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Update

Lloyd's mulls central bailout of members facing big losses

LONDON—Senior executives at Lloyd's of London are discussing various schemes to centrally bail out members suffering billions of dollars in catastrophe losses from 1988 to 1990.

Proposals include making retrospective to 1988 a compulsory stop-loss scheme suggested by the Lloyd's task force. The scheme, which caps members' losses at an amount equal to 100% of their overall premium limit in any underwriting year, is due to be implemented for the 1993 under-

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Dingell unveils regulatory plan

Insurers offered federal charter; big buyers lose guaranty fund protection

By JERRY GEISEL and MARK A. HOFMANN

WASHINGTON—Policies sold to large insurance buyers by federally certified commercial insurers would be exempt from rate and policy form regulation but would not be protected by a new federal guaranty fund under sweeping insurance solvency legislation introduced last week.

Rep. John Dingell, D-Mich., unveiled the long-awaited measure after a hearing Thursday at which insurance regulators asserted that federal intervention is unnecessary because their state insurance department accreditation program will go a long way toward shoring up solvency regulation.

But, General Accounting Office officials testified that the regulators' plan was insufficient, though they praised the regulators' efforts.

The measure by the House Energy and Commerce Committee chairman would give insurers the option of continuing to be regulated for solvency by the states or—for those obtaining a federal certificate—by a new federal agency, the Federal Insurance Solvency Commission.

Insurers with more than $50 million in net worth would be exempt from rate and form regulation on commercial policies sold to buyers with a net worth exceeding $10 million.

However, other insurers obtaining a federal certificate would still be subject to state rate and form regulation and would be required to participate in state residual risk pools.

Federal guaranty fund protection would not be available to large policyholders.

However, the new National Insurance Protection Corp. would pay claims filed against large

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EBP rebuts rumor storm surrounding stock plunge and lawsuits

By DOUGLAS McLEOD

MINNEAPOLIS—Choose the correct answer: Employee Benefit Plans Inc., the nation's third-largest claims administrator, is:

a.) Being investigated by the FBI and the Internal Revenue Service.

b.) Trying to find a new auditor to replace Arthur Andersen & Co., which resigned the EBP account.

c.) Going out of business.

d.) None of the above.

If you picked "none of the above," you're right.

The other choices are among the dozen or more rumors that have swirled around the Minneapolis-based company in recent months as its stock price soared to a new high, then plunged on a disappointing quarterly earnings report.

EBP—which faces shareholder litigation from the stock price drop—blames the rumors and some of the wild swings in its stock price on traders who have sold the stock short and are hoping to see the company stumble.

At least one short seller has posed as an FBI agent in phone calls soliciting information about the company, EBP officials say. Two short sellers told *Business Insurance* of the alleged FBI investigation, the existence of which could not be confirmed.

"Are we under attack? Yes, we are under attack," said EBP Senior Vp Robert P. Brook, assailing what he describes as a smear campaign aimed at manipulating the company's stock price.

The negative rumors have become so widespread that EBP has circulated an internal "rumor list," coaching its sales staff on how to respond to clients' questions.

However, while these and some other rumors are demonstrably false, EDP is not without its problems, though it says they are distorted or exaggerated by its critics. These problems include:

- Several lawsuits that have challenged the basic structure of EBP's business.

EBP provides claims administration and other

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Worried about health care

Most Americans expect government to make care affordable: Poll

By CHRISTINE WOOLSEY

WASHINGTON—Most Americans worry they will not be able to afford health insurance in the future and say the federal government should take responsibility for health system reform, according to a new survey.

Sixty-one percent of individuals surveyed said they worry that health insurance will become unaffordable, while 50% said they worry that they will be stuck with very expensive medical bills not covered by health insurance.

Most Americans—60%—said they expect the federal government—not state governments or the private sector—to take the lead in reforming the nation's health care system, including providing health insurance to all Americans and controlling health care cost increases, the Harris poll found.

However, opinion is about evenly divided on which of three leading options for health insurance reform is preferable.

Thirty-three percent of the people surveyed said they would favor a national health plan in which employers are required to either offer private health insurance or pay a payroll tax to support a government program—the so-called play-or-pay approach.

Meanwhile, 30% said they would favor a single-payer national health plan financed by taxpayers in which

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Health care frustration mounts

Americans are growing more dissatisfied with the health care system.

Source: Louis Harris & Associates Inc., The Henry J. Kaiser Family Foundation and The Commonwealth Fund

GRAPHIC BY JOHN SMITHER

N.Y. exempts Blues, self-insurers from new inpatient surcharge

By MICHAEL SCHACHNER

ALBANY, N.Y.—Buried in the 1992 state budget is a provision that gives the six New York Blue Cross & Blue Shield Assn. plans and self-insurers a distinct pricing advantage over commercial insurers.

Gov. Mario Cuomo's budget, approved April 2 after four weeks of debate, increases the surcharge commercial group health insurers pay on inpatient hospital charges. The increase, which is effective until March 31, 1993, means commercial insurers will pay 24% more than the Blues plans for inpatient hospital charges.

However, the Blues contend that until the state requires all licensed insurers to offer costly open enrollment and community-rated health care plans, as it does, provisions like this are merely stopgap measures.

Self-insured employers also will pay less than commercial insurers, since they are exempt from the new 11% inpatient supplemental charge.

Under a separate budget provision, all health maintenance organizations licensed to operate in New York, including BC/BS HMOs, beginning July 1 will be required to pay up to a 9% surcharge on all inpatient hospital charges unless they cover a percentage of Medicare-eligible people in their region equal to their percentage of market share.

Commercial insurers, which along with self-insurers have been paying a 13% supplemental charge to hospitals since 1988 to offset uncompensated inpatient care, say they are preparing to pass the additional 11% surcharge on to policyholders in the form of 4% to 6% premium increases.

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Sun sets on 1992 RIMS conference

A discussion of ethical dilemmas was among the risk management sessions at the 30th annual Risk & Insurance Management Society conference. Stories begin on page 3.

Update

Lloyd's looks at aiding names

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writing year onward (*BI*, Jan. 20).

Last week, Lloyd's Chairman David Coleridge said at the annual conference of the Assn. of Insurance & Risk Managers in Industry & Commerce that "the question of whether we should help the walking wounded is actively on my desk at the moment."

New Texas work comp insurer

CHICAGO—Old Republic International Corp. will seek to renew business written by Dallas-based Employers Casualty Co., a major underwriter of Texas workers comp insurance that was ordered to stop writing new and renewal business in February.

ECC was placed into conservatorship last month (*BI*, Feb. 17).

As many as 55,000 ECC policyholders may be able to renew with Employers General Insurance Corp., a unit of Employers General Insurance Group, which Chicago-based Old Republic formed.

Old Republic invested $26 million in Employers General and will offer ECC shareholders the option to buy shares in the new holding company, which could boost the surplus to $50 million, said A.C. Zucaro, president and chief executive officer of Old Republic.

Old Republic will pay ECC 5% of any renewal premiums written for the right to offer its policyholders renewals. The payments will reduce ECC's estimated $65 million deficit in loss reserves.

Mr. Zucaro said Employers General plans initially to write roughly $75 million in premiums, including up to $40 million in commercial lines. "It's our hope to grow that business to $200 million to $300 million" within a few years, Mr. Zucaro said.

The new Texas insurer will retain at least 100 of ECC's 900 employees. Employers Casualty Executive Vp H. Wayne Dortch will be president and chief operating officer of Employers General.

Maxus appealing cover denial

TRENTON, N.J.—Maxus Energy Corp. will ask a New Jersey appellate court to reconsider a 3-0 ruling that its former Diamond Shamrock Chemicals Co. unit has no insurance for either an Agent Orange settlement or for claims from a contaminated Newark, N.J., plant site.

Reversing a state judge's 1989 ruling, the appeals court last week ruled that Diamond Shamrock could not recover from insurers $19.6 million of the $23.3 million it paid as part of a settlement with Vietnam veterans injured by toxic defoliant Agent Orange (*BI*, April 17, 1989; Feb. 27, 1989).

Coverage of the Agent Orange settlement is barred because the loss "fell squarely within the war risk exclusion" to Diamond Shamrock's policies, the court found. "Since the hazard was 'incidental to war' and not common to civilian life in peacetime, we find it abundantly plain that the war risk exclusion was applicable," the appeals panel said.

The appeals court also affirmed the trial court's finding that Diamond Shamrock has no coverage for cleanup costs and other claims arising from its dioxin-contaminated Newark plant, finding that Diamond's "deliberate course of pollution" could not have been unexpected or unintended.

Maxus, whose chemicals unit formerly operated Diamond Shamrock's parent company, intends to take a $19.6 million non-cash charge against earnings for the first quarter of 1992 to write off a receivable it had carried on its books since 1985.

Skandia thwarts takeover

STOCKHOLM, Sweden—Skandia Insurance Co. Ltd. reached an agreement last week designed to defuse efforts by shareholders UNI Storebrand A/S of Norway and Hafnia Insurance Co. Ltd. of Denmark to create a Scandinavian insurance alliance.

Under the agreement, Skandia would acquire 100% of Hafnia through a stock swap, merging it into its Danish operations. And, in return for its Skandia stake, UNI Storebrand would obtain all Skandia reinsurance operations, except New York-based Skandia America Group. The non-U.S. reinsurance units wrote about $850 million in net premiums in 1990.

Skandia America operates independently from Skandia's other reinsurance operations, which are located throughout Europe.

Hafnia and UNI Storebrand acquired 42.9% of Skandia last year, which led to extensive discussions about Skandia's ownership structure among the three insurers (*BI*, Dec. 2, 1991).

The deal is expected to be completed in July.

Updates continued on page 82

Errors & omissions

• The Reliance Insurance Group's 1991 statutory combined ratio for its property/casualty operations for 1991 is 115.2%. *Business Insurance* reported its combined ratio on a generally accepted accounting principles basis in the April 6 issue.

• Legislation awaiting final congressional approval would require employers with more than 50 employees to extend up to 12 weeks of unpaid job-protected family and medical leave to their workers. A story in the April 6 issue incorrectly reported the size of employers subject to the legislation.

• U.S. property/casualty insurers' net income rose 29.7% in 1991 to $14 billion from $10.8 billion in 1990, according to the Insurance Services Offices Inc. and the National Assn. of Independent Insurers, restating figures supplied for the March 30 issue. Also, policyholder surplus rose 14.3% to a restated $158.2 billion at year-end 1991 from $138.4 billion.

D&O insurers, MGM settle bad faith charge

By STACY GORDON

LOS ANGELES—Three directors and officers liability insurers will pay MGM-Pathe Communications Co. $19.46 million to settle bad-faith charges stemming from shareholder litigation over the 1986 sale of the company.

However, MGM-Pathe's bad-faith claim against a fourth insurer that refused to settle is scheduled to go to trial today.

The four insurers that wrote D&O insurance for MGM in 1985, when the sale was negotiated, are Los Angeles-based Harbor Insurance Co., a unit of Continental Corp.; Schaumburg, Ill.-based Forum Insurance Co., a unit of General Electric Co.; Los Angeles-based Associated International Insurance Co., a unit of Willis Corroon Corp.; and New York-based National Union Fire Insurance Co. of Pittsburgh, Pa., a unit of American International Group Inc.

Harbor wrote a $5 million primary policy and Forum wrote a $10 million layer excess of $5 million. Associated wrote $5 million of limits excess of $15 million, and National Union wrote $70 million of coverage excess of $20 million. MGM coinsured portions of this layer.

Under the terms of the settlement with MGM, Harbor will pay

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Bankruptcy law vs. ERISA

Supreme Court to decide if creditors can tap pensions

By JERRY GEISEL

WASHINGTON—The U.S. Supreme Court will decide whether creditors are entitled to a bankrupt individual's pension benefits, and the decision could threaten the tax-favored status of pension plans.

If the high court says pension benefits are part of a bankruptcy estate and can be seized by creditors, pension plans that comply with such bankruptcy court orders would run the risk of violating federal pension law that says benefits cannot be attached or seized by another party.

Violating those rules would put a plan at risk of disqualification by the Internal Revenue Service. That would mean vested employees would be taxed on their benefits and employers would lose their tax deductions for contributions made on behalf of non-vested employees.

However, benefits consultants say Congress almost assuredly would act to overturn any Supreme Court decision that threatens workers' and retirees' pension benefits.

"Congressional action would become an urgent necessity, and action would be considered highly likely," said Henry Saveth, a principal with A. Foster Higgins & Co. Inc. in New York.

But, a ruling in favor of debtors would resolve a troublesome issue that has split courts around

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Acquisitions in A&H, life reinsurance market

UNUM buys D&H; Hodson buys RAI

By DOUGLAS McLEOD

NEW YORK—UNUM Corp. is acquiring Duncanson & Holt Inc., one of the world's largest accident and health reinsurance underwriting managers.

Separately, G.L. Hodson & Son Inc., the reinsurance brokerage unit of Willis Corroon Group P.L.C., is acquiring Reinsurance Alternatives Inc., one of the largest life and accident and health treaty reinsurance brokers in the country.

New York-based Duncanson & Holt, which is privately held by its management, operates nine reinsurance pools with more than 50 reinsurance company members, the largest of which is American Accident Reinsurance Group.

The facilities generated about $350 million in annualized earned premiums last year, according to Thomas G. Brown, the company's chairman and chief executive.

Duncanson & Holt has 239 employees and offices in nine other U.S. cities, London, Toronto and Singapore.

Mr. Brown called the merger a "perfect fit," because UNUM was active only in long-term disability reinsurance, while Dun-

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Buchalter to appeal $2.7 million award

By STACY GORDON

LOS ANGELES—Buchalter, Nemer, Fields, & Younger, a well-known insurance defense law firm, will appeal a $2.7 million malpractice award handed down late last month by a state court jury here.

The Los Angeles-based firm is insured for the award by Attorneys Insurance Mutual Ltd., a Barbados-based group captive that writes malpractice coverage for 17 U.S. law firms.

The jury verdict stems from a 1986 lawsuit filed by Pine Top Insurance Co. Ltd. of London, which alleged the law firm negligently represented it in a reinsurance dispute.

Buchalter, though, argues that it did not even represent Pine Top in the dispute.

In its lawsuit, Pine Top alleged that Buchalter, Nemer, Fields & Younger "failed to exercise reasonable care and skill, and failed to perform services in a competent, expeditious and professional manner."

Pine Top also alleged fraud and breach of fiduciary duty, but these claims were thrown out by the judge. A request for punitive damages was similarly dismissed, as were claims against the only two lawyers named individually—Jonathan Bank and

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Inside

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1992 RIMS conference

Proposing a code of ethics risk managers can turn to when they're in the hot seat

John F. Roskopf, left, John W. Twomey, Carol A. Fox, Pete Ligeros and Donald S. Malecki played out some ethical dilemmas risk managers might face and discussed how they should respond.

By JUDY GREENWALD

ANAHEIM, Calif.—What's a risk manager to do?

A risk manager receives a call informing her that a temporary warehouse her company leased six months ago has gone up in smoke, along with $5 million in product.

She recalls a conversation a few months earlier with the company's vp for East Coast operations, who told her the inventory in the warehouse would be worth less than $500,000, so there was no need to add the location to the property coverage and add to his insurance costs.

Frantically studying her policy, she discovers a clause allowing automatic coverage in effect for 90 days, with a $500,000 limit.

She then gets a call from the vp of East Coast operations, who is later providentially able to produce a memo dated six months earlier in which he requests coverage for the location. Attached is an unsigned note that says, "I don't think the CEO will be happy if this loss isn't insured."

The risk manager wonders if she herself should "discover" a similar letter to her broker in her own files.

Hypothetical situations like these demonstrate the need for the development of a code of ethics by the Risk & Insurance Management Society Inc., according to Carol A. Fox, corporate risk manager for Gibson Greetings Inc., based in Cincinnati.

Ms. Fox said that while deputy members of RIMS do have guidelines for professional conduct, there is no ethics code. "This is a topic we need to discuss as a society," she said.

Ms. Fox was the coordinator and moderator of a session on ethics at the 30th annual Risk & Insurance Management Society conference in Anaheim, Calif.

The session featured the presentation and discussion of various hypothetical dilemmas involving ethical issues comparable to those faced by the worried risk manager. Panel members invited the audience to give their opinions as well.

In the case of the warehouse, for instance, several questions were asked of panel members:

- Should the risk manager report the developing situation to her boss at the risk of losing her job?
- Upon reporting the loss to her broker, should the risk manager insist the broker help her find a way to cover the loss?
- Should the risk manager contact a consultant who might testify that more extensive automatic coverage provisions are readily available, and the broker had failed in his or her duty to offer this coverage?

Discussing this case was Pete Ligeros, an Irvine, Calif.-based attorney and an associate consultant with risk and employee benefits consultant Warren, McVeigh & Griffin, based in Newport Beach, Calif. Mr. Ligeros said the risk manager should act ethically and try to obtain coverage for the fire, but also do what she can to protect her own reputation.

For instance, Mr. Ligeros said "she should absolutely report it to her boss," but probably only after talking to a lawyer and putting everything that has occurred in writing. "You have to attack the people who are coming after you," he said.

On whether the risk manager should enlist the broker's help to find coverage, Mr. Ligeros said there could be other legitimate options to find coverage that should be explored.

The risk manager should not insist her brokerage find coverage that does not actually exist, he said. However, "if you're

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Anticipating the impact of ADA requirements

Advice on minimizing risk that employment practices will run afoul of the law

By SARA J. HARTY

ANAHEIM, Calif.—The Americans with Disabilities Act will help people with disabilities find satisfying work without proving to be a burden to employers, predicted two rehabilitation specialists.

However, a risk manager suggested that employers maintain a wait-and-see attitude concerning the impact of the act, especially small firms that may face paying for expensive accommodations.

Portions of the Americans with Disabilities Act, including employment provisions for public employers, are already in effect. Employment provisions for private employers with more than 25 employees will become effective July 26 (*BI*, Jan. 27). Private employers with 15 to 25 employees will have to comply in 1994.

The ADA prohibits employers from instituting " 'protections' that do not allow opportunities for people with disabilities," John G. Carlson, president of RHM Consulting in Marlboro, Mass., explained at a session of the 30th annual Risk & Insurance Management Society conference, held March 30-April 1. RHM specializes in risk and health management issues.

The ADA prohibits discrimination against people with a physical or mental impairment that substantially limits one or more major life activities; people with a record of such an impairment; or people who are regarded as having such an impairment, like an able-bodied person who is disfigured.

Gains in medical technology are resulting in more "survivors" of disease and accidents—who are sometimes impaired in some way, Mr. Carlson said.

"There are 43 million Americans with disabilities who make up a discrete and insular minority," he said. For them, "isolation is the greatest disability risk," he said, adding that the ADA could help change that.

Risk managers who are trying to ensure that their company is in compliance with the law can take several steps, suggested Brian T. McMahon, a rehabilitation educator and counselor affiliated with the University of Wisconsin at Milwaukee.

If a company's human resource policies are already sound, the ADA will require minimal change, Mr. McMahon said. If the policies are not sound, the ADA will require a great deal of change, he said.

For example, "How you portray the disabled, especially in writing" is important, Mr. McMahon said.

Place the emphasis on the person, rather than on the disability, he suggested. For instance, use phrases such as "people who are. . ." or "persons with. . ." or "persons who have. . .," rather than saying "the deaf" or "the blind," he advised. Those terms and others such as " 'birth defects,' or 'spastic' are considered defamatory," Mr. McMahon said.

The law will also require some changes in the way many companies interview job applicants, he noted.

When interviewing prospective employees, employers may not ask about the applicant's health status, disabilities or workers compensation claims history, Mr. McMahon said.

The employer can, however, show the applicant a description of the job and ask how he or she "would perform both the essential and marginal functions," he said.

The applicant also can be asked to give a demonstration "if there is obvious interference," or even if there is no disability that would obviously interfere with the applicant's ability to perform the job, but all applicants are required by the employer to give such a demonstration, Mr. McMahon said.

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Code of ethics

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forceful enough, maybe something will come out of it," he added. By insisting, maybe the person involved will find a legitimate way.

Similarly, the risk manager should also find out what a consultant can do for you, Mr. Ligeros said.

Discussing the issue of ethics in general, he quipped that a lot of people believe lawyers and ethics are "mutually exclusive," although he does not hold that belief. People also mistakenly believe that good business practices are mutually exclusive with ethics, he added.

Risk managers must develop a system of accountability, said Mr. Ligeros, adding, "ethics is basically another word for morals."

Ethics today call for the common-sense application of moral purposes, he said. Problems arise, however, in balancing the business world with the legal system and other factors.

Ethics cannot be learned from a sheet of paper, he stressed. Instead, it must "come from your heart" and be a set of values with which you were raised.

Mr. Ligeros also said that if RIMS adopts a code of ethical standards, it should also adopt a mechanism to make it work.

But a RIMS code of ethics raises the possibility of a situation where someone is fired as a result of adhering to it, he said. What should RIMS do?

"There have to be guidelines set out," said Mr. Ligeros. There must be financial planning available to members to cover the costs that will be incurred in such a case, he said.

Most people would regard the legal business as professional, and everyone considers the medical business professional, observed another panelist, John W. Twomey, senior vp-specialty lines with Great American Insurance Cos. in Cincinnati. Risk managers also regard themselves as professionals, but if risk management is truly a profession, high ethical standards are needed, Mr. Twomey said.

Another attribute of a profession, he noted, is a spirit of altruism towards others, "putting others before other interests."

The third attribute would be a continuing education program of some type, he said.

A code of professional ethics for risk managers is needed, according to Mr. Twomey, who noted that the Society of Chartered Property & Casualty Underwriters adopted a code of professional ethics in 1976.

"You need a self-policing mechanism," said Mr. Twomey, who holds the CPCU designation and has taught CPCU classes. "If you don't do it, there are people who will do it for you" from the outside.

John F. Roskopf, vp and a risk management consultant at Rollins Burdick Hunter Co. in Chicago, addressed the issue from a broker's perspective.

Ethical problems, he said, arise from a conscious decision to select from various alternatives. "It's a sin of commission rather than a sin of omission," he said.

Issues involving brokers for the most part are those of unprofessionalism, rather than a matter of ethics, said Mr. Roskopf. "It depends on the financial interest involved," he said.

Among the instances Mr. Roskopf gave that could be considered either a lack of professionalism or of ethics is when a broker sells a client insurance rather than seeking an alternative solution. Another example is when a broker with a captive management arm tries to convince a client a captive is needed when in fact it is not.

Donald S. Malecki of Donald S. Malecki & Associates Inc., insurance and risk management consultants with offices in Cincinnati and Fort Thomas, Ky., said that as children, we are told that Washington told the truth and Lincoln walked miles to give the correct change. Today, he said, we live in a society where Vice President Spiro T. Agnew resigned because of dishonesty.

"Emphasis on ethics changes over time," said Mr. Malecki, who also called for a code of ethics.

During the 1960s Vietnam era, people were more concerned about themselves, while the yuppie lifestyle flourished in the 1980s. Today, though, there is more emphasis on ethics, Mr. Malecki contends.

It is safe to say most people want to be ethical, he said. But "the pressure on people who want to be ethical can be enormous." How many risk managers would be praised for making an ethical decision that costs their company $1 million? he asked.

Among the other hypothetical situations discussed during the session were:

- A corporate risk manager allows a competing broker to provide a quote for the company's casualty program. The risk manager does not volunteer information about minor, but unique, products and workers compensation exposures confronting the operation; however, the broker does not ask. What should the risk manager have done?

Mr. Malecki said the risk manager should have told the broker of the risks. "Risk managers should not participate in the game 'I've Got a Secret,' " he said.

- The board of directors of a Midwest chapter of RIMS receives corroborated information that one of its members is requiring "full service" from his broker, which includes a "consultation" by a "rehabilitation nurse." In other words, the broker provides him with a prostitute.

The member is informed that his membership in RIMS could be terminated if he is found guilty by the executive committee of unethical conduct. The member's attorney, though, asks for a copy of the ethics code under which his client is being accused and states the expulsion will tarnish his reputation. Should the Board of Directors have left well enough alone?

Because the information was corroborated, "I think they had an obligation" to report the information to RIMS' Executive Committee, said Ms. Fox.

"I think if we allow unprofessional conduct among our members it grows like a cancer," she said. Furthermore, "there's a perception you can be bought," which sends out a message to the brokerage community.

In actuality, though, Ms. Fox said this entire episode would probably have been handled more discreetly. ■

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Disabilities act

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The ADA will encourage employers to keep an open mind about applicants, he said.

For example, a man in a wheelchair applied for a telephone company position that required him to climb telephone poles. Company representatives feared that they were being set up for a discrimination suit and called Mr. McMahon for advice.

He suggested that they act as if the ADA were in effect and ask the applicant how he would fulfill job requirements. It turned out that while the man did not have full use of his legs, he was a professional climber, fully capable of climbing poles.

Physicians who perform medical exams for job applicants are free to gather a great deal of medical information. However, any information released to human resources, Mr. McMahon said, should only address the pertinent questions of "Can the applicant perform the essential functions?" and "Is there a direct threat" to the applicant or other workers when the applicant is performing job functions?

Employers are still allowed to require drug and agility tests as long as all applicants are subjected to the tests, Mr. McMahon added.

Employers that have not determined the essential functions of a job will be "quite vulnerable," he suggested. A well-founded, written job description "is going to be crucial."

Some employers worry that the lack of clear language in the law will be their downfall.

For instance, an employer cannot refuse to hire or bring back an injured employee if "reasonable and necessary" accommodations would enable that individual to perform the "essential" functions of the job. Such accommodations are not required if they would create an "undue hardship" for the employer.

These phrases are never clearly defined by the law, although some guidelines are given in the Federal Register by way of example, he said.

"I understand that employers are upset with the vagueness of the wording, but you should understand that the vagueness is not by ignorance or by default; it is by design," Mr. McMahon said. The wording will guarantee a case-by-case evaluation of complaints, he explained.

In the area of "undue hardship," employers should be aware that this goes beyond "financial hardships," Mr. McMahon said. "It could also be the amount of disruption an accommodation would cause."

However, never say the accommodation would be "bad for morale," he warned.

Also, before rejecting an accommodation outright as too expensive, employers should investigate the various organizations and foundations willing to help finance the costs of many accommodations, Mr. McMahon said. In addition, tax credits for many accommodations also are available.

Federal agencies are not likely to smile upon employers that reject an accommodation as too expensive without considering these outside sources that could mitigate the overall costs, he said.

Employers also should budget for the "transaction costs" associated with the time and work involved when the employer is determining whether a person is disabled and what accommodation might be needed, Mr. McMahon said.

Not all "professionals" are up on the ADA, Mr. Carlson warned.

"Watch out for 'experts,' " agreed Mr. McMahon. When expert advice is needed, "ask a person with a disability."

Mr. McMahon and Mr. Carlson further discussed the ADA for a segment of "The Premium Dollar Today," a cable television program that was taped during the RIMS conference.

They were joined by James E. Crockett, manager of risk and benefits for the Board of Water Commissioners in Denver.

In presenting the employer concerns with the ADA, Mr. Crockett noted that "most employers support the moral aspect" of the act.

Before rejecting an accommodation outright as too expensive, employers should investigate the various organizations willing to help finance the costs. And, tax credits for many accommodations also are available, says Mr. McMahon.

The "problem is how to finance" the provisions, he said. "Ultimately, you and I will share the costs" associated with the ADA.

However, the costs associated with the ADA already are being paid for by "society" as it subsidizes potentially productive but unemployed workers, Mr. Carlson countered.

Furthermore, the ADA "is not a full employment act for the disabled," Mr. Carlson said. "It's always up to the employer to make the decision" about hiring an individual.

Another concern of employers is a scenario in which an employee is permanently injured doing heavy work—like "manually laying underground pipelines"—but the employee insists upon expensive and complex accommodations that would allow him or her to return to that particular job, according to Mr. Crockett.

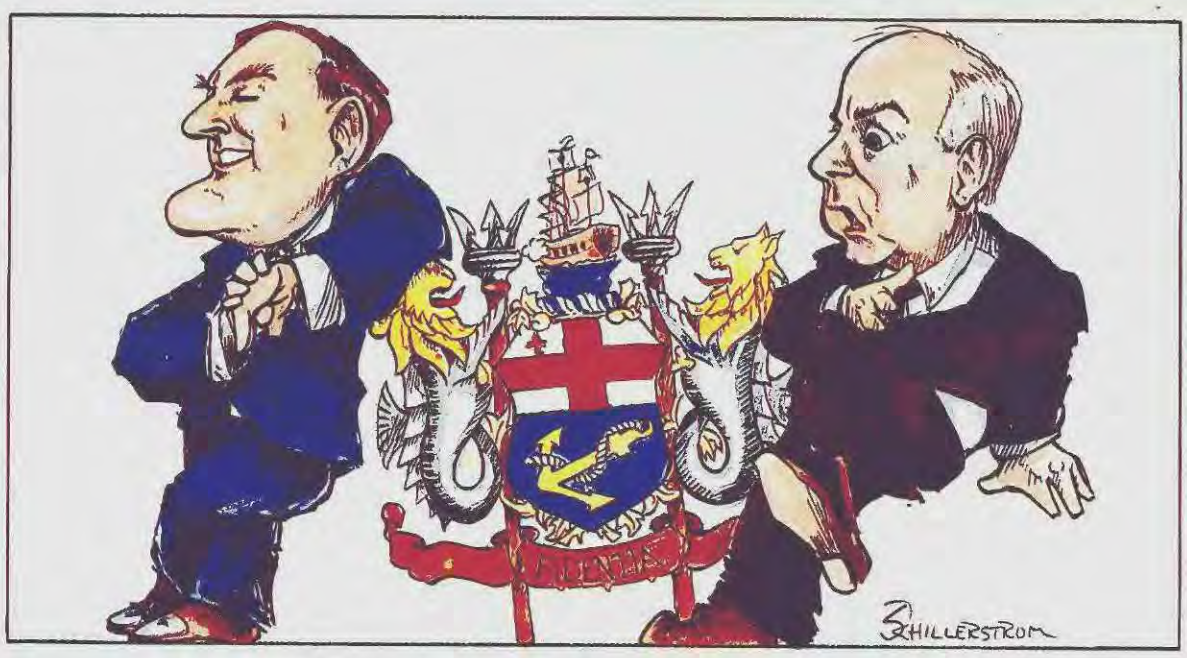
"We could get worried about what might happen," suggested Mr. McMahon, but such scenarios are "extremely unlikely" and "completely against the spirit of the law."

"I'm very optimistic" about the law, Mr. McMahon said. "I do believe that the overwhelming majority of employers agree with the law."

However, in the long run, "I'm skeptical about the ADA's future," Mr. Crockett said, predicting that there may be some amendments to the law.

Herbert E. Goodfriend, director of insurance analysis for KPMG Peat Marwick in New York, moderated the program.

The program will air April 17 on the USA network at 6 a.m. EDT. ■



Despite hard times, the Lloyd's tradition will continue on: Panel

Task force report offers opportunity

By GAVIN SOUTER

ANAHEIM, Calif.—Lloyd's of London—like most insurance markets around the world—has hit hard times, but its underlying strength and its new recipe for survival will ensure its continuation, two market professionals agree.

Underwriters like Richard Hazell may underestimate the value of brokers, says Dennis Mahoney.

Despite losses, litigation by members and a capacity crunch, Lloyd's, through the implementation of recommendations made by a task force in January, will return to profitability, they said.

And brokers will be at the leading edge of the market revival, a Lloyd's broker said at a session titled "Trouble in the Coffee House? What's Going On at Lloyd's?" at the 30th annual Risk & Insurance Management Society conference.

Despite Lloyd's difficulties over the past 10 years—including scandals and overcapacity—it has paid its claims, said Richard Hazell, a deputy chairman of Lloyd's and underwriter for syndicate 190, managed by Cater Allen Syndicate Management Ltd.

"We have a great advantage—none of our difficulties have affected our policyholders, and that means that we retain the confidence of our customers," he said.

Regardless of the much publicized losses at Lloyd's, the market's troubles should not be viewed in isolation, he said. "It's possible, contrary to popular belief, to lose money other than at Lloyd's."

For example, more than 100 property/casualty insurers in the United States became insolvent between 1988 and 1990, he said.

The insolvency problem will not affect Lloyd's because of its reserves for future liabilities, which stood at $21 billion at the end of 1990, he said. "How many other insurers are as well reserved?"

Lloyd's also faces the problem of litigation by members who have lost money at Lloyd's. Mr. Hazell charged that these members are essentially trying to change the terms of their Lloyd's membership.

"They are trying to mutualize the market which they joined as sole traders," he commented.

Money in the Central Fund at Lloyd's, which is used to pay cliams when a member cannot, belongs to the membership, and by seeking to use the fund to pay their own losses, the litigating members are trying to make other members pay their losses, he said.

Another issue is the reduction in capacity as members flee the market in record numbers. However, it has not become a problem, he said.

"There is seldom a shortage in capacity for a good risk," he noted.

And in most years, Lloyd's only used 65% to 70% of the capacity available in the market, he said.

Any future problems with Lloyd's capital base should be addressed by recent task force recommendations, he said (*BI* Jan. 20).

One of the task force's principal recommendations is the establishment of a stop-loss insurance fund. The fund would cap members' losses stemming from any one year's underwriting account at an amount equal to 100% of their overall premium limit for that year. However, members would be again responsible for their losses if the stop-loss fund is depleted.

"This leaves the principle of unlimited liability intact, but only in the most exceptional circumstances. To all intents and purposes, a name would be limited beyond a certain amount," Mr. Hazell

Continued on page 10

Opinions

Make your voices heard

THE ANNUAL RISK & Insurance Management Society conference is perhaps the best time of year to take the pulse of the risk management profession. And, judging from the success of this year's conference and related events, the risk management profession is thriving.

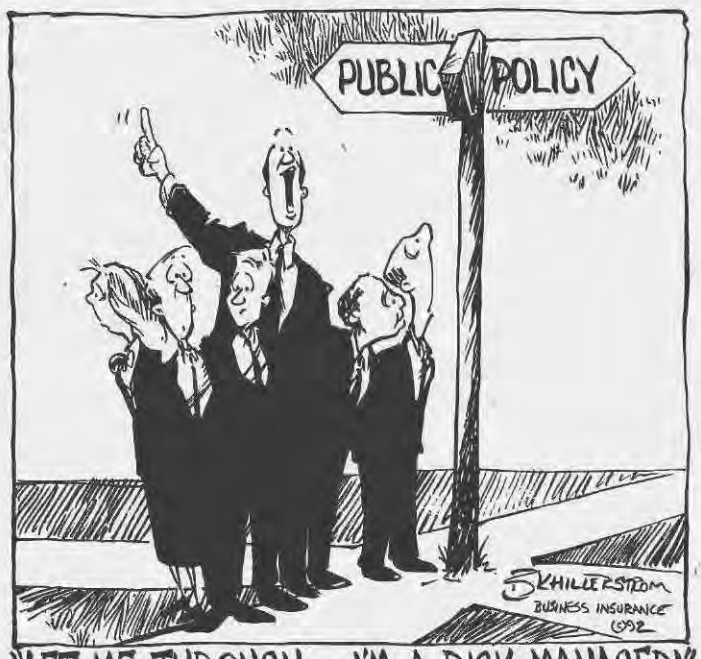
Looking strictly at the numbers, one could get the wrong idea. The 8,000 registrants and exhibitors at this year's Anaheim conference were fewer than the previous two years. But, the recession certainly did not help this year's registration figures. And, Anaheim—despite its warm weather and many attractions—may not have been as attractive a site for some East Coast registrants as Boston or New Orleans, which hosted the 1990 and 1991 RIMS conferences.

However, the 1992 conference attracted a record number of companies exhibiting their products and services. This cannot be ignored: More and more vendors are taking note of the important role that risk management plays, both to individual organizations and to society at large.

Many of these vendors used the conference to unveil new products and services to risk and employee benefit managers (see story, page 14, and *BI,* April 6). And, as the risk management profession matures, insurers and other firms are working to introduce products that fill needs that risk managers cite. For example, two insurers recently introduced stand-alone policies that cover damages stemming from employment discrimination lawsuits, coverage that insurers generally no longer offer in standard general liability and workers compensation policies (*BI,* March 23).

Insurers—as well as brokers, claims administrators, computer and software firms, consultants and other vendors—will continue to respond to risk managers' needs, but only if risk managers make their needs known—loud and clear.

In fact, if the risk management profession is to continue to prosper, risk managers must make their voices heard, both to the insurance industry and to regulators and legislators. That's why we're glad that RIMS during the conference issued a policy statement that advocates federal regulation of insurers serving large commercial policyholders.



"LET ME THROUGH...I'M A RISK MANAGER!"

While it's hard to comment on the RIMS policy statement until more specifics are ironed out—for example, we would like to know what size company RIMS considers as a "large" policyholder and how insurers that write coverage for both large and small companies would be regulated—it is important that the world's largest organization of insurance consumers take a position on one of the most pressing issues of the day.

Incoming RIMS President Suzanne H. Crager noted at the annual membership meeting: "We must take on an even greater public posture. . .on key issues. This is our most visible activity."

We hope risk managers hear Ms. Crager's call and that RIMS, under Ms. Crager's leadership, follows the public policy example set during this year's conference. By taking a leadership position on risk management and insurance-related issues, RIMS can only help propel the risk management profession to greater heights.

Letters

Punitive damage report needs further explanation

To the editor: I found your reporting in "Punitive Damage Problem Is Exaggerated: Report" (*BI,* Jan. 13) to be excellent and well-balanced. But while tight space constraints undoubtedly preclude fuller explanations of issues, I believe that the abbreviated reporting of my views in your publication has generated misleading conclusions.

My research concludes that punitive damages must remain available for at least three reasons: They clearly provide critical safety incentives, are typically justified by gross misconduct of defendants and usually are awarded for death or serious injury. As exhaustive research shows, they are also rarely awarded. Therefore:

- I support appropriate "uniform" state laws on this subject *not* because the law presently varies from state to state, but because the safety incentive provided by punitive damages should be available to citizens of every state.
- I support separate trials on compensatory and punitive damages because separation protects everyone involved from the possibility that the same evidence of serious misconduct that justifies punitive damages might influence the award of compensatory damages, thereby rendering a possible injustice to one side or the other.
- I support use of the "clear and convincing evidence" standard of proof because, in practice, fact-finders already apply this standard. Imposition of punitive damages requires proof of serious misconduct and this almost always satisfies the "clear and convincing" standard.

Please note, too, that complete reporting of funding sources for the report should also include Suffolk University. Further, internal peer review of methodology and findings was conducted by Suffolk faculty. Indispensable review by other academic colleagues is similarly acknowledged in my report, but not in your article.

Michael Rustad
Professor
Suffolk University Law School
Boston

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Georgia shouldn't be overlooked

To the editor: The March 30 *Business Insurance* survey of captive insurance domiciles correctly indicated that Vermont's high overriding captive insurance company premium tax may encourage United States captives to domicile in states where the captive premium tax is lower, such as Hawaii.

However, in describing the characteristics of the Georgia captive statute, *Business Insurance* failed to note that Georgia does not impose an overriding premium tax.

This feature of the Georgia statute should encourage captive formation in Georgia, where the Insurance Department currently has a policy to welcome such formations.

Joe T. Taylor
Partner
Alston & Bird
Atlanta

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Lloyd's tradition

Continued from page 7
said.

Although the other recommendations made by the task force will generally benefit Lloyd's, it was disappointing that the panel did not recommend an end to Lloyd's three-year accounting system, he said.

"I had hoped for the abandonment of three-year accounting because it has long been an anachronism and a hindrance during negotiations with people in other countries," Mr. Hazell said.

Lloyd's could also be made more efficient if the role of the broker were changed, he said. "Although they are good salesmen, they are seldom the best administrators."

Consequently, Lloyd's brokers should not be concerned with the documentation of policies, and the wording of terms and conditions should be left to underwriters, he said.

Also, the payment of premiums and claims should be handled directly between the policyholder and its underwriters rather than through brokers, Mr. Hazell said.

If a policyholder needs the aid of a broker when submitting a claim, then the broker should be remunerated on a fee basis for adding value, he said.

But underwriters should not underestimate the benefits they receive from all of the activities of Lloyd's brokers, said Dennis Mahoney, chairman of Alexander Howden Ltd. in London, a unit of Alexander & Alexander Services Inc.

Brokers "prepare the policy and market the risk," he said.

The Lloyd's broker then handles any claims and is responsible for keeping the information on the risk, sometimes for 80 years, Mr. Mahoney said.

"In return, we get a commission of between 2.5% and 10%, and that's pretty good value from underwriters' and names' perspective," he said.

The brokers also give underwriters access to overseas markets through their international offices and subsidiaries, Mr. Mahoney said.

"Lloyd's underwriters do not have to spend a penny to access all of the business in the world," he said.

Most of Lloyd's business is handled by large brokers, he said.

Although there are 219 Lloyd's brokers, the 20 largest handled 71% of Lloyd's business in 1990, he said.

As a whole, Lloyd's brokers employ 38,000 people and handle premiums totaling $25 billion, which help contribute $1.5 billion to Britain's invisible earnings, Mr. Mahoney said.

"We are clearly doing something right," he said.

Mr. Mahoney agreed that future prospects of profits at Lloyd's are good despite the number of members who are leaving the market.

In fact they are so good, Mr. Mahoney said he increased his underwriting line as a member of Lloyd's for 1992.

"This decision was not based on emotion or blindness, but because I believe that I will make money in the long term," Mr. Mahoney said.

The session was moderated by Myriam Fontaine, director of risk management at The Gap Inc. in San Bruno, Calif., and coordinated by W. Lee Carter III, vp director of research and development at A&A in Dallas. ■

Productivity is not waning, Drucker says

ANAHEIM, Calif.—When Peter F. Drucker speaks, managers listen—and learn.

Hundreds of risk managers at the 30th annual Risk & Insurance Management Society conference gathered to hear the management guru's views on the state of productivity in the United States.

"Most people do not realize how great an economic expansion there has been in the last 100 years," said Mr. Drucker, a long-time professor of management and social science at Claremont Graduate School in Claremont, Calif. Productivity has risen an average of 4% every year, he added.

"It is simply not true that productivity is lower in this country than it has been in the past," said Mr. Drucker, the author of 24 books on management topics.

The productivity of farmers and manual laborers has never increased faster, suggested Mr. Drucker, whose first major book was his landmark 1946 study of General Motors Corp. But the country is "simply moving away from manufacturing, labor and construction."

In fact, "skilled or unskilled" workers who make things with their hands "make up only a fifth of the people in this country—if that much," he said. "They will only make up an eighth by the end of the century."

To enhance productivity within their own companies, managers must "organize work by skill, not by subject matter," suggested Mr. Drucker, whose most recent book is "Managing for the Future: The 1990s and Beyond," published earlier this year.

Managers must determine what an employee is being paid to do and what tools and information he or she needs to do the job. The work should "be organized so that it flows properly and you have a job and not just several tasks," he said.

In assembling a team to do the job, the manager must decide what will best increase productivity. Some jobs will require a baseball-like team, on which everyone maintains his or her fixed positions. Others will require a doubles tennis-type team, on which the team members adjust themselves to the strengths and weaknesses of their teammates, he said.

And, managers must make sure that people do what they are paid to do. Instead, too often their time is wasted on extraneous tasks, he stressed.

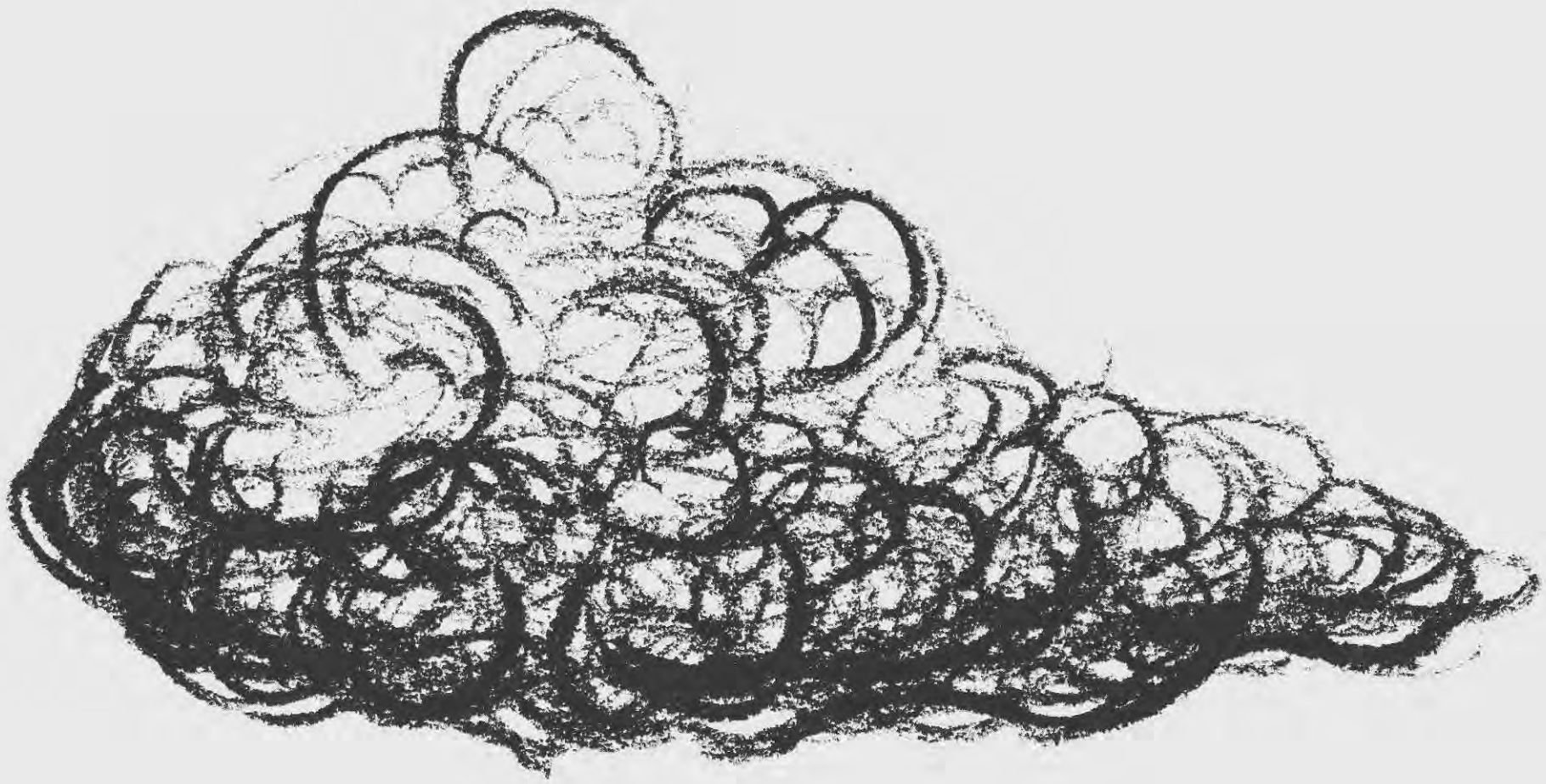
As an example of this wasting of talent, he cites nursing.

The United States continues to graduate and import more nurses than in years past, said Mr. Drucker. At the same time, the number of available hospital beds in the country has continued to decline.

Yet because nurses must spend a majority of their time doing paper and computer work, rather than actual caring for patients, there is a nursing shortage.

The situation could be remedied if nurses were allowed to do the job they are trained to do and others were hired to handle peripheral tasks, he said.

—By Sara J. Harty



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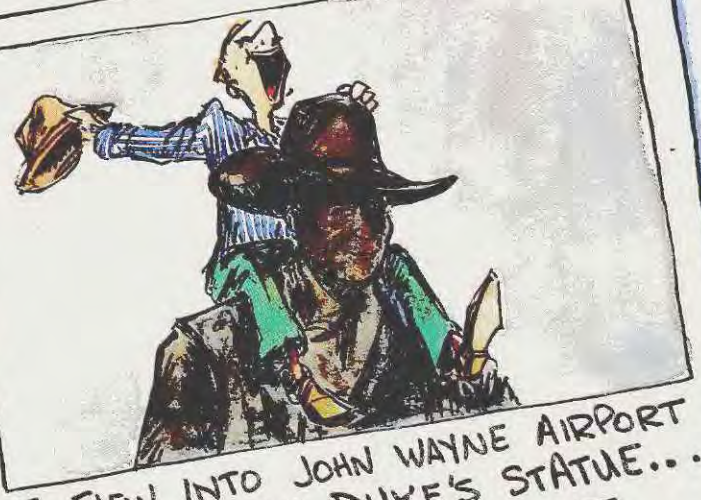

I FLEW INTO JOHN WAYNE AIRPORT & LOCATED THE DUKE'S STATUE... THEY ASKED ME TO FLY OUT OF L.A.X. WHEN I LEFT...

I HAD FUN AT DISNEYLAND.... THERE WASN'T A LINE I DIDN'T STAND IN — BUT THERE WERE PLENTY OF RIDES I DIDN'T GO ON!

I WENT TO THE NIXON LIBRARY & TRIED TO CHECK OUT SOME TAPES BUT THEY WOULDN'T HONOR MY BLOCKBUSTER VIDEO CARD.

IF THERE HAD BEEN ANY DOUBT, RIMS MADE IT OFFICIAL... THE CALIFORNIA DROUGHT IS OVER!

THE FLOOR PLAN FOR THE MEETING ROOMS AT THE HILTON WERE SIMPLY A-MAZE-ING!

SUZANNE CRAGER SAID, "HI" AND BOB ESENBERG SAID, "BYE" AT THE ANNUAL MEETING... I THINK I SLEPT LATE... I MISSED THE BREAKFAST!

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Risk Management Planning and Support

Spotlight report

Exhibitors link wares to Southern California

Risk managers load up on info, goodies

By JOANNE WOJCIK

ANAHEIM, Calif.—Exhibitors at the 30th annual Risk & Insurance Management Society conference promoted the leisurely lifestyle for which Southern California is known.

And even though the weather did not live up to the long-held belief that it never rains in Southern California, exhibitors tried to perpetuate the myth by doling out sunglasses, beach towels, T-shirts, golf balls and tees.

One exhibitor even hired Elvis and Marilyn Monroe impersonators to give risk managers a taste of the glitzy Hollywood culture.

Some companies, though, shunned the Southern California scene and offered trinkets that represented their own headquarters location. For example, the Vermont Captive Managers Assn. offered samples of cheese, Ben & Jerry's ice cream and maple syrup to passers-by.

But, for the most part, risk managers saw past the gimmicky hand-outs and scoured the exhibit hall floor to learn more about the tools needed to perform their trade.

It was purely coincidental that the handouts from various members of the Factory Mutual System comprised just about everything necessary for a trip to the beach, according to John L. Troutman, operations sales manager in Allendale Insurance Co.'s San Francisco office.

As Mr. Troutman handed out mirrored sunglasses to passers-by, Arkwright Mutual Insurance Co. distributed beach towels, Protection Mutual Insurance Co. offered miniature cameras. Factory Mutual Engineering gave out digital thermometers, which it said would help people from overheating on the beach.

"We believe in total asset protection," quipped Florine Edwards, assistant vp in Allendale's Johnston, R.I., office.

Other exhibitors followed the same general theme. For example, the Illinois Insurance Exchange kept with the beach trip theme by distributing logo-embossed water bottles.

The Assn. of Insurance Managers in the Turks & Caicos Islands also unwittingly perpetuated the theme by handing out foam rubber beverage can insulators, and ITT Hartford Group Inc. distributed fanny packs to sports-minded RIMS-goers.

Skandia America Group's alternative risk transfer department lured conference-goers into its booth with bright blue T-shirts splashed with the palette logo of the New York-based reinsurer's ART department.

"We coined the phrase 'alternative risk transfer,' and now it's pretty much 'state of the art,' " chuckled Senior Vp Albert Beer as he handed out the shirts, along with information on Skandia America's services.

It was more fun and games at some of the other booths, like Helmsman Management Services Inc., which featured teal-and-mango-colored Slinkies and golf tees, and Liberty Mutual Insurance Co., which offered golfers copies of "18 Tips From 18 Legends of Golf."

The Slinkies "show how flexible we are at Helmsman," a subsidiary of Liberty Mutual that offers services to companies that self-insure their workers compensation risks. These services include a claims administration system that provides statistical risk management reports and allows risk managers to view adjuster notes, explained Patricia Hurley, assistant vp and regional account manager in the Glendale, Calif., office.

The system, called Risktrac, also includes electronic mail capabilities that allow the employer to communicate directly with Helmsman, she added.

The golf tips come from the headliners of Liberty Mutual's Legends of Golf tournament, a nationally televised golf classic, said Shirley Smith, account executive in Liberty Mutual's Westlake Village, Calif., office.

In addition to promoting Helmsman, Liberty Mutual also took advantage of the RIMS exhibit hall to tout its new international department.

Liberty Mutual now provides worldwide property/casualty coverage to U.S. multinationals through its affiliation with Winterthur Insurance Group of Switzerland, according to Virginia Coffin, national sales account executive in Liberty Mutual's Los Angeles office.

"We've gone global," she said.

Nearby, Milliman & Robertson Inc. handed out golf balls to illustrate that the actuarial and consulting firm "will keep you from going out of bounds," said Gary Josephson, an actuary.

Meanwhile, Prudential Reinsurance Co. distributed yo-yos signifying the ups and downs of the property/casualty insurance market, while the Barbados

Continued on page 18

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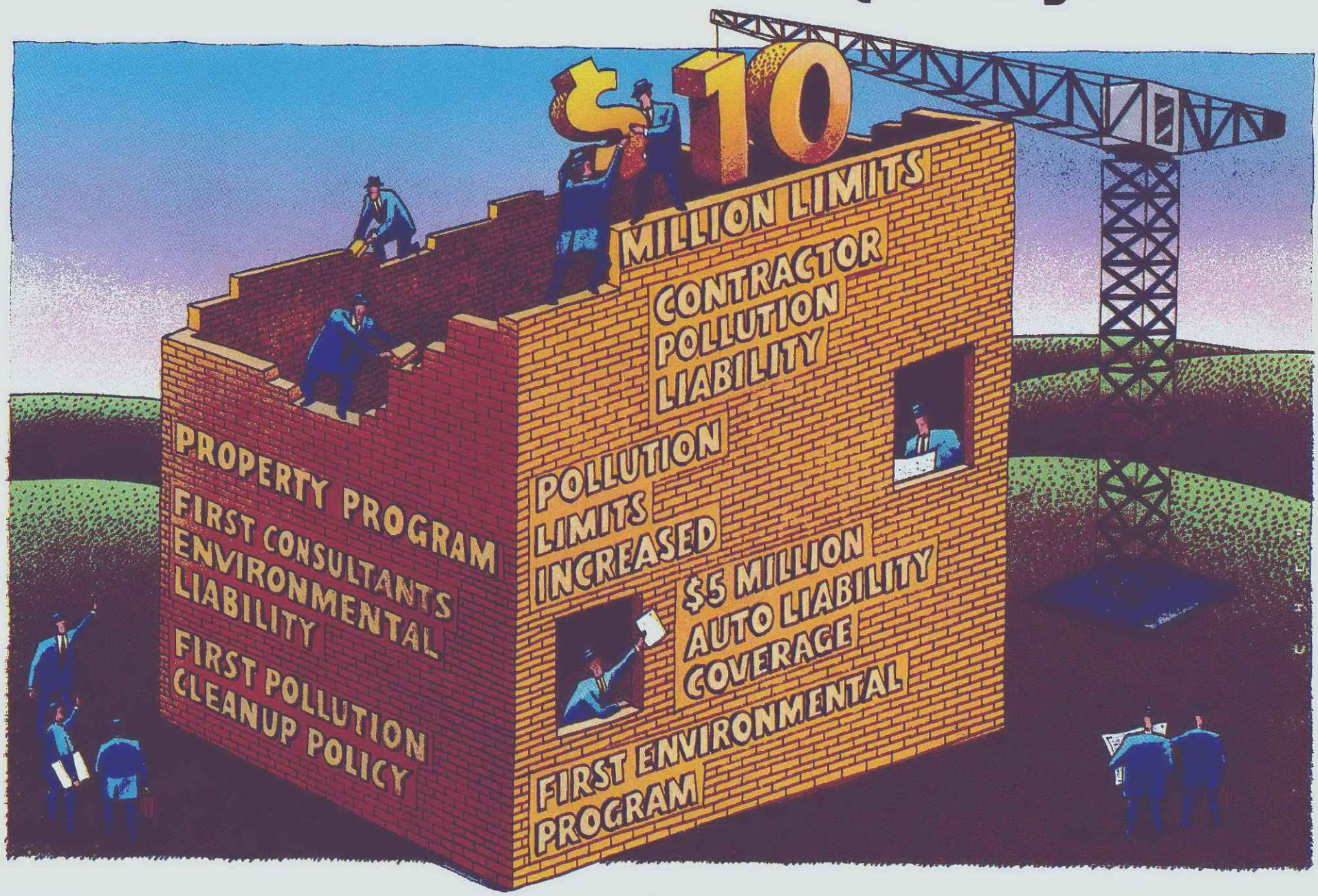

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Exhibit hall

Continued from page 14
booth offered miniature mahogany flying fish, a species indigenous to the Caribbean captive domicile.

Reliance National Insurance Co. served coffee in the mornings and soft drinks in the afternoons from a replica of a vintage railroad car furnished with comfy tufted leather seats.

Coincidentally, Reliance's railcar was situated strategically beside Wausau Insurance Cos.' distinctive railroad depot booth, and The Hartford Steam Boiler Inspection & Insurance Co. carried on the railroad motif with a miniature locomotive that graced its booth.

The Colorado Assn. of Captive Entities booth distributed colorful copies of Colorado travel guides and samples of Denver "mints."

Mobile, Ala.-based claims adjusters Pilot Catastrophe Services Inc. gave Norway spruce tree "kits"—a peat pellet and seeds—to those who viewed a graphic video of a devastating tornado in Wichita Falls, Texas, in the late 1970s.

San Francisco-based David Corp., a risk management information system subsidiary of The Wyatt Co., handed out wooden slingshots made by the Cherokee tribe of South Carolina to represent the company's theme of using the innovative David system to slay the claims administration giant, explained Dennis Klum, director of sales promotion.

Media/Professional Insurance Inc. of Kansas City, Mo., distributed vocabulary-building desk calendars "since we're in the business of insuring the word," explained Rhonda Jones, senior underwriting executive for the managing general agency specializing in libel and other forms of professional liability coverage.

Media/Professional, which was completing its acquisition by Chicago-based Aon Corp. during the RIMS conference, also was touting its revised specialty errors and omissions insurance program, which provides primary and excess capacity of $10 million to a variety of professionals.

One booth that might not have been visited by throngs of RIMS attendees at the start of the conference was soon swarming with paparazzi after the arrival of "Elvis Presley" and "Marilyn Monroe."

The two late luminaries—portrayed by two actors from The Southern Connection of Atlanta—posed for pictures at Adjustco Inc.'s booth before a backdrop of the famous Hollywood sign surrounded by silver-leafed palm trees.

Fans who dared wore their photos displayed in a plastic button that advertised the workers comp claims administrator's presence at RIMS.

More serious exhibits featured new products and services available to risk managers.

For example, Paradigm Infosystems of Bothell, Wash., demonstrated its Macintosh-based personal computer risk management information system. Called ParaRisk, the system features an easy-to-use graphic interface.

"It's the only Mac-based RMIS on the market," said Richard Hoehne, chief executive officer of Paradigm, which was a first-time exhibitor at RIMS.

Using on-screen prompts, risk managers who use ParaRisk can break down losses by state, region, division and plant location. Injuries can be broken down not only by body parts, but by the location within a given body part, such as lower arm.

The system can also be used to track incidents that may or may not eventually become workers compensation claims, explained Shira Wilson, marketing manager.

ParaRisk was given the highest possible rating in the categories of flexibility and user-friendliness in a recently released report by Betterley Risk Consultants Inc., Ms. Wilson noted.

Manufacturers Bank N.A. of Detroit was the only bank hosting a booth at this year's RIMS conference, boasted Vp Carlyle E. Justus.

The bank deliberately chose a spot beside the Bermuda booth since it is marketing support services to captive owners and managers and "Bermuda is the domicile of choice," Mr. Justus explained.

Among the services it provides for captives, Manufacturers can establish depository accounts for capital and surplus, issue standby letters of credit, confirm LOCs issued by other banks and provide insurance premium financing services, Mr. Justus said.

"We're one of the few banks that do premium financing for captives' reinsurance activities," he said.

Medata Inc. of Santa Ana, Calif., demonstrated its "URC National Database," a workers compensation claims review software program that can be used to spot claims fraud.

The system also can be used to monitor utilization trends, according to Cy King, a Medata marketing representative.

The URC National Database includes fee schedule information published by the U.S. Department of Health and Human Services, as well as Medata's own 17-year-old data base of 25 million medical bills for 10,500 different diagnoses.

The system can hold up to six state fee schedules as well as reasonable and customary charges for all 50 states and the District of Columbia, according to John Allison, another Medata marketing representative. ■

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Funding options could be triage for workers comp

Elude 'death spiral,' broker urges

ANAHEIM, Calif.—Alternative risk financing can help companies staunch the bleeding of the "workers compensation chainsaw massacre," a broker says.

"Workers comp was set up to be a no-fault system; it no longer is. The system has broken down somewhere," said Brian M. Kawamoto, president and chief executive officer of the national accounts services division at Willis Corroon Corp. in Nashville, Tenn.

Speaking at a session during the recent 30th annual Risk & Insurance Management Society conference, Mr. Kawamoto said the current workers comp system is in a "death spiral." The contributing factors to the crisis, he said, are rate inadequacy, increasing medical costs, an expanded definition of job injury, attorney involvement and fraud.

While employers cannot solve the system's problems, they can explore all the options available to finance their workers comp risks most effectively, Mr. Kawamoto said.

One option, he said, is a large deductible plan, typically involving a $100,000 to $250,000 annual deductible per jurisdiction (*BI,* Sept. 16, 1991).

"It's good short-term relief," Mr. Kawamoto said. But, "in the long term someone's got to pay the bill. The smaller buyer is ultimately picking up the bill for some other people."

A certain number of claims per jurisdiction are necessary to make a large deductible plan worthwhile, he added.

And there are drawbacks to large deductible plans, according to Mr. Kawamoto: They are not available in all states, aggregate stop-loss coverage may be difficult to obtain, and collateral is required for projected deductible losses.

Another option in financing workers compensation risk is self-insurance, which also is not an option in all states.

But with increased administrative costs, "don't get lulled into a false sense of security that self-insurance is the best alternative," he cautioned. Companies must look at individual states and loss patterns to determine if self-insurance is the best alternative, he said.

Opting out of the workers compensation system is an option for employers in Texas, South Carolina and New Jersey.

However, the disadvantage of such "non-subscription" is that the company loses its common law defenses of contributory negligence, assumption of risk and negligent acts of fellow workers if an employee sues the company, he said.

Another option is using a captive to reinsure workers comp coverage written by a fronting insurer, giving the company greater control over claims and an incentive for loss control, Mr. Kawamoto said.

Managed care techniques can also be added to workers comp program to help control losses, said Paul W. Glover, senior vp at Travelers Insurance Co. in Hartford, Conn. "The workers compensation medical care system we now have is a system with built-in-incentives for, at best, careless use of medical services at a time when the cost of those services is soaring," said Mr. Glover.

Also advocating managed care was Keith T. Terrano, assistant director of risk management for Hillhaven Corp., a nursing home chain based in Tacoma, Wash.

In addition to using a preferred provider organization, Hillhaven's local managers are involved from the time of injury, he said. The managers refer injured workers to medical care, follow up on their progress and encourage rapid return to work.

Mr. Terrano was the session moderator; Mr. Kawamoto was the coordinator.

—By Sara Marley

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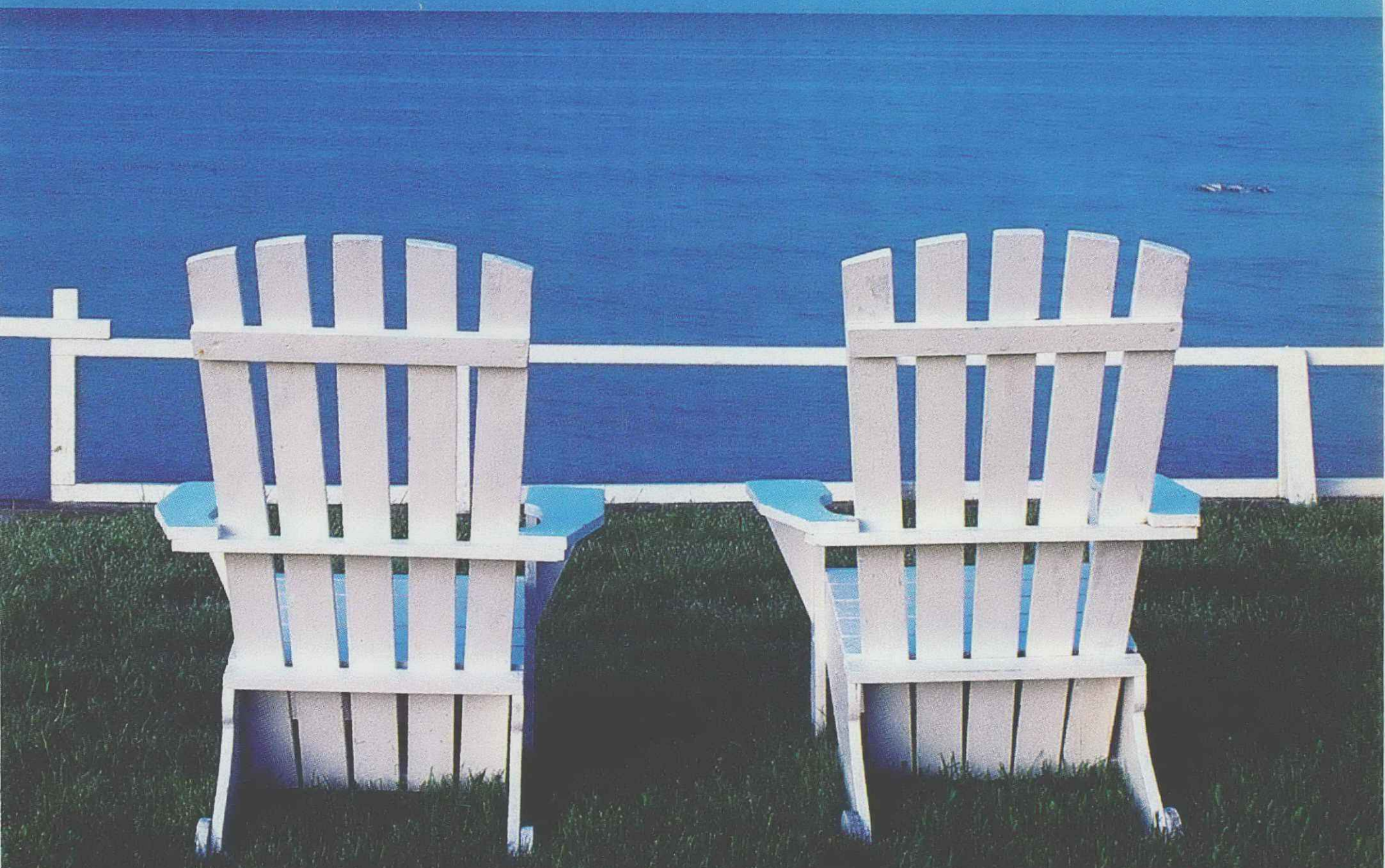

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Avoiding workers comp claims crush following layoffs and plant closings

Risk managers can help minimize exposure, panel says

By JOANNE WOJCIK

ANAHEIM, Calif.—Layoffs and plant closings create an adversarial atmosphere that can trigger an onslaught of workers compensation claims.

Risk managers can help mitigate the exposure to layoff-triggered claims if they are informed early, experts say.

But settling these claims—even the fraudulent ones—may be more cost-effective than fighting them, a workers comp claims manager says.

Approximately 40% to 50% of laid-off workers will file workers comp claims against their employer within six months of termination, according to Craig A. Stroinski, vp-workers compensation management at Electric Mutual Liability Insurance Co. in Beverly, Mass. Mr. Stroinski spoke during a panel discussion at the 30th annual Risk & Insurance Management Society conference.

While "all claims from a layoff aren't fraudulent, a lot of them are," pointed out Thomas J. Lyon, senior vp and national claims manager for Johnson & Higgins in Pittsburgh.

That's why risk managers should be involved early in the layoff or plant closing decision-making process, according to Mr. Lyon.

"It is important that your management be given an assessment of the financial impact the company may face as a result of your increased workers compensation exposure from the layoff or shutdown," he said. "There may be some costs they didn't anticipate."

For example, General Electric Corp. reserved $2.5 million to pay anticipated workers comp claims when it began a gradual shutdown of a Southern California plant that employed 250 workers, according to Mr. Stroinski, GE's regional workers comp insurer.

But the claims activity didn't immediately follow the layoffs, which began in April 1991, he said.

Rather, a total of 70 claims were filed within the first six months—27 in October alone—by just 125 workers that were terminated in the initial layoff phase, Mr. Stroinski reported. He said the likely trigger was that unemployment benefits usually last for six months.

"We're anticipating our second onslaught this month when the SDI (supplemental disability income benefits) runs out" after 12 months, he said.

Even though a sizable number of those claims likely were fraudulent, GE and Electric Mutual decided it wasn't worth fighting them because "the liberal nature of workers compensation is slanted toward the employee," Mr. Stroinski explained.

Instead, GE offered the workers it felt had filed questionable claims $1,500 apiece in exchange for their signing a release relieving the company of liability.

While the amount was equal to what it would cost GE to fight each claim individually, it was far less than the company would have had to pay had it lost any of the cases, Mr. Stroinski explained.

"We had one stress claimant who had over $50,000 in bills in five months," he said.

Through the settlements, "we're hoping to break even," he said. "It was a dollars-and-cents decision."

Mr. Stroinski is confident that the proposed settlements will be approved by the California Workers Compensation Board because "the alternative is clogging up the system when we fight these claims."

Layoffs and plant closings provide special motivation for employees to file workers compensation claims, according to Mr. Lyon of J&H.

Workers comp benefits are usually larger and are paid over a longer period than unemployment benefits, he said.

In addition, employees filing new claims have no incentive to return to work because there is no job for them to go back to.

Furthermore, when a plant is closed, management's commitment to controlling workers comp costs through the use of rehabilitation programs or restricted-duty programs is eliminated, Mr. Lyon added.

A risk manager will be better able to limit a company's liability if he or she is "part of the 'inner circle' of senior management who are aware, in advance, of any notification of plant closure," Mr Lyon said.

Once informed, risk managers should take the following steps, according to Mr. Lyon:

- Build a core defense team composed of key personnel including: the risk management department, broker, insurer or third-party administrator, defense counsel, medical and legal departments if they exist, labor relations or personnel administration, industrial hygiene department, and outplacement services.
- The defense team should review all relevant workers compensation statutes in the jurisdiction in which the affected plant is located to establish a defense posture.
- Establish an outplacement facility to assist displaced employees in finding new employment.
- Establish a "red flag" procedure for handling all workers comp claims arising from job termination.
- Inspect the plant to be closed prior to shutdown with defense counsel, claim supervisor and broker representative.
- Determine whether to administer exit physicals.

Exit physicals may be a double-edged sword, Mr. Lyon warned: While they will ensure that some employees were not injured at the time of the plant closure they may turn up some "hidden' injuries or illnesses that had not been reported, he noted.

The session was moderated by Michael J. Jank, risk manager for Kentucky Fried Chicken Corp. in Louisville, Ky., and coordinated by Alexander S. Cameron, vp of Johnson & Higgins of Kentucky. ■

Return-to-work plans boost bottom lines

Employees less likely to sue employers that are 'upfront'

By SARA J. HARTY

ANAHEIM, Calif.—Establishing a return-to-work program for injured workers can help improve almost any organization's bottom line, according to a third-party administrator and a risk manager.

Return-to-work programs can succeed "regardless of the size of the organization," said Billy R. Boguski, assistant vp of Specialty Risk Services Inc. in East Hartford, Conn. Specialty Risk Services is the third-party administration arm of ITT/Hartford Group Inc.

Successful programs have been established in organizations with as few as 30 employees, he said at a session during the recent 30th annual Risk & Insurance Management Society conference.

The need for return-to-work programs is apparent from statistics compiled by the Washington Business Group on Health and the Institute for Rehabilitation & Disability Management, Mr. Boguski said.

Those statistics show that "a company with 1,000 employees and a 4.5% profit margin must realize an additional $11.3 million in sales just to offset injury loss costs," he said. And, "for every $1 million in payroll, $50,000 is spent on disability alone."

"Unfortunately, the workers comp system really contributes to a reluctance (by injured workers) to adapt to change and move on with one's life," he said.

But, return-to-work programs can help change injured workers' outlook, he said.

Such a program also can help a company in ways other than helping contain workers compensation costs.

For example, a company with 150 employees that produces hard rubber developed alternative or "transition" duty for injured employees returning to the workplace, Mr. Boguski said.

The job involved recovering waste rubber. Employees are seated as they recover waste rubber from the plant's exhaust system. The process allowed some waste rubber to be reintroduced into the production process, leading to a net savings of $150 per hour, he said.

The position became a permanent job, available for light duty as needed.

The success of a return-to-work program depends largely on a well-planned communications effort, Mr. Boguski said.

When introducing the return-to-work program to the workforce, it should be presented "as an addition to the benefit package," he said.

"There is resumption of salary. There is job security and open communication, and it relieves some of the stress that is often associated with disability."

An employee who is concerned about the delivery of workers comp benefits may get on the phone with "Tarantula & Tarantula Attorneys," Mr. Boguski noted. Employees who believe that their company is "upfront with them" do not feel the need to contact an attorney, he said.

The plan must be communicated to all employees at all levels, including part-time workers. If the company "is a union shop, union representatives should be apprised" of the program's elements, Mr. Boguski said.

"Over time, return-to-work should become part of the standard operating procedures of your company. Just as employees are expected to put on gloves or hard hats, make them understand that return to work is part of working" for the company, Mr. Boguski said.

Employers also should take this opportunity to stress workplace safety and physical fitness, said Lucille A. Gallagher, vp-risk management for Monfort Inc., a Greeley, Colo.-based meat packer. "Empower the employees with knowledge."

Monfort, for example, requires all new employees to participate in a four-week "industrial athlete program." The program, which begins a half-hour before a shift begins, is split into 15 minutes of conditioning exercises, followed by 15 minutes of education on how to reduce workplace injuries.

Good communication also must continue after an accident.

"Immediate and frequent contact with the employee is very, very important," Mr. Boguski said. He cited a study contained in a Workers Compensation Research Institute publication that found employers could save 21% in workers comp costs by simply contacting the employee immediately after an accident to express concern and hope for a speedy recovery.

And, once the employee is ready to return to work, communicating a positive outlook on the employee's abilities can make a huge difference in the injured worker's and the supervisor's perceptions about the worker's capabilities, he said.

For instance, employers should request that treating physicians state that the injured employee "can lift up to 40 pounds" rather than the employee "cannot lift more than 40 pounds."

Likewise, referring to an employee as "very mobile with wheelchair" is preferable to "wheelchair-bound," he said.

When selecting physicians, employers should look for a panel of physicians who understand the company's philosophy regarding return to work, he said.

Company physicians must be willing to work with the employer in establishing treatment protocols, Ms. Gallagher agreed. They should be willing to tour the facility so that they will have a clearer picture of the kind of work employees in various divisions perform and the kinds of equipment they use.

Ms. Gallagher moderated the session. W. Lee Carter III, vp and director of research and development for Alexander & Alexander Inc. in Dallas, coordinated the session. ■

In workers comp, a picture may be worth thousands

Companies resort to surveillance techniques during the 'decade of the sophisticated scam'

By LOUISE KERTESZ

ANAHEIM, Calif.—Fraud is rampant in the workers compensation system, but employers needn't take it lying down since proven methods can be used to combat the problem.

The 1980s have been dubbed "the decade of fraud' and the 1990s will become known as "the decade of the sophisticated scam," forecasts Edward A. Pouzar, senior consultant at Betterley Risk Consultants Inc. in Worcester, Mass.

But insurers and employers are taking steps to protect themselves against the fraud and abuse riddling the workers comp system, he asserted. And employers are finding that the media and video technology are helping them.

Mr. Pouzar spoke on a panel titled "Expose: Uncovering the Fraud in Workers Compensation" at the recent Risk & Insurance Management Society conference.

Those attending the session saw a video of a groundbreaking investigative report by Harvey Levin, a Los Angeles television reporter. Posing as an unemployed worker, Mr. Levin was videotaped as he was solicited by an agent for an attorney who promised to help Mr. Levin file a phony workers comp claim.

Next, Mr. Levin was seen visiting the attorney's office and then a medical clinic—with a packed waiting room. Clinic employees fabricated injuries and prescribed costly tests, even though Mr. Levin said repeatedly that he was not hurt and that he was nervous about being caught doing something illegal.

The clinic's employees reassured him that no one would tell unless he did.

Mr. Levin did, of course, tell, and organizations like Californians for Compensation Reform, an employer group in Sacramento, have disseminated copies of his report.

Employers have several ways to detect claims from so-called workers comp "mills" like the one Mr. Levin visited.

First, said Mr. Pouzar, they can conduct fraud audits of their claims. Tip-offs to scams involving "mills" include multiple claims from the same claimant; multiple claims involving the same lawyer and the same doctor; and indications that the lawyers and the doctors have a business arrangement.

Workers whose injuries are not job-related also will try to file claims under the workers comp system, which provides more generous benefits than group health plans, Mr. Pouzar pointed out. Fraud audits have shown that younger employees injured in weekend activities often file a workers comp claim within the first two hours of work on Monday, he said.

An adjuster's report without photos or videos is 'probably almost useless,' Mr. Juge says.

Workers with legitimate work-related injuries also can be tempted to exaggerate claims. The best way to prevent fraud in the case of a worker injured on the job is by establishing light-duty work programs so that the employee can get back to work as quickly as possible, Mr. Pouzar said.

Many employers, though, by not taking advantage of this method of preventing fraud, actually encourage malingering, he said.

And insurers have not been aggressive enough in combating fraud, which has "tarnished their image further," Mr. Pouzar asserted.

One classic method that employers and insurers use to expose the malingerer is surveillance.

Surveillance involves having an investigator or adjuster document the actions of a claimant with photos or videos that can be used at trial after a claim is denied.

An adjuster's or investigator's report without photos or videos is "probably almost useless," warned attorney Denis Paul Juge, a partner with Sutherland, Juge, Horack & Dwyer in New Orleans.

"A judge will be suspicious of the testimony of an investigator who is paid by an insurer or employer," Mr. Juge said.

But photos or videos showing a claimant doing things he has

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Work comp fraud

Continued from page 24

sworn in court that his injuries prevent him from doing are "dynamite," Mr. Juge said.

Surveillance is "an expensive tool," Mr. Juge pointed out, so it should only be used when employers really suspect exaggeration or fraud.

And the investigator should know what his or her limits are —whether to "make a quick check" to see if a particular claimant has taken another job or whether to conduct a lengthier surveillance.

The nature of the injury will also determine whether surveillance should be used.

For instance, it is usually not useful in exposing a fraudulent head injury claim or a psychological claim, though there are exceptions to this rule, said Mr. Juge.

Surveillance is most useful for claims involving neck, back, arm, hand, leg and knee injuries, he said.

In deciding whether to conduct surveillance, employers may study their medical examiner's report.

"Few doctors will come right out and say that a patient is a malingerer," Mr. Juge said. But physicians will use "code words" indicating that they do not believe the patient is truly injured,

'Few doctors will come right out and say that a patient is a malingerer,' says Mr. Juge.

he said.

Doctors may, for example, indicate that they "cannot find an explanation" for patients being in so much pain, Mr. Juge observed.

Once a decision is made to do surveillance, "communicate with the investigator" about the nature of the claim.

Photos and videos must show, for instance, that the employee can bend quite easily, even though he or she maintains that an injury makes bending impossible, Mr. Juge said.

Once the investigator has made the video, "withhold information about it" until trial, or its value may be diminished, he continued. "You want to carry the case to the point where (the claimant) is on record as having committed fraud" in depositions and other statements, he said.

In taking depositions from workers who are lying about or exaggerating injuries, "if you give them enough rope, they'll hang themselves," Mr. Juge observed.

Workers should be given the opportunity to embroider details and exaggerate as much as they like.

What may foil the surveillance plan is a claimant's statement— usually learned from his lawyer —that "I have good days and bad days," he contended.

But those taking depositions from injured workers have found them all too willing to say they are almost completely incapacitated as a result of their particular injury.

Once the film is taken, "try to move the case to trial as quickly as possible," Mr. Juge advises, because the claimant may find a way to discredit the film as outdated.

The film should be edited "without destroying evidence" for impact and brevity before being shown at trial, Mr. Juge said.

And there should be one clear shot of the claimant's face for identification purposes.

Mr. Juge showed several surveillance videos during his presentation. His—and the audience's—favorite was a video of an employee who claimed a painful back injury prevented his return to work.

The video, which was 2½ hours long in its uncut version, showed him bending and shoveling horse manure into a truck.

The session was moderated by T.G. DeOrio, vp and general manager of Ryder Services Corp. in Miami. ■

Comp medical costs targeted

Latest weapon in state arsenal is managed care

By MICHAEL BRADFORD

ANAHEIM, Calif.—Medical costs are the target of the latest attack on rising workers compensation costs, according to a panel of experts.

States have become particularly interested in using managed care to control medical costs related to worker injuries, said George Hatch, a consultant with Conservco Inc., a Travelers Corp. medical cost management unit in Tampa, Fla.

In the past three years, as workers comp costs have steadily climbed, state legislatures have increasingly begun to approve medical cost containment measures, said Mr. Hatch during a panel discussion at the recent 30th annual Risk & Insurance Management Society conference.

He pointed out that a study by the Workers Compensation Research Institute showed that between July 1990 and July 1991 16 states approved medical cost containment measures as part of their workers comp systems.

Since then, several more have added such measures and a handful of others are considering them, according to Mr. Hatch.

Some states, though, have rejected cost control proposals.

In some states, the cost control efforts go well beyond the fee schedules, hospital audits and "the kinds of things we've seen for the past eight years," said Mr. Hatch.

"Many of them involve comprehensive managed care programs. These are radically different approaches in workers compensation."

Managed care, he said, involves a health care professional who oversees treatment of an injury or illness and attempts to keep costs down while providing quality services.

Mr. Hatch said some of the im-

Continued on next page

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petus for the use of managed care in workers compensation cases comes from a report released in 1990 by the medical committee of the International Assn. of Industrial Accident Boards & Commissions.

In that report, the committee stated that the overuse of medical services inflates workers comp medical costs.

The report said: "It is clear that in many jurisdictions, serious utilization problems exist. Overuse of prescription drugs, excessive surgeries and use of non-standard or inappropriate treatments absorb a large portion of workers compensation resources. Undoubtedly there are instances of underutilization as well, for example when an injured worker links up with a provider who renders a course of treatment not recognized by mainstream providers," resulting in proper care being delayed or absent.

The report said managed care, "based upon cost-effective provision of good-quality care, offers a possible solution to excessive utilization and underutilization."

Mr. Hatch said it is "encouraging that this report was written by a segment of the administrative establishment" that has been willing to lead the effort to control workers comp costs through managed care.

Florida is one of the states zeroing in on medical expenses as a way to stem the rise of workers comp costs, said Ann Clayton, director of the division of workers compensation at the Florida Department of Labor and Employment Security.

'Cost containment can succeed. But you have to define. . . what success is,' Mr. Cavanaugh says.

Ms. Clayton said a proposal now before the state Legislature could substantially cut workers comp costs in Florida and add even greater punch to legislation already passed. The bill, H.B. 41E, has cleared the House but not the Senate. The Florida Legislature is in its third special session this year.

Medical fee schedules already are slated to go into effect this year under previous legislation, and a utilization control program also is in place.

H.B. 41E would limit increases in the fee schedule to an amount tied to medical inflation. The bill would also clarify "who is responsible for utilization control," said Ms. Clayton.

Under the suggested reforms, a self-insured employer would have the right to refuse payment for services that it determines were not medically necessary.

"To substantiate that is the challenge," said Ms. Clayton. "If the provider believes that (the contested service) is necessary and wants to pursue that, they can bring the issue to the commission and we will have an administrative resolution, not a judicial resolution."

Louisiana is another state trying to control workers comp medical costs, said Stephen W. Cavanaugh, president and chief executive officer of the Louisiana Workers' Compensation Corp., the Baton Rouge-based state workers comp insurance fund.

"Cost containment can succeed," Mr. Cavanaugh told his audience. "But you have to define carefully what success is. It is by any definition a relative term.

"If you expect to decrease medical costs to zero, you're certainly not going to succeed," he explained. "Moreover, if you expect ever to make workers compensation inexpensive, you will not succeed."

A job-related injury is "an expensive thing," he said. "Who bears the cost is quite a different question, but ultimately a workers compensation injury is expensive and it cannot be made to be cheap. It might be made to be less expensive."

Currently, Louisiana takes several steps to control costs. Its work comp law requires preadmission certification in workers comp cases and a flow of information from the health care provider to the employer that includes a diagnosis, description of the type of services to be provided, test results, a prognosis and other information.

In addition, doctors in Louisiana are prevented from providing more than $750 in non-emergency care without the approval of an employer or insurer.

"That statute hasn't worked very well," Mr. Cavanaugh conceded, because of a provision that penalizes insurers for "unreasonably" refusing care above $750.

The session was moderated by Karen M. Doolittle, director-risk management at Dayton Hudson Corp. in Minneapolis. The session was coordinated by Karen Davis Austin, director-customer service at Conservco. ■

Spotlight report

Gauging performance when hiring a work comp TPA

Risk managers should base selection of firm on much more than price, panel recommends

By LOUISE KERTESZ

ANAHEIM, Calif.—Risk managers at companies that self-insure their workers compensation risks can use various methods to evaluate prospective third-party claims administrators.

"A question we ask ourselves all the time is, 'Are we getting good dollar value for our TPAs?' " said Nathaniel Lord, assistant vp and director of risk management at Fedco Inc. in Santa Fe Springs, Calif.

Fedco uses TPAs "extensively," said Mr. Lord, who moderated a panel discussion at the recent 30th annual Risk & Insurance Management Society conference.

A key guideline for evaluating a prospective TPA is "the overall performance of the service company," according to Robert L. Young, president-claims management services at Sedgwick James Inc. in Chicago.

There should be "a comfortable relationship" in terms of the services the client needs and the TPA's ability to meet those needs, he said.

An employer should ask how flexible a TPA will be, Mr. Young said.

"Will it change its procedures to accommodate you?" he asked. Is the TPA willing "to modify its standard contractual agreement to meet your needs?"

Mr. Young said an employer also should review the TPA's capabilities in many other areas to determine:

- Whether the TPA's computer capability is sufficient to meet the company's needs. "The computer business seems to be more important than the claims nowadays," as clients want information faster, he said.
- Whether the TPA can handle the volume of cases a company generates. How many open claims would the TPA be responsible for and can the TPA handle that load? Mr. Young asked.
- The adequacy of a TPA's various auditing and reporting duties. "Does the TPA conduct file reviews and audit the performance of contractual obligations? Does it report to you" adequately? Does it report to government agencies and insurers "in a fashion that's appropriate"?
- How quickly the TPA will respond to claims and how quickly payment is made to an employee.
- How the TPA makes payment decisions and what the TPA considers "a controversial case."
- What kind of record the TPA has in the area of fines and penalties for payment delays. In some states, deadlines for avoiding fines and penalties "require almost daily attention," he said.

Employers should ask the TPA who would be responsible for paying those fines and penalties, Mr. Young said.

Sedgwick James believes that as a vendor, "it's our expense and we pay it," he said.

If the structure of the business arrangement with the client "is such that we have to use your funds (to pay a fine), we will reimburse you," he said.

- How accurate the TPA's payment record is. Does the TPA make duplicate or wrong payments? "Do they get the money back to you if they do?" he asked.

If it is possible to audit a TPA's records, they will give an employer "an interesting picture" of the firm's performance, Mr. Young observed.

The TPA should be willing to provide references from current and former clients. And employers can also inquire at government and community agencies about a TPA's reputation, Mr. Young suggested.

Another panelist said the "philosophical requirements" of the employer and the TPA should "match."

If, for example, a TPA believes in maintaining high reserves and in involving counsel as soon as a claim is filed, "Is that what your organization wants?" asked Michael R. Vogler, director-risk management consulting services at Coopers & Lybrand in Atlanta.

The 'philosophical requirements' of the employer and the TPA should 'match,' says Mr. Vogler. If, for example, a TPA believes in maintaining high reserves and in involving counsel as soon as a claim is filed, 'Is that what your organization wants?'

And the TPA should bring something unique to the table, "something you can't touch" that uniquely serves the employer, Mr. Vogler said.

Though price is important, it should not be the ultimate criterion when selecting a TPA, both Mr. Vogler and Mr. Young of Sedgwick James agreed.

Controlling workers comp claims is crucial, Mr. Young asserted.

Both Fedco's Mr. Lord and Mr. Young said a risk manager can do much of the evaluation.

"This is not rocket scientist work," Mr. Lord said. "You can do a lot of it internally," or do some of it in-house and use outside expertise when needed, he said.

Outside help could be provided by an employer's broker, Mr. Vogler said.

A competing TPA also can conduct the evaluation if it knows that it is not a contender for the employer's business for a certain period of time, Mr. Young said.

Richard M. Price, financial analyst at Sedgwick James Inc. in Nashville, Tenn., coordinated the session. ■

Unfulfilled expectations spur work comp claims

But communication can prevent suits

By SARA J. HARTY

ANAHEIM, Calif.—While risk managers face increasing workers compensation litigation, good communication practices within an organization can reduce internal problems that can lead to litigated claims.

And, once an employee decides to litigate a claim, understanding why that choice was made can help risk managers manage those claims better, suggested speakers at a session on workers compensation legal issues at the recent 30th annual Risk & Insurance Management Society conference.

"An employee comes to work in an organization with certain expectations," said William J. Armstrong, a partner with the law firm Mullen & Filippi in San Jose, Calif. He or she expects to work and, in turn, expects payment from the company.

However, the expectations of local and federal governments are far more complex than that, Mr. Armstrong noted. For example, government expects that the employer will:

- Provide the employee with a safe place to work.
- Inform the employee of dangers and new hazards in the workplace.
- Provide the employee with necessary instruction to properly perform required duties.
- Provide the employee with a discrimination-free workplace.
- Not violate any laws or regulations.

"Some injuries are accidents. More frequently, however, injuries occur in violation of one or all five" of these expectations. And, there can be "a violation with no injury resulting," he said.

And, if an employer violates one of these expectations, it is more likely that an injured employee will hire an attorney to help win compensation.

Good communication within an organization can help to ensure that all of the concerned parties within an organization are aware of these basic expectations, Mr. Armstrong suggested.

Companies that communicate well "vertically" may still have underinformed or misinformed departments, he said. For example, even if one department sends vital information up the chain of command, there may be a department positioned laterally that never receives the information because the vp that oversees both departments does not share it with the other department.

A company that operates in this way is "spinning its wheels," Mr. Armstrong warned.

Good communication and a prompt response are important after an accident occurs as well.

Documentation and accident reports are of "maximum importance" and can potentially make a company look "terrible," Mr. Armstrong said.

Using accident reports that provide the supervisor with boxes to check for the cause of the accident—like a box for "negligence"—is asking for trouble, he said.

Instead, reports should be designed so that they are filled out "in language that shows what can be fixed and then documents that the problem was fixed."

Keeping the lines of communication open with employees has become increasingly important with the passage of the Americans with Disabilities Act (see story, page 3).

Previously, "most states did not have requirements to accommodate the industrially injured employee at the workplace," but such injuries are "no longer a vehicle to get rid of an employee," Mr. Armstrong said.

In the past, an employee who chose to litigate a workers compensation claim was generally choosing the equivalent of divorce from the workforce, said Mary E. Garry, manager of workers compensation and corporate risk management for Hewlett-Packard Co. in Palo Alto, Calif.

Today, employees litigating workers comp claims remain part of the workforce more often than not and, with the advent of the ADA, they will remain in the workforce even longer, she said.

As a result, it is more important than ever to avoid alienating them, Ms. Garry said.

When the company—or its representative—"decides that the claimant got an attorney for 'no good reason,' there is a psychological shift away from the real goal—returning the employee to meaningful work," she said.

A risk manager or workers comp claims manager should "maintain a non-adversarial relationship" with the injured employee, even when represented by an attorney, she said.

While discussion about the actual claim must be limited, the claims manager can still talk to the employee to find out how he or she is feeling and to talk about company policies, she said.

When a claim is litigated, the claims manager should also be responsible for working with the involved supervisor to "get rid of any animosity" toward the claimant, she said.

In addition, if a supervisor or other employee must testify, "I think it is money well-spent to prepare" by having them meet with the company's attorney twice, once in advance and once right before the trial, Ms. Garry said.

When litigating a claim, risk managers should remember that the company reputation can become one of the deciding factors in settling a claim, Ms. Garry said. Trial judges "may make some decisions" based on whether the employer is considered fair and willing to deliver work comp benefits or if the employer is known to have a philosophy of trying to avoid payment of legitimate claims, she said.

Laurence E. Weissman, corporate risk manager of Nissan North America Inc. in Torrance, Calif., also spoke at the session. The session was coordinated by Leo Jeffers, vp-operations of Risk Sciences Group Inc. in Corte Madera, Calif. Ms. Garry was the moderator. ■

Spotlight report

Who should pick up the tab?

Attorneys point fingers on pollution cleanup issue

By GAVIN SOUTER

ANAHEIM, Calif.—Are insurers unfairly denying coverage for pollution cleanups?

Or, are policyholders now expecting insurers to cover claims that the insurers specifically attempted to exclude from coverage 20 years ago?

Those were the charges traded by lawyers representing policyholders and insurers during a session at the 30th annual Risk & Insurance Management Society conference.

Regardless of who ends up paying for cleaning up past pollution, risk managers should make sure their insurers pay valid pollution claims in the future, another lawyer advises.

The U.S. insurance and tort systems "stink," said Eugene Anderson, a partner at Anderson Kill Olick & Oshinsky in New York who represents policyholders in coverage disputes.

Insurance companies typically deny coverage for nearly every major loss, Mr. Anderson charged. They work on the premise that they can deny coverage because policyholders cannot afford to litigate, he said.

This is particularly so when policyholders seek coverage for pollution cleanups, Mr. Anderson said.

"Some policyholders have dared to ask for coverage for pollution cleanup costs. Insurance companies will tell you that this is sacrilege and that the policyholder should be committed rather than covered."

Insurance companies also complain that policyholders are antisocial if they file pollution-related claims, since pollution is a national problem, Mr. Anderson said. But so are other problems for which insurance companies pay claims, like accidents involving drunk drivers, he said.

But, another attorney complained that Mr. Anderson expects insurers to pick up the tab for all of the nation's problems.

"He blames the common cold and everything else on the insurance industry," said Roger Warin, a partner at Steptoe & Johnson in Washington who represents insurers in coverage disputes.

Environmental cleanup is a difficult problem for U.S. companies, but they should not try to unload their responsibilities on their insurers, he said.

"Industry is trying to pass on to insurers the bill which the government (through the Superfund law) has imposed on them," Mr. Warin said.

Policyholders have a responsibility for financing cleanups because, in many cases, they knowingly caused the pollution but were not concerned about it at the time because there was no laws prohibiting their actions, he argued.

Cleaning up pollution is just part of the expense of doing business, according to Mr. Warin.

Indeed, most of the Superfund cleanup sites in the United States are not covered by insurance because insurance companies have excluded coverage for non-sudden, gradual pollution from comprehensive general liability policies since 1971, he said.

"Yet policyholders' lawyers will say forget about the exclusion. They will look at the documents and say that the exclusions are nothing more than a restatement of the occurrence wording. They will say that the insurance industry took three years rewording policies for the fun of it.

"Everybody who was involved knows that the wording was changed," Mr. Warin said.

The purpose of all insurance is to cover the policyholder, whether the policyholder is correctly or incorrectly held liable, said Peter Huber, of counsel to Mayer, Brown & Platt in Washington, D.C., and the author of "Galileo's Revenge: Junk Science in the Courtroom."

The trouble with many environmental insurance claims, however, is that they stem from legislative changes that resulted in huge costs for policyholders, he said.

"Normally, insurers are supposed to cover uncertainties in the law; the problem here is that the law has changed to the tune of half a trillion dollars," he said.

The country has also undergone a cultural revolution in regards to the environment, and insurers can not be expected to pay for that change in attitude on their own, according to Mr. Huber.

Insurers and policyholders must reconsider the policies that have led to coverage disputes, he said.

"We have to pause and ask where are we going. We have gone through a period where we have claimed that words have no meaning. We have seen cases where sudden and accidental is taken to mean slow and gradual," he said.

To combat this, insurers and policyholders will have to move back to a liability system based on contract law rather than tort law, Mr. Huber suggested.

The cleanup coverage problem is not black and white, said Steven Gilford, a partner at Mayer, Brown & Platt. In some cases insurance companies have had to pay, while in others policyholders have paid, he noted.

Consequently, risk managers should be careful who they buy their insurance from, Mr. Gilford advised.

Insurance buyers are highly motivated by price, but risk managers should also consider the likelihood of whether a certain insurer will pay a claim when it is filed, he said.

Also, some insurance companies are doing so poorly financially that they might not be able to pay a large claim in the future, Mr. Gilford said.

The session was moderated by Robert Wheeler, manager-risk and litigation at BC Rail in Vancouver, British Columbia. Mr. Gilford substituted for Ronald A. Jacks, another partner at Mayer, Brown & Platt, who coordinated the session. ■

Reservation of rights letters need stamp of tact

Additional communications with policyholders can prevent hostility

By SARA MARLEY

ANAHEIM, Calif.—Reservation of rights letters are here to stay, but insurance companies can make them more palatable to risk managers.

"With the uncertainty of litigation, reservation of rights serves a legitimate legal purpose" for insurers, said Bob Finney, director of risk management for DHL Airways Inc. in Redwood City, Calif.

Policyholders, however, often have a problem with the way the letters are presented.

"We must emphasize the mutuality of interest between the insurance company and the insured, not create a hostile environment. The last thing you need is to be fighting with the plaintiff and fighting with the insurance company," said Tony Falkowski, senior vp of claims for Executive Risk Management Associates, the directors and officers underwriting management unit of Aetna Casualty & Surety Co. in Simsbury, Conn.

"If an insurer does not issue a reservation of rights, they might be precluded from denying coverage later," Mr. Falkowski said at the recent 30th annual Risk & Insurance Management Society conference.

"Reservation of rights is happening more and more in all cases," particularly product liability and pollution cleanup disputes, said Leon Kellner, a partner with Anderson, Kill, Olick & Oshinsky in Washington, D.C. The result has been longer and more standardized letters, some of which will not apply in a particular case, Mr. Kellner said.

'Insurance companies are not investigating claims before sending letters,' says attorney Leon Kellner, who charges: 'The reservation of rights letter has been perverted. Insurance companies don't want to take any position on anything.'

"The reservation of rights letter has been perverted. Insurance companies don't want to take any position on anything," he said.

"Insurance companies are not investigating claims before sending letters. No thought is being given to them. They don't narrow the focus for policyholders or insurance companies," Mr. Kellner continued.

Insurance companies must improve their presentation of reservation of rights letters and their communication with risk managers, Mr. Falkowski said. He suggests an insurer place a call to the risk manager before the letter is sent, explaining the reasons for it and urging the risk manager to call with any questions.

Insurance companies should watch the language in their letters, which should go out on their own letterhead—not a law firm's, he noted.

The letter on the insurer's letterhead is "less confrontational than if it comes from a law firm (policyholders) have never heard of," Mr. Falkowski said.

Long letters are not necessary; specific ones are. Insurers should paraphrase rather than quote directly at length from the policy or complaint.

"The tone is important. It sets the stage for how we are going to deal with the claim. We are very careful to look at the adjectives and try to soften them," Mr. Falkowski said. "We want to renew that policy next year. We want to maintain a relationship."

At the heart of many reservation of rights disputes is the insurance company's duty to defend.

"The problem with the duty to defend is what may be an inherent conflict of interest," Mr. Falkowski said. The insurer selects the attorney to defend the policyholder, and when "the insurance company exercises that degree of control, it can move the case toward exclusions of coverage or where there's no coverage."

Some statutes and court rulings allow a company that has received a reservation of rights letter to hire its own lawyers at the insurer's expense. Other policyholders hire "monitoring" counsel.

Allocation of legal resources can become a problem when a corporation as well as directors and officers are sued, Mr. Falkowski said. Companies must decide whether to hire separate counsel to represent the different groups of defendants or whether to present a unified front with a single legal team for all.

A disadvantage of a combined defense is the "conflict of interest that may develop later on between various defendants," he said. Some defenses may be available only to certain groups.

The policy determines at what point in the legal process an insurance company must pay defense costs, Mr. Falkowski said. If it is an indemnity policy, the insurer has no obligation to pay until the litigation is over.

"Regardless of what the policy says, the insurance company is better off paying defense costs as they are incurred," Mr. Falkowski said. "Our underwriters would much rather have the instant feedback of what a particular claim is going to cost us."

Corbette S. Doyle, senior vp of Willis Corroon Corp. in Nashville, Tenn., coordinated the session. Mr. Finney was the moderator. ■

Spotlight report

Don't let the lawyers out of your sight

Monitor legal costs like any others, companies told

By SARA MARLEY

ANAHEIM, Calif.—Companies can improve service from outside law firms by carefully selecting, educating and monitoring them.

"The era of the passive client is over. The era of consumerism is upon us," said Kevin M. Quinley, vp-risk services for Hamilton Resources Corp., a Fairfax, Va.-based managing general agent for MEDMARC Insurance Co. domiciled in Vermont.

Companies must "manage legal services as any other substantial expenditure," Mr. Quinley said at the recent 30th annual Risk & Insurance Management Society conference. "Lawyers are in a service business. They are slow to come around to that realization."

"You need to invest time and energy up front before you hire outside counsel," said Deborah Bloom, senior attorney with McDonnell Douglas Helicopter Co. in Mesa, Ariz.

Even with an 80-lawyer staff and two litigation support centers, McDonnell Douglas Corp. still routes much of its legal work to outside firms.

Ms. Bloom recommends evaluating many outside law firms and interviewing the best two or three, keeping in mind the complexity of a particular suit, the company's exposure and the overall significance of the case.

"Give thought to what you want from outside counsel," Mr. Quinley advised. Companies should expect accessibility and responsiveness, he said.

After a law firm is selected, the client has a duty to educate the lawyers about the case, Ms. Bloom said.

And that means more than just relaying the facts of the particular suit. The lawyers also need to know about:

- The general history of the corporation.
- Information on any related litigation, either pending or resolved.
- Research on the pending lawsuit or related suits that has already been conducted.
- The company's goals and strategies for the lawsuit.

For example, sometimes winning the case is the only objective. But, other times, it may be important for the client to maintain amicable relationships with the opposing side.

"There is no substitute for establishing a relationship where the outside attorney consults with you on decisions and strategy," Ms. Bloom said.

Initial discussions with the outside counsel should also establish ground rules about the client's budget, what expenses it will reimburse, its billing requirements, how the case will be staffed and the degree of the company's involvement in various phases of the litigation.

"Put in writing what you will and won't pay for," Mr. Quinley said.

William H. Ginsburg, senior partner with the Los Angeles firm Ginsburg, Stephan, Oringher & Richmond, recommended that the administrative staffs for the client and the outside legal firm establish a working relationship and deal with any billing problems.

Companies should remember that law firms have to accommodate different billing requirements for each client. In case of a dispute, the company should pay the part of the bill that is not in question, Mr. Ginsburg said.

Companies that use several outside law firms should bring them together to share information on expert witnesses and evidence, Mr. Ginsburg suggests.

Once the case is under way, it is important for the company to monitor its progress, receiving all documentation and even making personal visits to the firm to review the file. "Nothing substitutes for getting copies of everything," Ms. Bloom said.

"Let firms know you are evaluating them," Mr. Ginsburg advised.

Following the case can lead to better service, because it "sends a signal that you, as a client, care," Mr. Quinley said.

He advised companies to watch for warning signs of deteriorating service, like overlawyering or underlawyering; lack of creativity in settlement talks or litigation; and being sent on "a trip down the letterhead."

Ms. Bloom said that other warning signs include endless discovery and depositions and numerous "strategy sessions." Her continuing case review also includes watching for signs of animosity in the correspondence between the opposing lawyers.

"It gives the impression they are not focusing on me as a client," she said.

However, "try to do everything you can before you part ways" with a law firm, Mr. Quinley said. "It doesn't do you any good to be perceived as a fickle client, jumping from firm to firm. Before you burn bridges make sure you have exhausted all conventional routes."

Those routes include working up the law firm's organizational chart to move around a problematic lawyer, Mr. Quinley said. Sometimes the problem might be a personality clash with the lawyer assigned to your case, and a switch might be possible.

Mr. Quinley and Ms. Bloom agreed that getting the best service can rest on having one attorney, preferably a partner, who is ultimately responsible for the case and to whom the company can turn in case of problems.

"Identify a lead attorney who is responsible and will look after your interest," Ms. Bloom said.

However, in extreme cases, companies should consider looking for another law firm.

"Act promptly when you are displeased. The sooner you decide to change attorneys, the less expensive it will be," Mr. Quinley said.

He also advised companies to "be realistic. Outside counsel cannot perform miracles."

Mr. Quinley moderated and coordinated the session. ■

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Spotlight report

Before suing broker, think twice: Panel

Brokers can be allies in disputes

By MARK A. HOFMANN

ANAHEIM, Calif.—Three lawyers offer risk managers who are considering suing their brokers over a coverage dispute a simple bit of advice.

Don't.

At least don't sue the broker in the initial stages of the dispute, cautioned a panel of lawyers during a discussion of "Suing the Broker" at the 30th annual Risk & Insurance Management Society conference.

"My purpose is to persuade—if not convince you—" that both insurance buyers and brokers would be better off to remain cooperative during coverage disputes, said Nora Winay, vp and general counsel of Alexander & Alexander Inc. in Owings Mills, Md. "The broker is more often than not the best advocate" for a policyholder.

Ms. Winay added the caveat that her remarks did not pertain to situations involving "clear broker error."

Brokers perform several functions for policyholders. These include assisting the policyholder in evaluating exposures, researching the market, presenting the policyholder with options and seeking coverage, she said.

"It is critical to remember that there is no such thing as a limitless or exclusionless policy," said Ms. Winay. She pointed out that only three types of claims exist: those that are clearly covered, those that are clearly excluded and those that give rise to questions of interpretation.

Brokers don't and can't make coverage decisions; such decisions are up to insurers, she said.

But the broker not only can act as an advocate for the policyholder, but also as a negotiator in situations involving claims with a question of interpretation, Ms. Winay said.

"It truly serves no purpose to initiate suit" against the broker when more likely than not the broker and the policyholder will find themselves on the same side in the dispute, she said.

A policyholder attorney specializing in suits against insurers agreed.

"Our initial strategy is to avoid litigation," said Leon B. Kellner of Anderson, Kill, Olick & Oshinsky in Washington, D.C. Litigation of any sort is extremely expensive, he said. In fact, his firm has never sued the broker initially, he noted.

Like Ms. Winay, Mr. Kellner stressed that most coverage disputes involve matters of interpretation. Brokers provide policyholders a powerful advantage in persuading insurers to settle before a case goes to court, in part because insurers need to maintain good relations with brokers to ensure a steady stream of business, he said. "In my view, the best place to get the money is from the insurance company."

If that strategy doesn't work, the question becomes whom to sue, said Mr. Kellner. At this point, the matter becomes personal for many risk managers. Their reaction, he said, is " 'I'm going to sue everybody under the sun.' "

Mr. Kellner advised restraint. "I'd rather hold my suit against the broker in abeyance," he said.

According to Mr. Kellner, most policies aren't manuscripted policies; their language has been drawn up by the insurer, not the broker And, this can definitely work to the policyholder's advantage if there are multiple insurers involved in the dispute, he said.

Mr. Kellner said he generally advises clients to sue all of the insurers involved at once. He said that contrary to public belief, insurers don't present a united front. It works to the policyholder's advantage for insurers to interpret identical policy language in different ways, he said.

If a policyholder decides to sue the broker at the same time suit is brought against the insurer or insurers, the broker might be forced to take a position in defense of the insurers simply to protect itself, Mr. Kellner said.

A third attorney said risk managers often hold the mistaken notion that a broker is somehow another source of coverage if an insurer denies coverage.

"Too many policyholders assume there must be liability on the part of the broker because an insurer didn't cover a claim," said Herb Lustig of Lustig & Brown in Buffalo, N.Y. Mr. Lustig specializes in defending brokers and insurance agents.

He said that most suits against brokers are based on one of two premises: The broker either breached a contract or was negligent.

The mere fact that the insurer is right and does not provide coverage does not mean that the broker did anything wrong, he said. The broker is not a provider of substitute coverage when an insurer did not provide such coverage, said Mr. Lustig.

Mr. Lustig also shared a few secrets of successful brokerage defense. One is for the broker to document every conversation in writing to show that the policyholder knowingly and willingly declined coverage or decided to handle more of its program than it was able to handle.

Another reason for brokers to keep records is that policyholders don't always read their policies and don't note when requested coverages are not included, he said.

Virginia F. Tormey-Lawson, director of risk management for Pacific Telesis Group in San Francisco, moderated the session. W. Lee Carter III, director of research and development for Alexander & Alexander Inc. in Dallas, was coordinator. ■

Insurers focus on individual niches

Specialization to benefit buyers, insurer execs say

By JUDY GREENWALD

ANAHEIM, Calif.—"Subcycles" are emerging within the property/casualty insurance market that affect individual niches within the overall marketplace.

This trend should ultimately benefit the insurance buyer in light of insurers' increasing specialization and their unwillingness to leave their niches, even in a hard market.

This was the consensus of a panel at a session titled "Will Specialization Change the Market Cycle?" at the 30th annual Risk & Insurance Management Society conference.

Dennis Kane, president of Special Risk Facilities, a CIGNA Corp. unit in New York, said he prefers the term "focused" to "specialized" in referring to insurers' niches.

There are three essential ways insurers can be focused: geographically, by product line or by customer segment, Mr. Kane said.

"Specialization may very well be the key strategy that keeps a company successful," said Kevin H. Kelley, president of Lexington Insurance Co., an American International Group Inc. unit in Boston. "Focus and change will give us opportunity," which will allow insurers to operate with flexibility and efficiency, he remarked.

But specialization alone does not spell survival, said Mr. Kane, pointing to Mission Insurance Co., a workers compensation specialist that was liquidated in 1987, and to Texas Employers Insurance Assn., a workers comp insurer that was placed in conservation in April 1990. In addition, Employers Casualty Co., a Texas workers compensation insurer that shared management with TEIA, was seized by regulators in February (*BI*, Feb. 17). A Texas state court placed Employers Casualty in conservation last month.

Knowing how to deploy capital is key to successful specialization, Mr. Kane said. Putting money into a structurally unsound market, he said, "can only spell disaster." Also important is the "ability to execute your plan," which requires "good, quality, people."

The key to success is serving the customer, commented Richard D. Heydinger, director of risk management services for Hallmark Cards Inc. of Kansas City, Mo.

As a risk manager, Mr. Heydinger said he actually spends little time with coverage and renewal negotiations. Instead, he spends considerable time with the corporate "customers" he serves as a risk manager, "trying to understand what their needs are."

Mr. Heydinger called for the development of long-term relationships with insurers. However, one concern, he noted, is that insurers that specialize and narrow their focus may be unwilling to compete in certain areas, leaving the risk manager with fewer options.

The panel also discussed a trend toward insurer consolidation.

"Clearly, from my perspective, there will be far fewer companies doing business" in the year 2000 than the 5,000 property/casualty and life/health insurers operating today, Mr. Kane commented. How long, he asked rhetorically, will insurance buyers put up with the inefficiency of 5,000 chief financial officers, 5,000 systems departments and other duplications?

Mr. Kane noted that the insurers represented on the panel write business on behalf of more than 50% of the Fortune 500 companies. Obviously, he said, the consolidation "trend has already started" and predicted that someday fewer than 1,000 insurers could be operating in the United States.

Mr. Kelley also recommended that risk managers pay close attention to insurers' financial viability to ensure that insurers will still be around to pay claims on long-tail business.

Meanwhile, increasing specialization will lead to a more stable environment, because insurers will not move out of their chosen areas of specialty, said C.J. Clarke, the Hartford, Conn.-based president of Travelers Corp.'s property/casualty operations. The focus will be on "How good can we get?" and on how long the insurer can retain its customers, he said.

Within multiline insurers, "the capital is flowing to where the returns are," Mr. Clarke said.

He also noted that an insurance company that specializes can deal with price variations a "lot easier" than one that does not. Specialization, said Mr. Clarke, spells the end of the days of the "herd mentality," when everyone entered and left a market simultaneously, leading to a sudden disappearance of capacity.

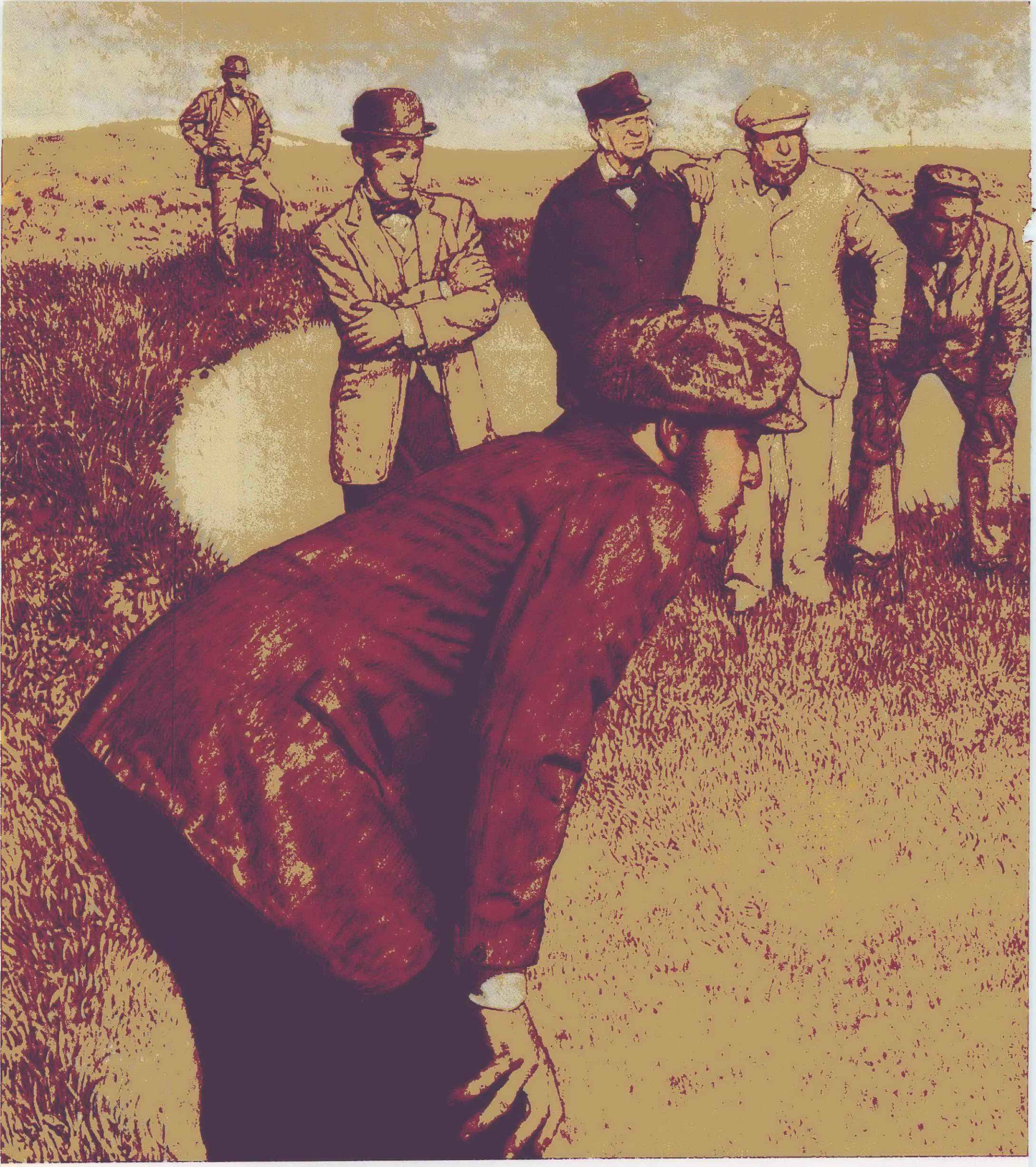
CIGNA's Mr. Kane also predicted the emergence of subcycles within the market. While factors, like a sudden shortage of reinsurance capacity, could cause the overall market to turn, niche markets, like the aviation market, already are in flux even though the overall market remains soft.

Once these niche markets do harden, "there's a tremendous responsibility on the shoulders of the risk managers" when "naive capacity" offers 50% price cuts, said Mr. Kane. If risk managers believe a price is right, they should support it, he said, "even if there's some lunatic out there."

These specialists insurers should be able to offer three- to five-year policies, said Mr. Clarke, "because now it's a relationship that you keep fine-tuning rather than renegotiating each year."

However, he noted that Travelers remains a multiline company, and he is not rejecting diversification. "You just can't carry all products anymore for any period of time."

The session was moderated and coordinated by Lawrence I. Drake II, managing director of Marsh & McLennan Inc. in New York. ■



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Spotlight report

Avoiding a world of problems

Communication is vital for global programs: Panel

By GAVIN SOUTER

ANAHEIM, Calif.—Strong communication links are fundamental to the success of a global property/casualty insurance program, several risk managers agree.

Although improved coverage and lower premiums are among the benefits of a global insurance program, they can only be achieved if the communication links between everyone involved are in place at the outset, they say.

And unless all of the participants are clear on each others' coverage definitions, a global program can turn into a disaster, they warned during a session at the recent 30th annual Risk & Insurance Management Society conference.

"Communication is the most important thing to get right when you are setting up a global program," said Charles Armstrong, manager-corporate risk management at Xerox Corp.

With a geographical spread as wide as Xerox's, the communication channels are wide and varied, he said.

The company, which is based in Stamford, Conn., obtains 59% of its revenues from U.S. operations, 28% from Europe, 7% from Latin America and 6% from Canada.

That diversity was one reason the computer and business-equipment company opted for a global property insurance program, Mr. Armstrong said. "We were concerned that with so many different coverages for the different operations, we might have missed something."

He cited seven main objectives for Xerox's global program:

- To have common insurance policy provisions worldwide.
- To have a single, quality multinational insurer.
- To improve its coverage provisions.
- To obtain higher or equal levels of coverage than it had under its previous programs.
- To satisfy all service requirements of the different operating units.
- To keep costs equal to or lower than its previous programs.
- To get an insurer to commit for at least three years.

The objectives were largely achieved, he said.

As primary insurer, Zurich Insurance Co. agreed to a fixed-rate, three-year program and the company's property insurance costs were cut 16% to 20% depending on the claims experience, Mr. Armstrong said.

Allendale Mutual Insurance Co. is the principal reinsurer for Xerox's program. The coverage limits remain at $4.2 billion for North America and were raised in Europe to $550 million from $300 million under the old program, and in Latin America to $250 million from $50 million.

"Also, all of our insurance services have been improved and we have Factory Mutual engineering worldwide," Mr. Armstrong said.

The program's broker is Johnson & Higgins.

For the program to work, all the participants—insurer, broker and policyholder—must be free to talk to one another, Mr. Armstrong said. "We work in a partnership and any member of the group can talk to any other member." Twice a year, all participants meet formally.

The global property program has been so successful that Xerox plans to set up a global casualty program in 1993, he said.

Strong communication is particularly important to ensure that the risk management program at Compagnie de Saint-Gobain runs smoothly, said Pierre Sonigo, director of risk and insurance for the Paris-based manufacturer.

Saint-Gobain has a risk management staff of only three. And those three people have to deal with 19 other people on risk management matters in the company's worldwide divisions, he said.

Lack of communication between the various divisions was one of the reasons for establishing a global property/casualty program, Mr. Sonigo said.

"When the Mexican earthquake happened and the communications in Mexico were cut, it took a week for the details of the coverage in Mexico to reach the head office in Paris," he recalled.

The global program also allows the company to develop a common approach toward risk. Mr. Sonigo said.

And if the senior managers in the company understand the risk management philosophy of the company, they can more easily provide the risk management department with the information it needs to monitor the program, he said. "We have to have regular information and indicators to show us when something is going wrong."

Also, to help it monitor the global program, the risk management department is immediately informed of all losses greater than $200,000, he said.

Mr. Sonigo also receives monthly reports from all of the brokers the company uses worldwide.

"You can never stress too much how important good communications are," he said.

To ensure that communication runs smoothly, local brokers only talk with the main broker, local insurers only talk with the lead insurer, and subsidiary companies only deal with the parent company. All ultimately report to the risk management department.

"When things go wrong, it is usually because these lines have been crossed. For example, if a local broker calls the risk manager in Paris for instructions without informing the main broker, you get confusion," Mr. Sonigo said.

Risk managers can also help communications by going out and meeting all of the people involved

Continued on next page

Continued from previous page
in the global program, he said.

"Nothing can beat a site visit," Mr. Sonigo said.

He urged risk managers to come down hard on brokers and others that do not meet their demands. "You must be tough on service providers and settle for nothing but excellence from them, because if you don't they have a tendency to be weak."

The need for clear communication in global programs is becoming even more important now that European insurers are seeking to become involved, said Kenneth Krenicky, director of risk management at Rhone-Poulenc Rorer Inc. in Collegeville, Pa.

"European insurers want part of the market in property and casualty, and they are talking a good game," he said.

However, the differences in coverages normally provided under U.S. and European policies can lead to confusion for risk managers, Mr. Krenicky said.

"For example, machinery breakdown is not a standard coverage in Europe. Also what we understand as replacement value and cash value does not mean the same everywhere," he said.

Business interruption coverage can also be problematic when you use international insurers, unless you comb through the policies first, Mr. Krenicky said.

"In Japan, for example, business interruption is not a standard coverage," he said.

There are even differences in definitions of geographical regions, Mr. Krenicky said.

"What does North America mean? For some foreign carriers it just means the United States, and you find out that you are not covered for Canada," he said.

Also, if you ask a European insurer for global coverage, he will assume that you mean coverage for everything outside the United States, Mr. Krenicky said.

When the coverage definitions are sorted out, there are still other communication problems to overcome when you implement a global program, he said.

Local managers who previously set up insurance programs for their units will find that much of the control is taken from their hands. This can be a blow to their egos and affect their future judgment, he said.

"Make sure that the local broker makes the local manager feel important and that he still gets the baseball tickets and the Christmas dinners," Mr. Krenicky said.

The session was coordinated by Richard Denning, president of Risk Sciences Group Inc. in Atlanta, and moderated by Richard Inserra, assistant treasurer-risk management of Union Carbide Corp. in Danbury, Conn. ■

Threats to warehouses: fire hazards, complacency

Fire departments are seen as allies

By MARK A. HOFMANN

ANAHEIM, Calif.—Warehouse owners and operators can't afford to be complacent about the changing fire exposures confronting their facilities.

And they must view local fire departments as allies—not adversaries—in the effort to protect property from catastrophic fires, three experts agreed. The panelists asked the rhetorical question, "Will Your Warehouse Fire Make the 11 p.m. News?" during the recent 30th annual conference of the Risk & Insurance Management Society in Anaheim, Calif.

Ladd Baumgart, corporate director-department of property conservation and safety for Levitz Furniture Corp. in Boca Raton, Fla., said that commodity changes within the past five years, like the increased use of plastic in packaging and in manufacturing, have made many existing fire suppression plans obsolete.

Mr. Baumgart, who served as coordinator and moderator of the session, said that today's warehouses often contain a variety of materials stacked in very high piles, a combination that considerably increases the fire exposure.

He explained that three commonly used forms of stacking goods present widely divergent levels of hazard.

Solid-piled storage, where boxes or containers are packed tightly together, presents the least hazard. This presents the least amount of "flue space," the space needed for a fire to draw oxygen and spread, he said.

Palletized storage, where commodities are placed on pallets on the floor and above each other, is more hazardous. The pallets allow fire to move horizontally and thus gain more access to oxygen.

Increasingly popular rack storage presents the greatest hazard. The goods are exposed to oxygen in every direction, meaning that fire can spread in every direction, Mr. Baumgart said.

"The higher the rack, the more difficult it is" to control the fire, said Mr. Baumgart. Fire plumes within a rack can travel at 50 mph, he said, which is almost instantaneous in a 40-foot-tall rack.

In an aside, Mr. Baumgart cautioned his audience to avoid storing goods in manufacturing facilities. The exposure to combustibles and power sources means "you have the worst of both worlds," he said.

"There is a changing situation" in warehousing, said Mr. Baumgart. Because of the introduction of plastics and the increasing height of racks, risk managers who thought only a few years ago that their facilities had adequate fire protection could be sorely mistaken, he said.

John Williams, vp and regional engineering manager for Waltham, Mass.-based Arkwright Mutual Insurance Co. in Atlanta, picked up

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on

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An era of opportunity

Newly opened markets make Latin America attractive to foreign insurers

By Douglas N. Smith

International issues

THE OPENING OF LATIN American markets to U.S. and foreign companies has been the subject of debate in both Georgetown cafes and Wall Street boardrooms. The Enterprise of the Americas initiative and the North American Free Trade Agreement, which I discussed in my Feb. 10 column, indicate the commitment of the U.S. government to promote political stability and economic prosperity close to home. These policy directives represent serious bilateral and multilateral, as well as public- and private-sector, efforts to promote greater integration of the economies of the Western Hemisphere.

In the past, restrictive national regulations hindered U.S. companies in gaining access to Latin American markets. This is no longer a contentious issue between the United States and its neighbors to the South: Economic liberalization policies in Latin America portend a new era for U.S. investment in the region. The proliferation of books on Latin American political and economic issues, as well as heightened attention in the popular media, are testament to the growing awareness of new business opportunities in the region. While the lion's share of attention is directed toward U.S. investment in manufactured products, increasingly we are seeing greater attention focused on the services industry and the financial community as investors in Latin America.

The liberalization of insurance markets in Latin America can be an instructive measure of the success of economic liberalization programs in the region. Latin America also is an interested peripheral viewer as U.S. insurers strive to find their niche in an increasingly competitive global insurance market. An understanding of the changes in Latin American markets, placed in context of recent trends in international insurance, may help to estimate the future of both U.S. and Latin American insurance markets.

The U.S. insurance market since the beginning of the 1990s has seen increased competition from European insurers for market share both at home and in the highly competitive insurance environment of the European Community, as well as in Eastern Europe. The proliferation of players has led to a global insurance market saturated with excess capacity. Heightened competition among insurers led to a sustained soft market through 1990-1991 that still does not appear to be hardening. But recent signals suggest that changes are coming in catastrophe coverages, and the tightening seen there could indicate hardening.

The challenge posed by European conglomerates to U.S. insurers is real. Acquisitions of, and investments in, U.S. insurers by foreign companies with extensive capacity resources are the best indicator of foreign insurers' interest in taking a slice of the U.S. market, a market which generates more than 50% of world premiums. With an abundance of capacity in Europe and additional players in the U.S. market, American insurers are being forced to adapt. Many U.S. insurers, while trying to maintain current market shares, are now beginning to look to Latin America, where their expertise in risk management and loss control engineering finds eager and receptive audiences and they enjoy a comparative geographical advantage.

The economic liberalization currently taking place in Latin America is part and parcel of U.S. insurers' interest in the region. Without marked economic development, the need for insurance and risk management services will not increase. As the countries of the region cut tariffs, privatize unprofitable state entities and deregulate many industries, U.S. investment in Latin America is increasing, with financial services and the insurance industry following the lead of manufacturers and bankers.

From 1986 to 1990, U.S. direct foreign investment in manufacturing, finance and insurance, banking and petroleum in the Latin American region almost doubled, to $72.5 billion from $36.9 billion. In Chile, U.S. DFI increased as much as 333%.

Overall, U.S. DFI in the Latin American finance and insurance sector increased from to $27.3 billion from $4.3 billion during that period. However, country-by-country results in this category were generally mixed, with Brazil and Chile managing slight increases. Argentina and Venezuela maintained static growth, and no figures on Colombia and Peru are available for this period. Political violence against state oil interests in Colombia and terrorist activity in Peru should be considered the primary reasons for lower insurance activity compared with other countries.

The relationship among economic development, growth in insurance demand and the position of U.S. insurers in Latin America is best illustrated by

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ASK A BENEFITS ACTUARY

IRS changes position on VEBA contributions

Q **Is there any fairness in the Internal Revenue Service's VEBA audit program?**

A This question comes from an actuary who wanted to discuss a program that the Internal Revenue Service is initiating against many employee benefit plan sponsors. The IRS is disallowing tax deductions for contributions to a voluntary employees beneficiary association—also known as a 501(c)(9) trust or VEBA—to fund the medical benefits of individuals who have already retired.

The Deficit Reduction Act of 1984 substantially changed the rules under which sponsors of health and welfare plans could make tax-deductible contributions to a VEBA to fund health and welfare benefits, including retiree medical benefits. Prior to DEFRA, the Internal Revenue Code permitted significantly greater tax-deductible contributions to fund a variety of health and welfare benefits. DEFRA amended the tax code to provide that tax-deductible contributions to fund retiree medical benefits had to be calculated "over the working lives of covered employees and determined on a level basis. . .as necessary for post-retirement medical benefits to be provided to covered employees. . ."

The DEFRA amendment is relatively clear about the funding of retiree medical benefits for future retirees, but is ambiguous about the funding of benefits for current retirees.

As a consequence, employers looked to the legislative history of DEFRA for insight into how Congress intended this statutory language to be applied to retirees. The conference committee report to DEFRA states that Congress intended to allow tax-deductible contributions "reasonably necessary to accumulate reserves under a welfare benefit plan, so that the medical benefit or life insurance (including death benefit) payable to a retired employee during retirement is fully funded upon retirement." Based on this and other items in the legislative history, some retiree medical plan sponsors funded all future retiree medical benefits for current retirees in a single year.

However, based on what a colleague tells me, it appears that the IRS has undertaken a program to disallow a deduction for contributions to a VEBA used to fund medical benefits for current retirees in a single year. These disallowances have occurred in the course of an IRS audit of the VEBA plan sponsor's income tax return and have been made by several different IRS district offices.

The IRS position is that the funding of the liability for retiree medical benefits for current retirees should be spread over the working lives of current employees, despite what the legislative history says. Under the IRS position, 85% to 95% of the tax deduction for the funding of retiree medical benefits for current retirees is generally disallowed.

My colleague complained bitterly about the fairness of the IRS position. His complaint is founded on two points:

- Congress changed the rules for funding retiree medical benefits in 1984 with ambiguous, statutory language. DEFRA's legislative history provides that the IRS is to prescribe rules for VEBA funding that would presumably provide guidance for funding the medical benefits of current retirees. Yet, nearly eight years have elapsed since DEFRA was enacted, and the IRS has not yet published regulations to provide guidance in this area.

It is hardly fair to plan sponsors for the IRS to fail to publish its position—as Congress intended—and at the same time to disallow tax deductions based on its unannounced position.

- Retiree medical benefits are generally an unsecured promise made to retirees; making an adequate provision for this promise is one of the major issues facing Corporate America today. Funding these benefits through a VEBA can provide security for retirees. Yet through its unpublished position, the IRS is discouraging plan sponsors from funding these benefits and making their promise more secure.

The Internal Revenue Service's position, too, is hardly fair to retirees who rely on the continued financial health of the corporate plan sponsor for their medical benefits. The inequities of this program seem obvious to many, but apparently not to the IRS. ■

William J. Miner is an actuary with The Wyatt Co. in Chicago. Mr. Miner's next column on employee benefit actuarial issues will appear in June.

ASK A RISK MANAGER

Positive thinking and the new disabilities law

Q **Many companies are troubled by compliance issues associated with the Americans with Disabilities Act. How can I show my management the positive aspects of this regulation?**

A I applaud your positive thinking, because viewing the Americans with Disabilities Act as a "plus" for business and not a negative certainly will make it easier to comply with the regulations. There is a tendency to view this act as just another governmental regulation that employers are forced to follow.

For the past several months, risk managers, human resource managers and legal representatives have been educating themselves and company management on how to meet the compliance deadlines. Because the majority of us are familiar with the act itself, I will not elaborate on the wording at this time. But, let me caution you that it's one thing to go through the motions of following the ADA—and another to truly subscribe to the principles behind it.

A sizable percentage of us have a preconceived image of a disabled person. In our mind's eye, he or she has a visible disability like the inability or limited capability to walk, see or hear. What we fail to understand is that there are millions of disabled people who suffer other ailments that limit their ability to participate in a major life activity. However, with "reasonable accommodation," these people often can enter the workforce and perform a valuable service to employers. The term "reasonable accommodation" is the buzzword of the ADA, and what it means to each employer is the subject of continuing controversy.

As the person responsible for safety issues within our organization, I believe the ADA will enable me to help create a safer workplace for all employees. There is nothing in the law requiring an employer to retain or hire a disabled person if that person is not qualified for the job. Under the act, a "qualified individual" is considered to be someone who, with or without reasonable accommodation, can perform the essential functions of a job. The fact that a person cannot perform a "marginal" function of a job is not a suitable reason to deny employment.

The act will cause employers to review carefully each job description, and if physical restrictions apply, we will have to focus on those elements and decide if there is an alternate method available to perform the function. Let me offer the following example: An employee is required to routinely lift 50 pounds as part of a basic element of a job. This weight restriction may be too stringent for someone with back problems or other physical limitations. Because most individuals could safely handle up to 25 pounds, a "reasonable accommodation" would be to purchase items in 25-pound increments instead of 50-pound loads. By reducing the lifting requirement, we also decrease the potential for injury to our healthy employees. It seems like a simple solution to a common accident exposure.

In the 1980s, the word "ergonomics" entered our vocabulary perhaps for the first time. In this decade, the term will take on greater meaning, because the ADA will require us to evaluate the physical work environment and remove or modify barriers that otherwise prohibit the disabled person from performing in that environment.

Again, the rule of "reasonable accommodation" applies. I believe many employers are perhaps unknowingly guilty of creating such physical barriers. In our desire to maximize profits by not upgrading equipment or furnishings—steps that would improve working conditions—we fail to consider the impact of the comfort factor on our workers.

Normally, the safest way of performing a task is also the easiest way. Accidents typically occur when we try to take shortcuts or deviate from preapproved "standard operating procedures." Also keep in mind that modifications to the physical work environment, with regard to the ADA, should not require us to spend great sums of money. Hopefully, employers will come to realize that dollars spent to improve working conditions can generate savings by reducing the number of medical claims filed by their workers and medical expenses associated with them.

Another possible benefit of the ADA is the integration of a "light-duty back-to-work program" into the company's overall medical cost containment program. Although light-duty programs are gaining in popularity as an effective means of controlling workers compensation and health care costs, many employers that are undecided on the concept will use the ADA as the reason to enact a program.

Light-duty programs offer opportunities to both the employee and employer. The employee remains "connected" with his or her employer instead of passing the time at home until capable of returning to pre-injury or illness status. Remember the saying "out of sight, out of mind"? Perhaps at no time is this more true than during those long days or weeks or months when an employee is out on disability leave. Too often, these people are lost in the system instead of contributing to both their emotional well-being and their company's operating efficiency by being a member of the team.

Remember the words "reasonable accommodation"? Light-duty programs offer many opportunities to modify certain job functions. I feel confident in saying that employers that have established these programs feel the "good will" they create is a strong incentive to initiate one.

Finally, the ADA will require us to think and work smarter. Every organization is composed of human beings, each with certain strengths and weaknesses. Perhaps in the past we have placed far too much importance on the perception of who is strong and who is weak. The ADA will sensitize us to the needs of all individuals.

Today, we find ourselves establishing new hiring guidelines and finding ways to adjust the way we operate our businesses. No doubt many of the unanswered questions on the "reasonable accommodation" issue will be decided in the courts. This potential impact of the regulation should be of concern to everyone. The act was not intended to result in a financial windfall for attorneys, but we should brace ourselves for an onslaught of frivolous suits. Let's trust, however, that common sense will prevail and that the legal decisions rendered will be fair and in the best interest of everyone. ■

Would you like advice from an experienced colleague on a risk management, benefits management or actuarial problem? Four features in the Perspective section of Business Insurance can give you some answers.

Ask A Risk Manager, Ask A Benefits Manager, Ask A Benefit Actuary and Ask A Casualty Actuary answer written questions from readers on risk and benefits management issues and actuarial problems.

This month's column on risk management issues is written by Susan M. Werner, director of risk management at Hardee's Food Systems Inc. in Rocky Mount, N.C. Dennis J. Nirtaut, manager of employee benefits at Continental Bank Corp. in Chicago, answers questions on employee benefit plans. William J. Miner, an actuary with The Wyatt Co. in Chicago, answers actuarial questions on benefits issues. And, Richard E. Sherman, president of Pacific Actuarial Resources (PAR) Excellence in Ashland, Ore., answers actuarial questions in the casualty field.

Ms. Werner

Ms. Werner's and Mr. Nirtaut's columns usually appear on the second Monday of alternate months. Mr. Miner's and Mr. Sherman's columns usually appear alternately on the first Monday of each month.

Ms. Werner's next column will appear in June.

Address your questions to ASK, Business Insurance, 740 N. Rush St., Chicago, Ill. 60611. Please give us your name, title and employer; however, Business Insurance will consider unsigned letters.

New era in Latin America

Continued from previous page

the case of Chile, the region's free-market shining star. In terms of privatization, economic growth and state financial stability, no other country in the region, except perhaps Mexico, can point to comparable development. There is virtually no area of the Chilean economy reserved exclusively for nationals. The insurance market has been completely deregulated since 1980, when the state insurance monopoly was abolished. It is estimated that almost three-quarters of Chile's $481 million in premiums is in the hands of foreign insurers.

While it is certain that development of a healthy and profitable insurance market for U.S. insurers in Latin America is still many years off, it seems certain that U.S. insurers could bring in technical know-how and myriad new products, including:

- Mass marketing of life insurance programs.
- Personal or specialty lines, like homeowners insurance and financial products.
- Employee benefits consulting.
- Property and casualty loss control techniques.
- Risk management concepts.

Many U.S. insurers already recognize that Latin America is changing. Some companies recently have acquired equity in Latin American insurers or increased equity positions in foreign correspondents. Others, like Chubb Corp. in Brazil and Colombia, have simply changed the operating name of local correspondents to identify their interests better.

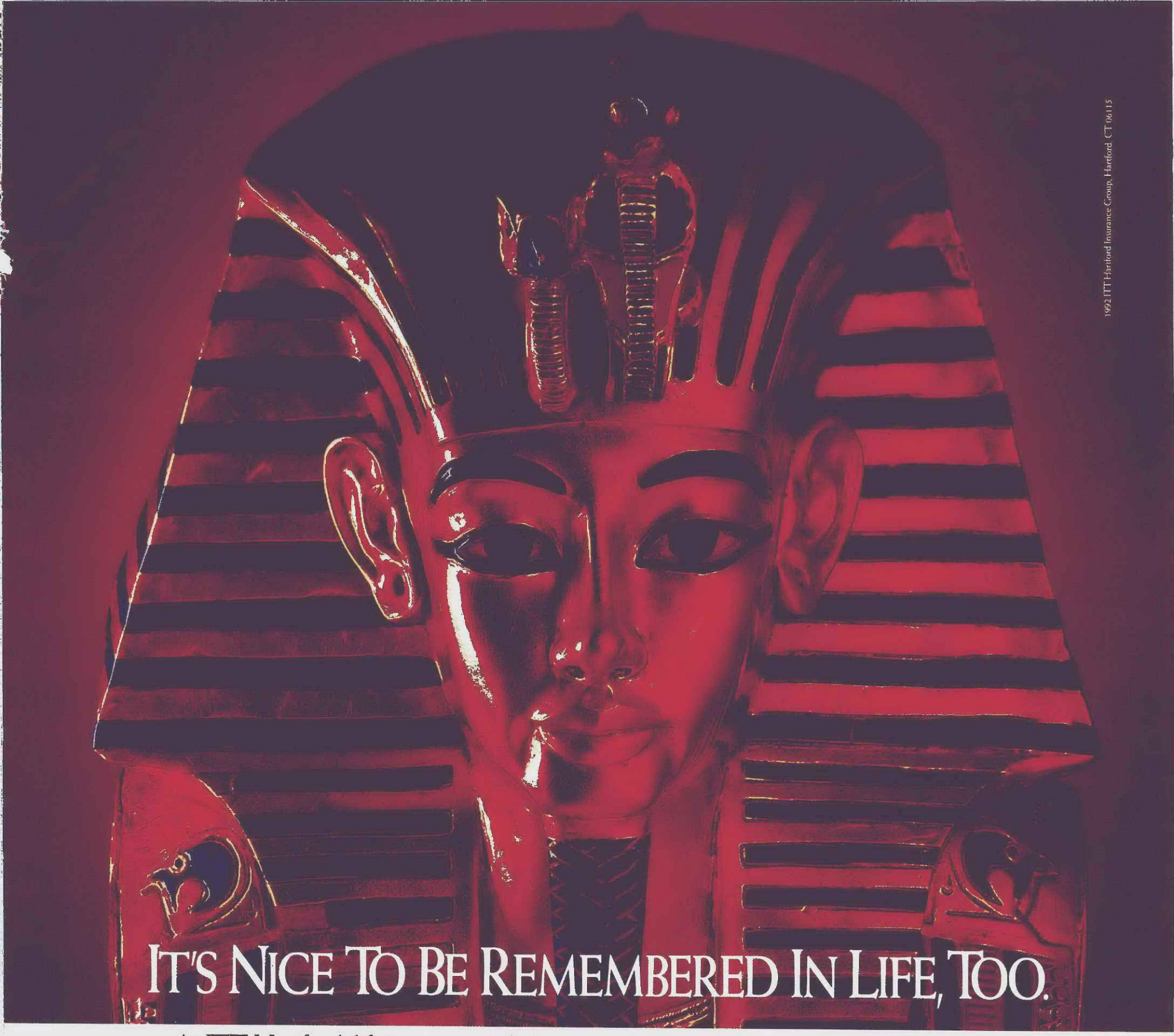
Without doubt, the privatization trend will open up insurance purchasing, promote development of new products and, as multinational corporations increase their operations, bring new opportunities for U.S. insurers in Latin America. Changes will be limited initially, but posturing for long-term growth will most likely increase.

Faced with a more competitive global market, U.S. insurers will seek to maintain their positions with the European insurers and look to Latin America for growth. European insurers, like the Spanish company Mapfre Mutualidad de Seguros, which has aggressively acquired equity positions in Argentina, Brazil and even Puerto Rico, will not be far behind. For multinationals with operations in Latin America, the impact of increased competition in insurance markets will be positive, since rates should remain low and professionalism and product sophistication would be enhanced.

Economic growth in Latin America, even with the expected stops and starts, should continue for the short to medium term. New opportunity for U.S. insurers should grow commensurate with this development.

Next month, I will discuss insurance trends in some of the major Latin American countries, with specific comments on how these nations have been affected by the liberalization and deregulation phenomenon. ■

Douglas N. Smith is senior vp and manager of the International Department of Johnson & Higgins in New York. His column appears the first Monday of every month.



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Warehouse fire

Continued from page 41

Mr. Baumgart's theme.

Mr. Williams noted that "highly protected risk" property loss conservation, which involves the adequate sprinklering of facilities with devices that respond automatically, must be kept up to date with changing exposures.

A sprinkler system can be rendered inadequate, according to Mr. Williams, if the commodity stored in a previously adequately protected structure changes, if flammable liquids are introduced, if the storage arrangement or quantity changes, or if solid-shelf racks are introduced.

One of the problems is that management often fails to recognize high-hazard conditions, he said. Like Mr. Baumgart, Mr. Williams cautioned that storage facilities within a manufacturing area have to be examined carefully.

Adequate protection is a matter of managing change, Mr. Williams said. The costs are immense. "It's not uncommon to have warehouses in the two- to three-football field size," he said.

He offered a list of mistaken assumptions that warehouse managers hold. These include:

- Believing that a sprinklered storage area is automatically safe from catastrophic fire.
- Believing that the fire department is automatically aware of changes in the hazards of a facility.
- Thinking that when the insurer becomes aware of changing hazards, the insurer simply calls the fire department directly to inform it of the change.
- Believing that the high value of many stored goods will lead the fire department to make frequent inspections to determine changes in hazards.
- Thinking that warehouse managers can bring in additional goods to be stored beyond the sprinklers' ability to protect, provided that the additional storage is temporary.
- Feeling secure that warehouse employees trained in fire suppression will be able to hold any fire in check until the fire department arrives.
- Thinking that the fire department's responsibility upon arrival will be to protect the warehouse and its contents.

Stephen Cobb, an inspector with the Orange County Fire Department in Orange, Calif., noted at this point that the fire department's "first priority is life safety" for both its own personnel and others at the scene of a blaze.

With that priority in mind, Mr. Williams stressed that one of the best ways to deal with the fire exposure is to open and keep open lines of communication among the owner-operators of warehouses, insurers and local fire officials.

Mr. Cobb agreed. He said he views warehouse owners as allies, not adversaries. His personal mission statement includes a commitment to doing all he can to prevent fires from occurring, he pointed out.

"When the bell rings, that's a failure," said Mr. Cobb.

He summarized some of the keys to success in keeping a warehouse fire from occurring in addition to treating the warehouse owner as an ally. These included preparing preincident plans for all warehouses, knowing current details about warehouse contents and never assuming that the sprinkler system is adequate.

Mr. Cobb also told his audience some of the basic factors a fire inspector considers when he or she inspects storage piled more than 40 feet high. These include:

- The height of storage and amount of area used for such high-piled storage.
- The method of storage, whether solid piles, pallets or racks.
- The combustibility, fuel load and heat release of the products, containers and packaging materials in the warehouse.
- The adequacy of the sprinkler system, which is assessed based on the commodity stored, the height and method of storage, and the widths of aisles in the facility.
- The need for any additional fire protection requirements based on the specific conditions of the facility.

"The level of hazards in your facility may overwhelm your protection," advised Mr. Baumgart. He again emphasized communication among all of the parties involved in warehouse protection.

"We all think that we have a corner on knowledge. We don't realize that the other player has something to contribute," Mr. Baumgart said.

"Put your hand out to the fire service," he advised. ■

Review keeps catastrophe risk in check

By MARK A. HOFMANN

ANAHEIM, Calif.—Risk managers should review their exposure to natural catastrophe yearly at least.

That was the advice offered by two loss-control experts during a panel discussion at the recent Risk & Insurance Management Society conference.

Michael A. Tuman, an assistant vp with Rollins Burdick Hunter of Illinois Inc. in Chicago, said building construction is the most critical factor in determining loss prevention effectiveness in a catastrophe.

"If the building fails, you can expect everything in it to fail, too," said Mr. Tuman.

William Oklesen, also an assistant vp with RBH of Illinois and the session's coordinator, said there are five key issues involved in developing a risk management response to natural catastrophes, including: the types of catastrophe, their frequency and magnitude, identifying areas susceptible to specific types of catastrophes, pre- and post-loss claims activity and loss-prevention activity.

The speakers cited six major types of catastrophe: hurricane/tornado, earthquake/land movement, ice/snow, flood, low temperatures and conflagrations, which are large-scale fires.

The most frequent catastrophe in North America is flooding, said Mr. Tuman, but in many cases the damage is negligible.

Tornadoes are the second most frequent catastrophe, he said. Hurricanes and low temperatures, including ice and snow storms, tie for third, with earthquakes and conflagrations rounding out the list.

But in terms of severity, hurricanes easily top the list, Mr. Tuman said. Hurricanes accounted for seven of the 14 most costly catastrophes since 1965, with 1989's Hurricane Hugo ranking as the single most expensive disaster, exceeding $4 billion in insured property damage, he said (*BI*, Sept. 25, 1989).

Low temperatures accounted for three of the most costly catastrophes, and tornadoes for two. The 1989 Northern California earthquake and the 1991 Oakland, Calif., fires also appeared on the list (*BI*, Oct. 28, 1991; Oct. 23, 1989).

"The susceptibility of a facility or company to the effects of a natural catastrophe, and the anticipated damage to each, can be predicted with reasonable accuracy. The amount of advance notice to prepare for the event varies widely by the type of disaster," said Mr. Tuman.

There almost always is some advance warning of hurricanes, floods, low temperatures, ice and snow, he said. But there is no advance warning for earthquakes, and little for tornadoes and conflagrations.

Mr. Oklesen offered some claims handling points involving pre- and post-loss conditions. For example, a risk manager must determine whether enough people will be available to deal with the post-catastrophe situation, he said. He advocated the creation of a plant emergency organization with preassigned duties. The organization should be put through trial runs to test its effectiveness, he said.

Another matter that must be considered is utility interruption. Although executives often think their utilities will survive a catastrophe, this isn't always the case, he said. He advises having backup generators in place.

Temporary structural supports, like four-by-four beams, should also be on hand, said Mr. Oklesen. The beams can shore up facilities and protect them from further damage.

"You want to get back into operations are quickly as possible," said Mr. Oklesen. Because of the demand for reconstruction services after a catastrophe, Mr. Oklesen said that risk managers should contract for repair services in advance as a means of ensuring that operations will resume as quickly as possible.

The speakers offered a series of specific recommendations and reminders regarding various catastrophes. For example, although the California earthquake exposure has received considerable attention, such disparate cities as Salt Like City and Charleston, S.C., also are in earthquake-prone areas.

Mr. Oklesen pointed out that if there is one type of catastrophe that demands immediate attention more than any other, that catastrophe is flooding. Flooding means more than inundation of a facility with water; it also means mud, silt and possible contamination of goods, he said.

Mr. Tuman also noted that hurricanes can lead to contamination. For example, high winds and water can sprinkle roof insulation into the products stored below.

Mr. Oklesen also advised risk managers to avoid attempting to thaw frozen pipes with a torch during a spell of extremely low temperatures. If a fire breaks out, there is a good chance that there will be no unfrozen water with which to put it out, he said.

The session was moderated by Georges Balcer, director of risk management for Stone Container Corp. in Chicago. ■

Spotlight report

Stumbling blocks to hazard communication

Employee involvement advised

ANAHEIM, Calif.—Risk managers must understand what motivates their workers in order to create a successful hazard communication program, a workplace safety expert says.

A successful program will allow for smooth communication of workplace hazards, whether notification of these exposures is initiated by management or by workers, said Philip E. Ulmer, advisor-health and safety for ARCO Alaska Inc. in Anchorage.

But first, risk managers must understand changes in worker motivation that have taken place in the past 25 years, Mr. Ulmer said during a session at the 30th annual Risk & Insurance Management Society conference.

Most of today's employees entered the workforce in 1965 or later, Mr. Ulmer noted. These workers' "motivators" are very different from the typical motivators of earlier workforces, he said.

"Prior to the mid-1960s, management used a carrot and stick approach to encourage" workers to maintain a hazard-free work environment, Mr. Ulmer said.

However, employees no longer feel the same loyalty to their employer and their respect for authority has "gone out the window," he said.

Today, employees are "more concerned with lifestyle and longer free hours," he said.

Previously, a manager could simply "tell employees, 'Don't have an accident,' and expect none to be reported," Mr. Ulmer said. If an accident did occur and was actually reported, the injured employee could expect "individual retribution" and "blacklisting," he said.

Employees now hold management accountable for an "atmosphere" that prompts people to make right decisions, he said.

Employees today also possess a "group instinct," according to Mr. Ulmer. They "feel the need for witnesses" as a result of "a lack of trust in management," he said.

As a result, relying on employees to individually notify management of hazards "tends not to work," Mr. Ulmer said. Instead, "overt problems are best reported in a group format," he said.

Information from workers about workplace hazards must be allowed to work its way up the ladder, and management must be responsive to that information, Mr. Ulmer said. Risk managers should especially watch out for problems created by middle managers, he said.

Middle management tends to filter information, whether from above or below, acting as "a bump in the road for up-and-down communication," Mr. Ulmer said.

Another barrier to effective hazard communication can be the job performance evaluation system. If performance reviews are tied to the accident history of an employee or a supervisor's employees, management will effectively dissuade employees from reporting accidents, Mr. Ulmer warned.

Hazard communication programs have a "notoriety for being completely successful or needing to be dumped" altogether, Mr. Ulmer noted.

To avoid falling into the latter category, he offered the following guidelines:

- A hazard communication program should be written in a simple, understandable manner and should be bilingual, if so necessitated by the composition of the workforce.

"Many successful programs are written at the eighth grade reading level," Mr. Ulmer noted. However, managers unsure of their workers' reading levels should aim for a fourth grade reading level to make sure everyone understands.

Workers who cannot read must have the program read to them, he added.

- The program should include a clear definition of what constitutes a hazard.

Mr. Ulmer cited an unnamed Fortune 500 company's program as an example of how *not* to define a hazard. The company, he said, had defined a hazard as "a workplace condition that leads to or has resulted in a traumatic injury."

"This says, 'Wait until you are injured before you report' dangerous conditions," Mr. Ulmer said.

- Use an objective technique to determine whether a hazard exists.

Employee complaints are likely to be subjective, Mr. Ulmer noted. The employee "thinks" something is not right or "feels" certain symptoms when he or she is at work.

Likewise, a manager may be tempted to make a subjective analysis and decide that he or she "thinks" it is all in that employee's head.

Allen G. Macenski, manager of the applied sciences department at CH2M Hill, an environmental engineering consulting firm in Santa Ana, Calif., also spoke at the session.

Dave Fisher, the risk and benefits manager at Mitsubishi Electric America Inc. in Cypress, Calif., acted as moderator. The coordinator was Judy T. Neel, executive director of the American Society of Safety Engineers, which co-sponsored the session.

—By Sara J. Harty

Pollution coverage in Europe is scarce

Emphasis placed on risk control

By GAVIN SOUTER

ANAHEIM, Calif.—Environmental pollution issues are a huge headache for many companies in Europe, and the pain may get worse before it gets better.

Government regulation and public opinion are elevating care of the environment to a top priority, and private industry must expect to pay for past pollution damage.

In addition, careful management of environmental risks is a necessity because insurance for pollution damage is scarce in Europe, a panel of experts say.

And where the coverage is available, stringent underwriting requirements are enforced, the panelists said at a session at the 30th Risk & Insurance Management Society conference.

The pollution problems already apparent in Western Europe have nothing on those emerging in Eastern Europe, said Paul York, vp-corporate staff, risk management and insurance at ABB Asea Brown Boveri Ltd. in Zurich, Switzerland, who moderated the session.

"If you look at Czechoslovakia, there is a town there where the life expectancy level has dropped to as low as 45 years, and that is purely because of pollution."

And in Russia, the Aral Sea has shrunk from being the second largest lake in the country to nothing much more than a trickle of water, he said.

"The lake is dead and it's all due to pollution."

Companies in Britain should be particularly concerned about environmental liabilities because of the Environmental Pollution Act 1990, said David Siesko, vp at General Environmental Management Corp. in Chicago.

The British law adopts the so-called "polluter pays" principle and requires companies to adopt stringent pollution control measures.

However, the poor state of the British economy is preventing companies from spending extra funds on the anti-pollution measures that are required by the law, Mr. Siesko said.

Authorities recognize the problems that companies face and are not currently enforcing compliance with the anti-pollution measures, but this stance is bound to change, he said.

"It will change and the change may come overnight and companies will be caught out."

To address the present and future problems of managing the environment, companies must develop their own strategies for managing environmental risks, said Andrew Hicks, managing director and chief executive of Bowring London U.K. Ltd.

"Environmental risks are ideal for the classical risk management approach of identify the hazards, assess the risk, eliminate and reduce the risk, and finance or insure the residual risk," he said.

However, the financing aspect is difficult because insurance for pollution damage is scarce, Mr. Hicks said. As a result, the emphasis must be placed on risk assessment and control, he said.

This is made more complex and difficult due to the mass of European Community legislation on the environment over the past 10 years, he said.

"In excess of 300 pieces of legislation have been processed in that time, ranging from the sulphur content of gas oils, to (chlorofluorocarbon) manufacture, to the quality of bathing water," Mr. Hicks said.

The financial consequences of not adequately meeting these requirements is severe, he said.

Companies can face the loss of production if a plant is shut down for non-compliance with environmental regulations; sales can drop if the public, which is growing more environmentally aware, deems a firm to be environmentally irresponsible; companies may find that the cost of decontaminating polluted land is more than the value of the land itself; and cleanup costs can be staggering, Mr. Hicks said.

The strategies that companies adopt to cope with pollution problems should become part of their corporate philosophy and should emanate from top management, he said.

As part of its strategy, a company should regularly audit the performance of its environmental policy, and it should monitor any improvements, according to Mr. Hicks.

Companies also should not fail to investigate their sites now for fear of what they may find, he said. "If you investigate now, you benefit because if you know the extent of the problem, if one exists, you can develop a reasoned approach to resolution of the problem. And, the timing and expense is under your control rather than imposed on you."

The few underwriters that do offer gradual pollution coverage should be equally careful when they are underwriting the policies, said Juerg Spuehler, vp,

Continued on next page

Federal-level oversight of insurance industry is inevitable: Lobbyists

Insurer failures raise questions

By JERRY GEISEL

ANAHEIM, Calif.—It is only a matter of time before Congress enacts legislation to regulate the solvency of insurance companies at the federal level, several insurance industry lobbyists say.

"I think it is a less question of whether we will see federal regulation of insurance, but when," said Barbara Haugen, director-federal affairs with the National Assn. of Insurance Brokers in Washington, D.C.

"I strongly believe some form of federal regulation is inevitable. It only is a question of when," said Laurie Londoner, vp-government and industry affairs with Alexander & Alexander Inc. in Washington, D.C.

Speaking at the Risk & Insurance Management Society conference, Ms. Haugen identified several forces fueling the drive for federal solvency regulation:

- The interest of John Dingell, D-Mich., who is chairman of the House Energy and Commerce Committee, in federal solvency legislation.

Rep. Dingell's staff currently is drafting comprehensive solvency legislation that is expected to be introduced soon in the House (see story, page 1).

- The worry of other members of Congress that the failure last year of Executive Life Insurance Co. and the state takeover of Mutual Benefit Life Insurance Co. is indicative of the weaknesses of state regulation.

"The failure of Executive Life, coupled with problems at Mutual Benefit, triggered a whole new set of questions about how well the states regulate the business of insurance," Ms. Haugen said.

- The support from a number of trade groups—including RIMS, the American Insurance Assn. and the Insurance Solvency Coalition, a group of brokers, insurers and policyholders—for some type of federal solvency regulation.

Earlier this month, RIMS released a policy statement calling for federal regulation of property/casualty insurers writing coverages for large commercial policyholders (*BI,* April 6).

An AIA proposal would allow all insurers to opt for federal regulation, while the ISC plan would allow only large commercial insurers to choose federal regulation (*BI,* Feb. 3).

"Key segments of the industry support some role for the federal government in regulation. The individual states have a limited ability to regulate a global insurance industry," Ms. Haugen said.

At the same time, public anger over the savings and loan fiasco is pushing Congress to act before problems develop in another financial services industry, said Peter Lefkin, vp of government and industry affairs in the Wash-

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Pollution coverage

Continued from previous page

product coordinator-casualty at Swiss Reinsurance Co. in Zurich, Switzerland.

In fact, the risks of providing pollution coverage may seem so extreme that it is questionable whether an insurer or reinsurer should offer any coverage, he said.

"In my view it is a true challenge to the reinsurance underwriter," Mr. Spuehler said.

The nature of environmental risks makes them difficult to assess, he said.

For example, the claims are spread out and increase gradually; the pollution is often not restricted to its source and it can be carried long distances through the air, water or soil; and the risks are dynamic and are constantly changing for technical, legal and social reasons, Mr. Spuehler said.

Because of these difficulties, few insurers offer gradual pollution coverage, which pushes premiums rates up, he said.

Those underwriters that do offer coverage will continue to do so only if they are confident that they are able to adequately assess the risks, Mr. Spuehler said.

"There must be a good relationship between the policyholder and the insurer, and it must be a long-term relationship," he said.

If the insurer and policyholder can agree to at least a three-year policy period, the insurer benefits from guaranteed premium volume, Mr. Spuehler said. And, the policyholder benefits by avoiding wild fluctuations in price from year to year.

Underwriting the coverage is a three-part process: risk assessment, wording the policy and rating the risk.

The risk assessment begins with a questionnaire for the potential buyer. "This indicates to us whether the risk is insurable and, if it is, we can offer tentative, non-binding quotes," Mr. Spuehler said.

The insurer next conducts a site survey to more accurately assess the risk, he said.

The wording of the policy must be carefully drafted so that the risks are specifically defined, Mr. Spuehler said.

"The environmental impairment events must be defined very carefully because the underwriter does not want to pick up ecological losses on property not owned by the insured," he said.

The policy also must contain a precise definition of what sudden and accidental pollution and gradual pollution mean, Mr. Spuehler said.

The rating of the risks must be based on a policyholder's exposures rather than past experience, he said.

"Things are changing so quickly and experience does not take account of what will happen in the future," Mr. Spuehler said.

The session was coordinated by Myra Tobin, managing director of Marsh & McLennan Inc., New York. ■

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ington, D.C., office of Fireman's Fund Insurance Co.

"Having taken so much political heat for being asleep at the switch for its failure to prevent the savings and loan debacle, Congress is loathe to make the same mistake twice," Mr. Lefkin said.

"Obviously, the financial condition of the insurance industry is far more sound than the S&Ls'. Nonetheless, many in Congress are unconvinced and even if the system is secure, they don't want to take the heat if something goes wrong."

While support for federal solvency regulation is increasing, no such legislation is likely to be passed soon, Ms. Haugen said.

"The earliest I think we will see action on a bill to create a federal insurance regulatory agency will probably be the end of the next Congress, which runs from 1993 through 1994."

Even if legislation is enacted within two years, it would take several years for a new federal regulatory agency to get up and running.

This relatively slow legislative track is probable for several reasons, even as support for federal solvency regulation increases, Ms. Haugen said.

While support for a federal role is rising, a consensus has not been reached on the extent of the federal role, Ms. Haugen explained, noting the differing positions on federal regulation taken by RIMS, the AIA and the ISC.

At the same time, any proposal could be slowed down by stiff opposition from a number of other trade groups, including the Alliance of American Insurers, the National Assn. of Independent Insurers, the American Council of Life Insurance and several agents' associations.

To defuse that opposition, backers of federal regulation will have to trade away specific provisions to win support of an overall plan.

"The initial proposal will have lots more bells and will be far more detailed than any bill that gets finally enacted. Unlike tax bills that turn into Christmas trees with every member of Congress adding a favorite provision, a proposal to enact a federal regulatory agency will have to be pared down to win enough support for enactment," she said.

For now, though, the immediate focus will be on the upcoming Dingell solvency legislation.

Ms. Haugen said her best guess is that the proposal will give insurers the option to choose federal or state regulation.

At the same time, the proposal will include provisions for federal regulation of reinsurance and will attempt to regulate offshore insurers.

"I also think it will set minimum standards for state regulation and will aim at a national system for liquidating insolvent carriers," she said.

Turning to another issue, Ms. Haugen says enactment this year of legislation that would remove several key insurance industry exemptions from federal antitrust law under the McCarran-Ferguson Act is all but out of the question.

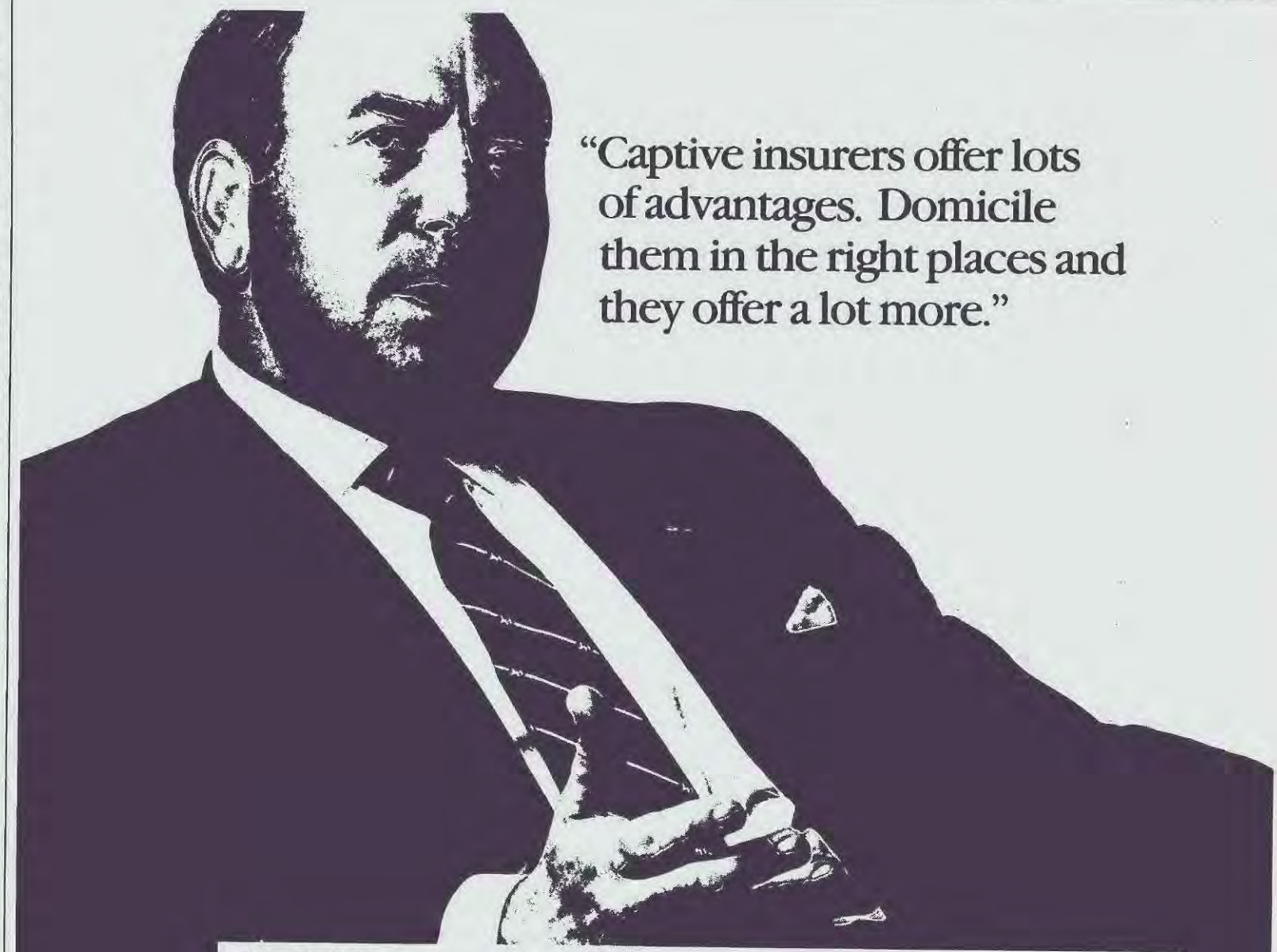
That proposal, H.R. 9, was introduced by Rep. Jack Brooks, D-Texas, and cleared the House Judiciary Committee last year.

"We think it could pass (the House), but there is no widespread support in the Senate," Ms. Haugen said.

The entire insurance industry opposes the bill, she pointed out. Among other things, insurers say the bill throws into doubt whether they or advisory rating groups—without fear of triggering antitrust litigation—can jointly trend loss data (*BI*, Nov. 25, 1991).

Still, while the industry opposes the Brooks bill, many insurers would support scaling back the McCarran-Ferguson Act because it draws so much criticism from consumer groups, Mr. Lefkin said.

The session was moderated by Stephen M. Wilder, assistant treasurer-risk management at The Walt Disney Co. in Burbank, Calif. It was coordinated by W. Lee Carter III, vp and director of research and development with A&A in Dallas. ■



Spotlight report

Groups stake out positions in federal regulatory debate

House staffer expects release of legislative draft soon, although there may be no action before November

By MARK A. HOFMANN

ANAHEIM, Calif.—A draft of a congressional proposal for federal regulation of insurer solvency will probably be released in the next few weeks, says a Capitol Hill staffer.

John B. Chesson, counsel to the U.S. House of Representatives' Subcommittee on Oversight and Investigations, said that his "best guess" is that a draft of a federal solvency law will be issued this spring, though he was not certain whether action would be taken before the November elections (see story, page 1).

"If it doesn't pass this year, we'll have a running start" in 1993, predicted Mr. Chesson.

And if a major insurance company fails in the near future, congressional attention will focus even more sharply on the matter, he said.

Mr. Chesson made his predictions during a discussion at the 30th annual Risk & Insurance Management Society conference.

Maurice W. Slayton, president and chief executive officer of Conning & Co., a Hartford, Conn.-based consultant, agreed that the federal government is likely to get involved in solvency regulation, which has been reserved to the states since 1945 by the McCarran-Ferguson Act.

"The insurance industry is responding to the threat of federal intervention in regulating solvency," he said. But Mr. Slayton added that the solvency agenda drawn up by the National Assn. of Insurance Commissioners "faces many hurdles and it seems likely that the federal government will probably have a role in regulating the industry."

Mr. Slayton predicted that any federal authority would be phased in over several years.

The insurance industry itself is divided over both the desirability of a role for the federal government and the shape that role should take.

For example, the American Insurance Assn. has come out in favor of a two-tiered approach in which insurance companies could choose to be regulated by the federal government.

The federal authorities would have the power to regulate some personal lines insurance companies (*BI*, Feb. 3).

Another less formal organization—the Insurance Solvency Coalition—would limit federal regulation to solvency only, and to "large" commercial insurers only.

The ISC—which currently consists of three national insurance brokerages, American International Group Inc. and Dow Chemical Co.—advocates leaving the regulation of small insurance companies and personal lines companies in the hands of state regulators.

Although the National Assn. of Insurance Brokers has not developed a formal position, it would support a federal role to improve solvency regulation, said Robert J. Murphy, president of the Washington, D.C.-based trade group.

The NAIB may announce a position next month, added Mr. Murphy, who is also a senior vp at Alexander & Alexander Inc. in Lyndhurst, N.J.

According to Mr. Murphy, at least two other trade groups—Independent Insurance Agents of America and National Assn. of Casualty & Surety Agents—have expressed a willingness to consider a federal role.

But strong opposition to federal solvency regulation remains from two major insurance company groups: the Alliance of American Insurers and the National Assn. of Independent Insurers.

One group that endorses the general concept of federal solvency regulation but has not endorsed a specific plan is RIMS itself (*BI*, April 6).

Lucille A. Gallagher, RIMS vp-government affairs and moderator of the session, said that the trade group will probably announce a formal proposal in the near future. Ms. Gallagher is also vp-risk management of Montfort Inc. in Greeley, Colo.

RIMS announced its support of federal solvency regulation in principle later during the conference. The announcement, made by President Robert W. Esenberg, endorsed neither the AIA nor ISC proposals.

Mr. Chesson, who works with House Energy and Commerce Committee Chairman John Dingell, D-Mich., said that Rep. Dingell believes "that to say the federal government has no role in (solvency regulation) doesn't make sense."

State regulation seems incapable of dealing with insolvencies of the magnitude of those currently rocking the industry, like the failure Executive Life Insurance Co., Mr. Chesson said.

"The old system just isn't working the way it ought to," said Mr. Chesson.

He made clear, however, that Rep. Dingell is not out to junk the current regulatory system.

"There's got to be some legitimate way state governments and federal government can work together," said Mr. Chesson. He repeated that it is not Rep. Dingell's view "that state regulation should be eradicated."

Looking ahead, Mr. Chesson said that in addition to drafting some sort of federal solvency re-

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John B. Chesson, Maurice W. Slayton, Robert J. Murphy and Lucille A. Gallagher discussed the route that federal regulatory proposals could take.

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gulation, Congress would be examining a number of insurance-related issues during the next year.

The investigations subcommittee, for example, held hearings on the adequacy of state regulation last week.

Mr. Chesson added that the subcommittee should begin examining the role of insurance holding companies in May or June. There will also be an examination of the impact of European economic integration sometime in the future.

Late this year or early next, the subcommittee will hold hearings on reinsurance subjects, said Mr. Chesson.

"We've learned reinsurance is the key to the primary insurer (paying) its claim," Mr. Chesson said.

He also cautioned his audience not to underestimate Rep. Dingell's interest in insurance solvency.

Rep. Dingell is "very, very vigorous on this issue and I can assure you that it's not going to go away," said Mr. Chesson.

Anne O. Riser, director of member services for the NAIB in Washington, D.C., served as session coordinator. ■

Progress unlikely on solvency laws, say panelists on insurance TV show

ANAHEIM, Calif.—The short-term prospects for federal solvency regulations are dim, according to panelists on a segment of "The Premium Dollar Today."

Attendees of the 30th annual Risk & Insurance Management Society conference were admitted to the taping of the segment in the Anaheim Convention Center.

George Bernstein, a Washington, D.C., attorney and former regulator, predicted there would be no congressional action on federal solvency regulation this year. "No one ever lost money underestimating the courage of Congress," he said.

Philip F. Petronis, managing director of Marsh & McLennan Inc. in New York, agreed with that assessment. He added, however, that a major insolvency in 1992 could spur Congress to act.

Kathleen Walters, director of risk management and insurance for Temple University in Philadelphia, predicted that the November election will bring changes to Congress as incumbents are defeated or choose to retire.

Regardless of what happens in Congress, Ms. Walters said the most important thing to her as a risk manager is an assurance that the insurer with which she deals remains solvent.

The episode dealing with solvency regulation aired April 7 on the USA cable network.

"The Premium Dollar Today" is sponsored by Reliance National Insurance Co. in association with the Society of Chartered Property & Casualty Underwriters, KPMG Peat Marwick Financial Services and A.M. Best Co. RIMS was a co-sponsor of this particular segment.

Business Insurance provides special editorial assistance to the series.

—By Mark A. Hofmann

Credit, political risk coverage to be used only as 'last resort,' panelists advise

Instead, multinationals must limit risks

By GAVIN SOUTER

ANAHEIM, Calif.—Risk managers should implement several strategies to protect their worldwide credit and political risk exposures since finding coverage for these risks is difficult, a broker and underwriter advise.

But, the coverage will be an integral part of multinationals' insurance programs by the beginning of the next century, an insurer executive predicts.

Various credit and political risks can threaten companies' investments abroad, noted Jacqueline Deane, regional manager for trade and political risk with American International Underwriters North America Inc. in San Francisco.

Those risks include: confiscation, expropriation, nationalization, deprivation and selective discrimination; war and terrorism; currency inconvertibility; non-payment of accounts; wrongful calling of standby letters of credit; export and import embargoes; and forced divestiture in companies.

But several risk management strategies can be adopted to curtail the risks, Ms. Deane said in a session during the recent 30th annual Risk & Insurance Management Society conference.

For example, companies can avoid trading with or establishing subsidiaries in high-risk countries.

"This works, but if you have subsidiaries anywhere overseas, in the long term you can get caught. You only have to look at the Philippines to see how quickly things can change," Ms. Deane said.

Companies also can ingratiate themselves with a government before setting up operations there by explaining that they will be contributing to the country's economy as well as providing employment and job training.

"This is usually a safer bet, but if, for example, the government of the country is taken over by religious fanatics, they might not think that you are acting in their people's best interests," Ms. Deane said.

To reduce these risks further, companies should ensure that they spread their risks and do not have all of their foreign subsidiaries in one country, Ms. Deane said.

One of the most effective ways to reduce risks is to obtain a sovereign immunity waiver from countries where governments might renege on commercial agreements, said David Forrest, managing director of broker Fenchurch Special Risks Ltd. in London.

"This enables you to bring a government to your agenda," Mr. Forrest said.

Such a waiver would allow assets of that country that are located in countries friendly to the policyholder's government to be seized in lieu of uncollectible promised payments, he said.

"You can persuade them to grant a sovereign immunity waiver by saying, 'If you really,

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really mean to pay us, you won't mind, or if you do mind, then do you really really mean to pay us,' " Mr. Forrest said.

Alternatively, risk managers can barter with governments that are unlikely to have the funds to pay their company and accept goods that are readily convertible to cash elsewhere, he said.

If this is not possible, then risk managers should ensure that they can arbitrate with their trading partners, Mr. Forrest said.

"When all else fails, make sure you have a good arbitration clause and then insure against that not being honored," Mr. Forrest said.

This coverage is a last resort, because claims are not usually paid quickly.

However, it is a good "long-stop provision," Mr. Forrest said.

Mr. Forrest and Ms. Deane also offered suggestions for obtaining the little credit and political risk coverage that is available in the market today.

When companies buy credit and political risk insurance, they should separate their risks into goods and services, Mr. Forrest advised.

"Services should be short-term and provided on a monthly basis, so if you don't get paid, you just stop work. This is much cheaper than buying insurance," he said.

Trade between the parent company and its foreign subsidiaries should be eliminated from the coverage, since this trade should involve no risk, Mr. Forrest said.

Export trade usually can be insured by government agencies, but to cover the more volatile remaining risks, risk managers have to go to the commercial insurance market.

But, "at this stage, we are looking at the thin edge of the wedge," he said.

The exposures often are high risk, and it is difficult for a broker to persuade an insurer that they are worth underwriting.

Consequently, there are only about six players in the market, and they are all struggling to make an underwriting profit on their political risk and credit business, he said.

But, by underwriting worldwide coverage, underwriters see that they have a chance to make a profit, and the coverage will be more cost-effective for risk managers, Mr. Forrest said.

If an underwriter is only presented with risks in politically volatile countries, the underwriter will charge an exorbitant premium.

But if operations in less risky countries are included, the premium will be more reasonable, he said.

In the same way that risk managers insure all of their buildings against fire damage, they should insure all of their foreign trading units for credit and political risk under a global program, Ms. Deane agreed.

The folly of buying credit and political risk coverage for only "high-risk" countries was shown during the Persian Gulf War, she said. "Kuwait was a small, friendly country; it was pro-United States; rich; and there was thought to be no political risk in Kuwait."

As a result, the only AIU policyholders that were covered for political and credit risks in Kuwait at the time of the war were those that had bought coverage on a worldwide basis, Ms. Deane said.

"What I try to get through to people is that I do not have a crystal ball, and I do not know which country will have the next political crisis," she said.

Although credit and political risk insurance has been available since the 1970s, trading companies do not automatically buy it, Ms. Deane said.

And, those companies that buy coverage are mainly insuring individual contracts rather than their worldwide operations, Ms. Deane said.

The folly of buying credit and political risk coverage for only 'high-risk' countries was shown during the Persian Gulf War, says Ms. Deane. 'Kuwait was a small, friendly country; it was pro-United States; rich; and there was thought to be no political risk.'

But, this approach is gradually changing.

"Within the next 10 years, most multinational companies will buy worldwide blanket coverage for their credit and political risks," according to Ms. Deane.

These policies offer protection in six main areas:

- Equity in foreign subsidiaries.
- Inventory located in foreign countries.
- The ability to remit profits and dividends.
- Accounts receivable.
- Standby bank letters of credit issued as guarantees.
- Revenues.

The session was moderated by John Pinner, assistant treasurer at Mattel Inc. in El Segundo, Calif.

Susan Randall, vp and political/credit manager at Rollins Burdick Hunter International Inc., in Universal City, Calif., coordinated the session. ■

Spotlight report

More suits against executives expected

New laws broaden officers' liability

By JOANNE WOJCIK

ANAHEIM, Calif.—Risk managers must protect corporate executives from exposures that extend beyond the typical directors and officers liability risk, D&O experts say.

Juries angered by the wealth differential created by "Reaganomics" increasingly are awarding huge sums to victims of corporate decisions, said William D. Smith, president of National Union Fire Insurance Co. of Pittsburgh, Pa., a New York-based unit of American International Group Inc.

And, newly enacted federal laws, like the Americans with Disabilities Act and the Civil Rights Act of 1991, will make it easier for workers to sue their employers for discrimination, wrongful termination and sexual harassment, among other things, pointed out Corbette S. Doyle, senior vp at Willis Corroon Corp. in Nashville, Tenn.

Furthermore, corporate board members are increasingly targeted in Securities and Exchange Commission litigation charging mismanagement, conflict of interest or self-dealing, observed Ray Hodges, vp and risk manager at National Medical Enterprises Inc. in Santa Monica, Calif.

However, some insurers are introducing new coverages to protect corporate executives from such exposures, Ms. Doyle assured risk managers attending a session at the 30th annual Risk & Insurance Management Society conference.

The current economic downturn is contributing to the recent surge in lawsuits filed against corporate executives, according to Mr. Smith of National Union. "The fact that virtually all cases filed against executives are in urban areas spells difficulty for corporate executives perceived as 'rich' by juries angry with the wealth differentiation."

Ms. Doyle agreed: "A lot of executives can be characterized as Michael Milken, especially if the jury members make as much money as the maid of the executive on trial."

Mr. Milken, a former official of New York-based securities firm Drexel Burnham Lambert Inc., was sued by numerous individuals, companies and government entities for fraud, negligent misrepresentation and breach of fiduciary duty, among other things. Insurers are expected to contribute about $100 million of a proposed settlement of the civil suits against Mr. Milken, who also was convicted on six counts of securities-related violations and is serving a 10-year prison sentence (*BI*, Feb. 24).

Furthermore, what corporate executives know about their business can hurt them when they serve on outside boards, according to Mr. Smith.

One case that could spell trouble for corporate executives is a June 1991 U.S. Supreme Court ruling involving Virginia Bankshares, which was sued by shareholders who alleged their stock was undervalued in a majority buyout.

In that case, which was dismissed at both the trial and appellate court levels, the Supreme Court found that corporate board members had sufficient financial expertise to know that an outside analyst's valuation of the minority shareholding was too low, Mr. Smith said.

As a result of this ruling, corporate executives who serve on outside boards "will be held to a higher standard, especially if they are a 25-year CFO at another company," he said.

D&O liability is expanding beyond the traditional D&O risk, agreed Willis Corroon's Ms. Doyle.

For example, while corporate boards usually have a fiduciary duty to shareholders, there is an increasing trend for courts to say they also owe a duty to creditors, she said. "If a company is on the verge of insolvency, the corporate board must consider both the long-term and short-term owners of the company."

In addition, the personal assets of corporate executives serving on outside boards are likely to be targeted in D&O litigation following the precedent set in the Milken case, Ms. Doyle said.

But, at least four new insurance products have been introduced in the last month that can protect corporate executives from broader exposures, she noted.

For example, Chubb & Son Inc. and AIG unit Lexington Insurance Co. recently began offering "Employment Practices Liability Insurance." These policies are designed to provide employers a defense and indemnification for unapproved acts by employees giving rise to discrimination, wrongful termination, sexual harassment and other claims by current or former workers or job applicants (*BI*, March 23).

Lexington's policy provides up to $5 million in primary or excess limits to pay for claims of discrimination, wrongful termination and sexual harassment. Chubb's policy provides up to $10 million in primary or excess limits to respond to those claims and others, including failure to promote, breach of employment contract and misrepresentation or defamation.

Wrongful employee termination was the most frequently cited source of a D&O claim last year, according to the annual D&O liability survey conducted by The Wyatt Co. (*BI*, Feb. 24).

In addition, Corporate Officers & Directors Assurance Ltd. of Bermuda will provide up to $25 million in primary or excess difference-in-condition coverage through an endorsement that covers corporate executives serving on outside boards, Ms. Doyle noted.

Aetna Casualty & Surety Co. of Hartford, Conn., provides $30 million of excess DIC coverage with its broad form D&O liability policy, she confirmed.

Mr. Hodges of National Medical Enterprises moderated the session. Ms. Doyle coordinated the session. ■

Looking beyond insurer ratings

Risk managers must decide for themselves, broker says

By JUDY GREENWALD

ANAHEIM, Calif.—Risk managers must be savvy about rating agencies' perspectives when evaluating their insurer ratings, and then make their own decisions, a brokerage executive advises.

For instance, A.M. Best Co. rates policyholder confidence and an insurer's ability to pay claims in addition to other quantifiable and qualifiable factors, said Richard A. Riley, president of Chicago-based Rollins Burdick Hunter Co.

But one of Best's primary functions is to keep insurers in business and avoid insolvency, he said. While this is admirable, with this perspective, "you may not be reacting as quickly to bad situations as you might otherwise," Mr. Riley said.

On the other hand, other rating agencies, including Standard & Poor's Corp. and Moody's Investors Service Inc. in New York and Chicago-based Duff & Phelps Inc., stress quantifiable data and "they could tend to overreact to numbers," he said.

Mr. Riley discussed rating agency perspectives during a session at the 30th annual Risk & Insurance Management Society conference.

In evaluating an insurer's ratings, Mr. Riley said that risk managers should also be aware that identical ratings from different agencies could mean quite different things.

For instance, Best says it gives its "A" rating, its third-highest mark, to companies that have a "strong ability to meet their policyholder and other contractual obligations over a long period of time."

But S&P, where an "A" is only the sixth-highest mark, says it gives this rating to insurers whose "capacity to meet policyholder obligations is somewhat more susceptible to adverse changes in economic or underwriting conditions than more highly rated insurers."

Furthermore, there are some significant differences in the distribution of ratings by major rating agencies, said Mr. Riley.

Best, for instance, gives a rating that is the equivalent of "good" or "better" to 79% of the life and health insurers it rates, while 95% of S&P's ratings and 93% of Moody's for the life and health insurers they rate are considered "good" or "better."

Mr. Riley also discussed a Best study of the ratings it gave insurers that became insolvent from 1969 through 1990. Forty-five of these companies received an "A" rating three years before their insolvencies, according to Mr. Riley. Forty-one were rated "A" two years prior to their insolvencies, while 26 still had an "A" rating one year prior, and six were still rated "A" the year they became insolvent.

Although on the face of it, six may look good, "that's not really good enough," he said.

Rating agencies that downgrade an insurer face the potential problem of creating a "run on the bank," which was considered one factor in Mutual Benefit Life Insurance Co.'s problems, acknowledged Mr. Riley (*BI*, July 22, 1991). "It just starts to pyramid and becomes self-fulfilling."

Look at the data and weigh it yourself, he advised risk managers. No one, including the broker, is likely to come right out and say, "Get your business out of there; this company's becoming insolvent," said Mr. Riley. Risk managers must make the decision themselves.

There is a pattern in insurer failures, he said. Most come right at the end of a soft cycle, which means now "is the time to be very careful," he said.

In 1975, for instance, just before the hard market, there were 29 insolvencies, while there were only nine in 1974 and eight in 1976. And in 1985, there were 49 insolvencies, compared with 26 in 1984 and 25 in 1986. The insolvencies in 1975 accounted for 1% of all property/casualty companies, while they amounted to 1.4% of the total in 1985.

To the extent that there is an insolvency problem, risk managers who chase the lowest price contribute to it, said Russell Miller, chairman of San Francisco-based Russell Miller Inc., an investment banking firm specializing in insurance.

Mr. Miller contended that risk managers contribute to the problem of insolvencies when, given a choice between obtaining a policy from the Travelers Insurance Co. or the Hartford Insurance Co. for $375,000 or "Sleaze Mutual" for $26,400, they pick the latter.

One way to avoid a problem is to pick a large insurer, which is much less likely to go out of business, Mr. Miller said. Risk managers should also avoid companies that are broker controlled, he said.

Urging risk managers to keep their eyes and ears open, Mr. Miller added that there are few insolvencies where "there's not a lot of stuff in the press" and a lot of talk about a company's imminent demise beforehand.

Also, "Go get the primary source," the convention statement the insurer files with state regulators, said Mr. Miller. Even companies that try to be deceptive have to report their reserve information on Schedule P, and problems can be detected by analyzing this data, he said.

There are other signs as well. Mission Insurance Co., for instance, wanted to write a lot of business in the last few years before it failed, Mr. Miller said. To generate premium volume, it paid commissions to brokers even before they had written the business, he added.

"That ought to tip off even the dimmest of us," he said.

Also speaking at the session was Mark R. Goodman, an attorney with Lord, Bissell & Brook in Chicago. The session was moderated by Mike Kelly, director of risk management at Secomerica Inc., in Newport Beach, Calif. The coordinator was John F. Roskopf, vp of Rollins Burdick Hunter. The session was presented in cooperation with the National Assn. of Insurance Commissioners. ■

Catastrophe coverage: A matter of survival

All companies need it, experts say

By GAVIN SOUTER

ANAHEIM, Calif.—Catastrophe insurance has one overriding function: ensuring corporate survival.

The amount of high excess liability coverage purchased varies from company to company, but some type of catastrophe coverage should be included in all insurance programs say several insurance experts.

With so much at stake, companies should take great care in evaluating their exposures and structuring their catastrophe programs, panelists said in a session titled "How High is Up? Evaluating Limits" at the recent 30th annual Risk & Insurance Management Society conference.

"In some cases companies become insolvent because they did not buy enough insurance coverage, and in other cases risk managers lose their jobs if the company survives but they are blamed for not buying enough coverage," pointed out Robert Lehmann, director of risk management at Coca-Cola Enterprises Inc. in Atlanta.

To prevent either possibility, he advises buying catastrophe insurance for automobile, general liability, product liability, directors and officers liability and any other liability exposures that could lead to a huge loss.

When deciding on limits, risk managers should consider both foreseeable and unforeseeable losses, Mr. Lehmann said.

One factor to consider when calculating foreseeable losses is the size of court awards handed down in various jurisdictions.

To cover unforeseeable losses, consider how much the company can afford to lose, Mr. Lehmann advised. "What you are trying to do is save the corporation, not premium dollars."

In the event of a catastrophic loss, risk managers should take charge, he said.

"If someone does not step up. . .the group will gravitate toward the most optimistic outlook, and they will not anticipate the catastrophic losses," Mr. Lehmann said.

When settling catastrophe claims, he advised having local attorneys who have a good relationship with plaintiffs' lawyers conduct the negotiations.

The frequency and severity of large liability claims are increasing, pointed out Walter Scott, president and chief executive of ACE Ltd., a policyholder-initiated, high-excess liability insurer in Hamilton, Bermuda.

"Social inflation, where the value of a human life is held higher by society, and the sheer increase in business activity mean that the frequency of large claims is increasing," he said.

Manufacturers have suffered the most losses exceeding $30 million, he said. Many manufacturers face asbestos claims, loss-of-hearing claims and product liability claims, Mr. Scott said.

Ranking second among the industries with the most large liability claims is chemicals and pharmaceuticals. Next is the petroleum industry, followed by utilities.

Viewing claims in terms of severity alters the picture, he said. While manufacturers suffer the most catastrophe losses, those losses tend to be less severe than those in other high-risk industries, Mr. Scott said.

Chemical and drug companies have ' by far" the most severe catastrophe liability losses, he added.

Underwriters have a lot of difficultly underwriting the wide variety of catastrophe exposures, Mr. Scott said.

"No price is right. There is no way you will receive back from the insured in premiums the amount you pay for a catastrophe loss," he said.

For example, $130 million of high-layer catastrophe coverage could produce a premium of $440,000, he said. "Divide that and you see that it would take you 300 years to get your money back."

Consequently, Mr. Scott said, catastrophe insurance is insurance in its purest form: A lot of people pay a relatively small premium to cover the relatively small number of people who have a catastrophe loss.

ACE sets its prices by estimating how many policyholders will suffer a catastrophe loss in one year and what the costs of those catastrophes might total. Premiums are then fine-tuned to reflect the relative degree of risk in different businesses, he said.

Available liability catastrophe capacity varies between marine and non-marine risks.

About $500 million in catastrophe capacity is available in the non-marine market, according to Mr. Scott. That compares with about $800 million in the marine market.

When companies are deciding how much of that capacity they should purchase, they should first conduct an objective analysis of their operations, said Robert Hessel, senior vp at Becher & Carlson Risk Management Inc. in Marietta, Ga.

This should include an estimate of the 10 worst possible potential losses; consultation with legal, risk management and claims personnel; an analysis of previous losses and near misses; and an analysis of large losses suffered by companies operating in the same field, he said.

When deciding how much coverage to buy, companies should also consider the insurers they use and the type of coverage they need, Mr. Hessel said. "Always choose people who have been in the big-risk business for a while and who are used to writing your kind of exposures."

Mr. Lehmann moderated and coordinated the session. ■

Financial reinsurance buyer's motto: 'Be prepared'

Merrill Lynch official says homework paid off in choosing among 'spectrum' of products

By JUDY GREENWALD

ANAHEIM, Calif.—Homework is essential to successfully completing a financial reinsurance transaction, a risk manager contends.

"Know your risk very well," advised Carolyn Simpson, vp of corporate staff-insurance and risk management for New York-based Merrill Lynch & Co. Inc.

Ms. Simpson negotiated finite risk reinsurance for her firm's fidelity exposures with Bermuda-based Zurich International (Bermuda) Ltd., an affiliate of finite risk specialist Centre Reinsurance Holdings Ltd. (*BI*, March 30).

Homework also pays off when selling management on the idea of using a financial reinsurance product.

Thanks to 1½ years of preparation, "I went to the (chief financial officer of Merrill Lynch) and spent 20 minutes and had a 'yes,' " she said.

Ms. Simpson discussed placing financial reinsurance policies during a session at the recent 30th annual Risk & Insurance Management Society conference. Other speakers forecast growing popularity and acceptance of the products, particularly when the next hard market occurs.

One of the problems risk managers encounter in obtaining financial reinsurance is sorting through the many different types of programs, said Ms. Simpson, who also moderated the session. She defined financial reinsurance as "any reinsurance transaction in which anticipated investment income is considered, a dividend is payable for good loss history and the reinsurer's ultimate liability is capped."

There also is a full spectrum of "blended programs" that combine elements of financial reinsurance and traditional stop-loss coverage, she noted. These programs can be obtained directly by a corporation or as a reinsurance program fronted by a captive.

At Zurich International (Bermuda)'s request, Merrill Lynch's coverage was written as reinsurance, with the firm's Vermont-based captive, Investor Protection Insurance Co., fronting the program, she noted.

One of the first steps risk managers interested in financial reinsurance products should take is to identify the risks the company is looking to finance, Ms. Simpson said.

Analysis of historical data also is important, she said. In her case, she examined 10 years of historical data, including premiums, losses and paid claims. This analysis, she said, helped Merrill Lynch reach the conclusion that purchasing traditional reinsurance for its captive would not be cost-effective.

The next step, she said, was to approach brokers and/or consultants for help in developing a conceptual approach to a financial reinsurance deal.

Merrill Lynch found that the various proposals differed in form, substance and the amount of risk shifting involved, she said.

There was a "very, very extensive amount of time required to analyze the different options available to us," said Ms. Simpson. "You're going to get some very interesting ideas back."

After analyzing the options, the focus shifted to narrowing the field to two brokers to obtain competitive bids.

She noted that in Merrill Lynch's case, there had been a "false start" a year earlier, when it used the services of three brokers and three consultants working on the project. However, the company did not have a good indication of where it wanted to go, she said.

The second time around, though, Merrill Lynch had a better idea of what it wanted to do. "We found that we learned a lot each step of the way," she said.

'I went to the (chief financial officer) and spent 20 minutes and had a "yes," ' says Ms. Simpson.

Nevertheless, it took a lot of preparation just to contact the reinsurer, said Ms. Simpson, who estimated that 90% of the work was done before initially contacting Zurich International (Bermuda). Once that homework was accomplished, she said, discussions with the reinsurer "were the easiest part of the transaction."

It is important to involve a company's accounting, legal and tax personnel before committing to a deal, Ms. Simpson said. Unfortunately, she said, many officers will not be familiar with these products and will say finite risk transactions do not qualify as insurance or reinsurance.

This hurdle was overcome at Merrill Lynch by using its broker's help to recruit an outside tax attorney and by obtaining an outside law firm's opinion to demonstrate to in-house accountants and tax attorneys that the deal was viable.

Once this was done, everyone in the company was comfortable that there was "real risk-taking involved," said Ms. Simpson.

The creditworthiness of the reinsurer also is a significant factor, said Ms. Simpson. She noted that at the time of the transaction, Zurich International (Bermuda) was not rated, although it has since received a double-A rating from Standard & Poor's Corp.

As a result, there were several phone calls between Merrill Lynch's credit department and

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the reinsurer to make sure Merrill Lynch was "comfortable" with Zurich International (Bermuda)'s financial viability, said Ms. Simpson. It is possible in some cases, she noted, to guarantee the investment portion of a financial reinsurance contract through a letter of credit.

There are significant benefits to financial reinsurance vs. traditional reinsurance, according to Ms. Simpson. For one, most contracts return premiums for good loss experience and permit policyholders to share in investment income. Another is that it allows "income smoothing," permitting the policyholder to spread the shock of a large loss over several years, she said.

Terms of coverage are usually more flexible than those of traditional insurance, said Ms. Simpson, while the liability limits are higher than in traditional insurance.

Ms. Simpson said she found there were limits of up to $100 million available for a single risk. In a normal insurance program, to achieve these limits there would have to be multiple layers covered by different insurers, and there could be different terms of coverage within the various layers, she said.

The other major benefit to financial coverage is that if the loss experience is good, the long-term cost is "far cheaper" than it would be for traditional insurance, because the policyholder is sharing investment income plus receiving the return premium if there is good experience.

Ms. Simpson acknowledged in response to a question that she may have had an advantage as a risk manager for a financial services organization in obtaining approval and that an industrial firm could face some additional problems.

But, "if you start a year in advance, you can adjust that budget," she said.

Teresa Quarante, vp at Johnson & Higgins in New York, said financial reinsurance will grow increasingly popular among risk managers.

One factor for this growth, she said, is that the traditional insurance industry's capital and surplus may erode. Furthermore, there is a search for viable alternatives to pure self-insurance, which can create financial reporting concerns, said Ms. Quarante, who coordinated the session.

Another factor fueling the need for financial products is the growth of "uninsurable" liabilities like environmental liabilities, which could far exceed the traditional insurance industry's capital and surplus, she said.

"Business risks that are not really insurable can be covered under financial reinsurance arrangements," said Ms. Quarante.

There also is an awareness of the need for cost-effective alternatives to "insurable liabilities" in areas like directors and officers liability and workers compensation, she said.

Insurers that specialize in financial reinsurance are willing to put capital at risk "in a very large way in these transactions," said Ms. Quarante.

These insurers also are willing to take increasing amounts of risk, she said.

Like Ms. Simpson, Ms. Quarante also discussed how financial reinsurance enables policyholders to take advantage of favorable loss experience. In some of the older programs, she noted, this involves getting a check back. Now, however, this reward can take the form of higher future limits, lower attachment points and broader terms, she said.

Ms. Quarante noted that insurance buyers that do not actually use financial reinsurance can still benefit from it. This is because financial reinsurers are moving into areas like umbrella and excess liability insurance, and "traditional reinsurers will respond" to this competition, which will benefit the insurance buyer, she said.

"I think some variation of finite risk will be in almost every risk manager's future," assuming they believe in loss control, are financially strong and are willing to assume risk, said Robert J. Cooney, senior vp-underwriting/excess liability, at Bermuda-based X.L. Insurance Co. Ltd.

'I think some variation of finite risk will be in almost every risk manager's future,' assuming they believe in loss control, are financially strong and are willing to assume risk, says Robert J. Cooney of Bermuda-based X.L. Insurance Co. Ltd.

One source of this demand is the likelihood of a hard market, he said. "There are signs it will happen."

While there are not too many signs yet that the U.S. market is changing, the contraction in the London market will eventually filter down, he predicted. If that happens, and the market hardens, "alternative approaches will become much more appealing."

Yet another factor, he said, will be the degree of sophistication of risk management departments, their familiarity with risk financing techniques and their willingness to consider an approach that preserves capital.

Furthermore, said Mr. Cooney, "there should be a willingness to commit to a long-term relationship or partnership with an insurance carrier," he said. There should be a willingness to commit to a three- to five-year deal when looking at a blended approach, he said.

The next generation of financial reinsurance products, he said, will involve a blending of the mechanics of financial reinsurance, in which there has been little underwriting risk, with traditional reinsurance. This "combines the best of both worlds," said Mr. Cooney.

He added that the "secret" of all these deals is that they are tailor-made to suit the needs of the particular client. By blending, "you can really create a product that suits your particular needs," said Mr. Cooney.

Also speaking at the session was Joseph Sarosi, vp of Am-Re Managers, a unit of American Re-Insurance Co. of Princeton, N.J. ■

Picking right captive domicile is important

Sunshine and golf are no longer the major issues

By MICHAEL BRADFORD

ANAHEIM, Calif.—Companies considering setting up captives should decide how they want to use the facilities before they find a domicile.

Parent companies should not view a domicile as an exotic destination or a recreation spot, agree Edward S. Koral, vp at Johnson & Higgins Services Inc. in New York, and Virginia F. Tormey-Lawson, director-risk management at Pacific Telesis Group in San Francisco.

"I think the days are over where people say picking a captive domicile depends on whether you like to ski or sun or go golfing," Mr. Koral during a session at the recent 30th annual Risk & Insurance Management Society conference.

Instead, business considerations must now come first.

Each domicile has unique advantages and disadvantages, depending in part on the type of parent and the coverage that will be written, Mr. Koral said.

But, "picking a domicile can be a very tricky business," he said. "If you ask somebody in the United States how to pick a domicile, they will tell you that unless there's a compelling reason to go offshore, you should stay onshore. If you ask a Bermudian or Caymanian, they will say unless there is a really compelling reason for staying onshore, you should go offshore."

But, there are some guidelines to follow when investigating domiciles, Mr. Koral noted. He said parents should consider:

- That competition and marketing has become fiercer among domiciles and some managers will tout only those locations where they have operations.

"People are interested in getting you to the right domicile and then having you decide what kind of program you can put together based on (its) rules and regulations," Mr. Koral said.

"I think that's backward thinking. What you should really be doing is planning exactly what your program should do and then figuring out where your program should be."

- What coverages the captive will write.

Generally, any type of property/casualty business written for a single U.S. parent is well-suited for domiciles in the States, Mr. Koral said.

But, "if you're interested in writing non-parent business, generally those are the kinds of programs that will send something offshore," he said.

- The type of monetary transactions that are permitted by domicile regulators.

For example, many onshore domiciles permit captives to easily loan nearly all assets back to the parent.

But, such action is more complicated in some offshore domiciles because of restrictions on the transfer of funds across international borders.

"Lending money to the parent company is very important to many captives," particularly for small captives, Mr. Koral said.

- A captive's financial statements in many cases can be consolidated with its parent's if the captive is domiciled in the United States. "When you're dealing with a non-U.S. captive, it becomes foreign-source income" and subject to a complicated section of the U.S. tax code, Mr. Koral explained.
- Regulators' flexibility.

Regulators should be competent and willing to "listen to what you're trying to do and accommodate you—rather than going to a rule book and saying, 'You can't do this and we're not going to discuss it anymore,'" Mr. Koral said.

- The threat of political "instability" in a U.S. domicile if a new governor or insurance regulator who opposes captives takes office.
- Taxation.

Parent companies should investigate premium taxes, how their U.S. income taxes will be affected and any other pertinent tax considerations.

For example, one disadvantage of establishing an offshore captive is the possibility that the domicile may withhold tax on funds that leave the domicile.

- The strength of the local infrastructure.

"You also want to know that you'll be able to find competent accountants, captive managers, banks, lawyers and even things like hotels, which can actually swing the balance between a good captive domicile and a place people don't want to visit," Mr. Koral said.

But, staying onshore means that the captive can use existing banking relationships with the parent, Mr. Koral said.

- That an offshore captive has the advantage of easier access to worldwide reinsurance markets.

But, fax machines and modern telecommunications have just about put all domiciles on par in that regard, Mr. Koral noted.

- The threat of regulation, like the National Assn. of Insurance Commissioners proposal that could limit fronting arrangements (*BI*, April 6).
- In offshore domiciles, "the big advantage is that there are not that many rules about what you can and cannot do," Mr. Koral said.

Ms. Tormey-Lawson said that Pacific Telesis had a few questions when establishing a captive in Hawaii, including the state's commitment to captive business.

When reviewing locations, she looked closely at the state's potential to benefit from the captive industry. "Are they really going to get enough out of it to stay with it?" she asked.

Low fees and taxes in Hawaii "did cause me some concern," she said. But she became convinced the domicile was a good choice because of the governor's commitment and the fact that the state's economic plan considers captives a vital industry.

Ms. Tormey-Lawson moderated the session. Mr. Koral coordinated the session. ■

Audits serve as checkup for captives

By MICHAEL BRADFORD

ANAHEIM, Calif.—Auditing a captive insurer's operations gives the parent company a gauge to measure the captive's performance as well as a way to judge the captive manager's worth, according to a risk manager who keeps close tabs on four insurers.

"The annual audit should be a useful tool rather than just some perfunctory report that you have to generate and hope you get by all right," said Frank Ascollilo, director of risk management at Wang Laboratories Inc. in Lowell, Mass.

Regulators in a given domicile usually set some captive auditing requirements.

Mr. Ascollilo, who oversees the operations of Wang's two offshore and two U.S. captives, made his remarks during a session at the 30th annual Risk & Insurance Management Society conference.

Mr. Ascollilo said that "the primary role of an audit is to clarify any vague areas or areas where you have questions that aren't getting answered" by the captive manager.

And risk managers shouldn't hesitate to be clear about the services they need from a captive manager, said Roger C. Gillett, senior vp at Johnson & Higgins (Bermuda) Ltd.

Often, he added, captive parents aren't sure of what they should get out of an audit and don't ask enough questions or provide enough information beforehand.

Mr. Ascollilo said that in addition to an annual meeting held in the captive domicile, the risk manager should schedule "at least one operational visit just before the audit starts" to discuss areas that will be covered by the audit, which firm will be conducting it and how the process can be used to improve the captive's operations.

Face-to-face meetings let risk managers discuss the captive manager's role in the audit and judge the manager's ability to carry out the process, Mr. Ascollilo noted.

While an "external auditor" usually conducts the audit, Mr. Ascollilo urged parent companies to involve their internal auditing staff. If the captive is group-owned, each policyholder/owner should have its internal team participate, he added.

"They know you; they know your company and operations," Mr. Ascollilo said of internal auditors. "And they keep you consistent with the policies and philosophy of your company, your management, so that you don't get off on a tangent."

Among the things an audit should cover, said Mr. Ascollilo and Mr. Gillett, are:

- Expenses, both actual and budgeted.

Mr. Gillett said most captive owners don't properly prepare budgets during the course of the year and have nothing for auditors to cite during the audit.

- Receivables.

"One of the trickiest things in the world is to work with a captive management company when you're dealing with receivables," said Mr. Ascollilo.

While some captive managers may regard receivables as "just a book entry" that can be regarded as cash, the captive owner wants the money in the bank, he said.

Mr. Ascollilo advised risk managers to impress upon captive managers the necessity of being vigilant about turning the paper entries into actual deposits.

- Claims.

The audit should reveal not only claim amounts but where claims originated, said Mr. Ascollilo. That information, Mr. Ascollilo noted, can be used as a loss control tool that allows the risk manager to take steps to prevent claims from recurring.

- Reinsurance.

Detailed reports should be available from the captive manager regarding all reinsurance transactions "broken down into dollars and cents," according to Mr. Ascollilo.

Mr. Gillett said there are several functions that captive owners should expect and demand of the management company.

One is for the manager to be aware of new business sources for the insurer and to present new ideas to the parent, he explained.

He said captive managers "do have some things to offer" in the way of ideas on expanding a captive's operations. "We may give you a list of 10, and you may reject 9½ of them, but there is something to be said for at least going through the process as you would in any other business."

Captive managers also must be competent in handling tax matters, Mr. Gillett pointed out.

"It's very common for the captive manager to become complacent" and begin relying on direction from the risk manager in correspondence rather than taking charge on tax matters, he said.

A manager should be one that has "been involved in management of captives for some time. . .and understands this game and will document the files clearly" to indicate the captive's authenticity to tax authorities, Mr. Gillett said.

Choosing where to locate a captive depends on a number of factors.

A captive manager should let an owner know when it would be advantageous to locate the insurer in a different domicile, Mr. Gillett said. As an example, he pointed out that "there are Canadian companies with captives in Bermuda, which in my view shouldn't be. There are still a lot of them there. In my view, they should be in Barbados," because Barbados offers Canadian captives more favorable tax treatment than Bermuda.

The session was moderated by Charlene Lucy, risk manager at The O'Brien Corp. in San Francisco. Mr. Gillett was the coordinator. ■

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Business Insurance

Domesticating captive insurers

Options available for going onshore

By LOUISE KERTESZ

ANAHEIM, Calif.—Parent companies that want to move their captives onshore from a non-U.S. domicile must choose among several options.

Risk managers also must decide what to do with the offshore company that is left behind after the captive is "domesticated," captive experts advised during a panel discussion at the recent 30th annual Risk & Insurance Management Society conference.

Corporate interest in domesticating captives was born in 1981. That was the year a new Vermont captive law created "a competitive environment onshore," explained Greg Myers, vp at Becher & Carlson Risk Management Inc. in Woodland Hills, Calif., who coordinated the session.

Captive laws in Tennessee and Colorado date back to the 1970s. But before the passage of Vermont's "flexible" captive legislation, "the domestic environment was not attractive to captives," agreed Dennis L. Allen, a partner with Sutherland, Asbill & Brennan in Washington, D.C.

Until Vermont became a "pioneer," the other states still required "a lot of filings and contact with the insurance department," he explained.

But while the domestic scene became "more hospitable" to captives in the early 1980s, the "real interest" in domestication dates from 1986 with the passage of new U.S. tax laws. The new tax laws became the "primary thrust" behind captives coming onshore, Mr. Myers said.

Beginning in 1986, the new tax laws provided several "disincentives" for offshore captives, agreed Mr. Allen. For example, a foreign captive engaging in U.S. business could face three levels of tax: corporate income tax, a branch profits tax and a tax to shareholders on distributions of earnings, Mr. Allen explained.

At the same time, since 1986-87, several domestic domiciles, like Hawaii, Georgia and Illinois, have become more flexible, he said.

When companies decide to move their offshore captives onshore, they may use one of three methods, all of which first require the formation of a new company in the domestic domicile, Mr. Myers explained. The methods are: portfolio transfer; merger; or transfer of stock to the domestic captive.

In a portfolio transfer, the foreign captive transfers all its assets and liabilities, including its loss reserves, to the new captive. An assumption agreement is required with the U.S.-domiciled captive that is assuming the offshore captive's business.

"The domicile's regulators will look closely to see that all of this is done properly," Mr. Myers warned. Consents to transfer are also required on the part of all entities involved in the captive, he said.

The second method of domestication is through merger, which involves the new domestic company acquiring all of the rights and obligations of the foreign company. Mergers require ratification by the insurance authorities of the offshore domicile, Mr. Myers said.

The easiest approach is a stock contribution, in which the offshore captive contributes stock to the new company, he continued.

In any case, a parent company will find it easiest to transfer its offshore captive's business to a domicile that has passed domestication statutes, he pointed out. Colorado, Illinois and Vermont have passed such statutes "to go after" offshore captives.

Domestication statutes make it possible to just "move the whole operation onshore," without having to formally license a new insurance company before the captive's business is transferred, Mr. Myers said.

A parent company also must decide whether it wants to continue to operate its offshore captive after it establishes an onshore captive.

"A lot of companies are keeping the two captives," recognizing that it is desirable to conduct some business through an offshore captive, which generally is subject to less regulation than a domestic captive, Mr. Myers said.

But keeping a foreign captive along with a domestic captive is costly and "only makes sense if you plan to do business there again," Mr. Myers warned.

A parent company with franchises might decide to split up its business, conducting the parent's business through the onshore captive and the franchises' business through the offshore captive, he observed.

Closure of a foreign captive is possible either through liquidation or "deregistration," he continued.

Liquidation costs approximately $5,000 in Bermuda and takes three to four months. It involves distributing all of the captive's surplus and obtaining government approval to shut the insurer down. Notices must be placed in newspapers so outside parties know the captive is being liquidated, Mr. Myers explained.

Deregistration costs about $15,000 in Bermuda and is is a "fairly straightforward" procedure, though it requires government approval, he added.

A deregistered captive in Bermuda has minimal reporting requirements and minimal fees. An annual general meeting of the board of directors is required to request a waiver of the audit required of active captives, Mr. Myers said.

With a deregistered captive, "it's far easier to get that company active again," Mr. Myers pointed out.

Bradley Wood, insurance manager at Marriott Corp. in Bethesda, Md.—which last year moved much of its business from its Bermuda captive to a new Hawaii captive through a portfolio transfer—moderated the session (*BI*, April 29, 1991). ■

Risk managers follow new rules amid today's rough job market

Recession, demographics now sharpening competition

By MICHAEL BRADFORD

ANAHEIM, Calif.—Risk managers looking to get ahead in their careers may have to play by a new set of rules.

"A lot of what we learned about business when we all started out simply no longer applies," said Brooks T. Chamberlin, managing director of executive recruiting firm Korn/Ferry International in New York.

For one thing, the job market is a lot more uncertain than it once was, Mr. Chamberlin said during a panel discussion at the recent 30th annual Risk & Insurance Management Society conference.

"A decade ago, executives expected promotions just for showing up, keeping their noses clean and, above all, never being caught speaking with an executive recruiter," Mr. Chamberlin remarked.

"You're going to need more than a pulse and a reliable alarm clock to cut it in the '90s," he said. "Talking to an executive recruiter today is definitely in."

Corporate loyalty, already dismissed in the 1980s as a "virtue of the past," is "not even perceived as a virtue" today, he said. "Prospective employers look at candidates who have spent 10 or 20 years at one company and they often say to themselves, 'What's wrong with this person? Why hasn't he or she been recruited at least once or made a move at least once?' "

If risk managers think they can ride out the competitive storm of today's job market, they may be in for a surprise, he said. "The demographics are changing, and the numbers indicate that the job market will become even more competitive in the future, particularly at the upper echelons.

"Because there are so many baby boomers and relatively few top management jobs, corporations can afford to be even more highly selective in the future than they have been in the past."

Corporate loyalty is 'not even perceived as a virtue' by management today, says Mr. Chamberlin.

And, he reminded risk managers that today's mobile workforce means "you are not only competing with the co-workers you know, but with your counterparts at the competition."

More workers also are changing industries. For example, he said, some in the insurance industry are becoming risk managers and vice versa. "That was unheard of 10 years ago."

Heightening the competition are the many executives thrown out of work by the recession, Mr. Chamberlin pointed out.

Another panelist said risk managers should be aggressive about taking on more responsibilities so they are more valuable to their companies and have a nice resume when changing jobs.

"Nothing is more important than expanding your job," said Ron Judd, a consultant with American International Group Inc. in New York and the former executive director of RIMS.

"I think it's the risk manager's job to expand his job," Mr. Judd said. "Don't wait for the corporation to come to you.

"If your job is not expanding, then start preparing for change" and act to broaden risk management responsibilities, he said. "Too many people sit back and don't take charge."

There are certain qualifications that might give job applicants a leg up or tip the scales in their favor when promotions are handed out, the panelists said.

Examples include time spent working in another country, fluency in a foreign language, and an understanding of other business cultures and markets, according to Mr. Chamberlin.

"International expertise is now

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considered a prerequisite for business leadership in most of the rest of the world," he added.

A survey by the insurance industry recruiting firm Ward Howell International in New York of more than 50 chief financial officers and risk managers at mostly Fortune 100 companies provided some insights on how risk managers can sell themselves, said A. Donald Ikle, a partner with the firm. The survey was conducted for presentation at the RIMS session.

The survey, along with face-to-face interviews with risk managers, indicated that CFOs want risk managers to become more involved, according to Mr. Ikle. "They're really inviting you to assert yourselves."

Comments from surveyed CFOs showed that they would like risk managers to "get closer to operations, anticipate problems, seek top management interaction, gain broader business backgrounds, become proactive," and develop economic and analytical skills, Mr. Ikle said.

He also said the survey indicated that risk managers need better communication skills.

They need to "learn to explain complex subjects in a clear, simple way" with little jargon, said Mr. Ikle. "People get comfortable with technical lingo, but you really have to break things down into fairly simple terms that your audience will understand."

Communication skills are particularly important when risk managers deal with the press, said Kathryn J. McIntyre, publisher and editorial director of *Business Insurance* in Chicago.

She encouraged risk managers not to take cover when a reporter calls. A properly coordinated interview can result in articles that will reflect well on the risk manager's employer, risk management in general and "most important, reflect better on you."

Why should a risk manager agree to an interview? she asked. "If the subject of the story is your company, you want the article to be accurate. And you want the article to contain your company's point of view."

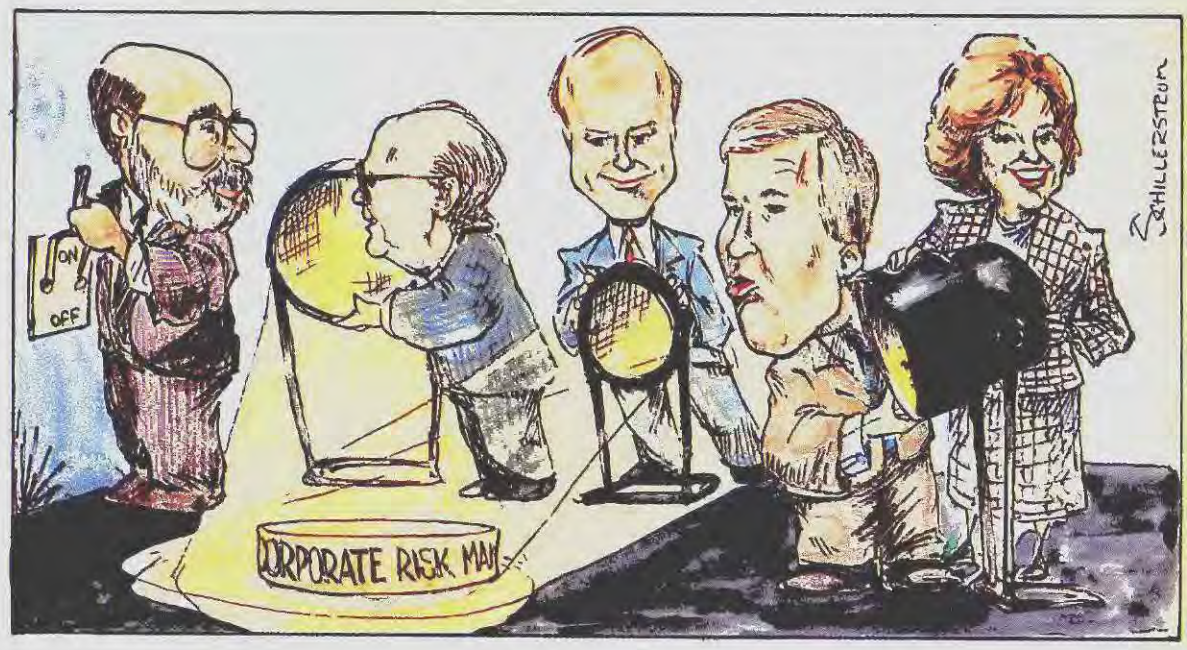
A story on risk management in general can enhance the image of the profession, she added, and can boost the profile of those quoted. "You want to sell yourself as an expert in the field."

When a risk manager is recognized as someone whose knowledge and opinion are sought by the press, it can enhance that person's image with his or her employer, staff and potential employers, Ms. McIntyre noted.

There are some "dos and don'ts" risk managers should keep in mind when talking with a reporter, Ms. McIntyre said. Some of those guidelines suggest risk managers should:

- Not force the reporter to work through a public relations person who lacks the expertise to answer questions.
- Realize the conversation is on the record as soon as someone says, "I'm a reporter."
- Never assume expertise on the part of the reporter or talk over the reporter's head by using jargon.
- Understand deadlines. The story will go to press without the risk manager's comments if calls aren't returned promptly.
- Take time to formulate answers and not dodge questions.
- Follow up with a phone call if, after the interview, the risk manager realizes something important wasn't discussed or incorrect information was provided.
- Provide written copies of speeches.
- Never ask to see a story before it is printed. Such practice smacks of censorship, Ms. McIntyre said.

The session was moderated by Thomas D. Lewison, director of corporate risk management at Hartz Group Inc. in Secaucus, N.J. It was coordinated by Bobbi Stone, a consultant with Robert Murphy Associates in New York. ■



Thomas D.Lewison, left, Ron Judd, A. Donald Ikle, Brooks T. Chamberlin and Kathryn J. McIntyre spotlight steps risk managers can take to market themselves in a new era.

Top executives disagree on timing of market turn

Tort reform prospects dim: Panel

By JUDY GREENWALD

ANAHEIM, Calif.—Top insurance executives are split over when the commercial property/casualty insurance market could turn.

A CIGNA Corp. executive predicts that the market could turn by year end, while officials of Liberty Mutual Insurance Co. and The St. Paul Cos. Inc. say they do not see any imminent change in the broad marketplace.

The president of American International Group Inc. noted that only certain lines are showing signs of turning at this time.

The timing of the market's turn, as well as a host of other issues—rating agencies, tort reform, the industry's ability to withstand a major earthquake, the McCarran-Ferguson Act and federal regulation—were discussed during a "CEO Roundtable" discussion during the 30th annual Risk & Insurance Management Society conference.

Caleb L. Fowler, who is president of CIGNA's domestic property/casualty division, said he is more optimistic than he was six months ago that the insurance market could turn by the end of this year.

Declining returns, slower cash flow and reduced investment income could "cause some semblance of rationality to return to the marketplace," he said.

But the answer to the question of when will the market turn does not lie in the industry's financial performance, responded Gary L. Countryman, Liberty Mutual's chairman and chief executive officer.

Previous major turns in the marketplace were caused by events external to the insurance industry, like stock market crashes, Mr. Countryman said.

As a result, "almost by definition they are not predictable," he said. While there could be a long, slow change, an abrupt change generated by a crisis is not easily foreseen, he added.

Mr. Countryman said he does not know when there will be a turn in the market, "but I can promise you it'll happen sometime."

"I don't see any real evidence" of a market turn, said Douglas Leatherdale, St. Paul's chairman and CEO. Certainly, it will not happen in 1992, and 1993 is a "question mark."

Parts of the market have remained very hard, he also pointed out.

Thomas R. Tizzio, AIG's president, said he does see a change in certain lines, particularly marine and energy insurance. Overall, though, "commercial results have not been very good" despite the industry's profitability, he said.

CIGNA's Mr. Fowler noted that despite his hope for change, CIGNA is not depending on it. Strategies must be good at any phase of the cycle, he said.

Turning to another issue, the insurer executives generally had good things to say about insurance rating agencies.

"I think (they) do a good job, generally speaking," said Mr. Countryman of Liberty Mutual. But they cannot be a substitute for insurance buyers' own assessments, which should take into account factors like a company's reputation, its rates "and a good bit of common sense."

The agencies do a better job than they did three years ago, commented Mr. Leatherdale.

All of the executives said the prospects for tort reform look bleak.

Mr. Countryman said he would like to say that an "enormous sea change" is about to happen. But, "nothing is going to happen, and I'm unhappy about that."

Vice President Dan Quayle's efforts in this area and the adminis-

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tration's 50-point reform proposal "are all good stuff, but the fact is, nothing is going to happen," Mr. Countryman said.

The major obstacle, he said, is the Assn. of Trial Lawyers of America, whose members are tough, bright, well-organized, political and well-financed.

"More often than not they get their way," he said.

There has been a tendency to think tort reform is an insurance industry problem, said Mr. Fowler, but this is not true. "It's a problem that affects most of you," he told the RIMS audience, calling for a joint effort in this area.

Any change, said Mr. Leatherdale, will be "very, very slow and very evolutionary, and basically, we're not very optimistic about this at all."

Mr. Countryman also expressed concern that no-fault systems for workers compensation and auto insurance are eroding. Of particular concern is attorney involvement in workers comp, which is "growing as we speak here today."

Opponents of the no-fault approach can be defeated, he said, but "what it takes is a crisis of major proportions" that mobilizes popular support, which no legislature can stand up to, said Mr. Countryman.

The executives were somewhat more optimistic about the industry's ability to withstand a major catastrophe.

That six or seven regional insurers went into receivership following Hurricane Hugo indicates the need to spread risk more, said Mr. Leatherdale.

But adequate surplus, a well-managed investment portfolio and a sensible reinsurance program "should see most companies through," he added.

Still, he allowed, if there is a "very, very major quake" with $50 billion in losses, "many companies will find it very difficult to respond and would probably fail."

The industry could probably withstand a major earthquake, said Mr. Countryman. But a $65 billion loss would cost the industry half its surplus, cause enormous dislocation and force an "enormous number" of insurers to go belly up, he said.

Mr. Countryman said he favors proposed federal legislation whose provisions include a federal reinsurance program for insured earthquake losses exceeding $10 billion (*BI*, April 9, 1990).

The insurer executives also called on risk managers' help in workers compensation reform.

"You are the constituency out there that can make a difference," said Mr. Countryman. The business, labor and medical community must be challenged to work together to provide a more affordable system.

Business should be motivated to help with this problem, said Mr. Countryman, "because in the end, you can be sure, whatever the system is, you're going to pay for it."

"We can't solve this problem for you," agreed Mr. Fowler.

Mr. Countryman said in response to another question that he does not anticipate any imminent changes to the McCarran-Ferguson Act. Members of the House currently are "busy trying to balance their checkbooks," he quipped. The House banking scandal, plus the November elections, makes it unlikely Congress will take on anything "terribly controversial."

Mr. Countryman added, though, that he is more interested in the prospects of proposals calling for a federal role in insurer solvency regulation. While it is "almost a certainty" that a proposal will not be approved this year, approval could come in 1993 or 1994, he said.

"In the end, there will be some kind of federal regulatory oversight," predicted Mr. Countryman, who said he favors continuing state regulation. He foresees a "fairly modest" role, including some federal standards and review of states' own regulatory efforts, but state regulatation will not be replaced with federal regulation.

The session was moderated by Gerald L. Belfiglio, pensions and insurance manager for Ford New Holland Inc. of New Holland, Pa. The speakers were introduced by Thomas D. Lewison, chairman of the conference programming committee and director-corporate risk management for Hartz Group Inc. in Secaucus, N.J. ■

Variety of pressing issues discussed at annual RIMS conference sessions

ANAHEIM, Calif.—The annual Risk & Insurance Management Society conference is an opportunity for risk managers to hear expert perspectives on pressing issues, learn solutions for problems and exchange ideas with their peers.

Following are summaries of six of the sessions at the 30th annual conference:

Coverage submissions

Risk managers often overwhelm insurers with reams of information they cannot digest when making a coverage submission, says an insurer.

"We need summaries so we can draw conclusions about the account," according to Janet C. Rickards, assistant vp at Reliance National Insurance Co., a Reliance Group Holdings Inc. unit, who spoke at a session on packaging uncertainty.

Session coordinator Mark G. Pinkowski, vp at Rollins Burdick Hunter Co. in Universal City, Calif., said if a client wants a policy renewed 30 days before expiration, work should begin at least 90 days before the expiration date.

The session was moderated by Gary L. Swinhart, director of risk management for CalMat Co., based in Los Angeles.

Reinsurance for self-insurers

Self-insured companies shopping for reinsurance should carefully evaluate the reinsurers courting alternative-market business, experts advise.

Among the factors that should be considered are the adequacy of the reinsurer's loss reserves, lines of business reinsured and the makeup of the reinsurer's investment portfolio, says G. Roger Greiner, president of Stamford, Conn.-based Genesis Underwriting Management Co., a division of General Re Corp.

Reinsurance buyers should be especially concerned about solvency, because most risk managers have experienced some type of insolvency among their insurers or reinsurers, according to Donald J. Krutek, senior vp at Johnson & Higgins of Illinois Inc. in Chicago.

The session was moderated by Brian Gardner, risk manager at Frito-Lay in Plano, Texas. Mr. Greiner served as coordinator.

Selling loss control

Risk managers must convince senior management that loss control has a significant impact on the bottom line, an insurer advises.

James M. Smirles, brokerage marketing officer for Kemper National Insurance Cos. in Long Grove, Ill., was among the speakers at a session on selling loss control to top management.

In addition, prompt claims reporting plays a key role in holding down loss costs, says Raymond M. Barrett, national account claims officer for Kemper National.

Also speaking was Gerald L. Maatman Jr., an attorney with Baker & McKenzie in Chicago, who discussed provisions of the Americans with Disabilities Act, which takes effect in July.

The session was moderated by Frank Sup, director of risk management for Pizza Hut Inc. in Wichita, Kan. Mr. Smirles coordinated the session.

Texas comp rulings

Texas employers that have opted out of the state workers compensation system are looking to the Employee Retirement Income Security Act of 1974 to offer some protection against lawsuits by injured employees.

But two federal courts have reversed rulings that originally prevented Texas workers from suing employers in state court, experts warn (*BI,* Aug. 26, 1991).

The rulings were discussed by John M. Collins of Haynes & Boone in Houston; Hugh Vinson, senior vp with Alexander & Alexander of Texas Inc. in Fort Worth; and Nancy Moore, deputy commissioner for workers compensation at the Texas Department of Insurance.

The session was moderated by John F. Leyenberger, risk manager for The Coca Cola Bottling Group (Southwest) Inc. in Dallas. The coordinator was W. Lee Carter III, director of research and development at A&A in Dallas.

California safety laws

Two new California laws impose significant penalties for employers that fail to maintain an effective injury-prevention program or knowingly conceal serious workplace dangers.

The ramifications of the measures—S.B. 198 and the Corporate Criminal Liability Act—were discussed by Dennis Brooks, managing partner of Comp Management Associates in Long Beach, Calif.; Jerry N. Growel, vp and corporate insurance manager for Home Savings of America in Irwindale, Calif.; and Fred Macksoud, deputy district attorney-environmental crimes/OSHA Division in Los Angeles.

The session was coordinated and moderated by Marilyn Sarich, risk manager at VMS Realty Partners in Laguna Hills, Calif.

Prefunding FAS 106 liability

Employers that choose to prefund their post-retirement medical benefits should prepare for an onslaught of funding proposals from a cornucopia of different vendors, a financial expert says.

Employers need to set specific objectives and strategies, including financial and tax priorities, to decide whether the funding proposals will work, says Kevin E. Flint, director of benefits finance at Bausch & Lomb Inc., a health care and optical company in Rochester, N.Y.

Godfrey Perrot, a consulting actuary with Milliman & Robertson Inc. in Wakefield, Mass., cites three ways in which an actuary can help a company dealing with its retiree medical obligations under Financial Accounting Standard 106: quantifying what the liability will be, helping to redesign the post-retirement medical plan to reduce that liability and analyzing alternative funding solutions.

Jon Harkavy, vp and general counsel for Vermont Insurance Management Inc. in Arlington, Va., coordinated the session. Mr. Flint served as moderator. ■

RIMS elects officers, honors deputy members

ANAHEIM, Calif.—The Risk & Insurance Management Society Inc. announced its 1992-1993 Executive Council at the society's recent 30th annual conference.

In addition, RIMS presented its highest award—the Dorothy & Harry Goodell Award—to former RIMS President Richard C. Heydinger.

In addition, Lloyd R. Hackett, risk manager for T. Eaton Co. Ltd. in Toronto, was presented with the 1992 Richard W. Bland Memorial Award.

Suzanne H. Crager, assistant vp-risk management and insurance for PNC Financial Corp in Pittsburgh, will become president of RIMS effective May 1.

Ms. Crager was elected to the Executive Council in 1989 and served as vp-finance/treasurer and vp-conference before becoming first vp last year. She succeeds Robert W. Esenberg, risk manager for the city of Virginia Beach, Va.

Current vp-business and industry liaison J.A. "Tony" Bridger will serve as first vp in 1992-1993, a post that is traditionally the stepping stone to the presidency.

Mr. Bridger, risk manager-corporate risk and insurance for the Bank of Montreal, was elected to the RIMS Executive Council in 1987 and has previously served as vp-member affairs and secretary and vp-conference.

J.A. Yvon Menard, manager-risk and insurance for Marathon Realty Co. Ltd. in Toronto, will serve as RIMS' first-ever vp-international affairs. An Executive Council member since 1989, Mr. Menard was previously vp-research and vp-conference.

Newly elected to the Executive Council is Frieda L. Jackson, president/risk manager of Park South Associates Inc. in Charlotte, N.C. Ms. Jackson will serve as vp-education in 1992-1993.

Louis J. Drapeau, manager-insurance and risk management for The Budd Co. in Troy, Mich., will become vp-business and industry liaison on May 1. Elected to the Executive Council last year, Mr. Drapeau is currently vp-education.

Lucille A. Gallagher, vp of risk management for Monfort Inc. in Greeley, Colo., and the red meat companies division of ConAgra of Omaha, Neb., will serve as vp-conference. She has served as vp-governmental affairs since her election to the Executive Council in 1990.

Gerald L. Belfiglio, pensions and insurance manager of Ford New Holland Inc. in New Holland, Pa., was named vp-government and public affairs. Elected to the RIMS Executive Council in 1989, Mr. Belfiglio has served as vp-finance/treasurer and vp-member affairs/secretary.

Gerald J. Ciardelli, corporate risk manager for Jostens Inc. in Minneapolis, becomes vp-finance/treasurer from vp-member affairs/secretary. He served as vp-education when he was elected to the Executive Council in 1990.

Marge P. Layne, corporate risk manager for Core-Mark International Inc. in South San Francisco, Calif., will serve as vp-membership and chapter services/secretary in 1992-1993. Currently vp-communications, Ms. Layne also served as vp-education in 1988-1989.

David R. Haight, director of risk management for CF Industries Inc. in Long Grove, Ill., will continue as vp-research. He was elected to the Executive Council in 1990 as vp-member affairs/secretary.

Meanwhile, RIMS presented the Goodell Award, which recognizes outstanding achievement in furthering the goals of risk management, to Mr. Heydinger, director-risk management services for Hallmark Cards Inc. in Kansas City, Mo.

Mr. Heydinger, president of RIMS in 1988-89, currently is chairman of the RIMS Nominating Committee and is a member of the Risk Management Roundtable and of the Risk Management Magazine Editorial Advisory Board.

Outside of RIMS, Mr. Heydinger is president of the Vermont Captive Insurance Assn., a member of the Vermont Captive Advisory Board and a board member of Tortuga Casualty Co., a Caymans-domiciled excess liability insurer.

He holds the Chartered Property & Casualty Underwriter and Fellow, Insurance Institute of America designations.

The Bland Award recognizes outstanding performance or effort by a deputy member of RIMS in the area of legislation and regulation.

Mr. Hackett has monitored risk management issues of national significance for 25 years, particularly as a member of the Canadian Chapters Legislation Committee. He served as president of the Ontario chapter of RIMS in 1968-69 and has been a member of the ORIMS legislation committee since then, including serving as chairman in 1984.

In 1988, Mr. Hackett received the Canadian RIMS chapters' Don Stuart Award for outstanding contributions to risk management.

A Fellow of the Insurance Institute of Canada, Mr. Hackett holds the Associate in Risk Management and Canadian Risk Management designations.

The Bland Award is presented by the RIMS Greater Kansas City Chapter.

The Cristy Award, which is given to the risk manager with the highest cumulative average for the three examinations leading to the Associate in Risk Management designation, went to Charles A. Ford, corporate counsel for Schnitzer Steel Products Co. of Portland, Ore.

—By Sara Marley

Court dismisses suit over ELIC annuities

LOS ANGELES—A group of Blue Cross of California retirees and employees whose pension benefits were funded through annuities purchased from Executive Life Insurance Co. will appeal a federal judge's decision to dismiss their suit against Blue Cross.

The one-line decision handed down last month by U.S. District Court Judge Terry Hatter in Los Angeles is the first court ruling in the many suits against employers that terminated overfunded pension plans and replaced benefits with ELIC-issued annuities.

Under a conservator's order, issued about a year ago following the California Insurance Department's takeover of ELIC, annuitants are receiving only 70% of promised benefits (*BI*, April 22, 1991).

However, under a rehabilitation plan, annuitants should receive nearly 100% of benefits from guaranty funds and a new insurer, Aurora National Life Assurance Co., which would assume most of ELIC's obligations (*BI*, Jan. 6).

While the suit is one of many filed against employers that purchased ELIC annuities, it is unusual for several reasons. For one thing, most of the other suits were filed by the U.S. Labor Department.

In addition, the suit not only sought reimbursement for any losses linked to the purchase of ELIC annuities, but also sought to require Blue Cross of California to guarantee annuities it bought from Provident National Assurance Co., even though those annuities continue to pay full benefits.

The case also is unusual because the former Blues employees covered under ELIC annuities have not suffered any losses. Blue Cross of California is providing interest-free "forgivable" loans through the end of this year to make up for the 30% cut in annuity benefits. The loans, which are costing Blue Cross of California about $30,000 a month, would have to be repaid only if annuitants are reimbursed by another source, like a guaranty fund, said Blue Cross attorney J. Neil Gielegehem, a partner with Crosby, Heafey, Roach & May in Los Angeles.

Blue Cross of California terminated its defined benefit plan in late 1986 to recover surplus assets. The plan bought annuities from ELIC and Provident to replace benefits promised to plan participants. Blue Cross subsequently recovered about $32 million in surplus assets, which were used for general corporate purposes.

In their suit, former plan participants alleged the annuities were not purchased for the sole benefit of plan beneficiaries. Instead, the annuities were purchased to provide Blue Cross with an "excessive" asset reversion, the suit alleged.

The suit also charged the annuity bidding process was rushed, resulting in "too little time for many potential annuity providers to submit bids concerning the retirement plan's termination. Because many potential bidders were incapable of providing bids in time. . .defendants failed to conduct a prudent bidding process to obtain quotations for the exclusive benefit of the retirement plan and its participants."

In addition, the defendants should have known that ELIC was not a "proper" annuity provider, the suit charged. Among other things, the defendants should have known that ELIC invested heavily in junk bonds and engaged in transactions that "fictitiously" increased its surplus.

While retirees covered by Provident annuities are receiving full benefits, they "are now concerned that they too will receive denials by Blue Cross of any responsibility if Provident becomes financially disabled," the suit says.

In its motion to dismiss the suit, Blue Cross of California argued that there is nothing in the Employee Retirement Income Security Act that bars expedited terminations or that bids be sought only from insurers of a certain size.

"In fact, precisely the opposite is true: The controlling ERISA regulation expressly provides that an employer is not required to obtain bids for replacement annuities from more than one insurance company unless special circumstances apply and expressly provides that in no event is the employer required to obtain more than three bids," the defendants' brief says.

Blue Cross obtained four bids.

Plaintiffs' attorney Michael A. Sherman of Barrack, Rodos & Bacine in San Diego described Judge Hatter's decision as "completely wrong." He added that the decision does not address substantive issues.

—By Jerry Geisel

MGM litigation

Continued from page 2

$5 million in addition to an earlier $206,582 defense payment it made, Forum will pay $9.5 million, and Associated will pay $4.75 million.

National Union participated in the bad-faith settlement negotiations but was not a party to the $19.46 million settlement.

As a result, MGM will pursue bad-faith claims against National Union in litigation scheduled to go to trial today in Los Angeles.

The bad-faith settlement and coverage litigation center on how the D&O insurers structured the settlement of the shareholder suit.

In that case, the shareholders, which sought unspecified economic and punitive damages, claimed that fiduciary duties to minority shareholders were breached when MGM/UA Communications Co., MGM's predecessor, was sold to Turner Broadcasting Systems Inc. in 1986. The assets of subsidiary United Artists were subsequently sold back to majority shareholder Kirk Kerkorian for an allegedly inadequate price (*BI*, Sept. 17, 1990).

Without the consent of MGM or its officers, the insurers offered the plaintiffs $8 million to settle with MGM, leaving Mr. Kerkorian and his Tracinda Corp. holding company as sole defendants.

The insurers also offered to pay class members an additional $12 million if they could not recover from Mr. Kerkorian and Tracinda.

This type of settlement is known as a Mary Carter agreement, named after a 1967 case in which this type of settlement first appeared.

However, the judge in this case set aside the $20 million settlement. Many courts hold that Mary Carter agreements violate public policy, reasoning that it is unfair if some defendants conspire with the plaintiff to pursue litigation against the remaining defendants.

At the same time, MGM reached a $35 million global settlement with the shareholders on behalf of all defendants. MGM settled the claims against Mr. Kerkorian in part because he "had a written agreement to be indemnified by the company," an MGM attorney explained earlier (*BI*, Oct. 15, 1990).

MGM then sought to recoup the $35 million in a bad-faith lawsuit against its D&O insurers. MGM alleged that the purpose of the insurer-instigated settlement was to provide the plaintiffs with $8 million to pursue their claims against Mr. Kerkorian and Tracinda, and the promise of an additional $12 million made it impossible for Mr. Kerkorian and Tracinda to settle the case for less than $20 million.

"This case shows how insurance companies can scheme against their own insureds to save substantial money for themselves," said MGM attorney William Shernoff of Shernoff, Bidart & Darras in Claremont, Calif. Mr. Shernoff, who specializes in insurer bad-faith litigation, said he expects MGM will be able to recoup the remainder of the underlying settlement from National Union.

"Since National Union was the prime architect of the Mary Carter agreement, we expect the jury will assess a large punitive damage award," he said.

Co-counsel Patty Glaser of Christensen, White, Miller, Fink & Jacobs in Los Angeles agreed: "It is unbelievable" that National Union could sit in on the negotiations and not be a party to the settlement.

National Union did not settle with MGM because the underlying coverage had not been exhausted and it is not clear that Mr. Kerkorian is covered by the policy, said David Reynolds, an attorney for National Union with Lewis, D'Amato, Brisbois & Bisgaard in Los Angeles.

In addition, Mr. Reynolds said National Union has filed a cross-claim against Mr. Kerkorian, alleging that he originally said he was not covered under the National Union policy but now fraudulently claims he is entitled to coverage. ■

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Health care poll

Continued from page 1
all Americans would be insured through one government plan.

And 27% said they would favor President Bush's proposal to offer low- and moderate-income uninsured Americans tax credits and income tax refunds to help purchase private health insurance.

Only 2% of those surveyed said the health system should be left as it is. Eight percent did not respond.

The lack of consensus puts policymakers in a quandary, said Thomas W. Moloney, senior vp of the Commonwealth Fund, a New York-based philanthropic group that co-sponsored the survey.

"It makes policymakers afraid to do anything. They are afraid they will have 'Son of Catastrophic' meet them in the parking lot," he said, referring to the outrage of upper-middle- and upper-income retirees about the big tax bite they would have paid under the 1988 Medicare Catastrophic Coverage Act.

Making matters worse is that conviction behind any one reform proposal is "wafer thin," Mr. Moloney noted. "There is no salience to their answers. As soon as you ask a follow-up question about one of the proposals, they move away from their choice."

For example, two-thirds of those who favored a play-or-pay approach said they would not favor such an approach if it would hurt small employers that could afford neither a private health plan nor a payroll tax, Mr. Moloney said.

The survey, released April 8, is based on 2,000 telephone interviews done between Jan. 31 and Feb. 24 by Louis Harris & Associates Inc. The Henry J. Kaiser Family Foundation, a national philanthropy based in Menlo Park, Calif., co-sponsored the survey with the Commonwealth Fund. The Kaiser Foundation is not associated with Kaiser Hospitals or Kaiser Permanente Medical Care programs.

The survey coincides with the 1992 presidential campaign in which health care has emerged as a prominent issue. In fact, the survey reported, 25% of respondents ranked health care as one of the two most important issues in the presidential election, second only to the economy and far ahead of other major issues, like taxes, jobs and education.

But, according to the survey, the public at this point sees no real difference between the health reform proposals of any party or candidate. And 80% of respondents say no political leader or candidate has a proposal for health care reform they support.

While most Americans—71%—are satisfied with the health care services they and their families have received in the last few years, a growing number are are dissatisfied, the survey reported. Some 26% of respondents reported being very or somewhat dissatisfied with health care services, including cost, access and quality, double the 13% who said they were dissatisfied in a 1987 poll (see chart, page 1).

That increasing dissatisfaction indicates that "the whole health reform issue in the minds of the public has moved from an armchair concern about others' problems to a real concern about themselves," said Mr. Moloney.

For example, 48% of individuals worry they will not be able to afford the health care they will require when they become very ill. And, 39% feared their health plan would refuse to insure them if they incurred large medical bills.

Even individuals who are covered under employer-sponsored health plans are anxious. "The firewall of health insurance is eroding—even for people with private health insurance," Mr. Moloney said. Some 26% of those surveyed said they feared their employers would drop their health plans.

Twenty-five percent rank health care as one of the two most important issues in the election.

Health insurance benefits influenced the career moves of 18% of the people surveyed, said Mr. Moloney. Nine percent said they did not take a better job because the health insurance was not as good as their current plan. And 5% said they are trying to change jobs strictly to improve their health insurance benefits.

At the same time, few individuals realize that increasing health care cost pressures are affecting employers' profits, Mr. Moloney said. Only 31% said they felt their raise last year was in any way affected by the rise in health insurance premiums paid by employers.

"If we are to do something about (the health care crisis) nationally, more of us have to understand that increasing health insurance premiums are eroding wages," Mr. Moloney said.

The survey indicates that people may be more willing to accept managed care if it means lower out-of-pocket costs. Fifty-five percent said they would be interested in a health plan that limits their choice of providers in return for real savings.

"This says to me that employees who even a couple of years ago may not have actively endorsed managed care may have changed their minds," Mr. Moloney said. "If I were an employer, I'd revisit this issue with my workers."

Americans are evenly split about who is to blame for the current health care system's ills, the survey found, though the government tops the list of scapegoats. Thirty-one percent include the government when spreading the blame, 25% blame doctors, 23% blame insurers, 15% blame hospitals and 25% blame "others."

While the public says it wants the government to have a primary role in solving the health care crisis, respondents weren't asked if they felt the government would do the best job, Mr. Moloney noted. "It wasn't a 'Who could do it better?' question. It's more like, if you feel you are about to drown, you call the party with the biggest boat to come get you.

"My interpretation is they want the government to be a better referee—not necessarily to put on a football uniform."

Americans want the government to take a more active role in regulating the price of health insurance and health care services, the survey found. For example, 75% say the government should set the rates health insurers can charge, 71% say the government should set the rates doctors and hospitals charge, and 73% say the government should set prescription drug prices.

"The public perceives the problem (of rising health care costs) as excess profits. But, in reality, if you took all the profits from all health insurers and drug companies, it would reduce national health expenditures by less than 2%," Mr. Moloney maintains.

"It's clear people are saying they want controls on the increases in health insurance premiums," commented a spokesman for the Health Insurance Assn. of America, a Washington, D.C.-based insurer trade group. "Unfortunately, the health insurance industry has to deliver the bad news" regarding health care cost increases by upping premiums. The blame insurers get is a bum rap, he said.

"The real problem of rising costs is driven by technological advances in medical procedures and drugs," Mr. Moloney said. "We have no methods to control that."

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Copies of the survey are available free from the Commonwealth Fund, Communications Office, 1 E. 75th St., New York, N.Y., 10021; 212-535-0400.

INTERNATIONAL

INTERNATIONAL DIGEST

1991 disasters cost $11.7 billion

Natural disasters caused **insured losses of $11.7 billion** in 1991, according to Munich Reinsurance Co. That makes 1991 the second-worst year in history, the German reinsurer says in a new report. It is exceeded only by 1990's restated total of $15.3 billion in insured losses (*BI*, April 22, 1991).

Maxwell pension payment agreement

Robert Maxwell's alleged theft of 426 million pounds ($745.5 million) **from Maxwell-controlled pension funds** (*BI*, Dec. 16, 1991) will not affect benefits for the plans' 12,000 members as long as Mirror Group Newspapers remains profitable, the plan members' lawyers say. Although MGN had already committed to maintain payments to the pension plans, the company and its bankers have now signed an agreement that would commit any future owner of the company to maintain the payments, said Ann Scurfield, a lawyer at Berwin Leighton, which represents the plan members.

Fondiaria raises stake in AMB

Italian insurer **Fondiaria S.p.A.** has exercised an option to purchase 14.2% of German insurer Aachener & Muenchener Beteiligungs A.G. through its German affiliate, Fondiaria Deutscheland GmbH. The stake comprised 663,818 AMB shares at a price of 846 deutsche marks ($521.14) per share, for an overall price of 562 million deutsche marks ($346.2 million). The purchase brings Fondiaria's holding in AMB to 20%.

Sun Alliance posts huge pretax loss

Sun Alliance & London Assurance P.L.C., the largest insurer in the United Kingdom, has reported a pretax loss for 1991 of 446.2 million pounds ($834 million at the year-end 1991 exchange rate), compared with a 180.9 million loss ($349.1 million at the year-end 1990 exchange rate) in 1990. U.K. gross premium income totaled 936 million pounds ($1.75 billion) last year, up from 929 million pounds ($1.79 billion) in 1990. But underwriting losses widened by 84% to 491 million pounds ($918.2 million) in 1991 from 267 million pounds ($515.3 million) the previous year.

Lloyd's managing agent E&O requirement cut

Lloyd's of London managing agents are required to only buy 5 million pounds ($8.75 million) of errors and omissions cover rather than the previous limits of 10 million pounds ($17.5 million) because of a hardening market, confirmed Lloyd's Chief Executive Alan Lord. The move follows a reduction in capacity available from an E&O line slip for managing agents to 2 million pounds ($3.5 million) from 20 million pounds ($35 million), Mr. Lord said.

By Maria Kielmas, Don Lewis Kirk Stacy Shapiro and Gavin Souter

Improprieties alleged at Lloyd's syndicate

By STACY SHAPIRO

LONDON—Lloyd's of London's reputation may be further strained by allegations that the largest of the loss-riddled syndicates formerly managed by Gooda Walker Ltd. may have published false accounts since 1981.

Allegations of improper accounting of time-and-distance policies for syndicate 290 and of inter-syndicate transactions among some of the eight Gooda Walker syndicates were contained in an affidavit filed by Lloyd's in ongoing litigation between members agents and members over refusal to pay cash calls (*BI*, March 9).

The March 31 affidavit is by Kenneth Randall, former chief executive of Merrett Holdings P.L.C. and now an independent consultant to Lloyd's. It describes syndicate 290's time-and-distance reinsurance policies for the syndicate years 1981 to 1988 and says that profit commissions to the managing agency totaling nearly 3.7 million pounds ($6.5 million) "could be regarded as attributable to profits generated from the use of time-and-distance policies."

Time-and-distance policies are a financial reinsurance product with no underwriting risk that pay guaranteed amounts at guaranteed times to the cedant.

Mr. Randall indicated in the affidavit that he is still investigating whether syndicate 290's 1988 profits were "overstated," since four time-and-distance policies with Pinnacle Reinsurance Co. Ltd. in Bermuda were commuted that year.

The allegations in Mr. Randall's affidavit could help the litigating Lloyd's members, many of which are Gooda Walker members, succeed in preventing the market from drawing down on their deposits to pay losses.

London High Court Justice Saville last week heard arguments on this issue from the members and Lloyd's (see related story, page 77).

If the members do not have to pay, the Gooda Walker syndicates are unlikely to meet their annual solvency test at the end of the month. If that happens, Lloyd's would have to earmark money in its Central Fund to cover unpaid Gooda Walker cash calls, which so far total more than 120 million pounds ($210 million).

Meanwhile, Lloyd's authorities are examining whether the allegations in Mr. Randall's report are serious enough to warrant disciplinary proceedings, said Lloyd's Chief Executive Alan Lord.

"This is one we shall take very seriously" to see if there should be disciplinary action against anyone in the Gooda Walker agency, he said.

The information in the affidavit shows "consistent and blatant false accounting," charged Alfred Doll-Steinberg, chairman of the Gooda Walker Action Group. "It discloses false accounting, which in laymen's terms is fraud."

Mr. Doll-Steinberg claims that his group had asked Lloyd's to freeze attempts to draw down on members' assets while the allegations were investigated, but Lloyd's instead filed the affidavit in court.

"We are not talking fraud" but a question of the handling of technical transactions, Mr. Lord said.

"We shall not have a moratorium on cash calls," Mr. Lord said. The allegations "won't stop us succeeding in drawing down on deposits," he added.

Members should pay their cash calls now, and seek to recover their losses later, Mr. Lord said.

Separately, Lloyd's currently is considering whether there also should be any disciplinary action against members agency Lime Street Underwriting Agencies Ltd., which placed 30% of all its members on Gooda Walker and loss-making syndicates managed by Feltrim Underwriting Agencies Ltd. (*BI*, Sept. 2, 1991).

Former Lloyd's underwriter and Gooda Walker Chairman Derek

Continued on page 76

British court ruling on guaranty fund hurts policyholders

Decision could leave some without cover

By STACY SHAPIRO

LONDON—A group of North American lawyers, doctors and accountants are appealing a recent London High Court test case ruling that could stick them with hundreds of millions of dollars in unpaid professional liability claims.

The April 1 decision by High Court Justice Webster is technically a victory for the professionals, all of whom purchased professional liability coverage from four insolvent units of London United Investments P.L.C.

A High Court judge ruled the professionals are entitled to receive payment of up to 90% of their claims from a British guaranty fund for individual policyholders that is administered by the Policyholder Protection Board.

However, the judge decided that the PPB only has to pay claims made as of the date the insurers are placed in liquidation. As a result, any claims not known or potential claims whose final size is unknown when the four LUI insurers are wound up would not be eligible for guaranty fund coverage.

In addition, some members of partnerships may be ineligible for guaranty fund coverage.

The insurance in question was placed with the four so-called KELM companies, all of which participated on the defunct U.S. casualty line slip underwritten by H.S. Weavers (Underwriting) Agencies Ltd. They insurers are: Kingscroft Insurance Co. Ltd., El Paso Insurance Co. Ltd., Lime Street Insurance Co. Ltd. and Mutual Reinsurance Co. Ltd.

The four insurers stopped paying claims in March 1990, when sister company Walbrook Insurance Co. Ltd. ceased underwriting and LUI was put into administration, which is equivalent to Chapter 11 reorganization in the United States (*BI*, April 2, 1990).

The KELM companies so far have not been put into liquidation, but provisional liquidators have been appointed to determine if proposed schemes of arrangement are viable and would benefit creditors (*BI*, March 2).

Meanwhile, a group of North American professionals asked the London High Court to determine how much the PPB would pay under the schemes of arrangement.

The Policyholders Protection Act 1975 says that "private policyholders" that bought "U.K. policies" written by an authorized U.K. insurer are entitled to 90% of claims payments if the insurer is liquidated. Justice Webster was asked specifically to interpret the meaning of "private policyholder" and "U.K. policy" under the the act.

The plaintiffs seeking the High Court ruling include 234 partners of the former accounting firm Clarkson Gordon, now part of Ernst & Young, in Canada; 123 partners of law firm Fried, Frank, Harris, Shriver & Jacobson in New

Continued on next page

Hardy sues Bermuda liquidators

By ROGER SCOTTON

BERMUDA

HAMILTON, Bermuda—Three Bermuda-based insurer liquidators and four related accounting firms are being sued for $90 million for allegedly conspiring to harm "by unlawful means" controversial businessman Mark Hardy and two affiliated entities.

Liquidators David Lines, Peter Mitchell and Kirk Cooper, partners with accounting firm Cooper & Lines in Bermuda, are named in the suit along with the accounting firm and its international affiliates: Coopers & Lybrand Deloitte, Cork Gully and Coopers & Lybrand (Cayman Islands).

The suit was filed April 1 in the Bermuda Supreme Court by Mr. Hardy; VillaRosa Establishment, a Liechtenstein affiliate of Mr. Hardy's; and Magnolia Trading S.A., a Zurich, Switzerland-based affiliate.

Mr. Hardy's allegations center on the defendants' activities as liquidators of Aneco Reinsurance Underwriting Ltd., Focus Insurance Co. Ltd. and Forum Reinsurance Co. Ltd., all of which were controlled by Mr. Hardy (*BI*, April 6; March 18, 1991; Dec. 31, 1990).

The suit alleges that the defendants wrongfully induced a Liechtenstein-domiciled business, Incovest Establishments, to breach a business contract with Magnolia, under which Magnolia would acquire 76 shares of Hia Inversiones S.A., a Spanish property development group. Mr. Hardy claims the 76 shares represent an interest in the firm worth $90 million.

The shares were being acquired ultimately to provide Mr. Hardy with a stake in Hia Inversiones subsidiary Corp. de Nueva Marbella, according to court papers. Mr. Hardy said the company owns 578 acres of undeveloped land just outside Marbella, Spain.

According to a Feb. 28 "letter before action," which is a document outlining allegations prior to filing a lawsuit, the real estate holding was intended to be a key asset of Mr. Hardy's Turks & Caicos company, Channel Reinsurance Co. Ltd.

As recently as a late March meeting of Aneco creditors, Mr. Hardy said Channel Re would meet its obligations as a reinsurer of his insolvent Bermuda companies "as and when they fall due."

The action also seeks an injunction restraining the liquidators and the accounting firms from inducing or procuring further breaches of contract or unlawfully interfering in contracts between Mr. Hardy and related entities.

Mr. Lines and Mr. Cooper could not be reached for comment, and Mr. Mitchell would not discuss the suit. However, the liquidators earlier publicly denied the allegations in Mr. Hardy's Feb. 28 "letter before action."

Peter Wilson, former president of Aneco, also is mentioned in the letter, though he has not been named in the suit. He, too, has denied the letter's assertions. He accused Mr. Hardy of "always attempting to implicate any and all parties in his activities."

Lawyers acting for Judah Binstock, a land developer involved in the Marbella real estate project, have rejected the letter as inaccurate and misleading. They have said that the reason Magnolia's involvement in the project ran into difficulties was because "Magnolia failed to make payment as it fell due."

Second EXEL offering

EXEL Ltd. has completed a second offering of 9.4 million shares, bringing to almost 66% the percentage of the excess liability insurer's stock that is publicly traded.

"We're much more of a public

Continued on next page

Gooda Walker

Continued from page 75

Walker was a major player in the market for London excess-of-loss catastrophe reinsurance and members' stop-loss insurance throughout the 1980s.

In 1981, Mr. Walker and former Lloyd's broker Christopher Moran were acquitted on charges of conspiracy to defraud Lloyd's names. Although Mr. Moran was later expelled from Lloyd's for "discreditable acts," Mr. Walker returned to underwriting (*BI*, Dec. 21, 1981; Oct. 4, 1982).

His syndicates produced excellent results from 1983 to 1988 while their capacity grew. Syndicate 290, for example, saw its gross capacity grow to 69.7 million pounds ($122 million at current exchange rates) in 1988 from 8.1 million pounds ($14.2 million at current exchange rates) in 1983, producing profits each year.

Attempts to locate Mr. Walker for comment last week were unsuccessful.

The first sign that there was trouble at the Gooda Walker syndicates was on June 3, 1991, when Mr. Walker and Managing Director D.R. Jewell were replaced by Lloyd's-approved executives and three of the seven Gooda Walker syndicates were placed into runoff (*BI*, Aug. 5, 1991).

This happened after Mr. Walker's syndicates 164 and 290 reported profits in 1988—earning profit commissions for the managing agency—but in the same breath made cash calls for the 1989 underwriting year.

In addition, Gooda Walker syndicate 298 had cash calls for 1988 and 1989 and ceased underwriting in 1990, while syndicate 299 made a cash call in 1988 and said it would have a significant loss in 1989 (*BI*, Sept. 2, 1991).

These four syndicates made a total of 137 million pounds ($239.8 million) in cash calls last year for the 1988 to 1990 underwriting years, of which all but 21 million pounds ($36.8 million) has been paid by members, according to information from G.W. Run-Off Ltd., an agent appointed by Lloyd's to run off the four syndicates.

Gooda Walker members formed an action group last August and have since been trying to avoid paying additional losses.

Total losses for five of the Gooda Walker syndicates—255, 290, 298, 540 and 847—from 1988 to 1990 could ultimately total 820 million pounds ($1.44 billion), Lloyd's member David Newton estimates in a recent report by consulting firm Lime Street Management Ltd.

Six months ago, Lloyd's set up a loss review panel to examine the Gooda Walker syndicate losses. Lloyd's also set up a committee headed by Sir David Walker to examine the members' accusations that the business written by Gooda Walker and other loss-riddled excess-of-loss reinsurance syndicates was questionable.

In recent discussions with G.W. Run-Off, "it gradually became clear to us that strong indications of serious irregularities in the accounts of (syndicate 290) were being found," said Mr. Doll-Steinberg in an April 3 letter to members of the Gooda Walker Action Group.

The members agreed with the runoff company that it "was in the best interests" of the members that "no premature publication of news of these indications should be made," Mr. Doll-Steinberg noted.

However, Lloyd's on March 4 began issuing 30-day notices of its intent to draw down on members' deposits, even though it was aware of the accounting "irregularities," he said.

"As a result, we were forced to advise GWRO that in the event that by (Thursday, April 2) either Lloyd's had not agreed formally to suspend the drawdown procedure or that Lloyd's had not agreed formally to suspend the publication of the evidence obtained by GWRO, we would have no alternative but to make an application on that date for an injunction against GWRO that would have the same effect," said Mr. Doll-Steinberg.

On April 2, though, Lloyd's itself made the information public during a crowded press conference and issued the Randall affidavit in court, highlighting the irregularities to Gooda Walker members and their agents.

But, members' lawyer Michael Freeman, senior partner of Michael Freeman & Co., said that the affidavit will only strengthen the members' attempt to block drawdowns. "It's a very serious matter."

In the affidavit, Mr. Randall cautioned that there is some risk that the "premature disclosure" of his investigation "might inhibit the future conduct of the investigation."

Mr. Randall said in the affidavit that he has conducted a "preliminary" analysis of Gooda Walker syndicate 290's accounts from 1983, for the 1981 underwriting year, to 1990, for the 1988 underwriting year, specifically looking at its time-and-distance policies.

In the affidavit, he notes that:

- Syndicate 290's accounts for the 1986 underwriting year ignored $3.6 million in claims payments made in 1987 for deteriorating accounts from previous years, choosing to defer recognition of the losses to future years via time-and-distance policies. None of the reinsurance recoveries were due before Dec. 31, 1990.
- The Gooda Walker agency received a total of 3.7 million pounds ($6.5 million) in profit commission charged to members between 1981 and 1988 that "could be regarded as attributable to profits generated from the use of time-and-distance policies."

Members between 1981 and 1988 also benefited from the time-and-distance policies in the profits they made, the affidavit noted.

- Throughout 1990, the Gooda Walker syndicates needed cash to pay for the huge accumulation of catastrophic claims that hit the excess-of-loss market between 1987 and 1990. By March 1991, the vast majority of syndicate investments had been liquidated and the syndicates "were substantially overdrawn within the Lloyd's American Trust Fund, and the board of Gooda Walker Ltd. was under considerable pressure from Lloyd's to clear the LATF overdraft," said Mr. Randall.

The syndicates also had short-term loans of $50 million from Citibank and 34 million pounds ($59.5 million) from National Westminster Bank that were due, he said.

Because of the high level of claims and the slow rate of reinsurance recoveries, the Gooda Walker syndicates were unable to repay their overdraft with the LATF, said Mr. Randall.

Gooda Walker held discussions

Continued on next page

KELM coverage ruling

Continued from previous page

York; and three New York doctors who represent the Federation of Jewish Philanthropists and the Combined Coordination Council in New York, which together buy professional liability insurance for 4,700 doctors.

Named as defendants were the PPB; Royal Insurance (U.K.) Ltd., representing the Assn. of British Insurers; and New Hampshire Insurance Co. Ltd., representing U.S. insurers' London units.

The insurers were named as defendants because if the PPB is liable for the KELM claims, insurers will be assessed up to 1% of their net British property/casualty premium volume to pay claims, or about 152 million pounds ($266 million).

Following a two-week hearing, Justice Webster said a "U.K. policy" under the act is one in which an authorized U.K. insurer's "outstanding obligations" had to be performed in the United Kingdom. He also concluded that a "private policyholder" under the act is considered to be any individual who is the legal holder of a U.K. policy, regardless of where they live.

But, personally owned "professional corporations" set up to protect the liability of individuals, including some partnerships, are not eligible for coverage under the act, according to Justice Webster. An individual also must be named as the legal policyholder to be eligible for guaranty fund coverage, he said.

"People in the U.K. who broke policies worldwide will welcome the judge's decision about the meaning of U.K. policies," said Philip Rocher, partner in the New York office of Wilde Sapte, a law firm representing the plaintiffs.

However, Mr. Rocher said there is a "sting in the tail" of the judge's decision that could be devastating to North American plaintiffs.

Without being asked by either side to do so, Justice Webster raised the question of whether the PPB is obliged to make any payment to policyholders whose claims are only "contingent" claims at the time an insurer is liquidated.

He held that under Section 8(2) of the act, only those policyholders whose claims against an insolvent insurer have "crystallized" on or before the date of liquidation are entitled to protection under the act.

"If the judge is correct, approximately 95% of the policyholders whose claims would otherwise have been eligible for protection under the act will be outside its scope because their claims will be contingent at the beginning of the liquidation," said Mr. Rocher.

Justice Webster's decision was particularly surprising because "it runs directly contrary" to a decision by another High Court judge last year, noted Mr. Rocher.

Justice Hoffman was asked by one of KELM's main creditors, the liquidators of Transit Casualty Co., and other creditors to decide if the PPB was liable to pay "contingent" claims under the Insurance Cos. (Winding-Up) Rules 1985.

Justice Hoffman concluded that contingent claims from insured incidents that occurred before an insurer enters liquidation are admissible claims in a liquidation (*BI*, May 20, 1991).

Justice Webster's decision "comes as a surprise by all those who are involved," PPB Secretary Derek Wright said.

Until an appeal is decided "we can't make interim payments" to creditors, he noted.

Mr. Wright points out that the PPB already has asked insurers in the United Kingdom for one quarter of the levy they would owe, or 38 million pounds ($66.5 million), to pay KELM claims. ■

BERMUDA

Continued from previous page

company than we were before," said Michael Kevany, president and chief executive officer.

Mr. Kevany said the shares were offered at $32.50, compared with $27.50 in the initial offering last July. EXEL stock, which is traded on the New York Stock Exchange, was trading at $34.38 on April 3.

The offering raised $305.5 million, which went to selling shareholders who contributed almost 5.3 million shares in the second offering, while a further 4.1 million shares were issued to meet the exercise of stock options.

Mr. Kevany explained that proceeds from the stock options, along with $36.9 million of EXEL funds, went to repurchase more than 3.6 million outstanding option contracts in a "simultaneous transaction." ■

Continued from previous page
with time-and-distance reinsurer Pinnacle Reinsurance Co. Ltd. in Bermuda to ask Pinnacle to advance funds to syndicate 290 against six time-and-distance policies. However, Pinnacle only allowed the agency to commute syndicate 290's time-and-distance policies and recover some of the funds, he said.

On April 2, 1991, the syndicate received nearly $50 million for the six commuted policies. However, the Gooda Walker agency only disclosed in its accounts that two of the policies were commuted, and not the remaining four.

Since all the policies had been commuted, the account should have taken credit for the proceeds of the commutations and not the full indemnity value of the policies as they did, said Mr. Randall. The profit therefore is overstated by around 11.3 million pounds ($19.8 million), he said.

These figures "will need to be reviewed by the syndicate auditors," he added.

Meanwhile, Mr. Randall is also investigating inter-syndicate transactions and loans of other Gooda Walker syndicates. ■

Members agents contend names must pay calls despite charges

LONDON—The right of Lloyd's of London members agents to call on their names for cash to meet syndicate losses even if the names suspect negligence or fraud is at issue in the London High Court.

The outcome of the court battle could affect Lloyd's future claims-paying ability.

Only eight names are involved, but the case will determine how hundreds of other Lloyd's members' respond to cash calls totaling hundreds of millions of pounds. The eight names are representative of members who have suffered heavy losses in syndicates managed by Gooda Walker Ltd., Feltrim Underwriting Agencies Ltd., Devonshire Underwriting Agencies Ltd. and Rose Thomson Young Underwriting Ltd.

The names are challenging the right of the five members agents to draw down on the funds held by the names at Lloyd's to pay cash calls.

These funds, which are held at Lloyd's for the members' accounts, are the "second link" in a chain that guarantees the "unique strength of Lloyd's security," according to Lloyd's, which joined the action last month (*BI*, March 9).

Neville Thomas, the attorney representing the members' agents, last week asserted that the names had no right to refuse cash calls from their members agencies, regardless of suspicion of fraud. Cash calls were designed to meet the "immediate cash needs of a syndicate," he argued. That need is no less pressing if it is a "self-created need" caused by negligence or fraud on the part of the managing agency that ran the syndicate, he said.

As a hypothetical example, Mr. Thomas described an employee of a Lloyd's managing agency who falls asleep one afternoon and thereby misses a telephone call offering cheap reinsurance for one of the agency's syndicates. It would be "quite absurd," he said, for names on that syndicate to resist a future cash call from that syndicate.

The proper course, he argued, is for names to "pay first and sue later" to recover money allegedly lost through negligence.

Justice Saville inquired whether a similar approach should be adopted in cases where the names have reason to suspect fraud on the part of the managing agent.

"Yes," Mr. Thomas replied.

Earlier in the week, Michael Burton, the plaintiffs' counsel, had argued that names are not obliged to honor cash calls in cases where the calls had arisen from a breach of trust.

The cash calls the names are being asked to pay arise mainly from the need to replenish Lloyd's American Trust Fund, which Lloyd's regards as the "first link" of its policyholder security. As of Dec. 31, 1990, the fund's account stood at $8.02 billion.

The case continues this week.

—By William Pitt

EBP

Continued from page 1
services to employers that self-insure health benefit programs for their employees. For many of these clients, EBP also arranges specific and aggregate stop-loss insurance with large, national insurers, which in turn reinsure all or most of the risk with EBPLife Insurance Co., a unit domiciled in Oklahoma.

Plaintiffs in these lawsuits allege the company has concealed its role as a stop-loss reinsurer and has intentionally delayed or denied claims to minimize losses to its reinsurance unit.

EBP officials deny these conflict-of-interest charges, saying that EBP's participation as a reinsurer puts its interests in line with employers' in cutting health costs.

In 1987, though, a law firm EBP hired to review its operations concluded that EBP's reinsurance activity "more probably than not" violated prohibitions against self-dealing contained in the Employee Retirement Income Security Act.

EBP then sought an opinion from a second law firm, which concluded in a 1989 opinion that the first firm was wrong and that the structure of EBP's programs did not violate ERISA.

The U.S. Department of Labor—which is auditing EBP and other third-party administrators—has issued few opinions on when ERISA bars related companies from acting both as a employee benefit plan's TPA and as a stop-loss insurer or reinsurer.

A 1989 opinion involving ALTA Health Strategies Inc. approved ALTA's proposed use of a reinsurance subsidiary for stop-loss coverage for clients provided the company met several conditions involving pricing, plan size, commissions and disclosure.

Any other rulings likely would rely heavily on the facts of individual cases.

A broad Labor Department position that such arrangements are improper could seriously disrupt the managed health care industry, since EBP is not alone in the way it does business: Many large insurers provide both claims administration and stop-loss coverage, either through their own TPA units or under administrative services only contracts.

"Our business practices are consistent with the industry," Mr. Brook said. "This is not an aberrant business practice."

• EBP's involvement as claims administrator and stop-loss reinsurer for a self-funded multiple employer welfare arrangement run by Action Staffing Inc., a Florida staff leasing company.

Based on Action Staffing's own

Continued on next page

EBP

Continued from previous page
financial statements showing it to be insolvent by $5 million last year, the Florida Insurance Department obtained a court order in February barring the firm from adding employees to the MEWA.

Claims against Action Staffing's MEWA could total $4 million, but there is only about $1 million available to cover them, EBP officials estimate.

Florida regulators could try to force EBP, Insurance Co. of North America—which fronted the stop-loss coverage for EBP's reinsurance unit—and others to cover unpaid claims under a Florida statute making those who aid and abet an unauthorized insurer liable for such claims.

EBP officials deny Action Staffing operated as an unauthorized insurer and say they are cooperating with the Florida department in trying to resolve the Action Staffing mess.

In an interview, Mr. Brook said EBP faces no more litigation than other companies in the managed health care industry, and he defended the company's efforts to provide a variety of managed care and reinsurance products.

EBP, which was founded in 1974, is the nation's third-largest claims administrator, paying $1.38 billion in claims last year for roughly 2,500 self-insured clients with more than 2.1 million employees and dependents (*BI*, Jan. 27).

Of EBP's $198.6 million in calendar-year 1991 revenues, $69.6 million was generated by claims administration work and nearly all of the balance was generated by its reinsurance operations.

The reinsurance coverages are written by EBPLife, which was created from the merger of the EBP's First Security Insurance Co. unit and Sooner Life Insurance Co., which EBP acquired last May. EBP also owns EBP Re Ltd., a Bermuda-based reinsurer the company says is now dormant.

EBP, which targets single employers with 50 to 2,500 employees, also offers benefit plan design and consulting services, utilization review programs and access to a network of preferred provider organizations.

Boom and bust

Life as a public company hasn't been easy for EBP.

The company went public at $12 a share in 1989, raising $34 million. A second common stock offering in 1990 raised $40 million more, and an issue of debentures last April raised $69 million, most of it earmarked to boost the capital of EBPLife.

As of March 13, about 1.2 million of EBP's 8.3 million outstanding shares were sold short, an unusually high volume of short sales, according to stock analysts.

EBP officials and analysts say the company has long been a target of short sellers, who sell borrowed stock hoping to repay the lender with shares they buy later at a lower price.

One rationale of the short sellers is that EBP actually functions as an insurer and that its stock should thus be trading at a multiple of 12 to 14 times earnings—as insurers' stocks do—rather than at the 20 times earnings more typical of EBP and other managed health care companies, said Patrick M. Burton, an analyst with Piper, Jaffray & Hopwood in Minneapolis, a lead underwriter of EBP's stock and debenture offerings.

EBP officials and analysts say the short sellers are at least partly to blame for the boom and bust in EBP stock earlier this year.

When EBP moved to the New York Stock Exchange from the over-the-counter market last December, its stock was trading at about $35 a share.

By Jan. 9, the stock had rocketed to $64 per share, fueled in part by a "short squeeze": short sellers who had bet on the stock dropping below $30 per share saw it rising instead and bought shares to cover their short positions, accelerating the upward move, Mr. Brook and analysts explain.

However, after the market closed on Jan. 9, EBP announced that its earnings for the fiscal 1992 second quarter ending Nov. 30, 1991, would be flat at 34 cents per share, far below analysts' estimates of 46 to 49 cents per share.

The company blamed the results on lower interest income, higher reinsurance expense levels and a rise in administrative and marketing costs aimed at producing long-term growth.

EBP's shares took a beating, falling to $30 the next day as nearly 4 million shares changed hands. The stock has since drifted downward, settling last Wednesday at $19.50 per share.

One perhaps predictable result of the earnings surprise was shareholder litigation.

Three suits seeking class-action status were filed in U.S. District Court in Minneapolis earlier this year, charging that EBP officials misled investors about the company's prospects.

The complaints—which are virtually identical—allege that an EBP official confirmed as late as Dec. 16, 1991, that the company was "comfortable" with analysts' estimates about EBP's second quarter earnings.

EBP and its top officials—including Mr. Brook and EBP President William E. Sagan—knew or should have known by Dec. 16 that the company's earnings were well below the analysts' estimates, the complaints charge.

The lawsuits allege that EBP officials intentionally misrepresented

Continued on next page

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Risk/Employee Benefits:
Vice-presidents, directors, managers, and other related department personnel of: insurance, risk, employee benefits, personnel, compensation, pension, safety, security, industrial relations, human resources and employee/labor relations 11,995
Sub-total 25,683

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Government, Unions and Educational Institutions 1,261
Commercial Consumers
Sub-total 27,386

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Single Copies 46
TOTAL 51,099

* Source Business/Occupational breakdown of qualified circulation, November 25, 1991 issue, as submitted to BPA for December 1991 BPA Publisher's Statement.

Continued from previous page
the company's results to conceal its true financial condition and to lure investors into buying EBP stock at artificially inflated prices.

EBP has not answered the complaints, but Timothy W. Kuck, its vp and general counsel, said they will be contested "vigorously."

Mr. Brook added that "nuisance is the word" that best describes the suits.

Conflict of interest?

Another group of lawsuits may be causing bigger headaches for EBP: Several suits filed in recent years have alleged that EBP conceals its role as a stop-loss reinsurer of the business of its self-insured claims administration clients, then intentionally delays and denies claims to limit losses to its reinsurance unit, EBPLife.

EBP says its critics exaggerate the extent of this litigation.

For example, EBP denies a report that it has been sued in at least 10 states by former clients alleging conflict of interest.

Business Insurance found only a handful of such suits in two states. Suits have been filed by:

- Fresh Western Marketing Inc., a Salinas, Calif., firm whose self-insured health plan was administered by EBP in 1987 and 1988. Fresh Western sued EBP, as well as other insurers and agents, in U.S. District Court in San Francisco in 1990 after agreeing to pay about $175,000 to an employee whose medical claims were denied under the Fresh Western plan.

Among other things, the lawsuit charged that EBP breached its fiduciary duties and violated federal racketeering laws by failing to disclose that it reinsured Mutual Benefit Life Insurance Co., the insurer EBP arranged to provide stop-loss coverage to Fresh Western.

EBP and Mutual Benefit conspired to delay and deny claims to benefit themselves and advised Fresh Western to deny its employee's claim because it was in Fresh Western's interest to do so, a violation of the Employee Retirement Income Security Act of 1974, the complaint alleged.

Fresh Western settled the case late last year, said its lawyer, who would not disclose terms.

EBP's Mr. Kuck said the case settled for less than the amount of the original claim.

- Beverly Roberts, a special education teacher who sued EBP in a Texas state court after EBP allegedly delayed action for several months on her preauthorization request for a procedure to correct a degenerative joint disorder. EBP ultimately denied coverage, and Ms. Roberts paid $14,000 for the surgery herself.

Ms. Roberts was insured through the Texas Educators Health Trust, a self-funded group health program for Texas school districts that EBP administered in the 1980s.

The suit alleges that EBP concealed the fact that stop-loss coverage placed with United Olympic Life Insurance Co. was ceded to Ebbtide Indemnity Ltd., a Bermuda reinsurer that later became EBP Re, the company's now-dormant offshore reinsurance unit.

"EBP's dual role as both claims administrator and reinsurer created an irreconcilable conflict of interest," the lawsuit alleged, charging that EBP's general business practice was to wrongfully delay or deny claims to benefit its reinsurance unit.

EBP settled the case last July. Without admitting or denying wrongdoing, it paid Ms. Roberts $317,500.

In its annual reports, EBP says it decided in 1990 to terminate its reinsurance of associations and small employer trusts like TEHT because of poor claims experience and the administrative burden they presented. EBP took a $9.8 million charge that year to bolster reserves on this business.

- The city of Galveston, Texas, which hired EBP in 1981 to help set up and administer a self-funded employee benefit plan.

The city amended its complaint in Texas state court in February, charging that EBP fraudulently delayed claim payments while concealing that EBP Re was reinsuring the city's stop-loss insurer, Firstmark Standard Life Insurance Co.

The complaint alleges, among other things, that EBP delayed processing more than $400,000 in claims exceeding the specific stop-loss attachment point and allowed the Firstmark policy to expire in the interim.

EBP also refused to account for alleged discrepancies in a claims trust account set up for the program, alleges the suit, which seeks more than $4 million in damages.

In an answer filed last month, EBP denied the allegations and leveled a counterclaim charging Galveston with bad faith and harassment in bringing the suit.

Mr. Brook complains plaintiffs' lawyers have "leveraged" run-of-the-mill claims disputes by throwing in unfounded conflict-of-interest charges.

He also noted that the Roberts and Galveston suits and a third conflict-of-interest complaint were all filed by the same Texas lawyer, who Mr. Brook charges is on an anti-EBP vendetta.

The attorney, B. Russell Horton, said he could not comment because of pending litigation.

EBP officials strenuously deny any failure to disclose the company's role as a reinsurer and deny any self-dealing or conflict in the way EBP sets up client programs.

Mr. Brook acknowledged that Fresh Western's 1987 and 1988 contracts with EBP did not disclose EBP's role in reinsuring Mutual Benefit.

However, he noted that ERISA at the time was unclear on whether disclosure in the contract was required. It was not until 1989 that the Society of Professional Benefit Administrators concluded that a TPA's involvement in risk sharing should be disclosed, he noted.

EBP added the disclosure to its contracts in late 1988, according to Mr. Kuck. A sample contract he provided to *Business Insurance* included the disclosure.

Within the last several weeks, EBP also has added the disclosure to the proposals it submits to potential clients, Mr. Kuck noted, emphasizing that the change is not an admission that disclosure was inadequate before.

Previously, EBP proposals described stop-loss coverage in general terms as one of EBP's services, but did not state that the prospective client's own risks might be ceded to EBP's reinsurance unit.

Along with these disclosures, EBP's assumption of client stop-loss risks is also described in its annual reports and Securities and Exchange Commission filings.

Mr. Brook also flatly denied allegations that EBP manipulates claims to aid its reinsurance units.

The company operates 18 claims offices across the country. Claims processing typically involves oversight by several layers of EBP employees and can even involve different computer systems in different areas, Mr. Brook said.

"Does anyone think we can sit in Minneapolis and orchestrate a sting with 1,400 employees?" he asked. "It's absurd.

"As a practical matter, I don't know how we would do that," he observed. "Secondly, the market would not allow us to do that."

In 1987, EBP solicited an opinion on ERISA compliance issues from the Washington office of the law firm Gibson, Dunn & Crutcher. In a 30-page letter, the law firm concluded that EBP's reinsurance activities probably violated ERISA Section 406(b) prohibitions against self-dealing and conflict of interest.

The opinion also concluded that EBP probably would be liable for excise taxes, civil penalties and damages in private suits as a result of the prohibited transactions. However, Gibson, Dunn later conceded that some of these findings were wrong and in an October 1988 letter withdrew its opinion on EBP's tax liabilities and modified its position on civil penalties.

Mr. Brook says Gibson, Dunn performed only a "cursory" review of EBP's operations.

EBP went to the Washington, D.C., firm of Groom & Nordberg for a second opinion.

In a 40-page memorandum, Groom & Nordberg also concluded that Gibson, Dunn was wrong in finding that EBP was engaged in transactions barred by ERISA.

Among other things, the memo concluded that EBP had structured its TPA operations so it probably would not be considered a "plan fiduciary" under ERISA and that the Section 406(b) prohibitions against self-dealing by fiduciaries therefore would not apply.

But, Groom & Nordberg cautioned that if EBP is ultimately ruled a fiduciary, "our conclusion would be subject to change."

The Kansas City, Mo., office of the Labor Department's Pension and Welfare Benefits Administration has been auditing EBP since early 1988, periodically requesting information and paying visits to the company's Minneapolis head-

Continued on next page

EBP

Continued from previous page
quarters, EBP officials confirm.

Documents requested by the Labor Department have included EBP's SEC filings, stock prospectuses, reinsurance agreements, standard administrative agreement, claims manual and other material.

Mr. Brook says the Labor Department has given no indication that it is looking specifically at the conflict-of-interest issue or that the audit is anything more than a part of the agency's nationwide effort to monitor third-party administrators.

MEWA problems

Meanwhile, EBP is also coping with the collapse of the self-funded MEWA set up by Action Staffing, a Tampa, Fla.-based staff leasing operation.

Action Staffing took over the staffs of small companies and leased them back to the companies while providing payroll, administration and other services, including health benefits. In all, Action Staffing leased more than 11,000 employees to more than 600 companies in 32 states.

Until last July, Action Staffing's health benefit program was fully insured by Aetna Life & Casualty Co., according to Philip M. Payne, a staff attorney with the Florida Insurance Department.

After the Aetna coverage was terminated, Metropolitan Life Insurance Co. briefly provided full coverage. However, Action Staffing soon forged an administrative-services-only contract with Met Life, according to Mr. Payne.

When the Met Life agreement was terminated last September, EBP became the administrator of a self-funded plan.

Under the plan, Action Staffing was to self-fund claims up to $100,000 per employee. Above that, Action Staffing had stop-loss coverage provided by INA, a CIGNA Corp. unit. INA ceded 100% of the stop-loss risk to EBPLife.

EBP started processing claims but quickly ran into problems, according to Mr. Kuck, EBP's general counsel. By November, Action Staffing was not providing the funds EBP needed to pay claims, and by mid-December EBP notified the Florida department that the program might be in trouble, Mr. Kuck said.

Action Staffing itself filed a 10-K statement with the SEC in early January showing a $5 million capital deficiency as of Aug. 31, 1991, the end of its fiscal year.

Meanwhile, the Labor Department—which is investigating Action Staffing—issued an opinion letter to the Georgia Insurance Department that Action Staffing's benefit program was a MEWA and therefore subject to state regulation.

In a separate Jan. 29 letter to Action Staffing Chairman David Miller, the Labor Department cited a $900,000 shortfall in funds available to pay claims and said Action Staffing may have breached its fiduciary duties to plan participants, according to the Florida department.

Based on Action Staffing's statement and the Labor Department's opinion letter, the Florida department ordered Action Staffing on Jan. 30 to stop enrolling employees in the program.

A Florida judge later ordered Action Staffing to set up escrow accounts for premium funds and a $1 million tax refund, believed to be the largest source of ready cash for claims payments.

Mr. Kuck said that only about 5,000 employees were enrolled in Action Staffing's self-funded program at its peak and that unfunded claims may total between $3.2 million and $4 million. None of claims exceed the $100,000 stop-loss threshold, Mr. Brook said.

EBP terminated its contract with Action Staffing Jan. 23 but has continued to process claims. Mr. Brook said the loss of the company as a client "will have no material impact on EBP."

In a meeting with Action Staffing's insurers earlier this year, Florida regulators asked the insurers if they would be willing to cover the unpaid claims.

But in a March 4 letter, CIGNA Counsel Walter Heindl responded that INA and EBPLife would be willing to refund only the $291,039 in stop-loss premiums they received.

Mr. Brook added in an interview that EBP may also forego its administration fees for Action Staffing claims.

The Florida department has raised the possibility of suing EBP and the insurers under a state statute holding those who aid and abet an unauthorized insurer responsible for unpaid claims, Mr. Payne confirmed.

Mr. Heindl denied any liability under the statute in his letter, though, arguing that the Labor Department was wrong in labeling Action Staffing's benefit program a MEWA, that the program was not an unauthorized insurer and that INA did not aid or abet an unauthorized insurer.

Mr. Brook also denied the aiding and abetting allegation and maintained that EBP is trying to cooperate with regulators.

As EBP prepares to announce its fiscal third quarter results this week, stock analysts' opinions on the company remain somewhat divided.

Analysts at Smith Barney, Harris Upham & Co. downgraded EBP's stock to "hold" from "buy" after the January price decline, citing possible increased competition and a management "credibility gap" created by the second quarter earnings surprise.

But, while acknowledging the disappointing second quarter, analysts at Piper Jaffray and Dean Witter Reynolds Inc. say the company is fundamentally strong and a good long-term investment.

For his part, Mr. Brook expressed belief in EBP's mission and prospects: "I believe we have really done a service to this country" in making health benefits affordable for small employers. ■

Dingell proposal

Continued from page 1
policyholders if the large policyholder is bankrupt and its federally certified insurer is insolvent.

Otherwise, the policyholder would be responsible to pay those claims.

Insurers welcome the rate and form exemption, which they say would lower administrative costs.

"These are transactions between sophisticated buyers and insurers who do not need that kind of regulation. That type of regulation needlessly adds to the cost of insurance," said David Pratt, vp-federal affairs with the American Insurance Assn. in Washington, D.C.

"For the commercial insurance buyer, this is very big news," Mr. Pratt added.

The AIA earlier had proposed to allow all insurers to opt for federal regulation.

And, the Risk & Insurance Management Society Inc. this month proposed that federally licensed insurers be free from rate and policy form requirements (*BI*, April 6).

The legislation is the result of more than four years of hearings by Rep. Dingell on the adequacy of state regulation. During those hearings, "what we have discovered is that insurance companies can be inviting targets for mischief, scoundrels and fraud," Rep. Dingell said.

But Rep. Dingell is not ready to throw out state regulation. Instead, he would let insurers choose either state or federal solvency regulation.

Insurers that choose federal regulation would have to meet specific financial standards, like minimum capital and surplus requirements, established by the Federal Insurance Solvency Commission. The commission would be modeled after the Securities and Exchange Commission.

The standards for a federal certificate would vary based on the size of the insurer, the lines of business it writes and whether it is a domestic or foreign company. As of late last week, those standards were not available.

The bill also would require foreign insurers to establish a commission-approved trust fund to assure claims payments. In addition, foreign insurers would be required to allow the commission to review all financial records.

A federal certificate of solvency would authorize an insurer to write business in any state without any regulation of its financial condition by a state.

Federally certified insurers also would be exempt from participating in state guaranty funds, but those insurers would have to join the new federal guaranty fund.

Reinsurers also could obtain federal certification.

Insurers would have a powerful incentive to encourage their reinsurers to obtain such certification: Under the measure, an insurer could take credit for reinsurance only from reinsurers that were federally certified.

Several types of reinsurers would be eligible for certification.

For example, a company that writes only reinsurance could obtain a certificate to be a "professional reinsurer." A professional reinsurer would have to maintain at least $50 million in capital and surplus.

In addition, a federal reinsurance certificate would be available to any insurer that also holds a federal solvency certificate, as well as to state-licensed insurers and to foreign reinsurers.

However, to obtain this reinsurance certificate, a reinsurer would have to meet higher capital and surplus requirements than are needed to provide insurance. The reinsurer also would have to allow the commission to monitor and regulate its financial condition.

Several insurer groups welcomed introduction of the legislation, though they caution they have not completed study of the 234-page bill.

"We will have to look at the full details," said Barbara Haugen, director of federal affairs for the National Assn. of Insurance Brokers in Washington, D.C.

"We have to examine how the different provisions interact with one another," said the AIA's Mr. Pratt.

However, the Alliance of American Insurers says a new system of federal regulation is not necessary and will add to costs.

"The record with dealing with problems at the state level demonstrates that state regulation is viable and effective. This will add a new layer of regulation that is unnecessary and costly," said David Farmer, vp-federal affairs in the Alliance's Washington, D.C., office.

National Assn. of Insurance Commissioners President William McCartney said regulation at the federal level could suffer while the new solvency commission develops regulatory expertise.

"It could take decades to replicate the regulatory system we now have in place. For a time, we could have the largest insurers regulated by amateurs. I don't see how that could help consumers or, in the final analysis, the industry itself," said Mr. McCartney, Nebraska's insurance director.

Insurance industry lobbyists say the introduction of the Dingell bill is only a starting point for discussion and doubt that Congress will act in the remaining months of this legislative session.

Earlier in the day at Rep. Dingell's hearing, proponents and opponents of federal solvency regulation—like actors in a regulatory morality play—attempted to convince a congressional audience of the virtue of their positions.

Unfortunately for advocates of continued state solvency regulation, only one member of the audience counted, and he tendered his review before the action began.

"Previous hearings and reports by the subcommittee and the General Accounting Office have found that the current state solvency regulation has serious deficiencies—both predictable and, quite frankly, intractable—stemming from 50 separate governments attempting to regulate a major international financial industry with a patchwork of piecemeal jurisdiction and solvency rules," Rep. Dingell said.

Rep. Dingell's dim view of state regulation was shared by the first witnesses, a panel of GAO officials who had studied the NAIC accreditation process. They praised the commissioners' efforts, but still found them lacking.

In a 1991 report, the GAO sharply criticized state regulation (*BI*, May 27, 1991). The GAO noted that, as a trade association, the NAIC is powerless to force states to comply with its standards on items like minimum insurer financial standards or minimum department staffing requirements.

Richard L. Fogel, the GAO's assistant comptroller general-general government programs who had presented that initial report to Rep. Dingell's subcommittee last year, made clear that he remains skeptical of the NAIC's abilities.

"Our message today is that while the NAIC accreditation program has encouraged wider adoption of NAIC standards, it is not yet a credible mechanism for indicating that a state insurance department adequately regulates insurers within its borders," he said.

Three major flaws mar the NAIC program, according to Mr. Fogel.

First, financial regulation standards "are for the most part general and have been interpreted permissively," he said.

In addition, the program "has too little focus" on "how well the state insurance department actually does its job," he said.

"Finally, the review teams' documentation of their accreditation decisions has not consistently supported the. . .decisions they've reached," said Mr. Fogel.

Wisconsin, for instance, has been accredited, despite a backlog of eight to 10 years in its examination of the financial strength of some domestic insurers, according to the GAO.

Rep. Dingell asked what the GAO considered to be the shortcomings of each of the nine states the NAIC has accredited.

Mr. Fogel obliged him, holding that some states had too few specialists on their examination teams, that others did not provide adequate documentation of how they had gone about meeting the NAIC standards and that still others had allowed "considerable variation" in how financial examiners had carried out their tasks.

When Rep. Dingell turned his attention to a panel of witnesses representing the NAIC, Mr. McCartney opened his defense of state regulation with a shot at the GAO.

"I fear that in the GAO's reports they may have found a few trees but missed the forest," he said.

"The existing state-based system has worked" for more than a century, Mr. McCartney said, and asked rhetorically whether consumers would benefit from a federal system. He said that a dual system of state and federal regulation, such as that used to oversee financial institutions, would be fraught with problems and that he could see no advantages to a pure federal system of regulation.

"I submit that our approach is taking a good system and making it better," said Mr. McCartney.

It was clear that Rep. Dingell did not agree. After briefly discussing the funding of state insurance departments, the chairman turned his attention to specific questions raised by the GAO. He began with Wisconsin's examination backlog.

"I'm very curious as to how a state with a 10-year backlog was accredited," he said.

Neil Rector, former Ohio deputy insurance commissioner and one of the team that had accredited Wisconsin, answered that he thought the backlog was actually five to six years and that it involved only a "few" of the state's largest, most financially stable companies.

Rep. Dingell asked how many companies constituted "a few." Mr. Rector said he didn't know, maybe five. A half-dozen or maybe a dozen? asked Rep. Dingell. Mr. Rector said he wasn't certain. Could it be 20? Could it be 30? Could it be 40? Could it be 100? asked the chairman. Mr. Rector replied "it could be" after each question.

Mr. Dingell continued a leisurely Midwestern tour of the reported shortcomings of state regulation before turning south and east to round out the trip through accredited states.

Toward the end of the nearly five-hour hearing, Rep. Dingell asked about the effectiveness of state guaranty funds. He said that somebody had to pay for the cost of bailing out insolvent insurers.

"I can assume that the people who are getting stuck are the policyholders in other states," he said.

This led to a discussion of who actually owns a mutual insurance company, with Mr. Rector likening mutual policyholders to members of a church.

"If a church owns an insurance business, who regulates that business, the Good Lord?" asked Rep. Dingell.

"I'd hope there'd be good regulation at both ends," responded Mr. Rector.

Rep. Dingell replied that "the Good Lord has a much better record" than earthbound insurance regulators. ■

Acquisitions

Continued from page 2
canson & Holt offers products including disability, long-term care, and special-risk reinsurance.

W. Francis Brennan, executive vp of UNUM's Related Businesses Group, said that the move "increases the depth and breadth of our reinsurance management experience and capitalizes on the complementary knowledge and expertise within each company."

Mr. Brown will remain chairman and CEO of Duncanson & Holt and will assume management of UNUM's consolidated reinsurance operations after the merger.

Terms of the acquisition—which is subject to regulatory approval and execution of a definitive agreement—were not disclosed.

Minneapolis-based RAI—formed in 1988 by former executives of E.W. Blanch Co.—generated between $7 million and $8 million in gross revenues in 1990, making it roughly one-third the size of Hodson, which generated $23.5 million.

The acquisition will be completed through an exchange of shares between Willis Corroon and RAI, which is jointly owned by Richard E. Swager, the company's chairman and CEO, and Christopher J. Williams, its president.

Mr. Swager will remain chairman and chief executive of Hodson's new Reinsurance Alternatives division and will become an executive vp of Hodson. Mr. Williams will remain division president and become a Hodson senior vp.

Stephen A. Crane, Hodson's president and chief executive, said Hodson had previously handled only a little accident and health reinsurance business, so there will be "no conflict of turf."

"We are going from a very low level (of life and A&H business) to a very high level in one transaction," he observed.

Mr. Williams added that referrals from Willis Corroon's worldwide retail brokerage network will be a big boost for Reinsurance Alternatives' business.

"We are excited about the prospect of accessing their retail outlets," he said.

Mr. Crane noted that the acquisition furthers Hodson's goal of building specialized expertise in the firm. Other specialties include trucking, aviation, medical malpractice, municipal liability, lawyers professional liability and surety and fidelity coverages. ■

Principals at jewelers indicted in heist fraud

NEW YORK—The Manhattan district attorney's office has indicted five principals of two New York jewelry makers for allegedly staging a phony burglary and filing a $5 million claim with Lloyd's of London underwriters and a CIGNA Corp. unit in London.

The April 7 indictment charges the principals of Cindy Royce Creations Inc. and Maximus Jewelry Creations Ltd. with rigging their alarm systems, torching safe doors and vandalizing the Madison Avenue location they shared to make the August 1989 staged burglary appear authentic.

Indicted were Samuel and Randy Scheiner, Morton Gold, Benoit Dreyfus and Daniel Squillante, some of whom were principals of both firms. All were arraigned last Tuesday and released on their own recognizance. If convicted, each faces up to 25 years in prison for insurance fraud, conspiracy and attempted grand larceny.

However, the jewelers' insurers never paid their claim. They denied the claim after their attorneys and an independent adjuster determined that the burglary had been staged to collect on the insurance policies, which were taken out only a month earlier.

The insurers include Lloyd's syndicate 404, managed by Cuthbert Heath Underwriting Ltd., lead underwriter on the jewelers' $2.5 million primary jewelers block policy; and syndicate 1014, managed by R.M. Pateman Underwriting Agencies Ltd., and INA U.K. Ltd., co-lead underwriters on a $2.5 million excess policy.

The jewelers later unsucessfully sued the insurers in London for indemnification, said insurer attorney Dennis Wade of White, Fleischner, Fino & Wade in New York.

—By Michael Schachner

Coverage for potential blast claims

BRENHAM, Texas—Insurance is available to pay liability claims that could result from an explosion last week at a petroleum gas storage facility in southern Texas.

The blast at the underground facility killed a child, injured 20 others, including several workers, and destroyed dozens of homes. It was triggered after a pipeline leaked propane and methane gas. Officials were unsure what caused the leak and explosion.

Commercial damage was limited to small structures at the site, but a county official said in a published report that personal property damage will total about $3 million.

The facility is run by Seminole Pipeline Co., which is 80% owned by MAPCO Transportation Inc., a subsidiary of MAPCO Inc.

Tulsa, Okla.-based MAPCO Inc. has property/casualty insurance written by domestic and foreign insurers, including Lloyd's of London syndicates, said Carl Paxton, manager of insurance and benefits investments. The coverage, which was brokered by Frank B. Hall & Co. Inc., has significant deductibles, he noted.

Coastline Gas Pipeline Co. in Houston also operated a pipeline at the facility. Coastline is a subsidiary of MidCon Corp. of Lombard, Ill., whose parent company is Occidental Petroleum Corp. in Los Angeles.

Occidental's insurance "is more than sufficient" to pay any claims, said MidCon Assistant Treasurer John Nylen.

—By Michael Bradford

Pension benefits

Continued from page 2
the country: the interplay between the Employee Retirement Income Security Act of 1974 and federal bankruptcy law.

Under ERISA, benefits generally cannot be attached or assigned to another party. A limited exception allows assignment of benefits in certain property settlement cases, like divorces.

Under federal bankruptcy law, creditors generally have a right to assets in a debtor's estate. However, Section 541 of the Bankruptcy Code of 1978 says assets protected under "applicable non-bankruptcy law" are not considered estate assets and are thus safe from creditors.

Several courts have interpreted applicable non-bankruptcy law to refer to so-called "spendthrift trusts" established under state law. Under this view, only pension plans that qualify as spendthrift trusts under the relevant state law would be excluded from the property of a bankruptcy estate.

A spendthrift trust is a mechanism to restrict access to funds. For example, a parent could establish a spendthrift trust for a child that would bar the child's access to the funds until the child turns 21. The trust could be designed to then limit the amount of money that may be withdrawn annually in succeeding years.

Regardless of how the high court rules in *Patterson vs. Shumate*, the outcome will be of vital importance for employers and pension plan participants.

"Every pension plan has a stake in the outcome in this case, as do participants," observed Mark Ugoretz, president of the ERISA Industry Committee, a Washington-based benefits lobbying organization representing large employers.

"The employer could be caught in a terrific bind. If an employer pays out benefits to creditors, it runs the risk of its plan being disqualified. If it doesn't, it would violate a bankruptcy court order," he said.

"If creditors can seize pension benefits, it would undermine the entire foundation of ERISA: the accumulation of benefits for retirement," said Lynn Dudley, senior legislative analyst at the Assn. of Private Pension & Welfare Plans in Washington, D.C.

"The consequences would be immense," she said.

The high stakes have not gone unnoticed by benefit groups and employers, which have filed friend of the court briefs. They include the APPWP, ERISA Industry Committee, the American Society of Pension Actuaries, the U.S. Chamber of Commerce and Hallmark Cards Inc. of Kansas City, Mo.

If bankruptcy trustees could obtain participants' benefits, a pension plan could be disqualified, "which would effectively destroy the plan," Hallmark says in its brief.

The case before the Supreme Court involves pension benefits promised to Joseph Shumate, a retired furniture company president who had worked for the company over three decades.

In 1984, Mr. Shumate filed for personal bankruptcy. A bankruptcy trustee representing Mr. Shumate's creditors challenged Mr. Shumate's right to receive his pension benefits, which were worth a total of about $250,000.

In 1988, a U.S. District Court in Virginia ruled that Mr. Shumate's pension was not protected under federal bankruptcy law and that his pension benefits did not qualify as a spendthrift trust under Virginia law.

But, the 4th U.S. Circuit Court of Appeals reversed the district court's ruling in 1990.

The appeals court ruled that ERISA's restrictions on benefit assignments are spendthrift restrictions protected by federal bankruptcy law.

"Applicable non-bankruptcy law means precisely what it says: all laws, state and federal, under which a transfer restriction is enforceable," the court wrote.

"Nothing in the phrase 'applicable non-bankruptcy law'. . . suggests (it) refers exclusively to state law much less to state spendthrift trust law. We further held that because ERISA enforces restrictions on the transfer of pension interests under its non-alienation requirement, it constitutes an applicable non-bankruptcy law," the court ruled, citing an earlier case.

In its brief filed with the Supreme Court, the Chamber of Commerce said there is sound social policy behind protecting retirement benefits from a bankrupt employee's creditors.

"An older worker. . .will simply be unable to replace either of the two remaining minimum components of his or her retirement income. For this reason, both Social Security and employer-sponsored retirement benefits have long been viewed as excluded from the estate of a bankrupt debtor. This assures that debtors who have accumulated credits under retirement plans will not have to depend upon public assistance or other assistance for the aged or infirm," the Chamber said. ■

Buchalter appeal

Continued from page 2
Linda Lasley.

Pine Top, which is not writing any new business and is in runoff, in March became a unit of GFC Financial Corp. of Phoenix. An affiliate, Pine Top Insurance Co. of Chicago, was ordered liquidated in Illinois in 1986 (*BI*, July 30, 1986). The London company, though, is not affected by the Illinois liquidation.

The underlying reinsurance dispute stemmed from Pine Top's participation in a London-based quota-share reinsurance pool developed by reinsurance broker Charman Mauduit (Insurance Brokers) Ltd. This pool, which included five other reinsurers, agreed to provide 100% reinsurance to a group of U.S. property/casualty insurers.

Los Angeles-based Fremont Indemnity Co. was the only U.S. reinsurer in the pool, and the ceding companies looked to it for payment of losses, according to court documents. Fremont in turn sought reimbursement from the other pool members, including Pine Top.

Fremont initiated arbitration proceedings in California to determine how much the pool owed to two ceding companies: Covenant Insurance Co. and affiliate Covenant Mutual Insurance Co.

Fremont also filed litigation in London to compel Pine Top to pay its share of the losses, court papers show.

Eventually, the two compromised. Pine Top agreed to pay 57.5% of the losses, and Fremont 42.5%.

It is not clear from the court papers why contributions were not also made by the other four pool members, which are not identified in the papers.

Pine Top then filed suit alleging that its liability for the Covenant companies' losses was a direct result of Buchalter's negligent legal representation in the arbitration.

In essence, the reinsurer claimed that if Buchalter had not negligently represented both Fremont and Pine Top in the arbitration with the ceding companies, the reinsurers would not be liable for their losses.

Pine Top accused Buchalter of failing to raise certain defenses in the arbitration. And, the reinsurer said the dispute with the Covenant companies should have been litigated and not arbitrated, so that there could have been discovery of documents.

Buchalter, however, claims that it represented only Fremont in the arbitration.

In a motion to avoid document production, the firm said: "Pine Top is not now and has never been a client of the Buchalter law firm."

After a five-week trial, the jury on March 31 ruled 12-0 to award Pine Top $2.7 million in compensatory damages for legal malpractice. Because the jury was not asked to answer any specific questions, it is difficult to discern the basis for the verdict.

Attorneys for Buchalter say they will file post-trial motions asking the judge to overturn the jury's verdict or order a new trial. If these motions fail, the law firm will appeal, said Thomas W. Johnson Jr. of Irell & Manella in Los Angeles.

Mr. Johnson and attorneys for Pine Top refused to further discuss the case.

In other news, Buchalter, Nemer, Fields & Younger is awaiting court approval of settlements reached between its client, Pacific Reinsurance Management Corp., the former reinsurance pooling unit of insolvent Mission Insurance Co., and six reinsurers.

Settlement terms were not disclosed.

PRMC won a $94.5 million arbitration award in 1989 against the six reinsurers (*BI*, Nov. 6, 1989).

The six reinsurers are: Ohio Reinsurance Corp., Abeille-Paix Reassurances, Hamburg International Reinsurance Co., Hassneh Insurance Co. of Israel Ltd., Seguros America S.A., and Compagnie Transcontinental de Reassurances.

The reinsurers subsequently sought to have the award overturned, alleging that PRMC attorney Ms. Lasley had a relationship with one of the arbitrators (*BI*, Jan. 22, 1990; Jan. 15, 1990).

PRMC settled with all of the reinsurers before this conflict of interest issue could be determined by a court.

The settlements have been occurring for the past two years and were completed two months ago (*BI*, April 23, 1990; March 19, 1990).

The settlements also mean that the six reinsurers are not part of litigation between PRMC and all of its reinsurers. In July 1991, Los Angeles Superior Court Judge Kurt J. Lewin ruled that the reinsurers cannot rescind their contracts by claiming they were defrauded (*BI*, July 8, 1991). ■

Update

SEC censures M&M auditors

NEW YORK—The Securities and Exchange Commission has censured two Arthur Andersen & Co. auditors for failing to exercise "due professional care" in auditing the 1983 financial statements of Marsh & McLennan Cos. Inc.

The audit failed to uncover unauthorized bond trading by M&M employees that ultimately produced $165 million in pretax losses.

Without admitting or denying wrongdoing, John R. Schoemer and Michael P. Denkensohn agreed to the censure, which limits their ability to audit public companies for one year.

Mr. Schoemer no longer works for Arthur Andersen. Mr. Denkensohn is an Andersen partner, according to the SEC.

M&M settled SEC charges stemming from the bond trading debacle in 1987 (*BI*, Jan. 26, 1987).

Maryland limits cleanup cover

ANNAPOLIS, Md.—Pollution cleanup costs are not insured "damages" as that term is used in the comprehensive general liability insurance policy, a Maryland appellate court has ruled.

The April 3 decision, which overturned a lower court ruling (*BI*, Jan. 7, 1991), bars Bausch & Lomb Inc. from recovering from Utica Mutual Insurance Co. the costs of a potential multimillion dollar cleanup at a site in Sparks, Md. B&L already has spent $700,000 to study and $200,000 to clean up pollution at the site.

The Utica policy contained standard CGL language that the policy "will pay on behalf of the insured all sums which the insured shall become legally obligated to pay as damages."

The three-member appellate court said it would follow the reasoning of the 4th Circuit in *Maryland Casualty Co. vs. Armco Inc.*, which held that "damages" includes only monetary judgments from a court of law (*BI*, Feb. 9, 1987). But, the Maryland appellate court did recognize that this holding is a minority view.

$6 million car seat settlement

WAUKEGAN, Ill.—Two insurers will pay $3 million each to settle a lawsuit by a boy injured in a car crash nearly six years ago while he was restrained by an allegedly defective car seat.

The settlement was announced last month, just before trial was to begin in state court here.

According to a lawyer for the defendants, RLI Insurance Co. in Peoria will pay on behalf of the former International Manufacturing Co., which made the seat. And Zurich American Insurance Co. in Schaumburg, Ill., will pay on behalf of Child World Inc., the store chain that allegedly sold the car seat.

The money will be placed in trust to pay medical expenses for the eight-year-old, who is now a quadriplegic.

Briefly noted

A preliminary version of an amendment to Financial Accounting Standards Board Statement No. 35 would require defined benefit plans to value **guaranteed investment and bank investment contracts** at market value. The board said it would rely on the American Institute of Certified Public Accountants to issue guidelines for assets held by defined contribution plans. . . .Bermuda-based financial reinsurer **Independence Insurance Co. Ltd.** has stopped writing new and renewal business, after the company's parent, Hill Samuel Bank, decided to wind up the operation (*BI*, March 30). . . .**Travelers Corp.** is filing a shelf registration with the Securities and Exchange Commission to issue up to $300 million in preferred stock as part of continuing efforts to raise capital. . . .The District of Columbia Council has approved a bill that would extend **health care benefits to domestic partners** of unmarried city employees who register with the city (*BI*, March 16). The bill faces opposition from conservative members in Congress, which must approve the measure. . . .**Wind, hail, tornadoes and flooding** caused about $385 million in damage to portions of Florida, Louisiana and Texas March 24-25, while more wind, hail and tornadoes caused about $25 million in damage to parts of Florida, Georgia and Texas March 28-30. . . .Georgia D. Flint has been named **Texas commissioner of insurance** after serving as interim commissioner since Jan. 1 and as acting commissioner since last November. . . .**American Business Insurance Inc.** named Stephen J. Lehman president and chief executive officer, replacing Bernard H. Mizell, who resigned in February (*BI*, March 2). . . .The continuing merger talks between the **Independent Insurance Agents of America and the National Assn. of Professional Insurance Agents** are expected to culminate in a membership vote by year end. A formal merger plan is scheduled for completion in August and will be voted on by both boards at an October meeting. . . .Rockwell International Corp. has agreed to pay $18.5 million in fines and will plead guilty to **five felony and five misdemeanor counts of violating environmental regulations** during its former management of the U.S. Department of Energy's Rocky Flats nuclear weapons plant near Denver. Rockwell managed the plant from June 30, 1975, to Dec. 31, 1989. . . .A state appeals court in San Francisco has overturned a decision against a blood bank finding **negligence in the case of a transfusion** of AIDS-tainted blood (*BI*, Dec. 12, 1988). The ruling overturns a 1989 award of $416,307. . . .**Capital Re Corp.**, the holding company for financial guarantee insurer Capital Reinsurance Co., raised $123.3 million with last week's sale of 6.3 million shares in its initial public offering. The stock was sold by the company as well as by stockholders (*BI*, March 30). Capital Re will receive net proceeds of $61.2 million from the sale. . . .Sun Life Insurance Co. of America is launching a GIC with financial guarantee insurer MBIA Corp., to be called **Five-Star GIC**. MBIA, which is rated triple-A, has agreed to guarantee payments should Sun Life be unable to meet its obligations.

N.Y. surcharges

Continued from page 1

As a result of the new 11% "tax," which, unlike the existing 13% surcharge, will be paid to the state treasury, commercial insurers' competitive position will be damaged.

Employers may consider switching group health plans written by commercial insurance companies to a Blues plan or self-insurance, according to health care consultants and insurers.

"There's no question this substantially hurts the competitive position of (commercial) insurers compared to the Blues," said Ray d'Amico, senior vp and general counsel with the Life Insurance Council of New York, an insurance company trade group. "Given that health insurance is barely a break-even venture to begin with, this will definitely result in rate increases."

"This will obviously impact our rate filings and will result in premium increases for our employer customers," said Emily Crandall, vp and associate general counsel with New York-based Guardian Life Insurance Co. of America, one of the state's largest group health insurers.

"It makes us much less competitive than the Blues, especially in the over-50-lives market, where we compete on the same terms. Now Blue Cross, which pays no taxes, has a 24% price advantage on hospitalization," she pointed out.

Phillip J. Harrington, vp-government relations with Newark, N.J.-based Prudential Insurance Co. of America, another of New York's large group health insurers, said his company is determining how much it will have to bump up premiums to offset the additional surcharge.

"Inpatient costs account for about 45% of total health care premiums, so I think you can expect about 5% premium increases on comprehensive health care policies," said Mr. Harrington.

"It's now very difficult for Prudential to continue competing with the Blues on hospitalization. They have been enjoying a 13% differential and pay no premium or income taxes," said Mr. Harrington.

But BC/BS maintains that this new measure will not help compensate for poor loss results in recent years. A spokesman for Empire Blue Cross & Blue Shield in New York City insisted that nothing short of a legislative mandate forcing all insurance companies to accept all risks will help the Blues.

The six New York BC/BS plans provide hospitalization coverage to about 12 million people statewide through both individual and group health plans, or about 52% of the state's insured health care market. They "offer community-rated open enrollment, make hospital payments in advance, subsidize Medicare supplemental products and participate in various programs that provide coverage for the uninsured," said the Empire BC/BS spokesman. The fact that the plans pay hospital charges at cost is "still not enough" to cover these costs, he said.

"We have been devastated by the commercial market, which has selectively picked off about 400,000 of our best group risks in recent years. They won't touch construction workers or restaurants. Somewhere, a stand must be made, or we'll need rate increases every six months," he said.

'Given that health insurance is barely a break-even venture to begin with, this will definitely result in rate increases,' says Mr. d'Amico.

Health care consultants say the increase in supplemental charges may force employers to reconsider how they fund hospital costs for their employees, especially if the provision is extended beyond fiscal year 1992.

"The additional supplemental charge may make former Blue Cross clients think again about insuring with the Blues," said Pat Wiley, managing consultant with A. Foster Higgins & Co. Inc. in New York.

"What I see coming out of this is more self-funding," said Edwin Freedman, managing director of The Alexander Consulting Group Inc.'s health and welfare practice in Lyndhurst, N.J. "What a clever way Albany has come up with to kill two birds with one stone. This provision props up Blue Cross until it can find a long-term solution (to its financial problems) and also generates money to help close the state's budget gap."

A separate provision in the 1992 budget will require health maintenance organizations, beginning July 1, to pay as much as a 9% surcharge on inpatient hospital charges unless they pick up a "fair share" of Medicaid participants in the region they service. This provision, which expires Dec. 31, 1993, applies to all New York HMOs, including BC/BS's HealthNet HMOs.

Ray Sweeney, director of health systems management with the Health Department in Albany, said that HMOs will be able to offset all or a portion of the 9% differential by taking in a percentage of Medicaid-eligible people, up to a number equal to the percentage of the HMO's market share.

For example, an HMO with a 20% market share in a region would be able to "buy back" the hospitalization surcharge by accepting 20% of the area's Medicaid participants. Below that percentage, a sliding scale determines what portion of the 9% surcharge will be returned to the HMO, said Mr. Sweeney.

"The whole principle is to provide an incentive for HMOs to accept their fair share of Medicaid patients. It's a clear, solid program that has the potential to extend beyond next year," he added.

In response to the HMO provision, Mr. Harrington of Prudential said PruCare, the company's HMO, is already enrolling Medicaid participants. "We're committed to meeting the state's goals and will try to work our way toward a zero surcharge."

LICNY's Mr. d'Amico said most insurers with HMO programs should be able to accrue enough "good deed" points to drive the HMO differential down to 3% or less.

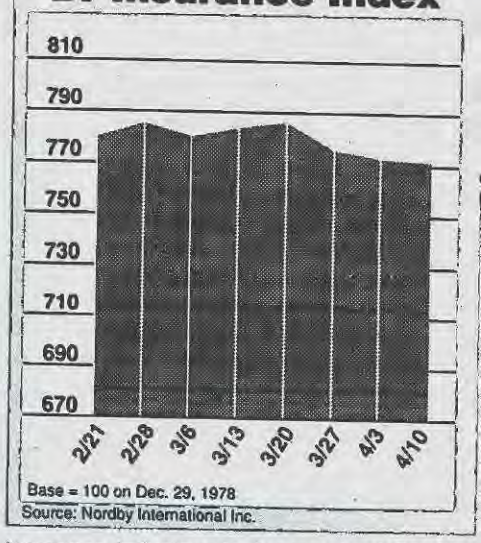
However, he pointed out that several New York HMOs operate in areas where Medicaid is not yet coordinated with managed care firms and, thus, will be subject to surcharges.

"It could be years before the state has a managed Medicaid program everywhere. Until then, HMOs will be hit," said Mr. d'Amico.

Alexander Consulting Group's Mr. Freedman found nothing wrong with the HMO incentive program.

"The state has really wrapped some public policy issues into this budget. Setting out incentives to meet Medicaid participation goals is a new one, and it could work," he said. ■

BI Insurance Index



Insurance industry stocks remained flat last week, as the *Business Insurance* Index fell 0.6 points to 771.6 on April 10 from 772.2 on April 3. Advancing issues for the week were led by USF&G Corp., up 21.5%; FHP International, up 11.2%; and Fremont General Corp., up 9.3%. Declining issues followed Lawrence Insurance Group, down 9.7%; Transatlantic Holdings, down 7.8%; and Selective Insurance Group, down 7.8%. The most active issue was U.S. Healthcare, 5.7 million shares traded. The *BI* Index was down 0.1%; the New York Stock Exchange Composite was up 0.6%; the Standard & Poor's 500 was up 0.7%; and the Dow Jones 30 Industrials rose 0.1%.

British Issues

April 9 Companies	Price pence	P/E	Div. pence	Yield %	1 Week High—Low pence pence
Comml Union	409	N/M	31.5	7.7	415—404
Genl Accident	400	N/M	35.7	8.9	400—390
Gdn Royal Exch	118	N/M	10.0	8.51	22—117
Royal	183	N/M	15.0	8.2	183—176
Sun Alliance	221	N/M	19.0	8.6	229—218
Brokers					
Bradstock	130	14.6	6.3	4.8	138—130
CE Heath	348	23.0	34.5	9.9	355—347
Hogg Group	165	11.0	10.9	6.6	165—165
JIB Group	172	12.6	10.0	5.8	173—170
Lloyd Thompson	211	21.1	6.0	2.8	218—211
Lowndes Lmbrt	293	12.2	17.3	5.9	297—292
PWS Holdings	48	5.2	5.3	11.0	49—48
Sedgwick Grp	211	16.5	16.0	7.6	211—201
Steel Brrl Jones	246	12.4	17.7	7.2	249—239
Willis Corroon	248	15.7	17.6	7.1	248—241

Source: Philip Olsen, Insurance Industry Analyst, London

BI Industry Stock Report

APRIL 3, 1992 THROUGH APRIL 10, 1992

		Price	Weekly % change	Year to Date % change	Annual High	Annual Low	Vol.(000)	$ Div.	% Yield	P/E	Book value	Mkt/Bk. value
BROKERS												
Alexander & Alexander	NYS	18.50	-2.63	-9.76	27.50	18.00	326	1.00	5.41	-74	9.77	1.89
Gallagher Arthur J. & Co.	NYS	21.88	-7.41	-2.23	26.50	19.00	32	0.64	2.93	17	5.88	3.72
Frank B. Hall	NYS	3.88	-6.06	-8.82	5.50	3.13	135	0.00	0.00	-3	-5.24	-0.74
Hilb, Rogal & Hamilton	OTC	11.75	-2.08	-11.32	17.50	11.25	94	0.40	3.40	19	3.56	3.30
Marsh & McLennan	NYS	72.75	-2.84	-10.60	86.00	70.00	481	2.60	3.57	17	14.77	4.93
Poe & Associates	OTC	15.75	-0.79	31.25	16.00	8.50	21	0.40	2.54	17	2.52	6.25
BROKERS	AVERAGE		-3.6	-1.9					2.5	-1		
CONGLOMERATES & HOLDING COMPANIES												
Berkley W.R. Corp.	OTC	32.75	-4.03	7.38	36.25	23.50	219	0.36	1.10	13	23.89	1.37
Berkshire Hathaway Inc.	NYS	8850.00	-0.56	2.21	9125.00	7760.00	0	0.00	0.00	-33	4612.00	1.92
ITT (Hartford Group)	NYS	64.38	-0.19	11.47	70.63	50.00	1788	1.84	2.86	10	64.01	1.01
Sears (Allstate)	NYS	45.50	0.55	20.13	47.88	32.50	4406	2.00	4.40	14	37.38	1.22
CONGLOMERATES	AVERAGE		-1.1	9.2					2.1	1		
INSURERS/REINSURERS												
AEGON N.V.	NYS	69.63	0.18	-0.54	71.75	54.75	4	2.30	3.30	7	N/A	N/A
Aetna Life & Casualty	NYS	43.50	1.75	-1.14	49.13	31.88	1278	2.76	6.34	9	64.23	0.68
Allied Group Inc.	OTC	20.50	-5.75	20.59	23.00	16.00	72	0.64	3.12	8	11.50	1.78
American General	NYS	41.88	1.21	-5.90	44.75	36.38	877	2.08	4.97	10	37.14	1.13
American Indemnity/Fin'l	OTC	6.88	-1.79	44.74	9.25	4.50	25	0.08	1.16	6	12.93	0.53
American International	NYS	85.38	-0.58	-13.21	101.88	78.63	1306	0.48	0.56	12	45.34	1.88
Aon Corp.	NYS	41.50	3.75	4.73	45.25	34.75	174	1.68	4.05	11	18.50	2.24
Argonaut Group	OTC	27.00	0.00	13.68	33.38	21.75	65	0.68	2.52	8	48.26	0.56
AVEMCO Corp.	NYS	25.38	3.57	1.50	28.00	19.63	11	0.40	1.58	19	9.55	2.66
Baldwin & Lyons Inc.	OTC	27.38	1.39	6.31	28.00	21.50	86	0.28	1.02	8	24.29	1.13
Belvedere Corp.	ASE	5.25	-2.33	61.54	6.13	2.88	23	0.04	0.76	15	7.65	0.69
Chandler Insurance	OTC	5.00	0.00	53.85	5.50	2.13	142	0.00	0.00	63	5.95	0.84
Chubb Corp.	NYS	65.50	1.16	-14.94	78.00	60.75	927	1.60	2.44	10	35.19	1.86
CIGNA Corp.	NYS	51.25	1.99	-16.16	61.75	41.25	884	3.04	5.93	11	73.15	0.70
CNA Financial Corp.	NYS	85.63	4.90	-12.63	104.50	75.50	124	0.00	0.00	9	70.23	1.22
Continental Corp.	NYS	27.00	1.41	-2.26	30.38	23.25	516	2.60	9.63	28	37.83	0.71
EXEL Ltd.	NYS	36.00	4.73	-4.00	40.25	27.38	2428	0.92	2.56	8	N/A	N/A
Fund American Corp.	NYS	65.00	-1.89	-6.98	70.25	62.00	508	0.68	1.05	15	36.11	1.80
Fremont General Corp.	OTC	20.50	9.33	-15.90	26.00	18.00	224	0.88	4.29	5	19.13	1.07
Frontier Insurance Group	NYS	30.75	1.23	13.89	31.50	19.22	73	0.60	1.95	12	11.20	2.75
Gainsco Inc.	ASE	13.00	1.96	-7.14	15.00	8.25	49	0.04	0.31	16	3.37	3.86
General RE Corp.	NYS	90.13	0.14	-11.53	104.75	85.00	762	1.80	2.00	12	37.50	2.40
Guaranty National Corp.	NYS	14.75	-4.84	1.72	17.00	12.63	89	0.48	3.25	10	N/A	N/A
Hanover Insurance Co.	OTC	37.25	1.36	4.20	42.75	27.13	183	0.44	1.18	16	37.44	0.99
Harleysville Group	OTC	20.00	1.27	-5.88	23.25	16.75	45	0.64	3.20	10	22.99	0.87
Hartford Steam Boiler	NYS	51.75	8.38	-10.00	63.75	45.13	279	2.00	3.86	15	17.05	3.04
Kemper Corp.	NYS	28.13	-3.02	-26.23	46.13	27.25	1278	0.92	3.27	7	34.20	0.82
Lawrence Insurance Group	ASE	8.13	-9.72	-26.97	11.13	7.88	2	0.48	5.91	16	4.71	1.73
Liberty Corp.	NYS	23.00	-4.66	3.95	25.38	19.50	37	0.48	2.09	12	23.86	0.96
Lincoln National	NYS	54.50	0.00	-0.46	61.00	45.38	315	2.92	5.36	12	45.16	1.21
Markel Corp.	OTC	25.75	-3.74	17.05	28.25	14.00	63	0.00	0.00	12	3.22	8.00
Mutual Risk Mgmt. Ltd.	NYS	33.25	-2.92	-5.34	37.75	17.00	94	0.12	0.36	25	-	-
NAC Re Corp.	OTC	27.63	-1.34	-12.30	33.00	21.75	423	0.16	0.58	13	18.90	1.46
National Re Holdings Corp.	NYS	17.50	-5.41	N/A	23.63	17.50	123	0.12	0.69	7	N/A	N/A
Navigators Group	OTC	41.00	-4.09	0.00	48.25	29.50	35	0.00	0.00	24	13.52	3.03
Nobel Insurance LTD.	OTC	5.00	-6.98	25.00	6.00	3.38	51	0.00	0.00	4	7.76	0.64
NWNL Companies	NYS	34.00	2.26	9.24	38.50	18.63	143	1.40	4.12	13	42.73	0.80
Ohio Casualty Corp.	OTC	53.50	1.42	8.08	58.25	43.50	163	2.68	5.01	9	36.38	1.47
Old Republic Int'l	NYS	40.88	-1.80	15.14	42.25	27.50	136	0.72	1.76	8	33.09	1.24
Orion Capital Corp.	NYS	30.13	-1.23	-4.74	34.25	25.00	94	0.92	3.05	5	20.42	1.48
Phoenix RE Corp.	OTC	10.50	0.00	0.00	11.75	8.50	36	0.20	1.90	42	13.30	0.79
Provident Life	OTC	21.63	-1.14	-6.99	24.25	16.75	179	1.00	4.62	8	25.88	0.84
Re Capital Corp.	ASE	16.00	-1.54	11.30	18.63	13.13	16	0.24	1.50	13	15.05	1.06
Reliance Group Holdings	NYS	4.38	2.94	6.06	6.25	3.50	78	0.32	7.31	3	5.61	0.78
RLI Insurance Corp.	NYS	18.38	-5.16	11.36	20.38	11.88	32	0.48	2.61	8	14.41	1.28
St. Paul Companies	NYS	70.13	0.18	-3.77	75.75	57.13	393	2.72	3.88	8	52.00	1.35
SAFECO Corp.	OTC	43.50	-2.79	-10.77	50.00	35.50	1030	1.48	3.40	11	31.50	1.38
SCOR U.S. Corp.	NYS	16.88	-3.57	9.76	18.88	11.63	12	0.28	1.66	10	11.19	1.51
Seibels Bruce Group	OTC	5.50	0.00	0.00	8.88	4.00	164	0.36	6.55	-2	7.35	0.75
Selective Ins. Group	OTC	17.75	-7.79	5.97	19.75	13.75	298	1.04	5.86	9	18.91	0.94
Statesman Group Inc.	OTC	5.38	-2.27	-6.52	6.88	2.31	140	0.00	0.00	3	2.48	2.17
Tokio Marine & Fire	OTC	36.50	1.74	-29.13	55.25	33.50	33	0.00	0.00	-	70.93	0.51
Torchmark Corp.	NYS	58.63	6.11	1.30	61.50	46.50	262	1.60	2.73	12	16.70	3.51
Transamerica	NYS	41.63	3.74	4.39	43.88	31.25	595	2.00	4.80	36	36.56	1.14
Transatlantic Holdings	NYS	32.50	-7.80	-16.40	39.63	29.00	70	0.24	0.74	11	18.38	1.77
Travelers Corp.	NYS	20.25	1.25	-6.36	25.13	17.25	1558	1.60	7.90	7	41.44	0.49
Trenwick Group Inc.	OTC	27.00	-4.85	-5.26	30.75	23.00	74	0.72	2.67	10	21.71	1.24
United Fire & Casualty	OTC	59.50	0.85	32.22	59.50	42.00	7	1.32	2.22	12	35.39	1.68
USF&G Corp.	NYS	9.88	21.54	36.21	12.38	5.63	3084	0.20	2.03	-4	11.96	0.83
UNUM Corp.	NYS	34.38	2.23	-15.12	40.63	28.81	950	0.52	1.51	11	37.25	0.92
USLIFE Corp.	NYS	45.25	-0.28	-5.48	47.88	37.50	163	1.64	3.62	9	60.34	0.75
Unitrin	OTC	33.00	0.00	-7.69	41.50	31.00	269	1.00	3.03	13	30.70	1.07
USLICO Corp.	NYS	18.25	0.69	-1.35	21.00	17.00	55	1.00	5.48	-19	29.44	0.62
Washington National	NYS	17.13	-0.72	7.87	19.25	13.38	7	1.08	6.31	-8	26.86	0.64
Zenith National Ins.	NYS	15.75	-6.67	-6.67	18.50	13.75	31	1.00	6.35	7	13.14	1.20
INSURERS/REINSURERS	AVERAGE		-0.2	1.6					3.4	12.7		
HEALTH MAINTENANCE ORGANIZATIONS												
FHP International	OTC	14.88	11.21	4.39	27.00	9.88	1209	0.00	0.00	14	5.44	2.73
HMO America Inc.	OTC	16.38	1.55	-2.24	24.88	11.38	883	0.00	0.00	18	0.61	26.84
Pacificare Health Sys.	OTC	60.00	6.67	51.90	62.50	21.50	533	0.00	0.00	23	6.55	9.16
Safeguard Health Enter.	OTC	12.00	-7.69	28.00	14.75	5.13	62	0.00	0.00	21	3.53	3.40
Sierra Health Services	ASE	23.13	-6.57	25.00	29.25	12.38	145	0.00	0.00	13	1.78	12.99
United Healthcare Corp.	NYS	78.25	-2.19	5.03	93.00	37.00	719	0.03	0.04	33	3.76	20.81
United Medical Corp.	ASE	8.25	-1.49	17.86	10.88	5.88	9	0.20	2.42	26	8.79	0.94
U.S. Healthcare	OTC	51.25	3.02	23.49	57.75	21.25	5651	0.56	1.09	25	3.38	15.16
HMOs	AVERAGE		0.6	19.2					0.4	22		
ALL COMPANIES	AVERAGE		-1.1	7.0					2.8	11		

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