HMOs.

● In May, Lloyd's of London reports a 1992 global loss of £1.19 billion ($1.87 billion) for the three years ended Dec. 31, 1994. It is Lloyd's fifth straight loss, bringing total losses between 1988 and 1992 to £8 billion ($12.56 billion).

● CIGNA Corp.'s plan to fully recognize and wall off its long-tail liabilities in a separately capitalized runoff operation faces new criticisms from regulators in addition to continuing criticism from a group of policyholders and competing insurers.

CIGNA

● For the workers comp insurers, the combined ratio after policyholder dividends improves by 8.1 percentage points to 101% in 1994 from 109.1% a year earlier, according to estimates by the National Council on Compensation Insurance. The dramatic improvement is a sharp contrast to the 1984-1992 period, when the annual combined ratio each year exceeded 117%.

● After Dow Corning Corp. files for bankruptcy protection, Dow Chemical Co., one of the parents of the joint venture company, is drawn into the fray of the silicone gel breast implant litigation. And the landmark $4.25 billion class-action settlement proposal all but crumbles after a determination that it didn't contain enough money to cover all the implant recipients seeking compensation.

● In November, President Clinton vetoes a tax bill

Continued on next page

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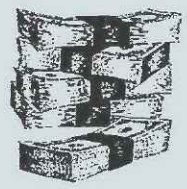
Continued from previous page

that includes a slew of pension simplification and other benefit reform provisions that employers support. The chief reason he vetoes the tax bill is because of his concern that the cuts it made in future Medicare spending were too great.

● Risk managers get a double dose of good news in 1994 when they learn the cost of risk for U.S. companies fell for the first time in a decade in 1993 and continued to decline in 1994. A 1994 study shows falling workers compensation costs led the decline in 1993.

● For the first time in more than a decade, various government and private industry sources report that average group health care costs dipped in 1994. Employee benefit consultant A. Foster Higgins & Co. Inc. finds that total costs for all health care plans fell 1.1% to an average of $3,741 per employee in 1994 from $3,781 in 1993. The switch to managed care gets much of the credit for the decline in costs.



● In 1995, states retreat on many reform initiatives launched several years ago. Washington state, for example, guts a 1993 law that would have required employers to offer and pay for group health care coverage.

—1996—

● A wave of mergers and acquisitions occurs in the health maintenance organization industry. The largest of these financial transactions is Aetna Life & Casualty Co.'s $8.9 billion purchase of U.S. Healthcare Inc., which catapults Aetna into the ranks of one of the nation's largest HMO operators.

● In May, President Clinton vetoes the Common Sense Product Liability Legal Reform Act, dashing product liability reform advocates' hopes that they had at last crafted a reform bill that could pass Congress and win the president's approval.

● The Health Insurance Portability and Accountability Act of 1996 is signed into law in August. It curbs the ability of health care plans to deny coverage for new employees' pre-existing medical conditions, making it easier for employees to move from job to job without fearing they will lose benefits. The law also allows small employers to set up tax-favored medical savings accounts.

● Pension simplification legislation is passed that begins to peel away the layers of complex rules legislators and regulators have added over the years. The Small Business Job Protection Act eliminates non-discrimination testing for employers with generous matching provisions in their 401(k) plans. It also offers an optional, easier way of running the 401(k) plan non-discrimination test.

● President Clinton is re-elected. During his first four years in office, the president either initiated or strongly supported a mass of benefits legislation that became law. The Clinton impact on employee benefit programs, already significant, is expected to continue during his next four years.

● Lloyd's of London posts its first profitable underwriting year in five years, signaling the end of the market's darkest hour and providing impetus to its efforts to reorganize. Lloyd's clears a final legal hurdle to its reconstruction and renewal plan when the 4th U.S. Circuit Court of Appeals rejects a lower court decision allowing U.S. members to sue.

● The world of reinsurance is made up of larger but fewer companies after a startling number of mergers and acquisitions. Among the transactions, General Re buys rival National Reinsurance Corp. in a $940 million deal, while Munich Reinsurance Co. steps in and buys American Reinsurance Corp. for $3.3 billion.

● Nearly 15 months after CIGNA Corp. unveils its plan to wall off most of its long-tail liabilities in a separately capitalized runoff facility, CIGNA continues its battle to protect its self-described financially vital reorganization effort. Critics argue that CIGNA reorganized through a novation—moving policyholders to a new insurance company—without first obtaining policyholder consent.

● Aon Group Inc.'s $1.23 billion acquisition of rival Alexander & Alexander Services Inc. is the largest brokerage deal on record and is enough to leapfrog Aon past Marsh & McLennan Cos. Inc. into the top spot among retail brokers. It also catapults Aon into the No. 1 spot among the world's largest reinsurance intermediaries.

● New employee benefit mandates, taking effect Jan. 1, 1998, are signed into law by President Clinton. Group health care plans, including self-funded plans, will be required to offer at least 48 hours of hospitalization after a vaginal delivery and 96 hours after a Caesarean section. Plans also will have to offer the same annual and lifetime limits for mental disorders as they do for physical problems. 30

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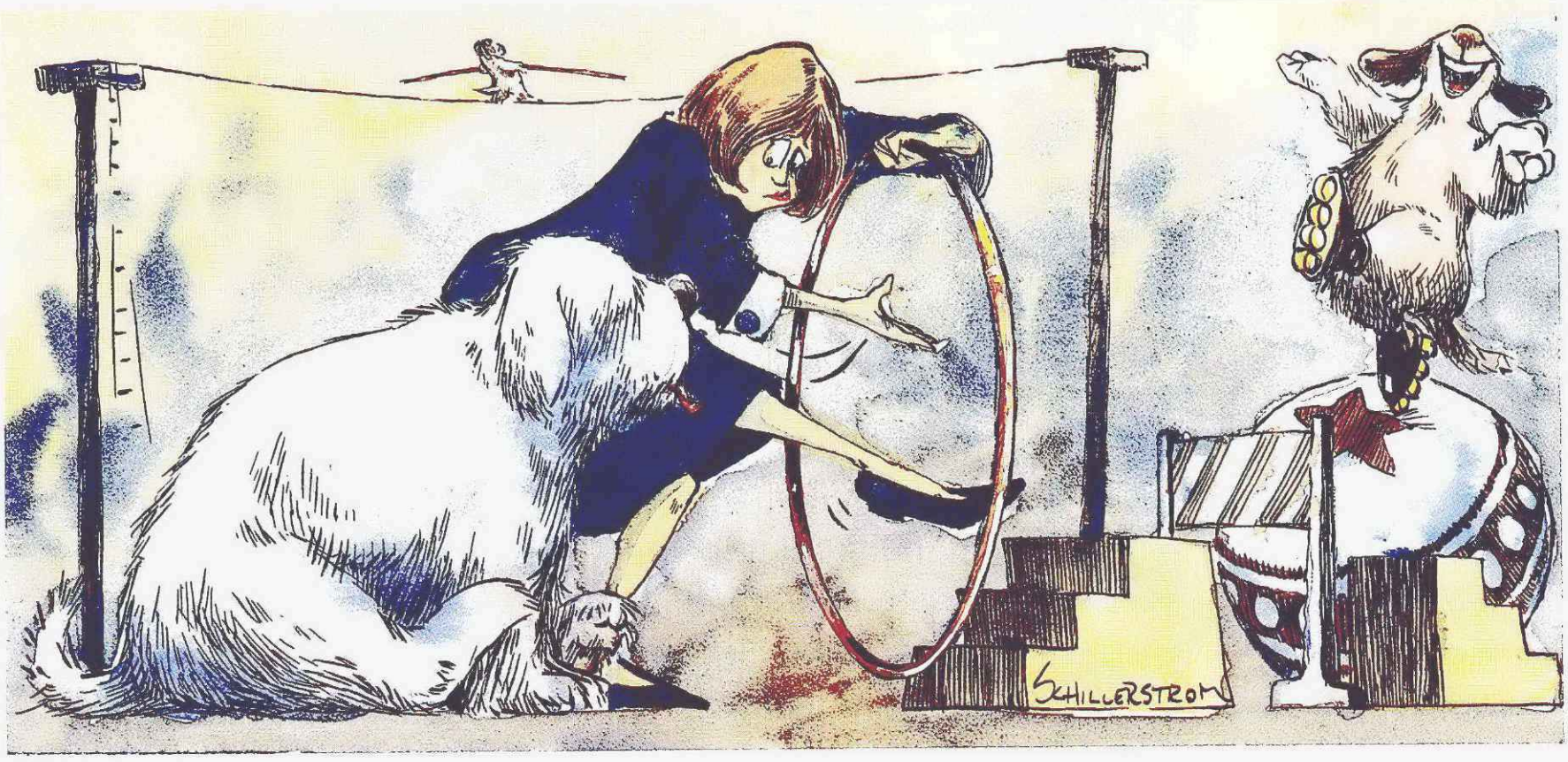

TRENDS & ISSUES

Industry still learning new tricks

While soft market slows self-insurance, innovation seen elsewhere

By MICHAEL BRADFORD

It took years of high-priced liability insurance and property catastrophes to lure the alternative risk financing genie out of the bottle.

He's taken a beating at the hands of cheap insurance and reinsurance rates, but it is unlikely that low premiums will ever force the genie back inside.

The lingering soft commercial insurance market has taken a toll on some alternative risk financing ideas, failed pharmaceutical product liability facilities being a notable discard. Self-insurance as a percentage of the total risk financing market is little changed in the past several years. There has been much talk but less action about new ways to finance risk.

"Soft markets always impede experimentation," observes Richard S. Betterley, president of Betterley Risk Consultants in Sterling, Mass. "This one more than any I've seen."

But innovation does continue in three areas: risk financing; where capacity problems exist; and where risk managers find cost advantages and tax and accounting benefits.

Experts cite several reasons why risk managers pursue a growing field of complex and less esoteric alternative risk-financing choices.

One is that risk managers are becoming more sophisticated in and comfortable with addressing issues like corporatewide, or holistic, risk as well as corporate capital valuation and allocation issues.

At the same time, risk managers' patience with the frictional costs and potential coverage disputes associated with insurance products is dwindling.

Risk managers, along with brokers and insurers, continue to develop new programs, like multiyear, multiline risk financing packages that include elements of finite risk coverage and the involvement of captive insurers and reinsurers.

Some of these programs also cover risks not traditionally insured, such as currency losses and interest rate variations. The threat of property catastrophes also has spurred the creation of some risk financing options, such as the California Earthquake Authority.

Earlier this year, a catastrophe bond was issued to provide an insurer with high-level reinsurance for hurricane risks. The capital markets continue to work on products to securitize risk, to provide capacity the traditional market lacks.

Some suggest that commercial insurance rates are staying low partly because of the existence of alternative risk financial mechanisms.

The notion of financing risk in ways other than the traditional route of buying coverage from an insurer began in the 1970s, often for tax reasons, and gained momentum in the high-priced commercial market of the mid- to late 1980s. During those years, when liability coverages were unavailable or unaffordable for many buyers, captive insurers and self-insured retentions became favorite ways to control costs.

"There was a time when, if you were big enough, you had a captive," said Mr. Betterley. "And if you didn't, people said, 'How come?' If you were big enough, you self-insured," and if not, the same question was likely to be asked.

During the high-priced hard market, self-insured retentions climbed into the millions of dollars, and captive insurers were formed, offshore and in the United States. Public entity pools were formed, and risk retention groups appeared. Risk managers were beginning to control their destinies.

Just when risk managers were getting comfortable with captives and other forms of self-insurance, the market began to soften in the late 1980s.

Insurers began competing again. Rates fell.

As cheap insurance pricing prevailed in the 1990s, some risk managers abandoned their self-insurance efforts for the comfort of paying premiums and letting someone else worry about paying claims.

Companies like PepsiCo Inc. and its subsidiaries, for example, are reducing their use of alternative risk financing to take advantage of low prices in the traditional marketplace.

PepsiCo has found coverage so cheap that the high retentions and other funding mechanisms it used for several years have been abandoned, said Christopher E. Mandel, senior director of risk management for Tricon Global Restaurants Inc., a Louisville, Ky.-based restaurant services company that was spun off from PepsiCo.

He said plenty of others have followed the same route.

Many risk managers don't have the time, budgets and expertise to flesh out the benefits of alternative markets when traditional market insurers are offering low rates, he said.

Even so, Mr. Mandel acknowledged that Tricon is trying not to overlook the benefits of alternative risk financing techniques.

The company has a consultant "looking at how we might be able to use some of these ART mechanisms to capture tax benefits," he said.

Some risk managers say insurers are charging less than they expect the losses to be, driving them to buy conventional insurance.

As a result, self-insurance, in the form of captives, self-insured retentions, risk retention groups and group facilities, is showing little growth in the persistent soft market.

Conning & Co., a Hartford, Conn.-based insurance research firm, reports that in 1996 these risk financing alternatives represented an estimated 33.2% of the total risk protection market (*BI*, Feb. 17). That's only a small increase from 30.7% in 1991.

Conning has projected that unless pricing changes, the alternative market's share of the total will fall to 32.8% this year and next.

Among the risk financing casualties of the soft market were three pharmaceutical facilities that were to offer product liability catastrophe insurance.

Most pharmaceutical companies have been able to buy all the coverage they want in the current competitive market, leaving little need for specialty companies to provide that capacity.

PharMed, proposed by Marsh & McLennan Inc. before its merger with Johnson & Higgins, was withdrawn earlier this year because of a lack of interest (*BI*, July 21). It followed two others that were withdrawn for the same reason (*BI*, June 9).

When the programs were being put together in 1995 and 1996, worldwide capacity of about $600 million to $650 million was available for the risk. Currently, pharmaceutical companies can buy more than $800 million in product liability coverage, plenty for most risk managers.

Although insurance buyers rejected the pharmaceutical facilities because of low rates elsewhere in the market, many companies have stayed put in their alternative programs, happy with the control they seized in retaining their risks.

Cheap insurance rates aren't likely to entice them away.

"The value that they got from having direct control has become so important to their operational practices that it is unlikely they will turn from it," said Mary Ann Godbout, assistant vp at Con-

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ning.

One of the most celebrated cases of self-insurance occurred at The British Petroleum Co. P.L.C., which in 1992 decided to self-fund on a pay-as-you-go basis losses in excess of $10 million. The oil giant adopted the strategy after a 1991 audit showed it had paid almost five times more in insurance premiums than it recovered in indemnity payments from its insurers during the 1980s.

The $10 million per occurrence threshold gave the decentralized company's various operations an opportunity to decide for themselves how to best finance risk. Since 1992, those operations largely have concurred with the corporation's outlook and now self-fund most exposures.

Mr. Betterley pointed out that mechanisms already in place still serve their purposes, and innovations in risk financing are continuing.

"Now, there are all kinds of alternatives," he said. "Some work, in some cases, and some don't. But I've not seen any that I would say are real dinosaurs. A lot of time is being spent now trying to think of new ones that haven't been thought of before."

Union Carbide Corp. of Danbury, Conn., for example, is about two years into a program that combines finite risk and integrated risk elements (*BI*, Feb. 26, 1996).

Generally, under an integrated or blended risk financing approach, a company maintains a single retention for many of its property and casualty exposures combined, rather than individual retentions for each exposure. The company's excess coverage is triggered only after that full retention is exhausted.

Swiss Reinsurance Co. reinsures Union Carbide's Bermuda captive with an aggregate of $200 million of coverage over three years and $100 million in any single year. However, there are sublimits for either property or casualty losses, or combined property and casualty losses stemming from a single incident.

If the program is loss-free after three years, Union Carbide is scheduled to recover the value of three-fourths of its premium. However, unlike typical finite risk programs, Union Carbide's premiums are much lower. The premiums equal what Union Carbide would have paid for the coverage under a conventional excess insurance arrangement in today's market, said Rick Inserra, assistant treasurer-risk management and insurance.

Losses could drive up Union Carbide's premium 25%, he said.

The integrated risk financing program that Norwest Corp. of Minneapolis began forging in 1993 and rolled out nearly a year later also contains a finite risk element (*BI*, April 24, 1995).

But unlike Union Carbide's program, Norwest's does not contain sublimits for the bank's property/casualty risks. The bank is subject to a single large retention for all the exposures the program covers. American International Group Inc. subsidiary National Union Fire Insurance Co. of Pittsburgh, Pa., reinsures Norwest's Vermont captive.

Among other things, Norwest's program has helped the bank come much closer to satisfying its risk appetite, cut insurance costs 70% and improved the bank's cash flow, said K.C. Kidder, vp and risk manager.

More recently, Minneapolis-based Honeywell Inc. cut its costs by buying property/casualty insurance under an integrated risk financing program that also covers the company's currency losses.

Many of these integrated programs involve reinsurance of a corporation's captive insurer.

Whether used as part of a blended program, or alone, captive insurers are still growing in popularity.

There were a record 3,104 captive insurers at year-end 1996 around the world, according to the *Business Insurance* survey of 27 captive domiciles (*BI*, April 14), a 6.8% increase.

On the property side, natural disasters have provided the impetus for innovations in risk financing. The threat of earthquakes, for example, led to the formation of the California Earthquake Authority.

The facility was proposed in 1995 at a time when insurers—still reeling from $12.5 billion in losses from the 1994 Northridge quake—were declining to write new and renewal earthquake coverage for California homeowners.

Faced with the market crisis, the California Legislature authorized creation of the facility. It was structured to issue policies through participating insurers, with existing policies converted to CEA policies at renewal.

The CEA is set up to provide a maximum aggregate limit of as much as $10.5 billion in several layers funded by property insurers, reinsurers, the state and policyholders. The maximum aggregate depends on the degree of insurer participation.

The threat of hurricanes also has stimulated new markets.

Hurricane Andrew, which caused an estimated $16.5 billion in property damage in South Florida in 1992, startled insurers and reinsurers into realizing it was time to take a closer look at their exposures. As a result, there was not enough reinsurance to answer demand.

In addition to causing capital to flow to newly created catastrophe reinsurers in Bermuda, Hurricane Andrew lent some urgency to development of the Chicago Board of Trade's catastrophe options, a product launched in 1992. The contracts are linked to an index of cat losses by the Property Claim Services division of the American Insurance Services Group.

In addition, investment bankers are developing other products to securitize risks.

In a closely watched offering, United Services Automobile Assn. generated tremendous interest among investors with a $477 million catastrophe bond issue that gives it a high-level reinsurance layer for East Coast hurricane risks (*BI*, June 23).

The bonds were issued by Residential Reinsurance Ltd., a Cayman Islands reinsurer USAA created last year. The reinsurer will manage the funds raised through the issue and administer a reinsurance contract it

See **Innovation** *on next page*

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provides to USAA.

The reinsurance contract covers USAA for a loss caused by a single Category 3, 4 or 5 hurricane resulting in insured losses between $1 billion and $1.5 billion to the insurer's policyholders along areas of the Gulf Coast and Atlantic Coast.

The success of the USAA bond offering was hailed as a big step in the cautious move by insurers to transfer risk to the capital markets.

"We've certainly seen a trend toward the convergence of the insurance markets and capital markets," said Gerard Vecchio, vp with Conning. "We're in the nascent stages of that right now, but I believe it will develop over time. The question is, what time frame will it be?"

James V. Davis, chairman of Willis Corroon Corp.'s Advanced Risk Management Services division in Nashville, Tenn., said, "If you look at the deals that have been done so far, almost all have been substitutes for reinsurance for property/casualty companies or what amounts to surplus relief in the event of a catastrophe."

"At current insurance pricing levels, it is unlikely that capital market products will have a big impact" anytime soon, Mr. Davis predicted. "Even the big international bankers acknowledge that. They pretty openly say that there will not be any dramatic growth unless there's a change in the pricing cycle."

Some insurers are moving toward capital markets faster than others.

Chicago-based CNA Insurance Cos. is among the most aggressive, creating Hedge Financial Products Inc. out of its acquisition of Centre Financial Products Ltd., an affiliate of Centre Reinsurance Co.

Plans call for Hedge Financial to explore over the next two years development of securitized products for CNA's approximately 30 business units, to help both the units with their business plans and meet clients' risk financing needs.

Richard L. Sandor, chairman of Hedge Financial, says the securitization of risk is a "20 year process, and we are three to four years into it."

The continuing search for ways to finance risk is in some ways related to risk managers' changing role within their companies.

They are now often described as operating in a more holistic fashion, which means their areas of responsibility have broadened to much more than purchasing coverages for common property/casualty risks.

"Firms are adopting a broader perspective of risk," Mr. Davis explained.

Increasingly, risk managers are coming up with ways to protect not only the common exposures but also to cover "some array of risks not normally thought of as property/casualty risks and not normally thought of as insurable by a property/casualty company," Mr. Davis added.

That could include financial risks such as those related to foreign exchange, interest rates and commodity prices.

Risk management "is more than asset value replacement; it's about shareholder value protection," according to Kevin R. Callahan, president and chief executive officer of Aon Capital Markets Inc. in Chicago.

The boom in risk financing also has helped raise the profile of the risk management profession, Mr. Betterley pointed out. "It's made more choices for risk managers; therefore, the opportunity to think independently is higher."

Some say the emergence of alternative risk financing methods has helped keep a lid on insurance price increases.

"One of the reasons I feel the commercial market is so competitive is the existence of a viable alternative market," commented Jon Harkavy, vp and general counsel of USA Risk Services Inc., an Arlington, Va.-based provider of administrative and management services for group captives and self-insurance pools.

"The biggest effect that it's had is to limit the ability of the traditional insurance industry to dictate price increases or coverage restrictions," pointed out William J. Kelly, senior vp with investment bank J.P. Morgan & Co. Inc. in New York.

The power of traditional underwriters to raise premiums or change terms is not as much of a threat to insurance buyers now that so many alternatives are available, Mr. Kelly noted.

"The traditional market can't unilaterally act because others will move in to provide funding," he said.

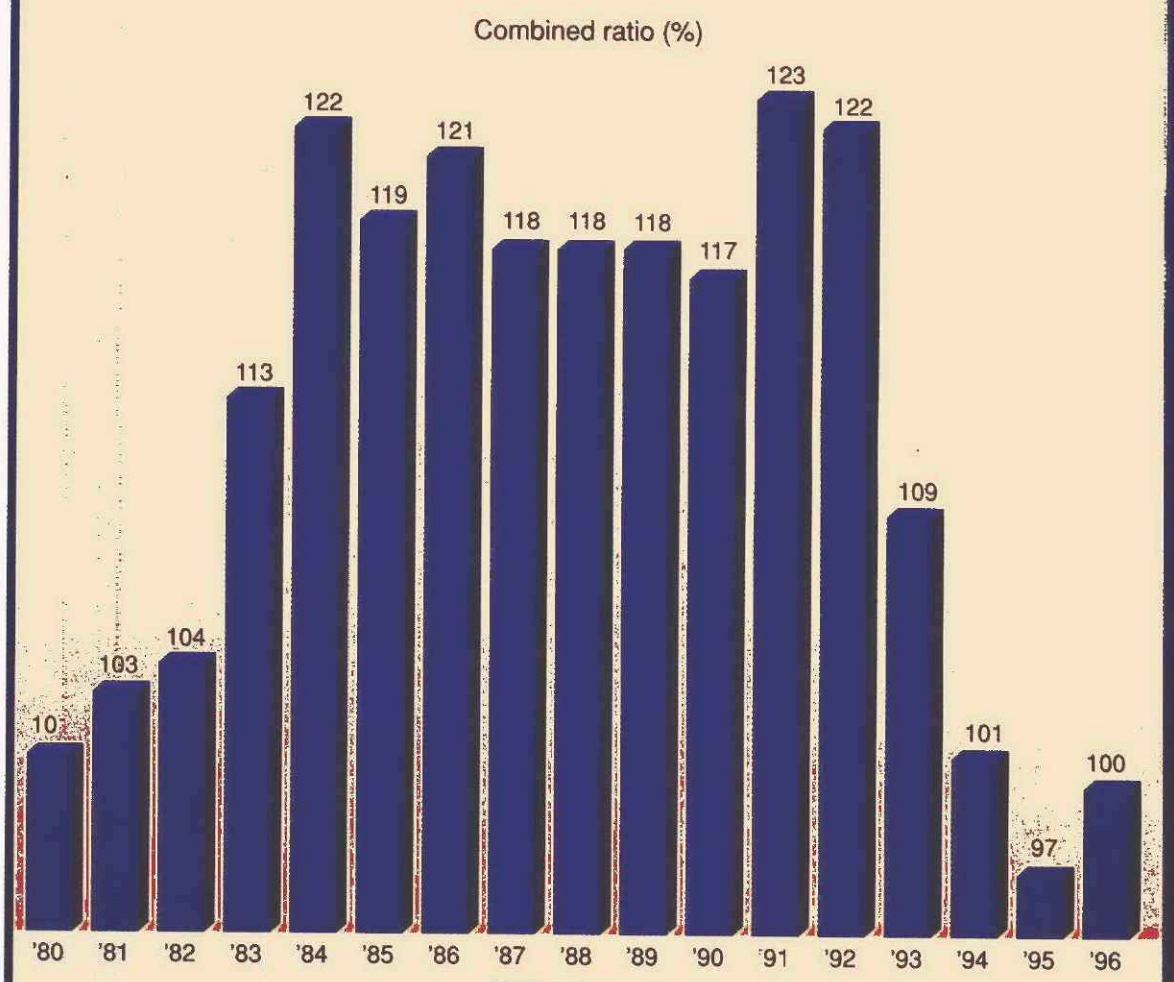
The same will be true for insurers seeking reinsurance.

"You won't see a 40% rate on line" for property catastrophe reinsurance, says Mr. Sandor, referring to the high reinsurance rates that were charged after Hurricane Andrew.

The capital markets will offer cat bonds at far less, Mr. Sandor observed. 30

Cost containment working

Combined ratio shows improvement for workers compensation insurers



Source: National Council on Compensation Insurance

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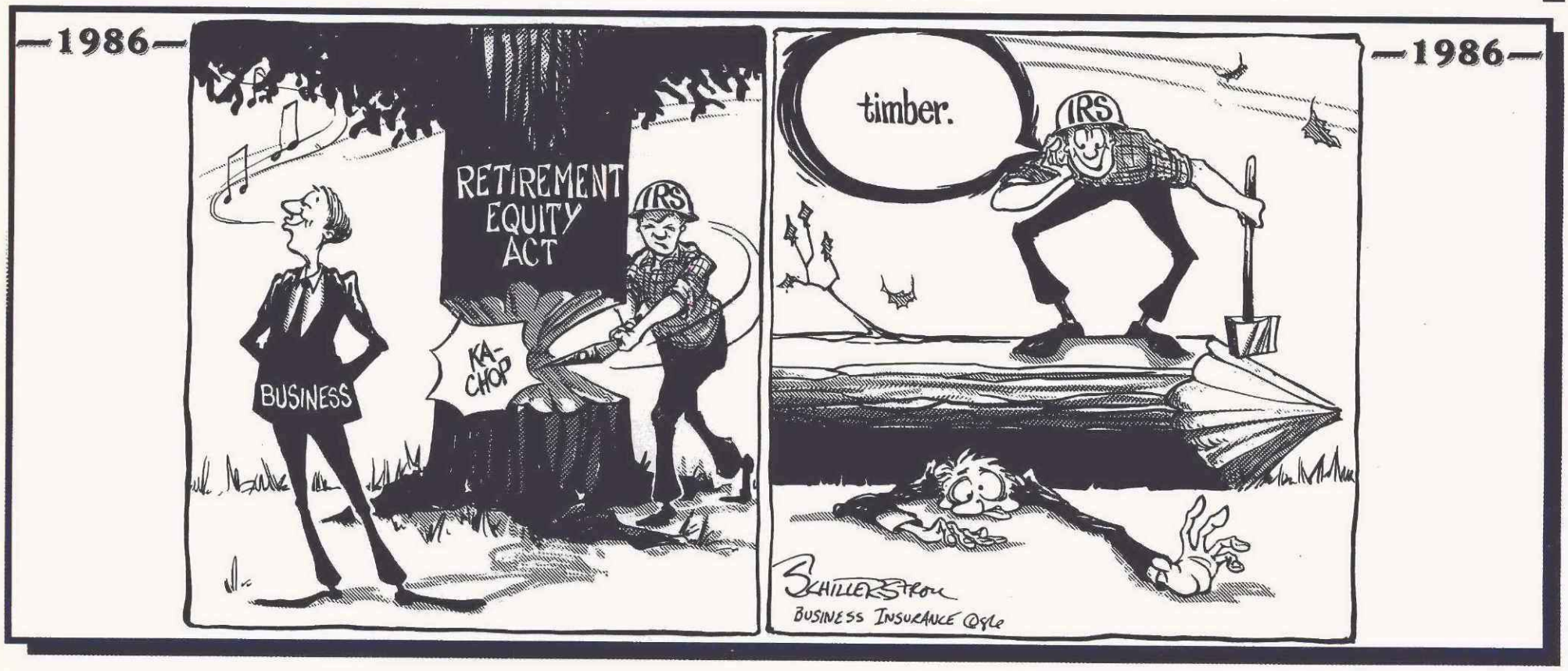

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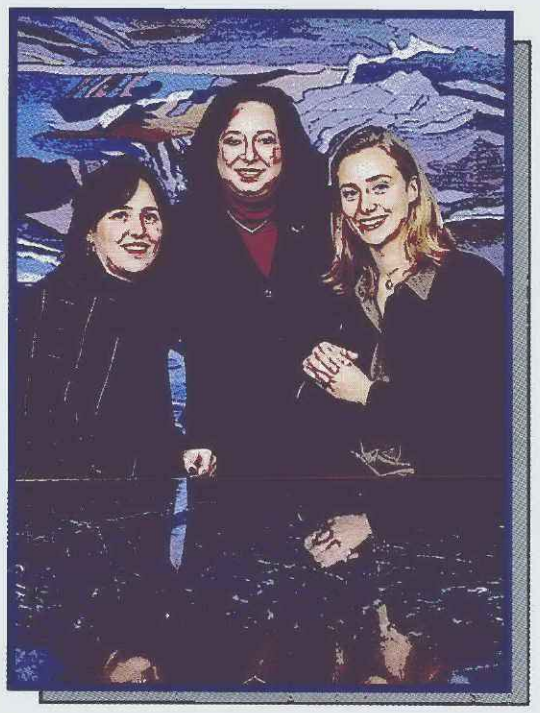
BI's sales and promotion staff

PHOTO: DAVID LUBARSKY

The New York sales staff comprises Associate Publisher and Ad Director Martin J. Ross III, seated, and from left, District Manager Elizabeth McGahren, District Manager Roger Lynch, Executive Secretary Pat Ghazvini, District Manager Cynthia Quinn, District Manager Blake Delany and Advertising Traffic Manager Carol Peacock.



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The Communication Services Department in New York, from left, Promotion Coordinator Barbara O'Brien, Director of Communications Ronnie I. Drachman and Promotion Assistant Rachelle Letersky.

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The Chicago sales staff consists of, from left, District Manager Deborah D. Neale, Midwest Advertising Manager Robert L. Niesse, Sales Assistant Irais Amleshi, Production Manager Elmer Kerstowske and Classified Advertising Manager Cheryl Adeszko.

Photos of *Business Insurance*'s editorial staff appear on the next page.

BI STAFF

Answers to the anniversary quiz

from page 36

Here are the answers to the benefits quiz:

1. a) General Electric Co.
2. c) $19.
3. b) Ira Magaziner.
4. a) Set non-discrimination rules for health plans.
5. c) End Stage Renal Disease.
6. b) 40 million.
7. a) Five-year cliff.
8. c) Buck Consultants Inc.
9. b) United States.
10. d) James Baker.
11. a) Imposed withdrawal liability on employers leaving underfunded multiemployer pension plans.
12. c) 750,000.
13. a) 12 months.
14. b) CSX Corp.
15. b) Howard Metzenbaum.
16. a) LTV Corp.
17. b) A requirement—no longer in effect—that said employers in certain situations had to offer HMO coverage to employees.
18. c) 48 hours.
19. d) 1993.
20. d) 20%.

Here are the answers to the risk management quiz:

1. a) Workers compensation.
2. c) Northridge earthquake.
3. c) J. Robert Hunter.
4. d) Colorado.
5. b) Alexander & Alexander Services Inc.
6. c) MGM Grand Hotels.
7. b) Howard Weber.
8. c) 1977.
9. c) John Garamendi.
10. b) Oregon.
11. b) American Society of Insurance Management.
12. c) Bill Clinton.
13. a) Bermuda.
14. a) The high court ruled on whether punitive damage awards can be so excessive as to be unconstitutional.
15. c) Keene Corp.
16. c) 1990.
17. d) Marsh & McLennan Cos. Inc.
18. c) 1994.
19. c) 1983.
20. a) Jack Brooks.

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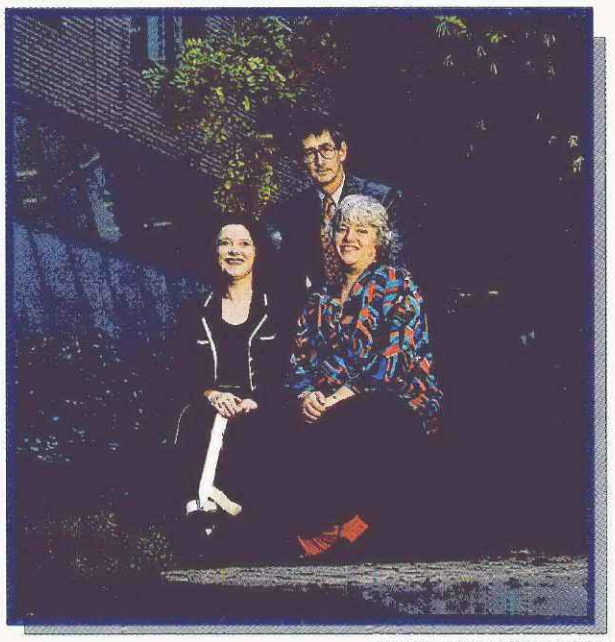

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Business Insurance's London Bureau comprises, clockwise from left, London Bureau Chief Sarah Goddard, Associate Editor Edwin Unsworth and International Editor Stacy Shapiro.

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In *BI*'s Washington office are, from left to right, Editor-at-Large Jerry Geisel, Managing Editor Roseanne White and Washington Editor Mark A. Hofmann.

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In *BI*'s home office in Chicago are, back row from left: Senior Editor Meg Fletcher, Production Assistant Amy Kepka, Publisher/Editorial Director Kathryn J. McIntyre, Associate Editor Rodd Zolkos, Editor Paul D. Winston, Copy Editor Todd J. Behme, Associate Editor Robert Kazel, Assistant Managing Editor Regis J. Coccia and Editorial Cartoonist Roger Schillerstrom. Front row, from left: Graphics Editor Kathy L. Barnes, Associate Editor Sally Roberts, Associate Editor Deborah Shalowitz Cowans, Editorial Assistant Amanda L. Milligan, Assistant Directory Editor Matt Scroggins, Directory Editor Sandra Budde, Assistant to the Publisher Karen Brown Tucker and Assistant Copy Editor Richard Trout. Not pictured is Copy Editor Sara J. Harty.

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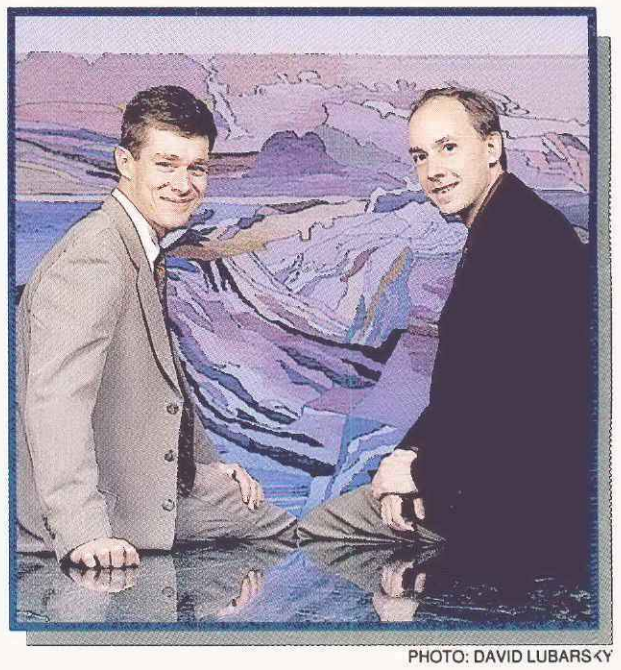
The Los Angeles office comprises, from left to right, Associate Editor Roberto Ceniceros, Senior Editor Joanne Wojcik and Sales Assistant Lori Lieberman. Not pictured are Senior Editor Judy Greenwald in San Jose, Calif., Senior Editor Dave Lenckus in Tucson, Ariz., and Associate Editor Michael Bradford in the Dallas office.



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Business Insurance's New York Bureau consists of New York Bureau Chief Gavin Souter, left, Senior Editor Douglas McLeod and Associate Editor Michael Prince, who is not pictured.

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