

business insurance

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Lloyd's suspends Sasse from transacting business

LONDON—Lloyd's of London has permanently suspended Fredrick Hugh Sasse, former chairman of Lloyd's underwriting agency Sasse, Turnbull & Co. Ltd., from transacting business at Lloyd's.

A Lloyd's disciplinary committee brought six charges against Mr. Sasse, who was underwriter for Syndicate 762. The syndicate was closed by Lloyd's after an avalanche of claims
Continued on next page

Auto warranty firm suing Orient-Pacific

By DOUGLAS McLEOD

LOS ANGELES—A Union Indemnity Insurance Co. policyholder is suing the agency that handled its business, charging that the agency and three of its officers and shareholders pocketed more than \$4.3 million of the policyholder's premiums.

The suit, brought by Universal Dealer Services Inc. of El Toro, Calif., names Orient-Pacific Insurance Agency Inc. and a group of related companies.

Also named as defendants in the suit are Lawrence R. Sellars and his wife, Eldora R. Sellars, and Russell E. March, all of whom are identified in the complaint as officers or shareholders of Orient-Pacific or the related companies.

The complaint, filed July 25 in California State Superior Court in Orange County, charges that the defendants conspired to divert more than \$4.3 million in premiums paid by UDS for automobile warranty insurance between 1981 and 1985.

About \$2.7 million of the premiums were supposed to go to Paxton National Insurance Co. of Harrisburg, Pa., which Mr. Sellars claimed was the 100% reinsurer of Union Indemnity on portions of the UDS program, according to the complaint.

However, the premiums never were paid to Paxton and were converted by the defendants "for their own use and benefit," the complaint charges.

Paxton, which is owned through two intermediate holding companies by Mr. March, was suspended from doing business by the Pennsylvania Insurance Department on July 17 (BI, July 29).

UDS also says that Mr. Sellars concealed his 1982 conviction for insurance fraud in Alaska. The conviction involved business unrelated to UDS that Mr. Sellars and another agent had written for Union Indemnity and Great Atlantic Insurance Co.

That conviction was overturned on a technicality last March, and Mr. Sellars is scheduled to be retried this month.

Despite the Alaska conviction, Mr. Sellars continued to act as a broker for Union Indemnity until early in 1985, according to Monroe Birnberg, former president of both Great Atlantic and Union Indemnity. Mr. Birnberg dealt with Mr. Sellars while president of both
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Senator's plan would dump insurer liability for cleanup

By ROBERT A. FINLAYSON

WASHINGTON—Risk managers and insurers are squaring off on Capitol Hill in a battle that may determine whether hazardous-waste generators or their insurers pick up the tab for cleaning up most of the nation's abandoned hazardous-waste dumps.

The battle is over a legislative proposal by Sen. Robert T. Stafford, R-Vt., and several major property/casualty insurers that may be offered as an amendment to Superfund reauthorization legislation.

Basically, the proposal would let insurers off the hook for billions of dollars in Superfund cleanup and litigation costs sought by waste generators under comprehensive general liability policies.

Sen. Stafford offered the proposal after insurers convinced him that such a proposal was necessary to end litigation and begin cleanup of waste sites, to assure a market for liability coverage for firms that perform the cleanup, and to avoid jeopardizing other lines of insurance because of unanticipated pollution-related CGL losses.

The debate over Sen. Stafford's proposal brings to a head a controversy that has been brewing in federal and state courts for several years over whether CGL policies provide coverage for cleaning up hazardous-waste disposal sites.

Insurers say they never anticipated such cleanup claims under CGL policies and never collected any premium for the coverage.

CGL policyholders say they fully expected such coverage when they purchased the policies, and many have gone to court to force insurers to defend them against government cleanup orders and indemnify them for cleanup costs. The courts generally have found for the policyholder in these coverage disputes.

Lower courts in 10 states have "misconstrued both the (general liability) contract itself and its pollution exclusion in such a way as to make general liability insurers liable for cleanup costs, even in instances where there has been no damage to third parties," says Leslie Cheek, vp of federal affairs for insurer Crum & Forster in Washington.

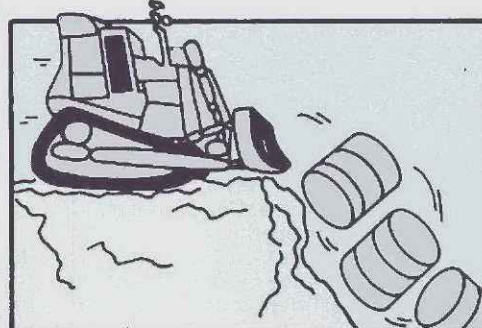
Mr. Cheek says the Stafford proposal is necessary "to prevent other courts from adopting interpretations of general liability insurance contracts that would impose Superfund cleanup liabilities on insurers of traditional bodily injury and property damage."

"What we've been doing is covering liability that we didn't contemplate and didn't charge any premium for," says David M. Farmer, vp of federal affairs with the Alliance of American Insurers in Washington.

And, insurers fear the cost of hazardous-waste cleanup could threaten the solvency of some insurers.

Mr. Farmer maintains that the Stafford proposal would "overrule inconsistent court decisions and bring some clarification to the CGL contract."

Specifically, Sen. Stafford's proposal would:
• Retroactively eliminate all insurance coverage for
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Graphic: Amy Palmer

States take steps to ease rate, capacity crisis

By CAROL CAIN

State regulators and legislators are considering a variety of new steps to protect commercial property/casualty insurance buyers from sharp rate increases, midterm cancellations and the unavailability of certain lines of coverage.

Among recent developments:

• An Illinois state legislator has proposed that the state Insurance Department be allowed to disapprove property/casualty insurers' rates. Currently, property/casualty insurers do not file rates with the department.

• Florida is investigating the formation of assigned risk pools for various property/casualty lines. The state Insurance Department is also considering a variety of other measures to help buyers cope with the tightening property/casualty market.

• The California Insurance Department is meeting with a group of underwriters in hopes of forming a statewide program to provide liability insurance to day-care centers.

• The Oregon insurance commissioner is expected to issue a permanent order restricting midterm policy cancellations.

• The Kansas insurance commissioner is threatening to take action to halt midterm cancellations.

In addition, insurance regulators attending last week's National Assn. of Insurance Commissioners' zone meeting in Syracuse, N.Y., discussed how to deal with current huge rate increases, midterm cancellations and the limited availability of some lines of coverage.

The NAIC in June adopted a resolution that opposed midterm coverage cancellation and short notices of non-renewals (BI, July 1).

Since then, several state regulators have said such activity can be considered an unfair trade practice. These regulators have issued either official orders or unofficial letters directing insurers to cease such practices voluntarily or face regulatory or legislative action (BI, Aug. 12).

"Regulators are looking at the availability

problems very closely," said Bruce Foudree, Iowa's insurance commissioner and president of the NAIC.

However, Mr. Foudree noted that rates currently being charged commercial buyers compare with the rates charged five years ago, though today's rates are shockingly high when compared with the cut rates offered by insurers over the past several years.

"Insurers are trying to recover losses quickly. . . In many instances, the increases are justified and should even be higher, based on the losses," Mr. Foudree said. "However, the problem that we're having is that (insurers) are increasing rates very suddenly. . . with no advance warnings."

Mr. Foudree noted that states, like Iowa, that must give insurers prior approval before they can raise rates, can move swiftly to limit the size of rate increases.

He added current market conditions are forcing regulators in about 25 states with open rate competition to reconsider that philosophy.

An Illinois state legislator wants open competition in that state to be replaced with a system that would alert the state Insurance Department to insurer rate hikes and give the department the opportunity to block the increases.

State Rep. Ellis B. Levin, D-Chicago, says property/casualty insurers should be subject to "file-and-use" regulation.

Under such a system, now used by about a dozen states, an insurer would be able to implement new rates as soon as they are filed with the Insurance Department; however, the department has a specified time period, usually 30 days, in which it can disapprove the rates.

Illinois used such a procedure until it expired in August 1971, Rep. Levin said. And, prior to January 1970, Illinois law called for a full-scale rate review before approval, he added.

Rep. Levin says the file-and-use law inadvertently was allowed to expire and later at
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update

Lloyd's suspends Sasse

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poured into the syndicate from substandard New York property risks it underwrote in 1976 (BI, Feb. 6, 1978; May 2, 1983).

Among the charges were that Mr. Sasse withheld documentation of the syndicate's premium volume from Lloyd's; failed to ensure that his syndicate's reinsurance had been properly placed; and permitted members of the syndicate to exceed their underwriting limit.

Mr. Sasse, who did not appear before the Lloyd's disciplinary committee, pleaded guilty in writing to all charges, Lloyd's says.

Under the terms of the suspension, Mr. Sasse cannot actively participate in the Lloyd's market, but he can continue to be an underwriting member and assist in the runoff of Syndicate 762's business.

Transit unit has no excess cover

CHICAGO—The Chicago Transit Authority, the nation's second-largest mass-transit district, has been operating its buses and trains without excess liability insurance since its coverage expired Sept. 7.

The CTA last year paid \$485,500 for excess insurance with \$50 million per-occurrence limits above self-insured retentions of \$2.5 million for each bus accident and \$5 million for each train accident, said Charles Anderson, CTA insurance and pension manager.

The first layer of the coverage was written by First State Insurance Co. in Boston, and other insurers were Evanston Insurance Co., Granite State Insurance Co. and Integrity Insurance Co., Mr. Anderson said. He declined to break down the layers of the coverage, which was placed by NAS Ltd. in Chicago.

Some of the insurers offered to renew portions of the coverage with different retentions, but Mr. Anderson declined to provide details because he still is negotiating with the insurers.

The CTA hasn't filed a claim since a 1977 train crash killed 11 people, said Edward Murnane, director of external relations for the Regional Transit Authority, which oversees the CTA.

The CTA has paid \$5.2 million of its own funds for claims and an additional \$3.4 million to process them so far this year, he said, adding a task force is seeking solutions to the problem.

Finishing touches put on ACE

HAMILTON, Bermuda—American Casualty Excess Insurance Co. Ltd., an investor-owned insurer being formed to write high excess casualty limits, will operate from Bermuda even though it is incorporated in the Cayman Islands.

ACE, which has an authorized capital base of \$200 million, is incorporated in Cayman partly to avoid a stamp duty of \$500,000 it would have had to pay the Bermuda government. However, ACE has applied for two permits to operate from Bermuda. One permit is for a mutual fund, and the other for its insurance operations.

ACE will be managed by Marsh and McLennan Cos. Inc., which was the driving force behind its formation (BI, May 6). However, it is likely to hire its own underwriter and support staff, sources say.

Elena claims hit \$543.3 million

NEW YORK—Insurers are expecting personal and commercial property damage claims from Hurricane Elena to reach \$543.3 million, according to the American Insurance Assn.

The AIA said hardest-hit was Mississippi, with \$352.3 million in commercial and personal lines losses. The storm also caused damage in Alabama, Florida and Louisiana (BI, Sept. 9).

The Travelers Corp. expects losses, exclusive of reinsurance, to total \$18 million, including \$6.5 million in commercial lines.

Aetna Life & Casualty Co. expects \$20 million to \$25 million in direct and reinsurance claims costs against it and its subsidiary American Re-Insurance Co., a spokesman said.

Industrial Risk Insurers is expecting claims from about 35 property damage losses to total \$10 million to \$12 million.

United States Fidelity & Guaranty Co. says losses are expected to be from \$17 million to \$22 million, with losses above \$14.5 million reinsured on a sliding scale, a spokeswoman said.

Pension insurance increase

WASHINGTON—The House Education and Labor Committee is proposing to increase employers' annual pension termination insurance premium to \$8.50 per plan participant, up from \$2.60.

The committee's proposal would also close loopholes in the Pension Benefit Guaranty Corp.'s pension termination insurance program (see story, page 3).

The proposal has been offered as an amendment to a budget reconciliation bill now pending in the House. A provision in that bill, which has been passed by the Ways and Means Committee, would increase the premium to \$8 per plan participant for only three years, after which it would return to \$2.60.

If Ways and Means refuses to accept the amendment, Education and Labor Committee Chairman Augustus Hawkins, D-Calif., says he will take the fight to the House Rules Committee.

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ISO is planning to withdraw two endorsements to CGL

By ROBERT A. FINLAYSON

NEW YORK—The Insurance Services Office plans to withdraw two controversial endorsements to its new claims-made commercial general liability contract that limited buyers' ability to extend coverage when necessary.

The endorsements to be withdrawn would have allowed insurers to:

- Limit the length of time the extended-reporting endorsement, or tail coverage, would be in effect on an individual policy, as long as that time limit was specified at policy inception.

- Endorse the policy so that the insurer is not obligated to provide tail coverage if the policyholder cancels or does not renew the policy.

ISO officials maintain both endorsements were intended for "limited" use; however, risk managers and brokers had feared that they would have allowed insurers to routinely deny tail coverage under the claims-made CGL contract. In many instances, tail coverage may be necessary with the new claims-made form to fill coverage gaps when a policyholder switches insurers or if renewing insurers advanced the retroactive date of the policy.

The new standard claims-made CGL contract includes a provision for tail coverage that must be offered to the policyholder regardless of which party cancels or

does not renew the policy.

However, tail coverage under the claims-made form still is limited by the overall policy aggregate, and the insurer can charge up to 200% of the initial policy premium for the coverage.

Furthermore, ISO officials explain, insurers are free to develop their own endorsements to the new policy forms, including the two withdrawn by ISO.

The withdrawal of the endorsements comes amid increasing concern on the part of state insurance commissioners about the effect the new claims-made commercial general liability form will have on policyholders.

Officials of ISO and the National Assn. of Insurance Commissioners plan to meet during the next few weeks to discuss the changes in the CGL forms, says Maryland Insurance Commissioner Edward J. Muhl.

Because of these latest changes, the Risk & Insurance Management Society in New York suggests that "breathing space" is needed to reassess the new CGL claims-made form before its scheduled implementation on Jan. 1, 1986.

"We think they need to take some more time to consider the program," says Jon Harkavy, director of governmental affairs at RIMS.

A spokesman for ISO said the insurers' trade group probably will file official notice of the withdrawal of the endorsements with state insurance departments within the next few weeks.

Latest Hughes satellite is malfunctioning

By MICHAEL BRADFORD

NEW YORK—A Hughes Aircraft Co. satellite launched last month aboard a space shuttle mission that carried out repairs on another Hughes probe is malfunctioning, the company says.

However, Hughes has not yet filed a claim with its satellite launch insurers, sources say.

The Syncom IV-F4 satellite, valued at an estimated \$94 million and insured for \$85 million, was successfully placed into orbit by the space shuttle Discovery in late August. However, the UHF relay links on the communications satellite failed earlier this month.

Hughes reported that the F4 worked well for two days before the relay links went dead. A spokeswoman for Hughes in Los Angeles said last week that all ground efforts to re-deploy the links had so far been unsuccessful.

Underwriting manager International Technology Underwriters Inc. in Washington wrote \$27 million of the \$85 million in coverage on the F4, according to sources. Intec writes on behalf of 85 insurance companies led by CIGNA Corp.

In London, Stephen Merrett, chairman of Merrett Syndicates Ltd. at Lloyd's of London, confirmed that he was the lead underwriter on the Lloyd's portion of the F4 coverage.

Although Mr. Merrett would not say how much coverage was placed with Lloyd's underwriters, other sources said the amount placed with Merrett, the Ariel Syndicate at Lloyd's and possibly other Lloyd's syndicates was about \$50 million.

The remainder of the coverage was placed with U.S.

and French insurers, sources said.

Marsh & McLennan Inc. in Los Angeles, Hughes' broker, placed the coverage on the F4 in conjunction with the M&M office in New York and M&M's London affiliate, C.T. Bowring & Co. Ltd.

The French coverage was placed by Paris broker Faugere & Jutheau.

During the same shuttle mission that placed the Syncom IV-F4 into orbit, astronauts made electrical repairs to the Syncom IV-F3, a similar Hughes satellite that had failed to enter its proper orbit in April because of faulty wiring (BI, Sept. 9).

Underwriters have already paid Hughes \$85 million for the failed F3, but stand to regain that amount if the satellite eventually becomes operational. About \$40 million of that loss was paid by the London market and Intec paid \$27 million.

Counting the loss of the F3, satellite insurers have paid \$367 million in launch insurance claims in the last 18 months (BI, Aug. 19). That cost would rise to \$452 million if the F4 is deemed a total loss.

Thomas W. Tily, managing director of M&M in Los Angeles, noted recent satellite losses have caused "considerable disquiet" in the satellite insurance market.

"It has created quite a bit of uncertainty," he added. "If there are any future losses, God forbid, it would only make the situation worse."

He said Hughes is being especially tight-lipped about releasing public information on the troubled F4 because the company wishes to avoid "undue speculation" about the fate of the satellite.

However, "It is (Hughes') wish to keep the underwriting community fully informed," said Mr. Tily.

Midwest Express covered for crash

By STEPHEN TARNOFF

MILWAUKEE—Midwest Express Airlines Inc. has a \$300 million combined single-limit liability insurance policy to cover losses from the Sept. 6 crash of a DC-9 in Milwaukee that killed 31 people, according to a London insurance source and the U.S. Department of Transportation.

Sources also say a \$15 million reserve has been established to pay claims stemming from the crash.

The hull is valued at \$3.1 million and United States Aircraft Insurance Group provided 100% of the hull coverage, according to the London source.

USAIG was Midwest's primary insurer, according to a spokeswoman for the airline's ultimate parent, Kimberly-Clark Corp. in Dallas. She also said that 25% of Midwest's coverage is placed in the United States and 75% in London.

Lead underwriter in London is Orion Insurance Co., the London source said.

USAIG would not comment on Midwest's insurance. Midwest's brokers are Marsh & McLennan Inc. in Chicago and C.T. Bowring & Co. Ltd. in London.

Midwest Express is a subsidiary of K.C. Aviation Inc., which is a subsidiary of Kimberly-Clark.

According to the DOT spokesman, the \$300 million in liability coverage far exceeds the federal government requirement of \$20 million per occurrence and the greater of \$300,000 multiplied by 75% of the plane's seating capacity or \$300,000 per person.

Total liability from the crash, including the value of the plane, could be between \$35 million to \$50 million,

estimated Morten Beyer, president of Avmark Inc. an aviation consulting firm in Arlington, Va.

The Milwaukee crash was the latest airline disaster in 1985, which already is the worst year ever for commercial aviation losses. Including the Midwest Express crash, about 1,400 people have died in commercial aviation accidents so far this year, and hull losses total about \$322.1 million.

The Midwest Express twin-engine DC-9 crashed in a wooded area shortly after takeoff from General Billy Mitchell Field in Milwaukee on a flight from Madison, Wis., to Atlanta with a stop in Milwaukee.

The plane was carrying six Kimberly-Clark employees in addition to the four crew members employed by Midwest Express.

Last week an investigation into the cause of the crash was continuing.

A spokeswoman for the National Transportation Safety Board said the main focus of the investigation would be on "uncontained engine failure" in the right engine. However, she noted, "Engine failure alone just does not cause a plane to crash."

Parts of the engine compressor blades were found on the runway. Also last week, investigators found a hole in a wall of the plane's right engine.

The other focus of the investigation would be on "operations factors" including the pilot's actions, she said.

The engines in the Midwest Express plane were manufactured by Pratt & Whitney Aircraft Group in East Hartford, Conn., and are JT8D-7B models. These are earlier models of the JT8D-15 engines involved in

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Questioning doctors

Workers trained to become assertive health care consumers

By DIANE LYNN KASTIEL

CHICAGO—As risky as it may sound, FMC Corp., Illinois Bell Telephone Co. and Commonwealth Edison Co. are teaching their employees to take over.

But, the three Chicago-based employers expect no mutiny, only lower health care costs.

FMC, Illinois Bell and Edison, along with more than 300 other companies nationwide, are teaching workers—and their spouses and retirees—how to be in control of the health care they receive through an assertiveness training program called "I'm in Charge."

The program, developed by employee benefits consultant Towers, Perrin, Forster & Crosby in Chicago, teaches employees how to explore their options when they require health care, primarily by pinpointing appropriate questions to ask their doctors (see sample).

"We really focus on the fact that the individual is the one in charge, regardless of what the company is doing in health care or what the insurance company pays," said Suzanne Peck, a TPF&C consultant and one of the originators of the program.

The cornerstone of "I'm in Charge" is an audio-visual presentation—narrated by actor Gregory Harrison, who portrays Dr. Gonzo Gates on the television series "Trapper John, M.D."—that depicts the problems patients have in communicating with doctors and offers solutions. This is followed by group discussions on how to ask questions of your doctor (see related story).

Finally, printed materials are distributed, stressing the seven basic questions that patients should ask their doctors before they agree to any treatment. Employees are even given a pad of note cards listing these questions to carry into the doctor's office as a prompt.

Overall, the program teaches employees not to assume that the doctor is always right; not to assume that they definitely need the drugs or tests or surgery their doctor prescribes; not to assume they have to be hospitalized to receive care; and not to assume they can do nothing to prevent a recurrence of their illness.

It teaches them that they—not the health care provider—are in the driver's seat when it comes to health care.

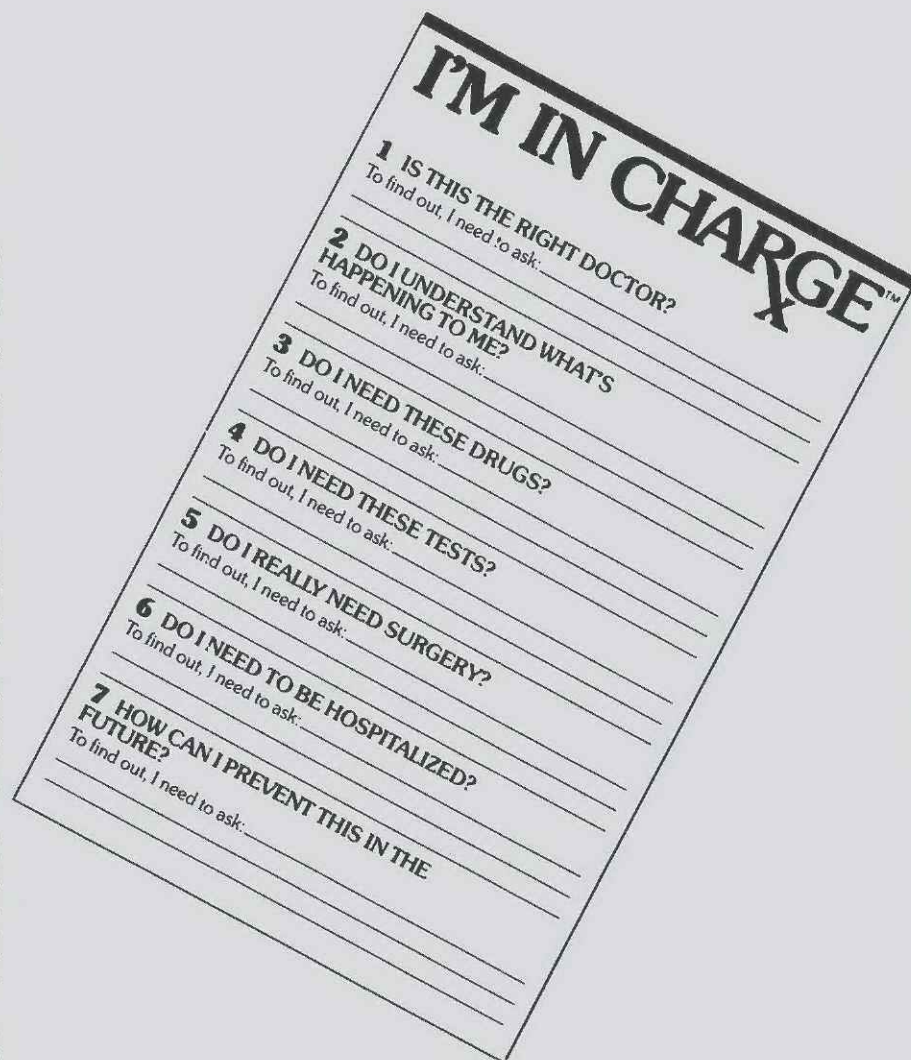
Commonwealth Edison introduced the "I'm in Charge" program to employees in January and is now training the last of its 19,000 employees. Next, Edison will introduce an "I'm in Charge" program for spouses and retirees later this fall.

"We passed out evaluations after each of the presentations, and I'd say 80% of the employees said they would like their spouse to see the film," said Kathleen Archibald, employee health educator for Commonwealth Edison.

"I'm in Charge" fit nicely into the consumerism aspect of Commonwealth Edison's wellness program, Ms. Archibald said, adding that programs like "I'm in Charge" are hard to find.

"I looked around, but there weren't any solid (consumer) programs out there," Ms. Archibald

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Talking the key to taking charge

By DIANE LYNN KASTIEL

Communication is the key to "I'm in Charge," a program designed to teach employees how to interact assertively with their doctors to make sure they are receiving cost-efficient health care.

"The whole purpose of the program is to show you how to talk to doctors," said Suzanne Peck, a consultant with Towers, Perrin, Forster & Crosby in Chicago, which developed the program.

"Research shows that most people don't know how to talk to doctors or what questions to ask," Ms. Peck said.

To date, 350 companies—including Illinois Bell Telephone Co., FMC Corp. and Commonwealth Edison Co.—have presented "I'm in Charge" to more than 1 million employees, dependents and retirees (see related story).

The program, comprising audio-visual and print materials and group discussions, shows employees how to take an active role in making sure they receive appropriate, cost-effective health care services by asking questions and by considering the purchase of health care as they would consider any other purchase.

"I'm in Charge" is the brainchild of Ms. Peck and David Glueck, vp for TPF&C's group benefits practice.

"We had been talking about doing something about employee education and consumer awareness for about two years," Ms. Peck said. "In the consulting work we did, we would tell companies that part of the problem was getting employees to be better consumers and they said, 'Great—but how do you do it?'"

The biggest challenge in designing the program was to create something to modify behavior, rather than just raise employees' awareness of health care

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PBGC head likes basing premiums on plan finances

By JERRY GEISEL

WASHINGTON—Basing pension termination insurance premiums on the financial condition of an employer's pension plan would encourage better pension plan funding, says the new executive director of the Pension Benefit Guaranty Corp.

Kathleen P. Utgoff, who was appointed to the top PBGC post last month, says it's more rational to base the premium employers pay to the PBGC on the financial condition of their plans rather than charging a uniform premium.

"I'm very sympathetic to the concept of a risk-related premium," Ms. Utgoff said.

Currently, all employers with defined benefit pension plans pay the PBGC an annual insurance premium of \$2.60 per plan participant. The premiums are used by the PBGC to guarantee workers' and retirees' pension benefits when employers terminate underfunded plans.

Ms. Utgoff acknowledges, though, that the implementation of a risk-related premium is a complicated issue. She acknowledged the argument that basing premiums on the financial condition of employer plans would hit hardest those firms least able to afford the premiums: financially troubled companies with big pension liabilities.

A PBGC study, which could be released later this year, could shed new light on the risk-related premium issue, she says.

"The risk-related premium study is of extreme importance to me. It is the opening move in a long-term project," she said.

In an interview with *Business Insurance*, Ms. Utgoff also said:

- Congress will likely act this year on legislation to increase the premium employers pay to the PBGC to prevent the agency from running out of money.

- Changes are needed in the PBGC insurance program to make it more difficult for employers to shift their pension liabilities to the agency.

- The Multiemployer Pension Plan Amendments Act of 1980 is causing financial problems for some companies, but Congress is not likely to make changes in the law soon.

- A single federal agency would not be a "panacea" to provide quick answers on retirement income issues.

Ms. Utgoff, 37, is the seventh person to head the PBGC since Congress created the agency 11 years ago as a key part of the Employee Retirement Income Security Act. She replaced Charles Tharp, who resigned earlier this year.

However, Ms. Utgoff is the first economist to direct the PBGC. She has a doctorate in economics from the University of California at Los Angeles and most recently served as a senior staff economist to William Niskanen, when he was a member of the President's Council of Economic Advisers. She also was a

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Ms. Utgoff

Mission, reinsurers discuss audit of Pacific pool

By STEVE TARAVELLA

LOS ANGELES—Mission Insurance Group and 26 reinsurers that were members of a treaty reinsurance pool managed by a Mission subsidiary are discussing the findings of an audit of the pool ordered by the reinsurers.

The reinsurers, all foreign-based companies, called for the audit in June after two separate lawsuits alleged the pool—run by Mission subsidiary Pacific Reinsurance Management Corp.—was mismanaged.

The Pacific pool stopped taking on new business in July 1984 and is now running off its business (*BI*, May 13; May 20; June 24). Accountant Coopers & Lybrand qualified MIG's 1984 financials, citing the uncertainty of the outcome of the two suits.

The 26 reinsurers are reviewing the findings of the audit before deciding whether to

join one of the suits. That action was initially filed in U.S. District Court in New York by Ohio Reinsurance Corp. of Celina, Ohio.

However, a federal court in Los Angeles ruled in June that Ohio Re and the other five plaintiffs in the suit must arbitrate their disputes with Pacific and Mission Insurance Co. (MIC), which fronted certain reinsurance policies for some of the pool members and also retroceded risks to other companies.

The plaintiffs are seeking rescission of their contracts with Pacific and MIC.

MIG officials took advantage of last week's annual Rendez-Vous de Septembre in Monte Carlo, which attracts much of the world's reinsurance community, to discuss the recently completed report on Pacific's operations with representatives of the companies that commissioned the audit.

The meeting was scheduled for last Thursday with as many of the 26 companies as

could be present, according to Lawrence G. Becker, Mission's vp, general counsel and secretary.

Mr. Becker was joined at the Monte Carlo meeting by Geoffrey A. Nicholls, Mission's senior vp in charge of reinsurance.

The 26 reinsurers commissioned Norman Reitman & Co. in New York to conduct an audit of the pool after European reinsurers met with MIG officials April 3 in London to discuss Pacific's business in light of the litigation.

The reaction of the reinsurers to the audit could play a key role in resolving the dispute.

"If Reitman concludes that what PRMC did was OK," the six plaintiffs in the Ohio Re suit "will have a tough row to hoe proving what it did was not OK," notes Lawrence I. Brandes, a Mission attorney with the New York firm of Miller, Singer & Raives.

"After an in-depth audit like this, if these

26 companies are convinced there's no basis to seek rescission of their agreements, if I were representing the other six, I'd have to rethink telling them they have a valuable claim for rescission," Mr. Brandes says.

Preliminary examination of pool records by Reitman staffers took place in June at Pacific's New York offices, but most of the audit was conducted in Los Angeles, where Pacific's books were moved after the New York office was closed early in the summer.

Three or four Reitman auditors have been at Mission's Los Angeles headquarters almost daily since and have been given access to all pertinent files, Mr. Becker reports.

In addition, two representatives of the concerned reinsurers—Paul Daneo, director of reinsurance at SAI Industrial Insurance Co. in Turin, Italy, and Benedicte Dollfus at Compagnie de Reassurances d'Ile de France

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Pacific pool audit

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(Corifrance) in London—spent about a week in Los Angeles in June conferring with the auditors and with Mission representatives, including Pacific Vp Bob Wolff.

Reitman sent a preliminary audit report and supplementary printed material to the reinsurers Aug. 31. That was followed by a second report last week offering a more detailed financial look at the operation.

The audit cost the 26 companies from \$300,000 to \$400,000, sources say. Norman Reitman, president of the auditing firm, could not be reached in Monte Carlo last week.

Depending on the reinsurers' response to the audit, subsequent reports may be issued by Reitman, according to Mr. Becker.

"We continue to be pleased with the cooperative nature of our relationship and hope to reach an amicable agreement," Mr. Becker said

shortly before leaving for Monte Carlo last week. He said Mission is willing to spend as much time as is necessary to resolve the dispute.

Since June, MIC has paid about \$28 million in claims on behalf of the 26 pool participants, according to Mr. Becker. Pending the outcome of the audit, Mission had agreed to temporarily relieve the companies of their responsibility to pay claims on business written by Pacific.

In the meantime, the six reinsurers that are plaintiffs in the Ohio Re suit have asked the federal court in New York to rule that they should be given the same rights of inspection that Mission is giving to the 26 reinsurers that commissioned the audit. However, the court has not yet ruled on the request and MIG is not now giving the companies access to records, Mr. Becker says.

Although the federal court in New York, where the Ohio Re suit was filed, has not officially stayed

the reinsurers' claims against MIC and Pacific while the dispute is in arbitration, it has cleared the way for the parties to proceed with the arbitration, Mr. Brandes says.

The Mission defendants have not asked that one allegation in the Ohio Re suit be stayed: the so-called "alter-ego" claim, in which the six reinsurers seek to hold MIG responsible for the actions of Pacific, its wholly owned subsidiary (BI, June 24).

MIG will litigate that claim, attempting to show that MIG cannot be held liable for the debts of its subsidiary, Pacific. MIG claims Pacific operated as an entirely separate corporate entity with an unusual degree of autonomy.

In addition, the plaintiff reinsurers recently selected Jack E. Koepke, senior vp at Gerling Global Reinsurance Corp. in New York, as their arbitrator. He is now working with arbitrators, named by Mission and Pacific in June, to agree on an umpire so the arbitra-

tion process can begin.

Mr. Becker does not expect the umpire to be named this month.

At one point, Ohio Re and the five reinsurers considered arbitrating their contracts with Pacific and MIC separately, but there is now speculation that the arbitration will be in some way consolidated.

For example, all the disputes over Pacific contracts might be aired in one process and all the disputes over MIC contracts in another, suggests Jonathan F. Bank, Mission's Los Angeles attorney with Buchalter, Nemer, Fields, Chrystie & Younger.

Consolidating the MIC and Pacific disputes into one large arbitration process is "a possibility," says Mr. Koepke.

"I don't see any point in arguing the same point five times," says Bruce Friedman with Kroll, Pomerantz & Cameron, Ohio Re's New York law firm. But he notes that the situation is "still up in the air" and that no official agreement

addressing consolidation has been made.

After the arbitration was ordered in June, MIC and Pacific asked the New York court to order the reinsurers to reimburse them for the legal expenses incurred while trying to enforce the arbitration clause of the contracts.

The court has not yet ruled on the request.

MIG and Pacific claim the "frivolous litigation" brought by the reinsurers "put PRMC and MIC to the wholly unwarranted expense and burden of vindicating their right to arbitrate in the face of plaintiffs' stubborn resistance."

The two companies are seeking \$85,509 in expenses they have already paid. Of that, \$51,709 was paid to Miller, Singer & Raives and \$33,800 was paid to Buchalter, Nemer, Fields, Chrystie & Younger in Los Angeles.

In a related matter, Ohio Re was sold two weeks ago by its parent, Celina Financial Corp. But the sale will not affect the status of this dispute, according to the parties involved.

Ohio Re was sold Sept. 3 to Kensu Holdings Inc., a 2-year-old insurance and real estate holding company in Kansas City, Mo. Celina will receive \$2.65 million for Ohio Re's stock after Ohio Re's net assets are transferred to a newly formed Celina subsidiary, First National Indemnity Co.

For the moment, First National will be used to run off Ohio Re's business; Ohio Re stopped writing new or renewal business a year ago. But the new company may later be activated as a multiline fire and casualty insurer, according to Donald W. Montgomery, chairman and president of Celina Group.

Kensu is renaming its acquisition The Ohio General Insurance Co. The company, with 21 multiline licenses, will principally write direct property/casualty coverage, not reinsurance, according to President Bernard Geis. He expects Ohio General to begin writing later this year or in early 1986.

Meanwhile, Federated Reinsurance Corp., which filed the second suit charging Pacific with mismanagement, is still waiting for a decision from the U.S. District Court in New York on MIG's April 20 motion for summary judgment to dismiss itself from the case.

Federated Re, in Piscataway, N.J., named both Pacific and MIG in its action, which was filed Feb. 19, but it did not name Mission Insurance Co.

The arbitration order in the Ohio Re suit does not affect Federated Re's claim.

Tornado damage set at \$231.6 million

NEW YORK—Tornadoes and other storms caused an estimated \$231.6 million in insured property damage May 29-June 1 in Pennsylvania, Ohio, New York and six other states, according to C.E. Hermanson, vp of the Property Claim Services division of American Insurance Services Group Inc.

The worst damage—an estimated \$101.2 million—occurred in Pennsylvania. Some \$91.2 million of this was attributed to tornadoes, and the remaining \$10 million was caused by wind and hail.

In Ohio, the estimate of damage was \$61.4 million, with tornadoes accounting for \$58.4 million and wind and hail accounting for the remaining \$3 million.

New York's damage estimate was \$10.5 million, of which \$5.5 million was caused by tornadoes.

Estimates of property damage in the other states, most of it caused by wind and hail, were: Missouri, \$40.5 million; Kansas and Michigan, \$6 million each; Illinois, \$2.5 million; Iowa, \$2 million; and Indiana, \$1.5 million.

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American Society for Hospital Risk Management conference

Solutions to coverage crunch are limited

By MEG FLETCHER

CHICAGO—Health care providers seeking professional liability insurance in a tightening insurance market are finding fewer markets, higher rates and more restrictive terms.

And, experts warn, there are no easy solutions to the problem.

Rates are up 100% to 500% for hospitals' excess liability insurance, which may include coverage for full-time staff doctors, says John P. Norris, president of American Health Systems Inc. in San Francisco, a consulting firm and a unit of broker Glen, Nyhan & Associates. Mr. Norris spoke at the American Society for Hospital Risk Management conference in Chicago last month.

St. Paul Fire & Marine Insurance Co., the largest insurer of hospital



Mr. Norris

liability risks, has raised hospital liability insurance rates—excluding coverage provided for practicing doctors—an average of 35% this year, a spokeswoman for St. Paul said in a separate interview.

Hospitals' liability limits vary "tremendously," said Rich Pfeiffer, St. Paul's senior underwriting officer. Annual aggregate limits typically range from \$5 million to \$10 million but can reach \$60 million to \$100 million for large teaching facilities, he said.

In addition, professional liability insurance rates have increased 40% to 150% for individual doctors, especially those performing high-risk and surgical procedures, and about 300% for dentists, Mr. Norris said.

One of the causes of higher rates, Mr. Norris said, is that financial problems have led to the insolvency of some insurers that wrote malpractice risks, including Ideal Mutual Insurance Co., which is in liquidation in New York, and Ambassador Insurance Co., which is contesting liquidation in Vermont.

In addition, other insurers have canceled nationwide insurance programs for obstetricians/gynecologists and for nurse midwives, he said.

Other markets—including domestic and foreign reinsurers—have reduced their medical professional liability writings. Even Lloyd's of London, which underwrites reinsurance for more than two-thirds of the doctor-owned mutual insurance companies, has reduced its volume, according to Mr. Norris.

When hospitals' and physicians' liability insurance coverage can be found, rates are "significantly" higher for lower limits of coverage and forms and terms are tighter, Mr. Norris added.

Policy restrictions include greater use of claims-made rather than occurrence policies, he said.

In addition, hospitals are being asked to increase their level of self-insured retention. And, insurers also are stipulating that hospitals require staff physicians to have certain levels of coverage on their own.

Also adding to the problem is the fact that doctors performing lower-risk procedures are asking that, for purposes of setting rates and coverage, they be considered separately from doctors in high-risk specialties like obstetrics, he said.

And, Mr. Norris said that, despite skepticism on the part of doctors and hospitals, the rate hikes and coverage restrictions are necessary.

"Substantial material losses are threatening the insurance companies which have them," he explained.

Property/casualty insurers and reinsurers are retrenching in the wake of "positively shocking" results in recent years, he said. Even doctor-owned insurers, which write about 50% of the market in physicians' malpractice coverage, had a 150% loss ratio, he said.

"Professional liability insurance is a pariah," Mr. Norris added.

The major cause of the poor results in the medical malpractice area has been a "terrific" increase in the frequency and severity of losses, said Mr. Norris.

"In recent years the total number of claims filed each year against

When hospitals' and physicians' liability insurance coverage can be found, rates are 'significantly' higher for lower limits of coverage and forms and terms are tighter, said American Health Systems' Mr. Norris.

physician-owned companies has more than doubled. The rate at which claims are closed lags behind the filing rate, leading to a sharp increase in the number of accumulated claims still open," he said.

The spokeswoman for St. Paul, which insures 1,600 of the 6,000 hospitals in the United States, said the number of claims filed in-

creased from 1.3 per 100 hospital beds in 1979 to 3.4 claims per 100 beds in 1984.

Although two-thirds of those claims are settled with no payment on the part of the insurer, the average cost of a liability claim—including defense costs and any settlement or award—has more than doubled to \$12,252 in 1984 from

\$5,843 in 1975, she added.

The median indemnity paid by physician-owned companies increased 440% to \$49,871 for 17 companies in 1983 from \$9,227 for 12 companies in 1979, Mr. Norris said.

He added that the number of claims filed is only the tip of the iceberg in terms of potentially compensable incidents. One study indicates that the number of potentially compensable incidents is about eight times the number of claims actually filed.

Contributing to the increases in judgment are expanded theories of negligence, including a broader interpretation of informed consent and theories like "wrongful birth," in which, for example, a man who

Continued on next page

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Continued from previous page
has had a vasectomy that failed
sues the doctor to recover the costs
of raising the resulting child.

In addition, plaintiffs seem to
have a "lottery mentality" about
striking it rich by finding fault
with doctors, whom many plain-
tiffs resent because of what they
perceive to be the doctor's affluent
lifestyle, Mr. Norris said.

He added that there are several
possible solutions to the tight mar-
ket for malpractice insurance, in-
cluding:

- The infusion of new capital
into liability insurers. Under-
writers eventually will be at-
tracted to the market in the next
few years, as premiums increase
and insurers decide there is money
to be made in writing medical mal-
practice insurance.

In addition, some mutual com-
panies may seek to raise money
through public offerings of stock,
he said.

- Expanded risk management

programs designed to reduce claims
through the reporting of incidents
and tracking claims.

"Most people are trying to man-
age this problem with incomplete
data," he said, adding that, as data
improves, so will the risk manage-
ment programs.

He suggested that hospitals
should consider spending for risk
management an amount equal to
1% of the premium they pay for li-
ability coverage. This money would
be well spent if it can reduce
claims, he said.

- Use of restrictive policy en-
dorsements to target high-risk spe-
cialties.

It is "Pollyanna-ish" to think that
all doctors and all hospitals should
have the same coverage, Mr. Norris
said.

He recommended adopting re-
strictions like those that apply for
anesthesiologists in California. In
that state, liability coverage for an-
esthesiologists is void if they fail to
meet certain conditions, including

having three monitoring devices
operating and remaining in the op-
erating room while the patient is
under their care.

- Greater cooperation between
doctors and hospitals.

Information, such as whether a
doctor has a drinking problem,
must be shared more broadly for
the benefit of both doctors and hos-
pitals, he said.

He said this is increasingly true
as doctors and hospitals must com-
pete against other doctors and hos-
pitals for patients.

- Passage of legislation that
would limit patient compensation to
economic losses and not allow
compensation for intangibles like
pain and suffering.

However, Mr. Norris said, the
proposed solutions offer no "quick
fixes."

He said that, as a way of dealing
with the market problems, risk
managers should step up their ef-
forts to reduce the frequency and
severity of losses.

Court decisions expanding hospital liability, expert says

By MEG FLETCHER

CHICAGO—Good hospital risk
management is even more vital in
light of court decisions that
broaden hospitals' liability expo-
sures, a legal expert says.

It is "critical" that hospitals have
good procedures for admitting and
reappointing doctors to the hospi-
tal's staff, according to Miles J.
Zaremski, partner in charge of
health care litigation for the firm of
Lurie Sklar & Simon Ltd. of Chi-
cago. Mr. Zaremski spoke at the
American Society for Hospital Risk
Management conference held last
month in Chicago.

One relatively new area of hospi-
tal liability, he explained, involves
granting hospital privileges to doc-
tors.

Although doctors say they effec-
tively police themselves, two re-
cent studies in Pennsylvania and
Illinois point up the need for a bet-
ter peer-review system to weed out
unqualified doctors, according to
Mr. Zaremski.

Failure to do so can result in hos-
pitals being sued for "hospital cor-
porate negligence." Such suits stem
from a 1965 court decision that
found that hospitals can be respon-
sible not only for actual negligence,
but also for failing to properly
monitor and investigate a doctor
practicing at the hospital, said Mr.
Zaremski.

Yet, hospitals may find them-
selves in a "Catch-22" situation, he
said, in that they may face claims
from patients for allowing an in-
competent doctor to practice or
claims from doctors who are denied
privileges.

"Physicians are more and more
prone to bring suit," he said.

In deciding whether a hospital
was justified in refusing to grant
privileges to a particular doctor,
most judges look at whether the
hospital followed its own guidelines
and gave the doctor due process be-
fore denying privileges, he said.

A denial of privileges by a pri-
vate hospital is not subject to court
review, according to a decision in a
Michigan Court of Appeals case,
*Veldhuis vs. Central Michigan
Community Hospital*. However, ac-
tion by a public hospital board can
be subject to court review, he
added.

In other cases related to granting
physician privileges:

- A Washington court found in
Anderson vs. Breda that although
state law protected the internal re-
cords of a hospital's quality review
board, the law did not apply to in-
formation about a doctor's "termi-
nation, suspension or restriction of
the doctor's hospital privileges."

- Similarly, an Illinois appellate
court in *Gleason vs. St. Elizabeth
Medical Center* found a plaintiff
could have access to information
regarding steps the hospital took to
supervise or restrict a physician,
while shielding the actual review
process itself.

- An Ohio appeals court in
Stratso vs. Song found that a hospi-
tal could be held liable for the ne-
gligence of an anesthesiologist, even
though he was an independent con-
tractor and not technically a hospi-
tal employee.

Hospitals are also facing lawsuits
over antitrust matters, although in
*Jefferson Parish Hospital District
No. 2 vs. Hyde*, the U.S. Supreme
Court ruled that an exclusive con-
tract between a hospital and a firm
of anesthesiologists was not a viola-
tion of the Sherman Antitrust Act.

And, courts have upheld hospi-
tals' right to require that doctors
have malpractice insurance, he
added.

Changes in the health care deliv-
ery system also will increase hospi-
tal's liability exposures, he said. For
example, hospitals that pressure
doctors to discharge patients be-
cause Medicare diagnostic-related
group payments will not cover the
cost of patient care could be found
liable if medical decisions are
skewed by non-medical factors, he
said.

Such decisions always should be
based on the quality of care, he
said.

And, Mr. Zaremski warned, "It is
not going to get any better for you
and your particular institution. It is
going to get worse."

As a result, he said, risk manage-
ment safeguards must be stepped
up to protect the hospital from its
new liabilities.

"It is important that you are in-
volved in the initial process," he
said.



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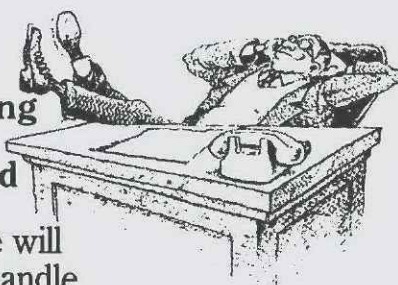
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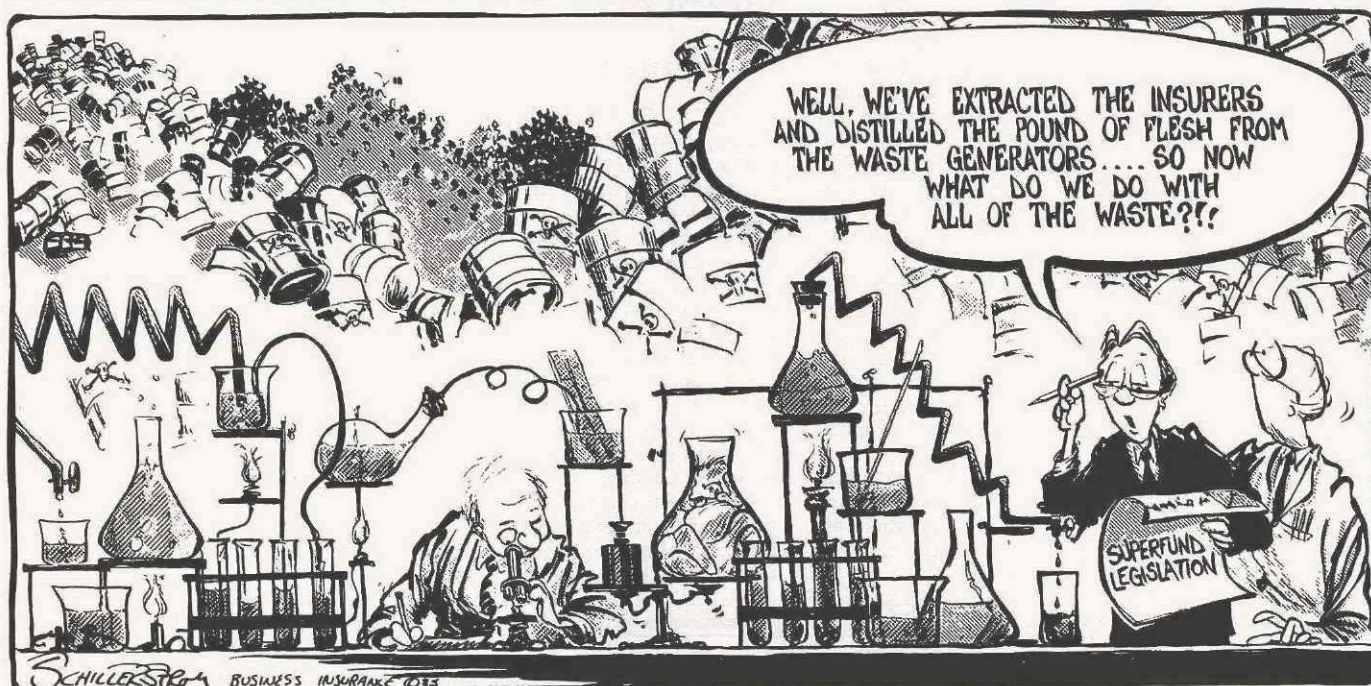
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opinions



Dump Superfund

IF CONGRESS is truly interested in expediting the cleanup of hazardous-waste sites, it should reject Sen. Robert T. Stafford's proposal to absolve insurers of liability for cleanup costs—and dump the rest of the Superfund reauthorization legislation along with it.

Laying the cost of cleanups solely on the waste generators—in an effort to punish polluters—is unfair and counterproductive.

First, just as insurers argue that they had no idea they were insuring cleanup costs when they underwrote liability policies decades ago for hazardous-waste generators, the generators can argue that at the time they dumped their waste they had no idea they were polluting but were purchasing comprehensive coverage for their liability risks.

In all probability, no insurer 20 years ago was selling cleanup coverage and no generator was looking to buy it because few realized that the wastes being dumped would pollute the environment. Consequently, can either side now be held responsible for cleanup costs?

Still, even if Sen. Stafford's crusade to punish someone—in this case the waste generator—for pollution were fair, it still would not be productive.

Without insurance coverage, many of the waste generators who could be slapped with joint and several liability for site cleanups would not have the financial resources to pay to get the job done. We propose that Congress not approve the Superfund reauthorization bill but instead draw up a new no-fault plan for cleaning up the environment.

One idea would be to forget about liability for pre-

Superfund pollution and instead broaden the Superfund tax base to include more industries, so funds would be available to clean up hazardous-waste sites without having to assess blame to decide who will pay.

For post-Superfund pollution, the responsible parties would be prosecuted, but while a verdict was awaited, cleanup of the damage they caused would be financed through the new, richer Superfund.

An even more radical approach would be to make the cleanup of the environment the social responsibility of the entire public, reasoning that all have enjoyed a higher quality of life due to the technology that generated the hazardous-waste products so all should now contribute—through higher taxes—for the cleanup.

Certainly, others can come up with different no-fault solutions. We do not pretend to have the solution in hand, but we do know that insisting that either insurers alone or waste generators alone—or insurers and generators in unison—foot the bill for cleaning up decades of pollution is not working.

Let us remind Congress that in the five years since Superfund became law, only about 50 of the 1,800 waste sites targeted for cleanup have been cleaned. In contrast, we have no idea how many lawyers have made their fortunes as a result of cleanup litigation.

If Congress is serious about improving the environment, let it take radical action. But if it insists on reauthorizing the current Superfund system, let it at least do it soon—to reduce the tax dollars it is now wasting to debate a solution that won't solve the problem.

letters

Illinois exchange's capacity problems not long-term

To the editor: In the article, "Surplus Lines Brokers Applaud Illinois Exchange's New Capital" (BI, Sept. 2), I was quoted with regard to our relationship with the Illinois Insurance Exchange as saying that the capacity at the Illinois Insurance Exchange "has been less than we would like, but there's been times when the exchange made the difference in placing a risk."

This is a correct statement. However, the preceding paragraph in the article states that our firm has placed little busi-

ness on the exchange during the past two years and that it does not expect to place much on the Illinois Insurance Exchange in the future. This is an incorrect statement.

I did acknowledge we have had a decreasing volume in the exchange due to the closings of several major syndicates over the past two years, but I anticipated our volume would increase as new syndi-

cates open up.

We have an excellent working relationship with the Illinois Insurance Exchange and look forward to a long-term relationship with their organization.

Raymond N. Lloyd
Vp

Triad Underwriting
Management Agency Inc.
Chicago

Don't point finger at surplus lines market

To the editor: The remarks made by Joseph F. Finnis in his letter to the editor (BI, Sept. 2) are pretty typical of the shortsightedness of the "standard" market in trying to place blame for the current industry situation on the surplus lines or specialty markets.

A few short years ago, we in the surplus lines business were rocking along, doing our own thing, which is primarily filling gaps left by standard insurers, when "they" decided that "cash-flow under-

writing for investment" was the way to go. "They" decided there was no such thing as a surplus risk.

Don't point your finger at us, Mr. Finnis. We only tried to survive, and will do so. Let's have a little less finger-pointing and guide our energies into constructive solutions.

George Knight Jr.
President

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Trend toward home care poses new liability worries

By MEG FLETCHER

CHICAGO—The trend toward home health care as an alternative to hospitalization is creating new concerns for risk managers of hospitals and independent agencies that provide home health care.

Patients are being discharged "sicker and quicker" from acute care facilities as a result of the nationwide movement toward health care cost containment, says Patricia A. Peters, director of hospital services for Park Ridge, Ill.-based Parkside Home Health Services Inc., a subsidiary of the Lutheran General Health Care System.

In addition, more elderly people are able to avoid or postpone hospi-

talization by receiving health care services in their homes.

Some discharged patients go to intermediate care facilities, but many return to their homes and have their medical needs met through a combination of health care services that can range from occasional visits by physical therapists to round-the-clock nurses or hospice care.

Other related services that also might pose liability problems include transportation to doctors' offices, adult day-care programs, home-delivered meals, emergency communication services and the use of sophisticated medical equipment in the home, Ms. Peters said.

"When I was in nursing eight

years ago, patients on ventilators were in (hospital) intensive care. Now they are at home," she said.

Ms. Peters spoke at the Aug. 25-28 annual meeting in Chicago of the American Society For Hospital Risk Management, which is affiliated with the American Hospital Assn.

About 110 Parkside staff members made 33,000 home visits in the Chicago area in fiscal 1985, Ms. Peters said.

As of July 1, there were 5,682 Medicare-certified home health care agencies in the United States. Of these, 1,116 were hospital-based.

The number of hospital-based and for-profit home health agencies are growing at an annual rate of 60%, so risk managers for these agencies increasingly will be concerned with reducing liability risks, Ms. Peters said.

She said liability claims related to home health care procedures can stem from several treatment-related and staff-related causes.

However, claims can be prevented or reduced through clear-cut policies and procedures, she said.

The treatment-related problems, and specific ways to avoid them, are:

- Inappropriate assigning of patients to a particular category of care. For example, part-time nursing care may be advised when full-time, private duty nurses are needed.

It is important for a home health care agency to have clearly worded admission and discharge standards and a clear description of services available. Procedures also should allow for feedback from care providers and patients, Ms. Peters said.

"The gray areas will get us into trouble," she added.

- Improper utilization, of medical equipment or malfunctioning equipment.

Special safeguards are needed because a home environment is much less controlled than that of a hospital, she said. For example, emergency generators may be needed to keep electrical equipment operating in a home during a blackout, Ms. Peters said.

Liability losses can be reduced by having standards and procedures for equipment inspection and use in the home.

And, home health care agencies must react quickly if they are notified by an equipment manufacturer of a potential problem, she added.

Ms. Peters also suggested that patients' homes be surveyed before sophisticated medical equipment is installed.

- Improper disposal of toxic wastes such as, for example, drugs used in chemotherapy.

- Potential for inadequate or unsafe services being provided by a vendor with which the home health care service contracts.

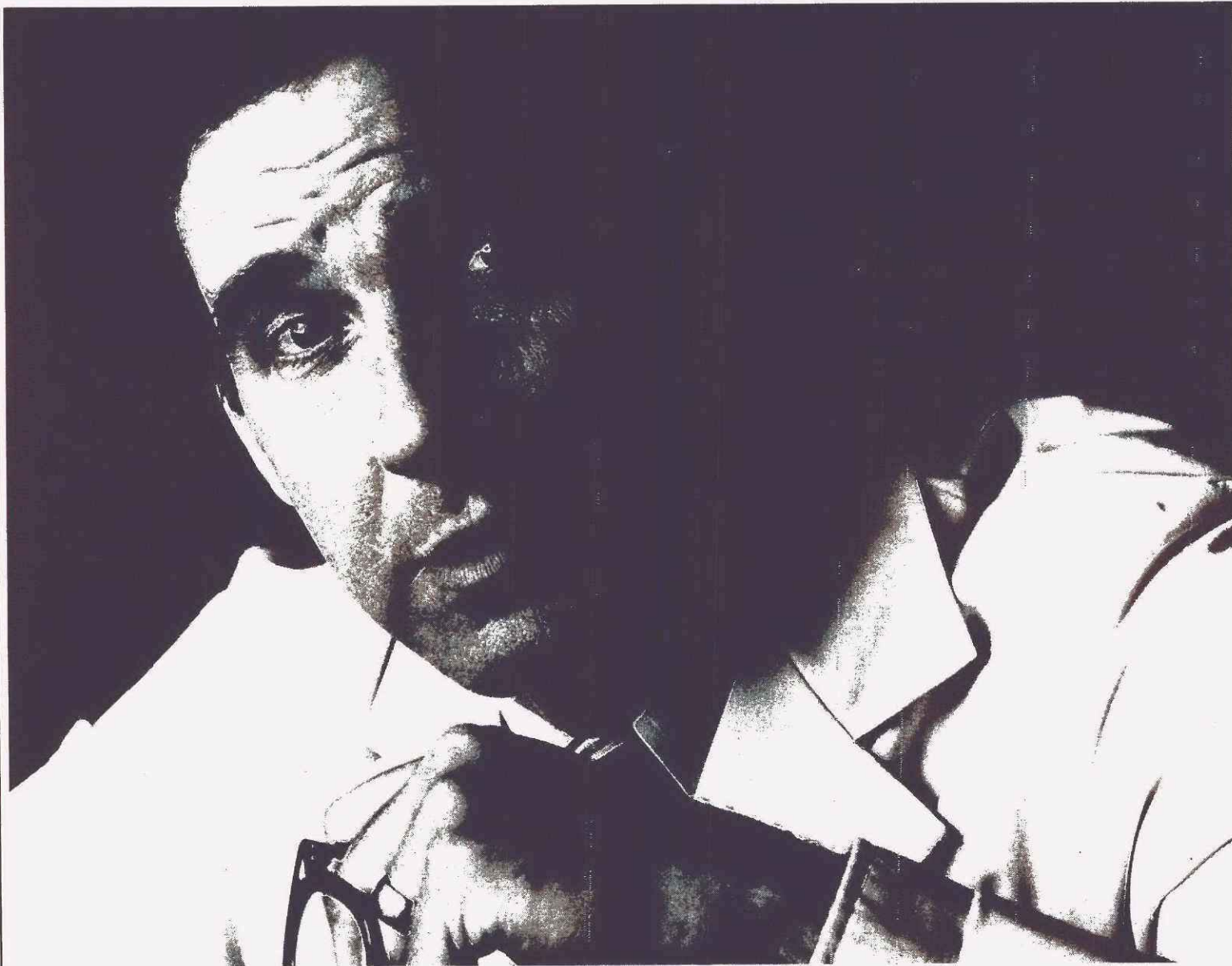
A home health care agency's liability in this area can be reduced through legal contracts with clearly stated specifications and delineation of responsibilities.

Also important are good follow-up and feedback mechanisms, including patient satisfaction surveys, she said.

- Potential antitrust issues, which may arise when there is too close a relationship between a hospital or physician and a home health care agency.

A home health care agency
Continued on page 12

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Home health care

Continued from page 10

should have a clear understanding of legal implications related to contractual arrangements, said Ms. Peter.

- Injury or loss noted by home care providers or patients but not reported to the home health care agency.

For example, she cited a case in which a stroke victim who could not speak went home after being discharged from the hospital. Three days later, a physical therapist was exercising the patient's limbs and heard a pop, but no injury was apparent and the therapist did not report the incident. A week later, a nurse discovered that the patient's leg was fractured.

A more common situation occurs when a patient thinks valuables have been stolen, and the only person in the house other than family members was the home health care staff member, she said.

Prompt reporting and follow-up of all injuries and losses is important, she said. And, it also is important to take a non-punitive approach with staff members, to ensure that proper documentation is done, she added.

- Potential transportation problems, which require adequate insurance coverage for both staff members and patients.

Transportation-related problems are very common and can be "very complex," Ms. Peters said. She requires staff members who drive both company- and privately-owned vehicles to provide proof of insurance.

The staff-related causes of liability also usually can be avoided through clear-cut policies and procedures and other measures, she said. These causes include:

- Staff members who are not qualified to perform certain activities.

"There is an assumption that a nurse can function anywhere," said Ms. Peters. However, some cannot function outside an acute care facility, she said. It is important that staff members be motivated to provide in-home care, she added.

The home health care organization should provide clear job descriptions for each position stating the necessary credentials.

The agency must assess the skills of potential and existing staff members and require them to have proper credentials for treatments and procedures they provide.

Ongoing continuing education programs should also be required, she said.

- Improper clinical treatment, such as errors in giving medications.

Liability for this is complicated by the fact that a patient usually is taking some medications between care providers' visits, Ms. Peters said. However, a visiting provider can monitor a patient's medication usage by, for example, counting the number of pills on an initial visit and comparing it with the number on subsequent visits.

Measures to prevent or reduce liability for improper clinical treatment should include documented standards of care, a good incident reporting system and adequate insurance, Ms. Peters said.

- Inadequate or inappropriate documentation in a patient's clinical record.

Problems can stem from comments that are biased, draw unwarranted conclusions or make editorial comments about family members and their impact on patients, she said.

Liability can be reduced or avoided through utilization review programs.

- Inadequate communication between care providers, which can best be reduced through patient care conferences among the providers.

- Inadequate communication

with doctors.

Written communication with doctors should be required at least every 60 days, and sometimes more often, Ms. Peters said. There should also be standards for levels of communication, she added.

- Problems with scheduling home health care.

"This is as bad (an area) as cars," said Ms. Peters, adding it is essential to have both a backup and on-call system for home patient care.

- Potential exposure to infectious disease—like acquired immune deficiency syndrome and hepatitis—for staffers and the community at large.

In addition to policies and procedures for dealing with infectious

diseases, health care providers may have to isolate patients, she said.

- Staffs' potential exposure to violent patients and high-risk neighborhoods.

Safety precautions and systems are essential, Ms. Peters said. For example, her organization reimburses staff members for parking

Transportation problems are very common and can be 'very complex,' Ms. Peters says.

tickets in high-risk neighborhoods so they can park as close as possible to the patient's building.

Staff members should be given the option of declining to provide service if they feel that doing so would pose a threat to their physical safety, she said.

Health care providers can be reassured through team visiting or use of an escort service, Ms. Peters said.

- Client emergencies when staff members are present or patients are alone.

All health care providers must be trained to respond to medical emergencies and must not leave the patient until appropriate follow-up care is obtained, Ms. Peters said.

Patients must be taught what to do in the event of an emergency and when help should be sought from other medical personnel.

- A wide range of potential incidents including falls, providers' back injuries, dog and rodent bites and some equipment mishaps.

There should be a centralized review system for incident reports and actions taken in response to them, Ms. Peters said.

Ms. Peters added that a home health care agency can set up various agreements with its own employees regarding pay and benefits.

Her agency's staff members are considered temporary employees and do not receive benefits, she said. ■



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People crucial to successful hospital RMIS

By MEG FLETCHER

CHICAGO—A hospital risk management information system can reduce claims, but only if the people operating the system are dedicated to loss prevention, a hospital risk manager says.

"It's not the computer program, it is the people committed to it," LeAna Osterman, assistant administrator and risk manager for University Hospital in Seattle, said at the American Society for Hospital Risk Management's conference in

Chicago last month.

In a session entitled, "When the System Works: Anatomy of a High-Performance Computerized Risk Management Information System," Ms. Osterman explained how to set up a hospital RMIS and how to get the most out of it.

Ms. Osterman based her address on the risk management program and information system at University Hospital. She has been risk manager since 1976 at the 336-bed hospital, which is one of two teaching hospitals operated by the Uni-

versity of Washington in Seattle.

Ms. Osterman carries out the hospital's day-to-day risk management activities under the direction of its Risk Management Committee, which consists of the hospital's medical director, assistant administrator of nursing, claims representative and in-house attorney. Also included are the university's risk manager and a representative of the state attorney general's office.

The hospital self-insures a portion of its property and liability risks, excluding workers compen-

sation, Ms. Osterman said, although she declined to say how much risk the hospital retains. The hospital then purchases excess insurance, she added.

The first step in establishing a high-performance risk management program consists of collecting information, which then is coded and entered into the hospital's computer, Ms. Osterman said. The hospital RMIS should integrate all aspects of the hospital's service delivery system, including patient billing, she added.

Ms. Osterman said the key to her risk management program—and the key to getting the data needed for the hospital RMIS—is a system for all hospital staff members to report unusual incidents and hazards. Staffers also are encouraged to recommend solutions.

Staff members are instructed to contact their supervisors immediately if a severe accident occurs. The staff members then fill out a one-page "unusual incident/accident report" form, which includes a section for the staffer's written comment. And, staff members then note on the form the action taken in response to the accident.

When a potential liability-causing event occurs, hospital personnel involved also are asked to record all pertinent information clearly and concisely in the patient's medical record.

There is some question whether, under Washington law, a hospital could be required to make its incident reports available to a plaintiff, Ms. Osterman said. So far, the hospital never has had to produce its incident reports in connection with a lawsuit, she said.

The staff member gives a completed incident report to his or her supervisor, and copies are routed according to the nature the incident.

For example, if the incident involves a service department, like a laboratory or pharmacy, one copy of the report is sent immediately to that department. If defective equipment is involved, a copy is included with the tag that indicates the equipment needs repair.

After a serious accident, the people involved also are asked to write a detailed statement addressed to the state attorney general. This is done to ensure that the information in the statement is protected by the attorney-client privilege, she said.

Generally, Ms. Osterman said, most hospital staff members fill out the reports because the risk management department has made sure that staff members are not subject to reprisals unless they have exceeded their authority or were under the influence of drugs.

Ms. Osterman said she will also intercede on behalf of employees whose managers get upset about having an incident reported.

"With this system, it is now rare to learn about an incident for the first time when a claim arrives," she said in an interview later. However, she added, this is not the case in many hospitals.

And, she admitted, some University Hospital doctors still are reluctant to fill out the incident reports.

"You need a physician ally," Ms. Osterman said. Making the hospital's medical director a permanent member of the hospital's Risk Management and Quality Assurance committees has helped, she said.

In addition, she said she has instituted two procedures that also have increased doctor participation in the risk management process.

When former patients complain about their doctor to the hospital's billing department, she sends a copy of the letter to the doctor and asks for comment. In addition, doctors cannot decide not to bill a patient without her approval.

Once the incident forms are filled out by hospital personnel, detailed information from the reports is coded and entered into the computer, Ms. Osterman said.

This extensive data base allows her to call up information on vir-

Continued on next page



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Nurses can be vital allies for risk manager

By MEG FLETCHER

CHICAGO—Nurses are increasingly concerned and frustrated about their increased legal liability in a health care system over which they feel they have little control, a hospital officer says.

Yet, nurses are also important allies for a hospital risk manager to cultivate in the fight to prevent medical malpractice claims, said Joanne Napiewocki, an attorney and former nurse who is vp of legal affairs for Providence Hospital in Southfield, Mich.

"If anyone knows what is going on in the hospital, it is the nurses," says Ms. Napiewocki.

Nurses can be a "very, very valuable resource" and serve as a risk manager's eyes and ears, she added during a session on "Liability Re-

'If anyone knows what is going on in the hospital, it is the nurses,' Ms. Napiewocki says, adding that nurses can be a 'very, very valuable resource' and serve as a risk manager's eyes and ears in a hospital.

duction in Nursing" at the American Society for Hospital Risk Management's conference last month in Chicago.

To cultivate a good relationship with nurses, a risk manager should get to know nurses on all shifts to show that the hospital's risk management department takes a non-punitive and non-judgmental approach to coping with incidents for which the hospital could be poten-

tially liable, according to Ms. Napiewocki.

"They must learn that you have an open door," Ms. Napiewocki said.

This open-door policy is especially necessary at a time when nurses are increasingly facing lawsuits alleging medical malpractice, she explained.

Although hospitals' professional liability policies typically insure

staff nurses, some nurses are purchasing their own medical malpractice coverage (see related story).

Ms. Napiewocki said frequent incidents for which nurses could be held liable include: patient falls; overadministering intravenous fluids; failing to summon medical attention; the inadvertent disconnection of respirators; and when catheters and other lines running into a patient's body accidentally invade other portions of the patient's body.

Ms. Napiewocki also singled out several other incidents that could trigger nurses' liability:

- Failure to properly assess the patient and take the necessary medical history. This is the most-frequent cause of claims against nurses, she said.

- Failure to observe and monitor the patient's condition.

- Failure to perform a procedure properly.

For example, Ms. Napiewocki said a plaintiff can allege a nurse damaged the patient's sciatic nerve with an improperly administered intramuscular injection.

However, some medical literature suggests that the nerve damage can result from seepage of the medication into the nerve, rather than from an error on the part of the nurse, she said.

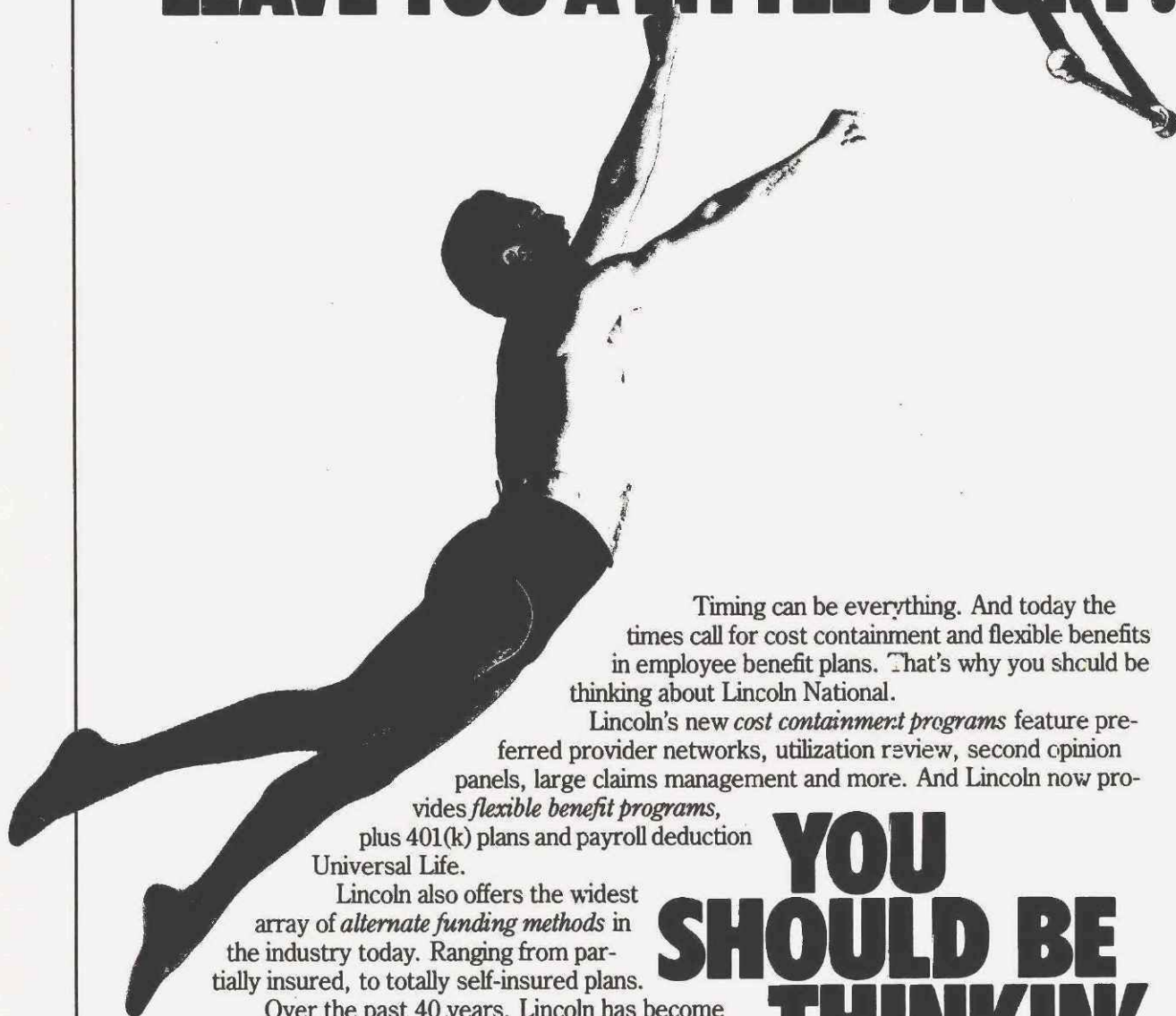
- Failure to follow a doctor's order promptly and accurately.

Recently, a Detroit-area hospital was sued on behalf of a patient who had a cancerous kidney removed, Ms. Napiewocki explained.

Following surgery, the doctor or

Continued on page 18

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Nurses buying own coverage for malpractice

Hospital staff nurses, who usually are covered under hospitals' medical malpractice insurance policies, increasingly are purchasing coverage on their own.

St. Paul Fire & Marine Insurance Co. in St. Paul, Minn., insures about 100,000 nurses individually, although it is not known what percentage of these are nurses on hospital staffs, according to a spokesman for St. Paul.

The minimum premium for the policy is \$100 for limits of \$1 million per occurrence and \$3 million per annual aggregate.

Whether the nurse's or the hospital's policy would be the primary coverage for a claim against a nurse depends on policy wording, according to a St. Paul spokeswoman.

Most of St. Paul's policies for nurses are worded so that insurers for the nurse and hospital would pay a pro-rata share of any judgment.

If such wording is not in the policy, a nurse's policy could technically become the primary coverage; however, the St. Paul spokeswoman pointed out the hospital's coverage takes precedence in most of these cases.

About 65,000 registered nurses, about 60% of whom are hospital staff nurses, have purchased professional liability insurance through a program underwritten by Granite State Insurance Co. in Manchester, N.H., and sponsored by the Kansas City, Mo.-based American Nurses Assn.

The most popular program option offers coverage of \$1 million per occurrence and \$3 million annual aggregate for a \$45 annual premium, according to Susan Vickery, account executive with broker Kirke-VanOrsdel Inc. in Washington, the administrator of the program.

Under the ANA-sponsored program, a nurse's coverage is secondary to any coverage provided by the nurse's hospital, says Karen Harrell, the ANA's membership benefits coordinator.

Some hospitals are suggesting that nurses purchase their own insurance because it would mean that more money would be available from insurers to pay claims, said Rich Pfeiffer, senior underwriting officer at St. Paul.

However, other experts say potential problems can arise when a nurse buys his or her own coverage, including the fragmented defense that could result if a nurse involved in a serious accident went first to her insurer for legal counsel, rather than to the hospital.

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Nurses' liability

Continued from page 16

dered the nurse to monitor the patient's urine production hourly, although no catheter had been installed.

The nurse was busy and finally, seven hours after the surgery, she discovered that the patient was producing very little urine, which meant the remaining kidney had stopped functioning, Ms. Napiewocki said.

The patient had to undergo dialysis treatments for a year until death. The hospital settled the case with a six-figure payment, according to Ms. Napiewocki.



Ms. Napiewocki

Nurses also have a duty to report known or accepted deviations from accepted practice by medical practitioners.

This obligation, Ms. Napiewocki said, stems from a 1965 case, *Darling vs. Charleston Community Memorial Hospital*, in which an 18-year-old's fractured leg deteriorated during two weeks of hospitalization to the point where it had to be amputated at another hospital.

As a result of the decision, hospitals and nurses are responsible for the quality of care provided by doctors and staff members, she explained.

In more recent cases, courts are ruling the hospitals have a duty to require that a patient or his survivors be informed about deviations in care, Ms. Napiewocki said.

While some nurses enjoy their increased responsibility to monitor the care provided to patients, others resent having to police doctors, she said. Nevertheless, all nurses must become both the advocate for the patient and the agent of the hospital to assure that patients are well treated, she said.

"Systems must be in place so nurses and administrators can intervene if a patient's not getting proper care," Ms. Napiewocki said. Many nurses need to learn the hospital's chain of command and be willing to use it when a doctor refuses to respond to a nurse's call about a change in a patient's condition.

"Everybody has a boss except God," she said. "It's time we stop being intimidated by doctors."

That lack of intimidation must be as true at a small hospital, where one doctor may be responsible for 20% of all admissions, as at a large hospital with hundreds of doctors, she said in responding to a question from the audience.

Ms. Napiewocki said steps hospitals can take to reduce liability include:

- Adopting good policies and procedures regarding the use and monitoring of tubes and other equipment that enter a patient's body.

- Requiring that entries made on the patient's chart be comprehensive and objective. Staff members should avoid drawing unwarranted conclusions.

In the past, entries in medical records were used to air grievances, especially between nurses and doctors. But these debates cannot be allowed since these charts are used as evidence in medical malpractice suits, Ms. Napiewocki said.

"We cannot afford the luxury of wars in the medical records."

- Refusing to protect or cover for a doctor.

A nurse's job is to care for the patient, deal with the system and keep her license, Ms. Napiewocki said.

She also encouraged nurses not to be intimidated by lawyers and to refuse to talk to attorneys until they notify the hospital of the inquiry. ■

Remove malpractice claims from courts: Expert

By MEG FLETCHER

CHICAGO—Contractual and legislative reforms may help hospitals settle medical malpractice claims more efficiently outside the tort system, a legal expert says.

"Lawyers have made an unholy mess of the medical malpractice system," commented Jeffrey O'Connell, a law professor at the University of Virginia in Charlottesville, Va.

"You have been unduly passive in letting us all run the insurance mechanism for paying your injury

claims," he said.

Mr. O'Connell discussed "Medical Malpractice Legislative and Judicial Reform: Issues, Objectives and Prospects for Success" before 500 people at the American Society for Hospital Risk Management's seventh annual meeting held Aug. 25-28 in Chicago.

Litigating injuries through the tort system, in which a responsible party pays an innocent party for his or her loss, made sense before the Industrial Revolution, because tort injuries at that time were almost always intentionally inflicted,

Mr. O'Connell said.

However, it is now illogical to adjudicate claims through the tort system, especially since a no-fault approach has been adopted with a workers compensation system to compensate for injuries in the workplace, according to Mr. O'Connell, who has been credited with being the architect of no-fault auto insurance.

The continued litigation of medical malpractice claims through the tort system has led to three "tragic" mistakes that lawyers have "coisted" on the health care system

and society in general, he added:

- The necessity of determining fault, despite the fact that many forms of insurance, like property coverage, are written without that requirement.

- That the tort system pays not only known losses over time but also tries to pay for pain and suffering. It is difficult to place a monetary value on non-monetary losses, Mr. O'Connell added.

- That insurance dollars sometimes are used to pay smaller losses several times over—because a

Continued on next page



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Continued from previous page
 plaintiff also can collect health insurance benefits and perhaps workers compensation benefits in addition to a tort award—while some larger losses are not compensated at all through the tort system.

But, while continued use of the tort system may not be appropriate to medical malpractice claims, injured parties need to be compensated, according to Mr. O'Connell.

"Injured people are a desperately injured lot," he said. "They do not meet in hotels like this."

The best approach would be one that promptly compensates an injured person for his or her net economic loss without the settlement

offer being viewed by a plaintiff's attorney as a sign of weakness, he said.

He added that hospitals have unduly locked themselves into a "tort mentality" without considering possible contractual reforms that would reduce the likelihood that patients will file medical malpractice claims.

Mr. O'Connell said such contractual reforms would probably take the form of a pre-treatment agree-



Mr. O'Connell

ment that could limit a patient's right to sue and provide for prompt payment of economic losses caused by hospital error, although he did not detail actual contractual reforms.

However, as an example of a contractual reform, Mr. O'Connell urged hospital risk managers to consider insurance policy wording that he devised for high school athletes.

The policy—which is offered through the National Federation of State High School Athletic Assns. in Kansas City, Kan., and costs an athlete \$1.25 annually—will compensate the student only for net economic loss in case of a sport-related injury.

After the injury, the insurer is given 90 days to offer a settlement and, after it is made, an athlete is given 90 days to decide whether to accept it, he said.

In the past two years, there have been 11 claimants, including victims of brain injury and paralysis, and all accepted the settlement offered by the insurer, he said.

The insurance is available to high schools nationwide except in California and New Hampshire. The program is underwritten by Insurance Co. of North America, a CIGNA Corp. unit, and is administered by Redlinger Co. in Topeka, Kan., he said.

Although Mr. O'Connell acknowledged that it may be "tough"

for hospitals to apply contractual limitations in their dealings with patients, he said, "I think there are ways to do it."

Compensating injured patients without resorting to the tort system is also the aim of federal legislation that is designed to serve as model for state legislatures to consider in passing their own laws to provide prompt payment of a patient's economic loss, Mr. O'Connell said.

If enacted, the federal legislation would apply to all beneficiaries of federal health programs, like Medicare or Medicaid, who are injured by health care providers. However, the law would not apply in states that implement their own medical malpractice tort reforms.

A new version of the bill, H.B. 3084, is similar to a previous version, H.B. 5400, in that it requires a health care provider to inform a patient if treatment has affected the patient adversely, he said.

The bill, co-sponsored by Rep. Henson Moore, R-La., and Rep. Richard A. Gephardt, D-Mo., generally gives the provider 180 days to make a commitment to periodically pay the patient's total net economic loss that has not been fully compensated by any other source, Mr. O'Connell said.

A provider's commitment to pay these losses would foreclose a patient's right to sue under the tort system except when the provider intentionally caused the injury or a wrongful death occurred, a spokesman for Rep. Moore said in a separate interview.

The provider making the commitment to pay may join with other third parties in making the settlement, and any disagreement between them would be settled by binding arbitration, he said.

In addition, patients would be allowed to sue should the provider default or breach his commitment to pay.

Mr. O'Connell said the new version of the bill increases the situations in which a health care provider is allowed to wait until a claim is filed by the patient before making a settlement offer. These instances are failure to have patient sign a consent form, erroneous diagnosis and natal injuries.

In such cases, the provider is then given 180 days from the time a claim is filed to make an offer.

The new bill also says that if a health care provider does not tender a settlement, he must be willing to promptly arbitrate the patient's right to receive money for his net income loss, Mr. O'Connell said.

Mr. Moore's spokesman noted other new provisions of the bill would:

- Require doctors to carry sufficient malpractice insurance or post a bond to ensure that doctors have adequate funds to pay settlements.
- Require that health care institutions notify state licensing authorities if they terminate or restrict the privileges of a health care professional.

The bill also would provide confidentiality and immunity for those who provide information to a hospital or its medical staff that a member of the staff is incompetent or impaired. It also provides immunity from suit for those who review health care professionals' conduct and those who take disciplinary action against them.

If enacted, the federal legislation would foreclose all tort claims and preclude later actions, including those by a minor when he becomes an adult, Mr. O'Connell said.

Mr. O'Connell predicted the bill has a 30% chance of passage in the next few years.

Although the bill is certain to face opposition from lawyers, "If they can pass DRGs over the AMA, they can get H.B. 3084 over the ABA," Mr. O'Connell said referring to the American Medical Assn. and the American Bar Assn. ■



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AUDITING THE PHYSICIAN

Program helps assure proper medical care at a reasonable price

By Ronald E. Gots
and Earl J. Kolb

TAKING THE LEAD from the federal government's Medicare and Medicaid programs—which include utilization review, concurrent review, diagnostic-related groups and other features—health and accident insurers and self-insured companies are implementing a variety of utilization controls.

Alternative delivery systems, second opinions, concurrent review and outpatient surgery are part of the new lexicon used by cost-conscious health insurers and self-insurers.

The casualty industry, too, has suffered the same onslaught of out-of-control medical costs, and in some cases it has been even harder-hit by those costs.

Casualty claims adjusters recognize some of the contributors to runaway medical costs. The adjusters contrast seemingly trivial injuries with the resulting exorbitant medical bills. They share tales of physicians who over-treat patients and those who seem to have a revolving-door relationship with plaintiff counsel. They are alarmed over the rapid emergence of costly new diagnostic and therapeutic modalities.

Nonetheless, to date they have been frustrated by their inability to curb practices that they perceive, often correctly, to be unnecessarily expensive at best, and downright abusive at worst.

An overriding fact of medical life has encouraged costs to escalate uncontrollably: Health services have been purchased with an open checkbook.

This fact has led to a proliferation of services that are of no particular value to the patient and to exorbitant costs that are far more expensive than would occur in a competitive marketplace.

The result is that medical care today is determined, not primarily by medical necessity, but by the availability of reimbursement.

Escalating medical care costs can be controlled. However, controlling these costs requires state-of-the-art medical utilization review broadly applied to the casualty industry.

Two principles form the bedrock of utilization review.

First, although physicians are in charge of medical expenditures, our third-party reimbursement system gives them no incentive to control costs. Therefore, external review by those who are paying the bills is essential to controlling those runaway costs.

Second, modern medical practice is based upon scientific principles. There are right ways and wrong ways to manage patients. There are expensive ways and less-expensive ways to accomplish the same medical goals.

Appropriate, standard, reasonable and necessary diagnostic and therapeutic approaches can be defined for most clinical problems.

There may be exceptions in some cases. However, there are rules, and physicians, chiropractors and other health care providers can be expected to play by those rules.

Consider this example: A claims person, complaining

of a sore throat, expects certain things from a physician: He or she expects, for example, an examination, particularly of the throat, perhaps a throat culture and possibly a prescription for an antibiotic.

He or she does not expect an electrocardiogram, a skull X-ray or a sonogram of the abdomen.

Why not? Because even a layman is relatively knowledgeable about sore throats and cannot see the necessity for multisystem testing. He has, in essence, carried out an informal utilization review.

That same claims person is less able to evaluate care for a problem that seems less clear-cut than a sore throat.

For example, he or she has been told that back strain is different in each patient, making rules impossible.

That false assertion has permitted medical providers to assume an "anything

goes" mandate.

However, the fact is that there is medical literature, textbooks, consensus and rules that chart the appropriate course for evaluation and treatment of back injuries, neck strains and every other condition faced by the claims person.

The extra month of physical therapy, the excessive chiropractic care, the misuse of thermography and the unnecessary EMGs make as little sense in the management of back strain as does the skull X-ray for the sore throat.

Physicians who most loudly proclaim the individuality of each patient are the very ones who ignore such professed differences and treat each patient identically.

Patterns of care are, in actuality, far more physician-specific than they are patient-specific. Those who over-evaluate and over-treat do so with every patient. Those attuned to proper utilization establish practice patterns, streamlined and conscious of cost-benefit.

Thus medical science permits physicians concerned about utilization to formalize those rules and then apply those formalized rules to all patients.

Some patients may fall outside those guidelines for valid reasons. However, these patients are the exception, rather than the rule.

And, when medical management violates those fundamental principles, the insurer or self-insured employer has a right to an explanation.

Utilization review can be applied broadly to casualty claims if two criteria are satisfied: First, the data base must be medically sound and thoroughly supportable, and then an effective program must be capable of screening large volumes of claims rapidly—it must be automated.

Following are the results of a pilot program using such a system, designed and marketed by the National Medical Advisory Service.

The computer's data base was developed by panels of physicians using standard algorithms of medical care, the scientific literature, the consensus regarding reasonable and necessary approaches to care and the many data bases that already are part of the field of utilization review.

The resulting data base allows the comparison of the management of casualty claim diagnoses—back strain, broken leg, heart disease and hundreds more—to accepted and proven practices.

Medical bills are entered into the computer. The

printout outlines the entire process of care, from the date of loss to the present, for each illness or injury. It shows every medical service—and its costs—provided by each physician or other health care provider over the total span of the illness or injury.

The input is compared with the data base to determine the appropriateness and necessity of each procedure or service—every office visit, hospital visit, X-ray, EKG, etc.

Necessity, frequency, duration and timing of such visits also are assessed and measured against mainstream norms.

The program takes into account individual variations in practice and expected patient differences. Hence, the program's norms permit ranges of medical management. However, when medical care is significantly outside those ranges, the care is noted to be potentially reducible and flagged for potential action by the claims professional.

The audit printout identifies all clear-cut and potential aberrant care practices. These are displayed in printed footnotes, and the charges pertaining to those practices are described as potential disallowances or reductions.

The footnotes place the recommended reductions into one of four categories:

- Category 1: A service or procedure that is unequivocally not the insurer's or self-insurer's responsibility.

Within this category are such findings as services that are inconsistent with the diagnosis—like a chest X-ray when the diagnosis is a sprained knee, or gynecological care when the diagnosis is back strain.

Also included in this category are charges for more than one comprehensive medical examination in one week, failure to adhere to accepted surgical ground rules, like reduced fees for each procedure performed during a single operation, and additional surgical charges for office visits within the post-operative follow-up period.

- Category 2: A service or procedure that violates norms in frequency, necessity and/or duration.

When these exceed the norms by one or two standard deviations (depending upon the insurer's or self-insurer's

preference), immediate disallowances can follow. In all instances, management issues in this category are flags to the claims person.

They do require application of medically guided judgment by the claims person involved, and they may, at times, recommend involvement of local peer review activity.

Within this category are such procedures as all office visits, hospital visits by the physician, X-rays, laboratory testing in which charges are made by a physician provider, physical therapy, chiropractic care, psychiatric care and other health care services that exceed the frequency and duration of proper utilization norms.

Also included are hospital lengths of stay that exceed the norm for the diagnosis.

- Category 3: Fees. This category includes fees in excess of fee schedules and findings that the fee for a particular service may be too high, such as when the service is just not worth the cost applied by the provider.

- Category 4: Findings that raise "red flags" regarding certain practices. Because these are not essential to the findings of this study, they will not be

Continued on next page

'Modern medical practice is based upon scientific principles. There are right ways and wrong ways to manage patients. There are expensive ways and less-expensive ways to accomplish the same medical goals.'

'Physicians who most loudly proclaim the individuality of each patient are the very ones who ignore such differences and treat each patient identically. Patterns of care are far more physician-specific than patient-specific.'



Ronald E. Gots, M.D., is president of National Medical Advisory Service Inc. in Bethesda, Md. Dr. Gots also is president and chairman of Medical Cost Reductions Systems Inc., an affiliated company in Bethesda.

Earl J. Kolb, M.D., L.L.D., is medical director of Medical Cost Reduction Systems Inc. in Bethesda, Md.

System helps assure good care at a fair cost

Continued from previous page described further here.

Approximately 30 separate footnotes describe different reasons for potential reductions or disallowances. Each of those footnotes falls into one of the four categories described above.

An initial study of workers compensation and liability claims was carried out using data from eight states: Texas, Louisiana, Georgia, New York, Massachusetts, Pennsylvania, Delaware and Florida.

In this study, medical bills were entered into the computer and reports were generated showing the process of care and outlining the potential cost reductions.

The aggregate results of this study are shown in Figure 1 of the accompanying chart.

Audited medical bills totaled \$1.2 million. Total potential reductions totaled \$560,000, or 47%. Category 1 reductions represented \$220,000 or 39% of the total reductions; Category 2 represented \$270,000 or 48% of the total; and Category 3 represented \$70,000 or 13% of the total reductions.

Figure 2 of the accompanying chart separates the liability claims from the workers compensation claims in this study. The potential reductions by category are shown for each type of claim.

The Category 1 reductions were relatively larger in workers compensation claims, comprising 60% of the total reductions. The Category 2 reductions were relatively larger in the liability claims, comprising 61% of the total.

These files did not include any compensation claims in fee-schedule states. Had they done so, the cost overruns would, undoubtedly, have been even greater than those uncovered.

What this data does show, for the first time, is the extraordinary overutilization and overpricing of medical services in casualty claims.

'This principle of contract by implication has been used rarely by insurers or self-insurers in the past. It is, however, a strong source of leverage for them, and it will become central to major cost-containment efforts in the future.'

The large percent of Category 1 overruns in workers compensation claims is due to the common practice of adding non-compensable services to the claimant's health bill.

For instance, a patient disabled by a back injury may undergo a hernia operation or diagnostic studies for coronary artery disease. Or, a patient suffering from an occupational cardiac disorder may be treated for diabetes or peripheral vascular disease.

All are billed inappropriately to the workers compensation insurer or self-insurer; all are disallowed under Category 1 because they are inconsistent with the diagnosis.

In liability claims we see a different pattern. There, the largest percent of disallowances appear in Category 2.

For the most part, these represent overutilization—not inappropriate treatment, but too much treatment. This is so high in liability claims because of the practice of "build up"—a well-known pattern of overtreatment of patients who are involved in litigation.

Armed with the results of such an audit, the claims person may deny payment or submit partial payment to the provider.

If this denial of payment or partial payment is accompanied by a copy of the audit, an explanation of the reasons for the disallowance and an invitation to rebut, the claims person has acted responsibly and has offered due process to the provider.

If the provider does offer support for the treatment, the reasons may be accepted or denied.

If denied, the next step may be peer review, arbitration or a hearing in which the provider will be forced to prove why he or she is right and the weight of medical evidence embodied in the audit program is wrong.

In most cases during this pilot program, providers have accepted audit findings.

In a number of cases that have been adjudicated, state

Figure 1

Potential reductions by category through medical audits (liability and workers compensation)

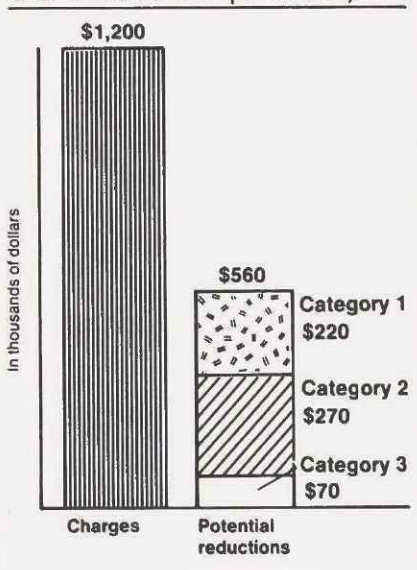


Figure 2

Potential reductions by claim type through medical audits

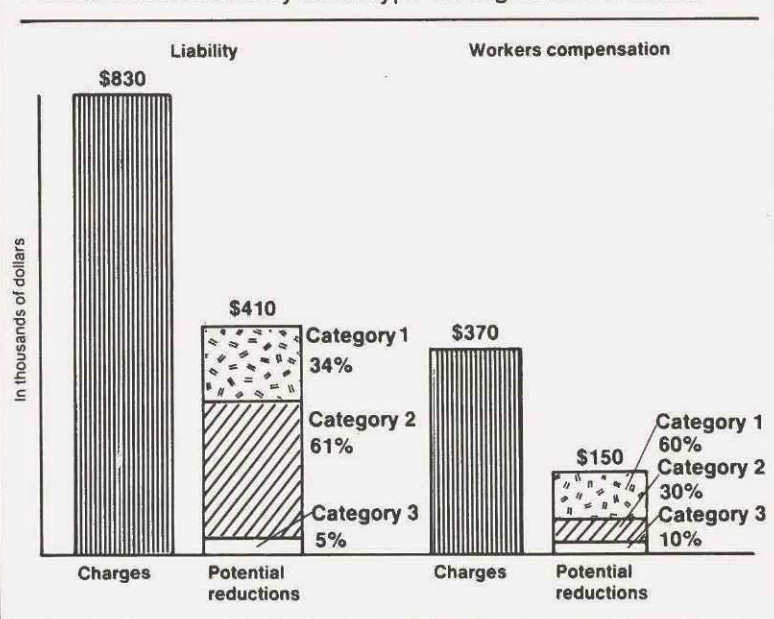


Chart: Amy Palmer

and district courts in tort claims and workers compensation boards and industrial accident arbitration panels in workers compensation claims have sided unanimously with the audit findings.

Medical costs are fixed or limited by certain statutes. Federal Medicare and Medicaid programs contain numerous cost and utilization restrictions.

In addition, a growing number of states have medical fee schedules in workers compensation. New York utilizes that same schedule in automobile no-fault. But, fee schedule or not, insurance programs that operate under

language of enabling statutes—workers compensation and automobile no-fault—all contain statutory language that describes, in varying detail, what insurers or self-insurers must pay.

The term "medically necessary services" most commonly defines the insurer's or self-insurer's legal responsibility for reimbursement of claims for medical services.

Finally, when a third-party payer is responsible for medical reimbursement, the treating physician is bound to the insurer or self-insurer through an implied contract.

This principle of contract by implication has been used rarely by insurers or self-insurers in the past. It is, however, a strong source of leverage for them, and it will become central to major cost-containment efforts in the future.

Under this principle, the insurer or self-insurer agrees to pay for care. The other party to the contract, the physician, agrees—by implication, though, and rarely by negotiation—that the fees must be reasonable, appropriate and necessary.

In the event of a dispute, the industrial accident commission or the courts would arbitrate, generally in favor of the physician. Thus, it is little wonder that insurers and self-insurers have found this avenue for recourse to be unrewarding.

Now, however, with medically derived standards, medical support for those standards and medical peer review involvement, the insurer or self-insurer no longer is standing alone against the treating physician.

Moreover, the notion that medical peers, not the insurer or self-insurer and not the physician provider—both of whom are self-interested—should set

the standards of reasonableness, necessity and appropriateness, makes indisputable sense.

And, the industrial accident boards and the courts are ready for this kind of impartial, peer-generated medical input.

In the case of third-party liability claims—general liability and automobile liability—the effect of this program is to analyze more accurately the medical specialists.

When misuse is identified and reductions are suggested, this effectively reduces the medical specials, and it also may affect the analysis of lost time and wages.

These factors—medical specials, lost time and wages—when multiplied by a factor (2 to 5 times) form the bulk of the medical special damages. This, in turn, determines the claim evaluation, the settlement value and the reserves.

The number is then used in negotiation, either with the claimant or the claimant's counsel.

To the extent that a medical utilization audit reduces the medical specials, it also reduces the evaluation and the settlement more accurately based upon actual, not built-up, medical specials.

In the first-party claims and workers compensation in which the insurer or self-insurer has a direct responsibility to pay the medical provider, the legal remedies follow principles outlined above.

Statutory provisions require insurers or self-insurers

to pay for "medically necessary" services. This medical utilization audit defines what is and what is not medically necessary.

The implied contract between insurer or

self-insurer and medical provider requires the provider to charge reasonably and to provide only necessary and appropriate services. Now the insurer or self-insurer has a way of knowing whether the provider complied with that duty.

We have described here a study of medical utilization in casualty claims performed with the aid of a computerized medical utilization review program. The results of this study demonstrate quantitatively what many have long believed—that misuse of health care services is wasting extraordinary sums of casualty claims dollars.

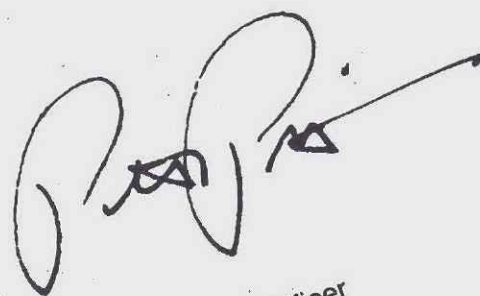
Cost-containment efforts must begin with effective first steps.

In addition, these first steps must be followed by well-reasoned, carefully applied rules of law to confirm the proposition that insurers, self-insurers and patients do not have to buy expensive and unnecessary health care services.

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Maintaining accurate data is vital task

IN LAST MONTH'S column, we discussed how to ensure that the information entered into a risk management information system is accurate.

Now, assuming that information is correct, we will focus on the RMIS itself: What are the problems and solutions, from hardware and software perspectives, connected with maintaining the integrity of the data once it is input into the system?

For those risk managers with systems maintained by third-party vendors, responsibility for data integrity is borne by the vendors. This is especially true for the "full-service RMIS vendors," such as Crawford & Co. and Gallagher Bassett Insurance Service, which not only provide claims adjusting/management services, but also provide the risk management information system, check-writing/financial system and brokerage services.

Other systems provided by such well-known firms as Corporate Systems, Anistics, etc., that also offer check-writing capabilities within their RMIS also assume a fiduciary responsibility for ensuring that the claims reported by the RMIS' loss run reports synchronize exactly with the accounting results of the check-writing module.

These are a few of the well-known systems. The risk managers should make certain that the RMIS provider/vendor will guarantee the integrity of the data it is managing. That should be specified in the contract, and such is the case with the major vendors mentioned above.

All RMIS should have three major emphases to ensure data integrity.

First, all should have validation procedures. Validation is defined as the matching of identical sets of data stored in different files within the data base. The emphasis is to identify any discrepancies such as, for example, claimants that are assigned to one

particular location in one data base and assigned to another in the payment module. The RMIS should be able to identify these problems through a variety of cross-checking procedures.

For example, Arthur J. Gallagher & Co.'s Risk-Facs system interfaces at several levels with its check-writing module and overall accounting data base. Each claim reserve, payment and entry on a loss report is checked and cross-referenced several times to pick up any deviations.

Most other major vendors have similar quality-control procedures.

In addition, there are a number of editing procedures that a system could

detailed evaluation of the quality control aspects of the risk management information system. This is especially important if check writing is to be a function of the RMIS. It is advisable that the RMIS' loss-reporting system and basic data base be tied to the accounting system responsible for paying the checks and reconciling with bank records.

The third point the risk manager should consider is the security aspect of a vendor-controlled system. Although this really is a large enough topic to discuss in a separate article, risk management information systems vary in their degree of internal security measures.

The mainframe vendor-supported

Therefore, the risk manager must weigh the amount of time—either the risk manager's or the data processing department's—needed for this vital element against the cost of having an outside vendor provide quality control services.

Major RMIS vendors, such as Corporate Systems and Anistics, that market stand-alone microcomputer-based systems are available to provide assistance on a continuing basis. Yet, the degree of certainty on data quality, as yet, cannot be as great as with the mainframe-based system.

Only the risk manager can decide what is acceptable, based on his or her own situation.

Data integrity is the lifeblood of a well-run risk management information system. Although an RMIS may have all the advanced analytical modules, storage capacity and speed, it is only as good as the quality of data entering and leaving it.

The greater the volume of data to be stored, processed and evaluated by the system, the more chance for error in data input.

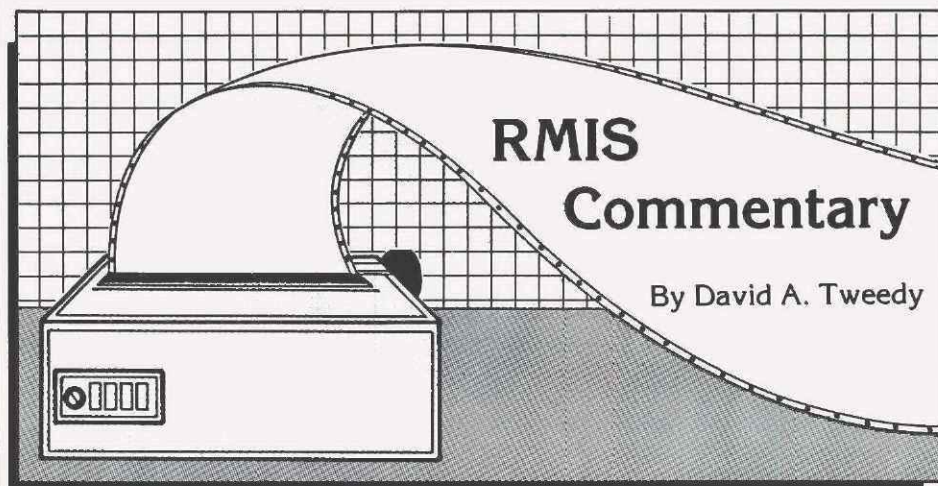
The RMIS must have sufficient validation/editing capabilities and the appropriate security safeguards to ensure that what enters the data base will not change within the system.

By the same token, the risk manager must be sure that the quality of data being collected in the field from the claims management organization is of equal quality and that it is transferred accurately into the risk management information system. And, if a company has many locations, the method of organizing data at those locations must be sound as well.

The risk manager has the primary responsibility for the integrity of the information in an RMIS, whether it is vendor-controlled or internal. After all, it is the risk manager who relies on the results produced by the RMIS based on that information, and the risk manager who must live or die with the recommendations made to senior management based on those results.

Norm Darling, director of system planning and development for Arthur J. Gallagher & Co., parent of Gallagher Bassett, says, "Information management is now equally as important as claims and reserve management."

I agree. A well-designed risk management information system using quality data will produce sound information management results for the risk manager.



have to prevent the entry of erroneous data, such as impossible dates, the assignment of an injury code beyond a predetermined range set for that particular type of injury, entering reserves on a closed claim, etc.

There are additional checks that either would prevent payment by an unauthorized user or would issue a prompt to a system claims supervisor desiring to raise a reserve beyond a previously defined boundary.

In other words, if a supervisor or adjuster inadvertently entered an indemnity reserve on a minor workers compensation claim and registered \$100,000 instead of \$10,000 in indemnity, the RMIS would highlight the field, thus prompting the adjuster to confirm the entry. The system also may require the adjuster to have his or her supervisor or claims manager verify and approve the reserve increase before the system will accept the change.

A well-designed RMIS will not allow data to enter the system if it cannot pass basic edit checks.

A risk manager deciding whether to choose an RMIS provided and maintained by a vendor should conduct a

systems are usually replete with authorization levels, security numbers and so forth. Microcomputer-based RMIS are not as sophisticated yet in this area, but they are improving.

Obviously, the number of people within the risk management department with access to change important data should be minimal to avoid accuracy problems.

Risk managers with either internal risk management information systems or stand-alone, microcomputer-based systems have a greater responsibility for data integrity.

The risk manager must depend on the data processing department, if it is an internally created system, to provide the necessary checks and quality control edits to prevent problems.

If the system was purchased as a stand-alone system from a vendor, the risk manager can rely, to some degree, on the vendor for quality control. Yet, it would be better to have a service contract with the provider to make periodic checks on the editing and validation features of the system's software.

More time is required to ensure accurate data with a stand-alone RMIS.

David A. Tweedy is a risk management consultant for D.A. Betterley Risk Consultants Inc. in Worcester, Mass. He is the assistant editor of *Betterley Risk Management Commentary* and the author of



RMIS Update, a yearly publication analyzing major risk management information systems and vendors. His column on risk management information systems appears the third Monday of every month.

Workers covered under work comp can't sue: Court

Mental or emotional injuries arising out of obscene remarks, sexual advances and touching by two employees' supervisor were exclusively compensable under the Workers Compensation Act, the Supreme Court of Wyoming ruled. Thus, the court held the employees could not sue the employer directly.

Two female employees of a restaurant sued their employer to recover for medical expenses and lost wages, as well as damages for emotional and mental injuries allegedly resulting from the intentional, improper acts of their male supervisor. The acts allegedly included touching the employees in an offensive manner and uttering obscene remarks.

The claimants also sought \$1 million in punitive

legal briefs

damages. The trial court granted the employer a summary judgment on the ground that the claims were barred by the Workers Compensation Act.

The appellate court said that since an employer may not avoid paying a compensation claim where a worker is injured through the worker's ordinary negligence, a worker does not have a tort action against the employer when the employer is negligent and the worker is covered under the act.

"This is so because the act creates liability without fault on the part of the contributing employer and

likewise provides the employer with absolute immunity from tort actions," the court said.

Such immunity, the court emphasized, is absolute. Since mental disorders are compensable under the act, the court said the claimants' exclusive remedy was to file a claim under the act. *Baker vs. Wendy's of Montana Inc.*, Supreme Court of Wyoming, Aug. 28, 1984 (BI/01/S.-\$5).

These abstracts were prepared by Cases Unlimited Inc. A copy of an entire decision may be obtained by sending a check for \$5 made out to Cases Unlimited to Business Insurance, 740 N. Rush St., Chicago, Ill. 60611. List the number for each opinion.

Talking to doctors

Continued from page 3

said, "I liked this one because it

could be administered by a layper-

son, and the quality of the materi-

als and the seven key areas at-

tracted me."

But, most of all, Ms. Archibald

liked the participatory nature of

the program.

"What happened in a lot of these

meetings is that people shared their

experiences, both good and bad.

People sharing their own experi-

ences was very helpful because it's

telling them and it's not something

a film is telling them. It adds so

much credibility," she said.

Ms. Archibald also likes the take-

home material the program offers.

"Eighty-five percent of our

workforce is male and the person

at home—their wife—makes the

health care purchasing decisions.

You can read the booklet by itself

without seeing the film and get a

lot out of it. At the very least, it

raises awareness."

Edison hopes teaching its em-

ployees to be assertive about their

medical care will help cut Edison's

health care costs.

"Between 1979 and 1984, our

medical care expenditures in-

creased 20% to 25% each year," said

Ms. Archibald.

"For active employees and their

families, medical care costs in-

creased 100% over that five-year

period and for retirees, they in-

creased 300%. If these increases

continued, we'd be paying over a

half of a billion dollars in health

care costs by the year 2000.

"We wanted to find out what we

could do to decrease our health care

costs while maintaining quality

health care."

In 1982, Edison established a joint

union-management committee,

called the Health Awareness Com-

mittee, to evaluate and try to con-

trol rising health costs.

The committee makes recom-

mendations for health education,

consumerism and wellness pro-

grams and appointed health aware-

ness coordinators at each of the

company's 24 locations to imple-

ment these programs.

Last December, these coordina-

tors were brought together at the

company's corporate headquarters

to learn about health care consum-

erism—and "I'm in Charge."

"We wanted to motivate employ-

ees so that informed choices would

be made and they would get the

most out of every health care dol-

lar," Ms. Archibald said. "We

wanted to create an atmosphere

where the patient was sharing in-

formation with the physician."

Ms. Archibald could not calculate

the cost of the "I'm in Charge" pro-

gram because its cost is combined

with that of other programs.

Besides instituting the "I'm in

Charge program," Edison also insti-

tuted a series of cost-containment

measures in its self-insured medical

plan. Beginning Sept. 1:

● Employees are required to ob-

tain second opinions for 15 com-

mon surgical procedures.

● Thirty-two common surgical

procedures must be performed on

an outpatient basis.

● Employees must obtain pre-

certification of all non-emergency

hospital admissions.

● All hospital stays are subject to

retrospective reviews.

If employees bypass any of these

cost-containment measures, they

must pay an extra \$100 charge or

they receive no reimbursement

from the company for any ex-

penses related to the illness or in-

jury. Ms. Archibald said.

Also, effective Sept. 1, Edison

employees are covered for hospice

care and are encouraged to use

skilled nursing facilities and home

health care instead of hospitals.

Commonwealth Edison also

began a hospital bill audit incentive

program that pays employees an

amount equal to 50% of any over-

charge they find in their hospital

bills, up to a maximum of \$1,000

per hospital bill.

When Illinois Bell introduced

"I'm in Charge" to 23,000 employ-

ees last year, it made sure the em-

ployees knew their unions backed

the plan and it made sure doctors

statewide understood that Illinois

Bell backed its employees.

On Nov. 1, all Illinois Bell em-

ployees received letters signed by

Vp of Personnel Paul Downing and

representatives of each of the com-

pany's four unions announcing the

"I'm in Charge" program.

"The support of the union leader-

ship is really quite important in

getting our message to employees,"

said Bill Watson, secretary of the

company's employee benefit com-

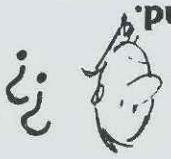
mittee. "Two-thirds of our employ-

ees are represented by unions."

The letters were accompanied by

Continued on next page

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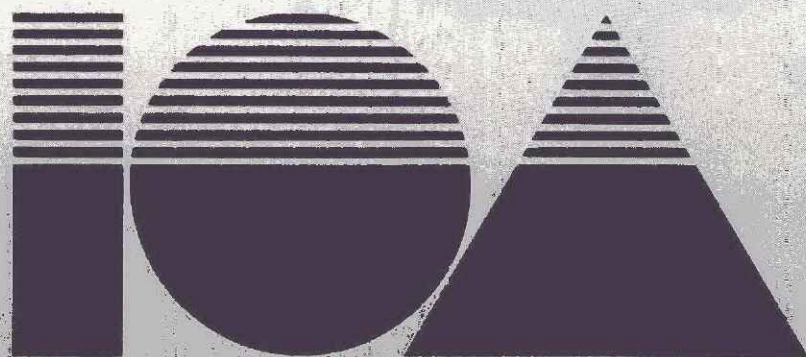
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Talking to doctors

Continued from previous page
 an introductory booklet explaining the concept of the program.

Then, from November to January, the "I'm in Charge" audio-visual was shown "to all employees, from the top to the bottom," said Alan Peres, manager of health care utilization for Illinois Bell.

He said it was shown to all employees, whether they participated in the traditional self-insured fee-for-service plan or a health maintenance organization.

"We really didn't think it made a difference because the principles of good health care use are basically the same," he said.

The educational aspects of "I'm in Charge" attracted Illinois Bell to the program, he said.

"It gave employees real tools to use when they use the medical program or when they're confronted with going to the hospital or doctor," Mr. Peres said.

"All of a sudden, people realize they do have choices. They realize they can say to a doctor, 'Tell me more about that,' or 'What does that mean?' or 'Let me think about that.'"

"Through interacting in a program like 'I'm in Charge,' employees get the opportunity to share experiences and they realize that the something they don't like (about their relationships with their doctors), other people don't like either."

"And they realize the next time they go to the doctor, they are not going to make the same mistake."

"I'm in Charge" also was shown to Illinois Bell retirees in parts of Illinois, Arizona and Florida.

Tapes of the "I'm in Charge" film also are available for employees to take home to show their families. Although Mr. Peres has no hard data, he said, "there's about 15 tapes available and they're usually all gone."

Besides preparing their employees for the new program, Illinois Bell alerted health care providers.

Letters describing "I'm in Charge" and the company's other health care cost-containment and wellness programs were sent to 22,000 doctors throughout the state.

"We were encouraging behavior that might be interpreted by health care professionals as a threat or offense to them," Mr. Watson said.

"It represents a considerable change in employees' approach to their doctors. And we simply wanted to let them know what our intentions were: to help employees get the best medical care they could and not approach medical care in the proverbial land-of-the-slaughter approach."

Mr. Peres said the "I'm in Charge Program" cost Illinois Bell about \$3.25 per employee.

Illinois Bell's other cost-containment and wellness programs are part of its "Healthwise" program, which includes a phone counseling service offered by the Parkside Medical Services unit of Lutheran General Hospital in Park Ridge, Ill.

The service allows employees to talk to health care professionals about any health-related issue, including the use of Illinois Bell's health care plan.

"Healthwise" also comprises a variety of other wellness and health care consumerism programs, from smoking cessation programs to informational paycheck stuffers to a hospital bill audit program that pays employees 50% of any overcharge they discover, up to a maximum payment of \$500 per bill.

"All these programs add up to having a well-informed consumer. And, we feel that's the most important thing because if people are well-informed, they make good decisions, and those decisions have effects on them as well as on us," Mr. Peres said.

FMC Corp.

At FMC, "I'm in Charge" is part

of a three-pronged attack on rising health care costs.

FMC has been seriously dedicated to wellness and employee health education since the summer of 1984, when it began its "Well Aware" program.

"Well Aware," which has cost FMC \$100,000 to date, has three components: informational, motivational and behavioral.

The informational component is comprised of the "Well Aware" newsletter, which most of FMC's 25 locations send to employees' homes. The newsletter contains information on health and wellness.

The "Wellness Works Wonders" guide to wellness programs is the motivational component, which benefit manager Ken Morrissey describes as a "cookbook approach" to wellness.

Created by John Hancock Mutual Life Insurance Co., "Wellness Works Wonders" supplies information on 15 health-related topics. The guide is sent to all FMC locations and can be tailored to each location's needs.

"What's neat about it is it allows all our locations to go at their own pace, regardless of their sophistication and resources," he said.

"I'm in Charge" is part of the behavioral component of "Well Aware."

"As soon as we saw the finished product, we decided to buy it," said Mr. Morrissey. "It fit perfectly into some of our plans with regards to wellness."

He said he especially likes "I'm in Charge" because information about cost-containment features in FMC's self-insured health plan—like ambulatory surgery and outpatient testing—can be easily incorporated.

"You can bring in a discussion concerning your health care plan into 'I'm in Charge,'" he explained. "For example, your second surgical opinion program can be incorporated into the area of the 'I'm in Charge' program that address second surgical opinions."

"'I'm in Charge' basically takes the knowledge the employee has and teaches him or her how to ask questions of the doctor. It brings the information provided in a worksite wellness program onto the firing line."

"I've run a number of the sessions and it really encourages employees to build those (purchasing) skills. It teaches you how to buy health care."

Like the other companies that have purchased "I'm in Charge," FMC used its own employees to present the program to its workers.

The company sponsored two two-day seminars to explain the total "Well Aware" program—including "I'm in Charge"—to 200 management employees from various locations. Since "I'm in Charge" was first shown in September 1984, about half of FMC's 25,000 employees have seen it.

The company also plans to buy the Spanish version of the program for its Los Angeles office.

FMC allows two hours for the "I'm in Charge" presentation, during which a light lunch is served.

Health risk assessment cards, which ask employees questions about themselves and their lifestyles, also are distributed during the program.

Although employees are not required to complete the cards, they receive a confidential health evaluation returned to them within a few weeks if they do participate.

FMC receives a report that contains only aggregate data on its employees' general health, he said.

Mr. Morrissey could not estimate the cost of the program to FMC, but said that "I'm in Charge" is worth the cost.

"Most of the feedback we get on our wellness programs is during 'I'm in Charge' because we have the opportunity there for immediate feedback," he said.

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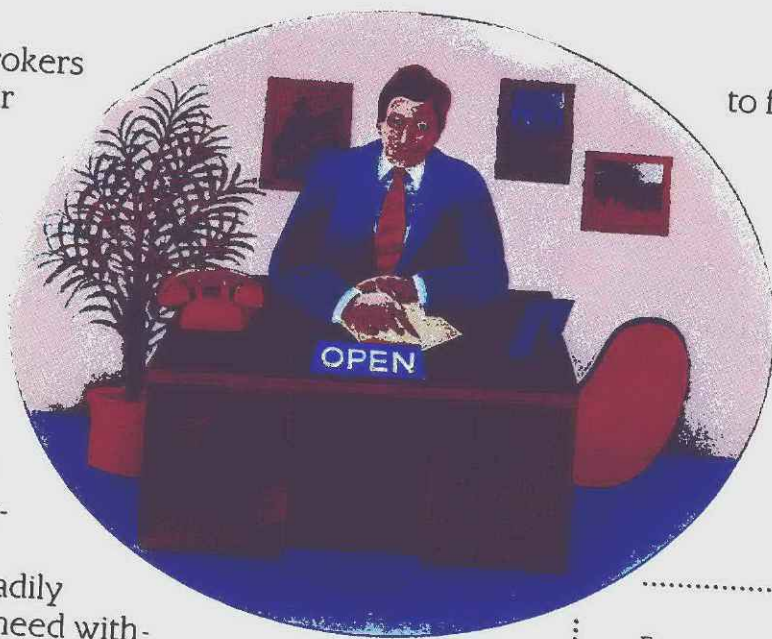
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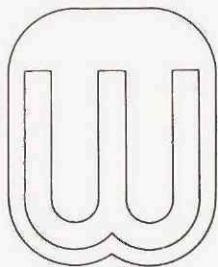
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'I'm in Charge'

Continued from page 3
costs, Ms. Peck said.

"I'm in Charge" tries to change behavior by showing employees what inefficient health care costs them—not the company—in time and effort, as well as money, she explained.

"Everybody can relate to wanting to be in charge of decisions that affect them," Ms. Peck said.

The "I'm in Charge" program takes about an hour to conduct, depending on how much time the employer allows for the group discussions that are an integral part of program. Although "I'm in Charge" has been presented to up to 100 people at a time, groups preferably should range from between 25 and 30 workers, Ms. Peck said.

"The program is really based on participation and interaction with the group," she said. "We want them to learn from each other. We don't want the meeting leader to be up there lecturing to them. We encourage small groups so the meeting leaders can encourage participation and really get discussions going."

Before employees are shown the audio-visual presentation, the meeting leader distributes printed information and discusses the essence of the program: seven questions that employees must answer to be "in charge" of their own health care.

The questions are:

- Is this doctor right for me?
- Do I understand what's happening to me?
- Do I need these drugs?
- Do I need these tests?
- Do I really need surgery?
- Do I need to be hospitalized?
- How can I prevent this in the future?

The meeting leader then tries to

prompt a group discussion by asking employees to brainstorm about the problems they have communicating with doctors and other health care professionals.

"The only way you're really going to change behavior is by having people talk and participate," Ms. Peck said. "If they just sit there passively and listen to a videotape, it'll go in one ear and out the other."

Sharing these experiences encourages people to admit they have problems dealing with doctors because it lets them see that many people have the same problems, Ms. Peck said.

"You can't learn if you're not going to admit that maybe you haven't dealt with your doctor very well," she said.

After the group members have discussed their experiences, the meeting leader shows a 33-minute film that consists of three vignettes depicting people interacting with doctors. In all three cases, a problem is posed that the audience is asked to solve by answering the seven key questions.

The episodes, which are based on real experiences, reflect common situations involving health care.

In one, a young woman who has recently moved from another town takes her mysteriously ill child to a hospital emergency room and encounters a staff physician who recommends a battery of expensive tests.

In another, a man who has dislocated a disk is told he should have surgery, although surgery may not solve his problem.

The third vignette features a woman who is told she needs foot surgery but feels she can't afford it, can't take the time off work and needs someone to stay with her children.

In each situation, common communication problems present themselves. For example, the man with the bad back has a doctor who speaks only in jargon. The woman with foot problems is nervous and intimidated by her doctor, who seems to be "scalpel happy." The woman with the ill child is dealing with abrupt doctors and nurses whom she doesn't trust and has no family doctor to call.

Each episode ends with the person involved feeling helpless and frustrated because he or she has allowed the doctor to make all the decisions—decisions that are going to cost the person time, money and personal trauma.

After each episode, the film is stopped and the audience is asked to discuss what questions they would ask the doctor and to apply the seven key questions to the episode.

Then, the meeting leader starts the film again and the narrator—actor Gregory Harrison, who portrays Dr. Gonzo Gates on the television series "Trapper John, M.D."—points out how the person could have "taken charge" of the situation. The scene is then played out accordingly.

"We used Gregory Harrison as a drawing card," Ms. Peck said. "He's perceived as being associated with the medical community and he's so good-looking that people like him and want to watch him and listen to him."

After the film, the meeting leader "walks" employees through an "I'm in Charge" booklet that reiterates and explains the need to answer the seven key questions.

Finally, employees break into small groups—Ms. Peck recommends three to five people to a group. Each group is told to create a difficult situation between a doctor and a patient, using the various communication problems discussed, and to solve the problem using the concepts taught in the "I'm in Charge" film.

The situations can be based on an actual experience of someone in the group or be totally fictional, Ms.

'The whole purpose of the program is to show you how to talk to doctors,' Ms. Peck explains.

Peck said.

"We break into small groups to give people the opportunity to discuss how they would apply the 'I'm in Charge' skills to their own personal situations," Ms. Peck said. In the format of a group discussion, the light bulb really turns on for people.

"Also, some people won't participate in a large-group situation, but will in a group of a few people."

Employees keep the "I'm in Charge" workbook which, in addition to reminding them of the seven key questions, includes space for the participant to take notes or for the company presenting the program to add its own information.

The booklet also provides information and statistics on health care costs and utilization. The statistics are aimed at raising employees' awareness of the waste in the health care delivery system.

For example, it tells employees that hospital costs have increased 250% in the last decade and that some estimates show that 70% of doctor visits are unnecessary, and it explains the concept of "defensive" health care, in which doctors provide unnecessary health care to protect themselves from medical malpractice lawsuits.

In addition, the booklet reminds employees to check their hospital bills and gives a toll-free "Second Opinion Hotline" number sponsored by the federal government.

It also lists other health care resources, including books on cost-efficient health care and the names and addresses of health care organizations, like Alcoholics Anonymous and the High Blood Pressure Information Center.

Employees also receive special pocket-sized "I'm in Charge" note pads, which are designed to be used during doctor visits. Each sheet lists the seven key question followed by the words, "To find out, I need to ask..." There is also space for the employee to write out his or her specific questions for the doctor. On the reverse side of each sheet is a place for employees to put their answers to each of the seven questions.

"We try to get people to use the pads before they get to the doctors office so they can think about things to ask in each of the seven areas," Ms. Peck said. "We try to get them to discuss it with someone else, too—maybe someone in their benefits department or a staff nurse."

"And, if they have the pad with them, they'll remember to ask the questions. Many people said they go to the doctor's office intending to ask questions and once they get there they forget what they wanted to ask, or they're so relieved after the doctor's appointment that they forget what the doctor said."

Although "I'm in Charge" has not been in use long enough to measure whether it has reduced the health care costs of companies who used it, employees seem to be getting good mileage out of the program.

"What we keep hearing from people who go through it is they really get a lot out of this and really appreciate it," Ms. Peck said. "They're using it when they go to the dentist and when they get their car fixed. It's interesting to see how people embrace the concept."

The full program costs from \$2 to \$6 per employee, depending upon the size of the company, says a TPF&C official. In addition, companies can purchase the film separately. ■

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The Home Insurance Co. and wholesale broker Alexander Howden Insurance Services Inc., a unit of Alexander & Alexander Services Inc., have formed a joint venture to underwrite intermediate- and long-haul trucking liability risks.

The new venture, Home Transportation Agency in Atlanta, is underwriting the coverage exclusively for The Home. A spokesman for The Home in New York says the agency expects to write around \$5 million in premiums this year.

Trucking risks have "traditionally been unprofitable for a lot of companies," the spokesman said. "But we think it will be successful because we have hired a lot of good people and are concentrating in just one area."

He said marketplace capacity for trucking liability risks "is shrinking every day."

Home Transportation is located at P.O. Box 19539, Atlanta, Ga. 30325; 404-351-5880.

Kentucky HMO

A new health maintenance organization, HealthCare Network of Kentucky Inc., has been formed in the metropolitan Louisville area with plans to eventually expand statewide.

The HMO is jointly owned by MetLife HealthCare Management Corp. of St. Louis, a subsidiary of Metropolitan Life Insurance Co., and J.H. Systems Inc., the holding company for Jewish Hospital in Louisville.

Developers of the new HMO say they expect about 200 physicians to agree to participate in the plan. Negotiations with area hospitals are expected to be completed by the end of September.

Walter Guller, chief operating officer of the HMO, said: "We will be targeting companies with 10 employees or more. At the present, Metropolitan Life has health care insurance policies with several major area employers. We will actively solicit these groups to convert their policies."

New consultant

Kusters Consulting International, an independent risk management consulting firm, has been formed in Houston.

The new company offers risk evaluation and risk control services for property, business interruption, safety and liability exposures. The company will specialize in product liability and environmental liability risks.

Kusters Consulting is located at 2100 Tanglewilde, Suite 392, Houston, Texas 77063; 713-784-8730.

EIL consultant

Environmental Compliance Services Inc., a Downingtown, Pa., managing general agency that specializes in coverage for handlers of hazardous waste, has formed a consulting company.

ECS Consulting Inc. provides hazardous waste companies with consulting services in the areas of risk management, site safety planning, personal safety planning, plant evaluation and regulatory compliance.

David M. Rosenberg, president of the new company, said ECS Consulting was first formed primarily to review the companies insured through the agency to ensure they adhere to proper safety and risk management practices.

ECS Consulting is located at 721 E. Lancaster Ave., Downingtown,

Pa. 19335; 215-269-6731 or 800-ECS-1414 outside Pennsylvania.

New offices

Professional Adjustment Services Inc. has opened an office at 444 N. Northwest Highway, Suite 340, Park Ridge, Ill. 60068; 312-825-0444.

Corporate Risk Advisors Inc. has opened an office at 1500 E. Tropicana Blvd., Suite 110, Las Vegas, Nev. 89119; 702-798-6222.

Risk Administrators Inc. has moved to expanded offices at 1211 Mall Drive, Richmond, Va. 23235; 804-379-0086.

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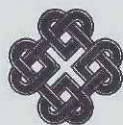
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THE HEALTH PLAN OF AMERICA

PBGC director

Continued from page 3

policy analyst for the Center for Naval Analyses in Alexandria, Va.

Ms. Utgoff explains that her approach to pension issues is influenced by her training as an economist. In tackling a problem, she says she first often asks herself: "How can resources be used more rationally?"

For example, with the current uniform pension insurance premium, financially healthy companies with fully funded pension plans are, in effect, "subsidizing" less well-funded plans, she says.

Then, when poorly funded plans collapse, the PBGC has to seek a premium increase from all employers to pay for the benefits.

Companies with well-funded plans resent that they are subsidizing the promises made—but not kept—by other employers. They also are concerned that a vicious cycle will develop, Ms. Utgoff says.

As PBGC premiums increase, more companies will terminate their pension plans and set up defined contribution plans, which aren't covered by the PBGC insurance program.

As more defined benefit plans are terminated, the PBGC will have to seek greater premium hikes, which would cause still more companies to terminate plans.

A risk-related premium system, though, might prevent such a cycle from developing, Ms. Utgoff said. By basing premiums on the amount of assets in a plan, employers would have a financial incentive to better fund their plans, Ms. Utgoff said.

And, as plan funding improves, the PBGC would face smaller liabilities when companies terminate their plans.

While a risk-related premium may be a future possibility, the

PBGC's immediate concern is congressional action to raise the current premium.

The agency's deficit on Sept. 31, 1984, was \$462 million, and the deficit now may exceed \$600 million. And, the shortfall could go much higher if several underfunded pension plans sponsored by financially troubled Wheeling-Pittsburgh Steel Corp. are terminated. If those plans fail, the PBGC would face at least \$400 million in losses—by far the biggest claim the agency would have incurred.

But, Ms. Utgoff says she is confident Congress will come to the agency's rescue. It is inconceivable, she says, that Congress would allow the PBGC to go broke and, thus, be unable to fulfill benefits promises to pension plan participants.

"I'm very encouraged about (the possibility) of a premium increase," she says.

Already, the House Ways and Means Committee has approved legislation, H.R. 3128, that would raise the annual premium to \$8 per plan participant.

Along with a premium increase, Ms. Utgoff says certain reforms are needed to decrease the PBGC's exposures.

For example, she favors a provision in legislation, H.R. 2995, that would give the PBGC a lien on corporate assets when companies win waivers from the Internal Revenue Service to delay making required contributions to their pension plans.

If such waivers are granted and the plans are subsequently terminated, the PBGC faces larger liabilities.

Funding waivers really are "low-interest government loans," Ms. Utgoff says. "Is this something we should allow?"

Ms. Utgoff also says many companies, particularly smaller em-

ployers, are complaining that the Multiemployer Amendments Act is interfering with their operations.

Under this law, companies that leave underfunded multiemployer plans have to pay a share of the plan's promised-but-not-funded benefits. Some multiemployer plans are so poorly funded that companies face multimillion-dollar withdrawal liability claims when they leave the plan.

Some companies participating in multiemployer plans say these claims may be so high that it is impossible for them to close operations and withdraw from the plans.

Although Ms. Utgoff agrees the act is causing problems for employ-

ers, she points out that the law is accomplishing its objective: encouraging employers to take more of an interest in multiemployer plans and improve plan funding.

She says she doubts if Congress will soon consider any changes to the Multiemployer Amendments Act. Legislators now are keying in on shoring up the PBGC's single-employer insurance program, she notes.

"You don't want to try to do too many things at one time," Ms. Utgoff says.

Like her predecessors, Ms. Utgoff questions whether pension and retirement policies would be better developed if there were one federal

agency administering ERISA. Currently, three agencies—the PBGC, the Labor Department and the Treasury—are responsible for administering the pension reform law.

Having different perspectives from three different agencies can improve pension policies, Ms. Utgoff explains.

Even if one agency were solely responsible for ERISA, there still would be problems developing pension policies, she says. Pension issues have to be considered from both retirement income and tax policy perspectives and the two perspectives are very different, she explains.

New Georgia commissioner says he'll seek another term

around the states

ATLANTA—State Rep. Warren D. Evans, who recently was appointed to fill out an unexpired term as Georgia's insurance commissioner, says he will run for a full term next November.

Georgia is one of 11 states that elects its insurance commissioner. The Georgia post also carries the titles of comptroller general, safety and fire commissioner and industrial loan commissioner.

Johnnie L. Caldwell, 63, will retire Oct. 1 after 15 years as insurance commissioner. Rep. Evans, who will resign his House seat, will assume the duties at that time.

Rep. Evans, chairman of the House Judiciary Committee, also has been a member of other House committees, including the Rules and Education committees.

Rep. Evans, 55, is an attorney. He received an undergraduate degree in political science from Emory University in Atlanta and a law degree from the University of Georgia in Athens.

Before his election to the General Assembly, Rep. Evans served for 10 years as a councilman in Thomson, Ga.

"I don't have any real insurance background," Rep. Evans said. However, he added that the state position is an administrative post.

Texas regulator

AUSTIN, Texas—Doyce R. Lee,

who has been general counsel to the Texas State Board of Insurance since 1980, took over as state insurance commissioner last month.

He replaces Tom Bond, who resigned July 31 to join a law firm (BI, July 22).

Mr. Lee, 44, joined the State Board of Insurance in 1975 as a member of its legal staff. Prior to that, he was in private law practice in northeastern Texas.

Mr. Lee also was a state representative from 1973-74.

Mr. Lee has an undergraduate degree in music education from East Texas State University in Commerce and a law degree from the University of Texas in Austin.

'Superpool' planned

SONOMA, Calif.—Eight public entity members of the California Assn. of Joint Powers Authorities hope to have a "superpool" operating by Jan. 1 for the purchase of excess property insurance.

A superpool is a pool whose members are individual municipal pools. The individual pools band together to jointly insure or self-insure a common loss exposure, according to Michael M. Kaddatz, a partner with the consulting firm of Advanced Risk Management

Techniques in Laguna Hills, Calif.

The California pool would operate without risk sharing, so that each individual pool would be responsible for paying losses below a set deductible, said Frank James, general manager of the Redwood Empire Municipal Insurance Trust, a pool of 14 public entities in northern California.

Broker Johnson & Higgins of San Francisco is now gathering data for market presentations.

A superpool can increase public entities' leverage in the marketplace through mass buying power that may lead to broader coverage at a lower price, Mr. Kaddatz said. It may also provide greater stability, he added.

California job injuries

SAN FRANCISCO—The number of injuries and illnesses resulting in lost time from work increased about 9% in California during 1984, according to the California Division of Labor Statistics & Research.

However, because of a 6% jump in employment, the number of disabling injuries per 1,000 workers increased only slightly to 35 in 1984 from 34.1 in 1983.

In 1984, California reported a total of 373,600 disabling work injuries—those causing one or more days of lost time. This total was exceeded only in 1979 and 1980.

But, the number of workers covered by workers compensation in the state reached an all-time high of 10.67 million.

Eight of the 10 major industries reported increases in the number of injuries in 1984 over 1983. The highest increase—33%—was in the construction industry.

Construction also reported the highest rate of disabling injuries: 87 per 1,000 workers. This was followed by mining, with 64.6; agriculture, with 48; and transportation and public utilities, with 46.3.

The lowest rate of injury was in finance, insurance and real estate, which reported 11.4 injuries per 1,000 workers.

Almost 42% of the workers suffering disabling injuries in 1984 had worked less than a year for their employer.

State officials said this supports the theory that injuries increase during times of increasing employment, because companies hire less-experienced workers.



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Orient-Pacific

Continued from page 1
companies and testified at Mr. Sellars' trial.

Mr. Birnberg resigned his post at Union Indemnity last February. Union Indemnity, which is owned by broker Frank B. Hall & Co. Inc., was placed in liquidation by a New York court in July (BI, June 17; July 22).

Daniel Warriner, a lawyer with the Newport Beach, Calif., firm of Marvin B. Kapelus & Associates, representing the defendants in the UDS lawsuit, said that the allegations made by UDS are "unfounded."

Neither Mr. Warriner nor Daniel I. Simon, UDS's lawyer, would comment further, noting that the court files on the case have been sealed.

Mr. Sellars also refused to comment on specifics of the suit other than to agree "emphatically" that the charges are unfounded.

"I'm forced to be speechless in this situation," he said, referring to the protective order sealing case files. "I would be in contempt of court."

Mr. Simon would not comment on who had requested the gag order, but Mr. Sellars said it was not the defendants.

Business Insurance has obtained a copy of the complaint which, in addition to fraud, charges the defendants with breaching fiduciary duties to UDS and illegally converting premium funds to their own use.

In addition to Orient-Pacific and the three individuals, the suit names Sellars Insurance Market Inc., Pacific International Management Inc., Pacific International Insurance Co., Universal Pacific Insurance Co. of the Marshall Islands, Pacific Imperial Management Inc., Pacific International Group Inc., Universal Pacific Claims Service, Universal Pacific Reinsurance Intermediaries and Universal Pacific Insurance Services.

All of these corporations are controlled by Mr. and Mrs. Sellars and Mr. March, and have no separate existence of their own, according to the complaint, which charges that the three individuals intermingled the assets of each company "to suit (their) convenience."

Between 1975 and 1985, Mr. Sellars, Sellars Insurance Market and Orient Pacific acted as insurance brokers for UDS and a predecessor company, Mobile Home Warranty Co. Inc., according to the complaint.

Mr. Sellars had helped form Mobile Home Warranty in 1975 and was a 25% shareholder in the company until 1978 when he sold his holding, the complaint says.

UDS sought insurance to cover service contracts issued by client automobile dealers on new and used cars and mobile homes. UDS issued certificates on a master insurance policy and handled claims for the dealers.

UDS paid a fee to Sellars Insurance Market for each insured service contract that UDS handled, according to the complaint.

In 1980, Mr. Sellars arranged to insure the UDS program with Union Indemnity, the complaint says.

Union Indemnity acted as a direct insurer on the program in all states except California, where it was not an admitted company.

On California risks, Protective National Insurance Co. of Omaha, Neb., a St. Regis Insurance Group unit, fronted for Union Indemnity, ceding it 100% of premiums and losses.

However, the complaint charges that while Mr. Sellars and Sellars Insurance Market were acting as brokers on behalf of UDS, Mr. Sellars and Orient-Pacific also acted as agents and representatives of Union Indemnity, an apparent conflict of interest.

Premiums paid by UDS to Sellars Insurance Market were deposited in an Orient-Pacific bank account, according to the complaint. In addition to the fees that UDS paid to Mr. Sellars and Sellars Insurance Market, Orient-Pacific collected 2% of the gross premiums paid to Union on UDS's California risks, the complaint says.

Mr. Sellars never told UDS that Orient-Pacific was acting as a producer for Union or that it was retaining any of the UDS premium, according to the complaint, which says that Orient-Pacific retained more than \$145,000 in premiums between 1980 and 1985.

In addition, the complaint charges that Mr. Sellars and the two companies improperly reported premiums and losses on portions of the UDS business, allowing them to "conceal and appropriate to their own account" more than \$1.5 million.

The largest premium diversions that are alleged in the complaint,

The complaint charges that while Mr. Sellars and Sellars Insurance Market were acting as brokers on behalf of UDS, Mr. Sellars and Orient-Pacific also acted as agents and representatives of Union Indemnity, an apparent conflict of interest.

however, relate to reinsurance of Union Indemnity on the UDS program.

In late 1984, Mr. Sellars told UDS that Orient-Pacific had acquired Paxton National Insurance Co. in order "to secure the long-range marketing interests of UDS," the complaint says.

However, the papers allege that this wasn't true. Paxton was actually acquired by Pacific Imperial Management, which is owned by Mr. March.

Mr. Sellars told UDS that Paxton had agreed to reinsure 100% of Union Indemnity's exposure on

UDS's business the complaint says.

Mr. Sellars also told UDS that Orient-Pacific had sent Paxton a check for \$1.88 million on Feb. 28, 1985, and another check for \$804,164 on March 5, 1985, representing premiums due to Paxton on the Union Indemnity reinsurance, the complaint alleges.

However, UDS charges that Paxton never received these checks and that Mr. Sellars and the two companies kept the money for their own benefit.

The complaint also charges that Paxton never sought approval of the reinsurance transaction from

the Pennsylvania Insurance Department, violating a supervisory order that the department imposed on Paxton when it was acquired in November 1984 by Pacific Imperial Management.

Alex Braddock, Pennsylvania's deputy insurance commissioner, confirmed that Paxton had violated the supervisory order.

"Paxton never told the Pennsylvania department that it was a reinsurer of Union on the UDS business," Mr. Braddock said, adding that Paxton officials themselves said they were unaware of the UDS business until an Insurance Department investigator informed them of it.

Mr. Braddock said that Orient-Pacific made out three or four checks totaling about \$3 million payable to Paxton on the UDS business, and that these checks were deposited in a Pacific Imperial Management account in a California bank. The Pennsylvania de-

Continued on next page



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business insurance

Orient-Pacific

Continued from previous page
partment doesn't know what happened to the funds after this, Mr. Braddock said.

Mr. Sellars, interviewed by telephone, would say only that Paxton's reinsurance of Union Indemnity was subject to certain conditions that Union Indemnity did not meet.

He would not comment on whether any of the premiums paid for the Paxton reinsurance were returned.

Along with these accusations, UDS charges it was not promptly notified that Protective National, in the summer of 1984, informed Mr. Sellars and Orient-Pacific that it would stop fronting the UDS program on Sept. 30, 1984.

UDS also complains that Mr. Sellars failed to advise UDS of the weak financial condition of Union and that the company couldn't be relied on as a viable insurer of UDS risks.

The complaint seeks to recover the \$4.3 million in premiums allegedly diverted, along with interest and punitive damages of \$10 million. It also asks the court to order the defendants to account for funds handled on the UDS business.

In addition, UDS had sought a temporary restraining order to block the defendants from withdrawing funds from bank accounts or from selling real estate or personal property.

Charging that some of the defendants had used UDS premiums to buy real estate and personal property, the lawsuit asked the court to order that all funds in bank accounts and all personal property controlled by the defendants be held in trust to pay UDS damage claims, and that the deeds to all real property acquired with UDS funds

Union Indemnity acted as a direct insurer on the program in all states except California.

be turned over to UDS.

On Aug. 19, a California Superior Court judge approved a modified temporary restraining order against the defendants.

It prohibits Mr. and Mrs. Sellars, Mr. March and the defendant corporations from:

- Withdrawing funds from bank accounts they control, except to meet ordinary expenses.

- Selling real or personal property, except in the ordinary course of business.

- Moving, altering or destroying records of business transactions.

The order allows the defendants to transmit premium funds due to non-affiliated insurers and to make claims payments to non-affiliated claimants.

The order also requires the defendants to turn over a variety of documents to UDS. Included in these are defendants' bank records and all corporate records of Orient-Pacific, Sellars Insurance Market and Mr. Sellars relating to business done with Union Indemnity, Monroe Birnberg, Paxton National and Protective National for the last five years.

Mr. Sellars, Mr. Warriner and Mr. Simon all refused to comment on why the original restraining order, granted Aug. 1, was modified, or whether the modified order is still in effect.

Mr. Sellars said the defendants will file an answer to the UDS complaint this week. ■

datebook

OCT. 6-8. Third International Risk Management Conference in Monte Carlo, Monaco, sponsored by the Risk & Insurance Management Society and the Assn. Europeenne des Assureurs de L'Industrie; \$420 (4,200 francs) for risk managers; \$550 (5,500 francs) for others; pre-registration for conference seminars is required. Marilyn Mafucci, RIMS, 205 E. 42nd St., New York, N.Y. 10017; 212-286-9292.

OCT. 6-8. 1985 Health Care Cost Management seminar in Lake Tahoe, Nev., sponsored by the International Foundation of Employee Benefit Plans; \$420 for members; \$495 for non-members. International Foundation of Employee Benefit Plans, Registration Department, 18700 W. Bluemound Road, P.O. Box 69, Brookfield, Wis. 53008-0069; 414-786-6700.

OCT. 6-10. Washington Insight on Employee Benefits conference in Washington, sponsored by the U.S. Chamber of Commerce; \$1,175. Suzanne Lulewicz or Deborah Murphy, U.S. Chamber of Commerce, 1615 H St. N.W., Washington, D.C. 20062; 202-463-5575.

OCT. 7-9. Risk Management Information Systems course in Arlington, Va., sponsored by the Risk & Insurance Management Society's Continuing Education Program; \$545 for members; \$645 for non-members. Fran Jordan, Administrator-Continuing Education Program, RIMS, 205 E. 42nd St., New York, N.Y. 10017; 212-286-9292.

OCT. 7-9. Basic Risk Management Techniques seminar in Washington, sponsored by the Public Risk & Insurance Management Assn.; \$350 for members; \$400 for non-members. Dean Phelus, PRIMA, 1120 G St. N.W., Suite 400, Washington, D.C. 20005; 202-626-4650.

OCT. 7-10. Highly Protected Risk Property Conservation course in Long Grove, Ill., sponsored by the Kemper Group; \$400; free for Kemper HPR-insured property owners. W.P. Thomas Jr., Manager, Engineering Research & Staff Development, HPR Department, A-1, Long Grove, Ill. 60049; 312-540-3360.

OCT. 7-11. Reinsurance Practice Course in London, sponsored by Risk Research Group Ltd.; 718 pounds (\$1,005). Judith Hobday, Risk Research Group Ltd., Bridge House, 181 Queen Victoria St., London, England EC4V 4DD; 011-441-236-217.

OCT. 7-11. Total Loss Control Management seminar in Philadelphia, sponsored by the International Safety Academy; \$655; \$625 for three or more registrants from the same company. International Safety Academy, P.O. Box 8527, 1600 Arch St., 12 Tower, Philadelphia, Pa. 19101; 800-231-3147; 215-241-5800 in Pennsylvania.

OCT. 8. The New Insurance Services Office Commercial General Liability Policy workshop in Dover, Del., sponsored by The Insurance Society of Philadelphia Inc.; \$90 for members; \$105 for non-members; special rates for three or more registrants from same organization. Also Oct. 18 in Philadelphia. The Insurance Society of Philadelphia Inc., 743 Public Ledger Building, Philadelphia, Pa. 19106; 215-627-5306. For registration in Dover, contact the Division of Continuing Education, Delaware Technical and Community College, Dover, Del. 19901; 302-736-5401.

OCT. 9-10. "Safety and Health—Mileposts to Progress: Sixth Annual Governor's Safety & Health Conference" in Anchorage, Alaska, sponsored by The Alaska Safety Advisory Council; \$150. Nancy Cannington, Governor's Safety and Advisory Council, Pouch 7-018, Anchorage, Alaska 99510; 907-264-2400.

OCT. 10-11. Self-Funding Your Employee Benefits meeting in New York, sponsored by American Management Assns.; \$620 for members; \$715 for non-members. Also Oct. 24-25 in San Francisco. Registrar, American Management Assns., P.O. Box 319, Saranac Lake, N.Y. 12983; 518-891-0065.

OCT. 10-11. Employers' Hidden Health Care

Costs conference in Washington, sponsored by the Clearinghouse on Business Coalitions for Health Action; \$99 for members; \$150 for non-members. U.S. Chamber of Commerce, 1615 H St. N.W., Washington, D.C. 20062; 202-463-5970.

OCT. 12. Solving the Workers Compensation Puzzle seminar in Santa Barbara, Calif., sponsored by Pre-Loss Systems Inc.; \$225. Elizabeth La Rovere, 189 Park Circle, Goleta, Calif. 93117; 805-968-3864.

OCT. 13-16. Society of Chartered Property & Casualty Underwriters 1985 Annual Meeting in St. Louis, sponsored by the Society of CPCU; \$250. Shirl Wood, Society of CPCU, Kahler Hall, 720 Providence Road, Malvern, Pa. 19355; 214-251-2737.

OCT. 15. Taxing Health Benefits seminar in New York, sponsored by The New York Business Group on Health Inc.; \$15 for members; \$25 for non-members. The New York Business Group on Health, 622 Third Avenue, 34th Floor, New York, N.Y. 10017; 212-808-0550.

OCT. 15. Controlling Unemployment Insurance Costs Workshop in Chicago, sponsored by the Illinois State Chamber of Commerce; \$90 for members; \$135 for non-members. Also Oct. 22 in Springfield. Carol Jensen, ISCC, 20 N. Wacker Drive, Chicago, Ill. 60606; 312-372-7373.

OCT. 16. Successful Retirement Planning workshop in Kansas City, Mo., sponsored by Retirement Advisors; \$375 before Sept. 25; \$450 after Sept. 25. Also, Nov. 6-8 in New York; \$375 before Oct. 16; \$450 after Oct. 16. Retirement Advisors (RAI), 919 Third Avenue, New York, N.Y. 10022; 212-421-2400.

OCT. 16. "Manage Your Claims So They Don't Manage You" seminar in Chicago, sponsored by Intracorp; \$65; \$55 for three or more registrants from one organization. Intracorp, 800 W. Roosevelt Road, Building C, Suite 210, Glen Ellyn, Ill. 60137; 312-858-8700.

OCT. 16. Health Promotion conference in Chicago, sponsored by the Illinois State Chamber of Commerce; \$90 for members; \$135 for non-members. Registrar, ISCC, Center for Business Management, 20 N. Wacker Drive, Chicago, Ill. 60606; 312-372-7373.

OCT. 16-17. Principles of Petroleum Insurance workshop in Denver, sponsored by the Professional Development Institute and Self-Insurance Resource Inc.; \$450. Also Oct. 29-30 in Oklahoma City, Nov. 6-7 in New Orleans, La., and Nov. 20-21 in Fort Worth, Texas. Jonathan Jeffrey, Professional Development Institute, P.O. Box 13288, NTSU, Denton, Texas 76203-3288; 817-565-2483.

OCT. 16-17. 1985 Central Regional Meeting of the National Assn. of Independent Insurance Adjusters in Columbus, Ohio; members will be assessed a pro-rata fee; free to company guests and claims representatives. David F. Mehren, NAIJA, 222 W. Adams, #845, Chicago, Ill. 60606; 312-853-0808.

OCT. 16-18. Solvency Assessment course in London, sponsored by Risk Research Group Ltd.; 471.50 pounds (\$660). Judith Hobday, Risk Research Group Ltd., Bridge House, 181 Queen Victoria St., London EC4V 4DD; 01-441-236-2175.

OCT. 16-18. Successful Retirement Planning Programs workshop in Kansas City, Kan., sponsored by Retirement Advisors Inc.; \$450. Also Nov. 6-8 in New York. Registrar, 919 Third Ave., New York, N.Y.; 212-421-2400.

OCT. 17. The Role of the Employee Benefit Manager as a Change Agent conference in Boston, sponsored by The New England Employee Benefits Council; \$35 for members; \$55 for non-members. The New England Employee Benefits Council, P.O. Box 2594, Boston, Mass. 02208; 617-423-6146.

OCT. 17. RIMS Midwest Regional Conference

in Northbrook, Ill., sponsored by the Northeast Illinois Chapter, Risk & Insurance Management Society; \$75, attendance limited to members and prospective members. Dorothy Chmielowski, Tribune Company, Suite 2100, 435 N. Michigan Ave., Chicago, Ill. 60611.

OCT. 17-18. Financial Analysis for Risk Management Decisions seminar in St. Louis, sponsored by The College of Insurance; \$750. Registrar, The College of Insurance, 101 Murray St., New York, N.Y. 10007; 212-962-4111, Ext. 303.

OCT. 17-18. Medical Malpractice for Attorneys, Physicians and Risk Managers national institute in Houston, sponsored by the American Bar Assn.'s Tort and Insurance Practice Section Committee on Law and Medicine and the American Society of Law & Medicine; \$325 for members; \$375 for non-members; \$50 for law students. American Bar Assn., National Institutes, 750 N. Lake Shore Drive, Chicago, Ill. 60611; 312-988-6200.

OCT. 18-20. California Chapter of the National Assn. of Rehabilitation Professionals in the Private Sector Regional Conference in Palm Springs, Calif.; \$140 for members before Sept. 27, \$165 after Sept. 27; \$160 for non-members before Sept. 27, \$175 after Sept. 27. NARPPS, P.O. Box 708, Twin Peaks, Calif. 92391; 714-337-0746.

OCT. 20-25. Fundamentals of Employee Benefits Management course in Brookfield, Wis., sponsored by the International Foundation of Employee Benefit Plans; \$800. Registrations Department, IFEBP, P.O. Box 69, Brookfield, Wis. 53008-0069; 414-786-6700.

OCT. 21-23. Second International Seminar on Strategic Planning for Insurance in London, sponsored by The Geneva Assn. and City Financial, a division of Kluwer Publishing Ltd.; 454 pounds (\$635.95). Caroline Fletcher, City Financial, 7th Floor, Africa House, 64-78 Kingsway, London WC2B 6BD; 011-441-831-6909.

OCT. 22. Data Workshop and NSDE Briefing in Boston, sponsored by the Health Research Institute; free. Also Nov. 5 in New York, Dec. 10 in Chicago. Workshop Coordinator, Health Research Institute, 49 Quail Court, Suite 200, Walnut Creek, Calif. 94596; 415-676-2320.

OCT. 22. Association Captives: Answer to the Insurance Crisis? conference in Washington, sponsored by the Risk Planning Group division of Tillinghast, Nelson & Warren; \$300. Micki Briskin, Risk Planning Group, 722 Post Road, Darien, Conn. 06820-4798; 203-655-9791.

OCT. 22-23. Improving Health Care Management in the Workplace conference in Scarsdale, N.Y., sponsored by The New York Business Group on Health; \$345 for members; \$395 for non-members. Work in America Institute Inc., 700 White Plains Road, Scarsdale, N.Y. 10583; 914-472-9600.

OCT. 23. Health Improvement/Prevention Workshop in Boston, sponsored by the Health Research Institute; \$195. Also Nov. 6 in New York, Dec. 11 in Chicago. Workshop Coordinator, Health Research Institute, 49 Quail Court, Suite 200, Walnut Creek, Calif. 94596; 415-676-2320.

OCT. 23. Advanced "Post-Graduate" Cost Containment workshop in Boston, sponsored by the Health Research Institute; \$195. Also Nov. 6 in New York, Dec. 11 in Chicago. Workshop Coordinator, Health Research Institute, 49 Quail Court, Suite 200, Walnut Creek, Calif. 94596; 415-676-2320.

OCT. 23. Hospital Trustee workshop in Boston, sponsored by the Health Research Institute; \$195. Also Nov. 6 in New York, Dec. 11 in Chicago. Workshop Coordinator, Health Research Institute, 49 Quail Court, Suite 200, Walnut Creek, Calif. 94596; 415-676-2320.

OCT. 23. Medical Directors workshop in Boston, sponsored by the Health Research Institute; \$195. Also Nov. 6 in New York, Dec. 11 in Chicago. Workshop Coordinator, Health Research Institute, 49 Quail Court, Suite 200, Walnut Creek, Calif. 94596; 415-676-2320.

OCT. 23. "Substance Abuse in the Workplace: Intervention—Resolution" teleconference sponsored by Macmillan Healthcare Information Symposiums International in association with The Annenberg Center for Health Sciences and Betty Ford Center at Eisenhower; \$225; \$195 for two or more registrants from same organization. Viewing at designated hotels in Los Angeles; San Francisco; Denver; Chicago; Bloomington, Minn.; St. Louis; Dallas; Houston; Arlington, Va.; Atlanta; Boston; Detroit; Pennsauken, N.J.; Cherry Hill, N.J.; Saddle Brook, N.J.; Philadelphia; New York; and Cleveland. Macmillan Healthcare Information, P.O. Box 35, Florham Park, N.J. 07932; 213-273-2157.

OCT. 23-25. Techniques of Finance and Accounting course in Minneapolis, sponsored by the Risk & Insurance Management Society's Continuing Education Program; \$445 for members; \$545 for non-members. Also Nov. 4-6 in Montreal. Fran Jordan, Administrator-Continuing Education Program, RIMS, 205 E. 42nd St., New York, N.Y. 10017; 212-286-9292.

OCT. 23-26. Worker's Compensation Issues seminar in Louisville, Ky., sponsored by the Kentucky Legislative Research Commission; \$150. Charlene Collins, Legislative Research Commission, State Capitol, Frankfort, Ky. 40601.

OCT. 24. Health Care Cost Management—An Organizational Approach seminar in New York, sponsored by The New York Business Group on Health; free. The New York Business Group on Health, 622 Third Ave., 34th Floor, New York, N.Y. 10017; 212-808-0550.

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Stafford plan

Continued from page 1

cleanup of hazardous-waste disposal sites under Superfund for policies issued before Dec. 11, 1980, the date the federal cleanup law was enacted.

- Specify that insurance policies issued after Dec. 11, 1980, and before July 1, 1985, provide coverage for hazardous-waste site cleanup only when the policies specifically obligate the insurer to provide such coverage.

- Allow insurers to obtain declaratory judgments as to whether they must provide a defense for policyholders in litigation involving a claim for cleanup of a hazardous-waste site and allow such a judgment to be appealed while the underlying litigation proceeds.

Currently in such cases, an insurer often must await the outcome of the entire cleanup litigation before appealing a decision that the insurer must provide a defense in the case.

The proposal would apply to all cleanup litigation pending at the time the Superfund reauthorization legislation is passed.

Although the insurance industry appears to have a substantial lead in its lobbying effort to win congressional acceptance of the Stafford proposal, insurers are by no means assured a victory.

Much of the business community has rallied against Sen. Stafford's proposal, and a major lobbying effort is being mounted to defeat the proposal.

"The Stafford proposal would eliminate a lot of funds that people might otherwise have to clean up these (Superfund) sites," maintains Richard C. Fortuna, executive director of the Hazardous Waste Treatment Council, a Washington-based trade group for hazardous-waste management firms.

"We view it as a slap in the face to all policyholders," says Jon Harkavy, director of governmental affairs with the Risk & Insurance Management Society in New York.

"I find it highly ironic that insurance carriers rather sanctimoniously plead the importance of state regulation of insurance and the McCarran-Ferguson Act, and then take this opportunity to pre-empt state law and judicial decision by retroactively eliminating insurance coverage," according to Mr. Harkavy.

RIMS already has alerted its members to the significance of the Stafford proposal and has urged members to ask their congressmen to vote against it.

Meanwhile, Sen. Stafford says he will offer the proposal as an amendment to a bill to extend the Superfund law, but only if it is widely supported by the property/casualty industry and if other senators will back it.

The Superfund extension bill, S. 51, is expected to come to the Senate floor for debate late this month (see story, page 37).

It is too early to tell how many senators will support the Stafford proposal.

And, the insurance industry has not yet given the proposal its unanimous support.

The Alliance of American Insurers and four major property/casualty insurers currently support the Stafford proposal.

However, members of the American Insurance Assn. still are debating the proposal and have yet to lend it their support.

James Kimble, senior counsel for federal affairs at the AIA, says that although AIA members favor legislative language that would "clarify (CGL) policy intent, members are still debating the effectiveness of Sen. Stafford's proposal."

AIA members do not feel that the Stafford proposal alone is enough to solve the insurance industry's problems with regard to Superfund liability, he says.

'We view (the proposal) as a slap in the face to all policyholders,' says Mr. Harkavy.

The AIA members also want to restrict their liability on policies written after 1980 that include coverage for hazardous-waste cleanup.

The association is backing a proposal developed by Sens. Pete V. Domenici, R-N.M., and Alan K. Simpson, R-Wyo., that would make several changes in the way joint and several liability is imposed under the Superfund Act.

Under the joint and several theory of liability, one waste generator can be held liable for cleaning up an entire waste dump, regardless of how much waste the generator actually deposited at the dump.

The Domenici-Simpson proposal would:

- Give the Environmental Protection Agency the authority to use Superfund money to pay for so-called "orphan" shares at waste-disposal sites. These are shares of liability that cannot be attributed to any of the companies the EPA says used the site.

- Eliminate liability in Superfund cleanup actions for companies that contributed very small amounts of waste to a site.

- Specifically allow EPA to release companies from all future liability after they agree to clean up a Superfund site. Currently, the agency often holds a firm liable for any pollution discovered at a site after the firm completes an EPA-ordered cleanup.

Insurers long have held that the current joint and several liability scheme is unacceptable because they cannot underwrite a pollution liability insurance policy if the insured can be held accountable for the improper disposal of other companies.

In fact, insurers originally had joined with risk managers and other industry groups to lobby for the repeal of joint and several liability under Superfund, contending that such a liability scheme was fostering endless litigation and was delaying cleanup of the nation's worst waste sites.

Mr. Kimble says AIA members are pushing for the Domenici-Simpson proposal as a necessary first step to any Superfund amendment designed to clarify CGL policy intent.

Insurers backing the Stafford proposal agree they would like to see the repeal of joint and several liability from the Superfund law, "but that isn't going to happen," says AAI's Mr. Farmer.

A wide range of business industry trade groups also have backed a no-fault approach to cleaning up abandoned hazardous-waste dumps. Under this approach, suggested by the insurance industry, waste generators, and consequently their insurers, would not be held liable for past disposal practices.

Rather, money to clean up sites created by past improper disposal of waste would come from the Superfund itself, which is funded by a tax on the chemical and petrochemical industries.

But, many members of Congress oppose this concept, including Sen. Stafford.

The Vermont Republican has said he will oppose any plan that overturns the basic philosophy behind Superfund: that the polluter must pay for damages stemming from improper waste disposal.

Staff members for the Environment and Public Works Committee say that although Sen. Stafford is "not necessarily sympathetic to the

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Sub-total 22,087

Associations 804
Government, unions and educational systems 1,030

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* Source: Business/Occupational breakdown of qualified circulation, May 6, 1985 issue, as submitted to BPA for June 1985. BPA Publisher's Statement.

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Stafford plan

Continued from page 35
insurance industry's concerns, he reasons that a lot of insureds, who are responsible parties at Superfund sites, are engaging in delaying tactics because they are spending the insurance companies' dollars for defense."

At an April hearing before the Environment and Public Works Committee, Sen. Stafford also voiced concern over a possible lack of insurance coverage for companies that do the actual cleanup work at Superfund sites.

The insurance industry argues that such coverage would not be widely available as long as insurers were forced to pay claims under past CGL policies that were not intended to cover cleanup costs, committee staffers say.

Further, Sen. Stafford was convinced by the insurance industry's argument that the billions of dollars in cleanup claims they may be forced to pay under CGL policies probably would drain off funds generated by other lines of insurance, one committee staff member noted.

"Sen. Stafford wants to make sure we don't spill the blood of innocent victims," the staffer explained.

Overall, committee staffers explain, Sen. Stafford's proposal is designed to scale back litigation over Superfund cleanup orders issued by the federal government by forcing companies named in such orders to pay their own litigation costs.

It also is designed to bolster the sagging environmental impairment

'Sen. Stafford wants to make sure we don't spill the blood of innocent victims,' his staffer says.

liability market by stemming insurers' losses under CGL policies.

Crum & Forster's Mr. Cheek predicts that "as time goes by, most insurers will support" the Stafford proposal.

Some congressional observers say if Sen. Stafford can convince his colleagues that his proposal would speed cleanup of hazardous-waste dumps, risk managers will have little chance of stopping the proposal.

However, Mr. Harkavy of RIMS says the Stafford proposal will not stop litigation over Superfund cleanup orders. "All it's going to do is force everything on to the policyholder," he maintains.

If Congress approves the Stafford proposal, risk managers may be able to attack it on the grounds that it is an unconstitutional taking of property, Mr. Harkavy points out.

"I really have tremendous, tremendous problems constitutionally with the federal government reviewing an insurance contract, whether or not correctly, and then denying coverage," he says.

Mr. Harkavy predicts that if the Stafford proposal is passed, the first policyholder that is denied coverage will raise the constitutionality issue.

Superfund reauthorization likely this year

By ROBERT A. FINLAYSON

WASHINGTON—Legislation to extend the Superfund law, which expires Sept. 30, is not expected to be passed by both houses of Congress before the statute expires, congressional staffers say.

However, a bill to reauthorize the hazardous-waste cleanup law probably will be approved by Congress later this year, staffers predict.

And, the delay in reauthorizing the 5-year-old Superfund Act will not have a major impact on the hazardous-waste cleanup program, according to congressional and administration sources.

Environmental Protection Agency officials took action several weeks ago to limit expenditures under Superfund in order to make funds last through the end of the year, EPA officials said.

And, while the cleanup law's taxing authority expires Sept. 30, EPA officials say the program still could continue to operate on money recovered from companies the agency identifies as responsible for the nation's abandoned hazardous-waste dumps.

The Senate is furthest along in its consideration of a Superfund reauthorization measure, S. 51. Senate Majority Leader Robert Dole, R-Kan., has scheduled the bill for floor debate later this month.

A companion measure in the House, H.R. 2817, is awaiting action by four separate committees: Public Works; Ways and Means; Judiciary; and Merchant Marine and Fisheries.

The House Energy and Commerce Committee passed the measure in late July, after a number of significant amendments (BI, Aug. 5). The Ways and Means Committee is expected to take action on the bill Tuesday, while the Public Works Committee has yet to schedule a consideration of the measure.

Once the bill is reported out of either Public Works or Ways and Means, the Judiciary and Merchant Marine and Fisheries committees have 10 days to complete work on H.R. 2817.

However, congressional sources say the Judiciary Committee is expected to consider the reauthoriza-

tion bill next week. The Merchant Marine and Fisheries Committee has not yet set a date for consideration of the bill.

Meanwhile, two congressmen are seeking to delay passage of a five-year Superfund reauthorization bill until next year.

Reps. James J. Florio, D-N.J., and Henry A. Waxman, D-Calif., have asked their House colleagues to delay a long-term reauthorization of Superfund and instead pass legislation that would extend the Superfund Act's taxing authority for one year to allow Congress additional time to consider amendments the pair thinks are needed in the Superfund law.

Those amendments include:

- A federal cause of action that would allow citizens to sue polluters for third-party damages under Superfund.

- A citizens' suit provision that would allow citizens to sue the federal government and hazardous-waste generators for failing to clean up abandoned hazardous-waste dumps.

- Mandatory standards for cleaning up hazardous-waste sites.

- A mandatory cleanup schedule for waste sites listed by the Environmental Protection Agency as the worst in the nation.

Reps. Florio and Waxman were unsuccessful earlier this year in gaining approval of the these amendments during the Energy and Commerce Committee's consideration of H.R. 2817.

Insurance lobbyists, who oppose the Florio-Waxman amendments, say the congressmen want to push consideration of Superfund amendments into next year because it is an election year, and "politicians will be afraid to vote against anything labeled an environmental bill."

If they fail to gain support for delaying reauthorization of Superfund, Reps. Florio and Waxman are expected to bring up their amendments during floor debate on the reauthorization bill, sources say.

However, they are unlikely to get House approval of the amendments, sources say.

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State actions

Continued from page 1

tempts to have it reinstated were stymied by the insurance industry.

"This clearly will be one of the major issues in the coming Illinois legislative session," Rep. Levin explained.

At a press conference at which he called for the legislation, Rep. Levin, flanked by small-business owners, retold stories of huge premium increases and canceled policies.

"The bottom line is that there is tremendous arbitrariness. . . . The action of many insurers is purely arbitrary," he said, explaining why the Insurance Department once again should regulate property/casualty rates.

According to research conducted by the NAIC, Illinois is the only state in which individual insurers' rates, as well as rating bureau advisory rates, are not filed with the state.

"It's in a category unto itself," Rep. Levin said, noting that in other states there is some mechanism for rate accountability.

Rep. Levin's proposal was presented Sept. 9 to the House Insurance Committee as an amendment to H.B. 1649, a bill that would amend the Illinois Insurance Code and the state Human Rights Act to prohibit sex discrimination in the insurance business.

That bill had been placed on the interim study calendar to be recalled next year.

The Levin proposal already has drawn strong opposition from insurance industry trade groups.

"We feel this proposal goes against the national trend and trends in the insurance industry to deregulate and go back to market-based pricing," said John R. Davis, a senior legislative analyst with the Alliance of American Insurers, based in Schaumburg, Ill.

Rate increases have resulted from a number of factors, Mr. Davis said, including poor underwriting results, the reduction of interest rates and liberal court awards.

And, rate hikes are the mechanism to offset and correct these problems, he said. "The system is not broke. Don't fix it. The system is working fine."

"Other states that have prior approval also are seeing skyrocketing rates," added William Vainisi, workers compensation counsel for the National Assn. of Independent Insurers in Des Plaines.

Illinois Insurance Director John Washburn said the regulatory philosophy in Illinois has been that competition is the best equalizer in the market.

Mr. Washburn was at the NAIC

meeting last week and had not seen Rep. Levin's proposal.

"There needs to be (rate) stabilization," Mr. Washburn noted, adding that open competition is the best way for the insurance industry to balance its losses.

Other state regulators say that insurers must find an answer to rate and capacity problems or else face additional regulation.

"State insurance commissioners are advising insurers that unless they expand capacity voluntarily, there will be a call for joint underwriting associations or other mechanisms," said Edward J. Muhl, Maryland's insurance commissioner and chairman of the National Assn. of Insurance Commissioners' Commercial Lines Property and Casualty Insurance Committee.

"There was a strong message sent out from the (commercial lines) committee and from other NAIC members, that the insurance industry will have to solve this problem or we will take action," Commissioner Muhl said.

The formation of joint underwriting associations, similar to assigned risk pools, are being considered by Florida Insurance Commissioner Bill Gunter to force insurers to provide coverage for property/casualty risks they now refuse to write.

The last in a series of three public meetings will be held Sept. 23 to address the "enormous price increases and limited availability of commercial property and liability insurance," said Davis Voss, Mr. Gunter's senior executive assistant.

"The meetings will be used to develop legislation aimed at lowering these insurance rates," Mr. Voss said.

Besides the possible creation of joint underwriting associations, the Florida Insurance Department also is considering proposing legislation for 1986 that would:

- Allow professionals—like engineers, architects and accountants—to form self-insurance pools for professional liability risks. Currently, physicians are the only Florida professionals that are allowed to form such pools.

- Expand and modify Florida's law governing insurance reciprocals to foster more self-insurance groups for small and medium-sized businesses.

- Give the state insurance commissioner more authority to review and approve commercial property insurance rates. Currently, individual insurers do not have to file commercial property rates with the department.

- Create an excess profits law for property/casualty rates, similar to the law governing workers com-

pensation rates, in which profits greater than a specified amount are required to be returned to policyholders.

- Develop incentives, like tax breaks, for employers that implement loss prevention measures.

A variety of business owners and representatives of professional organizations have been invited to attend the meetings where these proposals for legislation will be discussed.

The Sept. 23 meeting will be from 10 a.m. to 2 p.m. in Jacksonville in the City Council chambers, 220 E. Bay St. Similar meetings were held last week in Orlando and Miami.

In California, 18 insurers are meeting today in San Francisco with Insurance Commissioner Bruce Bunner to discuss plans for a statewide program to provide day-care centers with hard-to-find liability insurance.

Unlike a joint underwriting association, underwriters would participate in the program—called a Market Assistance Plan or MAP—on a voluntarily basis.

Among the details of the plan not yet determined is how day-care center risks would be distributed among the pool participants. One possibility is that the insurers would underwrite on a rotating basis as risks are submitted, according to a California Insurance Department spokesman.

The Market Assistance Plan was proposed as an alternative to state legislation introduced by Sen. John Seymour, R-Anaheim, that would create a joint underwriting pool of all licensed liability insurers in California to insure day-care centers.

That measure, S.B. 1474, which most observers say has an excellent chance of becoming law, is opposed by the insurance industry.

Sen. Seymour has put his bill on hold pending the outcome of the Insurance Department's plan to convince insurers to voluntarily provide affordable liability coverage to day-care centers.

Sen. Seymour wanted assurances that 25 to 30 insurers would participate in the MAP before he agreed to withdraw his legislation. The 18 insurers that have agreed to participate were still trying to draw additional support last week, but may proceed with the plan anyway, according to an Insurance Department spokesman.

The MAP could be operating within "a matter of weeks," the spokesman said.

If the MAP is unable to attract at least seven more underwriters or if the plan cannot operate properly with only 18 insurers, S.B. 1474 will be reintroduced in January, according to a spokesman for Sen. Seymour.

Sen. Seymour's bill was prompted by cries from day-care center operators that they could be forced to close because liability insurers have withdrawn from the market in the wake of widespread and well-publicized allegations of child abuse at day-care centers (BI, June 10).

In Oregon, Insurance Commissioner Josephine M. Driscoll is expected to issue a permanent order this month, perhaps as soon as this week, restricting midterm cover-

Air crash cover

Continued from page 2
the crash of a British Airways jet last month in Manchester, England, in which 54 persons were killed. (BI, Aug. 26)

A spokesman for Pratt & Whitney said there was "no similarity in the accidents. If anything what was experienced was a freakish occurrence."

He said it was "too early" to speculate on any potential liability for the engine manufacturer but "we do have liability coverage and are covered adequately, we believe." ■

age cancellations and timely notice of non-renewals.

A temporary order has been in effect since June 15 and a public hearing to consider the permanent adoption of that order was held Aug. 15 (BI, July 1).

Under the temporary order, "no insurance policy may be canceled by the insurer prior to the expiration of the agreed term or one year from the effective date of the policy or renewal, whichever is less."

The order does allow midterm cancellation if the policyholder fails to promptly pay the premium or if the cancellation is based on grounds related to the policy conditions, like misrepresentation or substantial changes in the risks assumed.

The department has not yet decided on the language of the permanent order, said Larry Kibbee, executive assistant to the commissioner.

Kansas Insurance Commissioner Fletcher Bell is also threatening to take action to block midterm cancellations.

"If midterm cancellations and non-renewals of Kansas policyholders continue, I will have no choice but to seek restrictions on insurers' ability to cancel or non-renew insurance contracts or take such other actions as seem appropriate," Mr. Bell said in a bulletin issued last month.

In that bulletin, Mr. Bell referred to the resolution opposing midterm cancellations and short notices of non-renewal passed by the NAIC in June and also made reference to individual action taken by other state regulators.

"Insurers should recognize these actions (in Kansas and other states) are only indicators that state legislatures and regulators are not going to sit idly by and let insurers correct their errors at the expense of innocent policyholders," Mr. Bell said.

The bulletin also noted that the Kansas Legislature earlier this year extended the notice that insurers must give before canceling or amending an independent agent's contract to 180 days from 120 days.

"Our problems are probably the same as in most other states," added Raymond E. Rathert, fire and casualty division supervisor in the Kansas Insurance Department. He noted that many insurers are panicking and overreacting in view of high losses.

Los Angeles Bureau Chief Robert A. Finlayson and Associate Editor Steve Taravella also contributed to this story.

Baldwin pact moving ahead

NEW YORK—Metropolitan Life Insurance Co. and some 50 other life insurers are moving toward a settlement with about 165,000 policyholders who purchased single-premium deferred annuities worth more than \$3 billion issued by insurance units of Baldwin-United Corp.

Two years ago, Cincinnati-based Baldwin filed for reorganization under the U.S. Bankruptcy Code in Ohio, and policyholders faced losing their entire investment.

Metropolitan and the other life insurers are making the settlement offer because they want policyholders to be treated fairly and to avoid triggering guaranty funds in at least 35 states, according to William G. Poortvliet, senior vp and chief actuary for Metropolitan.

According to the agreement, known as the enhancement plan, Metropolitan will let policyholders exchange their Baldwin annuities for Metropolitan annuities with a guaranteed interest rate of between 7.5% and 8%, Mr. Poortvliet said.

Under a current rehabilitation plan approved by the courts in Arkansas and Indiana, where the six Baldwin insurers were based, policyholders have been told they are likely to receive 5.5% interest plus the return of their initial investment on Nov. 1, 1987—the closing date of the rehabilitation period.

The money for the enhancement plan is coming from three sources:

- Some \$50 million has been pledged by the life insurers.

- Baldwin-United is expected to provide \$170 million to \$185 million from the sale of some subsidiaries.

- At least \$157 million will come from 22 securities brokerage firms that sold the annuities. Other brokers also sold the annuities and could also join the plan.

The brokers agreed to join the plan in lieu of "fines, forfeitures or other claims that state officials could have assessed" in state or civil actions, according to a spokesman for the National Assn. of Insurance Commissioners.

The NAIC, as well as the National Assn. of Attorneys General, worked with the brokers, insurers and courts for the past 18 months to reach the agreement.

The enhancement plan still needs final approval from the courts in Arkansas, Indiana and New York. The guaranty funds also will be asked to approve the plan, Mr. Poortvliet said, adding he expects the plan to be approved. ■

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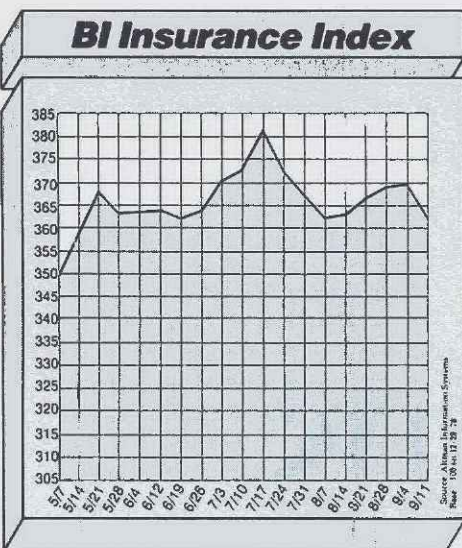
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The *Business Insurance* stock index took a drastic downward turn during the most recent trading period, bringing its upward climb over the last four weeks to an end. The *Business Insurance* index closed at 362.2 points for the period ending Sept. 11, dropping 6.8 points from 369.0 points on Sept. 4. A total of only six stocks posted gains, and 40 stocks declined. Eleven stocks remained unchanged. The biggest gains were posted by Crown Life Insurance Co., up 4.6%; Combined International Corp., up 2.9%; Statesman Group Inc., up 2.9%; Farmers Group Inc., up 2.7%; and Business Men's Assurance Co. of America, up 0.9%. The biggest losses were posted by Nobel Insurance Ltd., down 7.8%; Emmett & Chandler Cos. Inc., down 7.7%; Zenith National Insurance Corp., down 7.1%; Washington National Corp., down 7%; and The Crump Cos., down 6.5%. The *Business Insurance* index dropped 1.8% for the period. In addition, the New York Stock Exchange composite declined 1.3%; the Standard & Poor's 500 index declined 1.2%; and the Dow Jones 30 Industrials average declined 0.5%.

British Issues

10 Sept Companies	Price	P/E	Div.	Yield	1 Week High—Low
Comml Union	225	N/M	16.9	7.5	229—221
Genl Accident	620	25.8	31.4	5.1	626—620
Gdn Royal Exch	670	58.3	38.6	5.8	685—670
Royal	650	81.2	35.0	5.4	655—650
Sun Alliance	460	N/M	23.6	5.1	475—460

Brokers	Price	P/E	Div.	Yield	1 Week High—Low
CE Heath	645	8.4	37.5	5.8	650—645
Hogg Robinson	284	11.8	14.3	5.0	289—284
JH Minet	208	10.9	11.0	5.3	209—202
Sedg Grp	398	15.3	17.8	4.5	410—395
Staw Wrightson	655	12.8	31.4	4.8	665—655
Willis Faber	700	17.9	23.6	3.4	725—700

Source: Philip Olsen/Alan Clifton, Insurance Industry Specialists Kitecat & Aitken Stockbrokers, London

Operating leverage widens brokerages' profit margins

By LEONARD M. WILSON

Special to Business Insurance

OPERATING leverage is a two-way street. Insurance brokers were confronted with unrelenting pressure on profit margins during the competitive phase of the underwriting cycle. Now, with rising prices on commercial insurance, leverage is working in a positive direction and profit margins are widening.

This is what is supposed to happen when revenues begin to advance at a pace in the high teens or better.

A typical insurance broker's expenses also accelerate in periods of prosperity, but they seldom match the extent of the increase in revenues. The ability to restrain cost advances while revenues are expanding strongly dictates the amount of positive operating leverage a broker will experience in favorable times.

Some observers have posed the question as to why a public broker's costs on a year-over-year basis should rise markedly, even with the improvement in top-line growth. Currently, public brokers are experiencing annualized cost escalations of 15% to 20%. In 1984, the corresponding figure was in the 5% range.

Is the workload any heavier this year than last? Certainly the bulk of revenue gains reflects pricing rather than a rise in physical workload as measured by policy count or transactions. Moreover, in most instances, head counts have not begun to expand materially.

Employment costs, on the face of it, ought to vary with the transaction count and general inflation, balanced by internal productivity gains.

Other operating expenses are composed primarily of such items as rent, data processing, communications, travel and entertainment and an assortment of other overlays. Most categories of other operating ex-

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Mr. Wilson

penses are fixed or semi-variable.

If transactions are not rising markedly, as we believe, and other operating expenses are not directly variable, then what is fueling the increases in 1985 costs? Clearly, other factors are at work.

We ascribe diminished expense restraint to several causes.

First, in most service businesses there is a tendency to ease up on the cost controls when prosperity arrives. For the public insurance brokers, we think there is a good deal of catch-up for expense austerity imposed over the prior several years.

In addition, employment costs through incentive systems are geared to production and profit. Both are performing well in 1985.

Finally, insurance brokerage is more entrepreneurial than most businesses and, as such, the rewards tend to reflect the ups as well as the downs of the business.

The rise in other operating expenses is a bit more inscrutable. We know that premiums for a broker's own insurance coverage have taken a quantum jump. The difficulty in placing business in today's tight markets may have escalated travel expenses, and possibly entertainment expenses as well.

Beyond the fairly obvious explanations, some of the rise in expenses can possibly be attributed to implementation of programs deferred or trimmed prior to 1985.

As we mulled over the issue of brokerage costs, we decided to look at historical data to determine just how much operating leverage in fact is available to the prospering public brokers. Essentially, we decided to measure operating leverage as the relationship between the change in revenues and the change in expenses for a given period. The changes were calculated on a year-over-year basis.

By way of example, Marsh & McLennan Cos. Inc. in the second quarter posted incremental pretax profit margins of 35%. This means that for each \$1 of increased revenues, 35 cents dropped down to pretax income. Or, to put it in a cost framework, for each \$1 advance in revenues, expenses rose 65 cents.

The corresponding incremental profit margins for the other largest brokers were as follows: Alexander & Alexander Services Inc., 52%; Frank B. Hall & Co. Inc., 20%; and Corroon & Black Corp., 34%.

In general, the greatest sales gains yield the greatest operating leverage. Frank B. Hall trailed its competitors in revenue growth

during the quarter. But, control of expenses is important as evidenced by Alexander & Alexander, which did not achieve the largest revenue increase in the quarter but had the highest incremental margin.

The last period of prosperity for the public brokers ran from 1975 through 1979. Revenue growth was especially strong during the middle phase. On an annual basis, Marsh & McLennan's incremental profit margins ranged from 27% to 37%, with an average over the five years of 32%. Thus, about 32 cents of each added revenue dollar dropped to the pretax line.

For the other brokers, the data looked like this:

● Alexander & Alexander also posted incremental margins of 32% on average over the period, with the annual range running from 22% to 46%.

● Frank B. Hall achieved an average incremental margin of 28%, though in one year the figure was as low as 12% while the high was 40%.

● Corroon & Black also registered an average of 28% based on our calculations, but with wide variation in individual years depending upon the extent of top-line growth.

It is interesting that the average incremental calculation over the five-year period was so close for all four brokers. This suggests considerable uniformity in the structure of expenses, including incentives. Given time and space, a more-detailed analysis might yield quantifiable statistical relationships based upon a regression correlation.

If the historical data has relevance, and we suspect it does, we can conclude that operating leverage as defined by the incremental profit margin will cluster in the 30% to 40% area for each of the public brokers during this current period of pronounced revenue growth. We would not expect incremental margins to surpass this range over a full year or over several years. As revenue gains diminish—perhaps in 1987 and thereafter—the incremental margin can be expected to contract or even vanish.

The recovery in profit margins that we envisage for the public brokers depends upon the ability to bring as much of the incremental revenue dollar to the bottom line. Incremental profit margins hold the key to the extent of the recovery, and are worth watching both as a tool of analysis as well as a measure of comparative performance.

The Home Reinsurance Co.

The Home Reinsurance Co. has increased its policyholder surplus to more than \$52.2 million as a result of an addition of \$21 million in capital from its parent, The Home Insurance Co.

Home Re says it plans to use some of the additional funds to expand its non-proportional treaty and facultative accounts.

Chubb Corp.

Chubb Corp. has declared a 3-for-2 split in its common shares. The new stock will be distributed Oct. 24 to shareholders of record Oct. 3.

In addition, Chubb's quarterly common stock dividend has been increased 6.4% to 58.5 cents per share, payable Oct. 7 to shareholders of record Sept. 23. Also, the regularly \$1.0625 per-share quarterly dividend on Chubb's \$4.25 Convertible Exchangeable Preferred Stock is payable Oct. 15 to shareholders of record Sept. 27.

Travelers Corp.

Travelers Corp. has begun its offering of 3.9 million shares of common stock at a price of \$41.375 per share. Travelers says it will use the proceeds for general corporate purposes.

Morgan Stanley & Co. Inc. is the underwriter for the offering.

Arthur J. Gallagher

Arthur J. Gallagher & Co. declared a quarterly cash dividend of 7 cents per share on the company's common stock, payable Oct. 15 to shareholders of record Sept. 30.

BI Industry Stock Report

September 11, 1985 9/5/85 thru 9/11/85

Brokers		Price	% Chg.	P/E	\$ Div.	% Yld.	High	Low	Vol.(000)		Price	% Chg.	P/E	\$ Div.	% Yld.	High	Low	Vol.(000)	
Alexander & Alexander Svcs	NYSE	27.38	-1.4	0.0	1.00	3.7	28.25	27.38	293.7	Avenco Corp	NYSE	30.63	-1.2	13.4	0.60	2.0	31.25	30.63	7.4
Baldwin & Lyons Inc	OTC	60.00	0.0	9.9	0.80	1.3	62.00	60.00	3.3	Business Mena Assurn Co Amer	OTC	27.25	0.9	7.9	1.04	3.8	28.00	27.00	18.5
Corroon & Black Corp	NYSE	47.88	-1.0	0.0	1.00	2.1	49.25	47.88	37.5	Chubb Corp	NYSE	70.13	-3.3	17.1	2.34	3.3	72.75	70.13	287.7
Crump E H Cos Inc	OTC	28.75	-5.5	18.5	0.50	1.7	31.00	28.75	61.7	Combined Intl Corp	NYSE	44.75	2.9	8.4	2.16	4.8	44.75	43.63	305.8
Emett & Chandler Cos Inc	OTC	15.00	-7.7	38.5	0.00	0.0	15.50	14.50	21.6										
										Continental Corp	NYSE	41.50	-1.5	20.3	2.60	6.3	42.75	41.50	593.0
Gallagher Arthur J & Co	OTC	37.88	-2.3	21.2	0.28	0.7	38.50	37.25	20.8	Crown Life Ins Co	OTC	240.00	4.6	14.5	0.00	0.0	245.00	229.50	0.1
Hall Frank B & Co Inc	NYSE	30.13	-0.8	0.0	1.00	3.3	31.00	30.13	203.5	Durham Corp	OTC	40.00	0.0	7.4	1.28	3.2	40.50	40.00	2.2
Marsh & McLennan Cos Inc	NYSE	68.25	-2.3	17.5	2.40	3.5	69.38	68.00	247.2	Farmers Group Inc	OTC	62.75	2.7	10.7	1.76	2.8	64.13	62.25	417.0
Poe & Assoc Inc	OTC	8.00	0.0	0.0	0.80	10.0	8.00	8.00	0.4	Fremont Gen Corp	OTC	23.88	-3.0	0.0	0.48	2.0	24.75	23.88	115.6
Reed Stenhouse Cos Ltd	OTC	21.88	0.0	28.4	0.00	0.0	21.88	21.63	19.3										
				=====		=====				Great West Life Assurn Co	OTC	425.00	0.0	10.9	1.60	0.4	425.00	425.00	0.0
AGENTS/BROKERS	AVERAGE			37.3		2.3				Hanover Ins Co	OTC	45.75	-1.1	62.7	0.56	1.2	46.00	45.75	148.0
										Hartford Steam Boiler Insaptn	OTC	53.00	-2.8	16.7	1.60	3.0	54.50	53.00	23.3
										Kans City Life Ins	OTC	25.25	-1.9	9.9	0.87	3.4	25.75	25.25	12.0
										Kemper Corp	OTC	55.38	-4.9	15.9	1.80	3.3	58.38	55.38	223.4
Conglomerates & Holding Cos.																			
American Express(Fireman's Fd)	NYSE	41.25	0.3	14.3	1.28	3.1	42.38	41.00	2,983.5	Liberty Corp S C	NYSE	30.38	-0.4	13.4	0.72	2.4	30.50	30.38	7.6
Anderson Clayton(Ranger/PanAm)	NYSE	41.50	3.1	30.5	1.32	3.2	41.50	40.25	26.5	Lincoln Natl Corp Ind	NYSE	41.50	-3.5	10.0	1.84	4.4	42.75	41.50	188.5
Araco Inc	NYSE	9.13	-5.2	0.0	0.00	0.0	9.88	9.13	550.0	Mission Ins Group Inc	NYSE	5.63	0.0	0.0	0.00	0.0	5.88	5.63	49.2
Berkley W R Corp	OTC	21.63	-2.8	63.6	0.32	1.5	22.13	21.63	226.8	Monumental Corp	OTC	32.25	-2.3	11.8	1.40	4.3	33.00	32.25	9.6
CIGNA Corp	NYSE	53.50	-2.3	75.4	2.60	4.9	54.75	53.50	1,141.8	Nobel Ins Ltd	OTC	11.75	-7.8	15.5	0.25	2.1	12.75	11.75	52.1
City Investing Co. (Home Ins.)	NYSE	7.38	-7.8	1.1	0.00	0.0	8.25	7.25	1,391.5	Northwestern Natl Life Ins	OTC	20.63	-2.9	5.3	0.80	3.9	21.50	20.63	467.6
CNA Finl Corp (CNA)	NYSE	54.75	-0.5	18.9	0.00	0.0	55.00	54.50	84.1	Ohio Cas Corp	OTC	59.50	-2.5	22.3	2.80	4.7	60.88	59.50	513.5
General Re Corp	NYSE	82.00	-3.2	130.2	1.56	1.9	85.13	82.00	350.7	Old Rep Intl Corp	OTC	30.38	-3.2	8.2	0.74	2.4	31.75	30.38	104.4
ITT (Hartford Group)	NYSE	33.38	-1.8	9.6	1.00	3.0	34.00	33.00	3,714.4	Orion Cap Corp	NYSE	24.13	-4.0	0.0	0.76	3.2	24.88	24.13	164.2
Sears Roebuck & Co. (Allstate)	NYSE	34.63	-0.4	9.3	1.76	5.1	35.13	34.38	2,227.6	Protective Corp	OTC	18.50	-1.3	6.8	0.66	3.6	18.75	18.50	22.1
Teledyne Inc (Argonaut)	NYSE	237.63	-2.8	5.1	0.00	0.0	244.75	237.50	143.7	Provident Life & Acc Ins Co	OTC	23.00	-1.1	6.2	0.76	3.3	23.50	23.00	492.0
Transamerica Corp										St Paul Cos Inc	OTC	71.88	-0.2	0.0	3.00	4.2	72.50	71.88	344.2
(Occidental & Fred S. James)	NYSE	28.25	0.0	14.6	1.64	5.8	28.88	28.25	1,062.1	SAFECO Corp	OTC	38.00	-4.4	12.3	1.60	4.2	39.75	38.00	535.6
				=====		=====				Sri Corp	OTC	19.63	-4.3	57.7	0.80	4.1	20.25	19.63	262.5
CONGLOMERATES/HOLDING COS.	AVERAGE			9.8		1.8				Seibels Bruce Group Inc	OTC	18.75	-2.6	0.0	0.80	4.3	19.50	18.75	88.9
Insurers																			
										Statesman Group Inc	OTC	4.50	2.9	0.0	0.15	3.3	4.63	4.50	62.2
Aetna Life & Cas Co	NYSE	42.88	-1.4	17.6	2.64	6.2	44.38	42.88	1,219.8	Tokio Marine & Fire Ins Co	OTC	182.25	0.8	31.5	1.05	0.6	182.25	179.25	4.7
American General Corp	NYSE	30.25	0.0	9.4	1.00	3.3	30.88	30.25	884.9	Torchmark Corp	NYSE	46.25	1.9	9.7	1.20	2.6	46.38	45.25	103.6
Ameri Heritage Life Invst Co	NYSE	33.88	-4.2	9.9	1.20	3.5	35.25	33.88	1.8	Travelers Corp	NYSE	40.00	-2.1	9.7	2.04	5.1	41.00	40.00	1,870.5
American Indty Finl Corp	OTC	19.50	0.0	0.0	1.12	5.7	19.50	19.50	1.2	United Fire & Cas Co	OTC	24.00	0.0	20.9	1.20	5.0	24.00	24.00	0.2
American Intl Group Inc	NYSE	84.38	-0.4	22.6	0.44	0.5	86.63	84.38	503.0										
										United States Fid & Gty Co	NYSE	32.00	-6.2	133.3	2.20	6.9	34.00	32.00	384.9
Aneco Reins Ltd	OTC	1.50	0.0	0.0	0.00	0.0	1.50	1.50	4.1	UsLife Corp	NYSE	36.00	-2.4	8.1	1.04	2.9	36.75	36.00	149.8
										Washington Natl Corp	NYSE	23.00	-7.1	6.7	1.08	4.7	24.75	23.00	58.2
										Zenith Natl Ins Corp	OTC	19.50	-7.1	0.0	0.68	3.5	21.00	19.50	58.5
														=====					
										INSURANCE COMPANIES	AVERAGE			17.4		2.3			

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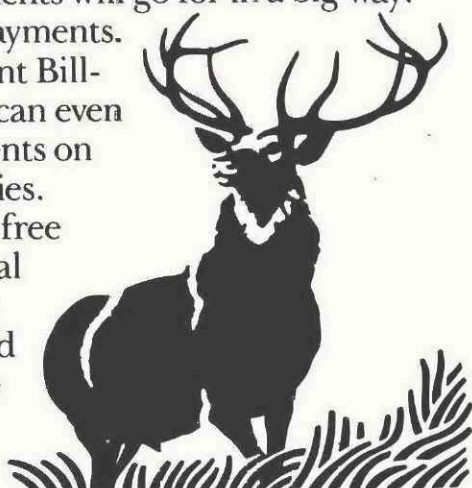
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