

Business Insurance

Reporting Weekly on Corporate Risk, Employee Benefit and Managed Health Care News / \$4

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\$800 million placement marks largest-ever pollution program

NEW YORK—A British building materials company has purchased the largest pollution insurance policy ever, which was assembled to cover the cost of cleaning up some 200 sites throughout the United States.

Units of broker Sedgwick Group P.L.C. assembled the \$800 million in environmental remediation and designated product liability coverage on behalf of London-based Hanson P.L.C. The coverage, which cost \$275 million, is underwritten by Hanson North America's Bermuda-based captive insurer. It is re-

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HMO's loss throws wrench in merger talks

United HealthCare takes big charge

By JUDY GREENWALD

MINNETONKA, Minn.—United HealthCare Corp.'s surprise announcement last week of a \$900 million charge against second-quarter earnings threw the future of its Humana Inc. deal into doubt and is likely to lead to higher rates for its employer clients.

"I think both companies have a lot of analysis and a lot of soul-searching to do," said Todd B. Richter, a health care analyst at Morgan Stanley Dean Witter in New York. He added, however, "I think it's way too soon to speculate on what's going to happen."

"I think United is going to look over very carefully the ways they price all of their products" as a result of the announcement, said Bill Gibson, client services manager for Sedgwick Noble Lowndes in Philadelphia.

"From a corporate standpoint, they must get maximum dollars from the profitable business they do have," said Mr. Gibson.

United HealthCare last week said the \$900 million charge—which led to a \$565 million quarterly loss and a \$433 million loss for the half—is in part because of its unprofitable Medicare plans.

The company also said that as part of its "realignment initiatives," it plans to either exit or "significantly change the nature of its operating presence" in several unspecified commercial health plan markets where its penetration is inadequate or where its profit or growth potential appears uncertain. The company would not comment further.

The \$900 million charge reflects \$620 million for withdrawal from selected markets and products and contractual disposition of "non-strategic operations"; \$190 million for consolidation of operational activities and systems platforms and \$90 million in operating cost reductions, including severance.

The stock market reacted strongly to the announcement. United HealthCare's stock dropped \$15, or 28.4%, to \$37.88 on Thursday, the day its earnings were announced. It closed at \$36.31 Friday. The announcement also had an impact on other health maintenance organization stocks, which dropped 13.4% last week, according to the *Business Insurance* Industry Stock Report.

The news means United's deal with Louisville, Ky.-based Humana, a deal that would

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Medicare, restructuring hit earnings

United HealthCare's \$900 million charge in the second quarter produced a loss for the HMO's first half.

	First half of 1998	First half of 1997
Total revenues:	\$8.35 billion	\$5.78 billion
Operating expenses:	\$8.82 billion	\$5.42 billion
Net income (loss):	(\$433 million)	\$225 million
Medical loss ratio:	88.4%	84.6%

Source: United HealthCare Corp.

401(k) tax law brings administrative woes

By JERRY GEISEL

WASHINGTON—In trying to close a loophole that allows employees to escape taxes on 401(k) hardship withdrawals, Congress may not have gone far enough.

A provision in a law overhauling the Internal Revenue Service enacted by Congress this year that will partially close the tax loophole is likely to confuse employees and burden employers.

"This is a big deal and a huge headache," warns Frank Roque, a consultant with Hewitt Associates L.L.C. in Lincolnshire, Ill.

Mr. Roque hopes legislators eliminate the problem by amending the law or at least give employers more time to comply with the new law, which takes effect in 1999.

The provision that closes the hardship withdrawal loophole has its origin in legislation signed into law last year that exempted certain distributions from

individual retirement accounts from a 10% penalty tax that normally applies to pre-retirement withdrawals.

Specifically exempted from the 10% tax are funds withdrawn from IRAs used for a first-time home purchase and for higher-education expenses.

The 1997 law kept the 10% penalty tax in place, however, for these and other types of hardship withdrawals from 401(k) plans.

Savvy employees and financial consultants, though, quickly discovered how employees willing to undertake a little extra work can escape the 10% penalty tax on 401(k) hardship withdrawals.

First, an employee takes a hardship withdrawal from the 401(k) plan and rolls over the distribution to an IRA. After that, the employee withdraws the funds from the IRA and uses the money toward a first-time home purchase or higher-education expenses.

See Loophole on page 7

Insurers not obligated to defend orders: Court

By GAVIN SOUTER

LOS ANGELES—Insurers do not have a duty to defend policyholders against government-ordered environmental cleanups, the California Supreme Court has ruled.

In a 4-3 decision, the court ruled that insurers must defend commercial general liability policyholders only in civil actions started by the filing of a complaint.

The decision resolves contradictory appeals court decisions

made last year (*BI*, July 28, 1997; Oct. 6, 1997). In both cases, the policyholders had received cleanup orders from the California Environmental Protection Agency and sought a defense from their general liability insurers.

In *Foster-Gardner Inc. vs. National Union Fire Insurance Co. of Pittsburgh, Pa., et al.* and *Fireman's Fund Insurance Co. vs. the Superior Court of Los Angeles County*, much of the contention was over the meaning of the word "suit" as used in

commercial general liability policies.

In *Foster-Gardner*, the California Court of Appeals ruled that "suit" could be extended to include administrative claims.

But in the *Fireman's Fund* case, another division of the same appeals court ruled that the meaning of the word "suit" was unambiguous and referred only to civil actions.

The state's Supreme Court agreed with the second analysis: "The unambiguous language of

See Cleanups on page 22

Freedom of associations?

Bill would exempt trade group health plans from state rules

By JERRY GEISEL

WASHINGTON—Trade associations could offer their members health care plans exempt from many state regulations under legislation passed by the House of Representatives.

Provisions tucked into broader patient protection legislation would create new "association health plans" that could operate nationwide after meeting new federal solvency benchmarks and other standards.

"This would open the door for national trade associations to offer health care plans certified under federal law and provide a uniform benefit package across state

lines," said George Pantos, Washington counsel for the Self Insurance Institute of America.

States, if they so chose, could regulate these plans, but they generally would have to enforce the federal rules and not their own. The U.S. Department of Labor would regulate the new plans in states where insurance commissioners declined to regulate the AHPs.

AHPs could be either self-insured or fully insured. However, to qualify for the special exemption from state regulation, at least one of the association health care plans offered to members would have to be fully insured.

As a practical matter, trade as-

sociations currently are limited to offering members insured health plans that are subject to state regulation.

If an association self-insures a health care plan, that plan generally is considered a multiple employer welfare arrangement, which is subject to state regulation.

States, however, historically have taken a dim view of MEWAs. Some state regulators consider MEWAs to be unauthorized insurers and have tried to shut them down, though a few states have passed statutes setting special rules to allow MEWAs to operate.

By contrast, health care plans

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insured by Centre Solutions, a member of the Zurich Group; and European Re, a member of Swiss Re Group.

The policy is a 50-50 combination of pure risk transfer and finite risk insurance, according to Timothy Cuddihy, associate director in Swiss Re New Markets' Financial Solutions Group. The reinsurers are not ceding any of the risk to retrocessionaires, he added.

The policy will provide an unlimited amount of coverage to pay for any cost overruns associated with the cleanup of some 200 sites nationwide, including several state and federal Superfund sites, Mr. Cuddihy said. The policy also will cover changes in government regulations and any third-party property damage claims. However, the policy will not respond to bodily injury claims, he said.

Hanson will maintain claims management and cleanup oversight throughout the project, which is expected to take 15 to 20 years, Mr. Cuddihy said.

Reinsurer negotiating MBO

LONDON—Zurich Re (London) Ltd.'s management is negotiating to buy the company from its parent, Zurich Insurance Group.

Dennis Purkiss, chief executive of Zurich Re (London), is heading the group proposing to purchase the property and casualty reinsurer. A lead equity partner in the proposed management buyout is Canover Investments, a venture capital group that was involved in last year's MBO of London-based broker C.E. Heath P.L.C. (BI, June 9, 1997).

The purchase negotiations follow rumors in June—which Switzerland-based Zurich Group refused to comment on at that time—that Zurich Group was planning to sell its London reinsurance unit ahead of the planned merger by October of its global financial service operations with those of London-based B.A.T Industries P.L.C.

The sale of Zurich Re (London) would throw into doubt the future of Eagle Star Reinsurance Co. Ltd., the reinsurance unit of B.A.T, which was expected to merge with Zurich Re (London). Details published at the time of the merger announcement had said: "How these operations will participate in the group's worldwide reinsurance business is currently under active consideration."

A spokesman for B.A.T declined to comment on Eagle Star Re or the proposed MBO, saying their future is still under consideration.

At year-end 1997, Zurich Re (London) had net assets of £208 million (\$340.2 million) and premium income of £380 million (\$621.6 million).

Humana faces Viagra lawsuit

HILLSBOROUGH, Fla.—A suit filed by a Florida man against Humana Inc. seeks class-action status for all Humana health plan members denied coverage for Viagra prescriptions.

Because the suit was brought on behalf of an individual participant in Humana's "Gold Plus" plan, it was filed in Florida circuit court, unlike other recent Viagra coverage claims to be filed in federal courts.

"The other ones were brought under ERISA because they were group plans," said Steven Cooper, a partner with the Anderson, Kill & Olick P.C. law firm in New York who is representing the plaintiff.

The federal Viagra coverage suits ultimately might be consolidated, Mr. Cooper said, though for now such claims are likely to continue on a company-by-company basis because of differences in plan policy language. And, Mr. Cooper said, because the Humana case was filed in state court, it would be difficult to consolidate it with those filed in federal courts.

Total damages sought in the Humana suit are consistent with those in the other cases, the attorney said. "In excess of \$1 million. It could be considerably higher than that; it could not reach it. It's just an estimate right now," Mr. Cooper said.

The real purpose of the Humana suit, he said, is to force the health care plan to cover the cost of Viagra, an impotence-fighting drug.

A spokeswoman for Louisville, Ky.-based Humana had no comment on the case, citing a company policy against commenting on pending litigation.

Lloyd's syndicates rated

LONDON—Duff & Phelps Credit Rating Co. has launched a new rating product to assess the financial viability of Lloyd's of London syndicates.

The voluntary product, available for a fee to all Lloyd's syndicates, is called the "Syndicate Continuity Score." It uses an assessment scale similar to the ratings Duff & Phelps now uses to rank the ability of insurance companies to pay claims, but ratings appear in lower-case letters—for example, "aaa" or "aa."

Larissa Knepper, associate director of Duff & Phelps' London-based insurance ratings group, says SCS will be more forward-looking than other rating agencies' assessments of Lloyd's syndicates.

Duff & Phelps will conduct onsite assessments of Lloyd's syndicates and managing agents. Areas assessed will include a syndicate's quality of underwriting and the health of its book of business; its financial controls, such as loss reserve and reinsurance programs; its brand name recognition; its products and services; and its management quality, including its strategic vision and risk appetite.

Errors & omissions

To clarify the July 27 article, "Financial Services Consortium Invests in USI": Equitable Cos. agents place business with Provident Cos. Inc. and CNA Financial Corp. through the Equitable-owned brokerage unit EquiSource. However, Provident has no direct ties to either CNA or EquiSource.

Y2K risks on several fronts

Insurers at risk of vendor flaws, unknown claims: Conning

By GAVIN SOUTER

The good news is that many insurers are on or ahead of schedule in their efforts to exterminate the millennium bug in their own computer systems.

The bad news, however, is that those efforts may remove only part of the problem for insurers.

Even if they clean up their own systems, insurers may suffer from problems caused by Year 2000-related computer glitches at third parties they deal with, particularly at sluggish government agen-

cies, according to a report from Hartford, Conn.-based consultant Conning & Co.

Even if third-party problems are averted, however, insurers still face billions of dollars in claims as policyholders seek coverage under several types of insurance

policies, the report warns. Generally, insurers are doing a

good job of fixing their own internal Year 2000 problems, according to the Conning report. Many large property and casualty insurers are close to becoming or are already Year 2000-compliant due to system upgrades made over the past several years, the report said.

However, insurers still may face Year 2000 problems from their extensive electronic links with other parties.

"Any company that communicates electronically with a non-compliant system risks data cor-

See Year 2000 on page 23



Railroad safety record improving, experts say

By GEORG SZALAI

Despite many high-profile accidents in recent years, industry officials and others maintain that the nation's railroad system is continuing to become safer.

Over the past few years, railroads have particularly focused on reducing highway grade crossing accidents and on improving safety through education and training. Also, more railroads are considering and sometimes implementing anti-fatigue measures and positive train separation technology.

Accidents in which trains collide with vehicles or pedestrians

have caused the most railroad-related fatalities for years; and in reports by the Federal Railroad Administration and the National Transportation Safety Board, better employee training and alertness, as well as positive train separation technology, often have been identified as measures that could have prevented train-related accidents.

FRA statistics show that the number of railroad accidents and incidents of all types was 15,074 in 1996, the last year for which figures are available. That is the lowest number for this decade.

"In 1995 and 1996, there were a

See Railroads on page 4



AP/WIDE WORLD PHOTOS

Despite high-profile derailments, such as this July accident in New York, the rail industry's overall accident rate is improving.

P/C insurer ratings vulnerable: S&P

NEW YORK—Insurers' financial strength ratings likely will fall as the industry's operating performance inevitably deteriorates, a rating agency says.

The good times for property and casualty insurers' results and ratings cannot buck the realities of low rates and expanded coverage for much longer, according to a report by Standard & Poor's Corp. in New York.

"Carriers are pressed to deploy their capital in a low-growth environment and, as a result, are taking actions optimistically characterized as creative, but realistically labeled as potentially unsound," the report said.

In particular, insurers are offering multiyear policies for inadequate rates, deleting standard exclusions, liberalizing claims reporting requirements, covering punitive damages, expanding pollution coverage, insuring employment practices-related risks and changing claims-made coverage to occurrence coverage, the report said. In commercial lines, this expanded coverage has been coupled with rate reductions of more than 10%, S&P noted.

A buoyant economy, good investment returns and a downturn in natural catastrophes currently are saving insurers from losses, the S&P report said. But a good financial performance is not sustainable in the long term, and a deterioration in results will lead to lower ratings, it said.

—By Gavin Souter

Surplus lines and wholesalers directory deadline

Business Insurance will publish its annual directory of surplus lines insurers and wholesalers in the Sept. 7 issue.

To be listed, surplus lines insurers must generate at least 50%, or \$10 million, of gross premiums from non-admitted commercial risks. Excess lines specialty insurers must generate at least 50%, or \$50 million, of gross premiums from excess liability policies written on either an admitted or non-admitted basis. A company must be U.S.-based or, if an alien non-admitted insurer, be currently listed by the NAIC's Non-Admitted Insurers Information Office as having met its criteria.

To be included in the directory of wholesalers, companies must act as a wholesale broker, managing general agent or underwriting manager for retail brokers and must report premium volume.

The directories are published as an editorial service, and there is no charge to be included. Completed questionnaires must be submitted by the extended deadline of Aug. 14. If your company meets the criteria for the directories but has not yet received a questionnaire, please request one immediately by calling Assistant Directory Editor Matt Scroggins at 312-649-5483.

Inside

• A House bill worthy of support would create tax disincentives for companies that buy up structured settlements for outrageously small percentages of total benefits, this week's editorial says. **PAGE 8**

• Three European state political risk insurers are again writing coverage for projects in Iran. **PAGE 17**

• U.K. companies are showing little interest in buying product recall insurance. **PAGE 17**

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Defibrillators save lives but may create liability

By RODD ZOLKOS

Deploying portable heart defibrillators in workplaces, large buildings and public facilities may save the lives of cardiac arrest victims, but the trend also may raise new liability exposures.

As portable defibrillators become more affordable and easier to use, ultimately they might become as commonplace in workplaces and public buildings as first-aid kits.

In the process, though, manufacturers and purchasers of defibrillators must ensure that the devices are used and maintained properly if they want to reduce their exposure to liability suits.

"When you put life-saving medical equipment in the hands of laypeople and you

have untoward outcomes, you're going to have claims against the manufacturer," said Kevin M. Quinley, senior vp at MEDMARC Insurance Group in Fairfax, Va.

Heart defibrillators send an electrical shock to restore a normal

heart rhythm after fibrillation—rapid and irregular contractions of the heart muscle. When used

See Cardiac on page 21



Automatic external defibrillators, such as an HP Heartstream model demonstrated at left, are becoming commonplace in public facilities and airplanes.

Policing their own risks

Formal risk management growing in law enforcement

By ROBERTO CENICEROS

LOS ANGELES—Overstay your sentence at the Los Angeles County jail due to a clerical error and investigators from the Civil Litigation Unit of the Sheriff's Risk Management Bureau will be waiting when you are released.

Agree not to sue and they will cut a check. The amount may not be huge by a successfully employed professional's yardstick—especially for having spent extra time in a dangerous, overcrowded prison system that typically houses 21,000 people each day—but it works for many just-released inmates.

In 1997, the Risk Management Bureau paid out almost \$200,000 to 548 inmates who were incarcerated an average of 6.7 days beyond their sentences. The bureau also recommended hiring additional staff to ease clerical problems that resulted in delayed releases.

Cutting the checks is a good risk management practice that has been upheld by a state Su-

perior Court and has diminished the potential for lawsuits, said Capt. Lee McCown, supervisor of the Sheriff's Risk Management Bureau.

It's not a tactic taught in risk management courses, but there really aren't any formal courses for law enforcement risk management personnel. Traditionally, across the country, there has been very little risk manage-

ment influence on policing and few training materials for introducing the concept.

Few law enforcement agencies nationwide have their own internal risk management departments, said Edward Farrell, risk management director for the Las Vegas Metropolitan Police Department, whose department is an exception. Most law en-

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PHOTO: LOS ANGELES COUNTY SHERIFF'S DEPARTMENT

The Los Angeles Sheriff's Department is one of the few law enforcement agencies with an internal risk management department.

N.Y. sets Holocaust law timetable

NEW YORK—Insurers licensed in New York are subject to strict new requirements for investigating and resolving claims on policies that may have been purchased by Holocaust victims.

The insurance superintendent last week announced a timetable for insurers licensed in the state to comply with the Holocaust Victims Insurance Act of 1998.

The law, which was signed July 3 and goes into effect in 120 days, "encourages insurers to comply with an international commission to resolve these claims. If they do not, then they come under stringent reporting requirements imposed by the New York Insurance Department," said a spokesman for the governor. Uncooperative insurers may face civil fines of \$1,000 per day.

Under the new timetable, insurers must file an outline by Nov. 5

of their procedures for obtaining data needed to investigate and resolve claims on property/casualty and life policies that Holocaust victims may have purchased.

Insurers also are required to investigate and resolve such claims and to provide the Insurance Department with specific claims data and other relevant information by Jan. 30, 1999, and annually thereafter for the next 10 years.

"This timetable brings us a step closer in bringing justice to Holocaust victims and their families and an even bigger step toward holding the insurance companies accountable for all overdue claims of survivors and their heirs," Insurance Superintendent Neil D. Levin said in a statement.

Under the law, insurers must file to the Insurance Department:

- The approximate number and total value of all unpaid policies

issued between 1920 and 1945 to Holocaust victims.

- Any attempts the insurer has made over the years to locate beneficiaries of those policies.

- The number of claims filed by Holocaust victims and whether payment was made on each of those claims.

New York is not alone in its efforts to aid Holocaust victims and their heirs.

Nearly all the members of the National Assn. of Insurance Commissioners have signed a memorandum of intent to establish an international commission charged with resolving the issue.

In addition, members of the NAIC's International Holocaust Commission Task Force recently met with several European insurance regulators about Holocaust survivors' claims (BI, July 6).

—By Meg Fletcher

California payers decry comp bills OK'd by judges

Excess doctor charges not overturned

By JOANNE WOJCIK

SAN FRANCISCO—Employers and insurers fear the dismissal of a fraud case against a California doctor could drive up workers compensation costs and undermine efforts to curb billing abuses.

Both the head of the California Division of Workers Compensation and the chairman of the Workers Compensation Appeals Board, however, say they believe the decision by an Orange County, Calif., judge to drop charges against Dr. Edward Boseker in the middle of a trial was an aberration not likely to be repeated.

Still, insurer trade groups and an employer coalition are seeking legislative review of how consistent workers compensation judges are in applying the law.

The controversy arose after an Orange County Superior Court judge used two retired WCAB judges' interpretation of the definition of face-to-face time as grounds for dismissing a 67-count indictment against Dr. Boseker, a Southern California orthopedist.

The Orange County District Attorney had charged the doctor with multiple felony counts of workers compensation fraud

for submitting medical-legal reports that exaggerated the amount of face-to-face time he spent with injured workers; the amount of time he spent reviewing records; and the number of X-rays he ordered.

Fraud investigators from 20 insurers worked with the district attorney's office for months to build the case, in which 20 injured workers testified at trial that the amount of face-to-face time they spent with Dr. Boseker varied from five minutes to an hour, even though he had billed for two hours in each case.

The California workers comp system allows doctors to charge higher rates for medical-legal evaluations that meet certain criteria, including two or more hours of "face-to-face time by the physician with the patient," according to the California Code of Regulations Section 9795. The regulations define "face-to-face" time as "only that time the evaluator spends in direct face-to-face contact with an injured workers," not that time spent in the waiting room filing out forms or being X-rayed.

However, in defending the case, Dr. Boseker's attorney presented two retired WCAB

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Pittsburgh group hits health cost, quality

PITTSBURGH—Concerned over rising health care costs and declining quality, the Pittsburgh Business Group on Health is calling for area employers to unite and raise awareness of those issues.

"We see quality-of-care issues becoming secondary concerns for key health care decision makers," Marcella Ashley, vp of the 36-employer coalition, said in a prepared statement, the coalition's first on this issue. "Filling hospital beds, winning bigger market share and making more money seem to come first," the statement added.

Members of the PBGH represent 300,000 covered lives.

The coalition plans to conduct meetings with members of the health care community in the Pittsburgh area to discuss its concerns. The next meeting, to include representatives from employers, health plans and providers, is slated for September, where the issues "will be hopefully discussed in depth," said M. Christine Whipple, the PBGH's executive director.

The coalition's goal, according to Ms. Whipple, is to get quality health care at reasonable prices. She said the provider community's response to the PBGH's call has been mixed.

Included on the PBGH's agenda are discussions of spending by hospitals to expand facilities—particularly by University of

Pittsburgh Medical Center Health System—and the proliferation of medical centers designed for high-end treatment such as heart surgery.

Dr. Kenneth Melani, executive vp of Highmark Blue Cross Blue Shield in Pittsburgh, agrees that the expansion by UPMC, as well as its purchase of other area hospitals, is an issue of concern. "The question is, what are they constructing and what will the ultimate outcome be?" he said.

Dr. Melani views the coalition's action as working to maintain the high quality of care offered by UPMC as it grows and dominates medical care in the Pittsburgh region.

UPMC, however, defends its expansion as adding capacity into areas where growth is needed while also looking to cut unnecessary facilities, said Patricia Lieberman, chief executive officer for UPMC Health Plan. She also said that buying local community hospitals brings local input into their system.

"That's the best way for health care to be delivered," she said.

She said UPMC plans to work with employers, including the PBGH, to address their concerns, which she says are understandable, as UPMC controls about 40% of hospital beds in the Pittsburgh area, while Highmark controls about 70% of the managed care market.

—By Michael Prince

Railroads

Continued from page 2

lot of large accidents" and losses, said Bridget Malone, New York-based assistant vp of underwriting in CNA E&S' railroad unit. "So, we did our own study to find out whether this would continue."

The CNA research found that the industry had developed an increased awareness of safety issues and reacted to accidents, Ms. Malone said. When accidents happen, "a lot of times, the industry or the FRA come out with new regulations or new technologies" to address safety issues, she said. "Given the number of railroads and trains in the country, this is a very safe industry," she said, referring to improving safety statistics.

The biggest industry safety gains came during the first half of the 1980s; since then, safety has improved, but not as significantly as it did during that time, said Robert Lauby, director of railroad safety at the NTSB in Washington. Figures for major types of accidents, such as derailments and collisions, follow the same trend. But in recent years, the railroads have made progress particularly in reducing grade crossing accidents and those that involve employees.

1997 marked a low in at least six years in the total number of grade crossing accidents and incidents, according to the FRA. The 3,865 such accidents and incidents last year compares with 4,257 in 1996 and 4,633 in 1995. The numbers of fatalities and injuries are at a low for at least the past 20 years, the FRA statistics show.

"From a liability standpoint, grade crossing accidents are a big concern," said Ian Savage, assistant professor of economics and transportation at Northwestern University in Evanston, Ill.

When it comes to grade crossing accidents, "railroads perpetually lose in the courts," though the state highway authorities are responsible for putting up warning devices, Mr. Savage said. He estimates that grade crossing acci-

dents cost the railroad industry about \$400 million to \$500 million a year, the same amount he estimates the industry spends on trains colliding with other trains and derailment losses, which get more public attention.

Another area where railroads have continued to make progress in recent years is even costlier for them, according to Mr. Savage. Even though FRA statistics show employee casualty rates currently are less than half what they were in 1990, "settlements for employees for injuries, sickness and compensation amount to about \$911 million" annually, he estimated.

Several railroad officials said they have been focusing on reducing grade crossing accidents for years.

"We have become very active in recent years" when it comes to grade crossings, said James McCloskey, assistant director safety-grade crossings at Norfolk, Va.-based Norfolk Southern Corp. Mr. McCloskey's position was established in December 1995 to strengthen the railroad's safety efforts. Grade crossing accidents at Norfolk Southern have decreased to 508 in 1997 from 826 in 1993, he said.

Like other railroads, Norfolk Southern has worked within Operation Lifesaver, a public information and education program founded in the 1970s to raise awareness of the dangers of grade crossings, and it has stepped up efforts to close grade crossings in cooperation with the states, according to Mr. McCloskey.

The states are responsible for equipping grade crossings with warning devices, which the railroads then must maintain. "We have our grade crossing safety committees that inspect sites to see how we can make them safer," he said. "And we get this information to the states."

Omaha, Neb.-based Union Pacific Railroad also has come up with new ways to address the crossings problem. "We have helped train 2,500 police officers in the police academies" to make sure that law enforcement prevents accidents, said Steve Kenyon, UP's general director of safety.

Two years ago, UP launched its

Crossing Accident Reduction Enforcement program, which teams up railroad police with local police to ticket drivers for traffic violations at crossings and to gain media attention for the problem. The program has led to reductions of more than 50% in the numbers of incidents in the targeted areas, Mr. Kenyon said.

Employee training and motivation also has been a focus for the railroads in attempts to improve personal and operational safety. Railroad employee errors in judgment and other lapses, such as maintenance employees missing problems or employees falling asleep, are the second-leading cause of train accidents after track and signal defects, FRA statistics show.

"The real safety officers are our workers and our managers," said Bob Jones, assistant vp-claims at Rosemont, Ill.-based Wisconsin Central Ltd. Over the past two years, the railroad has looked at all its training programs and reassessed its approach, he said. A training center was established, and the length of the initial training for employees was stretched to 12 weeks from two, he said.

Crew fatigue is an employee-related safety problem some railroads have started working on and others are looking at. "Currently, the biggest problem (in the industry) is crew fatigue," said Mr. Lauby of the NTSB.

Fort Worth, Texas-based Burlington Northern & Santa Fe Railway Co. launched a Fatigue Countermeasure Program as part of its March 1996 Era of Safer Operations program, which was introduced after a train derailment at the Cajon Pass in California killed two employees early that year.

BNSF has since allowed train crews to take "opportunity naps" whenever a train stands still—if it has to wait for another train to clear a track, for example—provided one crew member stays awake, said Alan Lindsey, general director safety and rules. Naps are restricted to 45 minutes to avoid engineers' falling into deep sleep, which would cause dizziness after waking up, Mr. Lindsey said. BNSF also started making work times more

predictable for employees, he said.

In the railroad industry, employees might be on call and called to work on short notice.

"If you want to improve safety, you must deal with this issue" of fatigue, said Dr. Mark Rosekind, president and chief scientist of Alertness Solutions, a Cupertino, Calif.-based consulting firm that this year helped UP start a four-year process to develop and gradually roll out an anti-fatigue program. UP's measures will combine education and training, new napping policies, a change in lodging environments, more predictable crew scheduling and the confidential identification of people with sleep disorders, said Dr. Rosekind.

UP also established and filled the new position of director of alertness management late last year.

Sleepiness and other human factors can cause big accidents that could be prevented through technology. To avoid derailments and crashes, many railroads have been looking at positive train separation or positive train control, systems usually based on satellite and computer technology that bring a train to an automatic stop when its locomotive engineer fails to comply with speed limits or misses a signal or when two trains come too close. The NTSB has had PTC/PTS on its most-wanted list for railroad safety since 1990.

According to the Assn. of American

Railroads, 11 PTC or PTS projects by all the major railroad companies are currently under way in different parts of the country to develop a reliable and economic system.

The railroads are spending millions on these projects, and organizations such as the FRA and AAR provide some money. Still, some railroad officials and experts have doubts that the safety benefits of the PTS or PTC technology will match the costs. Experts and safety officials said they expect that nationwide PTC or PTS introduction would cost billions.

Jeff Young, general director-advanced operating systems at UP, estimated a systemwide introduction for his company alone would cost about \$500 million. "The safety benefits do not at all justify that cost," he said. While collisions and overspeed accidents caused by human error could be prevented, only "\$30 million worth of accidents" would be prevented by this system and that amount would be saved only "in a bad year," he said.

Railroad officials said they think all these safety initiatives and programs are producing further improvements of their safety records. Nevertheless, the costs per million train miles for accident-related train, track and equipment repair have increased from \$275,615 in 1994 to \$329,586 in 1996, according to the FRA. Before that, the figures showed a downward trend. **BI**

BI promotes two on editorial staff

CHICAGO—*Business Insurance* has made several changes among editorial management.

Effective July 27, Regis J. Coccia is managing editor and Todd J. Behme is assistant managing editor.

Messrs. Behme and Coccia each assume duties formerly managed by Roseanne C. White, who is now reporting on risk and insurance issues on a part-time basis as a senior editor in the Washington bureau.

In her previous role as managing editor, Ms. White, 40, managed editorial staff, helped set editorial policy and also was the magazine's chief news editor. Ms. White joined *Business Insurance* in December 1991 in Chicago as a copy editor. She was promoted to assistant managing editor-news in July 1994 and promoted to managing editor in July 1996.



Ms. White

She moved to *BI*'s Washington bureau in 1995. Before joining *BI*, Ms. White was editor of FLASH, a magazine for creative professionals in advertising and graphic design. She also was editor of Heavy-Duty Distribution, a magazine covering the truck parts and service market, and Midwest editor of Business Travel News, a newspaper for corporate travel managers. And, she was media relations manager for Midway Airlines in Chicago.

Ms. White holds a master of science degree in journalism from Northwestern University's Medill School of Journalism in Evanston, Ill., and a bachelor of arts degree in political science from Northwestern.

Ms. White can be reached at 202-662-7216.

Mr. Coccia, 30, based in Chicago, will manage the editorial staff, help set editorial policy and continue to oversee the magazine's day-to-day operations, including copy editing.

He has served as assistant managing editor since July 1996, and previously was a copy editor.



Mr. Coccia

Previously, he managed *BI*'s Agent/Broker Topics and Insurer Topics demographic sections. He joined *BI* in February 1993.

Mr. Coccia had been assistant city editor at The Jasper, Ind., Herald. He interned at The South Bend, Ind., Tribune while earning a bachelor's degree in American studies at the University of Notre Dame in Notre Dame, Ind.

Mr. Coccia can be reached at 312-649-5274.

As assistant managing editor, Behme, 30, will become the magazine's chief news editor. He previously was a copy editor and managed the Insurer Topics section a joining *BI* in July 1996.

Before joining *BI*, Mr. Behme was an account executive with Th



Mr. Behme

Reynolds Communications Group, a public relations firm in Evanston, Ill. Prior to that, he served as a reporter and as a copy editor for the Rockford Register Star in Rockford, Ill. from 1992 to 1995. In addition, Mr. Behme was a reporter for the St. Cloud Times in St. Cloud, Minn. from 1990 to 1992.

He received a bachelor of science degree in journalism from the Medill School of Journalism at Northwestern University in Evanston, Ill.

Mr. Behme can be reached at 312-649-5440. **BI**

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THE BUSINESS
INSURANCE EXPERTS



Opinions

Settlements should last

CURRENT TAX LAW DISCOURAGES people from cashing in or tapping their retirement savings so that those funds serve their intended long-term purpose.

Why should structured settlement payments designed to meet current and future financial and medical needs of people be any different?

Currently, however, recipients of structured settlement payments can trade in that long-term security for the short-term gain of a lump-sum payment that invariably is worth far less than the value of their promised payments. There is a thriving industry of special finance companies, called factoring companies, that buy up all or a portion of the annuities used in structured settlements for a percentage of their worth and securitize these tax-free payments for resale on the secondary market, much like mortgage-backed securities.

We support legislation introduced in the House by Reps. E. Clay Shaw Jr., R-Fla., and Fortney "Pete" Stark, D-Calif., that would create disincentives for these transactions in the interest of protecting injured parties from the temptation of getting their hands on a pot of cash at the expense of their future needs.

Typically, structured settlements are arranged when the future financial needs of a claimant outstrip his or her current requirements. This is frequently the case with claimants who are minors, individuals who are totally disabled, or those who are incompetent to manage their affairs.

Many of these people have never had as large an amount of cash as they may be offered by a factoring company, and they are not equipped to handle the demands of managing it for their long-term needs—exactly what the structured payments were designed to accomplish in the first place.

Therefore, even if the lump sum paid to the claimant is not quickly squandered on some form of immediate gratification, it is certain to disappear more quickly than the original benefit. That can put claimants between a rock and a hard place: They likely still have sizable expenses but no source of adequate income to cover them. Certainly, they have no recourse to seek damages from the party that originally settled their claim.

Where does that leave them—especially if the circumstances of their claim have left them unable to earn a living? In all likelihood, at the doorstep of the taxpayer who finances Medicare, Medicaid and public assistance programs.

The proposal in Congress—as well as bills introduced in a handful of states—would greatly minimize this risk.

As we have reported, H.R. 4314 would create a new excise tax to be paid by the factoring companies that purchase structured settlements. The bill calls for a 50% excise tax on the difference between the value of the annuity payments and the discounted lump sum the factoring company pays for them. An exclusion would be allowed only in hardship cases authorized by court order.

We would support even more onerous tax penalties on factoring companies that prey like vultures on these injured parties and pay lump-sum amounts that are an outrageously small percentage of the original benefits. In some extreme cases, those lump sums may



be discounted by as much as 60% of the value of total payments.

Are there cases where a whole or partial exchange of a long-term settlement payout for a lump sum may be warranted? Of course, but such situations should be clearly spelled out or reviewed by judges, as is proposed by the bill.

If the prognosis changes for a person receiving a long-term payout, for example, and he or she is expected to survive only a short while longer, then cashing in the payments to meet short-term financial and medical needs, or to provide a benefit to heirs, may make sense.

Alternatively, perhaps a settlement beneficiary needs to cash in part of his or her payments to purchase a first home or to meet tuition costs and is willing to accept the trade-off of a diminution of his or her long-term security.

In both cases, such safe harbors should be specified in the tax code, just as there are now steep excise taxes on withdrawals of retirement savings for all but a handful of circumstances deemed essential.

It is also worth noting that currently there is nothing to prevent a settlement from being structured so as to provide an upfront lump sum, in addition to regular future payments.

If the practice of buying out those future payments is not discouraged, the tax-favored status of these settlements could be in jeopardy. A change in the tax status could discourage companies and insurers from negotiating settlements of injury claims, as the cost of making such payments would have to increase to factor in the impact of taxes. The higher stakes likely would result in added litigation costs and delays in compensating deserving parties.

One caveat to the legislation raised by risk managers is that the proposed tax could raise the stakes in settlement negotiations to offset the excise tax. The risk managers suggest that plaintiffs attorneys and factoring companies could work in tandem to seek larger settlements, knowing that the ultimate value of the payments would be worth less if they were subject to taxes.

While anything is possible, we believe the excise tax penalty is likely to be onerous enough to curb these transactions, thereby making the risk of such inflated settlements relatively rare.

We also think that the risk is outweighed by the legislation's goal: discouraging companies that prey on disabled recipients of structured settlements, while protecting these people from making foolish decisions that may bring short-term gains but long-term ruin.

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Denver: 303-698-7601

London: 171-457-1400

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OCTOBER 26-28, 1998

*The Ritz-Carlton Hotel
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WHO SHOULD ATTEND

Risk managers, loss prevention and safety managers, workers compensation and benefit managers, plus insurers, brokers, consultants and representatives from HMOs, PPOs and state and local governments.

PROGRAM AGENDA

MONDAY, OCTOBER 26

9:30 AM
GOLF TOURNAMENT
Hosted by: Deloitte & Touche LLP and SAC³

3:00 PM
EARLY REGISTRATION

4:00 PM
**EMPLOYER'S PRIVATE
 ROUNDTABLE**
Moderator:
Kathryn J. McIntyre
*Vice President, Publisher and Editorial Director
 Business Insurance*

5:30 PM
WELCOME RECEPTION
Hosted by: Integra Group

TUESDAY, OCTOBER 27

7:45 AM
**REGISTRATION AND
 CONTINENTAL BREAKFAST**
Hosted by: Bayne Consulting Group, Ltd.

9:00 AM
OPENING REMARKS
Alexandra Scott
*President & CEO
 International Business Forum*

9:05 AM
KEYNOTE
Bruce G. Sundquist
*Vice President
 American Re-Insurance Company*

**CHALLENGING TRADITIONAL
 WORKERS COMPENSATION
 PARADIGMS**

9:45 AM
**THE NEW WORLD OF
 WORKERS COMPENSATION**

Moderator:
Maddy E. Bowling
Independent Consultant

William Granahan
*Senior Consultant
 Milliman & Robertson Inc.*

Barry E. Thompson
*National Practice Co-Leader
 Workers Compensation and
 Disability Management Services
 Deloitte & Touche LLP*

Daniel J. McVey
*President
 Missouri AFL-CIO*

Greg Owen
*Manager, Claims Administration
 Risk Management
 Harrah's Entertainment Inc.*

Scott Lund
*Vice President, Marketing
 SAC³*

10:30 AM
**TABLE-TOP EXHIBITS
 REFRESHMENTS**
Hosted by: Paradigm Health Corporation

11:00 AM
**THE DECISION WHETHER TO
 IMPLEMENT AN INTEGRATED
 DISABILITY MANAGEMENT
 PROGRAM**

Moderator:
Terry R. Bolz
*Vice President, Casualty Managed Care
 Wausau Insurance Companies*

Tom Parry
*President
 Integrated Benefits Institute*

Victor Paganucci
*Director, Integrated Disability Systems
 Champion International Corp.*

Joanne L. Pomerleau, B.S., RN
*Workers Compensation Coordinator
 Maine Employee Health and Benefits*

Arthur Wilcox
*Director, Public Employee Division
 New York State AFL-CIO*

12:00 PM
**MEETING THE CHALLENGES
 CREATED BY THE AMERICANS
 WITH DISABILITIES ACT AND
 FAMILY MEDICAL LEAVE ACT**

Moderator:
Betsy Robinson
*Vice President
 Product Development and Management
 GENEX Services Inc.*

Robert B. Stegert
*Vice President, Casualty Claims
 Marriott Corporation*

Ken Mitchell
*Vice President, Return-to-Work Programs
 Provident Insurance Company*

Marylou Kinlen
*Manager of Disability Plans
 Norwest Bank Corp.*

Sharon Kaleta
*Director of Risk and Benefits
 Paragon Steak House Restaurants Inc.*

12:45 PM
LUNCHEON
Hosted by: Intracorp

1:45 PM
LUNCHEON SPEAKER
Susan K. Moreland
*Director of Risk Management
 San Francisco Newspaper Agency*

**A CASE STUDY ON REDUCING
 WORKERS COMPENSATION
 LIABILITIES**

2:15 PM
BREAK

Presented by Business Insurance and IBF • International Business Forum

2:30 PM CONCURRENT SESSIONS: A OR B

Session A: ALTERNATIVE DISPUTE RESOLUTION

Moderator:
Duncan Ballantyne
Senior Analyst
Workers Compensation Research Institute

Ed Zutler
Vice President, Integrated Benefits
AIG

Pat McGinn
Senior Business Representative
Regional Council of Carpenters

Mike Massey
Assistant Executive Director
Piping Industry Progress and
Education Trust Fund

Session B: ARE YOU USING THE RIGHT REPORT CARD?

Moderator:
Peter F. Rousmaniere
President
Rousmaniere Designs

Nicholas J. Lannutti
Senior Vice President, Corporate Actuary
National Council on Compensation
Insurance Inc.

Alex Swedlow
Research Consultant
California Workers Compensation Institute

Eloise Lincicum
International Workers Compensation/
Employers' Liability Manager
Apple Computer Inc.

Fred Scardelletta
Vice President, Information Management Services
Intracorp

9:00 AM KEYS TO RESPONSIVE RETURN-TO-WORK PROGRAMS

Moderator:
Dr. Thorv Hesselund
Director of Vocational Programs
Paradigm Health Corporation

Jean M. Long, RN, COHN, CCM
Manager, Loss Control
Fireman's Fund Insurance Company

Clifton Matsuno
Administrator for Rehabilitation Services
Protect Physical Therapy

Marshall Sherman
Director, Risk Management
Aramark Corporation

Soraya M. Wright
Corporate Risk Manager
The Clorox Company

John J. Larkin Jr., M.D.
Vice President, Clinical Affairs
Integra Group

10:00 AM TABLE-TOP EXHIBITS REFRESHMENTS Hosted by: Specialty Risk Services/The Hartford

10:30 AM DOING WHAT'S BEST FOR THE WORKER: CAUGHT BETWEEN THE EMPLOYER, THE TPA, INSURANCE COMPANY AND THE OCCUPATIONAL HEALTH PROVIDER

Moderator:
Stephen M. Holcomb
Senior Vice President
Specialty Risk Services/The Hartford

Panelists:
Leo Costantino
Workers Compensation Manager
UCLA

Jerry L. Thomas
Managing Director, Workers Compensation
American Airlines/AMR Corp.

11:30 AM WORKERS COMPENSATION INSURANCE FRAUD: SPECIFIC STEPS AND SOLUTIONS TO COMBATING FRAUD

Moderator:
Dominic Dugo
San Diego County District Attorney

William Kizorek
President
InPhoto Surveillance

Jeff Nale, Esq.
Bello, Tade & Nale

Kevin Saucier, R.S.A., REA
Director of Environmental, Health and Safety
Guess? Inc.

Maria Bayne
President
Bayne Consulting Group Ltd.

12:30 PM LUNCHEON Hosted by: AIG American Home Assurance/ Specialty Workers Compensation

**1:30 PM
LUNCHEON SPEAKER**
Jerry L. Thomas
Managing Director, Workers Compensation
American Airlines/AMR Corp.

THE AMERICAN AIRLINES SUCCESS STORY: BEST PRACTICES AND LESSONS LEARNED

2:00 PM BREAK

2:15 PM LOW BACK TREATMENT GUIDELINES

Moderator:
Edward C. Woodward
President
California Workers Compensation Institute

Nancy Geedey, RNC, CCM
Director, Case Management
Managed Care USA Services

Michael D. Roback, M.D.
Diplomate, American Board of
Orthopaedic Surgery
Industrial Medical Council of California

3:15 PM CONFERENCE ADJOURNS

COMMENTS FROM SOME OF LAST YEAR'S ATTENDEES:

"The whole conference was a great opportunity to listen to very good presentations."

Al J. Rhodes • President • SIGMA

"Well worth the investment. I came away from the forum with ideas I was able to implement and it allowed me to hear the experiences of others. Great networking."

Leo Costantino • Workers Compensation Manager • UCLA

"Everything you included on the agenda was interesting and informative."

Sam Fulginiti • Risk Manager • GODIVA CHOCOLATIER

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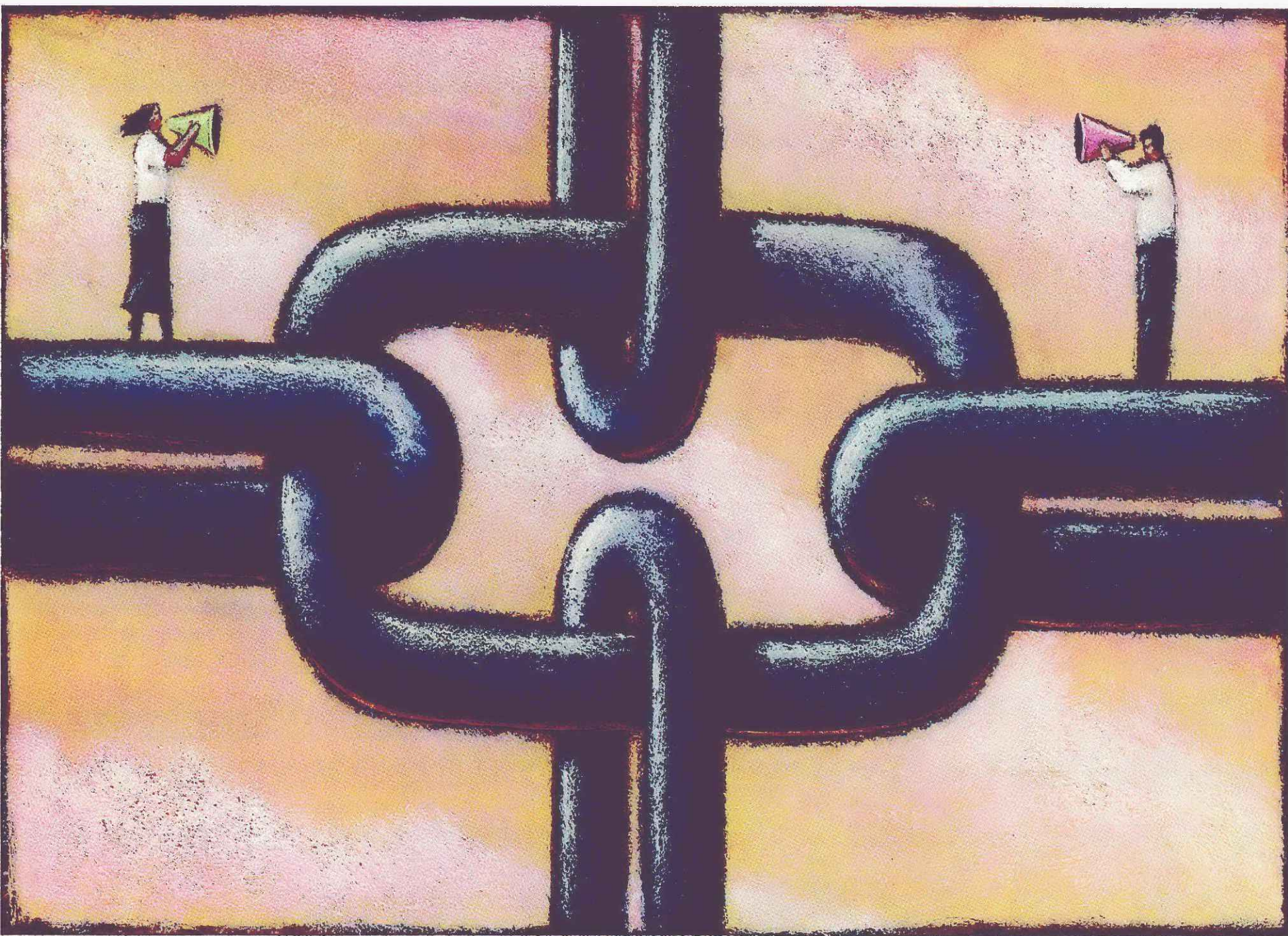
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BIWCFPS

WEDNESDAY, OCTOBER 28

7:45 AM CONTINENTAL BREAKFAST Hosted by: TravelersPropertyCasualty/ Constitution State Services

5:00 PM COCKTAIL RECEPTION Hosted by: GENEX Services Inc.



SURPLUS LINES

A Spotlight Report on
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*including BI's Directory of
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The year 2000 will be felt for many to come

By Andrew M. Pegalis
and David L. Schaefer

THE YEAR 2000 PROBLEM is already upon us. Forty-four percent of companies in a recent survey by the Information Technology Assn. of America have already experienced operational disruptions because of the Year 2000 problem.

Sen. Robert Bennett, R-Utah, noted in a recent Senate hearing that the question is not would we be affected by the problem, but rather how badly will we be affected. Those once scoffed at as techno-apocalyptic doomsayers are now respected leaders in a developing Year 2000 problem industry that is working diligently to prepare its clients for the next millennium. Sen. Bennett himself has begun referring to Y2K as "The Asteroid."

Only now that awareness has been raised to a level slightly above complete denial are the outlines of loss scenarios taking shape. These loss scenarios must be anticipated to the extent possible.

Nowhere is this more important than in the insurance industry. Insurers, like all other organizations, have misunderstood the Year 2000 problem as a mere technical problem until only recently. While the status of internal Y2K programs is important to insurers and policyholders alike, the greatest risk related to the insurer/policyholder relationship is the uncertainty of how existing policies may respond to Year 2000-problem events.

Looking at the issue from a macroeconomic perspective, determinations against coverage can leave policyholders without a viable cost recovery vehicle and potentially bankrupt a significant portion of corporate America, leaving insurers with a reduced marketplace. On the other hand, wholesale determinations in favor of coverage also can potentially bankrupt many insurers, leaving policyholders with fewer coverage options at significantly higher premiums.

Even the most conservative cost-recovery estimates range upwards of \$300 billion, which, if substantially covered, would make the Year 2000 problem the most significant single catastrophe in insurance history by far.

The Year 2000-problem coverage debate is critical to have at this juncture, because the question of whether coverage exists under today's insurance policies is very much unsettled.

Beginning on or before the stroke of midnight, Dec. 31, 1999, and continuing on for years, the effects of the problem will be felt in four waves:

- The first wave will be the technical manifestations in software, hardware and date-sensitive embedded electronic systems.
- The second wave will be first-party property insurance claims, many of which could involve direct damage scenarios, such as system incompatibilities, operational disruptions, supply chain shortages and physically manifested consequential losses, such as accidents from traffic light failures.
- The third wave will be breached contracts, liability insurance claims, liability-based third-party litigation and insurer subrogation actions.
- The fourth wave will be the aftermath. After all the cost recovery and litigation is complete, individual companies may no longer exist, or they may be forced to restructure, and others will stand in a better competitive position because of the effect of the Year 2000 problem.

The greatest societal concern is the preservation of essential industries, including the insurance industry.

The first series of insurance claims likely will be for the value of damaged software, hardware or embedded systems and/or the cost of remediation. Most property policies are written on an special form or all-risk basis that provides a broad coverage grant for "direct physical damage or injury" unless a specific exclusion applies.

The "direct physical damage or injury" requirement may eliminate many potential Year 2000 problem-related claims or require creative legal theories. Insurers will likely maintain that the Year 2000 problem is not direct physical damage, but rather a programming error or expected event and therefore not covered.

The counterargument could be that software—and the medium upon which it is contained—is a physical item

that suffered damage. There is also a more esoteric argument that a Y2K event is essentially the transference of electrons, which are physical, and that damage resulted directly from that transference. Even if insurers' arguments are more persuasive, this may not effectively prevent coverage for "consequential losses." Under many Y2K scenarios, consequential losses can far exceed the loss to the information technology product itself.

There will be tremendous pressure on the courts to find a socially acceptable "deep pocket" to bear the enormous cost that business will likely incur. The insurance industry has been here before, as witnessed by asbestos and environmental liability.

For example, a controller in a commercial HVAC system experiences an event on Jan. 1, 2000, due to Y2K and shuts down the environmental controls. By Jan. 3, the static water in the fire suppression system freezes and expands, bursting the pipes, causing significant water damage.

In this instance, the insurer will be called upon to respond to the costs of repairing the consequential direct damage to the premises and contents and the business interruption costs. Only a very onerous Year 2000-problem exclusion might prevent coverage under these circumstances. Relying on a "direct damage" requirement, a boiler and machinery insurer may successfully avoid paying for the failed microcontroller or the HVAC system itself, but this may be a Pyrrhic victory compared with the insurer's cost to repair the damage to the premises and associated business interruption losses.

From that hypothetical situation, one can easily envision the potential subrogation issues between the boiler and machinery insurer and the insurers of the manufacturer, reseller, maintenance contractor and installer of the HVAC system as well as the manufacturer of the microcontroller itself.

The other hurdle property claimants must overcome is the fortuity requirement. Only fortuitous losses may be the basis for nearly all insurance claims. There is a great debate already forming as to whether a Year 2000 event is, in fact, fortuitous. The arrival of the year 2000 is no surprise, nor the existence of the Year 2000 problem. However, the process of remediating software is expensive, laborious and imperfect.

As the Securities and Exchange Commission noted in its June 1997 report to Congress, it is important that one essential principle be understood: It is not, and will not, be possible for any single entity or collective enterprise to represent that it has achieved complete Year 2000 compliance and, thus, to guarantee its remediation efforts. The problem is simply too complex for such a claim to have legitimacy. Efforts to solve Year 2000 problems are best described as "risk mitigation."

With this as a backdrop, property claimants will likely argue that the Y2K event was indeed a chance occurrence, in that it occurred despite remediation efforts. We predict that many declaratory judgment actions and the practical definition of "fortuity" will turn on the timing, funding, comprehensiveness and pragmatism of policyholders' Year 2000 programs.

While some insurers are adding specific Year 2000-problem exclusions to their property forms as extra protection against Year 2000 claims, it is important to note that, in many instances, determining that a Year 2000 event was in fact the ultimate cause of loss may be virtually impossible. This is particularly noteworthy for all-risk—or special form—policies, where the burden rests on insurers to prove that exclusions apply.

Another troublesome aspect of Year 2000 problem-related property insurance losses will be claims adjusting. Adjusters will likely find themselves inundated with numerous complex claims requiring an understanding of the Year 2000 problem and specialized investigating skills in which they likely will not have been trained. These claims will come at a time when claim-handling systems themselves could be Year 2000-impaired. Errors or delays in claims adjustments can result in bad-faith claims (and treble damages), unnecessary claim payments, or hasty claim payments that fail to consider the future impact of subrogation.

The implications of the Year 2000 problem on liability

policies are more complex because the sources of liability stem from mismanagement of Year 2000-problem projects, failure to adhere to a professional standard, breach of corporate duties, fraud, disclosure violations, etc. Although most Year 2000 problem-related liability claims will not occur until the third wave of Year 2000 problem impacts, these are the coverages that insurers see as being most affected and have chosen to address first.

In the directors and officers liability insurance context, there are many predictable loss scenarios. Corporate governance of Y2K programs, disclosure and other securities violations, making major corporate decisions in anticipation of (or disregarding) Y2K, and generally failing to anticipate and remedy Y2K can all be the bases of D&O liability. For this reason, D&O insurers are scrambling to develop corporate policy toward dealing with D&O risks and coverage.

There are particular pitfalls for the D&O policyholder. Renewals for claims-made policies are generally tenuous regardless of Y2K. The only reason policyholders are able to renew policies without Year 2000 problem exclusions or without completing detailed Year 2000 problem questionnaires is because of an unprecedented and extended soft insurance market.

The risk of losing D&O coverage for Year 2000 problem-related claims might be the greatest insurance-related threat to policyholders before the year 2000. Failure to report material changes in risk or making material misstatements during the policy period or at renewal can void coverage for a specific claim or create an *ab initio* (the policy is null and void and the premiums are returned) situation. Much of this might turn on what the board of directors or senior officers knew (actually or constructively) and when did they know it.

For those industries deemed "professions," there is errors and omissions liability exposure and insurance. Physicians, architects, attorneys, accountants and insurance brokers all face the Year 2000 problem, yet no standards-generating organizations have addressed it. This fact poses a problem for E&O insurers, as adherence to time-honored professional standards, without change, will generate liability claims.

For example, physicians relying on readouts from untested and non-compliant medical equipment; omitting Y2K from a legal due diligence of an information technology company acquisition; or inaccurately auditing financial controls of an organization impacted by Y2K all can generate liability.

For this reason, E&O insurers have begun to make inquiries at renewal. Surprisingly, these inquiries have been limited to the status of standard Y2K programs (internal computer systems, external business dependencies, etc.) and have not addressed the modification of professional conduct.

It is interesting to note that the information technology industry remains a trade and not a profession. While miscellaneous E&O policies have been written for information technology companies, there are currently no professional designations or accreditations for software programming, systems analysis, hardware architecture development or embedded chip manufacturing. This may well change in the post-year-2000 economy, as disparate protocols become challenged and the Year 2000 problem angers information technology consumers.

Commercial general liability policies are at risk, particularly those held by information technology manufacturers, systems integrators, consultants, and maintenance contractors. While most disputes over Y2K-prone information technology products will be brought under traditional contract theories (not covered by CGL), the products these and other companies make which actually cause some physical harm due to a Y2K event may be covered losses under CGL policies absent Y2K exclusions.

The first area of debate is the requirement for "bodily injury or direct property damage" to a third party. Instances of bodily injury are fairly straightforward, but direct property damage is an area of controversy. While a Y2K-caused power outage that results in frozen pipes may not qualify as direct property damage, a Y2K-caused failure of a pressure

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valve that leads to an explosion most likely does qualify. These sorts of direct property damage claims are expected to be prevalent, particularly in Northern and Midwestern states, where freeze and water damage can be caused by failures in environmental control systems.

The other area of great debate is the "expected or intended loss" exclusion. Particularly for information technology manufacturers, insurers already maintain that the Year 2000 risk is expected and/or intended and therefore any resulting loss is not covered. Relying on this basis to deny claims will require litigation as each case is fact specific and a determination of what the policyholder actually knew (subjective jurisdictions) or should have known (objective jurisdictions) will be required. Policyholders may also argue that Y2K was indeed a design protocol, but that the specific manifestations of Y2K problems, particularly when systems are interconnected, were neither expected nor intended.

This is an appropriate place to highlight that an insurer's duty to defend is broader than the duty to provide coverage. Many jurisdictions do not allow declaratory judgment actions to determine coverage prior to the adjudication of the underlying claim.

For trustees, financial institutions, investment advisers and benefits administrators, there is a particular concern for fiduciary liability.

Those entrusted to manage the assets of others face the

daunting task of overcoming denial and affirmatively adopt investment and money management strategies that contemplate the impacts of Y2K. This is particularly troublesome for Y2K since its impact remains the subject of speculation and debate among various experts. Failure to ensure compliance of, or at least inquire about the same, among banks holding assets, securities and other investments, could bring swift claims by those losing asset value. Insurers of fiduciary liability, in general, have begun to address Y2K in terms of inquiries but not with exclusions. For this reason and, potentially the passage of recently introduced legislation that could heighten the fiduciary standard of care related to Y2K, there are likely to be greater-than-expected loss experience against these policies.

When it comes to Y2K, the only certainty is uncertainty. Insurers are fighting a competitive battle for premium dollars and market share in a protracted soft market. While corporate policy may require renewal inquiries or warranty statements, the competitive pressures of the market make it more than likely that there will be no uniform evaluation of the answers to these questions.

Conflicting insurer positions regarding silence and what it means will warrant adjudication, jurisdiction by jurisdiction and policy by policy. There are infinite Y2K loss scenarios that will find coverage under existing policies. Insurers have not taken a consistent approach to Y2K, with some excluding it, some expressly offering limited coverage and others attempting to underwrite it at renewal based on a simple 15- to 30-question survey with

untrained underwriters and inconsistent standards.

In short, the insurance industry is headed directly into a collision with Y2K and is not steering away or applying the brakes. No one will benefit from insurer insolvency, but policyholders will certainly lose if their losses are uninsured. Without a more forthcoming position on the part of every insurer, this could happen. On a scale this large, the courts will look to public policy to determine fairness and insurers may find themselves looking for assistance from state regulators or their reinsurers to protect them from insolvency. **BI**



Mr. Pegalis



Mr. Schaefer

Andrew M. Pegalis is president of Next Millennium Consulting Inc., a risk management consulting company in Bethesda, Md., that provides Year 2000 risk management services. David L. Schaefer is vp/principal specializing in technology at brokerage Armfield, Harrison & Thomas Inc. in Leesburg, Va.

ASK A BENEFIT MANAGER

Q

There has been a great deal of discussion with regard to quality health care being delivered and how to measure quality. Are there any new initiatives in the area of quality?

A

During the past four to five years, there has been a significant increase and focus on quality in health care. With health care costs moderating over this period, employers appear to have shifted their primary focus from cost and are now focusing on the quality of health care. It is generally agreed that improved quality of health care will result in healthier people and that long-term cost will be reduced as a result of the improved quality.

Numerous accrediting organizations review both health plans and hospitals. For example, the National Committee for Quality Assurance accredits health care plans. The NCQA will implement a new accreditation program next year, called Accreditation '99. The enhanced program will incorporate certain Health Plan Employer Data and Information Set measures relating to access to care, member satisfaction and effectiveness of care. The program also will include a new accreditation status of excellent to distinguish the nation's top health plans.

The Joint Commission on Accreditation of Health Care Organizations—or the JCAHO—also accredits hospitals and health care networks. Other accreditation organizations include the Accreditation Assn. for Ambulatory Health Care and the Utilization Review Accreditation Commission. When choosing health care plans to offer to employees, we should be aware of these accreditations.

The American Medical Assn. is sponsoring a new accreditation process. This new accreditation program for individual doctors is referred to as the American Medical Accreditation Program.

AMAP is governed by a 22-member board that includes a jury of physicians as well as representatives of consumers, employers, the federal Health Care Financing Administration, managed care plans, voluntary health organizations and accreditation organizations, among others.

The AMAP accreditation is awarded to licensed

physicians who have conducted their professional activities in accordance with standards set to define quality in professional practice.

These standards include:

- Ethical behavior.
- Absence of disciplinary actions by hospitals, licensing agencies or financing programs.
- Participation in peer review.
- Participation in clinical self-assessment.
- Operation of a safe patient center practice that meets criteria for quality.
- Participation in measurement of clinical performance and patient care results including patient safety.

This new accreditation certainly will be of help to both health care organizations and health plans that want a tool to evaluate physicians. This accreditation is not specialty-specific, and detailed reports on accreditations are provided upon request to health care organizations and health plans. These reports include information on the physicians' licensure status and specialty board certification.

The AMAP standards and criteria have been reviewed by a national interdisciplinary group of health professionals and interested parties that comprise the five AMAP Advisory Committees. These committees include credentials and personal qualifications, environment of care, performance measures, federation of medicine and specialty care.

Additionally, more than 1,400 potential users of AMAP information have had the opportunity to review the standards and criteria. This group includes practicing physicians, state medical licensing boards, medical societies, employee benefit managers, business groups on health, consumer groups, liability insurers, medical management groups, hospital groups, managed care organizations, credentials verification organizations, accreditation organizations, and peer review organizations. The review of such a broad spectrum of organizations and interest groups should assure a meaningful process.

Two key elements of the physician credentialing are clinical performance and patient care results. These elements encourage physicians to participate in continuous quality improvement programs and provide them useful feedback on their performance and patient care results compared with their relevant peers. The focus of these components is not a single point in time measure or judgment, but rather information and improvement over time.

The AMAP program is a significant undertaking by the AMA. It appears that this accreditation program will be of significant help to health care plans and hospitals alike.

The program also should be of help to employers in evaluating health care plans to be offered to their employees. From the benefit professional perspective, it will be good to see the health care plans and medical organizations using a single standard for accrediting physicians. Ultimately, this program should lead to improved quality health care being provided through health plans offered by employers.

This program is in its infancy. Currently it is operational in only one state—New Jersey—with 4,000 physicians applying. Two additional states—Idaho and Montana—and the District of Columbia are scheduled to start this summer. The ultimate target is to have the program operational in all 50 states by January 2001. Look forward to this accreditation in dealing with your health plans in the future. **BI**

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

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



Mr. Nirtaut

This month's column on employee benefit management issues is written by Dennis J. Nirtaut, managing director of compensation and benefits for Andersen Worldwide S.C. in Chicago. Christopher E. Mandel, director-risk management at TRICON Global Restaurants Inc. in Louisville, Ky., answers questions on risk management issues. William J. Miner, an actuary with Watson Wyatt Worldwide in Chicago, answers actuarial questions on benefits issues. And, Richard E.

Sherman, president of Richard E. Sherman & Associates Inc. in Ashland, Ore., answers actuarial questions in the casualty field.

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

Employer not insured for claim by assault victim

Where employment conditions provide the time and place for an assault and contribute to an employee's bodily injuries, the employer's liability exclusion in a commercial general liability insurance policy precludes coverage, according to the Court of Appeals of Minnesota.

Seagate Technologies Inc. was insured by St. Paul Fire & Marine Insurance Co. under a standard CGL policy. The policy excluded bodily injury to an employee arising out of and in the course of his or her employment by a protected person. Vicki Mae Christian and Skylar L. Lipscomb were both employed by Seagate, although in distinct departments located in separate areas at Seagate's facility. Ms. Christian and Mr. Lipscomb began a personal relationship. However, the relationship eroded with Mr. Lipscomb assaulting Ms. Christian. She obtained an order for protection against Mr. Lipscomb and informed her employer and its security department of that. Nevertheless, Mr. Lipscomb continued to harass and intimidate Ms. Christian at work, resulting in a physical assault on her on May 30, 1993, wherein Ms. Christian suffered a skull contusion, lacerations to her nose and lip, abrasions to her hands and two black eyes. Ms. Christian sued her employer and Mr. Lipscomb for negligent supervision, assault and battery and negligent infliction of emotional distress. Seagate tendered its defense to the insurer but was refused. The insurer then brought this suit, seeking a declaration from the court that it had no duty to defend Seagate under the CGL policy. The trial court ruled against the insurer.

On appeal, Seagate argued that Ms. Christian's claims did not stem from her employment but were caused by personal animosity. But, the court said the conditions of Ms. Christian's employment provided the time and place for the assault. Moreover, the court said that Mr. Lipscomb's access to her at her workstation and Seagate's failure to investigate or take steps to stop the harassment of Ms. Christian increased her risk of being assaulted. "Under these circumstances," the court said, "(Ms.) Christian's claims fit within the employer's liability exclusion." The court concluded that the insurer had no duty to defend because no part of Ms. Christian's cause of action was within the scope of coverage. The trial court decision was reversed.

St. Paul Fire & Marine Insurance Co. vs. Seagate Technologies Inc., Minnesota Court of Appeals, Nov. 18, 1997 (BI/01/Jy.-\$10).

Suspension not ERISA violation

The administrator of an Employee Retirement Income and Security Act plan did not reduce a participant's accrued benefits so as to violate ERISA's anti-cutback provision when it suspended his early retirement benefits pursuant to a plan amendment adopted after he retired, according to the 5th U.S. Circuit Court of Appeals.

The Maritime Assn.-I.L.A. Pension Plan was subject to ERISA. In 1985, Daniel A. Spacek, who worked for 30 years in the Houston longshoring industry for an entity covered by the plan, retired at age 51. At the time Mr. Spacek retired, the plan provided that an employee re-employed in the industry prior to his normal retirement age would cease receiving benefits. A person "employed in the industry" had to meet two requirements, one of which was to be credited with at least one credit hour for the payroll period ending in such month. In April 1991, the plan was amended to eliminate this requirement. Three years later, Mr. Spacek began working as a superintendent for an employer signed on to the plan. The plan suspended his benefit payments for six months based on the amendment. Mr. Spacek sued and won in the trial court.

On appeal, Mr. Spacek argued that the application of the amendment to him violated ERISA because the amendment decreased his early retirement benefits. But, the court said ERISA distinguishes between reduction of benefits and suspension of benefit payments. The court said to interpret reduction of benefits as including suspension of benefit payments would make the word "suspension" redundant in all these statutory provisions. Thus, under the plain language of the law, the court said,

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a suspension of benefit payments was not a reduction of benefits. The trial court decision was reversed.

Spacek vs. Maritime Assn., 5th U.S. Circuit Court of Appeals, Jan. 22, 1998, (BI/01/S.-\$10)

No benefits in mental illness

A claimant diagnosed with a mental illness that was not preceded or accompanied by a physical injury could not recover workers compensation benefits, according to the Supreme Court of Georgia, notwithstanding the undeniably horrible situation with which he was faced.

Joe Abernathy had been a park maintenance supervisor for the City of Albany, Ga., since the 1980's. In July 1994, torrential rain caused the Flint River to flood, and flood waters lifted several hundred caskets from the city cemetery ground, tore some of the caskets asunder and carried caskets and corpses away from the cemetery. Mr. Abernathy and three other employees toiled for hours over three days recovering some 400 caskets and 18 corpses, 12 of which Mr. Abernathy personally retrieved. The bodies had to be manually lifted into the boats and some corpses came apart during the recovery efforts so that Abernathy had to retrieve them in pieces. Although he continued to work after the flood subsided, Mr. Abernathy began to experience vivid recurring nightmares of a dead and decaying body emerging from the water to attack him. He was diagnosed and treated for a post-traumatic stress disorder. He filed for and was denied workers compensation benefits because he had not sustained any physical injury. He appealed.

The state Supreme Court said a compensable "injury" in Georgia requires that a psychological injury is compensable only if it arises naturally and unavoidably from some discernible physical occurrence. According to the court, it was up to the legislature, not the courts, to amend the law. The court acknowledged that the result mandated by the application of the law to the facts of this case appeared to be a harsh one. However, the court said an appellate court "must be just before it is generous." The lower court decision denying benefits was affirmed. Justice Hunstein dissented because he would interpret "injury" as providing protection to employees like Mr. Abernathy who sustained an injury—a mental injury—as a result of his employment.

Abernathy vs. City of Albany, Supreme Court of Georgia, Jan. 26, 1998, Reconsideration Denied, Feb. 23, 1998 (BI/02/S.-\$10).

Sex discrimination not covered

The word "injury" in an exclusion of a commercial excess umbrella insurance policy for liability arising out of injury of an employee of the policyholder included personal injury and, thus, the policy did not cover sex discrimination claimed by a policyholder's employee, according to the 4th U.S. Circuit Court of Appeals.

Gates, Hudson & Associates Inc., a Virginia corporation, was covered by a commercial excess umbrella policy issued by Federal Insurance Co. The policy covered damages when liability was imposed on Gates because of personal injury. Personal injury was defined to include "humiliation or discrimination." However, the policy excluded liability for an injury of an employee in the course of employment. During the period of coverage, a former employee of Gates filed a charge with the Equal Employment Opportunity Commission alleging she had been subject to sexual harassment by her supervisor at Gates. Gates sought Federal to defend or indemnify the claim. Federal refused. Gates then brought this suit, seeking a declaration that Federal had breached its contractual obligations under the policy. The trial court ruled for Federal.

The appellate court interpreted the word "injury" according to the plain meaning, i.e., any wrong or damage done to another, either on his person, rights, reputation or property. According to the court, if "personal injury" were not a subset of injury, an

individual could suffer personal injury, but no injury. The trial court decision was affirmed.

Gates, Hudson & Associates Inc. vs. Federal Insurance Co., 4th U.S. Circuit Court of Appeals, Oct. 9, 1997, Order Published Feb. 24, 1998 (BI/03/S.-\$10).

Rape ruled employment-related injury

An employee's rape by her supervisor was an accidental injury arising out of and in the course of her employment for the purposes of workers compensation, according to the Supreme Court of Oklahoma.

Terri L. Reinholtz, a Wal-Mart Stores Inc. employee, was forcefully and brutally raped by her supervisor while at work in the early working hours. The rape occurred in the automotive store at Wal-Mart on a morning when Ms. Reinholtz was scheduled to open the store and would have been there alone for several hours. She suffered a back injury during the course of the rape. She sought continuous treatment for a psychological overlay and a skin rash for which there was no apparent physical cause. She filed a claim for workers compensation and was awarded benefits for both the physical and psychological injuries. The appellate court denied her psychological benefits. The employer appealed.

The appellate court said that when a willful injury is inflicted by a third party, who is the aggressor, upon a worker discharging the tasks the worker is engaged to perform, and the assault is not motivated solely by personal animosity, wholly disconnected from the employment, the resulting injury is regarded as accidental and as having arisen out of and in the course of employment. Furthermore, the court said a psychological injury accompanied by a physical injury is compensable. The court restored benefits to Ms. Reinholtz for the psychological injury.

Wal-Mart Stores Inc. vs. Reinholtz, Supreme Court of Oklahoma, Feb. 3, 1998, Dissenting Opinion Corrected Feb. 5, 1998 (BI/04/S.-\$10).

No vacation benefits in voluntary plan

Employees under an Employee Retirement Income and Security Act voluntary severance plan were not entitled to vacation benefits that vested on the final day of their employment, according to the 8th U.S. Circuit Court of Appeals.

The plaintiffs here were employees of the Petrolite Corp. who accepted either a voluntary retirement program or a voluntary separation program the employer offered in order to reduce its workforce. Under the company's ordinary vacation policy, an employee earned vacation benefits during one fiscal year that vested at the close of that fiscal year, i.e., Oct. 31, and were available for use during the next fiscal year. The employees here pointed out that vacation benefits vested on their final day of employment—Oct. 31, 1994—and they maintained that, either under the program they accepted or under the company's ordinary vacation policy, the employer had an obligation to pay them the value of their vested vacation benefits. The employees sued and lost in the trial court.

The appellate court agreed with the trial court, stating that the employees' claim that they were entitled to the vacation benefits in question under the relevant programs failed because those programs did not include those vacation benefits. The court emphasized the vacation for which the employees sought benefits now could not have been taken prior to Oct. 31, 1994, and is not included among the benefits provided by the employer to its departing employees in its programs. The trial court decision was affirmed.

Mange vs. Petrolite Corp., 8th U.S. Circuit Court of Appeals, Feb. 2, 1998 (BI/05/S.-\$10).

BI

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.

Police

Continued from page 3

forcement agencies receive risk management advice from civilian city or county administrators, he said.

But that is starting to change. Pressure from public insurance pools to stem losses, a newer guard of better-educated police administrators due to federal funding for college tuition, and increased media and public scrutiny are all adding to the discussion of risk management among police and their associations.

"What seems to be happening is agencies that have the resources to send people to national conferences, trainers' conferences and chiefs' conferences are getting more and more exposed to the idea," said Steven Ashley, loss control manager and director of law enforcement risk control for Meadowbrook Insurance Co. in Southfield, Mich.

Police agencies that practice risk management are combating losses peculiar to their profession, such as those stemming from police officers who raid the wrong residences or apply excessive force. They also are reducing losses more familiar to private-sector risk managers, such as workers compensation claims—albeit in a sometimes unusual environment.

One obstacle to implementing risk management programs has been law enforcement's traditional focus on apprehending criminals while ignoring financial losses.

"Police chiefs never bleed when there is a loss," said Pat Gallagher, a risk management consultant to police for The Gallagher-Westfall Group in Indian Valley, Va. "In many cases, they just turn it over to the insurance pool, or they turn it over to their insurance agent. Maybe they are deposed, and they are ticked off at the settlement. But it never really affects them, and I think that is one of the reasons why they don't see the need to do a lot more proactively."

But some agencies, particularly larger ones such as the Los Angeles County Sheriff's Department, are making the issue a top priority by funding risk management operations within the law enforcement department.

The Los Angeles County Sheriff's Department has approximately

9,000 sworn personnel and 3,000 civilian employees who provide police services for several cities and unincorporated areas in the county, operate the jail system and provide security for several courthouses.

Staggering liability losses, leadership by an elected sheriff and budget necessities all have influenced the department to make risk management a priority.

A department Risk Management Bureau, which now has 70 members, was formed in 1995. It has developed and implemented several new programs and policies and has refined others whose oversight was previously scattered throughout the department.

In 1996, the Sheriff's Department received a first-place award from the Public Risk Management Assn. in Arlington, Va., for "Outstanding Achievement for a Public Risk Management Program."

Risk management efforts are aimed at demanding that the department's leaders and deputies adhere to more professional standards, Capt. McCown said. "We looked to see how we could improve not only our performance but also to make sure that we were not losing money in litigation that we shouldn't."

Deputies and supervisors are now more closely monitored through statistical compilation of incidents, such as public discourtesy complaints, preventable auto collisions and use of force.

One measure of success is the amount paid out in judgments and settlements. In the 1991/1992 fiscal year, the department paid out \$26.2 million; in fiscal 1996/97, the figure had dropped to \$12.5 million.

The Los Angeles Sheriff's Department has borrowed common risk management techniques such as return-to-work practices from private industry, said Capt. McCown, a 30-year veteran of the department who also holds a master's degree in public administration. Yet the sheriff's risk managers confront concerns—with their own ironies—not faced by the private sector.

For example, budget cuts have closed many California mental institutions, making the Los Angeles County jail system a warehouse for the mentally ill, some of whom can be dangerous to work with, Capt. McCown said. There is also the usual array of felons who, though incarcerated, are able to fashion

crudely made jail knives and other weapons.

But the daily processing of thousands of inmates, many of them in poor health or lacking hygiene, makes communicable diseases a bigger cause of workers comp losses than violent inmates, Capt. McCown said. "We lose a lot of time because of conjunctivitis," he explained. "That isn't inmates jumping on deputies and beating on them. There are sprains and twists and things like that. We don't have a whole lot of stabbings."

There are also large, high-profile losses. In May, a California Appellate Court upheld a \$23 million verdict against the Sheriff's Department, stemming from accusations that deputies beat several plaintiffs attending a bridal shower.

The Sheriff's Department is appealing the ruling to the California Supreme Court concerning the event, which took place in 1989, before the Risk Management Bureau was formed, Capt. McCown said.

Would it be less likely for that to happen now?

"Certainly," Capt. McCown said. "The ultimate compliment for us is (that) the plaintiffs bar, the attorneys that sue the department, have looked at us, and we are getting fewer and fewer suits from them."

Risk management policies and reforms, such as use of force reviews,

have helped the Sheriff's Department win 11 of 12 recent court cases. "The things they used to be able to attack us on are not available any more. So they are going out and looking at other law enforcement agencies," Capt. McCown said.

A thick manual now serves as a cornerstone for the department's broad risk management policy (see related story). The manual offers a look at how the department has implemented top-down accountability for loss prevention and risk management. Commanders and captains are held accountable for losses attributed to their underlings. The sheriff's upper management draws on statistics compiled by the Risk Management Bureau on incidents such as work-related injuries and car chases to pre-empt budding problems.

Peer pressure and upper management's ability to deny rank advancements to captains and other supervisors are a means to gain their cooperation. "We do not have stockholders because we are civil servants," Capt. McCown said. "But it will be noticed by everyone who makes the decisions if you are doing a good job. Before, it wasn't noticed because we are so large."

Effective risk management in law enforcement takes an insider to do the job well, Capt. McCown said. Risk managers from outside the po-

lice department often will be viewed with suspicion and hamstringed. To put it bluntly, he said, cops are just too difficult to work with.

"It's not going to work unless you get cops involved, because law enforcement is a closed shop," Capt. McCown said. "They don't have a lot of trust for, a., attorneys and, b., non-sworn members."

One preventive risk management measure that more law enforcement risk managers nationwide are striving for is quick claim settlement, before claimants have time to consult plaintiffs attorneys and escalate costs. Such is the case with the sheriff's risk manager staff who settle immediately with inmates held too long in the county jail.

Jeffrey Jinkens, acting risk manager for Broward County Sheriff's Department in Florida, said his risk management department is on call 24 hours a day for a variety of incidents that may call for a relatively quick settlement. If the facts and circumstances call for it, he has the authority to cut a check for tens of thousands of dollars.

"I'm not saying I would ever use it," he said. "In the perfect situation, if you were able to determine without a doubt that 100% of the responsibility rests with you, would it be a smart thing to settle that claim on the spot? Yes, it would." **BI**

Police agencies look to peers for risk management advice

By ROBERTO CENICEROS

LOS ANGELES—For the past year, risk managers for the Los Angeles County Sheriff's Department and the Los Angeles Police Department have played host to about 25 law enforcement agencies throughout Southern California.

They call themselves the Police Civil Liability Assn., and they meet quarterly. Through keynote speakers and informal discussions, association members share information about personnel concerns, the best experts on current risks facing their departments and other pertinent subjects.

"We're trying to facilitate more of a law enforcement-united approach toward risk management," said LAPD Detective Kelly Muldorfer. "We talk about different liability and risk management issues as they come up, court decisions and policies."

The Sheriff's Department and the LAPD also are leaders in spreading law enforcement risk management nationwide and helping fill an information void. In the past two years, risk managers from both agencies have boosted the visibility of law enforcement within the Public Risk Management Assn. by delivering presentations at PRIMA conferences.

Risk managers who have attended those sessions give them high praise.

Like other agencies across the country, the Sheriff's Department and the LAPD have had professional standards and policies for years. Only in the past few years, however, have they worked at centralizing and bolstering those practices under expanded risk management departments.

When she first undertook that task two years ago, there was little information on risk management and policing, Detective Muldorfer said.

"There was nothing when we first started the unit," she said. "One of the first things we did is try to research and find what other departments were doing. We surfed the Net and went through a lot of publications. But there just really wasn't anything out there for us."

Some of the best information available came from a neighboring agency, the Los Angeles County Sheriff's Department. The Sheriff's Department in 1995 consolidated its efforts under a Risk Management Bureau staffed by 70 employees and supervised by a captain.

LAPD joined the Police Civil Liability Assn. after the Sheriff's Department founded the group.

A thick manual details the Sheriff's risk management policy. "I would say the Sheriff's Department actually had the most to offer," Detective Muldorfer said. "They had done more than just about anybody else and had it written up."

Capt. Lee C. McCown, supervisor of the Los Angeles County Sheriff's Department Risk Management Bureau, created the manual. To do so, he learned what he could from PRIMA and borrowed ideas from the private sector, Capt. McCown said.

The Sheriff's Department also spent months interviewing its lieutenants—the agency's line managers—for their views. Now law enforcement risk managers from as far away as New York call and ask Capt. McCown for copies of the manual.

Among other things, the manual describes the responsibilities of three committees that oversee areas with the potential for problems. Three Sheriff's Department commanders head each of the committees and hold the department's captains accountable for the actions of their personnel. The committees are:

- The Executive Force Review

Committee, which reviews the tactics applied in excessive force incidents to determine if policy was followed, what civil liability risks exist, and what future improvements can be made.

- The Risk Review Committee, which examines all sexual harassment, discrimination and workplace violence cases, as well as significant employee-related traffic accidents.

- The Executive Performance Review Committee, which evaluates cases where employee, supervisor or manager practices raise concern.

There is also an Accountability/Risk Management Committee that is responsible for a quarterly review of the risk management plan and evaluating yearly goals, which each unit within the Sheriff's Department is required to establish. The committee is chaired by the undersheriff, and it looks at the performance of commanders, captains and civilian leaders in their areas of responsibility.

Just this year, a Critical Issues Forum was added to the mix. The forum is staffed by the department's upper management, the undersheriff and two assistant sheriffs. They review statistical information compiled by the Risk Management Bureau in areas such as crimes committed, employee injuries, car pursuits, traffic accidents, citizen complaints and return-to-work efforts. Each command unit provides data on a monthly basis.

Captains who do not live up to their goals for risk management, or whose underlings show areas for concern, are questioned about their difficulties, Capt. McCown said.

"Three years ago, captains wouldn't have done those things," he explained. "Like most (law enforcement agencies), we were reacting. But this requires captains to know their commands."

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INTERNATIONAL

Global Briefs

U.S. health care providers can purchase coverage for defense costs and civil fines brought under the federal False Claims Act through a new policy developed by Lloyd's of London agency **SVB Syndicates Ltd.** Allegations of overbilling either Medicare or Medicaid can be covered under the policy, which includes risk management services, audit and legal defense costs. Limits are up to \$25 million, with retentions a minimum of \$50,000 for each claim. SVB developed the policy in conjunction with Willis Faber Re, London's global health care reinsurance unit, and New Jersey broker Boynton & Boynton. . . **Judith Hanratty** has been appointed a nominated member of the Council of Lloyd's. Ms. Hanratty is company secretary for British Petroleum P.L.C. and fills the gap on the council left by Sir Jeremy Morse, who retired in June. . . Lloyd's investment trust **Lomond Underwriting P.L.C.** is buying Atrium Cockell Group Ltd., one of the few remaining independent underwriting agencies at Lloyd's. Atrium Cockell manages syndicates 570 and 609, which together have £116 million (\$189.4 million) of capacity for the 1998 year of account. Lomond is providing the market with £113 million (\$184.5 million) of capacity this year and is expected to pay about £23 million (\$38.2 million) for Atrium Cockell in the form of new shares. . . At the same time, **Underwriters Reinsurance Corp.**, a unit of Alleghany Corp., has agreed to buy Venton Holdings Ltd., the Bermuda-based parent of Lloyd's agency Venton Underwriting Agencies Ltd., and corporate Lloyd's member Venton Underwriting Ltd. Underwriters Re will pay \$190 million cash to Venton's current owners, EXEL Ltd., Trident Partnership L.P., Risk Capital Reinsurance Corp. and Venton executives. In June 1997, EXEL bought a 20% stake in Venton Holdings from Trident Partnership for \$17 million in cash and the same amount in letters of credit. In this deal, Underwriters Re will take over \$123 million in letter of credit obligations supporting the corporate member's underwriting business. . . Bermuda-based **Sovereign Risk Insurance Ltd.** is doubling its capacity limits and upping its country limits for political risk business. It now will accept up to \$100 million exposure per project and \$250 million limits per country, and it has expanded its lines to include contract frustration. Sovereign is a joint venture of ACE Ltd., EXEL Ltd. and Risk Capital Holdings. . . Swiss insurer **Winterthur Group** has sold its majority stake in Australian insurer **HIH Winterthur International Holdings Ltd.** in the open market for 400 million Swiss francs (\$268.8 million). Winterthur said the decision was made to focus on core markets, though the insurer will continue to operate in Australia through Winterthur International, its multinational corporate client arm. . . Shareholders representing more than 80% of the outstanding shares of EXEL Ltd. and Mid Ocean Ltd. **approved their merger** last week. . . Aon Corp. has combined its two London-based consulting businesses, Godwins and Alexander Clay, to form **Aon Consulting Financial Services**, starting at the beginning of this month. . . **CNA Financial Corp.** and Copenhagen, Denmark-based underwriting agency Hansen & Klein Insurance Management A/S have entered a strategic venture that will expand each company's market presence. The deal will give Chicago-based CNA greater access to Scandinavia and the Baltic region. Terms were not disclosed. . . **Royal & Sun Alliance Insurance Group P.L.C.** is turning down unprofitable business in all segments and reviewing its operations to improve efficiency. The London-based insurer announced the move last week in reporting that first-half pretax profits were down 21% to £437 million (\$712 million), mainly as a result of increased weather-related claims after ice storms in Canada and flooding in the United Kingdom.

Cover for Iran trade resumes

European agencies end hiatus on political risk coverage for Iran

By MARIA KIELMAS

LONDON—British, German and Italian corporations wanting to invest in Iran will once again be able to buy political risk insurance and export credit guarantees from government agencies.

Three of the largest European export credit agencies—the U.K. Export Credit Guarantee Department, Germany's Hermes Kreditversicherung and Italy's Sezione Speciale per l'Assicurazione del Credito all'Esportazione, or SACE—are restoring coverage for risks in Iran after a two- to four-year hiatus. The agencies withdrew coverage between 1994 and 1996 because of Iran's default on short-term debt payments and ongoing political tensions with the West.

The agencies resumed offering coverage for three reasons, agency spokesmen said:

- Improved political relations between Iran and the European Union following the 1997 election of the reformist government of president Mohamed Khatami.
- Iran's successful rescheduling of past debts owed to the agencies.
- Demand for coverage from European companies that want to take advantage of

investment opportunities in Iran, especially in the oil, energy and infrastructure sectors.

Despite Iran's poor relations with Western countries since the 1979 Islamic revolution, private-sector insurers have continued to write Iranian political risk coverage, but with narrower terms. And they remain cautious about risks in Iran.

"There is still a lot of uncertainty in Iran when someone as important as the mayor of Tehran is sentenced to a lashing," said Geoffrey Lynch, head of political risk at Lloyd's of London syndicate 33, managed by Hiscox Ltd. The mayor of Iran's capital recently was sentenced to a prison term and flogging after his conviction for misusing campaign funds.

Syndicate 33 has re-

ceived few inquiries from potential clients about political risk coverage to Iran, Mr. Lynch said.

But the state agencies are seeing lots of interest. "We have received a lot of inquiries from Italian companies. Many have been working in Iran without cover

See Iran on page 19



AP/WIDE WORLD PHOTOS

Tehran judge Gholamhossein Mohseni Ejaei speaks with journalists after sentencing the city's mayor to jail.

Demand for recall cover fizzles in U.K. market

By MATTHEW MacDERMOTT

LONDON—Demand for product recall insurance in the United Kingdom is about as flat as an open can of soda pop.

Despite several high-profile recalls of tainted food and beverages in 1997 (*BI*, Aug. 4, 1997), a scarcity of such events this year has kept U.K. interest in the insurance low. The only major U.K. recall so far in 1998 was a voluntary recall of more than 2 million liters of contaminated carbonated beverages in June.

David Page, director of the special risks division of London-based broker Nelson Hurst International Ltd., said small product recalls are almost a daily occurrence in the United Kingdom, with children's toys and manufacturing parts among the most frequently recalled products.

However, he said, it is the "big name"

food and beverage product recalls that raise public and company awareness of the possible risks and costs associated with contaminated or defective products.

Mr. Page said the June recall of contaminated beverages in the United Kingdom should raise awareness and interest in product recall insurance.

Nevertheless, there is still a mentality of "it won't happen to us" among many U.K. companies, such as manufacturers, suppliers and retailers, that are exposed to such risks, he said.

Mr. Page said awareness of product recall exposures in the United Kingdom is increasing, but it is still "nowhere near where you would think it would be."

He believed large U.S. and European companies are generally more aware of product recall risks than are U.K. com-

See Recall on next page

German EIL rates soften
Buyers get significant rate cuts from insurers

By DON LEWIS KIRK

BONN, Germany—German insurers are showing greater flexibility when setting rates and conditions for environmental impairment liability insurance, say buyers.

The once-hard market for EIL insurance has softened, according to Bund Versichert-er Unternehmen e.V., a German buyer's association representing mid-sized industry. "Buyers no longer must settle for high rates and poor coverage," said Managing Director Stephan Jens.

Since EIL insurance was introduced to Germany in 1993, insurers have taken a cautious and—for buyers—often costly stand on premiums and conditions. But that is changing, said Mr. Jens.

In some cases, the shift is dramatic. "Just recently, a company did nothing more than send a letter to an insurer and saved 50% on its premium," he said.

Previously, insurers offered little room to negotiate either rates or conditions, said Mr. Jens. "As is so often the case, premiums

were determined on the basis of what reinsurers wanted, but claims experience didn't warrant high rates. A correction was inevitable."

Insurers admit a change has come.

"When Germany passed environmental protection legislation in 1993, we had no statistics on which to base premiums," admits a spokeswoman for Munich, Germany-based Allianz A.G. "Now we know more. It's true; in many cases, premiums have dropped 50%," she said.

Policy exclusions and restrictions are also being corrected, according to Mr. Jens. "Conditions for coverage are being eased," he said. "Previously, companies had to report regularly on the storage, type and volume of substances used in production. Those restrictions have been eased. It not only saves time but prevents a lack of coverage when every little change is not reported."

The easing up is being felt especially in new German states, where policy condi-

See EIL on next page

Hibernian
sells U.K.
unit to
Skandia

DUBLIN, Ireland—Irish multiline insurer Hibernian Group P.L.C. plans to use the proceeds from the sale of a British subsidiary to make acquisitions in Ireland.

Hibernian last week sold its Hibernian Insurance U.K. Ltd. subsidiary to National Insurance & Guarantee Corp. Skandia, a subsidiary of Swedish insurance company Skandia A.B.

The sale, pending due diligence and regulatory approval, will yield 37 million Irish pounds (\$54 million) for Hibernian.

Hibernian Insurance U.K.'s book of business

'We are keen to make a major acquisition in the Republic of Ireland. Investments are also planned in our distribution network,' says Cecil Hays.

is 50% auto and 50% commercial lines. The U.K. operation was developed around commercial insurer Hallmark Insurance Co. Ltd., which Hibernian acquired from Pearl Assurance P.L.C. in 1994.

Hallmark subsequently was integrated into Hibernian's branch network in February 1997, which until then had focused primarily on personal auto insurance. The operation was renamed Hibernian Insurance U.K. Ltd.

"We sold the operation because we did not have sufficient scale to make a success of the business," explained Cecil Hays, Hibernian Group's finance director. The sale, he said, is "clean," with no long-term guarantee of the company's reserves. Hibernian Insurance U.K. posted a loss of 100,000 Irish pounds (\$146,000) for the 1997 financial year.

"Right now, we are keen to make a major acquisition in the Republic of Ireland. Investments are also planned in our distribution network," said Mr. Hays. With the cash from the sale of the U.K. insurer, Hibernian Group will have a reserve of 120 million Irish pounds (\$176 million) to finance acquisitions in Ireland, he said.

—By Gerard O'Dwyer

Recall

Continued from previous page
panies. "I am constantly amazed at the companies that don't have it," he said.

The beverage recall in June occurred after traces of the carcinogen benzene were found in the supplies of carbon dioxide gas used to carbonate the drinks.

Cadbury Schweppes P.L.C. and Bass P.L.C., two of the United Kingdom's biggest beverage companies, both based in London, recalled several products made with the suspect carbon dioxide.

Cadbury Schweppes recalled a total of 1.5 million liters of bottled drinks, including Malvern mineral water, Dr Pepper soft drink and Schweppes Shandy alcoholic beverage.

Bass recalled about 800,000 liters of bottled soft drinks, including Tango, Pepsi and 7Up.

Neither Cadbury Schweppes nor Bass spokespeople would comment on the cost of the recalls or insurance arrangements.

The two companies made the recall decision independently. There was no recall order made by the U.K. government or the British Soft Drinks Assn. Ltd.

The levels of benzene reported were a negligible risk to public health, according to a statement by the U.K. government's Ministry of Agriculture, Fisheries and Food. It said citizens in urban environments

are exposed daily to benzene levels 40 times higher than traffic fumes.

A statement by the BSDA also said the benzene levels did not raise public health concerns and any actions taken by U.K. beverage companies were to ensure the quality of their

'Everyone in the supply chain should have some form of product recall' coverage, says David Page.

products.

Ian Harrison, underwriter at Lloyd's of London syndicate 623, which is managed by Beazley Furlong Ltd. and markets a product recall brand protection policy, said Cadbury Schweppes and Bass handled the benzene incident very well. "They got the message out clearly and quickly and the publicity died, which shows the crisis was managed well," he said.

Mr. Harrison said product recall insurance is aimed at companies like Cadbury Schweppes and Bass. "You would expect them to have it," he said. But he noted that product recall insurance is actually acts of extortion.

Nelson Hurst's Mr. Page agreed that large companies are the prime market for product recall insurance, but they don't always have it. "You

expect (these types of companies) to have cover, but it is not always the case," he said.

Mr. Page said suppliers to consumer product companies are also heavily exposed to product recall risks, but they usually have even less awareness of their exposure than manufacturers of consumer products.

The contaminated carbon dioxide was supplied to Cadbury Schweppes and Bass by the chemical company Terra Industries Ltd., of Severnside, England. Terra is one of four suppliers of carbon dioxide to the U.K. beverage industry, according to the British Soft Drinks Assn.

Terra spokespeople could not be reached for comment on the incident.

Mr. Page said the beverage recall case highlights the risks in manufacturing and production supply chains. "Everyone in the supply chain should have some form of product recall, especially if they supply retailers or big-brand manufacturers," he said.

Mr. Page said small companies are most at risk, as they can often get "knocked out" by the costs of recalls that big companies can usually absorb.

Mr. Harrison agreed that the beverage recall raises the question of risks facing suppliers. "In the past, companies were only focused on their own production," he said. "Now there is a growing recognition that a supplier can be a weak link. The lesson is to keep a close eye on suppliers." **BI**

EIL

Continued from previous page
tions had been most stringent, said Mr. Jens. After reunification, insurers were hesitant to insure EIL risks for companies located in the former Communist East Germany. With over five years of experience with EIL risks, however, insurers are making more concessions everywhere in Germany.

One such concession involves per-claim coverage limits. Within the last six months, German insurers increased coverage limits for accidents occurring during normal operations to 50 million deutsche marks (\$28.2

'The difficult thing about EIL is the long-tail exposure,' says Gerling's Peter Geppert.

million) from 20 million deutsche marks (\$11.3 million) per claim.

Peter Geppert, director of EIL product development at Cologne, Germany-based Gerling A.G. said the move reflects experience with claims but admits he is worried about rate cuts. "The difficult thing about EIL is the long-tail exposure," he said. "It's foolish to be too short-sighted. Rates reflect client experi-

ence, but also the potential for loss."

In addition, Mr. Jens said that insurers have also eased restrictions on how companies can use their insurance. In the past, some insurers refused to cover claims that went beyond an annual limit, the so-called "single maximum." Now, Mr. Jens said, buyers can negotiate better conditions and even increase the insured maximum that can be used in any given year. "In the past," said Mr. Jens, "companies could easily exhaust insurance with several claims. That's changed. Buyers can easily double that amount, and we recommend they do."

But Gerling's Mr. Geppert contends it was always possible to obtain increased coverage. "We have always offered double-maximum. Some buyers are just now finding that out."

The "double maximum" limit is a boon to buyers, who say it reduces their fear that several claims in the same year will eat up coverage limits.

Insurers are also expanding coverage for the cleanup of a buyer's own property after an environmental accident protection known as "preclaim coverage." Initially, EIL insurance covered only third-party cleanup costs, and it recently allowed just 10% or 20% of the amount of a claim for the cleanup of a company's own facility, even in instances where environmental damage was limited to the buyer's property. "We have had to settle for 10% of the insurance sum in the past," said Mr. Jens, "but now it's possible to have the entire insurance sum apply." **BI**

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INTERNATIONAL

Iran

Continued from page 17
during this period," said Vicenzo d'Elia, area manager at SACE in Rome.

SACE is proposing to restore short-term, or 180-day, coverage for letters of credit guaranteed by Iranian banks. Medium-term insurance for investment projects will also be restored on a case-by-case basis, Mr. d'Elia said. "For this transaction to be approved, it must generate an income for the Italian system and develop the Iranian economy," he added. SACE's board was expected to consider the proposal late last week.

The Italian agency's coverage will be available to projects financed by a \$1.2 billion credit facility to Iran granted by the Italian government and announced late last month. The credit, extended by Milan-based commercial bank Mediobanca, will be repaid by Iran over a 10-year period, said Italian Foreign Trade Minister Augusto Fantozzi.

SACE suspended coverage to Iran in January 1996, when Iran could not meet debt payments. At that time, SACE's exposure to Iran was 2.7 trillion lire (\$1.78 billion). But the debt has been either paid or rescheduled and there have been no repeat problems since, Mr. d'Elia said.

The United Kingdom's Export Credit Guarantee Department late last month said it agreed to insure British goods exported to Iran on cash terms and to boost reinsurance capacity for exports sold on short terms of credit, or 180 days.

ECGD said in a statement that it had withdrawn coverage from Iran as a result of rising concerns about the country's ability to service its debts. "ECGD is not resuming cover for medium-term credits at the present

time but will take a further look at the situation in due course, taking account of, among other things, the prevailing economic circumstances," the statement added.

An ECGD spokesman called the decision a first step toward normalizing relations. "We are not talking never for providing medium-term cover. The trouble is the fluctuation in oil prices. When they go down, the goal posts move," he added.

Iran receives 90% of its export earnings from oil sales. Because of low oil prices this year, Iran's export earnings are expected to fall.

Hanover, Germany-based Hermes Kreditversicherung also is restoring coverage to Iran. The German government did not formally suspend coverage, but Hermes had reached its predetermined exposure limit of 100 million deutsche marks (\$56.4 million), said a Hermes spokesman.

"The government has now decided to reopen cover carefully on a case-by-case basis for short term. Cover for medium term is also available, but we will be looking strictly at the products," he added. All investment in Iran requesting Hermes insurance will be subject to approval by a government committee. This is not Hermes' usual practice, the spokesman said. Normally, the company decides what to insure up to a government-determined threshold.

France's state agency, Paris-based Coface, resumed writing credit risks in Iran in 1996. Coface suspended coverage in 1992 because of debt arrears, but these have been rescheduled, a Coface spokeswoman said. Coface provides cover for short-term trade, but only with a guarantee from an Iranian bank. It will also provide medium- and long-term coverage for French investors up to an exposure limit that Coface would not disclose.

European state political risk insur-

ers began to restrict coverage to Iran in the early 1990s, when the country had accumulated as much as \$30 billion in foreign debt, mostly in short-term liabilities.

Private-sector insurers, meanwhile, are seeing an increase in Iranian business. "Our portfolio on Iran is steadily growing, and there are a lot of opportunities, even though we apply some restrictions," said Simon Gibbon, head of country risk at London-based credit insurer Trade Indemnity P.L.C. "We are not typically looking at an open account, ever. Normally, we tend to cover at the letter of credit level," he added. Trade Indemnity does not plan to write coverage for periods exceeding 180 days, he said.

An "open account" refers to a project in which a foreign investor derives income but does not own assets. For example, the Iranian government is offering so-called "buyback contracts" that pay a fee to foreign oil and gas companies that restore Iranian-owned petroleum fields to production.

At a meeting in London early last month, an Iranian delegation announced \$5.4 billion in buyback contracts to foreign oil and gas companies.

Hiscox's Mr. Lynch is not keen to insure an open account, though he has been approached by a number of oil companies about insuring these projects. "You are not talking about expropriation cover because you don't own anything to expropriate, and the Iranians hold all of the receipts from the projects," he said.

One problem for foreign investors is that the buyback program is contrary to the Iranian Constitution, said an official at the European Commission in Brussels, Belgium, who has been involved in developing E.U. relations with Iran. Article 81 of Iran's Constitution forbids foreign owner-

ship of assets in the oil or gas sector, while Article 44 states that the public sector is predominant in the economy.

"This is a big problem. The buyback contracts are fine for the large companies that want to take the risk, but, when it comes to the crunch, the smaller companies will be hurt," the E.C. official said.

Oslo, Norway-based Saga Petroleum A/S is interested in investment opportunities in Iran, its senior executives say. But Norway's state credit insurer stopped offering coverage for Iran in 1988, and Saga is not considering political risk insurance. "We haven't purchased political risk insurance for many years. We usually make a higher demand on the returns of a project where the risks are high, and that remains our attitude," said Kaare Hagness, risk manager at Saga Petroleum.

Risk managers outside the petroleum industry remain circumspect about Iran. "I do not believe so strongly in such a huge change in the political situation in Iran, and I am skeptical that investments will increase there," said a risk manager for a large German engineering multinational who asked not to be identified.

"Even in the old Eastern Bloc countries, where there is inadequate legislation and no consumer protection, contracts are done under international business law. That is not the same in Iran," the risk manager added.

Norwegian companies are among the most interested in Iranian investment opportunities, but they are unable to obtain political risk insurance from the Norwegian state agency. The state agency, Garanti Instituttet for Exportkredit, a division of the Norwegian Commerce Ministry, ceased writing coverage in September 1998 after the late Iranian leader Ayatollah Khomeini issued a death warrant on the British writer Salman

Rushdie. The Norwegian publisher of Mr. Rushdie's book, "The Satanic Verses," was killed by Iranian terrorists.

Norwegian public opinion remains very opposed to investments in Iran, a situation similar to that in the United States, said Edvard Stang, deputy managing director of GIE.

U.S. corporations have been barred outright from doing business in Iran through an executive order in the 1990s. "U.S. companies are now suffering the worst of both worlds," said Rodman Bundy, a partner in the law firm Frere Cholmeley Bischoff in Paris. "They are precluded from investing in Iran under (President) Clinton's executive order, and now they see their European competitors taking those opportunities."

U.S. insurers are similarly unable to do business in Iran. When an insurer provides a global policy for a large non-U.S. multinational, it must exclude coverage from those countries sanctioned by the U.S. government. "We have had this issue with Iran, Iraq, Cuba, Burma," said Dan Riordan, head of political risk at Zurich-American Insurance Group in Washington.

However, U.S. companies are participating in major projects in countries bordering Iran, such as in the Caucasus and central Asia. If any project, such as a pipeline, crosses a border into Iran, then the U.S. investor in the project must ensure there are separate companies and have separate books for each side of a sanctioned border, Mr. Riordan said.

Despite some thawing of the relationship between Iran and the United States and calls from business and policy think tanks for an elimination of U.S. sanctions against Iran, Messrs. Riordan and Bundy both believe U.S. companies will be excluded from Iran for quite some time to come. **[B]**

United

Continued from page 1
create the nation's largest single managed care organization and was originally valued at about \$5.5 billion, may be either restructured or killed altogether (*BI*, June 1).

Humana said in a statement that it will comment on United's announcement only after it has had the opportunity to work with United's management "to understand the problem underlying the action taken today" and its impact on the deal. "We really won't have anything more to say until such time as we have a better understanding of the issue," a spokesman said Friday.

Humana reported \$52 million in net income for the quarter, up 23.8% from \$42 million for the comparable quarter a year ago.

A hearing on the deal scheduled by the Kentucky Insurance Department for Friday was canceled. Both Humana and United HealthCare officials met informally with Kentucky Insurance Department officials Friday.

"Humana is going to step back and very, very carefully look at the finan-

cial commitment that's involved," said Sedgwick's Mr. Gibson. "I wouldn't be at all surprised if they re-evaluate the deal and restructure the deal. A lot of that is going to depend on what they find," he added. If it turns out this announcement is only the tip of the iceberg, the deal may be killed altogether, he said.

"I think everyone is equally divided as to whether this is something that

'Everyone is equally divided as to whether this will go through or not,' says Mark Jamilkowski of Conning & Co.

will go through or not," said Mark Jamilkowski, an HMO analyst with Conning & Co. in Hartford, Conn. "It's a tough decision for Humana's board of directors," he said.

"The larger question is, if the merger with Humana is consummated, whether there will be additional writeoffs associated with the integra-

tion, staff reductions and so on," said Arun N. Kumar, managing director at Standard & Poor's Corp. in New York. He also said it is still early to determine if the deal will go through.

Whatever the outcome of the deal, it is expected to mean higher prices for employers doing business with United. "I would predict that employers that are dealing with United, at least, will see higher rates, and if Humana gets swept into the deal, it would be predictable that those clients would see higher rates, too," said Ken Jacobsen, national director-health care practice for The Segal Co. in Atlanta.

Conversely, if Humana backs out of the deal, to stay competitive it will "find ways to keep their premiums in line," said Mr. Jacobsen. "Hopefully, they wouldn't be faced with the same internal pressures to increase prices as high as United might."

The announcement will lead to higher rates for employers doing business with United "for sure," said Barry Barnett, a principal at Kwasha HR Solutions, a unit of Price Waterhouse Coopers in Fort Lee, N.J.

Mr. Barnett also predicted that if the deal does not go through, Humana will find another buyer. **[B]**

Tool eyes weather risk

OKEMOS, Mich.—To assist insurance professionals in risk selection, rating and total exposure control, WeatherTrends has released a climatological program that evaluates the risk of six weather conditions for each U.S. county.

WeatherTrends ranks the risks—lightning, wind, tornado, temperature, hurricane and earthquake—by frequency and/or severity for each of the 3,101 counties in the United States. The program can be customized to illustrate total gross limits and total limits net of reinsurance for liabilities within each county or ZIP code. It also can list all properties insured by a particular company within each county or ZIP code.

The information will be updated annually and expanded to include other climatological issues. WeatherTrends is available on a 3.5-inch diskette or CD-ROM.

The base program is available for \$2,000 for one state, plus \$1,000 for each additional state, or \$12,000 for the entire United States. Annual updates cost \$250 per state, and \$1,200 for the entire United States.

For information, contact Karyn Lundberg, product manager for WeatherTrends, 800-968-5432.

School assault policy

SPRINGFIELD, Ill.—Horace Mann Life Insurance Co. is offering a school assault recovery policy nationally via the Internet to ease the financial burden educators face after being injured at work.

Horace Mann's Assault Recovery Plan is offered to individuals or as a group product for employers to purchase as a school employee benefit. The policy provides benefits to educa-

tors and school personnel injured due to workplace violence. Those benefits include a victim assistance payment, in-hospital indemnity, and accidental death and dismemberment coverage for policyholders assaulted at school.

While the product has been available on a limited basis for just more than a year, the company now is able to offer it to educators in 42 states through its agents and on its World Wide Web site at www.horacemann.com.

Educators and school personnel who want more details on the benefits and availability of ARP should contact their local Horace Mann agent, call the company's customer service department at 800-999-1030, or visit www.horacemann.com to submit an individual application. **[B]**

Maxicare to shed plans in 3 states

LOS ANGELES—Maxicare Health Plans Inc., which reported a \$19.8 million second-quarter loss last week, also said it has agreed to sell its Wisconsin operations to Managed Health Services Insurance Corp., a subsidiary of St. Louis-based Centene Corp.

The sale of the Wisconsin plan, which has about 14,850 members, is expected to close Sept. 30. The price of the sale was not disclosed.

In addition, Maxicare announced

last week a "strategic disposition program" under which it also plans to shed its operations in Illinois and the Carolinas through sale or closure. The managed care company said the Wisconsin, Illinois and Carolinas plans reported combined losses of \$7.6 million for the second quarter.

Maxicare's \$19.8 million second quarter loss compares with a \$4.2 million profit for 1997's second quarter. The loss includes a \$10 million charge for divestiture costs, as well as \$1.2

million in costs generated in connection with a shareholder consent action.

This relates to a settlement agreement Maxicare reached last month with dissident shareholder Paul R. Dupee Jr., under which the company agreed to reimburse him for certain expenses and elected him to its board of directors. Mr. Dupee and the company also dismissed litigation they had filed against one another.

—By Judy Greenwald

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Commentary

Gut check time for stock market

Does anyone besides me wonder why so much power is placed in the hands of stock market analysts who, despite all their purported financial analysis skills, appear about as scientific at identifying market trends as you are at deciding when it's time to eat?

Is it smart that trillions of dollars of investments—and the fortunes of our nation's companies—are subject to the vagaries of people willing to move their clients in and out of the market based on the disclosure that a young woman has a stain on her dress allegedly produced by the president?

Does that really have any bearing on the expected stock performance of Intel Corp. or American International Group Inc.? Maybe I was sleeping the day when my 9th-grade economics class covered Stain Theory.

And then there are the gurus who say our stock market is bound to implode because of the Asian crisis. Why? I realize the fates of some companies are intertwined with Asia and the global economy, but the entire market? I doubt it.

I don't see the rationale for pulling down the entire U.S. market because a few companies may lose their customers and contracts for a couple years. I suspect it is because stock market analysts don't have the ability (or will?) to distinguish between companies that might be vulnerable to Southeast Asia's

woes and those that are not. Last time I checked, I wasn't investing in any Indonesian government bonds by accident. How hard can it be?

Last week, the market took a nose dive when a Prudential Securities analyst issued a forecast on Tuesday morning that the Dow Jones Industrial Average could (not would, but could) make a major correction. Like so many lemmings, the naysayers in the market opted to be led by this dubious insight, falling over themselves in a mass move that dropped the Dow by 9%.

Thankfully, a few stubborn bulls refused to budge, pausing to question the sanity of jumping over the edge on one person's say-so. The market began to creep back up the very next day and continued moving upward for the remainder of last week. Go figure.

Even the Prudential analyst, quoted in news reports the next day, appeared befuddled that so many people had followed his lead. The analyst himself, in what I find a perverse twist of logic, said he expected the market would continue to move up several hundred points in spite of his dire pronouncements. If not even *he* expects his forecast to come true, then why should anyone else follow it?

While I'm grateful to the bullish analysts who rushed to assure the market that they would stand their ground, I'm not sure their reasons for staying the course are any better or more rational than those of the bears. I just happen to benefit from their gut reactions, as opposed to the other guys. Maybe the bullish analysts checked the freshness date on their bottles of Maalox more recently than the bears did?

Frankly, I'm tired of seeing my retirement savings buffeted like a paper ship in a hurricane because a few stock market insiders periodically lose their nerve as the Dow approaches the five-digit mark, only to be calmed a few days later by the opposite actions of others. I've got a while to go before I cash in those chips and sail off into the sunset. Until then, I guess I'm obligated to let my nest egg ride on the game of chance that the market has become.

I might have better luck building for the future by spreading my money around the country to form syndicates to buy Power Ball tickets, or letting it ride on the Chicago Cubs' playoff chances. Alas, the IRS (let alone my wife and my employer) won't let me.

If the gnomes who influence the stock market don't know why the overall market moves up or down and what is likely to be a solid investment vs. a shaky one, I wish they'd at least have the courtesy of keeping it to themselves. I suspect many of their decisions are based less on their much-vaunted analyses and research and more on superstition, gut instinct or the identification of questionable omens.

While I'm no wizard at picking winning stocks (I leave it to the mutual fund companies), at least I'm not moving my funds in and out of the market on a daily basis because I don't like the way the tea leaves look at the bottom of my cup.

Editor Paul D. Winston and Publisher and Editorial Director Kathryn J. McIntyre publish columns on alternate weeks.



Paul D. Winston

Cardiac

Continued from page 3

properly, the devices can greatly reduce the risk of death from sudden cardiac arrest. If used improperly, though, they can exacerbate fibrillation or fail to restore a normal heart rhythm.

One factor behind the wider deployment of the devices is that current models are far easier to use. In the past, defibrillator users, typically emergency medical personnel, had to be able to recognize irregular heart rhythms and determine whether to administer an electric shock to the heart. New computerized models, called automatic external defibrillators, or AEDs, use microcomputers to determine whether shocking the victim's heart is appropriate, as well as the appropriate level of electrical shock.

Employers or property owners deploying defibrillators must ensure that anyone who might use the equipment is adequately trained to use the devices and to recognize when they should be used, Mr. Quinley said.

At the same time, if deploying portable defibrillators does become commonplace—a situation that already may be developing among airlines—employers or property owners that don't make the life-saving equipment available might find themselves subject to claims for failing to meet a new standard of care.

While AEDs may be easier to use and more foolproof, and even though manufacturers such as HP Heartstream are offering to indemnify users, liability concerns still have hindered some recent moves toward defibrillator deployment.

In June, for example, a measure brought before a Chicago City Council committee to require that the devices be available in large private and city-owned buildings was tabled as a local realtors group and others raised the question of liability exposures.

Using her own company as an example, Deborah DiSanzo, operations manager of defibrillator manufacturer HP Heartstream in Seattle, noted that before Hewlett-Packard Co. bought Heartstream last year, HP already had approached the company about purchasing defibrillators for the computer company's Vancouver, Wash., work site.

That initiative stemmed "from the sheer reason that they wanted to help prevent peoples' deaths from sudden cardiac arrest if they could," Ms. DiSanzo said. After using the Vancouver facility as a test site, HP subsequently deployed the devices at its Andover, Mass., work site.

"From a Hewlett-Packard Co. perspective, if we can help our employees by getting them the best medical care in emergency circumstances, then HP wanted to do that," said Ms. DiSanzo.

HP Heartstream has seen employer interest in deploying defibrillators grow in the past two years, and Ms. DiSanzo said she thinks it stems from various sources. In the last quarter of 1997, HP Heartstream reported \$3.3 million in sales, compared with \$957,000 for the same quarter in 1996.

One source, she said, is that many companies are following the lead of commercial airlines and installing the devices on corporate aircraft.

"Then you have CEOs saying, 'Well, if they're going on my airplane, why aren't they just as good in my plant?'" Ms. DiSanzo said.

Another factor is that some companies see the growing availability and affordability of high-tech life-saving equipment in the same light as other opportunities afforded by new technology. "Forward-thinking companies who are on the edge of other technologies are starting to consider AEDs," she said.

Dr. David Brill, medical director of Michelin North America in Greenville, S.C., said, "When you think about it, industry has a tremendous opportunity, because we can get to people much more rapidly than an ambulance."

Michelin has had AEDs at its work sites since 1986.

"We've had them in the hands of company (emergency medical technicians), which we have decided was the floor of emergency response we want to have in our company," said Dr. Brill, who noted that some companies have decided they wanted the devices available to whoever is first to respond to an employee suffering cardiac arrest.

Hewlett-Packard deployed AEDs because 'they wanted to help prevent peoples' deaths from sudden cardiac arrest if they could,' says Deborah DiSanzo of HP Heartstream.

"People are as likely to have these events at work as anywhere else," he said, adding that an aging workforce gives employers even more reason to consider deploying defibrillators at the sites.

Dr. Brill said he didn't have statistics on how often Michelin's defibrillators were used, but he said they have saved lives over the years. He cited the example of a retiree visiting the employee wellness center in January "who walked behind the counter and just fell over. He was unconscious. There was no pulse."

A Michelin EMT called to the scene defibrillated the cardiac arrest victim before sending him by ambulance to the hospital, "and by the time he arrived at the hospital he was awake and talking," Dr. Brill said.

Ms. DiSanzo said her company also is seeing interest from recreational facilities, such as golf courses and ski areas—"any place where large groups of people congregate and could have a risk of sudden cardiac arrest."

As the devices' use increases, it also might become increasingly necessary for employers and property owners to consider whether to include them in their own facilities or risk exposure to claims that they are not meeting a new standard of care.

"As these things become increasingly prevalent in airplanes, at ball games, I think the bar is raised with respect to standard of care," said Mr. Quinley of MEDMARC.

"If you own or operate premises, commercial premises particularly, you've got to look at whether there is a responsibility to stock some resuscitating equipment," Mr. Quinley said.

"For workplaces, I would see where, from a safety and management standpoint, companies might want to have that on hand just like a first-aid kit," he said. "And if companies forgo the technology just because they don't want to take on the training responsibilities, that could create some new liabilities."

"There are concerns coming up where, if the standard of care is providing first-aid and emergency medical care and defibrillators and you're not providing defibrillators, could you be held liable?" Ms. DiSanzo said.

"I think you could make a case

that, in the airlines right now, it's becoming a standard of care," she said. "Most of the major airlines in the world now are putting AEDs in their planes."

Another exposure likely to increase along with the deployment of portable defibrillators in workplaces and public facilities is the risk of product liability claims against defibrillator manufacturers.

MEDMARC insures some of the "leading players" in the portable defibrillator market, Mr. Quinley said, adding: "We haven't seen these claims yet from anybody but ambulance types. The claims have involved professionals."

But, he said, it's probably a matter of time until claims emerge involving situations where the equipment was used by laypeople.

Those suits will focus on the design and manufacturer of the equipment, its labeling and training for potential users, Mr. Quinley said.

Defibrillator use requirements as established by the federal Food and

Drug Administration "are sort of the bare minimum" that the equipment's manufacturers must consider, Mr. Quinley said.

"But," he continued, "well beyond that, (manufacturers) have to take a look at who's going to be using the equipment, what kind of training they're going to undergo, how accessible will that equipment be, and if and how well will it be maintained."

HP Heartstream went so far as to indemnify those purchasing, renting or leasing their defibrillators against claims emerging from their use, providing the devices were properly used and maintained. Such a move isn't unique in the medical device industry, but it's not standard operating procedure, Mr. Quinley said.

HP Heartstream indemnified its defibrillators' users to eliminate potential purchasers' "barriers" to acquiring AEDs, Ms. DiSanzo said, namely, the concern that if an AED didn't work, the purchaser would be liable.

But Michelin's Dr. Brill suggested that the new generation of portable defibrillators is so superior to its forebears that it greatly reduces the risks associated with defibrillator use, while making training remarkably easy.

In the past, defibrillator users had to be able to recognize irregular heart rhythms and determine which people would benefit from defibrillation, but the new computerized models can determine whether shocking the victim's heart is appropriate.

Dr. Brill described the defibrillators his company acquired earlier this year to replace aging equipment as "about the size of a college geography textbook."

"In a sense, what it is is a computer that delivers a shock," he said. "Almost any person can be trained to use it within 10 minutes."

His company's decision to keep the defibrillators in the hands of EMTs was based on their high level of training and experience in emergency situations, Dr. Brill explained. "We value the coolness and professional expertise that comes with that."

That approach also allows Michelin to better synchronize emergency medical activities with local emergency medical systems, he said.

The company isn't trying to replace the local ambulance service, according to Dr. Brill. "Our goal is to intervene in the 10 to 15 minutes before the ambulance arrives." **BI**

AHPs

Continued from page 1

Sponsored by individual employers can escape state regulation if they are self-funded. That is because a provision in the Employee Retirement Income Security Act exempts self-funded plans sponsored by employers from state laws and regulations that relate to employee benefit plans.

But that ERISA pre-emption is largely meaningless to smaller companies that alone lack the size to take on the financial risk of self-funding their health care risks. And even if a small employer joins a trade association offering health insurance plans from insurers or health maintenance organizations, those plans are subject to state requirements, which can mean higher costs.

AHPs—through their special exemption from state requirements—would be eagerly embraced by trade association members, many of which are so small as to have little leverage in dealing with commercial insurers and HMOs, according to trade group officials.

"This could be the best thing that ever happened for small business in health care," said Victoria Caldeira, manager of Senate legislative affairs for the National Federation of Independent Business in Washington. The NFIB projects that about 4 million employees who are now uninsured could be covered through AHPs if the legislation were enacted.

Indeed, trade groups say the AHPs—through their exemption from state health insurance rules—would be a cost-effective way to provide consistent benefit packages to small businesses that belong to trade groups.

"This would allow us to offer a more uniform benefit plan to members with lower administrative costs," said Joe Rossman, vp-fringe benefits at the Associated Builders & Contractors, an Arlington, Va.-based trade group whose fully insured health plan covers about 27,000 of its members' employees and dependents.

But critics of the legislation—chiefly insurance companies and state regulators—warn that a regulatory vacuum could develop. They say state regulators might be reluctant to enforce rules other than their own, as well as ones that may be less stringent than their own.

"If the federal government lowers standards, states may not want anything to do with AHPs," said Christina Nyquist, director of health policy at Blue Cross & Blue Shield Assn. in Washington.

In addition, Ms. Nyquist notes, AHPs have the potential of attracting the healthiest of risks,

leaving insurers to cover older, sicker employees.

"I hope that legislators see these plans as a real threat to the viability of the insured market," Ms. Nyquist added.

What legislators decide to do likely will be known in the next few weeks. While the House has included the AHP provision in its patient protection legislation, the two main patient protection bills that the Senate could take up in September currently lack a comparable provision.

That would mean—assuming the Senate passes patient protection legislation—that a conference committee would have to resolve the fate of the AHP provision. And what the conference committee would do is not clear.

In fact, last year, a conference

to offer an AHP, a trade group would have to be established for a purpose other than providing health insurance to members. In addition, the AHP would have to be controlled by a board of trustees composed of trade association employers that participate in the plan.

These provisions are a direct response to avoid problems that often occurred with MEWAs before Congress passed legislation in 1983 to make clear that states could regulate them. In many cases, MEWAs were organized and controlled by outsiders—often insurance agents—who created associations with few or no eligibility rules. These entrepreneurs established low-cost self-funded plans to attract employers, chiefly smaller, less-sophisticated firms.

'This would allow us to offer a more uniform benefit plan to members with lower administrative costs,' says Joe Rossman of the Associated Builders & Contractors.

committee stripped a somewhat different AHP provision when that committee met to put together a uniform budget bill. As is the case this year, the House last year put an AHP provision in its budget bill, while the Senate did not.

AHP backers say it is less likely that the same scenario—conferees removing the AHP provision—will develop this year.

"I think there is more interest in the Senate, which improves the chances," said Mr. Pantos, who noted that Senate Majority Leader Trent Lott, R-Miss., supports the concept.

Mr. Pantos and others say chances of the AHP provision surviving also are improved because of changes made to address concerns of state regulators. For example, among other things, the current bill would require AHPs to meet tougher solvency standards than last year's proposal.

"This is a different bill than last year, something the critics have yet to acknowledge," said Don Dresser, president of the Western Growers Assn. Mr. Dresser's Irvine, Calif.-based group of fruit and vegetable growers offers its members a self-funded health care plan, which is allowed under California law. The health plan, one of the largest of its kind, is purchased by about 3,000 members and covers about 100,000 employees and dependents.

Under the legislation, only established trade associations—those in existence at least three years—could offer AHPs. In order

The plans offered low premiums but paid agents high commissions. Inadequate premiums and outright fraud by some plan organizers led to the collapse of dozens of MEWAs and their predecessors—multiple employer trusts or METs—in the 1970s and early 1980s, sticking employers and employees with hundreds of millions of dollars in unpaid claims.

AHP backers say that because AHPs would be controlled by trade group members—not outsiders—it is unfair to compare them to the trouble-plagued self-funded MEWAs of past.

"It is like comparing apples and oranges. MEWAs had no requirements on who could set them up, and there were no solvency requirements," the NFIB's Ms. Caldeira said.

Solvency requirements for self-funded AHPs set by the legislation include:

- Purchase of aggregate stop-loss insurance, with an attachment point not greater than 125% of expected claims.

- Purchase of specific stop-loss insurance coverage, with an attachment point, as recommended by the plan's actuary, of up to \$200,000.

- Payments to a new "AHP fund" that would pay covered claims if an AHP failed and its reserves and stop-loss insurance did not meet outstanding claims. This provision in the legislation does not contain much detail on how such a program would be administered. **BI**

gation. They did not," the high court ruled.

Insurers should not be compelled to pay for defenses when they are not contractually required to do so, according to the court.

The high court ruled that insurers shouldn't have to pay for defenses when they're not contractually required to do so.

The decision is an important precedent, said Laura A. Foggan, a partner at Wiley, Rein & Fielding in Washington and counsel to the

Insurance Environmental Litigation Assn.

"The court recognized that commercial general liability contracts do not respond to the vicissitudes of business life. Rather, they afford a defense to suits seeking damages for injuries covered by the policy," she said.

California joins courts in at least seven other states as well as the 6th U.S. Circuit Court of Appeals, which have determined that a cleanup order does not amount to a lawsuit. At least 14 states and the 2nd U.S. Circuit Court of Appeals have ruled in policyholders' favor.

Foster-Gardner Inc. vs. National Union Fire Insurance Co. of Pittsburgh, Pa., et al., California Supreme Court, No. 5063425.

Updates

Harassment plaintiff protection

GREENBELT, Md.—A U.S. District Court last week ordered Townsend Culinary Inc. to emphasize to its workers that it will not allow harassment of employees participating in a lawsuit alleging sexual harassment of primarily Hispanic women at a food processing facility in Laurel, Md.

The judge told the company to clearly articulate this policy in a statement to its approximately 300 employees. However, he refused a request by the U.S. Equal Employment Opportunity Commission for a temporary restraining order, said Dana Hutter, an EEOC trial attorney.

The EEOC had sought the order because some employees complained of harassment through the circulation of a petition stating that defamation charges should be brought against two current women workers who complained of sexual harassment on a local television show. Those women alleged that some women were sleeping with their bosses.

David Major, Townsend's vp-human resources in Wilmington, Del., said sexual harassment problems predated Townsend's purchase of the plant in March 1996 and were resolved, after a company investigation, by firings and other disciplinary actions. He said the sexual harassment complaint was "directly related" to a dispute with Local 400 of the United Food & Commercial Workers Union. Townsend withdrew recognition of the union in November 1997, at workers' request, he said.

However, the National Labor Relations Board staff is recommending, after an extensive investigation, that an administrative law judge require Townsend to reinstate the union and take other actions to curb unfair labor practices, said Louis D'Amico, director of the NLRB's regional office in Baltimore.

Blues in talks with state

ST. LOUIS—A proposed settlement between Blue Cross & Blue Shield of Missouri and state officials is still on track, despite a Missouri Court of Appeals decision last week that the non-profit Blue Cross & Blue Shield of Missouri had illegally converted to for-profit status.

On Aug. 4, the appeals court affirmed the decision of Cole County Circuit Court Judge Thomas Brown III that BC/BS of Missouri "had continued to exceed or abuse the authority conferred upon it by law." The decision concerns a dispute that began in April 1994, when BC/BS of Missouri proposed to the Insurance Department that the company transfer part of its business to a new, for-profit subsidiary. The department "later alleged that BCBSMO transferred substantially more business than it proposed, that it changed its purposes to reflect for-profit goals rather than non-profit goals and that it failed to disclose those changes," as required by law, according to a department statement.

In May of 1996, BC/BS of Missouri sued the department and the attorney general, alleging it was acting within the law. However, state officials argued that the company had exceeded its authority as a non-profit corporation by acting as a for-profit company.

Nevertheless, the parties are developing a settlement to propose to Judge Brown. The parties have agreed that the appellate decision will have no effect on the settlement agreement, which is expected to be signed by Sept. 15, according to a BC/BS of Missouri statement.

Insurance Director Jay Angoff said in a statement that the decision did not reflect badly on the current management of BC/BS of Missouri, or on its for-profit subsidiary, RightCHOICE Managed Care Inc.

"The people who got Blue Cross into this mess are gone. The new management team is working diligently to get this episode behind them, and we are very pleased with the progress we are making in resolving this issue," he said.

RightCHOICE is the state's largest provider of managed health care services.

Briefly noted

Chicago-based CNA Financial Corp. plans to reduce its current work force by a total of about 10%, or 2,400 employees, and to close several facilities as part of a previously announced reorganization (BI, July 20). The insurer also reported \$210 million in net income for the second quarter, down 10.6% from \$235 million for the comparable quarter a year ago. . . . Ellen R. Dunkin has been named general counsel for the Risk & Insurance Management Society Inc. Ms. Dunkin has worked as a corporate associate at Willkie Farr & Gallagher in New York and as a senior attorney at Marsh & McLennan Cos. Inc. . . . Sovereign Risk Insurance Ltd., a political risk insurer in Bermuda, has doubled its per-project limits to \$100 million and increased its country limits to \$250 million from \$100 million. Sovereign has also started offering contract frustration insurance in addition to its existing coverage for investments. . . . Shareholders of both companies have approved the \$2.2 billion purchase of Mid Ocean Ltd. by EXEL Ltd. The transaction closed Friday. . . . Long Grove, Ill.-based Kemper Insurance Co. said last week it had completed its acquisition of Seattle-based workers compensation underwriter Eagle Insurance Group, comprised of Eagle Pacific Insurance Co. and Pacific Eagle Insurance Co. The group had 1997 net written premiums of \$49.8 million and assets of \$191 million, Kemper adopted in a statement. . . . The American Bar Assn.'s House of Delegates adopted a resolution at the association's annual meeting last week stating that "the American Bar Assn. urges employers to address workplace violence by adopting policies and practices to help them better prevent and manage on-site violence and threats." . . . Jay M. Gellert has been appointed president and chief executive officer of Willard Hills, Calif.-based Foundation Health Systems Inc., the company said. Mr. Gellert, who had been president and chief operating officer, will replace the retiring Dr. Malik M. Hasan, who will remain non-executive chairman but will resign from that post sometime in 1999, FHS said. . . . Timothy J. Mahoney Sr., an executive vp at J&H Marsh & McLennan Inc., died last Thursday in Los Angeles after suffering a brain aneurysm. Prior to joining Marsh & McLennan in 1985, Mr. Mahoney, who was 60, had been chief executive officer of Fred S. James New York.

Cleanups

Continued from page 1

the policies obligated the insurers to defend a 'suit,' not, as Foster-Gardner asserts, 'the substantive equivalent' of a 'suit.' "

In the CGL policies at issue, the insurers specified that a "suit," rather than a "claim," would trigger a duty to defend, court papers show.

"This delineation encourages stability and efficiency in the insurance system. In exchange for a higher premium, the policies might have obligated the insurer to defend any 'demand' against the insurer, or to provide a defense whenever the insured is subject to government compulsion or investi-

Allstate sued by temp workers

By **MICHAEL FRITZ**
Crain News Service

NORTHBROOK, Ill.—A group of women fired by Allstate Corp. and rehired as leased office workers has launched a class action seeking to recover benefits denied more than 10,000 people who have worked for the insurer on the same basis since 1983.

The suit charges that Allstate orchestrated a paper shuffle by switching to contracted workers to eliminate the corporation's obligation to pay retirement and other benefits.

An Allstate official declined to comment on the suit, saying the insurer hadn't reviewed it yet.

Filed last month in U.S. District Court in Beaumont, Texas, the suit seeks triple damages under the Racketeer Influenced and Corrupt Organizations Act. If it is certified as a class action involving thousands of people, Northbrook, Ill.-based Allstate could face defending hundreds of millions of dollars in claims.

The suit could foreshadow similar exposure for other employers, as more corporations move to cut costs by replacing employees with independent contractors or temporary workers employed by outside staffing companies.

The Allstate suit is patterned after a case in which independent contractors working

for Microsoft Corp. were found to have been "common law employees" illegally restricted from participating in its 401(k) retirement plan and lucrative stock purchase program.

"Every large corporation is aware of it," said Robert Pike, Allstate senior vp and general counsel, commenting only on the implications of the Microsoft suit. "We have taken steps to insure that those individuals (independent contract workers) are not part of our welfare or pension plans."

"Much attention has been paid to the Microsoft decision because they got socked with such a dramatic decision and potentially very high damages," said Beverly Garofalo, an employment lawyer at Brown Raysman Millstein Felder & Steiner L.L.P. in Hartford, Conn.

A Microsoft spokesman declined to say how much the decision might cost the Redmond, Wash., software maker, since it is still counting people who fit into the class.

In the Allstate complaint, the six plaintiffs in Texas and Florida charge that in the early 1980s senior executives "directed the heads of Allstate Neighborhood Office agencies to fire and rehire office staff members in order to classify them as leased employees."

By using temporary employees, the complaint argues, Allstate avoided paying benefits and other obligations guaranteed un-

der the Employee Retirement Income Security Act. The suit contends the workers were rehired through Allstate-approved temporary agencies and continued working in the same jobs.

In addition, the complaint alleges that the temporary agencies exercise practically no control over the office staffers.

"In actual practice, the Allstate agent and manager recruits, interviews, assesses, hires, trains, and manages every temporary employee," the complaint says. "In fact, the temporary service usually never even meets the employee."

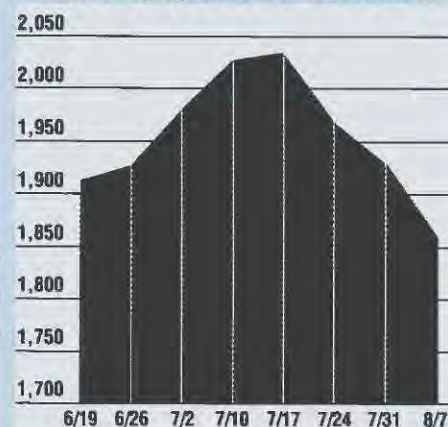
One plaintiff, Linda Berry, a licensed agent and contracted worker in a Port Neches, Texas, Allstate office, says she hasn't met face-to-face with any of the three firms that have administered her payroll checks over the years.

"We've investigated the claims, and we find them to be strongly with merit and we intend to go forward with the case and see it through," said lead lawyer Karl Novak of Ness Motley Loadholt Richardson & Poole, one of three firms representing the Allstate workers.

The Charleston, S.C., law firm was involved in tobacco suit settlements in Mississippi, Florida and Texas.

Michael Fritz works for Investment News, a sister publication of Business Insurance.

B/I Insurance Index



Base=100 on Dec. 29, 1978
Source: Nordby International Inc. (nordby.com) Boulder, Colo.

PCS catastrophe options

As of Aug. 7	Call spread	Price bid/ask	Call spread	Price bid/ask
National Annual 1998			California Annual 1998	
60/80	5.0/12.0		150C	6/—
100/120	3.0/6.0			
120/140	1.0/—			
Southeastern September 1998			Western Annual 1998	
40/60	2.0/3.5		150C	8/—
Midwest 1999 June			Eastern September 1998	
10/20	—/2.0		20/40	3.0/—
			40/60	2.2/3.5
Florida September 1998			Western Annual 1999	
40/60	1.0/2.4		40/60	1.4/—
			80/100	1.0/2.0

Total volume: 20 Total open interest: 19,536

For information on PCS cat options, call the Chicago Board of Trade at 312-435-3674.

Source: Chicago Board of Trade

British Issues

Companies	Price pence	P/E	Div. pence	Yield %	52-week high-low
Gdn Royal Exch	326	5.1	13.4	4.1	495-266
Legal & Gen	725	20.0	13.3	2.4	785-400
Royal & Sun	633	15.5	23.6	3.8	825-491
Brokers					
Lmbt Fenchurch	100	7.6	5.7	7.3	138-100
Lloyd Thompson	175	11.8	10.0	7.1	194-151
Sedgwick Grp	156	14.2	7.0	4.4	171-117
Willis Corroon	204	23.5	6.9	4.2	210-116

Note: Prices are Aug. 7 closings; other numbers from Aug. 6.

Source: Nordby International Inc. (nordby.com) Boulder, Colo.

Year 2000

Continued from page 2
ruption and business disruptions in 2000 or before, and needs to contact these outside entities to ensure that they are Y2K compliant as well," the report says.

In particular, insurers could have problems when they communicate electronically with government agencies.

"Unfortunately, government efforts in a number of areas are behind schedule in achieving Y2K compliance," the report contends.

To minimize their exposure to these problems, insurers should work directly with all entities with which they are electronically linked, to try to overcome potential Year 2000 problems, according to the re-

port.

Property and casualty insurers and reinsurers also may face significant liabilities as a result of Year 2000 losses of their policyholders (see Perspective, page 13).

'Unfortunately, government efforts in a number of areas are behind schedule in achieving Y2K compliance,' the report contends.

"While the magnitude of this problem is uncertain, it is very real and potentially enormous in scope," the report says.

Insurers most likely will face claims on

business interruption, directors and officers liability, errors and omissions, and general liability policies, according to the Conning report.

"Historically, property/casualty insurers have been a favorite target as society has sought to spread the economic cost of various problems," the report noted.

It is still too early to say what the potential liability for insurers could be, but "it is safe to say that the ultimate claims could easily surpass the losses of two recent catastrophes—the Northridge earthquake and Hurricane Andrew," the report said. Insured losses from those two events totaled about \$28 billion.

"Insurers and the Year 2000 Computer Bug: The Tower of Babel Revisited" is available from Conning & Co. for \$550 by calling 860-520-1521.

B/I Industry Stock Report AUG. 3, 1998, THROUGH AUG. 7, 1998

BROKERS																																	
	Price	Weekly % change	Year to date % change	52-week High	Low	Vol.(000)		Price	Weekly % change	Year to date % change	52-week High	Low	Vol.(000)		Price	Weekly % change	Year to date % change	52-week High	Low	Vol.(000)		Price	Weekly % change	Year to date % change	52-week High	Low	Vol.(000)						
Aon Corp.	NYS	66.44	-2.30	13.33	75.56	50.00	1787	EMC Insurance Group Inc.	NDO	12.88	-3.29	-2.83	15.88	12.25	58	Refiastar Financial Corp.	NYS	46.94	-5.42	13.96	52.44	33.63	1508										
E.W. Blanch Holdings Inc.	NYS	36.94	-1.01	7.26	38.75	27.94	166	ESG Re Limited	NDO	20.25	-8.99	-13.83	28.88	19.88	183	RenaissanceRe Holdings Ltd.	NYS	47.63	6.57	7.93	50.75	38.19	207										
Gallagher Arthur J. & Co.	NYS	39.50	0.80	14.70	46.56	33.56	176	Enhance Financial Services	NYS	31.38	0.00	5.46	37.56	22.75	651	Risk Capital Holdings	NDO	25.00	0.50	12.36	25.50	19.75	84										
Hibb, Rogal & Hamilton	NYS	18.50	-0.67	-4.21	19.63	13.38	61	Everest Reinsurance	NYS	40.75	6.02	-1.21	45.25	33.00	1347	RLI Corp.	NYS	40.19	-5.02	0.85	45.63	28.81	55										
Kaye Group Inc.	NDO	7.00	-3.45	5.66	9.00	6.13	37	Executive Risk Inc.	NYS	44.44	-8.26	-36.35	75.75	41.38	1232	St. Paul Companies	NYS	36.38	0.52	-11.35	47.19	33.69	5861										
Marsh & McLennan	NYS	60.69	-0.61	22.09	64.31	44.00	4032	EXEL Ltd.	NYS	79.19	1.44	24.95	84.00	53.75	2390	SCOR	NYS	68.00	-3.03	42.41	72.75	39.25	7										
Poe & Brown	NYS	41.00	-1.20	37.82	42.50	23.88	53	Fremont General Corp.	NYS	52.75	-7.76	-3.65	62.13	36.75	474	SAFECO Corp.	NDO	46.31	2.77	-5.00	56.00	40.75	5783										
Sedgwick Group PLC	NYS	12.81	-5.96	4.06	14.44	9.38	82	Frontier Insurance Group	NYS	17.13	-3.52	-25.14	35.68	16.25	830	SCPIE Holdings Inc.	NYS	30.44	2.74	5.18	38.38	25.75	NA										
Willis Corroon Corp.	NYS	16.31	0.38	32.49	16.88	9.75	586	Gainsco Inc.	NYS	6.75	11.34	-20.59	10.19	5.75	368	Seibels Bruce Group	NDO	6.44	-11.21	-14.17	8.94	6.44	100										
BROKERS AVERAGE							-1.47	14.98																									
INSURERS/REINSURERS																																	
ACE Ltd.	NYS	35.44	-3.41	10.17	43.00	26.38	1800	General RE Corp.	NYS	240.00	1.27	13.21	275.00	191.00	1683	Selective Ins. Group	NDO	20.00	3.23	-25.93	29.25	18.25	530										
Acceptance Insurance Cos.	NYS	23.06	4.24	-4.65	26.53	21.13	79	Gryphon Holdings	NDO	15.25	-4.69	-8.96	19.38	14.75	122	Terra Nova Insurance Co. Ltd.	NYS	31.00	-3.13	18.10	35.00	22.25	128										
AEGON N.V.	NYS	92.13	0.41	105.58	111.31	34.00	676	Harleysville Group	NDO	25.75	10.16	7.29	28.50	18.88	329	TIG Holdings	NYS	17.94	-13.29	-45.95	36.56	17.69	1413										
Aetna Life & Casualty	NYS	68.69	-0.90	-2.66	106.94	65.00	5650	Hartford Steam Boiler	NYS	50.31	-3.13	36.75	59.56	33.25	330	Tokio Marine & Fire	NDO	49.00	-2.73	-15.15	66.00	41.25	70										
AFLAC Inc.	NYS	33.38	-2.91	30.56	38.25	22.13	1178	HCC Insurance Holdings	NYS	18.69	-7.72	-12.06	29.94	15.63	563	Torchmark Corp.	NYS	40.75	-7.39	-3.41	49.81	34.81	2302										
Allied Group Inc.	NYS	47.00	-0.27	64.19	47.19	25.00	374	ING Groep N.V.	NYS	71.38	-4.67	68.69	76.75	38.88	420	Transatlantic Holdings	NYS	91.44	1.18	27.88	91.44	67.44	580										
Allstate Corp.	NYS	41.75	-1.62	-7.73	52.38	35.44	18558	IPC Holdings Ltd.	NDO	27.13	2.36	-15.73	33.25	25.88	132	Travelers Property Casualty	NYS	38.06	-11.99	-13.49	48.06	34.88	1885										
AMBAC Indemnity Corp.	NYS	56.81	-2.47	23.51	65.94	38.94	1718	Hartford Financial Services	NYS	50.81	-2.40	8.62	60.00	39.25	2601	Travelers Corp.	NYS	61.19	-9.01	13.57	73.50	42.00	26135										
American Bankers Ins.	NDO	58.50	-3.01	27.35	66.06	32.38	572	LaSalle Re Holdings Ltd.	NYS	32.00	-8.57	-9.54	42.94	30.50	172	Trenwick Group Inc.	NDO	35.00	0.72	-6.98	41.75	33.38	250										
American Financial Group	NYS	38.00	-4.55	-5.74	46.75	34.56	570	Life Re Corp.	NYS	91.19	0.00	39.88	92.94	49.75	1813	Unico American Corp.	NDO	14.00	-3.45	14.29	18.13	10.75	48										
American General	NYS	66.31	-2.93	22.66	75.69	46.56	3301	Lincoln National	NYS	92.88	-3.13	18.88	98.88	64.63	3014	United Fire & Casualty	NDO	38.00	-1.94	-14.12	47.00	37.25	6										
American Heritage Life Ins.	NYS	22.88	-5.18	27.08	26.06	17.06	80	MAIC Holdings Inc.	NYS	27.31	1.16	1.97	30.38	22.44	94	Unitrin	NDO	64.13	-1.72	-0.77	74.13	56.25	728										
American Indemnity/Fin'l	NDO	13.88	11.00	0.00	15.50	9.50	51	Market Corp.	NYS	164.94	-3.40	5.64	187.00	135.00	18	UNUM Corp.	NYS	51.69	-1.90	-4.94	59.63	40.69	2052										
American International	NYS	94.00	-6.51	29.66	102.38	62.50	9919	MBIA Insurance Group	NYS	66.19	-1.76	-0.94	80.94	56.50	2862	Vesta Insurance Co	NYS	15.81	5.42	-73.37	64.75	13.50	1085										
American Safety Insurance	NDO	11.13	-1.11	-9.64	15.06	10.75	92	Meadowbrook Insur. Group	NYS	28.88	0.22	10.79	35.00	21.88	26	Zenith National Ins.	NYS	26.44	-1.40	2.67	30.50	24.50	33										
Argonaut Group	NDO	30.50	-0.41	-9.96	38.13	28.63	138	Mid Ocean Ltd.	NYS	80.13	1.42	47.70	84.88	52.75	353	INSURERS/REINSURERS AVERAGE							-1.27	4.33									
AXA-UAP Group	NYS	67.31	-0.19	72.60	71.25	31.69	325	MMI Cos. Inc.	NYS	19.38	-3.73	-22.89	27.06	19.06	65	HEALTH MAINTENANCE ORGANIZATIONS																	
Baldwin & Lyons Inc.	NDO	20.75	-6.74	-13.99	29.75	18.50	8	Mutual Risk Mgmt. Ltd.	NYS	35.81	-6.07	19.62	39.94	22.63	799	Foundation Health Systems Inc.	NYS	18.06	-12.42	-18.82	33.94	17.25	3013										
Berkley W.R. Corp.	NDO	34.81	3.92	-20.66	49.88	33.13	447	NAC Re Corp.	NYS	53.50	4.01	9.60	55.88	43.50	409	Humana Inc.	NYS	18.31	-32.64	-11.75	32.13	16.25	27987										
Berkshire Hathaway Inc.	NYS	89900.00	-0.44	51.74	84000.00	41300.00	2	Navigators Group	NDO	18.13	0.00	-3.49	22.50	17.00	17	Oxford Health Plans	NDO	6.88	-14.73	-55.82	83.50	6.88	7299										
Capital RE Corporation	NYS	33.75	2.27	8.76	38.69	24.94	275	Nobel Insurance Ltd.	NDO	0.84	28.57	-93.57	1.00	0.40	4	Pacificare Health Sys.	NDO	62.81	-7.97	25.00	86.88	46.75	253										
Capitol Transamerica Corp.	NAS	21.25	2.10	-0.29	28.13	19.00	57	NYMagic Inc.	NYS	26.38	-5.80	-4.31	34.25	22.88	46	Safeguard Health Enter.	NDO	5.75	2.22	-57.41	14.88	5.38	17										
Centis Group Inc.	NDO	-2.22	-1.40	14.81	9.69	190	Ohio Casualty Corp.	NDO	41.63	-2.35	-6.72	51.75	37.50	273	Sierra Health Services	NYS	18.25	1.39	-18.59	27.75	17.63	626											
Chartwell Re	NYS	29.00	0.43	-14.07	36.25	27.81	88	Old Republic Int'l	NYS	25.81	-3.50	4.12	32.25	22.38	1869	United Healthcare Corp.	NYS	36.31	-35.73	-26.92	73.94	32.63	33279										
Chubb Corp.	NYS	72.06	-1.79	-4.71	88.81	63.50	4188	Orion Capital Corp.	NYS	44.13	-9.49	-4.98	59.25	39.06	1091	Wellpoint Health Networks	NYS	57.00	-7.03	34.91	75.00	38.63	4304										
CIGNA Corp.	NYS	64.38	-2.55	12.04	74.50	45.63	4444	Partner Re Ltd.	NYS	48.31	-2.89	4.18	52.50	39.44	216	HMOs	AVERAGE	-13.36	-16.17														
CNA Financial Corp.	NYS	39.50	-0.32	-7.24	53.25	36.44	527	Penn-America Group Inc.	NYS	12.88	-2.83	-37.20	23.00	12.25	201	ALL COMPANIES	AVERAGE	-5.37	1.04														
CNA Surety	NYS	14.00	4.67	-9.31	16.75	12.75	370	Philadelphia Cons. Holding	NDO	20.31	7.62	14.44	24.38	15.50	403																		
								PXRE Corp.	NYS	29.06	7.84	-12.43	35.25	26.44	239																		
								Reliance Group Holdings	NYS	15.81	-8.66	11.95	19.81	11.63	1020																		



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