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Updates

Dole proposes tort reforms as part of election platform

WASHINGTON—Former Sen. Robert J. Dole will push for a series of tort and regulatory reforms if elected president.

Among Mr. Dole's legal reform initiatives, which are part of his economic growth proposal unveiled last week, is limiting punitive damages in all but a few types of civil cases to the greater of $250,000 or three times economic damages. He also advocates abolishing joint and several liability in all civil cases; "curbing abuse of contingency fee representation"; and allowing defen-

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HMO jumps into top ranks

By JUDY GREENWALD

CYPRESS HILLS, Calif.—PacifiCare Health Systems' planned $2.1 billion acquisition of FHP International Corp. will create the nation's fifth-largest managed care organization and also will result in a more efficient health maintenance organization that can exercise greater leverage with providers and offer employers access to more markets.

The two companies announced the acquisition last week and expect to complete the deal within the next three to five months. Under terms of the deal, which still must receive regulatory and shareholder approval, FHP common stock owners will receive the equivalent of $35 per share, of which $17.50 will be in cash and the rest in PacifiCare shares.

The combined company, which will have revenues of more than $8.6 billion, will have 3.9 million members, including 2.9 million commercial members, and will operate in 15 states, plus Guam.

In terms of HMO membership, the combined company would be surpassed only by Oakland, Calif.-based Kaiser Permanente; Hartford, Conn.-based Aetna Inc.; Minneapolis-based United HealthCare Corp.; and Woodland Hills, Calif.-based Wellpoint Health Networks. This does not take into account the combined enrollment of independent Blue Cross & Blue Shield plans.

"I suppose by some measure the resulting company is not a giant, but we're within earshot of the giants," said Alan Hoops, PacifiCare's president and chief executive officer.

Perhaps ironically, both PacifiCare and FHP at one time were considered to be likely acquisition targets of Aetna, which eventually reached a deal with U.S.

See **PacifiCare** *on page 30*

Managed care merger

PacifiCare and FHP will form the fifth-largest HMO

PacifiCare Health Systems	FHP International Corp.	New Company
*Enrollment: 1.97 million	*Enrollment: 1.9 million	Enrollment: 3.9 million
1995 Revenues: $3.7 billion	1995 Revenues: $3.9 billion	

* Includes commercial Medicare and Medicaid enrollment.

Source: PacifiCare Health Systems

GRAPHIC BY TONY BUCCINI

Worthless notes back insurer

Westwood exec pledges to replace assets

By DOUGLAS McLEOD

CHARLOTTESVILLE, Va.—Buying insurance always involves a bet on the insurer's financial strength, but buying from some companies requires an act of faith.

Take Westwood Insurance Co. Ltd. of Antigua.

Westwood, writing mainly marine business, is headed by a former Louisiana Insurance Department examiner, boasts "solid" capitalization and reinsurance and last year announced plans to buy a New Jersey mansion for meetings.

Apart from the fact that Westwood is not in good standing with the Antigua government, documents show the majority of its assets—described by Westwood as Chase Manhattan Bank certificates of deposit—actually consist of worthless World War II-era Philippine government notes.

Several Westwood advisers and directors also have been involved in the past with insurers that have failed or had regulatory trouble.

Westwood's investment adviser, for example, earlier supplied assets to a British Virgin Islands insurer thrown out of California in 1991 after the assets—$72 million in Indonesian war bonds—were disallowed by regulators.

Westwood's changing cast of directors has included former claims managers for the failed Anchorage Fire & Casualty Insurance Co. Ltd. of the Turks & Caicos Islands. A Westwood consultant is the former president of Union Indemnity Insurance Co., a defunct underwriting unit of Frank B. Hall & Co.

Owen Guidry, Westwood's managing director and a former Louisiana and Arizona insurance department examiner, said in an initial interview he knew nothing about the Philippine notes.

"This was set up by (Westwood's parent, Lock Investments Ltd.) and its board. I just run the insurance company," Mr. Guidry said.

After saying he had consulted with a Lock officer—whom he would not name—Mr. Guidry later said Westwood's Chase Manhattan CDs are "collateralized" with the Philippine notes and that Lock will replace them with other assets if they prove worthless.

"They will be making a move immediately to re-collateralize the CDs or replace them with entirely new assets at their disposal," said Mr. Guidry, who also heads Grace Worldwide Management Corp., Westwood's Charlottesville-based management firm.

Meanwhile, Westwood—which had failed to make required financial filings in Antigua—is correcting this problem and taking other steps to restore its status as a company in good standing, he added.

Westwood, not licensed anywhere in the United States, has a short but colorful history.

It was originally incorporated in 1987 in Antigua as Wirral Insurance Co. Ltd. Wirral was one of several members of International Underwriting Assn. Inc., a pool of offshore insurers used by the late insurance con man Alan Teale, U.S. Senate records show.

See **Westwood** *on page 28*

California fraud cops, regulators trade charges

By ROBERTO CENICEROS and JOANNE WOJCIK

SACRAMENTO, Calif.—A dispute centered in the California Insurance Department's Fraud Division is generating a lot of finger pointing among regulators.

State insurance investigators complain in a lawsuit that they are being ordered to rubber stamp for prosecution insurer-referred workers compensation fraud cases. Without proper review of suspected fraud cases, the investigators contend that innocent claimants could wind up in jail and insurers could gain undue influence over California's Insurance Department.

Some attorneys speculate that employers could be hit with defamation and harassment suits filed by employees falsely charged with fraud, though other attorneys say it would be difficult to hold employers liable.

However, the Insurance Department rebuts the allegations contained in the suit, which names two aides appointed by Insurance Commissioner Chuck Quackenbush.

A department official contends that the lawsuit was filed in retaliation for efforts by the aides to accelerate fraud investigations.

In addition, insurers and prosecutors discounted the risk of innocent parties being sued

See **California** *on page 29*

Drugstores target Lilly in petition to FTC

Drug interactions

Several drug makers have bought prescription benefit managers in recent years

Deal	Price	Lives covered
Merck & Co./Medco Containment Services Inc. 1993	$6.6 billion	48 million
SmithKline Beecham Corp./ Diversified Pharmaceutical Services Inc. 1994	$2.3 billion	14 million
Eli Lilly & Co./PCS Health Systems Inc. 1994	$4.1 billion	56 million

GRAPHIC BY TONY BUCCINI

By RODD ZOLKOS

A national group representing drugstore owners is asking federal regulators to take a fresh look at the acquisition of prescription benefit managers by several major pharmaceutical companies.

A petition filed with the Federal Trade Commission by the National Assn. of Chain Drug Stores charges Indianapolis-based Eli Lilly & Co.'s 1994 purchase of Scottsdale, Ariz.-based PCS Health Systems Inc. is anti-competitive and has led to higher prices for the chains.

"Manufacturer ownership of pharmacy benefit management companies has resulted in increased costs of prescription drugs and distorted the marketplace in anti-competitive fashion," the petition states.

Citing statistics from IMS America, NACDS claims prescription drug prices rose faster than the overall rate of inflation from the fourth quarter of 1994 to the fourth quarter of 1995, despite the suggestions of Lilly and other drug makers that acquiring the PBMs would create efficiencies and lead to reduced costs.

"We're asking the FTC to reopen its approval of the Lilly-PCS merger, strengthen the consent decree," said a spokesman for the Alexandria, Va.-based NACDS.

The association then wants the FTC to apply any beefed-up provisions to other drug maker-PBM relationships, including Merck & Co. Inc.'s 1993 acquisition of Medco Containment Services Inc. and SmithKline Beecham Corp.'s 1994 purchase of Diversified Pharmacy Services.

The NACDS represents more than 135 drugstore chains, ranging in size from four pharmacies to more than 2,500, including Walgreen Co., Rite Aid Corp. and Eckerd Corp. Its members fill more than 60% of the 2.3 billion prescriptions dispensed annually in the United States.

The NACDS seeks six specific modifications in the Lilly-PCS

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Updates

Dole touts tort reforms

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dants to make a so-called "early offer" to compensate a plaintiff for all economic damages with the provision that if the plaintiff refuses the offer, he or she would be entitled to non-economic damages if "there is clear and convincing proof that the defendant's conduct was caused by intentional or wanton misconduct."

Mr. Dole would allow states to opt out of the early offer system as well as a proposed national "auto choice" insurance system that would let drivers buy cheaper liability policies that would cover only economic damages.

The Republican presidential hopeful also calls for reducing business' regulatory burdens by requiring that: "benefits justify the costs for all new major federal regulations"; all new regulations be re-evaluated every four years; and a federal task force be created to evaluate all existing major regulations and recommend eliminating those found to be outdated, ineffective or not cost-effective.

U.K. commuter trains collide

LONDON—U.K. rail companies late last week were trying to determine their potential liabilities and coverage for losses from Thursday's collision of two commuter trains north of London.

Investigators last week were still trying to determine the cause of the crash, which occurred at Watford Junction on the main rail line between London and northwest England. One person died and more than 60 people were injured as the trains collided head on.

Commuter and other rail services were disrupted by the accident and will not be back to normal until the investigation is complete. Although alternative routes and bus services are available, freight trains from London were not able to travel beyond Watford Junction late last week because the wreckage was blocking the tracks.

Britain's entire rail network is in the midst of privatization, though North London Railways, which operates the two trains involved in the crash, has yet to be sold. If the crash is found to be the result of human error or a problem with the rolling stock, North London Railways could be liable. A spokesman for the rail company could not provide coverage details.

Upon privatization, rail operators are required to purchase at least £155 million ($239.2 million) in liability insurance.

A failure in the system's infrastructure, such as a signal or faulty track, likely would place responsibility with track operator Railtrack P.L.C.

More big hurricanes on horizon

FORT COLLINS, Colo.—Risk managers and insurers should expect two more major hurricanes this year, according to William Gray, professor of atmospheric science at Colorado State University.

The two predicted major hurricanes will join Hurricane Bertha to lead the list of 11 named storms predicted for the season, he said. The latest prediction is an increase from the two major hurricanes Mr. Gray predicted in the spring (*BI*, April 22).

Last year, Mr. Gray had predicted 16 named storms and three major hurricanes for 1995 (*BI*, July 10, 1995). By the end of the season, there were 19 named storms and five intense hurricanes.

Judge to rule on CIGNA report

PHILADELPHIA—A Pennsylvania judge this week is expected to rule on an Aug. 5 motion by the Pennsylvania Insurance Department to prevent the department, as well as critics challenging CIGNA Corp.'s reorganization, from relying on an actuarial report that underpinned the department's approval of the transaction.

Critics of CIGNA's split into separately capitalized active and runoff operations oppose the motion. But, the department's case for approving the split would be greatly weakened if the judge approves the motion, contends Floyd Abrams of Cahill Gordon & Reindel of New York, who represents American International Group Inc. in the litigation opposing CIGNA's reorganization.

A department spokeswoman would not comment. Department attorney Edward F. Mannino of Wolf, Block, Schorr & Solis-Cohen in Philadelphia could not be reached.

Critics have been seeking access to the report, which CIGNA officials and consultants say proves that policyholders in the runoff operation are well protected (*BI*, Dec. 4, 1995). The critics want to see whether Tillinghast's conclusions contain caveats.

The Pennsylvania department, which hired Tillinghast, and CIGNA have refused to release the report, contending it contains proprietary information about the insurer. Pennsylvania Commonwealth Court President Judge James G. Colins in March agreed to decide whether the department had to release the report and other material that CIGNA's critics sought (*BI*, March 25).

Judge Colins in late July rejected a motion by St. Paul Fire & Marine Insurance Co. to disqualify CIGNA's attorney from the case. St. Paul hired the firm in 1994, when it was helping CIGNA plan its restructuring. St. Paul argued the firm should have revealed that its work with CIGNA could adversely affect St. Paul.

Errors & omissions

• Under Edina, Minn.-based United HealthCare Corp.'s open access program, patients do not need permission to go directly to a specialist for their visits, though recommended procedures do need network approval. This was not clearly stated in the Aug. 5 issue.

Employers breathe sigh of relief over new 401(k) transfer rules

By MARK A. HOFMANN

WASHINGTON—The final version of a Labor Department rule governing how quickly employers have to transfer employee deferrals to their 401(k) plans will cause fewer administrative headaches than businesses had originally feared.

Employers had reason to worry about early indications that they would be required to make the transfers within a few days of collecting the contributions, rather than the 90 days permitted under current law. The new regulation is not nearly as onerous as feared, and could give some employers well over a month to make the contributions.

But some employer organizations are questioning whether the rule is anything more than a public relations ploy. "There is very little need for the regulation. It appears to have been promulgated in main for press release value," said Mark Ugoretz, president of the ERISA Industry Committee in Washington.

The new regulation is a boon for employees, Labor Secretary Robert Reich told a Washington press conference last week.

He claimed that some employers are using the 90-day grace period as "a sort of interest-free revolving loan fund."

According to the secretary, the changes would mean that employees making contributions to 401(k) plans would collectively earn an additional $75 million a

See **401(k)** *on page 4*

Reformers balk at Superfund tax without reform

By MARK A. HOFMANN

WASHINGTON—Superfund reform advocates are girding to fight any efforts in Congress to raise special taxes for cleanups without also enacting comprehensive liability reforms.

And comprehensive reform, they admit, does not appear likely before the 104th Congress closes later this year. Congress currently is in recess until next month, and after the break members will be restless to campaign for the fall elections. In addition, with the Clinton administration and the congressional Republican leadership far apart on Superfund liability reform, action before the 105th Congress convenes next year appears virtually impossible.

As a result, advocates of repealing Superfund's retroactive liability for cleaning up waste dumped legally before Superfund's last major reauthorization in 1986 plan to fight any attempt to separately reauthorize the taxes that fund Superfund cleanups.

The taxes, which consist of two excise taxes on oil and chemical industries and a broad-based corporate environmental income tax, fund the so-called "orphan share" at Superfund sites for which no solvent, potentially responsible

See **Superfund** *on page 21*

Cleanup cover valid if it stops more damage: state high court

By DAVE LENCKUS

OLYMPIA, Wash.—In one of the first decisions of its kind by a state Supreme Court, Washington's highest court has ruled that general liability insurers must cover property owners' costs of cleaning up pollution on their property if the cleanup prevents further damage to another's property.

The July 11 ruling is clearer than similar decisions by the Washington court and a California appellate court, and it likely will influence other courts nationwide, insurer and plaintiffs attorneys say.

But Kenneth J. Cusack, who represents the primary insurer involved in the Washington case, said the ruling does not open a door to policyholders recovering the cost of cleaning their property. A concurring opinion makes that clear, he said.

The majority opinion, though, did not resolve whether the policyholder in this case may recover cleanup costs from its primary and excess liability insurers. The court remanded the case to a trial court jury to determine whether the policyholder had a legal obligation to clean up third-party property.

The policyholder, Olds-Olympic Inc., owned a site in Seattle from where it operated its home-heating oil distribution business for nearly 60 years.

After an underground storage tank leak was discovered in 1988, Olds-Olympic's environmental consultants and the state's Department of Ecology advised the company to remove all tanks on the site and clean up the soil. The DOE provided Olds-Olympic recommended ground water cleanup levels.

The company cleaned only the site's soil. But the purpose of the cleanup, completed in 1990, was to remove the source of ground water contamination, pointed out Olds-Olympic attorney Sylvia Luppert, a partner with Reaugh Fischnaller Oettinger of Seattle.

The company's environmental consultants, though, did not measure contamination because they concluded that ground water contamination was obvious.

"As one of our experts said, you don't have to measure it with a micrometer if you're go-

See **Cleanup** *on page 29*

Forum to explore captive issues

By MICHAEL SCHACHNER

AVENTURA, Fla.—The Sixth Annual World Captive and Alternative Risk Financing Forum will present captive insurance company users with a unique opportunity to interact with industry colleagues and learn about emerging risk financing techniques both in formal conference sessions and casual receptions.

The conference will be held Nov. 17-20 at the Turnberry Isle Resort and Club in Aventura, Fla., just north of Miami Beach. Like previous captive forums, the gathering features three days of formal conference sessions mixed with breaks and luncheons designed to allow attendees to share information about topics of particular interest.

The conference, co-sponsored again this year by *Business Insurance*, Skandia International Risk Management Ltd./SINSER and Tillinghast-Towers Perrin, is aimed both at experienced captive insurance company users and those interested in exploring captive arrangements. In attendance will be risk managers, captive managers, regulators from various domiciles, consultants, insurance and reinsurance brokers, accountants, lawyers, bankers and insurer and reinsurer executives.

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Cab companies aren't hailing coverage mandate

By MICHAEL BRADFORD

DALLAS—Taxicab companies are fighting a new Dallas ordinance that is forcing some to pay twice as much for automobile liability insurance covering their fleets.

Twelve companies and one independent cab owner have filed suit in U.S. District Court in Dallas, arguing that the ordinance that now requires each cab to carry $500,000 in liability insurance—up from $300,000—was passed under pressure from larger operators that want smaller competitors out of business.

The coverage requirement previously was $500,000, but that amount was reduced to $300,000 in 1991. The lower limit resulted from heavy lobbying by an insurance agent who convinced city officials that it would bring other insurers into the marketplace, said Jim Richards, vp of Yellow Cab, which is not party to the suit, but "it never opened up the market."

The suit lists the city of Dallas as a defendant, along with unnamed individuals who the suit charges conspired to deprive the plaintiffs of their rights to operate. No hearings are scheduled yet.

The suit asks the court to declare the ordinance unconstitutional, partly because the extra expense allegedly would put minority-owned taxicab companies out of business.

The plaintiffs also argue the ordinance is unconstitutional because of the requirement that insurers provide first-dollar coverage, a provision "susceptible to arbitrary enforcement" that "fails to give fair and adequate notice," according to the suit.

The plaintiffs' complaint also maintains that the ordinance is "constitutionally irrational when the result of its application is to destroy the majority of the Dallas taxicab fleet. . . ."

While the lawsuit contends that the cost of the additional insurance coverage is prohibitive, the plaintiffs in the case have been able to buy coverage that

See **Taxicabs** *on page 7*

Taking a bite out of comp costs

By MEG FLETCHER

DANVERS, Mass.—Sydney was chief cook at a university dining hall operated by DAKA International Inc. when he cut a tendon in his left hand with the serrated edge of an industrial plastic wrap box.

The deep gash, which required multiple surgeries, made it impossible for him to perform all his regular duties in the cafeteria operated by the Danvers, Mass.-based food services conglomerate. The accident threatened to keep the 38-year-old off work for several months while his hand healed.

However, Sydney was able to return to work several weeks earlier than estimated because of DAKA's comprehensive, three-year program to improve worker safety and reduce the cost of insured workers compensation, liability and auto claims.

The program, which just completed its second year, covers about 18,000 full- and part-time employees working at most of DAKA's nearly 900 food service operations in 45 states, which includes the Fuddruckers restaurant chain.

Under the program, DAKA required its broker, underwriter and claims handling company to cooperate extensively and use state-of-the-art data assessment techniques to reduce claim costs.

DAKA bolstered the team's performance with incentives, including a confidential formula that thus far has returned $200,000 in total bonuses to the outside service providers, which are: Boston-based broker Willis Corroon Corp. of Massachusetts; New York-based AIG Risk Management Inc., which underwrites large accounts on behalf of AIG insurance companies; and New York-based claims administrator AIG Claims Services Inc.

In Sydney's case, AIG Claims Services sent an early-return-to-work specialist to meet with the general manager of the university dining hall. They modified Sydney's "head cook" duties to make

See **DAKA** *on page 20*

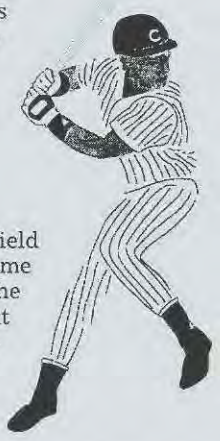
JOE IADANZA

Peggy Benard, right, is vp-risk management and David Parker is senior vp and chief administrative officer for DAKA International Inc., which owns Fuddruckers restaurants.

Some pros on ineligible list for workers comp benefits

By SALLY ROBERTS

If Sammy Sosa were to sustain a career-ending injury, the right fielder for the Chicago Cubs would be entitled to $760.51 tax-free per week in workers compensation benefits—the maximum allowed under Illinois' workers comp statutes.



But if Gary Sheffield were to sustain the same career-ending injury, the Florida Marlins' right fielder would not receive state workers comp benefits and would have to rely on other means.

Although Illinois and many other states regard professional athletes as just another class of employee entitled to workers comp benefits for on-the-job injuries, some states treat pro athletes differently and restrict compensation.

Florida's workers compensation statutes exclude all professional athletes from receiving benefits.

Similarly, Michigan statutes exclude professional athletes if their average weekly wage is 200% more than the statewide average weekly wage.

In Massachusetts, workers comp statutes exclude professional athletes whose contracts provide them wages during job disabilities.

Rhode Island statutes exempt professional hockey players from workers comp benefits.

Exclusions historically have been based on the notion that professional athletes are independent contractors rather than employees, said Vincent M. Tentindo, an

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Neighbors settle with Lockheed

By JOANNE WOJCIK

BURBANK, Calif.—Lockheed Martin Corp. has settled a dispute with some 1,300 neighbors of its former military airplane plant in Burbank, Calif.

The amount of the settlement was not disclosed but reportedly was as high as $70 million. It was reached quietly last month after more than a year of negotiations and without a lawsuit being filed. All 1,300 affected residents settled.

"We have settled that case with a number of Burbank residents relating to historical operations by Lockheed in Burbank," a company spokeswoman confirmed. However, she said she could not provide details of the settlement "because we have a confidentiality agreement on all of the elements."

The Lockheed spokeswoman also would not say whether any of the settlement would be covered by insurance.

The residents' attorney, David Casselman, did not return phone calls.

According to local news reports, residents who settled will receive payments ranging from $2,500 to $300,000 each, and up to $10 million in additional money will be set aside by the company to pay for long-term medical monitoring and insurance protection for some of the residents. The total settlement has been estimated in news reports at between $60 million and $70 million.

Separately, Lockheed acknowledged it reached an agreement with the city of Burbank over plans to build a $13.7 million vapor extraction system to clean up several sites, one of which was involved in the residents' dispute.

The system of wells, pipes and charcoal filters will treat potentially cancer-causing substances contained in the soil and pump the treated vapors into the air.

The residents involved in the dispute with Lockheed blamed an array of ailments, including cancer, on chemicals that had seeped into the soil and ground water for more than 60 years. Some residents also contended that the chemical contamination caused their property values to decline.

However, "Lockheed has always maintained that its properties in Burbank pose no risk to the community now or at the time that we were in operation," the spokeswoman said.

Lockheed's Burbank airplane manufacturing plant opened in 1928. The company began moving away from the plant in the 1980s and vacated it in the summer of 1994.

After its 1995 merger with Martin Marietta Corp., Lockheed's Burbank operations were divided between Palmdale, Calif., and Marietta, Ga.

New law may help long-term care

Tax breaks for employees may boost interest

By ROBERT KAZEL

When preaching the merits of long-term care insurance at his company, Ken Johnson has had to delicately cross a tightrope: how to alert his co-workers to the debilitating perils that face everyone in life while avoiding being so morbid no one will listen.

"Frankly, a lot of people don't like to focus on this because it conjures up a lot of things people don't want to think about," said the benefit manager of Lexmark Inc., a Lexington, Ky.-based manufacturer of computer printers.

Despite several campaigns over five years to interest employees in long-term care coverage, only about 5% of the company's active U.S. workforce of 4,500 has opted for it.

"We've obviously got a whole lot of potential ground we can plow," Mr. Johnson said.

For that task, Lexmark and other employers got a new tool earlier this month. Though the congressional health insurance reform package passed by Congress includes far-reaching measures on insurance portability and pre-existing conditions, lesser-discussed provisions on LTC could make the benefit more attractive to employees.

LTC coverage typically offers benefits such as nursing home care, home health care and assisted living care.

The law would allow plan sponsors to pay employees' long-term care insurance premiums, up to a prescribed limit, and does not penalize the employee by taxing those payments as income.

And, employees who do not have group coverage and purchase their own LTC coverage can take an income tax deduction, just as they have been able to do for unreimbursed medical expenses, if those expenses and the LTC premiums total more than 7.5% of adjusted gross income.

Until now, virtually all employers offering LTC have required employees to pay all or most of the premiums. Now, the amount of annual premiums that can be paid by a plan sponsor without a tax bite for the employee are $200 for workers younger than 40; $375 for those 40 to 50; $750 for those older than 50 but not more than 60; $2,000 for those older than 60 but not more than 70; and $2,500 for those older than 70.

"For some people, there will be a real benefit here," said Mary Case, a principal at Kwasha Lipton L.L.C. in Fort Lee, N.J. Those most likely to benefit are, obviously, those with employers who decide to shoulder part of the benefit cost themselves and, second, those financially struggling with unpaid medical bills, especially the elderly, whose payment of long-term care insurance premiums will bring tax relief for the first time.

Although it is unlikely that plan sponsors will abruptly start steering large sums of money into LTC premiums for employees, the change in the law could be enough to catch the attention of employees and plan sponsors in companies that currently offer LTC insurance and those that do not, Ms. Case said. "Now that it is part of the tax code, employers may become more aware of the importance of long-term care and employees may ask employers to offer it," she said. "There's a possibility that the industry will get a boost."

Leading insurers in the LTC insurance market obviously hope that's true, and they are cautiously betting that Congress' greasing of LTC's wheels will result in a gradual resurgence of a market where growth has slowed recently.

Visibility of the product is crucial, said Nancy F. Bern, senior vp of group account development at Boston-based John Hancock Mutual Life Insurance Co., the leading seller of LTC policies.

"I think it will spur future growth," she said. "What we have found is once people have found out about long-term benefits, they are interested in buying it from their employers."

That interest won't come only from people nearing retirement, she said. The average age for people purchasing a group LTC policy is 48, she said. The average annual premium is "less than $500."

About one in five companies with 500 or more employees offers long-term care insurance, Ms. Bern said.

About 10% of employees sign up for coverage, she said.

There is still much room for growth in LTC products, because baby boomers will look to them as a source of security as they enter middle age and find themselves financially strapped, juggling children and parents and their own retirements, Ms. Bern said.

Benefit managers need to become better-

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401(k)

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year in interest and that it "would take away the temptation for some employers to divert the money."

The secretary of labor also used the press conference to push for enactment of legislation that would subject some pension plans to more rigorous auditing practices.

The pension measure is currently awaiting action in the Senate Labor and Human Resources Committee.

The 401(k) regulation, which appeared in the Aug. 7 edition of the Federal Register, will require employers to complete the transfers of funds no later than the 15th business day of the month after the employer received the plan contribution.

The regulation will become effective 180 days from the date of its publication in the Federal Register, or on Feb. 3, 1997.

Employers can receive up to an additional 90 days to comply with the rule, but must notify employees of the postponement, tell them when the postponement will end and explain why the plan cannot meet the new requirement. The notice must also be sent to the Labor Department.

In addition, the Labor Department rule requires employers to post bond or meet other financial requirements at least equal to the total amount of participant contributions made during the previous three months.

The rule also allows employers to extend the deadline by an additional 10 days, provided that notification and bonding requirements are met. Under most circumstances, an employer could only request such an extension twice in any one plan year.

An initial Labor Department proposal would have forced employers to meet much more rigid standards.

'I think for larger employers it will be some burden but not an overly onerous burden. Larger employers had sought 30 days after the end of the month,' says Pam Scott.

Under that original proposal, employers would have had to make the employee contribution on the same schedule that they withheld federal income taxes and made Social Security payments. That could have meant that some employers would have had only a matter of days during which to make the transfers of funds (*BI*, Dec. 18, 1995).

Not surprisingly, the Labor Department's proposal drew quick and overwhelming opposition from business groups.

Compared with what might have been, this transfer schedule is "terrific," said Michael Pikelny, corporate actuary for Chicago-based Hartmarx Corp.

Mr. Pikelny pointed out that the clothing company has weekly payrolls, biweekly payrolls and bimonthly payrolls, which would have made complying with the initial proposal expensive.

Hartmarx does not anticipate any difficulty in complying with the new rule, however. The company typically makes monthly remittances, usually on or before the 10th of the month, he said.

"We have no problem with the final regulations," Mr. Pikelny said.

"My guess is that the people who will have the problems are the ones who don't have a centralized payroll system," he predicted.

"I think for larger employers it will be some burden but not an overly onerous burden. Larger employers had sought 30 days after the end of the month," said Pam Scott, a principal with employee benefit consulting company Kwasha Lipton L.L.C. in Fort Lee, N.J.

"The major victory was that the plan asset regulations no longer tie the time limit for deposit to the rules for deposit for withheld taxes. That has never been the law, but that was part of the Department of Labor's initial proposal.

"Employers felt that it was unrealistic because employers needed time to identify assets to be invested in particular funds and employers wanted to make sure that mistakes in deposits were minimized," Ms. Scott said.

"I think employers generally can live with this compromise," she said.

The new regulation is "a step in the right direction, and it's certainly better than the original proposals," agreed Henry Saveth, a principal with benefit consultant A. Foster Higgins & Co. Inc. in New York.

"But I think some employers are still going to say: 'Why not give us the whole month following?' " he said.

"I think we're going to find we'll be able to live with them. They're reasonable. They represent a craftsman-like effort by the career professionals at DOL," said Stephen Elkins, director-employee benefits for the National Assn. of Manufacturers. He added, though, that the regulations "are also annoying."

He noted that Department of Labor itself says that 94% of the plans affected are already in compliance. "So one might well ask, why are you doing this?"

"For a regulatory project that really never needed to happen, they came out really not so bad," said James A. Klein, president of the employer-backed Assn. of Private Pension & Welfare Plans in Washington.

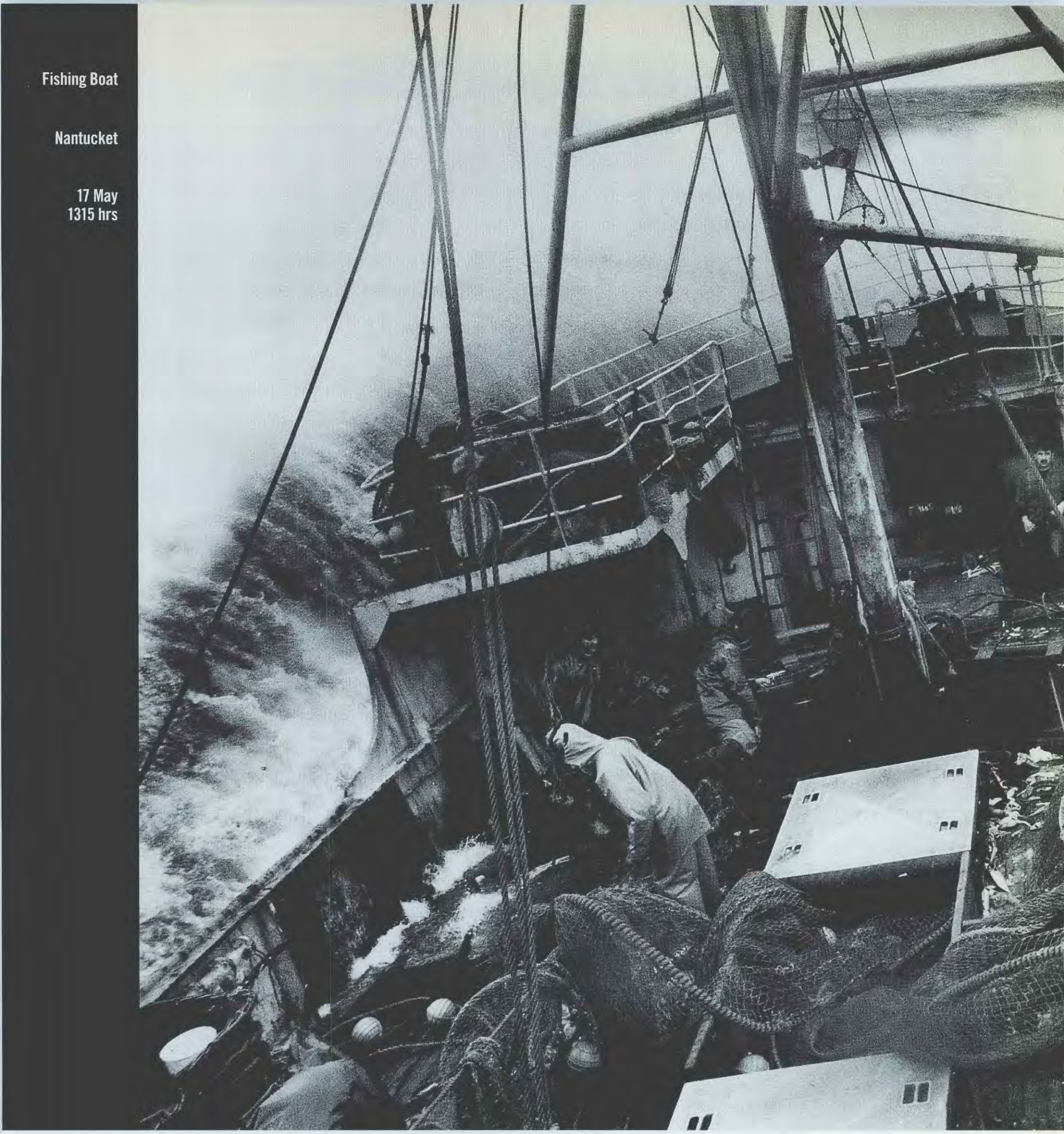
"I think the DOL was pretty responsive to the comments that we and others made, clearly it was good that they backed off the original proposal."

Mr. Klein added, however, that the change in transfer rules "was a politically driven regulatory project" for which the Labor Department never made a real case.

"What concerns a lot of people is the DOL's continuous drumbeat that employers are stealing from participants and that is an absolute falsehood. . .with this regulation and their plan audit bill, they're creating a climate of suspicion that has no basis in fact," according to ERIC's Mr. Ugoretz.

"The vast majority of plans will be able to meet the new rule. But there are companies that have to change their payroll practices. This means they'll re-evaluate their current practices.

"It might be cheaper to drop the 401(k) or defined contribution plan than to change your payroll system," he said. BI



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Mexican employers boosting benefits

Companies in Mexico are improving the benefits they offer their white-collar workers despite the country's recent economic turmoil, according to a new survey.

Multinational and domestic corporations have increased some medical benefits and have begun entering into discount provider networks to keep costs down, according to a survey by Brockman y Schuh, a Mexico City-based consulting firm and sister company to New York-based benefit consulting firm A. Foster Higgins & Co. Inc.

"Clearly, medical costs are going up very fast and many of the companies hope to adjust this benefit to make up for it," said Anthony Gilliam, managing consultant at Foster Higgins.

The survey of 97 employers found that nearly 91% offer major medical insurance to some employees and that of those, 95% offer benefits to their spouses and 96% offer benefits to their dependent children.

Virtually all recipients of private health insurance, however, are salaried workers, while hourly workers get medical attention at state facilities, Mr. Gilliam said. Hourly workers so far have not pressed management for benefits, he said.

A small but growing segment of Mexican companies also has begun offering what the report categorized as "minor medical expenses" coverage.

This insurance, depending on the employer, may reimburse employees for such expenses as medical examinations, pharmaceuticals, X-rays, laboratory work, dental work, eyeglasses and hearing aids, or other expenses not adequately reimbursed by the national Social Security system.

Among the study's other findings:

- Two-thirds of companies offer medical benefits that are generally uniform throughout for all covered workers, while about a third give different benefits depending on the executive or manager's rank.
- The average waiting period for coverage of pre-existing conditions is 1.4 years. However, some conditions typically require a longer waiting period. For example, 61% of companies reported they require at least five years' service before coverage for AIDS begins, and congenital illnesses require an average length of service of 1.8 years for all employers in the survey.
- Employee-paid, additional medical coverage is available on a voluntary basis from 14.4% of the Mexican employers, and among these nearly one-half of eligible employees elect to purchase the additional insurance.

Copies of "Encuestra de Prestaciones," or "Benefits Inquiry," which is written in Spanish and English, are available for $250 from Deborah Harrison at Foster Higgins International in New York, 212-574-7727.

—By Robert Kazel

Human resource survey

Human resource departments across the country can identify areas where they need to improve through a service award contest and survey conducted by a management consulting company.

This year, 179 corporate human resource departments participated in Chicago-based HR Solutions Inc.'s HR Service Excellence Award contest, which recognizes the best human resource departments in the country. More than 2,000 "internal customers," or employees of the companies participating in the survey, rated their human resource department on employee relations, service orientation, communication, knowledge and overall performance.

Benefit Beat

Kevin Sheridan, chief executive officer of HR Solutions, said the survey showed differences between management and non-management responses, seemingly because management received more attention from their human resource departments than employees.

Mr. Sheridan said this could result from departments not viewing employees outside management as part of the internal team.

"Most are using it (the contest) to set a baseline for customer service from the HR department," he said, adding the departments will conduct another survey in a year and "identify whether they improved those areas."

John Klein, director of the human resources department at Elkhart General Hospital in Elkhart, Ind., which won the 1996 HR Service Excellence Award, said his department entered the contest to identify benchmarks for service.

"We constantly have to stay on top to be re-educating all of our staff in terms of what services we provide and changes that have occurred or don't occur, for some reason," he said.

According to the survey, the five most favorable responses on human resource departments and the areas involved included:

- Employee relations: 80% of employee respondents rated the human resource department staff as friendly and helpful.
- Performance: 77% listed human resource staff as able to address benefit-related questions.
- Knowledge: 75% said their department is knowledgeable on benefit issues.
- Communication: 74% understand their department's written communication.
- Performance: 71% say human resources staff are helpful in answering pay-related questions.

Among the five least favorable responses:

- Communication: 24% don't know whom to call in human resources for help on specific questions.
- Employee relations: 24% state that the human resource department does not use employee input when making recommendations to management.
- Performance: 22% believe employees are left blind to career opportunities within the company.
- Employee relations: 21% say human resource staff are not available when employees need to discuss benefit matters
- Employee relations: 21% of respondents say their human resource department does not return calls promptly.

Human resource departments wishing to participate in the 1997 HR Service Excellence Award contest may call HR Solutions at 312-236-7170.

—By Cristal Cody

Taxicabs

Continued from page 3

will allow them to operate at least through this month, said Timothy A. Duffy, an attorney with the Dallas firm Burleson, Pate & Gibson L.L.P., who represents the plaintiffs.

Mr. Richards, however, contends that the additional insurance is not prohibitively expensive, with premiums depending on a cab company's loss experience and other factors.

"Your exposure is in the first layers. After the first $300,000, it gets fairly inexpensive," he said.

Additional monthly premiums for the added $200,000 in limits generally run $18 to $20 per car but could go as high as $50, depending on the company's loss experience, he said.

Cowboy Cab Co., one of the plaintiffs, has seen its premiums double because of the new requirements, according to Saied Rafie, operations manager for the company. Although he would not disclose figures, Mr. Rafie said a large deposit also was required by the insurer writing the coverage.

Cowboy Cab Co., one of the plaintiffs, has seen its premiums double because of the new requirements, says Saied Rafie, operations manager for the company.

The numbers Mr. Richards cited may be true for large companies, Mr. Rafie said, but the additional per car amount for Cowboy Cab's fleet is much higher. "I am paying 1½ times more per month," he said.

Court papers indicate that an insurer asked Eagle Cab, another plaintiff, for prepayment of $80,000 to $100,000 to cover a deposit and premiums for an unspecified term of coverage.

The ordinance, which became effective Aug. 1, requires companies to buy the higher liability limits from an insurer with an A.M. Best Co. rating of B+ or higher. The insurer must be rated at least Class VI by Best's financial size ratings. Insurers are required to write first-dollar coverage.

The ordinance was written because the city "believed that increasing the coverage limits and requirements for coverage would strengthen the impetus for having high-quality operations," said Mike Marcotte, director of economic development for the City of Dallas. Companies convicted of violating the ordinance are subject to fines of $500 per incident.

"The council has been concerned about some highly publicized claims where serious injuries were involved," he noted.

The ordinance passed after "considerable debate" by the city council, according to Mr. Marcotte. While there is no record of the final vote in the council meeting minutes, that document states that the ordinance passed on a "divided voice vote."

IMAGE BANK

The cab companies' suit, however, states that "all claims arising out of taxicab accidents have been resolved" within the $300,000 limit in effect since 1991. The papers refer to a claim currently in litigation that could cost more than $300,000.

The plaintiffs, which operate about 1,100 of the city's 1,730 cabs, say reasons for the ordinance are more sinister than concern for the public.

"There are certain large companies that are pushing to get the small companies like us out of business," said Majid Askari, general manager of Allied Taxi Service.

According to court papers, the ordinance "was actually drafted by an agent for the Yellow Cab permit holder" and was heavily lobbied for by representatives of Yellow Cab and Terminal Cab. Those two companies and their affiliates operate the remaining 630 cabs in the city, the suit says.

Mr. Marcotte said that Yellow Cab and Terminal Cab had no influence on the ordinance and said it was written by the city attorney's office based on recommendations from the economic development office.

Yellow Cab's Mr. Richards denied there was any conspiracy to put smaller competitors out of business but acknowledged that his company has advocated upping the coverage requirement since it was lowered to $300,000 in 1991.

"We think it's imperative that there be quality coverage" written by financially stable insurers to ensure the public is safe, Mr. Richards remarked.

It is to the advantage of taxicab companies to buy coverage from stable insurers, he indicated. "We've experienced carriers going under before and it's tremendously expensive."

The suit says only two of four insurers writing taxicab coverage prior to the ordinance's adoption are writing the insurance now. One withdrew from the market, and Dallas-based Universal Insurance Exchange has not been in business long enough to meet the rating requirements and is therefore ineligible to write the coverage, according to court documents.

Universal Insurance Exchange policyholders are being allowed to continue their coverage with that insurer until the insurance expires, Mr. Marcotte said.

That has prompted Yellow Cab and six other taxi companies to file suit earlier this week in state district court, claiming the city is not enforcing the ordinance because it is allowing the exchange to continue coverage in place. A hearing on that issue has been set for Aug. 26. BI

FTC

Continued from page 1

consent order:

- Eliminating all financial incentives to PCS and its employees to use Lilly products in PCS formularies.
- A requirement of disclosure to payers, such as an insurer or employer, and to physicians involved in switches of prescription medication of all financial incentives to PCS for the use of Lilly drugs.
- The requirement that Lilly/PCS develop an oversight body including customers and patients to monitor the activities of the pharmacy and therapeutics committee—whose creation was required under the consent order and which is intended to ensure that the selection of drugs for formularies was based on patients' best interests.
- A measure prohibiting PCS from specifying a particular manufacturer's generic drug for filling prescriptions in accordance with a formulary.
- The development of an objective clinical evaluation system for inclusion of prescription drugs on any formulary offered by PCS.
- A provision related to the sale of Lilly drugs to PCS requiring that Lilly's pricing to PCS be offered to other prescription benefit managers.

An FTC spokeswoman would not comment on the petition beyond saying: "We take these things seriously. We will review the situation." The FTC has no deadline to act.

A Lilly spokesman said the company believes there is no merit to the NACDS petition.

"The terms of the consent agreement were firmly established to ensure that consumers were protected from any anti-competitive activities," the spokesman said. "Lilly and PCS have always complied with the terms of the consent agreement."

The Lilly spokesman also disputed the association's suggestion that manufacturer ownership of PBMs has driven up prescription costs, "at least as it applies to Lilly."

Lilly had an overall reduction of pricing of 0.8% in 1995 and 4.1% in 1994. "So our prices have gone down over the past two years," he said.

A Merck spokesman declined to comment on action the FTC may take regarding the Lilly-PCS deal.

He did defend Merck-Medco's business practices, however, and said, "We believe that the way we operate our business is pro-competition and in keeping with the laws enforced by the FTC."

A spokeswoman for SmithKline Beecham likewise defended the way that manufacturer and its PBM subsidiary, Diversified Pharmacy Services, conduct business.

"We have a system in place to ensure that independent judgment is exercised in the best interest of patients and customers in making formulary decisions," she said. "We don't give preference to any one company's products, including (SmithKline Beecham's.)"

She added that the "highly competitive and sophisticated market" for PBM services forces prescription benefit managers to look for ways to keep costs down and enhance the quality of service they provide in order to distinguish themselves from the competition. Increasing drug costs would go against client demands.

David W. Stewart, a marketing professor at the University of Southern California's School of Business Administration in Los Angeles, described the drug manufacturers' purchase of PBMs as "sort of the equivalent of forward integration," in which the manufacturer buys the distribution channel for its product.

"We've seen that in other industries," Mr. Stewart said. "There are some potential problems that result." Competitors relying on those same distribution channels can be at a disadvantage, for example.

In the case of the pharmaceutical company-PBM mergers, problems would most likely occur when a manufacturer of a branded product interferes with the distribution of competitors' less expensive generic equivalents, he suggested.

FTC review isn't the only recourse for combating anti-competitive behavior, however. Alleged anti-competitive acts could be challenged in the federal courts, Mr. Stewart said.

"There's lots of legal precedent here that people will be drawing on," he said. "But it's kind of new territory in this industry."

The drugstore group's spokesman wouldn't speculate on whether the group would go to court if the FTC failed to act on its petition.

Several recent events may give the drugstore chains hope that the FTC will listen to their concerns. One was the settlement earlier this year of a federal antitrust suit brought on behalf of more than 30,000 independent pharmacies against 13 large drug manufacturers (*BI*, May 13).

That agreement gave the pharmacies access to the same discounts the drug makers provide for-profit managed care drug vendors.

And, in 1995, the federal General Accounting Office released a report urging continued monitoring of drug company-PBM ties.

When the FTC finally signed off on the Lilly-PCS deal in July 1995, its consent order specified that the agency could revisit the issue if it deemed it necessary.

"If subsequent developments indicate anti-competitive effects, despite the presence of the negotiated order, the commission commits itself to seek other relief including, if necessary, post-acquisition divestiture," FTC Chairman Robert Pitofsky said when the consent order was announced.

The drugstore chains' action comes even as Wall Street has shown doubts about Lilly's acquisition of PCS, and suggestions by some analysts that the drug maker might be best served by writing off a portion of the acquisition's cost.

The NACDS petition allows that "the integration of PCS into Lilly's overall strategy appears to have taken more time than Lilly expected."

But, it concludes, "The commission should not be deterred from preventing consumers from paying more for prescription drugs because of a slow integration or potential error in judgment on Lilly's part." BI

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Gillette names Underwood risk manager

Comings & Goings: Buyers

Edward S. Underwood is the new director of risk management at Gillette Co., replacing **William L. Mather**, who retired this summer.

Mr. Underwood, 52, takes on the responsibility of directing the Boston-based personal care products company's risk management and security programs. Mr. Underwood previously held the position of director-international finance at Gillette.

He reports to L.B. Swaim, Gillette's treasurer.

Mr. Underwood earned a bachelor of arts degree from the University of Pennsylvania and a master of business administration degree from the University of Pennsylvania's Wharton School.

Mr. Mather, the 1988 *Business Insurance* Risk Manager of the Year, retired June 30 after spending 33 years at Gillette.

He began his career there in 1963 as a staff assistant tc the controller.

* * *

Charles J. Salek has been appointed manager and vp of corporate staff risk management and insurance in the Stamford, Conn., office of ABB Asea Brown Boveri Ltd., a Zurich, Switzerland-based electrical and industrial products company.

Mr. Salek, 45, is responsible for the company's worldwide risk management and insurance programs.

Mr. Salek replaces **Paul F. York**, who left ABB last year to join AIG Risk Management in Paris.

Mr. Salek reports to Beat Hess, senior vp and general counsel at ABB.

Mr. Salek takes his new position after serving since 1990 as managing director-risk management services for the company's U.S. region.

Before joining ABB, he was assistant treasurer and director of risk management for Combustion Engineering Inc., a Stamford-based company that ABB acquired in late 1989.

Mr. Salek earned a degree in business administration from Rutgers University in New Brunswick, N.J.

Mr. Salek holds the Associate in Risk Management designation from the Insurance Institute of America.

He is a director of Connecticut Valley Claims Service Co. in Rocky Hill, Conn., a former director of ACE Ltd. and CODA Holdings Ltd., a member of the risk management council of the Manufacturers' Alliance for Productivity and Innovation and a deputy member of the Risk & Insurance Management Society Inc.

Separately, **Volker Ahrens**, a member of the risk management staff at ABB's Zurich headquarters, has taken the position of assistant vp of corporate staff risk management and insurance.

Mr. Ahrens will continue to work in the Zurich office and will serve as Mr. Salek's deputy.

* * *

Leilani Kicklighter has been appointed assistant administrator for safety and risk management for the North Broward Hospital District in Fort Lauderdale, Fla.

Ms. Kicklighter is responsible for overall safety and risk management at the hospital district.

The job previously was held by **Mark Gomez**, who now works as director of safety, health and environmental affairs at the University of New Mexico in Albuquerque.

Ms. Kicklighter reports to Carl Taylor, vp-business development.

Prior to joining the hospital district, Ms. Kicklighter was vp of the Southeast region for health care risk management at Alexander & Alexander Services Inc. in Fort Lauderdale.

Ms. Kicklighter earned a bachelor of health science degree from Florida International University in Miami and a master of business administration degree from Nova Southeastern University in Fort Lauderdale.

* * *

Edward Pratt, 38, is the new director of risk management at PCA Solutions Inc., a workers compensation third-party administrator based in Oklahoma City.

Mr. Pratt is responsible for the company's overall risk management program, and he reports to Roy A. Nuttall, regional vp and chief operating officer.

Mr. Pratt was a senior loss control consultant with USF&G Corp. in Little Rock, Ark., before joining PCA Solutions.

He earned a bachelor of science degree in biology and a minor in chemistry from the University of Mary Hardin-Baylor in Belton, Texas.

He holds the Certified Safety Professional designation.

•

We'd like to report on staff changes in your company's risk management, safety and employee benefit departments. Contact Michael Bradford, Associate Editor, Business Insurance, Suite 114, 8950 N. Central Expressway, Dallas, Texas 75231; 214-361-2295; fax: 214-696-1936. Please send a photograph, too.

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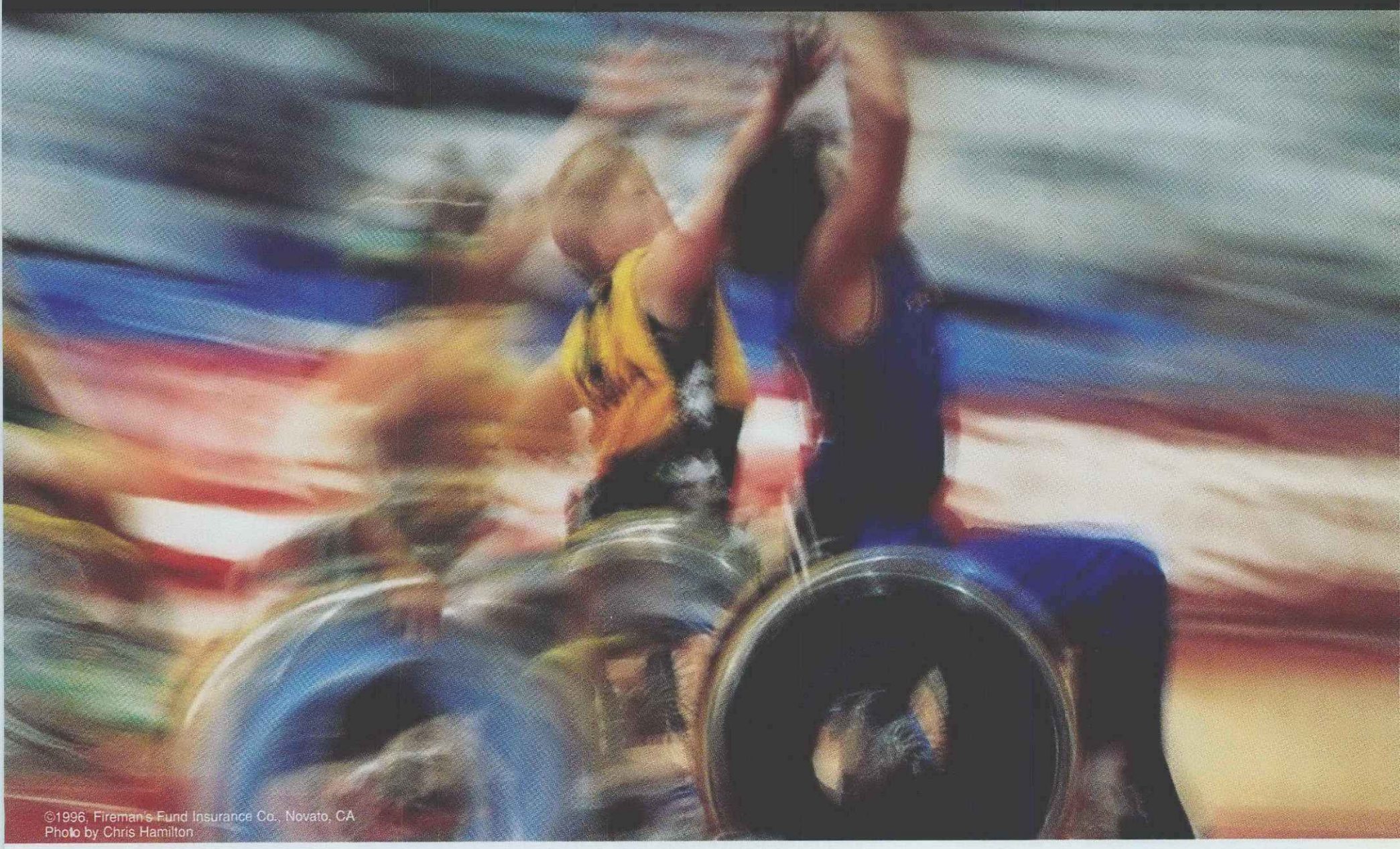

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ASK A CASUALTY ACTUARY

Q **I am concerned about the adequacy of reserves for our casualty losses. Should I have a claims audit or actuarial study performed?**

A There are many factors to be considered when trying to determine whether an actuarial study or a claims audit would be more valuable to your company or entity.

Among those factors are the types of claims to be evaluated, e.g. workers compensation, liability, property. The longer the tail of the types of claims, the more likely an actuarial study would be more valuable than a claims audit. On the other hand, a claims audit of property claims likely would be more valuable than an actuarial study.

Other considerations include the relative presence or absence of large claims, management's philosophy with respect to what should be reserved, e.g. including or excluding incurred-but-not-reported claims and reopened claims, and how conservative reserves should be. For example, should reserves only be sufficient to cover:

1. The current year's paid losses?
2. The present value of all reported claims?
3. The ultimate settlement value of all reported claims?
4. The present value of all types of claims—reported, opened and IBNR?
5. The ultimate settlement value of all types of claims?

In addition, a variety of factors can affect the validity of the findings of an actuarial review or a claims audit. Among these considerations are the availability of a history of claims tabulations or summaries, the condition of claim files, the frequency and magnitude of significant changes in claim and case reserve estimation practices during the recent past, and the total volume of claims.

We will discuss the most common factors affecting the need for and the validity of each type of service. A series of charts will provide a step-by-step illustration of the information and calculations involved in each type of review.

First, we should describe what sort of information typically is provided by an actuarial study and by a claims audit.

Profile of a typical actuarial study

An actuarial study starts with a review of summary data from a series of claims tabulations.

These tabulations typically segregate claims according to incident date (accident year), the policy inception date (policy year) or the report date (report year).

Reported incurred losses (in thousands) as of:

Year	Dec. 92	Dec. 93	Dec. 94	Dec. 95
1991	$8,600	$9,600	$10,100	$10,400
1992	7,300	9,900	11,300	12,000
1993	-	9,100	12,800	14,000
1994	-	-	10,300	13,600
1995	-	-	-	11,200

CHART A GRAPHIC BY TONY BUCCINI

In the example we will consider, summary tabulations from the latest four year-end periods provide the following information about reported incurred losses—cumulative losses paid plus case reserves as of the evaluation date (see chart A).

Claims audits, actuarial studies each have their own place

This information then is reorganized according to the length of time that has elapsed since the beginning of the year.

For example, reported incurred losses would be broken out over four years by 12-month intervals.

For each year the percentage change in incurred losses between successive year-end periods is then reviewed and comparable changes for future years are selected as the basis of projecting losses to an ultimate basis (see chart B).

Percentage development

Year	24/12 mos.	36/24 mos.	36/24 mos.
1991	+34.4%	+11.6%	+5.2%
1992	+35.6	+14.1	+7.1
1993	+40.7	+9.4	+6.0
1994	+32.0	+12.0	+6.0
1995	+35.0	+12.0	+6.0

CHART B GRAPHIC BY TONY BUCCINI

For example, for report year 1994, 12% development is expected between year-end 1995 and year-end 1996, and 6% development is anticipated between year-end 1996 and year-end 1997.

These judgments are based on the assumption that the future will repeat the past. With such selections, current reported incurred losses are projected to a final basis (see chart C). In this simplified example, we have assumed there will not be any further development beyond 48 months.

Year	(1) Incurred losses as of year-end 1995 (000's)	(2) Percentage development to 48 mos.	(3) Projected losses to 48 mos. (000's)	(4) Cumulative paid losses (000's)	(5) Projected loss reserve (000's)
1991	$10,400	-	$10,400	$9,600	$800
1992	12,100	-	12,100	10,800	1,300
1993	14,000	+6.0	14,840	11,100	3,740
1994	13,600	+18.7	16,143	9,700	6,443
1995	11,200	+60.3	17,954	4,200	13,754
	$61,300		$71,437	$45,400	$26,037

CHART C GRAPHIC BY TONY BUCCINI

In the above example, case reserves of $15.9 million are being carried as of year-end 1995 ($61.3 million total incurred less $45.4 million total paid). The actuarial projection of this same reserve is $26.04 million, or 63.8% higher.

If practices in estimating case reserves have been consistent over time, this type of analysis can produce a reasonable estimate of the ultimate settlement value of claims.

Typically, an actuarial study also will include the projections of other methods, such as paid loss development or incurred losses per reported claim, as well as a general reconciliation of the differences between the projections of these methods in terms of changes in claims procedures and the claims environment.

Profile of a typical claims audit

A claims audit typically will include a review of the individual files of all claims with reserves exceeding a given amount, such as $25,000. Sometimes, it also will include a review of a random sample of claim files for smaller claims.

An experienced claims auditor frequently will detect situations where things could take a turn for the better—or for the worse—and provide a comparison chart of his or her own reserve estimates with the current reserves established on each reviewed file.

A good audit usually will indicate whether the individual case reserves set in open claims realistically reflect the facts in each file. It may present a series of recommendations for improving the management of larger claims to minimize the aggregate total of losses to be paid to settle all currently open claims.

If there have been changes in reserving guidelines or claims settlement practices over recent years, a thorough claims audit should uncover those changes and provide some basis for quantifying the extent of such changes and documenting their nature.

In the above example, the claim auditor's report would include a summary table like the following (see chart D).

Nature of injury	Report date	Initial reserve	Current reserve	Paid to date	Auditor's reserve estimate
Back	Mar. 78	$6,000	$31,000	$15,000	$47,000
Paraplegic	Jun. 81	$5,000	$350,000	$91,400	$750,000
3rd-degree burns	Aug. 82	$12,000	$65,000	$18,300	$125,000

CHART D GRAPHIC BY TONY BUCCINI

At the end of this chart, the following totals are provided for all audited claims:

- $9,212,000, total initial reserves.
- $6,814,000, total payments to date.
- $8,462,000, total current reserves.
- $15,276,000, current estimate of incurred losses.
- $6,064,000, current estimate of shortfall in initial reserves.
- $11,319,000, auditor's estimate of total current reserves.

In this case, the claims audit included a review of all claims with current case reserves greater than $50,000.

These reserves accounted for somewhat more than half of total current case reserves.

The audit also includes summary comments on ways to improve procedures.

In the above example, both the claims audit and the actuarial review indicate serious shortages in current case reserves. What is the relative value of each type of service?

Consider these differences:

- An overall statistical approach, like that used in an actuarial study, will be less effective in reflecting the characteristics of the largest individual claims and the effect these claims have on the ultimate liability.
- By definition, the claims audit only includes a review of a portion of all claims, whereas the actuarial review monitors trends and results for all claims.

At the end of a claims audit, there is always the problem of guessing what the results would have been if all claims had been audited.

- The value and accuracy of a claims audit is constrained by the information currently in the claims file and what an experienced adjuster reasonably can infer from that information.

If there is a shortage of documentation, either because of weakness in the skills or dedication of claims adjusters or because the case is new enough that few facts are known, then even the best claims audit will not fully reflect the final outcome with accuracy.

If a good history of claims tabulation exists and claims procedures have been relatively consistent, an actuarial review should reasonably reflect the effects of the emergence of new facts on many claim files over time.

That the facts will change on many files as they mature is a primary cause of the "loss development" an actuary tracks.

It is the other major component of "loss development" that is tested by the claims audit—the competence and experience of the claims adjusters. If there is a good track record over time, this latter element also will be reflected in an actuarial review.

There are additional items an actuarial review can

See **Audit** *on page 18*

Courts wrongly cloud pollution clause

By Michael M. Baylson and Robert L. Pratter

THE POLLUTION EXCLUSION CLAUSE, which limits coverage to "sudden and accidental" pollution events, was designed to limit the insurance industry's liability for environmental claims.

Some courts that have interpreted the pollution exclusion clause, however, have contorted its plain meaning and allowed coverage for clearly non-fortuitous pollution events.

These courts, guided more by a perceived need to find "deep pockets" to finance environmental cleanups than a rational analysis of the clause itself, have failed to recognize the policy objectives underlying the pollution exclusion clause and the long-term negative implications of their decisions.

The typical pollution exclusion clause in commercial general liability policies indicates this insurance does not apply to "bodily injury or property damage arising out of the discharge, dispersal, release or escape of smoke, vapors, soot, fumes, acids, alkalis, toxic chemicals, liquids or gases, waste materials or other irritants, contaminants or pollutants into or upon the land, the atmosphere or any watercourse or body of water; but this exclusion does not apply if such discharge, dispersal, release or escape is sudden and accidental."

Although the language of this clause is straightforward, courts are divided on the meaning of the "sudden and accidental" exception to the clause.

The courts that have correctly concluded that the pollution exclusion clause was unambiguous have generally reasoned that an insurance contract, like any other contract, should be enforced according to its plain meaning.

These courts have acknowledged that the common definition of the term "sudden" includes a temporal aspect of immediacy or abruptness. As a result, these courts have properly denied coverage unless the pollution loss was caused by a sudden and accidental event like a fire or explosion.

On the other hand, the courts that have allowed coverage have relied on a contorted definition of the term "sudden." These courts generally have reasoned that the term "sudden" was ambiguous because it did not necessarily possess a temporal element. Because ambiguities generally are construed against the drafter, these courts have allowed coverage unless the policyholders intentionally caused the pollution.

The New Jersey Supreme Court's reasoning in 1993 in *Morton International Inc. vs. General Accident Insurance Co. of America* provides an example of the lengths courts will go to achieve outcome-oriented results. In that case, the court initially held that the common definition of the term "sudden" had a temporal element and that the pollution exclusion clause was unambiguous. The court then acknowledged that coverage for pollution claims would be restricted under such a holding. As a result, the court disregarded the plain meaning of the clause and focused on the regulatory history of the clause.

Without the benefit of a full factual record, the court concluded that the regulatory authorities had relied on certain insurance industry statements that the pollution exclusion clause was designed to clarify, rather than restrict, the scope of coverage.

The court reasoned that the insurance industry should be bound by its alleged representations to regulators and held that the clause would be interpreted to provide coverage for any pollution loss unless there was evidence that an intentional act caused the loss.

Neither the courts nor responsible insurers dispute the fact that coverage should be allowed under the pollution exclusion clause for pollution events that truly are sudden and accidental. Similarly, no one should seriously dispute the fact that coverage should be denied for pollution losses that result from intentional acts.

Problems arise when, as in the typical landfill or underground storage tank case, pollution occurs gradually as the result of negligence, indifference toward the environment or the simple exhaustion of materials over time.

In these gradual pollution cases, courts often have contorted the plain language of the insurance policy in an attempt to reach the perceived deep pockets of insurers. In a concurring opinion in the 1993 case *Dimmitt Chevrolet Inc. vs. Southeastern Fidelity Inc. Corp.*, Justice Stephen Grimes of the Florida Supreme Court candidly summarized what is perhaps the underlying premise in many of the pro-policyholder decisions to date:

"I originally concurred with the position of the dissenters (to allow coverage) in this case. I have now become convinced that I relied too much on what was said to be the drafting history of the pollution exclusion clause and perhaps subconsciously upon the social premise that I would rather have insurance companies cover these losses rather than parties such as (the policyholder) who did not actually cause the pollution damage. In so doing, I departed from the basic rule of interpretation that language should be given its plain and ordinary meaning. Try as I will, I cannot wrench the words 'sudden and accidental' to mean 'gradual and accidental,' which must be done in order to provide coverage in this case."

Courts that have adopted the premise that it is better to "have insurance companies cover these losses" have ignored the policy considerations served by a rational and consistent interpretation of the pollution exclusion clause.

As a threshold matter, permitting coverage for gradual pollution events under the "sudden and accidental" exception to the pollution exclusion clause undermines the underwriting process. Insurers rely on the ordinary meaning of their policies to estimate risks and to establish premiums on a prospective basis. Outcome-oriented judicial decisions, which ignore the plain language of the insurance contract, retroactively shift liability from a corporation that never paid for such coverage to an insurance company that never received premiums for the risk imposed or established appropriate reserves for such losses.

The Supreme Court of North Carolina acknowledged this policy concern when it stated in 1986 in *Waste Management of Carolinas Inc. vs. Peerless* In-

See **Pollution** *on page 19*

Audit

Continued from previous page

cover that a claims audit could not be reasonably expected to cover, including:

- A provision for currently closed claims that will reopen at some future date. The reserve for reopened claims can be significant for workers compensation.
- A provision for claims for which the accident already has occurred but a claim has not yet been filed—incurred but not reported claims.
- A provision for adverse fluctuations in losses. A good claims auditor will point to specific claims where a strong potential exists for things to take a turn for the worse. It is difficult, if not impossible, to translate this type of useful information into estimates of how much final payments may differ from current reserves in the aggregate.

An experienced actuary can, however, provide reasonable estimates of the likelihood that the best estimates of total reserves will be off by more than various stated amounts.

In the above example, the degree of potential variation around the projected reserve of $26 million might be stated as follows (see chart E).

Probability that reserve will be less than the stated amount	Amount of reserve
10 %	$21 (million)
25	24
50	26
75	28
90	32
95	35

CHART E GRAPHIC BY TONY BUCCINI

With such a range of estimates, management can select the level of confidence it wishes to have in its total reserves, subject to accounting standards.

- Because an actuarial review typically does not review individual files, it will not provide insight on improvements in claims management policies.

Here are some considerations that affect the relative validity of the findings of each service:

- If there is only a small volume of claims, e.g., fewer than 250 total claims for all years, then the indications of an actuarial study will be very volatile, and thus less reliable.
- If a series of claims tabulations is not available covering a yearly succession of evaluation dates, e.g. June 30, 1991, and each subsequent June 30, it will not be possible for an actuary to give some weight to your actual development history; that history doesn't exist.
- If major changes in claims procedures have occurred in recent years, a claims audit can help gain insights into the nature and extent of those changes.

It might be worth considering the possibility of alternating these services over successive years. There are some clear benefits to be derived from having both services performed, including:

- A quality claims audit will provide the actuary with substantial useful information that should enhance the accuracy of projections. The audit can identify the nature and indicate the extent of changes in claims procedures.
- A thorough actuarial review may uncover trends or abrupt changes in loss development patterns that should be investigated by the claims auditor.

Here is a case in point. A claims audit had been performed recently on all claims with reserves over $50,000, and the audit had concluded that case reserves were adequate. During an actuarial review, it was noticed that there had been a sudden dropoff in the number of opening reserves over $35,000.

An investigation then revealed that a recent change in claims procedures called for no new claim to carry an initial reserve greater than $35,000.

The historical practice had been that of setting initial reserves on serious cases at either $100,000 or $250,000.

This change would have resulted in a serious understatement of reserve needs by both the actuary and the claims auditor if they had not worked together in their evaluations. BI

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

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

Mr. Sherman

This month's column on actuarial issues in the casualty field is written by Richard E. Sherman, president of Richard E. Sherman & Associates Inc. in Ashland, Ore. William J. Miner, an actuary with Watson Wyatt Worldwide in Chicago, answers actuarial questions in the benefits field. Susan M. Werner, director of risk management at Hardee's Food Systems Inc. in Rocky Mount, N.C., answers risk management questions. And Dennis J. Nirtaut, managing director of compensation and benefits for Andersen Worldwide S.C. in Chicago, answers questions on employee benefit plans.

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.

Pollution

Continued from previous page
surance Co. that "the court must enforce the contract as the parties have made it and may not, under the guise of interpreting an ambiguous provision, remake the contract and impose liability upon the (insurance) company which it did not assume and for which the policyholder did not pay."

On a more basic level, permitting coverage for events that are not truly sudden and accidental is contrary to the traditional notion of insurance, which is to provide protection against fortuitous events. It is illogical to provide coverage for pollution a policyholder could have reasonably expected to occur; doing so would be analogous to providing automobile insurance coverage for a car that breaks down after years of use.

The 1st U.S. Court of Appeals endorsed this idea in 1991 in *Lumbermens Mutual Casualty Co. vs. Belleville Industries Inc.*, stating it is "illogical to believe that insurers intended through the 'sudden and accidental' exception to buy into a risk and/or litigation package" involving gradual pollution as a result of daily business activities.

When a policyholder can reasonably foresee the likelihood of eventual pollution damage due to its own activities, the damage clearly is not "sudden and accidental" and should not be subject to insurance coverage.

Allowing coverage for gradual pollution events under the "sudden and accidental" exception to the pollution exclusion clause also rewards polluters who made no effort to prevent or mitigate the release of hazardous substances into the environment and shifts the cost of cleanup to an insurance company that collected no premiums for such coverage.

At least one court, the North Carolina Supreme Court in its 1986 *Waste Management* decision, has recognized the importance of this public policy: "If an insured knows that liability incurred by all manner of negligent or careless spills and releases is covered by his liability policy, he is tempted to diminish his precautions and relax his vigilance. Relaxed vigilance is even more likely where the insured knows that the intentional deposit of toxic material in his trash containers, so long as it is unexpected, affords him coverage. In this case, it pays the insured to keep his head in the sand."

When the pollution exclusion clause is interpreted correctly to provide coverage for only sudden and accidental pollution damage, the clause excludes damage resulting from deliberately indifferent conduct. Furthermore, construing the clause properly encourages businesses to monitor their own activities and maintain their facilities to prevent gradual and extended pollution.

Due in part to misguided judicial interpretation of the pollution exclusion clause, insurance companies have been forced either to stop offering environmental coverage, charge increasingly higher premiums for such coverage or offer specialized policies that may not meet all the needs of a particular business. For example, under the absolute pollution exclusion clause, which replaced the standard pollution exclusion clause in 1986, insurance coverage no longer is available for truly sudden and accidental pollution events.

Observers have recognized that the lack of available insurance has delayed and increased the cost of remediating hazardous-waste sites.

For example, many licensed hazardous-waste facilities and transporters have been unable to obtain insurance coverage to meet the financial responsibility provisions of U.S. Environmental Protection Agency regulations. As a result, fewer hazardous-waste facilities and transporters are available.

Litigation over the terms of the pollution exclusion clause has produced confusing and disappointing results. While some courts have correctly reasoned that gradual pollution events will not be covered because they are not "sudden and accidental," other courts, rightly motivated by the desire to clean up the environment—but wrongly enticed by the perceived deep pockets of insurance companies—have deemed the phrase "sudden and accidental" to be ambiguous. Due to this judicially created ambiguity, these courts have erroneously construed the policy in favor of the policyholder and have thereby shifted the liability for gradual pollution events to the insurance industry.

Permitting coverage for gradual pollution is illogical and contrary to public policy. The traditional notion of insurance has been lost in the wake of misguided judicial interpretation. The pollution exclusion clause was designed to encourage policyholders to take responsibility for their pollution-causing activities. Instead, as interpreted by some courts, it has provided a windfall to policyholders that were either negligent or indifferent toward the environmental consequences of their actions.

In this time of environmental enlightenment, the insurance industry should not serve as a scapegoat for parties that created and benefited from pollution. Companies that bought insurance policies years ago should not be given a benefit for which they did not pay and that insurers did not expect to bear. Only truly fortuitous environmental events should enjoy the protection of coverage. The "sudden and accidental" exception to the pollution exclusion clause should be interpreted to bar coverage for damage caused by gradual pollution events and thereby impose the cost of cleanup on the policyholder. BI

Michael M. Baylson and Robert L. Pratter are partners with the Philadelphia law firm Duane, Morris & Heckscher. E. Lynne Hirsch and Lauren K. Lonergan, associates with the law firm, also contributed to this article.

ERISA plan benefits terminated for dishonesty

The 6th U.S. Circuit Court of Appeals upheld a decision of the administrator of an Employee Retirement Income Security Act plan to deny benefits to a terminated employee for dishonesty.

Jerrold Moos worked for the Square D Co. since 1971 under false credentials, including an altered college transcript and resume falsely stating that he had graduated as an accounting major. In 1991, the employer adopted a "Change of Control Separation Plan for Salaried Employees" which was governed by ERISA. Under the plan, an eligible employee would receive benefits if he lost his job within two years of a change in management, unless one of five exceptions applied. One of the exceptions was termination "for good cause." The control of the company changed in 1991 and the new management asked all employees to review their files for accuracy. Mr. Moos did not correct the misinformation he had supplied 21 years earlier. Mr. Moos then applied for a new position with the company claiming to have a college degree. He provided a copy of the same altered transcript used years earlier. When the company discovered Mr. Moos' misrepresentations, he was fired. Mr. Moos applied for benefits under the plan since his termination was within two years of the change of control. His request was denied. He sued and lost in the trial court.

On appeal, Mr. Moos argued the decision to deny him benefits was arbitrary and capricious because no evidence showed that his misconduct was "materially and demonstrably injurious to the company." But, the court said that "it was well within the range of the administrator's discretion to decide that Moos' continuing misrepresentations were materially and demonstrably injurious to the company." The trial court was affirmed.

Moos vs. Square D Co., 6th U.S. Circuit Court of Appeals, Dec. 22, 1995 (*BI*/04/Ju.-$10).

Legal Briefs

Comp covers car accident

A nurse injured in an car accident when traveling between patients' homes was not precluded from recovery of workers compensation benefits even though she was not paid for traveling time, according to the Supreme Court of Rhode Island.

Arlene Toolin was employed as a nursing assistant for Aquidneck Island Medical Resources. Her duties involved providing care for patients in their own homes.

She used her own vehicle to drive directly to each patient's home on a schedule controlled by her employer. Ms. Toolin was paid by the hour for actual time spent at each patient's home. She was not paid for travel time, nor was she reimbursed for travel-related expenses. In January 1991, while traveling between appointments, Ms. Toolin was in a car accident that rendered her incapacitated. She was denied workers comp benefits by the trial court, but an intermediate appellate court found in her favor.

On appeal, the employer argued that the "going and coming rule" barred Ms. Toolin's claim since her injuries occurred while she was traveling in her own vehicle and because she was not compensated for travel time. The state Supreme Court concluded there was a connection between her injuries and her employment and, therefore, the going and coming rule did not operate to preclude compensation in this case. The court emphasized that her injuries occurred within her employment period and her employer specifically directed and controlled her daily schedule. The court concluded that she was not precluded from recovery simply because she was not compensated for travel time.

Toolin vs. Aquidneck Island Medical Resources, Supreme Court of Rhode Island, Dec. 19, 1995 (*BI*/05/Ju.-$10).

Power failure exclusion upheld

Food spoilage as a result of a power outage at grocery stores was not covered under a commercial property insurance policy, according to an Ohio appellate court.

In July 1993, high winds and severe storms struck the northeast Ohio area, resulting in power outages and food spoilage at two grocery stores. The cause of the outage was a downed wire away from their premises. The stores had "Business Owners' Special Property" coverage under their insurance policies with Motorists Mutual Insurance Co. The policies excluded coverage for power failure if the failure occurs "away from the described premises." The stores filed claims for damages. The insurer declined coverage. The stores sought a declaration by the court that the policies covered the losses. The trial court ruled for the insurer.

On appeal, the stores argued that the phrase "away from the premises" in the exclusionary clause was ambiguous and, thus, the policies has to be construed in their favor. But, the court said that, if the power failure here did not fall within the meaning of a power failure "away from the premises," then the phrase was bereft of meaning. The court was satisfied that the ordinary meaning of the phrase was that there was no coverage when the power failure occurred away from the premises, i.e. somewhere off the stores' premises. The trial court decision was affirmed.

Mapletown Foods vs. Motorists Mutual Insurance Co., Ohio Court of Appeals, June 5, 1995 (*BI*/05/Jy.-$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.

DAKA

Continued from page 3

him "head prep/cook," which allowed him primarily to supervise food preparation while protecting his healing hand.

Modified duties allowed Sydney to return to the dining hall 10 to 12 weeks earlier than his doctor originally anticipated and maintain his livelihood while recuperating, though he was eligible for workers compensation benefits.

The arrangement saved DAKA up to $2,616 in wage-loss benefits as well as the services of a knowledgeable employee, who eventually resumed his original duties.

Sydney's story is one of many that resulted from DAKA's comprehensive program, which began in July 1994. The program is unusual for a variety of reasons.

It was negotiated as a three-year plan, instead of the typical one year. That allows the team to focus on long-term results.

"We are ecstatic with our three-year program," said David G. Parker, DAKA's senior vp and chief administrative officer.

After two years, the multiline program's most notable success is reducing the frequency of workers comp accidents and claims, according to DAKA's fiscal-year data.

The average accident rate per DAKA restaurant decreased 27.1% to 8.96 in the year ended June 30 from 12.3 the previous year. DAKA's frequency rate is now below the 9.1 average for the restaurant industry calculated by the Occupational Safety and Health Administration.

In addition, the number of lost-time claims dropped 17.6% at the end of fiscal 1995, compared with a year earlier. The reduction continued, dropping an additional 8.4% at the end of fiscal 1996.

Improvements also were seen in the cost of workers comp and general liability claims, DAKA reports.

The average cost of a workers comp claim dropped 15.5%—to $1,650 from $1,953—in 1995, compared with a year earlier, according to DAKA's tally.

In addition, the average cost of a general liability claim dropped 17.8%—to $1,566 from $1,906—in 1995, compared with a year earlier.

Achieving those improved results was no accident.

Working with broker Willis Corroon, DAKA searched for a claims handler and underwriter that would commit to DAKA's vision of how to improve its loss experience and form a team to achieve those results.

"DAKA uses traditional services in an untraditional manner," said Bob Wynne, a Willis Corroon account executive in Boston.

DAKA International, which reported revenues of $320.6 million in 1995, primarily self-insures most of its workers comp, general liability and auto liability claim costs using paid-loss plans supported by catastrophic insurance coverages.

However, the line for which DAKA buys the most coverage is workers comp, because of regulatory requirements in the 45 states in which it operates, DAKA's Mr. Parker added.

DAKA chose AIG Claims Services as its TPA after a visit to its regional claims office in Manchester, N.H. Mr. Parker said "the offices were quiet, neat and clean," rather than noisy and messy like others he had seen. In addition, he liked the fact that individual claims representatives monitored on colored charts personal performance goals for clients, such as reducing the number of lost-time days.

DAKA subsequently accepted AIG Risk Management as its underwriter for the program, though it still considers AIG's claims services operation to be "the cherry on the sundae," Mr. Parker said.

Willis Corroon's role involved its traditional duties as well as the technical skills of its claims management and loss control specialists, said Mr. Wynne. The team helped DAKA develop and implement a comprehensive claims management plan to reduce accidents and more quickly resolve claims that do occur, said Peggy Benard, DAKA's vp-risk management. Key elements include:

- A preferred provider network that helps lower work-related medical costs.
- A formal liability management program that allows DAKA to select and manage its own attorneys, rather than relying on its insurer's attorneys.

That unusual stipulation allows DAKA to direct its cases to fewer but more knowledgeable attorneys who understand the company's philosophy and approach, Ms. Benard said.

- A return-to-work program that focuses on getting injured employees back to work and reducing wage-loss costs.
- An analysis of the causes of slips and falls, which constitute most of DAKA's losses, and establishment of a program to prevent them.

DAKA's overall program is "a broad, comprehensive, leading-edge effort including all these components at once," said Stanton Long, president of AIG Claims Services in New York.

Adding a performance award plan to the agreement "was an afterthought" but an effective one, Mr. Parker said.

Although DAKA considers its incentive formula confidential, it provided some details. The agreement provides bonuses for implementation of its claims management program and accident reduction, rather than compensating the providers for services as a percentage of claims costs.

"Performance-based arrangements are often not very objective or precise," though DAKA's formula "is one of the more precise examples I've seen," said Mr. Long. "Here we have an opportunity for good performance because we have a good line of sight between the goal and the reward."

A key feature of the formula is having the insurer use DAKA-specified loss development factors, which were independently calculated by the broker's actuarial services division.

"It is unusual for an insurer to rely on a policyholder's actuarial analysis to the great extent used in this program," said Willis Corroon's Mr. Wynne.

In addition, DAKA's historical loss development factors are used in a variety of ways, including bonus calculations.

The three service providers jointly received a total of $200,000 in bonuses for the first fiscal year, which represents half of the potential incentive bonus available, DAKA's Mr. Parker said. Although DAKA would not disclose its bonus formula, the split is not equal.

DAKA's loss development factors also are used to reconcile the letter of credit that DAKA's bank provides to AIG's claims services as security for DAKA reimbursing the claims handler for DAKA-related payouts.

In addition, DAKA itself uses the loss development factors to project its ultimate casualty losses and related expenses.

While DAKA is enjoying the success of its program, its philosophy of continuous improvement won't let it stop there. "Ultimately our goal is to refine our business culture and work process so safety is a routine part of the work environment," Mr. Parker said. BI

Superfund

Continued from page 2

parties can be found to pay for the cleanup. Because Superfund—formally known as the Comprehensive Environmental Response, Cleanup and Liability Act—was not reauthorized in 1994, the government's ability to collect those taxes lapsed at the end of 1995. However, the fund currently has a surplus, limiting the urgency among lawmakers for reauthorization.

"Comprehensive Superfund reform is not going to happen this year," predicted Julie Rochman, assistant. vp of the Alliance of American Insurers in Washington. "However, the name of the game for us for the rest of the session is defense, defense, defense. There's still a chance that in the late-night, constant search for revenues, someone may try to reauthorize the expired business taxes without reform," she added.

The insistence on liability reform as the price for collecting taxes is shared by much of the business community.

"RIMS would fight extending the taxes without reform. I would imagine some of our members are doing things in the background now, but would imagine they're holding back their major firepower for the debate next year," said Louis Drapeau, president of the Risk & Insurance Management Society Inc. and manager-risk and insurance for The Budd Co. in Troy, Mich.

"The NAM strongly opposes a tax reauthorization without comprehensive program reform. We do not support piecemeal changes to the Superfund program," said Theresa Larson, director of environmental policy at the National Assn. of Manufacturers in Washington.

Even the Rosslyn, Va.-based Chemical Manufacturers Assn., often at odds with insurers during the most recent debate over liability reform, agreed with the general position.

'The name of the game for us for the rest of the session is defense, defense, defense,' says Julie Rochman of the Alliance of American Insurers.

The CMA "could support repeal of retroactive liability provided it was adequately funded. However, we pay more than our fair share in terms of the taxes," said Paul Hirsh, associate director-Superfund for the CMA.

"You'd have to look at a more broad base. CMA would oppose the reauthorization of existing taxes without comprehensive reform," he added. "The prospects look dim for comprehensive reform this year. The legislative calendar has not been on our side."

Peter Lefkin, vp-federal affairs in Fireman's Fund Insurance Co.'s Washington office, blamed election-year politics for the lack of action.

"It is quite clear that this White House and the EPA have been in an election-year mode since January. They've shown a complete unwillingness to engage and negotiate in good faith with congressional leaders who have an earnest interest in reforming this fatally flawed law."

"Our efforts should be directed at insuring that Congress not be tempted to look for a piecemeal solution and instead we must direct our energies toward a 1997 legislative strategy," he said.

If re-elected, President Clinton might "move to the center" on the liability question because of the inability to collect taxes to pay for Superfund cleanups, Mr. Lefkin predicted.

Joel Wood, vp-government affairs for the Council of Insurance Agents & Brokers in Washington, also blasted election-year politicking by the White House and expressed concern that "the demagoguery could spill into 1997."

"It's clear that they have been intent on milking this issue for every last ounce," Mr. Wood said.

But "regardless of this election-year atmosphere, it's clear that no reform of Superfund's liability system can ultimately be signed into law without bipartisan support," he added.

Mr. Wood said the defeat earlier this summer of an attempt by Rep. Edward Markey, D-Mass., to prohibit the use of any money appropriated for Superfund for liability relief could bode well for next year's efforts. That could "create momentum for a real reform package" during the 105th Congress, Mr. Wood said.

The issue is unlikely to go unresolved yet again the way it did in the 103rd and 104th Congresses, he added. "The longer the taxes are not reauthorized, the more difficult it's going to be achieve an authorization. It can't be another two-year process."

The emphasis on no taxes without liability reform is not, however, central to the strategy of one organization in the pro-reform camp.

"It's unlikely we'll see any legislative reforms this year. From a small-business perspective, we're going to try to push some of the administrative reforms they've already proposed, such as increasing the threshold (of the amount of waste dumped) for relieving smaller parties of liability," said K.C. Tominovich, legislative representative for the National Federation of Independent Business in Washington. Ms. Tominovich said the excise taxes to help fund cleanups are not an overriding concern for NFIB members because few must pay them.

She made clear, though, that liability reform remains high on the NFIB's legislative list, adding that the association also is waiting to see if a federal judge's decision this year in *United States vs. Olin Corp.* will be upheld. In that case, a U.S. District Court judge in Alabama ruled that the Environmental Protection Agency had acted unconstitutionally in imposing retroactive liability for cleaning up a site in McIntosh, Ala. (*BI*, June 3).

Risk managers also are keeping a close eye on the *Olin* case, which is under review by the 11th U.S. Circuit Court of Appeals.

"If the ruling in *Olin* is upheld, that will remove retroactivity under current law. That's the other activity that we're watching with great interest," said David R. Haight, RIMS vp-government affairs and director-risk management for CF Industries Inc. in Long Grove, Ill. BI

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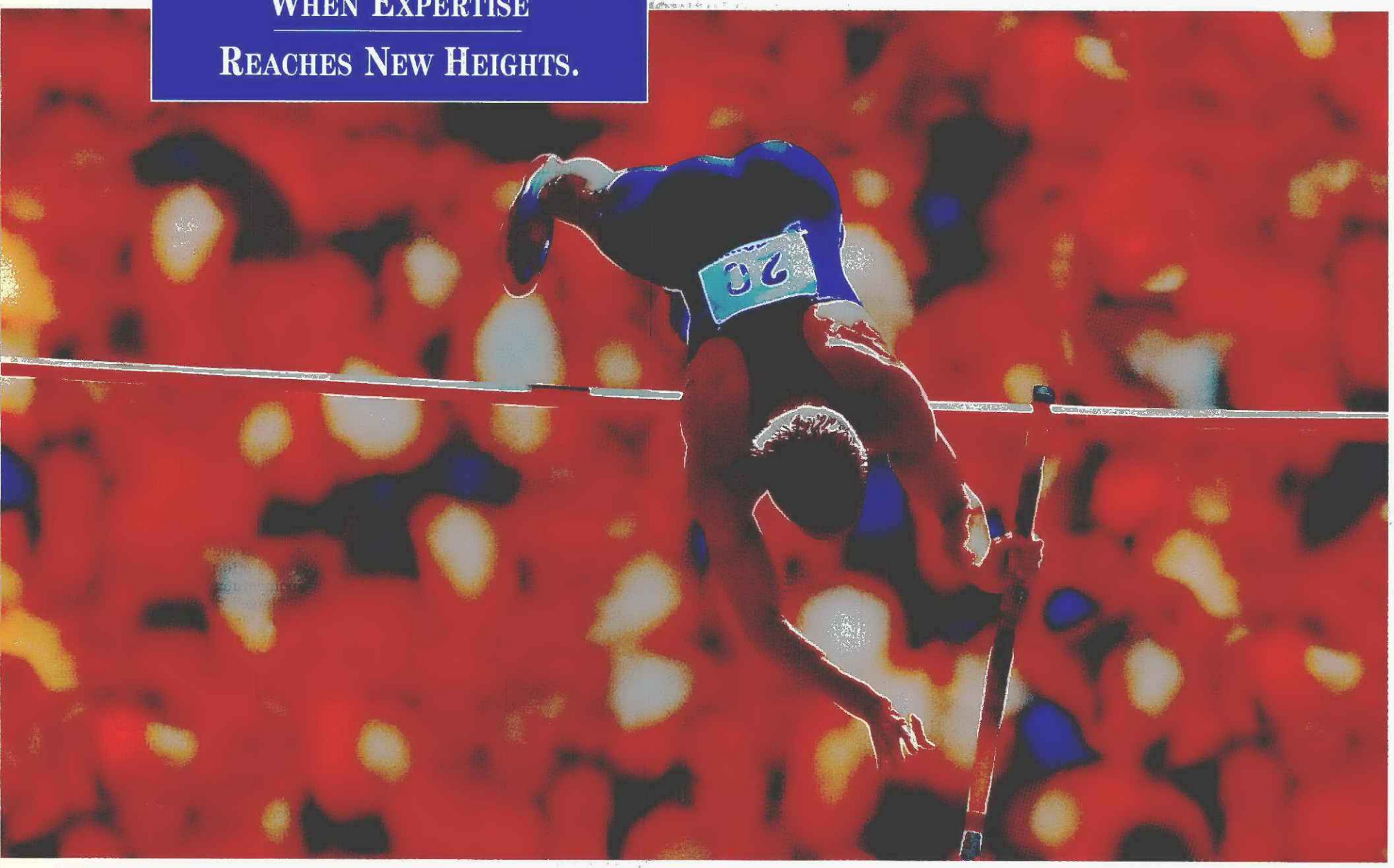

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INTERNATIONAL

Trade strikes disrupt U.K.

By SARAH GODDARD

LONDON—It's been a summer of discontent in the United Kingdom, with strikes by trade unions disrupting businesses throughout the country.

Continuing disputes between management and London subway workers and within the Royal Mail service appear likely to continue into the fall, and workers at some of the country's newly privatized train companies are threatening strikes later this month.

Estimates of the economic cost of the labor walkouts, which so far have been on a one-day rather than continuous basis, are difficult to assess.

But, analysts have calculated that the seven one-day stoppages by members of the Associated Society of Locomotive Engineers & Firemen working at London Underground Ltd. are costing businesses in the nation's capital around £300 million ($461.4 million) each day in lost earnings from employee absences, lost production and income and other costs, such as providing alternative transportation for staff and hotel accommodations near the workplace.

Five more days of work stoppage into September are planned by ASLEF, and the National Union of Rail, Maritime & Transport Workers, whose members include both Underground and commuter rail employees, is planning walkouts on two of them, further exacerbating the problem for London-based businesses.

Subway and Royal Mail disputes appear likely to continue into the fall, and some rail workers are threatening to walk out.

The London insurance market offers third-party coverage for strikes, covering loss of profits during the action period and reimbursement for increased costs.

In a transportation strike, this will typically include the cost of alternative forms of transportation provided by the employer such as taxis and buses, and accommodation costs for employees who are temporarily put up at local hotels.

However, the coverage can only be purchased before any threats or rumors of a strike have surfaced.

"Currently we are seeing a lot of interest, but we can't provide

See **Strikes** *on next page*

AP/WORLD WIDE PHOTOS

A 24-hour strike by underground train drivers last month in London delayed commuters.

Jump in ship losses won't drive up rates, underwriters predict

By EDWIN UNSWORTH

LONDON—Shipping losses increased sharply in the first half of 1996 but, in spite of that trend, marine insurance buyers are unlikely to see higher rates, underwriters say.

Figures released last week by the Institute of London Underwriters show 53 ships of more than 500 gross tons each were lost from Jan. 1 to June 30, an increase of nearly 10.4% on the 48 vessels lost in the same period of 1995. Given that the second half of the year historically produces somewhat heavier casualties, the ILU fears losses for the year may be well above the 95 total losses for 1995.

However, based on the marine market's cyclical nature and the fact that last year's toll was a record low for losses, marine underwriters do not think the latest loss figures alone will reverse declining rates.

Matthew Marshall, ILU technical director, said underwriters will be closely watching losses in the third quarter—the last full quarter before year-end renewals, "but I would not expect it to have a significant impact."

He attributed the London marine market's weakness to the problem of overcapacity, which developed as more underwriters began offering coverage when shipping losses were decreasing.

There is almost always a time lag before those underwriters begin to withdraw capacity, and that is unlikely to happen until they start to feel the sting of losses, he said.

The ILU warned that the number of ship losses in the first-half of 1996 may increase if some damaged ships initially deemed partial losses by underwriters are later judged to be total losses.

In addition, the number of people killed or reported missing as a result of total and partial shipping losses in the first half rose to 730, more than double the 316 lives lost in the whole of 1995.

However, much of that increase was due to sinking of Tanzanian ferry Bukoba. The heavily overloaded vessel capsized and sank on Lake Victoria during the second quarter, resulting in 543 deaths (*BI*, May 27).

ILU statistics apply to ships of 500 or more gross tons and thus exclude small fishing vessels and other craft like small ferries.

They do not include a total for the insured values, though the ILU says the most costly hull loss so far this year was the 16,915 gross ton Liberian-registered Nedlloyd Recife, a container ship that broke up after grounding off Brazil. It's hull was insured for about $40 million.

The ILU said of the first-half losses: "The reversal is disappointing, and if this trend continues it will mean that the exceptional improvement seen in 1995 could have been a blip. A return to a more normal annual loss pattern may thus be emerging."

However, two other points also will affect insurers' attitudes toward renewals.

The ILU figures indicate the ships lost in the first half of 1996 were generally smaller and older than in 1995. Although the number of ships lost was much higher for the first half of 1996, total lost tonnage was only 4.8% greater, at 309,273 gross tons.

Also, of the 53 confirmed total losses, 36 ships were at least 18 years old.

One underwriter said that with the possible exception of older vessels, which command higher insurance premiums anyway in relation to their value, the results are unlikely to enable marine insurers to raise rates significantly.

The fact that the vessels were older, and thus of lesser value, means their losses will impact less on insurance claims and on underwriters' resolve to lift rates.

The ILU said that at December renewals hull insurance rates were down approximately 12.5%.

Aetna Re gets new name, owner

Reinsurer expanding into casualty risks

LONDON—Aetna Re-Insurance Co. (U.K.) Ltd. is now under new ownership, a new name and is preparing to enter new lines of business.

Aetna Inc. sold all but a 19% stake in its London-based unit—which has been renamed Imperial Fire & Marine Re-Insurance Co. Ltd.—for an undisclosed sum to a group of investors led by Loay Al-Naqib, former general manager of Arig Reinsurance Co. Ltd., a London-based unit of the Arab Insurance Group BSC of Bahrain.

Other unnamed investors include U.S. and Bermuda-based investors.

A spokesman for Mr. Al-Naqib said details about the new company are expected to be announced early this week, while a spokesman for Aetna in Hartford, Conn., also confirmed that a statement was being prepared.

Aetna Re had been running off its property/casualty portfolio. Net premiums this year are expected to total only £10 million ($15.4 million), down from 1993 net premiums of £35.5 million ($52.5 million) and 1994 premiums of £24.3 million ($38 million).

Imperial Re will specialize in facultative aviation, marine and energy risks, as well as property and short-tail casualty reinsurance. Aetna Re had concentrated almost entirely on property.

A spokesman confirmed that Imperial Re is assembling a new underwriting team, adding that the company has no intention of undercutting other reinsurers in an already soft market. Imperial Re hopes to win business in rapidly developing areas such as the Middle and Far East, India and eastern Europe.

Earlier this year, Aetna made its major move out of property/casualty business with the $4 billion sale of these interests to Travelers Corp. (*BI*, Dec. 4, 1995). In 1992 it sold for $1.4 billion American Reinsurance Co., which has recently been the subject of sale rumors (*BI*, Aug. 5).

—By Edwin Unsworth

Lloyd's review begins today

By SARAH GODDARD

London

LONDON—The High Court today will hear opening arguments in the Paying Names' Action Group's request for judicial review of Lloyd's of London's treatment of so-called paying names under the reconstruction and renewal plan.

PNAG won the right to have its case heard last week, when in a preliminary hearing Justice Michael Turner decided its arguments warranted judicial review.

Prior to last week's decision, Barry O'Brien, Lloyd's legal adviser and a partner in London law firm Freshfields, had said he believed there were no grounds for a review to be granted.

A Lloyd's spokesman said last week that Lloyd's did not oppose the PNAG arguments at last week's preliminary hearing because it wanted the group's full arguments tested. The spokesman said he was confident the judicial review would favor Lloyd's.

The PNAG argues that Lloyd's R&R proposals are unfair to names who have paid all their losses to date and that it does not recognize the sums those names have contributed to Lloyd's over the years. By contrast, names who have filed litigation to avoid paying their debts receive special debt credits under the R&R plan.

The judicial hearing has been expedited in order to be completed before the Aug. 28 R&R deadline, according to John Abramson, the PNAG's lawyer and a senior associate with London law firm Warner Cranston.

He predicted the hearing would last about three days, though a decision by the judges is not likely before next week. This will bring it dangerously near to the R&R closing date.

"If the paying names' action is successful, it is up to Lloyd's to decide what to do next," said Mr. Abramson. The judges may order Lloyd's to make fair provisions for paying names should the decision fall their way, he added.

Tony Welford, chairman of PNAG, said he was confident Lloyd's has extra provisions up its sleeve should the judges rule in favor of the names. "Lloyd's has known about this action for some time," he noted. "They will for certain have contingency plans." He said he does not expect or want the action to jeopardize the R&R implementation.

PNAG members, embittered by what they view as mistreatment by a market they have loyally supported, did not want to take legal action, but were forced to by Lloyd's refusal to negotiate with them, according to Mr. Welford. Talks—which Lloyd's had said would be meaningful—had proved fruitless and were merely "delaying tactics," he asserted.

He said they are seeking equal treatment to that of non-paying names, adding that some PNAG members are now regretting they acted honorably in paying their losses while incurring severe financial hardship. "It sets a very bad example for the future," warned Mr. Welford. "It shows that if you have losses at Lloyd's in the future, it is better not to pay them."

AIRMIC rejects tax

The Assn. of Insurance & Risk Managers is urging Chancellor of the Exchequer Kenneth Clarke not to increase the insurance premium tax in his forthcoming November budget.

AIRMIC is adding its support to the Assn. of British Insurers' call last month to abandon the tax (*BI*, July 29).

The premium tax was first levied in November 1994 and applies to a number of non-life classes of insurance, but excludes marine, aviation and transport, overseas and reinsurance business.

AIRMIC Executive Director Ina Barker warned that any increase in the tax could result in large companies finding alternative methods of financing catastrophe risks.

"The danger is (companies) may take a risk and decide to save money by not taking out insurance," she predicted. "Companies have a statutory obligation to insure some risks—not least for third-party motor and employers liability—and a decision not to do so would be very serious."

Lloyd's discipline

Lloyd's of London has announced sweeping changes to its disciplinary system in an effort to simplify its procedures. Central to the changes is the establishment of a new Disciplinary Board responsible for approving settlements, issuing fixed penalty decisions and appointing disciplinary tribunals for certain proceedings.

To make the necessary changes,

See **London** *on next page*

Strikes

Continued from previous page

cover when (disputes) are happening," said John Allen, managing director of London-based Strike Risks Management Ltd., an underwriting agency that offers the coverage underwritten by Lloyd's of London syndicates.

Strike Risks will not insure against losses from strikes by an organization's own employees. Instead, the coverage protects a company against losses resulting from a strike by a third-party.

"It has got to be a third party strike," he said.

But so far, the six Royal Mail walkouts have not resulted in claims.

"It is coming along a day at a time," explained Mr. Allen.

"In contrast, the 1989 strike was continuous and so cost businesses a lot of money," he said.

AP/WORLD WIDE PHOTOS

Strikes by Royal Mail workers have slowed mail delivery at times.

Policyholder retentions are based on the number of action days—and the levels have not been reached yet in either of the disputes.

For the underground workers' action, there is a three to five day aggregate—but the actions have generally not been "all-out" and limited skeleton services have been available.

Policy limits vary, though Mr. Allen said that $10 million was "quite commonplace." There is no maximum limit.

"Above $10 million, we can spread (the risk) further around the market. . .nothing is standard. Each policy is considered on its own merits," according to Mr. Allen.

Although premiums are affected to varying degrees by deductibles, rates run at about 2% of the policy limit.

Policyholders run the gamut of businesses from the one-man operation to large international corporations.

Coverage is available for overseas businesses as well as companies based in the United Kingdom.

Strike Risks provides strike insurance for corporations in Australia, the United States, South America, New Zealand, France and Spain. BI

Strike coverage available to keep shipowners afloat

Shipowners and charterers—those who lease ships—can obtain strike insurance.

The largest underwriter of this coverage is the Monte Carlo-based Strike Club Management Ltd., which has reserves of more than $31 million and premiums for 1996 of $11.4 million.

The Strike Club provides three types of coverage:

- Reimbursement for the daily running costs of a vessel that has been prevented from operating because of third party lock-outs, stoppages, restraint of labor or strikes.
- Reimbursement for daily running costs during delays after a strike or similar action has taken place.
- Reimbursement for delays caused by industrial action by the ship's crew.

A spokesman for the Strike Club said there had been "a lot of claims" in the last two or three years.

Simon Bradley, manager of the Transmarine Mutual Strike Assurance Assn. Ltd. in London, agreed, though he said the last six months had been relatively quiet.

However, he anticipated more and more industrial labor disputes in the future, particularly in Australia, Canada and South American countries.

Mr. Bradley identified a growing interest in the coverage, reversing the recent trend of shipowners getting rid of this coverage in an effort to trim their budgets.

But, he said, many shipowners wait too late to buy the coverage.

"We can't insure a certainty," he said.

—By Sarah Goddard

London

Continued from previous page

the Lloyd's Council has implemented five new bylaws and has approved reforms to the existing appeals process. Also, the terms now give Lloyd's greater control over a broad range of actions. For example, Lloyd's can discipline people previously associated with the market for misdemeanors dating back to their time at Lloyd's.

Disciplinary proceedings will now be dealt with under a three-tier process comprising formal, summary or fixed penalty proceedings. Lloyd's described the proceedings as analogous to fixed penalty notices under the Road Traffic Acts. Summary cases will be dealt with in writing, for both submissions and evidence, and both individuals and companies may receive censures or fines. The maximum fine for an individual will be £15,000 ($23,145), while that for a company will be £30,000 ($46,290). Cases that could result in a larger penalty will be dealt with under the formal proceedings, which will be materially the same as under the current system.

Sir Alan Hardcastle, chairman of Lloyd's Regulatory Board, said the new disciplinary proceedings are an important plank of the regulatory plan (*BI*, Jan. 22). "Our objective is to ensure that our disciplinary machinery is fair but firm and fast in dealing with those who are foolish enough to expose themselves to disciplinary action," he said.

Lloyd's also is currently evaluating the fitness and propriety of about 3,000 market practitioners for registration.

Reinsurer payouts

Creditors of failed Singapore reinsurance companies ICS Reinsurance Private Ltd. and RMCA Reinsurance Ltd. are to receive an interim dividend of 50 cents on the dollar under a scheme of arrangement set up and administered by London-based accounting firm Coopers & Lybrand.

ICS Re and RMCA Re entered into the schemes in April 1994, which provided an alternative to a formal liquidation. The companies have agreed-on liabilities of about $126 million and assets of about $80 million.

Using actuarial techniques, Coopers & Lybrand has been able to identify creditors' claims early, allowing them to make the first payment of $60 million. The balance of $20 million has been set aside for claims yet to be agreed.

Philip Singer, a partner at Coopers & Lybrand who co-authored the scheme, said he was pleased with the speed at which the first dividends were paid.

"This proves how effective crystallization schemes can be for creditors," he said, adding that he anticipates more distributions in the near future. BI

E.C. threatens lawsuits to enforce directives

BRUSSELS, Belgium—The European Commission has threatened to sue Germany and Spain in the European Court of Justice if those countries fail to come up with "satisfactory replies" to questions over their failure to properly implement E.C. insurance directives.

The European Commission is sending "reasoned opinions" to Germany for incorrectly implementing health insurance provisions in the third non-life directive and Spain for incorrectly applying the second motor directive.

Both countries have 40 days in which to reply, after which the matter may be referred to the Court of Justice.

German social legislation is considered to infringe on the third non-life directive, and Spain has not yet created a government agency for handling vehicle claims in which a culprit cannot be identified.

The European Commission's current action is the second step in infringement proceedings; the commission issued a formal notice previously.

In addition, the European Commission has urged all E.U. member states to speed up their implementation of insurance-related directives.

—By Sarah Goddard

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ADA® American Dental Association

Privatization and infrastructure projects to get help from newly formed AIU unit

Markets

NEW YORK—American International Underwriters, the overseas property-casualty operation of American International Group Inc., has formed a new infrastructure/privatization project group.

The new group, which will provide clients involved in infrastructure and privatization projects access to AIG's global underwriting, will be headed by Peter J. Haller, AIU senior vp.

Drawing on AIU's insurance and financial risk management, engineering and claims management resources, the infrastructure/privatization group will focus on the needs of such infrastructure projects as power generation, oil and petrochemical, communications, port refurbishment, water utilities and airports. Among the coverages it will offer are political risk insurance, contractors all-risk, casualty, accident and health insurance and bonds.

The group has dedicated regional teams in North America, Latin America and Southeast Asia.

For more information call 212-770-5203.

New specialty group

FRANKLIN LAKES, N.J.—The Western World Insurance Group has formed a specialty brokerage division to focus on hard-to-place general liability and products liability risks.

Gary Resman has been named vp of the new group. The specialty brokerage division will be available to appointed wholesale surplus lines producers and will offer coverages underwritten by Tudor Insurance Co.

In addition to Tudor, other companies that are part of the Franklin Lakes, N.J.,-based Western World Group include Western World Insurance Co., Stratford Insurance Co. and Westco Claims Management Services Inc.

For more information about the new specialty division call 201-847-8600.

New USF&G groups

BALTIMORE—USF&G Corp. has established two new business groups, the Commercial Insurance Group and the Surety Group.

Glenn W. Anderson was named president of the Commercial Insurance Group, and Robert J. Lamendola was named president of the Surety Group. Both report directly to USF&G Chairman Norman P. Blake Jr.

IPAs, centers sold

SAN DIEGO—FPA Medical Management Inc. has bought two individual practice associations and has agreed to buy 30 health care centers from Foundation Health Corp. and its affiliates for about $220 million in cash, common stock and notes.

The transactions are expected to bring FPA 294,000 new health maintenance organization members, bringing its total HMO membership to more than 630,000.

The purchases of the two IPAs, in Arizona and Florida and consisting of 63 primary care physicians and 21,000 HMO members, were effective July 1.

The health care centers purchase is expected to close on or about Oct. 1 and is subject to regulatory and other approvals.

The centers include 12 Foundation Health Medical Group centers in FPA's existing service areas of Sacramento and Ventura counties in California and 18 Thomas Davis Medical Centers in Arizona. The health care centers have about 245 primary care physicians.

FPA's existing corporate and information facilities in California, Arizona and Florida will manage the new HMO members. The transactions are expected to add $60 million to FPA's 1996 revenue.

Broker acquires Fink

CHICAGO—Insurance broker Julius Moll & Son Inc. has acquired insurance agency Morton A. Fink in a move that allows both Chicago-based firms to deliver new products and services through the facilities of the national USI Insurance Services Corp. network, of which Moll is a member.

Terms of the transaction, under which Mr. Fink will become a senior vp of Moll & Son, were not disclosed.

Morton Fink, a broker that has special expertise in serving automobile dealers, is Moll's first acquisition since becoming affiliated with USI last year.

Moll offers full-service property-casualty insurance, risk management and benefits capabilities to commercial and personal lines clients, with expertise insuring various manufacturing and service companies, the aviation and hotel/motel industries and professional organizations including optometrists, architects and engineers.

Moll & Son also has a financial planning department providing life, accident, group, disability and pension services.

For more information, call 312-286-7737.

New INTERRA office

INDIANAPOLIS—Reinsurance intermediary, management and underwriting company INTERRA Group has announced plans for a Chicago office that will contain two units, a North American managed care division and a property and casualty division.

The managed care division, which falls under INTERRA's sister organization, Associated Facilities Management Inc., will be headed by Ruan Sexton, vp of managed care underwriting. AFM is an Indianapolis-based reinsurance managing underwriter with a European branch office in London.

The P&C division operates under INTERRA Reinsurance Group, a reinsurance intermediary broker also based in Indianapolis. Daniel Ryan III has been named senior vp of the new division. His primary focus will be reinsuring medical liability programs.

For more information, call 317-581-0651.

Name change

BEACHWOOD, Ohio—PRMS Inc., which writes directors and officers liability insurance, has changed its name to Genesis D&O Liability Insurance Program.

In addition, the insurer has moved to a new office at 25550 Chagrin Blvd., Suite 300, Beachwood, Ohio; 44122; 216-766-5416, fax: 216-591-0906.

Benefit outsourcing

NEW YORK—Johnson & Higgins' subsidiaries A. Foster Higgins & Co. Inc.—J&H's benefit consulting unit—and Johnson & Higgins/Kirke-Van Orsdel Inc.—a third-party claims administrator—are joining forces to offer employee benefit outsourcing services through a new unit—Higgins Human Resource Administration.

Outsourcing services will be provided through centers in Des Moines, Iowa, and Princeton, N.J.

For more information, call 515-248-1458. BI

Coverage

Continued from page 3

attorney with Peabody & Arnold in Boston.

Also, the high wages athletes earn and their knowledge of the risks of injury may have prompted other states to exclude or limit their workers comp benefits, he said.

To protect athletes, most professional sports leagues specifically address workers compensation in states that do not provide benefits. Workers comp for professional sports teams applies, however, to coaches and other employees of organizations even in states that deny benefits to athletes.

The National Football League's collective bargaining agreement, for example, mandates that teams in states whose statutes exclude professional athletes must pay the equivalent of workers comp benefits to injured players, said Tom DePaso, an attorney for the National Football League Players Assn. in Washington.

All the teams in the National Hockey League and the National Basketball Assn. in states that exclude professional athletes purchase coverage anyway, said Roger Blumencranz, president of BWD Group Ltd., the program administrator for the NHL's and the NBA's Bermuda-based captives.

As a result, "all players in the NHL and NBA are covered by workers comp," he said.

The issue is less clear for Major League Baseball.

The MLB players currently have no collective bargaining agreement, so players are operating under the old agreement, said Ned Ehrlich, an attorney with Anapol, Schwartz, Weiss, Cohan P.C. in Philadelphia, who represents injured Major League Baseball players.

"I'm not aware of that provision," under the old agreement, he said, referring to teams offering workers comp or equivalent benefits in states whose statutes exclude athletes from workers comp benefits.

Professional sports is one occupation where the risk of injury is acknowledged and visible. It also is one of the only professions to guarantee employees their benefits and full salaries whether they are performing their job or sitting on the bench with torn ligaments.

Under the terms of most players' contracts in professional baseball, basketball and hockey, each team is responsible to pay the injured player's medical expenses and loss of salary for the duration of his guaranteed contract.

In contrast, professional football players typically sign multiple one-year contracts with injury clauses. Under the collectively bargained injury clauses, teams are responsible for paying the injured player his remaining salary and medical expenses only for the rest of the season, explained Mr. DePaso.

If the NFL player sustains a career-ending injury and is under contract for the next season, he would get half his designated salary for that season up to a maximum of $200,000. However, no workers comp medical benefits would be paid during that time, he said.

If the contract runs out and a player still is injured, he can elect to receive workers comp benefits, where eligible, Mr. DePaso said.

In some cases, however, highly paid professional athletes are unaware they are eligible for the benefits.

"I suspect workers compensation has been largely ignored by both (players and teams) for years," said Bob Russell, senior consultant for Watson Wyatt Worldwide in Chicago. Typically, players will "collect under disability and don't think about workers comp. It's just coming into vogue as more players decide to pursue it," he said.

'I suspect workers compensation has been largely ignored by both (players and teams) for years,' says Bob Russell.

Part of this ignorance of workers comp is an "information shortfall," said Ken Davidson, senior vp and co-chairman of Johnson & Higgins' sports and entertainment target group in Boston. "Very little time is spent communicating (workers comp) to athletes."

At the same time, many of the young athletes come to professional teams with "an immortal mind-set," said Mr. Davidson. They do not think they will get hurt, and if they do get hurt, they think the team will take care of them, he said.

"I never gave it a second thought that a cent of mine would come out of playing football," said Phil McConkey, former wide receiver for the New York Giants and current director of insurance services for the greater New York area at Alexander & Alexander Services Inc. in Lyndhurst, N.J. "I expected that the Giants would take care of any problem I had."

Mr. McConkey said football teams typically go beyond the collective bargaining agreement and will cover players for disabilities after the season ends.

Mr. Davidson said that while more athletes may be informed today that they have a remedy if they are injured, some athletes do not elect the coverage because they are such an "inconsequential" amount compared with their actual salaries. "It gets lost in the shuffle," he said.

For example, the $760.51 per week that the Cubs' Mr. Sosa would be entitled to under Illinois' workers comp statutes amounts to $39,547 per year, a far cry from the $4.75 million he earns per year under his contract with the Cubs.

"It's junk change," said Paul Wiedner, an attorney with Wiedner & McAuliffe Ltd. in Chicago, referring to the amount many high-paid athletes receive in workers comp benefits. But at the same time, he said, athletes are entitled to the benefits.

Mr. Wiedner successfully sued for benefits on behalf of Ted Albrecht, a former offensive lineman for the Chicago Bears who sustained a career-ending back injury during the Bears mini-camp in 1982.

If Mr. Albrecht were to have played for another three years, he "would have earned another $750,000. It would take two lifetimes to recoup that under workers comp," Mr. Wiedner said.

In March, after years of court battles, the Industrial Commission of Illinois awarded Mr. Albrecht $282.25 per week in wage-loss benefits for the remainder of his disability. That amounts to less than $15,000 a year, or an 88.5% pay cut, compared with the $130,000 Mr. Albrecht earned in his last year with the Bears in 1982.

According to a 1990 study by the NFL Players Assn., more than one-third of the 645 players with careers between 1940 and 1986 retired with disability injuries. Approximately two out of three retired NFL players live with a permanent injury.

Despite the relatively small amount of money at stake, the number of workers comp claims filed by professional athletes may increase, some observers say.

This is partially attributable to higher salaries, longer playing seasons, bigger players, and more pressure to play hurt, they say.

Peabody & Arnold's Mr. Tentindo said that as this trend continues, workers comp claims will continue to increase as players seek ways to compensate for their losses and medical expenses.

"It appears to me that because of longer seasons and more games, the athletes' bodies are breaking down more than ever," he said. And with higher salaries, athletes are pressured more than ever to continue playing, even if they are hurt.

Mr. Tentindo recently represented the Boston Red Sox in workers comp dispute with former second baseman Marty Barrett, who sustained a career-ending knee injury during a game in 1989. The Red Sox settled with Mr. Barrett for an undisclosed amount. BI

Baseball may get into swing of group work comp program

By SALLY ROBERTS

The success of the National Hockey League and National Basketball Assn. at controlling their workers compensation premiums may prompt Major League Baseball to also step up to the plate.

For years, teams in the NHL and NBA have benefited from low costs because of their mandatory participation in workers comp programs written by league-owned captives and centralized claims management.

On the heels of declining baseball revenues and the decision of its voluntary Bermuda-based captive, National American Insurance Ltd., to cease underwriting workers comp earlier this year, professional baseball is looking to the NHL and NBA for some direction.

"Major League Baseball is on the road to do what the NHL and NBA are doing," said Jeff Bloemke, an account executive at Chicago-based Near North Insurance Brokerage Inc.

Purchasing workers comp on a group basis, rather than each individual team arranging for its own coverage, would allow baseball "to get a handle on claims and to manage loss control on an industry-wide basis," Mr. Bloemke said.

The nation's other major professional sports league—the National Football League—also is looking to cut its workers comp costs, and group purchasing is one idea being entertained by management and the players union.

Near North currently is conducting a feasibility study for the Office of the Commissioner of Baseball on group purchasing of workers comp insurance and collective risk management services. The study should be concluded next month.

"Workers comp is one of many cost factors threatening the league," Mr. Bloemke said. "Major League Baseball has lived fat and happy over a period of time," but recently "they haven't had the best press, and not having an agreement with the players is difficult. Fans are not coming out to the ballpark."

Since the league's captive insurer stopped underwriting in January, all 28 teams in the league have been responsible for buying their own insurance and handling their own claims and loss control.

And in a profession where injuries are indigenous to the job and employee salaries often exceed $1 million, efficient claims management is needed with every professional sports team, brokers say.

"We've seen really a night-and-day difference in risk management. Some (baseball) clubs have state-of-the-art risk management while other clubs. . .it's really different," Mr. Bloemke said.

Indeed, "individual teams need to take a much more conscious, professional management approach to workers comp claims," said Ken Davidson, senior vp and co-chairman of Johnson & Higgins' sports and entertainment target group in Boston.

Because baseball is a homogeneous risk group, the environment exists where workers comp "could be better managed and controlled," he added.

If the league had one insurer involved and standard loss control and claims management, it would develop a consistent level of service, Mr. Bloemke said. "Then you can take the best at what some teams are doing and implement that on a league-wide basis."

This is one of the advantages of the NHL and NBA programs.

Workers compensation is a "predicament germane to the minor leagues and to (professional) baseball and football," contends Roger Blumencranz, president of BWD Group Ltd. of Lake Success, N.Y. BWD is program administrator for workers comp coverage written by the NBA's and NHL's Bermuda captives, Planet Insurers Ltd. and Intra Continental Ensurers Ltd., respectively.

"For a professional football team, if workers comp is a problem and they haven't been controlling it, they are facing seven figures" in workers comp premiums, added Marc Blumencranz, executive vp of BWD.

One reason the NBA and NHL have been successful in controlling workers comp premiums is that it has been mandatory for the teams to buy insurance collectively, Messrs. Blumencranz said.

The two league's captives are fronted by domestic insurers and each team has its own broker. BWD has "oversight" on all claims administration and management.

Managing reserves is key to keeping workers comp premiums down, Roger Blumencranz said. After a player is hurt, instead of leaving a reserve open, "adversely affecting a team's experience (modification factor), we make sure a player is back to work and is no longer injured" and then take the reserve down, Mr. Blumencranz said.

"We have checks and balances in place that other sports teams are capable of doing," he said.

It was the lack of some of these checks and balances that was behind the decision of National

See **Teams** *on next page*

Westwood

Continued from page 1

The company later changed its name to Westwood and its charter was sold in February 1994 to Lock Investments, which Mr. Guidry described as another Antigua company. He would not identify any of the owners, officers or directors of Lock.

In an opening balance sheet dated March 31, 1994, Westwood reported $3.5 million in assets, consisting entirely of mutual fund investments that are not further identified.

By Sept. 30, 1994, the insurer had produced a new financial statement showing $13.8 million in assets, including $10 million in "Certificates—U.S. Currency notes."

According to Westwood promotional material, this asset and an additional $1.5 million capital infusion in February 1995 consisted of CDs issued by a London branch of Chase Manhattan and held in trust for Westwood at a Chicago bank.

Unlike typical CDs that pay interest and carry fixed maturity dates, the Chase instruments are non-interest bearing "special certificates of deposit" representing the deposit of "U.S. currency notes issued by the United States of America to the Philippines and known as Series 66 Victory Notes," according to a 1994 confirmation letter provided to Dennis LaVorgna, Westwood's San Diego-based accountant.

Mr. LaVorgna reviewed Westwood's September 1994 balance sheet but did not audit it using generally accepted auditing standards and did not express an opinion.

The confirmation letter—written by Barry E. Burke, a Chicago lawyer acting as a Westwood trustee—says the Series 66 notes are backed by the full faith and credit of the U.S. government and were further backed by U.S. silver certificates at the time of issue, raising the "possibility (that) the value of the notes is greater than standard currency exchange market or the par value stated by the U.S. government."

While Westwood claimed a "current market value" of $10 million for the initial group of notes—which are denominated in Philippine pesos—they could have a "metal value" of up to $325 million based on the "value of silver metal backing the currency," Mr. Burke's letter says.

Westwood's deposit of the notes, Mr. Burke adds, "is in full compliance with the U.S. Treasury guidelines established by the Innsbruck/Schweizer Conference and the 1985 Conference of Paris that govern Series 66 currency."

In fact, Series 66 notes were issued by the Philippines and were never U.S. government obligations, said a spokesman for the Treasury Department's Bureau of the Public Debt. First used by General Douglas MacArthur's troops on Leyte Island in 1944, the notes ceased being legal tender in 1957. Some of the notes were exchangable for legal currency until 1967, when they were demonetized by the Philippines government and became worthless, he said.

Mr. Burke could not be reached.

A Chase spokesman declined comment.

Mr. Burke's confirmation letter shows that a copy was sent to Bruce W. Strunk, a Houston businessman. Mr. Guidry confirmed Mr. Strunk was an investment adviser to Westwood, but said he is unsure of Mr. Strunk's exact role in the Series 66 note investment. Mr. Strunk—who could not be reached—previously supplied $72 million in purported Indonesian "National Defense Security Council" bonds to Palisades National Insurance Co. Ltd. of the B.V.I. Palisades was barred from California after regulators found the bonds were of "questionable" value and concluded Palisades was insolvent.

In a "draft" Dec. 31, 1995, financial statement—marked "for internal review only" but circulated to Westwood agents—Westwood reports total assets of $16.7 million, including $15.5 million in CDs and $982,677 in accounts receivable.

The insurer also reported writing $2.3 million in premiums, including $1.7 million in marine hull and machinery and protection and indemnity business. Other Westwood business included small volumes of cargo, assumed reinsurance and insurance agents errors and omissions risks, along with a reinsurance program for a Russian insurer Mr. Guidry identified as Dalacfes Insurance Co. of Vladivostok.

An audited version of this "draft" statement is not available.

In Westwood promotional material, Mr. Guidry says KPMG Peat Marwick L.L.P. is auditing the insurer's 1995 financials. In an interview, however, he would not confirm the purported Peat Marwick audit and would not say who is now acting as Westwood's auditor. Peat Marwick officials could not be reached.

Other elements of Westwood's operations are also in flux: Its board of directors, for example, is now being reorganized, Mr. Guidry said.

As of late last year, Antigua records showed the board consisted of John Brown, Richard Bingaman and Jon Miklebost, all San Diego-area businessmen. Mr. Guidry is reported to have resigned as a director in 1994, though he says he never resigned. Mr. Brown and Mr. Miklebost formerly operated Certified Claims Management Inc., a now-defunct adjusting firm that processed claims for the insolvent Anchorage Fire & Casualty and other insurers, including Westwood.

In an interview, Mr. Brown said Westwood had planned to expand in California but "never got off the ground" in the state, and that he and Mr. Bingaman have not been directors for a year or more.

He also complained that Certified Claims was stuck by Anchorage with $180,000 in unpaid bills.

Mr. Bingaman and Mr. Miklebost could not be reached.

Mr. Guidry said Westwood's only current directors are himself and Monroe Birnberg, former president of New York-based Union Indemnity, which collapsed in 1985.

Reached at his Miami office, however, Mr. Birnberg said Mr. Guidry offered him a director's spot but he has not decided whether to accept it. Mr. Birnberg said he has been acting as an underwriting consultant to Westwood for about a year.

Also up in the air is Westwood's purchase of Blairsden, a 31-bedroom Peapack, N.J., mansion built in 1902 by a former governor of the New York Stock Exchange. Westwood announced the purchase last September in an advertisement in the *Journal of Commerce*, where Mr. Guidry was quoted saying the insurer would spend $1 million on initial renovations and use the estate for corporate functions.

In an interview, though, Mr. Guidry said Westwood still has only an "option" to buy the estate from its longtime owner, the Sisters of St. John the Baptist, an order of Catholic nuns. Westwood is paying rent to use the house while details of the purchase are being worked out. BI

Soccer league aiming to kick high cost of workers comp with group purchase

LOS ANGELES—A new professional soccer league has a game plan for holding down workers compensation costs that may be unique in professional sports.

Major League Soccer, which was formed in January 1996, has player agreements that allow it to centrally purchase workers comp coverage and administer claims for all 10 teams. This enables the league to monitor workers comp claims more diligently than its predecessor, the North American Soccer League, which folded in 1984, and also differs from how other pro leagues handle workers comp.

"Clearly workers comp is such a huge cost for any business. We took a serious look at it when we formed the league earlier this year," said Mark Abbott, senior vp-business affairs for the Los Angeles-based soccer league.

While Mr. Abbott said he was unsure of the factors that led to the NASL's demise, "my guess is workers comp got out of control. Each team handled its own workers comp and they probably did not have the greatest controls in place."

Unlike other major professional sports teams, all 200 players representing Major League Soccer are under contract with the league and not an individual team. Because of the "very unique" contracts, all workers comp claims are handled centrally, Mr. Abbott explained.

Through a program set up by broker Johnson & Higgins and underwritten by a unit of CIGNA Corp., each of the 10 soccer teams has its own doctor and trainer who will be responsible for reporting injuries to a central claims handling facility right after they occur, Mr. Abbott said.

The claims then will be "diligently monitored" every step of the way throughout the player's entire injury, which is expected to keep workers comp costs "relatively low," he said.

—*By Sally Roberts*

Teams

Continued from previous page

American Insurance, baseball's captive, to cease underwriting.

"We felt management was not as good as it could have been in a captive structure," said Mr. Bloemke of Near North, which is administering the captive. For instance, "accounting was not performing up to snuff and some administration aspects needed fine tuning."

In the mid-1980s, the captive wrote workers comp coverage for a majority of the baseball teams, but went "through tough times" when the workers comp market went soft, he said. Many teams began exiting the captive program when they figured out it was more advantageous to buy paid-loss retrospective programs from traditional insurers.

By the end of 1995, the five baseball clubs remaining in the captive were rolled into a group program underwritten by CNA Insurance Cos., he said.

While the NHL and NBA have found success in mandatory captives for workers comp risks, Major League Baseball is striving for something less restrictive.

"Baseball really dislikes the word mandatory," Mr. Bloemke said.

Additionally, there are five teams in Major League Baseball owned by corporate entities that allocate money to the clubs to buy insurance.

"These guys in the corporate programs are getting a good deal," so they likely would not participate in a league group purchasing arrangement, he said.

However, "there needs to be an overwhelming majority of teams committed to group purchasing," for it to succeed, Mr. Bloemke added.

Like Major League Baseball, the NFL also is looking at ways to reduce its workers comp costs, and centralizing claims management and insurance purchasing is one option being explored.

Under the 1993 collective bargaining agreement reached by the NFL Management Council and the NFL Players Assn., it was mandated that both management and the union discuss ways to control workers comp costs, said Dorothy Mitchell, an attorney for the management council in New York.

Different ways of pooling risks is just one idea out there, she said.

"We haven't even met to discuss the idea," added Richard Berthelsen, general council of the NFL Players Assn. in Washington.

However, both the union and management have an interest in controlling workers comp costs.

Under the collective bargaining agreement, each team has a salary cap of $40 million and a benefit cap—which includes workers comp costs—above that. If in any given year the total benefit cost from the league is lower than projected, more money can be allocated for players' salaries, Ms. Mitchell explained.

Unlike National American Insurance, which is still a viable entity that professional baseball teams could return to, N.F.L. Insurance Ltd., the NFL's captive, was liquidated in 1991.

Liquidators of the mutual insurer, capitalized by 13 NFL teams in 1984, said the company was paying out more in workers comp claims than it was receiving in premiums. In June 1987, the year before it stopped underwriting, they said its balance sheet showed reserves of $432,000 and a deficit of $1.5 million (*BI*, Jan. 20, 1992).

In a resulting lawsuit, liquidators alleged the teams, the league, its commissioner and the NFL Management Council were jointly and severally liable for the more than $14.5 million in debts and liabilities of the defunct mutual insurer.

A federal judge later ruled the league and individual teams were not liable for its debts because, as participants in a limited liability company, they were only required to finance an initial reserve fund (*BI*, April 5, 1993). BI

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Cleanup

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ing to be cutting it with an ax," Ms. Luppert said.

Olds-Olympic sought coverage in 1989 for its cleanup costs, which totaled about $350,000, according to Ms. Luppert.

Commercial Union Insurance Co. wrote Olds-Olympics primary CGL coverage from 1968 through 1984, according to Mr. Cusack, a partner with Cusack & Knowles of Seattle. Annual limits ranged from $50,000 to $100,000, he said. The coverage provided $350,000 in limits during one year, he said.

Fireman's Fund Insurance Co. wrote two consecutive three-year excess liability insurance policies that covered Olds-Olympic from 1969 through 1975, according to Fireman's Fund attorney Jeffrey Grant, a partner with Hagens & Berman in Seattle. The policies provided $1 million of occurrence-based coverage excess of Commercial Union's $50,000 coverage. There was a $1 million aggregate for each policy period.

Both insurers denied coverage. Other insurers that covered Olds-Olympic until 1990 either settled or had written policies containing the absolute pollution exclusion, Ms. Luppert said.

Olds-Olympic, now in Lynwood, Wash., sued Commercial Union and Fireman's Fund in 1992 in King County Superior Court. During the trial, the two sides presented conflicting evidence about the level of ground water contamination at the site.

A jury in May 1994 decided that while several separate occurrences contaminated the site's ground water from 1972 to 1990, Olds-Olympic had no legal obligation to clean the ground water.

Olds-Olympic appealed, and the state Supreme Court agreed to review the case directly.

The high court found that in asking the jury whether Olds-Olympic had a legal liability to clean the ground water, King County Superior Court Judge Larry Jordan worded the question ambiguously. Writing for the Supreme Court majority, Judge Philip Talmadge said the jury could have interpreted the question in one of three ways:

- Did the ground water contamination exceed levels set by state or federal regulations that trigger a property owner's obligation to clean the ground water?
- Did Olds-Olympic clean the site because of any legal compulsion or because it intended to prevent a future problem?

Judge Talmadge noted the trial judge did not advise the jury about the legal distinction between remediation efforts Olds-Olympic was obliged to take and preventive measures, which are not insurable. Judge Talmadge said the company's efforts were not preventive.

- Were Olds-Olympic's cleanup efforts motivated by a desire to clean its own property or the ground water?

In contemplating this possible interpretation, Judge Talmadge wrote that the owned-property exclusion "did not apply to Olds-Olympic" because the ground water at its site was neither its property nor within its "care, custody or control."

"Under any CGL policy, only those portions of cleanup costs necessary to prevent further degradation of property belonging to another will be covered, given the owned-property exclusion. Any portion of the cleanup affecting only the insured's property would still be subject to such an exclusion," Judge Talmadge elaborated in a footnote.

The judge also admonished the insurers. "Insureds are not purchasing 'almost comprehensive.' CGL policies are marketed by insurers as comprehensive in their scope and should be strictly construed when the insurer attempts to subtract from the comprehensive scope of its undertaking."

The ruling merely adopts the insurance industry practice of covering loss mitigation costs, said plaintiffs attorney Robert Horkovich, a partner with Anderson Kill & Olick P.C. in New York, which filed an amicus brief in the case.

Few other state high courts have considered this issue. In a coverage dispute between Boeing Co. and Aetna Casualty & Surety Co., the Washington court in 1990 suggested the owned-property exclusion would not apply when a policyholder's property must be cleaned up to prevent further damage to another's property.

The court in that case relied on a California appellate court's 1989 decision in Aerojet-General Corp.'s coverage dispute with 55 of its insurers. The California Supreme Court refused to review that case.

But, compared with those cases, the Olds-Olympic decision "gets further into the issue" of whether a policyholder's cleanup costs for its property are covered when the cleanup is intended to prevent further damage to a another's property, said insurer attorney Richard Seabolt. Mr. Seabolt, a partner with Hancock, Rothert & Bunshoft in San Francisco, represented Aerojet's insurers.

A portion of a 1992 New Jersey Supreme Court decision is similar to the owned-property exclusion ruling in the Olds-Olympic case. But the New Jersey case is more noteworthy for the court's unusual finding that the exclusion bars coverage for the cost of state-mandated pollution cleanups of a policyholder's property (*BI*, Oct. 5, 1992).

The Maryland Supreme Court in 1993, though, ruled that ground water at a site is owned by the property owner and therefore its cleanup costs are not covered.

Insurer defense attorney David W. Ichel, a partner with Simpson Thacher & Bartlett of New York, agreed the Olds-Olympic decision is "relatively favorable" to other CGL policyholders on the "legal issue" of the scope of the exclusion.

However, he asserted that the scope of the exclusion will continue to be litigated.

He also predicted that the outcome of other cases will turn on case-specific facts. For example, a policyholder may have to prove its cleanup costs were incurred to remediate third-party property damage rather than comply with environmental rules that govern onsite water treatment of waste water.

Mr. Seabolt agreed, noting that some chemicals do not migrate through the ground and that others migrate at various speeds.

And, in some cases, remediation of ground water contamination may be unnecessary because the ground water is unsuitable for use for other reasons, like its naturally high salt content, he said.

Mr. Seabolt also said the Olds-Olympic decision raises a public policy concern because it gives policyholders an incentive to delay addressing an environmental problem on their property until it also damages another's property. "If the policyholder's tank is leaking enough or if he can just ignore it long enough, then the policyholder will argue that whole thing is covered."

But, Mr. Cusack, Commercial Union's attorney, said the ruling does not mean some policyholders can recover costs incurred to clean up their own property. That "reading of the opinion is pretty expansive" in light of a concurring opinion to the majority opinion, he said.

The concurring opinion by a lone judge states that while insurers must cover policyholders' costs to clean a third-party's property, insurers may subtract any costs incurred to clean up the policyholder's own property if those cleanup efforts did not remedy or prevent future damage to another's property.

Ms. Luppert, Olds-Olympic's attorney, suggested that as much as 90% of the company's cleanup costs should be covered then because ground water was present under that much of the site.

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Olds-Olympic Inc. vs. Commercial Union Insurance Co. and Fireman's Fund Insurance Co., Washington Supreme Court; No. 61914-0.

California

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for fraud, noting that cases are carefully screened by prosecutors, regardless of how they are submitted.

The lawsuit was filed last month in Sacramento County Superior Court by nine employees and supervisors in the Insurance Department's Fraud Division. The suit, which seeks $90 million in damages, names Insurance Department Deputy Commissioner Barbara Dotta and General Counsel William Palmer, alleging they harassed and slandered the plaintiffs and created a hostile working environment (*BI*, Aug. 5).

In their lawsuit, the investigators allege that:

- They have been ordered by Ms. Dotta to forward to prosecutors insurer-investigated fraud cases, which they contend would prevent them from first verifying the validity of the insurers' claims.

They contend in the suit that this violates their oath as sworn peace officers by forcing them to side with insurers, rather than impartially investigate fraud claims.

- Insurers stand to gain financially because incomplete or inaccurate investigations help obtain plea bargains from individuals falsely investigated and thus insulate insurers from potential bad faith claims, the plaintiffs charge.
- A "steering committee" of insurance industry personnel has been formed by the defendants to direct the Fraud Division's duties, responsibilities and practices, they contend.

The plaintiffs also claim that they were told by Ms. Dotta to attend meetings at which insurance industry representatives told them that they could "pull the plug" on Fraud Division funding if they didn't follow insurers' directives.

An Insurance Department official pointed out that the division's funding comes from insurers.

"Those are not empty threats," said Deputy Insurance Commissioner Richard Wiebe, who took telephone calls for Ms. Dotta. "Lets not forget who funds the fraud division. It is the self-insured employers and the insurance companies who are assessed and determine what level they will assess themselves to fight fraud.

"And, if in their view the job is not being done it is within the authority granted to them by the Legislature to cut back on funding or to redirect the funding," Mr. Wiebe said.

Insurers in the state are hopeful that Ms. Dotta will eliminate the backlog of cases awaiting referral to prosecutors, said Barry Carmody, president of the Assn. of California Insurance Cos. in Sacramento. Some of those 2,000 cases have languished in the Fraud Division for six months or more, he said, adding that such delays slow down the industry's anti-fraud effort.

But the "old guard" in the department didn't like her tactics and filed suit to stop her, Mr. Carmody said of the lawsuit. "She's making some dramatic changes in the unit, but as a former law enforcement officer and prosecutor, she knows what she's doing."

Before being named deputy commissioner of the DOI fraud division, Ms. Dotta had been a senior deputy district attorney in Fresno County. She also worked as a detective in the Organized Crime Unit for the Washoe County Sheriff's Department in Reno, Nevada.

While the Insurance Department Fraud Division was created six years ago, the state's 1993 workers comp reforms increased the unit's funding and allowed it to grow from just 50 employees to 236 today, including 166 sworn peace officers.

Funding for the division comes from three sources:

- Assessments on workers compensation insurers and self-insured employers, which are set by the governor-appointed Fraud Assessment Commission. The commission's current chairman is Joseph Markey, association manager of the California Self-Insurers Assn.
- A general assessment of $1,000 per insurer, which is charged to cover the expense of property/casualty insurance fraud cases.
- A $1 assessment on every insured vehicle in the state, which is allocated to auto insurance fraud cases. The first 5 cents of the assessment goes to the California Highway Patrol and local district attorneys. Of the remainder, 34% goes to the Fraud Division.

Insurers' financial backing of anti-fraud efforts also has helped to bolster district attorney offices throughout the state, many of which face tight budgets due to state funding cuts.

The Insurance Department contends that the plaintiffs are just "foot-dragging" and unwilling to cooperate with Ms. Dotta, who was recently hired to clear up a backlog of some 2,000 fraud cases that have yet to be referred to state prosecutors.

"They are saying Dotta is attempting to ramrod cases through the fraud division without meaningful review," said Mr. Wiebe. "What they call 'meaningful review' *she* would call foot-dragging. And I think the insurance companies that have invested millions of dollars in these special investigative units and the DAs who are sitting around for cases to be referred to them would disagree (that these cases lack meaningful review)."

"Their job is not to police the insurers," Mr. Wiebe said of the investigators. "Their job is to put fraud artists—people who commit fraud against insurance companies—in jail. This is not the same division that investigates allegations of insurance misconduct. This is claimant fraud they are investigating."

Mr. Wiebe said the suit may be in retaliation for action taken after Ms. Dotta uncovered sexual harassment problems within the department, for which the department recently paid out $125,000 to settle sexual harassment allegations against some of the plaintiffs. Two of the plaintiffs have been placed on administrative leave pending an investigation into the allegations.

However, Paul E. Lacy, an attorney for the plaintiffs contends that bringing up 2-year-old sexual harassment allegations is just a subterfuge. In fact, he said, the charges were withdrawn after an internal investigation found them to be groundless.

Despite the department's assertion that the investigators' job is not to police insurers, the plaintiffs say they believe their role includes weeding out insurer-submitted fraud cases that have no merit so that people aren't investigated without cause.

The investigators contend that claims submitted by insurers' investigators require review by professional peace officers to spot cases with inadequate proof or other problems.

However, prosecutors and insurers say they are confident that few, if any, innocent people are prosecuted.

One reason is that prosecutors review all cases submitted to them before deciding whether to prosecute.

"No DA is going to charge on a promise that the evidence is going to come later," said Bob Ring, an assistant district attorney responsible for prosecuting insurance fraud in San Francisco. "We just don't do that. We won't charge a case unless we know we can win it."

"No matter what anybody says here, if (Ms. Dotta) moves cases prematurely or moves cases that are not well put together, the cases wouldn't be successfully prosecuted," agreed the ACIC's Mr. Carmody.

But some prosecutors also say they prefer to have sworn peace officers conduct the investigations of cases brought to them, even if it means those officers repeat the same procedures taken by an insurer's investigators.

"It gives an unbiased perspective to the investigation because the insurance company does have a little bias in the matter," Mr. Ring said.

Some district attorneys also say sworn peace officers have a better understanding of what prosecutors are looking for, while investigations submitted directly by insurer investigators tend to vary in their thoroughness.

"There is a wide range of quality in what we get from various carriers," said Ed Feldman, acting head deputy of the Workers Comp Fraud Division of the Los Angeles County District Attorney's Office.

"But it really doesn't compare with Department of Insurance investigations because everything we get from the carriers does get a follow-up investigation either from (Insurance Department) investigators or investigators within the district attorney's office," he said. "Sometimes it is a fairly thorough follow-up investigation. Sometimes it's just a confirmatory one, filling in whatever gaps there are."

If, as the state investigators allege, false or inaccurate fraud claims are referred for prosecution, that could spell trouble for employers, some attorneys contend.

While California reforms and some subsequent court decisions have given insurers immunity from civil liability for bringing false fraud charges against workers comp claimants, employers do not have similar immunities from defamation, discrimination or harassment suits, the most likely causes of action.

A California appellate court recently ruled that an aggrieved worker may sue a former employer for defamation outside of the workers compensation system.

"Patently, defamatory statements which have no other purpose than to damage an employee's reputation are neither a 'normal part of the employment relationship' nor a risk of employment within the Workers Compensation Act," the 2nd District Court of Appeal ruled in *Davaris vs. Cubaleski* in February.

An employer's potential liability exposure would depend on whether the employer knew that the insurer's case against the employee was false, "and ratified and contributed infor-

See **California** *on next page*

California

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mation that the employee was engaging in fraud," said John True, former chair of the California Bar's labor and employment law section and a San Francisco plaintiffs attorney specializing in employment law.

But, Mr. True added, if the employer did not know of the insurer's actions then "I would hesitate long and hard before suing the employer."

An employer would not be directly liable for damage to a worker's reputation because the employer is independent of the insurer, said Richard Simmons, an attorney with Sheppard, Mullin, Richter & Hampton.

"The only link is if the insurer relied entirely on information from the employer," he said.

But that's often the case, according to attorneys who represent workers compensation claimants charged with fraud. It's generally the employer that tips off the workers compensation insurance company when fraud is suspected, they say.

Nevertheless, several employment attorneys say they have yet to hear of such cases against employers primarily because insurers usually don't pursue cases with only marginal evidence.

"It's possible" if the employer turns the carrier on to the motion of fraud that the employer is increasing his liability, said Robert Millman, a management and labor attorney in Los Angeles for Littler, Mendelson, Fastiff, Tichy & Mathiason.

"I would hope (an attorney) representing an employer might be able to isolate the employer from liability," he said. BI

PacifiCare

Continued from page 1
Healthcare (*BI*, April 8).

The PacifiCare-FHP deal illustrates the merger and acquisition trend in the managed care field, which is expected to continue.

Employers say they are essentially taking a wait-and-see attitude to see how the acquisition affects them.

The deal is expected to save $110 million in its first year. It will lead to an indeterminate number of layoffs, particularly among FHP employees in California, where both companies are concentrated. Among the deal's economic advantages is that PacifiCare's Cypress Hills and FHP's Fountain Valley headquarters are only about 10 miles apart.

"We will try to take advantage of all overlaps that exist to try to provide a more affordable product for health care consumers," said Mr. Hoops, who will continue in his position. Weston W. Price III, FHP's president and CEO, said he eventually plans to leave the company.

Observers say, however, they do not expect the acquisition to lead to any immediate or dramatic change in the HMO industry's rate structure.

A major impetus of the deal, say company officials, is both companies' focus on the promising and lucrative Medicare-HMO business. Combined, the two companies now serve about 928,000 Medicare participants, or about 25% of the total existing market. Medicare participants use four times the amount of health care services as do those under 65.

However, employers with active employees are also expected to benefit from any leverage the company earns because of its position in the Medicare market.

In addition, PacifiCare members will now have access to FHP markets in Arizona, Colorado, Illinois, Indiana, Kentucky, New Mexico, Nevada, Ohio, Utah and Guam. FHP members will also have access to PacifiCare markets in Florida, Oklahoma, Oregon and Washington. In addition to California, both companies have operations in Texas.

"Because FHP is in different areas across the country, it might actually be good for some of our members who are in more distant locations," said Suzanne Mercure, manager of benefits administration for Southern California Edison Co. in Rosemead, Calif., which now does business with PacifiCare, but not FHP.

The acquisition provides "terrific opportunities" for efficiencies and to improve affordability and service to members, said Mr. Hoops.

"As far as acquisitions go, this one makes a lot of strategic sense," said Ken Laudan, an HMO analyst with Hambrecht & Quist in San Francisco.

Although there is clearly some risk inherent in the acquisition, he said, the companies' corporate offices are close to one another, they offer similar product lines and there is a strong complementary fit geographically.

PacifiCare's bid to buy FHP may have been done with the intent to prevent a competitor from snapping it up, some observers say.

PacifiCare was probably approached by Aetna before it acquired U.S. Healthcare, and "I wouldn't be surprised if that impressed upon PacifiCare that bigger is better, that they had to either grow or perhaps be acquired at some point in time," said Jack Doerr, group benefits practice leader for Sedgwick Noble Lowndes in Chicago.

"To some extent, it seems defensive," said Mark Jamilkowski, an analyst with Conning & Co. in Hartford, Conn.

"FHP is a weak sister of the California HMOs and to some extent it has been well known on the street that FHP has been up for sale in parts or in whole for some time." And, PacifiCare may have wanted to ensure its California-based membership was not threatened, he said.

Observers noted that FHP had some difficulties absorbing its 1994 TakeCare Inc. acquisition (*BI*, March 7, 1994). "They've just not been successful in their expansion efforts outside of California throughout their history," said Randall Huyser, an HMO analyst with Furman Selz Inc. in San Francisco.

The company has also moved away from the staff model HMO (*BI*, Aug. 5).

"FHP clearly over the last couple of years has been trying to spin off its clinics and sell its facilities so it really did turn into more of a pure (independent practice association)," said Larry Tucker, a principal with Hewitt Associates L.L.C. in Newport Beach, Calif.

"That probably made it more attractive to PacifiCare because in effect you're basically merging together two IPA arrangements" that are organizationally compatible.

Observers also point out this would be unlike some other recent deals that combined traditional indemnity companies with HMOs, which should help expedite the absorption process.

PacifiCare, FHP and TakeCare are "three relatively well-run HMOs that came from the same starting place" and are continuing to focus on what has made them successful, said Jim Foreman, a principal with Towers Perrin in San Francisco.

"At a macro level, we are remarkably alike," said FHP's Mr. Price.

"I am sure, however, as we explore and examine each benefit package and each product line, we are going to find small differences in things like co-payments, drug payments and minor differences that will have to be brought into alignment for us to achieve some of the efficiencies that we have in mind. But, I believe from a consumer point of view these are very, very minor issues."

"We have a very willing set of buyers and sellers, and those two things go further to insure this deal will be carried through to its end than anything else we can do," said Mr. Hoops.

The acquisition is not expected to lead to any dramatic change in rates, however. "There's no intent to use leverage to increase price," he said. "We will be like everyone else in that regard. The market sets price."

Hopefully, he added, the deal will lead to cost efficiencies so the company can flourish at market pricing better than the competition.

John Sarri, an executive consultant with Coopers & Lybrand L.L.P. in San Francisco, said, "It's certainly possible that employers will get more competitive rates out of the combined entity because of the leverage that it will have." In addition, the leverage created by the amount of Medicare risk business it does could lead to better deals on its commercial business, Mr. Sarri said.

"From a business concept sense, clearly it gives the combined company greater power to go to employers and demonstrate that they have a broad presence in the market in terms of providers and locations," said Michael Kaplan, director of corporate health care ratings for Standard & Poor's Corp. in New York.

"In terms of going to the providers and seeking discounts based on that market power. . .there's the ability to obtain the lowest price that was secured by either one of the organizations in their local market areas."

As HMOs continue to merge and consolidate, it "will give HMOs more strength and power over providers overall," said Barbara Wachsman, western region practice manager for Towers Perrin's integrated health systems consulting practice in San Francisco.

More mergers and acquisitions can be expected.

"This is today's version of what we seem to be seeing once a week or once a month here, with these mammoth health mergers leapfrogging over one another to become the biggest provider," said Stephen Parahus, a consultant with Kwasha Lipton L.L.C. in Fort Lee, N.J.

"Right now, with the price of HMO stocks being depressed, it'll make acquisitions more economical," said Manfred Nowacki, vp at A.M. Best Co. in Oldwick, N.J.

"I think we're in the midst of a shakeout period and you're going to see more of them," agreed Michael LeConey, an analyst with National Securities Inc. in New York. "It's a very logical benefit in a very difficult period as people search for sizes and scale and stability."

"There's no doubt that short term, you're talking about healthy, capable companies" in viewing this deal, said Dr. Kenia Casarreal, head of William M. Mercer Inc.'s western health care provider consulting practice.

However, if merger and acquisition activity continues, at some point, employers may say "Gee, this is a reduction in our ability to negotiate," Dr. Casarreal said.

Tanya Bednarski, adviser-health care plans for Chevron Inc. in San Francisco, said that ironically, Chevron had added both HMOs last year to give its employees more choices. It may now decide to look for another HMO to replace FHP, she said.

Ms. Bednarski said she hopes the acquisition is accomplished in an or-

See **PacifiCare** *on next page*

Updates

Ford fined $10 million

DALLAS—Ford Motor Co. is asking a state court judge to dismiss a $10 million fine assessed against the company for improperly obtaining documents from State Farm Group relating to a lawsuit pending against the automaker.

The fine, levied even before the trial has begun, was ordered last week after a plaintiffs' attorney in the case contended that Ford purchased confidential reports from the insurer. The lawsuit, scheduled to go to trial in December, was filed by the family of a Dallas woman who died in a 1991 crash when the brakes and cruise control failed on the 1989 Ford Probe she was driving.

State District Judge Candace Tyson ruled that Ford improperly obtained independent engineering reports that State Farm commissioned after the accident. Attorneys contended that Ford bought the reports, which should have been considered confidential, for $500 after Ford's attorney threatened to obtain a subpoena.

A Ford spokesman said the Dearborn, Mich.-based automaker did pay $500 for the reports to offset the insurer's cost of preparation but said the papers were not protected by confidentiality agreements.

Bloomington, Ill.-based State Farm, which is not party to the lawsuit, would not comment on the report or the case.

GOP has convention coverage

SAN DIEGO—The Republican National Committee has a total of $125 million in primary property and casualty coverage for this week's convention in San Diego.

Johnson & Higgins is the broker for the coverage, which is underwritten by American International Group Inc. of New York, said Jerry Johnson, the claims and insurance manager for the city of San Diego.

The RNC's $125 million in coverage will serve as the primary layer, Mr. Johnson said. For any one occurrence exceeding those limits, the city has a $3 million self-insured retention and $22 million in excess coverage, also underwritten by AIG, that would respond.

J&H confirmed it is the broker for the convention but said the RNC would not permit release of more details. AIG refused to comment.

The Republican National Committee would not return calls.

Guardian Royal sells reinsurer

LONDON—As part of a strategy to focus on core business, U.K. insurer Guardian Royal Exchange P.L.C. is selling its Swiss reinsurance subsidiary, Guardian Ruckversicherungs-Gesellschaft.

Although GRE will not name the buyer until the U.K. Department of Trade and Industry has approved the deal, a spokesman confirmed the subsidiary has been sold for £65 million ($100.1 million), slightly above the net asset value.

GRE Re was established 20 years ago but has contributed about £12 million ($18.6 million) in losses since 1994. "GRE Re didn't seem appropriate to the current structure of the group," which is focused on general insurance in the United Kingdom and overseas, he said.

Exxon to secure spill award

IRVING, Texas—Exxon Corp. will negotiate with plaintiffs on an acceptable form of security to back a $5 billion punitive damage award in the Exxon Valdez oil spill case.

U.S. District Judge Russel Holland last week rejected the company's attempt to delay payment while the case is on appeal. He said he opposed the idea of an unsecured judgment without a specified date for payment, but he acknowledged Exxon's difficulty in finding an underwriter for a $5 billion surety bond to back the 1994 award.

In its motion, Exxon had asked that, in lieu of the company securing the bond to cover its liability, the judge accept the company's word that it will pay full damages after conclusion of all appeals.

Judge Holland ordered Exxon to work with plaintiffs on an acceptable form of security if a bond is not found. The ruling paves the way for Exxon to begin the appeals process.

Briefly noted

General Electric Capital Corp is buying First Colony Corp., a life insurer in Lynchburg, Va., for $1.8 billion. Another GE unit, Employers Reinsurance Corp., was the focus of speculation on Wall Street that it might acquire American Re-Insurance Co. (*BI* , Aug. 5). GE Capital would not comment on the speculation. Separately, **American Re** confirmed its board of directors is considering "strategic alternatives," including the reinsurer's possible merger or sale. Am Re said it has received inquiries from several parties, though "there is no assurance that the company will conclude a transaction on terms that will be acceptable to it." . . .**America Online** said it would compensate subscribers with one day of free service at a cost of about $3 million for last week's service disruption, which left its 6 million members without online services for almost 19 hours. A spokeswoman said AOL has business interruption coverage, but could not say whether it would file a claim. . . .A Jacksonville, Fla., jury awarded $750,000 last Friday to a smoker who sued **Brown & Williamson Tobacco Co.** Grady Carter, 66, brought suit against the manufacturer of Lucky Strike cigarettes and alleged that he was unable to stop smoking until he was diagnosed with cancer. He initially asked for at least $1.5 million in damages. . . .Alabama Lt. Gov. Don Siegelman, acting as a private attorney, last week filed suit against the **tobacco industry** on behalf of four individuals seeking damages to reimburse the state for the cost of treating smoking-related illnesses. . . .**Smith Corona Corp.** has asked the Pension Benefit Guaranty Corp. to take over its underfunded defined benefit pension plans for hourly and salaried workers. The plans have assets of $68 million and liabilities of $96 million, a PBGC spokeswoman said. The company has about 300 current employees and some 4,300 retirees in the pension plans.

Long-term

Continued from page 3

educated on what LTC offers, from nursing care to home health care to assisted living care, she said.

John Hancock will "seize the educational opportunities that this offers us" in promoting LTC anew to both plan sponsors and workers, she said.

LTC coverage witnessed a surge in business in the past year, even before final congressional action, and especially in the past six months, said Doreen Goodnough, vp of long-term care of Middletown, Conn.-based Aetna Health Plans. The tax code change "really solidifies LTC as a benefit," she said.

"A plan sponsor who might have been on the cusp of deciding if they want to do this may be persuaded to do this," she said.

Insurers say they expect some plan sponsors to make modest contributions to employees' LTC premiums, but even those that already offer the benefit may not make full use of the change in federal law.

"For sure, we'll take a long look at the whole (health insurance) bill," according to Mr. Johnson of Lexmark.

"There are certain things I'd like to do to publicize it more, and have an ongoing campaign," he said.

But it is too early to tell if Lexmark or others will shift scarce benefit dollars to LTC, at least until the company's messages on bulletin boards and in enrollments kits generate more curiosity from employees and inquiries to management. BI

PacifiCare

Continued from previous page

derly manner and that "they don't lose sight that the reason they're there in the first place is the members."

Quality of service is also the focus of the California Public Employees Retirement System, said a spokeswoman. "CALPERS isn't concerned whether there are 10 players or 220 players," she said.

Its members will want to be sure that they can keep their own physicians with the acquisition. There is no indication that will be a problem, she added. "If anything, the merger will accomplish some economies of scale that are cost effective."

If the move does result in some savings, however, "we would certainly want to make sure that some of those savings are passed along and have some benefit to the customer," she said.

Lisa Hamill, president and CEO of the Colorado Health Care Purchasing Alliance in Denver, an employer alliance, said she is taking a wait-and-see attitude.

FHP is one of four HMOs participating in its Cooperative for Health Insurance Purchasing product for fully insured employers.

The four, including FHP, were picked in order to offer employees a choice of different-sized HMOs, she said.

"We would like to see FHP continue with the CHIP. They've been a terrific partner," she said.

There will be no immediate impact in any case, said Stirling Somers, a consultant with Alexander & Alexander Consulting Group in San Francisco, who works primarily with employers with 1,000 to 10,000 employees.

"From my experience with all these acquisitions, it takes about a year for the acquiring company to influence what was already in place." BI

OSHA and accreditation group join forces to clean up health care

By ROBERT KAZEL

CHICAGO—The health and safety practices affecting U.S. health care workers are about to come under a more systematic microscope, though undercover inspectors won't be looming in the halls of the nation's hospitals and nursing homes anytime soon.

The federal Occupational Safety and Health Administration announced last week that it was launching a three-year program, in cooperation with the Oakbrook Terrace, Ill.-based Joint Commission on the Accreditation of Healthcare Organizations, to upgrade safety practices in hospitals and long-term care facilities.

The program, which will include joint education and training, will make health care organizations' compliance with OSHA rules easier than before.

OSHA until now has devoted 85% of its inspections to manufacturing and construction sites and has had minimal involvement with health care worksites, said Joseph A. Dear, the assistant secretary of labor who heads OSHA.

The increased movement into the health care field is part of a current OSHA plan to reinvent itself through entry into non-traditional sectors and to work on a more cooperative basis with more industries.

The move also is due in part to the health care industry's rapid growth in recent years.

The JCAHO, a private, non-profit group that accredits 15,000 U.S. health care organizations, is in an excellent position to learn OSHA standards for hospital safety and to train its representatives to work with hospital administrators to improve conditions, thereby avoiding the need for OSHA intervention, he said.

But the administrator emphasized in a news conference last week that OSHA would neither be ceding its enforcement powers nor taking over accreditation responsibilities.

JCAHO representatives will try to address worker safety problems they notice at health care organizations but won't report them to OSHA, said Dr. Dennis S. O'Leary, JCAHO president.

Instead, the new partnership will focus on education and training of JCAHO and OSHA staff, efforts to analyze JCAHO standards and duplicate OSHA rules, and new collaborative publications and educational workshops.

With the commission's help, OSHA will be able to monitor health and safety in hospitals without using many of its own resources in doing inspections, according to Mr. Dear.

The program will be evaluated by both groups after three years to see if employee injury and illness rates have declined.

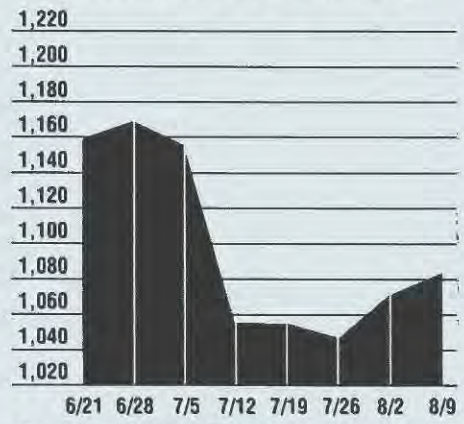
A hospital safety and accreditation executive said the new initiative could help hospitals get out from a mountain of safety rules.

"The more they (private and public agencies) can get together and come up with a more consistent and coherent set of standards among all agencies, I guarantee the happier we will be," said Cynthia Barnard, director of quality strategies at Chicago's Northwestern Memorial Hospital.

She did, however, question how effectively JCAHO surveyors would be able to scout OSHA-related safety problems during their inspections of hospitals once every three years.

Their visits already are extremely busy, according to Ms. Barnard. BI

BI Insurance Index



Base=100 on Dec. 29, 1978
Source: Nordby International Inc.

PCS catastrophe options

As of Aug. 9

Call spread	Price bid/ask	Call spread	Price bid/ask
Eastern September 1996		**California Annual**	
40/60	2.8/3.8	40/60	.6/1.3
50/70	2.5/3.5	80/100	.4/1.1
80/100	1.4/2.9		
Southeast Sept. 1996		**Western Annual**	
40/60	2.5/3.5	40/60	1.1/1.5
80/100	1.2/2.6	80/100	.5/1.3
Texas Sept. 1996		**Northeast Sept. 1996**	
40/60	1.2/2.1	40/60	.5/1.2
80/100	.5/1.8		

Total volume: 88 Total open interest: 3,575

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

Source: Chicago Board of Trade

British Issues

Aug. 8	Price	P/E	Div.	Yield	1 week
Companies	pence		pence	%	high—low
Comml Union	613	11.8	35.3	5.8	617—602
Genl Accident	666	10.0	38.8	5.8	671—652
Gdn Royal Exch	244	9.0	11.3	4.6	251—244
Independent	490	9.2	14.1	2.9	490—490
Royal & Sun	394	9.4	21.6	5.5	395—394
Brokers					
Bradstock	71	11.8	7.1	10.0	71—71
Fenchurch	94	6.3	10.6	11.3	94—94
CE Heath	93	10.9	6.3	6.8	93—93
JIB Group	104	10.3	9.4	9.0	105—104
Lloyd Thmpson	184	11.3	11.3	6.1	184—182
Lowndes Lmbrt	131	8.6	10.5	8.0	131—130
Nelson Hurst	185	11.3	9.8	5.3	185—185
Sedgwick Grp	128	10.0	8.1	6.3	128—124
Steel Brl Jones	39	5.1	5.6	14.3	39—39
Willis Corroon	137	12.3	8.3	6.0	137—133

Source: Philip Olsen, London

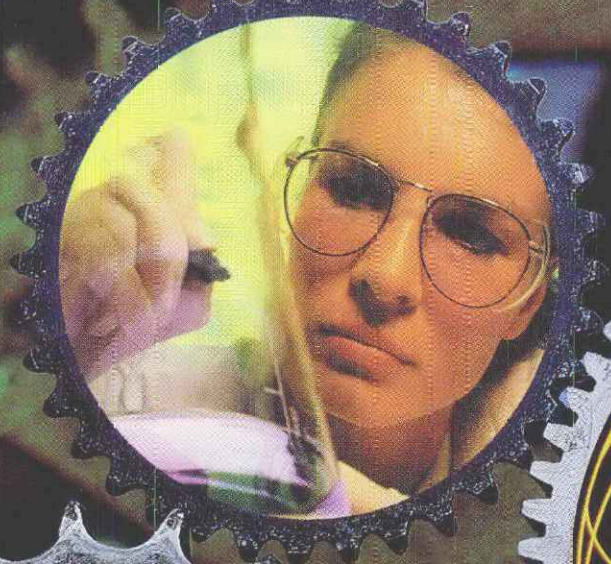
BI Industry Stock Report AUG. 5, 1996, THROUGH AUG. 9, 1996

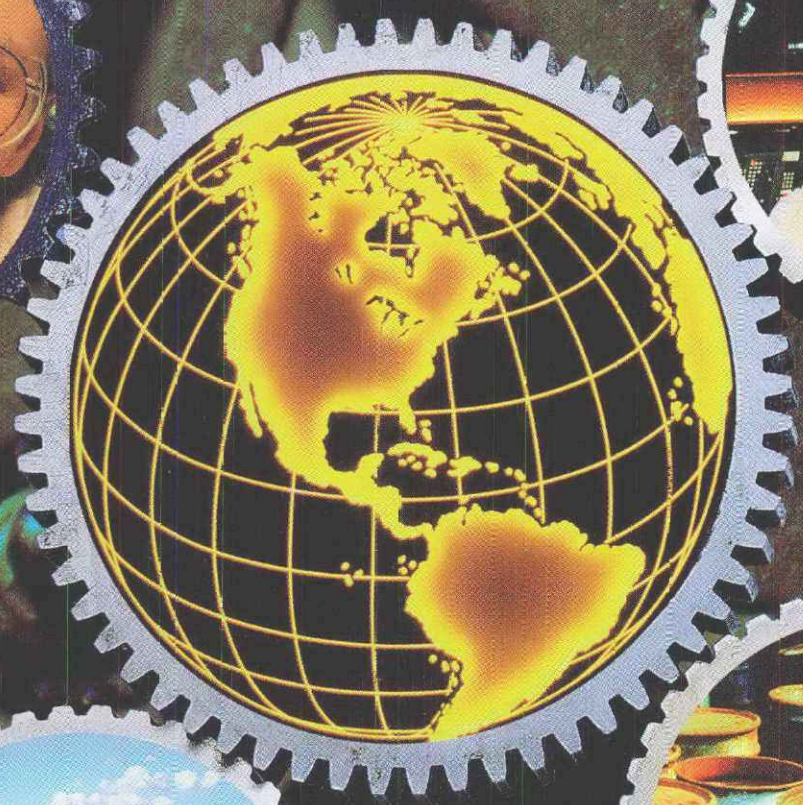
		Price	Weekly % change	Year to date % change	Year to date High	Year to date Low	Vol.(000)
BROKERS							
Acordia Inc.	NYS	30.875	-0.40	3.78	33.75	23.50	16
Alexander & Alexander	NYS	16.75	-2.19	-11.84	25.50	16.00	358
E.W. Blanch Holdings Inc.	NYS	19.375	0.65	-17.11	25.50	16.75	60
Gallagher Arthur J. & Co.	NYS	32	1.19	-14.09	39.50	30.00	98
Hilb, Rogal & Hamilton	NYS	13.125	0.00	-1.87	14.38	11.38	177
Kaye Group Inc.	NDQ	5	5.26	-37.50	8.75	4.63	26
Marsh & McLennan	NYS	92.125	-0.14	3.60	101.63	77.75	623
Poe & Brown	NDQ	24.375	2.63	-2.01	25.50	22.75	37
BROKERS	AVERAGE		0.9	-9.6			
INSURERS/REINSURERS							
ACE Ltd.	NYS	46.375	4.51	16.67	50.38	29.00	1310
Acceptance Insurance Cos.	NYS	17.625	-2.76	18.49	18.63	13.13	337
AEGON N.V.	NYS	48.625	0.52	10.51	50.38	33.25	28
Aetna Life & Casualty	NYS	64.5	9.09	-6.86	78.75	55.38	7348
AFLAC Inc.	NYS	34.125	-1.09	17.67	34.75	24.38	1176
Allied Group Inc.	NDQ	39.25	10.56	9.03	44.25	28.75	190
Allmerica Prop. & Casualty	NYS	26.125	-1.42	-3.24	27.25	21.88	51
Allstate Corp.	NYS	46.125	0.27	12.16	47.00	29.88	2821
AMBAC Indemnity Corp.	NYS	51	3.55	8.80	55.25	40.38	448
American Bankers Ins.	NDQ	44.5	5.95	14.10	44.50	31.38	540
American Financial Group	NYS	30.375	-2.41	-0.82	34.50	25.25	182
American General	NYS	36.5	3.18	4.66	39.13	31.00	1118
American Heritage Life Ins.	NYS	19.125	0.00	-16.39	24.25	18.88	96
American Indemnity/Fin'l	NDQ	10.5	2.44	5.00	13.38	9.00	2
American International	NYS	99.5	0.63	7.57	103.38	72.13	2923
American Re Corp.	NYS	57.625	-1.07	40.98	59.75	34.00	1813
Aon Corp.	NYS	48.5	-2.02	-2.76	56.00	37.00	502
Argonaut Group	NDQ	29.375	-0.42	-9.62	35.00	28.88	205
AVEMCO Corp.	NYS	16.25	4.00	1.56	17.50	11.75	56
Baldwin & Lyons Inc.	NDQ	18.25	0.00	12.31	20.75	14.25	1
Berkley W.R. Corp.	NDQ	46	12.20	-14.42	55.50	38.75	562
Berkshire Hathaway Inc.	NYS	31100	-0.96	-3.12	38000.00	24500.00	0
Capital RE Corporation	NYS	36.125	3.58	17.48	38.25	27.00	44
CapMac Holdings Ltd.	NYS	32	-0.78	NA	32.00	21.13	150
Capsure Holdings Corp.	NYS	18.5	4.23	4.96	18.88	13.00	138
Chartwell Re	NDQ	21.5	0.00	NA	24.75	10.00	15
Chubb Corp.	NYS	44.75	-2.19	-7.49	52.25	40.88	2430
CIGNA Corp.	NYS	115.375	5.01	11.74	125.50	88.25	1062
CNA Financial Corp.	NYS	101.875	-0.73	-10.24	123.25	91.13	88
EMC Insurance Group Inc.	NDQ	11.5	-4.17	-16.36	15.25	10.13	14
Everest Reinsurance	NYS	24.625	-1.99	5.35	26.50	18.50	306
Executive Risk Inc.	NYS	35.625	1.06	22.84	38.25	18.75	93
EXEL Ltd.	NYS	34.625	1.84	13.76	36.88	26.25	906
Fremont General Corp.	NYS	26.75	3.88	9.18	26.75	17.75	311
Frontier Insurance Group	NYS	36.75	6.14	14.84	38.00	27.50	92
Gainsco Inc.	NYS	10.25	1.23	-9.89	12.38	8.31	274
GCE Holding Ltd.	NDQ	22.875	-1.08	NA	27.25	19.75	198
General RE Corp.	NYS	149.5	-1.89	-3.55	158.25	132.50	1223
Gryphon Holdings	NDQ	12	-15.79	-37.66	20.25	12.00	446
Guaranty National Corp.	NYS	14.25	-2.56	-7.32	18.13	13.38	12
Harleysville Group	NDQ	24.875	-1.00	-23.17	33.00	24.75	201
Hartford Steam Boiler	NYS	44	-0.56	-12.00	52.50	43.25	238
HCC Insurance Holdings	NYS	30	7.62	62.16	30.38	10.25	64
IPC Holdings Ltd.	NDQ	19.625	-1.26	NA	22.25	19.00	637
ITT Hartford Group	NYS	53.875	-0.46	11.37	55.00	44.50	743
LaSalle Re Ltd.	NDQ	23	-1.08	NA	23.63	19.50	218
Lincoln National	NYS	44.25	-0.56	-17.67	57.00	39.88	1059
Markel Corp.	NDQ	87.5	1.74	15.89	94.50	64.00	7
MBIA Insurance Group	NYS	78.5	0.16	4.67	80.88	65.25	163
Meadowbrook Insur. Group	NYS	28.75	10.05	-14.18	34.13	24.00	93
Mid Ocean Ltd.	NYS	41.125	-1.20	10.77	43.00	30.88	66
MMI Cos. Inc.	NYS	32.875	2.33	36.98	32.88	20.00	85
Mutual Risk Mgmt. Ltd.	NYS	27.75	-0.89	-19.13	34.88	25.63	202
NAC Re Corp.	NYS	34.5	-2.47	-4.17	39.00	28.50	317
National Re Corp.	NYS	51.875	0.24	36.51	52.13	30.00	176
Navigators Group	NDQ	18.75	4.17	6.38	20.25	13.50	38
Nobel Insurance Ltd.	NDQ	11.75	6.21	3.30	12.75	10.13	55
Ohio Casualty Corp.	NDQ	33.75	2.27	-12.90	40.00	30.00	209
Old Republic Int'l	NYS	21.5	2.38	-9.15	24.38	17.63	773
Orion Capital Corp.	NYS	49.375	-0.25	13.83	51.00	39.88	471
Partner Re Ltd.	NDQ	28	-5.08	1.82	31.88	23.75	1305
Penn-America Group Inc.	NDQ	15	3.45	5.26	16.75	10.25	42
Philadelphia Cons. Holding	NDQ	17.5	0.72	7.69	22.50	15.50	49
PXRE Corp.	NDQ	23.125	1.65	-12.74	29.75	22.25	157
Reliance Group Holdings	NYS	8	1.59	-7.25	9.25	6.25	1003
Reliastar Financial Corp.	NYS	44.75	4.07	0.85	51.63	36.25	378
RenaissanceRe Holdings Ltd.	NYS	29.375	0.00	-3.29	33.13	22.00	59
Risk Capital Holdings	NDQ	17.625	-0.70	-24.60	23.38	16.75	7
RLI Corp.	NYS	23.75	-0.52	-5.00	25.88	21.75	68
St. Paul Companies	NYS	52	0.48	-6.52	60.50	48.63	700
SAFECO Corp.	NDQ	33.25	-2.21	-3.62	39.75	28.88	1779
Seibels Bruce Group	NDQ	2.125	6.25	41.67	4.25	0.44	99
Selective Ins. Group	NDQ	32.75	2.34	-7.75	38.75	31.00	70
Sphere Drake Holdings	NYS	8.25	-1.49	-41.07	19.13	8.13	55
TIG Holdings	NYS	28.375	0.44	-0.44	34.25	23.88	600
Titan Holdings, Inc.	NYS	15.125	0.83	5.22	16.63	12.25	8
Tokio Marine & Fire	NDQ	57.5	-8.18	-12.88	69.25	50.88	17
Torchmark Corp.	NYS	43.625	1.16	-3.59	49.88	38.25	1072
Transatlantic Holdings	NYS	71.25	5.17	-2.90	75.25	62.38	137
Transnational Re Corp.	NDQ	22.75	1.11	-7.14	27.25	20.88	46
Travelers Aetna Property	NYS	27	0.93	NA	28.50	23.13	436
Travelers Corp.	NYS	45.375	1.11	8.68	47.25	30.88	3510
Trenwick Group Inc.	NDQ	50.5	3.59	-10.22	57.50	45.75	120
Unico American Corp.	NDQ	7.25	0.00	16.00	7.75	5.50	80
Unionamerica Holdings	NYS	17.625	5.22	NA	18.13	14.75	78
United Fire & Casualty	NDQ	35	6.06	25.00	40.00	20.38	0
Unitrin	NDQ	48.25	3.74	1.04	51.75	44.25	138
UNUM Corp.	NYS	63.25	2.85	15.00	63.25	45.38	441
US Facilities Corp.	NDQ	16.75	0.37	-21.64	23.38	14.88	132
USF&G Corp.	NYS	16.25	1.56	-3.70	19.50	14.25	768
USLIFE Corp.	NYS	30.75	2.50	2.93	33.25	26.88	500
Washington National	NYS	28.875	3.59	4.52	30.50	21.75	326
Zenith National Ins.	NYS	28.5	1.79	33.33	28.88	45	
Zurich Reinsurance Centr.	NYS	28.625	-3.78	-5.76	32.63	28.13	101
INSURERS/REINSURERS	AVERAGE			1.2	2.0		
HEALTH MAINTENANCE ORGANIZATIONS							
FHP International	NDQ	35.9375	28.92	26.10	35.94	21.75	18829
Healthsource Inc.	NYS	14.5	27.47	-59.72	40.88	9.75	4848
Humana Inc.	NYS	19.25	18.46	-29.68	28.88	15.00	6839
Oxford Health Plans	NDQ	45.5	20.93	23.18	55.25	23.00	15543
Pacificare Health Sys.	NDQ	72	4.73	-17.24	98.75	52.00	385
Safeguard Health Enter.	NDQ	20.75	3.11	78.49	20.88	10.50	42
Sierra Health Services	NYS	29.25	7.34	-7.87	36.00	24.13	613
United Healthcare Corp.	NYS	39.625	12.81	-39.39	69.00	30.00	11502
Wellpoint Health Networks	NYS	26.5	0.95	-17.51	39.13	23.38	439
HMOs	AVERAGE			13.9	-4.8		
ALL COMPANIES	AVERAGE			5.3	-4.2		

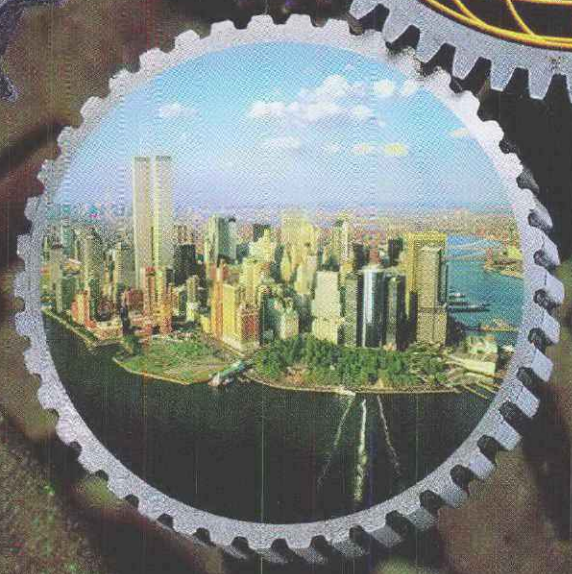
Top advancing issues: FHP International, Healthsource Inc., Oxford Health Plans. Leading decliners: Gryphon Holdings, Tokio Marine & Fire, Partner Re Ltd. Most active issue: FHP International. The BI Index rose 1.2%; the Dow Jones 30 Industrials rose 0.03%; the S&P 500 decreased 0.1% and the NYSE Composite lost 0.1%. Average P/E: Brokers, 14.7; Insurers/reinsurers, 15.9; HMOs, 28.1.

System design: Nordby International Inc.

Reliance National's
Risk Management Services







Machinery won't function properly or produce positive results unless all of its parts and gears are working in conjunction with each other. Like machinery, the mechanism of managing risk can also be a complex, multi-faceted process that requires the right alignment and balance.

At Reliance National, our Risk Management Services Division accommodates the nuances and synergistic approach necessary to do business with larger accounts – allowing for smooth, efficient and responsive outcomes. Multi-disciplined, innovative underwriters, creative and strategic programs and customized insurance products are all part of our approach.

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