

Business Insurance

Reporting weekly for corporate risk, employee benefit and financial executives / \$2.00 a copy; \$80 a year

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Lloyd's to draw member funds after High Court lifts injunction

LONDON—Lloyd's of London can immediately draw down on disgruntled members' deposits to pay policyholders' claims following a crucial High Court ruling last week.

After a week-long hearing, Justice Saville lifted injunctions barring Lloyd's members' agencies from drawing down on the members' deposits to pay claims (*BI*, April 13; March 9). But, the judge denied Lloyd's request that members pay its legal costs.

The 828 members affected by the ruling
Continued on next page

A flood of questions

Liability, coverage for Chicago disaster unclear

By SARA J. HARTY and GAVIN SOUTER

CHICAGO—Determining who will pay for damage caused by last week's Chicago flood is as murky as the Chicago River water that inundated basements in the city's Loop, causing businesses to grind to a halt.

The bizarre flood—and a resulting power blackout—shut down the city's entire business district last Monday and left many buildings, including its largest department stores, shuttered all week with no power and no firm idea when they would reopen.

Chicago Mayor Richard M. Daley admitted that city officials knew that a tunnel running under the Chicago River was leaking and that city officials earlier this month had determined that the problem could have been repaired for about \$10,000. Yet no action—beyond soliciting bids for the work—ever was taken.

Losses—both from property damage and loss of business—now could run into the billions.

While many businesses have property insurance to cover their losses, policy disputes could arise over whether the catastrophe should be classified as a "flood" or as "water damage" (see story, page 38).

In addition, some businesses in downtown skyscrapers lacked flood coverage, because the risk of flood appeared to be so remote. And, many businesses—especially those that did not suffer actual property damage—may not have business interruption coverage.

However, businesses with uninsured losses as well as property insurers will sue those blamed for the flood, in-

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Water hoses and electrical equipment litter Chicago's Loop in an effort to pump out flooded basements.

Photo by Brooke Hummer

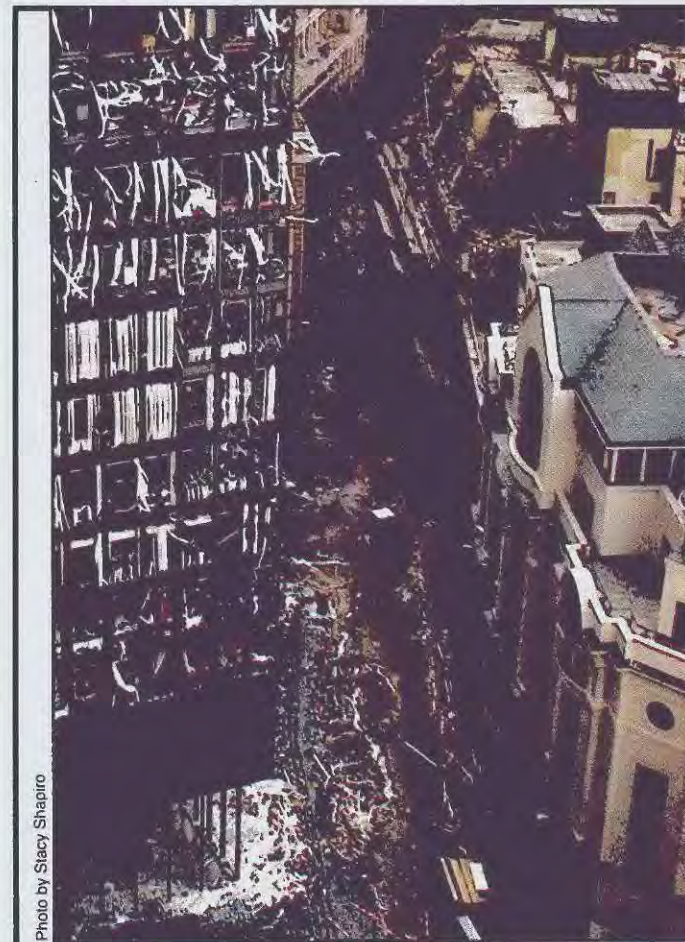


Photo by Stacy Shapiro

A bomb was detonated near the Commercial Union building, blowing out windows on three sides.

London bombs cause damage topping \$1 billion

By STACY SHAPIRO

LONDON—The worst bomb blasts on the British mainland since World War II could cost insurers more than 1 billion pounds (\$1.76 billion).

However, while one of the explosions ripped through the heart of the London insurance market, it did not disrupt the operation of most insurers and brokers.

Two terrorist bombs exploded on Friday night, April 10, including a huge car bomb that was detonated at about 9:20 p.m. just outside the Commercial Union building opposite Lloyd's of London, killing three people and injuring 91. The Lloyd's building might have been the intended target.

The other car bomb ignited three hours later at a major highway intersection on the outskirts of London, injuring no one but creating massive damage to the highway and surrounding buildings.

The Irish Republican Army claimed responsibility for the explosions, which occurred as some were ce-

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Dingell bill reaction mixed

Measure to be debated at hearings this summer

By DOUGLAS McLEOD

WASHINGTON—Several insurer and policyholder groups are praising Rep. John D. Dingell's insurance solvency regulation bill as a good first step, while expressing reservations about some of its provisions.

Other groups that have long opposed a federal solvency regulatory

role—including some insurer groups and state regulators—remain opposed to the bill introduced this month by Rep. Dingell, D-Mich., chairman of the House Energy and Commerce Committee.

Most of those involved in the debate were trying to digest the 234-page bill last week and offered only preliminary reactions.

More detailed responses are expected by early summer, when the House Subcommittee on Commerce, Consumer Protection and Competitiveness is expected to hold hearings

on the proposal.

The hearings likely will serve as a forum to debate the measure, but legislative action is not expected this year. Instead, the hearings are expected to collect comments and suggestions from interested parties on how to modify the legislation when it is reintroduced next year.

"This bill is an opening gambit," said Andrew Wright, vp-federal affairs for the American Insurance Assn. in Washington, D.C. "It's a really good start. I was pleasantly

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Employers unsure of savings, but expanding efforts

Wellness impact uncertain

By JERRY GEISEL

Only a small percentage of employers say health promotion—or wellness—programs have reduced medical plan costs, but the overwhelming majority of employers plan to expand promotion activities, according to a new survey.

Just 16% of employers said their health promotion efforts have reduced medical plan costs, while most—73%—weren't sure and 11% said the efforts have not reduced plan

costs, according to Hewitt Associates in Lincolnshire, Ill.

Similarly, only 14% of employers said health promotion programs reduced the number of medical claims, while 75% weren't sure and 11% said the programs didn't reduce the number of claims.

Of the 8% of employers that could provide specific dollar figures on medical plan cost savings from health promotion programs, 15% reported per-employee savings of at least \$100 in 1990; 10% reported savings of \$26

to \$50; and 13% estimated savings at \$5 to \$25. Sixty-two percent of employers didn't report any savings.

Even though most employers aren't sure of the impact of health care promotion activities, a whopping 89% plan to expand activities in the next five years, such as by offering employees more incentives to participate in the programs.

Health promotion programs encompass a broad spectrum of activities intended to improve the overall

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Lloyd's wins injunction ruling

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will not appeal, said Michael Freeman, senior partner of Michael Freeman & Co. He initiated the action on behalf of members on syndicates once managed by Gooda Walker Ltd., Feltrim Underwriting Agencies Ltd., Devonshire Underwriting Agencies Ltd. and Rose Thomson Young Underwriting Ltd. But, litigation by these members to recover damages for the losses they have suffered will continue, he said.

Members of these syndicates face 200 million pounds (\$351 million) in unpaid cash calls, he said, though he did not know how much of that was apportioned among the plaintiffs.

Lloyd's Chairman David Coleridge said the ruling was a victory for the principles under which Lloyd's works. "We have every sympathy with those who have made substantial underwriting losses in recent years, but Lloyd's owes its first duty to policyholders with valid claims, which must be met," he said.

GAO projects guaranty strain

WASHINGTON—The collapse of just one of the nation's 10 largest property/casualty insurers could overwhelm state guaranty funds, reports the General Accounting Office.

With their limited ability to assess insurers, only about one-third of guaranty funds would be able to pay one year of claims incurred by a huge failed insurer before reaching annual assessment limits, a new GAO study concludes. The GAO assumes the failure of one of the largest property/casualty insurers could generate as much as \$4 billion in claims in a single year.

"Many states would not be able to pay off their state's share of one year's losses within a year, and some could not do so within two years," said the GAO in a report requested by Sen. Howard M. Metzenbaum, D-Ohio.

The GAO also found that the surge of property/casualty insurer failures in recent years already is straining guaranty funds.

At least eight funds unidentified in the report have either hit or approached their maximum annual assessments in one or more lines of business in a given year since year-end 1985. In most cases, capacity problems were triggered by the failures of Mission Insurance Co. and American Mutual Insurance Co., the GAO says.

California workers comp rates

LOS ANGELES—California employers could face higher workers compensation insurance costs following a recommended 23.1% rate hike by the Workers Compensation Insurance Rating Bureau and a state appellate court ruling.

If the rating bureau's recommendation for the rate hike as of July 1 is approved, employers' premiums will rise by about \$2 billion from \$8.7 billion last year.

State workers comp insurers face a \$3.5 billion deficit for 1991 and 1992, said Thomas F. Conneely, president of the Assn. of California Insurance Companies. ACIC members write more than 50% of the state's private workers comp insurance.

The proposed 23% increase "is a clear signal that this system is out of control," said Insurance Commissioner John Garamendi. He supports legislation, A.B. 2380, that would give the Insurance Department "greater discretion to reduce rates" by no longer allowing workers comp insurers to build a standard expense ratio into their rates (BI, Feb. 10).

Workers comp costs could be exacerbated as a result of a March 20 state appeals court decision that physicians do not have to prove "extraordinary circumstances" to charge fees that exceed the official medical fee schedule. The court criticized the California Division of Workers Compensation for failing to update the fee schedule since 1987, though state law requires revision at least biennially.

The decision likely will have a significant impact on workers comp rates since 50% of an employer's workers comp premium is based on the fee schedule, said Alan Tebb, general manager of the industry-supported California Workers Compensation Institute.

OSHA probes Phillips charge

BARTLESVILLE, Okla.—The Occupational Health and Safety Administration is investigating an allegation that Phillips Petroleum Co. supervisors ordered a worker to give as little information as possible to OSHA investigators following the October 1989 explosion at the company's plant in Pasadena, Texas.

An unidentified worker at the Texas plant made the allegation in a letter to the company's chairman, Phillips confirmed. Phillips, which says it began its own investigation earlier this month, vows to cooperate with OSHA. "If there have been any variances (from safety rules), we will take appropriate action," a spokesman said.

The explosion killed 23 people and injured more than 100 others. Estimated damages exceeded \$1 billion (BI, Oct. 30, 1989).

Seidman judgment overturned

MIAMI—A Florida appeals court has overturned a \$15.7 million judgment against New York accounting firm BDO Seidman arising from its audits of the defunct Universal Casualty & Surety Co. Ltd. of the Cayman Islands.

A jury awarded the money to Universal Casualty's liquidator in 1990 after finding that Seidman was negligent in its audits in the five years before Universal collapsed in 1984. The liquidator charged that Seidman failed to discover that Universal's main assets—\$10 million in certificates of deposit—were fraudulent (BI, Dec. 17, 1990).

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41 benefit mandates added by states in '91

By CHRISTINE WOOLSEY

WASHINGTON—States enacted 41 new benefit mandates in 1991, bringing the total facing insured employers nationwide to more than 900, according to the Blue Cross & Blue Shield Assn.

The trend toward requiring group health insurers to cover particular types of care, though, is slowing down, a BC/BS Assn. researcher says.

"The total of 41 that were enacted in 1991 equals the number

that were passed during 1990 and is about half the amount that became law during 1989," said Susan S. Laudicina, director of state services research in BC/BS Assn.'s government relations office in Washington, D.C.

That slowdown is "not for want of ideas," she added. Hundreds of proposals were introduced in state legislatures last year, "it's just that only 41 were enacted," she pointed out.

Twenty-four states enacted benefit mandates in 1991, ac-

ording to BC/BS.

The most common mandate last year was mammography screening, Ms. Laudicina noted. Eight states—Alabama, Louisiana, Maryland, Montana, New Jersey, North Carolina, South Dakota and Vermont—began requiring commercially insured group health plans to cover mammography screenings, she said.

In addition, Indiana now requires all commercial insurers to

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Liberty Mutual still fighting \$16.8 million judgment

Bad faith award upheld

By LOUISE KERTESZ

LOS ANGELES—Liberty Mutual Insurance Co. will appeal a federal judge's decision to uphold a \$16.8 million bad faith jury award for failing to defend a policyholder against homeowners' property damage claims.

U.S. District Judge Harry L. Hupp last month upheld a January jury award of \$2.8 million in compensatory damages and

\$14 million in punitive damages to Chemstar Inc., a Fort Worth, Texas-based manufacturer of lime products for industrial and construction use.

Boston-based Liberty Mutual had filed various post-trial motions to set aside or reduce the award, court papers show.

The case involves 28 property damage claims made by Los Angeles County homeowners alleging a defect in lime products produced by Genstar Lime Co.

The defective lime allegedly caused widespread pitting in plaster interior walls.

San Francisco-based Genstar, which Chemstar acquired in 1986, was covered under an occurrence-based comprehensive general liability policy issued by Liberty Mutual, with limits of \$2 million per occurrence/\$5 million aggregate, said Ronald Oster, of Paul, Hastings, Janofsky & Walker of Los Angeles,

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Deadline nears for mental health network directory

Business Insurance will publish its second annual directory of employee assistance programs/managed mental health care networks in the June 8 issue, which will contain a Spotlight Report on mental health care.

The directory is published as an editorial service; there is no charge to be included. To be listed, organizations must complete a questionnaire provided by *Business Insurance*.

If your organization provides EAP or managed mental health services on a stand-alone basis and you would like a questionnaire, contact Karen Armaganian, *Business Insurance*, 740 N. Rush St., Chicago, Ill. 60611-2590; 312-280-3195.

May 4 is the deadline for returning questionnaires.

Beleaguered TPA's depressed earnings set off stock sale

By DOUGLAS McLEOD

MINNEAPOLIS—Employee Benefit Plans Inc. announced lower-than-expected quarterly earnings last week and said competition and other factors could depress its profits for up to a year.

The announcement triggered a sell-off in EBP stock, which closed last Tuesday at \$15, down from \$19.50 the Friday before EBP reported its results for its third fiscal quarter ending Feb. 29. EBP stock closed at \$14.38 at the end of trading last Thursday.

The report was the second successive quarterly earnings disappointment for EBP, the nation's third-largest claims administrator. Lower-than-expected sec-

ond-quarter earnings caused EBP stock to drop to \$30 from a high of \$64 in January.

The company has been besieged by a variety of problems, including lawsuits that challenge the basic structure of EBP's business and a flood of negative rumors that EBP officials label as a smear campaign by investors who have sold the stock short (BI, April 13).

EBP provides claims administration and other services for clients that self-insure health benefit programs. It also reinsures many clients' specific and aggregate stop-loss risks.

Last Monday, EBP reported third-quarter revenues of \$57.5 million, up 28.9% from \$44.6

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✓ Building bridges with employees may pay off for employers when health care reform proposals receive serious scrutiny, this week's editorial says. **PAGE 8**

✓ Pine Top Insurance Co. directors and officers may have made some bad business decisions, but they can't be held accountable for the insurer's failure because they are not charged with illegal acts, two Illinois courts have ruled. **PAGE 19**

✓ The health insurance industry is a perfect target for fraud and abuse because of its enormous size and limited safeguards, a government adviser says at a conference sponsored by the New York Business Group on Health. **PAGE 20**

✓ Caterpillar Inc. will begin recalling striking United Auto Workers this week after a six-month labor dispute. Workers will receive higher wages and pension benefits and a new managed health care plan. **PAGE 37**

Departments

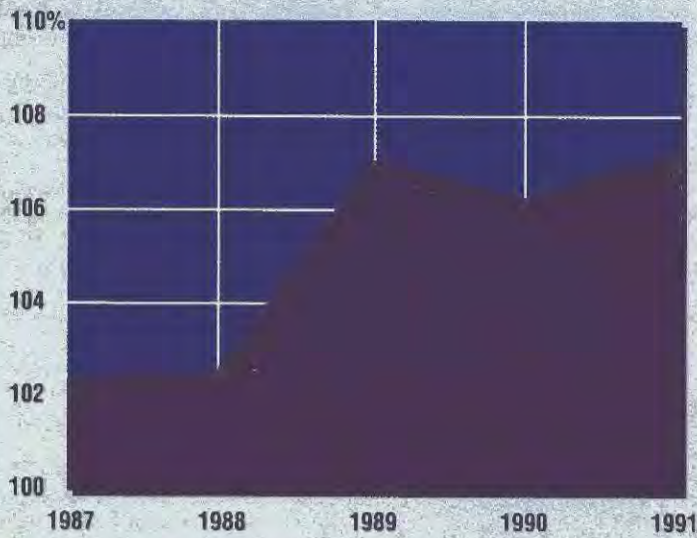
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Vol. 26, No. 16—*Business Insurance* (ISSN 0007-6864) is published weekly by Crain Communications Inc., 740 N. Rush St., Chicago, Ill. 60611-2590. Second-class postage is paid at Chicago, Ill., and at additional mailing offices. Postmaster: Send address changes to *Business Insurance*, Circulation Department, 965 E. Jefferson Ave., Detroit, Mich. 48207-3185; 800-678-9595 or 313-446-1611. Copyright 1992 by Crain Communications Inc.

Reinsurers' profits improve

Reinsurers back in the doldrums

U.S. reinsurers saw their combined ratio worsen last year, reversing the improvement seen in 1990.



Source: Reinsurance Assn. of America

GRAPHIC BY JOHN HALL

Trends dim hopes for turn in market

By JUDY GREENWALD

Despite poorer underwriting results, the U.S. reinsurance industry posted improved profits and premium volume in 1991, dashing any hopes for a hardening of the broad U.S. reinsurance market this year.

In fact, there is little impetus for the reinsurance market to tighten before 1993 at the earliest.

"I think '92 is going to be much of the same. I see nothing that's going to jog us out of our lethargy, and maybe '93 will see some improvements," said Michael G. Fitt, chairman and chief executive officer of Employers Reinsurance Corp. of Overland Park, Kan.

Not even two catastrophes in the past 10 days—the Irish Republican Army's bomb attacks in London and the flooding in downtown Chicago—will shake the market, Mr. Fitt said (see stories, page 1).

"I keep on thinking these big losses are going to hurt, something is going to happen," he said. But there is still so much excess capital that "maybe it won't change anything."

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Aetna ponders leveraged buyout of American Re

By JUDY GREENWALD

HARTFORD, Conn.—A leveraged buyout of American Re-Insurance Co., an Aetna Life & Casualty Co. unit, by LBO specialist Kohlberg, Kravis & Roberts would benefit both Aetna and American Re, say observers.

Aetna confirmed last week it is negotiating with New York-based KKR for the sale of its reinsurance subsidiary, which is the third-largest U.S. reinsurer.

The LBO, with an estimated \$1.4 billion price tag, could be the largest leveraged buyout ever in the insurance industry.

That \$1.4 billion could help Aetna bolster its balance sheet, which has been hurt by problem real estate loans. It also would allow Aetna to focus on its core businesses, freeing up management and capital for its managed care and financial services opera-

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Make unions allies in health war: Manager

By MICHAEL SCHACHNER

WASHINGTON—To avert strikes by labor unions, companies must convince workers that health care costs—not management—are the enemy, according to a corporate insurance manager.

"Health care is clearly the most difficult subject to negotiate. What management calls controlling costs, the union often calls shifting costs to the employees. We need to be on the same side," points out Dennis P. McCafferty, director-group insurance with Detroit Edison Co.

Noting that 78% of today's labor strikes involve health care disputes, Mr. McCafferty urged unions and management to come together in the fight against skyrocketing health care costs.

"We need to foster an 'Us vs. It' mentality rather than 'Us vs. Them,'" he said during a session at the annual National Managed Health Care Congress conference. "Our goal should be to reduce the overall health care bill instead of shifting a percentage of payments to one side or the other. You achieve this through buying smarter and reducing waste."

Patrick Carolan, president of the Administrative & Residual Employees Union Local 4200 in Hartford, Conn., agreed with Mr. McCafferty that "labor and management can no longer work separately."

He called health care costs "an exploding issue in contract disputes, which both sides have been willing to war over."

"This issue is long-standing and leaves people feeling very bitter when there's a disagreement," Mr. Carolan said. "On the other hand, if it's settled properly, it can lead to productivity and a very happy workforce."

While Messrs. McCafferty and Carolan agree labor and management are beginning to realize that they must be allies in the battle against health care costs, they also acknowledge that the fight is a hard one to win.

"It's very difficult to reduce health care costs when the market isn't willing to comply," lamented Mr. Carolan.

"I don't have all the answers. My only warning is for management not to bring in a bunch of consultants to present information on union health care costs. We'll reject that right away and the company will have wasted a

lot of money on the consultant," he said.

He also urged management to sit down to discuss health care costs with union representatives before official negotiations begin.

"At the bargaining table we're all adversaries. Health care shouldn't be an issue we're at odds over, because we'll all end up losing out," Mr. Carolan explained.

Mr. McCafferty echoed those sentiments, and explained how Detroit Edison smoothly negotiated a contract in 1988, only

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Oregon probes state comp fund claims handling

By MEG FLETCHER

SALEM, Ore.—A simmering controversy over the claims handling practices of Oregon's quasi-public workers compensation fund may boil over by year end.

The state's Department of Insurance and Finance has told the fund, SAIF Corp., to halt what the state contends are overly aggressive claims handling practices or face departmental examination and possible sanctions in December.

The department also questions the legality of some claims rejections in light of new claims handling laws that became effective last fall.

SAIF's denial rate for workers comp claims is double that of commercial workers comp insurers in the state, according to the department.

However, SAIF officials contend that its claims handling practices are legal. They say the department's allegations are an inappropriate, bureaucratic response to SAIF's successful implementation of sweeping 1990 workers comp reforms.

Oregon created SAIF in 1980 after abolishing the state-run State Accident Insurance Fund. SAIF, which says it is the nation's first "public, non-profit corporation specializing in workers compensation insurance," was created to increase competition in the state's workers comp insurance market. It operates today like a mutual insurer.

Although SAIF is not a governmental agency, it is not subject to all regulations that apply to other private workers comp insurers. In addition, the governor appoints members of SAIF's board.

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Garamendi joins Clinton

Commissioner to head statewide presidential campaign

By JOANNE WOJCIK

LOS ANGELES—California's first elected insurance commissioner is nudging his way into national politics as California chairman of Arkansas Gov. Bill Clinton's presidential campaign.

Los Angeles attorney Mickey Kantor, Mr. Clinton's national campaign chairman, made the appointment last week during a state Democratic Party central committee meeting in Los Angeles during which Insurance Commissioner John Garamendi formally endorsed Mr. Clinton.

Mr. Garamendi lauded Mr. Clinton as a political leader who has thought long and hard about the serious economic and social problems confronting the nation.

Mr. Clinton's platform is "a tough and honest plan for rebuilding America, one that empowers the people of this nation to take responsibility for their lives and compete successfully in the world economy," the insurance commissioner said.

Mr. Garamendi said he agreed to serve as Mr. Clinton's state campaign chairman after several meetings with the candidate during which they discussed Mr. Garamendi's single-payer health care proposal for California.

Under the plan, the medical



Mr. Garamendi has met several times with Gov. Clinton.

components of workers compensation, auto liability insurance and health insurance would be combined to provide a 24-hour coverage program for all Californians (BI, Feb. 24).

While Mr. Clinton agrees in principle with the plan, it has met considerable opposition in California, most recently from

the Republican governor.

After rejecting Mr. Garamendi's proposal, Gov. Pete Wilson unveiled a more modest plan last week to create a state-run insurance purchasing pool "to allow small businesses to band together and buy health insurance as though they were big businesses."

The governor's plan is similar to legislation introduced last month by Assemblyman Paul Horcher, R-Whittier.

A.B. 3657 has been endorsed by Blue Cross of California, Blue Shield of California and Pacific Mutual Life Insurance Co., three of the state's major health insurers.

The bill, among other things, would guarantee coverage for small employers, limit pre-existing condition exclusions, guarantee renewability, establish a premium rate band for employers with similar risks and restrict premium increases.

Gov. Wilson also endorsed portions of several other health care bills moving through the state Legislature that would require insurers to provide coverage to most small businesses that seek it, limit premium increases, repeal laws requiring certain benefits, and prohibit doctors

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Solvency bill

Continued from page 1
surprised by it."

The bill, H.R. 4900, would:

- Allow property/casualty and life/health insurers the option of obtaining a federal certificate of solvency from a newly established Federal Insurance Solvency Commission, which would set solvency standards for U.S. and alien insurers.

Federally certified insurers generally would be exempt from state solvency regulation, but would be subject to state rate, form and market-conduct regulations and would have to participate in residual market mechanisms. They also would be subject to state corporation and tax laws.

A partial exception to this would be "highly capitalized" insurers with more than \$50 million of net worth writing coverages for "large

insurance buyers" with more than \$10 million in net worth. These insurers would also be exempt from state rate, form and market-conduct regulation.

To qualify for certification, alien insurers also would have to maintain a U.S. trust fund exclusively for the purpose of paying U.S. policyholders' claims.

- Allow all U.S. insurers credit for reinsurance only when it is ceded to federally certified reinsurers.

Professional reinsurers would need at least \$50 million of surplus to qualify for certification.

Insurers that also write reinsurance would have to meet higher capitalization requirements than for insurance underwriting alone.

Certified reinsurers would be subject to state corporation and tax laws but not to any state regulation of their reinsurance activities.

- Establish the National Insurance Protection Corp., a guaranty

fund to cover claims against insolvent federally certified insurers.

With the exception of surplus lines insurers, risk retention groups and captives, federally certified insurers would be required to join the NIPC and would no longer participate in state guaranty funds.

The NIPC would be prefunded through assessments on member companies. It would not cover claims by large commercial policyholders but would cover third-party claims against large policyholders that are bankrupt.

- Establish a National Assn. of Registered Agents & Brokers, a self-regulatory organization similar to the National Assn. of Securities Dealers, to set professional qualifications and act as a clearinghouse for state license applications and renewals.

The states would continue to regulate agents and brokers but would not be able to impose additional re-

quirements in areas subject to regulation by NARAB.

Industry groups that had supported the idea of federal regulation generally praised the bill as a good start.

"Overall, it was an excellent effort by Rep. Dingell's staff," said Paul Brown, director of governmental affairs and general counsel for the Risk & Insurance Management Society Inc., which recently announced its support for a federal role in regulation (*BI*, April 6).

Mr. Brown said he was pleased with the exemption from rate, form and solvency regulation for large insurers writing large commercial risks.

He also noted that the provision allowing insurers credit only for reinsurance ceded to certified reinsurers specifically excludes reinsurance ceded to captives and risk retention groups. "It will be business as usual for captives," he said.

In addition, the bill's definition of property/casualty insurance specifically includes workers compensation coverage, presumably meaning that large insurers writing workers comp for large policyholders would be exempt from state rate regulation, Mr. Brown noted.

But, even supporters of federal regulation see shortcomings in the bill. Several of these asked not to be quoted by name because their organizations are still developing official responses to the legislation.

One of the bill's central problems is its creation of dual federal and state regulation of the same companies.

"It's neither fish nor fowl," one Washington lawyer said, complaining that Rep. Dingell's staff "tried to make too many people happy."

For example, nothing in the bill pre-empts state licensing laws. So, even large commercial insurers with the broadest exemption from state regulatory authority would still have to maintain state insurance licenses.

While the bill forbids states from discriminating against federally certified companies, its failure to preempt state licensing authority is a "formula for mischief," an insurance trade group official said.

"If a state wanted to discourage a company from becoming federally certified, it could do it through the licensing provisions," he said. "I can think of a world of things that a determined bureaucracy could do."

While the division of federal solvency regulation from state rate regulation may not be a problem for insurers in many lines of coverage, it could become a problem in lines like workers comp, where inadequate rates in many states could affect solvency, Mr. Brown added.

Insurance and regulatory groups that oppose federal regulation broadly criticized the bill.

"I just don't see the necessity of it," said Nebraska Insurance Director William H. McCartney, president of the National Assn. of Insurance Commissioners. "If there is any lesson from the savings and loan crisis, it is that when you have two regulators, often nobody is accountable."

Mr. McCartney also attacked the proposed exemptions for large commercial insurers, saying they reflect a congressional pattern of granting special favors to large companies.

"We don't think there are any advantages for insurers or consumers in the proposal," said David Farmer, vp of federal affairs for the Alliance of American Insurers in Washington.

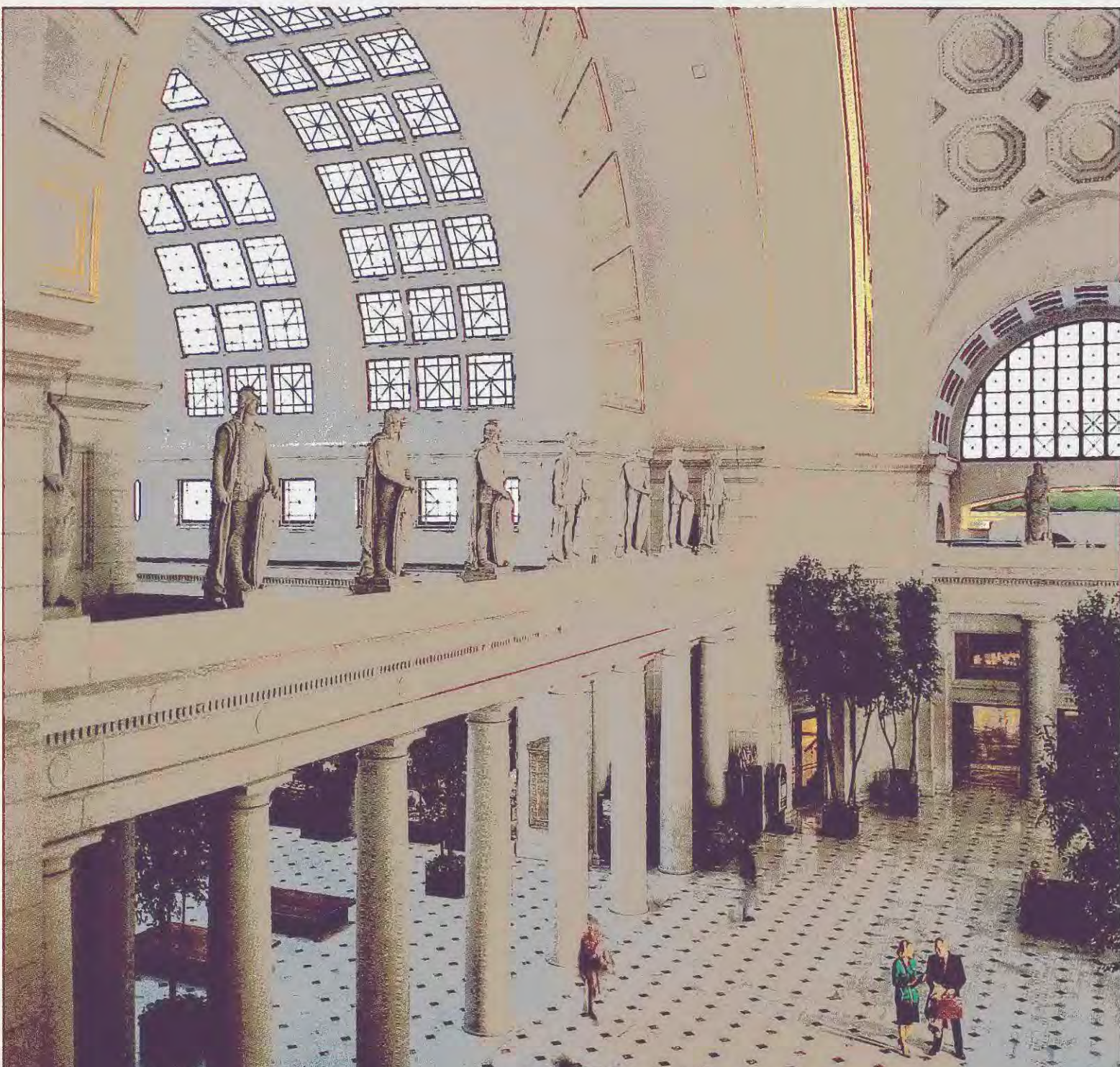
"It doesn't appear to me that there is enough pre-emption to justify the additional expense and burden of duplicate regulation."

Mr. Farmer noted that FISC—funded by certified companies through assessments capped at 0.25% of direct premiums and 0.125% of reinsurance premiums—could cost \$1.2 billion annually, compared with the roughly \$500 million total annual cost of state regulation.

"We don't see a need for a federal system. We think the state system can be remedied," commented Darrell Coover, senior vp-government relations for the National Assn. of Independent Insurers in Washington, D.C.

Mr. Coover and others also worried that the federal guaranty fund could weaken state guaranty funds by drawing the largest insurers out of that system.

Agents' groups are divided on the legislation. The National Assn. of Casualty & Surety Agents last week endorsed the concept of the bill, but the National Assn. of Professional Insurance Agents opposes the NARAB concept. ■



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WHY A COMPANY KNOWN FOR ITS STEEL STRUCTURES CHOOSES WAUSAU FOR SUPPORT.



The service structure of Wausau is strong enough to support the needs of Pitt-Des Moines.

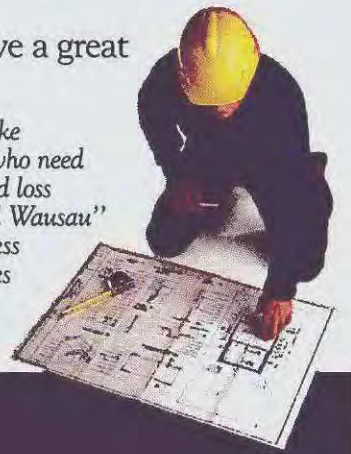
The St. Louis Gateway Arch. A 14,000,000 gallon water storage reservoir in California. Roosevelt Lake Bridge in Arizona. The storage vaults of Fort Knox — a few of the structures fabricated and erected by Pitt-Des Moines, Inc. What insurer has the service strength to support this company? Wausau

Insurance. "We view our relationship with Wausau as a partnership, and we have a great deal of respect for their professionalism and the high quality

of service they provide," says Richard Byers, PDM Vice President and Treasurer.

A good example of that service is "Dial Wausau," an on-line communications

For policyholders like Pitt-Des Moines, who need instant and detailed loss information, "Dial Wausau" provides direct access to PDM claims files in our computers.



link between Pitt-Des Moines and Wausau's claims department, providing immediate and detailed information on the activity of PDM claims. "Our company has realized substantial savings with Dial Wausau," concludes Mr. Byers. And that's how Pitt-Des Moines, a company known for steel structures, is made stronger with Wausau.



A+ (Superior) A.M. Best Rating

Banc One offers point-of-service plan

Banc One Corp. hopes to save millions on health care by implementing a point-of-service plan in two states and by offering employees a choice of two levels of health care benefits.

Banc One's new point-of-service option became available for about 13,000 employees in Ohio and Texas on Jan. 1. It allows employees to seek care from non-network providers, but at reduced benefit levels.

Employees with access to Prudential Insurance Co. of America's Prudential Plus provider network also can enroll in either a "high" or "standard" plan, neither of which requires deductibles.

Enrollees in the high-level plan pay lower office visit copayments and inpatient coinsurance, but also

Benefit beat

make proportionally higher monthly contributions, said Michael Hager, senior vp-personnel with Columbus, Ohio-based Banc One.

For example, the high-level office visit copayment within the network is \$10, compared with \$15 under the standard option. An admission to a network-affiliated emergency room requires a \$50 copayment under the high-level option, compared with \$100 under the standard option.

Under the high-level option, employees with individual coverage pay 10% of hospital costs up to \$400 per year. The standard option

requires 20% coinsurance up to \$800 per year.

Employees with dependents can select limited family coverage—for a family of three or fewer members—or full family coverage—for families with four or more—under which coinsurance for inpatient care remains 10% or 20%, depending on whether the high-level or standard option is selected. However, out-of-pocket maximums are significantly higher under the standard plan.

The out-of-pocket maximum for limited families is \$700 under the high plan or \$1,300 under the standard plan. For full families, the maximums are \$1,000 and \$1,800.

Enrollees in the network plan can opt out of the network at the point of service, but face higher

coinsurance and out-of-pocket maximums than what the company's indemnity plan requires employees outside of Ohio and Texas to pay.

Out-of-network deductibles are \$200 for an individual, \$350 for a limited family and \$500 for a full family. Under the out-of-network high option, employees must pay 30% of inpatient costs up to \$1,400 for an individual, \$2,200 for a limited family or \$3,300 for a full family.

Under the standard option, employees using out-of-network providers must pay 30% of inpatient costs up to \$2,400 for an individual, \$3,700 for a limited family or \$5,000 for a full family.

Banc One's 18,000 employees outside Ohio and Texas are still of-

fered a traditional indemnity plan, but with a choice of deductible levels. Banc One self-insures this plan, which is administered by Prudential.

Under the high-level option, individual employees are subject to a \$200 deductible and 20% copayment of inpatient costs, up to \$1,200 per year. A limited family pays a \$350 deductible and 20% coinsurance up to \$1,800 annually. The full family pays a \$500 deductible and 20% of costs up to \$2,400 per year under the high option.

The standard plan requires a \$400 deductible for single employees and a 30% copayment up to an out-of-pocket maximum of \$1,900. Those selecting the limited family option pay a \$700 deductible plus a 30% copayment up to \$3,000 per year. The full family benefit calls for a \$1,000 deductible plus a 30% copayment up to \$4,100.

There are no lifetime limits under any of the plans.

Mr. Hager said the changes would save millions of dollars, but would not be more specific.

"The only way to ensure that employees still pay 30% of overall plan costs without hitting them with annual 25% premium increases was to institute these changes. Within the network, benefit levels are better and the cost is lower. And for those without the network choice, the split-level options should allow them to control costs in one way or the other."

—By Michael Schachner

Teachers LTC plan

The State Teachers Retirement System of Ohio is offering a new long-term care insurance plan to Ohio teachers and their spouses and parents.

Approximately 120,000 full- and part-time teachers are eligible to enroll.

The plan can be accessed via any of the state's 750 different school districts. Since it is offered by the STRS, participants can move between school districts without losing benefits, said Lynne Hokanson, assistant director of health care services.

Coverage for both nursing home and home-based care is included, even when the home care is provided by a family member.

No prior hospitalizations or nursing facility confinements are required for coverage to begin. Alzheimer's disease and other degenerative illnesses are covered.

Benefit payments begin after a 90-day waiting period during which the covered individual must be dependent in two of five activities of daily living: walking, dressing, eating, using the toilet, and getting in or out of a bed or chair.

Benefits are based on an individual's inability to function without help and do not require diagnosis of a specific condition or disease.

The STRS plan offers four benefit options in \$20 increments from \$50 to \$110 per day with monthly premiums adjusted according to the level of coverage.

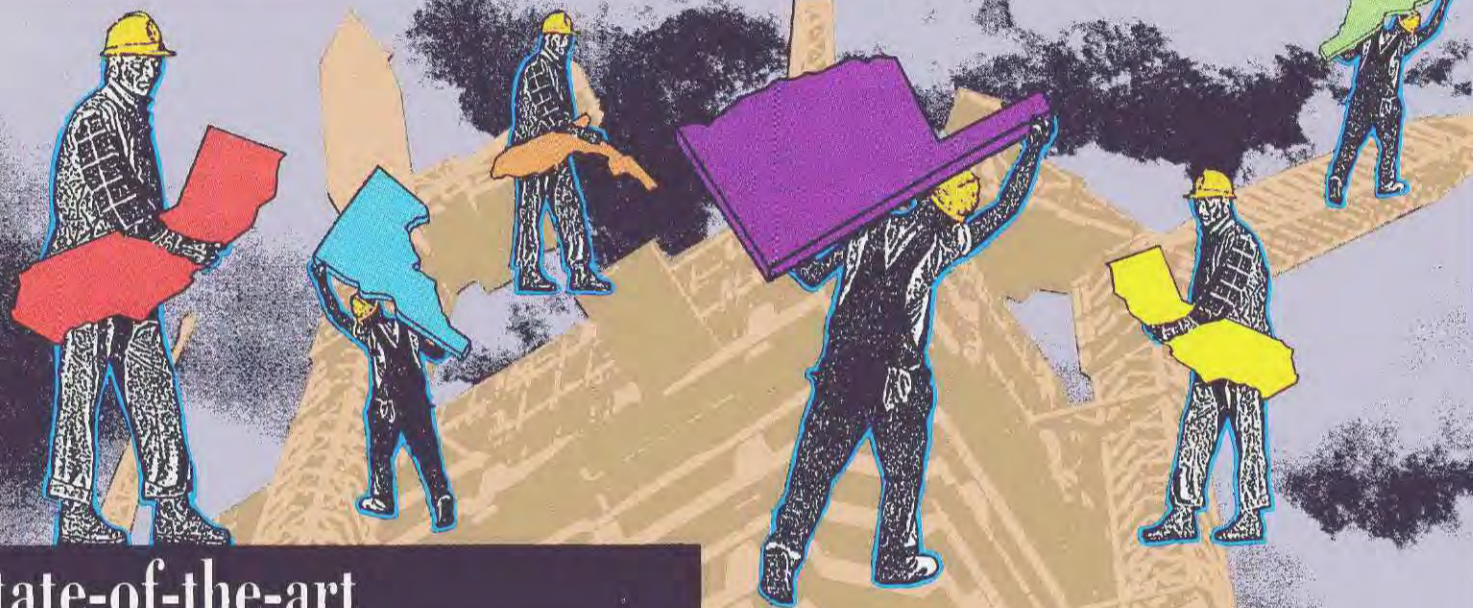
Home care or adult daycare benefits are 50% of the nursing home benefit selected.

Coverage is provided for up to five years in a nursing facility or 10 years of home care.

The enrollment period began on March 1 and runs through May 31. The plan, which is underwritten by Hartford, Conn.-based Aetna Life & Casualty Co., goes into effect on June 1.

—By Sara J. Hart

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Be willing to compromise

WHEN MICK JAGGER sings "You Can't Always Get What You Want," he most likely is not thinking about the U.S. health care system.

But, if any refrain sums up the health care system today, it's probably this Rolling Stones song. The plain truth is that everyone with a stake in the health care system—doctors, hospitals, employers, workers, insurers and politicians—is looking for something different. Until they come to a consensus, most will wind up empty-handed.

We've often preached about the need for compromise in the debate over health care reform, something that is as likely in an election year as winning the lottery in consecutive weeks. However, employers can engage now in a bit of consensus-building that may pay off when the various health care reform proposals receive serious scrutiny.

The advice is simple: Start building bridges with your employees.

The average Joe or Josephine is just as concerned—and dissatisfied—with the future of the health care system as most employers, according to a recent Harris poll (*BI*, April 13). For example, only 2% of the 2,000 Americans surveyed said the health insurance system should remain in its current form.

Other findings from the survey: 61% worry that health insurance will become unaffordable. Sound familiar, benefit managers? And, 50% fear that they will be stuck with big medical bills that their insurance will not cover.

Although many health care "experts"—including doctors, insurers and employers—write off the average American as being uninformed and unconcerned about the health care system, that's no longer true.

Employers must link up with a natural ally in the health care reform process and work alongside their workers to make sure that the health care system is truly reformed to hold down costs and increase access to care.

This kind of understanding is possible. Take the example of Detroit Edison Co. (see story, page 3). After a bitter labor dispute over health care costs



in 1984, the utility handed an olive branch to employees and formed a joint labor/management health care cost containment committee, through which the company explained to union members why health care costs are rising.

Four years later, health care issues—including some major cost containment initiatives—were resolved five weeks before the existing contract expired. And, the new cost containment features helped Detroit Edison significantly reduce the rate at which its health care costs are rising.

Compromise will be the key to the debate over reform of the health care system, something that all parties—from the committee room to the emergency room to the board room to the family room—must remember. While it's true that employers probably won't get everything they want in terms of health care reform, by actively joining forces with employees they may find—to again quote Mr. Jagger—they may "get what they need."

Rejecting 20/20 hindsight

SHOULD AN EMPLOYER be expected to have 20/20 vision when buying annuities to replace pension benefits promised to workers and retirees?

We don't think so, and we're glad a federal court doesn't rely on hindsight, either.

In a single-line decision, U.S. District Court Judge Terry J. Hatter last month dismissed a suit filed by a group of Blue Cross of California employees and retirees whose pension plan was terminated and replaced with annuities Blue Cross purchased from Executive Life Insurance Co. (*BI*, April 13).

The suit was one of many that have been filed against employers that terminated overfunded pension plans in the 1980s, replaced pension benefits with ELIC-issued annuities and then recovered the surplus assets in the pension plan.

Under a conservator's order issued last year after the California Insurance Department took control of ELIC, annuitants are receiving only 70% of promised benefits. However, payments should rise substantially, perhaps to nearly 100%, after ELIC's rehabilitation plan is put in place.

If there ever was a category kept of suits that lacked merit, the suit against Blue Cross of California by the annuitants would qualify.

First, the annuitants have not suffered injury. Although it is not required to do so, Blue Cross is making up—at a cost of about \$30,000 a month—any

shortfall in their benefits.

Second, Blue Cross of California did all the things it should have done in selecting an annuity insurer. It conducted a bidding process, it received multiple bids and it selected an annuity insurer with the highest ratings.

In their suit, the Blue Cross of California employees and retirees charge that Blue Cross should have known that ELIC was not a "proper" insurer, referring, among other things, to its heavy junk bond holdings. That charge may have been reasonable in 1990 or 1991, when ELIC's problems were widely known, but not in 1986, when the annuities were purchased. At that time, the insurer was very profitable, a fact reflected in the top ratings it earned from A.M. Best Co. and Standard & Poor's Corp.

Foreseeing the problems that would envelop a top-rated insurer five years later would be difficult, if not impossible.

This isn't to say that all the suits against employers who terminated pension plans and purchased Executive Life annuities are without merit. Courts will have to examine the other suits individually.

And, broader policy issues must be addressed. Should there be, for example, new tougher standards that employers must follow in selecting an annuity insurer? Current rules do not spell out the financial qualifications an annuity insurer must meet.

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Published weekly at 740 Rush St., Chicago, Ill. 60611-2590, Telex 6871241,

Fax 312/280-3174, Cable CRAINCOM. Offices: 220 E. 42nd St., New York,

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Canada and all other foreign add \$38 for surface mail. Europe and Middle

East only add \$116 for air delivery. First-class mail to U.S., add \$95; to

Canada add \$105. Bermuda only, \$180 per year expedited delivery; Aus-

tralia only, \$305 per year expedited delivery. SHEILA GORMLEY, circulation

manager. Four weeks' notice required for change of address. Send subscrip-

tion correspondence to Circulation Department, Business Insurance, 965 E.

Jefferson Ave., Detroit, Mich., 48207-3185, or phone 800-678-9595

or 313-446-1611, Fax 313/446-1650. Microfilm copies are available from

University Microfilms, 300 Zeeb Road, Ann Arbor, Mich. 48103. Microfiche

copies available: Bell & Howell, Micro Photo Division, Old Mansfield Road,

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State mandates

Continued from page 2

offer policies that cover mammography screenings, but employers in the state are not required to buy that coverage, Ms. Laudicina pointed out.

The next most common new benefit requirement in 1991 was requiring commercially insured employers to cover adopted children of parents covered by employer plans. This requirement was added by seven states: Connecticut, Hawaii, Maryland, Montana, North Carolina, Oregon and Virginia.

Ms. Laudicina also pointed out that three states—Mississippi, Missouri and Texas—now require commercial insurers to offer policies covering mental health care.

Several benefit mandates were adopted by only two states apiece last year, including:

- Louisiana and North Carolina began requiring commercially insured employers to cover Pap tests, which are used to detect cervical cancer.

- Illinois and Rhode Island began requiring commercially insured employers to cover in vitro fertilization procedures.

- California and Rhode Island

began requiring commercially insured employers to cover blood lead level screening for children.

- California and Maine require services of nurse midwives to be covered by commercially insured employers.

- California and Rhode Island mandate that the services of nurse practitioners must be covered by commercially insured employers.

Also in 1991, insured health plans were required to cover: the services of professional counselors and psychological examiners in Arkansas; treatment by social workers in California; breast reconstruction in Maine; treatment

by physician assistants in Michigan; well-child care and acupuncture in Montana; care by psychiatric nurses in Rhode Island; and the services of dieticians in Wyoming.

In addition, Missouri requires commercial insurers to offer policies including both alcoholism and drug abuse treatment coverage, and Mississippi requires insurers to offer policies covering temporo-mandibular joint disorders, a condition that requires jaw restructuring.

Including the requirements enacted last year, BC/BS found that the most common coverage mandate is alcoholism treatment, re-

quired in 42 states. That is followed by mammography screening, which must be covered in 41 states; mental health care coverage, which is required in 32 states; and drug abuse treatment, required in 31 states.

Maryland requires coverage for the most types of treatment—41—followed by California with 33. Connecticut and Minnesota both have 30 benefit mandates, according to the study.

At the opposite end of the spectrum are Alabama, Delaware, Idaho, South Carolina, Vermont and the District of Columbia, all of which mandate coverage for fewer than 10 types of treatment, Ms. Laudicina said.

Employer groups, for the most part, oppose state benefit mandates.

"From our perspective, 50 state legislatures making decisions on a piecemeal basis about what should or should not be covered is not very helpful," said Richard Smith, director of public policy for the Washington Business Group on Health, an employer coalition. Mandating coverage does not solve the health care access problem and it wreaks havoc on both small firms and large, multi-state employers, he said.

"Obviously cost is the big issue" associated with benefit mandates, said a spokesman from the National Federation of Independent Business, a small business lobbying group in Washington, D.C. The major reason the majority of small employers are not offering coverage is because they cannot afford it, he said.

"There is a lot of documented evidence about how mandates add to costs," said Ellen Goldstein, director of health policy for the Assn. of Private Pension & Welfare Plans, an employer lobbying group in Washington, D.C. "Some mandates may be well-intentioned, but I think a lot of it is driven by political pressure."

"The cost impact of any single mandate may not be very large, but the cumulative cost of many mandates can be very high," said Ms. Laudicina of BC/BS.

According to BC/BS economists and actuaries, 21.3% of all claims payments made by Blue Cross & Blue Shield of Virginia, for example, are attributable to state benefit mandates, Ms. Laudicina said.

"I cannot find any evidence of savings that result from benefit mandates," she said.

Some health care provider groups—like psychiatric associations—maintain that mandating coverage for outpatient psychiatric care will save employers money because it will discourage inpatient utilization.

"But what happens is utilization for outpatient services increases without a concurrent decrease in inpatient utilization, Ms. Laudicina explained.

New benefit requirements may be slowing down, she said.

Laws in 19 states now require an objective analysis of the cost and benefit of any new mandates, Ms. Laudicina said. "State legislators are finally listening to what employers and others have been saying—that mandates raise costs and aren't fair."

The passage of these laws "encourages an intelligent debate" about which benefits are worthwhile, she added.

Although these evaluation laws are "a good sign," states "should probably be evaluating more than mandated benefits, though," said Mr. Smith of the WBGH. "There is an awful lot in the basic benefits package—like medical appropriateness—that needs scrutiny." ■

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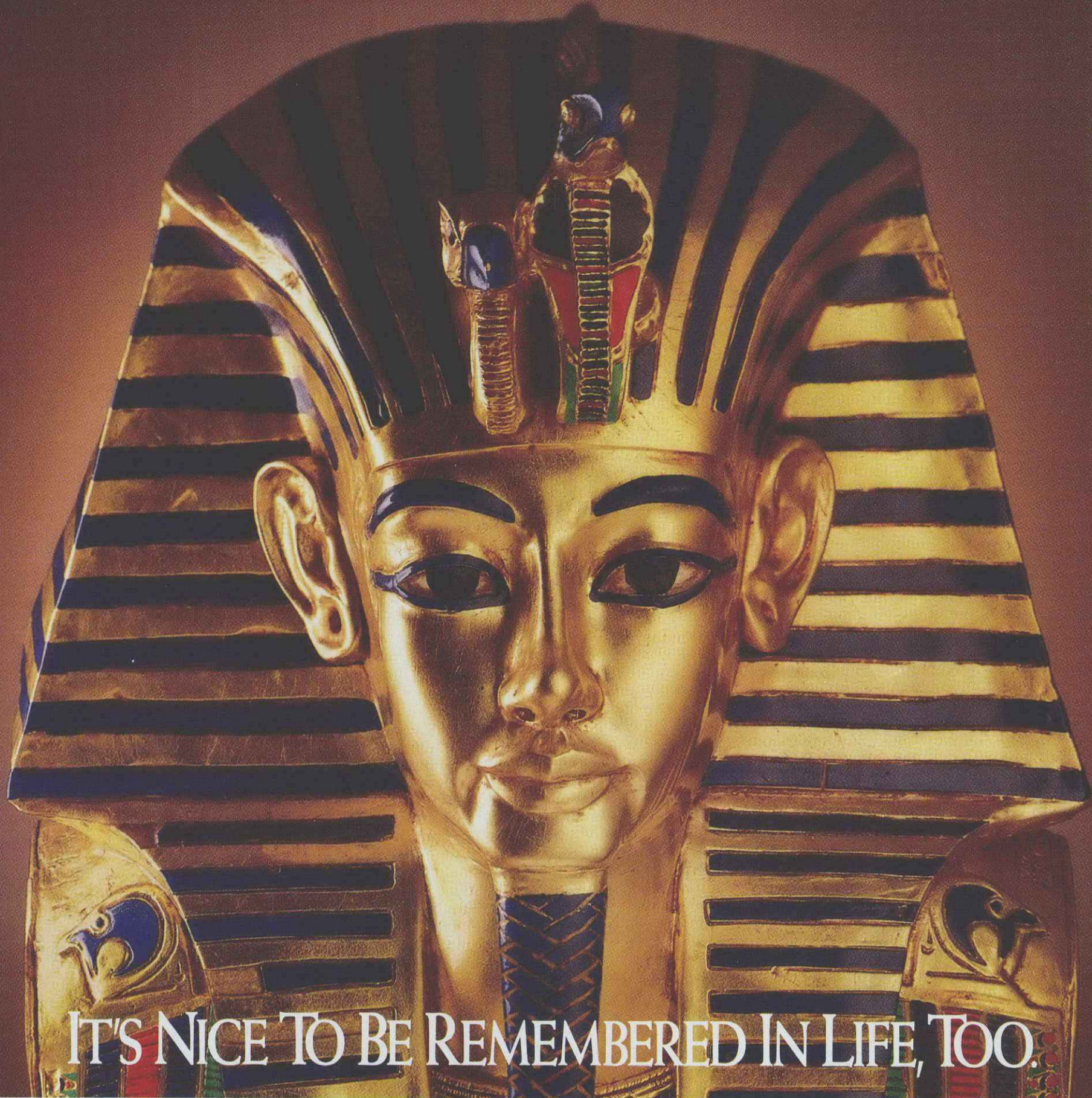
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Spencer proceeds are tallied

By MICHAEL BRADFORD

ANAHEIM, Calif.—Bids, hockey pucks and golf balls were flying at the Risk & Insurance Management Society conference to raise money for the Spencer Educational Foundation.

Various special events added around \$17,000 to the foundation's year-long fund-raising drive.

The foundation's annual silent auction, which featured 73 items ranging from Caribbean vacations to Chicago Cubs tickets, generated about \$13,000. Final figures are not yet available, said Arita Benedetti, president of the foundation.

"We had good participation," said Jim Smirles, auction co-chairman. "Almost every item was bid on."

The number of RIMS chapters among donors was higher compared to previous years, said Mr. Smirles, national brokerage marketing officer at Kemper National Insurance Cos. in Long Grove, Ill.

The RIMS Hockey "All Stars" returned to the ice and raised around \$3,000 for the Spencer Foundation. The game pitted Team U.S.A. and Team Canada for the first time in two years. The teams took a hiatus last year from the annual competition, which began in 1986.

"It was probably the best game we've played so far," said Peter

At issue

What are you doing to control workers compensation costs?



John O. Blevins
Corporate Safety Director/Administrator-Workers Compensation
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Christopher Johnson
Director of Safety and Risk Management
City of Evanston,
Evanston, Ill.

We are addressing this universal problem in several ways. I perceive our most important steps to be: implementation of in-house claims administration; identification of a superior medical provider; and establishment of a formal light-duty program. In an effort to reduce legal fees, we make every effort to settle claims on a pro se basis.

Compiled by Sara Harty

King, an assistant vp with Marsh & McLennan Inc. in Philadelphia. "There was stellar goaltending at both ends."

Team U.S.A. pulled off a 10-6 win at Paramount Iceland in Paramount to keep the coveted Golden Skate trophy on U.S. soil for another year.

"We've started to line up our ice time" for next year's showdown in Orlando, Fla., Mr. King said.

In addition, a golf tournament sponsored by Arthur J. Gallagher & Co. at Tustin Ranch Golf Club in Tustin, Calif., raised \$1,000 for the foundation.

"Everything went really well," said Lynn Mobley, co-chairwoman of the tournament. Ms. Mobley, an account executive with Gallagher,

said about 45 golfers competed. The Spencer High School Outreach Program during this year's conference awarded three grants to RIMS chapters to be used to foster awareness of the risk management profession.

A \$2,500 grant was awarded to the Central Illinois Chapter to help fund a two-day career planning workshop for high school students held in conjunction with the Illinois State University Katie Center for Insurance.

At the workshop, 25 to 50 students will meet with risk management and insurance professionals who will discuss careers in those professions.

The Orange Empire Chapter in California was awarded a \$2,000

grant to fund a risk management career development program for high school juniors and seniors.

A \$500 grant goes to the New York Chapter to be used for essay awards presented to high school students who submit essays to the Insurance Education Council.

The foundation also elected new officers and directors.

Anne M. Zug, corporate director of insurance at Main Line Health in Radnor, Pa., a hospital holding company, takes over as chairwoman. She replaces James C. Newton Jr., director of loss administration at Fuqua Industries Inc. in Atlanta, who is stepping down as chairman after 12 years. But, he was named a director emeritus of the foundation.

M. Michael Zuckerman, associate vp-university risk management and insurance at Thomas Jefferson University in Philadelphia, joins the board of directors to fill out Mr. Newton's expiring term.

William E. Drum, vp and director of risk management at Ralston-Purina Co. in St. Louis, will fill the unexpired term of director Marge P. Layne, corporate risk manager at Core Mark International in South San Francisco, Calif.

Carol N. Childers, assistant director of risk management at Metropolitan Transit Authority in New York, will fill the unexpired term of director John Robert James, formerly vp-risk management at Chemical Bank in New York.

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Cost containment efforts failing

By MICHAEL SCHACHNER

WASHINGTON—None of U.S. business' current cost containment efforts alone will prevent health care from eating up 20% of the nation's gross national product by the year 2000, a health care attorney and consultant warns.

If employers stick to their current managed health care efforts,

Negotiations

Continued from page 3

a few years after a bitter strike.

"Eight years ago, we had a seven-week strike over health care. We wanted to lower our costs by shifting part of it to the employees. Eventually we settled, but the real positive that came out of that agreement was the creation of a union/management cost containment committee," he said.

He explained that the committee's goal is to understand why health care costs are escalating.

Through a series of half-day forums every two or three months, "we have stressed that health care dollars are part of overall compensation and that value is related to costs. I think we have succeeded in developing a 'We vs. It' attitude as opposed to 'Us vs. Them.' "

To reach this level of understanding, Detroit Edison shared large amounts of data with its two unions. That data allows the unions to compare the utility's expenses with national averages.

The seminars also focused on identifying waste and abuse.

"Specialty care is probably the worst area for abuse. We were able to support this by providing examples of a lot of real cases," said Mr. McCafferty.

The health care committee representatives also attempted to expose the profit motives of Detroit-area providers. "We had to defrock the medical community. This I think got us on the same team," he said.

The committee also identified alternatives for reducing costs without reducing benefits, as well as ways to reduce waste and abuse.

Lastly, the committee identified alternatives for improving quality. "We all agreed that better care really costs less in the long-run," Mr. McCafferty said.

The end result: Detroit Edison and its two unions reached agreement on health care issues in 1988 five weeks before the existing contract expired.

The contract contained many cost containment features like front-end deductibles, out-of-pocket maximums, copayments, precertification and mandatory second opinions for surgery. It also contained expanded wellness benefits and new prescription drug benefits.

"It was great to take health care off the table five weeks before the contract deadline—what an improvement over 1984," Mr. McCafferty said. "The company's cost per employee decreased under the new plan, and it was union leadership that allowed for its introduction."

Under the new pact, Detroit Edison's average annual health care inflation in 1989 and 1990 was about 4.5% as opposed to nearly 20% before it was heavily managed, and "union leadership continues to support the cost containment strategy of cost reduction over cost shifting," he said.

F. Bernard Forand, cost containment adviser for the state of Connecticut in Hartford, also spoke at the session. ■

The portion of GNP allotted to health care still will increase, insists Rick Carlson, an independent consultant in Washington, D.C.

Gains from basic cost containment programs are being offset by the program's expense, said Mr. Carlson, who spoke at a session of the recent annual National Managed Health Care Congress.

"The iron law of big numbers is governing health care today. Cost containment has become a \$40 billion industry. And, even if managed care can hold inflation down to 10% annually, we're at \$800 billion per year and climbing."

Mr. Carlson equated America's

attitude toward health care to the story of Chicken Little, who told everyone around him the sky was falling but nobody believed him.

"I don't think there's anything we're prepared to do in the aggregate to control costs. You can only do better in isolated cases. This decade is the last one we have to turn the oil tanker. We're at the point where radical changes must be undertaken if we agree that 20% of GNP is too much to pay for medical care," he said.

But "if you believe 20% is not too much, then you're fine," he quipped.

Health care comprised about 13% of GNP last year.

He identified three reasons why the U.S. health care delivery system is not controlling its growth:

- There's too much "gaming, negotiating and leveraging" going on between providers and payers. Health maintenance organizations are the worst offenders.

- "HMOs as we know them should probably be called health manipulation organizations. They negotiate and bargain like crazy, but don't provide much care," he said.

- Health care information is too often treated as top secret.

"Health care is one of the most classified bodies of information in the country. Health care information gets unofficially classified by so-called experts who think no one will understand the information but them," he said.

- Employers are not spending enough time and money on "soft" health plans.

"There is a lot more we can do to influence personal behavior. This isn't just California talk. Research shows that wellness pro-

grams and other lifestyle plans have had an effect," he said.

One company that has devoted itself to what Mr. Carlson called soft health plans is the Coors Brewing Co. in Golden, Colo.

Max Morton, manager of Coors' on-site wellness center, said the brewer views prevention as an investment in health.

Coors, which launched its wellness program in 1981, provides employees with free health risk appraisals, on-site mammography, cholesterol testing, smoking cessation programs including company-paid nicotine gum and patches, individual nutrition counseling and weight loss counseling (*BI*, May 7, 1990; April 16, 1990).

"The average term of our employee is 14.6 years. Obviously we have an investment in them and would like for them to be as healthy as possible for their own sake and ours," said Mr. Morton. ■

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More candor sought on mental treatment

By MICHAEL SCHACHNER

WASHINGTON—Mental health and substance abuse treatment facilities need to be more honest with employers and less concerned with providing a country club setting for treatment, contends a corporate executive.

Employers have lost faith in the mental health and substance abuse treatment system, because private providers and managed care vendors appear more intent on playing games with savings figures and offering pristine environments for treatment than in truly curing patients, asserts

David Nassef, corporate ombudsman with Pitney Bowes Inc. of Stamford, Conn.

Inpatient treatment facilities should concentrate more on helping patients beat their disease than on offering relaxed "educational sessions" intermixed with horseback riding and swimming, Mr. Nassef said.

And what employers really need in order to control mental health-related treatment costs is for providers to be honest about courses of treatment and the potential for relapse, Mr. Nassef said at the annual National Managed Health Care Congress held here recently.

"Employers are paying about 60% of all health care costs in America today, but we have little

faith in the mental health and substance abuse treatment system. There seems to be a basic lack of understanding among providers as to the disease of substance abuse," he said.

He also criticized the mental health industry for placing too much emphasis on credentials. "Behavioral health providers are credentializing themselves out of business. We're at the point where it's cheaper for an employer to buy an insurance policy that covers mental health treatment than to hire all these expensive credentialized people who can't help.

"We're paying as much as \$4,000 per week, for what? Credentials, swimming pools, green fields and rustic-looking lodg-

ing? If you think about this, it's obvious we deserve more," he said.

Specifically, behavioral health care providers need to be more honest with employers about treatment patterns and success rates, said Mr. Nassef.

"Providers must let us know approximately what percentage of our employees will fall into relapse. Honest figures won't scare us away, and it will permit us to budget better. Getting some used car salesman's pitch about 95% first-time success rates is much worse than the truth. Providers must be more honest up-front," Mr. Nassef said.

He also urged mental health and chemical dependency treatment providers to come up with

more courses of treatment than the standard inpatient or outpatient paths.

"There has to be more available than simply inpatient vs. outpatient. If there isn't anything else, we need to know why. Basically, we need to know more. Why do some programs last 28 days? Why do others last only six days? In truth, (neither sounds) sufficient, because ridding someone of a chemical dependency is a long-term process. Purchasers should be made more aware of this," he said.

Managed mental health care providers also must bring more to the table than they have so far, according to Mr. Nassef.

"As a purchaser, I want to know what value they'll add to the treatment process other than taking money away from other providers. At this point, there are far too many secrets being kept from us about what managing mental health benefits can accomplish," he concluded.

John J. Mahoney, a consultant with Hewitt Associates in Rowayton, Conn., who also spoke on the subject of what purchasers want from behavioral health providers, said managed mental health care providers must avoid spending too much time negotiating pricing.

"It's best that providers simply put straight contract numbers on the table. Providers don't need to play games with numbers, nor should they insist on putting out the lowest price. To me, a provider offering quality service and 20% savings compared with non-managed services should be considered," he said.

According to Mr. Mahoney, other factors to consider when contracting for managed mental health care services are:

- Stability.

"A company with eight to 10 years' experience with turnover below 10% is worth looking at," he said.

- Growth.

For younger companies, growth can signify that a company is moving in the right direction. However, when companies grow too quickly or make acquisitions they cannot absorb, service often drops off.

"When a company grows by more than 30% in one chunk, that can signal that a dropoff in service is impending," he said.

- Guarantees on employee access to individual providers and timeliness of service.

"There should be a provider within 20 minutes of your employees, and employees should be able to have a face-to-face appointment... within 48 hours," he said.

- An automated administrative system.

A provider that is capable of conducting coverage eligibility checks via computer and can handle electronic claims submissions is a positive.

Also look into a provider's reporting capabilities. "This can be the Achilles' heel for many managed care companies. Clients need and want information on admissions and total costs," said Mr. Mahoney.

- One-stop shopping.

Companies that can arrange inpatient, outpatient and other behavioral health treatment services are desirable.

Dr. S. Alan Savitz, head of clinical policies and programs with Human Affairs International, the Salt Lake City-based employee assistance program division of Aetna Life & Casualty Co., also spoke at this session. ■

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EAPs work best with tie to managed care: Panel

By MICHAEL SCHACHNER

WASHINGTON—Integrating an in-house employee assistance program with a managed health care plan improves an employer's ability to channel employees to appropriate providers and increases the program's visibility, EAP managers say.

When an employee assistance program and a managed health care firm combine efforts, both the employer and employee benefit from improved care, says James M. Oher, health care manager-benefit plans with Texaco Inc. in White Plains, N.Y. "Being a severe critic of off-the-shelf managed care programs, I believe that by interfacing an EAP with the utilization management firm, we can reach the singular

goal of prompt, appropriate and affordable care," Mr. Oher said. Mr. Oher and two other corporate EAP managers spoke at the annual National Managed Health Care Congress conference held here recently. The major problem with integrating these two programs is getting in-house EAPs and managed care plans on the same page in terms of goals and responsibilities, says Janice Dragotta, EAP program manager with Pacific Bell, a unit of San Francisco-based Pacific Telesis Group.

"The EAP's traditional perspective has been that benefits people contract with managed care only to control costs and they end up losing sight of benefits. Meanwhile, benefits people feel just the opposite about EAPs. They think we care only about benefits and nothing about cost," Ms. Dragotta explained.

"This long-standing turf issue between EAPs and benefits people must be resolved before the two sides can work together positively," she said.

But if EAPs and managed care plans can work out this ideological difference, as well as issues such as which entity is responsible for patient referrals and which program handles pre- and post-care employee assessments, the two programs can work extremely well together, according to Bruce Davidson, corporate manager-employee assistance programs with Digital Equipment Corp. in Maynard, Mass.

"There are some legitimate questions to be answered when integrating these programs. But if the EAP and managed care provider can work in conjunction on treatment plans and on patient follow-ups, I firmly believe they can positively influence outcomes," Mr. Davidson said.

An EAP that is integrated with a managed care plan can function as an internal gatekeeper to care outside the managed care network, he said.

Texaco's Mr. Oher noted that EAPs are highly valuable when interfaced with a managed mental health and substance abuse treatment program. In these cases, EAPs can assume the role of the "workplace guardian" by providing on-site attention and encouraging employees to voluntarily enter treatment programs for

NMHCC draws another crowd

WASHINGTON—The fourth annual National Managed Health Care Congress again drew overflow crowds to the nation's capital March 29-April 1. Approximately 275 speakers were featured at this year's conference, which attracted more than 4,000 attendees and 250 exhibitors to the Sheraton Washington Hotel.

Included in the conference was an "employer summit" on strategic planning, which was offered exclusively to senior human resource, benefits and financial officers of companies with more than 5,000 employees. The summit featured seminars on corporate benefit strategies, potential reforms on the horizon and the impact these factors will have on employers.

The conference also featured approximately 100 concurrent workshops covering topics like corporate health planning for the 1990s, behavioral health care options, pharmaceutical cost containment and major managed care trends.

The annual spring meeting of the American Assn. of Preferred Provider Organizations, a managed care trade group, was held in conjunction with the conference.

The NMHCC, which has grown steadily since its inception in 1988, is designed to inform consumer, provider and consulting segments of the health care industry about changes taking place in the managed care marketplace.

The NMHCC is planning three regional conferences over the remainder of this year and early next year.

The Northeast regional conference is scheduled for Aug. 27-29 at the New York Hilton. A Midwest conference is slated for Oct. 29-31 at the Chicago Sheraton. The Western conference is scheduled for Jan. 21-23, 1993, at the San Francisco Hilton.

The fifth annual NMHCC will be held April 12-15, 1993, at the Sheraton Washington. For more information call Sara Evangelous, Communications Director, NMHCC Conference Information, at 617-487-6700.

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chemical dependency.

"EAPs are also valuable in that they can coordinate and monitor care for safety-sensitive employees with substance abuse problems, as well as protecting the confidentiality of employees who come to the EAP on their own and comply with its recommendations," Mr. Oher said.

Pacific Bell's Ms. Dragotta pointed out that EAPs can offer employees an additional access point to care.

"If the EAP has referral power, employees aren't bound to an 800 number or their primary physician to get to a provider. For example, our EAP has on-line capability with our managed care vendor and can check employee eligibility and can certify initial treatment," she explained.

Ms. Dragotta also emphasized that Pacific Bell's EAP functions only as an authorization point for treatment. "After referral, we back off. We don't want to be considered a case manager. That's what the benefits department hired a managed care company for. We're doing very little follow-up."

As a result of integration between Pacific Bell's EAP and its managed care plan, the EAP has become more visible to employees.

"Our caseload is up 11%, and 25% of all managed care cases are accessing treatment through the EAP," said Ms. Dragotta. "This is just the opposite of what we thought would happen when managed care was implemented in 1987. At that time, we thought managed care would drive us into extinction, but apparently we're a good source for referrals."

Ms. Dragotta emphasized the importance of educating employees and union representatives about the relationship between the EAP and managed care.

"As with all benefit and human resource programs, communications need to be ongoing and comprehensive. It requires printed materials and 'health expos.' Employers also need to educate the individual providers about the union between EAPs and managed care, because in most cases, providers don't like managed care or they don't understand it," Ms. Dragotta said.

Garamendi

Continued from page 3

from referring patients to laboratories in which they have a financial stake.

"The high administrative cost of insurance purchased by small businesses and the fact that the risk is spread among so few people often pushes the cost of insurance beyond their reach," Gov. Wilson said.

"Providing the opportunity for businesses to join together in a voluntary, state-administered pool will help them overcome these barriers. At the same time, it will promote competition in the insurance industry for the small business market."

Mr. Garamendi criticized the governor's proposal as "nothing new."

"The governor's proposal doesn't provide coverage for the state's 6.75 million uninsured and it doesn't even offer a significant first step in that direction. Nor does it do anything to reverse the devastating increases in health care costs," Mr. Gara-

mendi said in a press release.

"His proposal offers Band-Aids when our health care system needs major surgery," the commissioner asserted.

Instead, he urged the governor to support his 24-hour proposal. "Creeping incrementalism is not enough," he said.

Before being inaugurated as insurance commissioner in January 1990, Mr. Garamendi served 14 years in the state Senate, including four years as majority leader, as well as two years in the state Assembly.

Department staff declined to comment on whether Mr. Garamendi would be tapped to serve in a Clinton administration.

However, rumors are circulating throughout the state Democratic Party that the commissioner is being considered as a possible vice presidential choice or perhaps the nation's first federal insurance regulator should federal solvency regulation become law under a Clinton administration.

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Execs not liable for bad judgment: Court

By SARA MARLEY

CHICAGO—Pine Top Insurance Co.'s directors and officers may have made some bad business decisions, but they cannot be held accountable for the insurer's failure because they are not charged with illegal acts, two Illinois courts have ruled.

In 1988 litigation, the Illinois insurance commissioner charged Pine Top's directors and officers with misrepresenting the insurer's financial condition and mismanaging underwriting, pricing and reserving.

But, the insurance commissioner, acting as Pine Top's liquidator, did not charge the defendants with fraud or other illegal acts. Therefore, Pine Top's directors are protected by the "business judgment rule," a state appeals court ruled last month. That rule says managers can't be held liable for the results of business decisions made with due care and in good faith.

A Cook County Circuit Court judge subsequently dismissed the liquidator's suit against 18 Pine Top officers on April 6.

Illinois Insurance Director Stephen F. Selcke is seeking a rehearing from the appeals court and is considering asking for a rehearing from the circuit court.

Schaumburg, Ill.-based Pine Top, a unit of Greyhound Corp., was placed in liquidation in January 1987 (*BI*, Dec. 29, 1986). The insurer is insolvent by more than \$300 million, said Ellen Robinson, a partner with Robinson, Curley & Clayton in Chicago, an attorney for the liquidator.

In 1988, then-Illinois Insurance Director John E. Washburn filed suit against Pine Top's directors and officers; its auditor, Touche Ross & Co.; and Pine Top's former parent, Whitney Financial Group of Phoenix, seeking damages in excess of \$100 million (*BI*, July 4, 1988). The complaints against each group of defendants were subsequently split into separate litigation.

The liquidator accused the directors and officers of failing to develop adequate underwriting procedures and controls, underpricing insurance and reinsurance, maintaining inadequate reserves and failing to cede to financially secure reinsurers.

The complaint also alleged that Pine Top directors and officers paid excessive commissions to managing general agents and then failed to monitor their performance, to collect balances due from them and to require MGAs to maintain adequate records.

A lower court dismissed the case against the directors, and a three-judge appeals court panel affirmed that decision March 13.

The liquidator's lawsuit "is exactly the type of second-guessing which the business judgment rule precludes," Judge Joseph Gordon wrote for the appeals court panel. "In the absence of factual allegations to the contrary, we must presume that defendants acted in good faith and with due care."

"This is a business that went under. It couldn't withstand market conditions. They made some wrong decisions," said attorney William Henry Barrett with Fox & Grove in Chicago, who represents a group of Pine Top directors and officers.

But, attorneys for Pine Top's liquidator are asking the appellate court for a rehearing to con-

sider remanding the case to a lower court. There, the liquidator could file an amended case against the directors and officers, charging them with inattentiveness and neglect—actions that are not protected under the business judgment rule.

The liquidator first learned in the appellate court ruling that its case could possibly proceed if it had been worded differently, explained attorney Dick O'Brien of

Sidley & Austin, the Chicago law firm that represented the liquidator in the appeal.

The appellate court justices "ruled on the law. Now, they should give us the chance to amend to meet the factual requirements," he said.

If the appeals court refuses to rehear the case, the liquidator may appeal to the Illinois Supreme Court.

Pine Top's liquidator also may

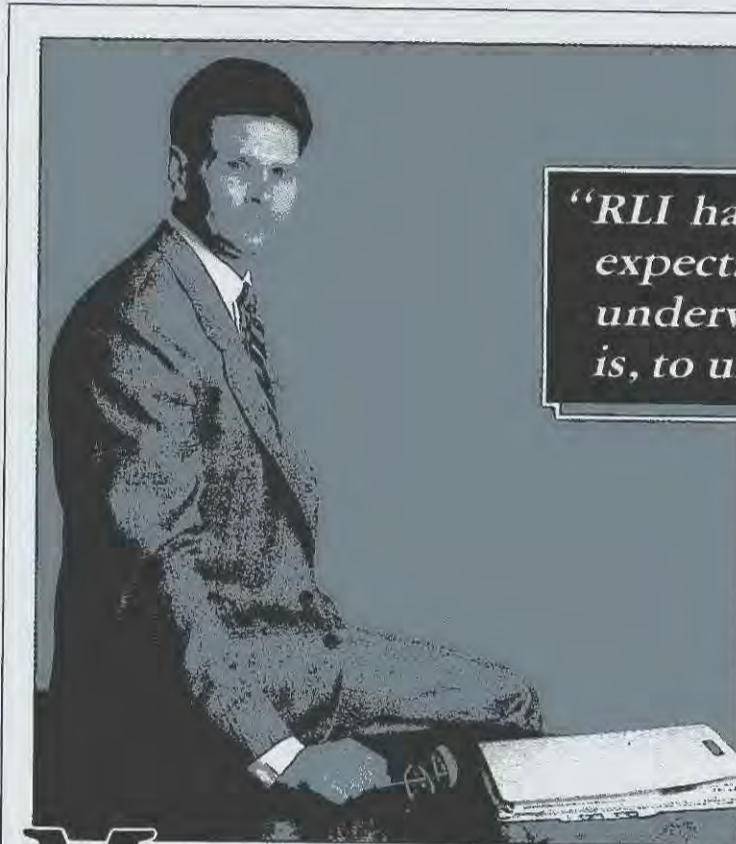
seek a rehearing from the circuit court or appeal its ruling to dismiss the case against the insurer's officers. The liquidator was seeking to amend the complaint in light of the appellate court ruling when the circuit court judge dismissed the case against the Pine Top officers.

"Insurance insolvency is such a tremendous burden on the entire American public. When a liquidator uncovers the misconduct

that caused the insolvency, the liquidator should be allowed the opportunity to prove those allegations," said Ms. Robinson, the liquidator's attorney in that case.

The liquidator's action against the other defendants named in the 1988 suit are pending.

Stephen F. Selcke, Director of Insurance for the State of Illinois as Liquidator of the Pine Top Insurance Co. vs. Touche Ross & Co. et al., Appellate Court of Illinois for the 1st District, 5th Division; No. 89-3214.



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GAO official details health insurance fraud

By MICHAEL SCHACHNER

NEW YORK—The health insurance industry is a perfect target for fraud and abuse because of its enormous size and limited safeguards, a government adviser says.

Fraud continues to permeate all facets of the health care environment and will continue to do so until state and federal investigators begin investigating health insurance fraud with the same vigor they have dedicated to drug trafficking and banking scandals, says Sheila Smythe, chief health policy advisor with the U.S. General Accounting Office in Washington, D.C.

"The only way we'll ever stop insurance fraud is by understanding the underlying causes rather than pointing fingers after

fraud cases have been discovered," she said during a session last month at a conference on health care reform sponsored by the New York Business Group on Health.

"Health insurance is a target for one primary reason, and that's sheer volume. Health care is more than a \$700 billion industry that takes up 12% of our GNP. The system virtually lacks safeguards and it's very easy to enter," Ms. Smythe said.

In recent years, insurance fraud safeguards have decreased, while claims volume has increased by about 70%, she contends.

"With a system this big that lacks standards, it's very easy for unscrupulous providers to overcharge, extract bribes for referrals, perform totally unnecessary

services and then bill for them. Lately, Medicare and Medicaid have become prime targets because they're centrally regulated. There's a lot of open space to get in the back door," she said.

Health care fraud and abuse is a growing problem, partly because the cost of detecting fraud and prosecuting offenders is nearly equal to the amount such a campaign might save.

Arthur Lifson, a vp with CIGNA Corp.'s employee benefit companies in Bloomfield, Conn., agreed with Ms. Smythe that the cost of pursuing fraud is not always worth the results.

"My advice for insurers is that if the fraud you detect is egregious, than by all means go after it. If it's not, or if it's very small, you're probably better off simply paying the claim and moving on

to what you do best," he said.

Mr. Lifson said fraud has run rampant through the health care system because state and federal investigators have generally not given it their full attention. However, he noted that recently federal and local investigators have begun cracking down on what he called "white-collar wilding."

In order to prevent paying bogus health claims, he urged health insurers to pay closer attention to the providers seeking reimbursement.

"Insurers have to be more aware of fly-by-night labs that bill for unperformed and unnecessary services," he said.

Advancements in claims processing systems should make it easier to detect fraudulent claims, Mr. Lifson said.

"Some people may argue that technology will make insurance fraud harder to detect because there are fewer humans in the system to catch miscoding. This is absolutely not true. Today's systems are actually better at suspending claims for further review," he said.

More importantly, today's claims processing systems are geared to identifying unnecessary services more than purely fraudulent claims, he said.

"In truth, the dollars spent on inappropriate care far outnumber flat-out fraud. This is what really needs to be caught and controlled," said Mr. Lifson.

Joseph Brophy, president of Travelers Corp.'s managed care and employee benefits operations in Hartford, Conn., also spoke at the session. ■

No consensus on reform

Panelists hash over ideas to improve health care system

By MICHAEL SCHACHNER

NEW YORK—The U.S. health care system is in desperate need of an overhaul, but there is little agreement as to what features a new system should have, health care experts say.

Suggestions range from the federal government taking an active role and introducing a single-payer national health care plan to creating a national health care budget that forces providers to compete within restrictive guidelines, they note.

Other recommendations include having federal and state governments make health care subsidies available to low-income citizens, and mandating that employers provide a minimum health benefits package to all workers.

These proposals and other theories on how the U.S. health care system should be structured were offered last month during a panel discussion at a conference on health care reform sponsored by the New York Business Group on Health.

"There seems to be support everywhere for radical reform, but the methods people are suggesting vary dramatically," said Bernard Tresnowski, president of the Blue Cross & Blue Shield Assn. in Chicago.

"Our system is clearly ineffi-

cient," added G. Robert O'Brien, president of CIGNA Corp.'s employee benefit companies in Bloomfield, Conn. "I feel we need fundamental change, and the federal government needs to take the leading role. We have the best medicine in the world. Let's make it available to everyone."

Stuart Altman, dean of the Heller Graduate School for Social Policy at Brandeis University in Waltham, Mass., said health care coverage could be more affordable if a national health care budget was created that included pricing restrictions on providers.

"Today there's no market constraint short of 100% of gross national product. We badly need a federal health care expenditures board that would control charges," said Mr. Altman.

However, Dr. Lonnie Bristow, a Chicago physician and a member of the American Medical Assn.'s Board of Trustees, argued that budgets restricting physician charges would violate the free-market foundation on which the U.S. economy is based.

"Physicians might accept practice parameters to ensure that payers are getting full value. I think we'd be willing to review charges with patients, so in case they feel they're being overcharged, they can respond. But placing doctors on a budget isn't the answer. It's tort reform we need," asserted Dr. Bristow.

Edward Neuschler, acting director-policy development and research with the Health Insurance Assn. of America, an insurer trade group in Washington, D.C., also bristled at the thought of a federally set budget.

"Who should set this budget?" he asked. "Not the federal government, given its record with Medicare."

"Only internal budgets work. Any budget set by an outside entity is truly scary," added Karen Wintringham, senior vp-corporate development with the Health Insurance Plan of Greater New York.

"No way can we manage the health care system through budgets," asserted Mr. Tresnowski of BC/BS.

Mr. Altman of Brandeis said another problem with the ongoing debate over health care reform is that too many people

want to move forward in small increments.

"The problem is the tidal wave may already be onshore. We simply cannot solve this monumental problem without presidential action. It's not enough just to throw a few crumbs out there," he said.

But in response to Mr. Altman's criticism that change is occurring too slowly, the AMA's Dr. Bristow said limited reform could still be of value to certain segments of the population.

"The value of incrementalism is in the eye of the beholder. For some, a small step may be very important," he said.

Several panelists suggested that government-sponsored subsidies for the nation's poor and uninsured could partially cure the access problem.

But others said subsidies alone wouldn't be sufficient to clear up all of the system's problems.

"If the government could free up \$75 million to \$100 million each year, it could easily subsidize low-income workers and much of the access problem would be relieved," said CIGNA's Mr. O'Brien. "We have to develop a partnership between public and private sectors. A voucher plan might be a step in the right direction."

However, BC/BS' Mr. Tresnowski said he opposes subsidies "until the system is fixed. Not until the group health insurance market is managing risk instead of selecting risk will this be acceptable."

Dr. Bristow of the AMA agreed with this assessment. "Insurance unfortunately is no longer risk sharing, but risk avoidance."

And John Rother, director of legislation and public policy with the American Assn. for Retired Persons in Washington, D.C., said that while subsidies for low-income workers and retirees may be necessary, "they would hardly be an efficient means of improving the system."

Instead, Mr. Rother urged policymakers to bring the system under more central control. "The biggest problem with our health care system is that it's too fragmented. No one is accountable or in charge of organization."

Stanley Jones, a private consultant to insurers in Sheperdstown, W.Va., moderated the session. ■

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Automated underwriting

By LAURA MAZZUCA

Spurred by earlier successes and a current need to hold down expenses, several insurers are beginning to expand their automated underwriting programs to small commercial business from tried-and-true personal lines.

Using lessons learned in the automation of personal lines underwriting, insurance companies are adding small commercial lines policies like business owners packages, workers compensation, fidelity and crime, and other small commercial risks to automated underwriting programs.

And insurers that still use automated underwriting solely for personal lines risks report they are expanding the number of policies written with the systems.

Advantages of computer-assisted underwriting include faster transactions, less duplication of efforts, fewer papers to handle, and a lighter load for insurance company underwriters, allowing them to concentrate on more complex risks.

Proponents claim that the increased efficiency and faster service afforded by automated underwriting is a boon for insurers, producers and policyholders alike.

"The major benefit is it gives better service at a greatly reduced cost," said Phillip H. McCall, vp of marketing and sales development—small commercial business group for Philadelphia-based CIGNA Corp.'s property/casualty division. The division launched an interactive automated underwriting system for small business accounts last April.

Because the CIGNA system is interactive, the producer gets "virtually instantaneous" quotes or policy approval on applications, he said.

Without automation, by contrast, policy approval usually takes two to three weeks, Mr. McCall said. Previously, an agent had to collect data, submit it to an underwriter, wait for a reply and sometimes had to provide additional information needed by the underwriter, he explained.

The fact that the information "doesn't go through two or three different hands" not only speeds up the process, but also improves accuracy, Mr. McCall added.

Because automated underwriting programs are typically used for relatively simple coverages, like personal lines or small commercial policies, producers or underwriting support staff can collect and input the initial data about a new risk.

The underwriter is then free to devote more time to more complex coverages that are beyond the capabilities of the automated program. That saves underwriters time and effort, while saving insurers money, proponents say.

For example, Transamerica Insurance Co.'s automated claims underwriting system for personal auto and homeowners is now sav-

Computer programs take a 'byte' out of costs as they expand to small commercial business



ing the company the equivalent of four compensation packages for underwriting support specialists annually, said Jim Stallard, vp-personal insurance administration for the Woodland Hills, Calif.-based insurer. Transamerica put the program into effect in 1989.

But insurers stress that more complex coverages still require a human touch, especially for new risks.

"We feel it's a fit for the smaller companies, but you can't really use it for your IBMs or your General Motors," said Frank Summer, divisional vp of National Union Fire Insurance Co. of Pittsburgh, Pa. "You still really have to underwrite those."

The New York-based subsidiary of American International Group Inc. introduced an automated underwriting program for fidelity and crime coverages last year.

Some companies, like Zurich-American Insurance Group and The Home Insurance Co., do not use automated underwriting at all.

And others, like Transamerica and Kemper National Insurance Cos., currently rely on automation solely for personal lines underwriting.

Kemper began developing its automated underwriting system six

years ago, but only began using the system for personal auto and homeowners coverages in the last two years, said Peter T. Standbridge, executive vp-personal lines group for the Long Grove, Ill.-based insurer.

Right now, about half its business in these two lines is underwritten through the system and Kemper hopes to increase that level to 60% by year end, he said. "It's been a little disappointing" that more business is not underwritten by the automated system, "but it's a cultural change," Mr. Standbridge explained.

Kemper producers, whose offices are electronically linked with the insurer, enter basic policy information, which is then assigned a numerical value, he explained.

"Alarm signals" go off if the total number is too low to qualify for automatic underwriting, Mr. Standbridge said. For example, an automobile insurance application for a person who drives a high-performance sports car or who has been convicted of driving while intoxicated would have to be personally reviewed by underwriters.

If the point total meets Kemper standards, the policy is automatically issued and "it's never seen by a human being," he noted. And,

much of the traditional paper-shuffling and wasted time associated with policy submissions is eliminated.

Mr. Standbridge agrees that such "template underwriting" is difficult to apply to commercial coverages other than small business owners' policies.

Also, agents must be sure to submit complete information, or the system simply doesn't work, Mr. Standbridge said. Automation forces both agency and insurer to "get it right the first time," he added.

Like the Kemper system, Transamerica's computer-assisted underwriting program is also based on a point system, in which information about the risk is assigned numerical values, Mr. Stallard said. Risks that then fail to generate enough points are electronically referred to an underwriter for a personal decision, he noted. The system, which is used to underwrite personal auto and homeowners coverages, never automatically declines coverage, he added.

If the system rejects a risk because of incomplete information in a submission, a letter to the agent is automatically drafted and sent. The letter itemizes any problems,

such as a missing vehicle identification number on an auto policy, Mr. Stallard said.

Transamerica several years ago tried to upgrade its underwriting automation by using expert system technology—which uses so-called artificial intelligence—to replace its points system for new business underwriting.

Expert systems, also known as knowledge-based systems, apply knowledge gleaned from human experts to specific problems (IT, May 20, 1991).

Transamerica developed its Knowledge Based Management System in 1987 in a partnership between Waltham, Mass.-based software manufacturer AI Corp. and a coalition composed of Transamerica and five non-insurance companies, including a local power company and, at one point, the U.S. Army, Mr. Stallard said.

But the insurer's attempts to apply the expert system to underwriting new business met with limited success because of the company's inexperience with the new technology, he said.

However, in 1989 Transamerica began using the expert system for underwriters to review claims made on existing policies when a policy is up for renewal, with much greater success.

The system, programmed to make basic decisions that would normally be handled by an underwriting support person, works for reviewing claims because the data on an existing account is already in the system, he said. Transamerica now clears about 40% of the auto claims reviewed by underwriters through the automated system, freeing up staff for other work.

Transamerica last September expanded the program to its homeowners claims reviews. Now more than half of the insurer's homeowner claims reviewed by underwriters are handled by the system, he added.

And in commercial lines, Transamerica is now considering implementing a system to process small workers compensation risks and track rating guidelines, which vary by state, using the expert system technology, he said.

Insurers are also finding other lines of business to be a good match for automated underwriting.

National Union designed an automated underwriting system specifically for its small business fidelity and crime program in order to retain smaller accounts and improve efficiency, Mr. Summer pointed out.

"The whole intent of this system is to make it simple and quick to produce," he said. "There are thousands of small companies out there that need fidelity coverage, but brokers don't want to go through a big rigamarole to write them."

National Union first examined
Continued on next page

Automation

Continued from previous page which commercial classes of business had good loss histories and would be good prospects for the automated program, he said. These businesses include wholesale textile companies, printers and publishers, department stores and advertising agencies.

After identifying about 65 classes of business, National Union developed criteria that a risk had to meet to qualify for the automated underwriting program. Because small businesses were targeted, these criteria include: total assets of \$100 million or less; 1,000 or fewer employees, all located in the United States or Canada; and verification of no crime claims in the last three years.

If the client meets the criteria established by National Union, the producer enters information about the risk as well as the would-be client's desired fidelity limits directly into the system via modem.

Like other systems, if the risk garners enough "points," the underwriting system automatically

calculates the premium. Then, the system prints an indication letter, stating limits and deductibles.

After the broker approves this letter, the system issues a quote letter and standard policy.

Any policy data rejected by the system is electronically routed to an underwriter for personalized evaluation.

With more than 100 policies now active in the system, National Union is planning to provide brokers with a toll-free telephone number so they can submit policy information without a computer to an employee of the insurer who inputs the data directly into the system, saving more processing time.

CIGNA, too, has targeted small businesses for its automated "Independence" program for small business accounts, Mr. McCall said. Tested in late 1990 and launched in April 1991, the automated underwriting program is now active in 32 states, including California, New York and Pennsylvania.

The system is based on an automation program that allows the producer to access several computer screens, based on the class of

business. Each screen prompts the producer for additional information as he inputs data. CIGNA agents using the company's interface system enter the data on which underwriting decisions are based directly into the company's mainframe system via modem.

Starting with a general data screen, the agent or broker can call up specific business classes—like retailers, apartments, condominiums, funeral directors, general service businesses, restaurants and offices—to classify the risk, Mr. McCall said.

These "small businesses" are eligible for inclusion in the automated underwriting system based on property value and sales receipts, but Mr. McCall stressed that some of the policies are larger than traditional small business owners policies because some premiums are "in the six figures."

When issued, policies are laser printed at CIGNA's Colorado printing center and sent directly to agents, he added.

Agents have been "tremendously responsive" to the new system. There are now 102 agencies on line with the program, and agencies in

additional states are coming on line, he said.

For agents, "it's like opening up a whole new sales department," because the system enables them to handle a larger volume of business with a minimum of administration. In fact, some have even set up separate sales centers to mine potential clients for the automated coverages, said Mr. McCall.

CIGNA helps by providing producers with a team of research and testing personnel and a toll-free telephone number so agents can ask questions.

So far, the few problems CIGNA has encountered with the system arose from program incompatibility between the company's system and individual agency systems, and the occasional phone line discrepancies in modem hookups, Mr. McCall noted.

But overall, "we've very pleased with the way the program is working," Mr. McCall said.

The results so far for the "Independence" program are in the numbers: Overall written premium production in the six months ending Dec. 31, 1991, was 60% above the year-earlier period. New busi-

ness grew 70% during the same period, Mr. McCall pointed out.

By the end of 1992, Mr. McCall predicts that the automated Independence program will be active in 35 states, reaching 90% of its eligible customers. Currently, about 35% of the insurer's Independence program is automatically underwritten.

CIGNA is now considering increasing the program's eligibility criteria. For example, in the offices class, maximum property value limits for eligibility might be raised to \$30 million from \$15 million, he said. CIGNA may also add other classes of business to the automated underwriting system, he said.

Advances in technology will also make automated underwriting more attractive to insurers, predicted Mr. Stallard of Transamerica.

As insurers begin to use more image processing—entering electronic images directly into computer systems—companies will be able to use expert technology to direct workflow and cut down on paper volume, Mr. Stallard commented. ■

Outsourcing vendors take on computer chores

By MICHAEL BRADFORD

But surveyed information officers aren't convinced of savings

Insurers are asking for help in the effort to gain control over the rising demands and costs of computerization.

As a result, insurers are increasingly looking to vendors that offer "outsourcing" services as a way to keep pace with technological changes while holding down expenses.

Vendors claim that outsourcing can make insurers more competitive by freeing much of the money and time spent on automation and putting it to work in product development and marketing.

Definitions of outsourcing vary, but the process generally allows insurers to contract with other companies to take over chores like claims processing, billing and policy renewals.

An outsourcing vendor also may provide in-house systems and may assume responsibility for the operation of all or part of an insurer's information systems. There are a variety of off-site and on-site arrangements.

"Outsourcing is a wave of the future," said Ted Wolf, president of Wolf Advisory International Ltd. in Lancaster, Pa. "In the future, organizations will be managing networks of subcontractors rather than departments of employees."

"It's more than a fad," agreed Jim Nowicki, vice president of marketing in the commercial insurance division at Dallas-based Electronic Data Systems Corp.

Mr. Nowicki said the importance of outsourcing has grown as technology has become "the central nervous system of the company. Everybody is touched by it."

While outsourcing is touted by vendors as a smart move for insurers, some questions have been raised about its viability. One survey, for example, has indicated that some users are uncertain about how much the service will actually save over the course of long-term contracts.

Among the vendors that promote outsourcing, CIGNA Information Services Inc. says outsourcing services are helping insurers become more efficient.

A key to an insurer's success is a low expense ratio, said Curtis B. Downer, chief operating officer of the CIGNA Corp. unit. That makes outsourcing an ideal tool, particularly for personal lines insurers, because it brings expenses down, he added.

While CIS has plans to offer its outsourcing services to some commercial lines underwriters and accident and health insurers, Mr. Downer said the thrust began in personal lines because that business is "very transaction driven," involving lots of computer support.

Outsourcing offers insurers several ways to trim expenses while remaining competitive, according to Mr. Downer.

"If a company is just starting in the insurance business, rather than investing in computers and networks, you can rent the capacity you need and avoid the capital investment," he pointed out.

Outsourcing also lowers the risk of entering new or niche markets, Mr. Downer said, by providing a low-cost alternative to developing the computer know-how to service the business.

Without spending a lot of money, an insurer "can get in early and get out if that is the indicated action," he observed.

Likewise, if an insurer is leaving a market, giving the computer functions to an outsourcer can be advantageous, Mr. Downer noted.

"You can shed the infrastructure you previously had serving that business," he said. "As the volume goes down, you're not overburdened by the expenses you would have had with that business."

An outsource vendor also can provide data on losses "in an understandable form" that can allow the insurer to pinpoint and attempt to correct problem areas, Mr. Downer added.

Another insurance company subsidiary is offering services to life insurers. Those insurers are looking for efficiencies and a competitive edge by installing an "intelligent" system patented last year by Lincoln National Risk Management Inc., a Fort Wayne, Ind., unit

of Lincoln National Corp.

The knowledge-based Life Underwriting System is designed to streamline the underwriting and issuance of new business.

The workstation-based system is "designed so that it implements a particular company's underwriting philosophy," explained Dave Burgoon, sales manager at Lincoln National Risk Management. "It's designed to make decisions in routine cases and let the underwriter make decisions" in those that are



Outsourcing offers insurers several ways to trim expenses while remaining competitive, according to Curtis B. Downer of CIGNA.

deemed to need human decision-making skills, he said.

Even if an underwriter needs to participate, the submission is "worked up electronically as much as possible" before it reaches human eyes, Mr. Burgoon said.

The system helps make underwriting operations cost-effective by "improving staff efficiencies," Mr. Burgoon noted. "We haven't seen a lot of staff reductions," he added, but companies instead "are able to process more business with the same staffing levels."

Electronic Data Systems, recognized among outsourcing professionals as the "grandfather" of outsourcing, advises insurers to first consider what they want to accomplish and where they need help, then decide what outsourcing services are needed.

Mr. Nowicki pointed out that EDS, which has been serving the insurance industry since 1963, defines outsourcing broadly, with services ranging from short-term consulting contracts to arrangements that can last from five to 10 years and call for EDS to actually run part of a client's business.

"You try not to start from a systems perspective and make it fit a particular situation," Mr. Nowicki

said.

For example, EDS provides services from basics such as consultations with insurers regarding their automation concerns to full-blown support like the "process management system" that is in place to handle a flood insurance program for Omaha Property & Casualty Insurance Co.

A process management system is one in which EDS takes on its heaviest outsourcing chores, sometimes assuming part of the customer's business operation. Often, it provides a way for insurers to enter niche markets without taking on the technological burdens, according to Mr. Nowicki.

Mr. Wolf of Wolf Advisory Services said his firm also takes the approach of helping companies work out their needs before making technological or personnel changes.

Wolf Advisory Services provides insurers and other companies with data processing technical support. "We sell no products, only services," Mr. Wolf explained.

His company's aim is to "implement a total quality environment," Mr. Wolf said, by providing highly qualified and efficient services like data processing help that some insurers need.

For example, an insurer can contract with Wolf Advisory Services to take over its data processing department and train its programming and computer operation staff.

Wolf Advisory Services may put some or all of a client's staffers on its payroll or provide its own personnel when taking over a data processing job. Mr. Wolf pointed out that the client sometimes uses talent that is freed up by the change to beef up other areas.

Even with the efficiencies indicated by vendors, not everyone is convinced that outsourcing makes sense.

In fact, some insurers and other companies are uncomfortable with their outsourcing decisions, according to Ray Manganelli, president of Gateway Information Services Inc., a New York management consulting subsidiary of

Swiss Reinsurance Co.

In an early 1992 survey of senior information officers at insurance companies, banks, manufacturers and other companies, Gateway found that respondents were beginning to question the true savings that outsourcing would provide.

The problem, Mr. Manganelli explained, is that while information officers can comfortably predict their costs related to technology for a maximum of three years, vendors are requiring average outsourcing contracts that range from 8.8 years to 9.3 years, according to the survey.

The survey, which drew 250 responses, was prompted because "people were making long-term outsourcing decisions but appeared uncomfortable in those decisions," Mr. Manganelli noted.

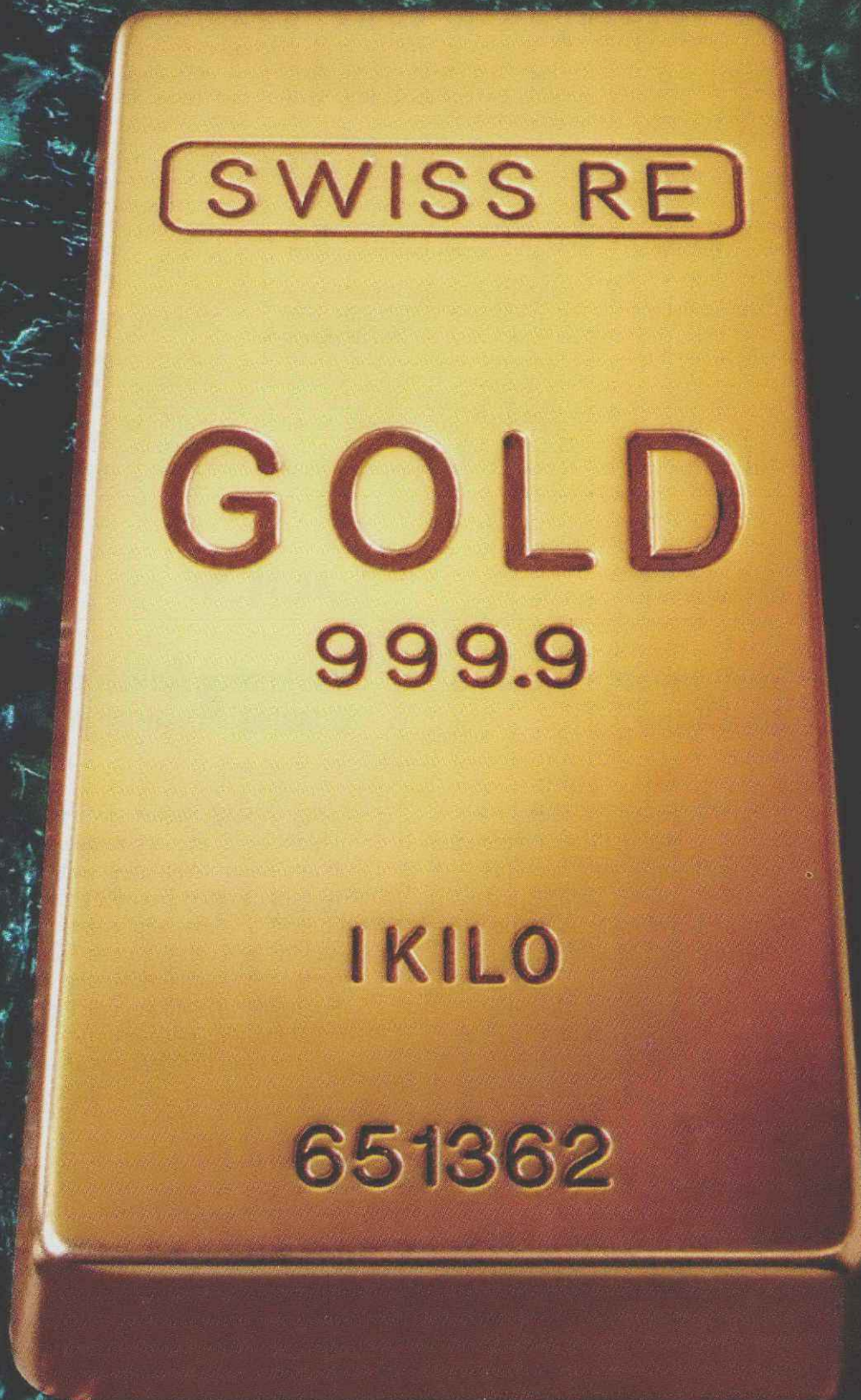
Predicting long-term costs in a field as rapidly changing as technology is extremely difficult, he said. "How can you possibly understand the economics of these deals? If you can't understand the economics, entering into a fixed-cost deal can be disastrous."

The lure of outsourcing for a company is an early drop in the cost of operating its automated systems, said Mr. Manganelli.

In the early years of the contract, the low price looks good, but vendors make up for their generosity with a stream of fees over the later years, he said. And at the same time, technology costs historically fall, Mr. Manganelli suggested.

"Who believes that in 2001 they will be running the same type of business, will be in the same products?" he asked. As businesses change, so do their technological requirements, which could render the contracted services obsolete, Mr. Manganelli added.

He said companies that feel comfortable projecting technology costs for three years should ask for a contract that covers that time period. Mr. Manganelli urged insurers and others to take a long look at outsourcing contracts and consider how they can improve their operations internally before handing over the operation for several years at a fixed cost. ■



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Spreading the gospel on insurance issues

Ex-preacher uses agency experience to defend small business in the House

By LAURA MAZZUCA

INDIANAPOLIS—As a young Protestant preacher in southern Ohio and Indiana, Dan Burton learned through experience the best way to preach the Word of the Lord.

Later, as an independent insurance agent, he discovered "the beauty of the free enterprise system" and brought the same zeal to pitching policies and running his own agency.

Today, that energy is put to work in a slightly larger arena: the U.S. House of Representatives.

"When you look in the Bible, they talk about not hiding your light under a basket," says the five-term Republican from his office in his hometown of Indianapolis. "If I see something wrong, I try to point it out and make it right."

And Dan Burton sees plenty wrong in government today. In more than 10 years as head of his own insurance agency, he learned

firsthand the plight of the small-business owner struggling with government red tape.

"The federal government is literally strangling the free enterprise system," Rep. Burton said. Regulations on workplace safety, employee benefits and other areas are killing the small-business owner, he said.

While legislation like the recently enacted Americans with Disabilities Act—as well as parental leave and clean-air bills—seems like a good idea, it ultimately costs the taxpayer dearly, he said. "We go overboard with regulations and demands on business."

He's not afraid to speak his mind

on other issues, either. When Soviet leader Mikhail Gorbachev addressed Congress in 1987, the outspoken ex-preacher said it was "analogous to having Adolf Hitler come before the British Parliament." Rep. Burton warned against cutting military budgets during the Cold War, vehemently opposes abortion and supports the death penalty.

Fighting banks' interests

And he's equally committed to proselytizing the word of the insurance industry on Capitol Hill.

An ultimately unsuccessful push for a banking reform bill last year gave him a chance to do just that.

Several proposed bills in the House and Senate would have taken away some of the exemptions from antitrust law that insurers now enjoy under the McCarran-Ferguson Act and would have broadened the authority of banks to sell insurance.

This did not sit well with Rep. Burton, to put it mildly. He says he "fought that hammer and tongs," because as an agent, he had seen firsthand how some mortgage lenders could pressure insurance customers.

When banking interests argue that safeguards exist to prevent conflicts of interest, Rep. Burton gets personal. He recounts how he lost several clients in the 1970s when the banks they applied to for loans hinted that the loans would be easier to secure if the clients transferred their insurance coverage to the bank.

"I go to the floor and tell them what happens, give specific cases that happened to me," Rep. Burton said. "I try to inform congressmen of the problems raised by such legislation."

As chairman of a caucus of members with insurance backgrounds, he is tapped by Congress for his expertise during debates on insurance-related bills. The caucus also stays close to proposed legislation and other insurance-related issues by working with trade associations.

Insurance industry lobbyists do a good job of educating members in how the business really works, he said. But because many in Congress don't understand the esoteric business of insurance, the atmosphere on the Hill is "mixed" on insurance issues, he said.

Although he retains his broker's license, House ethics rules prevent Rep. Burton from having any direct dealing with the insurance agency he established in Indianapolis in 1968. His wife, Barbara, still runs the bond division of Agency Burton Agency; another local agency handles the casualty and life insurance business for a commission split.

Rep. Burton is not the only erstwhile agent in the halls of Congress. There's also Sen. Jake Garn, R-Utah, the ranking Republican on the Senate Banking, Housing and Urban Affairs Committee. In the House, former agents include Rep. John Tanner, D-Tenn.; Rep. Gerald Solomon, R-N.Y., the ranking Republican on the House Rules Committee; and freshman Rep. Bill Barrett, R-Neb.

It is Rep. Burton's outspokenness that has given him a relatively high profile in Congress.

From his seat on the very visible House Foreign Affairs Committee, he has championed—with varying degrees of success—issues dear to the hearts of those on the right. For years, he backed aid to the Contra rebels in Nicaragua, opposed sanctions against South Africa and urged active opposition to Soviet expansion.

He's also known for his golfing prowess, having taken a few congressional championships from Rep. Marty Russo, D-Illinois, the Democrats' best.

And he's a crowd pleaser at home in suburban Indianapolis. His district, the sixth, is so Republican that Rep. Burton has been re-elected three times with comfortable margins of victory—63% to 37% in 1990.

Continued on next page

MAY

Reinsurance Issues; Relations with Intermediaries

What do insurers want from their intermediaries? Are the ties that bind becoming tighter, or are accounts being shifted rapidly in the face of rising catastrophe reinsurance rates? *BI's Insurer Topics* section will look at ceding companies ... what services are they seeking, or are they turning their backs on intermediaries and

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* An Audience Profile of the *Business Insurance* 'Insurance & Reinsurance Company' Subscriber, 1990.

Insurer Topics

Continued from previous page

In both insurance and politics, Rep. Burton worked his way up from the bottom.

While in high school, he landed a job as a file clerk at State Automobile Mutual Insurance Co. in Indianapolis. After a year at Indiana University, then working as a preacher and serving a year in the Army, Rep. Burton worked at Continental Casualty Co. in Cincinnati as an underwriter.

He later worked as a special agent for Phoenix Mutual Life Insurance Co. and in the same capacity for New Amsterdam Insurance Co. in Indianapolis.

Rep. Burton went on to work four years as a junior partner with Cleveland Smith Agency in Indianapolis before leaving to start his own agency in 1968.

For years, his dual careers in insurance and politics overlapped.

In the early days of his agency, his wife, Barbara, worked days as a secretary, then at night did the agency billing and paperwork that Rep. Burton's political schedule as an Indiana legislator didn't allow him the time to handle. She later obtained her agent's license and worked full time for the agency.

Political training ground

"A hearty, bluff backslapper, he made his way up selling insurance," The Almanac of American Politics has written of Rep. Burton. In fact, those years spent selling insurance and real estate were the perfect training ground for politics, he said.

"I had to go out and sell individual policies," Rep. Burton recalled. "The more I worked, the more I sold. So the insurance business as an agent is the perfect example of how the free enterprise system works."

For Rep. Burton, as for many others of his political stripe, 1964 proved a watershed year.

That was the year he saw Norman Thomas, former head of the American Socialist Party, interviewed on television. Americans would never accept socialism from the Socialist Party, but they would support the same ideologies under the guise of liberalism, said Mr. Thomas, who went on to predict a "socialist victory" by 1970.

"I was an independent thinker at the time," recalls Rep. Burton, "and I thought, my gosh, if that guy's right, I don't want anything to do with it."

After poring over the Congressional Record at his local library, he became convinced that the United States was, in fact, headed toward a social-welfare state. "I became concerned with government intrusion in the private sector," especially on issues like taxes, insurance regulation and other government mandates, he said. "I wanted to get involved to change things."

Thus galvanized, he joined the Young Republicans and worked to support Barry Goldwater's presidential campaign in 1964. Two years later, he was running his own campaign for state legislator.

He ran for the Indiana House of Representatives and won, serving from 1967-1968. He then served in the Indiana Senate from 1969-1970. In both 1970 and 1972, he unsuccessfully sought the U.S. House seat he now holds.

Rep. Burton finally won a U.S. House seat on his third try in 1982, and was re-elected to three consecutive terms.

It's been an eventful 10 years. During that time, the Berlin Wall fell and the Soviet Union, Ronald Reagan's one-time "Evil Empire,"

crumbled into a collection of states struggling for democracy.

Rep. Burton feels he played a small part in such world events. "Those of us who were outspoken on the floor played a role, too," he said. "You don't win battles by being a wallflower."

Some of his positions have provoked charges of extremism. Rep. Burton, for instance, is on record as supporting mandatory, universal AIDS testing.

Even his opponents, however, give him high marks for integrity. He's never taken a position that he didn't personally believe in, said Rep. Andrew Jacobs Jr., the Democrat whose district abuts the sixth. "When he says something, he really means it."

Their relationship got off to an inauspicious start: Rep. Jacobs de-

feated Rep. Burton in the 1970 race. But today they're friends, "even though his place on the spectrum is a little different from mine," Rep. Jacobs said. "We're the kind of friends who can disagree very strongly on things, but go the other way by kidding each other about it."

Rep. Burton faces re-election this year, and although the strong Republican alliances in his district seem to indicate that he's a shoo-in, he's still gearing up for a hard race. "In politics, you never take anything for granted," he said.

If by some fluke he does lose his seat, Rep. Burton will probably go back to being an insurance agent. But he'll continue to stay active in government, "because I feel so strongly that government is out of control." ■



Rep. Dan Burton, R-Ind., says he entered politics because he 'became concerned with governmental intrusion in the private sector.'

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One of Murphy's followers decides to reject his law

There'll always be insurance, enthuses Home's Meenaghan

By CHRISTINE WOOLSEY

SAN FRANCISCO—While the lingering recession and the soft property/casualty insurance market are keeping the corners of most insurance executives' mouths turned down, there are a few optimists in the crowd.

One is James J. Meenaghan, chairman, president and chief executive officer of The Home Insurance Co. in New York, who says that despite being Irish—and therefore a true believer in Murphy's Law—he is optimistic that things will improve.

But, optimism alone is not enough, he said, adding that successful insurers in the 1990s will have at least four things going for them: a strong balance sheet, a well-defined marketplace focus, quality people and internal cost controls.

"Surprising as it may seem, I am optimistic," Mr. Meenaghan said last month at a conference sponsored by Russell Miller Inc. in San Francisco.

"This country has been in recessions far deeper than the one we're in now—and has fully recovered." In fact, economists say that the worst of the recession already is behind us, he said.

Also, Mr. Meenaghan said, "I'm optimistic because there will always be a need for what we sell—insurance and other risk-sharing mechanisms. Individuals and businesses will always want and need

to avoid, or at least to spread, risk."

And, he said, "I'm optimistic because I know rates are going to increase. I don't know when...but it is going to happen."

When the market does turn, however, it won't be characterized by the "same kind of sharp, dramatic price increases we saw at the end of the last cycle," Mr. Meenaghan said. As a result, "a price correction, when it does occur, will not solve the current problems of every company or every producer."

"I believe the days of industry-wide solutions to individual company problems are over, gone, a thing of the past. From here on—in fact, it is happening already—every man for himself and every company for itself. Period."

Mr. Meenaghan pointed out that "in a competitive world, there are going to be winners as well as losers," noting that many of the winners become winners by exploiting the problems of the losers. "Like it or not, this is a fundamental fact of life—in business and everywhere else," he said.

To be among the "winners" in the next decade, companies must establish economic staying power, Mr. Meenaghan suggested.

"Today financial strength, and just as importantly the perception of financial strength, is critical. I cannot foresee any circumstances during the next five years (in which) financial strength and financial issues—like quality of assets, A.M. Best Co. and Standard & Poor's Corp. ratings, leverage

and adequacy of loss reserves—will be any less important than they are today," he said.

A successful company must also have a well-defined market focus, Mr. Meenaghan said. "Unlike the situation five years ago, today many companies and producers recognize they can no longer be all things to all people." Today, companies must increasingly focus on specific market segments where they have special skills or can bring added value.

Everyone says he or she is "looking for market niches and everyone claims to be a specialist," Mr. Meenaghan noted. But, "let's not kid each other; just saying your company has market focus doesn't make it so."

A truly specialized company is one that has invested significantly over time in people, technology and its producers and has well-developed technical skill in its underwriting staff and in its claims, loss control and marketing functions, he explained.

Like specialization, "globalization" is another concept that often carries little weight at some companies, Mr. Meenaghan said. "Merely saying you have a multinational capability doesn't make it so. There are companies today that think they have international or global ability and you and I both know the only thing they really have is a guy in New York named Pierre, who speaks with a heavy French accent."

But globalization is imperative, he said. "Market forces will in-

Focus was on redefinition

SAN FRANCISCO—"The Insurance Industry Redefining Itself" was the theme of the fourth annual Russell Miller Inc. National Insurance Symposium Leadership Conference, held March 1-3.



A record crowd of about 160 heard speeches by the heads of major property/casualty, life/health and surplus lines insurance companies.

Speakers at the conference included one insurer executive who offered an optimistic view of the property/casualty industry's future; several life/health insurance executives discussing ways to boost the weakened life/health industry; and a panel of surplus lines insurer executives who said the continuing soft market does not necessarily spell doom and gloom for the surplus lines industry.

Russell Miller Inc. is a specialty investment banking and consulting firm with a focus on insurance industry clients. The firm will host its fifth annual symposium next April in San Francisco.

For more information, contact Alice Berreyesa, Director of Marketing, Russell Miller Inc., 300 Montgomery St., San Francisco, Calif. 94104; 415-956-7474.

—By Christine Woolsey

creasingly promote the sale of multi-country insurance products and services to insureds with locations in more than one country. If I were a producer and I had an insured with locations in several countries, I would certainly begin to think about which of my insurance companies has true multinational capability," he said.

The third ingredient for success is a "tough approach to internal costs," Mr. Meenaghan said. "In the competitive world of the '90s, the game will be a game of margins," he explained.

And, he noted, a company's internal costs also should be important to its producers. "If a company doesn't have its costs under control, it won't be able to price competitively, and over the long term, a producer won't be competitive if his companies are not competitive."

The fourth ingredient for success is people. The best insurers in the

1990s will be those with the best trained, best paid and most highly motivated people, he noted. And, those employees should not be disproportionately placed in headquarters locations, but instead should be in each office across the country, Mr. Meenaghan stressed.

"There is no great secret to having superior people," he said. "You hire the brighter people, you pay them more than your competitors, you train them in a technical way on a continuing basis, you bonus them if they beat specific business objectives, you truly reward those that make money for you and you dismiss those that can't or won't perform at a superior level."

One more vital ingredient—perhaps more important than the others—is leadership, Mr. Meenaghan noted. "A firm can have the money, the focus, the people and the tight control on costs, but it is going nowhere unless it has leadership at the top." ■

Groggy from the 1980s, life insurers need checkup

By CHRISTINE WOOLSEY

SAN FRANCISCO—It may be time for the life insurance industry to get a checkup, as life insurers' financial health comes under increasing scrutiny.

Solvency pains now being felt by the life insurance industry are akin to a "hangover that resulted from 1980s' bingeing on risky investments," says Lowndes A. Smith, president and chief operating officer of Hartford Life Insurance Co. in Simsbury, Conn.

"The 1980s was an aggressive time," Mr. Smith said. "There was a move from traditional life insurance products to universal life. Profit margins were lower than expected, and companies had thinner capital bases. The industry went on an investment binge—moving into real estate, risky securities and junk bonds."

As a result of this binge, many life insurers are now suffering rating downgrades and takeovers, Mr. Smith said during a panel discussion at the Russell Miller Inc. National Insurance Symposium Leadership Conference last month.

"Right now there are 100,000 policyholders whose life insurance is in danger somehow," he warned.

This situation does not do much to improve the industry's image with consumers, he noted.

Consumers "are frightened, and they are moving their business to

the top companies," he said. "These customers are more challenging to us. It's more difficult to sell products to them."

Regulators, too, are responding to life insurers' problems, Mr. Smith observed, by pressing for solvency guarantees and other regulations.

"Nonetheless, I think we have to stop apologizing to policyholders, the media and rating agencies," Mr. Smith said. "For the most part, the industry is in good shape."

The industry probably will never regain the level of customer trust it once enjoyed, he said. But, by being more proactive, some of that trust can be regained.

"We need to improve ratings and display more honesty to customers if we are to regain their confidence," Mr. Smith. "And, we need to manage our growth and be careful about what we do. We have to be pragmatic instead of expounding on the history of our companies."

"Life insurers that did properly invest during the 1980s and that have pristine balance sheets now have the freedom to develop and expand and get the prices they want. Companies that were conservative in the past now have the opportunity to grow."

"Frankly, we were uncompetitive years ago because of our conservatism," Mr. Smith said, referring to Hartford Life. But now the company is ready to expand. "We

took over Mutual Benefit's corporate life book of business and also took over a small book of group business from Lincoln National," he said.

Mutual Benefit Life Insurance Co. was placed in rehabilitation last year (BI, July 22, 1991). Lincoln National Corp. sold most of its group life and health operations earlier this year (BI, Jan. 13).

And Hartford may buy additional books of business, he said.

Life insurers also can guarantee growth by increasing their investment in the group health segment, said Graham B. Blanton, president of Mid-South Insurance Co. in Fayetteville, N.C.

The small group life/health insurer wants to increase its involvement in health insurance reform efforts, because the health issue is at the forefront of the 1992 election campaign, and life insurers should have a voice in health reform discussions, he said.

Mid-South was involved in getting the Small Employer Group Health Coverage Reform Act passed in North Carolina, Mr. Blanton said. The measure bars insurers from denying coverage to small employers—those with three to 25 employees—because of pre-existing medical conditions or because of the employer's industry, among other things.

Insurers must comply with the guaranteed access provisions by Aug. 14; other provisions became effective Jan. 1.



Giving their prognoses for an ailing industry were, from left to right: Graham B. Blanton, William E. Sagan, and Lowndes A. Smith.

"We have been proactive in reforming the small-group market," Mr. Blanton said. But, he noted, "we must do more to communicate our involvement in small-group reform to our customers."

Insurance companies that will succeed in the group health market for companies with fewer than 100 lives will have several common characteristics, Mr. Blanton said. Those characteristics are:

- Standardized plans and underwriting guidelines.
- Expert knowledge of the local market and its providers.
- Separate managed care operations.
- Elaborate, but standardized, administration systems.
- Specialized packages to assist small employers that are not set up

to handle extensive administrative tasks.

Concentrated marketing. In addition, to succeed within the managed care market for small employers, Mr. Blanton said insurers must have: professionally staffed utilization review panels, quality case management services performed on a local level, a carefully chosen preferred hospital network, a transplant network and preferred provider arrangements with doctors and other health care practitioners.

William E. Sagan, chairman, president and CEO of Employee Benefit Plans Inc. in Minneapolis, also participated in the panel.

Mark S. Lefenfeld, managing director at Russell Miller, moderated the session. ■

Pressure hits surplus lines

Hungry admitted market vies for share of alternative market

By CHRISTINE WOOLSEY

SAN FRANCISCO—The void created when the admitted market refuses to write difficult coverages is a boon for surplus lines insurers.

Unfortunately for surplus lines insurers, that void has ceased to exist as the soft market continues to whet admitted insurers' appetites for just about any risk.

That doesn't necessarily spell disaster for surplus lines insurers, though, say three surplus lines executives.

"There's no question" that the surplus lines market "is here to stay, because it provides stability and predictability in volatile market conditions," said Michael J. Snead, chairman of Admiral Insurance Co., a W.R. Berkley Corp. unit in Cherry Hill, N.J.

However, Mr. Snead added, "this intense competitive environment will demand that companies and producers improve their efficiency."

Mr. Snead participated in a panel discussion titled "The Other Markets: Permanent or Fleeting?" during a recent conference sponsored by Russell Miller Inc. in San Francisco.

"The present mood in the excess and surplus field is gloomy, and... as an E&S professional, I believe the situation can get worse," Mr. Snead said.

"With the standard markets offering producer incentives and higher commission in an effort to maintain market share, it should come as no surprise that large blocks of premium are leaving the wholesale/surplus lines marketplace," he said. That outflow of business will continue "as long as prices are cheap, capacity abundant and investment income manages to balance the underwriting losses and facilitate sufficient return on equity."

Others agree that the non-admitted market is hurting: "The surplus lines insurance market is suffering as more standard insurers move in and offer lower deductibles for the same coverage," said John M. Griffin, chairman, president and chief executive officer of The London Agency Inc., a Crum & Forster Inc. underwriting management unit in Atlanta.

Both Messrs. Snead and Griffin predicted that the soft market will continue.

"It is evident that the soft side of the insurance cycle is getting longer and the hard side of the cycle is becoming shorter," Mr. Snead explained. And it is possible that the current market conditions will endure, he said.

If this trend continues, my company and others will have no choice but to substantially change their method of operation," he said.

Mr. Griffin agreed, advising surplus lines insurers and brokers to improve their operations.

Surplus lines companies need to become much more responsive to customer needs, Mr. Griffin said. "We have to be the first, fast and best: the first to respond to coverage gaps faster than any other company and in the best way.

"After the hard market, there were many new competitors to deal with in the surplus lines market-

place. We write about \$300 million in premium volume, but that volume is eroding because of increased competition."

To combat that erosion, The London Agency is committing itself to quality, according to Mr. Griffin. "Just like in the manufacturing process, we want to improve our operations with an emphasis on quality," he said.

In its attempt to improve quality, The London Agency will follow a process that includes identifying policyholder needs; enhancing product flexibility "because not every customer needs the

same products"; and responding quickly and before any other company, because "if we do that we'll get the sale," said Mr. Griffin.

The advent of the fax machine has been a blessing to many businesses, including insurers, because it speeds up the transfer of information. However, Mr. Griffin acknowledged, "getting the fax through the first 3,500 miles is easy; it's the last 20 feet that are important, and we are going to try to focus on that."

In addition, Mr. Griffin said his company will try to respond more positively to submissions. "We

need to learn how to write them, not avoid them," he said. And, he wants his agency to become more accessible to buyers—in some cases encouraging risk managers to visit the agency's office.

Mr. Griffin also wants to hire the best talent available. "We want to have confidence in all our underwriters," he said. And, those underwriters must be motivated, because "customers like underwriters who want to make money and have good results."

The London Agency also will dedicate itself to competitive pricing. "We want to price our products so that they sell; they don't always have to be on the low end, and they don't always have to be on the high end."

The wholesaler introduced its quality message to its employees

on Jan. 9, Mr. Griffin said. "There is 100% dedication on our part to becoming a quality operation. We want to know, understand, meet and exceed customer needs. That is how we'll remain a permanent market," he said.

Wholesale brokers face the same challenges, noted Kieran P. Burke, president and chief executive officer of Tri-City Insurance Brokers Inc. in New York.

"The key for survival for the wholesale broker is to be able to market business in today's climate. Today is probably the 'normal' market. If it turns, fine, but you can't pay your bills on that 'if,'" Mr. Burke said.

Frederick E. Dopfel, executive vp and managing director of Russell Miller Inc., moderated the session.

MAY

Mergers/Acquisitions/Divestitures

Issue: May 4
Ad Closing: April 22

Reality: there are fewer agencies today than 5 years ago; smaller agencies had trouble surviving as larger competitors gobbled them up, and in the throes of a recession the numbers are dwindling still. *BI's Agent/Broker Topics* section will look at what small to medium-sized agencies can do to hang on... merge with similar sized agencies, buy books of business handled by smaller firms, groom themselves for acquisition by a bigger operation. Editors will examine how agencies can improve their financial management in a sluggish market.

JUNE

Legislative Issues; NAIB Report

Issue: June 1
Ad Closing: May 19

The role of lobbyists and political action committees takes on new importance during an election year. *BI's Agent/Broker Topics* section will look at the role insurance lobbyists and PACs will be playing in this year's campaign. Are legislators shunning insurance PAC money for fear of being branded as a tool of big business? In addition, editors will report on developments from the National Association of Insurance Brokers meeting in Pebble Beach, California.

JULY

Compensation & Incentives

Issue: July 6
Ad Closing: June 24

Can employee compensation at independent agencies continue to increase faster than revenues during the current recession and soft market? *BI's Agent/Broker Topics* section will focus on this critical issue, reporting on how agencies can attract and keep qualified personnel without going overboard on compensation. What perks and benefits are being offered as an alternative to big raises?

Agent/Broker Topics

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* An Audience Profile of the Business Insurance 'Agent/Broker' Subscriber, 1990.

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Continental program opens doors for women

Effort aimed at its best and brightest honored by women's advocacy group

By MARK A. HOFMANN

NEW YORK—A program designed to encourage the best and the brightest employees to climb the management ladder recently brought recognition to Continental Corp. for the initiative's impact on women, even though the program is gender-blind.

Continental received the annual Catalyst Award March 3 for its Advanced Development Program, which was begun in 1987 to cultivate talent from within its own ranks.

The award is made by Catalyst, a non-profit organization in New York that works with private industry to promote change for women.

Continental's program is neither specifically geared toward women nor filled by quota, pointed out Ann Pauker, an assistant vp-employee relations in Cranbury, N.J. Yet each year

more than half of the employees participating are women.

The program aims to create a cadre of management leaders from within Continental's ranks, an objective spelled out by John Mascotte, the insurer's chairman and chief executive officer, shortly after joining the company in the mid-1980s.

Both headquarters and branch office employees are eligible to participate in the Advanced Development Program.

Workers, who can be nominated or enroll on their own, undergo a rigorous screening process.

Their supervisors complete detailed questionnaires and the candidates themselves write several essays and a biographical resume.

Finally, interviews are held at Continental headquarters with employee development department personnel.

Finalists are selected after the interviews and are then interviewed by two of the corporation's top four officers, who make the final decision.

Ms. Pauker said that the size of each ADP class ranges from six to 12. About 40 people have participated or are participating in the program, which can last anywhere from three to seven years.

"Each person's career development program is very personal," she said. For example, someone who did not have any supervisory experience might take longer to complete the program than a colleague who did.

After a three-month stint in the home office, ADP participants take on a variety of one- to two-year assignments in a career area they choose.

These assignments are expected to give the candidate a

mix of staff and line experience, as well as home office and branch exposures. Employees will also have to move at least once.

The ADP candidates "take charge of their own careers," said Ms. Pauker. The program is very self-directed despite its reliance on three people—an advisor, program manager and supervisor—assigned to each candidate to provide coaching and help in the development of career plans for the participants.

Continental's program is neither specifically geared toward women nor filled by quota, pointed out Ann Pauker.



Other insurers also try to cultivate in-house talent. But Ms. Pauker said she believes Continental's program is "unique in the way it is executed." The program is aimed at developing the "whole person," rather than just managerial skills, she said.

Ms. Pauker also said that while most companies want to attract and keep qualified women man-

agers, many do nothing to groom them. "We actually follow through," she said.

Catalyst agreed. In announcing this year's awards, its president, Felice Schwartz, said: "As we enter our fourth decade of working to assimilate women at every level of management, we applaud the progress that has been achieved over the last 30 years, and we celebrate the promise of women's achievements in the future. The companies that we're honoring in our 30th anniversary year are all exceptional because they've recognized the immense talent and value that women can bring to business, and they've taken steps to ensure that women's talent is fully used."

Ms. Schwartz, who is well-known for a 1989 Harvard Business Review article on what came to be called the "mommy track," is author of "Breaking with Tradition: Women in Work, The New Facts of Life."

The other Catalyst awards went to American Airlines and Hewlett-Packard Co.

45 people are charged in New York arson scam

NEW YORK—The Manhattan District Attorney is charging 45 individuals—including a broker and insurance company claims adjusters—with conspiracy in an arson-for-profit ring that netted more than \$3 million in claims payments from numerous insurers.

An indictment, unsealed this month by District Attorney Robert M. Morgenthau, alleges the ring set more than 20 fires and submitted more than 100 fraudulent claims totaling more than \$12 million to more than 20 insurers.

The indictment alleges that Anthony Trapani, an independent insurance broker, and Michael Volpe, an adjuster for the New York Property Insurance Underwriters Assn., an insurer-sponsored high-risk pool, established a multilevel conspiracy ring. Marvin Barry, an insurance adjuster, also is charged for his alleged role in finding other adjusters to participate in the ring.

Ring members opened small leather goods shops in Manhat-

IT briefs

tan and set minor fires in the shops, according to the indictment. Inflated property claims then were approved by adjusters participating in the scheme, the indictment says.

The scheme hit the high-risk pool the hardest. The pool made about 59 damage settlements related to the scheme, according to the indictment. A spokesman said the pool had not seen the indictment and could not estimate its payments.

One participant in the investigation was the National Insurance Crime Bureau of Palos Hills, Ill. The non-profit group, designed to combat crime and vehicle theft, is funded by property/casualty insurance companies.

New Alliance chief

NEWARK, N.J.—Stephen R. Braswell, president of Prudential

Property & Casualty Insurance Co., was elected chairman of the Alliance of American Insurers at the trade group's annual meeting last month. He succeeds W. Craig Heston, chairman and chief executive officer of the Utica National Insurance Group.

Mr. Braswell had been chairman-elect and was previously a director of the Schaumburg, Ill.-based trade group.

F. David Rolwing, president of Montgomery Mutual Insurance Co. in Sandy Spring, Md., was elected chairman-elect at the meeting.

SAFECO settlements

ST. LOUIS—A regional office of SAFECO Insurance Co. sponsored its first "Carrier Settlement Day" last month.

Nine other companies joined in the event to settle a total of 90 files, amounting to an estimated \$60,000.

The day was designed "to allow insurance companies to resolve subrogation claims more quickly, thus saving time and money and getting deductibles returned to their policyholders," said Clifford Duever, a SAFECO regional vp.

SAFECO, which is based in Seattle, plans to hold another settlement day this fall.

Fireman's Fund gripes

SCOTTSDALE, Ariz.—Independent insurance agents had a chance to air their concerns to officials of Fireman's Fund Insurance Co. during a recent three-day "President's Circle" conference here.

The issues discussed included pricing, marketing, agency compensation, field office communication, automation and underwriting issues.

The Allianz A.G. Holding unit will "use the feedback to become more responsive to producers and insureds," said Herbert Hansmeyer, chairman, president and chief executive officer. This

meeting strengthens our partnership with agents, which is especially crucial in the current soft market."

An "Issues and Answers" publication based on the meeting will be distributed later this year to all of the insurer's agents.

Travelers wins award

HARTFORD, Conn.—Travelers Corp.'s CARENET computer system received a first-place Management Information Systems Summit Award for Information Technology Excellence. The CARENET system won in the Overall Systems Design and Implementation category.

The Summit Award, introduced this year, is sponsored by the Waltham, Mass.-based National Managed Health Care Congress. The award, which will be presented annually, is also given in two other categories—technological innovation and clinical applications. It is the only one of its kind in the managed care industry.

CARENET's functions include provider contracting, sales support, billing, enrollment processing and printing identification cards for employees and dependents. The system also holds a data base of more than 50,000 providers.

—By Mark Hofmann

Advertiser

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Liberty Mutual

Continued from page 2
Chemstar's attorney.

Judge Hupp observed in his order that Liberty Mutual had canceled the policy in December 1986, when Genstar was acquired by Chemstar, "but, of course, still owed the obligations to defend claims of damage resulting from occurrences taking place before the sale."

Liberty Mutual "began handling the claims in July 1986 and continued to do so until October 1989, when it abruptly withdrew the defense of all claims on the supposed ground that Chemstar was not its insured," according to court documents.

"After defending the claims for three years without a reservation of rights, Liberty, without notice to Chemstar, abandoned the defense of the claims, taking the position that Chemstar is not an insured.

"The conclusion that Chemstar was not an insured is inexplicable, even astounding, since

Chemstar is the same corporate entity as Genstar Lime Co., which Liberty admits is an insured," Judge Hupp wrote in the order.

Liberty Mutual had estimated that it would cost \$500,000 per home to remove the damaged plaster, or a total of \$14 million, said Mr. Oster, Chemstar's attorney.

While Liberty Mutual defended and paid some claims, "when the magnitude of the loss became clear, Liberty Mutual looked for ways to get out of it," he charged.

"To find in Liberty's motion (to dismiss) the line that Chemstar is not an insured stirs the blood," Judge Hupp wrote in the order.

"The punitive damage finding is supported by evidence of oppression and malice as it is defined under California law (reck-

'To find in Liberty's motion (to dismiss) the line that Chemstar is not an insured stirs the blood,' says Judge Hupp. 'The factors in the case were as egregious as the court has ever seen in an insurance bad faith case in 20 years as a judge.'

less disregard of the rights of others)," according to Judge Hupp.

"The factors in the case were as egregious as the court has ever seen in an insurance bad faith case in 20 years as a judge," he added.

Following the judge's dismissal of Liberty Mutual's motions, the insurance company announced that it intends to appeal the award.

"Liberty Mutual does not agree with a number of rulings

made by the court in this case, which focuses on a series of complex corporate transactions involving the plaintiff," the insurance company said in a statement.

Liberty Mutual said it will appeal the compensatory and punitive awards. The insurer also intends to appeal how the court divided the issues to be decided at trial.

While the court has already ruled on the allegations that Liberty Mutual breached its duty to

defend and the covenant of good faith and fair dealing, a trial to determine whether coverage actually exists for the plaster damage claims will not be held until later this year.

Liberty Mutual declined to comment further.

However, in his order, Judge Hupp went on to say, "Liberty claims that the court committed error when it excluded evidence of policy limits, retrospective premiums and excess coverage. None of these were relevant to the duty to defend, and pursuing them would have taken time out of all proportion to any tangential relevancy to the case being tried."

Chemstar Inc. vs. Liberty Mutual Insurance Co., et al, U.S. District Court for the Central District of California, March 16, 1992; No. 90-2904.

Health care conference addresses reform issues

NEW YORK—A conference on the nation's health insurance system and reform issues sponsored by the New York Business Group on Health attracted 188 registrants.

The first-time conference, held here March 25-26, featured 40 speakers and moderators representing all facets of the health insurance industry.

Topics covered during the conference's concurrent sessions included forming a consensus for health care reform, health insurance fraud, technological advancements in health care claims processing, health care rationing and the debate over quality, among other things.

"The conference was very successful in terms of quality, interest and the responses it created. It was only a first step in developing a dialogue for reform," said Dr. Leon Warshaw, director of the NYBGH. "We avoided discussing specific proposals, but tried to crystallize issues that must be addressed for reform to be possible."

NYBGH is currently publishing a journalistic account of the two-day conference that is expected to be available to the public by summer. Although no price has been set, information about the account can be obtained by contacting Dr. Warshaw at the NYBGH, 622 Third Ave., 34th Floor, New York, N.Y. 10017-6763; 212-808-0550.

Co-sponsors of the conference included U.S. Healthcare Inc.; Travelers Corp.; The Robert Wood Johnson Foundation; Prudential Insurance Co. of America; TPF&C, a unit of Towers, Perrin, Forster & Crosby Inc.; Health Insurance Plan of Greater New York; Marion Merrell Dow Inc.; Guardian Life Insurance Co. of America; CIGNA Corp.; and Aetna Life & Casualty Co.

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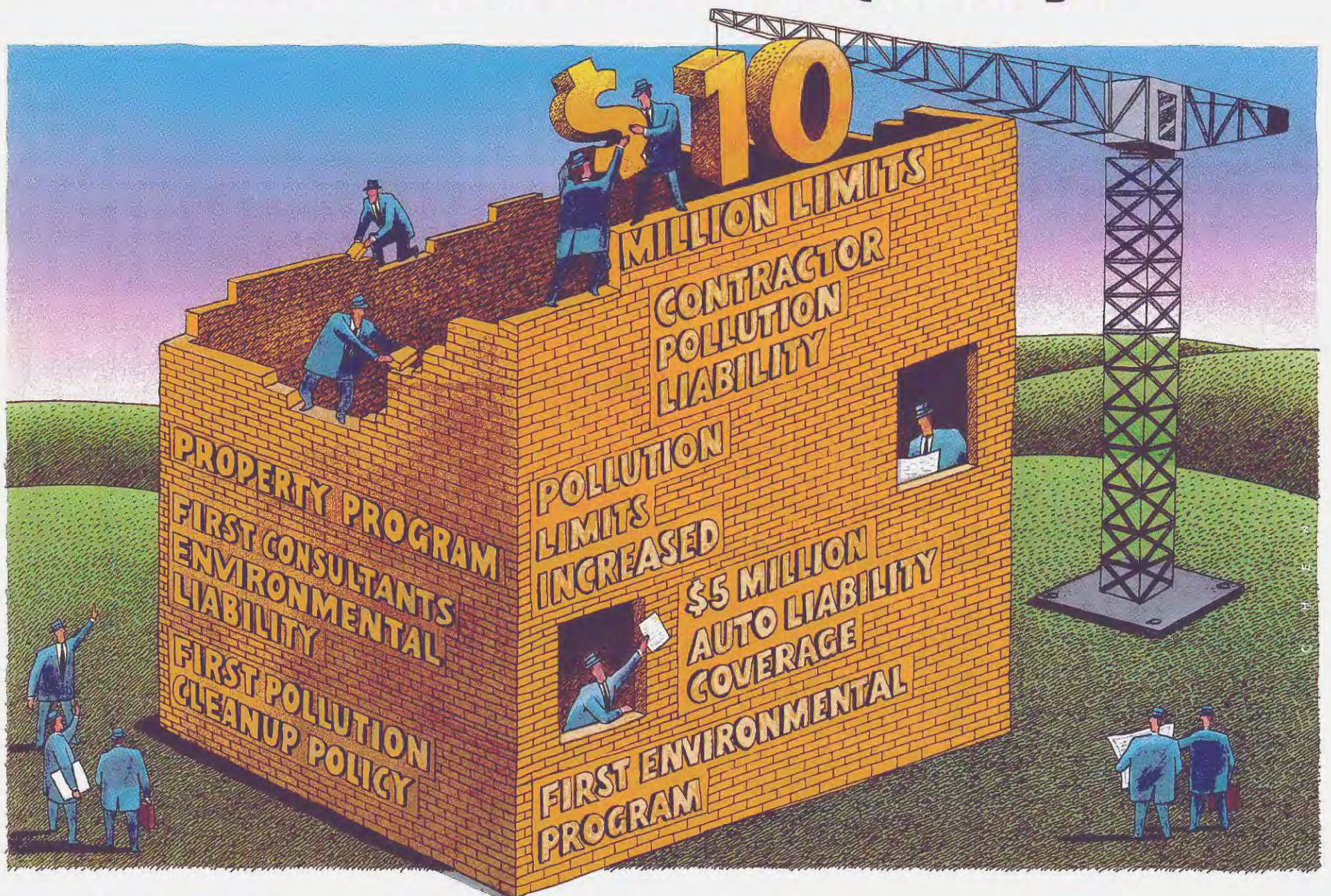
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Shopping for health care

If employees are payers, doctors will charge reasonable rates

By Ron Jones

HOW CAN HEALTH PLAN sponsors get overpriced doctors to accept reasonable and customary charges?

Don't pay them anything. Instead, pay the plan member.

Without recognition of assignment and direct payment by health care plans, most overpriced doctors cannot survive. It is too difficult for doctors to get their money when large payments are made to the employee. When paid directly, employees often use the money for other purposes, string out their payments to the doctor, or not pay the doctor at all.

Other factors come into play when assignment is not recognized. For example, when you allow \$1,700 as reasonable payment on a \$2,400 charge and pay the employee directly, the employee has an incentive to negotiate with the doctor before paying the doctor anything. Moreover, this approach creates a discussion of fees between the patient and the doctor, a much needed and revolutionary direction for our health care system.

Proper use of the assignment lever by employers and health plans can cure the overpriced physician component of the health care cost problem without the need for government assistance. Widespread use of this simple but dynamic concept would unleash

Speaking out

the equivalent of a hydrogen bomb on those who overcharge in American medicine.

The physician's defense may be to require the patient to pay cash in advance. However, such action by the doctor drives patients away to other doctors who are willing to provide the same service at a reasonable price.

Insured plans generally reserve the right to recognize (or not recognize) an assignment of benefits.

Self-funded health care plans, of course, are controlled by the plan document or plan description. If your plan is subject to the Employee Retirement Income Security Act of 1974, the state does not have any jurisdiction for regulating it. And since ERISA only established welfare plan rules for disclosure, reporting and party-in-interest transactions, the benefits and administrative details of your plan are left solely up to the plan sponsor on the issue of assignment. If your health care plan does not already have the right to reject assignment, you can establish this right with an amendment. Medical Mutual Plans Inc., a third-party administrator, has used the following sample plan language:

"The Plan may elect to pay benefits directly to the health care provider unless the bill has already been paid. However, where the party rendering services does not have an agreement with the Plan, the Plan may elect to pay benefits directly to you (the employee). In the event you are deceased, benefits may be paid at the Plan's option to your spouse or closest relative as determined by the Plan."

We discovered the incredible power of the assignment lever when we received a \$10,500 bill from a Chicago doctor for inpatient hospital visits on a liver failure case. We calculated a generous reasonable and customary allowance to be \$4,700. Rather than paying \$4,700 to the doctor, we offered the doctor a choice between accepting \$4,700 as full payment, or not receiving any payment from us. Our offer was to pay the patient rather than the doctor, unless the doctor agreed to accept the \$4,700 as payment in full and write off the balance. The doctor readily agreed to our proposition.

On another case, a major national vendor of home intravenous services sent us a bill for \$54,600. When we compared their charges to those of our local hospital-based home health care program, we discovered that a reasonable charge would have been slightly under \$25,000. We reasoned that just cutting this bill off at reasonable and customary,

Continued on next page

1992 RIMS conference

ANOTHER RISK & Insurance Management Society conference has come and gone. The attendees can relax—as they face a desk full of unreturned messages and mail, while trying to digest the information they just picked up at the conference.

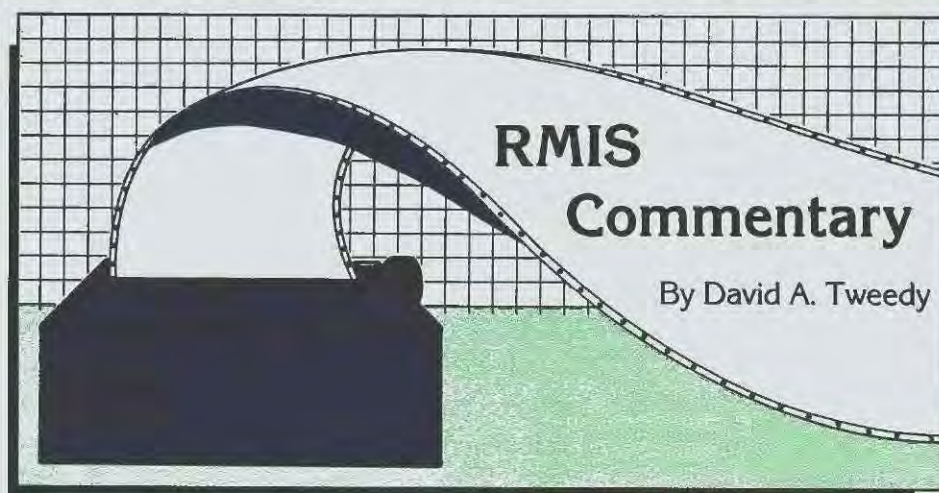
First, some impressions. The tone of the conference was somewhat muted, perhaps reflective of the current recession, squeezed budgets and the continued soft market for brokers and insurers. The exhibit hall was well laid out and quite impressive; RIMS did an outstanding job. As in previous years, the overwhelming focus of attention was on cost containment, especially related to workers compensation.

One of the sessions I coordinated and spoke at, "Managing in the Maze—Selecting Workers Compensation Services," emphasized the explosion of full-service and niche-service-oriented providers targeting a \$75 billion workers comp industry. In fact, the majority of exhibitors had something to do with workers comp. The bottom line is that many firms are defining very specialty-oriented niches, like carpal tunnel screening services, managed care for health plans and substance abuse programs, loss reserving systems and psychometric testing, which is stress testing related to workers comp claims.

Now, to the risk management information system vendors.

As the old saying goes, "there is nothing new under the sun." With very few exceptions, this statement describes the RMIS industry represented at the conference. Many of

Use of artificial intelligence to calculate workers comp case reserves makes its debut



the old timers were present. In some cases, the difficult part was in picking them out. Almost every exhibitor had some form of personal computer or system tie-in at its exhibit booth, whether it was an insurance company, brokerage, third-party administrator or specialty firm.

There were two major categories of system vendors: full-service risk/claims management information system providers and specialists. I counted 17 full-service providers, most of which are veterans of past RIMS conferences. The notable exception was Electronic Data Systems Corp. of Dallas, the largest insurance

industry-related software vendor according to Information and Technology magazine. (Corporate Systems Ltd. of Amarillo, Texas, is the largest RMIS vendor, according to the same publication.) Most of these vendors followed up on past conference themes: workers comp, cost control techniques and risk financing analysis. Further, they emphasized technological improvements, like a more graphic user interface to increase user friendliness.

In the other group were the "specialists" that centered their attention on one specific area. I counted 13 such businesses, but there

were more, depending on the definition. There were three major groups of functional specialties:

- Medical cost management/cost containment.
- Litigation analysis and management.
- Financial analysis.

Some of the full-service vendors have specific capabilities in each of these areas. However, these specialist firms either subcontract with third-party administrators or other risk management information system vendors, or their products are purchased or leased by the end user on a specific case-by-case basis.

I counted eight specialized systems for medical cost management, and the emphasis comes as no surprise. This continues a trend of the recent RIMS conferences and emphasizes the concern with the rising cost of the medical component of the workers comp system. There were other vendors that specialized completely on the group health side. Obviously, many of these specialists on both sides are working toward unifying the system completely for a "24-hour coverage" capability.

There was the continued presence of systems focusing on litigation management. Most of these systems track the details following a litigated liability or workers comp case. Again, traditional RMIS vendors, like Corporate Systems and Crawford & Co.'s Risk Sciences Group unit, have devoted separate modules to this very important area. Others focus more on the details of litigation analysis, like

Continued on next page

Dealing with providers

Continued from previous page
and paying \$25,000 to the IV firm would have created three problems.

First, it would have left our plan member with a balance of \$29,600. Second, our plan member would have complained to the employer, thus creating an employee relations problem for the employer, and requiring further involvement for our claim office. And third, we would have been eliminating much of the plan member's bargaining power with the IV firm.

Instead, we gave the IV firm the choice between a payment from us of \$25,000 or nothing. We told them that if the patient were forced to file bankruptcy over the \$29,600, then we would be better off to pay nothing and let the patient declare bankruptcy against the entire \$54,600. And for good measure, we would pay the bankruptcy filing fee. The result was immediate acceptance of our \$25,000 offer, and agreement by the IV firm to write off the balance.

The individual case negotiation with the doctor is starting to work well in bills exceeding \$1,500 and smaller bills if the doctor's charge is too far out of line. This is particularly true when the patient does not have sizable assets. We feel that it does not make much sense to cut a doctor off substantially for reasonable and customary (but still pay the doctor), and then expect the patient to deal with the doctor on the account balance after the health care plan has given away all of the patient's bargaining chips.

Why do providers such as the home IV firm bill inflated charges up to 200% or 300% of prevailing reasonable and customary rates? It is because employers everywhere are paying the drastically higher charges with no questions asked.

We see many claim offices that pay billed charges without determining the reasonable and customary amounts. Other claim offices have chosen to avoid disputes with providers and plan members by

turning up the reasonable and customary formula to maximize allowances. Employer laxity in allowing this to happen is a significant contributor to rising health care costs.

Health care plans are seen by many providers as an oversized, unguarded Fort Knox. Employers have more of a "spending" problem than a "cost" problem. Suggested remedies for this problem include the following:

- Evaluate your claim office practices to ensure that your adjusters are not giving away the store. Ask specifically for the amount of billed physician charges and the amount disallowed over reasonable and customary during recent months. Between 2%

Even the most conservative doctors envy the ease with which some of their colleagues milk the system. Each year, more doctors join the ranks of those who are gouging the public.

and 4% of all billed doctor charges should be disallowed above reasonable and customary, if you are clipping the excessive doctor charges properly.

- Amend your health care plan to provide authority to not pay doctors who are significantly overpriced. If your plan identification cards refer to assignment, you may need to revise the language and issue new cards. In addition, if you have previously instructed doctor offices on your plan's acceptance of assignment, you should communicate revised procedures.

- Ask other payers in your area to take a unified position on the policy of not recognizing assignment from physicians who are overpriced. Keep it simple because complicated coalitions have difficulty in getting action.

If you do not address this pervasive issue, you will contribute to the growing health care spending

problem. Even the most conservative doctors envy the ease with which some of their colleagues are milking the system. Each year more and more doctors are unable to resist joining the ranks of those who are succeeding in gouging the public. The abuse is having a snowball effect, helped by employer inaction.

One should note that U.S. group health care plans were created by hospitals and doctors, for the benefit of hospitals and doctors. The idea has been a fabulous success. During our half-century experiment with these provider revenue enhancement programs, employers have played a minor role within the system, other than to pay most of the bill. Runaway spending has caused payers to wake up, resulting in the concepts of managed care, pretreatment approval, preadmission certification and broader exclusions.

However, the non-recognition of assignment lever contains more "payer power" than all of the other available tools combined. With this lever, payers can lower the fees to those doctors who are overpriced. Eventually, employers may use this lever to bargain and contract with providers over payer approval of facility expansion, unnecessary equipment duplication, or even to shut down an unneeded facility.

In short, widespread use of the non-recognition of assignment lever can bring the payer to center stage in this country's health care system, as in most other fields where the party with the purse strings is in control. And this will happen when payers feel enough financial pressure to act. ■



Ron Jones is president of Mutual Medical Plans Inc., a third-party administrator in Peoria, Ill.

Systems vendors

Continued from previous page
Allan Camp & Associates of Lafayette, La., and Jury Verdict Research Inc. of Solon, Ohio.

These specialty systems are much more closely tied with the vendor's consulting abilities. Their goal is to help risk managers, TPAs and insurers make informed decisions on the impact of potential jury verdicts or litigation results.

Finally, there was the usual separate emphasis on risk financing analysis, which in years past was one of the chief attractions of a RMIS.

Today, with the emphasis on cost containment, loss management and loss prevention, the risk financing modules have taken second place. Nevertheless, they remain very important.

Perhaps the most interesting specialty differentiation that I saw at the conference was in the area of using artificial intelligence to set case reserves for workers comp. A first-time exhibitor in this area is Micro Insurance Reserve Analysis, or MIRA, from Risk Data Corp. of Irvine, Calif. It is an on-line/mainframe/timeshare system, utilizing a statistical model based on a data base containing more than \$10 million in workers comp claims collected from many insurers nationwide.

Essentially, the MIRA system can take the data from this historical data base and predict reserves based on information taken from the first report of injury. This capability is quite intriguing, and I have wondered why the insurance industry has not

invested in this area. With the introduction of MIRA, it appears that we will be moving toward this capability.

Both existing and specialty vendors also are differentiating their services based on ease of use. One attendee remarked: "All these vendors are going GUI." This is an acronym for

Perhaps the most interesting specialty differentiation at the conference was in the area of using artificial intelligence to set case reserves for workers comp. A first-time exhibitor showed an on-line/mainframe/timeshare system, based on a data base containing more than \$10 million in workers comp claims.

graphical user interface that describes software which is icon-driven and mouse-compatible with the ultimate objective of making novices into confident users with a minimum of instruction.

Mainframe vendors, in particular, have been criticized for being non-user friendly and have made an effort to develop a "Windows" or "MacIntosh" look. Both Risk Data Corp. and Corporate Systems are well along into this technology.

One unnamed competitor complained that if the focus on GUI is just "window dressing" and is not based on a solid system foundation, it is deceptive.

I agree with this observation to a point. I am a strong proponent of a system being accessible to any level person at a client company. I support

any improvement that makes a system more accessible to senior management or line and staff managers, and GUI greatly augments this accessibility. But, when the GUI is just a coverup for an inadequate system, the deception should be exposed. Fortunately, my impression of those vendors that I review in Betterley's

survey and those attending the RIMS conference is that they do not fall into that category.

Joint ventures continue. The last observation is that this mature RMIS marketplace is causing more and more joint ventures or associations between vendors or specialties.

It is a given that entering the RMIS industry, as with any mature industry, represents a tremendous cost barrier. Even developing a specific niche area represents a considerable investment to obtain the capability. Vendors like Electronic Data Systems and Data General Corp. of Westboro, Mass., are using their reputations gained in other fields to secure a market niche in this industry. Data General is doing it through joint ventures with software firms in the employee benefit, workers comp and property/casualty fields,

giving those firms entrance into their booth to market their services.

Also, some of the larger vendors continue to look for joint ventures with specialty firms, such as in the medical cost management and litigation management areas, or even using the PC-based vendors to make usage easier for large mainframe systems, which are anything but user friendly.

There were predictably few major changes at this year's conference. RMIS is a mature industry, and vendors are seeking to differentiate themselves through increased functions, joint venture relationships, improved user friendliness and new technology, like multi-platform abilities to gain or maintain market share. Artificial intelligence for case reserving made its entrance at this conference, and I plan to address this in a future column. ■

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



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

Health care survival strategies

System cannot continue as is, authors of book say

"The Crisis in Health Care: Costs, Choices and Strategies"

By Richard L. Clarke, Dean C. Coddington, David J. Keen and Keith D. Moore

Published by Jossey Bass Publishers, 350 Sansome St., San Francisco, Calif. 94104 \$32.95

By Christine D. Woolsey

JUST AS THE MILITARY relies on strategic and tactical planning and modeling in its efforts to anticipate the kinds of battlefield situations U.S. forces might face, employers also should attempt to identify and select strategies that will be successful in battling skyrocketing health care costs under various health care system reforms, say the authors of a new book.

While it is difficult to predict what type of health care system will evolve in the 1990s, one thing is certain: The current system is no longer sustainable. The authors warn that any notion the future of health care "will be a continuation of past trends is erroneous—a dangerous basis for strategic planning."

In "The Crisis in Health Care: Costs, Choices and Strategies," the authors—executives of an economic research consulting firm and the president of an association of hospital financial professionals—argue that the health care industry has lost its ability to control costs and that the present payment system will inevitably change in the next several years.

Among the factors the authors identify as key contributors to rising health care costs are increased demand for health care services due to the aging population, technology, the trend toward diagnosing and treating more patients on an outpatient basis and the availability of third-party payments. Also, the authors say, "health care marketing efforts are designed to stimulate demand, and they have had an impact, particularly in areas such as mental health and substance abuse."

Higher operating expenses, including increasing

Books & ideas

expenses incurred by physicians and hospitals; expenses related to excess capacity; and duplication of services also contribute to health care cost increases, the authors say. And, they note, "high physician earnings and the health plan industry playing catch-up for previous losses" have fueled cost increases as well.

Like many other researchers, the authors found that "costs for both physician and hospital services have been increasing at rates greater than the rate of inflation, but not nearly as rapidly as health plan premiums. The move toward managed care was supposed to lead to cost control, but the results have been disappointing to both health plan executives and payers."

The authors argue that "one of the most important reasons for the big difference between the rates of growth in physician and hospital costs and in insurance premiums is cost shifting—passing on the losses experienced from serving patients who do not pay anything or whose health coverage pays only a portion of the normal price of providing services."

But, the authors go further than simply identifying the crisis and naming the culprits that have led the nation to the brink. They devote several chapters to discussing how hospitals, physicians and health plans should respond to the health care crisis and how their long-term strategies and initiatives should change depending on what type of reform is adopted. Four scenarios are discussed.

"Several considerations are important in developing scenarios of what the future payment system may hold," the authors write. For example, any reform proposal should address: who will be covered by health plans, who will pay, what will be the level of payment and how will providers be selected.

The authors contend that any reform proposal must define who is covered. "In our view, without broadening the base of those covered by health insurance, and thus reducing the amount of cost shifting to those with insurance, there can be no meaningful reform," they say.

And, the authors say, it is also important for health plans, doctors and hospitals to ask who will

pay, because "the ultimate payer drives the system, and the payer's preferences dictate the shape of the delivery system."

While noting that the "political reluctance to reform the health care system is real," the authors put forth three possible payment systems:

- Employer-based universal access model. This would entail an employer-based payment system with universal access for the currently uninsured, coupled with a consolidation within the health plan industry.

- Consumer choice plan. Responsibility for selecting health plans would shift to individuals and households, through their own funds or government-paid vouchers. Universal coverage would be available for the medically indigent.

- Single-payer system. Implementation of a Canadian-type health care system at either the state or national level.

The authors also point out that there is one other possible reform, called the incremental change scenario. Under such a reform, "the key change in the structure of the health care delivery system is a decline in the use of fee-for-service and growth in the contract and capitated sectors," the authors explain. "This world of cost containment and managed care favors payers—business, government and consumers—but has less palatable effects on providers, the disadvantaged working poor and the medically indigent."

Under this scenario, "we do not anticipate a solution to the problem of the uninsured," the authors note. "We fully expect that the number of persons in this group will exceed 40 million" in the early 1990s. "Because of continuing double-digit health plan rate increases, smaller firms will drop their health plans, or they will drastically cut back on coverage. Some firms will find that even if they want coverage, their prior loss experience will make it difficult to buy health plan coverage for all their employees," the authors say.

The authors complete the book by analyzing various reform proposals and discussing how they would affect various players, including employers, providers, the government and consumers.

While it offers no definitive solution, "The Crisis in Health Care" offers health care policy specialists another tool for building a solution to the nation's health care crisis. ■

Conversion policy must equal prior benefits

The District Court of Appeal of Florida held that an employee insured under a group health policy was entitled to a conversion policy providing benefits equal to those which the group coverage provided.

Mary Elizabeth Clark was employed as an attorney by Gulfcoast Legal Services Inc. She was insured under a group health insurance plan underwritten by Northbrook Life Insurance Co.

In December 1988, while the policy was in effect, Ms. Clark was diagnosed as having cancer. She had surgery in January 1989 but was unable to return to work and was totally disabled from December 1988. Ms. Clark received full medical benefits under the group plan through June 30, 1989, the effective date of her resignation. From July 1, 1989, through June 30, 1990, she received an extension of her benefits pursuant to Florida law.

In March 1989, Ms. Clark's employer received notice from the insurer that it intended to terminate the group coverage effective July 1, 1989. Ms. Clark exercised her right of conversion

Legal briefs

pursuant to the group policy and requested a policy of equal benefits. However, the policy issued did not provide the same level of benefits as her former group contract.

A lawsuit was filed seeking a declaration of what benefits she was entitled to receive. The trial court granted her benefits equal to those she had under the group contract.

On appeal, the insurer argued that, on conversion, it only had to provide minimum benefits as required by state law. However, the court said that even though the policy did not define conversion, the conversion policy must provide coverage equal to the benefits provided in the group plan.

According to the court, the state law merely established the minimum criteria a conversion policy had to meet.

Northbrook Life Insurance Co. vs. Clark, District Court of Appeal of Florida, June 12, 1991, Rehearing denied Aug. 5, 1991 (BI/02/My.-\$10)

Injury en route from work

The Supreme Court of Mississippi held that an employee was entitled to workers compensation benefits for injuries occurring en route to and from work where the employer provides travel expenses to the employee.

Gwendolyn A. Favre was employee for two dental services as of September 1983. She and all other employees were paid in part for their automobile and gasoline expenses to and from work. For such reimbursement purposes, each employee was told to clock in 45 minutes before arriving at the office and to clock out 45 minutes after leaving the office. This system compensated Ms. Favre at about \$2.73 per day for travel.

On Jan. 26, 1984, at about 6:45 p.m., Ms. Favre was injured in an automobile accident while en route home. There was evidence that she had still been at work between 6:15 p.m. and 6:30 p.m. that day. Ms. Favre applied for and was awarded workers compensation benefits.

On appeal, the employer argued, in part, that the case was controlled by the general rule that an employee is not within the course and scope of his or her employment while driving to and from work. However, the court pointed out that many exceptions to this rule have been recognized, including one where the employer provides travel expenses to the employee. The court rejected the employer's argument that this exception did not apply here because the gas money paid to Ms. Favre had no relation at all to the expense per mile. The court said payment on a per diem basis met the exception.

Matheson vs. Favre, Supreme Court of Mississippi, Sept. 25, 1991 (BI/01/My.-\$10)

These abstracts were prepared by Mayo H. Stiegler. Copies of these decisions are available by sending a \$10 check payable to Mayo H. Stiegler to Business Insurance, 740 N. Rush St., Chicago, Ill. 60611-2590. List the number for each opinion.

Self-insurers must clear legal hurdles

By LOUISE KERTESZ

ANAHEIM, Calif.—Varying state laws and contractual requirements make self-insuring automobile liability risks a challenge for large companies, although the marketplace continues to make self-insurance a necessity, a risk management executive says.

"The Hertz Corp. is now self-insured because traditional automobile liability insurance is not available or affordable for a risk of Hertz' size and exposure," according to Richard P. McEvily, staff vp-risk management and casualty claims for the Park Ridge, N.J.-based rental car company.

But self-insuring its auto liabilities in some states means clearing "several hurdles," and fulfilling the insurance requirements of many of Hertz' contractual arrangements is complicated by self-insurance, he said.

Mr. McEvily spoke at a session titled "How To Satisfy Insurance Requirements: Statutory and Contractual" at the American Bar Assn.'s National Institute, which was held last month in Anaheim, Calif., prior to the 30th annual Risk & Insurance Management Society annual conference.

Hertz' rental fleet of approximately 230,000 vehicles in the United States—94% of which are owned by the company—represents an annual investment of about \$2.8 billion, Mr. McEvily said.

Purchasing traditional insurance would require an auto liability policy or policies with limits of \$1 million per occurrence and deductibles of \$10,000 to \$25,000 for each car, he explained.

But such coverage is not available in the commercial insurance market.

Hertz, though, does not at-

tempt to self-insure all of its exposures. "Quite the contrary, Hertz' insurance program in the U.S. is a mix of insured and self-insured exposures," Mr. McEvily said.

Hertz self-insures its general liability exposures at the primary level where permitted by state statute and purchases various levels of excess insurance from commercial insurers, Mr. McEvily explained.

The company purchases workers compensation insurance from commercial insurers. It also purchases primary and excess property coverages in the commercial market.

To illustrate the demands put on self-insurers by various state statutes, Mr. McEvily noted that California requires extensive documentation to self-insure auto liability risks.

An owner of more than 25 vehicles may self-insure its auto liability risk in California by first making a cash deposit of \$35,000 with the Department of Motor Vehicles.

The self-insurer must also show that it can pay judgments of "not less than \$15,000 because of bodily injury to or death of one person in any one accident, and . . . not less than \$30,000 because of bodily injury to or death of two or more persons in any one accident, and . . . not less than \$5,000 because of injury to or destruction of property of others in any one accident," he said.

To qualify as a self-insurer in California, an application must be completed and accompanied by an audited financial statement for the three-year period immediately preceding the date of application. The statement must reflect a net worth of not less than \$575,000 on the date of application.

The department may also require various other documents. Mr. McEvily said Hertz submits to the state, on an annual basis, the following:

- Audited financial statements for the previous year.

- A loss-experience record, showing personal injury and property damage claims. This record itemizes: the number of accidents in which Hertz vehicles were involved in the previous year, the number of claims settled with and without payment, the number of open claims, payments on claims and reserves on pending claims.

The state of New York has recently made self-insuring auto liability "more burdensome," Mr. McEvily said. In addition to reporting requirements similar to those of California, New York requires that a self-insurer maintain \$5 million of excess liability coverage and to provide a list of all vehicle identification numbers, Mr. McEvily said.

Hawaii has similar statutes for automobile liability self-insurance.

"However, the application process for becoming self-insured—and for maintaining that status—in Hawaii has the additional kicker of requiring an annual evaluation by an independent actuary to establish the funding requirements for the self-insurer

to cover 75% of the unpaid portion of expected ultimate losses to be incurred during the self-insurance period," he said.

As a result, an applicant in Hawaii is required to submit a self-insurance bond, "which can run into some large numbers since the evaluation includes open claims for all years of self-insurance," Mr. McEvily said, noting that Hertz recently submitted a self-insurance bond of more than \$3 million to Hawaii officials.

The state of Maine does not permit "owners of vehicles for hire" to self-insure their auto liability, so Hertz has entered into a fronting arrangement with an admitted insurer in Maine, Mr. McEvily said.

Because it needs a fronting insurer in Maine, Hertz is hoping that the final version of the National Assn. of Insurance Commissioners' model act limiting fronting activities will not be "too restrictive," he pointed out.

Compliance issues also arise for Hertz as a self-insurer because it "has entered into a large number of contractual agreements—most notably airport-concession agreements"—whose provisions affect Hertz' self-in-

surance program, Mr. McEvily said.

For example, an airport authority typically requires a bid bond as part of a company's response to a request for proposals.

"The real magic that is required" for a self-insurer in this situation "involves the establishment of a relationship with an insurance broker and with a surety company who understand the scope of your operations and the demands of your business, as both are essential" to respond to the request for proposal in a timely manner, Mr. McEvily explained.

And it is sometimes necessary for Hertz as a vendor to enter into a fronting arrangement to satisfy certain parties to a contract, Mr. McEvily said.

Self-insurance is not for the faint-hearted, Mr. McEvily said in a question-and-answer period following his presentation.

He recalled one case in which Hertz was sued after a driver fell asleep at the wheel and the vehicle rolled over, seriously injuring the driver's wife. "On one rental we lost \$3.4 million" in damages, Mr. McEvily said. ■

Bringing in the experts

Self-insurers must make effective use of outside counsel

By LOUISE KERTESZ

ANAHEIM, Calif.—A self-insured company needs to make effective use of outside counsel to be successful in litigation defense, says an attorney who specializes in product liability litigation.

An ineffective relationship with the company may result in outside counsel being "blindsided" by plaintiffs' counsel, who may be more informed about the case, said Richard H. Rubenstein, a partner with Wilson, Elser, Moskowitz, Edelman & Dicker in New York.

Mr. Rubenstein spoke at a session titled "Going Bare—The Use of Outside Counsel" at the American Bar Assn.'s National Institute, held here last month before the Risk & Insurance Management Society conference.

Mr. Rubenstein defined outside counsel as "local counsel retained to defend individual suits and supervisory counsel retained . . . to manage claims on a nationwide basis."

Outside counsel is distinguished from in-house counsel, which includes "corporate counsel, as well as risk managers and other personnel responsible for claims management within the self-insured corporation," Mr. Rubenstein said.

Mr. Rubenstein used the example of product liability litigation against a self-insured manufacturer to illustrate the proper use of outside counsel.

Manufacturers that sell their products nationwide "have the potential to be sued in many different jurisdictions," Mr. Rubenstein said. They must therefore have a "game plan" for successful defense of product liability cases.

According to Mr. Rubenstein, a successful product liability defense includes—but is not limited to:

- Selection of the highest-quality local counsel consistent with the company's fiscal constraints.

- Prompt and thorough investigation of claims.

- Selection of the highest-quality outside experts consistent with the company's fiscal constraints.

"You're not going to win the Super Bowl if you have the Tampa Bay Buccaneers' personnel," Mr. Rubenstein quipped.

- Education of local counsel and outside experts as to the specific product and recurring tech-

sel in product liability cases, the self-insured company must first decide which litigation philosophy it will follow.

One option is the "brick wall" philosophy, which involves trying most or all cases. "Few or no cases will be settled prior to trial in order to discourage the bringing of thin liability cases against the company," he said.

"This philosophy is probably best suited to a very large and prosperous corporation, because the cost of defense will be substantial," he said. And the company must be prepared to lose "a fair percentage of cases."

Another option is the "soft touch" philosophy, in which "no cases will be tried, because the company cannot live with an adverse finding regarding its product or cannot afford the cost of defense through trial," he said.

Very small self-insurers or companies that do not have a significant number of serious cases might choose this option, Mr. Rubenstein said.

Under a third option, the "hard-nosed" philosophy, "most cases will be settled, but the most defensible cases and those cases which are important from a philosophical standpoint will be tried," he said.

"This is a reasonable middle ground which is probably suitable for medium-sized to large companies, in that the defense costs should fall in between" the other two options, he said.

The philosophy that the company espouses should be communicated to and followed by any outside counsel it retains, Mr. Rubenstein said.

The company should evaluate its in-house capabilities to determine whether it needs to employ outside supervisory counsel.

After deciding to employ outside counsel, the company should then properly communicate with that counsel. Such communication involves providing informa-

Continued on next page

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Outside counsel

Continued from previous page
tion on "reporting requirements and other guidelines for case handling."

"A self-insured company that is involved in technical litigation, such as product liability in multiple jurisdictions, has the best chance of obtaining favorable results and controlling defense costs by not letting local counsel proceed without close direction," which involves "a smooth flow of communication in both directions," Mr. Rubenstein asserted.

"Overall supervision of the program should be conducted by an experienced product liability attorney with hands-on experience, whether in-house or outside the company," he said.

Once it has decided to use outside supervisory counsel, the company should defer in matters of strategy to that counsel, which is the "head coach" in litigation against the company, Mr. Rubenstein said.

"The outside supervisory counsel's primary role is to ensure that the local counsel is performing in accordance with the company's expectations and is adopting consistent positions with local counsel in similar cases against the company in other jurisdictions," Mr. Rubenstein added.

Outside supervisory counsel oversees the background investigation of the claim if a suit has not yet been filed; selects local counsel and national and local experts and, "with the assistance of in-house staff," educates local counsel as to the product itself and recurring technical concerns; ensures nationwide coordination and uniformity of responses to discovery demands; and supports local counsel in its various responsibilities, Mr. Rubenstein said.

Outside supervisory counsel also provides analysis and recommendations for settlement strategy or trial "based upon broad experience and considering global factors in addition to the opinions of local counsel."

Outside supervisory counsel also provides guidance to the corporation "regarding (product) design or warnings changes, retrofits (and) reporting requirements," he said.

The outside local counsel is the "quarterback" in the company's defense game plan, Mr. Rubenstein said. Outside local counsel prepares the case for trial, keeps the corporation advised as the case progresses and participates in the trial, he said.

This involves working with outside experts and supervising their work and reporting the progress of the case to outside or inside supervisory counsel, Mr. Rubenstein said.

Outside local counsel also is responsible for "specifying available courses of action for strategy decisions" and making strategy recommendations, as well as providing analyses of liability, damages and legal issues, he said.

Outside local counsel also should provide background information on opposing counsel, the trial judge and local juries, Mr. Rubenstein said.

Dennis L. Fetzer, corporate claims manager for Albertson's Inc., a nationwide self-insured supermarket chain headquartered in Boise, Idaho, also spoke at the session about his company's experience with selecting outside counsel. ■

By LOUISE KERTESZ

ABA ANAHEIM, Calif.—A company that insures its exposures through non-traditional means may be "ambushed by problems it never anticipated," warns a lawyer.

But the key to sidestepping those problems is to try to avoid having a self-insurance program "characterized as insurance," said Jill B. Berkeley of Cassidy, Schade & Gloor of Chicago.

Ms. Berkeley—who specializes in insurance law and coverage litigation—gave an overview of recent case law on self-insurance at a session during the American Bar Assn. National Institute, which was held in Anaheim, Calif., last month before the annual Risk & Insurance Management Society conference.

She noted that "there is no body of law that addresses the problems of self-insurance," so self-insured firms must rely on guidance from developing case law. The issue is complicated

Beware self-insurance that looks like coverage: Lawyer

by the fact that firms may be self-insured for some risks and not others, she said.

Cases often turn on whether a company that is using non-traditional means to insure its exposures is a "self-insurer" or a "self-insured," Ms. Berkeley said.

She explained: "If the business is performing a function related to assuming risk where no traditional insurance is provided, it will be referred to as a self-insurer. If it has maintained a portion of the risk in relationship with an insurance company (as in the form of a self-insured retention), then the company will be referred to as a self-insured."

Some cases have viewed a self-insurer as engaging in "insurance-like behavior," she said. An example of such behavior would be filing a certificate of self-insurance with a state agency to comply, for example, with the "insurance minimum requirements" for rental

car and leasing companies.

If a court views a self-insurer as engaging in insurance, several problems may arise.

For example, case law is struggling with the "thorny problem" of whether a self-insured governmental body has waived its sovereign immunity under the general rule that a governmental body may waive such immunity by the purchase of insurance coverage.

"Several cases have addressed questions of whether the form of self-insurance is equivalent to a waiver; does a deductible or SIR remove the waiver; does a denial of coverage (by an insurer) affect the waiver?" she asked.

Another problem, she said, is that if a firm's self-insured retention "looks too much like an insurance policy" deductible, the firm may lose the right to dictate settlement terms.

In several recent cases involving companies with large self-insured retentions, the courts upheld the decisions of insurance companies in the settlements of those cases, even though the policyholders had objected to the terms, she explained.

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Largest U.S. reinsurers' 1991 results

Ranked by net reinsurance premiums written. All amounts in thousands of dollars.

Reinsurers	Net reinsurance premiums written 1991	Net reinsurance premiums written 1990	Policyholders surplus (reinsurers only)	Net income 1991	Losses & loss adjustment expenses	Loss ratio	Underwriting expenses	Expense ratio	Combined ratio 1991	Combined ratio 1990
1. General Re	\$2,122,317	\$2,065,003	\$3,363,071	\$612,767	\$1,535,714	72.5%	\$630,343	29.7%	102.2%	99.0%
2. Employers Re	1,238,283	1,135,568	1,453,185	307,408	905,077	76.5	343,223	27.7	104.3	102.9
3. American Re	893,916	875,515	735,708	157,763	673,411	73.0	264,915	29.6	102.7	103.7
4. North American/Swiss Re	798,677	676,082	723,561	59,898	508,696	69.7	289,222	36.2	105.9	108.7
5. Prudential Re	692,582	562,556	590,284	62,568	534,938	78.1	233,981	33.8	111.9	119.1
6. Berkshire Hathaway	667,035	435,205	N/A	N/A	731,917	115.2	20,577	3.2	118.4	106.2
7. Munich Re	561,048	527,421	669,584	46,950	418,775	77.4	180,177	32.1	109.5	107.4
8. Kemper Re	526,035	355,640	N/A	N/A	426,080	84.2	112,315	21.4	105.6	113.2
9. Transatlantic/Putnam	483,859	483,623	414,463	64,804	404,764	81.4	125,817	26.0	107.4	107.0
10. The St. Paul Cos.	445,504	404,904	N/A	N/A	442,434	100.4	137,401	30.8	131.2	130.8
11. Skandia America Group	404,383	414,122	353,011	27,534	304,926	76.8	137,365	34.0	110.8	110.2
12. Transamerica Re	346,024	313,546	229,645	37,721	271,736	76.8	97,335	28.1	105.0	105.6
13. CIGNA Re	335,825	302,574	242,011	26,990	279,070	83.8	74,515	22.2	106.0	107.4
14. National Re	259,530	268,953	253,657	55,150	194,740	72.2	78,987	30.4	102.7	102.0
15. Constitution Re	256,832	318,405	246,844	32,240	183,930	74.4	83,734	32.6	107.0	107.7
16. NAC Re	233,044	217,106	230,040	32,317	164,773	71.8	85,012	36.5	108.3	108.2
17. F&G Re	211,138	460,299	N/A	N/A	124,714	56.9	64,436	30.5	87.4	95.9
18. Winterthur Re	205,420	172,727	178,208	14,903	144,925	74.9	67,211	32.7	107.6	105.4
19. Scor Re/Unity	172,710	179,502	224,327	30,719	113,184	65.5	63,629	36.8	102.3	101.6
20. Re Capital Re	140,533	106,615	102,609	7,177	82,448	61.1	57,407	40.8	102.0	99.0
Totals for Top 20	10,994,695	10,275,366	10,010,208	1,576,909	8,446,252	78.1	3,147,602	28.7	106.8	105.9
Total for all companies	12,282,732	11,668,096	13,686,362	1,866,644	9,148,011	76.1	3,805,355	31.0	107.1	106.1

Source: Reinsurance Assn. of America and Business Insurance

Reinsurer results

Continued from page 3

Mr. Fitt said 1991 "was a disappointing year for most people, including ourselves."

There was little change in the U.S. reinsurance market in 1991, agreed Craig Eisenacher, senior vp and controller for Prudential Reinsurance Co. in Newark, N.J. "There was plenty of sweat, but no forward movement."

And this year is unlikely to look much different, he said. "There's a lot of surplus in the industry," said Mr. Eisenacher, noting that the U.S. reinsurance industry's premium-to-surplus ratio is less than 1-to-1.

"Things are still muddling along," commented Shaun Flynn, vp with Standard & Poor's Corp. in New York. "It doesn't look like any turn is in sight, period."

The 65 reinsurers surveyed by the Reinsurance Assn. of America reported a combined ratio of 107.1% for 1991, a one-point deterioration from the 106.1% combined ratio posted by a comparable group of reinsurers in 1990 (BI, April 22, 1991).

Net premium volume for the

group of 65 reinsurers increased 5.3% to \$12.28 billion from \$11.67 billion.

The 20 largest reinsurers based on net premiums written reported a 106.8% combined ratio, compared with 105.9% in 1990. This includes reinsurance operations of Berkshire Hathaway Inc. and Kemper Corp., which do not participate in the RAA survey.

Net premium volume for the Top 20 rose 7% to \$11 billion from \$10.28 billion.

While many reinsurers bemoan the state of the market, one executive points out that conditions are not as bad as they could be.

Steven Bensinger, president and chief operating officer of Skandia America Reinsurance Corp. in New York, said the reinsurance market is not as undisciplined as it was in the early 1980s, before the last hard market. "It's much more realistic pricing today than it was then."

The large rate deficiencies of the early '80s have not reappeared, he said.

Still, Mr. Bensinger said, the overall market continues to stagnate, while claims costs continue to rise with inflation. This means that even if terms and conditions

remain stable, reinsurers' costs continue to grow as claims costs increase, he said.

"You're losing ground by standing still" and, as a result, reinsurers "may be lulled into a false sense of security and ease," he warned.

Mr. Bensinger said that while he is disappointed with the reinsurance industry's underwriting results, "I think margins will not really have the pressure on them (for reinsurers) to make the really tough underwriting decisions" until investment returns worsen.

Mr. Bensinger noted that Skandia America has tried to introduce higher rates, "and in almost all cases, the business moved somewhere else for better terms."

Paul Ingrey, president of F&G Re, a unit of USF&G Corp., also pointed to investment returns as a factor in reinsurers' higher profits. "I think that the results are coming from the wrong place. They're not coming from underwriting returns."

The RAA reported that U.S. reinsurers' net income was up 21.8% to \$1.58 billion in 1991, compared with \$1.29 billion in 1990.

Reserves could also be a concern, Mr. Ingrey added, noting that the property/casualty insurance industry's reserve increases last year were the lowest they have been in at least 20 years (BI, April 6). "If you look at the numbers, they appear adequate," but problems could emerge in future years, he said.

"I'd say there's some significant underreserving going on," agreed James Roberts, president and chief executive officer of Re Capital Reinsurance Corp. in Stamford, Conn. Published results, he said, are "unrealistic. . . True results are probably appreciably worse."

"Combined ratios, I think, have yet to reflect anything close to the full effect of the last five to six years of softening rates," said Mark Mosca, vp and manager of the treaty department at NAC Re Corp. in Greenwich, Conn.

In addition, he said, the casualty exposures the industry has assumed over the last few years have not yet been reflected

in its reserves.

"I think it's only a matter of time" before loss experience from long-tail exposures develops and has "a real impact on financial statements," he said.

The question, said Mr. Mosca, is whether this happens before or after the market hardens.

U.S. reinsurers' losses and loss adjustment expenses jumped 15.6% to \$9.15 billion in 1991, up from \$7.92 billion in 1990, according to the RAA.

Underwriting expenses rose 16.2% to \$3.81 billion last year from \$3.27 billion in 1990, the RAA reported.

Mr. Mosca also said he believes the U.S. reinsurance industry's 5.3% premium growth primarily reflects financial reinsurance transactions.

If financial reinsurance was excluded, he said, "you would not see much, if any, growth in actual premium writing."

Mr. Mosca said he does not know when the market will turn. "The continued accumulation of capital is really a strong deterrent against a general turn in the market," he said.

The market appears to recognize its problems in narrowly defined areas like catastrophe, directors and officers, and petrochemical risks, but it has not spilled over into other areas, he said.

Furthermore, in addition to an apparent abundance of capital, reinsurers' reported results are not particularly bad, which means "there's no impetus for a change," said Mr. Mosca.

"I think we're going to see some deterioration this year," said Bard E. Bunaes, chairman and CEO of Constitution Reinsurance Corp. in New York.

"It's going to get worse before it gets better. It has to. The results are not bad enough to force a turnaround," he said.

"I don't see significant price strengthening before the end of the year," agreed Michael Smith, an analyst with Lehman Bros. in New York. The fact that the pricing cycle has not turned on the primary level "is certainly going to work itself up to the reinsurance market in terms of price adequacy, given the fact that reinsurance premiums are driven by premiums written by

the primary companies," he said.

But the shift away from proportional business has insulated most reinsurers, particularly the big ones, from the worst aspects of the cycle, Mr. Smith said.

As a result, he predicted that while the combined ratio may deteriorate a small amount over the next year, the reinsurance industry will throughout the soft market see "results that are, in actuality, not bad."

Mr. Smith observed also that the top 10 to 15 players are "in the catbird seat" as business moves toward the larger reinsurers. For the other companies, particularly small reinsurers having difficulty obtaining adequate retrocessional coverage, it will be "tough going," he said.

Jerome Karter, president of Scor Reinsurance Co. in New York, a unit of SCOR U.S. Corp., said the reinsurance industry's "de-coupling" from the primary industry's fortunes has led to improved reinsurer results. That has occurred as the proportion of excess-of-loss business has increased and primary insurers have increased their retentions.

But, he added, "generally, the market as a whole is not exactly in great shape, and risks are still being underpriced in most areas. . . and, unfortunately, I don't see any change in that yet."

He added that as long as reinsurers reserve properly, make the right kind of investments and maintain a careful underwriting policy, they will be in a strong position when the market does change, "which it will."

"I don't see any real change until 1993 and beyond," said Mark Hinkley, senior vp of Transamerica Reinsurance Co. in Stamford, Conn. Mr. Hinkley said he believes 1992 is similar to 1982, when people were also predicting that the market might never turn, though he does not believe that the next turn will be as severe as in the mid-'80s.

The market could turn at the end of 1993, said F&G Re's Mr. Ingrey, noting the likely triggers will be inadequate reserves, lower investment gains and increasingly negative cash flows. "To the extent these come together, it will tend to hasten the process," he said.

April 1992

HealthChicago, Inc.

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The undersigned represented HealthChicago, Inc. in this transaction.



THE CHICAGO CORPORATION

Health promotion

Continued from page 1
health of employees and ultimately help control health care costs.

At one end of the spectrum, this could mean simply distributing newsletters with tips for better health, subsidizing health club dues and offering smoking cessation classes. At the other end of the spectrum, employers amend their health care plans to tie employee premium contributions and coverage levels to health factors like cholesterol levels or tobacco use.

The Hewitt survey found that more than a handful of employers have redesigned their medical plans to base coverage levels on employee health (BI, Feb. 17).

Nine percent of surveyed employers tie contribution rates or coverage levels to employee health or lifestyle decisions, while 10% are considering doing so within the next two years.

"Employers have taken a lot of steps to try to control medical plans costs, but costs continue to go up," notes Leigh Williams, a Hewitt consultant in Lincolnshire.

"Now, employers are moving to the next frontier, a move to a more targeted approach, by trying to manage risks, like cholesterol, that drive up costs. It is a more active, targeted approach, unlike wellness programs, which often are used by employees who already are well."

Ms. Williams added.

And, while linking contribution rates and coverage levels to an individual employee's health is controversial, employers are carefully communicating those programs to win over employees, she said.

Employers may explain that benefits are part of a total compensation package and that compensation should be the same for employees with identical work experience doing the same job.

A company may say that if it is to keep compensation costs equal for employees with identical work experience and skill, it has to raise deductibles for employees whose health decisions, like smoking, result in higher absenteeism and higher company compensation costs.

"That is a message we are seeing a lot of," Ms. Williams said.

Steps employers are taking to improve employee health are detailed in the Hewitt survey, "Managed Health: Employer Health Promotion Initiatives." Some 618 employers, most with more than 1,000 employees, were surveyed; 76% offer at least one health promotion activity.

For various reasons, employers aren't sure whether health promotion programs are actually saving money, Ms. Williams said.

For employers that take only small steps—like publishing a health newsletter—trying to mea-

sure the results may cost as much as the program.

Other employers, Ms. Williams, said, have read of other employers' success with health promotion programs and are convinced the programs will work. Those employers say it isn't necessary to try to measure results.

Employers cite a variety of objectives in health promotion. The two most popular were improving employee health, cited by 86% in the survey, and containing health costs, cited by 84%. Improved employee morale was cited by 40%.

Most—88%—of employers said they designed their own health promotion program, while 19% used an outside vendor and 10% used an association, like the American Heart Assn. Some 7% used a local hospital and 10% tapped other sources, like a local health club or a health maintenance organization.

While employers typically design health promotion programs internally, they often bring in outside experts, like consultants, to discuss ideas.

"Employers want to hear about the experiences of other companies. Some companies will ask us: 'Take a look at what we are doing and tell us what we can do better or differently.' They will want to know whether they are using their resources wisely," Ms. Williams said.

SAIF Executive Vp Katherine Keene says nothing in the new claims settlement act—or any other state law—will make SAIF change its current claims handling procedures, because they comply with existing law.

SAIF is challenging the regulators' motives and conclusions. "This process has not been objective," Ms. Keene asserted.

She also complained about "excessive" regulation, which she said favors less efficient insurers.

"The notion of the regulator that all insurance companies must play by the same rules is fine. To expect all companies to conform to an incorrect interpretation of those rules rewards mediocrity," SAIF said in its response to the department's report.

The regulator's approach is "fundamentally flawed" because it fails to recognize SAIF's historic mission to improve the system through effective competition, SAIF said.

Despite SAIF's recalcitrance, Mr. Weeks said that recent conversations with SAIF personnel indicate that the insurer is making some changes in its practices.

For example, Mr. Weeks has heard that SAIF claims handlers are making more of an effort to investigate individual claims before deciding whether to accept or reject them.

SAIF denied that it has altered its procedures for the handling of claims.

The controversy has sparked "a lot of concern" by legislators and groups interested in workers comp, said the Labor Committee's Ms. Talbott.

SAIF's proponents include two business groups that offer their member companies an option of participating in group workers comp insurance programs underwritten by SAIF.

"Let the system work and quit bothering SAIF, which is doing a magnificent job," said Karl Frederick, vp and director of legislation for Associated Oregon Industries in Salem.

"SAIF appears to be the only
Continued on next page

Some 41% of employers said they offer an on-site exercise facility, while 38% provide exercise classes. In addition, 32% obtain corporate discounts on health club dues and 32% provide fitness education classes. And, 22% of employers subsidize the cost of off-site exercise classes or health club memberships.

While corporate exercise facilities may be popular with workers, Ms. Williams questions how good an investment they are for employers.

"They provide a convenience for employees who probably would be exercising anyway. Meanwhile, the 250-pound employee who is afraid of how he or she would look in a leotard probably won't go," Ms. Williams said.

Other employers take a more direct role in health promotion. For example, 51% of employers said they offer health risk appraisals, a written questionnaire in which employees are asked about certain health habits, like smoking or exercising. Feedback from the appraisals can help employees detect certain health conditions they may not be aware of, and may identify unhealthy aspects of their lifestyle that can be changed.

Among employers offering health appraisals, 38% provide them at all corporate locations; 27% provide them at corporate headquarters and certain other locations; 15% offer them only at corporate headquarters; 13% with one location offer at that location, while 3% offer them only at certain non-headquarters locations. Four percent offer appraisals at other locations, like an HMO.

Of those employers offering appraisals, 69% provide them only to employees, while 13% provide them to employees and spouses regardless of whether they are covered under the medical plan. Four percent only provide them if the employee and spouse are covered by the medical plan.

In addition, 11% of employers say they offer health appraisals to employees, spouses and dependents regardless of whether they are covered by the medical plan, while 3% offer appraisals only to employees, spouses and dependents covered under the company's med-

ical plan.

Only 15% of employers offering health appraisals impose penalties or provide incentives to encourage participation. Incentives or penalties include different employee contributions to the medical plan, different flexible benefit plan credit allocation, prizes or, in the case of 2% of employers that responded, requiring a health appraisal as a condition of employment.

Other employers offer health risk assessments—physical and biomedical tests that screen for specific health conditions, like high blood pressure or diabetes.

Fifty-nine percent of employers offer assessments, including 56% on a voluntary basis and 3% on a mandatory basis. Thirty percent of employers do not provide assessments, while 11% say they may offer assessments within the next two years.

Eighty-three percent of employers do not impose penalties or give incentives to employees to participate in health assessments, while 2% make participation a condition of employment. Other employers base either employee contributions to the medical plan or coverage levels on participation in a health assessment program.

Fifty-four percent of respondents said they use a local hospital, clinic or specialized firm, like a mobile testing service, to conduct health risk assessments, while 33% conduct the tests in house and 13% use other methods, like a combination of providers.

Employers also are trying to improve the health of their employees by paying a higher percentage of expenses for certain preventive services in their indemnity plans.

For example, 21% of respondents provided higher levels of coverage—compared to other medical services—for mammograms, while 19% offered a higher level of coverage for both Pap smears and well-child care.

Copies of "Managed Health: Employer Health Promotion Initiatives," are available from Diane Schuett, Hewitt Associates, 100 Half Day Road, Lincolnshire, Ill. 60609-708-295-5000. The cost is \$75.

Oregon controversy

Continued from page 3

In a report released in February, the Insurance Department said that SAIF's denial rate for disabling claims was substantially higher than the denial rate by private and self-insured employers in each of the past four years. A disabling claim typically involves more than three lost days of work or a permanent disability.

For example, during the first 10 months of 1991, SAIF denied 29% of all disabling claims, according to the department. Originally, the insurer's denial rate was reported at 44.9%, but that was reduced after a SAIF reporting error was corrected.

Still, the corrected figure is nearly double that reported by private insurers and self-insured employers in the state, the department charges.

The department also compared SAIF's claims handling to that of the state's largest private workers comp insurer, Liberty Northwest Insurance Corp., a Portland-based unit of Liberty Mutual Insurance Co.

That comparison led the department to identify "several issues of concern" with SAIF's practices. These included SAIF's:

- Investigation of claims. "While SAIF's claims philosophy requires investigation in determining compensability, in practice, claims are denied prior to the completion of an investigation," the department's report said. This occurred in 15.3% of the files examined.

- Proof-of-injury requirements. "SAIF places the burden of proof on the worker at the time the claim is filed," the report said. However, the law requires that the burden of proof not fall on the worker unless the claim ends up in litigation.

- Analysis of medical evidence. In addition, SAIF routinely denies claims when it has any reason to doubt whether a claim is valid, according to the report. SAIF "does not differentiate between 'doubt,' 'any doubt' and 'legitimate doubt' in their compensability determinations," the department said.

The department contends that SAIF takes too narrow a view of what constitutes "medical evidence supported by objective findings," which is the legal standard for a compensable claim.

That issue is being litigated by a SAIF workers comp claimant before the Oregon Court of Appeals.

The department followed its study by warning SAIF to better adhere to state requirements in administering claims.

Department Director Gary K. Weeks later told SAIF that the department would conduct "a compliance examination" in December "to assure that (its) claims management practices are in compliance with the law."

Immediate sanctions were not sought for several reasons, including the fact that the state's conclusions were based on a survey of 1991 claims, most of which SAIF processed before it was subject to Oregon's Unfair Claims Settlement Practices Act, a department spokesman said. The act became effective Sept. 29, 1991.

The state Senate's Labor Committee held a hearing last month on the controversy that has developed since the department released its report and raised additional concerns.

For example, the Senate committee questioned why SAIF covered the cost of medical payments for injured workers whose claims were denied, according to Annette Talbott, committee counsel.

The department's Mr. Weeks says the department's position is also supported by a Feb. 12 opinion letter from the state's Department of Justice to SAIF.

The opinion stated that many of the claims-handling investigations by SAIF that the Department of Justice studied were "clearly adequate" under the old standard but "may well have been judged debatable or clearly inadequate" under the newer standard.

However, Chris Davie, SAIF's manager of governmental affairs, emphasized the "may" in that statement and said that "the new standard wasn't applied" in the Justice Department's study.

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NAIC, industry square off over dividend limits

By MEG FLETCHER

Insurers fear model law will cause insurer capital to dry up

SEATTLE—State insurance regulators are squaring off against insurers, bankers and state legislators over the appropriate definition of "extraordinary dividends" paid by insurers.

At issue is the size of dividends an insurer can pay to individual and corporate shareholders without approval from state regulators.

The National Assn. of Insurance Commissioners says that extraordinary dividends that exceed the lesser of 10% of surplus or net income should be subject to regulatory approval. That language is contained in the NAIC's 1986 model act for insurance holding companies.

Requiring prior approval for dividends exceeding that benchmark allows state insurance departments to prevent excessive dividend payments that could jeopardize the solvency of an insurer, regulators contend.

However, insurers, bankers and state legislators generally want a higher threshold, like the one in the old model act, which was "the greater of 10% of surplus or net income."

In addition, they would like to consider other ways to limit regulators' ability to intervene in insurers' dividend payments to increase investors' comfort level.

Critics of the new model act warn that if the benchmark is not raised, insurers will find it more difficult—and more expensive—to attract capital, which in turn could reduce capacity.

However, "there is no going back to the old standard," NAIC President William H. McCartney, the Nebraska insurance commissioner, vowed at the start of a public hearing held during the NAIC's spring zone meeting in Seattle.

The difference between the two standards is significant, he emphasized.

An NAIC study of stock insurers' dividend payout capabilities in 1990 showed that property/casualty insurers' collective dividend payment ability, without regulatory approval, was nearly \$8.5 billion if the standard was set at the "lesser" of 10% of surplus or net income, compared with nearly \$20.6 billion if approval was not required unless dividends exceeded 10% of net income or surplus, whichever is greater. For life/health insurers, the "lesser" standard would have permitted \$5.7 billion in dividends without regulatory approval, compared with \$13.1 billion under the "greater" definition.

"The difference is dramatic and completely illustrative of the reason that the now-replaced 'greater of' standard cannot be viewed by any reasonable stretch to be 'substantially similar' to the 1986 language," Mr. McCartney said.

The NAIC does not know how much insurers actually pay out in

dividends annually, though the regulatory group's staff is trying to develop such data.

The NAIC committed itself to the tougher standard late last year after reviewing the issue at the request of accreditation review teams, which evaluate whether an individual state has enacted standards that are similar to certain NAIC model laws.

The teams sought NAIC guidance last year because they were uneasy about whether states should be allowed to use the old dividend standard and receive accreditation.

"The Financial Regulation Standards and Accreditation Committee extensively debated this issue... and determined that the 'lesser of' language must be present in order for a state to be accredited. The Executive Committee adopted the Accreditation Committee's position and it was then endorsed" by the full NAIC in December, Mr. McCartney said.

"After legislative sessions began, opposition to the 1986 language began to mount in several states. Lobbyists and others advocating against the stricter standard have conveyed misinformation—some of which has been attributed to me—which has been effective in blocking legislation in several states," he said.

The misinformation included statements that the NAIC never voted on the new standard, that it now is considering reversing its decision to adopt the standard or plans to do so in the future.

It is "simply unacceptable" to think that the NAIC would reverse its position and go back to a "greater than" standard, Mr. McCartney said at the hearing.

However, NAIC leaders now say they would consider as acceptable a state law that is substantially similar to the "lesser of" language.

"Verbatim compliance is not required," said Earl R. Pomeroy, insurance director of North Dakota and chairman of the Accreditation Committee. While the "greater than" language alone is not allowed, a law incorporating the "greater than" standard with other restrictions "may not be deal killers," he said.

The NAIC held the hearing at its Seattle meeting to receive testimony from about a dozen people on what other "dividend restriction schemes" could be "substantially similar" to the 1986 standards, Mr. McCartney said.

The regulators' introductory remarks have gone a long way in clarifying the situation, said Phillip Schwartz, vp-financial reporting and associate general counsel with the American Insurance Assn. in Washington, D.C. But, "we still need to get a clearer understanding of what will be acceptable as 'substantially similar,'" he said.

Among the states, only a few

have laws that are identical to the 1986 model act, while others—including some accredited states—have adopted what appears to be unacceptable wording based on the pre-1986 model law.

Mr. Pomeroy, who chairs the accreditation committee, declined to categorize the states except to say that a state's dividend scheme must be evaluated and, if not in compliance, must be changed or the state will risk decertification by as early as Oct. 1, 1993.

The NAIC accreditation program generally gives accredited states two years to comply with changes in accreditation standards.

New Hampshire state Sen. Leo W. Fraser, speaking as chairman of the National Conference of Insurance Legislators' Task Force on Insurer Solvency, said that while NCOIL generally supports the NAIC's accreditation process, state insurance regulators need to be wary of "overly restrictive barriers to upstream dividending from insurers to affiliates and parents."

"Indeed, the record shows that insurer solvency can be best served when dividend channels within holding company systems are kept open," he said. "In the first half of 1991 alone, capital infusions from

'There is no going back to the old standard,' says NAIC President William H. McCartney.

parent companies improved the financial positions of 10 large life insurers."

Sen. Fraser urged state insurance regulators to give state legislators three options in drafting state legislation containing a prior approval standard for dividends or risk being criticized for usurping legislators' prerogatives. Those options include: the NAIC-preferred "lesser of" language, the "greater of" language or establishment of a uniform standard of 10% of policyholder surplus.

NCOIL's recommendation "supports prior approval by commissioners of dividends or accumulations of dividends that impair solvency. But, at the same time, it would leave room for state enactments which respond to state needs and the financial condition of domestic insurers within national minimum standards," Sen. Fraser said.

"The old rule is too permissive and the new rule is too restrictive," said David J. Brummond, assistant vp and assistant general counsel of the National Assn. of Independent Insurers in Des Plaines, Ill. Insurers need greater latitude in their dividend practices

without prior regulatory approval, he said.

"The most objectionable aspect of the current extraordinary dividend provision is the NAIC's condition that a single test must be applied to all companies regardless of their financial situation," said Lenore S. Marema, vp-legal and regulatory affairs for the Alliance of American Insurers in Schaumburg, Ill.

The new, tougher standard for extraordinary dividends should apply only to financially troubled insurers, she said.

In addition, the NAIC's "strong" focus on extraordinary dividends seems "unwarranted" at this time because of significant improvements in state solvency regulation, Ms. Marema added.

The rigid requirement of a "lesser of" standard should be relaxed, because it is "a mechanical, artificial rule" that creates a roadblock to an insurer's ability to reward investors with dividends, said James M. Jackson, vp and deputy general counsel of Transamerica Occidental Life Insurance Co. in Los Angeles.

Had the rule been in place in California during the past eight years, Transamerica Occidental would have had to seek prior notification in four of those years before paying dividends, he said.

Such a rule is "puzzling" to investors and lenders who greatly prize predictability and who become "nervous" at the prospect of regulatory approvals for dividend payouts, Mr. Jackson said. The result is to discourage lending and investment in the insurance industry, he said.

Meanwhile, B. Shelby Baetz, senior attorney with American General Corp. in Houston, suggested that "the best way" to ensure an insurer's capital adequacy is to use a dividend-approval requirement based on an insurer's risk-based capital (BI, Dec. 9, 1991).

"For example, a company with a risk-based capital (to surplus) ratio of 1.00 would be subject to the 'lesser of' restriction. A company with risk-based capital ratio of 1.50 or greater would be subject to the 'greater of' restriction. A company with a risk based capital ratio of 1.25 would be subject to a limit equaling the sum of the 'lesser of' restriction, plus 50% of the difference between the 'greater of' restriction and the 'lesser of' restriction," she said in a statement.

However, Vincent Laurenzano, chief of the New York Insurance Department's Property Companies Bureau, is concerned about proposals that attempt to use the NAIC's risk-based capital thresholds for purposes other than the limited ones for which they were designed.

NAIC Vp Steven T. Foster, the Virginia insurance commissioner, said he was "just astonished" at

the high level of interest in the risk-based capital topic at this time.

However, nearly all regulatory discussion of the issue had been behind closed doors until now, insurer spokesmen countered.

In other action at the NAIC's Seattle meeting:

• David B. Simmons, the NAIC's general counsel, was promoted to executive vp, the organization's highest administrative position, effective last week.

He will succeed Sandra L. Gilfillan, who is resigning to own and manage a country inn with her husband in Estes Park, Colo. Ms. Gilfillan had been executive vp for nearly five years.

Mr. Simmons, 42, has been the NAIC's general counsel since May 1988. Before joining the NAIC, he served as assistant commissioner and chief counsel to the Arkansas Insurance Department.

The NAIC honored Ms. Gilfillan by renaming the Robert Dineen Award, its most prestigious award for state insurance regulators, the Dineen-Gilfillan Award.

• The NAIC announced a new operational plan for quarterly meetings beginning in June that will delay plenary sessions, where members take final votes on recommendations.

Under the new plan, the NAIC will take final votes on issues discussed during a quarterly meeting on the opening day of the next meeting. Under the old format, final votes on issues discussed during a quarterly meeting could have been taken on the final day of that meeting.

The new schedule will allow regulators to consider issues for several months before taking a final vote.

• Eight consumer representatives attended their first NAIC meeting as part of an NAIC effort to broaden input into the development of regulations.

The NAIC allocated \$50,000 this year to help pay those representatives' expenses.

• The NAIC released for comment several model laws, including one designed to protect the rights of policyholders when their policies are transferred from one insurer to another through assumption of reinsurance contracts.

The model, which primarily affects individuals who purchase annuity-type products from life insurers, states that a policyholder's consent is implied after two notices are sent during a three-year period.

However, Joseph M. Belth, an Indiana University insurance professor and editor of an industry newsletter, is urging consumers to contact the NAIC to demand that a policyholder's affirmative consent be necessary before a transfer and that insurers give policyholders the information necessary to make a sound decision on whether to agree to the transfer. ■

Oregon controversy

Continued from previous page
insurer taking full advantage of the tighter claims standards in the (workers comp) law, which benefits employers," said Jeff Davidson, an official of the Oregon-Columbia Chapter of Associated General Contractors.

However, the Oregon office of the National Federation of Independent Business has a different view.

"We support the idea of aggressive claims management.

However, SAIF's refusal to follow the Insurance Department's request to examine its claims handling process causes us great concern," says NFIB State Director Joe Gilliam in Salem.

"By SAIF not wanting to review their practices, it appears to the public that SAIF is taking unfair advantage of injured workers, which could lead to support to undo the reforms," he said.

SAIF's opponents also include

Liberty Northwest.

SAIF's assertions that it is doing things correctly is "ludicrous," said Steve Beckham, Liberty Northwest's government affairs manager. "I don't think SAIF is complying with the letter of the law or the spirit of the law."

SAIF's claims handling practices have not put Liberty Northwest at a competitive disadvantage, but its tax-exempt status has, Mr. Beckham pointed

out.

Labor also is critical of SAIF. "We are concerned SAIF is denying disability claims at two times the rate of private carriers and self-insured employers," said Brad Witt, secretary-treasurer of the Oregon AFL-CIO. He said the union "fully supports" the department's oversight and regulatory activities.

Meanwhile, SAIF's orientation and operations are expected to continue essentially unchanged

despite upcoming personnel changes.

SAIF President Stanton F. Long is leaving to become president of the cost containment division of American International Group Inc. in New York around May 1. His replacement will be named by the SAIF board.

Oregon's governor also will be appointing two members of SAIF's five-member board of directors when terms expire in June. ■

INTERNATIONAL

Battle for Skandia has no clear winner

By MARIA KIELMAS and GAVIN SOUTER

LONDON—The resolution of attempts by Denmark's Hafnia Insurance Co. Ltd. and Norway's UNI Storebrand A/S to take over Skandia Insurance Co. Ltd. of Sweden may hurt the credit ratings of the companies involved. Standard & Poor's Corp. last week placed several Skandia units on CreditWatch with negative implications. S&P cited the debt Skandia will incur to extricate itself from the tussle, as well as poor 1991 results. UNI Storebrand also is likely

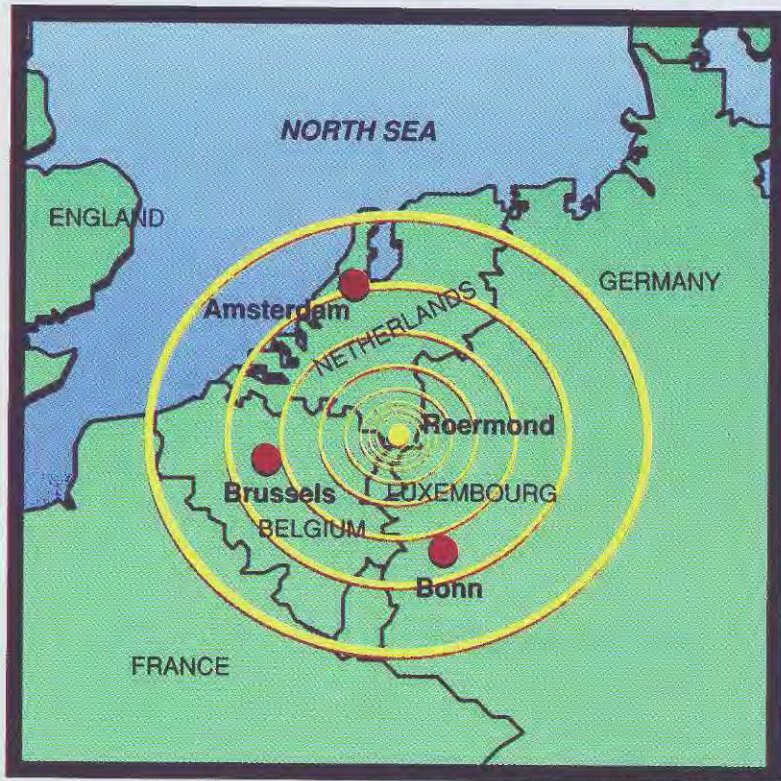
to suffer from its involvement in the deal, S&P said. Under an agreement reached April 9, Skandia will buy 100% of Hafnia through a stock swap, merging it into its Danish operations. And, in return for surrendering its Skandia stake, UNI Storebrand will obtain all of Skandia's international reinsurance operations, with the exception of its U.S. reinsurance arm, Skandia America Reinsurance Corp. (BI, April 13). "In the long term, it's quite a fundable deal for Skandia but it will take it quite a long time to digest it and that could be detri-

mental in the short term," said Paul Galpin, a vp with S&P in London. If the purchase goes through, Skandia will significantly increase its debt due to the debt owed by Hafnia, he said. Prior to the move on Skandia, Hafnia had acquired a 33.7% stake in Denmark's largest insurer, Baltica Insurance Co. Ltd. Other analysts, many of whom have been very critical of the exercise from the outset, believe the deal is untidy but the best that could be arranged. "It's the best of a bad job. It wasn't an incredibly neat solu-

tion," says Jonathan Lawlor of London-based Kleinwort Benson Securities. "Reading between the lines, no continental white knight was going to come along and rescue UNI Storebrand and Hafnia, so it had to be an internal solution. It does leave a few ends untied and it was an ignominious exit for UNI Storebrand." One outcome of the tussle is that Hafnia Chief Executive Per Villum Hansen and Deputy Chief Executive Henrik Klaebel have resigned. Hafnia's annual statement, published April 9, noted that the

company's shareholding in Baltica and Skandia had a "negative effect on the investment result, and also the direct return deteriorated as a consequence of interest expenses connected with capital tied up in the investments." Tim Dawson, stock analyst at Merrill Lynch Capital Markets in London, said: "Hafnia management have gotten their just deserts. To quote Oscar Wilde, to do it once with Baltica may be unfortunate, to do it twice with Skandia smacks of carelessness." Mr. Dawson adds, "UNI Store-

Continued on next page



GRAPHIC BY JOHN HALL

European quake damage confined to personal lines

By DON LEWIS KIRK and GAVIN SOUTER

BONN, Germany—Western European companies escaped largely unharmed from a freak earthquake last week that was centered in southeastern Netherlands. While damage in the region affected by the quake is estimated at about \$60 million, it was confined almost exclusively to homes, which suffered toppled chimneys, damaged roofs and walls, and to automobiles hit by

falling debris. Insurance industry officials point out that earthquake damage is excluded from European property insurance policies. And, while the coverage is available separately, few companies or homeowners purchased the coverage. The epicenter of the quake, which measured 5.8 on the Richter scale, was near Roermond, Netherlands. More than 200 homes were reportedly destroyed in the town, which is near

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Current Lloyd's bailout idea had frightened off task force

By STACY SHAPIRO and GAVIN SOUTER

LONDON

LONDON—An idea that Lloyd's of London senior executives currently are considering to alleviate members' loss burden was considered earlier this year by the task force examining the market but was not included in its report. The task force favored making a compulsory stop-loss scheme to cap members' heavy losses retroactive to 1988, Robert Hiscox, one of the task force members, said last week. But losses from syndicates managed by Gooda Walker Ltd. "looked so horrific" that the rec-

ommendation was left out of the task force's report, said Mr. Hiscox, chairman of managing agency Roberts & Hiscox Ltd. Instead, the scheme proposed by the task force would cap members' losses at an amount equal to 100% of their overall premium limit in any underwriting year, but would not take effect until the 1993 underwriting year (BI, Jan. 20). Now, however, making the stop-loss fund retroactive may be reconsidered, Mr. Hiscox said. That move is one being consid-

ered by Lloyd's executives to bail out members facing billions of dollars in losses from 1988 to 1990 (BI, April 13). Such a central solution "will be a very hard sell" to members who have not been seriously affected by the 1988-1990 losses, Mr. Hiscox said last week. Another possible solution would be for Lloyd's to indemnify banks for loans to members to pay the losses over a 10-year period, suggested Mr. Hiscox. This could be done through Lloyd's runoff insurer CentreWrite Ltd., he said. Speaking at a conference last week in London, sponsored by

Continued on next page

With Home under belt, European partner sought

Trygg-Hansa eyes growth

By JUDY GREENWALD

NEW YORK—Trygg-Hansa SPP Holdings A.B., which acquired a majority interest in The Home Insurance Co. last year, now wants to find a European partner, says a top official. "The present plan is to find a strong strategic operation in Europe with cross ownership," said Lars-Goran Nilsson, the Trygg-Hansa executive vp who is executive vice chairman of Home Holdings Inc., Home's immediate parent. Stockholm, Sweden-based Trygg-Hansa would like to team up with another European insurer whose capacity could easily compete with the largest

companies' and is now searching for a partner with that in mind, said Mr. Nilsson. Only 10 to 15 companies in Europe would fit the bill. "You just have to eliminate" and go down the list to find a partner, he said. James J. Meenaghan, chairman, president and chief executive officer of The Home, noted that acquiring The Home put Trygg-Hansa on a short list of insurers that have strong positions in both Europe and the United States. Others include Allianz A.G. Holding, which owns Fireman's Fund Insurance Co., Skandia Group, Zurich Insurance Co., American International Group Inc. and CIGNA Corp.

Home Holdings, which is about 60% owned by Trygg-Hansa, acquired The Home Insurance Co. from troubled AmBase Corp. in February 1991 for \$541 million in cash (BI, Feb. 18, 1991). "The fit between (Home and Trygg-Hansa) is fine," said Mr. Meenaghan, noting that The Home has been attracting additional international clients since the acquisition. The acquisition has worked well particularly in light of The Home's decision to focus on insurance for mid-sized to large businesses, as well as on specialty lines like errors and omissions and directors and officers liability, he said.

Continued on next page

Filipino ban on new insurer formations lifted

By REYNALDO A. de DIOS

MANILA, Philippines—President Corazon C. Aquino has lifted a more than 25-year-old ban on new insurance company formations imposed by former President Ferdinand Marcos. The ban was imposed in 1966 by an executive order because the domestic market was perceived as being too crowded. The move ultimately is expected to strengthen the Filipino

insurance industry, although the market's immediate reaction was cautious. Ms. Aquino in January issued a directive to Insurance Commissioner Adelita A. Vergel de Dios to resume issuing licenses to new insurance companies that meet regulatory requirements. Subsequently, the Department of Finance last month issued new regulations for insurance companies in the Philippines. These include rules governing foreign

ownership and capital and surplus requirements, among other things. Specifically, the rules say "an existing domestic life or non-life insurance company or professional reinsurance company, or one which may be organized hereafter, is allowed to do business in the Philippines with non-Philippine national stockholders provided the equity of the latter does not exceed 40% percent of the outstanding capital."

Various capital and surplus requirements for new insurance and reinsurance companies are promulgated by the new rules. These include:

- New life or non-life insurers, which will require paid-up capital equal to at least 75 million pesos (\$3.2 million) and surplus of at least 25 million pesos (\$1.1 million).
- New composite insurers, which will require paid-up capital of 150 million pesos (\$6.3

million) and surplus of 75 million pesos.

- New reinsurers, which will require paid-up capital of 120 million pesos (\$5 million) and surplus of 30 million pesos (\$1.3 million).

 Reactions to the new regulations have been mixed. The Filipino market is still considered overcrowded, and the entry of new insurance companies at the required capital

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INTERNATIONAL

Home prospects

Continued from previous page

Policyholder interest in The Home has increased dramatically, particularly since a \$125 million capital infusion last fall, said Mr. Meenaghan, adding that "a good part of it is this international dimension" (BI, Oct. 21, 1991).

Outside of Sweden, Trygg-Hansa also targets commercial business, which "fits very well with what The Home is doing," said Mr. Nilsson.

He noted most European insurance companies are multiline, rather than specialized, insurers. This means Trygg-Hansa can go forward and invest, not divest, he said.

The Home's future looks bright, Mr. Meenaghan said, and its relationship with Trygg-Hansa is certainly helping. Large companies are trying to develop on the multinational level, and they want insurers that can operate the same way, he explained.

Interest in The Home's international capabilities is coming from cities like Jackson, Miss., and Milwaukee. "It just isn't New York and L.A. and Chicago," he said. "It came at us at a rate I hadn't anticipated, to be honest with you."

Insurers that want to be successful need money, strength and the perception that they have staying power, Mr. Meenaghan noted. With its new ownership, The Home now has a financially secure position that it has not had in the past 25 years, he said.

"You've got to have the cash."

Market focus is also needed to be successful, he said, including a knowledge of "what is it you're going to do." The Home has established this focus, he said.

Expenses are a third important element, said Mr. Meenaghan. "You've got to have your costs down" or else you cannot be price-competitive.

Fourth, you need people, he said. "You've got to have really good people in your offices."

"We're working in these areas

'You've got to have your costs down' or else you cannot be price-competitive, says Mr. Meenaghan.

and many others at the same time," he said, adding, "our prospects are very good."

He noted, for instance, that over the past five years, The Home has shaved its staff by a third to 4,300 from 6,600 employees. Yet skilled positions have not been cut, and The Home is paying employees over the market rate. Instead, it has cut staff by eliminating clerical help.

The company's philosophy is to have as many talented people in as many places as it is prudent, said Mr. Meenaghan, noting that this is different from the trend at other insurers that are consolidating operations. ■

Skandia battle

Continued from previous page

brand got off pretty lightly, while Skandia quite unjustifiably got off very well since, from a corporate governance point of view, Skandia's underwriting record, especially in Sweden, is not very good."

Skandia has reported a 645 million Swedish krona (\$116.6 million at year-end 1991 exchange rate) aftertax loss in 1991, compared with a 228 million Swedish krona (\$40.5 million at year-end 1990 exchange rate) profit in 1990, says S&P.

The messy affair started when UNI Storebrand and Hafnia jointly acquired 42.9% of Skandia last November (BI, Dec. 2, 1991) and announced that they planned to form a pan-Nordic insurance alliance.

Their ambitions were stalled, however, because Skandia's voting structure allows for each shareholder to have only one vote, irrespective of the size of its holding. In addition, Norwegian insurance authorities earlier this year instructed UNI Storebrand to either resolve the takeover or reduce the size of its Skandia stake by June (BI Feb. 10).

At the time of the April 9 agreement, UNI Storebrand held 28% of Skandia stock, while Hafnia held 14.9%.

UNI Storebrand said that it will combine the Skandia reinsurance operations with its existing international operations into a new company to be named

Christiania International Insurance.

The Skandia reinsurance operations it will assume represent a net premium volume of 3.8 billion Norwegian kroner (\$584.1 million at current exchange rates) and involve 450 employees spread throughout 15 offices in Europe, Asia and Latin America. The Skandia shares it holds are valued at 4 billion Norwegian kroner (\$614.8 million).

Merrill Lynch's Mr. Dawson says that both sides have a relatively good deal here. "If Skandia were to go out and sell its reinsurance operations, it would get slightly less than that. If UNI Storebrand were to go out and buy it, it would probably pay less."

Mr. Dawson added that the deal appears to have been structured so that UNI Storebrand would not end up with a loss on its accounts after the whole transaction. "And it's probably not a bad time to buy into reinsurance," he said.

The merger of Hafnia and Skandia would produce an entity with gross premium volume of approximately 40 billion Swedish kronor (\$6.66 billion) annually and total group assets of 250 billion Swedish kronor (\$41.63 billion).

Skandia's acquisition of Hafnia has drawn fierce criticism in Denmark, particularly from pension funds that are large shareholders of Hafnia.

Hafnia last week stressed in a statement to stock analysts that the deal is contingent, among

other things, on two-thirds of Hafnia shareholders giving their assent, as well as the approval of regulatory authorities in Denmark, Norway and Sweden.

Although the Nordic press has heralded Skandia as the winner in the affair, Mr. Dawson says that Skandia management also deserves some criticism.

"The performance of the group over time has not been good. Skandia has not had a happy experience with its international expansion. I hope this affair has shaken them up a bit."

S&P put several Skandia operations on CreditWatch with negative implications: Skandia International Insurance Corp.'s AA claims-paying ability, its AA-rated senior debt, and its A-1+ rated commercial paper; Skandia America Reinsurance Corp. and American Skandia Life Assurance Corp.'s AA claims-paying ability; the A-1+ debt ratings of Skandia International Capital Corp., Skandia Capital A.B. and Skandia International Holding A.B.; and the AA senior debt rating of Skandia Capital and Skandia International Holding.

S&P also put UNI Storebrand's A-1 eurocommercial paper rating on CreditWatch with negative implications.

Merrill Lynch's Mr. Dawson says that the entire experience will be a salutary lesson for all European insurers not to expand for the sake of expansion.

"Hopefully, they have all learned a lesson. I do detect a distinct change in the attitude of other European insurance groups. They have all had such a lousy year that you hear a lot more about premium rates and cutting expenses rather than going for expansion. I think the events of last year and the spectacle of what's happening in the U.K. has focused people's attention," he said. ■

LONDON

Continued from previous page

Westminster Management Consultants, Mr. Hiscox noted that the market "urgently needs a new Lloyd's act" to implement some of the radical reforms suggested by the task force, including allowing corporations to join Lloyd's as limited liability members.

That sense of urgency was not shared by Conservative member of Parliament Ian Taylor, who urged Lloyd's not to propose a new bill to the government until Lloyd's house is in order.

"If you want Lloyd's to continue, but you want to make it a place that's proud to work in, there is a great deal that you must do," said Mr. Taylor. "Intervention by Parliament should be the last resort."

While the market considers whether to aid members stuck with enormous losses, the leaders of 13 legal action groups comprising 6,000 members have formed a "super action group" to see if there is a single solution that would be acceptable to all the members, said Tom Benyon, chairman of the Society of Names. The members in the group together face around 1 billion pounds (\$1.76 billion) in losses.

Outhwaite delay

There is a delay in the payment of a 116 million pounds (\$203.6 million) settlement to Lloyd's of London members belonging to underwriter Richard Outhwaite's syndicate as Lloyd's threatens to hold the members' representatives liable for breach of trust if the funds are paid out.

Lloyd's contends the money should be paid into the members' premium trust fund held by their members' agencies.

Because the Outhwaite members' law firm, Richards Butler, and the Outhwaite 1982 Action Group are the current trustees of the settlement money, they could be in breach of trust if the funds are disbursed to the members, Lloyd's contends.

Richards Butler is challenging Lloyd's assertions in High Court, said partner John White Thomson, who represents the members. The members, meanwhile, are challenging Lloyd's claim to the funds.

Outhwaite members' stop-loss underwriters are also laying claim to some of the settlement money, since some of the members have made recoveries under their stop-loss policies for some of the Outhwaite losses, said Mr.

White-Thomson.

LUI creditors rebuffed

The assets of the four insolvent insurers owned by London United Investments P.L.C. are now protected from claims from creditors in the United States under a temporary court injunction.

The provisional liquidators of the companies, Chris Hughes and Ian Bond of Cork Gully, say the injunction gives them "breathing space" to determine how to distribute the funds available to creditors.

The four companies are: Kingscroft Insurance Co. Ltd., El Paso Insurance Co. Ltd., Lime Street Insurance Co. Ltd. and Mutual Reinsurance Co. Ltd.

The injunction was granted in the U.S. District Court in Manhattan under Section 304 of the Federal Bankruptcy Act.

A full hearing to permanently protect the assets will be held on May 12.

More than 150 suits are pending in the United States against the KELM companies, according to Cork Gully.

The companies have gross liabilities of between \$2 billion and \$2.3 billion. As of August 1990, the companies had total assets of 281.9 million pounds (\$544.1 million at year-end 1990 exchange rates) and liabilities net of reinsurance of 351.1 million (\$677.6 million).

"It has been difficult for us to get the full picture of the U.S. litigation in the short period since we were appointed. Many of the actions involve substantial pollution and environmental claims. The Section 304 relief should give us the opportunity to reach constructive solutions in the interests of all KELM creditors," Mr. Hughes said. ■

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Business Insurance

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Business Insurance
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INTERNATIONAL

European quake

Continued from page 31

the Dutch border with Belgium, Germany and Luxembourg.

The last severe earthquake to hit the Rhine region was in 1765.

In 1985, a major earthquake struck neighboring Belgium, causing about \$75 million in damage.

Few homes in Germany damaged by the quake are insured, said a spokesman for the Assn. of German Property Insurers. "The same applies to businesses and industry. There was just no demand."

Dutch insurers also do not expect to be troubled with property damage claims from the earthquake.

"The earthquake will not affect Dutch insurers because earthquake cover is excluded from most policies," said Rolf van der Wal, deputy chairman of broker Hudig-Langeveldt Group b.v. in Rotterdam.

The only policies that give coverage for earthquake damage are some manuscripted all-risk policies for large industrial clients and no large plants are located near the epicenter of the earthquake at Roermond, he said.

However, some claims may be paid under auto policies for cars damaged by falling masonry, Mr. van der Wal added. Dutch insurance policies cover damage caused by events related to—but not directly caused by—an earthquake, he said.

"But there were only maybe 300 or 400 cars damaged so the loss will not be large," Mr. van der Wal said.

Building owners will be stuck with property losses, confirmed a spokesman for insurer Nationale-Nederlanden N.V. in The Hague.

The earthquake has not been classified as a national disaster so state funds will not be used to meet rebuilding costs, he said.

Filipino insurers

Continued from page 31

and surplus levels is viewed as a threat to smaller existing companies.

The minimum capital and surplus levels for existing direct insurers are 10 million pesos (\$420,000) and 500,000 pesos (\$21,000), respectively.

The Insurance Commission says there are no plans to increase the capital requirements of the existing companies.

It is expected, however, that market forces will spur the domestic Filipino insurers, most of which are family-owned, to strengthen their capital base so that they can effectively meet the competition.

Mergers are also expected, although none has yet occurred.

Meanwhile, the entry of new investors in the domestic insurance industry is expected to increase the capacity of non-life insurers and lessen the market's dependency on overseas reinsurance.

In the life sector, new foreign investors will help improve the competitiveness in the market by introducing new technology and products to provide more benefits to the average buyer of life insurance policies.

The private insurance industry in the Philippines currently comprises 128 insurance companies, which include: 23 life insurance companies, 100 non-life insurers, two composite companies and three professional reinsurers.

"There have been some comments in Parliament about setting up a fund for the earthquake but it doesn't seem likely," the spokesman said.

German insurers note that interest in earthquake coverage has jumped since the quake.

However, a spokesman for Colonia Insurance Co. believes that the heightened interest will soon abate. "It's a short-term phenomenon," he said, adding that German insurers "do not as a rule offer insurance coverage for flood, earthquake, mountain

slides, avalanches or snow damage."

"Insurance coverage for earthquakes is new to most regions of Germany," noted a spokesman for Munich Reinsurance Co.

The first policies were available three years ago but few insurers actually offer the coverage. Until the quake, "most people would have laughed if an insurance agent offered them earthquake insurance," the spokesman said.

In 1990, Deutsche Lloyd Versicherungen A.G., a unit of Assi-

curazioni Generali S.p.A., began offering property insurance policies with optional endorsements for coverage of damage from floods, earthquakes, mountain slides and avalanches. A spokesman for the insurer in Munich said only three claims have filed from the quake.

Although the Rhine region in Germany contains most of the country's coal and chemical production facilities, there were no reports of industrial damage.

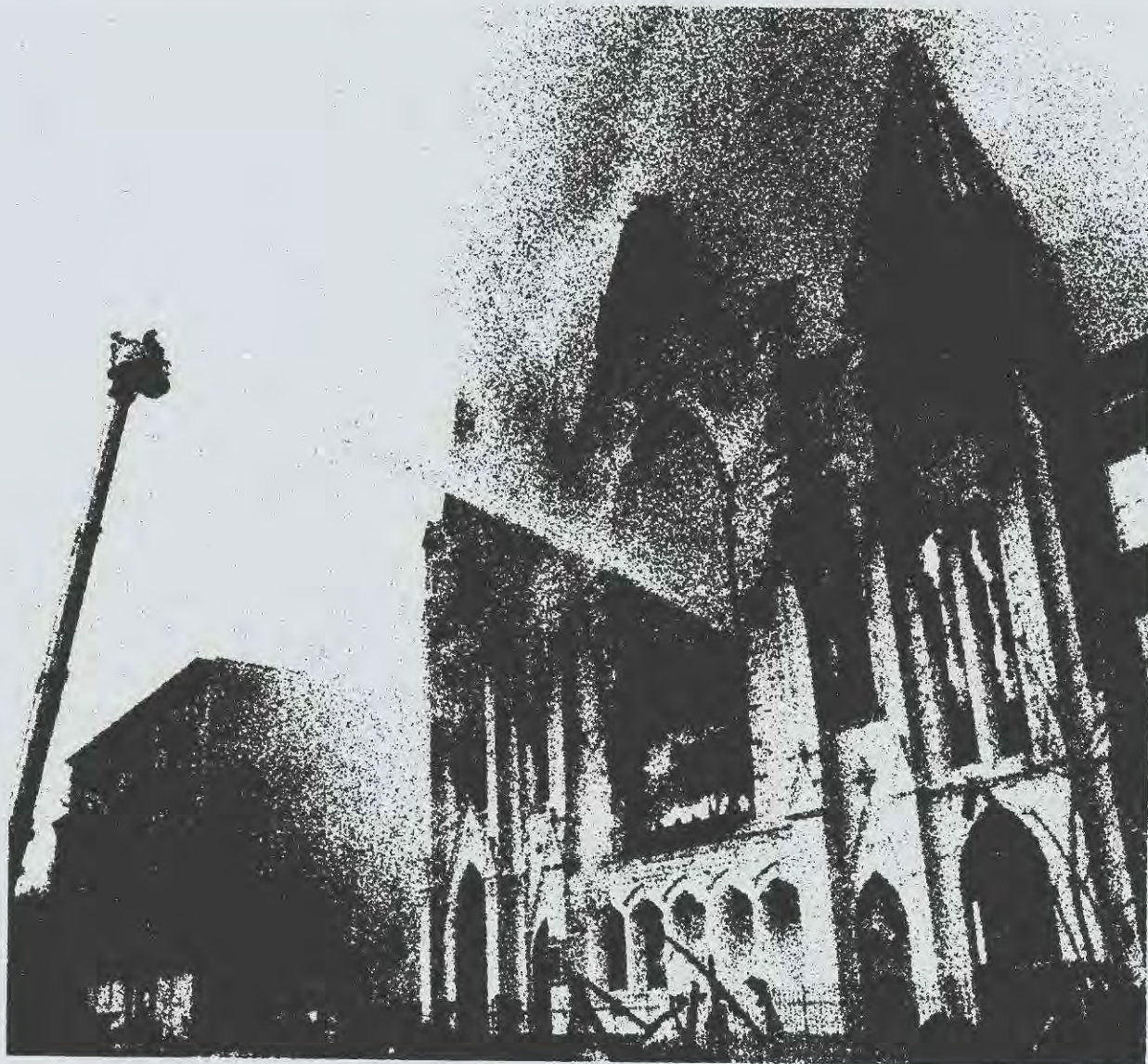
A spokesman for chemical manufacturer Bayer A.G. said

the quake was not strong enough to set off a plant's alarm system.

And steel producer Thyssen A.G. has inspected facilities and found no damage, a spokesman said.

Plant construction was secure enough to withstand the quake, he said, although the possibility of a quake was not considered when the facility was built.

Nuclear power plants in the region also were unaffected by the quake, even though some were shut down temporarily as a precaution.



AP/WIDE WORLD PHOTOS

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NCCI proposes residual market changes

By MEG FLETCHER

BOCA RATON, Fla.—The nation's largest workers compensation statistical and ratemaking organization is developing several new initiatives aimed at improving the efficiency of residual market servicing insurers.

The National Council on Compensation Insurance, based in Boca Raton, Fla., plans to file requests in July with state insurance regulators seeking approval of the changes.

Under the proposal, regulators could increase their oversight of the residual market in their state, replacing oversight provided since 1970 by the National Workers' Compensation Reinsurance Pool.

The pool, which the NCCI administers, is a voluntary, non-profit agreement among workers comp insurers that provides reinsurance to insurers that participate in residual market plans in many states. The pool's board of governors consists primarily of insurer and residual market plan representatives.

The NCCI also is proposing that state regulators require all insurers licensed to write workers comp in their jurisdictions to

either act as a pool member or accept direct assignments of residual market risks.

In a direct assignment arrangement, an insurer assumes total responsibility, including underwriting and claims payments, for certain policies written in the residual market without receiving reinsurance support from the pool.

Under the NCCI proposal, insurers could decide whether to participate as a pool member or accept direct assignments on a state-by-state basis, according to Chapin Clark, the NCCI's senior vp of rates and external affairs.

Currently, some states do not require all workers comp insurers to act as residual market servicing insurers or to assume direct assignments, he said.

All states, though, make workers comp insurers share the cost of residual market plan losses in proportion to the amount of their voluntary market writings.

If a regulator chooses to increase his or her oversight of the residual market, the plan administrator—which is the NCCI in most states—also would transfer to the regulator much of the authority for overseeing insurers that assume residual market

risks through direct assignment. However, the NCCI would continue to make the assignments and collect financial information.

In addition, the NCCI is developing more economic incentives to strengthen servicing insurer performance and cost management, which it hopes regulators will approve in concept by Jan. 1.

The program may include disincentives, like a reduced allowance, for servicing insurers that provide inadequate service, Mr. Chapin said.

The NCCI points out, though, that servicing insurers already have incentives to provide good service at a reasonable cost because servicing insurers share the residual market burden; must meet safety engineering and claims standards or face disciplinary action by the national pool's board; want to maintain a good corporate image; and want to maintain the monetary allowance they receive for acting as servicing insurers.

The NCCI also is recommending that state regulators adopt a more open appeals process to resolve disputes with employers over workers comp issues

like the proper classification of employees.

The organization wants regulators in each state to establish a five-person appeals board consisting of three members from the general public, one from the state insurance department and one from the NCCI. In addition, an insurer representative would participate as a non-voting member.

The proposed board would replace a committee of insurers.

The NCCI's proposals are part of its continuing effort to answer regulators' concerns about ways to improve the efficiency and effectiveness residual market operations.

The issue arose because "explosive growth" in residual market risks put "tremendous pressure" on workers compensation systems and insurers' ability to respond, Mr. Clark said.

Between 1984 and 1990, the residual market grew from 6% of the total workers compensation insurance market to more than 24%.

Regulators—including members of the National Assn. of Insurance Commissioners' Residual Market Working Group—generally acknowledge that the

NCCI is making progress toward improving residual market operations, but want the organization to continue to improve efficiency and cost-effectiveness (BI, April 29, 1991).

The NCCI also announced recently that it is in the midst of "a major structural change" that delegates to staff members much of the authority previously exercised by the council's member insurance companies.

The NCCI also plans at its annual meeting later this month to name its second board member from outside the insurance industry. John Sarpy, deputy director of the federal Occupational Safety and Health Administration, was named to the board last year.

A third outsider will be appointed in 1993, said President William D. Hager.

In addition, the NCCI also plans to move toward charging insurers a fee for the NCCI services they receive, rather than charging a flat assessment to support the council's activities.

This change should allow the NCCI to create and market services individually tailored to member insurers' needs, Mr. Hager said. ■

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Secretaries, Treasurers, controllers and other Financial Personnel . . . 4,204

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

Associations . . . 442
Government, Unions and Educational Institutions . . . 1,261

Commercial Consumers
Sub-total . . . 27,386

Insurance Agents and Brokers . . . 9,090
Insurance Companies . . . 8,128
Accountants, Actuaries, Attorneys & Consultants . . . 3,340
Adjusters, Appraisers, TPA's, Captive Managers & Health Care Providers . . . 1,529
Others Allied to the Field . . . 1,580
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.

London bombs

Continued from page 1

celebrating the Conservative Party's victory in the British election the previous day. Three police last week questioned suspects, two of whom have been charged in connection with a small bomb blast in London several weeks earlier.

An estimated 200 buildings were damaged in the explosions, ranging from some—including the CU building—that may have to be demolished to many with shattered windows.

The center of the City, London's financial district, was in chaos after the explosion, but "life will go on," summed up Lloyd's of London Chairman David Coleridge last Monday, the first business day after the bombing. "It's been going on in Northern Ireland for the last few hundred years. We will simply work as usual. . . . Of course, we won't be intimidated."

There had been a threat that Lloyd's would not open last week because the building had no power or telephones. But crews worked through the weekend to restore all utilities in time for normal opening Monday.

"We're up and running and working as normal," said a spokesman for Commercial Union Assurance Co. P.L.C., which had to move 650 employees to 15 alternative sites after the explosion caused heavy damage to CU's headquarters. "Our customers should be largely unaffected."

"It's business as usual and the tower has been working normally," said a spokesman for National Westminster Bank P.L.C., one of the nation's largest banks. Nat West's office tower headquarters—one of London's tallest buildings—lost 170 windows.

Most employees in the City trudged into work last Monday crunching glass under their feet, even though another bomb threat disrupted train travel into London.

Last week, as blocks around Lloyd's were cordoned off by police, loss adjusters assessed damage to buildings. No official damage estimates were released as of midweek, but media reports suggest insured and uninsured property damage could total 1 billion pounds (\$1.76 billion) to 1.5 billion pounds (\$2.64 billion).

Mr. Coleridge said while he thought that figure may be too high, "the loss will be huge."

A total loss of 1.5 billion pounds is probably exaggerated, said a spokesman for the Assn. of British Insurers. But the estimate may not be too far off if the cost of the estimated 12-month repair to the highway on the outskirts of London is included, he said. Highway repairs will be paid for by the British government.

Building owners' and tenants' property and business interruption policies will cover the cost of damage, loss of rent, moving expenses and loss of business under the "explosion" portion of property policies, the spokesman said. The bomb blasts will not be considered war risks, which are excluded from coverage.

Property damage caused by IRA attacks is excluded from property policies in Northern Ireland. Damage from bomb blasts in Northern Ireland is covered under a government compensation fund.

Commercial Union Chairman N.H. Baring told shareholders last week he would discuss with

government officials whether such a compensation fund should also cover IRA attacks on the British mainland.

In the City, the buildings most heavily damaged were the Baltic Exchange Chambers, the Baltic Mercantile & Shipping Exchange and the Chamber of Shipping, in front of which the van carrying the bomb was parked when it went off on St. Mary's Axe. Among those killed was a security guard for the Baltic Exchange.

It is likely that the actual target was the new Lloyd's building—a well-known site in London—which is only 200 yards away. However, road work was in progress in front of Lloyd's the night of the explosion, and Mr. Coleridge speculated the terrorists were forced to park the van around the corner outside the Baltic Exchange.

The new Lloyd's building—which was built to withstand hurricane winds—lost six windows and had a few outside pipes pierced by debris, but was otherwise unscathed. Lloyd's 1958 building across the street lost about 40 windows, Mr. Coleridge said.

Lloyd's had a bomb scare a week earlier, though that threat was probably a hoax unrelated to the subsequent explosion, said a Lloyd's spokesman.

Rebuilding the historic Baltic Exchange building will cost about 150 million pounds (\$264 million), said Peter Tudball, chairman of the Baltic Exchange, a ship charterers' organization with 600 members.

The coverage for the Baltic Exchange building has a limit of 115 million pounds (\$202.4 million), said Howard Fryer, a director at S.B.J. Stephenson, a division of broker Steel Burrill Jones Group P.L.C. that placed the coverage.

The exchange also has 30.8 million pounds (\$54.2 million) in business interruption coverage and 6.5 million pounds (\$11.4 million) of coverage for loss of contents, he said.

The property policy was led by Royal Insurance (Global) Ltd., he said. Royal wrote 50% of the coverage.

Initial damage estimates to the Baltic Exchange have been put at 50 million pounds (\$88 million) by loss adjuster Ellis & Buckle, Mr. Fryer said.

The exchange has the option to build a new building, but redevelopment costs would not be met by insurers, he said.

The Baltic Exchange also purchased personal accident insurance that will provide payments to the family of the security guard killed in the blast and to another security guard who was injured. The policy is led by a Lloyd's syndicate managed by R.J. Kiln & Co.

Lloyd's has offered temporary office space on its fourth floor to Baltic Exchange executives. That space will probably house 30 to 40 of the 100 to 150 full-time employees of the exchange and will be used for member meetings, said Mr. Tudball.

"Lloyd's has been magnificent and I personally thank Lloyd's for all their help," he said last week. "This shows the City at its best. 'Our word is our bond' is the motto of the Baltic Exchange, and I give my word to our members that that building will be rebuilt and we will return."

Although it may be two to three years before the Baltic Exchange returns to its own build-

ing, "no business is being lost to the London market" as a result of the bombing, he said.

Coverage for the Chamber of Shipping, a trade association for ship management companies, also was placed by SBJ Stephenson and led by Royal, which wrote 90% of the coverage.

The coverage is thought to have limits of up to 20 million pounds (\$35.2 million) for property damage and 2.5 million (\$4.4 million) for business interruption.

Also severely damaged is the 23-story Commercial Union building, which lost all of its windows on three sides and has been closed since the blast. Tenants say there also is extensive damage to elevators and stairwells.

Two CU employees and a guard were injured in the explosion.

Commercial Union leads the property coverage for the building. The insurer owns 20% and occupies less than 50% of the building. A consortium—including Goodwill Nominees and Prostel, a pension fund for employees of the British post office and British Telecom P.L.C.—owned the remainder.

Commercial Union also has business interruption and loss of rental income coverage.

Early last week it wasn't known whether the building would have to be demolished or could be restored, said Chief Executive Anthony Brend at the CU annual general meeting last week. The meeting had to be rescheduled for later in the week because it originally was to be held at the Baltic Exchange.

Tenants of the building say replacing the windows alone could cost from 10 million pounds to 100 million pounds (\$17.6 million to \$176 million).

Commercial Union also writes coverage for some of the other buildings damaged by the explosion, though it is not the lead insurer on any of these buildings, Mr. Brend said.

While CU has not calculated how much it will have to pay because of the explosion, "it will be as bad" as the 120 million pound (\$211.2 million) fire at the London Underwriting Centre last year, Mr. Baring said. Commercial Union will pay 11 million pounds (\$19.4 million) in claims from that fire, he told shareholders.

In line with the company's emergency planning, all key executives met less than 24 hours after the explosion to decide on a plan of action.

By Monday morning, 650 Commercial Union employees had been moved to 15 new locations. Those needed in London were transferred to Plantation House or the Broadgate development a few blocks away, while others were moved to offices elsewhere, mainly in Croydon.

All computer operations were set up over the weekend so that Commercial Union was "up and running" by Monday, said a spokesman, quoting the company's motto, "we won't make a drama out of a crisis."

However, CU, like other tenants, has not been able to remove much of the equipment and files still in the building. Police only allowed 100 representatives of the tenants two hours of access to the building on Monday, after which they barred access to the building because of the threat of falling glass.

"It's horrific inside our office," said Robert Hiscox, chairman of

Lloyd's underwriting agency Roberts & Hiscox Ltd., a tenant of the CU building. The agency is temporarily housed at managing agency Beazley Furlonge & Hiscox Ltd.

One agency employee went in on Saturday to move the agency's valuable art collection to safety and remove computer data and files.

By Monday, there was twice as much damage to contents because wind blew papers out the shattered windows, Mr. Hiscox said.

"It's a nightmare," Andrew Fleming-Williams, managing director of Winterthur Insurance Co. (U.K.) Ltd., said last week from temporary accommodations at Leslie & Godwin Ltd. Winterthur's London office, which employs 35 people, was located on the fourth floor of the CU building and is now in ruins, he said. "Anything that was sitting on someone's desk is now on the ground."

Mr. Fleming-Williams has found new space for the company in Guild House and hopes to be

operating normally by the end of next week. "In a perfect world it takes months to move offices," not days, he noted.

"It is amazing how marvelous people have been," he said, echoing others' sentiments. "We have had loads of offices offered to us and we're borrowing desks."

Other tenants in the CU building tell of similar generosity.

"Everything's sailing smoothly," said Geoffrey Johnson, managing director of Lloyd's underwriting agency M.J. Marchant Underwriting Agency Ltd. The agency, with about 38 staff, has new offices in Asia House on Lime Street near Lloyd's where the staff and computers were installed by the middle of last week.

"We had an emergency plan and mercifully it worked," said Mr. Johnson from his temporary home in the agency's underwriting box at Lloyd's. This plan included storing computer data off-site. While the agency thought it might have lost a day's computer data, five employees

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London bomb

Continued from previous page
were allowed to enter the damaged building and carry away "hand luggage" including the data, he said.

Fortunately, a lot of empty office space is available to accommodate those ousted from their offices, Mr. Johnson said. "We could have taken half the City so many offers poured in. But that's the way the Lloyd's community works."

Ironically, Lloyd's leading terrorist-related underwriters, Cassidy Davis Holdings Ltd., were

forced from their offices on the 18th floor in the CU building. Just under 80 people were moved to a pre-arranged site on Brushfield Street.

"The IRA bomb is an inconvenience and our office is wrecked," said Beryl Hobson, marketing manager for Cassidy Davis. A "sophisticated crisis management plan" was implemented over the weekend with team members working around the clock, the agency stated. By Monday, underwriting and claims employees were back to work.

Cassidy Davis decided which

data it wanted from the old offices—mainly records to close its syndicates' 1989 underwriting accounts, which are being audited, Ms. Hobson said.

In the meantime, other businesses around the City are picking up the debris and repairing windows and ceilings. Among them are the Institute of London Underwriters, the British Insurance Intermediaries Brokers Assn. and underwriting agency Merrett Holdings P.L.C., where a couple of people received minor injuries from the blast.

Some market officials, like Winterthur's Mr. Fleming-Wil-

liams are miffed that some Americans are canceling meetings in London in the aftermath of the explosion. "I feel much safer here than ever in New York," he said. "We've been struggling with this (problem) for 25 years."

Americans won't journey to London "and yet they risk death walking through New York every day," he said.

"People see this as a fact of life," added Merrett Managing Director Dennis Purkiss.

Associate Editor Gavin Souter in London contributed to this story.

PRIMA sets '92 meeting for May 17-20

Public entity risk managers are being invited to a treasure hunt.

From May 17-20, they will be seeking out "The Hidden Treasures of Risk Management" at the 13th annual Public Risk Management Assn. conference in Anaheim, Calif.

On Sunday, May 17, PRIMA is offering two day-long programs. The Basic Insurance Primer is aimed at new risk managers and will focus on coverage issues and policy questions they face in a day's work.

The second pre-conference program, Risk Management Information Systems for Pools, is designed for risk managers who are faced with buying a new information system and those who are not sure they are using their current system to its fullest potential.

In addition, a special one-hour briefing Sunday night will help new PRIMA members and first-time conference attendees get off on the right track. PRIMA staff members will be available to answer questions.

Regional meetings will be held on the morning of Monday, May 18, to allow participants to meet local PRIMA representatives and other risk managers in their area.

More than 70 risk management and employee benefit sessions will be offered on Monday, Tuesday and Wednesday, May 18-20. Specialized sessions are oriented toward new or advanced risk managers, employee benefit managers, school risk managers and risk managers whose governments are members of risk sharing pools.

Basic session topics include claims administration, contractual risk transfer and risk management techniques.

Employee benefit issues that will be covered include controlling costs in mental health and substance abuse treatment programs, funding wellness programs, integrating disability programs and coordinating retiree health benefits.

School risk management sessions will cover compliance with Occupational Safety and Health Administration regulations, new playground safety standards, lab safety for schools and how to communicate errors and omission exposures to a school board.

The annual business meeting for PRIMA's pooling section will be held during breakfast on Tuesday morning, May 19.

Pooling sessions will look at pooling medical benefits, pooling environmental risk management and a session for pools considering construction of a waterslide.

Participants also will be able to network with other risk managers and chat with vendors while touring the conference exhibit hall.

Registration fees for PRIMA members are \$450; additional registrants from the same member organization pay \$395. The fee for a non-members from the government sector is \$575, which includes a PRIMA membership. Fees for non-members from the private sector are \$695.

The registration fee includes conference lunches on May 18 and May 19 and tickets to the PRIMA "Shipwreck Party" on Wednesday night.

For more information, contact PRIMA at 1117 N. 19th St., Suite 900, Arlington, Va. 22209; 703-528-7966. ■

The IRI Difference:

Our Commitment to Your Long-Term Needs Is a Way of Life

When Harry Coor, IRI Senior Vice President-Operations, reflects back on a career that spans more than three decades, he recalls with great satisfaction the long-standing, uninterrupted relationships with many of IRI's insureds. Mr. Coor observes, "1990 was IRI's one hundredth year in business."



Harry Coor,
Industrial Risk Insurers

Our centennial celebration gave us a unique opportunity to visit with and pay honor to 185 customers who have chosen to do business with us continuously for fifty years or more... one, in fact, for ninety-eight years. I imagine that each of these customers has a personal perception of what The IRI Difference has meant to them decade after decade."

He continued, "In these days of instability, changing values, planned obsolescence and financial turmoil, it is comforting to know how many of these relationships have not only survived but have grown and been strengthened over the years. IRI's dedication to the highest standards of business ethics, fairness, honesty, and quality products and services continues with renewed intensity as we move into our second century.

"At IRI, our commitment to long-term relationships is not a hollow promise—it's an inherent characteristic of The IRI Difference, it's a way of life."

IRI

can make a difference

Flood damages

Continued from page 1
cluding the city of Chicago and a marine engineering firm, to recover damages.

At least two such suits were filed last week.

Precise estimates of damage, lost business and extra expenses taken to stem the tide of river water washing through the city's antique underground tunnels were unavailable last week as 11 buildings, including department stores Marshall Field & Co. and Carson Pirie Scott & Co., were left without power.

In addition, Commonwealth Edison Co. cut power to seven other buildings on Friday in an attempt to restore power to some flooded buildings. Other planned outages are likely, the utility said.

"At this point we can make no assessment of damage until the water is out," said Jim Oskandy, vp of corporate affairs at Protection Mutual Insurance Co. in Park Ridge, Ill., whose policyholders were hard hit. "It's a dynamic situation. It's changing from day to day."

The flood has been labeled a catastrophe by the Property Claims Services division of the American Insurance Services Group Inc.

Damage estimates won't be available for a week to 10 days, Gary Kerney, director of catastrophe services for the division, said Friday.

"A lot of information is not available. We are trying to identify the number of firms and individuals affected not only by the water, but by the subsequent interruption of power and services," he said. "Our secondary concern is to establish the role of insurance in providing reimbursement for the losses."

Llanie O'Connor, president of the Building Owners & Managers Assn. of Chicago, said that "from everything we know" property damage would likely exceed \$1 billion.

The flood cost the city \$484 mil-

lion in economic activity last week apart from property losses, according to an analysis by the Regional Economics Applications Laboratory, a joint project of the University of Illinois and the Federal Reserve Bank of Chicago.

Chicago River water began pouring through a maze of tunnels once used to deliver coal and into basements in the city's downtown Loop last Monday. The cause: an automobile-sized hole in the bottom of the river that sent countless millions of gallons of water gushing into a tunnel below.

The initial damage may have occurred between July and September when a private contractor working under a city contract drove a set of pilings into the bed of the Chicago River near the spot where the tunnel collapsed, city officials suggest.

Businesses and insurers seeking to recover their losses will probably sue the city of Chicago; Great Lakes Dredge & Dock Co., the firm that installed the pilings; and various other agencies and consultants.

The city of Chicago self-insures its liability exposures. City risk management officials could not be reached for comment. City Hall was one of the buildings that remained closed last week due to flooding.

Great Lakes Dredge & Dock purchases unlimited marine liability coverage from Steamship Mutual Underwriting Assn. Ltd., a London-based protection and indemnity club, sources in London say.

Steamship Mutual officials could not be reached for comment.

Chicago-based Rollins Burdick Hunter Co. is Great Lakes' broker.

Steamship Mutual will pay flood-related claims only if the activities that damaged the tunnel were conducted from a waterborne vessel, like a barge, and if the operation was not specifically excluded, the sources said.

Chicago newspapers reported last week that Great Lakes drove the

pilings into the riverbed using barge-mounted hammers.

The first \$2 million of claims against Great Lakes would be paid by Steamship Mutual. Claims between \$2 million and \$15 million would be paid by the international pool operated by various P&I clubs, while claims between \$15 million and \$1.05 billion would be paid by international reinsurers led by Lloyd's of London syndicates. Any claims exceeding \$1.05 billion would revert to the international pool.

According to a chronology of the disaster outlined by Mayor Richard M. Daley last week, the tunnel damage was initially discovered in January by employees of a cable television company whose cables run through the tunnel network.

A video taken by the cable TV company in January and presented by Mayor Daley at a press conference last week showed that portions of the tunnel wall had caved in and that sludge had risen knee-high.

While the cable TV company reportedly attempted to inform city officials of the damage, a city specialist first viewed the damage in mid-March. A series of inspections and meetings followed. Finally, on April 2, a memo was sent to acting Transportation Commissioner John LaPlante advising him of the extent of the damage and the need for immediate repairs to prevent flooding.

An internal estimate placed the cost of the repairs at \$10,000 and suggested the work would take two weeks. But contractors' estimates on the work exceeded the internal estimates, Mr. Daley said, and rather than authorizing the work, city officials sought additional estimates.

"This was a serious problem... it should've been expedited," said Mr. Daley, who fired Mr. LaPlante the day after flooding began.

While the city conceded it did not quickly react to reports of damage in the tunnel, city officials last week

also pointed their finger at Great Lakes for not installing the pilings in the precise location requested.

A Great Lakes official refused to comment. The company issued a public statement that the work had been accepted by the city as satisfactory.

If the city is held at least partially liable for flood losses, the Illinois Governmental Tort Immunity Act could come into play.

The act is broken into two parts, according to Dwight Palmer, a partner with Keck, Mahin & Cate in Chicago:

- A governmental entity can be held liable for damages caused while the injured party was using its property—a city playground, for instance—only if the entity showed a "willful and wanton disregard of a known danger," a standard commonly termed gross negligence.

- The entity can be held liable for damages caused by a failure to properly care for and maintain city property—a city sidewalk in disrepair, for example—if it failed to use "ordinary care." In other words, if the entity is found negligent—not grossly negligent—in its maintenance, it loses its immunity for failure to maintain property.

"The tunnels appear to be like a sidewalk," Mr. Palmer said.

Besides property damages, the city may be held liable for businesses' consequential losses, like loss of income, Mr. Palmer said.

Liability for consequential damages is not clearly addressed by the tort immunity act or, for that matter, by general tort law, said James R. Schirott, an attorney with Schirott & Hervas in Itasca, Ill.

Under general law, businesses cannot regain any lost profits that are "speculative" in nature, noted Thomas M. Crisham, a senior partner with Hinshaw & Culbertson in Chicago. However, there is a possibility that clearly documented business interruption losses could be re-

covered from the city, he said.

The governmental tort immunity act specifically precludes any claims for punitive damages.

Under Illinois' comparative fault law, any party found to be more than 25% at fault for an incident can wind up paying 100% of any claims.

If a party is found to be less than 25% at fault, it can only be forced to pay a percentage of damages equal to its liability, Mr. Palmer said.

Attorneys were divided over whether Mayor Daley erred last week in candidly admitting that city officials knew the tunnel was damaged before the flood occurred and for singling out Mr. LaPlante.

"Strategically it is a bad move to point fingers publicly and admit fault publicly," suggested Mr. Palmer. "It might have been better to say that 'We have a problem, we are sorting it out and will report to the public at a later date.'"

However, "it's never a mistake for a politician to be honest," Mr. Crisham commented, noting that lawsuits were inevitable and that the videotape, memo and other documentation would have eventually become public.

Kelly Welsh, the city's corporation counsel, insists that neither Mr. LaPlante's firing nor public admissions by the mayor that city workers "had dropped the ball" constitutes a conclusion as to who is liable.

The first lawsuit in connection with the flood was filed Tuesday, just a day after the flooding was discovered.

The suit—which seeks class-action status—was filed on behalf of G.P. Antons Restaurant & Lounge and Merit Insurance Co., a Chicago-based property/casualty insurer. Both were affected by the Monday blackout.

Both businesses were forced to evacuate their buildings on the first day of flooding, resulting in an interruption of business and "enor-

Continued on next page

American Re

Continued from page 3

tions, according to a spokesman for the company. Aetna had \$1.4 billion in problem real estate loans at year-end 1991, and \$975 million in foreclosed properties.

The deal also could free American Re's management—which is expected to remain in place—to obtain a greater stake in the company and act in a more entrepreneurial manner.

Observers say, however, that the success of an LBO from American Re's perspective will hinge on the financial structure of the deal. A traditional leveraged buyout typically involves the assumption of large amounts of debt, which could hinder American Re in the market.

But many observers believe that this factor is highly likely to be taken into consideration by KKR and Aetna in structuring the deal.

The estimated \$1.4 billion sale would be a significant gain on Aetna's original investment: Aetna bought American Re in 1979 for \$389 million.

The Aetna spokesman said that along with bolstering the insurer's core business, funds from the LBO also could strengthen Aetna's balance sheet and allow it to repurchase some of its common stock.

"I view it as a positive development," said Michael A. Lewis, first vp with Dean Witter Reynolds Inc. in New York. The estimated \$1.4 billion sale price "appears reasonable," he said, and the sale "will go a long way" toward alleviating concerns about Aetna's capital.

Furthermore, the deal would end potential conflicts caused by American Re doing business with insurers that are Aetna competitors, said Ro-

bert Riegel, assistant vp at Moody's Investors Service Inc. "It's pretty unusual for a company to be a major player in both of these markets."

But Alan Levin, senior vp at Standard & Poor's Corp. in New York, noted that American Re accounted for a significant portion of Aetna's earnings last year. American Re's 1991 net income of \$132.9 million accounted for 26.3% of Aetna's \$505.2 million total.

This contribution was also cited by Joyce Culbert, an analyst with investment bank Chicago Corp. "My own present view is American Re is a wonderful property, and it's a shame Aetna has to sell it."

Aetna also is selling the reinsurer in a soft market, even though it might fetch a better price in a harder market.

"My impression is that Aetna really needs the money. Why else would it sell American Re at this point?" said Joanne Morrissey, a principal with Firemark Consultants Inc. in Morristown, N.J.

Charles Ronson, an analyst with Balestra Capital in New York, a money management firm, was critical of the deal's structure, contending Aetna should sell part of American Re in an initial public offering.

"This is a big, very profitable successful franchise, and Aetna is not going to let its shareholders participate in the full maximization of its worth," he complained.

Aetna said it had considered an IPO, but rejected that option. Selling American Re all at once, the spokesman said, means "more capital more quickly." Furthermore, Aetna did not want to have a large stake in a company with many other shareholders, he said.

An LBO also will benefit American Re, observers say.

American Re's management will be "more free to make its own decisions in the marketplace," said David Wells, an analyst with Fitch Investors Service in New York.

It could be good for the industry to have entrepreneurially oriented managers, said Mark Hinkley, senior vp at Transamerica Reinsurance Co. in Stamford, Conn.

He noted that American Re's management is likely to have some ownership participation in the LBO. "I think management involvement in the ownership is de facto a good thing."

Caterpillar workers face health care changes

PEORIA, Ill.—Caterpillar Inc. workers for the first time will face limits on the health care providers they can use at no cost when they begin returning to work this week.

However, the workers also will receive improved pension benefits and higher wages.

Caterpillar will begin recalling 12,600 striking United Auto Workers this week after a 5½-month labor dispute over health care benefits, pensions and wages.

Caterpillar and the union have been unable to reach an agreement since Oct. 1, when the previous contract expired. Caterpillar earlier this month began advertising for replacement workers. Nearly 8,000 people applied for those jobs.

The striking workers agreed to return to work under Caterpillar's latest offer, but only as an interim agreement. A federal mediator will help negotiate a final contract.

The success of an LBO from American Re's perspective, however, could hinge on the amount of debt assumed by the reinsurer. "Clearly, there's going to be some requirement to pay debt and service debt of the parent company," said S&P's Mr. Levin. Right now, he said, there is virtually no debt on American Re's balance sheet.

S&P has put American Re, which now has a AA+ claims-paying ability rating, on Credit-Watch with negative implications. Any buyout "will likely involve a more aggressive financial structure and an increased call upon Am Re's future earnings stream."

Under their previous contract, UAW members and retirees had unlimited health care coverage at no cost. Under the interim agreement, Caterpillar, which self-funds its indemnity health plan, will implement health care cost-containment programs.

Beginning July 1, UAW members and retirees in the Peoria area will receive full coverage only if they obtain care through a managed care network. There will be no deductibles or copayments for network care.

Caterpillar already had planned to implement the network for salaried employees and management.

Employees who opt out of the network will be required to pay 30% of the cost.

Workers and retirees who do not live within the network area will pay towards the cost of their coverage: up to 1% of wages or pension

benefits, depending on the number of dependents.

Also under the interim plan, there is a \$2 copayment for prescription drugs. That rises to \$5 if a generic drug is available and is not used.

UAW workers' pension benefits rise under the interim agreement to \$31.45 per month per year of service, up from \$30.45. On Jan. 1, 1993, benefits rise to \$33 per month per year of service.

The company also will offer voluntary early retirement options to workers in certain jobs and locations, based on age and years of service, among other factors.

Caterpillar said it determined during the strike that it needs about 1,350 fewer workers. If every striking worker returns and few choose early retirement, the company will eliminate the positions through normal attrition.

—By Christine Woolsey

Update

Seidman judgment overturned

Continued from page 2

However, a three-judge panel of Florida's 3rd District Court of Appeals ruled unanimously April 14 that Seidman could not be held liable. Because former Universal Casualty official Vishwa Shah committed the alleged fraud to benefit the insurer rather than to harm it, Universal Casualty and its liquidator cannot claim that Seidman damaged the company by failing to discover the fraud, the court ruled.

The liquidator, Allan Gee, a senior manager with Ernst & Young in Cayman, will ask for a review by the full appeals court and will petition for a review by the Florida Supreme Court, said Thomas M. Sherouse, a partner with the law firm of Anderson, Moss, Parks, Meyers & Sherouse in Miami.

Briefly noted

Negotiations over SCOR U.S. Corp.'s bid to purchase Crum & Forster Inc. unit **Constitution Reinsurance Corp.** broke off last week. Crum & Forster in 1991 postponed a planned public offering of Constitution Re's holding company, citing market conditions. . . .Raytheon Co. estimates its accumulated **retiree health care liability** under Financial Accounting Standard 106 is about \$500 million. It is considering amortizing the obligation over several years. Gillette Co. says its aftertax charge for FAS 106 obligations will be about \$125 million. Gillette has not decided how to recognize the liability. . . .**PMA Reinsurance Corp.** has increased its capital 48% to \$185 million from \$125 million through a stock purchase by parent company Pennsylvania Manufacturers Corp. . . .District of Columbia Mayor Sharon Pratt Kelly has signed legislation to extend health care benefits to **domestic partners** of unmarried city employees who register with the city (*BI*, March 16). Congress still must review the measure. . . .Former asbestos manufacturers Keene Corp. and Robert A. Keasbey Co. must pay \$30 million in compensatory damages to seven **construction workers exposed to asbestos**, a New York state jury has ruled. . . .Only women seeking reconstructive surgery after a mastectomy or those who need a ruptured implant replaced will be permitted to receive **silicone breast implants**, the U.S. Food and Drug Administration said. All women who receive the implants will be subject to scientific studies to answer unresolved questions regarding the implants' safety. . . .About 3,000 former pension plan participants covered by **Executive Life Insurance Co. annuities** purchased by units of Halliburton Co. would receive full benefits under a proposed U.S. Labor Department settlement. The payments, which Halliburton would guarantee, would make up the difference between annuitants' reduced benefit payments after regulators seized Executive Life and what the annuitants were promised. . . .Companies that manufactured the **anti-miscarriage drug DES** but did not sell it in New York can be held liable to New York plaintiffs, a U.S. District Court has ruled. Under New York law, manufacturers of diethylstilbestrol can be held liable for women's injuries based on their share of the market when the drug was prescribed (*BI*, April 10, 1989).

EBP results

Continued from page 2

million in the previous fiscal year's third quarter. Operating earnings increased 9.1% to \$6 million from \$5.5 million a year earlier. But, after income taxes and rising interest expenses, net earnings dropped to \$2.8 million or 34 cents per share compared with \$3.5 million or 40 cents a year earlier.

EBP also reported that its client based grew to 2,525 companies with 568,200 covered employees in the quarter from 2,200 companies with 496,400 employees in the year-earlier period.

The loss ratio on stop-loss reinsurance written by EBPLife Insurance Co. widened to 56.8% in the third quarter, compared with a 50.2% loss ratio in fiscal 1991's third quarter. This was largely due to growing competition in the market, EBP said.

Continuing competition and higher expenses to support sales, managed care and claim processing functions will reduce operating margins for the next three or four quarters, EBP said.

Separately, the California Insurance Department last week fined USLIFE Corp. \$100,000 for transactions relating to its sale of an insurance subsidiary to EBP last year.

USLIFE last May sold its Sooner Life Insurance Co. unit to EBP, which merged Sooner with its First Security Insurance Co. subsidiary to

create EBPLife.

The California department charged that USLIFE failed to obtain proper regulatory approval before selling the business.

EBP has applications pending with the California Insurance Department to approve the merger of Sooner and First Security and to change Sooner's name to EBPLife. Of the 38 states where Oklahoma-domiciled Sooner was licensed, only California and Michigan have not issued amended licenses allowing it to operate as EBPLife, according to Timothy W. Kuck, vp and general counsel.

EBP did not file its applications with the California department until February 1992. The department said it is investigating EBP in connection with the filings.

At the time of the Sooner acquisition, EBP was not aware it needed the California department's prior approval to merge Sooner and First Security, believing it only needed to notify regulators of the acquisition and file for a name change, Mr. Kuck said.

While the applications are pending, EBP has agreed that its insurance unit will not write direct insurance business in California, though the company is not barred from writing reinsurance.

EBPLife will write stop-loss coverage on a direct basis if its applications are approved. ■

Flood damages

Continued from previous page

ious damages," the suit says. The suit names as defendants the city of Chicago, the Metropolitan Water Reclamation District of Greater Chicago and Great Lakes.

In addition to damages, court costs and attorneys' fees, the suit seeks to protect the subrogation interests of the insurance industry, noted Robert A. Holstein, an attorney with Holstein, Mack & Klein in Chicago who filed the suit.

Another suit was filed later in the week by a doctor who alleged his

practice was disrupted.

Additional suits are expected from businesses whose losses were not covered by insurance and by insurers seeking to recover their claims costs from the parties responsible for the flood.

As soon as insurers pay those claims that are covered, "they will be in a position to turn around and subrogate" against those responsible for the damages, noted Joseph Branch, a partner at Foley & Lardner in Milwaukee.

"The insurers in the U.S. are becoming more and more confident that as the city had known about the

leak for weeks, either the city or the contractors will be held liable" when insurers subrogate, one London broker pointed out.

Mr. Branch noted that besides property damage and lost business costs, the disaster also will spawn substantial legal costs.

"How much added cost is there as the initial claims reverberate throughout the system" as property damage claims lead to subrogation claims? he asked.

The "ripple effect" will be evident, said David W. Eryou, chairman of the Defense Research Institute's construction law committee. ■

Coverage questions abound

By SARA MARLEY
and SARA J. HARTY

CHICAGO—While water-weary Chicago businesses are expected to deluge property insurers with claims, questions remain over the interpretation of coverage for last week's disaster.

While one property insurer said that the disaster would be classified as a "flood," other insurers had not yet decided whether losses were caused by a "flood" or "water damage," a distinction that could affect coverage.

"We consider it a flood. If the policyholder had purchased flood coverage, we intend to respond," said Jim Oskandy, vp of corporate affairs at Protection Mutual Insurance Co. of Park Ridge, Ill.

However, "it is definitely water damage, not flood," said a spokesman for Allstate Insurance Co. in Northbrook, Ill.

"We can't say if it is or isn't a flood. It's some type of water damage," said Tom Kaye, national catastrophe coordinator at Kemper National Insurance Cos. in Long Grove, Ill. However, Kemper had not received any claims for the disaster last week.

CNA Insurance Cos. in Chicago also had not yet determined how it would classify claims, a spokeswoman said. And, a spokeswoman said ITT Hartford Group Inc. "is still examining whether or not they are covered."

While they may not have determined whether coverage applies, property insurers stress they are standing by policyholders' side during the crisis.

Protection Mutual has been offering engineering advice and arranging for pumping and cleaning equipment for policyholders, Mr. Oskandy said. "We are concentrating on mitigating the loss and restoring fire protection systems."

"Our company has taken the posture that we are going to lean over backwards for our policyholders. We are going to give them the benefit of the doubt without compromising our policies," said a spokeswoman for Nationwide Mutual Insurance Co. of Columbus, Ohio, which received three claims as of last week.

Flood damage is excluded from standard Insurance Services Organization Inc. property policies, an ISO spokeswoman said. Coverage also is excluded for certain types of water damage, including "water under the ground surface" that seeps through foundations and basements.

"Water on the ground that causes problems is considered a flood," said Richard S. Betterley, president of Betterley Risk Consultants Inc. of Worcester, Mass. Water damage is more closely associated with broken pipes or leaky roofs, he noted.

However, "it's probably not a flood because it's not a natural event. It's not an overflow" of the river, said Michael R. Levin, a consultant in Chicago with the Til-

linghast unit of Towers, Perrin, Forster & Crosby Inc.

"A flood is generally defined as a 'rising natural body of water.' It's going to be hard to say that this case was caused by a flood," agreed Michael Segal, president and chief executive officer of Near North Insurance Brokerage Inc. in Chicago.

Although flood damage is specifically excluded from standard ISO property policies, it's "quite common" for large businesses to have flood coverage under all-risk or manuscript property policies, noted William D. O'Connell, national director of business insurance consulting for Deloitte & Touche.

However, Bill Leinheiser, senior consultant with Corporate Policyholder Counsel Inc. in Park Ridge, Ill., estimated that only half of the affected companies in Chicago's Loop have flood coverage.

The applicability of business interruption and extra-expense coverage also is being questioned, because business owners usually must be insured for the underlying peril in order to collect on these types of coverage, consultants said.

"Most standard policies require physical damage to insured property before business interruption or extra expense is triggered," said Paul Van Zuiden, a risk management consultant with The Wyatt Co. in Chicago. Thus, a tenant on a high floor of a building that suffered no property loss could not collect for business interruption, even if the building was damaged.

Many affected businesses may not have bought business interruption coverage.

"Most of the firms affected are service industries. It's unlikely that many of them will carry business interruption" insurance because it is difficult for businesses like law and accounting firms to document lost profits, Mr. Van Zuiden said. "The fact that you were unable to operate for a few days is insufficient to prove a loss."

Transaction-oriented service businesses like the Chicago Board of Trade—which was shut down on Monday and Tuesday and was open for limited trading on Wednesday and Thursday—may have an easier time proving losses, he continued.

Business interruption coverage might also be voided because many businesses were closed as a result of power outages, not actual flooding.

Many businesses won't "be able to get coverage from their own policies, unless they had coverage specifically endorsed to protect them from off-premises power interruption," noted Craig Van der Voort, area president of the Chicago office of broker Arthur J. Gallagher & Co.

However, few firms are likely to have off-premises power failure endorsements, consultants said.

"For those fortunate enough to have that coverage, there is no question" that they will be covered, said Bill Hoffman, a consultant with KPMG Peat Marwick in Chicago.

However, some policies may stipulate that the power outage be caused by a utility breakdown as opposed to an imposed shutdown.

Failure to tell clients about the availability of power interruption coverage could cause some policyholders to sue agents, brokers and consultants, Mr. Van Zuiden said.

With all the confusion over what is and is not covered, coverage disputes are likely.

Policyholders who believe that they have coverage "should promptly involve their insurers, brokers, public adjusters and attorneys," said Dwight Palmer, a partner in the Chicago law firm of Keck, Mahin & Cate.

Meanwhile, some insurers last week noted they had received claims from policyholders, though many major property underwriters hadn't received any claims notices.

Few insurers could provide any estimate of potential losses.

Protection Mutual insures more than 100 properties in the affected business district, and insurer officials had visited more than 50 as of Thursday, Mr. Oskandy said.

About 12 buildings insured by Protection Mutual suffered some property damage, from a few inches of water in the Sears Tower to devastating water damage at the Marshall Field & Co. department store.

The lowest level of the department store, which contains boilers and other mechanical equipment, was totally submerged. The water line in the level above, which is used to store inventory, was just several feet short of the ceiling.

Six buildings, including Marshall Field's and fellow retailer Filene's Basement, have suffered serious damage, Mr. Oskandy said.

Protection Mutual has "been associated with Field's for a number of years" and also writes property coverage for Field's parent, Dayton Hudson Corp. of Minneapolis, he said.

CNA received 78 claims last week, including 70 business interruption claims from dentists insured under an association program written by CNA, a spokeswoman said.

ITT Hartford received 24 claims; Travelers Corp., six; Allstate Insurance Co., nine; and Allendale Mutual Insurance Co. and Industrial Risk Insurers, both one.

American International Group Inc. has had "a limited number of reports of water" in insured properties, a spokesman said.

Fireman's Fund Insurance Co. has received 12 business interruption claims, averaging about \$2,500 each, a spokesman said.

While Aetna Life & Casualty Co. has not received any claims, it is aware of damage at two or three of the Loop properties it insures.

However, several major property insurers—including Kemper, Arkwright Mutual Insurance Co., CIGNA Corp. and Zurich-American Insurance Co.—had received no claims notices as of late last week. ■

Flooding shuts down Loop businesses

By MEG FLETCHER and SARA MARLEY

CHICAGO—Businesses in Chicago's water-logged Loop were still assessing damage and lost-business costs last week, and it appears the toll will be high.

"It's a classic case of a small amount of damage causing a large amount of loss," said Michael R. Levin, a consultant in Chicago with the Tillinghast division of Towers, Perrin, Forster & Crosby Inc. Business interruption and extra-expense losses will far exceed actual property losses, but are less likely to be covered by insurance, he noted.

Commonwealth Edison Co. faced some of the greatest challenges. On Monday, power was cut to 96 buildings in the downtown area and restored through the week until only 11 buildings were dark by Thursday afternoon.

Com Ed's manpower costs to respond to the flood were running at about \$330,000 per day, the utility reported last week.

So far the utility knows of only "minimal physical damage" to about 30 transformers due to the flooding, a spokesman said.

Com Ed is "primarily self-insured" for the losses it knows of at this time, said Gerald Porento, Com Ed's assistant general counsel. However, "this thing is far from over. Every day, new losses mount," he said.

While Commonwealth Edison officials declined to comment on coverage, the utility reported in 1990 that it had more than \$200 million in property insurance limits with a deductible that exceeded \$1 million. Underwriters included Lloyd's of London syndicates (BI, Aug. 6, 1990).

Perhaps the hardest-hit businesses were the major retailers along State Street.

Beneath the ornamental cast-iron facade of Carson Pirie Scott's landmark building, workers last week pumped out water from two subterranean levels at the rate of 200,000 gallons per hour. Still, the level had dropped only five inches in four days, and 25 feet still remained as of late Thursday, said John Beachum, director of marketing and promotions for P.A. Bergner & Co., Carson's parent in Milwaukee.

Though he had no damage figures, it was estimated that Carson's lost at least \$300,000 in sales each day it was closed.

The State Street store—the chain's largest-volume store—is insured for damage to build-

ing, contents and business interruption, he said.

Marshall Field & Co., a unit of Dayton-Hudson Corp. in Minneapolis, lost some inventory due to flooding in one sub-basement level, a spokeswoman said. Its lowest level, which houses boilers and other mechanical equipment, was totally submerged.

Retailing sources put the daily revenue at Field's State Street store at \$500,000.

Field's has coverage for property damage and business interruption from Protection Mutual Insurance Co. in Park Ridge, Ill., the spokeswoman said.

A spokeswoman for Filene's Basement, another State Street retailer, said the store lost "everything" in a stockroom below the basement selling floor that held two weeks worth of merchandise. Protection Mutual also writes property and business interruption coverage for Filene's, a May Department Stores Co. unit headquartered in Boston.

Hartmarx Corp. had retail sales operations interrupted due to power outages at two of its four Loop stores. The firm has broad coverage for such losses, including off-premises power outages, but Hartmarx also has deductibles "which are substantial," said John Wagner, assistant treasurer and director of risk management.

Two Loop buildings managed by Tishman Speyer Properties Inc. remained flooded late last week, said Craig W. Bayless, managing director. Tishman owns one of the buildings.

Damage to the building is "going to be in the millions," he said. Virtually all mechanical and electrical equipment in both buildings—including switching gears, motors, water pumps, air conditioning condensers and computer controls—were under water.

Tishman purchases its property coverage from Protection Mutual.

Limited trading has resumed at The Chicago Board of Trade, but for nearly two days the exchange was closed due to 30-40 feet of water in the basement where electrical, heat and air conditioning equipment are located.

The commodity exchange reopened Wednesday—even though its basement still was submerged—with the help of jerry-rigged electrical service and a fire department pumper.

A CBOT spokesman could not estimate losses, but noted that about 500,000 contracts are typically traded daily. The effect of the ex-

change's closure was felt internationally because "the cash markets dried up," he noted.

The Chicago Mercantile Exchange did not make the 300,000 to 400,000 trades it normally would have because of reduced hours Monday and Tuesday, primarily due to power outages and the need to allow firms to complete trades, a spokesman said. The Merc is "largely self-insured" for its loss, he said.

The Merc had considered buying business interruption coverage. But it did not because insurers demanded that the exchange maintain duplicate backup facilities, which the Merc did not consider cost-effective, he said.

At accounting firm Arthur Andersen & Co., subbasement flooding kept 450 employees out of their downtown offices.

On Monday, 900 cartons of tax files were moved to another corporate location, where auditors took over lunch and conference rooms to work on clients' tax returns.

Andersen's business interruption insurance should cover lost profits and the cost of the move, a spokesman said.

Loss control experts noted that most businesses were unprepared for the catastrophe.

"You don't think about things underground, but they can put you out of business if they fail," said Earl Aurelius, vp of EQE International, a San Francisco property loss consultant.

The city of Chicago suffered huge losses, both from property damage—flooding kept City Hall closed during the week—and from the costly attempt to plug the river leak.

While the city self-insures its property and liability exposures, it will receive significant funds from the federal government, which declared the flood area a disaster area.

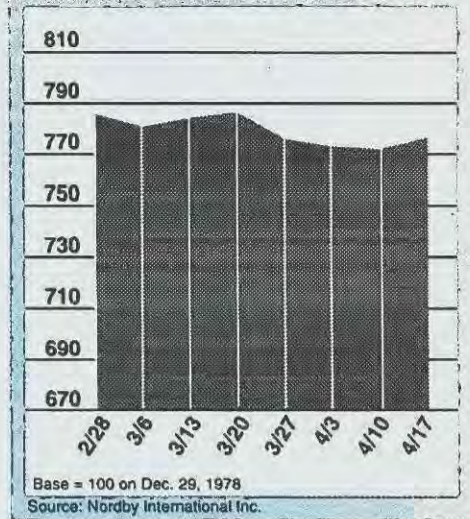
As a result of the disaster proclamation, the U.S. Treasury will cover 75% of state and local governments' flood-related costs.

Even so, Chicago is likely to seek special legislation from Congress to provide federal help beyond existing disaster relief, according to aides to Mayor Richard M. Daley and members of the Chicago congressional delegation.

Federal disaster assistance for business comes primarily in the form of low-interest loans up to \$500,000, but only if a company can't obtain credit elsewhere.

This story contains reports from the Crain News Service.

BI Insurance Index



Insurance industry stocks inched up last week, as the *Business Insurance Index* rose 5.1 points to 776.7 on April 16 from 771.6 on April 10. Advancing issues were led by Safeguard Health Enterprise, up 8.3%; NAC Re Corp., up 6.8%; and Washington National, up 5.8%. Declining issues followed HMO America Inc., down 6.1%; Poe & Associates, down 4.8%; and Sierra Health Services, down 3.2%. The most active issue was Sears, Roebuck & Co. (Allstate), 4.2 million shares traded. The BI Index was up 0.7%; the NYSE Composite was up 2.5%; the Standard & Poor's 500 was up 2.9%; and the Dow Jones 30 Industrials rose 3.4%.

British Issues

April 16 Companies	Price pence	P/E	Div. pence	Yield %	1 Week	
					High	Low
Comml Union	450	N/M	31.5	7.0	450-425	N/A
Genl Accident	461	N/M	35.7	7.7	461-435	N/A
Gdn Royal Exch	144	N/M	10.0	6.9	144-128	N/A
Royal	202	N/M	15.0	7.4	202-196	N/A
Sun Alliance	279	N/M	19.0	6.8	280-262	N/A
Brokers						
Bradstock	137	15.4	6.3	4.6	137-136	N/A
CE Health	373	24.7	34.5	9.2	373-361	N/A
Hogg Group	175	11.7	10.9	6.2	175-174	N/A
JIB Group	188	13.8	10.0	5.3	188-183	N/A
Lloyd Thompson	228	22.8	6.0	2.6	228-227	N/A
Lowndes Lmbt	317	13.2	17.3	5.5	317-313	N/A
PWS Holdings	54	5.9	5.3	9.8	54-52	N/A
Sedgwick Grp	205	16.0	16.0	7.6	205-197	N/A
Steel Brl Jones	255	12.8	17.7	6.9	255-253	N/A
Wills Corroon	260	16.4	17.6	6.8	260-247	N/A

Source: Philip Olsen, Insurance Industry Analyst, London

BI Industry Stock Report

APRIL 13, 1992 THROUGH APRIL 17, 1992

BROKERS

	Price	Weekly % change	Year to Date % change	Annual High	Annual Low	Vol.(000)	\$ Div.	% Yield	P/E	Book value	Mkt/Bk. value	
Alexander & Alexander	NYS	19.00	2.70	-7.32	27.00	18.00	243	1.00	5.26	-76	9.77	1.94
Gallagher Arthur J. & Co.	NYS	21.88	0.00	-2.23	25.38	19.00	41	0.64	2.93	17	5.88	3.72
Frank B. Hall	NYS	4.00	3.23	-5.88	5.50	3.13	133	0.00	0.00	-3	-5.24	-0.76
Hibb, Rogal & Hamilton	OTC	11.75	0.00	-11.32	17.50	11.00	75	0.40	3.40	19	3.56	3.30
Marsh & McLennan	NYS	75.00	3.09	-7.83	83.75	70.00	274	2.60	3.47	18	14.77	5.08
Poe & Associates	OTC	15.00	-4.76	25.00	16.00	8.88	14	0.40	2.67	16	2.52	5.95
BROKERS AVERAGE			0.7	-1.6				2.5	-1			

CONGLOMERATES & HOLDING COMPANIES

	Price	Weekly % change	Year to Date % change	Annual High	Annual Low	Vol.(000)	\$ Div.	% Yield	P/E	Book value	Mkt/Bk. value	
Berkley W.R. Corp.	OTC	33.13	1.15	8.61	36.25	23.50	161	0.36	1.09	13	23.89	1.39
Berkshire Hathaway Inc.	NYS	9025.00	1.98	-0.28	9025.00	245.31	0	0.00	0.00	-33	4612.00	1.96
ITT (Hartford Group)	NYS	65.50	1.75	13.42	70.63	50.00	979	1.84	2.81	10	64.01	1.02
Sears (Allstate)	NYS	46.88	3.02	23.76	47.88	32.50	4186	2.00	4.27	14	37.38	1.25
CONGLOMERATES AVERAGE			2.0	11.4				2.0	1			

INSURERS/REINSURERS

	Price	Weekly % change	Year to Date % change	Annual High	Annual Low	Vol.(000)	\$ Div.	% Yield	P/E	Book value	Mkt/Bk. value	
AEGON N.V.	NYS	69.25	-0.54	-1.07	71.75	54.75	3	2.30	3.32	7	N/A	N/A
Aetna Life & Casualty	NYS	43.25	-0.57	-1.70	48.00	31.88	826	2.76	6.38	9	64.23	0.67
Allied Group Inc.	OTC	21.25	3.66	25.00	23.00	16.00	80	0.64	3.01	8	11.50	1.85
American General	NYS	42.63	1.79	-4.21	44.75	36.38	559	2.08	4.88	10	37.14	1.15
American Indemnity/Finl	OTC	6.88	0.00	44.74	9.25	4.50	13	0.08	1.16	6	12.93	0.53
American International	NYS	86.88	1.76	-11.69	99.38	78.63	1296	0.48	0.55	12	45.34	1.92
Aon Corp.	NYS	43.88	5.72	10.73	45.25	34.75	240	1.68	3.83	12	18.50	2.37
Argonaut Group	OTC	27.00	0.00	13.68	33.38	21.75	74	0.68	2.52	8	48.26	0.56
AVEMCO Corp.	NYS	25.88	1.97	3.50	28.00	19.63	8	0.40	1.55	19	9.55	2.71
Baldwin & Lyons Inc.	OTC	27.50	0.46	6.80	28.00	21.50	86	0.28	1.02	8	24.29	1.13
Belvedere Corp.	ASE	5.25	0.00	61.54	6.13	2.88	2	0.04	0.76	15	7.65	0.69
Chandler Insurance	OTC	5.13	2.50	57.69	5.50	2.13	108	0.00	0.00	64	5.95	0.86
Chubb Corp.	NYS	69.00	5.34	-10.39	78.00	60.75	1082	1.60	2.32	11	35.19	1.96
CIGNA Corp.	NYS	53.38	4.15	-12.68	61.75	41.25	517	3.04	5.70	11	73.15	0.73
CNA Financial Corp.	NYS	90.50	5.69	-7.65	104.50	75.50	94	0.00	0.00	9	70.23	1.29
Continental Corp.	NYS	27.38	1.39	-0.90	30.38	23.25	433	2.60	9.50	28	37.83	0.72
EXEL Ltd.	NYS	35.63	-1.04	-5.00	40.25	27.38	567	0.92	2.58	8	N/A	N/A
Fund American Corp.	NYS	64.63	-0.58	-7.51	70.25	62.00	574	0.68	1.05	14	36.11	1.79
Fremont General Corp.	OTC	20.63	0.61	-15.38	26.00	18.00	192	0.88	4.27	5	19.13	1.08
Frontier Insurance Group	NYS	31.50	2.44	16.67	31.50	19.22	62	0.60	1.90	12	11.20	2.81
Gainsco Inc.	ASE	12.75	-1.92	-8.93	15.00	8.25	26	0.04	0.31	15	3.37	3.78
General RE Corp.	NYS	91.25	1.25	-10.43	104.75	85.00	799	1.80	1.97	12	37.50	2.43
Guaranty National Corp.	NYS	14.75	0.00	1.72	17.00	12.63	34	0.48	3.25	10	N/A	N/A
Hanover Insurance Co.	OTC	37.13	-0.34	3.85	42.75	27.13	71	0.44	1.19	16	37.44	0.99
Harleysville Group	OTC	20.63	3.13	-2.94	23.25	16.75	29	0.64	3.10	10	22.99	0.90
Hanford Steam Boiler	NYS	51.63	-0.24	-10.22	62.38	45.13	78	2.00	3.87	15	17.05	3.03
Kemper Corp.	NYS	27.75	-1.33	-27.21	46.13	24.88	558	0.92	3.32	7	34.20	0.81
Lawrence Insurance Group	ASE	8.13	0.00	-26.97	11.13	7.88	3	0.48	5.91	16	4.71	1.73
Liberty Corp.	NYS	23.75	3.26	7.34	25.38	19.50	59	0.48	2.02	13	23.86	1.00
Lincoln National	NYS	54.50	0.00	-0.46	61.00	45.38	219	2.92	5.36	12	45.15	1.21
Market Corp.	OTC	26.75	3.88	21.59	28.25	14.00	16	0.00	0.00	13	3.22	8.31

BROKERS

	Price	Weekly % change	Year to Date % change	Annual High	Annual Low	Vol.(000)	\$ Div.	% Yield	P/E	Book value	Mkt/Bk. value	
Mutual Risk Mgmt. Ltd.	NYS	32.75	-1.50	-6.76	37.75	17.00	19	0.12	0.37	24		
NAC Re Corp.	OTC	29.50	6.79	-6.35	33.00	21.75	194	0.16	0.54	13	18.90	1.56
National Re Holdings Corp.	NYS	18.25	4.29	N/A	23.63	17.00	144	0.12	0.66	8	N/A	N/A
Navigators Group	OTC	41.75	1.83	1.83	48.25	29.50	22	0.00	0.00	24	13.52	3.09
Nobel Insurance LTD.	OTC	5.13	2.50	28.13	6.00	3.38	19	0.00	0.00	4	7.76	0.66
NWNL Companies	NYS	35.25	4.83	13.25	38.50	18.63	187	1.48	4.20	10	42.73	0.82
Ohio Casualty Corp.	OTC	53.25	-0.47	7.58	58.25	43.50	75	2.68	5.03	-9	36.38	1.46
Old Republic Int'l	NYS	40.50	-0.92	14.08	42.25	27.50	141	0.72	1.78	8	33.09	1.22
Orion Capital Corp.	NYS	29.88	-0.83	-5.53	34.25	27.00	32	0.92	3.08	5	20.42	1.46
Phoenix RE Corp.	OTC	11.00	4.76	4.76	11.75	8.50	3	0.20	1.82	44	13.30	0.83
Provident Life	OTC	22.38	3.47	-3.76	24.25	16.75	59	1.00	4.47	9	25.88	0.86
Re Capital Corp.	ASE	16.00	0.00	11.30	18.63	13.13	13	0.24	1.50	13	15.05	1.06
Reliance Group Holdings	NYS	4.50	2.86	9.09	6.13	3.50	57	0.32	7.11	3	5.61	0.80
RLI Insurance Corp.	NYS	18.25	-0.68	10.61	20.38	11.88	8	0.48	2.63	8	14.41	1.27
St. Paul Companies	NYS	70.00	-0.18	-3.95	75.75	5						

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